Health and Wellbeing Board

Date: Wednesday 11 January 2023
Time: 1.30 pm
Venue: Committee Room 2, Shire Hall

Membership

Councillor Margaret Bell (Chair)
Councillor Jeff Morgan
Councillor Jerry Roodhouse
Councillor Isobel Seccombe OBE
Councillor Marian Humphreys
Councillor Julian Gutteridge
Councillor Howard Roberts
Councillor Jo Barker
Councillor Judy Falp

Warwickshire County Council Officers: Shade Agboola and Nigel Minns

Coventry and Warwickshire Integrated Care Board: Danielle Oum

Provider Representatives: Russell Hardy (South Warwickshire NHS Foundation Trust and George Eliot Hospital NHS Trust), Dame Stella Manzie (University Hospitals Coventry & Warwickshire), Dianne Whitfield (Coventry and Warwickshire Partnership Trust)

Healthwatch Warwickshire: Elizabeth Hancock

NHS England: Julie Grant

Police and Crime Commissioner: Emma Daniell (Deputy PCC)

Items on the agenda: -

1. General

(1) Apologies

(2) Appointment of Vice Chair
The Board is asked to appoint a Vice-Chair.

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

(4) Minutes of the Meeting of the Warwickshire Health and Wellbeing Board on 7 September 2022 and Matters Arising 5 - 16

Draft minutes of the previous meeting held on 7 September 2022 are attached for approval.

(5) Chair's Announcements

Discussion items

2. Place Partnership Update 17 - 24

The Health and Wellbeing Board will receive an update from the Place Partnerships.

3. Coventry and Warwickshire Integrated Care Strategy 25 - 122

To receive the annual report of the Integrated Care Partnership Strategy.

4. Director of Public Health Annual Report 2022 123 - 126

The annual report from the Director of Public Health is submitted for the Board's consideration.

5. Preventing Homelessness in Warwickshire Report - a multi-agency approach 127 - 146

The Board is asked to note and support the content of the report and endorse the ongoing review of the action plan.

6. Coventry and Warwickshire Suicide Prevention Strategy 2023 - 2030 147 - 184

The Board is asked to endorse the content of the Coventry and Warwickshire Suicide Prevention Strategy 2023-2030 and support the delivery of the strategic ambitions and local priorities. It is proposed that a formal presentation of the Strategy and Delivery Plan be requested in March 2023.

7. JSNA Prioritisation Programme 185 - 190

To consider the outlined proposed thematic Joint Strategic Needs Assessment (JSNA) workplan for October 2022 to November 2024 and support the development of future needs assessments.

Updates to the Board

8. Coventry and Warwickshire Health and Wellbeing Forum 191 - 230

To receive an update on the presentation and discussions that took place at the first meeting of the Coventry and Warwickshire Integrated Health and Wellbeing Forum (formally the Place Forum).

9. Better Care Fund - Update, Planning for 23/24 and Adult Social Care Hospital Discharge Fund 231 - 242

To note the progress of the Better Together Programme in 2022/23, provide feedback on the proposed schemes and support the plan

approved under delegation by the HWBB Sub-Committee on 16 December 2022. It is suggested that a further update will be provided, following publication of the national Better Care Fund Policy Framework for 2023/24.

10. Assistive Technology and the Integrated Care Record 243 - 288

To receive updates on improving and increasing the offer of assistive technology to Warwickshire residents; and the Integrated Care Record.

11. Warwickshire Hospital Discharge Community Recovery Programme 289 - 304

To receive an overview of the proposed Warwickshire Hospital Discharge Community Recovery Programme.

12. Children and Young People Partnership Update Report 305 - 308

To receive an update on the progress made by the Children and Young People Partnership, including an update on health visiting.

13. Health and Wellbeing Board Sub-Committee 309 - 316

To note the minutes of the Health and Wellbeing Board Sub-Committee meetings held on 22 September and 16 December 2022.

Board Management

14. Forward Plan 317 - 318

An update on the Forward Plan for the Health and Wellbeing Board.

Monica Fogarty
Chief Executive
Warwickshire County Council
Shire Hall, Warwick

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- Declare the interest if they have not already registered it
- Not participate in any discussion or vote
- Leave the meeting room until the matter has been dealt with
- Give written notice of any unregistered interest to the Monitoring Officer within 28 days of the meeting

Non-pecuniary interests relevant to the agenda should be declared at the commencement of the meeting.

The public reports referred to are available on the Warwickshire Web https://democracy.warwickshire.gov.uk/uuCoverPage.aspx?bcr=1

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Health and Wellbeing Board

Wednesday 7 September 2022

Minutes

Attendance

Board Members

Warwickshire County Council (WCC)
Councillor Margaret Bell (Chair)
Councillor Jerry Roodhouse
Shade Agboola
Nigel Minns

Provider Trusts
Jerry Gould (University Hospitals Coventry & Warwickshire (UHCW)),

Healthwatch Warwickshire (HWW)
Elizabeth Hancock

Borough/District Councillors
Councillor Jo Barker (Stratford-on-Avon District Council)
Councillor Judy Falp (Warwick District Council)
Councillor Marian Humphreys (North Warwickshire Borough Council)

Police and Crime Commissioner: Emma Daniell (Deputy PCC)

Other Attendees

Councillor John Holland (WCC), Rachel Briden, Ali Cole, Gemma McKinnon, Michael Maddocks, Isabelle Moorhouse, Rob Sabin, Pete Sidgwick Paul Spencer, Jonathon Toy and Duncan Vernon (WCC Officers).
Chris Bain (HWW), Katy Coates, Anjali Dave and Sarah Foster (South Warwickshire NHS Foundation Trust (SWFT)) and David Lawrence (Press)

1. General

(1) Apologies

Apologies for absence had been received from Councillor Jeff Morgan (WCC), Russell Hardy (SWFT and George Eliot Hospital NHS Trust), Dame Stella Manzie and Justine Richards (UHCW), Jagtar Singh (Coventry and Warwickshire Partnership Trust (viewing the meeting on-line)), Councillor Julian Gutteridge (Nuneaton and Bedworth Borough Council), Councillor Howard Roberts (Rugby Borough Council), Danielle Oum and Phil Johns (Coventry and Warwickshire Integrated Care System (ICS)).

(2) Appointment of Vice-Chair

The Chair advised that it was proposed to speak to the ICS regarding non-executive representation for the position of Vice-Chair. Other nominations from the Board would similarly be considered and this matter be revisited at the January Board meeting.

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

Councillor Jerry Roodhouse declared an interest as a Director of Healthwatch Warwickshire. Councillor Falp declared a personal interest in the item on the Health Visiting Service.

(4) Minutes of the Meeting of the Warwickshire Health and Wellbeing Board on 4 May and Matters Arising

The minutes of the Board meeting held on 4 May 2022 were approved as a true record and signed by the Chair.

As a matter arising, Councillor Roodhouse sought an update regarding discussions with the West Midlands Ambulance Service (WMAS). Nigel Minns provided a verbal update. There had been lengthy discussions about engagement with WMAS at the Integrated Care Board (ICB) and good progress had been made. WMAS were regular attendees at an Urgent and Emergency Care Board, also attended by WCC, so there was an ongoing dialogue. Particular areas being discussed were delayed ambulance transfers, hospital waits and the balance of risk around people waiting either in an ambulance or a hospital corridor. He spoke further about urgent non-emergency (category 3) cases, conveyancing aspects, response to falls, frailty and a directory of services to provide other options to emergency admission. The Chair asked for regular updates to be provided. Councillor Humphreys raised a concern for patients with dementia who were delayed in an ambulance awaiting hospital handover. It was agreed that WMAS be asked to permit dementia patients to be accompanied when such waits occurred.

(5) Chair's Announcements

The Chair gave an update on the Children and Young People Partnership Board. An initial scoping meeting took place at the end of July, the draft terms of reference had been produced and its first meeting would take place in late September. Periodic reports would be provided back to this Board.

The first formal meeting of the Integrated Care Partnership (ICP) took place on 26th July. The two Health and Wellbeing Board Chairs for Coventry and Warwickshire had been appointed as joint deputy chairs. The Partnership had agreed its terms of reference and ways of working together in alliance. The ICP had started to develop its Integrated Care Strategy, which would include engagement with Healthwatch and others. The Chair spoke of the progress made to date by a strategy development working group and the plans to discuss this further at the Integrated Health and Wellbeing Forum on 13 October.

The Chair asked for brevity in presentations due to the weight of the Agenda and to enable adequate discussion.

2. Adult Social Care Reforms

The Health and Wellbeing Board received a presentation from Pete Sidgwick, Assistant Director for Adult Social Care. This summarised the current requirements and progress to deliver adult social care reform in Warwickshire with a focus on the care cap, Fair Cost of Care (FCoC) and Care Quality Commission (CQC) oversight. Health and social care integration was not a focus for this presentation but remained a priority, as evidenced through the joint working and development of the Coventry and Warwickshire Integrated Care System.

The work programme provided a consolidated and joined up response to the objectives, key features and requirements of Government policies/white papers relating to adult social care reforms:

- Build-back-better: Our plan for health and social care Sept 21 & Jan 2022 update
- "People at the heart of care" adult social care reform white paper
- Market Sustainability and Fair Cost of Care Fund
- Health and Care Integration - Joining up care for people, places and populations

The presentation expanded on the key messages with slides on:

- Adult Social Care Government Policy Reforms
- General points:
  - High level ‘indications’ lacking detail
  - Multiple aspirations being articulated amongst requirements
  - A landscape which doesn’t keep to timescales
  - Lots of national, regional and local ‘views’
  - A number of significant financial implications within the reforms without the clarity on funding streams
  - Questions if the pace of delivery is realistic
- The overarching approach and officer leads.
- CQC oversight (People at the Heart of Care)
- Cost of Care Cap (Build Back Better)

Debate took place on the following areas:

- The Chair recognised the considerable work underway to respond to these changes and significant implications of them.
- Points about packages of care following hospital discharge. The benefits of rehabilitation in step-down care and ensuring that all required equipment was provided in a timely way, as this benefitted patients significantly. It was confirmed that the County Council administered the discharge to assess pathway on behalf of health and the approach taken was considered to be correct, with support out of hospital. The involvement of the CQC was also considered to be the right thing to do with regulation likely to drive improvements, hearing the customer voice and a focus on carers. There had been a step change in hospital discharge, and it was expected that the number of people being supported would increase. The challenges would remain going into the winter period.
- A request for regular information to be provided to the County Council Network (CCN) and Local Government Association (LGA). The CCN was considering this area in detail. The proposed timescales were considered to be unrealistic with delays being sought, not least

due to government ministerial changes. The cost elements were raised and potential impact for care home viability questioned. There was variance amongst local authorities of the percentage costs being used and submitted to the government as part of this process. It was confirmed there was a continuous dialogue and information sharing took place with the CCN, LGA and County Council Treasurers. The challenges around timescales were significant as were the financial aspects. There was a loss of income for the Council and some of the projections did not stack up, so the funding aspects needed to be addressed. There was a need for the FCoC and the care cap would have a positive impact for the care market.

- A discussion about the CQC involvement, variance in interpretation of the Care Act requirements and especially record keeping. It was questioned if an additional IT system would be needed and if there was potential to collaborate with others. Interpretation of Care Act compliance was tested through the courts and the Ombudsman. The customer aspects were less easy, but it was unlikely there would be a uniform approach. On record keeping this would be a challenge for the CQC, due to the different ways data was collected. These could use a strength based, tick box or conversation approach. It was more about the 'so what' question and the impact to ensure needs were identified and met. There was a need for metrics but also a supporting narrative to explain the data. A standardised approach was unlikely, but it was for local authorities to demonstrate the good work taking place and the challenges faced. There may be additional IT system needs for the Care Cap aspects. If additional time was granted perhaps a national system could be developed which would be beneficial as this was a complex area.
- A question about the recruitment and training of additional care workers. WCC did support the market on recruitment campaigns, training and development. Having a buoyant domiciliary care market was a key factor. The FCoC would provide additional grants and ensuring correct pay rates would be important. Further points about the perceptions of care work and the success stories of progression to other roles and services.
- Nigel Minns added that a comprehensive report was considered at the Adult Social Care and Health Overview and Scrutiny Committee in June, which could be shared.

In closing the item, the Chair asked for periodic updates by briefing note.

Resolved
That Health and Wellbeing Board notes the programme of work underway to support Adult Social Care Reform in Warwickshire.

3. Health Visiting Paper

The Board received a comprehensive update and presentation on the 0-5 Health Visiting Service (HVS) from Rob Sabin, WCC commissioner and Sarah Foster, Deputy General Manager for 0-5 HVS, SWFT.

Background was provided on the role of the service to protect and promote the health and wellbeing of children and their families through the delivery of the nationally mandated Healthy Child Programme (0-5). The HVS was key to delivering the Warwickshire Health and Wellbeing Strategy priority around helping children and young people to have the best start in life. The current service was delivered by SWFT, with the contract due to expire on 31 March 2023.

A summary was provided of service performance. This service met a wide spectrum of needs for all children (birth to five) within Warwickshire, with some key areas that delivered more targeted needs. The service continued to innovate and adapt its practice, with examples being provided. Developmental reviews and checks were mandated, and contract performance was monitored against five HV mandated contact performance indicators. The provider's performance in this area had declined with tables providing data to demonstrate this.

The report then set out the identified service issues and challenges. It included challenges around recruitment and retention of qualified HVs, which was a national issue. It was coupled with increasing caseloads, increases in population, complexity of cases and level of need.

SWFT and WCC had co-developed a joint recovery/restoration plan in the Autumn of 2021. The report set out the short-term and longer-term actions proposed. The recovery plan was reviewed monthly involving service and commissioning leads, with oversight from the WCC Assistant Directors. A presentation was provided to highlight key messages from the report.

The following questions and comments were submitted, with responses provided as indicated:

- The re-employment of retired HVs was discussed. Such people had vast experience and recently a retired HV had recommenced work in the Rugby area.
- The value of nursery nurses was recognised, it being questioned how they could contribute to HV roles. It was also asked what WCC could do to assist. It was noted that some HV functions could not be undertaken by other personnel.
- The recommendation was to note this report but there were concerns. Reference to the challenges observed at the Rugby Family Centre, specifically around HV caseloads. Also, the increasing complexity of cases identified at a body which determined grant funding applications. These included concerns around mental health and drug/alcohol issues. There was a national staffing shortfall in HVs. In the Rugby area a meeting to discuss the Joint Strategic Needs Assessment had included a number of aspects relevant to this discussion. However, there was no awareness of the concerns around the HV service, which showed the need within the system to better connect. Co-production was seen as a good way forward and it was about ‘how’ organisations could work together and enabling that to happen.
- Another speaker echoed the points around how WCC and other organisations could help, focussing on recruitment aspects and making the HV role more attractive. There was potential to provide support in schools and through seeking volunteers to help too.
- In response to these points, it was confirmed there was a shortage of HV staff. There were some roles such as mandated contact which only HVs could undertake. There were roles that others could deliver and an outline was given of the approaches utilised so far and potential for greater collaboration with other agencies. Referrals and making the best use of all staff in related services were emphasised. However, there were staff shortages in those areas too. Assurance was provided of the additional HV staffing secured recently for the Rugby area. Whilst there was still a shortfall, the position was much improved. There was praise for the way that current staff had responded too.
- Katy Coates added context around the staffing shortage to deliver the healthy child programme in Warwickshire, which would need some 120-130 HVs. Elected members needed to consider the forward planning for the next five years, the increased funding which would be required, albeit that the shortage of qualified HVs currently meant that finance was not the only concern.

- The Chair noted the requirements around reporting on mandated contacts, the current challenges and resultant performance levels. The Council owned its health visiting contract, setting the targets and measures within it. She spoke of the priority of seeing new babies and 98% were seen within 30 days. This enabled triage to specialist help and other pathways where it was required. She advocated having a contract which worked for Warwickshire, with appropriate priorities set against the known shortage of HV staff to focus on the areas deemed of most importance.
- Anjali Dave, an Associate Director of SWFT agreed with the idea of local criteria for recovery of the services, with a focus on vulnerable families. Reporting on those figures would mitigate the clinical risk given the current resources. There was a need to influence national strategies around university courses and making the HV role more attractive to address the recruitment challenges.
- Shade Agboola provided reassurance of the ongoing work with health colleagues to seek to escalate the known concerns. Conversations were also taking place with local universities. She spoke about the current indicators and whether there was an appetite as a local system to deviate from the national criteria. This had been required in response to the Covid pandemic to provide tailored solutions for the local area.
- The need to provide university courses to create the future workforce was reiterated. It was questioned if the voluntary sector was currently assisting where it could.
- Similarly, a question about other skills available within the county council and whether these could provide additional support. The points about co-production were reiterated. This did include the voluntary sector and it was evident from a meeting earlier in the day that different parts of the same organisation had different levels of awareness of voluntary sector involvement. Aside from making representations at the national level, there was an opportunity to shape things locally and ensure information was shared effectively across all relevant organisations.
- In response to the above points, context was provided on the number of applicants for vacant HV positions and the shortages in other parts of the NHS. In terms of co-production, there was a HV representative on all of the Children and Family Centre advisory boards. From discussion it was evident that other health leads could similarly be invited to attend such meetings and Sarah Foster offered to be the contact.
- The Chair added that WCC offered a range of training opportunities. There was a need to ensure that once trained, the funding for HV posts was sustainable. The demand for such support was increasing and it was necessary to ensure that forward planning took place. There were other professionals involved including midwives and GPs. A need to avoid duplication and to make sure the appropriate professional undertook each role. In terms of the report recommendations, she proposed that the Children and Young People Group take on monitoring of this area. The Chair was keen to find a local solution in addition to the ongoing national lobbying.

Resolved

That Health and Wellbeing Board:

1. Notes and endorses the best practice and innovation associated with the service.

2. Notes and comments, as set out above, upon the issues and challenges the service is currently experiencing.

3. Supports the short-term and long-term actions being taken locally by the Health Visiting Service and Commissioners to assist with and improve recruitment and retention, as well as improve performance and mitigate the risks and to look at local solutions.

4. That this area becomes part of the agenda for the Children and Young People's Partnership Board.

4. Better Care Fund (BCF) Annual Plan 2022/23

The Board considered a report on the Better Care Fund (BCF) submission and annual plan for 2022/23. The BCF was a programme spanning local government and the NHS which sought to join-up health and care services. The report set out key information on the BCF Policy Framework and the requirements for this year's submission to NHS England by 26th September. Agreement was therefore sought for approval of the final version of the plan to be delegated to a Sub-Committee of the Board, once it had been approved by the Integrated Care Board and the County Council.

The report set out the four national conditions of the policy framework, along with additional system requirements for this year to agree high level capacity and demand plans for intermediate care services. It set out the compliance and other requirements for the local system. A section was provided on the future of the BCF policy framework. The financial implications detailed the grant funding to local government, which comprised the Improved Better Care Fund (iBCF) and Disabled Facilities Grant. Detail was provided on the financial contributions and mandatory funding sources, totalling just over £63million. Similar to previous years, the County Council continued as the pooled budget holder for the fund.

The report included supporting information on the metrics that must be included in BCF plans in 2022/23. It detailed the approvals already provided for this year's BCF, those required prior to submission to NHS England and the future timetable for the BCF. Appended to the report were the BCF Narrative Plan, Planning Template and Capacity and Demand Plan.

Further information was provided around the completion of the sign-off processes, culminating in a meeting of the Board's Sub-Committee on 22nd September at 2pm in Atherstone. The documents for that meeting would be published a week in advance showing tracked changes from those provided at this meeting.

Resolved

That Health and Wellbeing Board:

1. Notes the Better Care Fund Policy Framework and Planning Requirements for 2022/23.

2. Provides the feedback set out above on the draft Better Care Fund Narrative Plan, Planning Template and Capacity and Demand Plan for 2022/23 to ensure that these contribute to the wider Health and Wellbeing Board's prevention priorities as well as meeting the BCF national conditions.

3. Agrees that the Board's Sub-Committee meets on 22nd September to approve the final version of the Better Care Fund Plan for 2022/23, for submission to NHS England.

5. Pharmaceutical Needs Assessment

Duncan Vernon and Michael Maddocks introduced a report and gave a presentation on the Coventry and Warwickshire Pharmaceutical Needs Assessment (PNA) 2022 – 2025. The purpose of the PNA was to assess local needs and identify gaps for pharmaceutical provision across Coventry and Warwickshire. It was a tool to enable the Health and Wellbeing Board to identify the current and future commissioning of services required from pharmaceutical service providers. A collaborative approach had been undertaken with Coventry. The PNA had undergone a period of formal consultation, which closed on 29th August and a verbal update was provided on the feedback received. Sections of the report provided background, and the minimum requirements for this process.

A copy of the PNA was included within the document pack. The accompanying presentation focussed on the service recommendations, overall recommendations and providing an update from consultation feedback. The key areas of feedback were:

- Opening times for boots pharmacies
- End of life medicines provision
- Sharps disposal
- Smoking cessation advanced service
- References to CCG updated to ICB in the document
- Additional note in appendices that pharmacies do not order or deliver scripts so any issues relating to that are beyond their control, and additional reflection on pharmacy pressures causing unplanned closures
- Hypertension recommendation expanded
- COVID-19 vaccination included (Phase 5)
- Numbers added to a chart on pharmacies per 10,000 population

Questions and comments were submitted:

- It was questioned if the PNA took account of anticipated population increases and whether the current pharmacies were in the correct locations. It was confirmed that there was adequate pharmacy provision now and there was the option to undertake a supplementary PNA, if required, following population growth.
- Further information was sought about smoking cessation services. There were two commissioned offers, a new one from NHS England for patients discharged from hospital and a locally commissioned service for Warwickshire, which had recently been reviewed and recommissioned.
- On drug and alcohol services, there was disparity across the County for example in the provision of needle disposal points. From feedback received it seemed that some pharmacies were not interested. The recommendation around sharps disposal was therefore welcomed.
- A question on needle exchange points, whether they were in the correct locations and whether a mapping exercise should be undertaken.

- On sharps bins, the numbers utilising the service was currently low, but it was hoped publicity and clarification of the service would increase uptake. An offer to seek more detailed feedback from the pharmaceutical steering group. For needle exchange, the core mapping had been undertaken and it appeared that adequate provision was made, but commissioners would keep this under review. The Chair requested a written update on the needle exchange and sharps disposal aspects.

Resolved

That Health and Wellbeing Board:

3. Notes and comments upon the contents of the Pharmaceutical Needs Assessment (PNA) as set out above.

5. Notes and comments as shown above upon the verbal update on consultation feedback.

Approves the publication of the PNA subject to any changes mentioned in the formal consultation verbal update.

6. Healthwatch Warwickshire Annual Report

Liz Hancock (Chair) and Chris Bain (Chief Executive) of Healthwatch Warwickshire (HWW) presented its annual report for 2021/22. The annual report had been published in June 2022 and had been circulated widely.

It reported on service delivery in 2021/22, including a full range of services to the public. HWW had published ten reports relating to the improvements people would like to see to health and social care services. These were available on HWW's website. In terms of future priorities, HWW would further develop its work to find out more about the lived experiences of people needing or using health and social care services. It planned to ensure that the lived experiences of seldom heard people and communities were properly considered. HWW would continue to engage positively with the Integrated Care System (ICS) at all levels to ensure that the voice of patients continued to be heard. It was already working proactively with various parts of the ICS. Similarly, it worked with colleagues in Healthwatch Coventry to ensure there was an effective service across the whole system. HWW was extending the focus of existing projects and developing new projects too. The accompanying presentation expanded on the key messages with Liz Hancock providing an overview and Chris Bain taking the Board through the detail of the annual report.

Councillor Falp commented that this agenda had included a lot of high-level strategic topics. This presentation showed how such strategies affected people and it was important for the Board to consider both aspects. The Chair agreed on the importance of hearing lived experience.

Resolved

That the Board notes the Healthwatch Warwickshire Annual Report.

7. Serious Violence Prevention Strategy

Jonathon Toy introduced this item which set out the duties for a number of partner agencies under the Police Crime, Sentencing and Courts Act 2022 to address the root causes of serious violence. These included requirements for collaboration and for consultation with education authorities and youth offending services in the preparation of a local Serious Violence Strategy.

The draft government guidance stated that the specified authorities come together to decide on the appropriate lead and structure of collaboration for their area. The government narrative had been referred to as a “Public Health Approach” to serious violence prevention. Public Health England, in its publication, “A whole system multi agency approach to violence prevention”, set out three levels of violence prevention. Investment had been aligned to areas with high levels of serious violence. This was not applicable to Warwickshire, even though it was surrounded by areas which did meet the criteria and the County was a net importer of serious violence.

It was recognised that prevention was a key aspect. This required a long-term commitment by a range of agencies, individuals and communities. This approach would also support action towards health and wellbeing priorities.

Interventions to address serious violence were defined as universal (aimed at a general population); selected (targeted at those more at risk); and indicated (targeted at those who use violence). The Warwickshire Serious Violence Prevention Model was provided as an appendix to the report. It combined these universal and selected interventions, supporting those most impacted by serious violence, whilst creating a climate where serious violence was not tolerated.

The strategic priorities were reported, together with the requirements for consultation on the Strategy and the wide engagement undertaken with partner agencies. It had been adopted by the Safer Warwickshire Partnership Board (SWPB), the Education Authority, Youth Justice Service and National Probation Service. The next step was the development of a multi-agency delivery plan.

The SWPB would work with key stakeholders to maximise the resources available and influence partner organisations to deliver the Strategy. Detail was provided on the lead group to agree the priorities within the delivery plan and the training requirements for frontline practitioners.

In addition to the statutory duty, the Act had introduced serious weapon homicide reviews. For defined qualifying homicides review partners were required to conduct a review into the person’s death. Meeting this requirement was currently being worked through with the West Midlands Violence Reduction Unit.

The financial implications were reported. There were revenue implications of a partnership commissioning fund in the region of £100-150,000 per annum for a three-year period. It was expected this would be part-funded by the Home Office and the Office of the Police and Crime Commissioner had indicated a willingness to provide matched funding. The WCC Community Safety Team would take a lead role and there would be resource implications for all partners in regard to training and establishing the commissioning fund.

Questions and comments were submitted, with responses provided as indicated:

- The Chair sought more information about monitoring and implementation of the strategy. This would be via a Serious Violence Strategic Group of the SWPB. It was suggested that as the delivery plan was developed it be brought to this and other boards to ensure ownership.
- The Chair referred to the report recommendations and specifically that relating to the establishment of a delivery fund. She reminded that this Board did not have authority to agree this or its own funding and therefore suggested an update to the wording of this recommendation.
- It was questioned if the removal of local police officers impacted on liaison. Mr Toy responded that from experience, community leaders provided a more important local voice that would be listened to. Whilst authorities like the police were important, using local influencers was more so.
- A view that schools should be more involved, to ensure a dialogue with young people from an early age and identify causes which led to people participating in serious crime. The Chair agreed that this was about early intervention, speaking of the implications of trauma for young people and the need for all parts of the community to be involved. The training and awareness raising aspects were welcomed.
- Chris Bain spoke of feedback at the recent Warwickshire pride event. There were increasing incidents of hate crime, and people felt more threatened. Other concerns were cyber violence with an associated impact on mental health and violence against women. It was questioned if the strategy would provide a sufficient response. Mr Toy referred to the hate crime partnership, the strategic approach taken to hate crime and the excellent work being undertaken by the WCC equality and diversity inclusion group. Work was also being undertaken within the Community Safety section including targeted use of ‘safer streets’ funding. The Strategy made direct reference to the impact of social media. It was about changing the narrative. There was an ambition to engage younger people, to shape social media messaging. An example was provided of current engagement with people who had been involved in county lines and serious violence. There was an opportunity to use messaging in a more positive environment. Chris Bain suggested a direct conversation with the LGBTQ+ community and he offered to make introductions.

The Chair added that the Board would welcome periodic updates and a revisit to this area at a future meeting.

Resolved

That the Health and Wellbeing Board:

1. Endorses the Warwickshire Serious Violence Prevention Strategy and will work collaboratively with the Safer Warwickshire Partnership Board and Local Criminal Justice Board to support delivery of the strategic priorities set out in the strategy and delivery plan.

2. Endorses the adoption of a public health approach to serious violence prevention as set out in “A whole system multi agency approach to violence prevention”, published by Public Health England.

3. Supports the work of lead officers across named statutory agencies for the establishment of a delivery fund to ensure the objectives set out in the Warwickshire Serious Violence Prevention Strategy delivery plan are achieved and are affordable within current budgets/resources.

4. Works in partnership to develop a training and awareness programme for front line health practitioners on the duty and how to identify and refer those at risk of serious violence.

5. Supports the Safer Warwickshire Partnership Board in the development of and response to Serious Weapon Homicide Reviews that are coming into force as part for the above act.

Updates

8. Warwickshire Health and Wellbeing Partnerships

The Board received updates from each of the place-based Health and Wellbeing Partnerships in Warwickshire. The Chair proposed that each partnership be invited to give an update by way of presentation at the January Board meeting.

9. Levelling Up

This update concerned the newly published countywide approach to levelling up in Warwickshire and the opportunity for greater alignment and synergy between Levelling Up, health inequalities and the wider work of the Health & Wellbeing Strategy.

10. Coventry and Warwickshire Integrated Health and Wellbeing Forum

A report on proposals for the establishment of the Coventry and Warwickshire Integrated Health and Wellbeing Forum, which would replace the Coventry and Warwickshire Joint Place Forum. The new Forum would provide system leadership around the wider health and wellbeing agenda. As such it would contribute to achievement of the aims of the ICS, specifically tackling inequalities in outcomes, experience and access, and helping the NHS support broader social and economic development.

11. Coventry and Warwickshire Population Health Management Roadmap

This report detailed the plans to improve population health through data-driven planning and delivery of proactive care. It sought to achieve this through use of analytical tools to identify local 'at risk' groups of people. It brought multi-disciplinary teams together to use these insights to design and target activity to prevent ill-health, improve health outcomes and reduce inequalities.

12. Forward Plan

The Chair gave an outline of the agenda content for the January Board meeting. Nigel Minns suggested that an item be included to give early consideration of the Better Care Fund, which was agreed.

……..
Councillor Margaret Bell, Chair

The meeting closed at 4:00pm

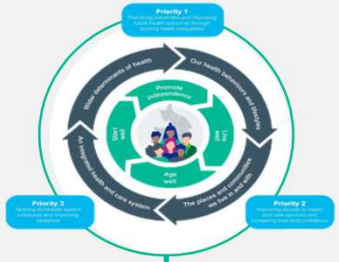
The Journey of Place

Place based JSNAs produced 2018-2020

Joint HWBB strategy adopted march 2021

Place Priorities:

- North
- Rugby
- South



ICS Strategy developed Dec 22

Place in 2023 and our ask to HWBB

TORs agreed March 2020

HWBB Strategy - population health framework adopted

ICS formed July 2022

What have we learned from working at place?

What does HWBB Strategy say about Place?

- We are taking a place-based approach to delivery. In Warwickshire, our 3 Places are:
  - North – covers North Warwickshire Borough and Nuneaton and Bedworth Borough
  - Rugby – covers Rugby Borough
  - South – covers Stratford on Avon District and Warwick District

- Leadership and accountability are key to knowing if we are getting things right. The HWBB will have oversight of progress against our strategic ambitions. The direction of travel indicators will be developed into an outcomes dashboard for the HWB, and the HWB will receive an annual performance report on progress.

- Each HWP in Warwickshire will develop an implementation plan with clear performance measures based around the four components of the population health framework.

- The HWP action plans will be tailored to meet the specific needs of each place and will routinely report to the HWB.

- Local HWPs will work with the HWB Executive Officer Group to ensure wider determinants and access to services are addressed collectively at a local level whilst contributing to the overall vision for the system. This will enable the places to be the future engine room of the NHS.

Progress to date with Place Partnerships

Warwickshire North

- Mapping exercise undertaken to review delivery priorities, aligned to population health framework
- Delivery group completed quality improvement project designed to provide health coaching and support to high intensity healthcare users

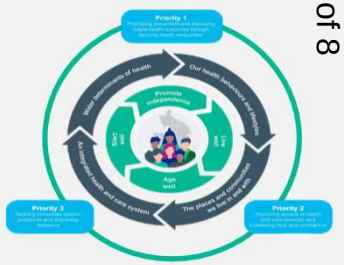
Rugby

- Plans to review and refresh terms of reference and agree model for delivering priorities i.e. task and finish groups for Rugby Town Centre project, Children and Young People mapping

South Warwickshire

- Utilising ICB funding to mobilise mental health project to support Children in Crisis and to carry out engagement to raise the profile of Place within the VCSE
- Place Development Programme, culminating in a Peer Review of Place…

What does the draft ICS Strategy say about Place?



- Much of the activity to integrate care and improve population health will be driven by organisations working together in our places, and through multi-disciplinary teams working together in our neighbourhoods.
- All partners in the system have signed up to four commitments that will define how we work together to achieve the four national aims and our system priorities.
- These include an underpinning commitment to the primacy of place in our decision-making and activity, whilst recognising the opportunity of system-wide working to deliver value at scale where appropriate.

Lessons learnt from South Place Peer Review

- Many strengths were highlighted and there is a clear commitment to Place working from partners
- The focus moving forward is on continuing to mature the partnership, refine the vision and broaden place work further to strengthen collaboration
- This includes considering what analyst support will look like, and how to turn findings into interventions
- There are also key opportunities to look at what sits at system, care collaborative, and place (and indeed below to PCN/ GP practices) and how we boost influence at ICB and how to tap into collective resources for population health

The Journey of Place

Place based JSNAs produced 2018-2020

Joint HWBB strategy adopted march 2021

Place Plans:

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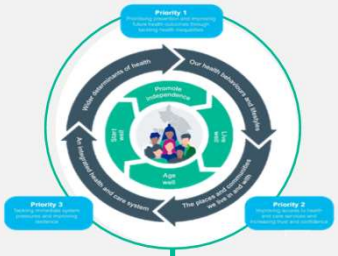
- Rugby
- South



ICS Strategy developed Dec 22

Place planning for 2023 and HWBB support...

TOR agreed March 2020

HWBB Strategy - population health framework adopted

ICS formed July 2022

What have we learned from working at place?

Place in 2023 and support from HWBB

1. Resources to deliver – how do we ensure Places receive resource to carry out activity that supports the commitments within the HWB Strategy and ICS Strategy?

2. Making connection back to system – how do we ensure that there is connectivity between places and the wider ICS?

3. Connecting to communities – Places are best fit to engage with communities, how do we utilise this to ensure two-way communication between communities and Place and the wider ICS?

4. Sustainability – how to make sure that activity at place transitions to business as usual?

The Journey of Place

Place based JSNAs produced 2018-2020

Joint HWBB strategy adopted march 2021

Place Plans:
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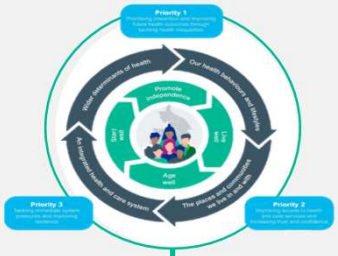
- Rugby
- South



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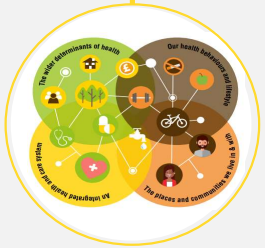


ICS formed July 2022

What have we learned from working at place?

Agenda Item 3

Health and Wellbeing Board

11 January 2023

COVENTRY AND WARWICKSHIRE INTEGRATED CARE STRATEGY

Recommendation(s)

The Board is recommended to:

1. Note the draft Integrated Care Strategy for Coventry and Warwickshire 2022 and provide feedback on the draft strategy ahead of publication;

2. Consider how the Board could contribute to delivery of the strategy, and how impact and success measures could be shared through regular reporting to the Board; and

3. Consider how the Integrated Care Strategy might inform further development of the Board's Health and Wellbeing Strategy.

1. Executive Summary

1.1 The Health and Care Act 2022 requires integrated care partnerships to write an integrated care strategy, setting out how the assessed needs of the population can be met by the Integrated Care System (ICS). The strategy is a crucial system document that provides a vision for health and care in Coventry and Warwickshire 5 years from now, leveraging the benefits of the system and enabling greater collaboration across partners. It sets the strategic direction and priorities for the system.

1.2 The draft strategy was approved by the Integrated Care Partnership (ICP) on 8 December 2022. It was co-developed by system partners through a widely inclusive process, and is informed by insight from our diverse communities, especially those with protected characteristics and groups that experience health inequalities.

1.3 This is an interim strategy, with plans for formal publication alongside the Integrated Care Five-Year Plan in April 2023.

2. Background

2.1 The passage of the Health and Care Act (2022) established Coventry and Warwickshire as an Integrated Care System on a statutory basis on 1 July

2022. This included creation of the Integrated Care Board (ICB), a statutory NHS organisation responsible for managing the NHS budget and arranging for the provision of health services in the ICS area to meet the health needs of the population.

2.2 The ICP is a statutory committee that brings together a broad alliance of partners concerned with improving the care, health and wellbeing of the population. The ICP is responsible for producing an integrated care strategy on how to meet the health and wellbeing needs of the population in the ICS area. National guidance recommended that ICPs publish their interim integrated care strategy by the end of December 2022.

2.3 The ICB is responsible for developing a 5-year integrated care forward plan before 31 March 2023, and must build this plan with due regard to the integrated care strategy. The plan will provide the operational detail about how the strategy's vision will be realised.

2.4 The national guidance recognised that time restraints in this transition year may limit the breadth and depth of the initial integrated care strategy, which will mature and develop over time. ICPs are expected to develop and refine the integrated care strategy as part of an annual cycle of planning and review.

3. Developing the Strategy

3.1 The ICP's approach to drafting the strategy was as inclusive as possible, with lead 'owners' from across the system identified for each core area of content. Over 40 individuals were involved in developing content, supported by a reference group, working group and core drafting team. A dedicated engagement task and finish group was also established to lead on community and stakeholder engagement. This included representatives from local authorities, NHS organisations, the voluntary and community sector, Healthwatch, faith groups and housing.

3.2 The strategy has been informed by:

- extensive system and partner strategy and engagement mapping, to ensure alignment with and building on existing system-wide activity
- the collation of needs data from across the system, especially from the Joint Strategic Needs Assessments (JSNAs)
- statutory guidance on the preparation of integrated care strategies
- feedback from a range of public and clinical engagement activities running concurrent to the strategy development.

3.3 Engagement with C&W Integrated Health and Wellbeing Forum on 13 October 2022 helped to inform priorities and identify what is most critical to the system now, and resulted in identification of a series of commitments that run through the strategy, aligned to achievement of the core purposes of the ICS.

3.4 Full details of the public and community engagement approach and activity are provided in the engagement report that accompanies the strategy. The strategy has been informed by insight from our diverse communities, with a particular emphasis on those with protected characteristics and groups that experience health inequalities. Key priority areas identified through community engagement included issues relating to digital inclusion, access to primary care and there being an erosion of trust in health services.

4. Strategy framework and content

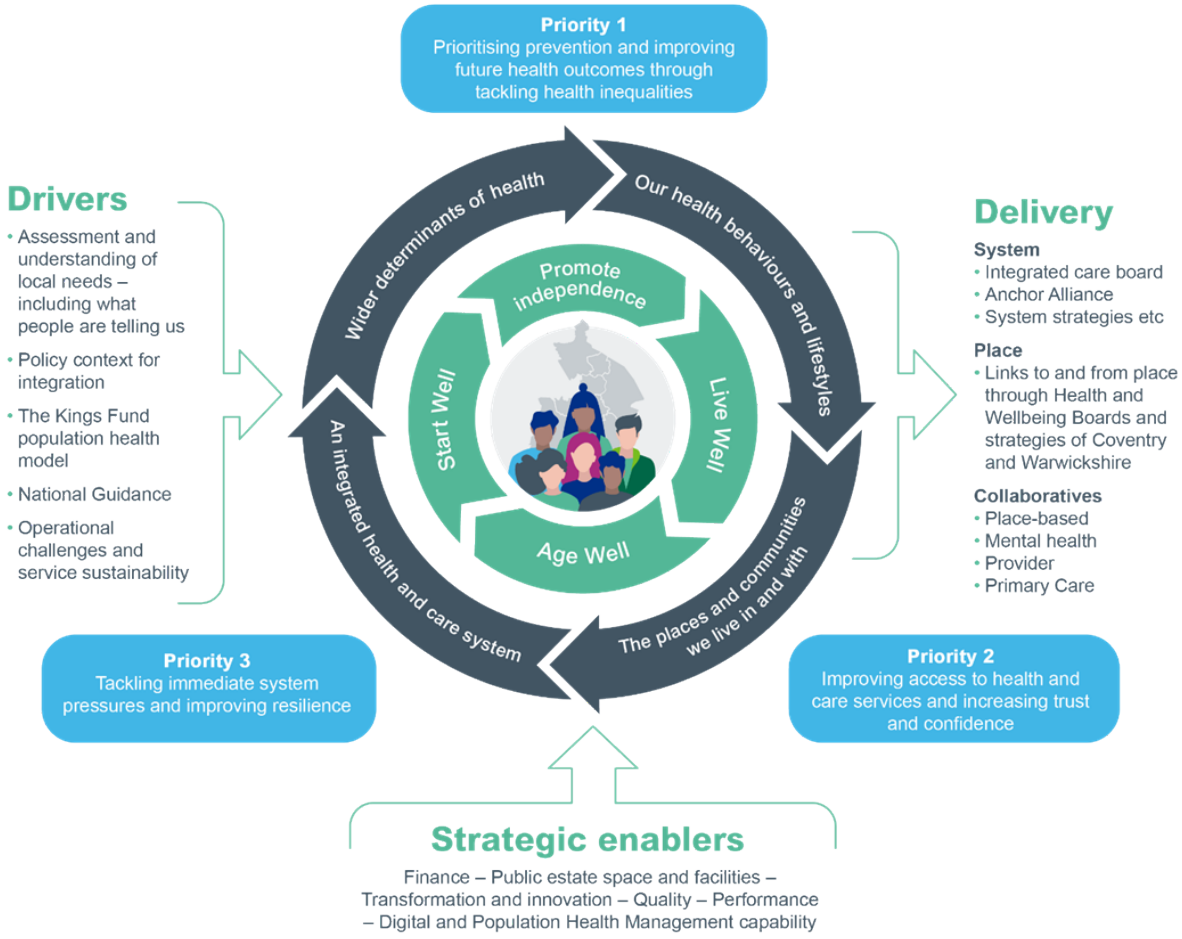
4.1 The final draft strategy includes three core priorities:

- Prioritising prevention and improving future health outcomes through tackling health inequalities
- Improving access to health and care services and increasing trust and confidence
- Tackling immediate system pressures and improving resilience.

4.2 For each of these core priorities we identify specific areas of focus and detail how we will change our ways of working over the next 5 years, and the actions we will prioritise. We have also identified a number of key enablers to delivery of our priorities, and we describe in the strategy where and how we need to integrate for each of these.

4.3 The overall framework for the strategy is described in the diagram below. There is a strong emphasis throughout on harnessing the energy and resource of a wide range of system partners to improve population health outcomes and address health inequalities, highlighting the connections and overlaps between different areas of activity. Like the local health and wellbeing strategies, it has the population health framework developed by The King's Fund at its heart.

4.4 The starting point for identifying our strategy priorities and areas of focus was an analysis of the two Health and Wellbeing Strategies, reflecting the needs identified in the JSNAs. Warwickshire's local priorities (Help our children and young people have the best start in life; Help people improve their mental health and wellbeing, particularly around prevention and early intervention in our communities; Reduce inequalities in health outcomes and the wider determinants of health) are reflected in particular in priority 1 of the strategy.



5. Financial Implications

5.1 Finance is identified as a key enabler within the strategy. It is expected that the priorities and strategic direction set out in the strategy will inform ICS decision-making and delivery, including spending priorities and the design of services.

6. Environmental Implications

6.1 The draft strategy details the opportunities of integrated health and care for addressing environmental factors and climate change. This includes opportunities to reduce the overall contribution of the integrated care system to climate change and particularly the impact of healthcare.

6.2 The strategy also details ‘win-win’ opportunities to reduce greenhouse gas emissions whilst also addressing major public health challenges, focusing on prevention and the wider determinants – such as increasing active travel and improving housing quality.

7. Supporting Information

7.1 National Government guidance for health and wellbeing boards following the creation of statutory integrated care systems states that:

- Health and wellbeing boards (HWBs) will need to consider the integrated care strategies when preparing their own strategy to ensure they are complementary
- HWBs should be active participants in the development of the integrated care strategy and the ICP and HWBs should "work collaboratively and iteratively in the preparation of the system-wide integrated care strategy that will tackle those challenges that are best dealt with at a system level"
- HWBs are required to consider revising their health and wellbeing strategy following the development of the integrated care strategy for their area, but are not required to make changes if they consider that the existing health and wellbeing strategy is sufficient
- The integrated care strategy should build on and complement local health and wellbeing strategies, identifying where needs could be better addressed at the system level
- ICPs should use the insight and data held by HWBs in developing the integrated care strategy, in particular the JSNAs.
- The introduction of integrated care strategies is an opportunity for JSNAs and health and wellbeing strategies to be revised and/or refreshed, to ensure that they remain effective tools for decision making at both place and system levels.

7.2 The guidance also makes clear that in an effective health and care system the ICP should build upon the existing work by HWBs and any place-based partnerships to integrate services. ICB and ICP strategies and priorities should not detract from or undermine the local collaboration at place level.

7.3 Coventry and Warwickshire Integrated Health and Wellbeing Forum is the key mechanism through which both Coventry and Warwickshire HWBs are involved in the preparation of the integrated care strategy and provide collective input to the strategic priorities of the ICP.

8. Timescales associated with the decision and next steps

8.1 The integrated care strategy will be formally published alongside the Integrated Care Five-Year Plan in April 2023. A suite of documents will be developed for publication, including an easy read version and an executive summary.

8.2 The Health and Wellbeing Boards and other key stakeholders, such as the Health and Wellbeing Place Partnerships and emerging Care Collaboratives, have an opportunity before formal publication to provide feedback on the draft strategy.

8.3 ICPs are expected to develop and refine the integrated care strategy as part of an annual cycle of planning and review. When refreshing its strategy the ICP must consider whether the strategy is being delivered by the integrated care board, NHS England and local authorities, including its impact on commissioning and delivery decisions.

8.4 The ICP plans to develop a core set of success measures for each of the three strategic priorities so that progress against intended outcomes can be properly monitored, with oversight through the Integrated Care Partnership and regular reporting to the Health and Wellbeing Boards.

Appendices

1. Appendix 1: Draft Coventry and Warwickshire Integrated Care Strategy
2. Appendix 2: List of contributors
3. Appendix 3: Local Priorities for Integrated Care – Interim Public and Community Engagement Report 2022
4. Appendix 4: Equality Impact Assessment

Background Papers

1. None.

	Name	**Contact Information**
Report Authors	Liz Gaulton, Chief Officer Population Health and Inequalities, NHS C&W Integrated Care Board	
	Debbie Dawson, Population Health Transformation Officer, C&W Integrated Care System	Debbie.dawson@coventry.gov.uk

happyhealthylives.uk

Coventry and Warwickshire
Integrated Care System

Coventry and Warwickshire

Integrated Care Strategy

Contents

Foreword

We will do everything in our power to enable people across Coventry and Warwickshire to pursue happy, healthy lives and put people and communities at the heart of everything we do.

Those are the words at the heart of the Coventry and Warwickshire Health and Wellbeing Concordat, developed in 2018 as a statement of intent for how health and care will work together for the benefit of all of our residents.

The Health and Care Act 2022 formalised the biggest health and care reforms for over a decade, mandating collaboration and cooperation, but working in partnership isn't new to Coventry and Warwickshire. We have a long and productive history of working closely together as local authorities, NHS organisations and with our wider partners for the benefit of the people we serve. The new reforms present a real opportunity for us to go further and faster in collaborating as a system to support everyone in Coventry and Warwickshire to be happier, healthier and more independent.

The purpose and intent of the Concordat vision statement still stands and has shaped the vision statement for our system:

We will enable people across Coventry and Warwickshire to start well, live well and age well, promote independence and put people at the heart of everything we do.

These are difficult times for public services, for people working to deliver those services and for people needing to access to those services. The pandemic has pushed health and care services to the brink of their capacity, it has pushed the health and care workforce to the edges of exhaustion. Communities have suffered greatly too, as have workers in many other sectors. We have huge waiting lists, a growing population and less and less resource.

Despite the challenges I believe that the Integrated Care System, guided by this strategy, can improve people's health and quality of life. We are committed to prioritising prevention and to working with partners and communities to address the wider determinants of health such as socio-economic inclusion, housing, employment and education. We will ensure that services are personalised so that services meet the needs of individual patients and service users and we will strive to tackle inequalities and understand the drivers of population health.

In many ways our system performs well and everything I've seen in my time as the chair of the ICB and ICP has shown me this, as well as the shared commitment to working together to make things

better. It is the will to help each other and to continue to strive for the best for our people that is our greatest strength. Together we can and will build a fit for the future local health and care system.

This strategy, which builds on the great work happening across Coventry and Warwickshire and the two Health and Wellbeing Board Strategies, sets out exactly how we intend, over the next five years, to confront the challenges we face, together, to improve outcomes for local people. It will inform the detailed five-year plan for our Integrated Care Board.

It is Coventry and Warwickshire's strategy, informed by significant engagement with local people and communities, with the health and care workforce, with patients and clinical leaders. This conversation will continue as we turn this strategy into delivery and monitor our progress and impact. I am proud to introduce it to you.

Danielle Oum

Integrated Care Board and Integrated Care Partnership Chair

December 2022

Introduction

Delivering Health and Care in Coventry and Warwickshire

Our new Integrated Care System (ICS) was formalised on 1 July 2022, with the establishment of the new Integrated Care Board and statutory Integrated Care Partnership. One of the most important actions of our new ICS has been the development of this strategy, to set out how we will come together as partners to improve health, care and wellbeing for the people of Coventry and Warwickshire.

We are developing our Integrated Care Strategy at a time of enormous challenge for health and care systems up and down the country. The pressures we face are not unique to Coventry and Warwickshire, but their impact is affected by our local context.

This strategy provides an opportunity for us to set out our ambitions for what we can achieve over the next five years as an ICS. It aims to outline, in high level terms, the difference we can make by working in an integrated way, taking advantage of a new legislative framework – and it sets the tone and focus for how we will work together. It doesn't seek to replace or duplicate existing strategies and activity underway in the system – instead it seeks to link them together by providing an overarching narrative about where we want to get to, and what it is that we are all trying to change and improve together.

Importantly, this is about far more than health and care services. The Integrated Care System has an opportunity to improve population health and wellbeing in its broadest sense, with a wide range of partners working together to improve health outcomes and tackle health inequalities, starting with the root causes by addressing the wider determinants of health.

And equally importantly, this is about working together at all levels and as locally as possible. We intend that much of the activity to integrate care and improve population health will be driven by organisations working together in our places, and through multi-disciplinary teams working together in our neighbourhoods, adopting new targeted and proactive approaches to service delivery, informed by a shared understanding of the needs of our population.

The Covid-19 pandemic brought us together as partners in the face of urgent need and accelerated collaborative working. From protecting and supporting extremely clinically vulnerable people, to implementing vaccinations, to delivering testing, we worked together as partners and with our wider community in ways we hadn't previously, recognising where public sector partners had a different role to play, empowering and facilitating where expertise and capability lies with our communities. We now have an opportunity as an Integrated Care System to embed and build on these new ways of working together. The challenges we face are no less urgent or significant, and demand just as much commitment and ambition in response.

More patients than ever are accessing primary care appointments. However, in our engagement with local people we have heard, loud and clear, concerns about access to health services – especially primary care – and, increasingly, indications that trust in the NHS is beginning to erode.

Challenges

facing the Coventry and Warwickshire Intergrated Care System

Financial strain

£84 Million

Expected effeciency ask equating to 4.7% of the **£1.8 Billion** NHS opening budget for 2022/23***

Deprivation

137,208

of people live in the top **20% most deprived** areas nationally; equating to **14.2%**

99,153 (**26.1%**) of the 137,208 people reside in Coventry

38,055 (**6.5%**) in Warwickshire

Living longer with greater need

	Healthy Life Expectancy (years)	Years spent in poor health	Total life expectancy
Coventry			
	61.1 (males)	16.9 years	78 years
	64 (females)	18 years	82 years
Warwickshire			
	62.1 (males)	17.6 years	79.7 years
	64.1 (females)	19.3 years	83.4 years

Population Growth

58,000

Predicted increase of GP registered patients by 2027/28, making the population **1,111,898**

Place-based variation

Willenhall	Warwickshire South
71.3 years	87.8 years

Staff Turnover

Continued increases in staff turnover (**recorded with an average of 15%**) poses a workforce challenge in capacity and service delivery.

Cost of living

Coventry is in the top decile **(10%)** of Local Authorities in the Cost of Living Vulnerability Index.

Health inequalities

The gap in life expectancy between most and least deprived **is widening**

Coventry	10.2 year gap (males)	7.5 year gap (females)
Warwickshire	7.7 year gap (males)	6.7 year gap (females)

Increasing demand

in Emergency Presentations and Primary Care following the COVID-19 pandemic.

*Based on an average increase of 15,800 patients year on year over the past seven years (2022).
**Mapped on Middle Super Output Area (MSOA) level, which on average comprises 7,200 people.
***The NHS Budget does not include Social Care.

Data Sources: Centre for Progressive Policy (2022); Coventry and Warwickshire ICS Internal Systems; 2020 Mid Year Population Estimates (ONS); Fingertips; The Segment Tool (OHID).

These are difficult messages to hear, but as an Integrated Care Partnership we are determined to tackle them head on.

As the local Integrated Care Partnership, we are uniquely placed to address the challenges facing the health and care system in Coventry and Warwickshire, and to harness collective energy and resource to achieve our ambitions for the health and wellbeing of our population. We bring together a wide range of partners – local government, NHS, voluntary and community sector, housing, Healthwatch, universities and others, to lead the system's activity on population health and wellbeing and drive the strategic direction and plans for integration across Coventry and Warwickshire.

Our Integrated Care Strategy charts a path for how we will work together over the next five years to deliver our vision.

Our Vision

'We will enable people across Coventry and Warwickshire to start well, live well and age well, promote independence, and put people at the heart of everything we do'

Improve outcomes in population health and health care

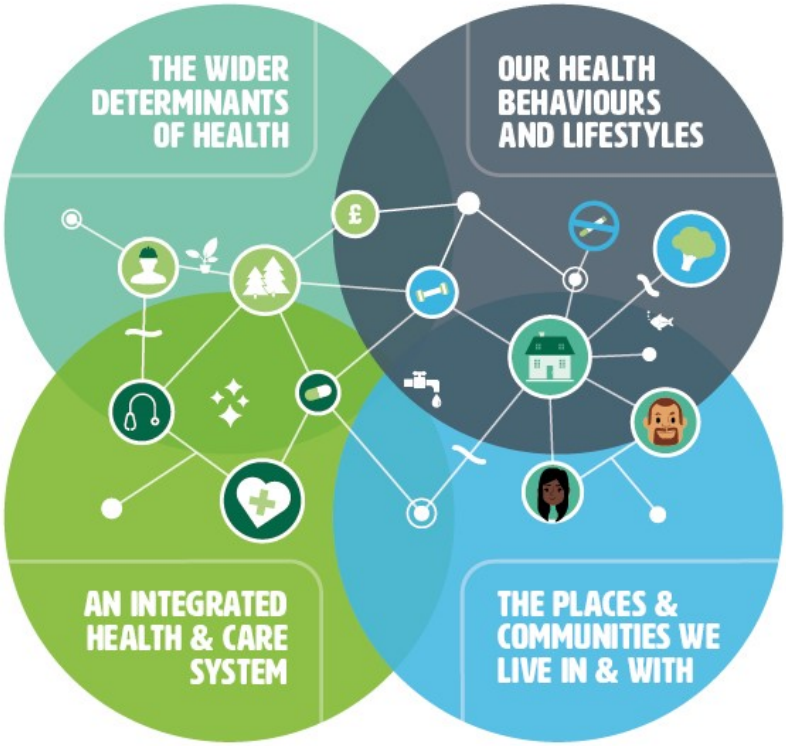
Tackle inequalities in outcomes, experience and access to services

Enhance productivity and value for money

Help the NHS support broader social and economic development

The Framework for our strategy

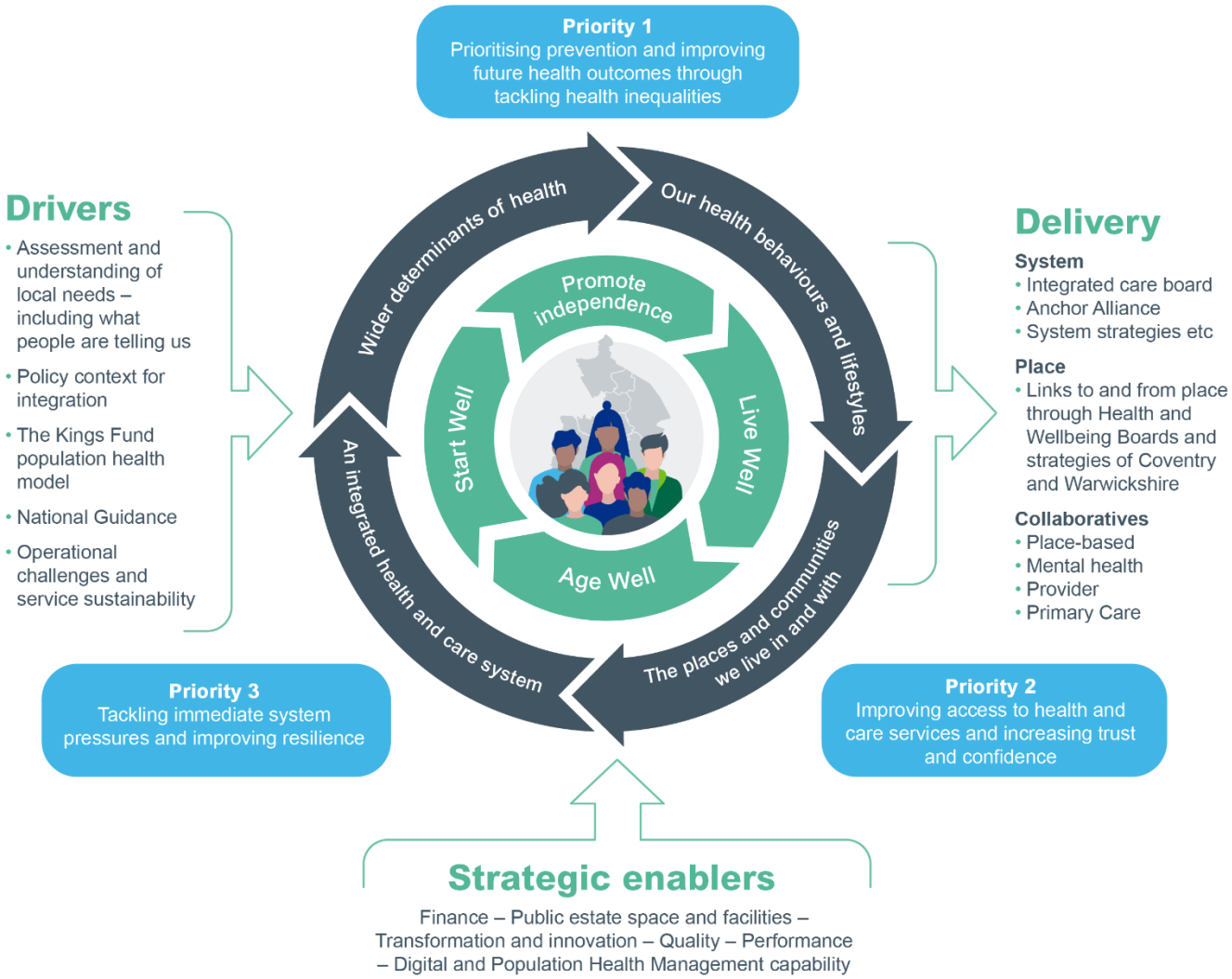
As we have transitioned to statutory ICS arrangements, The King's Fund population health model has framed our ICS strategic direction and underpins an inclusive, integrated approach to health and wellbeing. Both Coventry and Warwickshire Health and Wellbeing Strategies[1] are based around this model, and it is embedded as our strategic approach right across the system. We are committed to ensuring that strategies and plans across our integrated care system consider each of these four components and – importantly – the connections between them. Our integrated care strategy is equally driven by this approach.



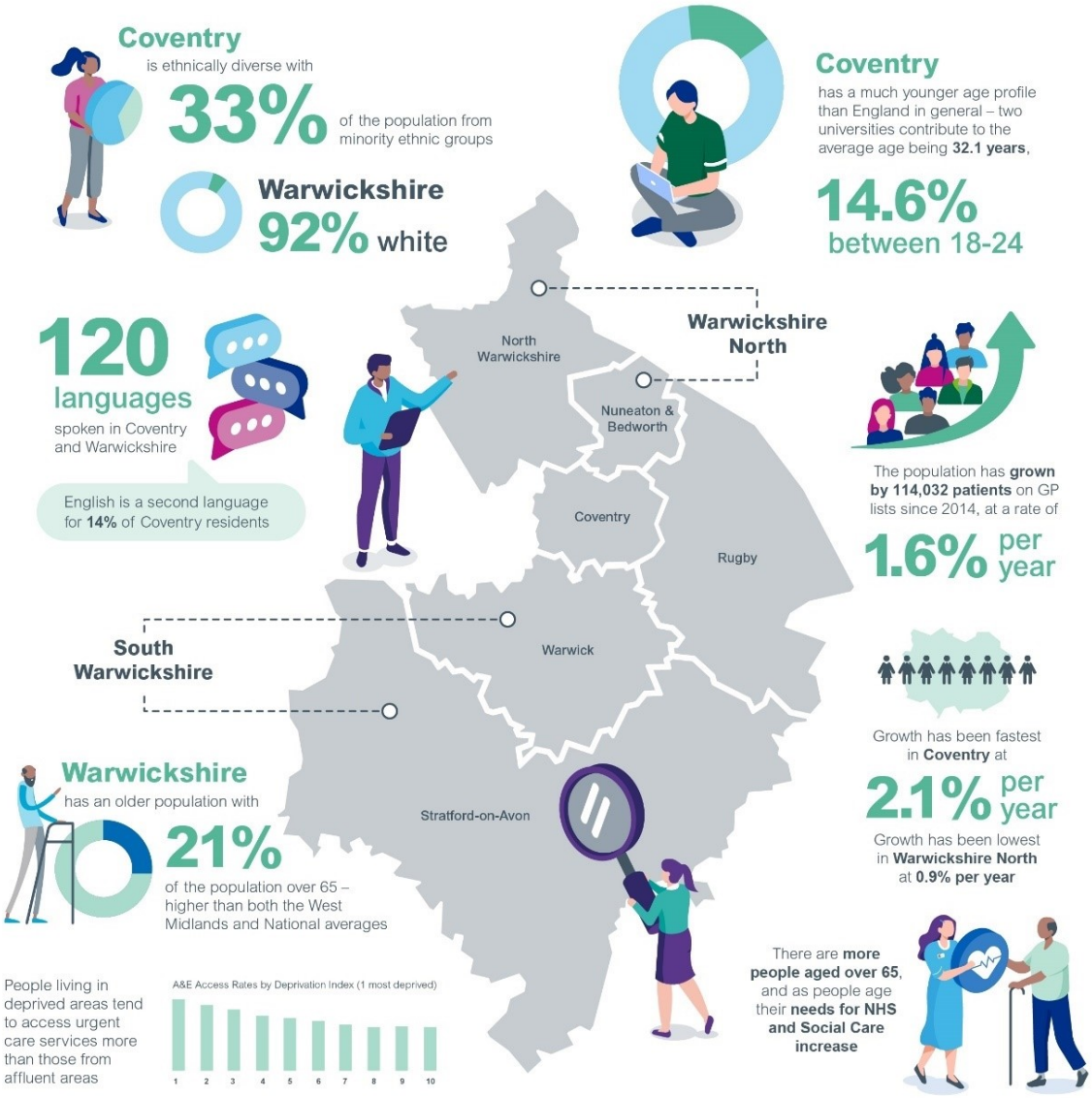
[1] Coventry Health and Wellbeing Strategy, 2019-2023
Warwickshire Health and Wellbeing Strategy 2021-2026

The diagram below sets out the overall framework for our strategy and helps describe the approach we have taken in developing its content.

Our priorities and planned activity are driven by the national and local policy context (and guidance) for integration and our understanding of local population health needs as set out in the Joint Strategic Needs Assessments, informed by local Health and Wellbeing Strategies and embracing the role and contribution of a wide range of partners at Place. And they reflect what we've learned from listening to our communities.



Our local people and communities



Six Councils

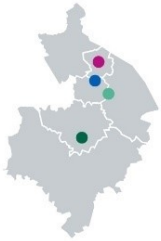
Resident Population	942,100
North Warwickshire	65,000
Nuneaton & Bedworth	134,200
Rugby	114,400
Coventry	345,300
Warwick	148,500
Stratford-on-Avon	134,700

Two Local Authorities

Resident Population	942,100
Coventry	345,300
Warwickshire	596,800

Four Places

GP Registered Population	1,053,898
Warwickshire North	163,993
Rugby	117,827
Coventry	432,247
South Warwickshire	338,987



4 NHS Providers

- George Eliot NHS Trust
- Coventry and Warwickshire Partnership Trust
- University Hospital Coventry and Warwickshire Trust
- South Warwickshire NHS Foundation Trust

The Coventry and Warwickshire Integrated Care System provides health, care and wellbeing services and support to a diverse population of over 1 million people, and that population is growing. With population growth concentrated in certain parts of the ICS, and the population profile varying between localities, a place-based approach to service planning remains important.

The Joint Strategic Needs Assessments provide a huge amount of data and evidence about the health and wellbeing of our residents:

- Coventry Joint Strategic Needs Assessment
- Warwickshire Joint Strategic Needs Assessment

More detailed information on health inequalities can be found in the Coventry and Warwickshire Director of Public Health annual reports[2] and Warwickshire's Health Inequalities Dashboard.

[2] Coventry Director of Public Health's Annual Reports
Warwickshire Director of Public Health's Annual Reports

Our opportunities to improve health and care

"ICSs… are part of a fundamental shift in the way the English health and care system is organised.

Following several decades during which the emphasis was on organisational autonomy, competition and the separation of commissioners and providers, ICSs depend instead on collaboration and a focus on places and local populations as the driving forces for improvement".

– The Kings Fund

The statutory basis for Integrated Care Systems (The Health and Care Act 2022) gives us an opportunity to go above and beyond what we have already achieved through collaborative working in Coventry and Warwickshire and to accelerate what has happened to date.

There are a number of empowering elements in the Act which we will seek to harness, especially around finance and tendering, and removal of the competitive environment. As collective stewards of public finance for the benefit of the population we serve, ICS partners have an opportunity to deliver real benefits from integration.

This includes:

- Targeting resource to where it is most needed to tackle health inequalities
- Joining up of currently disconnected services across providers, to deliver more complementary and seamless health and care services to our population
- Working together in our places to build strong community links and relationships
- Sharing best practice and expertise at scale across the system, and offering greater training and OD opportunities for our workforce
- Benefitting from procurement partnerships and economies of scale
- Data sharing and intelligent use of data for population health modelling and proactive and preventative work
- Improving resilience by, for example, providing mutual aid
- Working together to help build and enable a thriving voluntary and community sector, with the public sector changing how it works with communities to build responsive, local, and inclusive capacity
- Ensuring that specialisation and consolidation occur where this will provide better outcomes and value
- Sharing finance and back-office systems, professional expertise and facilities

The wider context and opportunities of integration

Inclusive Economic Growth

Integrated care relates not just to integration within the health sector, but also reaching out further to the integration of health and care to other key sectors.

We recognise the importance of the link between good health and a strong economy – the two are intrinsically connected and mutually dependant on each other.

Income, skills and employment levels all affect people's ability to live healthily. Similarly high levels of health and wellbeing create a strong, diverse and reliable workforce for our businesses and employers.

Whilst Coventry & Warwickshire enjoy both strong economic performance and comparatively strong levels of health and wellbeing, we know there is work to do for particular communities, groups and business sectors – this is a key focus for our shared approached to Levelling Up across the sub-region and our commitment to reduce disparities and increase opportunities.

Focusing on inclusive economic growth within an integrated care strategy allows us to explore issues of connectivity, access, and equality as well as providing a health lens to investment, infrastructure, sustainability which enables economic growth and improved health and wellbeing.

We are also aware of our own collective role on the local economy. Our Coventry and Warwickshire Anchor Alliance seeks to harness the role of local councils, health bodies and our universities as key local employers and contributors to the local economy.

The burning platform of the cost-of-living pressures provides a catalyst for long needed change. We now have an important opportunity to bring together the connected agendas of economy and health as inclusive growth within our developing Coventry and Warwickshire Economic Strategy.

Addressing environmental factors and climate change

"Climate change is the single biggest health threat facing humanity" (WHO)

We cannot consider health and care across our System without giving due attention to the environment and climate crisis. Extreme temperatures and air pollution are just some of the ways in which climate change is already starting to impact upon the health of our population; the severity and range of ways health and wellbeing will be impacted is only going to increase and concerted action is required at local, national and global levels. Sadly, we know that the impacts of climate change will disproportionately affect the most vulnerable in society, thus worsening the health inequalities that we are trying to address; those people living in deprived areas are more likely to experience poor air quality and individuals with underlying health conditions are more severely affected by extreme temperatures.

Not only do we have to be prepared as a System to deal with the consequences of climate change and take steps to mitigate, but we must also take responsibility as a System to reduce our overall

contribution to the climate crisis, including importantly the impact of healthcare. Coventry and Warwickshire ICS Green Plan seeks to embed sustainability and low carbon practice in the way that the system delivers healthcare services. The Green Plan allows our ICS to set out our current position in addition to our goals for the next three years, with a view to helping the NHS to become the first health service in the world with net zero greenhouse gas (GHG) emissions. A wide range of other action is being taken across the System, including through the development of a range of strategies: WM2041 5 Year Plan 2021-2026- West Midlands Combined Authority's plan on carbon emission reduction, Coventry Climate Change Strategy and Taking Action on Climate Change - Warwick District Council's plan to achieve Net Zero

As described by the Office for Health Improvement and Disparities (OHID), there are a number of so-called 'win-win' opportunities, whereby we can reduce greenhouse gas emissions whilst also addressing major public health challenges, focusing on prevention and the wider determinants. Good examples include:

- An increase in active travel by foot or bike will reduce green-house gas emissions and air pollution from private vehicles.
- Making homes more energy efficient will help tackle fuel poverty and the associated negative impacts on health.

Prioritising the wider determinants of health, including housing quality, will not only have an impact on climate change, but also a positive impact on an individual's immediate living environment, including for example damp and mould, that can be very damaging to health and wellbeing.

By all partners across the System committing to being green and sustainability led, we can not only improve the health and wellbeing of our local population, but also join the national and global effort to tackle the climate crisis.

People at the heart of our strategy

From the outset we wanted to ensure the strategy was informed by the people it speaks for –local people and their communities, as well as our health and care workforce.

Key priority areas identified through community engagement included **issues relating to digital inclusion, access to primary care and there being an erosion of trust in health services.** Ensuring a **focus on prevention, health inequalities and workforce** emerged as key themes from stakeholder engagement. Full details of the engagement are included as an appendix to the strategy.

As we develop the Integrated Health and Care five-year Plan, we will ensure we continue to engage and seek feedback and input in an aligned and connected way, local residents, stakeholders and all of those we have communicated with, engaged and involved throughout.

We will make sure this is coordinated with other engagement and involvement planned by local authorities, NHS organisations and others in the system.

Our strategic priorities

Our strategy priorities have evolved through engagement with stakeholders and the communities we serve, and are drawn from:

- the two Health and Wellbeing Strategies, reflecting the needs identified in the Joint Strategic Needs Assessments
- national guidance about the design of ICSs and the development of integrated care strategies
- key themes emerging from public and stakeholder engagement.

We have identified three overarching priorities that will drive our activity as a system over the next five years, with a number of key areas of focus within these. The strongest message we have heard in our public engagement has been about access to and trust in health and care services, and so we are committing to invest our energies in addressing this as one of our system priorities.

The other priorities reflect a shared understanding that there is both an immediate imperative to tackle specific burning issues around system capacity and resilience, and action we need to take now that will have an impact on population health long-term. It is by prioritising prevention across all we do that we have a real opportunity as an integrated care system to shift the dial on population health outcomes and inequalities.

Our priorities

Prioritising prevention and improving future health outcomes through **tackling health inequalities**

- Reducing health inequalities
- Prioritising prevention and wider determinants to protect the health and wellbeing of people and communities
- Enabling the best start in life for children and young people

Improving access to health and care services and increasing trust and confidence

- Enabling personalised care
- Improve access to services especially primary care
- Engaging and involving our people, communities and stakeholders
- Making services more effective through greater collaboration and integration

Tackling immediate system pressures and improving resilience

- Supporting people at home
- Develop, grow and invest in our workforce, culture and clinical and professional leadership

As we have developed these priorities and identified the outcomes and actions for each, we have done so through the lens of our population health model. Whilst each is an important and distinct area of activity, we also seek to highlight the connections and overlaps between them. So, for example:

- personalised care gives power to people to live independently, take greater control of their own care and focus on “what matters to me?” rather than “what’s the matter with me?” This citizen empowerment is key to the prevention of ill health
- protecting the health of people and communities requires culturally competent approaches, which will be underpinned by a deeper understanding and involvement of our communities
- there are opportunities to address the wider determinants of health through our approach to workforce challenges, by recruiting locally and taking action to attract and prepare young people living in areas of deprivation for careers in health and care.

We are determined to see an unswerving commitment to reducing inequalities running through everything we do but have also included this as a specific area of focus, to ensure it is given the attention and scrutiny required to deliver progress and impact over time.

All partners in the system have signed up to the following set of commitments that will define how we work together to achieve the four national aims and our system priorities. These include an underpinning commitment to the primacy of place in our decision-making and activity, whilst recognising the opportunity of system-wide working to deliver value at scale where appropriate.

Our commitments

Priority 1: Prioritising prevention and improving future health outcomes through tackling health inequalities

What this means to me

I will be supported to live a healthy, happy and fulfilled life, being equipped with the knowledge and resources needed to prevent ill health and maintain my independence at home, whilst knowing that effective services are in place for me to access should the need arise. This will include having access to support relating to the wider aspects of my life, including housing, employment and finances.

Context

As a system we want to prioritise supporting our population to remain as independent and healthy as possible, whilst also providing effective, timely and accessible treatment and care when required, from early years through to the end of life.

Informed by engagement, we have identified three key areas that we need to focus on in order to prioritise prevention and improve future health outcomes locally. They are:

- Reducing Health Inequalities
- Prioritising Prevention and Wider Determinants to protect the health and wellbeing of people and communities
- Enabling the Best Start in Life for Children and Young People

Nationally, **prevention** has been placed at the heart of the newly developed Office for Health Improvement and Disparities and forms a key aspect of the NHS Long Term Plan and the Care Act 2014. This focus reflects the ever-increasing evidence base demonstrating the benefits and cost-effectiveness of shifting resources 'upstream' towards prevention. Locally, prevention is not only at the forefront of our vision for Coventry and Warwickshire ICS and a key ICB principle, but more importantly there is a genuine drive across partners within our system, exhibited throughout stakeholder and also community engagement, for prevention to be given the priority it deserves

moving forward. This includes an all age, whole population approach to personalised care, where people are supported to manage their health and wellbeing rather than only receiving treatment when they get ill, which is a key component of the prevention commitment

Unprecedented demand on health and social care services means that protecting public health and preventing physical and mental ill health and disability and the associated need for care have never been more important or relevant and there is arguably no better way of ensuring the sustainability of our services. By focusing on prevention at all levels across the system, future health outcomes for our population, and demand for health and care services of Coventry and Warwickshire can be improved.

As we strive towards equity, some groups will need to have more opportunities to benefit from these improvements in future health outcomes than others. Currently **inequalities** exist in health outcomes and life chances nationally and across Coventry and Warwickshire; these inequalities are well documented and yet have remained largely unchanged. The Covid-19 pandemic highlighted and unfortunately further exacerbated these, which in part has led to a national drive to reduce health inequalities through programmes such as NHS England's National Healthcare Inequalities Improvement Programme (HiQiP) and more locally through our Health Inequalities Strategic Plan. Our public engagement highlighted the negative impact of such inequalities locally, particularly for Black and Minority Ethnic communities.

While the health and care an individual receives is important, we know that as much as 80% of a person's long-term health is related to wider factors, including employment, housing and education. The Integrated Care System is a unique opportunity to provide a more holistic approach to health and care across the system, to enable people to access the support they need relating to these **wider determinants of health,** to create and support healthy communities and environments in Coventry and Warwickshire. Local authorities will be crucial to this work and how we work with VCSE organisations.

We also know that happy and healthy **children and young people** have more chance of becoming happy and healthy adults and that adverse events in childhood can have a life-long impact. There is no better place to start when thinking about prevention and future outcomes than by focusing on children and young people, a time when the foundations of a healthy and fulfilled life are being laid.

Reducing Health Inequalities

We want to be a system that effectively identifies, tracks and takes action to reduce entrenched inequalities in health and the wider determinants, by taking a population health approach, ensuring that Coventry and Warwickshire is a place where everyone starts, lives and ages well. We recognise that some groups who are disadvantaged by current arrangements may need differential access or specific targeted services in order to reduce inequity.

"Everyone should be able to access the same healthcare regardless of their colour, background or culture." (Feedback from an engagement session held with CARAG, Coventry Asylum and Refugee Action Group)

What are we doing already?

Coventry and Warwickshire ICS has a new five-year Health Inequalities Strategic Plan which provides an important basis to shape our work. The Plan sets out our commitments on how we are going to reduce health inequalities in Coventry and Warwickshire, taking account of the delivery of key elements of the NHS Long Term Plan and Core20PLUS5. We have a Population Health Inequalities and Prevention Board, supported by the Inequalities Delivery Group that come together to strategically align and drive forward this work, which is also being supported by the creation of two new Health Inequalities Programme Manager posts aligned to Place.

A range of programmes and strategies relating to health inequalities exist across Warwickshire and Coventry, including Tackling social inequalities in Warwickshire (2021-2030) and the emerging One Coventry Plan and work of the Marmot Partnership. It is hoped that this strategy, alongside the ICS Health Inequalities Strategic Plan will support in aligning work to ensure an integrated and coordinated approach to tackling health inequalities across Coventry and Warwickshire; embedding reducing health inequalities across all programmes of work will be key to achieving our goals.

What will change in our ways of working?

- Action to tackle inequalities will be embedded strategically and operationally across the system, making it core to the work of the ICS and built around Core20Plus5, ensuring it is at the heart of decision making and prioritising.
- We will build a culture of prioritising those in greatest need and an understanding that health inequalities can only be addressed in a systematic system-wide way and by taking a population health approach. This includes reducing inequalities being key to decisions on the prioritisation and allocation of resources.
- Service provision and preventative activities will be aligned with intelligence around the wider determinants of health and existing inequalities.
- All of our services will be planned and delivered in an inclusive way, encouraging innovation and community co-production through design.

What actions are we prioritising?

- Delivery of the Health Inequalities Strategic Plan across place and workstreams.
- Establishing a process to collect and share data and intelligence about health inequalities efficiently and effectively across the system and use them to plan service provision and preventative work.
- Ensuring all partners across the system have a shared understanding of what health inequalities are, how they relate to their work on a day-to-day basis and how to address them – for example by using HEAT (Health Equity Assessment Tool). This will also include supporting the personalisation agenda at a population level.
- Shifting resources to target population groups demonstrating the greatest need to achieve equity in outcomes, taking a gradient approach known as proportionate universalism.

Prioritising Prevention and Wider Determinants to protect the health and wellbeing of people and communities

We want to see prevention being explicitly embedded and resourced across all plans, policies and strategies for our population, supporting a reduction in inequalities and improvement in health and wellbeing outcomes. This includes addressing the impact of the wider determinants of health across the life course, ensuring residents live in affordable and good quality homes, have access to good jobs, feel safe and connected to their communities, utilize green space and are enabled to use active travel.

"More prevention plans and strategies - maybe this will help to save money and resources in the future." (Feedback from an engagement session held at a Hindu Temple)

We also want to be as prepared as possible for the very real threat of future pandemics, but also effectively manage all aspects of health protection, taking a population health and multi-agency approach. This includes ensuring ready access to and high uptake of immunisation and screening opportunities and appropriate and safe antibiotic prescribing. Our public health workforce, leadership and the lessons from Covid-19 will be key.

Within our communities people living in shared accommodation such as care homes, refugee and asylum seeker accommodation are more vulnerable to outbreaks of infectious diseases; we will continue to work collaboratively with partners to ensure additional measures are in place.

"Refugee and asylum seeker's mental and physical health is being affected due to the long delays with paperwork, housing conditions, financial constraints and isolation." (Feedback from an engagement session held at a Coventry and Warwickshire LGBTQI+ Support Group)

We want to deliver a whole system, all-age, person-centred approach to mental health and wellbeing, that is driven by access to physical and mental health and social care in the same place at the same time, with no wrong door, and where prevention is at the heart of all we do.

What are we doing already?

Our system approach based on the population health model not only recognises the interplay between wider determinants of health, our health behaviours and lifestyles, the communities in which we live and the health and care system, but also demonstrates our commitment to addressing these vital dimensions of health across the system. The Coventry and Warwickshire Population Health Inequalities and Prevention Board brings together and aligns local action around Population Health Management, Inequalities and Prevention across the system and is a vital aspect of developing the prevention agenda.

Both Coventry and Warwickshire Health and Wellbeing Boards have Health and Wellbeing Strategies in place that are rooted within the wider determinants of health, including a focus on connected, safe and sustainable communities. Our local authorities – Coventry City, Warwickshire County and our district and boroughs – also have strategies and plans and programmes of work in place around prevention and the wider determinants of health. In the context of significant cost-of-living pressures, with more people struggling to cover even basic bills and food costs, protecting people from the impact wider determinants can have on health and wellbeing is vitally important and will undoubtedly be more effective through an integrated approach across our system.

The nature of wider determinants means scope is broad and several workstreams will be relevant, including but not limited to:

- Domestic abuse and serious violence
- Transport
- Drugs and alcohol
- Homelessness
- Housing
- Employment
- Environment and health

Locally we are harnessing the valuable lessons learnt from the Covid-19 pandemic through an update of the local 2017-2021 Health Protection Strategy. This sets out a partnership approach to our identified priorities including emergency planning, infection control, screening and immunizations and air quality. Working closely in partnership with our UK Health Security Agency colleagues ensures a coordinated response to these key challenges, particularly emergencies and outbreaks.

Identified by the World Health Organization as being one of the biggest threats to global health, antibiotic resistance is also a priority locally and the Coventry and Warwickshire Antimicrobial Resistance (AMR) Strategy is delivered in partnership with colleagues from the ICS, including system prescribing leads. This aims to reduce inappropriate antimicrobial prescribing across primary and secondary care.

What will change in our ways of working?

- A commitment across the system to support prevention activity, recognising the value for money of prevention and early intervention. This includes prevention and early intervention being embedded explicitly across all system, place and neighbourhood plans, policies, strategies and programmes and maximising opportunities for primary, secondary and tertiary prevention across all pathways.
- Prevention of ill-health and promotion of wellbeing will be the first step of every NHS and local government pathway.
- There will be an increased recognition of the need for broad partnerships and the contribution that all partners can make, including academic institutions and voluntary and community sector organisations.
- A 'Health in All Policies' approach embedded across the system, whereby organisations adopt policies that promote health and wellbeing and support people with the rising cost of living, as major local employers.
- Effective coordination of all relevant health partners across the ICS to ensure migrant, refugee and asylum seeker populations receive appropriate physical healthcare, tailored mental health support and access to all services.

What actions are we prioritising?

- Resources will be allocated to reflect our focus on prevention and the wider determinants of health. This will include a systematic shift in resources 'upstream' towards prevention, and Health and Wellbeing Partnerships acting as delivery for the wider determinants of health.
- We will consider how to apply the Midlands Health Inequalities toolkit, including the Health Inequalities Decision Tool, to our decision-making across the system and specifically any targeted health inequalities interventions decisions.
- All system partner policies will be assessed for their contribution (positive or negative) to the health of our population. This will include conducting Health Equity Assessment Tools on new work programmes and policies and conducting Health Impact Assessments, for example by using the HUDU HIA or the WHIASU toolkit.
- We will use population health methodology and the voice of people with lived experience to drive strategic commissioning decisions and plan service changes to address health inequalities and provide more preventative services.
- Health services and partners will be equipped with the knowledge and resources to be able to appropriately signpost to services related to the wider determinants of health, with the aim of systematically addressing social needs within the health and care systems, for example through social prescribing approaches - enabled by linked data.
- Colleagues across the whole ICS will work collaboratively to maximise vaccination uptake via a variety of campaigns, especially relating to childhood vaccines such as MMR and our Core20PLUS5 populations.
- The Coventry and Warwickshire Health Protection Committee will effectively implement the updated Health Protection Strategy, ensuring that there is appropriate representation and involvement from all relevant stakeholders across the whole ICS.

Enabling the Best Start in Life for Children and Young People

We want to be a system that ensures children have the best possible start in life, where seamless, collaborative and evidence-based care is delivered to enable all children and young people to have the best start as a foundation for happy, healthy, safe, and productive lives, with effective and timely interventions in place when expected outcomes are not being met.

Greater focus and attention will be given to the children and young people agenda, ensuring all our young people receive the right support at the right time. This includes children and young people who may be more vulnerable or require additional support, including looked after children and children with special educational needs for example autism or learning disabilities, ensuring that they receive the additional care and support that they need to thrive and make a strong start in life.

What are we doing already?

We are seeing increasing population growth and diversity of needs amongst Coventry and Warwickshire's young children; services will need to expand and adapt to increasing numbers and complexity.

Warwickshire are establishing a Children and Young People Partnership (CYPP) sub-group of the Health and Wellbeing Board, the purpose of which is to provide strategic oversight to the CYP agenda, facilitate integration and collaboration across Warwickshire and take a holistic population health approach. Priorities and activities of the CYPP will be evidence-based and informed by the JSNA.

Coventry has a Children and Young People Partnership Board that reviews the Coventry Children and Young People Plan to deliver and provide the best support possible for children, young people and their families. There is also a multiagency Early Help Strategic Partnership focused on reaching children, young people and families when the need first emerges.

Some children and young people require additional support, care and protection either due to disability or specific vulnerabilities that mean they are at risk. This includes for example those experiencing homelessness or substance misuse, Looked After Children and children or young people on the edge of the youth justice system.

Coventry and Warwickshire are committed to supporting continued quality improvement to ensure that all children and young people are safe as well as healthy and that those with Special Educational Needs and Disabilities achieve the best possible outcomes through having every opportunity to take control of their lives, be as independent as possible and achieve their full potential. This requires strong partnership working across health, education and social care, with staff who take a holistic view of the child or young person that they work with.

The ICS is an opportunity to further align the great work already happening across Coventry and Warwickshire, led by the local authorities, through collaboration and a partnership approach. Ensuring the best start in life begins before conception and involves a wide range of partners and agencies across the system that contribute to children and young people's health and wellbeing. A

focus on perinatal services is particularly important from a prevention perspective, including for example interventions to reduce smoking in pregnancy. There are several key strategies and programmes of work across the system that set out evidence and objectives to progress with the children and young people agenda. These include:

- Coventry and Warwickshire's Child & Adolescent Mental Health Services (CAMHS) Transformation Plan
- Coventry and Warwickshire Joint Strategy for Autistic People (2021-2026)
- Warwickshire Children and Young People Strategy (2021-2030),
- Warwickshire Education Strategy (2018 to 2023)
- Warwickshire SEND & Inclusion Strategy
- Child Friendly Warwickshire
- Coventry Integrated Early Years Strategy (September 2021)
- Coventry Parenting Strategy 2018 – 2023
- Coventry Education Partnership & School Improvement Strategy
- Coventry Children and Young People Plan 2021/22
- Coventry Early Help Strategy (2020-2022)
- Coventry's Children's Services Strategic Plan and Journey to Excellence

Our local activity is informed by national policy, in particular The Early Years Healthy Development Review Report, and First 1000 Days of Life. We are working to implement the CHILDS framework for integration, applying a population health management approach to our health and care provision for children and young people. NHS England's Core20PLUS5 approach has recently been adapted to apply to children and young people, which will support the reduction of health inequalities for this age group.

What will change in our ways of working?

- There will be clear pathways in place across the system for communication and identification of need, with transformation of services to enable re-investment in sufficient capacity in the right place to respond to that need.
- We will ensure all-age pathways are in place across services to support the transition to adulthood and prevent unnecessary or ineffective transfer between services.
- We will adopt a strength-based approach to working with children and families across all services.
- We will invest in evidence-based quality support programmes, create school networks which collaborate to provide effective peer support systems and make a local commitment to workforce development, to improve school readiness and education outcomes.

What actions are we prioritising?

- We will establish a system-wide Children and Young People Board and develop a Children and Young People Health and Wellbeing Strategy.
- We will prioritise investment in children and young people's mental health and wellbeing services, with a specific focus on the current and future needs for 18–25-year-old people.
- We will establish a process to collect and share insight and intelligence efficiently and effectively about health inequalities and the needs of children and young people across the system. This will be used to inform service provision and preventative work.
- Resources will be pooled, through joined up planning and integrated working around children and their families, including across healthcare, children's services & education, pre-maternity and maternity care, peri-natal mental health, health visiting, Early Help, and special educational needs & disability.
- Services will be co-produced to ensure the voices of children, young people and their families are heard and are at the heart of decision making and prioritising.
- We will work with all partners to ensure that services for children and young people are poverty proofed.

Priority 2: Improving access to health and care services and increasing trust and confidence

What this means to me

I will find it easier to access the health and care services that I need wherever I live across Coventry and Warwickshire. Those services will feel more like one service, I will have more say over the services I receive and greater trust in their quality, effectiveness and safety.

Context

The NHS was founded to provide universal access to health care. We know that the pandemic had an impact on access and also on trust and confidence in services. We also know the two are related and both have a strong link to and impact on health inequalities.

This strategy has been informed by extensive engagement with people and patient and community groups across Coventry and Warwickshire. People told us that we need:

- Greater access and quality of access and fairness of treatment for all
- More access to health and care services in our communities
- Greater access to specialists
- More access to screening and diagnostic services locally
- Clearer information about how to access services and support for those that face challenges accessing them

One of the greatest strengths of our health and care services is their accessibility. We know that this is as important as ever and that different people and groups face different barriers and challenges accessing services. We also know that trust in key health and care services is variable across groups and communities and from service to service. We want to tackle this variability and raise levels of trust across the board.

Our mission over the next five years is to improve access to and trust in health and care services across Coventry and Warwickshire. When we say health and care services, we mean this in the

widest possible sense, including those such as housing and active living that impact wellbeing, and those provided by the community and voluntary sector.

We are facing greater demand for health and care services, have an ageing and growing population and like everywhere else across the NHS, a significant elective waiting list to work through. At the same time, we are facing continued financial pressures. We need to find more and better ways to work together, involving people and communities in this as well as partners such as the fire service, police and our many amazing voluntary and community groups.

There are four key areas which we need to focus on in order to improve access and trust informed by our engagement, they are:

- Personalised care
- Improving access to services especially primary care
- Meaningfully engaging people, patients and communities
- Making services more effective through collaboration and integration

Below we go into more detail on each area around what we want to achieve.

Enabling personalised care

Personalised care is all about giving people more choice and control over the way their care is planned and delivered based on “what matters to them” and their individual strengths, needs and preferences.

Our ambition is to achieve better experiences and health outcomes for people by embedding the six components of the universal personalised care model across our health and care services. We want this to be a hallmark of the care we provide and a shared ethos of all practitioners who are committed to shared decision making with people and patients

As we collaborate more as health and care service providers to align what we do, personalised care means:

- putting the care receiver, at the heart of this integration and the centre point of a whole-system approach – ensuring “what matters to you” is listened to and understood
- continuity of care and an all-age approach from maternity and childhood right through to end of life, encompassing both mental and physical health
- a new relationship between care receivers and care providers.

Personalised care has significant links across this strategy and, especially with health inequalities - by focusing on what matters to people, taking account of their circumstances, challenges and assets, and giving everyone the opportunity to lead a healthy life, no matter where they live or who they are. We want to promote and embed a personalised care approach across all of our workforce and reflect personalised care in our integrated care pathways and commissioned services across the Coventry and Warwickshire system. Our aim is to be clear about what this means for practitioners and providers and to empower individuals to be active and prepared participants in their own care.

What are we doing already?

Personalised care is a priority for the NHS nationally. It is one of the five key focus areas for change outlined in the NHS Long Term Plan. There is work underway already in the system, to develop a more consistent understanding of and set of practices around personalised care and a strategy for how this is implemented across Coventry and Warwickshire.

The C&W personalisation programme has produced a strategy for 22/24 setting out the programme's ambitions and approach for embedding personalised care across our system, supporting each of the Trusts, place partnerships, primary care and social care.

The programme has identified five principles of personalised care:

- It starts with the principle of "what matters to you" as opposed to "what's the matter with you?"
- It's about shared power and collaboration between people, families, and health professionals.
- It enables people to have choice and control over their lives.
- It moves people from being passive recipients of services to active citizens.
- It is about getting a life, not a service

We are working towards a universal service standard that builds in personalisation and is flexible enough to accommodate specific needs as well as more common ones. A key part of this will be how we better understand service access, patient experience and personal requirements.

What will change in our ways of working?

- Further integration to deliver enhanced personalisation, choice and flexibility for people accessing health and care services
- Joined up sharing of patient records and information across partners in the system
- Better experiences and health outcomes for people by an embedded universal personalised care (UPC) model across our system, place and neighbourhoods
- A reduction in health inequalities driven by greater access and trust in services and delivery of personalised care
- A population more empowered and supported to manage their health and wellbeing.

What actions are we prioritising?

- Develop and clearly communicate to all health and care practitioners what we mean by personalised care and a set of working practices to support its implementation and adoption
- Support each of our Trusts, place partnerships and primary care colleagues to identify opportunities to embed personalised care approaches
- Support our workforce through training to better understand and be equipped to deliver personalised care
- Support our people and patients to share "what matters to them" in their health care interactions
- Evaluate the impact for people/patients, staff and our system.

Improving access to services especially primary care

Through the engagement that we have undertaken to support the development of this strategy, we have heard a lot from local people about the importance of timely and simple access to joined-up health and care services when they need them. People have told us about the challenges and frustrations that they currently experience accessing a range of different services – in particular, the importance of access to general practice services

We have been honest about the challenges that we are facing as a system. Specifically, rising patient demand, financial pressures and increasing workforce shortages. While these impact on our ability to improve access to services, we remain positive about the opportunities to deliver new and innovative methods of delivering General Practice services through face-to-face, online and telephone appointments from an increasingly varied and professional workforce. In Coventry and Warwickshire, we are clear that the future of General Practice is to adapt and develop, to support the needs of our patients. We believe that the new structure of the NHS creates the opportunity to accelerate work already underway to deliver a much more integrated way of working, enabling partner organisations of the ICP to respond to the needs of local populations within available resources, to improve patient care, outcomes through access to services.

From our engagement with local people, we recognise that everyone wishes to access services in a different way, and we need to adapt to this choice. Many of these new routes into General Practice services were driven by our response to the Covid-19 pandemic. Local Providers of health and care services, including GP practices, rapidly adopted a range of new technologies and, as a result, digital access to services became much more widespread in our system. Whilst we recognise that accessing services through digital channels does not suit everyone, our local vision is to harness digital technology to enable local people to access information, support and care easily and confidently.

Key to our ability to provide the primary health care services that our patients need, will be the workforce. We have already seen significant increases in certain roles, such as pharmacists, physiotherapists, social prescribers and paramedics, who have had enormous value to patients as part of the wider multi-disciplinary team. Key over the coming months and years will be to increase these roles alongside a clear plan to support increased numbers of General Practitioners and the wider nursing team.

If we are successful, we expect to see increased patient satisfaction relating to shared decision making and access to services, including general practice services.

What are we doing already?

Every day in Coventry and Warwickshire tens of thousands of people access services through our 120 local GP practices and 19 Primary Care Networks ('PCNs').

While local GP practices are delivering more appointments than ever before and national GP Patient Survey results continue to demonstrate that they are performing better than the national average across a range of key areas, we also hear from some local people about the difficulties that they experience accessing their local GP practice. We are already using the data available to us, including data relating to GP appointment activity, to understand and tackle variation, and this will continue to be an area of focus for us over the coming years.

As we have set out, we believe that integrated working will be central to improving access. Dr Claire Fuller's recent landmark report, strongly reinforces the direction of travel that we have already set out on to transform our local out of hospital system in Coventry and Warwickshire through greater integration between primary, community and secondary care, social care and the Voluntary Community and Social Enterprise sector. Through our local out of hospital contracts, providers of services are working together to redesign care pathways in a more joined up way which supports our most vulnerable and complex patients to be able to remain safely at home through access to proactive care in the community.

Critical to our success in building a more integrated health and care system will be for us to continue to sustain and nurture the development of our 19 local PCNs, which bring together groups of GP practices to work together, alongside other NHS service providers, to develop services around the needs of local communities. These PCNs will continue to be the building blocks for wider out of hospital service integration.

Local PCNs have engaged with their local populations to develop new 'enhanced access' services which are extending access to general practice services during evenings and at weekends across Coventry and Warwickshire. They have also continued to expand the provision of social prescribing, supporting people to self-care and to access different sources of support in their communities, from creative activities such as art and singing to advice on housing and employment issues.

The delegation of responsibility for commissioning pharmacy, optometry and dental services from NHS England to the ICB in April 2023 offers an opportunity to strengthen the links across the different primary care contractor groups and to further drive integration across the primary care sector.

We have also been working on enhancing the community diagnostic capability and resources across the system to improve access to diagnosis services following the Sir Mike Richard's review of NHS diagnostic capacity. Capital investment in community diagnostics for Coventry and Warwickshire to support this work has been secured.

What will change in our ways of working?

In order to improve access to services and especially general practice services, we will work towards:

- Increased collaborative working across partner organisations of the ICP, driving increasingly integrated models of care/service delivery, including a transformed model of integrated out of hospital care
- Well supported PCNs operating with increasing maturity
- Resilient General Practices delivering accessible, personalised, high quality care
- Increased diagnostic capability and capacity across the workforce and improved access to community diagnostic services
- Improved and increased digital interoperability between primary and secondary care.

What actions are we prioritising?

- Delivering the funding guarantee for primary and community care, and continuing to maximise use of available primary care development funding
- Continuing to support PCN development and delivery of the national PCN services set out in Network Contract Directed Enhanced Service
- Development of the primary care collaborative – a 'guiding coalition' of leaders from within the general practice sector
- Developing our local Fuller Stocktake implementation programme centred on the action areas identified in the Fuller Stocktake Framework for Action
- Working with our primary care collaborative to refresh our Primary Care Strategy in the context of the integrated care strategy and the Fuller Stocktake. To ensure that our plans meet the needs of practices, PCNs and patients
- Working with our local Out of Hospital service providers to better integrate services across primary, community and secondary care, taking a more proactive and preventative approach to health care
- Establishment of three community diagnostic hubs across Coventry and Warwickshire.

Engaging and involving local people, stakeholders and communities

To involve individuals and communities in shaping the services they receive in a way that is both meaningful and representative, working together across the system to make services work for everyone

In order for our ICS to be effective we will have local people and communities at the heart of what we do and how we do it, enabling all those who want to be to be able to be part of identifying the issues and helping to find solutions in ways that work for them and meet the real priorities of local communities. Without the insights and diverse thinking of local people we will not be able to meaningfully tackle health inequalities and the challenges faced by health and care systems.

At the heart of how we work together as an ICS will be an ethos of learning from local people and, where needed, changing the way health and care partners work together, removing the barriers between services and joining up care around people and populations. This engagement will be an ongoing dialogue between the providers of care services and the recipients of those services to drive continuous improvement and involve people in care that is personalised to them.

This engagement and involvement of people is pivotal to improving access to and increasing trust and confidence in the health and care services we provide. Our engagement will always be meaningful, undertaken in culturally competent ways and we will do our best to coordinate engagement and involvement across the system understanding people's priorities and experiences in the context of their lives, not just their health conditions.

What are we doing already?

We have some really strong foundations to build on. The Covid pandemic and delivering the vaccination programme has shown us that when we work together to engage and involve communities with a common purpose, and without barriers between local authorities, NHS providers and commissioners and communities, we can better support and respond to the true priorities of local residents and extend our reach much wider and deeper into local communities, particularly those who may have been or felt excluded in the past.

Across Coventry and Warwickshire, all partner organisations, particularly the two Local Authorities, voluntary sector and Healthwatch, have developed many examples of excellent best practice in working with communities, understanding experiences and championing co-production, and we will build on and learn from their experiences in shaping the ICS approach.

We will adhere to the NHS England principles on how we communicate, engage and involve people and communities.

Our Communities Strategy outlines in detail the steps we will take to deliver these priorities. Throughout the strategy, there are case studies from across the partners of the ICS which demonstrate the breadth and depth of engagement activity that already takes place. We will build on these strong foundations, learning from each other to design how we work together as a system and better collaborate and engage with both individuals and communities.

Engagement is something which must be done *with* local communities not *to* them, and there are many great examples of communities being empowered to look after their own health across our

health and care system. The National Lottery Community Fund and The Kings Fund-supported Healthy Communities Together programme presents an enormous opportunity for us to learn about how best to mobilise communities and redefine the shape and scope of local systems to improve the outcomes for our population.

However, there remain barriers to delivering engagement, both as a system and at local, place and neighbourhood level, which this strategy aims to eradicate as we begin to work as one whole system – working in co-ordination at a system level where appropriate and empowering local communities to lead the way.

What will change in our ways of working?

- Greater levels of personalised care enabled by effective engagement with patients and communities
- An improved methodology and approach to how we engage patients and communities consistently across system partners based on a shared framework
- Developing and maintaining ongoing relationships with our diverse communities

What actions are we prioritising?

- Investing in the community and voluntary sector
- Delivery of our Communities Strategy
- Developing a framework for how we work together as partner organisations within the ICS
- Promoting cultural change across the ICS to put people at the heart of everything we do
- Building trust and relationships through always listening to and learning from our communities
- Equipping everyone with the tools they need and demonstrating the difference that community involvement makes, drawing on learning from across the system

Making services more effective and efficient through collaboration and integration

We want to make health and care services in Coventry and Warwickshire more efficient, effective and ensure they provide better value for everyone.

We will only be able to do this if we develop the ways in which we work together and the organisation of our health and care system so we have right vehicles through which to collaborate and integrate. These should enable us to develop new ways of working, speed up processes, share good practice and resource and align high standards. Clarity is required in the roles and responsibilities across each component and in the links between all parts of our new system.

A more joined-up commissioning and coordinated provision approach, closer to patient communities, will deliver a more efficient health care service. It will also provide a more coherent response to local population needs, supporting improved outcomes for all and reducing inequity in access and outcomes across Coventry and Warwickshire.

Key to achieving this will be the strategic leadership work of our ICP, the leadership and commissioning role of our ICB and the work of our care and provider collaboratives organising local delivery of services. This will enable us to transition to an infrastructure where decisions can be taken closer to communities, with better understanding of those communities and their needs, supporting collaboration between partners to address inequalities and improve outcomes in physical and mental health and wellbeing, and sustaining joined-up value for money services.

What are we doing already?

The Health and Care Act 2022, and other statutory guidance, sets out a clear intention of a more joined-up approach to health and care built on collaborative relations; using collective resources of the local system, NHS, local authorities, the voluntary sector, and others to improve the health of local areas.

Our operating model has a number of core components, which we have been establishing and developing, with specific roles:

- Integrated Care Partnership – as a partnership of key health and care leaders across Coventry and Warwickshire with specific responsibilities to develop this integrated care strategy for the whole population.
- Integrated Care Board - taking responsibility for ‘strategic commissioning’ and leading integration in the NHS to bring together all those involved in the planning and providing NHS services to take a collaborative approach.
- Three provider collaboratives with distinct roles and responsibilities to facilitate the sharing of expertise, knowledge and skills between providers and to draw on the strength of its members to redesign service delivery and develop new models of care:
    - Acute Provider Collaborative
        - Focus on at scale Acute pathway redesign
        - This collaborative will bring together all key stakeholders including Acute and other appropriate stakeholders e.g. Primary Care

  - Mental Health Provider Collaborative
    - This collaborative will bring together mental health partner providers to respond collectively to improve delivery of mental health services across the system
  - Primary Care Provider Collaborative
    - This collaborative will bring together all core Primary Care providers at a Coventry and Warwickshire level
    - This has commenced with General Practice at present but over time wider core Primary Care providers will also be incorporated.
    - The immediate focus of this collaborative will be to provide strategic direction and support to local PCN programmes
- Two geographical care collaboratives which will have an influencing responsibility on commissioning decisions made by the ICB so that services can be developed and tailored to meet local population needs. As care collaboratives develop and mature, this responsibility may increase to direct commissioning responsibility for an agreed scope of services:
    - One for Coventry, one for Warwickshire. The Care Collaboratives will map to our Local Authority (LA) boundaries recognising the opportunities for deeper integration and collaborative work on health inequalities and the wider determinants of health in the smaller, contained footprints of the local authorities
    - The Warwickshire care collaborative will be made of three equal Place partnerships.

What will change in our ways of working?

- We will have a whole-system approach that is reoriented to focus on keeping people healthy, well and in control of their lives
- We will build a sustainable system in which every resident of our area can expect to receive high-quality health and care services when they need them and barriers that currently prevent or hinder joined up care across services have been broken-down
- Everyone in the health and care system will work together to do the right thing for our population and the right thing for the system, where the health and care workforce feel valued and supported
- We will take collective decisions closer to the patient, based on a shared understanding of the local population and how people live their lives in a system that looks beyond health and care services to the wider determinants.

What actions are we prioritising?

- Getting the structures and governance of our system right, making them lean, effective and efficient
- Developing the strategic leadership capability of our ICB and ICP
- Developing the capability and capacity of our care collaboratives and local care partnerships as vehicles for driving collaboration and innovation
- Setting conditions to create greater collaboration, removing barriers to integrated care to allow local partnerships to thrive, and empowering staff and communities to deliver the ambitious service changes needed within the system
- Empowering the right groups of people with the expertise and evidence to make decisions on how to redesign and reorganise services
- Ensuring that there is agility and pace in decision making to enable transformation to occur at the rate that the system needs.

Priority 3: Tackling immediate system pressures and improving resilience

What this means to me

Everyone works together to make sure I receive appropriate and timely care when I need it, from skilled and valued staff.

Context

As we emerge from the global pandemic, the challenges that health and care services have faced over the last decade have only increased in severity. So, while we have clear ambitions for the future, we recognise that there are some immediate pressures facing our integrated care system that we need to address as a priority. A failure to do so will mean a constant cycle of immediate pressures and an inability to look beyond that and invest in the future.

We are seeing increasing demand for health and care services, complexity of need and challenges around the flow of patients through the system, all at a time of significant financial pressure. Many within our workforce are tired, having moved from the pandemic to recovery of services, and now face the additional stress of increased demand, increased vacancies and higher sickness absence.

Immediate system pressures include increasing demand for urgent and emergency care, a need to restore elective or planned care as quickly as possible, a requirement to manage the impact of winter, and mental health services impacted significantly by the COVID-19 pandemic. As an Integrated Care System, we also need to be able to demonstrate that partners can plan for, and respond to, a wide range of incidents and emergencies that could affect health or patient care.

We need to work together both to reduce immediate demand on services and to secure the system capacity required to meet the current and future health and care needs of our population – which include both physical and mental health care, and social care needs.

Traditional approaches aren't working, and increasingly we recognise a need to do something different as we embrace the opportunity of collaborative working through our integrated care system.

Reducing demand on services means enabling people with complex needs to live independently at home, which we describe in more detail below. Linking to priorities 1 and 2, we also need to minimise avoidable A&E attendances through improved service access and advice upstream – particularly for those in Core20 and priority groups who are overrepresented in urgent and emergency care.

Securing system capacity and building resilience involves:

- Ensuring effective system flow, by having the correct capacity, resource and processes in the system to ensure that we are able to most effectively and efficiently meet current and future service demands in a timely manner
- Working to support the resilience and sustainability of the social care independent, voluntary and community sector market, including support with recruitment, quality improvement and business continuity and making best use of resources through Fair Cost of Care
- Building workforce capacity by maintaining our focus on recruitment, development and support strategies to keep our people happy and safe at work
- Ensuring our limited resources are consumed to best effect through our approach to financial sustainability, productivity and efficiency.

There are two key areas which we need to focus on in order to improve resilience and tackle system pressures. These are:

- Supporting people at home
- Develop, grow and invest in our workforce, culture and clinical and professional leadership

Supporting People at Home

Supporting people to live at home as they develop or encounter health-related difficulties is a core ambition of health and social care. Achieving this requires resilient, responsive, accessible and adaptable health and care services that have personalised care principles at the heart of what they deliver and work in tandem with the individual, their friends and family carers to help people achieve positive outcomes.

The impact of not supporting people effectively at home is experienced both at an individual level and across our health and care system through increased demand on urgent and emergency care services and social care.

There is an important equality aspect to this priority as we know that some cohorts of our population seek support from health and care services earlier on, whereas others delay seeking help until at or close to crisis. This priority is therefore important to improve the experience and effectiveness of care and support within our system.

Through focussing on this priority area our aim is to provide support, across health and care and with wider partners, to enable people to be supported within their own home environment.

This will support the delivery of the ICS vision through:

- Supporting residents to lead an independent life
- Enabling people to remain in their communities for longer
- Improving sustainability of services through helping focus acute services on those who absolutely cannot be supported at home.

What are we doing already?

In Coventry, the Improving Lives programme presents the opportunity to significantly transform how older people are supported through organisations working together across community support, hospital processes and discharge/reablement. Although this programme is focussed on people aged 65 and over there will be benefits to other cohorts of the population

In Warwickshire, the Hospital Discharge Community Recovery Programme presents an opportunity to further develop pathway 1 (support at home) discharge to assess services in Warwickshire to enable all people in an acute hospital, who need further support, to access timely therapeutic intermediate care services on discharge.

Across both Coventry and Warwickshire, the learning from these programmes will be shared as the work progresses – this sharing and learning will enable the interventions with greatest impact to be used to accelerate progress across the whole system.

We are also working on ageing well and specific frailty programmes which have been making progress in our support for older people. We have a Proactive Care at Home workstream which is supporting individuals in their own homes and in care homes. These system wide programmes will

connect with the Coventry and Warwickshire specific programmes to make a step change in how people are supported.

We have recently implemented an Integrated Care Records system which is being rolled out to all organisations. This enables health and care records to be shared, which leads to better informed professionals, who will be better able to support people as a result.

What will change in our ways of working?

- An improved and more responsive coordination and delivery of health and care within an individual's own home when urgent and emergency care is required – this will help prevent people making unnecessary visits to hospitals
- Where ongoing support (health or care or both) is required to enable people to continue to live independently, this will be reliable, sustainable and responsive to change as people's requirements change
- Where people are required to visit hospital for treatment, this will be undertaken in a patient-centred and effective manner, with the focus on returning home as soon as possible
- Where people have had a change in their health as a result of deterioration or a specific episode in their life, they will be supported to recover and re-abled to maximise their individual outcomes

What actions are we prioritising?

- Development and implementation of an integrated model that focusses on support at home and stemming the 'flow' to hospital settings in Coventry and reabling people to regain independence they may have lost as a result of a health episode
- Further development of pathway 1 (support at home) discharge to assess services in Warwickshire to enable all people in an acute hospital, who need further support, to access timely therapeutic intermediate care services on discharge
- Taking the opportunities presented by social care reforms that can form a wider part of our ability as a system to support people to live independently, whether through housing, innovation, or use of technology
- Supporting informal family carers – our ambition to support more people to be independent at home will also require us to consider how we work with and support informal carers who are a critical and integral part of the care and support system

Develop, grow and invest in our workforce, culture and clinical and professional leadership

We have a total workforce of 47,800 in Coventry and Warwickshire. This includes 20,700 employed by NHS providers, 23,500 in adult social care, 3,200 in primary care and around 400 employed by our Integrated Care Board. Staff turnover is high, presenting real challenges in terms of workforce capacity and service delivery.

In order to deliver quality health and care services for our population, we need people with the right skills, the right values, and in the right places. We have an ICB priority to care for and develop our workforce, ensuring they continue to have the resilience and support to deliver the best care to our patients and communities, especially employees from black, Asian and minority ethnic communities who make up 30% of our NHS and social care workforce.

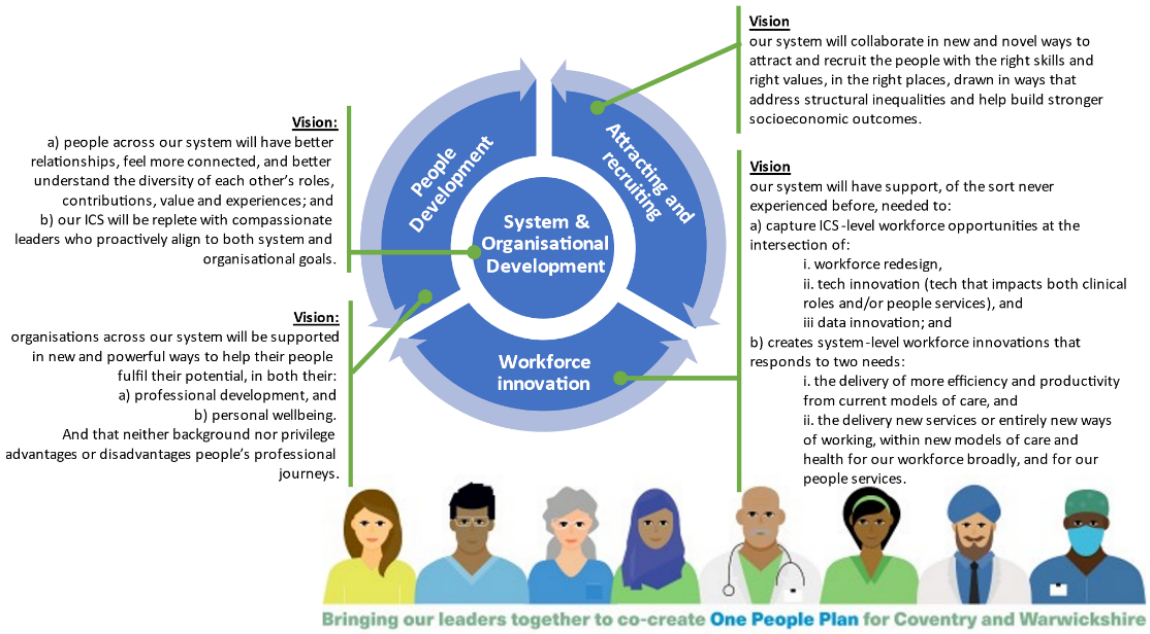
We have a diverse population and a diverse workforce, and to ensure we develop a sense of belonging and inclusion for all staff we must raise the profile of our diversity and inclusion work.

Clinical and Care Professional Leadership (CCPL) needs to be a core foundation of the system and how we act, engage, and make decisions in the future. The system needs buy in from clinical and care professionals to enable effective integrated working. Equally important is a population health mindset, and the expertise and leadership of our public health workforce and their input into decision making in the system will be key.

Our informal workforce is critical to our system too. There are an estimated 34,000 unpaid carers in Coventry and 62,000 in Warwickshire, and there is a strong volunteer sector which supports our services and offers wider community support.

What are we doing already?

Following an extensive programme of engagement, the Coventry and Warwickshire People Plan is now being updated. The NHS People Plan and ICS 10 people outcomes are key drivers for the development of this refreshed strategy.



Nationally there was acknowledgement at the inception of ICBs that clinical and care professional leadership (CCPL) will be critical to success[3] and our local CCPL Framework was developed in preparation. The framework sets out the work so far for a new way of doing multidisciplinary engagement and leadership through a clinical forum function and clinical executive group. The framework will be refreshed to ensure it meets the needs of staff, avoids duplication and builds on the work being done already in constituent organisations.

It is fundamental to have framework to guide us as we change our thinking, ways of working, and collaboration across the system. The part of the framework that will describe how we do this together is called our Philosophy of Care; this will bring staff voices together to aspire to work as one Coventry and Warwickshire team. Other elements focus on how we share learning, improve quality and safety, network, communicate and develop leadership.

What will change in our ways of working?

We want to see an ICS workforce that is aligned to and effectively enables the delivery of our system aims and priorities. This includes:

- People feeling looked after, supported and developed to enable new ways of working to improve services, and a culture of shared learning and collaboration
- An expansion of the substantive workforce, where required to meet service needs, focussing on the local population, increasing uptake of health and care careers and retaining colleagues for longer

[3] https://www.england.nhs.uk/wp-content/uploads/2021/06/B0664-ics-clinical-and-care-professional-leadership.pdf

- Frequent and open system-wide clinical interaction being embedded and supported by a strong clinical and care network in which all ICS members are included.

What actions are we prioritising?

The priorities in our People Plan are:

- **Attracting and recruiting** more staff and ensuring bias is removed from our processes, including launching our employability programme.
- **People development** and in particular the transformation of nurse education to ensure we can meet the requirement to expand the numbers of places and increase other routes into nursing. This priority also covers all other professions in particular AHP, medical, public health, social care and scientific roles. There is an important link with our widening participation priorities.
- **Leadership Capability Building**, through system wide approaches to development and talent management, giving increased opportunity to ICS members.
- **Inclusion and Diversity** – ensuring that our recruitment approach is equitable, diverse and inclusive and raising the profile of our diversity and inclusion work to ensure we attract, retain and improve the working experience of diverse groups
- **Health and Wellbeing** – continued focus on provision of support for our people to ensure they feel supported, valued and able to provide great services to residents.
- **Planning and efficiency –** ensuring we clearly scope and plan workforce needs for the future working, particularly with key system transformation programmes.

We will work with Anchor Alliance partners to improve employability for the Coventry and Warwickshire population and improve access to training, education and employment for our most vulnerable residents, working with local university partners to develop education pathways for our future workforce.

We also plan to undertake wide engagement to secure clinical and professional buy-in for integrated working and development of strong governance and networks to connect clinical and care professional leaders and ensure their voice and influence within the system.

Strategic Enablers

A number of key enablers have been identified to facilitate delivery of our vision and the priorities within our integrated care strategy. These are all areas where we think we can have a real impact on health and wellbeing outcomes by working together on a system-wide basis.

Finance

How we manage and use our resource collectively as an integrated care system is key to the achievement of our aims and ambitions. If we are to progress our priorities around prioritising prevention, improving access and tackling immediate system pressures, we will need to make difficult decisions about shifting resource. If we are serious about tackling health inequalities, where and how we spend resource will need to change.

We will be working with system partners to develop an integrated Finance strategy which will provide the outline framework for more detailed policies and processes to deliver and embed:

- A culture of financial stewardship, including our approach to investment and disinvestment decisions.
- A continuous improvement approach to financial sustainability, incorporating the Healthcare Financial Management Association sustainability checklist and framework, core financial controls and a programme of value-based reviews.
- A robust approach to integrated financial planning and reporting, linked to workforce, demand and capacity, and quality.
- An innovative approach to financial transformation: supporting productivity maximisation, providing professional advice services for business case appraisal and benefits realisation, developing forecasting and modelling capacity and streamlining back-office processes.
- System financial expertise: developing the system finance workforce through education and training, peer to peer reviews and cross system finance staff development supported by participation with Future Focused Finance and One NHS Finance programmes.

Where appropriate and following suitable due diligence, decision-making responsibility may be delegated to a more local level, but with the same approach to delivering and demonstrating sustainability and value.

We will continue to develop integrated working arrangements with system partners, where this allows better cross boundary working such as integrated budgets – and the delegation of functions into places, supporting the principle of subsidiarity and facilitating integration. For example, using Section 75 arrangements to manage or support pooled budgets across the NHS and local authorities.

Our finance strategy will have good regard to the four core aims of the ICS:

- improving outcomes in population health and health care; our value approach to investment and disinvestment will explicitly link resources to expected outcomes.
- tackling inequalities in outcomes, experience and access; we will work to develop a place-based allocation methodology which reflects the needs of the populations served.
- enhancing productivity and value for money; our approach to sustainability and efficiency will seek to ensure our limited resources are consumed to best effect.
- helping the NHS to support broader social and economic development; we will look to work across traditional health boundaries, developing joint working arrangements with local authority partners and VSCE organisations to support our communities leading health lives.

Digital, Data and Technology and Population Health Management capability

Integrated digital, data and technology is a key enabler to proactive, seamless and person-centric care, and to the collective stewardship of public funding for health and care to meet the needs of the population. It is crucial to facilitating evidence-led decision-making in the commissioning, planning, design and delivery of care, with insights from data used to improve quality, efficiency, population health outcomes and to tackle health inequalities.

Our Digital Transformation Strategy sets out an ambitious plan for digital integration aligned to the national 'What Good Looks Like' framework. We also have a Population Health Management (PHM) Roadmap, which sets out how we plan to spread, scale and sustain core PHM capabilities – around infrastructure, intelligence, interventions and incentives - across all levels of our system.

Digital Transformation is using digital, data and technology to reimagine health and care delivery improve our population's wellness. To achieve this, we need to ensure this thinking is central to our decision making, transformation, resourcing and partnerships, and promote the continued development of our leadership, organisational cultures, people and processes to embrace the benefits of the digital age.

Key areas of integration activity include:

- **Improving care**: we are using new technology and innovative digital solutions to enhance services for patients and citizens through consistent digital front door and virtual health and care capabilities. This will facilitate more joined up and personalised care, and improve access and self-support. The expansion of digitally transformed care includes measures to ensure standards for safe care are maintained.
- **Digital literacy**: work to ensure that health and care services suit all literacy and digital inclusion needs, whilst working collaboratively across integrated care partners to build digital literacy that enables access to health and care services digitally where appropriate.

- **Integrated records**: we are building on our electronic patient care records initiatives, shared care record and platforms and services that support research and innovation across health and care providers in Coventry and Warwickshire.
- **Population Health Management infrastructure**: implementation of a local PHM digital platform which will provide a near real-time linked dataset across all Coventry and Warwickshire ICS data systems and analytical tooling, enabling more targeted and proactive care to meet population health needs and address unwarranted variations in outcomes and experience.
- **Supporting our people**: we are working to ensure our workforce is digitally literate and equipped to work optimally with digital workforce tools.
- **Digital and data infrastructure**: working together to create digital, data and infrastructure operating environments that are reliable, modern, secure, sustainable and resilient. This includes ensuring robust digital assurance including information governance, cyber and clinical safety.

Public estates space and facilities

We will work together as partners to ensure our collective estate is managed most effectively to support and enable more joined-up easier to access care, support the aims and priorities of the system and ensure better safer care for patients.

The ICS has developed an Estates Strategy which sets out how we will work together to do this. It presents the collective work undertaken at provider, commissioner, and local authority place level both individually and in partnership with one another to improve the quality and outcomes derived from the public estate. The strategy is iterative to reflect subsequent funding requirements and priorities of an ever-evolving estate which looks to shift care closer to where it is needed and most suitably delivered aligning to many of our ICS priorities. Our Estates Strategy sits within the wider context of national priorities including; Carter Report, NHS Long Term Plan, Net-Zero NHS, Place-Based Systems of Care, One Public Estate, and the Naylor Review.

Our key areas of focus to deliver the priorities of the Estates Strategy are:

Capital Planning and Prioritisation - we will continue to review, update, and evolve our process to prioritise our major capital schemes. Develop a process for the management of Business-as-Usual Schemes. Review any alternative funding opportunities available to the system. Monitor the outputs of the Section 106 & CIL. Look to interface with the Digital Workstream to explore how we can advance our digital capabilities

Greener Delivery aligned to the ICS Green Plan - we will focus on areas such as creating a multi-purpose, biodiverse estate with greenspaces utilized for our local population, staff, and visitors. Transitioning to low/zero carbon solutions for the provision of energy services. Improve local air quality and reduce carbon emissions from travelling sustainably. Create partnership working to improve efficiency and eliminate carbon.

Disposals and Void management - develop, monitor, and keep under review our Strategic Disposals Tracker. Review our system void space to identify potential projects that could support better utilisation of space. Work in conjunction with the Capital workstream to monitor schemes, project, and programmes where opportunity exists to release surplus land. Develop greater partnership and collaborative working with our local authorities to explore opportunities to identify projects to reduce void. To explore alternative ways of delivering our clinical services, including the use of digitisation. Explore opportunities to develop agile working across our system

Effective Asset management - work in conjunction with the Disposal and Void workstream to drive the reduction of Void Space. Develop a systemwide approach to ERIC data recording, analysis, metrification, and reporting. Commit to developing our SHAPE atlas in order to create a single repository for our estates data. Generate a better understanding of backlog maintenance liabilities and continuous management and reduction.

Our key aims are:

- Working towards all Trusts operating with a maximum of 35% non-clinical space and 2.5% unoccupied space with alignment to Trust Premises Assurance Models.
- The NHS Carbon Footprint for the emissions under direct control, net zero by 2040.
- The NHS Carbon Footprint 'Plus' for the emissions under influence, net zero by 2045.

Performance and Assurance

Performance has been impacted significantly over the past two years following the global pandemic, including needing to wait longer to access services and the change in complexity resulting from this. Focusing on performance as a whole across all organisations within the System will be a key enabler for the effective delivery of our Integrated Care System priorities.

There remains the need to respond to the requirements of the NHS Long Term Plan and the annual NHS Operational Plan and we need to understand the current position with regards to how organisations in our System are performing, the areas of challenge, actions in place to address these and to be assured that health outcomes are improving.

The National System Oversight Framework aims to achieve and promote delivery of the metrics under the 5 domains, including:

- Quality of care, access and outcomes
- Preventing ill health and reducing inequalities
- Leadership and capability
- Finance and use of resources
- People

The Framework encompasses the aims of the Operational Plan within these domains. There is now a national dashboard, that shows current performance and ranking information to enable

benchmarking. A local dashboard is being developed to support this and to provide supplementary background information. This will help to drive the programmes of work that are needed to improve performance within agreed timescales and through co-designed action plans.

Meeting the needs of the population and population health is key to performance management and links closely with the Joint Strategic Needs Assessment and also the Health Inequalities Strategy.

Key areas of activity include:

- Develop a **single oversight framework** for the system, that:
    - includes high quality and up-to-date information from all organisations, to improve healthcare and population health and to tackle inequalities in outcomes, experience and access. Integrated performance management and monitoring is essential to enable transformation of services and evidence-based interventions that will improve outcomes across all focus areas.
    - includes broader health metrics, with a focus on outcome measures to transform and improve population health.
    - is open and transparent to enable joint ownership of issues, mutual accountability and collaborative working.
- Ensure a **robust monitoring and tracking system** for performance, that:
    - enables **early detection** of challenged areas, monitoring of progress and understanding of impact to reduce variation and inequalities across the System.
    - includes **granular information** to ensure that inequalities are able to be highlighted down to small geographic locations across the System, to support in service provision and targeting interventions.
- Embed a **mature assurance process** routed in principles of mutual accountability and equal partnership to collaboratively tackle challenged areas and achieve the Integrated Care Aims.
- Increase partnership working, including on **effective performance improvement strategies**, with routes to share good practice within the System.

Quality

Our system needs to be quality focused with a systemic oversight of quality for the population we serve, using a whole pathway approach to future proof prevention, selfcare, direct care and bedded care.

Key areas of activity include:

- Establishing a **Quality Governance Framework** which operates across the whole system, as the quality outcome of our provision is essential to understand and provide a base to improve from. This will be in line with the National Quality Boards (NQB) guidance and escalation levels.

- Embedding the new **Patient Safety Strategy** to ensure the move from serious incident management to The Patient Safety Incident Response Framework (PSIRF) and establish safe systems, structures and an escalation framework within which to operate across the whole System. The use of the DATIX incident reporting system where possible will be important to enhance system learning.
- Further strengthening the established **safeguarding partnerships**, by focussing on system wide working on safer communities and harder to reach communities.
- **Triangulating quality improvement** by establishing an approach which focuses on prevention, health inequalities and a reduction in unwarranted variation. This includes developing an approach that triangulates the wider determinants of health with quality, safety and effectiveness of services.
- Delivering the System **Quality Strategy**, ensuring involvement from broader health partners and developing empowered communities.
- Establishing a **System Quality Group** to work collaboratively across the system on continuous improvement, supporting system learning and development.

Transformation and Innovation

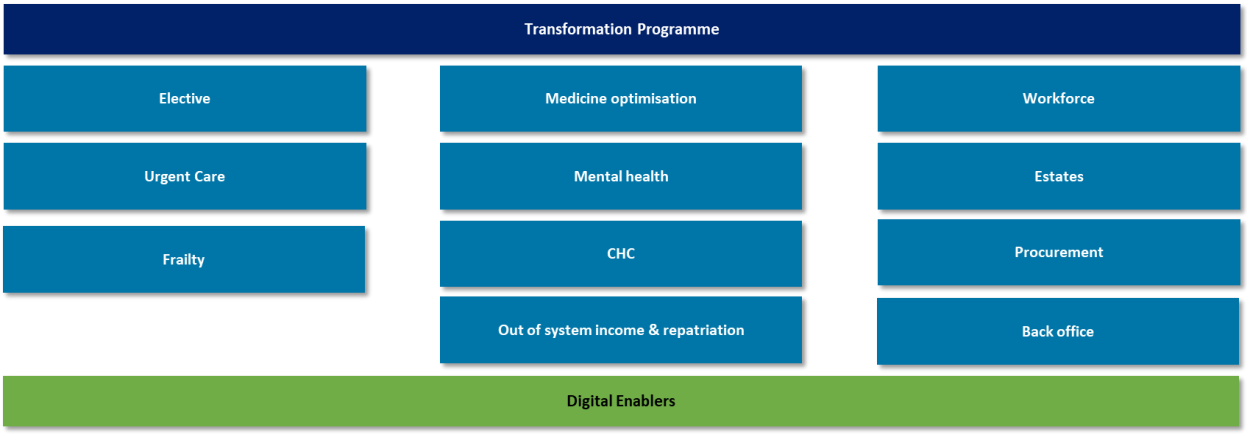
Following the Covid 19 pandemic, the recovery and sustainability of services is critical for our population. The innovations prompted by COVID-19 show the potential for us to revolutionise and transform service delivery and there are huge opportunities for collaboration, enhanced integration and transformation in our system.

Our ongoing approach to transformation will play a key role in determining the extent to which we are able to meet our ICS aims and deliver on our priorities. Transformation will also be a significant determinant of how we innovate to support service recovery and help shift care to better and more efficient, sustainable models.

We have developed a Transformation Programme which will drive system-wide innovation to support clinical, operational, performance, and financial recovery. This Transformation Programme is part of the ICS' six-point Financial Strategy and identifies a number of clinical and enabler work-streams that will:

- transform health and care services for the population of Coventry and Warwickshire to improve health outcomes and meet the needs of our population
- evidence how the ICS will deliver its health and care aims and priorities
- drive high quality and safe service delivery
- drive improved productivity and ensure the delivery of services that are efficient, affordable, convenient and offer high value

Our key focus areas of activity are:



Whilst our system Transformation Programme will deliver the changes that we need to improve patient care in the long-term and develop new service models that better meet the future needs of our patients and communities, we also need to keep driving localised continuous improvement on a daily basis to ensure our patients receive the right care, in the right place at the right time. To achieve this, staff engagement and clinical and care leadership are key components to our transformation approach as are the continuous improvement methodologies adopted across the system.

Our approach to innovation embraces research and the use of practice-based evidence, in assessing and identifying need and improving our understanding of how such need can be effectively met. Similarly, the adoption and spread of proven innovation, working closely with research, innovation and academic partners, supports us to drive transformation and best practice at scale and pace.

Impact

Our strategy sets out bold ambitions for our integrated care system and the difference we can make by working together and leveraging the benefits of the new legislative framework for health and care. We expect it to underpin everything we do as an integrated care system and to drive change in:

- how, as partners, we relate to each other and to our communities
- the way we use our resources
- the design and delivery of our services
- how we plan and make decisions.

Ultimately, we will see the impact of our strategy in improved population health outcomes, reduced health inequalities across Coventry and Warwickshire, and improved quality of health and care services for our population over the next five years and beyond.

If we are successful, people will:

- be supported to live a healthy, happy and fulfilled life, equipped with the knowledge and resources to prevent ill health and maintain their independence at home
- find it easier to access the health and care services they need wherever they live and will have more say over the services they receive and greater trust in their quality, effectiveness and safety; and
- receive appropriate and timely care when they need it, from skilled and valued staff.

This strategy is informed by existing strategies and will inform future strategies and delivery plans across and within Coventry and Warwickshire health and care system; including the ICB integrated care five-year plan which must be in place before 31 March 2023. The plan will provide the operational detail about how the strategy's vision will be realised at an ICB level. We expect to see a clear delivery plan for achievement of the outcomes we have identified for each of our priorities.

For many of the areas of focus and enablers detailed in this strategy, there are existing or emerging strategies and plans which have their own governance mechanisms for delivery and monitoring. We will not create burdensome reporting mechanisms on top of these. However, we do plan to develop a core set of high-level metrics for each of our priorities so that progress against intended outcomes can be properly monitored, with oversight through our Integrated Care Partnership and regular reporting to our Health and Wellbeing Boards.

As we monitor our impact and hold ourselves to account for delivery of this strategy, we will also draw on stories and lived experiences from the people we serve, to understand where we are making a difference and where there is more to be done.

Coventry and Warwickshire Integrated Care Partnership

Coventry and Warwickshire Integrated Care Strategy

Appendix 1: Contributors

Content leads and contributors

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Coventry and Warwickshire
Integrated Care System

Local priorities for Integrated Care

Interim Public and Community Engagement Report 2022

Coventry and Warwickshire Integrated Care Partnership (ICP) is currently developing the Integrated Care Strategy to set out how the assessed needs (from the Joint Strategic Needs Assessments already developed by local authorities) can be met. It will outline the direction of the system, setting out how decision makers in the NHS and local authorities, working with providers and other partners including the voluntary sector, will deliver more joined-up, preventative, and person-centered care for their whole population, across the course of their life.

As a system we needed to make sure that the development of the Integrated Care Strategy and the Integrated Care 5-year Plan is done in an aligned and connected way, with local communities, stakeholders and all other interested groups and individuals in the strategy communicated with, engaged and involved throughout.

From 20 August until 30th November 2022 a group assembled by the ICP to lead on the development of the strategy undertook engagement work with local communities, the ICS workforce, stakeholders and the voluntary and community sector to fill in those gaps identified in the desktop research and hear more about local priorities for health and care. This document provides a summary of this work, the themes emerging from the engagement and recommended actions for the development of the strategy as well as for the upcoming Integrated Care Five Year Forward Plan.

NOTE: This engagement report has been prepared to inform and support the first draft of the Integrated Care Strategy for submission and provides insight into the common, cross-cutting themes which we heard throughout our engagement.

Engagement continued until the 30th November and there remains significant work to do to further interrogate the outputs of this work to fully represent the views which we heard over the course of the engagement, particularly to understand the priorities and experiences of individual communities and to identify the inequalities in experiences and needs.

This information will inform the Integrated Care Five Year Forward Plan development, ensuring it is representative and addresses the needs of all local communities, our workforce and other stakeholders.

Methodology for engagement

This engagement needed to be completed with the support of all ICS partner organisations, as well as those wider partners in the voluntary and community sector and our local communities, in order to ensure our reach was wider than those who the NHS has historically engaged.

An engagement task and finish group was established, including representatives from Local Authorities, NHS organisations, the voluntary and community sector, faith groups and others, to first establish what we already know from previous engagement to feed into the development of the strategy. The group then supported further engagement across the area to ensure that the feedback gathered accurately represents the priorities of residents, particularly those with a protected characteristic.

Identification of audience

As a health and care strategy for the whole of Coventry and Warwickshire, we were aware that the strategy has a potential impact on every person within this area.

The overall intention of our approach is that we only ask our public and stakeholders to become involved in the development of the Integrated Care Strategy and Integrated Care 5-year Plan when it is meaningful, and we strive only to ask for input when we know that we have a gap in our knowledge.

A significant piece of system wide mapping and analysis had already taken place to determine the insight already available within the system in order to avoid duplication and asking people to repeat information they have already shared within the ICS. All ICS partners contributed to this desktop research exercise to ensure a broad reach throughout the population.

Following this analysis work we identified that we already had a wide range of insight into people's priorities around health and care, as well as those issues which may influence their health and wellbeing, the wider determinants of health. Considerable work has been undertaken via the local authorities to engage with their local populations and understand their priorities, such as through the development of the One Coventry Plan and the Community Powered work in Warwickshire as well as the work of the Directors of Public Health, and those learnings were key to the writers of the strategy, particularly in addressing areas of prevention and the wider determinants of health.

The Engagement Task and Finish Group identified that the gap in our knowledge was around the integration of services and priorities for health and care.

As we already had significant information about local people's priorities we focused the majority of our engagement on the following audiences

- Regular users of health and care services
- Carers
- Those with a characteristic which may affect how they perceive and receive health services including

  - Older people
  - Faith groups
  - Those of different genders or sexual orientation
  - Children and young people
  - Users of antenatal and maternity services
  - Local Black, Asian and Minority Ethnic communities
  - Those with a long-term condition / cancer service users
  - Refugees and asylum seekers
- Core 20 plus 5 groups
- Workforce across the ICS
- Voluntary and Community sector workers

However, we wanted to ensure that everyone who wanted to have a say had the opportunity to do so. To support this we promoted our online survey to a much wider audience, supported by the engagement task and finish group. These audiences included

- Housing Association residents
- Patient Participation Groups
- Wider community groups
- Local residents via local authority contact routes, posters and flyers

Targeting methodology

The engagement took two forms

Qualitative – Targeted focus groups and one to one conversations

An engagement calendar was developed to enable us to talk directly to residents of Coventry and Warwickshire and to hear about their priorities for health and care and what integration means to them. These opportunities targeted both those groups who are within the 'Core 20 plus 5' groups and those who are seldom heard or who may not be able to access online services to ensure their voices were heard.

Our primary route for qualitative engagement was through attending group sessions, both on and offline, to give a presentation on the background to the development of the strategy and then run a discussion session where people were able to share their thoughts on integration and their priorities for health care.

The content of our engagement activity was adapted at each session to meet the needs of individual groups, for instance; people with a sight impairment or who had difficulty with their hearing meant adjusting the session, giving extra time to feedback and speaking to individuals on a one-to-one basis.

There were some groups who requested to have the entire session interpreted in their language as English was difficult for them to understand. Volunteers and Co-ordinators who run local support

groups were key in liaising with the engagement team by making sure that we were prepared in advance to meet the needs of community groups.

Representatives from the ICB engagement team also attended a range of community events to have one on one qualitative discussions around their priorities and views on integration.

Quantitative – Survey on Integration and Priorities

We launched an online survey which was being promoted widely through ICS and ICP networks via email, newsletter articles and posters. This survey remained open for a month to enable people to contribute.

The survey incorporated the following questions

- What is the one thing that matters most to you about health and care services?
- What (if anything) stops you from accessing the health and care services you need?
- What is one thing you would change about how organisations provide health and care services for you?
- What do you think is the most important thing for health and care organisations to work together on now as a top priority?
- What other things do you think should be prioritised?
- If all health and care services worked more closely together would it improve the care you receive?
- If all health and care services worked more closely together would it improve the way you can do your job? (Note – this question was for those who work in health and care or with caring responsibilities)
- Is there anything else you'd like to tell us?

We recognised that not everyone is able to access an online survey, so paper copies of the survey were also produced and circulated through community representatives as well as by the engagement team at health events.

Overview of engagement results

Breakdown of audiences reached

Format	Involvement uptake
Online survey	244 people completed the online survey
Face to face	26 engagement sessions took place in various community settings 686 individuals participated in the sessions
Paper surveys	72 paper copies of the survey were completed
Virtual sessions	8 virtual sessions online
One to one	35 individual conversations
Translated sessions	4 individual group sessions translated

Detail of quantitative and qualitative research

Qualitative research

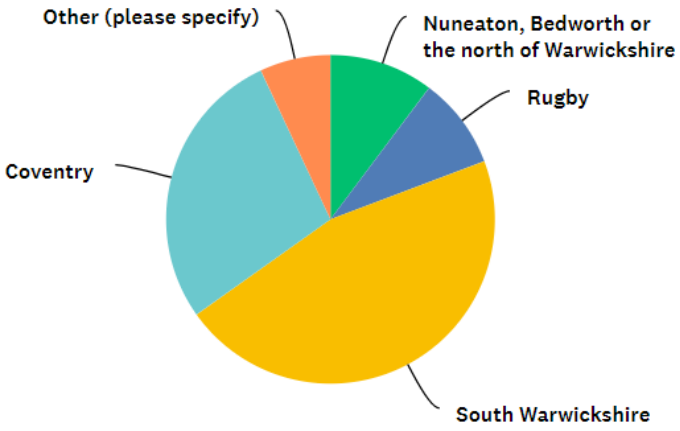
The response we have received from local communities and support groups was encouraging and the willingness by community leads to engage was extremely positive. We engaged with sectors of society who are vulnerable, under-represented and seldomly heard across the NHS system

Groups and communities involved in engagement		
South Asian community groups	Learning disability groups	Men's health support groups
Black and African Caribbean groups	Cancer support groups	Care Homes staff
Ante-natal support group	Charities	NHS and social care staff
Refugee, migrant and asylum seeker groups	Elderly support groups	Roma and gypsy traveller group
Mental health support groups	Housing support groups	LGBTQi+ support groups

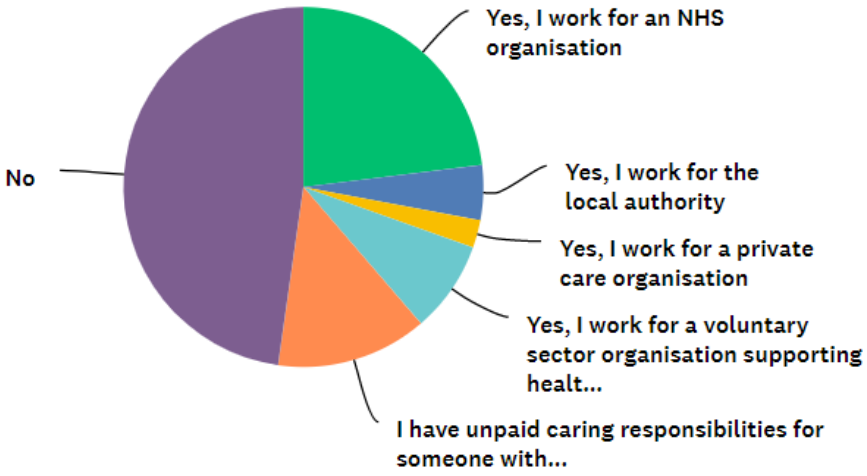
A full calendar of events and list of groups can be found in Appendix A – Engagement calendar

Breakdown of respondents online:

The majority of respondents to our online survey came from South Warwickshire.



The majority of respondents to our online survey were local residents but not employed by the health and care service (Shown here through the no response following the question “Do you work in health and care”)



Online survey equalities responses

The diversity of our survey responses does not reflect the diversity of the population of Coventry and Warwickshire. We have mitigated against this in our face to face work, ensuring that we gathered the views of a diverse range of local communities.

What is your sex?	Is the gender you identify with the same as your sex registered at birth?	What age group do you belong to?	What is your sexual orientation	Do you have caring responsibilities for someone with a physical or mental health care need?
184 - Female	231 – Yes	(18-24) – 5 people	< 5 - Bisexual (both sexes)	66 – Yes
49 - Male	< 5 – No	(25-34) – 18 people	200 - Heterosexual (other sex)	163 – No
5 - Prefer not to say	5 – prefer not to say	(35-44) – 34 people	< 5 - Lesbian woman	8 – Prefer not to say
		(45-54) – 50 people	< 5 - Gay man	
		(55-64) – 47 people	25 - Prefer not to say	
		(65-74) – 52 people		
		(75+) - 29 people		
		< 5 - people prefer not to say		

What is your ethnic background?	Do you consider yourself to have a disability?	Do you consider yourself to have any religion?
122 – White	192 – No	102 - Christianity
86 - Welsh/English/Scottish/Northern Irish/British	40 – Yes	< 5 - Hinduism
8 – Asian, Asian British	6 – Prefer not to say	< 5 - Sikhism
< 5 – Asian and White		< 5 - Islam
< 5 – Mixed		< 5 - Judaism
< 5 – Indian		< 5 - Buddhism
< 5 – Black, Black British		5 - Atheism
< 5 – Chinese		94 - No religion
		24 – Prefer not to say
		5 - Other

Key themes

Throughout our engagement we heard a number of key themes emerge as to what people's priorities were. These are cross-cutting themes which remained consistent regardless of the social-economic, age or other characteristics of the group in discussion.

The themes were

- Access to services
- Digital inclusion
- Trust in services

These themes, which are explored in more detail below, helped shape the overarching strategic structure and focus of the strategy.

Access to services

Overwhelmingly, across all groups, access to primary care services were raised as people's biggest priority for health and care. The GP is seen as the gateway to all other health services, and there was a significant level of concern and distress that these services were not perceived to be accessible, with many noting that this seemed to be a change for the worse since COVID. Although dentistry does not at this stage fall under the remit of the ICB, there was significant concern raised about access to dental services as well.

The focus of feedback was very strongly based around the access to primary care services, with many people reflecting that once they had managed to secure an appointment they were happy with the care they received.

The issues raised with access raised can be broken down into specific areas

- Booking an appointment with a GP practice
- Receptionists as barriers to access
- Face to face appointments
- Ordering prescriptions
- Access to dentistry

GP Services are the services which the majority of people access most often, so it is natural that it is what comes up most in discussion with local communities as the vast majority of people who are broadly healthy do not interact with wider service. However, this does not mean that access is not proving an issue in other areas and is important to reflect the wider picture. Respondents shared many other experiences of struggle to access urgent care services, which are summarised below.

Booking an appointment at a GP practice

Many respondents raised issues with getting through to their GP practice on the telephone to book an appointment. Many reported that the only way to get an appointment at their practice was to call at 8AM and get in an, often long, queue and when they did manage to get through all the appointments for the day were gone.

"GP appointments not available and patients asked to ring following day after 8am. This carries on for days."

"It's important for us from an LGBTQi community that we build trust with one clinician, it's a challenge to even get an appointment when calling the surgery at 8am - there are serious issues in accessing primary care services."

"Trying to get through when you need a GP appointment. e.g. Phoning at 8.30 a.m. and sitting in a queue for 40 minutes with no guarantee of getting an appointment."

'GP Appointments very difficult – problems with language, access to GP services remotely does not work, GP appointments take a long time and the GP call back do not always work – window given is too long and people have to get back to work and for genuine reasons cannot answer the calls with the GP rings.'

'We have to wait for a long time to get through to the Drs - people's phone bills are going up as a result of this long wait!'

Getting through on the telephone - not being number 30 in the queue without speaking to a receptionist. Sometimes I have to wait up to an hour on the phone.'

"Make it easier to contact GP practices/get appointments"

'Accessibility to doctors, we need more appointments either face to face or by phone.'

Receptionists

People also raised issues with dealing with receptionists at their local practice. Many people reflected that they feel that the receptionist is a gatekeeper to GP services and makes the decisions on whether they feel the patient needs an appointment or not. This raised concerns for people about privacy, as well as frustration that the receptionist was able to block them from what they considered to be essential appointments.

‘I get very distressed and anxious when having to call the Drs surgery, I don't like to explain my personal health problems to the receptionist.’

‘Receptionists in GP surgeries are the biggest challenge.’

‘To be able to at least speak to someone if you have to ring for appointments that can offer you effective advice, a lot of the time you have to speak to receptionists who may not have that experience to offer

‘We need a more confidential service at the GP reception desk!’

“We should have medically trained receptionists - this could ease pressure on doctors and nurses.”

Access to face to face GP appointments

Seeing the GP in person is another area where people perceive access has become much more challenging. The reasons behind this varied, but the most common reasons given by people were a lack of trust in digital services, concern they would not get the same level of treatment over the phone or online.

Lack of face-to-face appts and GP services being too quick to assess over the phone which is leaving lives at risk.’

‘We need face-to-face appointments - the Dr tells you to take a picture of your skin condition - how can this to be a true reflection of my condition as my skin colour is black and you can't see a rash on black skin in a photo.’

As an elderly person you want to see someone face to face rather than talking about your health condition over the phone

‘Accessibility to doctors, we need more appointments either face to face or by phone.’

“Face to face means I can get the vibe if they are racist or not – can’t put my finger on it but when you see them [face to face], if you know, you know. How can I trust him if I can’t see him”

Prescription ordering

In Coventry and Warwickshire, many GPs use the "Prescription Ordering Direct" or POD service to facilitate ordering of prescriptions, as part of an initiative to reduce waste and support people to only order what they need. This service was a theme predominantly with older age groups who were often on multiple medications and struggled to use the POD service effectively, reporting long waits on the phone, difficultly with using the callback options on the web or ordering online. This service was not mentioned by any respondents on the online survey, which suggests that those more comfortable with online are better able to navigate the service online and avoid the call center.

'Sometimes we have to wait for over an hour to get through to the POD service to order medications!'

'Is it acceptable to call the POD service 52 times before you get through to a call handler to order one repeat prescription?'

'The POD service is not working for patients, long delays and phone lines are busy all the time.'

The email prescription service only works for people who can get online.

Access to dentistry

Although dental services are not yet a part of the ICB, they are primary care services which do have significant impact of people's wider health and wellbeing and people reported significant issues in access. As we continue our journey to closer integration and are seen as the responsible organization for dentists we expect that the volume of this sort of feedback will increase.

The old dental care system worked better!'

'How will Dentists operate under the new ICB organisation (they will need to work together to fulfil their contracts).'

Access to dentists is another problem for local people.

women in refuge [are] unable to access dentists

We need to have more dentists, GPs, nurses, ambulance and hospital staff so that patients are seen quicker.'

Access to urgent care services

Although GP services received the most commentary about the access issues which people are experiencing, there was significant concern relating to the availability of those services needed when you have an urgent or emergency care need. People are concerned about the waiting times and the availability of urgent care services close to where they live and shared many personal experiences of long wait times.

> Very long waits for ambulances and in A&E departments – sometimes more than 12-15 hours.'
>
> Ambulance waiting times are appalling!
>
> 'Ambulance waiting times are too long and there is staff shortages in the NHS.'

> 'We have to wait for hours at the walk-in centre but at least you can see a doctor.'
>
> 'I waited 6 hours to see a Dr at the [walk-in] centre.'
>
> 'The walk-in centre is helpful but the waiting time is too long.'

> 'Long delays at A&E – 10-12 hours.'
>
> 'Since the A&E service was taken away in Rugby - people are struggling with their health and have to travel out of area.'
>
> 'Admission times at A&E are extremely long waiting hours, I've seen patients vomiting in their waiting chairs.'

Digital Inclusion

This theme was one which was raised, understandably, more within our face-to-face meetings than in our online survey, however within the context of the face-to-face discussions it was one that came up repeatedly and for a variety of different reasons. The move of services from face-to-face and telephone based to online services has caused significant concern to many residents, particularly those who are not used to using digital services or do not have regular access to the internet. A recurrent theme in the feedback was worry about being shut out from services and left behind because they did not have the resources or the ability to access things online. This was not just health services but also services to access support for local authority services such as warm home support or the Department of Work and Pensions.

With regards to the resources to access, what people most commonly referenced was the cost of accessing digital services both in lack of suitable equipment and data costs.

> Too much by mobile – who is going to pay for my WiFi?
>
> 'If you are struggling with your mobility or if you don't have good digital access you easily give up - how can people access the service in a more equitable way?'
>
> Trying to join up support and access is a real challenge for those people who don't have access to digital technology.
>
> We have a very clear digital divide which needs addressing - there needs to be more inclusion for people who do not have technology.

When ability was raised there was considerable concern that, particularly the older generation lacked the knowledge and ability to navigate through online services. Although voluntary sector and local authorities used to provide support in this, it was also noted that many of them had shut down during COVID and not reopened, leaving people feeling more isolated.

People being forced to use technology they don't know how to and the services which used to help them are gone

Some of the elderly Asian people do not know how to use a computer or book appointments online.

Community members particularly the older members lack IT knowledge and how to use technology. Training should be made available and having videos in different languages to educate community members.'

We need more access to blood test services - some people don't know how to book online.

Even if resource and ability are not at issue then there is still reluctance from people to access online services for health as they do not feel they get the same response from clinicians online that they would if seen in person.

Being able to get an appointment and talk Face to Face and not these phone calls and online chats, that's how things are missed.

Digital technology is not for everyone - not many elderly people know how to use a smartphone.

Less online more access to people contact, more concern for the older generation that don't like or do modern technology

What will happen to the older generation who do not use digital technology - how are they supposed to communicate online?

It is also important to note however that, amongst those who can access online services and filled in the online survey, there was considerable support for the extension and implementation of more online services. This was frequently mentioned in the context of improving access to GP services.

> [The one thing I would change would be] Online appointment bookings for routine non urgent situations
>
> Make it more accessible e.g. be able to book appointments on online at suitable time, have online meetings if possible
>
> Better online systems and virtual appointments (triaged by reception first).
>
> Back to being able to book Appointments online.
>
> provide email and online consultation bookings for patients who can use online. there are many things we want to talk to doctor about that are not extremely sensitive, and often it is easier to write things than talk to receptionist
>
> more online access: fill in forms and book appointed call back from a professional. This would allow you to get on with your day e.g. no hanging on for a GP as soon as they open to try and get an appointment only to be asked to call back at another time/day - when you work it is very hard to fit it in

Trust in services

Throughout our engagement we heard from people who are concerned about the sustainability of health and care services and are losing trust in its ability to respond if they have a health or care need. This is partly as a result of the two previous themes as people struggle to access the services that they need and feel shut out from digital services that they may not have the ability or the resource to access. Public perception of services also plays a large part, with several respondents expressing concern that services will not be able to cope with them if they were to attempt access, meaning they were choosing to not even try to make contact to get support.

Fear of how I'd be treated, not able to get an appointment when needed due to having to phone that morning and hope to be high up enough in the phone queue

Long wait times to get through to someone who then stops you accessing the care you need

The system discourages easy access. Services increasingly limited.

There is no link up no who do you go to its assumed families will do it...I'm single? And I haven't even EVER seen any medical person regarding having dementia.

Knowing how swamped NHS staff are, not wanting to add to their workload or inconvenience them

I am concerned that services are under increasing pressure and the quality of provision may suffer as a result.

Lack of understanding of who does what /worried about cost/waiting lists

Distrust of who I might see (due to new jobs introduced especially in mental health services like trainee WP's seeing people for counselling whereas years ago you would have typically seen a trained counsellor)

Difficulty to get appointments, long waiting lists, only seen if emergency - and then only if lucky.

Too much red tape, being told you don't meet an arbitrary invisible criteria when you are begging for help.

Not wishing to be a burden on what appears to be an overstretched service for what would be perceived as relatively petty problems to some people

Conclusions and recommendations

Conclusions

Throughout our engagement we heard from a wide range of local people and communities regarding their priorities and how they felt about services. People were willing to share their experiences and talk openly about what mattered most to them, and though our work we were able to reach a wide range of local communities.

Their key issues were as follows:

Access to services

It was striking that, although there were issues raised with specific services and people's experiences of them, for the most part when people were able to get to a service or speak to a clinician or other relevant health and care worker who was able to support them, people were happy with the service which they received. This highlights that access (and lack of access) is considered to be the biggest priority and concern people have around health and care services.

Access to GP services was something we heard about from every group that we visited, and also formed a large part of the feedback received in the online survey. Although it is important to note that this is likely in some part due to the proportional amount of appointments GPs deliver within the health system, the vast majority of people who raised issues had experienced them personally. This is not something which was caused by negative media or "received wisdom", the issues are very much real and seeing them addressed is a key priority for many of our local communities.

However, it is important to break down the areas which are causing most concern and where people feel things could be improved.

- Booking an appointment
- Receptionists as barriers to access
- Face to face appointments

With booking appointments, the single biggest issue was the need to phone at 8AM and get into a queue, referred to by one respondent as "The 8AM hustle". Several respondents to the online survey offered the solution of re-introducing online booking for appointments while others felt that the ability to book appointments in advance, particularly for long term conditions would help. This issues is something which must be considered, looking at how the Strategy and associated Forward plan can support GP Practices to deliver online or other mechanisms for booking.

Particularly in our face to face conversations respondents raised issues with GP receptionists. This specifically focused on concern of the lack of privacy and dignity in describing a health issue to a non-medical professional but also resentment in feeling that the receptionist was the one making the decision as to whether they thought the condition was serious enough to "need" a GP appointment.

This issue could, in part, be addressed through better patient education, supporting people to understand more clearly the reasons why a receptionist may ask for a brief summary of the reason for wanting an appointment, and informing the patient of the mechanism in place to protect their confidentiality. It will also be important to communicate the scope of the receptionist role to patients, and that the receptionist is not in a position to do any form or medical triage.

The issue with face to face appointments is ongoing despite the number of face to face appointments delivered in Coventry and Warwickshire increasing over the past months. It is important to understand the reasons behind a desire for face to face appointments are both varied and valid and not dismissed as personal preference. There are real concerns among local residents that the service may not be as effective online, one example raised was the doctor asking to send a photo of a rash, but the patient feeling that he needed to see them in person as they have black skin and a rash will not show up well in a photograph. These reasons must be recognized and clearly addressed in order to build confidence in online consultations.

Issues with access are multi-faceted and it would be a mistake to only focus on General Practice when considering a response. Waiting lists and referrals for hospital treatment were also mentioned frequently as well as access to urgent and emergency care. Local communities are fully aware of the extreme pressures on health or care services and this is leading to them making decisions not to access care at all, or in a timely way. This area is picked up further below.

Digital Inclusion

Digital services are part of our future, and this is widely welcomed by many, who see them as the solution to some of the access issues outlined above. However there remains a significant cohort of people who are not able or willing to access these services, either because they lack the resources or ability to do so, or because they do not trust them.

It is important that these concerns are acknowledged and mitigations put in place to support people to access care through other routes. Training and support was suggested as being vital to supporting the uptake of digital services, but this will not be suitable for everyone and it is important to avoid the onus being put upon the service user to learn, without also acknowledging the need for support and alternative routes of accessing care for those who are unable to do so. Many barriers to accessing service digitally were raised across our focus groups, and these barriers must be acknowledged and address as part of the development of the Strategy and Integrated Care Five Year Forward Plan.

Trust in services

Throughout our engagement, both on and offline, we heard a great deal of concern and worry across the full range of health and care services. People are worried that the services won't be there when they need them and they don't want to burden an already overstretched system. This lack of trust is a combination of personal experiences in struggling to access service and the information they hear on the news and from others. Some respondents said that their concerns about the pressure on the health system is one of the biggest barriers to them trying to access care, which can lead to people's conditions escalating and becoming an emergency.

In addition to access issues, there were a cohort of respondents who expressed a wider lack of trust in health services, having little faith that they would be treated equitably and fairly.

Improving trust in services is not something which can happen in isolation and can only be achieved through acknowledging and addressing the reasons which lie behind the lack of trust. This engagement work forms a part of that, and the data must be more fully interrogated to understand the individual priorities and needs of the different communities we serve so that we can begin the process of building trust. It is important that the Strategy and Integrated Care Five Year Forward Plan reflect these priorities and continue to be developed in as inclusive way as possible, allowing all voices to not only be heard, but to influence and lead change.

Recommendations

- Recognise the need of improvement in access to GP appointments and consider where the Strategy and Integrated Care Five Year Forward Plan are able to support the delivery of changes.
- Explore production of information to explain the role of a receptionist in triage and appointment booking.
- Recognise the importance of digital inclusion in the development of the Strategy and Integrated Care Five Year Forward Plan.
- Acknowledge the lack of trust in health and care services to treat people equitably and ensure that inclusive service development is at the heart of the Strategy and Integrated Care Five Year Forward Plan
- Continue the process of ongoing engagement with all groups who have contributed to this work, sharing the findings and continuing the process of involving them in the development of all our work.

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Equality and Quality Impact Assessment Tool

The following assessment screening tool will require judgement against all listed areas of risk in relation to quality. Each proposal will need to be assessed whether it will impact adversely on patients / staff / organisations.

Insert your assessment as positive (P), negative (N) or neutral (N/A) for each area.
Record your reasons for arriving at that conclusion in the comment's column. If the assessment is negative, you must also calculate the score for the impact and likelihood and multiply the two to provide the overall risk score. Insert the total in the appropriate box.

Quality Impact Assessment

Quality and Equality Impact Assessment

Title:	Integrated Care Strategy December 2022		
Lead:	Liz Gaulton, Chief Officer for Health Inequalities and Population Health	**Senior Responsible Officer:**	Danielle Oum, Chair ICP
Intended impact	The strategy sets out bold ambitions for our System and the difference working together and leveraging the benefits of the new legislative framework for health and care can bring. We expect the Strategy, and the forthcoming ICB 5-year Integrated Care Plan will drive change in: • how, as partners, we relate to each other and to our communities • the way we use our resources • the design and delivery of our services • how we plan and make decisions. Ultimately, we want to see the impact of our strategy in improved population health outcomes and reduced health inequalities across Coventry and Warwickshire over the next 5 years and beyond. If we are successful residents of Coventry and Warwickshire will • be supported to live a healthy, happy, and fulfilled life, equipped with the knowledge and resources to prevent ill health, and maintain their independence at home		

	• find it easier to access the health and care services they need wherever they live and will have more say over the services they receive and greater trust in their quality, effectiveness, and safety; and • receive appropriate and timely care when they need it, from skilled and valued staff.
How will it be achieved:	Our Integrated Care Partnership brings together a wide range of partners – local government, NHS, voluntary and community sector, housing, health watch, universities, and others, to lead the system's activity on population health and wellbeing and drive the strategic direction and plans for integration across Coventry and Warwickshire. Its scope of influence extends beyond the integration of health and care services to encompass opportunities to work together to address the wider determinants of health. We adopted some core principles that underpin how we work together and how we will achieve the aims of the Strategy: **Principles** Championing better health for everyone Providing strategic leadership Prioritising prevention Strengthening and empowering communities Championing integration and coordinating services Sharing responsibility and accountability Engaging, listening, and learning

Name of person completing assessment:	**Anita Wilson**
Position:	**Director of Corporate Affairs, Coventry, and Warwickshire ICB**
Date of Assessment:	**30 November 2022**

Equality Impact Assessment

What is the aim of the Integrated Care Strategy?
This strategy provides an opportunity for us to set out our ambitions for what we can achieve over the next 5 years as an Integrated Care System. It aims to outline, in high level terms, the difference we can make by working in an integrated way, taking advantage of a new legislative framework – and setting the tone and focus for how we will work together. It doesn't seek to replace or duplicate existing strategies and activity underway in the system – instead it seeks to link them together by providing an overarching narrative about where we want to get to, and what it is that we are all trying to change and improve together. The Integrated Care System has an opportunity to improve population health and wellbeing in its broadest sense, with a wide range of partners working together to improve health outcomes and tackle health inequalities, starting with the root causes by addressing the wider determinants of health. And equally importantly, this is about working together at all levels and as locally as possible. We intend that much of the activity to integrate care and improve population health will be driven by organisations working together in our places, and through multi-disciplinary teams working together in our neighbourhoods, adopting new targeted and proactive approaches to service delivery, informed by a shared understanding of the needs of our population.

Who will be affected by this work? e.g., staff, patients, service users, partner organisations etc.
The Impact of the strategy on Coventry and Warwickshire will be far reaching. We expect it to underpin everything we do as an integrated care system and to drive change in: • how, as partners, we relate to each other and to our communities • the way we use our resources • the design and delivery of our services • how we plan and make decisions. Therefore, staff living and working in Coventry and Warwickshire, patients and service users, statutory organisations and the voluntary and community sectors may and will be affected by the Strategy.

Is a full Equality Analysis Required for this project?			
Yes	Proceed to complete this form.	No	Explain why further equality analysis is not required.
If no, explain below why further equality analysis is not required. For example, the decision concerned may not have been made by the ICB or it is very clear that it will not have any impact on patients or staff.			

Equality Analysis Form

1. Evidence used

What evidence have you identified and considered? This can include national research, surveys, reports, NICE guidelines, focus groups, pilot activity evaluations, clinical experts or working groups, JSNA or other equality analyses.

This strategy has been informed in several ways; namely

Existing C&W Strategies and plans

- Coventry Health and Wellbeing Strategy 2019-2023
- Warwickshire Health and Wellbeing Strategy 2021-2026
- Joint Strategic Needs Assessments (JSNAs)
- Health Inequalities Strategic Plan
- NHS Trust Organisational Strategies
- ICB Strategies e.g. Local people and Communities, Green, Tackling health inequalities
- Local Council Strategies/Plans e.g., Children and Young People, Levelling up, One Coventry

National Guidance

- NHS Long Term Plan
- NHS England Guidance documents on the role of the ICP
- NHS England National Healthcare inequalities Improvement Programme
- Local Government Association, Dept. Health, and Social Care guidance on ICP engagement
- Public Health England Strategy 2020-2025

Legal Framework

- Health and Care Act 2022

Engagement Activities: Ensuring effective and widespread community and stakeholder engagement to inform the development of this strategy through an inclusive approach has been a priority from the outset. A specific Engagement Task and Finish Group was established early in the process to ensure that engagement and co-production remained at the forefront throughout and got the specialist attention required. The Task and Finish Group included representatives from Local Authorities, NHS organisations, the voluntary and community sector, Healthwatch, faith groups and housing.

Across September, October, and November we have held over 30 community engagement events and launched an online survey widely promoted across the system. In addition, our Joint Integrated Health, and Wellbeing Forum (C&W HWBB) have come together to engage on the drafts as well as out ICP members.

2. Impact and Evidence:

In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should also include any identified health inequalities which exist in relation to this work.

Age: A person belonging to a particular age (e.g., 32-year-old) or a range of ages (e.g., 18–30-year old's)

Across Coventry and Warwickshire there is difference in life expectancy. Overall people living in Coventry have significantly lower life expectancy than the England Average. The average life expectancy of males in Coventry is 76.1 years and for Females 82 years. In Warwickshire the average for males is 79.7yrs and for females 83.4yrs. (England Avg. 74.9 for males and 83.1 Females)

The priority of the Strategy is to prioritise prevention and improve future health outcomes through tackling inequalities. The Strategy promotes the careful consideration of this protected characteristic from design through to implementation of any service changes and policies. In doing this organisations will ensure there is no negative impact on this protected characteristic and where possible, positive impacts are identified and delivered.

Disability: A person has a disability if he/she has a physical, hearing, visual or mental impairment, which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities

60% of those who died from Covid-19 in the first year of the pandemic were disabled. (The Kings Fund, Towards a new partnership between disabled people and health and care services, July 2022). The health inequalities disabled people face were made worse by the pandemic and as such it is important to ensure disabled people feel and are involved and engaged in planning and designing of health and care services.

As part of the ICP strategy development, several groups were engaged including Warwickshire and Coventry Vision, Grapevine (a charity supporting people with Learning Disabilities) employability groups and various smaller groups of which disabled members make up membership.

They told us that there needs to be a better interface between the NHS and social care especially across borders and access to GP face to face appointments. Transport issues were of concern as well as issues of isolation and not being digitally enabled.

The ICP Strategy supports and promotes the careful consideration of this protected characteristic within all three of the Priorities. From design through to implementation of service changes and policies organisations should ensure there is no negative impact on this protected characteristic and where possible, positive impacts are identified and delivered.

Gender reassignment (including transgender): Where a person has proposed, started, or completed a process to change his or her sex.

Existing evidence from sources such as GP patient Surveys, Healthwatch and the CQC point towards poorer health outcomes and poorer access for trans people. Evidence from the GP patient Survey sees younger trans and non-binary patients (Aged 16-44) more likely to report a long-term condition, disability (including physical mobility) or illness compared with patients of the same age.

As we have developed the ICP Strategy priorities and identified the outcomes and actions for each, we have done so through the lens of our population health model. Protecting the health of people and communities requires culturally competent approaches, which will be underpinned by a deeper understanding and involvement of our communities. The ICS as part of its Local People and Communities Strategy will continue to engage with the trans community who can help identify issues and co-produce solutions

The ICP Strategy supports and promotes the careful consideration of this protected characteristic within all three of the Priorities. From design through to implementation of service changes and policies organisations should ensure there is no negative impact on this protected characteristic and where possible, positive impacts are identified and delivered.

Marriage and civil partnership: A person who is married or in a civil partnership.

The ICP Strategy supports and promotes the careful consideration of this protected characteristic within all three of the Priorities. From design through to implementation of service changes and policies organisations should ensure there is no negative impact on this protected characteristic and where possible, positive impacts are identified and delivered.

Pregnancy and maternity: A woman is protected against discrimination on the grounds of pregnancy and maternity. With regard to employment, the woman is protected during the period of her pregnancy and any statutory maternity leave to which she is entitled. Also, it is unlawful to discriminate against women breastfeeding in a public place.

Coventry and Warwickshire have a local Maternity and Neonatal System (LMNS) that operates to work together across providers of maternity care to deliver high quality and consistent care to women and their families. We know that across C&W 8.3 % of babies are born with a low birth weight as compared to the national average of 6.9% (NMPA 2017), Coventry, Rugby and North Warwickshire have higher than average teenage conceptions, smoking at delivery in North Warwickshire is 13.7% which is higher than the national average of 10.6 % and 1 in 5 women in Coventry and Warwickshire will experience issues relating to mental health.

In addition to significant workforce challenges in terms of recruitment and vacancies across Coventry and Warwickshire we need to ensure our workforce feel valued and supported.

The ICP Strategy supports and promotes the careful consideration of this protected characteristic within Priority 1 - Prioritising prevention and improving future health outcomes through tackling inequalities, specifically with a focus on enabling the best start in life for children and young people. Within Priority 3 – tackling immediate system pressures and improving resilience there is a focus on developing & investing in our workforce, culture, and clinical and professional leadership. From design through to implementation of service changes and policies organisations should ensure there is no negative impact on this protected characteristic and where possible, positive impacts are identified and delivered.

Race: A group of people defined by their race, colour, and nationality (including citizenship) ethnic or national origins.

Coventry and Warwickshire have a multicultural population. 15.6% of the population come from a non-white background with the proportion living in the most deprived areas greater than the proportion for white residents. Research published by the Nuffield Trust and the NHS Race and Health observatory (RHO) has found that people from Asian groups experienced a much larger fall in planned hospital care during the pandemic that people from White, Black, or Mixed ethnic groups, worsening ethnic disparities in care. In addition, the RHO infographic 'Ethnic health inequalities in the UK' has some stark contrasts for which the ICS needs to consider.

The engagement activities the ICP undertook in developing the strategy highlighted that people from a migrant and asylum seeker background felt as though they received discrimination and experienced disparities in the care they received.

Asian and Black African and Caribbean people spoke of a lack of cultural awareness and wanting clinicians and professionals to be trained to support better conversations and face to face appointments to build trust.

The ICP Strategy supports and promotes the careful consideration of this protected characteristic within all three of the Priorities. From design through to implementation of service changes and policies organisations should ensure there is no negative impact on this protected characteristic and where possible, positive impacts are identified and delivered.

Religion or belief: A group of people defined by their religious and philosophical beliefs including lack of belief (e.g., atheism). Generally a belief should affect an individual's life choices or the way in which they live.

In 2020 the Office for National Statistics published ' Religion and Health in England and Wales' with a view to add to the growing evidence base on equalities. A finding was that a prevalence of long-standing

impairment, illness or disability was significantly lower among those who identified as Sikh compared with several other religious groups.

Therefore, protecting the health of people and communities requires culturally competent approaches, which will be underpinned by a deeper understanding and involvement of our communities

The ICP Strategy supports and promotes the careful consideration of this protected characteristic within all three of the Priorities. From design through to implementation of service changes and policies organisations should ensure there is no negative impact on this protected characteristic and where possible, positive impacts are identified and delivered.

Sex: A man or a woman

Women can be disadvantaged in the formal labour market by a combination of employment in low pay, low profile, low progression industries and the impact of caring on time and availability for paid work. Relative poverty rates are also highest for single women with children, although this gap is shrinking. (UK Women's Budget Group)

The ICP Strategy supports and promotes the careful consideration of this protected characteristic within all three of the Priorities. From design through to implementation of service changes and policies organisations should ensure there is no negative impact on this protected characteristic and where possible, positive impacts are identified and delivered.

Sexual orientation: Whether a person feels generally attracted to people of the same gender, people of a different gender, or to more than one gender (whether someone is heterosexual, lesbian, gay or bisexual).

LGBTQIA+ groups that were engaged with told us screening programmes were important as well as having Trust in clinicians. Access to talking therapies and counselling was also a key area of importance.
The evidence that LGBT+ people have disproportionately worse health outcomes and experiences of healthcare is consistent (NHS England).
In 2017 a national LGBT survey was completed with over 108,000 responses at least 16% of survey respondents who accessed or tried to access public health services had a negative experience because of their sexual orientation, and at least 38% had a negative experience because of their gender identity.

Following this the Government Equalities Office brought together a national LGBT+ Action Plan.
The ICP Strategy supports and promotes the careful consideration of this protected characteristic within all three of the Priorities. From design through to implementation of service changes and policies organisations should ensure there is no negative impact on this protected characteristic and where possible, positive impacts are identified and delivered.

Carers: A person who cares, unpaid, for a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support

An ageing population combined with economic austerity means an increasing reliance on family carers to support people with long term health conditions (Al-Janabi, 2016).

Most of the care in the UK is provided by family and friends. Recent polling suggests there could be around 8.8 million adult carers in the UK, up from 6.3 million in 2011 (Carers UK, 2019a), which social services and the NHS rely on to function.

Age
Most Carers are below state pension age, and the peak age for caring is 50-64. The number of Carers over the age of 65 is increasing more rapidly than the general carer population.

Sex
Women are more likely to undertake responsibility for caring, often happening at the peak of their careers, and while raising children (Carers UK, 2019a). There numbers of female carers are higher for young carers (Barnardo's, 2017) and for those providing round the clock care. Carers over 85 are more likely to be male. Female carers were found to experience more negative health impacts than male carers. Male carers are more likely to experience less carer burden, and more work interference (Brenna, 2016).

Race
Carers UK found that Black, Asian, and Minority Ethnic carers were less likely to receive financial and practical support, often through difficulty accessing culturally appropriate information, and a lack of engagement with these communities. The Children's Society found that young carers are 1.5 times more likely to be from BAME communities and hidden from services (Barnardo's 2017).

Disability
A 2019 survey (Carers UK, 2019b) found carers are more likely to report having a long term condition, disability or illness than non-carers. More than half of those who considered themselves to have a disability said their financial circumstances were affecting their health. Carers with disabilities are:

- more likely to give up work to care
- less likely to be in paid work alongside caring
- more likely to be on lower incomes when working
- more likely to be the sole earner in their household
- more likely to be in debt and higher levels of debt.

Local engagement with carers reinforces the importance of acknowledging the important role they play within the health system and the need to priortise the health of the carer.

The ICP Strategy supports and promotes the careful consideration of this protected characteristic within all three of the Priorities. From design through to implementation of service changes and policies organisations should ensure there is no negative impact on this protected characteristic and where possible, positive impacts are identified and delivered.

Other disadvantaged groups:

The Strategy outlines the Systems ambition to achieve the vision of the ICS to *do everything in our power to enable people across Coventry and Warwickshire to pursue happy, healthy lives and put people and communities at the heart of everything we do.*

Any impact and evidence on groups experiencing disadvantage and barriers to access and outcomes including lower socio-economic status, resident status (migrants, asylum seekers), homeless, looked after children, single parent households, victims of domestic abuse for example will be given careful consideration within all three of the Priorities. From design through to implementation of service changes and policies, organisations should ensure there is no negative impact on this protected characteristic and where possible, positive impacts are identified and delivered.

3. Human Rights

FREDA Principles / Human Rights	Question	Response

Fairness – Fair and equal access to services	How will this respect a person's entitlement to access this service?	The specific purpose of the Strategy is to achieve fair access to all services for all protected groups. Enhanced access may be needed for some groups to reduce inequity and achieve fairness.
Respect – right to have private and family life respected	How will the person's right to respect for private and family life, confidentiality and consent be upheld?	The personalised care model is core to our strategy and will help to ensure that health and care is shaped around "what matters to me". Through our digital and PHM enabler we will ensure robust information governance and data protection controls in place for the sharing of personal data.
Equality – right not to be discriminated against based on your protected characteristics	How will this process ensure that people are not discriminated against and have their needs met and identified?	The careful consideration of protected characteristics in the creation and implementation of services helps mitigate those observable perverse outcomes for those with protected characteristics, while being mindful that it does not account for those which arise through unconscious bias. We know there is more to do as a system to address institutional and structural inequalities that are the most damaging aspects of inequity. Health inequalities, specifically, is a core area of focus in our strategy.
Dignity – the right not to be treated in a degrading way	How will you ensure that individuals are not being treated in an inhuman or degrading way?	The personalised care model is core to our strategy and will help to ensure that health and care is shaped around "what matters to me". Our strategy also identifies 'quality' as a strategic enabler, which helps ensure that individuals receiving care are safe and treated with dignity.
Autonomy – right to respect for private & family life; being able to make informed decisions and choices	How will individuals have the opportunity to be involved in discussions and decisions about their own healthcare?	The personalised care model is core to our strategy and will help to ensure that health and care is shaped around "what matters to me".

Right to **Life**	Will or could it affect someone's right to life? How?	Through our integrated approach to delivering care outlined in the strategy and our accompanying Quality strategy we will ensure that we take positive steps to safeguard life and carrying out an effective investigation into the death of any adult at risk, identifying and addressing any bias, conscious or unconscious which may have affected decision making. The need to create a culture of continuous quality improvement, where safeguarding and improving care is everyone's responsibility, reducing health inequalities is further outlined in our Quality Strategy and this Integrated Care Strategy will help create the conditions under which this can be delivered across the whole system.
Right to **Liberty**	Will or could someone be deprived of their liberty? How?	Our actions in delivering this strategy will strive to identify and eliminate discriminatory biases against disabled people (including older people with disabilities such as dementia or cognitive conditions), in line with the Mental Capacity Act 2005 deprivation of liberty safeguards (DoLS), and with the new framework of Liberty Protection Safeguards (LPS) due to come into force in 2023. In implementing our system-wide approach to promoting mental wellbeing and resilience, we expect to see people who have experienced problems with their mental health empowered to take greater control over their own care, ensuring they are helped to manage their own conditions more effectively.

4. Engagement, Involvement and Consultation		
If relevant, please state what engagement activity has been undertaken and the date and with which protected groups:		
Engagement Activity	**Protected Characteristic/**	**Date**

	Group/ Community	
Please See Separate Engagement Report		
For each engagement activity, please state the key feedback and how this will shape policy / service decisions (E.g., patient told us …. So we will …..):		
See Engagement Report		

5. Mitigations and Changes
Please give an outline of what you are going to do, based on the gaps, challenges and opportunities you have identified in the summary of analysis section. This might include action(s) to mitigate against any actual or potential adverse impacts, reduce health inequalities, or promote social value. Identify the **recommendations** and any **changes** to the proposal arising from the equality analysis.
The Strategy outlines the Systems ambition to achieve the vision of the ICS to *do everything in our power to enable people across Coventry and Warwickshire to pursue happy, healthy lives and put people and communities at the heart of everything we do.* Coventry and Warwickshire Integrated Care System recognises that action on health inequalities requires improving the lives of those with the worst health outcomes, fastest. The West Midlands InequalitiesnAL toolkit, and in particular the Health Equity Assessment Tool (HEAT) empowers professionals to identify practical action in work programmes. Its 'subscription' across Coventry and Warwickshire will help colleagues to mitigate any negative impacts in collaboration with other system partners. Recommendation is for the ICB to use this EQIA and apply HEAT in developing its 5-year Integrated Care Plan with reference to the engagement feedback around the key themes that were: Access to Primary Care Services, digital inclusion and building trust and confidence in our services.

6. How will you measure how the proposal impacts health inequalities?
e.g., Patients with a learning disability were accessing cancer screening in substantially lower numbers than other patients. By revising the pathway, the ICB can show increased take up from this group, this is a positive impact on health inequalities. You can also detail how and when the service will be monitored and what key equality performance indicators or reporting requirements will be included within the contract.
The Strategy does not relate to the specific implementation of services, and it is therefore not possible to identify specific measures.

7. Is further work required to complete this assessment?
Please state what work is required and to what section. e.g., additional consultation or engagement is required to fully understand the impact on a particular protected group (e.g.,

disability).

Work needed	Section	When	Dare completed
Further engagement with groups will continue as the 5yr Integrated Care Plan is developed	All sections	Jan- March 2023	July 2023

8. Sign off

The Equality Analysis will need to go through a process of **quality assurance** by a Senior Manager within the department responsible for the service concerned before being submitted to the Policy, Procedure and Strategy Assurance Group for approval. Committee approval of the policy / project can only be sought once approval has been received from the Policy, Procedure and Strategy Assurance Group.

Requirement	Name	Date
Senior Manager Signoff	Liz Gaulton, Chief Officer Health Inequalities and Population Health	30 November 2022
Which committee will be considering the findings and signing off the EA?	Integrated Care Partnership	8 December 2022

Agenda Item 4

Health and Wellbeing Board

11 January 2023

Director of Public Health Annual Report 2022

Recommendation

That the Health and Wellbeing Board considers and endorses the 2022 Annual Report of the Director of Public Health and the recommendations within it.

1. Executive Summary

1.1 Under section 73B of the National Health Service Act 2006 Directors of Public Health are required to write an annual report on the health and wellbeing of their population, and the local authority is required to publish it.

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

1.3 The theme of this year's Annual Report (which is attached as an appendix to this report) is health and the rising cost of living. The Annual Report includes an overview of the health and wellbeing of the Warwickshire population and information on progress with the 2020/21 recommendations. The Annual Report includes a series of recommendations which require a concerted joint effort from health and social care partners across the Integrated Care System (ICS) if they are to be achieved.

1.4 There is evidence that the rising cost-of-living is already starting to impact on the health and wellbeing of residents across Warwickshire. The rising cost of living is something that is affecting everyone; however, there is a risk that it will exacerbate some of the health inequalities which already exist in Warwickshire as those who are already disadvantaged are more likely to experience difficulties with the increasing costs, which may for example impact on their ability to keep their home warm, eat nutritious meals and travel effectively.

1.5 This year's Annual Report is vital to raise awareness of the impact that wider determinants of health such as food, rent or mortgage payments can have on the health and wellbeing of our residents, highlighting where provisions are required to support Warwickshire residents, improve health and wellbeing, and reduce health inequalities.

1.6 In order to highlight how the increasing cost of living impacts on the health of residents across Warwickshire, case studies have been used to illustrate the

support that different partners across the Integrated Care System have already been providing to residents. These demonstrate both the barriers that people have faced, as well as the benefits from accessing services. Volunteers and users of food banks and community pantries have also provided written consent for their experiences to be shared via a short film, developed to complement the information within the Annual Report.

1.7 The recommendations in the Annual Report aim to mitigate the impact of the rising cost of living on health and improve the overall health and wellbeing of the Warwickshire population.

2. Financial Implications

2.1 None.

3. Environmental Implications

3.1 None.

4. Timescales associated with the decision and next steps

4.1 The Annual Report will be published in a digital format alongside the engagement video on Warwickshire County Council's website following Health and Wellbeing Board's consideration of this report on the 11 January 2023 and Full Council in March 2023. This is to provide a picture of how the cost-of-living is impacting people locally. References for evidence detailed in the Annual Report will also be made available online.

4.2 A detailed marketing and communications plan will be prepared to ensure the Annual Report is communicated widely with partners across the Integrated Care System as well as to the residents of Warwickshire. Printed copies of the Annual Report will be made available upon request for those unable to access the report digitally.

Appendices

	Name	**Contact Information**
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The report was circulated to the following members prior to publication:

Local Member(s): none.

Other members: Cllrs Bell, Drew, Golby, Holland and Rolfe

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Agenda Item 5

Health and Wellbeing Board

11 January 2023

Preventing Homelessness in Warwickshire Report – a multi-agency approach

Recommendations

That the Health and Wellbeing Board

1. Notes and supports the contents of this report; and

2. Endorses the ongoing review of the action plan

1. Executive Summary

1.1 Health and Wellbeing Board Members endorsed the Preventing Homelessness in Warwickshire Strategy in March 2021 to support the development of an action plan underpinning recommendations to reduce homelessness. This strategy links into the priority to *reduce inequalities in health outcomes and the wider determinants of health* in the Warwickshire Health and Wellbeing Strategy 2021-2026.

1.2 Since the adoption of the strategy, the strategic group have met quarterly and working groups for each of the chapters have met regularly to progress actions for each of the chapters. These are health, financial inclusion, young people, domestic abuse and offending. Updates on key actions for each workstreams are presented in this report.

1.3 In progressing the strategy, the group will gather data from a number of sources including from Experts by Experience, which provides a space for people experiencing homelessness/rough sleeping to communicate their views and experiences across a range of topics and services highlighted in the Preventing Homelessness in Warwickshire Strategy. The data gathered will be used to inform and where appropriate, amend the actions for each chapter of the strategy.

1.4 The strategic group will review the current action plan set for March 2021-March 2023 and revise accordingly to reflect actions moving forward.

2. Financial Implications

2.1 More work needs to be undertaken to understand the financial implications for each workstream. From a Warwickshire County Council (WCC) perspective,

any costs that emerge from this work will either be covered within existing budgets; or existing budgets will be reprioritised to accommodate these costs.

3. Environmental Implications

3.1 None.

4. Supporting Information

4.1 In January 2019, Warwickshire's Housing Board sought approval from Warwickshire's Health and Wellbeing Board to:

- Form a Homelessness Strategic Group that reports directly to the Warwickshire Health and Wellbeing Board.
- To begin to work on a countywide strategy on tackling and reducing homelessness.

The strategic group worked collaboratively across a wide range of partners, writing a countywide strategy on preventing homelessness.

The Joint Health and Wellbeing Strategy 2021-26 has identified reducing inequalities in health outcomes and the wider determinants of health as one its three main priorities. Health and Wellbeing Board Members endorsed the Preventing Homelessness in Warwickshire Strategy in March 2021 to support the development of an action plan underpinning recommendations to reduce homelessness.

4.2 Strategic priorities included in the strategy are:

- Health – to reduce the inequalities and improve the health of people at risk of homelessness, homeless or sleeping rough.
- Financial inclusion – to ensure that a wide range of appropriate services are available to support those at risk of homelessness due to financial difficulties.
- Young people – to enhance and improve services that prevent homelessness among young people.
- Domestic abuse – to prevent domestic abuse and the crisis homelessness resulting from it wherever possible.
- Offending – to deliver better-focused housing and related support services for those at risk of homelessness when leaving prison.

4.3 The strategic group have met quarterly and working groups for each of the chapters have met regularly to progress actions.

4.4 Key highlights from each priority:

Homelessness and health

The Homeless Street Outreach Physical Health Nursing Service

- The Homeless Street Outreach Physical Health Nursing service has proved to be invaluable to the homeless population of Warwickshire. The service consists of a team of street outreach nurses hosted by South Warwickshire University NHS Foundation Trust (SWFT) Out of Hospital services, to provide healthcare to the local homeless population in Warwickshire. The nurses aim to respond quickly to emerging health needs and engaging individuals in wider health services. Referrals can be made to the team for any individual in need of healthcare who presents as homeless, including supporting hospital discharge to reduce the likelihood of readmission.

- Since the service began in Jan 2020, the service has built successful relationships with other NHS services, voluntary sector and community services, benefitting patients and the timely care and support they receive.

- The service works closely with the Coventry and Warwickshire Partnership NHS Trust (CWPT) Homeless Street Outreach Mental Health Nursing service to provide holistic healthcare provision, often working together at the same clinics or location. CWPT has funded the acquisition of a vehicle that has been specially adapted to enable all aspects of treatment.

- The Rough Sleeping Initiative has allocated funding to support the Physical Health Nursing Service for 3 years (2022-2025).

- This service has successfully expanded with an additional band 7 practitioner and two additional band 3 support workers appointed in Autumn 2022.

- A qualitative evaluation of the homeless nursing service was completed by Coventry University and has been published (March 2022): Nurse-led mental and physical healthcare for the homeless community: A qualitative evaluation https://onlinelibrary.wiley.com/doi/full/10.1111/hsc.13778. Findings from this evaluation included benefits of homeless healthcare in reducing health inequalities and promoting a more accessible, flexible and person-centred approach to holistic care.

- A qualitative study to explore the experiences of people who were homeless during the governments ‘everyone in’ directive and an evaluation of the Physical Health nursing service was led by Coventry University but has not yet been published.

Pathway

- Pathway are a homeless healthcare charity, helping the NHS to create hospital teams to support homeless patients. They were commissioned to undertake the Pathway Needs Assessments for homeless patients for the 4 NHS hospital trusts in Coventry and Warwickshire: SWFT, University Hospitals Coventry and Warwickshire NHS Trust (UHCW), George Eliot

Hospital NHS Trust (GEH) and CWPT. The 4 needs assessments are now complete. The aim of the Pathway needs assessments is to review the number of homeless people attending the hospitals and make recommendations for how a better care co-ordination approach could be implemented.

Dual Diagnosis

- ‘Dual diagnosis’ covers a broad spectrum of moderate to severe mental health and substance misuse that an individual might experience concurrently and includes both illicit drug use and alcohol abuse. Although dual diagnosis infers there are two diagnoses, the policy recognises that the relationship between mental health and substance misuse can be both controversial and complex. Dual Diagnosis workers are embedding themselves into the inpatient settings.

GP Drop-in Clinic Pilot

- Public Health, in partnership with the commissioned services, including Change Grow Live (CGL), SWFT and CWPT homeless nurses, Housing Related Support (HRS), are piloting a project commencing January 2023 within the Leamington Primary Care Network (PCN) area for a GP clinic session specifically for the homeless.

- In addition, Public Health are working in partnership with the Personalisation Programme Manager for Coventry & Warwickshire to review how to embed personalised care into the engagement with patients for this project.

Housing Liaison Service

- The Housing Hospital Liaison Officers promote liaison and provide practical support for hospital discharge arrangements in circumstances where ‘housing’ has been raised as an issue preventing timely discharge. ‘Housing’ is a broad term and issues can range from homelessness to hoarding or the need for adaptations or an environmental clean. It could include room clearance to provide space for hospital equipment to enable safe care to be provided.

- This service is funded from Warwickshire Cares Better Together funding. There are three liaison officers covering hospital discharge across the County at UHCW/St. Cross, GEH, SWFT and CWPT. Each has a designated area, but they work together to support colleagues who need assistance to resolve housing issues.

Financial Inclusion

- The strategy recognises that financial circumstances can lead to homelessness. It seeks to provide services which can support and advise to prevent this. Housing Options Teams provide advice about housing and homelessness and services are delivered by the districts and boroughs. They use their early contact with applicants to explore their financial circumstances and if necessary, refer into specialist services such as PHIL

(Preventing Homelessness and Improving Lives) and the Citizens Advice Bureau.

- In this Chapter the strategy seeks to co-ordinate information about services that act to promote financial inclusion initiatives particularly to prevent homelessness. It encourages proactive relationships with services that support families and individuals (such as Family Information Services and the Department of Work and Pensions) to support customers to maximise their income, manage their expenditure & deal with debt. Currently there is a particular attention on services that can support those struggling with energy bills.

Young People

- The refreshed 16/17-year-old homeless protocol and the Care Leaver Homelessness protocol are in final version and have now been approved by the districts and boroughs through their own governance routes.

- Upcoming proposal from the Young People's working group to Warwickshire Heads of Housing and WCC Social Care for rolling out muti-agency training.

- The House Project (funded through WCC Children & Families Service) are aiming to expand the service in 2023.

- Increased payments of 2% (in line with inflation) to carers for 'Supported Lodgings'.

Domestic Abuse

- Commissioning response to Warwickshire's Safe Accommodation Strategy: Commissioners are evaluating the appropriate accommodation options and developing appropriate support to ensure that domestic abuse support (and accommodation) is in place for all victim-survivors who need it.

- A new Domestic Abuse Counselling and Therapy Service went live on 1st September 2022 to support all victim-survivors supported by the Warwickshire Domestic Violence and Abuse (WDVA) Service. Warwickshire's Dispersed Safe Accommodation Service will also provide advocacy and support for those who are in accommodation.

- Key messages are being linked up to ensure a countywide approach towards communications around domestic abuse. Future communications will be developed around the dispersed model.

Offending

- Introduced Registered Social Landlords to the Offenders and Accommodation Task and Finish Group to get more active involvement.

- Completed Duty to Refer Training for Probation and the Pre-Release Teams in the Prison Service.

- Devised a protocol which has been signed off by housing authorities within the five districts and boroughs within Warwickshire that agreed to changes to deal with the transfer of cases for offenders who may have exclusions in our own areas.

- Completed a survey with the Registered Social Landlords and district and borough Councils in Warwickshire as housing authorities to get more information with regard to their housing allocation policies and providing tenancies to offenders.

- The Office of the Police and Crime Commissioner has now included homelessness and housing within their Police and Crime Plan.

- Currently looking to run a pilot project with the Pre-Release Teams in our local Prisons to receive Duty to Refers on the Unconvicted Cohort who have not yet been sentenced, but are currently on remand, which should help with dealing with any homelessness issues before their release dates cutting down on crisis management.

4.5 Experts by Experience

- The Experts by Experience groups in Warwickshire provide an opportunity for members to communicate their views and experiences. The main objective of this project is to engage with the homeless and rough sleeper population in Warwickshire about their experiences and needs across a range of topics and services highlighted in the Preventing Homelessness in Warwickshire Strategy. Data will be used to inform/amend actions devised from each chapter of the strategy. Warwickshire County Council Research Governance has been completed for this project and an Equality Impact Assessment will also be completed.

4.6 The Housing, Homelessness and Covid-19 Working Group

- The Housing, Homelessness and Covid-19 working group was set up to respond to the needs of the homeless population during the pandemic which met online on a weekly basis from March 2020 – March 2022. The working group comprised of members from housing teams from Warwickshire district and borough councils, Warwickshire County Council, Public Health, WCC People Strategy and Commissioning, and SWFT. Partners in this working group had already begun working together and forming relationships from the WCC Homelessness Conference in Autumn 2018, which meant there was a solid working foundation already established which grew with the work on the Preventing Homelessness in Warwickshire Strategy.

- See Appendix 1 for a summary of the Housing Homelessness and Covid 19 Report

- Partners have provided case studies that reflect the response to supporting people experiencing homelessness. See Appendices 2-5.

5. Timescales associated with the decision and next steps

5.1 The strategic group will review the current action plan set for March 2021 – March 2023 and revise accordingly to reflect actions moving forward.

Appendices

1. Appendix 1 HHC19 Report Summary
2. Appendix 2 Case Study PH Outreach
3. Appendix 3 Case Study PH and MH outreach
4. Appendix 4 Case Study Change Grow Live
5. Appendix 5 Case Study Rugby Hope4
6. Appendix 6 Case Study Mental Health

Background Papers

None

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Portfolio Holder for Adult Social Care & Health	Cllr Margaret Bell	margaretbell@warwickshire.gov.uk

The report was circulated to the following members prior to publication:

Local Member(s):
Other members: Cllrs Bell, Drew, Golby, Holland and Rolfe

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Appendix 1

Housing, Homelessness and Covid-19: Reflections and Lessons Learned

Report Summary

People experiencing homelessness face disproportionate rates of underlying health conditions and substance use disorders, stigma, and marginalization that often disenfranchise them from health and social service. In addition, living conditions contributed to a heightened risk of infection and adverse outcomes of COVID-19. The Housing, Homelessness and Covid-19 (HHC19) working group was set up to respond to the needs of the homeless population during the pandemic which met online on a weekly basis from March 2020 – March 2022. The working group comprised of members from housing teams across Warwickshire districts and boroughs (D&Bs) Warwickshire County Council (WCC) Public Health, WCC People Strategy & Commissioning, and South Warwickshire Foundation Trust (SWFT).

Partners in this working group had already begun working together and forming relationships from the WCC Homelessness Conference in Autumn 2018, which provided a solid foundation that grew with the work on the Preventing Homelessness in Warwickshire Strategy (PHWS). This report reveals not only the challenges the wide partnership has experienced, but also the wealth of learning opportunities that can be used to inform future provision and policy.

It has now been well-documented that, alongside the work of the voluntary sector, the rapid steps taken by national and local government helped to save lives and to reduce the potential for hospitalisations due to Covid-19 of those experiencing homelessness in England. The pandemic response resulted in more collaboration and joined up working across the sector and across local authorities and service provisions. The HHC19 partnership worked closely with a broad range of partners including voluntary and charitable sectors. Housing teams have successfully worked with a number of rough sleepers that have been entrenched for a significant period and were able to move individuals into stable accommodation and secure next step units as a result of the Everyone In initiative. In addition, there was greater recognition and visibility of the diversity amongst those experiencing or threatened with homelessness, including ‘hidden’ groups, such as an increase in ‘sofa surfers’ discovered in Rugby.

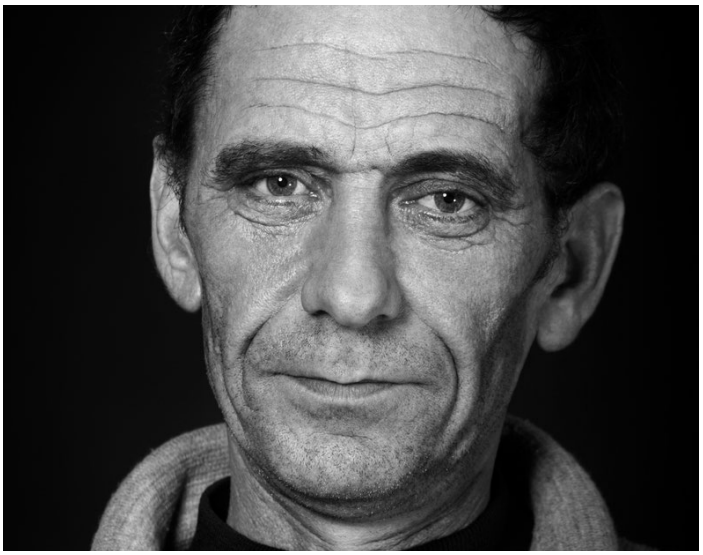
Outcomes that resulted from this partnership were commended for their health approach and being innovative and ahead of the game. When the Joint Committee on Immunisation and Vaccination agreed to expand the definition of vulnerable individuals to include people who experienced homelessness and rough sleeping, the physical health Nurse Outreach to the Homeless Service provision was already in place in Warwickshire, set up and running for several months. The partnership

also described improvements in local ways of working, with the hope that these practices would continue and develop moving forward.

Challenges during this period included data sharing between agencies. During the vaccine rollout, housing team officers were unable to determine which clients were vaccinated and which were not. Being aware of individual vaccination status for accommodation placement risk assessment would have been supportive. Moving forward, the partnership agreed to ensure data sharing agreements are in place in order to manage expectations. Similarly, challenges were experienced with the Homeless Dashboard for Warwickshire which was introduced by Public Health to assess data on the number of people accommodated under Everyone In. Housing teams in the District and Borough councils highlighted pressures and challenges in collating this data. Moving forward, a recommendation was agreed to ensure collaboration with partners to share decisions on data fields, how and where data will be collated and clear communications on how findings will be used to inform practice. These initiatives will involve Information Governance teams across partners to ensure compliance with information legislation. A further challenge experienced by the partnership was the self-funding of alcohol detox programmes. This has since been discussed as a part of the Preventing Homelessness in Warwickshire Strategy.

Case Study:
Mr M, Male aged, 55 years

Professional involved:
Band 7 Clinical Practitioner



Story

Mr M had been living rough on the streets in his local town for 10 years. He previously lived with his mother but due to her passing away, he was back on the streets.

Having moved to a local hostel and during a drop-in clinic, Mr M was seen by the Homeless Nursing Team. He was diagnosed with Tinea Pedia (TP), ulcers on his feet and self-neglect. The Clinical Practitioner was able to see to Mr M's TP and ulcers and once healed, continued to visit him to wash his feet. Mr M had been known by the staff as an alcoholic but the Clinical Practitioner picked up there was either a learning difficulty or disability. Mr M was considered to have Korsakoff's Syndrome and an appointment was made to see the mental health street outreach team (SOT) nurse.

The Clinical Practitioner referred Mr M to social services for safeguarding and an assessment to the Learning Disability Team for his mental capacity. Unfortunately, due to the onset of Covid-19, Mr M's appointments were cancelled, however, the SOT continued with face-to-face visits throughout the pandemic and lockdowns.

The LD team eventually discharged Mr M and suggested a referral to CWPT for an assessment around mental health and alcohol related dementia. The Clinical Practitioner liaised with the GP to request a diagnosis of Korsakoff's Syndrome. Mr M would have to be seen by a Psychiatrist to confirm the diagnosis. Due to his vulnerable state, the hostel staff had also applied for an advocate for Mr M as it was suspected that he was being financially abused by family members.

A speech and language therapist was also bought onboard, however, Mr M didn't always turn up for his appointments. However, the Clinical Practitioner agreed that he could carry out a joint assessment as part of the wellbeing appointment with Mr M. Eventually, Mr M was able to follow some speech and language strategies provided by the therapist who passed this onto the hostel staff. Mr M could explain to staff how he saw the world and the staff could adjust their care for him according to his perspective.

After a referral to CGL, Mr M was given help with his alcohol dependency. Joint visits were agreed with the Clinical Practitioner alongside the MDT's, safeguarding, social services, WDC, and hostel staff. Following a refurbishment of the hostel, Mr M was placed into a B&B with support from the Clinical Practitioner and hostel staff (x2 daily, initially). Mr M had a tour of the B&B and settled in well, as he had a room of his own. The Clinical Practitioner and hostel staff communicated with Mr M with a mix of communication aids from the speech and language team, in addition to drawing pictures themselves.

Outcome

He really enjoyed the B&B and began to thrive. A property then become available in a sheltered housing complex. Mr M moved in and has been there since January 2021. In addition to all of his Covid-19 vaccinations, Mr M has support package, a social care practitioner and now support visiting his GP from his support team. Mr M had not visited his GP in 20 years before this intervention. He now takes regular medication for his cholesterol and blood pressure and despite a few bumps along the way Mr M is doing well. He is happy, safe and warm and is able to communicate with others

and is supported in a world that he does not understand and found extremely difficult to cope with.

Case Study:
Coventry and Warwickshire Primary Trust Homeless Street Outreach Physical and Mental Health Nursing Mobile Service.

Coventry and Warwickshire Primary Trust Homeless Street Outreach Mental Health and Physical Health Nursing Mobile Service, wanted to take healthcare interventions to the homeless and rough sleepers who were in need of care and treatment.

A specially adapted camper van, funded by CWPT Mental Health partners, provided the solution to the problem and ultimately, provided a treatment station on wheels.

Nurses were able to visit those hard to reach individuals who wouldn't otherwise visit a shelter or a healthcare facility to report a physical ailment.

The nurses provide support, assessment and treatment for health issues such as wounds (leg ulcers and podiatry issues), respiratory conditions, substance misuse, psychological conditions, blood disorders and skin problems. We are able to assess someone's mental health as well as physical health on the unit using the private space.

In addition, the nursing service linked in with Healthwatch Warwickshire to ensure the cases are registered with a GP.

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Case Study:
Change Grow Live – Adult Drug and Alcohol Treatment Services for Warwickshire Residents

Locality Manager for Change Grow Live in Warwickshire gives her thoughts on how the service is helping vulnerable residents across the county…

Change Grow Live is a service focusing on helping people recover from drug and alcohol addictions and assisting them to take control of their own recovery goals. Here the Locality Manager recounts her experience of running the service during COVID-19:

"Managing the Nuneaton and Rugby hubs has been something that I have done for nearly 10 years. However, the experience of managing so many new scenarios during COVID was a situation none of us expected to be in when we started the year in 2020."

"I was so lucky to have such dedicated and like-minded team leaders to bounce ideas off, we were all learning together and getting through the situation of COVID together. The two main aims of overseeing a service during COVID were keeping the staff and service users safe and keeping our doors open at a time when people needed us."

"I am so pleased we have and are continuing to achieve these goals. We have had positives come out of the pandemic; we now offer much more telephone support; successful home detox's and we have an extremely successful online group offer and online professionals training. I feel proud to have worked throughout COVID and feel proud of the whole team I work with."

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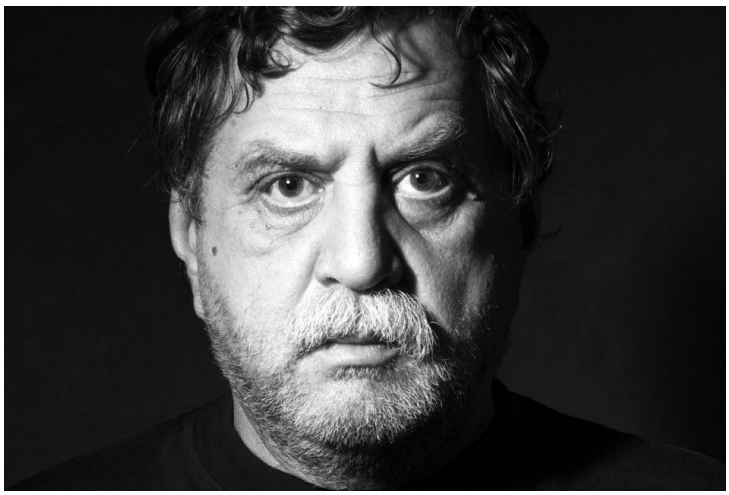
Case Study:
CT, 54, homeless

Reason for homelessness:
Eviction due to non-payment of rent



CT has been homeless for many years. He lived with his mother and succeeded to the tenancy but was evicted for non-payment of rent. When accessing Hope 4 services, CT declined services and support and had no interaction with other visitors to the Hope 4 centre and didn't want to talk about the past, present or future.

Staff at Hope4 and from Rugby Borough Council (RBC) would endeavour to engage with CT, helping him to access services including accommodation. They provided pictures and details of potential homes, offered accompanied visits, provided reassurance that help would be given with furniture, carpets, budgeting and settling in.

CT continued to resist help to accommodate him, until the onset of COVID-19. CT realised that the services he accessed would no longer be available to him and unfortunately, his only accommodation, the night shelter, had closed.

Staff from RBC worked with Hope4 to encourage CT to accept a placement in a local hotel – a small room, set away from the rest, providing reassurances around costs and with provision of food.

CT had no income, was not registered with a GP, and had no family or social support network.

RBC recognised that to sustain accommodation, a quick and effective alternative was required. Outreach and in-reach work continued to work with CT to maintain his motivation and to build his confidence to stay in his accommodation. CT was given a self-contained accommodation and partner agencies helped to furnish the flat too.

An Outreach Officer took CT to the flat and he moved in immediately. The Pathway Team have continued to support CT but on a slow progressive basis, applying for benefits, providing a television, social interaction, health checks, encouragement around food and diet and ensuring he still goes out and about for a form of exercise.

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Case Study:
Mr B, 61, homeless

Reason for homelessness:
Mental Health issues

Story

Following a relationship breakdown with his family, Mr B, who has mental health issues, found himself homeless and sleeping rough on the streets.

Over the Christmas period of 2021, Mr B was picked up by Warwickshire Police, who completed a Duty to Refer on his behalf. Having already committed offences in the past, Mr B was subject to a Probation Order. Most of these offences centred around his mental health issues, mainly non-engagement and erratic behaviour.

North Warwickshire Borough Council were able to offer Mr B a room at the Watling Street Project. Mr B accepted.

Outcome

In the six months Mr B was at the Watling Street Project, the team observed a change to his character. The team were able to explore his behaviour and why he reacts negatively to certain people, mainly those in authority. His behaviour began to improve, so much so, he was able to find a job.

The change in Mr B was apparent and he became a popular figure in the hostel. Mr B even provided assistance to residents who were older and who had health issues. He regularly went to the shop or ran errands for them.

Mr B is now living in his own tenancy and has been much happier since being involved with the project. He can still ask for support from the project for up to 12 months after he left the hostel should he come across any difficulties.

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Agenda Item 6

Health and Wellbeing Board

11 January 2023

Coventry and Warwickshire Suicide Prevention Strategy 2023 - 2030

Recommendations

That the Health and Wellbeing Board:

1. Endorses the content of the Coventry and Warwickshire Suicide Prevention Strategy 2023 – 2030;

2. Consider their organisational contributions to suicide prevention and identify any governance routes for approving and sharing the Strategy;

3. Supports the delivery of the strategic ambitions and local priorities as set out in strategy and delivery plan through collaboration with the Coventry and Warwickshire Suicide Prevention Partnership; and

4. Requests a formal presentation of the Strategy and Delivery Plan at the Coventry and Warwickshire Integrated Health and Wellbeing Forum at its meeting in March 2023.

1. Executive Summary

1.1 Following completion of the NHS England (NHSE) funded national suicide prevention programme in Coventry and Warwickshire (2018 – 2021) work has been underway to develop a new partnership work programme that sets out a vision for suicide prevention in Coventry and Warwickshire until 2030.

1.2 Early engagement on this process identified that the new work programme should build on the work developed through the NHSE funded programme and bring together the previously separate (and now out of date) suicide prevention strategies for Coventry and Warwickshire into a single system-wide strategy and approach.

1.3 A significant amount of engagement has been undertaken to test the draft vision, strategic ambitions and local priorities and help shape the content of the strategy.

1.4 In addition, there has been a refresh of the existing partnership arrangements for delivering the suicide prevention work programme and a review of the

governance structures that are needed to embed suicide prevention at an organisational and system level.

1.5 As a system-wide strategy, the delivery of the associated work programme will be undertaken as part of the Coventry and Warwickshire Integrated Care System, with partners involved in developing, implementing, and where appropriate resourcing the actions that will help achieve the vision, ambitions and priorities of the strategy.

1.6 The new Strategy promotes taking a zero-suicide approach, with the overall aim **to reduce the rate of suicide across Coventry and Warwickshire**.

1.7 A new and evolving Suicide Prevention Delivery Plan will set out the actions and activity required to achieve the strategy's ambitions. This will also aim to:

- Show activity required or delivered at a system, place and local level
- Outline delivery mechanisms across the whole system
- Demonstrate alignment and association to related activity or programmes of work
- Show lines of accountability and responsible delivery partners.

1.8 Both the Health and Wellbeing Boards in Coventry and Warwickshire will monitor the Suicide Prevention Delivery Plan, with progress and impact reported on an annual basis.

1.9 Highlight reports will also be presented to other appropriate local strategic boards to ensure the suicide prevention programme is reflected in and aligned to other work stream areas. This includes the Boards overseeing Safeguarding, Community Safety, Wider Determinants (eg. Housing, Education, Financial Inclusion), Equalities (eg. Armed Forces) and the Place Partnerships.

1.10 The Strategy and ongoing delivery of the work programme is led and overseen by the Coventry City Council and Warwickshire County Council Public Health Teams on behalf of the Coventry and Warwickshire Suicide Prevention Partnership.

1.11 The Coventry and Warwickshire Suicide Prevention Partnership is the multi-agency mechanism for working together towards the vision that no-one in Coventry and Warwickshire ever feels that suicide is their only option.

1.12 The Partnership is made up of organisations, groups, communities and individuals from across Coventry and Warwickshire, who collectively deliver three distinct functions, each with their own area of responsibility:

- **Network:** enables joint working, information sharing and networking amongst all members to contribute to the vision and ambitions of the Coventry and Warwickshire Suicide Prevention Strategy

- **Steering Group:** provides leadership, expertise and accountability for the wider partnership

- **Learning Panel:** considers the local data on deaths by suicide and suspected suicide as captured through the real time surveillance system to identify learning points to inform local suicide prevention activity. Monthly insight meetings are also scheduled in response to specific groups, patterns, or trends of deaths by suicide.

1.13 The Partnership aims to take a holistic approach to suicide prevention, starting with the individual and building to an environment that supports a suicide aware society.

1.14 There are ongoing conversations regarding the links between suicide and related risk factors, including substance misuse, domestic abuse and self-harm. Further work is planned to identify specific actions that could be explored in relation to this. The Strategy itself also identifies these links and the need for a collective response.

1.15 The final draft of the Coventry and Warwickshire Suicide Prevention Strategy and outline Delivery Plan is being presented to both the local Health and Wellbeing Boards in Coventry and Warwickshire for endorsement as the bodies responsible for encouraging integrated working such as the development of a system-wide partnership strategy for suicide prevention.

1.16 The new Coventry and Warwickshire Suicide Prevention Strategy will contribute directly to the delivery of the Warwickshire Health and Wellbeing Strategy, both in terms of its long-term ambitions and short-term priority areas.

WARWICKSHIRE HEALTH AND WELLBEING STRATEGY		
Healthy People	Strong Communities	Effective Services
Help our children and young people have the best start in life	Help people improve their mental health and wellbeing, particularly around prevention and early intervention in our communities	Reduce inequalities in health outcomes and the wider determinants of health

COVENTRY AND WARWICKSHIRE SUICIDE PREVENTION STRATEGY ***No-one in Coventry and Warwickshire should ever feel like suicide is their only option.***	
People have access to the information, support and services they need	People are confident to talk about suicide

Target our approach for those groups and communities at a higher risk of suicide	Increase awareness to help change public attitudes about suicide	Promote suicide prevention as a priority within the wider health and wellbeing activity of system partners (public, private, VCSE sectors)	Sharing learning and data to ensure that prevention activity is targeted in response to locally identified priorities	Facilitate coproduction, collaboration and coordination to maximise the impact of suicide prevention activity across C&W

1.17 A content only version of the final draft Strategy is attached as **Appendix 1**.

1.18 An outline Delivery Plan for the early phase implementation of the Strategy will be presented at the meeting. It is intended that the Delivery Plan will evolve over time to reflect the organisational and sectoral contributions of system partners.

2. Financial Implications

2.1 There are no capital implications related to the delivery of the Coventry and Warwickshire Suicide Prevention Strategy.

2.2 Warwickshire County Council has committed dedicated resource to the development and implementation of suicide prevention activity across Warwickshire. This includes the permanent employment of a Suicide Prevention and Partnership Manager (commenced September 2021).

2.3 A small project budget was also initially made available (by Warwickshire County Council) for the first 2 years to support the implementation and embedding of the new Suicide Prevention Strategy. This includes a dedicated allocation for suicide prevention activity across Coventry and Warwickshire for 2023-24.

2.4 There will be further resource implications across all partners to support ongoing suicide prevention activity where this cannot be absorbed into existing budgets or as part of ongoing activity. For example:

- Suicide awareness and prevention training
- Awareness campaigns and resources
- Service redesign or transformation
- Sustainability of Real Time Surveillance system
- Exploration of a local Suicide Review process

2.5 There are also opportunities to explore alternative funding streams to meet some of these costs, including: social value commitments, joint prevention

programmes (particularly around risk or causal factors) and external or national funding programme.

3. Environmental Implications

3.1 None.

4. Supporting Information

4.1 The most recent suicide data shows that the suicide rates in Warwickshire are currently 11.2 per 100,000 (2019-21). This represents a slight increase from the previous figures (9.2 per 100,000 for 2018-2020) The comparative figures for Coventry are 9.3 per 100,000 (2019-2021). For the same time frame, the West Midlands region and England as a whole, the figures are 10.7 and 10.4 respectively.

4.2 Whilst there is some variation in these rates between the district/boroughs within Warwickshire, the overall picture shows an increase in the suicide rate – which is higher than both the regional and national average.

4.3 Positively, this national data shows a decline in the overall suicide rate in Warwickshire since a peak in 2014-16 (12.2 per 100,00). It is however important to note that national figures are up to 2 years behind real time data at the point at which the data is reported.

4.4 To address this, it is critical that we can identify real time figures across Coventry and Warwickshire in order that we can respond to emerging trends or areas of concern in a timely manner.

4.5 A local Real Time Surveillance (RTS) system (for suspected suicides) was developed and as part of the NHSE funded suicide prevention programme, and the data collected through this process ensures we have access to weekly figures which are used to provide quarterly updates to system partners. Importantly this information also enables us to activate an immediate response if a potential cluster is identified.

4.6 In the current climate of financial uncertainty and societal challenges and the increased anxiety that this can cause, it is increasingly important that we are able to monitor any changes in suicide trends. This would include new or emerging trends in the demographic profile, location or method used and background circumstances of people who die by suicide.

4.7 Discussions are currently underway to identify long term funding to secure the future of this as an essential and ongoing part of the suicide prevention programme.

4.8 The existing National Suicide Prevention Strategy for England (‘Preventing suicide in England: A cross-government outcomes strategy to save lives’): identifies seven key areas for action. These are:

- Reducing the risk of suicide in key high-risk groups
- Tailor approaches to improve mental health in specific groups
- Reduce access to the means of suicide
- Provide better information and support to those bereaved or affected by suicide
- Support the media in delivering sensitive approaches to suicide and suicidal behaviour
- Support research, data collection and monitoring
- Reducing rates of self-harm as an indicator for suicide risk

4.9 A new National Plan for Suicide Prevention is currently in development and will outline the new national priorities. Coventry and Warwickshire are committed to supporting with the delivery of the new national strategy and will align to the national priorities within the local delivery plan, at the same time reflecting local needs across the area.

5. Timescales associated with the decision and next steps

5.1 Once endorsed by the Health and Wellbeing Boards, a final designed version of the Strategy will be presented to the Coventry and Warwickshire Integrated Health and Wellbeing Forum for information.

5.2 This will include a request to partners to consider their organisational contributions to suicide prevention and identify any governance routes for approving and sharing the Strategy.

5.3 It is proposed that the Coventry and Warwickshire Suicide Prevention Partnership hosts a multi-agency Suicide Prevention Conference in spring 2023. This will help shape the delivery plan and gain partnership support for the ongoing delivery and embedding of suicide prevention activity across Coventry and Warwickshire.

5.4 The Suicide Prevention Delivery Plan will be reviewed and refreshed every two years to reflect local circumstances and changes within the national guidance.

5.5 There are ongoing discussions to ensure that the Strategy is presented and available in a variety of formats to ensure it is accessible to the widest audience.

Appendices

1. Appendix 1: Coventry and Warwickshire Suicide Prevention Strategy 2023-2030

Background Papers

1. Equality Impact Assessment

	Name	Contact Information
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The report was circulated to the following members prior to publication:

Local Member(s): None
Other members: Cllr Jo Barker

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Coventry and Warwickshire
Suicide Prevention Strategy 2023 – 2030

…the world is better with you in it.

No-one in Coventry and Warwickshire should ever feel like suicide is their only option.

Contents

Foreword

To be added:

- signed by portfolio holders for C&W (or H&WB Board chairs)

Coventry Health and Wellbeing Board
Coventry
Cllr Kamran Caan, Public Health and Sport
Cllr Patricia Seaman, Children and Young People

Warwickshire Health and Wellbeing Board
Warwickshire
Cllr Margaret Bell, Adult Social Care and Health
Cllr Jeff Morgan, Children, Families and Education

Introduction

"I lived with a fun guy at university, he was always laughing and messing about and was from a rich family. A year after we left university I found out he died by suicide."

Why is a suicide prevention strategy important?

Every life lost to suicide is a life lost too soon.

Deaths by suicide have complex causes and are rarely due to a single event, but a culmination of factors that may lead to someone feeling hopeless and unable to change their circumstances, with death seen as the only way to end suffering. We are all potentially susceptible to suicidal thoughts, but in the past stigma around mental ill-health and suicide has contributed to a lack of discussion at a societal level and, importantly, preventing people from speaking up and seeking support when it is most needed. It is therefore imperative to normalise talking about mental health and to give individuals the knowledge, skills and confidence to talk about suicide and improve awareness of preventative approaches and support available.

A single death by suicide has a devastating impact on those closest to the individual, as well as wider reaching impacts on members of the community who are affected by the distressing news of such a death of someone they knew. It has been estimated that 15-30 people are directly and severely impacted by a single death by suicide, and around 135 people affected by each death[1]. This broad impact on communities from a single death highlights the need for a shared health approach to preventing and responding to deaths by suicide.

Finally, deaths by suicide contribute to population level life-expectancy figures, given deaths at younger age-groups have a greater impact on this population level indicator of health outcomes, a strategic driver to prioritising suicide prevention activity.

A new national plan for suicide prevention

As part of the development of a new national plan for suicide prevention, Coventry and Warwickshire submitted a joint response to the Government's Call for Evidence to inform longer-term priorities for mental health, wellbeing and suicide prevention. The Call for Evidence closed in July 2022 and a new long-term plan will set out priorities for suicide prevention at a national level. Coventry and Warwickshire are committed to supporting with the delivery of the new national strategy and will align to the national priorities within the local delivery plan, at the same time recognising that there are local needs across the area.

[1] Cerel et. al. 2019 How many people are exposed to suicide? Not Six. Suicide and Life-threatening Behaviour, 49(2), 529-534

A strategy for Coventry and Warwickshire

The Health and Wellbeing Strategies for both Coventry and Warwickshire identify priorities around improving mental health and wellbeing. The Coventry and Warwickshire Suicide Prevention Strategy 2023-2030 is part of the delivery of these priorities. Whilst Coventry and Warwickshire have previously had separate suicide prevention strategies to set out the vision and approach in both areas, the success of the NHSE funded programme and the outcomes of the Mental Health JSNA have demonstrated the need for partnership working when developing a local approach to suicide prevention. This new single Strategy will build on the previous work and ensure that suicide prevention activity is embedded and prioritised across the system. This approach requires ongoing collaboration through the Suicide Prevention Partnership with system wide commitment to the resources and implementation required for the ongoing delivery of a local suicide prevention work programme. There will be elements of the work programme that will be coproduced to utilise key experience, knowledge and skills from a range of stakeholders, including those with lived experience.

The Coventry and Warwickshire Suicide Prevention Strategy is an all-age strategy and is intended to be relevant across the whole life course of an individual or population. The Strategy also represents the principle that preventing suicide is everyone's business.

Long term strategy: (2023-2030)	Coventry and Warwickshire take a zero-suicide approach, with the aim **to reduce the rate of suicide across the local area**. Vision: **to ensure that no one in Coventry and Warwickshire ever feels that suicide is their only option.** Strategic ambitions: **1) People have access to the information, support and services they need** **2) People are confident to talk about suicide**
Early phase delivery: (2023-2025)	Local priorities for 2023-2025: • **target our approach for those groups and communities at a higher risk of suicide** • **increase awareness to help change public attitudes about suicide** • **promote suicide prevention as a priority within the wider health and wellbeing activity of system partners (public, private, VCSE sectors)** • **sharing learning and data to ensure that prevention activity is targeted in response to locally identified priorities**

	• **facilitate coproduction, collaboration and coordination to maximise the impact of suicide prevention activity across Coventry and Warwickshire**

The national and local picture: what the data tells us

Suicide: what we know

- on an average day in the UK, someone dies by suicide every 90 minutes (Samaritans).
- A death by suicide impacts approximately 135 people
- 74% of deaths by suicide are male (Office for National Statistics, ONS 2018)
- Suicide is the biggest killer of under 35s in the UK (ONS 2018)
- Around a third of people who die by suicide have had no contact with mental health or primary care services before their death (*A third of people who die through suicide have been in contact with mental health services before their death, a further third have been in contact with primary care services but the remaining third have had no contact with services. Young men are the most likely to be among the third with no contact with services before their death).*

National guidance identifies a number of factors that can influence the risk of suicide.

Specific factors that increase the risk of suicide:

- Strongest identified predictor of suicide is previous episodes of self-harm
- Mental ill health and substance misuse also contribute to many suicides
- Individuals bereaved by suicide are at increased risk of suicide (also increased risk of suicidal ideation, depression, psychiatric admissions as well as poor social functioning).

One of the priorities within the current Suicide Prevention Strategy for England, is for all local strategies to deliver work to reduce the risk of suicide among the following high-risk groups:

- Men
- People who self-harm
- People who misuse alcohol and drugs
- People in the care of mental health services
- People in contact with the criminal justice systems
- Specific occupational groups (eg. doctors, nurses, veterinary workers, farmers and agricultural workers).

These groups are identified as those where the suicide rate is high and there is a known statistically significant increased risk of death by suicide.

Men remain the highest risk group with a range of factors associated with suicide that are particularly common in males, including: depression (especially untreated or undiagnosed), alcohol and drug misuse, unemployment, family and relationship problems, social isolation and low self-esteem.

Additional vulnerable groups include

- People in financial difficulty or struggling with debt
- Autistic people
- People addicted to gambling
- Women experiencing poor perinatal mental health
- LGBTQ+ individuals

People in the lowest socio-economic group and living in the most deprived geographical areas are 10 times more at risk of suicide than those in the highest socio-economic group living in the most affluent areas.

Local data: trends in suicide rates

The following graphs illustrate the trends in suicide figures in Coventry and Warwickshire over the last 20 years.

Source: Public health profiles - OHID (phe.org.uk)

Coventry and Warwickshire suicide rates compared to England, 2001-2021

Time period	Coventry	Warwickshire	England
2019-21	9.3	11.2	10.4
2018-20	10.0	9.2	10.4
2017-19	10.6	9.4	10.1
2016-18	8.6	10.1	9.6
2015-17	8.8	11.3	9.6
2014-16	8.4	12.2	9.9
2013-15	10.1	11.8	10.1
2012-14	10.1	11.6	10.0
2011-13	11.2	10.4	9.8

2010-12	11.4	10.8	9.5
2009-11	13.0	9.7	9.5
2008-10	12.3	10.0	9.4
2007-09	11.7	8.9	9.3
2006-08	10.2	8.7	9.2
2005-07	11.0	6.8	9.4
2004-06	11.9	7.7	9.8
2003-05	11.0	7.9	10.1
2002-04	9.0	9.2	10.2
2001-03	9.1	10.2	10.3

Source: Suicide prevention profiles, OHID, fingertips, 2022

Significantly worse than the England figure

Significantly better than the England figure

Local data: the current picture

Between January 2021 and September 2022, 111 deaths were concluded as a death by suicide by the Coventry and Warwickshire Coroner. An analysis of these deaths in October 2022 provided the following findings*

*(these figures do not reflect total number of suspected suicides during this period as not all deaths have been heard at inquest).

Demographics of the 111 Coventry and Warwickshire deaths by suicide 2021-2022

Figures contained in infographics relating to real time suicide data from the Coventry and Warwickshire coroner have been subject to disclosure control methodology to avoid the identification of individuals (see Appendix 1). Numbers are rounded to the nearest 5, those between 1 to 7 inclusive are marked *. Numbers may not, therefore, sum to total deaths.

Gender

Male 85

Female 25

Age

13 – 25	10
26 – 45	40
45 – 64	40
65+	25

Marital status

Single	55
Married	30
Divorced	20
Widowed	*

Employment status

Employed	65
Retired	20
Student/employed	10
Self-employed	*
Unemployed	15

Incident location *(may differ to where individual died)

Type of location	Number of deaths
Home	75
Park	*
Railway	*
Woodland	*
Road	*
Other (eg. hotel, place of employment, hospital)	10

Method of death

Hanging	65
Asphyxiation	10
Overdose	10
Railway	*
Fire	*
Self-poisoning	*
Drowning	*
Jump from a height	*
Self-inflicted wound	*
Other (including gunshot wounds and unascertainable methods of death)	*

- Presentation of above – group by place
    - Group 1
        - Hanging
    - Group 2 – Location Specific
        - Railway
        - Drowning
        - Jump from a height

    Group 3

    - Asphyxiation
    - Overdose
    - Fire
    - Self-poisoning
    - Self-inflicted wound
    - Other (including gunshot wounds and unascertainable methods of death)

Due to the geography of Warwickshire, with 5 district/borough areas, the following map illustrates the usual place of residence of the 66 Warwickshire residents.

District/ borough of usual place of residence

DISTRICT OR BOROUGH	NUMBER OF INDIVIDUALS
COVENTRY	35
NORTH WARWICKSHIRE	*
NUNEATON AND BEDWORTH	20
RUGBY	10
STRATFORD	15
WARWICK	20
OUT OF AREA	10

Risk factors evident*

Known risk factors for death by suicide include:

- A previous attempt/a history of self-harm, particularly if the method used was an overdose.
- A diagnosis of depression or anxiety with the strongest risk being attached to people with both depression and anxiety
- Individuals who use illicit substances (drug use is typically around 27% of the population according to real-time surveillance (RTS) data, compared to 8% of the general population according to OHID estimates).
- Chronic pain or long-term conditions
- Relationship breakdown: not just romantic relationships but any relationship breakdown
- Individuals with a history of domestic abuse, whether as a victim, perpetrator, or witness are at increased risk of death by suicide.
- Bereavement
- Financial hardship

*The data here is taken from coronial records so is limited to available data. It is unlikely that the risk factors outlined above are the true extent of risk factors experienced for individuals who die by suicide.

Deprivation

Reflecting on the current national economic climate and the links identified between suicide and financial circumstances the following maps illustrate the relative levels of deprivation across Coventry and Warwickshire using the Index of Multiple Deprivation. This allows users to identify the most and least deprived areas in England and to compare whether one area is more deprived than another. An area has a higher deprivation score than another if there is a higher proportion of people living there who are classed as deprived. However, it is important to note that a geographical area itself is not deprived: it is the circumstances and lifestyles of the people living there that affect its deprivation score. Not everyone living in a deprived area is deprived, and that not all people experiencing deprivation live in deprived areas. The following maps show the areas in Coventry and Warwickshire (by Lower Super Output Areas) ranked from the most to the least deprived. In Coventry, the data shows particular areas of deprivation from the city centre into the North East of the city, as well as in the South East and pockets in the South West. In Warwickshire, there are particular areas of deprivation around North Warwickshire, Nuneaton and Bedworth, and Rugby.

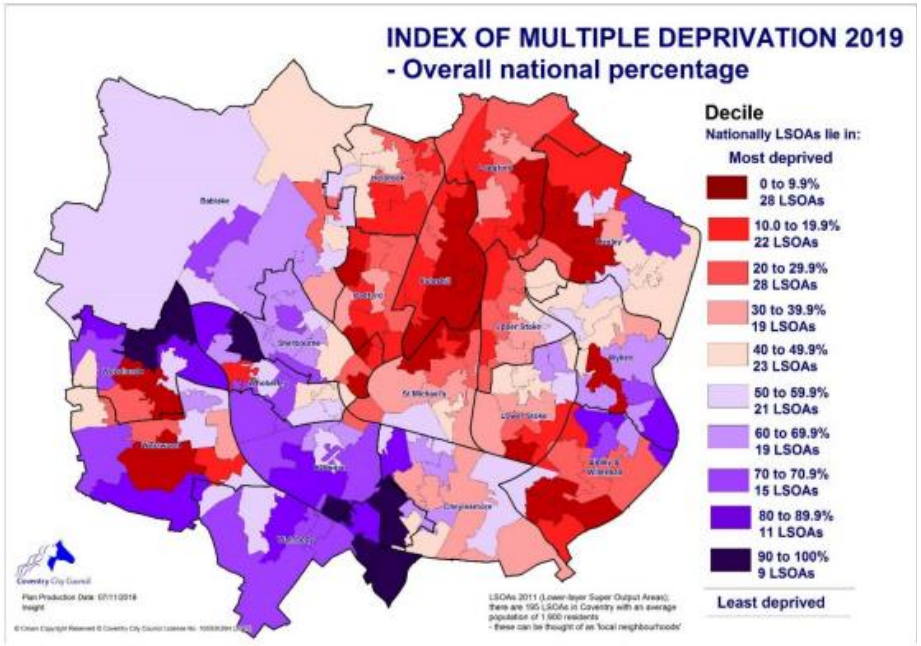


Figure: Coventry LSOAs by deprivation decile
Source: Index of Multiple Deprivation 2019

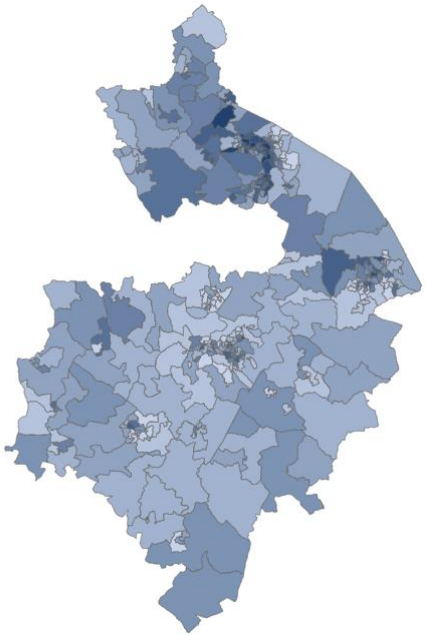


Figure: Warwickshire LSOAs by deprivation decile
Source: Index of Multiple Deprivation 2019

Our approach: starting with strengths

"My boyfriend's dad died by suicide, we were 16 years old at the time. He didn't know anything was wrong with his dad."

Where are now (and how did we get here)

In 2018 the Coventry and Warwickshire system partnership received funding through the NHS England National Suicide Prevention Programme. As an area with higher than average suicide rates at the time, Coventry and Warwickshire was one of the first areas to receive this additional funding to develop suicide prevention and reduction schemes. The programme ran from 2018-2021 and resulted in a partnership action plan which was delivered across the duration of the programme and has provided much of the suicide prevention infrastructure still in place today.

In 2021, a Coventry and Warwickshire Joint Strategic Needs Assessment (JSNA) focussing on Adult Mental Health and Wellbeing was also undertaken. As a result of this, a series of recommendations were made in relation to suicide prevention activity across Coventry and Warwickshire and these have provided the basis for this new strategy.

In 2023, a Warwickshire Mental Health and Wellbeing of Infants, Children and Young People JSNA will be published. This will also help inform future actions relevant to suicide prevention specifically in relation to Coventry and Warwickshire's younger population.

Continuing the legacy

In order to achieve the long-term ambitions for suicide prevention, this strategy aims to develop the infrastructure that has already been established.

Some of the key successes to date across Coventry and Warwickshire are outlined below. We will continue to develop and build on these as part of our ongoing work programme.

- **Dear Life website**
  Dear Life is the local online suicide prevention platform for Coventry and Warwickshire. Initially developed as part of the NHSE funded suicide prevention programme, it was co-produced by local stakeholders including both service providers and people with lived experience. The site offers advice, information and support to those individuals experiencing suicidal crisis or ideation as well as the people who are supporting them. The site is now hosted by Coventry and Warwickshire Partnership Trust and continues to be developed as a key part of the Coventry and Warwickshire suicide prevention work programme.

- **Training the frontline**
  Ensuring that people working on the frontline – whether in paid roles in the public sector, emergency services, voluntary and community sector, or as volunteers supporting groups or individuals – are equipped to support people at risk of suicide or expressing suicide ideation remains a key priority. Two separate Suicide Prevention Gatekeeper Training programmes have been delivered, offering free targeted training for frontline workers. As well as increasing general awareness and providing the necessary knowledge and tools, the aim of the training has been to create a network of suicide prevention gatekeepers who can share their learning and good practice within their workplaces (and beyond). This "community of practice" will help build resilience within the workforce and wider community. There has also been promotion of other suicide awareness and prevention training aimed at whole workforce groups as well as the general population. This includes national on-line training packages, funded suicide prevention sessions and local awareness campaigns.

- **Effective partnership working**
  The commitment to develop and deliver a suicide prevention work programme is demonstrated by the Coventry and Warwickshire Suicide Prevention Partnership. This provides the multi-agency mechanism for working together, contributing to the vision and ambitions of the Coventry and Warwickshire Suicide Prevention Strategy. The Multi Agency Network enables joint working, information sharing and networking. The Learning Panel ensures partners have access to real time information about emerging trends and can develop collective responses when needed. The Steering Group provides leadership, expertise and accountability for the wider partnership. There are also a number of other related strategies, programmes of work and services that complement the suicide prevention agenda and it is recognised that this Strategy is not being delivered in isolation from the wider health, social care and community safety system.

- **Targeting high risk groups**
  Men, children and young people, people who self-harm and those bereaved by suicide remain a key focus for suicide prevention activity both nationally and locally. Evidence also shows that some population groups are at higher risk of dying by suicide, in particular those people who are from groups who may feel marginalised or struggle to access the support they need. This can include individuals, specific population groups or specific job roles and professions. Targeted interventions and addressing inequalities with these groups as early as possible are key to preventing escalation to crisis. Activity undertaken to date, includes: mobilisation of the local suicide bereavement support service, Amparo; and development of a new and targeted Self Harm Policy for educational settings across Coventry and Warwickshire. A proposal to ensure that the voice of people with lived experience is embedded in the development of the Coventry and Warwickshire Suicide Prevention Delivery Plan is also in progress.

- **Prevention and tackling risk factors**
  A recognition of the underlying causes that can lead to suicidal crisis is fundamental to preventing people finding themselves in a situation that they can see no way out of. Working together with partners and providers who tackle known suicide risk factors remains a priority. This includes identifying opportunities to align prevention activity across different workstreams, including: domestic abuse, serious violence, drugs and alcohol, armed forces community, and gambling and financial inclusion.

- **Service provision**
  There are a number of services that have been commissioned or that are being delivered that contribute to the overall aim and ambitions of this Strategy. In particular, those that focus on early help and prevention have a significant role to play in preventing the escalation of individuals to reaching crisis point. As part of the wider system these services will contribute to the overall aim of reducing the rate of suicide across Coventry and Warwickshire.

- **Response to external societal factors**
  The covid pandemic, health and social inequalities, deprivation, financial vulnerability and economic uncertainty can all impact on the mental health and wellbeing of communities. Although unpredictable and often difficult to quantify, anecdotally there is a suspected link between these factors and increased suicide ideation, self-harm, poorer mental health, and negative lifestyle behaviours. In addition, such factors can also lead to isolation, bereavement, financial hardship and trauma – all of which are known suicide risk factors. In some instances, there may be a delay in realising the impact on suicide rates as a result of these circumstances, making access to real time suspected suicide data even more important. The ability to respond to these issues as they arise remains a key part of the local approach to suicide prevention.

Real Time Surveillance

Critical for the successful delivery of the Suicide Prevention Strategy is the continued development of the Coventry and Warwickshire Real Time Surveillance System. Initially developed as part of the NHSE funded programme, the current system continues to evolve with 3 distinct functions to ensure the availability, analysis and response to real time suspected suicide data.

1. <u>Coordination</u>

To provide oversight and analysis of local suspected suicide data, Coventry and Warwickshire have appointed a Real Time Surveillance Co-ordinator. This is a coroner-led function across both Coventry and Warwickshire and has been in place since January 2021. This enables early identification of suspected suicides in advance of the Coroner's conclusion at inquest. The real time

surveillance data ensures timely data collection and analysis which is shared initially with Public Health teams in Coventry and Warwickshire, and then more widely with relevant partners. This allows the system to identify any emerging trends or patterns in the data and respond accordingly, which is key to ensure the most effective intervention.

Learning Panels are held on a quarterly basis to share the data captured with colleagues working as part of the suicide prevention programme. The Panels provide the opportunity to share learning and facilitate discussion around prevention work in response to local trends. In addition, monthly insight meetings are scheduled to enable more focussed discussion around emerging trends or to consider the need for review and discussion of deaths which may require further action due to the increased risk of cluster or contagion.

The coordination role is key to the ongoing development of the response and review process for suspected suicides, providing the data and analysis required to ensure that the learning from both suspected and confirmed suicides is available to help prevent further deaths by suicide.

2. Data Management

To help manage the data collection and analysis process, a data management system is used by the Co-ordinator. This assists with the effective analysis of the data and facilitates the opportunity for multi-agency collaboration for the sharing of data, intelligence and learning.

The current system enables real time collection of suspected suicides. Future ambitions include aligning the real time collection of other related data, including drug related other preventable deaths. Longer term aspirations include capturing data on suicide ideation, suicide attempts and incidents of self-harm.

3. Suicide Bereavement Support

In September 2021 Listening Ear was jointly commissioned to deliver the Amparo postvention service across Coventry and Warwickshire. Postvention refers to specialist support for people bereaved by suicide (family, friends, professionals and peers) and reflects the NHS Long Term Plan commitment. This all-age service provides postvention bereavement support is currently funded until September 2024 and is available to those who have been impacted by suicide in the Coventry and Warwickshire, including proactively contacting the bereaved family within 72 hours, offering short and long term emotional and practical support, and referring to specialist services if needed. Individuals can be referred to Amparo at any point following bereavement and they will receive support to meet their needs.

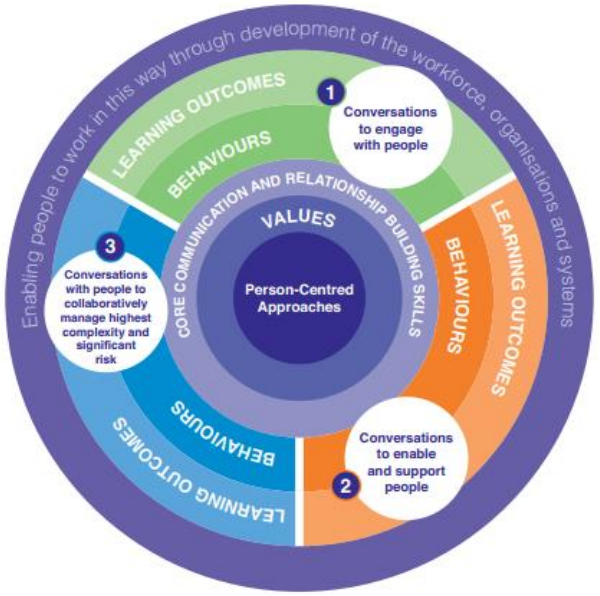
Our approach: what matters to people

"For a time the only thoughts that gave me comfort were thoughts of ending my life. I was coming to terms with a diagnosis of bipolar disorder, no-one understood what it was like to go through this, everyone else was getting on with their lives."

An individual response

The strategy aims to ensure that all individuals who are in crisis or at risk of ending their life, will experience a person-centred approach when accessing support across Coventry and Warwickshire.

Individuals accessing support and services should feel safe, experience a non-judgemental interaction and receive an intervention that is based on trust and respect.



A person-centred approach focusses on the needs of an individual, ensuring that their preferences, needs and values guide clinical decisions. In turn, this ensures that the care and support provided is respectful of and responsive to their individual circumstances.

No two individuals are the same and every suicide is unique. Where someone is in crisis or is at risk of ending their own life, they should expect to be supported and treated as an individual.

Recognition of their specific needs and experiences should be taken into account. The impact of past and present experiences, including trauma, bereavement or mental health is recognised and acknowledged in the support provided. Plans to manage the risks presented should be tailored to reflect these circumstances to ensure they are appropriate to the individual.

Coproduction is an essential part of developing this approach, ensuring that the voices of those individuals requiring support helps shape the type and delivery of support available.

Our approach: a public health response

"On Christmas Eve my brother-in-law told us he wanted to end his life, he said we would all be better off without him, nothing we said seemed to make a difference to his thoughts. None of us as his close family saw this coming, or knew what to do."

What is the public health approach to suicide prevention?

- Suicide is preventable not inevitable
- Prevention is at the core with a focus on causal factors
- Public health is everyone's business – suicide prevention is everyone's business
- Focused on generating long term as well as short term solutions underpinned by public health and partner outcomes
- Informed by local needs assessment with a focus on inequalities
- Rooted in evidence of effectiveness to tackle problems
- Working in and with communities
- Not constrained by organisational and professional boundaries

A population response

Taking a population wide approach to suicide prevention means not only focusing on support for people at crisis point, but also earlier action to reduce the risk factors that contribute to poor mental health and risk of suicide, and even earlier to promote positive wellbeing and coping strategies among population groups at higher risk of poor mental health.

Important risk factors include financial or housing insecurity, relationship breakdown, loneliness and isolation, living with chronic pain, having previously lost a loved one by suicide, substance misuse, living with a mental health condition such as depression, or having recent contact with the criminal justice system. Evidence also shows that some population groups are at higher risk of dying by suicide. These include people from groups who may feel marginalised or struggle to access the support they need. People going through significant life transitions such as teens and young adults, young and new mothers and middle-aged men can also be at higher risk of suicide.

Action on the breadth of factors contributing to risk of suicide requires a "population health approach" to be taken and the consideration of the range of factors that contribute to overall health and wellbeing. This requires all parts of society taking steps to reduce deaths by suicide. Through this approach we aim to harness the power of the public sector, those working in the voluntary and community sector, and residents themselves in a collaborative approach to making our communities and services suicide safer.

Finally, taking a public health approach means ensuring actions are informed by data and evidence. The Real Time Surveillance system for deaths by suspected suicide in Coventry and Warwickshire strengthens our ability to identify and react to changes in patterns of deaths or risk factors in a timely manner. This will inform the local suicide response plan enabling timely identification of possible clusters and preventing further contagion.

Embedding suicide prevention: promoting positive action

Tackling risk and building resilience: the Strategy recognises the impact that different circumstances can have on an individual. The table below outlines some of the circumstances that can increase suicide risk, as well as those that act as protective factors. These risk and protective factors will inform the ongoing suicide prevention work programme and be considered as part of the delivery planning process. These factors should be considered across the whole life course, with a recognition that the impact of these factors will differ between individuals and at different times.

RISK FACTORS		PROTECTIVE FACTORS
• Previous suicide attempt • History of depression and other mental illnesses • Serious illness such as chronic pain • Criminal/legal problems • Job/financial problems or loss • Impulsive or aggressive tendencies • Substance misuse • Current or prior history of adverse childhood experiences • Sense of hopelessness • Violence victimisation and/or perpetration	INDIVIDUAL personal factors	• Effective coping and problem-solving skills • Reasons for living (for example, family, friends, pets, etc.) • Strong sense of cultural identity

• Bullying • Family/loved one's history of suicide • Loss of relationships • High conflict or violent relationships • Social isolation	RELATIONSHIP harmful and hurtful or healthy relationship experiences	• Support from partners, friends, and family • Supportive environments • Feeling connected to others
• Lack of access to healthcare • Suicide cluster in the community • Stress of acculturation • Community violence • Historical trauma • Discrimination	COMMUNITY challenging issues or supportive experiences	• Feeling connected to school, community, and other social institutions • Supportive environment • Availability of consistent and high quality physical and behavioural healthcare
• Stigma associated with help-seeking, and mental illness • Easy access to lethal means of suicide among people at risk • Harmful media messaging around suicide	SOCIETY cultural and environmental factors	• Reduced access to lethal means of suicide among people at risk • Suicide and mental health awareness Cultural, religious, or moral objections to suicide

The three pillars of prevention: there are many factors that can influence mental health and whilst it isn't possible to stop all mental ill-health from developing, the right approach can help prevent many mental health problems. The Strategy recognises the need to address the causes of poor mental wellbeing and suicidal crisis as well as improving access to services and treatment for ongoing mental ill health. This can be summarised as follows:

- **Primary Prevention:** stopping mental health problems before they start (tackling the causes) – targeting whole population and benefitting everyone in a community
- **Secondary Prevention:** supporting those at higher risk of experiencing suicide ideation or crisis (early intervention / immediate action) – aimed at groups and individuals at a higher risk due to circumstance and/or experience
- **Tertiary Prevention:** helping people with severe mental illness or complex needs (services) – supporting vulnerable individuals requiring long term support and care

A holistic approach: the Strategy promotes a holistic approach to suicide prevention which supports a suicide aware society. This responsibility lies with individuals, family and friends, local communities and workplaces, and the wider society and services.

The table below illustrates some examples across Coventry and Warwickshire:

RESPONSIBILITY	GOAL	C&W ACTIVITY
INDIVIDUALS	• Awareness of signs and risk of suicide • Awareness of impact of changes through the life course	• Data from real time surveillance for risk factors • C&W support services; perinatal mental health, CYP, adults, older adults
FAMILY AND FRIENDS	• Information and support available to those impacted by suicide • Encourage to talk and seek support • Response to concerns • Supportive networks	• C&W Postvention Bereavement Service – Listening Ear • Local targeted campaigns e.g. world suicide prevention day, wellbeing for life • Signposting for all ages to services • Dear Life website and resources
COMMUNITY AND WORKPLACE	• Resilient and supported workforce • Boost positive mental health and emotional wellbeing • Trained frontline services across all sectors • Increased awareness • Supportive environment	• Mental Health First Aid training • Workplace wellbeing forums • C&W Mental Health JSNA 2021 • Wellbeing 4 Life programme • Suicide awareness/prevention training • Thrive at Work programme • Community networks
SOCIETY AND SERVICES	• Support relevant commissioning of support services • Appropriate pathways to access support • Reducing stigma of suicide • Tackling health inequalities	• Mapping of existing services to ensure appropriate referral pathways • Local awareness raising campaign • Accessing relevant funding to support suicide prevention work

Children and Young People: specific consideration will be given to the needs of and support to children and young people. This will include further work in relation to the:

- levels of self-harm (particularly among teenage girls),
- impact of the pandemic and how this has affected the social and emotional development of younger people, including the local student population.
- significant transition phases during the life course of children and young people, from the very early years (including the perinatal period) right through to early adulthood (including students, those that enter the workforce and those moving from children to adult mental health services)

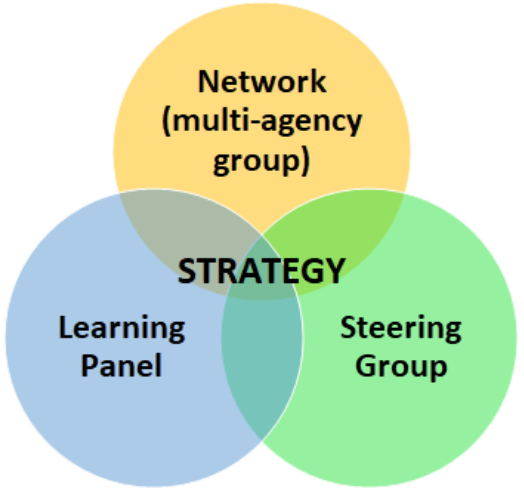
The findings of the Mental Health and Wellbeing of Infants, Children and Young People Joint Strategic Needs Assessment for Warwickshire (due to be published 2023) will help inform a programme of work specifically targeted at Coventry and Warwickshire's younger population.

"Nearly half of 17-19 year-olds with a diagnosable mental health disorder have self-harmed or attempted suicide at some point, rising to 52.7% for young women." Young Minds 2022

Our approach: partnership and engagement

Coventry and Warwickshire Suicide Prevention Partnership

The Coventry and Warwickshire Suicide Prevention Partnership is made up of organisations, groups, communities and individuals from across Coventry and Warwickshire, who collectively support the vision that no one in Coventry and Warwickshire will ever feel that suicide is their only option.



The Partnership is broadly made up of three distinct functions, which together form the basis for the delivery of the Coventry and Warwickshire Suicide Prevention Strategy. The Partnership sits within the wider context of the Coventry and Warwickshire Integrated Care System (ICS) and the desire for a comprehensive approach to suicide prevention across system partners is reflected in the Coventry and Warwickshire Integrated Care Strategy.

This Strategy will help the System and all partners across Coventry and Warwickshire to embed suicide prevention within their priorities and workstreams.

Stakeholder engagement…and what it has told us

Local strategic partnerships: a number of local partnership boards were engaged with developing the vision and approach for the Suicide Prevention strategy. Key outcomes were:

- There is commitment across the system for embedding suicide prevention activity
- There is priority at place around the mental and emotional wellbeing of communities
- There are key themes which may require a priority focus for suicide prevention

Stakeholder workshops: Through a series of workshops, feedback from local organisations and services told us that our approach to suicide prevention across Coventry and Warwickshire needs to:

- have clear and consistent messaging
- raise awareness of suicide prevention within communities and organisations
- ensure that people know where to go for the right support at the right time
- understand and reflect the reasons that may lead to suicide or suicidal thought
- be relevant to all ages and different communities and population groups
- target people and groups at higher risk of suicide
- involve people with lived experience
- provide support to the people who are working with or caring for people who self harm or are at risk of suicide
- use the knowledge and experience of existing networks and groups to share best practice
- enable the sharing of information to support better joint working and coordination of service delivery
- focus on prevention and early intervention to support the emotional wellbeing of people

Public engagement survey: This engagement process concluded that the strategic vision and priorities were largely consistent with what respondents felt was needed. There was an emphasis on societal risk factors and prevention at the earliest opportunity. Where there was disagreement or alternative suggestions put forward, this will be picked up through the delivery planning process. Where appropriate, the feedback from the public engagement survey will be reflected in the suicide prevention work programme, with specific actions developed in response to this.

Specific themes were identified in relation to:

- The need for early intervention and support before crisis is reached
- Ensuring that individual needs are at the centre of any intervention, particularly at crisis point
- Tackling risk factors that might be a causal factor for suicide
- Taking a holistic approach that takes account of the individual and complex nature of suicidal crisis and ideation
- Coproduction and ensuring that lived experience forms the basis of suicide prevention activity
- Funding, service capacity and joined up working locally
- Increasing awareness of suicide so that people are better to equipped to identify and support individuals in suicidal crisis
- Improving the general wellbeing and resilience of individuals and communities

Of those that responded, approximately 70% had been impacted by suicide.

Delivering the Strategy: what are we going to do

"Doing suicide prevention training helped me understand how to spot and manage the risks of suicide in individuals. Whilst this helped me in my work, it is at home where I have applied it most. I live with someone who experiences suicidal thoughts at times. After the training I feel more confident discussing these feelings with my loved one and better able to judge if there is intent to act when these thoughts are expressed".

Local priorities for Coventry and Warwickshire

To bring about the partnerships and transformation required to realise our vision for this strategy five key local priorities have been identified to focus on in the first instance. To have the greatest impact these priorities must be pursued together and build upon the wealth of the good practice already in place. Together these priorities will support the delivery of our long-term strategic ambitions.

LOCAL PRIORITIES (WHAT)	AIM (WHY)
Target our approach for those groups and communities at a higher risk of suicide	*Reducing inequality and addressing gaps*
Increase awareness to help change public attitudes about suicide	*Working towards suicide safer communities*
Promote suicide prevention as a priority within the wider health and wellbeing activity of system partners (public, private, VCSE sectors)	*Influencing workplace practices*
Provide real time data to ensure that prevention activity is targeted in response to locally identified priorities	*Sharing data and learning*
Facilitate coproduction, collaboration and coordination to maximise the impact of suicide prevention activity across Coventry and Warwickshire	*Maintaining effective partnerships*

A two-year delivery plan will be developed by the Suicide Prevention Partnership to deliver on these local priorities. This will include a series of measures to determine the impact of what is being delivered through Task and Finish Groups and wider organisational contributions.

Accountability

The Coventry and Warwickshire Suicide Prevention Strategy is accountable to the two local Health and Wellbeing Boards in Coventry and Warwickshire. The Strategy forms part of the delivery of the wider Health and Wellbeing Strategies for both areas.

The Health and Wellbeing Boards will monitor the Suicide Prevention Delivery Plan, with progress and impact reported on an annual basis to Coventry and Warwickshire Integrated Health and Wellbeing Forum.

Highlight reports will also be presented to other appropriate local strategic boards to ensure the suicide prevention programme is reflected in and aligned to other work stream areas and themes, including:

- Safeguarding
- Community safety
- Mental health and wellbeing
- Social Inequalities
- Children and young people
- Loneliness and social isolation
- Health and social care

Ownership and delivery partners

The Strategy and ongoing delivery of the work programme is led and overseen by the Coventry City Council and Warwickshire County Council Public Health Teams on behalf of the Coventry and Warwickshire Suicide Prevention Partnership.

The Strategy itself has been created in collaboration with: partners of the Integrated Care System, members of the Suicide Prevention Partnership, Voluntary and Community Sector stakeholders, residents and elected representatives from across Coventry and Warwickshire.

With special thanks to:

References and sources

To add…

APPENDIX 1

Number Suppression Approach Used (if required)

While disclosure control is not required as mortality data used is classified as 'discoverable' by ONS, ie they can be obtained from individual death certificates, some data is derived from the real time surveillance service and so not all data will be available on the death certificates at time of publication therefore the following steps are applied to reduce the risk of identifying individuals from small numbers based on NHS Digital Guidance - https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/hospital-episode-statistics/change-to-disclosure-control-methodology-for-hes-and-ecds-from-september-2018

a. Counts between 1 and 7 (inclusive) will be displayed as '*'.

b. Zeroes will be unchanged.

c. All other counts will be rounded to the nearest 5.

Numbers1 to 13 will therefore appear as follows, all other numbers will be rounded to the nearest 5.

Before disclosure control	0	1	2	3	4	5	6	7	8	9	10	11	12	13
After disclosure control	0	*	*	*	*	*	*	*	10	10	10	10	10	15

Agenda Item 7

Health and Wellbeing Board

11 January 2023

JSNA Prioritisation Programme

Recommendations

That the Health and Wellbeing Board

1. Approves the outlined proposed thematic Joint Strategic Needs Assessment (JSNA) workplan for October 2022 – November 2024; and

2. Supports the development of future needs assessments through promoting the work of the JSNA and supporting the established partnership approach to producing the JSNA between Health and Wellbeing Board Members.

1. Executive Summary

1.1 This paper provides an overview of the JSNA Prioritisation Process undertaken to establish a new workplan for 2023/24.

1.2 The JSNA seeks to analyse current and future wellbeing needs of the local population to inform the commissioning of health, wellbeing, and social care services. The JSNA aims to establish a shared, evidence-based consensus on the key local priorities across health and social care by bringing together key partners and stakeholders from across the system to give interpretation, provide insight, and ultimately inform decision making. This information enables the prioritising of resources, redesigning services and the commissioning and decommissioning of services that will improve outcomes for Warwickshire's residents.

1.3 Since 2013 the production of JSNAs has been a statutory responsibility of each local authority's Health and Wellbeing Board. It is each Health and Wellbeing Board's responsibility to decide what approach their JSNA will take in order to best understand their population.

1.4 A JSNA Strategic Group sits under the Health and Wellbeing Board to provide leadership, strategic guidance, and direction to the JSNA work programme, identifying clear priorities and championing the work of Warwickshire's JSNA and wider needs assessment activity. The JSNA Strategic Group has representation from the following organisations:

- Warwickshire Community and Voluntary Action (CAVA)

- NHS Coventry and Warwickshire Integrated Care Board (ICB)
- University Hospitals Coventry and Warwickshire NHS Trust (UHCW)
- George Eliot Hospital NHS Trust (GEH)
- South Warwickshire University NHS Foundation Trust (SWFT)
- Healthwatch
- North Warwickshire Borough Council
- Nuneaton and Bedworth Borough Council
- Rugby Borough Council
- Stratford-on-Avon District Council
- Warwick District Council
- Warwickshire County Council
- Warwickshire & West Midlands Association of Local Councils (WALC)

1.5 The process is formed of the following steps:

(Imagine alternative text – flow diagram showing the stages of the prioritisation process as follows: Long List Collection, Completion of Population Prioritisation Using a Matrix, Working Group Discussion, Strategic Group Sign Off, and Health and Wellbeing Board Approval).

1.6 The prioritisation process commenced in July with a long list of needs assessments proposed by members of the JSNA Strategic Group and other key stakeholders such as the Joint Commissioning Board. The list was as follows:

- People who provide informal care
- People with dementia
- People with a disability
- Children at risk of exploitation
- Children and young people experiencing homelessness
- People aged 65+
- People who are obese
- Children and young people aged 6-25's physical health
- People who identify as LGBTQ+

1.7 Lead stakeholders were identified for each of the topics listed above to join the Business Intelligence Lead and JSNA Programme Manager in the completion of a prioritisation matrix for each of the proposed populations.

1.8 Following the completion of the prioritisation matrices, a proposed workplan was produced which was then taken to the JSNA Prioritisation Working Group for agreement. The group was formed of the representatives from the

following organisations and partnerships:

- Consultant in Public Health responsible for the JSNA, Warwickshire County Council
- Public Health Principle – JSNA Programme Manager, Warwickshire County Council
- Business Intelligence, Warwickshire County Council
- Commissioning, Warwickshire County Council
- Health and Wellbeing Board Strategy, Warwickshire County Council
- Business Intelligence, Coventry and Warwickshire ICB
- Healthwatch
- Warwickshire CAVA
- South Warwickshire place-based Health and Wellbeing Partnership (South Place)
- North Warwickshire place-based Health and Wellbeing Partnership (North Place)
- Rugby place-based Health and Wellbeing Partnership (Rugby Place)

1.9 The proposed work plan was then signed off by the JSNA Strategic Group. The two-year thematic work programme is outlined below.

JSNA	Provisional Timescales	Comments
People aged 65+ (to consider dementia and older carers)	October 2022 – July 2023	This needs assessment will inform the recommissioning of domiciliary care in 2024, as well as informing integrated discharges and intermediate care.
Children and Young People aged 6-25's Physical Health (to consider exploitation, homelessness and obesity)	February 2023 – November 2023	This needs assessment will inform the recommissioning of the school nursing contract for September 2022-25. It will also be used to help inform the ICB 5-year forward plan which must set out what will be done for children and young people under 25, as well as the new Children's Transformation programme.
Review of Workplan	June 2023	A review has been scheduled to allow for any new proposals to be prioritised and included in the work programme. This will include a JSNA Working Group review and JSNA Strategic Group sign off.
People with a Disability	October 2023 – July 2024	To ensure appropriate market development, commissioning plans, and strategy development. In addition, a recent funding bid was missed out on due to a current lack of evidence which this needs assessment will help provide.

People who identify as LGBTQ+	February 2024 – November 2024	There is a considerable lack of local data and information on this population to provide appropriate support. This needs assessment will help provide that evidence base.

1.10 It should be noted that these timescales are proposed and may be adjusted slightly as work is progressed over the two-year period. This may include changes required if additional requests are made for needs assessments during this time. The Health and Wellbeing Board will be informed of any changes to the work programme.

1.11 Scoping work has started on the People aged 65+ JSNA.

2. Financial Implications

2.1 There are no financial implications arising directly from this report. The activities required to implement the plans detailed within the report are budgeted for within the Public Health team.

3. Environmental Implications

3.1 None

Appendices

None

Background Papers

None

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and Health		

The report was circulated to the following members prior to publication:

Local Member(s): None
Other members: Councillors Bell, Drew, Golby, Holland, and Rolfe

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Agenda Item 8

Health and Wellbeing Board

11 January 2023

Coventry and Warwickshire Health and Wellbeing Forum

Recommendation

1. That the Health and Wellbeing Board notes the content of the presentation and the summary of the discussion findings from first meeting of Coventry and Warwickshire Integrated Health and Wellbeing Forum (formally Place Forum).

1. Executive Summary

1.1 Place Forum was established in December 2017 as the joint Coventry and Warwickshire Health and Wellbeing Board. Its aim was to set the vision and principles for how the health and care system works together.

1.2 In July 2022, to coincide with the formal establishment of the Integrated Care Board (ICB), the Place Forum was refreshed to become the Coventry and Warwickshire Integrated Health and Wellbeing Forum.

1.3 The Forum consists of HWBB members, Integrated Care Partnership (ICP) members and key partners from across the Coventry and Warwickshire health and care landscape.

1.4 The Forum will act as a key space for engagement and system leadership around the wider HWB agenda. It will also act in an advisory capacity for the Integrated Care System (ICS) and a community voice across Coventry and Warwickshire.

1.5 The first meeting of the Integrated Health and Wellbeing Forum was held in October 2022. The session aims were to:

1.5.1 Reconnect as an integrated forum face to face
1.5.2 Update on recent changes to our system and reflect on our role in relation to our current context
1.5.3 Take an active role in engaging in the development of the C&W Integrated Care Strategy and contribute to identifying what is most critical
1.5.4 Build on the successes of the Place Forum to date, identify the shared ambition for the ICS and the opportunities it presents

1.6 The presentation delivered on the day can be found in Appendix 1 of this report. The notes on feedback, from group work for the Integrated Care Strategy, can be found in Appendix 2 of this report.

2. Financial Implications

2.1 None.

3. Environmental Implications

3.1 None.

4. Timescales associated with the decision and next steps

4.1 The next C&W Integrated Health and Wellbeing Forum will take place on the 02 March 2023.

Appendices

1. CW I Health and Wellbeing Forum Final slide deck (13 Oct)
2. CW I Health and Wellbeing Forum – feedback from group work (13 Oct)

Coventry and Warwickshire Integrated Health and Wellbeing Forum

13 October 2022

Wifi name: CovWarIHWF
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Welcome to the first meeting of Coventry and Warwickshire Integrated Health and Wellbeing Forum

Cllr Kamran Caan, Chair of Coventry Health and Wellbeing Board
Cllr Margaret Bell, Chair of Warwickshire Health and Wellbeing Board; and
Danielle Oum, Chair of Coventry and Warwickshire Integrated Care System

Session aims

- *Reconnect as an integrated forum face to face*
- *Update on recent changes to our system and reflect on our role in relation to our current context.*
- *Take an active role in engaging in the development of the C&W Integrated Care Strategy and contribute to identifying what is most critical*
- *Building on the successes of your work to date, identify your shared ambition for the ICS and the opportunities this presents*

Wifi name: CovWarIHWF
Password: W3llb3ing

Agenda

Timings	Agenda item	Led by
09.00	Welcome and introduction	Cllr Bell, Cllr Caan and Danielle Oum
09.10	Session aims	NHS Elect
09.15	Where are we now as an ICS?	Kirston Nelson, Nigel Minns, Phil Johns
09.30	Developing the Integrated Care Strategy	Danielle Oum and Liz Gaulton, with group work led by NHS Elect
10.30	Coffee break	
10.40	Our ambitions for the future – how can we support the implementation of the Integrated Care Strategy?	Group work led by NHS Elect
11.20	Next steps and close	NHS Elect, Cllr Caan and Danielle Oum
11.30	Close	

Where are we now as an ICS?

Kirston Nelson, Nigel Minns, Phil Johns

Our four key aims

- **Improve outcomes** in population health and healthcare
- **Tackle inequalities** in outcomes, experience and access
- **Enhance productivity** and **value for money**
- Help the NHS **support broader social and economic development.**

Foundations

- Formal Establishment of the ICB and the ICP on 1 July
- **ICB Board**
  - 5 Non Executive Members appointed
  - 1 Partner Member for Primary Medical Services in recruitment stages
  - Agendas of the Board organised around the 4 aims of the ICS
  - August session on risk, October session planned on Board development
- **Integrated Care Partnership (ICP)** – a Joint Committee of the ICB and Warwickshire CC & Coventry CC
  - Inaugural Meeting on 26th focused on ambition, purpose and alignment
  - Deputy Chairs – HWBB Chairs
  - Good membership that is still evolving
  - Developed Principles of working based on the established concordat
- **C&W Integrated Health and Wellbeing Forum (previously Place Forum)**
  - ICP and HWBB Members from C&W and key partners
  - Key forum for engagement and system leadership around the wider HWB agenda
  - Advisory role for the ICS and community voice from across C&W

Working arrangements
We will work together in alliance with each other, operating with mutual respect and accountability
We will design systems which are easy for everyone to understand and use
We will agree a common set of outcomes to be delivered
We will streamline system governance to enable decisions to be taken at scale and pace
We will make evidence-based commissioning decisions focused on the best way to achieve good results
We will learn from others and from our own experiences.

Coventry and Warwickshire Integrated Care System

Our ICP Principles

Championing better health for everyone

Providing strategic leadership

Prioritising prevention

Strengthening and empowering communities

Championing integration and co-ordinating services

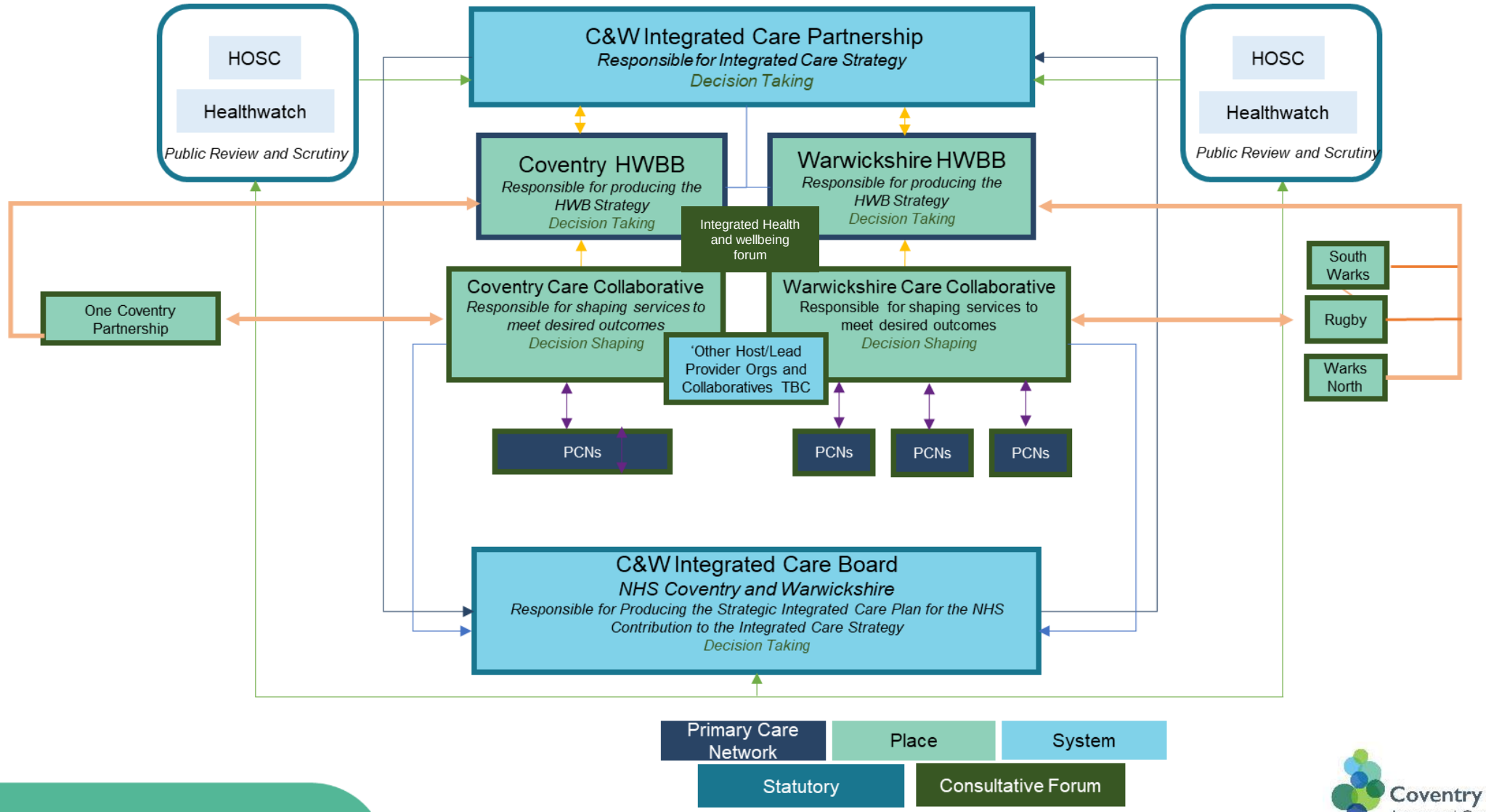
Sharing responsibility and accountability

Engaging, listening and learning

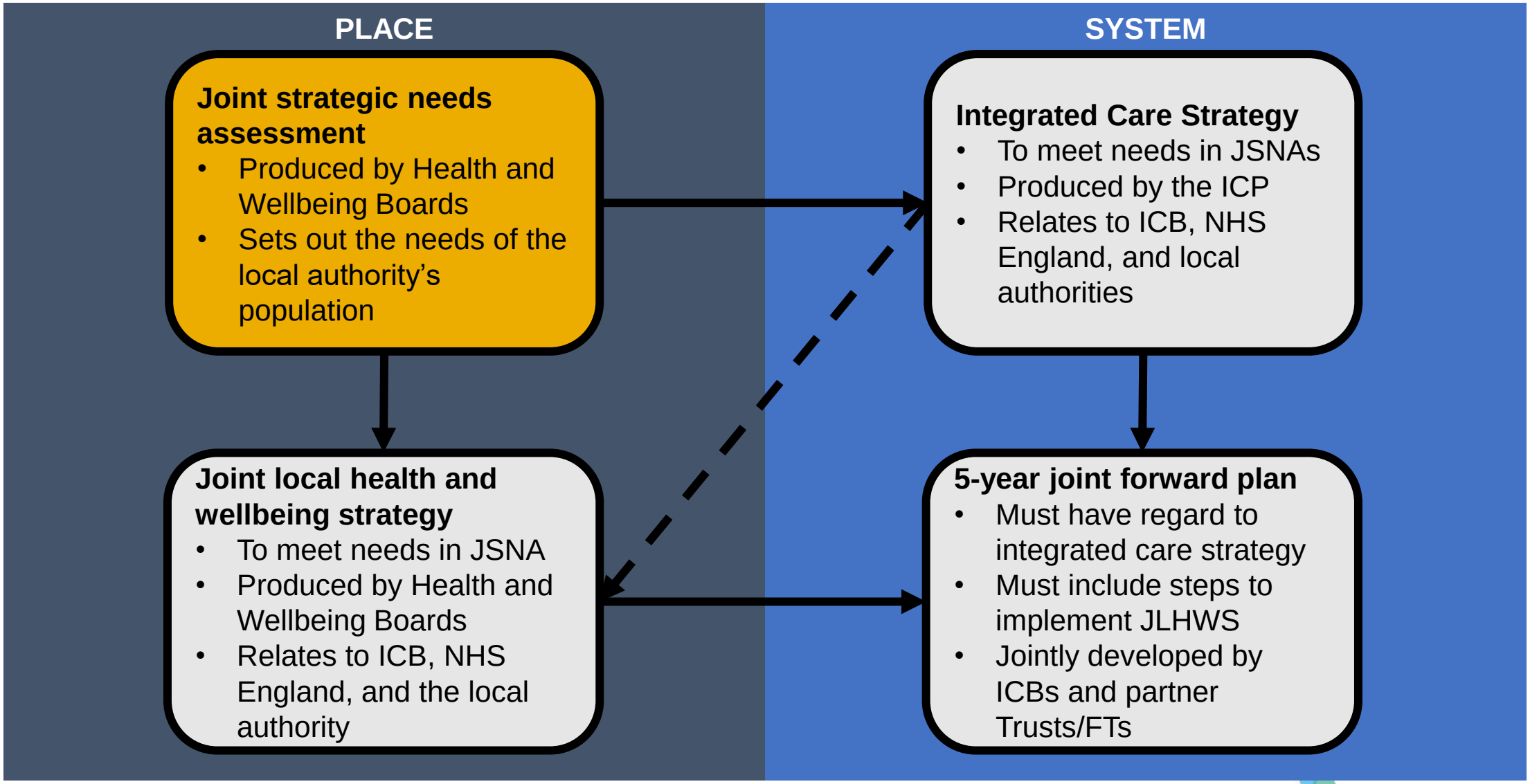
Our ICP Principles

Principles	What this means
Championing better health for everyone	• We will champion better, patient-centred, care for everyone and support subsidiarity throughout the system and putting people at the heart of decision making.
Providing strategic leadership	• We will provide collective strategic leadership for the ICP, aligned to and driven by the four key aims of ICSs. • We will lead with a strong, collective, moral purpose.
Prioritising prevention	• We will tackle the causes of health-related problems to reduce the impact of ill-health on people's lives, their families and communities. • We will seek to address the root cases of problems, listening to local people's priorities and acting on their concerns.
Strengthening and empowering communities	• We will support strong and stable communities. • We will support the voice of communities and people in the planning and delivery of the services they need. • We will ensure our work is connected to the communities we serve.
Championing integration and co-ordinating services	• We will work together to design services which take account of the complexity of people's lives and their over-lapping health and social needs. • We will focus on the best way to achieve good outcomes for people, reducing the number of interactions people have with our services and avoiding multiple interventions from different providers. • We will champion care for those in need being delivered by teams of staff working seamlessly across different sectors, so that support can be provided as efficiently and effectively as possible.
Sharing responsibility and accountability	• We will treat each other with respect and equality and value the distinct contributions made by all the organisations that are part of the ICP. • We will maintain partnerships between the public sector, voluntary and community sector, local businesses and residents, recognising that we share responsibility to transform the health and well-being of our communities. • We will pool resources, budgets and accountabilities where it will improve services for the public.
Engaging, listening and learning	• We will actively engage the people and communities of Coventry and Warwickshire on the strategic work of the ICP. • We will foster a culture of engagement, learning and sharing across the ICS. • We will engage with, listen to and learn from the expertise of professional, clinical, political and community leaders at the forefront of the ICP's strategic thinking and help promote strong clinical and professional system leadership.

The evolving structure of our ICS

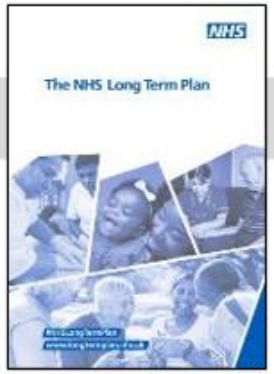


ICS strategies and plans

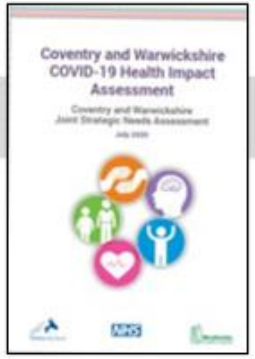


Our journey as a Place Forum

Place Forum was established in Dec 2017 and set a vision and principles for how the health and care system across Coventry and Warwickshire works together.



Coventry and Warwickshire
Health and Care Partnership



The last six months

- Our new ICB has approved:
  - Health Inequalities Strategic Plan
  - Population Health Management Roadmap
  - Communities Strategy
- We've had a big conversation about our system-wide workforce and will be publishing our One People Plan this autumn
- We're finalising our ambitious system-wide Digital Transformation Strategy
- We've continued to promote workforce wellbeing and community wellbeing initiatives through Wellbeing for Life
- Coventry and Warwickshire Anchor Alliance Development Group has reframed commitments through a new proposed model
- We have been working together across the system to tackle the Cost of Living crisis and develop our approach to Levelling Up.

OUR PEOPLE OUR PURPOSE

COVENTRY & WARWICKSHIRE WELLBEING FOR LIFE

Coventry and Warwickshire Integrated Care System

Agenda

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Coventry and Warwickshire Integrated Care System

Developing the Integrated Care Strategy

Danielle Oum and Liz Gaulton

Working together to improve the health and wellbeing of our people

Good Governance Institute

Coventry and Warwickshire Integrated Care System

Planning for the future

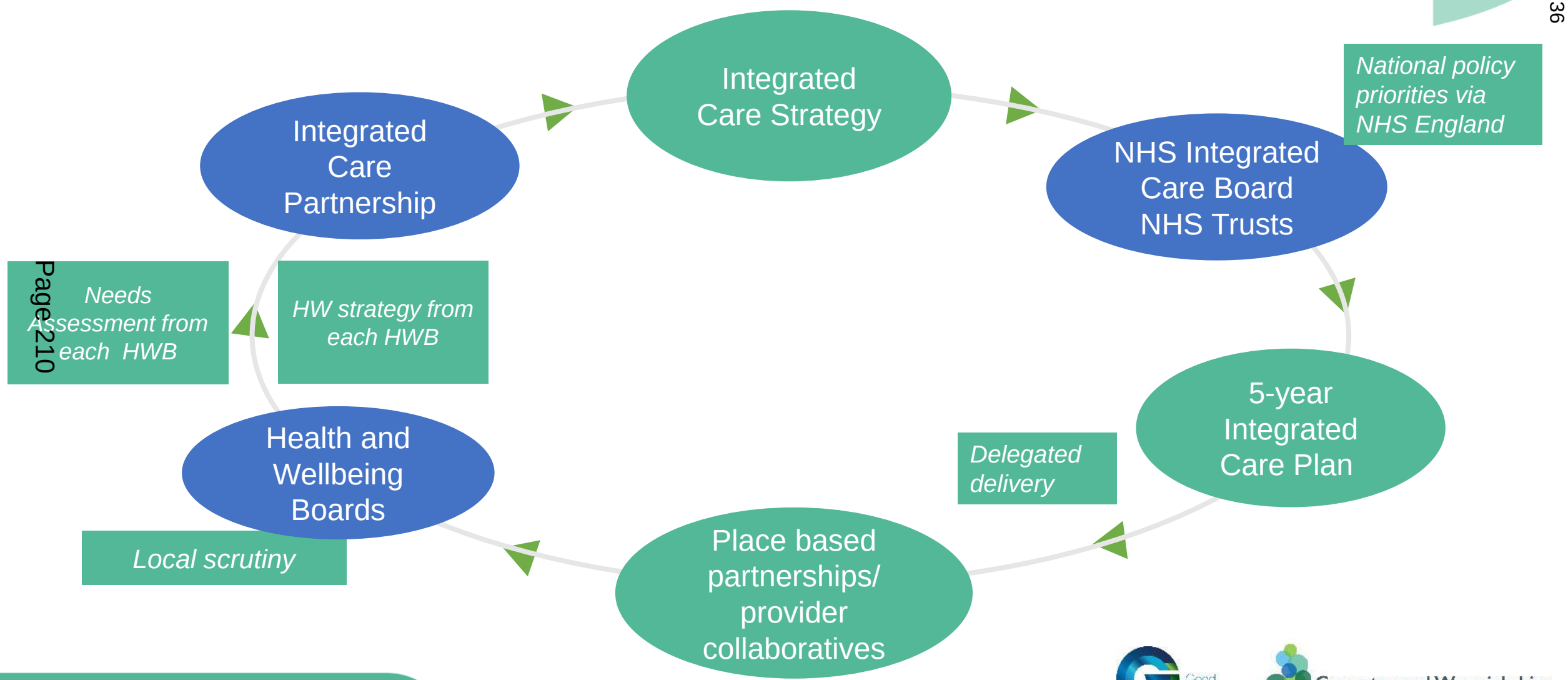
- By April 2023 Coventry and Warwickshire Integrated Care System must have developed:
    - An **Integrated Care Strategy**, developed by the Integrated Care Partnership based on local health and Wellbeing Strategies
    - A 5 year **Integrated Care Plan**, developed by the Integrated Care Board, which responds to the Strategy and outlines how we will address the aims of the Integrated Care Strategy
- Involvement of our communities and stakeholders is vital to ensure people are at the heart of our strategy and planning

Our ICP Principle of Engaging, Listening and Learning

- We will actively engage the people and communities of Coventry and Warwickshire on the strategic work of the ICP.
- We will foster a culture of engagement, learning and sharing across the ICS.
- We will engage with, listen to and learn from the expertise of professional, clinical, political and community leaders at the forefront of the ICP's strategic thinking and help promote strong clinical and professional system leadership.

Coventry and Warwickshire Integrated Care System

The strategy will inform the Integrated Care Board's 5 year plan & both build on and influence partner and place plans & strategies



Good Governance Institute

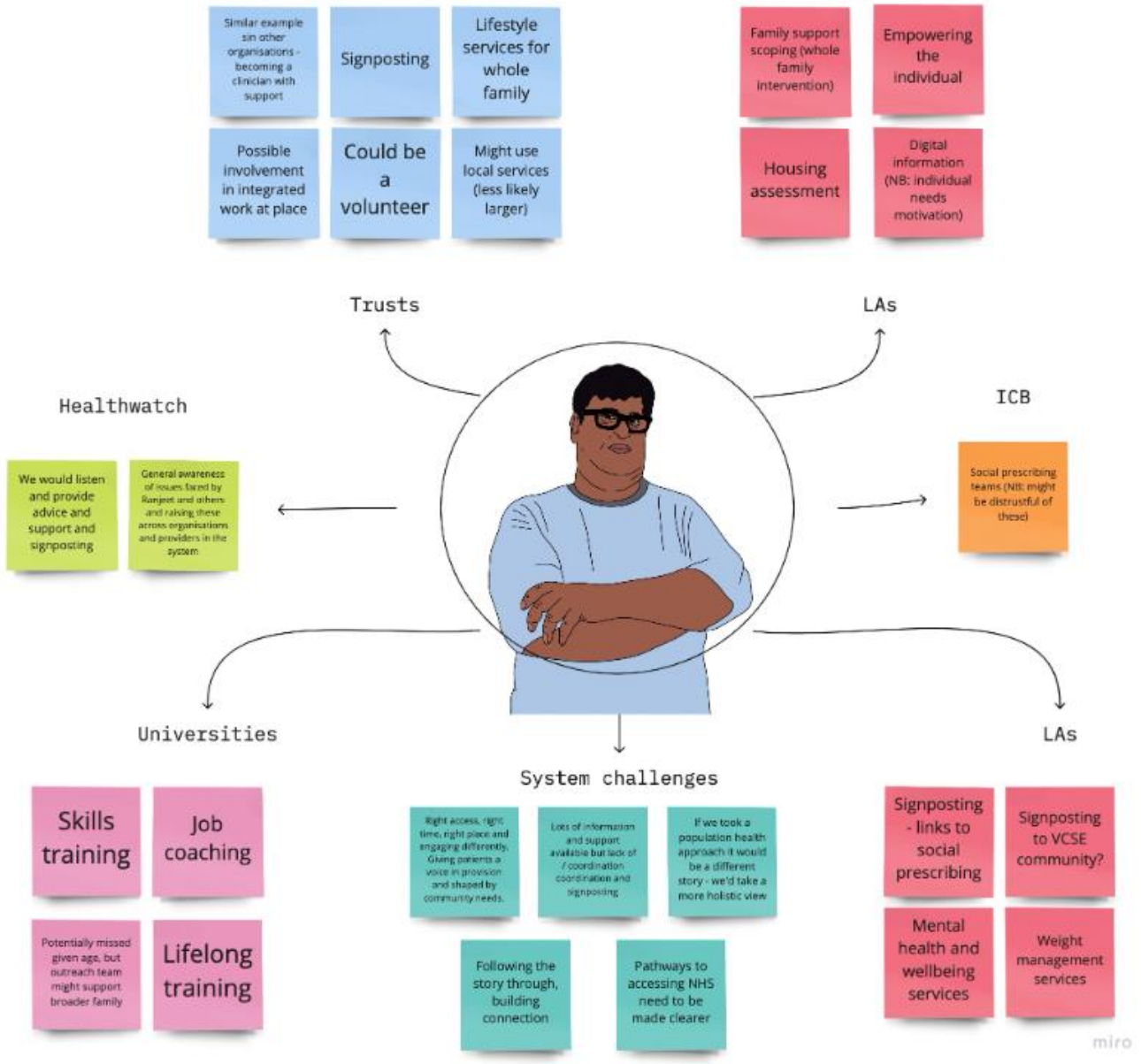
Coventry and Warwickshire Integrated Care System

What is the Integrated Care Strategy and why is it important?

The **master strategy for the system**, providing a joint strategic mandate for working together around shared purpose

A vision for better health and care in C&W **5 years from now**

Driven by collaboration & integration across the system to achieve the four key aims & local priorities



That **leverages the benefits of the system** and **enables** greater **collaboration** across partners

And **aligns the ambition, purpose and strategies** of partners across the system

To transform the lives of people like Ranjeet and make a **meaningful impact on health and wellbeing**

Coventry and Warwickshire Integrated Care System

Getting the most out of the advantages of the system

- Joining up of currently disconnected services across providers
- Strong community links and relationships
- Sharing best practice and expertise at scale
- Benefitting from procurement partnerships and economies of scale
- Greater training and OD opportunities
- Data sharing and intelligent use of data for population health modelling and preventative work
- Improving resilience by, for example, providing mutual aid
- Thriving Voluntary and community sector
- Sharing resource
- Collaborating on sustainability initiatives at scale
- Reducing unwarranted variation and inequality in health outcomes, access to services and experience
- Ensuring that specialisation and consolidation occur where this will provide better outcomes and value

Coventry and Warwickshire Integrated Care System

Brief discussion

Any feedback or reflections on what you have heard so far?

Developing our Integrated Care Strategy

Approach

- Inclusive and co-productive approach to developing both the Integrated Care Strategy and the 5-year Integrated Care Plan
- Focus area/ enabler leads identified from across the system

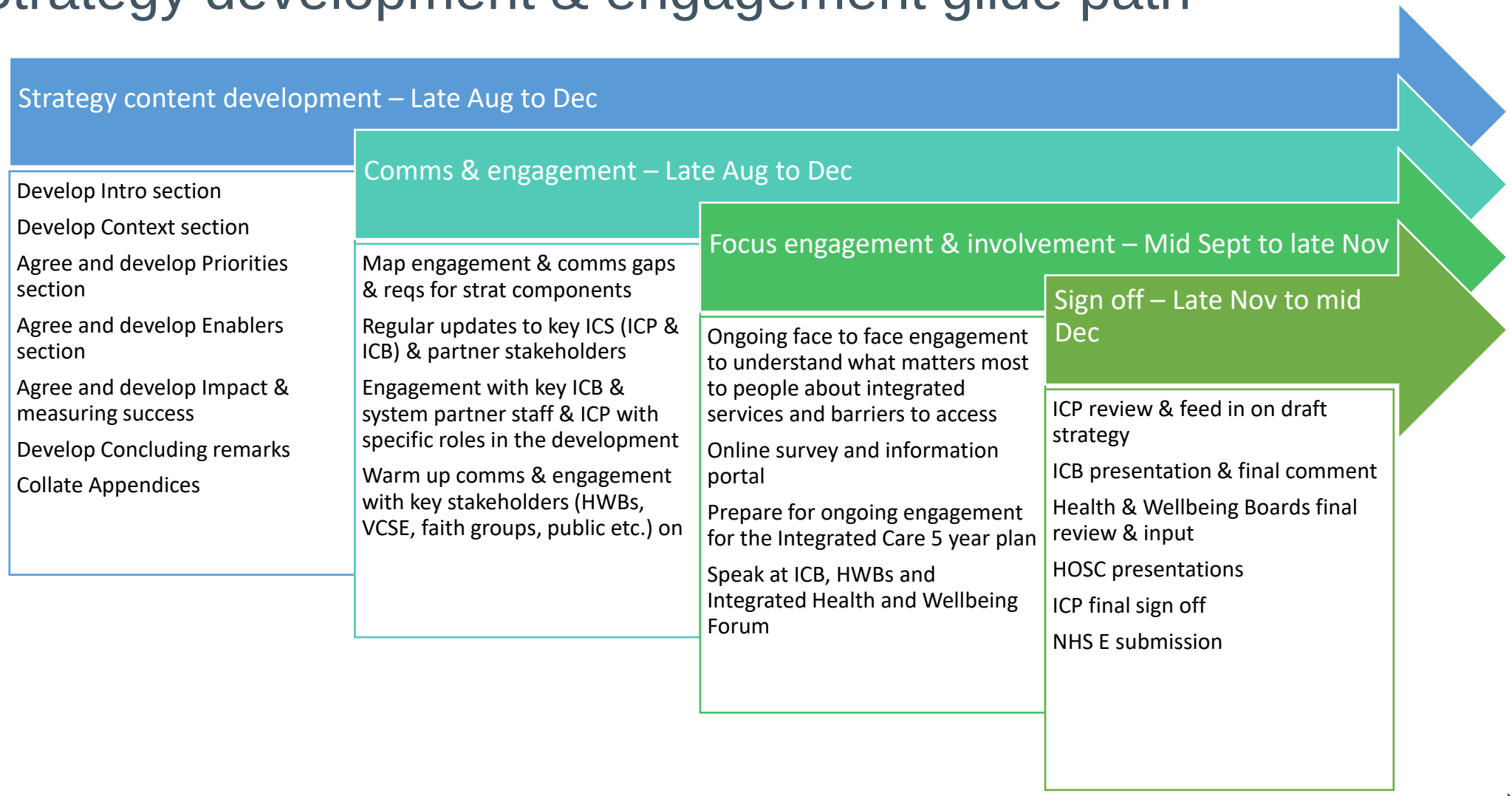
Content

- The focus areas and enablers have been shaped by input from across the system and by the initial broader public and community engagement we've done but are still being thought about and developed – we'd welcome your input on them
- We want the strategy to
  - be a short and concise document (around 30 pages)
  - recognise and build upon work already in place by signposting to existing strategies throughout
  - include one worked up example of a focus in practice, informed by engagement, to bring it to life

Engagement

- There is a limited timeframe for engagement but we will be doing what we can especially around the gaps we have identified.
- The strategies that will inform the Integrated Care Strategy have been developed with input from and engagement with lots of the key stakeholders in the system so we are building on that

Strategy development & engagement glide path



Coventry and Warwickshire Integrated Care System

What we've heard so far

You need to make health care services more accessible and easy to navigate

Greater diversity in our health and care workforce "it would be helpful if we could see clinicians from the same ethnic/ cultural background as us"

More needs to be done to address mental health and especially in Black And Minority Ethnic communities

We need more personalised care derived from listening to patient and community needs - "one size does not fit all!"

More needs to be done to address inequalities and disparities in care

Need to improve how information about health and care is shared with communities

We need more social events and engagement to tackle isolation among elderly, disabled and cut off groups

A more consistent approach is needed and more needs to be done to support people with mental health, Autism, Dementia and Alzheimers

Can we support those most in need to help them get to health & wellbeing appointments

Engage with and listen to carers!

We need to fund and support grassroots voluntary and community organisations and make more of them – they have access to so many people

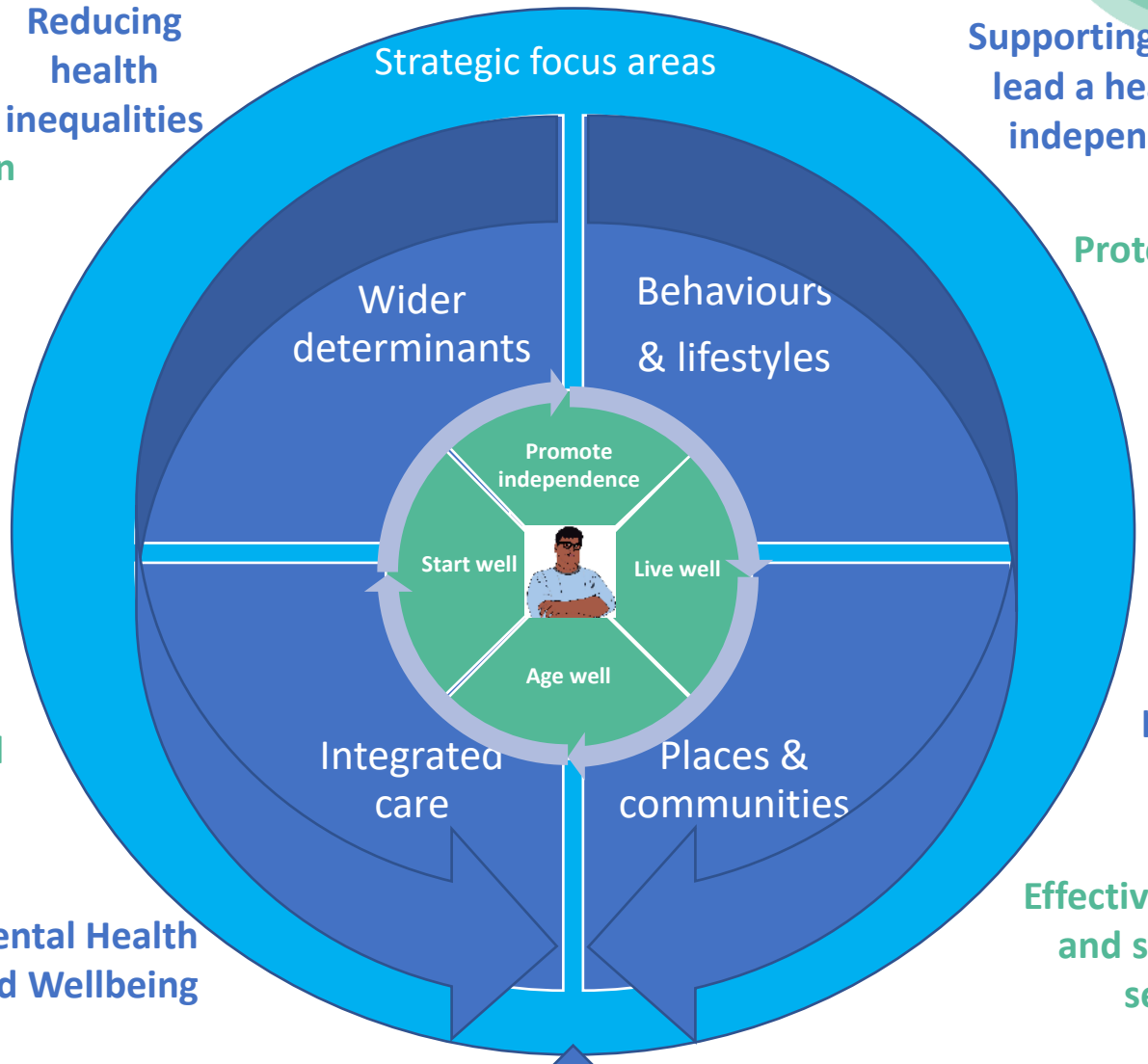
Framing for our Integrated Care Strategy

C&W wider system (e.g. CWLEP, Anchors etc.)

Drivers =

- Policy context for integration
- Assessment of local needs
- Kings Fund pop health model
- National Guidance

Place
Links to and from place through Health and Wellbeing Boards and strategies of Coventry and Warwickshire



Reducing health inequalities

Supporting people to lead a healthy and independent life

Best start in life

Protecting the health of people and communities

Support social and economic development

Enable personalised care

Operational resilience

Effective, accessible and sustainable services

Mental Health and Wellbeing

Enablers

Digital & data – Quality – Estates – Performance – People – Finance – Wider determinants of health – Transformation & innovation – Clinical leadership - Engagement

Coventry and Warwickshire Integrated Care System

Our Integrated Care Strategy content structure on a page

Strategic focus areas -
---Enable personalised care
---Reducing Health Inequalities
---Supporting people to lead a healthy and independent life
---Protecting the health of people and communities
---Best start in life for children and young people
---Effective accessible and sustainable services
---Mental Health and Wellbeing
---Operational resilience
--Support social and economic development

These strategic system focus areas and enablers have been informed by -

- Areas of alignment in Coventry and Warwickshire Health and Wellbeing strategies
- National guidance steer
- Other key system strategies
- Input from key stakeholders in the system
- Feedback from people and groups in Coventry and Warwickshire through the engagement sessions we have done

But they still need more work and this is something we want to focus on with you at this Forum meeting.

Strategic enablers -
Finance
Estates
Green
People (workforce & OD)
Transformation & innovation
Quality
Performance
Digital and Population Health Management
Partnerships & engagement
Wider determinants of health
Clinical & care professional leadership

Coventry and Warwickshire Integrated Care System

Developing strategy content

- We have identified lead ‘owners’ from across the system for each of the focus areas and enablers.
- The first drafting exercise with identified leads involved a workshop and completion of a slide template for each focus area and enabler.
- Slide summarised the key themes, priorities and strategy links.
- Through this exercise some key initial actions and priorities have been identified, a summary of which is provided on your tables. Examples on following slides
- Some areas are more developed than others and there may be a need for some streamlining or merging of focus areas/enablers.
- The specific titles of focus areas and enablers may also change.

EXAMPLE

Focus area: Reduce Health Inequalities

- Ensure that reducing health inequalities becomes Business as Usual
- Take a wider perspective of health and the drivers of health when considering services – King's Fund model of population health
- Make health inequalities everyone's business, and recognise the contribution that all partners can make through collaboration
- Promote proportionate universalism
- Shift resources upstream to prevention and reducing inequalities. Focus on primary, secondary, tertiary prevention.
- Ensure equity of access, experience and outcomes

EXAMPLE

Enabler: Digital and Population Health Management

Digitise

- Well led: Ensure an agreed strategy for digital transformation and collaboration is in place, with collective ownership of the digital transformation journey. Ensure digital and data expertise and accountability are incorporated into leadership and governance arrangements, with delivery of the system-wide digital and data strategy.
- Smart foundations: Ensure digital, data and infrastructure operating environments are reliable, modern, secure, sustainable and resilient, with well-resourced teams across the ICS.
- Safe Practice: Ensure organisations across the ICS maintain standards for safe care, as set out by the Digital Technology Assessment Criteria for health and social care (DTAC) and that they routinely review system-wide security, sustainability and resilience.

Connect

- Supporting People: Ensure the workforce is digitally literate and are able to work optimally with data and technology.
- Empowering Citizens: Place citizens at the centre of service design, ensuring they have access to their healthcare information and a standard set of digital services that suit all literacy/digital inclusion needs.

Transform

- Improving Care: Ensure ICS embeds digital and data within their improvement capability to transform care pathways, reduce unwarranted variation and improve health and wellbeing.
- Health Populations: Promote the use of data to design and deliver improvements to population health and wellbeing, making best use of collective resources.

Group work 1 – reflections on the integrated care strategy

In groups, please can you reflect on the following 3 questions:

1. Have we identified the right priorities and enablers? Any surprises, anything missing?
2. What is my organisation's contribution to delivering the strategy?
3. What is most critical for our system now?

You have 20 minutes for your discussion. Please make some notes on the flipcharts and choose someone to feedback key points (3 minutes)

We will ask groups 1&2 to lead the feedback on Q1, groups 3&4 to lead the feedback on Q2 and groups 5&6 to lead the feedback on Q3.

Coffee break

Agenda

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Group work 2 – our ambitions for the future

Again, in groups please could you consider the following questions:

1. How can we (as the Integrated H&W Forum) help ensure the Integrated Care Strategy is successfully implemented?
2. Building on our collective strengths and partnerships, how will we hold ourselves to account?

Your commitments

- Actively champion the purpose and importance of the Integrated Care Strategy
- Work with your organisation to support the delivery of the Integrated Care Strategy
- Contribute collectively through Health and Wellbeing Boards and Integrated Care Partnership to successful implementation of the Strategy
- Commit to holding ourselves to account, through our partnerships, for realising the value and potential benefits of the Integrated Care System

Next steps and actions

- **31 October**: Integrated Care Partnership meeting to agree outline content of Integrated Care Strategy drawing on outcomes from today
- **November**: further development / refinement of Strategy with content leads, informed by engagement activity
- **December**: Integrated Care Partnership approve final Strategy for submission to NHSE
- **January**: Health and Wellbeing Boards meet. Opportunity to align Health and Wellbeing Strategy development process with Integrated Care Strategy and 5-Year Integrated Care Plan development and engagement
- **March**: ICB approve 5-Year Integrated Care Plan

Next Forum meeting: March 2023

Closing remarks

Cllr Kamran Caan, Chair of Coventry Health and Wellbeing Board
Danielle Oum, Chair of Coventry and Warwickshire Integrated Care System

Coventry and Warwickshire Integrated Health and Wellbeing Forum

Notes from the feedback from group work at the inaugural meeting held on 13th October 2022

1. **Have we identified the right priorities and enablers? Any surprises, anything missing?**

- Most of the right priorities have been identified – can we distil the list to make a smaller number of priorities?
- The 'wider determinants of health' such be a focus, rather than an enabler
- We need to keep 'prevention' and 'workforce' (including the social care workforce) front and centre of the strategy
- Tackling health inequalities needs to be a key driver that runs through the entire strategy
- What do we mean by 'operational resilience'?
- Can we add reference to end of life care please?
- Can we work together to agree a collective focus and ask each organisation to describe 'Ranjit's journey' and the positive impact they can have on this, adopting the key principles and approaches set out in the integrated care strategy (including the VCSE)?
- Can we agree some shared definitions for terms such as 'prevention' and 'early intervention'?

2. **What is my organisation's contribution to delivering the strategy?**

- We need to work together to 'make every contact count'
- How can we improve things with our limited funds? We need to remain focused on the 'biggest bang for our buck' – i.e. how can we invest together ('pool our money') in initiatives now that will potentially improve lives of local people and offer opportunities to save health and social care demand in the longer term?
- Can we make sure we have the data that shows the impact of any investments or changes to approach
- We can all pledge that tackling health inequalities will underpin everything we do and can align our organisational strategies to the integrated care strategy (reinforcing the commitments we made in the concordat we've all signed)
- We need to listen to, hear and understand the perspectives that others bring
- We need to ensure that the patient and resident voice is at the heart of our planning – let's be patient obsessed (or even community obsessed)!

3. **What is most critical for our system now?**

- Supporting our workforce – we have a workforce 'in distress' and need to engage with our workforce to tap into people's intrinsic motivations to help us deliver better, more integrated care. How do we create the right conditions for 'workforce resilience'?
- This will also help in improving 'population wellbeing', as health and social care employs 10% of the UK workforce and we also need to focus on the informal workforce – e.g. carers
- Let's also focus on the wider economic position of communities and consider how we can boost this
- We need to plan now to make a difference for tomorrow (and not just chase solutions to our current problems) – so let's focus on giving children and young people the best possible start in life and recognise that much of what we need to do centres on the wider determinants of health.
- What does the data tell us about where we should focus our efforts?

4. **How can we (as the Integrated H&W Forum) help ensure the integrated care strategy is successfully implemented? Building on our collective strengths and partnerships, how will we hold ourselves to account?**

- Can we meet more frequently (3/4 times a year) to support and ensure implementation?
- We need to be clear about the milestones and deliverables – check that we've done what we agreed to do – but avoid creating an industry around reporting and performance management
- Can we understand the governance and mechanics of the ICB – and how we influence and have 2-way conversations and also how we make decisions in this Forum
- Let's bring successes back to this meeting
- Accountability sits between the ICS and our service users and local people – we need to make sure we are making a difference to people living in C&W
- Can we find a way to share 'lifetime stories' and map backwards from these to spot opportunities to make a difference as early as possible for people. Using data, can we undertake some longitudinal studies?
- Let's make sure we keep momentum on the point prevalence work
- Let's provide better information about what services and support are out there and ask people what they need – don't make assumptions
- Please can you share a summary of today's conversations to share within organisations.

Agenda Item 9

Health and Wellbeing Board

11 January 2023

Better Care Fund - Update, Planning for 23/24 and Adult Social Care Hospital Discharge Fund

Recommendations

The Board is recommended to:

1. Note the progress of the Better Together Programme in 2022/23 to improve performance against the four national Better Care Fund areas of focus;

2. Support the approach to reviewing and agreeing the list of schemes to be funded from the Improved Better Care Fund (iBCF) for 2023/24;

3. Provide feedback on the proposed schemes to ensure that these contribute to the wider Health and Wellbeing Board's prevention priorities as well meeting the iBCF grant conditions as set out in the current national Better Care Fund (BCF) Policy Framework;

4. Support the plan to be funded from the Adult Social Care Discharge Fund to 31/03/23, approved under delegation by the Health and Wellbeing Board Sub-Committee on 16th December 2022; and

5. Note that a further update will be provided to the Board, following publication of the national Better Care Fund Policy Framework for 2023/24.

1. Executive Summary

Performance Update

1.1 Locally our Better Care Fund plan for 2022/23 focusses our activities to improve performance in the four key areas which are measured against the National Performance Metrics. These being:

a. Reducing Non-Elective Admissions (General and Acute)
b. Improving the proportion of people discharged home to their usual place of residence
c. Reducing permanent admissions to residential and care homes; and
d. Increasing effectiveness of reablement

1.2 A summary of performance against the four national areas of focus using the most recent data available:

Metric	22/23 performance where available	Target	Status
Reducing Avoidable Admissions (General and Acute)	Quarter 2 Actual: 1,162	1,213	Under (better than) target
Improving the proportion of people discharged home to their usual place of residence	Quarter 2 Actual: 95.6%	95.5%	On target
Reducing permanent admissions to residential and care homes; and	Quarter 2 Actual: 131	182	Under (better than) target
Increasing effectiveness of reablement	2021/22 Actual: 94.5% YTD: Data for 22/23 not available until May 23	94.2%	N/A

Draft List of Schemes to be funded from the Improved Better Care Fund

1.3 Similar to previous years, a draft list of schemes to be funded from the Improved Better Care Fund has been prepared in advance during quarter three of the preceding year, to give sufficient time for discussions between partners to take place, contracts to be extended including those with staff to ensure continuity of service; or notice to be given of services to be decommissioned.

1.4 When preparing the list of schemes, the local authority and Integrated Care Board (ICB) has carried out an in-depth review of twenty of the thirty schemes currently funded from the Improved Better Care Fund. The context to the review is that the majority of schemes have been in place for a number of years now and cost pressures to both the local authority and ICB have been created by the ending of the national Hospital Discharge Grant (introduced during the Covid-19 pandemic) on 31/03/22. A similar exercise has also been carried out in Coventry. The review commenced in October 2022.

1.5 The review has focussed on assuring that schemes continue to meet the BCF conditions, are aligned to current system pressures/priorities, are demonstrating impact and are as efficient and effective as possible; taking into account whether there are alternative ways of achieving similar outcomes or alternative funding arrangements.

1.6 As the review is concluding at the time of writing this report, an update on the proposed list of schemes will be shared with the Health and Wellbeing Board at the meeting on the 11th January 2023. In the meantime, key findings from the review so far indicate that potential efficiencies could be released to cover cost pressures, for some of the following schemes:

- W-IBCF 3 - Hospital Based Social Prescribing

- W-IBCF 4 - Trusted Assessors
- W-IBCF 6 - Hospital to Home Service
- W-IBCF 12 - OT capacity
- W-IBCF 22 - Provider Learning and Development
- W-IBCF 29 - Communications Support
- W-IBCF 30 - Support

1.7 Where possible, alternative funding, including more permanent funding arrangements are also being considered for the following schemes:

- W-IBCF 2 - Housing Hospital Liaison
- W-IBCF 8 – Integrated Community Equipment contract increases (WCC & ICB)
- W-IBCF 9 - Clearing/deep cleaning properties
- W-IBCF 14 - Falls prevention
- W-IBCF 15 - Mental Health Street Triage
- W-IBCF 16 - Adults with Autism
- W-IBCF 17 - Residential Respite Care Charging Policy
- W-ICBF 24 - Market Sustainability

1.8 A copy of the current list of schemes funded from the iBCF in 2022/23 is attached as Appendix 1. Proposed changes to this for 2023/24 will be provided at the meeting on the 11th January 2023.

Adult Social Care Discharge Fund

1.9 On the 18th November 2022, the allocations, conditions and metrics for the Adult Social Care Discharge Fund were published by the Department for Health and Social Care.

1.10 The fund can be used flexibly on the interventions that best enable the discharge of patients from hospital to the most appropriate location for their ongoing care, up to and including, 31st March 2023.

1.11 £1.862m was allocated to Warwickshire County Council Adult Social Care, and £6.715m allocated to Coventry and Warwickshire Integrated Care Board, with the split for Warwickshire to be agreed locally. 40% of the funding will be received in early December, with the remaining 60% to follow in January, subject to the conditions and reporting requirements being met. These funds are expected to be pooled with the Better Care Fund pooled budgets.

1.12 Spending plans needed to be agreed by both the local authority and Integrated Care Board and submitted to the Department of Health and Social Care and NHS England by 16th December 2022.

Deadline	Requirement
16 Dec 22	Submission of agreed spending plans - completed
6 Jan 23	First of fortnightly activity reports, setting out what activities

	have been delivered in line with spending plan
2 May 23	Final spend report, as part of BCF End of Year Submission

1.13 To achieve this, in line with delegation of the Health and Wellbeing Board, a Sub-Committee of the Health and Wellbeing Board approved the Adult Social Care Discharge Fund Plan on the 16th December 2022.

1.14 A summary of Warwickshire's plan is attached as Appendix 2.

2. Financial Implications

2022/23

2.1 - The Improved Better Care Fund allocation for 2022/23 is £15.132m.
- The Adult Social Care Discharge Fund allocation for 2022/23 announced on the 18th November 2022 is £5.960m, comprising of:
  - £1.862m from the local authority allocation; and
  - £4.098m from the Integrated Care Board allocation.

2023/24

- The Improved Better Care Fund allocation for 2023/24 has not yet been published and so planning will commence based on the current allocation.
- The Adult Social Care Discharge Fund or equivalent allocation for 2023/24 has also not yet been published.

2.2 The iBCF is temporary. In order to counter the risk inherent in temporary funding, all new initiatives are temporary or commissioned with exit clauses. There are, however, a number of areas where the funding is being used to maintain statutory adult social care spending and this would require replacement funding if the Better Care Fund was removed without replacement. This risk continues to be noted in Warwickshire County Council's annual and medium-term financial planning.

3. Environmental Implications.

3.1 None.

4. Supporting Information

Performance against the four national areas of focus using the latest confirmed data available.

4.1 Reducing Avoidable Admissions (General and Acute)

Year to date (April 2022 to October 2022), unplanned hospitalisations for chronic ambulatory care sensitive conditions in Warwickshire were 11.9% lower than the same period last year and 0.1% below target.

Quarter	Actual (lower is better)	Target	% below target

Q1 2022/23	1,212	1,213	-0.08%
Q2 2022/23	1,162	1,213	-4.4%

4.2 Improving the proportion of people discharged home to their usual place of residence

Year to date (April 2022 to October 2022), the proportion of people discharged home to their usual place of residence in Warwickshire was 0.1% lower than the same period last year and 0.25% above (better than) target.

Quarter	**Actual** (higher is better)	**Target**	**% over target**
Q1 2022/23	95.8%	95.5%	0.3%
Q2 2022/23	95.6%	95.5%	0.1%

4.3 Reducing long term admissions to residential and nursing care 65+

Year to date (April 2022 to October 2022), permanent admissions were 25.4% lower than the same period last year and 3.1% above target.

The target for 2022/23 is 732 admissions per 100k population, which equates to a quarterly target of 182.

Quarter	**Actual** (lower is better)	**Target**	**% over/under target**
Q1 22/23	191	182	4.9%
Q2 22/23	131	182	-28%

4.4 Increasing the effectiveness of reablement

This target measures the percentage of older people (65 and over) who are still at home 91 days after discharge from hospital into reablement or rehabilitative services. This target is an annual measure and performance for 2021/22 was 93.7%.

Year	**Actual** (higher is better)	**Target**	**% over target**
2019/20	94.5%	89%	5.8%
2020/21	93.6%	89%	5.1%
2021/22	93.7%	91.7%	2%

5. Timescales associated with the decision and next steps

Better Care Fund Plan 2022/23

5.1 At the time of writing this report, confirmation has still not been received from NHS England, that our Better Care Plan for this year has met the planning requirements and conditions and has been approved. The deadline for receipt of this was 30th November 2022.

5.2 As in previous years, a Section 75 Legal Agreement will underpin the financial pooling arrangements, including for the Adult Social Care Discharge Fund outlined in sections 1.9 to 1.13. This cannot be signed until our Plan has been nationally approved. The intention is that the Section 75 agreement will be finalised and signed by 31st January 2023.

Better Care Fund Policy Framework 2023/24

5.3 As the Health and Wellbeing Board is already aware, the Better Care Fund Policy Framework is not usually published in advance of the year it relates to. Therefore, as in previous years, until more detail is available and timescales are known, it is proposed to plan ahead as normal. At the time of writing this report the Improved Better Care Fund (iBCF) settlement for 2023/24 has not been published, and so the draft iBCF plan for 2023/24 will be prepared based on the current allocation. Following feedback from Coventry and Warwickshire Integrated Care Board, and Warwickshire County Council's Corporate Board later in January, the draft iBCF plan will then be amended before finalisation in early 2023.

Appendices

1. Appendix 1 - Current iBCF list of schemes and draft changes.
2. Appendix 2 – ASC Discharge Fund Plan to 31/03/23.

Background Papers

1. None.
2. None.

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The report was circulated to the following members prior to publication:

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Other members:

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APPROVED LIST OF IBCF SCHEMES FOR 2022/23 - THIS WILL FORM THE BASIS FOR THE SCHEMES TO BE FUNDED IN 2023/24 - WITH CONTINUATION OF THE MAJORITY OF SCHEMES

National condition	Outcome	Scheme Ref	Summary of schemes	Existing or new scheme	22/23 Budget £000s
Reducing Pressure on the NHS	Reducing LOS, improving flow, supporting Discharge to usual place of residence	**Schemes include additional resources or support in acute or community based hospital settings and schemes directly supporting discharge and flow**			**2,067**
		W-IBCF 1	Hospital Social Care Team	Existing	**704**
		W-IBCF 2	Housing Hospital Liaison	Existing	**63**
		W-IBCF 3	Hospital Based Social Prescribing	Existing	**140**
		W-IBCF 4	Trusted Assessments	Existing	**152**
		W-IBCF 5	Domiciliary Care Referral Team	Existing	**75**
		W-IBCF 6	Hospital to Home Service	Existing	**444**
		W-IBCF 7	Moving on Beds	Existing	**294**
		W-IBCF 8	ICE Contract Increases (WCC & ICB)	Existing	**155**
		W- IBCF 9	Clearing/deep cleaning properties to support discharge	NEW in 22/23	**40**
	Admissions Avoidance	**Schemes include specialist and targeted support and interventions in the community to support admission or readmission prevention**			**1,927**
		W-IBCF 10	Support to Carers	Existing	**281**
		W-IBCF 11	Advocacy	Existing	**180**
		W-IBCF 12	Occupational Therapist capacity	Existing	**310**
		W-IBCF 13	End of Life	Existing	**249**
		W-IBCF 14	Falls prevention	Existing	**35**
		W-IBCF 15	Mental Health Street Triage	Existing	**263**
		W-IBCF 16	Adults with Autism	Existing	**280**
		W-IBCF 17	Residential Respite Care Charging Policy	Existing	**250**
		W-IBCF 18	Joint Commissioning	Existing	**79**
e market	Fee rates / increases	**Contributions to protecting older people community care budgets and NHS budgets through night support in ECH and Specialised Settings**			**5,752**
		W-IBCF 19	Residential and nursing care fee rates	Existing	**2,900**
		W-IBCF 20	Care at Home fee rates	Existing	**2,350**
		W-IBCF 21	Extra Care Housing Waking Nights Cover	Existing	**502**

Stabilising th	Market support and development	**Schemes to support the Provider Market include: Learning and Development, additional OT and specialist quality assurance resource and expertise to improve quality, reduce provider costs and prevent admissions, market sustainability and support for winter pressures etc**			**890**
		W-IBCF 22	Provider Learning and Development	Existing	**334**
		W-IBCF 23	Specialist support for providers, including OT to upskill providers, Quality Assurance support including a MH/Autism/LD practitioner	Existing	**181**
		W-ICBF 24	Market Sustainability	Existing	**375**
Meeting Social Care needs	Supporting adult social care pressures	**Schemes include contributions to demand pressures relating to older people community care budgets, dementia, social care capacity and housing related support**			**4,327**
		W-IBCF 25	Protecting older people community care budgets	Existing	**2,735**
		W-IBCF 26	Services to support dementia in the community	Existing	**475**
		W-IBCF 27	Care Management Capacity	Existing	**639**
		W-IBCF 28	Cost transfers from housing related support	Existing	**478**
Resource arrangements	Resources	**These schemes fund the resources (programme, project, analytical, insight and comms) to meet the BCF requirements and support system wide operational improvements to support discharge.**			**281**
		W-IBCF 29	Communications Support	Existing	**41**
		W-IBCF 30	Support	Existing	**240**
				Total	**15,244**
				Budget	**15,132**
					112

In previous years, delays and underspends to schemes have meant new initiatives have been scoped and agreed by the partnership Finance Sub-Group in year, to ensure funds are spent as per the conditions of the grant. The iBCF plan for 2022/23 is £0.1m (0.7%) more than funding, to pre-empt the need for this. This creates a potential risk to the ASC budget of £0.1m if all IBCF schemes were to spend their full allocation, which will be monitored by the Finance Sub-Group, and will be forecast through ASC budget monitoring to ensure any pressure is highlighted and mitigated or managed down. This risk is managed by WCC.

Appendix 2 – HWBB 11/01/23
Adult Social Care Discharge Fund list of schemes

Strategic Objectives and Schemes			**Estimated Scheme Cost**
Pathway 1 - Discharge to usual place of residence	Includes: 1. funding for the local authority to enable Care Act assessments to continue to be completed outside of the acute setting (package of care costs) 2. additional capacity for palliative care and hospice at home to support people to die at home 3. incentives for domiciliary care providers 4. Occupational Therapy support for Mental Health patient discharges		£1,304,083
	Includes: 5. Intermediate Care - Additional capacity in the Rehab at Home Offer supporting people to return home with therapy, and domiciliary care.		£296,520
Pathway 2 - Discharge to interim/ temporary step down bed	Includes: 1. funding for the local authority to enable Care Act assessments to continue to be completed outside of the acute setting (residential placement costs) 2. additional capacity re: nursing assessment placements outside of acute settings 3. designated settings (isolation beds) 4. additional capacity re: placements for complex patients 5. incentives for residential and nursing care providers		£2,123,216
	6. Bed Based Intermediate Care - Additional therapy beds and therapy provision		£336,333
	7. Additional hours and agency costs including to: mobilise increased community bed capacity and, clinical support and cover to support the additional bed capacity		£1,247,592
Assistive Technologies and Equipment to support Pathway 1 & 2 discharges	Includes: 1. Additional vans, drivers, equipment for additional intermediate care and assessment beds 2. Additional equipment for stroke patients		£123,200
Pathways 1, 2 & 3 - Other	Includes: 1. Integrated Care Board and local authority costs to cover additional resources to manage the additional activity		£529,652
			£5,960,596

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Agenda Item 10

Health and Wellbeing Board

11 January 2023

Assistive Technology and the Integrated Care Record

Recommendations

That the Health and Wellbeing Board

1. Note the update on improving and increasing the offer of assistive technology to Warwickshire residents to support prevention, early intervention and people with long term / complex needs; and

2. Note the update on the Integrated Care Record and how this technology enables health and social care staff and practitioners to have a more joined-up view of an individual's information to help them give better, safer care.

1. Executive Summary

1.1 Warwickshire County Council published an Assistive Technology Statement of Intent in 2018. The Statement of Intent highlighted three priority areas to improve and increase the assistive technology offer to customers across Warwickshire:

- Priority 1: Prevention - Technological solutions that empower people to enhance their own independence and well-being
- Priority 2: Early intervention - Technology that supports people to stay independent at home for longer and to access the community, education or employment.
- Priority 3: Long term/complex needs - Technology that helps support people with complex/long term conditions or health needs (telehealth)

1.2 Since publication of the Statement of Intent, a number of pilots and assistive technology schemes have been introduced to progress the ambitions outlined above. This paper, and the slides at Appendix 1, include some examples of the assistive technology being made available in Warwickshire across each of the priority areas of the Statement of Intent.

1.3 Evaluation of pilots has identified a number of challenges which need to be considered in improving access to assistive technology. These include:

- A need for culture change with customers and professionals to engage with non-traditional self-management solutions. Linked to this, it takes time for people to adopt new technologies.
- There needs to be consideration of how different technologies work together, and a greater consideration of what can be installed on personal phones.
- The new national analogue to digital switchover in due in 2023, when many analogue phone services will no longer be available for use. Whilst this transition period, until the final switchover deadline in 2025, will have an impact on care technology, it will also provide opportunities for the use of technology to offer greater input into the understanding of health and care for customers. Within the coming months, the Council will be upgrading its assistive technology equipment to digital solutions, further enhancing the benefits for customers health and wellbeing.

Integrated Care Record

1.4 The Coventry and Warwickshire Integrated Care Record (ICR) is an electronic, confidential, health and care record for people living in Coventry and Warwickshire, which brings together separate records from different organisations involved in an individual's health and social care. It lets professionals see relevant information about the care and treatment an individual has had or is currently receiving across all services. The roll out is essential to the delivery of the key priorities within the Coventry and Warwickshire Health and Care Partnership (HCP) and forms part of the HCP 5-year Digital Strategy.

1.5 Within Warwickshire County Council:

1. Relevant adult social care information from Warwickshire County Council has been shared since January 2022.
2. In March 2022 Adult Social Care and Support staff and practitioners started using the ICR, accessing relevant health information.
3. A project is in place to extend the Integrated Care Record to Children and Families' during February and March 2023.

2. Financial Implications

2.1 The pilots and schemes outlined in this paper have been funded by partners across Warwickshire and Coventry. There is the potential to reduce costs over time and evaluation of the impact of the pilots will be required in order to determine the long-term requirements.

2.2 In November 2020 Warwickshire County Council allocated £613k from the Corporate Investment Fund to deliver the Integrated Care Record in Warwickshire for Adults, with the project being extended to include under 18s and Children and Families. The funding included the IT development costs and licence fees for the first 5 years of use. The project has been across Adults and Children's Social Care with annual licence fees of c£66k. After 5 years, when the investment funding ceases, this will need to be funded by

revenue from within the two services. This will not be before 2025/26 and budget will need to be identified ahead of this.

3. Environmental Implications

3.1 There is the potential for some assistive technology solutions to reduce the need for travel, for example remote monitoring. The environmental implications of each of the pilot schemes will be considered within the evaluation.

4. Supporting Information

4.1 There are a range of assistive technology pilots and schemes that have been introduced across the three priorities within the Statement of Intent.

Priority 1 - Prevention

4.2 Kooth, which delivers a digital, mental wellbeing, early intervention, and prevention service available for those aged 11 up to 25, was commissioned in 2021 across Warwickshire and Coventry in response to an increasing number of young people self-harming, ending their own lives and presenting to mental health services and acute settings in crisis. This offer compliments the wider Coventry and Warwickshire Children and Young people's Emotional Wellbeing and Mental Health service, currently delivered by Coventry Warwickshire Partnership (CWPT)[1] and known as Rise and was supported with financial contributions from the ICB. Since its introduction in 2021, Kooth has widely enhanced the early intervention and prevention offer across Coventry and Warwickshire and has helped to manage the increased demand for emotional wellbeing and mental health support.

4.3 The new Wellbeing for Warwickshire collaborative partnership, which launched in April 2022, comprises a combination of methods for adults to access support around mental health and wellbeing. This includes Qwell, a standalone anonymous digital platform, which is available on any web-enabled, internet connected device (including laptop, smart phone, tablet) 24/7, 365 days a year. The service includes features such as messaging, forums, magazine articles and scheduled and 'drop-in' counselling sessions that take place between midday-10pm, Monday-Friday and 6pm-10pm Saturday and Sunday; counselling also occurs 365 days a year.

4.4 Four software applications have been piloted across Warwickshire and Coventry to evaluate their potential to support young people with autism to self-manage their needs following a mental health hospital discharge, or to avoid admission in the future. These are Brain in Hand, Molehill Mountains, Champions of the Shengha (Pro) and Lumi Nova – Tales of Courage. An initial evaluation of these pilots found that they were more suitable to support

[1] https://cwrise.com/

young people with lower levels of need, rather than those with very poor mental health and wellbeing. The evaluation also highlighted the need for culture shift to engaging with non-traditional self-management digital support solutions. A self-referral programme to these applications is being introduced from January 2023.

Priority 2: Early Intervention

4.5 The Warwickshire Integrated Community Equipment Service currently incorporates assistive technology within the community equipment offer, through the provision of a Lifeline service. Lifeline is a pendant alarm along with selected sensor devices that are worn by or placed within a customer's home to enable early indication, prevention and monitoring of a person's health and wellbeing. An alarm can be raised to a call centre that will notify next of kin or emergency services for a response, whilst sensors can monitor and detect when a person may require intervention such as experiencing a fall or seizure.

4.6 South Warwickshire Place identified an opportunity to use the Tribe application to help further develop support for vulnerable and isolated people who are more at risk following Covid-19 through making it easy to find local support providers, community groups and voluntary services. Tribe is being piloted with two groups: over 55 year olds living in extra care in Leamington and new parents in Shipston and surrounding villages.

4.7 The TEC (Technology Enabled Care) pilot started in February 2022 with 30 people who were discharged from George Elliot Hospital to North Warwickshire and Nuneaton and Bedworth areas. A set of monitoring sensors placed in people's homes to record activity such as mobility, nutrition and hydration levels. Case studies have shown the technology can identify a need for targeted support with nutrition and hydration due to self-neglect as well as ensuring the safety of people who frequently leave their property whilst offering reassurance to their family.

4.8 The Together We Grow pilot was launched in April 2022 to support 14 people with learning disabilities to develop a personalised programme to meet personal outcomes and goals that will promote independence. An interactive tablet is used to promote a person/s independence and improve independent living skills using apps, videos and prompts which are personally tailored to their individual needs. This could include prompting to take medication, having a shower, make a telephone call or video instructions to make meals.

Priority 3: Long Term / Complex Needs

4.9 The Virtual Care team have implemented Remote Monitoring for patients at home with Long Term Conditions (LTC), across Coventry and Warwickshire. This proactive remote care enables prevention of admissions, reduction in hospital and GP appointments and empowers the patient to enable management of their care with timely support. All supports the reduction of

load on the hospitals and Primary Care, improving patient flow and optimising capacity.

4.10 The parameters utilised within the digital technology are reviewed clinically enabling personalised care, tailoring the support from the ICC hub and triaging the alerts to activate an intervention where required within 2 hours. The frequent observations also enable longer term mapping of the long term condition, which further benefits the quality of personalised care.

4.11 The two main conditions currently supported are Chronic Obstructive Pulmonary Disease (COPD) and Heart Failure, with current expansion into other areas such as palliative care and continuation into other conditions within respiratory.

The Integrated Care Record (ICR)

4.12 The NHS Five Year Forward View set out that the traditional divide between hospitals, GP practices, community-based care and social care is increasingly a barrier to providing personalised and joined up services to people. The publication of Local Digital Roadmaps in 2016 across the NHS and Local Government indicated high levels of ambition for making better use of information for health and care. The Coventry and Warwickshire ICR is one element of the local response to this.

4.13 Implementation of the Integrated Care Record across health and social care commenced in 2021. Initially implementation was focussed on sharing information for adults (people aged 18 or over). Work has now commenced to extend it and the associated benefits to Children and Young People (under 18s). The IT development and infrastructure that has been implemented will enable further information sharing opportunities between health and social care to potentially now be able to be progressed in the future.

4.14 The organisations currently taking part in the programme are:

- GP practices within Coventry and Warwickshire
- Coventry and Warwickshire Partnership NHS Trust
- University Hospitals Coventry and Warwickshire NHS Trust
- George Eliot Hospital NHS Trust
- South Warwickshire NHS Foundation Trust
- Coventry City Council
- Warwickshire County Council
- West Midlands Ambulance Service University NHS Foundation Trust

4.15 Health and social care professionals are able to see appropriate information from an individual's records. Benefits to the individual include:

- not having to repeat their details every time they need care
- better and potentially, faster treatment as the professionals caring for them will be able to quickly see their records
- not having to explain their social care support to health professionals

- clinicians being able to see what medications they're taking, what they've taken in the past, and if they have any allergies – making your treatment safer.

It will also continue to make treatment more effective for anyone needing care for COVID-19 for example, thanks to the fast availability of information about any pre-existing conditions they might have and their medications.

4.16 Individual's do have the 'Right to Object' - the ability to opt out of their information being shared across health services and/or with social care.

5. Timescales associated with the decision and next steps

5.1 The following project milestones are in place for the Integrated Care Record:

- By end of January 2023 - Inclusion of relevant Children and Families information for under 18s in the ICR for use by health staff
- By the end of March 2023 - Children and Families' practitioners and staff to have access to relevant health information in the ICR.
- On-going activity – Continuing to embed the ICR in health and social care practitioners and staff development and practice (for Adults and Children and Families) to maximise the benefits for individuals and our workforce.
- April 2023 onwards – Potential further development of the ICR.

Appendices

Appendix 1 - Slides describing the assistive technology offers
Appendix 2 – Update on Docobo

Background Papers

1. For more information on the Integrated Care Record please refer to https://www.happyhealthylives.uk/staying-happy-and-healthy/digital/integrated-care-record/what-is-an-integrated-care-record/

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Introduction

Assistive technology is a broad term used to describe a range of different sensors and small pieces of equipment that can monitor, detect and support with a persons health and wellbeing. Technology advances at a rapid pace and not only includes traditional sensors but now can make use of everyday tools such as Alexa to interact and support with a persons health and wellbeing.

Warwickshire County Council currently commission a Lifeline Service which includes a pendant that is worn by the customer, along with optional monitored sensors to support with areas of health, wellbeing and daily living. Across Warwickshire just over 1000 people currently access this service.

Bed Sensor

Epilepsy Sensor

Medication Dispenser

The Council is keen to promote the opportunities and benefits of assistive technology as part of early intervention approaches as well as the benefits technology solutions can bring to complementing more formal methods of care.

Commissioning arrangements will be reviewed in early 2023 to explore how the assistive technology can be enhanced and promoted further across Warwickshire.

Assistive Technology Pilots

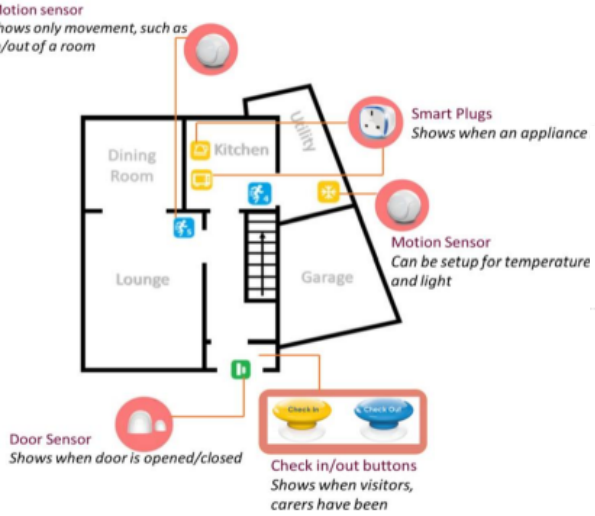
TEC Me Home Pilot

The TEC (Technology Enabled Care) pilot started in February 2022 with 30 people who were discharged from George Elliot Hospital to North Warwickshire and Nuneaton and Bedworth areas.

A set of monitoring sensors placed in peoples homes to record activity such as mobility, nutrition and hydration levels. Practitioners and families were able to easily see progress and changes in patterns of behaviour through a dashboard. The system identifies lifestyle alerts for anything it senses out of the 'norm' for that individual that carers and family can then consider. Examples – not switched kettle on

Outcomes for the pilot:

- Utilising peoples strengths to complement existing services and enhance physical health and wellbeing
- Preventing increased need for statutory services
- Supporting increased access to the local community
- Collaborative approach between housing, health and social care



Assistive Technology Pilots

TEC Me Home Pilot

TEC Me Home AT Pilot with Cascade 3d Connected Care System is showing how the latest technology can work for people in Warwickshire, it can support to reduce the barriers and fear of using technology to support with care and provides informal carers with new tools and access to support their role and improve their own health and wellbeing.

So far informal carers have reported regularly looking at the dashboard to check on their family member, such as before they go to sleep, when they are on holiday or if they are unable to contact them on the phone.

Case studies have shown the technology to identify a need for targeted support with nutrition and hydration due to self-neglect as well as ensuring the safety of people who frequently leave their property whilst offering reassurance to their family.

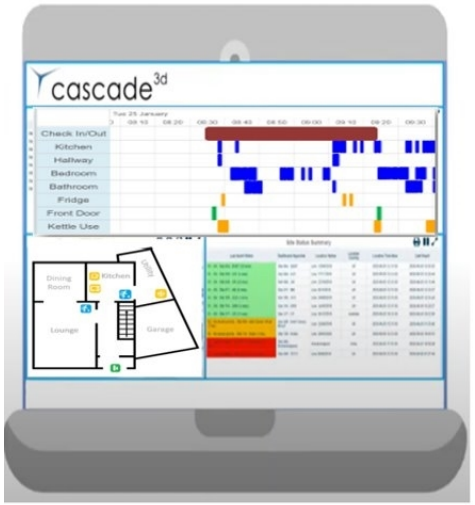
"Thank goodness someone has created it, I'm so grateful for the reassurance"

"My sister lives far away so this will help her be part of dads care. Seeing the floor plan and where the sensors are in the house is a good idea."

"The system has become more accepted the longer it has been in."

"Dad said he was making himself teas throughout the day but we can see he hasn't as the sensor shows the kettle has not been used"

"I check the dashboard of an evening, it gives me such peace of mind."



Door sensors

Smart plugs

Motion sensors

Assistive Technology Pilots

Together We Grow Pilot

This pilot was launched in April 2022 to support 14 people with learning disabilities to develop a personalised programme to meet personal outcomes and goals that will promote independence.

Interactive tablets that can allows a range of apps to be installed to promote a persons independence and improve everyday skills using apps, videos and prompts which are personally tailored to their individual needs.

This could include:

- Prompting for example to take medication, having a shower, make a telephone call
- Video instructions for example to make meals

Outcomes for the pilot:

- Utilise a strength based approach to promote self choice and control over their lives and support received
- To gain an evaluation of the outcomes that can successfully be achieved through an interactive digital service
- To support increased access to the local community
- Collaborative approach between housing, health and social care

Assistive Technology Pilots

Together We Grow

The Together We Grow pilot has proven to enable and support people with learning disabilities to live confident and independent lives.

As customers gain confidence or independence levels increase, such as moving to new accommodation, the technology can be adapted and updated with new apps or prompts to ensure it always meets their needs.

Five case studies from the pilot have been supported with a move to college/university or into supported living.

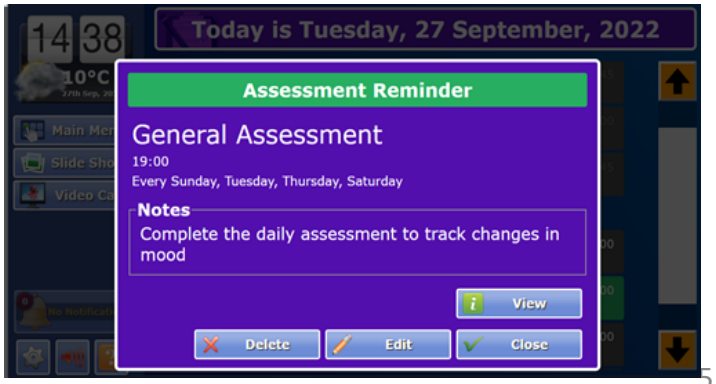
Mood assessment apps have been used for two customers to monitor customers wellbeing and raise alerts to carers if needed. So far this has shown to be working well.

The pilot has also led to some lessons learnt for future work with assistive technology:

- To make sure systems are interoperable and can work with each other
- To make sure systems can be accessed on mobile phones as well as tablet devices
- To consider the length of time for implementing new technology and engaging with target groups.

I use it for everything… I don't rely on anyone else for anything now… I will want to keep using it for the foreseeable future

Case Study: Customer was living with daughter but now lives alone. Was initially very intimidated by technology but now uses to check prompts for medication, meals, caring for pet and has a daily mood assessment tool. She can video call her daughter and is enjoying games like Patience!



Introduction

Coventry and Warwickshire, Birmingham and Solihull, and Herefordshire and Worcestershire have localised plans for implementation of a 'Shared Care Record'. The three ICS areas cover a population of 3.1m with a total of thirty-eight lead organisations – nine lead partner organisations in Birmingham and Solihull, twenty lead partner organisations in Hereford & Worcestershire, and nine lead partner organisations in Coventry & Warwickshire involved. The Shared Care Record is locally called the:

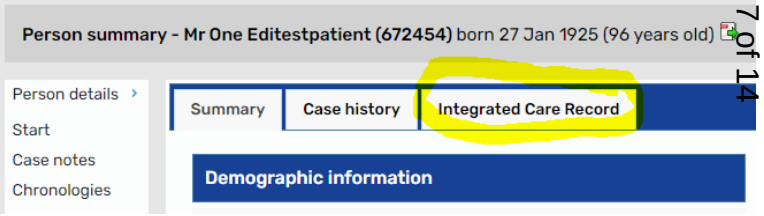
- **Coventry and Warwickshire Integrated Care Record (ICR)**
- Birmingham and Solihull Health Information Exchange
- Herefordshire and Worcestershire Integrated Care and Wellbeing Record

The ICR is an electronic confidential health and care record for people living in Coventry and Warwickshire, which brings together separate records from different organisations involved in an individual's health and social care. It lets professionals see relevant information about the care and treatment an individual has had or is currently receiving across all services, and forms part of the Health and Care Partnership's 5-year Digital Strategy.

[Video - The Integrated Care Record Purpose and Benefits]

Warwickshire County Council

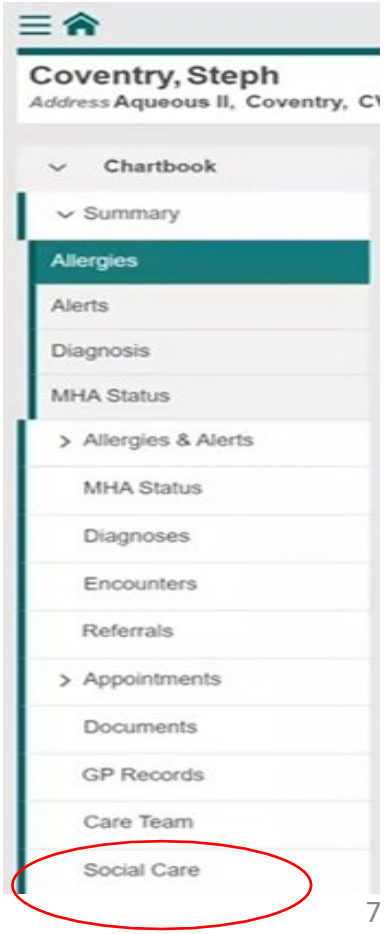
How easy is it to use and access relevant information?



For social care staff the ICR is launched from within Mosaic (the Social Care case management system), when in a customer's record

As well as demographic information the following health information is now shared with social care:

- ✓ GP Details
- ✓ Details of other health professionals working with the customer
- ✓ Allergies and alerts
- ✓ Family, illness, and social history
- ✓ Medication
- ✓ Current illnesses and diagnoses
- ✓ Electronic discharge documents
- ✓ Care Plans
- ✓ Contacts the person has had with health services



NHS staff are also now able to see the following Adult Social Care information

- ✓ Address and Contact Details
- ✓ Next of Kin
- ✓ Service User Group (e.g. Learning Disabilities, Physical Disabilities or Sensory Services, Older People)
- ✓ Any communication Needs
- ✓ Name of the allocated worker or team
- ✓ If the person has a support plan and basic details about this
- ✓ The date of Care Act Assessments for the last two years
- ✓ If there is an active safeguarding enquiry or safeguarding plan (including self-neglect)

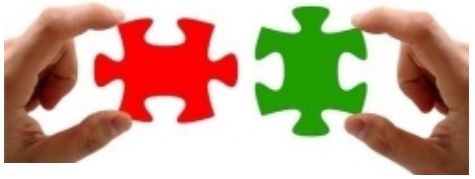
Warwickshire County Council

[For more information refer to the Integrated Care Board website]

Progress to date

There are two parts to implementing the ICR in each partner organisation:

1. **Sharing** relevant health or social care information, and
2. **Viewing** the information shared and embedding into practice



The initial focus for all partners was on sharing information relating to adults (18+).

- Adult Social Care and Support Teams in Warwickshire County Council started sharing relevant social care information for 18+ in January 2022 and gained access to the health information in the ICR in March 2022. During week ending 7th November 2022, the ICR was viewed 122 times by social care teams, relating to 102 individual customers.
- The focus has now moved to under 18s, with an aim to start sharing and using relevant information during January to March 2023.

Current roll-out plan

All partners (with the exception of West Midlands Ambulance Service which is planned for Nov/Dec 22) are now sharing relevant information into the ICR for people aged 18+. In addition, GPs and Coventry and Warwickshire NHS Partnership Trust are also sharing information for under 18s.

South Warwickshire Place Partnership

tribe
Care. Support. Community.

Key Priority: Covid 19 Recovery

South Warwickshire Place identified an opportunity to use the Tribe to help further develop support for vulnerable and isolated people who are more at risk following Covid-19 through making it easy to find local Support Providers, Community Groups and Voluntary Services.

tribe
Care. Support. Community.

South Warwickshire Tribe Pilot sites

Two distinct cohorts and areas within South Warwickshire have become early adopters to test and develop Tribe's potential. Tribe is currently being populated by Support Providers, Community Groups and Voluntary Services.

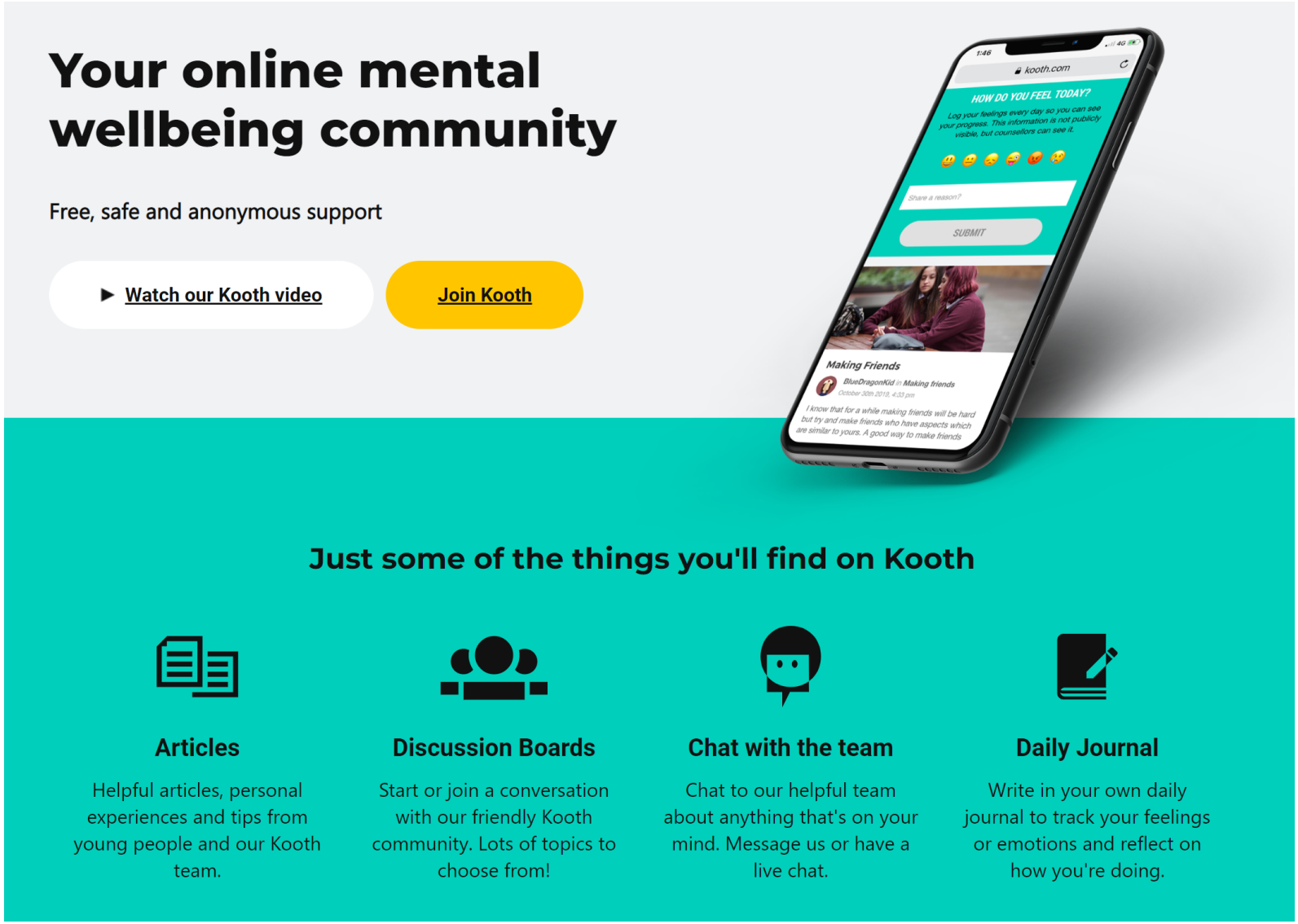
1) Over 55s cohort at Queensway Court Extra Care Facility in Warwick - supporting increased access to services that may help prevent health deterioration.

2) New parents in Shipston and surrounding villages - with particular focus on mental health and new parents who did not have access to usual services due to lockdown and high number of covid cases.

Place is working with Bronze Labs and Public Perspectives to evaluate the pilots and inform next steps and potential wider rollout. Partners include, WCC, SWFT, WCAVA, Bernados, Parentlink, Age UK, Orbit, Stour Heath & Wellbeing Partnership,

Screenshot of Wellbeing for Warwickshire website

Watch the video outlining the offer here:
https://www.youtube.com/watch?v=RI8wM6YVR6Y



Screenshot of Kooth website www.kooth.com

Watch the video outlining the offer here:
https://www.kooth.com/video

braininhand

BiH | For Me | Education | Health & Social Care | Workplace | Assessors | Main Menu | Login or Register

Click to navigate: about | settings | case studies | mission | research | careers | contact

You on your best day

Manage life's bumps in the road, the unexpected and unfamiliar, with simple digital tools and real human support just when you need it.

Brain in Hand is your link to the organised, calm, in-control you who knows exactly what to do when things get difficult. It's with you every step of the way, helping you to solve problems, stay on top of things, and manage anxiety so you can achieve your goals.

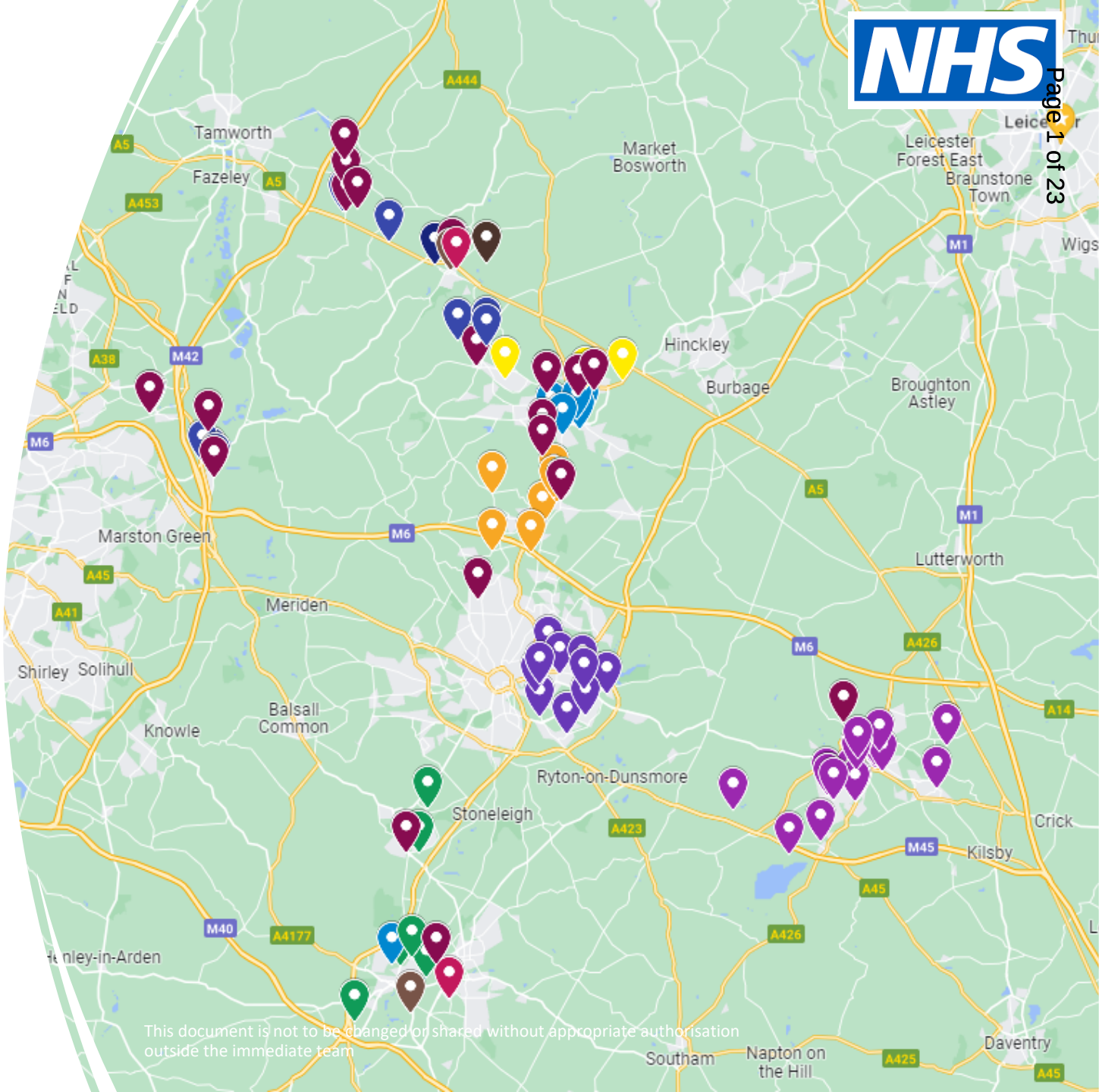
The integrated Brain in Hand system

Brain in Hand is a digital self-management support system for people who need help remembering things, making decisions, planning, or managing anxiety. It's not condition-specific, but is often used by people who are autistic or managing anxiety-related mental health challenges. Combining practical human support and digital self-management technology, Brain in Hand helps people live more independently.

Screenshot of brain in hand website https://braininhand.co.uk/

Teleheath Remote Monitoring Programme Summary November 2022

Programme Board Report – November 2022



Contents

1. Programme Summary

Programme Summary November 2022

Current – 3850

Remote Monitoring in care Homes – Total 3281	
North	1403
South	396
Rugby	754
Coventry	1297

Totals include Care Homes and Long Term Conditions

Programme Summary November 2022

Key Success

- Champions Events – *SB to present*
- Care homes - Considerable potential time saving with the GP average time saving total of approx. **214 hours** (inc. admin time) and approx. **148 hours** for Care Home hours
- Triage time under 2 hours at 62 mins for 92% of alerts
- Heart Failure Patient Evaluation – *see slides*
- COPD Evaluation – *see slides*

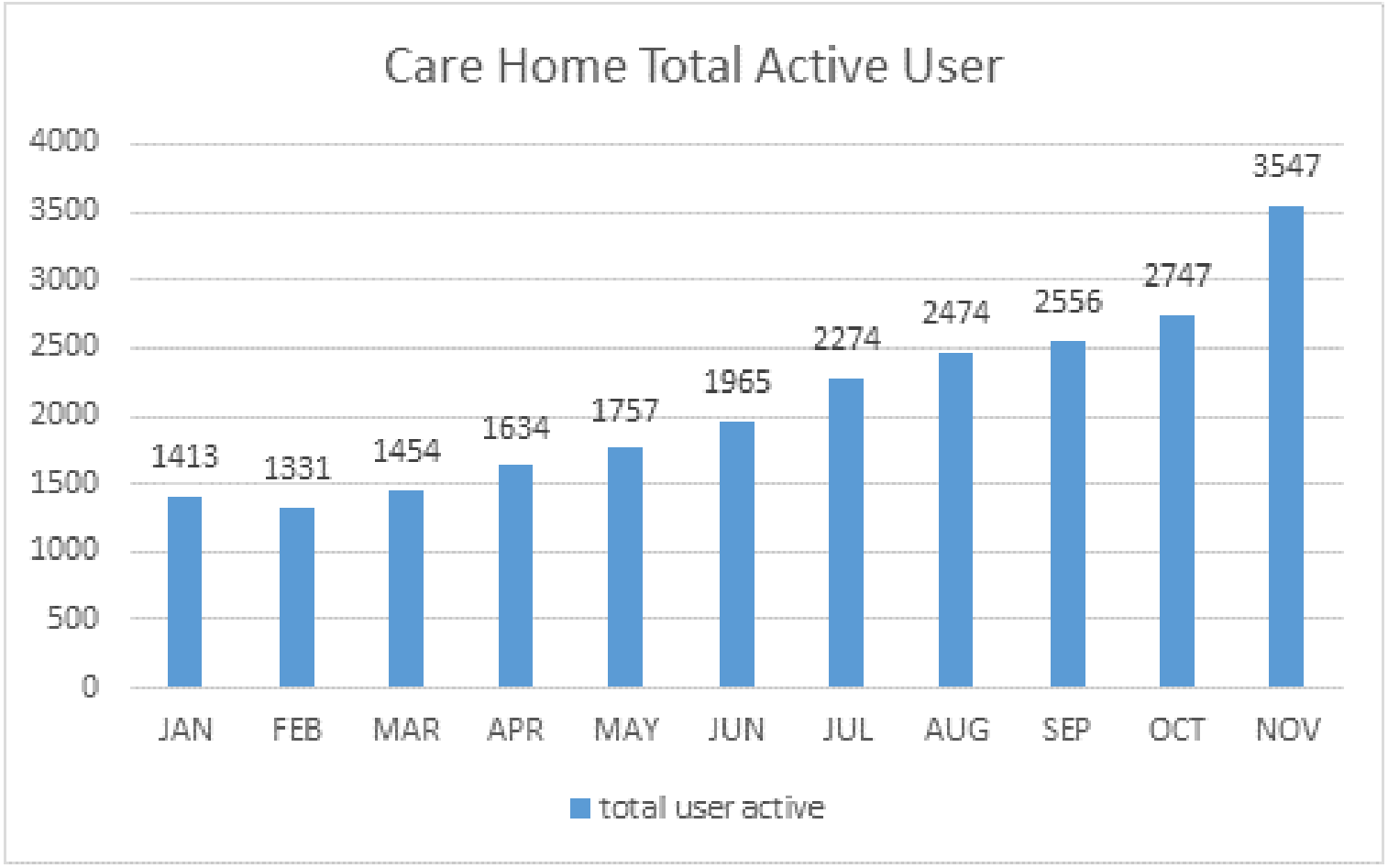
Focus & Delivery

- Coventry Care homes have now been delivered apart from in Coventry North PCN
- Long Term Conditions January – March to be upscaled increasing the COPD and Heart Failure patients in line with resource
- Benefit analysis – Admission avoidance, time saving, speciality audits

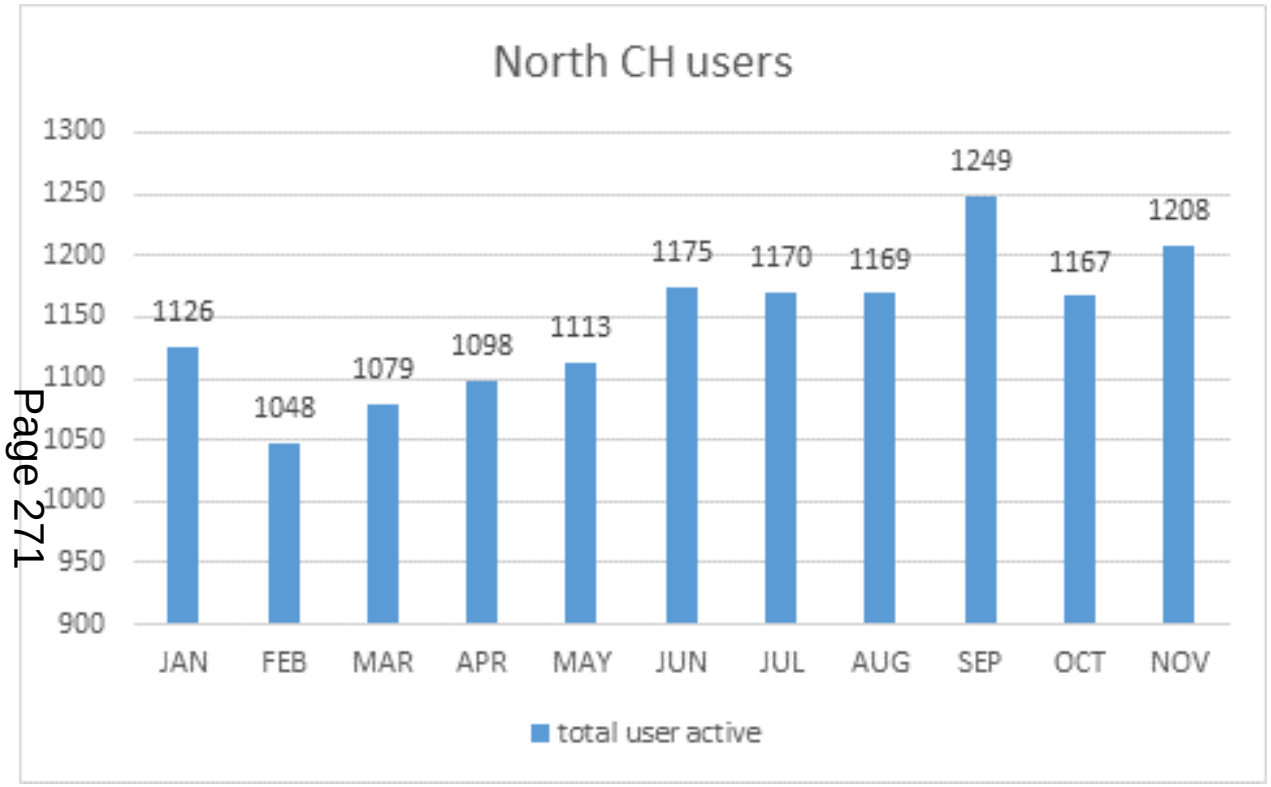
Key Risks & Issues

- Recruitment and resource is impacting the team. This should be in part resolved in part by January 2023
- Recruitment drive to be planned to increase the clinical Caseload Nursing /Project Management team with a potential information day

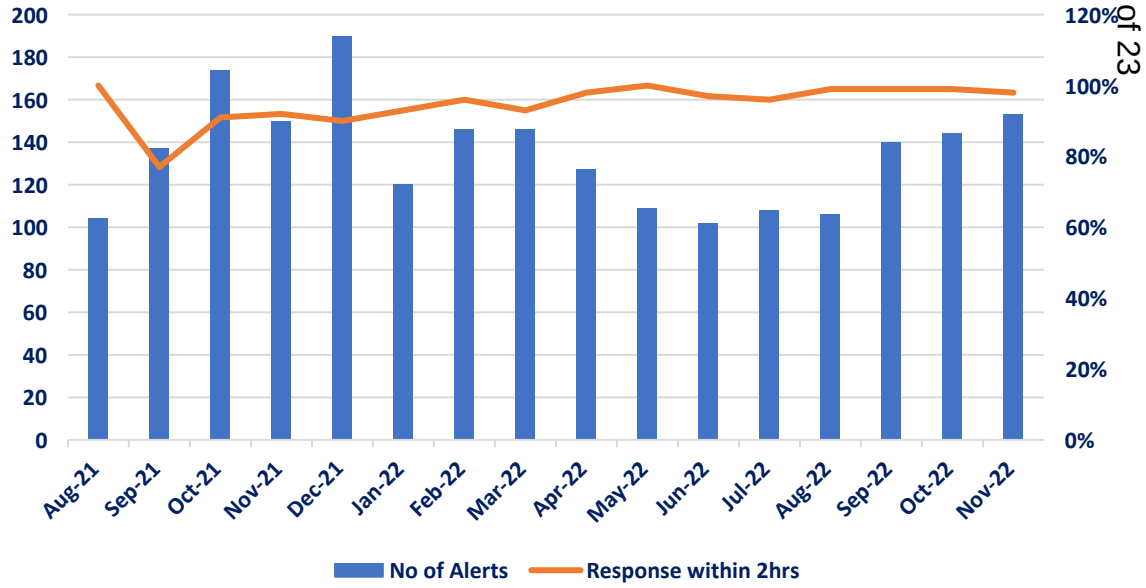
Programme Summary November 2022



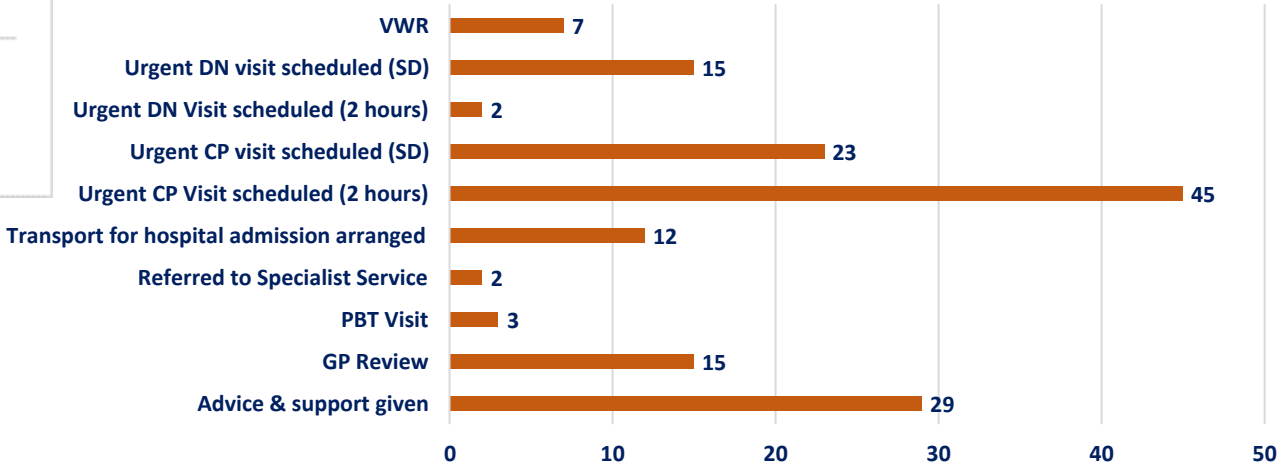
Programme Summary November 2022
North Warwickshire



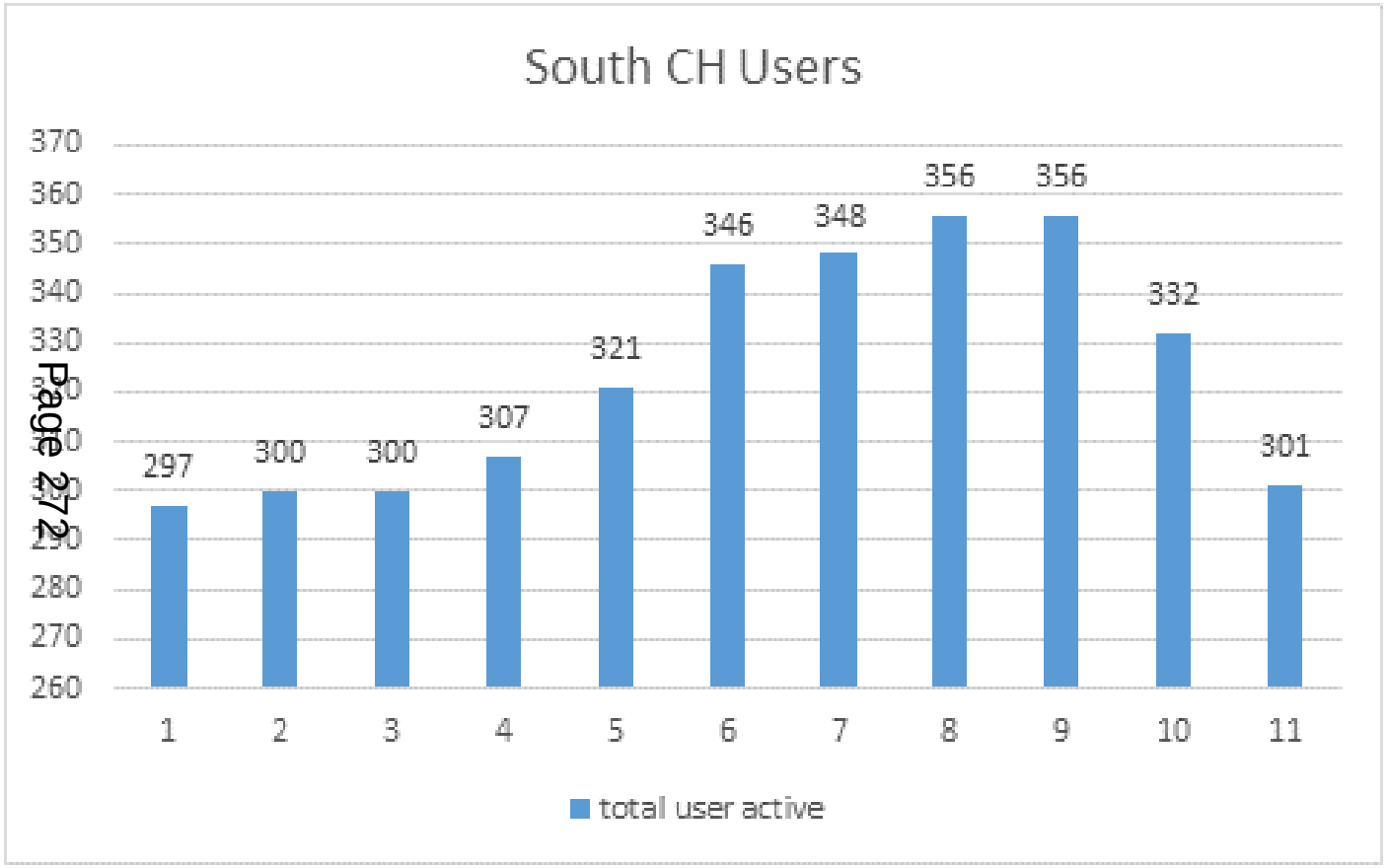
Docobo North - ICC Alerts & Time Taken



Deteriorating Alerts Actions Completed North - November 22

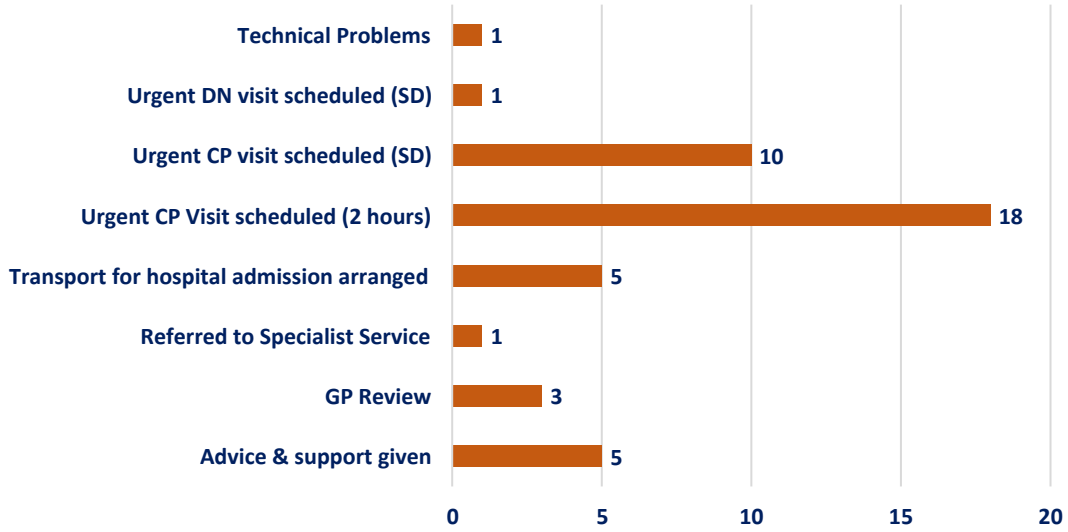


Programme Summary November 2022
South Warwickshire

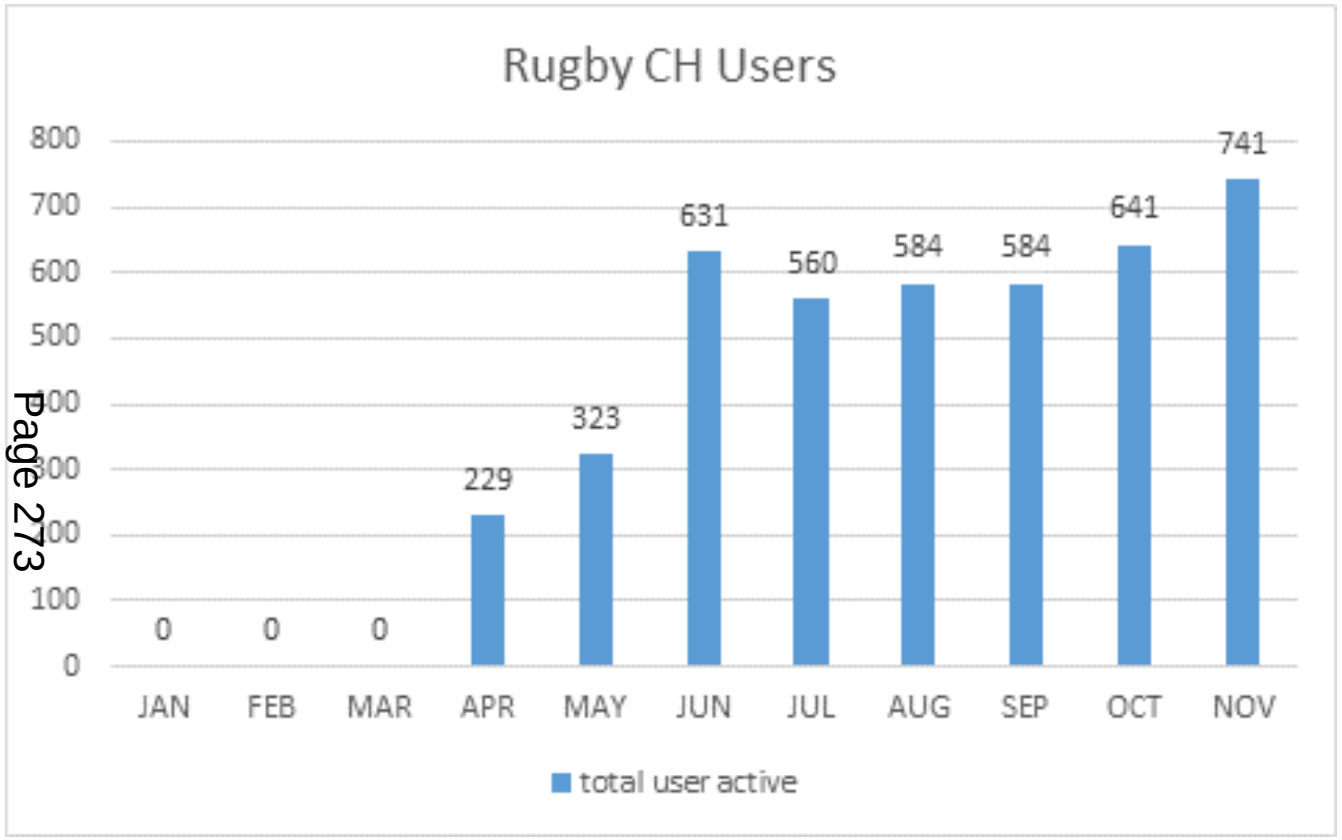


Docobo South - ICC Alerts & Response within 2 Hours

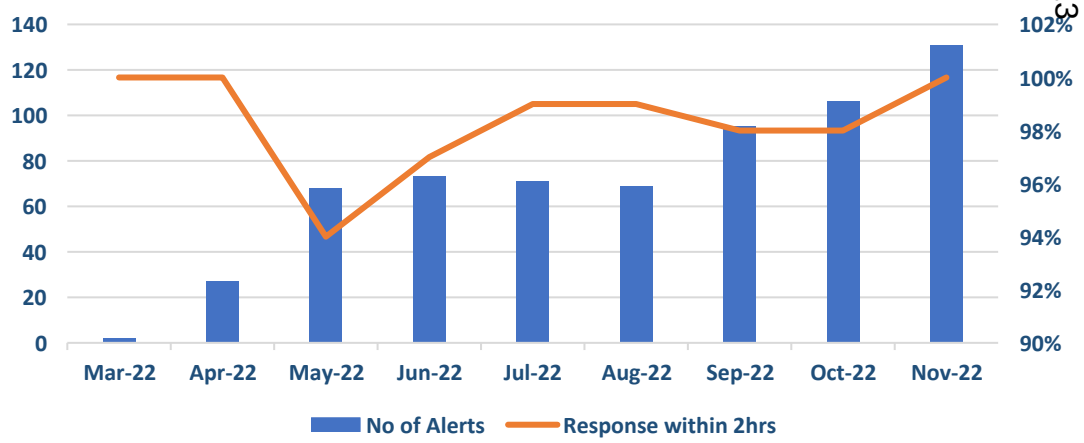
Deteriorating Alerts Actions Completed South - November 22



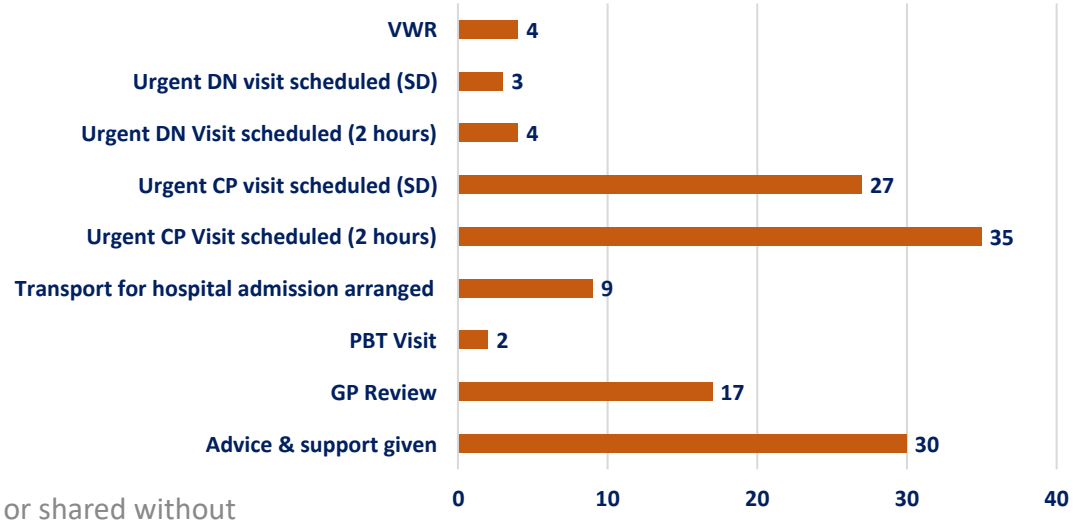
Programme Summary November 2022
Rugby



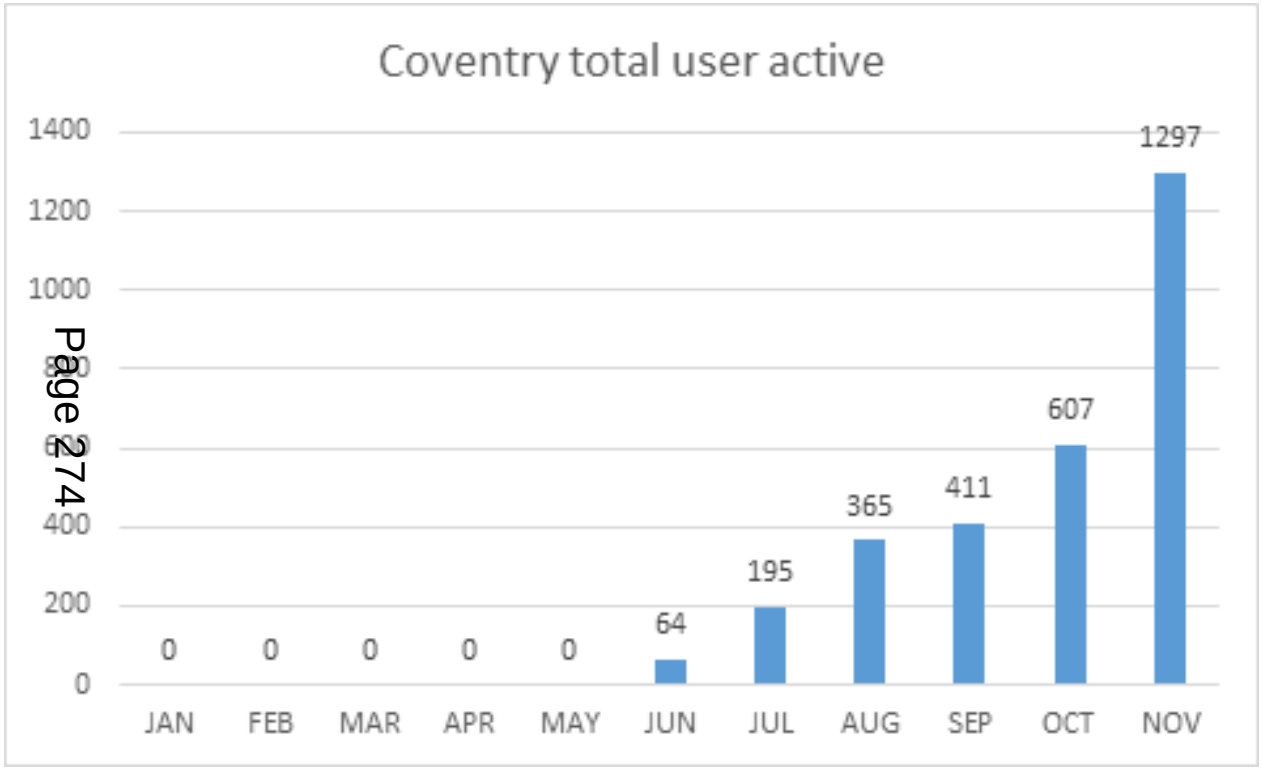
Docobo Rugby - ICC Alerts & Response within 2 Hours



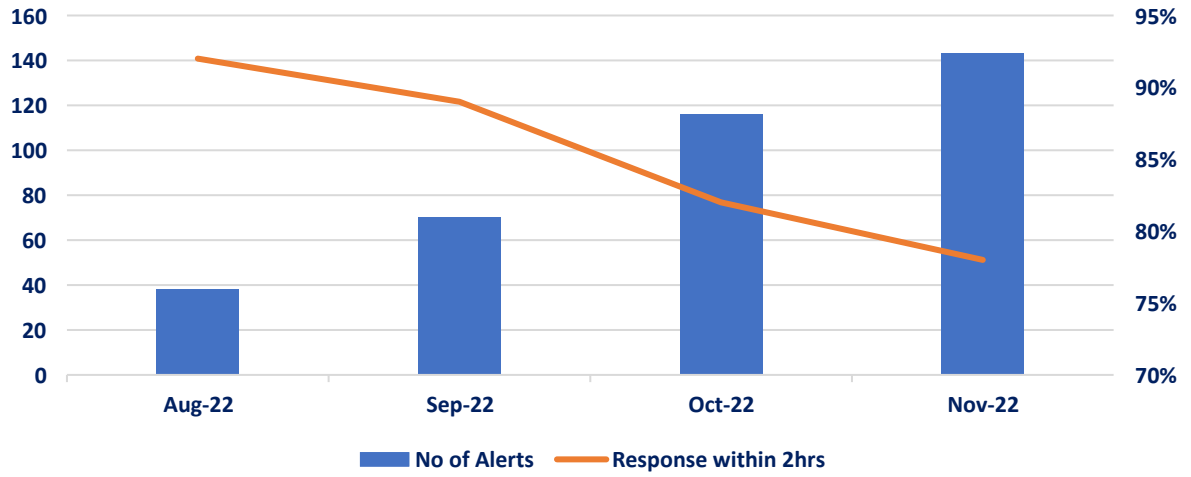
Deteriorating Alerts Actions Completed Rugby - November 22



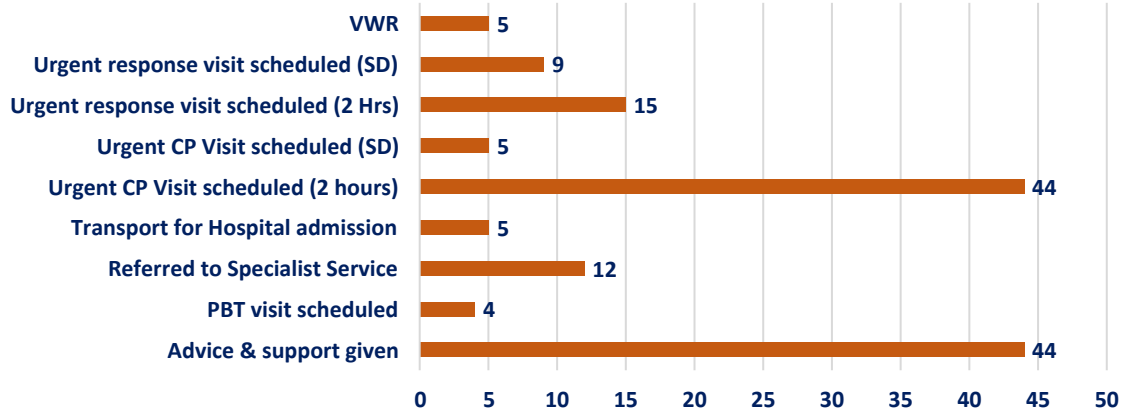
Programme Summary November 2022
Coventry



Docobo Coventry - ICC Alerts & Response within 2 Hours

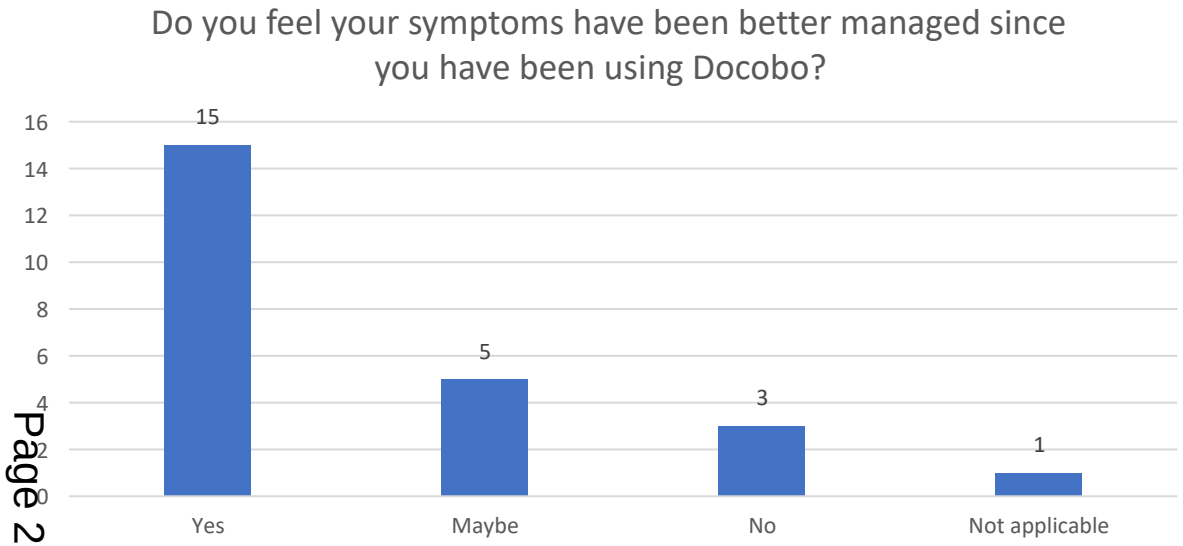


Deteriorating Alerts Actions Completed Coventry - November 22

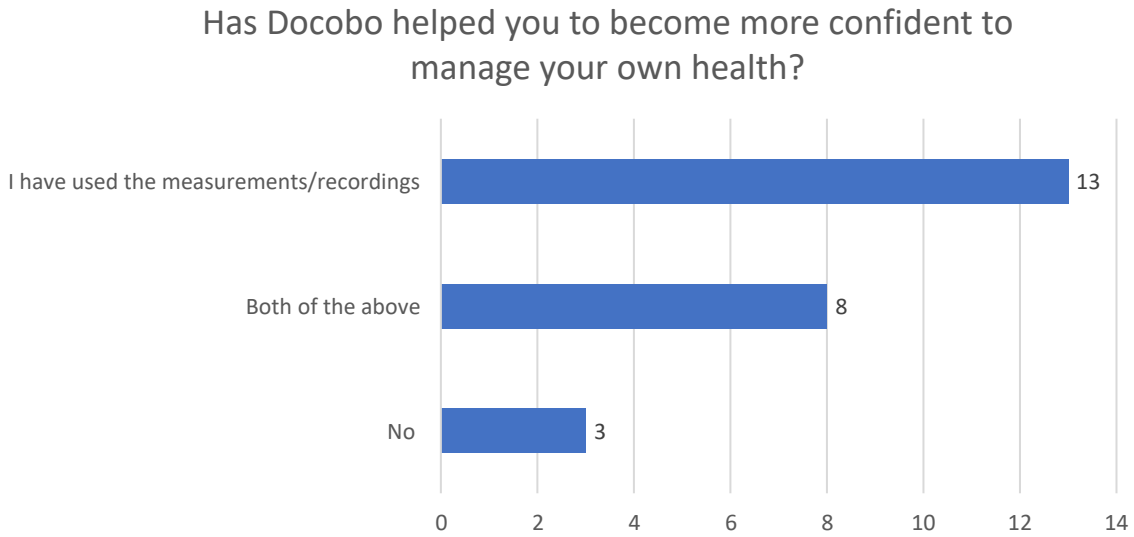


2. Heart Failure Evaluation

Telehealth Docobo – Heart Failure Patient survey – Nov 2022

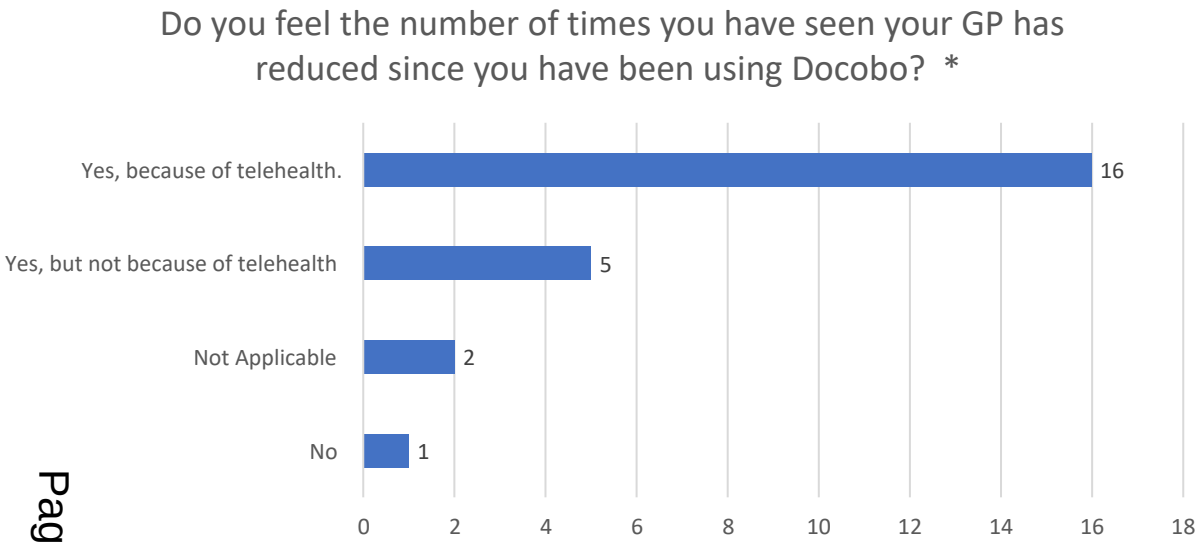


- The next questions focused on Patients health since using the service.
- 15 or 62% said they thought that their symptoms had been managed better since using the service.

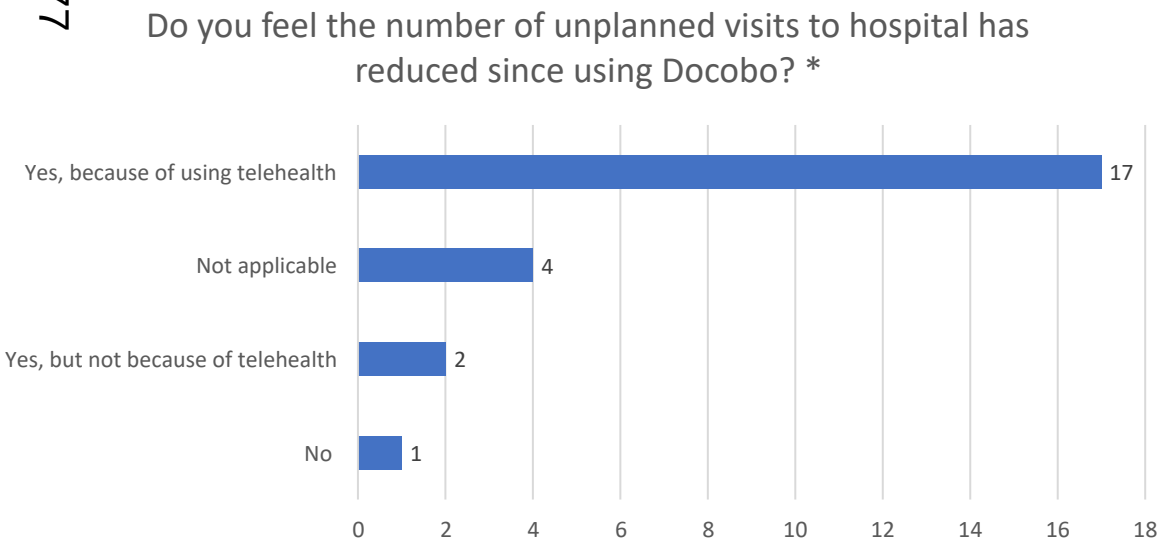


- 21 or 87% of responders said they felt more confident about managing their help as a result of using measurements and recordings they had taken whilst using the service.

Telehealth Docobo – Heart Failure Patient survey – Nov 2022

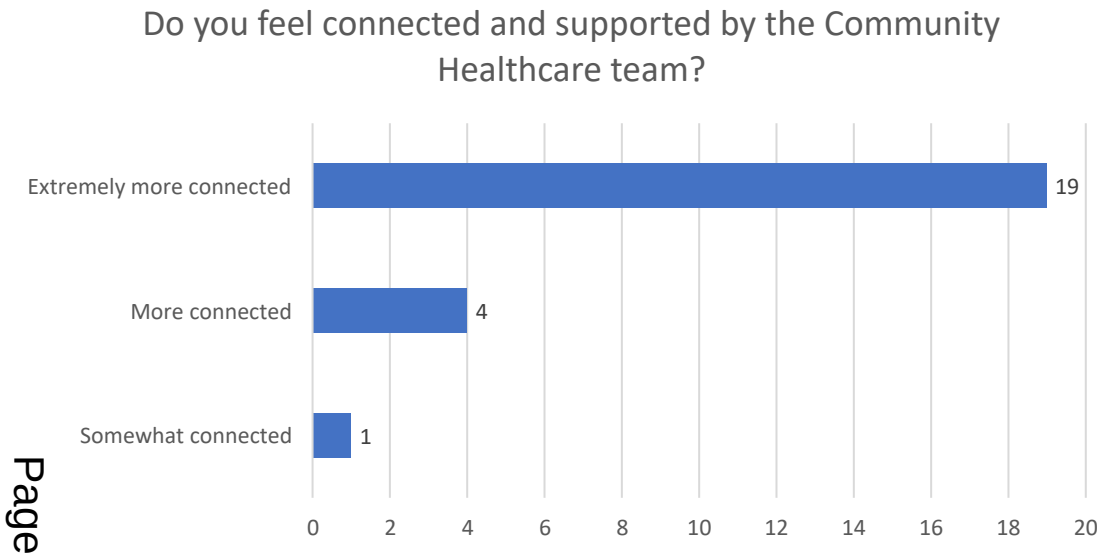


- The next questions focused the Patients thoughts about impact of using Primary Care since using the service.
- 16 or 66% of Patients said they thought their need to see GP had reduced because of using Docobo service

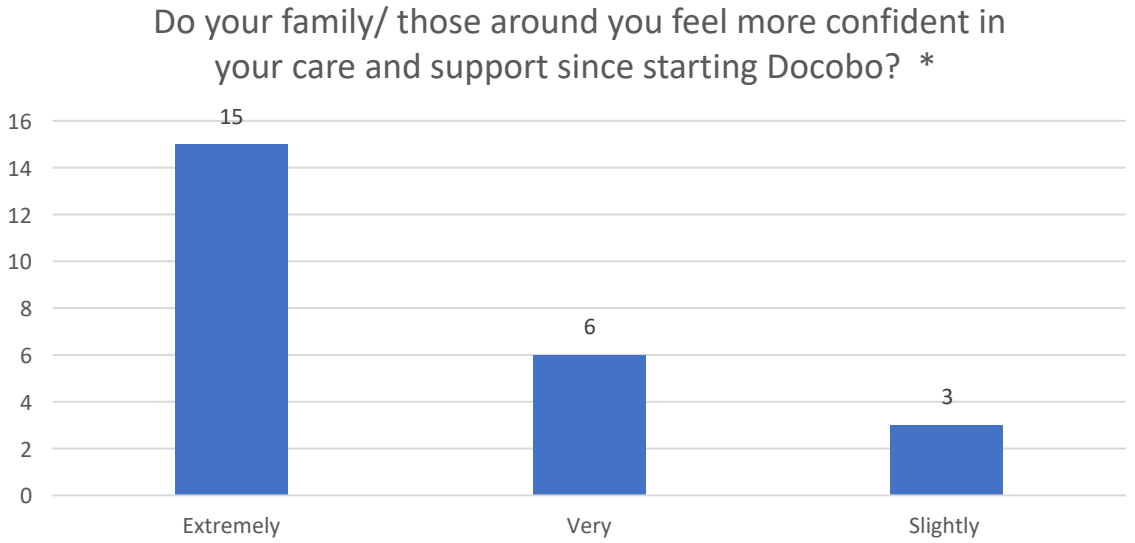


- 17 or 70 % of responders said they thought the number of unplanned visits to Hospital had reduced as a result of using Docobo Service.

Telehealth Docobo – Heart Failure Patient survey – Nov 2022



- The next questions focused on Patients confidence in the service and Confidence of their Families and Loved ones since thy had used Docobo.
- 23 or 95% of Patients said they felt More or extremely more connected to Community Health since using the service.



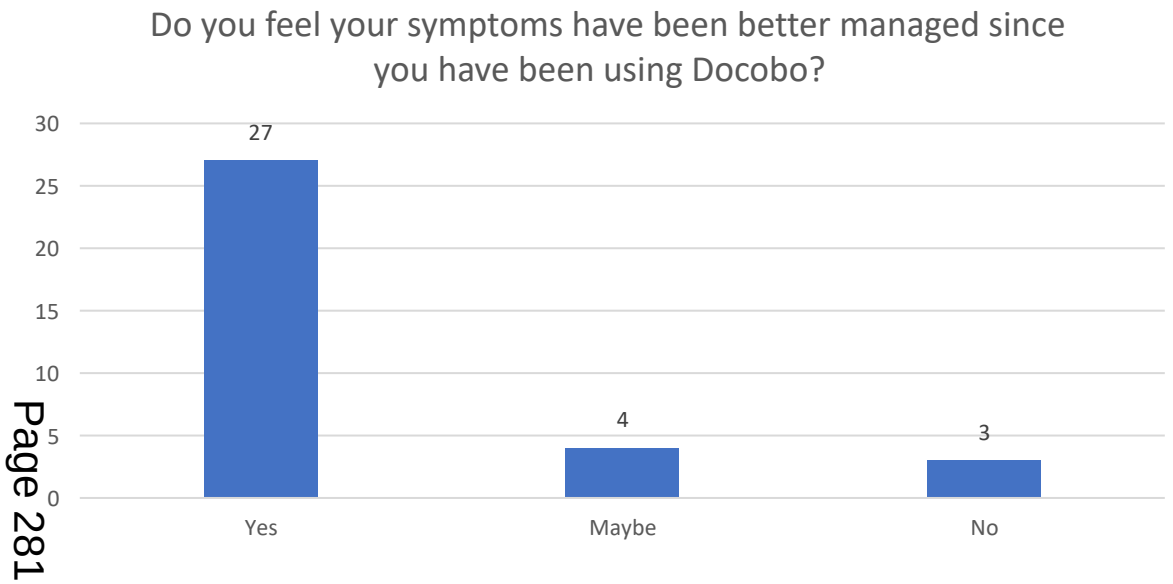
- All Patients said they felt their Families and Loved ones felt more confident about their Care since using the service with 21 or 87% feeling Very or extremely more confident.

Telehealth Docobo – Heart Failure Patient survey – Nov 2022

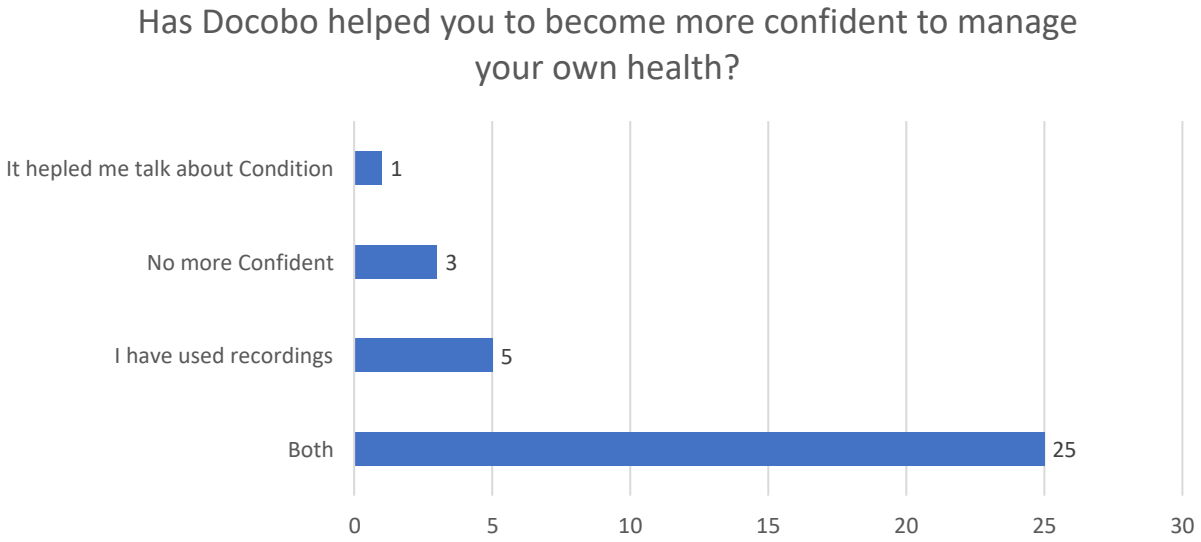
Comments & Feedback

3. COPD Evaluation

Telehealth Docobo – COPD Patient survey – Nov 2022

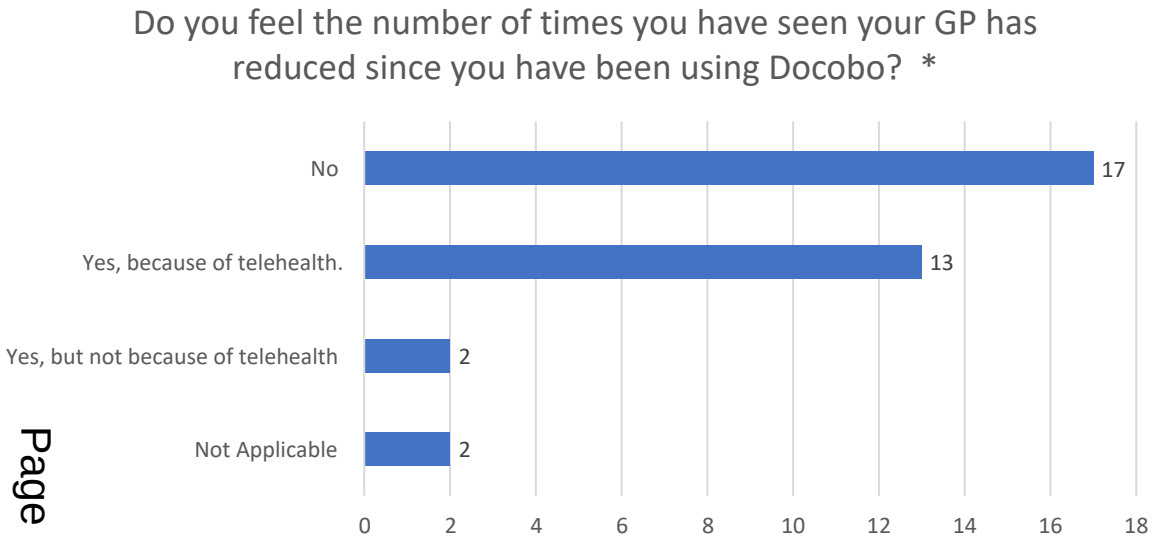


- The next questions focused on Patients health had been managed since using the service.
- 27 or 79% said they thought that their symptoms had been managed better since using the service.

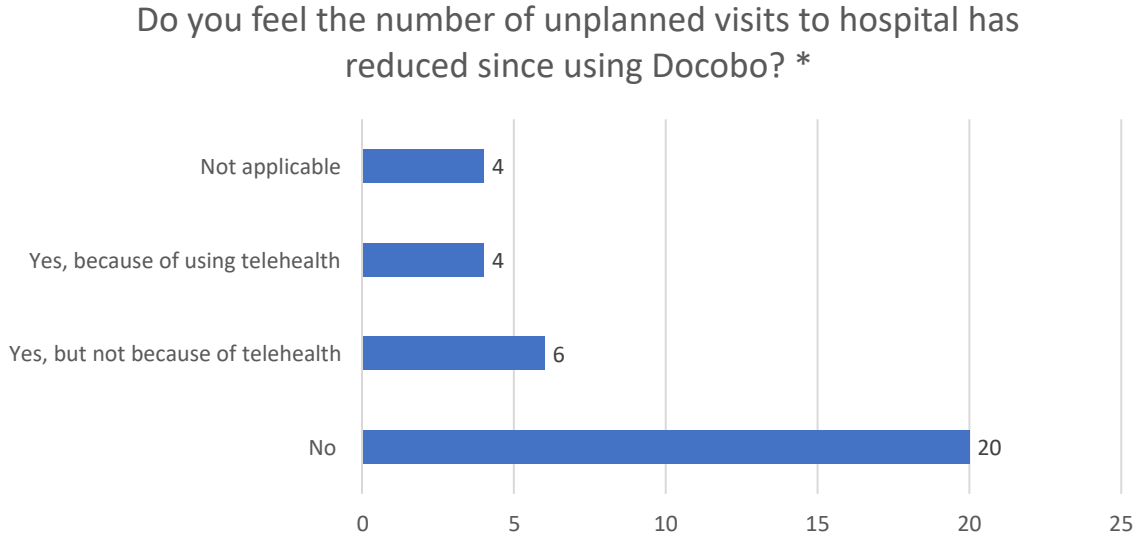


- 31 or 91% of responders said they felt more confident about managing their health as a result of using measurements and recordings they had taken whilst using the service.

Telehealth Docobo – COPD Patient survey – Nov 2022

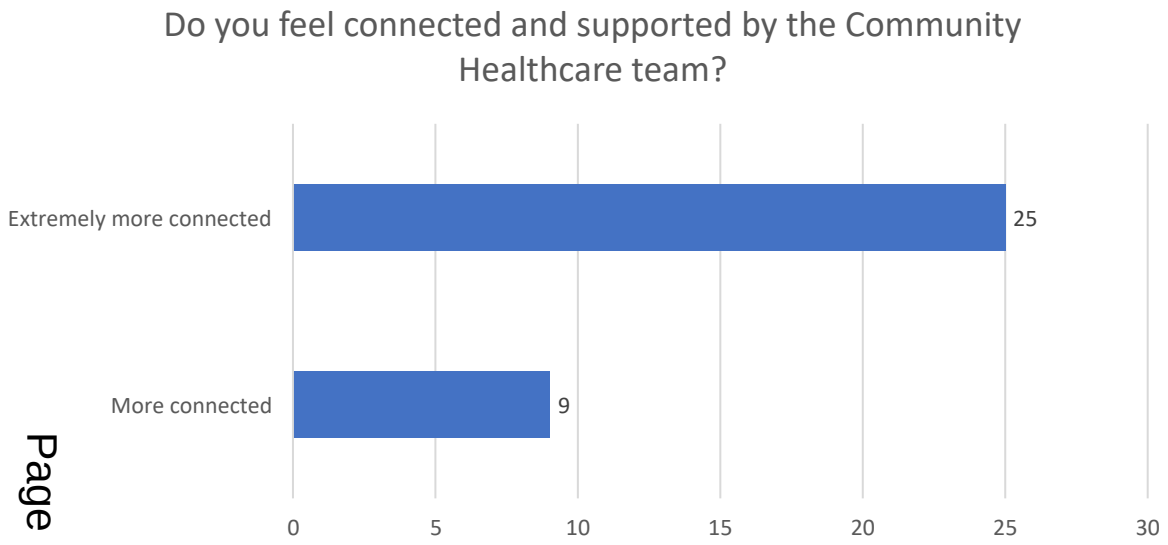


- The next questions focused the Patients thoughts about impact of using Primary Care since using the service.
- 13 or 38% of Patients said they thought their need to see GP had reduced because of using the Docobo service.

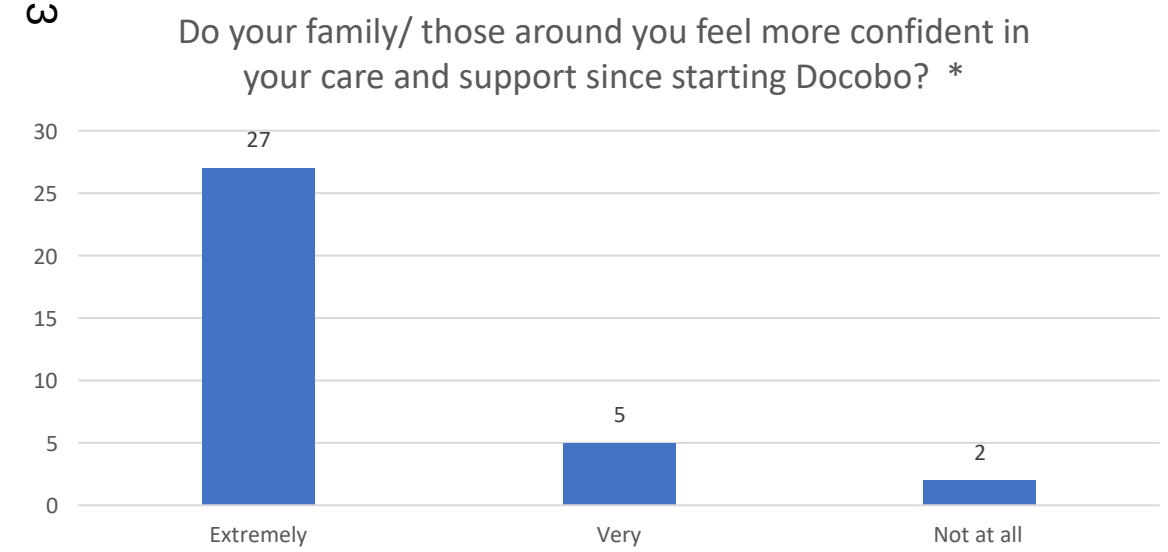


- 4 or 12 % of responders said they thought the number of unplanned visits to Hospital had reduced as a result of using Docobo Service.

Telehealth Docobo – COPD Patient survey – Nov 2022



- The next questions focused on Patients confidence in the service and Confidence of their Families and Loved ones since thy had used Docobo.
- 34 or 100% of Patients said they felt More or Extremely more connected to Community Health since using the service.



- 32 or 94% Patients said they felt their Families and Loved ones felt more confident about their Care since using the service with 27 or 89% feeling extremely more confident.

Telehealth Docobo – COPD Patient survey – Nov 2022

4. Risks & Issues

Programme Risks October 2022

Risk Name	Risk Description	Project	Likelihood	Severity	RAG Status / Risk Score	Mitigation Plan	Owner	Executive Owner	Status
Potential Security Risk	Docobo app allows free text data entry to identify specific user. This potentially leads to erroneous data in the audit trail, meaning the data entered cannot be directly attributed to a specific, authenticated user. A rogue user could deliberately enter false data, resulting in changes to the clinical response.		1	3	3	Patient issues not properly escalated would be routinely escalated through normal care home procedures (111/999). Patient data cannot be entered without entering the correct DOB of a registered patient. Appropriate care home policies and procedures and corresponding staff training.	AF	J.Northcote	Open
Resourcing	The resource for the team to deliver against target is extremely limited, which will have a negative impact on the programme.		4	4	16	There is plan in place for recruitment of further clinical and administrative staff to enable the programme but this is currently paused. Limited uptake with some roles and an recruitment event to be organised	JL	RH	Open

'multi agency, multi disciplinary working at its best'

A collaborative project by:

Docobo Ltd NHS Coventry and Warwickshire ICB

NHS Coventry and Warwickshire Partnership Trust

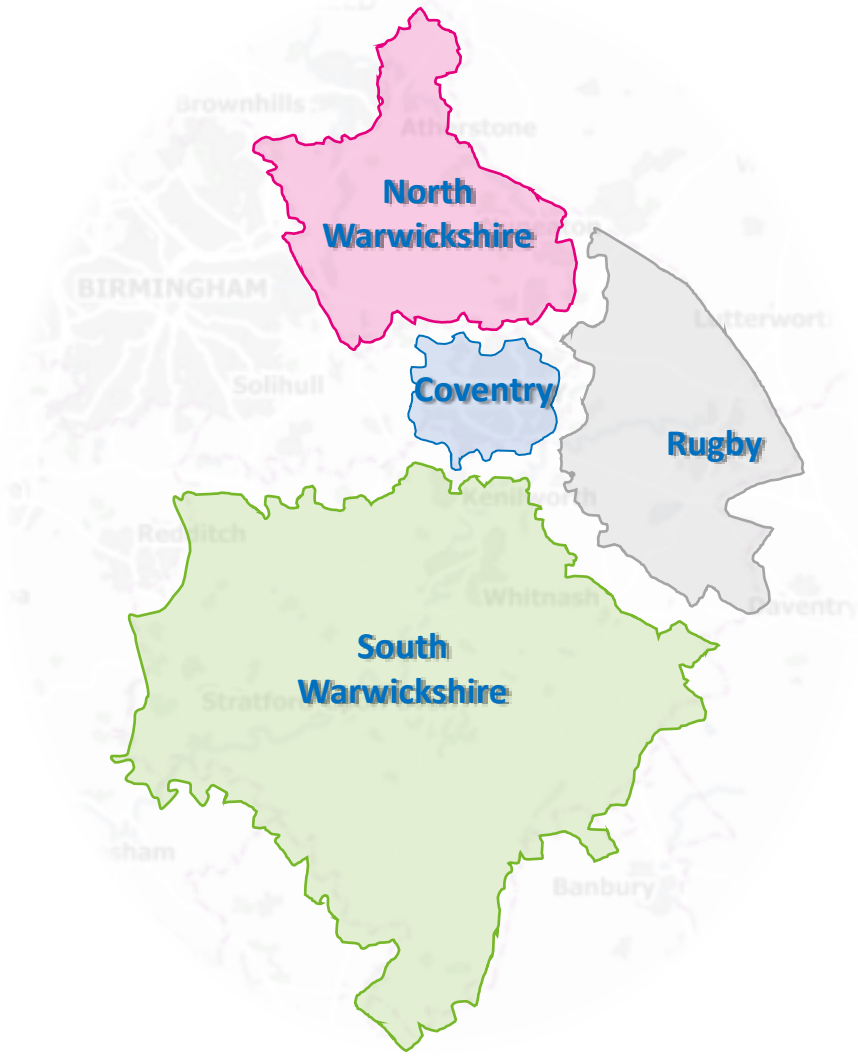
NHS George Eliot Hospital

University Hospitals Coventry and Warwickshire NHS South Warwickshire Foundation Trust

NHS Integrated Care Community Coventry City Council

Warwickshire County Council

North Warwickshire Primary Care Network



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Health and Wellbeing Board
11 January 2023
Warwickshire Hospital Discharge Community Recovery Programme

Recommendation

That the Health and Wellbeing Board note the proposed Warwickshire Hospital Discharge Community Recovery Programme.

1. Executive Summary

1.1 The attached presentation (appendix 1) provides an overview of our vision for improving out-of-hospital services in Warwickshire through the delivery of Warwickshire's Hospital Discharge Community Recovery Programme.

1.2 The Hospital Discharge Community Recovery programme has evolved from Warwickshire's National Integration Frontrunner proposal submitted to NHS England in July 2022. Following this submission, Warwickshire was identified to become one of a number of national pilot sites for developing intermediate care/community recovery provision.

2. Financial Implications

2.1 On behalf of Warwickshire partners, NHS Coventry and Warwickshire ICB applied for pilot funding in July 2022, and this has been approved in principle by NHS England linked to the intermediate care/community recovery pilot objectives. Confirmation of final allocation is expected imminently.

3. Environmental Implications

3.1 None.

4. Timescales associated with the decision and next steps

4.1 Work continues to develop plans and determine associated timelines. Services are expected to go live March/April 2023.

4.2 The next steps at place have been outlined in the attached presentation (appendix 1).

Appendices

1. Appendix 1 - Warwickshire Hospital Discharge Community Recovery Programme Summary (Presentation)

Background Papers

1. Programme mobilisation (November 2022)

	Name	Contact Information
Report Author	Zoe Mayhew	zoemayhew@warwickshire.gov.uk
Assistant Director	Becky Hale	beckyhale@warwickshire.gov.uk
Strategic Director for People	Nigel Minns	nigelminns@warwickshire.gov.uk
Portfolio Holder for Adult Social Care & Health	Cllr Margaret Bell	margaretbell@warwickshire.gov.uk

The report was circulated to the following members prior to publication:

Local Member(s): None

Other members: Cllrs Bell, Drew, Golby, Holland and Rolfe

Warwickshire Hospital Discharge Community Recovery Programme

Version date: 18.11.22

Warwickshire Health and Wellbeing

How have we got to this point?

Warwickshire Health and Wellbeing

National Integration Frontrunner Objectives

- Our national frontrunner proposal ambition would be realised by a partnership between NHS and Social Care providing care and support at the point of discharge linked to each of our acute centres; injecting new capacity into the system by enabling an NHS provider to become a registered domiciliary care provision; and seeking to exploit the new visa opportunities for bringing overseas working into domiciliary care which are currently difficult for SMEs providing this care to support
- We would also
  - Seek to strengthen our relationships with the voluntary and community sector and to understand new or enhanced opportunities
  - Realise further benefit from initiatives and partnerships we currently have in place e.g. levelling up, using technology such as DOCABO, Tribe and MySense as enablers
  - Support recovery post discharge
  - Continue working closely with our hospices
  - Use the opportunity to explore our role in preventing admission linked to ambulatory care and frailty assessment pathways

Intermediate Care – vision and key principles (1)

- The transformation of out-of-hospital services is a key element of the NHS' recovery. We are working with systems to increase overall capacity of community services to provide care for more patients at home and develop new models of care such as a new community recovery service.
- **Our vision is that within 5 years ALL people in an acute hospital, who need further support to recover, will have access to effective therapeutic intermediate care services within 24 hours of no longer meeting the criteria to reside.**
- We intend to test and evaluate a new model of intermediate care services post-discharge that would effectively see:

Commissioning of recovery services as one single intermediate care step-down (post-discharge from acute hospital) service at Place through one lead commissioner

National common professional and performance standards, including a 24 hour standard from no longer meeting the criteria to reside to being in receipt of the New Community Recovery Services

Single data architecture, pulling data from clinical systems

Intermediate Care - Key principles summary (2)

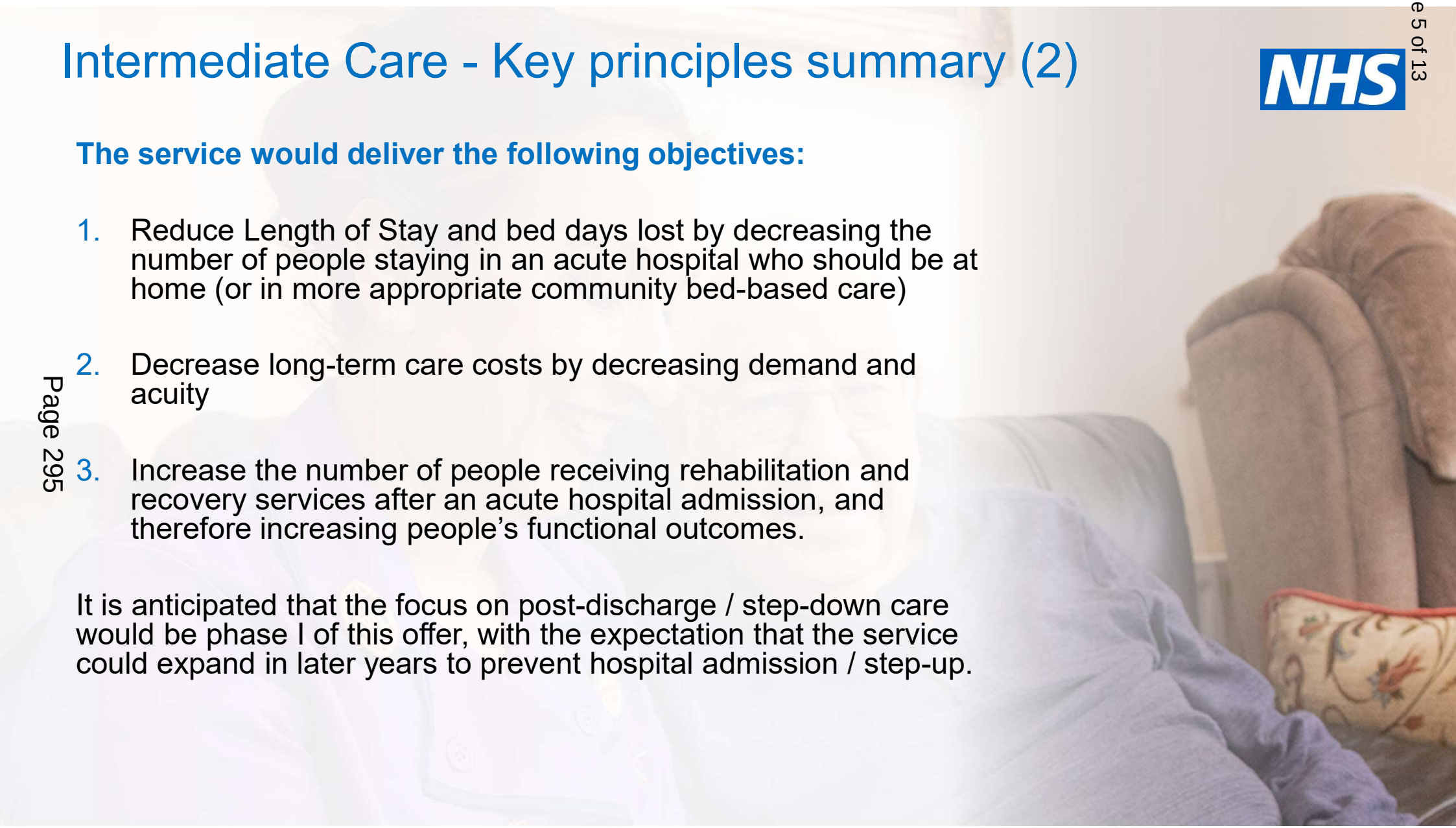
The service would deliver the following objectives:

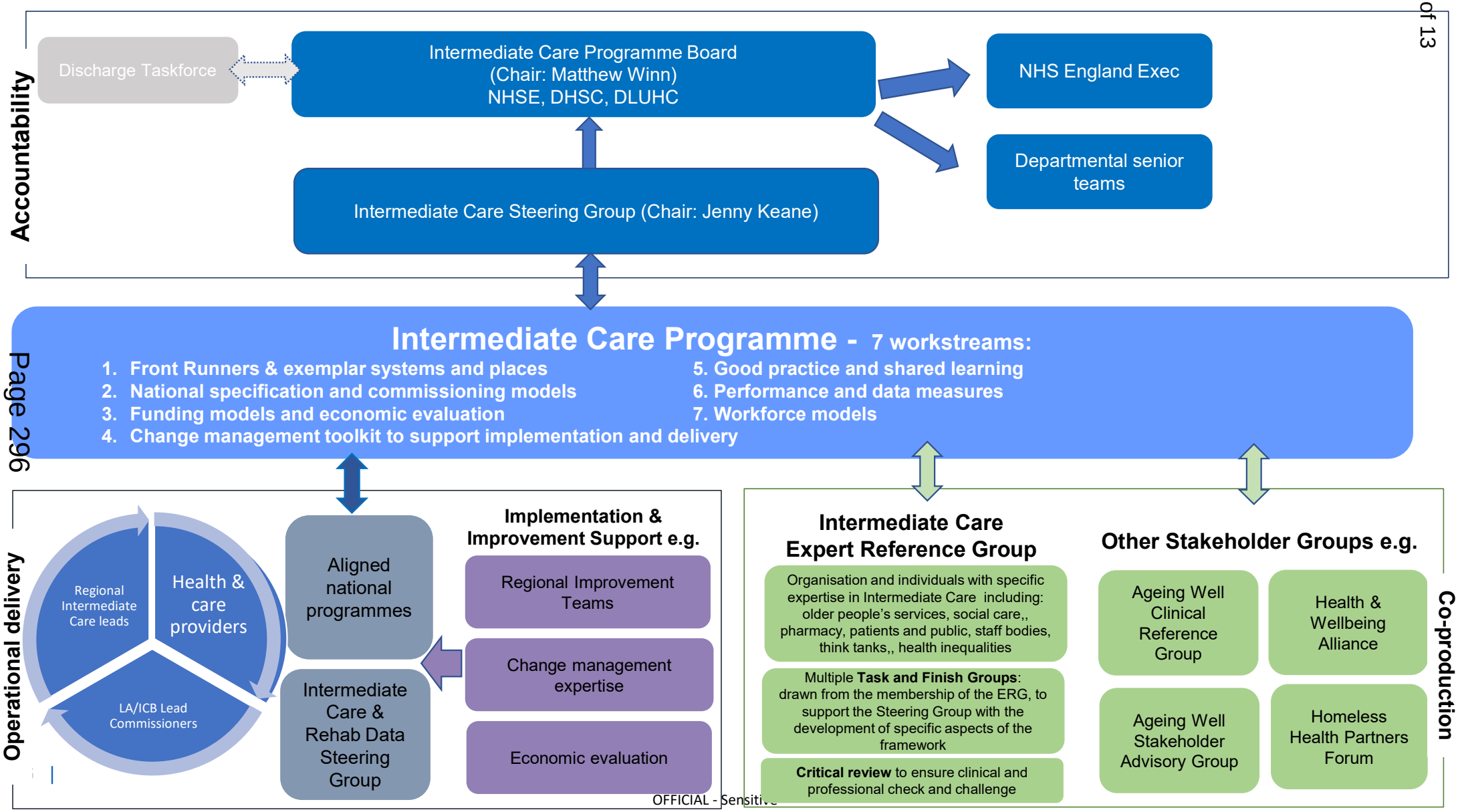
1. Reduce Length of Stay and bed days lost by decreasing the number of people staying in an acute hospital who should be at home (or in more appropriate community bed-based care)

2. Decrease long-term care costs by decreasing demand and acuity

3. Increase the number of people receiving rehabilitation and recovery services after an acute hospital admission, and therefore increasing people's functional outcomes.

It is anticipated that the focus on post-discharge / step-down care would be phase I of this offer, with the expectation that the service could expand in later years to prevent hospital admission / step-up.





What are we committed to?

Warwickshire Health and Wellbeing

Warwickshire Hospital Discharge Community Recovery Programme
National Pilot

SRO: Becky Hale

Purpose:

Aim

To further develop pathway 1 discharge to assess services in Warwickshire to enable **all** people in an acute hospital, who need further support, to access timely therapeutic intermediate care services on discharge.

Objectives

- Develop a Hospital Discharge Community Support Service building on existing arrangements and ensuring compliance with Hospital Discharge Guidance
- Reduce Length of Stay and bed days lost by decreasing the number of individuals staying in an acute hospital who should be at home.
- Decrease long-term care costs by decreasing demand and acuity
- Increase the number of people receiving rehabilitation and recovery services after an acute hospital admission.
- Develop integrated commissioning and delivery arrangements for hospital discharge

Outcomes

Individuals are supported to recover and re-able to maximise their individual outcomes.

Key Stakeholders:

Patients, Acute Providers, Community Providers, Primary Care, ICB, Social Care, Independent Care Sector, VCSE

Key Workstreams and proposed leads:

Service Design and Commissioning Arrangements – Zoe Mayhew
Integrated Discharge Operational Arrangements – Rachael Hayter
Finance – Adam Philips / Vicki Forrester / Ravi Basi
Redesign of Continuing Healthcare – Paul Smith
NHS care provider development – TBC SWFT
Data – Steve Jarman-Davies

Key Enablers:

NHSE Pilot Funding
System Resource including PMO
OD and Comms
Data and performance monitoring

Risks

Ceasing of hospital discharge grant; resource; market and workforce capacity

Interdependencies

Ageing Well, Coventry Improving Lives Programme, existing programmes of work across Warwickshire

Governance:

ICB commissioning responsibility delegated to SWFT integrated out of hospital function.
Programme Board reporting to Warwickshire Care Collaborative (and Place Partnerships)

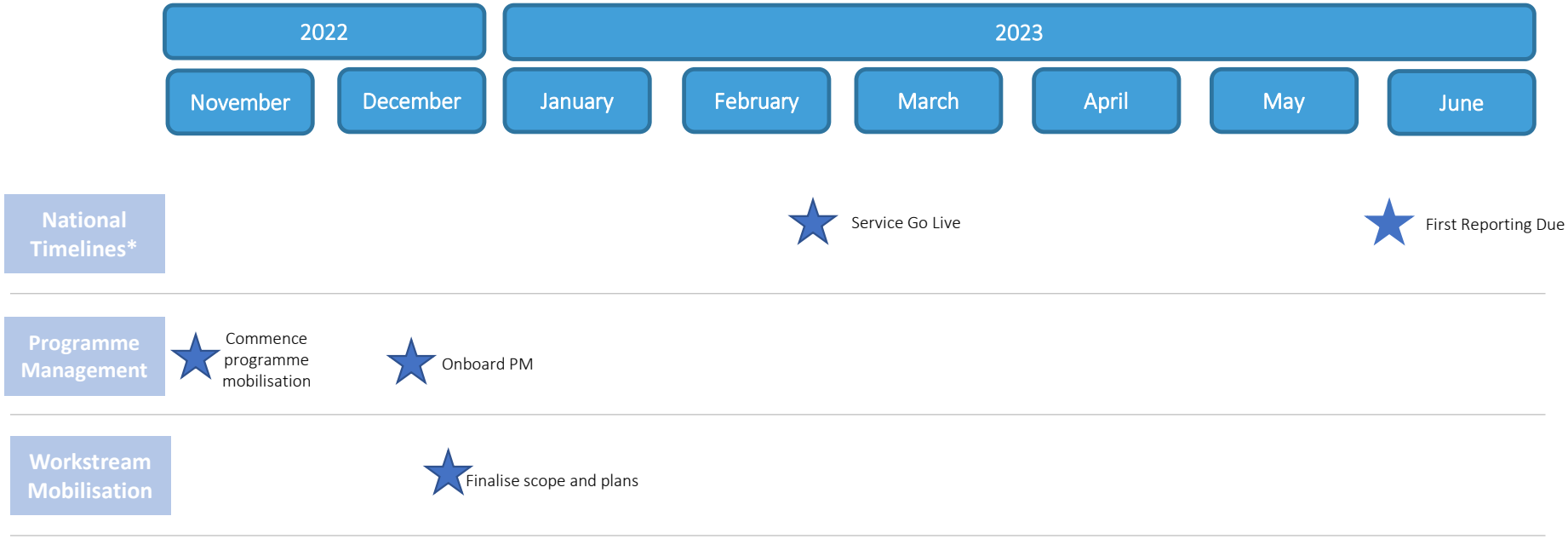
What are we testing?

Project area	Hypothesis	Pilot Site Actions	Supporting National/Regional Actions
Workforce	If systems understand the staffing levels and skills mix in an engaged and motivated workforce, they can redesign and plan a flexible approach across system partners to meet demand.	Review current staffing levels in all related roles and locations to fully understand resource capacity	Workforce modelling tool including staffing level principles
Workforce		Workforce capacity planning based on flexible approach to meeting system-wide demand by discharge pathway underpinned by robust workforce data collection	New role definitions with all roles supported by a professionally-endorsed skills and capabilities framework
Workforce		Develop a staff engagement and wellbeing strategy	HEE/partner-endorsed enhancements to create advanced practitioner roles
Workforce		Local recruitment and retention strategy including new support worker role	National recruitment campaign for therapy staff including initiatives to support international recruitment
Commissioning	If there is a lead commissioner model, then responsibility to commission the Community Recovery Service against national standards will be clear, duplication of services will be reduced, patient flow across the system will be improved and services will become more effective and personalised	Identify a lead commissioner across the ICS / Place footprint and test the impact of a singular approach to commissioning intermediate care post-discharge	Development of national service specification(s) for intermediate care working with experts and stakeholders across health and care
Commissioning		Review leadership arrangements across health and care, develop integrated system cultures and promote integration (at all levels) within the current system architecture	Professional standards developed in partnership with national bodies
Commissioning		Consider the effectiveness of services for often excluded health populations – and test innovations to ensure equitable access to recovery services	Demand and capacity modelling toolkit
Commissioning		Create a culture of collaboration with the independent care sector. This should look to improve communications and lead to a joint workforce approach	Stakeholder relationship management of key national bodies and lead independent sector providers to ensure consistency of message
Commissioning		Work with new market sectors such as personalised care delivered via personal assistants and live-in care and expanding care provision to include working-age adults	Peer support and community of practice for lead commissioners
Performance Measures & Data	If systems have a single data architecture across health and social care will enable them to evidence the impact of the 24 hour standard on reducing LoS and improving patients functional outcomes.	Systems should review their current data and its effectiveness as business/planning intelligence to support commissioning, assessing if the right data is being collected and agreeing the actions required to drive up quality and completeness	TBC - we propose to design the performance measures alongside the service and will come back as soon as is appropriate with these recommendations. However, we intend to measure customer experience – ensuring the right support at the right time, supporting independence and choice

Key Pilot Site Actions

Project area	Hypothesis	Pilot Site Actions	Supporting National/Regional Actions
Funding	If the new Community Recovery Service is commissioned through a lead commissioner model it will show a return on investment by reducing the long term costs to Health and Social Care.	Baselining existing expenditure on post-discharge services (health and social care)	Expert input from national partners to develop the economic case for investment
Funding		Develop estimates for the cost of delivering an NHS Community Recovery Service	National modelling to provide a framework for anticipated costs to deliver the recovery service and the resulting savings on long term care and support needs
Funding		Consider the impact of recovery service expenditure on long term care costs (health and social care), within the context of the impending Fair Cost of Care exercise	Bespoke support for pilot sites in evaluating costs and impact
Funding		Support the development of assumptions regarding demand levels, period of need and at which point a recovery service breaks even and delivers efficiencies (return on investment)?	National stakeholder relationship management to ensure support across national health and social care bodies and maintain consistency of message
Capacity and Demand	If systems commission effective recovery services they will release acute bed capacity and reduce the overall adult social care capacity required to support flow across the system.	Ensure there is system-wide demand and capacity modelling for intermediate care/Community Recovery Service	Support systems to build capacity by providing input to a national workforce strategy
Capacity and Demand		Transition D2A therapy staff into the community to meet the demand within the recovery service.	Work with pilot sites and partners to develop an optimum process for assessment practices
Capacity and Demand		Assess the impact on domiciliary care capacity (volume and acuity)	Targeted improvement support and expertise
Capacity and Demand		Demonstrate the impact on NHS acute and community bed capacity	Demonstrate the impact on NHS acute and community bed capacity

Implementation timelines (still in discussion)



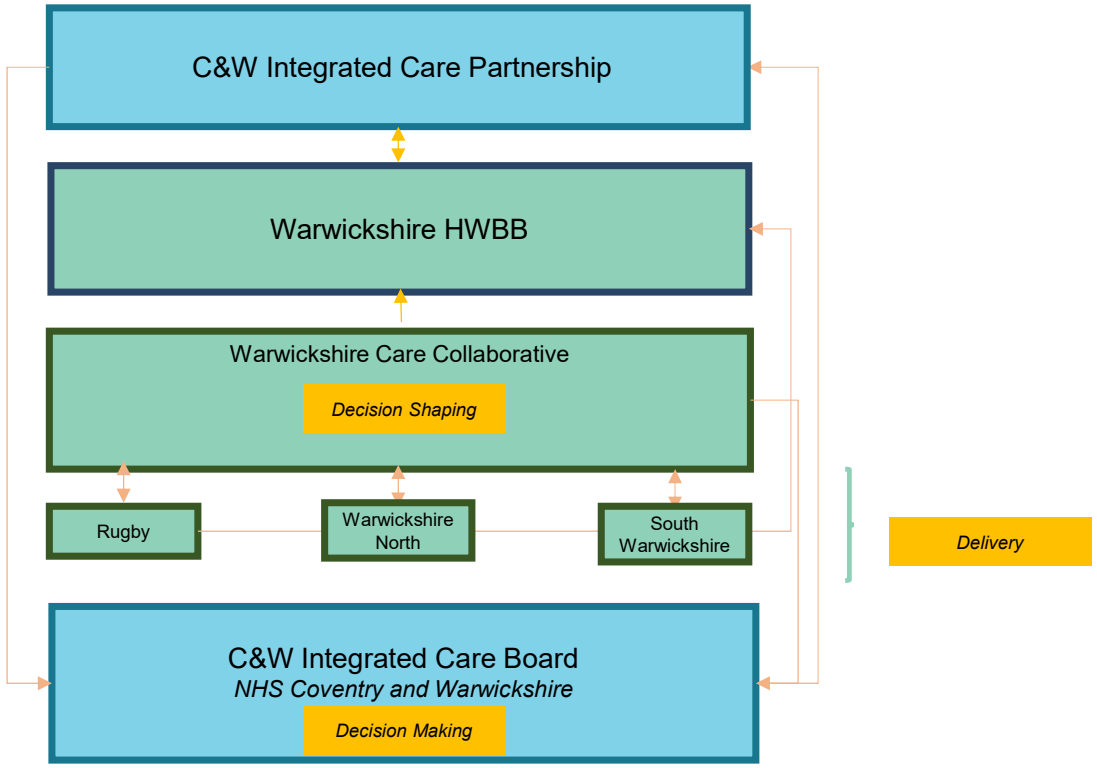
*Subject to national funding being made available by end November

Next Steps at Pace

- Ensuring effective engagement in programme development and delivery – People, Place and Collaboratives (including links to Coventry Improving Lives Programme)
- Baseline finance, performance and operational processes
- Specify the HD Community Recovery Service including feasibility of scaling up the Home-Based Therapy pathway
- Finalise workstreams and develop plans
- Incorporate areas of the model for local 'testing' in plans (workforce, commissioning, performance measurement, funding, capacity)
- Confirm funding including SDF
- Confirm people resource to support delivery
- Progress project management and domiciliary development support (in train)

Warwickshire Health and Wellbeing

Proposed Governance



Discharge Governance | Place | System

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Health and Wellbeing Board

11 January 2023

Children and Young People Partnership Update Report

Recommendation

That the Health and Wellbeing Board note the progress made by the Children and Young People Partnership, including an update on health visiting.

1. Executive Summary

Children and Young People Partnership

1.1 At the 4 May 2022 Health and Wellbeing Board (HWBB) the chair requested that a Children and Young People Partnership (CYPP) be established to provide strategic oversight and facilitate integration and collaboration across Warwickshire to support the *helping every child have the best start in life* priority (Health and Wellbeing Strategy 2021-26).

1.2 It was agreed that Councillor Jo Barker would chair the CYPP, and the first meeting was held on October 6. During this meeting it was agreed that this is an informal sub-group and, therefore, no formal minutes from the CYPP would be shared with HWBB, but that progress updates would be provided routinely.

1.3 Members of the CYPP include representatives from the Council's Education, Public Health, Children and Families' services, and Community Safety as well as the Integrated Care Board (ICB) Chief Nursing Officer, representatives from North, Rugby and South Place, South Warwickshire University NHS Foundation Trust (SWFT), George Eliot Hospital NHS Trust (GEH), Coventry and Warwickshire Partnership NHS Trust (CWPT), Warwickshire Police and Primary Care.

1.4 During an initial scoping session and the inaugural CYPP meeting it was agreed that focus should be given to two priority areas in the first year. Gap analysis has been carried out across key plans and priorities that do not currently have a formal work stream include:

- Priority 1 - Early years – Including the first 1001 days (conception to age 2) and pre-school age (up to 5 years old)
- Priority 2 - Children and Young People's Mental Health. We will ensure that children and young people with social, emotional and behavioral needs have appropriate support and access to appropriate services.

1.5 Priority 1 objectives will be informed by the Warwickshire Children's 0-5 Joint Strategic Needs Assessment (JSNA) (2022) with a focus on meeting the key recommendations from the paper, see Appendix 1.

1.6 Within the Children's Strategy, improving social, emotional and mental health and wellbeing is listed as a priority with a number of objectives around it. Additionally, a Warwickshire Infant, Children's and Young People's Mental Health (ICYP MH) JSNA is currently in work and due to be published in May 2023. Objectives for Priority 2 will be developed to include Children's Strategy objectives and recommendations from the ICYP MH JSNA in the second phase of this sub-committee's workplan.

Update on Health Visiting

1.7 Since the Health and Wellbeing Board on 7 September 2022, work has been undertaken to identify and agree some additional local metrics to maximise the reach of the Health Visiting service.

1.8 This work has taken place jointly with Commissioners, Public Health and SWFT, and work is underway to agree additional metrics. The local metrics are being designed to ensure that the service to families in Warwickshire mirrors the Healthy Child Programme as well as utilises a skills mix given the shortage nationally of Health Visitors.

1.9 The local metrics that have been prioritised so far are:

- Reinstating Antenatal checks to families following the universal pathway and will be undertaken by Band 5 nurses. This will not meet the nationally required mandated contact as the check will be carried out by a Band 5 nurse rather than a fully qualified Band 6 Health Visitor. However, as there are currently national shortages of fully qualified health visitors, this would mean children and families within Warwickshire would still be seen by a qualified nurse or midwife, if not by a health visitor.

- Reinstating the 6-8 weeks check offered to families who are following the universal pathway. Those families who are targeted or specialist will meet the timescales of the nationally required Mandated check, but the universal families will be offered a check within 13 weeks of baby's birth. It was agreed that skills mix was not an option given the need for families to see a fully qualified Health Visitor.

1.10 SWFT as the Provider has agreed to start to report on the local metrics for Quarter 3, which will become available in mid-February 2023.

1.11 The action plan to support the service has also been refreshed within the same timeframe. A real focus on addressing health inequalities has been taken including identifying actions around the Core20plus/ place-based working.

2. Financial Implications

2.1 None

3. Environmental Implications

3.1 None

Appendices

1. None.

Background Papers

1. None.

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Portfolio Holder for Adult Social Care & Health	Cllr Margaret Bell	margaretbell@warwickshire.gov.uk

The report was circulated to the following members prior to publication:

Local Member(s): None.
Other members: Councillors Bell, Drew, Golby, Holland and Rolfe.

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Health and Wellbeing Board

11 January 2023

Health and Wellbeing Board Sub-Committee

Recommendation(s)

That the Board notes the decisions taken by the Health and Wellbeing Board Sub-Committee at its meetings on 22 September 2022 and 16 December 2022.

1. Executive Summary

1.1 This item provides a report back to the Health and Wellbeing Board (HWBB) on decisions taken by the Sub-Committee since the last Board meeting.

1.2 At its meeting on 23 September 2015, the HWBB agreed proposals for a Sub-Committee to meet where a decision is required within a timeframe which does not fall within the cycle of scheduled meetings of the Board.

1.3 At its meeting on 7 September 2022, the Board considered a report on the Better Care Fund (BCF) submission and annual plan for 2022/23. It delegated authority to a sub-committee to approve the final version of the Better Care Fund Plan for 2022/23, for submission to NHS England. The sub-committee met for this purpose on 22 September. A copy of the meeting documents were publicised to all members of the HWBB. The Minutes of the meeting are attached at Appendix ‘A’ for information.

1.4 At its meeting on 16 December 2022, the Sub-Committee was asked to note the conditions and reporting requirements relating to the Adult Social Care Discharge Fund 2022/23 and to support the scheme and areas of focus for submission to NHS England and the Department for Health and Social Care. The spending plans had to be submitted to the DHSC and NHS England by 16 December, before the next Board meeting on 11 January 2023. Therefore, it had been agreed with the Chair that a sub-committee should be held to enable officers to respond appropriately.

1.5 A copy of the agenda and report for the sub-committee were publicised to all members of the HWBB and the minutes from the meeting are attached at Appendix ‘B’ for information.

2. Financial Implications

2.1 None arising directly from this report.

3. Environmental Implications

3.1 None.

Appendices

Appendix A – Minutes of the meeting of the Sub-Committee held on 22 November 2022
Appendix B – Minutes of the meeting of the Sub-committee held on 16 December 2022

Background Papers

None.

	Name	Contact Information
Report Author	Paul Spencer Amy Bridgewater-Carnall	paulspencer@warwickshire.gov.uk Tel: 01926 418615 Amybridgewater-carnall@warwickshire.gov.uk
Assistant Director	Sarah Duxbury, Assistant Director of Governance and Policy	sarahduxbury@warwickshire.gov.uk
Strategic Director	Rob Powell, Strategic Director for Resources	robpowell@warwickshire.gov.uk
Portfolio Holder	Councillor Margaret Bell, Portfolio Holder for Adult Social Care & Health	

The report was circulated to the following members prior to publication:

Local Member(s): None
Other members: Councillors Bell, Drew, Golby, Holland, and Rolfe.

Health and Wellbeing Board

Thursday 22 September 2022

Minutes

Attendance

Board Members
Councillor Margaret Bell (Chair, Warwickshire County Council (WCC))
Councillor Marian Humphreys (North Warwickshire Borough Council)

Other Attendees
Rachel Briden, Becky Hale, Gemma McKinnon and Paul Spencer (WCC Officers)

1. General

(1) Apologies

Apologies for absence had been received from Councillor Jerry Roodhouse and Nigel Minns (WCC), Russell Hardy (South Warwickshire NHS Foundation Trust and George Eliot Hospital NHS Trust), Emma Daniell (Deputy Police and Crime Commissioner) and Liz Hancock (Healthwatch Warwickshire).

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

None.

(3) Chair's Announcements

None.

2. Better Care Fund

At the Health and Wellbeing Board on 7th September, consideration was given to the Better Care Fund (BCF) Annual Plan for 2022/23 and the requirements for submission to NHS England by 26th September. It was agreed that approval of the final version of the plan be delegated to a Sub-Committee of the Board, once it had been approved by the Integrated Care Board and the County Council. It was confirmed that those approvals had now been received.

Rachel Briden, Integrated Partnership Manager presented the updated version of the documents. Following feedback from the Regional BCF Manager, minor amendments had been made to the BCF Narrative Plan. These were shown as tracked changes in the appended document and were pointed out to the Sub-Committee.

Discussion took place on the final documents as follows:

- The Chair asked a question about overall responsibilities within the new integrated care structures. This had been raised the previous day at the Adult Social Care and Health Overview and Scrutiny Committee. Responsibility for the BCF rested with the Health and Wellbeing Board. The commitment to its delivery had been endorsed by both the Integrated Care Board and the County Council's Cabinet. The lead officers for the BCF were confirmed.
- There was discussion about how the BCF aligned to specific services, those which came within the BCF and those such as hospital discharge which were not part of the BCF. There was a lot of improvement activity underway both jointly and within individual organisations.
- Questions were submitted about monitoring arrangements. There were some areas such as care which needed to be kept under review. Officers confirmed that all organisations had monitoring arrangements and there were numerous boards which received periodic updates. An outline was given of the various arrangements including the weekly monitoring meetings.
- Officers confirmed the use of some of the BCF funds through the IBCF to support workforce development, recruitment and retention campaigns, both for health and social care and some wider activity.
- Further information was provided on the high-level capacity and demand plans for intermediate care services. This was a new requirement for a monthly forecast for quarters three and four. It would also look at the capacity and flexibility of teams to potentially support increased demand. This was expected to become a planning requirement moving forwards. An outline was given of the local services this included. It would provide a joined-up and more transparent approach.
- Following the BCF submission, there would be a month for the assurance process in case any further information was required. The final outcome would be known by 30th November 2022.

Resolved

That the Board's Sub-Committee approves the final version of the BetterCare Fund Plan for 2022/23, for submission to NHS England in line with the recommendation and delegation of the Board on 7th September 2022.

……..
Councillor Margaret Bell, Chair

The meeting closed at 2:20pm

Health and Wellbeing Board

Friday 16 December 2022

Minutes

Attendance

Committee Members
Councillor Margaret Bell (Chair)
Councillor Marian Humphreys
Councillor Dave Humphreys

Officers
Rachel Briden, Integrated Partnership Manager
Becky Hale, Chief Commissioning Officer
Amy Bridgewater-Carnall, Senior Democratic Services Officer

Others Present
Chris Bain (Healthwatch)

1. General

(1) Apologies

None.

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

None.

(3) Chair's Announcements

None.

2. Adult Social Care Discharge Fund 2022/23

Rachel Briden (Integrated Partnership Manager, Adult Social Care) introduced the report which asked the sub-committee to note the conditions and reporting requirements relating to the Adult Social Care Discharge Fund 2022/23 and to support the scheme and areas of focus for submission to NHS England and the Department for Health and Social Care.

Rachel Briden advised that following the announcement by the DHSC in September, details of the Adult Social Care Discharge Fund had been published on 18 November 2022. It was noted that the allocation to Warwickshire County Council Adult Social Care was £1.862m and to the NHS Coventry and Warwickshire Integrated Care Board (ICB) was £6.715m. Members were advised

that since the publication of the report, updated and finalised figures had now been agreed with the Integrated Care Board, replacing some of the expected or estimated figures in the report.

Members were signposted to the revised figures throughout the report and each revision was explained in full by officers. Rachel Briden explained that there were conditions attached to the funding, which would be used for discharge activities in order to free up acute beds and reduce patients' length of stay in hospital. The allocation of funding had been jointly agreed with the Council and the ICB and met the Health and Wellbeing Board's (HWBB) priorities.

It was noted that the allocation of the £6.715m referred to in paragraph 1.5 for Warwickshire would be £4.095m, to be split between social care and NHS activities.

In addition, the table detailed at paragraph 1.6 had been updated as follows:

Strategic Objectives and Conditions which the scheme relates to	**Estimated Scheme Cost**
Home Care or Domiciliary Care	£1,286,083
Residential & Nursing Placements	£2,123,216
Domiciliary Care and Reablement in a Person's own Home (Rehab at Home)	£296,520
Other	£383,652
Assistive Technologies and Equipment	£123,200
Bed Based Intermediate Care Services	£336,333
Increase hours worked by existing workforce	£1,247,592
Reablement in a Person's Own Home	£18,000
Local recruitment initiatives	£0
Additional or redeployed capacity	£146,000
Total	**£5,960,596**

Following a question from Councillor Bell, clarification was given on the Home Care allocation of £1.286m which had reduced from the original report. It was hoped this would fund the shortfall from the hospital discharge fund which was a cost pressure for the Council at present. In response to further questions, it was confirmed that there would be no financial assessment of patients at the point they left hospital and they would leave with a package of care. Any assessment would be completed outside of the acute setting and completed as soon as possible thereafter.

Officers also confirmed that they had enough staff to be able to carry out the assessments but highlighted that this funding was only available to the end of March 2023.

In relation to the Domiciliary Care and Reablement in a Person's Home, this service included the need for a physiotherapist or occupational therapist to attend the patient in their home or usual place of residence. It was noted that officers were looking at the number of therapists available and were working with the lead officer to mobilise this scheme. Councillor Humphreys highlighted the importance of this service in the community and expressed a desire to raise the profile of this valuable work.

The figure detailed ‘Other’ in the table related to the ICB’s costs to cover the delivery of the scheme and the ongoing monitoring that would need to take place.

Rachel Briden advised that the Assistive Technologies section often included additional vans, drivers and equipment and highlighted that there was a lack of specialist wheelchairs to support discharges for Stroke patients in Warwickshire. The additional funding should enable further purchases to be made and it was noted how important assistive technologies were in enabling patients to return to their homes. Councillor Humphreys reinforced this point by referring to specific stroke patients’ circumstances in her ward.

Following a question from Councillor Bell relating to the Bed Based Intermediate Care Services, officers advised that commissioners would identify where the beds would be located. Market testing had been carried out and the aim was for the service to be provided across the County and deliver a wide spread and good access. Members were keen that balance was achieved because some patients did not want to have to travel to the south of the County. Councillor Humphreys referred to the closure of the facility at Bramcote which she felt should have remained open.

The figure allocated to the ‘Increase Hours worked’ referred to the funding of additional agency staff and the community bed based support staff costs. Whilst a specific breakdown of the figures was not available, Rachel Briden advised this could be shared outside of the meeting but the aim was to cover all additional NHS staffing costs.

In relation to the lower figure allocation to the ‘Reablement in a Person’s Own Home’, it was noted that this had incorrectly been added as a whole year cost rather than only up to the end of March 2023.

An additional line had been added to the table entitled ‘Additional or redeployed capacity’ which aimed to provide additional support for the domiciliary care market and the redeployment of staff.

The Chair then invited the Healthwatch representative, Chris Bain, to address the meeting and raise any further points he may have. Chris Bain advised that he felt this was a well structured package and Councillors had covered all the points he wished to ask. Councillor Bell was pleased that the funding would be in place in the areas detailed and hoped this could provide an opportunity to look at some pilot schemes.

Rachel Briden outlined how the governance of the funding and schemes would work and advised that the deadline for signing the BCF section 75 agreement had been extended to 31 January 2023. Due to the inclusion of updated figures, the financial implications section of the report had been revised to reflect the total allocation of funds as £5,960,596 to be spent by the end of March 2023. Members noted that the funding would be provided in two tranches and fortnightly reporting conditions would be in place.

In addition, the HWBB would receive a further update at its meeting in January 2023 along with the minutes of this meeting.

Having considered the report and having received clarification on a number of points, the Chair proposed the recommendations based on the revised figures presented.

Resolved

That the Health and Wellbeing Board Sub-Committee

1) Notes the conditions and reporting requirements relating to the Adult Social Care Discharge Fund 2022/23 and that decisions relating to this funding will be made in accordance with existing Better Care Fund governance;

2) Supports the schemes and areas of focus set out in the Adult Social Care Discharge Fund Plan for 2022/23 for submission to NHS England and the Department for Health and Social Care;

3) Authorises the Strategic Director for People to agree and finalise the Adult Social Care Discharge Fund Plan for 2022/23 in consultation with the Chief Executive Officer of NHS Coventry and Warwickshire Integrated Care Board; and

4) Notes that a further update will be provided to the Health and Wellbeing Board on the 11 January 2023.

The meeting rose at 12:12

Agenda Item 14

Warwickshire Health and Wellbeing Board Forward Plan 2023/24

Health and Wellbeing Board Bulletin circulated March 8th		
Joint HWBB Mar/April 23	*Coventry and Warwickshire Integrated Health and Wellbeing Forum*	
	Discussion: TBC	TBC
HWBB 3 May 23	Discussion items	
	Joint Strategic Needs Assessment (JSNA) Children and Young People Mental Health	Duncan Vernon
	Progress report: Children and Young People Partnership	Nigel Minns
	Warwickshire Health and Wellbeing Place Partnerships	Steve Maxey, Mannie Ketley, Chris Elliott
	Annual report: Health and Wellbeing Strategy	Nigel Minns / Gemma Mckinnon
	C&W Palliative & End of Life Strategy	Kate Butler / Katherine Herbet
	Update items	
	Coventry and Warwickshire Integrated Health and Wellbeing Forum	Gemma McKinnon
	Better Care Fund - Metrics	Rachel Briden
	Integrated Care Board	Danielle Oum
	Annual report: Warwickshire Safeguarding Board	Amrita Sharma
Health and Wellbeing Board Bulletin circulated July 5th		
Joint HWBB TBC	*Coventry and Warwickshire Integrated Health and Wellbeing Forum*	
	Discussion: TBC	TBC
HWBB 6 September 23	Discussion items	
	Healthwatch Warwickshire Annual Report	Elizabeth Hancock / Chris Bain
	Adults 65+ Strategic Needs assessment	Duncan Vernon
	Better Care Fund – Annual Planning Report 2022/23	Rachel Briden
	Update items	
	Coventry and Warwickshire Integrated Health and Wellbeing Forum	Gemma McKinnon
	Warwickshire Health and Wellbeing Place Partnerships	Steve Maxey, Mannie Ketley, Chris Elliott
	Integrated Care Board	Danielle Oum

	Better Care Fund – Metrics	Rachel Briden
Health and Wellbeing Board Bulletin circulated tbc		
Joint HWBB TBC	*Coventry and Warwickshire Integrated Health and Wellbeing Forum*	
HWBB January 24	Discussion items	
	Annual Report of the Integrated Care Partnership Strategy	Liz Gaulton / Anita Wilson
	Update items	
	Coventry and Warwickshire Integrated Health and Wellbeing Forum	Gemma McKinnon
	Warwickshire Health and Wellbeing Place Partnerships	Steve Maxey, Mannie Ketley, Chris Elliott
	Integrated Care Board	Danielle Oum
	Better Care Fund – Metrics	Rachel Briden