Warwickshire Health and Wellbeing Board

Agenda

21st May 2014

A meeting of the Warwickshire Health and Wellbeing Board will take place in **Committee Room 2, Shire Hall, Warwick** on **Wednesday 21st May 2014 at 13.30.**

The agenda will be:-

1. (13.30 – 13.35) General

(1) Apologies for Absence

(2) Appointment of Board Member

To appoint a representative for the Warwickshire North Clinical Commissioning Group.

(3) 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.

(4) Minutes of the Meeting of the Warwickshire Health and Wellbeing Board on 26th March 2014 and Matters Arising.

Draft minutes of the meeting are attached for approval.

Mobilising Communities to Develop and Maintain Independence

2. (13.35 – 13:45) Planning for Healthier Communities

Neil Benison

Working Together

3. (13.45 – 13.55) Better Care Fund Update

Chris Lewington

4. (13.55 – 14.00) The Care Bill – Task and Finish Group

Wendy Fabbro

5. (14.00 – 14.25) Joint Strategic Needs Assessment Annual Update 2013/14

John Linnane

6. (14.25 – 14.45) Development of the Board.

Nicola Wright

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

Health and Wellbeing Board Newsletter Link to Newsletter

Minutes of Safeguarding Boards, Joint Commissioning Boards and Health Protection Committees Link to Minutes

Date of Future Meetings and Events:

23 June	JSNA and HWB Strategy Prioritisation Workshop
15 July	Health and Wellbeing Board Meeting
1 Sept.	HWB workshop to discuss draft HWB Strategy

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: Vacancy (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)

General Enquiries: Please contact Paul Spencer on 01926 418615
E-mail: paulspencer@warwickshire.gov.uk

Minutes of the Meeting of the Warwickshire Health and Wellbeing Board held on 26 March 2014.

Present:-

Chair

Councillor Izzi Seccombe

Warwickshire County Councillors (In addition to the Chair)

Councillor Maggie O'Rourke
Councillor Bob Stevens
Councillor Heather Timms

Clinical Commissioning Groups

Andrea Green (Warwickshire North CCG)
Juliet Hancox (Coventry and Rugby CCG)
Dr David Spraggett (South Warwickshire CCG)

Warwickshire County Council Officers

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

Healthwatch Warwickshire

Deb Saunders – Chief Executive

NHS England

Martin Lee – Medical Director

Borough/District Councillors

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

1. (1) Apologies for Absence

Councillor Michael Coker (Warwick District Council)
Heather Gorringe (Warwickshire North CCG)

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

Councillor Maggie O'Rourke declared a non-pecuniary interest as an employee of South Warwickshire NHS Foundation Trust. Councillors Derek Pickard and Claire Watson declared a non-pecuniary interest as members 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 20 January 2014 and of the Extraordinary Meeting held on 11 February 2014 and matters arising.

The Minutes were agreed as true records of the two meetings, subject to the inclusion of the attendance of Gillian Entwhistle, representing Dr David Spraggett of South Warwickshire CCG at the 20 January meeting.

2. A Summary of the Care Bill and its Implications

Jenny Wood, Head of Social Care and Support (WCC) updated the Board on the Care Bill and to give a summary of the potential implications for Warwickshire based on the information currently available.

A background and context was provided on the Law Commission review and its recommendations for a review of legislation in the report 'Adult Social Care'. Additionally, the Dilnot Commission was established by the Government to report on how to deliver a fair, affordable and sustainable funding system for adult social care. Progress of the Care Bill continued and an overview was given of the Bill as brought from the House of Lords. The report focussed on the three key parts of the Bill, which looked in turn at care and support, care standards and Health Education England / the Health Research Authority. A table was included which showed examples of the Care Bill's implications for Warwickshire. Further information was circulated to the Board on the financial implications for the County Council and on next steps.

The Chair commented that this was a significant piece of legislation. She referred to work through the Local Government Association (LGA), to shape the Bill and would endeavour to keep the Board informed of the LGAs work.

Councillor Maggie O'Rourke referred to the formal recognition of support for carers and asked how their needs would be assessed, noting the significant implications this aspect of the Bill would have. It was confirmed there was now a statutory duty to assess carers' needs separately. The assessment process was pursued by Councillor Bob Stevens and there was discussion about appeal and complaint

processes. It was explained that assessments were undertaken by social workers and detailed guidance was awaited.

Dr John Linnane, Director of Public Health sought a distinction between statutory principles and duties as referred to in the paper. Further information was provided by Wendy Fabbro, Director of the People Group and it was noted that the final wording of the Act would be definitive.

Another area discussed was the identification of failing services. Care Quality Commission Inspections would be the key mechanism, but complaints to the County Council or via Healthwatch were further indicators. Finally, the service provision around transition from youth to adult services was discussed.

Resolved

That the report is noted and that further reports be provided to the Board as the implications of this legislation become clearer.

3. Coventry and Warwickshire Partnership Trust – Update

The Board received a presentation from Rachel Newson, Chief Executive of the Coventry and Warwickshire Partnership Trust (CWPT), on their two year plan for sustainability. The presentation provided a background, a high level outline of the Trust's strategies and transformational change programme, together with details of the Trust's operating model and financial planning arrangements. Further slides looked at workforce aspects, system alignment, the information gathered from joint strategic needs assessments and the Trust's forward plans.

The Chair asked for an update on the Care Quality Commission (CQC) inspection of the CWPT and it was confirmed that the draft CQC report had been received, but could not yet be commented on. The Chair also spoke about the Trust's relationship with the Board and the need for an ongoing dialogue.

Monica Fogarty, Director of Communities questioned the financial aspects of the presentation, regarding the generation of 1.4% of surpluses. Rachel Newson explained how the Trust's income and expenditure projections were calculated. She also spoke about staffing reviews, care pathways, maximising use of Trust premises and procurement reviews.

Councillor Gill Roache queried the cost pressure for the IT Strategy in the sum of £1.7 million. This was discussed and information was provided about the move to a new IT system for patient records, confidence about its delivery, the procurement process and providing a common protocol to connect IT systems across the NHS.

The Chair advised that the CWPT would also be attending the County Council's Overview and Scrutiny Committee for Adult Social Care and Health in May. She reiterated the need for a stronger working relationship with the Board, with regular updates from the CWPT on its plans.

Resolved

That the presentation is noted.

4. Planning for Healthy Communities

Dr. John Linnane, Director of Public Health introduced this discussion item. At the January Board meeting, planning issues had been raised. Local planning authorities had been invited to attend this meeting, to discuss how the Health and Wellbeing Strategy and advice from Public Health could be incorporated into planning advice and core strategies. For 18 months, work had been undertaken to produce supplementary planning guidance to incorporate health into planning guidance. To assist the discussion, a series of questions had been circulated to the contributors ahead of the meeting.

Contributions were received from Anna Rose of Rugby Borough Council, Ashley Baldwin, Nuneaton and Bedworth Borough Council, Steve Maxey, North Warwickshire Borough Council and Paul Lankester of Stratford District Council. Additionally, Martin Lee and Margaret Johnson spoke on behalf of NHS England. It was noted that an apology had been received from Graham Nuttall of the NHS Property Services Company.

Anna Rose, Rugby Borough Council discussed the relationships between planning and the health sector, the external influences on planning and local plans, including the public inquiry process. Rugby BC had a 2011 adopted Local Plan and was about to start work on a new Local Plan. There was a need for evidence from the Health and Wellbeing Board, to ensure that the area's health needs would be met within the local plan.

Ashley Baldwin of Nuneaton and Bedworth BC echoed the points made above, also speaking about health impact assessments. These were currently included in the Authority's planning policies, but had been challenged successfully at planning appeal and so the policies might need to be withdrawn. This Authority was part way through its local plan process, so input to policies would be timely. He added that the Authority had an infrastructure group, which met twice each year and included health sector representatives.

Steve Maxey of North Warwickshire BC referred to some of the Borough's planning policies promoting cycling and avoiding a concentration of takeaway food premises. He also mentioned the sub-

regional planners group, which he felt would be a useful forum to progress the dialogue on health inputs to planning.

Monica Fogarty spoke of the need to link together the key partners. She introduced Neil Benison, the County Council's Infrastructure Delivery Manager, whose role was to bring together key strands of work on issues such as highways and transport, health and education.

Paul Lankester of Stratford District Council stated the need to consider political aspects and the involvement of portfolio holders. Another point was having a 30-year vision for strategic planning, and through design, to reduce crime and promote health issues.

Martin Lee referred to the reorganisation of the NHS and its need to re-establish links with other partners. As a context, he stated that health services could no longer be delivered in the same way as previously. He referred to the transformation of primary care services and their delivery on a wider scale. The need for close links between planning and clinical commissioning groups was also stated. Margaret Johnson of NHS England then spoke about the growing number of premises that were not CQC compliant. As such premises became obsolete, there were issues with people being decanted and in future, economies of scale would dictate that some care facilities were not as local.

NHS England was asked to give an update on primary care developments in the County, it being questioned whether there was a moratorium on additional development. Nationally, 17 development commitments had been inherited by NHS England, having received prior PCT Board approval and these were the priority for funding. In Warwickshire, there were two schemes being considered at the regional level, for developments in Rugby and Warwick. It was agreed that a list of the schemes be provided by NHS England, for circulation to the Board and to district and borough councils.

Further points were made about developments and population growth. Whilst individual developments did not meet the criteria to justify new health facilities, there was a cumulative impact and the need for investment in both primary care and education facilities. The pooling of health facility contributions was suggested.

Councillor Heather Timms declared a non-pecuniary interest in respect of the proposed health development in Rugby. She explained that the local authority had contributed the land towards this scheme. There was a need for a long-term view to deliver the best health outcomes.

David Spraggett spoke about changes to the delivery of primary care services. There were no additional resources within the NHS and the redirection of funds from secondary care services was one method which could be used, but this often attracted political opposition. There was also discussion about the evidence that planners required to justify

health contributions in a robust way and guidance on how this should be provided would be helpful. It was reiterated that the sub-regional planning forum would be a useful meeting for the health sector to engage with.

The Chair summarised the points raised and felt this item had demonstrated the need for key partners to have a regular dialogue.

Resolved

That points raised be noted and that progress would is reviewed later in the year.

5. Better Care Fund Update

Wendy Fabbro introduced this update as an information report. It provided details about the initial Better Care submission and feedback received from the West Midlands Local Area Team. Detail was also provided on national changes to guidance and the funding allocation and on progress towards the next submission deadline of 4th April.

Resolved

That update is noted.

6. Any Other Business

Dr Linnane spoke about a review of WCC Community Transport arrangements and offered to circulate further information to the Board. It was reported that Deb Saunders, Chief Executive of Healthwatch Warwickshire would leave her position in May. The Chair also advised that this would be Monika Rozanski's last meeting before commencing maternity leave. The Board recorded its thanks and good wishes both to Deb and Monika.

The meeting rose at 15.30

……..Chair

Item No 2

Warwickshire Health and Well Being Board

21st May 2014

Report Title: Planning for Healthy Communities

Recommendations

The Board note the contents of the report and the current work with District and Borough Councils regarding their emerging core strategies.

1.0 Introduction

1.1 To update the Board on the current progress of Planning for Healthy Communities and the work being carried out with the District and Boroughs on their local plans.

1.2 The report will cover, health policies included in Warwick District Councils Draft Local Plan, Health Impact Assessment being carried out to support Nuneaton and Bedworth Borough Councils emerging Local Plan, work on major site allocations in Stratford on Avon Districts Councils emerging Local Plan and an update from NHS England.

2.0 Background

Infrastructure Delivery.

2.1 The Infrastructure Delivery Team will provides a one stop service with regards to all planning obligations secured via Section 106 Agreements and/or Unilateral Undertakings. Provide a transparent system for securing site specific infrastructure and identify, at an early stage, potential barriers to growth and seeking ways of removing them.

2.2 The team also works closely with the District and Borough Councils and Warwickshire's internal stakeholders bringing together the key strands of major infrastructure required to support each of the five Local Plans. We are working to supply evidence based information to demonstrate the sustainability and viability of these plans. Public Health is one of the prime strands of infrastructure required to ensure that the current new and expanded communities, are able to maximise public health opportunities at an early stage.

Health and Wellbeing Board 26th March 2014.

2.3 Planning for Healthy Communities were discussed extensively at the last Board, with contributions from various District and Borough Councils. The key result of these discussions was an identified need for all key partners to have regular dialogue and that progress would be presented to future Board meetings.

3.0 Warwick District Council – Draft Local Plan

3.1 On the 23rd April 2014 Warwick District Council published its Draft Local Plan, which includes their current preferred options for development and the draft policies which will be carried forward into the final published Plan. Warwickshire County Council has / and are currently liaising with the District Council over a number of Infrastructure matters relating to the Draft Plan, including Public Health. This has led to a number of Public Health orientated polices being included.

3.2 The Key policy in the Draft Plan, for Public Health, is Policy HS6 Creating Healthy Communities. An excerpt of the Draft Local Plan showing Policy HS6 is included as **Appendix 1**.

3.3 Policy HS6 sets out the following key requirements for delivering healthy communities:

- good access to healthcare facilities;
- opportunities for incidental healthy exercise including safe and convenient walking and
- cycling networks;
- opportunities for community cohesion by the provision of accessible services and
- community facilities and places and opportunities for people to interact regardless of;
- high quality housing outcomes to meet the needs of all age groups in society (including
- the right mix by size and tenure);
- Access to high quality and safe green or open spaces, and;
- Access to opportunities to partake in indoor and outdoor sport and recreation.

3.4 Paragraph 5.77 of the explanatory notes to the policy, sets out a clear commitment for Warwick District Council to work with Public Health Warwickshire and the Health and Wellbeing Board. The notes go on to say

that WCC are producing health guidance and a Health and Wellbeing Strategy which ties in with the work being carried out by Emily Fernandez.

3.5 We are committed to working with Warwick District, to ensure that these policies are carried forward into the final adopted plan. It is also envisaged that these draft policies can be used as an exemplar in our discussions with the remaining Districts and Boroughs.

4.0 Nuneaton and Bedworth Borough Council – Health Impact Assessment

4.1 Warwickshire County Council has commissioned, in consultation with Nuneaton and Bedworth Borough Council, a Health Impact Assessment (HIA) of the strategic site allocations for Nuneaton and Bedworth's emerging Local Plan. It is currently programmed for this assessment to be completed before the end of May 2014.

4.2 The HIA is intended to provide constructive comment and to provide opportunities to consider modifications to proposed draft polices contained within the Plan. The HIA will then be submitted as one of the supporting documents to the Plan as it goes to public examination and will strengthen the evidence base and viability of the plan when it is considered.

4.3 The HIA report will include the following:

- a summary of key aspects of the Plan;
- an introduction to the wider determinants of health and the HIA approach;
- a brief record of the 'screening exercise' that determined the need for HIA;
- results of the 'scoping exercise' that identified the potentially important health issues that are the focus of the HIA;
- an analysis section that considers the evidence and reaches a judgement on potential conflicts or opportunities presented by the Plan;
- a conclusion and recommendations section that draws together the key findings of the HIA and the next steps;

4.4 Work on this project is ongoing and will require us to continue to work closely with Nuneaton and Bedworth Borough Council. A meeting is being organised for later in the year for a HIA workshop with the remaining District and Borough Councils in an effort to highlight to them the help and support we can provide.

5.0 Stratford on Avon District Council – Major Site Discussions

5.1 Stratford on Avon District Council are currently finalising their preferred site allocations for their Emerging Local Plan. Among the preferred options are a number of strategic housing allocations, which will form significant new communities.

5.2 One such allocation is a proposal for three thousand new dwellings at Gaydon/Lighthorne Heath.

5.3 The Infrastructure Delivery Team has been involved in a series of meetings with the developers of this site and their consultants regarding a number of potential infrastructure requirements. These meetings are to facilitate both the Developers and Stratford to gather supporting information for the allocation which will be used to produce a draft plan.

5.4 One element of infrastructure required is Public Health, and early contact with the developers have allowed us to get early input into the master planning of the proposed new community. Emily Fernandez was able to submit the Draft Public Health Evidence for Planning paper to the developers and this will be subject to a number of forthcoming meetings.

6.0 NHS England Update

6.1 Premises for Warwickshire which had received PCT Board approval were given a Category 1 status and these are:

- New Premises for 95 Surgery & Beech Tree Medical Practice, Rugby (Cattlemarket) Completed March 2014
- New Premises for Albert Street Medical Centre, Rugby (Brownsover)Board approval - on hold
- New Premises for Bidford Health Centre Expected Completion May 2014

6.2 In addition to those 3 premises, NHS England have received a number of business cases since 1st April 2013 asking that NHSE consider requests for additional funding for premises. These are schemes which are in the 'pipeline' and until the process and finance have been confirmed for such schemes an answer cannot be given. These are categorised below.

6.3 If the Business Cases for these schemes had been received prior to October 2013 they will have been entered onto a Regional return and given a Category 2 status. The two for Warwickshire at Category 2 are:

- Cape Road, Warwickshire and
- Cubbington, Leamington

6.4 Any business cases received since that date will be as Category 3 scheme.

6.5 There are also discussions with developers and local authorities where new housing developments are taking place and which will have a significant impact on the health provision infrastructure and these will be in addition to the above e.g:

- Rugby Radio Station site,
- South Leamington Spa,
- Nuneaton Northern strategic sites.

6.6 Planning and Public Health continue to liaise with NHS England to ensure that health infrastructure requirements are submitted for these new developments.

7.0 Conclusions

7.1 This report identifies the current and ongoing work being carried out in Public Health in terms of Planning. .

7.2 The current work being undertaken also includes opportunities to bring in other District and Borough Councils, highlighting the help and support which is available. It is envisaged that work in this area will continue to grow and the Infrastructure Delivery Team will continue to work to encourage greater early engagement wherever possible.

	Name	**Contact details**
Report Author	Neil Benison	neilbenison@warwickshire.gov.uk Tel: (01926) 418004
Head of Service	John Linnane	johnlinnane@warwickshire.gov.uk Tel: (01926) 413705
Strategic Director	Monica Fogarty	monicafogarty@warwickshire.gov.uk Tel: (01926) 412514
Portfolio Holder	Bob Stevens	cllrstevens@warwickshire.gov.uk

Warwickshire Health and Well Being Board

21st May 2014

APPENDIX 1

Excerpt from Warwick District Council's Draft Local Plan

HS6 Creating Healthy Communities

Development Proposals will be permitted provided that they address the following key requirements associated with delivering health benefits to the community:

a) good access to healthcare facilities;

b) opportunities for incidental healthy exercise including safe and convenient walking and

c) cycling networks;

d) opportunities for community cohesion by the provision of accessible services and

e) community facilities and places and opportunities for people to interact regardless of;

f) high quality housing outcomes to meet the needs of all age groups in society (including

g) the right mix by size and tenure);

h) Access to high quality and safe green or open spaces, and;

i) Access to opportunities to partake in indoor and outdoor sport and recreation.

Explanation

5.76 It is important that new developments are designed to a high standard to ensure that they have a positive impact on the health and wellbeing of both existing and future communities in Warwick District. The design and layout of new housing developments in particular can do much to influence the health of its residents by changing people's behaviour towards embracing a healthy lifestyle.

5.77 The Council is committed to working with Public Health Warwickshire and the Warwickshire Health and Well Being Board to ensure developers and their consultants give full consideration to health and wellbeing outcomes in the design and delivery of development proposals. This will be particularly important in relation to the master planning and formulation of planning applications for strategic housing and employment allocations in this Plan.

5.78 Public Health Warwickshire is to produce health guidance that will assist in the assessment of planning applications to ensure good development outcomes. The Council is also developing a Health and Wellbeing strategy that will also inform and influence decisions that it makes with regard to developing healthy communities across Warwick District, reflecting its commitment to the goal of setting health issues high on its agenda. The Council will also, through its infrastructure planning, liaise with the relevant agencies including Public Health Warwickshire, NHS England, NHS Property Services, South Warwickshire Clinical Commissioning Group and the South Warwickshire Foundation Trust to ensure that new development contributes to the delivery of additional healthcare provision and infrastructure as required throughout the plan period.

5.79 Good access to healthcare facilities is essential and is particularly relevant in relation to housing developments for the elderly and less physically able people in society. Access to well designed, energy efficient housing stock to cater for all sectors of society will be also be beneficial in reducing health inequalities and there should be an appropriate mix by type (size) and tenure to reduce housing waiting lists and create neighbourhoods that are welcoming, accessible and inviting for all regardless of age, health or disability. 5.80 Opportunities to partake in exercise can be provided in many ways. Good footpath and cycling networks are fundamental in creating environments where people can move safely and benefit from opportunities to access local services and facilities. Similarly, access to high quality public open space and recreational facilities for sport and leisure can help motivate people to partake in healthy activities/lifestyles.

5.81 The protection of existing, and future provision of local shops and services and community facilities is also central in delivering sustainable developments that reduce dependency on the use of private motor vehicles. This brings two-fold benefits of increasing the opportunity to walk and cycle as well as ensuring that there are appropriate places for people to meet and interact.

5.82 There are a wide range of other policies contained in this this Plan that will assist in the aim of ensuring good development and are integral in the delivery of positive health benefits.

5.83 It is important that new developments meet the requirements of these policies and that collectively they deliver good development conducive to encouraging people to partake in healthier lifestyles.

5.84 It will be important to monitor the on-going impacts of policy requirements on the delivery of healthier communities. The Director of Public Health's annual report will be a vehicle for providing information about the health of local communities and identifying health gaps and priorities that need to be addressed.

Item 3

Health & Wellbeing Board
21st May 2014

Better Care Fund Update.

Recommendations

(1) That the Health & Wellbeing Board notes the progress being made, and approves quarterly progress reports from the Adult Joint Commissioning Board on the progress being made.

1.0 Key Issues

Attached is the 14th April Better Care Fund submission which outlines the hi level plans for integration in Warwickshire.

The Local Area Team have approved the plans to progress for sign off by NHS England. However, given recent media coverage it is unclear whether further steps towards authorisation will be applied over the coming months. National government has been clear that 2014/15 is considered the planning year and the full implementation will begin from 2015 onwards.

Further more detailed work is now being progressed with each of the respective clinical commissioning groups to establish locally developed delivery plans. A key part of this will be the engagement of key stakeholders including; people who use services, Acutes, Healthwatch and the voluntary and community sector.

An update will be provided as a short presentation to Health & Wellbeing Board given the continuing changing landscape.

Background Papers

1. http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/

	Name	Contact Information
Head of Service	Christine Lewington	01926 745101
Strategic Director	Wendy Fabbro	01926 742967
Portfolio Holder for social care Portfolio Holder for Health	Cllr Jose Compton Cllr Bob Stephens	

Better Care Fund planning template – Part 1

Please note, there are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts must be completed as part of your Better Care Fund Submission.

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

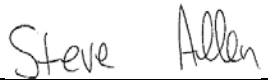
To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Warwickshire county Council**
Clinical Commissioning Groups	**Coventry & Rugby CCG**
	South Warwickshire CCG
	Warwickshire North CCG
Boundary Differences	Coventry and Rugby CCG spans two Local Authorities and two Health and Wellbeing Boards. This plan covers the Rugby population. There is a separate plan for the Coventry population
Date agreed at Health and Well-Being Board:	**11/02/2014**
Date submitted: 1st submission 2nd submission	**14/02/14** **04/04/14**
Minimum required value of ITF pooled budget: 2014/15	**£17462**
2015/16	**£103,651**
Total agreed value of pooled budget: 2014/15	**£0.00**
2015/16	**£0.00**

b) Authorisation and signoff

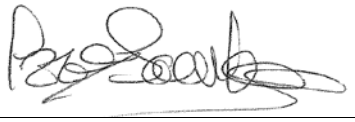
Signed on behalf of the Clinical Commissioning Group	Coventry & Rugby CCG
By	Steve Allen 
Position	Accountable Officer
Date	14th February 2014

Signed on behalf of the Clinical Commissioning Group	South Warwickshire CCG
By	Gill Entwistle
Position	Accountable Officer
Date	14th February 2014

Signed on behalf of the Clinical Commissioning Group	Warwickshire North CCG
By	Andrea Green 
Position	Accountable Officer
Date	14th February 2014

Signed on behalf of the Council	Warwickshire County Council
By	Wendy Fabbro 
Position	Strategic Director for the People Group
Date	14th February 2014

Signed on behalf of the Health and Wellbeing Board	Warwickshire Health & Wellbeing Board
By Chair of Health and Wellbeing Board	Isobel Seccombe

	
Date	14th February 2014

c) Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

This plan has been developed alongside the 5 year system plan as the BCF is central to the delivery of a clinically and financially sustainable care system. Therefore the strategic direction set out in this plan has been widely discussed with providers through: -

a) Routine dialogue between commissioners and providers;
b) Urgent Care Working Groups and;
c) Coventry and Warwickshire Integrated System Board that brings together leaders of the health and care system. As the specific initiatives outlined in this plan are developed in greater detail there will be focused discussions with relevant providers.

More specifically the three Acute providers and the Coventry Warwickshire Partnership Trust have all been actively engaged in scoping and designing the plans at a CCG level;

- CRCCG have held three days planning sessions with a range of key stakeholders including the four main providers.
- SWCCG engage with provider through the Urgent Care Board and have also engaged in a specific provider workshop to support the shape of the plans.
- WNCCG have held a stakeholder workshop and have also revised the scope of the Urgent Care Board to now include the BCF.

All stakeholders agree that existing forums and meetings should be used to drive the BCF forward with a particular preference to use the Urgent Care Board as the primary vehicle for provider engagement, where practical and relevant.

d) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

The three CCGs and Social Care have well developed engagement networks. These networks will continue to have a core role in shaping the direction of travel. Our vision for integration has been informed through engagement with a variety of stakeholders alongside the outputs of the JSNA and the Health and Wellbeing Strategy. This vision underpins the 5 year system plan and the BCF.

The high level content of this plan has been shared with patient, service and user groups and they have been supportive of the direction of travel. As with service providers we will continue to engage these groups as we develop schemes in greater detail.

e) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
Health & Wellbeing Strategy	**Attached in zip file**
JSNA	
Quality of Life Report	
Commissioning intentions SWCCG	
Commissioning intentions WNCCG	
Commissioning intentions CRCCG	
Warwickshire county council commissioning intentions	
Public Health Commissioning intentions	
BCF Governance Structure	
BCF Draft Partnership Agreement	

2) VISION AND SCHEMES

a) Vision for health and care services
Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

Our vision is nothing less than a fundamental transformation of the quality and experience of care, across all elements of commissioning and provision, and on behalf of our communities as a whole.

As a partnership we believe that joining together will make us stronger commissioners and enable us to respond so that:

Our Vision

Individuals will experience better outcomes by delivering the Right Care at the Right Time, in the Right Place – Every Time – Together.

We will know this by using 'I' statements for example:

"I can plan my care with people who work together to understand me and my carers, allow me control, and bring together services to achieve the outcomes important to me."

We recognise that change on this scale will mean consistently providing care that is planned and tailored to individual capabilities and needs; care that is delivered in partnership, to the highest possible standards. This will involve putting individuals at the heart of everything we do because this is the only way we will ensure a sustainable, healthy future for the communities we serve.

We will know we have been successful in five years time through the 'I' statements for example:

Patients/users of health and social care services will feedback that services delivered to them enabled them to make good lifestyle choices in the knowledge that services will wrap around their needs at key stages throughout their life;

Patient/users and their carers will feedback that they were able to make informed decisions about their health and social care needs and were able to remain in control, directing care through personal budgets and personal health budgets.

Patients/users will provide feedback on the quality of services that they had commissioned and/or directed their care co-ordinator to deliver on their behalf;

Staff will equally feedback the positive contributions that they made to a patient/users experience of services and the benefits of joint assessment and care planning;

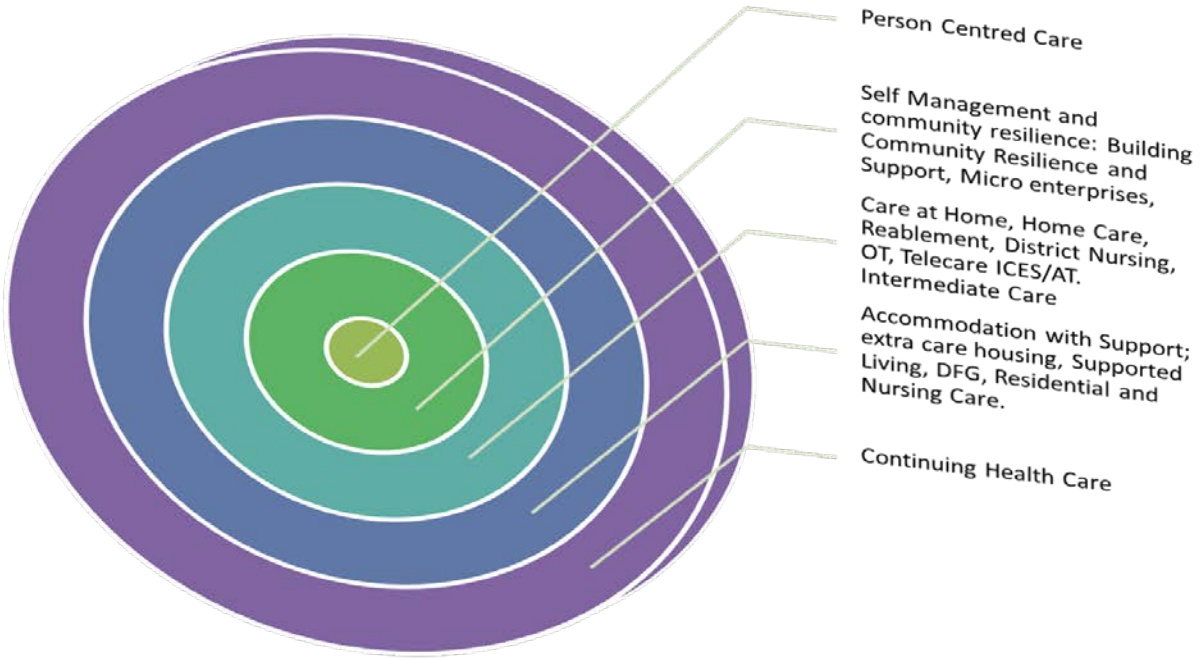
Patients/users and their carers confidence will increase in the quality of care and the levels of satisfaction in terms of people's dignity and respect across all health and social

care services would define Warwickshire as an exemplar of health and social care services.

This plan encompasses the needs of;
Older people
People with Mental Health needs including CAMHS
People with Learning Disabilities
Carers

The Warwickshire plan, below, illustrates a pluralistic model of care which enables a range of packages to be provided, dependent on individual need. An advantage of this is that it allows care to converge where possible towards patient self management and greater control to remain independent for as long as possible. To explain further, as much as possible we want the population to remain independent and to be able to be self sufficient and to only call on health and social care services for time limited re-abling interventions. This means commissioned services (and the market) need to recognise the value of re-ablement, rehabilitation and recovery as the drivers for the whole health and social care economy.

This is better reflected in the diagram below



b) Purpose and Objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

Purpose
The core purpose of this integrated model is to improve outcomes for all people who need health and social care services.

This means:

- People will be helped in their goal to manage their own care and remain healthy and independent;
- People will have real choices and greater access in both health and social care;
- Far more services will be delivered – safely and effectively – in the community and/or at home.

Objectives:

- To build relationships with patients and our communities and determine how the voice of the public remains central to the evolution of the BFC and the associated work programme;
- To identify opportunities for prevention and to promote wellbeing as underpinning patient/user contact;
- To facilitate a risk based model and act as an enabler for people to retain their independence and autonomy;
- To re-engineer how the public and the workforce consider this revised core offer from the health and social care economy to the public;
- To systematically tackle the pressures within the health and social care system to deliver better outcomes for our people and support the transformational, transitional and transactional elements of integration, within available resources;
- To stimulate and drive innovation across the health and social care economy ensuring continued safety and quality of services;
- To build further the close working relationships between all partners to deliver improved outcomes within local resources and establish a single solution to meet need that is affordable for the whole system and each agency;
- To recognise each partners strategic priorities, constraints and responsibilities in order to achieve mutual beneficial outcomes;
- To secure strong and effective clinical and professional practice engagement and leadership across the health and social care economy;
- To demonstrate system wide projects and programmes that deliver value for money;
- To collective agree the priority work programme to deliver a system wide change in how services are commissioned and delivered on the ground.

c) Description of planned changes
Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery

- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

The BCF is central to the delivery of the 5 year system plan. In the 5 year system plan we articulate how we will: -

a) Radically change our approach to wellbeing and self-management
b) Take a systematic approach to transfer activity that should be undertaken by primary care back to primary care. This will include relocating the workforce that currently sits within acute services to the community;
c) Remove the boundaries between practice staff and those working in the community to deliver team based care to individuals who need the support of care professionals to manage their care;
d) Reconfigure site based services in order to deliver safe and effective services within the constraints on the money that we have available.

The content and yearly expansion of the BCF reflects the phasing of the 5 year system plan. The 5 year plan has been developed with a bottom-up approach and builds on each CCGs plan to address the health needs of its population. There are demonstrable links to the JSNA, JHWS, NHS Outcomes Framework, Public Health Outcomes Framework and the Peoples Group Outcomes Framework, (all attached as related documentation) the basis of which will form our Joint Outcomes Framework and Success Criteria. This will be underpinned by a benefits realisation model incorporating the key national metrics as well as some locally defined measure.

Our agreed target operating model is one which puts the patient, service user and carer at the heart. It begins and ends with their voice being heard and acknowledges the expertise that patients and services users and carers bring to a solution based integration model.

The operating model will be built on an evidenced based approach and will recognise the assets people and communities have. It will facilitate a risk based model and act as an enabler for people to retain their independence and autonomy and will re-engineer how the public and the workforce consider this revised core offer from the health and social care economy to the public.

It will be built on the premise of self service and management and will focus on acting as a support mechanism to allow people to make the right choices and decisions about their own health and wellbeing throughout their life course.

Scheme 1: Joint assessment and care planning

Prevention is part of the process of joint assessment of need. We know that approximately a quarter of the population smoke across all ages, hospital admissions as a result of alcohol and just under half of the population are overweight or obese. Identification and signposting particularly through the use of the Making Every Contact Count philosophy is an important part of the assessment process and a key of underpinning a better quality of life for patients/users. To make integration effective Warwickshire is committed to the principle of joint assessments and care planning and to

do this with the patient/user at the heart. We have already begun this work with the development of the ECAT and Common Assessment Framework (CAF) as examples, but further work is required to bring more formally the process of assessment together. We will develop a joint assessment and care planning process building on the trusted assessor model and using technology in its wider capabilities. Our transactional business processes will need to be agreed and embedded across the health and social care economy. We will be investing in co-ordinated care that promotes a holistic view of an individuals need and work with people to empower them and enable them to stay as independent as possible.

We want to move towards a model of integrated assessment of need across health, public health, housing and social care needs. This will begin with empowering the public to determine their own needs and to do this in advance of their need for more formal forms of support. We anticipate that this will also act as a tool to empower people to self manage their own care within the most appropriate environment. Core will be a mobilised and competently trained workforce. A key element of the model is the introduction of housing to improve the environments within which people live either to postpone or delay their need for formal support or to ensure that they enter into more appropriate forms of support for their eligible needs. Using technology the assessment function would be available for all citizens in Warwickshire irrespective of eligibility criteria or ability to pay for a service. In other words, the assessment service would help self-funders to manage their own care and would provide a platform for those on the edge of care. This would mean one assessment shared across organisations that is visible to the patient/users and with permissions to the primary carer.

Scheme 2: Promoting Independence through Self-management and Community Resilience

We have already begun the work to support local communities to galvanise around those who need support, such as the Safer Places scheme across the County which has seen the communities and local businesses engaging in making our streets safer for vulnerable people. And as well as the MECC approach highlighted above a key to promoting individual and community resilience is our effective public mental health strategy which prioritises; the three tier approach with; universal interventions, targeted intervention and early intervention for patients/users.

We need to continue to build on our information strategies and support people by providing the right information, advice and signposting to appropriate forms of support that are available and accessible within the communities in which they live. It means shifting from a model of dependency and direct provision to one of self management and care. It means people taking some responsibility for their own health and wellbeing and reducing the recourse to formal forms of support. Incorporated into this principle is the concept of community resilience and empowering communities to support local initiatives and forms of support eg; self management programmes for people with long terms conditions, financial advice, housing improvement schemes, building local community

enterprises, peer support groups for carers, supporting the growth of voluntary activity for example through time banking. It will require investment in technology enabling people to identify and manage their own care or the care of those close to them. It will mean a different mind set to the potential of technology not just in the way we process our business but also in the way we deliver services. And the voluntary and community sector would need to reconfigure its offer to the public and build resilience to support our drive to invest in the army of informal carers. And within this framework we will put strong mechanisms in place to support young carers and work across the health and social care economy to minimise the impact of illness, disability on a young person's life. Some of this work will begin in earnest over the coming year, for example we are at the cusp of reviewing the support to informal carers of people with dementia. We have listened to them and redesigned services to better reflect their needs and reduce the risk of carer breakdown which is a primary cause of entry into residential care. Taking this forward will require a joint health and social care commissioning and operational approach. It will mean a different offer from the voluntary and independent sector but better outcomes for the patient/client are evidenced and admissions due to carer breakdown reduced.

Scheme 3: Care at Home

The main thrust of the Better Care Fund is to secure the transition of care from Acutes to Communities. This accords with the preferences of patients and users of services who confirm that they wish to remain at home, living independently for as long as possible. By improving individual health and wellbeing, and access to home and community based services, we will relieve pressures on Acute Services and help to eliminate the costs that arise from failures to provide adequate help to those at greatest risk of deterioration. We will work to reduce unnecessary admissions to hospitals and to residential and nursing care through enhanced preventative and community support in the home. Further and wider attention needs to be given to the role of GPs and Primary Care with services wrapping around the individual to avoid such admissions.

We want to create a more holistic recovery based model which promotes the independence of patients/users to enable them to lead the life they choose and reduce their dependency on packages of care and support by using a reabling/recovery model. It means commissioning a model of service interventions that is based on reablement and rehabilitation. This means working with a belief that assisting older people within their communities is an important part of the task and that providers of this service can demonstrate person centred approaches that deliver the outcomes defined by customers. It means commissioning an outcomes based model for care at home that is predicated on the ability of older people to recover (albeit it different rates). It would have an emphasis of capturing community support, would utilise equipment and assistive technology and would expect access to housing grants and home improvements to align with discharge from hospital. This multi layered approach would begin with a response from a joint emergency response unit to avoid admissions, it would be complimented by a

workforce of generic health/care assistants delivering a range of outcome based home care services and it would link with the voluntary and community sector to support and sustain vulnerable people at home.

Scheme 4: Accommodation with Support

Through the provision of accommodation with support and access to efficient delivery of home improvements more older people and those with complex needs would be supported to remain at home for longer. Through the use of technology and access to equipment there would be an expectation that people would be able to return home much more quickly and not be diverted into residential and/or nursing care as the only option.

We want to explore how to support older people to live independently by promoting the development of 'lifetime neighbourhoods'. These are places that are designed to be lived in by all people regardless of their age or disability. Part of our ambitions is to continue to develop the model of Extra Care so that people can remain in their own homes for as long as possible.

And for those who genuinely cannot live independently we will continue to build and focus on improving outcomes through transforming the quality, consistency and co-ordination of care within residential and nursing care provision across the County.

All of this, of course, links to our initiative to support people to die a place of their choosing. By supporting and enabling people to remain at home (and within this definition we include residential and nursing care) we will be supporting people to achieve their final ambitions at the end of their life.

Scheme 5: NHS Continuing Health Care

Currently health and social care are operating independently in relation to NHS CHC in terms of practice and commissioning activity. Whilst the key issues continue to be around market capacity and value for money, there are also missed opportunities in relation to personalisation (e.g.; Direct payment users), quality and choice within the market, all of which impact on the patients experience of service provision. We have already agreed that there are real opportunities through joint commissioning to;

- Develop a sustainable residential and nursing care market strategy
- Improve the quality, diversity, and sustainability of provision
- Redesign the pathway and processes for CHC across the health and social care system to better align the systems to improve outcomes and deliver value for money for the health and social care economy.

Some of the priorities as defined in this scheme include:

- Commitment to addressing inefficiencies in CHC processes across health and social care
- Securing better prices and higher quality within commissioned services
- Increased diversity in the market
- Demand management ie' expectation of increasing demand/need to manage down especially in light of; increasing demographics and impact of Care Bill.

NHS data shows that the numbers are rising and are significantly higher than the local, regional and national benchmark. In partnership we can work together to address this and to ensure that the system(s) works. This means having a joined up approach recognising that there will be ebbs and flow across the system which can be managed through an alignment of our CHC and residential/nursing care market. There is no doubt that this will improve outcomes for patients and their carers.

We have agreed that through joint commissioning we can achieve a higher visibility of all customers with PMLD who usually need a combination of health and social care support. The Better Care Fund is enabling us to build on some excellent joint work and to now bring this centre stage and joint commission, through pooled budget arrangements, a different model for people with PMLD, a model that positively demonstrates the principles of Personalisation. As an example, we will use the councils micro commissioning methodology to source and secure packages of care for people with PMLD where customers and their families can decide who is the best provider to provide for their care within their personal budget. This will, over time, extend to include personal health budgets.

Better Care Fund Two Year Plan (indicative and to be further scoped into local delivery plans)

Description	**14/15**	**15/16**
Self management Expert Patient Programme/111/online resource directory	X	
Home care/Care at Home/Re-ablement/Intermediate Care.		X
Vol sector community capacity/engagement/SROI	X	
Nursing Homes		X
CHC		X
PHB		X
Learning Disabilities		X
CAMHS/MH Community services/hospices	X	
ICEA/AT	X	
Carers	X	
DFG	X	
Commissioning and back office	X	
Market Management		
Co-production		
Extra care		
Data sharing	x	

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

The BCF will be included in each of the CCG's 2 year operating plan and will be part of their QIPP programme. Each CCG will be talking to their main NHS provider about the impact of the QIPP programme.

e) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

Since the inception of the Health and Wellbeing Board the council and the three clinical commissioning groups have built a strong alliance to the delivery of services within Warwickshire alongside other key partners such as; the Acute sector, Pharmacy, District and Borough Council. In addition the Chief Officer of each of the Clinical Commissioning Groups and the Portfolio holders of Health and Adult Social Care respectively with the Leader of the Council meet on a quarterly basis to identify key issues and themes for partnership work. The Health & Wellbeing Board is therefore well placed to oversee the progress of the BCF plans.

The BCF and the schemes that it encompasses will be overseen by the Warwickshire Joint Adult Commissioning Board (terms of reference attached) and chaired by the Strategic Director for the People Group within the Council. And as a key member of the Health & Wellbeing Board the Strategic Director is well placed to report the progress to respective accountable bodies of the Council and the CCGs.

The governance structure (attached) shows that at a CCG level there will be joint commissioning groups whose responsibility is to, using the five BCF schemes, produce and implement delivery plans. Workstreams are already being scoped, with key stakeholders and partners, that replicate the schemes including key foundations projects within which the national conditions are incorporated. All delivery plans will be the primary vehicle for assuring that the national metrics for the BCF are achieved. Progress will be monitored through the Joint Adults Commissioning Board with an exception report received by the Health & Wellbeing Board at regular intervals.

We have agreed that the following values and principles will guide our work within the Better Care Fund:

Our Values	**Our Principles**
Person centred	Consider Joint First.
Seamless and Aligned	Apply the Affordability Challenge
Collaborative	Always Focus on Outcomes
Efficient	Be Agile
Open	
Trust (this includes trusting when someone/org needs to say no)	

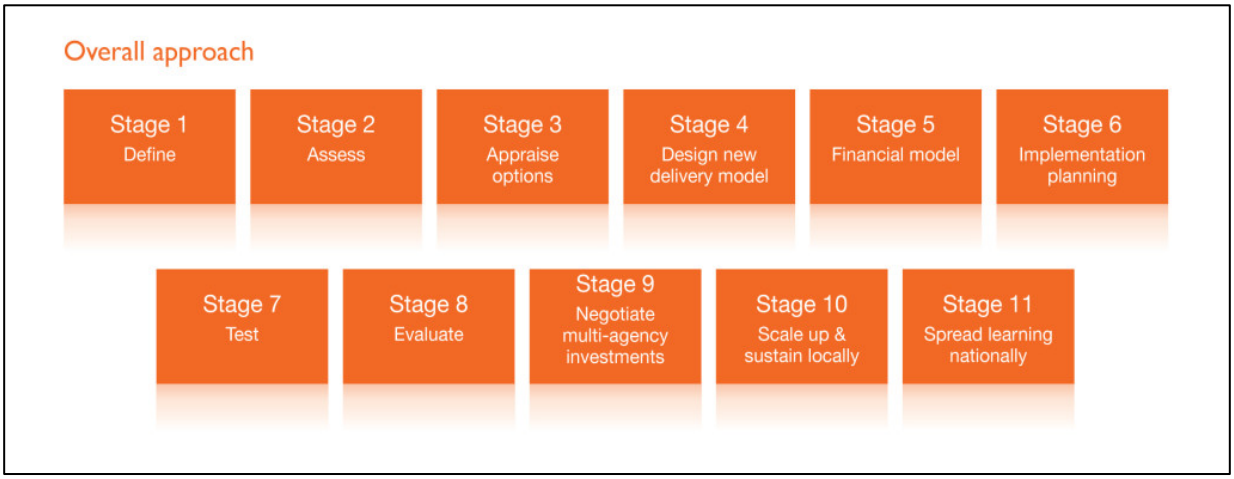
Key stakeholders will be engaged, including patients/clients, through existing forums. For example, the local authority has a Transformation Assembly which consists of people who use health and social care services and they are actively engaged in a range of projects, service reviews and improvements. Additionally a small group of clients have also been trained to act as peer auditors and their skills will be fully utilise to support the progress the BCF makes over the coming years and this will be complimented by qualitative surveys using the 'I' statements. Providers will continue to be engaged and where specific working projects are established acute providers will play a key role.

Where relevant we will use the scrutiny role of the council to assure ourselves of the progress and direction of travel taken.

The 5 year system plan of which the BCF is part will be overseen by the Coventry and Warwickshire Integrated System Board.

A clearly defined programme approach will be utilised to ensure the BCF drives forward across key partner organisations. A Prince 2 methodology will be applied to deliver to the Local Authority and CCGs Governing Bodies progress reports and outcomes achieved across the BCF programme. To support this detailed plan, delivery plans will be produced at a CCG level. Senior Responsible Officers for key projects will be identified and responsible for reporting to the BCF CCG Team and up to the Adult Joint Commissioning Board. A Partnership Agreement has been (attached) scoped for approval and will be the precursor during 2014/15 to more formal agreed arrangements such as a Section 75. A similar hierarchy will be developed for reporting risks and issues across the health and social care system. It is our intention to utilise the expertise of an external body to assure the quality of our plans and also our progress going forward.

As described above the Board will adopt a project management approach. In addition to this and to secure confidence in service redesign and financial robustness the diagram below illustrates a process for assuring projects which will be adopted locally. This is to ensure that the need for contingency plans are mitigated and/or are understood well in advance.



We have already aligned the timetabling of our commissioning intentions which will assist in developing joint schemes and proposals for S256 allocation as well as opportunities for joint commissioning and pooled budget arrangements. Further work is progressing to

draw together key performance data through improved data sharing. There is already a strong integrated quality assurance framework for the monitoring of quality within residential and nursing care homes. We want to review this and bring together our respective quality premium payments and CQUINs to incentivise and drive quality even further to improve outcomes and reduce the admissions to acute care.

3) NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services

BCF funding will be made available to complement recurrent social care funding to ensure the core, statutory, 'FACS-eligible' social care services will continue to be delivered safely and appropriately, thus avoiding adverse impact on health (such as delayed discharges). And that the impact of any additional demand on social care (within the above definition) resulting from successful initiatives to transfer activity from the acute sector to community services is recognised and financed via the BCF.

We also recognise that there will be significant pressures within the social care system with the implementation of the Care Bill which will see; additional and extra assessments including the management of Care Accounts, additional packages of care, increased market shaping and facilitation to support and sustain a market for self funders. There will be additional pressures within the homecare market driving up costs and pressures within a diminishing workforce for some pockets of the County.

We recognise that 'demand management' success is actually going to be predicated on activity largely 'outside' adult social care, because it needs to happen 'before' people come to the adult social care 'front door' as much as possible. Examples include – good housing / planning strategies, community health services, community capital and voluntary sector contracting etc.

Working with Public Health with a focus on prevention, early help and targeted support will act as a protection from rising demand on social care, via the aim of enabling people to remain as independent and healthy as possible for as long as possible. The pooling of budgets and a joint focus on the core offer from the voluntary and community sector will support this aim.

We have also looked at a number of national examples of 'budget management' techniques that have been used in other Local Authorities and may need to be considered unless a whole system approach continues to be maintained.

We will also build on our nationally recognised models of improving discharge processes and admission avoidance through the utilisation of Discharge to Assess Beds and Moving on Beds.

We have created a template to summarize anticipated pressures which we feel need reflecting in the BCF funding and we will be undertaking a further round of negotiations post 4th April 2014.

Please explain how local social care services will be protected within your plans

The BCF funding will be made available to complement recurrent social care funding to ensure the core, statutory, FAC eligible social care services will continue to be delivered safely and appropriately, thus avoiding adverse impact on health (such as delayed discharges or increase admissions to hospital). There are undoubtedly significant and growing pressures on adult social care budgets. These will be compounded by; increasing demographics, the implementation of the Care Bill and the ongoing economic pressures at a national and local level.

The primary areas to be protected include; an enhanced home care provision, the delivery of re-ablement as a key mechanism for supporting discharge, increased utilisation of personal budgets that are aligned to personal health budgets.

And that the impact of any additional demand on social care (within the above definition) resulting from successful initiatives to transfer activity from the acute sector to community services is recognised and financed via BCF.

NATIONAL CONDITIONS

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends

There are already some good examples of 7 day working across the health and social care economy; emergency duty team, access to emergency short stays, re-ablement. However more can been done as we recognise that one part of the system cannot function effectively at the weekend if other parts don't, it has to be a whole system wide approach. 7 day working opportunities are being scoped across the health and social care landscape to improve performance and outcomes. Given the complexities of achieving this across the whole system further work is being progressed to scope and cost a 7 day service to reduce the pressure on the health and social care economy at key points. Some of the areas being considered and/or scoped include; 7 day access to information and advice, improvements to EDT, reablement, home care, night support and carer support.

There are clearly complexities inherent within this such as; exploring the different working patterns and changing traditional 5 day service model (37hrs per week 5 times 9-5pm shifts) to 7 day service model (37hrs per week, 4 times 8 – 6pm shifts) for social care services. However, health and social care are committed to exploring this across commissioning and operational teams and work has already begun to scope extending

services such as; 7 day per week hospital social care cover – full team in each hospital, Re-ablement presence in each A&E to ascertain and advise of existing support packages in place or negotiate small temporary changes with providers, to prevent admissions.

Work will commence in 2014 to build on current 7 day provision with the intention to increasing 7 day working before the Autumn in some key areas of the health and social care system, for example within care homes so that people can be discharged back to the home over the weekends.

NATIONAL CONDITIONS

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

No we do not currently use the NHS number but have plans to do so in the future

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

Plans developing to use the NHS number and progress will be enhanced by the review and retender of the local authorities' main data system and the implementation of the data sharing protocol.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

No we do not currently use the NHS number but have plans to do so in the future

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

Yes

NATIONAL CONDITIONS

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

The Risk Model
In Warwickshire we offer the Combined Predictive model[1] which uses an algorithm developed by the Kings Fund, Health Dialog and New York University. It uses both primary and secondary care data to produce a risk score between 0 and 100% - this is the patient's risk of being admitted for an emergency chronic admission within the next 12 months.

To support the Risk profiling of patients, the Ventris report provides the following information;
NHS Number, Age, Gender
Current & Previous Risk Score (%)
Long Term Conditions/Co-morbidity
Hospitalisation (A&E)
Substance Misuse
Multiple Drug Use

The data is refreshed on a monthly basis using data feeds from GP Clinical Systems (via Apollo/MSDI), SUS and Exeter.

Access and Usage
All GP practices in Warwickshire have the ability to access Risk stratification reports via Ventris, the CSU Business Intelligence solution. Access is granted via strict data sharing agreements and 64 out of 76 (84%) practices have these agreements set up to view these reports. By locality this is;

South Warwickshire – 31/36 (86%)
North Warwickshire – 26/28 (93%)
Rugby – 12/12 (100%)

The uptake has increased significantly since the start of the Risk Profiling DES (April 2013) which recommends practices use a Risk Stratification tool to profile their most 'at risk' patients. The necessity to monitor these patients will intensify even more next year (April 2014) with the roll out of the 'Unplanned Admissions LES'[2].

Ventris usage statistics (for South Warwickshire only) for the last 2 months (Dec – Jan) show practices have accessed these reports 77 times.

[1] http://www.kingsfund.org.uk/sites/files/kf/field/field_document/PARR-combined-predictive-model-final-report-dec06.pdf

[2] http://bma.org.uk/working-for-change/negotiating-for-the-profession/bma-general-practitioners-committee/general-practice-contract/unplanned-admissions-2014

Across all three CGs, practices are making plans for GPs to be accountable for co-ordinating patient-centred care for older people and those with complex needs. The work streams within the BCF (underpinned by the CCG £5 per head funding as per national guidelines) will support practices to play a key role in developing a joined-up approach to assessment and care planning. For example, in SWCCG practices are working with the voluntary sector and third sector providers to develop an innovative navigator role. In WNCCG practices have identified a need to align community, social care, and voluntary care sector around the practices to support better care for this vulnerable group. In CRCCG, Rugby GPs have identified a need to work more closely with the voluntary sector to provide support for vulnerable patients and are working closely with CAVA.

4) RISKS

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

Risk	Risk Rating	Mitigating Actions
Inability to meet financial challenges across the health and social care economy	16	• Agreed understanding to share wider financial envelope and challenges across the health and social care economy to better understand the respective pressures.
Failure to secure capacity, capability and quality provision from the market	12	• Renegotiate contracts based on outcomes framework and revised financial envelope. • Complete soft market testing for some niche areas. • Introduce quality premium payment for key areas e.g. dementia
Political and GP member buy in for proposed new service model	12	• Establish strong brand and key message. • Demonstrate financial viability across the economy. • Evidence value for money and outcomes to be delivered for each scheme.
Leadership and continuity of the new service model	16	• Produce robust communication strategy. • Strategic Director lead for Integration agreed and owned across the health and social care economy.
Introduction of the Care Bill, will result in a significant increase in the cost of care from April 2016 which will impact on social care funding and any associated savings plans	16	• Scoping the impact of the Care Bill is underway and will be further refined and updated as the Bill progresses through Parliament.
Moving resources to fund new joint interventions and schemes will destabilise current service providers, particularly the Acute Services.	16	• A Whole Systems integrated Care model will need to be mapped and further developed with all key stakeholders engaged and involved . • Co-design of the system including key transitional points to be mapped and agreed across all stakeholders.
Insufficient and therefore confidence in the baseline data.	9	• Further investment throughout 14/15 and beyond will ensure that data sharing and performance will improve.
Lack of understanding of the BCF function and intentions resulting in little change in behaviours/systems and outcomes for patients/users	12	• Strong Communication Strategy needs to be developed alongside the BCF that is implemented across the whole system.

Association

Finance - Summary

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in 2015/16. It is important that these figures match those in the plan details of planning template part 1. Please insert extra rows if necessary

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15 /£	Minimum contribution (15/16) /£	Actual contribution (15/16) /£
Warwickshire County Council	Y	£ 1,187	£ *1,244*	£ *40,222*
Coventry & Rugby CCG	N	£ 2,900	£ *6,432*	£ *13,960*
South Warwickshire CCG	N	£ 6,688	£ *15,500*	£ *31,301*
Warwickshire North CCG	N	£ 4,762	£ *11,036*	£ *16,243*
District Councils	N	£ 1,925	£ *1,925*	£ *1,925*
BCF Total		**£ 17,462**	**£ 36,137**	**£ 103,651**

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

There will be throughout the BCF implementation a formal review stage throughout. There will be key gateway processes to 'catch and stop' for all projects. Pipeline management - where the risks are within the pipeline. There will also be a continual process of new ideas being captured and brought through. Consideration would be given to the use of respective organisation reserves and/or construct a reserve from the BCF. We would construct the BCF in a similar way within our own organisations. What we don't spend in 14/15 this would be carry forward as a specific reserve for the BCF. Further more detailed work is required to determine the level of savings and contingencies required.

Contingency plan:		2015/16	Ongoing
Outcome 1	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		
Outcome 2	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		

Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please add rows to the table if necessary.

BCF Investment	Lead provider	2014/15 spend		2014/15 benefits		2015/16 spend		2015/16 benefits	
		Recurrent /£	Non-recurrent /£	Recurrent /£	Non-recurrent /£	Recurrent /£	Non-recurrent /£	Recurrent /£	Non-recurrent /£
Promoting Independence - Self Management - supporting social care services that are around the boundaries of health and social care.	Warwickshire County Council	£ 2,196	£ -	£ -	£ -	£ 4,668	£ -	£ -	£ -
Care at Home e.g.; Reablement, respite, telecare, Homecare, support to carers, ICES.	Warwickshire County Council	£ 11,347	£ -	£ -	£ -	£ 14,316	£ -	£ -	£ -
Community resilience - e.g.; vol sector, community capacity micro enterprises, time banks,	Warwickshire County Council	£ 1,437	£ -	£ -	£ -	£ 1,548	£ -	£ -	£ -
Accommodation with support, res/nursing care, extra care, Assistive Technology, supported living.	Warwickshire County Council	£ 2,057	£ -	£ -	£ -	£ 40,960	£ -	£ -	£ -
Continuing Health Care (include end of life Care)	Warwickshire County Council					£ 41,659			
Patient Pathway - Joint Assessment and Care planning, 7 day working	Warwickshire County Council	£ 200				£ 200	£ -	£ -	£ -
Whole Systems Realignment	Warwickshire County Council	£ 225				£ 300			
Total		£ 17,462	£ -	£ -	£ -	£ 103,651	£ -	£ -	£ -

Association

England

Outcomes and metrics

Please provide details of how your BCF plans will enable you to achieve the metric targets, and how you will monitor and measure achievement

1. Jointly redesign commissioned services from the voluntary and community sector to support people to remain in their own homes. 2. Increase the range and type of homecare/re-ablement/community emergency response to support people to remain at home. 3. Reduce delayed discharges through the use of GP supported care home placements and wrap around services in the community. 4. Jointly commission res/nursing care market for CHC patients.

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015 payment. Please see the technical guidance for further detail. If you are using a local metric please provide details of the expected outcomes and benefits and how these will be measured, and include the relevant details in the table below

We are proposing to use the measure 'Carer-reported Quality of Life'. This is taken from both ASCOF and the NHS Outcomes Framework.
This measure combines individual responses to six questions in the Carers' Survey measuring different outcomes related to overall quality of life. A higher score is better. This measure is out of a maximum possible score of 12.

For each metric, please provide details of the assurance process underpinning the agreement of the performance plans

Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population - complying with Health & Social Care Information Centre Adult Social Care Combined Activity Return guidelines for production of this measure. Warwickshire County Council has an internal audit function that routinely audits the production of annual returns.

If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template both for each HWB and for the multiple-HWB combined

n/a

Please complete all pink cells:

Metrics		Baseline*	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	673.5	N/A	616.4
	Numerator	703		684
	Denominator	104380		110968
		(Apr 2012 - Mar 2013)		(Apr 2014 - Mar 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services *NB. The metric can be entered either as a % or as a figure e.g. 75% (0.75) or 75.0*	*Metric Value*	82.20	N/A	85.20
	Numerator	695		approx 804
	Denominator	845		approx 944
		(Apr 2012 - Mar 2013)		(Apr 2014 - Mar 2015)
Delayed transfers of care (delayed days) from hospital per 100,000 population (average per month) *NB. The numerator should either be the average monthly count or the appropriate total count for the time period*	*Metric Value*	293.6	282.2	275.0
	Numerator	1295	1255	1233
	Denominator	441092	444664	448314
		(April - November 2013) 8	Apr - Dec 2014 (9 months)	Jan - Jun 2015 (6 months)
Avoidable emergency admissions (average per month) *NB. The numerator should either be the average monthly count or the appropriate total count for the time period*	*Metric Value*	155.5	147.8	143.5
	Numerator	852	826	809
	Denominator	547974	559108	563655
		(April - September 2013) 6	Apr - Sep 2014 (6 months)	Oct 2014 - Mar 2015 (6 months)
Patient / service user experience *Carer-reported Quality of Life (ASCOF 1D)*		8.1 *(July 2012 - March 2013)* 9	N/A	8.4 *(July 2014 - March 2015)* 9
Local measure *The proportion of people feeling supported to manage their (long term) condition. NHS Outcomes Framework indicator 2.1 / CCG Indicator 2.2* *(Please note the metric is directly standardised and is not a straight calculation of denominator dvided by numerator)*	*Metric Value*	66.5	67.6	68.7
	Numerator	2447	2479	2511
	Denominator	3547	3547	3547
		(July 2012 - March 2013) 9	*(July 2013 - March 2014)* 9	*(July 2014 - March 2015)* 9

Care Bill Task and Finish group Scoping Document

Review Topic (Name of review)	**Care Bill Health and Wellbeing considerations**
Task and Finish Group Members	WCC (from Jenny Wood, Chris Lewington David Soley, Kushal Birla, Phil EvansChris Norton) CCG (South Warwickshire, Warwickshire North and Coventry and Rugby) Other Health colleagues for relevant sections of the Bill Health watch and or 2x Members of the Transformation Assembly (service users and carers) Representative of the Patient participation group
Key HWB Officers / Departments	Wendy Fabbro, Strategic Director People Group John Linnane Director Public Health
Relevant Board Ambitions	- Mobilising Communities - Access to Services - Public Services Working Together
Timescales	To respond to DH consultation on statutory guidance to be issued on 'topics' from the end of May- November; and to report on Warwickshire's readiness to implement the new legislation if it proceeds as anticipated for April 2015
Rationale (Key issues and/or reason for doing the review)	The Care Bill presents new challenges and opportunities to member agencies to develop the strategic objectives within our Health and well being strategy
Objectives of Review (Specify exactly what the review should achieve)	1. To consider the Warwickshire HWB position and be delegated to draft responses to the various DH consultation invitations planned for the period May- October 2. To evaluate and report on the HWB of member agencies readiness to implement the new legislation in its final form 3. To provide evaluation and report on managing the cost implications of the new Bill
Scope of the Topic (What is specifically to be included/excluded)	<u>Include</u> The following is included in the scope of the review: - Identifying and specifying the new duties for each agency - Commissioning public awareness raising - Drafting the WHWB response to government consultation to influence the final guidance - Review of costing models from each partner agency and their relative interdependence - <u>Excluded</u> The following falls outside the scope of the review: -Decisions relating to allocating resources
How will the public be involved? (See Public Engagement Toolkit / Flowchart)	DH will be leading a public information campaign through summer 2014, and seeking local support to disseminate information about new rights and services, and financial arrangements

What site visits will be undertaken?	n/a
How will our partners be involved? (consultation with relevant stakeholders, District / Borough reps)	The task and finish group will report back to each HWB meeting in 2014/15
How will the scrutiny achieve value for money for HWB	The task and finish group will report on the cost impact of implementation
What primary / new evidence is needed for the scrutiny? (What information needs to be identified / is not already available?)	- Costing models, including for self funders. - Current activity in wellbeing, and 'front door' customer/patient demand - Current activity in market development, spend analysis - Safeguarding board gap analysis for the transition to legal status (already complete for the WSAB) -
What secondary / existing information will be needed? (i.e. risk register, background information, performance indicators, complaints, existing reports, legislation, central government information and reports)	Risk register Complaints DH consultations, Statutory guidance
Indicators of Success – (What factors would tell you what a good review should look like? What are the potential outcomes of the review e.g. service improvements, policy change, etc?)	Warwickshire HWB clear strategic and partnership position in relation to DH consultations and statutory guidance All key partner agencies reporting an understanding of their new duties and agreeing readiness to implement in April 2014
Other Work Being Undertaken (What other work is currently being undertaken in relation to this topic, and any appropriate timescales and deadlines for that work)	WCC is also undertaking specific work on :- Customer services provision of information and advice Financial arrangements for self funders to register their eligibility and 'start the meter' towards their ceiling of care payments Self assessment processes (including on line) Resource Directory of all care services to enable market diversity and choice and control On line purchase of care services via the Resource Directory Other partnership work includes:- Better Care Fund Discharge to Assess

Warwickshire Health and Wellbeing Board

21 May 2014

Warwickshire Joint Strategic Needs Assessment (JSNA) 2013/14 Annual Update

Recommendations

That the Warwickshire Health and Wellbeing Board (HWB):

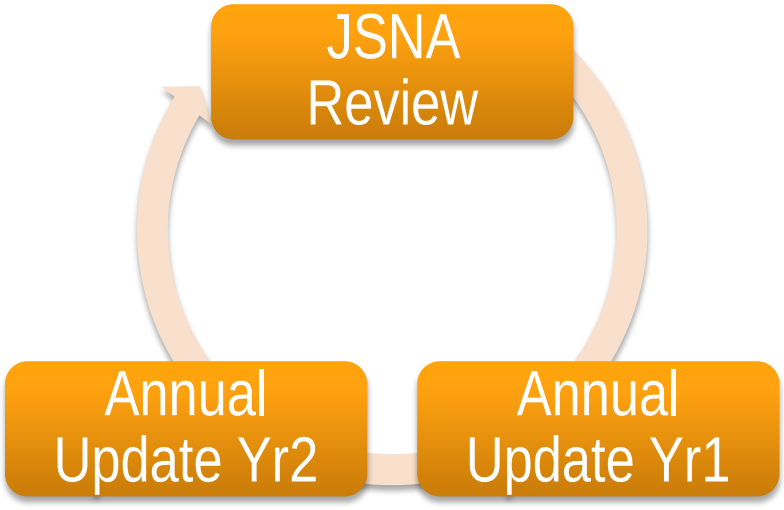
1. **Consider, note and approve the Warwickshire Joint Strategic Needs Assessment (JSNA) 2013/14 Annual Update.**
2. **Note and comment on the key health and wellbeing issues outlined in the update and ensure they are considered as part of the development of Warwickshire's Health and Wellbeing Strategy.**
3. **Continue to engage with the 2014 work programme of the full JSNA 3 year review.**

1.0 Background

1.1 This report provides a short summary of the second Warwickshire JSNA Annual Update, which forms part of a cycle of two annual updates produced between the three-yearly reviews of the JSNA priorities. The document follows the same format as the 2012/13 Annual Update produced in May 2013.

1.2 In particular, the Annual Update provides important contextual information on changes in demography, lifestyle and behaviours in Warwickshire which impact on the need for health and social care. It also provides an updated picture with regard to the five theme areas and ten priority topics identified in the first 2011 JSNA Review.

Figure 1: Warwickshire's 3-year JSNA Production Cycle



2.0 Summary

2.1 The JSNA Annual Update aims to provide commissioners and other parties interested in Warwickshire's health and wellbeing with:

a) A summary of Warwickshire's approach to the JSNA process.
b) An update on the latest analysis and interpretation of need across health and social care.
c) Key messages from that information that our target audience should hear.

The 2013/14 Annual JSNA Update is structured in the following manner:

2.2 **Warwickshire People and Place: Key Messages for All**

This section provides the key macro-level messages from the JSNA that are applicable to all commissioners and interested parties. They are not specific to individual areas of health or care.

What are the key messages?

The population in Warwickshire continues to increase

- Latest figures show that the overall number of people living in the county is now 548,000. It is expected that the population in the county will be 577,400 by 2018; an increase of 5.4% on the 2012 mid-year estimates.

The number of births in the county continues to increase

- Between 2002 and 2012, there was a 19% increase in annual births in Warwickshire with the biggest rise of 31% in Rugby Borough.

A growing and ageing population is likely to result in increasing pressure on health and social care services as more people could suffer from long term physical and mental problems. The challenge will be ensuring that older people enjoy the best quality of life they can in ways that are of their own choosing.

Increasing pressure on housing supply in the county

- Population increases combined with changes in family units and how people choose to live increase demand for housing.
- One person and lone parent households increased from 2001 to 2011, the latter by 28%.

Lone parent households and people with disabilities are expected to be most affected by the spare room subsidy ('bedroom tax').

The national economy is improving

- Difficult financial decisions are still being made by many local public services, leading to continued future pressures on service delivery.
- The numbers of people who are unemployed continues to fall.

Improvements in local quality of life indicators have continued

- Crime rates are continuing to fall, GCSE attainment is above the national average and there has been a reduction in the numbers who are not in employment, education and training (NEET).

Those who have been out of work for longer periods of time will find it increasingly difficult to get a job, with accompanying negative impacts on health and wellbeing. When the job market does improve the long-term unemployed may find it harder to compete with other jobseekers.

Significant disparities on both a geographic and population group basis continue to persist

- Differences in average life expectancy range from 78.2 years for males in Nuneaton & Bedworth Borough to 81.0 years in Stratford-on-Avon District, and from 82.6 years for females in Nuneaton & Bedworth Borough to 84.9 years in Stratford-on-Avon District.
- Geographical differences in number of years a person is expected to live without a limiting long-standing illness or disability. 8.9 year gap in disability-free life expectancy at age 16 for males between North Warwickshire and Stratford-on-Avon (2007-09).

The health of the most disadvantaged in our society should be our top priority. However, there is a need to ensure that our programmes target people across the inequality profile. In line with the Marmot report on health inequalities, the highest priority should be given to children from pre-conception through to adolescence.

2.3 Key Topic Messages

This section of this update contains key messages from the JSNA that are organised by the five themes and ten topics from the 2011 Review. The messages are targeted at those commissioners and parties who work or have an interest in particular areas but they may also be of interest to a wider audience. Each topic contains the key messages that we think people need to hear, a summary of what the available data is telling us and consultation/case study findings.

Children

- A third of Warwickshire's pupils are not achieving the level of education which the government expects.
- Looked after children numbers continue to increase but at a slower pace than seen in recent years.
- Attainment figures for looked after children are significantly lower than those achieved by non-looked after children in the county.

Education influences both physical and mental health aspects; better educated people are less likely to suffer from certain diseases and less likely to report depression. As a consequence of their life experiences, outcomes for looked after children are traditionally poorer than non-looked after children.

Survival rates of children with learning disabilities and complex needs are growing

- Increasing numbers of adults with learning disabilities surviving into old age.

- Estimates of 34,743 people aged 18-64 with a moderate or serious physical disability in Warwickshire, predicted to rise to 36,157 by 2020.

Warwickshire has an ageing population because we are living longer. However, the quality of those extra years may be diminished because of long-term conditions, physical disabilities and/or sensory impairment.

Only 20% of the Warwickshire population are currently physically active

- 18% of total premature deaths could be prevented if 100% of the population were physically active. This is equivalent to 388 avoidable deaths in Warwickshire each year.
- Two thirds of adults in Warwickshire are estimated to be overweight or obese.
- The prevalence of smoking in pregnancy is high in Warwickshire and statistically significantly higher than the England proportion.

Roughly one in six of us is estimated to be experiencing a mental health problem.

- Hospital admission due to self-harm rates for 10-24 year olds statistically significantly higher than the equivalent England figure (2012/13).
- Suicide rate for males in the County is statistically significantly higher than the equivalent national figure (2010-12).

Poor mental health is associated with an increased risk of diseases, while good mental health is a protective factor. Poor physical health also increases the risk of people developing mental health problems. Focusing on the links between the two will help tackle the poor long term health outcomes.

Dementia is increasingly important cause of disability in older people.

- In line with a growing and ageing population, numbers of people with dementia are set to increase rapidly in the future.
- However, data suggests that only 46% of people in Warwickshire with dementia have been formally diagnosed.

Across Warwickshire as a whole, the highest rates of projected population growth are in the groups aged 65 years and over. Population projections help inform the planning of services and decisions about the future allocation of resources. An ageing population, in particular, has implications for the future provision of many health and social services linked to older age groups.

3.0 Next Steps

3.0.1 The full 3-year review of Warwickshire's JSNA priority themes and topics in conjunction with stakeholders is currently underway and will be used by the HWB to inform the development of its new Joint Health & Wellbeing Strategy (JHWBS). This process of engagement was started with a JSNA and JHWBS workshop hosted on 29th April 2014.

4.0 Background Papers

4.1 Appendix I – Draft Warwickshire JSNA Annual Update 2013/14

	Name	**Contact Information**
Report Authors	Gareth Wrench Jenny Bevan	garethwrench@warwickshire.gov.uk Tel: 01926 413753 jennybevan@warwickshire.gov.uk Tel: 01926 742355
Heads of Service	Dr John Linnane Chris Lewington	johnlinnane@warwickshire.gov.uk chrislewington@warwickshire.gov.uk
Strategic Directors	Monica Fogarty Wendy Fabbro	monicafogarty@warwickshire.gov.uk wendyfabbro@warwickshire.gov.uk
Portfolio Holder	Cllr Bob Stevens	bobstevens@warwickshire.gov.uk

Appendix

Warwickshire JSNA

Warwickshire Joint Strategic Needs Assessment 2013/2014

FOREWORD

Our Promise

This short report is the second JSNA Annual Update promised to you as part of a cycle of two annual updates produced between the three-yearly reviews of the JSNA priorities. It follows the same format as the annual update produced in May 2013 and provides an overview of the key achievements of our JSNA during the previous year. The briefing also updates the important contextual information which impacts on the overall need for health and social care in Warwickshire, specifically on changes in demography, lifestyle and behaviours. It also provides a revised picture with regard to the 5 theme areas and 10 priority topics identified in the 2012 JSNA Review.

What are the key messages?

- Our needs reflect a changing demography with higher birth rates and all of us living longer.
- The need for health and care services continues to grow year on year particularly among older residents.
- The economic situation, although improving, continues to impact on our population, especially the most vulnerable in society.
- Our lifestyle choices give cause for concern, particularly with regard to the impact on children and young people.

Why is this important?

- This Needs Statement must underpin and direct the commissioning plans for Health and Social Care organisations.
- The profile of continuing and emerging inequalities needs to be tackled.
- It begins to paint a picture of what Warwickshire's society will look like in the future as the population continues to grow and age.
- The impact on a wide range of other services from transport to community safety should be considered.
- A healthy, robust population is required to underpin successful economic growth and prosperity in Warwickshire in the future.

What have we achieved in the last year?

- Development of a process to prioritise & approve projects and continued work to raise the profile of, and engagement with, the JSNA.
- Delivery of specific projects and needs assessments including undertaking the 'Living in Warwickshire Survey' and 'Understanding Child Sexual Exploitation'.
- Integration of the Warwickshire Health and Wellbeing Board Blog and JSNA website.
- Carried out a review of how people have used the JSNA to inform strategy development and commissioning priorities in the County Council, Clinical Commissioning Groups and District/Borough Councils. Initial feedback shows it is being actively used by to prioritise and underpin commissioning decisions.

We commend this report to you and look forward to working jointly to address the needs identified. We also welcome your contributions to the 2015 JSNA Review which is now underway.

Dr John Linnane, Director of Public Health

Wendy Fabbro, Strategic Director – People Group

CONTENTS

Acknowledgements:

Editorial Team: Jenny Bevan, Gareth Wrench

Contributors: Public Health Intelligence Team, Strategic Commissioning Business Intelligence Team, Warwickshire Observatory, Members of the JSNA Working Group and Commissioning Groups.

1 INTRODUCTION

1.1 PURPOSE

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

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

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

1.2 BACKGROUND

Warwickshire's JSNA is currently reviewed on a three year cycle with an *Annual Update* published in May or June on the intervening two years. This document is the second Annual Update since Warwickshire's 2011 JSNA Review, published in 2012.[1] The first Annual Update was published in 2013.[2]

The publication of this document forms the first stage in the 2014 JSNA Review and aligns with the publication of Warwickshire's Joint Health and Wellbeing Strategy 2014 – 2017 (JHWS).[3]

It is currently the intention to publish the JSNA 2014 Review in March 2015.

1.3 STRUCTURE OF THE UPDATE

This update consists of two elements.

1.3.1 Document

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

Warwickshire's Approach to the JSNA. This section describes the context and history to the JSNA in Warwickshire as well as the current approach including its governance, products and the timeframes for their delivery. This section may be of interest to those unfamiliar with Warwickshire's JSNA or who want to learn more about how it is produced. Commissioners and those

[1] The 2011 Review was published in March 2012 and can be found here: Warwickshire JSNA 2011 Review.
[2] The 2012 Annual Update was published in May 2013 and can be found here: Warwickshire JSNA 2012 Annual Update.
[3] The Interim JHWS can be found here: Interim JHWS

readers who just want to know the key messages from the JSNA may wish to go directly to the relevant sections below.

Warwickshire People and Place: Key Messages for All. This section provides the key messages from the JSNA that are applicable to all commissioners and interested parties. They have been selected from the Observatory's 2013/14 Quality of Life Report as the underlying contextual evidence base for the JSNA. These messages relate to some of the key sociodeterminants of health and wellbeing. This section aligns with the menu pages from the JSNA website of the same name.[4]

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

1.3.2 Updated Interactive Mapping Reports

The second element of this update consists of new Local Information System (LIS) reports. There is a report for each of the ten 2011 Review topics, with the inclusion of new data, where possible. These reports can all be found on the Warwickshire Health & Wellbeing website, under their relevant topic. Weblinks to them are provided below: – ALL LINKS CURRENTLY TO 2012 LIS REPORTS – HAVE REQUESTED LB/PL TO UPDATE 25/3/2014 – end April deadline

Children & Young People

Educational Attainment

Looked after Children

Lifestyle

Lifestyle Factors Affecting Health

Vulnerable Communities

Reducing Health Inequalities

Disability

Safeguarding

Ill-Health

Long-Term Conditions

Mental Wellbeing

Old Age

Dementia

Ageing & Frailty

[4] Warwickshire People and Place

2 WARWICKSHIRE'S APPROACH TO THE JSNA

2.1 HISTORICAL DEVELOPMENT

2.1.1 Original Production (2007-2009)

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

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

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

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

2.1.2 Learning and Development (2010-2011)

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

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

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

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

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

2.2 THE JSNA FROM 2012

2.2.1 The Local Vision

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

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

The JSNA will help to:

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

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

2.2.2 Governance Arrangements

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

2.2.3 Health & Wellbeing Board (HWB)

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

[6] This statutory requirement was introduced by The Local Government and Public Involvement in Health Act (2007): Section 116 (as amended by The Health and Social Care Act (2012): Section 192) and section 116A (as inserted by The Health and Social Care Act (2012): Section 193).
[7] Warwickshire's Health & Wellbeing Board has produced an Interim JHWS, which can be found here: Interim JHWS

2.2.4 JSNA Strategic Group

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

2.2.5 JSNA Commissioning Group

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

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

2.2.6 JSNA Working Group

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

The group coordinates small project teams who meet on a an ad-hoc basis and its membership includes research, intelligence, consultation and commissioning representatives covering a wide range of partners as required and subject to commissioning priorities.

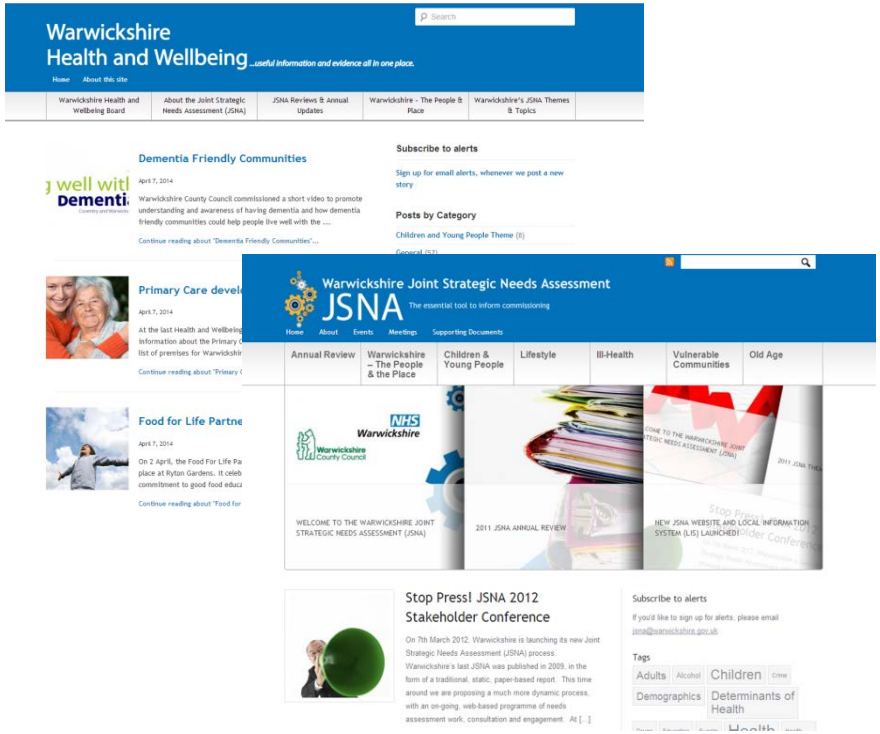
2.3 THE STRUCTURE OF WARWICKSHIRE'S JSNA

Warwickshire's JSNA has three key elements:

2.3.1 The Website

All of the products produced as a part of Warwickshire's JSNA are hosted on the JSNA section of the new Warwickshire Health & Wellbeing website, which can be found at: http://hwb.warwickshire.gov.uk/.

We have been working on integrating the former Health & Wellbeing Board blog and JSNA web content to bring together all of Warwickshire's information and intelligence on health and wellbeing together in a single place online.



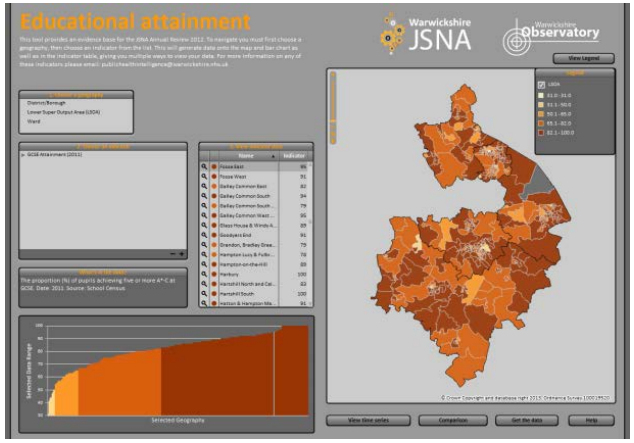
2.3.2 Reports & Specific Needs Assessments.

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

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

2.3.3 Local Information System (LIS)

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

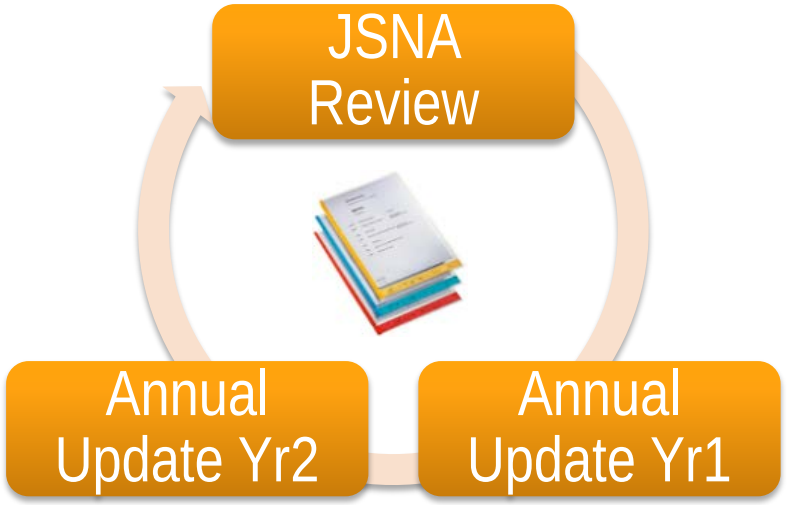


There is a local element to the LIS but, in addition, there are a number of national reports and data sets which the website will hold and also provide access to.

2.3.4 Timeframes for production

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

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



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

This document is the Year 2 Annual Update which will be followed by a second Review due to be carried out later in 2014-15. This full review of Warwickshire's JSNA priority themes and topics will be used by the HWB to inform the development of its new JHWS. A detailed timetable of this process can be found on page 12.

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

2.4 WORK IN 2013-14

During 2013-14, work on the JSNA has built upon the structures and governance that were put in place last year. The JSNA Commissioning Board is now well established and has provided considerable input and direction to the identification of suitable projects and the development of a detailed work programme.

Substantial work has gone into trying to raise the profile of, and engagement with, the JSNA with the relevant audiences. The team have continued to attend and present to numerous meetings/forums to promote our work on the JSNA[11]. Details of these events and future ones can be found here: JSNA Events

In addition, a number of JSNA programme management tools have been developed and brought into use to better manage the flow of projects and work conducted for Warwickshire's JSNA in the future. The JSNA Commissioning Group now routinely uses a work approval process and prioritisation matrix when deciding on which pieces of Needs Assessment activity to undertake. These and more information about how Warwickshire's JSNA works can be found here: How Warwickshire's JSNA Works.

Finally, there have also been a number of discrete and specific needs assessments and projects completed in 2013-14, further details of which can be found at the links below:

[11] Including: Presentations to District/Borough Council committees, local partnership groups, CCG Governing Body & Executive Groups, Acute Trust Equality & Diversity Groups and County Council Community Forums.

Autism Spectrum Disorder Needs Assessment

Revised Warwickshire Children and Mental Health Services Needs Assessment

Substance Misuse among Young People in Warwickshire

2.4.1 Living in Warwickshire Survey

As part of our previous work on the JSNA, it was widely 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, the Health & Wellbeing Board agreed to sponsor a large scale survey of local people which focussed on issues around 'Living in Warwickshire'. The aim of the survey was to capture perceptions type data about life in Warwickshire, use and satisfaction with public services, and also health and lifestyle data and intelligence.

During Autumn 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.

Key headline findings and implications from the research are presented within this update and more detailed topic-based analyses from the research will be published in due course.

2.4.2 JSNA District & Borough/Clinical Commissioning Group (CCG) Analysis

In order to supplement last year's JSNA Annual Update, further analysis was carried out at a District/Borough level to support the work of the local District and Borough Councils and Clinical Commissioning Groups (CCGs). These were presented in the form of individual reports which outlined district/borough data and highlighted the key issues for each corresponding area.

Work on the JSNA is also part of the Public Health 'Core Offer' to CCGs. This includes analysis which CCGs can use to better inform their commissioning plans and local decision-making.

2.4.3 District/Borough Progress with the JSNA

In December 2013, a report was taken to the County Council Overview & Scrutiny Committee. This provided an update on our work as part of the JSNA and included information on how the County and District/Borough Councils have used the JSNA in their work. We are looking to ensure overview and scrutiny is now routinely incorporated into the JSNA process.

2.5 FUTURE INTENTIONS

2013/14 represented a year of significant change for health and social care with the formal introduction of the HWB, the move of Public Health from the NHS into local authorities, the abolition of Primary Care Trusts (PCTs), the formal arrival of the Clinical Commissioning Groups and the introduction of Healthwatch. This has undoubtedly had an impact both directly on the JSNA and more importantly, the services the JSNA informs.

Whilst these new working arrangements have now settled down, we aim to ensure that during 2014/15, **the JSNA remains the essential tool to inform commissioning**. The governance structures, processes and work programme we now have put in place will help to facilitate this.

Currently, as part of our wider JSNA work programme, there are several discrete projects underway, with more yet to be started. Needs Assessment Topics have been identified and prioritised at the JSNA Commissioning Board meetings, via input from within the County Council, the CCGs, the District and Borough Councils, Healthwatch and the voluntary sector. The key projects in the programme for progress in the current year, and other anticipated work, are listed below and more information can be found here: JSNA Current Work Programme.

- Learning Disabilities Needs Assessment
- Understanding Child Sexual Exploitation
- Delaying Parenthood in Looked After Children Project
- Helping Vulnerable Children
- The Impact of Austerity Project
  - This has been identified as a key piece of work across the County and is now being worked on jointly with Healthwatch. In particular, it will attempt to better understand the impact of the welfare reforms on the Warwickshire population, building upon detailed work

already carried out by the District/Borough Councils and the Warwickshire Financial Inclusion Partnership. This will form part of a wider piece of research on 'health & wellbeing and vulnerable communities'.

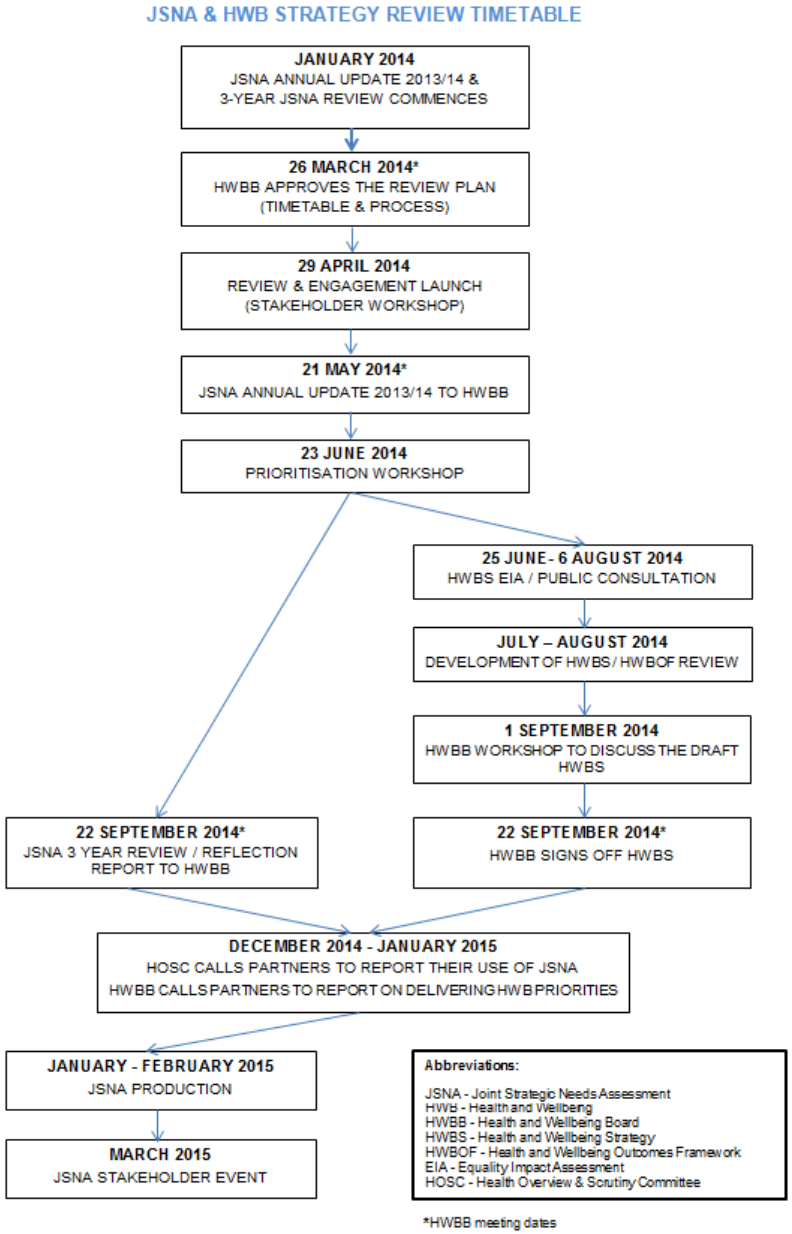
2.5.1 Next JSNA Review

During 2014/15, work will also concentrate on the second review of our JSNA. This will reflect on the existing JSNA key priorities and themes, and will include a full detailed assessment of data, information and intelligence on the health and wellbeing needs of the local population. This will be used to inform the development of Warwickshire's next Joint Health and Wellbeing Strategy.

Key dates as part of this process include:

- JSNA and HWB Strategy Review Launch and Stakeholder Event - 29 April 2014
- HWB Board Meeting and Annual Review Conference - 21 May 2014
- JSNA and HWB Strategy Prioritisation Workshop - 23 June 2014

The JSNA Annual Review process will also encompass a series of consultation activities with stakeholders and the public. All this work will culminate in the launch of the 'new' Warwickshire JSNA at a stakeholder event in March 2015.



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

3.1 BACKGROUND

The following key messages have been taken from the latest 2013/14 Quality of Life in Warwickshire Report. This document provides a detailed look at the people, places and communities in our county. The report is an assessment of the demographic, social, economic and environmental themes that all play a part in influencing our residents' quality of life.

The need for this type of material is more important than ever, as increasingly limited resources need to be deployed in transparent, evidence-led ways. The Quality of Life in Warwickshire report provides the underlying contextual evidence base for our JSNA so that improving the lives of all of Warwickshire's residents remains our collective priority.

3.2 OVERALL KEY MESSAGES

Over the past year the positive trend in improvements in a number of local quality of life indicators has continued; crime rates are continuing to fall, GCSE attainment is above the national average and there has been a reduction in the numbers who are not in employment, education and training (NEET). The numbers of people who are unemployed had been falling on a month by month basis but rose between December and January, which is likely to be due to seasonal factors. The national economy is improving but difficult financial decisions are still being made by many local public services, leading to continued future pressures on service delivery.

3.3 POPULATION CHANGE AND INCREASING DEPENDENCY

The population in Warwickshire is continuing to rise with latest figures showing that the overall number of people living in the county is now 547,974. It is expected that the population in the county will be 577,400 by 2018; an increase of 5.4% on the 2012 mid-year estimates. Alongside the general trend of people in the county living longer, the Census shows that Warwickshire's rural population is generally older than in the urban areas; the proportion of people aged 65 or over in rural areas is 21%, whilst in urban areas it is 17%.

The number of births in the county is also continuing to rise. Between 2002 and 2012, there was a 19% increase in annual births in Warwickshire with the biggest rise of 31% in Rugby

borough. The age of mothers varies across the county with Stratford-on-Avon and Warwick districts having the highest percentage aged over 30, at 62% and 63% respectively. The possible reasons for this are varied and may include career aspirations or conversely, uncertainty about employment, barriers to home ownership for younger couples, and the increased costs of bringing up a child.

The dependency ratio is now 1.70 people of working age for every dependent in the county (those aged under 16 or over 64). The projection for 2021 is 1.48, a fall that will impact on a number of areas such as the economy, education, health and social care.

A growing and ageing population is likely to result in increasing pressure on health and social care services as more people could suffer from long term physical and mental problems such as heart disease, high blood pressure and dementia. The challenge will be ensuring that older people enjoy the best quality of life they can in ways that are of their own choosing.

3.4 PRESSURE ON HOUSING

The availability of safe, secure and good quality housing is of fundamental importance to the health and wellbeing of residents.

The increase in population as well as changes in family units and how people choose to live will put pressure on housing supply in the county. The 2011 Census showed that 29% of all households in Warwickshire were one person households with the figure rising to 32% in Warwick District. Of these, one person households aged over 65 accounted for 13% of all households. A comparison between the 2001 and 2011 Census shows that the number of lone parent households has risen by 28%. It is this sector of the population along with disabled people that are expected to be most affected by the spare room subsidy ('bedroom tax') as the current programme of reforms for the welfare system are implemented.

The housing market started to recover in 2013 and this is predicted to continue in 2014. Between December 2012 and December 2013, lending to first time buyers increased by 37% and the number and proportion of mortgages ending in repossession was lower in 2013 than in any year since 2007. However, this recovery in the housing market is not as developed in the north of the County than the south.

Nationally, one of the key headlines from the 2011 Census has been the rise in the proportion of privately rented homes. Warwickshire has been no exception to the trend and between 2001 and 2011, the county saw the number of privately rented homes double from 14,809 in 2001 to 29,628 in 2011. The proportion of homes being privately rented increased in the same period from 7.0% to 12.8%. Nuneaton and Bedworth Borough and Rugby Borough both saw the number of privately rented homes increase by 150%. Both boroughs, along with Warwick District, recorded proportional shifts in private renting which were higher than the county average. Warwick District records the highest levels of private renting at almost 17% of homes. In part, this is likely to be a reflection of higher student numbers in the district and higher numbers of young professionals in the area.

Evidence from Strategic Housing Market Assessments across Warwickshire will help us to better assess housing needs and pressures in the context of future anticipated housing growth. Gypsy and Traveller Accommodation Assessments will also provide useful insight on additional housing need.

The rise in privately rented homes is part of a wider shift in patterns of housing tenure generally, which in Warwickshire has seen increasing numbers of homes owned outright, but declines in both the number of socially rented and mortgaged properties. The rapid rise in the number of privately rented homes since 2001 and decline in mortgaged properties could be linked to the economic climate in recent years where access to the housing market is more restricted. A combination of higher average house prices, tighter lending requirements and declining wage growth may all have contributed to the higher demand for rented accommodation. More local factors such as the presence of students in some areas, young people and more transient communities who may find it easier to access private renting than home ownership will also help to explain patterns of housing tenure in Warwickshire.

Private renting of homes carries with it a number of potential implications including issues relating to rent levels, security of tenure and housing quality. The analysis indicates that some communities in Warwickshire, notably students, lone households, lone parent households and some ethnic groups may be more vulnerable to these issues because of the higher levels of private renting evident in those groups.

Additional housing related needs may also arise from the roll out of universal credit and other welfare reforms.

Increasing utility costs, the impact of austerity and consequent levels of social exclusion within some communities continue to present challenges. The issue of how to best configure new build housing for occupants experiencing these difficulties, in addition to the cost of social and rented housing remains important.

3.5 IS THE ECONOMY RECOVERING?

At the end of 2013, there were signs that the UK economy was the strongest that it had been since 2007. Productivity is a key indicator of economic performance and estimates tend to use gross value added (GVA) as a measure of output.[12] Locally, Warwick District is faring best in terms of GVA, a trend that is forecast to continue through to 2025. GVA per worker however shows that Stratford-on-Avon District is the most productive. It is of some concern locally that Warwickshire is not projected to match the productivity levels of the UK at any point between now and 2025, and this could hamper a speedy and strong economic recovery locally[13].

Since January 2010 there have been minor fluctuations in the overall number of Jobseekers Allowance (JSA) claimants in the

[12] GVA is the total monetary value of all goods and services produced in a local economy, minus the costs that were involved in their production.
[13] Warwickshire County Council, Quarterly Economic Briefing, 2013

county but the overall trend has been downwards with the numbers halving in the recent four year period. This trend may continue but it should be noted that between December 2013 and January 2014 the overall number of claimants in Warwickshire rose by just over 240 or 4%. In the twelve months between January 2013 and this year the number of people claiming for more than twelve months has remained relatively static, down by 245 to 1,515. Long term unemployment continues to be highest in Nuneaton & Bedworth with 30% claiming JSA for over twelve months. Generally speaking, those who have been out of work for longer periods of time will find it increasingly difficult to get a job and there may also be a negative impacts on their health and wellbeing. This means that when the job market does pick up the long-term unemployed will find it harder to compete with other jobseekers. Despite this, long term unemployment in Warwickshire remains below the regional and national averages.

At a national level, the number of women in work is the highest figure on record and this trend is being reflected in the county. In the last year the number of women claiming JSA has fallen by 579 and now stands at around 2,200.

As employment continues to fall in the public sector the service sector is expected to the main source of jobs growth nationally between 2010 and 2020[14] with employment in this part of the economy projected to rise by more than 1.5 million (9%). There is forecast to be a continued trend of employment growth in higher skilled occupations and demand for skills as measured by formal qualifications. Continuing declines are expected in skilled and semi-skilled manual roles although lower skilled jobs will remain a significant component of the labour market.

3.6 INEQUALITIES STILL EXIST…

Generally, the Quality of Life Report 2013/14 continues to show that the north of the county fares less well than the other districts and boroughs across a range of indicators, with Nuneaton & Bedworth generally being in a slightly worse position than North Warwickshire. The exception for the borough is housing affordability, and the report highlights that there is more affordable housing in Nuneaton & Bedworth than elsewhere in the county and fewer people are affected by fuel poverty. However, it is significantly worse for levels of unemployment, numbers claiming workless benefits and housing repossessions. All other indicators reported on show that it is also worse than the county average[15]. That said, it is also to recognise the inequalities that exist and remain within all of our districts and boroughs in Warwickshire.

[14] Warwick Institute for Employment Research (2011) *'Working Futures 2010-2020'*

[15] Quality of Life Report 2013/14, Warwickshire Observatory, 2013.

3.7 DELIVERING SERVICES IN THE 21ST CENTURY…

The pace of technological change is increasingly affecting the way services are delivered. The Government updated its Digital Strategy in December 2013 which outlines how it will become 'digital by default'. The same approach has been adopted by the local public services in Warwickshire in order to improve services for customers whilst maintaining an awareness of those who are unable to access or use an internet enabled device. New technologies can also facilitate change in the way services are delivered, reducing the need to travel and speeding up the way tasks can be completed.

In 2010, around 20% of people owned smartphones[16]. At the end of 2012, this figure rose above 50% for the first time. Analysts predict that in two years, 90% of mobile users will have no choice but to own smartphones. At the same time, there are improvements in broadband speed and availability, providing even more opportunities to engage with and deliver services to residents in cost effective ways. This is being delivered in the sub-region through the Coventry, Solihull & Warwickshire Superfast Broadband project with the first communities to benefit being connected in the Spring of 2014. A survey undertaken as part of the project showed that, of the 7,494 responses from residents in Warwickshire, 67% said they had poor broadband speed. The areas identified with the poorest broadband service are all defined as rural using the rural/urban definition from the Department for Environment, Food & Rural Affairs.

Whilst the immediate benefits might be seen in terms of customers accessing information it will also encourage businesses to locate in rural areas and therefore help boost our rural economy. Not all customers will be receptive to the change however; there may be some who are still reluctant or unable to access services digitally and these are also the most likely to be the most vulnerable people in the community.

3.8 EXPECT THE UNEXPECTED…

Whilst the county escaped the worst of the winter weather, it has, in relatively recent years, experienced significant weather events. Several areas were flooded in 2007 and more recently both Rugby and Nuneaton have been hit by high winds and localised tornados. The immediate impact of such weather events may be seen to be on homeowners and communities but a report produced by Maplecroft[17] states that the UK economy may be at more risk from the climate than maybe imagined. It ranks the country in the top 10 list of countries worldwide that are at greatest risk of flooding. In addition it is in 16th place out of 197 countries for economic exposure to all natural hazards.

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

[17] Maplecroft Global Risk Analytics, 2014

There are a number of impacts that such adverse weather events can have on the health and wellbeing of residents which should therefore be considered.

3.9 WHO CARES?

Data from the 2011 Census shows that 11% of people in Warwickshire provide unpaid care for someone. Generally it is the older age groups who provide the most care; 62% of all unpaid carers are aged over 50. Young carers however should not be overlooked, with 2% less than 15 years old. Across the county the carers that provide the most hours of care per week (over 50 hours) are all in the older age groups, i.e. age 65 and over. Nearly 5,000 individuals fall into this category which raises some concerns about their well-being too.

3.10 WORKING TOGETHER IN STRAITENED TIMES

Budgets for Local Authorities have reduced and will continue to do so. The 2013 budget survey by the Association of Directors of Adult Social Services (ADASS) revealed that adult social care budgets in England had reduced by almost twenty per cent since 2011.

The number of children in care in Warwickshire has once again increased; however, its pace has slowed as the economic outlook has improved.[18] The death of Daniel Pelka and the subsequent Serious Case Review on so close to Warwickshire's borders may have an impact on referrals to social care in future.

The Children and Families Bill was introduced in February 2013 and aims to reform the systems for adoption, looked after children, family justice and for children and young people with Special Educational Needs (SEN), including those who are disabled, so that services support the best outcomes for them.

Child Sexual Exploitation (CSE) has become an issue of increasing concern, particularly in the wake of a number of serious incidents that have been of national interest e.g. in Rochdale and Oxfordshire. It is a requirement of Local Children's Safeguarding Boards to understand the prevalence of CSE in their area and consequently an **Understanding Child Exploitation needs assessment** was carried out in Warwickshire.

From 2013, all young people have a **duty to participate in education or training** until the end of the academic year in which they turn 17 and authorities should be supporting them to meet that duty.

The final report into failings at the Mid Staffordshire NHS Foundation Trust (Francis Report) has focussed attention on the culture of health and care organisations. **All relevant health and social care organisations have developed action plans**

[18] There is a statistically significant relationship between the looked after population and the unemployment rate, which means changes in unemployment can act as a useful indicator of the likely change in demand for care in the following year.

designed to improve standards and address the issues identified in the report.

Following the report of the abuse which took place at Winterbourne View, all people with learning disabilities who have been placed in homes outside the county are having a social care review to see whether they want to come back to Warwickshire.

Further plans to better integrate health and social care services, in order to give people a more consistent and joined-up experience as they move between hospital and community care, have been supported by a range of health and social care leaders. Warwickshire has put together a plan to use the Better Care Funding provided by the government for this purpose.

The Care Bill is 2013-14 (due for implementation in April 2015) is made up of 3 parts: reform of care and legislation; responses to the findings of the Francis Inquiry and the establishment of Health Education England (HEE) and the Health Research Authority (HRA). It will reform the law relating to care and support for adults and the law relating to support for carers, make provision about safeguarding adults from abuse or neglect and make provision about care standards.

The **Welfare Reform Act 2012** implemented changes to housing and other benefits many of which came into force in April 2013. Warwickshire County Council is currently undertaking a needs assessment which aims to understand the 'Impact of Austerity'.

Following the implementation of the **Public Services (Social Value) Act 2012**, public bodies, including Warwickshire County Council, have a duty to consider social value ahead of procurement.

It is important to also acknowledge the potential impact on need when initiatives such as Priority Families and the Warwickshire Local Welfare Scheme come to an end.

3.11 WHAT IS LIVING IN WARWICKSHIRE REALLY LIKE?

In September and October last year, Warwickshire County Council sent a survey[19] to 25,000 households in the county with the aim of gaining intelligence on the lifestyle characteristics of the local population and the perception of residents with regard to local public services. The headline results show that 89% of respondents are very or fairly satisfied with their local area as a place to live. The most important factors selected in making somewhere a good place to live are level of crime (61%), health services (53%) and clean streets (34%). Over two thirds (39%) of the responses indicated that people felt strongly or not at all strongly that they did not belong to their immediate neighbourhood. In terms of neighbourliness however, over two thirds of respondents said they had taken in a parcel on behalf of a neighbour, taken in or put out their bins or kept an eye on their property.

[19] Living in Warwickshire Survey, Warwickshire County Council, 2013

The survey also asked what people liked and disliked about living in the county. Key positive aspects mentioned were its easily accessible central location and attractive countryside whereas downsides that were given included traffic congestion and provision of public transport. If the county was located closer to the sea it also appears that more respondents would be happy! More detailed topic specific results from the survey are presented later in the report.

3.12 INCREASING USE OF FOODBANKS

The Trussell Trust reported in October 2013 that numbers relying on foodbanks across the UK had tripled in a year, according to new figures.

The Trust, which runs 400 food banks across the UK, said it handed out supplies to more than 350,000 people between April and September this year. A third of those being helped included children, and a third needed food following a delay in the payment of benefits.

In Warwickshire, the Trussell Trust has fed over 4,200 people so far in 2013/14 across their nine foodbanks[20]. Each foodbank records the numbers of children and adults using their service. Children account for just over 30% on average of those fed by foodbanks in Warwickshire. However, there is considerable variation between each foodbank, with the proportion of children fed ranging from 24% to 42% of the total numbers of people fed.

Similar to the national picture, over a third of people using Warwickshire foodbanks needed food following a delay in the payment of benefits in 2013/14. This has increased from 28% from the previous year. Over one in five (21%) people in the county who have used foodbanks so far in 2013/14 have done so due to benefit changes.

[20] Note: These figures do not include the North Warwickshire Foodbanks

4 THEME & TOPIC KEY MESSAGES

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

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

4.1 CHILDREN & YOUNG PEOPLE

4.1.1 Educational Attainment

"Amount and quality of education experience reinforces the effects of early years development on subsequent social and economic well-being, health and other outcomes…education inequalities continue to influence health throughout the life-course"[21]

[21] Review of social determinants and the health divide in the WHO European Region: final report. Review chair: Michael Marmot. 2013 UCL Institute of Health Equity.

4.1.1.1 What is the headline issue?

Education and health go hand in hand[22], with higher life expectancy and lower morbidity from the most common acute and chronic diseases as educational levels increase. Education influences both physical and mental health aspects; for example better educated people are less likely to suffer from heart disease, diabetes or emphysema and less likely to report depression or anxiety.[23] Maternal education has a particularly important effect on health outcomes for children.

The percentage of students in Warwickshire achieving 5 A*-C grades including English and mathematics at GCSE level has increased by 2 percentage points for the second year in a row (from 61 to 63 to 65, 2011-2013). Whilst this continues to be a positive trend, **a third of Warwickshire's pupils are not achieving the level of education which the government expects**.

Attainment gaps persist across geography and demography, although the percentage of students in Rugby Borough achieving these standards has increased by 7 percentage points from 62 in 2012 to 69 in 2013. However, it is in Warwick District where the percentage of disadvantaged

[22] MDG Summit: Remarks at Roundtable 2: Meeting the goals for health and education. Dr Margaret Chan Director-General of the World Health Organization. 20 September 2010 New York, United States of America.
[23] Education and Health: Evaluating Theories and Evidence, David M. Cutler and Adriana Lleras-Muney, NBER Working Paper No. 12352, June 2006, JEL No. I1, I2.

pupils achieving 5 A*-C grades including English and mathematics is highest (36% in 2012, 44% in 2013). Continued educational attainment inequalities will contribute to future health inequalities and poorer health outcomes, particularly for those in North Warwickshire and Nuneaton & Bedworth Boroughs.

Increasing numbers of primary schools are converting to academies which affects Warwickshire County Council's ability to positively influence education quality at the earliest opportunity.

During the academic year 2013/14 there have been 12 primary and 2 secondary schools which have converted to academies, and 3 primary and 1 secondary are due to covert before the end of the academic year.

During the academic year 2012/13 8 primary schools (plus 1 primary special school) and 2 secondary schools (plus 1 secondary special school) converted to academies.

During the academic year 2011/12 1 primary school and 7 secondary schools converted to academies. 1 primary free school was also opened.

4.1.1.2 What does the data say?

In 2011/12 Nuneaton and Bedworth had the lowest attainment levels (54%) and Stratford upon Avon District had the highest (69%). In 2012/13 Stratford's attainment remains the highest at 72% but North Warwickshire is now the Borough with the lowest percentage at 55%. This mean there is now a 17 percentage point difference in the proportion of pupils gaining 5 or more GCSEs at grades A*-C, including English and mathematics, up from 11 percentage points in 2011/12.

As seen in 2011/12, there continue to be considerable differences in attainment at very local levels. Last year the largest difference was 35 percentage points between localities in Warwick. This has reduced to 28 percentage points due to South Leamington raising its attainment levels from 48% in 2011/12 to 54% in 2012/13 with Kenilworth remaining high at 82% (83% in 2011/12).

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

Fewer localities have less than half of pupils achieving what is commonly regarded as the minimum educational standard. In 2011/12 four localities fell into this category; in 2012/13 it is only two, Abbey & Wem Brook and Arbury & Stockingford both in Nuneaton.

Children considered to be 'disadvantaged' had an attainment gap of 32 percentage points in 2012/13 between them and those not considered to be disadvantaged (33 percentage points in 2011/12). This new measure includes any child who has been eligible for free school meals in the last six years or is a looked after child. This GCSE five or more A*-C grade attainment gap was widest in Stratford (36 percentage points: 40.1% for disadvantaged pupils, 76.1% for not disadvantaged) but this had narrowed from 2011/12 (43

percentage points: 31.6% for disadvantaged pupils, 74.7% for not disadvantaged).

Those children who have been continuously looked after for at least 12 months continue to have lower levels of educational attainment compared with those in the general population. In 2010/11 and 2011/12 **attainment levels were 47 percentage points lower for looked after children in Warwickshire**, in terms of achieving 5+ GCSEs at grades A*-C including English and mathematics, compared to the remainder of the pupil base[24]. However, the gap has narrowed slightly in 2012/13 with a difference of 44 percentage points. This suggests an improvement after two years of stasis but the gap remains unsatisfactorily large.

Looking at the socio-economic profile of those completing their GCSEs in 2012/13, the disparity between groups remains. In 2012/11 the proportion of children gaining five or more GCSE grades A*-C or equivalent including GCSE English and mathematics was 90% for Mosiac Group C, but was only 34% for children from Mosaic Group O. In 2012/13 it was 83% and 36% respectively[25].

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

[25] More information on the Mosaic groups can be found here: Mosaic Guide. Group C is: Households classified as "wealthy people living in sought-after areas" and Group O: "Families in low rise social housing with high levels of benefit need".

Warwickshire holds a large volume of information on those undertaking assessments at all stages of education: from Early Years Foundation Stage in reception year to Key Stage 2 examinations in Year 6, to Key Stage 4 (GCSE) examinations in Year 11, to Key Stage 5 (A-Level) examinations in Year 13. The Department for Education aims to use this ability to track progress over time to reform the accountability of secondary schools.

"A pupil's key stage 2 results, achieved at the end of primary school, will be used to set a reasonable expectation of what they should achieve at GCSE. Schools will get credit where pupils outperform these expectations. A child who gets an A when they are expected to get a B, or a D when they were expected to get an E, will score points for their school."[26]

Combined with the ability to analyse attainment by socio-economic, demographic and geographical characteristics, Warwickshire has the tools to provide the intelligence behind the discrepancies.

In 2011/12 there were an estimated 830 (4.5%) 16-19 year olds in Warwickshire who were Not in Education, Employment or Training (NEET). This number dropped to 660 (3.6%) in 2012/13. Therefore, there has been an improvement of 0.9% in the NEET's rate 2012/13 compared to 2011/12.

[26] https://www.gov.uk/government/speeches/reforming-the-accountability-system-for-secondary-schools

The NEETs by district data shows improvements from 2011/12 in all areas with the exception of Nuneaton and Bedworth, which remained unchanged and stands at the highest rate of 4.6% (224).

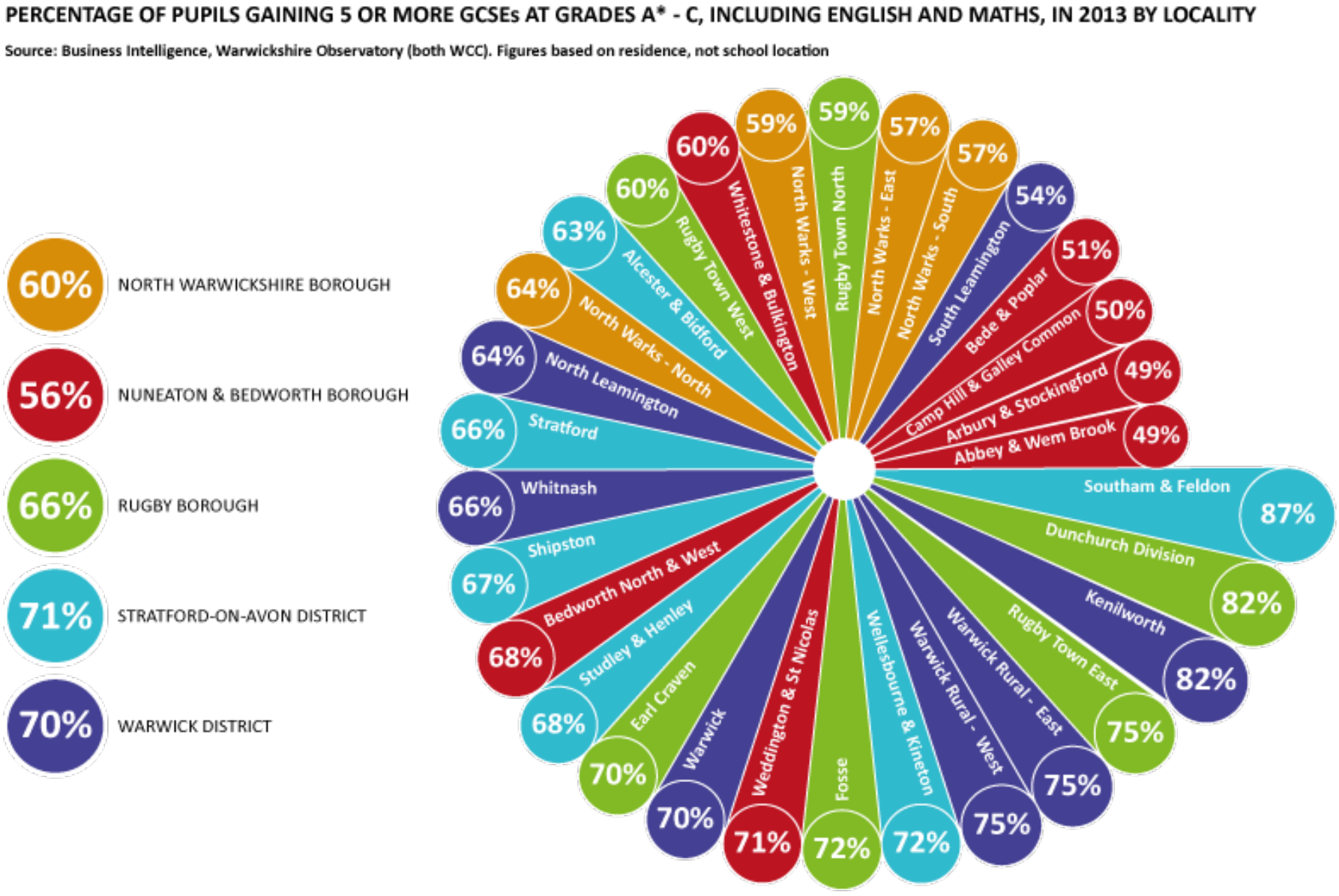
Early predictions show that Warwickshire's NEET figure has increased to 5.5% in 2013/14. This is due to changes in the counting methodology,[27] as well as more effective tracking, which has reduced the Not Known cohort by up to 7 percentage points.

The percentage of Warwickshire's school leavers aged 16/17 years old entering education or training remained the same at 90.8% in 2012/13 (90.7% in 2011/12). However higher levels of NEETs and Not Known are seen in the 18 and 19 year olds.[28]

[27] From April 2013 young people who are recorded as NEET but whose records have lapsed will no longer expire from being NEET but remain NEET until they go into a positive destination.

[28] NEETs performance update to Warwickshire County Council's Children and Young People
Overview and Scrutiny Committee, 22nd January 2014.

Figure 1: Warwickshire GCSE attainment in 2013



4.1.2 Looked After Children

"To remember each child is an individual. What works for one child may not work for another"[29]

"I think it very important that when a care leaver goes wrong, no matter how many times, they know you will be there to support them and not judge them"[30]

4.1.2.1 What is the headline issue?

The number of Looked After Children (LAC) in Warwickshire has increased from 681 at 31st March 2012 to 698 at 31st March 2013. This represents an increase of 3%, which is smaller than the 7% seen last year. The number of LAC increases year on year with the past five year increase 30.2% between 31st March 2009 and 31st March 2013. The district with the largest percentage increase between 2009 and 2013 is Rugby with a 64.2% increase in the number of looked after cases. All districts saw an increase in their looked after population between 2012 and 2013 except Warwick which saw a reduction of 5.1%.

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

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

4.1.2.2 What does the data say?

The rate of LAC per 10,000 population is highest in Nuneaton and Bedworth Borough at 87 and lowest in Stratford-on-Avon District at 36. The largest numbers of LAC are aged between 10 and 15. However, the group which has seen the largest increase between 2008 and 2013 is those aged 1-4 years old whose numbers have doubled in five years and now make up 19% of the looked after population (up from 12% in 2009).

The majority of LAC have a main need category of 'Abuse and Neglect', which has not changed over the past five years, although proportionately it has decreased, down from 62.9% at 31st March 2009 to 57.7% at 31st March 2013.

The number of children with a main need of 'Family Dysfunction' has increased over the past five years, with this need now accounting for 16.0% of children being looked after at 31st March 2013 (up from 7.3% at 31st March 2009).

[29] Key message from care leaver responding in the Children in Care Council Care Leavers Charter Survey Results – 2013.
[30] Key message from support worker responding in the Children in Care Council Care Leavers Charter Survey Results – 2013.

4.2 LIFESTYLE

4.2.1 Factors Affecting Health & Wellbeing

A local family from Nuneaton was recently referred to the 'Family Food & Fitness' programme by a Family Change for Life Advisor. Health advisors across Warwickshire support families with overweight/very overweight children who have been identified through the National Child Measurement Programme (NCMP).

Upon the first visit to 'Family Food and Fitness', the son was confirmed as having a high Body Mass Index (BMI), putting him into the obese category. The mother and daughter's BMI figures also identified them as being obese.

The whole family attended nine exercise sessions as part of the programme. This is where families undertake exercise, learn about healthy eating, healthy living and work together as a family unit to improve their health. Following this, the son started swimming regularly and the mother and daughter went on to the Warwickshire 'Exercise on Referral' programme where they continued to receive exercise guidance and dietary advice. The family also now play badminton on a regular basis at their local sports centre as a result of being coached during the programme.

The whole family's' BMI figures had decreased at week 9 of the programme and all have sustained healthy eating behaviours and continued to increase their levels of physical activity. This family are one of 119 families who completed the structured family weight management programme during 2013/14.[31]

4.2.1.1 What is the headline issue?

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

Issues around obesity particularly in children, particularly the large increase between reception and year 6, are likely to result in health problems in later life. **There is a need, supported by the Marmot Report[32], to instil healthy lifestyle choices and behaviour at a young age to reduce risks in later life**.

4.2.1.2 What does the data say?

A variety of lifestyle factors can have a major impact on a person's health. These include smoking and alcohol consumption[33], diet and physical exercise [34], sexual behaviour[35], and problems resulting from drug taking. Each of these are addressed in turn below:

4.2.1.2.1 Obesity

Obesity can have a severe impact on people's health and is recognised as a major determinant of premature mortality and avoidable ill health. Obesity increases the risk of type 2 diabetes, some cancers, and heart and liver disease. Latest estimates from the Active People Survey carried out by Sport

[31] Nuneaton & Bedworth Leisure Trust Case Study
[32] Marmot Review Website
[33] Which account for many coronary heart disease and cancer deaths.
[34] Which contribute to obesity or malnutrition and affect life expectancy.
[35] Which can lead to infection or teenage pregnancy.

England suggest that **almost two thirds of adults in Warwickshire are estimated to be overweight or obese.** This is in line with national estimates but equates to approximately 290,000 adults in the County and this figure continues to increase**.**

As a comparison, results from the Living in Warwickshire Survey showed that 46% of respondents stated that they were either 'a little' or 'a lot' overweight.

In terms of childhood obesity, data from the 2012/13 National Child Measurement Programme shows that **one in five reception age children in Warwickshire are classed as being overweight and obese, but this increases to almost one in three by the time they have reached Year 6 age**.

The prevalence of obesity in Warwickshire more than doubles between reception age and year 6, from 8% to 16.3%. These figures emphasise the importance of encouraging healthy eating and exercise at the start of school life in order to reduce the risk of obesity in later years.

Although these rates appear high, the County level figures are actually statistically significantly lower than the overall England figure. However, when the data is presented for the Districts and Boroughs**, the prevalence of overweight (including obese) Year 6 children in North Warwickshire and Nuneaton & Bedworth Boroughs are statistically significantly higher than the national figure.** In contrast, the prevalence of overweight (including obese) children in both reception and Year 6 is statistically significantly lower in Warwick and Stratford-on-Avon Districts when compared to England as a whole.

Rates of childhood obesity in Warwickshire over time now appear to have stabilised.

4.2.1.2.2 Physical activity

The Health Impacts of Physical Inactivity (HIPI) tool estimates that **only 20% of the Warwickshire population are currently physically active** and 18% of total premature deaths could be prevented if 100% of the population were physically active.[36] This is equivalent to 388 avoidable deaths in Warwickshire each year. The tool also details that approximately 3,144 cases of diabetes could also be prevented in the county if 100% of the population were active.

These results are in contrast to those from the Living in Warwickshire Survey, which show that, 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.

However, due to this being a voluntary survey, this is likely to include an element of responder bias where 'healthier' people

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

tend to be more inclined to complete questionnaires on health issues.

4.2.1.2.3 Smoking

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

It is estimated that 17.9%[37] of people aged over 18 in Warwickshire are smokers, which equates to approximately 78,000 adults. There is a clear socio-economic gradient in terms of smoking prevalence and it is estimated that 33.9% of the county's adults employed in routine and manual occupations are smokers.

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

The prevalence of smoking in pregnancy is high in Warwickshire, with 17.6% of women smoking at the time of delivery for 2012/13. This equates to nearly 1,000 babies a year who are being born to women who still smoked at the time of delivery and is a **statistically significantly higher rate than the England proportion of 12.7% for the same period.**[38]

Smoking in pregnancy has also been identified as a key local priority in the 2013 Director of Public Health Annual Report[39].

4.2.1.2.4 Alcohol & substance misuse

The 2012 Warwickshire Young People & Substance Misuse Needs Assessment shows that alcohol use by young people in Warwickshire indicates that **fewer young people are drinking alcohol**, those that do are drinking less frequently, and fewer are attending A&E or being admitted to hospital as a result of alcohol misuse. However, comparisons show that **more young people are drinking every week in Warwickshire (10%) compared to the 2011 national average (6%)**. This is consistent for every age group. Efforts to reduce alcohol misuse therefore, must not be diminished.

Most young people have never tried illegal drugs (92%). And fewer young people are using illicit drugs in Warwickshire compared with the national average. Research shows that young people who have truanted from school or been excluded, are more likely to have taken drugs in the last year than those who were not vulnerable in this way.

[37] Source: Integrated Household Survey, 2012 data

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

[39] 2013 Director of Public Health Annual Report

Cannabis is the most frequently used substance of those that have tried illegal drugs with 2.8% of young people reported using cannabis in the last four weeks. Efforts to reduce drug misuse therefore, must not be diminished.

A report by Public Health England on substance misuse among young people in England for 2012/13 was recently published. Following a similar structure, a Warwickshire based report[40] by the Observatory has been produced highlighting the key messages around young people who accessed specialist treatment as a result of substance misuse in 2012/13.

The analysis highlighted that 161 young people received help for alcohol or drug problems in Warwickshire during the year. 77% of which were new presentations. 87% reported cannabis as their main drug. Alcohol was the second substance that young people were being treated for in Warwickshire, accounting for 34% of clients. Over half (54%) of young people in treatment successfully completed their treatment

4.2.1.2.5 Sexual Health

The rate of under-18 conceptions in Warwickshire for 2012 was 24.3 per 1,000 females aged 15–17, which equates to 234 conceptions. **This represents a reduction of 37.1% from the 1998 baseline rate and a 21.7% decline on the number of conceptions in 2011.** Historically, Warwickshire has not performed as well when compared to its statistical neighbours.

However, in 2012, **the teenage conception rate was around the average rate of the statistical neighbours.** Warwickshire also performed well in terms of percentage change since the 1998 baseline when compared to these other areas[41].

Although across the County, the overall rate of under-18 conceptions has declined, some District and Borough variation persists. **Rates are still comparatively high in northern areas of the County with particular local hotspots, such as Camp Hill ward in Nuneaton**, where the conception rate has consistently been around 100 conceptions per 1,000 15-17 year old females.

Throughout Warwickshire, in recent years, the rate of acute chlamydia diagnoses has been in decline for both the overall population and the population aged 16-24. **The population aged 16-24 are at higher risk of chlamydia due to higher sexual activity in this age group**, and in 2012, the rate per 100,000 within this age group was 1,485, compared to 245 per 100,000 in the general population. There are inequalities in the rate of chlamydia diagnoses amongst the districts and boroughs, with consistently (although declining) higher rates across all age groups within Nuneaton and Bedworth and Rugby.

Genital warts remain the second most prevalent STI in Warwickshire, with 16-24 years olds again at increased risk of infection. There is only a small amount of variation in rates

[40] Substance Misuse among Young People in Warwickshire, Warwickshire Observatory

[41] ONS teenage conception release

throughout the county, and a pattern of slight decline has been seen in previous years.

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

4.3 ILL HEALTH

4.3.1 Long Term Conditions[42]

Alan, a 50 year old Leamington resident who hadn't been to see his doctor for a number of years was recently invited for a Health Check at his local GP Practice. He was unaware of any medical problems and had no obvious symptoms, but following a simple, short check, he was found to have raised blood pressure and cholesterol levels. Alan was asked to come back for further blood tests and blood pressure checks and was prescribed a statin to help manage his condition. He was also provided with a range of comprehensive advice in relation to his lifestyle.[43]

4.3.1.1 What is the headline issue?

The numbers of patients recorded on general practice disease registers, in Warwickshire show that there are potentially large numbers of undiagnosed or unrecorded cases of Long Term Conditions (LTCs), especially for coronary heart disease, hypertension, diabetes, chronic obstructive pulmonary disease, asthma and chronic kidney disease[4445].

An estimated 1 in 3 people in Warwickshire, aged over 16 are living with one or more long-term conditions. This equates to approximately 150,000 people.

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

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

[43] NHS Health Checks Programme

[44] When compared with the expected numbers of people with specific conditions calculated from population prevalence rates.

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

Table 1: The Burden of LTCs in Warwickshire, 2013/14[46]

	Estimated Number & Prevalence (%)	GP Practice Disease Registers	Hospital Admns	Deaths
			Avg. per year	Avg. per year
Any Long Term Condition	150,000 (33.3% of the adult population aged 18+)		20,000	2,800
Coronary Heart Disease (CHD)	25,200 (5.7% aged 16+)	17,658 (3.2%)	1,500	650
Stroke & Transient Ischaemic Attacks (TIA)	11,700 (2.6% aged 16+)	9,504 (1.7%)	1,000	400
Hypertension	139,300 (31.0% aged 16+)	82,302 (14.7%)	350	50
Diabetes	34,500 (7.8% aged 17+)	25,929 (5.7% aged 17+)	450	60
Chronic Obstructive Pulmonary Disorder (COPD)	12,600 (2.8% aged 16+)	8,801 (1.6%)	850	200
Asthma	46,500 (37,500 adults & 9,000 children) (1 adult aged 16+ in 12, 1 child aged 0-15 in 11)	34,376 (6.1%)	500	15
Epilepsy	4,400 (1 in 100 aged 18+)	3,512 (0.8% aged 18+)	350	15
Cancer	2,500 new cases per year (incidence)	11,335 (2.0%)	15,000	1,400
Hypo-thyroidism	3,700 (15 in every 1,000 women, 1 in 1,000 men aged 16+)	19,601 (3.5%)	12	5
Renal Disease/CKD	41,000 (9.4% aged 18+)	22,756 (5.1% aged 18+)	400	20

[46] Data table updated from the Director of Public Health's Annual Report 2012, which can be found here: DPH Annual Report 2012

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

In addition, we need to consider people living with multiple conditions, which will be the norm rather than the exception. Multi-morbidity is associated with poorer quality of life, higher hospital admissions and mortality.

4.3.1.2 What does the data say?

The chronic conditions in the table below account for approximately 20,000 hospital admissions and around 3,000 deaths on average each year.

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

NHS Health Checks

The NHS Health Check programme is a public health programme in England for people aged 40-74 which aims to keep people well for longer. It is a risk assessment and management programme to prevent or delay the onset of diabetes, heart disease and stroke.

Together diabetes, heart, kidney disease and stroke make up a third of the difference in life expectancy between the most deprived areas and the rest of the country. Addressing these differences is a key aim of this programme. With the rise in obesity, type 2 diabetes, and the associated cost to the NHS and social care, prevention of disease is also a key driver.

In Warwickshire, it was decided to roll the programme out a locality at a time rather than across the whole county. The programme was delivered initially in Nuneaton and Bedworth Borough during 2010. It was decided to start in the north of the county as this is the area where evidence shows that health outcomes are poorest. North Warwickshire began delivering NHS Health Checks in 2011, Rugby in 2012 and South Warwickshire in 2013.

Since the start of the NHS Health Check programme, a total of 65,008 NHS Health Checks have been offered and 24,873 have been completed (38%). Figures are to the end of April 2014.

The number of patients with cardiovascular disease risk factors that have been identified are:

- 419 patients with Diabetes
- 79 patients with Coronary Heart Disease
- 224 patients with Chronic Kidney Disease
- 1,480 patients with Hypertension
- 64 patients with Atrial Fibrillation[47].

These patients have now been added to practice risk registers where they are monitored and receive suitable medication.

From a needs perspective, these figures provide us with an indication of the numbers of people living with chronic health conditions in the wider population who have yet to be medically diagnosed.

Self-reported Health Status

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

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

[47] Atrial fibrillation is a heart condition that causes an irregular and often abnormally fast heart rate.

4.3.2 Mental Wellbeing

Feeling Low? Lying awake worrying? Stressed?

Books on prescription (BOP)[48] is a scheme which enables GPs and mental health professionals to offer their patients and service users self-help books available from the local library. The books are recommended by health professionals, and they can help people learn about and manage a range of commonly experienced mental health problems, including depression, anxiety and stress. Most of the books are written by leading psychologists and many present self-help versions of established treatment programmes.

"The Books on Prescription service has made a real difference to my health and my life"

4.3.2.1 What is the headline issue?

At any one time, roughly one in six of us is estimated to be experiencing a mental health problem. It is vitally important to monitor and investigate the levels of mental health in order to target and improve mental health services at a local level. Mental health needs vary on a broad spectrum from mild disorders to more complex and severe conditions.

For people aged between 16 and 74 living in Warwickshire, the rate of common mental health conditions is 121.4 per 1,000 population[49]. This means that an estimated 46,000 people aged between 16 and 74 in Warwickshire have a common mental health problem.

4.3.2.2 What does the data say?

4.3.2.2.1 Living in Warwickshire Survey Data

Analysis from the 'Living in Warwickshire' survey 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 7,500 Warwickshire residents who responded, i.e. 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.

[48] Warwickshire Books on Prescription webpage

[49] Common mental health conditions include depression, generalised anxiety disorder, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD), phobias and social anxiety disorder.

4.3.2.2.2 Adult Mental Health

10.6% of adults aged over 18 in Warwickshire had depression in 2011/12 compared with the England average of 11.7%[50]. This is the estimated prevalence based on GP records, but it is likely that there will also be significant numbers in the wider population who have not been formally diagnosed with the condition.

The overall suicide rate across Warwickshire is comparable to both the England rate and the West Midlands regional rate. However, the latest data for 2010-12 shows that the suicide rate for males in the County is statistically significantly higher than the equivalent national figure[51].

4.3.2.2.3 Young People's Mental Health

In comparison with the 2007/08-2009/10 period, the rate of young people aged 10 to 24 years in Warwickshire who are admitted to hospital as a result of self-harm is higher in the 2010/11-2012/13 period[52]. The admission rate in the 2010/11-2012/13 period is similar to the England average. However, for the latest year only, 2012/13, the directly standardised rate per 100,000 population aged 10-24 years in the County for hospital admissions due to self-harm was statistically significantly higher than the equivalent England figure. Nationally, levels of self-harm are higher among young women than young men.

There were 404 hospital admissions as a result of self-harm in young people aged 10 to 24 years in Warwickshire during 2012/13 against the England average of 346.

[50] Community Mental Health Profiles 2013, North East Public Health Observatory.
[51] Public Health Outcomes Framework
[52] Child Health Profile, CHIMAT, Hospital Episode Statistics, Health and Social Care Information Centre.

4.4 VULNERABLE COMMUNITIES

4.4.1 Reducing Health & Wellbeing Inequalities

4.4.1.1 What is the headline issue?

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

4.4.1.2 What does the data say?

4.4.1.2.1 Life expectancy

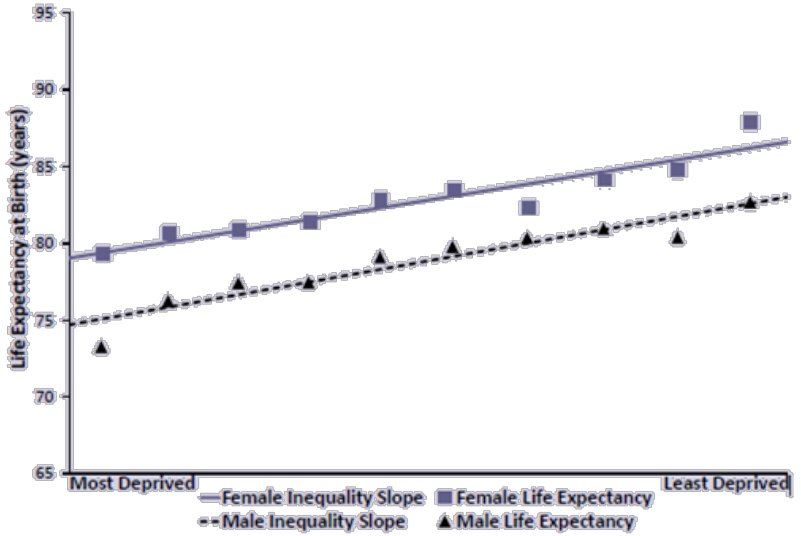
Inequalities remain throughout Warwickshire. This is reflected in **differences in average life expectancy** which range from 78.2 years for males in Nuneaton & Bedworth Borough to 81.0 years in Stratford-on-Avon District, and from

82.6 years for females in Nuneaton & Bedworth Borough to 84.9 years in Stratford-on-Avon District.

There are also marked differences between different parts of the County in terms of the number of years a person is expected to live without a limiting long-standing illness or disability. For example, an 8.9 year gap in disability-free life expectancy at age 16 for males exists between North Warwickshire and Stratford-on-Avon for the time period, 2007-09.

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

Figure 2: Warwickshire Slope Index of Inequality[53]



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

[53] The points on this chart show the average life expectancy in each tenth of the population.

4.4.1.2.2 Premature Mortality

In Warwickshire, there were 4,563 premature deaths[54] in the three year period 2010-12, which equates to approximately 30% of all deaths.

The county ranks 39th out of 150 local authorities for overall premature deaths per 100,000 population for 2010-12 (where a ranking of 1 indicates the lowest rate nationally).

Compared to the national picture, Warwickshire is doing well on most mortality indicators, other than liver disease where it is ranked 47th.

However, the county fares less well compared to similar local authorities, where it ranks 11th out of 15 for overall premature deaths.

4.4.1.2.3 Fuel poverty

Under the new 'Low Income High Cost' definition of fuel poverty, a household is considered to be fuel poor where they have required fuel costs that are above average (the national median level), and were they to spend that amount, they would be left with a residual income below the official poverty line.

According to this definition, in 2011, **13% of households in Warwickshire lived in fuel poverty compared with a national average of 10.9%**[55]. This equates to 30,000 households across the County[56].

The proportions of 'fuel poor' households using the new measure are remarkably similar across Warwickshire's Districts and Boroughs and range from 12.4% in North Warwickshire to 13.9% in Rugby. However, it should be noted that at Lower Super-Output Area level, there are some parts of the county where the estimated proportion of households living in fuel poverty is in excess of 25%.

4.4.1.2.4 Child poverty

The proportion of children in poverty (all dependent children under 20) in Warwickshire in 2011 was 13.5% against the England average of 20.1%[57]. This equates to approximately 17,000 dependent children under the age of 20. The proportion of children living in poverty is lowest in Stratford-on-Avon at 9.7% and highest in Nuneaton and Bedworth at 19.3%.

[54] http://longerlives.phe.org.uk/

[55] 2011 'Low Income, High Cost' fuel poverty estimates data from the Department of Energy and Climate Change (DECC).
[56] These figures are likely to represent an underestimate of the current picture given the recent above inflation increases in the cost of energy.
[57] Source: Public Health Outcomes Framework.

4.4.1.2.5 Teenage conceptions

There is considerable variation in the teenage conception rate at district and borough level across Warwickshire. However, for the first year, all districts and boroughs have experienced a decline in the rate, with each area experiencing its lowest rate since the 1998 baseline.

North Warwickshire experienced the smallest decline, with the rate decreasing from 29.5 conceptions per 1,000 females aged 15-17 in 2011 to 29.0 in 2012. In Nuneaton and Bedworth, the rate declined from 43.2 in 2011 to 38.4 in 2012, making it the borough with the highest rate in the county for 2012. The conception rate in Rugby for 2012 was 20.8, which is a decrease on the rate of 24.3 for the previous year. The last few years have seen an increase in the conception rate in Stratford-on-Avon, however from 2011 to 2012 the rate declined from 25.4 to a new low of 16.2, which also represents the lowest rate in Warwickshire. Warwick District saw the largest decline in the conception rate across the county, with a reduction in rate from 29.6 in 2011 to 17.1 in 2012.

There has been a slight increase in the percentage of teenage conceptions leading to abortion across Warwickshire, increasing from 51.2% in 2011 to 52.1% in 2012. However, variations persist across the county, with a 31 percentage point difference between Stratford-on-Avon, which has the highest proportion of conceptions that lead to abortion (71.4% in 2012), and Nuneaton and Bedworth, which had the lowest proportion (40.2% in 2012). The difference in 2011 between the highest and lowest proportions leading to abortion was 13 percentage points, which highlights increasing variation across the County[58].

4.4.2 Disability

"By providing high quality and effective information and advice about the support that is available locally we can encourage people to stay active, healthy, engaged and independent in their communities."[59]

"To actually go out and have the ability to socialise and be like everyone else to go to work and have a purpose - confidence building and it's really good when people get those sorts of opportunities."[60]

4.4.2.1 What is the headline issue?

Warwickshire has an ageing population because we are living longer. However, the quality of those extra years may be diminished because of physical disabilities and/or sensory impairment. The World Health Organisation states that *"People with disabilities report seeking more health care than people without disabilities and have greater unmet needs."*[61]

[58] Source: Respect Yourself update; ONS teenage conception release
[59] Respondent, Professional/Carers Survey October 2013
[60] Support Worker, South Warwickshire, Learning Disabilities Needs Assessment
[61] Who.int. (2014). Who | disability and health. [online] Retrieved from: http://www.who.int/mediacentre/factsheets/fs352/en/ [Accessed: 12 Mar 2014].

The survival rates of children with learning disabilities and complex needs are growing and increasing numbers of adults with learning disabilities are surviving into old age. *"Older people are more likely to be disabled than younger people, but over the past thirty years the incidence of disability has risen fastest amongst children*[62]*…Trends in impairment show an increasing number of children being reported as having complex needs, Autistic Spectrum Disorders and mental health issues. Among adults there are increasing numbers of people reporting mental illness and behavioural disorders, while the number of people reporting physical impairments is decreasing."*[63]

By providing high quality and effective information and advice about the support that is available locally we can encourage people to stay active, healthy, engaged and independent in their communities.

4.4.2.2 What does the data say?

There are estimated to be 34,743 people aged 18-64 with a moderate or serious physical disability in Warwickshire. Within that figure 26,750 are classed as having a moderate physical disability, with a further 7,993 classed as serious.

The total is predicted to rise to 36157 by 2020 with 27,758 classified as having moderate physical disability and 8,399 as severe.

Countywide there are 3,990 Disability Living Allowance claimants aged under 25 (2.5%) of the U25 population)[64]. Nuneaton & Bedworth has the highest number of Disability Living Allowance claimants (1150) and the highest percentage of U25 population (3.05%), with Warwick at the second highest (830 & 1.94%). Both the number and percentage of U25 claimants have increased since August 2012, from 3680 (8.4%).

In 2012/13 808 social care customers with a learning disability were identified as living in their own home or with their family. This represents 72.6% of customers, compared to 54.5% in 2011/12 the national average is 74%. 71% of customers with a learning disability and 28% of customers with a physical disability who were living at home had either a personal budget or a direct payment, giving them greater choice and control over their care.

64 social care customers with a learning disability were in paid employment. This represents 5.8% of the social care customers with a learning disability, compared to 5.9% in 2011/12; the national average is 7%.

[62] Possible explanations include increasing prevalence of impairment among children, children with complex conditions surviving longer, increased diagnosis, increased reporting and/or overall increases in the population.
[63] pg.9. Prime Minister's Strategy Unit (2005) Improving the Life Chances of Disabled People

[64] Data on Disability Living Allowance claimants aged under 25 figures from August 2013.

In the 2013 Adult Social Care Survey, 91% (86% in 2012) of customers with a learning disability and 66% (68% in 2012) of customers with a physical disability said they had enough control over their daily life. This compares to 71% (73% in 2012) for all social care customers. 85% (89% in 2012) of customers with a learning disability and 52% (48% in 2012) of customers with a physical disability said their quality of life was either good or better. This compares to 56% (60% in 2012) for all social care customers[65].

The percentage of pupils with Special Educational Needs (SEN) has decreased by 1% year on year since 2012 (20% in 2012, 19% in 2013 and 18% in 2014)[66]. This decrease has consistently been those at School Action stage. In 2013 the attainment data show that **there was a gap of 46 percentage points between those without SEN achieving 5 or more GCSEs A*-C** and those with SEN. This is a slight decrease from 2012's figure of 47%.

4.4.3 Safeguarding

"I do feel safe because I've learnt a lot about being safe now and I know the Safe Places I can go"[67]

"If I was frightened I could go in and ask them if I could stay for a bit and the shops have CCTV".[68]

"Thank you for taking care of me"[69]

"Thank you for everything….you have made a difference"[70]

4.4.3.1 What is the headline issue?

Over the previous three years**,** referrals to children's social care in Warwickshire steadily rose, including by 18% between 2009/10 and 2011/12. However, over the **last year there has been a clear decrease** of 7% from 6998 referrals in 2011/12 to 6524 in 2012/13[71]. There has again been an increase in **the number of children made the subject of Section 47 enquiries**, up 21% in 2012/13.

The number of children who were made subject to a CP Plan once again rose from 534 plans initiated during 2011/12 in comparison to the 550 initiated in 2012/13[72]. However, this shows a slowing in the rate (3%) compared with that seen over

[65] It should be noted that customers with a learning disability were a lot more likely to have assistance in completing the survey which results in more positive answers compared to those completing their own survey.
[66] January 2014 School Census
[67] Vulnerable Adult commenting on the Safe Places scheme
[68] Vulnerable Adult commenting on the Safe Places scheme
[69] Young person adopted by her foster carer taking to an Independent Reviewing Officer.
[70] Long term foster carer taking to an Independent Reviewing Officer.
[71] Although data is collected with regard to social care referrals, it is not possible to identify how many referrals move onto an Initial Assessment. Assessments and may lead to no further action, the direct provision of services, and Section 47 enquiries.
[72] The reasons for the increase are complex and are currently being addressed by the work being undertaken in conjunction with the Dartington Social Research Unit.

the previous year (16%). **CP activity remains highest in Nuneaton and Bedworth, followed by Rugby**.

Warwickshire County Council is working with the Dartington Social Research Unit to build upon the work on looked after children. Our aims are to reduce safely the numbers of children needing to become subject to child protection plans and to reduce safely the duration of plans. The drivers behind this work are that Warwickshire has a disproportionally high number of referrals to social care, relative to its statistical neighbours, but it has a low proportion of referrals which go on to be assessed and receive a service. We have disproportionally high numbers of children subject to CPP and we need to understand if this is because there is a better earlier identification of need or a lack of shared understanding about thresholds of intervention.

4.4.3.2 What does the data say?

550 children were subject to a CP plan in Warwickshire, a 3.0% increase on 534 in 2011. 609 plans were initiated and 590 were closed over the financial year 2012/13 which is a similar pattern to the previous year.

The county rate per 10,000 0-17 population has increased from 47.8 to 48.9. There is an interesting pattern of rate change across the districts and boroughs. North Warwickshire's and Warwick's rose from 54 to 60 and from 35 to 44 respectively. Nuneaton & Bedworth's remained the same at 86. Rugby's and Stratford's reduced from 42 to 40 and from 23 to 15 respectively[73].

The proportion of children subject to a CP plan whose ethnic was Black/Minority decreased, from 12.4% last year to 8.9% at 31st March 2013. White British children subject to a plan increased, from 85.4% to 87.1%.

[73] All as at 31st March 2012 and 31st March 2013

4.5 OLD AGE

4.5.1 Dementia

[My wife] has not been going long to [the day care] but the difference it has made to her confidence, wellbeing and social involvement is wonderful. She is well looked after, the activities are well suited to her needs and we are touched by their kindness by treating her as an individual regardless of her dementia[74]

Has been helpful in showing the ways to enhance our project of making our local community dementia friendly[75]

4.5.1.1 What is the headline issue?

Dementia is increasingly becoming one of the most important causes of disability in older people[76].

In 2012/13 in Warwickshire, there were 3,416 patients on the GP disease register for dementia[77]. However, **population prevalence data suggests that only 46% of people in Warwickshire with dementia have been formally diagnosed**. This equates to around 3,800 people without a formal diagnosis[78]. **In line with a growing and ageing population, numbers of people with dementia are set to increase rapidly in the future**.

Dementia diagnosis rates in Warwickshire appear to be lowest in North Warwickshire Borough where only 38% of people anticipated to have dementia have received a formal diagnosis. The diagnosis rate is highest in Rugby Borough at 51% but even here nearly half of all people expected to have dementia have not been diagnosed.

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

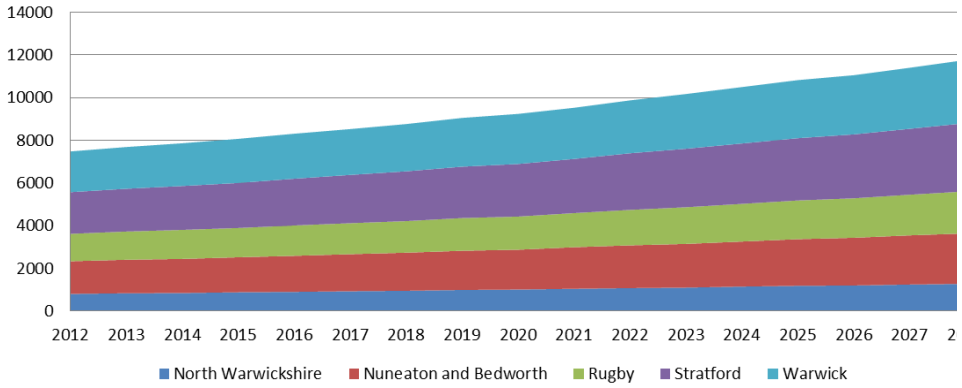
Work is currently on-going at a more local level to support case-finding and improve levels of diagnosis by identifying those areas where detection rates are lower than expected.

[74] Questionnaire for people with Dementia using Day Care Services and their Carers. November 2013.
[75] Feedback given by voluntary sector colleague at the Living Well with Dementia conference 'Dementia in the Community' hosted by Warwickshire County Council on behalf of Warwickshire's Health and Wellbeing Board.
[76] The term 'dementia' is used to describe the symptoms that occur when the brain is affected by specific conditions including Alzheimer's disease and stroke.
[77] Quality & Outcomes Framework (QOF)
[78] Source QOF register and Alzheimer's Society 2007 report, via the NHS Dementia Prevalence Calculator: The total number of people estimated to have dementia from the overall prevalence information minus the QOF information.

4.5.1.2 What does the data say?

Between 2012 and 2028 the number of people with dementia is projected to increase by 57%[79]. The Alzheimer's Society estimated in 2007 that on average a person with dementia costs £25,472 per year. 41% of this is for accommodation and 36% informal care, the remaining 23% is costs to NHS and social services.

Figure 3: Predicted number of people with dementia in Warwickshire 2012 to 2028[80].



In the 2013 Adult Social Care Survey, 58% of customers with dementia said they felt they had enough control over their daily life, this compares to 70% for all social care customers. 30% of customers with dementia said their quality of life was either good or better than good; this compares to 46% for all social care customers[81]. This suggests a huge decrease in quality of life perceptions for all social care customers but particularly those with dementia (76% and 60% respectively in 2012).

4.5.2 Ageing & Frailty

"An excellent service"[82]

"To support my discharge from hospital the Occupational Therapist visited me on the ward to assess if I would require any assistance when I got home. I really needed support with my housework and general domestic tasks so I was assessed for the Lifestyle service from Age UK Warwickshire. I now have a Support Worker helps me with my domestic tasks once a week. It is so nice to have the continuity of the same Support Worker for each visit and we are getting to know each other quite well. I was made aware of other Age UK Warwickshire services and had a Home Safety Check and a key safe installed which could be used in case of emergencies. Following advice at the Home Safety Check, handymen from Age UK Warwickshire fitted a stair gate at the top of my stairs, hand rails in my bathroom and re hung my shower door; how safe I now feel when using my bathroom! I am very grateful for the continuing support I am having from Age UK Warwickshire. The services I have accessed have increased my independence and allowed me to continue living safely within my own home."

[79] Figures from Projecting Older People Population Information System (POPPI). More up to date figures have not been released yet.
[80] Figures from Projecting Older People Population Information System (POPPI). More up to date figures have not been released yet.
[81] National Adult Social Care Survey. A statutory annual return. Of the 491 respondents to the survey, 33 were aged 65+ with mental Health client groups. Thus, the response rate for those with dementia may too low to be significant.

4.5.2.1 What is the headline issue?

Across Warwickshire as a whole, the highest rates of projected population growth are in the groups aged 65 years and over. The rate of growth increases with age, with the eldest age group, those aged 85 and over, projected to increase by more than 40% between 2011 and 2021[83]. Population projections help inform the planning of services and decisions about the future allocation of resources. An ageing population, in particular, has implications for the future provision of many health and social services linked to older age groups.

The National End of Life Care Intelligence Network profiles show that the largest underlying causes of death, for the three years from 2008-10, are cancers and cardiovascular diseases, each of which account for nearly 30% of all deaths across the county. During the same period, 39% of deaths occurred either at home or in care homes whereas 55% were in hospitals. The profile also includes a **'Total spend on end of life care per death' figure of £553 for Warwickshire against an England average of £1,096**[84].

[82] User of Rapid Hospital Discharge service through service user questionnaire

[83] 2011-based Sub-National Population Projections, National Statistics (www.statistics.gov.uk), © Crown Copyright 2013.

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

4.5.2.2 What does the data say?

Figures for Excess Winter Mortality (EWM) are now available at Local Authority level for 2010/11. There are approximately 300 excess winter deaths in Warwickshire each year.

The standard Office for National Statistics (ONS) methodology defines the winter period as December to March, and compares the number of deaths that occurred in this winter period with the average number of deaths occurring in the preceding August to November and the following April to July:

EWM = winter deaths – average non-winter deaths

This produces the number of excess winter deaths.

At District and Borough level, due to the relatively small numbers involved, there are random fluctuations meaning that EWM figures are quite variable. As there is no consistent pattern, limited analysis can be performed. However, averaging the five Local Authorities in Warwickshire does reveal a pattern which largely reflects the regional and national trend.

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

Warwickshire Health and Wellbeing Board

21 May 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. **Discuss and re-state the governance of the Health and Wellbeing Board and agree proposed activities for the Board and its partners**
3. **Discuss and support the opportunity for Peer Review of the HWBB**

1.0 Background

The Warwickshire Health and Wellbeing Board has now completed one year in its full form (following one year of being in shadow form). It is therefore an appropriate time to review the activities that the Board has undertaken, reflect on the priorities of the HWBB, and to identify developments and activity for the next 12 months.

2013/2014 has been a year of developing relationships, challenges around commissioning and bringing together plans for health, social care and providers, against a backdrop of reduced funds and providers being under the microscope of inspection.

This paper reflects on the work programme of the HWBB and its Strategy:

- HWBB Development
- Mobilising Communities
- Access to Services
- Public Services Working Together

2.0 Activities in 2013/14

The following reports and discussions were completed in 2013/14, with suggested standing items identified for 2014/15:

Topic	**2013/14 Agenda**	**Required in 2014/15?**
HWBB Development		
Agree membership	May 2013	Yes
Review and clarify governance requirements	May 2013	Yes
Report on the Board's activity and performance	Jan 2014	Yes
Discuss and agree a relationship with Overview & Scrutiny	Sept 2013	

(MoU)		
Discuss and agree a relationship with Healthwatch Warwickshire (MoU)	Sept 2013	
Health and Social Care commissioning intentions	Sept 2013	Yes
Review and approve JSNA	May 2013	Yes – May 2014
Discuss and approve WHWBB Communications & Engagement Strategy	July 2013	
Agree the approach to developing & review Warwickshire Health & Wellbeing Strategy	Jan 2014	
Director of Public Health Annual Report	Sept 2013	Yes – July 2014

Topic	**2013/14 Agenda**	**Required in 2014/15?**
Priority 1 – Mobilising Communities		
Alcohol Approve action plans and monitor progress on alcohol consumption and related health & wellbeing issues	Nov 2013	
Autism Strategy and Self-Assessment Framework	Nov 2013	Yes
Dementia Workshop to discuss and agree action plans around dementia	Sept 2013	
Priority Families Programme Monitor progress of the Priority Families programme	Nov 2013	Yes - new programme
Smoking in Pregnancy Approve action plans and monitor progress on smoking in pregnancy	Nov 2013	Yes
Veterans Consider/ discuss veterans' health and wellbeing issues	Jan 2014	
Tobacco Control Draft Tobacco Declaration	July 2013	Update
Winterbourne Consider impact of the Winterbourne View and approve learning disability strategies	Jan 2014	Yes
Winter Plans Consider issues relating to winter pressures and approve relevant plans	Nov 2013	Yes

Priority 2 – Access To Services		
Acute Providers Monitor progress and outcomes of the George Eliot Hospital Inquiry, approve strategies for improvement and monitor their implementation. Coventry and Warwickshire Partnership Trust – CQC South Warwickshire Foundation Trust University Hospital Coventry and Warwickshire NHS Trust	Regular Updates	Yes - Scenario planning
Healthwatch Warwickshire Discuss submitted reports	Regular Updates	
Mental Wellbeing Discuss and agree strategies to improve mental wellbeing of the local population	Jan 2014	
Offender Health and the Criminal Justice Mental Health Liaison Service	July 2013	
Priority 3 – Public Services working together		
Better Care Fund Agree and approve Warwickshire's Better Care Fund integration plans	Regular Updates	Regular Updates
Care Bill development and implementation plus development of a task and finish group for scenario planning	Regular updates	Regular updates
Francis Report Discuss and agree plans for monitoring progress on the implementation of the recommendations in the Francis Report	Nov 2013	Yes
Health Protection Strategy	June 2013	Yes
Housing and HWBB	Sept 2013	
Joint Commissioning Boards for Adults and for Children, young people and families	March 2014	Yes
"Living in Warwickshire" survey	Regular updates	
Planning for healthy communities and HWBB	May 2014	Yes
Police & Crime Commissioner Engagement with the Police & Crime Commissioner/ Police and consider the PCC priorities	June 2013	Yes
Safeguarding Children and Adult Safeguarding	Nov 2013	Regular updates

3.0 Board Development in 2014/15

3.1 Background

The summary table above identifies a number of responsibilities that the HWBB has and should be considered as standing items for the Work Programme in 2014/15.

3.2 Achieved Outcomes

The Board underwent a successful transition from shadow to full form, whilst continuing to develop internal relationships as well as enhanced relationships with external partners such as acute providers.

The Board has discussed and agreed relationships with OSC and Healthwatch with the formation of a Memorandum of Understanding to set a framework for outlining the working relationship between parties.

There was also agreement of Health and Wellbeing Board performance indicators.

In April 2014, there was a joint workshop for the HWBBs of Coventry and Warwickshire. Two key priorities were emphasised at this event:

- The integration and 'Better Care Fund' programme
- Identifying a consistent message and culture across Coventry and Warwickshire

3.3 2014/2015 Priorities

There continues to be the opportunity for the HWBB to nominate itself for a Peer Review in 2014/15. This would enable all HWBB partners to reflect on its progress and receive constructive feedback on areas for improvement.

4.0 Priority 1 - Mobilising Communities

4.1 Background

Strong and resilient communities underpin all three priorities within the Warwickshire Health and Wellbeing Strategy, but have particular reference to priority 1 - '**Mobilising communities to develop and sustain their independence, health and wellbeing'.**

We want to concentrate our efforts on encouraging communities to set up support networks which will help individuals to improve their lifestyle choices and which will significantly reduce Warwickshire's health deficit.

4.2 Reflection on 2013/2014

Service providers in Warwickshire have a relationship with the Voluntary and Community Sector and have worked in partnership with our communities to deliver change projects in the past. Current initiatives relating to Health and Wellbeing (including the Wellbeing duties in the Care Bill, Dementia Friends, Early Help and Support Policy, Public Mental Health and Wellbeing Strategy, the Social Isolation and Loneliness Project, Voluntary and Community Sector Funding Relationships, Better Care Fund Scheme 2) rely upon an enhanced relationship with the Voluntary and Community Sector and an increase in community capacity.

4.3 **Achieved Outcomes**

- A range of positive outcomes including a reduction in crime, improved educational attainment and a reduction in the number of NEETs
- A workshop to discuss and plan a response to the Winterbourne Concordat
- A workshop to discuss the Francis Report and agree an MoU

4.4 **2014/2015 Priorities**

Amongst many others, the Board will receive papers on the following strategies that it will be required to endorse and agree:

- Learning Disability Strategy
- Dementia strategy

Furthermore, in line with newly identified priorities, the Board will consider issues such as the persisting gaps in educational attainment between, for example, pupils in receipt of free school meals and those who are not, and pupils who are looked after and those who are not.

Priority 2 - Access to Services

4.5 **Background**

We need to improve access to our public services, by ensuring quality, developing co-ordinated delivery, increasing out-of-hours access and developing alternative models for health and social care.

4.6 **Reflection on 2013/2014**

The HWBB received a number of reports in 2013/14 relating to acute providers, issues affecting particular vulnerable groups, and potential access issues such as out of hours and winter pressures.

4.7 **Achieved Outcomes**

- An assurance of providers' winter pressure plans
- Regular updates by providers on their external reviews
- Better understanding of health and social care commissioning intentions

4.8 **2014/2015 Priorities**

In 2014/15, a programme of work will address the commissioning intentions and long term plans in a series of scenario planning events to ensure the viability and effectiveness of our providers. This programme of work will include the following, amongst others:

- Changes to the arrangements for commissioning child health services
- Impact of the Care Bill
- Children and Families Act Implementation - with reference to services for children with disabilities

Priority 3 - Public Services Working Together

4.9 Background

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

4.10 Reflection on 2013/2014

A key national development in 2013/14 was the Better Care Fund. Locally, the core purpose of this integrated model is to improve outcomes for all people who need health and social care services. This means:

- People will be helped in their goal to manage their own care and remain healthy and independent;
- People will have real choices and greater access in both health and social care;
- Far more services will be delivered safely and effectively in the community and or at home.

A workshop in April 2014 (to commence the consultation and engagement with partners regarding the JSNA and Health and Wellbeing Strategy in 2014) highlighted common themes:

- Integration and working together
- Promoting Independence
- Community Resilience

The output from this workshop provides an opportunity for the HWBB to determine the priorities for its work programme for 2014/15.

4.11 Achieved Outcomes

- Strengthening the relationship with Coventry's HWBB
- Stakeholder engagement and consultation on the development of the JSNA and Health and Wellbeing Strategy
- Public Health and Regulatory Services collaborated for a countywide workshop to share joint working and to continue building relationships across service areas
- A reduction in teenage conception rates from 299 in 2011 to 234 in 2012 (a 20% decline)
- An Arden-wide Health Protection Strategy

4.12 2014/2015 Priorities

- Completion of the Health and Wellbeing Board Strategy, agreed with all partners
- Agreed priorities via the JSNA
- Adoption and delivery of the Better Care Fund objectives

5.0 Focus of the Board in 2014/2015

The production and implementation of the second Health and Wellbeing strategy and a review and update of the JSNA will support the Board to refocus priorities towards those identified nationally and within local workshops with partners and stakeholders. Preliminarily identified themes are around prevention, children and young people, older people, communities and housing.

There is also the need to look imaginatively at where we can support partners to make savings whilst still improving the offer, acknowledging that this in itself will present challenges that will require the continuation of effective working relationships.

6.0 Recommendations for Board development in 2014/2015

6.1 For partners to acknowledge the progress made to date

6.2 For partners to agree continuation of current governance arrangements

6.3 To commission a Peer Review of the Health and Wellbeing Board. The benefits of this would be:

- peer challenge is not inspection but improvement focused. It is designed to support councils and HWBBs in reflecting on and improving their practice;
- peer challenge will be undertaken at a time that most suits the council and its HWBB;
- the challenge is tailored to local need. Concentrating on the areas the HWBB wants to focus on, the make-up of the team and the results it wants to achieve;
- the process will be proportionate. While peer challenges require preparation, the LGA strive to minimise the demands on services in the council.

7.0 Conclusions

7.1 With a year's experience and understanding of its demands, the HWBB has the opportunity to develop a formal work programme for 2014/15.

	Name	**Contact Information**
Report Author(s)	Nicola Wright	nicolawright@warwickshire.gov.uk
Head of Service	John Linnane	johnlinnane@warwickshire.gov.uk
Strategic Director	Monica Fogarty Wendy Fabbro	monicafogarty@warwickshire.gov.uk wendyfabbro@warwickshire.gov.uk
Portfolio Holder	HWB Chair & Portfolio Holder for Public Health	cllrseccombe@warwickshire.gov.uk cllrstevens@warwickshire.gov.uk