Health and Wellbeing Board

Date: Wednesday 15 May 2024
Time: 10.00 am
Venue: Committee Room 2, Shire Hall

Membership

Councillor Margaret Bell (Chair)
Councillor Sue Markham
Councillor Jerry Roodhouse
Councillor Penny-Anne O'Donnell

Nuneaton & Bedworth Borough Council representative (TBC following May 2024 elections)
Councillor Sandra Smith
Councillor Jim Sinnott
Councillor Liz Coles
Councillor Adam Daly

Warwickshire County Council Officers: Shade Agboola, Nigel Minns and Pete Sidgewick

Coventry and Warwickshire Integrated Care Board: Danielle Oum (Vice-Chair)

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

Healthwatch Warwickshire: Elizabeth Hancock / Chris Bain

Police and Crime Commissioner: Emma Daniells (Deputy PCC)

Items on the agenda: -

1. General

(1) Apologies

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

(3) Minutes of the Meeting of the Warwickshire Health and Wellbeing Board on 10 January 2024 and Matters Arising 5 - 14

To approve the minutes of the meeting held on 10 January 2024.

(4) Chair's Announcements

Discussion items

2. Place-based HWBB Partnership Plans 15 - 18
To receive verbal updates from the place-based Health and Wellbeing Board Partnerships.

3. Health and Wellbeing Board Executive Group 19 - 44
To receive an update from the Health and Wellbeing Board Executive Group meeting held on 18 January 2024.

4. Delivering the Warwickshire Public Health Offer 45 - 54
To consider the new structure of the Public Health service within Warwickshire County Council and the range of activity being undertaken in 2024/25.

5. Better Care Fund 2023/25 overview and progress update 55 - 70
This report provides an overview and impact of the Better Care Fund, along with performance against national metrics and the changes outlined in the addendum published in March 2024.

6. The Empowering Futures: Growing Up Well in Warwickshire JSNA 71 - 166
A report requesting approval of the JSNA, support for its dissemination within member organisations, and encouraging its use in the planning and commissioning of relevant services.

7. Menopause Services Task and Finish Review 167 - 202
To receive and consider the recommendations from the Menopause Task & Finish Group, following the reports' recent approval at Adults Social Care & Health OSC.

Updates to the Board

8. Coventry and Warwickshire Joint Health and Wellbeing Board Update 203 - 222
To receive a report updating Members following the joint development session held on 8 January 2024.

9. Children and Young People Partnership 223 - 232
A report advising the Board on the progress made by the Partnership since the last update.

10. Warwickshire Safeguarding Annual Report 2022-2023 233 - 256
To receive and note the Warwickshire Safeguarding Annual Report 2022-2023.

11. **Coventry and Warwickshire Living Well with Dementia Strategy 2024-2029** 257 - 266

An update on the publication of the Coventry and Warwickshire Living Well with Dementia Strategy 2024-2029 and the progress made on the first year of delivery.

12. **Services delegated to the ICB: Dentistry, Optometry, Pharmacy and specified Prescribed Specialised Services** 267 - 332

A report advising on the delegation of responsibility for Primary Pharmacy, Optometry & Primary and Secondary Dental Services from NHS England to the Coventry and Warwickshire ICB taking effect from on 1 April 2023 and the processes outlined for the management and governance of these arrangements.

Board Management

13. **Forward Plan** 333 - 334

To receive the Forward Plan of items for consideration by the Health and Wellbeing Board in 2024.

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

Health and Wellbeing Board

Wednesday 10 January 2024

Minutes

Attendance

Committee Members

Warwickshire County Council (WCC)
Councillor Margaret Bell (Chair)
Councillor Sue Markham
Councillor Jerry Roodhouse

Shade Agboola (Director Public Health)
Nigel Minns (Strategic Director for People)
Pete Sidgwick (Director of Social Care and Support)

Provider Trusts
Jerry Gould (University Hospitals Coventry & Warwickshire (UHCW))
Dianne Whitfield (Vice Chair of CWPT)
Danielle Oum (Coventry and Warwickshire Integrated Care System)

Healthwatch Warwickshire (HWW)
Chris Bain
Elizabeth Hancock

Borough / District Councillors
Councillor Tim Willis obo Rugby Borough Council

Others Present
Councillor Jo Barker (WCC)
Councillor John Holland (WCC)
Councillor Marian Humphreys (WCC)
Councillor Isobel Seccombe (WCC)

Adam Carson (South Warwickshire University NHS Foundation Trust)
Catherine Free (George Eliot Hospital NHS Trust)

Philip Seccombe – Police and Crime Commissioner for Warwickshire
Chief Constable Debbie Tedds – Warwickshire Police

Officers
Amy Bridgewater-Carnall (Senior Democratic Services Officer)
Rachel Briden, (Integrated Partnership Manager)
Rosanna Fforde (Public Health officer)

Becky Hale (Executive Director Adult Social Care and Health)
Kelly Hayward (Technical Specialist - Public Health)
Gemma Mckinnon, Health and Wellbeing Delivery Manager
Michael Maddocks (Public Health Principal)
Chloe Rousseau (Public Health officer)
Duncan Vernon (Public Health Consultant)

1. General

The Chair welcomed everyone to the first meeting of 2024 and referred to the immense pressure local health services were experiencing, combined with planned industrial action resulting in further disruption.

(1) Apologies

Apologies were received from Councillor Penny O'Donnell, Emma Daniells, Deputy Police and Crime Commissioner and Councillor Sandra Smith, North Warwickshire Borough Council.

However, the Chair welcomed Police & Crime Commissioner, Philip Seccombe and Chief Constable Debbie Tedds of Warwickshire Police.

Councillor Timm Willis substituted for Councillor Adam Daly, Rugby Borough Council.

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

None.

(3) Minutes of the Meeting of the previous Warwickshire Health and Wellbeing Board and Matters Arising

Councillor Bell proposed the minutes of the meeting held on 6 September 2024 and advised of the following actions:

There had been a request for data from Trusts in relation to numbers of children and adults in hospital with mental health needs. It had been suggested that this be picked up by Overview and Scrutiny as it was more relevant to their role however, the Chair felt this was information that would still be valuable to the Board and asked for an update on a future agenda.

An additional action had been a request for the ICB to provide an update on the 'voice of the patient'. A comprehensive report was due to be considered by the ICB Board in March and therefore an item would be added to the HWBB forward plan for May 2024.

A request had also been made to the ICB for the national action plan for GP's to be circulated. This would be included in the HWBB Bulletin in March 2024.

In addition, Gemma McKinnon provided an update from the Community Pharmacy Steering Group on closures across Coventry and Warwickshire.

Councillor Marian Humphreys and Councillor Jim Sinnott requested that their attendance be

added to the minutes.

(4) Chair's Announcements

Councillor Bell welcomed Jeremy Gould to his first meeting as interim chair of UHCW, following the stepping down of Dame Stella Manzie. Councillor Bell also advised that Sue Noyes would be appointed as the substantive Chair as of 1 February 2024 and looked forward to welcoming her to future meetings.

The Chair also provided an overview of the recent internal changes to the WCC Executive Team, the impact this had on some of the HWBB representation and welcomed all officers to their new roles.

Councillor Bell then invited provider representatives to deliver updates where necessary.

Catherine Free, George Elliot Hospital, addressed the meeting and gave a description of how busy the first two weeks after Christmas were, combined with the industrial action from junior doctors. She praised the work of partners in the community recovery service whilst they dealt with the challenge of high bed occupancy.

Adam Carson, South Warwickshire University NHS Foundation Trust, echoed the challenges being experienced and recognised the good partnership working taking place. He noted the difficulties in discharging out of area patients but felt that some improvement could be seen now.

Jerry Gould, UHCW, described recent weeks as extremely busy with numbers of patients having to wait over an hour at a manageable level. The hospital had expanded fourteen wards with extra beds but recognised the difficulties being experienced with ambulances waiting outside for lengthy periods.

Diane Whitfield, Vice Chair CWPT provided an overview of the positive work underway despite the recent industrial action, with acute services running routine clinics. She updated the meeting on recent Health Service Journal Awards, the exploration of community referrals for NHS talking therapies and peri-natal services and the good levels of feedback from the recent ‘I Want Great Care’ programme.

Pete Sidgwick, WCC, advised that the Adult Social Care and Health service was under pressure, with community providers feeling significant pressure as well as hospitals, however he felt that providers were supporting and managing demand. He felt that demand would remain high for the next few months.

2. Director of Public Health Annual Report 2023

Shade Agboola, Director of Public Health, introduced the report and provided a presentation focusing on the health impacts of domestic abuse.

This was the third annual report in Warwickshire since Shade had taken up the role and she thanked everyone involved for their input which included a range of partners across the system.

Whilst the Council was required to produce a report each year, the theme to focus on could be chosen and, having asked widely, it had been agreed that this year's theme would focus on Domestic Abuse. This built on previous Council publications such as the Violence Against Women and Girls (VAWG) strategy (2023-2026). Shade explained that the report told a fictional story of a character named Mia and her experience of domestic violence. The story was told through the words of those surrounding her and the services involved and was reflective of real-life domestic abuse experiences.

The report included data on the local picture of domestic abuse within Warwickshire and provided a range of recommendations for 2023. Following feedback on previous reports, an update on progress of the 2022 recommendations was also included.

Diane Whitfield referred to the figure advising that only 8.3% of domestic abuse recorded crimes resulted in a positive outcome and asked if there was any further information on why some recorded crimes did not progress. In response, Chief Constable Tedds explained that there were a number of reasons why a victim may not seek to continue with an investigation and assured that the Police were very mindful to listen to the voice of the victim. She advised that they worked closely with the CPS and agreed to report back to the Board via a briefing note.

Councillor Holland queried the reference to resources in the recommendations, specifically in relation to primary school meals, as he had hoped that this issue could have been acted on more quickly from last year, despite the timings in relation to budget setting. Councillor Bell reminded Councillor Holland of the progress made with regards to Free School Meals and referred him to the section of the report outlining the actions taken since last year.

Shade Agboola supported the comments from the Chair and advised that a review had taken place, a working group established and officers were currently scoping a pilot scheme in a north Warwickshire school. However, she noted the lack of synergy between some recommendations and budget setting.

Councillor Roodhouse raised the correlation between alcohol consumption and coercive behaviour, querying if any work had been carried out focusing on this. He also asked about the availability of safe spaces, such as churches or libraries, how the Council was working in partnership with organisations to advertise these and how he hoped to see more work in this area.

Shade confirmed that there was a clear correlation between alcohol and domestic violence and whilst she was not sure of the percentage of admissions, further exploration work was being carried out as part of the VAWG strategy. In relation to the level of safer accommodation available, Shade agreed to take the query away and report back to Councillor Roodhouse. Becky Hale drew Members attention to the Safe Accommodation Strategy which laid out the actions being taken across the County, detailed community venues and outlined the support on offer to enable people to stay safe at home. It was agreed that the strategy should be recirculated.

Russell Hardy recognised that domestic violence often went underreported for a variety of reasons including cultural beliefs. He fully supported the first recommendation relating to education, particularly with regard to changing male attitudes. He reiterated the need to educate young boys, making it a requirement at school to reinforce how unacceptable behaviour of this type was. In response, Nigel Minns advised that education providers were very aware of the issue, recognised

the difficulties brought about social media and how some high-profile individuals made this more challenging.

Councillor Humphreys acknowledged the abuse experienced by infants and requested more information on how they could be protected.

Councillor Jo Barker agreed that domestic violence was well under reported and challenged the Police that some victims felt they were not always taken seriously. She referred to a number of women she had been supporting who needed persuading to report incidents as they did not feel enough was being done. In response, Chief Constable Tedds asked that Councillor Barker send her details of the incidents referred to, which she would look into personally. She assured that VAWG was a Police priority and was not just about enforcement but prevention as well. She reminded the meeting that abuse was a very complex and personal matter but wanted to give everyone the widest opportunity to raise fears and concerns regarding their safety.

Shade referred back to the role of education and hoped that more schools would take up the offer of training commissioned by WCC. She acknowledged the impact on babies and children and how maternity services and midwives had a role to play, along with other professionals likely to have contact with women.

Russell Hardy suggested that the Council, Police and NHS as some of the largest employers in Warwickshire could join up with a collective campaign to educate staff on safe routes and inappropriate, intimidatory behaviour.

The Chair supported this idea and proposed the recommendations as laid out in the report.

Resolved that the 2023 Annual Report of the Director of Public Health and the recommendations within it are endorsed.

3. Healthy Ageing JSNA

Michael Maddocks and Rosie Fforde introduced a report outlining the Joint Strategic Needs Assessment (JSNA) relating to Healthy Ageing. The assessment sought to analyse the current and future wellbeing needs of the older adult population to inform the commissioning of health, wellbeing and care services.

The presentation included a lot of information and data related to healthy ageing and gave an overview of the following:

- What is a JSNA – purpose, responsibilities and approach;
- Why healthy ageing – local rationale and national context;
- Approach to JSNA – Definitions, scope and engagement;
- Key points – Strategic implications from JSNA;
- Recommendations – for Health and Wellbeing Board and from JSNA; and
- Next steps – Publication and dissemination.

Officers explained how older adults made up a growing part of the population and tended to have more health and care needs. An overview of the national context was given with the Healthy

Ageing Consensus Statement from 2019 alongside the Chief Medical Officer's Annual Report 2023.

Rosie Fforde outlined the engagement tools utilised to gather the views of residents including story circles, focus group style sessions and a County wide survey. Key points from the JSNA concluded the presentation, with prevention highlighted as an important thread, to improve quality of life, reduce inequalities and ensure the sustainability of services.

A number of queries were raised by Members of the Board and responded to by officers as summarised below.

Councillor Humphreys enquired about the incontinence service which she had been fighting for years for and supported the comments made about changing attitudes towards ageing as many older residents were working in the community volunteering.

Russell Hardy highlighted that by 2035 there would be more people over 65 than in the working population. He proposed that by working together, organisations could make Warwickshire the easiest place to volunteer, providing benefits to the individuals and as part of the economy.

Councillor Roodhouse welcomed the vision of friendly ageing communities and referred to some good examples in other parts of the country. He encouraged coalition of strategies to ensure they delivered strong outputs and fed into one another.

Councillor Bell acknowledged that this issue had been discussed for a number of years and was now being lived in real time. She asked the ICB if there was any news on the incontinence information being brought forwards. In response, Danielle Oum agreed to take this away and report back as she was not sure how far along the work was.

Rosie Fforde agreed that volunteering should be recognised and this had been included in the 25 recommendations being put forward, along with encouraging age friendly employers. In response to Councillor Roodhouse, she referred the meeting to the next steps to move the work forwards and assured that many conversations would be taking place.

Chris Bain of Healthwatch welcomed the JSNA and referred to his previous work with Age Concern England. He reiterated that the response to ageing was not just about access to services but access to society. He advised that studies had shown that people were at their most productive age between 60 and 70 years. He encouraged everyone to work with older people to develop services and was keen to see how this would influence policies and practice moving forwards.

The Chair referred everyone to the recommendations for the Board, one of which was to explore becoming a signatory to the healthy ageing consensus. She proposed that officers explore this and report back with further details.

The Health and Wellbeing Board **Resolved** that

1) the findings and recommendations arising from the Healthy Ageing Joint Strategic Needs Assessment (JSNA) are endorsed;

2) the publication of the Healthy Ageing JSNA is approved and supports its dissemination within member organisations; and

Encourages all member organisations to make use of and have regard to the Healthy Ageing JSNA in the exercise of their functions, including in the planning and commissioning of relevant services.

4. Overview from Foundation Group Hospitals new Directors – Adam Carson (SWFT) and Catherine Free (GEH)

Russell Hardy introduced Adam Carson, Managing Director of South Warwickshire University NHS Foundation Trust and Catherine Free, Managing Director of George Eliot Hospital NHS Trust, who were in attendance to deliver presentations on their trusts and outline future plans.

Russell provided some background as to how the foundation group had started when he and a colleague had been asked to help at Wye Valley. It had been recognised that there was no facility in place for providers to share best practice and the work had resulted in setting up joint teams to learn from one another. This work had continued with George Eliot Hospital and latterly Worcester Acute. Whilst all of the organisations were still legally autonomous, they had a committee in common as well as joint teams covering a wide range of issues.

Catherine Free addressed the meeting and delivered a presentation on Warwickshire North Place Clinical Strategy. She advised that the ambition was to become a diagnostic centre of excellence, ensure patients received same day emergency care, deliver integrated care without barriers and improve clinical outcomes by tackling health inequalities.

She went on to outline the Improvement Journey so far, the different phases of development, addressing waiting list backlogs and the work undertaken to reduce vacancy rates amongst staff.

Catherine explained that the trust had identified five ‘big moves’ to underpin the work including creating resilience in the domiciliary care marketplace and embedding prevention in every service. In summary, she advised that there was a genuine commitment to excel at patient care and whilst finance may be challenging, the trust had a track record for delivering. In conclusion, they were a sustainable organisation with much to offer the local population.

Adam Carson delivered his presentation, which covered:

The range of acute services provided across Warwickshire;
The trusts ranking from the CQC and NHS Oversight Framework;
Becoming a University Trust in 2022;
Awarded Top 5 best acute Trusts as part f NHS Staff Survey 2022.

The Trusts objectives for 2023/24 were outlined along with how these would be delivered. Recruitment and retention remained a large challenge and the trust was focusing on growing and developing its workforce.

Adam explained the current priorities and referred to the level of development work taking place at the Warwick Site. This was multi-phased with phase 1 due for completion in January 2025. He recognised the disruption this was causing, especially in relation to car parking and noted the new Lillington Health Hub and redevelopment of the Ellen Badger site.

Work with Place Partners continued, particularly in relation to prevention and how the trust could collaborate on priorities such as mental health, wellbeing, climate change and the cost of living. In summary, Adam felt the Trust had a strong track record for innovation and improvement and hoped to continue integrating services and partnerships in a challenging financial landscape.

Councillor Bell thanked both Managing Directors for their presentation and was encouraged to hear their future plans and ideas for working with communities.

Chris Bain of Healthwatch agreed but requested that where there were delays in communication, it became all the more important to use clear and simple language. He was also keen that the interface between mental and physical health be strengthened, with multiple diagnoses.

Councillor Humphreys referred to dementia policies and how not all NHS staff seemed to be aware of the diagnosis or rights of families and carers. Adam Carson agreed that this was an important area to monitor, with SWFT investing in dementia services and the employment of a new lead nurse.

Councillor Jim Sinnott, Warwick District Council welcomed the ambition to embed prevention in every service and asked that some good news stories be reported back, evidencing where this had been successful.

The Chair also hoped to hear how the work for both Trusts was progressing at future meetings and outlined the recommendations in the reports.

Resolved that

1) the strategic direction for George Eliot Hospital, is noted;
2) the Improvement Journey of George Eliot Hospital, is noted;
3) the role George Eliot Hospital is taking within Warwickshire North Place, is noted;
4) the strategic direction for South Warwickshire University NHS Foundation Trust, is noted; and the role South Warwickshire Foundation Trust is playing in wider work across Warwickshire, and within South Warwickshire Place, is noted.

5. Better Care Fund 23/25 progress update

A presentation was received from Rachel Briden, Integrated Partnership Manager which provided an update on progress against the key areas of focus in the Better Care Fund Plan for 2023-25. The report also advised on progress against the national metrics and preparations for 2024/25.

Rachel Briden outlined the quarterly report and signposted Members to key areas including performance, the positive outcomes of the Community Recovery Service and the move to Community Integrator arrangements.

She reminded the meeting of the recommendations in last year's report with funding aimed at supporting older people in the community to help avoid admittance to hospital where possible. Paragraph 1.7 of the report also provided an update on changes to the discharge to assess model helping to support more timely discharges into temporary 'step down' beds.

With regard to recommissioning the Integrated Community Equipment Service, Rachel highlighted that the current providers contract was due to expire in August this year and a new service provider would be transitioned in. Further information was outlined in paragraph 1.18 but the aim was to prevent admission, facilitate discharge from hospital and keep people independent in their own homes.

In a summary of performance, the Board were advised that quarters 1 and 2 were better than last year with a drastic improvement in emergency admissions due to a fall. Section 2 of the report gave an update on the improved Better Care Fund, the schemes funded since its inception in 2017 and the draft list of schemes to be continued in 2024/25. Rachel advised that there was no national inflationary increase to the improved Better Care Fund allocation planned and so individual scheme budgets could not be uplifted. The ICB and WCC were working through the list of schemes to be funded at present, and this would be confirmed shortly.

Councillor Marian Humphreys raised the issue of the level of support provided on discharge from hospital as some of her constituents had been experiencing difficulties and some processes did not seem to be working as well in the community as it had been hoped. Becky Hale encouraged Councillors to share the details of such cases so they could be looked into on an individual basis and used to inform improvement.

The Chair acknowledged the importance of coordinated working between acute settings and the value of all community partners.

Resolved that the Health and Wellbeing Board;

1) Notes the progress of the Better Together Programme in 2023/24 and the updates provided on the key areas of joint focus in the Better Care Fund plan for 2023-25;

2) Notes performance against the national Better Care Fund metrics; and

Supports the plan for schemes to be funded from the Improved Better Care Fund in 2024/25.

6. Health and Wellbeing Board Place-based Partnerships

The Chair reiterated the importance of understanding what each of the individual Place Partnerships were undertaking and the challenges being faced. She proposed that an update be added as a discussion item at the next meeting in May.

7. Children and Young People Partnership

The Chair reminded the Board that the Children and Young People Partnership was a subgroup of the Board, focusing on mental health, health and health visiting. She advised that the group would update the Board on the work being undertaken at the next meeting.

8. Update on All Age Carers

The Board were reminded that an update had been circulated on 4 January 2024.

9. Forward Plan

Councillor Bell advised that, as discussed earlier in the meeting, the following items would be added to the forward plan for the meeting in May 2024:

- ‘Voice of the Patient’ update from the ICB following the ICB Board meeting in March 2024;
- Feedback from the Health and Wellbeing Board Executive Group on 18 January 2024;
- Update from the ICB on pharmacy, optometry and dentistry commissioning transfers;
- An update from the Children and Young People Partnership; and
- Health and Wellbeing Board Place-based Partnerships.

The meeting rose at 15:36

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Chair

Agenda Item 2

Health and Wellbeing Board

15 May 2024

Place-based HWBB Partnership Plans

Recommendation

That the Health and Wellbeing Board notes and comments on the verbal updates provided by representatives from the place-based HWBB Partnerships.

1. Executive Summary

1.1. Warwickshire's Health and Wellbeing Strategy (HWS) 2021-2026 is underpinned by the King's Fund population health framework (figure 1). The framework demonstrates that to improve health and wellbeing outcomes for people, we must take action in a holistic way, across organisations, disciplines, and sectors. This population health view is based on robust evidence that healthcare influences approximately 20% of our health, whilst the wider determinants of health, our health behaviours and lifestyles, and the places and communities we live in and with influences approximately 80%.

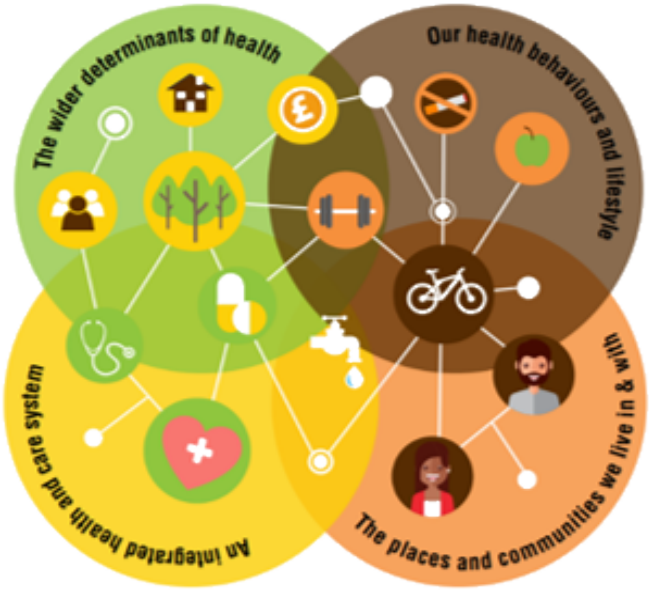

Figure 1: King's Fund Population Health Framework

1.2. The HWS sets out how we will take a place-based approach to delivery via the three HWBB Partnerships for Warwickshire North, Rugby, and South Warwickshire. This is to ensure that delivery is tailored to meet the local evidenced need and built upon the strengths within each geographical Place.

1.3. The priorities within the HWB relate to:

- Helping children and young people have the best start in life.
- Helping people to support their mental health and wellbeing with a focus on prevention and early intervention.
- Reducing inequalities in health and the wider determinants of health.

1.4. Each place-based HWBB Partnership makes informed decisions on how it will support delivery of these priorities via the Partnership mechanism. The priorities of each Place are in table 1.

Table 1: Priorities at Place

Warwickshire North Partnership	**Rugby Partnership**	**South Warwickshire Partnership**

• Access to services
• Mental health and wellbeing
• Children and young people
• Wider determinants of health
• Healthy lifestyles and long-term conditions
	• Improving access to health services via:
	  ○ Town centre regeneration
	  ○ Opportunities at St Cross
	  ○ Understanding the barriers to accessing services
		• Cost of living
		• Mental health and wellbeing
		• Climate change

1.5. Each HWBB Partnership has prepared a verbal presentation on progress with Place Plans over the past twelve months.

1.6. In addition to progress with Place Plans, there have also been changes to the membership and governance of HWBB Partnerships, including:

- To strengthen the links between the Creating Opportunities / Levelling Up agenda a senior Warwickshire County Council (WCC) officer has joined each Partnership. The Creating Opportunities / Levelling Up Plans have been incorporated into the HWBB Delivery Plan 2024-25, reflecting the role this agenda plays in improving health outcomes and reducing inequalities in health within each Place.

- To respond to the formation of the Warwickshire Care Collaborative, each Place has been considering how it will most effectively inform Collaborative commissioning activity, for example through reviewing terms of reference and governance mechanisms.

2. Financial Implications

There are no financial implications linked to the recommendations.

3. Environmental Implications

None.

4. Timescales associated with the decision and next steps

4.1. Annual review of activity is on the HWBB Forward Plan for May 2025.

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Agenda Item 3

Health and Wellbeing Board

15 May 2024

Health and Wellbeing Board Executive Group

Recommendations

That the Health and Wellbeing Board

1. Notes and comments on the outcome of the Health and Wellbeing Board Executive Group meeting from the 18th of January 2024;

2. Approves the amended Health and Wellbeing Board Strategy Delivery Plan 2024-25 attached at Appendix 1; and the proposal to develop a more comprehensive and robust Warwickshire Health and Wellbeing Board Delivery Plan, with a view to bringing a completed product to September Health and Wellbeing Board for approval;

3. Agrees to utilise a future Health and Wellbeing Board meeting to focus on Priority 1 of the HWBB Strategy – helping children and young people to have the best start in life (BSiL); and

4. Approves the amended Health and Wellbeing Board Executive Group governance arrangements.

1. Executive Summary

Background

1.1 The Health and Wellbeing Board (HWBB) Executive Group (EG) is a sub-group of the HWBB rather than a formal sub-committee. It was established in 2015 to set the strategic direction of HWBB and to drive delivery of integrated services. During the last two years, as the Integrated Care System (ICS) and associated bodies (such as the Integrated Care Board and the Integrated Care Partnership) have been establishing, the HWBB EG has been stood down. However, in September 2023 the HWBB endorsed the recommendation to reinstate the HWBB EG with the purpose of setting, agreeing, and reviewing the HWBB Delivery Plan on an annual basis.

1.2 The HWBB Delivery Plan seeks to capture partnership activity that takes place across the four quadrants of the population health framework, relating to the priorities of the HWBB Strategy 2021-26. The focus of the Delivery Plan is on integration, collaboration and joining up of work programmes and services, rather than on individual organisations' activity. Despite this, the role of the Council's Public Health service is vital to delivering on the HWBB Strategy

2021-26, and as such an outline of Public Health activity and spending is provided elsewhere on this agenda and for context.

1.3 The HWBB EG met in January 2024 and agreed the proposed HWBB Delivery Plan 24-25 put forward in this report (and pending any amendments from HWBB). The proposed Plan includes requirement for progress updates, greater focus on Best Start in Life, inclusion of Creating Opportunities (formally Levelling Up) and an outline of how well citizen voice is captured throughout. The proposed Delivery Plan 24-25 is included at Appendix 1 of this report for information and approval by the HWBB.

Best Start in Life

1.4 Priority 1 of the HWBB Strategy is to help children to have the best start in life. To support this priority, the HWBB Joint Strategic Needs Assessment (JSNA) Strategic Group has developed several children's JSNAs covering children 0-5 (May 2022), mental health and wellbeing of children and young people (Sept 2023) and the physical health of children and young people (May 2024). The recommendations from the 2022 and 2023JSNAs mentioned are supporting the development of the Early Years Integrated Delivery Plan (IDP), which is scheduled for September HWBB.

1.5 The HWBB Delivery Plan 24-25 has been strengthened to include the IDP, which will be overseen by the Children and Young People Partnership (CYPP). To ensure that HWBB remains focused on Priority 1 and understands the implications of prioritising resources on this cohort, HWBB EG asks that focus is given to Best Start in Life at a future HWBB.

Creating Opportunities

1.6 Priority 3 of the HWBB Strategy is to reduce inequalities in health and the wider determinants of health. The HWBB Place-based Partnerships for Warwickshire North, Rugby and South Warwickshire act as key delivery vehicles for this priority, due to the range of wider determinants services such as leisure, housing and town planning that sit within district and borough councils. Key deliverables for the Place Plans are listed within the HWBB Delivery Plan 2024-25 and each Place is providing further information via a presentation to HWBB under Item 4.

1.7 In addition to enabling place-based conversations on the wider determinants of health, HWBB Partnerships also seek to tackle inequalities in health by targeting initiatives and interventions towards areas with higher rates of deprivation and/or towards populations who experience greater inequality, such as those with long term conditions, people experiencing homelessness, or black and minority ethnic groups. This is in line with the NHS CORE20+5 approach and the creating opportunities (formally levelling up) agenda. With this in mind, local Creating Opportunities (CO) Plans for each district and borough feed into HWBB Partnerships, contributing towards each Place Plan. The CO Plans are evidence-based and were developed through multi-agency stakeholder workshops and engagement with local communities. The CO associated Social Fabric Fund is supporting investment into local

communities, with the aim of improving residents' life chances and reducing inequalities.

Citizen voice

1.8 Within the HWBB Delivery Plan 24-25 (Appendix 1) programme leads have been asked to self-report on how well an activity is being coproduced, against a scale with 1 being the lowest (informing) and 5 being the highest (co-producing). Examples of how citizen voice is being embedded within these programmes are highlighted in Appendix 2. We are exploring better ways of capturing and recording citizen voice for future HWBBs.

1.9 In relation to HWBB Place Partnerships, Warwickshire North and South Warwickshire have recognised that more could be done to ensure activity incorporates the citizen voice. In Autumn 2023, Healthwatch Warwickshire (HWW) held a Rugby Health and Care Forum focused on access to services. HWW worked with local residents to understand barriers and make recommendations to Rugby Partnership that are now informing activity within the Rugby Place Plan.

Governance

1.10 The purpose of the HWBB Executive Group is to review and monitor the HWBB Delivery Plan on an annual basis. It will also take a lead in shaping the next iteration of the HWBB Strategy (2026).

1.11 HWBB Executive Group agreed that the meeting will stand up as and when required. Where the HWBB Chair has a request for input, the Executive Group will consider the role of other groups and forums (such as scrutiny, place or specialist collaborates) to take this on in the first instance.

1.12 Regarding Joint Health and Wellbeing Board arrangements, consensus from Executive Group was the Joint HWBB had served its purpose by setting the strategic direction for the system and should be stood down (as per Item 7 of this HWBB agenda). However, it was reinforced that there needs to be a clear mechanism for districts and boroughs and the democratic voice to be represented through the current Integrated Care Partnership (ICP) infrastructure.

1.13 In relation to the Warwickshire Care Collaborative, Executive Group agreed to continue to monitor the interface between the evolving collaborative and the HWBB noting integration should be driven from place and communities.

2. Financial Implications

2.1 None.

3. Environmental Implications

3.1 None.

4. Timescales associated with the decision and next steps.

4.1 Year 2 of the delivery plan commenced on 1st April 2024. Quarterly updates will be provided to the Coventry and Warwickshire Dementia Steering Group.

Appendices

1. Appendix 1 - HWBB Strategy Delivery Plan 2024-25
2. Appendix 2 - Examples of how citizen voice is being embedded

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Local Member(s): None - this is a County wide report.
Other members: Councillor Margaret Bell and Councillors Barker, Drew, Holland and Rolfe.

	A	B	C	D	E	F	G	H	I	J	L	N	O	P	Q	R
1	**Delivering the statutory functions of HWBB in 2023-2025**															
2	**Key Activity**		**HWBB Priorities**			**Statutory Functions**			**Evidence**		**Reporting**		**Progress update**			
3	**Key delivery mechanisms**	**Headline activity 23-25**	**Prior 1: CYP BSiL**	**Priority 2: MH&W**	**Priority 3: RHI & WDoH**	**JSNA**	**Joint Comm**	**BCF**	**Evidence informed?**	**Coproduction scale**	**Reporting Group**	**Lead org**	**Progress (May 2024)**	**Year of activity**	**status of activity**	**RAG**
4		Mental Health and Wellbeing of Infants, Children and Young People JSNA This JSNA will support the recommissioning of the CAMHS service.	X	X		X	X		4	3	JSNA Strategic Group	WCC	Completed and disseminated - next steps to integrate relevant intelligence into the Empowering Futures JSNA Dashboard to present a fuller view of child health.	2023	Completed	
5		Empowering Futures: Growing Up Well in Warwickshire JSNA (school age children's physical health). This has been developed to align with school nursing service commissioning and the children and young people making every contact count (MECC) offer in development.	X			X			4	3	JSNA Strategic Group	WCC	On track - due to be presented at the May 2024 HWBB in an online, interactive format.	2024	In progress	
6	**Development and delivery of JSNA work programme**	Healthy Ageing JSNA The Healthy Ageing JSNA was produced to support the commissioning of adult social care services, as well as informing the Adult Social Care Strategy and Community Integrator arrangements.			X	X	X		5	3	JSNA Strategic Group	WCC	Completed and currently being disseminated much more widely than previous JSNAs. Conscious decision to spend dedicated time thinking through the implications for specific stakeholder groups.	2024	Completed	

	A	B	C	D	E	F	G	H	I	J	L	N	O	P	Q	R
7		Learning Disabilities JSNA The initial scoping is focusing this JSNA on those with a learning disability aged 16+.		X	X	X	X	X	TBC	TBC	JSNA Strategic Group	WCC	Currently being scoped with stakeholder group	2024	not yet started	
8		LGBTQ+ JSNA The scoping is initially looking at what data we are able to pull together on the protected characteristics of our population in relation to LGBTQ+ and producing a literature review on the health needs of this population.	X	X	X	X		X	TBC	TBC	JSNA Strategic Group	WCC	Currently being scoped with stakeholder group	2024	not yet started	
9	**Development and delivery of Better Care Fund Plan for 2023-25**	Joint activity through the Better Together Programme is delivered and supports more people to • Live independently at home for longer; and • Receive the right care in the right place at the right time.			X		X	X	2	4	Joint Commissioning Board (transitioning to Warwickshire Care Collaborative)	WCC/ICB	2 Year BCF Plan produced and met national moderation and assurance requirements, supported by a 2 year section 75 agreement. Good progress made implementing priorities, particularly the new Community Recovery Service. Q3 Performance against national metrics: - Admissions Avoidance - Over/worse than target. - Discharge to usual place of residence - On target - Residential admissions - Over/worse than target - Reablement - On target - Falls - Over/worse than target but much better than previous years	2023/24	in progress	

	A	B	C	D	E	F	G	H	I	J	L	N	O	P	Q	R
10	**Delivery of Joint Health and Housing Action Plan**	a. Ensuring there is an integrated approach to Housing, Social Care and Health where housing is embedded into health and social care pathways					X	X	2	3	Housing Partnership Board	WDC / NWBC	The 2 year Housing Partnership Board details the joint and integrated approach between health, housing and social care. Central to this are the Housing Hospital Liaison Officers, with funding from the BCF now extended to March 2025.	2023/24	in progress and on target	
11		b. Early intervention activities before the point of crisis			X				2	3	Housing Partnership Board	WDC / NWBC / WCC	The switchover from analogue to digital for lifeline and other assistive technology devices provided by the District, Boroughs and County Council is in progress to meet the 2025 deadline. In addition, AT pilots continue to test new ways of working and evaluation will inform future options.	2023/24	in progress and on target	
12		c. Supporting people smoothly transition into more appropriate housing			X				3	4	Housing Partnership Board	WCC	Significant progress has been made in 2023/24 to provide targeted support and housing for people with more complex needs including: -transient and newly arrived communities through workforce training and development to understand their specific needs, - the development/maintenance of a pipeline of housing options, - regular demand and capacity mapping (including inpatient mapping) to meet more specialist needs, particularly for people with LDA/PD or those supported through the Transforming Care Programme, - resolution of issues with the DFG Protocol for individuals with LDA.	2023/24	in progress	
13		d. Improving choice and access to appropriate housing support, advice and information			X				3	4	Housing Partnership Board	WCC	As part of our focus on Green Homes we have been working together to prevent ill-health caused by poor housing and living conditions by providing practical advice and information relating to damp and mould, working on ensuring homes have EPC certificates and promoting information and advice provided by Act on Energy. The Accommodation Related Support Service has been re-designed and re-tendered ready for a new contract to commence later in 2024. Hoarding, deep cleaning due to self-neglect is also becoming more of an issue.	2023/24	in progress and on target	
14		e. Increasing Housing Adaptations through effective use and monitoring of the Disabled Facilities Grant (DFG)			X				2	5	Housing Partnership Board	NWBC	Following extension of the multi-agency HEART Partnership for a further 5 years in April 2023, housing adaptations using the DFG continue to support both discharge, which is not means tested, and people in the community. Work is also underway to maximise use of the DFG in 2024/25 by increasing staff resources.	2023/24	in progress	

	A	B	C	D	E	F	G	H	I	J	L	N	O	P	Q	R
15		f. Co-ordinating homelessness prevention activities			X				3	5	Housing Partnership Board	WCC	The Homeless Strategy Group are/has: - reviewing the dual diagnosis policy, new dual diagnosis workers are in place, - completed the call for evidence for the Drug Needs Assessment, - focussing on expansion of the Physical Health Nursing Outreach Service, - evaluating impact of the GP drop in clinic - refreshing the Preventing Homeless Strategy, - have finalised and rolled out training on the Warks Young Person's Protocol, - established a Drug and Alcohol Strategic Partnership Board, and are now implementing the priorities in this plan	2023/24	in progress and on target	
16	**Community Recovery Service**	Deliver the Warwickshire intermediate care frontrunner pilot and demonstrate the following outcomes: • Increase the number of people receiving rehabilitation and recovery services after an acute hospital admission • Decrease the need for long term care by decreasing demand and acuity • Reduce the length of stay for people in an acute hospital who should be at home (or in a more appropriate community bed-based care)					X	X	3	5	Joint Commissioning Board	WCC/ SWFT	The national front runner pilot was for 12 months to the end of March 2024 and this has now been completed. Lessons learnt from the pilot have been collated and are being shared amongst the 6 pilot areas and with NHSE to continue to inform the development of intermediate care nationally. Outcomes from the pilot currently show: - a significant increase in the number of people receiving therapy, and - a reduced length of time in hospital and in sourcing packages of care In terms of decreasing the need for long term care and decreasing demand and acuity - it is not possible to clearly evidence this yet. The intention is to now locally continue the pilot for a second year, with funding primarily from the Discharge Fund to enable the impact to be properly understood.	2023/24	Completed	
17		Continue operating within current Section 75 arrangements including the Better Together programme, integrated community equipment, RISE, Discharge to Assess and residential care.	X	X	X		X	X	2	3	Joint Commissioning Board	WCC/ICB	Separate section 75s are currently in place. For the BCF a 2 year s75 to March 2025 has been agreed, whilst the new Care Collaborative and Integrated Care System takes more shape.	2023/24	Completed	

	A	B	C	D	E	F	G	H	I	J	L	N	O	P	Q	R
18	**Development of section 75 agreements to support joint commissioning activity**	Progress the establishment of a Section 75 for Health Visiting Services subject to public consultation and partnership decision making processes.	X		X				4	4	Joint Commissioning Board	WCC	Extension to the current contract has been agreed. Further work underway to support decision making regarding future arrangements.	2023 - 25	Work continues	
19		Progress work to consider the development of an overarching Section 75 arrangement for joint commissioning activity.							2	4	Joint Commissioning Board	WCC/ICB	Area of focus commencing in April 2024	2024/25	Not yet started	
20		Priority 1: Improving access to services Flagship project example - Frailty Community Hub			X				3	4	Warwickshire North Health and Wellbeing Partnership and Place Executive Group	RWN PCN	• Health Intent frailty dashboard has now been launched, which gives the ability to generate real time lists of relevant patients. • The clinic base has now moved to new premises in Hartshill, which has allowed a move to weekday clinic sessions, increasing capacity within the service. • Identified patients from all 6 practices in the PCN are being invited in for their assessment and care planning. • Recruitment of therapy posts is underway. • Plans to support embedding personalisation with the team are progressing. Links have been made with Think Active to explore a potential joined up approach incorporating learning around the role of activity in health outcomes. • Initial figures on use of the frailty clinic for proactive care have been compiled. Data on the use of primary care before and after the clinic has been included. • Work is underway to match hospital data to the cohort who have completed the proactive care intervention to monitor the impact on secondary care.	2024/25	On track	
21		Priority 2: Improving mental health & wellbeing Flagship project example - Suicide Prevention		X					3	3	Warwickshire North Health and Wellbeing Partnership and Place Executive Group	PH	• Service review of existing postvention support service underway. • Ongoing development of Suicide Prevention Delivery Plan: 2 year high level actions to support SP Strategy. • WCC Suicide Prevention lead (Hannah Cramp) to attend future WN Place Coordination meeting to explore place-based approach to suicide prevention delivery. • Permanent recruitment of Real Time Surveillance Coordinator post. • Market testing for postvention support service Jan/Feb 2024 - with full tender process.	2024/25	On track	

	A	B	C	D	E	F	G	H	I	J	L	N	O	P	Q	R
22		Priority 3: Children and young people Flagship project example - Child Accident Audit & Prevention	X						3	3	Warwickshire North Health and Wellbeing Partnership and Place Executive Group	PH	• Initial stakeholder meeting held on 4th March to review draft action plan and assign tasks/ownership, set Terms of Reference.	2024/25	On track	
23 24	**Deliver Warwickshire North Place Plan**	Priority 4: Addressing the wider determinants of health Flagship project example - Back to Health Volunteering			X				3	3	e North Health and Wellbeing Partnership and Place Executive Group	GEH	• Positive response from ICB Health inequalities funding panel on future funding - decision subject to board approval. • Final draft from Helpforce impact report - shared with steering group for approval. • Working with GEH Business Case Review Group support team to develop long term business case. • Health Awareness Session with Gurkha Community covering social prescribing, breast cancer screening for men and women, and Sky Blues in the Community discussed their sports and physical health programmes for underrepresented communities. • Mobile Health Unit visit to Kirby Glebe Farm and Alvecote sites, arranged further mobile health unit sessions for the next 6 months at all 3 sites. Agreed and coordinated new drop-in sessions at Griff Hollow for next 3 months where external agencies can interact and support GRT community. Introductions made between Oral Health Team and site managers to arrange oral healthcare training for GRT community. •Community Engagement Event with Abbey Green residents (low-income, poor housing) in Nuneaton and attended Lunar New Year Festival for Hong Kong BNO community. •Diabetes Prevention Session with Armed Forces. •Linked in with Social Prescribers for all 3 PCNs to arrange further health awareness sessions in the community. •Linked with Neurodiversity/ Autism Strategy Lead to discuss the Coventry & Warwickshire All Age Autism Strategy and experiences of underrepresented communities – information distributed to Community Groups for support. •Everything now in place to start making regular scheduled calls for Respiratory and Gastroenterology (these started 4th March and will be weekly from now on). •Everything now in place to start making regular calls for Ophthalmology, ENT, Pain, Oral, Urology, Plastics, T&O, Breast, Colorectal and General Surgery. •With the commitment from the above teams, we can now look to recruit more volunteers to the contact centre. •Successful meeting with Emma West-Eggar as we look to move in to a trial phase of making comfort calls	2024/25	Some issues with a plan in place	

	A	B	C	D	E	F	G	H	I	J	L	N	O	P	Q	R
25											Warwickshir		to heart failure patients on virtual wards. •Successful meeting with wider DNA project – Deep Medical/volunteer team/outpatients team etc to discuss milestones etc. •723 hours of responder volunteer support provided across 653 tasks in most recent month. •26 out of hours driver deliveries of medication. •84 hours of comfort calls volunteer support provided. •850 Patients "successfully" contacted by calls. •5 internal referrals (within GEH). •13 External referrals - Health Exchange, Age UK and others.			
26		Priority 5: Promoting and improving healthy lifestyles and reducing the burden of long-term conditions Flagship project example - Cardiovascular Disease Checks			X				3	3	Warwickshire North Health and Wellbeing Partnership and Place Executive Group	GEH	• CVD Community 'Healthy Heart Checks' Weekly Events have now been taking place across Warwickshire North targeted to community venues highlighted as being within CORE 20 LSOAs. September Start. With this patient referrals are continuously being processed through to Primary Care who are picking up patients that trigger further intervention. • As well as outreach events which are already underway, Project Team have now agreed on 3 UCL Cohort Groups to focus Primary Care Engagement. Rolled out best practice guidance and communications to aid PCN targeted approach, led by Primary Care Stakeholders. • Agreed with ICB, project extension to run through 24/25 financial year with available funding to support continuation of services. • Project Outcome Reporting: an outline of required data sets has been agreed by project leads and primary care, to ensure outcome data, timelines etc. support INHIP and NHS England Reporting. • The CVD Project has Evaluation Partner under contract discussions with Warwickshire County Council Business Intelligence Team, with Interim Evaluation Report agreed for March once contract formally signed. • Working with PCNs to share update on project processes and involvement needed in next steps, with continuous GP communications circulated.	2024/25	Some issues with a plan in place	

	A	B	C	D	E	F	G	H	I	J	L	N	O	P	Q	R
27		Overarching priority: Reducing health inequalities Flagship project example - VISO Hypertension Remote Monitoring			X				3	3	Warwickshire North Health and Wellbeing Partnership and Place Executive Group	N&B PCN	• Invoice to the ICB for Health Inequalities funding has been paid. • 121 patients enrolled to Viso up by 24 in the last reporting period. • 3 patients from Groups 2b only from Manor Court & Red Roof's Surgery. • 37 patients from Group 3a covering Bulkington Surgery, Manor Court & Red Roof's Surgery. • 80 patients that are Hypertensive across Bulkington, Manor Court & Red Roof's Surgery. • The number of patients enrolled has now activated access to the Quicksight reporting tool to commence data analysis of enrolled patients. • Developed joined up approach to CVD project; onboarding suitable patients identified through community HC. • Arranging next wave of Viso training for new stater clinical pharmacists to increase resource for managing patients on Viso dashboard. • Care Coordinator process flow is being followed for patient enrolment and engagement. • EMIS protocol now live to alert clinicians when a patient is enrolled to Viso - prompting them to use the Viso dashboard for patients' Hypertension management.	2024/25	On track	
28	**Delivery Rugby Place Plan**	Tackling Social Inequalities Strategy (TSI)- producing proposal and allocation of funding aligned to the TSI priorities	X	X	X				2	1	Rugby Health and Wellbeing Partnership	RBC	RBC and WCAVA led on the development of a proposal outlying how the Rugby Partnership would allocate the £28,164. The proposal splits the funding between the three priorities of the TSI Strategy. The funding will support: mental health first aid awareness and the On Track Youth Programme (priority 1), community transport scheme (priority 2) and a DWP Job Fair and Employability Workshop and Hardship Fund to support more disadvantaged areas as identified in JSNA (priority 3). The proposals are now moving into delivery.	2024	On-track	
29		Task and Finish Group led by Warwickshire Community and Voluntary Action (WCAVA) looking at children's mental health support provision	X	X					2	3	Rugby Health and Wellbeing Partnership	WCAVA	This has been incorporated into the TSI projects (highlighted above)	2024	some delays	

	A	B	C	D	E	F	G	H	I	J	L	N	O	P	Q	R
30		Alignment of Place Plan priorities (e.g. town centre regeneration and access to services) with Levelling Up/Creating Opportunities Plan			X	X			2	3	Rugby Health and Wellbeing Partnership	RBC	Developed a proposal for health on the high St. Approval of levelling up approach at RBC cabinet. Further work on alignment of Place Plan with LU to be undertaken in 24/25	24-25	On-track	
31		Carers Place Innovation Fund			X				3	3	Rugby Health and Wellbeing Partnership	RBC/WCAVA	Two bids have been received and circulated for comment. TK and TS have confirmed support for both applications.	24-25	On-track	
32		Recruitment of place officer					X		N/A	1	Rugby Health and Wellbeing Partnership	SWFT/UHCW	Job description for a joint role across SWFT and UHCW has been created and comments from Rugby Partnership received. The role will support Rugby Partnership in delivering on its priorities. Aim is to recruit in next three months.	24-25	On-track	
33		Piloting PHM approaches to identify patients with diabetes and associated conditions to then support through a virtual Multi-Disciplinary Team			X				4	1	South Warwickshire Place Partnership	WCC/ICB	Complete - Final report and next steps produced on pilot which was part of wider system Transformation programme.	23/24	Complete	
34		Piloting of the Tribe digital platform to connect vulnerable people to local services and volunteers	X	X	X				3	3	South Warwickshire Place Partnership	WCAVA	Complete - final report and lessons learned being produced	23/24	Risks, plans in place	

	A	B	C	D	E	F	G	H	I	J	L	N	O	P	Q	R
35	**Deliver South Place Plan**	Delivery of an Innovation Fund to support all-age carers	X	X	X				3	3	South Warwickshire Place Partnership	WDC/WCAVA/SWFT	Delivery - Application window closed March 2024. Applications currently being assessed	24/25	On-track	
36		Piloting home efficiency grants for patients with long-term conditions		X	X				3	1	South Warwickshire Place Partnership	SDC	Delivery - currently finalising pathway documentation, training and processes	24-25	On-track	
37		Improving respiratory health in Lillington through a new Housing & Health role, improving smoking cessation, vaccine uptake and piloting free swimming for children with asthma	X	X					3	TBC	South Warwickshire Place Partnership	WDC	Delivery - new health and housing role started April 2024	24-25	On-track	
38		Allocation of funding aligned to the Tackling Social Inequalities Strategy to piloting a new CYP MH prevention role within primary care	X	X	X				3	TBC	South Warwickshire Place Partnership	SWGPs	Re-scoping pilot to support TSI objectives and feedback from CWPT. Leamington North PCN identified as pilot area for an initial MH post	24/25	Significant delay, plans in place	

	A	B	C	D	E	F	G	H	I	J	L	N	O	P	Q	R
39		Scoping a proactive care pilot in a rural PCN to support moderate to severe frailty with long-term conditions		X					3	TBC	South Warwickshire Place Partnership	SWFT	Scoping - Reviewing evidence and engagement to inform next steps	TBC	Risks, plans in place	
40		Scoping ways to build MH resilience in communities		X	X				3	TBC	South Warwickshire Place Partnership	TBC	Not started. Due to commence scoping later in Q1	TBC	not yet started	
41		TBC Warwick District Levelling Up Plan			X				3	3	Warwick District Council	WDC	Scoping - Setting out structures for delivery, setting out engagement plan	24	not yet started	
42		Stratford-on-Avon District Growing Opportunities (Levelling Up) Plan			X				3	4	Stratford-on-Avon District Council	SDC	Action Plan live from 1 April 2024 but many green actions	24-25	On-track	
43		Strengthened social, emotional and mental health and wellbeing for Children and Young People	X	X		X			3	1 to 2	Children and Young People Partnership	ICB	Work planned to analyse the relationship between school attendance and the presence of mental health in schools teams. Peer mentoring service established to support children transitioning from children's to adults mental health services	24-25	not yet started	

	A	B	C	D	E	F	G	H	I	J	L	N	O	P	Q	R
44	**Oversight of the Children and Young People agenda via the Children and Young People Partnership**	Promotion of healthy weight in Children and Young People and reducing childhood obesity	X			X			3	1 to 3	Children and Young People Partnership	WCC	Whole-systems approach to childhood obesity being scoped, with the end product an options appraisal to inform next steps. High priority schools (based on rates of BMI and deprivation) are being targeted for whole-school healthy lifestyle interventions. Pilot of free school meals to all primary school-aged children is in progress and evaluation of initial outcomes expected for September 2024.	2024-25	On-track	
45		Targeted support at the most deprived populations, suffering the most health inequalities.	X		X	X			3	-	Children and Young People Partnership	WCC	Maternal Circles pilot launched (March 24) in Nuneaton & Bedworth. To improve access and support for new parents most at risk of health inequalities.	2024-25	On-track	
46		Closer alignment of services (joined up working) and collaborative models of support including health, education, and voluntary/third sector. With an emphasis on social support and addressing stigma.	X			X			3	3 to 4	Children and Young People Partnership	WCC	Development of the Early Years Integrated Delivery Plan (see line 52).	24-25	On-track	
47		Health promotion/very brief advice is utilised as a key tool for early intervention and prevention.	X			X			3	2 to 3	Children and Young People Partnership	WCC	Children and Young People Making Every Contact Count training programme developed and first set of training has taken place with front line staff in different settings. Timetable to roll out the training further has been developed.	2024 - 2025	On-track	

	A	B	C	D	E	F	G	H	I	J	L	N	O	P	Q	R
48	**Development of Warwickshire Special Educational Needs and Disability (SEND) and Inclusion Strategic Partnership Group**	Co-production and feedback from children, young people and parent carers is evidenced at individual and strategic levels.	X		X				4	5	Children and Young People Partnership	WCC	Warwickshire Parent Carer Voice and IMPACT (young people's group) are both part of the SEND & Inclusion Strategic Partnership Board. At project level, parents are engaged and represented on projects affecting changes to services and approach, as well as feedback from young people as appropriate. At an individual level, views are gathered through the family conversation at the point of the EHC plan being issued and each annual review.		On-track	
49		Co-ordination of the Self-Evaluation Framework	X		X				3	3	Children and Young People Partnership	WCC	The Local Area SEND Self-Evaluation has been drafted and presented to the Partnership Board. This has included feedback from parents and carers and young people. The document will continue to be reviewed and updated.		On-track	
50		Delivery of the SEND & Inclusion Local Area Strategy, building on the SEND needs assessment and self-evaluation.	X		X				3	2 to 3	Children and Young People Partnership	WCC	The Children and Young People's Strategy and Education Strategy include priorities and performance measures for children and young people with SEND. The SEND & Inclusion Strategy is in development to add further to these strategies.		On-track	
51		Develop a Local Area Inclusion Plan to deliver the vision and aims of the strategy; to strategically plan and deliver services and assess the quality and sufficiency of all elements of the SEND Local Offer.	X		X				3	2 to 3	Children and Young People Partnership	WCC	Based on the Self-Evaluation and the work from the Delivering Better Value Programme, a Local Area Inclusion Plan has been drafted.		On-track	

	A	B	C	D	E	F	G	H	I	J	L	N	O	P	Q	R
52		Provision of strategic leadership to prepare for the Ofsted/CQC Area SEND Inspection.	X		X				2	1	Children and Young People Partnership	WCC	A logistics plan has been developed as preparation for inspection.		On-track	
53	**Development and delivery of the Integrated Early Years Delivery Plan**	Establishment of the Education Services Early Years Integrated Planning Group and accompanying Early Years Integrated Delivery Plan. This is in response to the Early Years Remote Peer Challenge Review (2023) and the 0-5 JSNA (2022).	X		X	X			3	3-4	Children and Young People Partnership	WCC	The first meeting on the IPG has taken place and terms of reference has been drafted collectively. A timeline for the development of the IDP has been created, with the aim of having the IDP prepared to take to CYP Partnership at the end of August, and HWBB in September. Delivery of the IDP will commence in the second half of this financial year. Prior to this, engagement will be undertaken with a range of key stakeholder including Parent Carer Voice, Early Years hubs, maintained nurses and schools with nurseries, and childminders	24-25	On-track	
54		Concordat approved by national team		X					3	-	Mental Health Provider Collaborative	CWPT	C&W system sign up approved by national team November 2023	2024	Complete	
55		System sign up to Concordat for better mental health		X					3	-	Mental Health Provider Collaborative	CWPT	Achieved November 2023	2024	Complete	
56		Launch of Mental health inequalities fund		X					3	-	Mental Health Provider Collaborative	ICB	Expressions of Interest launched October 2023	2024	Complete	

	A	B	C	D	E	F	G	H	I	J	L	N	O	P	Q	R
57	**Deliver the mental health concordat**	Review of adult mental health and wellbeing offer in WCC		X					3	-	Mental Health Provider Collaborative	WCC	Initial review undertaken. Recommendations, report and dissemination process underway	2024	Underway / on track	
58		Launch of Mental Health and Emotional Wellbeing Board		X					3	-	Mental Health Provider Collaborative	CWPT	The MHEWB Board will be called the Coventry and Warwickshire Prevention Concordat for Better Mental Health Delivery Group. This group will be responsible for delivery of the Concordat and will report to the Mental Health Collaborative	2024	Complete	
59		Improving outcomes for people with SMI		X					3	1 to 2	Mental Health Provider Collaborative	CWPT	Annual physical health checks for people with SMI are increasing. Work underway to develop pathways to healthy lifestyle interventions and to pilot additional peer support.	2024	Underway / on track	
60		Wellbeing 4 Warwickshire service		X					3	1 to 2	Mental Health Provider Collaborative	WCC	A Health Equity Assessment is currently being undertaken for Wellbeing 4 Warwickshire, aiming to further address health inequalities.	2024	Underway / on track	
61		Launch place-based approach to suicide prevention and MH&WB		X					1	1	Mental Health Provider Collaborative	WCC	In development, with key links to Creating Opportunities work programme.	2024	Underway / on track	

	A	B	C	D	E	F	G	H	I	J	L	N	O	P	Q	R
62	**Addressing health and healthcare inequalities**	Refresh of the Integrated Care System (ICS) Health Inequalities Strategic Plan. Refreshed strategy outlines how transformation programmes will seek to reduce healthcare inequalities in line with the NHS CORE20PLUS5 framework.			X				1	1	Health Inequalities Delivery Group	WCC / ICB	All partners within the ICS have adopted a Health in All Policies approach, using key tools such as health equity assessment tool (HEAT) to understand inequalities related to key programmes of work and/or services and how to mitigate against them. The Healthcare Inequalities Strategy reports on specific NHS-led transformation programmes.	2024	Closed	
63		Delivery of the Health Inequalities Transformation Fund. The bidding prioritisation process is agreed through the Care Collaborative. Activity is funded at Place and aligned to place-based partnership priorities and the CORE20PLUS5 framework.			X				3	2 - 4	Care Collaboratives	WCC	Bids funded through Warwickshire Care Collaborative include: dedicated vaccination midwife to improve vaccination rates for pregnant women in Warwickshire North; mobile community clinic to support community access to a CVD secondary prevention heart failure service; enhanced physical health checks for UK armed forces veterans.	2024-2026	Underway / on track	
64		Embed Health in All Policies across HWBB partners this includes an evaluation of the impact to date. In 2024-25 there will be a theme-specific focus on the areas of Children and Young People, Transport, Green Spaces and Housing, to facilitate partnership work for health and health equity considerations.			X				3	1	Care Collaboratives	WCC	HWBB endorsed HiAP in March 2021, following this a number of HiAP workshops were delivered in collaboration with the LGA including to place based Health and Wellbeing Partnerships. HiAP toolkit was developed bringing together a range of resources including the Health Equity Assessment Tool and our local offer. HiAP has been embedded into the Strategic Framework, so all WCC strategies must consider HiAP.	2024	Closed	

	A	B	C	D	E	F	G	H	I	J	L	N	O	P	Q	R
65	**Deliver key prevention activity**	Through Wellbeing for Life focus on workplace wellbeing and implementation of work programme to support workplace wellbeing, including the Workplace Wellbeing event programme.			X				3	3	Workplace Wellbeing Forum Project Team	WCC	Developed the Workplace Wellbeing bid with Coventry (awaiting outcome). Developing a bid for CVD/full workplace health checks, to be delivered to businesses in Warwickshire North. Plans to develop an options appraisal on workplace wellbeing accreditation schemes.	2024/25	Underway / on track	
66		A system-wide Prevention Forum, is being established to support the delivery of the NHS Long Term Plan prevention programmes			X				2 and 3	-	Prevention Board	ICB/WCC /CCC	Development of a practical strategic framework for prevention, built on and supporting work within NHS providers, and successful delivery of the prevention elements of the NHS Long Term Plan including Tobacco Dependency services in all four NHS Trusts	2024/25	Underway / on track	
67																

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	A	B	C
1	**Delivering the statutory functions of HWBB in 2023-2025 - examples of embedding citizens voice**		
2	**Statutory function**	**Activity to meet delivery of statutory function**	**Embedding citizens voice**
3	**Development and delivery of JSNA work programme**	**Approval of Mental Health and Wellbeing of Infants, Children and Young People JSNA (May 2023)**	Engagement work done across the council with the 0-25 population was mapped, and key themes identified to ensure that the JSNA reflected the wishes of children and young people at its centre. This included engagement from: - Warwickshire Youth Council - Child Friendly Warwickshire - Compassionate Communities at UHCW - The Care Leavers Forum - The Children in Care Council - IMPACT, the Young Person's Forum for SEND - Highly Sprung Young People's group This engagement work helped to inform the scope and approach of this JSNA, as well as contributing to the following recommendations: - *"From our mapping of engagement with children and young people in Warwickshire, they said that social stigma still exists around mental health, this needs to be addressed"* . - *"This JSNA has included the views of children and young people in Warwickshire gained indirectly from a variety of sources and recommends cocreation of services and pathways. Children should be included and involved in finding the solutions to issues that impact them"* . - *"Children and young people said that activities such as art, music, and performing can help support their mental health and wellbeing. Whilst currently offered to those accessing early help services, social prescribing should be expanded to all children and young people at the earliest signs of need"* . - *"The engagement mapping found that children an young people said they want more spaces in which to talk about mental health and that these should not always be in services. A universal open access drop-in offer across the county in school and community settings should be developed"* . - *"Children and young people said that there needs to be more information about mental health support and services that is all in one place, promoted and easy to access. This should include building on existing information, utilising different social media platforms where possible, and should be co-produced with children and young people"* .
4		**Approval of Empowering Futures: Growing Up Well in Warwickshire (May 2024 HWBB)**	An Empowering Futures JSNA survey was undertaken to support both this JSNA and the development of a Children and Young People Making Every Contact Count (MECC) offer. The survey asked people who work or volunteer with children and young people how confident they were talking about physical health, barriers they face in discussing physical health, and their experiences of services supporting children's physical health. A report has been produced which will be published alongside the JSNA on the Warwickshire JSNA website, and findings from the engagement have been fed into the JSNA report. A synthesis of engagement with children and young people completed as part of the development of the Children and Young People MECC offer will also be published alongside on the Warwickshire JSNA website to help inform actions coming from this JSNA.
5		**Approval of Healthy Ageing JSNA (January 2024)**	Two engagement activities were undertaken for the Healthy Ageing JSNA, a series of Story Circles which are focus group style sessions that took place in each District and Borough and a survey which received 440 responses. Findings, themes, and quotes from the engagement were fed into and helped to shape the JSNA report, and an engagement report for each was published alongside the JSNA on the Warwickshire JSNA website. The engagement findings helped to shape the recommendations coming from the JSNA, particularly a set of cross-cutting recommendations which suggest ways to support and work with older people based on themes coming from the engagement. These included: - Making messages and services appropriate for older people. - Using age-friendly language and imagery. - Ensuring barriers to services and community life are considered and pre-empted. - Ensuring prevention at every opportunity. - Ensuring older people can volunteer and contribute. - Using intergenerational approaches.
6		**Approval of Disabilities JSNA (September 2024 HWBB)**	An exercise mapping engagement done with adults with a learning disability is currently underway which will be used to help inform and shape this JSNA.

	A	B	C
13	**We will oversee delivery of the Health and Wellbeing Strategy 2021-26 and its three priorities:** **Priority 1: Children and young people having the best start in life.** **Priority 2: Improve mental health and wellbeing with a focus on prevention and early intervention.** **Priority 3: Reduce inequalities in health and the wider determinants of health.**	**Delivery of Warwickshire North Place Plan**	March Place-wide face-to-face event asked 4 key questions to partners across all of our Place priorities, one of which was: how do we / could we embed citizen voice in the work we do? Answers will be used to strengthen our Place approach, working with Healthwatch and others. Examples of responses include: - Visible endorsement from trusted people in the community - Identify community champions - Communications and collaboration between organisations - Advocacy services - Local WhatsApp groups - Neighbourhood apps - Local magazines - Libraries - Comms for people who can't read/write.
14		**Delivery of Rugby Place Plan**	Healthwatch Warwickshire held a Rugby Health and Social Care Forum on the state of care. The forum was attended by 120 people who provided over 150 comments on access to services. Commons themes from the day included: digital access, the impact of delays to care on residents, communication preferences and access to GP services. The findings are being used to inform future discussions on Rugby's Place Plan.
15		**Delivery of South Warwickshire Place Plan**	In 2023/24 South Warwickshire reviewed its Vision and Priorites. This was informed by resident feedback via WDCs engagment work within Lillington, patient feedback through Warwickshire Healthwatch and VCSE feedback from networking events. Community engagement will be a key focus for South Warwickshire Place in 24/25 and this will be supported by a new VCSE Coordinator role funded by Place and hosted by WCAVA.
16		**Children and Young People Partnership's key deliverables are developed and agreed, based on recommendations from:** **- Warwickshire Children and Young Peoples Strategy 2021-2030** **- Children's 0-5 JSNA** **- Children and Young People's Mental Health and Wellbeing JSNA** **- Physical Health of Children and Young Peoples JSNA**	**<u>Children and Young People MECC (Making Every Contact Count)</u>** Prior to the development of the CYP MECC engagement took place at with young people at Warwickshire's Annual Youth Conference in November 2023. this is a conference organised by young people for young people. WCC public Health were invited to attend and host a stall. Young people were asked four questions and 67 responses were collected. Questions included: 1) If someone was struggling (a friend) is struggling with their health, what would you say to them? 2) Can you tell us some of the things you do to stay healthy? 3) Can you tell us what being unhealthy looks or feels like? 4) Can you tell us what being healthy looks or feels like? These responses were used to inform and develop the language and content of the CYP MECC. Responses also helped understand from young people what social media channels they use to help support their own health and wellbeing. **<u>Engagement with families and staff for Health Visiting</u>** In preparing for the re-commissioning of the health visiting service and entering a possible partnership arrangement with the current provider (SWFT), WCC alongside SWFT undertook a 7 week consultation to actively hear the voices and views of service users, the public, healthcare professionals and others interested in supporting children have the best start in life. The consultation took place primarily on the Ask Warwickshire platform inviting responses and asking for opinions and comments on the proposed arrangement in addition to asking questions related to future service design. Alongside this, three focus groups were designed, developed and undertaken with seldom heard parents including young mothers under 19, care leaver parents and parents/carers of children with special educational needs and disabilities. Creative tools and methods were used to engage these parents and gather their feedback and views for both the proposal and to influence the future design of the service. In person drop-in sessions were also held at two children and family centres during baby clinics to engage with parents. In total the survey and focus groups heard from more than 160 people. The results have been analysed and key themes drawn out and strongly influenced the future service specification, priorities and outcomes the service will seek to achieve.
17		**Development of Warwickshire Special Educational Needs and Disability (SEND) and Inclusion Strategic Partnership Group**	The SEND Strategic Partnership Board is in place from September 2023 including officers of the County Council, colleagues from the NHS, Warwickshire Parent Carer Voice, IMPACT (young people's group) and the Department for Education. The Board is responsible for the local area' self-evaluation, preparation for local area inspection, strategic plan and monitoring of performance.

	A	B	C
20		**Development of the Mental Health Concordat and delivery through the Coventry and Warwickshire Prevention Concordat for Better Mental Health Delivery Group**	**Assess mental health and wellbeing needs including risk and protective factors for prevention/promotion.** The development of the ICS Mental Health strategy has been led by Coventry and Warwickshire Mental Health Collaborative with system wide partners. The Collaborative has taken into consideration current information that is available via Experts by Experience and JSNAs and have agreed to core principles of the strategy including to always seek co-production with people with lived experience. **Engaging with local communities to map assets** • Plans for system wide mapping of the protective factors for mental health assets to be undertaken with support by Experts by Experience. • Plans to work with Coventry and Warwickshire VCSE Mental Health Alliance who support all VCSE mental health alliance members to develop actions and ensure collaboration with VCSE as well as embedding prevention into VCSE work. We are planning to develop closer links with VCSE on co-production and involvement of people with lived experience and with VCSE organisations. • Plans to work with local authority Communities and Partnerships Teams to support engagement with local communities and mapping of assets to support MHWB. For example Community Powered Warwickshire takes an asset based approach to community development and supports Levelling Up. The importance of community-based approaches and working with communities to build resilience and focus on prevention for future generations is also reflected in our emerging Mental Health Strategy being developed by the MHC.
21			**Involve and co-produce with diverse communities** We will work with Coventry and Warwickshire ICB to support development of an Involvement Co-ordination Network, which aims to develop our mechanisms to co-ordinate involvement across the system, improving our engagement with people communities and stakeholders, many of whom work with diverse communities. We will also: • Continue to work closely with the VCSE Mental Health Alliance who work in partnership with a wide range of VCSE organisations. Many of these organisations work with diverse communities. • Work with a range of organisations, services, networks and teams to involve and co-produce with diverse communities, such as the Involvement Co-ordination Network and the Cultural Inclusion Network across Coventry and Warwickshire. This will include commissioned services such as EQuiP (Equality and Inclusion Partnership, who are commissioned to reach and support diverse communities across Warwickshire). • Continue to work with the Cultural Inclusion Network across Coventry and Warwickshire, who work to enhance access to services by those who may find it difficult to access services such as LGBTQ+ and those from the Global Ethnic Majority (GEM). • Continue to involve and co-produce with diverse communities such as Veterans, LGBTQ+ groups, faith groups, people experiencing homelessness, gypsies, travellers and boaters, newly arrived communities including refugees and asylum seekers. • Look to develop greater peer support for those with severe mental illness to access healthy lifestyle interventions and build on models such as Realising Everyone's Access to Community Help (REACH) - an extensive and collaborative effort involving a total of 11 services has been crafted and co produced to provide essential support to individuals in need. REACH is dedicated to offering peer support to those who have been referred to Coventry and Warwickshire Partnership NHS Trust (CWPT) but do not meet the initial eligibility criteria. These individuals are carefully guided through the intricacies of the Locality Pathway Allocation Multi-Disciplinary Teams (MDTs) to ensure they receive the support they require from the VCFSE via the REACH Peer Workers. • We will continue to work with commissioned MHWB services to ensure continued engagement and co-production with experts by experience to support continuous quality improvement. • We will support the development and delivery of Carers Delivery Plans, which have a strong focus on co-production. • We will identify opportunities to combine our Public Involvement strategies across the system to reduce duplication and prevent community fatigue and disengagement.
22			**Target interventions (to those at greater risk including those with existing mental health problems)** A fundamental part of the framework is co-production, to ensure all aspects of the framework and work we do is child-led. This funding has enabled the ICB and partners to pilot work with our young people to lead on designing the framework and offers a unique opportunity to respond to assess the impact of this new way of working to achieve cultural and organisational change.

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Agenda Item 4

Health and Wellbeing Board

15 May 2024

Delivering the Warwickshire Public Health Offer

Recommendations

That the Health and Wellbeing Board

1) Notes and comments on the new structure of the Public Health service within Warwickshire County Council, and

2) Notes and comments on the range of activity Public Health is undertaking in 2024/25 and the commitments made to deliver duties and responsibilities.

1. Executive summary

1.1 Purpose of Report

1.1.1 This report sets out for Warwickshire Health and Wellbeing Board (HWBB):

a) The new structure of the Public Health service and its host directorate within Warwckshire County Council, the Social Care and Health Directorate;

b) The business of the Public Health service, with a clear description of its prescribed and non-prescribed functions;

c) Public Health spend in Warwickshire; and,

d) Key priorities, opportunities and challenges facing Public Health activities in 2024/25

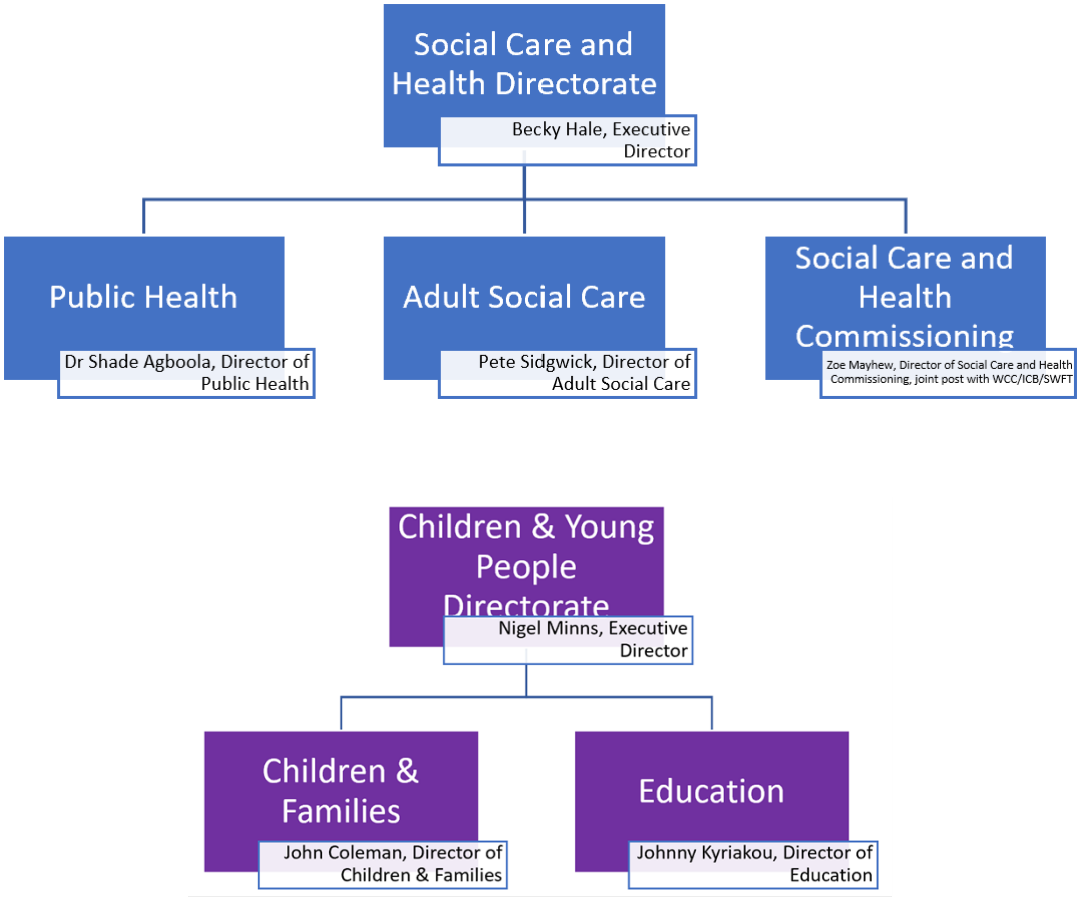
1.1.2 By providing this information, the report aims to illuminate the opportunities and challenges noted by Public Health within the Coventry and Warwickshire Integrated Care System (ICS) and generate a debate about how the profile and impact of prevention activity can be raised across system partners as a long-term strategy to improve population health, wellbeing, and outcomes.

1.2 Background

1.2.1 2024 marks the eleventh year since Public Health transferred into local government from the NHS (Primary Care Trusts). This was a significant transfer of powers which enabled greater opportunities for influencing prevention within the 'wider determinants of health' (the estimated 80% of health outcomes which are determined by non-health inputs such as education, housing, and built environment). Public Health is predominantly funded by the Department of Health and Social Care through an annual grant arrangement, using a formula and set of conditions set in 2013/14.

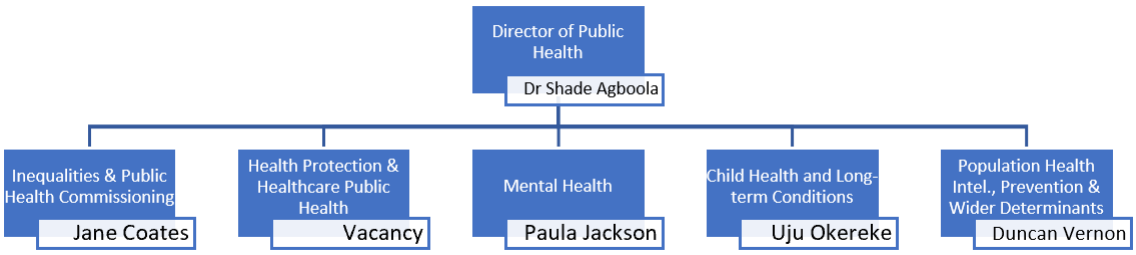
1.3 New Directorates

1.3.1 In January 2024 the People Directorate in Warwickshire County Council (the Council) was split into two for a trial period of two years. The two new Directorates are Social Care and Health and Children and Young People. Public Health is part of the Social Care and Health Directorate as shown below.



1.4 Public Health Service Portfolio Areas

1.4.1 A restructure of some Directorate functions took place simultaneously, which placed the Public Health budget and commissioning function back into the Public Health service. The high-level structure is below:



1.4.2 The portfolio areas have evolved over time so that the service is able to plan for, and respond to, areas of priority for Warwickshire's population. The 'business as usual' activity encompasses the following range of themes.

Economic & social inequality	Workplace wellbeing and employment	Strategic partnerships and place-based work
Commissioning	Migrant health	Health protection
Individual Funding Requests and advice to NHS commissioners	Healthcare public health	Mental health
Suicide prevention, surveillance and self-harm	Drug and alcohol	Child Death Overview Panel
Child physical and mental health	Maternity and neonatal	Long-term conditions
Healthy lifestyles, smoking cessation, weight management	Prevention	Joint Strategic Needs Assessments
Population Health Management	Wider Determinants of Health	Domestic abuse & violence against women and girls
Sexual health	Oral health	Safe accommodation

1.5 Public Health Spending

1.5.1 Public Health is funded by the Department of Health and Social Care through an annual grant arrangement, using a formula and set of conditions established in 2013/14. In 2024/25 the Warwickshire Public Heath grant allocation is £25.6m. Over recent years around £2m per year is being spent on the directly-employed Public Health workforce in Warwickshire, encompassing consultants, technical specialists, commissioners, and running costs. The remainder of the budget is spent on services.

1.5.2 The grant is ring-fenced and must be spent on a core set of 'prescribed' activities, although the apportionment of budget to services is locally determined. (The spend is benchmarked nationally to enable the Office for Health Improvement and Disparities – OHID - to identify notable variations, which must be explained).

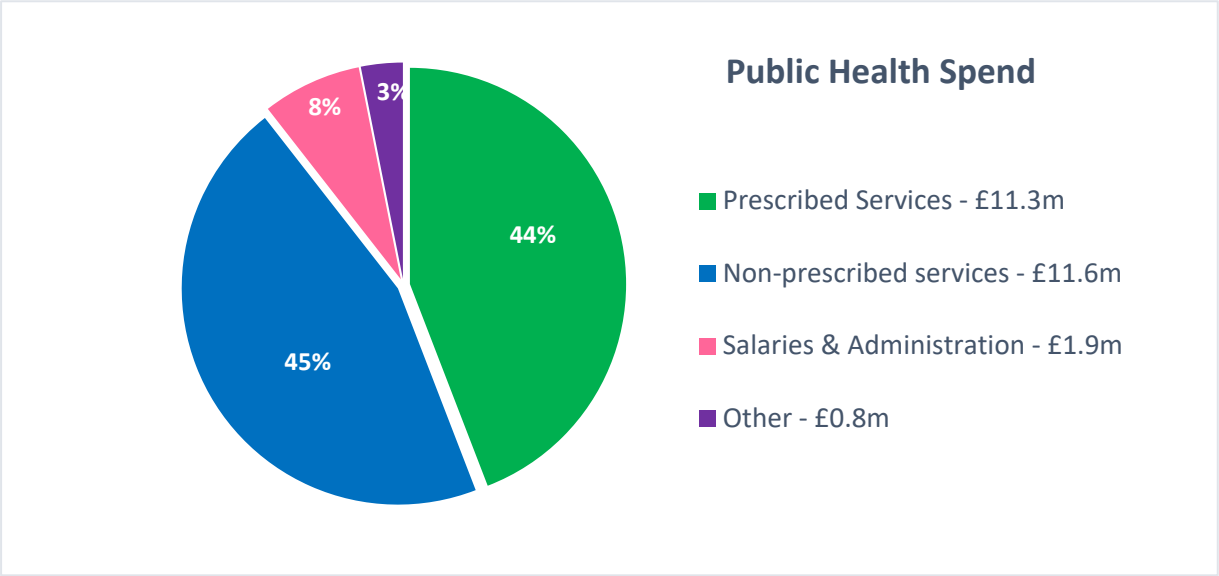
Prescribed functions of the Public Health Grant	
Sexual health services - sexually transmitted infections testing and treatment	Public health advice to NHS commissioners
Sexual health services - contraception	National child measurement programme
NHS Health Check programme	Prescribed children's 0 to 5 services
Local authority role in health protection	

1.5.3 There is a further range of 'non-prescribed' functions of the Public Health Grant, covering areas where Public Health might reasonably fund activity. These functions are summarised below.

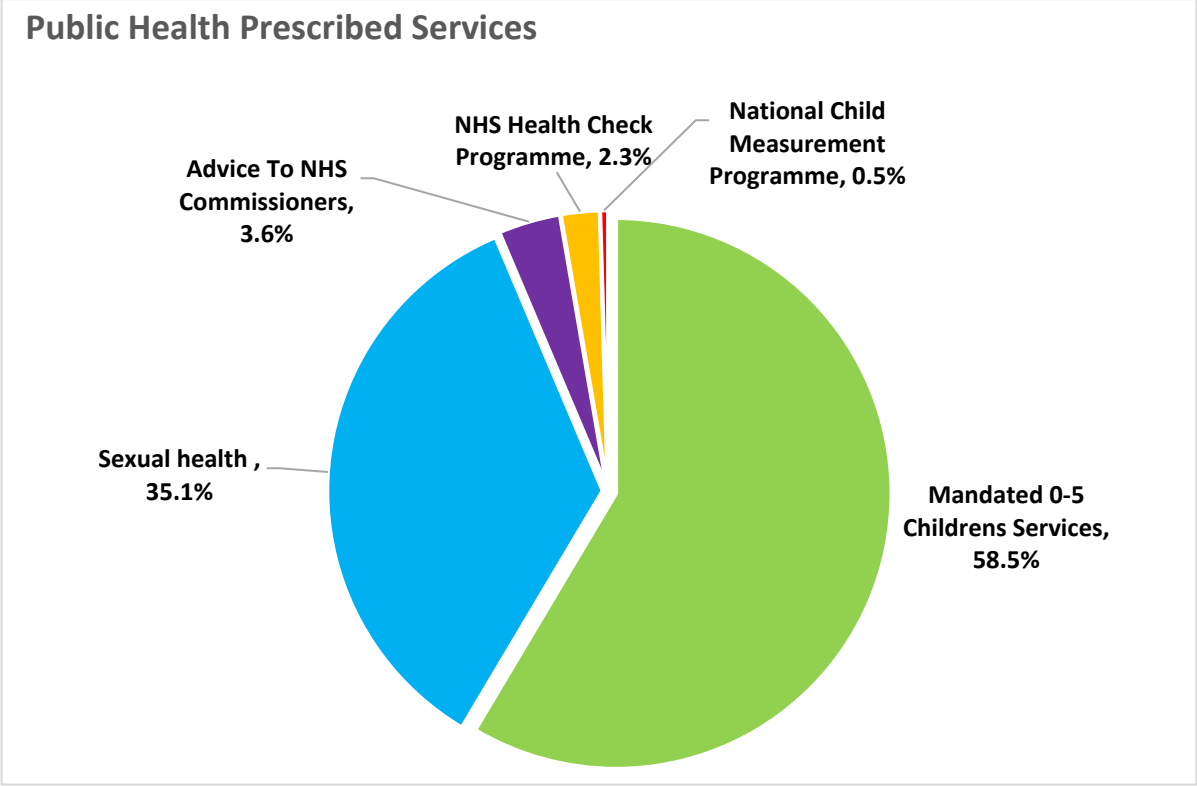
Non-prescribed functions	
Sexual health services – advice, prevention, promotion	Drug and alcohol treatment, prevention, harm reduction
Physical activity	Child drug and alcohol misuse
Obesity	Stop smoking
5-19 public health	Wider tobacco control
Mental health	Test, track, trace, outbreak management
Covid-19	Miscellaneous

1.5.4 Public Health funds or contributes to all the prescribed functions in 1.5.1. In terms of non-prescribed functions, the Public Health budget funds or contributes to: drug and alcohol; mental health and wellbeing; physical health; adult weight management; smoking cessation; dietetics; HIV online testing; Warm & Well; domestic/sexual abuse counselling and support, safe accommodation, Multi-agency Risk Assessment Coordination (MARAC), and Independent Sexual Violence Advisers (ISVA); real-time suicide surveillance; homelessness nursing; Home Environment Assessment and Response (HEART).

1.5.5 The pie chart below shows a high-level distribution of Public Health Grant spend in 2024/25 (excluding overheads).

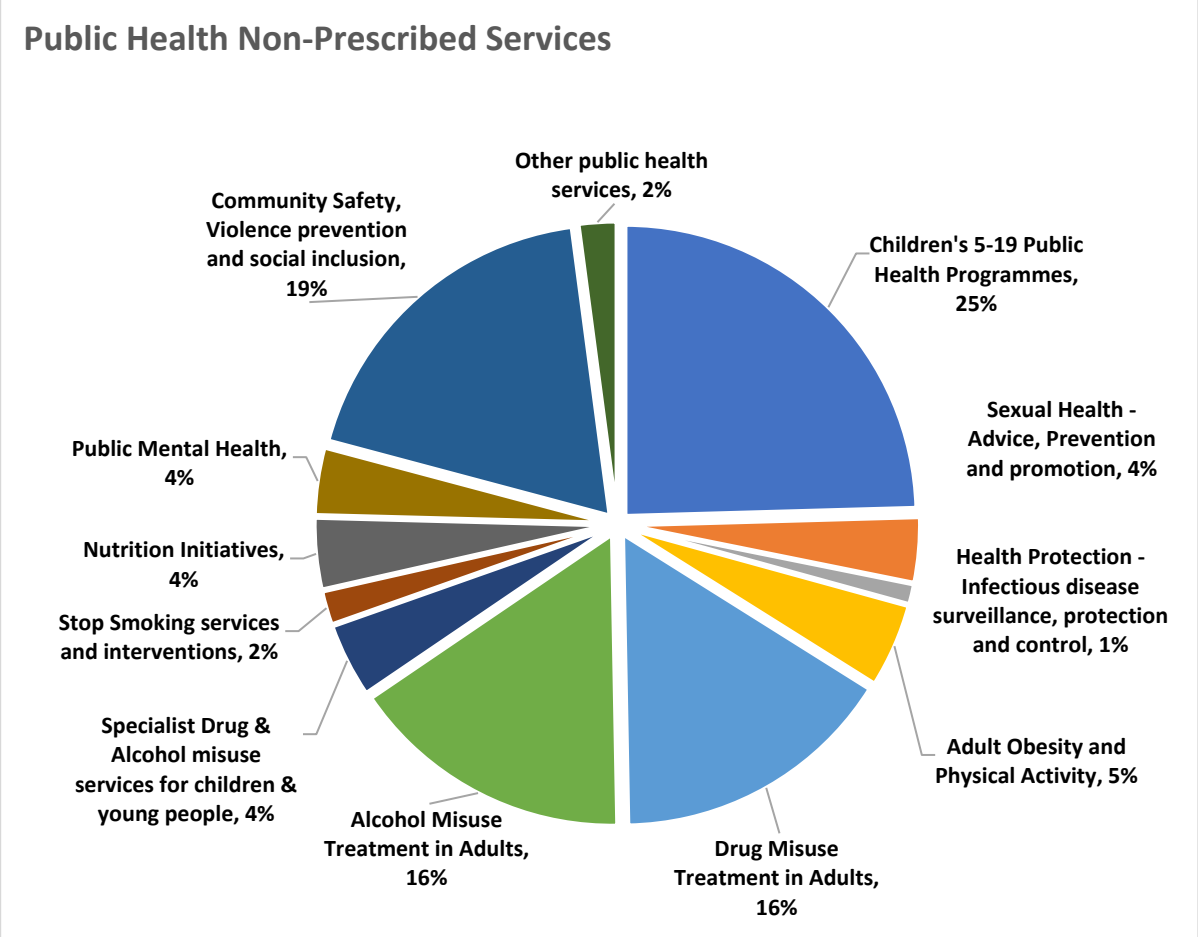


1.5.5 The pie chart below shows the distribution of the Public Health Grant money spent on prescribed and non-prescribed services:



1.5.6 Public Health is not always the sole funder of these prescribed and non-prescribed activities, with contributions coming from sources such as other grants under section 31 (see 1.5.7), the Integrated Care Board (ICB), the Office of the Police and Crime Commissioner, District & Borough Councils, and the Office for Health Improvement and Disparities (OHID).

1.5.7 The table below sets out time-limited section 31 grants and areas of work that have been aligned to Warwickshire Public Health, and are being delivered by Public Health staff, but are not prescribed functions of Public Health. They are time-limited duties of the local authority.



Period of budget allocation	Purpose	Approx. annual £
2021 to 2025	Local Authority Domestic Abuse Safe Accommodation Duty	£1.05m
2022 to 2025	Supplementary Substance Misuse Treatment & Recovery	£0.5m to £0.9m
2024 to 2029	Smokefree Generation 5-year programme	£0.8m

1.5.8 While the formula for calculating the Public Health Grant has stayed the same, the conditions of the grant have changed over time.

Year of change	Theme	Comment
2015/16	Transfer in of 0-5 health visiting	Now included in the PH grant as a permanent duty
2023/24	Fluoridation payments to water companies	Duty taken away from local authorities and centralised
2024/25	Agenda for Change – NHS pay award for contracted services	Updated 2024/25 Public Health Grant allocations now include funding for additional recurrent impact of the 2023/24 consolidated NHS Agenda for Change pay award, this was previously settled from Integrated Care Board funding allocations

1.6 Service Priorities For 2024/25.

1.6.1 Public Health sets priorities each year in the context not only of its role within the Council, but also the Coventry & Warwickshire Integrated Care System (ICS). The Public Health service's priorities for 2024/25 are:

1.6.2 Warwickshire Health & Wellbeing Board
Supporting the delivery of the Health and Wellbeing Board (HWBB) and the HWBB Strategy Delivery Plan 2024-25 by:

- Playing an active role within the HWBB Place Partnerships, to promote the delivery of the Strategy at Place
- Supporting the Children and Young People Partnership to deliver on the JSNA recommendations
- Delivering the JSNA programme to inform decision making and commissioning intentions at County and Place

1.6.3 Warwickshire County Council

- Deliver targeted and place-based public health activity to support a reduction in health inequalities, with a focus on:
    - delivering on the Smokefree Generation ambitions locally to reduce smoking prevalence;
    - supporting the tackling of childhood obesity through the National Child Measurement programme; and
    - delivering improvements in drug and alcohol support services.

- Deliver agreed additional safe accommodation for victim survivors of domestic abuse

- Continue to be an active partner in the Coventry and Warwickshire's Integrated Care System particularly:

- deliver those agreed and funded actions in the Coventry and Warwickshire Integrated Health and Care Plan for which the Council is responsible or contributes to;
- develop and implement the Warwickshire Care Collaborative in collaboration with partners; and
- deliver those agreed and funded actions in the three Health Place Partnerships plans for which the Council is responsible or contributes to.

1.6.4 Public Health Commissioning

- Progressing and confirming a sustainable future position for health visiting services
- Reviewing activity and performance against all demand-led budget lines, such as NHS health checks, drug and alcohol treatment, and sexual health
- Drug and alcohol recommissioning, for 2025
- Refreshing the Safe Accommodation Strategy, to 2027

1.6.5 Integrated Care System

- Delivering on the *prioritising prevention and wider determinants of health* Integrated Care Strategy priority for 204/25 includes:
  - Publication of the revised C&W Health Protection Strategy
  - Supporting delivery of the NHS Long Term Plan Prevention programme
  - Implementing the Homelessness Strategy
  - Maintaining effective coordination across relevant health and care partners through the Newly Arrived Communities Strategic Health Group
- Working collaboratively to maximise vaccination uptake
- Active contribution and shaping of the future model of Care collaborative. Role in both Strategic and Tactical Commissioning at ICB/Care collaborative levels

1.7 Opportunities And Challenges

1.7.1 Work was undertaken in 2022 to review how the Public Health budget was being spent in Warwickshire, to establish a post-pandemic baseline, and seek to identify opportunities to do things differently based on changing population needs, provider market pressures, and the implications of cost of living pressures. This exercise enabled Public Health to understand in detail the contract commitments it had made during the pandemic period, how services and customer usage had evolved during that time, and how – and when – the service might plan to use the budget differently to improve outcomes. Public Health is phasing its thinking to align to the schedule for commissioning new services, and also to identify ways to support the Creating Opportunities

(nationally, Levelling Up) agenda and increase collaboration with system partners.

1.7.2 Funding for public sector services across the board is strained, and the service notes the challenges that other integrated care system partners are having, alongside its own. The annual Public Health Grant award is subject to change, with increases in recent years not matching rising costs. It is expected that this will be a continuing pattern, and thus the overall implication for Warwickshire is that the public health budget will offer annually decreasing levels of resourcing for work covered by this portfolio. It is recognised that there are difficult decisions to be made, some with immediate effect, and that these will contribute to system-wide resourcing challenges.

1.8 The Public Health service is experiencing tougher commissioning cycles, often linked to a reducing number of providers (sometimes only one) submitting tenders due to decreasing contract envelopes. It is also noted that commissioned providers are seeking sizable budget increases mid-contract or at extension points, to cover escalating costs, and meeting these creates significant challenges and knock-on impacts for the other Public Health services and priority population groups, and wider legal and procurement challenges.

1.9 Public Health will take the opportunity to look at its commissioned service contracts at the appropriate break points to review prioritisation of activity, although the limited opportunities for movement are noted due to existing and anticipated pressures across all areas of activity.

1.10 Public Health is conscious of the risks associated with any changes to funding arrangements that it might wish to make, and the unintended consequences for other funding partners of these decisions. The service is, however, at risk of becoming stuck in a holding pattern, and thus is working to link system finance leads together to look for collaborative ways forward. It is critical that services work together for the overall benefit of Warwickshire people.

1.11 In its February 2024 report *Investing in the public health grant*, the Health Foundation noted that the Public Health Grant has been reduced on a real-terms per person basis by 27% since 2015/16. It is likely that within the next 3-5 years, it will be necessary to decrease the resourcing to non-prescribed parts of the public health portfolio to secure the continuity of prescribed parts. It is likely that any such changes will have an unavoidable impact on other ICS partners, but of greater concern, a reduction in services for people in thematic areas that we would not wish to reduce.

1.11.1 Across the range of its activity, Public Health has some challenges which require detailed work to resolve. These include:

- Reviewing the funding and delivery arrangements for the health visiting service, to close the gap to the national benchmark for statutory visits
- Reviewing its performance against the NHS health check targets, to close the gap to the national benchmark

- Reviewing non-opiate drug and alcohol treatment services to improve completion rates
- Reviewing the evidence base linking to healthy lifestyle offers for both children and adults, with a particular focus on healthy weight
- Understanding the implications of emerging legislation such as the Victims and Prisoners Bill, which will create a duty on the Council to work together with the Police and Crime Commissioner and the ICB when commissioning support services for victims of sexual abuse and domestic violence and other serious violence.

2. Financial Implications

2.1 None in addition to the context outlined in the report.

3. Environmental Implications

3.1 None.

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

Local Member(s): None – this is a County wide report.

Other members: Councillor Margaret Bell and Councillors Barker, Drew, Holland and Rolfe.

Agenda Item 5

Health and Wellbeing Board

15 May 2024

Better Care Fund 2023/25 overview and progress update

Recommendations

That the Health and Wellbeing Board:

1. Note the update on the overview and impact of the Better Care Fund outlined in the presentation, Appendix A;

2. Note performance against the national Better Care Fund metrics;

3. Note the requirements and changes outlined in the Addendum to the Better Care Fund for 2024/25 published on 28 March 2024, submission deadline and assurance process; and

4. Agree to arrange a Sub-Committee of the Health and Wellbeing Board to approve the final version of the Better Care Fund Plan for 2024/25, in line with the recommendation and delegation of the Health and Wellbeing Board on 23 September 2015.

1. Executive Summary

1.1 In addition to the standard quarterly update on the progress of the Better Care Fund (BCF) and performance against the BCF metrics, this report and supporting presentation also provides an overview of how the BCF is funded and delivered locally.

Overview of the Better Care Fund

1.2 Established in 2015, the BCF is the flagship health and social care integration fund, delivered through partnership working and agreement at system and place level. Local authorities and Integrated Care Boards (ICBs) are required to work together to develop and implement BCF plans with local partners.

1.3 The Board will be aware that each year the BCF Policy Framework is published or updated, which sets out the national conditions each Health and Wellbeing Board area must meet and evidence to NHS England and the Department of Levelling Up Housing and Communities (DLUHC) through submission of a BCF planning template and a narrative plan.

1.4 The presentation in Appendix A provides an overview of the BCF, the funding contributions and summarises how the funds are spent locally to meet the national conditions.

Performance Update

1.5 Locally our BCF plan for 2023/25 focusses our activities to improve our performance in the five key areas which are measured against the National Performance Metrics. These being:

a. Reducing Avoidable 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;
d. Increasing effectiveness of reablement; and
e. Reducing emergency admissions due to falls.

Performance in 2023/24 against these is detailed in section 4 of this report.

Requirements for 2024/25

1.6 An Addendum to the BCF Policy Framework was published on the 28 March 2024 and detailed the requirements and changes for 2024-25, which include submitting an updated Planning Template detailing:

- ambitions against the existing metrics, except for the reablement target (detailed in 1.5 d above) which has now been dropped;
- updated demand and capacity plans in line with Market Sustainability and Improvement; and Urgent and Emergency Care Plans; and
- plans for use of the Improved BCF (iBCF).

1.7 At the point of writing this report, the allocation for the Disabled Facilities Grant and conditions relating to the Discharge Fund are still to be confirmed.

2. Financial Implications

2.1 Funding contributions for 2024/25 are detailed in the table below.

2.2 The Board is asked to note that a total budget of £374.313m is included in our current two-year BCF section 75 agreement. This is £0.467m less than the total in the table below, which reflects the updated 2024/25 budget for the Disabled Facilities Grant which has only just been confirmed.

	2024/25			Notes or changes to 2023/24
	Pooled Contribution	**Aligned Allocation**	**Total Budget**	
	£'000	**£'000**	**£'000**	
Minimum NHS ring-fenced from ICB allocation	47,762	**116,799**	**164,562**	Nationally set allocation increased by 5.66%
Disabled Facilities Grant (DFG)	5,589	**-**	**5,589**	Allocation increased from £5.124m
Warwickshire County Council Improved Better Care Fund (iBCF)	15,133	**-**	**15,133**	Allocation has remained the same for the last 3 years, creating a cost pressure
ICB Discharge Fund	4,970	**-**	**4,970**	Allocation has increased by £1.45m
WCC Discharge Fund	3,536	**-**	**3,536**	Allocation has increased by £1.41m
Warwickshire County Council	**-**	**180,988**	**180,988**	Aligned base social care budgets increased by £5.05m or 2.8%
Total Pooled Contribution	**76,990**			
Total Additional Aligned Allocation		**297,788**		
Total Budget			**374,780**	

2.3 As the Board is aware, the iBCF allocation is temporary and must be confirmed on an annual basis. In order to counter the risk inherent in temporary funding, all new initiatives are either temporary or commissioned with exit clauses. There are, however, a number of areas where the funding is being used to maintain statutory social care spending and this would require replacement funding if the BCF 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

4.1 Summary of performance against the national areas of focus using the most recent data available:

Metric	23/24 performance where available	Target	Status
Reducing Avoidable Admissions (General and Acute)	Quarter 1 Actual: 1,383 Quarter 2 Actual: 1,323 Quarter 3 Actual: 1,493 Quarter 4 Actual: 839 (Jan and Feb only)	1,213	Over (worse than) target
Improving the proportion of people discharged home to their usual place of residence	Quarter 1 Actual: 95.0% Quarter 2 Actual: 95.0% Quarter 3 Actual: 95.0% Quarter 4 Actual: 95.0%	95.8%	On target
Reducing permanent admissions to residential and care homes; and	Quarter 1 Actual: 253 Quarter 2 Actual: 250 Quarter 3 Actual: 222 Quarter 4 Actual: 198	176.5	Over (worse than) target
Increasing effectiveness of reablement	2022/23 Actual: 94.4% 23/24: Data for 23/24 not available until May 24	94.2%	Target achieved
Reducing emergency admissions due to a fall	Quarter 1 Actual: 681 Quarter 2 Actual: 620 Quarter 3 Actual: 659 Quarter 4 Actual: 627	466.25	Over (worse than) target

5. Timescales associated with the decision and next steps

Better Care Fund Plan 2024/25 Assurance Process

5.1 Similar to previous years, NHS England will approve updated BCF plans submitted in the form of the BCF Planning Template in consultation with the Department for Health and Social Care and the Department for Levelling Up, Housing and Communities. BCF Narrative Plans are not required to be updated.

5.2 Assurance processes will confirm that national conditions are met, ambitions are agreed for all national metrics, demand and capacity plans are robust and that all funding is pooled, with relevant spend agreed. Assurance of plans will be led by Better Care Managers (BCMs) with input from NHS England and local government representatives and will be a single stage exercise. A cross-regional calibration meeting will be held after regions have submitted their recommendations, bringing together representatives from each region. Once approved - NHS England, as the accountable body for the NHS minimum contribution to the fund, will write to areas to confirm that the NHS minimum funding can be released.

Assurance activity	Date
BCF planning requirements received	28 March 2024
Optional draft BCF planning submission submitted to BCM	During May
BCF planning submission from local HWB areas (agreed by ICB and WCC) sent to national BCF Team at NHS England	10 June 2024
Scrutiny of BCF plans by regional assurers and regional moderation	15 July 2024
Cross regional calibration	Mid July 2024
Approval letters issued giving formal permission to spend (NHS minimum)	31 July 2024
All section 75 agreements to be signed and in place	30 Sept 2024

5.3 To meet these timescales, it is proposed that a Sub-Committee of the HWBB is held on 13th June 2024 to approve the final version of the BCF Plan for 2024/25 prior to submission.

Appendices

Appendix A – Overview of the Better Care Fund.

Background Papers

None.

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

Local Member(s): County wide report
Other members: Councillors Barker, Drew, Holland and Rolfe

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Overview of the Better Care Fund (BCF) in Warwickshire

2 May 2024

Rachel Briden, Integrated Partnership Manager, WCC

Aims

To provide for Health and Wellbeing Board members:

- an overview of the main purpose and principles of the Better Care Fund,
- a reminder of the national BCF Policy Framework and requirements,
- an update on how the funding works,
- a reminder of the core services funded,
- the impact and benefits to patients, the NHS and social care
- 2-year delivery plan, and
- proposed changes to governance arrangements

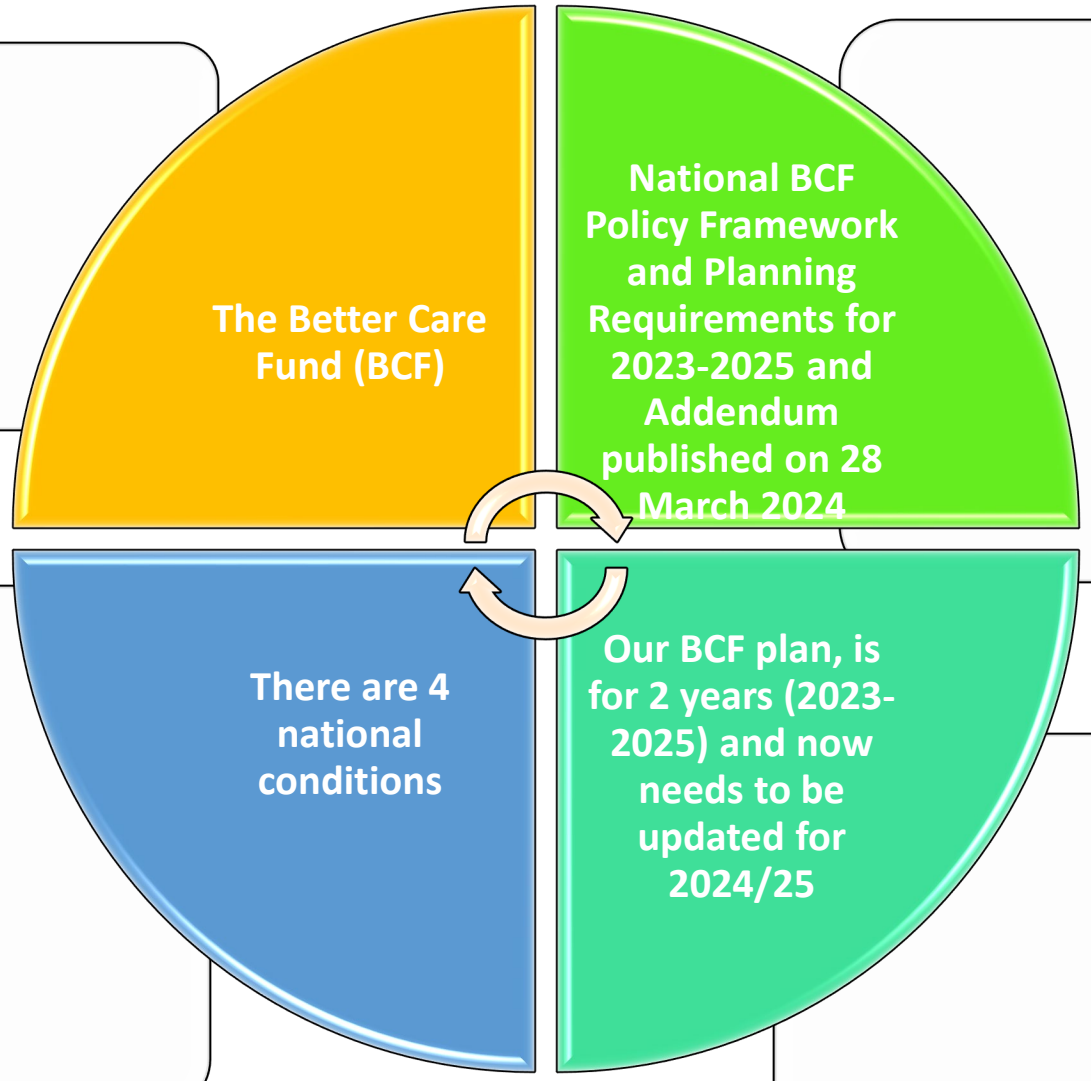
Warwickshire Health and Wellbeing

Main Purpose and Core Principles of the BCF

- The Better Care Fund is a partnership programme between Department for Levelling Up, Housing and Communities, NHS England, the LGA and Department of Health and Social Care.
- The programme has established pooled budgets between ICBs and Local Authorities at place level to drive integration.
- Every Health and Wellbeing Board is required to submit a BCF plan with the aim of working towards improved performance against the two programme objectives.
- BCF pooled funds must be placed into a section 75 agreement(s) in each HWB area

National Policy Framework – Better Care Fund

National programme which seeks to join-up health and care services, so that people can manage their own health and wellbeing and live independently in their communities for as long as possible.



Sets out the **national conditions** each Health and Wellbeing Board area must meet and evidence to NHSE and the DLUHC through submission of a Better Care Fund narrative plan and completed planning template for 2 years (2023-2025) and to be updated for 2024/25.

1. A jointly agreed BCF Plan which covers all mandatory funding
2. Implementing Policy Objective 1 – enabling people to stay well, safe and independent for longer
3. Implementing Policy Objective 2 – providing the right care in the right place at the right time
4. Maintaining NHS Contributions (from the ICB) to adult social care (WCC) and out of hospital services

Subject to a regional and national BCF assurance and calibration process.

Once approved, section 75 agreements must be entered into (between WCC and the ICB as funding partners).

How the funding works

The National Policy Framework and Planning Requirements apply to the 'pooled budget' (the minimum budget each area must jointly agree) - £76.5m. Additional conditions also apply, specific to each grant/fund.

NHS budget which funds core NHS and local authority services

Funds received directly by the local authority

	2024/25		
	Pooled Contribution	Aligned Allocation	Total Budget
	£'000	£'000	£'000
Minimum NHS ring-fenced from ICB allocation	47,762	**116,799**	**164,562**
Disabled Facilities Grant (DFG)	5,589	-	**5,589**
Warwickshire County Council Improved Better Care Fund (iBCF)	15,133	-	**15,133**
ICB Discharge Fund	4,970	-	**4,970**
WCC Discharge Fund	3,536	-	**3,536**
Warwickshire County Council	-	**180,988**	**180,988**
Total Pooled Contribution	**76,990**		
Total Additional Aligned Allocation		**297,788**	
Total Budget			**374,780**

National funding allocated for the District & Borough Councils delivered via HEART - The Home Environment Assessment & Response Team, a partnership venture of all 6 Councils in Warwickshire which provides tailored advice and support on a range of issues including:

- Home aids and adaptations
- Housing conditions, repairs and safety matters
- Benefits, grants or loans for essential building works

The majority of the budget is either WCC's or the ICB's base budgets covering Adult Social Care or Community Health.

Warwickshire Health and Wellbeing

Services delivered

- The majority of the NHS contribution in the pooled budget funds core local authority and NHS services, in place since 2016 e.g.

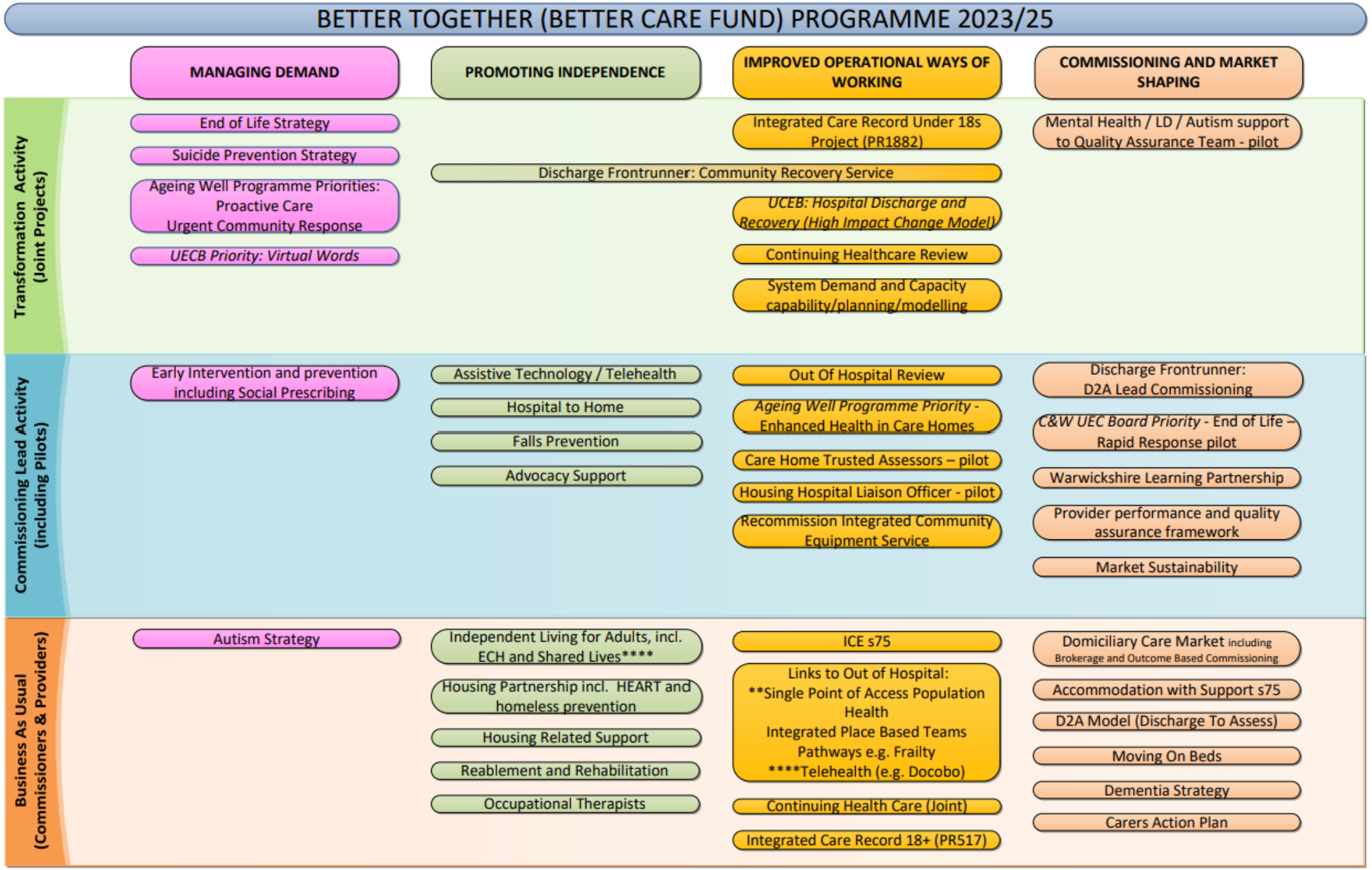
Service	Budget	Delivered by NHS or LA
Out of hospital collaborative	£17.2m	NHS service delivered by SWFT
Contribution to Domiciliary Care costs	£9.2m	Delivered by the local authority
Integrated Community Equipment Service	£6.5m	Service commissioned by the local authority for health and social care
Joint Funded Continuing Health Care	£6.2m	Service delivered by the ICB supporting social care and health
Reablement	£5.5m	Service delivered by the local authority

- In addition, almost 68% of the Improved Better Care Fund (fund received directly into the local authority since 2017) contributes to social care base budget pressures due to increases in fee rates, demand and population
- New initiatives such as the Community Recovery Service and the consolidation of Pathway 2 Discharge to Assess short term beds are being funded by the Discharge Fund

Impact

- Schemes and services funded by the Better Care Fund contribute, along with many other initiatives, to improving or maintaining people's independence, reducing demand on the NHS and on long-term social care.
- If these schemes were not in place or reduced, there would be a significant impact on achieving these already challenging ambitions.
- The impact is currently measured by the following national indicators:
- In 2023/24:
  - (to end of Feb 24 only), 5,038 admissions were identified as avoidable. This equates to c15 per day across the 3 acute hospitals (in Coventry and Warwickshire) and is a 4.6% increase compared to the previous year,
  - 95% of patients were discharged to their usual place of residence, which continues the good performance from previous years and meets the national ambition,
  - permanent admissions to residential care at 923 remained similar to 901 in the previous year, and
  - (to end of Feb 24 only), there were 2,587 emergency admissions due to a fall, which equates to c8 per day across the 3 acute hospitals and is 8.5% higher than the same period the previous year.

Delivery Plan

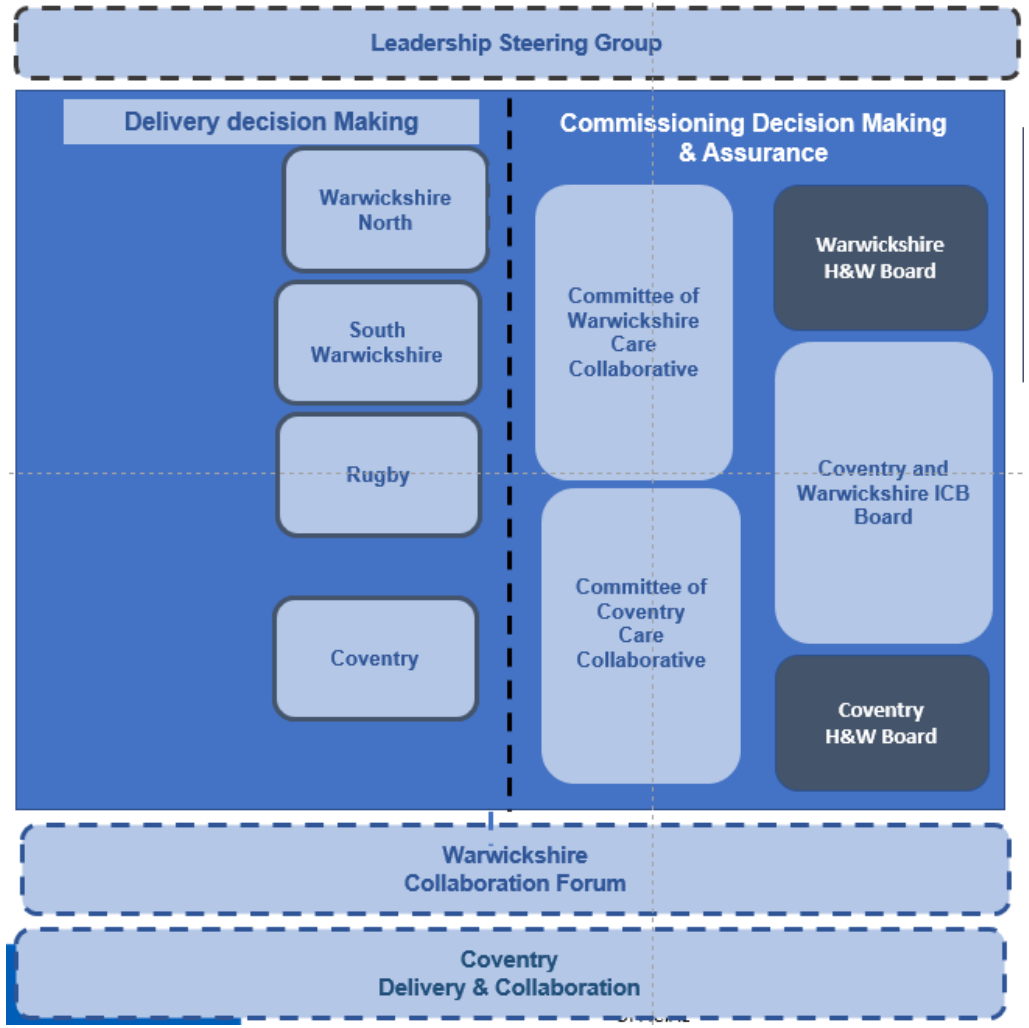


Changes to BCF governance arrangements

During 2024-26 the new Integrated Care System arrangements will come into effect.

As part of this, development and oversight of the NHS and ICB elements of the BCF will move from the Joint Commissioning Board to the Committee of the Warwickshire Care Collaborative.

Final approval of BCF Plans will remain with the Warwickshire Health and Wellbeing Board as per the national BCF conditions.



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Agenda Item 6

Health and Wellbeing Board

15 May 2024

Empowering Futures: Growing Up Well in Warwickshire JSNA

Recommendations

That the Health and Wellbeing Board:

1) Approves the Empowering Futures: Growing Up Well in Warwickshire Joint Strategic Needs Assessment (JSNA) and particularly notes and approves the recommendation that the Children & Young People's Partnership will nominate an appropriate group to own and drive the future development of the dashboard;

2) Approves the publication of the Empowering Futures: Growing Up Well in Warwickshire JSNA and supports its dissemination within member organisations; and

3) Encourages all member organisations to make use of the Empowering Futures: Growing Up Well in Warwickshire JSNA, including in the planning and commissioning of relevant services.

1. Executive Summary

1.1 The Empowering Futures: Growing Up Well in Warwickshire JSNA is the second needs assessment in the JSNA work programme approved by the Health and Wellbeing Board on 11th January 2023 and focuses on the physical health of school-aged children.

1.2 The JSNA provides an assessment of the current and future health and care needs of our local population in order to inform the commissioning of health and care services. The JSNA aims to establish a shared, evidence-based consensus on the key local priorities across health and care by bringing together key partners and stakeholders across the system to provide insight and interpretation to inform decision making. This intelligence supports and enables the prioritisation of resources and the redesign and commissioning of services that will improve outcomes for Warwickshire's residents.

1.3 The Empowering Futures: Growing Up Well in Warwickshire JSNA was prioritised to support the delivery of the school nursing service and the development of a Children and Young Person's Making Every Contact Count (MECC) offer.

1.4 The Empowering Futures: Growing Up Well in Warwickshire JSNA has been structured around the six school-aged high impact areas, which were developed to support the delivery of the Healthy Child Programme: From 5 to 19 and commissioning of school nursing services. The six areas are:

1. Supporting resilience and wellbeing
2. Improving health behaviours and reducing risk
3. Supporting healthy lifestyles
4. Reducing vulnerabilities and improving life chances
5. Supporting additional and complex health needs
6. Supporting self-care and improving health literacy

1.5 The Empowering Futures: Growing Up Well in Warwickshire JSNA has been produced as an interactive report rather than a static document, and can be viewed here: https://app.powerbi.com/view?r=eyJrIjoiNjM2ZWIwYWYtNGYwYi00NDYzLWEyNzMtNDc1M2I0ZmM5MDcxIiwidCI6Ijg4YjBhYTA2LTU5MjctNGJiYi1hODkzLTg5Y2MyNzEzYWM4MiIsImMiOjh9. Appendix 1 gives an overview of the interactive report to demonstrate for those receiving paper copies examples of what the dashboard contains. Once approved by the Health and Wellbeing Board, the JSNA interactive report will be published on the Warwickshire JSNA website. The intention is that the report will be:

- Interactive – users will be able to interact with the dashboard to explore the data and findings.
- Iterative – it will be updated, developed, and added to beyond the end of the JSNA timeline.
- Editorial – the data in the dashboard has been carefully selected to highlight the key messages as part of this work and original scope. This can be built on as part of the iterative nature of this report, subject to agreement by the group who will have oversight of this report moving forward.

1.6 The interactive output will be published on the Warwickshire JSNA website, alongside a methodology document and an engagement report.

1.7 Engagement was undertaken to inform both this JSNA as well as the Children and Young People MECC offer. This took the form of a survey (a report of which is attached at Appendix 2) which aimed to understand how people who work or volunteer with children and young people feel about discussing physical health concerns.

1.8 In addition, as part of the development of the Children and Young People MECC offer, multiple engagement activities with children and young people has been synthesised into one youth voice report. This valuable insight will be made available alongside the interactive report and the engagement highlighted in paragraph 1.7 above to provide both quantitative and qualitative insight into the physical health of school aged children in Warwickshire.

1.9 Responding to feedback on previous JSNA recommendations and acknowledging there have been two previous JSNAs focused on children and

young people in the last two years, this JSNA has followed a set of principles to try and add to, but not overwhelm, discussions and action around children and young people. The principles for the recommendations are that:

1. The recommendations need to be evidenced within the JSNA.
2. There will be a small number of high-level recommendations, with thought given as to how they translate into actions for specific audiences.
3. Consideration of how these recommendations will feed into the Children & Young People's Partnership.
4. Specific recommendations and actions identified as part of this work will be collated and developed into an initial action plan.

1.10 The Empowering Futures: Growing Up Well in Warwickshire JSNA makes the following six recommendations:

1. The Health and Wellbeing Board to endorse the dashboard produced for this JSNA and commit to this new iterative approach to producing this JSNA that is live and timely.

   To support this, the Board are asked to ensure partner organisations work together, committing subject matter expertise and analytical resource to keep the dashboard up-to-date with new data releases, evidence and intelligence.

2. An appropriate sub-group, appointed by the Children and Young People's Partnership, will own this dashboard, and coordinate developing it with partners to ensure it acts as a comprehensive evidence base when making decisions around child health.

3. The appropriate sub-group should drive the Healthy Child Programme forward in a structured way around the high impact areas for health.

4. In partnership with colleagues, review health surveillance approaches to support their continued use as key sources of intelligence locally and to ensure robust reporting across a range of child health issues. These include Health Needs Assessments, Holistic Health Assessments, and Children in Care Assessments.

5. The limited resources which are available should be targeted towards high priority communities, settings, and vulnerable children and young people.

6. Linked to the engagement undertaken as part of this JSNA, the Children and Young Person Making Every Contact Count (MECC) should be utilised to empower practitioners to have strengths-based conversations with children and young people about their health and wellbeing.

1.11 An initial action plan has been developed alongside the recommendations to drive action and impact following the approval of this JSNA. This action plan will be owned and progressed by the group outlined in the second recommendation, which will be appointed by the Children and Young People's Partnership. As a result, the action plan will likely change and develop over time, responding as new data and intelligence emerges or as the group shapes and prioritises future development. The action plan will not be published on the Warwickshire JSNA website; however, it will act as a mechanism for the JSNA programme to demonstrate progress on the recommendations to both the JSNA Strategic Group and Health & Wellbeing Board at appropriate points.

2. Financial Implications

2.1 No financial implications arise directly from this report. All work required to deliver on the recommendations will be met from within existing approved budgets.

3. Environmental Implications

3.1 None.

Appendices

1. Appendix 1 – Examples from the Empowering Futures: Growing Up Well in Warwickshire Joint Strategic Needs Assessment (JSNA) dashboard
2. Appendix 2 - Empowering Futures Survey report

Background Papers

1. No background papers.

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Portfolio Holder	Cllr Bell, Portfolio Holder for Adult Social Care & Health Cllr Markham, Portfolio Holder for Children & Families	margaretbell@warwickshire.gov.uk suemarkham@warwickshire.gov.uk

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

Local Member(s): None
Other members: Councillors Bell, Markham, Drew, Golby, Holland, and Rolfe

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Empowering Futures JSNA Survey - Supporting children and young people with their physical health

Report of results

Produced by Business Intelligence

February 2024

Contents

1. Key Messages

The survey generated 98 responses from professionals in a range of areas. Health, education and family support saw the highest amount of responses within the survey. Almost half (49%, n= 48) of all respondents work across Warwickshire. The majority of respondents said they interacted with every age group aged 18 and below. Around a third (30.6%, n=30) of respondents said they worked with those aged 19-25 with special educational needs and disabilities.

Section 2: How comfortable and confident are you in talking to children and young people about their physical health?

When considering the statement "I feel confident talking to children and young people about their physical health", most respondents (81.6%, n=80) said they strongly agreed or agreed with this statement. There were 7.1% (n=7) of respondents who either disagreed or strongly disagreed. Respondents felt most confident talking about healthy lifestyles, whilst respondents overall felt least confident talking about 'long term physical conditions'.

Section 3: What do you do and where do you go if you think a child or young person needs additional support with their health?

When asked about their role in supporting children and young people with their physical health, half (51%, n=50) of respondents identified their role as being predominantly signposting and referral to other services. There were 13.3% (n=13) of respondents who offered direct /clinical support; 7.1% (n=7) for a range of health needs, and 6.1% (n=6) for specific health needs. In relation to this question, several respondents provided additional detail in the free text box provided relating to the support they provide in their role, with themes including; guidance, general support of signposting, specific professional roles, and healthy lifestyles.

Section 4: What do you want or need to know about children or young people's health to improve the support you offer?

Nearly half (43.9%, n=43) of the respondents were not sure if they needed more information about physical health to improve their support. A further 38.8% (n=38) said they needed more information, whilst 14.3% (n=14) said they did not.

When considering specific health concerns, nearly a third (29.6%, n=29) of respondents felt that services for toileting, sleeping and eating, are difficult to access and don't meet need, which was more than any other health need. When looking at support that is easy to access and meets need, the areas of health with the highest levels of agreement was healthy lifestyles (22.5%, n=22) and alcohol, drugs, smoking and vaping (22.5%, n=22).

Section 5: Your experience of mental and physical health together.

Professionals responding to the survey said they supported with mental health more than physical health. When considering the balance between physical and mental health, just over half (52%, n=51) of respondents said that they supported with mental health most of the time, whilst 11.2% (n=11) said they supported with mental health slightly more than physical health.

The majority of respondents (81.6%, n=80) said they had used physical health interventions with the aim to also support mental health and wellbeing. Most respondents said they consider physical health needs 'all the time' (42.9%, n=42) or 'most of the time' (35.7%, n=37) alongside mental/emotional health.

Most respondents said they had a good knowledge of resources and services to support both mental and physical health. The proportion of respondents who said this about mental health (72.5%, n=71) was higher than physical health (56.1%, n=55). Nearly a quarter (22.5%, n=22) of respondents disagreed or strongly disagreed with the statement 'I have a good knowledge of resources and services available to support children and young people's physical health'. When responding to the statement 'I feel confident talking to children and young people about their mental health', 77.6% (n=76) of respondents said they agreed or strongly agreed.

Section 6: Your experience of vulnerable children and young people.

When considering specific groups of children and young people, the largest proportion of respondents said they worked with and supported the health of children and young people open to social care (43.9%, n=43), children and young people in care (40.8% n=40), and children and young people who are care experienced (37.8%, n=37). In contrast, young carers (36.7%, n=37) were the group for which the highest proportion of respondents said they had worked with but not supported physical health. Most respondents (60.2%, n=59) had not worked with children and young people who are part of military families. In free text box comments, there were six mentions of children and young people with disability, SEND or complex needs. Other comments highlighted additional groups that professionals worked with.

2. Background

This survey asked respondents to participate if they work or volunteer with children and young people. The aim was to understand how professionals feel about talking to children and young people (aged 5-18) about their physical health, their knowledge and experience of services, and what help professionals need to provide support.

As well as broader public health priorities and activities, the aim is for this survey to specifically inform:

- The Empowering Futures: Growing Up Well in Warwickshire Joint Strategic Needs Assessment (JSNA). This JSNA seeks to understand the physical health needs of children and young people in Warwickshire.

- The Children and Young People Making Every Contact Count (MECC) offer. The children and young people MECC is being developed to support professionals to have strengths based conversations with the children and young people they support.

The survey aimed to look at physical health in children and young people, covering all areas including; oral health, healthy lifestyles (weight, nutrition, physical activity), sexual health, alcohol, drugs, smoking and vaping, adolescence and teenage health (puberty, hygiene, self-care), toileting, sleeping, and eating, long-term conditions (e.g. chronic illnesses, asthma, diabetes, eczema, allergies, bladder and bowel conditions) and short-term conditions (e.g. acute illnesses, infections, injuries).

3. Method

An online survey was published on Ask Warwickshire (https://ask.warwickshire.gov.uk/), hosted by Citizen space. It was open for responses from 6th December 2023 until 31st January 2024. Individuals were invited to submit their views either individually or as a group, using the online survey or via an alternative format. There were no surveys requested in an alternative format.

The survey was promoted through the following avenues;

- General public release
- Working for Warwickshire
- WCC intranet
- Shared internally in WCC teams (including Public Health, Early Help network, SEND and Inclusion team, Partnerships and communities team, and Children and Families team)
- Shared with health partners externally (including with health leads at SWFT, GEH, UHCW, Asthma clinical network, Paediatric diabetes teams, Epilepsy clinical network)
- GP Newsletter
- Heads Up
- Think Active
- Active Travel
- WCC commissioned services - School Health and Wellbeing Service, RISE, Mental health in schools teams, Compass young person drugs and alcohol service

4. Questionnaire results

Section 1: Respondent Profile

Question 2: Which of the following best describes your main involvement with children and young people?

Respondents were first asked 'Which of the following best describes your main involvement with children and young people?'. Figure 1 shows the responses received for this question. The category with the highest proportion of responses is Health (24.5%, n=24), followed by Education (21.4%, n=21) and Family support (19.4%, n=19). The category with the lowest level of response was Sport and Leisure (3.1%, n=3).

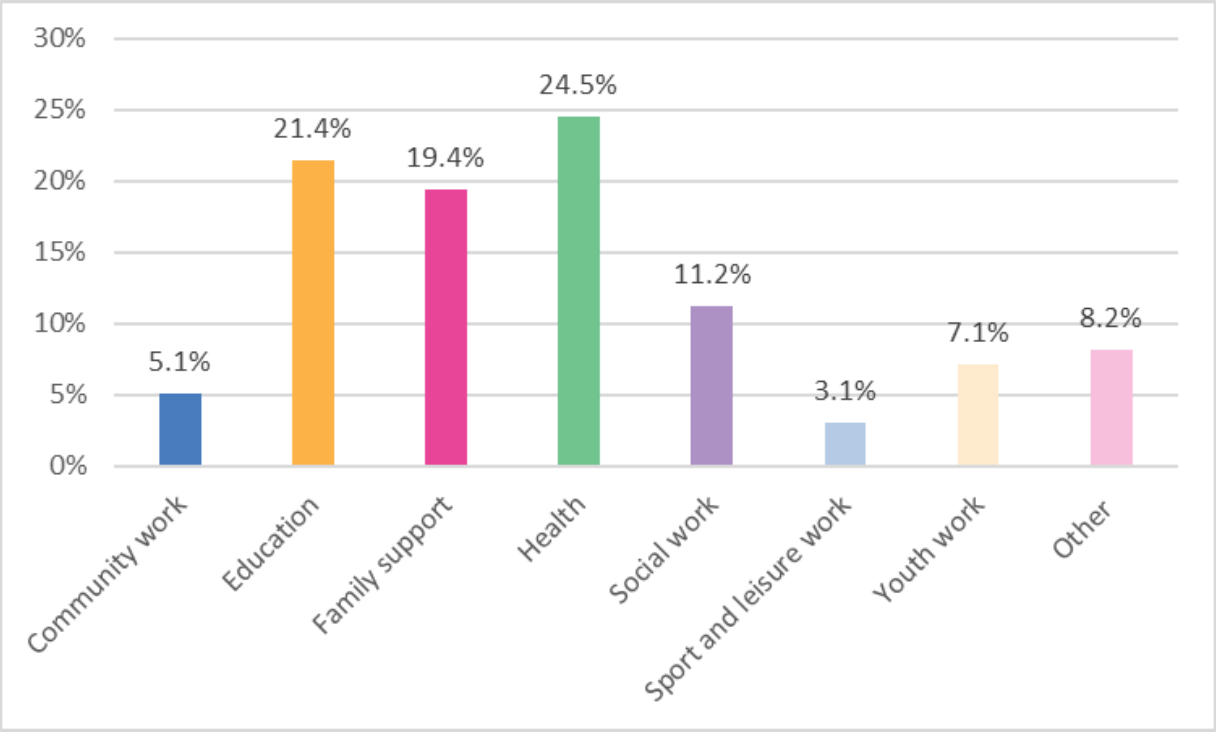

Figure 1 - Which of the following best describes your main involvement with children and young people?

There were a number (8.2%, n=8) of responses that selected the option 'other', seven of which provided further detail as below (some details have been removed to protect respondent confidentiality)

Foster carer
Promoting active travel
Brokerage with families
Residential children's home
A mix of community, health and sport and leisure
Supported accommodation
Support work

Two other respondents selected a category above and added further detail using the 'other' box. One respondent working in health specified 'school nurse' and one respondent who selected family support provided further detail 'Children and Family Centre Early Years'.

Question 3: What age ranges of children and young people do you normally interact with?

Respondents were then asked 'What age ranges of children and young people do you normally interact with?'. For this question, respondents could tick multiple options – therefore, figure 2 below shows the responses given as a percentage of all participants. Apart from 19-25 with Special Educational Needs, the majority of respondents said they interacted with every age group. The age group that showed the highest proportion of respondents (81.6%, n=80) working with were 12-16 year olds. Around a third (30.6%, n=30) of respondents said they worked with those aged 19-25 with special educational needs and disabilities.

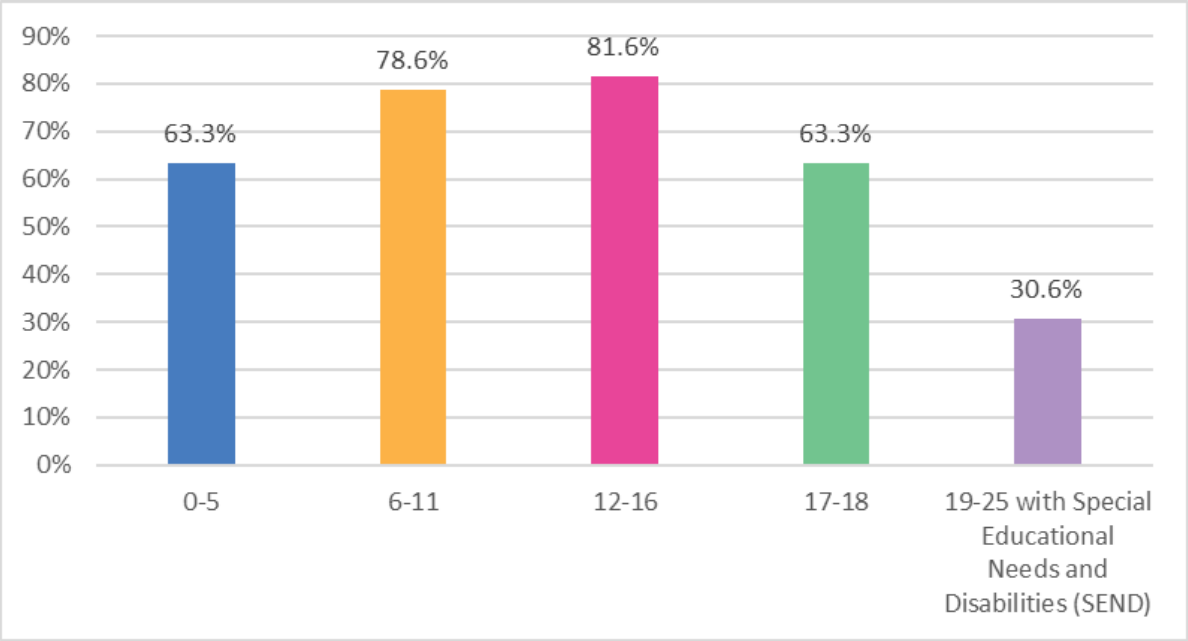

Figure 2 - What age ranges of children and young people do you normally interact with?

Question 4: What geography do you cover in your role?

Respondents were asked which geography they covered within their professional role. Almost half (49%, n= 48) of all respondents worked across Warwickshire – four of these responses originally selected 'other' and then specified across Warwickshire in their response, thus these responses have been re-categorised. There were no responses from professionals working outside Coventry or Warwickshire.

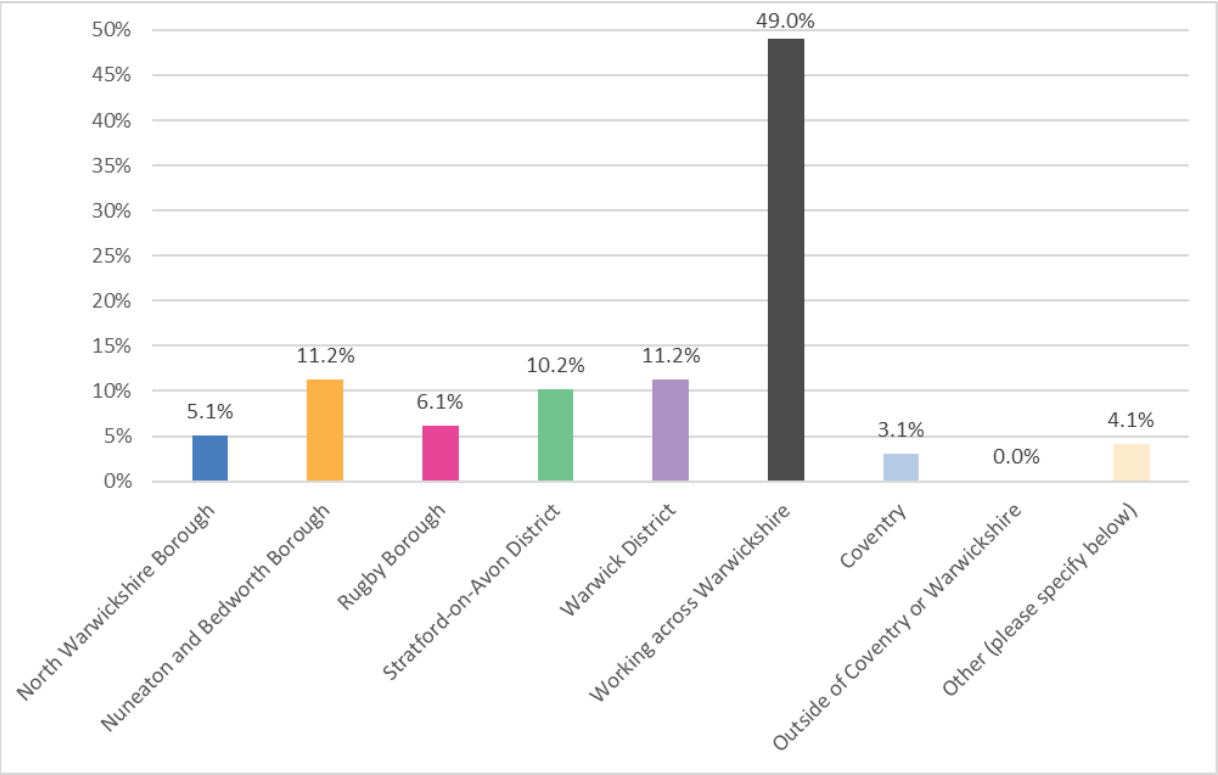

Figure 3 - What geography do you cover in your role?

There were 4.1% (n=4) responses that said 'other', specifying the areas they worked as 'Stratford and Warwick' 'South Warwickshire', 'Southam', and 'Both Coventry and Warwickshire'. One respondent who said they worked across Warwickshire added further detail to say 'and Coventry', and one respondent who said Nuneaton and Bedworth said 'Coventry and Warwickshire' in the additional information box.

Question 5: In the last 12 months, how often have you identified that a child or young person may need support with the following areas of physical health?

Respondents were asked more specifically which areas of health they have supported with, with the question 'In the last 12 months, how often have you identified that a child or young person may need support with the following areas of physical health?'. Figures 4 and 5 show the frequency with which respondents supported with each category of health. Out of all categories, 'toileting, sleeping and eating' had the highest proportion of respondents saying 'frequently' (36.7%, n=36), whilst sexual health had the lowest proportion (9.2%, n=9). Similarly, sexual health had the highest proportion of respondents responding 'never' (37.8%, n=37), whilst the health concerns with the lowest proportions of participants responding 'never' being 'toileting, sleeping and eating' and 'healthy lifestyles' (both 8.2%, n=8).

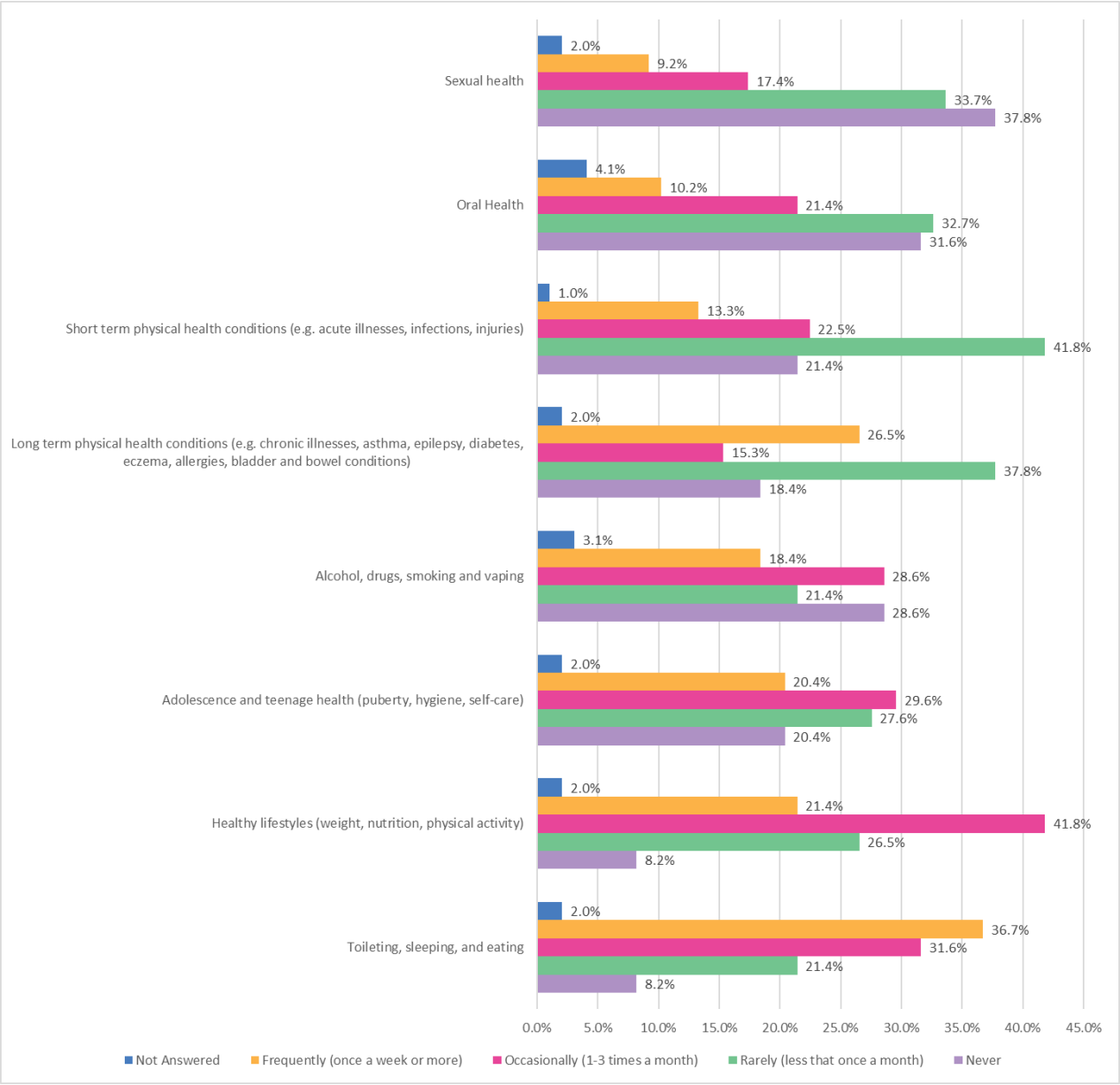

Figure 4 - In the last 12 months, how often have you identified that a child or young person may need support with the following areas of physical health?

Figure 5 provides a summarised overview of the responses to this question, grouping responses together that stated rarely or never, and occasionally and frequently. This demonstrates that overall, 'toileting, sleeping and eating' and 'healthy lifestyles' were the most frequently supported issues by professionals, whilst sexual health was the least commonly supported issue. For all health issues, at least a quarter of respondents provided frequent or occasional support.

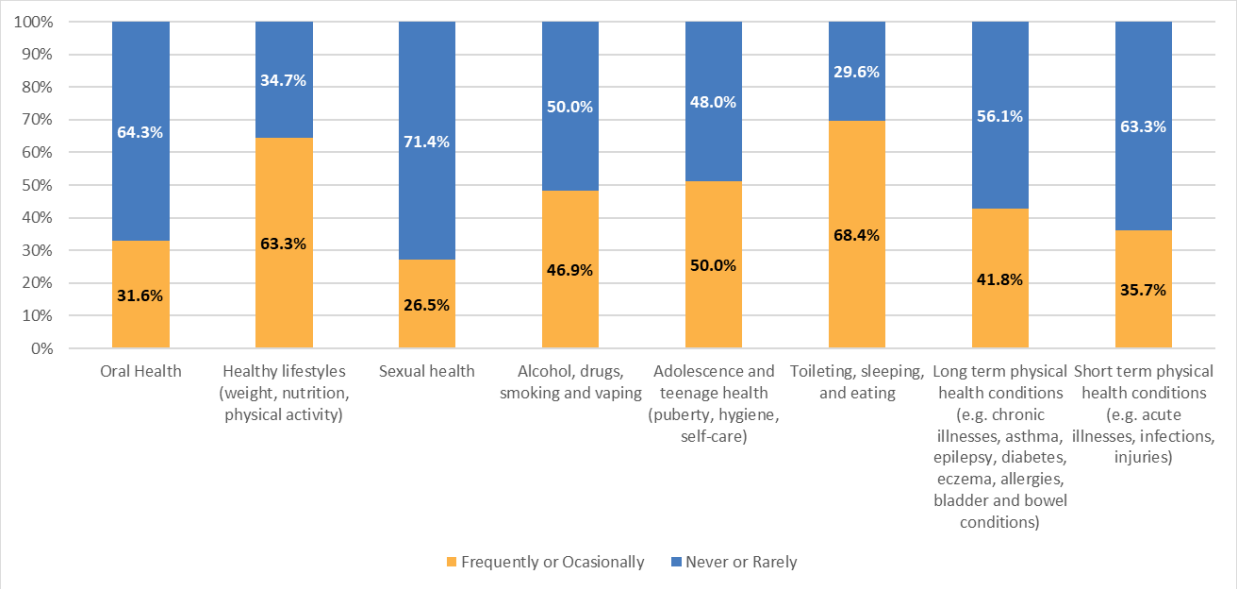

Figure 5 - In the last 12 months, how often have you identified that a child or young person may need support with the following areas of physical health?

Question 6: How often do you see children or young people with the following symptoms that impact on activities of daily living?

Respondents were then asked 'How often do you see children or young people with the following symptoms that impact on activities of daily living?'. The symptom that the highest proportion of respondents supported frequently was 'generalised/systemic symptoms' (21.4%, n=21). In contrast, just 3.1% (n=3) of respondents said they frequently supported with ophthalmic symptoms. Just over half (51%, n=50) of respondents said they never support with cardiac symptoms.

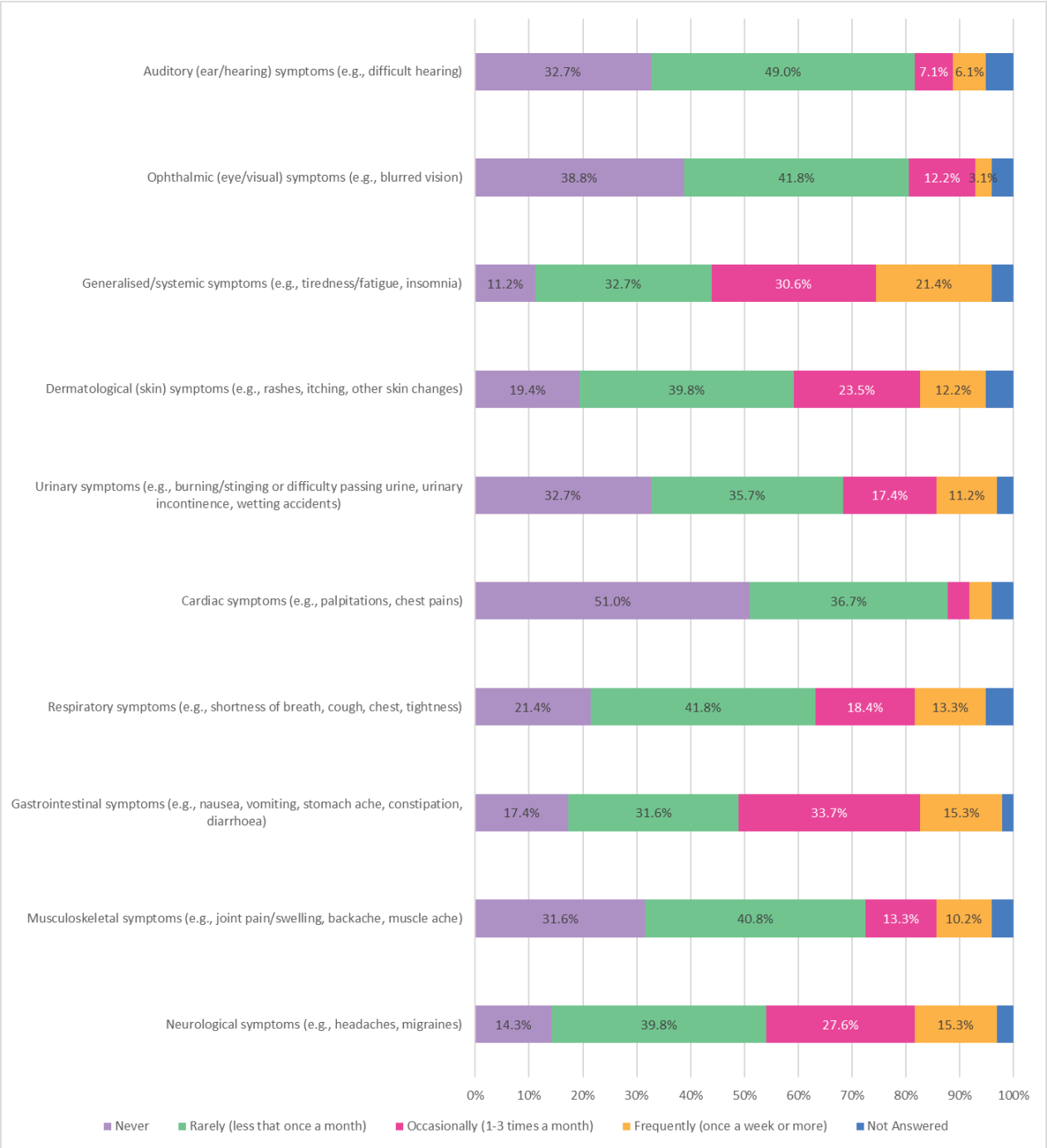

Figure 6 - How often do you see children or young people with the following symptoms that impact on activities of daily living?

Figure 7 shows the summarised responses for this question, grouping 'rarely' and 'never' responses, and 'occasionally' and 'frequently' responses. Cardiac symptoms are the least frequently encountered symptom for respondents, with 87.8% (n=86) of respondents never or rarely seeing children with this symptom. In contrast, generalised/systemic symptoms were occasionally or frequently seen by 52% (n=51) of respondents.

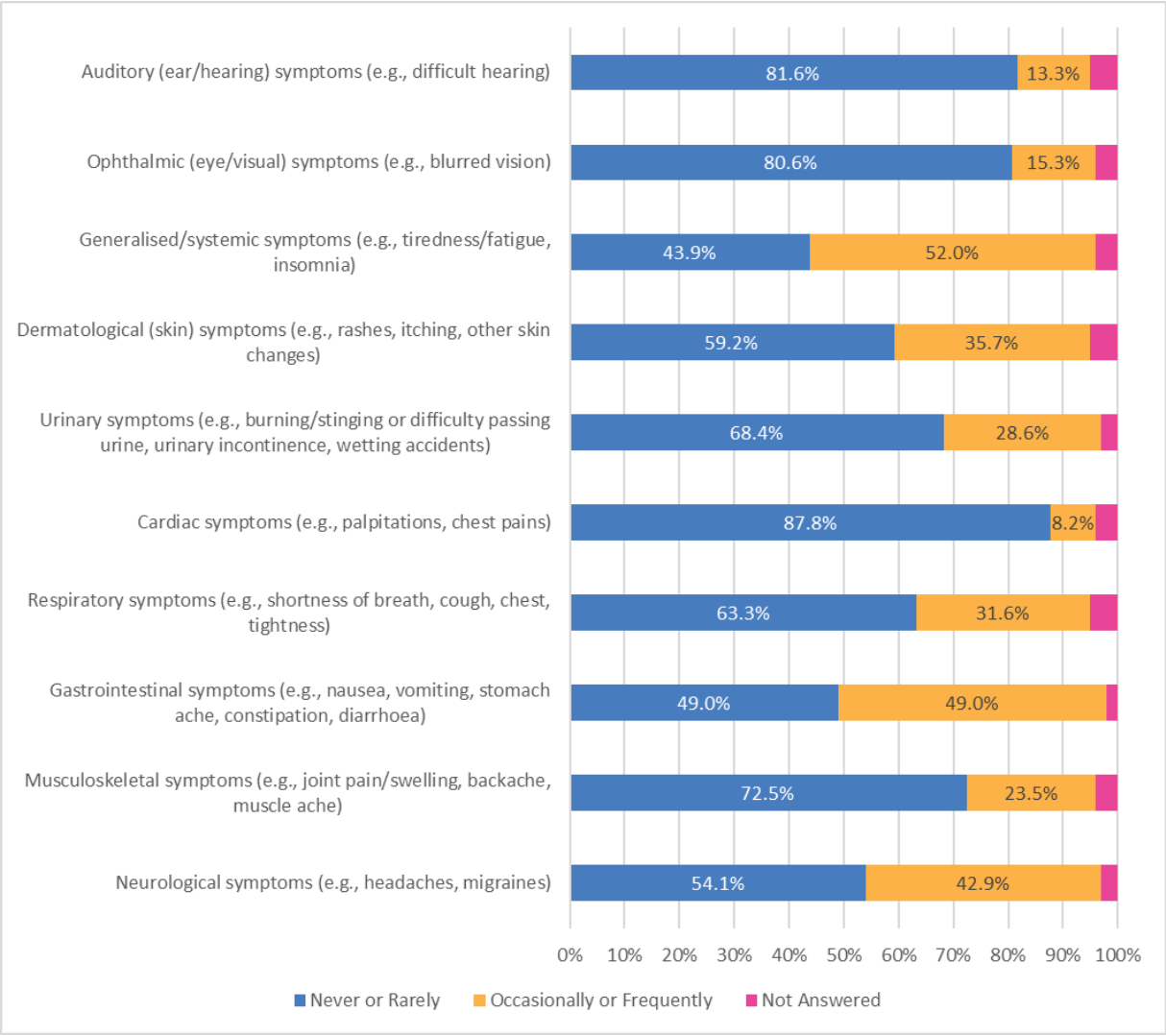

Figure 7 - How often do you see children or young people with the following symptoms that impact on activities of daily living?

Respondents were also given the option to select other and provided with a free text box to add additional detail. Most respondents did not answer this part of the question, but around a quarter (23.5%, n=23) of respondents said 'never', 2% (n=2) said rarely, 3.1% (n=3) said frequently and one respondent said occasionally. Four respondents added further detail in the free text box:

Anxiety
Behavioural, Trauma Neurodevelopmental ie ADHD, Autism
Tics can come up now and again, I'd say rarely on this scale. Selective mutism has come up a few times, again, I'd say rarely on this scale, but still enough times to be significant.
SEND and their families

Section 2: How comfortable and confident are you in talking to children and young people about their physical health?

Question 7: Overall, to what extent do you agree with the statement "I feel confident talking to children and young people about their physical health"?

When asked 'Overall, to what extent do you agree with the statement "I feel confident talking to children and young people about their physical health"?', most respondents (81.6%, n=80) said they strongly agreed or agreed with this statement (Figure 8). There were 7.1% (n=7) of respondents who either disagreed or strongly disagreed.

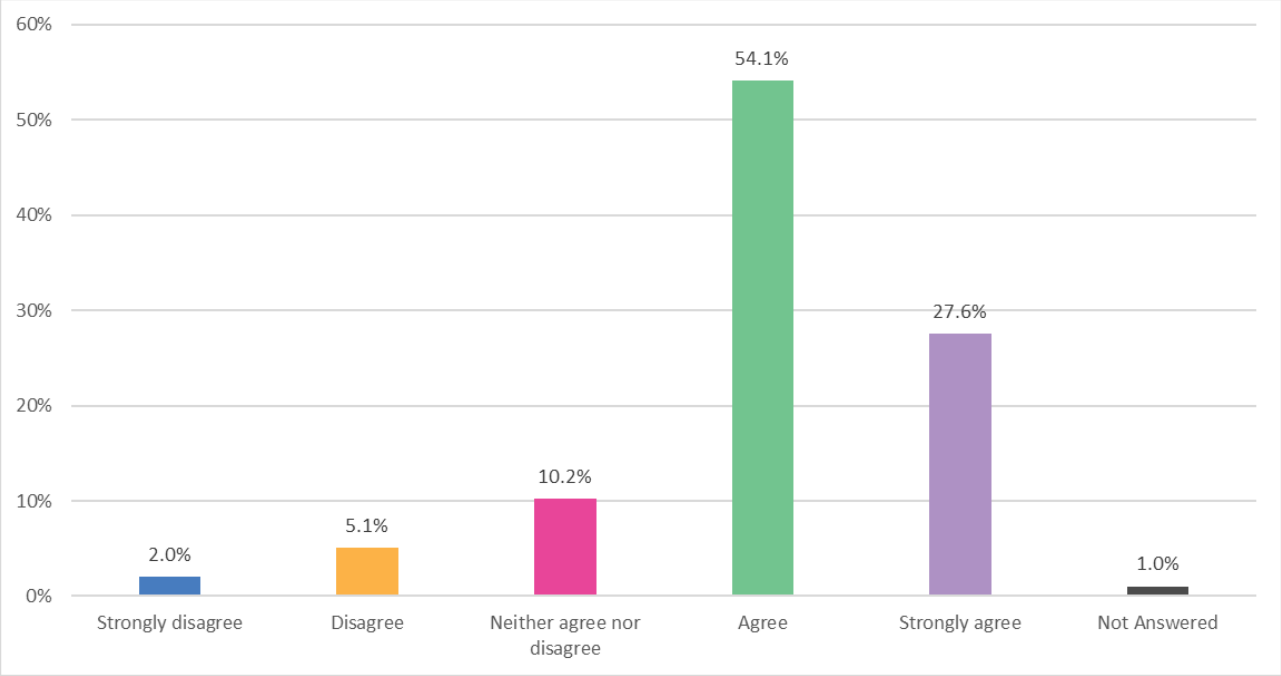

Figure 8 - Overall, to what extent do you agree with the statement "I feel confident talking to children and young people about their physical health"?

Figure 9 shows a breakdown of responses to this question by professional sector (question 2). Across all professional groups, the majority of each sector said they felt confident to some extent. All respondents working in social work said they agreed or strongly agreed that they felt confident. Within health, education, and family support some respondents said they disagreed whilst some respondents in education and youth work said they strongly disagreed.

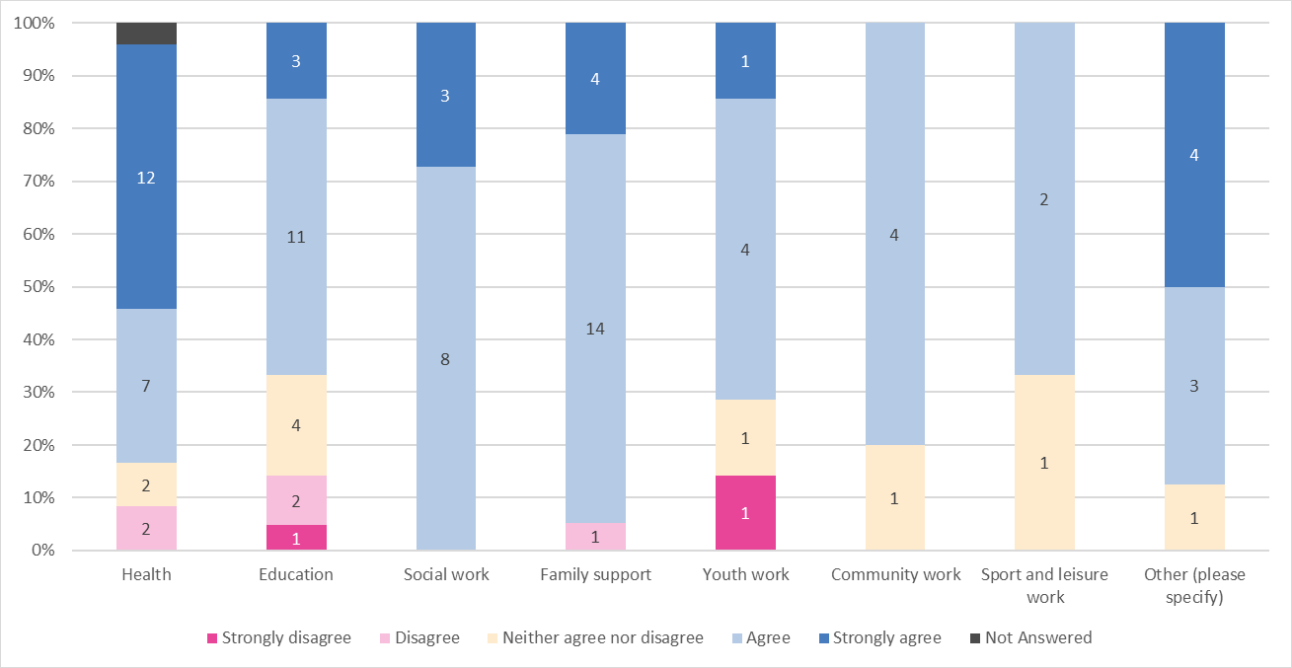

Figure 9 - Overall, to what extent do you agree with the statement "I feel confident talking to children and young people about their physical health"? (Breakdown by professional sector)

Question 8: To what extent would you agree or disagree that you feel confident talking to children and young people about these specific physical health conditions?

Respondents were then asked more specifically 'To what extent would you agree or disagree that you feel confident talking to children and young people about these specific physical health conditions?'. When looking at combined responses for 'strongly agree' and 'agree', healthy lifestyles was the aspect of health that respondents felt most confident talking about, with 85.7% (n=84) respondents saying they strongly agreed (27.6%, n=27) or agreed (58.2% n=57). Apart from the category 'other', 'long term physical conditions' was the health aspect that respondents overall felt least confident talking about, with 24.5% (n=24) respondents saying they disagreed (17.4%, n=17) or strongly disagreed (7.1%, n=7) with the question statement.

There was an additional 'other' option provided, for which 10.2% (n=10) responded 'strongly disagree', 7.1% (n=7) responded 'agree' and 3.1% (n=3) responded 'strongly agree'. There were 7.1% (n=7) of respondents who said neither agree nor disagree. Most respondents did not answer this question (72.5%, n=71).

In the additional text box provided, three respondents provided extra details, where four other health aspects were listed; anxiety, mental health, self harm injury, and suicidal ideation. It is unclear whether these conditions were aspects that respondents felt confident or not confident talking about.

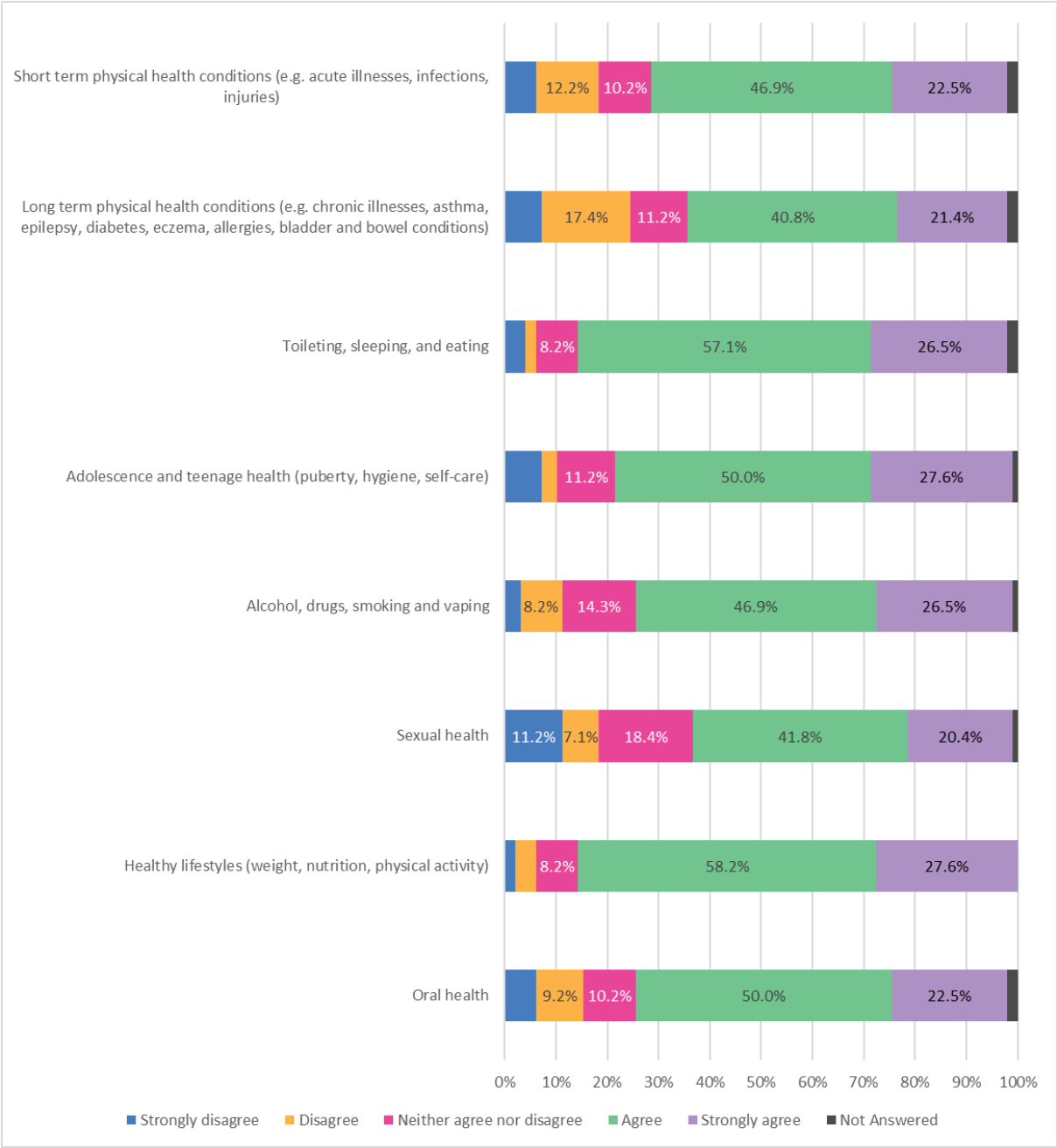

Figure 10 - To what extent would you agree or disagree that you feel confident talking to children and young people about these specific physical health conditions?

Question 9: Can you describe any difficulties you experience when talking to children about their physical health?

When asked what difficulties are experienced when talking to children about their physical health, respondents made a range of comments summarised in the table below.

Theme	Explanation	Examples for Illustration
Confidence and knowledge surrounding children and young people's health and wellbeing	Many responders reported feeling they were not knowledgeable enough about certain topics. Topics that were reported as being difficult to address included: • Weight management • Drugs/alcohol • Puberty/ sexual health • Mental health Additionally, several responses suggested a lack of confidence and felt they were not in the right role to have these conversations with children and young people.	*"lack of knowledge"* *"I volunteer with young people but I have a range of qualifications in youth work. My job is in health which gives me a massive advantage. If it wasn't for this I would not be confident in this. There is no simple guidance of concerns to raise or how to challenge and support young people to be empowered about health."* *"Sometimes if it's a health condition I don't know much about I can feel unsure about how to broach the subject especially if the symptoms are very personal and/or embarrassing for the young person i.e. toileting or sexual behaviours. It is also, not part of my current role to do much physical health exploration/signposting therefore, I worry that perhaps I should not be exploring these issues in any depth as I should be focusing on the mental health."* *"For conditions I don't know anything about, though would be very happy to listen. I would feel it wasn't my place to challenge eg on weight or oral hygiene (only volunteering on a community project) but rather would talk about how the physical activity we're doing will help our bodies be healthy, how eating a variety of things will help their brains and bodies work well etc. I wouldn't specifically mention eg drugs, sexual health etc with the age group I volunteer with but always happy to discuss honestly and encourage them to fully ask any questions they have if they start talking about these things."*
Children and young people's own	Children and young people's understanding and comprehension	*"The main issue is that children can't fully understand/appreciate the*

knowledge/ comprehension of health and wellbeing	of their own health and wellbeing appeared to be a barrier when discussing the topic. Often this was reported to be the case when talking to Children with complex needs. Furthermore, social media was reported to influence the pre-existing knowledge that children and young people had around health and wellbeing topics	*importance of these physical health areas so talking to them doesn't change behaviours, but parents don't take on board the advice and appear reluctant to upset their children by setting boundaries around "have to do" activities or teaching them the tasks."* *"Occasionally there may be a neurodevelopmental factor which can impact upon the understanding of the child/YP"* *"If they have delayed communication skills impacting upon their level of understanding. They may have physical delay/diagnosis impacting their skills or have limited access to outdoor spaces."* *"Not much apart from the 'fake news' or articles they read or see online..."*
Building relationships	Several reported struggling to engage with children and young people. Many highlighted to importance of building trust with children and young people and ensuring they have the appropriate relationship to discuss certain topics. Another issue faced when engaging with children and young people was the Stigma and feelings of embarrassment that children and young people feel when discussing certain topics.	*"The majority of difficulties come from the lack of attention from the child. I rarely have issues talking to them about any issues, but often they feel ashamed to talk about such topics."* *"Just to be mindful of lived experiences and any undue impact on self-esteem or well-being if discussing topics that may be triggering"* *"children not wanting to talk about it."* *"Young people aged between 16-18 often do not heed the advice given to them and may not necessarily see a need for themselves to improve on certain areas.* *It is also difficult when they have accepted the advice that you have given them but health appointments can take a long time so by the time*

		the appointment day comes they no longer wish to engage." *"Takes time to build up trust with a child"* *"the shyness of the YP depending on the topic and our relationship"* *"Sometimes they are shy or embarrassed, but I generally take things slowly and make them feel comfortable when discussions are on sensitive subjects"*
Services	Some expressed concerns that services that they signpost to, may either be difficult to access or not appropriate for children and young people.	*"I work with CYP who have additional needs and are in care. Sometimes they do not want to engage with services and the services can seem impersonal to them"*
Parents/ families/carers	The influence of parents/ families/ carers was mentioned as playing a pivotal role in conversations around young people's mental health. It was felt that parents/carers may influence children and young people's behaviours at home and were believed to play an important role in whether suggested behavioural changes continue at home and the effectiveness of conversations with children and young people.	*"Often children will do what their parents do, so I find it hard to explain why certain things/food are not the best for your body if its what they see every day their parents doing/eating. I find no matter what my direct work involves, whatever is the norm to eat/do at home will still be done regardless."* *"Individual families beliefs and barriers regarding this subject. Use of 'proper' names for genitalia due to family using nick names/family embarrassment using these and accepting use of them"*
Barriers to engagement	Respondents reported several barriers which make it difficult to engage with children and young people. These include: • Language - knowing the appropriate terminology to use. • Environment - this may not always be appropriate for some conversations.	*"The majority of difficulties come from the lack of attention from the child. I rarely have issues talking to them about any issues, but often they feel ashamed to talk about such topics."* *"Takes time to build up trust with a child"* *"Finding the right time and appropriate environment"*

	• Time constraints - some felt they did not have enough time available and that this was needed to build trust. • Cultural differences- sometimes cultural differences made conversations about health difficult as some topics may be taboo.	*"Barriers that affect their understanding. Not being in an appropriate environment Knowledge"* *"I work exclusively with children from Gypsy, Roma and Traveller communities and am happy to speak with young people or parents about general health issues however, discussions about sexual health and puberty are taboo in GRT cultures and talking about these subjects is difficult."*

Question 10: What key thing(s) would be useful to improve your confidence and lower barriers to talking to children and young people about their physical health?

Respondents were asked what key thing(s) would be useful to improve their confidence and lower barriers when talking to children and young people about their physical health. Themes and examples are presented below.

Theme	Explanation	Examples for Illustration
Training	Many felt that receiving training would help improve their confidence. Respondents requested training on both techniques for how to have health related conversations with children and young people as well as training to enhance their knowledge on relevant health topics.	*"Improved knowledge to empower people to have educated conversations, particularly when transitioning children into adult services. Youth work support to give young people time and an open platform to discuss issues that could benefit their physical health. Sport and exercise initiatives across Warwickshire. Education on vaping in schools."* *"Training* *Support from management/ supervisions"* *"More training on physical health such as infections and long term health needs"* *"FORMAL TRAINING"* *"More available and accessible free training"*

		"Workshops to educate and support parents" *"Clear training and guidance"* *"Support workers to understand the benefits of being active and how to have conversations about activity - not just because a young person is saying they want to be active but how to raise a conversation about being active to help with other challenges a young person is facing eg mental health, low self esteem etc* *Understanding of CMO Guidelines for physical activity and how to support young people who face barriers to being active to work towards meeting these guidelines* *This can be through training and keeping physical activity on the agenda at team meetings etc, sharing examples of how colleagues have been using physical activity with the young people they are working with.* *However, it also requires a shift in culture within organisations to:* *1. encourage and embed conversions about being active into routine practice to help with a range of challenges facing young people and* *2. Support workers to be active themselves as a way of helping their own physical and mental wellbeing - its more difficult to advocate being active when you aren't active yourself."*
Resources and information	Access to resources with up-to-date information was requested e.g. signposting towards available services. This was requested in the in the format of online information, toolkits or something professionals can 'have to hand'.	*"Up to date information and resources."* *"Easily accessible information that we can pass on"* *"Child friendly leaflets with age-appropriate information, Parent leaflets with parental information,*

	Desired resources were to be targeted towards either parents or children and young people (appropriate to different stages of development).	*Accessible information for health care providers and available training when needed"* *"More training, increase my knowledge* *Leaflets, information to hand,* *Knowing where to signpost if need to"* *"Programmes online that we can use with young people"* *"Easily accessible videos that could be shared with parents"* *"Workshops to educate and support parents."* *"Child friendly leaflets with age appropriate information, Parent leaflets with parental information, Accessible information for health care providers and available training when needed"* *"More information around certain topics, so i know i am giving the right advice.* *A kit to explain and show the importance of physical health so the children had visuals."* *"More awareness of routes into healthcare provisions"* *"Access to local information* *Knowing what is available"*
Support	Several believed that having further support available would be beneficial. This may be though having additional access to local services, support from medical professionals, or from their employers.	*"access to more services without long waiting lists"* *"More professionals inputting* *"Having more information about where the child or parent can access support and advice. Having the back up of a health professional."* *"To have greater access to health professionals, to have health*

		professionals attend meetings especially where there are multiple or complex health needs." *"Better access to ongoing support and greater knowledge of what is already available as I suspect that there is more than I am aware of."* *"knowledge support with discussing sensitive issues - especially those not in my usual clinical area of work / how to raise issues in a manner that will be welcomed"*
Time	Some desired additional time to have conversations with children and young people.	*"More time."* *"Having more time resources to be able to allow adequate time to discuss health. Often have limited time constraints. Having more understanding about mental health & how this impacts physical health."* *"More time allocated with patients to enable these discussions without a time constraint"* *"More time to dedicated to cases to build rapport with child and family and better understand the child holistically."* *"More time so trusting relationship can be established, and time taken over conversations"*
Other	Addressing stigma: many felt that stigma was an issue and that it would be beneficial to work to remove this. Outside job role: some felt it was not their responsibility to have these conversations with children and young people. More openness: one person suggested that more openness is needed, especially with boys.	*"Removing stigma's and empowering children and young people. It's important the voices of young people and children are heard, but not just heard. We should be using the information we receive to develop the work we do and factor this in to our decision making otherwise the status quo continues. I think Officers and adults would feel more confident if they felt barriers were removed and that the conversations we have will be impactful. If people do not believe*

		the conversations will have a demonstrable impact you may not get the desired conversations and outcomes." *"Is it part of my job?"* *"More openness - especially with boys"*

Section 3: What do you do and where do you go if you think a child or young person needs additional support with their health?

Question 11: Overall, how would you describe your role in supporting children and young people with their physical health?

When asked about their role in supporting children and young people with their physical health, half (51%, n=50) of respondents identified their role as being predominantly signposting and referral to other services. Respondents could only select one response to this question. A further 15.3% (n=15) provide information, advice and guidance on general health issues. There were 13.3% (n=13) of respondents providing direct and/or clinical support – 7.1% (n=7) for a range of health needs and 6.1% (n=6) for specific health needs. Around a tenth (11.2%, n=11) of respondents said that they did not currenly support children or young people with their physical health, whilst 8.2% (n=8) selected the 'other' option.

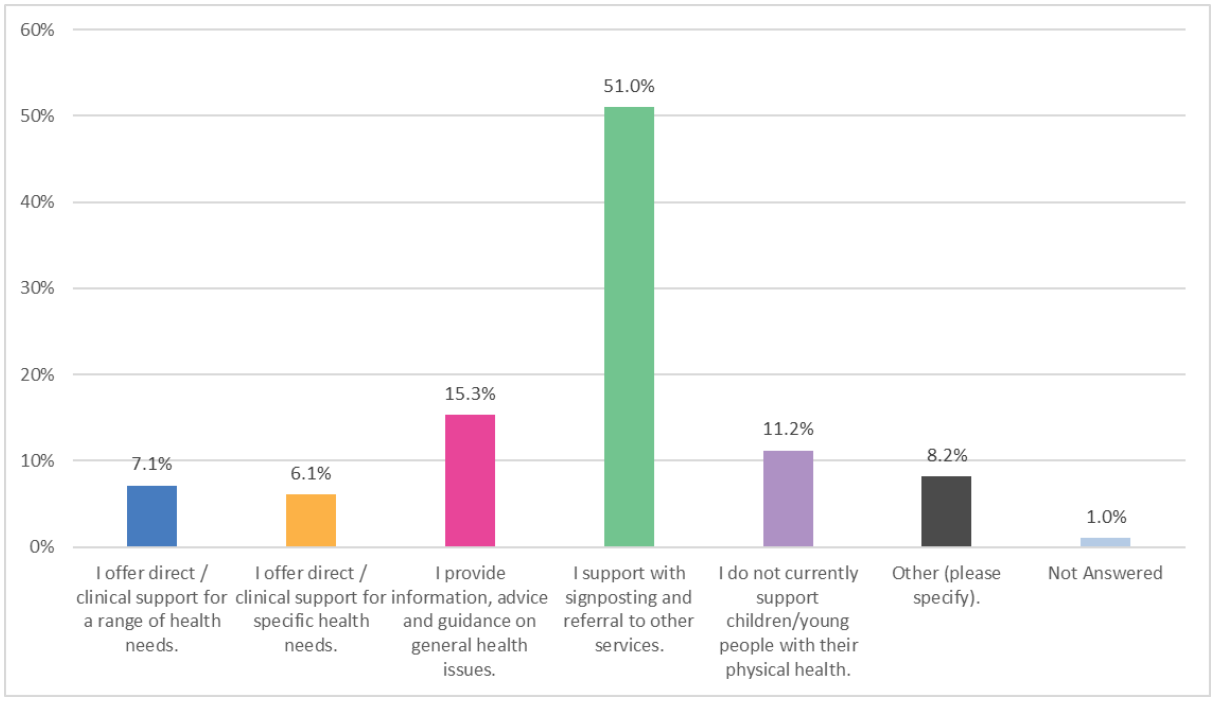

Figure 11 - Overall, how would you describe your role in supporting children and young people with their physical health?

Numerous comments were also received in response to this question, from which three themes can be identified. There were seven comments mentioning guidance, general support of signposting;

- *"I do a mix of the above; within my specialty I can offer direct clinic support if it is outside of my specialty I can refer for support/guidance."*
- *"I offer direct support for certain needs, sometimes just advice/information and other times I signpost"*
- *"I provide information, advice and guidance on general health issues. I support with signposting and referral to other services."*
- *"And also support with signposting where it's outside my expertise. This question should allow more than one option to be selected"*
- *"As supported accommodation we are there to offer advice and point young people in the direction that they need should they need extra support."*
- *"I mainly signpost but there is a level of information sharing you do as a youth worker too"*
- *"I provide occasional advice and guidance around physical health and I will make referrals to other organisations including Warwickshire front door around physical health."*

Five respondents identified more specifically their professional role;

- *"Hospital based consultant paediatrician"*
- *"Clinical Nurse Specialist in Complex Care inc PMLD, tracheostomy's and vented children*
- *"Support a team of FSW's holding caseloads."*
- *"I give daily information and support with health. I am responsible for prompting young people with oral hygiene/ diet/ personal hygiene. I administer medication. I take young people to appointments and will work with them if there are any anxieties or worries. I advise and signpost as well as support with individual difficulties around substance misuse, alcohol, smoking."*
- *"I provide 1:1 support for young people and their parents/carers. I support in improving their physical health and wellbeing. I support with emotional and mental health. I work in the safeguarding arena, supporting those who are experiencing neglect, abuse and trauma."*

Four comments mentioned promoting some aspect of healthy lifestyles;

- "*I don't specifically support children with physical health, but work with them in outdoor gardening and creative projects, so there's a lot of physical activity and we grow healthy food so talk about that and how to use it."*
- *"[Respondent's organisation] has the potential to increase the number of children walking, scooting, cycling and wheeling to school which would have a positive impact on their health. If children and adults enjoy these journeys they are more likely to travel actively for other journeys or take up pursuits which are active."*
- *"We provide support, advice and guidance on being active by encouraging those who come into contact with those who are least active to embed physical activity within their practice"*
- *"we support people/children who want to quit smoking"*

Question 12: What level of support do you give to children and young people with these specific health needs?

Respondents were asked about the level of support they provide to children and young people, relating to specific health needs. Signposting and referral were the most common forms of support provided by respondents, with between 35-50% of respondents saying they provided this for each health need. The health need with the highest response for signposting and referral was oral health (48%, n=47), whilst the lowest response for signposting and referral was for adolescence and teenage health (36.7%, n=36) (with the exception of 'other' health needs).

There was an option to select 'other'. Most respondents (71.4%, n=70) did not respond to this part of the question and 13.3% (n=13) said they do not provide support in relation to 'other' health needs. There were 6.1% (n=6) respondents who said they provide signposting and referral support for other health needs, and 7.1% (n=7) who provide information, advice and guidance. There were 2.0% (n=2) of respondents who provide direct/clinical support for other health needs.

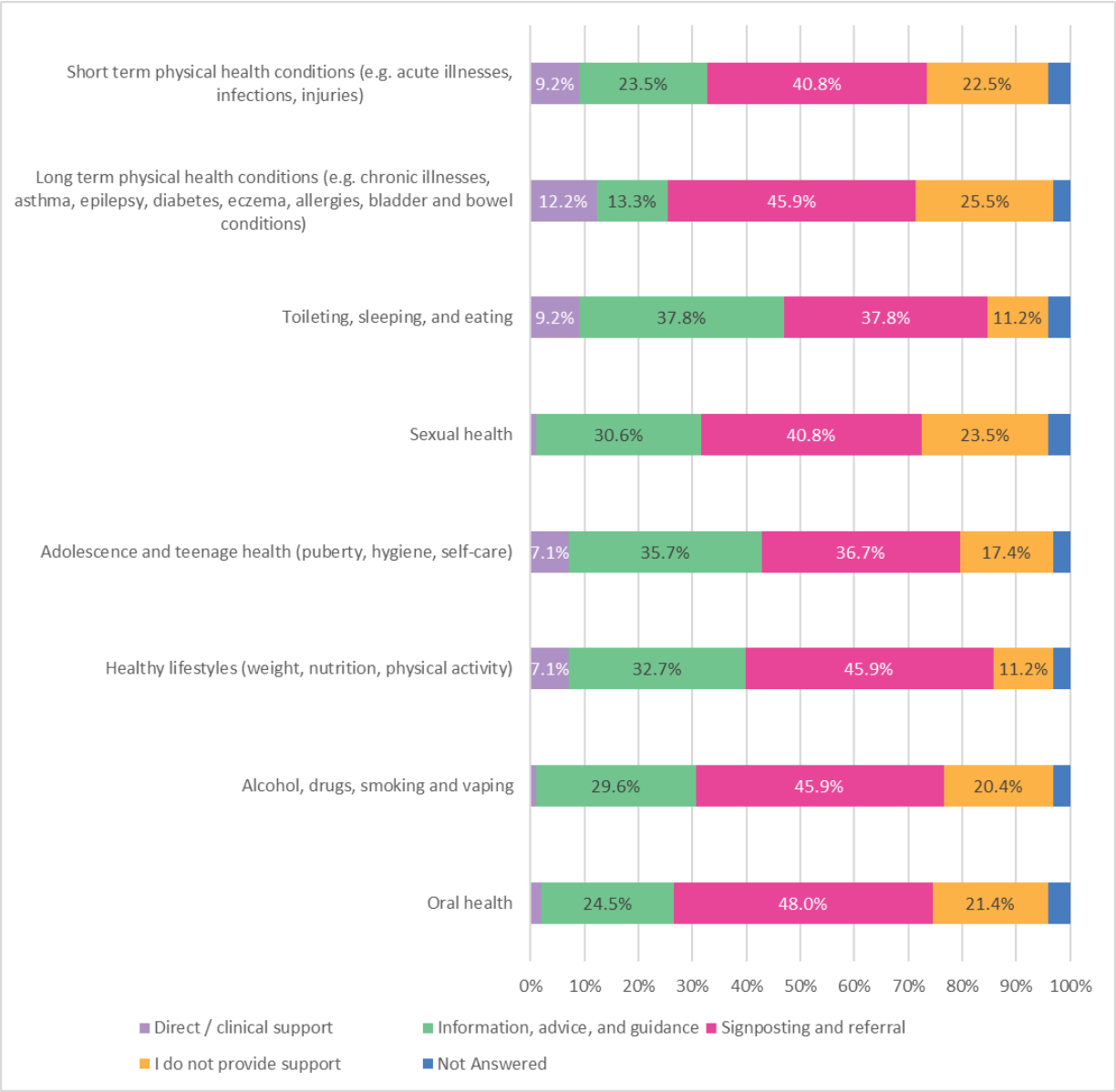

Figure 12 - What level of support do you give to children and young people with these specific health needs?

There were several additional answers provided in the free text box, as displayed below. There were additional forms of support highlighted, such as going to a Speech and Language Therapist or SENCO, signposting to active events, and signposting other staff and information resources such as books or leaflets. Six of the comments mentioned signposting. There were also additional health needs identified, including mental health, behavioural concerns and neurodevelopmental.

All areas are signposted or supported with advice. Depends on the subject / needs of person. Some actions may be required rather than discussed and non-actioned
Most of these I would offer 1-1 support and guidance and signposting or referral as required
I would involve SLT Senco.
Mental health

We offer signposting via schools to walking and cycling events and provide active travel maps to families.
Behavioural concerns, Neurodevelopmental
I signpost school staff to the relevant agencies to provide support to the child and their family.
I signpost and may refer for the above as well.
Sometimes it is a mix of providing information and signposting.
If I have information leaflets or posters to offer to young people or books etc that may be helpful if parents ask questions I will pass that on

Question 13: Could you describe what actions you would normally take if a child or young person's health needs exceeded the support you could offer them?

Respondents were then asked 'Could you describe what actions you would normally take if a child or young person's health needs exceeded the support you could offer them?'. Respondents were allowed to select more than one answer and therefore the percentage below represents the proportion of overall respondents. Most respondents would take the following actions; 'I would speak to a specific service' (79.6%, n=78), 'I would speak to colleagues I work with' (66.3%, n=65), and 'I would flag with the parent/carer' (65.3%, n=64). There were 10.2% (n=10) of respondents that said other.

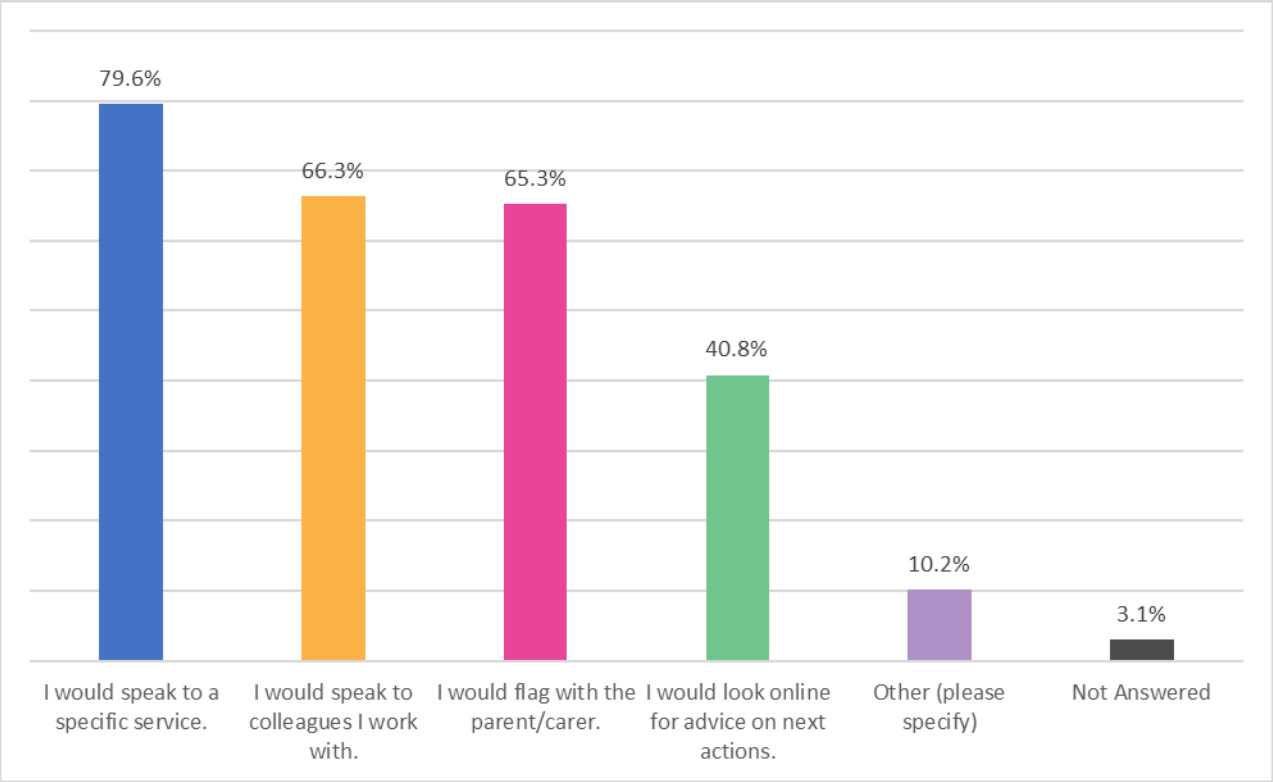

Figure 13 - Could you describe what actions you would normally take if a child or young person's health needs exceeded the support you could offer them?

Respondents were given the opportunity to provide more details, from which several topics emerged. Some topics were mentioned more than once including; Discussion with manager/supervision (n=3), Seeking relevant further support (n=3), 'Connect for health' referral (n=2), and signposting (n=2). Several other topics were also raised including; escalating for school, offering direct support, speaking to the SLT/SENCO, Fraser guidelines and Gillick principles, Referral to specialist service, GP/111, speaking to the social worker, referring to the teacher or TA and speaking to the parent or carer. The table below shows the full detail of the comments added.

It's usually linked to the school so if I had a concern I would escalate it to them. However, I've worked with them in the past to directly seek support such as counselling for children with their families' consent.
discuss with manager - appropriate advice can be decided / discussed
Signpost to other professionals who may be able to offer advice/support.
Joint supervision with social worker and managers, Supervision with line manager
I would suggest referral to connect 2 health
Speak with SLT Senco.
raise in supervision and signpost
Abide by Frasers Guidelines and Gillick Principles and respects the young persons right to confidentiality in line with safeguarding procedures
everything that is relevant
Not applicable to my role
I would make a referral to a specific service, such as connect for health, or advise the parent/carer to make a GP appointment, or call 111 for advice.
Flag with social worker
I would refer to the teacher or TA
It could be a mix of all the options, it would depend on the subject
Speak to the CYPs parent/carer.
We can offer support on health needs but if it were to surpass the advice that we were able to give or became a cause for concern we would then both communicate with the young persons professionals and seek further support for the young person either via: Doctors, dentist, Opticians, hospital or other relevant services.

Section 4: What do you want or need to know about children or young people's health to improve the support you offer?

Question 14: Are there areas of children's physical health that you feel you need to know more about to improve the support you offer?

Respondents were then asked 'Are there areas of children's physical health that you feel you need to know more about to improve the support you offer?'. Nearly half (43.9%, n=43) of the respondents said 'not sure'. A further 38.8% (n=38) said 'yes', whilst 14.3% (n=14) said no. A small minority (3.1%, n=3) did not answer.

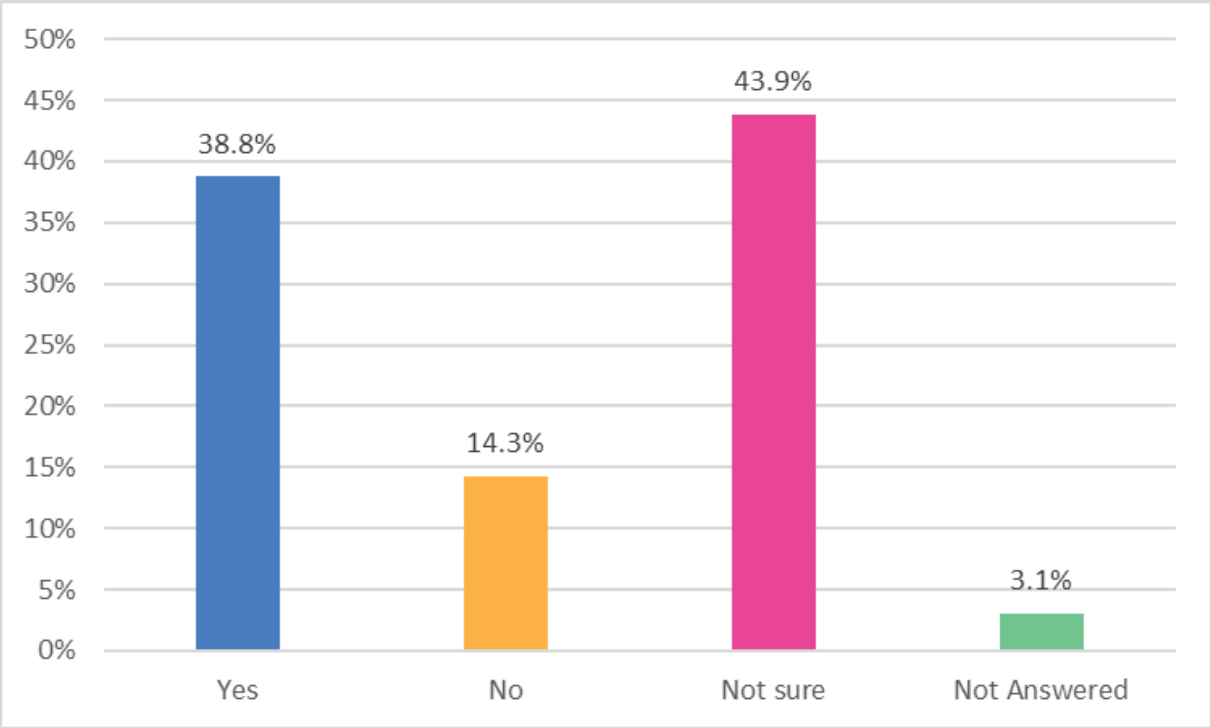

Figure 14 - Are there areas of children's physical health that you feel you need to know more about to improve the support you offer?

Respondents who answered "Yes" to question 14 were asked what areas they would like to know more about. The responses are summarised below.

Theme	Explanation	Examples for Illustration
Physical health conditions or concerns	Respondents highlighted several physical health conditions or concerns that they would like to know more about. These included: • Sexual health • Adolescent health • Long term health conditions • Learning disabilities and difficulties. • Toileting	*"Sexual health is always a big issue that needs to be discussed but can often present a number of barriers. I am also not confident in menstrual cycles and how to discuss those with young ladies so I feel that I would struggle in those situations."*

	• Sleeping issues • Drugs & alcohol • Eating & nutrition • Oral health • Infections • The impact of long COVID. • Personal hygiene Some respondents said they could do with more knowledge on physical health in general, without mentioning specific areas. There was one response wanting more knowledge on toileting specifically relating to those with autism.	*"An over view of all areas especially around teenagers and adolescents and the struggles they may have."* *"I would like to know more about chronic health issues, however this might be something that would come up as and when we needed for children we look after."* *"More needs to be offered by way of educating people/parents/carers/professionals around children who suffer trauma, attachments difficulties, neurodivergence. Many are not well adverse in understanding children who are, for example ADHD, autistic, dyslexic, or have attachment and trauma. These are huge issues that need to be addressed as the gap is widening and children and young people needs are not be met through a lack of awareness, understanding, insights and services."* *"Toileting – particularly in autism community as they often withhold."* *"I would also like to have more information and training to hold supportive conversations about eating when there are serious concerns (e.g. binge eating, eating disorders).* *"I actually don't know much about oral health other than brush your teeth twice a day."* *"Long term covid and impact on physical health"*
Services & support	Several responses said they would like more information on services and support in the county to help them know where to refer for different physical health issues.	*"An easy guide on how to refer and who to for certain things i.e. sexual health would be really useful as a lot of the time we refer back to the GP which may not always be the most appropriate."*

	One response said they would like to work more with services to provide more activities promoting physical development. One response said they would like more child friendly information on physical health that they can share with children. Respondents identified different areas of services and support they would like to know more about, including: • Healthy lifestyles and weight management • Sexual health • Parenting support • Tics and tourettes • Continence	*"The directory of services that are available and what support they offer."* *"I work in a children's nursery and I wish we would cooperate more with some service to provide and deliver more activities promoting physical development. From my experience it's all up to us and us only even if we do not have enough knowledge or resources. My dream would be to have proper PE lessons for the children, lead by a physical education specialist. Nursery practitioners are not PE teachers, some of us do not even have a basic ability to do any sports with the children."* *"More child friendly info on all topics (resources) to share with children."* *"What support is available for: Healthy lifestyles/weight management Risky sexual behaviours Parenting support"* *"Tics and Tourette's. Not from the perspective of offering direct support, but where support could be accessed from."* *"Continence support"*
Knowledge of the picture of children's physical health	Some respondents wanted to know more about the picture of children's physical health in the area. This includes information/data relating to the physical health of children, and best practice approaches identified by children to support their physical health, including overcoming barriers.	*"Information about how active children and young people are. How many children are not active but would like to be but to not pursue this due to actual or perceived barriers. This would help us to start breaking down these barriers and look at how the work we do can improve the physical environment to allow them to be more active."* *"Knowing about physical health of children in our village would help us target work we do".*

		"What the 'right' way or best practice way is that children themselves have said they would like improved support on." *"Difficulties (very personalised experiences, to come from service user). Day to day experiences – impacts that are often unheard/unseen barriers."*
Mental health	Some respondents identified the link between mental health and physical health and wanted more knowledge on how to understand this link. One respondent also wanted to know more about mental health.	*"When working in mental health it is important to understand the context in which the symptoms happen, the frequency, intensity and duration – as many symptoms can cross over with physical health needs."* *"Mental health"*

Question 15: Which statement most closely aligns with your view on services and support for these broad areas of children and young people's physical health?

Respondents were then asked 'Which statement most closely aligns with your view on services and support for these broad areas of children and young people's physical health?', the responses are demonstrated in Figure 15.

Nearly a third (29.6%, n=29) of respondents felt that services for toileting, sleeping and eating, were difficult to access and don't meet need, which was more than any other area of health. When looking at support that is easy to access and meets need, the areas of health with the highest levels of agreement were healthy lifestyles and alcohol (22.5%, n=22), drugs, smoking and vaping (22.5%, n=22). A quarter of respondents (25.5%, n=25) felt that services for long term health conditions met need but were difficult to access. This was higher than any other health area.

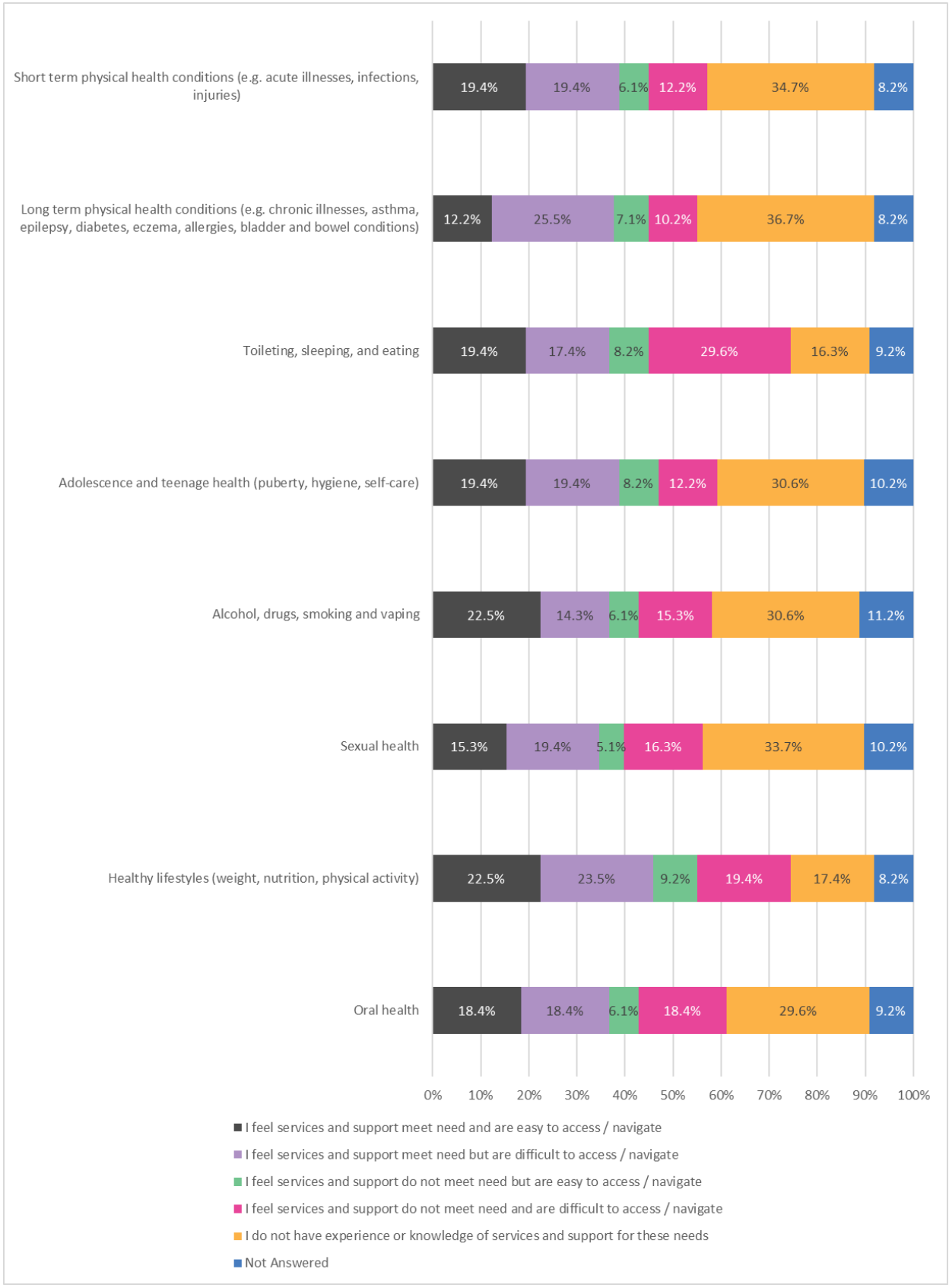

Figure 15 - Which statement most closely aligns with your view on services and support for these broad areas of children and young people's physical health?

There was an option to pick 'other', most respondents did not answer this part of the question, though 10.2% (n=10) responded with the option 'I do not have experience or knowledge of services and support for these needs'. There were 3.1% (n=3) of respondents who felt services were difficult to access and didn't meet need, whilst 4.1% (n=4) felt services met need but were difficult to access. One respondent said services are easy to access but don't meet need. Two respondents said services were both easy to access and met need. Respondents were also given an opportunity to provide more detail in a free text box under question 15. Three comments were provided as below.

Parents sometimes find it difficult to access health needs after 5 years of age and upwards and it is limited eg toileting/soiling if the child has autism in mainstream schools as school staff are reluctant to intervene due to their restrictions etc
Support for children with neurodevelopmental needs such as ADHD and autism is very difficult to access and these children are being failed.
Waiting lists for families to see support around sleep in any age child is ridiculous and many have to wait to see an adult service before getting any useful support. This has a long term impact on parents who may have different views about approaching sleep with young people/kids/infants and as no one may be getting sleep can leave to break up of parental relationships etc

Question 16: If you would like to explain your answers to question 15 please comment below. – is there anything you would like to add about the provision of clinical and preventative/lifestyle services for children's physical health?

Respondents were given an opportunity to expand on their answers to question 15. Answers are captured below.

Theme	Explanation	Examples for Illustration
Access	Respondents highlighted different access concerns, including: • Lack of GP and primary care health appointments. • Knowing how to access support. • Lack of capacity in all services and long waiting lists. • Access to dental care for children with SEND. • Access to services for students. • Barriers to training opportunities. One respondent highlighted that dentists are available throughout Warwickshire.	*"Access to GP and other primary care health appointments is not adequate for need and families do not know where to get support for common health concerns. Inadequate general health education and support for all families to help reduce demand on more specialist support".* *"Lack of GP appointments for short term medical conditions* *Lack of continence service in Warwickshire* *Lack of sexual health services accessible in the community for young people".* *"You need the knowledge on how to access the support and it's not always easy."*

		"All services are lacking capacity. The impact fluctuates depending on specific needs (sometimes trends) of people accessing services." *"Long waiting lists and caseloads".* *"In terms of oral health, I have come across several cases where parents have not been able to access dental care for their child who has SEND. I have worked with families who have struggled to get GP appointments to get a referral to see the paediatrician when their child has ongoing medical needs related to their SEND."* *"There needs to be more services to support student access to "appropriate support". EG: service needs that are listed above are available (GP covers some/dentists etc), but it's getting those students to locations/to access the support when required/before required…before crisis point."* *"As a team we are provided with vast and various training opportunities but often met by barriers in the way due to funding from local councils, especially the CRG who continue to not understand the needs and burden of care that comes with having a child with PMLD requiring 24/7 care. These families are constantly fighting to receive the basic care their child is entitled to."* *"Oral health – dentists are available throughout Warwickshire".*
Signposting and referral	Respondents highlighted challenges with knowing where to signpost or difficulty navigating to find signposting opportunities.	*"Other than googling NHS website or asking drs I do not know where to go".* *"As a professional, I occasionally find it challenging to navigate around pages to find the correct*

	There was also a suggestion that lead professionals refer for specialist advice and provide contact details.	*service to support when helping families".* *"Our service is strictly mental health, any concerns of physical health needs we signpost."* *"I would suggest lead professional refer for specialist advice and provide contact details".*
Information	Respondents highlighted that sharing key messages and data would help to provide information that could then prompt further understanding about key challenges and how to support children and young people experiencing them.	*"Advice and conversations about being active could be included more broadly within practice – helping practitioners to understand the benefits to young people of being active, the full breadth of opportunities to be active (formal in informal), supporting young people to work out how they would like to be active in a way which works for them or co design new activities and be able to support young people to access these opportunities."* *"I believe we have a lot of data and evidence surrounding physical health however, I feel we need to use this data positively to bring about change. The data we have childhood obesity is startling and I think would shock a lot of people. Rather than using the data though to shock we should use the data to say this is why its so important we make our streets safer, its why we should factor this information with a lot more weight than we currently do. If we look at nations which have lower rates of obesity they have better access to sports facilities and infrastructure that supports children and young people to travel actively and independently. The impact of doing this is exponential. It would save the NHS millions if not billions, it would decrease levels of diabetes, decrease levels of obesity and, reduce congestion if more people are travelling actively. This in turn also would improve air quality and*

		reduce the health risks posed by poor air quality."
Other	One respondent was concerned about the availability of interpreters and translations in the NHS. Another respondent suggested some families may struggle to get help over certain subjects due to a fear of stigma.	*"NHS services are under a legal obligation to provide interpreters and translations for linguistically diverse groups, but on occasion, I have had to challenge service providers who are failing in their duty. In some cases I have referred medical services to Equip to challenge at NHS Trust level."* *"Often certain subjects such as sexual health a family may not reach out for help with due to stigma."*

Section 5: Your experience of mental and physical health together.

Question 17: When supporting children and young people with their health as part of your work, what is the balance between supporting physical health needs and mental health/emotional wellbeing needs?

Respondents were then asked 'When supporting children and young people with their health as part of your work, what is the balance between supporting physical health needs and mental health/emotional wellbeing needs?'. Only one response could be given. Just over half (52%, n=51) of respondents said that they supported with mental health most of the time (Figure 16). A further 11.2% (n=11) said they supported with mental health slightly more than physical health. These two figures suggest that professionals responding to the survey tended to support with mental health more than physical health. There were 10.2% (n=10) of respondents who said they supported with physical health most of the time and a further 7.1% (n=7) who said they supported with physical health slightly more than mental health. For 17.4% (n=17) of respondents, the balance between mental and physical health was about the same.

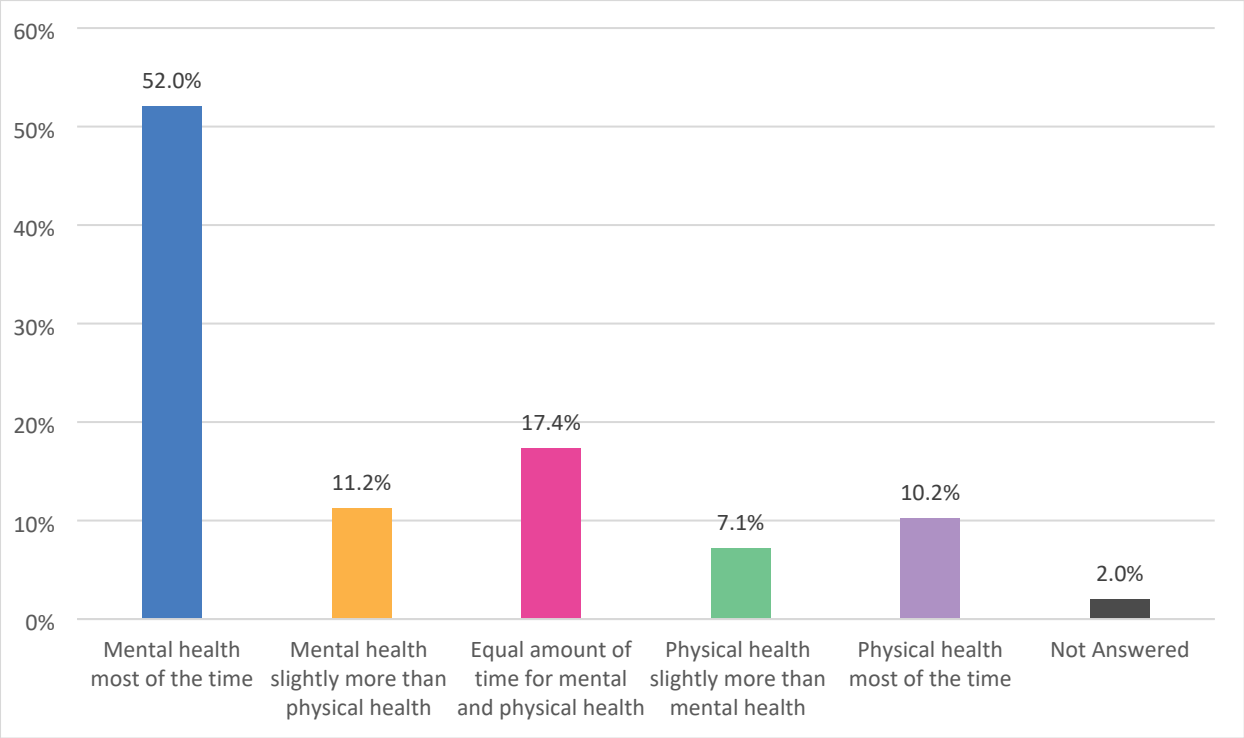

Figure 16 - When supporting children and young people with their health as part of your work, what is the balance between supporting physical health needs and mental health/emotional wellbeing needs?

Figure 17 below shows the responses to this question by professional sector. For youth work, all respondents said 'mental health most of the time'. The majority of professionals from Education, Social Work, Family support, Youth work and Community work, supported with mental health more than physical health. For Health, there were slightly more professionals (n=11) working to support physical health, than those working mostly to support mental health (n=9).

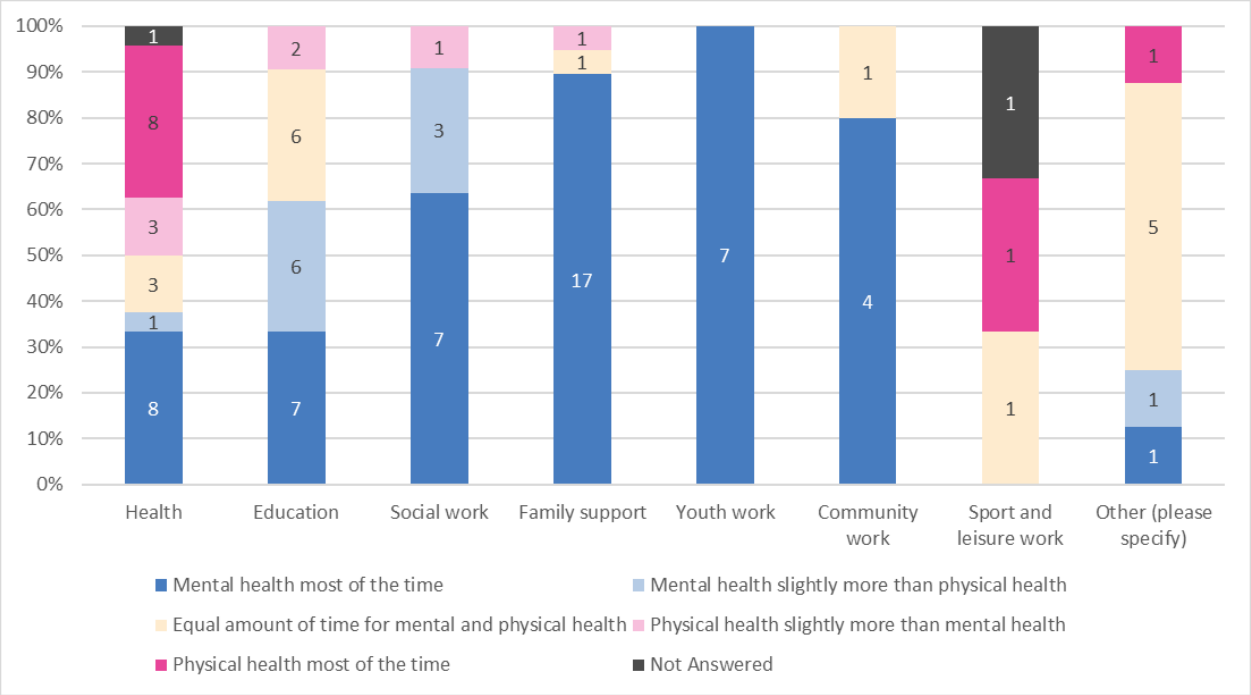

Figure 17 - When supporting children and young people with their health as part of your work, what is the balance between supporting physical health needs and mental health/emotional wellbeing needs?

Question 18: Have you ever used physical health interventions with the aim to also support mental health and wellbeing? For example, encouraging someone to take part in a sports activity to support their physical activity and their mental wellbeing.

Respondents were asked a follow up question 'Have you ever used physical health interventions with the aim to also support mental health and wellbeing?'. The majority of respondents (81.6%, n=80) responded 'yes'. Just under a fifth (18.4%, n=18) of respondents said 'no' (Figure 17).

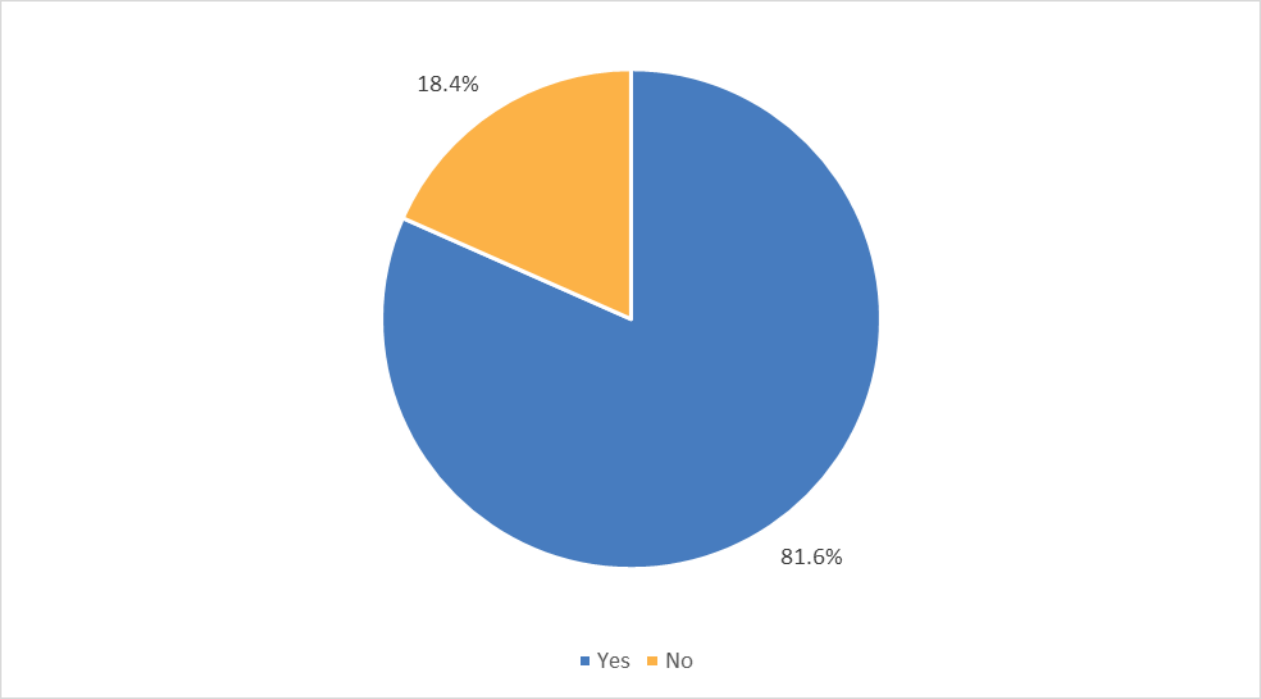

Figure 18 - Have you ever used physical health interventions with the aim to also support mental health and wellbeing? For example, encouraging someone to take part in a sports activity to support their physical activity and their mental wellbeing.

Question 19: If you are supporting a child or young person with mental health needs, how often would you also consider their physical health needs?

Another question was then asked; 'If you are supporting a child or young person with mental health needs, how often would you also consider their physical health needs?'. One response could be given. Nearly half (42.9%, n=42) said they also consider physical health needs 'all the time' (Figure 18). A further 35.7% (n=37) said most of the time, meaning the majority of professionals responding to the survey supported physical health alongside mental health for the majority of the time.

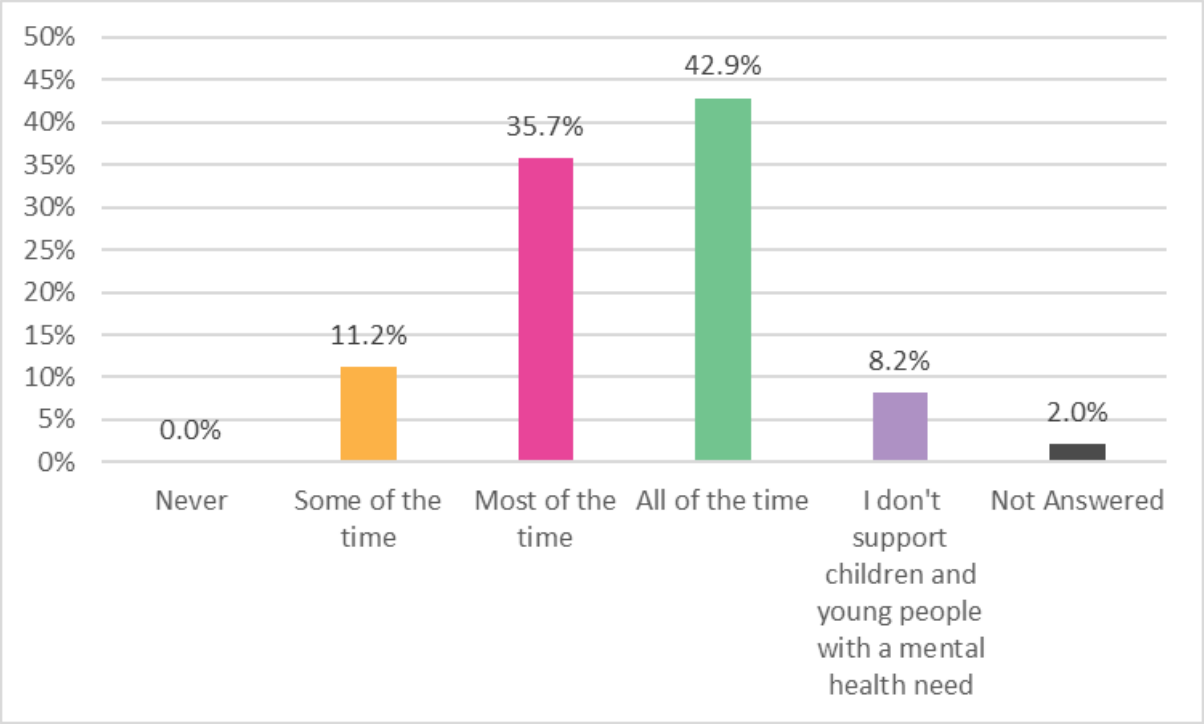

Figure 19 - If you are supporting a child or young person with mental health needs, how often would you also consider their physical health needs?

Question 20: How strongly do you agree or disagree with the following statements?

In response to this question, the majority of respondents strongly agreed or agreed that they felt confident offering general advice and guidance about both mental health (75.5%, n=74) and physical health (69.4%, n=68) (Figure 20). Most respondents also said they had a good knowledge of resources and services to support both mental and physical health. The proportion of respondents who said this about mental health (72.5%, n=71) was higher than physical health (56.1%, n=55). However nearly a quarter (22.5%, n=22) of respondents disagreed or strongly disagreed with the statement 'I have a good knowledge of resources and services available to support children and young people's physical health'.

When responding to the statement 'I feel confident talking to children and young people about their mental health', 77.6% (n=76) of respondents said they agreed or strongly agreed.

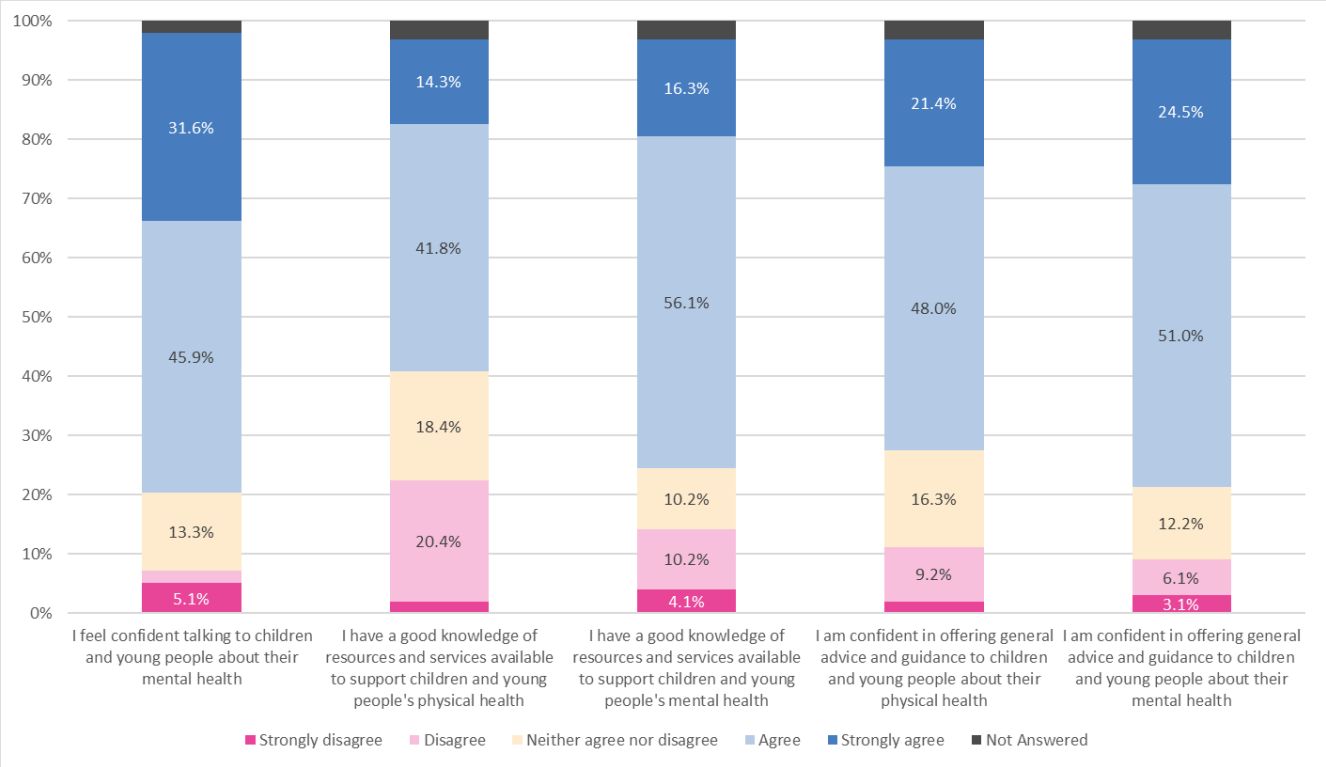

Figure 20 - How strongly do you agree or disagree with the following statements?

Question 21: If you would like to explain your answers to question 20 please comment below. – Would you like to provide any comments to explain your answer to questions 18-20?

Respondents were given the opportunity to expand on their answers to question 20. The answers are summarised below.

Theme	Explanation	Examples for Illustration
Relationship between Mental Health and Physical Health	The majority of the responses which mentioned a relationship between MH and PH discussed how the two are interlinked and overlap, with a few of the responses going into further details/highlighting other themes. A response from a Tier 2 service (working within a children's MH team) highlighted that mental and physical health seem very separate and stated they only felt confident discussing physical health due to a previous role they had had. It was mentioned that the quality of services can directly impact on both mental and physical health.	*"I work predominantly in physical health but this does overlap with mental health."* *"I see a significant amount of children presenting with physical health symptoms secondary to mental health difficulties"* *"I feel confident to talk to children/young people about their physical health, however I think this is only due to my previous role in a health visiting team rather than the role I have within a children's mental health team now. Physical & mental health seem very separate. However, I'm assuming this is*

	Regarding schools, it was mentioned that despite the respondent recognising the link between mental and physical health, they did not feel this was the case within schools	*because it's a tier 2 service therefore needs to be more 'specialist'."* *"Where can they really go to get the help they need whilst they're on the long waiting list? Their mental and physical health declines and then you have a serious issue to resolve. Whereas earlier intervention would make their lives better sooner, not ruin their childhood AND save money on acute services. It's a poorly resourced system and children are being failed."* *"Mental and physical wellbeing are clearly linked, I don't think that message is what schools understand yet and often I deal with the fall out with young people who have struggled with e.g. a long term health concern that school don't seem to consider impacts on their general wellbeing"*
Confidence levels	Part of the question asked respondents to rate their confidence on offering general advice and guidance about children's mental and physical health. There was a mix of responses, with some stating a confidence in just mental health or just physical health and some stating feeling confident in both physical and mental health. Examples of confidence in mental health included feeling able to discuss topics with children and young people and the ability to refer to services where appropriate, with one going into more detail about the mental health specific training/tools they are equipped with which gives them confidence to support children and young people. Some responses stated they felt the need to seek support from a colleague when discussing mental health.	*"It's part of the job - support the service users"* *"I feel confident to talk to children/young people about their physical health, however I think this is only due to my previous role in a health visiting team rather than the role I have within a children's mental health team now. Physical & mental health seem very separate. However, I'm assuming this is because it's a tier 2 service therefore needs to be more 'specialist'."* *"I work predominantly in physical health but this does overlap with mental health. If I feel the mental health aspect is out of my remit I will liaise with colleagues & make referrals where needed."* *"As i work with CYP with mental health needs daily, I feel confident in addressing this topic and providing*

	One response stated a confidence in knowing what the correct response would be for a mental health referral, but a lack of options available/wait lists make it difficult to support the child	*advice moreso with guidance of supervision for complex cases."* *"I have worked alongside children who suffer with mental health. I have trained in emotional resilience, drawing and talking to support, MH first aid, knowledge of what services are available online and face to face, an able to refer to services and have built up good relationships with services and children to offer them support"* *"For mental health we use cas and mind but waiting lists are long for diagnosis and edpsych are not available. We know what to do but cannot find support easily that is specific to that child's needs"*
Referrals	Some of the responses spoke about making referrals and when this would be – all of the responses which spoke about referrals were related to children and young people and mental health.	*"If I feel the mental health aspect is out of my remit I will liaise with colleagues & make referrals where needed."* *"If I feel that a young person is struggling with their mental health I will advise them to speak to a GP and request counselling services."* *"I have worked alongside children who suffer with mental health. I have trained in emotional resilience, drawing and talking to support, MH first aid, knowledge of what services are available online and face to face, an able to refer to services and have built up good relationships with services and children to offer them support"*
Services	Some of the responses brought up the services which are currently available, again mainly focusing on mental health. None of the responses were positive when speaking about the services, with quite a few being named as being inadequate to support the mental	*"I feel we need more services available to support with this growing need as they are mainly reaching crisis point intervention"* *"The real issue is the delay in camhs and the delay in school counselling"*

	health needs of children and young people. Those named included CAMHS. A few responses identified the long wait times for services as being a problem and spoke about the need to services to be available before it becomes crisis point intervention	*"For mental health we use cas and mind but waiting lists are long for diagnosis and edpsych are not available."* *"I know about the services but the services aren't good enough. The CAMHS waiting lists are disgraceful and no where near meeting young person need. Where can they really go to get the help they need whilst they're on the long waiting list? Their mental and physical health declines and then you have a serious issue to resolve. Whereas earlier intervention would make their lives better sooner, not ruin their childhood AND save money on acute services. It's a poorly resourced system and children are being failed."* *"Cahms service info sometimes sends you around in circles to gain the info needed to support and if this is like this for myself then what is it like for parents especially if the parent has learning needs themselves which is sometimes the case"*
Other	One response recognised the impact of the pandemic on children and young people's wellbeing and mental health and the importance of keeping up to date with the evolving needs of children and young people.	*"I keep myself updated of the mental health needs of children and young people as this is important especially since the pandemic and the impact this has had on our children's everyday wellbeing and mental health."*

Section 6: Your experience of vulnerable children and young people

Question 22: We know that some children and young people experience health inequalities which can make them more vulnerable to poor health outcomes than others. Do you ever work with any of these groups, and have you ever given them support with their physical health?

Respondents were then asked whether they have worked with or support the health of specific groups of children that may be more vulnerable to poor health outcomes. The groups where the largest proportion of respondents said they worked with and supported their health, were; children and young people open to social care (43.9%, n=43), children and young people in care (40.8% n=40), and children and young people who are care experienced (37.8%, n=37) (Figure 20). In contrast, young carers (36.7%, n=37) were the group for which the highest proportion of respondents said they had worked with but not supported physical health. Most respondents (60.2%, n=59) had not worked with children and young people who are part of military families.

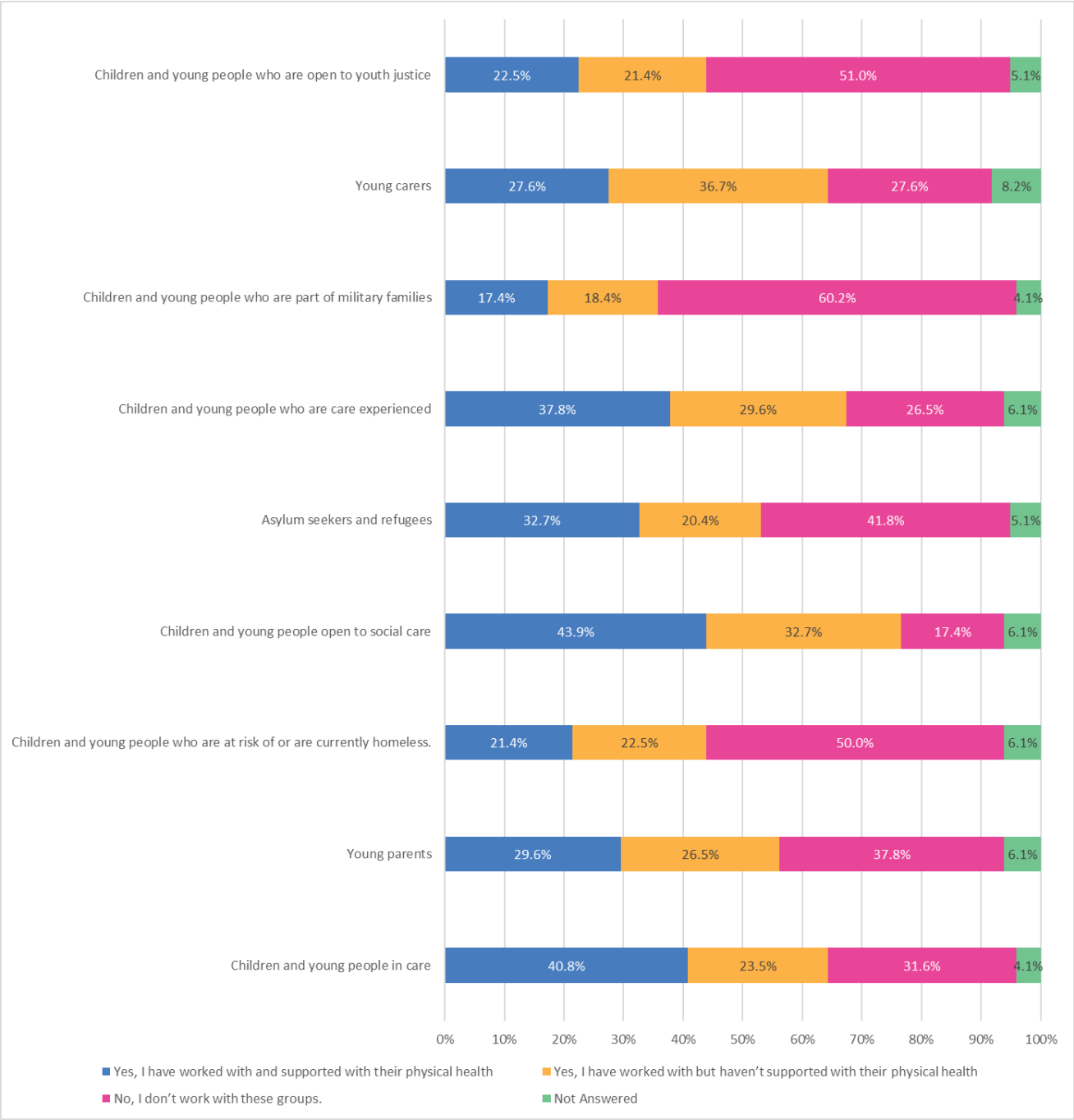

Figure 21 - We know that some children and young people experience health inequalities which can make them more vulnerable to poor health outcomes than others. Do you ever work with any of these groups, and have you ever given them support with their physical health?

There were numerous respondents that added further detail in the free text box, relating to other groups they support within their work. These comments are shown below. There were six mentions of children and young people with disability, SEND or complex needs. Other comments highlighted additional groups.

Disabilities and bereavement
CYP with Special Educational Needs

Children with identified additional needs
Pupils from GRT communities
I have put that I don't work with these groups however it is not that I don't work with this group, its that I have not as of yet
children with disabilities
I work with families experiencing poverty
Children with complex needs
Insight tells us that girls are less likely to be active than boys and that young people from an ethnically diverse community, living in a deprived area or who are living with a disability or long term health condition are less lively to be active. The Active Lives children's survey provides more detail on young peoples attitudes and behaviours to being active: https://activelives.sportengland.org/
I work with asylum seeking families . A large part of my role is health /medical .
LGBTQ - mental and physical health.
SEND

Question 23: If you would like to share your experiences of supporting these groups with their physical health please comment below (please only talk about general experiences and please do not include any identifiable information about individual children, young people or families).

Respondents were asked if they'd like to share any experiences of supporting these groups with their physical health. Answers are summarised below.

Theme	Explanation	Examples for Illustration
Supporting children and young people	There were few responses to this question, however of those that did answer, majority spoke about the ways they support children and young people and their physical health. Some of the ways in which this is achieved are: - Signposting to improve access - Encouraging children and young people to join physical clubs (such as sports clubs) - Referrals to GP - Referrals to sports centres - Referrals to services One response detailed some examples of work being done to improve children and young people's physical health, such as	*"support all areas - focus is service user. Role is to support (education), but signposting is big part of improving all round access / service user health and well-being"* *"Encouraging young people to join sports clubs e.g. football; rugby; boxing"* *"Referred and supported to local sports centres, GP, other services etc that can help their physical health in the long and short term"* *"We have examples from both our work and from across the Network of Active Partnerships and our partners such as Streetgames of projects which use sport/physical activity to support vulnerable young people. Happy to share these"* *"Streetgames have also developed a CYP social prescribing toolkit which may be of interest https://www.streetgames.org/2023/12/04/toolkit-childrens-social-prescribing/"*

	Streetgames, and had a link to a toolkit which is available	
Access	Access to services was brought up a couple of times, with the following factors being identified as having an impact on access: - Poor knowledge/understanding of services - Not knowing how to access services - Transport - Financial impact Mental health services were mentioned in one response which stated they are underfunded despite seeing a rise in poor mental health amongst children and young people, and stated there is a need to improve this.	*"These families often struggle with poor knowledge or understanding of services, how to access and difficulties with transport/financial impact of attending appointments"* *"Services for children and young people can be difficult to access for example children experiencing mental health issues. We know mental health services are poorly funded and yet the increase of deteriorating mental health in the young is staggering. I feel we need to more within this area to improve quality of life and aspirations for young people by supporting them with education, training, employment and housing options."*
Services	As above, mental health services and their importance were mentioned by one respondent. Another mentioned that families who are experiencing health inequalities may not have the knowledge of what services are available to them and may be held back by other constraints, such as transport or finances	*"Services for children and young people can be difficult to access for example children experiencing mental health issues. We know mental health services are poorly funded and yet the increase of deteriorating mental health in the young is staggering. I feel we need to more within this area to improve quality of life and aspirations for young people by supporting them with education, training, employment and housing options."* *"These families often struggle with poor knowledge or understanding of services, how to access and difficulties with transport/financial impact of attending appointments"*

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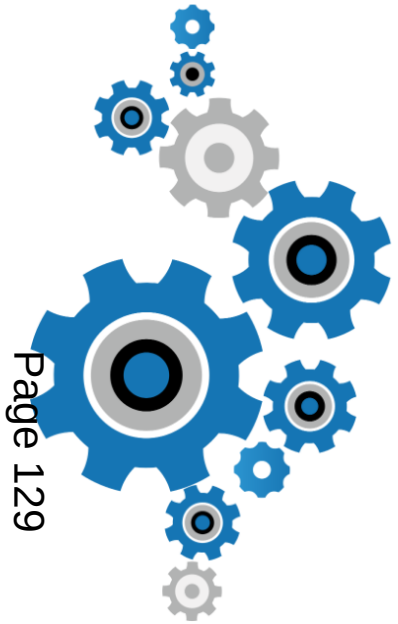


Warwickshire JSNA

Joint Strategic Needs Assessment

Welcome to the

Empowering Futures: Growing Up Well in Warwickshire

Interactive Report

An assessment of the physical health of school-aged children

Use the arrows at the bottom of the page to progress in order Next →

Or use the menu to navigate to a particular page MENU

This JSNA is an interactive report. Use this page to understand how you can interact with each page to understand the information and change the data displayed.

Page context
Read the text in the grey boxes to understand the context for the page and the key messages for the topic.

Hover over an (i) symbol for more detail, and some can be clicked for an external link.

External links may also be found with the text.

Category Slicer:

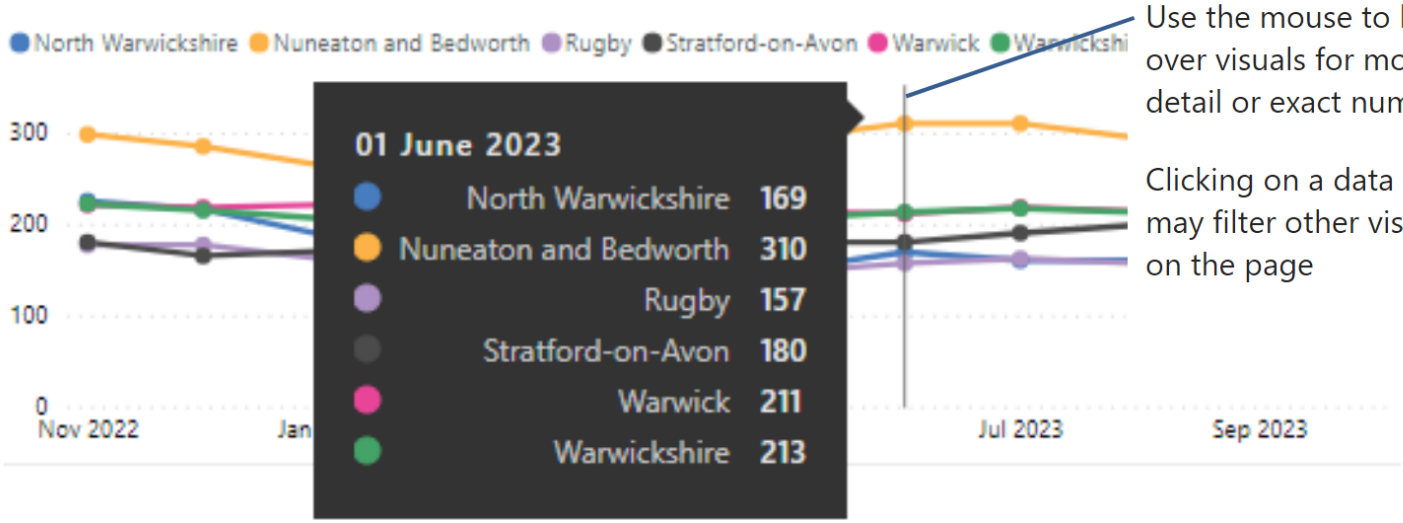
Selected
Not selected
Not selected

On many pages you can change the data or text displayed by changing the option on a slicer to a different category. For example, you might be able to display data for a specific area or age range. The slicer clearly shows which category is currently selected.

Use the arrows at the bottom to navigate Next →

or click the MENU at the top left. MENU

Graph titles highlight key messages



Use the mouse to hover over visuals for more detail or exact numbers

Clicking on a data point may filter other visuals on the page

Information on the sources for the data and the methodology used are found at the bottom of the page

What is the Joint Strategic Needs Assessment?

The purpose of the JSNA programme is to analyse the current and future health and wellbeing needs of the local population to inform the commissioning of health, wellbeing, and social care services. It aims to establish a shared, evidence-based consensus on the key local priorities across health and social care.

The Health and Wellbeing Board is statutorily responsible for developing joint Health and Wellbeing Strategies based on the assessment of need outlined in the JSNA. To find out more about Warwickshire's Health and Wellbeing Board click here.

A JSNA can be used as an evidence base to inform strategic action including commissioning and delivery of services, as well as informing activities such as funding bids and equality impact assessments.

The different aspects of JSNA can be broken down as the following:

Joint

They are carried out jointly by health, local authorities, and community and voluntary organisations to produce a picture of people's needs and to help them work together to find answers to those needs.

Strategic

They identify the 'big picture' of the health and wellbeing needs and differences across Warwickshire. They do not find out the needs of individual people.

Needs

They set out to find what people require to help their health and wellbeing and to identify where these requirements are not being met, and recognise the strengths and assets of the population.

Assessment

Facts and figures, together with people's knowledge, experience and opinions are used to find out what people's current and future needs are. The JSNAs use a wide range of data collected from different sources including the Census, GPs, hospital admissions, social services, housing, police, leisure, education, voluntary and community organisations.

For more information and past JSNAs, please visit the Warwickshire JSNA page.

This JSNA examines the picture of physical health in school-aged children and young people. One of the priorities of the Warwickshire Health and Wellbeing Board is to "Help our children and young people have the best start to life", and this JSNA completes a set of three JSNAs exploring the physical health and wellbeing of children, having completed a 0-5 JSNA in 2022 and a Mental Health and Wellbeing of Infants, Children, and Young People JSNA in 2023. These have informed and will continue to shape the development of the Children and Young People Making Every Contact Count (MECC) training programme.

This JSNA is structured around the six school-aged high impact areas for children's health, which focus on factors that have the greatest potential for improving health outcomes for children, young people, and their families.

Developed in 2014 and updated in 2016, these were established nationally alongside the maternity and early years high impact areas to provide a comprehensive picture of 0-24 services, under the Healthy Child Programme. Locally, this shapes Warwickshire's School Health and Wellbeing Service and this JSNA dashboard will be used as a key evidence base for future service development.

The 6 school-aged high impact areas for children's health are:

- High Impact Area 1: Supporting resilience and wellbeing
- High Impact Area 2: Improving health behaviours and reducing risk taking
- High Impact Area 3: Supporting healthy lifestyles
- High Impact Area 4: Supporting vulnerable young people and improving health inequalities
- High Impact Area 5: Supporting complex and additional health needs
- High Impact Area 6: Supporting self-care and improving health literacy

Front Page | How to use | About the Joint Strategic Needs Assessment | Context for this JSNA | Conclusions

High Impact Areas

Supporting Resilience and Wellbeing	Improving Health Behaviours and Reducing Risk	Supporting Healthy Lifestyles	Reducing Vulnerabilities and Improving Life Chances	Supporting Additional and Complex Health Needs	Supporting Self-care and Improving Health Literacy
Introduction	Introduction	Introduction	Introduction	Introduction	Introduction
tbc	Drugs and Alcohol	Nutrition	Demographics	Asthma	Self Care
tbc	Injuries	Oral Health	Health Impacts	Diabetes	Immunisations
Survey Results	Sexual Health	Physical Activity		Epilepsy	School Absence
	Smoking and Vaping	Obesity		Speech, Language and Communication Needs	Transitions
	Teenage Conceptions				

Further Information

Recommendations 2024 | **Methodology** | **Warwickshire JSNA Homepage**

Supporting Resilience and Wellbeing

Nationally, the prevalence of children and young people with a mental health condition has been increasing. Mental health has a direct impact on an individuals ability to thrive, including impacting their education, relationships, and development. Mental health also has a strong link to physical health, with physical health needs such as risky behaviours, long-term conditions or disabilities, and healthy lifestyles all impacting an individuals mental health. Similarly, those experiencing mental health are more likely to undertake risky behaviours and struggle with healthy lifestyles.

In 2022 Warwickshire County Council completed a Mental Health and Wellbeing of Infants, Children and Young People JSNA which looked at the mental health needs of the 0-25 year old population in Warwickshire. This can be see in more detail here - Mental Health and Wellbeing of Infants, Children and Young People

Key Findings:

•

Previous: Context

Full details of the methodology used for this page are available on the Warwickshire JSNA page.

Next:

A range of people working or volunteering with children and young people were engaged with in winter 2023 through the Empowering Futures survey. One of the survey's aims was to better understand how people recognise the link between mental and physical health.

The 2023 Mental Health and Wellbeing of Infants, Children, and Young People JSNA highlighted the interplay between mental and physical health and the need to approach both together in a holistic way to ensure the best outcomes for children and young people.

Professionals and practitioners therefore need confidence with health promotion messaging that includes support for both physical and mental health.

Explore this page to see a summary of results from this engagement.

82% **of respondents said they had used physical health interventions with the aim of also supporting mental health and wellbeing.**

79% **of respondents said they consider physical health when supporting mental health needs all or most of the time.**

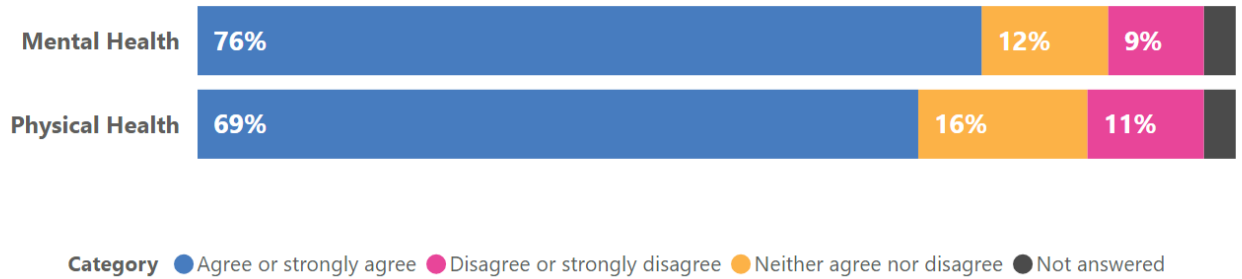
The Empowering Futures JSNA survey asked people who work or volunteer with children or young people whether they agreed or disagreed with statements related to physical and mental health.

Select a statement:

I am confident in offering general advice and guidance to children and young people about their:

I feel confident talking to children and young people about their:

I have a good knowledge of resources and services available to support children and young people's:

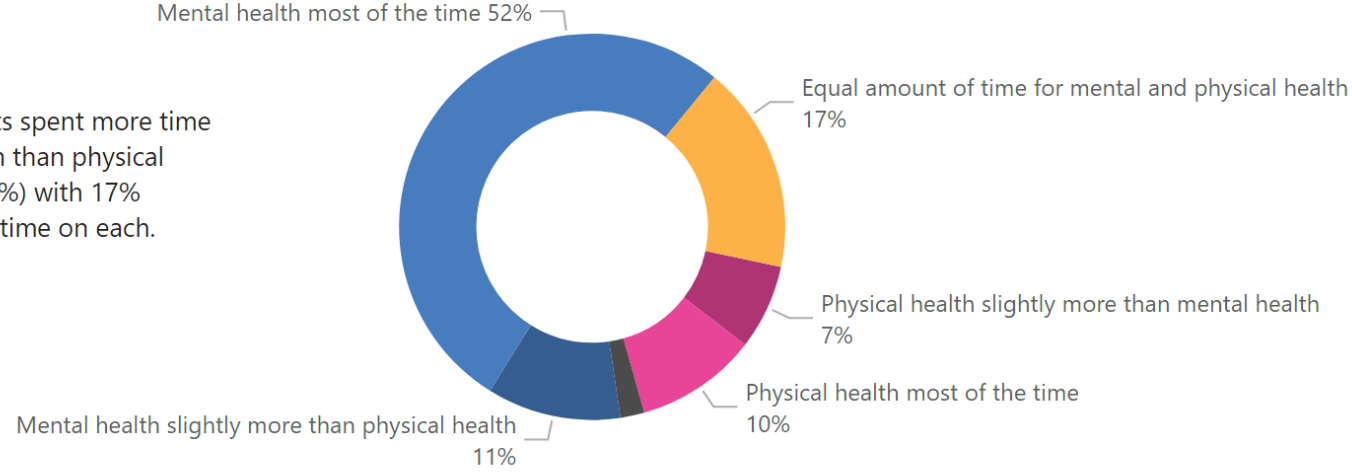


Respondents were more confident talking and giving advice about mental health than physical health.

When asked whether they knew about resources and services related to physical health, fewer respondents agreed than for mental health (56% vs. 72%)

What is your work balance between supporting physical health needs and mental health/wellbeing needs?

A majority of respondents spent more time supporting mental health than physical health needs (63% vs. 17%) with 17% saying they spend equal time on each.



Full details of the methodology used for this page are available on the Warwickshire JSNA page.

Improving Health Behaviours & Reducing Risk Taking

As children and young people grow and develop they will seek out new experiences, and some experimentation is healthy and normal. However, risky behaviours can expose a child or young person to harm or impact their development. This can be influenced by peer pressure, social media, friends, family, and the wider community.

This section includes sexual health, conceptions, smoking & vaping, alcohol & drugs, and injuries.

Key findings:

- Warwickshire HPV vaccination rates are above the national average.
- Chlamydia screening rates in 15-24 year olds are low. Improving this will help prevent hidden infections that can have serious reproductive health consequences.
- Whilst under-18 conception rates have been falling across Warwickshire, there is variation in rates across the county.
- Whilst smoking rates have been falling, more can still be done to support smoke-free homes.
- In recent years the number of children and young people who vape has become a growing concern. Vapes are not risk free, with illegal vapes becoming more dangerous as illicit substances are added with no regulation. If you don't smoke, you shouldn't start to vape.

The data presented on this page show, per month, the average number of visits to A&E in the previous 12 months. This helps to smooth out monthly fluctuations, allowing trends to be seen more clearly. A visit is counted where alcohol or drugs was a contributing factor, for example a fracture but the patient is under the influence. These rates are then split by area and age.

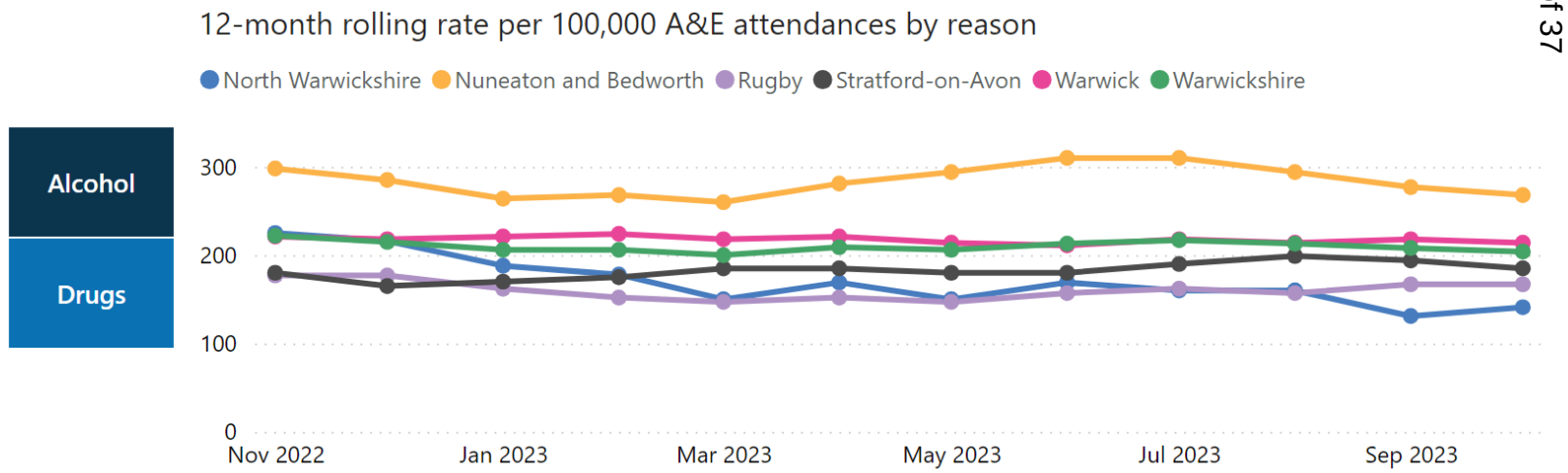
Over time excessive alcohol use can lead to the development of chronic diseases and other serious problems including high blood pressure, liver disease, cancer and a weakened immune system.

"Binge drinking" – consuming a lot of alcohol in a short space of time – can be extremely dangerous and stop your body from working properly. This puts you at greater risk of accidents, alcohol poisoning and other short and long-term health issues.

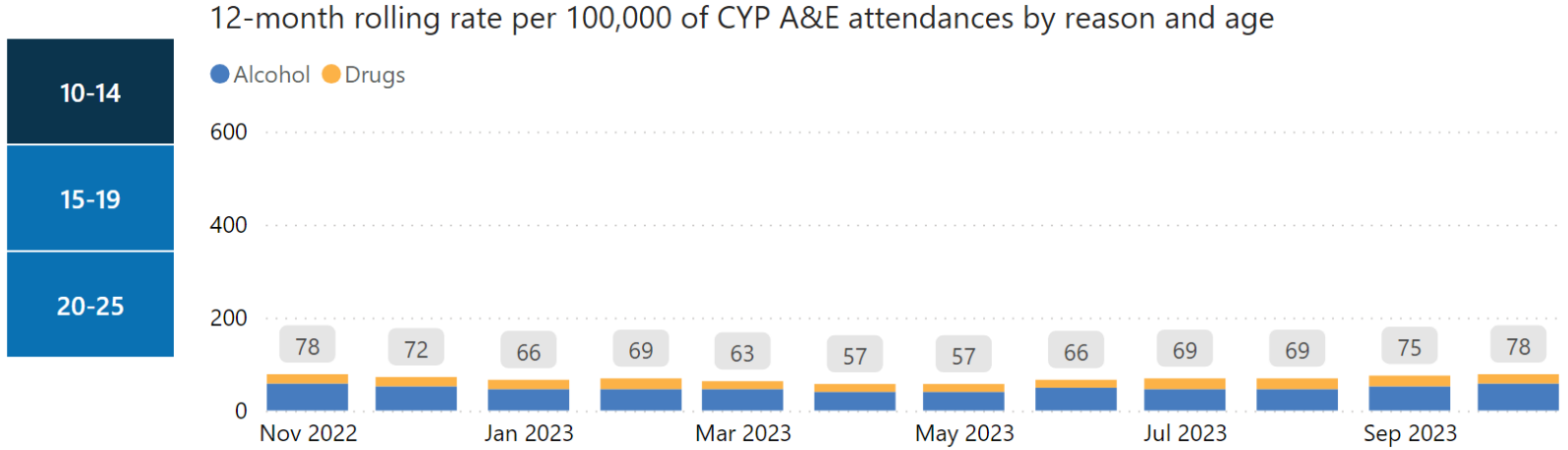
Recreational drug use comes with risks. Some drugs are highly addictive and can significantly impact your health. Support is available for anyone in Warwickshire affected by alcohol and/or drugs.

Overdoses of opioid drugs can be reversed using a Naloxone kit which are available at some local services. Contact the Warwickshire Drug & Alcohol Service - Change Grow Live for more information.

Alcohol-related A&E attendances rates are highest in Nuneaton & Bedworth. Drug-related attendances are much lower, with recent data showing a decrease in Warwick and a slight increase in Nuneaton & Bedworth



In Warwickshire overall, both alcohol and drug-related A&E attendances are highest in the 15-19 age group. There is a consistent demand on A&E throughout the year in all age groups



← Previous: Improving Behaviours Intro

Full details of the methodology used for this page are available on the Warwickshire JSNA page.

Next: Injuries →

Injuries are major causes of ill health and disability in children and young people.

Unintentional injuries are injuries where there is no evidence of intention to cause harm, while intentional injuries are those that are purposefully inflicted. Unintentional injuries in Warwickshire vastly outnumber intentional injuries.

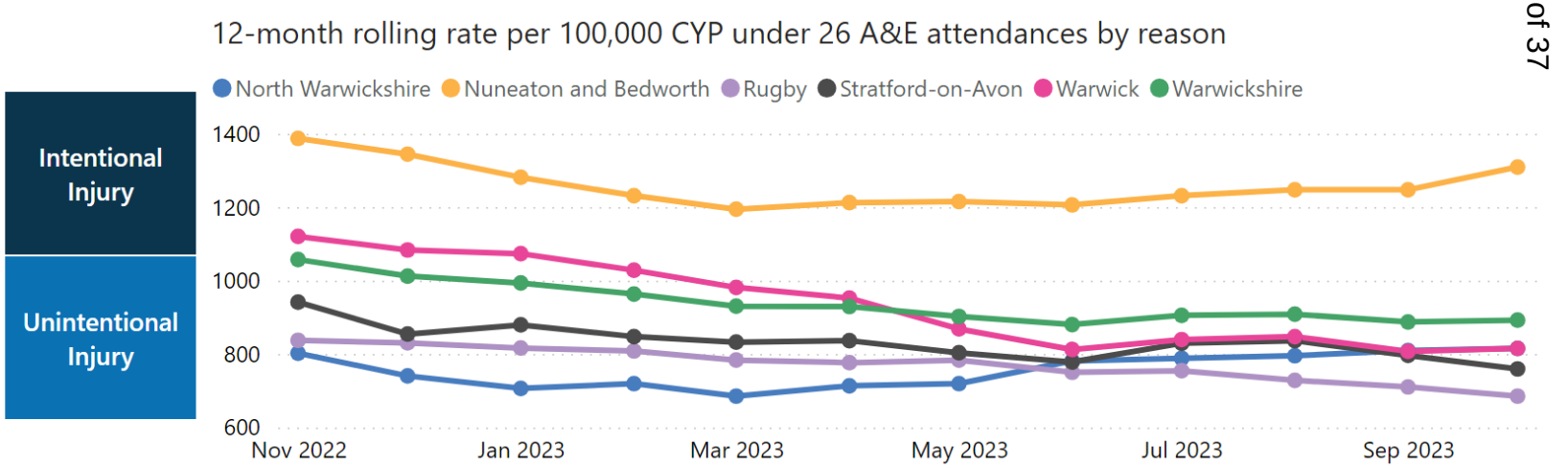
The data presented on this page shows, per month, the average number of visits to A&E in the previous 12 months. This helps to smooth out monthly fluctuations, allowing trends to be spotted more clearly. These rates are then split by area and age.

In 2022/23, the 5 highest reasons for A&E visits in those aged under 26 in Warwickshire for unintentional injuries were:

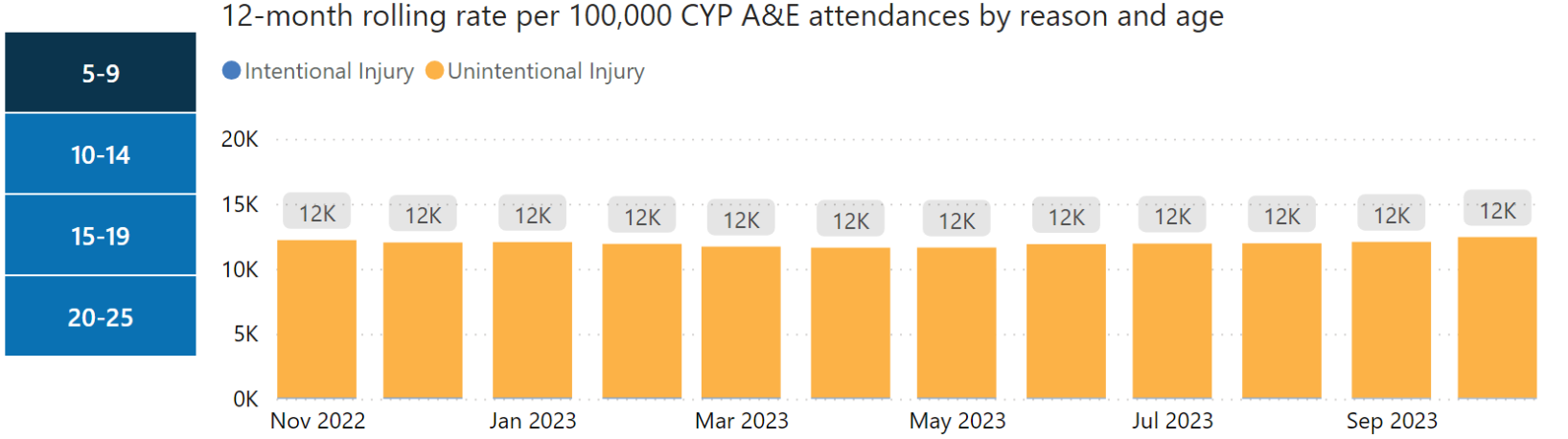
- Injury of upper extremity
- Injury of lower extremity
- Head injury
- Laceration (deep cut or tear in the skin)
- Facial injury

For intentional injuries, the main reasons for A&E visits were poisoning, self-injurious behaviour, and substance misuse.

Over 1 in 10 young people attend A&E per year for injuries, with unintentional rates ten times those of intentional. There is a downward trend for intentional injuries in Warwickshire but areas in the north have been rising



At a Warwickshire level, total injuries are highest in the 10-14 age group but intentional injuries are highest in those aged 15-19. Rates of intentional injury have decreased the most in those aged 10-14 and 15-19



← Previous: Drugs & Alcohol

Full details of the methodology used for this page are available on the Warwickshire JSNA page.

Next: Sexual Health →

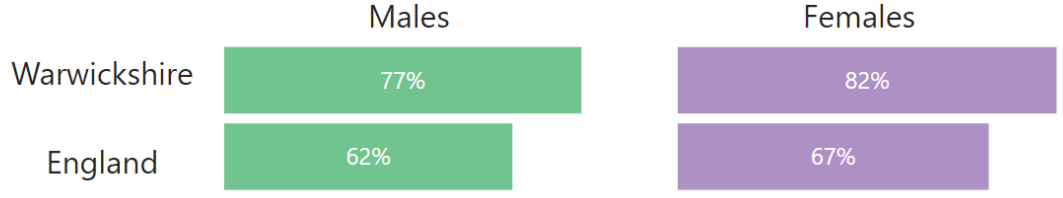
Good sexual health can have a positive impact on physical and reproductive health and wellbeing, but also interpersonal, educational, and financial wellbeing.

The Human Papilloma Virus (HPV) vaccine can protect children and young people from being infected with HPV which is known to increase the risk of developing some cancers later in life. The national HPV vaccination programme for 12-13 year-olds (year 8) began in 2008 and was initially offered to girls only. In 2019, the offer was extended to boys, and in 2023 moved from a two-dose course to a single dose vaccination offered to both boys and girls.

The chlamydia detection rate in 2022 for persons aged 15 to 24 Warwickshire was 1,397, lower than both the England average (1,680) and the national target of 3,250. Variation in rates of chlamydia detection may represent difference in prevalence but are influenced by screening coverage and whether most at risk populations are being reached. Since chlamydia often shows no symptoms, a high detection rate reflects success at identifying infections that, if left untreated, may lead to serious reproductive health consequences.

Screening in Warwickshire can be undertaken by attending the Integrated Sexual Health service, or by requesting a test kit to be posted from the online provider SH:UK.

Warwickshire has a higher HPV vaccine (2-dose) coverage in year 9 students than England, but still below the 90% coverage goal



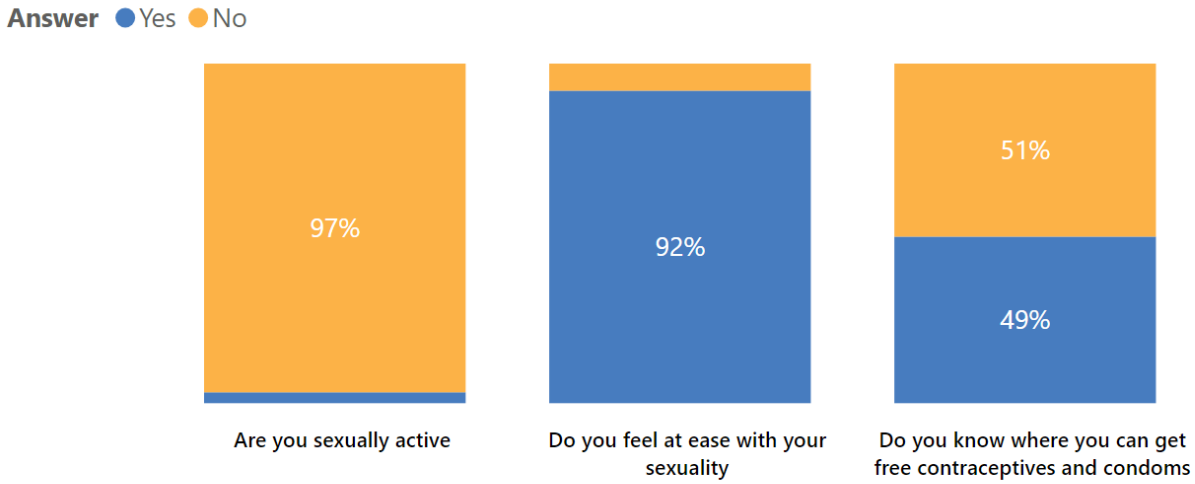
North Warwickshire	Nuneaton and Bedworth	Rugby
Stratford-on-Avon	Warwick	Warwickshire

Chlamydia screening rates are low:

In **2022** there were **900** cases of chlamydia found through screening **12.4%** of 15 - 24 year olds in **Warwickshire**.

It is estimated that there were around **4,285** cases of chlamydia for this age group in **Warwickshire**, showing an estimated **3,385** missed cases in **2022**.

In Warwickshire secondary schools, Year 9 pupils (aged 13 to 14) were asked about sexuality and contraception as part of the Health Needs Assessment.
During the 2022/23 school year, respondents from Warwickshire answered:



Previous: Injuries

Full details of the methodology used for this page are available on the Warwickshire JSNA page.

Next: Smoking & Vaping

Tobacco is the single most important risk factor for preventing ill health, disability, and death in the UK.

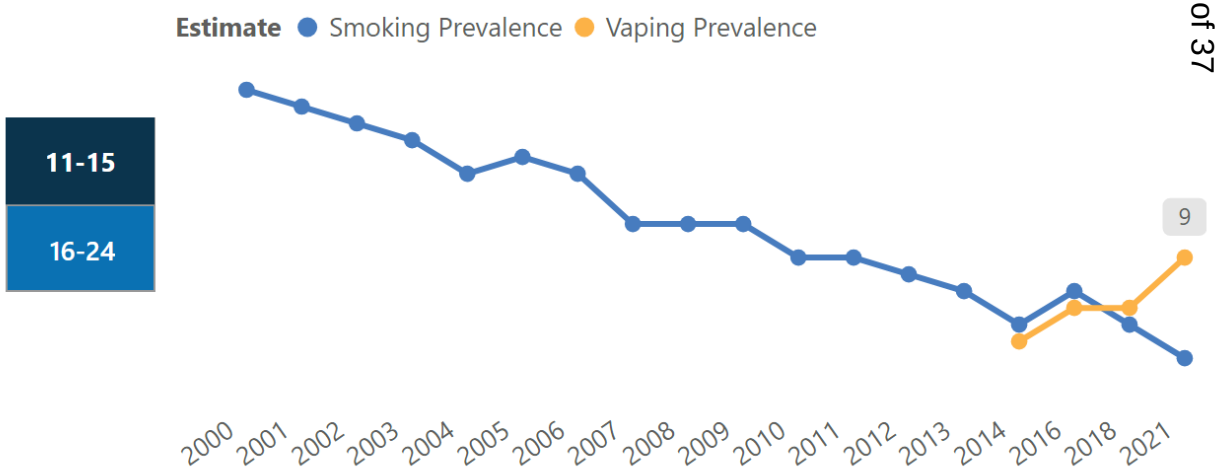
It is illegal to sell tobacco products and nicotine vaping products to anyone under 18, or for adults to buy them on behalf of under-18s. If you smoke or vape, support is available

Don't smoke? Don't start to vape. Vaping is not risk free. NICE recommends that vaping should be discouraged in children and young people. It is much less harmful than smoking and is an effective quitting aid for adult smokers.

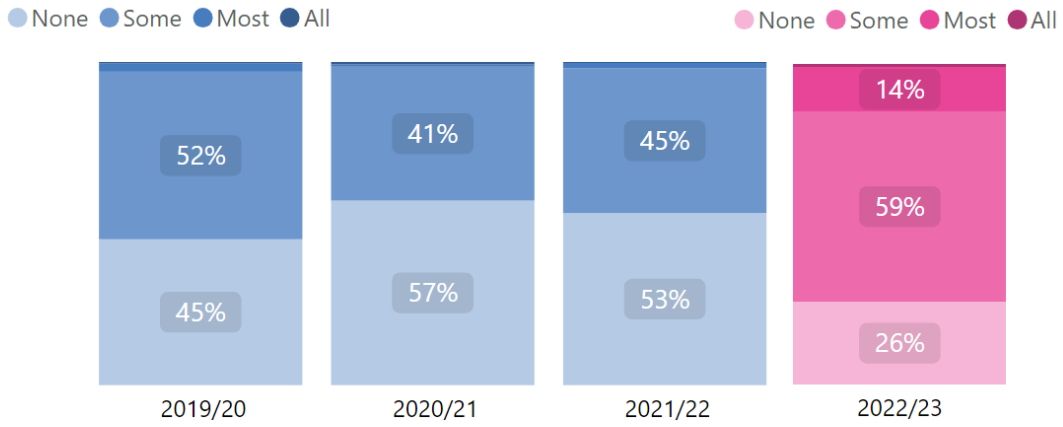
Vapes are becoming more dangerous as illicit substances are being added to vapes with no regulation. Vapes should only be bought from regulated premises.

Sales of vapes has been linked to county lines drug trafficking, if an individual is in vape-related debt or being pressured into selling vapes support is available here.

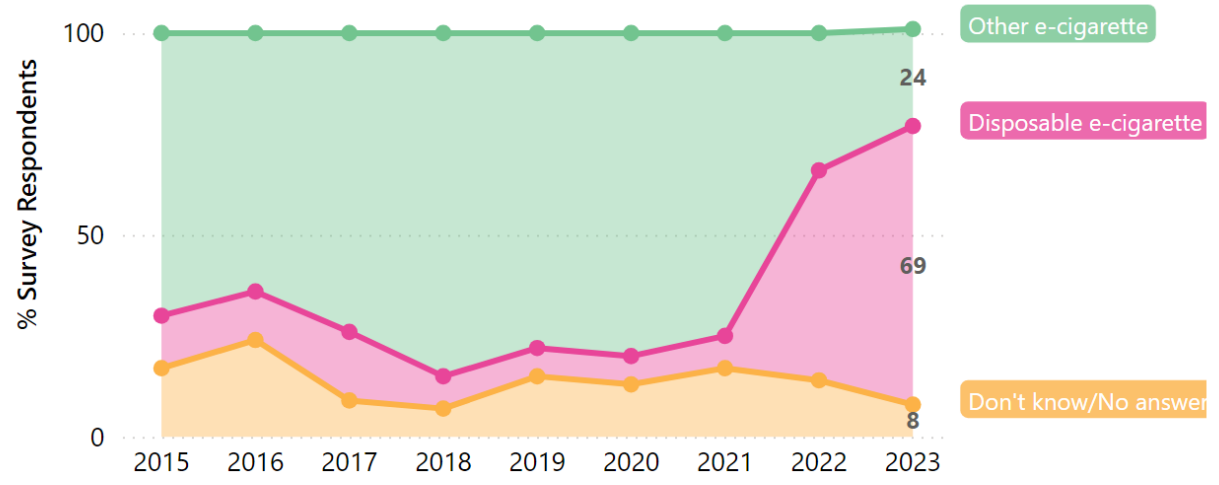
National estimates of smoking prevalence have decreased sharply in both 11-15 and 16-24 age groups. Recent data shows a fast rise in e-cigarette use, particularly in females aged 16-24



In Warwickshire, year 9 students were asked what proportion of their class smoked cigarettes. In 2022/23, the question was updated to include e-cigarettes. With the updated question, the 'none' category shrunk from 53% to 26%.



In 2021, disposable vapes flooded the market and quickly became the preferred e-cigarette amongst an increasing group of young people aged 11-17 who vape, England



Previous: Sexual Health

Full details of the methodology used for this page are available on the Warwickshire JSNA page.

Next: Teenage Conceptions

Teenage pregnancy is associated with poorer outcomes for young women and their children. For mothers, there is a higher risk of poor educational attainment, social isolation and poorer mental and physical health, whilst their children are more likely to be born preterm or with low birthweight.

The Office for National Statistics (ONS) uses the following definitions:

Conception – a pregnancy that leads either to a maternity or an abortion.

Maternity – refers to a pregnancy resulting in the birth of one or more live-born or stillborn children. The number of maternities represents the number of women giving birth rather than the number of babies born (live-born and stillborn).

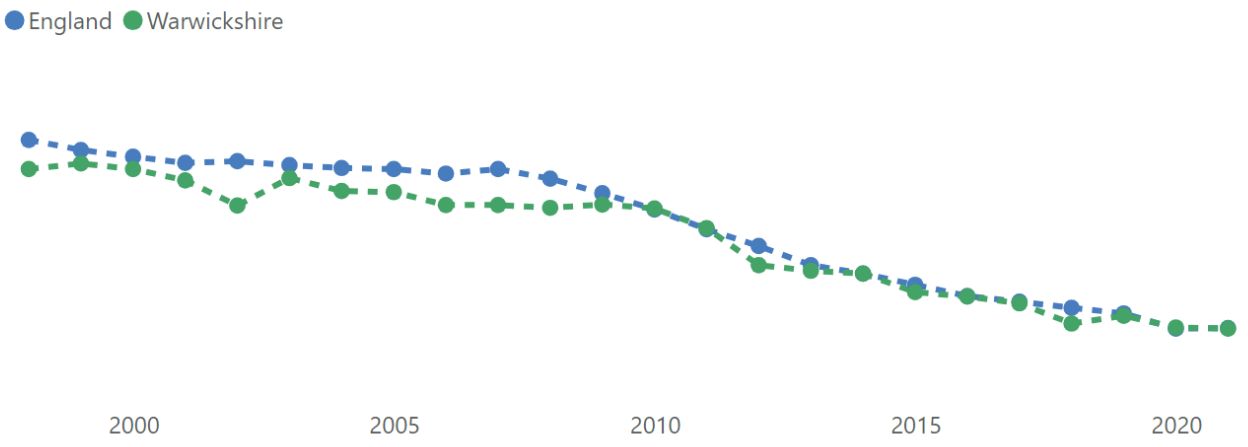
Abortion - the legal termination of a pregnancy under the 1967 Abortion Act.

Between 1998 and 2021 there has been a 69% decrease in the under-18 conception rate which is now 13 per 1,000 females. This equates to 125 conceptions in Warwickshire in 2021.

Prompt access to abortion lowers the risk of complications. In Warwickshire, the percentage of NHS-funded abortions that were under 10 weeks was 88.2% in 2021, similar to the percentage in England of 88.6%.

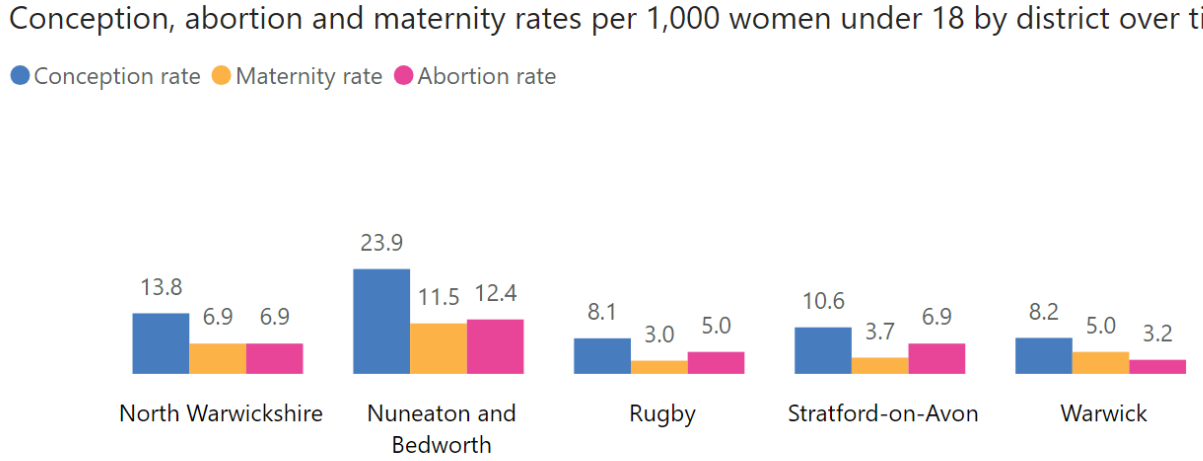
The under-18 conception rate in Warwickshire has more than halved in the last twenty years to 13 per 1,000

Conception rate | Maternity rate | Abortion rate



All districts have also seen a fall in under-18 conceptions, but with more fluctuation year-to-year. Districts in the North generally have higher rates than those in the South.

2021 | 2020 | 2019 | 2017 | 2016 | 2015 | 2014 | 2013 | 2012 | 2011 | 2010 | 2009



Previous: Smoking & Vaping

Full details of the methodology used for this page are available on the Warwickshire JSNA page.

Next: Healthy Lifestyles Intro

Supporting Healthy Lifestyles

Supporting healthy lifestyles such as physical activity, maintaining a healthy weight, good diet, and oral health, helps enable children and young people to maintain good health.

In England, people living in the least deprived areas live around 20 years longer in good health than people in the most deprived areas. Targeting support around healthy lifestyles in areas of deprivation can have a significant impact.

This section consists of healthy lifestyle indicators mapped across the county to understand variation and help better target areas of focus.

Key Findings:

- Across all healthy lifestyles indicators there is variation in, and within, District and Boroughs.
- There is a difference in uptake of Health Needs Assessments (HNA) between schools, which informs our analysis. Increasing this uptake will help to improve our view of children's health.
- There are differences in the HNA between parental (reception) and child (year 6 and 9) responses in terms of themes of concern.

← Previous: Teenage Conceptions

Full details of the methodology used for this page are available on the Warwickshire JSNA page.

Next: Health Themes Map →

Supporting Healthy Lifestyles: Nutrition

This page displays modelled data on four health themes. The results are generated using responses to the annual Health Needs Assessment (i) for three of the themes and the National Child Measurement Programme (i) for the obesity theme.

What this page can tell you:

- Results per JSNA area (i) and school year where possible, that indicate the rate of flagged health behaviours or levels of obesity.
- Insights below highlight the key information per health theme.
- Darker colours on the map indicate higher % of flagged responses.

A healthy balanced diet including daily fruit and vegetables supports healthy weight. Reducing the intake of sugar in food and drink reduces the risk of obesity and tooth decay.

Across Warwickshire, 1 in 7 children recorded flagged responses to Nutrition questions. At JSNA level this ranged from 1 in 6 (Nuneaton Common and West JSNA) to 1 in 10 children (Kenilworth JSNA and Cubbington, Lillington and Warwick District East JSNA).

Warwick and Stratford-on-Avon Districts recorded a lower proportion of flagged nutrition responses with 1 in 9 children. Comparatively, Nuneaton & Bedworth and North Warwickshire Boroughs had a higher proportion of around 1 in 6.

Reception-aged children had around half as many flagged responses compared to Year 6 and Year 9 children. This difference may be due to parent/caregivers providing responses for reception-aged children whilst Year 6 and Year 9 students respond independently.

1) Select a health theme:

Nutrition | Oral Health | Activity | Obesity

2) Explore how the rate of flagged responses varies across the county

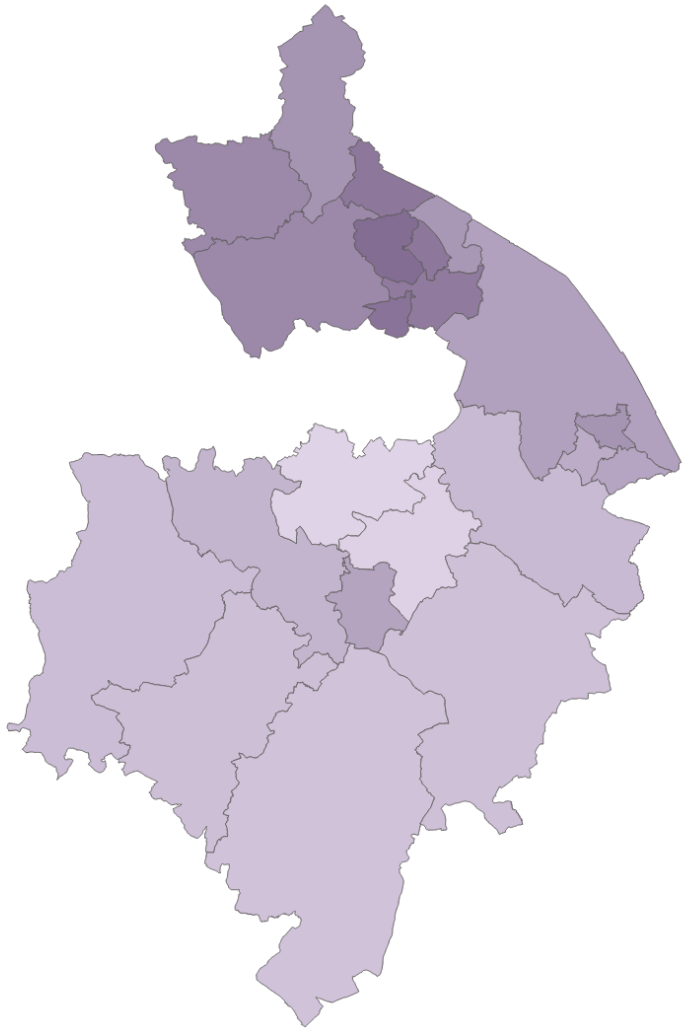
3) Filter by district to see variation within an area.

District/Borough:

- Select all
- North Warwickshire
- Nuneaton and Bedworth
- Rugby
- Stratford-on-Avon
- Warwick

4) Explore insights and components of each indicator.

Insight | Methodology



← Previous: Healthy Lifestyles Intro

Full details of the methodology used for this page are available on the Warwickshire JSNA page.

Next: Vulnerabilities Intro →

Reducing Vulnerabilities and Improving Life Chances

Vulnerable children and young people are those who are at an increased risk of experiencing negative impacts on their physical or mental health and may experience poorer outcomes due to factors in their lives. Reducing inequalities and improving the health and wellbeing of these children and young people is crucial to enable them to reach their full potential.

This section considers the size of the following populations in Warwickshire, what we know about their health, the health inequalities they may experience, and how we can support these populations locally:

- Care experienced young people
- Families at risk of homelessness
- Refugees, asylum seekers, and migrants
- Roma, gypsy, and traveller communities
- Young carers
- Young parents
- Young people working with the Youth Justice service

Key findings:

- There is a lack of available local data and information on vulnerable populations and their health needs.
- Some children and young people in these vulnerable populations may experience health inequalities which have the potential to impact across their entire lives, not just in childhood.
- A number of specialist teams that support these vulnerable populations were identified. Working with these teams, that have established trust, and developing new links will support children and young people to reach their full potential.

ll details of the methodology used for this page are available on the Warwickshire JSNA page.

Armed Forces Families
Children open to Social Care
Gypsy, Roma & Traveller
Homelessness
Refugees, Migrants and Asylum Seekers
Young Carers
Youth Justice
Young Mothers

Children of armed forces families may reside in Warwickshire permanently or temporarily while their family members are posted to the area

They are identified in two ways:

Service children registered in school census:

Children where at least one parent is serving in the regular armed forces and also pupils whose parent/s is serving in the armed forces of another nation and is formally stationed in England.

There are **446** children across Warwickshire as of **05/10/2023**

Children with service pupil premium funding:

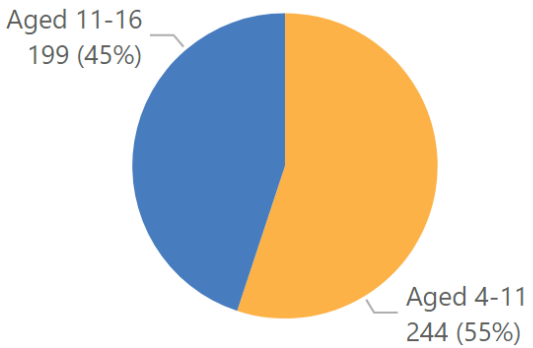
The pupil premium grant is funding to improve educational outcomes for disadvantaged pupils in state-funded schools in England. This measure includes all service children (above) but also any child who has been recorded as a service child in the last six years and those whose armed forces parent/s have died.

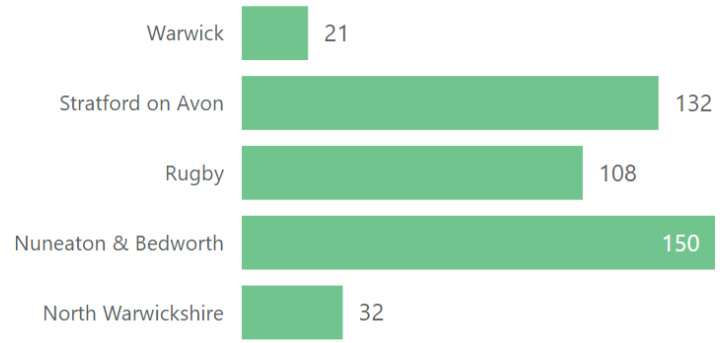
There are **530** children across Warwickshire as of **27/09/2023**

Service children registered in school census | Children with pupil premium funding

Over 80% of armed forces children and young people live in Nuneaton & Bedworth, Stratford-on-Avon or Rugby and there are more primary school aged children than secondary

Service children registered in school census by age and area, click a segment to see the area breakdown of that group





Children and young people in military families are recognised in the Armed Forces Covenant which Warwickshire County Council signed in 2012. The Armed Forces Covenant is how society recognises the unique obligations of, and sacrifices made by, the Armed Forces and Armed Forces community and provides support to them.

What do we know about the health of this group?

Children and young people in military families normally attend schools in the same way as non-service children. Many service children thrive, but the following health related disadvantages can arise:

- Mental wellbeing can be affected by a disrupted social experience, by losing access to support structures such as friends and teachers due to re-location, or being unable to be placed in the same new school as their siblings.
- Worry and anxiety caused by separation from a serving parent on deployment.
- Helping to care for other family members while a serving parent is deployed or injured.

How can we support this population?

Children and young people in military families can be supported through:

- Finding out more about their experiences and how they feel they can be best supported, in and out of a school setting.
- Supporting schools in the best use of the Pupil Premium.
- The use of the Thriving Lives toolkit within schools

Full details of the methodology used for this page are available on the Warwickshire JSNA page.

Armed Forces Families
Children open to Social Care
Gypsy, Roma & Traveller
Homelessness
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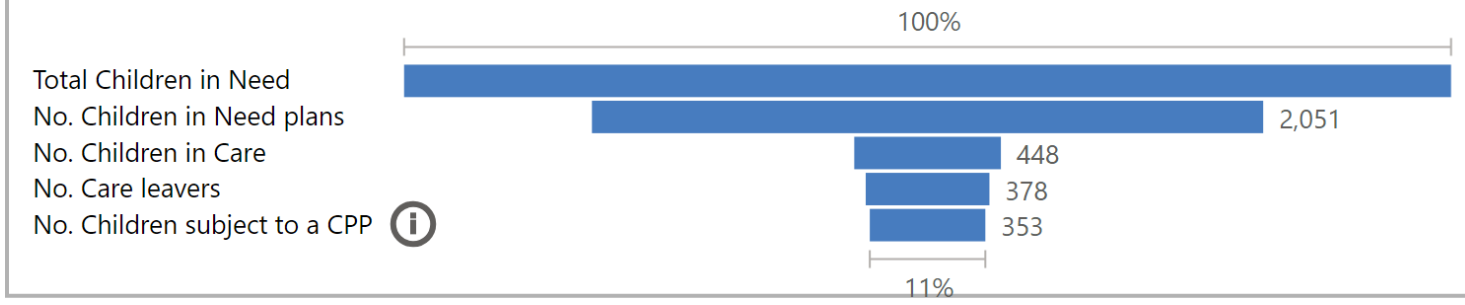
Young Carers
Youth Justice
Young Mothers

Total children in need is a measure of all children open to social care, it's made up of categories such as those on 'Child in Need Plans' and those in care. This visual shows the number of children, as of 30/11/2023, within each category in Warwickshire. Filter by district to see the variation across the county.

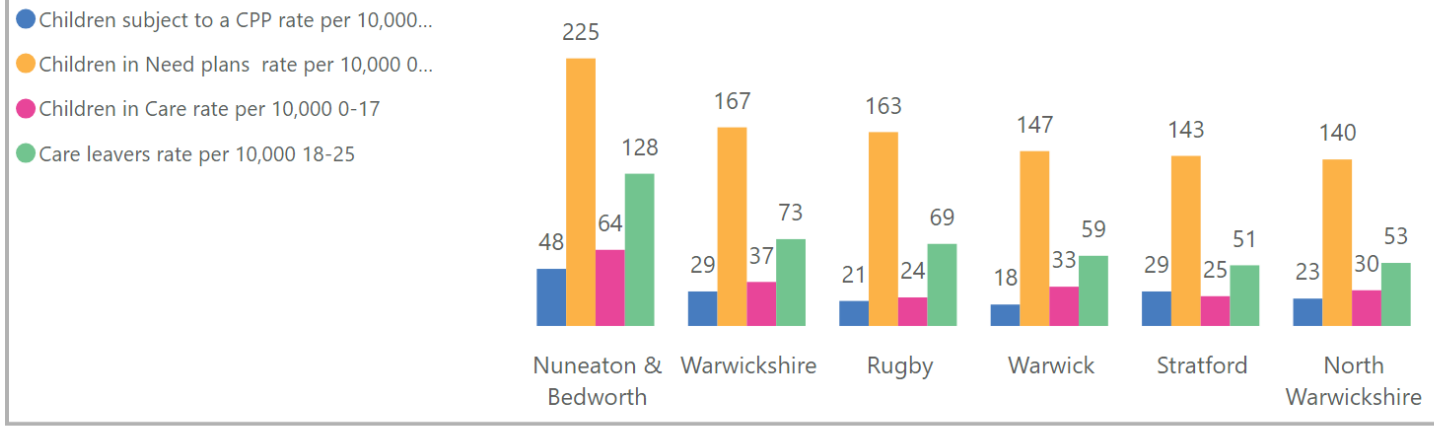
North Warwickshire	Nuneaton & Bedworth	Rugby
Stratford	Warwick	Warwickshire

No. children (aged 0-17) and care leavers (aged 18-25)



When these categories are expressed as rates per 10,000, Nuneaton & Bedworth is the highest across all districts and categories

Rates per 10,000 by category and area



Children in Need are a legally defined group of children (under the Children Act 1989), assessed as needing help and protection as a result of risks to their development or health. Children in need include young people aged 18 or over who continue to receive care, accommodation or support from children's services, and unborn children.

What do we know about the health of this group?

Children in care have regular reviews, including an annual health assessment. This is an opportunity to flag any health concerns, including healthy weight, eating, oral health, mental health, behaviour, and immunisations.

In the year to March 2023, 90% of children in care had an annual health assessment, 84% had up-to-date immunisations and 80% had their teeth checked by a dentist.

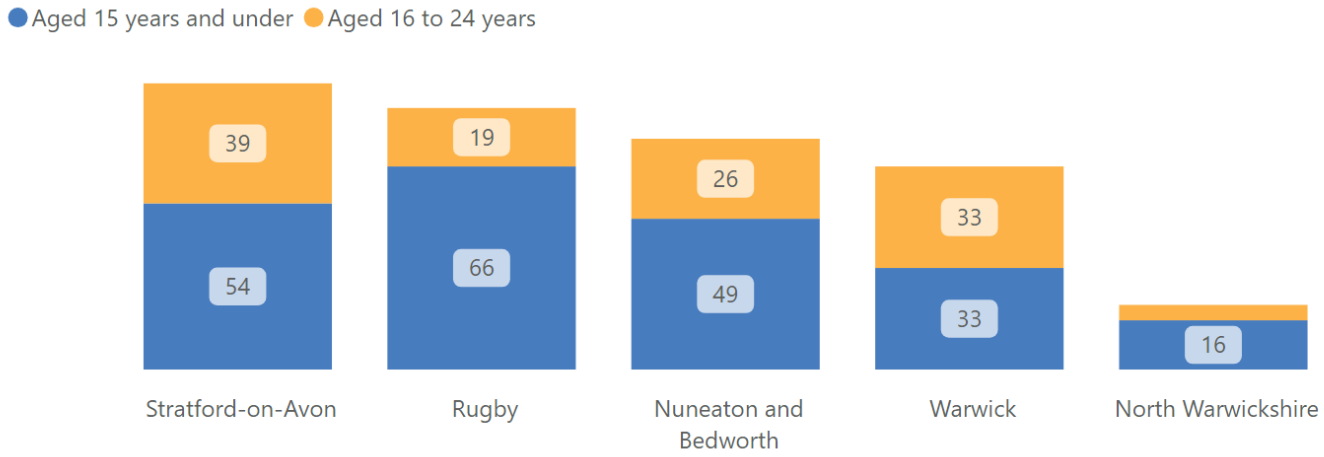
They may have issues accessing services due to potential unstable living conditions, particularly if their placement is outside of their local authority.

How can we support this population?

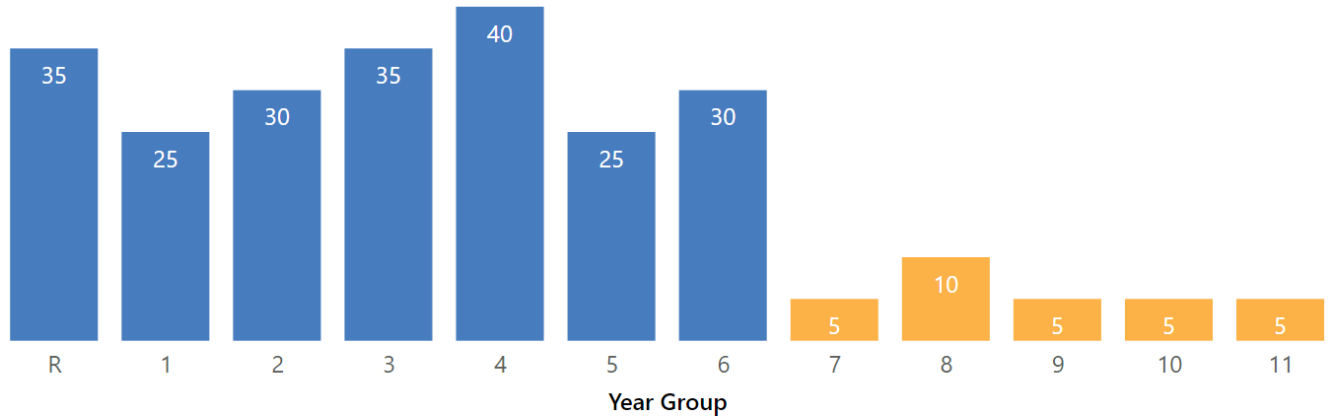
Whilst care experienced children and young people have an annual health assessment, these health assessments are not currently in a form in which it can be analysed for the purposes of this JSNA.

Developing this evidence base will help to understand the specific needs of this population locally, and therefore help to plan support and interventions.

This graph shows those reporting their ethnic group as White: Gypsy or Irish Traveller or White: Roma in the 2021 Census.



The number of pupils identifying as Gypsy/Roma or Traveller of Irish Origin drops off at secondary school.



The term Gypsy, Roma, and Traveller is used to describe a range of ethnic groups who do not have fixed habitation and regularly move to and from areas. This term includes:
- Gypsies (including English Gypsies, Scottish Gypsies or Travellers, Welsh Gypsies and other Romany people).
- Irish Travellers (who have specific Irish roots)
- Groups that travel, including but not limited to New Travellers, Boaters, Bargees, and Show-people.
- Roma, understood to be more recent migrants from Central and Eastern Europe

What do we know about the health of this group?

The data from schools and the census may not pick up the whole population. This may be due to the transient nature of the community, or prejudice may stop people declaring themselves as this community.

There is a notable drop in numbers of Gypsy, Roma, and Travellers in secondary school compared to primary. This may be due to a fear of prejudice, as

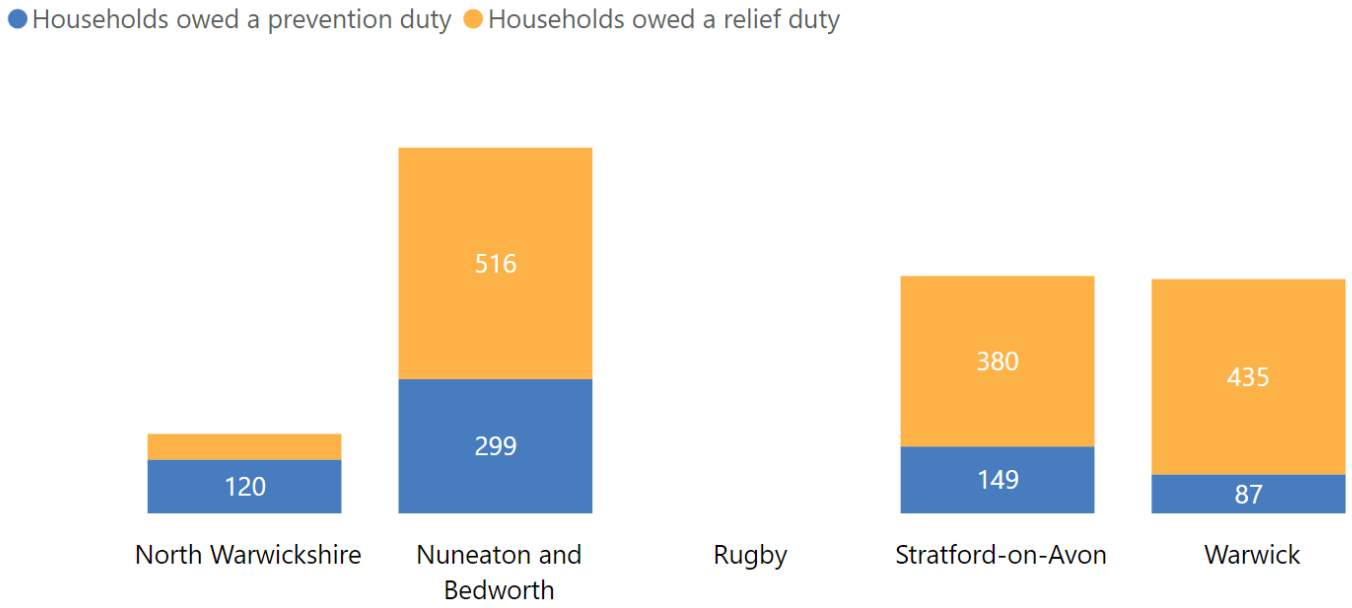
Recommended Actions to Improve:

To support the children and young people in this population, particularly those who are home schooled and not in contact with the education system, trust needs to continue to be built and discrimination removed. Working with professionals, such as the WCC GRT team, who already have relationships can help to build connections.

Help is available for those who are homeless or threatened with homelessness in the form of duties paid by local authorities. Prevention duty is granted when an applicant is likely to become homeless within 56 days and requires a local authority to help prevent them from becoming homeless. Relief duty is granted when an applicant has become homeless and requires action from the local authority to help to secure accommodation.

The chart below shows the number of households containing children that were eligible for each duty in the **2022/23 financial year**. Please note that a single household may be granted multiple duties within the same financial year.

There are greater numbers of households containing children receiving support for being homeless or threatened with homelessness in Nuneaton and Bedworth than the other Boroughs though there is a significant number across all boroughs. Rugby data is currently unavailable.



While it is possible to see all children (aged 17 and under) in households claiming duties, there is only a partial picture for those in the 18 - 25 age range. There were just over 200 duties owed where one member of the household was a young person aged 18 - 25 who required support to manage independently.

What do we know about the health of this group?

Recommended Actions to Improve:

Full details of the methodology used for this page are available on the Warwickshire JSNA page.

Refugees, migrants and asylum seeking young people can be housed in Warwickshire by the following schemes. There are an estimated 870 across Warwickshire as of 01/04/2024.

Asylum
166 19.08%

An asylum-seeker is a person who is seeking international protection and has applied for refugee status, but whose claim has not yet been determined.

Ukraine
395 45.40%

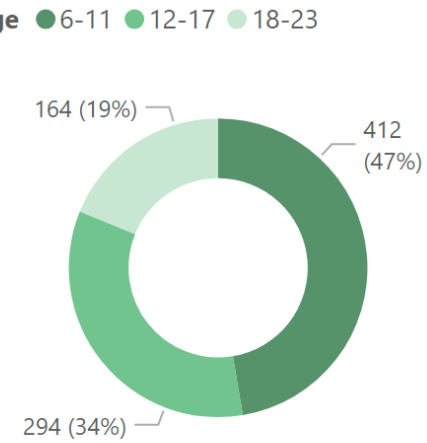
Those who have arrived via the Homes for Ukraine scheme but does not take into account those who have left or arrived via a different scheme such as the family scheme.

Resettlement
94 10.80%

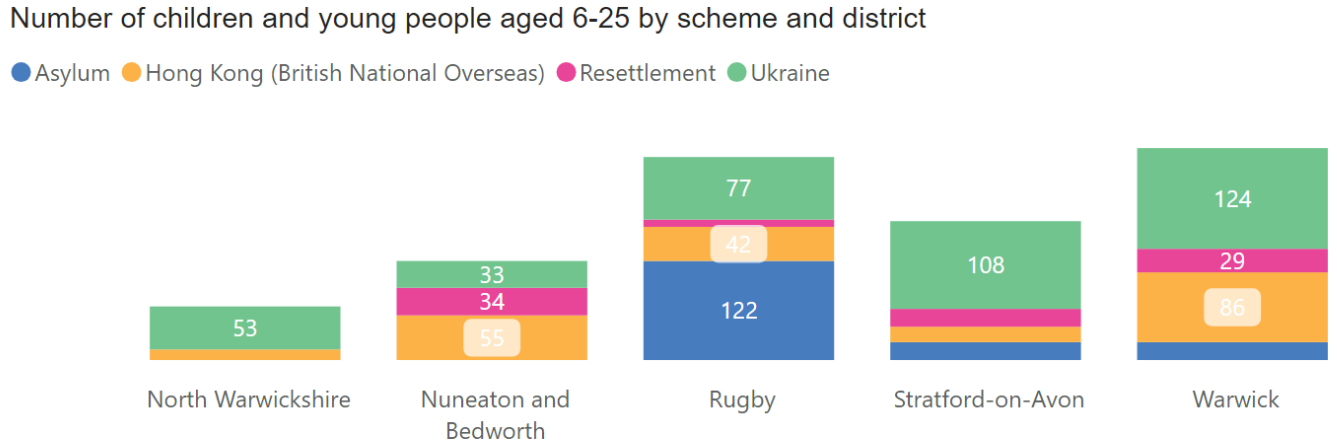
The voluntary transfer of recognised refugees from the country they were granted asylum in. This is primarily from the Afghanistan resettlement scheme.

Hong Kong (British National Overseas)
215 24.71%

The Hong Kong UK Welcome programme provides British National (Overseas) status holders and their eligible dependents opportunity to live, study and work in the UK.



Young people settled under the asylum and Ukrainian scheme are primarily in Rugby and the south of the county. Those in the HK BNO scheme are mostly in Warwick and Nuneaton & Bedworth, those without a location have been added to North Warwickshire for suppression



The schemes outlined on this page may have young people that fall into one or more of the following categories:

- **Refugees** are those who have fled their country due to conflict or persecution.
- **Asylum seekers** have also fled their country due to conflict or persecution but have not yet received a decision on their claim which would then make them a refugee.
- **Migrants** may have left their country for a variety of reasons, which may include danger to themselves, but do not classify as a refugee or asylum seeker.

What do we know about the health of this group?

The physical and mental health of refugees, migrants, and asylum seekers may deteriorate due to their experiences in their originating countries, travelling, and their experience once in the UK. This can include exposure to infectious diseases, increased stress and isolation, and a lack of access to health support and services.

Their health may vary depending on their circumstances; those in hotels or without a set address may experience a deterioration in their health.

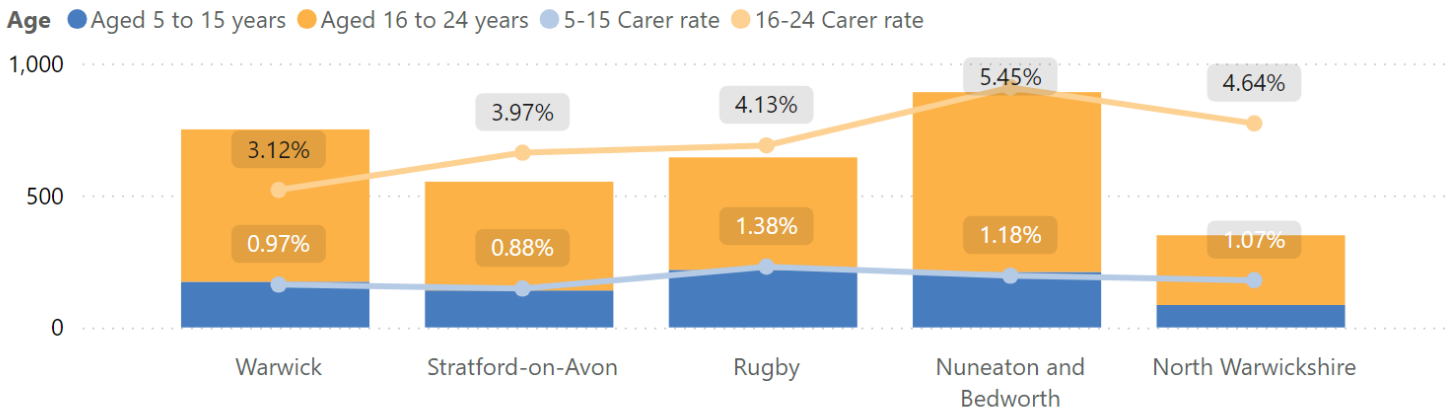
Some Ukrainian migrants have travelled home to receive healthcare due to barriers experienced.

Recommended Actions to Improve:

There is a lack of local data and evidence on the refugee, migrant, and asylum seeker population within Warwickshire. Developing this evidence base will help to understand the specific needs of this population locally, and therefore help to plan support and interventions.

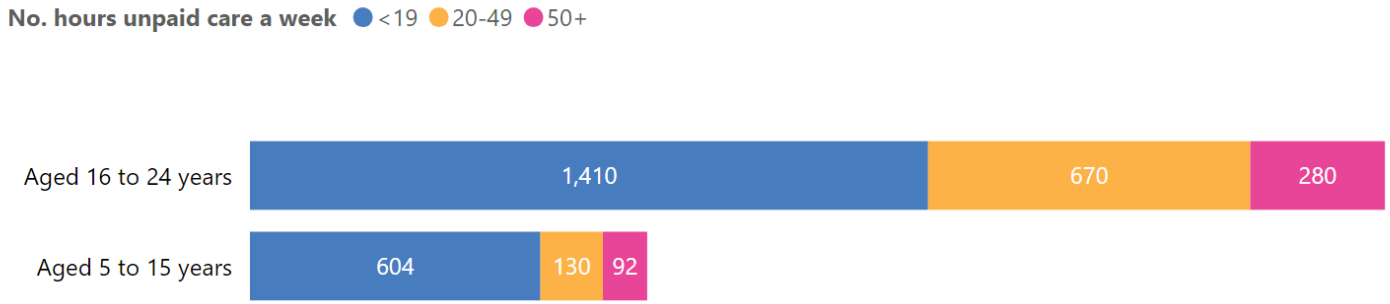
This visual shows the numbers and rates of young people stating they provide some care per week. More 16-24 year olds provide care than those aged 5-15. Nuneaton and Bedworth has the highest number and rate of carers.

No. carers and crude carer rate by district and age band



90% of Warwickshire children & young people provide no unpaid care, but of those who do, the majority of those aged 5-15 provides up to 19 hours a week and those 16-24 up to 50 hours.

No. carer by age band and hours of unpaid care a week



Young carers are children and young people aged 25 and under who provide care for a family member or friend who would not be able to cope without their support. This may be due to illness, disability, a mental health problem, or an addiction. According to the latest Census, there are approximately 3,186 young carers in Warwickshire.

What do we know about the health of this group?

Those providing care have extra responsibility that may cause them day-to-day stress and leave them less time to look after themselves. This can impact both their mental and physical health.

Warwickshire Young Carers is commissioned by WCC. It seeks to register young carers and offer ad-hoc support and group sessions. They currently have **780** young carers registered of the **3,186** estimated from the census.

How can we support this population?:

By raising awareness of, and encouraging young carers to register with, the Warwickshire Young Carers service, young carers can get information and support to help them in their caring roles and enable them to fulfil their own needs as an individual.

Additionally, collecting more data on young carers will help us to identify how they are most impacted and where targeted work is best focused.

Full details of the methodology used for this page are available on the Warwickshire JSNA page.

Armed Forces Families
Children open to Social Care
Gypsy, Roma & Traveller
Homelessness
Refugees, Migrants and Asylum Seekers
Young Carers
Youth Justice
Young Mothers

The age of criminal responsibility in England begins at ten years old and young people are considered adults in the legal system when they turn eighteen.

The youth justice system therefore covers those aged 10-17, whether they are:

- An offender
- A victim
- A witness

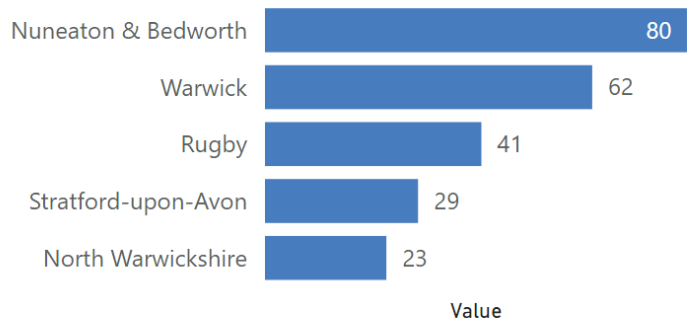
There are two principles that underpin the youth justice system:

- The court shall have regard to the welfare of children and young people involved
- Preventing further offending

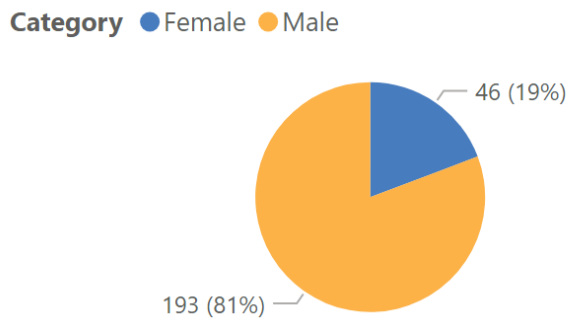
Young people are generally sentenced in the Youth Court and the service is overseen nationally by the Youth Justice Board for England and Wales, and delivered locally by the Warwickshire Youth Justice Team.

There are 239 children and young people (10-17) that were active at any point in the youth justice system in 2022/23. This includes those on bail, voluntary participation and preventative programmes. This 239 is broken down by area and gender below, some categories have been suppressed.

CYP receiving youth justice intervention by area



CYP receiving youth justice intervention by gender



The youth justice system works with children and young people who offend to support them to make sure their offence does not define them, and try to ensure they still have good life chances.

What do we know about the health of this group?

Children and young people who offend may have complex vulnerabilities that have contributed to them offending, such as early childhood trauma and neglect, school exclusion, poor mental health, and growing up in relative deprivation.

Each offender has a comprehensive assessment that asks about their physical and mental health. In addition, it asks about risky behaviours like alcohol and drug consumption and access to other services.

How can we support this population?

Young people open to youth justice have regular, trusted contact with professionals in the youth justice team. Colleagues working to support physical health should link in with these professionals as a trusted point of contact for these young people to best deliver physical health support.

Full details of the methodology used for this page are available on the Warwickshire JSNA page.

Armed Forces Families
Children open to Social Care
Gypsy, Roma & Traveller
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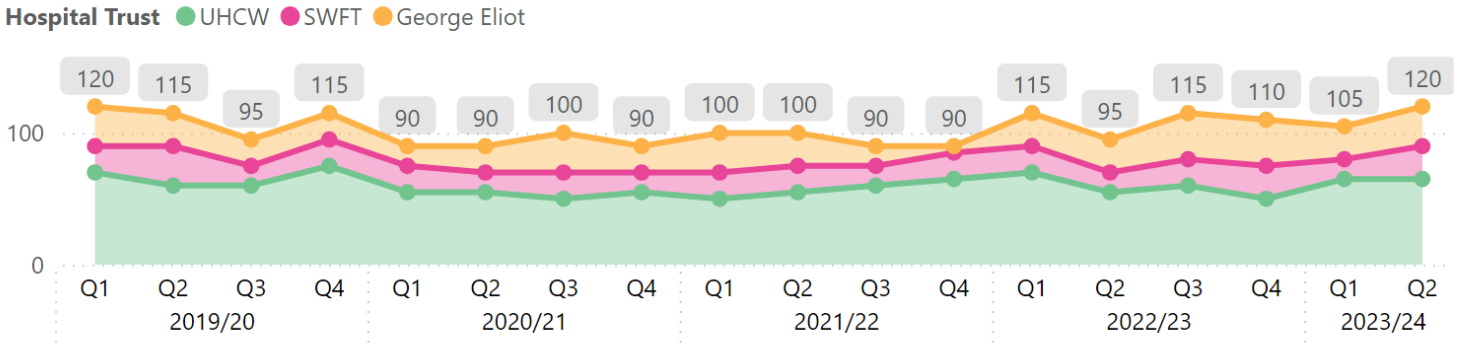
Youth Justice
Young Mothers

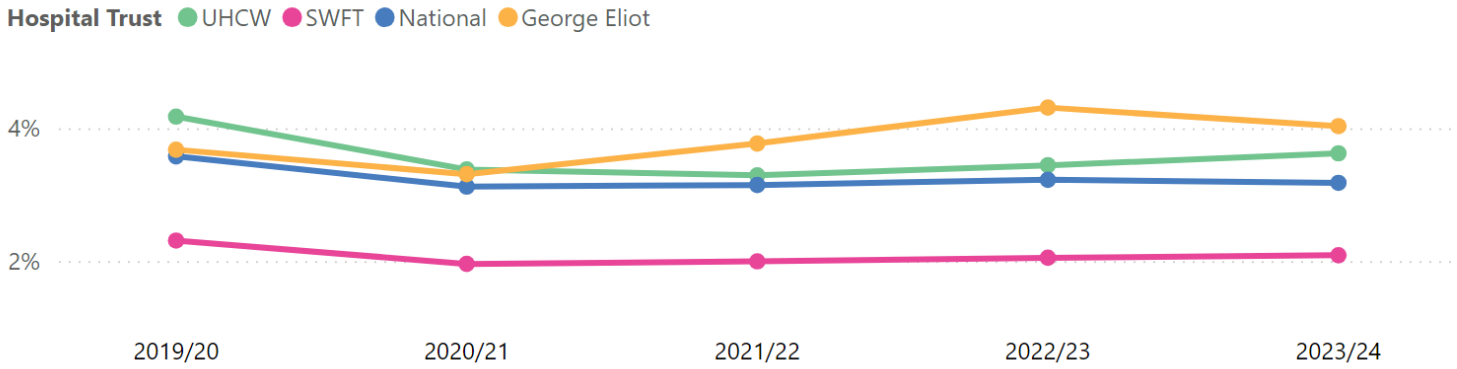
The number of mothers aged under 20 seen by the local maternity and neonatal service (LMNS) dropped slightly in the pandemic years but has since recovered. University Hospital Coventry & Warwickshire see more than South Warwickshire University Foundation Trust and George Elliot combined but this includes Coventry patients.

No. mothers under 20 seen by the local maternity and neonatal service (LMNS) by trust. Not exclusive to Warwickshire residents



There is a larger share of young mothers, as a proportion of all patients, at George Eliot Hospital Trust. South Warwickshire University Foundation Trust has the lowest proportion.

% maternity patients who were under 20 at time of appointment by trust over time



Being a young parent is associated with poorer outcomes for both the parents and their children. For the parents, there is a higher risk of poor educational attainment, social isolation and poorer mental and physical health, while their children are more likely to be born preterm or with low birthweight.

What do we know about the health of this group?

Having a child at a young age can make it harder to re-engage with education and employment, as well as decreasing the amount of social contact and therefore increasing social isolation and loneliness.

These circumstances can impact a young families finances, carer development, and housing. This can then lead to poorer physical and mental health outcomes then their peers.

How can we support this population?

Young parents perception of judgement can be high and make them reluctant to engage with support and services.

How to engage with young parents therefore needs to be considered to ensure they are being welcomed in, thinking about language and ensuring the service is client centred.

Full details of the methodology used for this page are available on the Warwickshire JSNA page.

Reducing Vulnerabilities and Improving Life Chances: Health Impacts

Select a group below to see day-to-day issues this community face and the short to long-term health impacts these may contribute to:

- Armed Forces Families
- Care experienced young people
- Families at risk of homelessness
- Gypsy, Roma, and Traveller communities
- Refugees, asylum seekers, and migrants
- Young carers
- Young parents
- Young people open to youth justice

Armed Forces Families may:

Move more frequently

Military families may be redeployed or moved, requiring moving house and/or school.

Have increased parental separation

Children in military families may experience extended and repeated periods of parental separation due to deployment.

Get sudden caring responsibilities

A child may need to care for a serving family member who has an injury or a physical and/or mental condition.

Which in childhood can contribute to:

Anxiety and Stress

Children in military families may experience high levels of anxiety and stress due to regularly moving home and school.

Having issues accessing services

The continuty of care and health records may be disrupted due to regularly moving home and school.

Hyperactivity

Military fathers with probable PTSD has been associated with child hyperactivity in boys and those under 11 years of age.

Feeling Lonely

78% of surveyed military children felt lonely or isolated due to a posting move.

Which in adulthood can potentially lead to:

Difficulty forming attachments to others

Someone who has experienced childhood instability in their relationships may struggle with relationships with others as an adult.

Increased low self-esteem, anxiety, and de...

Patterns established in childhood can continue into adulthood and become a feature of their lives.

Poor coping skills

Not all children from military families develop resilience and an ability to cope with adverse experiences which can impact adulthood.

Undiagnosed health issues

Due to re-location, assessments or diagnosis may not be completed, leading to entering adulthood with an undiagnosed health issue.

Full details of the methodology used for this page are available on the Warwickshire JSNA page.

Supporting Additional and Complex Health Needs

Children with additional or complex health needs may need extra support to achieve their full potential, engage with learning, and maintain their health and wellbeing. Educational attainment may be affected by medical appointments, hospitalisation, or a lack of support to promote their attendance including support or medication during the school day to ensure they stay well.

The Core20PLUS5 for children and young people identify three long term conditions as part of its five clinical areas of focus; asthma, diabetes, and epilepsy. This section will consider each of those conditions, as well as those with a speech, language, and communication need (SLCN).

Key findings:

- Since COVID-19 there has been an increase in the levels of identified SLCN.
- There is a sharp drop in the number of pupils receiving SLCN support between primary and secondary school.
- There is currently a lack of local data on children and young people with an asthma diagnosis or an asthma care plan.
- There is variation across the county with the provision of technology for children and young people that can help monitor diabetes.

Full details of the methodology used for this page are available on the Warwickshire JSNA page.

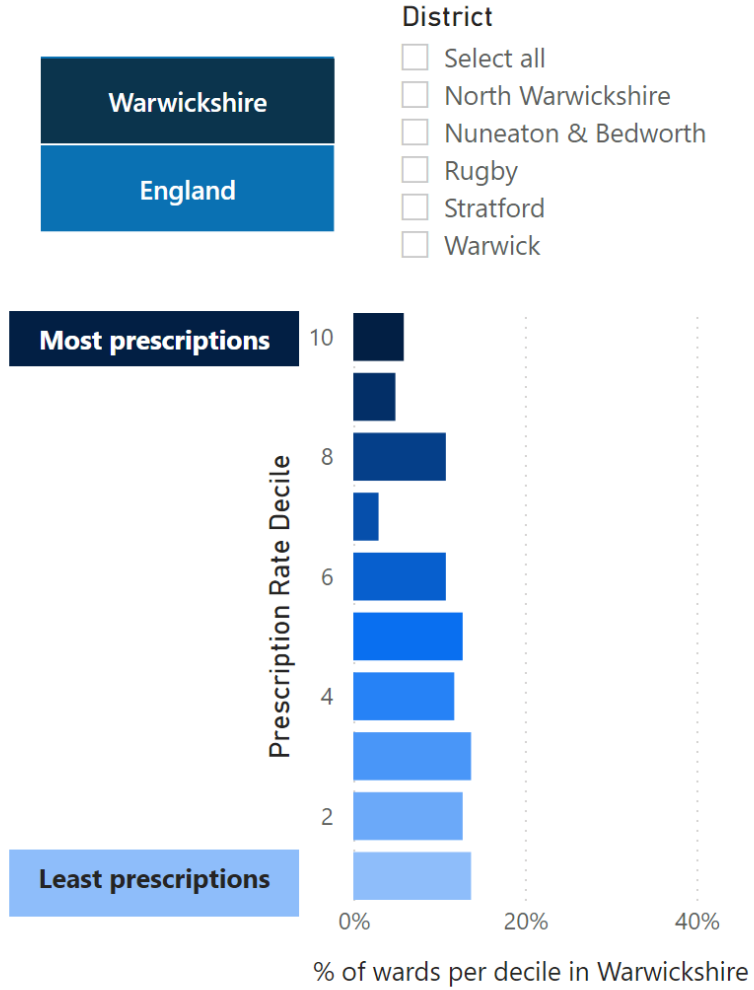
Around 1 in 11 children and young people live with asthma, this equates to over 12,000 between the ages of 6-25 in Warwickshire. Some evidence points to asthma prevalence being higher in areas of deprivation but there is a consensus that outcomes, for example hospital admissions, are worse for children living in more deprived areas.

Children and young people with asthma can have symptoms that interfere with their daily lives including school, sports, social life, and sleep. It is therefore important that their asthma condition and symptoms are appropriately managed to maximise their quality of life.

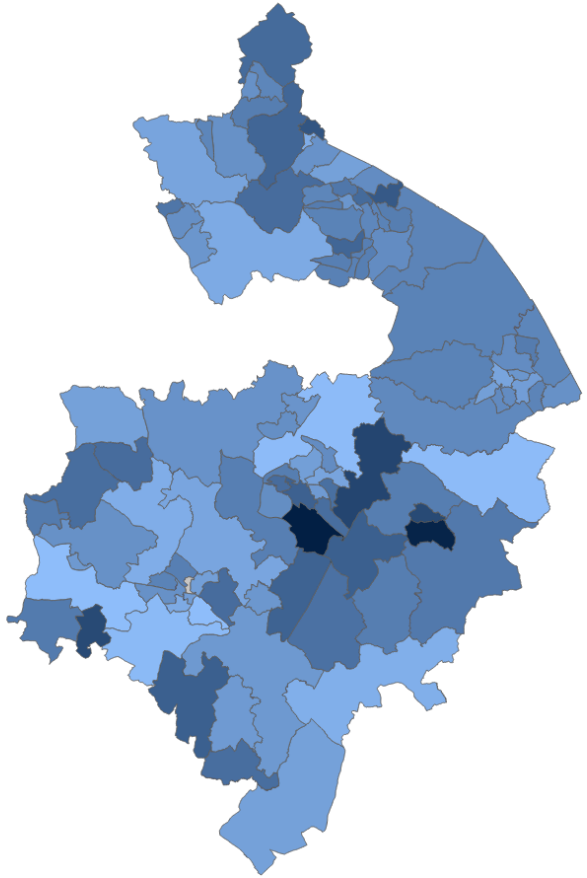
There is currently no good data locally on how many children are diagnosed with asthma or how many children have asthma care plans.

This JSNA has therefore used data from NHS Business Services Authority showing children aged 0-17 prescribed with an asthma-related medication as a proxy indicator. This does not show asthma prevalence, but is instead an indicator of demand for asthma medicines.

These visuals show the proportion of children aged 0-17 who have received at least one NHS prescription for a product typically prescribed in the treatment of Asthma in 2022/23.



There are 2 wards in Warwickshire with prescribing rates for asthma medication (0-17) in the 99th percentile of England



Previous: Complex Health Needs Intro

Full details of the methodology used for this page are available on the Warwickshire JSNA page.

Next: Diabetes

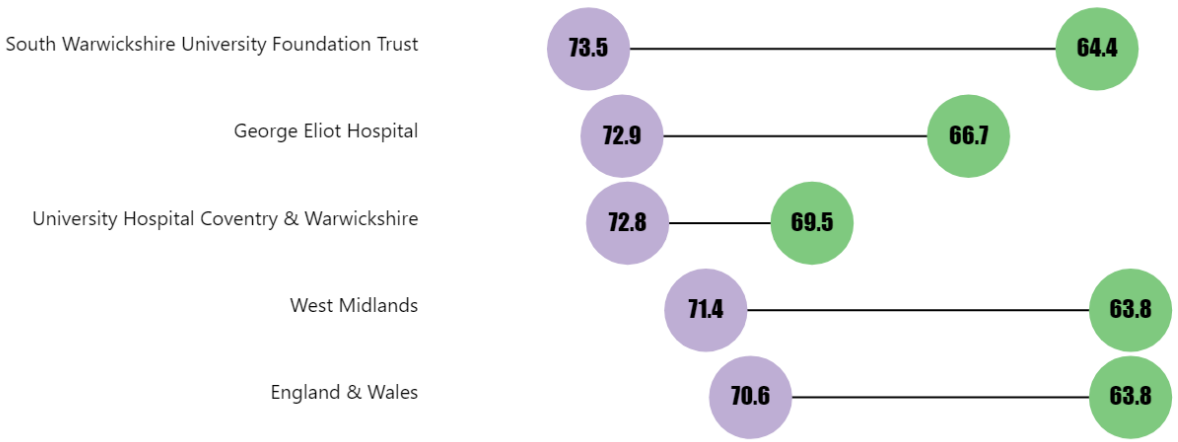
Children with diabetes need to pay close attention to their blood glucose and aim to keep it as low as possible.

To monitor this, clinical teams measure HbA1c values which reflect average blood glucose levels over a longer period of time. These values are then adjusted to account for certain characteristics to allow comparison between areas.

They can better manage their condition when they have access to technology such as blood glucose monitors and insulin pumps.

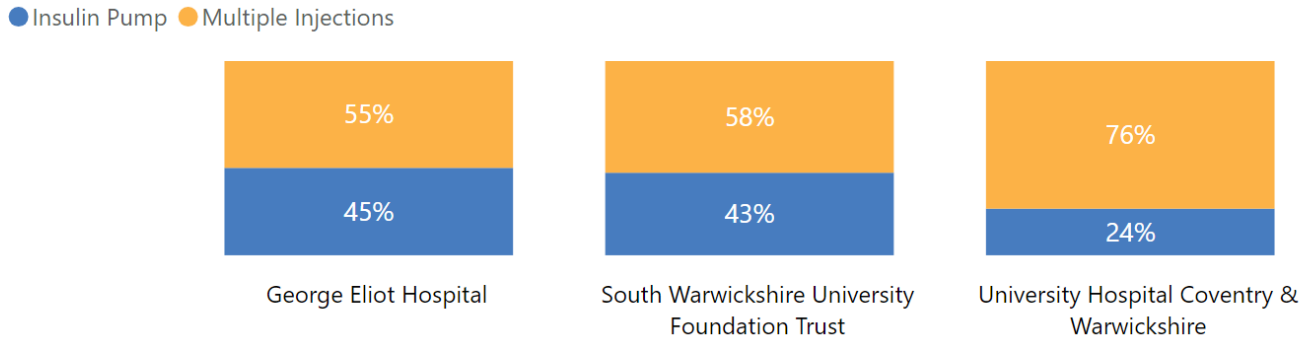
Both reduce invasive procedures: a monitor by connecting to a smart phone app replacing the need for finger prick tests, and insulin pumps detect when blood sugar is high and release insulin directly, reducing need for injections.

Mean adjusted HbA1c has dropped for all areas from 2014/15 to 2021/22, which is positive.



However, there is variation in % of children within recommended range for HbA1c (<56mmol) across the county from 38 % in South Warwickshire to 26 % in the North and Rugby.

Access to insulin pumps is higher for diabetes patients at George Eliot Hospital and SWFT than at UHCW



Access to blood glucose monitors varies across the county from 91 % at SWFT, 81 % at George Eliot and 68 % at UHCW.

← Previous: Asthma

Full details of the methodology used for this page are available on the Warwickshire JSNA page.

Next: Epilepsy →

Epilepsy is a complex condition that has the potential to impact on many aspects of a child or young person's life, including their education, emotions, behaviour, and social interactions. It is therefore important to plan appropriate support and condition management to help these children and young people reach their full potential.

Children and young people in the most deprived areas of England are more likely to have epilepsy and twice as likely to have an emergency epilepsy admission than those in the least deprived areas.

Each child will have a unique experience of how their epilepsy impacts them and the effect it has on their lives. However overall, children and young people with epilepsy are at an increased risk of learning and behavioural difficulties compared to children and young people without epilepsy.

Epilepsy can develop at any age, but it's more common in older children as they have had more time for the condition to develop and be diagnosed. Explore the estimated epilepsy population below:

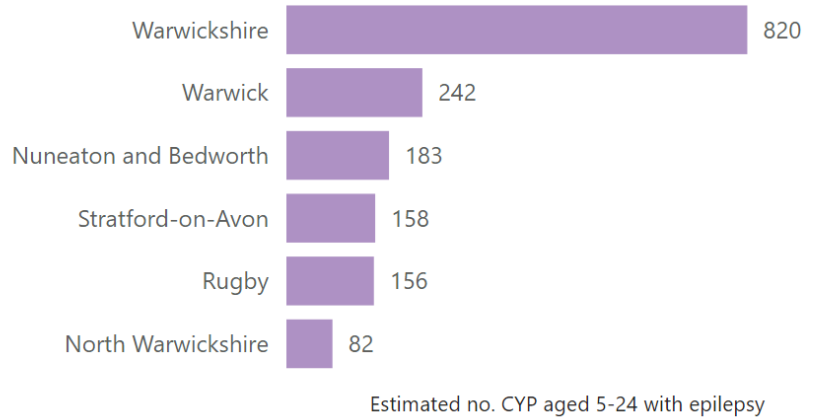
1 in 333 children aged 5-9 have epilepsy.
In Warwickshire, that's approximately **104**

1 in 200 children aged 10-14 have epilepsy.
In Warwickshire, that's approximately **180**

1 in 133 young people aged 15-19 have epilepsy.
In Warwickshire, that's approximately **248**

1 in 111 young people aged 20-24 have epilepsy.
In Warwickshire, that's approximately **289**

Select an area:



The NHS national bundle of care for children and young people with epilepsy recommends that trusts track diagnosis and treatment and submit results to the Epilepsy12 clinical audit, administered by the Royal College of Paediatrics and Child Health

Since its inception, SWFT and UHCW have consistently submitted to the audit. CWPT and GEH made their first submission in 2022, however the data is incomplete.

Warwickshire NHS trusts by year and whether they submitted to the audit

NHS Trust	2019	2020	2021	2022
Coventry & Warwickshire Partnership Trust	No	No	No	Yes
George Eliot Hospital	No	No	No	Yes
South Warwickshire University Foundation Trust	Yes	Yes	Yes	Yes
University Hospitals Coventry & Warwickshire	Yes	Yes	Yes	Yes

RCPCH Royal College of Paediatrics and Child Health
Leading the way in Children's Health

EPILEPSY12
National Clinical Audit of Seizures and Epilepsies for Children and Young People

Previous: Diabetes

Full details of the methodology used for this page are available on the Warwickshire JSNA page.

Next: Speech, Language & Communication

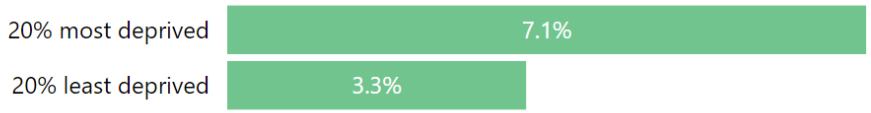
Speech, language, and communication needs (SLCN) is the term given to describe a range of needs related to difficulties with aspects of communication. Children and young people with SLCN require appropriate support so that they can reach their full potential.

A drop is seen between Year 6 and 7 in those registered with SLCN, likely due to a drop in SLCN support, a re-evaluation of need, and a difference in how primary and secondary schools categorise these needs. Children can be registered with SLCN either receiving SEN support or an EHCP. If a child has an EHCP they can assess the SWFT SLCN service.

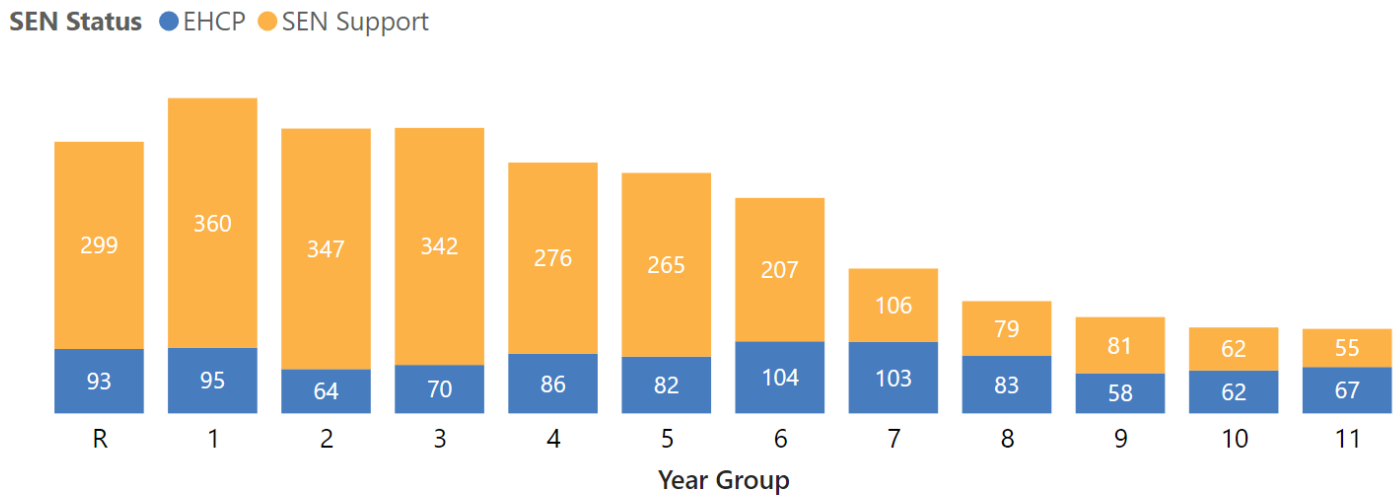
When moving to secondary school some children may no longer be registered with a special educational need whilst the category of need for others may be changed from SLCN to other learning difficulties. It should be noted that, without an EHCP, children in year 6 are discharged from the SWFT SLCN service when they move to year 7 and that secondary schools generally regard SLCN as a primary school age problem.

Since COVID-19 there has been a rise in the levels of identified SLCN from **4.4% in 2019** to **5.8% in 2023** for **primary school** pupils and **1.7% to 2.2%** in **2023** for **secondary school** pupils. This could be due to the reduced social interaction and changes in the approach to education experienced during the pandemic.

More deprived areas of Warwickshire have higher incidence of speech, language and communication needs

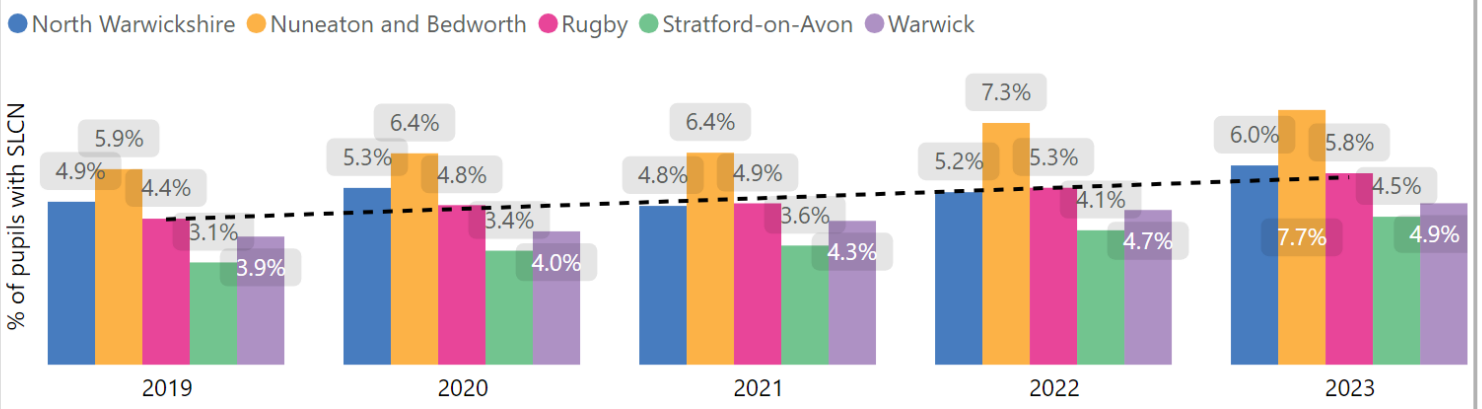


The number of pupils receiving support for SLCN decreases from Year 1 to Year 11, with the sharpest drop at the transition from primary to secondary school.



Levels of identified SLCN have been increasing in recent years, especially in Nuneaton and Bedworth.

School Phase: **Primary** | **Secondary**



Full details of the methodology used for this page are available on the Warwickshire JSNA page.

Supporting Self Care and Improving Health Literacy

Ensuring children and young people are informed about their physical and mental health, are confident in accessing health services, and are able to make informed decisions for themselves is crucial as part of their development to adulthood. Health literacy is vital for young people as they increase their independence and become less reliant on parents and carers. Helping them to build knowledge and skills about their health and wellbeing provides them with skills for life and empowers them to make decisions about their own health.

This section considers a range of self care areas that can impact a child or young persons health and wellbeing, immunisations that protect a child in their development, as well as showing how school absences and transitions can impact on a child or young person.

Key findings:

- There is variation in year groups and District and Boroughs across all self care measures.
- The pre-school booster and MMR vaccine coverage rates are both below the target of 95% coverage.
- There has been an increase in school absences. Part of this may be the impact of the pandemic, however rates of absences have not decreased following the end of COVID-19 restrictions.
- Transition points can be challenging for children and young people, particularly for those with a long-term condition or for vulnerable communities.

Full details of the methodology used for this page are available on the Warwickshire JSNA pag

A dentist can help prevent oral health problems at an early stage and advise on how to prevent tooth decay. Poor oral health can cause pain and disruption to children and their families and impacts on eating, sleeping, concentration at school, and overall wellbeing.

NHS dental care is free for children. Children should be taken to the dentist when their first milk teeth appear so they can get to know their dentist and get use to the environemnt.

The data presented on this page is sourced from HNA and is 3-year combined data from 2020 to 2023. In Rugby secondary schools, this is limited to just two schools and one year of data - 2022/23.

We have analysed responses to Health Needs Assessment questions that relate to self-care. Answers were flagged if they indicated poor health behaviour such as not visiting a dentist or not getting enough sleep.

Select a theme and see how the value has been calculated and how it varies across school phases and areas:

Dentist	General Wellness	Happiness	Hearing
Sleep	Sun Protection	Vision	

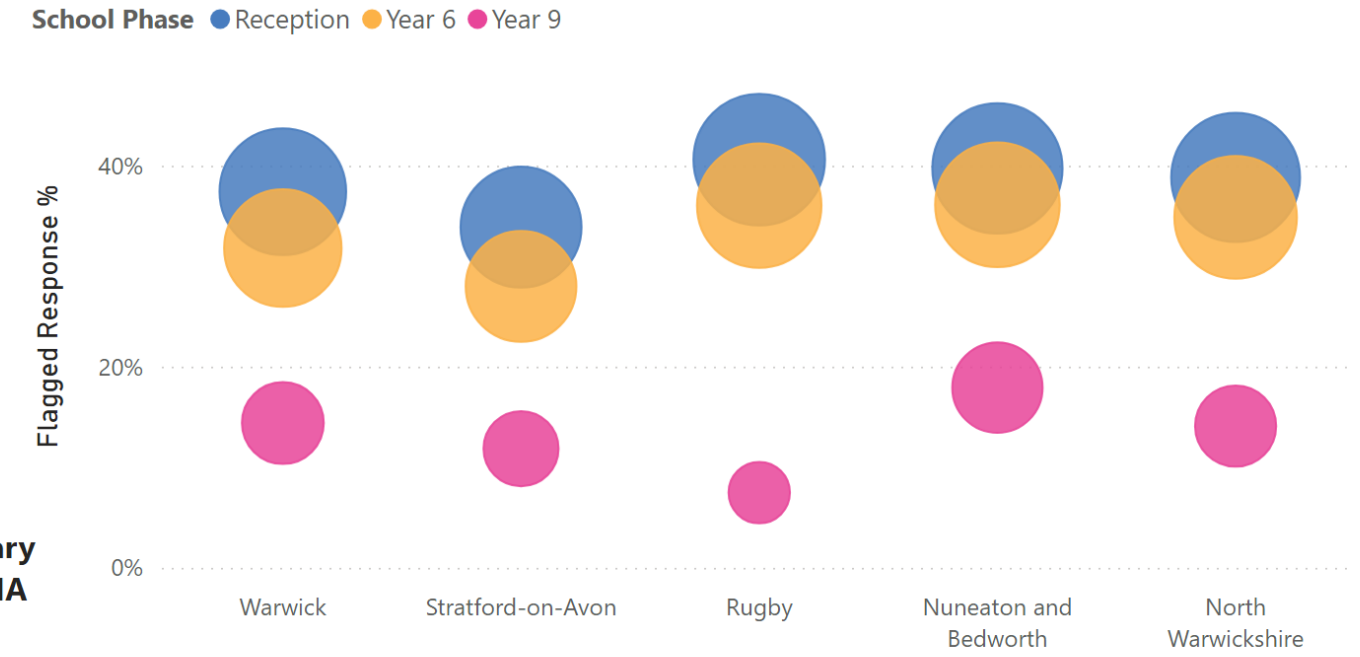
Respondents were asked whether they/their child had visited the dentist in the last year with "No" being a flagged answer for Reception/Year 9 and "No" or "Don't know" for Year 6

JSNA results for 'Dentist' theme:

The Warwickshire '% flagged' is **30%** for comparison

District and JSNA	Flagged Response % (aged 5-13 combined)
North Warwickshire	
Atherstone and Hartshill	29%
Coleshill and Arley	28%
Kingsbury	32%
Polesworth	28%
Nuneaton and Bedworth	
Bedworth Central and Bulkington	29%
Bedworth West	28%
Nuneaton Central	31%
Nuneaton Common and West	34%
Weddington, Horestone Grange and	24%

See how results vary across smaller JSNA geographies



← Previous: Self Care & Health Literacy Intro

Full details of the methodology used for this page are available on the Warwickshire JSNA page

Next: Immunisations →

Children in Warwickshire should receive two vaccines from the age of 3 years and 4 months, the 4-in-1 pre-school booster and a second dose of the MMR vaccine.

The **4-in-1 pre-school booster** helps protect children against 4 serious illnesses: diphtheria, poli, tetanus and whooping cough. Children would have received previous vaccines against these diseases at under a year old.

The **MMR vaccine** gives protection against measles, mumps and rubella. The second dose is important for long-term protection.

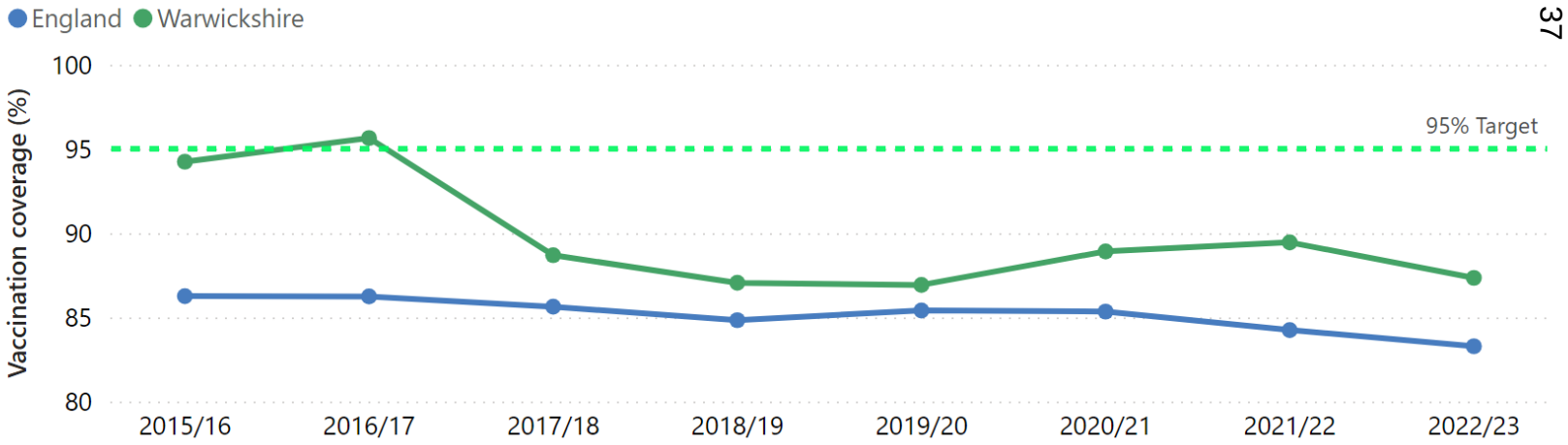
Why is there a 95% target for vaccination?

The World Health Organisation (WHO) recommends that at least 95% of children are immunised against vaccine-preventable diseases. Wide coverage against these diseases helps benefit the whole community through "herd immunity". If enough people are vaccinated, it's harder for the disease to spread to those people who cannot have vaccines, such as those with a weakened immune system, or those who didn't receive vaccines as children.

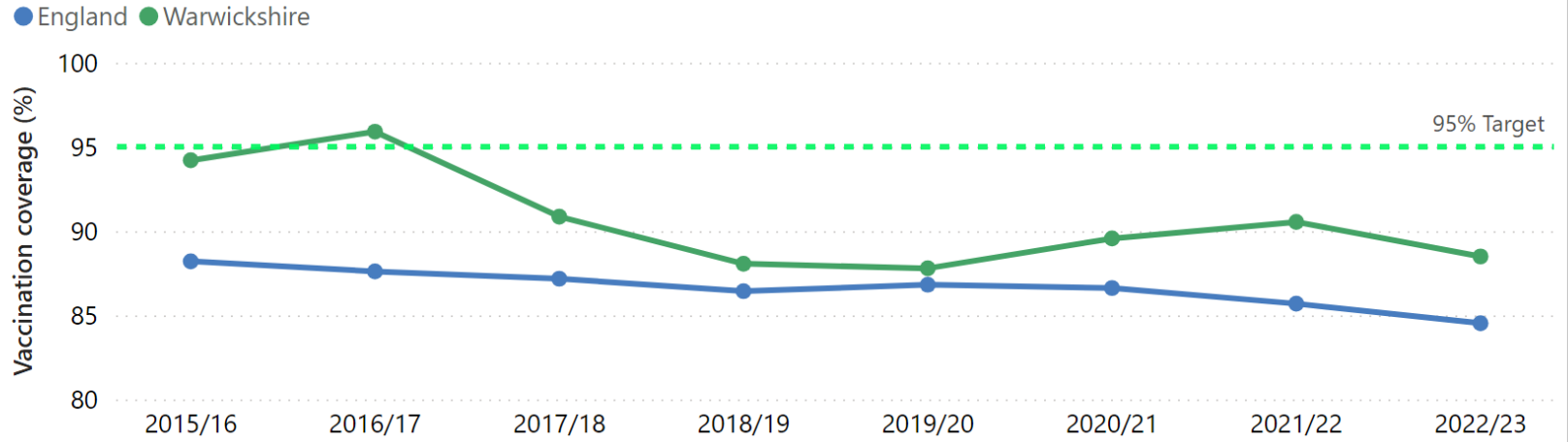
Increased rates of measles cases have been seen recently, and one of the reasons is low rates of vaccination. Measles can have serious and life changing consequences for children and is completely preventable with vaccination. There is a risk of increased levels of preventable disease if vaccine rates remain low.

Estimates at GP level for Warwickshire practices show a range from 97.6% to 27.8% for children receiving both the 4-in-1 booster and the second dose of the MMR vaccine. This shows a high variation in coverage across Warwickshire.

While the population coverage for the '4-in-1 pre-school booster' at 5 years in Warwickshire has been above England levels, it has remained significantly below the 95% coverage goal.



Similarly, coverage of two doses of MMR by 5 years has been above England levels but below target levels. Data going further back shows how Warwickshire has achieved the goal in the past.



← Previous: Self Care

Full details of the methodology used for this page are available on the Warwickshire JSNA page.

Next: School Absence →

For the vast majority of children and young people, school is the best environment to learn in, build social skills and networks to achieve their full potential. Being in school and supported by teachers and friends can also help to keep children and young people safe.

There has been a rise in school absences since 2020/21 across all absence categories. Whilst the pandemic may have impacted on this, rates have not decreased since the end of COVID-19 restrictions.

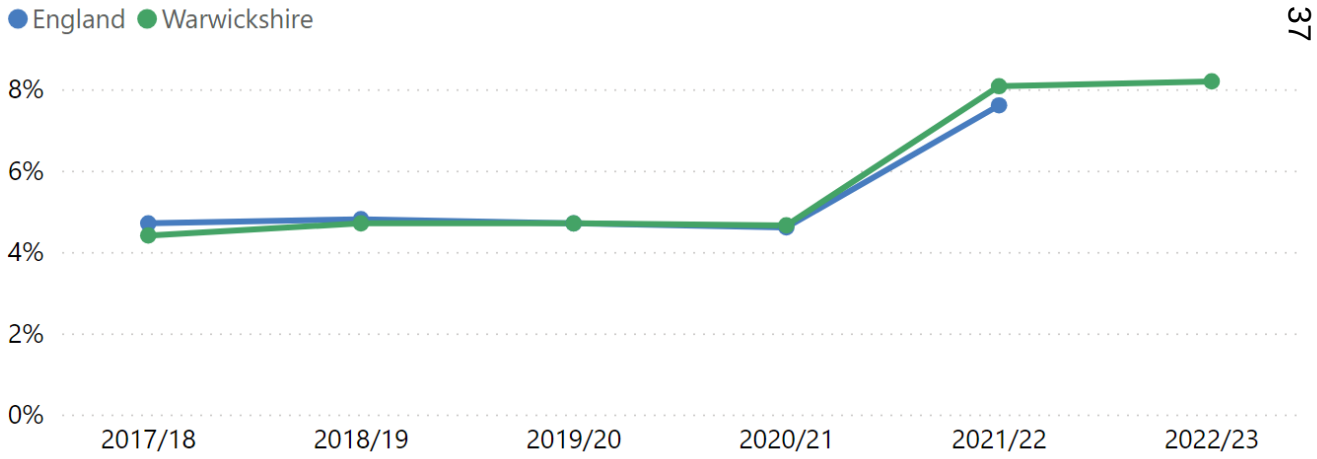
The better a child or young person's school attendance, the more likely they are to perform well in exams and formal assessments, which will help a child be set up for future life. National data from 2019 shows that 84% of Key Stage 2 pupils who had 100% attendance achieved the expected standard compared to 40% who were persistently absent across the key stage.

Studies have showed that persistent school absences can lead, in childhood or later life, to worse mental health outcomes, a greater risk of domestic abuse, an increased likelihood of criminal convictions, lower academic achievement, and lower employability rates.

The rate of school absence has sharply increased in recent years compared to before the COVID-19 pandemic with students attending Warwickshire State Schools now missing around twice as much school as before.

Absence rate: (i)

- Total absence
- Unauthorised absence
- Illness



There has been a recent sharp rise in persistent absenteeism among pupils at Warwickshire State Schools, reducing the academic prospects of these pupils.

11.6% of pupils missed **10% or more** of school sessions in **2020/21**. This increased to **24.2%** in **2022/23.**

1.1% of pupils missed **50% or more** of school sessions in **2020/21**. This increased to **2.6%** in **2022/23.**

Persistent absenteeism is much more pronounced in Warwickshire Secondary Schools than Primary Schools

In 2022/23 **15.7%** of **Primary** pupils missed 10%+ sessions in compared to **34.9%** of **Secondary** pupils.

← Previous: Immunisations

Full details of the methodology used for this page are available on the Warwickshire JSNA page.

Next: Transitions →

Transitions in Childhood and Adolescence

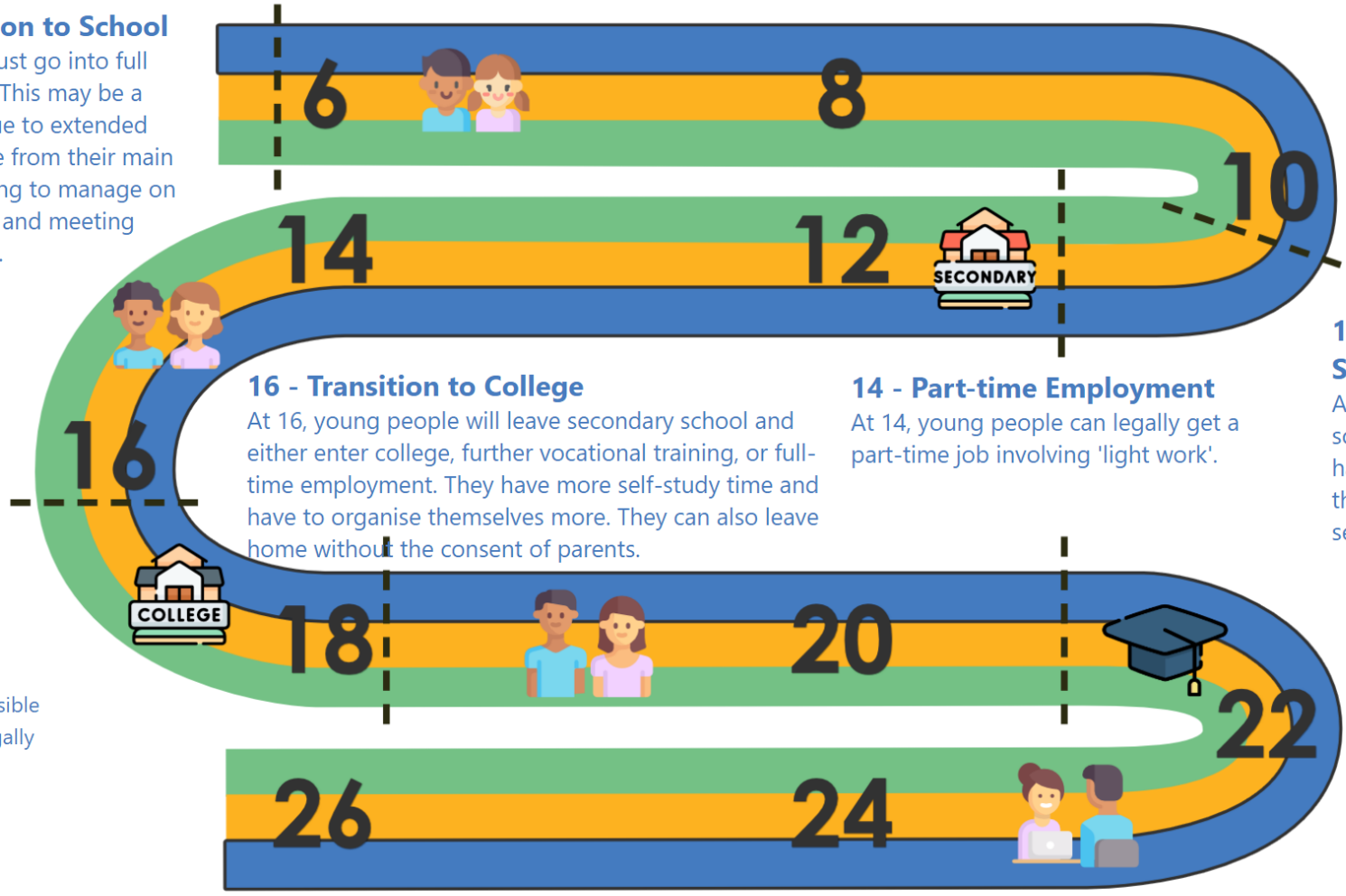
Explore how transition points affect different groups of children and young people

Select a group:

- General Transitions
- Those with Long-term Conditions
- Vulnerable Communities

4-5 - Transition to School

At 5, children must go into full time education. This may be a stressful time due to extended periods separate from their main caregiver, needing to manage on their own more, and meeting different people.



10 - Criminally Responsible

At 10, children can be charged and prosecuted for a criminal offence.

11 - Transition to Secondary School

At 11, children move to larger schools with larger class sizes. They have more subjects to study and there is a higher expectation of self-study.

14 - Part-time Employment

At 14, young people can legally get a part-time job involving 'light work'.

16 - Transition to College

At 16, young people will leave secondary school and either enter college, further vocational training, or full-time employment. They have more self-study time and have to organise themselves more. They can also leave home without the consent of parents.

18 - Transition to Adulthood:

Legally an adult, they may pursue further education, employment, or training. They are financially responsible for themselves, participate in democracy and can legally drink alcohol and buy cigarettes,

21+ - Transition from Higher Education

After 21, young adults who attended higher education will be graduating and moving on to employment or further study.

← Previous: School Absence

Full details of the methodology used for this page are available on the Warwickshire JSNA page.

Next: Conclusions →

The breadth of the six-school age high impact areas highlights the range of factors that can impact outcomes for children, young people, and families. Consideration of all these areas, utilising data and surveillance, will help to inform and target work that will improve health outcomes in a structured way.

This JSNA has been created to be a live and iterative product. It is intended that the following steps should happen following its publication:

EMBED

The findings and approach of the JSNA should be embedded into workstreams to inform decision making and action. This includes aligning work to the six school-aged high impact areas.

ACTION

Action should be taken to support and improve the health of children and young people, as evidenced in this JSNA, and responding to updated data and content.

REFRESH

The data in this JSNA will be updated. When this happens, actions and approaches should be refreshed to align with the latest data findings.

REVIEW

The contents of this JSNA should be reviewed and developed. This JSNA has been created to show key messages which should be updated depending on latest intelligence. Additional sections can also be added dependent on need.

2024 Recommendations

1) The Health and Wellbeing Board to endorse the dashboard produced for this JSNA and commit to this new iterative approach to producing this JSNA that is live and timely.

To support this, the Board are asked to ensure partner organisations work together, committing subject matter expertise and analytical resource to keep the dashboard up to date in line with new data releases, evidence, and intelligence.

2) An appropriate sub-group, appointed by the Children and Young People's Partnership, will own this dashboard and coordinate developing it with partners to ensure it acts as a comprehensive evidence base when making decisions around child health.

3) The appropriate sub-group should drive the Healthy Child Programme forward in a structured way around the high impact areas for health.

4) In partnership with colleagues, review health surveillance approaches to support their continued use as key sources of intelligence locally and to ensure robust reporting around a range of child health issues.

These include Health Needs Assessments, Holistic Health Assessments, Children in Care Assessments.

5) The limited resources which are available should be targeted towards high priority communities, settings, and vulnerable children and young people.

6) Linked to the engagement undertaken as part of this JSNA, the Children and Young Person Making Every Contact Count (MECC) should be utilised to empower practitioners to have strengths-based conversations with children and young people about their health and wellbeing.

Previous: Conclusions

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Health and Wellbeing Board

15 May 2024

Menopause Services Task and Finish Review

Recommendation

That the Health and Wellbeing Board considers and comments on the report of the Menopause Services Task and Finish Review, endorsing the recommendations it contains for the Integrated Care System.

1. Executive Summary

1.1 At its meeting in February 2023, Warwickshire County Council's Adult Social Care and Health Overview and Scrutiny Committee agreed to a focussed 'task and finish' review of Menopause Services in Warwickshire. The remit was to undertake research, to assess the sufficiency of services, any gaps in provision and to make recommendations to those responsible for the services. In doing so, it outlined the areas to be included, being NHS menopause services in Warwickshire and those which the County Council provided.

1.2 In addition to written background information, three evidence sessions took place with the Integrated Care Board, from groups providing 'lived experience' of the services, and the County Council's staff on the internal support offer. Through this review, the Task and Finish Group (TFG) has developed a detailed understanding of the way that Menopause Services are commissioned and the learning from those with lived experience of services. It is clear that the County Council has developed a substantial 'offer' of support and advice for its own staff. These findings could usefully be shared with partner organisations and more widely with employers in Warwickshire.

1.3 Attached at Appendix A is the review report. The TFG makes a series of recommendations for the Coventry and Warwickshire Integrated Care Board, and for the Council and partners in respect of those services within their remit. The recommendations are reproduced below. The appended review report provides the supporting information, detailing the evidence heard, the stages of the review and its findings.

1.4 Recommendations:

Recommendation 1 - Communications Activity and Information

1. That the Integrated Care Board be requested to develop a robust and targeted communications strategy with the aim of improving communication to the public about the availability of menopause services across the County.

The wider Integrated Care System partners are asked to use their channels to share the ICB communications on menopause services.

Recommendation 2 – Access to Primary Care Menopause Specialists

2. That the Integrated Care Board considers options to improve access to menopause specialists in primary care settings.

Data shows that 80% of menopausal women can be supported via primary care. GPs may opt to take additional training in menopause services, so some, but not all, practices have a menopause specialist. It is not viable to recommend menopause specialists at every surgery. A question for the ICB is whether triage and the use of technology could offer remote appointments with a menopause specialist. A further suggestion is providing periodic clinics or 'drop in' centres where people can talk to a specialist.

Recommendation 3 – Recognising and Developing Voluntary Support

3. That endeavours are made by the Integrated Care System to seek the establishment of voluntary sector menopause support groups in the North of Warwickshire and Rugby areas.

A valuable community resource is provided by the voluntary groups, which offer support, advice and information. There are eight groups in Warwickshire, but notable gaps in provision in the north of Warwickshire and Rugby areas. It would be beneficial to seek the establishment of similar support groups in those areas.

Recommendation 4 – Sharing Information

4. That the County Council considers sharing information on the menopause support offer it has developed for staff with partner organisations and with other employers in Warwickshire. Seeking details of the support already in place in those organisations is also suggested. The aim is to encourage more menopause support in Warwickshire workplaces.

Members recognise the amount of work being undertaken to provide support for the County Council's staff. There is an opportunity to share this information and to seek feedback from others, to provide real benefits for Warwickshire residents and their employers, given the data that one in ten women leave their employment due to the menopause. Through the Council's partnerships, discussion with the Chamber of Commerce and other business groups this could be explored.

Recommendation 5 – Ongoing Monitoring

5. That the Adult Social Care and Health Overview and Scrutiny Committee monitors the implementation of these recommendations through periodic updates and briefings from the ICB.

2. Financial Implications

2.1 There are no direct financial implications arising from this review report.

3. Environmental Implications

3.1 None arising directly from this report.

4. Timescales associated with the decision and next steps

4.1 The Menopause Services review report and its recommendations will also be submitted to the County Council's Cabinet and to the Integrated Care Board for consideration.

Appendices

Appendix 1- Review Report

Background Papers

None

	Name	**Contact Information**
Report Author	Paul Spencer Senior Democratic Services Officer	paulspencer@warwickshire.gov.uk Tel: 01926 418615
Director	Sarah Duxbury, Director of Strategy, Planning and Governance	sarahduxbury@warwickshire.gov.uk
Executive Director	Becky Hale, Executive Director for Social Care and Health	beckyhale@warwickshire.gov.uk
Portfolio Holder	Councillor Margaret Bell, Portfolio Holder for Adult Social Care & Health	margaretbell@warwickshire.gov.uk

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

Local Member(s): None
Other members: Councillors Barker, Bell, Drew, Holland and Rolfe.

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MENOPAUSE SERVICES TASK AND FINISH GROUP REPORT

17 April 2024

Working for Warwickshire

CONTENTS **PAGE**

1.0 Introduction

1.1 Executive Summary

Over 50% of the population is female. At some time or other in their lives the majority of women will go through the menopause, the stage of their lives when a change in hormone levels leads to the cessation of menstruation. For some females the menopause is barely noticeable. For many, however, it can take a heavy mental and physical toll. This review has been undertaken in an effort to ensure that appropriate support is available to women who are experiencing menopause.

Concerns were raised by the former chair of the scrutiny committee responsible for all matters linked to health and social care. She had identified an absence of menopause services in the Nuneaton and Bedworth area of Warwickshire where she lived. Furthermore, there was little knowledge of any NHS services being provided throughout the County. The scrutiny committee supported these concerns. In agreeing this focussed piece of work, the committee outlined the areas to be included, being NHS menopause services in Warwickshire and those which the County Council provided.

Through this review process, members have considered written information, presentations and personal testimony. Members held three evidence gathering sessions, with representatives from a range of organisations. The evidence gathered informs this resultant report which proposes a number of recommendations. These recommendations will be submitted to the Adult Social Care and Health Overview and Scrutiny Committee (the Scrutiny Committee), to the Cabinet, the Warwickshire Health and Wellbeing Board and to partner organisations for them to consider. The recommendations can be seen at Section 2 (page 6 onwards).

1.2 Appointment

The Scrutiny Committee was concerned at the perceived lack of NHS menopause services in Warwickshire. It commissioned this review to undertake research, to understand if the services provided are sufficient, to identify any gaps in provision and to make recommendations to those responsible for the services.

To undertake this review, the Scrutiny Committee appointed a member task and finish group (TFG). The TFG comprised six elected members of the County Council, some of whom also represented district and borough councils. Representatives of the Coventry and Warwickshire Integrated Care Board (C&W ICB), Healthwatch Warwickshire (HWW) and a specialist group Action Menopause Warwickshire (AMW) also contributed through providing evidence to the review.

A scoping exercise was undertaken resulting in the scoping document attached at Appendix A to this report (see page 16).

1.3 Members and Contributors

The members appointed to the Task and Finish Group (TFG) were Councillors Kate Rolfe (Chair), Marian Humphreys (Vice-Chair), Barbara Brown, Tracey Drew, Judy Falp and Penny-Anne O'Donnell.

The TFG was supported by officers from Democratic Services and from Organisational Development. Further support was available between meetings from the Public Health and Business Intelligence teams.

1.4 Evidence

In order to achieve an understanding of the review topic, the TFG considered both primary and secondary evidence from a range of sources. This included circulation of an advance pack of information, with background reading. It comprised a previous presentation from the Director of Public Health (DPH), a report to Norfolk County Council and weblinks to publications from the Department of Health, British Menopause Society and the National Health Service (NHS). The pack included data sources and tools from the Council's Business Intelligence Team. The body of this report and Appendix B (see page 20) provide detail on the evidence heard.

1.5 Dates and Timescales

Stage 1: A meeting to consider the review's scope (See Appendix A) – April 2023.

Stage 2: Consideration of primary evidence, through presentations, questioning and more general discussion over three meetings held in June, September and November 2023.

Stage 3: The consideration of conclusions and recommendations from this Task and Finish Group (TFG) – February 2024.

Stage 4: Approval of the final TFG report by the Adult Social Care and Health Overview and Scrutiny Committee – 17 April 2024.

Stage 5: Presentation of the TFG report to Cabinet and the Warwickshire Health and Wellbeing Board – TBC 2024.

2.0 Recommendations

The Menopause Services task and finish group (TFG) makes a series of recommendations for the Coventry and Warwickshire Integrated Care System (ICS) and those within the remit of individual agencies. The rationale for each of these recommendations is provided in the conclusions (Section 5, page 13). Subsequent sections of the report and appendices provide the detail which supports these recommendations.

Recommendation 1 – Communications Activity and Information

1. That the Integrated Care Board, be requested to develop a robust and targeted communications strategy with the aim of improving communication to the public about the availability of menopause services across the County.

The wider Integrated Care System partners are asked to use their channels to share the ICB communications on menopause services.

Recommendation 2 – Access to Primary Care Menopause Specialists

2. That the Integrated Care Board considers options to improve access to menopause specialists in primary care settings.

Data shows that 80% of menopausal women can be supported via primary care. GPs may opt to take additional training in menopause services, so some, but not all practices have a menopause specialist. It is not viable to recommend menopause specialists at every surgery. A question for the ICB is whether triage and the use of technology could offer remote appointments with a menopause specialist. A further suggestion is providing periodic clinics or ‘drop in’ centres where people can talk to a specialist.

Recommendation 3 – Recognising and Developing Voluntary Support

3. That endeavours are made by the Integrated Care System to seek the establishment of voluntary sector menopause support groups in the North of Warwickshire and Rugby areas.

A valuable community resource is provided by the voluntary groups, which offer support, advice and information. There are eight groups in Warwickshire, but notable gaps in provision in the north of Warwickshire and Rugby areas. It would be beneficial to seek the establishment of similar support groups in those areas.

Recommendation 4 – Sharing Information

4. That the County Council considers sharing information on the menopause support offer it has developed for staff with partner

organisations and with other employers in Warwickshire. Seeking details of the support already in place in those organisations is also suggested. The aim is to encourage more menopause support in Warwickshire workplaces.

Members recognise the amount of work being undertaken to provide support for the County Council's staff. There is an opportunity to share this information and to seek feedback from others, to provide real benefits for Warwickshire residents and their employers, given the data that one in ten women leave their employment due to the menopause. Through the Council's partnerships, discussion with the Chamber of Commerce and other business groups this could be explored.

Recommendation 5 – Ongoing Monitoring

5. That the Adult Social Care and Health Overview and Scrutiny Committee monitors the implementation of these recommendations through periodic updates and briefings from the ICB.

3.0 Overview

3.1 Background

At its meeting in February 2023, the scrutiny committee heard concerns about an absence of menopause services in the Nuneaton and Bedworth area of Warwickshire. Furthermore, there was little knowledge of any NHS menopause services being provided throughout the County. The scrutiny committee agreed to a focussed review to undertake research, to assess the sufficiency of services, any gaps in provision and to make recommendations to those responsible for the services. In doing so, it outlined the areas to be included, being NHS menopause services in Warwickshire and those which the County Council provided.

The C&W ICB needed to be involved at an early stage in the review to provide factual information on the health pathways, and to ascertain if there was any disconnect and options to bridge any gaps.

3.2 Objectives

The objectives of this review were to establish a clear picture of current provision of menopause services in Warwickshire. A copy of the full scope for the review is attached at Appendix A.

3.3 Acknowledgements

The TFG values the significant input from those involved in this review, including, but not limited to partner organisations and those providing expert

evidence. Members also wish to place on record their thanks for the WCC Officer support.

4.0 Detailed Findings

4.1 Secondary Evidence

A pack of information was circulated to the TFG members at the commencement of the review. This included a presentation provided by the Director of Public Health (DPH) to an earlier scrutiny meeting and a report to Norfolk County Council on menopause services. A number of documents and web links on the topic were provided by WCC Public Health, the Department for Health and Social Care and the British Menopause Society. Further information from the local specialist group, Action Menopause Warwickshire and a range of NHS publications including from Birmingham Women's Hospital Menopause Service were provided. Data sources were provided by the Council's Business Intelligence Team including Public Health England 'Fingertips' website and the Council's Power BI platform. Copies of the background information can be provided on request.

4.2 Primary Evidence

The TFG invited contributions through evidence gathering sessions. The detailed report of each session is provided at Appendix B (from page 20):

25 April	The TFG discussed the review's scope, which was approved formally at the second meeting in June.
15 June	The TFG received a detailed presentation by the Coventry and Warwickshire Integrated Care Board (C&W ICB) on the services commissioned in Warwickshire. Outcomes from this meeting were a clearer understanding of the service offer in Warwickshire and the potential to improve communication of this service offer.
29 Sept.	A discussion with Action Menopause Warwickshire and Healthwatch Warwickshire. This provided the 'lived experience' of patients giving a useful comparison to the evidence of the services commissioned by health services. It provided a number of areas for recommendation shown in Section 2 below.
7 Nov.	The support provided to the County Council's staff. A range of initiatives to raise awareness, offer training, peer support and commissioned services. The key outcomes were a greater understanding of the significant support provided to the Council's staff and the potential to share these findings with other organisations in the County.

5.0 Findings and Conclusions

5.1 Overview

A key finding from this work is a much deeper understanding of the way that Menopause services are commissioned and the learning from those with lived experience of services. There is a misconception that the only services available in Warwickshire are from private service providers. It is clear that the County Council has developed a substantial 'offer' of support and advice for its own staff. These findings could usefully be shared with partner organisations and more widely with employers in Warwickshire.

Primary Care does offer a range of services, with some practices having specialists in menopause services. For some patients (typically 20%) they require more specialist menopause support services.

5.2 Evidence

5.2.1 The first evidence session heard from the C&W ICB, which commissions Warwickshire health services including Menopause services. A detailed presentation with a question-and-answer session covered the areas shown below:

- The core menopause services provided in each of Warwickshire's 120 GP practices, in accordance with National Institute of Clinical Excellence (NICE) guidance. A range of treatment options are available, not just issuing a prescription for Hormone Replacement Therapy (HRT).
- A learning area is the option for an annual HRT pre-payment certificate for £19.30, which would provide savings against the costs of individual prescriptions.
- The known variance in terms of waiting times to access secondary care gynaecology services and details of an initiative using 'accelerator' funding to enhance community provision and take patients out of acute waiting lists. The average waiting time (in June 2023) was 39 days. It had reduced the need for referral to an acute trust for 20% of gynaecological conditions.
- The hospital services available at all three acute trusts. These showed a divergence of waiting times (in June 2023) from 17 weeks at South Warwickshire Foundation Trust to University Hospitals Coventry and Warwickshire where the wait was 28 weeks.

5.2.2 Through questioning, the following points were noted:

- GP practices don't all have menopause experts, but the services they provide do meet NICE guidelines, enabling management of most (typically 80%) of cases. More complex menopause cases are referred

to the primary care gynaecology service or secondary care. GPs may opt to undertake additional training in menopause services (this is the same for many clinical specialisms).

- A concern raised is prescription of sedatives for patients who need referral to secondary care. It would be useful to understand where patients submitting complaints are located, to assess if the new arrangements for the primary care pathway and triage via the contact hub are working effectively.
- Communication is a key area where the local health and care system can assist. Raising reported concerns with health partners will assist the ICB to support practices, ensuring they communicate the service offer to patients effectively. There is a lack of public awareness of the NHS services available, an example being alternatives to HRT. Councillors receive feedback from constituents, and Healthwatch similarly gathers the 'lived experience' of patients, which could provide data for the ICB of the concerns reported.
- The current NICE standards date from 2017[1]. There have been medical developments including different types of HRT and non-HRT pharmaceuticals, giving more choice of prescription. However, HRT remains the primary and preferred treatment. It should be noted that there are wider benefits from taking HRT examples being bone health and cardio protection; it is not just for alleviating menopause symptoms. The NHS provides advice on the benefits and risk of HRT.
- Healthwatch reported the stigma associated with not coping and a lack of confidence in speaking about the menopause in public. There is a view that patients have to fit the service available, rather than services being tailored to the patient. A need to recognise the cultural aspects too. Some women are reluctant to speak publicly about both menopause and periods. This is less so for younger generations. The later findings from discussion with Action Menopause Warwickshire also show a reluctance amongst many females in speaking publicly about Menopause.
- However, increased media coverage, coupled with a number of celebrities speaking openly about menopause has helped to make conversations on menopause more frequent[2].The Government has similarly looked at menopause and the workplace through a review by the Women and Equalities Committee.

5.2.3 The key outcome from this session was the need for information sharing. Prior to the review there was a lack of understanding of the NHS commissioned services in Warwickshire and a perception that the only menopause support provision was through private providers. The evidence has shown the NHS primary and specialist secondary care services available. Through elected members and the wider

[1] See also paragraph 5.2.14 below which updates on the review of NICE guidance.
[2] Television presenters Davina McCall and Lorraine Kelly, actor Dawn French, entrepreneurs Liz Earle and Seema Malhotra, and GP Dr Louise Newson are just a few high-profile people who have spoken candidly about the menopause and the symptoms that often come with it.

partnership working of the Council, communication is a key area where assistance can be provided. This forms one of the recommendations for the review. Such information may be provided in a number of ways, through leaflets and digital media. It could include information for members' constituency work, signposting to services, links to websites and to social media. The evidence from the ICB provided factual knowledge of the services provided in Warwickshire.

5.2.4 The second evidence session heard from Action Menopause Warwickshire (AMW) and Healthwatch Warwickshire (HWW). This session aimed to gather the 'lived experience' of people using Menopause Services in Warwickshire.

5.2.5 Ahead of the meeting, AMW provided its focus group report, written information and internet links. The discussion provided rich information on the work of this charitable group. It highlighted the variance in GP knowledge of Menopause services, and potential for misdiagnosis especially in younger women. There were long waiting times for specialist referrals in some cases. The discussion included training for clinicians, advising patients so they had sufficient information when speaking to their GP, the prescription of HRT and alternatives to HRT. The group provided a social forum for people to discuss their symptoms, to hear from guest speakers and professionals, offering a holistic approach. AMW explained that it has development aspirations around the workplace and training for employers.

5.2.6 The second part of this meeting heard evidence from HWW) A briefing document provided national and local background. HWW had attended local support groups (including AMW). Throughout Warwickshire, there were eight menopause support groups but some gaps in provision in the North and Rugby areas. HWW was undertaking a survey on the experiences of those using Menopause services. The early findings were reported through a presentation. This showed patient feedback where repeated GP appointments were required, a lack of GP knowledge or support and some misdiagnosis, before correctly identifying menopause symptoms. People had spoken about the impact on their lives, poor mental health, some had thoughts of suicide, challenges in caring for others and being concerned about job loss. The survey sought to understand people's experience, circumstances, and the impact of menopause, with questions around demographics. It sought feedback on the medical support in primary care and barriers to contacting a healthcare professional. It sought to assess satisfaction with treatment and access to HRT. To date (September 2023) 83 responses had been received. HWW offered to report the final findings after the survey closed in December 2023.

5.2.7 The key findings from this evidence session were:

- The value of the social groups including Action Menopause Warwickshire (and those groups listed on page 28 of Appendix 2) in providing support, advice and information. A collaborative approach would be helpful to share knowledge between these groups.
- The research from Healthwatch shows the gaps in provision, notably in the north of Warwickshire and Rugby areas. The Integrated Care System is urged to seek the establishment of similar support groups in those areas.
- The evidence from AMW and HWW shows that the 'lived experience' of patients does not align with the information in June from the ICB on Menopause service availability. This supports the need for improved communication and is a role for the system as a whole to ensure that patients are aware of the service offer.
- Linked to the above, Improving the patient information literature may help women to recognise when they are experiencing the menopause. Such clear information will assist patient conversations with their GP and may reduce the potential for a misdiagnosis, especially in younger women.
- Providing greater understanding of the symptoms for partners would be helpful along with literature about HRT, non-HRT, and complementary therapies.
- Receiving the final data from the HWW survey, and subject to the consent of HWW, incorporating these findings in the evidence, conclusions and recommendations of this review as appropriate.
- Access to Menopause specialists. Evidence from both the ICB and the groups providing lived experience of services showed that access to a menopause specialist in primary care varies. It is not feasible to have a specialist for menopause located at every GP practice. There are referral processes for those requiring specialist support, but evidence of lengthy delays in some cases. The ICB data shows that 80% of menopausal women can be supported via primary care. A question for the ICB is whether triage and the use of technology could offer remote appointments with a primary care menopause specialist. A further suggestion for patients who need or would prefer a face-to-face appointment is providing periodic clinics or the use of 'drop in' centres where people can talk to a menopause specialist.

5.2.8 The final evidence session focussed on the support the County Council provides for its staff. The session comprised a presentation, menopause data and a briefing document, which pulled together extracts of the different information sources the Council shared with its staff, offering advice and support.

5.2.9 The presentation included context on the proportion of female staff who were likely to be going through the menopause, and at least one had

left their employment due to the menopause. Nationally, data showed that one in ten women left their role due to the menopause[3].

5.2.10 The slides described the Council's 'journey' to develop support and services for its staff with detail on the activities, awareness raising, training, peer support, the 'listening mates' and commissioned services. Appendix 2 of the report (page 30) provides more detail from the presentation.

5.2.11 There is evidence of demand for the services with training sessions being oversubscribed resulting in a waiting list, very positive feedback from those attending the training and a high number of visits to the information provided via the Council's staff Intranet pages and social media platforms. The feedback on symptoms experienced led to e-learning and awareness raising courses, both for staff and managers. Through menopause awareness month, sessions were provided looking beyond medical aspects, to include nutrition, yoga, foraging and herbal solutions. The sessions involved both women and men. A peer support group had been established and menopause was now recognised as a reason for sickness absence.

5.2.12 The data report confirmed and evidenced many of the above points. The WCC workforce comprised 70% female employees. From a 'Wellbeing Check In', a total of 1248 responses were received (24.6% of the workforce). Specific question areas and response data linked to menopause support were provided. Overall, the results showed that a high percentage of people who responded to the 'Check In' were aware of the information and support available regarding the menopause, and that it was a valued resource.

5.2.13 The media platforms used to inform staff included the staff Intranet, Yammer and the weekly newsletter 'Working for Warwickshire'. Through questioning, the following points were noted:

- The County Council's support for its staff was well regarded by partners, evidenced by a request for Abbie Macfarlane to speak at the Integrated Healthcare Women's Network on the work WCC was doing.
- A suggestion to share the findings and learning WCC had gathered with the five Warwickshire district and borough councils. Similarly, sharing this information and seeking to influence other employers in the County, noting the data that one in ten women left their employment due to the menopause.
- The potential for WCC to have a pledge as a menopause friendly organisation. It should be mindful of the other conditions or life

[3] The Menopause and the Workplace report by the Fawcett Society and Channel 4, which polled 4,000 women aged 45-55, found that 10 per cent had left their job because of symptoms of the menopause.

challenges staff faced. This may include care responsibilities for both children and/or elderly relatives, which could contribute to stress.

- Changing culture and the need for a continued dialogue, so that conditions linked to the female life cycle were not a cause for fear in terms of reporting to an employer. Recognising the impact for partners too and there needed to be open conversations.
- The challenges for clinicians in terms of diagnosis, especially for younger women. There was a lot more information available to women now, with some potentially being more informed than their GP.

5.2.13 Learning points from this evidence:

- The key learning for members was an appreciation of the amount of work being undertaken to support WCC staff. Abbie Macfarlane and Laura Chapling were thanked by members. Members held the view that the Council needed to publicise the work it was doing, and it should be seen as an exemplar.

- Sharing the learning WCC had gathered with the five Warwickshire district and borough councils. Also, considering the potential to share such information and seeking to influence other Warwickshire employers.

5.2.14 After the evidence sessions, the TFG learned that NICE is revising the guidance for menopause diagnosis and management (expected by May 2024). This comprehensive guidance, whilst still in draft form covers extensively the identification and management of menopause, providing updated recommendations, and that some further research is undertaken. Updated recommendations are made in regard to HRT and its effects on cardiovascular disease and stroke, breast cancer and dementia. New information is provided on endometrial cancer, ovarian cancer and all-cause mortality (life expectancy) and the effects of either taking or not taking HRT on health outcomes for people experiencing early menopause (age 40 to 44). This will provide detailed guidance to health care professionals, patients experiencing menopause symptoms, their families, carers and the public. It makes clear the need to give each woman tailored information on the benefits and risks of HRT, dependent on their age, individual circumstances and potential risk factors. Further detail on the NICE evidence reviews is available here.

5.3 Conclusions

5.3.1 The findings from the three evidence sessions inform the following conclusions and support the recommendations shown in Section 2 of this report. As with many scrutiny reviews, an outcome is the significant learning for members. The review has identified some challenges and

potential opportunities to improve with provision of information and joining up services across the local system.

5.3.2 A need for coordinated communications activity to explain to the public the menopause services available. Prior to the review there was a lack of understanding of the NHS commissioned services in Warwickshire. This is an area where partners in the local health and care system, including councillors as community leaders and the Health and Wellbeing Board members can assist.

5.3.3 The evidence from AMW and HWW shows that the 'lived experience' of patients does not align with the ICB information on NHS menopause services. This further demonstrates the need for coordinated communications activity and a review of literature for patients. Clear information in a range of formats/media on menopause symptoms will assist patient conversations with their GP, and may reduce the potential for a misdiagnosis, especially in younger women. Providing greater understanding of the symptoms for partners would be helpful along with literature about HRT, non-HRT and complementary therapies.

5.3.4 A valuable community resource is provided by the voluntary groups, which offer support, advice and information. Healthwatch confirmed there are eight groups in Warwickshire, but also notable gaps in provision in the north of Warwickshire and Rugby areas. The Integrated Care System may wish to consider actions to seek the establishment of similar support groups in those areas. A collaborative approach would be helpful to share knowledge across these third sector groups.

5.3.5 It is not feasible to have a menopause specialist at every GP practice. There are referral processes for those requiring specialist support but evidence of lengthy delays in some cases. It is stated that 80% of menopausal women can be supported via primary care. Current services could be enhanced through triage and the use of technology to provide remote appointments where there is not a menopause specialist at the patient's local GP practice. A further suggestion for patients who need or would prefer a face-to-face appointment is periodic clinics or the use of 'drop in' centres where people can talk to a menopause specialist. These may need to be based in larger population centres to ensure a viable service demand. Collaboration with services providing psychological support such as IAPT may also be valuable.

5.3.6 In terms of support for the County Council's staff, members of the TFG place on record their appreciation for the amount of work being undertaken. A suggestion to share the findings and learning WCC has gathered with the five Warwickshire district and borough councils. Similarly, sharing this information and seeking to influence other employers in the County may provide real benefits for Warwickshire

residents and their employers, given the data that one in ten women leave their employment due to the menopause. Through the Council's partnerships, discussion with the Chamber of Commerce and other business groups this could be explored.

5.3.6 The Adult Social Care and Health OSC should monitor the implementation of the recommendations in Section two of this report through annual updates and briefings.

6.0 Feedback

The views of relevant Directors, Legal, Finance, Equalities and Diversity and the Integrated Care Board have been sought on this report, prior to its submission to the Adult Social Care and Health Overview and Scrutiny Committee. Legal advice will be taken in respect of activities required to implement any approved recommendations to ensure compliance.

The Executive Director for Social Care and Health commented on the recommendations as they emerged endorsing and supporting them and highlighting the need for all partners in our Integrated Care System to actively support implementation and share best practice with each other.

Chief Medical Officer, Coventry and Warwickshire Integrated Care Board – Feedback awaited

Appendix A
Scoping Document

Review Topic (Name of review)	Menopause Services
Members of the Group	Councillors Brown, Drew, Falp, Humphreys (Vice Chair), O'Donnell and Rolfe (Chair)
Co-option of District and Borough members (where relevant)	District and borough health scrutiny Portfolio Holders to contribute to the evidence after their respective elections/appointment.
Key Officers / Departments	Officer support is available to provide research between meetings from the Public Health and Business Intelligence sections. Organisational Development will detail the support provided to staff.
Lead Democratic Services Officers	Isabelle Moorhouse and Paul Spencer
Relevant Portfolio Holder(s)	Councillor Margaret Bell, Portfolio Holder for Adult Social Care and Health
Relevant Corporate Ambitions	'We want to be a County where all people can live their best lives; where communities and individuals are supported to live safely, healthily, happily and independently'.
Type of Review	Task and Finish Review
Timescales	To be determined. There are five planned meetings in total with at least three of these being information gathering meetings from external participants.
Rationale (Key issues and/or reason for doing the review)	A need to understand more about service provision across the county, how well this is communicated to residents, to assess the consistency of service and any gaps in provision. Members would like to understand the support the Council provides to its employees. The TFG wants to receive case studies of good and bad 'lived experience'.
Objectives of Review (Specify exactly what the review should achieve)	The focus of the review to be on the services available to Warwickshire residents from both the Council and the NHS. People are presenting with symptoms that are menopause related, which may be diagnosed as other conditions. The objectives mirror the scope of this review shown below. Key aspects are understanding the services provided and any gaps in provision, assessing the effectiveness of communication of the available services and how the Council supports its staff as a mindful employer.

Scope of the Topic (What is specifically to be included/excluded)	Include The commissioning OSC has outlined the areas to be included: • Research of the services provided in neighbouring geographic areas including Coventry and also in councils of similar size/demography. • The focus of the review to be on the services available to Warwickshire residents from both the Council and the NHS. People are presenting with symptoms, which may be diagnosed as other conditions. • The Coventry and Warwickshire Integrated Care Board (ICB), which is responsible for health pathways will be involved in this review and be asked about the pathways for menopause services. The ICB should provide details of what services are provided, to assess if there is a disconnect and options to bridge any gaps. Does not include • NHS services outside of Menopause services • The TFG will not be used as a forum purely for discussion or complaint. The TFG will be constructive and give value, with good and demonstrable outcomes, which could be implemented, to effect some change.
How will the public be involved? (See Public Engagement Toolkit / Flowchart)	Healthwatch Warwickshire provides a useful link with the public as does the specialist group Action Menopause Warwickshire. The TFG will seek case studies of patient experience to highlight where services have performed well or not so well.
What site visits will be undertaken?	It is not considered that a site visit will add material value to this review.
How will our partners be involved? (consultation with relevant stakeholders, District / Borough reps)	Seek input and evidence from the Coventry and Warwickshire ICB. Seek lived experience and patient voice input from Healthwatch Warwickshire and the specialist group Action Menopause Warwickshire. Feedback from WCC Officers may also be useful.
How will the scrutiny achieve value for money for the Council / Council Tax payers?	It is not envisaged that any costs will be incurred in undertaking the review.

What primary / new evidence is needed for the scrutiny? (What information needs to be identified / is not already available?)	The first evidence meeting will hear from the ICB, the commissioner for health services in Coventry and Warwickshire. It is envisaged this will be a presentation with a question and answer session to explore current service provision. Healthwatch Warwickshire will be invited to input on 'lived experience', providing its findings and data from residents on the services received in comparison to that reported by the ICB. The TFG will hear from the Council's Organisation Development officers about the services provided to support staff. Invite Action Menopause Warwickshire, a specialist group to provide its findings. This session to be linked with case studies of good and bad lived experience.
What secondary / existing information will be needed? (i.e. risk register, background information, performance indicators, complaints, existing reports, legislation, central government information and reports)	Background information and internet links have been circulated to enable members of the TFG to undertake initial research. This includes a scrutiny report from Norfolk County Council and a presentation provided by the Council's Director of Public Health. Documents were supplied from the NHS, the Department for Health and Social Care, the British Menopause Society, Public Health England and data from the Council's Power BI platform. There is an offer of further background support from both Public Health and Business Intelligence.
Indicators of Success – (What factors would tell you what a good review should look like? What are the potential outcomes of the review e.g. service improvements, policy change, etc?)	Evidence of the effective communication of the services available for Warwickshire residents, or an undertaking from the ICB and others to improve this. Assessing the differences in service provision and access to menopause specialists across individual practices, primary care networks or the Warwickshire geography and then influencing the ICB to 'level up' such service provision throughout the County.

Other Work Being Undertaken (What other work is currently being undertaken in relation to this topic, and any appropriate timescales and deadlines for that work)	It is evident from the publications and national media coverage over the last year that there is much discussion of menopause services. This TFG seeks to understand the comparative service provision in Warwickshire, to highlight areas of good practice and a provide a focus on effective communication, so Warwickshire residents know how to access services. Local authorities cross-country have prioritised menopause services in the last couple of years.

Appendix B
Primary Evidence Detail

1.1 Scoping – 25 April 2023

1.1.1 A clear guide had been provided by the commissioning ASC&H OSC on the remit for this TFG. This provided the basis for the scope and the areas below were raised by the TFG in finalising the scope.

1.1.2 Objectives

- WCC should ensure that it is a mindful employer.
- Gather knowledge on current services for staff and residents which are provided both by the NHS and WCC. How well are services communicated?
- Look at how the menopause affects the whole family; raise awareness of available treatment and advice services.
- An influencing role for larger employers within Warwickshire on menopause support in the workplace.

1.1.3 Co-option of District and Borough members

- Seeking input from each Warwickshire Borough and District Council to gather local knowledge on services and what each authority was doing to support people.

1.14 Key Officers / Departments

- In addition to Democratic support, Public Health and Business Intelligence could undertake research and provide information between meetings.
- Human Resources and Organisational Development would provide input on the support available for staff.

1.15 Timescales

- It was agreed that there would be three evidence gathering meetings and five meetings in total.
- The TFG's report would be submitted to the Adult Social Care & Health OSC before going to Cabinet and the Health and Wellbeing Board.

1.16 Involving the public and partners

- Chris Bain and lead colleagues from HWW would be invited to future meetings.
- Seek case studies from people who have used/are currently using WCC or NHS menopausal services sharing their good and bad experiences. This would help to identify gaps in services. Having criteria of what constitutes a good service would make this more objective. Healthwatch and/or Action Menopause Warwickshire could suggest people to share their experiences.

- The ICB would be asked to detail the current services provided. Understanding the primary care offer and consistency of service were aspects raised.
- It was known that some private menopause health services were available in the South of Warwickshire. The costs and speed of access to those services were discussed.

1.17 Indicators of Success

- Securing effective communication to residents and WCC staff of the services available. The review may find that members of the public and some GPs did not know where to go or to signpost people to available menopause services on the NHS.
- Recognition of the limited influence the TFG had on commissioning and provision of NHS services. To understand 'what does good look like' which needed factual data and more qualitative and subjective data around how people felt they were being supported.
- The ICB would be able to detail the services available. Outcomes from scrutiny reviews could include rich data and learning about service provision. The review report would share such learning. Assessing system capacity and access to menopause services was a key area for this review, it being expected that services would vary across individual GP practices.

1.2 Evidence Session – 15 June 2023

1.2.1 Scoping Document - The TFG approved the review scoping document.

1.2.2 Presentation from the C&W ICB. A presentation from senior officers responsible for commissioning primary care and specialist services. The presentation covered the following areas:

- Local Service Overview
- GP Services
- NICE Quality Standard
- HRT Provision
- Primary Care Gynaecology Service
- Hospital Services

1.2.3 The presentation evidenced that there were core menopause services provided in each of Warwickshire's 120 GP practices, in accordance with National Institute of Clinical Excellence (NICE) guidance. A range of treatment options were available, not just issuing a prescription for Hormone Replacement Therapy (HRT). Others included Non-hormonal products for symptom relief and non-pharmaceutical products. The ICB did provide training for GPs and other practice staff.

1.2.4 A learning area was the option for an annual HRT pre-payment certificate for £19.30, which would provide savings against the costs of individual prescriptions.

1.2.5 There was a known variance in terms of waiting times to access secondary care gynaecology services and that waiting times had lengthened. Details were given of an initiative, part of the elective recovery programme, using ‘accelerator’ funding to enhance community provision and take patients out of acute waiting lists. This had been successful with 500 patients returning to GP led services. The average waiting time was now 39 days. It had reduced the need for referral to an acute trust for 20% of gynaecological conditions.

1.2.6 The presentation outlined the hospital services available at all three acute trusts. These showed a divergence of waiting times from 17 weeks at SWFT to UHCW where the wait was at that time 28 weeks.

1.2.7 The subsequent question and answer session confirmed that not all GPs or indeed practices had menopause experts, but the services met NICE guidelines. This should enable management of most cases (typically 80%), with more complex menopause cases being referred either to the primary care gynaecology service or secondary care. A parallel could be drawn to onward referral to many other specialist services. GPs could opt to undertake additional training in menopause services (or many other areas).

1.2.8 A discussion around the prescription of sedatives for some patients who were subsequently referred to secondary care. Such referrals should be undertaken at the earliest possible date. The referral pathway was discussed. It would be useful to see where the patient submitting a complaint were located, to assess if the new arrangements for the primary care pathway and triage via the contact hub were working effectively.

1.2.9 Communications was a key area where other parts of the system, including Councillors as community leaders may be able to assist. An example would be reports of poor communication by primary care of the services available. The ICB could engage with specific practices as necessary. There was often a lack of awareness of the NHS services available, in this case alternatives to HRT. Councillors received feedback from constituents, and Healthwatch similarly gathered the patient voice and lived experience, which could provide data for the ICB of the concerns reported.

1.2.10 It was noted that the NICE standards dated from 2017 and there had been medical developments including different types of HRT and non-HRT pharmaceuticals, giving more choice of prescription. However, HRT remained the primary and preferred treatment.

1.2.11 Feedback to Healthwatch included the stigma associated with not coping and a lack of confidence in speaking about the menopause in public. It seemed that patients had to fit the service available, rather than asking what

the patient needed. A need to sense check how the current provision landed with patients. It was important to recognise the cultural aspects too. Healthwatch was surprised at the depth of feeling and intended to do more research. Members shared the views on women being reluctant to talk publicly about both menopause and periods. This was less so for younger generations and the increased media coverage was a further point discussed.

The key outcome from this session was the need for information sharing. Through elected members and the wider partnership working of the Council, communication was a key area where assistance could be provided. This could form one of the recommendations for the review report and action plan. Such information could be provided in a number of ways, through leaflets and digital media. It could include information for members' constituency work, signposting to services, links to websites and to social media. The session had provided factual knowledge of the services provided in Warwickshire.

1.3 Evidence Session – 29 September 2023

1.3.1 Action Menopause Warwickshire (AMW). A discussion item with Sue Thomas (founder) and Susie Weston (Chair) of AMW. The document pack circulated ahead of the meeting included:

- A copy of the AMW focus group report.
- Additional information and web links.
- Menopause and the Workplace - final proof of a paper written by Sue Thomas which had been accepted for publication in The Journal of General Practice Nursing.

1.3.2 Context was provided on the role of this small specialist and voluntary group which had recently achieved charitable status. The founder had a poor personal experience in terms of Menopause support from NHS services. As a nurse practitioner, she was better informed than many women, who may not know where to seek assistance. There was variance in GP knowledge of Menopause services and only some practices had menopause specialists.

1.3.3 The position was improving, and many women were now more aware, approaching their GP in the first instance. Points were made about misdiagnosis, with women being prescribed anti-depressant medication. Others were experiencing long waiting times of over twelve months for specialist referrals and some received little or no support from their GP. From questioning, it was explained that some women started the menopause early and could present with a wide range of symptoms. Healthcare professionals could confuse those symptoms for other conditions, especially in younger women.

1.3.4 Discussion about the training requirements for clinicians. There was no mandatory requirement for the vast majority of health professionals to undertake menopause training. There was a quality and outcomes framework

and prioritised approach for chronic disease management. It would be helpful if menopause was brought into this framework. The NICE (National Institute for Health and Care Excellence) guidelines were being updated, which could also be an accelerator to provide more training, pathways and better guidance. Diagnosis of menopause was a key issue and misdiagnosis may result in unnecessary and/or costly treatments. A need for basic advice around menopause symptoms, so women could seek medical support. Reliance on internet research and informal channels was not appropriate or sufficient. People rightly expected precise medical services and correct diagnosis.

1.3.5 A discussion area was the realistic aspirations in regard to menopause training for general practice staff. It was not practical for every surgery to have a specialist, but having periodic clinics should work especially in towns. One suggestion was for local ‘drop in’ centres where people could talk to a specialist. There was value in seeking collaboration amongst local groups with professional services providing psychological support such as IAPT. The opportunity to work with the third sector was suggested.

1.3.6 Increasing knowledge amongst a patient’s partner was also raised. However, it was noted that AMW participants wanted this group to be for women only, due to the nature of the issues discussed.

1.3.7 The prescription of HRT was discussed at length, for many women being the only treatment offered. It did not suit all women however and other Non-HRT options were available. HRT availability had been a challenge in the recent past, which had been resolved.

1.3.8 AMW provided feedback from its focus group, on the services and support which women wanted. This also showed the value in meeting as a social group (with up to 40 attending) to discuss the symptoms experienced. Having professional input and guest speakers was valued, with examples of the topics including pelvic health, diet, exercise, reflexology, dance and a physical activity quiz. The sessions gathered lived experiences, for example on GP visits and HRT. Through providing advice, women had more information for subsequent GP appointments to evidence that their symptoms could be menopause related.

1.3.9 The group would like to do more, for example around the workplace and training for employers. There was evidence of one in ten women leaving an employment due to the menopause. This was an area considered to be under-reported with other reasons recorded. Employers should have a workplace menopause policy, but many didn’t.

1.3.10 The potential to expand the services to cover all Warwickshire. It would be beneficial to have similar groups in each of the five district and borough areas. From discussion, there may be potential to link with services delivered from the Lifeways Therapy Centre in Stratford, which would be pursued.

1.3.11 The second part of this meeting heard evidence from Healthwatch Warwickshire (HWW) comprising an information pack and presentation. The briefing provided national and local background, together with the current menopause survey which HWW was undertaking. Caroline Graham from HWW reminded of the Department of Health call for evidence. She noted that some women were less willing to talk about menopause openly or would only speak with friends and there were cultural aspects too.

1.3.12 Healthwatch had/was attending the following local menopause support groups:

- Abbey Surgery in Kenilworth - running a menopause support group.
- Action Menopause Warwickshire
- Brunswick Hub (brunswickhlc.org.uk) Menopause Support
- Lifeways ran their menopause support session themselves.
- MOD Kineton run a menopause support group.
- Pause For Menopause — St Wulfstan Southam Surgery
- South Warwickshire and Worcester MIND - delivering a number of workshops around Menopause and Mental Health.
- Stratford Town Trust and Alcester town council provided information events run by Home - Menopause Knowledge

1.3.13 The survey findings to date showed the need for repeated GP appointments, a lack of GP knowledge or support, and sometimes misdiagnosis. People had spoken about the impact on their lives, poor mental health, some had thoughts of suicide, challenges in caring for others and being concerned about job loss. The survey sought to understand people's experience, circumstances, and the impact of menopause, with questions around demographics. It sought feedback on the medical support in primary care and barriers to contacting a healthcare professional. It sought to assess satisfaction with treatment and access to HRT. To date (September 2023) 83 responses had been received and Caroline displayed slides to show the resultant data across the following areas:

- Were you satisfied with the care you received? Yes 30 No32
- What people have told us – mixed messages.
- Early findings about HRT:
  - How well-informed people felt - 38 did, 27 did not
  - How comfortable they felt in speaking to healthcare professionals – 45 did, 5 did not
  - Concerns about side effects of HRT 21 (26.25% of responses)
  - Have you ever been prescribed HRT – Yes 48 No 34
  - Access issues to HRT and the reasons for non-prescription.
- Does your GP Surgery have a specified person to provide menopause support? Yes14; No 19; Unknown 50
- What people have told us.

The survey would continue until December 2023. The results to date were not clear and it was hoped that additional feedback would show themes, or geographic and age-related patterns. It was evident that mapping was a key aspect.

1.3.14 There were various support groups, and a collaborative approach would be helpful to share knowledge. It would be interesting to see the data at the conclusion of the survey. Technology could facilitate remote appointments and access to specialists if they were not available in a local surgery for a face-to-face appointment. It was acknowledged that this solution did not suit all patients. When considering the report recommendations perhaps there was something around triage or use of technology to give access to menopause specialists.

1.3.15 There was evidence that HRT had preventative benefits for other medical conditions linked to the menopause, such as an increased risk of heart disease and cardiovascular conditions. There were misconceptions linking HRT to an increased risk of breast cancer where some HRT medicines could actually reduce that risk. Reference to education, complementary therapies and the need for a holistic approach.

1.3.16 It was noted that part of this meeting was held informally, due to a lack of quorum. The evidence heard was circulated to all members of the TFG, with the opportunity for questions and points of clarification after the meeting. The evidence was revisited at the following TFG meeting.

1.3.17 Learning points from this evidence:

- The evidence from AMW shows the value of such social groups in providing support and information. A collaborative approach would be helpful to share knowledge.
- The research from HWW shows there are some gaps in provision, notably in the north of Warwickshire and Rugby areas. Recommendations could be made for the Council and partner agencies to consider actions to stimulate or facilitate the establishment of similar support groups in those areas.
- The evidence from AMW and HWW shows that the ‘lived experience’ of patients does not align with the information from the ICB on Menopause service availability. This supports the need for improved communication to ensure that patients are aware of the service offer.
- Linked to the above, helping patients to be more informed of menopause symptoms when seeking assistance from their GP, should reduce the potential for a misdiagnosis, especially in younger women.
- Improving the information available for patients, partners and others in a range of formats and media. Such information to include HRT, non-HRT and complementary therapies, information for partners and those in a support role.

- Receiving a further update on the findings of the HWW survey after it closes in December 2023, incorporating these findings in the evidence, conclusions and recommendations of this review as appropriate and subject to the consent of HWW.
- Access to Menopause specialists. Through triage and use of technology it may be feasible to offer remote appointments and access to primary care menopause specialists, whilst noting this may not suit all patients. Another suggestion is periodic clinics or the use of 'drop in' centres where people can talk to a menopause specialist. Collaboration with professional services providing psychological support such as IAPT, is also suggested.

1.4 Evidence Session – 7 November 2023

1.4.1 As the previous meeting in September became inquorate, all members were invited to review and comment on the evidence heard informally at that meeting.

1.4.2 Workforce Support. The main focus for the final evidence session was the support provided by the County Council to its staff. The session was in three parts with a presentation from Abbie Macfarlane, menopause data presented by Laura Chapling (both from the Council's Human Resources and Organisational Development function) and a briefing document, which pulled together extracts of the different information sources the Council shared with its staff, offering advice and support.

1.4.3 The presentation covered the following areas:

- Why? A slide quoting from the Women's Health Strategy about support in the workplace. There were 1461 women employed by WCC in the age range (45-60), where they were likely to be going through the menopause (data from September 2022). One woman leaving WCC had cited menopause as the reason. Nationally, data showed that one in ten women left their role due to the menopause.
- 'Our menopause journey'. Information on the timeline from May 2022 onwards detailing activities, awareness raising, training, peer support, the 'listening mates' and commissioned services.
- Feedback. A slide showing data and feedback from those engaging with the information sources.
- Three menopause sessions were booked with a health coach. This was oversubscribed with a waiting list of 150 women, which evidenced the support requirement. It was followed by a questionnaire to assess needs and a dedicated intranet page was provided, which had been viewed 1,965 times, with more views daily.
- Feedback on the symptoms women reported, including 'brain fog' and neurological conditions which may impact on work activity. E-learning and awareness raising courses were now offered, both for staff and managers.

- Through Menopause awareness month a number of sessions were provided looking beyond medical aspects, to include nutrition, yoga, foraging and herbal solutions. The sessions involved both women and men.
- A peer support group had been established.
- Every woman's menopause journey was different, although there were some commonalities in terms of symptoms. Some roles at WCC lent themselves to more flexible working patterns, in terms of time or location, than others. Specific reference to the support needs for those with cancer.
- Menopause was now listed as a reason for sickness absence. It was known that some people attending their GP with menopause symptoms were recorded as suffering from stress. There was still some stigma about reporting menopause symptoms as the cause for not coping.
- Through 'listening mates', colleagues volunteered their time and support to others, also signposting them to services. The group approach did not work for everyone. Some women were not comfortable speaking to a younger male manager, so a menopause ambassador approach was being suggested. This was similar to that established for staff with cancer who provided a liaison role between the staff member and their manager.
- Through the Yammer platform, 2050 people had viewed a post on menopause and the feedback from those attending menopause sessions was very positive. Individual feedback from staff was highlighted.
- In summary, there was now more awareness of the menopause support available amongst both staff and managers.
- Members praised the impressive amount of work undertaken.

1.4.4 The data report confirmed the following points:

- The WCC workforce comprised 70% female employees.
- Just over half of the WCC workforce were between the ages of 25 and 50 (54.3%).
- A 'Wellbeing Check In' was undertaken between May-July 2023. There was a total of 1248 responses (24.6% of the workforce). Specific question areas and response data were provided.
- Overall, the results showed that a high percentage of people who responded to the 'Check In' were aware of the information and support available regarding the menopause, and that it was a valued resource. Details were given of the different platforms used to inform staff, through the Intranet, Yammer and the weekly staff newsletter 'Working for Warwickshire'.

1.4.5 From member questioning, the following points were established:

- The County Council's support for its staff was well regarded, evidenced by a request for Abbie Macfarlane to speak at the Integrated Healthcare Women's Network on the menopause support WCC was providing. There was anecdotal feedback from NHS colleagues too.
- Members explored the potential to influence other employers, noting the data that one in ten women may leave their employment due to the menopause.
- The potential to have a pledge as a menopause friendly organisation. Sometimes staff were experiencing menopause symptoms alongside other conditions or life challenges. This may include care responsibilities for both children and/or elderly relatives, which could contribute to stress.
- Changing culture and the need for a continued dialogue, so that conditions linked to the female life cycle were not a cause for fear in terms of reporting to an employer.
- There were challenges for clinicians in terms of diagnosis and some were embarrassed to discuss menopause. Some women only realised retrospectively that the symptoms they had been experiencing were menopause related. Diagnosis was even more challenging for younger aged women. There was a lot more information available to women now, with some being more informed than their GP.
- The impact for partners was touched upon. Menopause had not been taken seriously in the past or was not discussed. There needed to be open conversations.
- The potential to share the learning WCC had gathered with the five Warwickshire district and borough councils.
- Seeking an update to the NICE guidelines to have a more holistic view of menopause.

1.4.6 Learning points from this evidence:

- The key learning for members was an appreciation of the amount of work being undertaken to support staff. Abbie Macfarlane and Laura Chapling were thanked by members. There was recognition of the range of resources and services to support staff. A view that the Council needed to publicise the work it was doing, and it should be seen as an exemplar.
- The potential to share the learning WCC had gathered with the five Warwickshire district and borough councils should be pursued.

Appendix C - Glossary

Term	Definition
AMW	Action Menopause Warwickshire A charitable organisation providing menopause information and support.
ASC&H OSC	The Adult Social Care and Health Overview and Scrutiny Committee which commissioned this review.
DPH	Director of Public Health
GP	General Practice Doctor
HWBB	The Health and Wellbeing Board is a partnership board comprising key partners from across the health, local authorities, the third sector and Police and Crime Commissioner.
HWW	Healthwatch was established under the Health and Social Care Act 2012 to understand the needs, experiences and concerns of people who use health and social care services and to speak out on their behalf.
HRT	Hormone Replacement Therapy is the main prescription drug used to treat menopause symptoms.
Integrated Care Board (ICB)	In July 2022 a revised system was introduced. The ICB is the NHS commissioning organisation. For this review, it is the body responsible for commissioning of health services.
Integrated Care System (ICS)	In July 2022 a revised system was introduced. ICSs are partnerships of organisations that come together to plan and deliver joined up health and care services.
NICE	National Institute of Clinical Excellence. For this review, NICE provides guidance on the menopause services to be provided by GP practices.
Primary Care Network (PCN)	These are GP practices working together with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas in groups of practices.
TFG	Task and Finish Group. This is the group of elected members undertaking the review.
WCC	Warwickshire County Council

Appendix D
Scrutiny Action Plan

	Recommendation National Issues	PfH Comments	Cabinet Comments	Target Date for Action	Lead Officer	OSC Update	Progress Notes
1.	That the Integrated Care Board, be requested to develop a robust and targeted communications strategy with the aim of improving communication to the public about the availability of menopause services across the County.						
2	That the Integrated Care Board considers options to improve access to menopause specialists in primary care settings.						
3	That endeavours are made by the Integrated Care System to seek the establishment of voluntary sector menopause support groups in the North of						

	Warwickshire and Rugby areas.						
4	That the County Council considers sharing information on the menopause support offer it has developed for staff with partner organisations and with other employers in Warwickshire. Seeking details of the support already in place in those organisations is also suggested. The aim is to encourage more menopause support in Warwickshire workplaces.						
5	That the Adult Social Care and Health Overview and Scrutiny Committee monitors the implementation of these recommendations through periodic updates and briefings from the ICB.						

Agenda Item 8

Health and Wellbeing Board

6 March 2024

Coventry and Warwickshire Joint Health and Wellbeing Board Update

Recommendations

That the Health and Wellbeing Board

1) Notes and comments on the dissolution of the Coventry and Warwickshire Joint Health and Wellbeing Board development sessions;

2) Supports the proposal for two cross-organisational working groups to be established to:

   a) Agree how the Integrated Care Partnership (ICP) should respond to the feedback from the Joint Health and Wellbeing Board development session; and

   b) Develop a shared set of principles across the Integrated Care System (ICS) that outline how we will effectively involve communities within our work.

3) Endorses the proposed governance and reporting arrangements between the Integrated Care Partnership and the Health and Wellbeing Board.

1. Executive Summary

1.1. The coming together of Coventry's and Warwickshire's Health and Wellbeing Board first took place in 2017 when they met with then Sustainability and Transformation Partnership (STP) to form the C&W Place Forum. In 2018 the Place Forum developed the C&W Health and Wellbeing Concordat, setting out how it would work together to improve health outcomes for local people. The Concordat was signed by both C&W Chairs of HWBBs and it led to joint working across C&W, including through the Year of Wellbeing 2019, the King's Fund population health framework, and the C&W COVID-19 Health Impact Assessment. The Concordat also fed into the both C&W Health and Wellbeing Strategies and later in December 2022 the Integrated Care System (ICS) Strategy.

1.2. Between 2021 and 2024, as the new ICS infrastructure was emerging, the C&W Place Forum morphed into the Joint Place Forum and Health and Care Partnership Board (2021); the C&W Integrated Health and Wellbeing Forum (2022) which was facilitated by NHS Elect and had a broad membership

across health and care; and finally the C&W Joint Health and Wellbeing Board development session (2024) chaired by the Local Government Association (LGA) and with a smaller membership consisting only of HWBB members.

1.3. Coventry and Warwickshire Joint Health and Wellbeing Board development session was held on the 8th January 2024. The development session was facilitated by the Local Government Association (LGA) peer associates, with support from the Partners in Care and Health Programme. All HWBB members and HWBB Executive Group members were invited to the development session. The session aims were to:

a) Develop a shared understanding about the unique role that HWBBs play within the wider system context across the country and HWBBs respective roles, purpose, and alignment with the C&W system (activity 1)

b) Utilise the C&W mental health concordat as an example to work through and understand the role that the Joint HWBB could play in taking this work forward (activity 2); and

c) Agree on whether, based on the above, the JHWBB should continue to meet.

1.4. Two group activities were facilitated on the day:

1.4.1. The first focused on the role of the HWBB within the wider integrated care system (ICS) architecture and asked participants to articulate their understanding of these roles, purpose and alignment across the ICS. The following emerged in relation to the utility of the Joint HWBB:

- Strategic direction set by the Joint HWBB (previously Place Forum) via adoption of the Kings Fund population health framework has influenced ways of working at a more local level and led to greater collaboration between place-based partnerships. For example, there are now stronger working relationships between North Warwickshire Borough Council and Nuneaton and Bedworth Borough Council and aligned priorities across the two boroughs.

- The Joint HWBB was a forerunner to the creation of the ICS and served a purpose as a space for partners to come together, prior to changes in statute and the creation of the Integrated Care Partnership (ICP).

- Initial thinking around the ICP having a small membership has now changed and the ICP membership has grown to where there is significant overlap between ICP and Joint HWBB development session membership.

1.4.2. There were also a number of gaps identified if the Joint HWBB development sessions were to be stood down:

- No district and borough representation on the ICP (either elected member or officer).

- Democratic voice is stronger on the Joint HWBB (due to the nature of HWBB make-up).

- Joint HWBB development sessions provided a private forum, whereas the ICP meets in public.

1.4.3. The scope of the second activity was adapted on the day in order to flow from the discussions within activity one. Each table was asked to explore establishing a system CEO forum; strengthening the citizens voice within the ICS; and how the HWBBs can better connect with the ICP:

- Consider establishing a CEO forum: the ICB took away an action to explore this, based on the perceived value it could add, and noting that local authority chief executives are not members of the ICB or ICP. The Anchor Alliance, as a similar forum in this space, does not have representation from all ICS partners and its focus on the wider determinants of health was considered not broad enough.

- Strengthening the citizens voice within the ICS: It was agreed that both Directors of Public Health (DPH), the ICB and both local Healthwatch organisations should meet to discuss this. There was particular emphasis on how to ensure that forums bring in the citizens voice in a non-tokenistic way; how we best utilise the JSNA as a valid tool for harnessing the citizens' voice; and how the ICS measures success in this area and through the Community Engagement Strategy.

- Understanding the need for wider engagement linked to the ICP: Chairs of HWBBs and chair of ICB to agree, and factor in the view that the Joint HWBB development sessions should only stand up if needed; and that alignment between the ICP and HWBB agendas and programmes of work should be explored.

1.5. Since the January 8th development session, progress against activity outlined in 1.4.3 has been made. The first meeting between the DPHs, ICB, Healthwatch Coventry and Healthwatch Warwickshire took place on the 27th of March. System challenges to community involvement were highlighted during the meeting and included that we have diminishing resources to carry out activity in a meaningful way; and queried how we effectively measure the impact that involvement has had on the design, delivery, and evaluation of outcomes. The ICB proposed convening a Citizen Involvement Working Group, with the aims of:

- Developing a specification for a project to undertake a system-wide gap analysis of community involvement activity, exploring the possibility of undertaking using a needs assessment methodology.

- In conjunction with the Involvement Coordination Network and the wider Voluntary, Community & Social Enterprise (VCSE), developing a

set of system-wide principles for community involvement and toolkit of best practice; and

- Utilising this to support elected members in scrutinising the quality and effectiveness of community involvement.

1.6. The chairs of the HWBBs and ICP met on the 4 March and agreed to stand down the Joint HWBB development sessions, given the discussion and findings from the 8 January session. The chairs agreed it was necessary to look at the alignment of the ICP and HWBB agendas and opportunities for collaboration. To enable this, an ICP and HWBB Governance Working Group was established with the aims of:

- Removing duplication and ambiguity from the system.
- Retaining what's good.
- Improving efficiency/effectiveness.
- Clarifying how they deliver shared goals.

1.7. In order to achieve its aims, the ICP and HWBB Governance Working Group has set out to map the role of the HWBB within the system architecture, review the roles of the HWBB and ICP, understand what this means for current work programmes by working through live examples, and consider a joint ICP and HWBB development programme. The Working Group intends on sharing outcomes of this work at a later HWBB.

2. Financial Implications

2.1. There are no financial implications linked to the recommendations.

2.2. There may be financial implications in the delivery of establishing a CEO forum and strengthening the citizens voice within the ICS (paragraph 1.4.3). The Coventry and Warwickshire ICB has set aside a small 1-year budget to look at the work linked to citizen voice in the development of services. The meeting of 27th January 2024 raised concerns about skilled capacity in the system to work with citizens with the purpose of meaningfully engaging them and their voices in coproduction and advisory capacities. Diminished staffing across several system partners was noted, with an overall risk level attached to being able to deliver on this work within the current context, without increased investment. Engagement work is more time consuming and resource intensive than often assumed, especially to do well, and the meeting felt that system partners need to commit resources across the piece to do it and make it a core function.

3. Environmental Implications

3.1. None.

4. Timescales associated with the decision and next steps

4.1 Further updates will be provided to September HWBB.

Appendices

1. Appendix 1: presentation from the 8 January 2024 Joint Health and wellbeing board development session.

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Portfolio Holder for Adult Social Care and Health	Cllr Margaret Bell	Margaretbell@warwickshire.gov.uk

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

Local Member(s): None – this is a County wide report.

Other members: Councillor Margaret Bell and Councillors Barker, Drew, Holland and Rolfe.

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Coventry and Warwickshire Joint Health and Wellbeing Board

8th January 2024

Facilitated by: Julie Wood and Anita Parkin, Local Government Association (LGA)
Welcome from: Councillor Kamran Caan, Chair of Coventry Health and Wellbeing Board
Closed by: Councillor Margaret Bell, Chair of Warwickshire Health and Wellbeing Board

Aims and outcomes of the day

- To **develop** a shared understanding about the unique role that HWBBs play within the wider system context across the country and HWBBs respective roles, purpose and alignment with the C&W system

- To **utilise** the C&W mental health concordat as an example to work through and understand the role that the Joint HWBB could play in taking this work forward; and

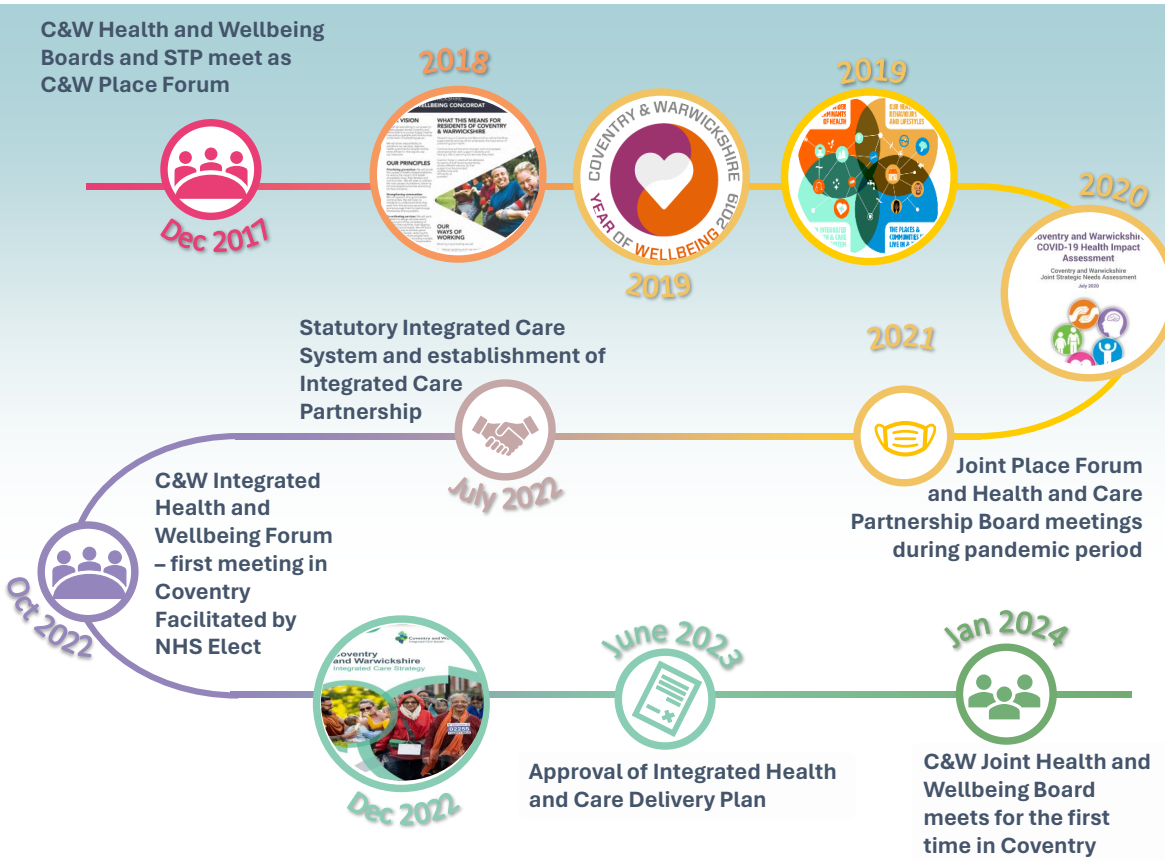
- To **agree** on whether, based on the above, the JHWBB should continue to meet

Getting the very best out of our time together today – some suggested ground rules for how we will work together today…

- Park distractions & stay mentally & physically present throughout the whole afternoon
- Respect time
- Let everyone participate with everyone being equal
- Listen with an open mind
- Challenge with respect
- Think before speaking
- Tackle the problem not the person
- Discuss 'undiscussable' issues / consider what's NOT being said
- Own the actions & be committed to follow up on them
- Give permission to speak out if these ground rules are not being followed

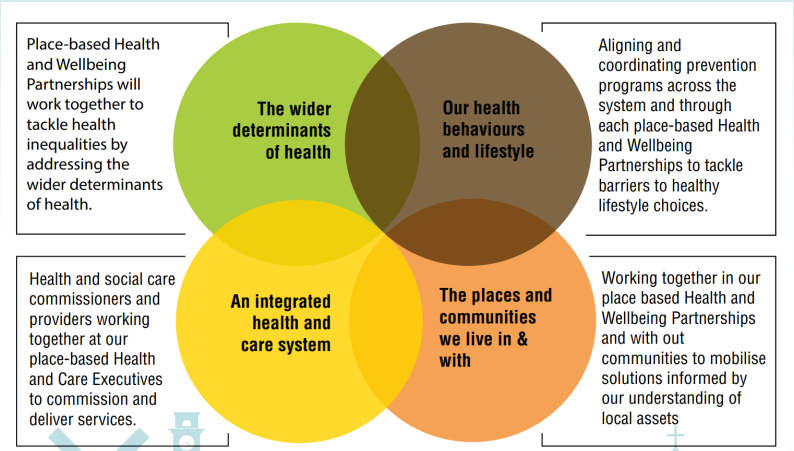
- ***…… Do we agree with these – any changes? / additions?***

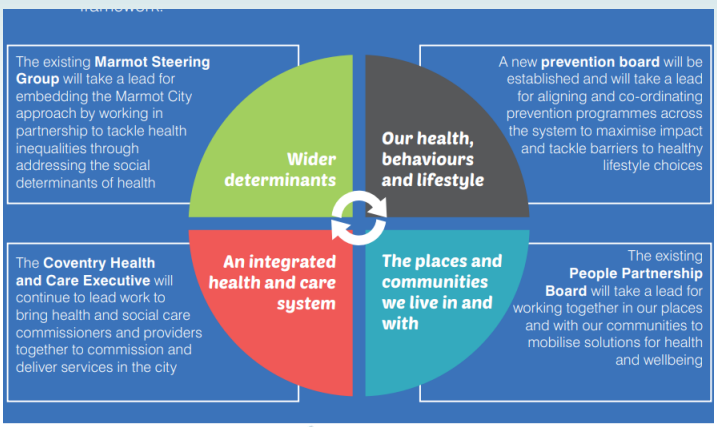
Our journey to Joint C&W Health and Wellbeing Board



Our Health and Wellbeing Strategies

Our Health and Wellbeing Strategies

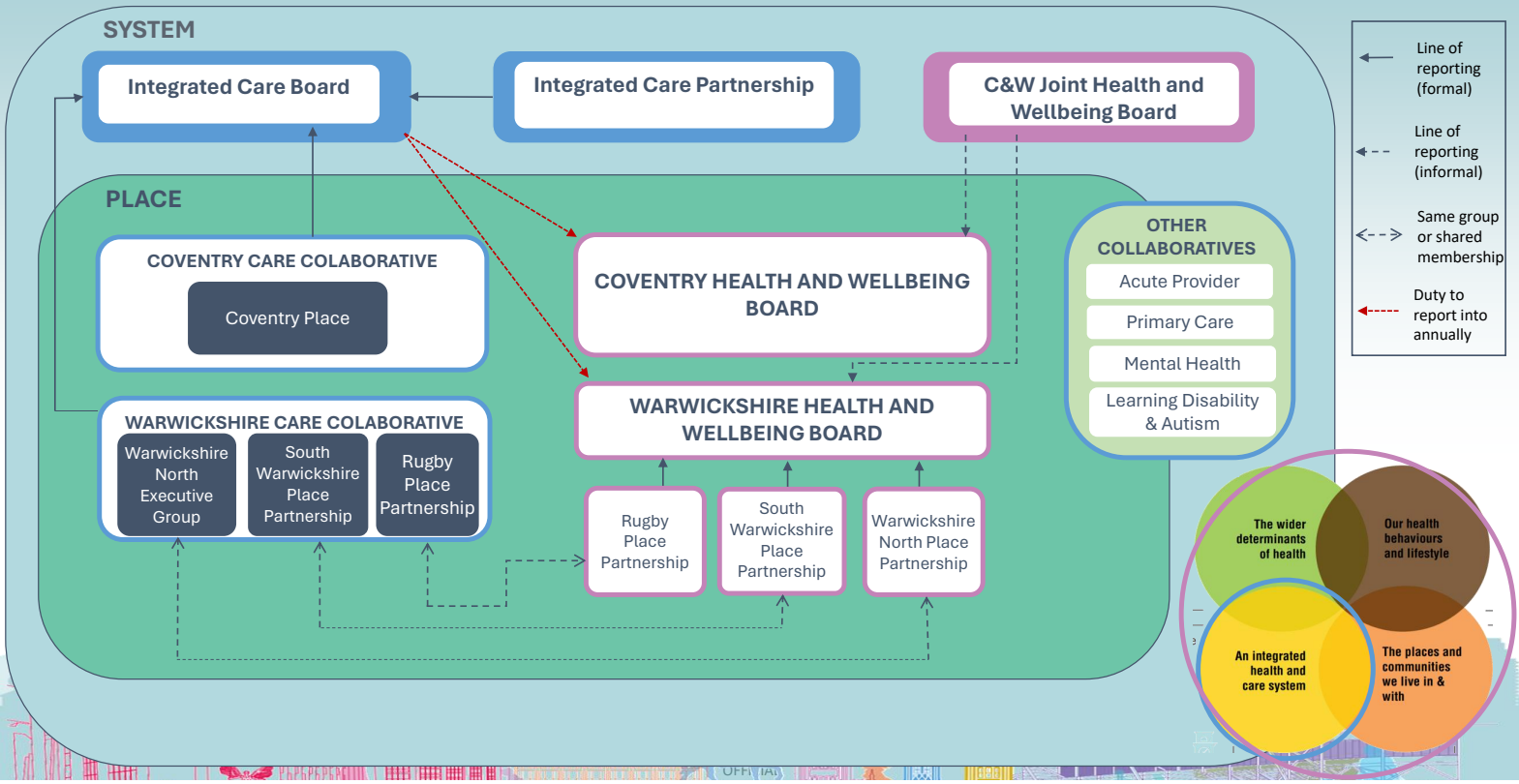




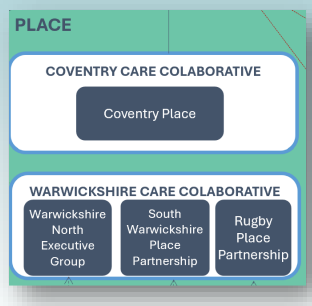
Our Priorities – Alignment and Differences

Warwickshire HWBB Strategy	Coventry HWBB Strategy	Integrated Care Strategy
Ambition: people will lead a healthy and independent life	Ambition: people are healthier and independent for longer	
Ambition: people will be a part of a strong community	Ambition: people live in connected, safe and sustainable communities	
	Priority: strengthen work with communities	
Ambition: people will experience effective and sustainable services		Priority: improving access to health and care services and increasing trust and confidence
Priority: help children and young people to have the best start in lie	Ambition: children and young people fulfil their potential	Priority prioritising prevention and improving future outcomes through tackling inequalities
Priority: help people improve their mental health and wellbeing, with a focus around prevention and early intervention	Priority: improving mental health for all	
	Priority: tackling loneliness and isolation	
Priority: reduce inequalities in health outcomes and the wider determinants of health	Priority: focus on employment and homelessness as a prevention opportunity	Priority: prioritising prevention and improving future health outcomes through tackling inequalities
		Priority: tackling immediate system pressures and improve resilience
	Priority: The need for co-production to achieve the priorities	

Joint HWBB within wider ICS



Current (Health) System Arrangements



Geographical Collaboratives (Warks and Cov)

- Delegated commissioning responsibility and budget for specific portfolio from April 24
- Make collaborative decisions about delivery and work together to move resource around to meet need
- Responsible for geographical population

Provider Collaboratives (Specialisms)

- Make collaborative decisions about delivery within scope of commissioning arrangements and work together to manage risk and move resource around to meet need
- Decision shaping – including strategy development and delivery
- Coventry and Warwickshire wide
- Currently not commissioning responsibility and budget

Why move to a Care Collaborative?

- Set the conditions for greater collaboration, removing barriers to integrated care to allow local partnerships to thrive
- Empower the right group of people with the expertise and capabilities to make decisions on how to redesign and reorganise services by transferring resources (budget allocations) allowing providers to take on more commissioning power
- Take collective decisions closer to the patient, based on shared understanding of the local population and how people live their lives (wider determinants)
- Agility and pace in decision making
- Initial Scope:
  - Urgent and emergency care
  - Out of Hospital
  - Continuing Health Care
  - Better Care Fund

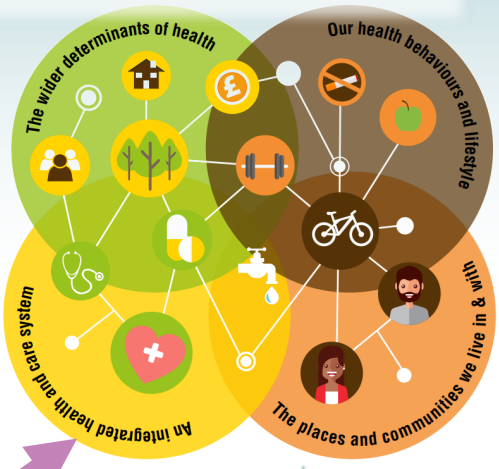


Figure 2: Population health model (Kings Fund, 2019)

Care Collaborative Focus

Health and Wellbeing Board

Place partnerships focus on all four quadrants

Development of the Care Collaboratives in Coventry and Warwickshire

STAGE 1 – NOW

Consultative Forum

- ICB holds commissioning responsibility and budget
- Decisions made by the ICB
- Decision shaping – ie The ICB ensures they consider views of the Consultative Forum
- Consultative Forum includes 30+ representatives of the partners at Place

STAGE 2 – 2024/25

Committee of the ICB

- ICB holds commissioning responsibility and budget
- Decisions made by the Committee and ratified by the Integrated Care Board for UEC, OOH, CHC and BCF
- Committee includes approx. 12 members who represent the ICB, Council and 3 places in Warwickshire

STAGE 3 – TBC

Committee of the Host Provider SWFT / UHCW

- Host Provider holds delegated commissioning responsibility and budget
- Provides assurance to the ICB
- TBC...

Mental Health Collaborative

MHC Shared Vision

Our vision is to improve the mental health and wellbeing of children, young people and adults in C&W by working together (at scale and at pace).

Through our work together and in partnership with local people, we will support staff across our communities to:

- Improve outcomes for all and reduce inequalities
- Ensure those who wait feel helped and heard while waiting
- Reduce waits and improve clinical quality and experience for our children, young people, and adults, and
- Work with communities to build resilience and focus on prevention for future generations.

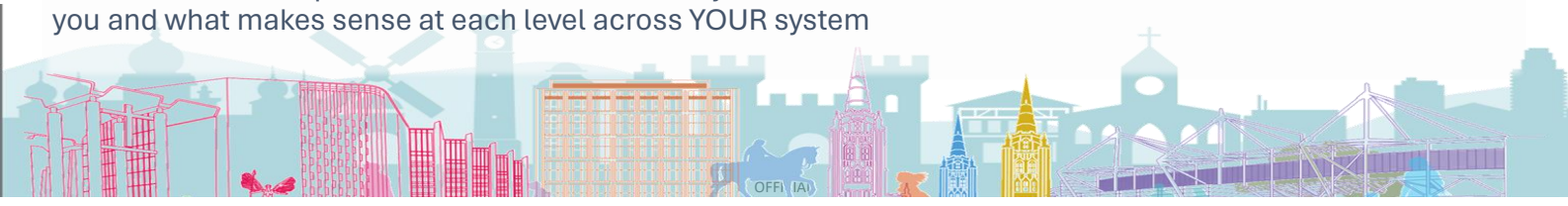
The national context for Health & Wellbeing Boards

- HWBs were originally established in 2013 and have been a key mechanism for driving joined up working across health and care, providing a *single point of continuity* in a constantly shifting health & care landscape
- The Health & Care Act 2022 introduced new architecture to the health & care system, with the establishment of integrated care boards (ICBs) and integrated care partnerships (ICPs) but HWBs continue to play an important statutory role in *'instilling mechanisms for joint working across health and care organisations and setting strategic direction to improve the health and well being of people locally'* (at place level)
- HWBs remain a formal statutory committee of the local authority and provides a forum where *political, clinical, professional and community leaders* from across the health & care system come together to improve the health & wellbeing of their local population and reduce health inequalities.

The national context contd.

- HWBs continue to be responsible for:
  - Assessing the health & wellbeing needs of their population and publishing a joint strategic needs assessment (JSNA)
  - Publishing a joint local health & wellbeing strategy (JLHWS), which should directly inform, the development of joint commissioning arrangements (under section 75) and the co-ordination of NHS and LA commissioning, including BCF Plans
  - Developing a Pharmaceutical Needs Assessment (PNA)
- The HWB should be a forum for discussions about strategic and operational co-ordination in the delivery of services already commissioned.
- The core statutory membership of the HWB is unchanged (an elected member, a representative from Healthwatch, an ICB member, the LA DCS, DASS and DPH) but membership should be reviewed following the establishment of the ICB and ICP and their associated functions and duties and establishment of additional forum / groups – for eg Collaboratives

..... so the national picture remains the same but you have considerable freedoms to decide what works for you and what makes sense at each level across YOUR system



The national context contd.

- Integrated Care Systems vary considerably in terms of size, complexity and ambitions for how they see the architecture of their HWBs developing to meet the needs of the residents/ patients they serve
- Options being worked on elsewhere include
  - Where there is more than 1 LA across the system, establishing joint HWBs across their system and in effect managing 'down' the ind LA focus
  - Using the ind LA focus of the HWB to act as the 'place' committee of the system and build up a clear service delivery (and potentially accountability) focus at that level.
  - Keeping the ind LA focus of HWBs and focusing responsibility on wider determinants' of health rather than on delivery of system priorities
  - Some are still letting the systems 'bed in' before making changes
- The important thing is to work out what will work best for your system and to give it a clear focus and sort the leadership, membership, governance and accountability, avoiding duplication, confusion and multiple repeated 'talking shops' at all levels across your system

Development activity 1

- Group work

So, in your groups we would like you to reflect on your understanding and clarity about respective roles, purpose and alignment between all the groups you have across the Coventry and Warwickshire Integrated Care System.

Are you clear about roles, purpose and alignment of all the groups?

What works, what doesn't?

At the individual level, as some one involved in these groups are you clear about your role, and how are you feeling about it?

We will invite brief feedback from groups on these 3 areas – pop brief thoughts on post it notes please

YOU HAVE 15 MINUTES

Development activity 1 – Feedback

Discussion on the feedback in plenary

15 MINUTES

Break

Prevention Concordat for Better Mental Health

Jane Fowles, Consultant in Public Health, Coventry City Council

Overview

The National Prevention Concordat for Better Mental Health was launched in 2017 and refreshed in 2020 with the ambition of supporting work to improve mental health and wellbeing in every local authority and Integrated Care System (ICS) across England

It is endorsed by the Association of Directors of Public Health, Local Government Association, NHS England and the Faculty of Public Health

The Prevention Concordat Consensus Statement describes the shared commitment of signatories to work collaboratively to prevent mental illness, tackle inequalities and promote better mental health.

Partnership approach across the public sector, local employers and the wider community & voluntary sector

Spans the life course and focuses on key settings including local communities, schools, workplaces & health services

Local Prevention Concordat Commitment

- Coventry City Council and Warwickshire County Council previously signed up to the Prevention Concordat pre pandemic, now there is a national drive for system level sign up
- Shared commitment evidenced by submission of an application to Office of Health Improvement and Disparities (OHID) – focus is system level action plan across 5 key domains
- Application draws on and aligns existing work undertaken systemwide and reflected in our local strategies and delivery plans including:
    - The Integrated Care Strategy
    - Integrated Health and Care delivery plan
    - ICB Healthcare Inequalities Strategy
    - Coventry & Warwickshire Health & Wellbeing Strategies
    - Coventry & Warwickshire Suicide Prevention Strategy
    - Mental Health Collaborative strategic priorities.
- Application approved by the National Office for Health Improvement and Disparities on 15th November 2023 with extremely positive feedback and emphasis placed on our application being an example of good practice at system level.

Prevention Concordat Programme 5 domain framework

1. **Effective use of data and intelligence.**
   Having a clear understanding of the key mental health issues affecting local communities, and which interventions should be prioritised to best meet local needs.
2. **Partnership and alignment.**
   Local organisations and populations working together across sectors to align plans and undertake joint or complementary programmes of work.
3. **a) Translate need into deliverable commitments**
   Ensuring that high-level strategic aims to promote better mental health are translated into actions and integrated into operational plans across a range of organisations and across the life course.

   b) Tackle inequalities
   Ensuring that tackling mental health inequalities is incorporated in all actions. This should include discrimination, racism and stigma, vulnerable groups and those at greater risk, with a focus on disadvantaged faced by local communities
4. **Defining success outcomes**
   Having a clear understanding of how to measure outcomes in preventing mental ill-health and promoting good mental health, and which would be most relevant to local communities.
5. **Leadership and accountability**
   Ensuring that the wide range of organisations are involved in better mental health and are held to account for jointly agreed actions, with clear leadership and direction.

Tried and tested evidence-based framework to:

- Support local action planning around:
    - Population mental health,
    - Galvanise local support,
    - Collaboration,
- Focus action on the groups facing the greatest health inequalities.

Coventry and Warwickshire Integrated Care System

Key benefits

- Provides vehicle for the delivery of our local system strategic priorities linked to improving mental health and wellbeing, preventing suicides, and tackling inequalities across the life course.
- Supports place-based population mental health through co-ordination of work at System, Place, and Neighbourhood levels.
- Uses existing and emerging needs assessments in partnership with local stakeholders, communities and people with lived experience, all of whom know what matters most.
- We will have an evidence-based framework to structure our local approach to improving mental health and monitor and evaluate impact and outcomes
- Gain access to a community of practice, webinars, specialist resources including evidence guidance, business case guidance, case studies, learning from the Better Mental Health Fund, as well as national and regional OHID support.

Coventry and Warwickshire Integrated Care System

Next steps

- A new Coventry and Warwickshire Mental Health Concordat Partnership (Delivery) Group will be established, reporting into the Coventry and Warwickshire Mental Health Collaborative.
- Representatives working on the Concordat will provide further information on plans to take forward the Concordat and to engage further with groups, including with:
  - Coventry and Warwickshire's VCSE Mental Health Alliance.
  - Coventry and Warwickshire's Mental Health Collaborative.
  - Mental Health Long Term Plan Programme Delivery Board.
  - Children and Young People's MHWB Board.
  - Integrated Care Partnership Board.

Development activity 2

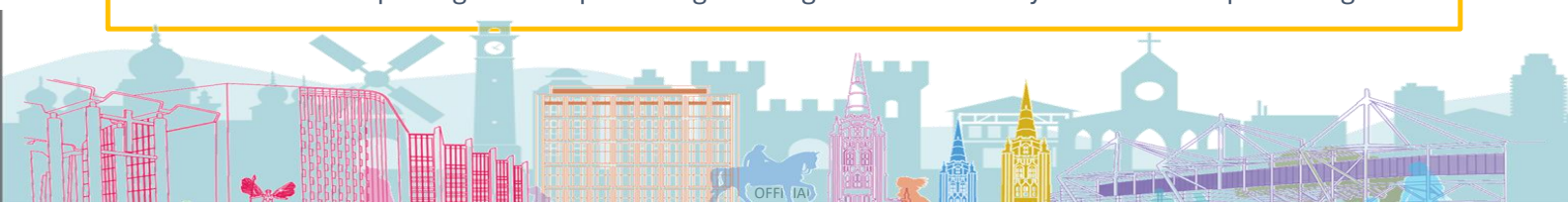
Prevention concordat for better mental health - major piece of work

Data/partnership/deliverables/inequality/outcomes/leadership

Is this the right place…JHWBB…will it work…fit elsewhere?

You will not solve this in 15 minutes!

This is about putting an example through the organisational theory we have been pondering



Development activity 2 – Feedback

Discussion on the feedback in plenary

15 MINUTES

What does this all mean?

Thank you and close.

Health and Wellbeing Board

15 May 2024

Children and Young People Partnership

Recommendations

That the Health and Wellbeing Board:

1) Notes and comments on the update provided by the Children and Young People Partnership; and

2) Endorses the proposed approach to development of the Early Years Integrated Delivery Plan.

1. Executive Summary

1.1 The Children and Young People Partnership (CYPP) was established in October 2022 as an informal sub-group of the Health and Wellbeing Board (HWBB) to support the ambitions of Warwickshire's Health and Wellbeing Strategy. The purpose of the CYPP is three-fold: provide strategic oversight of the HWBB children and young people agenda; facilitate integration and collaboration across Warwickshire; and take a population health approach in doing this.

1.2 The Terms of Reference (Appendix 1) were last updated in July 2023. They set out the CYPPs priorities:

- Priority 1: Early years, including the first 1001 days (conception to age 2) and pre-school age (up to age 5 years)
- Priority 2 – children and young people's mental health and wellbeing, with a focus on social, emotional, and behavioural needs.

1.3 The focus on these priorities aligned with the publication of the Childrens 0-5 Joint Strategic Needs Assessment (JSNA) and the Mental Health and Wellbeing of Infants, Children and Young People JSNA (published January 2023 and May 2023 respectively).

1.4 Since the HWBB's last update from the CYPP in September 2023, the Partnership has met twice and, in line with the forward plan, focused on:

- Priority 1: Improvements to the Warwickshire 0-5 offer including Health Visiting review and re-modelling and the development of an Early Years Integrated Delivery Plan.

- Priority 2: School attendance challenges and opportunities; and supporting transitions from Childrens to Adults mental health services.

Improvements to the Health Visiting service

1.5 The rate of new birth visits (NBV) is increasing across Warwickshire. 2023/24 data has seen a consistency in 97% of babies seen by 30 days for NBV. During the last two quarters of 2023/24 approximately 70% of NBV took place before 14 days.

1.6 In relation to receiving 6-8 weeks review by 13 weeks, in 2022/23 this figure was 41% and as of end of 2023/24 had risen to 87-96%. This is due to an increase in mix of appointments offered and includes telephone and video call as well as face to face.

1.7 In terms of staffing, the service has a shortfall of 10 whole time equivalent (WTE) staff, however it is currently training student health visitors and of 12 students, 6 are due to complete training in September 2024 with the remaining 6 due to complete in February 2025. A Special Education Needs and Disabilities (SEND) specialist health visitor has been in post since October 2023.

1.8 Areas for improvement identified by the service include with communications between midwifery and health visiting, particularly for women living in Rugby. This is due to challenges with different IT systems being used across University Hospitals Coventry and Warwickshire NHS Trust (UHCW) midwifery and South Warwickshire University NHS Foundation Trust (SWFT) health visiting service This is currently being picked up by the Local Maternity and Neonatal System (LMNS) antenatal workstream.

1.9 Due to an increase in asylum seekers across Warwickshire, and particularly in Rugby and Leamington, the health visiting service are working closely with Warwickshire County Council Public Health to improve communication and reduce duplication of activity with this population.

1.10 To support the tackling inequalities agenda, the service has allocated staff according to areas of greatest need, with a higher proportion of staff allocated within the north of the county, and face-to-face appointments offered to those women most in need.

Development of the Early Years Integrated Plan

1.11 In line with the HWBB Strategy 2021-26 priority of Best Start in Life, and in response to the 0-5 JSNA (January 2023) and the Early Years Remote Peer Challenge Review (March 2023), the Council's Education Services are leading the development of an Early Years Integrated Plan (EYIP) through the Early Years Integrated Planning Group (EYIPG). Membership of the EYIP includes the Council's education, early help and public health services and NHS Integrated Care Board (ICB) Childrens transformation and Local Maternity and Neonatal System (LMNS) leads.

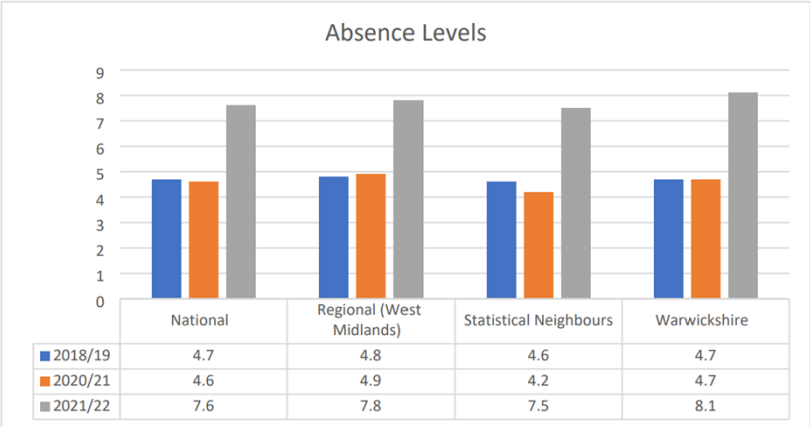
1.12 The EYIPG are in the initial planning stages of the EYIP but have identified key themes across Integrated Care System (ICS) partners including workforce challenges, training, funding and prioritising families that experience greater inequality.

1.13 The EYIPG aims to develop the EYIP for September HWBB, with delivery commencing in the second half of 2024/25. To inform the EYIP engagement will be undertaken with a range of key stakeholder including Parent Carer Voice, Early Years hubs, maintained nurses and schools with nurseries, and childminders.

School attendance

1.14 Pupil absence levels were shared with the CYPP and highlight the increasing trend in the proportion of children overall absent year-on-year from 2018 (table 1).

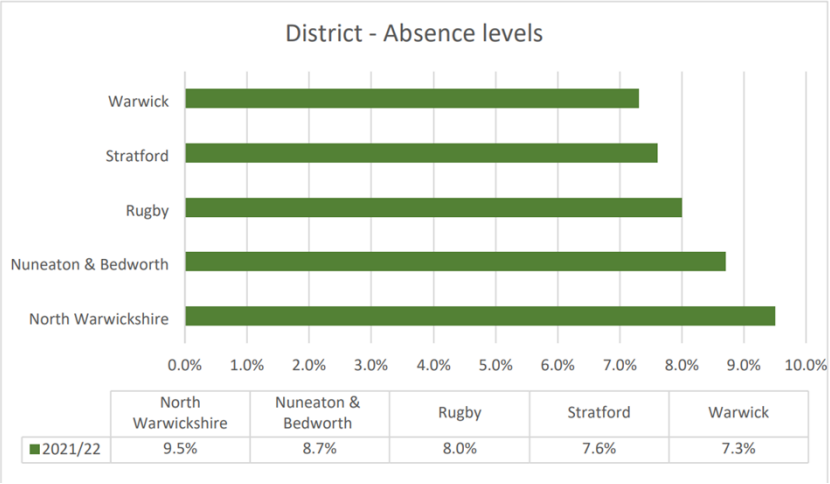
Table 1- School Absence Levels 2018/19 – 2021/22.



	National	Regional (West Midlands)	Statistical Neighbours	Warwickshire
2018/19	4.7	4.8	4.6	4.7
2020/21	4.6	4.9	4.2	4.7
2021/22	7.6	7.8	7.5	8.1

1.15 The proportion of severe absence levels (% of pupils who missed 50% or more sessions) has also increased year on year since 2018 from 0.75% to 2.15%. There is disparity in the proportion of overall absence across the county, with higher levels of absence recorded in North Warwickshire Borough and Nuneaton and Bedworth Borough. There are also lower levels of absence recorded in the south of the county (table 2). This picture of inequality mirrors the disparity in health outcomes and scores of deprivation we see across Warwickshire and aligns with the geographical areas for Creating Opportunities (formally Levelling Up).

Table 2: Overall absence at district and borough level



1.16 The Council's Education service is working with public health and other system stakeholders to develop a joined-up approach to school attendance.

1.17 There has been a rise in non-attendance at school due to social, emotional and behavioural needs and CYPP partners discussed using intelligence from Child and Adolescent Mental Health Services (CAMHS) to understand potential blockers to school attendance, and support schools to make reasonable adjustments for pupils with social, emotional and behavioural needs. CYPP also discussed analysing how well the mental health support teams in schools are supporting children to stay in school.

Transition from Childrens to Adults mental health service

1.18 Coventry and Warwickshire Partnership NHS Trust (CWPT) described the current mechanism that exists for patients transitioning from CAMHS to adult mental health services. This is following feedback from both children, carers and parents and staff that the process can feel disjointed and difficult to navigate.

1.19 Improvement work has been underway and has included:

- 18-25 workstream as part of the community transformation programme. Working with local charity Grapevine to co-produce with young people and the development of the 18-25 peer support workers offer through Coventry and Warwickshire Mind.
- Focusing on the process of transition by developing greater joint working and simplifying the process.
- Lowering the age threshold for intervention for care leavers and working with care leavers to get health passports in place to support easier movement through the system.

2. Financial Implications

2.1 None arising directly from this report.

3. Environmental Implications

3.1 None arising directly from this report.

4. Timescales associated with the decision and next steps

4.1 In addition to following up on the items listed above, the CYPP's forward plan includes:

- **May 2024:** Getting risk support recommendations update (Mental Health and Wellbeing of CYP JSNA) including self-harm working group; newly developed and recently launched Children and Young People Making Every Contact Count (MECC); and Peer Mentor Scheme.

- **August 2024:** Recommendations from the Empowering Futures: Growing up Well in Warwickshire JSNA; progress on Child Accident Prevention work; and overview of the whole family wraparound offer.

	Name	**Contact Information**
Report Author	Gemma Mckinnon, Public Health Service Manager	gemmamckinnon@warwickshire.gov.uk
Director	Shade Agboola, Director of Public Health	shadeagboola@warwickshire.gov.uk
Executive Director	Nigel Minns, Executive Director for Children and Young People	Nigelminns@warwickshire.gov.uk
Portfolio Holder	Councillor Margaret Bell, Portfolio Holder for Adult Social Care and Health	Margaretbell@warwickshire.gov.uk

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

Local Member(s): Not applicable as county wide report.
Other members: Councillor Margaret Bell and Councillors Barker, Drew, Holland, and Rolfe.

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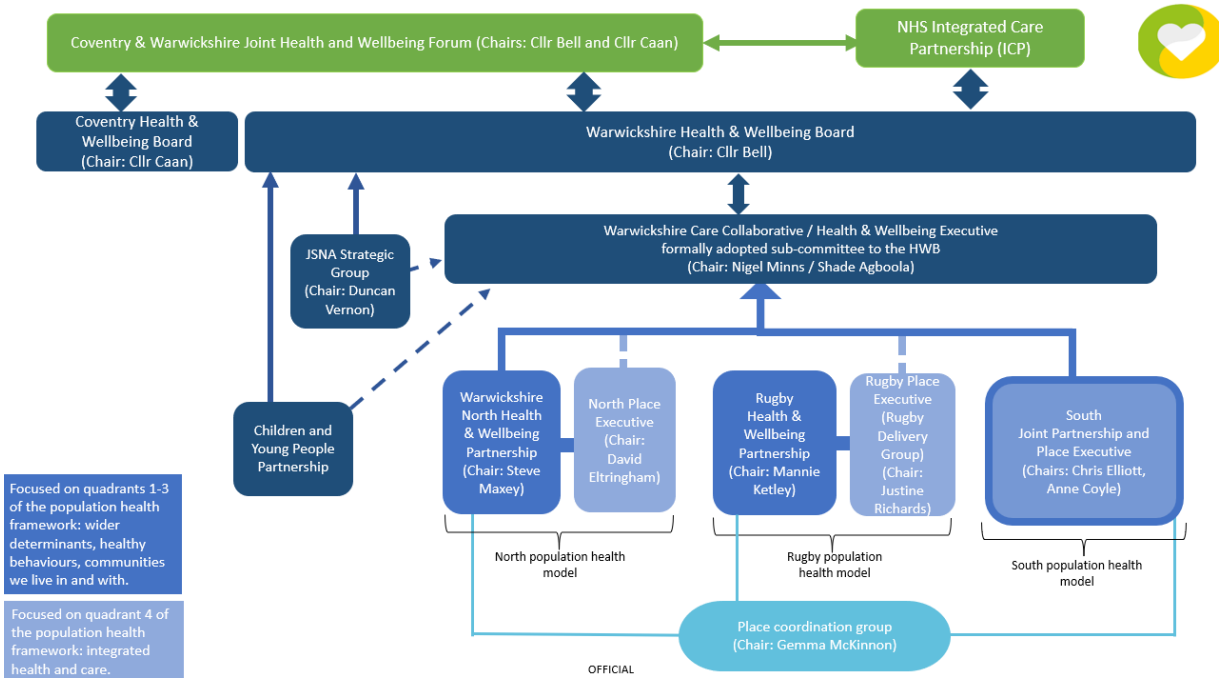
Terms of Reference (ToR) for Warwickshire Children and Young People Partnership Board

Warwickshire Children and Young People Partnership Board	
Purpose	Warwickshire Health and Wellbeing Board's (HWBB) Strategy 2021- 2026 priorities are to: • Help children and young people have the best start in life. • Help people to support their mental health and wellbeing, with a focus on prevention and early intervention. • Reduce inequalities in health and the wider determinants of health. An outcome of the March 2022 HWBB Development Session highlighted a need for greater focus and attention to be given to the children and young people agenda, and in particular their mental health and wellbeing. As such, Councillor Bell (Chair of HWBB) requested the establishment of a Children and Young People Partnership (CYPP). The CYPP will replace the Children Together Board. It will act as a sub-committee to HWBB and report directly into the board. The purpose of the partnership is to: • Provide strategic oversight to the CYP agenda. • Facilitate integration and collaboration across Warwickshire; by • Taking a holistic population health framework approach. The CYPP will have a relationship with the ICB, but due to primacy of place, will focus on Warwickshire's three places; Warwickshire North place partnership, Rugby place partnership, and South Warwickshire place partnership.
Work programme/ objectives	The Office for Health Improvement and Disparities (OHID) outlines the ways in which children and young people and their services are unique: o Adverse childhood experiences are strongly associated with poorer outcomes throughout and individual's life, hence investing in prevention and early intervention is critical. o Children who have experienced care are at particular risk of poor outcomes and mut be a focus of the ICSs in their mission to tackle health inequalities. o Parity of esteem between physical and mental health is particularly important for children and young people, as half of lifetime cases of mental illness start by age 14. o Families play an important role in supporting the health and wellbeing of children, therefore local systems must consider how the provision of adults' services can have a knock-on impact on the health and wellbeing of children. o The provision of children's services is shared by many partners, hence partnership working through ICSs is even more important. o Where children need specialist health services, population footprints required for planning and delivery will often be larger than for adults. o The welfare of the child is paramount, and the voices of children, young people and families should be listened to in decision making. It is for these reasons that babies, children, young people and families must be placed at the heart of each ICS. The CYPP provides a mechanism for partnership working within the C&W ICS, whilst ensuring that delivery occurs at place. There are several key plans that set out evidence and objectives to progress with the children and young people agenda. These include: • Warwickshire Health and Wellbeing Strategy 2021-2026 • 0-5 Children's Joint Strategic Needs Assessment

	• Warwickshire Children and Families Strategy • Warwickshire Education Strategy • C&W Children's Transformation – Physical Health • C&W Children's Mental Health Transformation Long Term Plan • Special Education Needs and Disabilities (SEND) and Inclusion programme, including the SEND Written Statement of Action (WSoA) • Serious Violence Prevention Strategy • Tackling Social Inequalities Strategy The CYPP has a number of priority programmes and objectives to oversee: • We will ensure that all HWB member organisations sign up to Child Friendly Warwickshire and commit to action. • We will work together to encourage healthy pregnancies and ensure the best outcomes for both parent and infant in the first 1001 days of an infant's life. • We will ensure that the recommendations of the Children's 0-5 JSNA and any further Children's JSNA are implemented, and progress monitored. • We will continue to embed Health in all Policies (HiaP) approach, ensuring that HEAT is carried out on all HWB partner services that have a role to play in CYP and families. • We will ensure that children and young people with social, emotional and behavioural needs have appropriate support and access to appropriate services. • We will work together to prevent child accidents. • We will seek to tackle social inequalities and improve outcomes for children and young people. • We will seek to build emotional resilience and improve wellbeing for our children and young people; and work to prevent self-harm and suicide. • We will work together to encourage children and young people to lead healthy lifestyles. During the initial scoping session and inaugural partnership meeting it was agreed that focus should be given to two priority areas in the first year. Gap analysis has been carried out across the 'key plans' documents and priorities that do not currently have a formal workstream include: • **Priority 1 – Early Years*- Including the first 1001 days (conception to age 2) and pre-school age (up to 5 years old).** Priority 1 objectives will be informed by the Warwickshire Children's 0-5 JSNA (2022) with a focus on meeting key recommendations from the paper, see Appendix 1. *This may include some additional SEND recommendations as a result of the mock SEND inspection conducted in July 2022. • **Priority 2 – Children and Young person's Mental Health. We will ensure that children and young people with social, emotional and behavioural needs have appropriate support and access to appropriate services.** 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 and Young Person'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.

Core Membership	See membership list in Appendix 2.
Member's responsibility	• To attend meetings as required and be prepared by reading agendas, action logs and associated papers. • To have actioned any areas agreed at the previous meeting and to meet deadlines as agreed by the partnership. • Each partner's representative on the Children and Young Peoples Partnership is responsible for ensuring decisions are submitted to their own relevant decision-making body.
Chair	Councillor Penny-Anne O'Donnell
SRO	Nigel Minns
Programme Management	WCC Public Health
Governance	Sub-group of Warwickshire Health and Wellbeing Board (see structure chart below). The Children and Young People Partnership will shape and make decisions.
Reporting	Reports to HWBB annually via summary report. Reports quarterly to Warwickshire Portfolio Holder's for Health Group. Reports quarterly to Warwickshire Care Collaborative. Reports to HWBB Place Partnerships (North, Rugby, South) and District and Borough councils.
Related Bodies	ICS Children's Strategic Board Warwickshire SEND and Inclusion Board Coventry and Warwickshire Mental Health Transformation Board Coventry and Warwickshire Local Maternity and Neonatal System (LMNS)
Meeting arrangements and frequency	The Children and Young Peoples Partnership will be a closed meeting. Meeting papers and associated programme management materials will be stored via MS Teams. Minutes will be anonymised and not shared outside of the CYPP board membership. Monthly through September-December 2022. Quarterly thereafter.

Warwickshire Health and Wellbeing Governance Structure



Appendix 2 - Membership List (July 2023)

Name	**Job title**	**Organisation**
Councillor Penny-Anne O'Donnell *(chair)*	County Councillor and cabinet support to Portfolio Holder for Adult Social Care and Health	Warwickshire County Council
Nigel Minns	Strategic Director – People Directorate	Warwickshire County Council
Uju Okereke	Associate Director of Public Health	Warwickshire County Council / Integrated Care Board
John Coleman	Associate Director – Children and Families	Warwickshire County Council
Johnny Kyriacou	Assistant Director for Education Services	Warwickshire County Council
Becky Hale	Chief Commissioning Officer (Health and Care)	Warwickshire County Council and South Warwickshire Foundation Trust
Tracy Pilcher	Chief Nursing Officer	Integrated Care Board
Matt Gilks	Director of Commissioning	Integrated Care Board
Jonathon Toy	Service Manager Trading Standards and Community Safety	Warwickshire County Council
Sharon Binyon	Medical Director and Senior Responsible Officer for Mental Health Transformation	Coventry and Warwickshire Partnership Trust
Anjali Dave	Associate Director of operations/Warks General Manager 0-5	South Warwickshire Foundation Trust
Jeanette Halborg	Deputy Chief Nurse	George Eliot Hospital Partnership Trust
Steve Maxey	Chief Executive	North Warwickshire Borough Council
Kevin Hollis	Head of Leisure	Nuneaton and Bedworth Borough Council
Tom Kittendorf	Chief Officer – Leisure and Wellbeing	Rugby Borough Council

WARWICKSHIRE SAFEGUARDING

ANNUAL REPORT 2022-2023

Warwickshire Safeguarding

TABLE OF CONTENTS

WELCOME FROM THE WS CHAIR & SCRUTINEER

In the 20 – 21 annual report I suggested that having emerged from the challenges of the pandemic period, we might find ourselves working with families and individuals coping with the impact of the emerging cost-of-living crisis. Over the past year, the UK has faced significant political and social turmoil. We have not been immune to this in Warwickshire as we have supported people coping with increased stress in their families and homes.

The Covid-19 pandemic presented partner agencies with significant challenges requiring us to adapt our services to respond to the ongoing demand in our community, not least in the management of safeguarding concerns. Further in this report you will be able to read about a significant number of new initiatives introduced by the multi-agency partnership designed to support you all in your work with individuals and families. This includes the introduction of

- the Vanguard project 'Positive Directions.
- The NRM Pilot for victims of modern slavery
- Operation Encompass
- Children in Care - Care Providers Information Pack

A key aspect of the work carried out by Warwickshire Safeguarding involves scrutinising the arrangements in place to ensure that agencies work together to safeguard children, adults and families.

When appropriate, the safeguarding partnership undertakes a 'Child Safeguarding Practice Review' or 'Safeguarding Adults Reviews' . These reviews are expected to show where things might have been done differently and what lessons can be learned to prevent similar incidents from happening to children, young people and adults in the future.

Child safeguarding practice reviews are subject to further scrutiny by the 'national panel'. In general, the feedback received from the national panel is positive and include comments such as '*The Panel thought that your rapid review was clear, providing a good rationale for undertaking a review and identifying some important themes to explore'.* This gives us confidence that the learning we share is based on accurate scrutiny and valid findings.

In August 2022, Warwickshire Safeguarding launched its multi-agency training programme for its safeguarding partners operating throughout Warwickshire. During the period of this report training was provided online through 'teams'. Feedback was positive and we were pleased with the uptake and our ability to reach a wide audience. In the coming year we will continue with online training, but will be pleased to introduce some face to face events that are so good at encouraging engagement across the partnership.

The funding for the partnership has remained largely at the same level as previous years' with the majority contributions coming from the statutory partners. We appreciate the contributions made by other partners, including those district and borough councils who support our work. We hope that you can see the benefits.

To summarise, this annual report reflects on our safeguarding practice across the partnership. It seeks to share the developments we have made in protecting children, young people and adults across Warwickshire. It considers how effective local systems and organisations have been in this work and identifies areas of work that need attention. It is a reflection of a considerable amount of hard work from everyone involved in safeguarding, and I thank all of you for your continued commitment to our children, families and adults in Warwickshire.

Thanks again everyone,

ELAINE COLERIDGE-SMITH

INDEPENDENT CHAIR & SCRUTINEER

ABOUT WARWICKSHIRE SAFEGUARDING

The Warwickshire safeguarding partnership operates in accordance with the legal frameworks set out in the Children Act 2004 and the Care Act 2014.

Warwickshire Safeguarding's new partnership arrangements came into force in September 2019 providing an overarching framework for the scrutiny and assurance of safeguarding practice, keeping children, young people and adults safe from harm of abuse or neglect throughout Warwickshire.

In Warwickshire, our local safeguarding arrangements support and enable local agencies to work together in a system where:

- Excellent practice is the norm
- Partners work collaboratively to achieve the same end goals
- Partner agencies hold one another to account effectively
- There is early identification of 'new' safeguarding issues
- Learning is promoted and embedded
- Information is shared effectively; and
- The public can feel confident that children and adults are protected from harm

GOVERNANCE

Warwickshire Safeguarding is overseen by an Executive Board of statutory safeguarding partners comprising:

- Warwickshire County Council Chief Executive
- The Clinical Commissioning Groups Accountable Officers
- The Chief Constable of Warwickshire Police

The Safeguarding Partners have equal and joint responsibility for making arrangements to safeguard and promote the welfare of all children, young people and adults in Warwickshire. The Board has an Independent Chair and Scrutineer and has four Subgroups operating within its structure overseeing exploitation work, safeguarding reviews, safeguarding in education and, development and review of safeguarding policy and procedures.

CORE DUTIES

1. Agreeing on ways to align the Safeguarding Partners' safeguarding services

2. Acting as a strategic leadership group in supporting and engaging others

3. Conducting safeguarding reviews of child/adult safeguarding cases which raise issues of importance in Warwickshire, arrange and supervise reviews of such cases, identify improvements and ensure that the outcomes are reported

4. Promoting the learning from local and national safeguarding reviews pertaining to children, young people and adults

5. Agreeing and communicating the Warwickshire priorities and commissioning intentions for safeguarding children, young people and adults through the publication of a Strategic Plan

6. Agreeing and publishing an Annual Report detailing what the safeguarding partnership has done during the year to achieve its objectives and implement its Strategic Plan priorities

SAFEGUARDING ACTIVITY IN WARWICKSHIRE

This section reports the Safeguarding activity recorded within Warwickshire over the last year

Adults:

3751

CONCERNS RECEIVED

(3146 in 2021/22)

288

S42 ENQUIRIES

(279 in 2021/22)

Top 3 Types of Abuse for concluded Section 42 Enquiries

Financial	Physical	Psychological
32%	15%	13%

Section 42 Enquiries – Top 3 primary support reasons:

- Physical Support
- Memory and Cognition
- Learning Disability Support

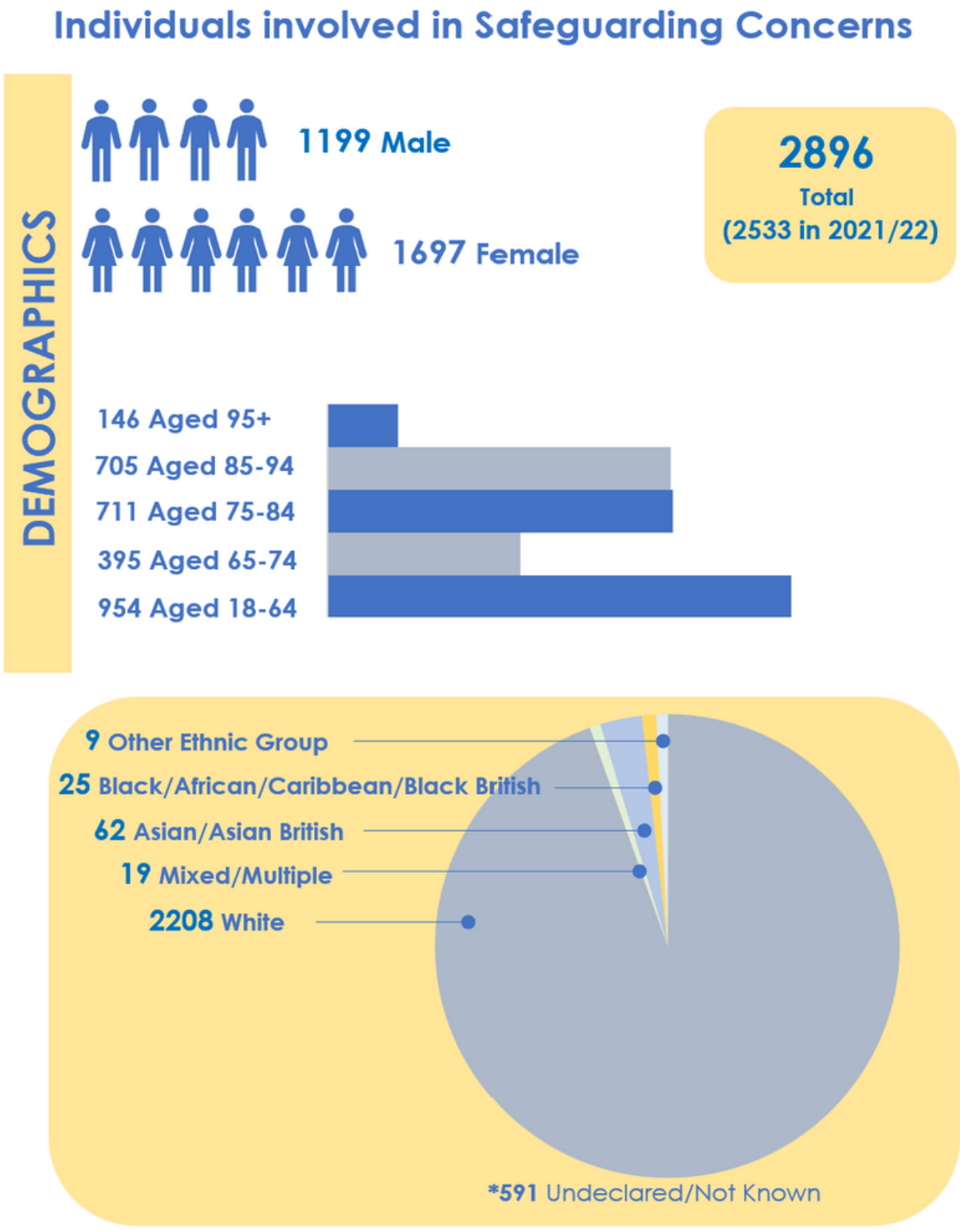
Asked what outcome they want	Outcome Fully or Partially Met	Risk Reduced or Removed
70.8%	90.6%	67.5%

Source of risk known to victim	Alleged abuse by service providers	Enquiries involving strangers
241	24	25

Top 2 locations of abuse for concluded Section 42 Enquiries

- Own home
- Community (excluding community services)

Adults:


Individuals involved in Safeguarding Concerns
DEMOGRAPHICS
1199 Male
1697 Female
2896
Total
(2533 in 2021/22)
146 Aged 95+
705 Aged 85-94
711 Aged 75-84
395 Aged 65-74
954 Aged 18-64
9 Other Ethnic Group
25 Black/African/Caribbean/Black British
62 Asian/Asian British
19 Mixed/Multiple
2208 White
*591 Undeclared/Not Known

Children:

Warwickshire has a resident population of approximately 119,153 children ages 0-17 years, who make up around a fifth of the total population of the county.

16,344
CONTACTS RECEIVED
(16,502 in 2021/22)

5,379
SAFEGUARDING REFERRALS RECEIVED
(5,700 in 2021/22)

Open to Family and Adolescent Support Team
85
(93 in 2021/22)

Care Leavers aged 19-21 in education, employment or training
57.8%
(52% in 2021/22)

Referrals received for children with a disability
3.3%
(2.6% in 2021/22)

In January 2023, **18%** of the school population were classified as being of an ethnic group other than White British, the largest minority ethnic group being 'Any Other White Background' **(7%)** followed by 'Indian' **(5%)**.

Top 3 types of abuse for children subject to Child Protection Plans:

Emotional Abuse	Neglect	Multiple
32.4%	51%	11.8%

Criminal Exploitation identified as a risk factor
137
(147 in 2021/22)

UASC identified as a risk factor
54
(88 in 2021/22)

Domestic Violence identified as a risk factor
2291
(2464 in 2021/22)

778 Looked After Children
(822 in 2021/22)

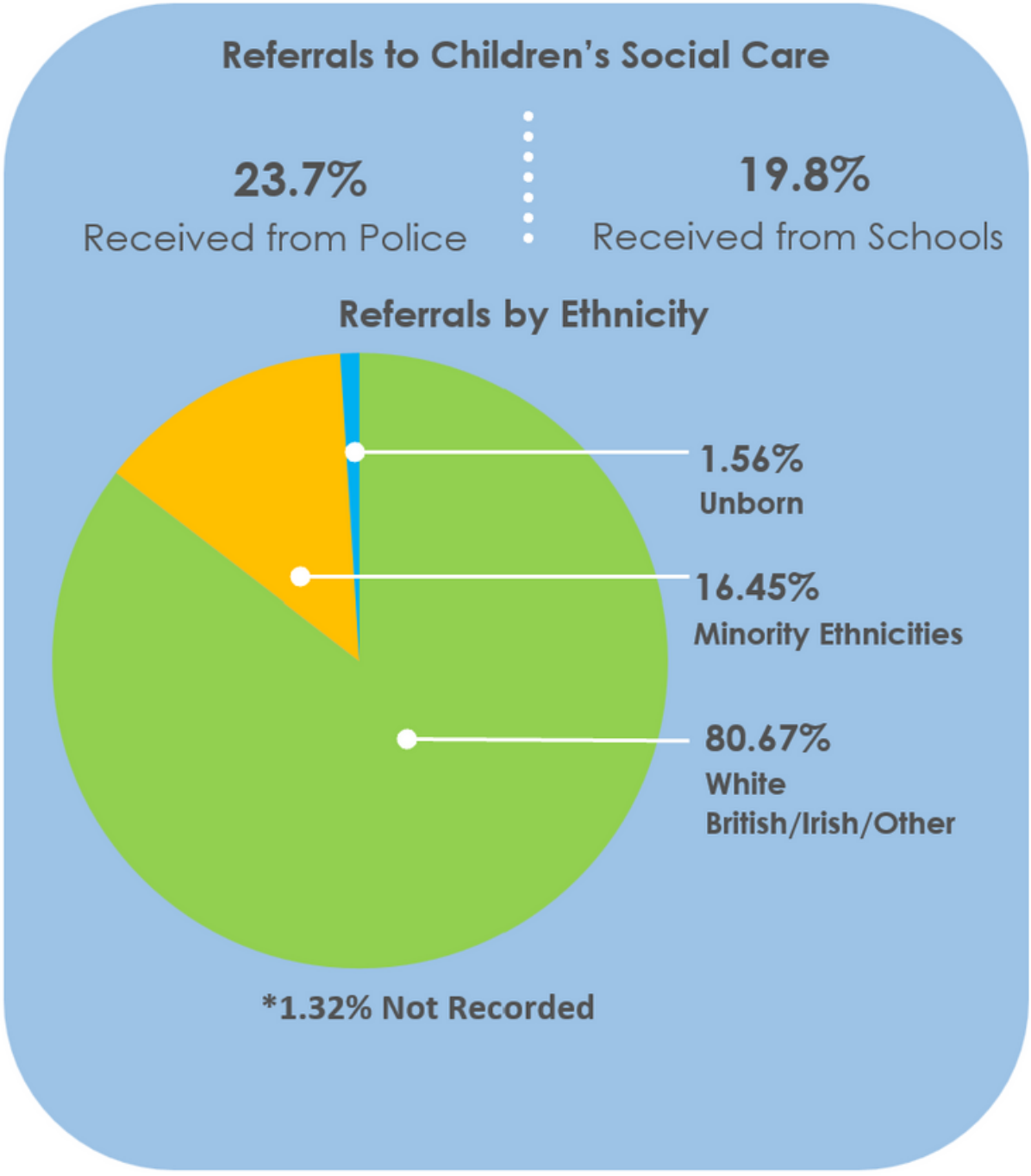
1146 CIC Missing Episodes
(982 in 2021/22)

152 Missing CIC
(130 in 2021/22)

306 Children subject to Plans
(400 in 2021/22)

Warwickshire Safeguarding

Children:


Referrals to Children's Social Care
23.7%
Received from Police
19.8%
Received from Schools
Referrals by Ethnicity
1.56%
Unborn
16.45%
Minority Ethnicities
80.67%
White
British/Irish/Other
*1.32% Not Recorded

MOVING ON FROM THE COVID-19 PANDEMIC

The Covid-19 pandemic presented partner agencies with significant challenges requiring them to adapt their services to respond to unprecedented demand, including the management of safeguarding concerns pertaining to its communities. Three years on, organisations have been able to reflect on their practices and review how they would respond if a similar situation were to present itself again. Part of this has been reviewing policy and procedures and practice guidance to ensure they provide clear processes whilst working within the boundaries of legislation governing their work.

PROGRESS ON OUR STRATEGIC PRIORITIES

Core Safeguarding

Strategic Thematic Review - Warwickshire Safeguarding completed its second Strategic Thematic Review focusing on the topic of 'Core Safeguarding Practice' of children and adults. 25 agencies from statutory and voluntary organisations and service providers engaged in this strategic thematic review. A significant amount of information was gathered and processed to provide an insight into all aspects of safeguarding work. areas of work which exemplify good practice, as well as identify practice where further development was still required, both at multi-agency and single agency levels.

WSEB Assurance visit to Front Door – The Executive Board partners from across Health, the Local Authority and Police undertook an assurance review of the Warwickshire Front Door and MASH in January 2023 to benchmark how local agencies in Warwickshire are working together to respond to the identification of initial need and risk to children; and to create a clearer line of sight between senior leaders and frontline practitioners. This included a review of the existing pathways and processes which was able to identify areas of good working practice, as well as flagging areas which needed some further development.

Trauma Informed Approach – Officers have been receiving trauma training and the impact on victims/witnesses, they also received training on vicarious trauma experienced by officers investigation Rape and Serious Sexual Offences (RASSO). Warwickshire Police has committed to further trauma training workshops in September 23 (45 officers attending) and in January 2024. Trauma training is embedded into all specialist police training, it is covered in the Rape and Serious Sexual Offences Investigative Skills Development Programme (RISDP), Specialist Child Abuse Investigators' Development Programme (SCAIDP), Specialist Sexual Assault Investigators Development Programme (SSAIDP) and Achieving Best Evidence (ABE) training courses. Several police officers have also completed the 'Trauma Train the Trainer' programme, to allow for more officers and staff to be trauma trained.

Vanguard project 'Positive Directions' – In August 2021, Coventry and Warwickshire CCG (now the Integrated Care Board) were successful in their bid to become the NHSE/I West Midlands Vanguard for the Framework for Integrated Care. The Framework for Integrated Care is the NHS's response to the Long-Term Plan commitment of investing in additional services for children and young people with complex needs. As an NHS England and NHS Improvement (West Midlands) health and justice funded initiative, the Positive Directions framework has a particular focus on improving outcomes for children and young people at risk of entering, or engaged with, the criminal justice system, as well as children and young people who are not engaged with services or in receipt of statutory support. We have commenced agreeing the operationalisation pathways that will underpin the mobilisation of the service in Warwickshire.

The Engagement Practitioner commenced a series of sessions with young people and is working in partnership with the Community Safety lead to inform the Serious Violence Strategy for Warwickshire.

A train the trainer programme for the Positive Directions work has been rolled out.

Exploitation

NRM Pilot for victims of modern slavery - Warwickshire County Council was successful in its bid to the Home Office to participate in a Pilot to devolve decision making for child victims of modern slavery. From the 20th February 2023, all NRM referrals completed by professionals for Warwickshire children are being referred to a local multi-agency NRM Panel set up for the purpose of making decisions on whether the children are victims of Modern Slavery.

This is a positive step for young people in Warwickshire, bringing more effective and timely decision making by agencies known to the child and connecting them to local safeguarding and support.

A positive NRM decision is the gateway for the victim to access:
- Services and support they need to start recovery
- Legal aid in immigration (non-asylum) claims
- Support, financial subsistence, and accommodation
- Counselling and interpreting

Limited protection from removal from the UK (the decision raises a barrier to removal).

Often for children this support has been initiated via Children's Services, but an NRM referral now assures a consistent intrinsic link of NRM to local safeguarding intervention.

Independent Modern Slavery Advisor (IMSA) - The OPCC commissioned support for victims of Modern Slavery and Human Trafficking (MSHT). One of the key priorities of this role is to raise awareness across the partnership of MSHT. Further specialist Modern Slavery and Human Trafficking training has been provided to a core of investigators to act as tactical advisors to staff investigating offences affecting adults and children.

Video bitesize briefings have been circulated to all operational teams on topics such as Voice of the Child, Police Protection Powers, Lessons learnt from Statutory reviews, Missing Persons and completing a Child Risk Assessment.

Prevention & Early Intervention

Launched new Children in Care - Care Providers Information Pack - developed by Warwickshire Safeguarding Partnership to provide useful information around responding to risks faced by children and young people (CYP) in care who may be vulnerable to going missing.

Operation Encompass – Warwickshire Police introduced a process for referrals to schools for children affected by domestic abuse, children reported missing and in September 2023 this will be expanded to include children affected by the peer-to-peer sharing of indecent images.

Operation Guarding - was launched to improve how the force responds to the peer-to-peer sharing of indecent images of children.

LEARNING FROM REVIEWS

Warwickshire Safeguarding co-ordinate the arrangements for agencies (such as schools, health service providers, police and social care) in the area to work together to safeguard children and promote their wellbeing. It is also responsible for looking into how well these arrangements are working and learning from things that do not go as well. In some situations, where children, young people or adults have died or have been seriously harmed and it is considered possible that agencies could have worked together better to prevent the harm, the safeguarding partnership have to hold a 'Child Safeguarding Practice Review' (0-18yrs) or 'Safeguarding Adults Reviews' (18+ yrs). These reviews are expected to show where things might have been done differently and what lessons can be learned to prevent similar incidents from happening to children, young people and adults in the future.

Referrals

Warwickshire Safeguarding received a steady stream of referrals for review of cases involving children, young people and adults throughout 2022-2023.

Provided below is a breakdown of the referrals received by Warwickshire Safeguarding during 2022-2023 and their progression:

Total number of referrals for review received in 2022-2023:
Children = 6 Child Safeguarding Practice Review referrals
Adult = 6 Safeguarding Adult Review referrals

Total number of referrals progressed to Review in 2022-2023:
Children = 1 Child Safeguarding Practice Review & 3 Single Agency Reviews
Adult = 1 Safeguarding Adult Review & 1 Alternative Learning Review

Breakdown of referrals by area:

Name of District/Borough Council	Child Referral	Adult Referral
Rugby	0	2
Nuneaton and Bedworth	2	3
Stratford upon Avon	1	1
North Warwickshire	1	0
Warwick	2	0

PUBLICATION OF REVIEWS

During 2022-2023, Warwickshire Safeguarding concluded four reviews which progressed to publication on its website to help raise awareness of the lessons drawn from the reviews, systemic learning and identification of actions which support continuous improvement in safeguarding practice.

Warwickshire Safeguarding Adults Review
CJ's Story:

CJ was a vulnerable young White British adult with a diagnosis of ASD and ADHD since the age of 5. CJ was intelligent, articulate and very able in many respects, however he had significant difficulties with his communication skills for which he had attended specialist schools from the age of 12.CJ was aware that he was treated differently to people his own age because of his vulnerabilities, which frustrated him. He was keen to make friends and more latterly, CJ gravitated to spending much of his time amongst the street homeless where he felt more accepted, and concerns grew that he was being exploited. CJ was taken into care by Warwickshire at his parents' request after they felt unable to care for him. Between the ages of 15 and 18 years old, CJ had experienced 12 different placements both in and outside of Warwickshire.

In late 2020, West Midlands Police visited CJ at his new temporary accommodation in Coventry at the request of his mother, who had been unable to reach him for some days. Police sadly found CJ dead in his room. The inquest concluded that CJ's death was drug related.

Click here to read CJ's story and lessons identified from this review

Warwickshire Child Safeguarding Practice Review
GRACE's Story:

In early 2021, 13-year-old Grace made a significant attempt to end her life. Grace was living with her mother, her mother's partner and the youngest two of her siblings in a one-bedroom flat at the time. This event was subsequently followed by another attempt 4 months later. Grace had a difficult childhood. She has largely lived with adults who had significant vulnerabilities of their own in a neglectful and risky home environment. Grace also experienced disruption due to several moves between family members. Her mother is known to have substance misuse issues and problematic drinking, domestic abuse in her current and past relationships, poor mental health and previous suicide attempts.

Following Grace's attempt to end her life in early 2021, the family were supported under a child in need plan. There were various indicators that Grace's needs were not being met at home in the months that followed the attempt to end her life, and that her mental health was being impacted on by this and her history of emotional abuse and neglect. The decision to escalate to an Initial Child Protection Conference (ICPC) in late 2021 was made after an incident where Grace was taken to A&E due to being very distressed and requiring a CAMHS assessment, followed by Grace's mother's statement that she no longer wished to cooperate with a child in need plan and one of the siblings stating she had been physically assaulted by her mother.

Click here to read Grace's story and lessons identified from this review

Warwickshire Child Safeguarding Practice Review
CHARLIE's Story:

Charlie was a little over 1 years old when they sustained extensive and life changing injuries as a result of a fire at the family home. Charlie lived with their mother, father and 4 young siblings. The family lived in a two-bedroom property in a close-knit community and kept many pets, including large dogs. At the time the fire started Charlie and their young siblings were left unsupervised whilst their father was at work and their mother had gone to visit a neighbour nearby. Prior to the fire no safeguarding concerns were raised regarding Charlie, however on one occasion when professionals visited the home, mum was on her way back from a neighbour's house. The home conditions were recorded by the Health Visiting Service as messy with rubbish on the floor and that the property was overcrowded with the parents being subject to rent areas. The family were open to Early help on two separate occasions.

The school submitted two separate referrals to the MASH following reports that Ben had been bitten by one of the family dogs and another when Charlie's older sibling, Dani, attended school with an unused small Kayser gas cylinder (used in dentistry and aerating cream but also as laughing gas) that they had found on the road on the way to school.

Click here to read Charlie's story and lessons identified from this review

Warwickshire Child Safeguarding Practice Review
JAMES' Story:

James stabbed his father at home in an apparent act of self-defence, his father was not seriously harmed but James and his family have been known to a wide range of services over a number of years. He is extremely vulnerable with several complex needs including risk of criminal exploitation, mental health issues, self-harm and suicide attempts, a history of traumatic childhood experiences and frequent cannabis misuse. He has also missed a significant part of his secondary education as he had not been in full time education for a number of years and only accessed very limited part time alternative education provision. James experienced chaotic early life experiences and instability in his care arrangements moving between his parents care throughout his childhood. He has been involved with Child and Adolescent Mental Health since the age of nine and there is an extensive history of mental health issues including nine recorded episodes of overdose and/or suicidal ideation. James has been subject to a child in need plan and a child protection plan, and the family have been offered support from several agencies.

At the heart of this case, however, is a fragmented approach where agencies struggled to engage or maintain engagement with this young person with complex needs. Practitioners described feeling a sense of paralysis and hopelessness when supports such as drug and alcohol services, education and mental health were not consistent or effective in engaging or supporting James.

Click here to read James's story and lessons identified from this review

7-MINUTE BRIEFINGS

To support learning from the reviews, Warwickshire Safeguarding continued to develop 7 Minute Briefings to place the spotlight on specific themes emerging from safeguarding reviews where improved understanding and awareness is required to support the safeguarding response for children, young people and adults. During 2022-2023 the following list of new briefings were added to Warwickshire's 7 Minute Briefing data base and published on its website:

UNDERAGE SEXUAL ACTIVITY	SAFEGUARDING ADULTS REVIEWS	MODERN SLAVERY & HUMAN TRAFFICKING (CHILDREN)	MAKING A REFERRAL TO THE FRONT DOOR (CHILDREN)
SUICIDE AWARENESS	NEW PARTNERS JOINING HOUSEHOLDS	MODERN SLAVERY & HUMAN TRAFFICKING (ADULTS)	LADO PROCESS (LOCAL AUTHORITY DESIGNATED OFFICER – CHILDREN)
HARMFUL SEXUAL BEHAVIOURS	FEMALE GENITAL MUTILATION	EARLY HELP	CONTEXTUAL SAFEGUARDING
CHILDREN ON PART-TIME OR REDUCED TIMETABLES	CHILD ACCIDENT PREVENTION	SAFEGUARDING CHILDREN AROUND DOGS	

LESSONS LEARNED BRIEFINGS

Learned Briefings are published alongside all review reports and are targeted at both professionals working with children and adults, as well as the Warwickshire community at large. They serve to provide a brief synopsis of the case alongside the key points of learning identified. These can be used to support discussion and reflection within Team meetings, 1:1 supervision and learning events to support continuous improvement in safeguarding practices. During 2022- 2023 Lessons Learned Briefings were developed to support learning from the following case stories:

CJ	GRACE	CHARLIE	JAMES

STRATEGIC THEMATIC REVIEW - 'CORE SAFEGUARDING PRACTICE'

Warwickshire Safeguarding completed its second Strategic Thematic Review focusing on the topic of 'Core Safeguarding Practice' of children and adults to gain a baseline understanding of performance across the following areas of practice:

- **25** agencies from statutory and voluntary organisations and service providers engaged in this strategic thematic review through the submission of single agency self-evaluations
- **121** case file audits were completed
- **188** returns were received professionals responding to an anonymised survey
- **15** face to face staff consultations were undertaken
- Direct feedback gathered from service users/carer's/families through the statutory safeguarding reviews work

STRATEGIC THEMATIC REVIEW - 'CORE SAFEGUARDING PRACTICE'

A significant amount of information was gathered and processed to provide an insight into all aspects of safeguarding work, areas of work which exemplified good practice, as well as identify practice where further development was required both at multi-agency and single agency levels to help the partnership to achieve better outcomes for children, young people and adults in need of safeguarding.

Headline findings identified the following:

To view a copy of the full report on Warwickshire Safeguarding's Strategic Thematic Review on 'Core Safeguarding Practice' please click on the following link - **FULL REPORT**

The Warwickshire Safeguarding Executive Board continues to oversee the delivery of the multi-agency action plan emerging from this review.

Warwickshire Safeguarding

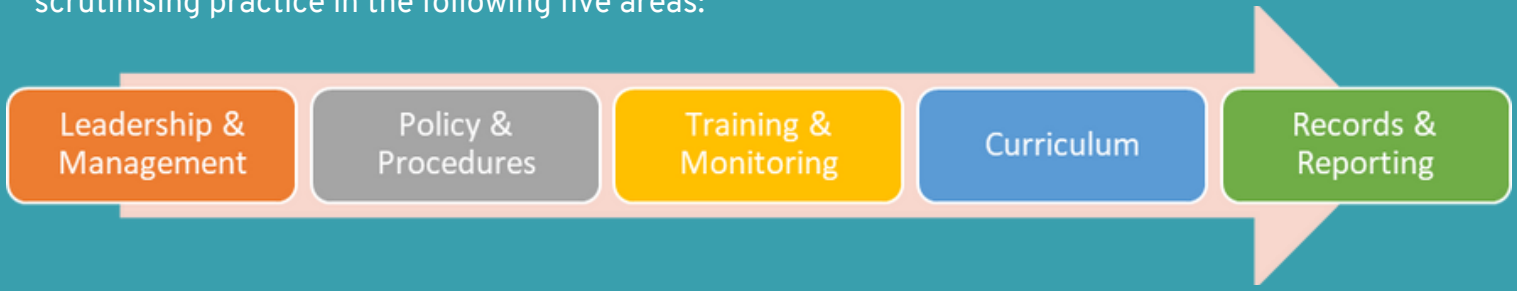
MULTI-AGENCY TRAINING PROGRAMME

In August 2022, Warwickshire Safeguarding launched its multi-agency training programme for its safeguarding partners operating throughout Warwickshire. The training was free to access and content was aligned to learning coming from Child Safeguarding Practice Review's, Safeguarding Adult Review's, findings from Thematic Reviews and the partnership's strategic priorities.

Appendix. 1 provides an overview of the training delivered throughout 2022/2023 alongside feedback from professionals joining the sessions.

WORKING WITH EDUCATION SETTINGS

Warwickshire undertook its annual section 175 audit of education settings to assess and evaluate the effectiveness of safeguarding arrangements. This year, a total of 284 responses were submitted from 294 contacted settings (i.e. Schools, colleges and alternative providers). The audit focused on scrutinising practice in the following five areas:



Each setting was requested to evaluate their arrangements by selecting one of the following options:

Emerging – Aspects require initial or immediate action.

Developing – Actions are being actioned and progressed but require further development to embed in the setting.

Established – Aspects are fully embedded in practice and are consistent and effective

Based on the returns submitted a number of areas requiring further focus and development were identified which have been included within the action plan for 2023-2024; provided below is a high-level snapshot of some of the areas of work:

Leadership & Management	Policy & Procedures	Training & Monitoring
•Improving levels of Governor oversight of relevant safeguarding policies, procedures, training and awareness of Lessons Learnt from Child Safeuaridng Practice Reviews	•Supporting education settings to develop and maintain up to date Prevent Risk Assessments and improve knowledge and awareness of Prevent duty through training	•Improving understanding and awareness on the topics of Behaviour Management & Physical Restraint, Mental Health & Self-harm. Total number of incidentsof seld-harm & suicide ideation recorded 2022-2023 were 6072

Implementation of the above will be monitored by Warwickshire Safeguarding's Education Subgroup who provide the Executive Board with regular updates on progress.

VOICE OF THE CHILD/ADULT

Advocacy

Local authorities have a duty to arrange for an independent advocate to be available to represent and support certain persons (Children and adults) for the purpose of facilitating those persons' involvement in the exercise of functions by local authorities. Advocacy is a process of supporting and enabling people to:

- **Express their views and concerns**
- **Access information and services**
- **Defend and promote their rights and responsibilities; and**
- **Explore choices and options**

CHILDREN'S ADVOCACY	Number of YP
Cases open at start of year	48
Referrals Received	168
Referrals Declined	8
Total number worked with	208

ADULT'S ADVOCACY	Year 4 Q4 Apr-Jun 2022	Year 5 Q1 July - Sept 2022	Year 5 Q2 Oct - Dec 2022	Year 5 Q3 Jan - Mar 2023	Total
Care Act Advocacy (ICAA) S.67	41	39	53	54	**187**
Care Act Advocacy (ICAA) S.68	23	9	11	15	**58**

Making safeguarding personal

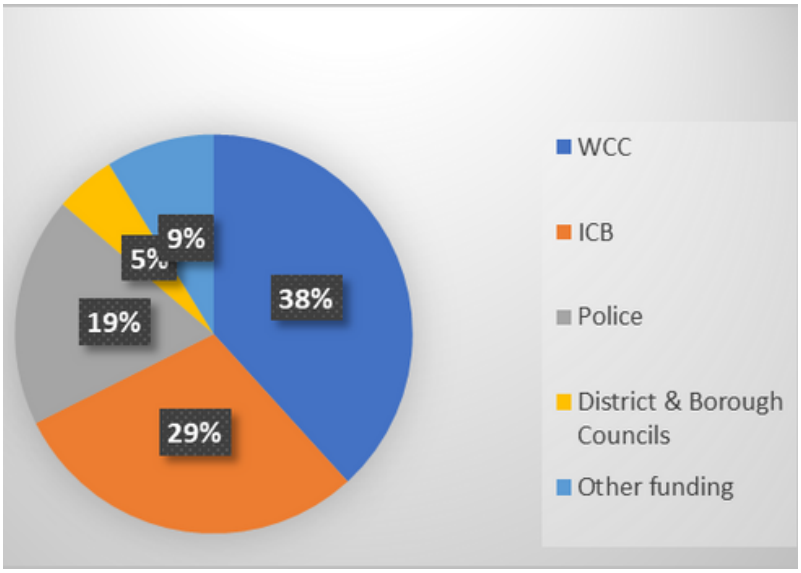
Making Safeguarding Personal requires agencies to ask individuals and/or their representatives what outcomes they would like to achieve from their safeguarding intervention. During the course of 2022-2023 Warwickshire concluded **220** s42 safeguarding enquiries of these:

- **159** individuals/their representatives expressed their views and desired outcomes
- **20** individuals/their representatives did not wish to express their views and desired outcomes
- **109** of the concluded s42 enquires recorded that the individual's outcomes had been fully achieved
- **57** of the concluded s42 enquiries recorded that the individual's outcomes had been partially achieved
- **18** of the concluded s42 enquiries recorded that the individual's outcomes had not been achieved

FUNDING THE PARTNERSHIP

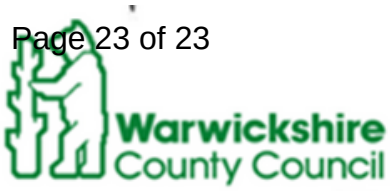
The funding for the partnership has remained largely at the same level as previous years' contributions from partners. In 2022-2023 the partnership operated within a total agreed budget of £323,876 received from the following sources which was used to resource:

- The Business Team staffing
- The Independent Chair & Scrutineer role
- Recruitment of CSPR and SAR review authors
- Development & delivery of the multi-agency training programme



ATTENDANCE

Agency	20 Jun 2022	4 Oct 2022	23 Mar 2023
Independent Chair and Scrutineer			
Age UK Warwickshire			
Barnardo's			
Care Quality Commission			
Councillors			
Coventry & Warwickshire Independent Care Board			
Coventry & Warwickshire NHS Partnership Trust			
District and Borough Councils			
George Eliot Hospital			
Healthwatch Warwickshire			
Myton Hospice			
National Probation Service			
Office of the Police and Commissioner			
Princethorpe College			
South Warwickshire Foundation Trust			
Universal Hospital Coventry & Warwickshire			
VoiceAbility			
Warwickshire County Council			
Warwickshire Fire & Rescue			
Warwickshire Police			
WCAVA			


Warwickshire
County Council


Warwickshire
POLICE


NHS
Coventry and
Warwickshire
Integrated Care Board


NHS
England


WARWICK
DISTRICT
COUNCIL


WARWICKSHIRE
FIRE & RESCUE SERVICE


RUGBY


VoiceAbility


STRATFORD-ON-AVON
DISTRICT COUNCIL


NHS
South Warwickshire
NHS Foundation Trust


Believe in
children
Barnardo's


WARWICKSHIRE
CAVA
COMMUNITY & VOLUNTARY ACTION


North Warwickshire
Borough Council


NHS
Coventry and
Warwickshire Partnership
NHS Trust


healthwatch
Warwickshire


The Polesworth School
ENSURING EXCELLENCE


Princethorpe
College


National
Probation
Service


CareQuality
Commission


Police and Crime
Commissioner
Warwickshire


NHS
University Hospitals
Coventry and Warwickshire
NHS Trust


Nuneaton
&
Bedworth


NHS
West Midlands
Ambulance Service
University NHS Foundation Trust


Warwickshire
age UK


NHS
George Eliot Hospital
NHS Trust

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Health and Wellbeing Board

15 May 2024

Coventry and Warwickshire Living Well with Dementia Strategy 2024 - 2029

Recommendations

That the Health and Wellbeing Board:

1) Notes and comments on the publication of the Coventry and Warwickshire Living Well with Dementia Strategy 2024 – 2029 (the Strategy) following governance approval from Coventry and Warwickshire Integrated Care Board in January 2024 (approved by Cabinet on 16 June 2022); and

2) Notes and comments on the progress made on the first year of the delivery of the Strategy alongside actions outlined to be achieved moving into the second year of delivery which commenced in April 2024.

1. Executive Summary

1.1 Warwickshire County Council, Coventry City Council, and Coventry and Warwickshire Integrated Care Board co-authored the Coventry and Warwickshire Living Well with Dementia Strategy, initially drafted in 2021 (the Strategy). This was approved by Cabinet on 16 June 2022. As part of that approval the then Strategic Director of People, in consultation with the Portfolio Holder for Adult Social Care and Health, was authorised to finalise the Strategy taking into account feedback from partners. Following an internal reorganisation in relation to Social Care within the Council this function now sits with the Executive Director for Social Care and Health. Due to delays with governance encountered whilst seeking approval from Coventry and Warwickshire Integrated Care Board, the dates of the strategy were changed from 2022-2027 to 2024-2029. The content of the Strategy remains the same as when it was approved in June 2022. The Cabinet paper from 16 June 2022 can be found here: Coventry and Warwickshires Living Well with Dementia Strategy 2022-2027.pdf (moderngov.co.uk)

1.2 The Strategy highlighted six priority areas to support those living with dementia across Coventry and Warwickshire:

- Priority 1: Reducing the risk of developing dementia by promoting healthy lifestyles.
- Priority 2: Ensuring people receive a timely, accurate diagnosis of dementia and that they are linked in with support soon after diagnosis.

- Priority 3: Supporting people living with dementia and their families and carers to access safe, high-quality support and care that is strengths-based and personalised.
- Priority 4: Ensuring people living with dementia can live in safe and accepting communities, where they can access a range of support services and enjoyable, meaningful activities.
- Priority 5: Support people with dementia to die with dignity in the place of their choosing, and that their families are supported.
- Priority 6: Offer training and awareness opportunities to support communities to increase their awareness of dementia.

1.3 Since April 2023, delivery of the Strategy has been ongoing with each priority having an identified lead, actions, and products attached. Delivery of the Strategy began prior to the publication of the Strategy so actions outlined to deliver the approved Strategy could commence.

1.4 A delivery plan was produced which included various work and projects that have been undertaken across Coventry and Warwickshire to support delivery of the Strategy. Successes have included embedding the dementia risk reduction messaging into communications linked to wider health campaigns, increasing the dementia diagnostic rate, and establishing an operational dementia hub in Coventry.

1.5 Delivery of the strategy is being overseen by the Coventry and Warwickshire Dementia Steering Group. Priority leads provide quarterly updates on progress along with any concerns for delivery. The steering group membership includes representation from Coventry City Council, Warwickshire County Council, and Coventry and Warwickshire Partnership Trust.

2. Financial Implications

1.6 The Strategy has been developed jointly with local partners, including NHS partners and the voluntary and community sector. Achievement of the Strategy's ambitions and priorities, outlined in the Delivery Plan, will utilise existing partner resources and include individual provider and partnership bids for funding.

1.7 Funding has been secured through Warwickshire County Council's Medium Term Financial Strategy to support development and implementation of the Dementia Strategy in Warwickshire.

1.8 The Board is asked to note that some of Warwickshire County Council's commissioned services for dementia are funded through the Better Care Fund and supplemented by Warwickshire County Council with approximately 80% being funded through the Better Care Fund.

1.9 As much of the Strategy is being delivered within current budgets, workload capacity has proved to be a challenge for delivery with many actions unable to

be delivered in year 1 as initially planned and instead, moved into year 2 as outlined throughout this report.

3. Environmental Implications

3.1 None arising directly from this report.

4. Supporting Information

1.10 There are a range of actions that have been introduced under each of the six priority areas outlined within the Living Well with Dementia Strategy.

Priority 1 – Reducing the risk of developing dementia by promoting healthy lifestyles. Lead organisation: Warwickshire County Council.

Year 1

1.11 Targeted communications were developed and delivered to the public in various formats to maximise reach across Warwickshire. Communications included information on the benefits of healthy lifestyles and how they can reduce the risk of dementia and were delivered in line with wider health campaigns such as No Smoking Day. A plan to review availability of resources has been developed and will be followed annually. For the second year of Strategy delivery, the same plan for Warwickshire will be developed and delivered for Coventry.

1.12 A review of existing Making Every Contact Count (MECC) messaging, resources, and training opportunities were reviewed with opportunities to develop messaging around healthy lifestyles and how they can reduce the risk of developing dementia for use by practitioners identified. This has now been built into the messaging and training delivered through MECC. Positive feedback has been received from those who have received training.

1.13 Dementia messaging has been identified and shared via GP practices to those who attend NHS Health Checks. All GP practices that have agreed all the paperwork to deliver NHS Health Checks as part of the new contract have been sent dementia resources. When practices sign up, they will be sent a pack of resources including the Fitter Futures dementia leaflet. Plans to monitor the number of individuals who attend NHS Health Checks and receive dementia risk reduction messaging have been established for year 2.

Year 2

1.14 A greater up-take of NHS Health Checks will be encouraged for those aged 40-74 across Coventry and Warwickshire. Everyone who has an NHS health check should be made aware that the risk factors for cardiovascular disease are the same as those for dementia. People aged 65-74 should be made aware of the signs and symptoms of dementia and be signposted to Memory Services

provided by Coventry and Warwickshire NHS Partnership Trust if this is appropriate.

1.15 Opportunities for carers to take part in a range of activities and programmes to enhance their physical and mental health will be promoted. A dementia representative will be present at carers forums and events to promote opportunities for carers.

1.16 Through awareness-raising targeted communications and support for those at greater risk (e.g., those with Mild Cognitive Impairment, individuals with learning disabilities and people from Black and Minority Ethnic backgrounds) will be included. This will lead to identification of groups so targeted communications are developed and distributed to them. Additional work with the Alzheimer's Society is planned to support the delivery of this action through the identification of groups and specific communications and awareness raising planned through communities.

Priority 2 - Ensuring people receive a timely, accurate diagnosis of dementia and that they are linked in with support soon after diagnosis. Lead organisation: Coventry and Warwickshire Partnership Trust.

Year 1

1.17 A data reconciliation exercise between primary care and the Memory Service was undertaken to ensure that GP records align with those of the Memory Service which means that dementia diagnoses are recorded across medical records. This piece of work required engagement from individual GP practices with over 50 practices having been involved so far. The exercise was supported by a designated worker assigned to 3 days a week to complete the exercise.

1.18 The DiaDem tool was used to assess appropriate patients in care homes. This supported work towards achieving the NHSE target of 66.7% DDR. The DDR has increased to 57.1% in Coventry and Warwickshire.

1.19 Work with primary care also saw training being delivered to GPs to facilitate the diagnosis of non-complex dementia, reducing the number of people needing to access the memory assessment service whilst increasing the DDR.

Year 2

1.20 Actions are planned to continue to work towards the dementia diagnostic rate of 66.7%. A recovery plan has been devised and implemented to include the wider systems in achieving the dementia diagnostic rate. A workshop was held in March 2024 with stakeholders from across the system including voluntary and community organisations, GPs, ICB colleagues, Social Care and Support colleagues, NHS England colleagues and commissioners, with a series of further workshops is being planned.

1.21 The plan continues work on the capacity and demand modelling outcomes to improve services and the patient journey. Working groups have been

established to work on the identified outcomes of the capacity and demand modelling outcomes. The wider systems are considering the suggested uplift in workforce and budgets.

1.22 The plan includes actions working towards a combined Older Adult's service that will encompass all older adults who are 65 or older with functional and organic diagnoses. The distinction being those that can be attributed to physical changes and those with symptoms but no measurable changes. The Older Adults service went live on 2nd April, and work is being progressed to develop a combined Older Adults Service with a 3-year implementation plan. Work to develop a training plan in line with Health Education England competencies for older adults is also planned.

1.23 There is a plan to set up and develop a Carers feedback group and to also join the adult mental health services in delivering listening clinics.

1.24 As work progresses nationally to explore potential new dementia modifying drugs, earlier Mild Cognitive Impairment pathways, and increased post-diagnostic support, work locally will see the development and introduction of a plan for this implementation. This will initially look at the establishment of Brain Health Clinics.

1.25 Coventry and Warwickshire Partnership Trust was assessed for the Memory Service National Accreditation Program on 19th March. Initial verbal feedback was positive and the full report which will contain areas for improvement will be received soon. The feedback from the report will be incorporated into the service.

<u>Priority 3 - Supporting people living with dementia and their families and carers to access safe, high-quality support and care that is strengths-based and personalised. Lead organisation: Coventry City Council</u>

1.26 A dementia lead nurse has been visiting all GP practices to discuss services available as part of the data reconciliation. GPs have been offered free comprehensive dementia training in dementia including post-diagnostic support for people with dementia and carers. The service is investigating employing a dementia communications lead who, amongst other things, would lead on ensuring information remained up to date.

1.27 The Dementia Promoting Independence Service provided by Coventry City Council working with Carer's Trust and ExtraCare Charitable Trust have regular meetings with referrers to ensure a smooth transition out of hospital. Other support services regularly communicate with referrers. All support services have recently attended a networking event.

1.28 Work to support carers has included the distribution of the carers bulletin every 6-8 weeks which includes activities and support available to carers. Strategic links between dementia and carers across Coventry and Warwickshire were identified and plans to monitor in the future are underway. Currently carer support services are contacting the Memory Service and

dementia support services commissioned by Coventry City Council and Warwickshire County Council (including the Dementia Navigator Information and Advice services provided by the Alzheimer's Society) through the Next Steps meetings in an ad hoc way. Next Steps is a partnership between people with dementia, their families and carers, and professionals, to deliver personalised support. Plans for year 2 include making this contact more routine.

1.29 The support offer across the area was reviewed as part of the dementia system work and gaps and disparities identified. Where relevant these will be picked up as part of the system-redesign. The service is looking at creating an equitable offer through recommissioning services where contracts are due to expire. Plans to build on good practice and sharing learning, such as the Admiral Nurse role in Warwick Hospital who supports advanced care planning for patients going back to the community were delayed as required further development before commencing. This work will be carried into year 2 and will be completed as part of the dementia system redesign work.

Year 2

1.30 Plans include work to stimulate the market to increase the supply of high-quality care and support for people with dementia in line with increasing numbers, including for those with behaviour that challenges and/or complex behaviours. This will include enhancing the community support offer and working with care home leads to identify current provision that can meet dementia need and identify where the gaps are. This work will then be used to support the development of service specifications that address these gaps.

1.31 The service will work to review and strengthen the dementia pathway for people with dementia entering and leaving hospital to minimise moves and changes in the environment. This will involve overseeing a system wide approach to reviewing pathways to be led by priority 3. The system redesign work will also focus on improving access to service for carers, ensuring geographical equity of commissioned services.

1.32 Work to raise awareness of post-diagnosis support available for people affected by dementia; ensuring that information is easily accessible, available in a range of formats, and easy to understand. This involves bespoke campaigns within different parts of the community. To support delivery of this action, there are plans to recruit a dedicated dementia communications lead in Coventry who will work with dementia support services to develop and deliver specific campaigns.

Priority 4 – Ensuring people living with dementia can live in safe and accepting communities, where they can access a range of support services and enjoyable, meaningful activities. Lead organisation: Warwickshire County Council

Year 1

1.33 Work to ensure that a variety of community support services and activities are available for people with dementia and their carers began with a scoping report detailing the current offer in Nuneaton and Bedworth and including a consideration of needs and gaps. The report has been used to understand local needs and interests that are tailored to protected characteristics where appropriate. Work with dementia groups, carers forums, WCAVA, and mental health and wellbeing forums has been undertaken to help better understand local need and current gaps. The relationships with these groups and the information obtained through the scoping report have resulted in activities such as the launch of a dementia group at Wembrook Community Centre.

1.34 The Living Well with Dementia website has been continually maintained including ensuring the local map of services is accurate and reflects current provision. Website visit statistics have also been obtained to facilitate better understand of reach.

1.35 Work to support the voluntary and community sector to grow, restore, and maintain services such as dementia cafes and activities has been successful including the opening of the dementia hub in Coventry. The hub is attended by providers and voluntary organisations which help offer support, advice, and social connections for individuals living with dementia and their carers.

1.36 A forum for Voluntary and Community Sector (VCS) providers across Coventry and Warwickshire has been established and is operational. The forum facilitates support and information sharing with VCS organisations and groups.

1.37 Work to establish a reference group of individuals who have been affected by dementia has encountered challenges in year 1 due to difficulty with securing membership. To progress this into year 2, the service will look to engage with existing community groups of people who have been affected by dementia. For example, the Alzheimer's Society (commissioned by both Warwickshire County Council and Coventry City Council) who provide information and advice services operate a Dementia Voice community group who seek to engage with professionals to help shape work.

Year 2

1.38 The scoping report undertaken in Nuneaton and Bedworth will be completed for the other 4 districts and boroughs in Warwickshire and the relationships with groups that now exist because of year 1 success will be used to help introduce and/ or maintain dementia groups elsewhere in Warwickshire.

1.39 The continual development of the living well with dementia website will incorporate user feedback via the website and a small group. Feedback will be obtained, and a report produced which will be used to inform how the website is developed.

1.40 Work to increase representation from VCS providers in the South of Warwickshire will be focused on. The group will provide increased levels of

support and information sharing for the dementia organisations with group membership.

Priority 5 - Support people with dementia to die with dignity in the place of their choosing, and that their families are supported. Lead organisation: Coventry and Warwickshire Partnership Trust.

Year 1

1.41 A questionnaire was developed to understand current knowledge about end of life in the community teams. The data obtained via this questionnaire is now being collated with the report being written in year 2.

1.42 Work has begun to support system wide partnerships including working with Coventry and Warwickshire ICB to identify where there are overlapping areas of work between the Living Well with Dementia Strategy and the End-of-Life Strategy.

Year 2

1.43 Development of an online toolkit for End-of-Life Care and Dementia is planned. It is intended to be hosted on the Palliative and End of Life Care website of the CASTLE Expert Advisory Group of Coventry and Warwickshire (care and support towards life's end). A multi-agency approach to the development of the toolkit will be adopted by involving carers of those with dementia, hospices, palliative care teams, speech and language therapy, physical health psychology, the Alzheimer's Society, and Admiral Nursing (dementia specialist nursing). Targets for users of the toolkit need to be developed along with a multi-agency review of the initial draft of the toolkit. Ongoing monitoring including refreshes of the toolkit will be planned.

1.44 Clear pathways for dementia will be developed for those in Acute Dementia Services and those in Community Dementia Services.

1.45 A focus on upskilling staff will be seen in year 2 with the development and delivery of training for staff working with people with dementia on end-of-life care. The training will be delivered to staff working in Palliative Care Teams and Hospices amongst others.

1.46 The use of Advance Care Plans for people with dementia will be increased by identifying pathway points at which these can be carried out with people living with dementia across organisations. Staff skills will need to be identified and addressed to complete this action.

1.47 A process will be developed to ensure safe decision making for people with dementia including end of life decisions. This will include considering the appropriateness of mechanisms such as a lasting power of attorney.

1.48 Identification of health inequalities will be mapped for people with dementia and end of life.

1.49 Overarching work to support a whole system approach will be adopted with a particular focus on engaging with Coventry and Warwickshire ICB such as with their End of Life Strategy.

Priority 6 - Offer training and awareness opportunities to support communities to increase their awareness of dementia. Lead organisation: Warwickshire County Council.

Year 1

1.50 The Social Care Information and Learning Service (SCILS) has been developed increasing both the number of people accessing resources and the number of available resources. This work will be furthered in year 2 by increasing the resources, webinars, and E-learning available.

1.51 The Dementia Friends training has been expanded to local businesses to increase awareness and support building dementia friendly communities. 2023/24 had 287 Dementia Friends sessions delivered with plans to increase this in year 2.

1.52 Warwickshire County Council established a new E-learning platform which included Dementia Awareness training which all staff are encouraged to undertake. Providers working with Warwickshire County Council receive communications promoting awareness training through the monthly Adult Social Care Bulletin, Social Care Information and Learning Services (SCILS), and general developments when new information becomes available.

1.53 All staff who began working for providers undertook relevant units of the Care Certificate and this was monitored through the contract monitoring and quality assurance process. The requirement to complete the Care Certificate will change in year 2 as a new, externally marked certificate is introduced with a dementia specific module. The service will continue to support those undertaking the Care Certificate whilst transitioning to the new qualification.

Year 2

1.54 Work to collate and promote a range of courses aimed at carers, delivered by local and national groups will be undertaken. This will involve the identification and dissemination of a list of relevant training opportunities for carers and working with organisations in contact with carers to promote the range of training on offer.

1.55 Work to expand the training offer in year 2 will involve working with organisations to support the delivery of sessions such as the Alzheimer’s Society. There will be a focus on delivering dementia friends sessions to family and carers at the point of diagnosis to help with understanding and support at the earliest opportunity.

1.56 Webinars for both internal staff and providers focusing on sessions that are tailored to meet local need will be developed and delivered. The webinar format will be adopted to increase blended learning and flexibility within the offer.

5. Timescales associated with the decision and next steps

1.57 Year 2 of the delivery plan commenced on 1st April 2024. Quarterly updates will be provided to the Coventry and Warwickshire Dementia Steering Group.

6. Appendices

None.

7. Background Papers

None

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

Local Member(s): not applicable county wide report

Other members:

Health and Wellbeing Board

15 May 2024

Services delegated to the ICB: Dentistry, Optometry, Pharmacy and specified Prescribed Specialised Services

Recommendation

That the Health and Wellbeing Board:

1. Notes and comments on the delegation of responsibility for Primary Pharmacy, Optometry & Primary and Secondary Dental Services from NHS England to the Coventry and Warwickshire ICB taking effect from on 1st April 2023 and the processes outlined for the management and governance of these arrangements;
2. Notes and comments on the delegation of responsibility for a portfolio of Prescribed Specialised services from NHS England to Coventry and Warwickshire ICB taking effect from on 1st April 2024 and the processes outlined for the management and governance of these arrangements;
3. Notes and comments on the status of the services delegated as outlined in the services profile report; and
4. Notes and comments on the further portfolio of Prescribed Specialised services planned for further delegation in 2025/26.

1. Executive Summary

1.1 Coventry and Warwickshire ICB received delegated responsibility for commissioning Primary Pharmacy, Optometry and Secondary Dental services from 1st April 2023.

1.2 Coventry and Warwickshire ICB received delegated responsibility for commissioning 59 prescribed Specialised services from 1st April 2024.

2. Primary Pharmacy, Optometry & Primary and Secondary Dental Services

2.1 The aim of NHS England in delegating commissioning functions to ICBs is to break down barriers and join up fragmentated pathways to deliver better health and care so that our patients can receive high quality services that are planned and resourced where people need it. The services that were be delegated to ICBs on 1st April 2023 are:

- Primary Pharmacy, Optometry & Primary and Secondary Dental Services
- Complaints functions associated with Primary Pharmacy, Optometry & Primary and Secondary Dental Services

2.2 Delegation of these services is a national policy. In all cases the responsibility and liability for the planning, performance, finance, quality, and improvement will move from NHS England to ICBs upon delegation. The ICB is responsible for any claims (negligence, fraud, recklessness, or breach of the Delegation). However, in all cases NHS England remains accountable to the Secretary of State for the services, which means that NHSE will have oversight, set standards and service specifications for the services.

2.3 The planning footprints of the East Midlands, West Midlands and Midlands are the continued basis for multi-ICB planning and decision making where it makes strategic sense in order to meet the quadruple aim objectives.

2.4 As a basis for joint planning for delegated and devolved functions, ICB Chief Executives and NHSE Executives have worked on the principle of pragmatic strategic planning ensuring that skills are retained and that specialised resources are shared between ICBs and between ICBs and NHSE, where appropriate.

2.5 Whilst all decisions will be through formal joint committees ensuring equal and equitable decision making for each individual ICB with no one ICB having primacy over another, the hosting of the workforce requires one ICB to provide this function on behalf of the other ICBs.

2.6 The Host ICB will provide, oversight, leadership, and support for the workforce. The workforce will work for and on behalf of, each ICB within the planning footprint (West Midlands in this case). This will be supported by a formal hosting agreement between the ICBs and, for specialised services, between the ICBs and NHSE.

2.7 The Host will not make commissioning decisions on behalf of other ICBs or NHSE; all decisions will be made through the Joint Committees and their sub-groups.

2.8 Recognising that authority do not rest with one individual or individual ICB a model of Distributed Leadership will be adopted to implement shared vision and values and continue the ICB and regional commitment to collaboration and building a strong learning culture.

2.9 The **Primary Care Pharmacy, Optometry and Dentistry workforce is hosted** on an East and a West footprint. The host ICBs have been approved by the ICB CEOs and are as follows:

- East Midlands - Nottingham & Nottinghamshire ICB
- West Midlands – Birmingham & Solihull ICB

2.10 The Distributed leadership model of strategic leadership for Primary Care POD will be through Herefordshire & Worcestershire ICB for the West, Nottingham & Nottinghamshire ICB for the East.

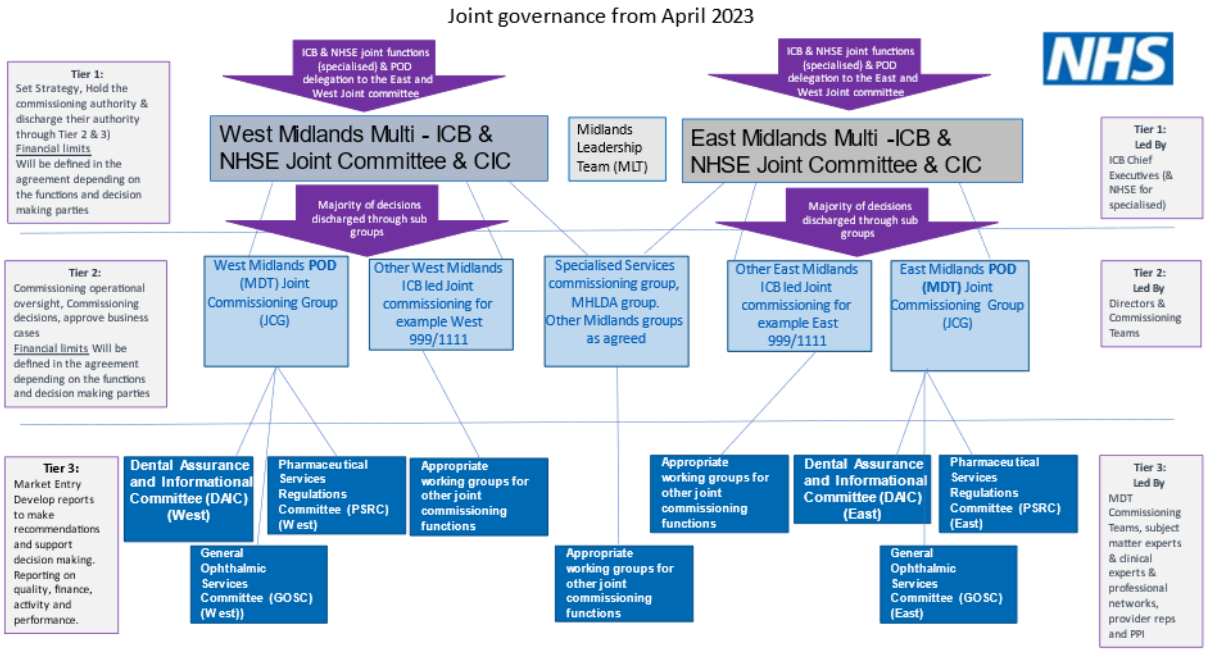
2.11 The complaints workforce that aligns to Primary Care will also transfer to the Hosts outlined above. However, there is recognition that there are still some national policy agreements and operating model challenges to be resolved, informed by national policy discussions.

2.12 Workforce transfers for POD, primary medical service support and complaints staffs took place on 1st July 2023. This was on a multi-disciplinary basis, also including commissioning finance and clinical reviewers but with specialised healthcare public health team members aligned or embedded to teams, not transferred.

2.13 The **governance arrangements** for the delegated and devolved functions will be through joint committee arrangements. The current East Midlands and West Midlands collaborative Commissioning Boards transitioned into formal joint committees, with quarterly Committee in Common where both East and West Midlands Boards will come together as 11 ICB for decisions that require a whole Midlands planning footprint. The governance framework is illustrated below.

2.14 For Primary Care Pharmacy, Optometry and Dentistry a Joint Commissioning Group led by ICB directors was fully operational in April 2023.

2.15 The model of distributed leadership continues through the POD Joint Commissioning Group. To ensure clinical and financial expertise into the group 1 POD ICS finance lead and 1 POD ICS Quality lead are core members of the group.



2.16 Given the strategic, infrastructure, and digital development work needed to underpin safe, effective and equitable **Screening Services**, and the complex

end-to-end nature of those services, delegation of screening services is currently out of scope.

2.17 Within the West Midlands footprint, the ICBs have agreed to jointly manage financial risk and have agreed various options to manage future growth and in year performance variations. Coventry and Warwickshire was initially set an allocation lower than the recurrent committed spend, but through these arrangements have secured a correction to baseline to cover existing commitments.

2.18 Appendix One covers 'frequently asked questions' with regard to Dental, Optometry and Pharmacy (DOP) services and delegation thereof for further information.

3. Prescribed Specialised Services

3.1 Since April 2023, the Midlands ICBs and NHS England have operated under statutory joint working arrangements to commission specified specialised services. This has included 59 Acute Specialised Services identified in the national NHS England Specialised Commissioning Roadmap (May 2022) as suitable and ready for delegation.

3.2 Following an agreed due diligence process, it was recommended that the 11 Midlands ICBs support formal delegation of the 59 services in April 2024. This was in line with the ICB readiness submission to NHS England though the pre-delegation assessment framework and the subsequent NHS England Board approval in December 2023.

3.3 National policy required ICBs to work in formal collaboration regarding Specialised Services. This responsibility will be enacted through the East and West Midlands Joint Committees. However. the decision to move from joint working to formal delegation was a decision for each statutory ICB Board. The Coventry and Warwickshire ICB approved the decision to accept delegation of these 59 services at the March 2024 board meeting and this takes on delegation from 1st April 2024.

3.4 All ICBs are expected to receive the delegation of all agreed Specialised Services (Acute, Mental Health and Learning Disabilities, and Vaccinations) by no later than April 2025. The proposed phasing of delegation, with 59 services proceeding in April 2024, provides the Midlands ICBs with the opportunity to build experience in commissioning these services with a developmental safety net of a transitional year. NHS England will provide significant support to ICBs from 2024 to 2025 as they take on these delegated functions.

3.5 The delegation of the 59 Acute specialised services is to individual ICBs, however, the formal Delegation Agreement requires ICBs to collaborate in a multi-ICB partnership. The Delegation Agreement is therefore be supported by a Collaboration Agreement and Commissioning Standard Operating Framework, which includes NHSE as a partner in their continued role in commissioning retained (non-delegated) services. The approach supports the

requirement to consider the cross-system population needs that support safe and sustainable care in specialised provision.

3.6 The Midlands have developed a joint Memorandum of Understanding as a part of the suite of delegation documents, setting out our collaborative commitment to working together to maximise the benefits of delegations for patients, populations and across complex pathways.

3.7 The primary purpose of delegation is to benefit the care provided to patients across their care pathways, improve access and reduce inequalities for whole populations. There is a significant opportunity to ensure that the disconnect between the commissioning of specialised services through NHS England and the local commissioning bodies is removed.

3.8 The clinical leaders across ICBs and NHSE have identified the delegation benefits as follows:

- **Equity of access for all patients:** There is good evidence that this varies across geographies with those further from specialised provision less likely to have access. Delegation provides the opportunity to understand access and consider outcomes and value across pathways.
- **Whole pathway approach:** Joining up the whole pathway is likely to encourage focus on upstream prevention improving overall patient outcomes and reducing pressure on specialised services.
  In addition, this ensures any proposed changes in specialised services are planned with interdependent local services; this could include diagnostic services, services that have a key pathway linkage or support services in health care or local authority provision.
- **Facilitation of whole pathway transformation** across ICS footprints as new services are introduced: It will allow implementation of clinical advances as close to home as possible for patients whilst maintaining speciality capacity for when needed most.

3.9 An example of the benefits of delegation is set out below:

Renal Services

The need for **renal dialysis** can be reduced by ICBs focusing on identifying those at risk for developing kidney disease and its progression. New treatments are now available to delay progression which if systematically implemented should reduce population dialysis and transplantation needs.

Currently planning and delivery are separate between primary and tertiary care and more local solutions could be developed. More integrated commissioning of specialised renal services would make innovations easier by:

- The same people and organisation being responsible for commissioning both the specialised (e.g., dialysis) and non- specialised (GP led) parts of the patient pathway ensuring complete clinical join up of pathway.
- Budgets could be pooled which creates more of an incentive to prevent renal progression, promotion of home therapies to reduce transportation costs and prompt referral for renal transplantation.
- Wider service provision could be included more easily e.g., psychological support and welfare support.
- Services can be tailored around the needs of local populations helping to address health inequalities.
- Those who do need specialist services will still be able to access them in line with national standards and policies.

3.10 The 11 ICB and NHS England worked together throughout 2023/24 on the formal joint working arrangements. This enabled ICB specialised services leads to understand and work alongside NHSE teams, making informed decisions on finance, quality and commissioning and contracting.

3.11 The approach to the transition process for delegation was led through joint working groups covering finance, governance, clinical quality, strategic commissioning, and planning. This approach was informed by the design principles and operating model set by ICB CEOs.

3.12 The comprehensive national safe delegation checklist, which all regions utilise to provide joint ICB and NHS England assurance on deliverables for safe delegation, has guided the approach to due diligence. In addition, learning from the POD delegation, an additional process was agreed and led in the Midlands including ICB and NHSE leads. The summary due diligence reports have focussed on four key domains and have been received by the East Midlands and West Midlands Joint Committees. The due diligence domains are set out below:

- **Quality** – understanding of the quality issues as the receiving organisations and the agreed framework for how ICBs will operate in 24/25
- **Finance** – Clarity on the absolute risks and issues required for transition. Agreed position on the ICB allocations and methodology and risk share to mitigate the risks for ICBs.
- **Resources** – staff capacity and capability over the transition year (in advance of transfer to ICB hosting in 2024/25) and the ability to meet requirements for delegation as ICBs take on the commissioning role.
- **Benefits and opportunities** – Clarity on the benefits of proceeding with delegation in 24 /25. This assessment must also consider the missed opportunity that may accrue through delay to delegation.

Assurance was met against each of these domains.

3.13 The joint working groups co-produced several key documents (these are included in a supporting pack for information) that support the delegation of these services, these included:

- Delegation Agreement
- Memorandum of Understanding (MoU) and Collaboration Agreement 2024/25
- Commissioning Team Agreement and Operating Framework
- Service Portfolio Reports

These outline the future operating model for the collaborative arrangements, including governance, supporting groups and terms of reference etc.

3.14. Appendix 3 is attached which includes the service portfolio reports for the 59 services delegated to Coventry and Warwickshire ICB

4. Financial Implications

4.1 For DOP services, in 2023/24, the overall year to date position as at M11 across the West ICBs was a surplus of £37.1m of which £3.1m related to Coventry and Warwickshire ICB. This was driven by under-performance on primary care dental services and over performance of Optometry and Pharmacy services activity. Note, at this stage in the year there was 8 months of actual financial activity for pharmacy services which was 3 months in arrears.

Table 1: Expenditure by West Midlands ICB

ICB	Annual Budget £'000s	YTD Budget £'000s	YTD Actual £'000s	Variance £'000s	%
Birmingham and Solihull	140,891	128,030	122,397	5,632	4.4%
Black Country	131,504	118,991	112,988	6,002	5.0%
Coventry and Warwickshire	88,146	79,827	76,661	3,167	4.0%
Herefordshire and Worcestershire	71,615	64,844	56,960	7,883	12.2%
Shropshire, Telford and Wrekin	52,775	47,715	41,960	5,755	12.1%
Staffordshire and Stoke on Trent	109,570	98,974	90,330	8,645	8.7%
West Midlands ICB Total	**594,501**	**538,381**	**501,296**	**37,084**	**6.9%**

4.1 The draft financial plan for Coventry and Warwickshire ICB for DOP services is £82.7m as outlined in Appendix 2, this does not correct for the baseline shortfall of c£6m identified and non-recurrently corrected in 2023/24 and our expectation is that this is likewise corrected again for 24/25.

4.2 The ICB should receive an allocation for delegated PSS services of c£218.8m as identified in the table below, albeit this remains subject to confirmation at this point in time. This is expected to cover all existing commitments and planned growth i.e., we will received a balanced plan. Due diligence is being completed on this as part of finalising the 2024/25 plan position.

Table 2: Delegated and retained service totals

Delegated & Retained Service Totals - 2 May 2024 draft plan

Midlands ICB	2 May Contract plan	2 May Reserves & Contingencies	Delegable Offer 2 May	Acute Orange	MH Orange	Orange Services 2 May	Total Delegated Services 2 May
NHS BIRMINGHAM AND SOLIHULL ICB	380,260,337	3,455,559	383,715,896	44,233,155	5,029,494	49,262,649	432,978,545
NHS BLACK COUNTRY ICB	253,906,572	2,407,712	256,314,284	24,465,138	3,061,212	27,526,351	283,840,635
NHS COVENTRY AND WARWICKSHIRE ICB	192,980,728	3,620,469	196,601,197	20,947,524	1,290,336	22,237,860	218,839,057
NHS DERBY AND DERBYSHIRE ICB	190,353,794	4,675,224	195,029,018	21,593,991	835,711	22,429,702	217,458,720
NHS HEREFORDSHIRE AND WORCESTERSHIRE ICB	143,563,850	3,167,510	146,731,360	13,334,174	1,695,762	15,029,936	161,761,296
NHS LEICESTER, LEICESTERSHIRE AND RUTLAND ICB	234,970,572	2,864,622	237,835,194	26,476,335	2,976,089	29,452,424	267,287,618
NHS LINCOLNSHIRE ICB	142,307,405	3,509,903	145,817,308	14,769,621	1,401,231	16,170,852	161,988,160
NHS NORTHAMPTONSHIRE ICB	141,682,876	3,954,510	145,637,386	14,256,447	1,176,340	15,432,786	161,070,172
NHS NOTTINGHAM AND NOTTINGHAMSHIRE ICB	255,658,028	1,288,761	256,946,789	29,444,595	3,166,174	32,610,769	289,557,558
NHS SHROPSHIRE, TELFORD AND WREKIN ICB	88,460,054	2,632,805	91,092,859	11,015,353	457,462	11,472,816	102,565,675
NHS STAFFORDSHIRE AND STOKE-ON-TRENT ICB	241,230,669	2,544,627	243,775,297	21,814,828	1,905,414	23,720,242	267,495,539
Midlands ICB Total	2,265,374,885	34,121,702	2,299,496,586	242,351,160	22,995,226	265,346,386	2,564,842,973

4.3 The ICBs have established a mutually agreed pooled fund arrangement for in-year financial management, with a defined contribution based on the allocation received for the 59 delegated specialised services which will be

transferred to the Host ICB, (Birmingham & Solihull ICB) on behalf of the Midlands. This is detailed in the collaboration agreement.

5. Environmental Implications

5.1 None directly associated with this report.

6. Conclusions

6.1 Health and wellbeing board is asked to:

- Note the delegation of responsibility for Primary Pharmacy, Optometry & Primary and Secondary Dental Services from NHS England to the Coventry and Warwickshire ICB taking effect from on 1st April 2023 and the processes outlined for the management and governance of these arrangements.
- Note the delegation of responsibility for a portfolio of Prescribed Specialised services from NHS England to Coventry and Warwickshire ICB taking effect from on 1st April 2024 and the processes outlined for the management and governance of these arrangements.
- To note the status of the services delegated as outline in the services profile report.
- Note the further portfolio of Prescribed Specialised services planned for further delegation in 2025/26.

7. Supporting Documents:

- Appendix One: Primary Care Delegation frequently asked questions
- Appendix Two: Draft 2024/25 DOP financial plans
- Appendix Three: Service portfolio reports for the 59 delegated prescribed specialised services.

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Primary Care Delegation Agreement Frequently Asked Questions

29 July 2022 – Version 2. Updates to version 1 are highlighted.

Terms and Conditions FAQs

Why is NHSE delegating its functions to ICBs?

Integrated Care Boards (ICBs) are being established to take responsibility for the health and care of their populations. In delegating its functions to ICBs, NHSE will enable ICBs to integrate care and improve population health. ICBs will have the flexibility to join up key pathways of care, leading to better outcomes and experiences for patients, and less bureaucracy and duplication for clinicians and other staff.

What is meant by delegation?

Delegation means that there is an agreement between NHSE and an ICB that enables the ICB to take on the responsibility for delivering NHSE functions. Following final approval and signature by each organisation's senior leadership team, the function becomes the responsibility of the ICB, meaning they can take commissioning decisions on behalf of its population. The ICB becomes the operational and legal owner of the function, being both responsible and liable for its delivery, with NHSE retaining accountability.

How has the delegation agreement been developed?

We started with the CCG Primary Medical Care delegation agreement and sought input from subject matter experts, regional and national NHSE teams, and legal colleagues. We also undertook extensive engagement with ICSs. NHSE worked closely with key stakeholders at each stage of development to clarify and refine the agreement, ensuring it supports the safe and effective delegation of commissioning functions.

Can an ICB delegate these functions to another organisation?

The Health and Care Act 2022 enables ICBs to delegate their functions to several other public organisations. But to fulfil its national role, NHSE recognises the need for parameters around the onward delegation of its delegated functions to provide safeguards. As such, the permissions available to ICBs are:

- Delegation to or joint commissioning with:
    - NHS Providers (Trusts and FTs) is not permitted

    - Local Authorities or Combined Authorities is subject to approval from NHSE
    - At least one other ICB is permitted
- Triple delegation (e.g. a scenario in which an ICB delegates to ‘another body’, which then delegates the function) is never permitted. This is because it may create confusion about responsibility.

Please note, internal arrangements do not constitute ‘onward delegation’ (e.g. where an ICB shifts responsibility for exercising these functions to a sub-committee of the ICB itself). It is only when functions are delegated to an external body that the ‘count’ of onward delegation begins. If an external body is represented on an internal sub-committee this is not deemed as onward delegation.

Where does liability sit when an NHSE function is delegated?

An ICB will be liable for any NHSE function delegated to them, while NHSE remains liable for any functions listed as reserved in the agreement. If there is significant doubt as to whether a function is delegated or reserved, it is considered to be reserved. Regardless of whether a function is delegated or not, NHSE remains accountable to Parliament for the function.

What is the difference between responsibility, liability, and accountability for a delegated function?

Liability means the legal responsibility to bear losses associated with the exercise of a function. The Health and Care Act 2022 locates liability for a function with the organisation which exercises it, meaning that if a function is delegated, the recipient holds the liability.

When a NHSE function is delegated to an ICB, the ICB will be responsible for ensuring the function is exercised in a proper way on behalf of NHSE. They will be responsible for planning and delivering the service in a way that meets the needs of the local population, offering high quality care accessible to all. The ICB will also be liable for how the NHSE function is being delivered. This means they will be responsible for responding where there are failings in the delivery of a service, for example, having to pay damages or taking any other necessary action.

NHSE will remain accountable to the Secretary of State for Health and Social Care for the function. This requires NHSE to seek assurance that the organisation they have delegated

the function to is delivering the service appropriately. NHSE will need to demonstrate assurance to third parties, such as the Secretary of State for Health and Social Care or the Health Select Committee, that the function is being exercised appropriately. Where an organisation is failing in the delivery of the function, NHSE must take action.

Will ICBs be liable for any failings of an NHSE function that happened prior to delegation?

No, liability from the pre-delegation period of an NHSE function remains with NHSE. An ICB is liable for the delivery of a function only from commencement of the agreement and not before. Liability for Primary Medical Care prior to 1 July 2022 sits with NHSE.

How will NHSE assure itself an ICB is exercising its function appropriately?

NHSE is working with regions and systems to develop an interim assurance framework for 2022/23 which will provide sufficient oversight on how an ICB is exercising, managing, and delivering its delegated functions. The intention is to develop an approach that is proportionate, limiting any unnecessary burden during this transitional year. The learning from this interim arrangement will contribute to later assurance approaches.

Will ICBs manage existing NHSE contracts after delegation?

ICBs will manage contracts which are currently held by NHSE for Primary Medical Care, Primary Ophthalmic Services and Dental Services. The contracts will not be replaced with a new contract for ICBs under delegation. The delegation agreement describes how ICBs will be responsible for contracting and provider selection. Pharmaceutical Services currently operate on a contractual framework.

Is there still a requirement for a Primary Care Commissioning Committee (PCCC)?

The need for a PCCC is no longer mandated in the delegation agreement. Removing this requirement is intended to enable ICBs to structure their internal governance in a way that supports their ambition for integrating care, and enhancing the delivery of services for the needs of their local populations. In recognition of this, the delegation agreement does not

mandate a PCCC or any equivalent requirement. However, ICBs are still able to use a PCCC where they wish to do so.

How should an ICB reflect their plans for NHSE delegated functions into their joint forward plan?

The joint forward plan will be a 5-year strategic plan, and local NHS delivery plan, describing how it will contribute to meeting the health needs of its local population in a way which reflects local priorities, address the four core purposes of ICSs, and is coherent with NHS planning returns.

The joint forward plan must describe how ICBs and partner trusts/FTs intend to exercise their functions over the next five years, and must describe how the ICB intends to meet population health needs of people in their area through delivery of primary, secondary, and community care. We expect this to address delegated functions as well as ICB functions.

Will NHSE define circumstances in which it may use its powers to adjust allocations for delegated functions?

NHSE has set out instances when ICB allocations for delegated Primary Care Services may be adjusted in Sections 9.5 and 9.6 of the delegation agreement. For example, ICB allocations may be adjusted under exceptional circumstances to reflect significant changes in ICB responsibilities.

Who is responsible for complaints for these functions after 1 July?

The management of complaints is an integral part of the commissioning of services, and so NHS England is delegating responsibility for the management of complaints along with our commissioning functions.

As the responsibility for complaints will shift with the delegated function after 1st July, there will be a period when NHS England and ICBs will work together sharing information on complaints for these functions and increasing the involvement of ICBs in delivery.

However, the core operating model for complaints will not change during 2022/23 and NHSE's teams will continue to handle complaints, sharing information with ICBs. We are currently developing the future operating model that will be implemented by 1 April 2023.

How will ICBs access legal advice in relation to Primary Care functions?

When ICBs take on delegated functions, they become responsible for seeking their own legal advice on any issues arising in relation to those functions. The same position previously applied to CCG delegated primary medical services, with CCGs seeking their own legal advice on these delegated functions. ICBs will continue to do so.

Prior to 1 July 2022, NHS England commissioning teams would be used to accessing legal advice from the NHS England Legal Team in relation to POD functions.

From 1 July, some POD commissioning functions were delegated to ICBs, while the majority remain with NHS England for 2022/23. This will affect arrangements for accessing legal advice, as follows:

- Where NHS England retains any POD functions, any legal advice should be requested from the NHS England Legal Team via the usual process (Legal Requisition Form).

- Where any POD functions are exercised by an ICB under delegated authority, any legal advice must be sought from lawyers acting for the ICB instead.

It is important to be aware that NHS England's Legal Team cannot advise an ICB. If the team receives a request to advise on an issue that falls within an ICB's delegated functions, the request will be returned along with confirmation that the ICB should obtain its own legal advice.

Primary Medical Care Services FAQs

How is the primary medical care delegation for ICBs different from CCGs?

The delegation of primary medical service functions to ICBs is very similar to the delegation to CCGs except for the changes introduced by the Health and Care Act 2022. This includes liability shifting to the ICB the function has been delegated to, while NHSE remains accountable for the function. The revised delegation agreement allows ICBs to have greater flexibility on how functions are delivered by ICBs, such as no longer mandating the need for a Primary Care Commissioning Committee.

Will ICBs need to comply with NHS England's national guidance for commissioning and contracting of GP services?

The delegation agreement sets out a requirement for the ICBs to comply with nationally set requirements including (but not exhaustively) agreed national contracts, guidance, and the national Primary Medical Care Policy and Guidance Manual which is available at: https://www.england.nhs.uk/publication/primary-medical-care-policy-and-guidance-manual-pgm/

NHS England is undertaking a review to ensure all areas of national policy guidance manual remain appropriate in supporting ICBs in the delivery of high quality primary medical care services for their population. Additionally, the delegation agreement is flexible enough to evolve as ICBs progress with implementation. NHS England will endeavour to ensure that content intended as 'guidance' for ICBs is clearly indicated and understood as such, enabling ICBs to adapt or improve services to support their local needs.

With the delegation of GP services to ICBs does this mean local authorities can now commission GP services under Section 75 (pooled budget) arrangements?

The delegation agreement permits commissioners to make s.75 arrangements with local authorities, and pool budgets to do so. However, the agreement requires ICBs to seek

approval for any form of onward delegation or joint exercise, including under Section 75 arrangements. In addition, triple delegation – delegating onwards from an S.75 or S.65Z5 arrangement – is indefinitely prohibited.

Can ICBs include local enhanced services in GP contracts, as they were previously commissioned by CCGs under NHS Standard Contracts?

Yes, the delegation agreement has been updated so that it is now administratively simpler for ICBs to arrange for a wider range of services to be delivered in general practice. ICBs will still need to have regard to relevant procurement rules. Further guidance will be produced on this change.

Can ICBs contract directly with PCNs for local enhanced services/local incentive schemes?

ICBs cannot contract directly with PCNs where these are not a legal entity in their own right. ICBs can however seek to mirror the Network Contract Directed Enhanced Service in any local enhanced service/local incentive scheme proposals to achieve the same effect.

The delegation agreement has been updated to acknowledge ICBs' role in the design and the commissioning of the Network Contract Directed Enhanced Services, including planning and managing the PCNs in the area.

Are there any other primary medical care services ICBs are responsible for?

Yes. All ICBs have been legally directed by NHS England to commission all GP Out of Hours services that GP practices have opted out of, along with overseeing the quality of them.

This is no different to current CCG arrangements which were put in place to support the commissioning of Integrated Urgent Care services which have now effectively replaced traditional GP out of hours services. This therefore represents de facto CCG function transferring to ICBs.

How can we exercise our delegated function when the service contract(s) for the delegated ancillary support services (e.g. clinical waste, translation and interpretation, occupational health) remains with NHSE?

Until such service contracts are able to be novated to ICBs (e.g. when all primary care services have been delegated or when procured directly by the ICB), the relevant ICBs and region should agree roles and responsibilities in the ongoing management of those services.

How are GP Out of Hours and GPIT services commissioned?

From 2013 until 30 June 2022, CCGs were directed by NHS England to commission all GP Out of Hours and GPIT services. Since 1 July 2022, ICBs have taken over this commissioning responsibility from CCGs, on the basis of the same directions from NHS England.

Amendments to the NHS Act 2006 made provision for the existing directions previously given by NHS England to CCGs to continue in force as if they had been addressed to ICBs in place of CCGs. This means ICBs must now comply with the directions that were issued to CCGs to commission these services.

Pharmacy Services FAQs

What will ICBs be responsible for when pharmacy services are delegated to them?

The full list of delegated functions is included in the delegation agreement. Some of the activities ICBs will be responsible for include:

- Contract management responsibilities for Community Pharmacy contractors, dispensing appliance contractors and dispensing doctors, including:
    - Market entry, contractual hours, directing, fitness to practise, provider assurance and post payment verification (PPV), recovery of overpayments, Pharmacy Contract Managers (PCM) and Pharmaceutical Services Regulations Committee (PSRC) decision-making functions;
    - Local Pharmaceutical Services Contracts, Local Enhanced Services, liaison with Local Pharmaceutical Committees, Pharmaceutical Needs Assessments with H&WB Boards, and ensuring adequate provision of pharmaceutical services.
- Supporting implementation of CPCF and increasing uptake of clinical services, transformation and integration of community pharmacy within ICBs and ICSs.

How are community pharmacy services commissioned?

Community pharmacies are commissioned in England under the terms of the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013. Under those arrangements, contractors on the pharmaceutical list operate in line with the Community Pharmacy Contractual Framework (CPCF), which is mainly negotiated nationally. As part of this, there are nationally agreed Advanced Services (which pharmacies can opt to provide if they meet the qualifying criteria) and National Enhanced Services used to commission specific services from some pharmacies according to need. In addition, community pharmacy services can be commissioned locally under a Local Enhanced Service (LES), Local Pharmaceutical Services, via the NHS Standard Contract or by local authorities.

Where can I find details of the Community Pharmacy Contractual Framework?

The details are outlined in the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 and the Drug Tariff. The content of the five year CPCF agreement (2019-2024) is on DHSC website[1].

What are the opportunities to use the Local Pharmaceutical Service (LPS) contractual route?

The LPS contract is a contractual mechanism that enables innovative commissioning of services from community pharmacy that meet specific local needs. Any LPS contract must contain an element of dispensing and a formal consultation must be undertaken as outlined in the regulations. ICBs can propose a new LPS and must also consider any proposals for an LPS submitted to the ICB. Prior to putting in place any new LPS contracts, the ICBs must seek written consent of the relevant NHS England regional team.

Will ICBs be able to commission community pharmacy services in accordance with local population needs?

Yes, ICBs will be able to commission services locally via Local Enhanced Services (LESs) or LPS where these meet the requirement of PLPS Regulations and Directions as they are required to arrange adequate delivery of pharmaceutical services across the ICB. Otherwise, ICBs will be able to commission services locally via the NHS Standard Contract or Local Authority Contract. ICBs should also use the local Pharmaceutical Needs Assessment (PNA) to consider gaps in provision.

What is the difference between a LES and a service commissioned via the NHS Standard Contract?

[1] https://www.gov.uk/government/publications/community-pharmacy-contractual-framework-2019-to-2024

With the delegation of pharmaceutical services, ICBs will have new powers to commission Local Enhanced Services). Enhanced services are those that are listed in The Pharmaceutical Services (Advanced and Enhanced Services) (England) Directions 2013[2].

Other services cannot be commissioned as Enhanced Services; Local Pharmaceutical Services contracts or the NHS Standard Contract give further flexibility to commission other services the ICB wishes to commission from community pharmacy.

All local services must be paid for from local budgets. Payments for Local Enhanced Services and Local Pharmaceutical Services must be made to pharmacies by the NHS BSA via the Local Payments Application administered by Primary Care Support (England). Local arrangements must be put in place to pay for services commissioned under the terms of the NHS Standard Contract.

Clinical governance and provider assurance arrangements should be considered when developing local services.

What happens to services that were commissioned by CCGs previously, are they considered to be LES services requiring new SLAs/contract documents issued?

Some services that were previously commissioned by CCGs might be listed in The Pharmaceutical Services (Advanced and Enhanced Services) (England) Directions 2013. Going forward, these could therefore be commissioned as LESs instead. There are no national requirements to change these contracts and deciding to do so is at ICBs discretion. The legislation made provisions for all existing CCG contracts, as of 1 July, to transfer to the relevant ICB. Where there are existing contracts, any decision to change those arrangements must be in accordance with the terms of the relevant contract e.g. notice period for termination, it is not simply at the ICBs discretion.

When should a service be commissioned via The NHS Standard Contract?

[2] https://www.gov.uk/government/publications/pharmaceutical-services-advanced-and-enhanced-services-england-directions-2013

The NHS Standard Contract is currently used by CCGs to commission services from community pharmacies. With delegation, ICBs will be able to commission services listed in The Pharmaceutical Services (Advanced and Enhanced Services) (England) Directions 2013 as Local Enhanced Services. Any services not listed will need to continue to be commissioned via the NHS Standard Contract, with implications described above.

NHS England can commission services on behalf of other organisations, can ICBs do the same?

Yes, ICBs may choose to commission services on behalf of other organisations, such as local authorities. Funding for these will need to be identified locally.

Are ICBs responsible for contract managing providers such as distance selling pharmacies and dispensing appliance contractors who dispense throughout the country?

Yes, ICBs are responsible for contract managing any provider based within the boundary of the ICB. The Pharmacy Manual sets out contract management processes and these should be applied in the same way as for other pharmaceutical providers.

Can ICBs make payments to community pharmacies for essential or advanced services outside of those specified in the Drug Tariff?

No, all payments must be made in line with the Drug Tariff, LES or LPS agreement or other formal contracting arrangement such as NHS Standard Contract or Local Authority contract.

Can ICBs change what is paid for essential or advanced services?

No, community pharmacy fees and allowances are pre-determined nationally and outlined in the Drug Tariff; all ICBs must commission in line with the CPCF.

Will ICBs need to comply with national guidance for commissioning and contracting services?

Yes, as pharmaceutical services are highly regulated. The Pharmacy Manual should be complied with when discharging this function, as well as the NHS Pharmacy Regulations Guidance 2020 and Guidance for ICSs and STPs on transformation and improvement opportunities to benefit patients through integrated pharmacy and medicines optimisation. Access to the latter guidance can be requested by emailing england.pharmacyintegration@nhs.net.

What other resources will be available to help ICBs manage delegated responsibilities?

Other resources available to ICBs include:

- Primary Care Support (England) undertakes most market entry applications and associated administration processes. The PCM or PSRC are responsible for decision-making.
- ICBs can also choose to pay for a licence with PCC who provide specialist advice and training on pharmaceutical service regulations; PCC can support ICBs in ensuring decisions made are in line with regulations.

Which functions will be carried out by NHS Business Services Authority (NHSBSA) on behalf of the ICB?

NHSBSA will provide support to the ICBs in the delivery of a number of key services, as detailed in the Mandated Assistance and Support schedule of the delegation agreement. These include:

- NHSBSA making payments to contractors in line with the Drug Tariff;
- Performance management – direct support to commissioners and community pharmacy contractors to implement corrective and preventative actions to ensure contractor compliance, such as:
    - Provision of dashboards and data products to support regional team/ICB decision making and inform on contractor performance;

    - Pre-payment validation activities on pharmacy quality scheme;
    - Some pre-reimbursement checks on dispensing claims for NHS prescriptions and verification of unusual claims;
    - Local dispute resolution process support and escalation of cases that require decision by PSRC;
- Community Pharmacy Assurance Framework – administration of the annual contractor assurance declaration and additional in-depth assurance declaration where appropriate, provision of assurance reports at ICS and contractor level supporting further assurance decisions by the ICB;
- Post-Payment Verification (PPV) – end-to-end process for identifying and verifying claims as part of the national PPV framework to support ICBs to play their part in ensuring compliance with contractual requirements and delivery of quality and value for money. This includes obtaining and reviewing claims, investigation of outliers and other potential inappropriate claims, along with referrals and investigatory reports to the ICB to consider and decide overpayment recoveries, and carrying out the financial recovery where appropriate. PPV can also be instigated by the ICS or Counter Fraud;
- Payment to contractors – process payments to contractors for provision of essential and advanced services, as well as services provided under a LES or LPS contract.

ICBs retain all approval and decision-making responsibilities for the above service areas.

How will ICBs exercise their responsibilities for contractual assurance processes?

ICBs will be responsible for monitoring contractors within their local area and taking contractual action as required. This includes ensuring contractors complete the annual Community Pharmacy Assurance Framework and undertaking contract monitoring, including site visits, where appropriate. ICBs will be supported by the NHSBSA Provider Assurance as outlined in the Delegation Agreement.

Which functions will be carried out by Primary Care Support England (PCSE) on behalf of the ICB?

PCSE provide administrative support for market entry application processes, distribution of dispensing tokens and administration for elements of the Local Payments Application.

These functions are described in the Pharmacy Manual. PCSE currently do not provide administrative support for market exit; this is the responsibility of the ICB community pharmacy team.

How will the ICB keep up to date with contract developments and raise operational issues?

NHS England Community Pharmacy Commissioning national team hold a monthly meeting with Contract Managers to update on any developments and provide an opportunity to discuss these. In addition, there is a Teams chat for contract managers which the national team are members of, the national team send out updates via email as required, and they can be contacted on ENGLAND.CommunityPharmacy@nhs.net.

How will Local Pharmaceutical Committees (LPCs) be engaged in decision making and on partnership work around patient pathways?

The ICBs are responsible for consulting with LPCs in respect of the delegated pharmaceutical functions as required by the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 and the Pharmacy Manual. ICBs should work closely with LPCs on integration and implementation and uptake of clinical services.

What is the role of the ICB pharmacy posts that are being funded nationally?

The role of these posts is to support the integration of community pharmacy and drive uptake of new clinical services within the ICB. The job description is available on NHSFutures.

Primary Ophthalmic Services FAQs

What are Primary Ophthalmic Services?

This term covers all NHS-funded eye care services delivered by primary care optometrists or ophthalmic medical practitioners. These services include minor eye conditions, urgent eyecare and glaucoma monitoring, commissioned by CCGs previously. It also includes sight tests that are commissioned through a national framework provided by NHS England and known as General Ophthalmic Services (GOS) which are the services that ICBs have the option of taking on delegated responsibility for from 1 July 2022.

What is the General Ophthalmic Services contract?

The GOS contract is an any qualified provider (AQP) model that enables contract holders to carry out sight tests for eligible people, and to receive payment for the service provided. The sight test must be carried out by a General Optical Council registered optometrist or General Medical Council registered ophthalmic medical professional and meet certain minimum criteria.

There are two types of GOS contracts – mandatory services (provided at fixed premises, typically a high street optical practice) and additional services (domiciliary or mobile services provided in private or residential/care homes). Contractors can hold one or both types. Contracts are issued and managed in accordance with the General Ophthalmic Services Contracts regulations.

Contractors and suppliers are also able to submit claims for optical vouchers that patients have redeemed with them towards the cost of spectacles or contact lenses.

Where can I find details of the General Ophthalmic Services commissioning framework?

GOS should be commissioned to meet the policies and procedures outlined in the Eye health Policy Book. Contracts should be issued utilising the General Ophthalmic Services model contract. The framework has been developed in accordance with the General Ophthalmic Services Contracts Regulations.

How can my ICB keep up to date with General Ophthalmic Services contract developments?

The NHS England central team for optometry commissioning hold regular engagement meetings with regional commissioners and Optometric Advisers. Commissioning teams from ICBs that have taken on delegated responsibility for optometry are invited to join these meetings. The meetings provide an opportunity for policy issues or local concerns to be escalated and discussed at a national level. They also provide a useful feedback and communication mechanism between the central team and commissioning teams. Please contact england.dentaloptoms@nhs.net if you would like information about this.

Will ICBs be able to tailor the provision of General Ophthalmic Services in accordance with local population needs?

No, GOS is a national contracting and commissioning framework, based on the GOS contracts regulations, and the contracts give all providers the right to carry out the services specified without restriction or locally agreed enhancements. GOS should continue to be carried out to the previously mentioned standard policies and procedures. Should ICBs wish to provide eye health services for a specific purpose, for example in order to address health inequalities, this should be commissioned in addition to the GOS national contracts.

Which functions will be carried out by NHS Business Services Authority (NHSBSA) on behalf of the ICB?

NHSBSA will provide support to the ICBs in the delivery of a number of key services as detailed in the Mandated Assistance and Support schedule of the delegation agreement:

- Contract management. End-to-end administration of new contract applications, contract variations and contract terminations
- Contract assurance. Administration of the annual contractor assurance declaration and additional in-depth assurance declaration where appropriate. Provision of assurance reports at ICB and contractor level, supporting further assurance decisions.
- GOS complaints. Administration of the annual GOS complaints survey.

- Pre-authorisation of contractor claims for repairs or replacement of spectacles.
- Post-Payment Verification (PPV). End-to-end process for identifying and verifying GOS claims as part of the national PPV framework. This includes obtaining and reviewing claims and carrying out a financial recovery where appropriate. PPV can also be instigated by the ICB or Counter Fraud.

ICBs retain all approval and decision-making responsibilities for the above service areas. The functions are agreed by NHS England as part of the national commissioning framework for GOS.

How do ICBs exercise their responsibilities for clinical and contractual assurance processes?

NHSBSA will issue and collate all relevant documentation for assurance processes and submit these to ICBs to approve and follow up. This could include carrying out practice visits and reviewing action plans with contractors. ICBs will need to ensure they have sufficient commissioning and clinical capacity available to carry out these functions.

NHS England are required to manage performers working in their area. This includes optometrists, optometry medical professionals and dispensing opticians. Investigations could be instigated by the General Optical Council or as a result of assurance activities. The work is carried out by Optometric Advisers.

Dental Services FAQs

What primary care dental services will ICBs be responsible for commissioning?

Primary care dental services are commissioned using either the ‘General Dental Service’ (GDS) contract or the ‘Personal Dental Service’ (PDS) Agreement. ICBs will commission all dental services. Dental services that can be commissioned under the GDS contract and PDS agreement includes:

- Mandatory services (General dental treatment)
- Additional services (Advanced mandatory services, Sedation services, Domiciliary services, Dental Public Health Services, Orthodontic services, Referral services)
- Further services which are not covered by Mandatory services or Additional services.

Examples of Further services includes level 2 Intermediate Minor Oral Surgery and level 2 Restorative services. Level 2 services can be provided within a primary care contract however they require a clinician with enhanced skills and experience due to the complexity of the procedure and or the patient.

Where can you find details of the dental commissioning framework?

Primary Care dental services should be commissioned to meet the policies and procedures outlined in the Policy Book for Primary Dental Services

Contracts should be issued utilising the GDS or PDS model contract. The framework has been developed in accordance with The National Health Service (General Dental Services Contracts) Regulations and The National Health Service (Personal Dental Services Agreements) Regulations.

Which functions will be carried out by NHS Business Services Authority (NHSBSA) on behalf of the ICB?

NHSBSA will provide support to the ICBs in the delivery of a number of key services as detailed in the Mandated Assistance and Support schedule of the delegation agreement. These are agreed nationally by NHS England with input from ICBs. ICBs will retain all decision-making responsibilities for any work that NHSBSA undertakes on behalf of the ICB.

- Contract management – end-to-end administration of contract variations and other regional team/ICB support activities;
- Performance management - provide mid and end of year administration process to support regional teams and ICBs and undertake risk-based assurance reviews - PPV can also be instigated by the ICS or Counter Fraud;
- Clinical assurance reviews – provide clinical support and data to assist in monitoring quality of dental services delivered, working in collaboration with regional teams/ICBs to identify and seek to address any concerns;
- Provide data reports to teams defining quantity and service delivery at a contractor level.

How do ICBs exercise their responsibilities for clinical and contractual assurance processes?

The contractual assurance process includes reviewing relevant documentation relating to concerns and complaints, undertaking contractual reviews, issuing remedial notices, remedial satisfaction letters, enforcement of breach notices and the consequences of termination notices. ICBs will need to review contract performance and to work with contractors that are at risk of delivering below 96% at year end because this underdelivered activity cannot be carried forward.

NHS England are required to manage performers working in their area. The work is carried out by Dental Practice Advisers.

Investigations could be instigated by the General Dental Council (GDC), Care Quality Commission (CQC) or as a result of local assurance activities.

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Delegated Pharmacy, Optometry and Dental Services

2024-25 Financial Plans - Draft

West Midlands
Integrated Care Boards
Working together

NHS Birmingham and Solihull ICB | NHS Black Country ICB
NHS Coventry and Warwickshire ICB | NHS Herefordshire and Worcestershire ICB
NHS Shropshire, Telford and Wrekin ICB | NHS Staffordshire and Stoke-on-Trent ICB

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2024-25 Allocations

2024/25 Baseline construction

Integrated Care Board (ICB)	2023/24 Recurrent baseline (£k)	2023/24 Transfer out: Pharmacy foundation training (£k)	2023/24 Delegated from region (£k)	2023/24 Boundary adjustment (£k)	2023/24 Secondary dental: AfC recurrent pay (£k)	2023/24 Secondary dental: Medical recurrent pay (£k)	2023/24 GDS recurrent (£k)	2023/24 Recurrent allocation transfers (£k)	2023/24 Staff transfer: In-year transfer (£k)	2023/24 Staff transfer: Increment to FYE (£k)	Domiciliary optometry baseline adjustment (£k)	Adjusted recurrent baseline (£k)	2024/25 Base growth (%)	2024/25 Convergence (%)	2024/25 Recurrent allocation (£k)	2024/25 Total allocation growth (%)
NHS Birmingham and Solihull ICB	138,818	-139	-	-	384	168	2,266	-	327	108	772	142,704	2.4%	0.0%	146,178	2.4%
NHS Black Country ICB	127,396	-142	-	-	347	152	2,073	-	292	97	-395	129,820	2.4%	0.0%	132,980	2.4%
NHS Coventry and Warwickshire ICB	78,254	-75	-	-	155	68	1,615	-	226	76	408	80,728	2.4%	0.0%	82,693	2.4%
NHS Herefordshire and Worcestershire ICB	69,161	-62	-	-	181	79	1,349	-	190	64	-154	70,808	2.4%	0.0%	72,532	2.4%
NHS Shropshire, Telford and Wrekin ICB	49,789	-46	-	-	130	57	941	-	122	41	218	51,252	2.4%	0.0%	52,500	2.4%
NHS Staffordshire and Stoke-On-Trent ICB	105,543	-120	-	-	279	122	1,836	-	272	92	-764	107,261	2.4%	0.0%	109,872	2.4%
West Total	**568,962**	**-584**	**-**	**-**	**1,476**	**646**	**10,080**	**-**	**1,429**	**478**	**86**	**582,572**			**596,755**	

Local and Fair Share Charging

Sevice Line	Contractor location	Where prescription issued	Patient Residence	Fair share
Community Pharmacy				
Single Activity Fee		✓		
Prescribed Items		✓		
Dispensing Doctors		✓		
Dispensing Appliances Contactors		✓		
Distance Selling Pharmacies		✓		
Prescription Charges/Income				✓
Hep C Provision of Testing Service				✓
Hep C Test Kit Reimbursement	✓			
New Medicine Services				✓
Discharge Medicine Services Review Fee				✓
Pharmacy Access Scheme Payment				✓
Transitional Payment				✓
GP Ref Pathway Engagement Fee				✓
NHS Community Pharmacist Consultation Service				✓
Pharmacy Quality Scheme				✓
COVID Vaccine Claim	✓			
COVID Home Delivery Services	✓			
Flu Premises Claim F		✓		
Flu Remuneration Payment A - fees		✓		
Local Schemes				✓
Pre-Registration Trainees Grant				✓
Optometry				
GOS Fees	✓			
Domiciliary Care	✓			
Dental Services				
Primary Dental Services	✓			
Community Dental Services	✓			
Secondary Care Dental Services			*	
Dental Income	✓			

- Fair Share – ICBs share of national expenditure.

Overall Financial Position

	NHS Birmingham and Solihull	NHS Black Country	NHS Coventry and Warwickshire	NHS Herefordshire and Worcestershire	NHS Shropshire, Telford and Wrekin	NHS Staffordshire and Stoke-On-Trent	West ICBs Total
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
2024-25 Allocation	**146,178**	**132,980**	**82,693**	**72,532**	**52,500**	**109,872**	**596,755**
Primary Care Dental Services							
PCD Services Gross - Baseline	79,355	75,979	59,921	43,761	34,109	67,806	360,931
PCD Services - Patient Charge Revenue	-15,190	-17,392	-15,821	-10,261	-7,678	-18,596	-84,938
PCD Services - Under Performance	-7,894	-8,676	-4,704	-8,360	-6,214	-11,780	-47,628
PCD Services - Other	3,804	3,622	2,895	1,751	1,501	2,813	16,386
PCD Services - Reserves	87	1,786	972	2,663	2,637	4,698	12,843
Reserves - Opening Risk Share Adjustments	2,904	-1,598	-2,720	925	-654	-955	-2,099
Primary Care Dental Services Total	63,066	53,721	40,543	30,479	23,700	43,986	255,494
Community Dental	8,037	6,892	5,194	7,190	3,925	6,199	37,437
Secondary Care Dental	26,029	23,666	10,431	13,430	8,704	18,723	100,983
Dental Services Total	**97,132**	**84,279**	**56,168**	**51,099**	**36,329**	**68,907**	**393,914**
Ophthalmic Services	**21,563**	**17,028**	**10,660**	**8,262**	**6,274**	**11,643**	**75,431**
Pharmacy Services	44,849	45,435	32,012	23,007	15,741	44,445	205,489
Prescription Fees & Charges	-16,201	-16,248	-11,753	-8,064	-5,351	-15,556	-73,173
Pharmacy Services Total	**28,648**	**29,187**	**20,259**	**14,943**	**10,391**	**28,889**	**132,317**
General Practice IT	9	9	9	9	9	9	55
Property Costs	435	389	302	254	515	364	2,259
Delegated GP							0
Other Primary Care Reserves/Contingency							0
Reserves - Opening Risk Share Adjustments	560	3,237	-3,527	-1,036	-615	1,351	-31
Other Services	**1,004**	**3,635**	**-3,215**	**-773**	**-91**	**1,724**	**2,284**
TOTAL EXPENDITURE	**148,347**	**134,130**	**83,873**	**73,531**	**52,903**	**111,163**	**603,945**
Surplus/(Deficit)	**-2,169**	**-1,150**	**-1,180**	**-999**	**-403**	**-1,291**	**-7,190**

Note:
Reduction on Dental PCR for under Performance | 2,907 | 3,373 | 2,211 | 3,872 | 1,899 | 3,656 | 17,918

Investments 2024-25

	NHS Birmingham and Solihull ICB	NHS Black Country ICB	NHS Coventry and Warwickshire ICB	NHS Herefordshire and Worcestershire ICB	NHS Shropshire, Telford and Wrekin ICB	NHS Staffordshire and Stoke-On-Trent ICB	West ICBs Total
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Dental Recovery Plan							
Minimum UDA Price - £28/UDA	715	726	81	618	25	407	2,572
New Patient Premium	4,567	4,614	3,123	1,528	1,121	2,853	17,807
Dental Vans							0
CDS Support Practices	126	144	108	108	72	90	646
Pharmacy							
Community Pharmacy Clinical Leads	103	103	103	103	103	113	627
	5,511	**5,587**	**3,415**	**2,357**	**1,320**	**3,463**	**21,652**

Planning Assumptions – Dental Services

2024/25	
General dental and community services	
Activity	1.30%
Pay growth	2.00%
Non-pay growth = GDP deflator	1.70%
Sub-total GDS	**3.20%**
Secondary dental services	
Activity	1.30%
Additional capacity funding	0.60%
Price = Net CUF	0.80%
Sub-total Secondary dental	**2.70%**
Dental fees and charges income growth	
Activity	0.00%
2023/24 price = GDP deflator	1.70%
Sub-total Dental fees and charges	**1.70%**
Total Dental services	**3.50%**

- Deliver Dental Ringfence Target.
- Budget based on 100% contract values for Primary Care Dental services.
- Underperformance credit budget set to take account of the potential clawback values. This will be based on the 23/24 forecast 23/24 values. The debit is used to create a non-recurrent reserve for:
  - New Patient Premium
  - Joint Groups/ICBs to decide how it is used i.e. offset in year ICB pressures or investments in dental services.
- SCD – Starting point is the 2023-24 contract envelopes.

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Dental Ringfence Target 2024-25

Integrated Care Board (ICB)	2023/24 Opening dental ring-fence (£k)	2023/24 Planning adjustments (£k)	2023/24 In-year adjustments (£k)	2023/24 Secondary dental: AfC recurrent pay (£k)	2023/24 Secondary dental: Medical recurrent pay (£k)	2023/24 GDS recurrent (£k)	2023/24 Adjusted recurrent dental ring-fence (£k)	Total Baseline Changes (£k)	2024/25 Dental ring-fence growth (%)	2024/25 Updated dental ring-fence (£k)
NHS Birmingham and Solihull ICB	91,021	-	-	384	168	2,266	93,839	2,818	3.5%	97,132
NHS Black Country ICB	78,850	-	-	347	152	2,073	81,422	2,572	3.5%	84,279
NHS Coventry and Warwickshire ICB	52,426	-	-	155	68	1,615	54,264	1,838	3.5%	56,168
NHS Herefordshire and Worcestershire ICB	47,758	-	-	181	79	1,349	49,366	1,608	3.5%	51,099
NHS Shropshire, Telford and Wrekin ICB	33,969	-	-	130	57	941	35,097	1,128	3.5%	36,329
NHS Staffordshire and Stoke-On-Trent ICB	64,333	-	-	279	122	1,836	66,571	2,238	3.5%	68,907
West Total	**368,357**	**-**	**-**	**1,476**	**646**	**10,080**	**380,559**	**12,202**		**393,914**

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Dental Budgets 2024-25

	NHS Birmingham and Solihull	NHS Black Country	NHS Coventry and Warwickshire	NHS Herefordshire and Worcestershire	NHS Shropshire, Telford and Wrekin	NHS Staffordshire and Stoke-On-Trent	West ICBs Total
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
2024-25 Allocation	**146,178**	**132,980**	**82,693**	**72,532**	**52,500**	**109,872**	**596,755**
Primary Care Dental Services							
PCD Services Gross - Baseline	79,355	75,979	59,921	43,761	34,109	67,806	360,931
PCD Services - Patient Charge Revenue	-15,190	-17,392	-15,821	-10,261	-7,678	-18,596	-84,938
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PCD Services - Reserves	87	1,786	972	2,663	2,637	4,698	12,843
Reserves - Opening Risk Share Adjustments	2,904	-1,598	-2,720	925	-654	-955	-2,099
Primary Care Dental Services Total	63,066	53,721	40,543	30,479	23,700	43,986	255,494
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Secondary Care Dental	26,029	23,666	10,431	13,430	8,704	18,723	100,983
Dental Services Total	**97,132**	**84,279**	**56,168**	**51,099**	**36,329**	**68,907**	**393,914**

- Opening risk share adjustment is required to ensure all ICBs have the baseline funding for contracts.
  - Transacted non-recurrently in 23/24.
  - Negative indicates ICB would receive allocation from other ICBs.
- Secondary Care Dental – based on the 23/24 closing envelopes.

Planning Assumptions – Ophthalmic Services

2024/25	
Ophthalmic services	
Activity	1.00%
Price	1.70%
Ophthalmic services base growth	**2.70%**

- Assume 2023-24 activity increase is recurrent.

	NHS Birmingham and Solihull	NHS Black Country	NHS Coventry and Warwickshire	NHS Herefordshire and Worcestershire	NHS Shropshire, Telford and Wrekin	NHS Staffordshire and Stoke-On-Trent	West ICBs Total
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Ophthalmic Services	21,563	17,028	10,660	8,262	6,274	11,643	75,431

- Additional allocation of £2m for change for Dom Providers, increase is mainly with LLR ICB.
- Eye Health in Special Schools is not included in budgets as allocations not yet confirmed.
- Includes PYE of Electronic Eyecare Referral System (EERS) - £1.4m.

Planning Assumptions – Pharmacy Services

2024/25	
Community pharmacy contractual framework (CPCF)	
Community pharmacy contract growth	**0.00%**
Other pharmacy services	
Activity	2.40%
Price = GDP deflator	1.70%
Sub-total Other pharmacy	**4.10%**
Prescription fees and charges: assumed income growth	
Activity	0.70%
2023/24 price = GDP deflator	1.70%
Sub-total Prescriptions fees and charges	**2.40%**
Total pharmacy base growth	**-0.90%**

- Assume 2023-24 activity increase is recurrent.
- Single Activity Fee remains at £1.27/item.
- Quality Payment Scheme is required in full - no reduction to offset SAF charge as in 23/24.
- Pharmacy First is not included within the budgets at this stage because ICBs have not been informed of the allocation.

Pharmacy Budgets – 2024-25

	NHS Birmingham and Solihull	NHS Black Country	NHS Coventry and Warwickshire	NHS Herefordshire and Worcestershire	NHS Shropshire, Telford and Wrekin	NHS Staffordshire and Stoke-On-Trent	West ICBs Total
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Pharmacy Services	44,849	45,435	32,012	23,007	15,741	44,445	205,489
Prescription Fees & Charges	-16,201	-16,248	-11,753	-8,064	-5,351	-15,556	-73,173
Pharmacy Services Total	**28,648**	**29,187**	**20,259**	**14,943**	**10,391**	**28,889**	**132,317**

Planning Assumptions – Other Services

	NHS Birmingham and Solihull	NHS Black Country	NHS Coventry and Warwickshire	NHS Herefordshire and Worcestershire	NHS Shropshire, Telford and Wrekin	NHS Staffordshire and Stoke-On-Trent	West ICBs Total
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
General Practice IT	9	9	9	9	9	9	55
Property Costs	435	389	302	254	515	364	2,259
Delegated GP							0
Other Primary Care Reserves/Contingency							0
Reserves - Opening Risk Share Adjustments	560	3,237	-3,527	-1,036	-615	1,351	-31
Other Services	**1,004**	**3,635**	**-3,215**	**-773**	**-91**	**1,724**	**2,284**

- The funding of £1.9m within Property costs relates to the staffing posts funded through programme allocation and matches the allocation.
- Opening Risk Share Adjustment - Negative indicates ICB would receive allocation from other ICBs.

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Reserves 2024-25

	NHS Birmingham and Solihull ICB	NHS Black Country ICB	NHS Coventry and Warwickshire ICB	NHS Herefordshire and Worcestershire ICB	NHS Shropshire, Telford and Wrekin ICB	NHS Staffordshire and Stoke-On-Trent ICB	West ICBs Total
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Dental Reserves							
Recurrent	-207	1,241	1,710	-189	-486	-483	1,586
Non Recurrent (Dental Clawback)	294	545	-738	2,852	3,123	5,181	11,257
Sub Total	87	1,786	972	2,663	2,637	4,698	12,843
Opening Risk Share Reserve							
Dental	2,904	-1,598	-2,720	925	-654	-955	-2,099
Non-Dental	560	3,237	-3,527	-1,036	-615	1,351	-31
Sub Total	3,464	1,638	-6,246	-112	-1,270	395	-2,130
Total Reserves	**3,551**	**3,425**	**-5,274**	**2,551**	**1,367**	**5,093**	**10,713**

- Recurrent reserves – required to achieve Dental Ringfence target.
- Non-recurrent – estimated under performance (UDA non deliver net of loss of PCR).
- New Patient Premium estimate already funded and not required from remaining reserves.

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Service Profile Pack Coventry & Warwickshire ICB

Midlands Specialised Delegation Programme

Date of issue: MAR 2024

1

Introduction

This service profile pack contains essential high-level information regarding the 59 specialised services being delegated to your ICB on the 1st April 2024. It has been co-designed by ICB and NHSE representatives from the Clinical & Quality workstream of the Midlands Specialised Delegation Programme and provides some examples of the clinical case for change and how delegation will better support better services for patients. It includes information about the services that are being delegated, where they are being provided, the volume of current activity and the planning priorities for 2024/25.

A suite of service profiles containing details of clinical outcomes, patient safety concerns and workforce challenges will be available at the time of delegation. The service profile for Vascular Services is included as an example.

Dr Colette Marshall
Regional Medical Director of Commissioning, NHS England

Dr Clara Day
Chief Medical Officer, BSOL ICB

Dr Nil Sanganee
Chief Medical Officer, LLR ICB

Sally Roberts
Chief Nursing Officer, Black Country ICB

Kay Darby
Chief Nursing Officer, LLR ICB

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Contents

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1. Case for Change

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Why delegate specialised services?

What should this mean for our patients, populations and their communities?

ICBs and providers to have **freedom to design services and to innovate** in meeting the national standards where they take on delegated or joint commissioning responsibility	ICBs and providers able to **pool specialised budget and non-specialised budgets** to best meet the needs of their population, tackle health inequalities and to join up care pathways for their patients	ICBs and providers able to use world class assets of specialised services to **better support their communities closer to home** (e.g. designing local public health initiatives, greater diagnostics and screening)
Quality of patient care	**Equity of access**	**Value**
Patients will receive more **joined up care** – better communication and sharing of information between professionals and services. More of a **holistic, multi-disciplinary approach** to care. A range of professionals can be involved in planning a patient's care. Increase focus and investment on **prevention**. Patients will receive the **right care at the right time in the right place**. Better **step-down care** to support patients who are ready to leave specialised care.	Population based budgets means decisions on spend are based on the **needs of a local population** – the demographics, health behaviours etc rather than on activity in hospitals. Specialised clinical expertise will have a role in managing population health and to **challenge underlying drivers of health inequalities**. Providers and professionals working collaboratively, free from organisational constraints and commissioning boundaries, will help improve **quality of care and tackle unwarranted variation**. Opportunity to **level up access across the country**	Investment in preventative care could **reduce demand** for specialised services. Providers and professionals can **better manage patient demand**, even when one part of the system becomes stretched. Patients can be re-directed or transferred so they have faster and better access to treatment A whole system approach creates opportunities **to protect and build 'workforce resilience'**, as shown during the pandemic. Pooled/delegated budgets allow **underspends to be shared or reinvested** and avoids commissioning pressures on any one organisation.

- Accessible care
- Tailored care
- Seamless care
- Effective care
- Preventative care

Case study examples of benefits are included in Appendix A.

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2.Contracted Delegated Services by Provider

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Contracts Overview

- The contract portfolio for Specialised Services in the Midlands in 2023/24 includes
  - 27 Main NHS Provider Contracts
  - 2 NHS Standalone Service Contracts
  - 4 Standalone Independent sector Contracts
- These contracts are currently managed for NHS England by the Midlands Acute Specialised Commissioning (MASC) Team
- Following the delegation of the 59 Specialised Services in April 2024, the MASC Team will continue to manage these contracts on behalf of the 11 ICBs for delegated services and on behalf on NHSE for retained services.

- **The next slide contains a list of which delegated specialised services are provided by Trusts within the Coventry & Warwickshire system.**

- **Further details including the following contact details is available in Appendix 1.1;**
  - Commissioning Lead
  - Contract Manager
  - Quality Lead
  - Finance Lead

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Specialised Services provided by Trust in Coventry & Warwickshire ICS

University Hospitals Coventry & Warwickshire
Adult specialist rheumatology services
Adult specialist cardiac services
Adult specialist endocrinology services
Adult specialist neurosciences services
Adult specialist ophthalmology services
Adult specialist orthopaedic services
Adult specialist renal services
Adult specialist vascular services
Adult thoracic surgery services
Bone conduction hearing implant services (adults and children)
Complex spinal surgery services (adults and children)
Fetal medicine services (adults and children)
Specialist adult gynaecological surgery and urinary services for females
Specialist services for adults with infectious diseases
Major trauma services (adults and children)
Radiotherapy services (adults and children)
Specialist cancer services (adults)
Specialist cancer services for children and young adults
Specialist colorectal surgery services (adults)
Specialist ear, nose and throat services for children
Specialist endocrinology services for children
Specialist gynaecology services for children
Neonatal critical care services
Specialist ophthalmology services for children
Specialist plastic surgery services for children
Specialist rheumatology services for children
Specialist services for complex liver, biliary and pancreatic diseases in adults
Specialist paediatric urology services
Adult Critical Care

George Elliot Hospital
Adult specialist services for people living with HIV
Specialist cancer services (adults)
Specialist gastroenterology, hepatology and nutritional support services for children
Neonatal critical care services
Adult Critical Care

South Warwickshire
Adult specialist rheumatology services
Adult specialist cardiac services
Specialist cancer services (adults)
Neonatal critical care services
Specialist rehabilitation services for patients with highly complex needs (adults and children)
Adult Critical Care

Coventry & Warwickshire Partnership
Adult specialist services for people living with HIV

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3. Activity Data by ICB

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Activity Overview

- Specialised Services are delivered to Midlands' patients at Trusts across the Midlands. In addition, some Midlands patients access Specialised Services in Trust outside of the Midlands region.
- Midlands' providers treat patients from the Midlands but also patients from other regions.
- The following slide (Slide 11) gives an overview of these activity flows for patients and providers in the Coventry & Warwickshire system for Month 1 to 9 of 2023
- Slide 12 aggregates the same information at a regional level and gives an overview of activity flows for patients and providers in the Midlands region for comparison.

Example

NPoC (National Programme of Care (NPoC) Category and Clinical Reference Group (CRG))	Intra Activity	Imported Activity	Exported Activity	Total Activity by Providers in Mid ICB	Total Activity for Patients from Mid ICB	Grand Total
A06 - RENAL SERVICES	58,578	5,791	2,191	64,369	60,769	**66,560**

- **Further detail, including a drill-down to individual provider. is available in Appendix 2.1.**

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Total Activities for QWU: NHS Coventry & Warwickshire ICB

Activity Period: M01-M09 2023/24 (Apr 2023 – Dec 2023)

NPoC (National Programme of Care (NPoC) Category and Clinical Reference Group (CRG)	Intra Activity	Imported Activity	Exported Activity	Total Activity by Providers in Mid ICB	Total Activity for Patients from Mid ICB	Grand Total
A06 - RENAL SERVICES	58,578	5,791	2,191	64,369	60,769	**66,560**
B03 - SPECIALISED CANCER SURGERY	49,203	4,638	5,918	53,841	55,121	**59,759**
B01 - RADIOTHERAPY	20,777	1,863	206	22,640	20,983	**22,846**
B02 - CHEMOTHERAPY	16,470	1,241	891	17,711	17,361	**18,602**
E06 - METABOLIC DISORDERS	-	-	17,581	-	-	**17,581**
B05 - CHILDREN AND YOUNG ADULT CANCER SERVICES	239	1	17,151	240	17,390	**17,391**
D04 - NEUROSCIENCES	11,293	3,378	2,403	14,671	13,696	**17,074**
E03 - PAEDIATRIC MEDICINE	1,492	119	11,824	1,611	13,316	**13,435**
D01 - REHABILITATION AND DISABILITY	6,592	4,064	2,647	10,656	9,239	**13,303**
E08 - NEONATAL CRITICAL CARE	10,039	2,186	472	12,225	10,511	**12,697**
A05 - CARDIOTHORACIC SERVICES	5,170	2,271	3,588	7,441	8,758	**11,029**
E02 - SPECIALISED SURGERY IN CHILDREN	1,565	261	4,827	1,826	6,392	**6,653**
D06 - SPECIALISED EAR AND OPHTHALMOLOGY SERVICES	3,051	255	2,693	3,306	5,744	**5,999**
A02 - HEPATOBILIARY AND PANCREAS	2,299	186	892	2,485	3,191	**3,377**
E05 - CONGENITAL HEART SERVICES	-	-	3,037	-	-	**3,037**
E04 - PAEDIATRIC NEUROSCIENCES	-	-	2,170	-	-	**2,170**
A09 - SPECIALISED RHEUMATOLOGY	1,417	177	358	1,594	1,775	**1,952**
A01 - SPECIALISED RESPIRATORY	-	-	1,652	-	-	**1,652**
F03 - HIV	1,099	-	157	-	1,256	**1,256**
D03 - SPINAL SERVICES	629	193	140	822	769	**962**
A03 - SPECIALISED ENDOCRINOLOGY	261	31	493	292	754	**785**
A04 - VASCULAR DISEASE	409	42	259	451	668	**710**
F04 - INFECTIOUS DISEASES	-	-	670	-	-	**670**
E07 - PAEDIATRIC INTENSIVE CARE	-	-	543	-	-	**543**
A08 - SPECIALISED DERMATOLOGY	240	14	114	254	354	**368**
D02 - MAJOR TRAUMA	184	101	39	285	223	**324**
F06 - SPECIALISED IMMUNOLOGY AND ALLERGY SERVICES / E03 - PAEDIATRIC MEDICINE	-	-	159	-	-	**159**
D10 - SPECIALISED ORTHOPAEDIC SERVICES	79	8	37	87	116	**124**
A07 - SPECIALISED COLORECTAL SERVICES	96	13	6	109	102	**115**
E09 - SPECIALISED WOMENS SERVICES	31	11	27	42	58	**69**
D07 - SPECIALISED PAIN	-	-	40	-	-	**40**
Unknown	39	1	161	40	200	**201**
Grand Total	**191,252**	**26,845**	**83,345**	**218,097**	**274,597**	**301,442**

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Total Activities for Midlands Region

Activity Period: M01-M09 2023/24 (Apr 2023 – Dec 2023)

	A	B	C	A+B	A+C	A+B+C
NPoC (National Programme of Care (NPoC) Category and Clinical Reference Group (CRG)	Intra Activity	Imported Activity	Exported Activity	Total Activity by Providers in Mid ICB	Total Activity for Patients from Mid ICB	Grand Total
A06 - RENAL SERVICES	761,379	38,806	37,405	800,185	798,783	**837,589**
B03 - SPECIALISED CANCER SURGERY	723,206	8,546	74,570	731,752	797,776	**806,322**
B05 - CHILDREN AND YOUNG ADULT CANCER SERVICES	332,751	343	2,546	333,094	335,297	**335,640**
A05 - CARDIOTHORACIC SERVICES	225,064	8,465	18,289	233,529	243,353	**251,818**
B02 - CHEMOTHERAPY	190,405	17,030	27,686	207,435	218,091	**235,121**
B01 - RADIOTHERAPY	173,641	3,242	31,152	176,883	204,793	**208,035**
E03 - PAEDIATRIC MEDICINE	156,469	7,358	9,089	163,827	165,558	**172,916**
E06 - METABOLIC DISORDERS	154,286	3,165	401	157,451	154,687	**157,852**
D04 - NEUROSCIENCES	99,651	4,807	26,781	104,458	126,432	**131,239**
E02 - SPECIALISED SURGERY IN CHILDREN	103,670	2,598	11,090	106,268	114,760	**117,358**
E08 - NEONATAL CRITICAL CARE	105,630	1,225	9,172	106,855	114,802	**116,027**
D06 - SPECIALISED EAR AND OPHTHALMOLOGY SERVICES	92,348	1,555	5,811	93,903	98,159	**99,714**
D01 - REHABILITATION AND DISABILITY	45,596	1,068	2,513	46,664	48,109	**49,177**
A02 - HEPATOBILIARY AND PANCREAS	31,850	3,463	4,058	35,313	35,908	**39,371**
E05 - CONGENITAL HEART SERVICES	31,235	917	3,217	32,152	34,452	**35,369**
E04 - PAEDIATRIC NEUROSCIENCES	25,760	425	4,088	26,185	29,848	**30,273**
F03 - HIV	25,665	488	1,529	26,153	27,194	**27,683**
A09 - SPECIALISED RHEUMATOLOGY	23,300	79	2,256	23,379	25,556	**25,635**
A04 - VASCULAR DISEASE	20,593	516	2,420	21,109	23,013	**23,529**
A01 - SPECIALISED RESPIRATORY	15,767	90	4,701	15,857	20,468	**20,558**
A03 - SPECIALISED ENDOCRINOLOGY	17,142	563	2,381	17,705	19,523	**20,086**
E07 - PAEDIATRIC INTENSIVE CARE	13,978	221	2,659	14,199	16,637	**16,858**
D02 - MAJOR TRAUMA	5,499	516	201	6,015	5,700	**6,216**
D03 - SPINAL SERVICES	4,113	296	549	4,409	4,662	**4,958**
A08 - SPECIALISED DERMATOLOGY	3,594	14	1,074	3,608	4,668	**4,682**
F06 - SPECIALISED IMMUNOLOGY AND ALLERGY SERVICES / E03 - PAEDIATRIC MEDICINE	2,640	74	804	2,714	3,444	**3,518**
E09 - SPECIALISED WOMENS SERVICES	2,661	10	117	2,671	2,778	**2,788**
D10 - SPECIALISED ORTHOPAEDIC SERVICES	2,081	460	66	2,541	2,147	**2,607**
F04 - INFECTIOUS DISEASES	120	-	2,202	120	2,322	**2,322**
D07 - SPECIALISED PAIN	812	3	901	815	1,713	**1,716**
A07 - SPECIALISED COLORECTAL SERVICES	970	7	135	977	1,105	**1,112**
Unknown	3,956	93	1,035	4,049	4,991	**5,084**
Grand Total	**3,395,830**	**106,444**	**290,897**	**3,502,273**	**3,686,727**	**3,793,170**

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4. Quality Dashboard Overview

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Quality Dashboard Overview

The following slides provide the following information on delegated specialised services

- How many units in the Midlands are delivering the service?
- Is the service required to submit data to the Specialised Services Quality Dashboard? (see next slide for definition on an SSQD)
- Is the service supported by an Operational Delivery Network (ODN) or other Clinical Network?
- Is the team aware of any Serious Incidents (Sis) relating to the service?
- Is the team aware of any complaints relating to the service?
- Is the team aware of any CQC reports relating to the service?
- Is the team aware of any other intelligence relating to the service?

Example

Priority	Service	Units	Has SSQD Y/N	Has Network Y/N	Any SIs reported April 2022-present Y/N	Any complaints reported 2021-present Y/N	CQC Reports Y/N	Any other intelligence available on quality of care e.g. Peer Review Visits, national audits, GIRFT reports
1	ACC	61	Y	Y	Y	N	1 UHB	Network Peer Reviews, GIRFT
		There are 61 sites in the Midlands delivering ACC (Adult Critical Care)	There are SSQDs relating to ACC	There is a Network for ACC	There are SIs relating to ACC	There are no complaints relating to ACC	There is a CQC report relating to ACC at UHB	There network peer reviews and a GIRFT report relating to ACC

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Specialised Services Quality Dashboard (SSQD)

- SSQDs are designed to provide assurance on the quality of care by collecting information about outcomes from healthcare providers. SSQDs are a key tool in monitoring the quality of services, enabling comparison between service providers and supporting improvements over time in the outcomes of services commissioned by NHS England.
- For each SSQD, there is a list of agreed measures for which data is to be collected. Healthcare providers, including NHS Trusts, NHS Foundation Trusts and independent providers, submit data for each of the agreed measures.
- Each SSQD is 'refreshed' with up-to-date outcomes submitted from national data sources, and where necessary healthcare providers, on a quarterly basis. The information provided by the SSQDs is used by NHS England specialised services commissioners to understand the quality and outcomes of services and reasons for excellent performance. Healthcare providers can use the information to provide an overview of service quality compared with other providers of the same service.

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Quality Overview Dashboard (1 of 4)

Priority	Service	Total No. of Units in Midlands	Has SSQD Y/N	Has Network Y/N	Any SIs reported April 2022-present Y/N	Any complaints reported 2021-present Y/N	CQC Reports Y/N	Any other intelligence available on quality of care e.g. Peer Review Visits, national audits, GIRFT reports
1	ACC	61	Y	Y	Y	N	1 UHB	Network Peer Reviews, GIRFT
2	Cancer- Chemotherapy	43	Y	Y	Y	N	N	GIRFT
3	Cirrhosis of the liver	36	Y	Y	N	N	N	N
4	Neonatal Care	25	Y	Y	Y	N	N	Network Peer Reviews
5	Cardiology: implantable cardioverter defibrillator (ICD)	17	Y	Y	Y	N	N	National Audit
6	Cardiology: primary percutaneous coronary intervention (PPCI) (Adult)	11	Y	Y	N	N	N	National audit, GIRFT
7	Cardiac MRI	11	Y	Y	N	N	N	National audit, GIRFT
8	In centre haemodialysis: main & satellite units	11	Y	Y	Y	N	N	N
9	Cardiac surgery (Adults)	10	Y	Y	Y	N	N	National Audit, GIRFT
10	Haemophilia (All ages)	10	Y	Y	N	N	N	National Audits
11	Fetal medicine – (West Mids has AIP & Fetal Med)	9	Y	Y	N	N	N	National Audits
12	Cancer: anal	8	Y	Y	N	N	N	National Audits, GIRFT
13	Specialised kidney, bladder, & prostate cancer services	8	Y	Y	Y	N	N	GIRFT
14	Cardiac: electrophysiology & ablation services	7	Y	Y	N	N	N	National Audits, GIRFT
15	Thoracic surgery (adults)	6	Y	Y		N	N	N
16	Hepatobiliary & pancreas (Adult)	6	Y	Y	N	N	N	N
17	Cancer: pancreatic (Adult)	5	Y	Y	N	N	N	N
18	Cancer: malignant mesothelioma (Adult)	4	Y	Y	N	N	N	N
19	Level 3 - Paediatric Critical Care	4	Y	Y	N	N	Y	GIRFT
20	Adult congenital heart disease (ACHD)	2	Y	Y	N	N	N	National Audits, GIRFT(Cardiology)
21	Stereotactic radiosurgery & stereotactic radiotherapy (Intracranial) (All ages)	2	Y	Y	N	N	N	N
22	Testicular cancer	2	Y	Y	N	N	N	GIRFT

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Quality Overview Dashboard (2 of 4)

Priority	Service	Total No. of Units in Midlands	Has SSQD Y/N	Has Network Y/N	Any SIs reported April 2022-present Y/N	Any complaints reported 2021-present Y/N	CQC Reports Y/N	Any other intelligence available on quality of care e.g. Peer Review Visits, national audits, GIRFT reports
23	Cancer: Clinical chemotherapy	28	N	Y	N	N	N	N
24	Cancer: chemotherapy ITC	18	N	Y	N	N	N	N
25	Cancer chemotherapy Higher Intensity	14	N	Y	N	N	N	N
26	Renal – assessment & prep for renal replacement therapy	10	N	Y	N	N	N	N
27	Haemodialysis to treat established renal failure	10	N	Y	N	N	N	N
28	Peritoneal dialysis to treat established renal failure	10	N	Y	N	N	N	N
29	Renal dialysis – intermittent haemodialysis & plasma exchange to treat acute kidney injury	10	N	Y	N	N	N	N
30	Level 2 - Paediatric Critical Care	8	N	Y	N	N	I KGH	N
31	Complex spinal surgery (All ages)	8	N	Y	N	N	N	N
32	Paed surgery: surgery (and surgical pathology, anaesthesia & pain)	7	N	Y	N	N	N	N
33	Colorectal: transanal endoscopic microsurgery (TEMS)	7	N	Y	N	N	N	N
34	Specialised HIV services (Adults)	7	N	Y	N	N	N	N
35	Specialised cancer surgery: non-surgical	6	N	Y	N	N	N	N
36	Paed medicine: respiratory	5	N	Y	Y	N	N	N
37	Neurosciences: specialised neurology (Adults)	5	N	Y	N	N	N	N
38	Cardiology: inherited cardiac services (All ages)	5	N	Y	N	N	N	N
39	Neurosurgery: Adults	4	N	Y	Y	N	N	N
40	Brain & other rare CNS tumours	4	N	Y	N	N	N	N
41	Major trauma (Adult)	4	N	Y	Y	N		Network Peer Reviews
42	Specialised services for haemoglobinopathy (All ages): haemoglobinopathies coordinating care centres	3	N	Y	N	N	N	N
43	Major trauma (children)	2	N	Y	Y	N	N	Network Peer Reviews
44	Paed surgery: chronic pain	2	N	Y	N	N	N	

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Quality Overview Dashboard (3 of 4)

Priority	Service	Total No. of Units in Midlands	Has SSQD Y/N	Has Network Y/N	Any SIs reported April 2022-present Y/N	Any complaints reported 2021-present Y/N	CQC Reports Y/N	Any other intelligence available on quality of care e.g. Peer Review Visits, national audits, GIRFT reports
45	Specialised immunology (All ages)	13	Y	N	N	N	N	National Audits, GIRFT
46	Vascular disease: arterial	11	Y	N	Y	N	N	National Audits, GIRFT
47	Specialised rheumatology services (Adult)	10	Y	N	N	N	N	Y GIRFT
48	Haemophilia (All ages)	10	Y	N	N	N	N	Y National Audits
49	Implantable hearing aids for microtia, bone anchored hearing aids.…	7	Y	N	N	N	N	N
50	Paed medicine: rheumatology	7	Y	N	N	N	N	N
51	Specialised complex surgery for urinary incontinence and vaginal prolapse (16yrs & above)	7	N	N	N	N	N	N
52	Colorectal: faecal incontinence (Adult)	6	Y	N	N	N	N	N
53	Interstitial lung disease	6	Y	N	N	N	N	QSIP self-assessment pilot
54	Intestinal failure (Adult)	6	Y	N	N	N	N	N
55	Specialised endocrinology services (Adult)	6	Y	N	N	N	N	N
56	Cystic fibrosis (children)	5	Y	N	N	N	N	N
57	Cystic fibrosis (Adult)	4	Y	N	N	N	N	N
58	Complex disability equipment: prosthetic specialised services (all ages) with limb loss	3	Y	N	N	N	N	N
59	Positron emission tomography – computed tomography (PET CT) (All ages)	3	Y	N	N	N	N	N
60	Cleft lip and/or palate	3	Y	N	N	N	N	N
61	Complex gynae: congenital gynae anomalies (Children 13yrs & above and adults)	4	Y	N	N	N	N	N
62	Fetal medicine (East Midlands don't have network)	3	Y	N	N	N	N	N
63	Specialised resp services (Adult): severe asthma	3	Y	N	N	N	N	N
64	Metabolic disorders (Children)	3	Y	N	N	N	N	N
65	Metabolic disorders (Adult)	1	Y	N	N	N	N	N
66	Adult highly specialist pain management services	1	Y	N	N	N	N	N
67	Spinal cord injuries	1	Y	N	N	N	N	N
68	Complex gynae/female urology: genito-urinary tract fistulae (Girls & women aged 16yrs & above)	1	Y	N	N	N	N	N

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Quality Overview Dashboard (4 of 4)

Priority	Service	Total No. of Units in Midlands	Has SSQD Y/N	Has Network Y/N	Any SIs reported April 2022-present Y/N	Any complaints reported 2021-present Y/N	CQC Reports Y/N	Any other intelligence available on quality of care e.g. Peer Review Visits, national audits, GIRFT reports
69	Specialised HIV (Adults)	19	N	N	N	N	N	N
70	Specialised ophthalmology (Paeds)	10	N	N	N	N	N	N
71	Colorectal: transanal endoscopic microsurgery (TEMS) (Adult)	7	N	N	N	N	N	N
72	Paed medicine: gastro, hepatology & nutrition	7	N	N	N	N	N	N
73	Paed medicine: endocrinology & diabetes	6	N	N	N	N	N	N
74	Colorectal: complex IBD (Adults)	6	N	N	N	N	N	N
75	Specialised rehabilitation services for patients with highly complex needs (All ages)	6	N	N	N	N	N	N
76	Specialised allergy services (All ages)	6	N	N	N	N	N	N
77	Specialised dermatology services (All ages)	6	N	N	N	N	N	N
78	Neurosciences: specialised neurology (Adults)	5	N	N	N	N	N	N
79	Paed medicine: respiratory	5	N	N	N	N	N	N
80	Specialised ophthalmology (Adult)	5	N	N	N	N	N	N
81	Specialised orthopaedics (Adult)	5	N	N	N	N	N	N
82	Colorectal: distal sacrectomy (Adult)	4	N	N	N	N	N	N
83	Complex gynae – severe endometriosis	4	N	N	N	N	N	N
84	Paed medicine: haematology	4	N	N	N	N	N	N
85	Specialised ear surgery: cochlear implants	3	N	N	N	N	N	N
86	Complex disability equipment: communication aids	2	N	N	N	N	N	N
87	Metabolic disorders (lab services)	2	N	N	N	N	N	N
88	Environmental control equipment for patients with complex disability (All ages)	2	N	N	N	N	N	N
89	Paed medicine: renal	2	N	N	N	N	N	N
90	Paed medicine: specialised allergy services	2	N	N	N	N	N	N
91	Paed neuroscience: neurology	2	N	N	N	N	N	N
92	Paed medicine: immunology & infectious diseases	1	N	N	N	N	N	N

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5. Quality Service Profile
Specialised Vascular (Arterial) Services

(Included as an example of profiles to follow)

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Overview of the Quality Service Profiles

The following slides provide an example of the level of information held for each delegated specialised service. This Quality Service Profile for Vascular Services is provided as an example. The full suite of Quality Service Profiles is being prepared to be handed over at the point of delegation.

The following information is included in the Quality Service Profiles

- Which Midlands providers are delivering the service?
- What are the contact values and activity levels used for contract monitoring?
- What site are delivering the service?
- What local intelligence does the commissioning team hold about the service?
- What patient safety information does the quality team hold about the service?
- What information on clinical outcomes does the quality team hold about the service?
- What information on workforce and sustainability does the quality team hold about the service?

Further information in relation to Vascular Services is included in appendices 5.1-5.3.

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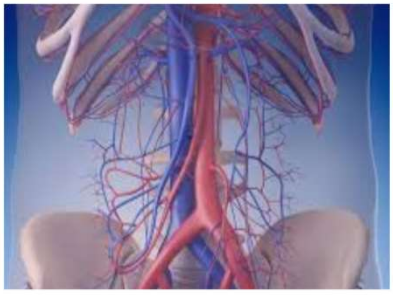
Specialised Vascular (Arterial) Services - Overview

Eleven (5 East & 6 West) Midlands Providers (Based on 2022/23 and all Points Of Delivery). Values based on SLAM.

			Contract Monitoring Actual Price	Contract Monitoring Actual Activity
Grand Total			£19,530,304	27,310
RJE : UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£2,236,112	4,243
RKB : UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£1,470,165	942
RNA : THE DUDLEY GROUP NHS FOUNDATION TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£89,878	657
RNS : NORTHAMPTON GENERAL HOSPITAL NHS TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£883,025	2,045
RR1 : HEART OF ENGLAND NHS FOUNDATION TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£5,956,526	2,033
RRK : UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£510,404	819
RTG : UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£1,339,425	1,324
RWD : UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£1,271,398	3,552
RWE : UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£1,526,080	4,834
RWP : WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£860,810	827
RX1 : NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£2,681,339	4,047
RXW : THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£705,142	1,987

The 11 Arterial Centres in the Midlands have no, one or more spokes as listed below
(information based on Trust returns to the National Vascular Registry (NVR)):

	Arterial centre (Hub)	Associated Centre (Spoke)
East Midlands	Nottingham University Hospital (Nottingham City Hospital)	Kings Mill (Mansfield)
	University Hospitals Leicester (Glenfield)	
	University Hospitals of Derby and Burton (Royal Derby Hospital)	Chesterfield Royal Hospital
	Northampton General Hospital	Kettering General Hospital
	United Lincolnshire Hospitals (Pilgrim Hospital Boston)	ULHT Lincoln County Hospital
West Midlands	University Hospitals North Midlands (Royal Stoke)	County Hospital Stafford, Leighton Hospital Crewe;
	Shrewsbury & Telford Hospitals (Royal Shrewsbury Hospital)	Princess Royal Telford;
	Dudley Group Hospitals (Russell's Hall)	New Cross Wolverhampton, Manor Hospital Walsall;
	University Hospitals Birmingham (Birmingham Heartlands Hospital)	QE Birmingham, Good Hope Sutton Coldfield, Solihull Hospital, City Hospital Birmingham, Sandwell Hospital
	Worcester Acute Hospitals (Worcester Royal Infirmary);	
	University Hospitals Coventry & Warwickshire (Walsgrave)	George Eliot, Warwick Hospital



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Specialised Vascular (Arterial) Services - Overview

The Action on Vascular (AoV) Project Closure Report (2023) using **National Vascular Registry (NVR) data** included a summary of outstanding issues for the Midlands region.

- In 2018, there were 12 vascular Arterial Centres in the Midlands. Following a merger in the **West Midlands**, one centre ceased providing inpatient vascular care – **Queen Elizabeth, Birmingham.** This did not result in a compliant service at **UHB (Heartlands),** with IR staffing and activity levels being low.
- Of the remaining hospitals in West Midlands none is fully compliant. Activity and staffing are low in **SaTH**, activity is low at **Dudley** and **UHCW**, with **Carotid Endartectomy (CEA)** activity low at **UHNM** and finally, **IR** staffing is low at **WAH**.
- There have been no changes in the provider landscape in **East Midlands**. Three hospitals have **acceptable staffing but low activity - UHDB (CEA), NUH Abdominal Aortic Aneurysm (AAA)** and **UHL (AAA).** The challenges in **NGH** and **ULHT** have been partially mitigated by the link with **UHL**, but activity and staffing remain low.
- Based on current activity the region could support nine or ten arterial centres (if activity levels in the index procedures fall no further), but current patient flows result in all of the current centres failing to meet minimum activity requirements with the exception of **WAH.**
- Complex aneurysm procedures are currently undertaken at ten centres. Based on current activity the region is unlikely to be able to support more than three centres undertaking this work. Currently only one centre does more than 12 complex procedures per year **(UHB).**

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Specialised Vascular (Arterial) Services

The below information is validated data as of 09/01/2024

Patient Safety		Clinical Outcomes	
Serious Incidents (consider PSIRF/LFPSE when available)	**Appendix 5.1** Details of two incidents reported between the period of April 2022 – present	**Notable examples of high performance / innovation**	None identified
Never Events	None identified	**Specialised Services Quality Dashboard (SSQD):**	**Appendix 5.2** Providers are required to submit; • Quarterly:13 quality indicators • Annually: 3 quality indicators Indicators include activity data for elective and emergency aneurysms, endarterectomy and amputation; as well as morbidity and mortality metrics
CQC Reports	None identified		
Workforce & Sustainability		**Mortality data**	Most recent National Vascular Registry report reveals no mortality outliers for the index procedures (aortic aneurysm surgery, carotid endarterectomy, amputation, lower limb revascularisation).
Workforce/ Recruitment & retention	GIRFT and Vascular Society recommend a minimum of 6 vascular surgeons and 6 Interventional Radiologists providing 24/7 cover in an arterial centre. Recruitment and retention of IR consultants is a challenge nationally and particularly for smaller centres. This can lead to service fragility and challenges in terms of sustainability (see below).	**GIRFT**	• National rollout of NCIP portal to consultant vascular surgeons is now under way - Getting It Right First Time - GIRFT Published 08 Jan 24 • arterial - Getting It Right First Time - GIRFT
GMC national training survey/ NETS – national education trainees survey	GMC NTS 2023 – no red flags, green flag for regional training in East Midlands (rated significantly better than expected)	**National Audits**	• National Vascular Registry State of the Nation report 2023 – HQIP Published: 09 Nov 2023 • Impact of the COVID-19 pandemic on vascular surgery in the UK (NVR) – HQIP Published: 08 Jun 2023
Summary of known risks of service/provider organisation	Census data collected in January 2023 as part of the national Action on Vascular Programme highlighted the following: Worcester – low IR staffing (4 consultants) SaTH – 5 surgeons and low IR staffing (3 consultants) UHB – low IR staffing (4 consultants) ULHT – 5 surgeons and low IR staffing (3 consultants) NGH – low IR staffing (3 consultants)	**Other information sources (if Applicable)**	**Appendix 5.3** Update from NHSE Trauma POC Lead Aug 23, CQUIN - critical limb ischaemia continues. CQUIN08 Revascularisation within 5 Days Objective: Revascularise patients with chronic limb-threatening ischaemia within 5 days, in line with the national standard, to reduce to length of stay, in-hospital mortality rates, readmissions and amputation rates. Target: 45% to 65% Q1 Scores - Specialised Commissioning Incentives Workspace - FutureNHS Collaboration Platform
Other Information	None identified		

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6. Services currently classified as Enhanced Monitoring or Intensive Support

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Overview of the ASC Quality Highlight report

There is an agreed Quality Assurance framework in place to manage risk across the 12 organisations for 2024/25. Clinical and Quality risks are reported when they are at an Intensive Level or an Enhances level surveillance in line with the NQB guidance. During 2023/24 these have been reported to the East and West Joint Committees, which will continue in 2024/25.

There are no services currently at an Intensive Level of surveillance

There are current 3 services that are being delegated that are at an Enhanced level of surveillance. The following slides contain a copy of January's ASC Quality Highlight report. This report is presented to the Midlands Acute Specialised Commissioning Group (MASC) and the East & West Midlands Joint Committees monthly.

The Quality Highlight report details

- Which services which are subject to enhanced monitoring or intensive support
- Any information relating to the issue/concern and its impact
- Any mitigating actions which are being carried out to address the issue/concern
- Any other intelligence received by the quality team that month
- Any learning or best practice to be shared

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Acute Specialised Commissioning Highlight Report – West Midlands

Date: 18/01/2024

Key messages

Quality concerns and issues arising in Specialised Services are assessed utilising the NHSE Midlands Quality Assurance Framework and are identified as on Routine, Enhanced or Intensive Surveillance in line with NQB Guidance.

Key Messages

#	Concern/Issue *New or Ongoing and Escalation Level*	Programme of care /Speciality	Organisation & Integrated Care System (ICS)	Concern/Issue identified, Description/Impact *Please include whether this requires **formal escalation** to RQG following discussion at commissioning meetings*	Proposed mitigation/Action being taken/Key Learning Points
1	Ongoing – Enhanced Surveillance	Neonatal Services	Dudley Group of Hospitals (DGOH) BLACK COUNTRY ICB	• Baby born at Russell Hall Hospital (RHH) at 30+6 weeks gestation on 30/01/2023. Baby had been treated for suspected necrotising enterocolitis (NEC) conservatively and had progressed to enteral feeds. • On 05/03/2023 the baby deteriorated and transferred to Birmingham Women's & Childrens' Hospital (BWCH) on 06/03/2023 but died on 07/03/2023. Cause of death unascertained at present. • Concerns raised by parents regarding IPC practices • In addition, on 28/09/23 notification received regarding unrelated death where Perinatal Mortality Review had classified as Category D, different management would likely have altered the outcome	• Escalation meeting held 22/03/23 and immediate actions undertaken by the DGOH regarding IPC practices. • A number of IPC assurance visits have been completed by NHSE with ICB. Good progress being made with action plan. • Peer Review Visit undertaken 03/07/23. Full report now signed off and progress with action plan will be monitored. • Serious Incident investigation report received from DGOH and signed off under the SIF process in conjunction with ICB • Results of forensic post-mortem still awaited. • NHSE met to consider information provided by the ODN and wider quality information in relation to the service & following a meeting with the ICB & the trust on 04/10/23, • Quality Improvement Meeting held with trust on 17/11/23. Positive progress noted and a number of supportive actions agreed. Letter sent to trust by CM to confirm these and ongoing monitoring continues. • The ODN will also continue working with the Trust and a neighbouring trust to commence rotation of medical staffing across the units along with other mitigations.

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Acute Specialised Commissioning Highlight Report – West Midlands

Date: 18/01/2024

Key Messages

#	Concern/Issue *New or Ongoing and Escalation Level*	Programme of care /Speciality	Organisation & Integrated Care System (ICS)	Concern/Issue identified, Description/Impact *Please include whether this requires **formal escalation** to RQG following discussion at commissioning meetings*	Proposed mitigation/Action being taken/Key Learning Points
2	Ongoing – Enhanced Surveillance	Deep Brain Stimulation Service	University Hospitals Birmingham (UHB) BSOL ICB	• Service is currently suspended. External review in 2021 identified a number of actions were required, including review and follow up for several patients, as a pre-condition of consideration of restarting the service. • The findings from the external review have also been the subject of media attention.	•UHB have confirmed completion of the follow up reviews for all but 7 patients, from 3 cohorts who had implantation surgery performed between 1999 and 2016. •Final Report including the outcome from completing all the reviews is being prepared by the Medical Director at UHB but is awaiting review of 3 patients by colleagues who undertook the Independent Review •A T&F Group is undertaking an option appraisal to determine the most appropriate future service model across Midlands.
3	Ongoing – Enhanced Surveillance	Adult Critical Care	University Hospitals Birmingham (UHB) BSOL ICB	• Unannounced CQC focused inspection within Critical Care services at QEH took place in August 2023. Feedback letter on concerns raised around staffing levels, leadership, meds management and equipment sent to trust 29/08/23.	Trust actions plan developed. Assurance oversight in place at the established BSOL ICB System Quality Group meetings which has NHSE representation. Update on progress received from trust at meeting on 1st November. Good progress in a number of areas but further work noted in terms of developing right culture. Further update scheduled end Jan 24.

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Acute Specialised Commissioning Highlight Report – West Midlands

INTELLIGENCE SHARING - horizon scanning, trends etc

Neonatal Unit Care
Neonatal care has been agreed as one of the joint NHSE/ICB priority areas and a paper outlining the intentions was previously presented to MASCG and the E & W Joint Commissioning Committees. Linked to the national focus on maternity and the Ockenden review at NUH, as well as in the wake of the Lucy Letby trial, there is significant media attention on neonatal care. Key challenges in neonatal care also include significant staffing challenges in a number of units, plus regional work continues in relation to high neonatal mortality rates. A number of reports have been produced over the last 6 months by N&Q, PH & Commissioning teams based on MBRRACE and local unit data, and action is in progress through the ODNs as well as through each LMNS. Oversight will continue through MASCG, the E & W JCCs as well as through the Regional Perinatal Quality Group which the ICB's also attend.
Work has also begun to develop a combined maternity and neonatal daily Sitrep across the region which will collate the operational position in each unit and system, and also then enable reports to be produced showing trends. The second phase of this work is to agree the key quality outcome metrics for neonatal care that can then be added to the Maternity Heatmap that already exists. An NHSE internal Perinatal Improvement Programme Group has also been established to coordinate actions across all involved directorates which includes specialised commissioners.

University Hospitals Birmingham Neurovascular service:
The MS service in UHB has developed a large backlog of patients requiring treatment with disease modifying drugs (approx. 550 patients affected). NHSE has met with the neurology team from UHB to discuss the recovery plan and subsequently has received a written response to some outstanding questions. Progress is slow but recruitment to new positions has commenced which should accelerate progress. NHSE is also in discussion with clinicians regarding starting a formal neurology network regionally. A discussion was also held on 10th January at BSOL SQG in relation to current issues and challenges in the neurology pathway which includes the MS but also the headaches service and potential for a standardised approach to neurosciences using a hub and spoke model. A joint CMO/CEO conversation is planned to discuss opportunities for ICS collaboration to achieve better results for the population and it will then be discussed at a future SQG meeting.

Fetal Medicine Services
There are a number of services in the WM region that have reported capacity issues particularly in the Consultant workforce. Mutual aid conversations continue and is noted on the regional Fragile Services Working Group. Commissioners have also supported a proposal from the Perinatal FM Network to provide a more sustainable model for consultant recruitment.

LEARNING AND SHARING - best practice, outcomes

Please share below any examples of positive assurance, good news stories, innovation, lessons learned, best practice, thematic work and intelligence that would be helpful to other regions

N/A

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7. Fragile Services

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Overview of Fragile Services database

The Fragile Services database is a list of services that the quality or commissioning team is monitoring due to information being received which suggests the service may be subject to some fragility.

This could be as a number of any of the following causes

- Capacity pressures
- Demand pressures
- Workforce issues
- Recruitment and retention issues
- Training and education issues
- Potential lack of provider

The Fragile Service Programme reviews the level of risk and takes appropriate mitigating actions. Whilst some fragile services can be attributed to a specific ICB, some affect whole pathways and have an impact at a regional level.

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Fragile Services

The table below contains a count of the number of services across the region that have been bought to the attention of the Fragile Services Programme. These services are across ICB and Specialised Commissioned services as fragile services have the potential to affect the whole pathway.

	ICB specific						Generic	Total
Midlands Region							34	34
East Midlands	LLR	Notts	N'hants	Lincs	Derby		3	92
	21	35	8	15	10			
West Midlands	BSOL	BC	C&W	H&W	SSOT	STW	2	63
	16	8	6	15	4	12		
								189

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Fragile Services in delegated Spec Comm services: Coventry & Warwickshire ICB

Specialty	Site	Reason for fragility	Detail and actions
Fetal medicine	UHCW	Lack of consultant workforce	Long term fragility due to lack of consultant workforce and difficulties recruiting. Fetal medicine network formed in 2023 and working on mitigating actions in West Midlands.
Aseptic pharmacy services	SWFT	Lack of workforce	Mutual aid being sought. Regional workshop held in November 2023. Regional board being set up.

Other C&W services on the fragility register which may impact on pathways for delegated services are:

- Breast cancer screening
- Colposcopy
- Histopathology

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8. Deep Dives

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Completed Deep Dives

As part of Joint Working on Specialised Services in 2023-24, the Midlands Acute Specialised Commissioning Team conducted a series of deep dives into priority services which were present to the East & West Midlands Joint Committees and the Clinical Collaborative Executive Forum (CCEF).

The following deep dives have been included in the appendices for information.

- **Appendix 8.1**
  Adult Critical Care
- **Appendix 8.2**
  Vascular Services
- **Appendix 8.3**
  Haemoglobinopathy
- **Appendix 8.4**
  Neonatal Services

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9. 2024-25 Priorities

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Overview of 2024-25 Priorities

As part of the 2024-25 planning round the Specialised Commissioning MDT have engaged with ICB to agree the 2024-25 priority pathways for specialised services in the Midlands.

The 9 priorities approved by ICBs and NHSE at the Midlands Acute Specialised Commissioning Group were as follows

- Neonatal Intensive Care,
- Adult Critical Care,
- Haemoglobinopathy,
- Severe Asthma,
- Oncology Review,
- Acute Aortic Dissection,
- Paediatric Critical Care,
- Multiple Sclerosis,
- Spinal Cord Injury.

Further details of each priority are included in Appendix B.

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10. Links

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Links

- NHS commissioning » Specialised services (england.nhs.uk)
- NHS England » Prescribed specialised services manual
- NHS commissioning » National Programmes of Care and Clinical Reference Groups (england.nhs.uk)
- NHS England » Service specifications
- NHS England » Commissioner assignment method 2024/25
- Prescribed Specialised Services Tools - NHS Digital
- NHS England » Directly commissioned services reporting requirements
- Integrating specialised services within Integrated Care Systems - FutureNHS Collaboration Platform

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Appendix A.
Case for change examples

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Example of how ICSs are already making a difference -Virtual e-clinics for kidney disease

- Patients with renal failure in Tower Hamlets now get more time with a specialist consultant thanks to the local ICS redesigning services around the sickest patients.
- Kidney doctors at Barts Health NHS Trust and GPs in the area set up a virtual e-clinic for GPs so they can send questions on kidney patients direct to consultants for a quick reply. The system also flags up patients that might need specialist treatment
- Since it began, waiting times for outpatients have dropped from as much as 15 weeks to just five days for advice, increasing face to face time for consultants and patients for those who most need it.
- The demand for outpatient appointments has reduced to a fifth of previous levels freeing up to time and money for reinvestment in NHS services.
- More integrated commissioning of specialised renal services would make these sorts of innovations easier as –
  - The same people and organisation would be responsible for commissioning both the specialised (eg dialysis) and non specialised (GP led) parts of the patient pathway reducing complexity and bureaucracy
  - Budgets will be pooled which creates more of an incentive to keep patients out of hospital and treat them closer to home
  - Services can be tailored around the needs of local populations helping to address health inequalities
  - Those who do need specialist services such as dialysis will still be able to access them in line with national standards and policies

"We were seeing a lot of patients who gained little from seeing a consultant, and instead are supporting GPs to help these patients. If we think a patient does need extra care then they can get in to see us far more easily, and into the right specialist clinic. Our team can now focus on those on dialysis, or with more severe kidney disease, where specialists can make the biggest difference."

Dr Neil Ashman, who developed the system with local GP Dr Sally Hull

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Case for change examples

Current Commissioning Arrangements	Consequences of Current Arrangements	Introduction of ICSs will…
HIV Services Commissioned nationally but Patient care delivered through HIV services via Local Authorities	Service and workforce fragmentation in some areas across England	• Enable NHSE and Local Government to collaborate on the commissioning of HIV and sexual health services strengthening pathways with domestic abuse, Sexual Assault Referral Centres and mental health services. • Help enable a joint approach to support and deliver recommendations from HIV action plan. • Help to ensure greater integration in the design of services informed by data and insight on the needs of local communities – helping to reduce inequalities. • Enable local providers of services for mental health and learning disabilities and /or autism to take control of budgets to improve outcomes by managing whole pathways of care. • Seek to avoid inpatient admissions and provide high quality alternatives to admission.
Mental Health and LDA Services Most Commissioned by CCGs. Only CYP, adult low and medium secure and adult eating disorder services are nationally commissioned.	Specialised MH services are at the end of the pathway focused on inpatient and interventionalist care leaving little incentive for upstream investment by CCGs	
Neurology Spec com funds neurology patients only at certain designated centres / in outpatients where the patient has been referred by a consultant. Neurological needs of patients not seen at a centre are met by hospitals funded by CCGs	Discourages development of local provision by CCGs at sites other than neuroscience centres – patients have to travel further. Discourages service evolution, patients not seen in the right places.	• Provide an opportunity to improve quality and access to services by moving decisions closer to communities • Enhance collaboration between partners including across larger geographical footprints • Make it easier to deliver upstream interventions in primary care around diagnosis and early treatment, to potentially prevent or delay the need for transplants further down the pathway • Potentially lead to greater investment in home dialysis with financial benefits (from reduction in travel costs) being reinvested elsewhere. • Support greater focus on prevention and provision of care closer to home.
Renal Costs of Kidney disease, dialysis and transplantation is funded via Spec com but surgery and most outpatient care is funded by CCGs. Transport is supported by CCGs and makes up 30% of elective transport in the NHS	Funding for renal medicine is complex and discourages upstream investment in prevention and earlier stages of the pathway.	

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What do we want to be different in the new model?

	Planning and Governance	Collaborative Delivery	Funding
PRESENT	Prevention, diagnosis, acute treatment, chronic management and specialised services are planned and commissioned by different organisations with plans based on different historic views resulting in misaligned priorities	Some patients have multiple touchpoints across multiple organisations for the same condition which results in limited opportunities to join up care and support innovation and technological advances	Current funding approach provides limited incentives to reduce cost through innovation which can result in specialised budgets outstripping funding available
FUTURE	All organisations across whole patient pathway working under a single planning structure with aligned incentives and plans based on a single forward view of population needs.	Fewer touchpoints which are built around the needs of the patient enabling greater innovation and collaboration and more joined up services across the patient pathway	Care funded on a population basis and with local organisations working together to set and manage budgets incentivised to innovate and save costs, leading to sustainable systems and more focus on the needs of local populations.
EXAMPLE	 Mr Wu, 68yrs Type II Diabetes End stage renal failure Needing dialysis. Can delay the need for dialysis through identification and intervention of his CKD by his GP, thereby improving his quality of life and care experience	 Mrs. Jagathesan, 74yrs Complex cardiac history awaiting a heart procedure, lives far from Cardiac centre. Can attend local hospital for pre-assessment ahead of her surgery, receive follow up care close to home in local or virtual clinics.	 Miss Jones, 19yrs Rare neurological disorder Waiting for multiple diagnostics. Gets co-ordinated diagnostics through a single point of access, reducing outpatient appointments and enabling faster diagnosis and treatment – meaning better patient experience and cost-effective care

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Case for change – examples and themes

Current Arrangements	Consequences	Integration Opportunities
Sickle Cell Spec comm funds haematology services. ICBs funds the upstream pathway – from genetic screening, pre-conception care, newborn screening, primary care, urgent and emergency care.	Lack of joined up care meant that significant service quality issues went unchecked for years. Opportunities to support patients through core ICB offerings (e.g. community nursing) were missed – haematology didn't have sight of the offering and ICBs didn't have sight of the service.	Single commissioner will have a view of the entire end-to-end pathway and will have the mechanism to identify and address issues. One accountable group for ensuring quality services. Integrating specialised haematology services in and end-to-end pathway can improve connectivity with ICB core services (maternity, primary care, community support, urgent and emergency care access) for people with Sickle Cell disease.
Fragmented funding and pathways	**Disincentives to improve outcomes and £**	**"steps to the left" and end-to-end pathways**
Neurology Only funded at certain Neurosciences centres – even if the specialist consultant works at multiple hospitals. Neurological needs of patients not seen at a centre are met by hospitals funded by ICBs.	Discourages development of local services outside the neuroscience centre (investment from ICBs) – patients have to travel further. Inconsistent provision leading to inequities. Discourages service evolution, with no common approach to pathway development.	Introduce a consistent approach to commissioning neurology services – enabling improved quality and access, and services closer to home. Enhance collaboration between partners including across larger geographical footprints. Create streamlined pathways leading to faster diagnosis and more cost effective care.

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HIV Pilot - Ensuring Comprehensive HIV Screening in Emergency Departments (EDs) Across South London

Almost all hospitals in South London in high or extremely high prevalence areas offer opt-out HIV ED testing.

Cases identified in South London EDs:

- At KCH, the oldest patient identified through ED testing was 95.
- At GSTT, a significant number of patients testing positive in ED have primary infection (20%) with very high viral loads.
- At SGUH, an HIV diagnosis was suspected in only 11 (22%) of the subsequently 50 positive cases.
- At Croydon, newly diagnosed HIV-positive patients now need shorter hospital stays, from an average of 34.9 days down to only 2.4.

2. Opt-out HIV tests are offered to those who need blood tests (c.300,000 people).

5. If a test is reactive, the patient is invited for further tests by the sexual health service.

7. On appropriate treatment, patients with HIV can expect to live as long as someone without HIV. Those with undetectable viral loads cannot pass HIV onto anyone else, even in unprotected sex. Clinicians try to re-engage patients lost to follow-up.

The process of HIV screening in EDs | What happens next | Uptake

1. Over 1 million people attend Emergency Departments* in South London every year.

3. The level of uptake of HIV tests varies across South London, from 34% - 98%.

4. One sample and blood bottle can be used for both the blood tests and the HIV test, meaning the additional costs are largely lab-associated.

6. Newly diagnosed patients are brought into care and put on treatment. Early detection is vital to reduce HIV/AIDS related complications.

This variation across South London means that not all patients who have HIV are being identified. This is due to key factors such as the age of those tested, the length of time before re-testing repeat ED attendees, and general operationalisation of the screening strategy.

This pilot aims to address this through 'levelling up' across south London, supported by a minimum service specification.

There is variation in lab costs across South London, with costs ranging from £2.50 to £5.55 per test. Some trusts use 2 blood bottles.

~150 patients are newly diagnosed with HIV in EDs in South London every year. Each person living with HIV newly linked to care could avoid NHS costs of over £200,000.

"Making a diagnosis of HIV today does mean spending money on the treatment tomorrow; missing a diagnosis today means greater treatment costs in years to come (and not just for one patient, but for anyone else before or after them in the chain of transmission)."

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Home based immunoglobulin therapy (IVIg) in Neurology in South London

1. Home based Immunoglobulin therapy for people with autoimmune neuropathies is safe and effective and less costly than hospital-administered intravenous immunoglobulin (IVIg)

3. This is highly disruptive to quality of life. Patients frequently require time off work which makes maintaining employment challenging and costs them greatly through loss of income and travel.

5. In addition to being more convenient, this method offers clinical benefits as lower drug doses can be used more frequently. This is better tolerated by patients (reduces adverse reactions), avoids fluctuations in condition between treatment and reduces risk of stroke and other blood related issues related to large doses.

7. The model has been in place at Kings College Hospital for several years. We are proposing to support the Neurosciences centre to establish a service, using learnings from Kings as well as learnings in home care from the OPAT pilot.

2. Some patients are required to come into hospital (day case units) for recurrent infusions every 3-6 weeks, which may takes place over two to five successive days. Each episode of treatment costs £4k.

4. Alternatively, many patients are suitable for home therapies – including a subcutaneous injection they can deliver themselves. This can transform the patient experience, and patients report high levels of satisfaction with this option.

6. This contributes to improved use of hospital estates (freeing capacity in day case units for other activity), reduces drug costs through VAT savings and is cheaper for patients (reduced travel and lost income). Additionally, it offers greater environmental sustainability (reduced travel).

8. Funding is available to recruit a CNS to support patients on this pathway. Project management support is available from SLOSS for implementation. **Trust and system support is required to manage and plan for day case activity and income changes.**

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Appendix B.
2024-25 priorities – detailed slides

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Midlands Oncology Service Review: Fragile		Lead: Laura Morris	Ref: C1
Delegation Status: Green (HCD retained)	**ICB:** All	**National Priorities: Recovery:** Cancer, Use of Resources. **LTP:** Workforce, Inequalities. **DCG**	
What is the problem in summary? Oncology is identified as a fragile service across the Midlands. Performance challenged, with 8/11 systems in tiered support. Inequity of timely access at Trust and tumour site level. Oncologist vacancy rate is 15% , expected to rise to 25% in 2027 with 20% forecast to retire over 5 years. Midlands has the lowest WTE per population in England. There are also workforce challenges in chemo nurses; therapeutic radiographers and medical physics. Across the Midlands, we spend £522 million on SACT per year (activity, drugs and support costs), plus Radiotherapy spending.		**What are we looking to achieve?** Reduce variation in waiting times; increase productivity and share best practice through the development of new models of care, workforce strategies and shared resource. **Scope:** Workforce; capacity; service models **Specific Partners:** Cancer Alliance (EAG/ECAG); EMAP (priority area); ICB cancer leads	
Planned Deliverables: - Mutual aid framework (Q1). - Develop plans for managing agency/locum costs (Q1). - Review and appraise variety of current financial spends and service models for oncology services (Q2). - Produce Virtual Ward criteria (Q2). - Confirm transformation plans in place at system for virtual or community clinics (Q4)		**How will we know if things have improved (KPI)?** - Reduced and consistent waiting times across systems. - Reduced vacancy rates. - Unit cost reduction. - Consistent approach to managing mutual aid.	

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Acute Aortic Dissection		**Lead:** Jon Gulliver	**Ref:** IM1
Delegation Status: Green	**ICB:** All	**National Priorities: Recovery:** UEC, Use of Resources. **LTP:** Workforce, Health Inequalities. **DCG**	
What is the problem in summary? Acute aortic dissection (AAD) is rare and immediately fatal for 48%. For Type A making it to cardiac surgery, mortality is 25%. Surgery is time critical. All cardiac surgery centres have at least one AAD specialist surgeon but with no coordinated regional on-call rota presenting challenges to accessing intervention. There is consensus that coordination will improve outcomes for patients and reduce waits but there is resistance to change.		**What are we looking to achieve?** Reduce variation in access to emergency surgery and improved outcomes through the introduction of coordinated East and West on call rotas. **Scope:** Workforce; capacity; service models **Specific Partners:** Cardiac Transformation Programme, Cardiac Networks.	
Planned Deliverables: - Approved SOP(Q1). - SPOC testing and training(Q1). - Recruit MDT coordinator (Q1). - Establish regional MDT(s) (Q2). - Agree process for collecting and reporting KPI (Q1). - Service go live (Q1 WM, Q2 EM).		**How will we know if things have improved (KPI)?** - In hospital mortality with/without intervention; 1 year mortality. - LOS. - Referral numbers. - Intervention/no intervention. - Time from referral to intervention. - Deaths between diagnosis and intervention Type A. - Deaths between diagnosis and place of safety Type B. - Patient satisfaction.	

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Severe Asthma		**Lead:** Jon Gulliver	**Ref:** IM2
Delegation Status: Green	**ICB:** All	**National Priorities: Recovery:** UEC, Use of Resources. **LTP:** Health Inequalities.	
What is the problem in summary? Severe asthma (SA) is a debilitating, chronic disease with an average of 4 asthma attacks and 4x more A&E visits pa, patients with SA account for ~50% of all asthma-related healthcare costs. Biologic treatment has the potential to improve lives and reduce the use of healthcare/social resource. Access is variable and ~80% of eligible patients are currently not prescribed a biologic.		**What are we looking to achieve?** Increase access to biologics for patients with SA to improve outcomes for patients and reduce the use of other healthcare resource. **Scope:** All patients with severe asthma. **Specific partners:** Respiratory Network	
Planned deliverables: - Review of current treatment and patient pathways for the management of asthma across primary and secondary care including case finding for biologics, diagnosis and treatment optimisation. - Review of the data to understand the inequalities that are present in accessing biologics treatment, based on underlying service and/or patient factors. - Share with respiratory networks and specialist asthma centres to inform options appraisal.		**How will we know if things have improved (KPI)?** - Number of new initiations per ICB - Increase in percentage bio penetration per ICB - Reduction of variation in bio penetration by ICB	

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Multiple Sclerosis Service Review: Risk Register		**Lead:** Dom Tolley	**Ref:** T1
Delegation Status: Green	**ICB: BSol; H+W; Black Country**	**National Priorities: Recovery:** Elective, Use of Resources. **LTP:** Workforce, Health Inequalities.	
What is the problem in summary? A review of the MS tertiary service provided by University Hospitals Birmingham to a number of ICBs has found significant waiting times and increasing numbers of patients to be seen for initial consultations to access to Drug Modifying Therapies (DMTs) and lack of structure for the ongoing management of this patient group. There is a lack of good governance with regards to the prescribing and monitoring of these patients, which has a potential of harm.		**What are we looking to achieve?** Improve access of eligible MS patients to DMTs and ongoing care of those already on treatment outside of BSol ICB. **Scope:** All patients eligible MS patients who should fall under the care of UHB. **Specific partners:** None	
Planned deliverables: - Review of West Midlands regional MS DMT pathways and governance and current financial spend for MS DMT patients and produce options appraisal for MASG and JCs, to include the development of Neurology ODNs (Q2) - Develop and implement a revised MS DMT clinical pathway, including shared care agreements (Q4).		**How will we know if things have improved (KPI)?** - Reduction in waiting list and waiting times for MS patients on DMT clinical pathway by the end of 2024/25	

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Spinal Cord Injury Services		**Lead:** Dom Tolly	**Ref:** T2
Delegation Status: Green	**ICB: All**	**National Priorities: Recovery:** UEC, Use of Resources. **LTP:** Workforce, Health Inequalities. **DCG**	
What is the problem in summary? The Midlands region only has one commissioned Spinal Cord Injury (SCI) rehabilitation unit (RJAH), which has the second longest waiting times for admission in England. The unit cannot manage high cervical spinal injuries, due to lack of ACC, resulting in out of region transfers. The East Midlands does not have a SCI rehabilitation centre. Patients are managed in Sheffield or Stoke Mandeville where there are long waits. This delay in rehabilitation treatment means poorer outcomes (increased rates of HCAI and pressure sores), potential harm and DTOC.		**What are we looking to achieve?** Improved access to SCI and outcomes. Reduction in harm and DTOC resulting into lower use of healthcare resource. **Scope:** All patients presenting with a SCI and requiring rehabilitation. **Specific partners:** None	
Planned deliverables: - Complete a demand and capacity analysis for SCI rehab, including patient acuity and complexity (Q1-Q2). -Review current financial spend for SCI patients and review potential options costs for SCI services (Q1-Q2) - Present review and options papers to MASG and JCs, including QIA and 13Q (Q3), including weaning and ventilated patient services for high c-spine injured patients.		**How will we know if things have improved (KPI)?** - Reduction in LOS SCI patients. - Reduction in DTOC both from Acute beds base and to CHC services - Reducing periods of bed rest. - Reduction in complications.	

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Adult Critical Care (ACC) Rehabilitation & Digital Enablement		**Lead:** Dom Tolly	**Ref:** T3
Delegation Status: Green	**ICB: All**	**National Priorities: Recovery:** UEC, Elective, Use of Resources. **LTP:** Workforce, Health Inequalities. **DCG**	
What is the problem in summary? The Midlands ACC Strategy has continued to develop a more diverse, resilient and holistic model of ACC care across the 29 ACC units. The major quality, clinical and operational improvement drive in the next 3 years of the strategy is to develop consistent 7-day services for ACC rehabilitation in line with national guidance. In doing so this potentially will reduce in LOS for ACC patients by up to 1.5 days, improve patient outcomes, reduce costs for patient episodes.		**What are we looking to achieve?** Digital enablement will provide clinical support, improved decision making through a networked approach to care through virtual ward rounds. Digital critical care platform will reduce clinical errors in transfers of care between providers, by allowing shared care records. **Scope:** All ACC units. **Specific partners:** EM and WM ACC ODNs.	
Planned deliverables: - Complete digital services review paper (Q1). - Complete ACC rehab gap analysis by provider/ICB (Q2). - Review of current spend for ACC rehab and review potential options costs for services (Q2). - Present review and options papers to MASG and JCs, including QIA (Q3).		**How will we know if things have improved (KPI)?** - Reduction in length of stays for ACC patients. - Reduction in pharmacy and parental nutritional spends.	

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Haemoglobinopathies		**Lead:** Nick Hey	**Ref:** BI1
Delegation Status: Amber	**ICB: All**	**National Priorities: Recovery:** UEC, Use of Resources. **LTP:** Workforce, Health Inequalities. **DCG**	
What is the problem in summary? The APPG on Sickle Cell and Thalassaemia conducted a review of services and experiences of patients and produced 'No one's listening.' This report revealed many years of sub-standard care, stigmatisation and lack of prioritisation and patients losing trust in the NHS system. A regional review demonstrated wide variance in the level of service on offer to patients and numerous areas for improvement, in particular in improved training and knowledge at non-specialist trusts and A&Es.		**What are we looking to achieve?** Improve outcomes for patients and reduce unnecessary admissions for patients by improving networks of care. **Scope:** All haemoglobinopathy services. **Specific partners:** EM and WM HCCs.	
Planned deliverables: • Med Tech Funding (Spectra Optia) business cases . Potential for approval of additional national funding to support red blood cell exchange services - (Q2). • Review of SCD prevalence, activity and provision (Q1). • Review position against APPG report (Q1). • Review of Specialist Haemoglobinopathy Team provision – Service provision review and re-commissioning (Q4).		**How will we know if things have improved (KPI)?** - Updated review of regional position against No one's listening recommendations demonstrating improvement, especially in non-specialist centres. - Increased access and activity for red blood cell exchange.	

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Neonatal Critical Care: Risk Register		**Lead:** Sumana Bassinder	**Ref:** WC1
Delegation Status: Green	**ICB: All**	**National Priorities: Recovery:** Maternity, Use of Resources. **LTP:** Workforce, Health Inequalities. **DCG**	
What is the problem in summary? Neonatal Critical Care remains an area of significant national and regional scrutiny. The Midlands also has one of the highest neonatal mortality rates in the country. There is significant work to do to implement the requirements of the NCCR including configuration, patient pathways, increase cot capacity, workforce strategy, neonatal transport review to support the revised neonatal networks. All against a backdrop of high-profile scrutiny (Ockenden, Thirlwall, Letby, Kirkup).		**What are we looking to achieve?** Improved outcomes for babies and a reduction in mortality rates. **Scope:** All NIC services. **Specific partners:** EM and WM ODNs. Perinatal Programme. LMNS	
Planned deliverables: • Review of WM capacity and configuration (Q1). • Describing patient pathways. • Financial impact of compliance (Q1) • Production of workforce strategy. • Review of neonatal transport. • Ongoing capacity monitoring and compliance review. • Perinatal dashboard (Q1) • Review of PMRT process.		**How will we know if things have improved (KPI)?** - Reduction in mortality rates. - Reduction in babies being transferred out of region for neonatal care. - Reduction in the number of cots closed due to staffing challenges.	

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Paediatric Critical Care (PCC)		**Lead:** Sumana Bassinder	**Ref:** WC2
Delegation Status: Green	**ICB: All**	**National Priorities: DCG**	
What is the problem in summary? PCC capacity is an area of concern regionally and nationally for both Level 2 (High Dependency) and Level 3 (Intensive Care). National funding was received in 23/24 to increase Level 2 capacity outside of Level 3 centres but so far only a partial implementation has been achieved. Further work required to identify, increase and progress additional capacity.		**What are we looking to achieve?** Right capacity in the right place. **Scope:** All PIC services. **Specific partners:** EM and WM ODNs.	
Planned deliverables: - Monitoring of delivery of WM plans. - Plan for increase of resilient L2 capacity in the EM in line with GIRFT (Q1) - Demand, capacity and financial review of L2 and L3 provision and production of options appraisal (Q4)		**How will we know if things have improved (KPI)?** - Reduction in OPEL status levels from 23/24 surge baseline during 24/25 surge periods. - Reduction in patients transferring out of area for paediatric critical care. - Improved cot utilisation, closer to home and outside of tertiary centres.	

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Health and Wellbeing Board Forward Plan 2024/25

	Board Jan 24	Executive Group Jan 24	Board May 24	Board Sept 24	Board Jan 25	Executive Group Jan 25	Board May 25	Board Sept 25
Item								
HWBB Delivery Plan		Agree Delivery Plan	Annual Review			Agree Delivery Plan	Annual Review	
HWBB Executive Group			Endorse Exec Group paper				Endorse Exec Group paper	
PH Grant Spend			Note and comment				Note and comment	
Care Collaborative								
JSNA	Healthy Ageing JSNA		Empowering Futures JSNA	Adults with a learning disability			Strategic Group update	
ICB Integrated Health and Care Delivery Plan								
North Place Plan			Annual update				Annual update	
Rugby Place Plan			Annual update				Annual update	
South Place Plan			Annual update				Annual update	
DPH Annual Report	Focus on VAWG				Focus TBC			
Safeguarding Boards			Annual Report for information	Annual report for info				Annual Report for information
Children and Young People Partnership	Update on progress			Discussion piece *(BSiL focus TBC)*	Update on progress		Update on progress	
Better Care Fund	Progress update		Year-end report for assurance	Progress update	Progress update		Progress update	Progress update
Healthwatch Warwickshire				Annual Report for assurance				Annual Report for assurance
ICS Prevention Board				Smokefree generation				

Note for future work programme:

- Schedule in focus on Best Start in Life
- Schedule Dementia Strategy discussion
- Schedule Pharmacy, Ophthalmology and Dentistry discussion

ICS	Integrated Care System	**DPH**	Director of Public Health	**JSNA**	Joint Strategic Needs Assessment
ICP	Integrated Care Partnership	**HWBB**	Health and Wellbeing Board	**SEND**	Special Educational Needs and Disabilities
ICB	Integrated Care Board	**ED**	Executive Director	**BSiL**	Best Start in Life

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