Warwickshire Health and Wellbeing Board

Agenda

22nd September 2014

A meeting of the Warwickshire Health and Wellbeing Board will take place in the **Conference Room at Northgate House, Warwick** on **Monday 22nd September 2014 at 13.30.**

The agenda will be:-

1. (13.30 – 13.35) General

(1) Apologies for Absence

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

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

- Declare the interest if s/he has not already registered it;
- Not participate in any discussion or vote;
- Must leave the meeting room until the matter has been dealt with (Standing Order 43); and
- Give written notice of any unregistered interest to the Monitoring Officer within 28 days of the meeting

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

(3) Minutes of the Meeting of the Warwickshire Health and Wellbeing Board on 15th July 2014 and Matters Arising.

Draft minutes of the meeting are attached for approval.

2. (13.35 – 13.40) 2014/15 Section 256 Transfer from Health to Social Care

Chris Norton

3. (13.40 – 13.50) Warwickshire SEND

Hugh Disley

4. (13.50 – 14.05) Introduction to Multi Agency Safeguarding Hubs (MASH)

Wendy Fabbro

5. (14.05 – 14.15) Warwickshire's Refreshed Alcohol Implementation Plan

Paul Hooper

6. (14.15 – 14.35) Better Care Fund

Chris Lewington

7. (14.35 – 14.55) Clinical Commissioning Group 5-year Strategy and Individual Commissioning Intentions

Adrian Canale-Parola, Juliet Hancox, Gill Entwhistle

8. (14.55 – 15.05) Progress on Health and Wellbeing Strategy

Nicola Wright

9. (15.05 – 15.20) Healthwatch Presentation

Phil Robson

10. (15.20 – 15.30) Director of Public Health's Annual Report – A Hidden Agenda

John Linnane

11. (15.30 – 15.45) Peer Review

Councillor Seccombe

12. Work Programme

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

Further Information, Future Meetings and Events:

Health and Wellbeing Board Newsletter Link to Newsletter

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

21 Oct.	Workshop on 5-year Acute Service Plans
19 Jan. 2015	HWB 4-day Peer Review

Health and Wellbeing Board Membership

Chair: Councillor Izzi Seccombe (Warwickshire County Council)

Warwickshire County Councillors: Councillor John Beaumont, Councillor Jose Compton, Councillor Bob Stevens,

Clinical Commissioning Groups: Karen Ashby (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: David Williams.

Healthwatch Warwickshire: Phil Robson

Borough/District Councillors: Councillor Neil Phillips (NBBC), Councillor Belinda Garcia (RBC), Councillor Michael Coker (WDC), Councillor Derek Pickard (NWBC), Councillor Gillian Roache (SDC)

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Minutes of the Meeting of the Warwickshire Health and Wellbeing Board held on 15th July 2014.

Present:-

Warwickshire County Councillors

Councillor John Beaumont
Councillor Jose Compton
Councillor Bob Stevens

Clinical Commissioning Groups

Andrea Green (Warwickshire North CCG)
Dr Adrian Canale-Parola (Coventry and Rugby CCG)
Dr David Spraggett (South Warwickshire CCG)

Warwickshire County Council Officers
Monica Fogarty – Strategic Director, Communities
Dr. John Linnane – Director of Public Health

Healthwatch Warwickshire

Phil Robson – Chair

Borough/District Councillors

Councillor Michael Coker (Warwick District Council)
Councillor Belinda Garcia (Rugby Borough Council)
Councillor Neil Phillips (Nuneaton and Bedworth Borough Council)
Councillor Derek Pickard (North Warwickshire Borough Council)

1. (1) Appointment of Chair for the Meeting

In the absence of the Chair, Councillor Jose Compton proposed that Councillor Bob Stevens chair the meeting and was seconded by Dr John Linnane. There were no other nominations.

Resolved

That Councillor Bob Stevens be appointed chair for the meeting.

(2) Apologies for Absence

Councillor Izzi Seccombe (Chair)
Karen Ashby (Warwickshire North CCG)
Wendy Fabbro (Warwickshire County Council)
Councillor Gillian Roache (Stratford District Council)
David Williams (NHS England)

(3) Appointment of Board Members

The Health and Wellbeing Board accepted the appointments of:

Councillor Belinda Garcia (Rugby Borough Council)
Councillor Neil Phillips (Nuneaton and Bedworth Borough Council)
Phil Robson (Healthwatch Warwickshire)
David Williams (NHS England)

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

Councillor Derek Pickard declared a non-pecuniary interest, as a member of the County Council's Adult Social Care and Health Overview and Scrutiny Committee.

(5) Minutes of the meeting held on 21st May 2014 and matters arising.

The Minutes were agreed as a true record, subject to a change to Minute No.2 on the Better Care Fund. It had been agreed to include Councillor John Beaumont (WCC) in the member consultation group to determine mechanisms for member input on the Better Care Fund.

2. Better Care Fund Progress Report

Chris Lewington, Head of Strategic Commissioning at Warwickshire County Council reminded of the previous reports to the Board and advised that the arrangements for the Better Care Fund (BCF) were changing rapidly.

NHS England (NHSE) had written to all clinical commissioning groups (CCGs) to request further information and the resubmission of operational plans to ensure compliance with recent guidance. The areas that NHSE wanted assurance on from CCGs and the Board were set out in the report, together with the actions taken by Warwickshire partners to date, to respond.

Reference was made to the 'fast track' implementation of Better Care initiatives and the very tight timescales to meet changes introduced by the Department of Health. Following discussions with the Board's Chair and the CCGs, it had been determined these timescales could not be achieved. An outline was given of the plans for stakeholder engagement and the completion of the BCF submission process with the Board's approval to the final proposals being sought in September or October 2014. It was stressed that Better Care was the vehicle for integration of services and not just about the BCF.

Two CCG workshops had been held recently and there were plans for a further CCG workshop. Another recent change to the guidance was the introduction of a performance element and targets, which could see the redirection of funds to CCGs for acute services, if performance levels were below a set threshold. Further discussions on proposed target levels would be needed with each CCG.

A question was submitted about how this would be articulated in service delivery to patients. In reply, the Board was reminded of the patient-centred approach, the aim for relevant records to be available to all service providers, the use of integrated teams crossing health and social care services and aims for earlier intervention.

For Healthwatch, it was difficult to comment on the high level plans and they would need to see the detail, to be able to contribute on behalf of consumers. There were planned events and communications work to inform on the detail, which would take place in August 2014.

Resolved

That the Board notes the progress report.

3. Children & Families Act 2014 - Briefing

Hugh Disley, Head of Service for Early Intervention (WCC) presented a report which informed the Board of the key changes from this legislation. The Children & Families Act 2014 is wide ranging and comprises ten parts. The report focussed on changes to family justice, adoption changes, the welfare of children and a number of miscellaneous areas. Particular reference was made to special educational needs and disabilities (SEND). Mr Disley referred the Board to an appended series of 'key questions' and a structure chart showing the governance arrangements. He also focussed on the section of the report on joint readiness. A further report would come to the Board in December, after a period of consultation, at which time, the Board would be asked to consider if the checklist of key questions could be answered.

In response to questions about the SEND local offer and related consultation, further information was provided. It was clarified that the

local authority advise and support schools SENCO plans and this would continue with the new single plan. Further aspects raised were an assurance from CCG representatives that the health sector would be involved and the submission of an interim strategy to Cabinet in September.

Resolved

That the Board notes of content of the report.

4. Introduction to Multi Agency Safeguarding Hubs

This item was deferred.

5. The Care Act Going Forward – Implementation and Progress

David Soley, Service Manager, Mental Health presented this item. The report focussed on Part 1 of the Care Act, which concerns care and support. The implementation timetable and deadlines were reported, showing progress achieved to date. The following areas would need to be implemented by 1st April 2015:

- Wellbeing
- Prevention
- Safeguarding Vulnerable Adults
- Transitions to Adulthood
- Information & Advice (including financial advice)
- Independent Advocacy
- Assessment - Care & Support Planning
- Carers – Assessment - Care & Support Planning

Key implementation activities over the period to 2016 were shown in a table and commentary was provided on the key implementation challenges ahead.

Mr Soley responded to questions from the Board. He spoke about the regulations due in October 2014, which would add detail and enable the County Council to understand fully the implications of the new duties. There was discussion about the involvement of GPs, service commissioners and providers, as well as the opportunity to improve patient pathways. A point was made that there was no additional funding for these duties. Finally, the potential for sanctions or judicial reviews was discussed.

Resolved

That the Board notes the report.

6. Pharmaceutical Needs Assessment

A report was presented by Rachel Robinson, of Public Health (WCC) on the Board's responsibilities in relation to Pharmaceutical Needs Assessments (PNA). Periodically, there was a requirement to publish supplementary statements explaining changes to service provision. The Board was asked to consider and approve PNA Supplementary Statement No.4, which had been circulated previously.

It was noted that a revised PNA would need to be published by 1st April 2015. Due to the timescales involved, Public Health had commissioned NHS Arden Commissioning Support (NHS ACS) to help develop the new PNA. Laurence Trester of NHS ACS was also present to respond to technical enquiries.

It was confirmed that the PNA would inform NHS England in its decisions about the location of future pharmacies, the services that would be required and hours of operation, to meet gaps in existing provision. Wide consultation was planned on the revised PNA over a 60-day period. Other points were made about the range of services that pharmacies could deliver, reducing reliance on acute services and about the healthy living pharmacy programme.

Resolved

1. That the Warwickshire Health and Wellbeing Board approves PNA Supplementary Statement No.4.

2. That progress of the development of the new Warwickshire PNA is monitored by the Board.

7. Public Health Procurement Timetable

Dr John Linnane , Director of Public Health, WCC gave an update on the joint tender for sexual health services, the transfer of health visitors and family nurses to Public Health in October 2015 and the weight management and exercise on referral contracts.

Dr Linnane clarified the elements of the weight management contract that Public Health commissioned and the signposting to other services that also took place. There was also discussion about the transfer of

health visitors, the transition board established to oversee this process and a suggestion was made that a primary care clinician be invited to join that board.

Resolved

That the Board notes the report.

8. Progress on Health and Wellbeing Strategy

Nicola Wright, Consultant, Wider Determinants of Health, Public Health, WCC provided a verbal update on the pre-consultation work on the Health and Wellbeing Strategy, completed over the previous 2 months. She outlined the themes proposed for the new Strategy and the feedback received to date from respondents. Views were sought on the size of the final strategy document and there seemed a consensus for a document of about 10 pages in length. Board members were reminded that the next workshop to progress the Strategy was scheduled for 1st September 2014. Thereafter, the draft strategy would be considered at the Adult Social Care and Health Overview and Scrutiny Committee, before final consideration at the Board's meeting on 19th November.

Resolved

That the Board notes the report.

9. Headlines from the Planning for Healthier Communities Event

Nicola Wright provided a verbal report on the Planning for Healthier Communities event held at Stoneleigh on 10th July. It had provided a useful opportunity for relationship building, enabling discussions between key partners on healthier communities initiatives, regeneration and development. A number of pledges had been made by participants, for example to take into consideration health needs when determining applications for development. Reassuring feedback had been received from Public Health England on the approach being taken in Warwickshire.

Resolved

That the Board notes the report.

10. Any Other Business

The Chair invited Philip Bushell-Matthews of the Coventry and Warwickshire Partnership Trust (CWPT) to address the Board. Those present were encouraged to become members of CWPT and further information would be circulated by email.

The meeting rose at 15.00

……..Chair

Item 2

Health and Wellbeing Board
22 September 2014

Funding Transfer from NHS England to Warwickshire County Council 2014/15

Recommendation

That the Health and Wellbeing Board approves the proposed spending proposals, outcomes, and monitoring arrangements set out in the Section 256 agreement and, subject to the addition of appropriate NHS England spending codes in Schedule 1, recommends it to Cabinet or the Leader for approval.

1 Introduction

1.1 In 2011/12 the Department of Health began to transfer significant sums of money into social care services in order to benefit health. In 2014/15 the transfer is being made directly from NHS England and administrated by the NHS England Area Team. The total amount to transfer for Warwickshire is £10.230m.

1.2 Payments have to be made via a "Section 256" agreement between NHS England and Warwickshire County Council (Section 256 refers to the part of the 2006 NHS Act which gives health authorities the power to transfer money to local authorities).

1.3 NHS England has set out that it requires local Health and Wellbeing Board approval for spending proposals, outcomes, and monitoring arrangements in order to transfer the money.

1.4 This report sets out the proposed use of the transfer and explains how the proposed use meets the criteria set out.

1.5 This fund will in 2015/16 become part of the Better Care Fund along with a number of other funding streams, but this report does not consider or make recommendations on any other funds. This report and the associated Section 256 agreement only relate to 2014/15. Any decisions about future funding in 2015/16 or beyond will be the subject of separate reports and decisions.

2 The Purpose of The Transfer

2.1 The following criteria are specified by the Department of Health:

- The funding must be spent on adult social care services that benefit health.
- The local authority must secure agreement with local health partners as to how the funding is best used and the outcomes expected from the investment.
- The proposals must have regard to the local Joint Strategic Needs Assessment and to the existing commissioning plans for local social care and health services.
- The local authority must demonstrate how the funding will make a positive difference to services and outcomes compared to what would have happened in the absence of the transfer.
- The funding can be used to support existing spending, to prevent reductions in spending that would otherwise occur due to budget pressures, or to support new spending.

3 Spending Proposals

3.1 The table below sets out the spending proposals.

Service	£'000
Telecare	140
Reablement	4,421
Respite Care	1,620
Integrated Community Equipment Services	1,223
Community resources (voluntary sector)	250
Dementia Care	500
Residential and Nursing Care (social care)	1,663
7 day working and avoiding hospital admissions	200
Supporting whole system realignment	225
Total	10,242

3.2 A number of services (reablement, telecare, community equipment services, respite care and dementia care) were supported by this funding in 2013/14. For 2014/15 the amounts are adjusted where appropriate to reflect expected spending this year.

3.3 The funding to support community resources is planned to support one off expenditure targeted at supporting community and voluntary sector organisations in making changes to their service offers in order to better support health and social care service users by maximising independence (e.g. support with marketing, branding, staff training, etc).

3.4 Funding to support residential and nursing care will support a key part of the social care system to maintain capacity to meet demand.

3.5 The funding to support 7 day working is intended to support the scoping of the need for year-round 7 day social care services, including the design and planning of delivery new models. Examples of services under consideration include hospital social work teams, reablement, and care home admissions.

3.6 The funding to support whole system realignment is intended to provide additional capacity in commissioning and finance to support work in relation to both the Better Care Fund and the Care Act.

3.7 The funding is provided as a single figure for Warwickshire, which is a legacy of the previous Primary Care Trust health structure. Other local health funding is now split between Clinical Commissioning Group (CCG) areas. The table below sets out how the funding would notionally be split by CCG.

Clinical Commissioning Group	% of County	£ Notional Apportionment of Transfer £'000
North	35%	3,595
Coventry and Rugby (Rugby element only)	18%	1,843
South	47%	4,804
Total	100%	10,242

3.8 Spending on social care services is guided by the application of FACS criteria which ensures consistency of support across the county. This means that spending on social care across the county may not be in direct proportion to how the health funding formula would apportion it. It is therefore not proposed to make the spending in each area match these figures but it is proposed that how the spending does happen across the county is monitored and that this pattern is then reported and understood to help to inform future commissioning activity.

3.9 The spending above is linked to the £10.2m Section 256 transfer. There are other local authority services that benefit health services. For example services funded by ring fenced public health grant such as seasonal flu vaccinations to all health and social care staff who provide direct personal care, aiming to ensure at least 75% of these staff are immunised, taking part in seasonal flu vaccination campaigns and promote uptake in eligible individuals to whom services are provided, and to staff who are eligible for an NHS flu vaccination, but who do not provide direct personal care, and ensuring staff have read and comply with hand hygiene and infection control requirements.

4 Outcomes

4.1 The high level outcomes for customers of social care and health services are summarised in the table below:

Outcomes	
People are independent	People, including those who are vulnerable, are able to live independently and in their own homes. When people develop are needs are able to recover their health and independence quickly.
People enjoy life	Carers of vulnerable people can balance their caring roles and maintain their desired quality of life.
People are cared for	People with care needs have security, stability and are cared for in a positive and safe environment which is appropriate to their individual needs. People with care needs are treated with dignity, respect and sensitivity to their individual circumstances.
People can access the right services: …at the right time	People have choice and control in the services they access. Services respond in a timely manner to assess and support people to regain, retain and maintain independence as soon as possible. People have the support they are entitled to, when they need it.

4.2 The transfer specifically relates to services around the boundaries of health and social care. To this end the following more specific areas are relevant.

- Minimising delayed discharges from hospital.
- Minimising inappropriate admissions to hospital, residential care, and nursing care.
- Minimising inappropriate discharges from and readmissions to hospital.

4.3 The following specific outcome indicators are proposed to reflect this:

- Proportion of older people (65+) who are still at home 91 days following discharge from hospital.
- Delayed discharges from hospital.

5 Monitoring Arrangements

5.1 It is proposed to monitor the outputs and outcomes listed in Section 4.3 above on a quarterly basis via the Joint Adults Commissioning Board.

5.2 Local authority and health services will monitor and manage a greater number of measures and indicators than these and review them more frequently and in more detail. However, the intention of this agreement is to set out the high level measures of activity that relate to the transfer, rather than to detail all of the measures that may be used.

6 Links to JSNA and Current Commissioning Plans

6.1 The priorities set out within the current joint strategic needs assessment include reference to long-term conditions, mental well-being, dementia, and ageing and frailty. The commissioning intentions of the local authority and health services are guided by the joint strategic needs assessment.

6.2 Long term conditions: around one in three adults live with at least one long-term condition, driven in part by an ageing population, and in part by unhealthy lifestyle choices.

6.3 Mental well-being: over 10% of adults living in Warwickshire live with common mental health problems.

6.4 Dementia: there are over 3000 patients on Warwickshire GPs disease register for dementia. However, data suggests that only 43% of people in Warwickshire with dementia have been formally diagnosed.

6.5 Ageing and frailty: the largest underlying causes of death for the three years from 2008 to 2010 are cancers and cardiovascular diseases each of which account for nearly 30% of all deaths across the County. During the same period, 39% of deaths occurred either at home or in care homes whereas 55% were in hospitals.

6.6 The customers being supported by this expenditure will in large part be living with long-term conditions, mental health conditions, dementia, and ageing and frailty related conditions.

7 Recommendations

7.1 That the Health and Wellbeing Board approves the proposed spending proposals, outcomes, and monitoring arrangements set out in the Section 256 agreement and, subject to the addition of appropriate NHS England spending codes in Schedule 1, recommends it to Cabinet or the Leader for approval.

8 Background Papers

8.1 There are no background papers.

September 2014

Author: Chris Norton, Strategic Finance Manager, People Group, Warwickshire County Council

Wendy Fabbro, Strategic Director, Warwickshire County Council

Gillian Entwhistle, Accountable Officer, South Warwickshire Clinical Commissioning Group

Steve Allen, Accountable Officer, Coventry and Rugby Clinical Commissioning Group

Andrea Green, Accountable Officer, North Warwickshire Clinical Commissioning Group

DATED **September 2014**

NHS England **(1)**

and

Warwickshire County Council **(2)**

Agreement

Section 256 Revenue Grant

(In duplicate)

THIS AGREEMENT is made on September 2014
BETWEEN:

(1) **NHS England** of Quarry House, Leeds, LS2 7UE, **('NHS England'** which expression shall include any successor body or other NHS body on whose behalf NHS England is authorised to enter into this Agreement);

(2) **THE WARWICKSHIRE COUNTY COUNCIL** of Shire Hall, Warwick CV34 4RR ("**the Council**").

RECITALS

(A) The Council is the local Social Services Authority for the County of Warwickshire within the meaning of the Local Authority Social Services Act 1970

(B) NHS England is empowered by Section 256 of the National Health Service Act 2006 to make payments to the Council as local Social Services Authority towards expenditure incurred or to be incurred by it in connection with any social services functions (within the meaning of the Local Authority Social Services Act 1970), other than functions under section 3 of the Disabled Persons (Employment) Act 1958

(C) NHS England has agreed to make payments to the Council towards expenditure incurred by it in commissioning and/or providing social care services.

(D) The Council has agreed to accept such payments and to use them to commission and/or provide social care services.

1. Definitions

1.1 The following expressions shall where the context so admits have the following meanings:

"**Agreement**" means this Agreement;

"**Annual Voucher**" means a document to be prepared by the Council and submitted to the PCT to show the correct use of the Revenue Grant in any Financial Year, in the form as set out in Schedule 3;

'Clinical Commissioning Groups' means Coventry and Rugby Clinical Commissioning Group, South Warwickshire Clinical Commissioning Group and Warwickshire North Clinical Commissioning Group;

"**Council**" means Warwickshire County Council;

"**Financial Year**" means the 12 month period from 1 April of any year to the following 31 March of the next year;

'**Local Area Team'** means the Arden, Herefordshire and Worcestershire Area Team which is the NHS body responsible for commissioning primary care services and supporting and developing Clinical Commissioning Groups.

"**Revenue Grant**" means the following sum to be paid to the Council. pursuant to this Agreement in accordance with the payment profiles set out in Schedule 2:

Financial Year	**2014/15**
Amount	£10,242,000

"Social Care Services" means services provided under the enactments listed in the Local Authority Social Services Act 1970), other than services provided under section 3 of the Disabled Persons (Employment) Act 1958

2 Interpretation

2.1 Obligations undertaken or to be undertaken pursuant to this Agreement by more than a single person shall be made and undertaken jointly and severally.

2.2 References to any statute or statutory provision in this Agreement shall be deemed to refer to any modification or re-enactment thereof for the time being in force whether by statute or directives and regulations (intended to have direct application within the United Kingdom) adopted by the Council or the European Communities.

2.3 The headings are inserted for convenience only and shall be ignored in construing the terms and provisions of this Agreement.

2.4 References in this Agreement to any clause or sub-clause or schedule without further designation shall be construed as a reference to the clause or sub-clause of or schedule to this Agreement so numbered.

3 Purpose of Transfer

3.1 It has been agreed between the parties how the Revenue Grant will be spent, and this is set out in Schedule 1.

3.2 The key joint strategic aims underpinning the Agreement are focussed around (1) principles of rehabilitation, recovery & reablement; (2) the development of joint pathways to ensure care support networks can respond to customers' needs, regardless of their capacity or complexity; and (3) providing a seamless journey for customers through the assessment and support process.

3.3 The following statements set out these aims more specifically…

3.3.1 To rehabilitate to the optimum so that patients return to the level of independence they had before becoming unwell.

3.3.2 To prevent inappropriate secondary care admission and to facilitate timely secondary care discharge

3.3.3 To prevent inappropriate admissions to nursing and residential care so that patients do not become unnecessarily institutionalised and are given every opportunity to regain their independence and return to their original place of residence.

3.3.4 To reduce impairments attributable to long term conditions

3.3.5 To be inclusive in nature and reflect equality requirements by allowing all people who would benefit from access to receive services including people with a learning difficulty, mental health need, and physical impairment

3.3.6 To promote social inclusion where appropriate

3.3.7 To allow the development of patient capability in self directing their care and self-managing their conditions

3.3.8 To allow patients to end their lives in the place of their choice

4 Revenue Grant

4.1 NHS England will pay the Revenue Grant to the Council in accordance with the payment schedule set out at Schedule 2.

4.2 The Revenue Grant is to be expended on or reserved for planned expenditure on Adult Social Care Services for the benefit of Warwickshire residents and for no other purpose.

4.3 Any Revenue Grant not committed or spent by 31st March 2015 will continue to be managed by joint agreement between the Council and the Clinical Commissioning Groups under the terms of this Agreement.

4.4 The Council shall submit to NHS England an Annual Voucher in the form set out in Schedule 3.

5 Commencement

5.1 This Agreement shall come into force on the 1st April 2014 and will continue until the 31st March 2015.

6 Warranty

6.1 The Council and NHS England both warrant that they have the power to enter into this Agreement.

7 Law

7.1 The construction validity and performance of this Agreement shall be governed by the laws of England and Wales.

8 Dispute Resolution

8.1 If any dispute or difference ("the Dispute") arises out of or in connection with this Agreement the parties shall use their best endeavours to reach agreement promptly and amicably.

8.2 Any dispute or disagreement which arises out of or in connection with this Agreement shall be referred to an appropriate manager by each of the parties who shall within 28 days of the dispute or difference arising attempt to resolve the same.

8.3 To the extent that the dispute or difference is not resolved by the managers referred to in clause 8.2 it shall be referred within 28 days after their consideration to the Strategic Director (People Group) of the Council and the Chief Executive of the Local Area Team who shall seek to resolve the same.

8.4 If agreement cannot be reached within 28 days of a referral to the officers referred to in clause 8.3 the Parties may seek mediation from a panel comprising members of the NHS England (or an equivalent authority), the Government Offices for the Region, and ADASS.

Schedule 1

The financial breakdown of the Revenue Grant is as follows:

Service	£'000	NHS England Subjective Description	NHS England Subjective Code
Telecare	140	Codes to be completed before submission	
Reablement	4,421		
Respite Care	1,620		
ICES	1,223		
Community resources (voluntary sector contracts and community capital)	250		
Dementia Care	500		
Residential and Nursing Care (Social Care)	1,663		
7 day working and avoiding hospital admissions	200		
Supporting whole system realignment - Commissioning and finance support	225		
Total	10,242		

Schedule 2
Schedule of Payments

The Revenue Grant will be paid in 12 monthly instalments of £853,500 throughout 2014/15, paid by the end of the month that the amount relates to.

Schedule 3

Annual Voucher

THE WARWICKSHIRE COUNTY COUNCIL .....…….....

PART 1 STATEMENT OF GRANT EXPENDITURE FOR THE YEAR 1 April 2014 to 31 MARCH 2015

(if the conditions of the payment have been varied, please explain what the changes are and why they have been made)

Scheme Ref No. Revenue

Total and Title of Expenditure Expenditure

Project £

PART 2 STATEMENT OF COMPLIANCE WITH CONDITIONS OF TRANSFER

I certify that the above expenditure has been incurred in accordance with the conditions including any cost variations for each scheme approved by NHS England in accordance with the Directions made by the Secretary of State under Section 256 of the NHS Act 2006 as substituted by Section 1 of the Health and Social Services Adjudication Act 1983 and amended by Section29 of the Health Act 1999

Signed ..... Date .....

Review by NHS England

I/We have examined the entries in this form and the related accounts and records of the WARWICKSHIRE COUNTY COUNCIL and have carried out such tests as I/we consider necessary and I/we have obtained such explanations as I/we consider necessary.

I am/We are of the opinion that:

- the entries are fairly stated
- the expenditure has been properly incurred in accordance with the Memorandum of Agreement signed by NHS England

Auditor ……. Date …….

NHS England

Name ……..

Signature ……..

Warwickshire County Council

Name ……..

Signature ……..

Warwickshire Health and Wellbeing Board

22nd September 2014

Warwickshire Special Educational Needs and Disability (SEND) Reform Plan

Recommendation(s)

That the Health and Wellbeing Board:-

1. **Notes the responsibilities on the local authority - working in partnership with other statutory agencies, parents, young people and children - to put in place new arrangements for Special Educational Needs and Disability (SEND).**

2. **Notes that consultation is under way to develop and refine the 'Local Offer' to meet the integrated education, health and social care needs of children and young people aged 0-25 with special educational needs or a disability, which will be brought to the Health and Wellbeing Board for comment and the Cabinet for approval in January 2015**

3. **Considers and comments on the Consultation process, Action Plan and Governance arrangements described in this report**

1. Background

1.1 Section 2 of this paper to the HWWB details the overarching regulatory and legislation requirements of the new SEND reforms, and the actions taken by the council to develop processes for the new requirements across partner agencies, children, young people and their parents and carers.

1.2 Section 2 also brings together the Local Offer for consultation being developed by the council and key partners including information on education, health and social care services.

1.3 Section 3 of the paper describes the consultation process running from 1 September 2014 until 21 November 2014 and the plans to bring a paper to Cabinet on 27 January 2015.

2. Special Educational Needs and Disability (SEND) Reform requirements

2.1 Services for disabled children and young people within Warwickshire are being remodelled as a result of the responsibilities on statutory bodies contained within the Children and Families Act 2014. From the 1st September 2014 the Local Authority is under a duty to put in place new arrangements for Special Educational Needs and Disability (SEND) including a 'Local Offer' that meets the relevant integrated education, health and social care needs of a child or young person with special education needs or disability. An integrated assessment process and single plan will be drawn up with parents and where appropriate children and young people (co-production).

2.2 The SEND reforms focus on the following themes:

- Working towards clearly defined outcomes
- Engagement and participation of parents and young people (co-production)
- Developing a Local Offer of support and Joint Commissioning
- Coordinated assessments and Education, Health and Care Plans
- Personalisation and personal budgets

Preparation for adulthood is a key element of the reforms that cuts across all of these themes.

2.3 **Working towards clearly defined outcomes**

Our aim is to improve the lives of children, young people, families and carers who are coping with Special education needs or a disability. We will do this by helping Families to be more independent and have more choice and control over their lives and that their needs are properly met. Previously assessments have been made on education, health or care needs without the focus of all of the child's needs being considered with parents. We will bring together the three elements in a single plan, with parents at the heart of the decision making including how personal budgets will be allocated to meet those needs.

Our defined desired outcomes are

- all children and young people with special educational needs or disabilities should be able to reach their full potential in school. They should also be supported to make a successful transition into adulthood, whether into employment, further or higher education or training;

- improvements in the support system for children and young people with SEN and their families;
- introduction of a single assessment process for education, health and care and include parents of children and young people with SEN in the assessment process;
- replacement of SEN statements and learning difficulty assessments with an education, health and care plan for children and young people with SEN aged 0 to 25 years;
- introduction of the option of personal budgets for young people and parents of children and with SEN so they can choose which services are best for their family;
- local commissioners work together in the interest of children and young people with SEN and improve communication between institutions and services.

2.4 **Engagement and participation of parents and young people (Co-production)**

The major change within the Act is the concept of co-production at all levels.

"Co-production means delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours. Where activities are co-produced in this way, both services and neighbourhoods become far more effective agents of change"
The engagement of all agencies involved in the design, implementation, monitoring and review of those services impacting on the child or young person's needs so that parents and carers and where it is appropriate, the children and young people are able to make informed decisions about their care and support.

This differs from consultation which is defined as; "the action or process of formally consulting or discussing". Consultation may influence a decision, co-production brings ownership and joint responsibility.

2.5 To deliver this requirement for co-production the Council has established a SEND Project Board which includes representation from Children's Social Care, Learning and Achievement, Early Help and Targeted Support, Adult Social Care, Strategic Commissioning, Resources Group, colleagues from Health, Special Schools and are now seeking representatives from parent groups. The Board's Action Plan is presented in Appendix 1. The SEND Board reports to the Joint Commissioning Board chaired by the Strategic Director for the People Group who has the statutory responsibility for Children Services. The IDS Social Care Reference Group of parent organisations and partners established in January 2014 is now the Warwickshire SEND Reference Group and has committed to working in a co-productive way such

as on our June consultation, and the writing of the report for Cabinet on the IDS Social Care. Key features of this include the recent Social Care consultation, meeting with DfE advisors, contributing to the letter sent to all parents of children with statements and having an input on the prototype for and trialling of the single plan. The Action Plan setting out how we plan to deliver the SEND Reforms has been agreed with parents representatives and officials from the Department for Education.

2.6 The SEND Reference Group includes parental involvement from Family Voice Warwickshire, Ups of Downs and Warwickshire Disability, in addition there is representation from the voluntary sector who support across the various areas of special education needs and disability, and interested Elected Members who sit on the Children's Overview and Scrutiny committee. This group is a fundamental part of the Council's strategy for co-production, a key expectation of the new SEND reforms.

Other initiatives include

- Regular meetings of the Reference Group as well as other opportunities in order to gauge parental and carer views in coming weeks.
- Family Voice Warwickshire work regarding parental involvement funded by the SEND Implementation Grant.
- The Wacky Forum, VOX (County Youth Forum) and elected Members of the Youth Parliament (MYP's) and will also include the Children in Care Council (CiCC).

Developing a Local Offer of support and Joint Commissioning

2.7 Before any new Local Offer can be implemented there must be consultation in accordance with the Regulations on the whole Local Offer. Whilst there has been co-production of the Social Care and Education strands the Health element of the Local Offer requires further work. In addition the Regulations set out a long list of statutory consultees who must be consulted on the Local Offer.

Under the SEN and Disability Regulations 2014 and the associated Code of Practice Local authorities **must** publish a Local Offer, setting out in one place information about provision they expect to be available across education, health and social care for children and young people in their area who have SEN or are disabled, including those who do not have Education, Health and Care (EHC) plans.

The content of the Local Offer is prescribed by Regulations. In setting out what they 'expect to be available', local authorities should include provision

which they believe will actually be available. The oversight of the delivery of Warwickshire's Local Offer is via the SEND Project Board and Reference Group who report to the Warwickshire Joint Commissioning Board.

2.8 The Local Offer has two key purposes:

- To provide clear, comprehensive, accessible and up-to-date information about the available provision and how to access it, and
- To make provision more responsive to local needs and aspirations by directly involving disabled children and those with SEN and their parents, and disabled young people and those with SEN, and service providers in its development and review. WCC Market Position Statements and commissioning intentions complete this assurance.

2.9 The Local Offer should not simply be a directory of existing services. Its success depends as much upon full engagement with children, young people and their parents as on the information it contains. The process of developing the Local Offer will help local authorities and their health partners to improve provision.

2.10 The Local Offer must include provision in the local authority's area. It also includes provision outside the local area that the local authority expects is likely to be used by children and young people with special education needs and/or disabilities (SEND) for whom they are responsible. This could, for example, be provision in a further education college in a neighbouring area or support services for children and young people with particular types of SEN that are provided jointly by local authorities. It should include relevant regional and national specialist provision, such as provision for children and young people with low-incidence and more complex SEN.

2.11 Warwickshire's Local Offer has been available from 1st September for consultation and can be found at www.warwickshire.gov.uk/send. A second letter has been sent to all parents with children who have statements advertising the web portal in the week leading up to the 1st September. The portal will signpost parents, carers, children and young people to the appropriate information detailing the education, health and care assessment processes, and the services available from education, health and care providers. Content of the web portal will be reviewed and updated on a regular basis following agreement at the SEND Board.

2.12 Joint Commissioning is being co-ordinated via the existing arrangements of the Joint Commissioning Board chaired by the Strategic Director of People Group. The consultation process to be undertaken for the Local Offer will provide indicators for priorities for discussion at the Board and feed into the

Health and Wellbeing Board and contribute towards the Joint Strategic Needs Assessment.

Coordinated assessments and Education, Health and Care (EHC) Plans

2.13 A key component of the SEND changes is the bringing together education, health and care assessments in to a single plan. Work on the new co-ordinated, co-produced assessment process has been trialled with a number of children and young people within Warwickshire and amended as a result of experience. The assessment and planning process has been shared with all schools, partners, and front door services so that all families seeking help from September 1st will be able to access relevant information, and be directed to consider the most appropriate services.

Personalisation and personal budgets

2.14 Personalisation is a social care approach described by the Department of Health as meaning that "every person who receives support, whether provided by statutory services or funded by themselves, will have choice and control over the shape of that support in all care settings". While it is often associated with direct payments and personal budgets, under which service users can choose the services that they receive, personalisation also entails that services are tailored to the needs of every individual, rather than delivered in a one-size-fits-all fashion. It also encompasses the provision of improved information and advice on care and support for families, investment in preventive services to reduce or delay people's need for care and the promotion of independence and self-reliance among individuals and communities.

2.15 A Personal Budget is an amount of money identified by the local authority to deliver provision set out in an Education Health and Care (EHC) plan where the parent or young person is involved in securing that provision.

2.16 Warwickshire County Council has run a successful Direct Payment scheme for disabled children for a number of years. The scheme puts service users in the driving seat and in control of their life by giving them a cash amount so that they can buy support that suits them best, like employing their own staff, choosing their own agency or a range of other options. The scheme is designed to help them manage funds for their support needs in a flexible way. Currently 84 families benefit from this scheme. Future plans will refine existing systems.

2.17 In accordance with our normal practice Equality Impact Assessments will be updated to take account of the outcome of the consultation.

3. The Consultation Process

Arrangements

3.1 The Action Plan builds in a new consultation that will be co-produced and widely consulted on with parents, carers, partners, schools, colleges and young people. The SEND Reference Group will then work on the Cabinet Paper following the twelve week consultation with the mind to bringing the recommendations to Cabinet at its January 2015 meeting. All future activity will meet both the legal requirements and principle of co-production with parent representatives and partners and this will be driven through the SEND Reference Group. The SEND Board will continue to ensure that we are reviewing and monitoring all issues regarding the new Act across Education, Health and Social Care. The Joint Commissioning Board that reports to both the Health & Wellbeing Board and Cabinet oversees the whole programme.

The consultation started on the 1st September and finishes on the 23rd November save for an additional individual session with the Wacky Forum which will be completed by 30th November. The consultation will include consultation with all the statutory consultees and will be advertised through the normal media channels, letters to parents/carers of all statemented children and young people and through all Warwickshire schools.

3.2 It will seek views on:

- The accessibility, style and content of information made available
- The type and quality of education, health and care services required
- The assessment process and single plan format
- Personal budget process
- The appeals and mediation process
- How children, parents, carers want to be involved in co-production in the future
- The arrangements for comments on the Local Offer

3.3 **Information about public meetings:**
There will be morning and evening meetings and drop-in sessions during the afternoon at each of the following locations – more information is available at www.warwickshire.gov.uk/ask

- 1 October - Mancetter Memorial Hall, Old Farm Road, Mancetter, Atherstone, Warwickshire, CV9 1QN (North Warwickshire)
- 7 October - Stratford Arts House, 14 Rother Street, Stratford-upon-Avon, Warwickshire, CV37 6LU (Stratford)

- 15 October - Nuneaton Town Hall, Coton Rd, Nuneaton, Warwickshire CV11 5AA (Nuneaton and Bedworth)
- 5 November - Benn Partnership Centre, Railway Terrace, Rugby, Warwickshire CV21 3HR (Rugby)
- 12 November - Warwick Racecourse, Hampton St, Warwick CV34 6HN (Warwick)

Each of the meetings will be jointly hosted by representatives from education, health and care. Parent representative groups will be there to offer support.

For direct input from children and young people with a special education need or disability we are working with our young people representative groups; The County Youth Forum (VOX), Members of the Youth Parliament, Children in Care Council, FAB TABs and Wacky Forum.

3.4 All responses to the consultation will be evaluated by SEND Reference Group and they will co-produce the paper through December for the Health and Wellbeing Board on 21st January 2015 and the Cabinet on the 27th January 2015.

4. Background Papers:

Revised IDS Framework for assessment
Progess since 13th March 2014 Cabinet and Consultation
Revised IDS Budget 2014/15
EHC Assessment and Plan Guidance
Personal Budgets
The Local Offer
Local Offer List of Statutory Consultees

Hugh Disley
SEND Lead Officer

WARWICKSHIRE SEND ACTION PLAN
Update 8th August 2014

● SEND Lead Officer	Hugh Disley, Head of Service, Early Help & Targeted Support
● Social Care Lead	Adrian Wells, Service Manager, Early Help & Targeted Support
● Education	Nigel Minns, Head of Service, Learning & Achievement
	Judith Humphry, Seconded to the LA, Headteacher, Welcombe Hills Special School
● Health	Jo Dillon, South Warwickshire CCG
● Commissioning	Kate Harker, Children's Commissioner, Strategic Commissioning
● DCS	Wendy Fabbro, Strategic Director, People Group
● Portfolio Holder	Bob Stevens (Children Services), Colin Hayfield (Education)
● Critical Friend	Jeanette Essex, Solihull Pathfinder
● Department for Education	Andre Imich

Principles in practice:

- Participating in decision making
- Supporting children, young people and parents to participate in decisions about their support
- Involving children, young people and parents in planning, commissioning and reviewing services
- Parent Carer Forums
- Identifying children and young people's needs
- Greater choice and control for parents and young people over their support
- Collaboration between education, health and social care services to provide support
- High quality provision to meet the needs of children and young people with SEN
- A focus on inclusive practice and removing barriers to learning
- Supporting successful preparation for adulthood

Children and Families Act

The Children & Families Act 2014 sets out a sweeping programme of reforms to the statutory framework for Special Educational Needs and Disability ('SEND'). The changes represent the most comprehensive reforms to the SEN system for over 30 years; many of these changes take effect from September 2014.

The key changes that the local authority is required to implement are as follows:

i. The introduction of an integrated assessment process and single Education, Health and Care Plan for those aged 0-25 yrs with SEND, which replaces and extends the current statutory SEN Statementing and Learning Difficulty Assessment process for 0 – 19s.

ii. Education, Social Care and Health Personal Budgets across the 0 to 25 age range

iii. A Local Offer – easily accessible information about services and support available and how to access them from across the local authority, education, health, voluntary sectors etc.

iv. The Act requires local authorities and partner commissioning bodies to jointly commission services for children and young people with SEN and disabilities, including those without Education Health and Care Plans where they think this would promote the well-being of children or young people in their area.

Local offer

17. From 1 September 2014 local authorities will be required to consult with families and providers of services and publish their local offer. Regulations and the SEND Code of Practice will outline who local authorities must consult in developing and reviewing their local offer.

18. We expect local offers to be developed and revised over time. Local authorities have been required for some time to publish information about support for children and young people with SEND, including what they expect schools to provide from their delegated budgets and provision for short breaks. These could provide a starting point for their local offer.

Contents of the local offer

19. Regulations and the SEND Code of Practice will provide a framework to guide local authorities on the content of the local offer. Local authorities will of course be able to go beyond this, depending on local needs and consultation with children, young people and parents.

20. The local offer must include information on services across education, health and social care and from birth to 25; how to access specialist support; how decisions are made including eligibility criteria for accessing services where appropriate; and how to complain or appeal.

SEND Reference Group

This Reference Group was formed in January 2014 and its original focus was on the Social Care Offer. Since May 2014 this has now also included the Education Offer and we are currently now working on the Health Offer. The make-up of the Group includes Family Voice Warwickshire, Parent Partnership, Warwickshire Disability, Ups and Downs, third sector and senior officers from Education, Health and Social Care. The focus of the Reference Group is on getting an agreed Local offer for social care, education and health and then a robust model of co-production that will assist with future design, monitoring and quality assurance.

Warwickshire is fully committed to co-production and recognise that there is much to learn in being effective and efficient in our way of working with children, young people, families, carers and partners.

SEND Action Plan to September 2014 and beyond

Local Offer

URN #	Action	Action By	By when	Current position
1	Development of the on line local offer web pages including refreshing existing content of FIS, IDS & Education & Health services	Elaine Coates	8th August 2014	First design of navigation pages produced and circulated to the Reference group for review. (PC, tablet and mobile versions). Core information about the new duties and the local offer added to existing SEN webpage. Meeting arranged 23rd July to map contents and links for new webpages.
2	Invite all services related to children with SEND (including voluntary and community services) to join the Directory for Warwickshire Services or refresh their information especially capturing those that are directly involved with Health Services	Elaine Coates	22nd August 2014	The Directory contains a category 'Special Needs and Disabilities'. Currently 178 records are live within this category, providing services or support for one or more type of need (eg physical disability, learning disability, autism, etc)
3	Parental engagement through the Reference Group regarding look and feel of the SEND web pages and the related Warwickshire Directory page	Adrian Wells	29th August 2014	SEND navigation page mock ups sent to Reference group for their consideration. Virtual

		Elaine Coates		dialogue throughout July and August and go live 22nd August for further comment by Reference Group. Live to all 29th August
4	Undertake the SEND Local Offer Readiness Self Audit	Hugh Disley Adrian Wells	Awaiting template from DfE	a) This will inform the Action Plan and determine the priorities for implementation.
5	Work with colleagues in adult services to map current transition pathways to inform parents and young people about their options for education, care and health services	Adrian Wells	15th August 2014	Transition Board have developed a coherent pathway that will need adapting to be easily readable by parents and young people
6	Implement communication strategy of Local Offer including the launch of on line tool (web pages and Directory) and FIS	Elaine Coates/ Helen List	22nd August 2014	To have uploaded onto the co-produced web-site that will be then trialled for a week whilst live and publicised as live from 29th August
7	Local Account to include feedback from customers from their experience of using SEND services.	Jayne Barrow	March 2015	The feedback from customers will be incorporated into the Action Plan implementation from September 2014 and this in turn will inform the Local Account which is published in June 2015.
8	A Development Manager post is included in the Social Care restructure. The purpose of this post is to be a Champion for inclusion by ensuring local services are encouraged to be as inclusive as possible and that service users have a point of contact to address issues around inclusion.	Adrian Wells	31st July 2014 n.b awaiting job evaluation exercise to be complete 1st	a) Interviews are scheduled throughout July with the final structure for social care confirmed by 8th August 2014 b) Proposals have been formulated to make best use of resources to design with parents

			September	/ young people local opportunities for activities that meet their needs.
9	Co-production of the Local Offer with young people to be lead through the existing network of young people representative organisations including Wacky Forum, CiCC, VOX; County Youth Council and MYP's	Hugh Disley Cheryl Jones	October 2014	a)The newly appointed network of apprentices will focus on how we can support children and young people representative groups engage in the Local Offer consultation and subsequent co-production of SEND. b) the plan ready by 1st September to engage in the implementation consultation throughout September and October.
10	Finalise the Parent Participation Strategy	Family Voice Warks. / Amanda Burn / Rachel Flowers	October 2014	a) Family Voice Warwickshire are coordinating parents groups working on this. b) We have key staff in adult services that can act as advisors to the group to support the strategy c) We will include the Parent Participation draft Strategy as part of the implementation consultation taking place in September and October that will then be part of the report for Cabinet in December.

	Finalise the Parent Participation Strategy (continued)			d) We have put forward a proposal that resources are made available so Family Voice Warwickshire can coordinate a training programme for front-line staff on the participation strategy e) Appointing Lead Co-Production Officer for SEND initially for 12 months possibly for 2 years

Personalisation

Action		Action By	By when	Current Position
11	A series of meetings are taking place with the Reference Group to co-produce a policy for personalisation development/ implementation and sign off at the People Group Leadership Team. This will include budgets in scope, eligibility and governance.	Adrian Wells	28th August 2014	An initial paper will be circulated with the Reference Group for comment / amendment by 28th August.
12	Ensure Family Information Service information/advice aligns with policy document	Elaine Coates	1st September 2014	Family Information Service will be part of the policy development group
13	Training in personal budgets, support planning and resource allocations system for staff across Education, Social Care & Health	Adrian Wells	a) 29th August 2014 b) 30th October	a) A training plan is being developed coordinating the activity across education, health and social care so that we have multi-agency training in place. b) Initial Training aimed at front line staff then a further schedule of staff will be trained

14	Review existing Resource Allocation System (RAS) and consider pilot RAS processes with the Reference Group to establish the tool for implementation	Adrian Wells	31st October 2014	Warwickshire have used a RAS for their individual budget pilot. This will be used in further development of the social care personalisation process.
15	Calibrate RAS tool by trialling across a large sample of social care cases	Adrian Wells	March 2015	Following autumn consultation review of RAS and re-design, if appropriate agree tool and trial January - March 2015.
16	New short break framework providers added to the Warwickshire Directory	Elaine Coates	22nd August 2014	a) Short break framework providers have been competitively tendered and contracts awarded to provide increased choice and control. b) There will be a constant updating of the Directory to ensure all providers are included and are appropriately updated.
17	Guidance document(s) produced and sent out to schools and parents outlining implications of personal budgets in education and how these will operate locally	Nigel Minns	1st September 2014	Example guidance developed by pilot LA's has been obtained and will be adapted to suit Warwickshire's position.
18	Establish different levels of social care provision available through a personal budget /direct payment	Adrian Wells	29th August 2014	Options for the use of personal budget are identified in the public consultation on the redesign of social care services, which includes short breaks, overnight breaks, overnight breaks transport and additional support services.

19	Establish different levels of education provision available through a personal budget /direct payment Pilot to be run through from January – March 2015	Nick Williams	March 2015	The West Midlands SEND group are exploring initiatives to develop into potential pilots.
20	Establish different levels of health provision available through a personal budget /direct payment Pilot to be run through from January – March 2015	Jo Dillon	March 2015	A scoping report will be presented to the Joint Commissioning Board with an options appraisal
21	Integrate back office functions of Adult and Children's direct payment/personal budgets processes	Adrian Wells	January 2015	An appraisal has confirmed that the model currently in use in Adult Social Care will enable back office functions for SEND activity. An implementation plan is being developed.
22	First phase implementation of personal budgets policy	Adrian Wells / Family Voice Warks	January 2015	Implementation will be aligned with the roll out of EHC plans.

Joint Commissioning

Action		Action By	By when	Current position
23	Through the Childrens Joint Commissioning Board and underpinned by the JSNA, health, education and social care to determine the range of services to be available for children with SEND. Agree Children's Joint Commissioning Strategy to set strategic direction across education, health and social care to include governance, services currently commissioned for this client group, alignment with JSNA, aligned budgets, gaps in provision, joint reviews and re design. Process to achieve this set out below	Kate Harker / Yee Chow	17th October 2014	a) JCB workshop identified key priorities for SEND. Priorities underpinned by comprehensive presentation of the latest JSNA and HWB strategy. b) Governance structure approved with clear route to the Health & Wellbeing Board c) Mapping exercise continues to be progressed d) Joint commissioning Workshop 9th July with health colleagues confirmed current services jointly commissioned, those available as part of the Local Offer, quick wins and more long terms opportunities for joint commissioning. e) SEND Project Group members confirmed and all stakeholders engaged,

				f) Positive joint work to cement the health component of the Local Officer into the next consultation round. (Final consultation stage begins 1st Sept) g) Joint commissioning intentions to be updated end of September in line with CCGs.
24	Share one page summaries of Commissioning Strategies for Health, Education and Social Care to illustrate the commissioning cycle	Kate Harker / Yee Chow / Nick Williams	25th July 2014	a) Agree overall commissioning statement for Local Offer to consult on with parents and partners b) Education commissioning strategy statement c) Health commissioning strategy statement d) Social Care commissioning strategy statement
25	Ensure that all commissioned services are well profiled to children, young people and their parents/families	Bill Campbell/Elaine Coates	1st iteration by 1st September with subsequent additions	a) Complete mapping exercise and work with communications to update SEND website with information about existing services across

			during 14/15.	health, education and social care. b) Finalise the improvements to the feedback mechanism for each service and incorporate into the website by 1st September 2014. c) All future contracts will now include requirement by providers to profile their services and to keep this up to date. d) All recently commissioned short breaks services will go live 30th September and will be profiled on the website.
26	Ensure that commissioned services are co-produced with children, young people and their parents/families.	Kate Harker / Yee Chow / Nick Williams	Ongoing	a) The All Age Autism Strategy provides the benchmark for best practice in co-production and will be sued to set the tone of all future co-production for commissioned services across partners. b) Currently tender out for

				provider to partners health, social care and education to co-produce review of CAMHS c) A newly designed resource for internal staff being finalised and published.as a training/learning tool for co-production. This will be supported by the Co-production team. d) Co-production plan completed and approved by the Board. e) Prepare plan for SEND Reference group on approach to future co-production for planning and commissioning f) Work through what necessary training would be needed so co-producers are able to participate fully g) Set out a timetable of the various planning and commissioning cycles

27	Establish joint, across education health and social care the Children's Joint Commissioning Intentions.	Kate Harker / Yee Chow	Sept/Oct2014	a) Review existing commissioning intentions (14/15) and progress made to date b) Commissioning intentions for 15/16 to be approved by JCB. c) Formal presentation and sign off will be at each respective governing body and HWB
28	Engage the market place to ensure personalisation readiness, including a review of existing contracts	Kate Harker / Becky Hale	Dec – March 2014/15	a) Identify areas within the commissioning intentions report that would benefits from a Market Position Statement and where business opportunities can be profiled to the market. b) Working with Market Facilitation Team replicate the model for adults to introduce provider forums for children services (across all partner agencies)

29	Market development regarding 16-25 FE placements in Warwickshire	Leon Kokkinos / Ed Roberts	September 2015	a) Market analysis is underway against need and capacity of Warwickshire placements b) Market position statement to be completed and profiled to the market.

EHC Assessment & Planning

Action		Action By	By when	Current position
30	0-25 assessment mapped and paperwork prepared	Nick Williams	25th July 2014	Draft EHC plan has been developed.
31	Referral process plan and supporting documentation shared with schools and settings	Nigel Minns	25th July 2014	Feedback on draft documentation received from Parents Partnership and schools. Documentation amended.
32	Assessment conversion plan signed off including 16-25	Nigel Minns	22nd August 2014	Work undertaken to construct the process and ensure the necessary resource is available to complete the planned conversion process.
33	Consult directly with SEN 16-25 students and their parents regarding their education offer	Cheryl Jones	October 2014	Work with participation group to develop how we may consult with young people in colleges post 16

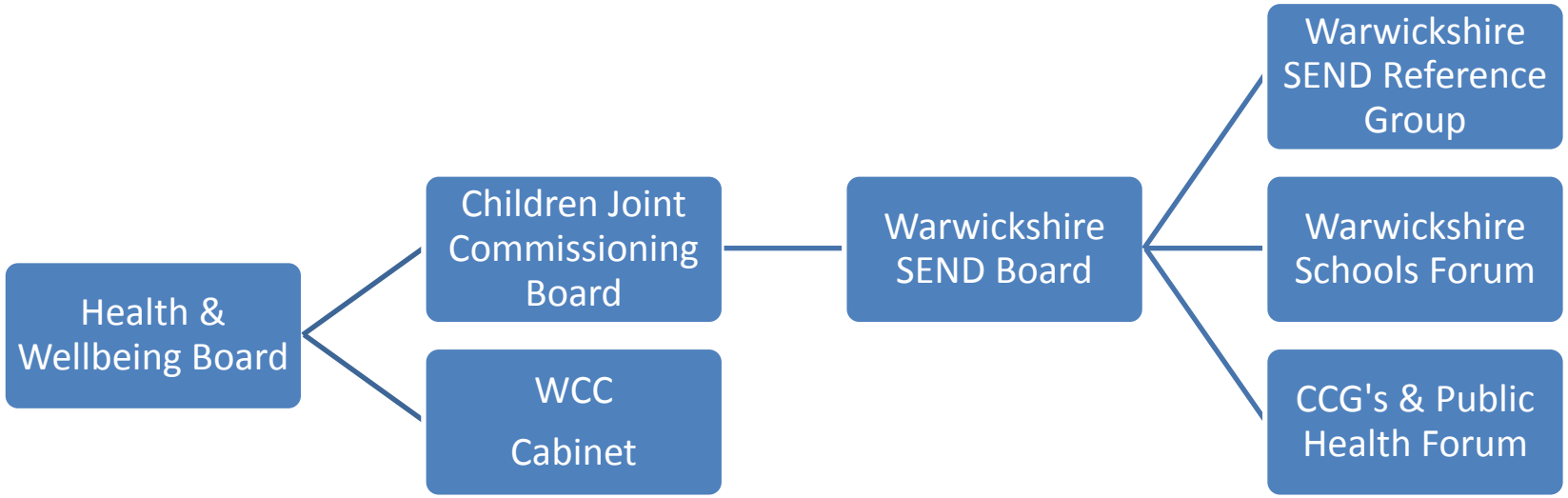
34	Work with education providers and parents to support readiness for change in the systems (mentoring, training, coaching)	Judith Humphrey	September – December 2014	Ongoing training and support for staff in educational settings to focus on child centred approach

Systems and Planning

Action		Action By	By when	Current position
35	Continuous engagement of cabinet members, portfolio holders and other councillors with regards to SEND reform requirements	Hugh Disley / Adrian Wells	18th August 2014	Cabinet Paper update in August. Overview and Scrutiny report in September. Monthly updating of portfolio holders
36	SEND is a standing agenda item of Children's Joint Commissioning Board (JCB)	Chris Lewington / Wendy Fabbro	31st July 2014	SEND is represented on the JCB by the Children's Commissioner and SEND Lead Officer
37	Full membership of SEND project board established with education, health and social care officers Parents representatives being recruited to SEND Project Board	Hugh Disley	18th July 2014 30th September	SEND Project board established May 2014, Health colleagues joined July 2014, weekly meetings commenced 25th July 2014.
38	Update paper was presented to Health and Wellbeing Board	Hugh Disley	15th July	Health colleagues identified at 9th July Workshop
39	Inclusion of EHC plans in newly tendered client information system(s)	Nigel Minns Adrian Wells Nick Williams	29th August 2014	Specification for new systems compiled and EHC requirements captured. Tender process for social care system in progress. Contract due to be awarded 25th July.

40	Pro-active programme of engagement with schools, FE colleges and other education providers	Judlth Humphry Nigel Minns	18th July 2014	a) A number of events have taken place during the summer term. Area meetings have regularly been attended to ensure headteachers, governors and SENCO's are fully briefed. b) New briefing paper to schools and colleges by 5th September 2014.

SEND Governance:



Item 4

Health and Wellbeing Board

Meeting Date 22-09-2014

Introduction to Multi Agency Safeguarding Hubs (MASH) and update of the current position in Warwickshire

Recommendation(s)

That the Board notes the current position in Warwickshire and considers and comments on the plans to develop a MASH

1.0 Key Issues

General introduction to Multi- Agency Safeguarding Hubs- (MASH)

1.1 The aim of any type of the MASH is to gather, analyse, assess and deliver complex information about a child or vulnerable adult in need in a simple format to assist in decision making about what the needs and risks are, and what services can best meet those needs and reduce the risks for that vulnerable person.

Around the country the Multi- Agency Safeguarding Hub (MASH) has become one term used for a range of different information sharing, screening, assessing and decision-making processes and structures. Not all Local Authorities have something called a MASH but all are trying to address the same issues.

There is no consistent membership of a MASH and this seems to depend on local relationships as to who has signed up to provide either staff and/or access to their data. Most have been additional to existing services and have required funding for staff, IT and in some cases premises.

1.2 Critical factors to consider include:

- The size of the area served and the complexity of organisations working together
- Clarity of existing thresholds for services and pathways for care
- Whether the MASH is to focus on referrals (where the author feels a crisis is emerging) or whether a wider scope is required ie: if insufficient arrangements exist at CAF early intervention
- Whether a “think family” approach is required involving all ages of vulnerable people
- Which agencies will be involved as complexity increases exponentially
- Potential access arrangements in large geographical areas
- How interfaces with statutory agency services will be maintained in parallel to the MASH service – or if the MASH will be more “virtually” delivered.
- Data sharing issues, including how to identify trends and patterns (such as how that would help to identify CSE)

Although there are other examples set out below, Warwickshire clearly needs to carefully tailor a response for our configuration, community needs and response capacity

1.3 Devon LSCB led the development of the first MASH implemented between April 2010 and April 2011. The Devon MASH includes local authority children's social care, police, health services and education co-located in one office. There are also virtual links to the early years team in children's centres; the youth offending team; probation; both children's and adults' mental health; housing; and the ambulance service.

Like Devon, many MASHs are based only on the children and young people who have been referred to Children's Social Care (Reading, London MASH Model, Calderdale, Wiltshire) and some are only available once a CP threshold is likely to be met (Sandwell). These models are focused on whether the thresholds for Child Protection are met or not.

Some authorities have developed the social care duty and assessment service to create a multi-agency interface for consultation, discussion and decision making for the provision of both Early Help and Social Work services (Cheshire East). Others have additional potential: Leicestershire and Hampshire are both interesting examples.

<u>Leicestershire</u>

Leicestershire has been chosen as a Centre of Excellence for Information Sharing. They have their MASH Multi-Agency Screening Team located as part of their early help offer, which is coordinated through the Supporting Leicestershire Families (SLF) programme under the Troubled Families initiative.

Leicestershire MASH summaries are produced for regular multi- agency meetings in the District localities. The locality meetings are chaired by the Serving Leicestershire Families hub coordinators, who request services to provide assessment and support and use the MASH summaries to help decide what is the most appropriate support. The locality professionals discuss the MASH summary and if appropriate can allocate someone in the professional network to do an early help assessment. Although centred around children and young people, the MASH do the checks on all members of the household (including when people are not related).

Leicestershire MASH is separate from the First Response service for Social Care. The First Response team can request a MASH summary and refer to the Locality Team for an early help package of support to be offered. The Child Protection work identified by First Response is followed up by the relevant SW team who are in the process of setting up a co-located CP joint investigation service with the police. At present the social work assessment team and police do not use their MASH for their lateral checks.

Hampshire

Hampshire recently had an Ofsted of Children's Services and came out as good with outstanding features.

The Hampshire Multi Agency Safeguarding Hub (MASH) provides triage and multi-agency assessment of safeguarding concerns in respect of vulnerable children and adults. It brings together professionals from a range of agencies including Children's Social Care Assessment Staff, Adult Safeguarding, Police Vulnerable People referral unit for Hampshire, , Children's Safeguarding Nurse, Approved Mental Health Practitioners,(AMPs) with access to Adult MH data and EDT. The MASH team collate their shared information and make assessments and decisions to ensure that vulnerable children and adults are responded to quickly and efficiently by the most appropriate professional.

Leicestershire and Hampshire are very different from each other but can both provide a broader way of thinking about the benefits of the hub approach and how these could be applied to Warwickshire.

Update on the current position in Warwickshire

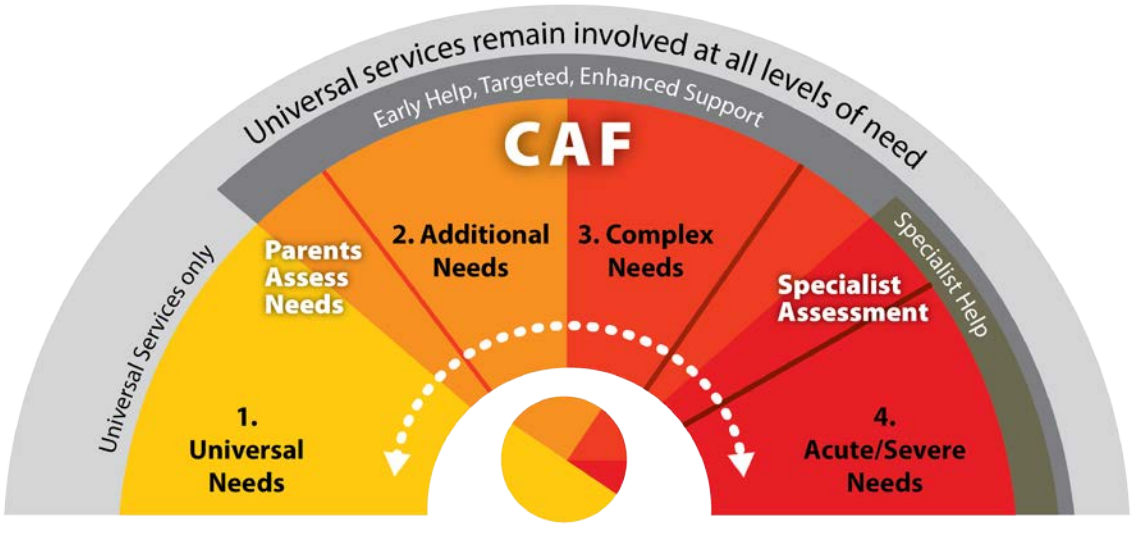
The possibility of a MASH of some kind in Warwickshire has been researched and explored since February 2014 working with partners in Police and Health

The MASH Project is in 3 phases:

Phase 1 – Scoping- 3rd March to 30th June 2014

Threshold for service approved by LSCB – http://www.warwickshire.gov.uk/wscbresources Appendix 17

The interim Project Lead completed a Scoping Paper with a proposal for an enhanced MASH model for Warwickshire, which would include Consultation, Information Sharing and Short Assessments in a co-located Hub, diagrammatically set out, as referrals are made



Phase 2 - Decision Making

A strategic working group met on 6th August to consider the proposal and the potential risks and benefits of the different aspects of the proposed model and agree next steps towards reaching a position where services can make decisions.

Phase 3 - Implementation if there is a decision to implement a MASH in Warwickshire

2.0 Options and Proposal

The MASH Project requires

1.1 A decision whether or not there is leadership support for further work to progress a Multi- Agency Safeguarding Hub (MASH) of some sort in Warwickshire.
1.2 If so a multi-agency MASH Executive Board with Chair would be needed to progress the MASH Project.
1.3 The MASH Executive Board would be responsible for agreeing the Project Team and who will chair the project meetings and provide the highlight reports to the Health and Wellbeing Board
1.4 The Project Team members would then lead the working groups

3.0 Background papers

None

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Portfolio Holder		

Item 5

Health and Wellbeing Board

22nd September 2014

Warwickshire's Refreshed Alcohol Implementation Plan

Recommendation

1. The Board endorses the new Warwickshire Alcohol Implementation Plan and encourages partners to fully support the plan and take action where required.

1.0 Background

1.1 The first Warwickshire alcohol implementation plan was agreed by partners in 2010. This plan was awarded the Alcohol Concern 'kitemark' for good practice. The plan was refreshed in 2012, based on the priorities within the new national alcohol strategy.

2.0 2014 Plan

2.1 Warwickshire's 'BIG Conversation About Alcohol' event was held in January 2014. Attendees represented a variety of organisations concerned with the negative effects alcohol has on both health and crime and disorder.

2.2 As part of the above event participants were invited to review and refresh the 2012 Alcohol Implementation Plan. These views and other comments and commitments were taken into account in the development of the 2014 version.

2.3 The refreshed implementation plan reflects the direction of the national alcohol strategy and developments locally since the original plan was produced. It shows how agencies, often working in partnership, will aim to tackle the harm caused by alcohol with activity under three mains themes

- Challenge and enforcement
- Health, treatment and recovery
- Education and prevention.

2.4 The new plan was approved at the Warwickshire Drugs and Alcohol Management Group meeting in April, endorsed by the Safer Warwickshire Partnership Board in June. It is being brought to the Health and Wellbeing Board for endorsement.

3.0 Monitoring

3.1 The Drug and Alcohol management Group oversees both the Drug and Alcohol Implementation Plans with 6 monthly updates being provided. Any

issues that arise will be escalated to the Safer Warwickshire Partnership Board and/or the Warwickshire Health and Wellbeing Board as appropriate.

4.0 Implications for partners

4.1 The effects of excessive alcohol consumption are felt not just by the individual but also by agencies including the health service; police and crime authorities; treatment services; road safety; fire and employers. There are also significant impacts on domestic abuse, children and adult services and mental health providers.

4.2 This implementation plan acknowledges that no single agency can tackle the problem and that a coordinated partnership response, where each relevant agency undertakes to carry out their respective role, is required.

4.3 The refreshed plan highlights areas of new activity and development and shows how a suite of coordinated actions may provide greater improvement than isolated activity.

Background papers

1. Warwickshire Alcohol Implementation Plan 2014

	Name	**Contact Information**
Report Author	Paul Hooper	paulhooper@warwickshire.gov.uk Tel: 01926412153
Head of Service	John Linnane	
Strategic Director	Monica Fogarty	
Portfolio Holder	Cllr Stevens and Cllr Caborn	

Appendix

Warwickshire Alcohol Implementation Plan

2014 – 2016

An Equality Impact Assessment on this policy was undertaken in October 2012 and will be reviewed in October 2015.

Joint Foreword

"For many people, alcohol can be something they enjoy with friends and family at home, at a local pub or restaurant, or at a social or recreational gathering. As well as contributing to social interaction and life, the alcohol industry plays an important part in enhancing the economy, supporting over 1.8 million jobs.

However, some people are not able to enjoy alcohol responsibly and the resulting alcohol-related crime, anti-social behaviour and high risk of chronic diseases are unacceptable and likely to be devastating for individuals, their families and the communities they live in.

The statistics around alcohol and violence are stark: in almost half of violent incidents, the victim believed the perpetrator was under the influence of alcohol, and a fifth of all violent incidents took place in or around a pub or club. In almost three quarters of domestic violence incidents the perpetrator had used alcohol prior to committing the offence. This kind of irresponsible and excessive consumption of alcohol imposes a significant and devastating cost on individuals, communities and society.

Alcohol-related healthcare costs in Warwickshire were an estimated £30.8m, equating to £70 per adult. We are concerned that harms to individuals and society as a whole may increase unless action is taken. There is strong evidence to show that for every £1 invested in specialist alcohol treatment, £5 is saved on health, welfare and crime costs.

This Alcohol Implementation Plan takes a partnership approach to tackling alcohol related issues from both a health and crime perspective and we encourage and applaud services to do all they can to support this and remain committed to improve the lives of Warwickshire residents who are affected by alcohol related problems."

Dr John Linnane,

Director of Public Health Warwickshire County Council

Mr Ronald Ball,

Warwickshire's Police and Crime Commissioner

Introduction

The original comprehensive alcohol implementation plan was agreed by partners in Warwickshire in 2010. This plan was awarded the Alcohol Concern 'kitemark' for good practice. It was then refreshed again in 2012, based on the priorities within the new national alcohol strategy. This current refresh is version 3 of the plan.

In March 2012, the Government launched its new National Alcohol Strategy. This strategy sets out the Government's approach to turning the tide against irresponsible drinking.

Activity within the national strategy sits under three broad themes:

- Challenge and enforcement
- Health, treatment and recovery
- Education and prevention.

Alcohol-related crime is estimated to cost society £11 billion in England and Wales alone. Alcohol misuse also costs the United Kingdom economy an estimated £7.3 billion a year in lost productivity and costs the National Health Service in England an estimated £3.5 billion a year.

In the UK it is estimated that 2.6 million children are living with parents who are drinking at hazardous levels. Parental or carer drug or alcohol use can reduce the capacity for effective parenting. In particular the children of parents or carers who are dependent on drugs or alcohol are more likely to develop behavioural problems, experience low educational attainment, and be vulnerable to developing substance misuse problems themselves. Some children's health or development may be impaired to the extent that they are suffering or likely to suffer significant harm. The aim of all practitioners working with alcohol or drug users who have parental responsibility or children residing with them is to maximise opportunities for families with multiple needs to get timely, appropriate support. This cannot be done in isolation. Drug and alcohol services must work collaboratively with children's services to ensure that children who are affected by parental or others drug or alcohol misuse are kept safe from harm and have the support they need to succeed. Treatment provides a platform for alcohol dependent parents or carers, or those living with children, to stabilise their lives, which can have a positive impact on their families.

Through the Alcohol Strategy, published in March 2012, the Government is promoting proportionate and targeted action to reduce the costs and problems caused to society by irresponsible and excessive drinking without disproportionately affecting responsible drinkers. As the Strategy made clear, reducing the harms caused by alcohol is not only a matter of concern for Government; collective action is required by industry, local agencies and individuals.

Significant progress has been made under the previous plan; however there is still clearly more work to do. The previous strategy aimed to, and achieved, increased access and monitoring of treatment services and the alcohol agenda. However due to the current economic climate, with major restructuring of Public Sector organisations and reductions in funding, the priority of a current, refreshed plan, is to maintain the profile of the agenda and find innovative ways to deliver, protect and tackle alcohol related harm.

Warwickshire's BIG Conversation About Alcohol event was held on Friday 17th January 2014 with a variety of people attending, and participating from, the private, public and voluntary sectors and wider communities to review and refresh the Alcohol Implementation Plan. This refreshed implementation plan reflects both the direction of the national strategy and developments locally since the original plan was produced. It shows how agencies in Warwickshire will aim to tackle the harm caused by alcohol, with a focus on activity under each of the three themes above where significant value can be added through effective partnership working.

Outcomes

Warwickshire partners have agreed that the overall success of this plan will be measured through the achievement of a number of high level performance indicators. Systems are already in place to measure the following indicators:

- A reduction in the amount of alcohol-related serious violent crime
- A reduction in the rate of alcohol-related hospital admissions for both adults and under 18s
- An increase in the numbers of adults and young people successfully completing alcohol treatment
- A reduction in the percentage of young people drinking alcohol on most days.

Monitoring

The plan is designed to achieve co-ordination, integration and best value of alcohol harm reduction activities across the private, public and voluntary sectors and the wider communities. The specific detail of the actions within this plan will be monitored through the Drugs and Alcohol Management Group (DAMG). The lead agency (or, in a few cases, agencies) is listed for each action and this agency is responsible for co-ordinating the activity required to develop the strand of work and providing updates to the Drug and Alcohol Action Team (DAAT) in a timely fashion. These structures will ensure the robust monitoring of implementation and delivery of the strategy, enabling the DAMG to evaluate and review the effectiveness of activities. The actual implementation of many of the actions within this plan is likely to involve several partners, and a list of all the partner agencies signed up to the plan can be found at Appendix A.

This is principally a countywide action plan, with a focus on county level actions. Additional actions to be undertaken at a District / Borough level can be found in the Community Safety Partnership (CSP) Partnership Plans and specific action plans, which will be monitored at a local level. Please note that each action within the plan is identified with a letter and number to aid navigation.

Theme 1: Challenge and Enforcement				
Action	**Who – Lead Agency**	**Timescale and Comments**	**1st Update**	**2nd Update**
A1. Implement intelligence led policing operations to ensure appropriate provision in town centres during peak times for alcohol related violence.	Local Policing – Chief Inspector. Will link to Observatory who can contribute to analysis.	Ongoing from Summer 2014. The success of this action will be a reduction in serious violent crime. Early intervention and arrests for lower level violence may prevent more serious harm later in the evening.		
A2. Undertake enforcement activity throughout the year to identify individuals involved in drink driving and take appropriate action against those caught over the limit.	Police – Road Safety	Ongoing from Summer 2014. Any driver involved in a collision (where Police are aware) is automatically tested for alcohol.		
A3. Manage and target local licensing issues based on intelligence via MALEM meetings. Develop evidence based action plans for the most problematic licensed premises in each area, as identified through multi-agency licensing meetings.	MALEM Partners, Police and Licensing.	Ongoing from Summer 2014.		
A4. Establish a countywide framework to raise awareness of suitable and appropriate court disposals for those guilty of alcohol related offences.	Police and DAMG.	Ongoing from Summer 2014.		
A5. Work with licensed premises	District and	Ongoing from Summer		

to ensure that they are aware of all their responsibilities under the Licensing Act via MALEM groups.	Borough Council Licensing Managers and MALEM Partners.	2014. Activity required will depend on the premise, but may include training to ensure all staff are aware of their responsibilities. Multi-agency licensing visits should be used to ensure all premises are complying with the conditions of their licence.		
A6. Amend data recording mechanisms to enable intelligence to be gathered about alcohol related attendances at Accident and Emergency departments.	Hospital Trusts	Ongoing from Summer 2014.		
A7. Undertake test purchase operations in on and off-licensed premises, focusing on those receiving a complaint or other intelligence. Target repeat sales.	Trading Standards	Ongoing from Summer 2014. Fixed Penalty Notices issued to all individuals caught selling alcohol to under 18s. Follow up advice offered to premises to prevent repeat offences.		
A8. Distribute information and	Trading	Ongoing from Summer		

literature about Challenge 25 and the illegality of proxy sales to priority on and off-licensed premises.	Standards	2014. A condition is also placed on all new premise licences, requiring the premise to display information about age check 25.		
A9. Utilise existing powers to prosecute and sentence those persistently selling alcohol to under 18s.	Trading Standards	Ongoing from Summer 2014. Problem premises to be targeted for test purchasing activity.		
A10. Undertake work to promote Alcohol Diversion Scheme more widely and increase awareness amongst partners.	Police – Wayne Cooke, Recovery Partnership	Ongoing from Summer 2014.		
A11. Rollout the Alcohol Diversion Scheme to include people arrested in the street and not taken into custody.	Police – Wayne Cooke, Recovery Partnership	Ongoing from Summer 2014.		

A12. Maintain the use of effective Alcohol Treatment Requirements (ATRs), delivered as part of a Community Sentence.	Probation	Ongoing from Summer 2014.		
A13. Provide information about all Drug and Alcohol sentencing options available with a balance of enforcement and support to all Magistrates' via training sessions.	Recovery Partnership and Probation.	Ongoing from Summer 2014.		
A14. Implement and run a number of educational campaigns and promotional activities warning of the dangers of Drink Driving on Warwickshire's roads.	Road Safety Warwickshire.	Summer & Winter		

Theme 2: Health, Treatment and Recovery				
Action	**Who – Lead Agency**	**Timescale and Comments**	**1st Update**	**2nd Update**
B1. Provide effective and appropriate alcohol treatment, support and recovery services for both adults and young people.	DAAT, Recovery Partnership, Compass	Ongoing from Summer 2014.		
B2. Provide effective alcohol treatment services for young people working with the Youth Justice Service, where this is appropriate.	Youth Justice Service	Ongoing from Summer 2014.		
B3. Provide support, including a peer mentoring service, for alcohol treatment service users and their carers.	ESH Works and Recovery Partnership.	Ongoing from Summer 2014.		
B4. Ensure GPs are appropriately supported to deliver the Identification and Brief Advice (IBA) section of the revised NHS Health Check and are aware of appropriate onward referral mechanisms to specialist alcohol treatment.	Public Health - Consultant in Public Health	Ongoing from Summer 2014.		
B5. Roll out IBA for alcohol to all mainstream services through the 'Making Every Contact Count' (MECC) programme designed to improve unhealthy lifestyles.	Public Health – Consultant in Public Health	Ongoing from Summer 2014.		

B6. Ensure appropriate links are in place between treatment services and the Integrated Offender Management (IOM) scheme, to enable all offenders with alcohol misuse issues to access appropriate treatment.	Recovery Partnership – Criminal Justice Team Leader, IOM Co-ordinator	Ongoing from Summer 2014. Drugs and alcohol has been identified as one of seven pathways required to break the cycle of reoffending in the Warwickshire Reducing Reoffending Strategy. Intensive outreach will be required with some offenders to (re)engage them in treatment.		
B7. Raise awareness of young people's treatment services in schools, academies, colleges, GPs and pharmacies.	DAAT, Compass	Ongoing from Summer 2014. All available opportunities (Alcohol Awareness Week, Alcohol and Pharmacy Week etc) utilised to promote services as widely as possible.		

B8. Extensively promote the adult treatment service to all partners, to ensure practitioners are aware of referral routes for clients requiring specialist support.	DAAT, Recovery Partnership	Ongoing from Summer 2014. All available opportunities utilised to promote services as widely as possible. Services to be promoted to and through agencies that may not previously have received information including; libraries, Children's Centres, cafes and hostels.		
B9. Ensure that all treatment services are offered are in accordance with current NICE guidelines.	Recovery Partnership, DAAT	Ongoing from Summer 2014. This can be monitored in a number of ways such as constant monitoring and review through Clinical Meetings, Audits and CCQ Inspections.		
B10. Ensure that appropriate care pathways are in place between treatment services and mental health providers for clients with a dual diagnosis.	Recovery Partnership, CWPT and Service User Involvement Agencies.	Ongoing from Summer 2014.		
B11. Ensure that appropriate	Recovery	Ongoing from Summer		

support is made available to families with drug or alcohol problems as identified through the Priority Families initiative.	Partnership, ESH and Priority Families.	2014.		
B12. Identify cases where drug and alcohol use is becoming intergenerational across families and liaise with relevant services to ensure that all family members are appropriately supported.	Recovery Partnership, ESH, Compass and Priority Families.	Ongoing from Summer 2014. Links with ESH Works and floating support provider for alcohol users, as well as wider family support services, will be crucial to ensuring the successful implementation of this action.		
B13. Ensure that all services commissioned by WCC adhere to local Safeguarding Protocols and must work collaboratively with children's services to ensure that children who are affected by parental or others' drug or alcohol misuse are kept safe from harm and have the support they need to succeed.	DAAT, Recovery Partnership, ESH, Independent Living Service, Compass, Priority Families and Children's Services.	Ongoing from Summer 2014		
B14. Undertake work with siblings of young people who offend, exploring a range of issues including substance misuse with the aim of breaking	Youth Justice Service, Compass and Priority Families.	Ongoing from Summer 2014.		

the cycle of offending.				
B15. Provide arrest referral services in Police custody suites at busy times to ensure individuals requiring alcohol treatment are identified at an early stage within the criminal justice system.	Recovery Partnership – Criminal Justice Lead.	Ongoing from Summer 2014.		
B16. Continue to implement the Substance Misuse and Fire Protocol and monitor delivery to ensure effective two-way referral processes are in place.	Recovery Partnership, Fire and Rescue	Ongoing from Summer 2014.		
B17. Implement regular Employability Workshops to improve and review employment outcomes for drug and alcohol service users.	DAAT and ILS to co-ordinate.	Ongoing from Summer 2014.		
Theme 3: Education and Prevention				

Action	Who - Lead Agency	Timescale and Comments	1st Update	2nd Update
C1. Develop a rolling programme of alcohol awareness campaigns targeting key groups.	DAAT Support Officer	Ongoing from Summer 2014. Delivery mechanisms appropriate to the target audience for each campaign need to be utilised. Initial campaigns could focus on: - Young people (under 18s) - Young adults (18-25) - Pregnant women and those trying to get pregnant - Parents - High risk drinkers - Appropriate migrant communities (information needs to be available in a variety of languages) - Prevention of drink driving (jointly with Road Safety). - Learning from any campaigns proven to work elsewhere to be incorporated into the		

		Warwickshire information.		
C2. Utilise all available opportunities to highlight the links between alcohol and domestic abuse, using both local and national resources.	Warwickshire County Council, Domestic Abuse Manager	Ongoing from Summer 2014, utilising available local and national materials.		
C3. Promote healthy lifestyle messages locally.	DAAT Support Officer	Ongoing from Summer 2014, utilising available national materials. Messages to be made relevant to Warwickshire where appropriate and promoted via social media and incorporated into local campaigns.		
C4. Explore and promote opportunities for delivering key messages about alcohol to young people.	DAAT Support Officer and Compass	Ongoing from Summer 2014. Explore and promote opportunities for delivering key messages about alcohol to young people. A variety of events, school health and wellbeing events, Leamington peace festival, colleges fresher's fair, Alcohol Awareness week, etc.		
C5. Circulate information about	DAAT Support	Ongoing from Summer		

alcohol to parents and promote this as appropriate throughout the year.	Officer in partnership with Family Information Service.	2014.		
C6. Increase the total number of young people receiving brief advice on substance misuse.	Compass	Ongoing from Summer 2014.		
C7. Work with universities and further education colleges to raise awareness about the risks of excessive alcohol consumption.	DAAT, Recovery Partnership and Compass	Ongoing from Summer 2014. Possible methods of engagement include: Freshers' Fairs Recruitment of student 'champions' to promote key messages to their peers Online debates. Engagement with student unions		
C8. Provide alcohol awareness training to targeted professionals from a range of partner agencies, including health trainers and those working with young people.	Recovery Partnership and Compass	Ongoing from Summer 2014. Sessions to be tailored to meet need. Links into MECC agenda.		
C9. Update and distribute the 'Guidance for practitioners working with young people using the Alcohol Concern alcohol' toolkit.	Compass	December 2014.		
Actions relating to the implementation plan as a whole				

Action	Who – Lead Agency	Timescale and Comments	1st Update	2nd Update
D1. Regularly report work to reduce alcohol harm to the Health and Well-Being Board, Clinical Commissioning Groups (CCGs), Safer Warwickshire Partnership Board (SWPB) and Police and Crime Commissioner (PCC).	DAAT	Ongoing from Summer 2014.		
D2. Review and consider other nationwide best practice schemes, initiatives and strategies, e.g Ipswich Reducing the Strength Initiative and if a similar need is identified consider adopting/adapting for Warwickshire.	DAAT	Ongoing from Summer 2014.		
D3. Respond to Government consultations when published.	DAAT to coordinate	Responses developed and submitted to meet deadlines for each consultation.		
D4. Share information as appropriate, within the principles of the Warwickshire Information Sharing Charter, to enable effective services to be delivered.	DAAT to coordinate	Ongoing from Summer 2014. All partners to ensure that the principle of appropriate information sharing is embedded within their organisation.		

Completed Actions from the Previous Plan			
Action	**Who – Lead Agency**	**When**	**Comments**
Undertake an assessment of the extent to which alcohol-related violence and anti-social behaviour occurs in Warwickshire's hospitals.	Warwickshire Observatory	Report presented to DAMG January 2013	
Implement the Alcohol Diversion Scheme in Warwickshire.	Police – Head of Incident Resolution, DAAT and Recovery Partnership	March 2013	
Develop the use of effective Alcohol Treatment Requirements (ATRs), delivered as part of a Community Sentence.	Warwickshire Probation Trust - Assistant Chief Executive (Interventions)	April 2013	
Explore the potential to provide information about ATRs to Magistrates via brief training sessions.	Recovery Partnership – Criminal Justice Team Leader	April 2013	
Develop, approve and implement an alcohol pathway between Warwickshire hospitals, Compass and school nurses.	Compass	September 2013	
Work with children and family services to develop and implement a substance misuse and safeguarding joint working protocol.	DAAT	April 2013	

Re-launch the Substance Misuse and Fire Protocol and monitor delivery to ensure effective two-way referral processes are in place.	Recovery Partnership, Fire and Rescue	Relaunched December 2012	
Develop housing related support provision that enhances recovery and rehabilitation.	Supporting People	The Independent Living Service started on 1st April 2013 and the service is delivered by Swanswell.	

Appendix A

The following agencies have committed to working in partnership to deliver the actions within this implementation plan:

- Warwickshire County Council
- Office of Police and Crime Commissioner for Warwickshire
- Public Health England
- Public Health Warwickshire
- Warwickshire Police
- Warwickshire Probation Trust
- Warwickshire Youth Justice Service
- North Warwickshire Borough Council
- Nuneaton and Bedworth Borough Council
- Rugby Borough Council
- Stratford District Council
- Warwick District Council
- The Recovery Partnership
- COMPASS
- ESH Works
- University Hospitals Coventry and Warwickshire NHS Trust
- South Warwickshire NHS Foundation Trust.
- Blue Sky Centre
- Open Hands Coventry
- Warwickshire Fire and Rescue Service
- Tophill Support Services
- Swanswell
- Alcohol Concern
- SMMGP (Substance Misuse Management in General Practice)
- Coventry Cyrenians Warwickshire Team
- Together
- Fry Housing Trust
- Warwickshire County Council Road Safety

- Warwickshire County Council Trading Standards
- Warwickshire County Council Family Information Service
- Warwickshire Association of Youth Clubs
- West Midlands Ambulance Service
- Chapter 1
- Age UK
- Ubique Partnerships
- Doorway
- Job Centre Plus
- Home Group
- Stratford Street Pastors

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Item 7

Transformational Change: Transforming Lives

Coventry and Warwickshire Clinical Commissioning Groups' Strategic Plan 2014-2019

NHS Coventry and Rugby CCG • NHS South Warwickshire CCG • NHS Warwickshire North CCG

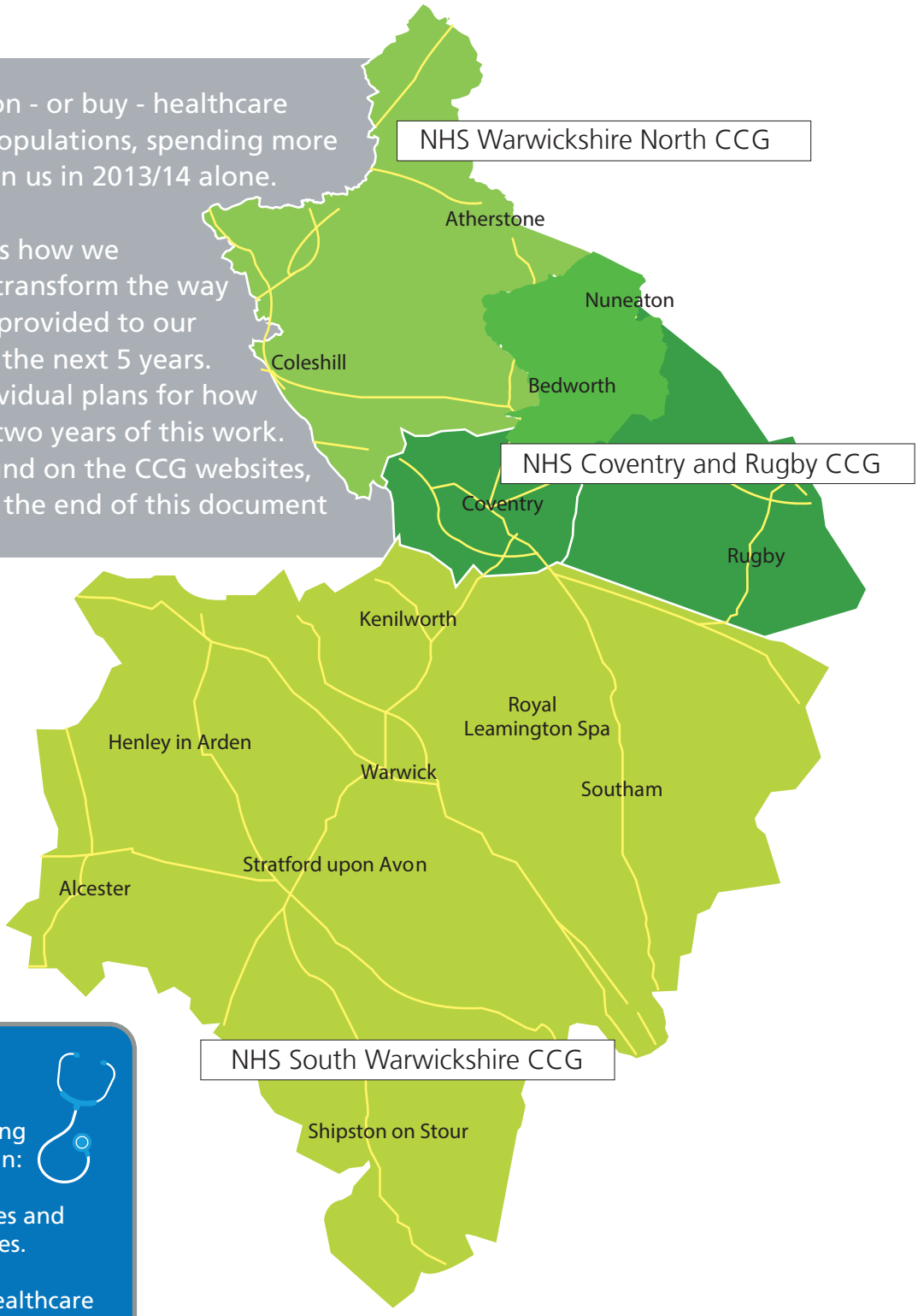
About us

There are three Clinical Commissioning Groups (CCGs) in Coventry and Warwickshire:

NHS Coventry and Rugby CCG • NHS South Warwickshire CCG • NHS Warwickshire North CCG

As CCGs, we commission - or buy - healthcare services for our local populations, spending more than £1 billion between us in 2013/14 alone.

This document explains how we will work together to transform the way in which healthcare is provided to our local populations over the next 5 years. Each CCG also has individual plans for how it will deliver the first two years of this work. These plans can be found on the CCG websites, details of which are at the end of this document



Glossary:

When you see the following words or phrases, we mean:

Primary care: GP practices and their teams and pharmacies.

Community services: healthcare provided in the community such as district nursing, podiatry, health visiting and physiotherapy.

Our services

Across Coventry and Warwickshire, our local health and care services are provided in a number of different ways:

Our challenges

As local CCGs, we have identified a number of challenges to address together to deliver improved health and wellbeing to our local populations. The key areas are explained below:

Our populations' needs

We face many health challenges across Coventry and Warwickshire:

Our population is expected to continue to grow between now and 2021, with the greatest percentage growth to be seen in Coventry (15%), closely followed by Rugby Borough (11.1%) and Stratford upon Avon District (9.5%).

- In Warwickshire, our population is ageing and more people are living for longer with long term medical conditions. The county currently has approximately 13,356 people aged over 85, and by 2021 this group is expected to grow by 42%.

- We have a mix of urban and rural populations, 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%.

- In Coventry there is a high ethnically diverse population, with 33% of the city's residents coming from minority ethnic communities compared to 20% for England as a whole.

- There is a large gap in life expectancy between the richest and poorest areas of both Coventry and the county of Warwickshire.

Our growing and ageing population means increasing pressure on health and social care services. More people are likely to suffer from long term physical and mental health problems such as heart disease, high blood pressure and dementia. People living with multiple health conditions will become the norm. This trend brings with it poorer quality of life, higher hospital admissions and increased mortality.

It is clear that as three CCGs, we have diverse populations and our diversity will continue to grow. We will need to commission services for our local population that are flexible and can respond to this diversity and the changing needs of our population, with more services provided closer to the patients' homes. We are committed to tackling the challenges that come with an ageing population and to improving the quality of life for those with long term conditions.

Our finances

Nationally, the public sector is facing an unprecedented challenge to operate more efficiently. Locally, we will need to make significant changes to improve services, meet rising demand, keep services safe and ensure that they are affordable in the long term.

In 2014/15, we as CCGs are responsible for spending £1,044 million across Coventry and Warwickshire.

Our challenge is that our health services are not affordable in their current form in the longer term. We need to work together with our local healthcare providers to transform local services so that we can maintain and improve the quality of services, changing them to meet the developing needs of our population, and do this within a challenging financial environment.

Our changing health services

We are extremely proud of our local NHS Trusts and the huge contribution they make to the health and care of our local populations. However, local Trusts are themselves facing challenges including:

- A national drive to achieve NHS foundation trust status (only NHS South Warwickshire Foundation Trust has achieved this to date) which changes the way hospitals work and their relationship with the communities they serve.
- A workforce with an older age profile. Many local clinicians are approaching retirement over the next few years and there are not enough new doctors and nurses to take their place
- Clinicians are wishing to work in increasingly specialist areas, rather than in a general hospital setting.

These challenges mean we need to adapt the way we provide hospital services, to ensure services are sustainable.

Our vision

We have committed to improving the lives of our local populations through transforming our local health and social care services.

Through this transformation we must continue to provide the care that our populations need, whilst taking account of the challenges we face.

The principles of our approach to transformation are:

- Care closer to home
- Specialist care in the right place, at the right time
- Enable patients to live the lives they choose
- Clinicians from across health and social care working together
- Use of innovative practice and technology to deliver care
- Care delivered within a financially sustainable system
- Mental disorders are treated on par with physical disorders.

Our ambitions

The challenges we have described and our vision for transforming healthcare will allow us to achieve a number of ambitions to improve the health of our populations and patients' experience of our services. By involving patients and the public, we aim to:

Increase life expectancy - by tackling specific health conditions for certain age groups, we will be able to improve life expectancy amongst local people.

Improve the quality of life for people with multiple long-term conditions - by changing the way we provide care to these patients and ensuring consistency of care across the area, we aim to improve patients' health and their quality of life.

Reduce the amount of time people unnecessarily spend in hospital - by putting care plans in place to support patients with certain health conditions, we will prevent them needing to be admitted to hospital.

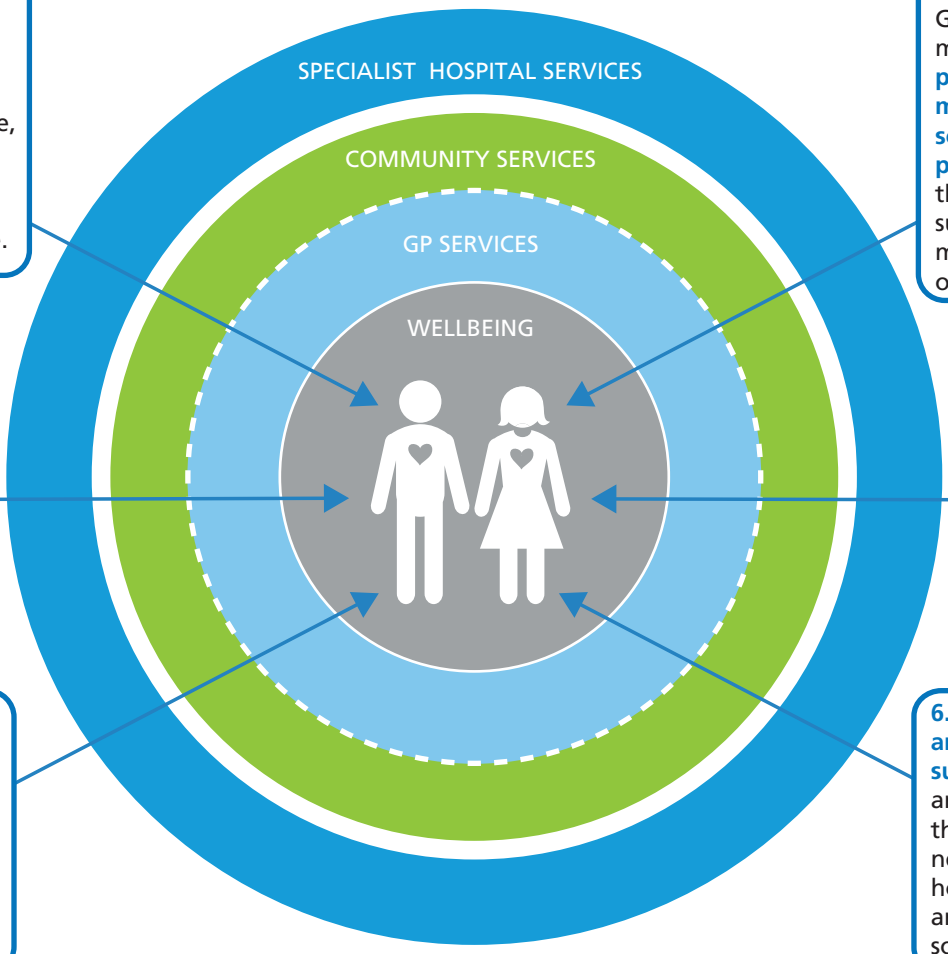
Give more people a positive experience of hospital care - by improving patient experience of hospital care, we hope to increase positive feedback about our hospital services.

Give more people a positive experience of care outside hospital - by improving the experience our patients have of services in the community, we hope to increase positive feedback about these services.

We will ensure that improvements in these areas are measurable and have specific targets in place for each ambition.

Our future model of care

Our future model of care is built around the needs of the patient population, providing support for individuals to look after their own health and wellbeing, whilst improving access to services that are closer to home, backed up by smaller-scale, specialist hospital services. This is described in the diagram below:



1. Patients in control. Patients manage their own care, where possible, whilst maintaining their independence.

2. Communities and individuals take responsibility for their health and wellbeing, with the support of voluntary organisations where required.

3. GP practices will lead on coordinating care for an individual, coordinating primary and community services.

4. Community services are centred around GP practices, meeting the **physical, mental and social needs of people** when they need more support to manage their own care.

5. Fewer services at hospitals as more care is provided closer to home, efficiency in hospitals is improved and there is better self-care in the community.

6. Services that are not clinically sustainable are provided through a network of hospitals or another solution.

7. Patients experience a seamless transition between services due to improved communication, better use of technology and better care planning.

Our work programme

In order to turn our vision into reality, we will establish six programmes of work. We are committed to working in partnership and are determined that the patient and public voice is heard throughout our transformation programme.

1. Enabling patients to manage their own health

- Health and wellbeing will become everyone's responsibility. We will develop ways to support people in taking responsibility for their own health, empowering them to care for themselves at home, where appropriate and to make lifestyle choices to prevent ill-health.
- We will help patients to manage their own long term conditions, without unnecessary hospital care.

2. The future of primary care

- The majority of healthcare will be delivered out of hospital and close to people's homes.
- Primary care teams will guide and coordinate a patient's care at every stage. Professionals from across health and social care will work together to provide care that is tailored to the individual needs of the patient.
- By working together we will keep people healthy and happy in their own homes and communities for as long as possible. This approach means going into hospital or being admitted to a care home should be planned and in line with a patient's needs.

3. Integrating health and social care

- Clinicians and professionals will work together as one team across health and social care, with services available seven days a week. This will reduce duplication and ensure a patient's care is coordinated more effectively. The patient's experience should be of a seamless transition throughout their care.

4. Urgent and emergency care

- By changing the way care is provided in the community, the majority of health conditions will be treated out of hospital. Therefore, people will only use urgent and emergency care services when necessary.
- This approach will allow emergency care services to focused on providing high quality services to treat more complex health conditions in hospital.

5. Improving planned hospital care

- We will improve our processes and use technology to ensure people are seen by the right clinician, at the right time. Where possible, care will be provided in the community.
- Specialised services will be offered in small number of hospitals, to provide safe, effective services whilst ensuring there is sufficient capacity to meet demand for these services.

6. Value and efficiency

- We will work to ensure that our services are run efficiently and that services provide value for money.
- We will support competition amongst healthcare providers, offering patients choice and encouraging improvements in the quality of services which meet local needs.

Next steps

We have committed to improving the lives of our local populations through transforming our local health and care services.

As we move this work forward, we will:

- Be transparent and accountable throughout our work
- Involve patients and the public at every stage
- Work in partnership across health and social care
- Aim to meet the health needs of our populations
- Improve the quality and sustainability of services

Contact us

We are interested in your views on our plans or from hearing from you if you are interested in being actively involved in this work. Get in touch with your local CCG using the contacts details below:

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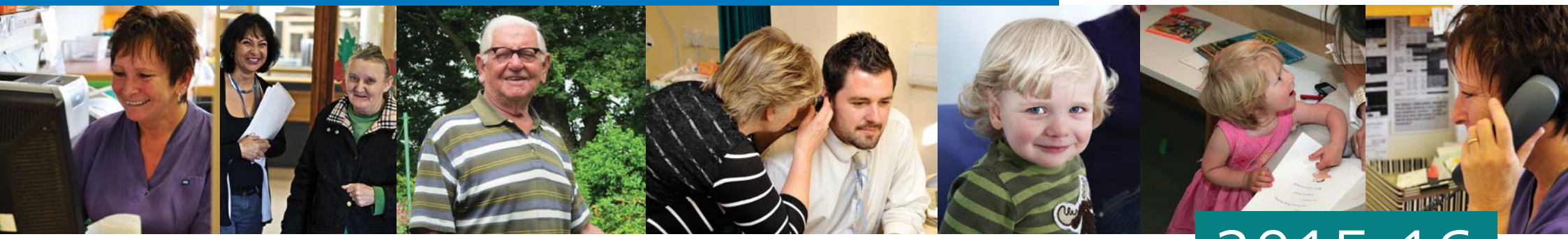
Item 7

NHS
South Warwickshire
Clinical Commissioning Group

Commissioning Intentions



2015-16

better healthcare for everyone

1 Introduction

This commissioning intentions document contains a summary of the initiatives that the CCG plans to deliver over the next 12 to 18 months, and which will result in improvements to the services that you, as patients, access in the forthcoming year. The document deliberately does not cover all of the initiatives, projects and changes that the CCG is planning – a process that is ongoing – but instead summarises the initiatives that are 'good to go' and require changes to our contracts or the way in which providers deliver services in 2015/16.

Who we are

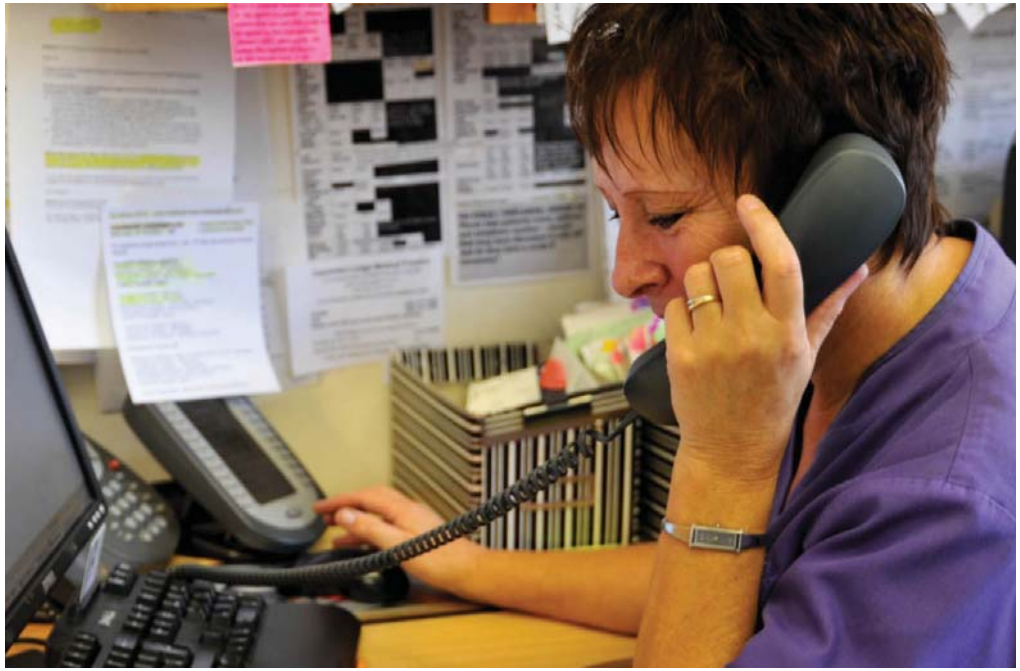
NHS South Warwickshire Clinical Commissioning Group (CCG) came into full operation in April 2013.

The CCG is made up of 36 GP practices and covers a population of 271,000 people over the geographical area of Warwick and Stratford-upon-Avon districts. GPs from each practice – as the people closest to dealing with people's healthcare needs on a daily basis – are responsible for leading the CCG and making sure that everything we do provides real benefit to the public.

We receive a set amount of money each year from the government (nearly £300 million in 2013/14). This is used to buy hospital and other services for patients.

Our responsibilities include commissioning ('planning' and 'buying') services from partner organisations such as NHS South Warwickshire Foundation Trust (SWFT), for acute and community services and Coventry and Warwickshire Partnership Trust (CWPT), for mental health and learning disability services. We also work closely with NHS England who directly commission primary care, specialised services, military and offender health services, to ensure local needs are taken into account at all times.

We work in partnership with Warwickshire County Council to ensure health (including Public Health services) and social care services are joined up, and we deal with other groups such as charities, education providers and community organisations to make sure that as many people as possible have their voices heard.



2 What we do

Our vision is:

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

To deliver this we consult with GP practices and the public, identify areas for improvement and take on board the key needs of local people in order to deliver the four aims that guide us as an organisation:

- To build relationships with patients and our communities;
- To improve health and reduce health inequalities;
- To improve the quality of care and transform services;
- To make the best use of our resources.

How we do it

NHS England issued guidance in December 2013 that outlined a planning process for two and five years. As a result of this, we produced two key documents that provide the context for the commissioning intentions contained in this document.

The first of these documents is called Transformational Change: Transforming Lives. This document describes the joint vision for services that we have developed with Coventry and Rugby CCG and Warwickshire North CCG.

The document explains what we want to achieve over the next five years, both collectively and individually. This document draws on our Integrated Plan 2013–16, which remains our principal planning document as we enter 2015/16. Transformational Change: Transforming Lives simply describes the end point more clearly.

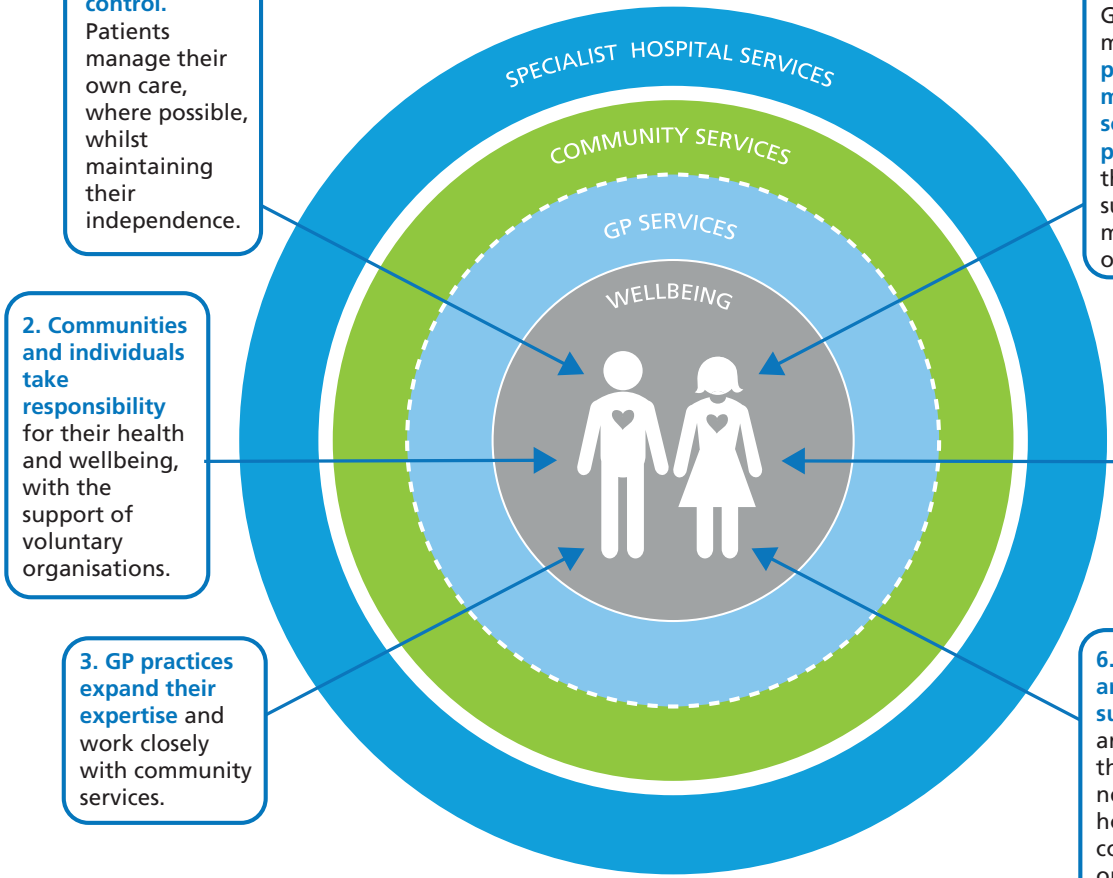
We were also required to produce a Two-year Operating Plan: 2014–16. This document describes what we are going to do to deliver the changes described in Transformational Change: Transforming Lives in more detail and at a south Warwickshire level.

In doing this we were able to describe in detail the impact of our commissioning activities on our providers; this, in turn, gave them the opportunity to plan and prepare for the changes we envisage for south Warwickshire over the next two years.

Central to Transformational Change: Transforming Lives and the Two-year Operating Plan: 2014–16 is the Better Care Fund (BCF). The BCF aims to drive greater integration between health and social care, with a single pooled budget enabling health and social care services to undertake more collaborative commissioning.

3 5 year stategy

The diagram below summarises the 5 year vision for services across Coventry and Warwickshire



1. Patients in control. Patients manage their own care, where possible, whilst maintaining their independence.

2. Communities and individuals take responsibility for their health and wellbeing, with the support of voluntary organisations.

3. GP practices expand their expertise and work closely with community services.

4. Community services are centred around GP practices, meeting the **physical, mental and social needs of people** when they need more support to manage their own care.

5. Fewer services at hospitals as more care is provided closer to home and there is better self-care in the community.

6. Services that are not clinically sustainable are provided through a network of hospitals or consolidated on one hospital site.

7. Patients experience a seamless transition between services due to improved communication, better use of technology and better care planning.

4 Our challenges

During 2015/16 we will require providers to start making changes to the way they deliver services, which will lead us towards our vision for services across Coventry and Warwickshire.

We recognise the challenge that this poses for healthcare providers but it is impossible to keep on providing health services as we do now in the long term, and so we must keep working closely with our providers to transform services, make them safer, more efficient and effective, and to develop flexibility to meet changing needs. All this has to be done on very tight budgets (in real terms our budget for 2015/16 will actually be less than 2014/15), and so it is essential we make every penny count.

The most significant change we want to make during 2015/16 is the shift to care that is more planned. The work undertaken by our member practices on the Proactive Care Programme and Accountable GP for the over 75s in 2014/15 puts us in a strong position to make this real. This means that patients who need co-ordinated care will be systematically identified and supported by a team of professionals who will ensure that the patient is in control of their own care and has a single point of contact. Providers will need to ensure that they are able to support our GPs to deliver team-based care.

We also want to make significant progress in ensuring that people feel equipped to self-manage their care. Many people are in regular contact with our healthcare providers and we therefore need providers to support people by equipping them with the support and knowledge to be effective at self-management. Providers also need to demonstrate progress in Putting Patients in Control.

Our challenges

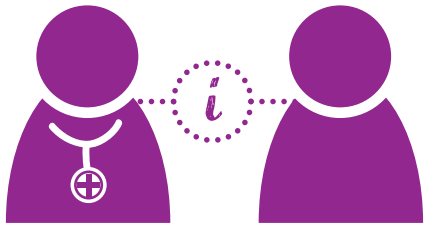
In order to improve health outcomes overall and reduce the inequalities in health outcomes of those with mental health needs and learning disabilities, healthcare providers will need to demonstrate how they give equal weighting to mental and physical health.

Equally, those individuals with physical long-term conditions often have unidentified mental health needs that healthcare providers must identify and address.

There is still a need to focus on issues that remain a challenge to us and indeed the wider NHS. As an example, delivery of the NHS Constitution remains absolutely essential and we will continue to work closely with all providers to ensure they are best placed to help achieve this.

We recognise the significant progress that has been made on seven-day services but we have not completed the journey. All too often patients experience a different service at the weekend or at night, and we want this to be resolved.

The move to seven-day working has also highlighted the importance of good information sharing systems. While some aspects of information sharing work well there is too much variation in the quality and timeliness of the transfer of clinical information between clinicians, and between clinicians and patients. Developing robust information sharing systems is an absolute must for providers in 2015/16.



5 Our 2015/16 Commissioning Intentions...

...and how we will achieve them

The table on the following pages show the improvements we are planning to make in 2015/16. These have been mapped against our 4 aims, 12 objectives and the 6 programmes that underpin the Transformational Change: Transforming Live's Document.

It must be stressed that these plans are simply a summary of the work that is 'good to go' over the next 12 months or so. The process of planning and improving services is ongoing, with plans for the next five years or so contained in the key documents already mentioned. This commissioning intentions document deliberately does not cover all of those initiatives, but instead summarises the parts ready to be delivered and that need our providers to respond to.

6 Our Commissioning Intentions

Aim	Objectives	How we will achieve it	Specific improvements
To build relationships with patients and our communities	**Primary care is able to provide the flexibility and expertise that people want**	**Primary Care at scale** • We are working in partnership with the AHW Area team to expand primary care expertise so that more care is delivered in a person's home or a GP surgery; • Consultants will support GPs through education, training and advice; • Primary care providers will collaborate with each other and other parts of the health and social care system (with GPs as the coordinator) to provide more 7-day services (where relevant), with emphasis placed on prevention of ill health, better management of chronic and long-term conditions, enhanced self-care and early intervention; • Individuals with learning difficulties or mental health issues will have greater focus placed on their physical health, while those with long-term conditions will be managed in a way that better supports their mental health; • Full use will be made of the opportunities to work differently and the benefits of Telemedicine will be harnessed.	• There will be a reduction in the number of outpatient appointments in secondary care following the implementation of Diabetes Super 6; • There will be a reduction in the number of patients requiring appointments with mental health services for a diagnosis of dementia as a consequence of an improved pathway that will allow a diagnosis to be made for the majority of patients in primary care; • Providers (SWFT, CWPT and Social Care teams) need to be operationally ready to support groups of practices to deliver care co-ordination; • A new ADHD pathway for young people in transition and newly presenting adults will allow GPs to manage individuals locally. We will therefore need to engage in a dialogue with CWPT about the implementation and resource implications; • We want our member practices to have increased the use of direct access diagnostics to support the management of patients on heart failure, dementia, anaemia and DVT pathways. Providers need to be able to be able to be able to operationalise the increased capacity required for the relevant diagnostic modalities; • We will continue our 'improving primary care quality' programme aimed at reducing the variations in primary care provision across practices and improving overall quality; • During 2015/16 we will conclude the process for re-commissioning of Out of Hours Services. Providers will need to respond to any system changes that may occur as a result of this process.

Our Commissioning Intentions

Aim	Objectives	How we will achieve it	Specific improvements
To improve health and reduce health inequalities	People are able to work with us to co-produce services People remain independent and manage their own care needs Improve health and reduce health inequalities by supporting people to make healthy lifestyle choices for themselves and their children People who are socially isolated are supported to engage with their local community	**Building community resilience and ownership** • Local communities and individuals will take responsibility for the health and wellbeing of the local population through the support of voluntary organisations and community groups; • The patient voice will be demonstrated in all of our commissioning decisions.	• All pregnant women, regardless of location, will be carbon monoxide screened at booking (KPI 95%) and at 36 weeks (KPI 95%) and provider are expected to record this electronically; • Every woman identified as a smoker will be given brief advice, including how to maintain a smoke free home, and referred to the Stop Smoking Service unless they opt out (KPI 95%); • Midwifery Services to send referrals to the Stop Smoking Service within 48 working hours (KPI 90%); • Secondary care services should ensure that women accessing inpatient maternity services have easy and immediate access to a full range of NRT products at all times (KPI percentage of identified smokers offered NRT on admission 90%); • Every appointment with a pregnant woman undertaken by allied services such as youth service, health visitors, children's centre staff, and priority families workers should be considered as an opportunity to discuss the risks of smoking in pregnancy and to make a referral (MECC KPIs apply); • A Senior Lead for tobacco control should be identified within each hospital setting. The role to be based on NICE Guidance PH 48 recommendation 10; • KPI Identified Lead and annual report to Trust Board; • All provider trusts will have a named MECC and 5 Ways to Wellbeing champion in each clinical area/ nursing team; • Each provider has a clear action plan to roll out MECC and 5 Ways to Wellbeing; • 100% of frontline staff are MECC and 5 Ways to Wellbeing trained by March 2016; • Achievement of 10% increase year on year in frontline staff flu immunisations; • BFI stage 3 achieved by December 2015 by all maternity providers; • 75% breast feeding initiation achieved by September 2015; • Signpost all people who meet the health criteria to exercise on referral; • ALL maternity providers to have a maternal obesity pathway implemented from April 2015;

Our Commissioning Intentions

Aim	Objectives	How we will achieve it	Specific improvements
To improve the quality of care and transform services			• Personal health budgets will give patients and the clinical teams working with them greater flexibility in meeting their healthcare needs; • Dementia navigators will support GPs to provide a greater level of support to patients and their carers in the post-diagnostic period; • We are seeking to commission improved Maternal Mental Health services in order to maximise the outcome for mothers and their babies in cases of post-natal depression. Providers will need to collaborate with each other to redesign services; • Providers and the voluntary sector need to develop systems and processes that allow them to work collaboratively to support care-coordination.
	Ensure that both the physical and mental health needs of people are addressed equitably	**Commission an integrated out-of-hospital service** • Building on the improvements to primary care and through increased collaboration with social care (via the BCF), we will develop a new service model that will meet the physical, mental and social needs of local people	• From September 2015 onwards a new CAHMS service will be in place that integrates levels 1–3 and incentivises early intervention – joint commissioning arrangements will be put in place and a new specification developed. Providers need to be aware of this development. We will engage and communicate progress throughout and formally write to providers at the appropriate time to notify any changes to contracts; • The Warwickshire Autism Strategy will be implemented, underpinned by a new diagnostic pathway that CWPT will implement; • We are keen to expand the Clinical Review Team (repatriation and review programme) to cover Learning disability and would like to enter into a dialogue with CWPT about the implications of this; • Providers need to ensure that looked after children receive well co-ordinated care that meets their needs; • Providers will need to be able to respond to the requirements of the SEND reforms from the 1st April. We will be reviewing the services available for children with complex needs (SEND) and considering the options for more integrated services. We will engage providers in this process and we will formally notify providers of any contractual changes at the appropriate time; • We require providers to work with primary care to develop systems and processes that support co-ordinated care; this will specifically require IT infrastructure development;
	Where people need support to manage their care, ensure that the care system responds in a co-ordinated way		

Our Commissioning Intentions

Aim	Objectives	How we will achieve it	Specific improvements
			• We will roll the community contract over for one more year. During this year we will undertake the process for the re-commissioning of community services. Existing providers will be required to provide us with the data required for us to undertake this process. This process is central to our work with Warwickshire County Council on the Better Care Fund. Existing and potential providers will be invited to engage in the process. We will formally notify providers of any contractual changes at the appropriate time; • In collaboration with Warwickshire County Council there will be changes to care home contracts to ensure that this part of our system supports the delivery of care outside the hospital; • We will undertake CHC and FNC regular clinical reviews in accordance with national framework timescales; • Providers are required to deliver a programme of work to ensure that information received in primary care is accurate and timely; • We will conclude the process for re-commissioning of NHS 111. Providers will need to respond to any system changes that may occur as a result of this process.
To make the best use of our resources	**People will receive the same response from the care system 24/7** **People will be confident that their care is safe and will feel that they have been treated with respect and dignity**	**Access to the highest quality care** • Commissioned services will deliver high-quality, safe, effective, consistent care 7 days a week; • Services will be systematically reviewed to ensure they are meeting standards and outcomes expected; • We have supported the national strategy for specialised services by developing local services that concentrate on centres of excellence for those services.	• We are currently developing options for the recommissioning of cardiac and pulmonary rehab, we anticipate that changes will be required to contracts during 2014/15 and that formal notification of change will be made at the appropriate time; • We are reviewing domiciliary phlebotomy services in order to improve the experience for patients. Formal notification of change will be made at the appropriate time; • The process to re-commission stroke services is underway and we will work with providers and patients to identify the best solution for Coventry and Warwickshire; • Providers will work with each other and the CCG to deliver improved access to local services in response to the Winterbourne Review.

Our Commissioning Intentions

Aim	Objectives	How we will achieve it	Specific improvements
To make the best use of our resources	**People will receive care that is evidence based and contributes to the improvement outcome they have agreed with professionals** **People will experience less duplication and waiting because of more efficient processes**	**Elective Productivity** • People undergoing elective procedures will be confident that they will benefit from improved clinical outcomes, that the procedure is safe and that each contact they have with the system will contribute to better health.	• Following a review of IAPT services, we will work with providers to improve access rates; • We will continue reviewing the referral patterns of our member GP practices to address variations in referral rates and we therefore expect the growth in GP referrals to remain at a similar level to our current contracted activity; • Increased Choose and Book utilisation remains a priority and we need providers to be able to respond to increase usage in primary care.
	People will have confidence that the CCG uses public money wisely and is in control of its finances	**Market management** • We will drive efficiency, effectiveness and value for money by managing contracts robustly; • We will maximize procurement opportunities and develop providers so that they can respond to our commissioning activities.	• Providers will adhere to NICE Technology Appraisals; • Providers will be required to adhere to a revised Patient Transport Service eligibility criteria.

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Item 8

Warwickshire Health and Wellbeing Board

22 September 2014

Warwickshire Health and Wellbeing Strategy: Update on Progress and Consultation

Recommendation(s)

1. Note the consultation process for the Health and Wellbeing Strategy
2. Consider the progress made to date on the Health and Wellbeing Strategy
3. Take part in the consultation process by feeding back on the Health and Wellbeing Strategy via the consultation documents

1.0 Key Issues

1.1 Background

The Health and Wellbeing Strategy provides Warwickshire with a picture of what the Health and Wellbeing Board will need to deliver over the next 5 years and how we will work together to achieve this. In July 2014, the Health and Wellbeing Board agreed on the approach to the review of the Strategy and on the proposed three priorities, as follows:

Priority 1: Promoting Independence
Priority 2: Community Resilience
Priority 3: Integration and Working Together

1.2 Current progress

Since May 2014, Public Health has been conducting in depth evidence reviews around the three priorities, to ensure that the Strategy is supported by robust and upto date national and local guidance.

It has been agreed that the Strategy will need to detail how it will be implemented and how its outcomes will measured. The Strategy will also make explicit links to relevant national guidance and emerging issues, particularly around the Better Care Fund and the Care Act.

1.3 Consultation activity

The Health and Wellbeing Strategy consultation process involves a two-step process. An initial consultation with members of the Health and Wellbeing Board members and active observers was undertaken in June 2014. A copy of the pre-consultation summary can be obtained by contacting the report authors.

The second stage is now underway - a full public and stakeholder consultation on the published draft strategy including a questionnaire conducted in line with the Warwickshire County Council engagement protocols. This includes general questions on the draft strategy, as well as specific questions on each topic area.

A workshop for Health and Wellbeing Board members and key stakeholders was held on 1st September 2014. The purpose of the workshop was to:

- receive early feedback and discussions from Health and Wellbeing Board members and active observers
- engage with partners on the review of the Performance Indicators that the Health and Wellbeing Board agreed over the last year and if there are any amendments required to tie in with the revised Health and Wellbeing Strategy
- commence discussions on how the Health and Wellbeing Board and its partners will provide performance and delivery updates against the revised Health and Wellbeing Strategy.

2.0 Implications for Board Members/Partner Organisations

2.1 Recipients are asked to disseminate within their organisation and identify a mechanism to raise awareness of the draft Strategy provide (organisational) feedback.

2.2 Feedback is also requested regarding the 2 appendices of the Draft Strategy – regarding the current performance indicators and action plan reporting tool.

3.0 Timescales associated with the decision and next steps

3.1 The draft Health and Wellbeing Strategy is being circulated for consultation from 18th August to last for a period of 6 weeks.

3.2 The outputs from the 1st September workshop will be able to be discussed as part of this report.

3.3 An Equality Impact Assessment for the Strategy is being undertaken.

3.4 The Health and Wellbeing Board will receive the final Health and Wellbeing Strategy on the 19th November 2014.

4.0 Background Papers

None.

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DRAFT Warwickshire Health and Wellbeing Strategy 2014 - 2018

Warwickshire Health and Wellbeing Board

Contents

Introduction

Maintaining health and wellbeing enables individuals to maximise their potential, lead active, fulfilled lives and participate fully in their community.

What is the Health and Wellbeing Board?

The Warwickshire Health and Wellbeing Board provides a countywide approach to improving local health and social care, public health and community services so that patients, service-users and the public experience more 'joined up' care. The Health and Wellbeing Board is also responsible for leading locally on tackling health inequalities.

The Health and Wellbeing Board is a forum for councillors, commissioners and communities to work with wider partners to address the determinants of health, reduce health inequalities and strengthen our communities. One of the key benefits of Health and Wellbeing Boards is to increase the influence of local people in shaping services by involving democratically elected councillors and through Healthwatch, so that services can better meet local need, improve the experience of service users, and improve the outcomes for individuals and communities[1].

What is the Purpose of a Health and Wellbeing Strategy?

Looking after the health and wellbeing of the population of Warwickshire is not the responsibility of one single body. Statutory and non-statutory organisations, including the voluntary sector, across the county all play a part in impacting on our health and wellbeing and influencing our behaviour.

The Health and Wellbeing Strategy provides Warwickshire – residents and organisations – with a picture of what the Health and Wellbeing Board (its members and wider partners) will need to deliver over the next 5 years and how we will work together to achieve this.

The Warwickshire Health and Wellbeing Board has agreed three priorities that will inform how we will work together, develop actions and report on our progress on improving the health and wellbeing of Warwickshire.

The Health and Wellbeing Strategy Priorities are:

[1] Joint Strategic Needs Assessment and joint health and wellbeing strategies explained

How does the Health and Wellbeing Strategy link with other responsibilities and requirements?

Warwickshire's Health and Wellbeing Strategy does not sit in isolation. We need to be aware of other priorities, legislation and documents that need to be addressed alongside this Strategy. Current key policy areas are:

1: Warwickshire's Joint Strategic Needs Assessment

Warwickshire's JSNA is a vital tool which brings together a range of high quality evidence and local information, local assessments and data to identify local priority groups across the county.

The JSNA highlights who, what and where Warwickshire's priority groups are in relation to health and social care need. The Health and Wellbeing Strategy identifies how we are going to deliver our services differently so that the needs of the identified priority groups are able to be met.

The Health and Wellbeing Board uses the JSNA to make collaborative decisions on how best to meet the needs of the priority groups, through joined up, integrated and appropriate services and by tackling the wider, or social, determinants of health. The JSNA and the Health and Wellbeing Strategy enable everyone to understand the factors that influence services in their area.

This Health and Wellbeing Strategy will not repeat the findings within the JSNA.

2: Better Care Fund

The Better Care Fund was announced by the Government in June 2013 to ensure a transformation in integrated health and social care. The Better Care Fund (BCF) is one of the most ambitious ever programmes across the NHS and Local Government. It creates a local single pooled budget to encourage the NHS and local government to work more closely together around people, placing their well-being as the focus of health and care services.

The BCF is a critical part of the NHS 2 year operational plans and the 5 year strategic plans as well as local government planning.

Warwickshire is committed to integrated working and will use the opportunities that BCF brings to increase the pace and priority that organisations give to delivering better integrated services.

Source: **Better Care Fund**

3: The Care Act and The Children's and Families Act

There are recent policy changes that will affect the lives of young people with Special Educational Needs (SEN), disabled young people and their families, and will impact on the range and quality of support available to them as they prepare for adulthood. The two pieces of legislation that have the greatest influence on support for disabled young people preparing for adulthood are Part 3 of the Children and Families Act 2014, which focuses on Special Educational Needs and Disability and Part 1 of the Care Act, which focuses on the care and support of adults with care and support needs.

Importantly, the Children and Families Act 2014 introduces a system of support which extends from birth to 25, while the Care Act deals with adult social care for anyone over the age of 18. This means there will be a group of young people aged 18-25 who will be entitled to support though both pieces of legislation. The two Acts also have the same emphasis on outcomes, personalisation, and the integration of services. It is therefore essential that the planning and implementation of both of these Acts is joined up at a local level in Warwickshire.

Source: **Factsheet: The Children and Families Act and The Care Act**

4: Information and Data Sharing

Sharing appropriate information enables those involved in providing health, care and community services to improve the quality of services for all. It is important to get a complete picture of what is happening across services to plan according to what works best.

The type of information shared, and how it is shared, is controlled by law and strict confidentiality rules.

Sharing information about the care provided helps us to understand the health and wellbeing needs of everyone and the quality of the treatment and care provided and reduce inequalities in the care provided.

There is a commitment within Warwickshire to further improve appropriate, safe and relevant data sharing.

Source: **Your records – Better information means better care**

What Happens Next?

The Warwickshire Health and Wellbeing Strategy identifies the Board's agreed priorities for the next 5 years. It is now for each partner organisation on the Health and Wellbeing Board to develop its own plans of how they will contribute to the delivery of these priorities and it is important that these plans are developed and shared with provider organisations and the voluntary and community sector.

Organisations across the county should be identifying opportunities in their locality, in the services that they commission and in their own strategies on how they can add value and focus on the priorities that have been agreed by the Health and Wellbeing Board.

Monitoring and Progress

We will measure our progress by focusing on the impact that the strategy will have on people's lives. We have chosen a number of indicators (appendix 1) that will help us measure our progress over the lifetime of this Strategy.

The Warwickshire Health and Wellbeing Board acknowledges that major change will not happen overnight, so we will be seeking gradual improvements in these indicators.

Warwickshire's Health and Wellbeing Board will review progress with:

- Regular locality performance updates at a District and Borough level
- Local reports at a CCG level
- An annual review to the Health and Wellbeing Board
- Submission of action plans to Warwickshire Overview and Scrutiny Committees

The Health and Wellbeing Strategy makes a difference by:-

- The Strategy provides clarity for public, community and voluntary sector providers of the Warwickshire Health and Wellbeing Board's priorities for its delivery of health and wellbeing across the county
- Providing a framework for organisations to use when commissioning, redesigning and decommissioning services
- Enabling Warwickshire to use existing assets and resources of partners, including workforce, communities and information to reshape services
- Influencing the wider determinants of health and wellbeing through joint working across the county.

Priority 1 – Promoting Independence for all

1.1 Definition

Independence can mean different things to different people, depending on their level of need and their individual situation. In Warwickshire, 'promoting independence' is considered an important concept across the life course starting out with babies and young children, running throughout adulthood and into old age. We believe that independence should be encouraged as part of all these events, roles and transitions in order to prevent ill health, disability and dependence on services throughout life.

We believe that promoting independence means….

- Providing a strong start in life, within a family environment, to enable babies and children to develop healthily and flourish in their learning and education
- Ensuring young people are prepared and supported to make successful transitions from care into independent living
- Enabling all people to manage and maintain their physical and mental health and wellbeing
- Ensuring all disabled people have the same choice, control and freedom as any other citizen – at home, at work and as members of the community
- Enabling older people to be able to remain in their own home and to live healthy active lives for as long as possible
- Keeping or improving physical and cognitive function to fulfil the tasks of independent living, maintaining social connections, and allowing people to have choice and control over how they live their lives.

1.2 Evidence Base – why is promoting independence important?

What happens to **babies and children** before they are born and in their early years (starting in the womb) has lifelong effects on many aspects of health and wellbeing– from obesity, heart disease and mental health, to educational achievement and economic status[2]. We know from the Warwickshire JSNA that vulnerable young people are a priority group and therefore we will work with families to give them the support and early help they need to nurture their children and provide them with the skills to become independent in their later life.

A particularly vulnerable group are **Looked After Children** (LAC) and as a consequence of their life experiences, outcomes for LAC are traditionally poorer than non-looked after children. Care leavers are more likely to have poor educational performance, contact with the criminal justice system, poorer health and be vulnerable to homelessness and unemployment. Some care leavers cope well, but require support on the path to independence[3]. In Warwickshire, we believe that focusing on care leavers and their

[2] Waldfogel J (2004) Social mobility, life chances, and the early years, CASE Paper 88, London: London School of Economics.
[3] National Children's Bureau, Supporting care leavers' successful transition to independent living [online] available from http://www.princes-trust.org.uk/pdf/NCB_RSCH_9_FINAL_FOR_WEB.pdf (07/08/2014)

transition to adulthood and independence will help prevent negative experiences and crises later on in adulthood.

One of the key features of independence is providing the tools and the information to enable people, of all ages, to manage and maintain their **physical and mental health and wellbeing**. However, although most of us know some of the everyday things we can do to improve our own health and wellbeing, some people are not able to make health decisions or struggle to adopt healthy behaviours. In Warwickshire, we aim to help people and communities gain control over the influences on their health, making the healthier choices the easiest choices. We will take pro-active steps to enable and encourage people in all age groups to have an active and healthy lifestyle, particularly those who are at higher risk of ill health.

A disability is a condition which affects an individual's ability to undertake everyday activities and may affect a person's sensory, mobility or mental function. There are estimated to be 85,000 **disabled people** living in Warwickshire - 19% of the population aged over 16. In Warwickshire, we believe that all disabled people should have the same choice, control and freedom as any other citizen – at home, at work and as members of the community. Through personalisation, disabled people should be enabled to live fully independent lives, putting them at the centre of their care. We will ensure that people have wider choice in how their needs are met and are able to access universal services such as transport, leisure and education, housing, health and opportunities for employment, regardless of age or disability.

In Warwickshire, we believe that there needs to be a fundamental shift in the way we think about **older people**, from dependency and deficit towards reablement, independence and wellbeing. The challenge for us all is to be inclusive, to help older people to stay healthy and active and to encourage their contribution to the community. Across Warwickshire as a whole, the highest rates of projected population growth are in the groups aged 65 years and over[4]. This means that there is the potential for a significant increase in the numbers of people accessing health, social care and community services in the years to come and resources will have to be used differently to provide more responsive and integrated health and social care services. For some older people, independence and wellbeing can be more difficult to maintain so we need to help the particularly vulnerable older people to manage their health conditions so that they can maintain the aspects of their lives that they value most[5].

[4] 2011-based Sub-National Population Projections, National Statistics (www.statistics.gov.uk), © Crown Copyright 2013.
[5] The Audit Commission, Older people – independence and well-being. The challenge for public services [online] available from http://archive.auditcommission.gov.uk/auditcommission/sitecollectiondocuments/AuditCommissionReports/NationalStudies/OlderPeople_overarch.pdf (13/08/14).

1.3 Our focus

Our focus in Warwickshire will be to…	In five years' time Warwickshire will have…
Ensure the best possible start to life for children, young people and their families.	• Improved maternal and infant health and wellbeing • Positive and resilient parenting and an increase in the number of families receiving early help to tackle problems • A reduction in the local variations between educational attainments • Fewer numbers and proportions of children living in poverty.
Support those young people who are most vulnerable and ensure their transition into adulthood is positive.	• Integrated services across education, health, social care and the voluntary sector which focus on the needs of the most complex and vulnerable children to ensure an effective transition to adult services • More young people remaining in education and training, delaying their entry to the adult labour market • More vulnerable children and young people helped to make positive life choices
Enable people to effectively manage and maintain their physical and mental health and wellbeing.	• More people, across all ages choosing to adopt healthier lifestyles • Enhanced services for the early prevention, treatment of mental health problems across all ages • People will have equitable access to screening and prevention services to help them avoid ill health • Communities that understand dementia issues and support dementia sufferers.
Ensure that people with disabilities have the same choice, control and freedom as any other citizen – at home, at work and as members of the community.	• Improved early assessment of needs for children with SEN, physical and learning disabilities • Better health outcomes and quality of life for people with disabilities through the implementation of personalisation • More people with learning disabilities in paid work • Adequate and appropriate housing for people with disabilities • Better support and information for carers of disabled people to empower them to live the lives they want and achieve their full potential.
Enable older people fulfil the tasks of independent living, maintaining social connections, and allowing people to have choice and control over how they live their lives.	• An increase in preventative interventions for older people which reduce unnecessary hospital admissions for people with long term conditions and co-morbidities. • A focus on reablement of older people to prevent further ill health and promote greater wellbeing • More older people being able to live at home longer and be supported to do so • Integrated services for frail older people with involvement from community health, housing, voluntary support and social care tailored to the needs of the individual • Fewer older people who feel lonely or socially isolated.

Priority 2 – Community Resilience

2.1 Definition

In Warwickshire, we believe community resilience is ***'the ability of communities to deal with and positively adapt to change or long term pressures, and to support themselves by utilising assets[6] to move forward and embrace their full potential'.***

We believe that community resilience means….

- Empowering the public to determine their own needs and support local initiatives
- Giving communities the capacity to identify assets and utilise them
- Having opportunities for a healthy life and taking responsibility for your own health and wellbeing
- Helping to protect communities and helping them to overcome adversity
- Supporting people by providing the right information, advice and signposting to appropriate forms of support that are available within the communities in which they live or work
- Working with communities, commissioners and partnerships to identify where interventions are needed and co-produce local services.

2.2 Evidence base - why is community resilience important?

Resilient and empowered communities respond proactively to new or adverse situations, prepare for change and cope better with crisis and hardship[7]. In Warwickshire we need to prioritise individuals and communities who are the least resilient, as they often experience poorer health and wellbeing and often arise from the difficulties in engaging with local services and the people around them.

The more resilient our people and communities are, the more they are able to support themselves, leading to less demand on public services, including high cost health and social care services. At a time of reducing budgets and tighter financial constraints, it is essential we ensure our services and resources are effective and targeted more efficiently.

Our **mental health** is an important part of our ability to cope with everyday life. Social isolation, unemployment, poor housing, financial worries and relationship problems, can make it harder for people to cope. We must ensure that our communities have good mental health so that they are more able to cope with life pressures. We are committed to supporting them in the areas that often have the greatest impact on mental health including financial worries and having suitable housing.

[6] By asset we mean 'hard' assets such as good transport links, access to services and amenities, local buildings and organisations that enable communities to come together. Also 'soft' assets such as relationships with family, friends, neighbours, colleagues and the support of the wider community.

[7] WHO. www.euro.who.int/en/health-topics/health-policy/health-2020-the-european-policy-for-health-and-well-being/about-health-2020/priority-areas/resilient-communities

Educational attainment is important for longer-term resilience and is closely associated with health and wellbeing throughout life. In Warwickshire our GCSE attainment is above the England average but there is a large gap in attainment between those who receive free school meals and those that do not. Pupils receiving free school meals have a lower educational attainment and will also be experiencing other issues that may also affect their health and wellbeing. We believe that everyone in Warwickshire should be able to achieve the best educational outcome they can and those receiving free school meals should not be disadvantaged.

Being able to **access services and resources** can be an important factor for a community to be resilient. In Warwickshire, approximately a third of our local areas have difficulty accessing key services. Some communities are more socially isolated - young people, older people, those living in rural areas and people with long term health conditions are more likely to report poor access to services. It is important that our infrastructure such as planning and transport and our services across Warwickshire are made available, accessible and targeted to those that need them most.

Social capital, meaning "networks with shared norms, values and understandings that facilitate co-operation within or among groups"[8], is important as greater interaction between people generates a greater sense of community spirit. Research has shown that higher levels of social capital are associated with better health, higher educational achievement, better employment outcomes, and lower crime rates. Across Warwickshire, one in three people responded that they didn't know their neighbours and nearly 39% of respondents felt that they didn't belong very strongly with their surrounding immediate area[9]. We will work with communities and organisations to foster social capital and 'neighbourliness' in our localities, helping to reduce social isolation and loneliness and increase resilience.

A number of national strategies and targets aiming to improve health and wellbeing and reduce health inequalities highlight the importance of **involving local communities**. Only one in three residents across Warwickshire felt that they could influence decisions affecting their local area.[2] Approaches that help communities to work as equal partners (co-production), or which delegate some power to them – or provide them with total control – may lead to more positive health outcomes[10]. We are committed to working with our communities, involving them in local decision making and co-producing services that will improve their health, wellbeing and resilience.

2.3 Our focus

Our focus in Warwickshire will be to…	In five years' time Warwickshire will have…
Increase the resilience and capacity of our communities, enabling them to better support themselves, vulnerable individuals and families.	• Individuals and communities who are more resilient and able to cope with and adapt to pressures • Strong social and community networks will have been developed to support this so that communities are more

[8] OECD. http://www.oecd.org/insights/37966934.pdf
[9] Warwickshire Observatory, Warwickshire County Council. Living in Warwickshire Survey.
[10] NICE. Community engagement (PH9). www.nice.org.uk/guidance/ph9/chapter/public-health-need-and-practicewww.nice.org.uk/advice/LGB16/chapter/introduction

	cohesive and connected • Using Better Care Fund to reduce reliance on statutory services.
Promote positive lifestyle behaviour changes and encourage individuals and communities to take responsibility for their own health.	• Individuals and communities who are healthier and more able to take responsibility for their own health and wellbeing • Front line workers from a range of sectors and community leaders delivering Making Every Contact Count (MECC) • Front line workers from a range of sectors and community leaders supporting 5 ways to wellbeing.
Target limited resources where they are most needed and bridge the gap in health and social inequalities where they exist across the county.	• Focus on prevention, early help and targeted support. Our most vulnerable communities will be supported through targeted interventions which encourage independence and improved wellbeing • Providers and commissioners will measure their outcomes using validated tools and measures.
Engage with and seek the views of individuals and communities and use neighbourhood data and analytics to ensure that the needs of communities are fully understood.	• 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 • Organisations and communities with an improved understanding of what community assets exist and how they can be better used and developed • Tailored and evidence based service delivery plans and commissioning intentions.
Support communities to participate in and influence the shaping and transforming of local services.	• A safe environment for residents to participate in community activities and increase the contribution that they can make to developing services • Communities and organisations working together to design and co-produce integrated services.
For residents to develop coping skills for the prevention of stress, depression and anxiety.	• Quick and easy access to mental health and wellbeing information and support services • Communities that are better able to cope with pressures and have improved mental health and wellbeing.
Improve educational attainment, particularly with those pupils that are eligible for free school meals.	• Improved educational attainment for all, and particularly with those that are claiming free school meals.
Maximise opportunities for local economic and job development.	• Improved local economic and job development, especially for those residents that are NEET, long term unemployed or with disabilities • LEP continuing to ensure all private and public sector parties in the region are working together to make a difference to the economy and increase prosperity.

Priority 3 – Integration and Working Together

3.1 Definition

The Health and Wellbeing Board in Warwickshire is committed to integration and working together effectively. Enhanced integration of the delivery of services is key to reducing costs, avoiding duplication and improving services across Health, Social Care, Public Health and Community sectors, but also those of other key organisations involved, such as; Community Safety, Environmental Health, Housing, Probation, Planning, Leisure, Transport, Library Services, Public Health England and NHS England (not an exhaustive list).

Integration and working together is the ultimate aim in Warwickshire and the Better Care Fund is one of the mechanisms by which this will be achieved and a live example of partnerships in Warwickshire working together towards a shared vision. The ultimate aim of integrated care is to support improved outcomes and experiences for individuals and communities through[11]:

- Population based public health, preventative and early integration strategies
- Individual experience of integrated Health and Social Care and support that is personalised and coordinated, in collaboration with the individual, carer and family
- Shift away from over reliance on acute care towards focus on primary care and self care.

We believe that integration and working effectively means…

- A commitment to partnership working, joint commissioning, and using resources (people, premises and finances) to maximise cost-effectiveness and health and wellbeing for individuals and communities
- Identifying the right health, social and community care at the right time in the right place
- Increasing the involvement of service users, representatives and local groups in the planning (including co-production) of services and policies.
- Ensuring that strategies for new and existing communities consider the health and wellbeing impacts for residents in the short and the long term
- Improved coordination of personalised care
- A shift in focus of care upstream from secondary care to primary care services. e.g. from inappropriate A&E visits to more appropriate use of Pharmacies and GP's
- The ability to share data on individuals without compromising information governance.

[11] National Collaboration for Integrated Care and Support, Integrated Cate and Support: Our Shared Commitment, May 2013, [online]

3.2 Evidence Base – why is integration and working together important?

The Health and Social Care Act 2012 saw that it became a statutory duty to promote integrated care[12].

Maintaining quality personalised care for vulnerable groups, an ageing population and supporting increasing numbers of people managing chronic long term conditions presents a challenge to organisations in Warwickshire. Increasing pressure on the system can result in increasing cost and in some cases inappropriate use of services; e.g. people visiting A&E rather than seeking the advice of their Pharmacies or GP; or, poor management of long term conditions, resulting in admission to hospital, sickness absence from work, rents arrears and financial hardship.

In order to achieve successful delivery of integrated services, we need to consider the needs of the individual and ensure they are at the heart of integration and services working together. Desired outcomes from successful integration of service delivery in Warwickshire will include, person centred coordinated care, co-production, improved outcomes for individuals, reduced pressure on the system by preventing illness, managing conditions effectively, avoiding falls, appropriate use of secondary care, appropriate discharge and reablement[13] - all of which should be underpinned by best practice and national evidence.

Improving key aspects of the way services are organised for older people, vulnerable groups and those with long term conditions are key in preventing hospital admissions in Warwickshire[14]. If we are able to identify individuals most at risk through effective utilisation of IT systems and data sharing, that it is in line with information governance requirements, we can support individuals to make informed decisions about how their care is planned and deliver care on a personalised level, this will support the proactive avoidance of emergency care and admissions[15].

Successful integration and data sharing requires commitment from organisations in Warwickshire with a role in supporting individuals. In order to achieve this, we need to be committed to innovation, governance and accountability. Support programmes for leadership and development are important to enable the impact of integrated care to be evaluated[16].

[12] Accountable care organisations in the United States and England Testing, Evaluating and Learning what works, The Kings Fund, March 2014
[13] National Collaboration for Integrated Care and Support, Integrated Cate and Support: Our Shared Commitment, May 2013, [online]
[14] The Kings Fund, Integrated Care in Northern Ireland, Scotland and Wales: Lessons for England, 2013

[15] National Collaboration for Integrated Care and Support, Integrated Cate and Support: Our Shared Commitment, May 2013, [online]
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/198748/DEFINITIVE_FINAL_VERSION_Integrated_Care_and_Support_-_Our_Shared_Commitment_2013-05-13.pdf

[16] Goodwin et al (2012) The Kings Fund. A Report to the Department of Health and the NHS Future Forum: Integrated care for patients and populations: Improving outcomes by working together

3.3 Our focus

Our focus in Warwickshire will be to…	In five years' time Warwickshire will have…
Support people to remain healthy and independent, in their own homes for longer.	• An emergency response team that will improve avoidance of admissions to acute and residential care • Utilised the care coordinator model based on clusters of GPs coordinating services to minimise acute sector usage • Delivered the reablement strategy and options appraisal for wrap around support.
Support people to get the right service at the right time and in the right place.	• A reduction in emergency admissions and an increase in more appropriate use of Pharmacy services, GPs and other community services.
Improve accessibility and visibility of 'front doors' to support people, to make the right choice, the easiest choice, informed by customer journey examples.	• Undertaken customer journey mapping of experiences at front doors to services • Facilitated redesign, having considered integration options • Scoped the IT and infrastructure requirements needed to facilitate delivery.
Improve care coordination in the community for high risk/cost patients.	• Established multi agency project groups to scope models that best fit the local areas, based around an integrated team approach, linked to GP clustered practices • Incorporated the requirement to align processes for accessing personal budgets • Utilised appropriate engagement methods and worked with individuals, their carers and families to assist in the redesign of services.
Improve data sharing, IT infrastructure and health and social care governance.	• Established compatible systems to enable sharing of data • Enabled the use of NHS numbers to be used as unique identifiers to share data and business intelligence, using a 'hub' where key data on individuals can be collated in a joint summary care record • Developed a solution for the ability to send information confidentially and safely between organisations without compromising information governance.

Partner responsibilities

The Warwickshire Health and Wellbeing Strategy identifies the Board's agreed priorities for the next 5 years. Organisations across the county should be identifying opportunities in their locality, in the services that they commission and in their own strategies on how they can add value and focus on the priorities that have been agreed (appendix 2).

Whether you are a commissioner, provider, councillor, community or an individual we all need to work together to improve the health and wellbeing of Warwickshire residents.

Commissioners

- Will commission services and resources that support the priorities of the Health and Wellbeing Board and strategy
- Will co-produce services and resources with other health, social care and community organisations
- Will tailor services and resources and target them according to need
- Will plan services that are person centred and developed with input from service users
- Will design services that promote independence rather than impose dependence
- Will ensure that services and resources are measured for effectiveness
- Will engage with and seek the views of individuals and communities, in line with the Good Engagement Charter standards[17]
- Will consider the physical, mental and emotional wellbeing of individuals needing care.

Providers

- Will co-produce services and resources with other health, social care and community organisations
- Will tailor services and resources to different areas and target them where they are most needed
- Will ensure that services and resources are measured for effectiveness
- Will engage with and seek the views of individuals and communities, in line with the Good Engagement Charter standards
- Support communities and individuals to become more empowered and resilient
- Will provide services which promote independence and discourage dependence.

Councillors

- Will act as leaders for their communities, deliverers of services and catalysts for change
- Will promote the importance of prevention to improve health and wellbeing to its communities
- Will engage with and seek the views of individuals and communities, in line with the Good Engagement Charter standards
- Support communities and individuals to become more resilient and empowered.

[17] Healthwatch Warwickshire. http://www.healthwatchwarwickshire.co.uk/sites/default/files/uploads/Good_Engagement_CharterWarwickshire.pdf

Communities

- Will take ownership and responsibility for their own health and wellbeing
- Will be proactive and access those services and resources readily available to them to increase their resilience
- Will work with organisations and commissioners to co-produce services and resources
- Will support more vulnerable members of the community to maintain good health and develop strong social connections.

Individuals

- Will take ownership and responsibility for their own health and wellbeing
- Will be proactive and access those services and resources readily available to them to increase their resilience
- Will use services and resources that are limited and high cost wisely and only when essential.

Appendix 1 Current Strategy Key Performance Indicators

To be amended after consultation

Description	Unit	Measure	Geography	Year 1	Year 1 Warwickshire	Year 2	Year 2 Warwickshire	Latest Year	Latest Year Warwickshire	Latest Year District / Borough range	Latest Year England	Warwickshire Trend
1. Mobilising communities to develop and sustain their independence health and wellbeing												
Life expectancy at birth - Male	Male	Years	county	2007-09	78.5	2008-10	79.0	2009-11	79.5	79.3-80.7	78.9	★
Life expectancy at birth - Female	Female	Years	county	2007-09	82.7	2008-10	83.1	2009-11	83.5	82.2-84.5	82.9	★
Smoking prevalence - adults (over 18s)	Persons	%	county	2010	19.8	2011	18.7	2012	17.9	10.4-19.8	19.5	★
Smoking status at time of delivery	Female	%	county	2010/11	16.4	2011/12	19.6	2012/13	17.6	-	12.7	●
Alcohol related hospital admissions	Persons	per 100,000	county	2008/09	1420.5	2009/10	1562.1	2010/11	1,693	1,519-1,935	1,895	▲
Excess weight in 4-5 and 10-11 year olds - 4-5 year olds	Persons	%	county	2010/11	20.2	2011/12	19.8	2012/13	20.0	17.1-23.6	22.2	●
Excess weight in 4-5 and 10-11 year olds - 10-11 year olds	Persons	%	county	2010/11	30.3	2011/12	31.6	2012/13	30.9	25.9-36.2	33.3	●
Utilisation of outdoor space for exercise/health reasons	Persons	%	county	-	-	Mar 2011 - Feb 2012	10.8	Mar 2012 - Feb 2013	14.0	-	15.3	★
Students obtaining 5 A*-C (including English and Maths) GCSE	Persons	%	county	2010/11	60.5	2011/12	63.0	2012/13	65.0	55-72	60.8	★
16-18 year olds not in education employment or training	Persons	%	county	-	-	2011	4.5	2012	3.6	-	5.8	★
Estimated diagnosis rate for people with dementia	Persons	%	England	-	-	-	-	2012/13	-	-	48.7	England data
A measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	*HSCIC developing indicator*
Adults with a learning disability who live in stable and appropriate accommodation	Persons	%	county	-	-	-	-	2011/12	54.5	-	70.2	●
People using social care who have control over their daily life	Persons	%	county	2010/11	67.8	2011/12	73.7	2012/13	71.6	-	75.9	●
Older people (65+) who are still at home after 91 days following discharge from hospital into rehabilitation services	Persons	% of all hospital discharges	county	2010/11	86.3	2011/12	81.2	2012/13	82.2	-	81.5	★
Delayed transfers of care - all delays	Persons aged 18+	per 100,000	county	2010/11	18.8	2011/12	17.0	2012/13	13.3	-	9.5	●
Permanent admissions to residential and nursing care homes, per 100,000 people	Persons	per 100,000	county	2010/11	594.9	2011/12	595.5	2012/13	685.6	-	708.8	▲
2. Improving access to services												
Emergency readmissions within 30 days of discharge from hospital (persons)	Persons	%	county	-	-	-	-	2010/11	10.8	-	11.8	one year data
Avoidable emergency admissions	-	ratio of actual to expected	Coventry & Warwickshire CCGs	-	-	-	-	2012/13	n/a	0.97-1.02	1.00	one year data
Access to GP services	Persons	%	England	-	-	-	-	Jul'12 - Mar'13	-	-	76.3	England data
People feeling supported to manage their condition	Persons	%	county	-	-	Jul'11 - Mar'12	71.2	Jul'12 - Mar'13	70.0	64.8-74.7	69.3	▲
Adults in contact with secondary mental health services in employment	Persons	%	county	2010/11	19.4	2011/12	17.2	2012/13	20.3	-	7.7	★
Excess under 75 mortality rate in adults with serious mental illness, 2010/11	Persons	per 100,000	county	-	-	-	-	2010/11	n/a	-	335.3	one year data
3. Public services working together												
Looked After Children aged 0-17 years	Persons	per 10,000	county			Mar 2013	62	Jan 2014	64	38-100		
Children subjected to a Child Protection Plan	Persons	per 10,000	county			Mar 2013	49	Jan 2014	49	28-86		
Better Care Plans developed and delivered	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	*To be reported separately*
Children in poverty (under 16s)	Persons	%	county	-	-	2010	14.6	2011	14.1	10.1-20.1	20.6	★
Excess Winter Deaths Index (Single year, all ages)	Persons	ratio	county	-	-	Aug 2010 - Jul 2011	20.4	Aug 2011 - Jul 2012	19.0	-	16.1	★
Proportion of affordable housing			county									

Performance improving ★ Performance similar ● Performance worsening ▲

Appendix 2 Priority Template

Priority	My Organisation will contribute to success by:
Promoting Independence	
Ensure the best possible start to life for children, young people and their families	
Support those young people who are most vulnerable and ensure their transition into adulthood is positive	
Enable people to effectively manage and maintain their physical and mental health and wellbeing	
Ensure that people with disabilities have the same choice, control and freedom as any other citizen – at home, at work and as members of the community	
Enable older people fulfil the tasks of independent living, maintaining social connections, and allowing people to have choice and control over how they live their lives	
Community Resilience	
Increase the resilience and capacity of our communities, enabling them to better support themselves, vulnerable individuals and families	
Promote positive lifestyle behaviour changes and encourage individuals and communities to take responsibility for their own health	
Target limited resources where they are most needed and bridge the gap in health and social inequalities where they exist across the county	
Engage with and seek the views of individuals and communities and use neighbourhood data and analytics to ensure that the needs of communities are fully understood	
Support communities to take participate in and influence the shaping and transforming of local services	
For residents to develop coping skills for the prevention of stress, depression and anxiety	
Improve educational attainment, particularly with those pupils that are eligible for free school meals	
Maximise opportunities for local economic and job development	
Integration and Working Together	
Support people to remain healthy and independent, in their own homes for longer	
Support people to get the right service at the right time and in the right place	
Improve accessibility and visibility of 'front doors' to support services, to make the right choice, the easiest choice, informed by customer journey examples	
Improve care coordination in the community for high risk/cost patients	
Improve data sharing, IT infrastructure and health and social care governance	

Consultation

This ***draft*** strategy has been developed under consultation with key local partners and stakeholders. To ensure ongoing and full consultation and feedback we are now opening the consultation to all Warwickshire residents, organisations and stakeholders.

After reading this ***draft*** strategy, please fill out the consultation survey, which is available here. We are keen to hear your views as an individual, organisation or a group.

If you prefer, we can post a hard copy of the questionnaire out to you. The questionnaire is also available in accessible versions upon request.

For more information or to request an alternative version please contact: phadmin@warwickshire.gov.uk or 01926 413751.

Warwickshire Health and Wellbeing Board

c/o Warwickshire County Council

PO Box 43, Shire Hall, Barrack Street, Warwick, CV34 4SX

Email: phadmin@warwickshire.gov.uk

http://hwb.warwickshire.gov.uk

A copy of this strategy is available electronically here:
http://hwb.warwickshire.gov.uk/consultation-hwbs/

Item 10

Health and Wellbeing Board
22 September 2014
Director of Public Health Annual Report 2014

Recommendation(s)

That the Health and Wellbeing Board:

1. Note and support the 2014 Director of Public Health Annual Report.
2. Agree to endorse the recommendations stated in the report.
3. Acknowledge and address specific recommendations, namely:

- For partner organisations to ensure they are meeting their responsibilities with regard to reducing the impact of hot and cold weather on the health of Warwickshire residents, as outlined in National Heatwave and Cold Weather plans, and to support Warwickshire Warm and Well initiatives through advice giving and signposting individuals to appropriate services.
- For professional awareness needs to be raised in primary and secondary care, sexual health, and drug and alcohol services, with regard to who to screen or test for blood-borne viruses, and how to manage and refer positive cases, working to improve uptake of testing and vaccination.
- To ensure infection control features in all contracts held with clinical or care providers, including primary and secondary care, social care, as well as licensed food venues, and ensure that contractual obligations are being met.
- To work to maximise uptake in all screening programmes, through the sharing of detailed information between organisations (NHS England, Public Health England and Local Authorities), allowing targeted messages to be delivered to the appropriate groups and particularly to groups with low uptake.

- For commissioners of health and social care providers to have seasonal flu vaccination of staff identified as a “duty of care” priority in their contracts.

1.0 Key Issues

Directors of Public Health have a statutory requirement to write an annual report on the health of their population, and the local authority is required to publish it. With the responsibility for public health moving back into local government, this presents a real opportunity to tackle these issues through a more collaborative and structured approach. We can build on the key functions of local government to shape the place and environment in which we live.

The Director of Public Health Annual Report is a vehicle for informing local people about the health of their community, as well as providing necessary information for decision makers in local health services and authorities on health gaps and priorities that need to be addressed.

The nature of public health is largely about achieving long term change and taking action now to prevent poor health outcomes for our population in the future. Health Protection, a key public health domain, is often hidden from sight but how long could we survive without clean water? Without sanitary facilities? Without food free from contamination? Essential to our health and wellbeing, these services and our ability to respond when something goes wrong underpins my annual report this year. There is a focus on some of the issues that pose risks to the population’s health, including sexual health, tuberculosis, and seasonal flu. It also considers the actions we currently take to protect the health of Warwickshire residents, including emergency planning, screening and immunisations and promotion of healthy behaviours such as handwashing.

The recommendations focus on raising awareness of health protection issues, and supporting professionals, commissioners and providers in ensuring that they are all informed about their responsibilities. The need to focus on high risk groups is also highlighted, in order to address inequalities in health.

2.0 Proposal

2.1 That the Health and Wellbeing Board take note of the current Health Profile for Warwickshire as outlined in Appendix 2 of the report.

2.2 That the Health and Wellbeing Board support and endorse the recommendations, ensuring public health is reflected in all policies and strategies.

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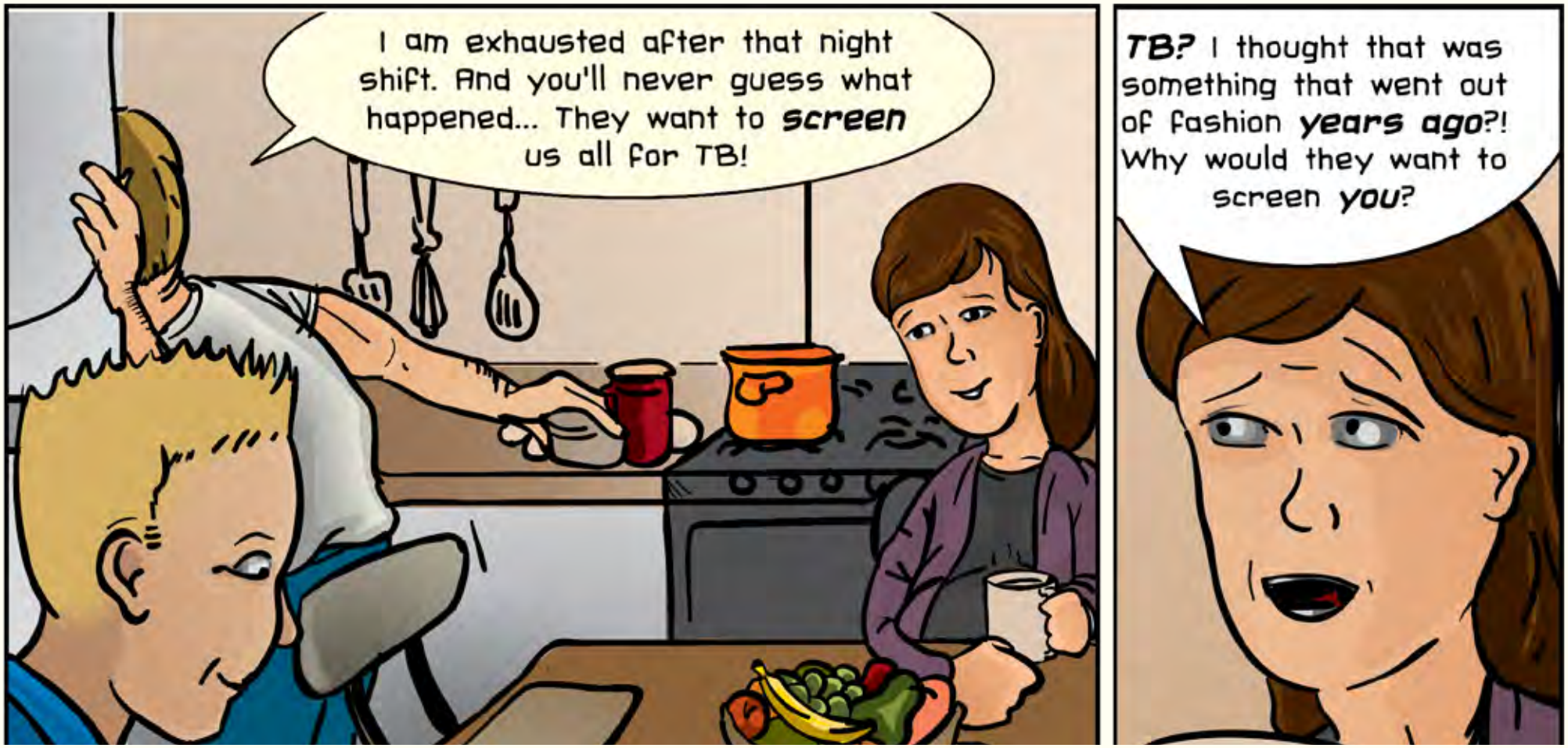


PROTECTING HEALTH – A HIDDEN AGENDA

Director of Public Health Annual Report 2014

PUBLIC HEALTH WARWICKSHIRE

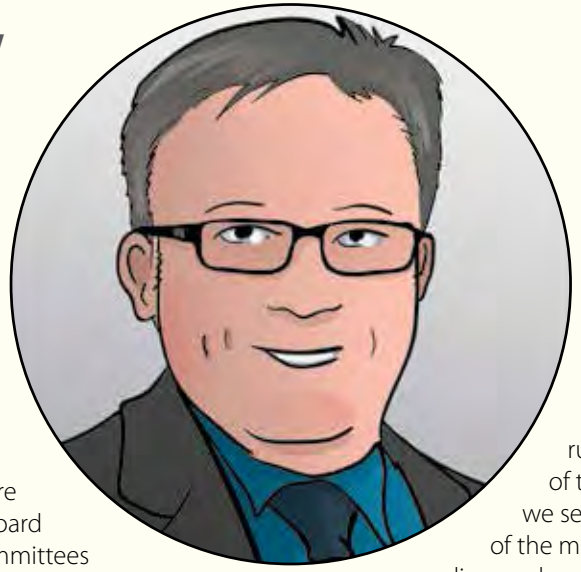
Warwickshire County Council

Working for Warwickshire

CONTENTS

INTRODUCTION

The transition of Public Health into local authorities in April 2013 brought new responsibilities for health, including health protection.[1] Health protection relates to planning for emergencies, and guarding our population against communicable diseases as well as a range of environmental hazards.



The health protection function is, however, not new to local authorities. Environmental Health, Trading Standards and Regulatory Services already work to protect health by monitoring food safety, improving health and safety in the workplace, promoting animal health and welfare, and ensuring that goods sold to the public are safe and fit for purpose. The challenge for local authorities now lies in delivering broader health protection functions in a new health landscape, in which there are multiple organisations with responsibilities relating to health protection.

The Directors of Public Health, on behalf of their local authorities, are responsible for ensuring there are plans in place to protect the health of the population from threats ranging from relatively minor outbreaks to full-scale emergencies.[1] This includes plans for communicable disease, infection control, sexual health, environmental health, emergency planning, screening and immunisation programmes. Therefore, the local authority role in health protection is one of assurance, which requires a robust means of providing support and challenge to partners, and advocacy on behalf of the local population. Key partners are identified in the recommendation section.

One of the ways in which this assurance is exercised is through the Arden Health Protection Committee, which provides a forum for partners to discuss successes, challenges, risks, and identify areas where joint work is likely to be of benefit in tackling particular problems. Some of the successes of the Committee relate to joint work carried out between NHS England and the local authority to promote the uptake of seasonal flu vaccination, work carried out to reach agreement among partners about how we work together in the event of an outbreak or public health incident, as well as joint work with social care colleagues to protect people and reduce demand on services during the winter.

However the assurance role of the local authority doesn't end there. We are looking to the Health and Wellbeing Board and Health Overview and Scrutiny Committees to take on the health protection challenge, to challenge ourselves in Public Health and our external partners regarding the work we are doing to protect population health and to champion health protection priorities through their own work. Both the County Council and the District and Borough Councils have many staff who come into contact with members of the public on a daily basis, and are ideally placed to disseminate key health protection messages. We are particularly challenging the Health and Wellbeing Board to consider health protection not only as a health priority, but also a commissioning priority, where appropriate, for the health and social care system. This report is written for Council Members, Council Officers, Health and Wellbeing Board members and our wider health protection partners. Importantly, we would also like to ask members of the public to see the role they can play in protecting their own health and that of their families.

The title of this report "Protecting Health – A Hidden Agenda" reflects the fact that a great deal of health protection work can be unseen and taken for granted. All of the work that goes into planning for emergencies, preventing and managing outbreaks, and ensuring screening and immunisation programmes are running well, tends to be out of the sight of the populations we serve. We no longer see some of the most dangerous communicable diseases because of our successful childhood vaccination programmes. Screening programmes work to identify those at risk of serious illnesses that early on may cause no symptoms. We may not appreciate when we buy food from a shop or outlet that there are professionals working to ensure it is safe and of high quality. It is hoped that this report, although it does not comprehensively describe all health protection work which is being undertaken, highlights some key areas of importance.

Dr John Linnane
Director of Public Health

RECOMMENDATIONS

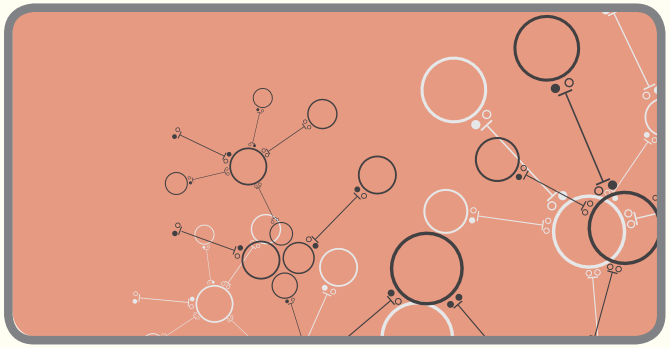
Tuberculosis (TB)

Professionals should be vigilant for TB, particularly those working with vulnerable populations such as the homeless, drug and alcohol misusers and recent migrants from countries with high numbers of new cases. Refer on to the Community Nursing Service if you suspect TB: [2-4]

• Clinicians suspicious of TB can make an urgent referral to the TB Clinics at all our local hospitals through the respiratory secretaries.

• Clinicians and other professionals may also wish to discuss with the Community TB Nursing Service at the City of Coventry Health Centre (Tel: 02476 961 351), or email geh-tr.ardentbservice@nhs.net

Partners are requested to support the establishment and activities of the TB Control Board in Warwickshire and Coventry, and to prioritise TB in commissioning priorities, particularly with regard to screening of new entrants and HIV positive patients.



Emergency Planning & Outbreaks

Health and social care commissioners must ensure that support required in relation to an outbreak or incident, i.e. staff resource and equipment for investigation and treatment, are detailed in contracts with providers of services. Providers and commissioners to ensure the requirements can be met.

Efforts to reduce communicable disease and improve environmental hazard control should be considered a crucial part of the commissioning processes of all health and local government commissioners. For example, specifying outcomes required for the management of communicable diseases, e.g. Hepatitis B, Hepatitis C and TB in secondary care, and prioritising air pollution reduction initiatives.

Partner organisations to ensure they are meeting their responsibilities with regard to reducing the impact of hot and cold weather on the health of Warwickshire residents, as outlined in National Heatwave and Cold Weather plans, and to support Warwickshire Warm and Well initiatives through advice giving and signposting individuals to appropriate services.

Immunisations

Ensure sharing of information between NHS England, Public Health England, and the local authority to provide assurance and allow opportunities for joint working to promote vaccination uptake and to resolve problems identified in delivering vaccination programmes.

Continue to actively promote immunisation uptake across Warwickshire, using school entry as an opportunity to check the vaccination status of children.

Partners to work together to promote the uptake of new immunisations as programmes are introduced, e.g. Meningococcal C vaccination amongst University students.[5]

Key

- Health & Wellbeing Board
- Health Overview & Scrutiny
- County Council & Provider Services
- District & Borough Councils, Housing & Partners
- District & Borough Councils, Environmental Health & Partners
- Public Health
- Social Care Commissioners & Providers
- Emergency Planning (multiagency)
- Public Health England
- NHS England
- Clinical Commissioning Groups
- Primary Care
- Community & Secondary Care (NHS)
- Drug & Alcohol Services
- Voluntary & Community Sector

Blood-Borne Viruses

Professional awareness needs to be raised in primary and secondary care, sexual health, and drug and alcohol services, with regard to who to screen or test for blood-borne viruses, and how to manage and refer positive cases, working to improve uptake of testing and vaccination. [6-8]

Ensure a robust system is in place for those most at risk (e.g. household and sexual contacts of known hepatitis B positive patients, babies born to Hepatitis B positive mothers etc.) to have their entire course of vaccinations.

Ensure a seamless pathway for people from diagnosis (in a range of services) to treatment of Hepatitis B and Hepatitis C through appropriate commissioning and strong referral pathways between services.

Screening

Work to maximise uptake in all screening programmes, through the sharing of detailed information between organisations (NHS England, Public Health England and Local Authorities), allowing targeted messages to be delivered to the appropriate groups and particularly to groups with low uptake.

Screening messages to become a more routine part of disease prevention messages communicated through health, social care, community and voluntary sector professionals to members of the public.

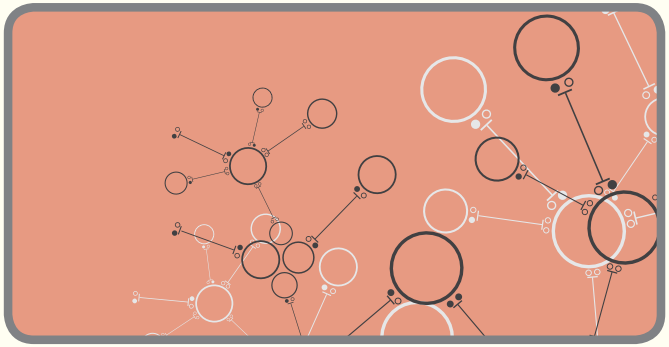
Sexual Health

Ensure that the new model of sexual health services enables increased access to comprehensive sexual health services in one place, works to reduce sexual health inequalities across the County, and has effective referral pathways to and from related services, e.g. termination of pregnancy services, drug and alcohol services etc.

Partners to continue to focus on signposting high risk groups for HIV testing in order to improve early diagnosis rates. [9]

Improve Chlamydia diagnostic rates through promotion of and delivery of targeted screening and testing in sexual health services and in community venues across the County, in order to reduce the overall number of new cases.

Continue the roll out of Spring Fever, and Respect Yourself programme work across the County and marketing of the programmes. (www.respectyourself.info)



Handwashing & Preventing Infections

Develop plans to embed teaching about infections and the importance of handwashing in school curricula.

Ensure infection control features in all contracts held with clinical or care providers, including primary and secondary care, social care, as well as licensed food venues, and ensure that contractual obligations are being met.

Maintain improvements in hospital and care home infection control by providing regular feedback to staff regarding the outcomes of infection control audits. [10]

Partners to work together to implement the recommendations of the Chief Medical Officer's Antimicrobial Resistance Strategy. [11]

Seasonal Flu

Commissioners of health and social care providers to have seasonal flu vaccination of staff identified as a "duty of care" priority in their contracts. [12]

Support is required from all partners for the seasonal flu campaign for 2014/15, to be based on "what worked" from the 2013/14 campaign, with a continued focus on clinical risk groups under the age of 65, pregnant women, carers, children and health and social care staff.

CHAPTER 1. TUBERCULOSIS

The nature of the challenge

Tuberculosis, or TB, is unfortunately not a problem of the past. It is a disease that can affect the lungs and cause a persistent cough, blood in the phlegm, fever, night sweats, and weight loss, and can cause death if not treated.[13] However, it can also (in around 50% of cases in the UK)[14] cause illness in many other parts of the body, making it difficult to diagnose.

TB is unusual because only 5% of people develop illness at the time they are infected.[15] In about 50% of people, TB causes a hidden or "latent" infection, which can make them unwell and infectious at a point later in their life.[16] People with latent infection don't have any symptoms, but people who have active disease (with symptoms of a cough) and aren't being treated, can infect up to 10-15 other people on average.[15]

Although the number of new TB cases reported every year was high at the beginning of the 20th century in England (mainly due to poor living and environmental conditions) a large decrease in numbers was seen over the course of the century until the mid-1980s (Figure 1).[17, 18] Since then the number of new cases has been increasing on an annual basis, largely due to migration, with the highest numbers found in urban areas.[17-19] Two thirds of TB cases seen in the UK occur in people born outside of the UK, and who were infected in their country of origin.[14] There is now a programme in place to test people for active disease before they come to the UK,[20] but the real challenge lies in making sure we have ways of detecting people with hidden or "latent" infection and treating them so that they don't develop active disease.

There are very effective treatments for TB and so the focus has to be on picking up the infection early, when it is still latent. Although the Bacillus Calmette–Guérin (BCG) vaccination protects against the most serious forms of TB in young children, it is not as effective in preventing respiratory TB [21]

(which is more common). Since 2005, BCG vaccinations have been given to babies and children who are more at risk of infection, for example because their parents or grandparents are from an area where active cases are reported commonly.[21] [22] The search for a more effective vaccination is ongoing.[22]

In Warwickshire the number of new cases of active TB seen every year is relatively low when compared to national and regional rates (Figure 2). 161 cases of active disease and 137 cases of latent infection were diagnosed in total between 2011 and 2013. The highest rates are seen in Rugby Borough, Nuneaton and Bedworth Borough, and Warwick District (Figure 2).[23] However, TB remains an extremely important public health problem, because the illness tends to affect some of our most vulnerable populations, including the homeless, alcohol and drug misusing communities, as well as people who have come from countries where there are a high number of new cases of the disease.

In Warwickshire and Coventry, the Community TB Nursing Service support patients with TB with their medications, and test people who live in close contact with those with infectious TB in order to pick up other people who may be infected. The number of household and close contacts tested in 2013/14 in Warwickshire and Coventry was 678.

In 2007, an outbreak of TB in the homeless community in Leamington Spa and Rugby was identified. Large screening events to identify the contacts of cases were held in order to manage the outbreak. In total 36 cases were associated with the outbreak and there were 6 deaths. This highlights the ongoing importance of professionals needing to remain vigilant for cases of TB, particularly given how infectious it is, and the difficulties there can be in diagnosis.

What is currently being done?

Key partners are responding to a national consultation on how to tackle the rising problem of TB at a national level.[24]

A TB Strategic Board is being set up which will oversee all the TB prevention and management activities in Warwickshire and Coventry, to make sure there are safe plans in place.

The best ways of identifying people with hidden or "latent" disease are being considered at a national level, whilst a number of local programmes are being evaluated elsewhere in the country. [25- 27]

New ways of ensuring that TB patients get high quality care are being launched in Warwickshire and Coventry (cohort review process). [28]

Public and professional awareness raising campaigns related to TB will continue to be undertaken by the Community TB Nursing Service in Warwickshire, in partnership with Coventry Citizen's Advice Bureau.

Work is ongoing to make sure that babies who are eligible for the BCG vaccination receive it.

Figure 2: Tuberculosis rate (active cases) per 100,000 population, Warwickshire, West Midlands and England, 2004 to 2012

Source: Public Health England, Annual report on Tuberculosis in the West Midlands, 2012, pg. 18

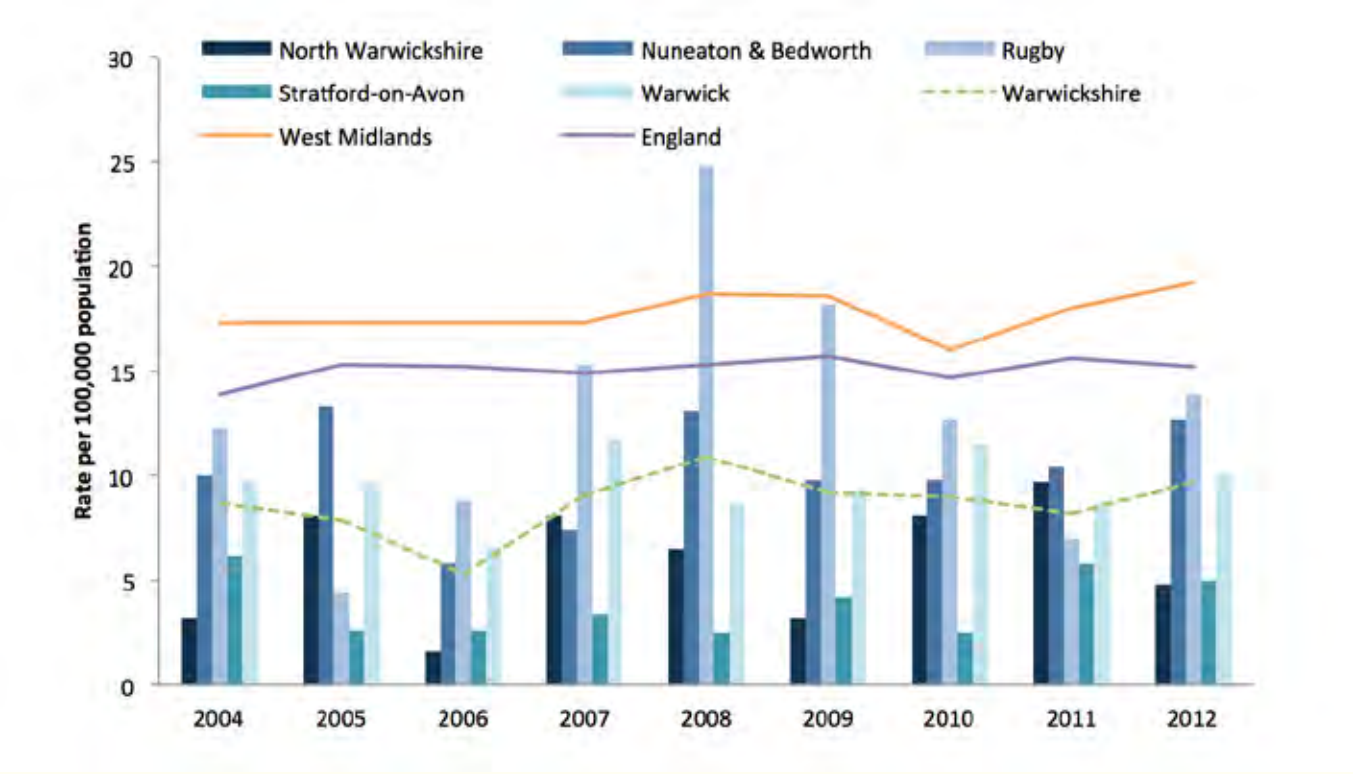
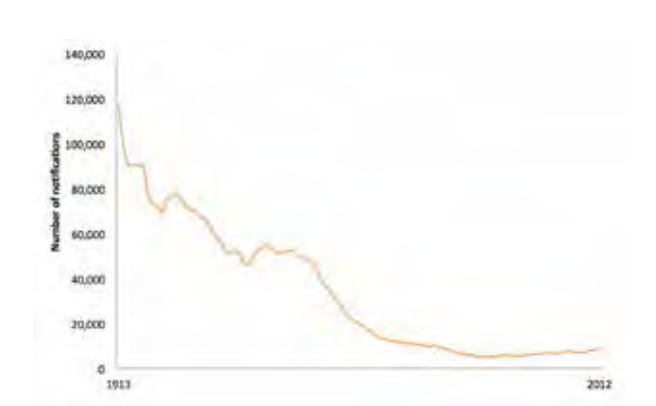


Figure 1: History of Tuberculosis notifications, England and Wales, 1913-2012

Source: Public Health England, 1913- 1982 Statutory Notifications of Infectious Diseases (NOIDs); 2010-2012 Enhanced Tuberculosis Surveillance (ETS)



RECOMMENDATIONS

TUBERCULOSIS

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Clinicians and other professionals may also wish to discuss with the Community TB Nursing Service at the City of Coventry Health Centre (Tel: 02476 961 351), or email ge-tr.ardentbservice@nhs.net

Partners are requested to support the establishment and activities of the TB control board in Warwickshire and Coventry, and to prioritise TB in commissioning priorities, particularly with regard to screening of new entrants and HIV positive patients.

CHAPTER 2: EMERGENCY PLANNING AND OUTBREAKS

The nature of the challenge

A key role of the Director of Public Health is to ensure there are plans in place to protect the health of the population. This includes protecting people from the health impacts of communicable diseases (diseases that can be passed from person to person), environmental hazards such as air pollution and extremes of weather (for example heatwaves, cold weather and flooding), as well as other emergencies which can have a significant impact on the health of the population, such as those which result in a large number of casualties. [29]

This role involves working closely with a wide range of professionals in and outside the Local Authority, who are responsible for putting plans in place to prevent these problems, [30] but also for responding in the case of an outbreak, incident or emergency that affects the health of the population.

Although it is crucial for plans to be in place which describe how we respond to these situations, our efforts need to focus on preventing them. This could mean preventing outbreaks by ensuring that the population is protected by vaccinations, or reducing the impact of extreme weather by supporting people to adequately insulate and heat their homes in the winter.

Responding to outbreaks

One of the key challenges in ensuring we reduce the risk posed by communicable diseases to the population, lies in how organisations work together in responding to outbreaks or incidents. This might be a measles outbreak on a traveller site, a flu outbreak in a care home, or a TB incident. Over the last year, an agreement has been developed between a number of partner agencies, which covers these types of scenarios, based on national guidance and work originally carried out in Staffordshire. The agreement reflects changes in the NHS that have taken place since April 2013, which were outlined in my annual report last year, and importantly identifies "who does what" in the event of an incident. [32]

The scale of the challenge is highlighted in Tables 1 and 2, which show the range of communicable disease infections and outbreaks reported to the local Health Protection Team (Public Health England) over the last year in Warwickshire. The Health Protection Team are responsible for managing communicable diseases and outbreaks that are notified to them.

As is seen, hospitals and care homes are common environments for outbreaks to occur. It is, therefore, crucial that there are strict measures in place for reducing the spread of infection in these settings. This is discussed in more detail in Chapter 7.

Environmental Hazards and Extremes of Cold Weather

With regard to environmental hazards, air pollution is a key priority for a number of areas in Warwickshire. It was covered in detail in my last annual report, which can be found on our website and so will not be discussed further in this report. [33, 34]

Work has also been ongoing in Warwickshire for a number of years to reduce the risk that cold weather poses to health, including causing health complications for people with heart and lung conditions, as well as having a negative impact on mental wellbeing. [35] Every year, detailed planning takes place prior to the winter to put in place measures to minimise the impact of cold weather on the population and on health and social care services. Part of this involves communicating information to frontline health and social care services to ensure they are protecting their most vulnerable patients or service users, and that key messages are being conveyed to the public. [36] Fuel poverty is an important public health problem, with 13% (or 30,120) of households in Warwickshire having a higher than average energy bill, which would leave them below the official poverty line. In small areas in Rugby Borough, Warwick District and Nuneaton and Bedworth Borough, over 25% of households are in this position (Figure 3). Understanding where these problems lie helps us target interventions to support those most in need.

Campaign work aimed at keeping people warm and well, ensuring eligible people receive their flu jabs, as well as longer term work considering the financial support available to people in fuel poverty, home insulation schemes, and

providing information and guidance regarding switching energy suppliers, are all important components of this work. Similar types of preparation also take place for hot weather.

What is currently being done?

The Agreement for Emergency Preparedness and Service Delivery in response to a significant Public Health incident or outbreak has been completed, with an outbreak plan also being developed.[24]

The 'Coventry, Solihull and Warwickshire Resilience Team', who maintain a range of emergency plans for the three authorities, recently held a scenario based exercise to test the above agreement, and have increased capacity in the team to take on more responsibility for public health work in this field.

Groups consisting of members from a number of organisations currently exist to oversee emergency planning, and outbreak and environmental hazard management, such as:
Arden Local Health Resilience Partnership – co-ordinates and ensures that all organisations with a responsibility for health have effective emergency plans in place, that they are tested, and that partners work together in responding to an emergency.

Warwickshire Local Resilience Forum - brings together senior representatives of the emergency services, local authority partners, NHS bodies and others to prepare for and respond to emergencies as part of national arrangements.

Warwickshire Warm and Well Steering Group – brings together a number of county, district and borough councils, and third sector partners, to oversee work and interventions that aim to reduce excess winter deaths, unnecessary hospital admissions and social care referrals.

A number of communicable disease strategy groups.

Pandemic flu is still one of the highest rated risks to the population identified at a national level and planning activities are taking place.

Preparations are being made for the coming year to support cold weather planning with interventions aimed at reducing fuel poverty in Warwickshire, alongside other linked work,

Table 1: Infections reported to Public Health England, Warwickshire residents, 2011 to 2013
Source: Public Health England, Notifiable Diseases reported to Public Health England, Warwickshire residents, January to December 2013 compared to the same period in 2011 and 2012 (includes possible, probable and confirmed cases)

Type of Infection	Infection	2011	2012	2013
Gastrointestinal	Campylobacteriosis	261	278	276
	Cryptosporidiosis	10	25	5
	E.coli infection, VTEC	<5	<5	<5
	Hepatitis A	0	<5	<5
	Hepatitis E	16	5	<5
	Other GI	23	33	40
	Salmonellosis	43	36	33
	Typhoid/Paratyphoid	<5	<5	<5
Vaccine preventable	Measles	34	44	59
	Mumps	93	84	100
	Pertussis (Whooping Cough)	5	89	50
	Pneumococcal infection	26	16	19
Other	Hepatitis B	215	117	114
	Hepatitis C	115	74	88
	iGAS (Invasive Group A Streptococcal) infection	<5	7	16
	Legionellosis	<5	<5	6
	Meningococcal infection	13	12	18
	Other	61	50	51
	PVL-associated staphylococcal infection	<5	<5	<5
	Streptococcal Group A infection, non-invasive or unspecified	25	54	59
	Tuberculosis	78	74	80
Total Warwickshire infections		**1035**	**1011**	**1027**

Table 2: Incidents/outbreaks report to Public Health England by principal context, Warwickshire, January to December 2013

Source: Public Health England, Outbreaks and Incidents reported to Public Health England, Warwickshire residents, January to December 2013 compared to the same period in 2011 and 2012

Principal Context	Cluster	Exposure	Issue	Outbreak	Total
Care home	2	0	0	30	32
Congregation	0	0	0	1	1
Food Outlet/Restaurant	0	0	0	2	2
Hospital	1	0	0	30	31
Nursery	1	0	0	4	5
School	0	0	1	1	2
Other	4	4	25	3	36
Total	**8**	**4**	**26**	**71**	**109**

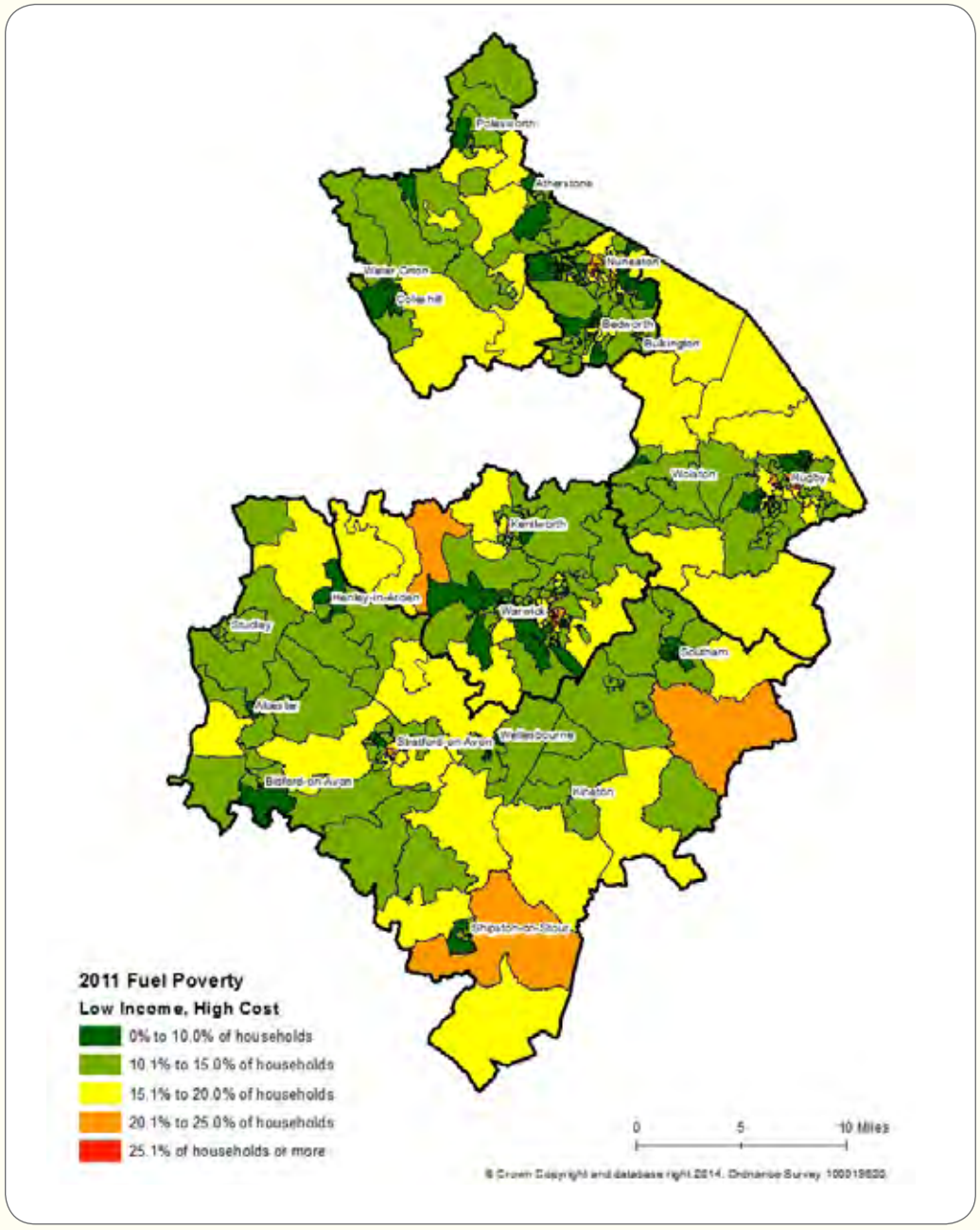
Please note that definitions of Cluster, Exposure and Outbreak can be found in the Glossary. An issue relates to a situation which needs ongoing monitoring and action.

such as that related to Seasonal Flu vaccination uptake (see Chapter 8). Campaign work last winter in Warwickshire included the "Feel Well in Winter" campaign, a Norovirus campaign (aimed at nurseries, schools and care homes),[38,39] and the "Warm and Well" campaign.[40] See below (Image 1) for some of the resources that were produced to support the campaign.

Image 1: Warm & Well winter warm checklist, Feel Well Guide & Handwashing poster.

Figure 3: Low income high cost fuel poverty, Warwickshire, 2011

Source: Department of Energy & Climate Change, 2011 sub-regional fuel poverty data: low income high costs indicator



RECOMMENDATIONS

EMERGENCY PLANNING AND OUTBREAKS

Health and social care commissioners should ensure that support required in relation to an outbreak or incident, i.e. staff resource and equipment for investigation and treatment, are detailed in contracts with providers of services. Providers and commissioners to ensure the requirements can be met.

Efforts to reduce communicable disease and to improve environmental hazard control should be considered a crucial part of the commissioning processes of all health and local government commissioners. For example, specifying outcomes required for the management of communicable diseases e.g. Hepatitis B, Hepatitis C and TB in secondary care, and prioritising air pollution reduction initiatives.

Partner organisations to ensure they are meeting their responsibilities with regard to reducing the impact of hot and cold weather on the health of Warwickshire residents, as outlined in National Heatwave and Cold Weather plans, and to support Warwickshire Warm and Well initiatives through advice giving and signposting individuals to appropriate services.

CHAPTER 3: IMMUNISATIONS

The nature of the challenge

Immunisations have been heralded as one of the biggest medical advances of the 19th and 20th centuries, sitting alongside sanitation and the discovery of antibiotics and anaesthaesia.[41] The current childhood immunisation programme we have in the UK has meant that some of the most serious communicable diseases are now rare in the UK.[42] However, examples such as the recent outbreaks of polio being declared in Syria, and the potential for other vaccine-preventable diseases to emerge in other parts of the world, it is crucial we make sure we continue to maintain good uptake of all immunisations.[43]

Vaccinations work by causing us to become immune to the diseases they protect against. This occurs because live organisms (bacteria/viruses) or inactivated (not live) parts of organisms are used to make up vaccinations.[44] If a certain proportion of people are immunised against an infection, the rest of the population are protected (because it is much less likely they are going to come into contact with someone who has the illness). This is known as "herd immunity".[37] The problem comes when certain groups or populations do not take up vaccinations, and disease spreads much more easily. This was partly responsible for the national measles outbreak in 2012.[45]

Whilst the uptake of childhood immunisations in Warwickshire is now generally high, and greater than the national 95% target,[46] it is only in recent years that the uptake of the Measles, Mumps and Rubella (MMR) vaccination has approached what is required for herd immunity. Please see Figures 6-9 for immunisation uptake at small area level in Warwickshire. The uptake of childhood immunisations has generally increased over the years in Warwickshire, however the greatest increase has been seen in the uptake of the MMR vaccination from 90.9% to 96.5% between 2009 and 2013. This is significant given the substantial drop in MMR vaccination uptake from the late 1990s, following the false claims by researchers linking MMR vaccination and autism.

One of the challenges related to promoting uptake of vaccinations is that people tend to view the risk of something "being done to them" as much higher than risks they decide to take for themselves with their health.[47] This is partly why vaccinations have created a great deal of controversy over the years.

Figures 4 and 5 show the effects of the pertussis (whooping cough) and measles outbreaks in 2011to 2013. The response in both cases was to set up temporary vaccination programmes. From October 2012, all pregnant women have been offered pertussis vaccinations, in the knowledge that mothers temporarily "pass on" immunity to their newborns. This was due to the increase in the number of cases and deaths in infants in 2011 and

Figure 4: Rate per 100,000 of confirmed Pertussis cases by month, Warwickshire, West Midlands and England 2011 to 2013
Source: Public Health England, Field Epidemiology Service and West Midlands East Health Protection Team, 2013

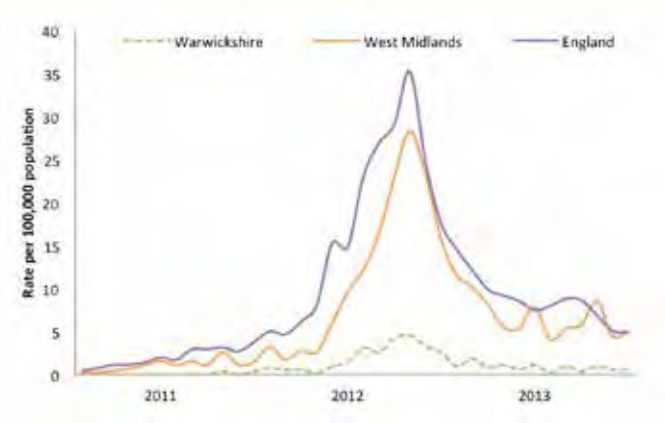
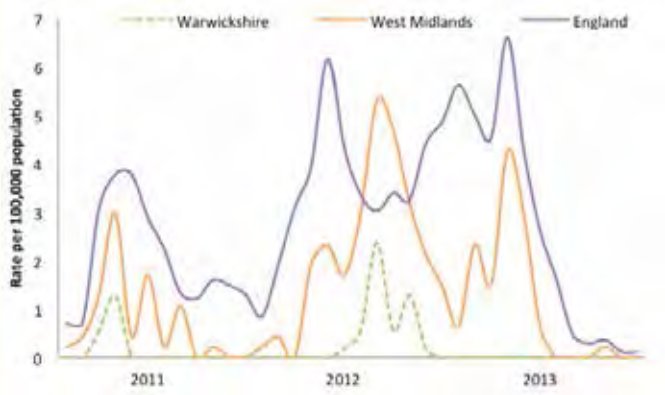


Figure 5: Rate per 100,000 of confirmed Measles cases by month, Warwickshire, 2011 to 2013
Source: Public Health England, Field Epidemiology Service and West Midlands East Health Protection Team, 2013



2012.[48] From April 2013 MMR vaccinations were offered to all 10-16 year olds, who had not been previously vaccinated, due to the large number of cases in this age group as part of a national outbreak which started in 2012.[49] The subsequent reduction in both pertussis and measles cases, due to these successful public health campaigns, can be seen for Warwickshire, the West Midlands and England in Figures 4 and 5.

In addition to these temporary vaccination programmes, a number of new vaccination programmes have recently been introduced, such as the rotavirus vaccination programme for infants, and shingles vaccination programme for older adults.[50] Making sure that enough vaccine is available, that staff are appropriately trained and that the right people receive invitations is a continual challenge for commissioners and providers of these programmes.

What is currently being done?

Ongoing work is taking place across Warwickshire and Coventry, Herefordshire and Worcestershire to put in place new immunisation programmes, including the shingles vaccination and the roll out (plans are awaited) of the seasonal flu vaccination programme to all 2-16 year olds (see Chapter 8).

Work is also taking place to ensure that all staff involved in immunisations both in primary care and in school settings are appropriately trained, to minimise the risk of immunisation incidents.

> In addition to these temporary vaccination programmes, a number of new vaccination programmes have recently been introduced.

Figure 6: 5-in-1 vaccination uptake (Diphtheria, Tetanus, Pertussis, Polio, Haemophilus Influenzae B), 5 year olds, Warwickshire, 2013
Source: Public Health England, Cover of Vaccination Evaluation Rapidly (COVER), 2013

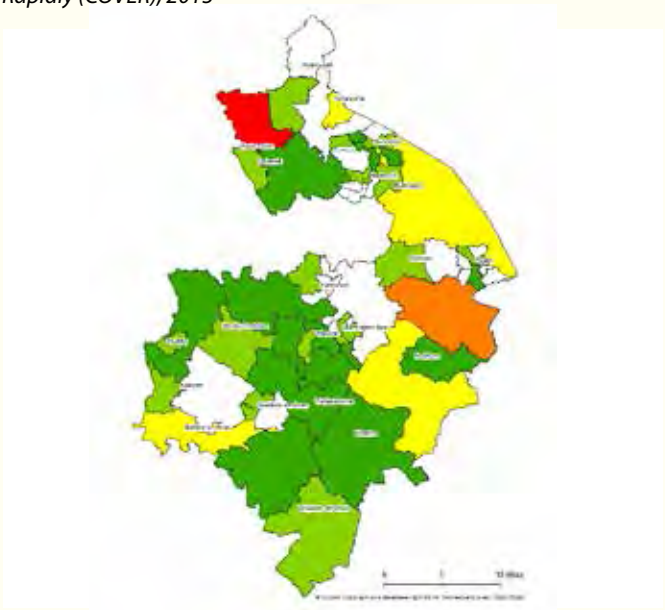


Figure 7: Haemophilus Influenzae B/Meningitis C vaccination uptake, 5 year olds, Warwickshire, 2013
Source: Public Health England, Cover of Vaccination Evaluation Rapidly (COVER), 2013

Figure 8: Measles, Mumps and Rubella (MMR) vaccination uptake, 5 year olds, Warwickshire, 2013
Source: Public Health England, Cover of Vaccination Evaluation Rapidly (COVER), 2013

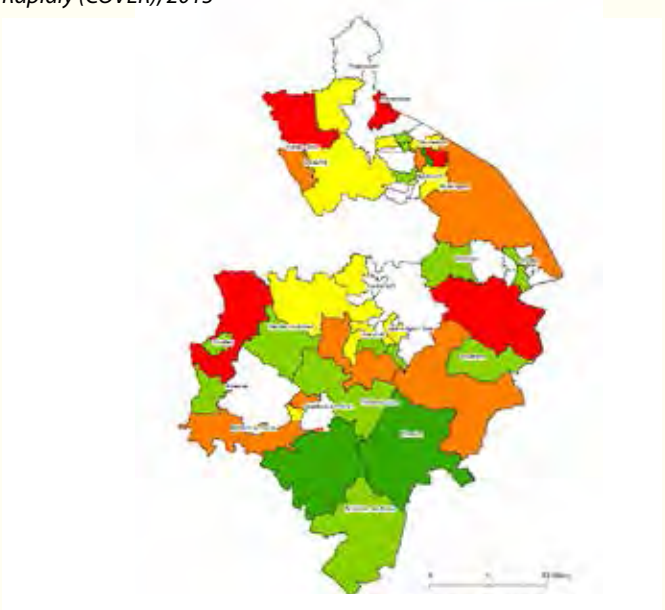
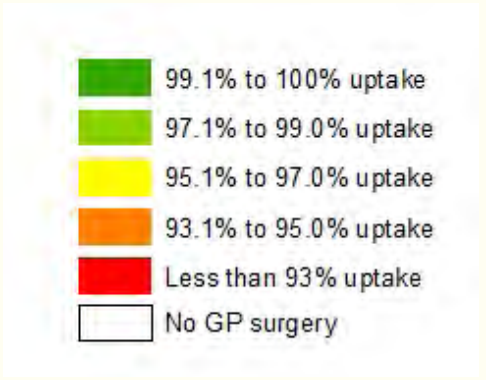
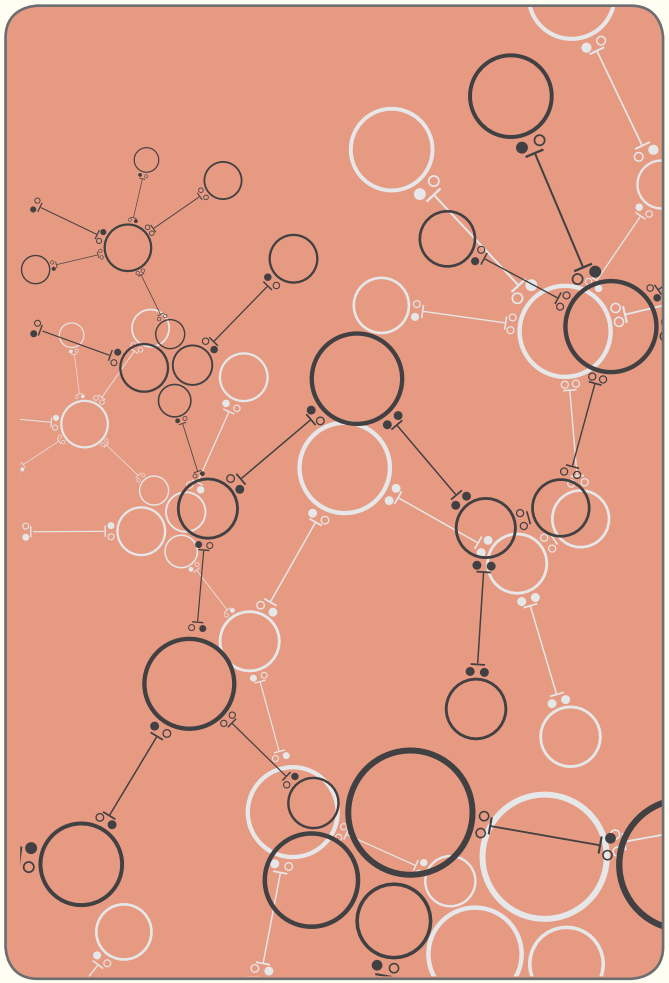


Figure 9: Pneumococcal vaccination uptake, 5 year olds, Warwickshire, 2013
Source: Public Health England, Cover of Vaccination Evaluation Rapidly (COVER), 2013





RECOMMENDATIONS

IMMUNISATIONS

Partners to work together to promote the uptake of new immunisations as programmes are introduced, e.g. Meningococcal C vaccination amongst University students.[5]

Ensure sharing of information between NHS England, Public Health England, and the local authority to provide assurance and allow opportunities for joint working to promote vaccination uptake and to resolve problems identified in delivering vaccination programmes.

Continue to actively promote immunisation uptake across Warwickshire, using school entry as an opportunity to check vaccination status of children.

CHAPTER 4: BLOOD-BORNE VIRUSES

The nature of the challenge

Blood-borne viruses cause infections that are carried in the blood, and can be transmitted from one person to another. Three of the most common are Hepatitis B (Hep B), Hepatitis C (Hep C) and HIV. As HIV is covered in Chapter 6, this section will focus on Hep B and Hep C.

Hep B and Hep C are both silent, because they can be present without people knowing about it. They can both be transmitted through unprotected sexual intercourse (Hep C less easily than Hep B), bites and scratches, childbirth (mother-to-baby transmission), sharing needles (commonly among intravenous drug users), and through exposure to contaminated items such as razors, toothbrushes, tattooist's needles, and equipment used for body piercing.[8, 52] Notably, transmission of Hep B to a baby during birth can lead to long term illness in 90% of babies of highly infectious mothers.

Both Hep B and Hep C can become long-term infections, but people with Hep B are more likely to clear their infection completely (10% of Hep B cases become long-term, in contrast to 80% of Hep C).[52] However they can both cause serious complications, such as scarring of the liver (cirrhosis) and liver cancer. These two diseases are common in all African countries and many parts of Asia, Eastern Europe and the Pacific Region.[53] Hep C is very common among intravenous drug users.[54]

Transmission of Hep B can be prevented through a course of vaccinations. These are offered to household contacts of people with Hep B, babies born to mothers with Hep B, intravenous drug users, healthcare workers and a number of other high-risk groups.[55] Although there is no vaccination for Hep C, it is more easily cured than Hep B, with treatment aiming to clear the virus completely.[56] However curative treatment is not always successful.

> Transmission of Hep B can be prevented through a course of vaccinations.

Compared with other local authorities in the West Midlands, the number of cases of Hep C in Warwickshire is low, but there are higher numbers of Hep B cases than in other rural local authority neighbours (Table 3). However, these infections often cause no symptoms in the early stages, can be passed from one person to another, and affect some of our most vulnerable communities, such as injecting drug users, and migrants from countries where Hep B and Hep C are common. This is what makes them important.

One of the biggest challenges related to blood-borne viruses lies in the number of different health settings that those most at risk present to. All intravenous drug users who use drug misuse services should be offered a test for Hep B and C viruses. Those who are not infected with Hep B virus should be vaccinated to protect against the infection. Sexual Health Clinics also see certain populations at risk (including men who have sex with men (MSM), those who have multiple sexual partners or who change partners frequently, and patients infected with HIV), as do maternity services and general practice. National guidance outlines where and who should be screened.[53] It is also crucial for those people who are diagnosed to be appropriately referred on and treated.

A further challenge lies in the fact that the Hep B vaccination requires a course of 3 or 4 injections with intervals of several months between each.[55] This means that there have to be good systems in place to make sure this happens, particularly for babies who are born to infected mothers, given the illness is much more severe in babies and young children. Currently NHS England and Public Health England have the role of ensuring that vaccinations take place as they should.

What is currently being done?

An Arden Hepatitis B/C strategy group exists and is made up of public health professionals, sexual health clinicians, gastroenterologists, microbiologists, GPs, drug and alcohol service providers and third sector organisations e.g. Hepatitis C Trust and British Liver Trust. A strategy and action plan have been developed.[57]

An easy guide for GPs is being developed through the strategy group to give information about who and how to screen/test for Hep B, and some primary care training is proposed.

Table 3: Number of laboratory reports of Hepatitis B and C, West Midlands, 2005 to 2012

Source: Public Health England, Hepatitis B and C Laboratory Reports - (NB. Numbers less than 5 have been supressed to maintain confidentiality)

Upper tier local authority	2005		2006		2007		2008		2009		2010		2011		2012	
	HEP B	HEP C	HEP B	HEP C	HEP B	HEP C	HEP B	HEP C	HEP B	HEP C	HEP B	HEP C	HEP B	HEP C	HEP B	HEP C
Birmingham	29	265	17	177	140	189	134	231	130	239	170	241	209	206	228	230
Coventry	<5	16	57	20	156	72	116	73	105	133	125	146	152	121	125	94
Dudley	6	36	21	43	23	32	19	61	21	38	30	29	20	29	20	39
Herefordshire	7	15	<5	6	9	25	15	14	7	7	6	31	11	27	9	27
Sandwell	10	14	15	25	26	38	<5	56	12	7	<5	15	11	<5	7	11
Shropshire	<5	17	9	24	13	48	12	37	16	52	13	28	12	34	15	35
Solihull	<5	8	<5	<5	7	6	8	6	<5	8	<5	<5	10	12	9	<5
Staffordshire	21	79	19	81	31	57	17	38	43	92	26	34	24	41	14	40
Stoke-on-Trent	11	11	27	8	39	5	59	<5	41	112	53	92	46	118	47	76
Telford and Wrekin	<5	0	<5	<5	7	6	11	9	<5	14	10	11	11	9	14	10
Walsall	<5	15	<5	23	13	7	33	23	26	40	24	24	23	32	15	21
Warwickshire	<5	0	12	<5	28	<5	44	5	29	8	40	13	34	35	48	42
Wolverhampton	<5	76	<5	38	<5	73	<5	70	<5	84	15	71	43	52	38	51
Worcestershire	20	22	11	40	22	50	27	48	24	30	35	44	18	52	21	57
West Midlands	**112**	**574**	**198**	**490**	**515**	**612**	**501**	**674**	**465**	**864**	**554**	**783**	**624**	**770**	**610**	**737**

RECOMMENDATIONS

BLOOD-BORNE VIRUSES

Professional awareness needs to be raised in primary and secondary care, sexual health, and drug and alcohol services, with regard to who to screen or test for blood-borne viruses, and how to manage and refer positive cases, working to improve uptake of testing and vaccination.[6-8]

Ensure a seamless pathway for people from diagnosis (in a range of services) to treatment of Hep B and Hep C, through appropriate commissioning and strong referral pathways between services.

Ensure a robust system is in place for those most at risk (e.g. household and sexual contacts of known Hepatitis B positive patients, babies born to Hepatitis B positive mothers etc.) to have their entire course of vaccinations.

CHAPTER 5: SCREENING

The nature of the challenge

Screening is a process of identifying apparently healthy people who may be at increased risk of a disease or condition. They can then be offered information, further tests and appropriate treatment to reduce their risk and/or any complications arising from the disease or condition. There are a number of national screening programmes currently run by NHS England and Public Health England: breast, bowel and cervical cancer screening, aortic aneurysm and diabetic retinopathy screening, and a range of antenatal and newborn screening programmes.

Although there are many tests we can do to diagnose a range of illnesses, we only screen for diseases if we know that when we pick them up early there is a good chance of a successful recovery. There are a number of important criteria that must be met related to the disease itself, the test, the treatment and the programme, before a screening programme is established.[58] It is important to note that screening identifies people at higher risk of disease, who then go on to have further tests to establish if they have the disease or not.

No screen test is 100% reliable. However, it is important to keep the proportion of people who might have false positive (wrongly identified as potentially having the disease) and false negative results (wrongly identified as not likely to have the disease) small. It is also important to look at who benefits most from being screened, and therefore screening programmes are often run for people in particular age groups. Screening programmes should do more good than harm. This is why at the moment there is no recommended national screening programme for prostate cancer, for example, as we do not know which individuals diagnosed through screening are likely to benefit from the treatments available. Table 4 outlines some of the key evidence related to the adult screening programmes. This evidence is constantly being reviewed, and there are national plans to consider the evidence for ovarian and lung cancer screening in 2015.[59]

In Warwickshire, the uptake of breast cancer screening (78.3%), cervical cancer screening (75.3 %) in 2013, and access to diabetic retinopathy screening for 2011/12 (86.4%) are all higher than the national average (76.3%, 73.9% and 80.9% respectively). This is a good thing, but the overall figure can hide much lower uptake figures in particular population groups.[59] Deaths from breast cancer and from bowel cancer have also reduced significantly in Warwickshire, by about 38% and 47% respectively between 1995-7 and 2008-10, although this is likely to relate to a number of other factors including screening and better treatments.[60]

Over the course of 2012, the "Are you ready for your Screen Test" campaign was run across Warwickshire and Coventry, which focused on promoting uptake of the three cancer screening programmes: breast, bowel and cervical cancer screening programmes.

Screening programmes themselves need to be run well to make sure that the right people are invited for screening at the right time intervals, and that people with positive results are appropriately referred on for further testing. Screening alone is clearly not the answer to reducing illness and death related to the conditions described. However, it goes hand in hand with efforts to prevent illness through reducing smoking, obesity, problem drinking and other lifestyle behaviours.[59]

> "Screening is a process of identifying apparently healthy people who may be at increased risk of a disease or condition.

What is being done?

A new Diabetic Retinopathy Eye Screening programme is being commissioned by NHS England for Warwickshire, Coventry, Herefordshire and Worcestershire.

There are ongoing visits taking place to assess the quality of all of the screening programmes provided in the Warwickshire, Coventry, Herefordshire and Worcestershire Area.

There are a number of IT systems being put in place which will allow screening programmes to capture information more efficiently.

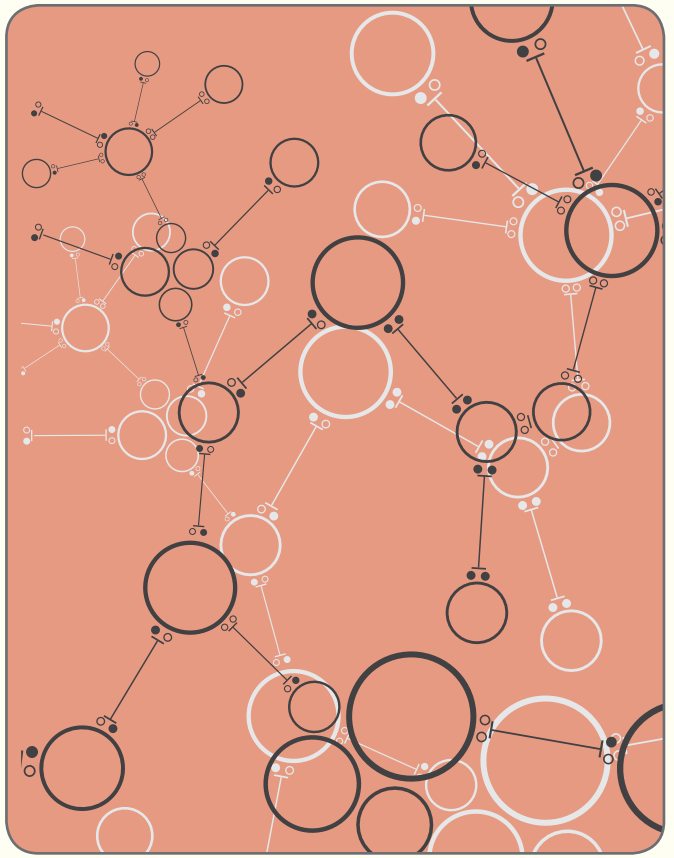


Table 4: Evidence related to adult screening programmes

Screening programme	Epidemiology	Benefits and risks of screening
Breast Cancer Screening [61] Test: Mammogram (X-ray of the breasts) Follow up tests (if positive): Further mammogram Ultrasound scan of breast Biopsy in some people (small sample taken from breast with needle)	Breast cancer is the most common type of cancer in the UK. About 12,000 women in the UK die of breast cancer every year.	Screening saves about 1 life from breast cancer for every 200 women who are screened. This adds up to about 1,300 lives saved from breast cancer each year in the UK. About 3 in every 200 women screened every 3 years from the age of 50 to 70 are diagnosed with a cancer that would never have been found without screening and would never have become life-threatening. This adds up to about 4,000 women each year in the UK who are offered treatment they did not need. This means that for every 1 woman who has her life saved from breast cancer, about 3 women are diagnosed with a cancer that would never have become life-threatening.
Bowel Cancer Screening [62] Test: Stool sample Follow up test (if positive): Colonoscopy (thin flexible tube with camera passed into back passage)	1 in 20 people will develop bowel cancer during their lifetime. It is the third most common cancer in the UK, and the second leading cause of cancer deaths.	Regular screening reduces the risk of bowel cancer by 16% About five in 10 people who have a colonoscopy will have a normal result. About four in 10 will be found to have a polyp, which if removed may prevent cancer developing. About one in 10 people will be found to have cancer when they have a colonoscopy. For most people, having a colonoscopy is a straightforward procedure. However, as with most medical procedures, there is the possibility of complications.
Cervical Cancer Screening [63] Test: Smear test (sample of cervix) Follow up test (if positive): Colposcopy (examination of the cells of the cervix using a magnifying instrument) with possible biopsy (sample taken from cervix)	Around 750 women die of cervical cancer in England each year. However many of those who develop it have not been screened regularly. Due to cervical screening, cervical cancer is now an uncommon disease in this country.	Early detection and treatment can prevent around 75% of cancers developing but, like other screening tests, it is not perfect. It may not always detect early cell changes that may lead to cancer. In around one in 20 tests, the cells cannot be seen properly under the microscope and the test must be taken again. Research suggests that up to 4,500 lives will be saved each year in England by cervical screening.

Screening programme	Epidemiology	Benefits and risks of screening
Diabetic Retinopathy Screening [64] Test: Photographs of back of eye	There are nearly 2.5 million people with diabetes identified by GP practices in England. It is estimated that in England every year there are around 4,200 people at risk of blindness caused by diabetic retinopathy, and there are 1,280 new cases of blindness caused by the diseases.	The screening programme, based on studies in other countries, has the potential to reduce the numbers of new cases of blindness in England from an estimated 1,280 to 256, saving the sight of more than 1,000 people a year. On rare occasions, screening can miss changes that could threaten sight, although every effort is made to reduce the risk of this happening. The eye drops used to dilate the pupils during the screening test may cause some temporary symptoms and very rarely, they can cause a sudden, dramatic rise in pressure within the eye.
Abdominal Aortic Aneurysm Screening (AAA) [65] Test: Ultrasound test	Around 1 in 25 men in England aged between 65 and 74 have an abdominal aortic aneurysm. Most of these are small and not serious. However, small AAAs can increase in size and develop into large AAAs which can rupture: a medical emergency that is often fatal.	It is estimated that the programme will reduce the death rate from ruptured AAA among men aged 65 and over by up to 50 per cent, eventually preventing around 2,000 premature deaths per year.

RECOMMENDATIONS

SCREENING

Work to maximise uptake in all screening programmes, through the sharing of detailed information between organisations (NHS England, Public Health England and Local Authorities), allowing targeted messages to be delivered to the appropriate groups and particularly to groups with low uptake.

Screening messages to become a more routine part of disease prevention messages communicated through health, social care, community and voluntary sector professionals to members of the public.

CHAPTER 6: SEXUAL HEALTH

The nature of the challenge

Efforts to improve sexual health in Warwickshire are aimed at reducing the rates of teenage pregnancy and sexually transmitted infections e.g. Chlamydia, Gonorrhoea, Syphilis and HIV (including the late diagnosis of HIV).[66] Since April 2013, Public Health in local authorities have had responsibility for commissioning sexual health services (not including HIV treatment services). We know that the best way of delivering these services is by making sure that people entering a service get advice, screening and treatment for sexually transmitted infections, but also contraceptive advice and treatment, all in the same place and preferably in the same appointment.[66] Users repeatedly tell us that it is important that there is easy access in the community to Emergency Hormonal Contraception and Chlamydia screens [67] and that young people receive sex positive advice (which acknowledges natural curiosity and encourages openness) wherever they use sexual health services. Developing innovative sex positive educational programmes which teach children and young people about healthy sexual relationships is also a priority.[66]

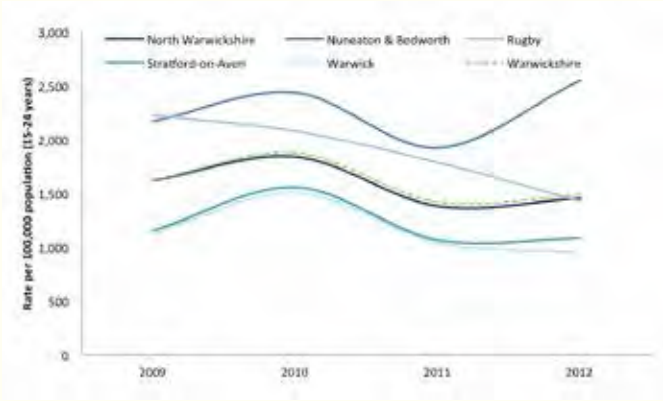
Currently in Warwickshire, contraceptive services and sexually transmitted infection services are provided separately and in different locations around the County. Over the course of 2014/15 a new service will be commissioned, which will bring together these services in accessible locations across the County. Being able to access services easily is something service users tell us they want, and so it is proposed that people will be able to book appointments online, but drop in appointments will also be available.[68] We are looking to improve the opening hours of services, so they are open outside of working and school hours, and that they are in locations that are easy to get to, wherever you live in Warwickshire.

Sexually transmitted infections

Chlamydia is one of the most common sexually transmitted infections and many cases are asymptomatic (do not have any symptoms). However, it can cause serious problems such as infertility, ectopic pregnancy and pelvic inflammatory disease.[69] Testing and diagnosis rates for Chlamydia are going up in Warwickshire (meaning we are detecting more cases, rather than there necessarily being more infection), particularly since the Chlamydia Screening Programme started in 2003. However, there is much variability between districts and boroughs in terms of rates (Figures 10 and 11). Although Nuneaton and Bedworth Borough has the highest rates in the County (and highest positive test rates), more people from Nuneaton and Bedworth Borough are tested than in other districts and boroughs which may partly explain this (Figure 12).

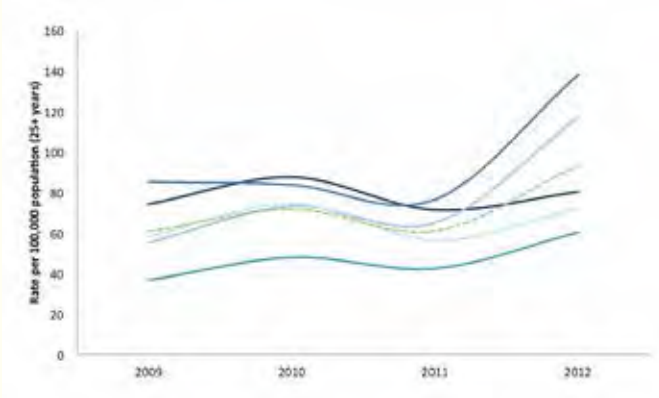
HIV remains an important problem also, particularly in those at highest risk, i.e. Men who have sex with Men and Black African

Figure 10: Chlamydia Diagnostic Rate per 100,000 population aged 15-24 years, Warwickshire, 2009 to 2012
Source: Public Health England, Chlamydia Testing Activity Dataset, 2009 - 2012



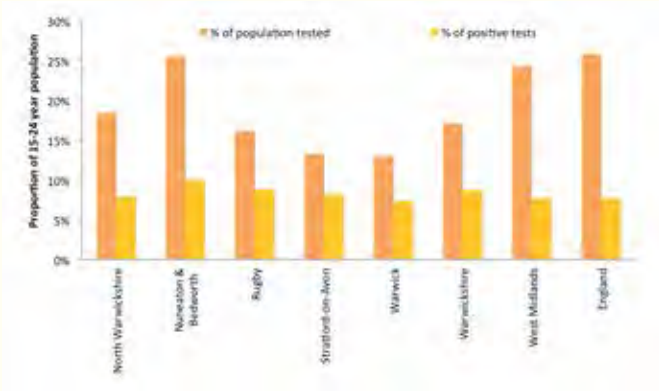
Please note, due to reporting, 2012 data cannot be compared to previous years.

Figure 11: Chlamydia Diagnostic Rate per 100,000 population aged 25 years and over, Warwickshire, 2009 to 2012
Source: Public Health England, Chlamydia Testing Activity Dataset, 2009 - 2012



Please note, due to data collection changes, 2012 data cannot be compared to previous years.

Figure 12: Proportion of 15-24 year population who were tested and those who tested positive for Chlamydia, Warwickshire, 2012
Source: Public Health England, Chlamydia Testing Activity Dataset, January to December 2012



Ethnic minority groups. Although a treatable condition, it can still cause serious illness. Despite the numbers of cases diagnosed each year in Warwickshire being small, 60.5% of cases of HIV diagnosed between 2010 and 2012 were diagnosed late, i.e. at a stage at which treatment is much less effective (Figure 13). Of all the districts and boroughs, Rugby Borough has the highest proportion of people living with HIV: approximately 1.5 in every 1000 people.

Under 18 conceptions

The under 18 conception rate has been falling in Warwickshire overall for a number of years (Figure 14). There is variability from year to year and between districts and boroughs in terms of rates, with Nuneaton and Bedworth Borough being consistently high. However, there were some notable reductions seen in rates in several districts and boroughs in 2012.

What is being done?

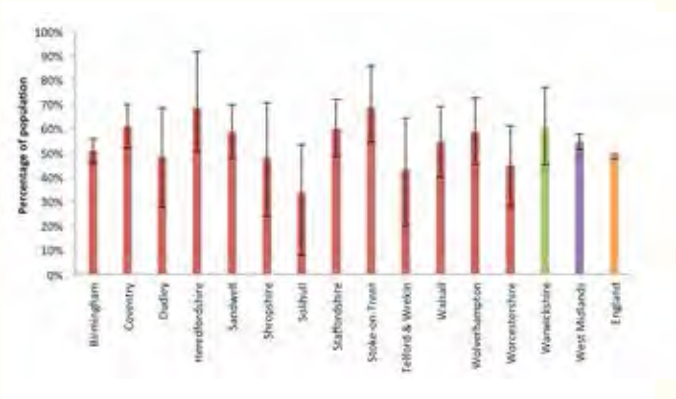
A new model for sexual health services is proposed in Warwickshire and is expected to be fully in place in 2016. It is important that this service continues to work to tackle some of the differences in outcomes seen across the County. [70]

The Respect Yourself health promotion programme engages with young people and schools. Its mobile app and website (www.respectyourself.info) were recently shortlisted for a National Sexual Health Award in the Best Young People's Resource section. Website licences are being offered to other local authorities, who can add their own local information to provide a cost effective (and evidence-based) solution to supporting young people's sexual health in their area.

The Spring Fever primary school programme is an innovative Relationships and Sex Education programme which is being rolled out in several primary schools in Warwickshire, providing them with an opportunity to improve the quality of their Relationship and Sex Education programme, as well as strengthening identification and safeguarding related to child sexual abuse.

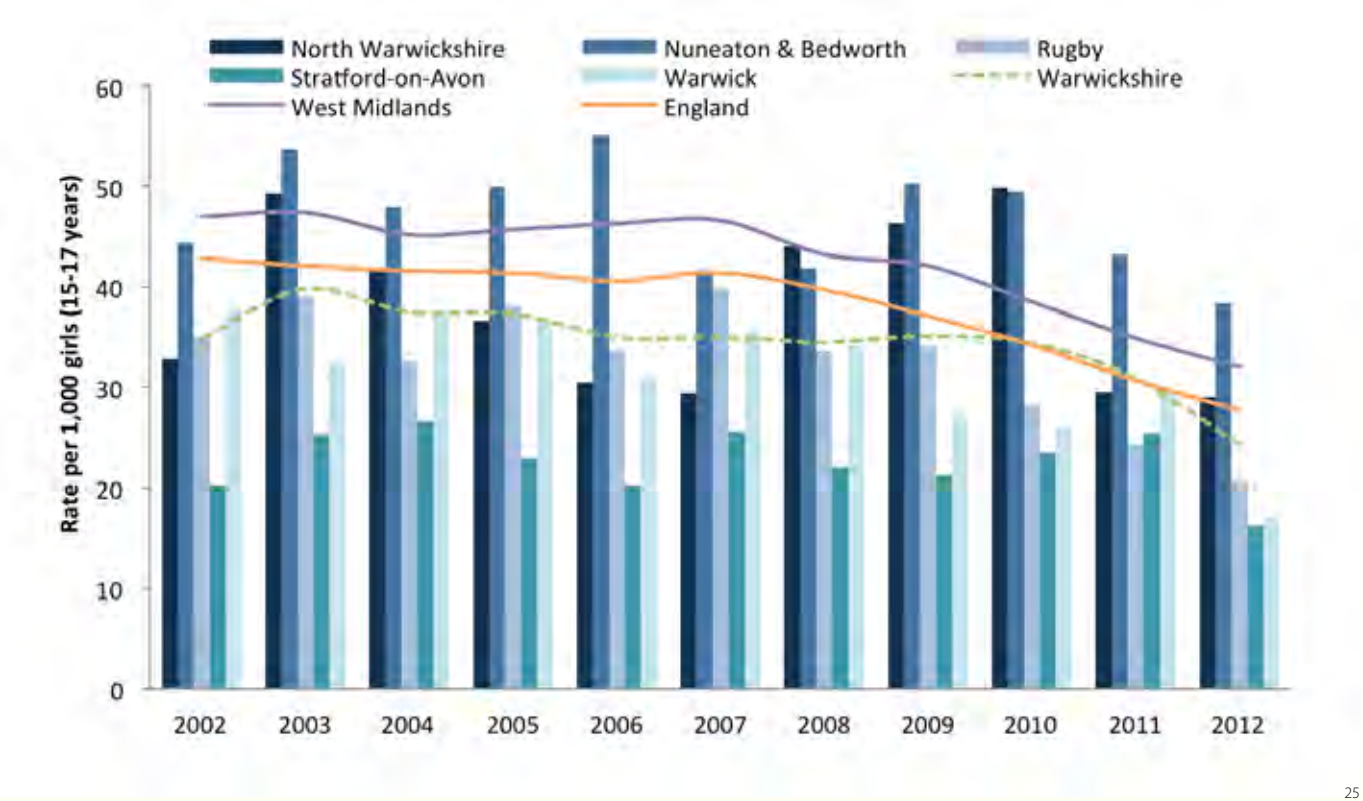
A community HIV testing service is currently provided in both Warwickshire and Coventry, which aims to raise awareness, reduce stigma associated with HIV, and encourage and deliver HIV testing in the community in high risk groups

Figure 13: Proportion of individuals diagnosed with HIV who are diagnosed at a late stage of infection, West Midlands, 2010-2012
Source: Integrated HIV surveillance data: SOPHID, HANDD, and CD4 Surveillance (HIV & STI Department, CIDSC, PHE)



> The under 18 conception rate has been falling in Warwickshire for a number of years.

Figure 14: Conception rate per 1,000 girls aged 15-17, Warwickshire, 2002 - 2012
Source: Office for National Statistics, Conceptions Statistics, England and Wales 2014



RECOMMENDATIONS

SEXUAL HEALTH

Partners to continue to focus on signposting high risk groups for HIV testing in order to improve early diagnosis rates.[9]

Ensure that the new model of sexual health services enables increased access to comprehensive sexual health services in one place, works to reduce sexual health inequalities across the County, and has effective referral pathways to and from related services, e.g. termination of pregnancy services, drug and alcohol services etc.

Improve Chlamydia diagnostic rates through promotion of and delivery of targeted screening and testing in sexual health services and in community venues across the County, in order to reduce the overall number of new cases.

Continue the roll out of Spring Fever, and Respect Yourself programme work across the County and marketing of the programmes.

CHAPTER 7: HANDWASHING AND PREVENTING INFECTIONS

Background

Washing hands with soap and water is one of the most effective ways of reducing the spread of infections, especially those that cause diarrhoea and vomiting, respiratory infections, as well as those that can be transmitted from open wounds.[10] This is why we call handwashing an 'infection control measure'.

A focus on handwashing alongside other infection control measures has led to the huge national decline in infections people acquire in hospital over the last 10 years.[71] Other measures include a focus on enhanced cleaning in hospitals, use of personal protective equipment (such as gloves and aprons), improvements in the use of antibiotics, and the priority given to hospitals to reduce healthcare associated infections (HCAI) with strict targets. For example, the frequency of HCAI dropped from 8.2% of patients in hospitals in England, in a study carried out in 2006, to 6.4% in 2011.[72] The two main types of infection originally focused on were MRSA and Clostridium difficile. MRSA is a bug that lives on the skin and in the nostrils and throat (even in many healthy people), so it can easily infect wounds and gain access to the blood stream. It is resistant to many of the antibiotics that we commonly use, so it can be very difficult to treat, and this can have serious consequences in people who are already unwell. Clostridium difficile can also live in healthy people, and is usually found in the gut. When people become unwell and are given antibiotics, this may sometimes lead to Clostridium Difficile taking over the gut and causing profuse diarrhoea and dehydration. Both of these infections can be passed from person to person through poor hand hygiene.

In Warwickshire the number of Clostridium Difficile cases in hospitals reduced from 766 in 2008/9 to 266 cases in 2012/13 (Figure 15). [73] The number of MRSA infections of the bloodstream has reduced from 38 cases to 7 cases per year in hospital settings between 2008/9 and 2013/14 (Figure 16).[74] However, a significant proportion of the Clostridium Difficile cases in 2013/14 were brought into hospital from the community, rather than being related to the hospital stay itself. Although the rate of infection in Warwickshire is higher than the West Midlands for both of these infections, these figures do not take into account the older population in Warwickshire, who are more vulnerable to infection. Handwashing in places of care and education, such as hospitals, care homes, schools and nurseries, is of particular importance. This is because of the ease with which infections are spread when there are a lot of people in close proximity to each other, especially those who may be vulnerable to infections.

Infection control measures become even more important over the winter period due to an increase in the circulation of tummy bugs such as Norovirus, as well as colds and flu. Norovirus is a highly infectious illness which causes projectile vomiting and diarrhoea.[75] The virus particles can stay in the environment for several days or even weeks. Although cleaning hands using alcohol based rubs is effective for reducing the risk of passing on some infections it does not work against Norovirus or Clostridium Difficile, and is less effective if hands are visibly dirty or contaminated. This is why hand washing with soap and water is a fundamental step in preventing the spread of these infections.

The battle against Norovirus is an ongoing one. In 2012/13 Warwickshire hospitals experienced ongoing outbreaks of Norovirus and as can be seen from the outbreak figures highlighted in Chapter 2, it is a persistent problem.

Figure 15: Rate per 100,000 population aged 2 years and over of C.difficile infection in hospitals in Warwickshire and West Midlands, 2007/08 to 2013/14
Source: Public Health England, Healthcare associated infections (HCAI), 2013

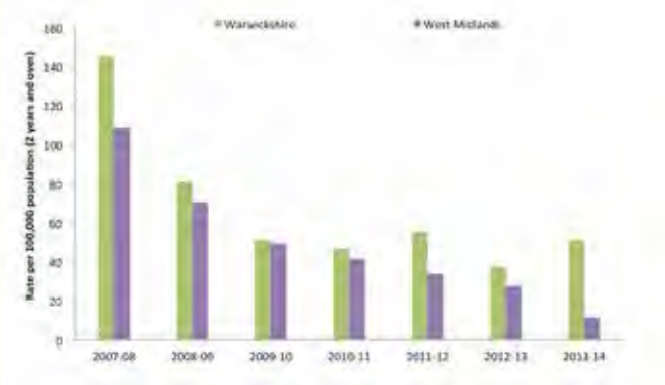


Figure 16: Rate per 100,000 population of MRSA bacteraemia in hospitals in Warwickshire and West Midlands, 2008/09 to 2013/14
Source: Public Health England, Healthcare associated infections (HCAI), 2013

However, fewer outbreaks were notified during the course of the 2013/14 winter season in Warwickshire, which is likely to be related to good planning and a relatively mild winter.

Over the course of last winter a number of campaigns were run in Warwickshire, including the 'Feel Well in Winter' campaign,[76] and a 'Say No to Norovirus' campaign.[77, 78] The latter was led by South Warwickshire Foundation Trust and was extended to cover care homes, schools and nurseries, as well as hospitals in both Warwickshire and Coventry. The message was a simple one: "Wash your hands with soap and water". The Feel Well campaign also delivered several key messages about the effectiveness of handwashing (particularly before eating and handling food, after coughing or sneezing, and after using the toilet), the importance of cleaning 'touch points' in the home, and the need to dispose of tissues properly. Vitally, it highlighted the need to defer visiting relatives in care homes or hospitals if unwell with a cold/flu or diarrhoea and vomiting, thus protecting a vulnerable population.

What is being done?

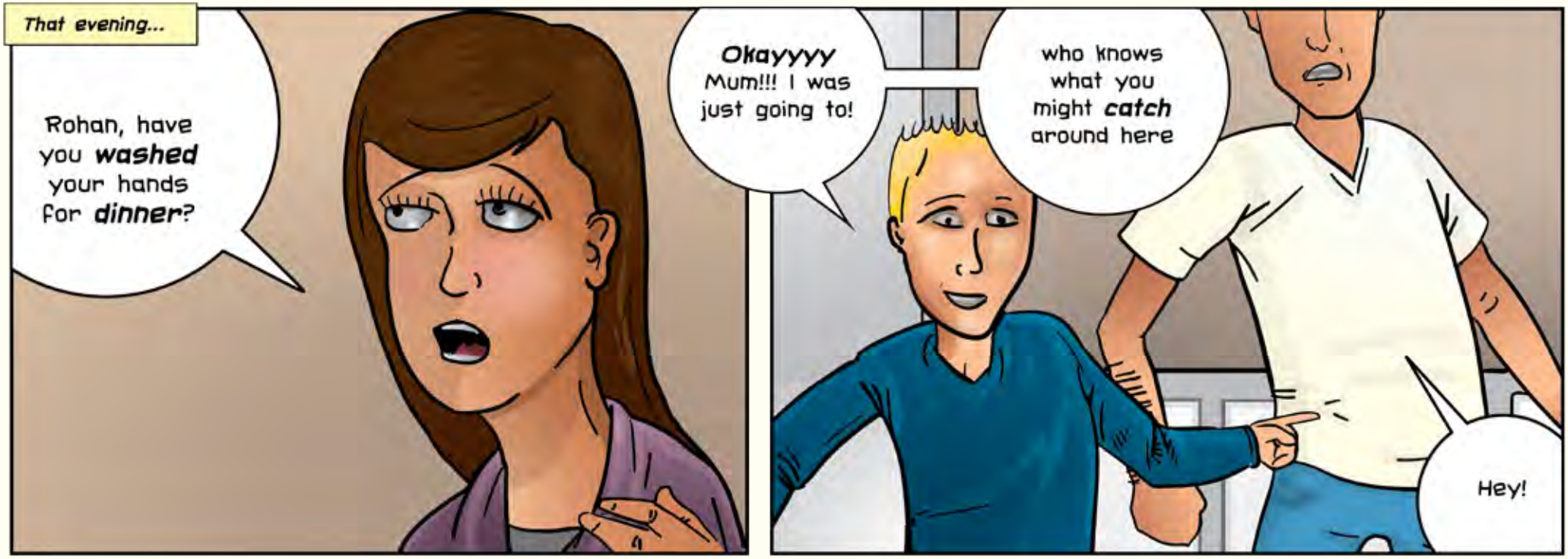
Winter campaigning which focuses on infection control particularly in relation to respiratory viruses and Norovirus.

A Norovirus plan for hospitals in Warwickshire was put in place for the winter 2013/14, and much less Norovirus activity was seen.

An infection control nurse currently provides practical support in Warwickshire to care home staff, and work is ongoing to maintain and improve infection control practices in care homes.

Ongoing work to maintain improvements in numbers of healthcare associated infections acquired in hospitals in Warwickshire.

> Washing hands with soap and water is one of the most effective ways of reducing the spread of infections.



RECOMMENDATIONS

HANDWASHING AND PREVENTING INFECTIONS

Develop plans to embed teaching about infections and the importance of handwashing in school curricula.

Ensure infection control features in all contracts held with clinical or care providers, including primary and secondary care, social care, as well as licensed food venues, and ensure that contractual obligations are being met.

Maintain improvements in hospital and care home infection control, through providing regular feedback to staff regarding the outcomes of infection control audits.[10]

Partners to work together to implement the recommendations of the Chief Medical Officer's Antimicrobial Resistance Strategy.[11]

CHAPTER 8: SEASONAL FLU

The nature of the challenge

For healthy people, Seasonal Influenza (flu) can be unpleasant, with most people recovering within a week. However, for some people flu can be more severe and lead to complications. Free NHS flu vaccination by injection, commonly known as the 'flu jab' is offered every year to protect people most at risk of the flu and its complications. This includes:

- Anyone aged 65 or over
- Adults and children with chronic underlying health conditions
- Pregnant women
- Adults and children with weakened immune systems

Vaccination is also offered to people who are likely to be in contact with vulnerable populations. This includes carers and health and social care employees who deliver patient care. In 2013/14 a new nasal spray vaccination was offered to all children aged 2 and 3 that not only protects them, but also helps to prevent the spread of flu to their family and wider community. Over time, as the programme rolls out, all children between the ages of 2 and 16 will be vaccinated against flu each year with the nasal spray.

A new vaccination formula is developed each year, based on the strains of flu most likely to circulate in the colder months, meaning that eligible people need to get a new vaccination every year to ensure that they are protected. In Warwickshire, one in three people were entitled to a free NHS flu vaccination in 2013/14. Vaccinations were provided at pharmacies and GP practices across Warwickshire.

With the transfer of Public Health to Local Authorities (LAs) in April 2013, the responsibility for assurance of effective immunisation programmes locally sits with the LA Director of Public Health (DPH).[79] In 2013/14, Warwickshire County Council undertook a programme of assurance and promotion to maximise uptake of flu vaccination in Warwickshire, which is described below.

Who had their flu vaccination in 2013/14?

Flu vaccinations were provided in pharmacies and through GP practices aligned to three Clinical Commissioning Groups (CCGs) – South Warwickshire CCG (Stratford District and Warwick District), Warwickshire North CCG (Nuneaton and Bedworth Borough and North Warwickshire Borough) and Coventry and Rugby CCG (Rugby Borough). Data for flu vaccination uptake is provided by CCG area.

Table 5 shows the percentage uptake by CCG area for each patient group. The range (lowest uptake and highest uptake by GP practice) is also provided for people over 65, those clinically at risk, and pregnant women.

Although the over 65s in South Warwickshire were the only group to achieve over the national 75% target, many individual practices across all areas had uptakes in excess of 75% for over 65s, those clinically at risk, and pregnant women.

Table 5: Seasonal flu vaccination uptake, Clinical Commissioning Groups in Warwickshire, West Midlands & England, 2013/14
Source: Public Health England (2014) Seasonal flu vaccine uptake 2013/14 in GP registered patients for flu vaccinations given from 1 September 2013 to 31 January 2014 in England

Area	Aged 65 and over % age and range	Clinical at risk (6 months to 65 years) % age and range	Pregnant women % age and range	Age 2 (not including clinical at risk) % age and range	Age 3 (not including clinical at risk) % age and range
South Warwickshire CCG	77.4% (57%-83%)	59.4% (38-70%)	47.7% (26%-73%)	55.80%	49.90%
Warwickshire North CCG	72.0% (69%-88%)	53.5% (45%-80%)	42.8% (29%-80%)	35.70%	33.40%
Coventry & Rugby CCG	73.0% (60%-89%)	57% (39%-82%)	44.2% (23%-79%)	39.30%	39%
Regional Uptake	**73.9%**	**55.9%**	**41.8%**	**42.9%**	**40.7%**
England Uptake	**73.2%**	**52.3%**	**39.8%**	**42.2%**	**38.9%**

Across Warwickshire and Coventry:

- A total of 121,591 (74.3%) of over 65s were vaccinated.
- 5239 (45%) of pregnant women received a vaccination, including 64% of at risk pregnant women (e.g. pregnant women with diabetes and other clinical conditions)
- Uptake in clinically at risk adults is higher than in children. 58% of 16-65 year olds received a vaccination compared to 48% of 2-16 year olds, and 33% of 6 month to 2 year olds.
- Almost 2000 (52%) registered carers in Warwickshire received a vaccination.

It is difficult to compare uptake with previous years as reporting has changed from countywide to CCG wide figures.

113 Warwickshire pharmacies were commissioned to provide NHS flu vaccinations. The Local Authority advocated for pharmacies to be commissioned to provide flu vaccination in 2013/14 based on evidence and evaluation of a local pilot pharmacy scheme.

Pharmacies vaccinated a total of 5257 eligible residents in Coventry, Warwickshire, Herefordshire and Worcestershire, including 110 pregnant women. Although this is a small number compared to the number vaccinated in General Practice, it is important as it represents a number of people that may not have accessed vaccination otherwise. Reasons for choosing pharmacies included more convenience and being unable to attend their GP, with 488 stating that they had never had a flu vaccination before.

Flu vaccination for health and social care workers is also recommended, and provides benefits including reducing the chances for flu to spread to vulnerable people and reducing sickness absence through winter.

Employers are responsible for funding flu vaccination for staff. At Warwickshire County Council, 280 staff members who provided direct patient care were identified in the workforce and offered vouchers for flu vaccinations at local venues. This was funded by Public Health. Staff were invited to provide feedback on the voucher scheme. Twenty five responses were received with staff members commenting on the convenience of the service. Some staff who were entitled to free NHS flu vaccinations returned vouchers.

Improvements were seen in the uptake of seasonal flu vaccination among staff in hospitals in Warwickshire, with 51.4% of frontline staff in South Warwickshire Foundation Trust being vaccinated (compared with 37.3% in 2012/13), 56.6% of frontline staff in George Eliot Hospital NHS Trust (compared with 43.6%), and 57.9% in UHCW (compared with 46.5%). It is essential that these improvements continue.

What is currently being done?

For the flu season in 2013/14, the role of Warwickshire County Council included:

Ensuring the availability of convenient opportunities for people to be immunised through advocating for pharmacy provision.

Supporting the plans of GP practices by providing information about the numbers they needed to vaccinate.
Writing to care home and home care services managers expressing the importance of ensuring their staff were vaccinated.

Providing vouchers for pharmacy flu vaccinations for all directly employed Local Authority health and social care staff.

Delivering a promotional campaign through health and Local Authority partners. The campaign used materials that had been developed through a regional campaign and adapted with local information. The messages and images had been tested on audiences and this meant that additional time and money was not spent on developing new resources. A website with information for each target group was developed and materials were distributed to pharmacies, GP practices, libraries, sports centres, children's centres and hospitals. Real life experiences of Warwickshire residents were shared with local media and resulted in an interview on local BBC TV news, a local radio interview and articles in local press. (Sample material, right).

An evaluation of the assurance and promotional campaign in 2013/14 is being undertaken in partnership with Coventry University and the NHS England Screening and Immunisation Team. The evaluation uses views and opinions of people providing flu vaccination, people entitled to flu vaccination (qualitative research), and evidence from flu vaccination programmes across the world to provide practical recommendations to plan the future delivery of Local Authority vaccination assurance.

RECOMMENDATIONS

SEASONAL FLU

Commissioners of health and social care providers to have seasonal flu vaccination of staff identified as a "duty of care" priority in their contracts.[12]

Support is required from all partners for the seasonal flu campaign for 2014/15, to ensure it is based on "what worked" from the 2013/2014 campaign, with a continued focus on clinical risk groups under the age of 65, pregnant women, carers, children and health and social care staff.

PROTECTING YOUR HEALTH: WHAT CAN YOU DO?

Always wash your hands with soap and water after going to the toilet, after touching animals, before eating food and after you have coughed or sneezed, to protect you and your family from tummy and cold and flu viruses.

Check that you and your children are up to date with your immunisations. It is the best way to protect you and your family from some serious illnesses.[81]

1 in 3 people in Warwickshire are entitled to a free flu vaccination. If you are aged 65 years or over, have a chronic health condition, are pregnant, are a carer, or have children aged 2, 3, or 4, make sure you get immunised before the winter. Vaccinations are available from September each year. [82]

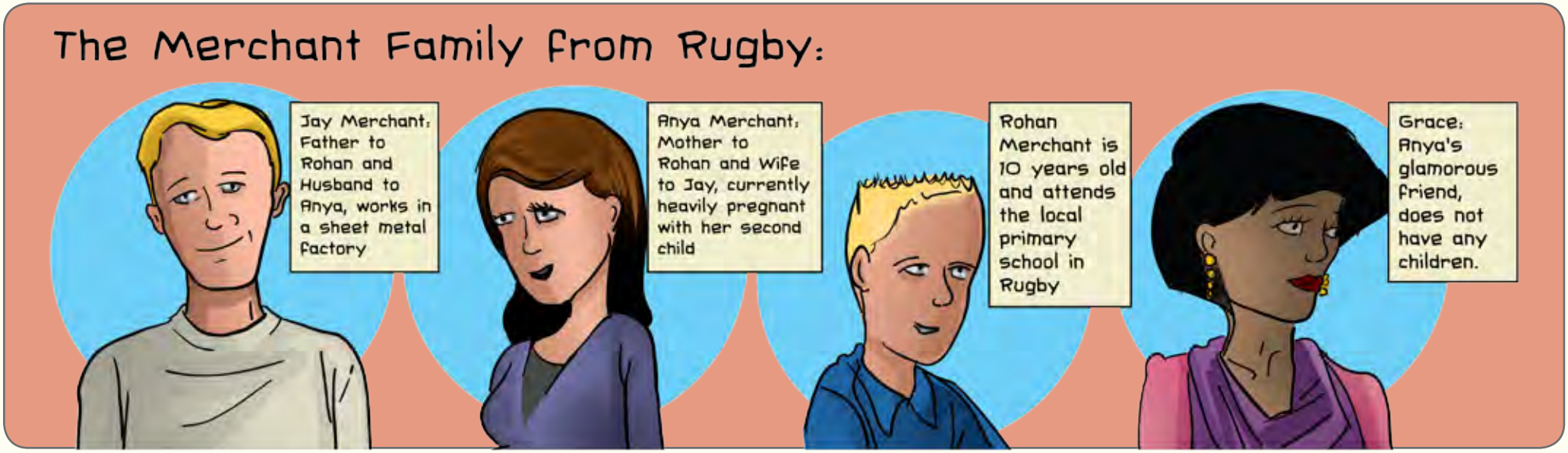
Are you ready for your screen test? Screening can save lives. Find out about screening programmes and how you can be screened.[56-65, 83-85]

Reduce the risk of getting a Sexually Transmitted Infection and stay safe in your relationships by using a condom. Find out how you can get screened for infections and what other contraceptive options might be good for you.[79]

Make sure you stay safe when you are travelling abroad. See your GP or go to a travel clinic at least 6 weeks before you go away for advice and any immunisations or medications you may need to take.[86]

Get informed about the symptoms of TB, and whether you might be at risk of Hepatitis B or C - talk to your GP if you are concerned. [4, 7, 8, 87-90]

Protect yourselves by keeping warm and well this winter, and looking after neighbours.[40] Keep your home warm, and find out the best way to do that and what support is available by ringing Act on Energy on 0800 988 2881.



The characters in this story are fictitious and bear no relation to any persons living or dead.

APPENDIX 1: ANNUAL REVIEW

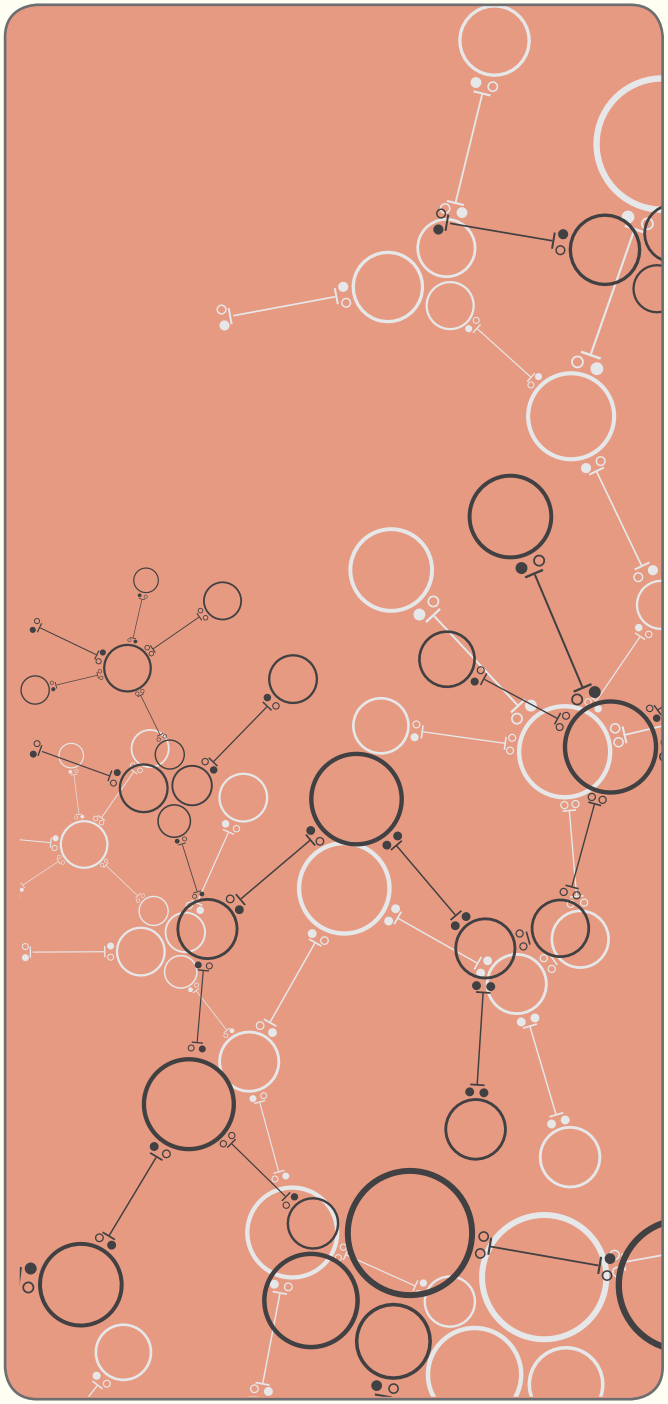
- We received visits from Duncan Selbie, Chief Executive, Public Health England, in March and June 2014. His feedback to the Council was very positive describing a "first class public health team" and "much to be proud of".

- We continue to advise the three Warwickshire Clinical Commissioning Groups and five District and Borough Councils on Public Health issues. All are fully engaged in the JSNA, Health and Wellbeing Board and Strategy development.

- Working with the People Group we have established the Living Well with Dementia Portal (www.livingwellwithdementia.org). This is a one stop shop for information and support for people with dementia, carers, professionals and the public. It has been widely praised (including by Prime Minister David Cameron).

- Reading Well Books on Prescription is a service developed with Warwickshire Library Service. This offers a range of self-help books and CDs (including electronic downloads) on issues such as depression, stress and anxiety. Over 2011/12 almost 20,000 items were loaned as part of the scheme.

- We are an active training department with junior doctors, GP trainees, apprentices and a range of other Public Health trainees. A recent Health Education England Inspection rated the Department as excellent for Education and Training.



Achievements The following data is for the financial year 2013/14

Health Protection:

- **121,591** people (74.3%) aged 65 and over were immunised against seasonal flu across Warwickshire and Coventry
- **2,000** (52%) carers in Warwickshire received their seasonal flu immunisation
- **5,802** one year old babies were fully immunised against serious infection
- **2,689** girls have been fully immunised against HPV, the virus that causes cervical cancer
- Well over **95%** of all children are fully immunised against serious infection, some of best results in the West Midlands
- Public Health England, Environmental Health and NHS colleagues, managed **1,072** cases and 109 communicable disease outbreaks and incidents
- **32,500** people were treated in sexual health services
- **178,067** users engaged with our Respect Yourself website

121,591

people (74.3%) aged 65 and over were immunised against seasonal flu across Warwickshire and Coventry

Health Improvement

- **2,742** 4-week smoking quitters and **6,243** setting a quit date in 2013-14
- **2,320** people have been treated for alcohol and drug misuse
- All practices in Warwickshire are now delivering NHS Health Checks
- **10,877** NHS Health Checks have been carried out and 442 people with an undiagnosed chronic health condition
- **11,000** children were weighed as part of the National Child Measurement Programme (99% of Reception age children and 97% of Year 6 children)
- **877** referrals have been made to the Exercise on Referral programme with 247 completed and 483 still in progress
- **746** families of primary school age children took up the family Change4life service (around weight management)
- **2,004** walkers registered for the walking schemes as part of the exercise on referral project
- **257** children completed a 9 week structured weight management programme as well as 164 parents/carers
- **70.6%** of mothers initiated breastfeeding

2,742

4-week smoking quitters and

6,243

setting a quitting date in 2013-14

Mental Health and Wellbeing

- Working with Learning and Development (Warwickshire County Council), Public Health England and Health Education England we have developed an e-learning package to increase the skills of Making Every Contact Count with **1,002** NHS staff trained in MECC this year
- **932** individual appointments were provided to people through our Wellbeing Hubs to support their mental wellbeing (additional sessions were also provided through People Group contracts)
- **108** people with severe and enduring mental illness were supported to remain in work, and a further 39 individuals were supported to obtain paid employment (contract also with People Group)
- **987** instances of engagement with people using mental health services to seek their views and opinions about local mental health strategies, services and plans (contract also with People Group)
- **82** people received direct advocacy support to help them to complain about the treatment or care they received from the NHS
- We have developed a Warwickshire Public Mental Health and Wellbeing Strategy for 2014-16 which lists the three tier approach - promotion of mental health wellbeing, prevention and early intervention
- We worked with Warwickshire County Council colleagues to launch the Coventry and Warwickshire Living Well with Dementia Portal. Over **7,000** unique users accessed the pages between November 2013 and January 2014 with excellent feedback
- The Dementia Friendly Communities DVD has also been launched recently and has been used to raise awareness of Dementia Friendly Communities in Warwickshire

108

people with severe and enduring mental illness were supported to remain in work

Wider Determinants

• We hosted the second annual conference in December 2013 to promote closer working relationships between Public Health, Environmental Health, Trading Standards, Planning Licensing and Transport with over 100 delegates participating

• Over **1,000** people attended and participated in the two Big Day Outs that we coordinated with partners (September 2013 and April 2014)

• We work closely with the Districts & Borough councils to influence the planning decisions being made as these can influence physical and mental health as well as reduce inequalities. This is done through commissioning Health Impact Assessments and evidence reviews to support Local Plans

• We are building strong working relationships with District & Borough Housing departments through shadowing, involvement in the development of local Housing Strategies and delivering MECC training to housing officers

• We have developed four measured mile routes in Alcester - two link in with the newly built health centre

• We received a **£20,000** grant from the Ministry of Defence to to develop the 'Service to Civvy Street' project and due to its success, we have been asked to share the booklet with other Local Authorities in the West Midlands

• **170,000** 'Thermocards' were distributed as part of the Warm and Well in Warwickshire campaign to GPs, Libraries, Children Centres, Wellbeing Hubs, Ambulance Service, Fire & Rescue, Hospital Social Workers, Age UK, Reablement Team and Act on Energy

• We continue to provide health responses on behalf of the county with regards to the proposed HS2

• We are working with our partners in the county to streamline and prioritise our commissioning of the third sector

• We sit on the Warwickshire Financial Inclusion Partnership Board and subgroups to tackle poverty across the county

• We regularly present relevant local health information at community forums with the most recent ones being earlier this year

• We are responding to concerns from the public on air quality and working with stakeholders on ways forward.

Population Health

• We are an active partner on the Joint Strategic Needs Assessment (JSNA) Commissioning Group; promoting the JSNA across the County including; taking a lead on a number of Needs Assessments and developing a matrix to prioritise individual needs assessments

• We co-produced the 2013/14 JSNA Annual Update endorsed by the Health and Wellbeing Board

• The three year review of the JSNA has been launched with a stakeholder event in April and June

• We worked in partnership with Warwickshire Observatory to carry out the 'Living in Warwickshire Survey' with over **7,600** surveys completed (a response rate of 30%) to allow us to fill gaps in our knowledge around local people's needs

• We have developed the Warwickshire Health & Wellbeing Portal which provides a source of information to practitioners in Warwickshire with information about public health services available, this will be launched across the County in the Summer 2014

• We have developed, and are continuing to enhance "locality" health profiles that pull together local health intelligence at lower level geographical area within the County

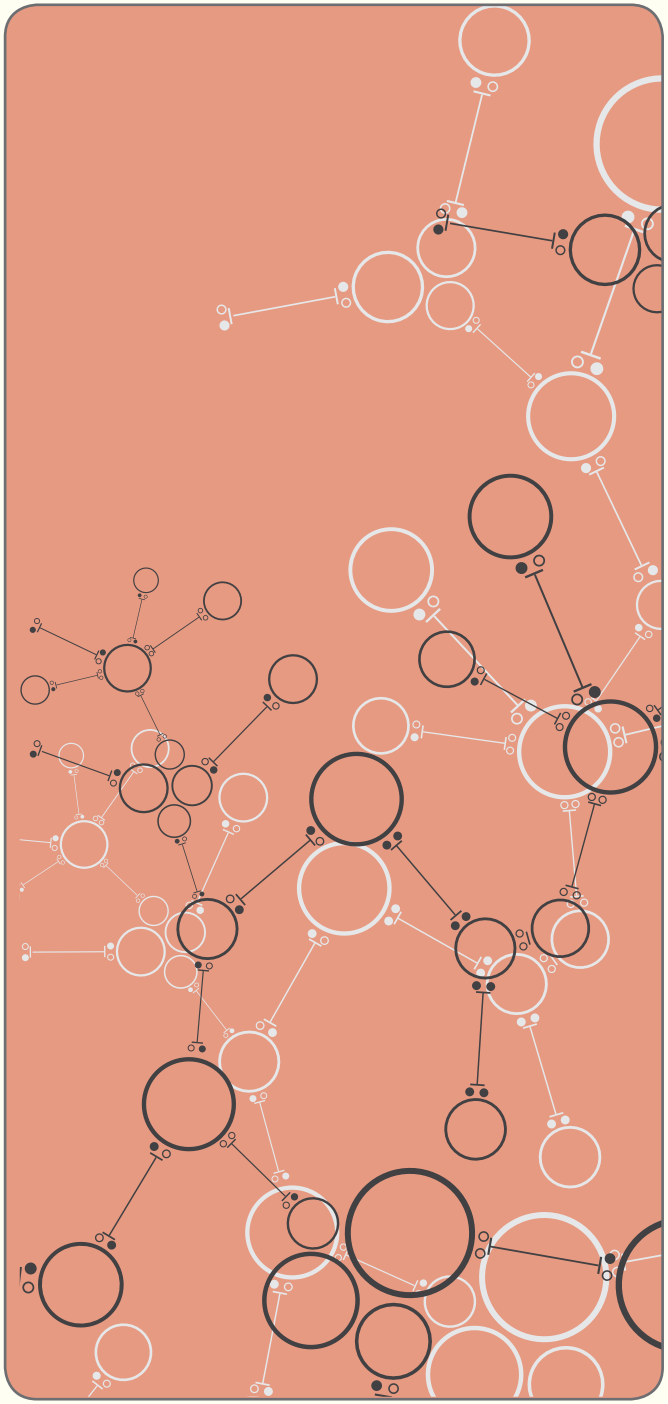
• We are embarking on a detailed piece of research around the impacts of the welfare reform in conjunction with Healthwatch as part of the JSNA work

• We supported the Health and Wellbeing Board to develop a performance dashboard to monitor key outcomes highlighted through the Interim Health and Wellbeing Strategy

• We have continued to update and develop the Public Health and Health and Wellbeing Board websites

7,600

'Living in Warwickshire' surveys completed



APPENDIX 2: HEALTH PROFILE FOR WARWICKSHIRE

While there are still significant health concerns within Warwickshire as highlighted in the updated Health Profile (Table 1) major achievements have been made in core areas of public health during the last 12 months in Warwickshire.

Health Profile

Domain	Indicator	Warwickshire 2013	England 2013	Trend	Variation across Districts	Data
Communities	Deprivation	5.8	20.3	↓	0.0 – 18.9	% living in deprivation
	Children in poverty	14.6	21.1	↓	10.5 – 20.4	%
	Statutory homelessness	1.9	2.3	↑	0.8 – 2.7	Rate per 1,000 households
	GCSE achieved (5A*-C inc Eng & Maths)	63.0	59.0	↑	53.8 – 69.4.8	%
	Violent Crime	9.6	13.6	↓	6.4 – 13.6	Rate per 1,000
	Long term unemployment	4.7	9.5	↑	2 – 8.3	Rate per 1,000
Children's and Young People	Smoking in pregnancy	19.7	13.3	↑	19.7	%
	Breast feeding initiation	72.7	74.8	↑	72.7	%
	Obese children (Year 6)	17.4	19.2	↑	14.3 – 19.9	%
	Alcohol-specific hospital stays (under 18)	63.9	61.8	→	44.1 – 82.1	Rate per 100,000
	Teenage pregnancy (under 18)	33.5	34.0	↓	23.4 – 47.6	Rate per 1,000
Adult's Health and Lifestyle	Adults smoking	19.1	20.0	→	12.8 – 22.9	%
	Increasing & higher risk drinking	23.3	22.3	→	22.1 – 116.5	%
	Healthy eating adults	28.2	28.2	→	22.6 – 32.6	%
	Physically active adults	55.3	55.3	↑	52.8 – 58.4	%
	Obese adults	25.5	25.5	→	21.4 – 29.8	%

Health Profile contd

Domain	Indicator	Warwickshire 2013	England 2013	Trend	Variation across Districts	Data
Disease and Poor Health	Incidence of malignant melanoma	14.0	14.5	↑	6.6 – 18.1	Rate per 100,000
	Hospital stays for self-harm	212.3	207.9	↑	162.3 – 312.6	Rate per 100,000
	Hospital stays for alcohol related harm	1,693	1,895	→	1,519 – 1,935	Rate per 100,000
	Drug misuse	6.2	8.6	→	3.3 – 8.4	Rate per 1,000
	People diagnosed with diabetes	5.4	5.8	→	4.8 – 6.7	%
	New cases of tuberculosis	8.8	15.4	↓		Rate per 100,000
	Acute sexually transmitted infections	612	804	↓	456 – 825	Rate per 100,000
	Hip fracture in over-65s	442	457	↓	425 - 491	Rate per 100,000
Life Expectancy and Causes of Death	Excess winter deaths	18.2	19.1	↑	15.2 – 21.3	Ratio
	Life expectancy – male	79.5	78.9	↑	77.7 – 80.7	Years at birth
	Life expectancy – female	83.5	82.9	↑	82.2 – 84.5	Years at birth
	Infant deaths	5.0	4.3	→	3.8 – 7.7	Rate per 1,000
	Smoking related deaths	162	201	↓	135 – 204	Rate per 100,000
	Early deaths: heart disease & stroke	52.8	60.9	↓	38.3 – 68.4	Rate per 100,000
	Early deaths: cancer	100.8	108.1	↓	90.8 – 111.8	Rate per 100,000
	Road injuries and deaths	56.5	41.9	↓	38.7 – 91.8	Rate per 100,000
Health Protection	Chlamydia	156.2	132.9	n/a	111.1 - 225.8	Rate per 100,000
	Gonorrhoea	23.2	25.1	n/a	7.5 – 118.5	Rate per 100,000
	Syphilis	2.2	3.1	n/a	0.8 – 6.0	Rate per 100,000
	Herpes	60.4	59.9	n/a	48.1 – 77.9	Rate per 100,000
	Warts	131.8	134.8	n/a	77.2 – 158.8	Rate per 100,000
	Flu Vaccinations in over 65s			↑	59.6-89.9	%

Finances

Many of the achievements of the last 12 months have been possible through services directly commissioned from the public health budget. A summary is provided below.
The grant for Public Health in 2013/14 was £21.2million and this ring-fence applies until 2016/17. In 2014/15, the Public Health grant has increased by £600,000 to £21.8million.
Public Health Warwickshire has a mandatory duty to provide key services as part of their Public Health responsibilities (clause 14 of the Health and Social Care Act 2014):

- **Child Measurement Programme**
- **NHS Health Checks**
- **Open access and confident Sexual Health services**
- **Healthcare Public Health advice to NHS commissioners**
- **Steps to protect the health of the local population**

As part of the transfer of Public Health Warwickshire into Warwickshire County Council, we agreed to fully review all commissioning activity to ensure that services support the wider inequalities agenda and that they target those in greatest need. This is a two year programme of work and it was agreed that any funds released from decommissioning services would be reinvested in agreed Public Health priorities. These include: Mental Health and Wellbeing, weight management and children's services.

In addition, £500,000 was held back as a contingency to meet prescribing and dispensing costs for Drugs and Alcohol and Smoking Cessation. In both cases, there was a lack of clarity over whether costs should be met by Warwickshire County Council or the National Health Service.

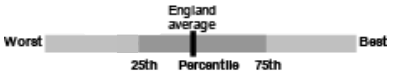
Public Health Warwickshire Finances, 2013/14

Source: Public Health and Warwickshire County Council Finance, 2014

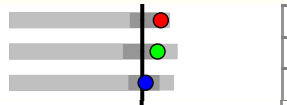
Services	Agreed budget £'000	Agreed changes £'000	Latest budget £'000	Final outturn £'000	Variation Over/(under) £'000
Public Health Leadership Management	2,636	(997)	1,519	1,519	(120)
Health Improvement	15,457	(138)	14,288	14,288	(1,031)
Health Protection	135	0	228	228	93
Population Health	32	25	47	47	(10)
Wider Determinants	3,786	1,060	3,774	3,774	(1,072)
Net service spending	**22,046**	**(50)**	**21,996**	**19856**	**(2,140)**

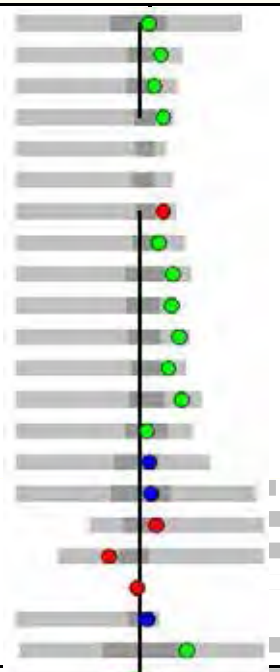
APPENDIX 3: THE PUBLIC HEALTH OUTCOMES FRAMEWORK - WARWICKSHIRE INDICATORS

- Significantly better than England average
- Not significantly different from England average
- Significantly worse than England average
- No significance can be calculated



		Indicator	Local Numbe	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Overarching	1	Healthy life expectancy at birth (males) (years)	n/a	66.4	63.2	55.0		70.3
	2	Healthy life expectancy at birth (females) (years)	n/a	66.3	64.2	54.1		72.1
	3	Life Expectancy at birth (males) (years)	n/a	79.8	79.2	74.0		82.1
	4	Life Expectancy at birth (females) (years)	n/a	83.8	83.0	79.5		85.9
	5	Gap in life expectancy at birth between each local authority and England as a whole (males) (years)	n/a	0.6	0.0	2.9		2.9
	6	Gap in life expectancy at birth between each local authority and England as a whole (females) (years)	n/a	0.8	0.0	2.9		2.9
Wider Determinants	7	Children in poverty (all dependent children under 20) (%)	15315	13.5	20.1	6.6		46.1
	8	Children in poverty (under 16s) (%)	13600	14.1	20.6	6.9		43.6
	9	School Readiness: Children achieving a good level of development at the end of reception (%)	2837	44.9	51.7	27.7		69.0
	10	School Readiness: Children with free school meal status achieving a good level of development at end of reception (%)	206	26.2	36.2	17.8		60.0
	11	School Readiness: Year 1 pupils achieving the expected level in the phonics screening check (%)	4346	71.7	69.1	58.8		79.0
	12	School Readiness: Year 1 pupils with free school meals achieving the expected level in the phonics screening check (%)	379	54.1	55.8	37.2		70.9
	13	Pupil absence (%)	976210	4.9	5.1	4.3		6.7
	14	First time entrants to the youth justice system (rate per 100,000)	190	370.9	537.0	151.0		1427.0
	15	16-18 year olds not in education employment or training (%)	660	3.6	5.8	2.0		10.5
	16	Adults with a learning disability who live in stable and appropriate accommodation (%)	810	72.6	73.5	96.6		96.6
	17	% of adults in contact with secondary mental health services who live in stable and appropriate accommodation (%)	1970	73.1	58.5	94.1		94.1
	18	Gap in the employment rate between those with a long-term health condition and the overall employment rate	n/a	9.5	7.1	21.7		21.7
	19	Gap in the employment rate between those with a learning disability and the overall employment rate	n/a	68.9	63.2	73.1		73.1
	20	Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate	n/a	55.3	62.3	75.1		75.1
	21	Sickness absence - The percentage of employees who had at least one day off in the previous week (%)	n/a	1.3	2.2	0.6		3.5
	22	Sickness absence - The percent of working days lost due to sickness absence (%)	n/a	0.7	1.5	0.3		2.7
	23	Killed and seriously injured casualties on England's roads (rate per 100,000)	913	55.7	40.5	16.9		81.8
	24	Domestic Abuse (rate per 1,000)	n/a	17.1	18.8	30.2		5.6
	25	Violent crime (including sexual violence) - hospital admissions for violence (rate per 100,000)	708	43.2	57.6	9.3		167.8
	26	Violent crime (including sexual violence) - violence offences per 1,000 population	4188	7.7	10.6	27.1		4.1
	27	Violent crime (including sexual violence) - Rate of sexual offences per 1,000 population	380	0.7	0.8	2.0		0.3
	28	Re-offending levels - percentage of offenders who re-offend (%)	888	21.4	26.9	36.3		14.4
	29	Re-offending levels - average number of re-offences per offender	2371	0.6	0.8	1.3		0.3
	30	The percentage of the population affected by noise - Number of complaints about noise	3436	6.3	7.5	2.5		58.4

	31	Population exposed to road, rail and air transport noise of 65 dB(A) or more, during the daytime (%)	10730	2.0	5.4	29.8		29.8
	32	Population exposed to road, rail and air transport noise of 55 dB(A) or more during the night-time (%)	39900	7.6	12.8	57.5		57.5
	33	Statutory homelessness - homelessness acceptances (rate per 1,000)	510	2.1	2.4	11.4		0.2
	34	Statutory homelessness - households in temporary accommodation (rate per 1,000)	70	0.3	2.4	0.0		33.2
	35	Utilisation of outdoor space for exercise/health reasons (%)	n/a	14.0	15.3	0.5		41.2
	36	Fuel Poverty (%)	30120	13.0	10.9	3.8		18.0
	37	Social Isolation: adult social care users who have as much social contact as they would like (%)	n/a	44.5	43.2	31.9		53.5
	38	Loneliness and Isolation in adult carers (%)	n/a	40.3	41.3	58.5		23.9
Health Improvement	39	Low birth weight of term babies (%)	146	2.5	2.8	1.6		5.3
	40	Breastfeeding - Breastfeeding initiation (%)	4232	71.9	73.9	40.8		94.7
	41	Breastfeeding - Breastfeeding prevalence at 6-8 weeks after birth (%)	2716	45.1	47.2	17.5		83.3
	42	Smoking status at time of delivery (%)	1033	17.6	12.7	2.3		30.8
	43	Under 18 conceptions (rate per 1,000)	234	24.3	27.7	14.2		52.0
	44	Under 18 conceptions: conceptions in those aged under 16 (rate per 1,000)	43	4.6	5.6	2.0		-
	45	Excess weight in 4-5 and 10-11 year olds - 4-5 year olds (%)	1197	20.0	22.2	16.1		-
	46	Excess weight in 4-5 and 10-11 year olds - 10-11 year olds (%)	1567	30.9	33.3	24.1		44.2
	47	Hospital admissions from unintentional and deliberate injuries in children (aged 0-14 years) (per 10,000)	994	108.1	103.8	61.7		191.3
	48	Hospital admissions from unintentional and deliberate injuries in children (aged 0-4 years) (per 10,000)	461	146.1	134.7	76.0		282.4
	49	Hospital admissions from unintentional and deliberate injuries in young people (aged 15-24) (per 10,000)	892	136.4	130.7	63.8		277.3
	50	Emotional well-being of looked after children	n/a	13.3	14.0	21.5		21.5
	51	Excess Weight in Adults (%)	907	64.8	63.8	45.9		74.4
	52	Percentage of physically active and inactive adults - active adults	n/a	55.3	56.0	43.8		68.5
	53	Percentage of active and inactive adults - inactive adults	n/a	27.0	28.5	18.2		40.2
	54	Smoking Prevalence (%)	n/a	17.9	19.5	12.1		29.8
	55	Smoking prevalence - routine & manual (%)	n/a	29.2	29.7	14.2		44.3
	56	Successful completion of drug treatment - opiate users (%)	65	6.4	8.2	3.8		17.6
	57	Successful completion of drug treatment - non-opiate users (%)	38	29.9	40.2	17.4		68.4
	58	Recorded diabetes (%)	25929	5.7	6.0	8.4		8.4
	59	Alcohol related admissions to hospital	3134	575.8	636.9	365.0		1121.0
	60	Cancer screening coverage - breast cancer 9%)	48802	78.3	76.3	58.2		84.5
	61	Cancer screening coverage - cervical cancer (%)	104323	75.3	73.9	58.6		79.9
	62	Access to non-cancer screening programmes - diabetic retinopathy (%)	17909	86.4	80.9	66.7		95.0
	63	Take up of NHS Health Check Programme by those eligible - health check offered (%)	12668	7.7	16.5	0.7		42.5
	64	Take up of NHS Health Check programme by those eligible - health check take up (%)	5679	44.8	49.1	7.7		100.0
	65	Self-reported well-being - people with a low satisfaction score (%)	n/a	5.1	5.8	3.4		10.1
	66	Self-reported well-being - people with a low worthwhile score (%)	n/a	n/a	4.4	2.9		2.9
	67	Self-reported well-being - people with a low happiness score (%)	n/a	7.8	10.4	5.5		15.8
	68	Self-reported well-being - people with a high anxiety score (%)	n/a	17.6	21.0	10.9		29.0
	69	Injuries due to falls in people aged 65 and over (rate per 100,000)	2062	1899.1	2011.0	1178.0		3508.0
	70	Injuries due to falls in people aged 65 and over - aged 65-79 (rate per 100,000)	678	912.8	975.0	544.0		1826.0
	71	Injuries due to falls in people aged 65 and over - aged 80+ (rate per 100,000)	1384	4759.5	5015.3	2876.0		9119.0

Health Protection	72	Fraction of mortality attributable to particulate air pollution (%)	n/a	5.2	5.4	8.3		8.3
	73	Chlamydia diagnoses (15-24 year olds) - Old NCSP data (rate per 100,000)	927	1472.5	2124.6	5995.0		783.0
	74	Chlamydia diagnoses (15-24 year olds) - CTAD (rate per 100,000)	972	1484.9	1979.1	6132.0		703.0
	75	Population vaccination coverage - Dtap / IPV / Hib (1 year old) (%)	5745	97.7	94.7	79.0		99.0
	76	Population vaccination coverage - Dtap / IPV / Hib (2 years old) (%)	5815	98.7	96.3	81.9		99.4
	77	Population vaccination coverage - MenC (%)	5714	97.2	93.9	75.9		98.8
	78	Population vaccination coverage - PCV (%)	5725	97.4	94.4	78.7		99.0
	79	Population vaccination coverage - Hib / Men C booster (5 years) (%)	5473	95.0	92.7	77.0		98.3
	80	Population vaccination coverage - Hib / MenC booster (2 years old) (%)	5636	95.7	91.5	75.7		98.1
	81	Population vaccination coverage - PCV booster (%)	5711	97.0	92.5	75.1		97.5
	82	Population vaccination coverage - MMR for one dose (2 years old) (%)	5717	97.1	92.3	77.4		98.4
	83	Population vaccination coverage - MMR for one dose (5 years old) (%)	5565	96.6	93.9	82.1		98.3
	84	Population vaccination coverage - MMR for two doses (5 years old) (%)	5420	94.1	87.7	68.9		97.0
	85	Population vaccination coverage - HPV (%)	2616	87.4	86.1	62.1		96.2
	86	Population vaccination coverage - PPV (%)	69560	70.2	69.1	55.3		77.0
	87	Population vaccination coverage - Flu (aged 65+) (%)	79150	74.1	73.4	65.5		80.8
	88	Population vaccination coverage - Flu (at risk individuals) (%)	27831	53.6	51.3	44.2		68.8
	89	People presenting with HIV at a late stage of infection (%)	24	60.0	48.3	80.0		0.0
	90	Treatment completion for TB (%)	n/a	84.4	82.8	0.0		0.0
	91	Incidence of TB (rate per 100,000)	49	8.9	15.1	112.3		0.0
	92	NHS organisations with a board approved sustainable development management plan (%)	3	42.9	59.0	100.0		100.0
Healthcare & Premature Mortality	93	Infant mortality (rate per 1,000)	75	4.0	4.1	1.1		7.5
	94	Tooth decay in children aged 5	n/a	0.6	0.9	0.4		2.1
	95	Mortality rate from causes considered preventable (rate per 100,000)	2655	166.9	187.8	136.2		340.5
	96	Under 75 mortality rate from all cardiovascular diseases (rate per 100,000)	1029	71.5	81.1	55.7		144.7
	97	Under 75 mortality rate from cardiovascular diseases considered preventable (rate per 100,000)	693	48.1	53.5	29.3		95.2
	98	Under 75 mortality rate from cancer (rate per 100,000)	1891	130.8	146.5	113.5		207.3
	99	Under 75 mortality rate from cancer considered preventable (rate per 100,000)	1026	70.9	84.9	53.8		134.9
	100	Under 75 mortality rate from liver disease (rate per 100,000)	236	16.1	18.0	10.3		41.6
	101	Under 75 mortality rate from liver disease considered preventable (rate per 100,000)	204	13.8	15.8	9.0		38.2
	102	Under 75 mortality rate from respiratory disease (rate per 100,000)	359	25.3	33.5	20.5		81.6
	103	Under 75 mortality rate from respiratory disease considered preventable (rate per 100,000)	182	12.8	17.6	7.9		45.0
	104	Mortality from communicable diseases (rate per 100,000)	938	60.4	64.8	47.0		97.9
	105	Suicide rate (rate per 100,000)	156	9.6	8.5	4.8		14.5
	106	Emergency readmissions within 30 days of discharge from hospital (%)	5955	11.2	11.8	8.8		14.5
	107	Preventable sight loss - age related macular degeneration (AMD) (rate per 100,000)	83	82.8	110.5	225.2		12.8
	108	Preventable sight loss - glaucoma (rate per 100,000)	24	8.3	12.8	34.5		3.0
	109	Preventable sight loss - diabetic eye disease (rate per 100,000)	16	3.4	3.8	15.8		0.9
	110	Preventable sight loss - sight loss certifications (rate per 100,000)	170	31.1	44.5	82.5		5.1
	111	Hip fractures in people aged 65 and over (rate per 100,000)	618	555.6	568.1	403.1		808.4
	112	Hip fractures in people aged 65 and over - aged 65-79 (rate per 100,000)	156	214.2	237.3	121.8		401.7
	113	Hip fractures in people aged 65 and over - aged 80+ (rate per 100,000)	462	1545.8	1527.6	1108.0		2150.0
	114	Excess Winter Deaths Index (Single year, all ages)	286	19.0	16.1	2.1		30.7
	115	Excess Winter Deaths Index (single year, ages 85+)	138	23.2	22.9	-7.6		53.1
	116	Estimated diagnosis rate for people with dementia (%)	n/a	n/a	48.7	n/a		n/a

APPENDIX 4: GLOSSARY

Abdominal aortic aneurysm: a weakness in the wall of the largest blood vessel that takes blood away from the heart, in this case as it passes through the tummy.

Active Disease: the disease is present in the body and is actively causing damage and symptoms.

Anaesthesia: a way of removing the feeling of pain, either by 'putting a patient to sleep' or by numbing nerves whilst the patient is awake.

Assurance: in the context of the role of the Director of Public Health refers to giving confirmation that suitable process and plans are in place.

Asymptomatic: a condition or disease that is not causing any symptoms, but may still require treatment.

Bacillius Calmette-Guerin vaccination: a vaccination to protect against tuberculosis (TB).

Cluster: groups of relatively uncommon events of diseases in a particular area and/or in a particular space in time in numbers that are believed or perceived to be greater than could be expected by chance (a possible link only, as compared to an outbreak, where link is highly probable or confirmed).

Colonoscopy: a test whereby a camera is inserted into the back passage, in order to look for any disease in the large intestine.

Commissioning: the process of ensuring that health and care services are provided so they meet the needs of the population; it includes a number of stages including assessing population needs, prioritising outcomes, procuring products and services, and evaluating outcomes. The concept of commissioning is expanding to include the way decisions are made about directing investment as well as direct service commissioning.

Communicable disease: a disease that is transmitted through direct contact (for example touching) or indirect contact (for example coughs and sneezes) with an infected individual.

Deprivation: covers a broad range of issues and refers to unmet needs caused by a lack of resources of all kinds, not just financial, and can be defined in a broad way to encompass a wide range of aspects of an individual's living conditions. These may include: employment, education, health, housing, crime and many more.

Diabetic Retinopathy: a type of eye disease that develops in people with diabetes. It is progressive and can lead to blindness.

Disseminate: to spread (usually information) widely.

Emergency: a wide range of events cause health emergencies, including natural hazards, accidents, outbreaks of disease and terrorist attacks. Emergencies can be minor events that threaten the health and lives of local communities or major events that affect the whole population.

Emergency hormonal contraception: a tablet of synthetic hormone that reduces the risk of pregnancy if taken within 72 hours (Levonelle) or 120 hours (ellaOne) of unprotected sex.

Environmental hazards: is a state of events which has the potential to threaten the surrounding natural environment and adversely affect people's health.

Epidemiology: is the study of how often diseases occur in different groups of people and why. Epidemiological information is used to plan and evaluate strategies to prevent illness and as a guide to the management of patients in whom disease has already developed.

Exposure: the process by which a biological, chemical or radiological agent comes into contact with a person in such a way that the person may develop the relative outcome, such as a disease.

Frontline health and social care services: any services that provide health care or social care support (for example GPs, hospitals and care home workers) to individuals.

Healthcare associated infections: infections that are usually picked up by patients from a hospital or healthcare environment.

Herd immunity: refers to the broader effects of vaccination in a community, and is achieved if enough members of a particular population have been vaccinated against a disease. It dramatically reduces the pathogen's ability to infect another host (or person) and in turns means that people who aren't vaccinated now have some measure of protection against the disease.

Incidence: Measures new cases of disease over a particular time period and is expressed in person-time units e.g. 2 per 1,000 people per year

Infection control: a measure taken to prevent or reduce the spread of infections. An example of this is hand washing.

Intravenous drug user: a person who deliberately injects drugs into their bloodstream (usually heroin).

Laboratory report: the result of a test after it has been processed and analysed in the laboratory e.g. Hepatitis B result after taking a blood test.

Latent infection: an infection that is present in the body, but is not actively causing damage or producing symptoms.

Measles Mumps and Rubella vaccination (MMR): a vaccination against the diseases measles, mumps and rubella.

Mortality: the number of deaths in a given population, location or other grouping of interest, usually over a particular period of time.

Norovirus: winter vomiting disease.

Outbreak: an incident in which two or more people experiencing illness are linked in time and/or place and there is a greater than expected rate of infection compared with the usual background rate for the place and time where the outbreak has occurred.

Pandemic flu: pandemics arise when a new virus emerges which is capable of spreading over a wide area, crossing international boundaries. Unlike ordinary seasonal influenza that occurs every winter in the UK, pandemic flu can occur at any time of the year.

Partner agencies: organisations which have close links and work together to deliver mutually agreed outcomes.

Poverty line: the most commonly used way to measure poverty is based on incomes. A person is considered poor if his or her income level falls below some minimum level necessary to meet basic needs. This minimum level is usually called the "poverty line". What is necessary to satisfy basic needs varies across time and societies. Therefore, poverty lines vary in time and place, and each country uses lines which are appropriate to its level of development, societal norms and values.

Prevalence: measures existing cases of disease and is expressed as a proportion e.g. 1% of the population.

Disease prevention message: a message that communicates to the general public the ways in which they can reduce the possibility of ill health by means of engaging in healthy behaviours, ensuring that they are fully vaccinated, and taking part in routine screening programmes.

Proportion: a type of ratio in which the numerator is included in the denominator. The ratio of a part to the whole, expressed as a 'decimal fraction' (e.g. 0.2), as a 'common fraction' (1 in 5 or 1/5), or as a percentage (20%).

Respiratory infection: a cough, cold or chest infection.

Respiratory: a collective word for the lungs and other organs of breathing.

Rotavirus: a common cause of tummy bug, particularly in children.

Sanitation: conditions relating to public health, especially the provision of clean drinking water and adequate sewage disposal.

Screening/screening programme: NHS national screening programmes are recommended to test whether you are at an increased risk of developing a condition that will help to catch and treat serious conditions sooner. There are different screening programmes recommended at different stages of life including during infancy and childhood, early adulthood, during pregnancy, middle years and later years.

Statutory homelessness: homelessness is often considered to apply to people 'sleeping rough'. However, most statistics on homelessness relate to statutorily homelessness i.e. those households which meet specific criteria of priority need set out in legislation (for example: Housing Act 1977, Hosing Act 1996 and the Homeless Act 2002), and to whom a homelessness duty has been accepted by a local authority. Such households are rarely homeless in the literal sense of being without a roof over their heads, but are more likely to be threatened with the loss of, or are unable to continue with, their current accommodation.

Uptake: the proportion of individuals taking or making use of something that is available e.g. the uptake of flu immunisations.

Vaccination: an injection that can be given to prevent a person being infected with a specific disease.

Vulnerable population: are defined as those at greater risk for poor health status and health care access.

NOTES

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PUBLIC HEALTH WARWICKSHIRE

Warwickshire County Council

Working for Warwickshire

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Item 12

Warwickshire Health and Wellbeing Board

22nd September 2014

Work Programme

Recommendation(s)

1. That the Health and Wellbeing Board reviews its work programme for the forthcoming meetings.

1.0 Key Issues

1.1 At its meeting on 21 May 2014, the Health and Wellbeing Board considered the Warwickshire Health & Wellbeing Strategy – progress on outcomes and future activity. The Board agreed the proposed activities for the Board and the working themes for 2014/15 as:

- Integration and working together
- Promoting independence
- Community Resilience

1.2 The Board received details of the areas completed in 2013/14 and agreed the following items 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
Health and Social Care commissioning intentions	Sept 2013	Yes
Review and approve JSNA	May 2013	Yes – May 2014
Director of Public Health Annual Report	Sept 2013	Yes – July 2014

Topic	2013/14 Agenda	Required in 2014/15?
Priority 1 – Mobilising Communities		
Autism Strategy and Self-Assessment Framework	Nov 2013	Yes
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
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

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		
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

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		
Better Care Fund Agree and approve Warwickshire's Better Care Fund integration plans	Regular Updates	Regular Updates
Care Act implementation plus work with a task and finish group for agreeing consultation responses to DH and considering plans to comply with duties relating to Health and wellbeing	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- regular reporting on activities	March 2014	Yes regular updates
"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
SEND- ensuring new duties for HWB members are in place, particularly in terms of co-production and person centred outcome focus		Yes
Children and Families Act	Regular updates	Yes

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
- SEND – the new legislation requires Health and Social Care agencies in Warwickshire to work together to deliver a single offer to families.
- The Children and Families Act – This comes into force on 1st April and requires all agencies to align services, to meet the biggest change in wellbeing legislation for 60 years.

2.0 Background Papers

2.1 None for this report.

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