Warwickshire Health and Wellbeing Board

Case Studies 2016/17

101

ways we are improving health and wellbeing in Warwickshire.

Summary

Welcome to the 2016/17 compendium of Heath & Wellbeing (HWB) casestudies.

Together there are 101 examples of success which support the outcomes contained within our HWB Strategy 2014/18.

Each casestudy has been provided by one of our Partners and is aligned to one of the 18 outcomes set out within the HWB Strategy 2014-18.

Health and Wellbeing Board members

This document is owned and produced by the Warwickshire Health and Wellbeing Board.

- Healthwatch
- Community and Voluntary Action
- Coventry and Rugby Clinical Commissioning Group
- Coventry and Warwickshire Partnership Trust
- George Eliot Hospital
- NHS England
- North Warwickshire Borough Council
- Rugby Borough Council
- Nuneaton & Bedworth Borough Council
- Warwick District Council
- Warwickshire County Council
- South Warwickshire Clinical Commissioning Group
- Warwickshire North Clinical Commissioning Group
- Warwickshire Police
- Warwickshire Police & Crime Commissioner
- South Warwickshire Foundation Trust
- Stratford District Council
- University Hospital Coventry and Warwickshire

Outcome 1

Ensure the best possible start to life for children, young people and their families.

1. Smoking in pregnancy
2. Smart start
3. Teenage Conception rates
4. Warwickshire Welcomes Breastfeeding Scheme
5. Childminders Food Safety
6. Priority Families (Childrens)
7. Family and Parenting and Support

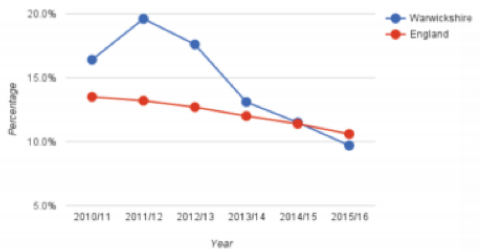
1–7

1. Smoking in Pregnancy

Summary

Smoking in pregnancy has been a priority in Warwickshire for the last 5 years and the percentage of women smoking at time of delivery in Warwickshire has reduced. In particular there has been a large reduction in the north of the county.

Figure 3: Percentage of births to mothers who smoked during pregnancy in Warwickshire.



Source: Public Health England and locally calculated

Activity

- Warwickshire Stop Smoking in Pregnancy Service
- Risk perception training for Midwives

Impact

During 2016 the Smoking in Pregnancy Services has seen an overall increase of 151 referrals (25%) compared to the previous year.

The increase in both South and North Warwickshire areas is likely to be due to collaborative work and the introduction of the Risk Perception Midwives in these areas.

What comes next?

Plans to align the Smoking in Pregnancy Service more closely with maternity services across the county.

Further information

Sue Wild - suewild@warwickshire.gov.uk or warwickshire.gov.uk/quit4good

2. Smart Start

Summary

Smart Start is a programme of work to ensure that all children in Warwickshire have the best possible start in life and that their parents and carers are well supported from the moment of conception through to the time their children reach school age.

Organisations like the County Council, the NHS, early years education and nurseries, and the third sector have been working together to develop and deliver a 3 year programme called Smart Start to meet these challenges.

Activity

The following SMART start projects have been approved

1. Making it REAL in Warwickshire run by Adult and Community Learning (Warwickshire County Council)
2. Re-imaging our Children's Centres by Barnardo's (on behalf of all Children's Centres providers)
3. Closing the gap in the Early Years by Bedworth Heath Nursery (Warwickshire County Council)
4. Family Information Service 0-5 Officers by Family and Parenting Support Team (Warwickshire County Council)
5. Using Family Group Conferencing to reduce Children Looked after aged 0-5 by Family and Parenting Support Team (Warwickshire County Council)
6. Inspiring Futures (Warwickshire) by Malachi Specialist Family Support
7. Food for Life Children's Centres and Maintained Nurseries Programme by Soil Association
8. HENRY – Health Exercise and Nutrition for the Really Young by South Warwickshire Foundation Trust (SWFT)
9. 'Chatter Matters' Parent Ambassadors and Bilingual Chatter Matters by Time to Talk (Warwickshire County Council & SWFT)
10. HY2 (Helping You Help Yourself) by Valley House
11. 'Are you Sitting Comfortably' by Integrated Disability Service (Warwickshire County Council)
12. Delaying Pregnancy by People Group, Warwickshire County Council
13. Early years pilot (3.5 years development check) by Public Health, Warwickshire County Council

Additionally, the programme funded 79 community based initiatives working towards improving school readiness and building community capacity and resilience.

Impact

Smart Start projects have so far supported and improved outcomes for over 1200 Warwickshire 0-5 families. School readiness of Warwickshire children has improved from 67% in 2015 to 71% in 2016. The Smart Start target by 2020 is 80%.

A return on investment analysis is being conducted to assess the value of Smart Start activity and inform future investment. So far, the findings show that the expected return of the investment to date is likely to be between £1.8 and £10.8 of every £1 invested. Based on national research, the investment into 0-5 service redesign and integration is likely to bring between £8 and £17 of return on every £1 invested.

Further information

warwickshire.gov.uk/smartstart

3. Teenage Conception Rate

Summary/Rationale

The Director of Public Health's annual report for 2016/17 highlighted that data for teenage conception rates in the north of the county was significantly higher than the national average.

Activity

- Following a successful partnership event, agencies from across the health, education, wellbeing spectrum came together and made commitments to work together to address the issues of teen conception. Emerging from this, the 'Addressing Teen Conception Task and Finish Group' has been established. Chaired by Nuneaton and Bedworth Borough Council and supported by the Relationship and Sex Education team (RSE) from WCC and Public Health. Work is beginning to progress on securing information and support services in Nuneaton, extending these into North Warwickshire.
- Who was involved: School, RSE Team, Nuneaton and Bedworth Borough Council, North Warwickshire Borough Council, Public Health, George Eliot Hospital, Barnado's, Public Health England, Clinical Commissioning Group (CCG), Social Care, Young People's workers.

Impact

- The Office for National Statistics (ONS) 2015 Under 18 conceptions data shows;
- Warwickshire (countywide), a reduction to 19.5 conceptions per 1000 women under 18 for 2015. The equivalent 2014 figure was 22.9. The figure for England is 20.8 (in 2014 it was 22.8)
- Nuneaton and Bedworth saw a significant decline. In 2014 the figure was the highest in England at 43.0. The 2015 figure is 25.4.
- North Warwickshire saw an increase. The 2014 figure was 24.3, the new 2015 figure is 29.6.

Planned actions

- Funding Secured for the health store in Nuneaton for 2017/18 – with longer term sustainability to be finalised.
- Pledges made by key agencies with clear messages being developed for organisations to share on teenage conception –see Addressing Teenage Conceptions Action Plan
- C Card Condom distribution pilot in Nuneaton & Atherstone
- Satellite Health Store (Sexual Health Service) proposed for Atherstone

4. Warwickshire Welcomes Breastfeeding Scheme

The Food Safety Team have been supporting the Warwickshire Welcomes Breastfeeding Scheme by taking time to raise awareness of the scheme with local cafés and restaurants.

This scheme aims to improve the support available to mothers to exercise their right to breastfeed their babies in public places by proactively encouraging local businesses to welcome mums and babies into their venues. By displaying "Warwickshire Welcome" signs in commercial premises, local women feel empowered and welcome to feed their babies in public.

Officers from the team have so far visited 26 premises and provided 'Welcome' signs. The team is planning to do more visits and publicise the scheme and the participating premises later on in the year.

Health partners from the George Eliot Hospital Trust, South Warwickshire NHS Foundation Trust, and all Children's Centres across Warwickshire adopted the UNICEF Baby Friendly Initiative in 2012.

5. Childminders Food Safety

Work is progressing with contacts and visits made to childminders to consider food safety issues and provide information and signposting to guidance and advice on providing healthy food choices for babies and children.

Of the 413 childminders notified to us by The County, 178 have been contacted by various means and 23 have already been programmed in for a visit. 36 of those responding no longer operate as a childminder. Work is likely to continue on this project for the rest of the year at least due to the high numbers involved.

6. Priority Families

As of 1st April 2017, 1509 families were attached to the programme and a total of 563 families have achieved significant and sustained progress. In monetary terms this has resulted in over £2 million being levered into Warwickshire since the inception of the Programme.

7. Family and Parenting Support

The Family and Parenting Support team provide a range of Early Help and Targeted Support services.

The Parenting Development Team co-ordinate the delivery of Triple P across the county, on a rolling programme basis. The Triple P Positive Parenting Programmes aim 'to give parents simple and practical strategies to help them build strong, healthy relationships, confidently manage their behaviour and prevent problems developing'. They are used in 25 countries with people from all backgrounds as 'one of the most effective evidence-based programmes in the world'.

- In 2016-17, 368 parents completed Group Triple P programmes (a completion rate of 84%). The completion rate in 2015-16 and 2016-17 has been higher than previous years, and the number of parents attending and completing these courses increased;
- 97% of parents submitting evaluations felt the programme met their child's needs; 95% said it met their own needs as parents; 97% felt able to deal with their child's behaviour; 100% were satisfied with the parenting programme; and 97% said the child's behaviour had improved.

The Early Help Officer team provide support to multi agency practitioners undertaking the Early Help Process in the community, overseeing the process and providing training to practitioners

The Early Help Single Assessment (EHSA) is a holistic assessment tool, which brings together multi-agency interventions to provide one support plan around the child. The EHSA allows support to be delivered in a focused and consistent way and for information to be shared appropriately among agencies working with a family. Once the EHSA has been completed, regular Family Support Meetings are held to focus on what has happened since using SMART targets to build an action plan to enact the changes identified as necessary.

The role of the Early Help Family Support Worker (EH FSW) is to work alongside families with children aged 0-18 years old, supporting families around issues in the home, often impacting on children's lives at school and in the community. The EH FSW works with all members of the family to build positive relationships within the home and community, including other family members like grandparents and fathers, who may be outside of the main household.

The services offered include one to one support with all or part of families in their home, exploring and encouraging positive parenting strategies, establishing routines, improving family communication and understanding. The team are trained in the use of various evidence based strategies, including: - Triple P, Family Transitions, Non Violent Resistance and the HOME toolkit.

- 286 cases were closed in 2016-17 (figures reflect reorganisation during the year – on an annualised basis they would be higher).
- Supported 162 children to improve their behaviour; 158 to improve their health and wellbeing; 151 to improve family relationships; 145 to reduce conflict within the home; and 90 to improve school attendance;
- Triple P was used with 169 families and when these cases were closed about 90% reported improved parenting as an outcome; the use of Non Violent Resistance has been increasing and it was used with 71 families.
- Received feedback from 65% of closed cases (79% excluding families who disengaged). Some 99% of adults and 98% of children gave feedback saying that they highly rated the help from their Family Support Worker.

Outcome 2

Support those young people who are most vulnerable and ensure their transition into adulthood is positive.

8. Warwickshire Youth Justice
9. Child Poverty
10. "Progress" For Young People
11. Transition Team in Adult Social care
12. Child Adolescent Mental Health Service (CAMHS) Redesign

8–12

8. Warwickshire Youth Justice

Summary/Rationale

Warwickshire Youth Justice Service (WYJS) is a statutory partnership with staff from agencies including Warwickshire County Council, Warwickshire Police, Warwickshire Probation Trust and frontline health professionals. They work together to address offending behaviours and to reduce the risk of re-offending. Youth offenders are recognised as a vulnerable group, many have experienced deprivation and neglect throughout their lives and their health and social care needs have often gone unrecognised. Their contact with Youth Justice Services presents the first opportunity many of these young people have had to have their needs recognised and addressed.

Activity

A needs assessment was undertaken which demonstrated the significant issues the young people in contact with WYJS face.

Examples in terms of social care/wellbeing needs:

- 55% of WYJS clients were either currently or previously 'looked after',
- 12% were excluded from school,
- 21% had an existing Special Educational Needs (SEN),
- 12% were identified with Autistic Spectrum Disorder,
- 33% were identified as having a Speech Language Communication Need

Examples of significant health needs identified:

- 61% had previous input from mental health and related services, prior to referral,
- 44% had self-harmed,
- 19% had attempted suicide

Impact

The needs assessment has renewed the focus on preventing youth crime, for example through working with schools and through the targeted provision of 'early help' services. The connection between WYJS and universal services, such as the School (and) Health and Wellbeing Service, has been strengthened and the health input into the WYJS will be recommissioned as part of Child Adolescent Mental Health Service (CAMHS).

What comes next?

Youth crime is one of many adverse outcomes for young people who are exposed to 'adverse childhood experiences' (ACEs). There is scope to do more work through the Early Years/Smart Start programme to address ACEs and Public Health will lead this work with other partners.

Contact details

Berni Lee - Consultant in Public Health

9. Child Poverty

Summary/Rationale

Closing the attainment gap for pupils from disadvantaged backgrounds is a high priority of the council. In late 2014 Her Majesty's Inspectorate (HMI) raised concerns about the size of gap in Warwickshire and in response the Closing the Gap project was established in January 2015. Cabinet agreed the Closing the Gap Strategy in January 2016, available here: https://apps.warwickshire.gov.uk/api/documents/WCCC-1023-211

Activity

The project operates across seven workstreams: peer reviews; governance; Free School Meals, Priority Families and Family Learning; Achievement for All; Early Years Foundation Stage; Primary and Transitions; Warwick University Research and Looked After Children. A wide range of projects are taking place across the workstreams. More information is available here: http://headsup.warwickshire.gov.uk/assets/1/closing_the_gap_workstreams_overview_2_.pdf

In addition to the above the project is also committed to holding annual Closing the Gap conferences to share strategies that are working effectively to close the achievement gap of disadvantaged pupils in schools.

Impact

The impact of the project on the attainment of disadvantaged pupils in yet to be seen in school performance data. It is expected to take some time to impact on the schools headline performance measures. The 2014, 2015 and 2016 performance can be found here: http://headsup.warwickshire.gov.uk/heads-up-8th-february2017/closing-the-gap/2016-data

Awareness raised and strategies shared with schools across Warwickshire through conferences, training, presentations at headteacher briefings, articles in HeadsUp and governor training courses.

What comes next?

The Closing the Gap project will continue in the academic year 2017/18 and has continued financial support. The following projects will be take place in 2017/18:

- Piloting Pupil progress meetings
- Family learning provision targeted in schools with largest attainment gaps
- REAM courses (Raising Early Achievement in maths)
- Evaluation of Governance training programmes
- Evaluation of peer reviews
- Free School Meals (FSM) automated enrolment in schools, initially in for reception and year 7 pupils
- Closing the Gap in Early Years, project rolling out more widely across the county
- Year 2 of science partnerships – raising standards in delivering the science curriculum, evaluation of year 1 of the partnerships to be completed
- National Collaborative Outreach programme targeting disadvantaged learners accessing higher education.
- Enhancing academic attainment project, led by the University of Warwick working in post 16 institutions with high number of FSM students to promote HE through study skills
- Sound Training negotiated discount scheme
- 3rd Annual Closing the Gap conference in December 2017 to share best practice

Further details available from Sophie Thompson, Intervention, data and project management officer, email sophiethompson@warwickshire.gov.uk

10. “Progress” For Young People

Targeted Support for Young People (TS4YP) is working across Warwickshire to deliver ‘Progress’, a tailored programme of coaching and support to help young people who are NEET (not in employment, education or training) and those at risk of NEET, to access training and employment opportunities. The programme is designed for young people aged 15 – 19 (up to 24 for young people who are care leavers or have a learning disability).

The programme of activity will offer young people one to one support from a dedicated Progress Coach and an eight week course running one day each week, plus referral to extra support if needed. Our Progress Coaches are all professionally qualified Youth Workers.

Young people will be offered up to six months support which will include:

- Job specific skills, job search skills & social skills for work
- Throughout progress young people will be given help to get into:
  - Employment
  - Education or training
  - Work placements
  - Job search or other provision

Targeted Support for Young People will be delivering ‘Progress’ across Warwickshire from now until December 2018.

11. Transition Team in Adult Social care

Summary

Following co-production work in 13/14, the recommendations of which led to the formation of a dedicated Transition Team in Adult Social care in April 2015 to improve the transition from children’s to adult social care.

Impact

The team has enabled the delivery of positive outcomes for an increased number of young people aged 16 – 25. The work includes supporting young people leaving school and college to find employment and move to independent living settings, including moving young people back into Warwickshire.

This work has delivered savings (via cost avoidance and reduction in package costs) as young people move out of residential into supported living, and includes utilisation of the accommodation with care schemes.

The project has enabled the development of better working between children’s and adult social care, and work is on-going with health partners and other stake holders, including clear protocols and guidance for staff. Close work with commissioning is supporting shaping of future services for our young people.

The project manager, finance and business analyst have worked to ensure analysis of demand and costs for young people for the next five years, enabling clearer planning to be undertaken, and there is a plan to undertake a Joint Strategic Needs Assessment (JSNA) with commissioning.

Recent work undertaken by Disability Sub-Programme Board has highlighted resource issues for Transition, and Head of Service and Senior Managers have agreed an increased budget in order to recruit more staff.

12. Child Adolescent Mental Health Service (CAMHS) Redesign

Alongside the commitment to co-produce a new system for children and young people's mental health is the principle of commissioning for outcomes. As such, an outcomes based specification and framework have been developed and will form the basis for the new model.

The draft specification is based on the national CAMHS specification template adopted and promoted by NHS England. However, it has been adapted to reflect the outcomes and key themes developed through the co-production process, including:

- A focus on prevention, early help and building resilience
- A focus on integrated working with aligned service areas as well working with families and the network around the child
- Delivering a seamless service without tiers that enables smooth transitions
- A focus on vulnerable children

Outcome 3

Enable people to effectively manage and maintain their physical and mental health and wellbeing.

13. Walking for Health
14. NHS Health Checks
15. Dementia Friends
16. Food for Life
17. Fitter Futures Warwickshire
18. Mental Health and Wellbeing Services
19. Dementia Awareness
20. South Warwickshire Mental Health Partnership
21. NHS South Warwickshire CCG
22. Dementia Pilot
23. Big Day Out
24. Dementia Friendly Communities
25. Atrial Fibrillation Pathway Redesign

13–25

13. Walking for Health

Summary

We recognise the benefits of exercise and being able to experience the natural environment on an individual's health and wellbeing. Therefore we have set up a programme of walks to deliver gentle exercise throughout the district of Warwick. This programme promotes social inclusion, prevents isolation, contributes to mental and physical health improvements and provides opportunities for physical exercise. Specifically the benefits of walking include:

- Helping heart and lungs to work better
- Lowering blood pressure
- Keeping weight down
- Lightening moods
- Keeping joints, muscles and bones strong
- Increasing 'good' cholesterol.

Activity

We recruited volunteers to lead walks and delivered walk leader training. We have delivered walks of different grades and distances throughout the district. We have used community groups and social prescribing to promote the walks.

We have delivered the programme with the support of Walking from Health, 4 medical surgeries, community hubs and volunteers.

Impact

What outcomes have been achieved.

- The number of walks per week vary and can be weather dependent
- Each walk has between 6-10 participants (weather dependent)
- The scheme has no costs but does require officers time. All of the materials are supplied free of charge from Walking for Health. The number of walks are limited by the number of available volunteers.
- Walk leaders are required to input data into the Walking For health website

What comes next

- We continue to promote walks to ensure that there are regular walks scheduled from community locations, throughout the district, which are accessible to all. We are working on promotional materials which will list each of the current walks.
- We will be delivering more walk leader training and supporting the walks already within the scheme. Officers will oversee the management of the scheme and manage referrals to it.
- Working alongside doctors' practises will refer patients who would benefit from the scheme. (Patients with the following example conditions: heart disease, type 2 diabetes, depression, osteoporosis and certain cancers.)
- Long term future plans include buggy walks and family walks.

Further information and/or contact details

Joanna Dagg, Community Development Worker - joanna.dagg@warwickdc.gov.uk,
Walking for health www.walkingforhealth.org.uk

14. NHS Health Checks

Summary/Rationale

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

Together diabetes, heart, kidney disease and stroke make up a third of the difference in life expectancy between the most deprived areas and the rest of the country. Addressing these differences is a key aim of this programme. In Warwickshire, GP's are commissioned to deliver NHS Health Checks, the programme has been delivered across of the county since 2013.

Activity

Warwickshire County Council, Public Health delivered a health check campaign to increase the number of eligible residents being offered and receiving a health check.

Impact

The number of completed Health Checks increased between January and March 2017 during the campaign period:

- January - 829 health checks
- February - 1007 health checks
- March - 1118 health checks

In 2016/17 the number of people who took up the offer of an NHS Health Check increased from 28% in 2015/16 to 44% in 2016/17 which exceeds the local target.

What comes next?

The service is mandated. In 2017/18 we are encouraging those patients who have already been offered an NHS Health Check to take up the offer. We will be working closely with the CCGs following the financial awards to address diabetes, in the North of the County, using the NHS Health Check to support improved outcomes and reduced risks linked to the #Onething campaign.

Link/contact details

Sue Wild - Commissioning Lead - Health Improvement
onething.warwickshire.gov.uk/news/nhs_health_checks

15. Dementia Friends

Summary/Rationale

Raising awareness of dementia, creating dementia friendly communities and supporting people to live well with dementia are key aims of Warwickshire's Living Well with Dementia Strategy (2016- 2019).

Activity

Dementia Friends aims to change the way people think, act and speak about dementia. The initiative is led nationally by the Alzheimer's Society and is based on the principle that people with dementia can live well with a greater understanding and a little help from other people.

Impact

Working together in Warwickshire, County Council and partners (including Clinical Commissioning Groups, District and Borough Councils, NHS Trusts and voluntary sector) set a target in January 2015 to create 10,000 Dementia Friends across Warwickshire during 2015. Various communication strategies were used to encourage people to get involved. People either attended a face-to-face information session or signed up online and the ambitious target was achieved by September 2015. There are currently over 13,500 Dementia Friends in Warwickshire.

A Dementia Friends survey undertaken with 1,472 Dementia Friends in 2016 by the Alzheimer's society found that: 86% had a better understanding of dementia and 73% felt more confident interacting with people with dementia

In addition to creating Dementia Friends, as part of its work to create Dementia Friendly Communities, Warwickshire County Council has also re-launched Warwickshire's Living Well with Dementia website in Autumn 2016. The website includes a map of services enabling greater access to information about support and services for people living with dementia and their carers in the local community (at district and borough level).

What comes next?

- A new target has now been set to create 30,000 Dementia Friends across Warwickshire by 2019.
- Dementia Friends supports the development of Dementia Friendly Communities across Warwickshire.

Link/contact details

Claire Taylor, Health Improvement Lead, Public Health
Become a Dementia Friend - dementiafriends.org.uk
Warwickshire's Living Well with Dementia website - warwickshire.gov.uk/dementia

16. Food for Life

Summary/Rationale

Public Health commissions the Food for Life (FFL) service. The service offers programme management support to all Warwickshire Schools, Children Centres and Nurseries.
Outcomes for the programme demonstrate that children and parents taking part in the programme consume one third more fruit and vegetables than children and families in a non Food for Life setting. The evidence also demonstrates that there is an increased uptake of free school meals in Food for Life schools and an increase in educational achievement in Food for Life settings.

Activity

Service delivery is the provision of programme management support for all primary and secondary schools, children centres, private and local authority nurseries. The service is offered to all setting and settings with the highest prevalence of childhood obesity are prioritised. Settings work towards achieving a bronze, silver and gold Food for Life award.

The aim is to achieve a whole setting health food philosophy from sourcing, growing and cooking, to staff training and farming. The service encourages children, their families and their wider community, to adopt healthier lifestyles through their involvement in the programme.

In addition Public Health have jointly funded a pilot Food for Life Hospital Leaders Programme with South Warwickshire Foundation Trust (SWFT). This is one of a few national pilots.

Impact

Achieving Food for Life awards 01/04/2015 - 31/03/2017

Award	Number
Schools Bronze	28
Schools Silver	2
Schools Gold	1
Children Centres	4
Private Nurseries	2

The pilot Food for Life Hospital Leaders service is the delivery of a Food and Drink Strategy which demonstrates it improves healthy eating in patients, visitors and staff using South Warwickshire NHS Foundation Trust services.

What comes next?.

Approximately 75 schools and early years settings have now engaged and registered for Food for Life across Warwickshire.

The Food for Life programme management support service for private nurseries was jointly funded with Smart Start funding. The funding has ceased and the support service will be sustained through the universal Food for Life provision from 17/18. This universal provision will also continue to engage and work with a year on year increase in a number of private nurseries going forward.

Link/contact details

Fran Poole, Health Improvement Performance and Commissioning Lead
foodforlife.org.uk

17. Fitter Futures Warwickshire

Summary/Rationale

The Fitter Futures Warwickshire services comprise of 4 evidence based behaviour change services which support children, young people, families and adults to improve health through weight management, physical activity and healthy lifestyles opportunities. The services comprise:

- Healthy lifestyle services for families with children aged 0-5
- Discounted 12 week Physical Activity / Healthy Lifestyles on Referral programmes for young people aged 12-16 and adults aged 16+.
- Free of charge 12 week weight management on referral programmes for young people aged 12-16 and adults aged 16+.
- Free of charge 9 week family weight management programmes for families with a child/children who are overweight aged 4-12.

Referrals are made by health and social care professionals and pharmacists. For the family weight management service, families can self- refer as well as be referred.

Impact

Between 01 July 2015 and 30 June 2017, there were 9,355 referrals made with 3,132 people completing a service and have shown many health improvements that are being sustained. This data includes 1,182 referrals and 393 completions of children and young people aged 4-16. Many people are still in progress of completing a service. Referrals for pregnant mothers and dementia are increasing annually and number of people making referrals is increasing quarter by quarter.

What comes next?.

From 01 April 2017 there has been additions to the referral criteria:

- Pre-diabetes and Cancer Recovery have been added to the existing referral criteria for the Physical Activity/Healthy lifestyles on Referral Service.
- Young people can access the Weight Management on Referral service if they are overweight - previously, only obese young people could be referred.

During 2018/19, the service will become open to the Warwickshire population who are at risk of a first fall due to a medical condition/s and ageing.

Link/contact details

Fran Poole, Health Improvement Performance and Commissioning Lead
fitterfutureswarwickshire.co.uk

18. Mental Health and Wellbeing Services

Summary/Rationale

Warwickshire's Public Mental Health and Wellbeing Strategy 2014-16 outlined plans to improve mental health and wellbeing for all Warwickshire residents. The activity below outlines some of the key achievements of the strategy.

Activity

Warwickshire County Council, through Public Health, launched a range of early intervention mental health and wellbeing services to support people experiencing difficulties with their mental health and wellbeing. Services are available in a range of formats including online, face to face, telephone and self help books - outlined below:

- Five Ways to Wellbeing eLearning launched for County Council staff and adapted for NHS staff.
- Enhanced the Five Ways to Wellbeing website available to all - warwickshire.gov.uk/5ways
- Suicide Prevention Strategy 2016-20 launched which outlines the ambition to reduce suicide to zero in Warwickshire. A multi-agency group has been set up to deliver on the 7 priorities outlined in the strategy.
- Supported the launch of It Takes Balls to Talk campaign developed by Coventry & Warwickshire Partnership Trust and Coventry & Warwickshire Mind.
- Commissioned Mental Health First Aid Training - nearly 200 frontline professionals trained and Suicide Prevention Training for GPs, taken up by over 100 GPs.

Impact

During 16-17 the public mental health and wellbeing services achieved the following:

- 6,427 issues of self help books from Warwickshire libraries through the Reading Well Books on Prescription Service,
- 252 individuals registered (and using) Big White Wall, an online mental health service,
- 102 individuals were supported by the Mental Health Employment Support Service to secure or retain paid employment,
- 370 individuals accessed up to six 1:1 appointments through the Wellbeing for Warwickshire service,
- 322 individuals accessed courses through the Recovery and Wellbeing Academy,
- 437 individuals with mental health conditions accessed a Fitter Futures Warwickshire physical activity service,
- 7,995 people viewed the updated mental health pages on the county council web-site,
- 5,784 people viewed the enhanced Five ways to wellbeing pages on the county council web-site.

What comes next?.

Launch of the refreshed Public Mental Health and Wellbeing Strategy for 2017-2020.

Link/contact details

Paula Mawson, Commissioning Lead - Public Mental Health
warwickshire.gov.uk/mentalhealth
warwickshire.gov.uk/5ways

19. Dementia Awareness Projects

Summary/Rationale
Dementia Awareness Projects in North Warwickshire and Nuneaton and Bedworth (working towards Dementia Action Alliance for northern Warwickshire).

Activity
- Borough-wide events for stakeholders focusing on how public, third and private sector agencies can work in partnership to best support people with dementia, their carers and families by adopting a Dementia Friendly approach
- Local public, third and private sector agencies

Impact
Local communities working together to be aware of the needs of people with dementia and take appropriate action to enable people to remain in their own community/environment for as long as possible, and offer support to their carers. This reduces/delays demand on public sector services.

What comes next?
- The initiative will be rolled out to Rugby, Stratford and Warwick Districts over the next 12 months

Contact details
loriharvey@warwickshire.gov.uk

This links very closely to Dementia Friendly Communities

20. South Warwickshire Mental Health Partnership

Summary/Rationale
Establishment of South Warwickshire Mental Health Partnership

Activity
- Warwickshire Community and Voluntary Action (WCAVA) is commissioned by the County Council to help identify gaps in service provision within the third sector and support partners to address needs (as part of the Third Sector Infrastructure Contract). WCAVA has set up this partnership as a result of an increase in the amount of reporting of people presenting with mental health issues at a variety of community settings. The partnership's aim is to encourage collaboration and cross-referral between mental health support services across South Warwickshire to ensure that residents who need help are offered this in a more streamlined and efficient way.
- Public and third sector partners in S Warks, and service users

Impact
Individuals receive a better quality service as a result of providers working together to reduce duplication, know what offers are available, and identify and fill gaps in provision. Agencies better able to refer people to the right service at the right time.

What comes next?
WCAVA planning to roll this initiative out Countywide - jane@wcava.org.uk

21. WCAVA Safeguarding Awareness Training

The Community

Warwickshire Community and Voluntary Action's (WCAVA) Safeguarding Awareness Training is recommended and encouraged to all organisations that work directly and indirectly with children and young people in Warwickshire.

The Challenge

To ensure the voluntary sector is better equipped to respond to safeguarding concerns by exploring the nature of child abuse and how we may best respond to children, young people and families when concerns arise. This includes ensuring the sector is aware of the roles played by the Multi-Agency Safeguarding Hub (MASH) and Warwickshire Safeguarding Children Board (WSCB).

Meeting the Challenge

WCAVA delivers five 3 hour safeguarding awareness courses throughout the year alongside additional courses 'Safeguarding for Trustees' and 'Safeguarding Online'. Each course is run from a community venue and in a different part of the County to enable maximum accessibility.

This quarter we have delivered 2 safeguarding awareness courses, one in Nuneaton and the other in Leamington Spa. The courses not only up skill the sector regarding safeguarding but enable networking opportunities with other organisations in the area.

The Outcome

In this quarter, 21 staff/volunteers from 8 different organisations have been trained in basic safeguarding awareness and as a follow up from this training, 2 organisations have been supported to draft their own safeguarding policies and procedures.

Feedback from the training shows that people feel more knowledgeable about abuse and have greater confidence to know what to do if they are faced with a disclosure.

This means that 21 more people now better understand what is meant by child abuse and its possible impact on children, how to identify signs and symptoms of possible abuse, understand how best to respond to children, young people and their carers when they suspect a child is being harmed and know what action to take to refer their concerns.

As well as this we have been able to emphasise the importance of looking after ourselves and have considered how best to seek help and support for both ourselves and colleagues.

The resources given out at the training are provided by Warwickshire Children's Safeguarding Board (WSCB) to ensure continuity of the key messages for Warwickshire.

22. Dementia Pilot

There has been a strategic drive to increase diagnosis rates and the timeliness of diagnosis in the Prime Minister's Challenge on Dementia 2020. CCGs across England were tasked with achievement of a 66.7% diagnosis target by March 2016. At the end of June 2016 the national dementia diagnosis rate was 66.6% and the rate for South Warwickshire CCG was 61.0%

The increase in prevalence in dementia coupled with improved diagnosis rates has resulted in increased referrals to dementia diagnosis and management services. Locally there have been significant fluctuations in referral rates to the Memory Assessment Service from the CCG, resulting in an increase in both numbers of patients waiting to be treated and in waiting times. The waiting list at the end of December 2015 had 104 patients with 20 patients having waited more than 20 weeks.

The pilot pathway will support patients with complex presentation to continue to access specialist provision through the Memory Assessment Service, but patients with less complex presentation will be assessed and managed closer to home with increased continuity of care and links to local advice and support networks. This will reduce the number of patients referred to and managed by Coventry & Warwickshire Partnership Trust (CWPT), thus alleviating the pressure on the Memory Assessment Service, enabling CWPT to reduce waiting lists and waiting times.

GP practices are ideally placed not only to identify patients at risk of dementia, but also to make a diagnosis by extending the service that they already provide through the Dementia Domain in Quality and Outcomes Framework (QOF). Some practices already undertake dementia diagnosis and / or continue prescribing initiated by CWPT through the shared care arrangements with CWPT.

The proposal to commission a primary care led service was supported by Member Practices as part of its engagement in relation to the CCG Strategy Development and Commissioning Intentions 2016/17. The CCG has also been working closely with clinicians at CWPT who have been proactive in development of the model and are enthusiastic about running a pilot across Coventry and South Warwickshire.

The Patient and Public Participation Group (PPPG) has supported the principle of community based diagnosis. A presentation regarding the pilot model was made to the Gateway meeting in March 2016.

It is expected that the new pathway model will ensure a more timely and holistic quality of care closer to home, with GP's managing dementia alongside other co-morbidities. It is anticipated that as a long term result of this, patients will be more proactively managed and are therefore likely to have fewer crises, thus supporting the CCG strategy to reduce A&E attendances and emergency admissions.

23. Big Day Out

Summary/Rationale

Initially a Public Health initiative, Big Day Out events aim to get the local community using and enjoying their local green space. They help to reduce isolation, raise awareness of local community assets and promote local services and businesses. North Warwickshire Borough Council is committed to organising two Big Day Out events each year.

Activity

- What activity was delivered and how? On Sunday 22 May, the Borough Council hosted a Big Day Out event at Gun Hill Recreation Ground, New Arley, and a second event at Mancetter Recreation Ground on Sunday 25 September 2016. Jointly, the events attracted over 2000 attendees.

- Who was involved e.g. partner agencies. The events incorporate the delivery of a wide range of free activities (such as giant inflatable slides and laser tag), catering and "market" stalls for local businesses. Partner agencies in attendance included Warwickshire Fire Service, Warwickshire Search and Rescue, #onething, Change Makers and CAVA (Community and Voluntary Action).

What comes next?

- As identified within the Authority's Health and Wellbeing Action Plan (2017 to 2020), North Warwickshire Borough Council will continue to host two Big Day Out events per year.

- For more information contact the Community Development Team on 01827 719317 or see the Community Development Facebook page for further information

24. Dementia Friendly Communities

Summary/Rationale

- Through the Warwickshire North Health and Wellbeing Partnership, the Borough Council has been encouraging local groups and organisations that offer a service for people with dementia and their carers to come together to help create a dementia friendly community.

- The response has been encouraging, with a growing local awareness of services in North Warwickshire and a consequent heightened number of clients accessing a range of related services. As a direct result of the Dementia Friendly Communities group, an event took place during Dementia Awareness Week at the Volunteer Centre, a leaflet is being created to showcase the range of services locally and a Memory Walk is being organised for the local community.

Activity

- What activity was delivered and how? Quarterly meetings have taken place with individuals from over 20 groups in North Warwickshire, with the intention of sharing good practice, offering assistance to those that require it and networking. Dementia Friendly Environment checks have been completed at each of the Authority's leisure centres, which has resulted in new flooring in the reception area at Atherstone Leisure Complex, better lighting and the use of consistent wall colours throughout the facilities. In January, an event was held in partnership with Warwickshire County Council's Localities Team, which brought together a range of external partners to raise awareness of the work taking place in North Warwickshire and how they can get involved.

- Who was involved eg. partner agencies. A variety of groups and organisations attend the quarterly Dementia Friendly Communities meetings, including Warwickshire County Council, the Alzheimer's Society, Libraries, Guidepost, Warwickshire Community and Voluntary Action and Age UK

What comes next?

The group will continue to meet quarterly, with an event organised annually to promote progress more widely. This will lead to the group signing up to the Dementia Action Alliance to get North Warwickshire recognised as a Dementia Friendly Community. Work will commence on establishing North Warwickshire Borough Council as a Dementia Friendly Organisation.

For more information contact Dave Winter, Community Development Officer (Health Improvement) on davewinter@northwarks.gov.uk or 01827 719273

25. Atrial Fibrillation Pathway Redesign

Summary/Rationale

As part of WNCCG programme to improve cardiovascular care, the CCG's redesign of the atrial fibrillation pathway aligns itself with The National Institute for Health and Care Excellence (NICE) recommendations.

Impact

The CCG is improving services for the whole community by identifying the at risk population (65+) and screening them to identify Atrial Fibrillation at the earliest opportunity. Each patient will have a personalised care plan which optimises their treatment and ensures that they are managed effectively and consistently to reduce the risk of stroke and patients have better outcomes.

What comes next?

Working closely with primary and secondary care the service aims to reduce the number of people suffering a stroke by 63 over a five year period.

Contact details

Yasser Din

Outcome 4

Ensure that people with disabilities have the same choice, control and freedom as any other individual - at home, at work and as members of the community.

26–27

26. Transforming Care for People with Learning Disabilities

The last 12 months has seen commissioners from across Coventry, Warwickshire and Solihull working together to establish a local service that supports people with learning disabilities move out of institutions and to live in their local communities. Coventry and Warwickshire Partnership Trust has established an Intensive Community Support Team that supports people in their community and this has meant together we have been able to close inpatient beds. By strengthening the support available in the community, promoting prevention and offering early intervention, we aspire to improve the quality of life for some of the most vulnerable members of our society.

The outcome from all has been very positive and this project will continue over 2017 and 2018 as we continue to look to support more and more people live in their community of choice.

We have been working with Getta Life who support people to live the life they choose based on their person-centred plan, this might include; attending college, getting involved in the community, football and many other activities.

27. Partnership with Oak Wood Secondary School

Oak Wood Secondary School provides education for young people aged 11-19 who have a wide range of special education needs including profound, severe and moderate learning disabilities. Nuneaton and Bedworth Borough Council work with Oak Wood to provide work experience placements for students in years 12 to 14. The placements are designed to provide the students with the key skills needed to secure jobs once they leave School and increase their employability.

Placements have taken place in a wide range of different departments across the Council including Human Resources, Legal and Building Services with students gaining administration and computer skills as well as broader social skills. Some of the students have gone onto the secure Supported Internship placements with Cadent (formerly National Grid).

Work is already underway to provide placements for the third cohort of students in the next academic year with more Council departments becoming involved with the School.

“The placements with Nuneaton and Bedworth Borough Council have provided our students with an invaluable opportunity to develop their work-based skills. We have seen them grow in confidence during their time with the Council and begin to use their skills back in the School environment.” Heather Pepper, Oak Wood School.

Outcome 5

Provide additional support to other vulnerable groups of people.

28. Public Health Advocacy Services
29. Discharge to Assess Project
30. IRIS (Identification and Referral to Improve Safety)
31. Adult Neuro Development Pathway Launch
32. End of Life in Warwickshire North
33. Suicide Prevention Strategy
34. Helping Hands Community Project

28–34

28. Public Health Advocacy Services

Summary/Rationale

Public Health funds 3 health advocacy services to support the most vulnerable members of our communities who are receiving NHS treatment.

Activity

The NHS Complaints Advocacy service aims to support individuals who wish to make and resolve a complaint against NHS funded treatment and care.

The General Health Advocacy Service aims to support individuals with complex needs who are receiving NHS care, and need support to advocate for themselves during their treatment and particularly at the point of discharge.

Independent Mental Health Advocacy Services supports individuals being treated under the Mental Health act and have a statutory right to an advocate. It also supports individuals who are a mental health inpatient or are being treated in the community, and are in need of advocacy support.

Impact

- NHS complaints Advocacy supported 63 new clients with direct advocacy to support them through the complaints process
- Independent Mental Health Advocacy supported 500 clients across the statutory, in-hospital and community referrals.
- General Health Advocacy supported 57 clients with complex needs who required intensive advocacy support.

What comes next?

These services will be retendered during 2017 with new provision in place for Spring 2018.

Contact details

Paula Mawson - Commissioning Lead, Public Mental Health

29. Discharge to Assess (D2A) Project

Where people who are clinically optimised and do not require an acute hospital bed, but may still require care services are provided with short term funded support to be discharged to their own home (where appropriate) or another community setting. Assessment for longer-term care and support needs is then undertaken in the most appropriate setting and at the right time for the person.

South Warwickshire

- Headline outcome: Reported 0.5m net long-term costs averted in year 1 for pathway 3.
- Funding arrangement: Funded by Clinical Commissioning Group (CCG) and Hospital Trust.
- D2A pathway operates across the whole hospital and has been running for 3 years.
- Patients are discharged from hospital via three pathways for care and rehabilitation support for up to 6 weeks:
- Pathway 1 - to intermediate care and reablement services provided in their own homes.
- Pathway 2 - to residential care within the independent and community sector.
- Pathway 3 - to nursing care within the independent sector.
- The trusted assessment between health and social care, in-house reablement and rehabilitation, and care co-ordinators support patients and their families throughout the discharge process.
- D2A pathways have built-in links with primary care- two GP practices have been commissioned to provide clinical input for 30 nursing home beds.

The benefits of a fully mature, integrated system that has the right capacity in the right place are outlined below.

People's health outcomes improve as more people will be able to live at home for longer if services are designed for discharge to home to be the default.

- People's length of stay in a hospital bed decreases due to longer-term assessments taking place in a more appropriate situation and place. Evidence suggests this should reduce deconditioning and improve outcomes significantly since 10 days in hospital (acute or community) leads to the equivalent of 10 years ageing in the muscles of people over 84.
- Encourages NHS and Adult Social Care leaders to work together for the best outcomes and experiences for people through joint approaches to discharge to assess. This may include joint commissioning or funding.
- Improves system flow by enabling patients to access urgent care at the time they need it.
- Reduces duplication and unnecessary time spent by people in the wrong place.
- Enhances working relationships between the health, social care and housing sectors and increases development opportunities for their staff.
- Sharing responsibility, risks and skills across partners leads to innovative and creative solutions that deliver safe, effective care and support.

30. IRIS (Identification and Referral to Improve Safety)

Summary

IRIS (Identification and Referral to Improve Safety) is a general practice-based domestic violence and abuse (DVA) support and referral programme for primary care staff.

In 2010 WCC commissioned an independent review of domestic abuse support in the county. The report specifically considered the needs of Warwickshire's rural communities. Each year, between 3,500 and 5,000 women and girls aged between 16 and 59 living in rural areas in Warwickshire will experience domestic abuse. Research has found that victims living in rural areas may experience more barriers accessing services, therefore services need to be targeted to overcome potential barriers.

There are centres across the county where victims can access support and are used as a base to go into the local community. However due to the rurality of some districts, accessibility of these centres was considered to be a problem for some of the clients interviewed. Research has found that women in rural areas valued health practitioners, particularly GPs, in providing confidential and safe services - for women, making it all the more important for GPs to be able to identify and respond effectively to DVA.

IRIS provides a targeted intervention for patients aged 16 and above experiencing current or former DVA. The Warwickshire IRIS service model rests on three full-time advocate educators working with 77 GP practices. The advocate educator is a specialist domestic abuse worker based in Warwickshire County Council's commissioned specialist domestic abuse support service. The advocate educator works in partnership with a local clinical lead to deliver the service model. As well as supporting victims at crisis and working to increase their safety, the advocate educator can refer and assess victims' needs in relation to other areas of their lives/ wellbeing such as housing, finances, mental health, children and substance misuse.

IRIS provides a unique opportunity for primary care clinicians and their patients to talk about DVA. General practice can play an essential role in preventing and responding to DVA by intervening early, providing treatment and information, and referring women on to specialist services. Since introducing IRIS in Warwickshire, the following benefits have been identified:

- victims of domestic abuse are identified earlier
- the right support is adopted sooner
- victims' safety is improved
- victims' quality of life has improved
- recurrence of domestic abuse has reduced. The end of 2016/17 all 77 GP practices had achieved full 'Domestic Violence Aware' status and were operating the services. Training has also been provided for the county's two main hospitals.

A very high percentage of clients have reported increased safety, and improved quality of life and health.

The programme provides a flexible and responsive approach to victims' needs. By the end of 2016/17 all 77 GP practices had achieved full 'Domestic Violence Aware' status and were operating the services. Training has also been provided for the county's two main hospitals.

A very high percentage of clients have reported increased safety, and improved quality of life and health.

Future Plans

Following the success of IRIS, the decision was taken to continue the programme and incorporate it into the WCC commissioned domestic violence and abuse support service. This service was re-commissioned during 2016/17 and Refuge are now delivering this service in Warwickshire.

31. Adult Neuro Development Pathway Launch

In February 17, the Adult Neuro Developmental Pathway was launched (including Autism Spectrum Disorder (ASD) and Attention Deficit and Hyperactivity Disorder (ADHD)) which provides therapy-led diagnostic assessment and post diagnostic support to ensure adults in South Warwickshire are diagnosed more quickly, achieving better mental health outcomes for those members of the population.

32. End of Life Care in Warwickshire North

Summary

One of the CCG's priorities was End of Life Care. We have established good working arrangements with a range of local service providers ranging from acute providers, local hospices and voluntary sector organisations. In December 2016 the CCG established a Palliative Care Network which involves key senior personnel from the CCG, George Eliot Hospital, South Warwickshire Foundation Trust, Carers Service, Out of Hours, and our local hospices. This group has identified a range of priority areas which include how partner organisations work better and more closely together going forward, redesigning pathways, establishing a commitment to provide more bedded hospice care within the CCG area examining workforce issues and constraints.

Impact

Increase the number of GP practices who implement a palliative care register to enable shared access to information about patients on the palliative care register. This will improve communications and enable services to better support patients on End of Life pathways to remain in their preferred place of death. Training on the palliative care register has been rolled out across primary care and new advisors have been employed to support the project during 2017. The Advisors have been liaising with practices to deliver training and support the implementation of the register.

The CCG has reinvigorated its plans to develop a model of care known as a Compassionate Community to enhance local people's capacity to support and care for those reaching the end of their life. In other areas this has been achieved through building a network between families, friends, workplaces, schools, local business and places of worship so they can learn about End of Life Care and play an active role in supporting GP's and community services in providing truly personalised support.

Expansion of community support for those requiring end of life care – increasing provision of 'hospice at home' will enable a greater proportion of patients to be treated and cared for in their own homes, avoiding unnecessary hospital visits and admissions.

What comes next?

Mortality Audit to review the Summary Hospital-level Mortality Indicator (SHMI) out of hospital deaths

End of Life Compassionate Communities

Contact details

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Rebecca.Bartholomew@warwickshirenorthccg.nhs.uk

Heather Kelly
Heather.kelly@warwickshirenorthccg.nhs.uk

33. Suicide Prevention Strategy

Activity
In Warwickshire, 105 people died by suicide, confirmed by Coroner's conclusions during 2013 and 2014, more than double the number of people who were killed in road accidents in the same time period.

Suicide is the leading cause of death for males in three age groups (5-19, 20-34 and 35-49), and for women in two age groups (5-19 and 20-34) (Source: Health Profile for England).

During November 2016, Warwickshire County Council, through the Public Health team, launched a multi-agency Suicide Prevention Strategy 2017-2020. The Strategy sets out a clear vision to reduce the number of deaths by suicide in the County: http://publichealth.warwickshire.gov.uk/health-improvement/mental-health/

Impact:
A conference was held in November 2016 to launch the Strategy in Warwickshire. It was attended by over 80 people representing a diverse range of organisations and key stakeholders.

A multiagency Steering Group has been established to develop and implement an Action Plan to deliver the Strategy. The Action Plan has 7 key priority areas:

- Reducing the risk of suicides in key high risk groups
- Tailored approaches to improve mental health in specific groups, with a particular focus on children and young people
- Reducing access to the means of suicide
- Reducing the impact of suicide for people who are bereaved by suicide
- Supporting the media in delivering sensitive approaches to suicide and suicidal behaviour
- Improving data and evidence

Strengthening partnership working to deliver the Strategy

What comes next:
Continued implementation of the Action Plan, to include:

- Improved signposting information for people who are in crisis or despair
- Suicide Prevention Training for key front-line workers
- Dissemination of the Help is at Hand resource for people who may have been bereaved by suicide: supportaftersuicide.org.uk/support-guides/help-is-at-hand/
- Public awareness campaigns through It takes Balls to Talk and World Suicide Prevention Day 10th September.
- Training for local media in sensitive reporting of suicides.

Contact details
Paula Mawson, Comissioning Lead - Public Mental Health
paulamawson@warwickshire.gov.uk

34. Helping Hands Community Project

The Community

Helping Hands Community Project is a local charity who support homeless people and people in need. They provide a soup kitchen and drop in facility for homeless people. They also recycle furniture to support people in need to furnish their homes.

The Challenge

In order to help give some of their customers a training opportunity and to help them move on, Helping Hands decided to open a charity shop and café. The idea was that customers could train in retail and catering in a safe environment where they were welcome and supported. At the same time the shop and café were seen as income generators for the charity to support the good work it does.

Meeting the Challenge

Helen (the Volunteering Co-ordinator) at Warwick District Community and Voluntary Action (CAVA) went to visit the project at the point that the building had been secured and stock was being collected and sorted. At this stage the project was desperately in need of a competent volunteer shop manager to make it a reality. Helen had met with Anthony Dwyer the previous week. Anthony had worked in retail management in the past and for personal reasons had given this up. He was looking to volunteer to keep himself busy until his next job came along. Anthony said "I was thinking of volunteer admin roles but Helen had told me about a local Charity called Helping Hands who wanted to open their first retail Charity Shop and encouraged me to get in contact due to my skills and experience". Helen put Anthony in touch with Lianne Kirkman Charity Operations Director. Anthony said: "I met with Lianne on the 6th October and it was great to be in touch with someone who was so passionate about the people she supports. On the 10th of October I started working for Helping Hands as a Volunteer Shop Manager."

The Outcome

The Shop opened on the 20th October and is exceeding target, with the support of some fantastic volunteers and supported volunteers. They have just started offering volunteers the opportunity to undertake NVQ's to support them on their path to getting paid work. Building work on the café is completed now and it is due to open in the New Year. Lianne Kirkman said "Can I just say, if you have any more volunteers like Anthony Dwyer that become available, we will happily have them. Thank you so much for sending him our way. He's been an absolute pleasure to work with and a God send!"

Outcome 6

Enable older people to be able to remain in their own homes and to live healthy lives for as long as possible.

35. HEART - Home Environment Assessment Response Team
36. Alcester Health and Wellbeing Partnership for Over 55's
37. Fit for Frailty Project
38. Respiratory Rehabilitation Scheme
39. Borough Care
40. Extra Care Housing
41. Lifeline Services

35–41

35. HEART - Home Environment Assessment Response Team (WCBT)

Activity
The new HEART service is an integrated approach between social care and housing which focuses on the customer and their carers, not organisations, to deliver the right practitioner at the right time with the right solution. This will enable the customer choice and control to manage their own lives and maintain their abilities in daily activities within their home that is safe and warm and enable delivery without delay. Customers are assessed for home aids and adaptations, housing conditions, repairs and safety, benefits, grants and loans for essential building works.

Impact
The HEART programme is made up of financial contributions from each District and Borough council and Warwickshire County Council, both Strategic Commissioning and Public Health Warwickshire. Through jointly funding this service, commissioning organisation have gained economies of scale and waiting times for housing adaptations have reduced.

What comes next?
The service will be formally launched in 2017 and will begin to be advertised for non Disabled Facilities Grant (DFG) eligible customers to self fund.

Contact details
paul.coopey@nuneatonandbedworth.gov.uk

36. Alcester Health and Wellbeing Partnership – Wellbeing Project for Over 55s

Summary/Rationale
Alcester Health and Wellbeing Partnership – Wellbeing Project for Over 55s

Activity
Alcester Town Council has been funded by the County Council's Transformation Fund to pilot the design and delivery of a wellbeing service for residents aged 55 and over. The Town Council directly employs a community worker to engage with residents through community networks and identify those who are particularly vulnerable and not engaged in services. The worker helps people to engage in community life, identifies gaps in provision, and develops solutions to meet need, including the recruitment and training of volunteers to develop and deliver their own services.

Impact
The ultimate aim of the project is to support people to remain in their own homes and live independently for as long as possible, reducing demand on public sector services whilst improving physical and mental wellbeing through engagement in community life.

What comes next?
The scheme will run for a further 18 months, and will be evaluated to establish if similar services could be managed and financed through other service providers such as Town Councils, who can access alternative sources of income

Contact
jennymurray@warwickshire.gov.uk

37. Fit for Frailty Project

The Fit for Frailty Scheme launched on 4th July 2016. The scheme consists of 4 components and its aim to encourage GP practices to identify and better manage patients with frailty.

The 4 components are:-
1. Prevention. The CCG have collated and distributed data showing how all 36 practices maximise the opportunities offered in universal screening and immunisation schemes. Data has been supplied by Public Health and has been shared with all practices allowing to see their own performance and how that compares to their 'buddy group' practices. The reporting suite has been designed to show data over the next 3 years. The objective is to drive performance by raising awareness and building on the competitive nature between practices.

2. Moderate Frailty. This component builds on the learning of the 2015/16 over 75's scheme. There are 3 pilots - Alcester and Pool, Prime GP (Meon, St Wulfstan and Arden) and the remaining 31 practices within South Warwickshire. The pilots vary in terms of the mix of the medical/social prescribing with the Prime GP focussing on social prescribing to reduce social isolation and the other 2 pilot schemes combining both. All schemes offer this service to anyone over 18.

3. Severe Frailty/End of Life/Complex. This is the new element for 2016/17. 22 practices have opted out of the Avoiding Unplanned Admissions Direction or Service (AUA DES) and instead the funds are being used to support practices deliver a service targeted at those with severe frailty. The scheme funding is broken into 4 parts - training, establishing a Severe Frailty Register, offering MY Care plan and finally running regular Multi Disciplinary Team (MDT) meetings.

4. The final component is based on infrastructure. Funds have been allocated to developing a robust evaluation process, producing templates to support primary care and ensuring integration with ongoing end of life work and ultimately aligning the whole programme with the Out of Hospital programme.

38. Respiratory Rehabilitation Scheme

Summary/Rationale

Respiratory Rehabilitation Scheme was set up due to a high number of respiratory clients being referred through the local exercise referral scheme. Chronic Obstructive Pulmonary Disease (COPD) is a lifelong debilitating condition that unfortunately there is no cure for. COPD is a massive strain on the NHS as the patient frequently suffers from reoccurring exacerbation attacks, which the patient generally ends up in hospital having to have high levels of steroids and then they are put through another block of physio.

Activity

Two gym sessions a week were set up to help COPD sufferers continue their physical activity post rehab as a high level of patients were readmitted to hospital for continuous Physio due to further exacerbation attacks. The class consists of a structured circuit based class which follows on from the rehabilitation class at the George Eliot Hospital. Within the class there are cardiovascular components to help improve endurance and lung efficiency. There's also a variety of resistance exercises to help strengthen other muscles that assist with breathing plus gaining an all over body work out. These sessions were set up to encourage participants to continue their rehabilitation in a similar environment to the hospital classes.

The class can accommodate various conditions including Asthma, COPD, Emphysema, Post chronic bronchitis, Pulmonary embolism, Post lung cancer, Post pneumonia, Pulmonary fibrosis and Sleep apnoea.

Who was involved e.g. partner agencies

NBBC Sports Development were involved in the setup of the classes and these sessions are linked with the GEH Physio department and the Fitter Futures Scheme (Commissioned by Public Health Warwickshire).

Impact

- COPD clients are more physically active
- Less Exacerbation attacks and reduce re-admittance to hospital
- Reduction of medications and medications stopped due to improvement of conditions
- Social aspects increased as participants have met new people and are now going to other sessions together for example two clients have teamed up and go to short mat bowls at Stockingford Community Centre together.
- Improved Quality of life
- Please see video of our respiratory class and participants – https://youtu.be/WscTBcwCak0
- One client in particular has improved her Peak flow results so much that she is now signed off from her consultant and has had her medication reduced.

What comes next?

Due to the success of our Respiratory Scheme we are now looking to provide further classes for a range of other conditions in the hope we can keep local residents out of hospital and improve their quality of life through physical activity

Link to further information and/or contact details

https://www.nuneatonandbedworth.gov.uk/info/21003/sport_and_fitness/41/get_involved_get_active

39. Borough Care

Summary/Rationale
The Borough Care Lifeline and Support Service provides:

Early intervention: The emergency response service that many of our customers find critical and re-assuring. If someone has a fall or is ill they contact the Borough Council easily for assistance and a prompt response. Support for independent living: Advice and support is available 24 hours a day. This includes a proactive visiting service to customers, which provides help and makes links to other providers tailored to customers' needs.

Activity
Customers contact the Borough Care service through their personal alarm. Our experienced and supportive team is able to act day and night. The service will provide assistance and / or emergency help and, if family or friends are not available, visits are undertaken.

Impact
Borough Care acts to prevent a problem becoming a crisis by getting to know its customers and their needs over time and delivering help such as:

- Home from hospital welfare checks
- Supporting carers
- Help to access to other valuable services
- Help to prevent social isolation
- Promote health and wellbeing
- Supportive visits when a partner has died
- Offering support with the completion of forms

One customer said:

"I value this service with my life. Without it I would be isolated from the outside world. No one would know if I was ill or anything if I could not contact anyone. Lifeline gives me independence. "

What comes next?
Customers can find out more by contacting Borough Care on 01827 711560 (24 hours) or email: **communitysupport@northwarks.gov.uk**, further to which a home visit will be arranged.

40. Extra Care Housing Integrated Model Project

Summary
The extra care housing model locates many elderly residents in one location and through a combination of independent living with communal facility and support provides a model for housing which is expected to increase significantly in the coming years. It was noted however that the cost of treating patients at one of these facilities, Queensway Court, was significant in part due to the lack of coordination between care providers and the large number of elective and emergency admission from this facility.

The integrated solution being developed is a solution for extra-care type of accommodation that can be scaled up or down to suit other types of accommodation. This solution is includes an onsite resource to co-ordinate services.

41. Lifeline Services

Summary/Rationale

Lifeline Service operates 24/7 and provides emergency response and reassurance to over 3,000 residents across Warwick and Stratford districts, and now further afield. Some of the key benefits of this service are;

- 99% of our calls are answered with 30 seconds, all calls are recorded
- We supply the equipment within 5 days of the initial enquiry
- We can fit same day for urgent referral (i.e. discharge from hospital)
- We offer 'fall detectors' to help monitor vulnerable customers with specific medical needs
- We can supply a range of telecare/telehealth products depending on specific needs
- We can supply CO2 detectors and the Lifeline units can be set up to warn when temperatures are too low (risk of hyperthermia)
- We fit keysafes to ensure customers with no contacts can still use the service
- We are a reassuring voice to customers with dementia/confusion
- We offer daily/weekly calls to check customers are ok (social interaction)
- We supply and fit 'bogus caller' buttons, so can listen in to unexpected callers (calls recorded)
- We supply and monitor free of charge to anyone with a terminal illness who wishes to remain at home
- We have refurbished units that we can supply free of charge in special cases

Activity

We have recently started to engage with West Midlands Ambulance Association (WMAA) to improve our service and support their work, as we do call 999 for our customers on a regular basis.

We have set up a system where by the Lifeline Control Centre can 'over ride' the door entry system at certain high rise blocks of flats in an emergency to allow quick access to the paramedics, this was welcomed by Martyn Scott, as at times the crews have to press lots of buzzers to gain access. We are hoping to roll this out to include Police and Fire later this year.

Impact

By working more closely with WMAA we are now able to simplify our 'sign up' form and only collect essential medical information that the paramedics need to know. Not only is this better for the customer, but is more efficient for our service.

We have not yet needed to 'over ride' a door entry system for the paramedics, but if and when we do – this will help to reduce the time it takes to get to someone in need of urgent medical attention.

What comes next

We will be actively promoting the Lifeline service and the benefits over the next 12 months, particularly to doctors' surgeries and hospitals to try and increase uptake of the service for their patients who are elderly/living alone with medical conditions/ risks of falls/vulnerability.

We are looking to trial 'I am a Lifeline customer' stickers for inside customers' homes and an ID card later this year, by initially offering them free of charge to new customers. We already have an agreed 'code word' with the ambulance service which would be used before we released any information relating to a customer.

Contact details

Zoe Court, Project Manager
zoe.court@warwickdc.gov.uk

James Baker, Housing Support & Lifeline Manager
james.court@warwickdc.gov.uk

Outcome 7

Take an asset based approach to working which values communities and the range of assets they possess.

42. Asset Based Community Development Service
43. Social Prescribing and Care coordinators
44. Connectwell - Social prescribing
45. End of Life - Compassionate Communities
46. Health Community Hubs

42–46

42. Asset Based Community Development Service

Summary/Rationale

The County Council offers an Asset Based Community Development Service delivered by 10 Community Development Workers in targeted neighbourhoods across the County. Alongside residents, community groups and local partners, they help to identify 'what's strong, not what's wrong' about an area in order to build community capacity.

Activity

- Over 150 separate projects have been/are being delivered across the county
- Residents, third, public and private sector partners

Impact

Individuals and groups are supported to devise solutions to meet their own needs, especially around physical and mental wellbeing, thus reducing demand on public sector services, eg support to set up volunteer led dementia schemes, youth clubs, lunch clubs, cinema clubs

What comes next?

The service is ongoing, and is designed to support residents to create sustainable solutions with a view to freeing capacity to develop new projects
- hannahcramp@warwickshire.gov.uk

43. Social Prescribing and Care coordinators

Summary/Rationale

Five projects in South Warwickshire encompassing care coordination and social prescribing to assess the impact of these schemes on patient health and wellbeing. The main aim is to support patients to stay fit, well and active and support their care holistically utilising currently existing voluntary and third sector services.

Activity

1. Care co-ordination for patients of St Wulfstan Surgery (practice staff, GP Federation and CCG)
2. Care co-ordination for patients as part of the CCG Fit For Frailty Scheme (practice staff, Age UK and CCG)
3. Care co-ordination for patients at Alcester health Centre (practice staff, and CCG)
4. Social prescribing at the Brunswick Hub, Leamington
5. Social prescribing at the Sydni Centre, Leamington

Organisations involved include practice staff, care coordinators, Age UK, Warwickshire County Council, South Warwickshire GP Federation, Prime GP and the Brunswick Hub.

Impact

- The pilots are still ongoing but early indications are that patients are able to better access non-medical care from third sector and other organisations, supporting them to remain healthy and stay fit and well in their own home. GPs who are utilising the Age UK service feel that they are a highly values resource to support their frail patients to stay well.
- The social prescribing schemes are slowly building as the coordinators get to know patients and the services available but a number of people have accessed the team to find out more about services in the area and the ways in which they can be supported in the community.

For example, it was arranged for an older lady who wanted to walk more to join a walking group where she met up with friends she hadn't seen for years. This has helped her become more active, increase strength and has meant she is not as socially isolated.

What comes next?

The social prescribing pilots at Brunswick and Sydni are being monitored by all partners and the aim for the Brunswick pilot is to increase GP referrals. Waterside Medical Centre who host the team on Mondays have recruited 5 volunteers from their patient group to help publicise the service available to patients.

44. Connectwell - Social prescribing

Summary/Rationale
WCC, Public Health and Warwickshire North CCG are progressing work towards a joined up model for commissioning future Social Prescribing activity from NHS England to support the Age UK model. There remain numerous different approaches in either full operation or pilot stage around the County.

Activity
To pilot a social prescribing approach based in GP practices. The pilot will test out the use of volunteer health buddies and coordinators who will support patients to identify and meet non-clinical needs, which if left unmet may impact on their health and wellbeing. Health buddies and coordinators support patients to access a range of local community provision.

Impact
A new Client Management System is being rolled out across the project to assist with data capture, monitoring and closing the feedback loop to referrers.
With secured funding support from WCC, ConnectWELL are set to extend the service across the county.

45. End of Life - Compassionate Communities

Summary
An End of Life Compassionate Community (EoL CC) is a programme whereby a community is supported to talk more about death and dying and are enabled to support those reaching the end of their life and their families and carers to have a better quality experience. The programme draws on and reinforces the strengths in communities and brings together a wide range of partners who can work together to meet local priorities around death, dying and the provision of end of life care.

Contact
Berni Lee – Consultant in Public Health
Amy Sirrs – Strategic Commissioning

46. Healthy Community Hubs

The facilitation service invitation for quotations closed at the end of February 2017 and was awarded to the Healthy Living Network. Work will begin during 2017/18.

Facilitation and service delivery support to champion health and wellbeing across the Community Hubs working with staff in the Borough Council, Warwickshire Community and Voluntary Action, Warwickshire County Council and the Hubs, to train, make materials available, support events and coordinate service delivery with commissioners.

Outcome 8

Work in partnership with our communities to build capacity and support them to increase their resilience, enabling them to better care for themselves within the community.

47. Wider Determinants Funding from Public Health
48. WCC County Councillor Grant Scheme
49. Warwickshire Association of Local Councils
50. Health and Wellbeing Working Party
51. Warwickshire Dietetic Service
52. Community Hubs- Adult Customer Journey (WCC)

47–52

47. Wider Determinants Funding from Public Health

Summary/Rationale

Warwickshire County Council, Public Health offer community and voluntary sector organisations the opportunity to bid for funding, with the aim to kick-start small projects across all of Warwickshire that pilot new ideas focussing on:

- Using and improving green spaces for exercise and/or health
- Reducing Loneliness & Social Isolation
- Reducing the harm caused by drugs & alcohol
- Mental health and wellbeing

A total of £60,000 was awarded to 11 projects throughout Warwickshire in 2016. These are detailed below.

Activity

Of the 11 projects awarded funding in 2016 these included:

- Age UK 'Dementia movement and music';
- Bidford on Avon Parish Council 'green gym on the big meadow;
- Harbury Parish Council encouraged and facilitated exercise in the elderly;
- Coleshill Town Council 'green gym' in the memorial park;
- Nuneaton and Bedworth Healthy Living Network linked volunteers who love cooking to share food with others in the local area to support a large number of people living with dementia and their carers;
- Outreach and community action project in Nuneaton, adult exercise class and a community choir aimed at reducing loneliness and social isolation in rural areas;
- Parkinson's UK Rugby 'shape it up Pilates';
- Rugby Art Gallery and museum set up a long term project aimed at people living with dementia, their carers and older people suffering from isolation in Rugby through craft sessions and one off small events and workshops;
- Warwickshire reminiscence 'looking after a loved one' provided information on a variety of dementia related issues that carers face and encouraged networking and peer support;
- Warwickshire Race Equality Partnership (WREP) 'physical and emotional wellbeing in the black minority and ethnic community';
- Warwickshire Wildlife Trust encouraged the local community around Rugby to be more active and increase the community's use of green spaces.

Impact

Through these 11 projects many individuals reported feelings of improved mental wellbeing, increased social interaction and increased use of outdoor green spaces for exercise/health.

What comes next?

Funding for the above projects ran from 1/4/16 to 31/3/17 with the potential for additional funding for a further 12 months, of which Rugby Art Gallery and Museum and Warwickshire Wildlife Trust were successful

Contact details

For more information please contact Gemma Stainthorp, Public Health Officer
gemmastainthorp@warwickshire.gov.uk

48. WCC County Councillor Grant Scheme

Summary/Rationale
The County Councillor Grant Scheme (£5k per Councillor) is available for grass roots community groups and town and parish councils to support the development of small scale locally based projects/activities which help to build community capacity.

Activity
- Each year the County Councillor grant scheme supports over 500 community organisations to deliver a range of activities that help their residents and offer new opportunities to engage in community life
- County Council and third sector organisations

Impact
- Investment of relatively small amounts of funding through grants rather than contracts can stimulate community engagement and activity
- Improvements to village halls results in increased use by community groups
- Support for community fun days results in increased community wellbeing
- Purchase of equipment enables groups to thrive, grow and encourage new membership
- Investment in training for community leaders results in more sustainable local groups
- Recruitment of new volunteers strengthens the community's and individual's sense of wellbeing
- Applicants are asked to demonstrate how their project helps the County Council to achieve it's objectives

What comes next?
The scheme will be made available on line this year - jennymurray@warwickshire.gov.uk

49. Warwickshire Association of Local Councils (WALC)

Summary/Rationale
The County Council invests in Warwickshire Association of Local Councils (WALC) to provide support to the 200+ Town and Parish Councils across the County in order to build capacity and improve communication and collaboration.

Activity
- As part of its service agreement with WALC, the county council supports the training of Town and Parish Councillors (T&PCs) and Clerks to operate high quality, responsive, community focused services on behalf of the residents of Warwickshire in parished areas
- In addition, the service agreement enables closer partnership working between the County Council and T and PCs as the grass roots community leaders in our area. Examples of this include some T and PCs taking on responsibility for environmental services to improve the appearance of their villages, a parish council developing a community resource hub through the village hall, and a town council developing a wellbeing service for local residents aged 55 and over
- County Council and WALC/ individual T and PCs

Impact
Ts & PCs empowered to take on the design and delivery (and future funding) of local services, thus reducing demand on other public sector services

What comes next?
Ongoing developments to further build capacity through shared training opportunities with WCC, WALC and WCAVA - jennymurray@warwickshire.gov.uk

50. Health and Wellbeing Working Party

Summary/Rationale

The Health and Wellbeing Working Party was created in April 2016 to establish and structure the corporate contribution to the health and wellbeing agenda

Activity

The Working Party monitored the implementation of the Health Improvement Action Plan (2014 to 2017). It has also coordinated and developed the Health and Wellbeing Action Plan (2017 to 2020). It was also responsible for the new pricing structure with regards to accessing the Physical Activity on Referral scheme at the Authority's leisure centres (Fitter Futures), and enabling all residents of North Warwickshire to access the scheme as opposed to participation being based on GP surgery.

Who was involved eg. partner agencies The Consultant in Public Health (Population and Place) attends the Working Party and the Health and Wellbeing Action Plan involves contributions from internal partners across the Borough Council. It also monitors activity led by Public Health, Warwickshire County Council, Nuneaton and Bedworth Leisure Trust (Fitter Futures) and Parish Councils.

51. Warwickshire Dietetic Service Talks delivered for Warwickshire Racial Equality Partnership (WREP) during 2016

Background

In March 2016, the Dietetic Service was contacted by the Trust Equality and Diversity lead with a request to deliver talks to some community groups. The Trust had been asked to provide this by WREP (Warwickshire Racial Equality Partnership).

WREP had been told that service users don't understand nutrition / healthy eating as the information given does not reflect cultural food and they find it hard to apply generic information to what they eat at home. They asked if a dietitian who understands the culture could deliver a talk and answer questions on how to eat healthier, especially for those at risk of diabetes and heart disease.

The talks were to be delivered to 5 groups across Warwickshire - to two in Nuneaton (one Punjabi, one Gujarati), two in Leamington Spa (both Punjabi) and one in Rugby (Caribbean). The intervention was added to the Trust Equality and Diversity Action Plan.

Planning

A dietitian met with the groups' co-ordinator to discuss the best way to address this request in Rugby, Leamington, and Nuneaton. It was decided that 3 sessions would be held for each group. The co-ordinator would run a session to identify the specific issues of concern for that group. These would be passed to the dietitian who would use them as the basis of her talk 2-3 weeks later.

It was agreed that the talks would be delivered in English and the co-ordinator or a member of the group translate as necessary. During the session, the people attending would be helped to identify an individual action plan for change. The co-ordinator would then organise a third session to give people the opportunity to discuss their progress with the action plan.

A resource was developed for the groups that included a pictorial representation of a healthy diet and space for individual action plans. The co-ordinator photographed each participant's action plan to use in the 3rd session. Participants took the paper copy home.

Feedback from Co-ordinator

"I have been back to the groups and the ladies have made the following changes;

- Eating less butter / oily foods
- Drinking more liquids & eating more fruit / vegetable
- Being more aware of the colour coding on food (The majority of ladies did not know what this meant previously and requested more information)
- Eating smaller portions & "trying" to cut down on salt
- Drinking more milk and eating yoghurt
- Eating less processed meat.

I think it definitely worked with you doing the talks and me interpreting. I also felt that as the sessions were informal there was less pressure on the ladies, they were able to be honest and not hide what they like to eat!

I think the groups found that previously the information that they were given was contradictory, so they were able to ask questions freely in their own "comfort space". I know that the sessions may have appeared chaotic, but I thought the sessions went down well and the ladies certainly found it useful."

52. Community Hubs – Adult customer Journey (WCC)

Summary

Supporting residents and community groups to utilise community assets to help themselves and others. This includes the development of three proof of concept community hubs and improved information and advice, which aim to help people to become more resilient and knowledgeable at an early stage, by making it easy for people to access the right information and advice easily.

Outcome 9

Empower individuals and communities to take control and responsibility for their own and the community's health and wellbeing.

53. Warm and Well
54. Making Every Contact Counts and Five Ways to Wellbeing
55. Over six stone lost by management team at SWFT
56. Nutrition and Hydration
57. #onething campaign
58. Citizen Advice
59. Armed forces community covenant
60. Alcester Health and Wellbeing
61. Community asset mapping

53–61

53. Warm and Well

Summary/Rationale

The 'Warm and Well in Warwickshire' programme offers advice and support to residents who may be living in fuel poverty and struggling to heat their homes to help them to stay well in winter. We know that living in a cold home can negatively impact on health and wellbeing, especially for those with long term health conditions, the elderly and very young.

Activity

Warwickshire County Council's commissioned provider Act on Energy service includes a freephone helpline for all Warwickshire residents offering advice and information on energy saving, switching, tariffs, benefits, and referrals for energy efficient insulation, boiler repair/replacement and other physical measures to those who are eligible. They also offer training to frontline staff to help them identify the signs of fuel poverty so they can refer people for help and support quickly.

Impact

Outcomes for 2016/17 reported from Act on Energy include:

- 2760 households received support in the form of information, advice and guidance, just under 70% of whom had a long term health condition, with a confirmed average saving of £250 (through switching)
- 147 households received a physical intervention (heating or insulation
- 84 households had a boiler replaced which provided them with more warmth and an average saving per household of £152 per annum.

The physical interventions have led to improved Energy Performance Ratings. The average increase is 10 SAP points and an average band D which is the 2025 fuel poverty target.

Warwickshire Welfare Rights have also provided benefit support to residents, this has resulted in households across Warwickshire gaining an additional £98,104 in benefits.

What comes next?

We will continue to explore all collaborative opportunities with a wide range of partners, especially CCG partners, to co-invest in projects to tackle fuel poverty and to evidence the health outcomes.

Link/contact details

Nadia Inglis, Consultant in Public Health
Rach Bentley, Public Health Officer
actonenergy.org.uk/project/warm-well-in-warwickshire/

54. Making Every Contact Counts and Five Ways to Wellbeing

Summary/Rationale/Activity

Warwickshire County Council (WCC), Public Health have developed a refreshed Making Every Contact Counts (MECC) training offer for front line staff in Warwickshire. The training comes in 3 parts:

- A 45 minute e-learning programme and/or
- A half day face-to-face training session delivered by Citizen's Advice Warwickshire
- A half-day train-the-trainer session for practitioners to cascade MECC training throughout their organisation

Public Health rolled out the training in April 2017 to all county council staff. The training will be available to all Health and Wellbeing Board partner organisations.

Five Ways to Wellbeing eLearning (initially launched in January 2016) has been updated and now provides further support for staff to build wellbeing into their daily life. All WCC staff have been encouraged to complete this elearning as a way to build wellbeing into their daily lives. In addition the eLearning also aims to build the confidence and skills of Frontline Practitioners when promoting and supporting others to build wellbeing into their daily lives (Frontline Practitioners are obliged to promote wellbeing under the Care Act legislation).

Impact

- Five Ways to Wellbeing eLearning has been rolled out to all staff in WCC, George Eliot Hospital NHS Trust and South Warwickshire Foundation Trust.
- MECC has been rolled out to front line staff in WCC

What comes next?

MECC will be rolled out to further front line staff within the NHS in Warwickshire from September 2017, with further roll-out planned for Districts and Borough Council staff.

Five Ways will be rolled out to CWPT and Districts and Borough Council staff in Autumn 2017, with further roll-out planned.

Link/contact details

Kate Ray, Public Health Officer - MECC
www.warwickshire.gov.uk/mecc

Claire Taylor, Health Improvement Lead - Five Ways to Wellbeing

warwickshire.gov.uk/5ways

55. Over six stone lost by management team at SWFT

Inspired by Warwickshire Council's 5 Ways to Wellbeing scheme, 14 members of staff, which included Executive Directors, took part in a 6 week weight loss programme.

The rules were simple – one side of the management corridor against the other to see which side could lose the most weight. Team A was headed up by Jayne Blacklay, Director of Development and Team B, Glen Burley, Chief Executive.

Each team also had an 'official' who was responsible for each week's weigh in and this meant that individual's weights were not known, just the amount lost or gained. A white board detailed all the results so everyone could see how they were doing and a running total of weight loss kept everyone motivated.

It generated a real team spirit and the first noticeable change came on day 2 when someone not taking part put out cakes for the corridor, which on a normal day would last ten minutes and instead did not get eaten at all.

The 5 Ways to Wellbeing is an e-learning programme being offered to Trust staff to encourage them to consider their own wellbeing as well as that of their patients.

The initiative highlights ways to build the different aspects of wellbeing into daily lives - Give, Connect, Take Notice, Keep Learning and be Active

In total 84.5lbs were lost over the 6 week period and it has generated a culture of wellbeing across the corridor. Overall the weight loss challenge was really successful and would definitely be recommended to any other departments or groups that would like to take part.

56. Nutrition and Hydration

Nutrition and Hydration are specialist areas of prevention work that both South Warwickshire NHS Foundation Trust and Warwickshire County Council have been working together on. An initial pilot project in South Warwickshire was aimed at reducing the demand on community services for patients with catheters during summer months by providing proactive advice.

A training package was developed and delivered to a number of staff who work in the Integrated Single Point of Access (i-spa), which is the main contact centre to access community health services. The staff in this centre were vital to the project as they speak with patients on a regular basis.

A letter was sent to 674 people who have a catheter to inform them that they would be contacted to discuss how they could keep themselves well during hot weather. This was because it had been identified that if not hydrated there can be additional problems with catheters.

The aim was to shift the focus from reactive to proactive care and to deliver education and advice to patients at risk of dehydration.

The results showed a decrease in community visits for catheter patients demonstrating the positive affect this preventative approach had on patient care.

57. #onething campaign

Summary/Rationale/Activity

The #onething campaign engages the population of Warwickshire North to pledge one thing to improve their lifestyle. Residents are then supported online and/or signposted to relevant services. The #onething campaign works in partnership to offer mini health checks within the local community.

Impact

- #onething team completed 1352 mini health checks and 845 #onething pledges in Warwickshire North
- The mini health checks targeted areas of high priority (based on deprivation, cardiovascular disease rates, mosaic data) to ensure that those that are most vulnerable to long term preventable/manageable conditions are identified early based on the demographic data. This has led to a high number of referral rates to GPs for further investigation.

What comes next?

We are looking at how to roll out the service to create a more sustainable model

Link/contact details

Yasser Din, Public Health Project Officer – youronething.co.uk

58. Citizen Advice

Summary/Rationale

The County Council invests in a Countywide Advice and Welfare Benefits Service (contract delivered through Citizens Advice, Warwickshire Employment Rights Service and Warwickshire Welfare Rights Service) offered to individuals most in need of support to manage debt and financial capability.

Activity

- The services are delivered in local settings around the County, including outreach in community venues and one to one support in peoples' homes when appropriate.
- Countywide, the service is overseen by a Financial Inclusion Partnership which generates specific projects to support individuals, eg tackling food and fuel poverty, provision of affordable credit
- Public and third sector partners across Warwickshire

Impact

The support offered helps people to manage crisis situations, which are often multi faceted and complex, and then offers advice on how to manage their finances on an ongoing basis, thus reducing demand on public sector services such as housing, mental health, council tax.

What comes next?

- Expansion of Reach Out and Help scheme delivered by Citizens Advice which targets potentially vulnerable people who are unlikely to self-refer to the service, and offers advice in peoples' homes

Contact details:

charlesbarlow@warwickshire.gov.uk

59. Armed forces community covenant

Summary/Rationale
Establishment of the Sub Regional Armed Forces Community Covenant Strategic Partnership – to ensure that the Covenant is implemented across Coventry, Solihull and Warwickshire to directly support ex forces personnel and their families who may face difficulties with integration into community life and remove barriers to accessing services

Activity
- Development and roll out of AFCC E-Learning modules, including modules for public sector staff, Serving Forces personnel and training on Housing and Transition for front line workers public and third sector partners across the sub region

Impact
Front line staff better equipped to offer appropriate and tailored support to ex forces personnel who may be vulnerable to ensure they are best equipped to engage in civilian life, thus reducing demand on public sector services

What comes next?
Ongoing work to identify opportunities to support ex forces personnel and their families.

Contact details:
louiserichards@warwickshire.gov.uk

60. Alcester Health and Wellbeing Board

Summary/Rationale
Establishment of Alcester Health and Wellbeing Board

Activity
- The Alcester H and WB Board was initially established by Alcester Town Council to be a steering group for their older peoples' wellbeing project. The remit of the Board is now extended to encompass all elements of H and WB in the Alcester area, and is investigating how it can take on the design and possible delivery of other services to meet the needs of local residents, engaging in the new JSNA process based on geography as opposed to theme.
- There is also an emerging Health and Wellbeing Forum in Studley, where local schools are engaged with the parish council and other partners to establish a variety of health and wellbeing schemes, including a community allotment, and trim trail on the school site for the local community to use

Impact
The outcomes are yet to be established, but the vision is one the County Council and other partners are keen to support in the roll out of the new JSNA approach

Contact details:
jennymurray@warwickshire.gov.uk

61. Community asset mapping

Summary/Rationale

Development of community asset maps of targeted neighbourhoods, as part of the County Council's overall approach to making information as accessible as possible to our residents and partners, so they have the information they need to manage their own health and wellbeing.

Activity

Each of the County Council's community development workers has completed a detailed asset mapping exercise in the targeted neighbourhoods they work in.

Impact

These maps are used mainly by partners at the moment to signpost residents to community provision, although some are produced in leaflet form for residents. This helps to maximise the impact of the wide range of services on offer in a specific locality – helping people to understand what is on offer, and how they access support. For example, the team has been working with the County Council's new Domiciliary Care providers to raise awareness of local community provision. In turn, the providers will ensure that residents are informed and encouraged/supported to engage in the community services that best meet their needs or aspirations. In turn this will help reduce demand on public sector services.

Impact

In the longer term, these maps will be used to inform the new app being developed to replace the Warwickshire Directory of Services. We aim to work with the County Council's other commissioned service providers to raise awareness of community provision, and also to offer this support to our in house social care teams as appropriate.

Contact details:

janecoates@warwickshire.gov.uk

Outcome 10

Ensure infrastructure, public services and resources are effective, accessible and tailored to those communities that need it the most.

62. Interdisciplinary Hubs
63. Community Hubs (WCC)
64. Out of Hospital
65. Strategic Leisure Review

62–65

62. Interdisciplinary Hubs

Activity
In 2016/17, a number of statutory and voluntary organisations got together to mobilise wider partner engagement and contribution to our interdisciplinary teams working together around clusters of GP practices (Interdisciplinary Hubs) in Warwickshire North.

Impact
The location of these four hubs has been modelled around clusters of GP surgeries that share similar patient priorities and challenges, working together with district and local councils, mental health, community health, public health and the voluntary sector to work together to meet the holistic health and social care needs of patients. With the aim of solving local issues and responding more sensitively to local needs through better joined up working at a very local level. Each team has worked together with other statutory and voluntary organisations in a local area to identify shared priorities, generate local solutions, identify opportunities for innovation, shared good practices and developed action plans which meet local needs and support the objectives of the CCG's out of hospital transformation programme and primary care strategy. We are grateful to our Practice Manager leads that have been instrumental in developing local relationships and working hard to wire together local partnerships which benefit patients.

What comes next?
Develop the model through the National Association Primary Care Homes programme

Contact details – jenni.northcote@warwickshirenorthccg.nhs.uk

63. Community Hubs (WCC)

Summary/Rationale
WCC is investigating the potential to establish 'Community Hubs' in Warwickshire. The Community Hubs would have three key functions: Access to Universal Services; Delivering Guided Conversations; Delivering Specialist Services.

A key underlying principle of the hubs model is that the initial point of contact for customers (Function 1) should be through self-serve, either from home or from a 'connected' community opportunity. A robust self-serve offer will mean that customers will be able to resolve many of their concerns and needs via a hub or online, rather than through direct contact with the Council. Function 2 involves delivering guided conversations and Function 3 involves the delivery of specialist help and support.

Activity
Initial proof of concept sites will be developed in Brownsover (and surrounding area); Alcester, Bidford and Studley; Atherstone (with a reach throughout North Warwickshire Borough).

64. Out of Hospital

Summary

Out of hospital services are those provided by GP practices; some community services such as occupational therapy, district nursing, and physiotherapy; some mental health services; and social care services. It is our belief that some specialist services that are currently provided in hospital could also be provided in the community.

Through the Out of Hospital Programme, we want to:

- Have a healthier population who feel able to care for themselves where they can and who receive the right treatment, in the right place, when they need it.
- Reduce demand on health and care services by planning the way we work and how patients access our services in a better way.
- Improve care and quality of services.
- Provide excellent health and care services over the long term within the limits of the funding we currently have.

The organisations that buy health and care services in Coventry and Warwickshire are coming together to commission (or buy) one service for Out of Hospital care. The organisation that is commissioned to provide the service will be given a budget and a number of specific health and care outcomes that they will need to achieve for the local population.

These outcomes are things like: people having an excellent experience of care; increasing the number of people making healthy lifestyle choices; keeping people independent as long as possible at the end of their life; and personalising care for the patient to meet their specific needs.

The organisation providing health and care services needs to work in a different way to achieve these outcomes. Doctors, nurses, therapists and social workers will work together to deliver different types of care in the community.

65. Strategic Leisure Review

The Review was commissioned in August 2016 and the associated Leisure Facilities, Green Space and Playing Pitch Strategies are due in 2017/18

Summary

Strategic Leisure Ltd was appointed to undertake to the production of a Health, Well-being and Leisure Strategy for the Authority. This work will include the production of a Leisure Facilities Strategy, a new Green Space Strategy and a Playing Pitch Strategy, which will shape service provision across the Borough until 2031.

Outcome 11

Facilitate communities to take ownership of shaping and transforming local services.

66. Kingswood Road Youth Club, Grove Farm, Nuneaton
67. Coventry and Warwickshire Stroke Services
68. Have Your Say Days
69. Rugby Edible Action Partnership (REAP)
70. Community Catalyst programme
71 Polesworth Youth Project

66–71

66. Kingswood Road Youth Club, Grove Farm, Nuneaton

Summary/Rationale

Kingswood Road Youth Club, Grove Farm, Nuneaton – the County Council has developed a scheme in partnership with local residents to set up a youth club in an area where there was previously no provision, and a high level of need

Activity

- The sessions run weekly, and offer sports activities, trips, cooking sessions, homework clubs, arts and crafts, and the programme has been designed by the young people themselves. Also on offer is a qualification in Youth Work.
- WCC, WAYC, local residents, police, N and BBC

Impact

- 5 young people being trained as rock climbers, improving health and wellbeing
- 2 young people being trained to be Youth Workers
- Improved health and wellbeing through healthy cooking and eating, improved confidence and skills gained for life

What comes next?

- A new parents forum to be established to work alongside the group
- Intergenerational activities
- tamsynkeyte@warwickshire.gov.uk

67. Coventry and Warwickshire Stroke Services

South Warwickshire CCG Governing Body approved the Improving Stroke Outcomes for Coventry and Warwickshire Business Case following public engagement and a consultation process has been designed in anticipation of NHS England approval.

The business case is our response to the regional approach for improving stroke services. We are implementing the Midlands and East Stroke Service specification which will ensure stroke services are fully integrated with an end to end pathway for pre hospital, assessment, treatment, rehabilitation and long term care.

The key improvements that will be made are:

1. In future everyone who suffers a stroke or who present with symptoms of a stroke will be assessed within 72 hours, mortality will be at national average and levels of dependency following stroke reduced.
2. In future everyone who suffers a stroke will have timely and equitable access to hyperacute and rehabilitative care as described in the Midlands and East pathway. People's ability to recover from a stroke will be optimised to similar levels for like populations.
3. In future everyone who suffers a mini stroke, or high risk Transient Ischemic Attack (TIA), will receive care within 24 hours from a central service at University Hospitals Coventry and Warwickshire NHS Trust (UHCW).
4. In future all staff who work with patients on the new pathway, will be part of an integrated stroke service across Coventry and Warwickshire, irrespective of whether they provide the care in an acute or community setting. They will work in an interdisciplinary team, learning and developing together.

We believe this improvement to stroke services will be of great benefit to the people of south Warwickshire.

68. Have Your Say Days

The CCG regularly undertakes Have Your Say Days which are used by the CCG to understand the needs and requirements from the local community that it serves.

It's important that the public come to meetings like this as the conversation and debate helps the CCG gain a real understanding of what matters to our local population and how, as commissioners, we can ensure that the services we commission are what patients need.

The feedback that we received from our previous Have Your Say Days has helped shape a number of initiatives that we have introduced in South Warwickshire. Now, more than ever, keeping well and accessing health care is important for many people and by hearing the views of the public we can ensure that these views help to shape our plans for the future

69. Rugby Edible Action Partnership (REAP)

Summary/Rationale

Rugby Edible Action Partnership (REAP) is a local network of organisations, groups and activities across Rugby borough who individually have an interest is: edible gardening, community cooking, healthy eating, and food budgeting.

The network aims to promote and support community well-being across Rugby Borough, by working in partnership to: tackle food poverty and inequality; develop strong communities; improve health and encourage better living.

The partnership aims to meet at least twice a year to ensure all partners can network, identify key priorities and work together to deliver agreed projects.

The current priorities are: 1) the need for better coordination of related activity across the borough to ensure the effective distribution of surplus produce to those who need it most and; 2) developing a pilot project(s) to address the issue of holiday hunger.

Activity

To date a number of community-led edible gardening schemes have been supported and it is hoped that these will be extended to cover more of the borough, providing a network of edible gardens across the borough. In some areas these beds have also provided the opportunity for community events which have focussed on celebrating local action through communal planting sessions and local cooking demonstrations (often using the produce from the beds themselves).

A very successful community cooking project was also delivered. This comprised a number of different elements, including: a small funding pot to enable groups to buy ingredients; community food information bulletins; and a community cooking course.

Two networking events have also been organised along with a dedicated session to look at proposals to address the 2 key priorities outlined previously.

NB. these activities have not necessarily been initiated by REAP but have been delivered by the organisations that are part of the network.

Impact

No official evaluation of the impact of REAP has been undertaken, however anecdotally it has been reported that the activities outlined above have encouraged communities to work together to support health and wellbeing outcomes, including: physical activity, heathy eating, tackling isolation and improving general wellbeing
NB. it should be noted that these activities have not necessarily been initiated by REAP but have been delivered by the organisations that are part of the network .

What comes next?

A planning group to develop the holiday hunger scheme(s) will be pulled together to meet early July.

Community Food bulletins continue to be circulated 3x a year with an annual update of the Lunch Clubs, Community Cafes and Coffee Mornings leaflet.

Continued promotion of the Rugby Community Cooking Resources (including the free loan of up to x10 cooking crates)

A “Community Edible Garden” leaflet is planned.

Further scoping about developing a more coordinated approach to food distribution

For further information, please contact Hannah Cramp, Localities and Communities Officer (Rugby), Community Safety and Locality Working Team, WCC at hannahcramp@warwickshire.gov.uk

70. Community Catalyst programme

Community Resilience
Facilitate communities to take ownership of shaping and transforming public services.

Summary/Rationale
Warwickshire is one of only 2 areas nationally to have been funded to establish a Community Catalyst programme over the next 2 years. Community Catalysts offer support to community groups/individuals to establish small scale, self organising enterprises (especially those focused on health and wellbeing) rooted in local neighbourhoods.

Activity

- A number of workshops to be held in June for local community organisations interested in engaging in the process
- Community Catalyst Co Ordinator to begin work with selected groups during the course of this year

This activity will support the HWB strategy, as it will build capacity and resilience in the social care/health market to support an increase in demand for services. It will also build capacity within groups and individuals to help them establish their own businesses, work locally and offer employment to local people. People in receipt of these services will be well supported at home by people from their neighbourhood. People will stay connected to their community and avoid loneliness. Money is saved as the cost of care delivered by community enterprises is cheaper.

Contact
janecoates@warwickshire.gov.uk

71. Polesworth Youth Project

The Community
Following on from previous work undertaken in Polesworth around anti-social behaviour, Warwick District Community and Voluntary Action (WCAVA) North Warwickshire worked in partnership with Warwickshire County Council (WCC) to support the setting up of a Youth committee. WCAVA supported the new committee with writing a constitution, opening a bank account and ensuring that the correct policies, procedures and insurances were in place.

The Challenge
WCAVA had already received £1,000 from WCC for some initial outreach work. We were then offered £4,960 from North Warwickshire Borough in order to get the youth project up and running. Once the committees bank account was up and running we were able to transfer some of the money across to them for the committee to take over responsibility for the youth project. We were aware, however, that this would only keep the youth project going for a limited time. As we had a proactive and passionate committee in place it seemed like the right time to look at applying for some additional external funding.

Meeting The Challenge
As we established the youth project we started to get large numbers regularly attending and a core group of young people were identified. The youth workers were able to recognise issue based work that the young people would benefit from. This looked at work around substance misuse including drugs and alcohol, healthy relationships, mental health, wellbeing and stress management. WCAVA then worked with the committee to put together an 'Awards for All' funding bid to continue the youth project and combat some of the issues identified by the youth workers.

The Outcome
Thankfully this bid was successful and the committee were awarded £9,956 which will secure the youth project for another year.

Outcome 12

Improve educational attainment
and access to learning at all ages.

72–73

72. Warwickshire School Health and Wellbeing Service

Summary/Rationale

During 2015, Warwickshire Public Health led the procurement of the 'School Health & Wellbeing Service' (formerly known as School Nursing). The development of the new service was informed by an audit of the school nursing service and engagement with children, young people, parents, schools and a broad range of professionals. School nurses play a crucial role in improving the health and wellbeing of children and young people in Warwickshire. The service is available to all school children aged between 5-19 years old (up to 25 years old for people with special educational needs) and their families and carers.

Activity

The transformation of the service has led to a number of changes to improve the service and meet local need. Examples include:

- Streamlined services - one countywide telephone number, three locality teams, North, Central and South
- Needs led health education sessions with children and young people
- Integrated referral and care pathways e.g. substance misuse service
- Each staff has a specialism e.g. mental health, young cares, to better understand/ respond to individual need

Impact

- 42% eligible reception children completed a needs assessment (up from 25% the previous year)
- 91% eligible year 6 children completed a needs assessment (up from 80% the previous year)

What comes next?

Examples of what is to come during 2017/18:

- Launch year 9 needs assessment, including a social norms pilot
- Launch of ChatHealth - free text messaging service for young people
- Development of youth health champions within schools

Link/contact details

Kate Sahota
Commissioning and Performance Lead
School Health & Wellbeing Service Annual Report is available online -
warwickshire.gov.uk/schoolhealthandwellbeing

73. Heart Shield

Activity
Cardiopulmonary resuscitation (CPR) training targeted at secondary school pupils delivered by Fire and Rescue Service joint funded in partnership with Public Health.

Impact
Heart Shield is a pilot project commissioned by Public Health and delivered by Warwickshire Fire & Rescue (WFRS) which was launched in June 2016. The sessions are designed for a class of 30 pupils to spend at least one hour, with delivery involving a short presentation and DVD, before the practical "hands on" learning takes place. We have created an hour's lesson in consultation with teachers, which fits in with Personal, Social Health Education (PSHE) lessons to suit the school timetable. The aim of the project is to enable secondary school pupils across the Warwickshire to be trained in:

- Emergency life support skills such as CPR.
- A Public Access Defibrillator/Automated External Defibrillator (PAD/AED).
- How to keep your heart healthy (eat healthily and keep physically active, and reduce their risk of having a heart attack in later life).
- Encouraging families and friends to reduce the risks of cardiovascular disease (CVD).

The long term aims are to

- Help people increase quality of life and decrease premature mortality from cardiovascular disease.
- Increase levels of bystander CPR.
- Reduce health inequalities across Warwickshire.
- Increase survival rates from out of hospital cardiac arrests.

Impact
Over 2,250 have been trained to become lifesavers and ambassadors to promote good heart health

What comes next?
The service will aim to reach out to more schools across Warwickshire and continue to train new pupils each year.

Contact details
Yasser Din

Outcome 13

Facilitate communities to expand social capital and neighbourliness, building and increase in resilience.

74. Promoting volunteering
75 Timebanking
76. Domiciliary care (WCBT)
77.South Warwickshire Health Champions
78. Nuneaton and Bedworth Volunteer Awards 2017
79. The Brownsover BREW

74–79

74. Promoting volunteering

Summary/Rationale

The County Council invests in Warwickshire Community and Volunteering Action (WCAVA), through a contract, to promote volunteering, recruit volunteers, ensure they are suitably placed, and support organisations who work with volunteers. The County Council also recruits and manages a wide range of volunteers to support and enhance a variety of services including libraries, countryside, heritage and culture, environment, footpaths, family support, youth justice and governors.

Activity

The service is available in each District and Borough, and through outreach in community settings. A new website Volunteer Connect has been developed to match volunteers to opportunities, in addition to face to face services and support. WCAVA is tasked with recruiting new volunteers, especially to support our priority services which are health and wellbeing focused. WCAVA is also working with private sector organisations to encourage staff volunteer schemes in support of their Corporate Social Responsibilty aspirations

Impact

There is a thriving volunteer economy in Warwickshire, where residents and employees donate their time to support their local community and individuals who may be vulnerable, isolated or lonely. Research has shown that volunteering can be beneficial to the wellbeing of the volunteer – helping to build skills, confidence, community connections and offering help to others

What comes next?

WCAVA has targets to recruit 10% increase in current volunteer base over the next 2 years.

The County Council will be conducting a variety of staff volunteer recruitment campaigns over the course of 2017

Contact

jennymurray@warwickshire.gov.uk

75. Timebanking

Summary/Rationale
Establishment of a Timebanking scheme across Stratford District, funded by Orbit Housing Association and Stratford Town Trust

Activity

- Through joint funding to employ a Timebroker, an existing small scale Time-banking scheme has been extended from Stratford Town to cover the whole District. Timebanking involves members of the scheme 'depositing' their time in the bank by giving help and support to other members and then are able to 'withdraw' their time when they need something done themselves or alterna-tively they can donate their time to other members in the Timebanking scheme. Everybody's time is worth the same and for every hour an individual gives helping someone, they are entitled to one hour's credit in return.
- Orbit and Stratford Town Trust

Impact
The intended impacts of the scheme, which will run for a further 18 months initially are:

1. To improve the self-sufficiency of Warwickshire residents by empowering them to support each other and improve the wellbeing and vibrancy of communities
2. To help foster neighbourliness and address loneliness and social isolation with-in the community by connecting people to help each other through a tried and trusted Timebank model
3. To encourage an outlet for the sharing and use of skills, knowledge and experi-ence held in abundance in every community by the residents who live there
4. To support the development of skills and interests as a pathway to employment and improved wellbeing

What comes next?
The County Council is currently considering options for adopting a countywide timebanking scheme

Contact details:
jennymurray@warwickshire.gov.uk

76. Domiciliary care (WCBT)

Summary/Rationale
Care at Home - Phase 3 of the redesign for the domiciliary care provision has been initiated. This brings domiciliary care providers together with local community assets in an attempt to locate people back into their communities.

Activity
New Project

Impact

- Reduce social isolation and the cost of packages of care.

77. South Warwickshire Health Champions

Summary/Rationale

We are continuing our drive to recruit 2700 Health Champions in South Warwickshire. It's easy to become a Health Champion and anyone can become one. When you sign up to be a Health Champion your role can be as big or small as you like. The main role Health Champions play is to talk to friends, family, colleagues and the community about health related issues. This could be as simple as telling a friend about NHS 111, completing an online survey about local health services or being invited to a consultation meeting. The more adventurous Health Champions may for example even talk to a community group about staying well in winter.
By becoming a South Warwickshire Health Champion you have the opportunity to have your voice heard and be involved in the important decisions that the CCG have to make.

78. Nuneaton & Bedworth Volunteer Awards 2017

The Nuneaton and Bedworth Volunteer Awards took place on Tuesday 13th June 2017 at the Life Church in Bedworth. The awards were a partnership event between Nuneaton & Bedworth Borough Council, Warwickshire County Council and Warwickshire Community and Voluntary Action.

We received nominations for over 40 group or individual volunteers, for categories such as Creative and the Arts, Sport, Health and Wellbeing and Long Service. During shortlisting, the panel heard incredible stories, about selfless volunteers, dedicating time to help others. There were a number of winners and the two specific awards relating to the Health and Wellbeing Board are as below.

Health and Wellbeing Group Award – St Michael's Children's Centre, Bedworth

The volunteers at the Children's Centre have helped to ensure that the Community Café has been a success, and has recently been providing over 70 meals to members of the public. As well as the Community Café, the Volunteers have also helped out with the allotment, and in the Early Years Centre. All the volunteers have shared their knowledge, skills, abilities and enthusiasm which have had an impact on the service they can deliver to the whole community.

Health and Wellbeing Individual Award – Jean Smith

Jean is one of a very small handful of Nuneaton's Community First Responders. She goes to a variety of incidents, often to the elderly. Some patients just need some TLC or a helping hand. Others have sometimes suffered a stroke or a cardiac arrest and need urgent medical treatment. In the most serious cases, every second counts and Jean's early intervention is vital. Jean's presence in these cases has literally saved countless lives and has made a huge difference to many others.

79. The Brownsover BREW

The Community

Within the Community at Brownsover, which is part of Brownsover, Benn and Newbold (BBN) Ward there is a great community spirit to get things done and to forge ahead with new ideas. At the moment there is a lack of community space in Brownsover and while everyone is waiting for the new doctor's surgery which will include a community space, the community want somewhere else to meet in the meantime.

The Church, Christchurch Church, at the moment is the main focal point and for a while they have been considering how else they can support the community. After the Church were gifted a new kitchen from local company Howdens, it was decided that they would be able to open a café and that is how The Brownsover BREW came into existence.

The Challenge

A small amount of funding was needed which would allow for a part time worker, supported by volunteers, to run the café.

Meeting the Challenge

Funding was obtained for a part time worker and a number of volunteers have been found. The enthusiasm of the volunteers and the local community has been so great that there are a large number of people committed to making this project a success. Planning and various meetings have been held and new tablecloths, china and anything else needed to run the Brew have been bought.

The Outcome

The official opening took place on 23rd May 2017. This was done by the Mayor, with children from Brownsover Community School entertaining everyone with songs relating to having a brew, cakes and biscuits. The Brew will be opening one afternoon a week to start with.

Outcome 14

Support people to remain healthy and independent, in their own homes for longer.

80. Mental Health Crisis Outreach Support Service (WCBT)
81. An emergency response team (WCBT)
82. Homefirst (WCBT)
83. Integrated community Equipment Service (ICES) service (WCBT)
84. Heart Failure Service
85. Extra Care Housing
86. Extra Care Housing Integrated Model Project

80–86

80. Mental Health Crisis Outreach Support Service (WCBT)

Summary/Rationale

The Crisis Outreach Support service has been set up to work collaboratively with the Coventry and Warwickshire Partnership Trust (CWPT) mental health teams to offer follow up support to patients after crisis. 187 people were referred into the service in 16/17, none of whom were re-referred subsequently into mental health crisis services.

81. An emergency response team (WCBT)

Summary/Rationale

We will be working towards commissioning a response team to avoid hospital and/or residential care admissions and a response service to work closely with residential care providers to reduce pressure on the NHS.

Activity

Commissioning.

Impact

- Reduce Delayed Transfers of Care.
- Reduce Non Elective Admissions.
- Reduce Carer Breakdown.

82. Homefirst project (WCBT)

Summary/Rationale

The effectiveness of reablement and rehabilitation services is a key measure for the Warwickshire Cares Better Together (WCBT) Programme Board and performance is measured quarterly.

HomeFirst is a WCBT and Adult Customer Journey (ACJ) Priority project within the Integrated Care arena and is at the vanguard of integration initiatives between Health and Social Care. HomeFirst is a potential cornerstone for the recently announced Out of Hospital Collaboration across Warwickshire.

Activity

Phase 1 of the HomeFirst project went live on 3/01/2017 involving co-location of health and social teams across two bases in the North and South of the county and the implementation of the joint triaging of referrals.

Impact

The next phase of the project will involve the streamlining of operations, integration of workflows and systems to maximise the benefits realised from this integration.

83. Integrated community Equipment Service (ICES) service (WCBT)

Reducing emergency admissions and the amount of time people unnecessarily stay in hospital are two sub-outcomes and have key metrics measuring it's progress on a quarterly basis. As a result the 2 year WCBT plan currently being developed, will show how we plan to achieve a reduction in both areas.

The Integrated Community Equipment Service has gone from strength to strength and now delivers a robust 7 day service.

Activity
We will continue to develop out ICES service and seek to integrate with other services so that the benefits of the service are maximised.

Impact
We have seen a significant growth in the number of requests from the Acute sector that is supporting people to be discharged earlier and/or avoiding admissions to residential care

84. Heart Failure Service

Activity
In December 2015 the Heart Failure Nursing Service was launched within George Eliot Hospital. The CCG commissioned the service based on the needs of the local population and it supports both patients and their carers.

Impact
The service has engaged 343 patients, of these patients:

- 95.9% offered the HF rehab programme within 2 weeks
- 99.4% completed the first phase of the programme
- 98.0% completed the second phase of the programme
- 58.3% completed the education sessions
- 37.3% completed the outpatient exercise classes
- 4.7% been given community exercise programme

This service has been very positively received and has demonstrated excellent patient experience feedback.

"My partner and I attended the Heart Failure Education and still learnt new advice and I also met others with my condition. I think it is very helpful and useful to have these meetings and informative education days. They are very friendly and informal so you feel relaxed and comfortable enough to be able to ask questions if you need to. I feel that Emma and the Education and Exercise programmes have helped me, more than anything, to come to terms with and deal with my heart failure. I feel reassured that if I have any problems I can call Emma for advice anytime."

Contact details
Yasser Din

85. Extra Care Housing (ECH)

Summary

The first ECH scheme suitable for Older People in Warwickshire opened in June 2010. There are now 9 schemes suitable for those aged 55+ in operation across Warwickshire. These are provided by two partners – Housing and Care 21 (H21) and Orbit Independent Living (Orbit) - yielding a total of 631 units (including the delivery of 399 units during 2015), of which 442 are rental units and 189 are shared ownership.

Impact

As a distinct service model, there are a number of assumptions that tend to be made with regard to the benefits of customers living in the ECH environment. These include:

- Living at home, support in maintaining independence
- Services for both Older People aged 55+ and Adults with Disabilities
- Keeping couples together
- Mixed tenure schemes – rent, shared equity (sale)
- Mix of low, medium and high level care needs
- 24-hour care and support, and assisted technology (inc. night care as needed)
- Social activities available
- Safer and more secure than living in the wider community
- Potential to be a 'home for life' and integrated into local communities

At April 2017, ECH schemes suitable for Older People were delivering a saving of approximately £970,000 per annum based on current activity at the schemes in operation, i.e. 442 rental units.

Customer engagement is now under way (May 2017), with questionnaires distributed to schemes for completion by tenants/residents prior to meeting with WCC officers. To date, 39 responses - representing a 23% response rate - have been received from tenants/residents at three schemes. The key headlines from questionnaire responses to date include:

- 95% of respondents consider ECH to be a 'home for life'
- 85% are supported to live as independently as possible
- 82% are in control of planning their care and support
- 72% consider that ECH has helped them to feel less isolated
- 64% have seen an improvement in their social lives
- 77% have seen an improvement in accessing activities
- 62% think they would need domiciliary care if not living in ECH
- 18% think they would need residential care if not living in ECH

What comes next?

With 442 units of rental ECH for Older People now available across Warwickshire, a further 24 are planned.

The immediate requirement is to deliver ECH schemes for Older People aged 55+ in each of the remaining towns of the 12 major towns in Warwickshire that currently either have no scheme in place or confirmed.

Contact details

Tim Willis - Extra Care Housing Programme Lead
timwillis@warwickshire.gov.uk

86. Extra Care Housing Integrated Model Project

Summary

The extra care housing model locates many elderly residents in one location and through a combination of indpendent living with communal facility and support provides a model for housing which is expected to increase significantly in the coming years. It was noted however that the cost of treating patients at one of these facilities, Queensway Court, was significant in part due to the lack of coordination between care providers and the large number of elective and emergency admission from this facility.

The integrated solution being developed is a solution for extra-care type of accommodation that can be scaled up or down to suit other types of accommodation. This solution includes an onsite resource to co-ordinate services.

Outcome 15

Improve accessibility and visibility of ‘front doors’ to support people, to make the right choice, the easiest choice, informed by customer journey examples.

87. Urgent Care Services
88. Multi Agency Safeguarding Hub
89. End to end process review

87–89

87. Urgent Care Services

Activity

The CCG mobilised plans to relocate the Walk In service from the Camp Hill practice to the George Eliot Hospital. A robust plan was initiated to ensure the public and key stakeholders were aware of the relocation; and to promote awareness of the range of urgent care same day service options available to people when they have an urgent care need.

Impact

The relocation was completed on 1 June 2016 and went smoothly with the service operating 8am till 8pm, 7 days a week

The CCG successfully worked with 22 CCGs across the West Midlands to procure new Integrated Urgent Care, NHS 111 service and local GP Out of Hours services. The procurement involved over 70 patient representatives, clinicians and CCG staff from across the region. Patients will now benefit from enhanced clinical advice from NHS 111 and greater information sharing and booking ability between different services. A new Alliance Agreement underpins the newly procured services, and ensures better partnership working between all parties going forward. The new services ensure that all patients in the community have equal access to the best advice in the most appropriate setting.

Contact details

jenni.northcote@warwickshirenorthccg.nhs.uk

88. Multi Agency Safeguarding Hub (MASH)

MASH is one years old!

In May 2017 the MASH will reach its first anniversary. In the first year the MASH have received over 23,000 contacts and referrals from professionals and members of the public. 18.9% of referrals were from nursery, schools or colleges. We receive 99 calls a day and 100 emails a day on average. 35% of calls across 2016-2017 were for consultations. However in the last quarter 55% of calls were for consultations. We are proud that we are able to offer professional support direct to a Social Worker for advice, information and consultation. Not many Local Authorities provide this.

To coincide with our first anniversary we will be launching our MASH Annual Report on 3rd May 2017. Some highlights from this report is the evidence we have that shows through the triangulation of information we are making co-ordinated decisions about children and adults. Timescales and caseloads of MASH professionals are inevitably linked. Positively since 1st March our caseloads are now 15 referrals per day on average. This means we ensure MASH have time to deep dive into referrals and really understand the concerns being raised.

We have also worked very hard with Police to ensure domestic abuse and are now able to report that incidents are being responded to through secondary multi-agency risk analysis in live time.

Escalation Process

Despite the high amount of referrals received, the MASH have received a tiny amount of case escalations - just six in 2016-2017. If you are not happy with the outcome or decision from the MASH please tell us and use the escalation process. (Link here to WSCB escalation Process) To feedback to the MASH or initiate a case escalation please email mashmanagers@warwickshire.gov.uk

To escalate issues upon cases allocated to Children's Teams please contact the district Operations Manager.

You said. We Acted

However, we are never complacent, we know there is still more to do. We constantly seek and listen to feedback. For example, Feedback from professionals has been that the Multi-Agency Referral Form (MARF) needs to improve. We have listened to the feedback and made changes to the form which was agreed last month by the Warwickshire Safeguarding Children's Board. The new form and updated guidance is available on the WSCN website www.warwickshire.gov.uk/wscb

Our annual report sets out a number of priorities following feedback and review of the MASH, which include:

- Working with professionals to ensure a co-ordinated service is provided when the outcome of the MASH is that Early Help Single Assessment
- Ensure feedback is provided to the referrer and other agencies who provide information through triage 100% of the time.
- Develop an online form and improve advice and support available on the website

89. End to end process review – Adult Social Care

Summary

Mapping the current customer journey within Adult Social Care linking with the Customer Service Centre journey and experience through to assessment and review. The aim is to create leaner processes to support an outcome based personalised care and support pathway. Revised processes will be simple to use and effective in guiding people towards appropriate levels of support, according to need, while maximising independence and community resources, ensuring assessments and reviews are timely, proportionate and outcome driven.

Outcome 16

Improve care coordination in the community for high risk/cost patients.

90.Warwickshire Joint Carers Strategy (WCBT)
91. Frail and Vulnerable Multi-Disciplinary Team (WCBT)

90–91

90. Warwickshire Joint Carers Strategy (WCBT)

Summary/Rationale
The WCBT Guidance for 2017-19 includes the importance of support available to informal carers and the benefit this has on helping people live independently in the community for longer and reducing the impact on commissioned services.

Activity
Warwickshire's Joint Carer's Strategy has been signed off by Warwickshire Cares Better Together Programme Board and by all key stakeholders internal governance systems. The Carer's Wellbeing contract has also been awarded with the new service going live on the 1st June 2017.

Impact
The impact of involving carers and the people they care for in the development of this strategy will be measured by the impact of carer crisis on the 4 WCBT metrics: the impact on non-elective admissions, permanent admissions to residential and nursing care, the effectiveness of reablement and DToC.

91. Frail and Vulnerable Multi-Disciplinary Team in north Warwickshire (WCBT)

Summary/Rationale
One model being piloted and delivered in Warwickshire North in 2016 was a Multi-Disciplinary Team for the Frail and Vulnerable

Activity
To support over 75's patients within GP practices in a more integrated way so to improve patient outcomes and experience through a systematic care coordination approach enhancing assessment, treatment and self-management capabilities across General Practice and Community Services.

This approach will move away from crisis intervention to more managed and coordinated support for over 75's so to reduce the growing demands on GP and Community services going forward.

Impact
The outcomes and impact of the MDTs are currently being evaluated.

Outcome 17

Improve data sharing, IT infrastructure and health and social care governance.

92. Ongoing Improvement to data sharing (WCBT)
93. NHS South Warwickshire CCG Telehealth Project

92–93

92. Ongoing improvements to data sharing (WCBT)

Summary/Rationale

Compatible ICT, data sharing and information security are key foundation programmes for WCBT with identified leads.

Activity

The NHS Number is used as the consistent identifier on all relevant correspondence relating to the provision of health and care services to an individual for GP, Hospitals, Social Care, Community and Mental Health.

Interim solutions and open API to enable data to be shared is currently available in parts, with a number of projects in flight to deliver improved data sharing across the health and social care system during 2017 and early 2018.

An Information Governance Protocol was agreed and signed up by all Partners of WCBT during 2016.

Impact

There is alignment of ICT plans to deliver either integrated systems or data sharing across the health and social care system.

93. NHS South Warwickshire CCG Telehealth Project

In April 2016 NHS England published the General Practice Forward View ('GPFV'). The GPFV underpins the NHS Five Year Forward View and sets out national investment and commitments to strengthen general practice in the short term and support sustainable transformation for the future. It incorporates specific, practical and funded investment in five areas including practice infrastructure.

Over the past 18 months the CCG has been working closely with our Member Practices to develop our response to the GPFV and to consider how we translate the national vision into a local solution. At an early stage, we recognised that maximising the potential of new technology enabled care services in meeting demand and supporting co-ordinated care would be a key enabler.

With this in mind, during the spring of 2016 the CCG worked with the local GP Federation South Warwickshire GP ('SWGP') to develop a bid to the national Estates and Technology Transformation Fund. The CCG was successful in securing a multi-million pound investment, part of which will be deployed to roll out a large scale supported self-care programme in South Warwickshire. The approach will recognise that many people can, and want to, self-care, provided that they are appropriately supported in doing so.

Through the project the CCG, SWGP and the service provider Philips will work together with other key partners within the local health system to develop improved ways of managing people living with the following long term conditions; heart failure, chronic obstructive pulmonary disease (COPD) and complex diabetics. Patients (who will be recruited into the programme through case finding) will be supported with tele-monitoring equipment and TV or tablet user interface in the home with the support of a clinical hub and a structured programme of case management, monitoring, education and coaching.

Similar projects in other areas have demonstrated delivery of a broad range of benefits including improvements in patient reported outcomes and positive feedback from GPs and other clinicians. One of the core aims of the programme is to improve health outcomes for patients by increasing their quality of life, increasing patient activation and improving confidence, health literacy and self-management skills. The programme offers an exciting opportunity for clinicians, patients and carers in South Warwickshire to work together in a different way, improving relationships and outcomes.

Outcome 18

Improve partnerships across the wider social determinants of health.

94. Health Planning
95. Local Estates Forum, Section 106 and Community Infrastructure Levy (CIL)
96. Housing (extension of HEART service) (WCBT)
97. Warwickshire Third and Public Sector Partnership Group
98. Community Partnerships
99. Cyber Safe Warwickshire
100. Warwickshire North Health and Wellbeing Partnership
101. Our Heath and Wellbeing Board

94–101

94. Health Planning

Summary
In 2015 Public Health dedicated a Public Health Officer to focus on embedding public health principles into planning and the built environment. As part of the workstream Public Health also committed to carrying out Health Impact Assessments (HIA) on each of the five district and borough local plans in Warwickshire.

Impact
The Public Health Officer role has provided the opportunity to work more collaboratively across planning and health. An example of this would be the joint health responses which are coordinated in response to planning consultations and applications.

In terms of the HIA, by the end of 2016 all five HIAs were completed. Many of the recommendations within the HIAs have been taken on board and the theme of health and wellbeing runs throughout each of the district / borough local plans.

What comes next?
To encourage design which promotes healthy, active, and sustainable communities we will:

- Continue to work with planners throughout the local plan process and at individual planning application stage; and
- Continue to engage with CCGs and provider trusts on health infrastructure requirements in line with growth plans.

Contact details
Gemma McKinnon, Public Health Officer

95. Local Estates Forum, Section 106 and Community Infrastructure Levy (CIL)

Integration and Working Together
South Warwickshire CCG updated the Health and Wellbeing Board on the impact of planning on primary care and the opportunities and challenges of Section 106/ Community Infrastructure Levy funding. We responded to 14 individual planning applications and engaged with both District Councils in relation to the major strategic development sites.

The 1st locality focused Local Estates Forum (LEF) has also taken place, bringing together estates teams from provider organisations, NHS England and engaging practices from the Stratford area and Stratford-on-Avon and Warwick District Councils.

96. Housing (extension of HEART service) (WCBT)

Summary

The WCBT Programme Board recognises that good housing is an essential building block in an effective health and social care system. This is reinforced by the Better Care Fund guidance for 2017-19. The WCBT Housing Board plans to refresh its role in supporting this ambition, primarily through delivering a successful HEART service where we continue to make good progress on adaptation and support within people's own homes.

97. Warwickshire Third and Public Sector Partnership Group

Summary/Rationale

Following consultation across the sectors, the County Council has established and co ordinates the Warwickshire Third and Public Sector Partnership Group. The Group's aims are to:

1. Build better relationships between the Public and Third sectors across the County for the benefit of the people of Warwickshire
2. Create a voice and greater influence for the Third sector and the communities of interest they support
3. Ensure the Public and Third sectors work in partnership in the strategic development of services that address the changing needs of the community
4. Maximise opportunities to strengthen/build community capacity and resilience and effectively manage demand for services within constrained resources across all sectors

Activity

- The Group has an action plan focused on improving commissioning and procurement processes, improving communication and influencing decision making
- Third sector representatives from thematic areas including social housing, physical and mental health, disability, equality, infrastructure, rural issues, older and young people, community safety. Public sector reps from across Warwickshire including County, District, Borough, Town, and Parish Councils.

Impact

- Stronger relationships and improved communication between the sectors
- Building a Stronger Warwickshire Conference to promote/raise awareness of the importance of using asset based approaches to developing Community Capacity
- Better awareness of commissioning intentions

What comes next?

- Ongoing activity linked to action plan

Contact details

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98. Community partnerships

Summary

1. The North Warwickshire Community Partnership has adopted health as a priority theme, with a Health and Wellbeing Action Plan presented and updated at each meeting. The Partnership comprises County Council, Borough Council, DWP, Public Health, Warwickshire CAVA and a variety of voluntary and community organisations. The link between the Community Partnership and Health and Wellbeing Board is maintained through shared attendees, i.e. Public Health and Borough Council senior management.
2. The North Warwickshire Financial Inclusion Partnership focuses on the determinants of health linked to financial resilience. The Partnership aims to provide a platform for awareness raising, discussion, support and a small amount of project delivery. The North Warwickshire Financial Inclusion Partnership links into the larger Warwickshire Financial Inclusion Partnership, which has responsibility for the Financial Inclusion and Resilience Theme in the Child Poverty Strategy. The North Warwickshire Financial Inclusion Partnership is led by North Warwickshire Borough Council with regular attendance from County Council, Citizens Advice, Trading Standards, Act on Energy and various other voluntary and community organisations.
3. The Rugby Local Strategic Partnership has responsibility for delivering the Rugby Regeneration Strategy Action Plan, which includes a number of health related actions.
4. The Nuneaton and Bedworth Community Development Partnership meets monthly and comprises attendees from the County Council, Borough Council (Community Development and Sports Development) and Warwickshire CAVA. The partnership, led by the County Council, focuses on the practical elements of community development on the ground, many times leading to health related outcomes. Recent examples include the development of a Health and Wellbeing Hub in Nuneaton and the staging of a Dementia conference.

Impact

1. Multiple initiatives delivering activities on the ground, including health walks, Big Day Out, creation of dementia friendly communities, addressing teenage conception, development of Health and Wellbeing Hubs in the Borough and community healthy cooking projects.
2. Awareness raising, discussion and small projects, including an affordable energy project delivered by Citizens Advice and a multi-agency door knocking exercise in targeted villages.
3. Recent actions around tackling fuel poverty and supporting the Rugby Edible Action Programme.
4. Recent actions include the development of a Health and Wellbeing Hub in Nuneaton and the staging of a Dementia conference.

99. Cyber Safe Warwickshire

Summary/Rationale

Cyber Safe Warwickshire is a Police and Crime Commissioner funded initiative delivered by Warwickshire County Council to promote online safety and protect vulnerable people from falling victim to cyber crime.

Cyber crime has emerged as one of the biggest challenges facing our society with most of our personal and work lives now conducted online. Cyber crime covers not only the obvious fraud and phishing scams but also online bullying, hate crime, abuse and harassment.

Two Cyber Crime Advisors are funded through the work and have been engaged in wide range of activities and projects over the last 12 months to raise awareness of the issues and help protect people online. They have included:

Activity - Public Engagement

2,743 members of the public have been engaged with in person this year, across 30 public events, and 65 presentations targeted at vulnerable groups. 203 blogs have been published on Safe in Warwickshire social media and are routinely shared by partners. Key messages have been distributed through various local publications and magazines. A cyber scam newsletter is produced monthly highlighting the latest crimes.

Activity - Cyber Safe Warwickshire Website

A website has been developed for partners and members of the public to access information on cyber crime. Information about local and national support services and how to report cyber crime is also provided. The website is scheduled to be launched in June.

Activity - Cyber Champions

Cyber Champions within key local services have been trained to help get the message out about cyber crime. Champions have been trained within Warwickshire Victim Support, Citizens Advice Bureau, Warwickshire Libraries and Learning Disability Hubs. The Cyber Crime Advisors are a point of contact for the Champions if any further practical advice is needed. This scheme is thought to be the first of this nature in the country.

Activity - Cyber Crime E-Learning Launch

An e-learning package was developed by the Cyber Crime Advisors and key partners aimed at raising awareness of the risks and safety tips residents can employ. This is available to WCC staff and to members of the public on Wilma.

Activity - Public Wi-Fi Campaign Launch

Launched on Safer Internet Day in February 2017, this scheme encourages Warwickshire residents to consider how they use public Wifi offered by local businesses. The campaign involves encouraging businesses to review their Wifi and offer customers increased security.

Activity - Partnership Working

Warwickshire Cyber Crime Task and Finish Group is a partnership forum established to oversee and steer cyber crime work in the county. It is attended by a wide range of partners across the public and private sector, including education, Trading Standards, Police, Youth Justice, Neighbourhood Watch, Victim Support and business representatives.

Future Work

The Cyber Crime Advisors will continue to train Cyber Champions across communities within Warwickshire and there will be a focus on getting the messages out to young people. New work is also being developed around online radicalisation in association with WCC's Prevent Officer with a view to developing awareness sessions for parents.

100. Warwickshire North Health and Wellbeing Partnership

Summary/Rationale

Warwickshire North Health and Wellbeing Partnership was formally established in 2012 to ensure local delivery of the Countywide Health and Wellbeing Strategy. The group meets bi-monthly and comprises elected members and officers from Nuneaton and Bedworth and North Warwickshire Borough Council's, NHS Warwickshire North Clinical Commissioning Group, Warwickshire CAVA and Warwickshire County Council. Using the JSNA to identify and prioritise the needs of the North Warwickshire population, in 2012 the partnership agreed it's local Strategy and vision for 2012-15. This was updated in 2016. The strategy outlines not only the needs and vision for Warwickshire North population but translates this into local, practical action delivered in partnership within priority communities. The Partnership is supported by a governance structure to deliver the work programme and outcome measures to monitor progress.

Impact

Partnership members agreed to jointly commission Hatters Space Health Store for 2016/17

The partnership supports the work and action plan to Address Teenage Conception across Warwickshire North

Through the group the #onething programme has been commissioned jointly and in partnership (see #onething)

The partnership has also supported the work to make Nuneaton and Bedworth and North Warwickshire dementia friendly.

What comes next?

The group continues to meet to share

Contact details

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101. Our Heath and Wellbeing Board

Summary/Rationale

As a Health and Wellbeing Board we come together as the leaders of the organisations who together make up the health and care system in Warwickshire.

Some of our work is also focused on developing the systems and relationships needed to effectively influence and shape practice and ultimately outcomes for Warwickshire residents.

In 2016/17 we signed the The Alliance Concordat with Coventry Health & Wellbeing board setting out the principles of how we want to work. This has helped shape the way we work together and provided a cornerstone for ongoing development work across Coventry and Warwickshire.

We also undertook a self assessment of the level of integration within the system ahead of being one of two national pilots for the Local Government Association's Peer review model.

Increasingly we are able as a Board to look across and draw together key transformation activity.

We hold the big picture and focus on how the work of individual organisations and projects can join up.

These reviews have helped us better understand the system and our role in it and led to the creation of the delivery Plan for 2017/18.

We continue to develop our approach and make sense of what is a complex landscape, to ensure we maximise heath and wellbeing outcomes and opportunities for our customers and residents.

Together this work has seen us recognised nationally as good practice.