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

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