Warwickshire Health and Wellbeing Board

Agenda

8 July 2015

A meeting of the Warwickshire Health and Wellbeing Board will take place at **Shire Hall, Warwick** on **Wednesday 8 July 2015 at 13:30.**

The agenda will be:-

1. (13.30 – 13.35) General

(1) Apologies for Absence

(2) Appointment of Board Members

To appoint the following representatives of the county, district and borough councils:

Warwickshire CC	Councillor Les Caborn
North Warwickshire BC	Councillor Margaret Bell
Rugby BC	Councillor Derek Poole
Stratford DC	Councillor Stephen Gray
Warwick DC	Councillor Moira-Ann Grainger

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

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

- Declare the interest if s/he has not already registered it;
- Not participate in any discussion or vote;

- Must leave the meeting room until the matter has been dealt with (Standing Order 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.

(4) Minutes of the Meeting of the Warwickshire Health and Wellbeing Board on 25 March 2015 and Matters Arising.

Draft minutes of the meeting are attached for approval.

2. (13.35 – 14.00) Governance Review

David Carter, Sarah Duxbury

3. (14.00 – 14.05) Health and Wellbeing Board Annual Report

John Linnane (verbal report)

4. (14.05 – 14.20) Director of Public Health's Annual Report

John Linnane

5. (14.20 – 14.35) Better Together – 2015/16 Better Care Fund Agreement

Chris Lewington

6. (14.35 – 14.50) Violence against Women and Girls

Helen King

7. (14.50 – 15.15) Joint Adult Health & Social Care Self-Assessment Framework 2015

Chris Lewington

8. (15.15 – 15.25) Public Health Funding

John Linnane (verbal update)

9. (15.25 – 15.35) Clinical Commissioning Groups 2015/16 Quality Premiums

Andrea Green, Juliet Hancox, Anna Hargrave

10. (15.35 – 15.40) Forward Plan

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

Further Information, Future Meetings and Events:

- Health and Wellbeing Board Newsletter Link to Newsletter
- Healthwatch Newsletter Link to Newsletter
- Minutes of Safeguarding Boards, Joint Commissioning Boards and Health Protection Committees Link to Minutes

Health and Wellbeing Board Membership

Chair: Councillor Izzi Seccombe (Warwickshire County Council)

Warwickshire County Councillors: Councillor John Beaumont, Councillor Les Caborn, Councillor Jose Compton.

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

Warwickshire County Council Officers: John Dixon – Interim 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 Derek Poole (RBC), Councillor Moira-Ann Grainger (WDC), Councillor Margaret Bell (NWBC), Councillor Stephen Gray (SDC)

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Minutes of the Meeting of the Warwickshire Health and Wellbeing Board held on 25th March 2015.

Present:-

Chair

Councillor Izzi Seccombe

Warwickshire County Councillors (In addition to the Chair)

Councillor John Beaumont
Councillor Jose Compton
Councillor Bob Stevens

Clinical Commissioning Groups

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

Warwickshire County Council Officers
Monica Fogarty – Strategic Director for Communities
John Dixon – Interim Director for the People Group
Dr John Linnane – Director of Public Health

Healthwatch Warwickshire

Phil Robson – Chair

Borough/District Councillors

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

1. (1) Apologies for Absence

David Williams (NHS England)
Councillor Michael Coker (Warwick District Council)
Councillor Gillian Roache (Stratford District Council)

The Chair noted that Councillor Roache was not seeking re-election in the 2015 local government elections and it was unlikely that Councillor Coker would be a member of the Board after those elections. She paid tribute to both members for their service to the Board.

(2) Appointment of Board Member

The Chair noted the resignation of Karen Ashby and paid tribute to her service to the Board. She welcomed Deryth Stevens as the replacement Board member for Warwickshire North CCG.

(3) 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.

(4) Minutes of the meeting held on 21st January 2015 and matters arising.

The Minutes were agreed as a true record.

2. Health & Wellbeing Peer Challenge

The Chair introduced this item, referring to the circulated letter from the Local Government Association (LGA) peer challenge team. A report was submitted which detailed the findings and recommendations from the recent peer challenge. She referred to the other peer challenges that the County Council had recently completed. A recommendation in the health and wellbeing peer challenge was for the appointment of a deputy chair from a health partner, which she asked representatives from clinical commissioning groups to consider.

John Dixon, Interim Director for the People Group presented the report. Background was provided on the process undertaken, the LGA's headline question areas and the specific areas the peer challenge team had been asked to comment on, in terms of leadership, governance, strategy and planning, relationships and operation of the Board.

The report gave a summary of the headline messages and findings. There was recognition of the work of the Chair to nurture relationships and an appetite amongst partners for the system to improve. The self-assessment identified a number of issues where the Board would like to make progress. The Health and Wellbeing Strategy had been agreed, but how it would be implemented was less clear. Warwickshire's health economy was complex, due to inherited factors, its geography and a lack of coterminous boundaries. All health and wellbeing boards were regarded on a statutory basis as a committee of upper tier councils, which had the risk of over-dominance from local authority partners. There were a wide range of views about the purpose and scope of the Board. Comments about governance were also reported. Other findings were the inconsistent input into the Board's business from all key members of the health economy, mixed views about what the purpose of

the Board is and who should have a seat on the Board. It was considered the current arrangements needed revisiting. The work of the Board also needed to have more input from officers, either from the County Council or its partners, to provide structured support for the Board's business. This should include resources for better agenda management, Board development, a forward plan of business for the Board, and performance management.

With regard to the recommendations, it was planned to arrange a workshop, towards the end of April, to look at these in detail. An analysis of the outcomes from the process had begun, with action and implementation plans being drafted for consideration by all partners. The workshop and subsequent board meeting would also consider future governance arrangements, capacity and support for the Chair.

Referring to the peer challenge letter, comments were made on the need for a forum to feed local councillors' views up to the Board. The chair responded that there were various governance models and it was important to select a model that best suited Warwickshire. The rapid pace of change was also noted.

Resolved

That the Health and Wellbeing Board notes the recommendations from the Peer Challenge as set out below and that these be considered at a workshop in April:

(1) Return to first principles and take steps to ensure there is:
   - o A clear definition of the purpose of the HWB and its added value
   - o More focus on developing a culture of "we" and "us"
   - o Moving towards acceptance that all partners are equal and should take ownership
   - o Agreement and understanding of each organisation's role in the delivery of outcomes
   - o Determine who holds the ring on activity and performance

(2) Review membership of the Board.
   - o A health partner should be considered in the role of Deputy Chair (or should this be Co-Chair?)
   - o Who sits around the table and why e.g., providers, 3rd sector
   - o Roles and responsibilities of individual Board members

(3) Develop clear and distinct support for the Chair

(4) Clarify and potentially simplify the complex structure beneath the Board and its interrelations with WCC's Health and Scrutiny Committee

(5) Focus on the development of a joint implementation plan for use by all partners across Warwickshire

(6) Work collectively to enable:
- Clarity around pooled budgets, resources and risks
- Clear performance management processes to develop

(7) Review your approach to digital media, including up to date information on the webpages

(8) Consider whether the Health and Wellbeing Board needs its own identity and how its success is communicated to the wider community

3. 0-5 Strategy Group

This item was presented by County Councillor Jerry Roodhouse, who thanked the Chair and members of the Council for their support for this initiative. He stressed that the money allocated was 'ring fenced' specifically for this project. The objective was for early intervention to make a difference and shape the lives of young people. There were some perceived gaps in service, inequalities in service provision across Warwickshire and a wish to look at the child's journey from 0-5 years of age.

It was reported that on 5 February 2015, the County Council agreed to set up a cross party and multi-agency Strategy Group for services for 0-5 year olds. This body would report to the Health & Wellbeing Board. Additional County Council funding had been allocated, of £800,000 in 2015/16 and £1.5M for each of the following two financial years.

Proposed terms of reference for the Strategy Group were submitted for consideration by the Board, together with details of the suggested composition, the appointment of the Chair, officer support for the group and a governance diagram. The role of the Group would be to set the strategic direction for both commissioning and delivery of services for 0-5 years across the County, to determine priorities for the additional budget provided by the Council, but in doing so would also seek to align existing County Council spend with that of other strategic partners.

It was proposed to co-construct a 'timeline' and 'Child's Journey' map. This would start with a large workshop on 3 June, to include the Strategy Group, partners and families/family groups. Following this the Group would formulate its work programme and the objective was for expenditure to start in the autumn of 2015.

John Dixon confirmed that initial conversations had taken place with health partners. Whilst the additional funding was welcomed, it needed

to be considered in the context of the wider spending through partners. With regard to governance, this body would work with the Joint Commissioning Board as its delivery arm. Its chair, Helen King, the Deputy Director of Public Health would be the key support for the Group. Other officers would support rather than be appointed to the Group.

It was felt this was an excellent opportunity to rationalise work on 0-5 services, to encourage the involvement of all partners and to avoid duplication in services. Specific reference was made to the excellent work on priority families. Another speaker voiced concerns about the reduction in funding for children's centres and the impact of austerity causing a reduction in the services provided. Councillor Roodhouse clarified that this funding was not earmarked to support children's centres. There was a wish to avoid duplication and to be aspirational. The meetings would take place around the County, so the group could see service delivery 'on the ground' and address aspects such as rural isolation.

Resolved

That the Warwickshire Health and Wellbeing Board approves the establishment of a Strategy Group for 0-5 years' services with the terms of reference set out at Appendix 1 and within the governance structure at Appendix 2 to the report.

4. NHS England briefing on Rugby surgeries and the GP funding process

Sue Price, NHS England's (NHSE) Director of Commissioning for the West Midlands presented an update on the changes in Primary Care Commissioning and specific detail on the progress regarding the Albert Street Medical Centre in Rugby and the Brownsover branch surgery.

In May 2014 NHSE invited clinical commissioning groups (CCGs) to expand their role in primary care commissioning by submitting expressions of interest based on three options i.e. the delegated exercise of certain specified primary care commissioning functions to a CCG, joint commissioning with NHSE or greater involvement in commissioning.

Nationally, 64 CCGs had been approved to take on greater 'delegated' commissioning responsibility for GP services, including South Warwickshire CCG. Warwickshire North CCG would develop joint commissioning with NHSE and Coventry & Rugby CCG would develop greater involvement in primary care commissioning. NHSE was currently working with the CCGs to develop transition plans.

With regard to the Albert Street Medical Practice and the Brownsover branch surgery in Rugby, an update was provided on arrangements when this contract ended on 17 April 2015.

An outline was given of events leading to the termination notice being served by NHSE. Temporary 'caretaker' arrangements would provide for continuity of care, whilst a more permanent solution was found. This involved a temporary contract following a competitive tendering process. Two local practices had been awarded a contract to work together for the next year, with the option to extend until a new development was completed. All patients would continue to receive the range of services currently provided. Work had commenced on securing a more permanent solution, which would be subject to patient consultation.

The report included details of the premises to be used in the interim, the consultation and communication undertaken with patients, future consultation plans, changes made in response to patient feedback and providing transport for some patients.

It was acknowledged that this was a difficult time for the 6,500 patients of the Albert Street Medical Practice and particularly the 3,500 who used the Brownsover branch surgery. The communication to date had been poor and NHSE had apologised for this. The temporary arrangements had been reviewed in the light of the patients' concerns and the caretaker practice was striving to ensure patients received a high quality service.

The Chair thanked Sue Price for the update and noted that this matter had also been considered by the Adult Social Care and Health Overview and Scrutiny Committee (OSC). Phil Robson, Chair of Healthwatch Warwickshire (HWW) referred to the short period of consultation, before this closure, when NHSE had been aware of the situation some months beforehand. He sought a meeting with NHSE to discuss the interim arrangements, the certainty that these arrangements would provide effective care and how HWW might be able to assist. Further points concerned how the consumer's view would be taken into account in future, on new commissioning arrangements and to plan future consultations further in advance, so patient feedback could inform decisions.

Local County Councillors had submitted their concerns both at the OSC and recent County Council meeting. It was agreed that effective communication was important and there was an opportunity to learn from this to improve systems. Sue Price clarified the difference between known reviews and emergency issues like this unusual case. She welcomed the offer to meet with HWW. Representatives of CCGs acknowledged the difficult circumstances in this case, involving legal and other issues, also recognising the significant work undertaken by NHSE.

Resolved

That the Board notes the update.

5. Pharmaceutical Needs Assessment

A report was presented by Caroline Galloway and Laurence Tressler of NHS Arden Commissioning Support. The Pharmaceutical Needs Assessment (PNA) was an assessment of the pharmaceutical services that were currently provided in Warwickshire. The Health and Social Care Act 2012 and related regulations transferred responsibility for the development and updating of the PNA from Primary Care Trusts to Health and Wellbeing Boards and the first PNA had to be produced by 1st April 2015.

The report set out the process, the methodology used and findings in compiling the PNA, a copy of which was submitted for the Board's consideration and approval.

It was confirmed that there was a three yearly review of the PNA. Additionally, the Board would receive updates twice each year of the services offered by pharmacists, to determine if any changes made were deemed significant. There was discussion about the training, experience and specialist skills provided by pharmacists, their registration with a national council and the role of NHS England in commissioning pharmacy services. It was noted that several of the responses to the PNA consultation shown in the report's appendix concerned hours of operation, which could be addressed by regular website updates.

Resolved

That the Health and Wellbeing Board:

1. Approves the Warwickshire PNA for publication by 1st April 2015

2. Champions and encourages local discussions between commissioners and the Local Pharmaceutical Committee (LPC) on how to support the wider delivery of the HWB priorities, by enhancing the use of current pharmaceutical services and the development of additional pharmacy services in the future.

3. Supports and liaises with the LPC to continue working with contractors to consider the findings of this PNA and the views of the public and patient respondents discussed in this report that relate directly to pharmacy contractors.

4. Supports and liaises with the LPC to explore options for improving communications between commissioners and the pharmacy contractor network, to facilitate better engagement in the future.

6. Warwickshire's Response to the Mental Health Crisis Care Concordat

Anna Hargrave of South Warwickshire CCG presented a report on behalf of the mental health commissioners. This provided the Board with information about the Mental Health Crisis Care Concordat, the associated requirements for its member organisations and the progress made to date.

The national Crisis Care Concordat was published in February 2014. It was underpinned by 'Closing the Gap: priorities for essential change in Mental Health', which outlined a programme to deliver essential services for people who experienced Mental Health Crisis and came into contact with emergency and acute services.

The Concordat had been developed in partnership and aimed to ensure people in mental health crisis received the appropriate response from services. It was concerned with recovery, early intervention and prevention. There had been significant work undertaken to progress the Concordat.

The arrangements in Warwickshire were reported, with publication of the Local Crisis Concordat Declaration in November 2014. All key agencies across the County were signatories to this declaration. A review of current provision and best practice was undertaken in January 2015. There was a requirement to publish the local plans on the Department of Health's website by 31st March 2015.

Currently, the action plan was still at a very high level. It would require the ongoing commitment of partners to engage in more detailed dialogue over the coming months, to develop the action plan. There were 4 areas where improvements were needed:

- Access to support before crisis point.
- Urgent and emergency access to crisis care.
- Quality of treatment and care when in crisis.
- Recovery and staying well / prevention.

It was planned to work across the Coventry and Warwickshire sub-region to progress the action plan.

Anna Hargrave responded to questions about the need for a timeline and milestones, that significant work was still required and a workshop was planned to make further progress. An example was given of how services would be delivered in practice, through joint work between the police and mental health experts. The links to the Child and Adolescent Mental Health Services (CAMHS) were discussed. The Chair had recently written to Jon Rouse, the Director General for Social Care, Local Government and Care Partnerships at the Department of Health,

who had agreed to visit Warwickshire to discuss CAMHS and she encouraged partners to be involved in that meeting.

Resolved

That the Health & Wellbeing Board:

1. Welcomes and supports the draft multi-agency action plan and that it is submitted to the Department of Health Website.

2. Supports and endorses future activity in respect of the Crisis Care Action Plan for Warwickshire and the implementation of the Plan.

7. Forward Plan

It was reported that to develop a longer-term strategic focus to the work of the Board, it was proposed to establish a Forward Plan for the year ahead. The Forward Plan would be included on each agenda for review and update. This would identify the dates for essential agenda items, proposed workshop topics and assist a thematic approach to future agenda setting. Partners were invited to submit items for inclusion on the Forward Plan.

Resolved

That the Board approves its initial Forward Plan and the items to be submitted to the next meeting.

8. Any Other Business

It was reported that NHS England had requested the submission of a self-assessment, as part of its work to assess the readiness of authorities to deliver Better Care Fund plans in 2015/16. Discussions had taken place with clinical commissioning groups to complete and submit the self-assessment and the Board was asked to note that this had been done. It was agreed that the document be circulated electronically to Board members.

The Adult Social Care and Health Overview and Scrutiny Committee had referred a matter to the Board. A joint task and finish group had submitted recommendations on transitions of mental health services, including a recommendation to the Board around the need for a protocol for data recording, information sharing and use of IT, to improve communication, referrals and transitions. This matter actually rested with the Joint Commissioning Board and would be referred to that body.

The meeting rose at 15.30

……..Chair

Item 2

Health & Well-being Board – 8th July 2015

Governance Proposals

Recommendations

That the Health and Well-being Board;

1. Supports adopting the form of governance at set out in paragraph 2 with membership of the HWB Board as set out in Appendix 1 and membership of the HWB Executive Team as set out in Appendix *2.*

2. Agrees the purpose of the Board as set out in paragraph 3.4

3. Adopts the principles of working for the HWB Board as set out in paragraph 3.5

4. Adopts the sub-structure proposals as set out in paragraph 4 and Appendix 3

5. Approves the action plan set out in Appendix 4 which addresses the remaining recommendations from the Peer Challenge as identified in paragraph 5;

1. Background

1.1 The LGA Health and Well-being Peer Challenge made a number of recommendations covering leadership, governance, strategy and planning and operational matters. The HWB workshop held on 20th May 2015 provided an opportunity for the Board to take stock and start thinking about how it would wish to take forward the peer challenge recommendations.

1.2 This report brings together the outcomes of the HWB workshop with a particular focus on the following governance related recommendations from the Peer Challenge;

- A clear definition of the purpose of the HWBB
- Review the membership of the Board, with Health to take Deputy Chair
- Define and collectively agree:
  - Who sits around the table e.g., providers, 3rd sector
  - Roles of individual Board members:
  - Responsibilities
- Clarify/simplify the current complex structure beneath the HWBB and interrelations with the Adult Social Care and Health Overview and Scrutiny Committee.

1.3 The report also sets out the further areas identified by the Peer Challenge for the Board to take forward and proposes a draft action plan that the Board may wish to consider adopting.

2. Membership of the Board and Role of Board Members

2.1 The workshop presented two models for Board membership which were discussed in the group sessions. Model A which involved a larger inclusive Board was supported by a significant majority of attendees. In this model the Board would have a public facing, strategic focus, receiving agenda items which were clear about the added value and the outcomes that the Board could deliver collectively.

2.2 Where specific feedback was received about who should sit on the Board, most supported the inclusion of providers on the Board at a strategic level (but not involved in commissioning decisions), recognising that there may be conflict situations when providers would need to leave the room and not take part in decision making. The Board and its members are required to operate under the County Council's Code of Conduct.

2.3 Representation on the Board under this model would be at Chairman/ Elected Member/ Non Executive level. The expectation is that Board members would;

- Act as 'systems leaders',
- Act as ambassadors for the HWB strategy, taking back accountability for delivery of the strategy to their organisations
- Act collegiately in support of delivery of the HWB strategy
- Adopt constructive and positive working relationships and behaviours

2.4 Option A also proposed that a smaller 'executive team' comprising Chief Executives and Senior Officers (who have delegated decision making powers from their own organisations). The executive team would form part of the Board's formal governance arrangements and would drive forward the HWB agenda and ensure a co-ordinated and cohesive approach to delivery. Recognising the extent of the potential coverage of 'health and well-being' and its impact on Warwickshire residents, the executive team would play a key role in focusing efforts to areas where collectively partners can make a tangible difference and targeting resources and efforts to HWB priorities as drawn from the HWB strategy. This in turn would help to focus the agendas of the Board and outcomes that the Board needs to deliver.

2.5 It is proposed that the current Integration Executive Board is reshaped into the new HWB Executive Team with its terms of reference reviewed and amended accordingly to encompass its wider brief. It is recognised however that there may be certain issues currently being pursued by the Integration Executive which won't necessarily require attendance of all partners on the HWB Executive Team. The County Council's Strategic Director for Resources will continue to work with the Board (and its senior responsible officer – see paragraph 2.6 below) to refine and implement the operational arrangements required.

2.6 For this proposed model to work effectively and have a clear line of accountability back to the Board, it is proposed that the County Council's Strategic Director of People Group takes on the role of 'senior responsible officer' with responsibility for delivery of the HWB outcomes and for ensuring that effective operational, delivery and performance management arrangements are in place.

2.7 It is proposed that the Board supports adopting the Model A form of governance with membership of the HWB Board as set out in ***Appendix 1*** and membership of the HWB Executive Team as set out in ***Appendix 2***.

3. Purpose of HWBB

3.1 The workshop asked delegates to review the purpose of the HWBB, with a focus on what they felt the Board does well and areas where it could do better. Areas where delegates feel the Board is performing well included;

- Building relationships between partners
- Giving partners a better understanding of the wider health and well-being landscape
- Enthusiasm among partners and a willingness to engage to make improvements
- Buy-in to the strategy by members and a real appetite for improvement

3.2 Areas where delegates felt that the Board could do better included;

- Be more transparent and improve engagement with the public
- Clarify the infrastructure that sits under the HWBB
- Focus on strategy and not get distracted by immediate delivery issues such as performance of acute hospital providers
- Ensure strategy reflects wider health and well-being landscape – not just health and social care
- Be clearer about how the HWB strategy is to be delivered and how partners are held to account to ensure delivery
- Improve communications in respect of action that has been taken
- Better agenda planning processes
- Provide more evidence of the impact the HWBB's actions are having on health and well-being.

3.3 The governance model proposed and the supporting recommendations in this paper attempt to address a number of the areas identified in paragraph 3.2. For example: adopting Model A with sufficiently robust agenda management should enable the Board to have a clear focus on strategy; and the greater clarity around the HWB related infrastructure (see paragraph 4 below) should enable greater line of sight for those elements of the strategy which are not purely health and social care related and in turn will provide greater clarity around how the different elements of the strategy are delivered.

3.4 Taking into account the feedback from the workshop it is proposed that the purpose of the HWB Board is as set out below with a review of its purpose taking place within 12 months of operation;

- To provide strategic direction and develop shared outcomes for improving health and well-being in Warwickshire by bringing together relevant partners whose functions have an impact on health and well-being
- To create collective ownership and accountability among partners for the delivery of shared health and well-being outcomes to Warwickshire residents
- To promote positive health and well-being among the Warwickshire public and encourage integration between social care and health
- To undertake the specific roles required of it under statute and best practice guidance (eg; prepare and publish JSNA and HWB Strategy, approve the BCF quarterly and annual reports, approve Section.75 agreements, act as a statutory consultee on a range of matters related to the CCGs, undertake a needs assessment for pharmaceutical services)
- To have oversight of commissioning activity which supports the delivery of the HWB strategy and to encourage a co-ordinated approach to commissioning activity across partner organisations

3.5 For this model to work, Board members and partner agencies will need to sign up to the following key principles;

- To maintain a strategic focus, the HWBB will meet only 3 or 4 times a year
- The HWBB will consider items they have a legal obligation to consider and anything of strategic importance as identified by the Executive Team
- Agenda management for the HWB will be tight – non statutory items will only be considered by the HWBB if it can be demonstrated that the HWBB can add value in that area – ie that the collective efforts of the HWBB partners and the decisions of the HWBB can make a difference to outcomes
- All reports going to the HWBB will be clear about what is expected of the Board and what decisions and outcomes are being sought
- The relationship with the Executive Team will involve upward and downward referrals. In other words, the HWBB can refer appropriate items to the Executive Team and similarly, the Executive Team can refer matters to the HWBB. If the Executive Team is convened as a sub-committee more formal delegations can be considered.

4 Sub-structure of HWBB

4.1 The workshop feedback acknowledged that there is a lot of confusion around how the HWBB interacts with other groups and that there is a lack of clarity around which boards and programmes have a reporting line or a link back to the HWB Board. This was noted at both the immediate sub-structure level and also at the delivery group level where there is a large number of groups working on outcomes relevant to the HWB strategy which appear to be 'free floating' and therefore could give rise to duplication of efforts.

4.2 A proposal for the sub-structure is attached at ***Appendix 3***. At the sub-structure level it is proposed that the HWB Board recognises that the groups set out below are connected to delivery of the HWB outcomes and that to effectively deliver the strategy there needs to be linkages and alignment between them and the HWBB, with the Executive Team pulling together the various threads and ensuring there is a cohesiveness about the work being carried out under the 'health and well-being' banner, linked back to the HWB strategy and the various partner agencies who collectively deliver against that strategy. These groups are:

- Better Together Programme
- 0-5s group
- MASH
- Warwickshire Community Safety Partnership (Safer Warwickshire Partnership Board)
- Infrastructure Board
- Skills for Employment Board
- Children's and Adults Commissioning Boards

4.3 Under this model, the expectation is not that each group is necessarily directly accountable back to the HWB for all the activity that particular group is undertaking. Rather that the groups are able to provide the assurance to the Executive Team and to the Board that the elements of the HWB strategy which fall within their remit are being addressed and delivered. This would enable the Executive Team and the Board to have a strategic overview as to how the elements of the HWB strategy are being delivered and could play an active role in shaping action on the ground. It would also ensure that the right linkages and alignments are made and there is a co-ordinated approach across partners.

4.4 This model, coupled with the Peer Challenge recommendations, would require a closer look at the HWB outcomes as set out in the HWB strategy. Clarity would be needed as to which outcomes are a strategic priority for the Board (ie where can the Board make greatest impact), where responsibility for delivery of those outcomes best sits (ie which themed work stream/group at the sub structure level) and what assurances and reporting back arrangements are required. It is recommended that this piece of work is taken forward by the newly formed Executive Team, under the direction of the senior responsible officer, with a report back to the autumn HWBB. This should help to distinguish between 'business as usual' activity and priority outcomes for the HWB Board as a collective.

5 Conclusion

5.1 This report addresses the main governance related recommendations emerging from the HWB Peer Challenge and asks the HWB Board to support the proposed new governance arrangements as set out in this report.

5.2 The Peer Challenge also made recommendations in a number of other areas, some of which are highlighted in this report. The key recommendations which require further work and discussion are set out below in summary;

5.2.1 The development of a clear action plan for delivery of the HWB strategy and ownership for delivery of its outcomes. The way forward for this is referenced in paragraph 4.4 above

5.2.2 The interrelationship between the HWB Board and scrutiny arrangements. It is proposed that this work is led by the County Council's Head of Law & Governance as a follow on from the governance work.

5.2.3 Securing a Deputy Chair of the Board from a health partner body (eg CCG)

5.2.4 The provision of structured officer support for Board development, forward planning of business for the Board and performance management – it is proposed that the County Council's Strategic Director of People Group as 'senior responsible officer' formulate appropriate working arrangements for this.

5.2.5 The continued development of the Board as a collective, building relationships, acting in support of Board objectives and the adoption of a system leadership approach – it is proposed that the series of workshops planned for the Board incorporate some sessions to focus on these issues, with other workshops focused on themes relevant to the different delivery boards. These would not be public meetings. Identification of relevant workshop topics would be overseen by the Executive Team. The Board could also consider a wider development programme for officers involved in delivery to embed the systems leadership approach at all levels. This will form part of the cultural theme of the action plan.

5.2.6 Customer, patient, service user accountability and wider stakeholder engagement – the recommendations of the peer challenge around this area were quite specific around how the Board can raise its profile, its approach to digital media, whether it should have its own identity, communication of success to the wider community and engagement with a wider range of stakeholders. The suggestion of a wider annual stakeholder engagement

event was largely welcomed at the workshop. It is proposed that this strand of work is developed by the officer support structure identified at 5.2.4 above under the direction of the senior responsible officer.

5.3 The above items have been incorporated into a draft Action Plan which is set out at ***Appendix 4***. Taking into account the feedback at the workshop, the plan also includes an action focused around review and rationalising arrangements at the delivery group level, which includes various free standing boards and groups, to ensure that the right linkages are made across the whole of the health and well-being landscape. The Board is invited to approve the action plan.

6. Background Papers

LGA Health & Well-being Peer Challenge Feedback Letter
Health and Well-being Workshop Feedback

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Appendix 1

Proposed Membership of HWB Board – Non executive, member, chairman level

Member	**Organisation / Number**
Director of Public Health	WCC (statutory requirement)
Director of Children's and Adults Services	WCC (statutory requirement)
County Council elected members	4 x WCC elected members
District and Borough Council elected members	5 x DC/BC Portfolio Holders (one representative from each area)
Chair of Health Watch Warwickshire	Health Watch (statutory requirement)
CCGs (at chair/non exec level)	3 x CCGs (one representative from each area)
NHS England representative	NHS England (statutory requirement for certain elements)
Providers (at chair/non exec level)	4 x Provider representatives; South Warwickshire Foundation Trust, University Hospitals Coventry and Warwickshire, George Eliot Hospital, Coventry and Warwickshire Partnership Trust
Police and Crime Commissioner	Police and Crime Commissioner
Total	**21**

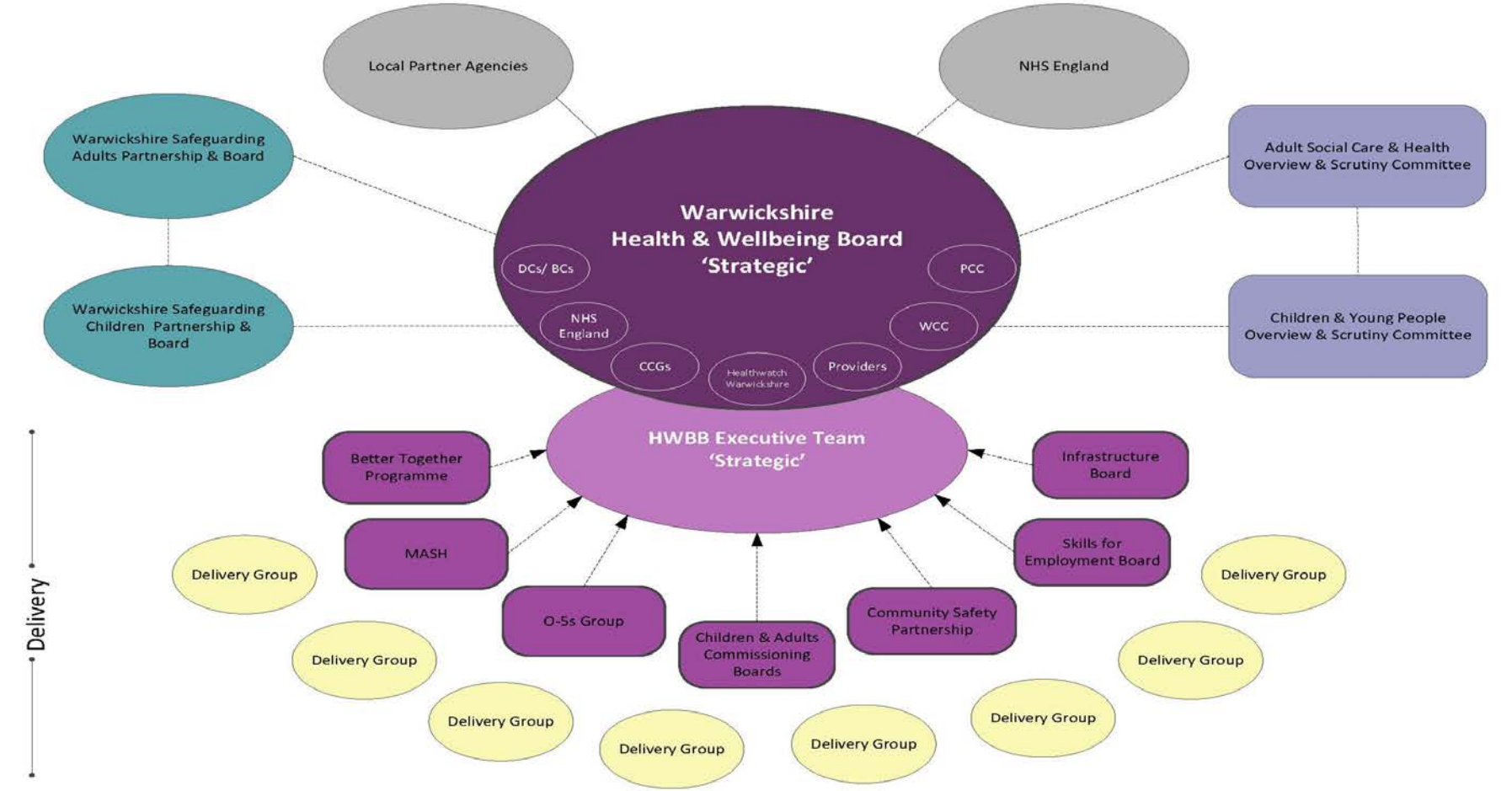
Appendix 2

Membership of HWB Executive Team

Member	**Organisation / Number**
Director of Public Health	WCC
Director of Children's and Adults Services	WCC
Director for Communities	WCC
District and Borough Council Chief Executives	3 x DC/BC Chief Executive Representatives (one representative from each CCG area)
Chief Executive of Health Watch Warwickshire	Health Watch
CCGs Chief Officers	3 x CCGs (one representative from each area)
Providers – Chief Executives / Chief Officers	4 x Provider representatives; South Warwickshire Foundation Trust, University Hospitals Coventry and Warwickshire, George Eliot Hospital, Coventry and Warwickshire Partnership Trust
Chief Constable	Chief Constable of Warwickshire Police
WCAVA – Chief Executive	WCAVA (Third Sector representative)
Total	**16**

HWBB sub structure proposals

Appendix 3



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Warwickshire County Council

Appendix 4
Draft Action Plan for consideration at the HWB Board Meeting on 8th July

HEALTH & WELL-BEING PEER CHALLENGE ACTION PLAN

THEME	PEER CHALLENGE RECOMMENDATION	PLANNED ACTIVITIES	PROGRESS TO DATE	LEADS
DELIVERY OF HWB STRATEGY	Develop shared ownership of the Health & Wellbeing Board agenda	Phase 2 of the governance review includes work for the Board to identify key priorities from the HWB Strategy and have clarity about which goup at the sub-structure level had lead responsibility for their delivery. Together with the culture actions below, this will start to address shared ownership of the HWBB agenda	The need for the Board to undertake this work has been flagged in the Governance Report being considered on 8th July 2015. The Senior Responsible Officer will lead on this work. It will be key that the Board engages in this work (possibly through workshop) to ensure that shared ownership secured. The cultural work stream (see below) will also have an impact	John Dixon
	Develop a joint implementation plan for use by all partners	Outcomes from the above work would be incorporated into the work programmes of the sub-structure level groups / boards	The development of the joint implementation plan will be part of the above work	John Dixon
	Clear performance management processes to develop	Existing performance management arrangements and processes to be reviewed as part of the above work	Performance management arrangements to be clarified through the above work	John Dixon
BOARD MEMBERSHIP	A Health partner should be considered in the role of Deputy Chair	CCGs to confirm nomination for Vice Chair by 30th September 2015	CCGs supportive of the proposal to nominate a Vice Chair. Discussions have taken place within the CCGs and dialogue is continuing to enable confirmation of a CCG representative as Vice Chair in the early autumn	CCGs
BOARD CULTURE, DEVELOPMENT & OPERATION	More focus of developing a culture of 'we' and 'us', moving towards acceptance that all partners are equal and should take ownership, agreement and understanding of each organisation's role in the delivery of outcomes	Executive Team to review plan for workshops to provide space for Board to progress these cultural themes. Board to consider thematic workshops (based around delivery work streams) and also workshops which build relationships and promote the systems leadership approach	Workshop dates confirmed. Focus and content to be considered by Executive Team	Executive Team
	Review approach to digital media, including up to date information on webpages	Executive Team to identify appropriate resource to take forward this piece of work, including development of Comms Strategy	To be considered by Executive Team - potential programme of work for officer support team	Executive Team
	Consider whether the HWBB needs its own identity and how its success is communicated to the wider community	Executive Team to consider further, in particular to review the proposal to hold an annual stakeholder engagement event	To be considered by Executive Team - potential programme of work for officer support team	Executive Team
	Develop clear and distinct support for the Chair (Board)	That the Senior Responsible Officer identifies appropriate officer support for Board development, forward planning of business and performance management monitoring	To be determined by Senior Responsible Officer	John Dixon
INTERRELATIONS WITH OTHERS	Clarify the Board's interrelations with WCC's Adult Social Care and Health Overview and Scrutiny Committee	Review to be undertaken led by WCC reporting back to the Board in the autumn	Sarah Duxbury to be the lead officer taking this work forward as a follow on to the governance work already completed.	Sarah Duxbury
	Clarify and potentially simplify the complex structure beneath the Board	Review and rationalisation of the various operational delivery boards that contribute to delivery of the HWB outcomes and feed into the HWBB. These include a number of groups focused on single issues.	The report to the HWB Board on 8th July makes proposals to simplify the boards and groups which operate at the sub structure level (ie immediately below the Board). A follow up piece of work will be to review the boards and groups which operate at the delivery/ operational level and are aligned with delivery of HWB outcomes	Sarah Duxbury

Item 4

Health & Wellbeing Board

8th July 2015

Director of Public Health Annual Report 2015

Recommendation(s)

That the Health and Wellbeing Board:

1. **Note and support the Director of Public Health Annual Report 2015.**
2. **Agree to endorse the recommendations stated in the report.**

1.0 Background

1.1 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 now firmly re-established in local government, this presents a real opportunity to tackle key health and wellbeing issues through a more collaborative and structured approach. We can build on the key functions of local government to better shape the place and environment in which we live.

1.2 The Director of Public Health (DPH) 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. It is the DPH's professional statement about the health of local communities, based on sound epidemiological evidence, and objective interpretation.

2.0 Purpose

2.1 The theme of this year's annual report is children and young people. It includes a focus on early years, education, mental health, healthy weight, risky behaviours and vulnerable groups. The main target audience are external partners, schools, councillors and internal staff.

2.2 The report emphasises the importance of adopting of a 'life course' approach to addressing health inequalities within the population, in-line with that advocated by Sir Michael Marmot in his report 'Fair Society Healthy Lives'[1].

[1] Institute of Health Equity (2009), 'Fair Society Healthy Lives' (The Marmot Review) (2009), Strategic Review of Health Inequalities in England Post-2010, http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

In particular, the report focuses on the first two key 'Marmot principles' of giving every child the best start in life, and enabling all children, young people and adults to maximise their capabilities and have control over their lives.

1.5 It should be recognised that the recommendations and desired outcomes outlined in the report are 'everybody's business' and require a concerted joint effort if they are to be achieved.

1.6 The report's recommendations and any consequent changes to service delivery that result can be delivered within the level of the approved budget.

1.7 It is of vital importance that the Health & Wellbeing Board provides leadership across all partners to ensure that our children and young people enjoy happy, healthy and fulfilled lives. In doing so, we will be helping to nurture the future society of Warwickshire.

3.0 Key Headlines

3.1 **Early Years**
13.1% of pregnant women are still smoking at the time of delivery – this means approximately 800 babies are born having been effectively smoking for 9 months.

3.2 **Education**
40% of children in Warwickshire are not achieving a good level of development at the end of reception.

There are particular concerns about looked after children, children eligible for free school meals and regular absentees – persistent development and attainment gaps remain between these pupils and their peers.

3.3 **Healthy Weight**
Latest data highlights a continued, approximate doubling in obesity prevalence between the ages of 4/5 and 10/11, and a clear North-South geographic divide across Warwickshire.

3.4 **Mental Health and Wellbeing**
The importance of recognising that building good health behaviours in childhood and adolescence can help to prevent risky behaviours and creates healthier adults is highlighted. Relationships can help develop self-esteem and make children and young people emotionally resilient, but they can also make them vulnerable. Recognising and supporting healthy relationships are key to improving young people's physical and mental health and wellbeing.

3.5 **Risky Behaviours**
Local rates of teenage pregnancy have declined over the past few years, although notable variation persists with rates still highest in the two northern boroughs.

Latest figures show a repeated drop in the rate of hospital admissions due to alcohol among under 18s in Warwickshire, evidence of a continuing decline in young people's harmful drinking. However, nationally, whilst we have seen a decline in binge drinking, drinking at dangerous levels and those aged 11-15 saying they had tried alcohol, young adults still remain one of the most likely groups to have binged.

3.6 **Vulnerable Groups**

Exposure to adverse childhood experiences (ACEs) such as parental separation or divorce, physical/emotional neglect, household substance abuse and household mental illness have been shown to have a detrimental impact on both future health and social outcomes in adulthood. Exposure to higher counts of ACEs has also been shown to present a higher risk of exposing their own children to ACEs.

4.0 Next steps

4.1 **Dissemination**

A detailed multi-channel communications plan has been prepared to ensure that the report reaches its target audience amongst WCC and other partners.

The report will also be used to support ongoing work focused on the 0-5 age group as the County Council takes on the responsibility for the commissioning of services for this group in October 2015.

4.2 **Audit**

The report will be subjected to a full audit process and will be peer reviewed by external public health colleagues. Progress against the recommendations will also be monitored and reported. We welcome any feedback on the content of the report. Comments can be directed to publichealthintelligence@warwickshire.gov.uk.

Background papers

1. 'Director of Public Health Annual Report 2015 – Children and Young People: Investing in the Future'. Hard copy versions to be disseminated at the meeting.

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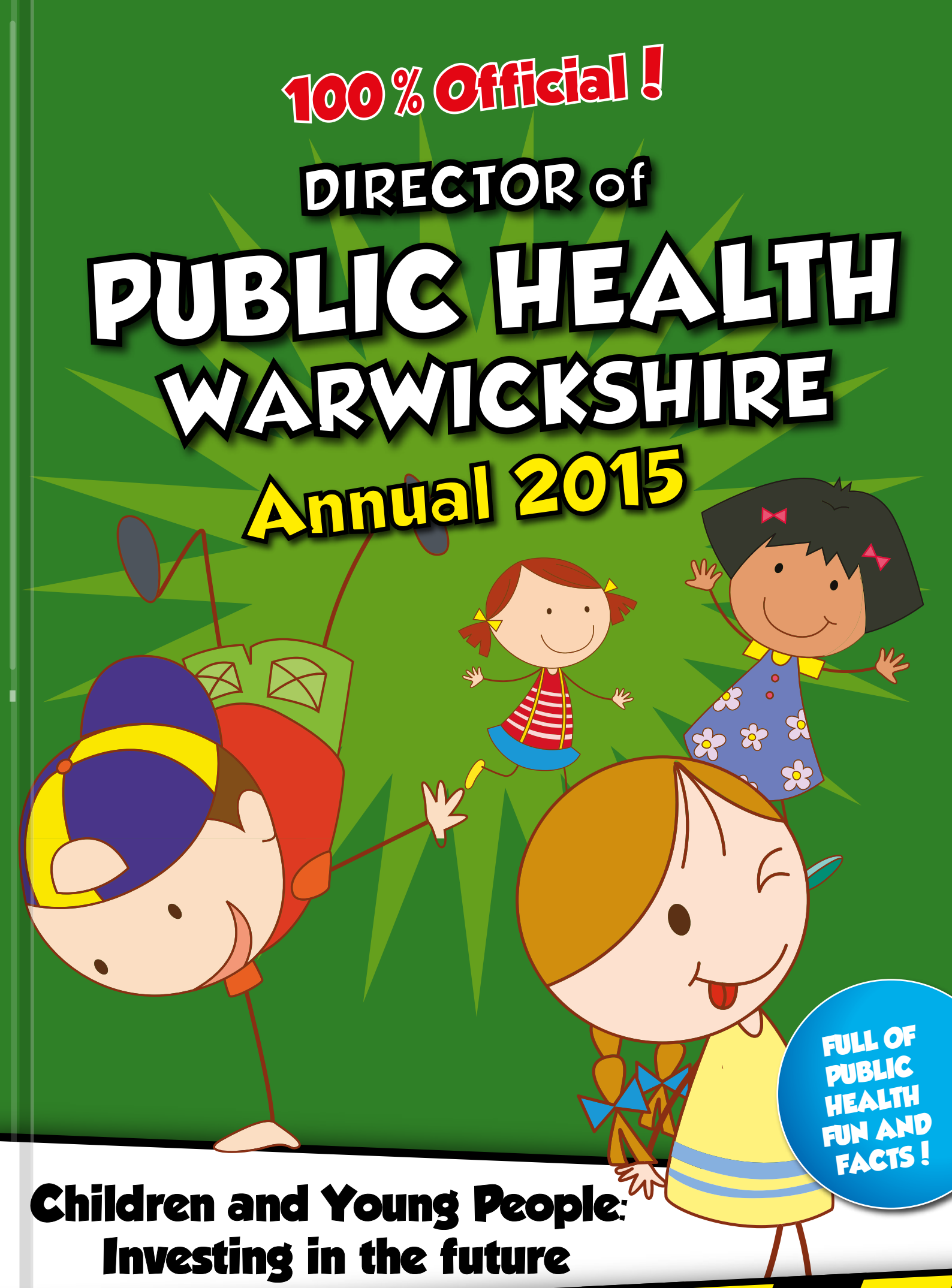
100 % Official !

DIRECTOR of PUBLIC HEALTH WARWICKSHIRE Annual 2015



FULL OF PUBLIC HEALTH FUN AND FACTS !

Children and Young People: Investing in the future

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INTRODUCTION

Children and young people growing up in England today are healthier than they have ever been before. Health and social changes have had dramatic impacts. Previously common fatal diseases are now rare and more children with serious illnesses and disabilities are surviving into adulthood. The infant mortality rate has fallen to less than a quarter of what it was at the beginning of the 1960s.

The picture in Warwickshire is similar, and for many indicators, the county outperforms the regional and national averages. Excellent uptake of childhood immunisations has meant that by the age of five, 95.9% of our children have received their second dose of Measles, Mumps and Rubella (MMR) immunisation and 98.5% of our two year olds have received their appropriate vaccinations. The numbers of overweight and obese year six school children have reduced slightly and the rate of teenage pregnancy has also come down.[1]

Despite these positive trends, we must not be complacent. As I have shown in my previous reports, we need to be as ambitious for our children and young people's health as for the adult population. In fact more so. Professor Sir Michael Marmot has shown in his 2010 review of health inequalities in England – *"Fair Society, Healthy Lives"* – that the early years (from 0-5) are critical in shaping health and wellbeing later in life.[2]

"Disadvantage starts before birth and accumulates throughout life. . . .Action to reduce health inequalities must start before birth and be followed through the life of the child. Only then can the close links between early disadvantage and poor outcomes throughout life be broken".[2]

Across a number of parameters we need to do better. I am concerned that 13.1% of pregnant women are still smoking at the time of delivery – this means approximately 800 babies are born having been effectively smoking for 9 months. Local rates for breastfeeding still lag behind the national average. Our mothers need more support to provide the best start possible for their children. Across Warwickshire not all our children are achieving a good level of development at the end of reception. 60% do but that leaves 40% who do not. A&E attendances for 0-4 year olds are higher than the national average, and in line with national trends, the rates of self harm in our young people aged 10-24 are rising.[3]

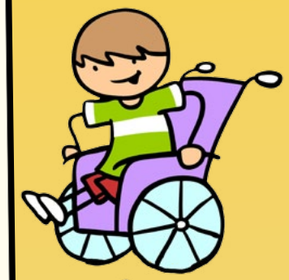
Overall, the Warwickshire picture, even when good, masks a variation in the situation of children, which requires a proportionate response.

Good health and wellbeing is not merely the absence of disease. To thrive, our children and young people need to: be healthy; stay safe; enjoy and achieve; make a positive contribution and achieve economic wellbeing.

The evidence tells us that treating different specific health issues separately will not tackle the overall wellbeing of this generation of young people. Young people's mental and physical health is intertwined, and at the heart of health and wellbeing are their relationships with others. Young people think about their health holistically. They want an integrated, youth friendly approach that recognises their particular needs, makes them feel supported, emphasises the positives and helps them to cope.

Meeting these needs is a joint task for the NHS and local government including Planning, Housing, Community Safety, Education and Public Health, as we show in the report. Giving every child the best start in life is crucial to reducing health inequalities across the life course.

"Giving every child the best start in life is crucial to reducing health inequalities across the life course."



Dr John Linnane

Director of Public Health Warwickshire

Recommendations

As Director of Public Health, I wish to make a series of recommendations for each of the chapters in this report. I believe these will help to ensure the delivery of better outcomes for the children and young people of Warwickshire.

Chapter 1: Early years

- ☐ **The Health and Wellbeing Board (HWBB) should ensure a robust comprehensive Early Years Strategy is in place which reflects the views of children, young people and their families.**
- ☐ **Maternity and health visiting services must achieve and maintain UNICEF Baby Friendly Stage 3 standards for supporting breastfeeding and parent infant relations.**
- ☐ **Health visiting must ensure the development of parenting skills within both antenatal and postnatal care. Warwickshire County Council (WCC) and the service provider must develop the capacity needed to deliver this.**
- ☐ **Partners must ensure effective engagement with parents experiencing problems, appreciating that parents most in need are often the least likely to access early years services.**
- ☐ **We need to focus on continuing to deliver a reduction in teenage pregnancies through the 'Respect Yourself Programme'; supporting those who do become pregnant through the Family Nurse Partnership.**
- ☐ **Maternal obesity and smoking in pregnancy are high risk for the mother and the developing child. These should be a priority for maternity and health visiting services, especially in the north of the county where rates are highest.**

Chapter 2: Healthy weight

In addition to improving breastfeeding rates and tackling maternal obesity:

- ☐ **A whole system approach for obesity and physical activity is required from all partners including transport, planning, financial inclusion, housing, environmental services and public health.**
- ☐ **Local hospitals must develop strategies to embed a healthy food culture for patients, staff and all visitors.**
- ☐ **Close gaps in service provision for early years children, their families and adolescents and reduce health inequalities through the Warwickshire-wide commissioning of:**
  - **services which have 'Making Every Contact Count' and promoting mental wellbeing embedded within them;**
  - **early years parenting/weight management programmes in all children's centres;**
  - **the 'Food for Life Partnership' whole food culture programme in all children's centres, primary schools and secondary schools;**
  - **structured family weight management programmes for overweight/obese children and their parents/carers;**
  - **weight management and physical activity services for adolescents and adults.**

Chapter 3: Mental health and wellbeing

- ☐ **Education and learning must develop a school and college based programme to reduce self-harm by young people in Warwickshire as a priority area.**
- ☐ **Early recognition and intervention for emerging mental health problems is key. We all have a responsibility to work together to ensure this service is available.**
- ☐ **A structured approach to promote mental wellbeing for children in schools and young people in colleges is required. This should include an adapted '5 Ways to Wellbeing' approach and mental health first aid training.**
- ☐ **We should commission cost-effective and evidence based parenting programmes for children at high risk and target support to families with specific needs.**

Cut out and keep! *Cut out and keep!*

Chapter 4: Educational attainment

- [ ] All schools should develop accurate assessments of the health and wellbeing needs of their school population.

- [ ] WCC to work together with schools to address the attainment gap between Looked After Children and other pupils.

- [ ] Schools and academies must ensure that personal, social and health education (PSHE), relationships and sex education are embedded across the curriculum and culture of the organisation, and are equally about building skills as well as knowledge.

- [ ] Schools to make effective use of the Pupil Premium to:

  - raise pupil aspirations using engagement/aspiration programmes;
  - develop social and emotional competencies;
  - intervene early and effectively, track progress and change approaches where necessary;
  - focus on transition, one-to-one tuition and progressive development of language and literacy skills;
  - search out the most effective ways of engaging parents and families, and listen to pupils and engage them in sustained dialogue about learning.

Chapter 5: Risky behaviours

- [ ] All services and sectors to empower young people in educational settings by giving them the skills they need to develop healthy relationships – for example, by providing opportunities within the curriculum to teach relationship skills (partly through PSHE, and sex and relationships education).

- [ ] We will work with and expand the role of pharmacists in sexual health. This is particularly important in terms of accessibility for young people.

- [ ] We will increase the online presence and use of technology to improve services.

- [ ] All school staff and staff who work with children and young people should have training to promote healthy relationships and improve awareness and support for issues of child sexual exploitation.

- [ ] We must adopt a social norms approach to discuss attitudes to sexting, consent and pornography – all of which underpin healthy relationships and avoid exploitation.

Cut out and keep!

Cut out and keep!

Chapter 6: Vulnerable children and young people

- [ ] Early identification of young carers is key to the success of supportive interventions. Health, Social Care and Education sectors need to work collaboratively with partners to facilitate the earlier identification of carers who can then be signposted to appropriate support.

- [ ] Schools and other professionals working with young carers need to ensure that staff are sufficiently skilled in recognising the signs and symptoms which could point to a child/person having a caring role.

- [ ] GP practices should identify carers within their practice, and clinicians need to give due consideration to the welfare of children and young people when they see patients in their care.

- [ ] WCC will need to ensure that there are joined up approaches between Adults and Children's services, with clear guidance available to practitioners, and clear working arrangements with Mental Health services. This is to ensure a 'whole systems approach' for young carers.

- [ ] Health and Social Care services need to provide clear pathways for accessing services, and make this information available to young carers at an early stage in their caring role.

Chapter 1
Early Years - A Good Start

Attachment

Positive attachment between a young child and their primary care-giver, usually but not necessarily the mother, has been consistently shown to be important for healthy early development. Early, secure attachments contribute to the growth of a broad range of competencies, including self-esteem, self-efficacy and positive social skills that are associated with better educational and social outcomes and improved job prospects in later life. Isolation and depression are two important factors that impact negatively on maternal attachment capacity and which supportive interventions can alleviate.

Sensitive and responsive parent–child relationships are associated with stronger cognitive skills in young children and enhanced social competence and work skills later in school. It is therefore important that we create the conditions to enable parents to develop this relationship during the child's critical first year. This involves making it practical and affordable, through providing paid parental leave for the whole of the first year, and, where required, providing parents with the understanding and skills needed to forge a positive relationship with their child.

Background/context: Why does it matter?

Over 6,000 babies are born in Warwickshire each year. Every birth provides a chance to support families to lay down a blueprint for the future health and wellbeing of a child.[2]

Giving every child the best start in life is critical in reducing health inequalities across the whole life course. The foundations for all aspects of development – physical, intellectual and emotional – are laid in early childhood. What happens in these early years (which start in the womb) has a lifelong impact on a whole range of health and wellbeing issues – from obesity, heart disease and mental health, to educational achievement and employment.

Early intervention in ensuring that all children have access to positive early experiences is crucial in addressing health inequalities. Whilst also important, later investment is considerably less effective if those early foundations have not been laid.

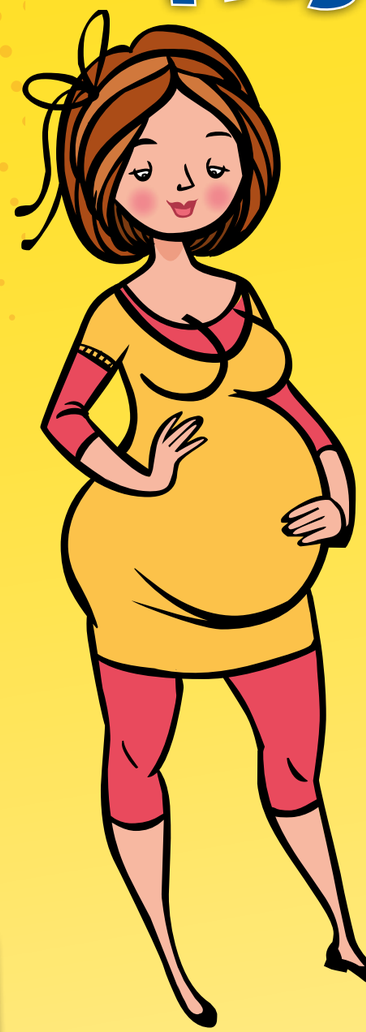
Current state and local variations:

The number of births and the general fertility rate (GFR) varies between different areas in Warwickshire:

Table 1: Live births and GFR, Warwickshire, 2009 – 2013[4]

District & Borough	2009		2010		2011		2012		2013	
	Live Births	GFR	Live Births	GFR	Live Births	GFR	Live Births	GFR	Live Births	GFR
North Warwickshire	626	55.3	683	61.8	651	58.3	688	62.6	676	62.7
Nuneaton & Bedworth	1,507	63.8	1,682	72.5	1,639	67.0	1,598	66.0	1,582	66.1
Rugby	1,203	70.1	1,228	72.7	1,273	66.4	1,261	66.6	1,243	65.9
Stratford-on-Avon	1,070	54.9	1,165	61.1	1,153	57.7	1,139	58.6	1,068	56.2
Warwick	1,591	54.1	1,555	54.1	1,557	55.6	1,619	58.0	1,521	55.3
Warwickshire	**5,997**	**59.4**	**6,313**	**63.8**	**6,273**	**61.0**	**6,305**	**62.1**	**6,090**	**60.8**

Pregnancy



Smoking

Smoking[5] during pregnancy can cause serious pregnancy-related health problems, including:

- complications during labour;
- increased risk of miscarriage;
- premature birth;
- still birth;
- low birth-weight; and
- infant mortality.

Compared to children exposed to tobacco smoke in the womb, those whose mothers did not smoke during their pregnancy are less likely to experience a range of health and behavioural conditions including wheezy illnesses and psychological problems that can negatively impact on the child's educational performance.

Mothers who are:

- younger;
- work in a routine and manual occupation;
- less educated;
- single;
- with a partner who smokes

…are more likely to smoke when pregnant.

12.0% of mothers in England were recorded as smokers at time of delivery (SATOD) for 2013/14, which is lower than 2012/13 (12.7%) and continues the year-on-year decline from 15.1% in 2006/07.

Infants of parents who smoke are more likely to suffer from:

- serious respiratory infections (such as bronchitis and pneumonia);
- symptoms of asthma;
- problems of the ear, nose and throat (including glue ear).

In England, 43% of children reported being exposed to second-hand smoke in their own home in the last year.[7] Every week in Warwickshire around 4,500 children are exposed to second-hand smoke while travelling in a vehicle.[8]

Table 2: Smoking at time of delivery (SATOD) 2013/14 – CCG level[6]

	Prevalence
Coventry and Rugby CCG	13.0%
South Warwickshire CCG	8.3%
Warwickshire North CCG	19.0%

Obesity/healthy weight

Maternal obesity increases health risks for both the mother and child during and after pregnancy

A healthy diet is important for both the baby and mother throughout pregnancy and after the birth.

However:

- 39% of people from low income groups worry about having enough food to eat before they receive money to buy more and;
- 36% report that they cannot afford to eat balanced meals.

Women who are overweight or obese before they conceive have an increased risk of complications during pregnancy and birth. This poses health risks for both mother and baby in the longer term. There is also evidence that maternal obesity is related to health inequalities, particularly socioeconomic deprivation, inequalities within ethnic groups and poor access to maternity services.[9]

Table 3: Pregnant women with a BMI 35+ (class II & III)[10]

Warwickshire:
6.2% (2009/10)
7.4% (2010/11)
7.0% (2011/12)

South Warwickshire CCG: 4.5% (2011/12)
Warwickshire North CCG: 9.2% (2011/12)
Coventry and Rugby CCG: 7.3% (2011/12)

Pregnancy cont... Age of mother

Babies born to teenage parents are more likely to become teenage parents themselves. Evidence shows that having children at a young age can damage young women's health and wellbeing and limit their education and career prospects.

There are also implications for the child, children born to teenage parents are more likely to experience a range of negative health and social outcomes. Local rates of teenage pregnancy have declined over the past few years, although notable variation persists with rates highest in the two northern boroughs.

Table 4: Rate of conceptions per 1,000 females aged 15-17 – 2008-2013:[11]

	2008	2013
North Warwickshire	44.0	26.6
Nuneaton and Bedworth	41.9	29.7
Rugby	33.6	22.6
Stratford-on-Avon	22.0	18.9
Warwick	34.2	19.7
Warwickshire	**34.5**	**23.4**
England	46.3	24.3

Birth

Breastfeeding

Ensuring mothers and their babies are well nourished is very important, a pregnant woman's nutritional status influences the growth and development of her foetus, which forms the foundations for the child's later health.

Diet during the early years also impacts on the growth and development of a child. Being well nourished can reduce a child's chances of developing many common childhood illnesses such as diarrhoeal disease, dental issues and iron and vitamin D deficiencies, and can also reduce the risk of developing conditions such as coronary heart disease, diabetes and obesity in later life.[5]

The Warwickshire target for breastfeeding is 75% for initiation and 50% for 6 – 8 weeks.

Table 5: Breastfeeding by district and borough - 2013/14:[12]
% of all mothers who breastfed their babies in the first 48 hours after delivery and at 6-8 week check

	% breastfed in first 48 hours	% breastfed at 6-8 weeks
North Warwickshire	68.4%	31.2%
Nuneaton and Bedworth	60.2%	32.5%
Rugby	82.5%	44.5%
Stratford-on-Avon	76.7%	50.8%
Warwick	78.2%	54.3%
Warwickshire	**73.5%**	**43.7%**
England	73.9%	N/A

Early years

The 0 – 5 years are a critical period, where foundations for the whole life course are laid.[13]

40% of children in Warwickshire do not achieve a good level of development at the end of reception.

What can we do in Warwickshire?

A healthy pregnancy and good attachment can contribute to a child's school readiness.

School readiness refers to a broad range of skills and abilities that a child needs in order for them to be successful in school. These can include both academic and cognitive skills, as well as social and emotional aspects. Acquiring these skills and the transition into school can be challenging for children, particularly those from disadvantaged backgrounds. This can manifest itself in behaviours that prevent a child from learning or a lack of communication skills that limit social interaction.

In Warwickshire, focussing on school readiness means we need to have:

Ready children – children are in the best position to maximise their learning, wellbeing and development.

Ready schools – the early years and education environment fosters and supports a smooth transition for children and promotes the learning and wellbeing of all children.

Ready families – parents and care-givers are involved in their child's early learning, development and transition to school.

Recommendations

- [ ] **The Health and Wellbeing Board (HWBB) should ensure a robust comprehensive Early Years Strategy is in place which reflects the views of children, young people and their families.**
- [ ] **Maternity and health visiting services must achieve and maintain UNICEF Baby Friendly Stage 3 standards for supporting breastfeeding and parent infant relations.**
- [ ] **Health visiting must ensure the development of parenting skills within both antenatal and postnatal care. Warwickshire County Council (WCC) and the service provider must develop the capacity needed to deliver this.**
- [ ] **Partners must ensure effective engagement with parents experiencing problems, appreciating that parents most in need are often the least likely to access early years services.**
- [ ] **We need to focus on continuing to deliver a reduction in teenage pregnancies through the 'Respect Yourself Programme'; supporting those who do become pregnant through the Family Nurse Partnership.**
- [ ] **Maternal obesity and smoking in pregnancy are high risk for the mother and the developing child. These should be a priority for maternity and health visiting services, especially in the north of the county where rates are highest.**

Word search

I	S	R	S	A	C	D	M	P	P	S	W	D	G	B
K	C	E	E	O	Q	J	G	R	S	T	L	E	X	B
Y	L	O	C	A	J	V	E	U	T	A	F	V	T	R
I	O	W	M	Z	D	G	O	O	N	R	C	E	Z	X
R	M	S	J	M	N	Y	U	B	E	T	J	L	G	P
H	B	L	M	A	I	P	P	N	R	K	P	O	R	M
H	Z	H	N	K	O	S	N	I	A	H	T	P	S	L
J	N	C	P	O	E	X	S	E	P	J	M	M	Q	C
K	Y	E	A	R	L	Y	Z	I	R	R	J	E	Q	P
D	I	W	M	U	L	S	A	R	O	D	V	N	Y	J
O	N	K	T	O	L	Z	R	E	T	N	L	T	M	C
I	A	R	O	T	A	L	J	H	X	M	E	I	H	M
P	Z	H	K	Q	V	F	C	P	B	L	Z	R	H	R
E	C	N	Q	Y	S	R	E	N	T	R	A	P	S	C
S	N	A	Z	C	F	D	I	V	N	N	K	K	W	Q

Can you find all these words in the grid:

EARLY
SCHOOL
READY
PREGNANCY
PARTNERS
COMMISSIONERS
CHILDREN
START
PARENTS
DEVELOPMENT

Chapter 2
Healthy Weight

Background/Context - Why is Obesity an Issue?

It's widespread !

More than one in three 11-15 year olds in England are obese or overweight.[14] Overweight and obese children and young people are more likely to become overweight adults who then suffer associated poor health, with a significantly increased risk of dying early.[15]

The latest 2013/14 National Child Measurement Programme (NCMP) figures in Warwickshire highlight that 12.5% of reception age schoolchildren are overweight and 8.2% are obese. For year 6 schoolchildren, 14.7% are overweight and 15.6% are obese. Whilst these figures are lower than the respective England statistics, there is no room for complacency with obesity levels nearly doubling between reception and year 6.

Prevalence is increasing...

The prevalence of overweight and obesity has increased greatly in England and in many other countries over the past 20 years. This increase in adults and children has mainly been due to changes in behaviour including increased availability and consumption of unhealthy foods, as well as most of us leading more sedentary lifestyles.

This is complicated by the fact that we may not see ourselves or our children as obese. Studies have shown that adults tend to underestimate their own weight, and half of all parents do not recognise that their own children are overweight or obese.[16,17,18]

Cause

Overweight and obesity is caused primarily by individuals consuming more energy (as measured in calories) than they are using up (energy used through daily activity, physical activity etc.), i.e. eating more and moving less.

The nature of overweight and obesity in children and young people is complex and multi-faceted. Contributory factors can include:

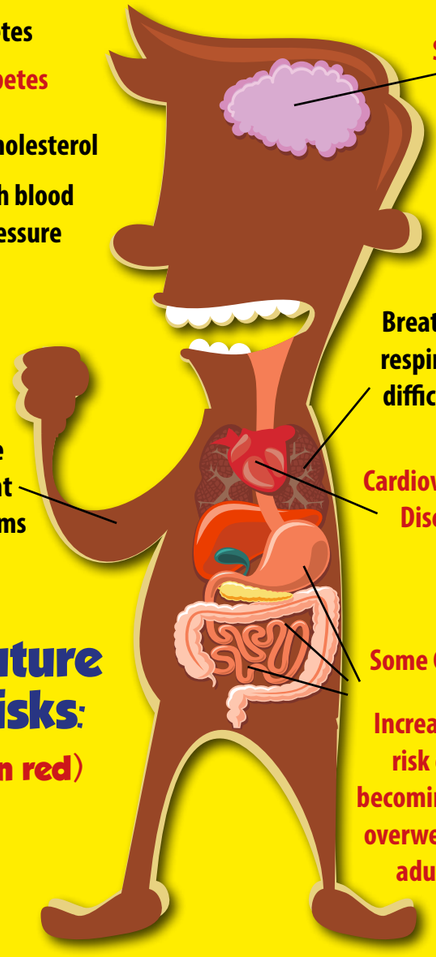
- Socioeconomic circumstance (i.e. debt, inability to afford / access healthy food etc.)
- Environmental influences (i.e. access to green spaces for exercise)
- Education levels
- ...and many other factors such as culture, family upbringing, etc.

It has detrimental consequences...

The Impacts of Obesity

Being overweight or obese can have a harmful impact on children's and young people's lives in a variety of different ways.

Health problems:



Future risks: (in red)

Increased risk of becoming an overweight adult

Greater risk of premature mortality in adulthood

Emotional & Behavioural Problems:

- Stigma
- Bullying
- Low self-esteem
- Body dissatisfaction
- Being absent from school

Economic Cost £

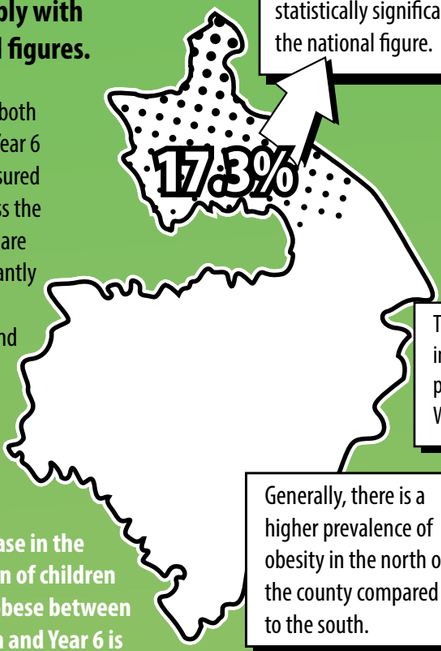
In addition to the risks of disease and ill-health, there are large economic costs associated with being overweight and obese in terms of treatment, social care and other costs. The UK's National Obesity Observatory, 2014, states that 'the resulting NHS costs attributable to overweight and obesity are projected to be £9.7 billion by 2050, with wider costs to society estimated to reach £49.9 billion per year'.

Table 6: Overweight and Obese Children in Warwickshire and England, 2013/2014.

	Overweight Children (Reception)	Obese Children (Reception)	Overweight Children (Year 6)	Obese Children (Year 6)
North Warwickshire	13.4%	10.6%	17.3%	19.8%
Nuneaton & Bedworth	13.7%	8.8%	13.0%	19.3%
Rugby	13.2%	8.2%	14.2%	14.4%
Stratford-on-Avon	11.0%	8.1%	13.9%	13.2%
Warwick	11.4%	6.3%	16.2%	12.9%
Warwickshire	**12.5%**	**8.2%**	**14.7%**	**15.6%**
England	13.1%	9.5%	14.4%	19.1%

Overall, overweight and obesity levels in Warwickshire compare favourably with national figures.

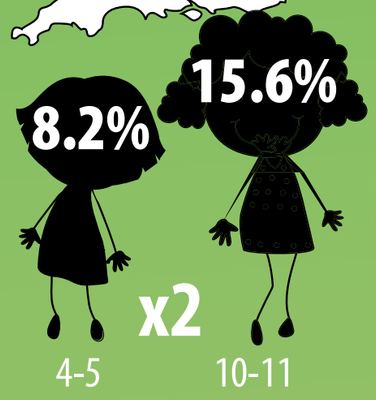
The proportions of both Reception age and Year 6 schoolchildren measured as being obese across the county as a whole are statistically significantly lower than the equivalent England figures.



However, the proportion of overweight Year 6 schoolchildren in North Warwickshire (17.3%) was statistically significantly higher than the national figure.

This highlights some inequalities in obesity prevalence across Warwickshire.

Generally, there is a higher prevalence of obesity in the north of the county compared to the south.

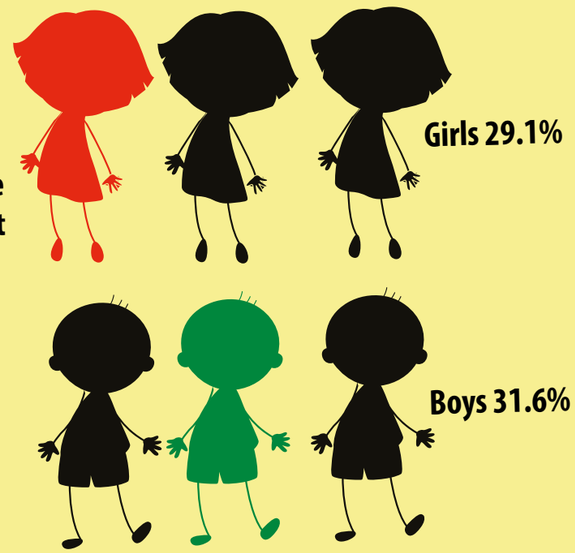


The increase in the proportion of children who are obese between Reception and Year 6 is also notable.

In Warwickshire, this almost doubles between the ages of 4-5 and 10-11, indicating that a sizeable number of children are experiencing significant weight gain from when they start school to when they reach Year 6.

Figure 1:

Almost 1 in 3 children in Year 6 in Warwickshire is overweight or obese.[19]



Obesity does not affect all groups equally. A strong relationship exists between deprivation and childhood obesity. Analysis of the National Child Measurement Programme data in Warwickshire shows that excess weight prevalence (those overweight and obese) among children in both Reception and Year 6 increases in-line with increased levels of socioeconomic deprivation.

Outcomes Wanted

The Government's vision In 'Healthy Lives, Healthy People: A Call to Action on Obesity' is that by 2020, there is:

'A sustained downward trend in the level of excess weight in children' [20]

The Government has set out some key priority actions for local authorities, the NHS and many other stakeholders to work collaboratively to help people to make healthier lifestyle choices, including healthier choices around eating and drinking and being more active.

As a result, in Warwickshire, it has been agreed by the county council and its partners, reducing overweight and obesity is a key priority which is being tackled from birth through to old age.

What have we done !

1. Promoted the importance of 'green space' in tackling obesity

Promoting healthy and active communities is a key factor in reducing obesity prevalence in the county. Public Health Warwickshire work with partner organisations across all sectors within the county to encourage healthy communities.

Being outdoors is great for our physical and mental health and wellbeing, making people feel good, helping them live longer and take part in their community. To support projects with a focus on 'green spaces', money for one-off projects was made available by Public Health Warwickshire. This has led to, for example, the installation of 'measured miles', way marking and community gardening.

What is a 'Measured Mile'?

A measured mile is a walk a mile long that has been marked out with distance markers and can be within a green space such as a park or in the urban environment. Installing measured miles can help local people understand the effort required in terms of time to walk from one location to another. This will support people who are physically inactive to make small, measurable improvements to their activity levels. Led walks can be introduced using measured miles, helping those who find being active on their own difficult, to increase motivation and decrease social isolation.

In Warwickshire, there is a measured mile in each of our five districts and boroughs.

As well as one-off projects, Public Health Warwickshire also commissions 'Big Day Out', an annual event delivered by partners, which aims to increase the utilisation of green spaces by people who do not typically use them. Activities as part of this event include 'park runs', orienteering, disc golf, edible gardening, kite flying, walking trail and a family fun day.

2. Planning 'healthy weights'

The planning process has a key role to play in tackling obesity, with the aim of embedding public health principles into strategic and local planning policies. Two key evidence based documents are being produced by the county's Public Health and Infrastructure teams, which will be released by July 2015: 'Neighbourhood Development Planning for Health' and 'Public Health Evidence for Developers and Planners'. Planners and developers will be encouraged to incorporate the findings into new developments, maximising walking and cycling opportunities based around the idea of a five minute 'walkable' neighbourhood.

In conjunction with the 'Town and Country Planning Association' (TCPA) and Public Health England (PHE), Public Health Warwickshire will also be running a Workshop in July 2015 on 'Planning Healthy Weight Environments'. This workshop aims to explore the ways in which the planning and design of the built environment can contribute to encouraging healthier populations. It focuses on the role that green spaces play, and also on the effectiveness of active travel in promoting healthy weight.

3. Recommending the use of Health Impact Assessments (HIAs)

I have previously stated that all partners on the Health and Wellbeing Board should commit to the use of Health Impact Assessments (HIAs) for all major developments and strategic policy changes. A HIA recognises that the way in which new communities are designed and built, will have a major effect on people's health and wellbeing. It is therefore a useful tool in identifying how much consideration a new development has given to the promotion of 'healthy weights'.

What we can do to improve?

Overweight and obesity prevalence continues to rise amongst both adults and school Reception year children across Warwickshire. However, for the past two years, school Year 6 overweight and obesity prevalence rates have slightly decreased. A contributing factor to this decrease is the evidence-based support services that have been commissioned by Public Health Warwickshire, for children and families, over the past 4 years. These services have been positively evaluated and have demonstrated that increasing numbers of families are accessing the services, with many children and their parents/carers moving into healthier weight categories and adopting healthier lifestyle behaviours as a result.

However, more needs to be done to reduce the overall prevalence of overweight and obesity in Warwickshire. We need to:

1. **Continue to work together and enhance collaborative integrated working, across organisations.**
2. **Commission and/or work collaboratively to provide evidence-based services, which meet the needs of the local population. Service delivery needs to be prioritised in localities of greatest need across Warwickshire, in order to reduce health inequalities.**
3. **Continue to promote the importance of 'green space' in tackling obesity.**

Recommendations

In addition to improving breastfeeding rates and tackling maternal obesity:

- ☐ **A whole system approach for obesity and physical activity is required from all partners including transport, planning, financial inclusion, housing, environmental services and public health.**

- ☐ **Local hospitals must develop strategies to embed a healthy food culture for patients, staff and all visitors.**

- ☐ **Close gaps in service provision for early years children, their families and adolescents and reduce health inequalities through the Warwickshire-wide commissioning of:**
  - **services which have 'Making Every Contact Count' and promoting mental well being embedded within them;**
  - **early years parenting/weight management programmes in all children's centres;**
  - **the 'Food for Life Partnership' whole food culture programme in all children's centres, primary schools and secondary schools;**
  - **structured family weight management programmes for overweight/obese children and their parents/carers;**
  - **weight management and physical activity services for adolescents and adults.**

Spot the difference

How many healthy lifestyle changes can you spot in the pictures below:

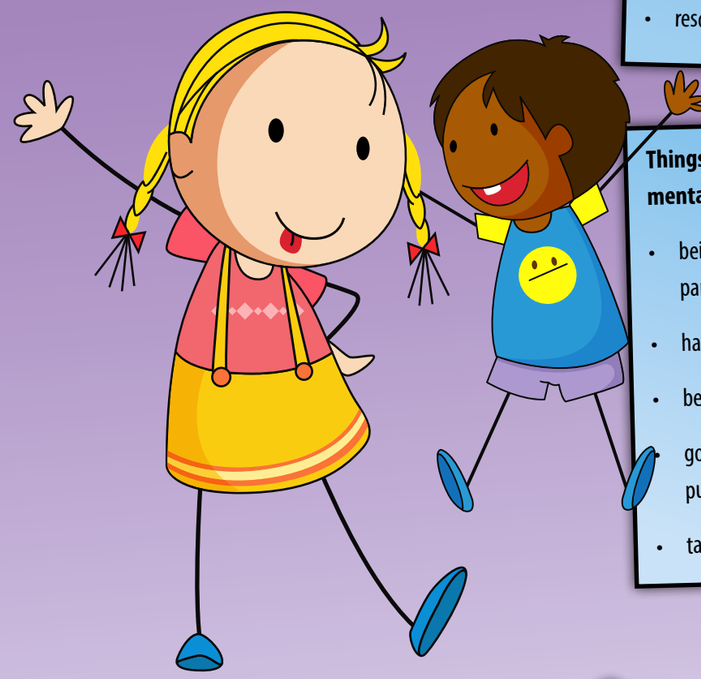
Chapter 3
Mental Health and Wellbeing

Background/Context - Why does it matter?

"With good mental health, children and young people do better in every way. They are happier in their families, are able to learn better, do better at school, and enjoy friendships and new experiences." – *Young Minds* [21]

Being mentally healthy is important for a child's development in many ways and is just as important as their physical wellbeing. **Being mentally healthy means children**:

- develop psychologically, emotionally, intellectually and spiritually;
- initiate, develop and sustain mutually satisfying personal relationships;
- use and enjoy solitude;
- become aware of others and empathise with them;
- play and learn;
- develop a sense of right and wrong; and
- resolve or face problems and setbacks and learn from them.



Things that can help keep children and young people mentally well include:[22]

- being in good physical health, eating a balanced diet and participating in regular exercise;
- having time and the freedom to play, indoors and outdoors;
- being part of a family that gets along well most of the time;
- going to a school that looks after the wellbeing of all its pupils; and
- taking part in local activities for young people.

The emotional wellbeing of children is just as important as their physical health. Good mental health allows children and young people to develop the resilience to cope with whatever life throws at them and grow into well-rounded, healthy adults.

Some children experience a range of emotional and behavioural problems that are outside the normal range for their age or gender. These children and young people are described as experiencing mental health problems or disorders. These include emotional, developmental, conduct and attachment disorders.

Mental health problems in children and young people can be long-lasting; 50% of mental illness in adult life (excluding dementia) starts before age 15 and 75% by age 18. [23]

50% of mental illness in adult life (excluding dementia) starts before age 15 and 75% by age 18.

Risk factors

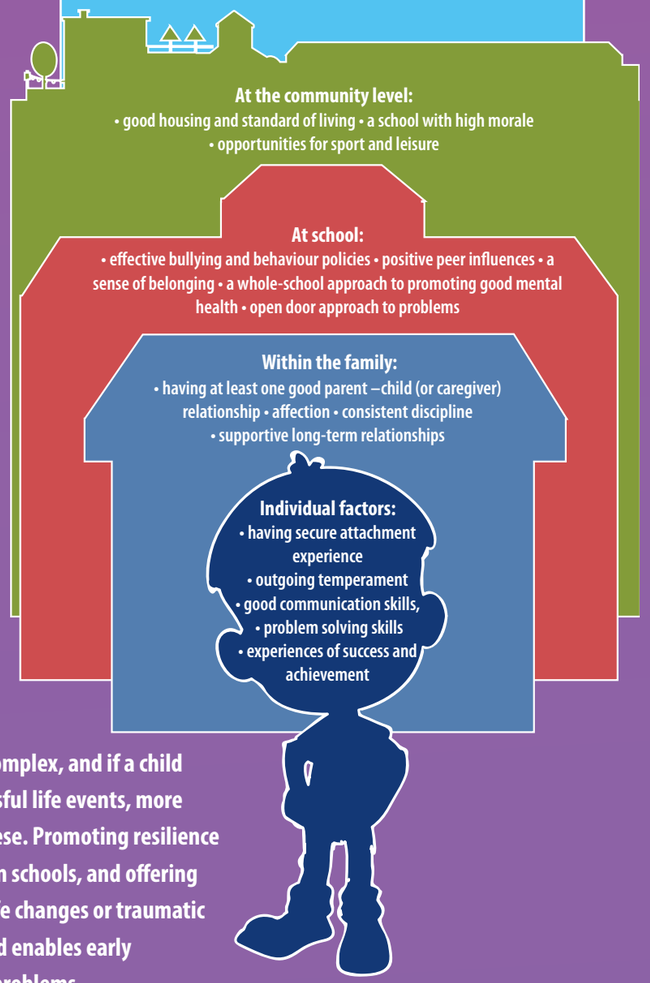
Some factors put children and young people more at risk of developing mental health problems than others, including:

- factors for the individual child (e.g. genetic influences, learning disability, physical illness, low self-esteem);
- their family (e.g. parental conflict and family breakdown, parental mental illness or substance misuse, bereavement);
- at school (e.g. bullying, discrimination, poor relationships with teachers); and
- in the community (e.g. socioeconomic disadvantage, homelessness).

The effects of these risk factors are cumulative, so that children exposed to multiple risks are many times more likely to develop behavioural problems. [24]

Protective factors

Protective factors make children more resilient, enabling them to cope when they encounter problems and challenges, even if exposed to some of the above risk factors. These may be individual, family, school or community factors:



The balance between risk factors and resilience is complex, and if a child is socially disadvantaged and has a number of stressful life events, more protective factors are needed to counterbalance these. Promoting resilience among children and young people, in families and in schools, and offering support to children at times of loss or separation, life changes or traumatic events, helps to promote positive mental health and enables early intervention in the development of mental health problems.

What do we know about children's mental health and wellbeing in Warwickshire?

Table 7:[25]

	Warwickshire	England	Comments
Mental health disorders aged 5 – 16 (2013).	8.8%	9.6%	6,503 children aged 5-16 are estimated to have any mental health disorder in Warwickshire.
Child admissions for mental health problems (rate per 100,000 aged 0-17 years in Warwickshire, 2012-2013).	66.1	87.6	Warwickshire rate has been variable over the last three years; 80.9 (2010/11), 60.8 (2011/12), although remained considerably lower than the England rates.
Hospital admissions for young people for self-harm (rate per 100,000 aged 10-24, 2013/2014).	490.4	412.1	This is well above the England average. Hospital admissions for self-harm in children have increased nationally, but have shown a marked local increase in recent years, with admissions for young women higher than for young men.
Young people in Warwickshire aged 16-24 providing 20 or more hours of unpaid care per week in 2011.	1.1%	1.3%	1 in 100 local young people had significant carer responsibilities at this age.
Children aged 0-15 with parents in drug treatment in 2011-12 (rate per 100,000).	41.7	110.4	Significantly lower than the England average.
Children aged 0-15 with parents in alcohol treatment in 2011-12 (rate per 100,000).	148.4	147.2	This equates to around 1.5 in every 1,000 local children having a parent in alcohol treatment.

What can we do in Warwickshire?

Improving wellbeing for children and young people falls into five broad areas:

Parenting support:

Quality of parenting is crucial in determining child outcomes, and various programmes have been developed to support parents to improve the quality of parent-child relationships and the skill of parents in managing child behaviour. These programmes can be very effective in improving child behaviour, and improving wellbeing of siblings and participating parents, particularly in families of children with conduct disorders.

Schools:

Pupils with better health and wellbeing are likely to achieve better academically.[26] Schools are in a position to strengthen resilience for all pupils, and intervene early, for pupils showing early signs of problems, and at risk families.

Socioeconomic factors:

Children from more deprived backgrounds have lower wellbeing than their peers so reducing socioeconomic and health inequalities, and targeting of vulnerable young people (such as those in homeless families) for support may start to tackle this. [27]

Physical activity:

Children need safe, public places to play, and affordable accessible leisure services; children see participation in play and leisure as essential for both their wellbeing and self-esteem.

'Five Ways to Wellbeing' and further research:

'Five Ways to Wellbeing' has already been adopted in Warwickshire but it was mainly developed for adults. Developing an adapted local version is one possibility for extending the Five Ways campaign for children and young people, or seeking further research evidence for what works best.

Recommendations

- [ ] Education and learning must develop a school and college based programme to reduce self-harm by young people in Warwickshire as a priority area.
- [ ] Early recognition and intervention for emerging mental health problems is key. We all have a responsibility to work together to ensure this service is available.
- [ ] A structured approach to promote mental wellbeing for children in schools and young people in colleges is required. This should include an adapted '5 Ways to Wellbeing' approach and mental health first aid training.
- [ ] We should commission cost-effective and evidence based parenting programmes for children at high risk and target support to families with specific needs.

Cross Quiz

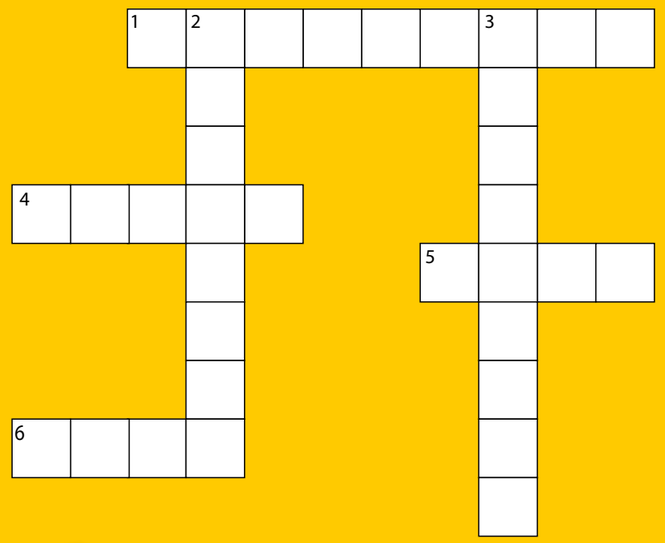
Clues

Across

1. Protective factors make children more? (9)
4. Children with good mental health are able to play and what? (5)
5. How many ways to wellbeing? (4)
6. In 2011, 1.1% of children in Warwickshire provided 20+ hours of unpaid what a week? (4)

Down

2. One of the things that can help children to stay mentally well is getting regular... (8)
3. What type of wellbeing for children is as important as their physical health? (9)



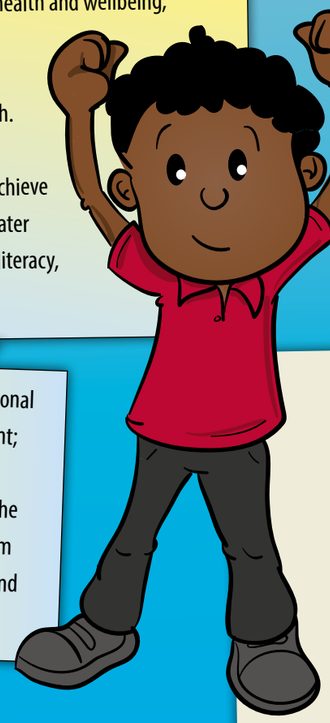
Chapter 4
Educational Attainment

Background/Context - Why is it important?

Education is a key determinant of health. Early child education and development are significant in future health and wellbeing, reaching further than educational attainment to better employment, income and mental and physical health. Acquiring basic skills in early years is fundamental, as children who fail to achieve these skills are likely to fall behind in later stages of education when it comes to literacy, numeracy and life skills.

However, for young people, educational outcome is not specific to attainment; it refers to the development of personalities, talents and abilities, the building of resilience and self-esteem and the skills needed to lead a full and satisfying life.

Having a foundation of good child health and wellbeing is also crucial – as being in good health can improve educational attainment.



"Just as we cannot hope to reduce health inequalities just by changing the NHS, similarly we cannot radically impact on education inequalities just by intervening in schools." – *Marmot*

Special Educational Needs and Disability (SEND) responsibilities

The Children and Families Act 2014 places legal duties on local authorities to identify and assess the SEND of children and young people for whom they are responsible. Local authorities become responsible for a child/young person in their area when they become aware that the child/young person has or may have SEND. They then must then ensure that those children and young people receive a level of support which will help them "achieve the best possible educational and other outcomes" – *Section 19 (d)* . [29]

Unfortunately, there are inequalities in educational outcomes which can be seen across social, ethnic and geographical gradients and amongst children with different educational needs.

Children and young people with special educational needs have learning difficulties or disabilities that make it harder for them to learn than other children and young people. In Warwickshire, approximately 17% of children have special educational needs, which is in line with the national figure and that for our comparable neighbours. These children and young people may face multiple barriers which means that they may need extra or different help from that given to others and can achieve different outcomes. Many who have special educational needs may also have a physical or mental disability. [28]

The Department for Education defines 'disadvantaged pupils' as children who have been eligible for Free School Meals (FSM) at any time in the last 6 years and/or Looked After Children. There are particular concerns about Looked After Children, children eligible for FSM and persistent absentees. There are development and attainment gaps between these pupils and their peers; when comparing Key Stage 2 and Key Stage 4 data, these 'disadvantaged pupils' underperform compared to their peers. [30]

Only around 10–20% of the variation in educational attainment between different pupils can be explained by differences between schools. A range of factors can impact on educational attainment outside of school, including:

Family background *(it is suggested that families have more of an influence than schools)*

Neighbourhood

Peers

Warwickshire's Vision

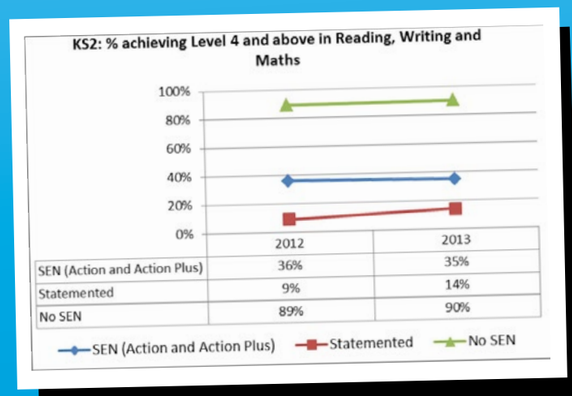
Many children flourish in Warwickshire's schools, but a minority face disadvantages that can have a significant limiting effect on their achievement and attainment, as well as on their broader life outcomes. There is a clear gap between the attainment of the majority of children and those from particular groups that are vulnerable to underachievement. If the county is serious about breaking cycles of disadvantage and ensuring that all children make good progress, then it is essential to narrow this gap. This is both a national and local priority, and is reflected in the commitment set out in the county's Education Vision, which states:

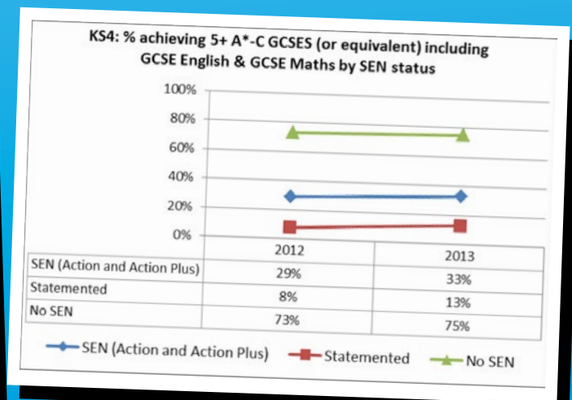
Warwickshire will be forward looking in Education and Learning, striving to ensure that every child and young person will:

- **attend a good or outstanding school or setting;**
- **achieve well — whatever their starting point or circumstance; and**
- **go on to positive destinations so that, as they become young adults, they have an independent economic and social life.**

Pupils with special educational needs and disability

Figure 2: Percentage of pupils achieving level 4 and above in reading, writing and maths, by SEND status and percentage of pupils at the end of KS4 achieving 5+ A*-C GCSEs (or equivalent) including GCSE English and Maths, by SEND status [31]



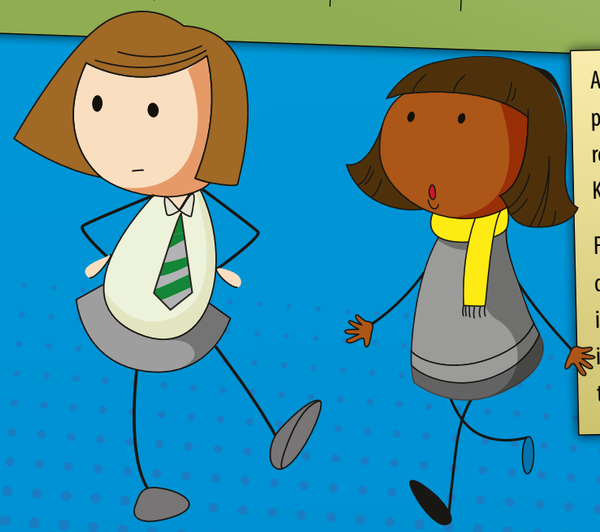


Current State and Inequalities

Disadvantaged Pupils

Table 8: Percentage of pupils achieving the expected level or above in reading, writing and maths at key stage 2 and 4

	Key Stage 2			Key Stage 4		
	Disadvantaged pupils (Warwickshire)	**Other pupils (national)**	**Gap (percentage points)**	**Disadvantaged pupils (Warwickshire)**	**Other pupils (national)**	**Gap (percentage points)**
Achieved expected level or above	65%	83%	18	33%	63%	30



As shown in table 8, a lower proportion of disadvantaged pupils in Warwickshire are achieving the expected levels in reading, writing and maths at both Key Stage 2 (KS2) and Key Stage 4 (KS4), when compared to pupils nationally.

Furthermore, the percentage point gap between disadvantaged and other pupils, in terms of attainment, increased from 18 points at KS2 to 30 points at KS4; the inequality gap widens as these groups advance through the Key Stages.

The attainment of both groups of children is higher than comparative data nationally and our statistical neighbour average. However, as shown in figure 2, at the end of KS2, 35% of SEND pupils without a statement achieved level 4 or above in Reading, Writing and Maths. This is compared with 90% of pupils with no SEND achieving this, a percentage point gap of 55.

At the end of KS4, only 33% of SEND pupils without a statement achieved 5+ A*-C GCSEs or equivalent, compared to 75% of those pupils with no SEND, a gap of 42 percentage points.

There is a decrease in the proportion of all pupils who are making expected progress in Writing/English and Maths between KS1 – KS2 and KS2 – KS4. However, the decline in this achievement is more marked amongst pupils with SEND, with a 24 percentage point decline for Writing/English and a 25 percentage point decline in Maths.

The gap between SEND and non-SEND pupils in this expected progress also increases between KS1 – KS2 and KS2 – KS4, with a 16 percentage point difference for writing and 19 percentage point difference for maths for KS1 – KS2, which increases to a 25 percentage point difference for writing and 31 percentage point difference for maths for KS2 – KS4.[31]

In Warwickshire, as is seen nationally, the figures for attainment by pupil type clearly show an inequality in achievement between disadvantaged and SEND pupils, and other pupils, with lower proportions within the disadvantaged and SEND groups achieving the expected levels.

The data also highlights a growing gap in this inequality, with the percentage point gap in attainment or expected progress between disadvantaged or SEND groups and other pupils, increasing between KS2 and KS4.

Outcomes for Learners Post-16

Warwickshire's Not in Education, Employment or Training (NEET) statistics for school leavers with a Learning Difficulty or Disability (LDD) reveal that the county is not performing as well as comparators:

- 81.9% of school leavers with LDD are in education or training and 18.1% are NEET
- 91.9% of school leavers without an LDD in Warwickshire are in education, employment or training and 8.1% are NEET.

Warwickshire has a lower percentage of young adults with LDD in education or training compared with average figures recorded nationally, regionally and with statistical neighbours.

The challenge for Warwickshire is to improve the effectiveness of transition for this cohort of students as they move from school into further education, training or employment and to ensure that the quality and range of provision is meeting needs and expectations. The effectiveness of these pathways is crucial in securing positive long-term outcomes.

What have we done in Warwickshire?

1. Established a 'Closing the Gap' project board which will identify issues and potential solutions and share best practice across the county.

2. Developed the WCC Strategy for Vulnerable Learners, which aims to champion better life chances for the county's most vulnerable learners, by developing a broader range of designated SEND provision, in partnership, between the county's special schools the mainstream sector.

Recommendations

- [ ] **All schools should develop accurate assessments of the health and wellbeing needs of their school population.**

- [ ] **WCC to work together with schools to address the attainment gap between Looked After Children and other pupils.**

- [ ] **Schools and academies must ensure that personal, social and health education (PSHE), relationships and sex education are embedded across the curriculum and culture of the organisation, and are equally about building skills as well as knowledge.**

- [ ] **Schools to make effective use of the Pupil Premium to:**
  - **raise pupil aspirations using engagement/aspiration programmes;**
  - **develop social and emotional competencies;**
  - **intervene early and effectively, track progress and change approaches where necessary;**
  - **focus on transition, one-to-one tuition and progressive development of language and literacy skills;**
  - **search out the most effective ways of engaging parents and families, and listen to pupils and engage them in sustained dialogue about learning.**

True or false?

	True	False
1. Being in good health can improve educational attainment.....	☐	☐
2. A higher percentage of disadvantaged pupils in Nuneaton and Bedworth achieve GCSE 5+ A*-C grades including English and Mathematics than in the rest of Warwickshire.....	☐	☐
3. There are no particular concerns about looked after children in regards to attainment	☐	☐
4. The local authority will produce a tool kit to capture and share good practice.....	☐	☐
5. Schools are not recommended to rigorously use data to identify gaps and to make them visible.....	☐	☐

Chapter 5
Risky Behaviours

Background/Context - What are risky behaviours?

Risky behaviours are those that potentially expose young people to harm, or significant risk of harm, and may result in unintended or undesirable consequences.

Some risky behaviour can be considered normal and merely part of growing up. However, there is a distinction between normal, curious and experimental behaviour, and behaviours that put children and young people, or others, at risks, which could escalate the behaviour to a harmful stage. It should be acknowledged that although children and young people may not be actively participating in risky behaviour, observing or being exposed to the behaviour can also have an impact on their own behaviour, as peer association can result in future involvement.

Risky behaviours are taken by all kinds of people every day and they are not exclusive to particular social groups or settings.

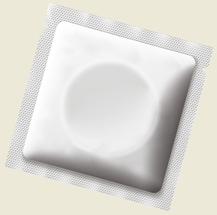
What risky behaviours happen in Warwickshire?

The use of tobacco, alcohol, pharmaceutical or illicit substances are the most common types of risk-taking behaviours that people engage in. Despite alcohol and tobacco being legal from the age of 18 years, many young people begin their use before this age. Drug and alcohol use, whether illegal or legal, can cause a variety of health problems depending on the particular substance. Intoxicating substances can also lead to impaired judgement and coordination resulting in physical harm from accidents or becoming involved in violence. Unsafe sex can also result in unplanned pregnancies or the transmission of sexually transmitted infections (STIs) and HIV/AIDS.

In Warwickshire, some of the behaviours we identify as risky for children and young people are:

Smoking

Use of new & unregulated drugs (NUDS)

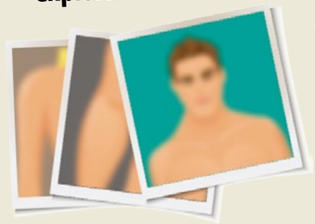


Unprotected sexual intercourse

Hazardous alcohol consumption

Illicit drug use

Child sexual exploitation (CSE)

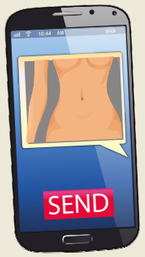


Engagement in criminal/gang activity

Risky online, cyber-activities/behaviours

(e.g. Posting personal information, interacting with online strangers, sending personal information to strangers, adding strangers to 'friends' lists, visiting X-rated websites, talking about sex online with strangers, 'sexting', sending explicit, personal images)

All of which can lead to cyberbullying, blackmail, grooming - child sexual exploitation, meeting people you don't know in the real world, depression, and even suicide.



It should be recognised that the degree to which these behaviours are considered risky may depend upon the young person's level or frequency of engagement.

Research has shown that adolescent exploratory behaviours overlap – for example, early substance misuse is associated with risky sexual behaviour, antisocial behaviour and poor educational attainment. The overlaps are stronger during adolescence than at earlier or later developmental stages. [32]

Unknown Risks

So-called 'legal highs' are a good example of unknown risks.

These are substances used like illegal drugs such as cocaine or cannabis, but which are not covered by current misuse of drugs laws.

We don't use the term 'Legal Highs' as it leads people to purposefully seek these out as an alternative to illegal drugs; however in many cases these are more harmful.

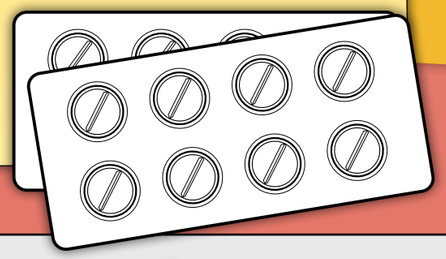
Warwickshire adopted the term New & Unregulated Drugs (NUDS) in 2014.

Although these drugs are marketed as legal substances, this does not mean that they are safe or approved for people to use. Some drugs marketed as 'legal highs' actually contain ingredients that are illegal to possess.

There has been little useful research into the short, medium and long-term risks of various NUDS. They can carry serious health risks, as the chemicals they contain, have in most cases never been used in drugs for human consumption before. This means they have not been tested to show that they are safe. Users can never be fully certain what they are taking and what the effects might be.

Why would you take a substance not knowing what it is or what it would do to you?

Are you a human guinea pig? No-one knows the effects of 'legal highs', or the damage they cause. Until it's too late.



What are the social norms around risky behaviours in Warwickshire?

To put things in perspective, there are approximately 95,000 children and young people (aged 10-24) in Warwickshire. The vast majority engage in some form of risky behaviour at some point during adolescence without suffering lasting negative or detrimental consequences. For instance, in Warwickshire, according to the 2013 'Every Child Matters' survey, 29% of secondary school pupils had never drunk alcohol, 75% had never smoked cigarettes, and 90% had never taken illegal drugs.

The following sections present the latest local headlines on the main forms of risky behaviours in Warwickshire.

Alcohol

Latest figures show repeated drop in the rate of hospital admissions due to alcohol among under 18s in Warwickshire, evidence of a continuing decline in young people's harmful drinking.

Between 2011/12 and 2013/14 in the county, there were 145 alcohol-specific hospital admission for those aged under 18. This equates to a crude rate of 42.6 per 100,000 under 18 year olds, which is statistically similar to the equivalent England figure. This represents a fall from 240 admissions and a rate of 70.7 between 2006/07 and 2008/09.

While nationally, we have seen a decline in binge drinking, drinking at dangerous levels, and those aged 11-15 saying they had tried alcohol, young adults still remain one of the most likely groups to have binged.

Drug Misuse

Nationally, although drug use in the under 25s has declined, there has been an increase in hospital admissions for treatment and poisoning by illicit drugs. This mixed picture is also present in the county.

In England during 2013, 16% of pupils had taken drugs, 11% had taken them in the last year and 6% had taken them in the last month. This is similar to the levels of drug use recorded in 2011 and 2012, although between 2003 and 2011 drug use amongst 11 to 15 year olds declined.

By applying nationally researched prevalence rates, we have crudely estimated that just under 3,000, or 1 in 10 Warwickshire schoolchildren aged between 11 and 16 have taken illegal drugs at some point during the last year. The number of Warwickshire Year 7-11 pupils estimated to have ever tried illicit drugs is estimated to be around 4,500, or just over 1 in 6.[33]

In Warwickshire, between 2011/12 and 2013/14, there were approximately 150 hospital admissions among 15-24 year olds due to substance misuse. This equates to a directly standardised rate of 82.4 per 100,000 15-24 year olds, which is statistically similar to the equivalent England figure, and represents a slight increase in recent years.[34]

What makes risks worse?

Multiple risk-taking, i.e. the combination of undertaking more than one risky behaviour (such as excessive alcohol consumption and sexual risk taking) can increase and exacerbate the likelihood of even greater unintended and undesirable consequences (such as contracting STIs or unplanned pregnancy).

Engaging in risky behaviours can also lead to young people underestimating the true risks and potential consequences. For example, alcohol-fuelled violence leading to life-changing injuries and a permanent criminal record.

Young people can get a criminal conviction, fine or imprisonment for the possession of illicit substances. Harsher penalties apply if they are found guilty of supplying it to others. If young people under the age of 18 years transmit explicit images of themselves or others to someone (sexting), they may be charged with child pornography offences.

It appears that the earlier a young person starts to drink alcohol, the more likely it is he/she will become alcohol dependent by the age of 20.[35]

What can be done to minimise risky behaviours in children and young people?

A recent report by Public Health England highlights the importance of recognising that building good health behaviours in childhood and adolescence can help to prevent risky behaviours and builds healthier adults.[36]

Relationships and a sense of belonging are central to young people's health and wellbeing. These relationships will be with friends, family, romantic/sexual partners, teachers, role models, health professionals and others in the local community.

Relationships can help develop self-esteem and make young people emotionally resilient, but they can also make them vulnerable. Recognising and supporting healthy relationships are key to improving young people's physical and mental health and wellbeing.

The preadolescent period and the transition from primary to secondary school can be considered critical periods where there is the opportunity to minimise exposure to risks and strengthen 'protective' factors.

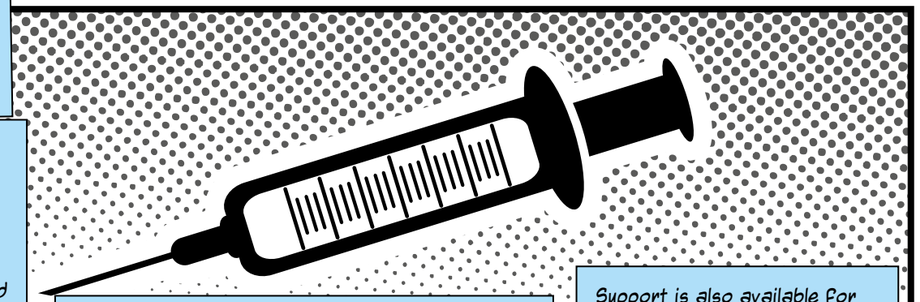
In terms of the evidence around the use of alcohol by young people, guidance on the consumption of alcohol by children and young people from the UK Chief Medical Officer states that an 'alcohol-free' childhood is the healthiest and best option.[37] If they consume alcohol at all, children should not do so until the age of 15 years. Between 15-17 years of age, young people should only consume alcohol under parental supervision.

Parents need more guidance to support sensible drinking for young people.[38] There appears to be some potential in providing alcohol-related primary prevention programmes for children and families, especially if they form part of a wider approach that brings together families, schools and other community-based organisations.[3]

Research indicates there is merit in building upon what young people know, by engaging them in informal educational activities that are responsive and relevant to their own alcohol-related needs, interests and concerns. For example, it might be useful to explore with young people how they distinguish and manage the boundaries between enjoying alcohol, or finding themselves in embarrassing or harmful situations.[40]

What are we doing about this in Warwickshire?

Hazardous Alcohol Consumption and Illicit Drug Use



Warwickshire has established services for adults through The *Recovery Partnership* in Leamington, Nuneaton, Rugby and Stratford, and for young people through the *Compass outreach service*.

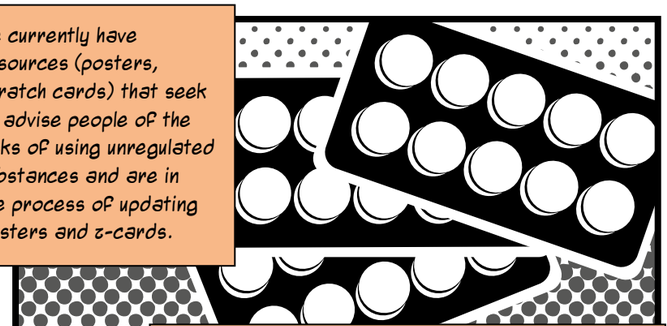
These services include everything from drop-ins, providing advice and information and group work to pharmacological therapies and detoxification.

Support is also available for people not yet engaged with services, their families and carers through ESH Works.

Use of 'Legal Highs'

We don't use the term 'Legal Highs' as it leads people to purposefully seek these out as an alternative to illegal drugs; however in many cases these are more harmful. Warwickshire adopted the term New and Unregulated Drugs (NUDS) in 2014.

We currently have resources (posters, scratch cards) that seek to advise people of the risks of using unregulated substances and are in the process of updating posters and z-cards.



NUDS mimic the effects of illicit substances, so treatment is available at existing Recovery Partnership and Compass services and users and their families can be supported through ESH Works.

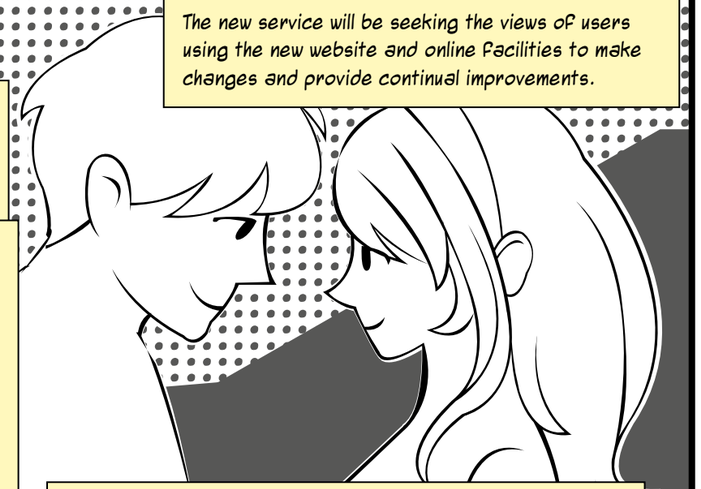
Sexual Health

To improve sexual health and wellbeing and to continue to reduce risky behaviours, Warwickshire Public Health have recently commissioned a new Integrated Sexual Health service for the county.

The service is designed to make it easier to access. For example, there will be a single easy to use telephone number and website for all sexual health matters.

This is the first stage of a range of new plans to make it easier to get sexual health advice and treatment where you want - when you want. The website provides information and details of how to look after your sexual health.

The new service will be seeking the views of users using the new website and online facilities to make changes and provide continual improvements.



Plans to increase the range of sexual health services in pharmacies are also being developed to increase the number of places where sexual health services are available.

Respect Yourself

The 'Respect Yourself' Programme aims to support young people's relationship and sexual health behaviours.

The www.respectyourself.info website regularly receives over 40,000 hits per month. The key to the sites' success is its innovative, comprehensive and sex positive approach that provides a trusted resource supporting relationships and sexual health. Young people support the development of the site and have worked hard to keep site content relevant. They have helped to create materials on issues such as sexting, pornography and child sexual exploitation.

As well as the website, 'Respect Yourself' are supporting the development of relationships and sex education (RSE) in schools;

- ***'Spring Fever'*** is aimed at primary schools and offers an evidence based age appropriate curriculum.
- ***'Doing It'*** is aimed at secondary schools, it incorporates the website resources in to school sessions - improving RSE and ensuring that more young people are aware of how www.respectyourself.info can give help to make positive, informed decisions about their relationships and sexual health.

Both RSE programmes offer staff training and information sessions for parents.

Child Sexual Exploitation (CSE)

The council has undertaken a public awareness campaign 'Something's not right' (http://warwickshirecse.co.uk/) and, under the direction of the Youth Justice Service, has developed a multi-agency CSE unit with co-location of staff. This is a precursor to the establishment of a Multi-Agency Safeguarding Hub (MASH).

Risky Online, Cyber-activities/Behaviours

Risky online behaviour is being addressed via education services to schools and through multi-agency cybercrime groups. Specific advice and support is being targeted at those most at risk. An internet safety survey has been undertaken by the Observatory which will be used to develop a baseline of risk and actions to reduce harm. There are links to the CSE work detailed above.

Recommendations

- ☐ All services and sectors to empower young people in educational settings by giving them the skills they need to develop healthy relationships – for example, by providing opportunities within the curriculum to teach relationship skills (partly through PSHE, and sex and relationships education).
- ☐ We will work with and expand the role of pharmacists in sexual health. This is particularly important in terms of accessibility for young people.
- ☐ We will increase the online presence and use of technology to improve services.
- ☐ All school staff and staff who work with children and young people should have training to promote healthy relationships and improve awareness and support for issues of child sexual exploitation.
- ☐ We must adopt a social norms approach to discuss attitudes to sexting, consent and pornography – all of which underpin healthy relationships and avoid exploitation.

Dot to dot!

Join the dots and colour the picture

Chapter 6

Vulnerable Children and Young People

Background/Context - Defining a vulnerable child/young person?

There are numerous different factors which could lead to a child being classed as vulnerable. In general, it can be said that a vulnerable child is one who is unable to keep themselves safe from harm, or who is at risk of not reaching their potential and achieving positive outcomes.

The following is a list of categories which children can fall into which can define them as being vulnerable:

- At risk of School Exclusion / Persistent Absenteeism
- Those at risk of becoming 'Not in Education, Employment or Training' (NEET)
- Learning Difficulties / Physical Disabilities / Long-Term Health Condition
- Migrant / Asylum Seeker / Refugee
- Gypsy, Roma & Traveller heritage
- From a Black & Minority Ethnic Group
- English as an Additional Language
- Socially Deprived
- Economically Disadvantaged
- Young Carer
- Known to the Police
- Exiting Youth Justice System
- Looked After Child
- On a Child Protection Plan
- Homeless / Unsettled Accommodation

N.B. This is not an exhaustive list

Public Sector agencies will be familiar with those children in some of the categories listed on the left (e.g. Looked After Children) but others (e.g. Young Carers) are much more difficult to identify and require a deeper understanding of the family characteristics, relationships and social circumstance. Important characteristics surrounding children's parents and their home life which could lead to children being viewed as vulnerable include the following:

- Divorced / Separated
- Not working
- Low income
- Work too much (don't make time for child)
- Rurally isolated
- No engagement with agencies / school
- Mental health problems
- Domestic abuse
- Substance misuse
- Parent in prison

Some of these characteristics have been referred to as adverse childhood experiences (ACEs). Studies suggest that ACEs contribute to poor life-course health and future social outcomes.

Recent research concluded that ACEs are linked to involvement in violence, early unplanned pregnancy, incarceration, and unemployment.[41] A cyclical effect was also demonstrated where those exposed to higher ACE counts have higher risks of exposing their own children to ACEs. Locally targeted initiatives and interventions aimed at breaking this cycle will therefore be key.

There are also 'softer' indicators that can be used in defining and identifying a vulnerable child. For example, those who come to school hungry and dirty, or children who struggle to make friends easily.

It is these children who are harder to identify and who therefore don't always get the services and help they may need.

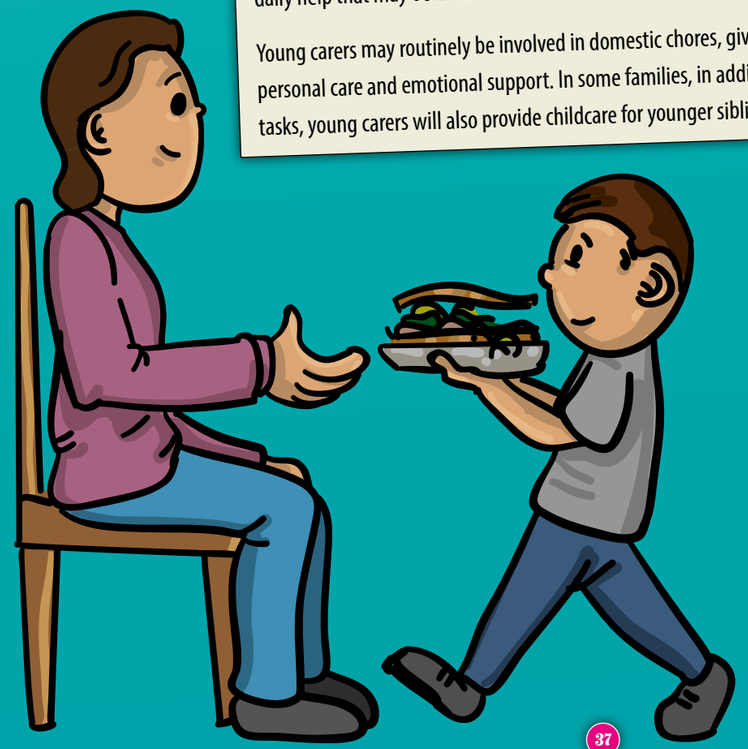
There are numerous ways in which children and young people can be deemed to be vulnerable. However, for the purposes of this chapter, I have chosen to focus on the issue of **Young Carers in Warwickshire**.

Young Carers

A young carer is a child or young person under the age of 18 who provides regular and ongoing care and emotional support to a family member, friend or neighbour who is physically or mentally ill, disabled or misuses substances.

Young carers provide care that is relied upon in maintaining the health, safety or day to day wellbeing of the person receiving support or care. This does not include children and young people who provide occasional or daily help that may occur in most families.

Young carers may routinely be involved in domestic chores, giving medication, assisting with mobility, personal care and emotional support. In some families, in addition to undertaking one or more of these tasks, young carers will also provide childcare for younger siblings.

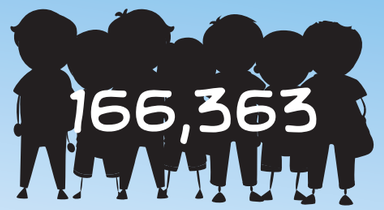


National guidance states that a young carer becomes vulnerable when the level of care-giving and responsibility to the person in need of care becomes excessive or inappropriate for that child, risking impacting on his or her emotional or physical wellbeing or educational achievement and life chances.

Young Carers

National Perspective

2011 Census data shows that there are **166,363** young carers aged 5 – 17 in England, an increase of 27,000 or 19.5% since the 2001 Census. The number of young carers under 10 years of age in England now totals 20,700.



Nearly **15,000** children aged 5 – 17 provide more than **50 hours** of care a week.

1 in 20 young carers miss school to care for a parent or sibling.

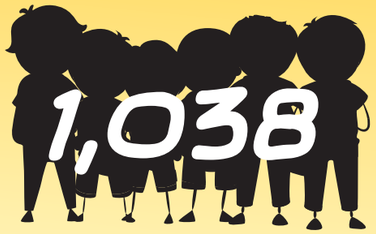
Young carers are one and a half times more likely than their peers to be from black Asian or minority ethnic communities, and are twice as likely to not speak English as their first language. They are equally likely to be a boy or girl.

Local Picture

Data from the 2011 Census suggest that 3,589 (2.3%) children and young people aged 0–24 in Warwickshire are providing care to members of their families, a 29% increase from the 2001 Census.

The majority of these (2,761) provide care for between 1 and 19 hours a week, whilst 435 provide care for between 20 and 49 hours, and 393 provide care for 50 or more hours a week.

The largest numbers and proportions of children and young people providing unpaid care to relatives are in Nuneaton & Bedworth Borough, a total of 1,038 (2.8%).



However, the use of Census data is likely to be an underestimate of the true overall numbers of young carers.

Current Situation

'Warwickshire Young Carers Project' (WYCP), is currently delivered on behalf of the county council by the Carers' Support Service (CSS). WYCP supports young carers through regular group activities, one-to-one support at school, and signposting, advice and advocacy for the whole family.

The Service is being redesigned to contribute to the local authority's statutory duties under new legislative requirements (Children and Families Act and Care Act 2014), and to reflect consultation with young carers.

Carers were identified as a key priority topic in Warwickshire's Joint Strategic Needs Assessment (JSNA) 2015 Review process, and as a result, a more detailed needs assessment of adult and young carers will be undertaken.

Inequalities

A recent evidence review identified four key areas of need for young carers:

- isolation, social exclusion and stigma;
- problems at school;
- lack of time for play and leisure activities; and
- lack of recognition, praise or respect for caring contribution.

Research has also identified a clear link between caring and deteriorating health, and an increased risk of psychological distress proportional to the amount of time devoted to caring. Carers aged 0-24 are twice as likely to report their health is 'not good' compared with peers who provide no care.[42]

In the first study of its kind, the Children's Society and the Open University School of Health and Social Welfare found that 70% of former young carers suffered long-term psychological effects, and 40% had mental health problems.[43]

Research carried out into young carers of school age found that the impact was significant in all age groups, with 28% of those aged between 5 and 15 experiencing educational difficulties or missing school.[44] Young carers have significantly lower educational attainment at GCSE level and are 1.5 times more likely than their peers to have a SEND.

Young adult carers may also find it difficult to fit their caring responsibilities around post-16 education, apprenticeships, or a job. Young carers aged 16-18 are twice as likely as their peers to be NEET.[45]

What we can do to improve

Increase reach /Improve access to support services

The number of young carers known to the Warwickshire Young Carers Project at the end of March 2013 was 1037; (924 aged 8-17 and 113 aged 18-25).

Local data suggests that there are a significant number of young carers (approximately 71%) who are currently either unknown to statutory and voluntary sector agencies, or deciding not to access services.

Remove barriers to improve access to support.

Frequently cited barriers to accessing support services include:

- Fears that approaching services will cause unwanted attention 'hassle', or loss of autonomy.
- Fear of stigmatisation or judgment by wider community, particularly in schools (notably for those with mental health and/or substance misuse needs).
- Overlooking young carers needs by focusing upon the cared for person (particularly in health services).
- Costs of travel to access services.
- Services not appropriately accommodating language and cultural needs.
- Services are provider-led as opposed to user/needs-led.

Recommendations

- [ ] Early identification of young carers is key to the success of supportive interventions. Health, Social Care and Education sectors need to work collaboratively with partners to facilitate the earlier identification of carers who can then be signposted to appropriate support.

- [ ] Schools and other professionals working with young carers need to ensure that staff are sufficiently skilled in recognising the signs and symptoms which could point to a child/person having a caring role.

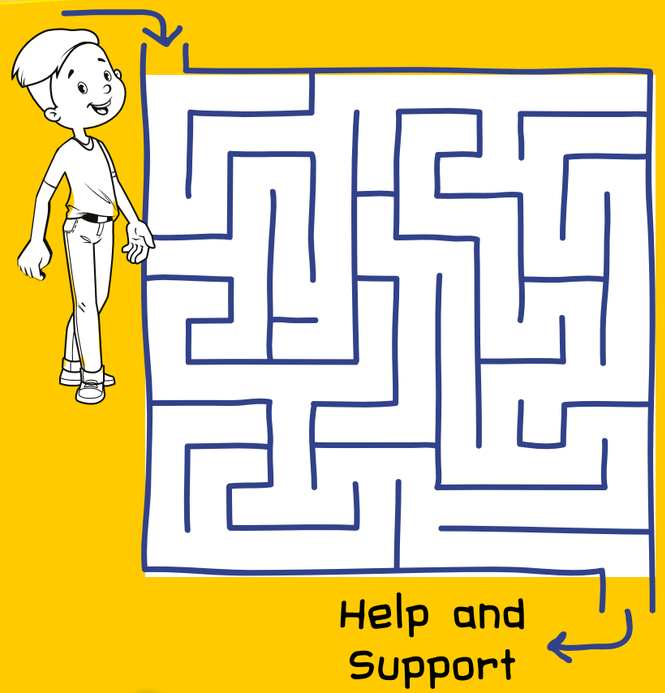
- [ ] GP practices should identify carers within their practice, and clinicians need to give due consideration to the welfare of children and young people when they see patients in their care.

- [ ] WCC will need to ensure that there are joined up approaches between Adults and Children's services, with clear guidance available to practitioners, and clear working arrangements with Mental Health services. This is to ensure a 'whole systems approach' for young carers.

- [ ] Health and Social Care services need to provide clear pathways for accessing services, and make this information available to young carers at an early stage in their caring role.

Maze

Help the young carer to find the quickest way to get to the help and support!



ACHIEVEMENTS

Public Health Business Unit

- A peer review of the Warwickshire Health and Wellbeing Board provided useful feedback and recommendations on the Board's future developments.
- Duncan Selbie, Chief Executive of Public Health England visited Warwickshire and noted the breadth and innovation of work across the county and the opportunities for improving public health.
- The revised Health and Wellbeing Strategy was produced focusing on three priorities; promoting and maintaining independence, developing community resilience and improving integration and joint working between partners.

Population Health

- Annual Report 2014: 'Protecting Health – A Hidden Agenda' received positive feedback and support.
- The Pharmaceutical Needs Assessment (PNA) was delivered meeting statutory requirements, presenting a picture of pharmaceutical service provision across the county.
- Over 3,000 user sessions since the Warwickshire Health & Wellbeing Portal launch in November.

Health Protection

- 267,410 users engaged with our 'Respect Yourself' website.
- 'Respect Yourself' nominated in the Young People's Sexual Health Service/Project category at the 2014 UK Sexual Health Awards.
- 7,500 views of the 'Yes or No' game competition looking at sexual consent in Warwickshire.
- 20 new schools signed up to deliver Spring Fever (Primary School RSE programme) in 2015 /16.
- Teenage pregnancy rates in Warwickshire have fallen to 24.3 conceptions per 1,000 women aged 15-17.
- 84,286 people (75.2%) aged 65 and over were immunised against seasonal flu across Warwickshire - the highest rate, and only upper tier local authority above the 75% target, in the West Midlands Region.
- 2,771 pregnant women (47.4%) were immunised against seasonal flu across Warwickshire in 2014/15, an increase from 44% in 2013/14.

- 5,545 children (95.9%) aged 5 years received the MMR vaccination (two doses) – the 5th highest proportion amongst England's upper tier local authorities.
- Warwickshire's Sexual Assault Referral Centre (SARC) has supported 383 clients, a 37.8% increase from last year and a 10% increase in self-referred clients.

Health Inequalities

- Developed two innovative training sessions for front-line workers; Safetalk session and Mental Health 1st Aid.
- A New 'Smoke free formula' book is available through the 'Books on Prescription Scheme' in Warwickshire libraries.
- Ex-Smoker Factor competition receives positive praise from other local authorities who are considering using the campaign.
- 1,243 referrals have been made to the Exercise on Referral programme.
- 32 registered walking schemes across Warwickshire with 3,461 walkers attending the schemes.
- 308 children completed a 9 week structured weight management programme as well 223 parents/carers. 100% of families reported sustaining healthy lifestyle changes.
- 11,096 reception and year 6 children were weighed and measured in 190 schools as part of the National Child Measurement Programme.
- National Child Measurement Programme participation rates exceeded national target of 85%; 98.4% of reception children and 97.4% of year 6 children in Warwickshire were measured.
- Health Visiting and children's centres achieved the UNICEF Baby Friendly Initiative Stage 3 accreditation scoring 100% in many areas.
- 73.5% of mothers initiated breastfeeding.
- 5,009 people have set a smoking quit date in 2014/15.
- 16,896 NHS Health Checks have been carried out and 682 people were found to have an undiagnosed long term health condition.
- 13.1% of pregnant women are known to be smokers at time of delivery, which has decreased from 2012/13.

- Over 400 people in North Warwickshire have pledged their '#Onething' change they will make for a healthier lifestyle.
- Public Health have worked with Warwickshire North CCG and Nuneaton & Bedworth and North Warwickshire Borough Councils to run and support a series of health awareness raising events, engaging with 100's of people, offering health checks and advice.

Mental Health and Wellbeing

- A '5 Ways to Wellbeing' e-learning resource developed.
- 1,223 staff trained in Making Every Contact Count.
- 1,500 appointments at the Wellbeing Hubs.
- 120 new referrals for direct advocacy support for general health issues and for complaints relating to NHS services.
- 4,542 users have accessed the 'Living Well with Dementia Portal'.
- We have helped create over 7,000 'Dementia Friends'.

Wider Determinants

- Worked closely with the districts and borough councils to encourage planners to take public health into account in line with the National Planning Policy Framework (NPPF).
- A programme of Health Impact Assessments commissioned to support local planners to gain insight into health impacts of potential local developments on existing communities.
- National coverage for the Warwickshire Veterans project in 'Veterans World' magazine.
- Public Health Warwickshire has jointly hosted an event with the Town and Country Planning Association called 'Healthy Weight Environments'. This examined how planning and development can create and influence the wider social and environmental determinants that encourage healthier lifestyles and healthier populations.
- 2 Apprentices have been recruited into the Wider Determinants team over the last year, as part of Public Health Warwickshire's commitment to training and development.

Warwickshire Public Health Report Card[46]

Indicator	Period	Warwickshire		England	North Warwickshire		Nuneaton & Bedworth		Rugby		Stratford-on-Avon		Warwick		
		Value	Trend	Value	Value	Trend	Value	Trend	Value	Trend	Value	Trend	Value	Trend	Data unit
Deprivation	2013	5.9	n/a	20.4	5.2	n/a	19.3	n/a	3.6	n/a	0	n/a	1	n/a	%
Children in poverty (under 16s)	2012	13.2		19.2	13.9		19.5		12.8		9.1		10.3		%
Statutory homelessness	2013/14	2.2		2.3	1.3	n/a	3.2	n/a	2.5	n/a	1.6	n/a	2.2	n/a	per 1,000
GCSE achieved (5A*-C inc. Eng & Maths)	2013/14	60.2	n/a	56.8	57	n/a	45.3	n/a	64	n/a	68	n/a	66	n/a	%
Violent crime (violence offences)	2013/14	7.6		11.1	6.4		10.5		7.4		6.7		6.7		per 1,000
Long term unemployment	2014	3.7	n/a	7.1	3.4	n/a	8.1	n/a	3.6	n/a	0.9	n/a	2.3	n/a	%
Smoking status at time of delivery	2013/14	13.1		12	19	n/a	19	n/a	13	n/a	8.3	n/a	8.3	n/a	%
Breastfeeding initiation	2013/14	73.5		73.9	68.4	n/a	n/a	n/a	82.5	n/a	76.7	n/a	78.2	n/a	%
Obese children (Year 6)	2013/14	15.6		19.1	19.8		19.3		14.4		13.2		12.9		%
Alcohol-specific hospital stays (under 18) †	2011/12-13/14	46.2	n/a	44.9	24.2	n/a	64.8	n/a	32.9	n/a	37.3	n/a	41.2	n/a	per 100,000
Under 18 conceptions	2013	23.4		24.3	26.6		29.7		22.6		18.9		19.7		per 1,000
Smoking prevalence	2013	14.5		18.4	12.4		13.8		12.7		13.3		18.2		%
Percentage of physically active adults	2013	59.1	n/a	56	61	n/a	53.3	n/a	58.9	n/a	59.4	n/a	63.3	n/a	%
Obese adults	2012	21.8	n/a	23	27.5	n/a	27	n/a	20.4	n/a	21.4	n/a	15.8	n/a	%
Excess weight in adults	2012	64.8	n/a	63.8	67.9	n/a	64.5	n/a	65.3	n/a	65.7	n/a	62.7	n/a	%
Incidence of malignant melanoma †	2010-12	18.2	n/a	18.4	18.4	n/a	17.2	n/a	15.5	n/a	18.7	n/a	20.6	n/a	per 100,000

Indicator	Period	Warwickshire		England	North Warwickshire		Nuneaton & Bedworth		Rugby		Stratford-on-Avon		Warwick		
		Value	Trend	Value	Value	Trend	Value	Trend	Value	Trend	Value	Trend	Value	Trend	Data unit
Hospital stays for self-harm	2013/14	216.3	n/a	203.2	195.9	n/a	305.9	n/a	224	n/a	173	n/a	184.8	n/a	per 100,000
Hospital stays for alcohol related harm †	2013/14	620	n/a	645	506	n/a	703	n/a	632	n/a	591	n/a	631	n/a	per 100,000
Prevalence of opiate and/or crack use	2011/12	5.1	n/a	8.4	4.3	n/a	5.4	n/a	5.2	n/a	3.3	n/a	6.6	n/a	per 1,000
Recorded diabetes	2013/14	6		6.2	6.5		7.3		6		5.3		5.3		%
Incidence of TB †	2011 - 13	8.6	n/a	14.8	5.4	n/a	13	n/a	10.9	n/a	4.4	n/a	8.2	n/a	per 100,000
All new STI diagnoses (exc Chlamydia aged <25)	2013	727	n/a	832	631	n/a	951	n/a	821	n/a	551	n/a	647	n/a	per 100,000
Hip fractures in people aged 65 and over	2013/14	578		580	687		655		514		554		539		per 100,000
Excess winter deaths (three year)	Aug 2010 - Jul 2013	19.5		17.4	25.6		19.1		22.7		17.5		16.5		
Life expectancy at birth (Male)	2011 - 13	80		79.4	79		78.3		80.6		81		80.5		Years
Life expectancy at birth (Female)	2011 - 13	83.8		83.1	82.2		82.5		84		85.2		84.4		Years
Infant mortality	2011 - 13	3.5		4	6.9		3.1		2.4		3.6		3.2		per 1,000
Smoking related deaths	2011- 13	235.8		288.7	249.8		278.7		234		200.4		230		per 100,000
Suicide rate	2011 - 13	9.3		8.8	n/a	n/a	9.2	n/a	n/a	n/a	7.3	n/a	13.6	n/a	per 100,000
Under 75 mortality rate: cardiovascular	2011 - 13	70.8		78.2	95.4		83.6		62.6		58.3		65.4		per 100,000
Under 75 mortality rate: cancer	2011 - 13	131.2		144.4	144.9		141.4		140.1		113.1		127		per 100,000
Killed and seriously injured on roads	2011 - 13	54.7	n/a	39.7	101.8	n/a	35.2	n/a	52.6	n/a	74.4	n/a	35.8		per 100,000

Compared to England

Better: Similar: Worse:

† Indicator has had methodological changes so is not directly comparable with previously released values.

GLOSSARY

ADHD (Attention deficit hyperactivity disorder) - A group of behavioural symptoms that include inattentiveness, hyperactivity and impulsiveness.

Adverse Childhood Experiences (ACEs) - An adverse childhood experience (ACE) describes a traumatic experience in a person's life occurring before the age of 18 that the person remembers as an adult.

Antenatal - Before birth; during or relating to pregnancy.

Bronchitis - Bronchitis is inflammation of the air passages between the nose and the lungs, causing a nasty cough.

BMI - Overweight and obesity is measured through the calculation of a body mass index (BMI). BMI is calculated by dividing body weight (kilograms) by height (metres) squared.

Adults BMI classifications:

- adults with a BMI below 18.5 are underweight;
- adults with a BMI between 18.5-24.9 are healthy weight;
- adults with a BMI of 25 or over are overweight;
- adults with a BMI of 30 or over are obese.

Further classifications of obesity by BMI in adults are:

- obesity, class I - 30-34.9;
- obesity, class II - 35-39.9;
- obesity, class III - ≥40.

In children and adolescents, BMI varies with age and sex, and because of this, a growth reference must be used. In England, the 'British 1990 growth reference charts' are used to classify the weight status of children according to their age and sex for the National Child Measurement Programme and Health Survey for England. To check out your own or your child's BMI, you can use an online tool on the NHS Choices website. http://www.nhs.uk/tools/pages/healthyweightcalculator.aspx

CCG (Clinical Commissioning Group) - Clinical Commissioning Groups are groups of GP Practices that are responsible for commissioning most health and care services for patients.

Cognitive skills - Cognition is the umbrella term for your learning skills - your ability to process information, reason, remember, and relate.

Commissioning (Public Health) - 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.

Competencies – A set (or list) of things you have to do (or be capable of) in order to reach a certain outcome.

Conduct disorder – A range of antisocial types of behaviour displayed in childhood or adolescence.

Cross sector organisations – In terms of organisations working together, this means; the variety of organisations that are involved in a project are from the public sector, private sector and voluntary sector.

Deprivation - The damaging lack of material benefits considered to be basic necessities in a society.

Determinant – A factor which decisively affects the nature or outcome of something. Many factors combine together to affect the health of individuals and communities. Whether people are healthy or not, is determined by their circumstances and environment.

ESH Works - 'Experience, Strength and Hope' is an independent non-profit making organisation providing mutual support for those addicted to or affected by alcohol, drugs or other dependencies in Warwickshire.

Family homelessness – An individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility (e.g., shelters) that provides temporary living accommodations, and an individual who is a resident in transitional housing.

Five Ways to Wellbeing – A public health campaign which details the five steps to take towards a good mental health. These are: connect; be active; take notice; keep learning and give.

GFR – General Fertility Rate is the total number of live births per 1,000 women of reproductive age (age 15 to 44 years) in a population per year.

Glue Ear - A common childhood condition in which the middle ear becomes filled with fluid.

Health Impact Assessment (HIA) – Similar to a study – viewing the impacts of certain things on the population's health, i.e. new care services. The impacts measured may be good or bad impacts.

Health inequalities – Health inequalities are differences between people or groups due to social, geographical, biological or other factors.

Incidence – the number of new events, e.g. new cases of disease in a defined population, within a specified time period.

Integrated working – See 'working collaboratively' definition.

Intervention - The action or process of intervening, which could relate to commissioning a service for disadvantaged populations, to attempt to address a particular issue.

Making Every Contact Count (MECC) - MECC is a concept which aims to improve lifestyles and reduce health inequalities. MECC encourages conversations based on behaviour change methodologies (ranging from brief advice, to more advanced behaviour change techniques), empowering healthier lifestyle choices and exploring the wider social determinants that influence all of our health.

Marmot Reviews - the work that is carried out by Professor Sir Michael Marmot and his team at University College London (UCL) focusing on population health and inequalities.

National Child Measurement Programme (NCMP) - An important element of the Government's work programme on child obesity, operated by Public Health England and the Department of Health (DH) and delivered by Local Authorities .

NEET (Not in Education, Employment or Training) – Young people aged 16 to 24 who are not considered to be undertaking a form of education, employment or training.

NUDS (New and Unregulated Drugs) – Substances with an unknown and underdetermined nature and status. These substances are referred to by a variety of names, including Legal Highs, Novel Psychoactive Substances and New & Emerging Drugs.

Outcomes (Public Health) - Involve change in health status; some stipulate that the population or group has to be defined (different outcomes are expected for different people & conditions), whilst others specify also that health outcomes are the result of interventions or their lack, rather than simply change over time.

Partners – Organisations that work together or are involved in work together.

Pneumonia - Lung inflammation caused by bacterial or viral infection. Inflammation may affect both lungs (double pneumonia) or only one (single pneumonia).

Postnatal - Relating to the period after childbirth.

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

Respect Yourself Programme – A public health project, aimed mainly at younger people, that provides relationship and sexual health information and advice.

SATOD (Smoking at time of delivery) – Pregnant women who are known to be smokers at the time of giving birth.

SEND/SEN – Following a reform in September 2014, SEN is now referred to as SEND; children and young people with special educational needs and disabilities.

Stakeholder – In terms of business, an organisation interested in your area of work, or a 'partner'.

'Time to Change' – A project which aims to change populations' behaviour in order to adopt healthier lifestyles.

'Triple P' – A parenting intervention with the main goal of increasing the knowledge, skills, and confidence of parents to reduce the prevalence of mental health, emotional, and behavioural problems in children and adolescents. The program is specifically tailored for at risk children and their parents.

UNICEF Baby Friendly Stage 3 – An award for maternity, neonatal, health visiting and children centre services who have achieved a set of interlinking evidence-based standards.

Warwickshire Health & Wellbeing Board – A board made up of partners from the county and district and borough councils, NHS and public and social care sector to ensure a coordinated approach to health, social care and public health in Warwickshire.

Working collaboratively – Involvement of two or more parties (organisations) working together.

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Warwickshire
County Council

Item 5

Health and Wellbeing Board

8th July 2015

Better Together - Better Care Fund Agreement 2015/16

Recommendations

1) That The Health and Wellbeing Board notes the position with regard to signing off the Better Care Fund agreement for 2015/16.

2) That the Health and Wellbeing Board supports the finalisation of the Better Care Fund agreement for 2015/16 in accordance with the parameters set out in Section 4.

1 Introduction

1.1 The purpose of this report is to update the Health and Wellbeing Board on the progress made in developing a formal agreement to manage the 2015/16 Better Care Fund budget, and to seek support for the finalisation of the agreement.

1.2 The agreement, which will set up a pooled budget to be led by the local authority, is being written under the auspices of Section 75 of the 2006 NHS Act which gives local authorities and health bodies the power to pool budgets.

1.3 The form and content of the agreement has been the subject of discussion between health and local authority partners and has been discussed at the Better Together Programme Board.

2 Funding Streams

2.1 There are three specific funding streams related to the £36 million Better Care Fund for Warwickshire:

- £33 million of health service funding which goes from the Department of Health to Clinical Commissioning Groups. This funding will be paid into the pooled budget, from where it will then be issued to the relevant organisation managing the spending directly.

- £1.9 million of Disabled Facilities Grant funding which is paid from the Department of Health to the County Council. This funding is then paid to

District and Borough councils.

- £1.2 million of adult social care capital grant which is paid to the County Council. This funding will be incorporated into the pooled budget, and held by the County Council.

2.2 There will be one single overarching agreement for the Warwickshire Better Care Fund. The agreement will set out arrangements for governance, risk sharing, joint working, performance monitoring, and the management of the pooled budget.

2.3 In addition to this, there will be an agreement between the County Council and the District/Borough councils in respect of the transfer of the Disabled Facilities Grant.

3 Better Care Fund Themes and Governance

3.1 The Better Care Fund aims to use resources as effectively as possible, reduce duplication and ensure we support the people of Warwickshire to get the care and support they need in the most appropriate place, which is often in or as close to their own home as possible

3.2 The Better Care Fund is being used to support integration and transformation of the health and care system. It is considered an enabling programme that will drive the systems changes required to create more joined up working.

3.3 The Vision for Warwickshire residents is encapsulated in the Plan on a Page (Appendix 1) which aspires to *enable people to plan their own care with people who work together to understand them and their carers, allowing them control, and bringing together services to achieve outcomes important to them*.

Translated to service delivery this means that:

- People are helped to remain healthy and independent.
- People are empowered to take an active role in managing their own care and the care they receive.
- People get the right services at the right time and in the right place.

The Better Together Programme Board will be overseen by the Better Together Integration Executive and report to the Health and Wellbeing Board on five key themes:

Community Resilience	Helping people to help themselves. Connecting people with their communities.
Integrated Care	Integrated health and social care teams working closely with GPs. Urgent care services as an alternative to hospital admission.
Care at Home	Transforming the delivery of care at home. Home adaptations and rehabilitation services.
Accommodation with Support	Reshaping the accommodation with care market. Supporting people to live independently.
Long Term Conditions	Supporting people to manage their long term conditions. Dementia friendly services.

3.4 There are four national measures (Non Elective Admissions, Residential Admissions, Reablement, Delayed Transfer of Care) and two local measures (Patient/Service user Experience and Support for Long Term Conditions) that will track the performance of the Better Care Fund. The Non Elective Admissions measure is a performance related target set at 2.3% reduction in volumes.

3.5 The value of the Better Care Fund for Warwickshire is £36 million but none of this is new money - it is already committed to particular services. Any investment of this money into new initiatives or services will require money to be redirected from somewhere else.

3.6 New commitments will only be proposed where they have been directed by the Department of Health, or where they are to do with redistributing budgets in order to promote intended developments, or to reflect where changes in patterns in spending have already been created.

3.7 Significant further changes in the planned use of the fund would be subject to agreement by partners.

4 Parameters for Agreement

4.1 The agreement will fit within the budgets already set by partner organisations.

4.2 The agreement will not change or delegate the statutory responsibilities of any partner organisation.

4.3 Risk sharing arrangements will be arranged such that they attempt to avoid perverse incentives, and such that that they attempt to incentivise partnership working.

4.4 The emphasis in the 2015/16 agreement is around beginning to share more information and beginning to think about and manage a wider set of health and social care budgets together. Lessons learned from the management of the agreement in 2015/16 will be applied to the agreement developed for 2016/17.

5 Supporting Papers

5.1 None.

6 Background Papers

6.1 None.

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Appendix 1

Warwickshire Cares - *Better Together*: Plan on a Page

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

Vision for Services

- People are helped to remain healthy and independent
- People are empowered to take an active role in managing their own care and the care they receive
- People get the right service at the right time and in the right place

To work collaboratively across Warwickshire's health and social care systems to:

Help people to manage their own care.

Deliver better care closer to home.

Reduce inappropriate admission to hospital and/or long term residential care.

Key themes:

Care at Home
- Transforming the delivery of care at home
- Home adaptation and rehabilitation services

Accommodation with Care
- Reshaping the accommodation with care market
- Supporting people to live independently

Community Resilience
- Helping people to help themselves
- Connecting people with their communities

Long Term Care
- Supporting people to manage long term conditions
- Dementia friendly services

Integrated Care
- Integrated health and social care teams working closely with GPs
- Urgent Care services as an alternative to hospital admission

Who is Involved: Warwickshire Cares - *Better Together* is an overarching initiative between commissioners and providers of health and care services and importantly the people of Warwickshire.

Warwickshire County Council

Item 6

Health and Wellbeing Board

Meeting Date 8th July 2015

Safe in Warwickshire
Warwickshire's Violence against Women and Girls Strategy 2015 - 18

Recommendation(s)

Members of the Health and Wellbeing Board are requested to:

- promote the Violence Against Women and Girls strategy within their organisations;
- support their organisation's participation in training programmes to improve identification and response to violence against women and girls; and
- support the future roll out of the implementation plan to improve services and address gaps, as set out in the strategy.

1.0 Key Issues

1.1 This is Warwickshire's first Violence Against Women and Girls (VAWG) Strategy. It brings together our existing work to tackle domestic abuse and sexual violence with a new, broader approach that addresses all forms of violence against women and girls. It aims to ensure a more integrated and effective partnership response that reflects the experiences of those affected. This includes: forced marriage; stalking; female genital mutilation; sexual exploitation; trafficking and crimes in the name of honour.

1.2 All forms of violence against women and girls are human rights violations and criminal offences; the impacts and consequences for health and wellbeing are similar; all are considerably underreported; minimisation and myths exist across all forms; those affected are under-reported by services; and perpetrators are often known to victim-survivors.

1.3 Based on the prevalence data available the estimated cost of domestic abuse to public services alone in Warwickshire is about £54.3 million per annum. The long term human and emotional cost of VAWG to the individual is immeasurable.

1.4 The Strategy has been developed following an in-depth consultation process both with professionals and agencies from the voluntary and statutory sectors and with victim-survivors themselves.

1.5 The Strategy recognises that men and boys can also be victims of violence and therefore does not exclude them from this work. However, women and girls are at greater risk of these crimes, therefore a gendered approach to VAWG is both appropriate and necessary.

2.0 The VAWG Strategy

2.1 Warwickshire's Strategy objectives and outcomes have been adopted from the national strategy, "Call to End Violence Against Women and Girls", focusing on: prevention; provision; protection; and partnership. Using this framework the strategy sets out what we have in place already and what we need to do to improve services and address gaps.

2.2 A multi-agency Violence Against Women and Girls Board has been established by the Safer Warwickshire Partnership Board. The VAWG Board has led the development of the Strategy and is now focusing on the Implementation Plan and communications strategy.

3.0 Timescales associated with the decision and next steps

3.1 The Safer Warwickshire Partnership Board approved the VAWG Strategy at its meeting in March 2015. The Strategy is now being presented to other key partnership boards to raise awareness about the issue, highlight interdependencies and secure commitment for the strategy outcomes and the development of the implementation plan.

3.2 In 2015 the VAWGB Board has agreed to focus on prevention: challenging the attitudes and behaviours which foster violence against women and girls; and intervening early where possible to prevent it. Work to achieve this objective includes completion of the communications strategy, undertaking a training needs analysis and building capacity with all stakeholders - especially frontline staff and schools - to enable them to recognise and support victims of violence and build resilience in young people and families.

3.3 Members of the Health and Wellbeing Board are therefore requested to commit their organisations to :

- supporting the development and the delivery of the Violence Against Women and Girls communications strategy;
- taking part in the training needs analysis; and
- ensuring staff take up training opportunities

Background papers

1. Background paper 1: Safe in Warwickshire…Warwickshire's Violence Against Women and Girl's Strategy 2015-18

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Item 6 Appendix

safe in... warwickshire

Warwickshire's Violence Against Women and Girls Strategy 2015-18

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Abbreviations

BME	Black and minority ethnic
CAADA	Coordinated Action Against Domestic Abuse
CRC	Community Rehabilitation Company
CSE	Child sexual exploitation
CSP	Community Safety Partnership
DA	Domestic abuse
DVA	Domestic violence and abuse
DACS	Domestic abuse counselling service
DAU	Domestic Abuse Unit
DHR	Domestic homicide review
FGM	Female genital mutilation
FM	Forced marriage
IDVA	Independent Domestic Violence Advisor
ISVA	Independent Sexual Violence Advisor
HBV	Honour-based violence
HWB	Health and Wellbeing Board
LGBT	Lesbian, gay, bisexual and transgender
MARAC	Multi-agency risk assessment conference
MAPPA	Multi-agency public protection arrangements
NPS	National Probation Service
PCC	Police and Crime Commissioner
SARC	Sexual assault referral centre
SDAC	Specialist Domestic Abuse Court
SWPB	Safer Warwickshire Partnership Board
WADA	Warwickshire Against Domestic Abuse
WCC	Warwickshire County Council
WSCB	Warwickshire Safeguarding Children Board
VAWG	Violence against women and girls
YPVA	Young Persons Violence Advocate

Foreword

Every year in the UK 3 million women experience rape, domestic violence, forced marriage and so-called 'honour' crimes, female genital mutilation, stalking, trafficking and sexual exploitation. Such violence is a major cause of death and disability and is linked to other issues such as poor health, child poverty, social exclusion, economic and educational disadvantage.

Over the last few years we have made significant progress in improving our services for those who experience gender-based violence, particularly domestic and sexual violence. However, we have more to do, including developing our response to all forms of violence against women and girls.

We are pleased, therefore, to present Warwickshire's first partnership Violence against Women and Girls Strategy, which draws on national and local evidence and consultation with key stakeholders, including victim-survivors themselves, to outline our approach to dealing with this important issue.

The Strategy brings together our existing work in these areas and sets out work we would like to do to improve services and address the gaps. We see this very much as a 'live' document which will evolve as the national and local context changes.

We will do as much as we can within our resources to lead this agenda in Warwickshire and deliver improved outcomes for victims. However, we cannot tackle this alone. We will endeavour to support and lobby others to play their part in delivering the national version of this strategy.

Cllr Les Caborn
Chair of the Safer Warwickshire Partnership Board, Portfolio Holder for Community Safety, Warwickshire County Council

Helen King
Deputy Director of Public Health in Warwickshire, Chair of the Violence Against Women and Girls Board

1. Introduction

This is Warwickshire's first Violence Against Women and Girls (VAWG) Strategy. It brings together our existing work on domestic abuse with a new broader approach that addresses all forms of violence against women and girls.

Over the last few years significant progress has been made as to how public and voluntary sector partners in Warwickshire respond; raise awareness and deliver support and prevention work in relation to the issue of domestic abuse and sexual violence.

We still however have a long way to go to deliver this work effectively and in developing our response to other types of violence against women and girls. This includes forced marriage, female genital mutilation, so-called 'honour' based violence, stalking, trafficking, sexual harassment and sexual exploitation.

The Strategy commits us to working together and strengthening our efforts to prevent and tackle violence against women and girls in all its forms.

Our key objectives are as follows:

Prevention	Preventing violence against women and girls from happening by challenging the attitudes and behaviour which foster it and intervening early where possible to prevent it
Provision	Providing high quality, joined-up support for victims where violence does occur
Protection	Taking action to reduce the risk of women and girls who are victims of violence and ensuring that perpetrators are brought to justice and provided with opportunities for change in a way that maximises safety
Partnership	Working in partnership to obtain the best outcome for victims and their families

How the Strategy has been developed

The Strategy has been developed following an in-depth consultation process both with professionals and agencies from the voluntary and statutory sectors and with victim-survivors themselves. The consultation process sought to map what is currently in place in Warwickshire for VAWG and to undertake a gap analysis to help identify what more needs to be done.

The Strategy will continue to evolve as the national and local VAWG context changes.

How the Strategy will be delivered

A Strategy Implementation Plan will be developed and monitored by the multi-agency VAWG Strategic Board to support the delivery of the Strategy. This will be reviewed and refreshed annually.

VAWG Strategic Board Members

- Warwickshire County Council
- North Warwickshire Borough Council
- Nuneaton & Bedworth Borough Council
- Rugby Borough Council
- Stratford District Council
- Warwick District Council
- National Probation Service
- Warwickshire and West Mercia Police Strategic Alliance
- Office of the Police and Crime Commissioner
- Warwickshire Safeguarding Children Board
- Warwickshire Safeguarding Adults Board
- Health – Acute Trusts, Clinical Commissioning Groups
- Warwickshire & West Mercia Community Rehabilitation Company
- Local Criminal Justice Board
- Voluntary and Community Sector

Interdependencies with other work

The Strategy does not sit in isolation. VAWG is closely connected to other issues such as poor health, child poverty, social exclusion and economic and educational disadvantage. It therefore has an impact on other local strategies and initiatives such as:

- Health and Wellbeing Strategy
- Safeguarding Strategies
- Priority Families
- Care Act 2014 Implementation Plans
- County and District Community Safety Plans
- Housing and Homelessness Strategies
- Drug and Alcohol Implementation Plans
- Warwickshire Police and Crime Plan
- Police Domestic Abuse Strategy

The Strategy does not intend to duplicate work being led by others. It aims to bring together work across all sectors on the issue of VAWG into one cohesive, co-ordinated statement.

VAWG is closely connected to other issues such as poor health, child poverty, social exclusion and economic and educational disadvantage.

2. Why Violence Against Women and Girls?

Definitions

The United Nations defines violence against women and girls (VAWG) as ***any act of gender based violence that results in or is likely to result in physical, sexual or psychological harm or suffering to women (or girls), including threats of such acts, coercion or arbitrary deprivation of liberty (United Nations Declaration on the Elimination of Violence towards Women (1993, Article 1).***

Adopting this definition does not mean we will neglect violence and abuse directed towards men and boys, or other groups and individuals who experience these forms of violence, however, women and girls are at substantially greater risk of these crimes, therefore a gendered approach to VAWG is both appropriate and necessary.

Forms of VAWG referenced in this Strategy are explained as follows:

Forms of VAWG

Domestic abuse is a pattern of coercive control, which includes physical, sexual, psychological and financial abuse by a current or former partner and can, in extreme cases, include murder.

Sexual violence including rape is sexual contact without the consent of the woman/girl, where perpetrators range from total strangers to relatives and intimate partners, but most are known in some way.

Female genital mutilation (FGM) is the complete or partial removal or alteration of external genitalia and is mostly carried out on young girls between infancy and 15 years.

Forced marriage is a marriage conducted without valid consent of one or both parties, where duress is a factor.

'Honour' based violence is violence committed to protect or defend the 'honour' of a family and/or community where young women are the most common targets and can, in extreme cases, include murder.

Prostitution/sex work and trafficking involves women and girls being forced, coerced or deceived to enter into prostitution. Trafficking involves the recruitment, transportation and exploitation of women and children for the purposes of prostitution and domestic servitude across international borders and within countries ('internal trafficking').

Sexual exploitation involves exploitative situations, contexts and relationships where someone receives 'something' (e.g. food, drugs, alcohol, cigarettes, affection, protection money) as a result of them performing, and/or others performing on them, sexual activities. Young women and girls involved in or connected to gangs are at risk of sexual exploitation by gang members.

Sexual harassment is unwanted verbal or physical conduct of a sexual nature. It can take place anywhere, including the workplace, schools, streets, public transport and social situations. It includes 'flashing', obscene and threatening calls, and online harassment.

Stalking is repeated (i.e. on at least two occasions) harassment causing fear, alarm or distress. It can include threatening phone calls, texts or letters; damaging property; spying on and following the victim.

From domestic abuse to VAWG

Warwickshire has followed the national approach by moving away from a domestic abuse strategy to one which encompasses all forms of violence ensuring a more integrated approach and effective response that better reflects the experiences of those affected.

Extensive research shows that violence, or the threat of violence, is rarely a one-off event and women are likely to have experienced multiple and intersecting forms of violence throughout their lives. For example:

- Histories of sexual violence, abuse and harassment are common among women in prostitution and the sex industry
- Around half of the women in prison have lived with domestic abuse and a third have survived sexual abuse
- The prevalence of sexual violence among victim-survivors of domestic abuse is extremely high
- The likelihood of being re-victimised as an adult is greater for women abused in childhood
- Sexual harassment in the workplace for women is a common experience
- Children who have been sexually exploited have a history of child sexual abuse in intra-familial settings

The strategic shift to a wider VAWG agenda also makes sense considering the overlaps and connections between forms of violence experienced by victim-survivors that are often missed in agency responses, such as:

- Domestic abuse includes sexual violence and stalking (in the form of post-separation violence), and some women are coerced into prostitution by abusive partners
- Domestic abuse overlaps with child abuse, including child sexual abuse, which is connected to early entry into the sex industry
- Sexual abuse in childhood increases the likelihood of experiencing sexual and/or domestic abuse in adulthood; or of being sexually exploited as children
- A forced marriage will inevitably also involve coerced sex
- Trafficked women and girls are repeatedly raped

It also recognises the commonalities across all forms of VAWG: they are human rights violations and criminal offences; the impacts and consequences for health and well-being are similar; all are considerably under-reported; minimisation and myths exist across all forms; those affected are under-supported by services; and perpetrators are often known to victim-survivors.

Greater integration creates opportunities to address these multiple issues through targeting limited resources more effectively.

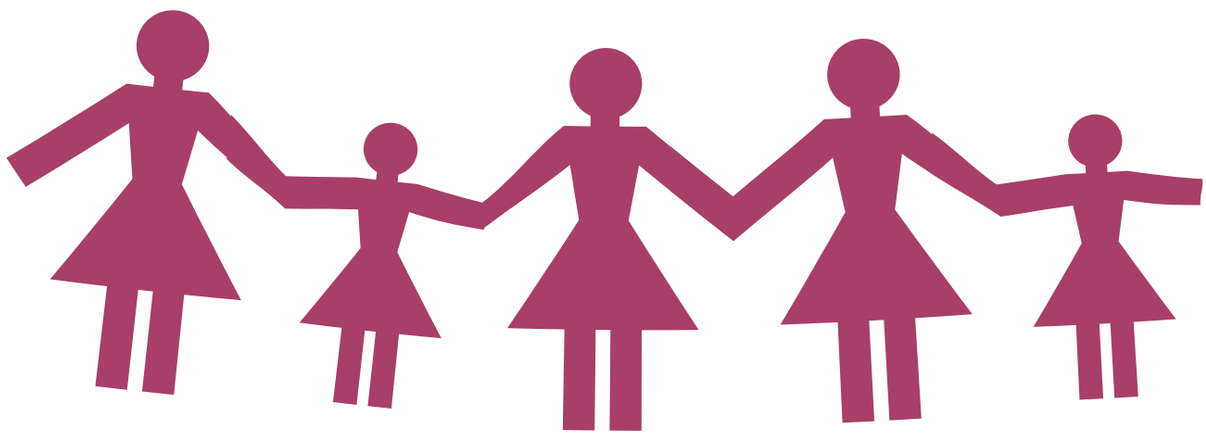
> Extensive research shows that violence, or the threat of violence, is rarely a one-off event

Why a gendered approach?

The Strategy recognises that men and boys can also be victims of violence and therefore does not exclude them from this work. Perpetrators may also be female. However, a gendered approach to VAWG is both appropriate and necessary because the majority of violence is perpetrated by men, against women and is gender-based.

Understanding gender as the central factor in VAWG allows us to understand the causes and consequences of VAWG and for the response to be developed accordingly. This approach is supported by robust research and a sound theoretical framework. Research and data presented to challenge a gendered approach does not adequately address the complex dynamic of such violence and abuse or influential social factors. Approaches which do not recognise the influence of gender in everyday experiences fail both men and women, and assumptions that experiences of men and women are equivalent will not achieve equality of outcome.

Understanding gender as the central factor in VAWG allows us to understand the causes and consequences of VAWG and for the response to be developed accordingly.



3. Background facts and figures

National context

Highlights from the data and research available nationally on VAWG are as follows:

Each year around three million women and girls in the UK experience some form of violence, including domestic violence and abuse, rape, forced marriage, stalking, female genital mutilation, sexual exploitation, trafficking and crimes in the name of honour *(Coy et al, 2008)*

In England and Wales, 2 women a week are killed by a partner or ex-partner *(Women's Aid, 2014)*

85,000 women are raped and 400,000 women are sexually assaulted every year in England and Wales *(MoJ , 2013)*

Each year 23,000 girls under 15 in England and Wales are at risk of female genital mutilation. A further 66,000 are living with its consequences *(Dorkenoo et al, 2007)*

The Forced Marriage Unit recorded 1,485 cases of forced marriage across the UK in 2012

1,000-10,000 women and girls trafficked into the UK each year for sexual exploitation *(Townsend, 2007)*

An overwhelming majority of VAWG is perpetrated by known men – family members, friends, neighbours, colleagues – as well as strangers

VAWG remains hugely under-reported with only one in four of those experiencing domestic abuse, and one in eight of those experiencing sexual violence, making an official report *(Walby and Allen, 2004)*

Some communities are less likely to report domestic abuse than others including BME groups, LGBT groups, disabled women, rural and more affluent communities, and male victims

VAWG has high rates of repeat victimisation compared to other crimes, and even when reported, conviction rates for perpetrators remain low

The societal cost of VAWG, in England and Wales, is estimated to be over £40 billion a year (including health, legal and social services).

The long-term human and emotional cost of VAWG to individuals is immeasurable.

Warwickshire context

Given its hidden nature and under-reporting, it is difficult to gain an accurate picture of the scale and extent of VAWG locally. Agency monitoring data and reported incidents to the police have been collated, however given the past focus on domestic abuse (and more recently sexual violence); data is mainly available for this form of VAWG. Data for other forms of VAWG remains a gap and requires addressing. This is picked up within the Strategy

Key points from the datasets available are as follows:

9,183
female victims

Each year there will be an estimated **9,183** female victims of domestic abuse **in Warwickshire.** This compares to 7,253 'incidents' of domestic abuse (approximately 20 per day) and 1,114 domestic abuse 'crimes' recorded by Warwickshire Police in 2013-14. Existing data does not tell us the actual number of victims who report to the police which will be less as some of these incidents and crimes will be repeats

Research suggests **only 40%** of domestic abuse incidents are reported to the police.
Assuming this, there may actually be **20,000 incidents** of domestic abuse occurring in Warwickshire each year

347 of the 1,114 domestic abuse crimes recorded in 2013-14 resulted in a **prosecution** and 289 converted into **convictions**

1,451 referrals were made to the Domestic Abuse Support Service in 2013-14. 361 individuals were taken on to the caseload. **80 individuals** were supported in Warwickshire refuges in 2013-14

538 high risk cases were discussed at MARACs in Warwickshire in 2013-14.
15.8% were repeat victims, **710** children were involved, **62** cases were BME and **31** were male victims

5 Domestic Homicide Reviews have been/are being undertaken in Warwickshire since the legislation came into force in 2011 (as of October 2014). 8 cases have been referred for consideration.

Local research estimates that there are around **184 sex workers** operating in Warwickshire with most sex work taking the form of escorting

522 sexual offences were recorded by Warwickshire Police in 2013-14 up from 424 in 2012-13.

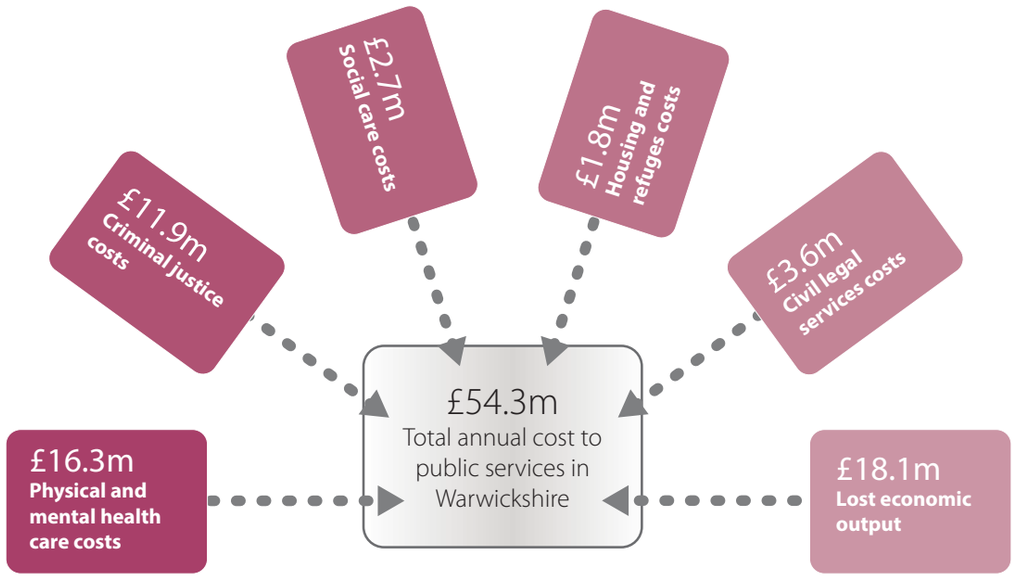
Prevalence is likely to be much higher – national research suggests **35% of women** aged 15-59 years will have experienced some form of sexual violence in their lifetime.

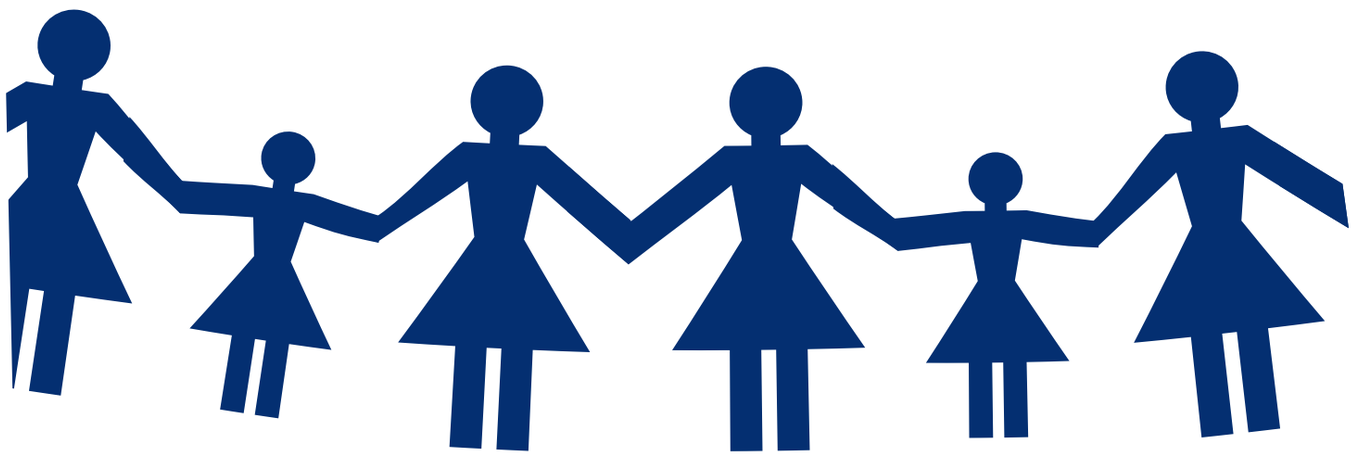
167 Warwickshire residents were seen at the Coventry and Warwickshire Sexual Assault Referral Centre in 2013-14.
The majority were white females and almost half were children and young people. Most were assaulted by an acquaintance with rape being the most prevalent offence

The cost of VAWG in Warwickshire

Based on the prevalence data available the estimated cost of domestic abuse to public services alone in Warwickshire is £54.3 million per annum:

When the human and emotional cost is included the total rises to £147.9 million per annum. These estimates are based on 2009 data and are therefore considered a conservative estimate. A more detailed analysis of the cost of VAWG as a whole needs to be undertaken and will be referenced within the Strategy.





4. Strategy Objectives and Next Steps

Warwickshire's Strategy objectives and outcomes have been adapted from the national strategy, "Call to End Violence Against Women and Girls", published by the Home Office in 2010.

This section highlights what we have in place already and what we will do to develop provision and address the gaps.

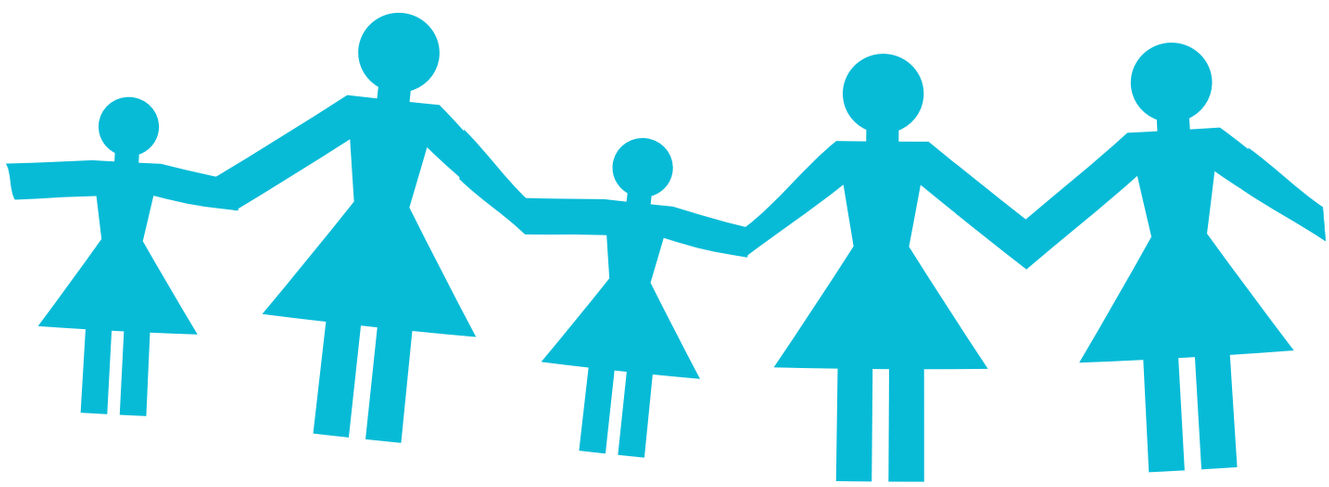
More information about the initiatives and services already in place is available at Appendix B.

A VAWG Strategy Implementation Plan is in development. This will prioritise the work we intend to do and provide details in relation to how, who and when the identified work will be delivered.

> The first priority is therefore to protect what is already in place, but maximise efficiency and reduce duplication

Whilst the Strategy seeks to be aspirational, recognition is given to the tight financial climate within which all public sector agencies are working. The first priority therefore is to protect and enhance what is already in place, but maximise efficiency and reduce duplication thereby freeing up resources to support the areas for development.

A Communications Plan will be developed by the VAWG Board during the early part of 2015-16 to support the Strategy. It will set out the approach and the key messages for use within both reactive and proactive scenarios.



Prevention

Key objective

Preventing violence against women and girls from happening by challenging the attitudes and behaviour which foster it and intervening early where possible to prevent it

Outcomes

- Victims, perpetrators and communities recognise that violence against women and girls is unacceptable and are empowered to challenge this behaviour
- Children and young people are provided with appropriate and joined-up education on the issue of violence against women and girls
- Attitudes towards harmful practices like female genital mutilation are changed
- Frontline professionals are better able to identify and respond to violence against women and girls at an early stage
- More employers are able to recognise and support victims of violence

What we've got already

- Respect Yourself Campaign
- Taking Care Programme
- Victim Support Domestic Violence and Relationship Abuse Project
- Coaching for a Healthy and Respectful Masculinity Programme
- Warwickshire Against Domestic Abuse helpline/website (single point of contact)
- Forced Marriage and Honour-Based Violence "Statement of Intent"
- Multi-agency and single agency training
- Police training
- CSE unit, protocol and training

What we will do to improve services and address gaps

- Centrally coordinate our public campaigns and community engagement activity to ensure a consistent message and enable VAWG issues, both in the general and harder-to-reach/protected communities, to be more effectively addressed. Campaign work will cover all forms of VAWG.
- Develop a co-ordinated package of VAWG education for schools to ensure messages are consistent and that schools are clear which programmes to offer to their staff and pupils.
- Undertake a training needs analysis to understand what frontline professionals within universal services require to support them in identifying and responding to VAWG.
- Develop and deliver a coordinated package of training for frontline professionals within universal services to improve and increase VAWG identification and response.
- Support universal services with developing and implementing VAWG policies and protocols which are supportive of disclosure and prioritise safety.
- Explore options for a professionals portal which will provide information and advice on all forms of VAWG, their impact, interfaces and risks, and the services available for people who experience or perpetrate VAWG.
- Introduce VAWG champions in universal services. VAWG champions would be responsible for developing their service's response (including training, enquiry, and referral pathways) and act as the "expert" when a team member has concerns and is unsure how to respond.
- Develop and promote a training package for employers, to raise awareness of VAWG, how to identify it and how to respond.
- Support the development of multi-agency safeguarding arrangements in Warwickshire ensuring that VAWG issues are an integral part of this new of way of working.

Provision

Key objective

Providing high quality, joined-up support for victims where violence does occur.

Outcomes

- Commissioners identify and provide high quality, joined-up support services which meet the needs of victims and perpetrators and prioritises the safety of victims and their families
- The service delivery model is clear to the end that statutory, voluntary and community sector agencies get the response right the first time
- Service users achieve their identified outcomes including long-term sustainable safety

What we've got already

- Public sector services: Police Protecting Vulnerable People Department, DA Social Work Team, Designated Young Persons Violence Advocate, Probation Women's Safety Workers
- Services commissioned by the public sector: National Domestic Violence Helpline, Domestic Abuse Support Service (including IDVAs), Refuge Service, Victim Support, Sexual Assault Referral Centre (SARC), Independent Sexual Violence Advisors (ISVA), IRIS GP Liaison Service
- Non-commissioned specialist services: Domestic Abuse Counselling Service (DACS) Barnados Child Sexual Exploitation Worker, RoSA, Safeline, Terrence Higgins Trust (THT)
- Universal services working with individuals and families

What we will do to improve services and address gaps

- Explore options to improve access and provision of services to hard-to-reach/protected communities including BME and emerging Eastern European communities.
- Explore options to develop specialist support services for children and young people affected by VAWG.
- Explore options to improve service provision for individuals and families with complex needs e.g. substance misuse and/or mental health.
- Continue to commission refuge services but explore additional safe accommodation options for victims and their families who do not need/want refuge.
- Develop guidance for working with young people aged 16 and 17 who are affected by VAWG.

Protection

Key objective

Taking action to reduce the risk to women and girls who are victims of violence and ensuring that perpetrators are brought to justice and provided with opportunities for change in a way that maximises safety

Outcomes

- Victims feel confident in accessing the criminal justice system
- The criminal justice experience and outcomes for victims, including the rate of convictions, is significantly improved
- Multiple incidents of violence are reduced
- The rehabilitation rate of both perpetrators and female offenders who are subjected to violence is increased

What we've got already

- Specialist Domestic Abuse Court
- DASH Risk Indicator Checklist endorsed as preferred risk assessment tool
- MARACs to reduce risk in high risk cases
- Domestic Homicide Reviews (DHRs)
- Court Mandated Perpetrator Programme
- Voluntary perpetrator work (fee payable)
- New Police training programme

What we will do to improve services and address gaps

- Explore ways to improve the criminal justice pathway and court room experience in line with the new Code of Practice for Victims of Crime and new Witness Charter.
- Work with universal services that have regular contact with victims of VAWG to ensure that they are systematically assessing risk and are using the preferred risk assessment tool: the DASH Risk Indicator Checklist. We will ensure that services take up appropriate training in risk assessment and have a good understanding of how to respond.
- Undertake work to ensure compliance with the Safe Lives national quality assurance framework for MARACs with the aim of developing a more systematic approach to the identification of who is at risk, what risks they face and from whom, and how the risk can be reduced.
- Develop a model workplace policy for employers to adopt to ensure that employees affected by VAWG are protected and supported. This will be promoted through the Chamber of Commerce alongside an appropriate training package.
- Develop an improved approach to dealing with perpetrators which includes equipping frontline professionals with the skills to engage and work with them.
- Explore options to address the needs of women offenders with a history of DVA. This will include the consideration of community-based alternatives to a custodial sentence to divert vulnerable women away from crime and tackle the root causes of their offending.

Partnership

Key objective

Working in partnership to obtain the best outcome for victims and their families

Outcome

➡ Coordinated action across all services and partnerships, informed by consistent and coordinated policies, systems and leadership, in order to deliver the Violence Against Women Girls Strategy in Warwickshire

What we've got already

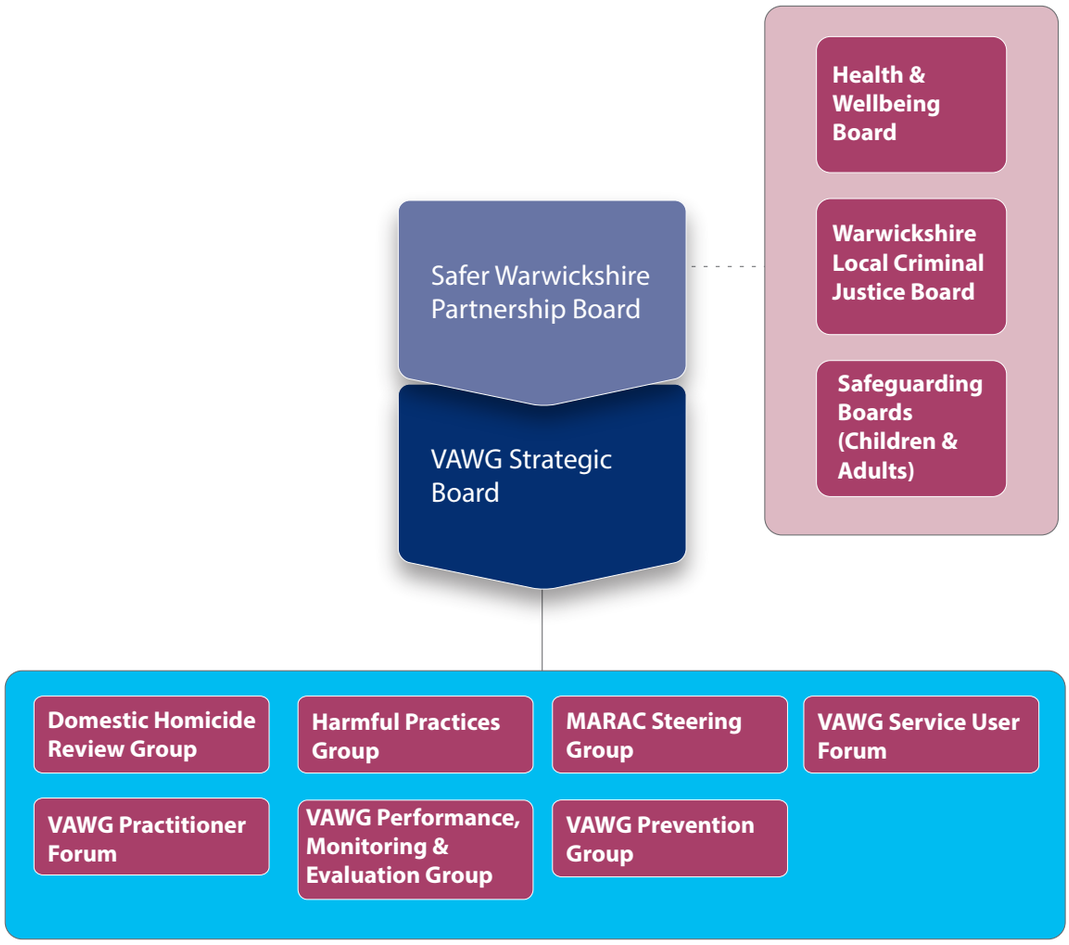
- Violence Against Women and Girls Strategic Board
- Safer Warwickshire Partnership Board and local Community Safety Partnerships
- Warwickshire Safeguarding Children Board
- Warwickshire Safeguarding Adults Board
- MARAC Steering Group
- Honour-Based Violence and Forced Marriage Group
- Specialist Domestic Abuse Court Steering Group
- Annual VAWG conferences

What we will do to improve services and address gaps

- Ensure that VAWG is a priority for all partners and partnerships whose work impacts on the VAWG agenda. This will include not only community safety partners but the Safeguarding Boards, the Health and Wellbeing Board, etc, and their associated strategies.
- Explore the concept of a "whole place community budget" as a means of delivering a coordinated, partnership response to those affected by VAWG, and increasing capacity to meet the needs of both medium and high risk victims.
- Explore options to improve information sharing between statutory and voluntary sector agencies.
- Deliver a programme of needs assessments on all forms of VAWG to ensure we fully understand prevalence in Warwickshire and to inform future service commissioning. We will ensure VAWG features in the Joint Strategic Needs Assessment.
- Develop core data requirements for services to support the ongoing assessment of need.
- Explore collaborative working options between agencies to increase capacity and improve the response to individuals and families affected by VAWG.
- Establish a VAWG Practitioner Forum for frontline professionals to come together and learn about the latest policy and practice developments, raise emerging issues and develop stronger working relationships. The Forum will report into the VAWG Board to ensure that any issues raised have an escalation route.
- Develop a VAWG performance dashboard which will support the VAWG Strategic Board in monitoring the success of the Strategy.

Appendix A

VAWG Partnership Governance Arrangements



Appendix B

What We've Got Already – Further Information

If you are affected by any of the issues covered within this document and would like someone to talk to, please visit www.talk2someone.org.uk or telephone the helpline on 0800 408 1552. In an emergency, please dial 999.

Prevention

Respect Yourself Campaign – Based in public health, the campaign involves provision of training to professionals so that they have the skills and expertise to support and change the behaviour of young people. Issues of domestic abuse, sexual violence and emotional wellbeing are integrated with messages about eating well and being healthy. The campaign also has a website for young people containing advice and information about services – www.respectyourself.info.

Taking Care Programme – Organised by the Warwickshire Safeguarding Children Board, this programme works with children in primary schools teaching them how to keep safe in a variety of situations. The programme covers empowerment, communication, self-esteem and other life skills, to help prevent abuse, reduce violence and promote life enhancing experiences.

Victim Support Domestic Violence and Relationship Abuse Project – Warwickshire is one of four pilot sites for this project which is funded by the DfE. It works with children aged four and over where they are living with domestic violence and abuse at home, and works with those aged thirteen and above at risk of being in their own abusive relationships. The project will also be developing work with schools to support teachers and other professionals. The project is funded until March 2015.

Coaching for a Healthy and Respectful Masculinity Programme – Offered by the Youth Justice Service in response to an increase in the number of young people serving community orders relating to sexual offences, or where discriminatory attitudes towards females have been identified during assessment.

Warwickshire Against Domestic Abuse helpline/website (single point of contact) – Warwickshire operates a single-point-of-contact for any member of the public concerned about domestic abuse or professionals with a query about services. This is run by the commissioned Domestic Abuse Support Service with the aim of not only offering support over the phone but being able to refer individuals to other specialist services where appropriate. WCC also maintains the WADA website which provides information and signposting – www.talk2someone.org.uk.

Forced Marriage and Honour-Based Violence "Statement of Intent" – Warwickshire has developed a "statement of Intent" which supports agencies in identifying and responding to FM and HBV. Warwickshire Safeguarding Children Board co-ordinates and delivers training on this issue which also includes legal and other tools for keeping victim-survivors safe.

Multi-agency training – Multi-agency training, funded by the County Council, is provided free of charge to all Warwickshire agencies and delivered by external trainers. Training has included identification and risk assessment of domestic abuse, understanding FM/ HBV, Forced Marriage Protection Orders, Domestic Violence and Disabled Women, Substance Misuse Awareness for DA practitioners, and most recently the

Freedom Programme for Professionals (experiential programme exploring the impact of living with DA). Warwickshire Safeguarding Children Board also offers a range of training on VAWG issues. This includes raising awareness of domestic abuse, domestic abuse and child protection, forced marriage awareness and child sexual exploitation awareness. Courses are free to member agencies and other agencies can attend for a small charge.

Single-agency training – In addition to the above, organisations also organise their own training e.g. police mandatory training is provided by an independent trainer and specialist training for children's and adult's social care staff is provided through the County Council's Learning and Development Team. In health, the Clinical Commissioning Group's designated nurse for child protection offers awareness raising to staff in GP and dental practices; Coventry and Warwickshire Partnership Trust (responsible for adult mental health) has a specialist DA nurse who works with the safeguarding team to develop training and awareness raising for staff.

CSE protocol and training – A procedure on child sexual exploitation (CSE) has been developed by WSCB and a programme of work is being devised with links to the Respect Yourself Campaign and the police. A new CSE sub-committee of the Warwickshire Safeguarding Children Board has been established to steer strategy development in this area.

Single-agency training – In addition to the above, organisations also organise their own training e.g. specialist training for children's and adult's social care staff is provided through the County Council's Learning and Development Team. In health, the Clinical Commissioning Group's designated nurse for child protection offers awareness raising to staff in GP and dental practices; Coventry and Warwickshire Partnership Trust (responsible for adult mental health) has a specialist DA nurse who works with the safeguarding team to develop training and awareness raising for staff.

Police training – Warwickshire & West Mercia Police Strategic Alliance have developed a revised training programme following the HMIC inspection into the police response to DA. All frontline officers are now required to do a new DA awareness course; DA specialist officers are required to complete the Freedom Programme; and a new requirement for all staff to undertake face-to-face sessions in relation to safeguarding and Protecting Vulnerable People is being pursued.

CSE protocol and training & CSE Unit – A procedure on child sexual exploitation (CSE) has been developed by WSCB and a programme of work is being devised with links to the Respect Yourself Campaign and the police. A new CSE sub-committee of the Warwickshire Safeguarding Children Board has been established to steer strategy development in this area. A multi-agency CSE unit has recently been established to improve Warwickshire's identification and response to CSE concerns.

Provision

Public sector services:

Police Protecting Vulnerable People Department – The Protecting Vulnerable People (PVP) department oversees the police response to child protection, safeguarding vulnerable adults, domestic abuse, missing persons and the management of registered sex offenders. Within the PVP sits a specialist Domestic Abuse Unit (DAU), which focuses on risk management/reduction in "high risk" domestic abuse cases reported to the police. Risk Officers in the DAU support high risk victims regardless of whether a charge is pursued against the perpetrator. The DAU is regaining a small specialist investigative function for high risk cases

as part of the drive to increase prosecution rates in domestic abuse cases. Within the PVP, a new multi-agency CSE team has also been established.

DA Social Work Team – Aside from the overarching safeguarding functions and services provided by Children's Social Care, Warwickshire operates a specialist domestic abuse social work team. The team specialises in undertaking risk assessments with perpetrators and preparing reports for family proceedings. The team also provides training to social care teams in Warwickshire. The team works closely with victims and children in complex cases open to social care focusing on safety planning, wishes and feelings. In partnership with Child and Adolescent Mental Health Services, the DA Social Work Team developed the Feeling Safe therapeutic group work programme for children and their non-abusing carers. The team is developing training for professionals across the county so this programme can be delivered in other settings i.e. Children's Centres and Schools. The team (which also includes the Missing Children's Worker) is based in the police DAU and is overseen by the specialist Children's Services Police Liaison Manager. Protocols are in place between Warwickshire Police and Children's Social Care to manage referrals from the police where an incident of domestic abuse has been reported and children are identified at the address.

Designated Young Persons Violence Advocate – The DfE have resourced training and accreditation for each local authority area to appoint a designated Young Persons Violence Advocate (YPVA). YPVAs work to ensure that young people experiencing serious intimate violence and abuse are offered easier access and engagement with someone who can offer help. They also provide training locally to other professionals.

Probation Women's Safety Workers – The National Probation Service (NPS) in Warwickshire resources a part-time Women's Safety Officer (WSO) and hosts a DA admin support that is directly funded by the Police and Crime Commissioner. The WSO provides support and signposting to other DA services and updates victims and new partners on the progress of perpetrators attending the domestic abuse group work programme, Building Better Relationships, which has replaced the Integrated Domestic Abuse Programme. The DA admin post checks all offenders either pre or post sentence where there is a Probation sentence outcome on the police information systems, to provide Offender Managers/ report authors both in the NPS and the local Community Rehabilitation Company (CRC) with detailed summary information of all police DA call outs. This information is essential to ensure that all offenders are accurately risk assessed and allocated to the correct organisation. The NPS are responsible for managing all dangerous high risk of serious harm and MAPPA eligible offenders and the CRC are responsible for managing low and medium risk offenders. Locally Probation has also developed a DA Workbook to be used on a one-to-one basis in DA cases where the offender is unsuitable or unavailable to attend the group work programme.

Services commissioned by the public sector:

National Domestic Violence Helpline – The national domestic violence helpline is delivered in partnership by Women's Aid and Refuge. The helpline, which operates 24 hours a day 365 days a year, offers support over the phone and refers women to local services.

Refuge Service – Commissioned by the County Council, there are 18 units of supported refuge accommodation available to women aged 16 and over and their children in Warwickshire. These units are currently provided in Nuneaton, Leamington and Rugby.

Domestic Abuse Support Service – Commissioned by the County Council, the Domestic Abuse Support Service provides practical and emotional support to victims or domestic abuse over the age of 16. The service offers drop-in sessions, support workers, specialist support for male and BME victims, sanctuary scheme, Independent Domestic Violence Advisors (IDVAs) and MARAC coordination.

IRIS GP Liaison Service – Commissioned by the County Council and the Office of the Police and Crime Commissioner, IRIS is a collaboration between primary care and the Domestic Abuse Support Service. Advocate Educators provide training and specialist DVA support to GP practices across Warwickshire. This service is funded by the Ministry of Justice

Victim Support – Victim Support provides a service to victims of all crime types. This is a national contract originally commissioned by the Ministry of Justice but has been devolved to Police and Crime Commissioners from 2015. Domestic abuse referrals to Victim Support are given priority and a response within 24 hours. If a service is requested each case is risk assessed and referrals made to other services e.g. DA Support Service if required. Victim Support have a team of dedicated DA volunteers which provide practical and emotional support to those not at high risk of DA.

Sexual Assault Referral Centre (SARC) – Coventry and Warwickshire SARC opened in 2013. It is a one-stop location for all victims of sexual violence to receive a high quality and empathetic health and forensic response and a careful assessment of their wider and on-going support needs. The SARC operates 24 hours, 365 days and takes referrals through self-referral, police and other agencies and provides direct access or referral to Independent Sexual Violence Advisors (ISVAs).

Independent Sexual Violence Advisors (ISVA) – Commissioned by Public Health, the ISVA service provides advocacy, mediation, practical support and signposting for sexual crime victims regardless of whether or not they have chosen to report this to the police.
Non-commissioned specialist services:

Domestic Abuse Counselling Service (DACS) – DACS is based in Nuneaton but offers a countywide service. The service is funded through a range of donors and they focus on three areas of work: victims of domestic abuse, perpetrators and support for the partners of perpetrators. In order to ensure the continuation of free counselling for victims, DACS has introduced a charge for the work with perpetrators.

Barnados: Child Sexual Exploitation Worker – Funded by the PCC this worker provides support to those at risk of and affected by child sexual exploitation. The worker is based in the Police DAU.

RoSA – In addition to providing Warwickshire's ISVA service, RoSA provides confidential counselling and support to victims and survivors of rape, sexual violence and sexual abuse. They work with both male and female survivors, young survivors from the age of five years and family members/carers/partners. Supervision and support is also offered to professionals working with survivors in any capacity.

Safeline – Safeline is a specialist charity offering confidential therapeutic and non-clinical support for survivors – men, women and young people – of sexual abuse and rape. Support is also offered to partners, carers and friends of surviviors and other interested parties who want to learn more about the subject of sexual abuse such as working with survivors and those who self-harm. This might include health professionals and teaching staff, who can attend workshops and training on these subjects.

Terrence Higgins Trust (THT) – THT offers a range of services for people affected by or living with HIV and STI's in Coventry and Warwickshire. One of the specialist services THT provide is SWISH (Sex Workers into Sexual Health). SWISH provides a range of sexual health and harm reduction services to women, men and the transgender community who sell sex both street and indoor based.

Generalist services working with individuals and families – There are a number of agencies and services in Warwickshire who do not provide specialist work on VAWG issues but who work with individuals and families affected by VAWG. These include Priority Families; Family and Parenting Service including Children's Centres and Common Assessment Framework (CAF) Team; The Recovery Partnership (alcohol and substance misuse service) and Youth Justice Service. Universal health services (hospitals, health visiting, midwifery, school nursing, GP's) and secondary health services, most significantly mental health, are all in contact with those affected by VAWG but at present do not offer specialist support.

Protection

Specialist Domestic Abuse Court – Warwickshire's Specialist Domestic Abuse Court (SDAC) provides protection and support to victims and witnesses of domestic abuse. It better enables appropriate sanctions to be made against perpetrators and manages cases more effectively thereby reducing delays and minimising risk. The SDAC increases agency coordination, including the Crown Court, in dealing with cases and holding perpetrators to account. The SDAC provides dedicated court sittings within the Magistrates Courts.

DASH Risk Indicator Checklist endorsed as preferred risk assessment tool – Warwickshire has endorsed the Domestic Abuse, Stalking and Honour Based Violence (DASH) Risk Indicator Checklist as the preferred tool for identifying risks to victims of domestic violence and abuse. Both statutory and voluntary agencies are encouraged and supported to use the DASH, though it is recognised that some agencies also have their own risk assessment tools.

MARACs to reduce risk in high risk cases – A Multi-Agency Risk Assessment Conference (MARAC) is a multi-agency meeting which domestic abuse victims who have been identified as at high risk of serious harm or homicide are referred to. The MARAC is attended by representatives from a range of statutory and voluntary sector agencies. The primary focus of the MARAC is to safeguard the adult victim. However, taking in to account the UK law which prioritises the safety of children, the MARAC will also make links with other multi-agency meetings and processes to safeguard children and manage the behaviour of the perpetrator. Warwickshire operates three localised MARACs each month which are overseen at county level.

Domestic Homicide Reviews (DHRs) – DHRs are a statutory responsibility for Community Safety Partnerships to review the circumstances in which the death (including suicide or 'near miss') of a person appears to have resulted from violence, abuse or neglect by a person to whom he (or she) was closely related/involved. They are aimed at identifying the lessons to be learnt from the incident of death/near miss. In Warwickshire, a shared risk approach to resourcing of DHRs and a single policy and procedure has been developed to ensure a consistent and shared approach throughout the county.

Court Mandated Perpetrator Programme – Warwickshire and West Mercia Community Rehabilitation Company deliver an accredited group work programme, the Building Better Relationships Programme, for perpetrators of domestic violence and abuse as either a condition of a Community Order or Suspended Sentence Order or as a licence condition for offenders released from prison.

Voluntary perpetrator work (fee payable) – Outside of the criminal justice system there is little available to challenge perpetrators of VAWG. DACS is the only agency in Warwickshire offering work with perpetrators. DACS undertake an initial assessment to ascertain resistance to work; 6 weeks work of challenge; and if able to engage further then therapeutic work through 10 weekly modules based on individual history, current circumstances and patterns of relating.

Partnership

Violence Against Women and Girls Strategic Board – The VAWG Strategic Board was established in 2013 in response to an identified strategic gap. The Board is responsible for the VAWG strategy and will oversee delivery of the implementation plan. It is chaired by the Deputy Director of Public Health and reports to the Safer Warwickshire Partnership Board. VAWG partnership governance arrangements are summarised at Appendix A.

Safer Warwickshire Partnership Board and local Community Safety Partnerships – The VAWG Board reports into the Safer Warwickshire Partnership Board at each meeting. Violence is a priority area of work for the Board and the local CSPs.

Warwickshire Safeguarding Children Board – The Warwickshire Safeguarding Children Board is an interagency forum for agreeing how the different services and professional groups should cooperate to safeguard children, and make sure that local arrangements work effectively to bring about good outcomes for children in Warwickshire. On the subject of VAWG, the Board provides on-going training on domestic abuse and held a conference on forced marriage and honour based violence in 2012. The 2013 annual conference focused on CSE.

Warwickshire Safeguarding Adults Board – Works in a similar way to the WSCB but on issues relating to adult safeguarding.

MARAC Steering Group – Warwickshire's MARACs are overseen by a MARAC Steering Group which aims to provide strategic governance to the MARAC in order to reduce repeat victimisation and reduce levels of harm posed to high risk victims of domestic abuse in Warwickshire, as well as provide quality assurance of the MARAC process. The Group reports into the VAWG Board.

Honour-Based Violence and Forced Marriage Group – This is a multi-agency group which is working together to combat all forms of HBV and FM in the county. The group draws its membership from statutory and voluntary sectors and reports to the VAWG Board. The group has developed a specific *implementation* plan to tackle this issue.

Specialist Domestic Abuse Court Steering Group – A multi-agency group which guides and monitors the work of the Specialist Domestic Abuse Court. This Group reports into the Local Criminal Justice Board.
VAWG Annual conference – Annual conferences are held to review progress and consider new developments in the VAWG arena. In 2014, the annual conference focused on learning from Domestic Homicide Reviews.

safe in... warwickshire

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Item 7

Health and Well-Being Board

Wednesday 8th July 2015

Joint Health and Social Care Self-Assessment Framework Action Plan 2015-2016

Recommendation

Health and Well-being Board endorse and support implementation of Warwickshire's Joint Health and Social Care Assessment Improvement Plan.

1. Background

1.1 The Learning Disability Health Self-Assessment started being used in England in 2007/2008. It has become an important guide for the NHS and Local Authorities. It has helped them to recognise the overall needs, experience and wishes of young people and adults with learning disabilities and their carers. This has made it easier to bring these perspectives into the tasks of determining local commissioning priorities and monitoring services.

1.2 The Learning Disability Health Self-Assessment has helped to improve services for people with a learning disability in many parts of the country by raising awareness of their health needs, supporting the case for increased health and local authority resources and improving inter-agency co-operation and co-ordination. However, the events at Winterbourne View, and subsequent investigations, have demonstrated there is still much to be done. As a result of this, the signatories to Transforming Care and the Winterbourne Concordat agreed to implement a joint health and social care self-assessment framework.

1.3 The Joint Health and Social Care Learning Disability Self-Assessment Framework (JHSCSAF) has been drafted collaboratively by learning disability specialists from the former Strategic Health Authority, the Association of Directors of Adult Social Services (ADASS), NHS England and members of the Winterbourne View Joint Improvement Programme Board. Intended to support all commissioners (Local Authorities, Clinical Commissioning Groups and NHS England) this jointly-created tool offers a robust and consistent framework to document a shared perspective of the services available across the full spectrum of health and social care in all local areas across the country. The JHSCSAF is an annual process and whilst not mandated it is seen as best practice to support the health and social care system to deliver their statutory responsibilities.

1.4 Consequently, the JHSCSAF improvement plan is designed to ensure a targeted approach to improving health inequalities and achieving equal and fulfilling citizenship. It is intended to help commissioners and local people assess how well people with a learning disability are supported to stay healthy, be safe and live well and to take action to deliver improvements.

2. Joint Health and Social Care Self-Assessment 2013/14

2.1 In December 2014 Warwickshire County Council collated and submitted the results of the Joint Health and Social Care Assessment Framework on behalf of health and social care commissioners. The joint assessment had three overarching themes - **Stay Healthy**, **Be Safe** and **Live Well**. The information collated was then RAG rated in accordance with specific outcome measures.

2.2 The agencies that contributed towards the self-assessment: Warwickshire County Council, Warwickshire North CCG, Coventry and Rugby CCG, South Warwickshire CCG, Arden Gem Commissioning Support Unit and Coventry and Warwickshire Partnership Trust were required to produce an improvement plan for the red and amber areas. In response a multi-agency improvement action plan has been devised to support progress towards achieving a green rating.

3. Joint Health and Social Care Self-Assessment Framework Action Plan 2015-2016

3.1 The action plan (attached) identifies what needs to be done to support progress towards achieving a green status. It also identifies the lead agency that is required to take responsibility for driving forward each action.

3.2 Warwickshire County Council have conducted engagement and consultation sessions with customers, carers, providers and key stakeholders regarding the RAG Rating and Improvement Plan. Learning Disability representatives from Warwickshire's Learning Disability Partnership Board also attended the Regional Peer Validation Event held in February 2015.

3.4 It is anticipated that a time limited steering group will be formed to agree ownership of the specific domains within the improvement action plan. There will be representation from key stakeholders from within the local authority and CCG's. This will be undertaken in conjunction with Coventry City Council as we share common stakeholders and have some shared challenges. Each section within the plan will have a nominated lead from either the local authority or CCG's. Each lead will be required to produce a detailed action plan with clear milestones to monitor progress.

3.5 In addition to this, a small working party reporting to the Learning Disability Partnership Board will meet bi-monthly to oversee and drive through the actions required. The progress towards achieving the milestones will be

reported to the Learning Disability Partnership Board at every meeting. Progress reports will be provided to the Health and Well-being Board.

4. Priority Areas

4.1 The action plan highlights the key focus areas for improvement this year. These include:

- The need for robust health data collection systems to ensure inequalities are highlighted and consequently addressed. This is a national as well as local issue.
- The need to support Primary Care to deliver annual health checks and health action plans.
- The provision of advice, training and education regarding maintaining healthy lifestyles.
- Increasing the uptake of national screening programmes and addressing the significant inequalities in access to mainstream screening services experienced by people with a learning disability in Warwickshire.
- Ensuring robust quality assurance mechanisms are in place to audit and scrutinise the quality of provision on both an individual and organisational level across social care and health.
- A focus on employment – this is also a key action within the Learning Disability Statement of Intent 2015-2020. People with a learning disability have stated loud and clear, during the engagement period, that they want better job opportunities.

4.2 The improvement action plan impacts all parties and will require actions from the CCG particularly in relation to primary care providers.

4.3 It is important to recognise and acknowledge that some of the actions required to progress the JHSCSAF need support and action on a national level. This has been raised with the National Learning Disability Public Health Observatory and Improving Health & Lives (IHal). These issues have consistently not achieved a green rag rating nationally;

- Section A Staying Healthy – LD Registers, Annual Health Checks and Health Action Plans – whilst they are recognised as good practice primary care are not mandated to undertake this. GP Practices choose via the Directed Enhanced Service they sign up to on an annual basis.
- Section A – Electronic Flagging System – this is a health system that will identify if an individual has a learning disability and therefore may require reasonable adjustments. Again whilst this is recognised as good practice in primary and secondary care there are no robust systems nationally or locally. Actions to overcome data protection and consent issues have been implemented across the region.

4.4 The JHSCSAF and action plan is directly linked to the new Joint Adult Learning Disability Statement of Intent, 'It's My Life' 2015-2020. The Statement of Intent has been subject to extensive stakeholder engagement and there has been overwhelming support of the commissioning intentions detailed within the plan. It is currently progressing through the governance

arrangements of CCG's and will be considered for approval by Warwickshire County Council Cabinet on 16th July 2015.

4.5 The JHSCSAF, Joint Learning Disability Statement of Intent, Coventry and Warwickshire's local response to Winterbourne View Hospital (joint plan) and Arden's Transforming Care Fast Track status all highlight the need to progress integrating working across health and social care to more effectively meet the needs of people with a learning disability in Warwickshire. The Statement of Intent and joint plan reinforce the need to actively progress joint and collaborative assessment and care management and commissioning arrangements for this population; with a strong presumption nationally that this will undertaken through pooled budgets.

5. Conclusion

5.1 The aim of this framework is to provide a single, consistent way of identifying the challenges in meeting the needs of people with learning disabilities, and documenting the extent to which the shared goals of providing quality care and support are met.

5.2 Locally, this will help Learning Disability Partnership Boards, Health and Wellbeing Boards, CCGs and Local Authorities identify the priorities, levers and opportunities to improve care and tackle health and social care inequalities in their areas. It should also provide a sound evidence base against which to monitor progress.

Background Papers

Winterbourne View Final Report Annex B (WBV)
Adult Social Care Outcomes Framework 2013-14 (ASCOF)
Public Health Outcomes Framework 2013-2016 (PHOF)
The Health Equalities Framework (HEF) - An outcomes framework based on the determinants of health inequalities (HEF)
National Health Service Outcomes Framework 2013-14 (NHSOF)

There are numerous reports on the Improving Health and Lives (IHAL) website about the health and wellbeing of people with learning disabilities.

IHAL: http://www.improvinghealthandlives.org.uk/publications/year/2011

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Item 7 Appendix

Joint Health and Social Care Self-Assessment Framework – Learning Disabilities

The Context

The Joint Health & Social Care Learning Disability Self-Assessment Framework (JHSCSAF) has been developed to align as consistently as possible with some key national policy and guidance in direct response to the consultation undertaken 2012-2013.

Drivers

Winterbourne View Final Report Annex B (WBV)
Adult Social Care Outcomes Framework 2013-14 (ASCOF)
Public Health Outcomes Framework 2013-2016 (PHOF)
The Health Equalities Framework (HEF) An outcomes framework based on the determinants of health inequalities (HEF)
National Health Service Outcomes Framework 2013-14 (NHSOF)

THE MEASURES

Section A - Staying Healthy
Section B – Being Safe
Section C – Living Well

A multi-agency response was compiled by Warwickshire County Council (WCC). This was submitted in December 2014. This Action Plan details the multi-agency collaboration and actions required for RED & AMBER rag rated areas.

Background

The Joint Self-Assessment Framework outcomes for 2013-2014 were partly achieved. It is important to recognise that the outcome measures and thresholds for the RAG rating for 2013-14 SAF do not correlate with the previous year. Therefore, whilst some progress was made this unfortunately is not recognised in the recent self-assessment. Improving Health & Lives (IHAL) plan for the outcomes measures to remain the same for next year's SAF. This will allow for local progress to be monitored, measured and compared at a national and regional level.

Process

A lead agency has been identified for each action area. The expectation being that the lead agency will identify a named lead that will devise a delivery plan, where required, to monitor and report on progress on a bi-monthly basis.

Monitoring

A Small Working Group affiliated to the Learning Disability Partnership Board will be established and meet on a bi-monthly basis. Progress towards this action plan will be monitored by the Learning Disability Partnership Boards and the Health and Well-being Board. A quarterly progress report will be written highlighting progress made risks to achieving targets and contingency plans, where required, to ensure success.

Area	Title	2013	2014
A1	LD QoF Register	AMBER	RED
A2	Screening – Obesity, CVD, Diabetes	RED	RED
A3	Annual Health Checks	AMBER	AMBER
A4	Health Action Plans	AMBER	AMBER
A5	Screening – Cervical, Breast & Bowel	RED	RED
A6	Electronic Alert	RED	RED
A7	Acute Liaison	GREEN	GREEN
A8	NHS Commissioned Care (Access)	AMBER	AMBER
A9	Offender Health & Criminal Justice System	AMBER	AMBER

Area	Title	2013 Rating	2014 Rating
B1	Regular Care Reviews	AMBER	RED
B2	Contract Compliance Assurance	RED	RED
B3	Assurance of Monitor Compliance (FT)	GREEN	GREEN
B4	Assurance of Safeguarding	AMBER	GREEN
B5	Recruitment & Training Involvement	AMBER	AMBER
B6	Compassion, dignity and respect	AMBER	GREEN
B7	Equality Impact Assessments	GREEN	GREEN
B8	Complaints lead to changes	N/A	AMBER

Area	Title	2013 Rating	2014 Rating
C1	Effective Joint Working	AMBER	AMBER
C2	Local Amenities	AMBER	AMBER
C3	Arts & Culture	AMBER	AMBER
C4	Sports & Leisure	AMBER	AMBER
C5	Employment	AMBER	AMBER
C6	Preparing for Adulthood	AMBER	AMBER
C7	Involvement & Co-production	AMBER	AMBER
C8	Carers Satisfaction	AMBER	GREEN

A1

Rationale

There is concern that many people with learning disability are unknown to services and do not subsequently get access to the healthcare that they need. This indicator aims to encourage the building of accurate registers to ensure equity of access to healthcare for people with learning disability. Using available prevalence data will allow some indicative benchmarking around whether numbers of people on registers are likely to be accurate. All people with learning disability are not being identified via the QOF and therefore local data needs to be scrutinised and systems put in place within primary care to ensure that all people are put onto the QOF register irrespective of if they are known to social services, or not.

Option – use a single standardised health check template & purchasing data collection system

RAG Rating Outcome Descriptor	Current Situation / What are the Issues	Action to achieve Green	Responsibility
Learning Disability and Down Syndrome Registers reflect prevalence data but are not stratified in every required data set (e.g. age / complexity)	28/76 GP Practices responded to this Mi-quest search query: people are registered as having a Learning Disability. Registers are currently validated via CWPT Community Nursing Teams however not all are validated on an annual basis. WCC, CWPT & GP registers are triangulated A standardised health check template is available this template also capture syndrome specific diagnosis Lack of accurate data regarding people with Down Syndrome	Each practice will ensure that Learning Disability and Down Syndrome Registers reflect prevalence data AND Data is stratified in every required data set (e.g. age / complexity / Autism diagnosis / BME etc.) CCG's will are mandated to provide o GP's with information and training. o GP's with guidance regarding Read Coding DS, Autism, and BME as per requirements. o To create reports for data extraction to capture this information	**Lead:** LAT & CCG's **Contributors**: CWPT & ACSU **Stakeholder's**: WCC

A2

Rationale

Currently there is little specific comparative data between the health of people with learning disability and the non-learning disabled population, yet we know that people with learning disability have poorer access to healthcare and die younger than their non-learning disabled peers. This means that there is a lack of robust data from which the JSNA and Health & Well-Being Strategy can be informed. This indicator looks at one specific clinical area where there may be an inequity of access to health screening and subsequent prevention of disease. Gathering this data enables us to respond more effectively to individual clinical needs and be in a very strong position for future strategic planning of reasonably adjusted health services for people with learning disability.

Option – purchase or create standardised data collection system

RAG Rating Outcome Descriptor	Current Situation / What are the Issues	Action to achieve Green	Responsibility
Evidence that people with learning disability are accessing disease prevention, health screening and health promotion in each of the following health areas: Obesity, Diabetes, Cardio vascular disease Epilepsy but NO COMPARATIVE DATA of the population that do not have a learning disability	There is some comparative data which does highlight health inequalities in Warwickshire;	o CCG's must ensure comparative data in all of the health areas listed in the descriptor at each of the following levels; o LOCAL AREA TEAM o CLINICAL COMMISSIONING GROUP o INDIVIDUAL GP PRACTICE o Commissioning / creating a robust data collection system agreed and implemented by all agencies. o WCC have produced a JSNA for pwld	**Lead:** CCG's **Contributors:** GP's, WCC, ACSU & LAT **Stakeholders**: CWPT WCC

Area / Screening	LD %	General Population %
Cervical	25.6	75.8
Breast	15.1	77.7
Bowel	23	62
Obesity +	40	22
Epilepsy	26	0.6
Diabetes	9.2	6.0
CHD	1.2	3.2

		No standardised data collection systems		

A3

Rationale

Whilst many practices sign up to the LD DES there is significant variability in the numbers of annual health checks that are actually completed. Underlying health conditions continue to be missed leading to poor health, sometimes death and long term costly interventions. Annual health checks have been shown to effectively reduce health inequality and improve health outcomes. Therefore a population wide 'roll out' at a local level is an essential action required to secure long term and consistent improvement in the health of this vulnerable group

Available Option – use of standardised annual health check template with intergrated health action plan

RAG Rating Outcome Descriptor	Current Situation / What are the Issues	Action to achieve Green	Responsibility
Annual Health Checks Registers Validated within past 12 months 80% of people with learning disability GP DES Register had an annual health check.	Registers have been validated however this is not on an annual basis. GP's are offered the support of HFN however this offer isn't always taken up. High number of GP's signed up to LD DES: South 36/36 North 27/28 Rugby 7/12 Warwickshire rates of annual health checks just below 50% in 2012-13. 775 people had a health check. 59 % health checks were completed in2013-14 (n=1'018) The national average is 42%.	o CCG's will work with PH observatory/ Primary Care info to identify ways of collecting/accessing screening data / uptake for LD. o Registers will be validated on a minimum of an annual basis and process in place for all people aged 18 or over to be put on register. o 80% of people with learning disability registered with a GP signed up to the DES will have an annual health check	**Lead:** LAT & CCG **Contributors:** ACSU & CWPT **Stakeholders:** WCC

A4	Rationale The LD DES guidance puts the onus on GPs to generate meaningful health action plans at the time of the annual health check to address health priorities. Integrated annual health checks and health action plans will ensure person centred care and improved individualised health outcomes. This indicator provides an opportunity to improve primary, secondary and specialist community team engagement which can support reduction inappropriate secondary care referrals. It also provides the person with a learning disability (and their Carer, if appropriate) with a clear understanding of 'what needs to happen' over the next 12 months. **Available Option – use of a standardised health assessment template that generates a Health Action Plan**			
	RAG Rating Outcome Descriptor	**Current Situation / What are the Issues**	**Action to achieve Green**	**Responsibility**
	Health Action Plans **Health Action Plans** are generated at the time of Annual Health Checks (AHC) in primary care and these include a small number of health improving activities. Refer to RCG guidance around health action plans.	GP Annual health check data do not currently demonstrate that a Health Action plan has been completed following a health check	o CCG's must ensure that GP HAP contain specific health improvement activities and are contained within a template for 80% of patients. o Include attendance at annual health checks and completion of HAP in all LD Service Specifications.	**Lead:** LAT & CCG **Contributors**: CWPT & LD Providers **Stakeholders: WCC**
A5	Rationale Currently there is little specific comparative data between the health of people with learning disability and the non-learning disabled population, yet we know that people with learning disability have poorer access to healthcare and die younger than their non-learning disabled peers. This means that there is a lack of robust data from which the JSNA and Health & Well-Being Strategy can be informed. This indicator looks at one specific clinical area where there may be an inequity of access to health screening and subsequent prevention of disease. Gathering this data enables us to respond more effectively to individual clinical needs and be in a very strong position for future strategic planning of reasonably adjusted health services for people with learning disability. **Available Option – to purchase (or create data) a collection and reporting system**			

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<tr><th>RAG Rating Outcome Descriptor</th><th>Current Situation / What are the Issues</th><th>Action to achieve Green</th><th>Responsibility</th></tr>
<tr>
<td>Screening
Comparative data of people with learning disability vs. similar age cohort of non-learning disabled population in each health screening area for :
a) Cervical screening
b) Breast screening
c) Bowel Screening (as applicable)</td>
<td>
<table>
<tr><th>Area / Screening</th><th>LD %</th><th>General Population %</th></tr>
<tr><td>Cervical</td><td>25.6</td><td>75.8</td></tr>
<tr><td>Breast</td><td>15.1</td><td>77.7</td></tr>
<tr><td>Bowel</td><td>23</td><td>62</td></tr>
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</td>
<td>o CCG to commission reliable reporting mechanism to regularly produce numbers of completed health screening for eligible people who have a learning disability in every screening group; Now available via Mi-quest search
AND
o Comparative data of screening rates in the non LD population for every screening group; Now available via Mi-quest search
AND Action needed
o Scrutinised exception reporting and evidence of reasonably adjusted services</td>
<td>Lead: LAT & CCG

Contributors:
WCC

Stakeholders:
CWPT</td>
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</td></tr>
<tr><td>A6</td><td><u>Rationale</u>
Healthcare providers frequently state that having no prior warning of somebody’s learning disability and specific needs resulting from their disability, prevents them from being able to fully meet their needs through reasonable adjustments. This indicator encourages the development of standardised local systems to address this problem. The patient journey of people with learning disabilities needs to be made trackable as identified within primary and secondary care. By including LD status in your referral you will give notice to the secondary care provider enabling them to make reasonable adjustments if necessary. This will lead to a potential reduction in DNA’s, length of stay</td></tr>
</table>

and inappropriate repeat attendances.

Note – Nationally this issue has not been resolved & solutions are being explored sub-regionally

RAG Rating Outcome Descriptor	Current Situation / What are the Issues	Action to achieve Green	Responsibility
Primary care communication of LD status to other healthcare providers	There are no LOCAL AREA TEAM/CLINICAL COMMISSIONING GROUP wide system for ensuring LD status and suggested reasonable adjustments are included in the referrals However, Acute Liaison Nurses are in post & there are non-electronic systems for identifying and 'flagging' people with a learning disability who have been admitted.	o Develop an electronic alert system with secondary care and other healthcare providers for identifying LD status on referrals based upon the L.D identification in primary care and acting on any reasonable adjustments suggested. Also ensuring that both an individual's capacity and consent are inherent to the system employed o Sub-regional collaboration on developing an electronic flagging system are being explored	**Lead:** LAT & CCG **Contributors:** WCC, CWPT & Secondary Care **Stakeholders:** ALL

A8

<u>Rationale</u>

Any health service accessed by a person with learning disability may need to reasonably adjust what it does in order to meet their additional needs. This indicator will capture examples of where this is happening well in the wider primary care community. In order for reasonable adjustments to occur routinely services need a way to both record patients' learning disability status and describe the required reasonable adjustments. This measure is about universal services NOT those services specifically commissioned for people with a learning disability.

	RAG Rating Outcome Descriptor	Current Situation / What are the Issues	Action to achieve Green	Responsibility
	NHS commissioned primary and community care: o Dentistry o Optometry o Community Pharmacy o Podiatry o Community nursing and midwifery This measure is about universal services **NOT** those services specifically commissioned for people with a learning disability.	Some of these services are able to provide evidence of reasonable adjustments and plans for service improvements	o CCG & CWPT must ensure that all people with learning disability accessing/using service are known and patient experience is captured o All of these services must provide evidence of reasonable adjustments and plans for service improvement	**Lead:** CCG & LAT **Contributors:** CWPT **Stakeholders:** WCC
A9	<u>Rationale</u> Evidence suggests 7% of the prison population - and greater number in the criminal justice system, have learning disabilities. It is important that these individuals have access to a range of health services. Information gathered from local criminal justice systems on prevalence will inform Provision, regarding: •what is available including prevention, •development required and •ensuring health services are accessible.			
	RAG Rating Outcome Descriptor	**Current Situation / What are the Issues**	**Action to achieve Green**	**Responsibility**
	Offender Health & the Criminal Justice System	An assessment process has been agreed to identify people with LD in all offender health services	o Local Commissioners will have good data about the numbers /prevalence of people with a	**Lead:** CCG **Contributors:**

		e.g. learning disability screening questionnaire. Offender health teams receive LD awareness training to know how best to support individuals to meet their health needs AND There is easy read accessible information provided by the criminal justice system.	learning disability in the CJS. Local commissioners have are working with regional, specialist prison health commissioners o CWPT must ensure there is good information on health needs of people with LD in local prisons /wider criminal justice system and a clear plan on how needs can be met. Prisoners and young offenders with LD have had an annual health check, or are scheduled to have one within 6 months (either as part of custodial sentence or following release, as part of GP health check cycle). They are offered a Health Action Plan.	CWPT **Stakeholders:** WCC
B1	Rationale **Regular Care Review – This measure is about ensuring that in all cases where a person with a learning disability is receiving care and support from commissioned services, the needs behind this support are reviewed in a co-productive and inclusive way.**			
	RAG Rating Outcome Descriptor	**Current Situation / What are the Issues**	**Action to achieve Green**	**Responsibility**
	Regular Care Review - Commissioners know of all funded individual health and social care packages for people with learning disability across all life stages and have mechanisms in	Evidence of less than 90% of all care packages including personal budgets reviewed at least annually	o All commissioning bodies must evidence that systems are in place to deliver 100% reviews of all care packages including	**Lead:** CCG & WCC **Contributors:**

	place for on-going placement monitoring and individual reviews. Type of contact is described (face to face or telephone etc.)		personal budgets reviewed at least annually. o This is a priority / focus area for Social Care.	CCG, WCC, ACSU, & CWPT **Stakeholders:**

B2

Rationale

This measure asks local authorities to demonstrate how thorough their contracting processes are. This is important as contract monitoring is one of the first methods of scrutiny and assurance. *(NOTE: the rationale guidance only refers to LA's however, the indicators also refer to health & social care commissioned services)*

RAG Rating Outcome Descriptor	Current Situation / What are the Issues	Action to achieve Green	Responsibility
Contract compliance assurance – For services primarily commissioned for people with a learning disability and their family carers	Less than 90% of health and social care commissioned services for people with learning disability have; - had full scheduled annual contract and service reviews. - Demonstrate a diverse range of indicators and outcomes supporting quality assurance	WCC & CCG's will develop systems and processes are to ensure100% of health and social care commissioned services for people with learning disability have; - had full scheduled annual contract and service reviews. - Demonstrate a diverse range of indicators and outcomes supporting quality assurance - Evidence that the number regularly reviewed is reported at executive board level in both Health & Social care.	**Lead:** WCC & CCG's **Contributors:** CCG, WCC **Stakeholders: Commissioner (Quality) WCC & Lead Nurse Quality CCG's**

			- This is a focus area for social care and a 6 month quality pilot will assist in informing future quality assurance methods	
B4	Rationale Governance, safety, quality and monitoring. Learning from Winterbourne View Review and good commissioning practice has identified failures and risks within the quality and safety of people's placements, both individually and across organisations. This must cease. This measure asks localities to robustly evidence the safety and safeguarding for people with learning disability in all provided services and support.			
	RAG Rating Outcome Descriptor	**Current Situation / What are the Issues**	**Action to achieve Green**	**Responsibility**
	Assurance of safeguarding for people with learning disability in **all** provided services and support This measure must be read in the context of an expectation that ALL sectors, Private, Public and Voluntary / Community are delivering equal safety and assurance.	Regular Board Reporting and key points and lessons learned are included in action plans Evidence that Learning Disability Partnership Board(s) and/or health sub group(s) involved in reviewing progress The provider can demonstrate delivery of Safeguarding adults within the current Statutory Accountability and Assurance Framework includes people with learning disabilities. This assurance is gained using DH Safeguarding Adults Assurance (SAAF) framework or equivalent. Every learning disability provider	o WCC & CCG's must ensure there are robust, transparent and sustainable governance arrangements in place in all statutory organisations including Local Safeguarding Adults Board(s), Health & Well-Being Boards and Clinical Commissioning Executive Boards o Ensure the delivery of Safeguarding adults within the current Statutory Accountability and Assurance Framework includes people with learning disabilities. This assurance is gained using DH Safeguarding Adults Assurance (SAAF)	**Lead:** WCC & CCG's **Contributors:** Secondary Care & CWPT **Stakeholders:** All providers

		service have assured their board that quality, safety and safeguarding for people with learning disabilities is a Clinical and strategic priority within all services.	framework or equivalent. o Every learning disability provider service must have assured their board and others that quality, safety and safeguarding for people with learning disabilities is a clinical and strategic priority within all services. Key lessons from national reviews are included. o Provide evidence of active provider forum work addressing the learning disability agenda	
B5	Rationale This measure is about the nature and benefit of involving 'Experts by Experiences'. A number of best practice reports suggested that there are improved outcomes when families and people with learning disabilities are involved in services. Localities should provide evidence from providers of routinely involving people with learning disabilities and family carers in recruitment and training.			
	RAG Rating Outcome Descriptor	**Current Situation / What are the Issues**	**Action to achieve Green**	**Responsibility**
	Training and Recruitment – Involvement	LD specific services: evidence of 90% of services involving people with learning disability and families in recruitment/ training and monitoring of staff. Some evidence of universal services embedding LD	o WCC & CCG's must ensure that LD specific services: can evidence of 100% of services involving people with learning disability and families in recruitment/ training and monitoring of staff including advocates.	**Lead:** WCC & CCG **Contributors:** ACSU & CWPT **Stakeholders:**

		awareness training and making reasonable adjustments for people with a learning disability and family carers to access and use the services.	o Commissioners must specifically ensure that raising the need for LD awareness training and reasonable adjustment within universal services in line with consultation by people with a learning disability and family carers. o Universal services must embed LD awareness training and making reasonable adjustments for people with a learning disability and family carers to access and use the services AND of universal service providers sharing good practice and experience.	All providers
B6	Rationale Commissioners can show that providers are required to demonstrate that recruitment and management of staff is based on compassion, dignity and respect and comes from a value based culture. It is clear from the Winterbourne View report and wider evidence from Six Lives and the Confidential Inquiry that compassion is core to the best care for people. This measure asks commissioners to think about how this can be assured in all care for people with a learning disability. This is a challenging measure but it is felt to be vital that all areas consider this. In this year's self-assessment commissioners are requested to ensure that this question is answered by people who use services and their family members. The reason for this is that they are best placed to answer the question on the basis of their experience. This question will be best answered by the local Learning Disability Partnership Board (or equivalent) representatives of family carers and self-advocates.			
	RAG Rating Outcome Descriptor	**Current Situation / What are the Issues**	**Action to achieve Green**	**Responsibility**
	Commissioners can demonstrate that providers are required to demonstrate that	LD Specific Provision: Some evidence of commissioning	o WCC & CCG's must provide evidence of commissioning	**Lead:** CCG's & WCC

	recruitment and management of staff is based on compassion, dignity and respect and comes from a value based culture. This is a challenging measure but it is felt to be vital that all areas consider this. Compassion, dignity and respect. To be answered by self-advocates and family - carers	practice that drives providers to demonstrate compassionate care and value base recruitment & management of the workforce No clear evidence of this approach in relevant universal services An on-line survey was conducted and feedback sought via Guideposts & LDPB.	practice that drives providers to demonstrate compassionate care and value base recruitment & management of the workforce o Evidence this approach in relevant universal services o Develop systems to capture on-going feedback from family carers	

B8	Rationale This standard requires evidence of a learning organisation that integrates, learning from complaints, incidents, patient, carer and staff feedback with wider learning from national reports and incidents to improve the quality safety, safeguarding and provision to people with learning disabilities. Failings by Services to respond to concerns raised about the quality of services are at the centre of the Winterbourne View Review. Evidence need to be provided of robust partnership working to assure the safety, quality and safeguarding of people's commissioned placements			
	RAG Rating Outcome Descriptor	**Current Situation / What are the Issues**	**Action to achieve Green**	**Responsibility**
	Commissioners can demonstrate that all providers change practice as a result of feedback from complaints, whistleblowing	Evidence that 50 % of commissioned practice and contracts require evidence of	o WCC & CCG's must demonstrate that 90 % of commissioned practice and contracts require	**Lead:** WCC & CCG's

	experience	improved practice, based on the use of patient experience data, and the review and analysis of complaints. There is evidence of effective use of a Whistle-blowing policy where appropriate.	evidence of improved practice, based on the use of patient experience data, and the review and analysis of complaints. There is evidence of effective use of a Whistle-blowing policy where appropriate.	**Contributors:** CWPT & ACSU
B9	Rationale Mental Capacity Act (MCA). MENCAP's report Death by Indifference: 74 Deaths and Counting highlighted the inconsistent application of the MCA 2005. This standard requires evidence that the five principles of the MCA are understood and consistently embedded within and across organisations to ensure safe, equal and high quality healthcare people with learning disability. Organisations are asked to demonstrate that there is evidence of routine monitoring across the whole organisation of implementation of MCA principles **Action – All providers must develop systems which routinely check the implementation of the MCA.**			
	RAG Rating Outcome Descriptor	**Current Situation / What are the Issues**	**Action to achieve Green**	**Responsibility**
	Mental Capacity Act & Deprivation of Liberty	There is limited evidence that organisations routinely check implementation of MCA guidance relating to decision making, capacity, and restrictions	All providers will have well understood policies in place and routinely monitor implementation of these in relation to, the Mental Capacity Act (including restraint, consent and deprivation of liberty). The provider can evidence action taken to improve and embed practice where necessary	**Lead:** WCC & CCG's **Contributors:** ACSU & CWPT
C1	Rationale This measure looks for the evidence that formal arrangements are in pace that foster the best joint working between commissioners. Informal arrangements and evidence of good practice are also welcomed, as are future plans, particularly where these have been signed up to formally if not yet implemented.			

	RAG Rating Outcome Descriptor	**Current Situation / What are the Issues**	**Action to achieve Green**	**Responsibility**
	Effective Joint Working	Commissioners can provide evidence of integrated governance structures. Monitoring is undertaken jointly and key partners are involved at Partnership Board level. Joint commissioning functions are in place – Joint Commissioning Board.	o WCC & CCG's will develop well-functioning formal partnership agreements and arrangements between health and social care organisations. o Ensure there are agreements in place and evidence of working towards pooled budgets or pooled budget arrangements, joint commissioning structures, intentions, monitoring and reporting arrangements.	**Lead:** CCG's & WCC **Contributors:** ACSU
C2	Rationale This measure asks for evidence of reasonable adjustment within providers and across the broader strategies for the community, reflecting the specialist needs of people with a learning disability.			
	RAG Rating Outcome Descriptor	**Current Situation / What are the Issues**	**Action to achieve Green**	**Responsibility**
	Local amenities and transport	Local examples of people with learning disability having access to reasonably adjusted facilities and services that enable them to participate fully and build / maintain social networks e.g.	o WCC will ensure there are extensive and equitably geographically distributed examples of people with learning disability having access to reasonably adjusted facilities and	**Lead:** WCC

		support to use local transport services, Changing Places in shopping centres, Safe Places.	services that enable them to participate fully and build / maintain social networks e.g. support to use local transport services, Changing Places in shopping centres, Safe Places and evidence that such schemes are communicated effectively.	
C3	Rationale This measure asks for evidence of reasonable adjustment within providers and across the broader strategies for the community, reflecting the specialist needs of people with a learning disability			
	RAG Rating Outcome Descriptor	**Current Situation / What are the Issues**	**Action to achieve Green**	**Responsibility**
	Arts and culture	There are few examples of people with learning disability having access to reasonably adjusted facilities and services that enable them to participate fully e.g. cinema, music venues, theatre, festivals.	o WCC will ensure providers of commissioned services are able to demonstrate numerous examples of people with learning disability having access to reasonably adjusted facilities and services that enable them to participate fully e.g. cinema, music venues, theatre, festivals and that the accessibility of such events and venues are communicated effectively	**Lead:** WCC

C4

Rationale
This measure asks for evidence of reasonable adjustment within providers and across the broader strategies for the community, reflecting the specialist needs of people with a learning disability

RAG Rating Outcome Descriptor	Current Situation / What are the Issues	Action to achieve Green	Responsibility
Sport & leisure	Some local examples of people with learning disability having access to reasonably adjusted facilities and services that enable them to participate fully e.g. local parks, leisure centres, swimming pools, walking groups etc.	o WCC will ensure there are extensive and equitably geographically distributed examples of people with learning disability having access to reasonably adjusted facilities and services that enable them to participate fully e.g. local parks, leisure centres, swimming pools, walking groups, designated participation facilitators with learning disability expertise etc. and evidence that such facilities and services are communicated effectively. o Ensure providers of commissioned services are able to demonstrate Reasonable Adjustments are made to ensure fair and equitable access to universal services. This will be reflected in customer Support Plans.	**Lead:** WCC

C5

Rationale
This measure is about the importance of occupation and the equity that needs to be shown for people with a learning disability. Evidence of initiatives, data of the actual local picture is important.

RAG Rating Outcome Descriptor	Current Situation / What are the Issues	Action to achieve Green	Responsibility
Supporting people with learning disability into and in employment	Relevant data available and collected. The targets nationally and locally determined (See ASCOF) have been met for people with learning disability supported into employment in the past 12 months AND Employment activity of people with learning disability is linked to data	o WCC will create system for relevant data available and collected. Ensure the targets nationally and locally determined (See ASCOF) have been met for people with learning disability supported into employment in the past 12 months o Employment activity of people with learning disability will be linked to commissioning intent for future services this will be incorporated into the 'Statement of Intent' o Commissioning is clearly linked to proportionate local need which is evidenced in the Joint Strategic Needs Assessment.	**Lead:** WCC

C6

Rationale

	Delivering effective transitions for young people is recognized as a way of addressing the difficulties confronted by young people with learning disabilities and their families at transition. Previous research has demonstrated that information is a key need at this time. Information relates to co-production of local services driven by parent and user involvement as well as having a sound knowledge base of future needs to inform commissioning strategies. This descriptor ascertains if localities have good plans in place to ensure locally available provision of the future mainstream and specialist health services needed to support young people approaching adulthood - and their families. This measure touches upon the national Single Education, Health and Care Plan for people with learning disability. This policy is one of your key ways of evidencing success in this area.			
	RAG Rating Outcome Descriptor	**Current Situation / What are the Issues**	**Action to achieve Green**	**Responsibility**
	Effective Transitions for young people A Single Education, Health and Care Plan for people with learning disability	Evidence of at least 50% of people with learning disability has a current and up to date Single Education, Health and Care Plan by 2014. There is evidence of effective plans, strategy, service pathways and multi-agency involvement across Health and Social Care	o Ensure that 85% of people with learning disability have a current and up to date Single Education, Health and Care Plan by 2014. o Create a monitored strategy, service pathways and multi-agency involvement across Health and Social Care. o Ensure there is a very clear transition service or functions that have joint health & social care scrutiny and ownership.	**Lead:** WCC & CCG's **Contributors:** Education & Health Services
C7	<u>Rationale</u> This is about people with learning disabilities and family carer's involvement in service planning and decision making, including personal budgets. This measure seeks to stimulate areas to continually review and improve the involvement of people who use and rely on services in strategic development and planning.			
	RAG Rating Outcome Descriptor	**Current Situation / What are the Issues**	**Action to achieve Green**	**Responsibility**

	Involvement in service planning and decision making	Clear evidence of co-production in all learning disability services that the commissioner uses to inform commissioning practice. The commissioners use this to inform commissioning practice. Inconsistent or no evidence of co-production in universal services	To ensure there is clear evidence of co-production in universal services and learning disability services active engagement and consultation will take place with people with learning disabilities and their carer's in the development of strategies and commissioning intentions. The commissioners use this to inform commissioning practice.	**Lead:** WCC & CCG's **Contributors**: Advocacy & Empowerment **Stakeholders:** Providers & CWPT

Item 9

Health and Wellbeing Board

8th July 2015

Clinical Commissioning Groups 2015/16 Quality Premiums

Recommendation(s)

1.1 That the Health & Wellbeing Board reviews the content of the report and confirms agreement with proposals.

Key Issues

2.1. CCGs are required to inform the Health & Wellbeing Board of their Quality Premium proposals included in the submission of the 2015/16 Planning Template submitted on 27th May 2015. Sign-off is required from the Board on the mental health, urgent care and local priority measures.

2.2. Quality Premium guidance was issued in late April 2015 and due to the timescales for national submission, it was not possible to seek formal Health and Wellbeing Board support in advance of the submission due date.

2.3. The Quality Premium is intended to reward CCGs for improvements in the quality of the services they commission and for associated improvements in health outcomes and reducing inequalities.

2.4. The national funding available to CCGs for the quality premium equates to £5 per registered patient.

2.5. The premium for 2015/16 (paid in 2016/17) is based on measures that cover a combination of national and local priorities:

- **Reducing potential years of lives lost through causes considered amenable to healthcare** – Mandatory, accounts for 10% of the Quality Premium

- **Urgent and emergency care menu** - CCG in conjunction with the Health and Wellbeing Board and NHSE can choose one, several or all measures. Accounts for 30% of the Quality Premium

- **Mental health** - CCG in conjunction with the Health and Wellbeing Board and NHSE can choose one, several or all measures. Accounts for 30% of the Quality Premium.

- **Improving antibiotic prescribing in primary and secondary care** – Mandatory, accounts for 10% of the Quality Premium

- **Two local measures** – each accounts for 10% of the Quality Premium. **Proposed measures**:

2.6. Each of the CCGs have identified measures that meet the strategic needs of their local population; some of these are shared priorities but inevitably given the different contexts of the CCGs there are some differences.

2.7. A CCG will not receive a quality premium if it:

- Is not considered to have operated in a manner that is consistent with Managing Public Money during 2015/16;
- Ends the 2015/16 financial year with an adverse variance against the planned surplus, breakeven or deficit position, or requires unplanned financial support to avoid being in this position;
- Incurs a qualified audit report in respect of 2015/16.

2.8. NHS England also reserves the right not to make a quality premium payment where there is a serious quality failure during 2015/16.

2.9. The total payment for a CCG will be reduced if its providers do not meet the NHS Constitution rights or pledges for patients in relation to:
- (a) maximum 18 weeks from referral to treatment
- (b) maximum 4 hour waits in A&E departments;
- (c) maximum 14 day wait from an urgent referral for suspected cancer
- (d) maximum 8 minute responses for Category A red 1 ambulance calls.

2.10. CCGs are required to use the funding awarded to them under the quality premium in ways that improve the quality of care or health outcomes and/or reduce health inequalities.

Background papers

3.1. Quality Premium: 2015/16 guidance for CCGs **(**NHS England) – see: http://www.england.nhs.uk/wp-content/uploads/2015/04/qual-prem-guid-1516.pdf

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Coventry and Rugby CCG Quality Premium for 2015/16

Measure	Indicators	Target (if applicable)	Total % available	CCG % submitted to NHS England
Reducing potential years of life lost	Reduce potential years of life lost (PYLL) from causes considered amenable to healthcare over time	No less than 1.2% between calendar years 2012-2013	10%	10%
Urgent and emergency care menu	1) Avoidable emergency admissions	1) Reduction in the percentage change over the 4 years 2012/13 to 2015/16	30%	20%
	2) Delayed transfers of care which are an NHS responsibility	2) The total number of delayed days caused by delayed transfers of care in 2015/16 should be less than the number in 2014/15		10%
Mental health menu	2) Reduction in the number of people with severe mental illness who are currently smokers	2) A reduction in the percentage of people with severe mental illness who are current smokers	30%	30%

Improving antibiotic prescribing	3 components parts (all requiring to be achieved) a) reduction in the number of antibiotics prescribed in primary care b) reduction in the proportion of broad spectrum antibiotics prescribed in primary care c) secondary care providers validating their total antibiotic prescription data	a) reduction in the number of antibiotics prescribed in primary care by 1% (or greater) from each CCG's 2013/14 value. Individual practice reduction to be agreed by the CCG with each practice. b) number of co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of selected antibiotics prescribed in primary care to be reduced by 10% from each CCG's 2013/14 value, or to be below the 2013/14 median proportion for English CCGs (11.3%), whichever represents the smallest reduction for the CCG in question. c) secondary care providers with 10% or more of their activity being commissioned by the relevant CCG have validated their total antibiotic prescribing data as certified by PHE	10%	10%
Local measure 1	1) Reduction in residential and nursing home non elective admissions	Reduction in non-elective admissions between 2014/15 and 2015/16	20%	10%
Local measure 2	2) Reduction in End of Life hospital admissions in last 3 months of life	Reduction in non-elective admissions between 2014/15 and 2015/16		10%

South Warwickshire CCG 2015/16 Quality Premium

Measure	Indicators	Target (if applicable)	Total % available	CCG % submitted to NHS England
Reducing potential years of life lost	Reduce potential years of life lost (PYLL) from causes considered amenable to healthcare over time	No less than 1.2% between calendar years 2012-2013	10%	10%
Urgent and emergency care menu	1) Avoidable emergency admissions	1) Reduction in the percentage change over the 4 years 2012/13 to 2015/16	30%	10%
	2) Delayed transfers of care which are an NHS responsibility	2) The total number of delayed days caused by delayed transfers of care in 2015/16 should be less than the number in 2014/15		10%
	3) Increase in the number of patients admitted for non-elective reasons, who are discharged at weekends or bank holidays.	3) The proportion of patients discharged on a Saturday, Sunday or English Public Holiday should be (a) at least 0.5% points higher in 2015/16 than in 2014/15; OR (b) Greater than 30% in 2015/16		10%
Mental health menu	2) Reduction in the number of people with severe mental illness who are currently smokers	2) A reduction in the percentage of people with severe mental illness who are current smokers	30%	15%

	4) Improvement in the health related quality of life for people with a long term mental health condition	4) A reduction in the difference between the health related quality of life for people with any long term conditions compared to those with a mental health long term condition		15%
Improving antibiotic prescribing	3 components parts (all requiring to be achieved) a) reduction in the number of antibiotics prescribed in primary care b) reduction in the proportion of broad spectrum antibiotics prescribed in primary care c) secondary care providers validating their total antibiotic prescription data	a) reduction in the number of antibiotics prescribed in primary care by 1% (or greater) from each CCG's 2013/14 value. Individual practice reduction to be agreed by the CCG with each practice. b) number of co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of selected antibiotics prescribed in primary care to be reduced by 10% from each CCG's 2013/14 value, or to be below the 2013/14 median proportion for English CCGs (11.3%), whichever represents the smallest reduction for the CCG in question. c) secondary care providers with 10% or more of their activity being commissioned by the relevant CCG have validated their total antibiotic prescribing data as certified by PHE	10%	10%
Local measure 1	% of people with a LTC who feel supported to manage their condition	Increase from 68.2% to 70%	20%	10%
Local measure 2	Health related quality of life for carers	Increase score from 0.825 to 0.827		10%

Warwickshire North 2015/16 Quality Premium

Measure	Indicators	Target (if applicable)	Total % available	CCG % submitted to NHS England
Reducing potential years of life lost	Reduce potential years of life lost (PYLL) from causes considered amenable to healthcare over time	No less than 1.2% between calendar years 2012-2013	10%	10%
Urgent and emergency care menu	1) Avoidable emergency admissions	1) Reduction in the percentage change over the 4 years 2012/13 to 2015/16	30%	5%
	2) Delayed transfers of care which are an NHS responsibility	2) The total number of delayed days caused by delayed transfers of care in 2015/16 should be less than the number in 2014/15		10%
	3) Increase in the number of patients admitted for non-elective reasons, who are discharged at weekends or bank holidays.	3) The proportion of patients discharged on a Saturday, Sunday or English Public Holiday should be (a) at least 0.5% points higher in 2015/16 than in 2014/15; OR (b) Greater than 30% in 2015/16		15%
Mental health menu	2) Reduction in the number of people with severe mental illness who are currently smokers	2) A reduction in the percentage of people with severe mental illness who are current smokers	30%	15%

	4) Improvement in the health related quality of life for people with a long term mental health condition	4) A reduction in the difference between the health related quality of life for people with any long term conditions compared to those with a mental health long term condition		15%
Improving antibiotic prescribing	3 components parts (all requiring to be achieved) a) reduction in the number of antibiotics prescribed in primary care b) reduction in the proportion of broad spectrum antibiotics prescribed in primary care c) secondary care providers validating their total antibiotic prescription data	a) reduction in the number of antibiotics prescribed in primary care by 1% (or greater) from each CCG's 2013/14 value. Individual practice reduction to be agreed by the CCG with each practice. b) number of co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of selected antibiotics prescribed in primary care to be reduced by 10% from each CCG's 2013/14 value, or to be below the 2013/14 median proportion for English CCGs (11.3%), whichever represents the smallest reduction for the CCG in question. c) secondary care providers with 10% or more of their activity being commissioned by the relevant CCG have validated their total antibiotic prescribing data as certified by PHE	10%	10%
Local measure 1	1) % of people with a LTC who feel supported to manage their condition	65.60%	20%	10%
Local measure 2	3) Flu uptake for at risk groups	54.00%		10%

Item 10

Health and Wellbeing Board

8 July 2015

Health and Wellbeing Board Forward Plan

Recommendation(s)

1. That the Board considers and agrees the Forward Plan including the items to be submitted to the next meeting.

1.0 Key Issues

1.1 This report provides an update on the Forward Plan for the Health and Wellbeing Board. Such updates will be presented to each meeting for the Board to review.

2.0 Options and Proposal

2.1 To develop a longer term strategic focus to the work of the Board, it has been agreed to use a Forward Plan. The Forward Plan will be submitted to each meeting for review and update. This will identify the dates for essential agenda items, proposed workshop topics and assist a thematic approach to future agenda setting.

2.2 The Forward Plan is attached at Appendix 'A' for discussion.

Background Papers

None

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Strategic Director	David Carter	
Portfolio Holder	Councillor Seccombe	

Warwickshire Health and Wellbeing Board Forward Plan

Reports to HWBB

Report Title	Date of Board Meeting	Lead Organisation / Officer	Comments
Governance Proposals	8 July 2015	WCC – David Carter / Sarah Duxbury	
Annual Report	8 July 2015	WCC - John Linnane & John Dixon	Verbal report to introduce.
Director of Public Health’s Annual Report	8 July 2015	WCC – John Linnane	
Better Together - 2015/16 Better Care Fund Agreement	8 July 2015	WCC – Chris Lewington	
Violence Against Women and Girls	8 July 2015	WCC - Helen King	
Joint Adult Health & Social Care Self-Assessment Framework 2015	8 July 2015	WCC – Chris Lewington	
Quality Premium 2015/16	8 July 2015	WN, CR and SW CCGs	
Winter Pressures	23 September 2015	WN, CR and SW CCGs / WCC - Jenny Wood	
Annual Report	23 September 2015	WCC - John Linnane & John Dixon	To be confirmed

Child and Adolescent Mental Health Services	23 September 2015	WN, CR and SW CCGs	
Better Together	TBC	WCC – Chris Lewington	

Future Board Meeting Dates: 4th November 2015 and 20th January 2016

Workshops

Theme / Subject	Date of Meeting / Event	Report Author / Lead Officer / Organisation	Comments
Workshop on the impact of population growth and the JSNA	23 July 2015	WCC and NHS England	PDS to advise HWBB Members of the dates
Better Care Workshop	19 October 2015	WCC – Chris Lewington	
Date reserved - theme / subject to be confirmed	17 February 2016		
Date reserved - theme / subject to be confirmed	20 April 2016		
End of Life Care Workshop	Date to be confirmed (not able to match dates for December)	WCC - Helen King	