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Agenda

Coventry Health and Well-being Board

Time and Date
2.00 pm on Monday, 28th November, 2016

Place
Committee Rooms 5 and 6 - Council House

Public Business

1. **Welcome and Apologies for Absence**

2. **Declarations of Interest**

3. **Minutes of Previous Meeting** (Pages 3 - 10)

   (a) To agree the minutes of the meeting held on 17th October, 2016

   (b) Matters Arising

4. **Sustainability and Transformation Plan (STP) Update**

   (a) Sustainability and Transformation Plan Submission

   The officers will report at the meeting

   (b) Sustainability and Transformation Plan Engagement Workstream (Pages 11 - 36)

   Report of Andrea Green, Coventry and Rugby CCG

   (c) Sustainability and Transformation Plan Pro-active/Prevention Workstream

   Presentation by Gail Quinton, Executive Director of People

5. **West Midlands Police Force Changes**

   Presentation by Chief Inspector Danny Long, West Midlands Police

6. **Draft Coventry and Warwickshire Health Protection Strategy 2017-2021** (Pages 37 - 86)

   Report of Dr Jane Moore, Director of Public Health

7. **Coventry Suicide Prevention Strategy 2016-19** (Pages 87 - 116)

   Report of Dr Jane Moore, Director of Public Health

8. **Children and Adolescent Mental Health Services (CAHMS) Transformation Plan - Year 1 Refresh** (Pages 117 - 180)

Report of Matt Gilks, Coventry and Rugby CCG

9. **Joint Coventry and Warwickshire Health and Wellbeing Boards Development Day** (Pages 181 - 194)

Report of Liz Gaulton, Deputy Director of Public Health

10. **Any other items of public business**

Any other items of public business which the Chair decides to take as matters of urgency because of the special circumstances involved

Private Business

Nil

Chris West, Executive Director, Resources, Council House, Coventry

Friday, 18 November 2016

Note: The person to contact about the agenda and documents for this meeting is Liz Knight, Governance Services, Tel: 024 7683 3073 Email: liz.knight@coventry.gov.uk

Membership: Councillor F Abbott, S Banbury, S Brake, K Caan (Chair), A Canale-Parola (Deputy Chair), G Daly, B Diamond, G Duggins, S Gilby, A Green, A Hardy, S Kumar, R Light, D Long, J Mason, J Moore, G Quinton, M Reeves, E Ruane, K Taylor and D Williams

Please note: a hearing loop is available in the committee rooms

If you require a British Sign Language interpreter for this meeting OR it you would like this information in another format or language please contact us.

Liz Knight
Governance Services
Telephone: (024) 7683 3073
e-mail: liz.knight@coventry.gov.uk

Coventry City Council
Minutes of the Meeting of Coventry Health and Well-being Board held at 2.00 pm on Monday, 17 October 2016

Present:

Board Members: Councillor Abbott
Councillor Caan (Chair)
Councillor Duggins
Councillor Taylor
Stephen Banbury, Voluntary Action Coventry
Simon Brake, Coventry and Rugby GP Federation
Dr Adrian Canale-Parola, Coventry and Rugby CCG (Deputy Chair)
Professor Guy Daly, Coventry University
Ben Diamond, West Midlands Fire Service
Andrea Green, Coventry and Rugby CCG
Andy Hardy, University Hospitals Coventry and Warwickshire
Professor Sudhesh Kumar, Warwick University
Ruth Light, Coventry Healthwatch
Danny Long, West Midlands Police
John Mason, Coventry Healthwatch
Dr Jane Moore, Director of Public Health
Gail Quinton, Executive Director of People
Justine Richards, Coventry and Warwickshire Partnership Trust
David Williams, NHS Area Team

Employees (by Directorate):

People: L Gaulton
J Reading

Resources: L Knight

Apologies: Councillor Ruane
Simon Gilby, Coventry and Warwickshire Partnership Trust
Martin Reeves, Coventry City Council

Public Business

75. **Welcome**

The Chair, Councillor Caan welcomed members to the meeting and thanked them for their attendance and contributions at the Coventry and Warwickshire Health and Wellbeing Boards development session held at Warwick University on 13th October (Minute 82 below refers)

76. **Declarations of Interest**

There were no declarations of interest.

77. **Minutes of Previous Meeting**

The minutes of the meeting held on 5th September, 2016 were signed as a true record. There were no matters arising.

78. **Reducing Health and Wellbeing Inequalities - Update from the Marmot Steering Group**

Ben Diamond, West Midlands Fire Service introduced the report of Gail Quinton, Executive Director of People which provided an update on progress with the Health and Wellbeing Strategy priority 'Working together as a Marmot City to reduce health and wellbeing inequalities'.

The report referred to Coventry's involvement with the Marmot programme which comprised partners working together to reduce health inequalities. Improvements to date included a reduction in the gap in male life expectancy; improvements in educational attainment, employment, and life satisfaction; and reductions in crime in priority locations. There was now a further three year commitment to Marmot, with priorities being to tackle inequalities disproportionally affecting young people and ensuring that all Coventry people, including vulnerable residents could benefit from 'good growth' which would bring jobs, housing and other benefits to the city.

Coventry's Marmot City Partners had worked together to produce an action plan with indicators and targets for the next three years to achieve these priorities. The plan was based on the needs identified in the Joint Strategic Needs Assessment and feedback from stakeholders. The Board noted that it was a live document that would be revised and updated on a regular basis.

Ben Diamond highlighted the initial progress against a number of aims and actions, progress against the young people priority included an internal and external evaluation of Acting Early; the establishment of the Ambition Coventry programme; the submission of a bid to the ESIF Growth Fund to extend the Ambition programme; and extending the Early Intervention Service provided by Compass to cover primary age children as well as secondary schools. Progress against the 'good growth' priority included DWP working with primary care services to educate professionals and trial employment support in GP surgeries; the development of a social value toolkit; the Chamber of Commerce working with employers to recruit locally; and the roll out of the Workplace Wellbeing Charter.

The report included detailed information on action plans, indicators, current baseline data and targets for the first, second and third years of the Marmot City programme relating to the two priorities. Data would be reported against programme indicators on a quarterly basis and against outcome indicators on an annual basis. It was noted that the Marmot Steering Group would meet once a quarter to receive updates from partners, discuss progress and identify areas for development and partnership working.

Members raised a number of issues arising from the update including:

- Support for all the detailed work that had been undertaken
- How feedback was to be secured from young people and how this would be taken into account in future actions
- Clarification that publication of the JSNA and the Health and Wellbeing Strategy was being promoted and if the promotional material could be used

in newsletters to inform those who took part in the JSNA call for evidence process or fed back in other ways, about the progress being made.

Further to Minute 66 of the previous meeting which concerned an update on the priority ‘Improving the Health and Well-being of Individuals with Multiple Complex Needs’, clarification was sought regarding the appointment of a representative from the private business sector to support the work of the Board. Discussion centred on whether it more appropriate for a representative to sit on the Health and Wellbeing Board, the Steering Group or the Multiple Complex Needs Board. The issue of inviting representatives from the Local Enterprise Partnership and the Coventry Chamber of Commerce to a future Board meeting was also raised as this would provide the opportunity to find out how their work reflected the priorities contained in the Health and Wellbeing Strategy.

RESOLVED that:

(1) The progress to date be endorsed.

(2) The action plans, indicators and targets for 2016-2019 be approved.

(3) Agreement be given to receive further progress updates from the Marmot Steering Group every six months.

(4) Information used to promote the publication of the JSNA and the Health and Wellbeing Strategy to be sent to Ruth Light, Coventry Healthwatch.

79. **Improving the Health and Wellbeing of Individuals with Multiple Complex Needs**

A report of Danny Long, West Midlands Police was circulated which provided an update on the progress made against the Health and Wellbeing Strategy priority ‘Improving the health and wellbeing of individuals with multiple complex needs’.

The report indicated that the Multiple Complex Needs Board was established in July to oversee the delivery of this priority. Following the initial Board meeting in July, a workshop was held on 5th October to help the Board to identify the vision, key objectives, priorities and work streams. It was agreed that the project would be divided into two phases: phase one focussing on improving outcomes for those who were already affected with multiple complex needs and phase two would look at developing and implementing early intervention and prevention approaches towards multiple complex needs whilst working with a range of partners and existing bodies.

The agreed vision was ‘People with multiple complex needs are able to build safe and healthy lives and fulfil their potential.’ The objectives were detailed under the following two headings: Improved life chances/outcomes and long term transformation of public services.

The Board were informed about the two initial work streams, the research work stream and the baseline work stream. A key task of the research element was to understand who was affected by multiple complex needs, how many, where in the city and how they were affected. Attention was drawn to the intention to link into

the research work being undertaken by the West Midlands Combined Authority around multiple complex needs. Key partners were now engaged. The baseline work stream would look at how agencies were currently managing individuals, what the care/service pathways were, and identify opportunities to integrate pathways ensuring that they were more customer focused.

Members raised a number of issues arising from the update including:

- Support for all the current work being undertaken in the health and care system to support individuals with multiple complex needs and for the progress to date with this priority
- Clarification about how the two work strands would run together
- Whether there was a tool that could be used to identify individuals likely to develop multiple complex needs and examples of best practice
- The importance of data sharing between partners to ensure success.

RESOLVED that:

(1) The progress made to date be noted.

(2) The proposed objectives and priorities of the work stream be noted and members commit to supporting the work by providing representatives to the Multiple Complex Needs Board where appropriate.

(3) A full update be submitted to a future meeting of the Board.

80. **Partnership for Coventry Conference 'Feeding Coventry Addressing Food Poverty and Creating a Sustainable Food Network'**

The Board considered a report of Councillor Abbott, Cabinet Member for Adult Services which sought commitment and support the Partnership for Coventry Conference ‘Feeding Coventry – addressing food poverty and creating a sustainable food network’ to be held on 22nd November, 2016.

Arising from an All Parliamentary Enquiry report ‘A strategy for zero hunger in England, Wales, Scotland and Northern Ireland’, Coventry had been chosen as one of twelve pilot projects which aimed to draw together private, voluntary and public expertise to eliminate hunger. A Feeding Coventry Steering Group was established in January 2016, chaired by Councillor Abbott comprising members from a wide range of organisations.

The Board were informed of the following key objectives of Feeding Coventry initiative:

- Addressing emergency food needs
- Increasing the understanding of the causes of food poverty
- Promoting a sustainable food economy
- Joining support networks which offer mentoring to achieve their goals
- Developing cohesive partnerships across all organisations involved in emergency food provision, welfare and research
- Providing a single simple information source for the city on the provision of food and related support.

The Board noted that Sub-Groups had been established to take some of the priority areas forward. The four current priority areas were:
i) More than Food – advice and support would be given at the point of accessing food support, for example job clubs and job shop
ii) Fuel Vouchers – to address the dilemma of heat or eat
iii) School Holiday Provision – school holiday meals and breakfast clubs
iv) Food Access/Securities/Resilience – community shops, surplus food distribution and support to grow food.

The conference aimed to broaden local awareness and involvement in the current initiatives led by the Feeding Coventry partnership and to gain support for new ambitious goals. The conference also aimed to enlarge and strengthen the partnership between the community, public, private and third party sector organisations.

Further information was provided on the Sustainable Food Cities Network.

Professor Kumar, Warwick University offered the support of Warwick Medical School who had set up a network whereby food destined for waste was put to good use. Professor Daly, Coventry University offered to ensure the engagement with dieticians who had previous involvement with the food banks.

RESOLVED that:

(1) The principles of Coventry joining the Sustainable Food Cities Network be supported.

(2) Members to raise awareness, within their organisations, of the key objectives of the Feeding Coventry Initiative, which will be further developed and supported at the Partnership for Coventry Conference on 22nd November 2016.

(3) The link between the overall aim of the Coventry Health and Wellbeing Strategy to create health, wealth and happiness for the people in Coventry and working together as a Marmot City to reduce health and wellbeing inequalities be acknowledged.

81. **Sustainability and Transformation Plan Update and Submission**

The Board received a brief update from Andy Hardy, University Hospitals Coventry and Warwickshire on Sustainability and Transformation Plan (STP).

Since the previous Board meeting, the financial template to close the financial gap had been submitted on 16th September and the detailed STP with implementation dates and finance details was to be submitted on 21st October. Following this the process would move to the communication and engagement phase.

Andy Hardy indicated that he anticipated that the financial gap would be closed however delivery would be the challenge. A delivery body would need to be established with the remit of ensuring that the financial targets were met.

Discussion centred on the financial challenges facing local authorities, particularly in light of the increasing demands on adult social care and the requirement for Council's to set a balanced budget. The Council couldn't continue to deliver all the current services it provides. The importance of effective partnership working with shared resources was emphasised to enable the successful delivery of the Plan.

82. **Reflection and Next Steps from Coventry and Warwickshire Health and Wellbeing Boards Development Session**

The Chair Councillor Caan referred to the success of the Coventry and Warwickshire Health and Wellbeing Boards Development Session held at Warwick University on 13th October when the Boards had reviewed and contributed to the emerging Sustainability and Transformation Plan (STP).

Reference was made to the signing of the Coventry and Warwickshire concordat and how this was an innovative way of working. Members were informed that an enquiry had already been received from the North of England about this new way of working between Health and Well-being Boards. It was suggested that more should be done to publicise this new concordat.

Attention was drawn to the role of all Board members to become involved with the engagement process for the STP.

Members were informed that a second Joint Development Session would be held on 16th January, 2017.

RESOLVED that:

(1) A detailed report on the first Joint Development Session be submitted to the next Board meeting on 28th November, 2016.

(2) Arrangements be put in place for the second Joint Development Session to be held on 16th January, 2017.

83. **Coventry's Draft Carers Strategy 2016-19**

The Board considered a report of Gail Quinton, Executive Director of People which sought endorsement for the Carer's Strategy 2016-19, a copy of which was set out at an appendix to the report.

The report indicated that a carer was someone who provided unpaid care for a family member or friend, who due to illness, disability, a mental health condition or an addiction, could not cope without support. The 2011 census identified 32,101 carers in Coventry, of these 3,100 were young carers under the age of 25. The economic value of the contribution made by carers to the city was estimated at £680m.

Coventry's multi-agency Carers Strategy expired in 2015. The new draft strategy had been developed through a multi-agency approach including health partners and voluntary sector organisations who played a key role in supporting carers. The carer reference group had also been engaged in the process. The strategy reflected the following four priorities set out in the national carers strategy:

- Identification and recognition
- Realising and releasing potential
- A life alongside caring
- Supporting carers to stay healthy.

For each of these priorities a number of improvement areas had been identified based on feedback and evidence and further information was set out at an appendix to the report. Improvement activities included:

- Developing and implementing a Carers Charter
- Clarifying the pathway for carers and simplifying processes for registering and signposting carers
- Increasing Carers' Clinics and information available in GP surgeries
- Improved co-ordination with other parts of the health and social Care System including urgent care and end of life care.

The Board were informed that two workshops had been held to provide the opportunity for feedback on the draft strategy as well as being presented at various carer groups and Board meetings and feedback had been very positive overall with improvements being widely supported. The Board noted that the strategy now included links with the Sustainability and Transformation Programme to ensure synergy with the major change programme across the health and care system.

Members expressed support for the consultation work that had been undertaken. Concerns were raised about the number of over 65s caring for spouses and the challenges involved with supporting these carers if they developed health issues as well, an issue which was likely to escalate with increasing life expectancy. There was a concern that the strategy didn't take account of these elderly carers. There was an acknowledgment of the importance of the STP and partnership working to improve healthy life expectancy for Coventry people. Further discussion centred on the communication with carers, particularly individuals who were not receiving any support.

Councillor Abbott, Cabinet Member for Adult Services informed about the activities that had taken place in the city during the Carers Week 2016.

RESOLVED that:

(1) The Coventry Carers Strategy be endorsed, with the manner in which the strategy has been developed with a wide range of stakeholders being noted.

(2) The Strategy be updated to include more references to older carers.

(3) Members of the Board to take responsibility for arranging sign off of the Strategy through their respective governance arrangements.

84. **Forward Plan Agenda Items**

The Board noted a Forward Plan of agenda items for the remaining meetings of the current municipal year which was tabled at the meeting.

RESOLVED that:

(1) Members to forward potential agenda items for inclusion on the Forward Plan.

(2) All Members to be contacted about their expectations for the next Coventry and Warwickshire Health and Wellbeing Boards development session to be held on 16th January, 2017 with views being sought as to the future frequency of these joint sessions.

85. **Any other items of public business**

There were no additional items of public business.

(Meeting closed at 3.30 pm)

Report

To: Coventry Health and Wellbeing Board **Date: 28th November 2016**

From: Andrea Green, Chief Officer, NHS Coventry and Rugby Clinical Commissioning Group and NHS Warwickshire North Clinical Commissioning Group

Subject: Draft Engagement Strategy – Sustainability and Transformation Plan

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1 Purpose of the Note

1.1 The draft Engagement Strategy for the STP is bought for discussion prior to consideration by Coventry Health Overview Scrutiny Committee on 9 December 2016.

2 Recommendation

Members are asked to review the draft Strategy and approach to engagement, and to advise of any suggested amendments that will enhance engagement with the public, patients, carers and specific communities of interest.

3 Information/Background

3.1 As previously reported to the Board, leaders from the health and social care economy, have been working on developing a plan to ensure the sustainability of health services over the next five years.

3.2 One element of the plan has been to consider how best we can engage the public, patients, carers and their representatives in the plans, once there is sufficient information on which to engage. The draft engagement strategy has been developed. This has been informed by the input of local Councillors at the joint Coventry and Warwickshire Health and Wellbeing Board event on the 13 October, and will be considered by the Coventry Health Overview and Scrutiny Committee on the 9 December 2016.

3.3 As well as considering the draft Strategy, an example of how we would plan to conduct one of the first conversations is attached, to offer Members a little more detail of how we propose to engage.

4 Draft Engagement Plan

4.1 The Health and Wellbeing Board is asked to critique and advise any amendments to the draft engagement plan and process and to note that:

- the draft plan has been amended following the outcomes of the Joint Health and Wellbeing Board event held on 13 October, specifically to develop the overarching compelling case for change
- the process suggested is to commence a ‘Big Conversation’ phase of pre-consultation engagement to start at the end of November 2016 for a proposed period of eight weeks, starting with a first conversation about maternity care. Following this period it is proposed to revisit the engagement approach and revise this using any learning from this first phase.

Report Author(s):

Name and Job Title:
Andrea Green, Chief Officer, NHS Coventry and Rugby Clinical Commissioning Group and NHS Warwickshire North Clinical Commissioning Group

Telephone and E-mail Contact:
andrea.green@warwickshirenorthccg.nhs.uk

Enquiries should be directed to the above person.

Appendices
Appendix A: Draft Engagement Plan – The Big Conversation

‘The Big Conversation’
STP Engagement Strategy

A route-map to delivering the Five Year Forward View

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1.0 Executive Summary

Sustainability and Transformation Plans act as a ‘route-map’ to achieving the improvement goals set out in the ‘Five Year Forward View’, determining at a strategic level, what is and is not possible in terms of service delivery. They

present the best opportunity for transforming health and social care services on a geographical basis to be both sustainable and high quality.

To succeed, STPs will need to be developed with, and based upon, the needs of local residents, patients and communities and engage clinicians and other care professionals, staff and wider partners such as local government. We cannot develop care which is centred on the needs of patients and users without understanding what communities want. As such a robust local engagement plan is needed that will increase understanding of the patient experience, the need for change and support options for improvement. in the early part of the STP process.

However, the engagement strategy must also work to manage expectations of the population where necessary. While pre-consultation engagement will be a key part of the process, conversations that are too general may create unrealistic expectations for services. For this reason it is important now that enough detail is available, that we translate each of the opportunities for improvement identified in the workstreams, and develop the overarching compelling narrative so as to make engagement as targeted as possible. Basing questions on drivers set out in the national strategies to come out of the Five Year Forward View such as the 'Better Births' national maternity review, and localising these.

To start involving local people and our stakeholders on the work of the STP to ensure they have a voice and their needs are reflected, the actions in this strategy are proposed to secure a safe listening and engagement process which would eventually see stakeholders support a case for change. We would also look to encourage stakeholders to propose innovative ideas about how services can change that will achieve the forward vision.

The Health and Well Being Board is asked to critique and advise amendments to the draft plan and process

- The draft plan has been amended following the outcomes of the Joint Health and Wellbeing Board event held on 13 October, specifically to develop the overarching compelling case for change.

- The process suggested is to commence a 'Big Conversation' phase of pre-consultation engagement to start at the end of November 2016 for a proposed period of eight weeks, starting with a first conversation about maternity care. Following this period it is proposed to revisit the engagement approach and revise this using any learning from this first phase.

This plan does not include staff engagement, a separate but linked plan is being developed to engage staff as part of the Workforce workstream.

2.0 Background

NHS England has asked every health and care system to work together to produce a multi-year Sustainability and Transformation Plan (STP) showing

how local services will evolve and become sustainable over the next five years, ultimately delivering the Five Year Forward View vision. To do this, local health and care systems have had to declare which STP ‘footprints’ (geographical areas) within which they will work to narrow the gaps in the health inequality; care and quality; financial sustainability.

There are 44 footprints, which collectively cover the whole of England and we have agreed to be the Coventry and Warwickshire footprint.

The STP plan must answer the below questions:

- How will you close the health and wellbeing gap?
- How will you drive transformation to close the care and quality gap?
- How will you close the finance and efficiency gap?

The analysis and opportunities have been developed to a sufficient level of detail and it is now critical that we start to engage with stakeholders to get co-production and involvement in what may need to change. This is the ethical course of action and will also ensure actions undertaken by the STP are in line with the Gunning Principles (Appendix 1) and form part of any formal consultation required at a later stage.

3.0 Aim and Objectives

The STP’s aim is to transform services and secure a sustainable provision of high quality health and social care for the people of Coventry and Warwickshire.

Our aims in terms of engagement should be:

- Objective 1: Deliver our duty as outlined under Section 242 of the National Health Service Act 2006 (as amended) to involve and consult with anyone who our services are currently provided to, or may be, in the planning of, development and/or changes to the way those services are provided (Legislation.gov.uk, 2016).

- Objective 2: Achieve local understanding of the need for change and ultimately a safe engagement and consultation process (where ‘safe’ refers to there being no successful legal challenge, which could potentially delay developing the plan and implementing improvements).

- Objective 3: Our organisations want to learn and understand from citizens and others about how services and behaviours could change to achieve the forward vision as stated above.

4.0 Vision & Narrative

The STP Vision was developed and agreed by the STP Programme Board as:

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To work together to deliver high quality care which supports our communities to live well, stay independent and enjoy life.

Building on the vision is the STP narrative, designed to give more detail about the work and direction of the STP but also taking in core points and language from the Coventry and Warwickshire Health and Well Being Alliance Concordat:

The way we care for each other needs to change. For too long, the focus has been on supporting you and your family when you're in crisis or ill rather than on keeping you healthy and independent.

We all know of excellent care and compassionate staff across Coventry and Warwickshire. But too often it's not the same for all – and it should be, whether you live in Atherstone, Allesley or Alcester.

That's why over the next five years all care organisations will come together to transform services and add value to our communities by supporting them to live well, stay independent and enjoy life.

We are going to work together to deliver Coventry and Warwickshire's Sustainability and Transformation Plan and as well as helping you stay healthy, we are going to focus on four key areas covering care in hospital and out of hospital:

- *Services for older people;*
- *Services for those who need mental health support;*
- *Services for those with joint or muscle problems;*
- *Services for women and children.*

These will be delivered where evidence shows care is best given and will be innovative, modern and efficient. This will ensure that high quality care can continue to be delivered for this generation without passing the cost onto the next and that those in our community can live independent and fulfilled lives.

Both local Health and Wellbeing Board Members reviewed the aspects of the STP and its status on 13 October 2016. A key outcome from the event was the need to create a shared simplified and compelling narrative about the plan, being clear about what it was, and what it wasn't. The outcome of the event has been used to shape that narrative by then end of October.

5.0 Case for Change

While the focus of engagement should be on the delivery of the Five Year Forward View rather than the STP in of itself, external discussion on the subject has been increasing, particularly as no detail of the work in progress has yet been released into the public domain. This has led to misgivings in sections of the press and unions that the plans are 'secret' and contain wide sweeping reforms that will decimate local health and social care services. This is not the case and so the perception will need addressing.

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Shaping a simple and compelling narrative about the case for change commenced at the event with the Health and Wellbeing Boards on the 13th October, however this needs completing before the launch of the "Big Conversations".

What is clear across the country is the economic challenge, that health and social care services will have to evolve and continuing with the status quo is not an option. Therefore it is proposed that we start engaging with local people, communities (of interest and demography), democratically elected representatives, and key stakeholders such as GPs across Coventry and Warwickshire, so that we better understand their needs and priorities as well as gain innovative ideas to better understand the need to change services. This is to ensure that all stakeholders understand the importance of health and social care organisations working together to deliver these.

As messages and options for specific STP work streams are not yet fully formed for all the areas, Stroke being an exception, it is proposed that a wider listening phase called 'The Big Conversation' is embarked upon from November. This would form the early part of the co-production and pre-consultation engagement and help to shape the approach where there is a need to consult formally on any service changes later in the STP process.

6.0 'The Big Conversation'

It is proposed that a wider listening exercise called 'The Big Conversation' is started in November 2016. This would be commissioner driven (with provider input) and to add focus, would be structured around the drivers of five key strategies involved in the delivery of the Five Year Forward View:

- Better Births – National Maternity Review
- Transforming urgent and emergency care services in England
- Five Year Forward View for Mental Health
- Five Year Forward View for Achieving World-Class Cancer Outcomes
- Building the Right Support – National plan for transforming LD services

While there are certain elements that fall outside of the STP focus, it will be important to ensure the patient/public voice continues to inform co-production and service improvement in all these areas. Existing intelligence from prior engagement activity will also be used to help inform service development in each area. It will be important moving forwards though, to be as specific as possible about the sorts of ideas we may be considering. This will support a genuine co-production approach in terms of options development for the STP. It will also help to further embed the message that there are limits to what services are able to do with the resources available and solutions will need to be about getting the best from what we have.

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One of the first tasks will be to build the compelling narrative which as yet is not defined as we would want to engage stakeholders in doing this. However suggested general key messages would be:

- Current health and social care services focus on caring for you at crisis rather than helping you stay well.
- The way we are caring for people is old fashioned, expensive and there is unwarranted variation across the region.
- The way you receive health and social care needs to change - focusing on keeping you well rather than waiting until you get ill.
- Health and social care bodies across Coventry and Warwickshire are working more closely together than ever before.
- We are looking at how we can improve services while reducing the gap in funding
- We need your help and involvement to transform our services for the better
- You need to be part of the solution so we want to work with you to solve some of the challenges we face e.g. reducing unnecessary demand

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These will give context to the key discussion points under each of the following five national areas:

Better Births **National Maternity Review**	**Urgent & Emergency Care Services in England** **National Strategy**	**Mental Health** **Five Year Forward View**	**Achieving World-Class Cancer Outcomes** **Five Year Forward View**	**Building the Right Support for transforming LD services** **National Plan**
Personalised Care Continuity of Carer Safer Care, and addressing local workforce challenges Better Postnatal Care and Perinatal Mental Health Care Multi- Professional Team Working Working Across Boundaries A Payment System and Voucher to support choice	Demand management and simplifying/ redefining what is A&E Primary care and urgent care Community services Out of Hospital services Emergency services and workforce challenges in ED Urgent Mental health	Good quality care for all 7 days a week Innovation and research to drive change Strengthening the workforce A transparency and data revolution	Upgrade in **prevention and public health** **Earlier diagnosis** **Patient experience** on par with clinical effectiveness and safety Transform our approach to support people **living with and beyond cancer** deliver a **modern, high-quality service** Ensure **commissioning, provision and accountability** processes are fit-for-purpose	Our journey so far Provision of services to a heterogeneous group The local service model Reducing need for inpatient services How we can work together to provide new services

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It is suggested that the Coventry and Warwickshire STP carries out engagement on all five work-streams between October and December 2016. Intelligence gained will complement work on the STP and aiding the development of a comprehensive route-map for achieving the vision set out in the Five Year Forward View. It will also inform options development ready for future engagement once detailed plans have been worked up.

A vital element of the STP will be getting an overall narrative that secures local understanding and ownership of what the case for change, and what the plan is, is and what it isn't. There is a need for senior leaders in health and wellbeing Boards across Coventry and Warwickshire to help to shape that message.

One of the first topic areas to focus on in the STP is developing options for maternity services, it is planned to use this, within the context of the agreed compelling narrative, as the first focus for the 'Big Conversation' phase of engagement. It will act as a pilot for engagement on the remaining four strands and specific questions will be developed in conjunction with the maternity lead for the STP. This will ensure engagement is targeted in terms of the knowledge gaps it is trying to fill.

Existing channels have already been mapped out by the STP communications and engagement group in order to identify as many routes as possible for engagement (appendices one and two). All partners will be asked to utilise existing engagement opportunities and to undertake targeted activity where necessary. For example, maternity services could be asked to carry out engagement with current and future mothers in hospitals and in the community. Local authorities could also undertake engagement with children's centres and voluntary sector and community groups.

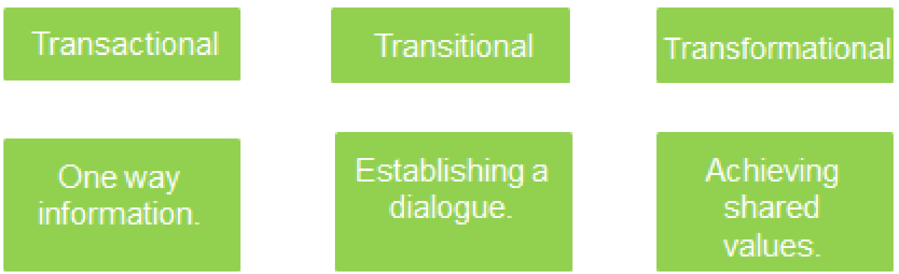
Engagement activity for the other four strands will follow the model used for the maternity engagement, with any necessary adaptations made following the pilot and taking account what works well. It is anticipated that planning for engagement around maternity services will be carried out during October, with engagement beginning to take place during November. Following engagement on all five areas of care a report will be produced which will inform continued planning for the STP.

The attached chart (appendix four) shows in detail the plan for the maternity engagement, and contains fields that can be populated with the timescale for the other four strands as the engagement for these is planned and carried out. It should be noted that mental health is likely to form an underlying theme within all of the five work-streams. The chart will be modified to reflect this if necessary.

8.0 Stakeholder Mapping

Up to this point engagement has been very transactional (e.g. one way) with regards to the STP. This has been done through updates at Board level or short articles in staff newsletters.

This now needs to progress to a transitional phase. The 'Big Conversation' should help establish understanding of the need for change and lay the foundation for what will ultimately be a safe engagement and consultation process that will help achieve the transformation we are looking for (where 'safe' refers to there being no successful legal challenge, and therefore damage to the reputation to the NHS organisations involved):



3Ts of community engagement (adapted from Bowen et al 2010)

When considering any kind of service development or transformation, the stakeholders below will be key to engagement. Constructive and positive relationships should be sought with all where possible in order to facilitate the transition and transformation set out above.

Power	Low Interest	High Interest
High	***Keep Satisfied*** • MPs • Elected council members • Organisation staff members • Media • Royal Colleges • WMAS	***Manage Closely*** • Health and Overview Scrutiny Committees • Health and Wellbeing Boards • Healthwatch • Unions • GPs • NHS E/I
Low	***Monitor (minimum effort)*** • Coventry and Warwickshire universities • Chambers of Commerce	***Keep Informed*** • Volunteers • 3rd Sector • Pressure groups

The table above is a basic snapshot and the process will be repeated in more detail for each of the 'Big Conversation' work streams. This will include triangulating information with local authority and voluntary sector partners and drilling down to identify specific stakeholder groups. With regards to maternity services, relevant stakeholder groups may include:

- Women between 20-40
- Women who are 41 +
- Women and girls between 13-19
- Voluntary orgs working alongside or within local authorities e.g. Surestart
- Healthcare professionals in the community
- Healthcare professionals in a hospital setting

Data would also be analysed with a number of variables in mind. For example, the input of a large group of pregnant women may be influenced by:

- Age
- Where they live
- Whether they already have children
- Economic status
- Ethnicity / Culture
- Whether they have had straightforward or complex pregnancies

7.0 West Midlands Messages

We should consider linking the 'Big Conversation' with similar listening phases going on in other STP footprints across the West Midlands region e.g. Hereford and Worcester's #YourConversation campaign.

Initial conversations with communication and engagement leads, as well as NHS England, demonstrate a desire to share messages where possible to demonstrate that key themes (e.g. demand prevention) are not footprint specific.

For example, a West Midlands wide electronic survey to gain quantitative and qualitative data on people's views about service changes is being drafted which would allow a baseline engagement level to be established and then tested against at regular periods in the future. This would touch upon the themes of the 'Big Conversation' and affecting all four STPs such as maternity, paediatrics, urgent and emergency care, mental health and self-care/prevention.

Conducting this as part of the 'Big Conversation' would allow the STP Board to understand the appetite for service change across the county and for various services. This would allow a mix of quantitative and qualitative data which could be used to inform work streams as they go forward and further target engagement work with them.

It is anticipated that this would be low cost and managed in house within the existing STP teams.

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9.0 Risks

A detailed risk log will be established but the current high level risks and mitigation are below. A standard Severity/Likelihood matrix was used to identify these:

Risk	Current rating	Desired rating	Mitigation
Risk of Judicial Review.	High risk	Low risk	Working within legal parameters set out.
Pressure groups do not engage with the process.	High risk	Low risk	Commencement of listening phase of engagement. Demonstrate that the board / authorities are engaged through publishing regular feedback reports that summarise engagement activities. Releasing information on how the views and ideas of citizens have been used to reshape services
Reputation (the Board is perceived as prioritising finance over patients).	High risk	Low risk	Commencement of listening phase of engagement. Demonstrate that the board / authorities are engaged through publishing regular feedback reports that summarise engagement activities. Releasing information on how the views and ideas of citizens have been used to reshape services
The benefits of proposed changes are not accepted by stakeholders.	High risk	Low risk	Commencement of listening phase of engagement. Demonstrate that the board / authorities are engaged through publishing regular feedback reports that

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			summarise engagement activities. Releasing information on how the views and ideas of citizens have been used to reshape services

Being taken to judicial review carries a high number of risks around the costs, resources and the effect on the timescales for change. These would have to be borne initially regardless of the outcome. If the case was lost it would set the timescales back at least one year and would have irreparably damaged the reputations of those involved as 33% think an organisation is automatically guilty if accused of wrongdoing.

11.0 Budget and Resource

Currently the budget and resource for the 'Big Conversation' will be covered through in-house arrangements with local partners. However the STP Board has to consider how practical this is going forward when increased engagement will be needed, possibly leading to formal consultation.

Initially this strategy proposes stakeholder events, newsletter and use of digital communications for the listening phase and so the Board must agree in principle that they will free up staff time and resource to deliver these, or agree to finance these activities separately.

12.0 Evaluation

Evaluation will take place following the listening phase. Based on the above it is anticipated that evaluation would consider the below:

	Outputs	Outtakes	Outcomes	STP Impact
Media	Number of articles	Number of comments/ letters	Increase positive proportion to at least 40% by March 2017.	Reduced likelihood of judicial review. Understanding of benefit of proposed changes.
Marketing	Number of events delivered / Attendance at events	Sentiment of qualitative feedback Message recall.	Increase in positive sentiment. Positively engaged stakeholders.	Reduced likelihood of judicial review. Understanding of benefit of proposed changes. Pressure

				groups engaged.
Internal communications	Number of articles	Number of comments at staff events	Greater understanding of the role of the STP.	Staff more positive about change.
Digital communications	Number of tweets Number of Facebook posts Number of vlogs/blogs Production of animation Production of infographic	Twitter re-tweets Facebook likes, shares and reach Vlog/blog comments Animation views	Increase in positive sentiment. Positively engaged stakeholders.	Reduced likelihood of judicial review. Understanding of benefit of proposed changes. Pressure groups engaged.

13.0 Next Steps

- Complete the simplified compelling narrative to set the context for the listening phase, through engagement with H&WBB's; HOSCs.
- Commence the listening phase with 'Big Conversation' activities from end November 2016.
- Between January to March 2017, review the pre-engagement approach to assess whether it met the objectives required, and can inform further approaches that may be required,
- Continue to build on and strengthen the links to the Coventry & Warwickshire HWB Concordat, the next event is 16 Jan 2017.
- Discussion with the Warwickshire HWB Board and Executives to develop the engagement further and as the programme moves on into more detailed plans.
- Utilise the outputs from the pre-consultation engagement to shape and inform any aspects that require consultation.
- Continue to work with other STP footprints in the West Midlands.

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Appendix 1
Current Transactional Engagement Channels

Region	Organisation	Engagement	Regularity
South Warwickshire	SWFT	Maternity staff community engagement with natal and postnatal women	Ongoing
South Warwickshire	SWFT	Closed Facebook group for young mum	Ongoing
South Warwickshire	SWFT	Health visitors engaging with community	Ongoing
South Warwickshire	SWFT	Group of 100 residents interested in out of hospital services (also some in North Warwickshire and Rugby)	Meeting planned in December 2016
South Warwickshire	SWFT	Foundation Trust Membership (6,000 with 40 Governors)	Quarterly Members' Events from September 2016
South Warwickshire	SWFT	Patient Forum	Ongoing
South Warwickshire	SWCCG	Health Champions (1,000 members of the public who have signed up to improve health services in their area)	Ongoing
South Warwickshire	SWCCG	Patient and Public Participation Group	Every six weeks
South Warwickshire	SWCCG	Have Your Say Days (Two sessions on main topics chosen by PPG or CCG followed by workshops. Open to the general public; sessions taken away and answers than given on the website.)	Biannually – next one is September 6 2016. Lunch session is taking place in a community centre and the evening session in a college.
Warwickshire North	WNCCG	Comprehensive engagement database listing	Ongoing

		stakeholder groups	
Warwickshire North	WNCCG	Patient Forum all 28 practices represented	Every other month
Warwickshire North	WNCCG	Feedback form – paper and online version	Ongoing
Warwickshire North	WNCCG	Health Champions in topic areas	Ongoing
Warwickshire North	WNCCG	#onething engagement with local community to raise awareness on health	Ongoing
Warwickshire North	WNCCG	Health Aware Communities group – proactive group to develop events and patient engagement activity	Ongoing
Warwickshire North	WNCCG	Bespoke surveys (hard copy and online)	As needed
Warwickshire North	WNCCG	Community Representatives Group	Every other month
Warwickshire North	WNCCG	Have Your Say Day	Ad hoc
Warwickshire North	WNCCG	Patient Panel (check and challenge)	As needed
Warwickshire North	WNCCG and WCC Public Health	Health and Wellbeing Partnership includes Borough Council health portfolio holders	Every other Month
Coventry and Rugby	CRCCG	Medicines Management team (engages with pharmacists)	Ongoing
Coventry and Rugby	CRCCG	Patient Reference Group (PRG) Summits (predominately white, over 55s)	Bimonthly – next two planned for late September
Coventry and Rugby	CRCCG	General feedback survey available (online / paper)	Ongoing
Coventry and Rugby	CRCCG	Bespoke surveys (online / paper)	As appropriate
Coventry and	CRCCG	Patient Reference	Ongoing –

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Rugby		Groups (PRGs) at each GP Practice across Coventry and Rugby (72 out of 75). CCG engages virtually via newsletters and emails.	virtually via email and newsletters
Coventry and Rugby	CRCCG	Focus groups	As appropriate
Coventry and Rugby	CRCCG	Community events – 2 per annum	Ongoing – but event due in Sept 16 would be superseded by suggested roadshow for the 'Big Conversation'
Coventry and Rugby	CRCCG	Patient Voice Champions (150 very engaged)	Ongoing
Coventry and Rugby	CRCCG	Online engagement: • Facebook – 1,142 followers • Twitter – 3,699 followers • Public website – 26,458 hits (July 2016)	Ongoing
Coventry and Rugby	CRCCG	Three locality meetings (Inspires and Godiva in Coventry and Rugby)	Monthly
Coventry and Rugby	CRCCG	Practice Manager Meetings	Monthly
Coventry and Rugby	CRCCG	Practice Nurse Meetings	Monthly
Coventry and Rugby	CRCCG	GP Protected Learning Time (Wednesday in Coventry and Thursdays in Rugby)	Weekly
Coventry and Rugby	UHCW	Impressions survey giving real time data from patients, relatives and visitors	Ongoing
Coventry and Rugby	UHCW	Various patient groups (parents of	Ongoing

		those in neonatal, survivors of cancer)	
Coventry and Rugby	UHCW	Rugby Forum (members of key Rugby groups meet and are updated on St Cross specific issues)	Quarterly
Coventry and Rugby	UHCW	Staff Forums and newsletters (sent to 8,000 staff)	Monthly

Appendix 2

Upcoming planned campaigns/events

Region	Organisation	Campaign	Date
South Warwickshire	SWFT and Warwickshire County Council's Public Health Team	Looking After You focusing on falls, hydration, dementia and nutrition.	Ongoing – about to focus on Falls Prevention in the over 55s.
Warwickshire	Warwickshire County Council's Public Health Team	Healthy Living Pharmacies – to promote the use of pharmacists for demand management.	Ongoing
Warwickshire	Warwickshire County Council's Public Health Team	Living Well with Dementia Portal launched	7 September 2016
Coventry and Warwickshire	Council led Adult social care channels and groups (already engaged with STP preventative stream)	TBC	Ongoing
Coventry and Warwickshire	Warwickshire County Council's Public Health Team and CWPT	It takes balls campaign raising awareness about speaking out about mental health issues	From September 2016
Warwickshire	Warwickshire County Council's Public Health Team	Mental Health campaign in conjunction with Coventry and Warwickshire MIND	5 October 2016
Coventry and Warwickshire	NHS England	Stay Well winter campaign (Will be less print ad and more television ads. Will be focusing on celebrities with long term conditions getting the flu jab and locally should be looking at local celebrities (e.g. sports stars). Flu roadshows will focus on targeting those in the C2D groups (will be able to hire/borrow roadshow kit).	October 2016- February 2017 (but can start in September 2016 locally)

Coventry and Rugby	CRCCG	Protected Learning Time	Nov/Dec events led by CRCCG
Warwickshire	Warwickshire County Council's Public Health Team	Mental health first aid training for frontline staff across Warwickshire	October 2016
Warwickshire	Warwickshire County Council's Public Health Team	E-learning 'Five ways to wellbeing' aimed at staff.	October 2016
Coventry and Warwickshire	Led by WNCCG	Stroke consultation	Jan 2017
Coventry and Rugby	CRCCG	Commissioner intentions	From end Sept 2016
Warwickshire	Warwickshire County Council's Public Health Team	Suicide Prevention Strategy	30 November 2016
Coventry and Rugby	CRCCG	Patient sharing work stream	
Warwickshire and Coventry	Council's corporate channels of engagement	TBC Separate event following on from the joint H&WBB event	Ongoing
Coventry	Acting Early (0-5) service reconfiguration (co-production)		Relevant learning and input from parents and service providers available

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Appendix 3 – STP Stakeholder Groups by theme *(in draft form)*

Engagement Theme	Population Group	Potential Ways to Engage
Maternity	Parents of young children in deprived areas of Coventry	Children's Centres Valley House Infant Feeding Team
	Parents of young children generally	Mums and Tots Groups – through Community Centre Managers and Faith Organisations Valley House Hospital Education Service – Teenage Pregnancy Unit
Learning Disability	Children, young people and adults with learning disabilities Parents and carers	Grapevine Special Schools Hereward College Schools Special Educational Needs and Disability Information Advice and Support Service Positive Youth Foundation OneVoice Parent Group Learning Disabilities Partnership
Mental Health		CAMHS CWPT Cov & Warks MIND Libraries
Cancer	Cancer survivors Families affected by cancer	Employees MacMillan GP MacMillan community mobilisation role (Ruth Nelson)
Urgent and Emergency Care	Looked After Children	Children's Champion
Young people's services	Teenagers Early intervention and SMS	Positive Youth Foundation Youth Clubs Schools Sky Blues in the Community Compass Valley House Cyrenians Be Active Be Healthy
	Homeless people	Salvation Army Cyrenians Winter Night Shelter (Dec) Kairos

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		CRISIS Rooted Project
Domestic and sexual violence and assault	Domestic violence survivors SVA	DV Shelters Coventry Domestic Violence and Abuse Support Services (CDVASS): CRASAC
	Social care service users	
	Vulnerable older people	Arm chair exercise groups Hope in Unity Age UK Age Friendly Cities Initiative
Proactive and Preventative (e.g. how to prevent obesity and this being passed on through generations)	General population Children/Families	Community networks, including community centres Children's healthy weight alliance (currently in formation)

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Appendix 4 – Key Legislation

- Coventry and Warwickshire Healthwatch Engagement Charter

- The Gunning Principles

The Gunning principles are now applicable to all public consultations that take place in the UK. Failure to adhere to the Gunning principles may underpin a challenge relating to consultation process that may be considered through judicial review.
The principles are as follows:

1. When proposals are still at a formative stage
2. Sufficient reasons for proposals to permit 'intelligent consideration'
3. Adequate time for consideration and response
4. Must be conscientiously taken into account

The Gunning principles are now applicable to all public consultations that take place in the UK. Failure to adhere to the Gunning principles may underpin a challenge relating to consultation process that may be considered through judicial review.

- NHS Act 2006 (As Amended by Health and Social Care Act 2012) Public involvement (13Q and 14Z2)
    - Under S14Z2 NHS Act 2006 (as amended by the Health and Social Care Act 2012) the CCG has a duty, for health services that it commissions, to make arrangements to ensure that users of these health services are involved at the different stages of the commissioning process including:
        - In planning commissioning arrangements
        - In the development and consideration of proposals for changes to services
        - In decisions which would have an impact on the way in which services are delivered or the range of services available; and
        - In decisions affecting the operation of commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

- S.82 NHS Act 2006 - Co-operation between NHS bodies and local authorities

- S.244 NHS Act 2006 (as amended)

The Act also updates s244 of the consolidated NHS Act 2006, which requires NHS organisations to consult relevant Local Authority Health Overview and Scrutiny Committees (HOSC) on any proposals for a substantial development of the health service in the area of the Local Authority, or a substantial variation in the provision of services.

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- “The Four Tests” – NHS Mandate 2013-15 (carried forward through NHS Mandate 2015-16)

The four tests are:

1. Strong public and patient engagement – including staff engagement
2. Consistency with current and prospective need for patient choice
3. A clear clinical evidence base
4. Support for proposals from clinical commissioners.

- S.149 Equality Act 2010

- S.3a NHS Constitution

- Mental Capacity Act 2005

- Human Rights Act 1998

- Planning, Assuring and Delivering Service Change for Patients – NHS England Guidance

- Transforming Participation in Health and Care – NHS England Guidance

Appendix 5 – Big Conversation Engagement Plan

(See supporting excel document)

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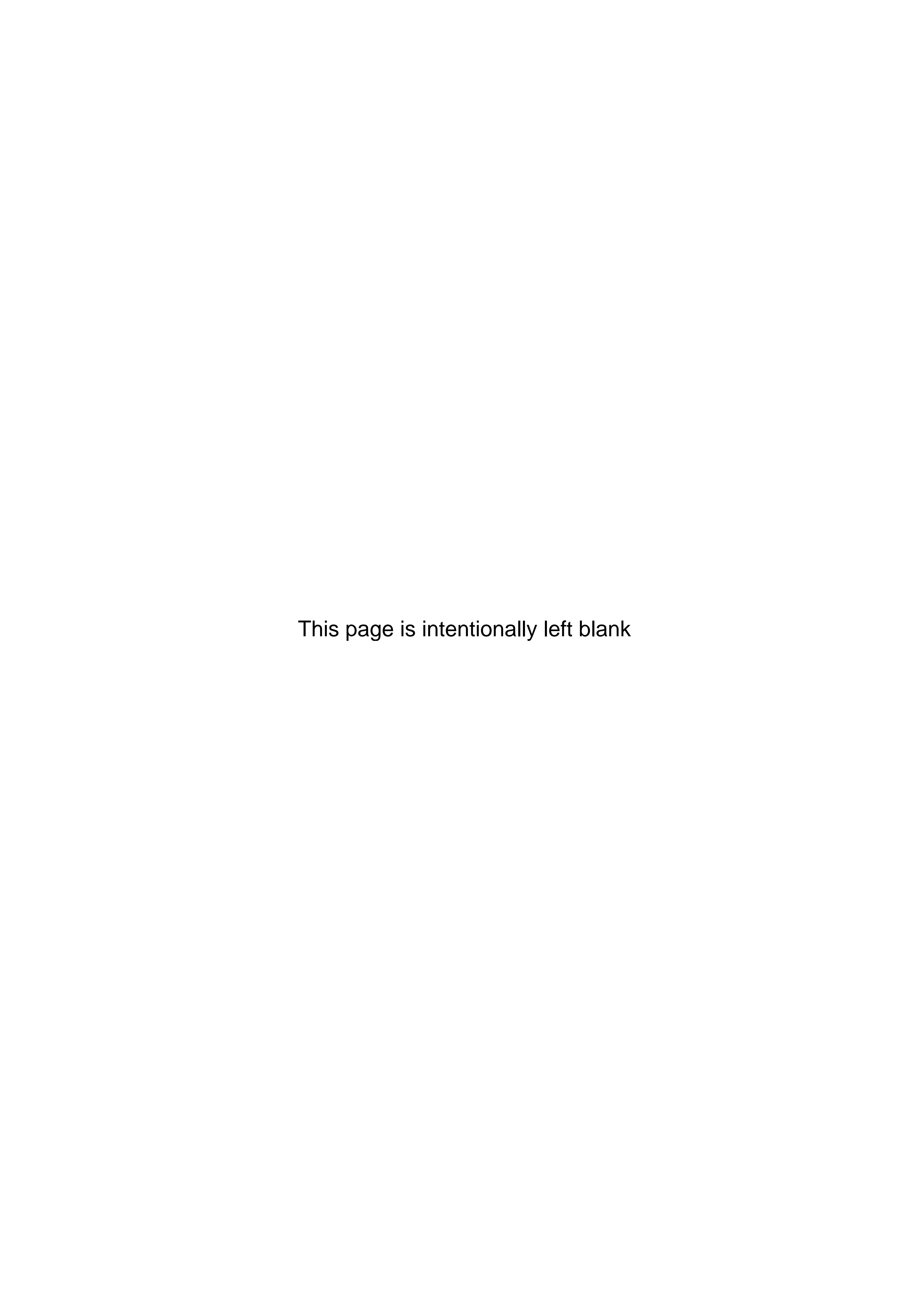

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Report

To: Coventry Health and Wellbeing Board **Date: 28th November 2016**

From: Director of Public Health

Title: Draft Health Protection Strategy 2017 - 2021

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1 Purpose

1.1 The Draft Health Protection Strategy 2017 - 2021 sets out the partnership approach, specific aims and seven priorities for Health Protection across Coventry and Warwickshire for 2017-2021. The strategy supports the local authority statutory duty to "ensure there are plans in place to protect the health of the population" as defined in the Health and Social Care Act 2012.

2 Recommendations

2.1 That the Strategy be approved and adopted by the Health and Wellbeing Board.
2.2 That key areas of influence outlined in Section 3.2 are supported strategically by Health and Wellbeing Board Members, and are adopted formally by their respective organisations

3 Information/Background

3.1 The joint Strategy covers the areas of both Coventry and Warwickshire, with joint ambitions outlined. The Strategy outlines progress made on a number of priority areas identified in the Health Protection Strategy 2013 – 2015 (in Appendix 1) and the joint ambitions for the new Strategy are outlined in the "Strategy on a Page" at the beginning of the document. The seven priorities identified in the Strategy are listed below, with a summary of the specific local focus being taken for Coventry, based on needs identified:

- *Air Quality* – the whole of Coventry is an Air Quality Management Area, and the newly established Coventry and Warwickshire Air Quality Alliance of officers from Transport, Planning, Environmental Health, Public Health and Public Health England are developing a work programme focusing on how best to improve air quality.

- *TB* – Although TB incidence has been reducing nationally and locally since 2010, the complexity of the medical and social needs of patients has increased. A new latent TB case-finding programme has also been established in Coventry/Rugby through GP practices and the Coventry Refugee and Migrant Centre.

- *Viral Hepatitis (B, C)* – Coventry has the highest incidence of Hepatitis B and C in the West Midlands and work to understand this, and expand the work currently

being carried out on this agenda is proposed, with particular reference to sexual health and drug and alcohol service users, as well as migrants from high incidence countries

- *Screening and Immunisations* – Childhood immunisation uptake remains good in Coventry. However, work is planned to address lower uptake observed among Looked after Children. Further work is also planned to consider how to address lower than optimal coverage of adult screening programmes.

- *Infection Control* – An independent infection control review has recently been conducted in health and care settings across Coventry and Warwickshire. Implementation of the recommendations of this review will be the focus of this Strategy, with a particular emphasis for Coventry on establishing robust root cause analysis processes for healthcare acquired infections that occur in the community, alongside development of an Antimicrobial Resistance strategy for the sub-region.

- *Emergency Planning* – The focus here will be on Pandemic Flu planning, furthering work that has already taken place, and ensuring multi-agency pandemic flu plans are in place and tested.

- *Excess Winter Deaths* – Reducing numbers and proportions of households in fuel poverty, alongside increasing seasonal flu uptake in all risk groups will be prioritised through actions to address this element of the proposed strategy

3.2 Within Coventry we would specifically ask Health and Wellbeing Board members to support the following objectives:

- Increasing uptake of flu vaccinations for health and social care staff who provide direct personal care, alongside promoting the role of frontline staff as important advocates for the vaccination programme for their own patients/service users

- Ensuring all frontline staff are aware of and referring vulnerable individuals to commissioned support and advice services related to affordable heating

- Working to improve air quality through championing active/sustainable travel strategies and programmes for their own organisations

- Supporting the development of a Coventry and Warwickshire-wide Anti-Microbial Resistance strategy, building on good work that is already being undertaken.

3.3 Progress against the Strategy will be monitored by the Health Protection Committee and reported (as required) annually to the Health and Wellbeing Board. The Health Protection Committee is a formal sub-committee of the Health and Wellbeing Board, consisting of partners from Public Health England, CCGs (Infection Control), Environmental Health, NHS England (Screening and Immunisation Teams), as well as Public Health. Action plans and work-streams/partnership boards (both formal and informal) are currently in place/will be developed for each of the seven priority areas.

4 Options Considered and Recommended Proposal

4.1 Local population Health Protection needs have been assessed to develop the current Strategy document being proposed for approval by the Board. The strategic aims and priorities have also importantly been aligned to those of member organisations of the Health Protection Committee

Report Author(s):

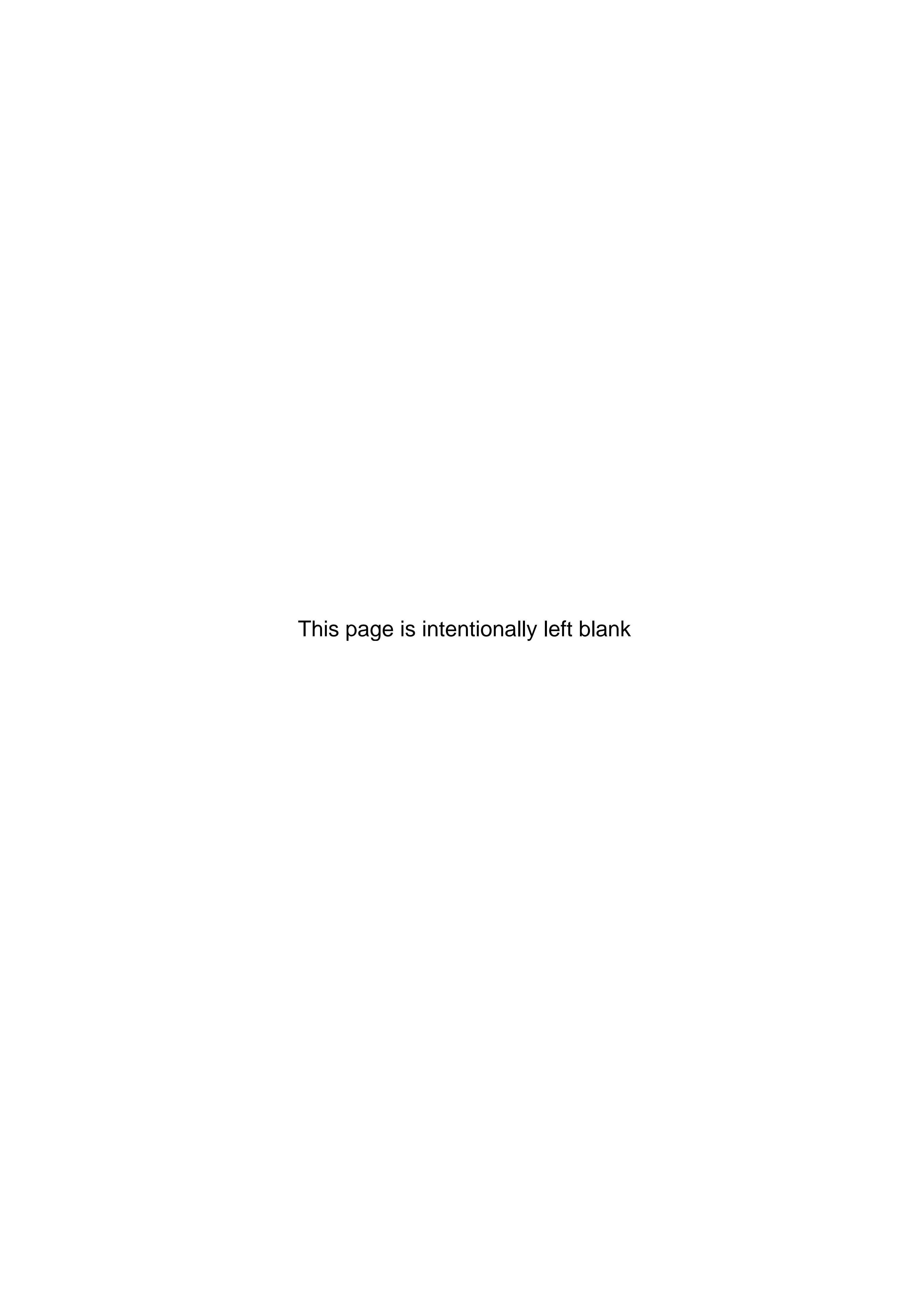
Name and Job Title:
Rachel Hawthorne, Health Protection Officer
Nadia Inglis, Consultant in Public Health

Directorate: People

Telephone and E-mail Contact:
nadiainglis@warwickshire.gov.uk
Tel: 07980501941

Enquiries should be directed to the above person.

Appendices
Appendix A: Draft Health Protection Strategy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Coventry and Warwickshire **Health Protection Strategy**

2017 - 2021

RUGBY

Protecting and improving the nation's health

Coventry City Council

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Members of the Working Group and Contributors

Mamoona Tahir - Consultant in Communicable Disease Control, Public Health England

Michael Enderby - Head of CSW Resilience

David Burrows - Regulatory Services Manager Rugby Borough Council

Stephen Whiles - Head of Environmental Services, North Warwickshire Borough Council

Steve Moore – Head of Environmental Services, Nuneaton and Bedworth Borough Council

Michael Jenkins – Environmental Protection, Warwick District Council

Geoff Turton – Head of Environmental Services, Stratford District Council

Sharon Stuart - Infection Control Lead, South Warwickshire CCG

Michelle Gorrell - Infection Control Lead, Coventry Rugby CCG

Ash Banerjee - Consultant Screening and Immunisation Lead, Public Health England

Nina Morton – Screening Manager, Public Health England

Debbie Crisp - Lead TB Nurse, Coventry and Warwickshire TB Service

Rach Hawthorne - Health Protection Officer

Joanna MacIver – Specialty Registrar in Public Health

John Linnane - Director of Public Health Warwickshire County Council

Nadia Inglis - Consultant in Public Health Warwickshire County Council/Coventry City Council

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Health Protection Strategy 2017-2021 Plan on a Page

Priority Area	Vision	Measures of success	What the Strategy will Deliver
Air Quality	To reduce the concentration of air pollutants which have a negative impact on health, with a focus on areas of poorest air quality	↓Concentrations of N02 and PM 2.5 ↓Use of cars for short journeys ↑Development of Cycleways and use of cycle ways	•Practical solutions to promote behaviour shifts and initiatives that reduce car journeys and promote physical activity, including in school and workplace environments •More 'active' travel infrastructure solutions with increased cycle ways, and improved public transport infrastructure •Evidence of designing in health through planning processes •Exploration of wider opportunities for improving fleet vehicles, and green procurement. opportunities
TB	To improve prompt diagnosis of suspected TB, maintain high treatment completion rates, and establish a latent TB case finding programme	↓Time between onset of symptoms and diagnosis ↑Treatment completion rates ↑Diagnosis and treatment of latent TB in new entrants from high incidence countries	•Raise TB awareness among professionals and high-risk communities to improve knowledge and early diagnosis in underserved groups. • Increase prompt diagnosis and treatment: All patients to commence treatment within 2 days of suspected diagnosis, with suspected infectious cases seen in clinic within 2 weeks •Screening of New Entrants: a nurse led Latent TB Screening programme is being established and will target people within Coventry and Rugby CCG catchment area who are new entrants from high incidence countries. •Effective management of both hospital and community incidents with outcomes and learning shared appropriately.
Hepatitis B/C	To develop clear and agreed pathways for testing of those at risk, high quality treatment for those diagnosed, and the public health management of contacts	Agreed commissioning policy re Hepatitis B/C testing in community NICE recommendations re Hepatitis B/C treatment in Acute contracts Agreed commissioning policy for screening of contacts	•Reduce the spread of Hepatitis B/C through appropriate targeted testing and screening and engagement with treatment •Increase uptake of appropriate Hepatitis B vaccinations for individuals in high risk groups and contacts of cases. •Support commissioned Sexual Health and Drug and Alcohol service providers in Coventry and Warwickshire to increase appropriate identification, treatment and vaccination within their service area. •Embed NICE Guidance into future commissioning planning and service specifications for treatment and care of individuals with Hepatitis B/C
Screening and Immunisations	To maintain/increase uptake in all screening/immunisation programmes, with a focus on groups with low uptake, and service-related disparities in uptake	Maintain or increase uptake in all screening and immunation programmes, with a focus on groups with low uptake	•Maintain or increase (as appropriate) uptake across all screening and vaccination programmes •Effectively targeting underserved/'harder to reach' groups or those programmes with lower levels to increase specific engagement and uptake. •Work with commissioners and services supporting Looked After Children to increase uptake of routine immunisations
Infection Control	To reduce the incidence and duration of outbreaks in health and care settings, and develop and deliver a system-wide Antimicrobial resistance strategy	↓incidence of outbreaks in health and care settings ↓duration of outbreaks in health and care settings	•Work to reduce both the incidence and duration of outbreaks in health and care settings, and ensure when these do occur, reflective learning drives service change and good practice is shared. •Embed a 'Champions' model in all care homes so all staff are trained and confident in preventing infections •Develop and embed an Antimicrobial Strategy to sit alongside this overarching strategy •Standardise the Root Cause Analysis approach for all C. difficile infection cases (caused by a number of things including inappropriate antibiotic prescribing).
Emergency Planning	To develop a comprehensive system-wide pandemic flu plan, and focus on continuous improvement in outbreak planning arrangements	NHS and LA/LRF pandemic flu plans in place and tested	•Development of comprehensive system-wide pandemic flu plan(s) that focus on continuous improvement in outbreak planning arrangements, at both strategic and operational levels, including NHS, Local Authority and Local Resilience Forum Plans.
Excess Winter Deaths and Health Effects of Cold Weather	To minimise excess winter deaths and morbidity through collective preventative action on key drivers of cold-related ill-health	↓Number of households in fuel poverty ↓Flu-related hospital admissions and deaths ↑Seasonal Flu vaccination uptake among risk groups	•Reduce the number of homes experiencing fuel poverty through increasing referrals to commissioned services that offer advice/support and physical interventions, including 'affordable warmth on prescription' services to vulnerable, eligible households. •Increase uptake of Flu vaccinations in eligible groups through annual campaigns, and engaging with frontline staff to recommend flu vaccinations •Explore multi agency commissioning opportunities to look at widening out affordable warmth initiatives •Ensure an ongoing collaborative approach to planning for cold weather across health and care services

Health Protection Strategy 2017 - 2021 – Local Focus		
Priority	Focus in Coventry	Focus in Warwickshire
Air Quality	City-wide Air Quality management required	Urban Areas
TB	Establishing Latent TB Case-finding programme and strengthening partnerships for managing patients with complex medical and social needs	Focus on education of health professionals regarding epidemiology of TB in Warwickshire, when to “think TB”, as well as maintaining excellent treatment completion rates
Hepatitis B/C	Understanding and tackling reasons for high incidence of Hepatitis B/C in Coventry	Ensuring whole pathway of care – from screening/testing to treatment is evidence-based and working well.
Screening and Immunisations	Focus on adult screening programmes (lower uptake than national), and immunisation uptake in Looked after Children	Focus on maintaining overall good immunisation and screening uptake, identifying geographical areas/particular groups where uptake is lower
Infection Control	Establishing Root Cause Analysis for healthcare acquired infections in the Community, and development of an Antimicrobial Resistance Strategy for the sub-region	Particular focus on infection control and outbreaks in health and care settings, and an Antimicrobial Resistance Strategy for the sub-region
Emergency Planning	Ensuring multi-agency pandemic flu plans are in place and tested.	Focus on access to treatment/prevention services (e.g. antivirals, vaccinations) during a pandemic, especially in rural areas
Excess Winter Deaths	Reducing numbers and proportions of households in fuel poverty, and increasing uptake of seasonal flu vaccinations across all risk groups	Reducing numbers and proportions of households in fuel poverty, with a focus on ensuring support services are accessible to rural populations. Increasing seasonal flu vaccination uptake across all risk groups, particularly in North of the County

Introduction

Background

This strategy sets out the partnership approach and specific aims and priorities for Health Protection across Coventry and Warwickshire for 2017-2021.

Health Protection is concerned with ensuring the health and wellbeing of the Coventry and Warwickshire populations. It uses population-wide surveillance and interventions to prevent disease and provide protection from a range of potential hazards and harms. To achieve this, a multi-agency approach is required.

Purpose and Priorities

The purpose of developing this strategy, which builds on work outlined in the previous 2013 - 2015 strategy document, is to produce a shared and integrated 5-year vision for Health Protection for the population of Coventry and Warwickshire. A summary of progress made since the 2013-15 strategy was implemented is outlined in Appendix 1.

The Health and Social Care Act 2012 proposed new duties and responsibilities for both the NHS and Local Authorities, creating a range of new organisations, each with a number of health protection responsibilities. It placed the responsibility for system-wide health protection assurance with Directors of Public Health, to ensure appropriate oversight and challenge in the system for the effective planning and delivery of health protection programmes.

Coventry and Warwickshire have well-established and effective relationships and a long history of collaborative working to deliver health protection functions. However, we are confronted with new and evolving challenges to population health; emerging epidemics and drug resistance; changing environments and demographics, and the ongoing risk of chemical and biological incidents. This clearly demands an ongoing robust health protection response.

This strategy is structured around the shared priorities and aims of the multi-agency membership of the Coventry and Warwickshire Health Protection Committee.

The collective role of the Health Protection Committee is to provide assurance on behalf of the population of Coventry and Warwickshire that there are safe and effective plans in place to protect local population health. This includes communicable disease control, infection prevention and control, emergency planning, environmental health, and screening and immunisation programmes. The Committee therefore takes a strategic lead for Health Protection, provides a professional forum for discussion/collaboration, ensures plans are tested, reviews risks and outbreaks as appropriate, and seeks assurance that quality improvements and incident 'lessons learnt' are embedded in practice.

The identified priorities, as set out below, have been agreed by the Committee, as well as being aligned to regional/national health protection priorities. It is the responsibility of Health

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Protection Committee members to monitor progress against the strategy and underpinning action plans delegated to specialist working groups/teams.
The overarching aims of the Committee with regard to supporting the strategy are to guide the collective work of partners on the priorities, monitor progress against actions and be a vehicle to discharge statutory Public Health obligations required through the Health and Social Care Act 2012.

The Priorities identified for 2017 – 2021 are:

- Air Quality
- Tuberculosis
- Viral Hepatitis
- Population Screening and Immunisation Programmes
- Infection Control
- Emergency Planning
- Excess Winter Deaths

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Who is the strategy for?

Coventry and Warwickshire residents, Local Health and Wellbeing Boards, Executive Teams of City, County, District and Borough Councils, local NHS organisations, Clinical Commissioning Groups, voluntary sector partner organisations and Public Health England in the West Midlands.

This strategy has links with other key local strategies such as the Joint Strategic Needs Assessments (JSNA), and Health and Wellbeing Strategies. It also links to and compliments a range of specific strategies underpinning the work of local partners and members of the Committee.

Implementation

The implementation of this strategy will be carried out jointly by partner organisations, and implementation groups and Boards which already exist (or will be convened in the future), e.g. the Coventry & Warwickshire TB Programme Board, Coventry and Warwickshire Hepatitis Strategic Group, Coventry and Warwickshire Air Quality Alliance, Warm and Well in Warwickshire and Keeping Coventry Warm Programme boards/operational groups.

Air Quality

Why is this important?

Poor air quality, both indoor (such as second hand smoke) and outdoor, can lead to significant adverse health effects. Our focus in this strategy is on outdoor air pollution, which has been linked to cancer, asthma/respiratory disease, strokes, and heart disease. Older people, those with existing long term conditions and children are more vulnerable to the effects of living or working in areas of high pollution.[1] There is also emerging evidence of effects in pregnancy and childhood.[1]

It is estimated that the equivalent of 40,000 deaths per year in the UK are directly attributable to outdoor air pollution.

Air quality across the UK has been impacted by the modern pollutants associated with the rapid increase in transport infrastructures, increased freight journeys and personal vehicle use/ownership. Nitrogen Dioxide (NO_2) and particulate matter PM_{10} and $PM_{2.5}$ are specific areas for concern.[2]

What does the data tell us?

Figure 1 shows that in Warwickshire, there has been a reduction in measured NO_2 concentrations from 2009-11 to 2012-14 across 15 of 17 monitoring sites (selected on the basis of showing the worst measured pollutant levels across the county), with half of the monitoring stations reporting levels below the annual mean objective. Please note the monitoring sites presented in Figure 1 are 17 (9%) of a total of 180 monitoring sites across the County. The remaining sites show lower measured levels of pollutants. It should be noted that the increasing trend shown for one of the roadside[3] monitoring sites in Nuneaton and Bedworth (34, Old Hinckley Rd, Nuneaton) is likely due to a high reading in 2012 attributed to the presence of roadworks. NO_2 concentrations have declined since 2012.

[1] https://www.rcplondon.ac.uk/projects/outputs/every-breath-we-take-lifelong-impact-air-pollution

[2] https://www.gov.uk/government/collections/comeap-reports

[3] NB This is not a receptor location.

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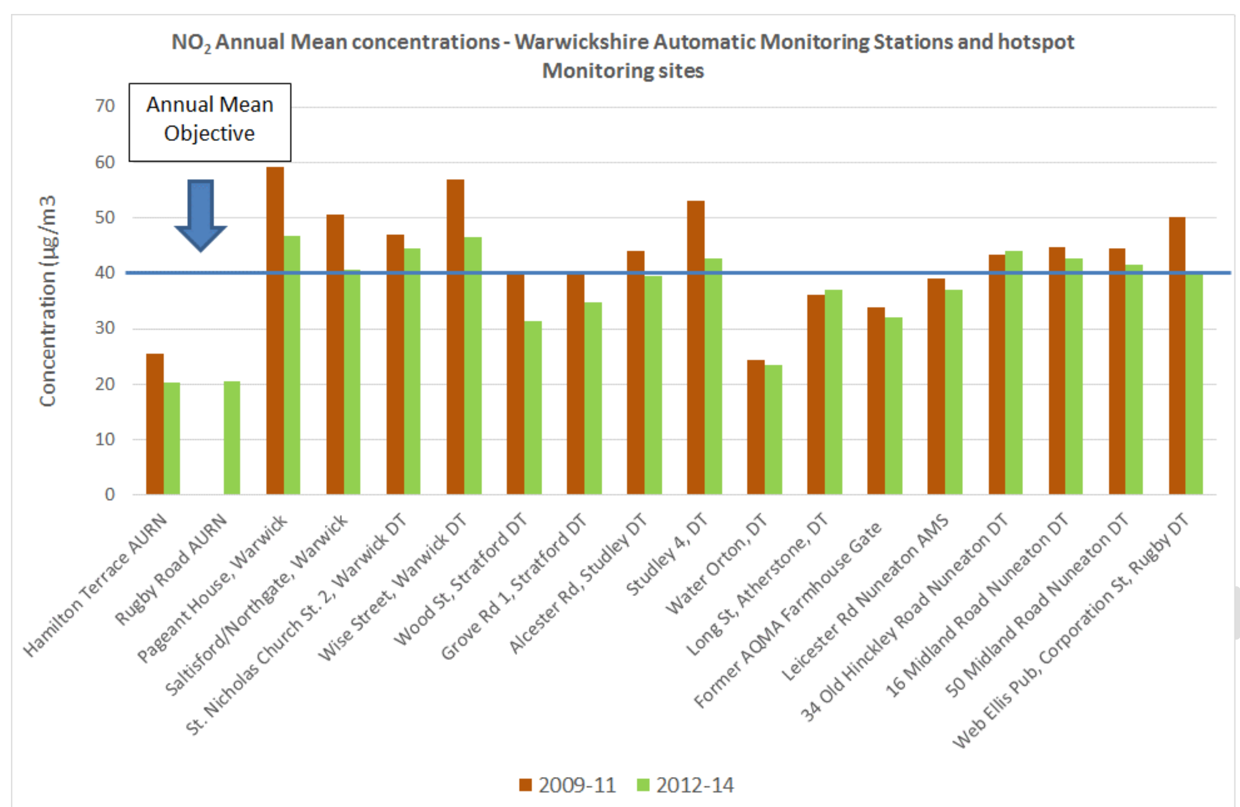
*Figure 1. NO_2 annual mean concentrations Warwickshire 2009-11 and 2012-14**



Source: Updating and Screening Assessment Reports, 2015

*All sites are roadside locations with the exception of Hamilton Terrace (urban background) and Long St. Atherstone (kerbside location).

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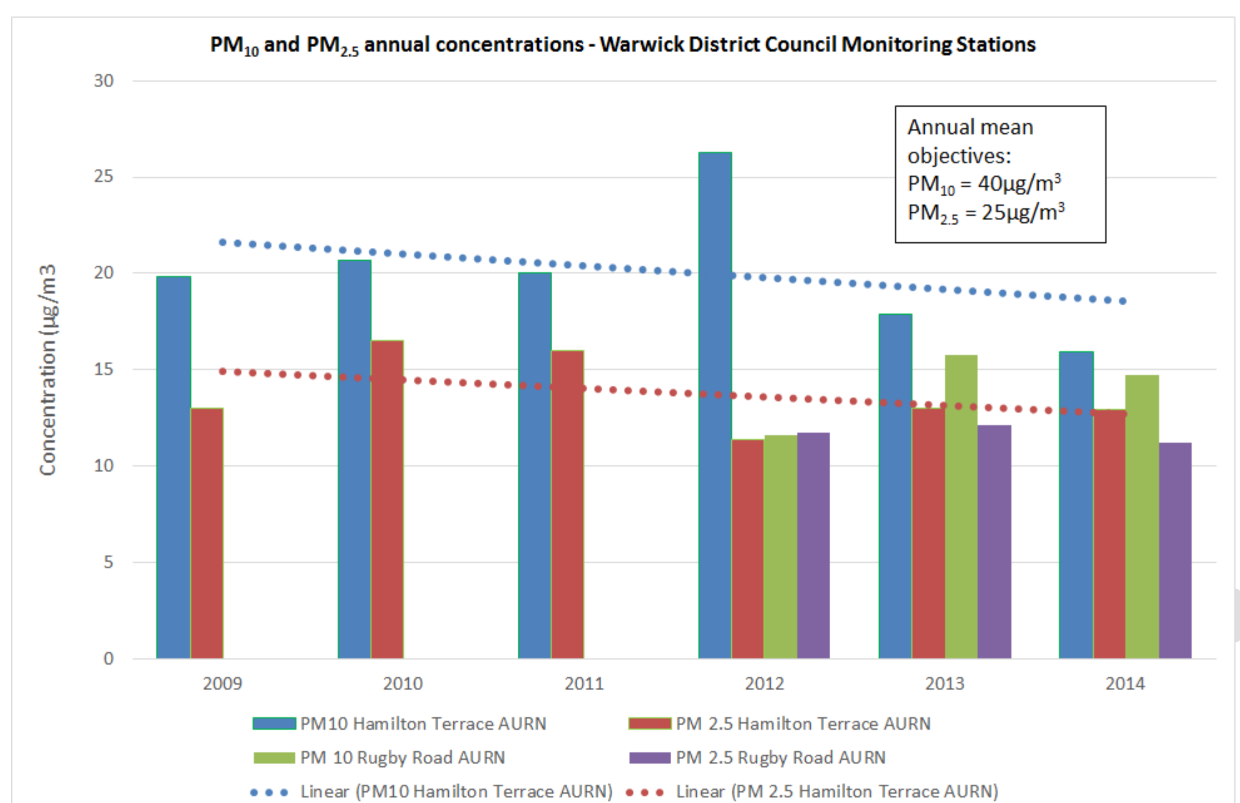
In Warwick district, there has emerged an overall trend towards a reduction in both PM_{10} and $PM_{2.5}$ at Hamilton Terrace automatic monitoring station between 2009 and 2014 (Figure 2).

*Figure 2. PM_{10} and $PM_{2.5}$ annual concentrations Warwick**



Source: Updating and Screening Assessment Reports, 2015

*All sites are roadside locations with the exception of Hamilton Terrace (urban background)

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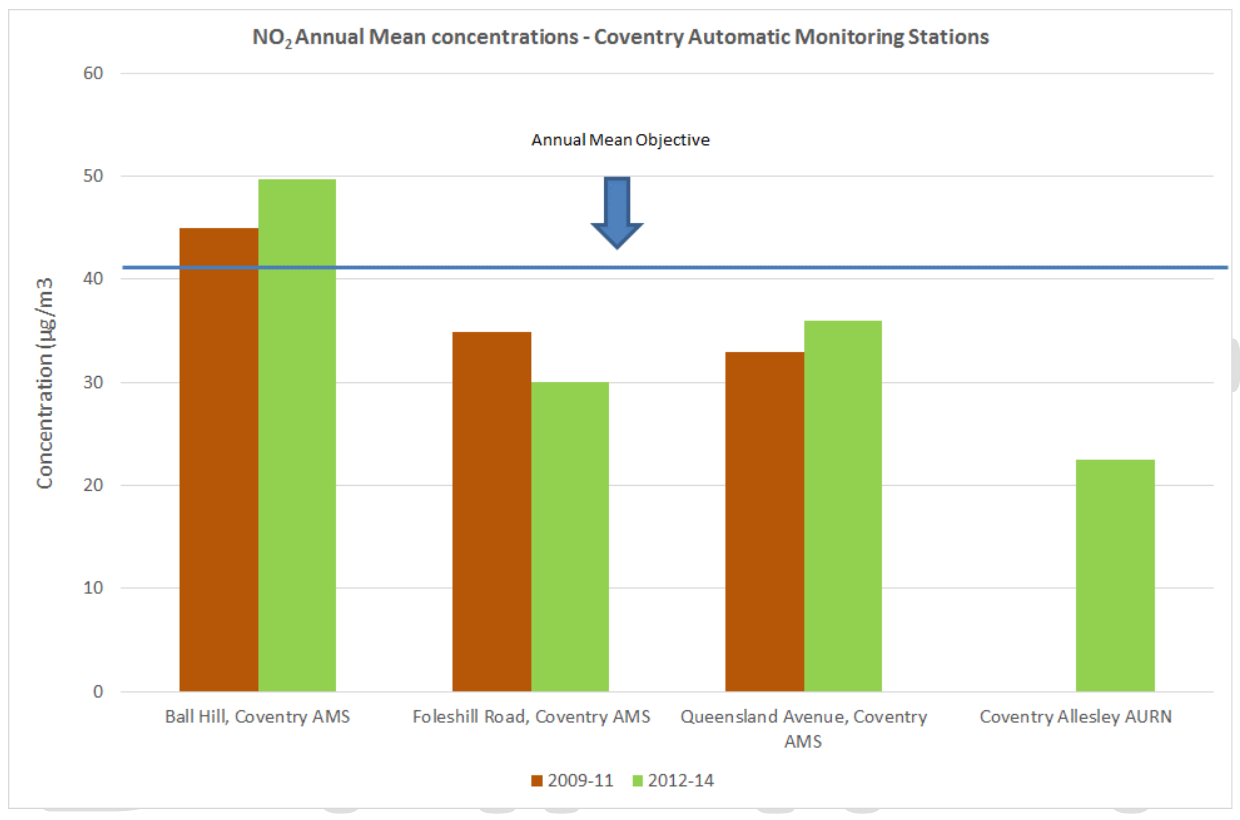
Figure 3 shows that in Coventry, 3 out of 4 automatic monitoring stations have shown NO_2 levels below the annual mean objective concentration, although in 2 of the 3 stations where data is available from both 2009-11 and 2012-14, an increase is seen between these time periods.

Figure 3. NO_2 annual mean concentrations Coventry 2009-11 and 2012-14*

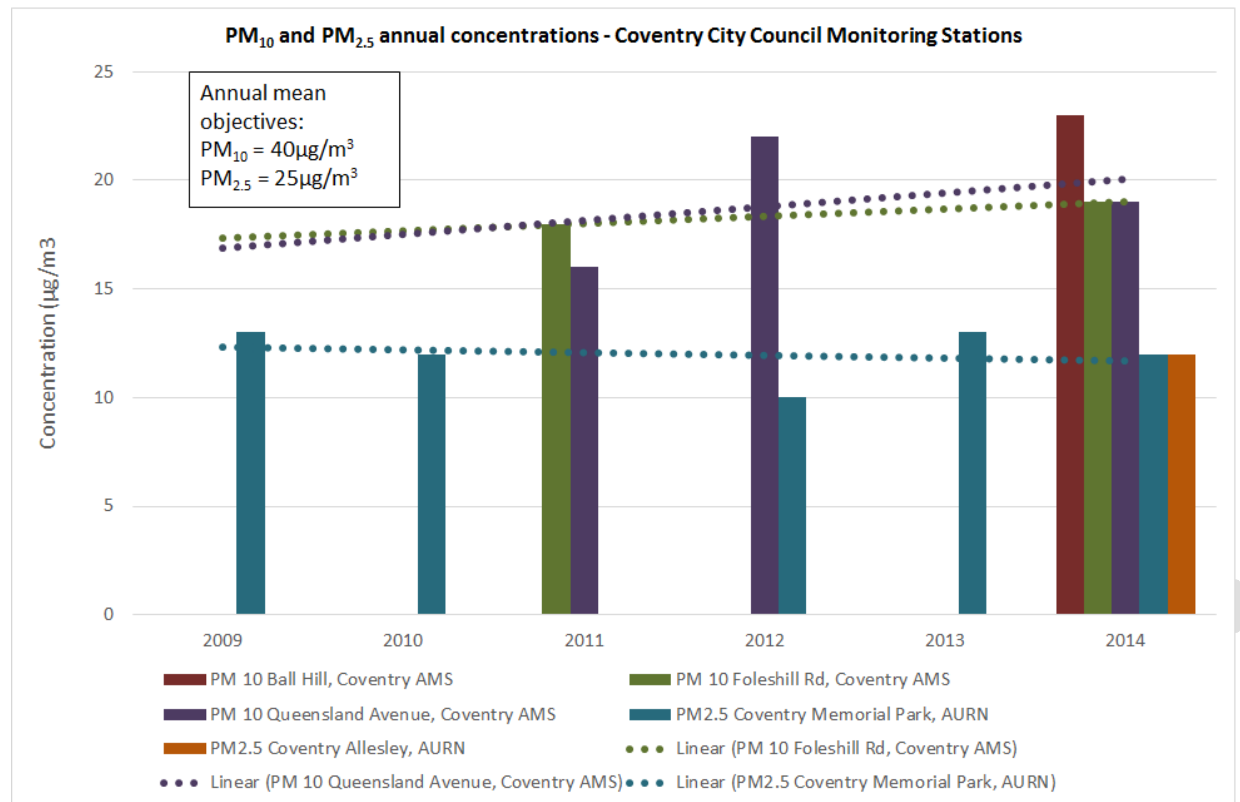


Source: Updating and Screening Assessment Reports, 2015

*All sites are roadside locations with the exception of the Allesley AURN (urban background)

In Coventry, there has been a small reduction in $PM_{2.5}$ annual concentrations at Memorial Park from 2009 to 2014, although there has been an increase in PM_{10} annual concentrations at Queensland Avenue and Foleshill Road between 2011 and 2014 (Figure 4). Please note that the only remaining monitoring station presented below is at Allesley. There is a further automatic monitoring station which will soon also be operational at Gosford Green. Non-automatic monitoring (with diffusion tubes) also continues across the City.

Figure 4. PM_{10} and $PM_{2.5}$ annual concentrations Coventry



Source: Updating and Screening Assessment Reports, 2015

*All sites are roadside locations with the exception of the Allesley and Memorial Park AURNs (urban background)

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What will the strategy deliver?

- **Practical solutions to promote behaviour shifts** and initiatives that reduce car journeys and promote physical activity, including in school and workplace environments.
- **More 'active' travel infrastructure solutions** with increased cycle ways, and improved public transport infrastructure.
- **Evidence of designing in health through planning** processes.
- **Exploration of wider opportunities** for improving fleet vehicles, and green procurement opportunities.

Tuberculosis

Why is this important?

Tuberculosis (TB) is an infectious disease commonly affecting the lungs, but which can involve any part of the body. It is usually spread by the cough of an infected person. Prolonged close contact with a person with active TB, for example living in the same household, is usually necessary for infection to be passed on. However, it may take many years before someone infected with TB develops the disease, this is known as latent TB.

Active TB requires a minimum of 6 months treatment, with drug resistant TB costing much more in terms of treatment, hospitalisation and complex social care needs.

Nationally, the rates of active TB have shown increases since the mid-1980s, but since 2010 the incidence has decreased, partly due to reduced migration into the UK from high incidence countries. This trend has been mirrored locally across Coventry and Warwickshire. However, the complexity of cases and incidents has increased locally.

The National Collaborative Tuberculosis Strategy for England 2015 - 2020[4] was launched in 2015 proposing key areas for action. One of these relates to establishing Latent TB case finding programmes, which is one of the four areas for action locally identified by the Coventry and Warwickshire TB programme board, and mirrored in the strategy priorities for TB highlighted below.

What does the data tell us?

Figure 5 shows that rates of TB in Warwickshire have remained fairly steady over time with around 5-10 per 100,000 population since 2002. Rates in Coventry have been higher, although there has been a reduction in rates from 2012 to 2015.

[4] https://www.gov.uk/government/publications/collaborative-tuberculosis-strategy-for-england

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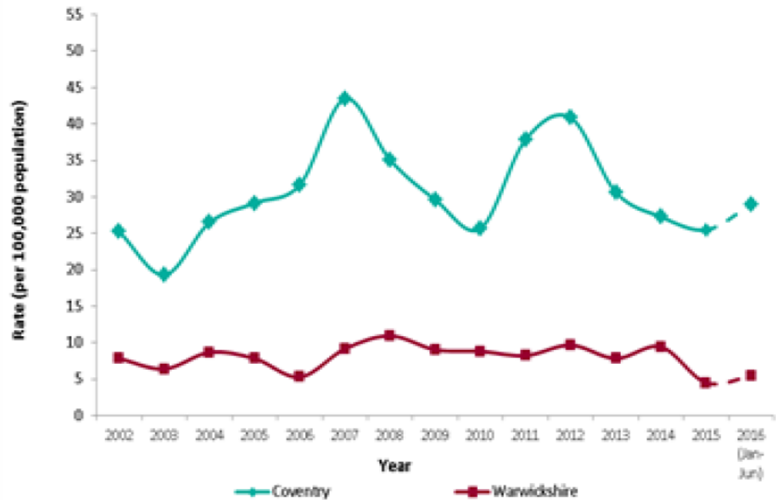
Figure 5. TB rates per 100,000 population in Coventry and Warwickshire 2002-2016



Source: PHE, Tuberculosis (TB) Quarterly Report West Midlands, Quarter 2, 2016

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There is variation in the rates of TB across Coventry and Warwickshire, as can be seen in Figures 6 and 7. In Coventry, the North and East of the city see more cases of TB, with Foleshill and St Michael's wards having the highest rates in the city. Across Warwickshire, the highest rates can be seen in areas of Rugby, Nuneaton and Bedworth and Leamington. Coventry and Rugby CCG has the third highest rate of TB amongst all CCGs across the West Midlands

Figure 6. Three year annual average TB incidence rate per 100,000 population Coventry 2012-2014

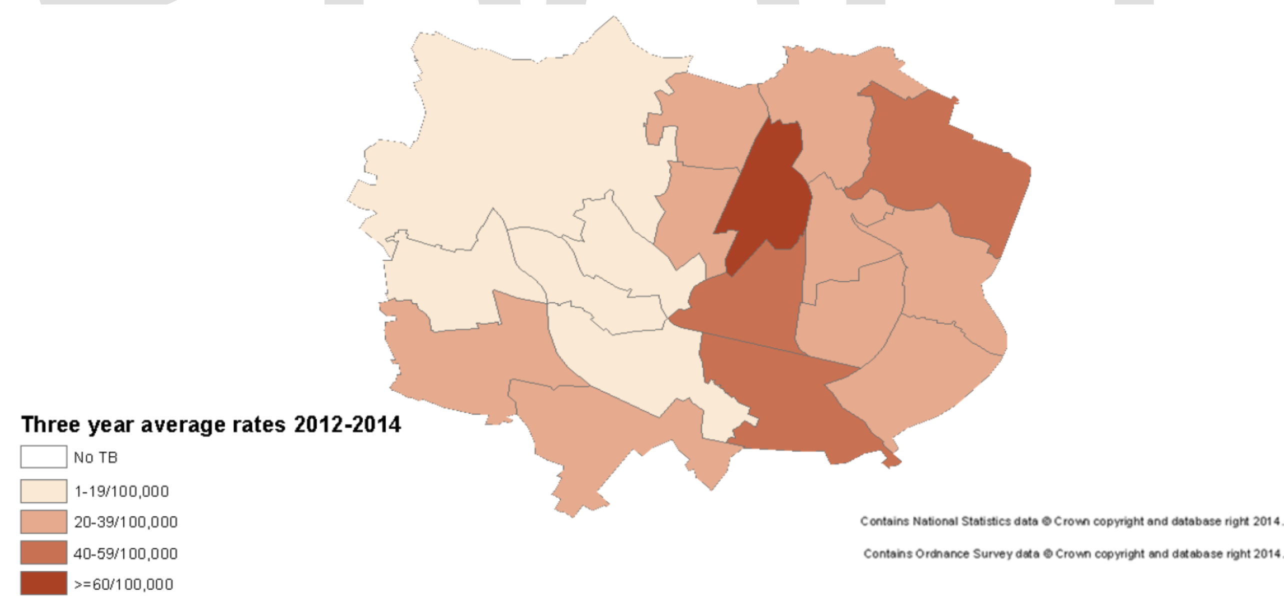
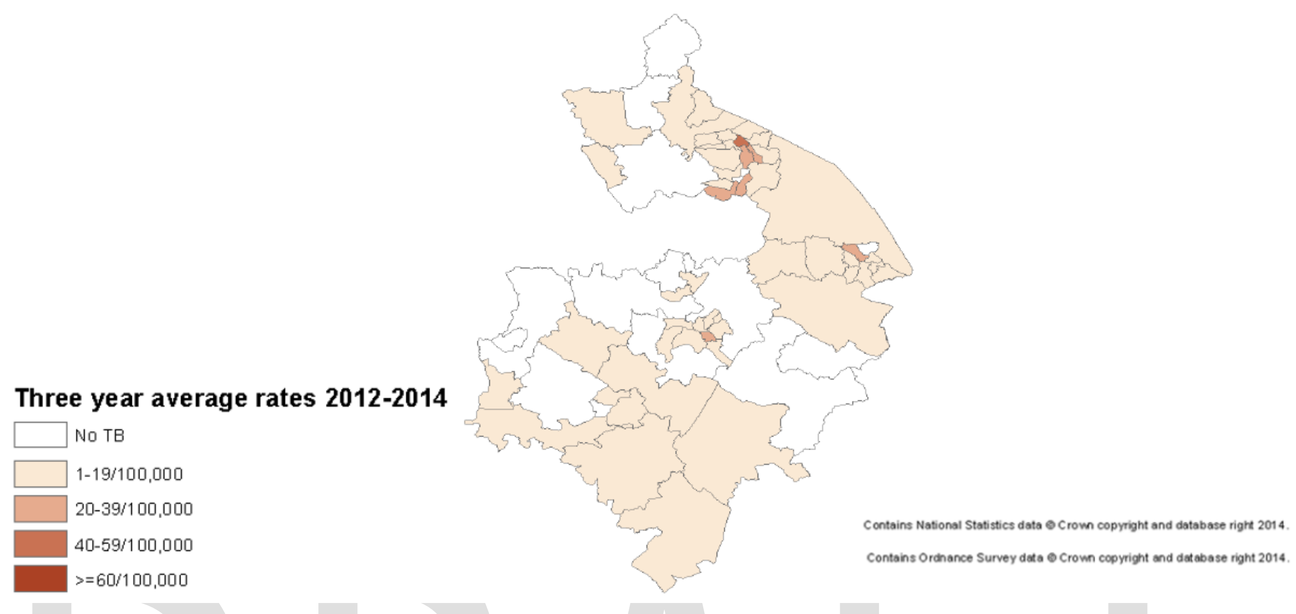


Figure 7. Three year annual average TB incidence rate per 100,000 population Warwickshire 2012-2014



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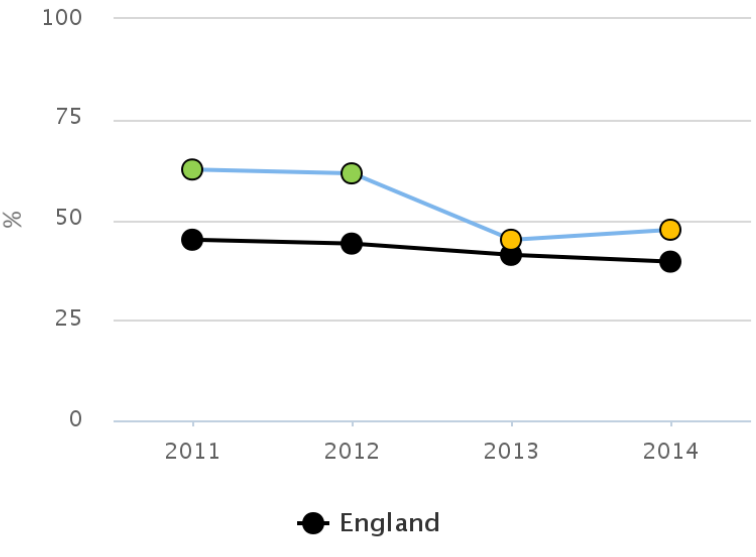
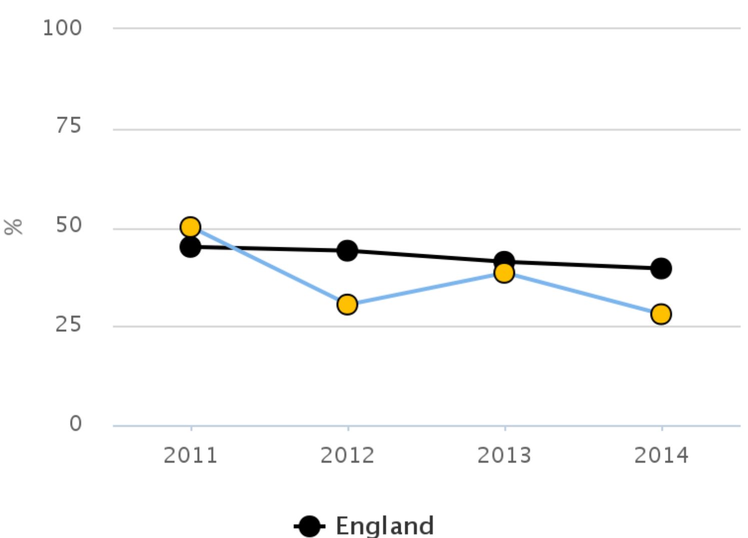
In Coventry, there is a higher proportion of pulmonary TB cases starting treatment within two months of symptom onset compared with the national average. The proportion in Warickshire has been similar to the national average. Figures 8 and 9 below show that in the latest figures for 2014, both areas show no significant difference compared to the national average.

Figure 8. Proportion of pulmonary TB cases starting treatment within two months of symptom onset Coventry 2011-2014



Source: Enhanced Tuberculosis Surveillance system (ETS)

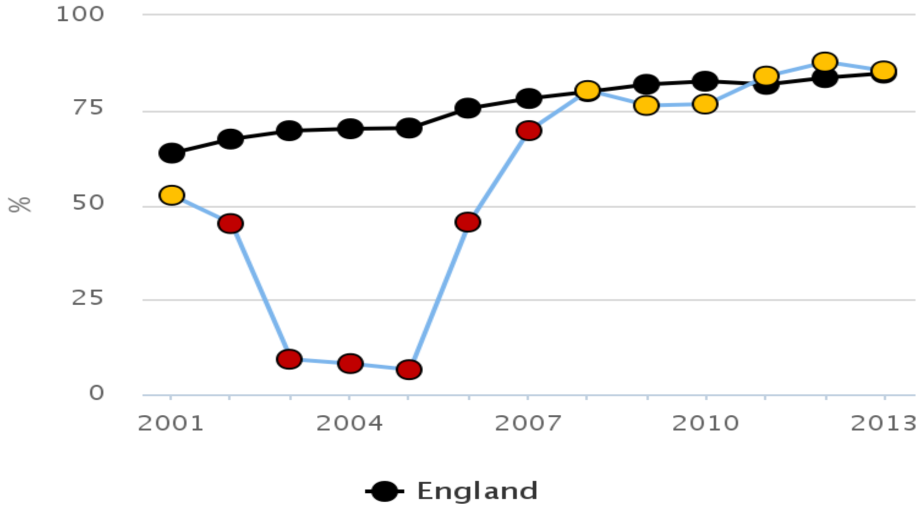
Figure 9. Proportion of pulmonary TB cases starting treatment within two months of symptom onset Warwickshire 2011-2014



Source: Enhanced Tuberculosis Surveillance system (ETS)

Figures 10 and 11 below show that since 2008, both Coventry and Warwickshire have seen similar rates of treatment completion for drug sensitive TB within 12 months compared to the national average, with an overall increase in treatment completion over time.

Figure 10. Proportion of drug sensitive TB cases who had completed a full course of treatment by 12 months Coventry 2001-2013



Source: Enhanced Tuberculosis Surveillance system (ETS)

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Figure 11. Proportion of drug sensitive TB cases who had completed a full course of treatment by 12 months Warwickshire 2001-2013

Source: Enhanced Tuberculosis Surveillance system (ETS)

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What will the strategy deliver?

- **Raise TB awareness** among professionals and high-risk communities to improve knowledge and early diagnosis in under-served groups.

- **Increase prompt diagnosis and treatment**: All patients to commence treatment within 2 days of suspected diagnosis, with suspected infectious cases seen in clinic within 2 weeks.

- **Screening of new entrants**: a nurse led Latent TB Screening programme is being established and will target people within Coventry and Rugby CCG catchment area who are new entrants from high incidence countries.

- **Effective management of both hospital and community incidents** with outcomes and learning shared appropriately.

Viral Hepatitis (Hepatitis B and Hepatitis C)

Why is this important?

Hepatitis B virus (HBV) and Hepatitis C virus (HCV) are both blood borne viruses which cause liver infection. Both viruses are spread by contact with blood or body fluids from an infected person, with HBV being more infectious than HCV. Many people who carry the viruses are unaware of this and can therefore spread the infection without knowing. Untreated Hepatitis infection can lead to cirrhosis and liver cancer. In the UK, the commonest risk factor for acute cases of HBV is transmission via unprotected sex, followed by injected drug use (IDU). In contrast, more than 90% of all newly diagnosed HCV infections for which the source of infection is reported, are acquired via IDU. Other groups at increased risk of infection include individuals originating from countries where the prevalence of Hepatitis B and C is high (such as South Asia and Africa). It should be noted that Hepatitis B is preventable by vaccination and both Hepatitis B and C are notifiable diseases.

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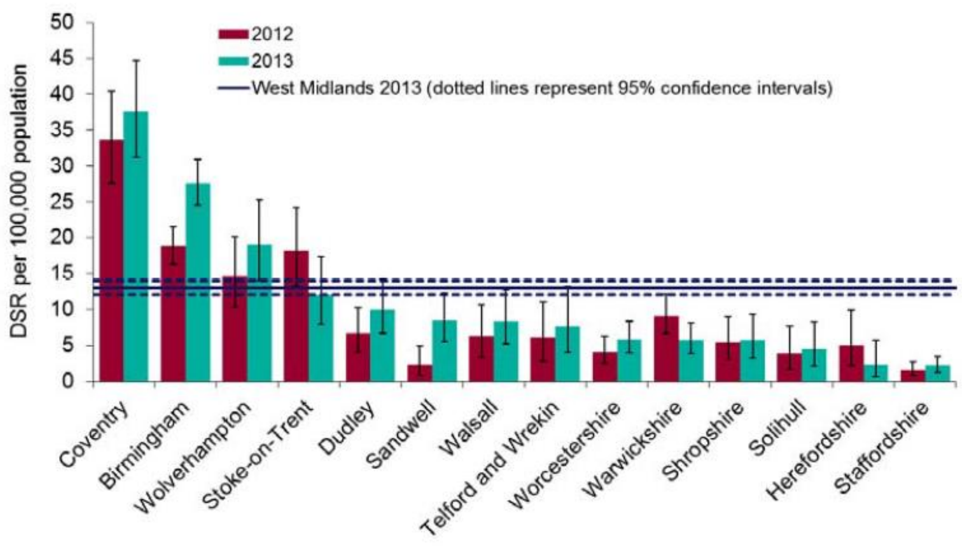
What does the data tell us?

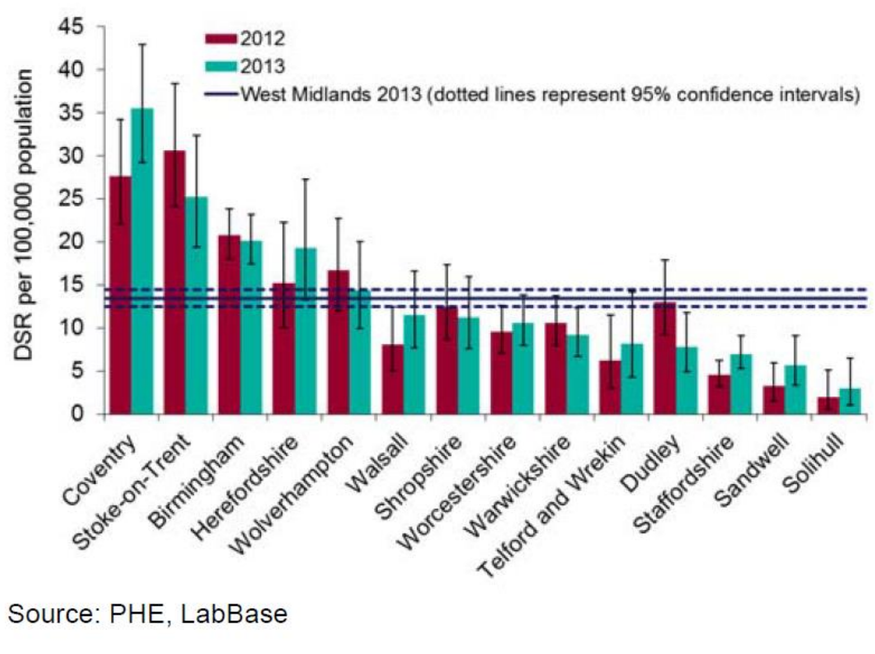
Standardised rates of Hepatitis B and C are shown in Figures 12 and 13 below. Rates in Coventry in 2012 and 2013 were both well above the West Midlands average, whilst rates in Warwickshire fall below the West Midlands average.

Figure 12. Laboratory reports of Hepatitis B (acute and chronic), directly standardised rate per 100,000 population, 2012 and 2013



Source: PHE LabBase

Figure 13. Directly standardised rate of laboratory reports of Hepatitis C per 100,000 population 2012 and 2013



Source: PHE, LabBase

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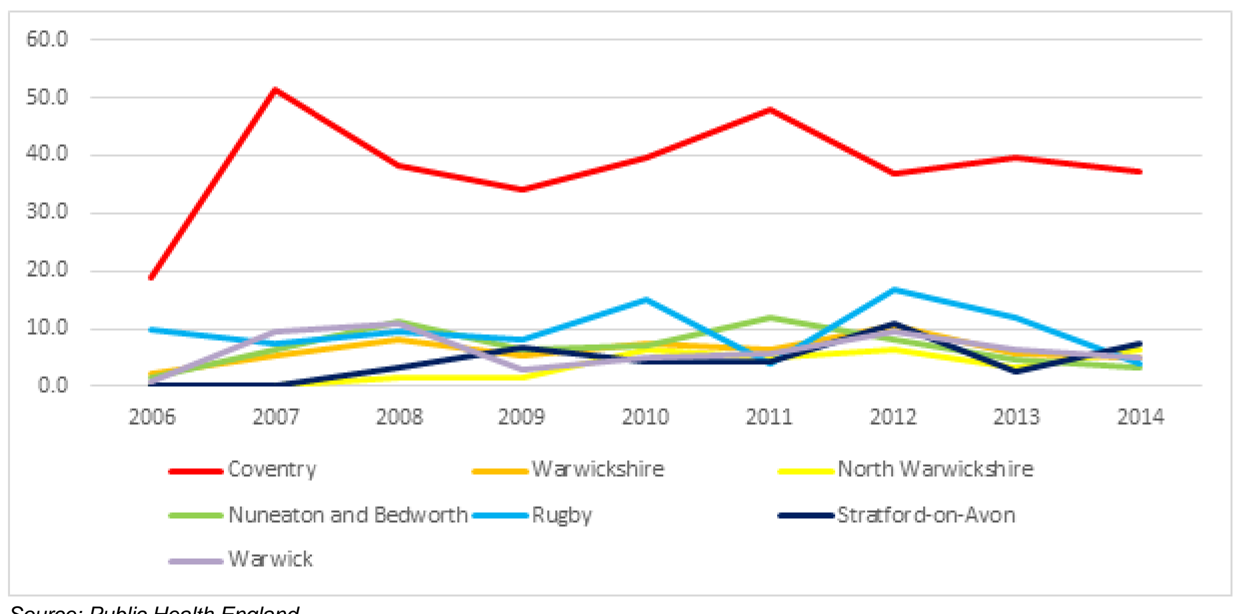
Figures 14 and 15 demonstrate the relatively stable rates of both Hepatitis B and C across the sub-region, with higher rates in Coventry compared with areas of Warwickshire. There has been a reduction in rates of Hepatitis C in Coventry since 2010.

Figure 14. Laboratory reports of Hepatitis B (acute and chronic) per 100,000 population by local authority of residence, Coventry and Warwickshire, 2006-2014



Source: Public Health England

Figure 15. Laboratory reports of Hepatitis C per 100,000 population by local authority of residence, Coventry and Warwickshire, 2006-2014

Source: Public Health England

In sexual health services in Warwickshire in 2015/16, 1332 individuals were screened for Hepatitis B/C, with 3 testing positive for Hepatitis B, and 3 for Hepatitis C. 119 individuals had their first dose of Hepatitis B vaccination in 2015/16. In Coventry sexual health services, 3298 individuals were screened for Hepatitis B and C in 2015/16, with 11 testing positive for Hepatitis B and/or C. 693 individuals were given a full course of Hep B vaccination and 498 a partial course during the year.

Figures 16 and 17 show testing, positivity and vaccination rates in Drug and Alcohol Services.

Figure 16. Uptake of Hepatitis B vaccination and positivity rates among Drug and Alcohol Priority Service Users (i.e. those with previous or current intravenous needle usage in structured support) (April 2015 - March 2016)

	Coventry ***Number (%)***	**Warwickshire** ***Number (%)***
No. of Priority Service Users	201	243
Offered Hep B vaccination	118 (59%)	125 (51%)
Completed full course	7 (6% of those offered)	9 (7% of those offered)
Tested positive for Hepatitis B	2 (1% of priority service users)	0 (0% of priority service users)

Source: The Recovery Partnership, Coventry and Warwickshire

In Coventry, the number of priority service users offered Hepatitis B vaccination has been steadily increasing over the past 3 years, with 59% of service users offered vaccination in 2015/16. For Warwickshire, this figure was slightly lower at 51%. Of those not offered vaccination, the majority are already immunised, or the vaccination was deemed inappropriate

due to compliance concerns. There are, however, low rates of completion of the vaccination course - 6% in Coventry and 7% in Warwickshire. Only 1% (2) of all priority service users in Coventry, and none of the priority service users in Warwickshire tested positive for Hepatitis B in 2015/16.

Figure 17. Uptake of Hepatitis C testing and positivity rates among Drug and Alcohol Priority Service Users (i.e. those with previous or current intravenous needle usage in structured support) (April 2015 -March 2016)

	Coventry *Number (%)*	Warwickshire *Number (%)*
No. of Priority Service Users	201	243
Offered Hep C testing	154 (77%)	175 (72%)
Tested	37 (24% of those offered)	69 (39% of those offered)
Tested positive for Hepatitis C	37 (18% of priority service users)	25 (10% of priority services users)

Source: The Recovery Partnership

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The number of priority service users offered Hepatitis C testing has remained steady in Coventry over the last 3 years, with some reduction in Warwickshire. 77% of priority services users were offered testing in Coventry and 72% in Warwickshire in 2015/16. The remaining were not offered testing due to concerns regarding compliance with treatment should they test positive. A higher proportion of priority service users who had been offered testing were tested in Warwickshire (40%) than in Coventry (24%). Of all priority service users, 18% were Hepatitis C positive in Coventry, and 10% were Hepatitis C positive in Warwickshire in 2015/16.

What will the strategy deliver?

- **Reduce the spread of Hepatitis B/C through appropriate targeted testing and screening and engagement with treatment.**

- **Increase uptake of appropriate Hepatitis B vaccinations** for individuals in high risk groups and contacts of cases.

- **Support commissioned Sexual Health and Drug and Alcohol service providers** in Coventry and Warwickshire to increase appropriate identification, treatment and vaccination within their service area.

- **Embed NICE guidance into future commissioning planning** and service specifications for treatment and care of individuals with Hepatitis B/C.

Population Screening and Immunisation Programmes

Why is this important?

Screening is the process of identifying health people who may be at increased risk of a disease or condition. The current UK population screening programmes include antenatal and newborn, as well as adult, screening programmes. They have an important role to play in population health by using a preventative model to identify individuals at higher risk of a health problem, offer them a diagnostic test which can lead to earlier diagnosis of disease, at a stage when treatment is more likely to be successful. This reduces costs to the NHS, and improves long term patient outcomes.

Robust quality assurance and initiatives to ensure good coverage are essential to ensure the effectiveness and safe operation of local screening programmes.

Worldwide vaccination and immunisation programmes have saved many lives and are the second most effective public health intervention after provision of clean water. It is important to emphasise the need to continue to achieve high uptake of vaccination in order to prevent the re-emergence of vaccine preventable diseases in our local communities. National evidence shows that inequalities in immunisation uptake persist.

Screening and immunisation programmes are currently commissioned by NHS England, with Public Health England providing oversight of the programmes. However, local authorities, and Directors of Public Health on their behalf, maintain the responsibility for health protection assurance, which includes that these programmes are working well.

Please note that Seasonal Flu vaccination programme is covered in the Excess Winter Deaths section.

What does the data tell us?

Adult Screening Programmes

Since 2010, breast cancer screening coverage has remained below the national average (75.4%) in Coventry (71.7%), and above the national average in Warwickshire (77.9%), although Warwickshire has shown a decline in rates since 2010 (from 79.3%). Rates in Stratford on Avon District are significantly higher than those in three of the four other Boroughs in Warwickshire, which are all above the England average.

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Figure 18. Breast cancer screening coverage (previous 3 years) for eligible women aged 53-70 years, West Midlands 2015

Area	Recent Trend	Count	Value
England	↓	4,327,589	75.4
West Midlands region	↓	458,009	76.0
Shropshire	↑	31,800	81.5
Worcestershire	↓	55,885	79.6
Telford and Wrekin	↑	14,364	78.6
Staffordshire	↓	80,180	78.5
Herefordshire	↓	18,424	78.2
Warwickshire	↓	49,697	77.9
Solihull	↓	18,729	76.8
Stoke-on-Trent	↑	19,471	76.5
Dudley	↓	25,877	76.0
Walsall	↑	20,542	75.7
Wolverhampton	↓	17,549	71.9
Coventry	→	20,773	71.7
Sandwell	↓	20,780	71.5
Birmingham	↓	63,938	69.6

Source: Health and Social Care Information Centre (Open Exeter)/Public Health England

Area	Count	Value
England	4,327,589	75.4
Warwickshire	49,697	77.9
Stratford-on-Avon	12,965	79.6
North Warwickshire	6,072	78.4
Nuneaton and Bedworth	11,030	77.7
Rugby	8,459	77.2
Warwick	11,171	76.6

Source: Health and Social Care Information Centre (Open Exeter)/Public Health England

Cervical screening coverage has declined from 72.7% to 71.7% in Coventry between 2010 and 2015, remaining below the national average (73.5%) in 2015. Warwickshire has remained above the national average since 2011, with coverage of 75.6% in 2015. Within Warwickshire, Nuneaton and Bedworth Borough have the lowest rates of 73.6% in 2015, significantly lower than other Districts and Boroughs, although just above the England average.

Figure 19. Cervical screening coverage West Midlands 2015[5]

Area	Recent Trend	Count	Value
England	↓	10,405,033	73.5
West Midlands region	↓	1,036,567	72.6
Shropshire	↓	54,700	77.6
Warwickshire	↓	106,518	75.6
Staffordshire	↓	158,089	75.5
Worcestershire	↓	106,772	75.5
Solihull	↓	40,491	75.3
Herefordshire	↓	32,058	74.8
Telford and Wrekin	↓	31,800	74.7
Walsall	↓	48,656	73.1
Dudley	↓	56,198	73.0
Stoke-on-Trent	↓	45,016	71.8
Coventry	↓	59,890	71.7
Sandwell	↓	58,442	69.9
Wolverhampton	↓	45,235	69.4
Birmingham	↓	192,702	67.1

Source: Health and Social Care Information Centre (Open Exeter)/Public Health England

Area	Count	Value
England	10,405,033	73.5
Warwickshire	106,518	75.6
Stratford-on-Avon	24,083	77.2
North Warwickshire	11,788	75.7
Rugby	20,087	75.7
Warwick	27,240	75.7
Nuneaton and Bedworth	23,320	73.6

Source: Health and Social Care Information Centre (Open Exeter)/Public Health England

[5] The percentage of women in the resident population eligible for cervical screening who were screened adequately within the previous 3.5 years or 5.5 years, according to age (3.5 years for women aged 25-49 and 5.5 years for women aged 50-64) on 31 March.

Bowel cancer screening coverage in Coventry (57.9%) and Warwickshire (63.1%) are higher than the national average (57.1%). Figure 18 (below) shows coverage in Warwickshire as the highest in the region. North Warwickshire and Nuneaton and Bedworth have significantly lower uptake rates than the other Districts and Boroughs, although they are above the England average

Figure 20. Bowel cancer screening coverage in 60-74 year olds (previous 2.5 yrs) West Midlands 2015

Area	Recent Trend	Count	Value
England	–	4,406,923	57.1
West Midlands region	–	479,641	57.3
Warwickshire	–	55,708	63.1
Herefordshire	–	21,446	62.8
Worcestershire	–	61,987	62.4
Solihull	–	20,662	61.2
Staffordshire	–	86,028	60.0
Dudley	–	29,512	59.1
Shropshire	–	33,189	58.4
Coventry	–	23,019	57.9
Walsall	–	20,515	54.4
Telford and Wrekin	–	13,526	53.9
Wolverhampton	–	17,498	52.9
Stoke-on-Trent	–	18,182	51.0
Sandwell	–	19,656	49.6
Birmingham	–	58,713	48.7

Source: Health and Social Care Information Centre (Open Exeter)/Public Health England

Area	Count	Value
England	4,406,923	57.1
Warwickshire	55,708	63.1
Stratford-on-Avon	14,975	64.9
Rugby	9,740	64.4
Warwick	12,716	63.6
North Warwickshire	6,795	62.0
Nuneaton and Bedworth	11,482	59.8

Source: Health and Social Care Information Centre (Open Exeter)/Public Health England

Figure 21 shows screening for abdominal aortic aneurism in Warwickshire is above the national average (84.5% compared with 79.4%). Coverage in Coventry is similar to the national average.

Figure 21. Abdominal aortic aneurism screening coverage (males aged 65 years) West Midlands 2014/15

Area	Recent Trend	Count	Value
England	–	233,315	79.4
West Midlands region	–	25,556	80.5*
Worcestershire	–	3,245	84.8*
Shropshire	–	1,761	84.7
Warwickshire	–	2,902	84.5*
Telford and Wrekin	–	848	83.4
Herefordshire	–	1,075	82.9
Solihull	–	989	82.8
Dudley	–	1,496	82.7
Staffordshire	–	4,555	81.8*
Walsall	–	1,127	81.4
Coventry	–	1,176	79.1
Wolverhampton	–	978	79.0
Sandwell	–	1,099	74.1
Birmingham	–	3,288	72.6
Stoke-on-Trent	–	1,017	72.4

Source: Screening Management and Referral Tracking (SMaRT) database

Area	Count	Value
England	233,315	79.4
Warwickshire	2,902	84.5*
Stratford-on-Avon	726	86.4
Warwick	670	84.8
North Warwickshire	365	84.7
Nuneaton and Bedworth	705	83.3
Rugby	436	82.9

Source: Screening Management and Referral Tracking (SMaRT) database

The latest local screening coverage for diabetic eye disease, as shown in Figure 22, is below the national average for Warwickshire North and Coventry and Rugby CCGs, but above the national average in South Warwickshire CCG. Figures for 2015/16, provided at a Coventry and Warwickshire-wide level show an uptake of approximately 85% across the sub-region for the first three quarters of the year.

Figure 22. Diabetic eye screening 2013/14

	England	*Coventry and Rugby CCG*	*South Warwickshire CCG*	*Warwickshire North CCG*
Diabetic eye screening 2013-14	*82.6*	*78.5*	*84.2*	*78.4*

Antenatal and Newborn Screening Programmes

Local data for Syphilis and Hepatitis B screening in pregnancy in Coventry and Warwickshire are not available through national Public Health England sources.

Figure 23 shows newborn bloodspot coverage is higher than the national average in South Warwickshire and Warwickshire North CCGs, and lower than the national average in Coventry and Rugby CCG.

Figure 23. Newborn bloodspot coverage Q4 2015-16

	England	*Coventry and Rugby CCG*	*South Warwickshire CCG*	*Warwickshire North CCG*
Newborn bloodspot screening coverage	*96.2*	*95.1*	*98.0*	*96.9*

PHE Q4 2015-16 KPI data submissions (01/01/2016 - 31/03/2016)

Local coverage of the newborn physical examination is higher than the national average. UHCW and GEH show similar coverage of antenatal testing for HIV, Sickle cell and Thalassaemia to the national average, with SWFT showing slightly lower levels.

Figure 24. Newborn physical examination, antenatal HIV screening and antenatal Sickle Cell and Thalassaemia screening by Trust Q4 2015-16

Trust	Newborn physical examination	Antenatal HIV screening coverage	Antenatal sickle cell and thalassaemia screening coverage
England	94.4	99.1	98.7
SWFT	97.5	98.5	96.8
GEH	97.1	99.8	99.8
UHCW	98.2	99.2	98.8

PHE Q4 2015-16 KPI data submissions (01/01/2016 - 31/03/2016)

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Coverage for newborn hearing screening nationwide is very high (98.5%), with similarly high rates in Coventry (98.9%) and Warwickshire (98.6%).

Figure 25. Newborn hearing screening coverage West Midlands 2014/15

Area	Recent Trend	Count	Value
England	–	639,841	98.5*
West Midlands region	–	67,943	99.1*
Shropshire	–	2,499	99.6
Birmingham	–	16,609	99.6
Stoke-on-Trent	–	3,487	99.5
Staffordshire	–	8,419	99.5
Worcestershire	–	5,712	99.4
Solihull	–	2,211	99.3
Herefordshire	–	1,647	99.2
Telford and Wrekin	–	2,016	99.2
Coventry	–	4,445	98.9
Wolverhampton	–	3,359	98.8
Sandwell	–	4,552	98.7
Warwickshire	–	5,748	98.6
Walsall	–	3,582	98.2
Dudley	–	3,657	97.5

Source: National hearing screening IT system

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Childhood Immunisations

DTaP/IPV/Hib[6] vaccination rates at 2 years, MMR[7] coverage at 5 years, and Hib/MenC[8] booster at 5 years in Coventry and Warwickshire are high and above the national coverage. DTaP/IPV/Hib vaccination rates have remained stable across Coventry and Warwickshire since 2010/11, MMR rates have increased year on year for Warwickshire over the same time period, with overall increases also seen in Coventry. Hib/Men C vaccination has seen a small decline in rates in Warwickshire. Figures 26 - 28 show how Coventry and Warwickshire compare to other areas in the West Midlands.

[6] Diphtheria, Tetanus, Pertussis (Whooping Cough), Polio and Haemophilus Influenzae B
[7] Measles, Mumps and Rubella
[8] Haemophilus Influenzae B and Meningitis C

Figure 26. DTaP/IPV/Hib vaccination coverage at 2 years West Midlands 2014/15

Area	Recent Trend	Count	Value
England	↓	662,348	95.7
West Midlands region	↓	71,049	96.5
Walsall	→	3,435	98.9*
Warwickshire	→	5,949	98.9*
Dudley	↑	3,755	98.6*
Coventry	→	4,531	98.4*
Staffordshire	→	9,105	98.1*
Stoke-on-Trent	→	3,550	98.1*
Worcestershire	↑	6,437	97.9*
Shropshire	→	2,904	97.7*
Telford and Wrekin	→	2,179	97.2*
Herefordshire	↑	1,884	97.0*
Solihull	↓	2,575	96.8*
Sandwell	↓	4,693	94.2*
Wolverhampton	→	3,433	93.9*
Birmingham	↓	16,619	93.4*

Source: Cover of Vaccination Evaluated Rapidly (COVER) data collected by Public Health England (PHE). Available from The Health and Social Care Information Centre (HSCIC)

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Figure 27. Hib/MenC booster vaccination coverage at 5 years West Midlands 2014/15

Area	Recent Trend	Count	Value
England	–	641,075	92.4
West Midlands region	–	65,712	93.0
Stoke-on-Trent	–	3,543	97.3*
Walsall	–	3,290	96.9*
Shropshire	–	2,900	95.5*
Telford and Wrekin	–	2,203	95.3*
Solihull	–	2,489	95.3*
Staffordshire	–	8,780	95.1*
Dudley	–	3,517	95.0*
Warwickshire	–	5,436	93.5*
Sandwell	–	4,192	93.1*
Coventry	–	4,153	92.5*
Worcestershire	–	5,713	91.2*
Birmingham	–	14,706	90.8*
Herefordshire	–	1,738	90.1*
Wolverhampton	–	3,052	86.2*

Source: Cover of Vaccination Evaluated Rapidly (COVER) data collected by Public Health England (PHE). Available from The Health and Social Care Information Centre (HSCIC)

Figure 28. MMR vaccination 2 doses coverage at 5 years West Midlands 2014/15

Area	Recent Trend	Count	Value
England	↑	614,892	88.6
West Midlands region	↑	63,988	90.6
Walsall	↑	3,255	95.8*
Warwickshire	↑	5,544	95.3*
Coventry	↑	4,262	94.9*
Telford and Wrekin	↑	2,173	94.0*
Stoke-on-Trent	↑	3,416	93.8*
Dudley	↑	3,464	93.6*
Shropshire	↑	2,835	93.4*
Worcestershire	↑	5,760	91.9*
Staffordshire	↑	8,453	91.6*
Solihull	↑	2,392	91.5*
Herefordshire	↑	1,690	87.6*
Sandwell	↑	3,919	87.0*
Wolverhampton	↑	3,065	86.6*
Birmingham	↓	13,760	85.0*

Source: Cover of Vaccination Evaluated Rapidly (COVER) data collected by Public Health England (PHE). Available from The Health and Social Care Information Centre (HSCIC)

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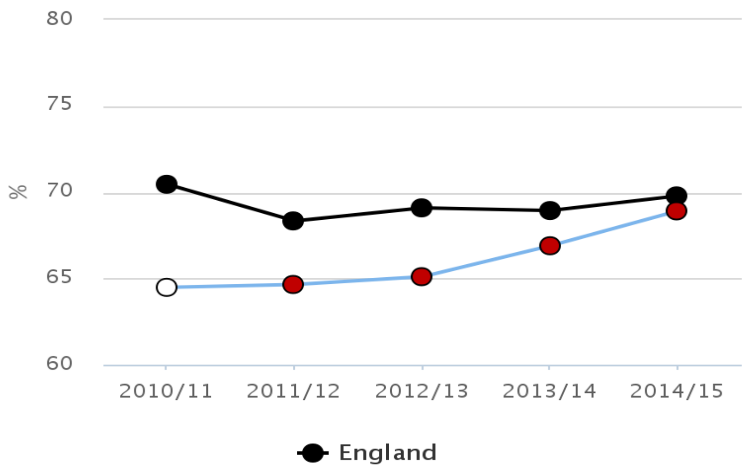
Whilst uptake of childhood immunisations is good locally, it must be noted that uptake is much lower in certain groups. For example, in 2015 only 85% of Looked after Children in both Coventry and Warwickshire were up to date with their immunisations.[9]

Older adult immunisations

Pneumococcal vaccination rates have been increasing in Coventry since 2010/11 although remain slightly below the national average. Rates in Warwickshire have been slightly above the national average for the past 3 years.

[9] https://www.gov.uk/government/statistics/children-looked-after-in-england-including-adoption-2014-to-2015

Figure 29. Pneumococcal vaccination uptake, Coventry



Source: Public Health England

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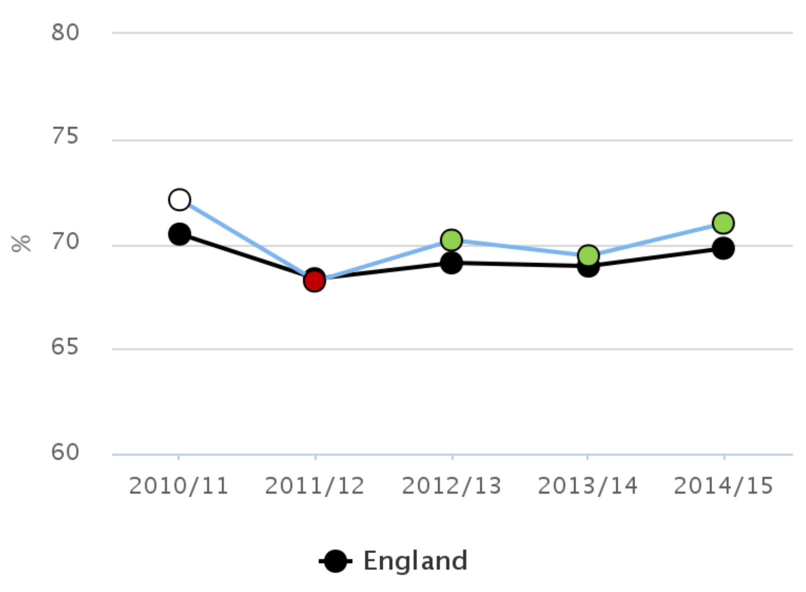
Figure 30. Pneumococcal vaccination uptake, Warwickshire



Source: Public Health England

What will the strategy deliver?

- **Maintain or increase (as appropriate) uptake across all screening and vaccination programmes**

- **Effectively target under-served/'harder to reach' groups** for those screening and immunisation programmes with lower levels of uptake to increase specific engagement and uptake.

- **Work with commissioners and services supporting Looked after Children to increase uptake of routine immunisations**

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Infection Control

Why is this important?

Infection Prevention and Control is concerned with preventing the spread of infection in health and care settings. Healthcare-associated infections can affect patients of all ages. Healthcare workers, family members and carers are also at risk of acquiring infections when supporting patients. All providers of healthcare services are expected to have appropriate provision for infection prevention and control.

Outbreaks like norovirus within a health or social care setting can impact on the ability to deliver effective services. This can add to severe demands and pressures on resources/systems, especially in the winter season. However, there is also a significant need for effective infection prevention alongside the healthcare sector, for example within social care settings, schools and nurseries. Significant progress has been made over the last 10 years, both nationally and locally, in reducing rates of health-care associated infections such as MRSA[10] (which lives on the skin, and in the nose and throat, but can get into the body and cause life-threatening infections) and C. difficile (which causes infectious diarrhoea). Continuing this progress is essential.

Furthermore, in 2014, the WHO raised concerns that globally we are entering a 'post antibiotic' era; organisms and bacteria are developing multiple resistances to available antibiotic and antimicrobial treatments, meaning common infectious diseases will no longer be able to be treated effectively.[11] This means we need to take urgent local action to embed antimicrobial stewardship policies that respond to and reduce over-prescription of antimicrobial treatments.

An independent Infection Control Review was undertaken in Coventry and Warwickshire in 2015, focusing on the full range of health and care setting, and its key recommendations underpin the strategic focus and delivery of this strategy.

What does the data tell us?

Figure 31 shows a comparison of local CCG antibiotic prescribing rates. Warwickshire North and Coventry and Rugby CCGs have slightly higher antibiotic prescription rates than the national rate, whilst South Warwickshire CCG has a slightly lower rate. Figure 32 shows that South Warwickshire CCG also has proportionally lower prescribing rates for those antibiotics considered to predispose individuals to developing C. difficile, an infectious diarrhoea. Despite this, Figure 33 shows that C. difficile rates were above the national and regional average in South Warwickshire CCG, and below these averages in Coventry and Warwickshire CCG and Warwickshire North CCG.

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[10] Methicillin Resistant Staph Aureus (resistant to a number of widely used antibiotics)
[11] http://www.who.int/mediacentre/factsheets/fs194/en/

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Figure 31. 12 month rolling total number of prescribed antibiotic items per 1000 individuals per day (crude rate) West Midlands 2015/16

Area	Count	Value
England	34,509,255	1.74
West Midlands NHS region	2,722,186	1.81
NHS Birmingham South And...	164,295	2.23
NHS Wyre Forest CCG	72,677	2.01
NHS Warwickshire North CC...	133,128	1.93
NHS Solihull CCG	146,416	1.91
NHS Redditch And Bromsgro...	123,434	1.88
NHS Walsall CCG	186,996	1.87
NHS Wolverhampton CCG	172,438	1.87
NHS Sandwell And West Bir...	321,307	1.82
NHS South Worcestershire...	194,721	1.80
NHS Dudley CCG	202,693	1.76
NHS Coventry And Rugby CC...	280,617	1.75
NHS South Warwickshire CC...	163,657	1.72
NHS Herefordshire CCG	116,206	1.70
NHS Birmingham Crosscity...	443,601	1.66

Prescribing data is sourced from HSCIC and supplied as monthly downloads that are aggregated into annual and quarterly datasets. Population data is produced by the Office of National Statistics.

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Figure 32. 12 month rolling percentage of prescribed antibiotic items from cephalosporins, quinolone and co-amoxiclav class West Midlands 2015/16

Area	Count	Value
England	3,343,298	9.73
West Midlands NHS region	225,725	8.33
NHS South Worcestershire...	20,699	10.71
NHS Warwickshire North CC...	13,807	10.40
NHS Birmingham South And...	16,769	10.24
NHS Redditch And Bromsgro...	12,005	9.79
NHS Wyre Forest CCG	6,669	9.24
NHS Coventry And Rugby CC...	25,574	9.14
NHS South Warwickshire CC...	14,725	9.03
NHS Birmingham Crosscity...	39,721	8.99
NHS Herefordshire CCG	9,094	7.88
NHS Solihull CCG	10,737	7.37
NHS Sandwell And West Bir...	21,589	6.75
NHS Dudley CCG	13,444	6.66
NHS Walsall CCG	11,100	5.96
NHS Wolverhampton CCG	9,792	5.70

Prescribing data is sourced from HSCIC and supplied as monthly downloads that are aggregated into annual and quarterly datasets. Population data is produced by the Office of National Statistics.

Figure 33. C. difficile rates per 100,000 by CCG West Midlands 2015/16 financial year

Area	Count	Value
England	13,960	26.0*
West Midlands NHS region	1,068	25.9*
NHS Dudley CCG	110	34.8
NHS Wolverhampton CCG	86	33.9
NHS South Warwickshire CC...	88	33.7
NHS Solihull CCG	70	33.3
NHS Herefordshire CCG	52	27.7
NHS Coventry And Rugby CC...	110	25.0
NHS Sandwell And West Bir...	113	23.3
NHS South Worcestershire...	69	23.2
NHS Birmingham Crosscity...	170	23.2
NHS Walsall CCG	63	22.9
NHS Warwickshire North CC...	41	21.7
NHS Birmingham South And...	43	21.3
NHS Redditch And Bromsgro...	35	19.4
NHS Wyre Forest CCG	18	18.2

Source: HCAI Mandatory Surveillance Data

From these Figures, it can be seen that there is no clear relationship between antibiotic prescribing and C. difficile rates. This is likely to be due to these indicators not taking into account age structures of populations (e.g. older people are more vulnerable), alongside other factors. Reducing inappropriate antibiotic prescribing remains an important public health intervention.

What will the strategy deliver?

- **Work to reduce both the incidence and duration of outbreaks in health and care settings,** and ensure when these do occur that reflective learning drives service change and good practice is shared.

- **Embed a 'Champions' model in all care homes** so all staff are trained and confident in preventing infections.

- **Develop and embed an Antimicrobial Strategy** to sit alongside this overarching strategy.

- **Standardise the Root Cause Analysis** approach for all C. difficile infection cases including, but not limited to, those involving inappropriate antibiotic prescribing.

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Emergency Planning - Pandemic Flu

Why is this important?

Planning for outbreaks, incidents, and environmental threats is crucial to support and protect the population, alongside protecting the provision of health and care, as well as wider services. Healthcare-related emergency planning is governed by the Local Health Resilience Partnership, which brings together health emergency planners, as well as those from local authorities.

This strategy will have a specific focus on Pandemic Flu. Following the learning from the pandemic in 2009, there needs to be assurance that all relevant agencies have plans in place, that procedures have been tested, that all partners are clear of roles and responsibilities, and that the care and support of people across the health and social care economy will continue to be effective during the next pandemic. This requires a multi-agency co-ordinated approach to testing and planning.

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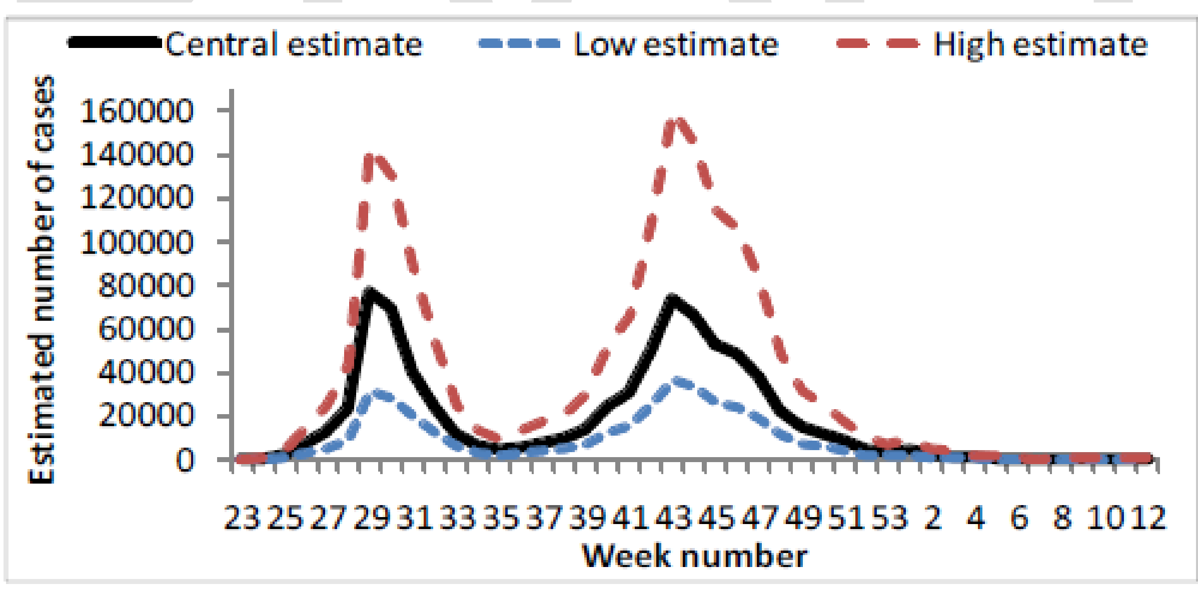
What does the data tell us?

Figure 34 shows the estimated number of cases and deaths due to the 2009 H1N1 pandemic.[12]

Figure 34. Estimated number of clinical cases in England June 2009- March 2010



The symptomatic case-fatality ratio for this pandemic was estimated to be 0.04%. This compared favourably with previous pandemics. However, it should be noted that the

[12] http://www.qresearch.org/Public_Documents/Pan%20flu%20report_final_8October2010%20covered[2].pdf

pandemic in 2009 still had a significant impact on health services. Estimates suggest we should be planning for a pandemic that: could emerge anywhere in the world at any time, may cause up to 50% of the population to present with symptoms (from mild to severe), of which 30% will require primary care services, and 1-4% critical care.[13,14] Employers need to plan for at least 50% of staff being off work at some stage, with between 15% and 20% of staff off at any one time.

What will the strategy deliver?

- **Development of comprehensive system-wide pandemic flu plan(s)** that focus on continuous improvement in outbreak planning arrangements, at both strategic and operational levels, including NHS, Local Authority and Local Resilience Forum Plans.

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[13] https://www.gov.uk/government/publications/responding-to-a-uk-flu-pandemic

[14] https://www.gov.uk/government/publications/health-and-social-care-response-to-flu-pandemics

Excess Winter Deaths and Health Effects of Cold Weather

Why is this important?

Living in a cold home and experiencing fuel poverty increase the risks of cold related illness, and account for between 10 and 30% of all excess winter deaths.[15]

Fuel poverty is measured in England using the low income-high cost definition, which states that a household is in fuel poverty if:

- Their required energy costs are above average and
- Were they to spend this amount, they would be left with a residual income below the official poverty line.

Alongside winter deaths, cold-related illnesses in Warwickshire and Coventry place significant strain on local health and care services. People living with long term conditions and /or disabilities, those over 75 years old or under 5 years old are particularly vulnerable to the effects of cold related illness/fuel poverty.

Seasonal Flu is also one of the main drivers of excess winter deaths. One in three people are entitled to a free flu vaccination in Coventry and Warwickshire and we need to strive to improve uptake year on year in eligible groups: those aged 65 and over, adults and children with a chronic health condition, carers, care home residents, pregnant women, with the programme being rolled out to all 2 – 16 year olds over the next few years. Health and care workers who provide direct personal care are also eligible for vaccination through their employers.

What does the data tell us?

Figure 35 shows that the number of excess winter deaths in Coventry and Warwickshire are not significantly different to other local authorities in the region or the national average. However, nationally, our excess winter deaths are significantly higher than our European counterparts.

[15] http://nhfshare.heartforum.org.uk/RMAssets/HealthyPlaces/FuelPoverty/ToolkitJan2015.pdf

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Figure 35. Excess winter death index 3 years (2011-14)

Area	Recent Trend	Count	Value
England	–	69,038	15.6
West Midlands region	–	7,751	16.1
Walsall	–	476	20.7
Staffordshire	–	1,351	17.8
Birmingham	–	1,361	17.5
Coventry	–	422	16.8
Stoke-on-Trent	–	372	16.5
Solihull	–	301	16.4
Wolverhampton	–	367	16.2
Worcestershire	–	860	16.1
Telford and Wrekin	–	203	15.8
Warwickshire	–	735	15.7
Shropshire	–	437	14.5
Dudley	–	377	13.2
Sandwell	–	353	13.0
Herefordshire	–	143	7.7

Source: Office for National Statistics: Public Health England Annual Births and Mortality Extracts

Figures 36 and 37 demonstrate the variation in fuel poverty across the sub-region. In Coventry, areas around the city centre and into the north and east of the City are highlighted as having particularly high levels of fuel poverty. In Warwickshire, areas in the south of Stratford-on-Avon District and east of Warwick District are noted as areas with high levels of fuel poverty.

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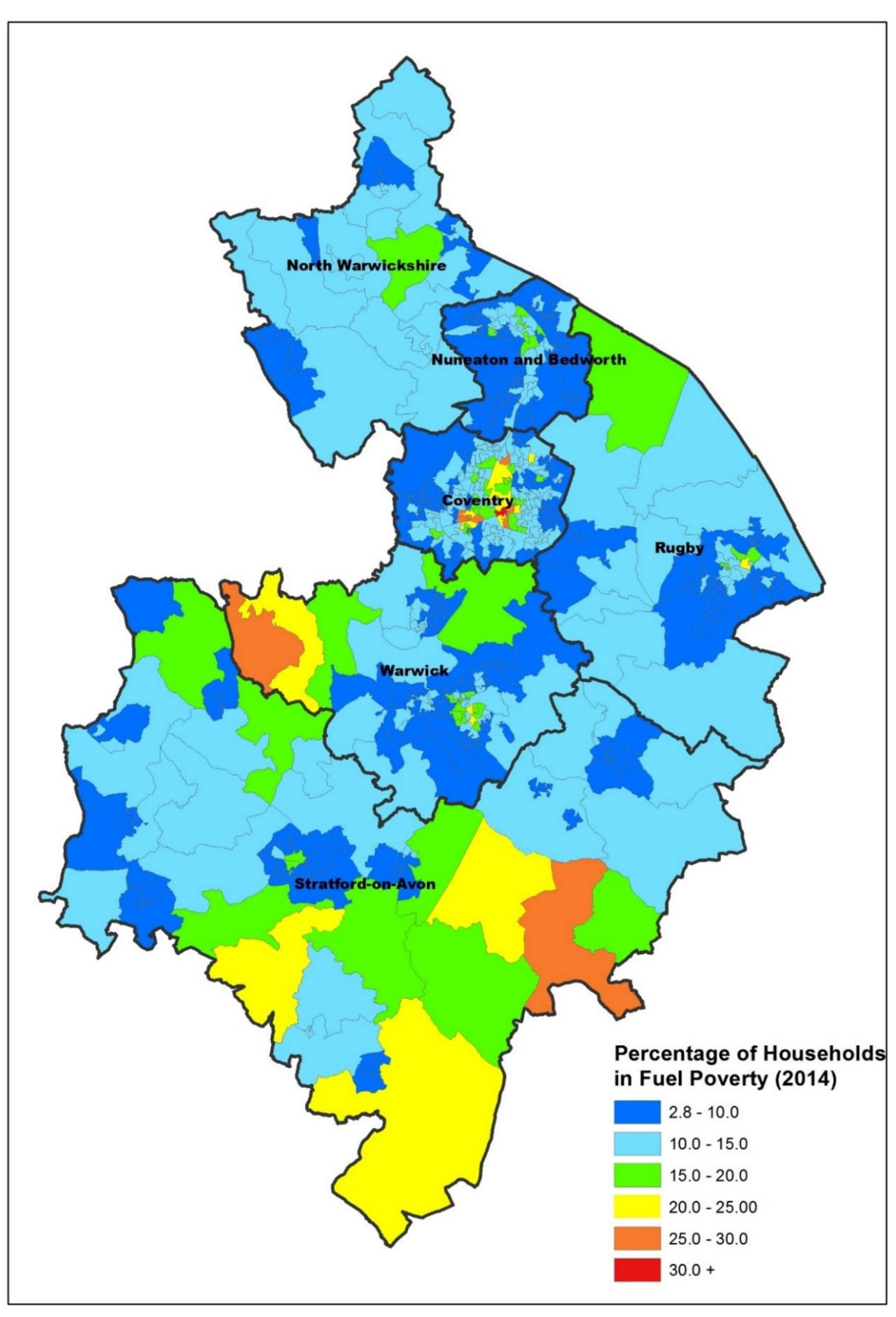
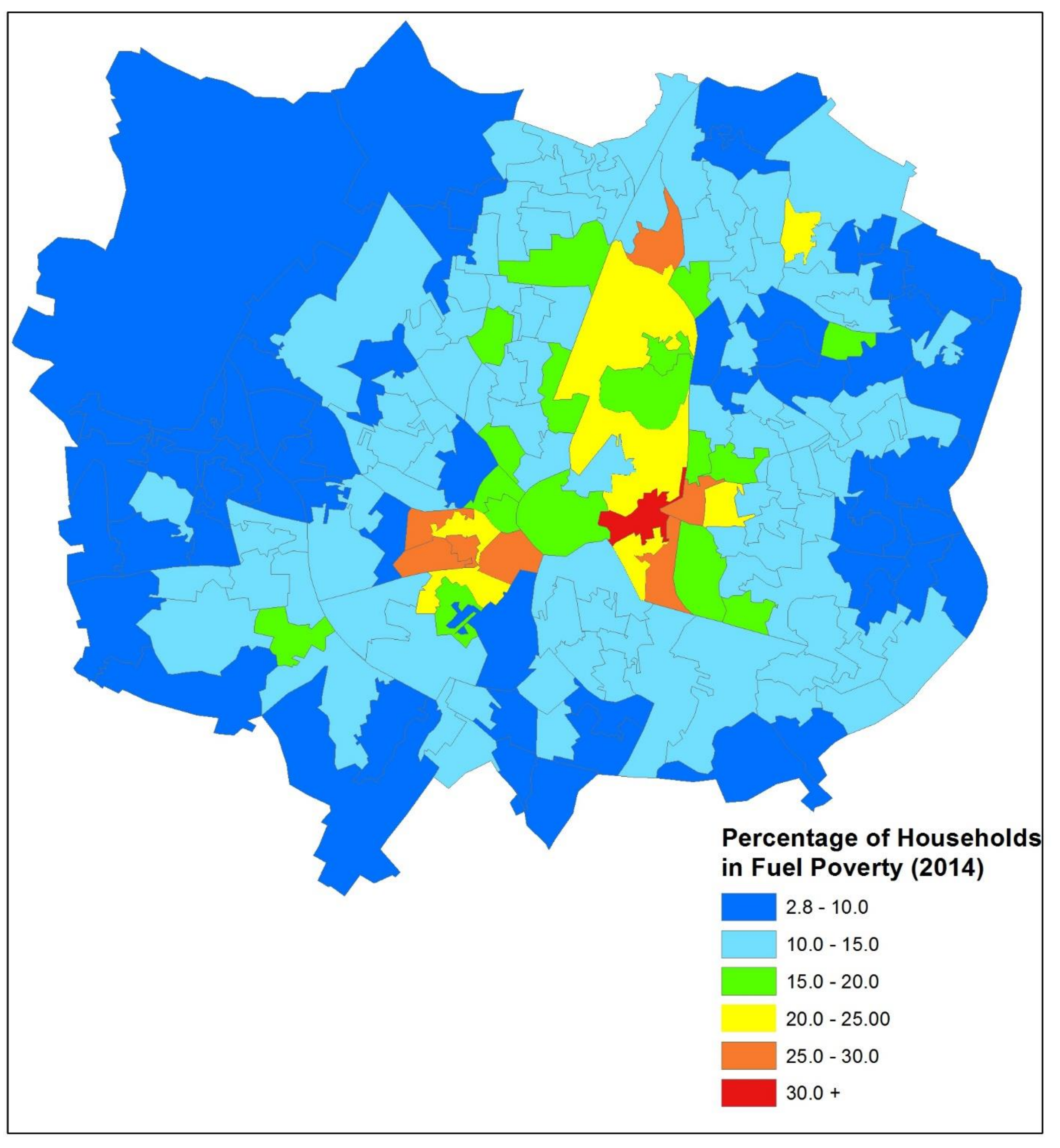
Figure 36. Percentage of households in fuel poverty, Coventry and Warwickshire, 2014



Source: 2014 sub-regional fuel poverty data: low income high costs indicator. 30 June 2016. Department of Energy & Climate Change, available from: https://www.gov.uk/government/statistics/2014-sub-regional-fuel-poverty-data-low-income-high-costs-indicator

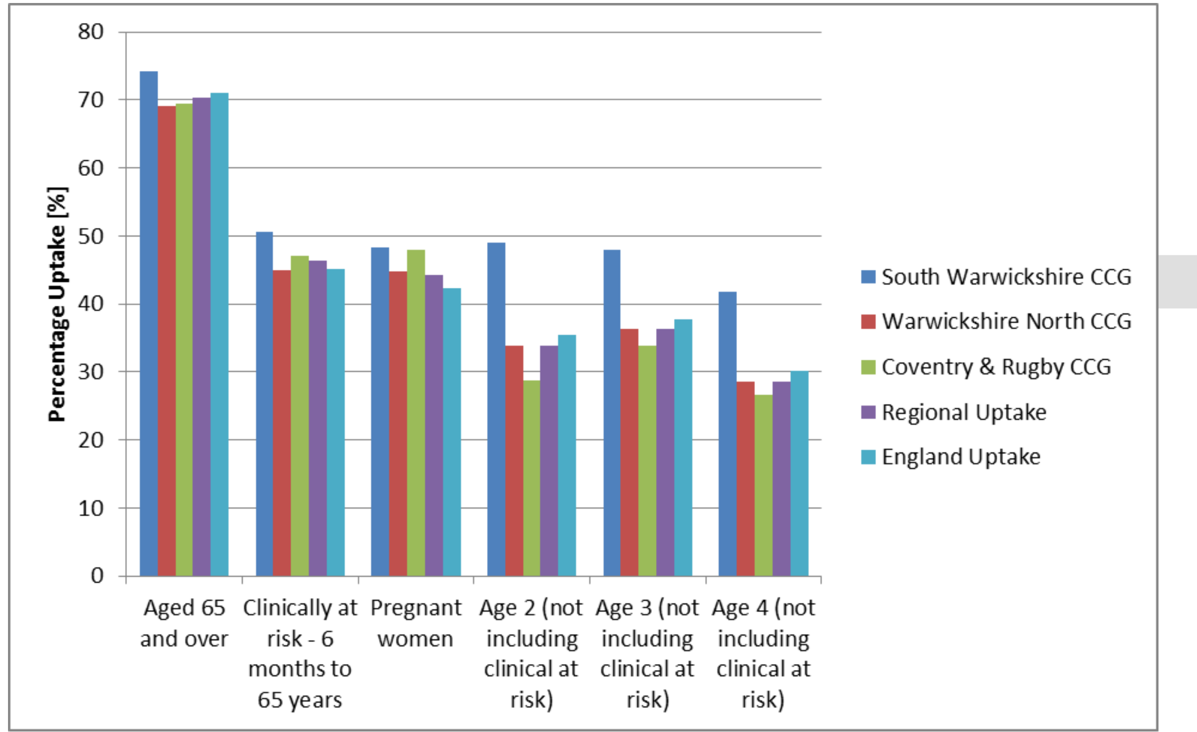
Figure 37. Percentage of households in fuel poverty, Coventry 2014



Source: 2014 sub-regional fuel poverty data: low income high costs indicator. 30 June 2016. Department of Energy & Climate Change, available from: https://www.gov.uk/government/statistics/2014-sub-regional-fuel-poverty-data-low-income-high-costs-indicator

Seasonal flu vaccination uptake for target groups within the three local CCG areas are shown in Figure 38. A general trend of higher uptake for those age 65 and over compared with those in clinical risk groups is seen nationally and locally, with lower levels still of vaccinations given to children in the eligible age groups. Locally, uptake across all eligible groups has been highest in South Warwickshire CCG, and uptake in adult at-risk groups lowest in Warwickshire North CCG.

Figure 38. Seasonal flu vaccine uptake 2015/16



Source: Seasonal flu vaccine uptake in GP patients: 1 September 2015 to 31 January 2016. Public Health England: 25 February 2016. Available from: https://www.gov.uk/government/statistics/seasonal-flu-vaccine-uptake-in-gp-patients-1-september-2015-to-31-january-2016

Variation in seasonal flu vaccination uptake amongst healthcare workers over time and by NHS Trust can be seen in Figure 39. The most recent data shows highest uptake at University Hospitals Coventry and Warwickshire NHS Trust, and lowest rates at Coventry and Warwickshire Partnership Trust.

Figure 39. Percentage uptake of influenza vaccination in healthcare workers by location (2012/13 to 2015/16)

Seasonal flu vaccine uptake in healthcare workers: 1 September 2015 to 29 February 2016. Public Health England: 17 March 2016. Available from: https://www.gov.uk/government/statistics/seasonal-flu-vaccine-uptake-in-healthcare-workers-1-september-2015-to-29-february-2016

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For 2016/17 there is an uptake ambition of 40-65% among the childhood cohorts, 55% for at risk clinical groups, and 75% for those aged 65 and over, and healthcare workers.[16]

What will the strategy deliver?

- **Reduce the number of households experiencing fuel poverty through increasing referrals to commissioned services that offer advice/support and physical interventions**, including 'affordable warmth on prescription' services to vulnerable, eligible households.

- **Increase uptake of Flu vaccinations in eligible groups** through annual campaigns, and engaging with frontline staff to recommend flu vaccinations.

- **Explore multi agency commissioning opportunities** to look at widening out affordable warmth initiatives.

- **Ensure an ongoing collaborative approach to planning for cold weather** across health and care services

16 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/529954/Annual_flu_letter_2016_2017.pdf

Appendix 1 Coventry and Warwickshire Health Protection Strategy 2013-2015: Summarising Progress

Priority	Progress
Gastrointestinal diseases	• Regular local and regional fora in place where food safety and food poisoning are discussed • Improvement in number of food premises classed as broadly compliant across the County and City (3* or above) • Work ongoing nationally to review food poisoning and food safety in the home
Viral Hepatitis	• Viral Hepatitis pathway for GPs developed and disseminated. • Viral Hepatitis GP training slide pack developed and delivered. • Neonatal Hepatitis B vaccination programme (of babies born to Hepatitis B positive mothers) continues to work well through a primary care model (with failsafes built in)
TB	• Treatment completion rates increasing across Coventry and Warwickshire. • Latent TB case finding programme established (nurse-led and working with primary care and community organisations supporting high risk groups). • Audit programme for all TB cases established. • Coventry and Warwickshire TB programme board established • West Midlands TB Control board established (with significant current local input from Coventry and Warwickshire).
Healthcare Associated Infection and Community Infection Control	• Healthcare associated infections continue to reduce in both hospitals and community settings in Coventry and Warwickshire. • Independent infection control review commissioned by Directors of Public Health • Establishment of process for conducting Root Cause Analysis of healthcare associated infections in the community in progress across Coventry and Warwickshire • Multi-agency Outbreak Plan and Memorandum of Understanding developed
Population Screening Programmes	• Screening and Immunisation Task and Finish Group established to look at effective partnership working between Local Authorities and Public Health England (including understanding of data required for understanding variation in uptake of programmes)
Immunisation and Vaccination	• Childhood immunisation rates remain above national average in both Coventry and Warwickshire. • A number of new vaccination programmes introduced (pertussis vaccination for pregnant women, rotavirus, Men ACWY programmes). • A multi-agency communications group has been established, and which is supporting annual seasonal flu/cold weather campaigns.
Sexually Transmitted Infections	• Integrated Sexual Health Service in Coventry and Warwickshire recommissioned, with a focus on reducing sexually transmitted infections and late diagnoses of HIV
Air Quality	• Coventry and Warwickshire Air Quality Alliance established, and working together on joint projects focusing on improving air quality. • Alliance comprises professionals from Transport, Planning, Environmental Health, Public Health and Public Health England.

Report

To: **Coventry Health and Wellbeing Board** **Date: 28th November 2016**

From: **Jane Moore, Director of Public Health**
Sue Frossell, Consultant in Public Health

Title: Coventry Suicide Prevention Strategy 2016-19

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1 Purpose

1.1 The purpose of this report is to seek endorsement from the Coventry Health and Wellbeing Board for One Suicide // One Too Many: A Suicide Prevention Strategy for Coventry 2016-19. Suicide prevention became a local authority responsibility in 2013 and this strategy aims to set out the scale of this issue and suggest what action Coventry can take to address it.

2 Recommendation

2.1 Health and Wellbeing board is recommended to:
- Endorse the Coventry Suicide Prevention Strategy 2016-19;
- Consider how their individual organisations could make a contribution to reducing suicide in Coventry;
- Agree that a multiagency task and finish group be set up to develop the plan and integrate the actions into the relevant boards and agencies represented in the HWB and beyond;
- Monitor progress against the action plan on an annual basis.

3 Background Information

3.1 Every year more adults under the age of 50 die from suicide than die as a result of road traffic accidents; it is the leading cause of death for this age range. National and international experience has shown that we can, and must, take action to avoid these unnecessary deaths.

3.2 Suicide prevention has been recognised as a priority at a national level with the All Party Parliamentary Group on Suicide and Self Harm in the process of reviewing local progress against the national prevention strategy issued in 2012. This has been supported by the recent Public Health England publication of guidance for local authorities in producing suicide prevention plans. The national recommendation is that every local authority should develop a suicide prevention action plan, access data on local suicide characteristics (a ‘suicide audit’) and develop a multi-sector agency approach to reducing suicides. In addition, suicide prevention has been identified as an area of focus for the West Midlands Combined Authority.

3.3 Suicide as an event is devastating to those close to it, causing pain, grief and isolation, as the stigma associated can limit attempts to seek support. The financial cost of a single suicide has been estimated at as much as £1.6 million in total.

3.4 An initial draft strategy for suicide prevention was developed by Terry Rigby from the suicide prevention Social Enterprise Forward for Life in 2015. This work has been updated to reflect the national recommendations and the progress made locally, with a particular focus on the strategy work completed in Warwickshire. This has led to a document which reflects a joint strategic vision across the Sustainability and Transformation Plan (STP) footprint, but which plans city-wide action through a Coventry based multi-agency Task and Finish Group.

3.5 Whilst the strategy does address issues around improving mental health care, in particular discharge planning and crisis response within these services, it is a fact that over 70% of those who die by suicide nationally have no contact with mental health services in the year prior to their death. A diagnosed mental illness is not a prerequisite to taking the decision to end one's life; factors such as debt, unemployment, relationship breakdown and other crises can trigger a suicidal crisis. These life events bring people in touch with a wide range of services and we must make sure that staff, employers and communities in Coventry are prepared to recognise when people are in crisis and have interventions available to prevent suicidal behaviour.

3.6 There are a range of complex interactions that make a person more likely to consider suicide. To work upstream of the crises which result in suicide, we need to tackle those factors which make a person more likely to consider suicide as an option. This strategy cannot be read in isolation as much of the work already happening contributes towards reducing suicide; for example, as a Marmot City, Coventry is already reducing inequalities and trying to increase mental and physical wellbeing in the city all of which reduces individual risk of suicide. Drug and alcohol recovery services play a significant role in providing support that mitigates against suicidal behaviour. Improving emotional resilience is a cornerstone of our plans to improve the lives of children and young people in our city; providing a solid emotional foundation in the early years reduces the risk of suicide if these children face difficulties as they grow into adulthood. The strategy is explicit that addressing these socio-economic factors is a key feature of our plan.

4 Options Considered and Recommended Proposal

4.1 Our vision is to realise a city that has zero suicides. It is an ambitious aim but one which recognises the tragedy of each life lost and emphasises that death by suicide is preventable. It is a philosophy based on work completed in the Henry Ford Health System in Detroit where service improvements and a proactive approach towards this goal drastically cut the rate of suicide. By aiming high, for perfection, better results are achieved than by aiming low.

4.2 In working towards this vision, our strategy sets out 3 core aims:

- Raise the level of understanding and awareness across Coventry of suicidal ideation, behaviours, acts and the impact of suicidal acts across our communities.
- To highlight key areas of service development and demonstrate ways forward to assist services in supporting Coventry to be 'Suicide Safer'.
- To set out a clear action plan to mobilise all sectors to reduce suicidal behaviour across the city.

4.3 In working toward this vision, we are also recommending adopting a close working relationship with Warwickshire. Where possible, we believe action should be shared across Coventry and Warwickshire – the efforts in prevention and the support available to those bereaved by suicide should be equable across the region. Our Action Plan is designed to be flexible and is intended to be regularly updated and adapted. The Task and Finish group will include an experienced membership that will be open to collaboration with their Warwickshire counterpart.

4.4 We have worked closely with Warwickshire in developing this strategy. In the context of the Health and Wellbeing Boards' concordat it is only right that we provide a joint strategic vision for our services and citizens, therefore both strategies have action set against seven priority areas:

- **Reducing the risk of suicide in key high risk groups** - These groups include men in mid-life, people with known mental health problems and/or history of self-harm, and people involved in substance misuse. The strategy supports the work of 'It Takes Balls to Talk', a suicide awareness campaign focused on sports events that aims to increase men's willingness to access support. We would expect the existing Health and Wellbeing Strategy focus on improving the lives of people with multiple complex needs to have a corollary impact on the risk of suicide for these individuals.

- **Tailoring approaches to improve mental health in specific groups** - This includes engaging with young people to improve emotional resilience through our 0-19s work and reducing the stigma around seeking help for suicidal thoughts.

- **Reducing access to the means of suicide** - We know that rail suicide is an issue in our locality and we support the work of the Samaritans in addressing this. We are also in contact with Network Rail who will be our partners in reducing rail suicide in the city. In addition, overdose of prescribed opiates is an issue nationally and we will ensure that our local Primary Care practitioners are aware of this. We also know that alcohol is all too often a contributing factor in suicide, and this strategy aims to support measures which tackle problem drinking in the city.

- **Reducing the impact of suicide** – we support the work of charitable organisations in the city in their efforts to support those bereaved by suicide but recognise that there is much more we can do. We recommend the use of the 'Help is at Hand' booklet as a starting point for improving post-suicide support, however a much more robust response is needed. One of the early areas of work for the Task and Finish group will be to engage with the organisations already providing support and those who have been bereaved by suicide personally to find out what we can do to improve our response.

- **Supporting the media in delivering sensitive approaches to suicide and suicidal behaviour** – we encourage local media outlets to utilise the Samaritans guidance around the reporting of suicide and will use participation in World Suicide Prevention Day as an opportunity to remind the press of their role in reporting suicide responsibly. We also recognise the positive force of the media in promoting awareness campaigns and reducing stigma and will use our communications networks to this end.

- **Improving data and evidence** – we are working with the coroner to undertake a 'suicide audit' to learn from the deaths which have occurred in Coventry. Network

Rail are sharing information with us about rail suicides in our city and we will work together to reduce these.

- **Working together** – the strategy makes clear that tackling the problem of suicide in Coventry requires whole system action. We therefore propose that a Task and Finish group is set up to include membership from relevant commissioners, providers and third sector agencies. This group will be responsible for leading the implementation of the strategy action plan as well as providing a forum for setting further specific goals. It is expected that this group will provide a forum for open communication with our colleagues in Warwickshire with both areas sharing and learning from one another. Furthermore, this group will be kept up to date with the latest data developments as they arise from the local suicide audit and publications distributed by Public Health England.

4.5 This strategy sets out our vision and priorities. If approved, the next step will be to bring together a variety of partners in a Task and Finish group to discuss and take forward practical action that addresses suicidal behaviour and the reasons underlying it in our city with a safer suicide community approach and in harmony with both national, regional and local goals, policy and service and community strengths.

Report Author:
Name and Job Title: Ruth Lister, GPVTS1, Public Health
Directorate: People Directorate
Telephone and E-mail Contact:
E-mail: ruth.lister@coventry.gov.uk, tel: 02476833638

Task and Finish Group /Strategy Implementation:
Name and Job Title: Adeola Agbebiyi, StR 5, Public Health
Directorate: People Directorate
E-mail: Adeola.agbebiyi@coventry.gov.uk

Enquiries should be directed to both the above people.

Appendices: Coventry Suicide Prevention Strategy 2016-2019

One suicide//One too many

A Suicide Prevention Strategy for Coventry

2016 - 2019

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One Suicide // One Too Many

1. Our Vision

Death by suicide *is* preventable. Each life lost is a tragedy. One suicide will always be one too many.

Coventry City Council and its partners will oversee the establishment of robust networks and clearly defined processes to reduce suicides in Coventry. Citizens will be in a stronger position to realise options for long term wellbeing and improved quality of life. Suicidal behaviours will be minimised through the availability of timely and effective support that is accessible to people in personal crisis. We propose a focused approach towards **zero suicides** in our city, an approach which has been shown to effective in significantly reducing suicides.

2. Introduction

Across the UK it has been a clear priority in recent years to end the disparity between physical and mental health with 'no health without mental health' becoming the mantra of reform for our health system[1]. A vital part of this agenda is recognising suicide as a major public health problem. The majority of those who die by suicide are not in contact with mental health services when they make the decision to end their life and so our strategy must reach beyond specialist services and take account of the broad range of societal and individual factors that lead to a person dying as a result of suicide. There is much more to be done across our whole community to prevent these unnecessary deaths.

This strategy was developed by Coventry Public Health to translate national guidance into local action. We talked to our local stakeholders in September 2015 (Appendix 2) then took the priorities they gave us and integrated them with our research into the national and international experience of suicide prevention. We worked closely with our colleagues in Warwickshire so that the plan we put forward provides a joint strategic vision. Our objectives have been mapped to the same seven priority areas identified by the *Warwickshire Suicide Prevention Strategy 2016-20* and our actions will be shared wherever possible.

This strategy is one example of how we plan to work collaboratively with Warwickshire in the future. The NHS Five Year Forward vision has tasked the health and care system to work across a Coventry and Warwickshire footprint to produce a Sustainability and Transformation plan (STP)[2]. The STP necessitates our two areas work in unison to provide the best possible services for our local populations. Many of our services already work across the footprint and we hope that the closer relationship between Coventry and Warwickshire at the strategic and commissioner level will yield positive results.

3. Our Aims

This strategy has three key aims to help us achieve our **Zero Suicides** vision:

1. Raise the level of understanding and awareness across Coventry of suicidal ideation, behaviours, acts and the impact of suicidal acts across our communities.
2. To highlight key areas of service development and demonstrate ways forward to assist services in supporting Coventry to be 'Suicide Safer'.
3. To set out a clear action plan to mobilise all sectors to reduce suicidal behaviour across the city.

[1] Department of Health, *No Health without Mental Health: a cross-government mental health outcomes strategy for all ages*, February 2011.
[2] Further information available from: https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/stp/ [Accessed 30/09/2016]. At the time of writing, specifics of the STP for Coventry and Warwickshire had not been published.

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We have worked closely with our colleagues in Warwickshire in developing this strategy to provide a joint strategic focus for our services. With this in mind we will achieve our aims by focusing our efforts in line with the same seven priority areas developed in the *Warwickshire Suicide Prevention Strategy 2016-20*:

1. Reducing the risk of suicide in key high risk groups.
2. Tailoring approaches to improve mental health in specific groups.
3. Reducing access to the means of suicide.
4. Reducing the impact of suicide.
5. Supporting the media in delivering sensitive approaches to suicide and suicidal behaviour.
6. Improving data and evidence.
7. Working together.

This strategy will outline the scale of the problem and why we believe suicide prevention is a vital component in improving wellbeing in our city. The deliberate similarities with Warwickshire allow us to put forward an action plan (see Appendix 1) that is coherent across the region whilst taking account of the particular challenges faced within Coventry's population.

4. Facts and Figures: The Bigger Picture

4.1 The United Kingdom

It is important to know the scale of an issue before we try to tackle it. Suicide has consistently been the leading cause of death for adults under the age of 50.[3] The Office of National Statistics (ONS) composes annual reports on death by suicide that demonstrate why suicide prevention needs to be a priority on a national and local level. The figures from the latest report are summarised below.[4]

In 2014, a total of 6,122 suicides of people aged 10 and over were registered in the UK, 120 fewer than in 2013. Historically, a generally downward trend in suicide rates was observed between 1981 and 2007, with a decrease from 14.7 to 10.0 deaths per 100,000 population (see Figure 1). Sadly, coinciding with the global economic downturn, suicide rates began to increase in 2008 – peaking at 11.1 deaths per 100,000 in 2013, before dropping slightly in 2014 to 10.8 deaths per 100,000.

Of the total number of suicides registered in 2014 in the UK, 76% were male and 24% were female. Although suicide rates fell significantly for both sexes between 1981 and 2007, the fall was more pronounced among women. Consequently, the proportion of male to female suicides has increased since 1981 when 63% were male and 37% were female.

The male suicide rate increased significantly between 2007 and 2013. It peaked at 17.8 deaths per 100,000 population in 2013, before falling to 16.8 deaths per 100,000 in 2014. In the same year as male suicides fell, 2013-14 saw UK female suicide increase by 8.3%. However, since 2007, the female suicide rate has remained relatively constant and throughout the whole time period covered by the data, female rates of suicide have been consistently lower than in males, currently standing at 5.2 deaths per 100,000 in 2014.[5]

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[3] ONS Digital, *What are the top causes of death by age and gender?*, February 2015. Available from: http://visual.ons.gov.uk/what-are-the-top-causes-of-death-by-age-and-gender/ [Accessed 22/09/2016]

[4]Statistics and figures taken from Office of National Statistics, *Suicide in the United Kingdom: 2014 registrations*. Available from: http://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2014registrations [Accessed 20/09/2016]

[5] Suicide data is based on coroners' records – the inquest causes a delay between the death occurring and the date the death is registered; 'Difficult to code' coroners' verdicts can skew data e.g. an area with a high proportion of narrative verdicts may falsely appear to have a lower suicide rate because of difficulties in coding those verdicts as suicide.

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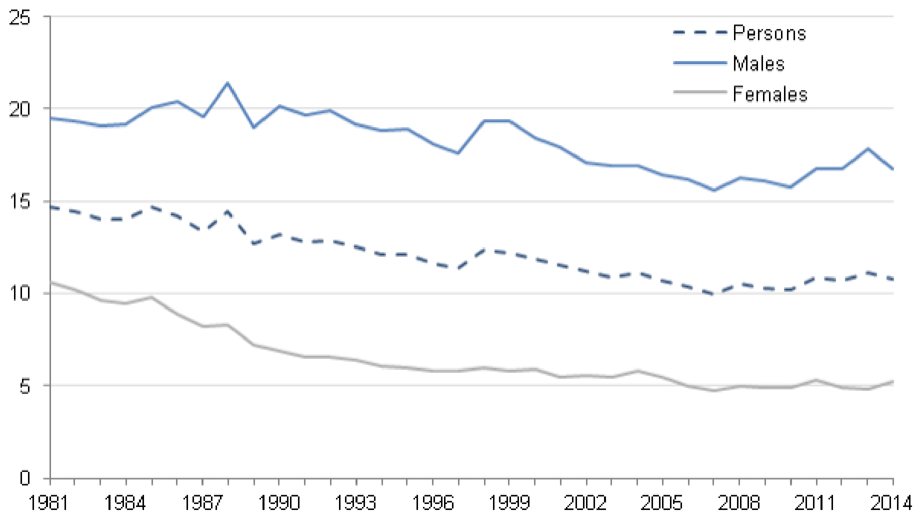
Figure 1: Age-standardised suicide rates by sex, deaths registered between 1981 and 2014

UK

Rate per 100,000 population



Source: Office for National Statistics, National Records of Scotland, Northern Ireland Statistics and Research Agency

4.2 England

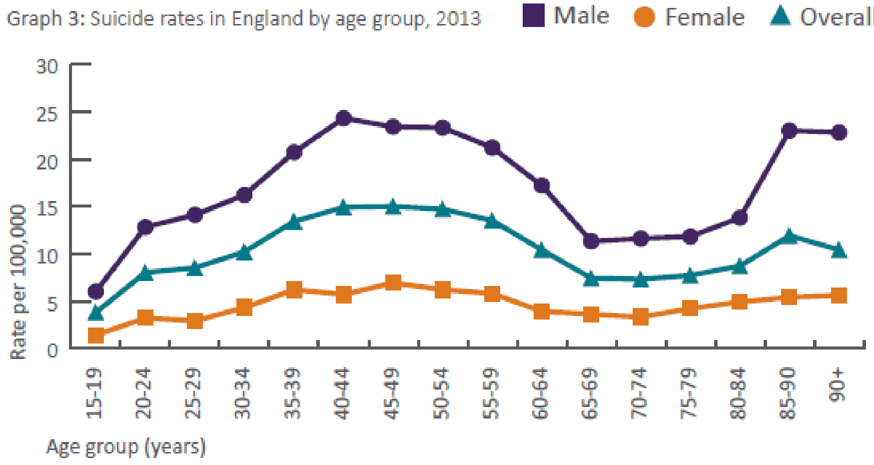
There were 4,882 suicides among people aged 10 and over registered in England in 2014, 155 more than 2013 (a 3% increase). This increase appears to have been driven by an increase in the number of female suicides, with 14% more suicides in females in England in 2014 than in 2013. In contrast, male suicide rates have remained stable.

The increase in the suicide rate for all persons in England in 2014 contrasts with the rest of the UK as suicide rates fell in Wales, Scotland and Northern Ireland in the same period. Overall, the age-standardised suicide rate increased slightly, from 10.1 deaths per 100,000 population in 2013 to 10.3 in 2014, equal to the previous highest suicide rate in recent times recorded in 2004.

Research by the Samaritans provides greater detail on the age of those who die by suicide. Their 2016 report uncovers a peak in rates for people aged 45-54 and again at age 80-85 years[6]. As can be seen from the figure below, whilst this true for both sexes, it is a trend much more pronounced for men:

[6] Elizabeth Scowcroft (Samaritans), *Suicide Statistics Report 2016*, May 2016. Available from: http://www.samaritans.org/about-us/our-research/facts-and-figures-about-suicide [Accessed 21/09/2016]

Figure 2: Suicide rates in England by age group[7]



Source: Samaritans (Elizabeth Scowcroft), Suicide Statistics Report 2015

This demonstrates that middle age is a high risk time for suicide in both men and women, but that coupled with a greater number of men dying by suicide overall leads us to the conclusion that men in mid-life are the group at highest risk.

5. Facts and Figures: The Local Picture

The national figures produced by the ONS look at suicides in 3 year aggregates. This is broken down into locality specific data. From this we can see that Coventry had 83 deaths by suicide in the 2012-14 period, which equates to an age-standardised rate of 10.1 per 100,000 population. This continues a downward trend from high of 103 deaths in 2009-11.[8] More recent figures that suggests this downward trend may be continuing with 18 deaths receiving a verdict of suicide following coroner's inquest in 2015 – although this number should be viewed with caution as it is likely to be an under-estimate given that a proportion of suicides do not receive this verdict at inquest.[9]

The table below shows the number of people who died by suicide in Coventry each year between 2005 and 2014; 300 lives were lost prematurely during this time period.

Number of deaths by suicide in Coventry over a 10 year period[8]

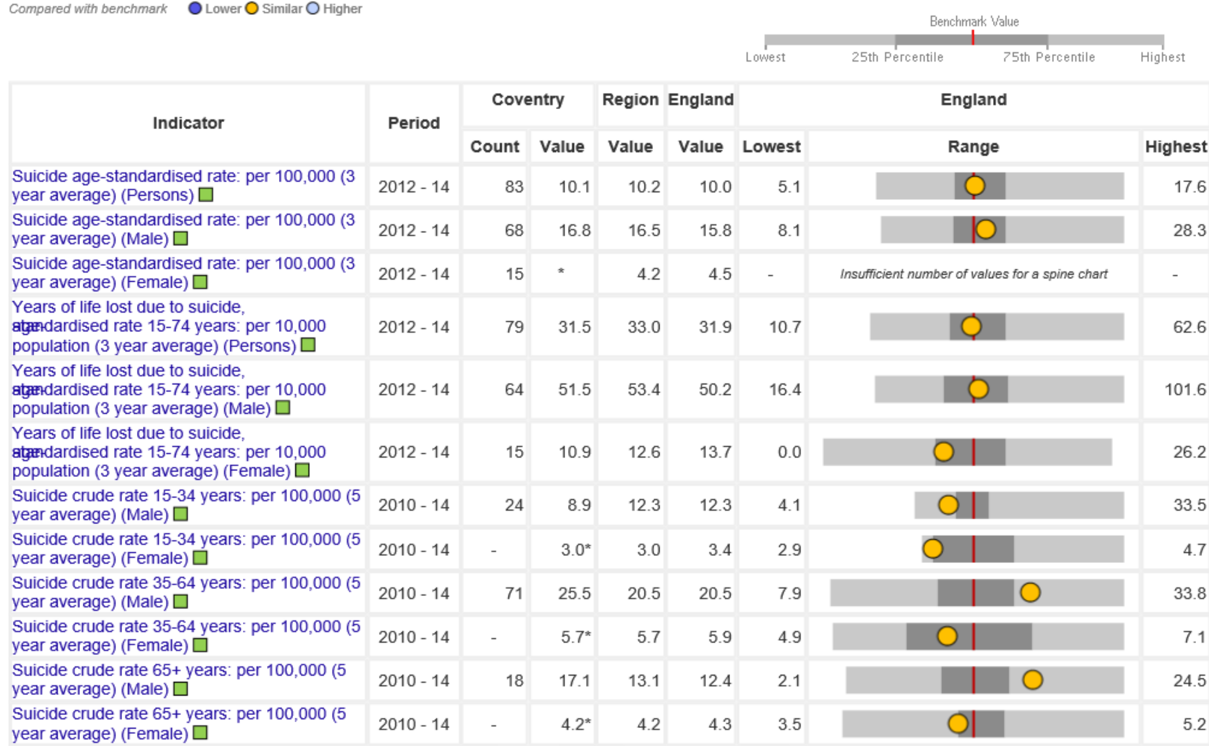
Year	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
No. of deaths	36	26	22	30	41	27	35	27	28	28

Source: Office of National Statistics, Suicide Registrations by Local Authority (February 2016)

Public Health England publishes data that allows us to compare Coventry with both national and regional rates. The table below (Figure 3) shows that, overall, Coventry does not have statistically significant differences in suicide rates to the West Midlands or England. We appear to follow the national trend which puts those in middle age, and particularly men in this stage of life, at the greatest risk of death by suicide.[10]

[7] Figure taken from Elizabeth Scowcroft (Samaritans), *Suicide Statistics Report 2015,* March 2015. Although not the most recent report, there was no change in the age distribution apparent in the updated 2016 report.
[8] ONS, *Table 2: Suicide Registrations by Local Authority*, February 2016. Available from: http://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/suicidesbylocalauthority [Accessed 23/09/2016] N.B. 2014 is the most recent data available from the ONS.
[9] Gunnell D et al, *A Multicentre Programme of clinical and public health research in support of the National Suicide Prevention Strategy for England; Chapter 3 The influence of changes in coroners' practices on the validity of national suicide rates in England,* October 2013, Programme Grants for Applied Research Vol1(1).

Figure 3: Public Health England Suicide Profile for Coventry



Indicator	Period	Coventry		Region	England	England		
		Count	Value	Value	Value	Lowest	Range	Highest
Suicide age-standardised rate: per 100,000 (3 year average) (Persons)	2012 - 14	83	10.1	10.2	10.0	5.1		17.6
Suicide age-standardised rate: per 100,000 (3 year average) (Male)	2012 - 14	68	16.8	16.5	15.8	8.1		28.3
Suicide age-standardised rate: per 100,000 (3 year average) (Female)	2012 - 14	15	*	4.2	4.5	-	Insufficient number of values for a spine chart	-
Years of life lost due to suicide, age-standardised rate 15-74 years: per 10,000 population (3 year average) (Persons)	2012 - 14	79	31.5	33.0	31.9	10.7		62.6
Years of life lost due to suicide, age-standardised rate 15-74 years: per 10,000 population (3 year average) (Male)	2012 - 14	64	51.5	53.4	50.2	16.4		101.6
Years of life lost due to suicide, age-standardised rate 15-74 years: per 10,000 population (3 year average) (Female)	2012 - 14	15	10.9	12.6	13.7	0.0		26.2
Suicide crude rate 15-34 years: per 100,000 (5 year average) (Male)	2010 - 14	24	8.9	12.3	12.3	4.1		33.5
Suicide crude rate 15-34 years: per 100,000 (5 year average) (Female)	2010 - 14	-	3.0*	3.0	3.4	2.9		4.7
Suicide crude rate 35-64 years: per 100,000 (5 year average) (Male)	2010 - 14	71	25.5	20.5	20.5	7.9		33.8
Suicide crude rate 35-64 years: per 100,000 (5 year average) (Female)	2010 - 14	-	5.7*	5.7	5.9	4.9		7.1
Suicide crude rate 65+ years: per 100,000 (5 year average) (Male)	2010 - 14	18	17.1	13.1	12.4	2.1		24.5
Suicide crude rate 65+ years: per 100,000 (5 year average) (Female)	2010 - 14	-	4.2*	4.2	4.3	3.5		5.2

Source: Public Health England, Suicide Prevention Profile

The latest publication from the National Confidential Inquiry has stratified their data across the Coventry and Warwickshire STP footprint – worryingly, this has shown the footprint's suicide rate to be in the upper quintile of English footprints.[11] This gives a different picture to the PHE data, suggesting that our population is more prone to suicide and should serve to emphasise the need to take co-ordinated action across the region.

Reducing suicide requires understanding the underlying causes that pre-dispose to suicidal action. Taking into account the wider determinants that place people at higher risk of suicide, we know that Coventry has high levels of deprivation and that this effects the number of people in our population at higher risk of suicide. Using the Public Health England fingertips data tool referenced above, compared to national figures Coventry has higher rates of homelessness, long term unemployment, children currently in care and consequently high numbers of care leavers in the city. Rates of hospital admissions related to alcohol and self-harm are higher than those for other areas in the West Midlands and nationally. These are areas we can work to understand and improve on, to make a real difference to the risk of suicide within the Coventry population.

The Coventry Mental Well-being and Mental Health Assets and Needs Assessment, completed in 2015, recognises that increasing health inequalities have a detrimental effect on mental health and well-being. There is evidence that suicide risk in men has a linear relationship with socio-economic position, with those who have stable employment, higher educational attainment and higher economic achievement at lowest risk.[12] It is interesting to note that this gradient does not clearly occur in all countries, and that the correlation is not as strong for female suicides. Understanding the role of these factors is vital; suicide prevention needs to be an

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[10] Public Health England, Public Health England Suicide Profile for Coventry [Accessed 21/09/2016]
[11] University of Manchester, The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Making Mental Health Care Safer: Annual Report and 20 year Review: England, Northern Ireland, Scotland and Wales, October 2016. The data used to calculate these rates is not age standardised and includes deaths by those aged 10-14 which are excluded from ONS figures. Furthermore the two differ in that this report uses date of death rather than the date death is registered, as such they include estimated figures in 2013/14 to account for those inquests which have yet to be included.
[12] Lorant V et al, Socio-economic inequalities in suicide: A European comparative study, British Journal of Psychiatry (June 2005) 187 (1) 49-54.

integral part of the wider public mental health and wellbeing agenda to reduce suicidal behaviour across all groups.

The good news is that Coventry has some positives to build on - the Public Health data suggests that mental wellbeing in the city is higher than the national average, with fewer people reporting high anxiety or low happiness scores.[13] We want Coventry to build on this and become a city that promotes mental wellbeing and emotional resilience for all.

6. What factors do we need to consider?

6.1 Gender and Suicide

As we have seen above, men are more likely to die by suicide - three quarters of deaths by suicide in England are men, with those in middle age at particular risk. This is typically a hard to reach group and it is vital that our strategy involves services that men are both able and willing to access.

However, it would be wrong to say that suicide is a male problem; whilst less likely to die by suicide, more women than men attempt to take their own lives each year. This gender paradox was demonstrated in the 2007 household survey of adult psychiatric morbidity which highlighted: [14]

"Women are more likely to experience suicidal thoughts - 19% of women had considered taking their own life. For men the figure was 14%. And women aren't simply more likely to think about suicide – they are also more likely to act on the idea. The survey found that 7% of women and 4% of men had attempted suicide at some point in their lives."

This incidence of suicidal ideation highlights the imperative that we take a holistic, person-centred approach to suicide prevention. Whilst identifying and protecting vulnerable groups is important, if our focus is only on these groups we will miss opportunities to save many others at risk of death by suicide.

6.2 Other Risk Factors

Many people who take their own life are known, or have been known, to mental health services, and as such the quality of their care is a vital aspect of any strategy to reduce suicide. The relationship between self-harm and suicide is complicated and far beyond the scope of this strategy to investigate in full, but it is know that people who self-harm have a significantly increased risk of suicide, particularly in the 12 months following initial presentation.[15] It is crucial to recognise that the right support at the right time for those who present with mental health problems or self-harm could make all the difference to that individual. However, it cannot be forgotten that figures suggest that only 28% of people were in contact with mental health services in the year leading up to their death.[16]

A number of other factors increase the likelihood of someone taking their own life. As well as younger men and those with a history of mental health problems or self-harm, the 2012 National Suicide Prevention Strategy identifies those in contact with the criminal justice system and specific occupational groups such as doctors, nurses, vets, farmers and agricultural workers as being at higher risk. We know that people who have adverse childhood experiences, or who have themselves been bereaved by suicide are also at increased risk.

Certain groups have specific mental health needs that in turn require specific service responses. The 2012 national strategy suggests nine groups that represent particular points of concern:

1. Children and young people – especially those currently in the care system, recent care leavers and those in contact with the criminal justice system.

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[13] Public Health England, Fingertips Data tool 'Related Risk Factors' based on Annual Population Survey published by the ONS, Available from: http://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide/data#page/1/gid/1938132831/pat/6/par/E12000005/ati/102/are/E08000026/iid/22303/age/164/sex/4 [Accessed 21/09/2016]

[14] Adult psychiatric morbidity in England: Results of a household survey, (2007), The NHS Information Centre For Health and Social Care.

[15] Cooper J, Kapur N, Webb R et al. (2005) Suicide after deliberate self-harm: a 4-year cohort study. *American Journal of Psychiatry* 162: 297–303

[16] The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, Annual Report 2015: England, Northern Ireland, Scotland and Wales, July 2015, University of Manchester.

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2. Survivors of domestic and sexual abuse
3. Veterans
4. People with long term physical health conditions
5. People with untreated depression
6. People who misuse drugs and alcohol
7. Lesbian, Gay, Bisexual and Transgender (LGBT) people
8. Black, Asian and other minority ethnic groups and Asylum Seekers
9. Those who are especially vulnerable due to socioeconomic conditions.

Some of these groups featured in the Warwickshire suicide audit, for example the coroner highlighted in one case that provision of high quality mental health care for military veterans needed to be addressed. We know from Coventry's demographics that a higher than average proportion of our population fits into one or more of these vulnerable groups. A particular challenge will be addressing suicide in our migrant and refugee communities, where we will need to address different cultural understandings of suicidal behaviour and mental ill health. This means it is vital that our strategy reaches beyond health services and has a truly multi-sector approach. We must address the barriers faced by these groups that prevent them from seeking and accessing help.

6.3 The Wider Determinants of Health

Suicide is about crisis, a sense of hopelessness and often a lack of purpose. When wider socioeconomic factors bring about negative circumstances, these added pressures, often outside of the control of the individual, can increase the likelihood of suicidal ideation and behaviours. We have seen above that these wider determinants have a significant impact on the likelihood of someone taking their own life. We must fully consider the wider negative socioeconomic determinants and how they can be addressed when developing and implementing our plan for suicide prevention.

6.4 Missed Opportunities

Effective suicide prevention across the public sector is crucial to saving lives. The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2014) highlighted that increased regularity in attendance at GP practices was evident for many people who took their own lives [17]. As the inquiry stated:

> *"Suicide risk increased with increasing number of GP consultations, particularly in the 2 to 3 months prior to suicide. In those who attended more than 24 times, risk was increased 12-fold."*

Every contact can be seen as an opportunity to change the outcome for a person considering suicide. This ethos stretches across primary and secondary care services and wider still in respect of culture, attitude, responses and practice regarding suicide prevention. There is good evidence that investing in GP suicide prevention training makes real differences to reduce the incidence of suicide.

As previously discussed, suicidal behaviour is influenced by a vast number of factors and people can come into contact with a wide variety of agencies. Although there was a correlation between suicide and frequent attenders to GP services, the same inquiry evidenced that 37% of the people who had died by suicide had not seen their GP at all in the previous year. The burden cannot solely be placed on health services to recognise warning signs of suicidal ideation and signpost people to help.

Prison suicides are at the rate of 0.7 per 1,000 and there is a considerable rise in apparent suicides within two days of release from police custody. Furthermore, in 2014 there were 84 self-inflicted deaths in prisons in England and Wales compared to 75 in 2013. Suicide is not just an issue for health services, it must be addressed across the board if we are to see real differences to people's lives.

6.5 Far-reaching Consequences

Suicide is a major social and public health issue. The impact of suicide is devastating and far reaching, affecting not just the individual and those that knew them, but the community as a whole. It carries a financial burden for the local economy and contributes to worsening inequalities. Work done in support of the Scottish suicide

[17] Suicide in primary care in England: 2002-2011. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH). Manchester: University of Manchester 2014.

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prevention strategy looked at the overall cost of suicide – when taking into account direct, indirect and intangible costs arising from the premature loss of life and the impact it has on those who survive them, each life lost carries a potential cost of £1.29-1.67million.[18] Based on the average number of deaths from suicide in Coventry this equates to an annual loss of at least £38.7million.

For family and friends, losing a loved one to suicide can be devastating; they are up to three times more at risk of taking their own lives and can experience severe effects on their health, quality of life, ability to function well at work and in their personal lives. This strategy considers the effect of suicide on people of all demographics in recognition of the fact that one suicide has a much wider impact on their family and community.

7. Our Approach

A half day stakeholder event to drive forward plans for a Coventry City Council Suicide Prevention Strategy was undertaken in September 2015. This event highlighted key areas where it was felt there was an opportunity for change and positive development in respect of suicide prevention. This is outlined in Appendix 2 and reflected within our approach outlined below. Our strategy brings together these local priorities with the national and Warwickshire strategies to put forward an action plan reflecting our **Zero Suicides** vision.

7.1 National Strategies

In 2012 the government published *Preventing Suicide in England: A Cross Government Outcomes Strategy to Save Lives*[19]. The strategy identifies six key areas for action:

1. Reduce the risk of suicide in key high-risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to the means of suicide
4. Provide better information and support to those bereaved or affected by suicide
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Support research, data collection and monitoring.

Following on from this guidance, an All-Party Parliamentary Group (APPG) was tasked with monitoring local authority responses. Their latest report in 2014 recommended that there are three elements vital to successful implementation of the national strategy[20]:

a. Undertaking a 'suicide audit' to understand local risk factors for suicide.
b. Developing a suicide prevention action plan.
c. Establishing a multi-agency suicide prevention group to implement the plan throughout the local community.

The advice of these two national documents, as well as the experiences of other local authorities and international developments in suicide prevention have been taken into account in the development of our Coventry strategy.

7.2 Coventry Stakeholder Event

Our stakeholder event in September 2015 looked at current gaps in provision of services for suicide prevention, the features of an 'excellent' community based suicide prevention programme and asked stakeholders to identify key priority areas. (Appendix 2). From this it was clear that our suicide prevention strategy needed to be rooted in our community with a focus on education and training. It also emphasised the importance of having all agencies working with a co-ordinated approach.

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[18] Knapp M, McDaid D, Parsonage M. *Mental Health Promotion and mental illness prevention: the economic case; 2.11 Population-level Suicide Awareness Training and Intervention*, January 2011, Department of Health. This work was and update to 2009 prices from the previous economic work completed in Platt S, McLean J, McCollam A et al, *Evaluation of the First Phase of Choose Life: the National Strategy and Action Plan to Prevent Suicide in Scotland*, 2006. Edinburgh: Scottish Executive.
[19] Department of Health, *Preventing Suicide in England: A Cross Government Outcomes Strategy to Save Lives,* September 2012. Available from: https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england [Accessed 16/09/2016]
[20] All-Party Parliamentary Group (APPG) on Suicide and Self-Harm prevention, *Inquiry into Local Suicide Prevention Plans in England,* January 2015.

In the course of developing this strategy, as well as considering national guidance, research was conducted into strategies in place elsewhere, both in and outside of the UK, to reduce suicides. Of particular interest was the work carried out by LivingWorks to adapt the Canadian 'suicide-safer communities' model into a framework for action that can be applied internationally[21]. Their work reflected the priorities highlighted by our stakeholder group and provided a focus on which actions provide the greatest impact.

Some significant aspects of the LivingWorks model have been incorporated into our strategy. Firstly, their model relies on gatekeepers - peers or professionals trained in recognising and responding to potential suicidal behaviour. This focus on training and suicide awareness is clear priority for our Coventry stakeholders and our colleagues in Warwickshire, who have commissioned suicide awareness training for all GPs in their area.

Secondly, their model emphasises the importance of sustainable, whole community approaches and multi-agency steering groups. This is an area where we will collaborate with Warwickshire to ensure congruity across the Coventry and Warwickshire region. We are acutely aware that improving mental wellbeing generally across the whole population is key protective feature against suicide and we plan to follow Warwickshire's lead in working to achieve this. We also recognise that working collaboratively with multiple partners and local communities will help embed our strategy to promote long lasting positive change.

The other aspects of the 'suicide-safer communities' model (e.g. services for those bereaved by suicide, improved data collection and evaluation, accessible mental health support and intervention services) are explicit in the national strategies and thus are reflected in our seven 'Warwickshire and Coventry Priorities'.

7.3 Warwickshire and Coventry Suicide Prevention Strategy Priorities

'Joined up provision' was a clear priority from our stakeholder event and many of our providers will work across both Coventry and Warwickshire. This is particularly key in the current climate with joint action occurring through the NHS-led Sustainability and Transformation plan (STP). We have worked closely with our colleagues in Warwickshire to ensure that this strategy mirrors the *Warwickshire Suicide Prevention Strategy 2016-20*.

Seven key priority areas were developed by Warwickshire Public Health with reference to the national strategies. These key priorities will provide the framework for our action plan. Below is an explanation of the seven key areas and what actions they entail within both the Coventry and Warwickshire areas:

1) Reducing the risk of suicide in key high risk groups

This includes efforts to reduce the stigma around suicidal thinking and seeking help, encouraging help seeking and ensuring services are responsive and offer appropriate support. The key high risk groups are identified as middle-aged men, those with known mental health issues especially those under Crisis Resolution/Home treatment plans, those with physical health problems (in particular chronic pain). Further to these key groups, there is an awareness of increased need for support to people in contact with the criminal justice system, certain occupational groups (doctors, vets, farmers, agricultural workers) and the LGBT community.

Both areas will commission suicide awareness training for groups best placed to provide support e.g. local GPs. Work with local GP practices will also aim to publicise the link between poor physical health and suicide. Providers often work across both Coventry and Warwickshire and we will work with them to improve care for those with mental health problems, particularly focusing on crisis care.

In recognition of the data around gender and suicide, we will both ensure services are accessible for men and provide appropriate support. This must also encompass addressing the stigma of suicide and help seeking in those not previously known to services. *It Takes Balls to Talk* has already begun tackling this issue with their successful campaign targeting men at sporting events in Coventry and Warwickshire; this strategy will support the continued promotion of their campaign message.

[21] LivingWorks, Suicide-safer Communities, Available from: https://www.livingworks.net/community/suicide-safer-communities/ [Accessed 16/09/2016]

2) Tailor approaches to improve mental health in specific groups

Young people who self-harm were identified at being at particular risk of suicide and thus efforts will be made to provide services to improve emotional resilience and wellbeing services aimed at young people. In Coventry we have a wider strategic aim across our 0-19 services to provide early help to families and provide the conditions that will build emotional resilience in future generations of children born in the city. In the here and now, we are working to develop a separate strategy to address the mental health and wellbeing of our children and young people. We must also be aware of the needs of our student population and recognise the great resource we have in our universities to address issues in this group.

3) Reduce access to the means of suicide

Both areas aim to address overdose suicides by highlighting issues surrounding the prescription on opiate medication, particularly tramadol and codeine in view of the National Confidential Inquiry figures[22].We have a commitment from Network Rail to work with Coventry to support suicide prevention on railways. Furthermore, we know that suicidal behaviour correlates with substance misuse; tackling the harmful use of alcohol in our city is one approach we can take to reduce impulsive suicidal acts.

4) Reducing the impact of suicide

In recognition of the wider impact of suicide, both areas have identified a need to improve their bereavement services. In order to do this, both areas will work with local people affected by suicide and charitable organisations with experience in this area to develop more effective, timely and practical support. At present, support in Coventry is available through drop-in groups run by SOBS (Survivors of Bereavement by Suicide) and *Facing the Future*, run in partnership between the Samaritans and Cruse Bereavement Care, which provides a more structured form of group support. We will use our connections to improve access to these services where appropriate, and work with them to develop new ideas of how support can be provided. We recognise that people who have lost a loved one to suicide are themselves at high risk of suicidal behaviour and support must be made available to them. There is a commitment from both local authorities to utilise nationally produced material in their provider services, such as the 'Help is at Hand' booklet produced by Public Health England (PHE) and the National Suicide Prevention Alliance (NSPA).

5) Supporting the media in delivering sensitive approaches to suicide and suicidal behaviour

Both areas have existing communications networks that can be used to disseminate national media guidelines to support the work the Samaritans are doing nationwide to address this. We also support the work of local charitable organisations in publicising campaigns which align with our aims of reducing suicide across the region.

6) Improving data and evidence

Having completed a local suicide audit, Warwickshire have a number of areas they plan to look into more deeply. Namely, variations in suicide rates across the region and qualitative work around young people and self-harm. We plan to undertake a similar piece of work in Coventry. Both areas also plan to keep up-to-date with PHE national publications and guidance.

7) Working together

Working together encompasses professional partnerships both within each local authority and further afield. There are plans to establish a multi-agency suicide prevention group with the potential to span both Coventry and Warwickshire. Membership would potentially include input from: the three CCGs

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[22] The report suggests that, in 40% of mental health patient suicides by opiate overdose, the medication had been prescribed for the patient; where the fatal overdose was of codeine or tramadol (or a both in combination) 73% had been prescribed. Although this latter category represents only 16 deaths nationally, it provides a clear focus for preventative action through increased prescription awareness. Report can be found at: University of Manchester, The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Making Mental Health Care Safer: Annual Report and 20 year Review: England, Northern Ireland, Scotland and Wales, October 2016.

in the area, Coventry and Warwickshire Partnership Trust (CWPT), Warwickshire County Council People Group mental health commissioners, Coventry Public Health, Network Rail, Warwickshire and Coventry Police, Coventry and Warwickshire Coroner's office, National Suicide Prevention Alliance (NSPA), Samaritans and other voluntary sector colleagues such as the Farming Community network, service users and suicide survivors from Warwickshire Well-Being Hubs, co-production services and families affected by suicide. This list is not exhaustive and we would encourage all interested partners to have a voice.

Warwickshire's Suicide strategy highlights the importance of sharing information and best practice with the rest of the West Midlands and we are in agreement that Coventry and Warwickshire will work together wherever possible.

Working Together also includes the need to foster closer working relationships with families, particularly those affected by suicide, and to improve communication between families and services around potentially suicidal individuals.

This strategy for Coventry will utilise these same seven priority areas and share actions where appropriate. An initial action plan based around these priorities is available in Appendix 1. Although the ultimate aim is to establish a suicide prevention group spanning Coventry and Warwickshire, it is recognised that achieving this level of collaboration takes time to establish. Therefore, in the first instance it is proposed to set up a Task and Finish Group of interested local partners in Coventry to convene in early 2017 so that action against suicide is not delayed. This group will include representatives from local mental health commissioners, providers and voluntary sector agencies. Through this group, it is envisaged that there will be close collaboration with wider local authority departments, universities and business leaders to broaden our reach beyond those already known to health services.

7.4 Our Potential Partners

In '*Preventing Suicide: A global imperative*' the World Health Organization call for a systematic response to suicide and making prevention a multi-sector priority involving not only health care but education, employment, social welfare, the judiciary and others.[23] The factors leading to someone taking their own life are complex but they *are* amenable to change. This strategy works on the assumption that every suicide is preventable provided that prevention measures address this complexity.

No single organisation is able to directly influence all factors - services, communities, individuals and society as a whole work together to help prevent suicides. Below are examples of areas we need to engage in our work towards **Zero Suicides**:

Arena for Action	**Examples of groups to involve**
Wider Community	Community and voluntary sector organisations, sports clubs, educational establishments, faith groups, retail organisations, housing trusts, prisons and probation services, workplaces, employment support
Health and Well Being Board	Local Authorities, Public Health, CCG, Police, Fire, Voluntary Sector etc.
Primary Care	GP Practices, Community Health Trusts, IAPT providers
Secondary Care	Mental Health Trusts, A&E Departments, CAMHs Teams, Hospitals, Ambulance Trusts

[23] World Health Organization (WHO), Preventing Suicide: A Global Imperative, 2014. Available from: http://www.who.int/mental_health/suicide-prevention/world_report_2014/en/ [Accessed 23/09/2016]

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8. Accountability and Governance

From April 2013 the co-ordination of suicide reduction became a local authority responsibility, with guidance provided by Health & Wellbeing Boards, as set out in the government's 2012 national strategy for suicide reduction "Preventing suicide in England - A cross government outcomes strategy to save lives". The Task and Finish Group leading the work arising from this strategy will provide reports to Coventry Health and Wellbeing board so that progress can be monitored.

9. How will we know when we have achieved our vision?

We will have achieved our overarching vision when we can demonstrate through an action plan that suicides in Coventry have reduced. We will strive to realise zero suicides in Coventry – some may say it is an overly ambitious aim but it is one that will always teach us lessons about where we can improve.

The action plan will be a practical tool for implementation and is intended to be updated regularly to reflect changing needs and demands.

10. Acknowledgements

This document has been produced with significant supporting material from *Warwickshire Suicide Prevention Strategy 2016-20* produced by the Warwickshire Public Mental Health and Wellbeing Team, Warwickshire County Council. We must credit them for developing the seven priority areas on which our strategy relies.

Special thanks to Terry Rigby for his significant contribution in the development of this strategy and to Dr Charlotte Gath (Consultant in Public Health, Warwickshire County Council) for her support.

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Appendix 1

DRAFT Action Plan

The following plan incorporates actions required to meet the nine pillars of a 'Suicide Safer Community' and aligns them to the priority areas produced by Warwickshire. It presents a clear, coherent approach to be applied across Coventry to reflect our vision of Zero Suicides. In the first instance, the Task and Finish Group will co-ordinate these actions and provide oversight between reports to Health and Wellbeing Board. It is expected that a more specific action plan will arise when this group convenes in early 2017.

Objective	Actions	Lead	Timescale	Target Group	Anticipated Outcome
Reducing the risk of suicide in key high risk groups	Support and commission accessible suicide intervention services e.g. improve crisis response, ensure services are responsive and offer appropriate support	CCG		Vulnerable groups, population at risk of mental ill health	Improved clinical intervention to reduce suicide rates
	Support and commission proactive suicide prevention activities e.g. training of community gatekeepers, suicide awareness training for frontline staff	CCG/Public Health		General population/community services involved in preventing suicide	Reduce the risk of suicide in the population; improve communication around the issue of suicide so that people feel safe to seek help and that help is clearly signposted
	Identify opportunities for establishing robust referral and support systems with the necessary training realised e.g. good links with substance misuse services, GP suicide prevention training.	CCG		Vulnerable groups, population at risk of mental ill health	Improve mental health services to allow early intervention to prevent suicide in those with mental health issues.
	Review and improve discharge	CCG/Acute and Mental Health Trusts		Vulnerable groups at higher risk of	Vulnerable people feel supported when they are

	planning processes for vulnerable people e.g. people with known mental health problems, people with chronic illnesses			suicide	stepped down from secondary/tertiary services.
	Build on the success of the It Takes Balls to Talk campaign by continuing to target the suicide awareness message at sporting events in the Coventry and Warwickshire area	It Takes Balls to Talk Steering Group	Ongoing	General population, particularly men	Reduce stigma surrounding suicide; increase help seeking behaviour with regards to mental and emotional health.
Tailoring approaches to improve mental health in specific groups	Within Public Health contracts ensure the promotion of mental health and wellness activities e.g. 0-19 services to increase emotional resilience in young people, reduce stigma around mental distress and suicide	Public Health		General population/ vulnerable groups	Improve overall public mental wellbeing to reduce the risk of suicide
	Ensure active engagement with the Coventry and Warwickshire Mental Health Care Crisis Concordat to drive forward the aim of reducing suicides	CCG	Ongoing	Those with a known mental health problem who could be at risk from suicide	Reduce rates of suicide amongst those known to mental health services
Reducing access to the means of suicide	Increase awareness of overdose of prescribed opiates amongst GPs and hospital prescribers	CCG		Vulnerable groups	Reduce fatal suicide attempts
	Work with network rail	Samaritans	Ongoing	Vulnerable groups	Reduce fatal suicide attempts

	around reducing railway suicide with a particular focus on high risk locations.				
Reducing the impact of suicide	Support accessible suicide bereavement services e.g. improve communication between mental health/crisis services and families	Voluntary sector bereavement support providers		People affected by suicide	Reduce the impact of suicide
	Work in conjunction with existing services to develop support for those exposed to, bereaved by or affected by suicide and encourage the use of the 'Help is at Hand' booklet developed by PHE	Task and Finish Group		Individuals affected/ bereaved by suicide	Reduce the impact of suicide; Standardise approach to supporting those bereaved by suicide
Supporting the media in delivering sensitive approaches to suicide and suicidal behaviour	Support local initiatives through existing communications networks to increase suicide awareness e.g. It Takes Balls to Talk campaign	Comms teams (Public Health/Local Authority/ CCG)	Ongoing	General Population/ Vulnerable populations	Increase in help seeking behaviour; reduce stigma around talking about suicidal feelings
	Participate in World Suicide Prevention Day; as well as publicising events, send an annual reminder to local press about the importance of adhering to Samaritans Media Guidance	Comms teams (Public Health/CCC), Voluntary sector agencies	10th Sept (annually)	General Population	Communicate with the general public that suicide prevention is a priority in Coventry; show support for those in the city affected by suicide

Improving Data and Evidence	Gather background information - incidence/prevalence of suicide in Coventry, awareness of current strategies in place	Public Health	October 2016	Local Authority, other members of the key partnership agencies	Provide knowledge base for interventions and baseline figures to measure improvement
	Undertake a 'Suicide Audit' of coroner's records	Public Health	End of 2016	Board overseeing Suicide Strategy	Identify any vulnerable groups or means of suicide that are a particular risk in Coventry
	Follow national publications, provide evidence for consultations where appropriate and discuss implementation of new recommendations as appropriate	Public Health	Ongoing	CCG/NHS Mental Health Trust, Board Overseeing Suicide Strategy	Coventry is in line with national strategies on suicide prevention
Working Together	Identify a multi-sector committee to oversee implementation of suicide prevention strategy and spearhead future initiatives.	Public Health	ASAP	Stakeholders, key partnership agencies	Clear governance structure and leadership to co-ordinate suicide reduction efforts
	Identify organisations linking in with the Task & Finish Group to support implementation and hold regular engagement events	Task and Finish Group	January 2017	Voluntary sector, national transport agencies, coroner's office etc.	Co-ordinated messages around suicide prevention across all sectors
	Further develop long term opportunities for effective suicide/suicidal	Task and Finish Group		General population whose circumstances increase the	Reduce the chances of reaching the 'crisis point' which we know

	behaviour reduction in the sectors of education, criminal justice, employment, housing, university, and public transport			likelihood of suicidal behaviour regardless of pre-existent mental illness	increases the risk of suicide
	Agree strategy and action plan priorities and monitor delivery of plan	Health and Well Being Board	December 2016	Vulnerable groups, population at risk of mental ill health	Planned actions are achievable within given timescales

Appendix 2

Suicide Prevention:

Overview of the stakeholder event to drive forward plans for a Coventry City Council Suicide Prevention Strategy // 22nd Sept 2015

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A Brief Background

In England, one person dies every two hours as a result of suicide. When someone takes their own life, the effect on their family and friends is devastating. Many others involved in providing support and care will feel the impact.

Figures released by the Office for National Statistics (ONS) in February 2015 showed that suicides in the UK had rose by four per cent in 2013,

In 2013, 6233 suicides were registered in the UK; a rate of 11.9 per 100,000 (19 per 100,000 for men and 5.1 per 100,000 for women).

The male suicide rate is the highest since 2001, and suicides among middle aged men aged 45-59 are at 25.1 per 100,000 which is the highest rate for this group since 1981.

Preventing suicide in England: A cross-government outcomes strategy to save lives (2012) stated

"THERE ARE DIRECT LINKS BETWEEN MENTAL ILL HEALTH AND SOCIAL FACTORS SUCH AS UNEMPLOYMENT AND DEBT. BOTH ARE RISK FACTORS FOR SUICIDE. PREVIOUS PERIODS OF HIGH UNEMPLOYMENT AND/OR SEVERE ECONOMIC PROBLEMS HAVE BEEN ACCOMPANIED BY INCREASED INCIDENCE OF MENTAL ILL HEALTH AND HIGHER SUICIDE RATES."

A recent British Medical Journal Study (published August 2012) showed clear evidence linking the recent increase in suicides in England with the financial crisis that began in 2008 for both men and women.

English regions with the largest rises in unemployment have had the largest increases in suicides, particularly among men. Recent figures for the West Midlands showed that suicide rates have increased by 24 per cent, with 2007 data recording 245 deaths by suicide/undetermined deaths and the 2010 data showing the number of recorded deaths being recorded as 450.

The draft Coventry Mental Well-being and Mental Health Assets and Needs Assessment recognises that increasing health inequalities are having a detrimental effect on the mental health and well-being of the most vulnerable communities and there is a need to develop intelligence and establish a clear framework for ensuring that suicide prevention is realised strategically as an integral part of the wider public mental health and wellbeing agenda.

ONS data 2011-13 highlights that although not statistically significant, suicide in Coventry was 10.0 deaths per 100,000 population, which was higher than both the regional and national estimates (8.3 and 8.8 deaths per 100,000 respectively).

It is recognised by Coventry City Council that to have a real impact on suicide rates across Coventry, there is a need for the development of a City Wide Suicide Prevention Strategy that brings together a range of sectors and service providers across Health and Social Care and beyond.

The Suicide Prevention Stakeholder Event on the 22nd September 2015 brought together a range of organisations from across the city with the following intended outcomes:

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- Awareness of the issue of suicide
- The start of a community approach to suicide prevention
- The development of a multi-agency steering group to inform a Coventry wide strategy
- Knowledge of services, gaps, needs.
- Access to potential future learning opportunities

The Presentation

Based on the outcomes outlined above – An overview of suicide (internationally, nationally and locally), suicide prevention approaches and an opportunity to consider possible next steps was presented to delegates present.

The abridged version of this presentation can be found at the following link in PDF Format

Workshop Discussions:

Three key questions were asked of delegates, with an opportunity to discuss for a 30-minute period of time, before frank on key points. The questions were as follows:

Workshop Responses:

Question 1: What, in your opinion, are the key service gaps in current provision regarding suicide prevention across communities?

The responses have been grouped according to key areas of commonality[24]:

A) Time:

- Time –not enough of this is spent or available, trying to get to the root of problems/issues
- Waiting time for counselling/other services
- GP's – time/approach

B) Knowledge:

- Lack of in depth information only stats
- Stigma of suicide, how it is managed in agencies – recognition not stigma
- Lack of knowledge about organisations/lack of links between organisation
- Links to other areas of wellbeing and support
- Need to have a clear action plan when someone presents suicidal thoughts. This takes the responsibility away from you as you know you have done everything you can to offer support.
- Lack of clarity around responsibility
- Gaps in information for public

C) Resources/Services

- 16-18 years' gap – No adults /Children
- Links to other areas of wellbeing and support
- Lack of prevention support prior to "crisis"
- Lack of knowledge about organisations/lack of links between organisation
- Lack of peer mentoring
- GP's – time/approach
- Out of hours' services / crisis team
- Mental health leads at GP surgeries
- Lack of services for isolated people
- Support for children /teenagers
- Advice for teachers
- Gaps in intervention in general

D) Financial:

- Funding

E) Training:

- Training/reflection upon ability to have difficult conversations or offer help
- Need to have a clear action plan when someone presents suicidal thoughts. This takes the responsibility away from you as you know you have done everything you can to offer support.
- GP's – time/approach
- Advice for teachers
- More training in general

F) Planning:

- Lack of clarity around responsibility
- Gaps in intervention in general

[24] Please note responses have been duplicated where it is felt they fit into more than one category.

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Question 2: What would excellent community based suicide prevention provision look like?

A range of ideas were supplied in respect to "Community Facing" suicide prevention provision. Many of these areas require little investment but would reap great rewards including the development of network opportunities and building on intelligence through improved information.

There appears to be a range of options to be considered further in respect of providing opportunities for upstream engagement in accessible, community based locations – For most of these areas proposed, there is a relatively strong evidence base regarding suicide prevention including GP Training, Buddy Services, Outreach work, Peer support and social media/technology development.

- *Develop inclusion in communities*
- *Things to do – places to go*
- *Build resilience*
- *Develop areas where people feel they can share information – have trust*
- *Training to identify and support (signs – symptoms and behaviour)*
- *A place/ someone to listen*
- *Multi agency working*
- *More outreach work e.g. Schools*
- *Improve drop in services – more accessible with shorter waiting times*
- *Services available to get people involved in activities which will support their wellbeing e.g. home visits to support people to take part*
- *More services for isolated people*
- *Buddy services*
- *Better information*
- *GP training/awareness*
- *Less onus on drugs*
- *Better communication between services (consistency)*
- *On-line support*
- *Peer support*
- *Directory of resources*
- *Appropriate training – for frontline staff*
- *Challenging ideas of suicide*
- *Early intervention*
- *Using different forms of media/tech to cascade messages*
- *Peer support/group support*

Question 3: Please provide 3 priority areas that you think should be included as an "absolute must" in a suicide prevention strategy for communities for Coventry.

The responses have been grouped according to key areas of commonality[25]:

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Education and Awareness Raising

- *Educating young people – schools etc.*
- *Education for people with responsibility i.e. teacher / community leaders etc.*
- *Training*
- *Awareness Campaigns (inclusive, not "mental Healthy" responsible reporting – pressure on media)*

Young People

- *Support for children and young people*
- *Educating young people – schools etc.*
- *Education for people with responsibility i.e. teacher / community leaders etc.*

Community Facing

- *Community based projects*
- *Increased outreach work*

Joined Up Provision

- *A clear formalised referral pathway to specialised services and support meeting the clients need*
- *Multi agency network which is accessible and communicates effectively*
- *Joined up (unified response from all services – coordinated approach)*
- *Clear strategy for information sharing – multi-agency working*
- *Better packages of care following first attempt*

Funding

- *Proper funding with infrastructure to support your clients*

Risk Minimisation

- *Alcohol abuse*

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[25] Please note responses have been duplicated where it is felt they fit into more than one category.

Appendix 3

References and Supporting Material

Data Sources

Updated annually unless otherwise stated.

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Guidance Documents

Department of Health, *Preventing Suicide in England: A Cross Government Outcomes Strategy to Save Lives,* September 2012. Available from: https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england [Accessed 15/11/2016]

All-Party Parliamentary Group (APPG) on Suicide and Self-Harm Prevention. Provided updates in 2014 and 2015 with regards to progress against the 2012 strategy. At the time of writing a further inquiry is underway. Available from: http://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/inquiries/parliament-2015/suicide-prevention-inquiry/ [Accessed 15/11/2016]

Public Health England, Suicide Prevention Resources. Available from: https://www.gov.uk/government/collections/suicide-prevention-resources-and-guidance [Accessed 15/11/2016] Multiple links to PHE guidance including Suicide Prevention: creating a local action plan and documents relating to specific problems e.g. LGBT suicide, suicide in public places).

World Health Organisation (WHO), Preventing Suicide: A Global Imperative. Available from: http://www.who.int/topics/suicide/en/ [Accessed 15/11/2016]

Other Resources

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The Samaritans, Research Report: Men, Suicide and Society, why disadvantaged men in mid-life die by suicide http://www.samaritans.org/about-us/our-research/research-report-men-suicide-and-society Research report containing 5 articles looking at the topic of male suicide.

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observatory/publications/report-series/ Concludes a stronger evidence base needed, but potentially GP training indicated and upstream training in schools effective

Knapp M, McDaid D, Parsonage M (DoH, LSE Personal Social Services Resourse Unit), Mental Health Promotion and Mental Illness Prevention: the economic case, April 2011. Available from: Section 2.11 and 2.12 show evidence for cost effective methods of suicide prevention, again GP training seen to be worthwhile. http://www.pssru.ac.uk/blogs/blog/population-level-suicide-awareness-training-and-intervention/ Blog update to figures in 2014.

Feltz-Cornelis, CM et al, Best Practice Elements of Multilevel Suicide Prevention Strategies: a review of systematic reviews, Crisis (2011). Available from: http://econtent.hogrefe.com/doi/abs/10.1027/0227-5910/a000109 [Accessed 25/10/2016]. Netherlands review of evidence – GP and community gatekeeper training, reducing access to fatal means, targeting high risks groups, sensitive journalistic approaches and public awareness campaigns provided there is access to support available are all potentially effective.

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Moulin L, Aiming for Zero Suicides: an evaluation of a whole system approach to suicide prevention in the East of England, October 2015 Available from: https://www.centreformentalhealth.org.uk/zero-suicides Evaluation of experience of a similar strategy in place in East of England – recommendation includes training for health and police services, importance of working with the coroner, and emphasised ongoing importance of evaluation and evidence building.

Important National Groups

The following groups produce evidence and guidance that have informed the development of this strategy.

The Samaritans http://www.samaritans.org/

National Suicide Prevention Alliance http://www.nspa.org.uk/

Survivors of Bereavement by Suicide (SOBS) http://uk-sobs.org.uk/

Support After Suicide Partnership (SASP) http://www.supportaftersuicide.org.uk/ Available from here is the 'Help is at Hand' the booklet created in conjunction with DoH, PHE, NSPA and TASC to support anyone bereaved by suicide.

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Report

To: Coventry Health and Wellbeing Board **Date: 28th November 2016**

From: Matt Gilks, Director of Commissioning,
Coventry and Rugby CCG and Chair of CAMHS Transformation Board

Title: CAMHS Transformation Plan – Year 1 Refresh

---

1. Purpose

1.1 The purpose of the report is to seek endorsement from the Coventry Health and Wellbeing Board for the refreshed CAMHS Transformation Plan.

2. Recommendations

2.1 Health and Wellbeing Board is recommended to:

- Formally endorse the end of year 1 refreshed plan.
- Receive a year 2 refreshed plan in October 2017.

3. Background

3.1 'Future in Mind' was published in March 2015 by the Department of Health and NHS England. The document set out a series of proposals to improve outcomes for children and young people with mental health problems, emphasising the need for joined up provision and commissioning. These proposals were endorsed by the Five Year Forward View for Mental Health published earlier this year.

3.2 NHS England agreed that access to the new funds for children and young people's mental health announced in the Autumn Statement 2014 and Spring Budget 2015 would follow the development of local Transformation Plans to describe how the national ambition could be translated and delivered locally over a period of 5 years.

3.3 Coventry and Warwickshire developed a joint plan that was submitted in October 2015, and subsequently assured by NHS England, which secured release of £878k funding annually for Coventry and Rugby, recurrent for 5 years.

3.4 Plans have now been in place for a year and each local area was required to refresh their transformation plan to demonstrate to NHS England the progress being made, that the funding is being spent as intended and provide evidence on how services are being transformed.

3.5 The refreshed Coventry and Warwickshire Plan was submitted to NHS England on 07.11.16 for assurance.

4. Coventry and Warwickshire Priorities

4.1 The focus has been on the planning and delivery of the following seven key strategic priority themes:

1. Reducing waiting times for mental health and emotional wellbeing services
2. Provide a crisis response service to support children and young people presenting with self-harm needs and preventing unnecessary hospital admissions
3. Improved access to specialist support, including autistic spectrum disorder (ASD)
4. Providing support to the most vulnerable
5. Strengthening mental health support to children and young people in schools
6. Enhancing access and support through the utilisation of technology
7. Implementation of a dedicated community based Eating Disorder Service

5. Challenges

5.1 There are a range of challenges that the plan has had to address, including:

- Increasing number of referrals
- High rates of ASD presentation
- Higher than average rates of hospital admission for self-harm
- Recruitment of additional staff at a time when nationally there has been an increase in demand for children's mental health professionals and therefore a limited pool of suitably qualified and experienced professionals to appoint

6. Year 1 Progress

6.1 The initial year of the five-year plan has focused on addressing some of the fundamental legacy challenges relating to capacity and demand. Since implementation of the five year plan, the investments made, and development activity has led to the following:

- Sustaining referral to treatment waiting times within 1 week for urgent cases and 18 weeks maximum for routines cases.
- A commitment to ensuring 95% of young people receive a follow up appointment within 12 weeks.
- Embedding the Acute Liaison Service at hospital has ensured timely assessment and support for young people presenting to hospital in crises.
- Approving a new Eating Disorder service model, and recruiting professionals to deliver the service.
- Approving a new service model for supporting Looked After Children and care leavers, and recruiting professionals to deliver the service.

7. **Next Steps**

7.1 For Coventry, in year two the focus will be on:

- When NHS England assure the plan, publish the plan online
- Launching the new dedicated service for Looked After Children and care leavers
- Launching the new Eating Disorder Service, to support young people quicker where they have an eating disorder.
- Signing off and implementing a revised ASD pathway, that ensures earlier support for young people with ASD and reduced waiting times for diagnosis
- The rollout of a strengthened training and support package for teachers, and professionals
- Developing collaborative pathways for young people who may require specialist treatment beds will be a priority, with the aim of supporting more young people in the community, preventing admission and supporting timely discharge.

7.2 The budget allocation for each priority is detailed in table 1. On 28.10.16 a further £210k was bid for from NHS England to facilitate acceleration of reduction in waiting times, including ASD. Commissioners are awaiting the outcome of this bid.

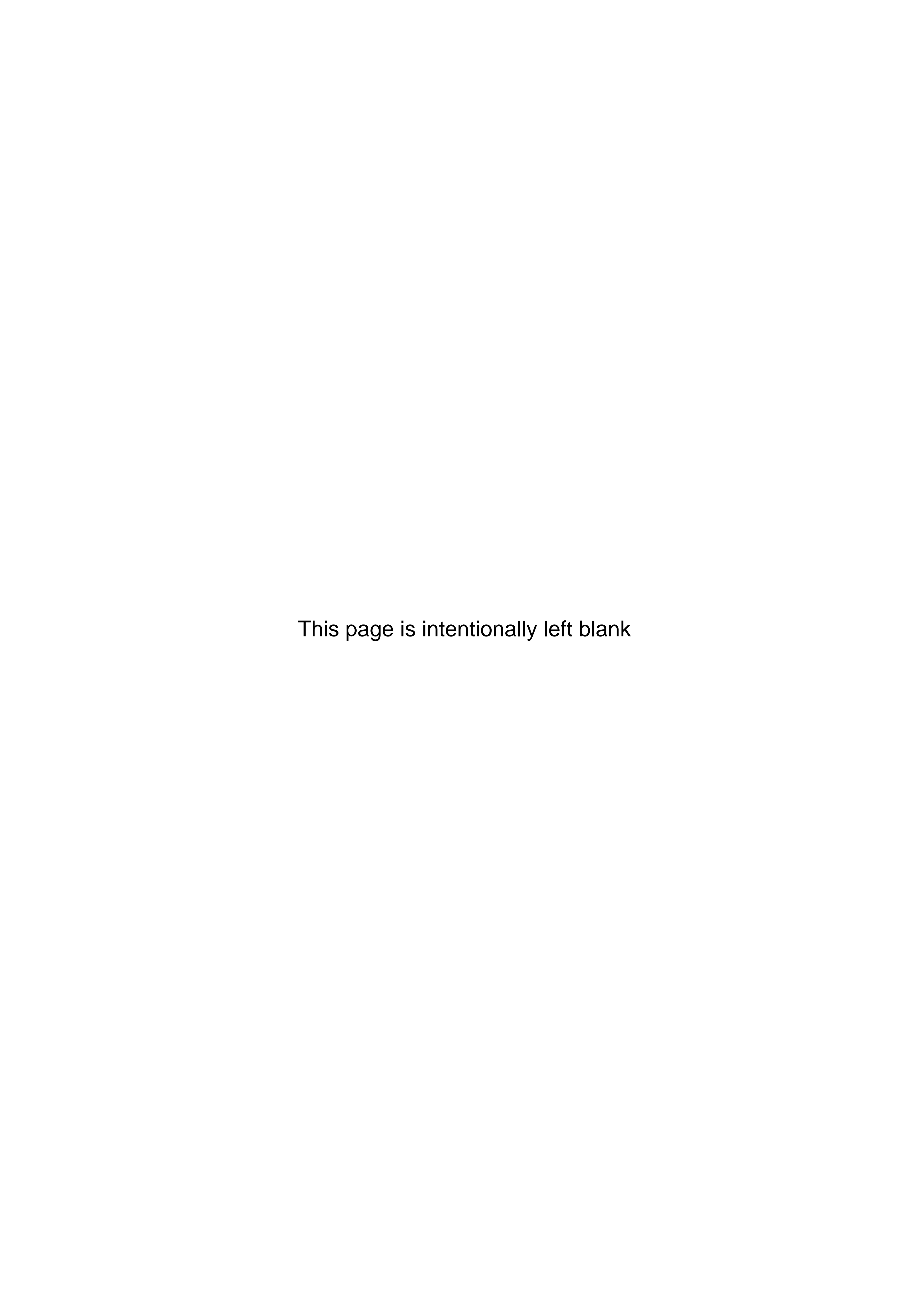
Table 1. Budget allocation for 2016/2017 to each priority

Priority	**Allocation**
Priority 1: Waiting times	£190,125
Priority 2: Crisis support	£143,327
Priority 3: ASD support	£99,000
Priority 4: Vulnerable YP	£87,077
Priority 5: School support	£108,145
Priority 6: Technology	£326
Priority 7: Eating Disorder:	£250,000

Appendices

Report Author:

- Alan Butler – Joint Commissioning Manager
- Tel: 024 7683 3557
- email: alan.butler@coventry.gov.uk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Appendix 1

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Transforming Children and Young People's Mental Health and Emotional Wellbeing

2015 – 2020

For Coventry and Warwickshire

End of Year 1 Refresh

<u>Draft submitted to NHS England for assurance 07.11.16</u>

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Report produced by:

Title	Organisation
Director of Commissioning	Coventry and Rugby CCG

Author/s:

Title	Organisation
CAMHS Programme Manager (Original plan)	Coventry City Council
Joint Commissioning Manager (Refresh)	Coventry City Council/ Coventry and Rugby CCG

Report contributors:

Title	Organisation
Director of Partnerships & Engagement	Warwickshire North CCG
CAMHS Commissioner	Warwickshire County Council
Director of Strategy and Engagement	South Warwickshire CCG
Head of Contracts	South Warwickshire CCG
Deputy Chief Finance Officer	Coventry and Rugby CCG
Medical Director	Coventry and Warwickshire Partnership Trust
General Manager – Specialist Health Service for Children and Young People	Coventry and Warwickshire Partnership Trust
Deputy Director – Public Health	Coventry City Council

Approvals received for original plan:

Approving Body/ Board	Locality	Approval date for original plan
Chair of Health and Wellbeing Board	Coventry & Rugby	13th October 2015
Joint Commissioning Board	Coventry & Rugby	6th October 2015
Chair of Health and Wellbeing Board	Warwickshire	22nd October 2015
Head of People Directorate	Warwickshire	13th October 2015

The refreshed plan is to be considered by Health and Wellbeing Board meetings on:

- Coventry - 28th November 2016
- Warwickshire 7th November 2016

Executive Summary

Funding from the transformation fund has allowed us to accelerate the transformation of our local mental health and emotional wellbeing support. The focus has been on the planning and delivery of the following seven key strategic priority themes:

1. Reducing waiting times for mental health and emotional wellbeing services
2. Provide a crisis response service to support children and young people presenting with self-harm needs and preventing unnecessary hospital admissions
3. Improved access to specialist support, including ASD
4. Providing support to the most vulnerable
5. Strengthening mental health support to children and young people in schools
6. Enhancing access and support through the utilisation of technology
7. Implementation of a dedicated community based Eating Disorder Service

The initial year of the five-year plan has focused on addressing some of the fundamental legacy challenges relating to capacity and demand. Since implementation of the five year plan, the investments made, and transformation activity has led to the following for children and families:

- Consistent delivery of waiting times within 1 week for urgent cases and 18 weeks maximum for routines cases.
- Reduced waiting times for follow up appointments.
- Quicker assessment and support for young people presenting to hospital in crises.

The next year will focus on the more systemic changes required to deliver long term transformation. The partner agencies represented at the CAMHS Transformation Board will plan and implement this change together.

To reflect that it is not in the gift of one agency to transform mental health and emotional wellbeing services and that innovative approaches are required, a new cross cutting theme has been added.

New Cross cutting theme: Implement a whole systems of care and prevention approach – Work more creatively across the system in terms of earlier intervention, preventative and proactive care. This will include developing innovative and partnership approaches across all statutory agencies, voluntary sector agencies, youth justice and communities to redesign services that can be delivered within the resource available and a wide base of organisations. There will be a focus on local authority and partners early help, parenting support and family hubs, to ensure those areas that are most in need can access support when they first need it and alongside other support.

For Coventry, in year two the focus will be on implementing some of the detailed proposals the partnership has developed for:

- A new dedicated service for Looked After Children and care leavers
- A revised ASD pathway, that ensures earlier support for young people with ASD and reduced waiting times for diagnosis
- The rollout of a strengthened training and support package for teachers, and professionals
- Supporting young people quicker where they have an eating disorder.

For Warwickshire commissioners, activity is centred on driving sustainable change through tendering for a single, children and young people's emotional well-being and mental health contract for the County. The competitive dialogue procurement process opened on September 27th 2016 and is due to run until March 2017 where a successful lead provider will be identified.

Across both localities, developing collaborative pathways for young people who may require beds will be a priority, with the aim of supporting more young people in the community, preventing admission and supporting timely discharge.

All the activity in Year 1, and planned for Year 2, is based on the extensive stakeholder engagement including children and young people, parents and carers, providers and professionals that was undertaken by Young Minds to coproduce an outcomes framework for Coventry and Warwickshire. Routine involvement of young people is taking place to inform the implementation, and is gaining momentum. The outcomes framework focusses on the need for increased early intervention and prevention to build the resilience of young people, with greater consistency, integration and support to children, young people and their families, including a crisis response service.

Our vision by 2020:

We will use our transformation plan to locally redesign services to serve the needs of young people and their families across Coventry and Warwickshire that will;

- Provide stepped care through early help, prevention and crisis support to young people and their families to improve their health outcomes, resilience and reduce tier 4 bed usage
- Young people will have access to flexible personalised care, that promotes equality of opportunity and accessibility to meet the individual needs of a diverse multicultural community
- Young people will receive early help and support within schools that will be delivered flexibly and locations and venues to support children including those from vulnerable and hard to reach backgrounds
- Services designed to meet the needs of children, young people and their families so that they can access the right support from the right service at the right time
- Improve and strengthen smoother transitions for young people (including adult services)
- Improved care for children and young people in crisis so they are treated in the right place at the right time and as close to home as possible
- More use of evidenced based practice and interventions
- Vulnerable young people will have access to flexible specialist mental health and emotional wellbeing support, designed and responsive to individual need
- Professionals, young people and their carers will have a greater awareness of mental health and emotional wellbeing services available locally
- Provide a clear sense of direction for all agencies and stakeholders working in partnership to improve the mental health and emotional wellbeing of children and young people in Coventry and Warwickshire

The refreshed plan endorsed for submission to NHS England by:

Councillor Kamran Caan
Chair of Coventry Health & Wellbeing Board

Warwickshire Health & Wellbeing Board
[being considered on 07.11.16]

Matt Gilks
Director of Commissioning
Coventry and Rugby CCG

Jenni Northcote
Director of Partnerships and Engagement
Warwickshire North CCG

Alison Scott
Director of Performance and Contracting
South Warwickshire CCG
(signature attached)

1) Introduction

1.1 Child and Adolescent Mental Health Services (CAMHS) are commissioned across Coventry and Warwickshire by five commissioning organisations using the national four tiered framework. Universal and targeted services (tiers 1 and 2) are primarily lead commissioned by the local authorities (Coventry City Council and Warwickshire County Council), whilst specialist services (tier 3) are funded by the three local Clinical Commissioning Groups (CCGs) – Coventry and Rugby CCG (CRCCG), South Warwickshire CCG (SWCCG) and Warwickshire North CCG (WNCCG), with Coventry and Rugby CCG acting as the contract lead. Inpatient services (tier 4) are funded by NHS England.

2) National and local strategic direction and policy

2.1 The local CAMHS Transformation Plan is informed by local and national policy and context considered to be pertinent in the development of mental health and wellbeing provision for children and young people. In addition to Future in Mind, these include:

- Children Act (2004)
- Closing the Gap (DH, 2014)
- Coventry Health and Wellbeing Strategy (2012)
- Mental Health Act (2007)
- No Health without Mental Health (DH, 2011)
- Promoting the Health and Wellbeing of Looked After Children (2011)
- Warwickshire Health and Wellbeing Strategy
- Working Together to Safeguard Children (2010)

2.2 Other relevant policy and contextual drivers include guidance from the National Institute for Health and Care Excellence (commonly referred to as NICE guidance), Access and Waiting Time standard for children and young people with an eating disorder, DfE guidance on Behaviour and Counselling, Transforming Care and the Crisis Care Concordat.

3) Understanding Local Need and Health Inequalities

3.1 The Office for National Statistics (ONS) population estimates in mid-2013 for all Local Authorities in the UK shows an increase in population year on year. Coventry's population now stands at an estimated 329,810 people, representing a 4.8% increase when compared to 2012. Warwickshire's population is estimated 548,729 people, indicating a 0.14% increase from 2012. Table 1 details the total population for Coventry and Warwickshire:

Table 1: Population of Coventry and Warwickshire

	Total population	0-17 population	18-24 population
Coventry	**329,810**	**74,158**	**41,538**
Warwickshire	**548,729**	**57,420**	**45,268**
North Warwickshire	62,124	6,315	4,562
Nuneaton and Bedworth	126,003	13,779	10,338
Rugby	101,373	11,620	6,996
Stratford-on-Avon	120,767	11,948	7,330
Warwick	138,462	13,845	16,042
Total / Combined	**878,539**	**131,578**	**86,806**

Source: ONS 2015

3.2 Figure 1 details the administrative boundaries for Coventry and Warwickshire, comprised of two upper tier local authorities and three CCG's

Figure 1: Map of Coventry and Warwickshire

Local Authority boundaries

- Coventry City Council: Unitary Authority
- Warwickshire County Council and Districts:
  - North Warwickshire
  - Nuneaton and Bedworth
  - Rugby
  - Warwick
  - Stratford-Upon-Avon

CCG boundaries

- Coventry and Rugby CCG: Coventry City and Rugby District
- South Warwickshire CCG: Warwick and Stratford Districts
- Warwickshire North CCG: North Warwickshire and Nuneaton and Bedworth Districts

3.3 Table 2 shows estimated prevalence rates across Coventry and Warwickshire of the most common mental disorders based on the ONS Child and Adolescent Mental Health Survey, 2004. While these figures are based on research data over 10 years old, the research base is comprehensive.

Table 2: Estimated prevalence rates of the most common mental health disorders

Disorder	Age (Years)	Prev. %	Warks	North	Nun & Bed	Rugby	Stratford	Warwick	Coventry	Total
Mental disorder	5-10	7.7	2848	301	675	562	592	685	1873	4720
	11-16	11.5	4276	500	1002	854	936	979	2410	6685
	5-16	*9.6*	*7119*	*792*	*1678*	*1414*	*1519*	*1672*	*4346*	*11466*
Anxiety Disorder	5-10	2.2	814	86	193	161	169	196	535	1349
	11-16	4.4	1636	191	383	327	358	375	922	2558
	5-16	*3.3*	*2447*	*272*	*577*	*486*	*522*	*575*	*1494*	*3941*
Depression	5-10	0.2	74	8	18	15	15	18	49	123
	11-16	1.4	521	61	122	104	114	119	293	814
	5-16	*0.9*	*667*	*74*	*157*	*133*	*142*	*157*	*407*	*1075*
Conduct Disorder	5-10	4.9	1812	191	430	358	376	436	1192	3004
	11-16	6.6	2454	287	575	490	537	562	1383	3837
	5-16	*5.8*	*4301*	*479*	*1014*	*854*	*917*	*1010*	*2626*	*6927*
Hyperkinetic (severe ADHD)	5-10	1.6	592	62	140	117	123	142	389	981
	11-16	1.4	521	61	122	104	114	119	293	814
	5-16	*1.5*	*1112*	*124*	*262*	*221*	*237*	*261*	*679*	*1792*
Self-Harm	5-16	8.3	6155	685	1451	1223	1313	1445	*3758*	*9913*

Looked After Children

3.4 There are currently 578 looked after children in Coventry and 736 in Warwickshire, who are accommodated by the local authority.

3.5 In Coventry 47.8% of the LAC population are female, and 52.2% male.

3.6 Teenagers make up the highest proportion of LAC in both Coventry and Warwickshire. However, the age range data is presented differently making comparisons difficult (figure. 2)

Figure 2: LAC age profiles (September 2016)

3.7 As of August 2016 the three highest rates of ethnicity for Coventry LAC were 68.4% white British ethnicity, 5% white Caribbean, 4.7% African. In Warwickshire, 76% are white British, 6% Asian, and 3% white and black Caribbean.

3.8 Of this population in Coventry, 11% have a recorded disability. In Warwickshire, 7% of LAC has a recorded disability.

3.9 In Coventry 11.7% of current LAC have had 3 or more placement in the last 12 months. In Warwickshire, 18.8% of current LAC has had 3 or more placements. The Social Inclusion Unit has highlighted placement instability as a key barrier to improving educational outcomes for children and young people.

3.10 21.2% of looked after children from Coventry are placed in more than 20 miles from the city.

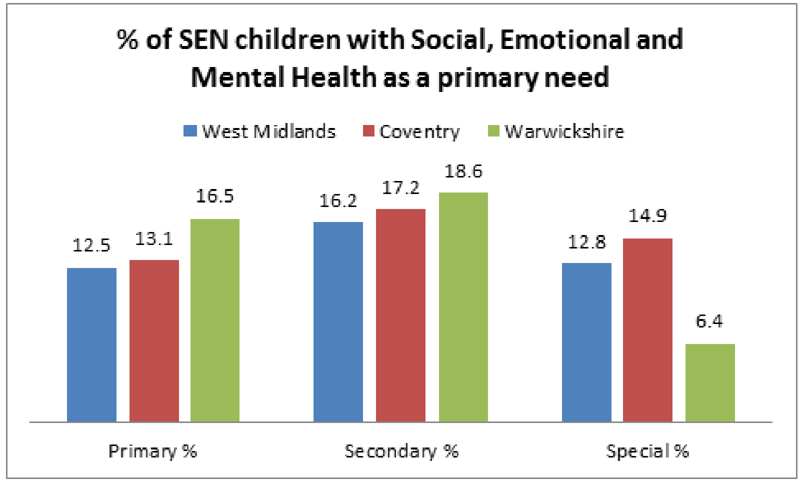
Educational Related Needs

3.11 Supporting educational attainment is a key driver for local change. In terms of the educational attainment of the whole young person population in Coventry, 47% of Year 6 children (provisional) achieved the expected standard in reading, writing and mathematics 2016. Coventry was placed 6th among its 11 statistical neighbours in 2016. In 2016, 54% of pupils achieved 5 A*-C GCSEs including English and Maths – a 3% point increase on 2015 and above statistical neighbour performance if it stays the same as in 2015 NB: 2016 data is provisional.

3.12 During 2016 in Warwickshire 57% of Year 6 children achieved at least the expected standard in reading, writing and mathematics, ranking 3rd among 11 statistical neighbours for this measure. Also, 67% of Year 11 pupils achieved grades A*-C in English and Maths GCSEs – a 4% increase on 2015 (63%) and above both national (63%) and statistical neighbour (64%) performance. NB: All 2016 data is provisional.

3.13 Coventry has a slightly higher percentage of children with a statement of SEN / EHC plan with social, emotional and mental health needs (identified as a primary need) compared to the West Midlands average. Coventry has a lower percentage when compared to Warwickshire in primary and secondary schools. The exception is found in special schools where Warwickshire has a significantly lower percentage at 6.4% compared to Coventry (14.9%) and West Midlands (12.8%)

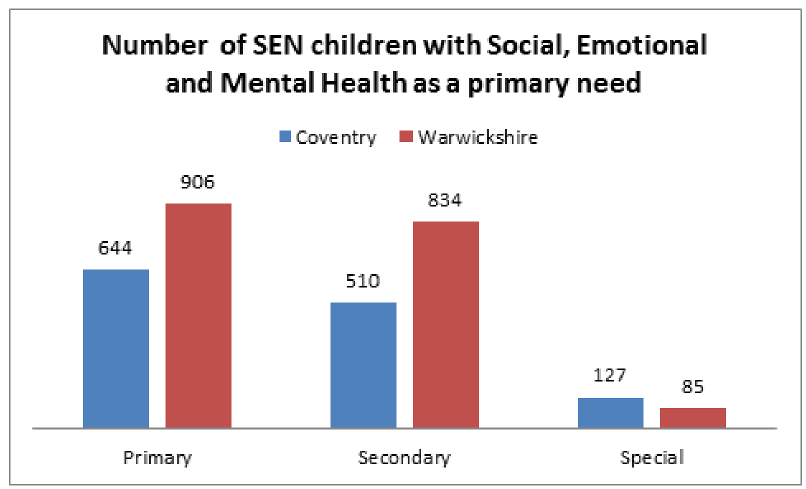
Figure 3: Percentage of SEN children with social, emotional and mental health as a primary need



Data source: Department for Education, Special Educational Needs in England 2016, first published July 2016
Link to data: https://www.gov.uk/government/statistics/special-educational-needs-in-england-january-2016

3.14 In terms of actual numbers of children, Coventry has significantly less children with a statement of SEN / EHC plan with social, emotional and mental health needs (identified as a primary need) compared to Warwickshire, except with regard to special schools.

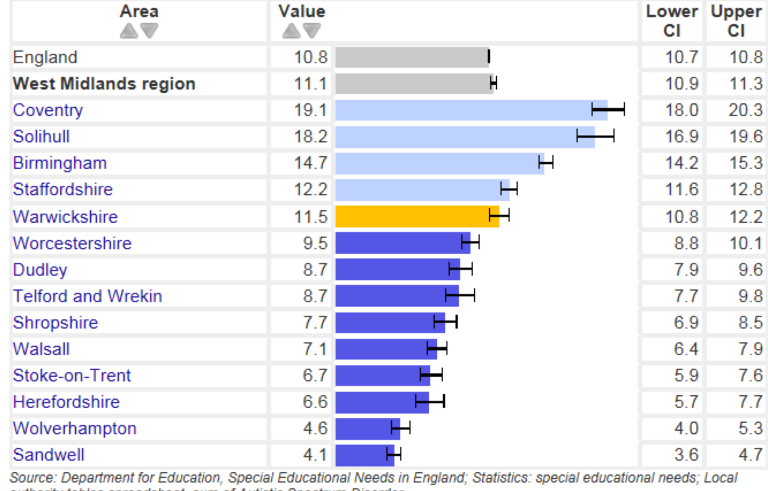
Figure 4: Number of SEN children with social, emotional and mental health as primary need.



Autistic Spectrum Disorder

3.15 Coventry has the highest rate of pupils with autism across the West Midlands (figure. 5). The key challenge for the service relates to the number of referrals and impact on the waiting list for an assessment. The pathway was based on a referral rate of 300 referrals per year. Currently the service is reporting around 90 referrals per month which equates to 1,080 per year. Warwickshire is 5th, and has different pathways.

Figure 5: Children with autism known to schools, per 1000 pupils



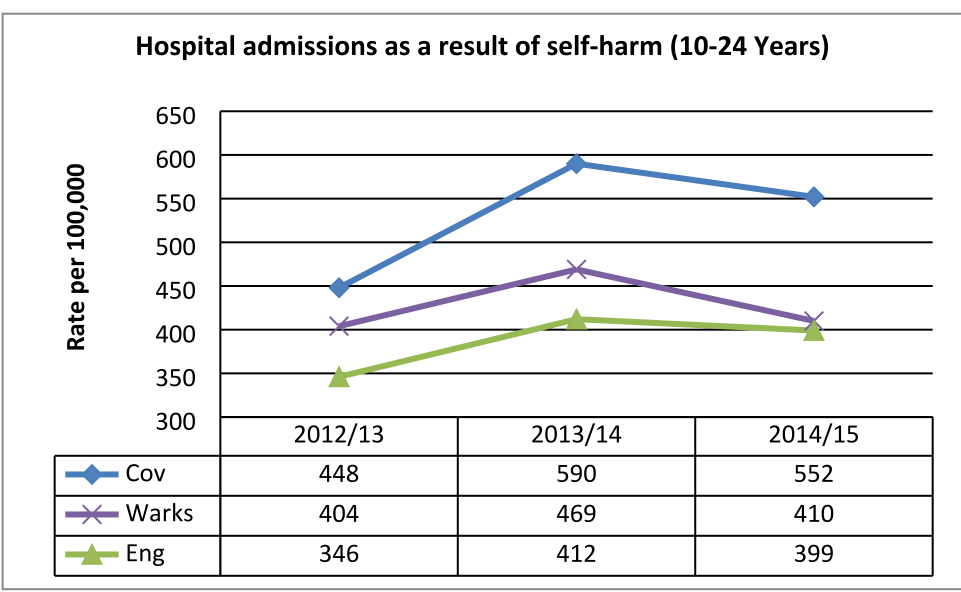
Area	Value	Lower CI	Upper CI
England	10.8	10.7	10.8
West Midlands region	11.1	10.9	11.3
Coventry	19.1	18.0	20.3
Solihull	18.2	16.9	19.6
Birmingham	14.7	14.2	15.3
Staffordshire	12.2	11.6	12.8
Warwickshire	11.5	10.8	12.2
Worcestershire	9.5	8.8	10.1
Dudley	8.7	7.9	9.6
Telford and Wrekin	8.7	7.7	9.8
Shropshire	7.7	6.9	8.5
Walsall	7.1	6.4	7.9
Stoke-on-Trent	6.7	5.9	7.6
Herefordshire	6.6	5.7	7.7
Wolverhampton	4.6	4.0	5.3
Sandwell	4.1	3.6	4.7

Source: Department for Education, Special Educational Needs in England; Statistics: special educational needs; Local authority tables spreadsheet, sum of Autistic Spectrum Disorder

Self-Harm

3.16 The latest validated comparative data available from Public Health England demonstrates that hospital admission for self-harm fell between 2013/14 and 2014/15 across Coventry and Warwickshire, in line with a fall across England as a whole.

Figure 6: Self-harm admissions



Eating Disorders

3.17 National statistics indicate the number of individuals affected by an eating disorder could be between 1.1 million to 1.6 million.

3.18 Data for the last full year (2015) shows that there were 88 referrals for eating disorders across Coventry and Warwickshire.

Table 3: Number of ED referrals over 30 months (2014 to Jun 2016)

	2014	2015	Jan – Jun 2016 (6 months)	Total (30 months)
C&RCCG	4	53	15	**72**
WNCCG	2	9	8	**19**
SWCCG	30	26	12	**68**
Total	**36**	**88**	**35**	**159**

3.19 However, it is important to note that the overall numbers of Eating Disorder referrals are small compared to other presentations and also difficult to predict and so it is very difficult to draw any meaningful conclusions from comparisons from one year to the next and the data cannot be considered to be statistically significant.

Youth Justice

3.20 Dedicated support is available for young people who are on the caseload of youth offending/ youth justice teams. In Coventry in 2015/2016 92 young people attached to the service had a specialist mental health assessment.

Full Joint Strategic Needs Assessment Documents

3.21 For a full overview of the wider needs assessment, consult the Joint Strategic Needs Assessments available at:

- Coventry: -
  http://www.coventry.gov.uk/downloads/file/21652/joint_strategic_needs_assessment_2016
- Warwickshire:
  http://hwb.warwickshire.gov.uk/about-jsna/
  http://hwb.warwickshire.gov.uk/2016/08/05/child-adolescent-mental-health-camhs-needs-analysis-published/

Implications

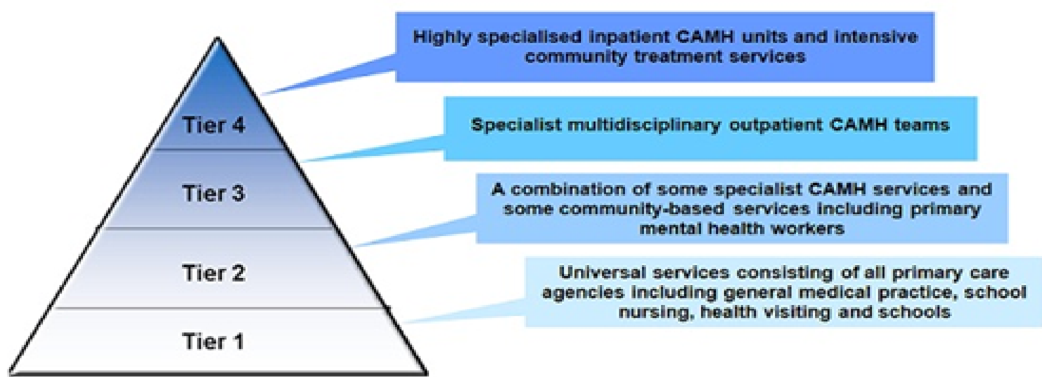
3.22 The high level overview of local need above demonstrates a significant level of need in Coventry and Warwickshire and specific variations in need.

3.23 The implication is that Coventry and Warwickshire, while being part of the same transformation programme and collaborative, the two localities require tailored approaches for some work streams to address the variations in local need. Specifically, section 8 of this document details the tailored approaches taken to service development for:
- ASD pathway in Coventry
- Support for vulnerable young people in Coventry
- The competitive dialogue approach being pursued in Warwickshire to identify and implement innovative solutions to local need

4) 2015-16 Baseline - Service provision and activity across Coventry and Warwickshire

4.1 Coventry and Warwickshire has historically adopted the national four tiered strategic framework to provide structure to the commissioning of local provision as illustrated in figure 7.

Figure 7: National Tiered Framework



4.2 A range of services are commissioned jointly across Coventry and Warwickshire, as detailed in table 4:

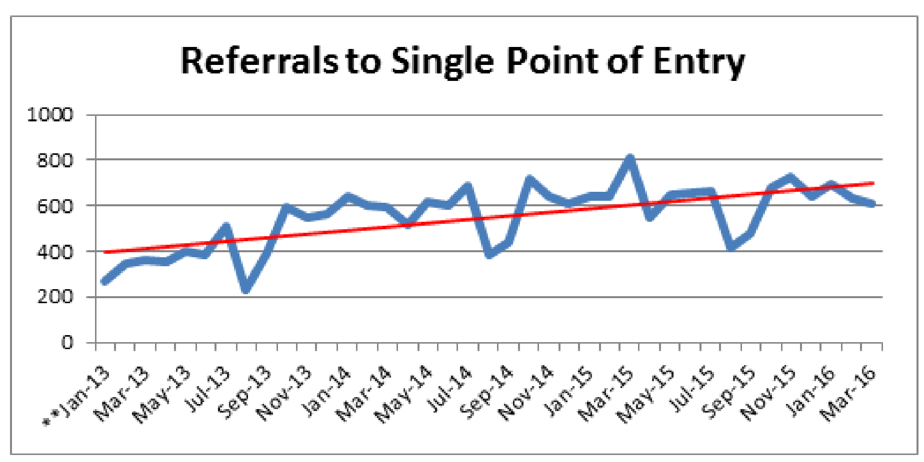
Table 4: Commissioned CAMHS services across Coventry and Warwickshire

Commissioner	Service	Provider	Description	Cost per annum
Tier 1: Support to universal services				**£519k**
Warwickshire County Council (WCC)	**Primary Mental Health Service (PMHW)**	Coventry and Warwickshire Partnership Trust (CWPT)	Consultation, advice and training to practitioners. Hold small caseload	£239,000

Commissioner	Service	Provider	Description	Cost per annum
Coventry City Council (CCC)	**Integrated Primary Health Service (IPMHS)**	CWPT, Coventry and Warwickshire Mind, Relate Coventry and Warwickshire	Consultation, advice and training to practitioners. Hold small caseload	£221,000
Tier 2: Early intervention for mild to moderate mental health issues				**£792k**
WCC CCC	**Reach**	Coventry and Warwickshire Mind and Relate Coventry and Warwickshire	Stepped care: 1. Online advice 2. Peer support 3. Therapeutic groups 4. Counselling	WCC: £160,000 CCC: £112,000
WCC CCC	**Journeys**	Coventry and Warwickshire Mind, Relate Coventry and Warwickshire	Targeted support to Looked After Children and young people (LAC) and their carers.	WCC: £185,000 CCC: £185,000
WCC	**MHISC (Mental Health Interventions for School Children)**	Framework of 11 providers	Targeted interventions for young people with an open CAF	£150,000 (from Dedicated School Grant)
Tier 3: Specialist interventions for severe mental health issues				**£7m**
CCGs (Coventry and Rugby CCG Lead Commissioner)	**Specialist CAMHS**	CWPT	Specialist Support for children with severe mental health issues	£7m approx. (across Coventry and Warwickshire)

4.3 CWPT host and manage the single point of entry (SPE), with input from Mind and Relate. The SPE triage referrals against joint thresholds to ensure children are directed to the right service. The key challenge for the system as a whole remains the volume of referrals. The overall trend is a steady increase in referrals (figure. 8).

Figure 8: Referrals to Single Point of Entry (January 2013 – March 2016)



4.4 7,368 referrals were received across Coventry and Warwickshire in 2015/2016 (table 5).

4.5 Approximately 12% of referrals were inappropriate in Coventry and Rugby, 10% in South Warwickshire and 16% in Warwickshire North.

Table 5: All referrals to Single Point of Entry 2015/16

ALL NEW REFERRALS TO SINGLE POINT OF ENTRY													
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Total**
Coventry & Rugby	308	360	383	376	250	252	371	419	363	395	346	377	**4200**

South Warks	131	164	142	166	92	139	145	171	151	172	158	137	**1768**
North Warks	110	126	127	124	70	85	160	134	127	128	113	96	**1400**
Total	**549**	**650**	**652**	**666**	**412**	**476**	**676**	**724**	**641**	**695**	**617**	**610**	**7368**
INAPPROPRIATE - returned to referrer													
Coventry & Rugby	38	44	49	54	32	30	53	46	49	31	38	21	**485**
South Warks	12	11	13	26	9	18	25	13	13	19	14	12	**185**
North Warks	20	18	23	26	16	19	32	17	20	20	10	5	**226**
Total	**70**	**73**	**85**	**106**	**57**	**67**	**110**	**76**	**82**	**70**	**62**	**38**	**896**

Mental health and emotional wellbeing support in universal services

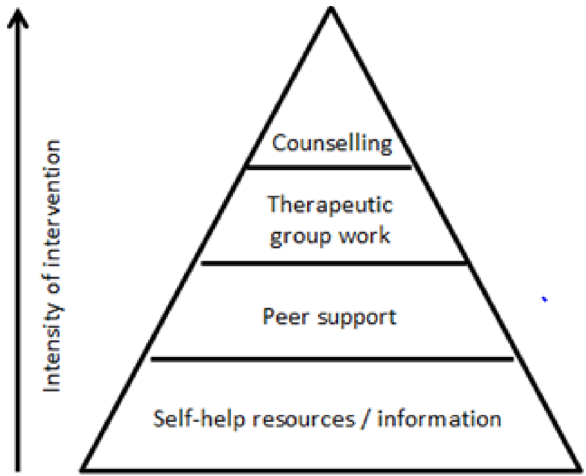
4.6 The **Primary Mental Health Service** provides practical support to universal professionals (including GP's, School teachers and social care professionals) to assist in the early identification and prevention of mental health and emotional wellbeing needs in children and young people.

4.7 The Coventry service consists of 5.6 full time equivalents (fte) including 1fte Team Leader, 2.6fte Primary Mental Health Workers and 2fte Primary Mental Health Advisors. The proposal is that that this service will expand in line with the transformation priority of increasing support in schools .The Warwickshire service consists of 4fte; including 1 part time Team Leader.

4.8 The workforce section later in this paper outlines the activity of the service, and its strategic role in building capacity.

4.9 **The Reach service** is commissioned across Coventry and Warwickshire to work directly with children and young people to provide therapeutic group work, face to face and online counselling services using a stepped care approach, as outlined in figure 9:

Figure 9: Stepped model of interventions



4.10 The service consists of 4.2fte Primary Mental Health Workers who hold qualifications in working with children and young people and 4.8fte counsellors specialising in CBT, systemic practice and family therapy and service managers to provide operational management and oversight.

4.11 During 2015/16, 1,975 children and young people were referred to the service. Most referrals came from either educational professionals (36%) or GP's (26%). The main areas of presenting concern were in relation to anger, family conflict, anxiety and phobias, behaviour and self-esteem.

4.12 During 2015/16, 2,295 children and young people commenced treatment, including 628 children and young people were supported through the counselling process, and 1,084 children and young people were support through a group based intervention. In the region of 40% of the service is directed to Coventry children and 60% to Warwickshire children.

4.13 There is an average wait of 8 weeks from referral to intervention across Coventry and Warwickshire for group work and 5 to 6 weeks for counselling.

4.14 Combined Coventry and Warwickshire outcomes reporting for Reach evidences the service has a positive impact on outcomes. In 2015/2016, on average, young people were presenting within the abnormal clinical range at the start of intervention, and had moved in to the normal clinical range by the end of the intervention.

Table 6: Mean SDQ Score 2015/2016 (Reach Service)

	Mean score	Clinical Range
Pre intervention	17.73	Abnormal
Post intervention	13.96	Normal

4.15 **The Journeys service** is commissioned to work with children and young people (0-18) who are Looked After or Adopted and have mild-moderate mental health and emotional wellbeing issues, in addition to Foster Carers/Adopters and professionals working with LAC.

4.16 The service consists of 5fte Primary Mental Health Workers and 2fte Counsellors, and received clinical consultation from Phoenix Psychological Services. The service works closely with the Specialist CAMHS service to enable the needs of the young person to be discussed at tier 3 for possible step up through the tiers, and also used to step cases down from CAMHS into Journeys.

4.17 The direct interventions delivered to children and young people include counselling and therapeutic conversations, family counselling, solution-focussed and behavioural therapeutic work delivered by Primary Mental Health Workers and Occupational Therapists and therapeutic work involving creative play and art.

4.18 During 2015/16, the service received 233 referrals across Coventry and Warwickshire. During this time the average caseload was 131 at any one time. 2,723 one to one sessions were delivered in 2015/2016. The service has also provided 63 training workshops for carers and professionals with an average of 100 attendees per quarter. The training workshops offered include fostering attachments, youth mental health first aid, basic counselling skills and case group supervision for residential social workers.

4.19 The current wait from referral received to assessment offered is 1 week; from assessment to intervention is 6-8 weeks.

4.20 Combined Coventry and Warwickshire outcomes reporting evidences the service has had a positive impact on outcomes in 2015/2016. On average, young people were presenting within the abnormal clinical range at the start of intervention, and had moved in to the normal clinical range by the end of the intervention. (table 7)

Table 7: Mean SDQ score Q4 (Journeys Service)

	Mean score	Clinical Range
Pre intervention	18.12	Abnormal

Post intervention	13.83	Normal

4.21 As described in later sections, for Coventry the Journeys service is in the process of integrating in to a new service in partnership with CWPT, for vulnerable young people, including LAC.

4.22 The **Specialist CAMHS Service** provides therapeutic support to children and young people with moderate to severe mental health and emotional wellbeing needs. Support is provided using a broad variety of interventions including, assessment, formulation and treatment planning, individual, group and family interventions, appropriate mental health psychometric tests, training and supervision.

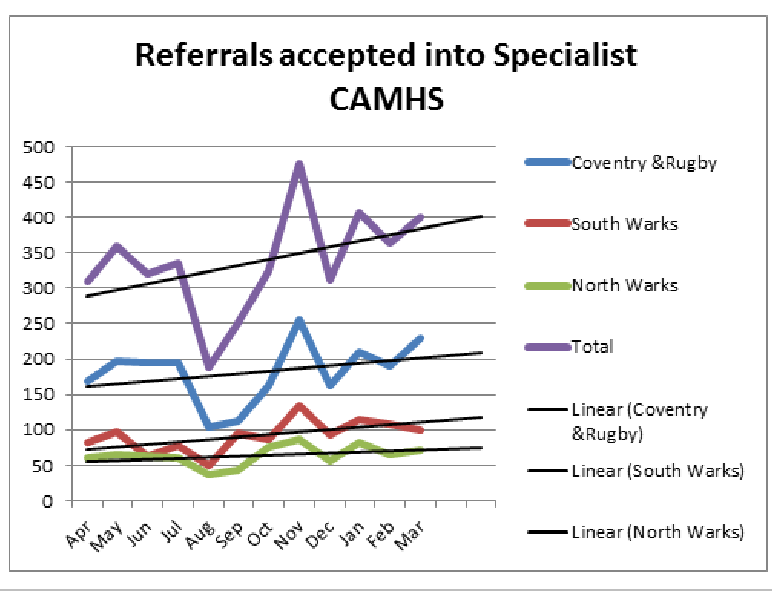
4.23 At the point of the this plan commencing the service consisted of 99.59fte including a range of clinical and non-medical professionals from a wide range of disciplines including Specialist Nurses, Psychologists, Psychiatrists, Art Therapists, Systemic Family Therapists, Child Psychotherapists, Occupational Therapists, Speech and Language Therapists, Nursery Nurses and Support Workers.

4.24 During 2015/16, over 4,047 referrals were accepted across Coventry and Warwickshire for Specialist CAMHS services (table 8) 54% of referrals accepted were for Coventry and Rugby, 27% within South Warwickshire, 19% within Warwickshire North.

Table 8: Referrals accepted by specialist CAMHS

ACCEPTED BY SPECIALIST CAMHS Excluding inappropriate and re-directed referrals													
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Coventry & Rugby	168	197	195	195	103	113	163	255	163	210	190	229	**2181**
South Warks	82	97	62	79	50	95	87	134	93	114	108	99	**1100**
North Warks	60	65	63	61	36	43	75	86	56	83	66	72	**766**
Total	**310**	**359**	**320**	**335**	**189**	**251**	**325**	**475**	**312**	**407**	**364**	**400**	**4047**

Figure 10: Referrals accepted into specialist CAMHS 2015/16



4.25 Data captured by the service details the main area of presenting concern with severe presentations were in relation to anxiety, self-harm, ADHD, Behavioural difficulties, care management, family relationships and attachment problems.

4.26 In 2015/16 the service met targets for referral to the commencement of treatment in 10 out of 12 months (table 9). In the two months where not all targets were met, urgent cases were still seen within timescale.

Table 9: 2015/16 specialist CAMHS response time KPI's

	URGENT				ROUTINE			
2015/16	**<5 days**	**%**	**>5 days**	**%**	**<18 wks**	**%**	**<26 wks**	**%**
January	9	100%	0	0%	132	97.10%	4	100%
February	7	100%	0	0%	127	96.40%	5	100%
March	11	100%	0	0%	129	97.70%	3	100%
April	4	100%	0	0%	98	98.00%	2	100%
May	3	100%	0	0%	127	97.69%	3	100%
June	7	100%	0	0%	123	90.44%	13	100%
July	8	100%	0	0%	121	91.67%	11	100%
August	3	100%	0	0%	94	98.95%	1	100%
September	3	100%	0	0%	108	100%	0	100%
October	1	100%	0	0%	137	100%	0	100%
November	6	100%	0	0%	149	100%	0	100%
December	1	100%	0	0%	104	100%	0	100%
January	2	100%	0	0%	121	100%	0	100%
February	0	-	0	0%	110	99.1%	0	100%
March	5	100%	0	0%	126	100%	0	100%

4.27 Waiting times for initial follow up appointments have improved (as demonstrated in progress on priority 1, later in this paper).

4.28 In 2015/16 in Coventry and Rugby, the number of children and young people open for treatment on the caseload increased from 1086 at the beginning to 1809 at the end of the year. In Warwickshire the caseload increased from 1454 to 1878 (table 10).

Table 10: 2015/16 Caseload of young people open for treatment

2015/16 Caseload	April 2015	March 2016
Coventry and Rugby	**1086**	**1809**
Warwickshire	**1454**	**1878**

4.29 In 2015/16 there were 3,205 young people discharged from treatment across Coventry and Warwickshire (table 11).

Table 11: 2015/16 Discharges

2015/16	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Coventry and Rugby	**160**	**148**	**181**	**234**	**182**	**122**	**132**	**138**	**126**	**131**	**149**	**127**	**1830**
South Warwickshire	**79**	**78**	**81**	**93**	**54**	**62**	**40**	**53**	**53**	**58**	**67**	**56**	**774**
Warwickshire North	**48**	**57**	**54**	**77**	**41**	**59**	**38**	**32**	**35**	**41**	**65**	**54**	**601**

4.30 The service has experienced an increasing demand for assessment for Autistic Spectrum Disorders (table 12).

Table 12: ASD referrals

Area	Number awaiting ASD assessment (school age) – Aug 2016
Coventry and Rugby	592
South Warwickshire	189
Warwickshire North	175

4.31 **The Acute Liaison Service** is based primarily at University Hospital Coventry and Warwickshire and Warwick Hospital, and is delivered by CWPT. The service provides a rapid response to incidences of self-harm amongst young people in Coventry and Warwickshire (table 13).

Table 13: Number of YP assessed at UHCW and provided with a follow up appointment 2015/16

Apr/May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
49	27	22	3	15	15	28	5	31	43	37

4.32 In addition to the commissioned CAMHS services across Coventry and Warwickshire, there is a vast array of diverse provision on offer to support the emotional wellbeing and mental health of children and young people, provided through the local authority.

4.33 Coventry City Council has been successful in obtaining additional funding from the Department of Education's Care Innovations Programme to implement the ***Multi Systemic Therapy Programme (MST)*** *and KEEP programme* in Coventry. MST provides intensive therapeutic support to children, young people and their families at the edge of entering care or custody aged 11 to 17 years, using evidenced based practice and providing wrap around support available 24 hours a day, 7 days a week.

4.34 The **KEEP programme** provides dedicated parenting training, using evidenced based practice techniques, to Foster Carers, friends and family carers and carers with guardianship responsibilities, to prevent placement breakdown and disruption. Based on the significant impact both evidenced based programmes have demonstrated since implemented in 2012, Coventry City Council has mainstreamed both services, as part of the core service offer available for vulnerable young people and their families in the city.

*The **Books on Prescription*** scheme enables health professionals to prescribe self-help books that may help with a range of common mental health problems including depression, anxiety, stress and panic attacks. The scheme currently running in Coventry and Warwickshire is part of the Improving Access to Psychological Therapies (IAPT) project. The scheme has clinical recognition and evidence that it supports its effectiveness is supporting people with common mental health problems. *Sorted and Mini-Sorted* in Warwickshire aimed at children and parent with pre-school children.

4.35 ***Mental Health Matters*** operate a 24 hour helpline across Coventry and Warwickshire, available for adults and young people aged 16 and over. The helpline consists of a team of trained and experienced support workers who use counselling skills for young people to access support in relation to low mood, anxiety, stress, emotional distress, and also available for carers.

4.36 The additional provision commissioned independently across organisations, highlights the need to ensure future commissioning arrangements of CAMHS provision is jointly developed across all organisations providing support and services to children, young people and families. The number of services, as identified through extensive engagement with service users highlighted

how challenging for professionals, service users and parents and carers it is to understand what is currently on offer, services available and where to refer to.

Service Data – Key national metrics in the Mental Health Services Data Set

4.37 It is a national mandatory requirement for providers of Mental Health Services to submit the Mental Health Services dataset centrally. Local partners recognise there is a requirement for all NHS commissioned services, including non-NHS providers to flow data for key national metrics in the MH Services data set.

4.38 In line with the national requirement, the main local provider of Child and Adolescent Mental Health Services, CWPT, has consistently submitted the Mental Health Services Dataset (MHSDS), since its introduction in January 2016.

4.39 Commissioner Reporting requirements of key CAMHS measures were identified for reporting from CWPT within the 2016/17 contract between Commissioner and Provider. Where applicable, CAMHS measures were identified as to be reported from the MHSDS, subject to availability of patient level extracts to Commissioners in 2016/17. Due to uncertainty around availability of the national extracts in 2016/17, a local flow of the MHSDS tables was agreed to support the reporting of key CAMHS measures from the MHSDS. The next planned step for quarter 3 in 2016/17 is to roll the data set flow out to Mind, who are partners with CWPT in a number of the key work streams

4.40 Pending the development of the local MHSDS flow, the Trust reported CAMHS measures in aggregate form to Commissioners in Q1.

4.41 It is noted that NHS Digital now report monthly CAMHS measures at the Commissioner/ Provider level with the potential to support the monitoring against key national metrics at the local level.

5) <u>Engagement and Governance</u>

5.1 This section evidences the role of a wide variety of relevant organisations, including children, young people and their parents/carers, youth justice and education in the original plan, and the refresh, including:

- Needs assessment
- Planning
- Service delivery and evaluation
- Governance

Engagement - What Informed the Original 2015 Transformation Plan?

5.2 The underpinning principles of the CAMHS Transformation in Coventry and Warwickshire can be found in the locally co-produced outcomes framework(appendix 1).

5.3 Young Minds, a leading national mental health charity and expert champions, were commissioned to deliver co-production work with stakeholders to develop the new model. This initial co-production work was delivered in two phases:

5.4 In phase 1, four reference groups were identified, as detailed below, to ensure the views of key stakeholders contributed to the redesign of the local comprehensive CAMHS system:

- Children and young people
- Parents and carers
- Providers and potential providers
- Professionals referring into CAMHS

5.5 The initial co-production sessions were undertaken from November 2014 to January 2015. 311 people engaged in these sessions to develop a set of themes and emerging outcomes. Key themes arising from this phase included:

- Need for emphasis on prevention and early intervention
- Need for a crisis response service and stepped care recovery model
- Need to focus on building the resilience of children and young people
- Increased integration with other services, particularly education
- Including the family and child's networks in the support process
- Delivering a 0-25 service
- Delivering a tier-less service
- Focusing on the needs of vulnerable and complex children and young people

5.6 Phase 2 ran until March 2015 with further workshops and online questionnaires to refine and develop these themes into a draft outcomes framework. A further 360 people engaged in this phase, where six headline outcomes were developed:

1) Promote positive mental health and increased resilience amongst all children and young people
2) Identify and treat children & young people's mental health needs earlier
3) Provide quality mental health services that meet the priorities and standards set by young people and their families
4) Support young people up to the age of 25 and provide support during transition
5) Enable parents and carers and other family members to support children and young people's mental health
6) Ensure that the most vulnerable young people are supported to improve their mental health

5.7 Appendix 2 is the report delivered by Young Minds that details the co-production activity and findings from this work. The six headline outcomes of the work now underpin all commissioning activity. The seven transformation plan priorities were agreed by partners with the aim of addressing gaps identified in current provision against the co-produced outcomes framework.

Year 1 - Engagement with Young People, Childrens Services, Education and Youth Justice

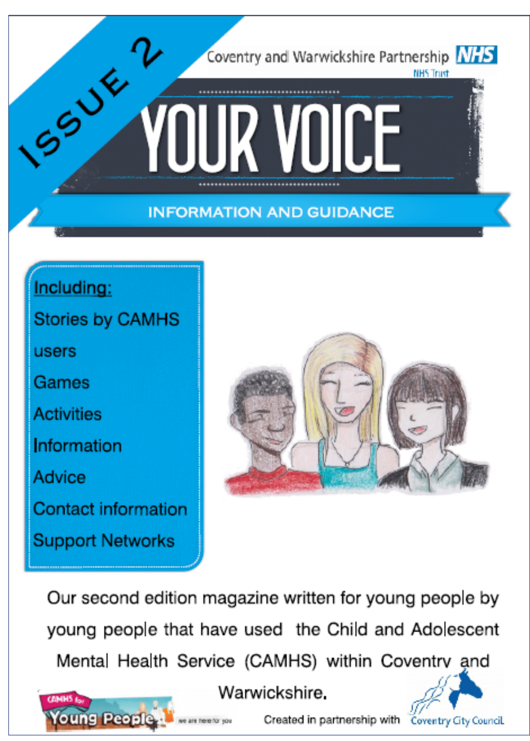
5.8 In recognition of the fact that engagement is an on-going cycle to inform service development planning, and evaluation, further engagement has been taken during year 1 of the plan, and was utilised to inform the plan refresh. The range of activity is summarised below.

5.9 CWPT appointed a Young People's Involvement Worker. Therefore since January 2016 a programme of work around service user involvement commenced including:

- A Young People's Group produces a magazine for service users. - "Your Voice" .https://www.covwarkpt.nhs.uk/search/text-content/resources-created-by-camhs-users-932 (front cover detailed in figure 11).
- The group inputs into the monthly website development group that has been set up to review and develop the CWPT CAMHS website and has been extended to look at a wider website in partnership with Mind.
- The group is developing a set of videos currently around clinicians talking about their roles-filmed by a young person on an iPhone and edited by the young person. The purpose of doing these videos is:
    a) to give some useful information, so someone waiting to see for instance a Psychotherapist, understands a little about the role and
    b) to take the mystique often connected to CAMHS, the clinicians are regular folks and are approachable etc.
- From last September-May, the Involvement Worker was supported by a colleague from CAMHS to deliver awareness sessions on mental health in schools and attended numerous school assemblies.

- CWPT undertaking surveys to gather baseline information (February 243 responses, August 140 responses)
- Face to face meetings with service users and families to explore feedback in more detail.
- Review of formal, and informal complaints
- Themes have been incorporated into an action plan, which has influenced the service redesign work.
- A quarterly Service User assembly, which includes service users from all Child and Family Services in CWPT including CAMHS service users

Figure 11: Front cover of young peoples' magazine 'Your Voice'



5.10 The Warwickshire competitive dialogue process embeds stakeholder engagement through the dialogue and evaluation of proposals. Stakeholders include children and young people, parents, education, social care and youth justice.

5.11 In Coventry a Children's Partnership Shadow Young Persons Board operates. The shadow board have been invaluable informing specific implementation plans in relation to the support in schools priority.

5.12 In year 1 there has been an increase in activity to engage with the needs of schools. CWPT, Mind and Commissioners supported a 'Perfect Week with' 4 schools as part of the 'Acting Early Initiative. The Acting Early model is a 'draw down' model with specialist services working more closely with schools. The idea is that formal opportunities are in place where schools can draw down expertise and collectively agree on the best support for a child of low level concern (this may be through a child case meeting, a consultation session between the schools and services or in another way). The model should also nurture the relationships between schools and specialist staff so that schools know which service and which individual within that service, they need to contact, when they have a concern. The learning and relationships developed with schools has informed the development of implementation plans relating to all of the priorities detailed within this plan refresh.

5.13 CWPT have also engaged with stakeholders, including head teachers at the SEN conference in Coventry on 8th July 2016. CWPT delivered a workshop to seek engagement on the development of the 'Dimensions Tool' which will be used to support the new ASD pathway referenced in section 8. The Dimensions Assessment Tool CWPT have developed is a new way

of managing demand and ensuring young people are directed to the right support, whether it be CAMHS or a community based provision outside of specialist mental health services. The interactive, electronic based tool/app will enable referrers to score a range of dimensions that the tool will process and give an outcome. The outcome will either support a referral and thus aid triage by CAMHS, or flag how the needs can be managed in the community or by which service if it is not a CAMHS specific need. This will in turn support a reduction in inappropriate referrals, and appropriate use of community resources. Head teachers overwhelmingly supported this as a tool to support professionals make more appropriate referrals, and use appropriate community resources. The outcome is that by February 2016 the tool will be launched as part of the new ASD pathway referenced in section 8.

5.14 Across Coventry and Warwickshire, there is dedicated provision of CAMHS within the respective youth justice/ offending teams. In Coventry the Joint Commissioning Team are a member of the Youth Offending Service Board and therefore contribute to the drafting of the Youth Justice Plan. These arrangements facilitate effective information sharing, and contribution to respective service development plans where there are youth justice implications.

Governance Arrangements - Stakeholder Engagement in the Plan Refresh

5.15 The multi-agency and sector governance arrangements in place since the development of the plan throughout year 1, have ensured that there has been an on-going dialogue with, and input from key stakeholder organisations/ departments. There has been an approach of co-producing solutions to each transformation plan priority.

5.16 The refresh of the plan and overall implementation has been overseen by the CAMHS Transformation Board which meets monthly. The Board has had regular with representation from the three CCG's and the following partners:

- Children's Services
- Public Health
- Local Authority Commissioning
- Education
- Service Providers (CWPT and Mind)

5.17 The Board has strategic oversight on delivery, implementation and management of the Transformation Plan and has reported to the Coventry Children and Young People partnership Board, and Warwickshire Joint Commissioning Boards. This has ensured a feedback loop from the Children's Partnership on progress, and specific plans to be adjusted accordingly. The respective partnership and commissioning boards report to the local Health and Wellbeing Boards.

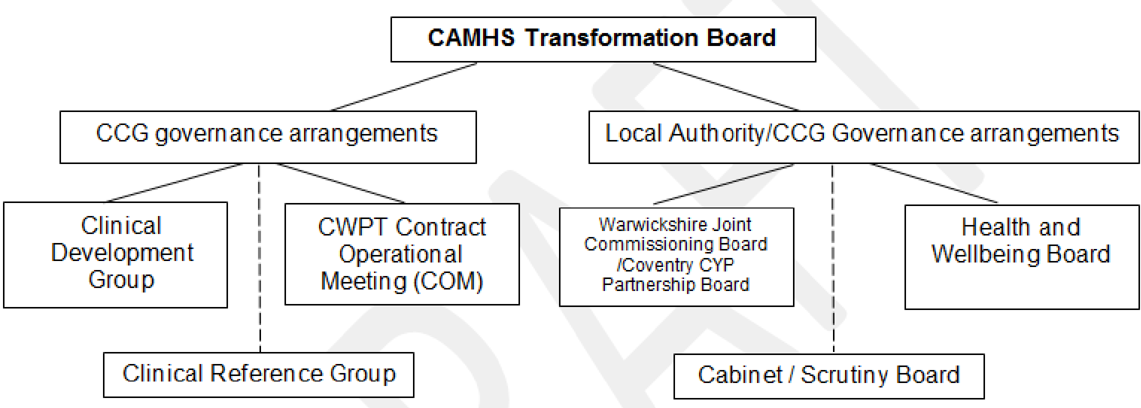
5.18 To further strengthen Coventry governance and multi sector support to the detailed implementation plans, a Coventry sub group is now meeting monthly. The group consists of Coventry representatives from the overall board.

5.19 An Operation Sub Group of the overall board meets to focus on the operational aspects of delivery.

5.20 The Plan will be refreshed every six months overseen by the partners and stakeholders.

5.21 The Health and Wellbeing Board is committed to improving the health and wellbeing of their local population and reduce health inequalities. This Board consists of multi-agency representation to consider cross cutting needs of the local population.

Figure 12: CAMHS Governance



Alignment with the Service Transformation Plan Programme (STP) and Whole System of Care

5.22 The detail of the STP is still embargoed pending feedback from NHS England. However, it is clear that mental health is a cross cutting theme and the STP explicitly states that mental health is embedded across all our transformational programmes within the Coventry and Warwickshire STP.

5.23 A number of the enablers for both good mental health for children and young people and effective and accessible mental health services are work streams within our local STP e.g. Proactive and preventative care is a transformational work stream. In addition, developing a workforce and an infrastructure that delivers are enabling work streams that will support the delivery of the STP.

5.24 In Coventry, alignment with the early help agenda has also been a key focus in 2015/16 to develop a joined up long term strategy to focus on avoiding crude cuts through closer partnership working, and working with communities. The Connecting Communities approach is to work with others to redesign services that can be delivered within the resources available, focusing on supporting those areas that are most in need. The Council is developing an integrated model of family support through the development of a series of family hubs that will support people earlier and provide interventions that prevent the need for more intensive involvement by the Council or other statutory agencies. The CAMHS service, and CAMHS commissioners from Coventry were full participants a detailed planning workshop in relation to the delivery of family hubs on 14th October 2016 to ensure all CAMHS planning is aligned to being part of integrated family hubs and CAMHS are part of the early help offer.

5.25 In Warwickshire a stepped approach to support is being implemented, including social care, MASH, advice and guidance, CAF and parenting support. This will become a single system for support with a focus on the right care at the right time, with a stated intention of reducing the number of LAC. There is a clear expectation that the CAMHS service being procured through competitive dialogue will integrate with this approach.

5.26 The revised Children and Young People Plan in Coventry aligns to the CAMHS Transformation plan. Positive mental health outcomes for young people have been included as one of the key outcomes in the city for the wider children's partnership to address. Furthermore, one of the 15 performance indicators included in the city-wide plan, is to minimise self-harm admissions to hospital, and forms part of the bi-monthly performance report senior level officers from the partnership review.

Publication of refreshed plan

5.27 The CCG's and partners will publish the refreshed plan when final assurance feedback has been received from NHS England and any revisions required made.

5.28 A short easy read version will be developed and published to ensure the plan is accessible to children, young people, parents/ carers and other stakeholders.

6) Aims and Objectives

6.1 The following key priorities and objectives have been identified across Coventry and Warwickshire, informed by national and local principles to improve and transform our local CAMHS service to ensure:

- Services work seamlessly and in collaboration to respond flexibly and creatively to meet needs and desired outcomes
- Use of evidenced based practice
- Better access to and awareness of services
- Reduced waiting times to access services and beyond
- Identifying, reaching out to and prioritising vulnerable group e.g., children on the edge of care, leaving care, homeless, complex needs, substance misuse, domestic violence and sexual exploitation
- Providing age appropriate support to young people and support through transitions
- Commissioning is informed by robust data, information and outcomes reporting
- Development of personalised care for children and young people, who will be able to receive flexible support based on individual need, designed to reduce health inequalities and reach the diverse needs of our population. Services will promote equality of opportunity and accessibility between people with protected characteristics and provided based on need, demographics and profile of young people.

6.2 Based on local evidence and intelligence gathered to implement sustainable transformational change across mental health and emotional wellbeing services for children and young people, Coventry and Warwickshire have identified a number of priorities which require additional investment and development, which will be driven and overseen by the CAMHS Transformation Plan.

7) Strategic priorities for 2015-2020

7.1 A number of local developments have been identified, which have been coproduced and agreed with stakeholders, to transform and improve mental health and emotional wellbeing services for children and young people over the 5 year transformation plan:

1. Reducing waiting times for mental health and emotional wellbeing services
2. Provide a crisis response service to support children and young people presenting with self-harm needs and preventing unnecessary hospital admissions
3. Improved access to specialist support, including ASD
4. Providing support to the most vulnerable
5. Strengthening mental health support to children and young people in schools
6. Enhancing access and support through the utilisation of technology
7. Implementation of a dedicated community based Eating Disorder Service

- Cross cutting theme: Implement a whole systems of care and prevention approach – Work more creatively across the system in terms of earlier intervention, preventative and proactive care.

7.2 System redesign, supported by funding from the transformation plan will allow us to accelerate the transformation of our local mental health and emotional wellbeing service over the five years, through continuation of local improvements as identified in our 7 key priorities.

7.3 The key priorities have been fully costed, in line with the allocation aligned to each CCG across Coventry and Warwickshire. Table 14 illustrates the budget allocations for 2016/17 and beyond

Table 14: Budget Allocations for 2016/17 and beyond

	2016/17 Indicative costs		
	CRCCG	SWCCG	WNCCG
Priority 1: Waiting times	£190,125	£92,333	£69,333
Priority 2: Crisis support	£143,327	£43,098	£33,575
Priority 3: ASD support	£99,000	£40,000	£34,500
Priority 4: Vulnerable YP	£87,077	£45,538	£43,538
Priority 5: School support	£108,145	£108,145	£81,109
Priority 6: Technology	£326	£98	£76
Total:	£628,000	£329,212	£262,131
Funding Allocation:	£628,000	£346,000	£262,000
Eating Disorder:	£250,000	£138,000	£104,000
Funding Allocation:	£250,000	£138,000	£104,000

7.4 A submission has been made to NHS England to secure additional funding in 2016/17 to accelerate progress for priority 1 (waiting times) and priority 3 (ASD) support. The proposal is to achieve this through additional capacity for waiting times and for both routine CAMHS, and ASD, and fast tracking the implementation of the Dimensions Tool to ensure a more targeted and engaged approach to assessing need.

Transformation Plan Ambition by 2020:

7.5 The Coventry and Warwickshire plan requires system wide transformation and joined up ambition. This requires local NHS organisations to work in partnership with the local authority third sector, youth justice, schools and colleges.

7.6 **Reducing waiting times** will ensure interventions are delivered in a timely manner to address presenting needs before they escalate. Services will be delivered at times to suit young people, designed to meet current and anticipated demand, delivered by skilled workforce providing evidenced based practice and interventions to young people and their families, which offer choice and delivered close to home.

7.7 **Providing crisis support to young people presenting with self-harm at hospital**, will increase the number of young people receiving appropriate support from skilled professionals in community settings, to manage mental health and emotional wellbeing needs in locations close to home. Additional support provided through earlier intervention, support available in the community, coupled with crisis support will reduce the number of young people requiring tier 4 inpatient beds and improve resilience and mental health outcomes of young people. Building on learning experiences of the local Acute Liaison service, children and young people will receive support using a stepped care approach and appropriate support at an earlier stage, prior to hospital admission, with the aim of managing presenting needs in a community setting, and reducing the cost and need of hospital admission.

7.8 **Improved access for specialist support**, **including young people with ASD** will have access to timely assessments, treatment and support in line with the Transforming Care Agenda and meet the recommendations set within the NHS England Care and Treatment Review Policy and

Guidance report (August 2015). Services will be provided offering person-centred and individualised support to ensure children and young people with learning disabilities and/or autism and their family's needs are met and barriers to access removed.

7.9 **Dedicated provision for vulnerable young people** will provide individuals with improved access to maximise their life chances, prevent placement disruption or breakdown and prevent mental health needs from escalating into their adult life. The implementation of a named contact will provide dedicated support to young people and families, to ensure support is available and provides consistency through a single contact which can liaise on their behalf with services and partner agencies, reducing the number of professional's involvement and provides co-ordinated support.

7.10 The **implementation of dedicated mental health support within schools and other universal settings** will reduce barriers to access and detect early identification of mental health need, using skilled dedicated resource embedded within school settings. There will be increased awareness and identification of mental health needs at universal level, and young people will receive support at school, or in venues to ensure children from vulnerable and hard to reach backgrounds are able to access the right level of support required.

7.11 **Enhancing access to information and communication through technology** will increase reach to young people in raising awareness of mental health and emotional wellbeing needs to reduce the stigma through mental health promotion and dedicated resource, designed to meet the needs of young people and stakeholders. The creation of a dedicated mental health and emotional wellbeing website will provide effective access for young people, in a confidential manner, supported by skilled professionals.

7.12 **Implementation of a newly developed community based Eating Disorder Service** across Coventry and Warwickshire, designed to meet the Access and Waiting Time Standards. The service will provide stepped care support to children near to home, designed to meet the population needs of Coventry and Warwickshire, which empowers young people and their family to manage, access and receive quality specialist support and improve their health outcomes.

7.13 **Cross cutting theme: Implement whole systems of care and prevention approach** – Work more creatively across the system in terms of earlier intervention, preventative and proactive care. This will include developing innovative and partnership approaches across all statutory agencies, voluntary sector agencies, youth justice and communities to redesign services that can be delivered within the resource available and a wide base of organisations. There will be a focus on early help and family hubs, to ensure those areas that are most in need can access support when they first need it and alongside other support.

Figure 13: High-level road map to achieve 2020 vision (larger version on page 60)

Vision

- Provide stepped care through early help, prevention and crisis support
- Young people will have access to flexible personalised care
- Young people will receive early help and support within schools
- Improve and strengthen smoother transitions
- Improved care for children and young people in crisis
- More use of evidenced based practice and interventions
- Greater awareness of mental health and emotional wellbeing services
- Provide clear direction for all agencies to improve mental health & emotional wellbeing

Priorities

- Implementation of dedicated mental health support within schools and other universal settings
- Improved access
- Specialist support for ASD
- Crisis support
- Vulnerable young people
- Technology
- Community based Eating Disorder Service

YEAR 1

- Implement capacity to improve access and waiting times
- Embed acute liaison service at hospital to improve crises response and avoid admissions.
- Agree new service required to support vulnerable young people
- Develop new clinical pathway for Eating Disorder Service and mobilise resource
- Draft new ASD pathway
- Draft revised primary mental health service model

YEAR 2

- Implement fully the new eating disorder service.
- Implement a new ASD pathway, with earlier support and reduced waiting times.
- Implement increased capacity and revised Primary Mental Health Service to enhance support in schools.
- Implement new dedicated and integrated service for vulnerable young people, co-located with LA.
- Launch the Dimensions Tool to improve referral pathway
- Develop and commission new integrated collaborative pathways for tier 4 to support crises, admission prevention and safe discharge
- Review opportunities for further integration with other areas of vulnerability for young people (e.g. substance misuse).

YEAR 3

- Embed CAMHS in multi-agency early help/ family hubs.
- New tier 4 pathways are fully embedded.
- Launch a new multi-agency owned website to reach young people and suite of associated apps.
- Integrate with other appropriate services

YEAR 4

- Sustain the impact of year 1-3 transformation through:
  - Robust contract monitoring.
  - Review of individual priorities

YEAR 5

- Develop and agree a sustainability plan

Indicative Trajectory & Targets

- Urgent cases – Referral to treatment within 5 days – 100% of cases (Year 1-5)
- Routines cases - Referral to treatment within 18 weeks – 95% of cases (Year 1-3), reducing to 12 weeks (Year
- Young peoples assessed within 48hrs of presenting to hospital (Year 1-3), reducing to 24 hours, (Year 4-5)
- LAC – referral to treatment – 4 weeks. (Year 1-3), reducing to 3 weeks (Year 4-5)
- Follow up treatment appointment within 12 weeks of initial appointment – 95% of cases (Year 1-3), reducing to 8 weeks (Year 4-5)
- Children and young people referred for an assessment or treatment of an eating disorder will access NICE concordant treatment within 1 week for urgent cases (Year 1-5)
- Children and young people referred for an assessment or treatment of an eating disorder will access NICE concordant treatment within 4 weeks for routine cases (Year 1-5)
- Undertake 53 ASD assessments per month, and reduce start of year waiting list by 25% (Year 1-5)
- 5% reduction in placement breakdowns. (Year 2-5)

Cross Cutting Theme: Implement whole systems of care approach

NB. The Warwickshire trajectory and targets will be determined through the competitive dialogue process due to commence in December 2016. The first two years of the new contract will focus on ensuring Providers meet their transformation plan.

8) Year 1 Progress - Headlines

8.1 This section provides an overview of the progress made in year 1 in delivering the plan. Some priorities have been delivered jointly across Coventry and Warwickshire, while some have a local approach.

Coventry and Warwickshire Progress

8.2 **Reducing waiting times for access to specialist mental health and emotional wellbeing services -** There has been intense joint commissioner and provider scrutiny of the investment made in waiting times to ensure the reductions are embedded and sustained. Young people are routinely commencing treatment within 18 weeks of referral, and are seen quicker where the need is urgent. In Coventry and Rugby follow up waiting times have improved and stabilised, and by 1st November 2016 95% of young people will receive an initial follow up appointment within 12 weeks (agreed KPI). In year-2 implementation will continue in Warwickshire to achieve the same position.

8.3 **Self-harm and crises response** –The Acute Liaison Service that launched in April 2015 has become embedded across Coventry and Warwickshire through the recurrent funding approved.

The service is assessing the majority of young people presenting with self-harm or in crises within 24 hours and young people have a follow up appointment within one week. Now that a firm foundation is in place, the next step is to revise the pathway to ensure the assessment and follow up becomes more multi-disciplinary with increased involvement from other agencies.

8.4 **Implement a community based eating disorder service –** A new clinical pathway and local service model has been signed off by all three CCG's. CWPT and Mind are now in the implementation phase, including recruiting to the new posts. The clinical pathway reflects the expected treatment interventions and waiting times as defined within national guidance including, Access and Waiting Time Standard for Children and Young People with an Eating Disorder July 2015, Future in mind: Promoting, protecting and improving our children and young people's mental health and wellbeing 2015 and Eating Disorder NICE guidelines (2004). The focus being the implementation of:

- treatment within a maximum of 4 weeks
- community based service with support and interventions in the home
- enhanced family involvement and therapy
- earlier intervention
- increased psychological interventions

Coventry Specific progress

8.5 **Improving ASD support** – A two-step process has been taken to improve ASD support and waiting times:

1) *Increase the number of assessments* - Additional funding has been released by CRCCG to increase the clinical capacity in CWPT to undertake more ASD assessments. This has increased capacity from 38 assessments per month to 53 (KPI).
2) *Revise the ASD pathway* - A benchmarking exercise has been undertaken which has demonstrated particularly high prevalence rates in Coventry and some alternative pathway approaches in other areas of the country. Recognising that a more sustainable solution needs to be found in the context of high referral rates, a revised multi-agency pathway has been endorsed to include more early support and consequently reduce demand and waiting times.

8.6 **Providing support to the most vulnerable** – A joint CWPT and Mind proposal to provide a tier-less mental health and emotional wellbeing service for LAC and care leavers has been agreed and implementation commenced. The whole ethos of the service is to become part of the team around the child, not waiting for a referral, instead identifying in partnership with social care and the primary carer where there are mental health, or emotional wellbeing needs that would benefit from therapeutic intervention, or support to the primary carer. Where a formal referral is received, the agreed KPI is for treatment to commence within 4 weeks.

8.7 **Commission early intervention and prevention work in schools and other community settings** – A revised primary mental health offer developed by CWPT and Mind, with improved support to schools has been developed. The overall emphasis is moving towards creating a whole school and community hub approach to build resilience. It is proposed that Implementation of a revised offer will begin in December 2016 subject to approvals.

Warwickshire Specific Progress Position

8.8 To deliver systemic change, Warwickshire commissioners are tendering for single children and young people's emotional well-being and mental health contract for the County. The competitive dialogue procurement process opened on 27th September 2016 and is due to run until March 2017 where a successful lead provider will be identified (as set out in table 15, below). This procurement is being led by Warwickshire County Council as lead commissioner on behalf of the three CCGs operating in Warwickshire.

8.9 This procurement is based on a substantial co-produced resign process, led by Young Minds and further supported Associate Development Solutions, which led to the development of an Outcomes Framework (Appendix 1) for the new service. Below are listed a number of key themes that the new service will achieve, and which are embedded through the outcomes framework:

- Increased emphasis on prevention and early intervention
- Focus on building resilience
- Integrated working, especially with schools
- Systemic work with families and child's network
- Increasing age from 18 to 25
- Tier less service
- Support for complex and vulnerable children

8.10 These themes reflect the five recommendations set out in *Future in Mind* and demonstrate the scale of transition that the new children and young people's emotional well-being and mental health service must achieve. CAMHS Transitions funding in Warwickshire, then, will be made available to the successful provider in effect this transition in the initial years of the seven year contract.

8.11 As described in section 7, prior to the new contract commencing, commissioners in Warwickshire have aligned their local CAMHS Transformation funding with Coventry CAMHS commissioners to reduce waiting times for existing service users, embed the acute liaison service and establish a community based eating disorder service.

8.12 Table 15 outlines Warwickshire's children and young people's emotional well-being and mental health contract procurement timetable.

Table 15: WCC Procurement timetable

Milestone	Date
Pre Procurement Market Engagement/Applicant Days	26th Sep 2016
Deadline for receipt of completed PQQ's	26th Oct 2016
Invitation to Participate in dialogue	14th Nov 2016*
1st round of dialogue meetings	5th to 9th Dec 2016*
Issue amended documents and Invitation to Continue Dialogue	3rd Jan 2017*
2nd round of dialogue meetings	23rd to 27th Jan 2017*
Issue amended documents and Invitation to Submit Final Tender	13th Feb 2017*
Clarification meetings (if required)	27th to 31st Mar 2017*
Contract award confirmed	16th Jun 2017*
Contract commences	1st Aug 2017*

Local Implementation of Children and Young People's Improving Access to Psychological Therapies (CYP IAPT)

8.13 CWPT has embarked on the CYP IAPT programme as part of a "learning collaborative" which involves 14 other Trusts and Reading University.

8.14 The nationally-driven CYP IAPT programme has a key role to play in the local ambitions to transform existing services and local health economies, in respect of improved access and waiting times, reduced numbers of children requiring inpatient care, development of a fully trained and competent workforce, and self-referral across the system. The key elements are:

- Working in partnership with children and young people and families to shape their local services, and at a national programme level. Participation is an essential element of the programme.
- Improving the workforce through training existing CAMHS staff in targeted and specialist (Tier 2, 3 and 4) services in an agreed, standardised curriculum of NICE approved and best evidence based therapies. The training will include modules covering supervision and transformational service leadership
- Supporting and facilitating services across the NHS, Local Authority, Voluntary and Independent Sectors to work together to develop efficient and effective integrated care pathways to ensure the right care at the right time.
- Delivering frequent / session by session outcome monitoring to help the therapist and service user work together in their session, help the supervisor support the therapist to improve the outcomes and to inform future service planning
- Mandating the collection of a nationally agreed outcomes framework on a high frequency or session by session basis across the services participating in the collaborative. Services are asked to ensure that 90% of closed cases, seen three or more times, have full data from at least two time points, one of which can be assessment.
- Outcome data will be used in direct supervision of the therapist, to determine the progress of therapy, overall effectiveness of the service and to benchmark services. Embedding outcome monitoring across the whole of CAMHS will transform how they operate, and how they are commissioned.

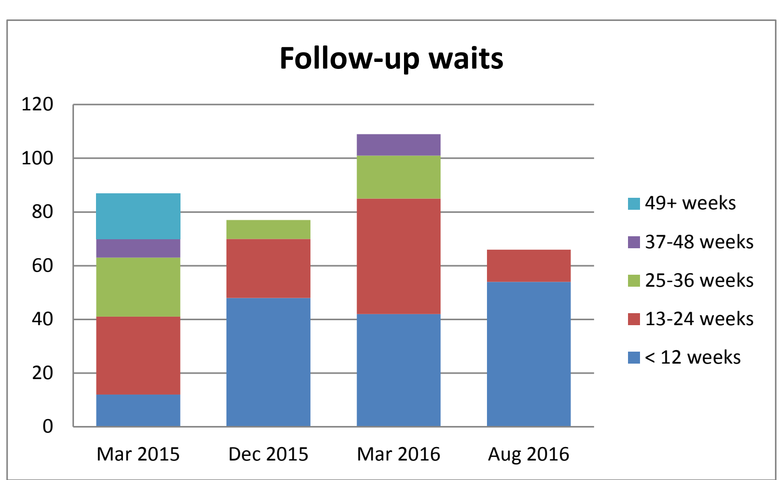
8.15 Learning from the programme is already being introduced to the Coventry and Warwickshire specialist CAMHS service. For instance, session-by-session measures are already being piloted. The outcomes framework is the subject of a work stream to enable phased introduction from October 2016.

8.16 There is commitment to support participation from staff from all agencies in CYP IAPT Training. The recent additional CAMHS funding bid for via NHS England demonstrates the commitment, and will be a key part of the partnership dialogue in the next quarter.

Priority 1:	**Reducing waiting times for access to specialist mental health and emotional wellbeing services** To enable children and young people to have timely access to specialist support, additional investment is required at local level to reduce the current waiting times for referral to treatment and treatment to follow up appointments. This includes strengthening transitions across services, to enable young people with diverse needs to access age appropriate services and support at times and locations to suit their individual needs.
Case for change	• Meets the recommendations set within Future in Minds • Additional investment made by Coventry and Rugby in 2015, reduced the number of young people waiting for an initial follow up appointment from over 100 in 2014, to 31 young people waiting for an appointment in August 2015. All urgent cases are seen within 5 days and 98% of young people are seen within 18 weeks for an appointment. • Whilst demand continues to increase, and to support the investment to early help and prevention services, we recognise the need to enable the trajectory for improvement to maintained and reduce backlog in time for the developments within the CAMHS redesign project to commence, further investment is required at local level to support the transformation of the new model.
Objectives:	By 2020 our local offer will: • Provide timely age appropriate access and support to children and young people at times and locations to suit them • The comprehensive CAMHS service will be commissioned across Coventry and Warwickshire consisting on a single service, without tiers to enable children, young people and young people to access support from one place • Support young people from wide range of backgrounds with varying levels including those with learning disabilities, language barriers and visual / hearing impairments to receive access tailored to meet their individual needs.
Outcomes:	• Reduced waiting times for children and young people across Coventry and Warwickshire • Improved access to services for children and young people with learning disabilities, language barriers, physical impairments and vulnerable young people • Improved transitions for young people to enable them to access support based on their individual need and not restricted by age limits
Year 1 Progress	**Referral to Treatment** • The investment in the waiting times priority has ensured that there is a sustainable approach to ensuring appropriate waiting times. • Across Coventry and Warwickshire young people are routinely receiving treatment within 18 weeks of referral. **1st Follow Up Appointments** • The implementation phase of this priority in Coventry and Rugby is nearing completion, and has ensured that the majority of young people wait less than 12 weeks for an initial follow up appointment (August 2016 snapshot data showed 14 young people waiting longer than 12 weeks). There is a trajectory attached to the additional transformation funding to reduce maximum follow-up waits to 12 weeks from November 2016.

- Across South and North Warwickshire, recruitment is partially complete to implement the detailed proposals signed off by South Warwickshire CCG and Warwickshire North CCG. This will ensure a similar trajectory of improvement will be delivered.

Figure 14: Follow up waits for Coventry and Rugby



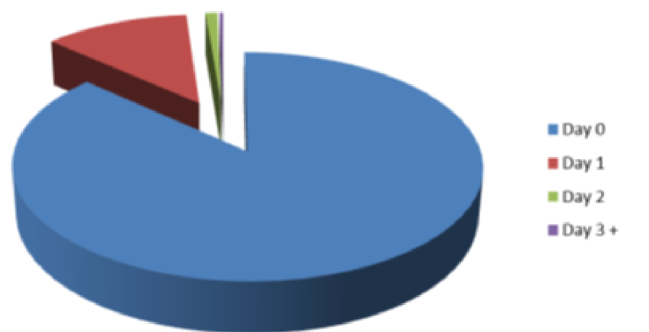
Next steps – Year 2

1. Sustain current referral to treatment waiting times (referral to treatment within a maximum of 18 weeks)
2. Consistently deliver follow up waiting times of 12 weeks or under for 95% of young people.

Key Performance Indicators & Current Performance

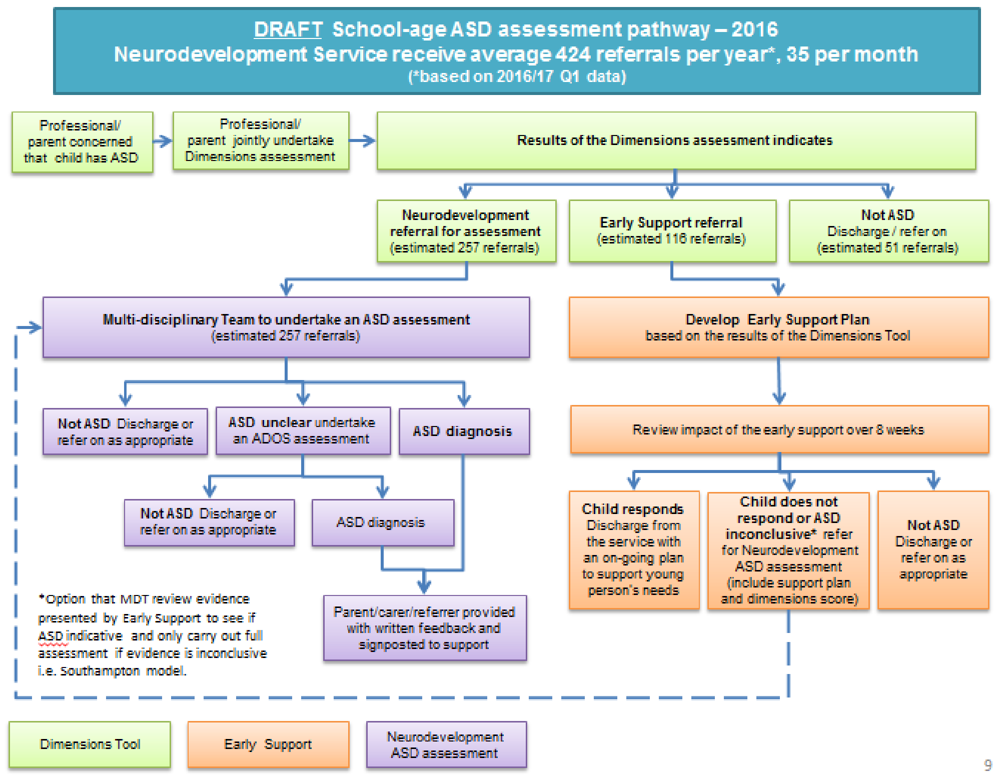
Key Performance Indicators	Current Performance
Referral to treatment (emergencies) - 100% within 48hrs	N/A – no emergency cases year to date.
Referral to treatment (urgent) – 100% within 5 working days	100%
Referral to treatment (routine cases) – 95% of patients within 18 weeks	96.7%
Referral to treatment – 100% of patients within 26 weeks	99.3%
95% of patients being seen for a follow up appointment by 12 weeks - by 1st November 2016 -Coventry and Rugby)	As of 31.08.16 14 people have been waiting longer than 12 weeks. On target to meet trajectory by November as planned.

Priority 2:	**Provide a crisis response service to support children and young people presenting with self-harm needs and preventing unnecessary hospital admissions** We intend to provide dedicated resource through utilising and sustaining the acute liaison function across Coventry and Warwickshire to support the increasing rise in children and young people presenting with self-harm needs, and to avoid unnecessary admission to in-patient hospitalisation by providing early intervention together with specialist crisis support to reduce tier 4 bed usage and increase resilience amongst young people and their families.
Case for change	• Supports the national priority set within Future in Minds, to ensure young people have access to timely effective support to reduce unnecessary hospital admission and release pressure from inpatient services and significant costs attached • Additional capacity to support in the early identification and support young people attending hospital and inpatient services with self-harm presenting needs • Implements a local stepped care approach to reduce unnecessary hospital admissions, by providing timely, flexible and responsive services to enable children and young people to receive support from community based services or specialist services as needs allow.
Objectives:	By 2020 our local offer will: • Provide effective, timely and accessible services for children and young people with mental health and emotional wellbeing needs, delivered using a range of evidenced based interventions delivered within the community, home and within assertive outreach practices • See an increase in the number of young people supported in the community with self-harm presentations • Reduce the number of young people requiring in-patient admission and support
Outcomes:	• Improved resilience amongst young people • Increased early identification and support, to prevent needs from escalating • Increased capacity within mental health and emotional wellbeing services
Year 1 progress	• The acute liaison team has been embedded on a permanent basis at University Hospital Coventry and Warwickshire and Warwick Hospital. • In 2015/16, the team has improved the responsiveness of the service to people who have been admitted to hospital following self-harm and the support to the acute hospitals in the care and treatment of these young people. • The Acute Liaison Team has decreased the length of stay for young people on the acute wards by providing more timely assessments. Before the team was in place, data on length of stay was not routinely captured by CWPT. Feedback for both acute hospitals confirms that young people are being assessed and discharged more quickly. • Key facts: o 88% of young people are assessed within 24 hours. o The average duration of each assessment is 2½ hours o Each young person is seen for a follow-up appointment within one week o The average duration of a follow-up appointment is one hour

	○ There is substantial non-face to face activity associated with making sure young people are properly assessed and supported following discharge – this includes liaison with family, social care and schools. **Figure 15: Acute liaison- response times for assessment** 
Next steps – year 2	• To build on the firm foundation achieved through the Acute Liaison Team, there is a need to develop a more multi-agency response to the systemic and complex needs young people present with. Discussions have commenced with social care to understand how a more integrated pathway can be developed. The key aim will be to develop and implement this pathway in year 2 and continue the downward trajectory in hospital admissions. • There is an expectation that the downward between 2013/14 and 2014/15 in figure 15 will be maintained across Coventry and Warwickshire
Key Performance Indicators & Current Performance	• Young people presenting at hospital – 95% assessed within 48hrs • 98% (May 2016)

Priority 3:	**Improved access to specialist support, including ASD**
Case for change	In response to the increase in demand across Coventry and Warwickshire of young people requiring assessment for ASD, has had significant impact on the waiting times for the service, with currently over 900 young people across Coventry and Warwickshire awaiting an assessment. We plan to enhance the clinical support to provide ASD diagnostic support, to ensure children, young people and their families are able to access services quicker and receive timely support as needs arise. • The additional clinical capacity will increase the number of children and young people assessed for ASD • Investment will enable additional assessments to be undertaken, reducing the waiting times across Coventry and Warwickshire • Interim improvements will alleviate pressures within the existing services to compliment the commissioning arrangements and timescales within the CAMHS redesign process • To support the objectives of the Transforming Care agenda
Objectives:	By 2020 our local offer will: • Ensure services are responsive to meet current and future demand and need, resourced appropriately and delivered by a skilled workforce, in line with the recommendations set within the Future in Minds report • Improved access and waiting times for children and young people requiring ASD assessments • Enables the redesigned service to operate more effectively, with less historical backlog of assessments and waits
Outcomes:	• Reduced waiting times for children and young people • Improved patient experience for children, young people and their families • Additional young people will be assessed by April 2016
Year 1 Progress	**Coventry** • A two stage approach has been taken in Coventry, with a specific focus on ASD initially. • Stage 1 – Increase clinical capacity to enable 53 assessments to be completed per month. Additional capacity of 1.5 wte psychologist is now in post. The second half of this additional capacity did not start until September, therefore the full impact of the additional capacity will be seen in September 2016 data onwards. • Stage 2 – Implement a more sustainable pathway that focusses on early support. A revised multi-agency pathway has been drafted to include more early support and consequently reduce demand and waiting times. The orange highlighted section is the new element of the pathway proposed to be implemented. Included within this is the launch of a new assessment and triage tool prior to accessing the pathway, to ensure appropriate access to specialist assessment, and diversion to early support where it would be more beneficial to improved outcomes. The tool has been termed the ‘Dimensions Tool’.

Figure 16: Draft school-age ASD pathway



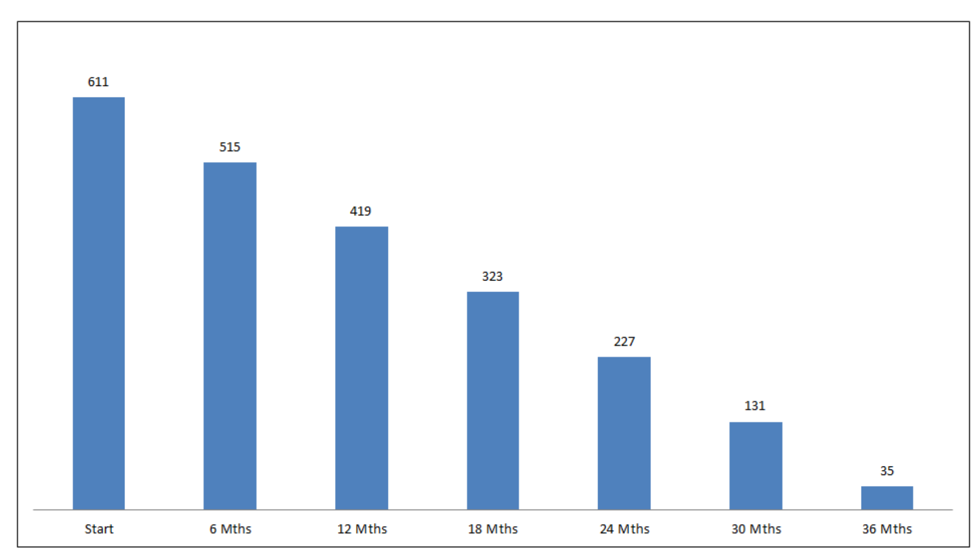
- The key features and benefits of the new pathway are

  - Where clinically appropriate, young people would get speedy early support
  - Young people requiring full ASD assessment would get quicker access – reduced wait
  - The Dimensions Tool will make referrals easier to understand and more appropriate
  - More effective and efficient use of resources based on appropriate need

- Conservative projections demonstrate that the pathway and current increased capacity for assessment will have the following

impact on the number of people waiting for assessment in Coventry:

Figure 17: Projected reduction in waiting numbers (school-age)



Warwickshire:

- Recruitment is underway to increase the ASD assessment capacity in Warwickshire. Clinical posts are due to be filled by December 2016 , which will enable the waiting times to be reduce to within 12 weeks over a nine month period. The number of assessments will increase significantly compared to the August data detailed below.

Next steps – year 2

- Delivering an increased number of assessments per month.
- Implement the revised ASD pathway, to improve early support, and as a consequence reduce demand for specialist ASD assessments.

Key Performance Indicators & Current Performance

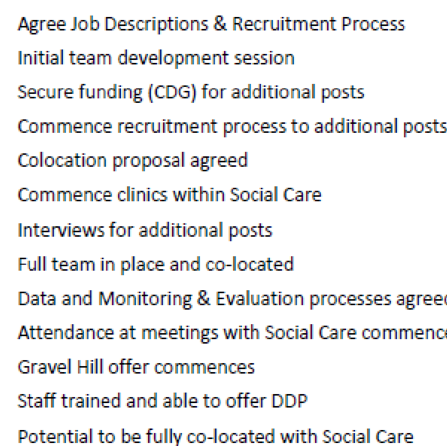
• CRCCG 53 ASD assessments to be completed per month	• 37
• SWCCG: 21 Assessments per month	• 2
• NW CCG: 23 assessments per month	• 14

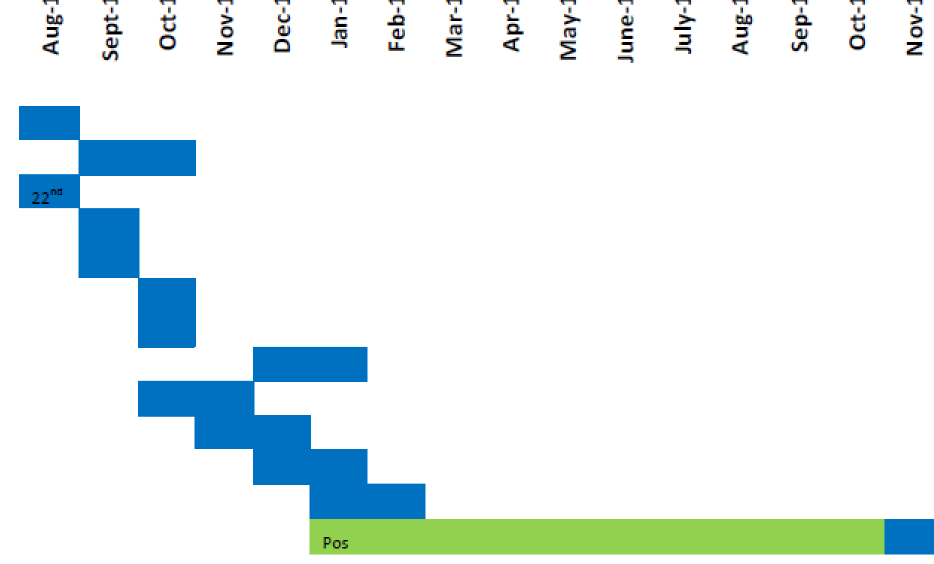
All August 2016 data. Note, key new posts did not start until September 2016 and one due to

start in December 2016. Therefore the impact of additional resource will not be seen in reporting until December 2016, where it is projected activity will be more aligned to KPI's, and fully achieved in January 2017.

Priority 4:	**Providing support to the most vulnerable** To support our corporate responsibilities to provide support to vulnerable young people beyond the generic mental health services available, we plan to enhance the current level of support by providing dedicated provision to this area to reduce the health inequalities of this population of young people, enabling young people with complex and often multiple needs to access time Early support and ensure their mental health and emotional wellbeing has been considered appropriately.
Case for change	• Meets the recommendations made within Future in Minds • Currently limited resources available to support vulnerable young people with mental health and emotional wellbeing needs, recognising cross cutting presenting needs often experienced by vulnerable young people increases the risk of adverse effects on placement stability, attainment and social factors. • There are currently 578 looked after children in Coventry, 736 in Warwickshire , and it is known approximately 45% of Lac have a mental health or emotional wellbeing need. • 68 young people aged 16-24 in supported accommodation(June 2015): 34 had mild to moderate mental health needs and 26 had moderate to severe mental health needs with no dedicated resource in place to support them. Occupancy data (Jan-Jun 2015) indicates that 45 young people who are LAC/care leavers are likely to experience a mental health disorder.
Objectives:	By 2020, our local offer will: • Increase the resilience of the most vulnerable young people in the city and their carers, and provide them with access to early help and dedicated resource to support them with any mental health and emotional wellbeing needs • We will have fewer vulnerable young people requiring inpatient services, by enabling them to access the right level of support by skilled professionals at times and locations to suit them • We will reduce the health inequalities by ensuring services are tailored and adapted to meet the needs of a diverse population, increases reach, accessibility and promotes services to capture hard to reach groups of young people • Professionals supporting vulnerable young people will have increase awareness to aid the early identification of mental health and emotional wellbeing needs
Outcomes:	• Early recognition and identification of mental health need by empowering professionals through dedicated training • Improved access and support for the most vulnerable young people and their carers • Improved resilience and health outcomes for vulnerable young people and their carers including Adopters / Foster Carers • Reduced risk of placement disruption and breakdown and planned move on to positive destinations.

	• Increased life chances
Year 1 progress	**Coventry** • Coventry and Rugby CCG and Coventry City Council, as joint commissioners of services for vulnerable young people, have signed off a new dedicated service to support vulnerable young people, including looked after children and care leavers. • Coventry & Warwickshire Partnership Trust and Coventry & Warwickshire Mind are delivering this as a partnership consortium led by Coventry & Warwickshire Partnership Trust. • The whole ethos of the service is to become part of the team around the child, and to facilitate this to be co-located with social care. • A joint workforce approach has been taken as described in section 9. • The service is working in close partnership with social care to commence co-location before the end of 2016. Recruitment to the roles is underway. • The service will o Provide therapeutic intervention o Advice and guidance on new referrals o Provide guidance on placements at risk of breakdown, placements where difficulties are impacting on the child's mental health o To support the early identification of placements at risk of breakdown or crises o To be a point of entry to services
Next steps – year 2	• The implementation plan detailed below was agreed. Figure 18: Outline Implementation Plan


Agree Job Descriptions & Recruitment Process
Initial team development session
Secure funding (CDG) for additional posts
Commence recruitment process to additional posts
Colocation proposal agreed
Commence clinics within Social Care
Interviews for additional posts
Full team in place and co-located
Data and Monitoring & Evaluation processes agreed
Attendance at meetings with Social Care commence
Gravel Hill offer commences
Staff trained and able to offer DDP
Potential to be fully co-located with Social Care



Key Performance Indicators & Current Performance

- Referral to treatment within 4 weeks (for LAC)
- Reduction in placement breakdowns for LAC

- 100% where referral has identified YP as LAC.
- To be introduced in year 2

Priority 5:	**Strengthening mental health support to children and young people in school** Recognising the cross-cutting needs of young people and the role of schools and interagency collaboration in improving resilience and mental health of young people, we plan to enhance support currently available in children of all ages in schools across Coventry and Warwickshire. In line with our early intervention and prevention agenda, we will invest in additional support within schools, which will aid in the early identification of mental health needs, tailored to meet individual need, applying targeted approaches to adolescents, delivered by professionals who can undertake timely assessments and support to children in the community including providing support to the most vulnerable.
Case for change	• We recognise the level of support available within schools is limited, with provision targeting low level awareness raising and training to professionals, relying on targeted and specialist services to provide assessment and treatment. • The additional capacity and resource to schools will enhance the early identification of mental health and emotional wellbeing needs of young people to be screened, assessed and supported by trained mental health professionals within the community or home based support tailored to meet the individual and diverse needs of young people and their families. • This proposal is in line with the Future in Minds recommendations to enhance mental health support in educational settings and builds on the Schools/Link scheme pilot objectives of enhancing provision in schools.
Objectives:	By 2020, our local offer will: • Enable young people to access age appropriate support in school, community and home based settings • Have implemented an anti-stigma programme within schools and the wider community • Providing evidenced based practice and training to aid the early identification of mental health and emotional wellbeing needs of young people within schools
Outcomes:	• Increased early identification within schools • Smooth transitions between services • Timely access and support to children and young people and their families • Improved resilience of young people • Reduction in the number of targeted and specialist CAMHS referrals • Improved levels of educational attainment and attendance • Additional support provided to vulnerable young people

Year 1 - Progress	**Coventry** • A programme of training is being delivered to universal professionals, including schools based staff (see section 9 – workforce) • A revised primary mental health offer developed by CWPT and Mind, with improved support to schools is to be considered for implementation. The overall emphasis is moving towards creating a whole school and community hub approach to build resilience. Implementation will begin in December 2016 subject to clinical sign off. **Warwickshire** • In Warwickshire, transformation for this priority is being driven through engaging with potential providers via the competitive dialogue procurement process. In the interim, a primary mental health service is available to schools, including the training programme.
Next steps – year 2	**Coventry** • Implement the revised primary mental health service. **Warwickshire** • Complete the competitive dialogue process and commence implementation of the specific schools pathway/model agreed through coproduction.
Key Performance Indicator	**TBC**

Priority 6:	**Enhancing access and support through technology** We plan to enhance the way we communicate and provide support to young people by developing a single comprehensive CAMHS website that provides age appropriate information, advice and guidance to children, young people, parents and professionals. The website will provide innovative and discrete interactive support to children and young people, to enable them to access confidential support and communicate virtually with their health consultants directly.
Case for change	• We know that one of the key challenges when supporting children and young people is ensuring that we communicate with them effectively using approaches to suit them. • We know nationally that 10% of children and young people aged 5-16 have a clinically diagnosable mental health need yet 70% of children and adolescents have not received appropriate intervention at a sufficiently early age. Recognising the increase in local need, planning for future demand and recognising the number of young people potentially at need, we plan to increase access and awareness through improved communication using technology. • There are currently two websites across Coventry and Warwickshire developed by our tier 2 providers and specialist CAMHS service. Both sites provide information on current services to children and young people and their carers. The tier 2 website also provides interactive peer support, self-help and online counselling provision.
Objectives:	By 2020, our local offer will be: • To provide effective access, support and age appropriate information to children, young people, families and professionals virtually to help remove barriers to access • Information will be adapted to meet the diverse needs of individuals, including those with learning disabilities and where English is a second language • Reduce stigma attached to mental health and emotional wellbeing by improved communication and health promotion
Outcomes:	• Enhancing online therapeutic and self-help support • Utilising technology for use in and between therapeutic sessions (text reminders, interactive therapeutic tools) • Making best use of social media which is developed by children and young people themselves • Ensuring technology helps removes barriers to access for young people with learning disabilities and where English is a second language
Deliverability	The procurement of a website developer will be commissioned. Transformation funding will be used to support the development and management of the website.

Year 1 -Progress	No work stream was established in year 1 for this priority, due to capacity being allocated to driving forward other priorities that could have a more immediate clinical impact.
Nest steps – year 2	In Coventry this will be a focus in year 2, through the commissioning of a single website resource for young people and associated apps. In Warwickshire this will be addressed through the competitive dialogue process.

Priority 7:	**Implementation of a Community Based Eating Disorder Service** We plan to enhance and implement a dedicated community based Eating Disorder Service across Coventry and Warwickshire, to support a diverse community and enhance provision to provide a stepped care approach providing early help and support through our early help and prevention services, and ensuring those requiring specialist interventions receive timely access to provision at locations close to young people and their families.
Case for change	• The current provision is supported through professionals within the Specialist CAMHS Service, with limited resource to meet the current demand and needs of our local population • The development of a community based eating disorder service will enable capacity to be released from the Specialist CAMHS service to undertake additional mental health assessments for children and young people with moderate to severe mental health needs, and support the service to alleviate waiting time pressures • Current waiting time and standards are not currently in line with the Access and Waiting Time Standards 2015
Objectives:	By 2020, our local offer will be: • For young people to receive support to services close to home and within the community based on meeting their individual needs • Greater awareness amongst early intervention, prevention and universal services in the early identification of eating disorders and greater support provided to prevent needs from escalating • Increased resilience amongst young people and their families
Outcomes:	• Released pressures in Specialist CAMHS and Inpatient services • Will release clinician time and capacity to undertake additional assessments • Empowers young people and families to manage and receive specialist support tailored to individual need • Reduced waiting times within the Specialist CAMHS service • Implementation of a stepped care community based service

Year 1 Progress	• A new clinical pathway and local service model has been signed off by all three CCGs and recruitment, and implementation is underway. • See section 10 for detail.	
Next steps – year 2	• Production of external communication to launch the service and share clinical pathway/ access criteria –October 2016 • Full team in post – December 2016 • Delivery of early intervention work – December 2016 • Service launch – December 2016	
Key Performance Indicators & Current Performance	• Children and young people referred for an assessment or treatment of an eating disorder will access NICE concordant treatment within 1 week for urgent cases • Children and young people referred for an assessment or treatment of an eating disorder will access NICE concordant treatment within 4 weeks for routine cases	• Routine cases – 6-7 weeks (Q2) • Full implementation of KPI's when service is embedded after launch in December 2016.

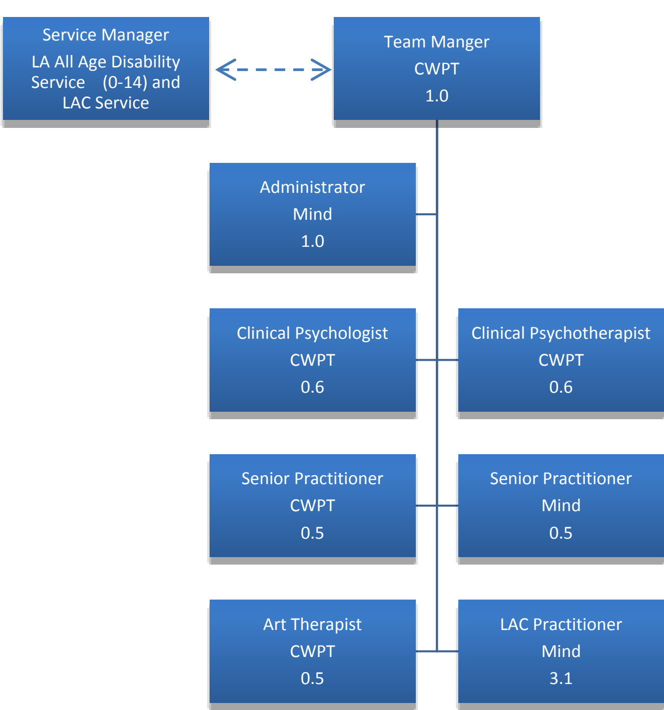
9) Workforce Planning and Development

Multi-agency workforce planning – Case Example

9.1 In December 2015, CWPT and Mind launched a Partnership Development Plan. Central to the plan is the belief that the two organisations are doing excellent work already, and can build on this to extend expertise together.

9.2 Skills and training is a key strand within the development plan. In practice, the development plan and partnership has led to an integrated and tangible approach to workforce planning across the two organisations and partner agencies. The most notable example is the development and implementation of a joint service and workforce for vulnerable young people in Coventry, including CWPT, Mind and reporting lines to the Local Authority, and co-location with the Local Authority. See structure chart below.

Figure 19: CAMHS LAC Structure Chart



9.3 While the above is one case example of the joint workforce approach, there are other examples, such as example the eating disorder service across Coventry and Warwickshire, which combines roles from CWPT and Mind.

9.4 The completive dialogue process for Warwickshire being undertaken which will encompass joint workforce planning and the process for transformation over the life time of the contract.

Additional Staff Required by 2020

9.5 To deliver the seven priorities within the transformation plan, recruitment of additional staff is essential for implementing the required increase in capacity and ensuring the relevant expertise for specific pathways.

9.6 Table 16 below details the projections of staff required to deliver the transformation based on the original transformation proposals published in 2015, and subsequent recruitment activity to

implement the staffing. Where posts are not yet recruited to, it often relates to challenges recruiting posts at a point time when nationwide there is a recruitment drive to transform services.

Table 16: Additional staffing

Priority	CRCCG	SWCCG	WNCCG
1. Waiting times	0.4 Consultant Psychiatrist – in post 1 wte Band 8a Clinical Psychologist – in post 1.5 wte band 6 CAMHS Practitioners/Nurses- in post	1 wte band 8a Clinical Psychologist – interviewed and post offered. 1.5 wte Band 7 Senior Practitioner/Nurses - interviewed and post offered 1 wte band 6 CAMHS Practitioner/Nurse – interviews held in September but not appointed – out to advert currently 1 wte band 2 admin – recruitment underway	1 wte Band 8a Clinical Psychologist – interviewed and post offered... 1 wte band 7 Senior CAMHS Practitioner/Nurse – interviews held in September but not appointed – re-advertised and shortlisted – interviews early November 1 wte band 6 CAMHS Practitioner/Nurse – interviews held in September but not appointed – out to advert again currently 0.8 wte band 2 admin – recruitment underway
Total additional staff in post or recruited to above historic baseline	2.9 wte	2.5 wte	1.0 wte
Additional staff required to meet 2015 plan	0	2 wte	2.8fte
2.Acute Liaison Service **(joint across Cov and Warks)**	1.0 wte Band 7 Team Leader 2.0 wte CAMHS Nurses 0.6 Consultant Psychiatrist		
Total additional staff in post or recruited to above historic baseline	3.6 fte		
Additional staff required to meet 2015 plan	0		
3. ASD	0.8 wte Band 8a Clinical Psychologist – in post 0.7 wte Band 8a Clinical Psychologist – in post. 0.4 band 3 co-ordinator – in post	0.4 wte Band 8a Clinical Psychologist – in place from September 0.4 wte band 3 co-ordinator – recruitment underway	0.6 wte Band 8a Clinical Psychologist – in place from September - 0.4 wte – recruited to and due to start in December 0.4 wte band 3 co-ordinator – recruitment underway
Total additional staff in post or recruited to above historic baseline	1.9 wte	0.4 wte	1.0 wte
Additional staff required to meet 2015 plan	0	0.4 wte	0.4 wte
4.Vulnerable young people	1.0 wte Band 7 Team Manager – advertised – interviews scheduled for November 0.6 wte Band 8a Clinical Psychologist – interviewed and appointed	To be addressed through the competitive dialogue process	To be addressed through the competitive dialogue process

Priority	CRCCG	SWCCG	WNCCG
	0.5 wte Band 7 Senior Practitioner/Nurse – interviewed and appointed 0.5 admin – recruitment underway		
Total additional staff in post or recruited to above baseline	**1.1 wte**		
Additional staff required to meet 2015 plan	**1.5 wte**		
5. Support to Schools	0.8 wte Band 6 Primary Mental Health Worker – MIND (upgraded form advisor post from existing resource) 0.6 wte Band 8a Clinical Psychologist 0.5 wte admin New posts to go out to advert at the beginning of November and recruitment pending final approval of detailed proposal.	To be addressed through the competitive dialogue process	To be addressed through the competitive dialogue process
Total additional staff in post or recruited to above historic baseline			
Additional staff required to meet 2015 plan	**1.9**		
7.Eating Disorders	1.0 wte Band 7 Team Manager – in post 1.0 wte Band 6 dietician – in post 1.0 wte Band 7 Senior Nurse – in post 1.0 wte band 7 Clinical Psychologist – in post 1.0 wte Band 7 Family Therapist – out to advert beginning of November 2.0 wte Band 5 CAMHS ED Practitioner – Mind – out to advert at the beginning of November 1.0 wte Band 3 admin – recruitment underway 0.4 wte Band 8b Senior Clinical Psychologist – recruitment commenced 0.4 wte Consultant Psychiatrist – recruitment commenced 0.2 wte band 4 medical secretary – recruitment commenced		
Total additional staff in post or recruited to above historic baseline	4 wte		
Additional staff required to meet 2015 plan	5 wte		

Wider Children's Workforce (Schools and universal settings)

9.7 All partner agencies are clear that on-going partnership working is required with schools and other universal settings to ensure that the wider children's workforce have the sufficient skills, confidence and capability to pro-actively identify the signs and symptoms of mental health or emotional wellbeing, and are confident responding appropriately and positively.

9.8 To achieve an increase in the capacity of the wider workforce to intervene appropriately a programme of training, advice and guidance for the universal workforce has been commissioned across Coventry and Warwickshire (in line with priority 5). The training is delivered in 4 workshop themes:

Table 17: Workshop themes

Workshop	High Level Objectives	Dates Workshops Held and Scheduled
Anxiety	• Explore physical symptoms • Consider how anxiety develops. • Strategies you can use to support a child/ young person with an anxiety related disorder • Understand when and how to access specialist services	September 2016 – 13th, 20th, 30th October 2016 - 4th, 11th, 13th, 21st March 2017 – 28th April 2017 – 4th,, 27th May 2017 – 2nd
Attachment	• To highlight the difference between attachment difficulties and attachment disorders • To discuss the consequences of maltreatment, including trauma • Explore how attachment difficulties impact upon learning, education and social development • Strategies for working with CYP • To discuss support available for signposting CYP	November 2016 – 3rd, 10th, 15th, 18th, 29th December 2016 – 9th, 15th
Depression	• To gain an understanding of depression in a CYP • To be able to recognise depression in a CYP - physical symptoms and warning signs • Risk and protective factors for children and young people with depression. • To explore strategies to support CYP suffering with depression • To understand when to refer a child or young person to specialist services	January 2017 – 19th, 19th, 24th 31st February 2017 – 7th, 16th June 2017 – 8th, 13th, 15th, 22nd
Self-harm	• To develop knowledge and understanding of self-harm behaviour in young people • To explore the reasons why young people self-harm. • To understand how to respond to a disclosure • To explore alternative coping strategies for reducing self-harm behaviour. • To identify support available for CYP and when to refer on.	March 2017 – 2nd, 7th, 16th, 23rd June 2017 – 27th July 2017 – 6th, 11th, 13th

9.9 The proposals relating to priority 6 to extend the primary mental health offer will further strengthen the local offer and will be a significant focus in 2016/17.

10) Community Eating Disorder Service

Baseline Position across Coventry and Warwickshire

10.1 In response to the rising number of young people across Coventry and Warwickshire diagnosed with an Eating Disorder, the Specialist CAMHS service developed a specific eating disorder pathway to aid early identification of an eating disorder as needs arise. The service provided support to children and young people aged 0-18 across Coventry and Warwickshire, covering a population of 131,000 people.

10.2 All referrals are currently received through the Single Point of Entry (SPE) service, screened initially by senior CAMHS clinician and then proceed for an Eating Disorder assessment by an identified professional with Eating Disorder experience.

10.3 The Eating Disorder pathway was historically supported by 2.8 full time equivalents, dedicating 50% of their time to the pathway. The service had 1fte CAMHS Eating Disorder Specialist. The following professionals provided support across Coventry and Warwickshire:

- 2x0.5fte Family Therapists
- 1fte Nurse Specialist
- 0.2fte Art Therapist
- 0.3fte Clinical Psychologist
- 0.3fte Family Therapist Supervisor

10.4 Local intelligence gathered indicates approximately 64% of referrals are received through GP referral, 18% of referrals are received from University Hospital Coventry and Warwick and 18% received from Paediatricians. All urgent cases were assessed by clinicians within 48 hours and routine referrals within 2-4 weeks.

10.5 The historic caseload indicates 25% of individuals require support for mild presentations, 50% with moderate need and 25% severe. There are currently 74 young people receiving support from Specialist CAMHS for eating disorders, 5-10 of whom are looked after children. Currently there are 9 children and young people with Eating Disorders occupying tier 4 CAMHS beds.

10.6 Support is currently provided to children and young people as young from 5 years of age up to 17. An analysis of data from 2011 to 2015 indicates the majority of young people with an Eating Disorder across Coventry and Warwickshire are 13 to 16 years of age.

10.7 In many cases, comorbidity is present for many young people diagnosed with an Eating Disorder. An analysis of data indicates a significant proportion of young people are diagnosed with depression, anxiety, ASD, OCD and ADHD in addition to an Eating Disorder.

10.8 The historic service provision for Eating Disorders has been broadly in line with the National Access and Waiting Time Standards, supporting a total population of over 500,000 across Coventry and Warwickshire, exceeding the minimum referral rate of 50 referrals per year and has an average wait of 4-5 weeks.

10.9 Local professionals in universal and targeted services have not previously had the have the skills, capacity or levels of resource to support the management of conditions associated with Eating Disorders at an earlier stage.

Service Model to be implemented

10.10 With the additional transformation resource allocated, CWPT and CW Mind are implementing:

a) a comprehensive community based Eating Disorder service for patients and their families across Coventry and Warwickshire – including carer support groups covering psycho-education (i.e. what is an ED and how you can support the young person through their treatment), peer and professional support;
b) providing a specialist hub, with one specialist team providing equitable access and treatment across localities;
c) fully implementing a clinical pathway which is based on guidance from the Royal College of Psychiatry and NICE Guidelines;
d) encompass individual, family and group interventions for patients and families in a timely manner, based upon their level of need;
e) providing an Enhanced Community Outreach Service for those patients who are more severely affected by their Eating Disorder diagnosis by delivering a home based service.

10.11 Referral rates for eating disorders are unpredictable across the three localities. However, the risk factors associated with development of eating disorders in some cases, such as low self-esteem, poor body confidence and a distorted body image; occur much more widely amongst young people in the general population. In order to ensure that each CCG locality receives a fair proportion of service provision that meets local needs, as well as direct specialist interventions for young people referred with an eating disorder, the service will be providing a range of pro-active early intervention and targeted prevention work. This will comprise of:

a) Groups outlined within the Eating Disorders pathway ('body image group' and 'understanding eating disorders') will be accessible to young people who may be presenting with those risk factors associated with the development of eating disorders. They will provide a supportive, educational and therapeutic, problem solving environment where young people can develop an understanding of the risks posed to their health by low self-esteem, poor body confidence and distorted body image.
b) School- based training- a bespoke package of education and training, available for students, staff and parents that aim to help parents, carers and school staff recognise early warning signs of eating disorders and provide them with basic skills to address their concerns and build resilience. The addition of the dietetic support provided by this proposal will enable the development of healthy eating, healthy life choice work;
c) Psychoeducation group , previously delivered by CW Mind around "Mood and Food" and covering themes such as:
    - body image / attitudes;
    - self-esteem;
    - identity and self-empowerment;
    - coping styles and alternative coping strategies;
    - living up to expectations;
    - assertiveness / anger;
    - anxiety management;

10.12 The service will engage schools and work closely with Primary Mental Health teams and other agencies to develop a structured approach to deliver a targeted range of early intervention and prevention options outside of the Specialist Clinical Pathway.

10.13 The staffing structure being implemented is as follows (table 18):

Table 18: Staffing structure

Role	Band	wte
Team Leader	7	1.00
Family Therapist	7	1.00
Dietician	6	1.00
Psychologist	8b	0.40
Psychologist	7	1.00
Nurse	7	1.00
CWM CAMHS Practitioner (ED)	5	2.00 (MIND)
Admin	3	1.00
Medical Sec	4	0.20
Psychiatrist		0.40
Sub-total		**9.00**

Outcomes

10.14 It is anticipated that the number of inpatient admissions for Eating Disorders will be reduced by providing the intensive level of support and containment required by families at this time. However, there are many other factors impacting on the number of referrals to Tier 4 each year, other than the provision of a specialist service and therefore, in isolation, this outcome alone would be insufficient to measure the success of the service. Longitudinal studies and research, however, indicate that what is most likely to decrease admissions and length of admission, is a dedicated community-based eating disorder service as opposed to generic CAMHS (Byford et al., 2007; House et al., 2012). Such provision has been shown to:

- Improve outcomes through reduction in relapse;
- Reduce need for inpatient care;
- Reduce disruption to school, family, social life;

10.15 In line with recent research, one of the key messages from the Access and Waiting Times document is that the availability of dedicated, Community Eating Disorder Services for children and young people (CEDS-CYP) has been shown to improve outcomes and cost effectiveness. If a child or young person starts their treatment in a general child and adolescents mental health service (CAMHS), they are more likely to be admitted to an inpatient service than those treated in community eating-disorder settings within the following year.

10.16 Table 19 below provides local information from CAMHS on numbers of admissions of young people from Coventry and Warwickshire.

Table 19: Number of admissions to Tier 4

Tier 4 new admissions	2014	2015	2016 (Jan- June)	Total
C&RCCG	4	2	1	**7**
WNCCG	2	3	0	**5**
SWCCG	3	2	1	**6**
Total	**9**	**7**	**2**	**18**

10.17 The service will work towards reducing the overall length of stay for those who are admitted to hospital by providing a step-down intensive support package on discharge from hospital to support the young person and their family to continue with the progress achieved in hospital.

10.18 However, it should be noted that historical length of stay information is not currently available and so it is not possible to have clear baseline data.

10.19 Previous informal information from NHS England Specialist Commissioning suggested the cost of an in-patient admission was between £160,000 and £200,000.

10.20 The service will demonstrate the progress young people make through the assessment and treatment pathway through the use of a range of clinical outcome measures, including

- SRS – Session rating scale
- ORS – Outcome rating scale
- SDQ – Strength and Difficulties Questionnaire
- Current view
- RCADs – Revised Child Anxiety and Depression Scale
- EDE-Q – Eating Disorder Examination – Questionnaire

10.21 As well as measuring the improvement that young people make, the data will be used to improve:

- Individual clinical practice and skills development;
- Service effectiveness and quality;

10.22 The service will work in collaboration with the Primary Mental Health Team and other voluntary sector partners to support the universal children's workforce by providing training and consultation to support the identification and early intervention and prevention of difficulties related to body image and eating. The service will evaluate the impact of training by measuring the self-reported skills and knowledge of professionals before and after training to evidence an improvement in universal services.

11) Collaborative Commissioning (tier 4)

Background

11.1 Children and young people with severe mental health and emotional wellbeing needs may require inpatient care and support, funded by NHS England. Data shows there were 32 young people across Coventry and Warwickshire were admitted to inpatient hospital services in 2015/216 compared to 33 in 2014/15. The following table details the tier 4 admissions made in 2014/15.

Table 20: Tier 4 admissions 2014/15

CCG	Independent sector		Parkview		Independent sector		Parkview	
	No. of admissions in 2014/15	Length of stay	No. of admissions in 2014/15	Length of stay	No. of admissions in 2015/16	Length of stay	No. of admissions in 2015/16	Length of stay
Coventry and Rugby	7	161 days (longest) & 8 days (shortest)	16	360 days (longest) & 5 days (shortest)	9	284 days (longest) & 5 days (shortest)	7	248 days (longest) & 28 days (shortest)
South Warwickshire	3	99 days (longest) & 10 days (shortest)	4	733 days (longest) & 103 days (shortest)	7	260 days (longest) & 1 day (shortest	3	207 days (longest) & 81 days (shortest)
Warwickshire North	2	65 days	1	273 days	2	155 days (longest) & 84 days (shortest	4	348 days (longest) & 63 days (shortest)

Aims

11.2 Across Coventry and Warwickshire there is commitment in year 2 of the plan to develop local integrated pathways for children that may require beds.

11.3 The aim of developing collaborative and integrated pathways for children and young people is to:

- Support young people in the local community where clinically appropriate
- Build on the Acute Liaison service to offer enhanced crises support
- Prevent admission
- Support appropriate and timely discharge
- Ensure where young people require more specialist inpatient care, it is age appropriate and close to home.
- Support transfer where commissioners across agencies agree it is beneficial to supporting young people needs differently.
- Build a network of supportive approaches, which could include:
    - Home treatment
    - Multi-systemic therapy
    - Treatment foster care

Scope

11.4 Historical prevalence data and local intelligence demonstrates that following pathways will need to be within the scope of the collaborative approach:

- Eating disorders
- Psychosis
- Self-harm
- Obsessive compulsive disorders
- Anxiety
- Developmental disorders, including ASD
- Transition
- Learning disabilities (where co-morbidity with mental health needs)

11.5 The partners that have been invited to take part in the initial scoping session with the CCG's are:

- Local Authority
- NHS England
- Social Care
- CWPT, Mind
- Youth Justice

Resources

11.6 The partners comprised above will form the project team. The project will be overseen by two programme managers, one representing Coventry and Rugby CCG, and another representing South Warwickshire CCG and Warwickshire North CCG.

Next Steps

Table 21: Project milestones - tier 4 collaborative commissioning

Milestone	Indicative Timescale
Project Set Up and Scoping Session	December 2016
Submit bid for additional funding/capacity to NHS England	31st December 2016
Stakeholder engagement	January 2017 and February 2017
Pathway development	March 2017 – May 2017
Organisational sign off	June 2017
Implementation (timescales may vary dependent on the requirement to go to market for any specific elements of pathways or recruitment)	July 2017 –October 2017

Potential Barriers

11.7 Potential barriers identified are:

- Provider and market capacity to respond to new pathways.
- Agreeing detail of resource transfer, and phasing of transfer.
- Alignment with Warwickshire procurement process timescales

12) Early Intervention in Psychosis

Baseline Position

12.1 Historically the provision of care for early intervention in psychosis is split between the Early Intervention for Psychosis team (EIPT) within CWPT Integrated Community Services (ICS) for those aged 17-65 years and CAMHS within Children's and Families Services (CFS) for those under age 17. Joint working arrangements are in place between these teams for those young people aged 14 – 17.

New Pathway – For implementation from January 2017

12.2 The new service model will be provided by the EIPT to patients within the age range of 0 to 65. It will be supported by CAMHS practitioners as part of their job plan to the EIPT to ensure an integrated approach to young people with psychosis in particular they would be able to provide advice about neurodevelopmental issues. The teams would provide consultation, assessment, treatment and co-ordinate the care of all young people with psychosis.

12.3 Referral for young people aged up to 16 will be triaged by the CAMHS SPE. EIPT will provide input into assessments for screening of 'at risk mental state'. This will ensure a clear indication of psychosis or At Risk Mental State (ARMS) prior to access by the patient to the EIPT pathway.

12.4 EIPT will train the nurses / care co-ordinators within CAMHS to deliver ARMS assessments.

12.5 Patients will receive a specialist timely assessment by EIPT, the timings for these interventions will be governed by the new standards outlined in 2.2.

12.6 It is anticipated that there will be a caseload of approximately 415 plus additional assessments from CAMHS and an increased use of ARMS would allow for 3 teams to cover the geography of Coventry and Warwickshire and retain a locality focus.

12.7 As Early Intervention continues to develop in accordance with recent NICE guidance the team would further develop expertise. Using tools such as the At Risk Mental State assessment ensures consistency, appropriate diagnosis and the offering of interventions to those at high risk of transition to psychosis to reduce that risk.

Staffing

12.8 To achieve this new service model, it is proposed some staff currently working within the CAMHS service would have a portion of their job plan attributed to EIPT. The workforce has been calculated based upon a current activity level of 23 children within CAMHS requiring psychosis intervention, as follows:

- 1.2 WTE Band 6 Nurse – 1 nurse dedicated to each locality e.g. 3 nurses 0.4 wte per locality
- 0.3 WTE Band 8a Psychologist
- 0.6 WTE Consultant Psychiatrist (most likely to be divided in 0.2 WTE in each locality)

Key Benefits

12.9 The following benefits will be delivered:

- Joining EIPT and CAMHS expertise would allow the specialist assessment of young people presenting with possible symptoms of psychosis, taking in to account systemic and family

issues. This combined approach would strengthen safeguarding and multi-agency work for example with schools, due to the expertise CAMHS has in these areas.

- Integrating CAMHS clinicians in to the current EI service would also allow their expertise to be drawn upon where young people present with developmental disorders.
- Continuing the development of the EIPT assessment process and the CAMHS psychosis pathway will streamline process.

13) Key Risks

Figure 20: Key Risks

Risk	Description	Risk Owner	Controls and Mitigation	Post Mitigation Rating
Slippage in timescales due to complexity of the programme	There is a risk that there may be slippage in delivery timescales due to the complexity of running multiple, often complex work streams in parallel.	CAMHS Transformation Board	Year 1 implementation of the work streams were prioritised based on clinical risk. Waiting times and embedding the acute liaison service were initially prioritised to ensure overall system risk was reduced. The more transformational work streams have now been mobilised.	Medium probability, medium impact
Unable to recruit the required clinical staff to deliver the transformation	Recruitment of additional staff to deliver the increased capacity and transformation has been a challenge for service providers. This is due to services nationwide increasing recruitment to drive transformation, and ensuring the right skills match with specialist roles in pathways.	Service Providers	CWPT have had a rolling programme of recruitment to try and attract both the volume of applicants and range of skilled applicants. The consortium CWPT and Mind have developed has enabled the sharing of expertise around recruitment and retention and made working in Coventry an attractive, innovative proposition.	Low probability, high impact
Commissioning programme management capacity to deliver the plan	The programme across Coventry and Warwickshire requires significant programme management capacity to manage the complexity and volume of transformation required	CRCCG, WNCCG, SWCCG	There are two programme managers allocated, one for Coventry and one for Warwickshire. The Coventry positions is vacant, however has been recruited to and cover arrangements is in place. A Coventry sub group consisting of CRCCG, CCC and Education has been established to provide additional support and overview to the local implementation.	Low probability, high impact

Risk	Description	Risk Owner	Controls and Mitigation	Post Mitigation Rating
Procurement	The procurement process for Warwickshire is unable to secure a provider to meet the required specification.	Warwickshire commissioners	Competitive dialogue is the method of procurement being used to ensure a collaborative approach and stimulate innovative solutions.	Low probability, high impact

Appendices

Larger version of Table 13

Vision

- Provide stepped care through early help, prevention and crisis support
- Young people will have access to flexible personalised care
- Young people will receive early help and support within schools
- Improve and strengthen smoother transitions
- Improved care for children and young people in crisis
- More use of evidenced based practice and interventions
- Greater awareness of mental health and emotional wellbeing services
- Provide clear direction for all agencies to improve mental health & emotional wellbeing

Priorities

- Implementation of dedicated mental health support within schools and other universal settings
- Improved access
- Specialist support for ASD
- Crisis support
- Vulnerable young people
- Technology
- Community based Eating Disorder Service

YEAR 1

- Implement capacity to improve access and waiting times
- Embed acute liaison service at hospital to improve crises response and avoid admissions.
- Agree new service required to support vulnerable young people
- Develop new clinical pathway for Eating Disorder Service and mobilise resource
- Draft new ASD pathway
- Draft revised primary mental health service model

YEAR 2

- Implement fully the new eating disorder service.
- Implement a new ASD pathway, with earlier support and reduced waiting times.
- Implement increased capacity and revised Primary Mental Health Service to enhance support in schools.
- Implement new dedicated and integrated service for vulnerable young people, co-located with LA.
- Launch the Dimensions Tool to improve referral pathway
- Develop and commission new integrated collaborative pathways for tier 4 to support crises, admission prevention and safe discharge
- Review opportunities for further integration with other areas of vulnerability for young people (e.g. substance misuse).

YEAR 3

- Embed CAMHS in multi-agency early help/ family hubs.
- New tier 4 pathways are fully embedded.
- Launch a new multi-agency owned website to reach young people and suite of associated apps.
- Integrate with other appropriate services

YEAR 4

- Sustain the impact of year 1-3 transformation through:
  - Robust contract monitoring.
  - Review of individual priorities

YEAR 5

- Develop and agree a sustainability plan

Indicative Trajectory & Targets

- Urgent cases – Referral to treatment within 5 days – 100% of cases (Year 1-5)
- Routines cases - Referral to treatment within 18 weeks – 95% of cases (Year 1-3), reducing to 12 weeks (Year
- Young peoples assessed within 48hrs of presenting to hospital (Year 1-3), reducing to 24 hours. (Year 4-5)
- LAC – referral to treatment – 4 weeks. (Year 1-3), reducing to 3 weeks (Year 4-5)
- Follow up treatment appointment within 12 weeks of initial appointment – 95% of cases (Year 1-3), reducing to 8 weeks (Year 4-5)
- Children and young people referred for an assessment or treatment of an eating disorder will access NICE concordant treatment within 1 week for urgent cases (Year 1-5)
- Children and young people referred for an assessment or treatment of an eating disorder will access NICE concordant treatment within 4 weeks for routine cases (Year 1-5)
- Undertake 53 ASD assessments per month, and reduce start of year waiting list by 25% (Year 1-5)
- 5% reduction in placement breakdowns. (Year 2-5)

Cross Cutting Theme: Implement whole systems of care approach

Report

To: Coventry Health and Wellbeing Board **Date: 28th November 2016**

From: Liz Gaulton, Deputy Director Public Health

Title: Joint Coventry and Warwickshire Health and Well-being Board Development Day

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1 Purpose

1.1 To ask the Board to note the feedback from the joint development workshop with Warwickshire Health and Well-being Board on the 13th October 2016.

1.2 To ask the Board to discuss and agree the focus for the joint development session with Warwickshire Health and Well-being Board on 16th January 2017.

2 Recommendations

2.1 It is recommended that the Board agree the proposed focus of the second development day.

3 Information/Background

3.1 Over recent months the Coventry and Warwickshire Health and Wellbeing Alliance Concordat has been developed and agreed. It sets out principles for joint working with Warwickshire Health and Wellbeing Board, with an emphasis on delivery of the Coventry and Warwickshire Sustainability and Transformation Plan. The concordat has the dual purpose of enabling people across Coventry and Warwickshire to pursue happy, healthy lives, and put people and communities at the heart of everything we do; whilst transforming our services and making significant financial savings.

3.2 At the September meeting Coventry Health & Wellbeing Board agreed, to hold two joint development sessions this municipal year aimed at seeking greater alignment of interest and approach across the two Health and Wellbeing Boards. With an opportunity to agree further development sessions in 2017/18.

4 Joint Development Sessions

4.1 In October 2016, the first development session was held between the two boards to look at how the Concordat could be put in practice and to identify ways of working together in future. Appendix A sets out the feedback from the workshop.

4.2 Following on from the discussions from the first joint workshop, this report proposes that the second development day, which will take place on 16th January 2017, be focussed on the STP. The STP will be published in November and the work streams are now being developed and so this will be an opportunity for both Boards to have a shared discussion on the STP and to shape and influence the work streams.

4.3 Board members are invited to share their views as to what they would like the second development day to focus on and identify what outcomes they would like to achieve through the day. This feedback will be used, in discussion with Warwickshire colleagues, to shape the agenda for the day.

Report Author(s):

Name and Job Title:
Robina Nawaz, Corporate Policy Officer
Liz Gaulton, Deputy Director Public Health

Directorate:
People

Telephone and E-mail Contact:
Robina.nawaz@coventry.gov.uk
Liz.gaulton@coventry.gov.uk

Enquiries should be directed to the above person.

Appendices
Appendix A: Autumn Health and Well-being Board Summit for Coventry & Warwickshire HWB Boards

Autumn Health & Wellbeing Summit
For Coventry & Warwickshire HWB Boards

“Transformation through integration”

Storyboard

13th October 2016

Members of the Health & Wellbeing Boards and Executive for Coventry and Warwickshire came together on 13th October 2016 to sign the Alliance concordat . . .

This is the second time the HWB Boards have met and marks a new chapter in our relationship. .

COVENTRY & WARWICKSHIRE

Health & Wellbeing Alliance Concordat

PRINCIPLES

- ***We will*** be bold, brave and challenging in the service of the people of Coventry and Warwickshire.
- ***We will*** align, share and pool resources, budgets and accountabilities where it improves outcomes for the public.
- ***We will*** focus on benefits to the public as a whole rather than organisational interests.
- ***We will*** take decisions that we know will impact on other parts of the system, only after we have talked to each other.
- ***We will*** streamline system governance to enable decisions to be taken at scale and pace.
- ***We will*** design a system that is easy for everyone to understand and use.

To achieve this we will work in alliance with each other operating with mutual respect and mutual accountability.

Signed on behalf of Coventry and Warwickshire's Health and Wellbeing Boards.

Cllr Isobel Seccombe
Chair of the Warwickshire Health and Wellbeing Board

Cllr Kamran Caan
Chair of the Coventry Health and Wellbeing Board

This is a momentous step for Coventry and Warwickshire working together around the health and care needs of our people and our shared place and I am excited to be going forward together."

Councillor Izzi Seccombe, Chair Warwickshire HWBB

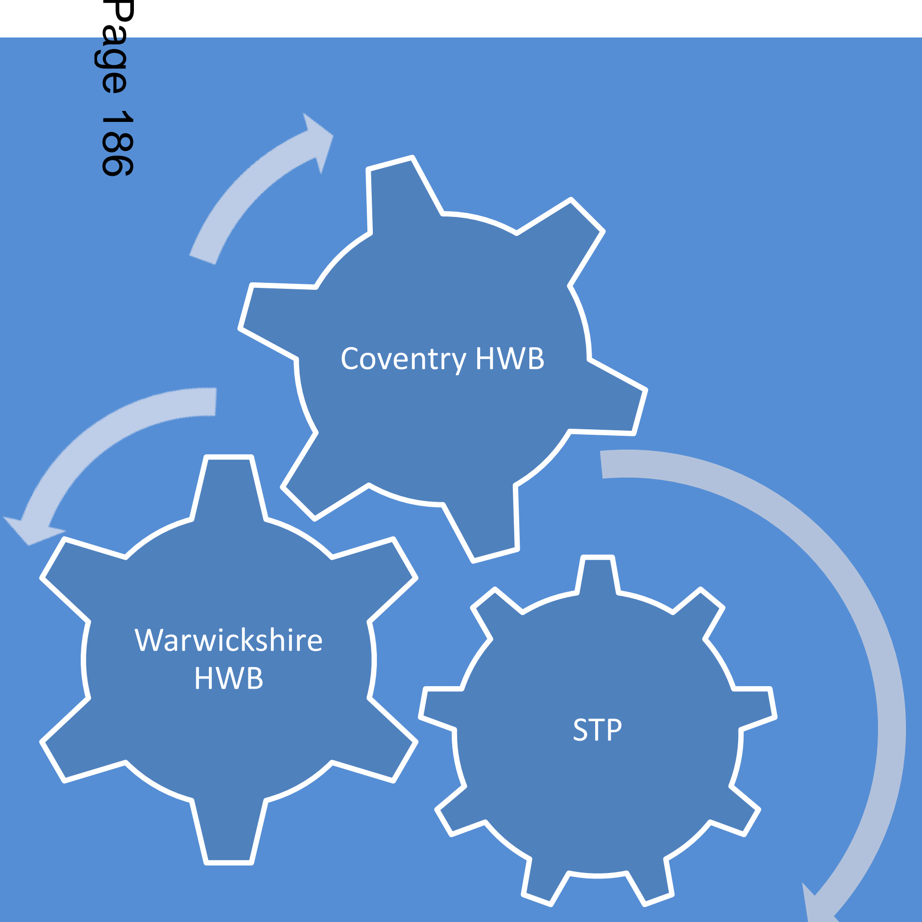
"People and communities are at the heart of everything we do and creating a partnership like this is going to help shape better futures for those that we want to support.

"This agreement allows us to work closer together to create a better system that improves the health, wellbeing and overall happiness of people and families across Coventry and Warwickshire

"We truly need to encourage innovative ideas and to be able to see positive outcomes."

Councillor Kamran Caan, Chair Coventry HWBB

The work of the HWB Boards and the STP are intertwined and inherently connected



"We will do everything in our power to enable people across Coventry & Warwickshire to pursue happy and heathy lives and put people and communities at the heart of everything we do" **– Coventry and Warwickshire HWB Alliance Concordat**

"To work together to deliver high quality care which supports our communities to live well, stay independent and enjoy" STP vision

Following a presentation from Andy Hardy, lead for the STP, delegates considered the questions they have . .

Process
Does the 21st submission need to be signed off by HWBBs?
Will national regulations and performance frameworks change to allow a system in the system to happen?
Accountability needs to be addressed through the STP?
How do we stop duplication?
Who would pay for legal challen
Need multiple plans and multip

Engagement
How do we get Elected members closer to the STP ?
Why does it need to be closed. How can we remove suspicion?
What vehicles are there for communicating with the public?
Is it an exercise about persuasion or public consultation ?
Do communities have the information they need to engage ?
Are we skilled enough to deliver this engagement – do we need expert help?
When is the right time for public involvement?
Are we being honest with the public on the financial challenge?
Are we being clear about what we can't do?

Buy in
How much does everyone understand/ potential of the STP?
How do we affect behavioural change required?
How do we ensure a positive joint engagement?
Is there still a chance to influence the plans?
How much buy in is there from partners to give something up for a shift in the system?
Does everyone really unders

Finance
When will we see the detail?
What is the full size of the C&W health economy – what % is £400m?
Is it a real saving or just addressing rising demand
Is the STP model building a new system model and fitting the finances to it, or vice versa?
What is the effect of local government budget reductions?
Are the differences between local authority and NHS finance planning understood

Innovation
How far is new thinking involved?
How do you build the required community infrastructure ?
How can we utilise the innovation and insight of our universities?
How do we move resource around the system?
Can we really work differently?
How do we decide what we need to turn off/stop doing?
Have closures of beds 'really' been considered?
IS CQC going to start looking at system rather than organisation?
How do we change the culture of consultants and who they work for?
How to support the need to invest to save?
Where is the evidence base to support the approach?

Questions led to challenges, opportunities and issues relevant to finances; prevention, link between STP & HWBBs; engagement; planned & emergency care; workforce.

Challenge to the room –

How do we unify and grab our collective learning across the whole system?

How can we design a place-based a system on multiple places?

Opportunities

- Prevention not cure
- Greater efficiencies
- Improved quality of life
- Link to economic growth
- Shared responsibility
- Consistent narrative
- Redirect and reduce demand
- Change expectations
- Local enpowerment
- Involving our universities
- Avert a crisis . . .

Headline observations

- STP is the mobilisation of the NHS 5 year forward view
- The total financial gap over the next 5 years if we do nothing is £400m
- Different conversations between ourselves and with the public
- We need to make prevention everybody's business
- The 21st October submission date is just the start of conversation

Issues

- Tensions between local and national drivers
- Immediate pressure v. long term benefits
- Not all in the room
- Too much secrecy
- Focus on money, not place has taken over
- NHS and Local Authority need to speak a common language

Questions led to challenges, opportunities and issues relevant to finances; prevention, link between STP & HWBBs; engagement; planned & emergency care; workforce

Planned and urgent care
We need a whole system appraoch to manage demand and rescale hospital provision -CQC should start looking at the system not organisations
We need to challenge existing attitudes and incentives in the system to evoke a shift to prevention

HWBB and STP links
It is critical that we embed the Concordat and our universal commitment to prevention into all our organisational processes and policies

In doing so , we have an opportunity to ensure our existing governance models are fit for purpose

Finances
The Coventry & Warwickshire £ should be spent in the best possible way – this means thinking outside the box

Existing financial incentives, structures, membership and access to transformation funds should all be challenged

Prevention
Prevention has to be made everybody's business and we need to make the contributions we already make more visible

Engagement
It is critical that after today we have a coherent narrative for our system that stretches across the STP, HWBBs and partner organisations

Workforce
Future workforce design needs to be considered now to have long term effect

Inefficiencies in the shared workforce need to be tackled together to remove duplication

Potential immediate actions and bold steps were then identified by the groups . .

Immediate actions we could take

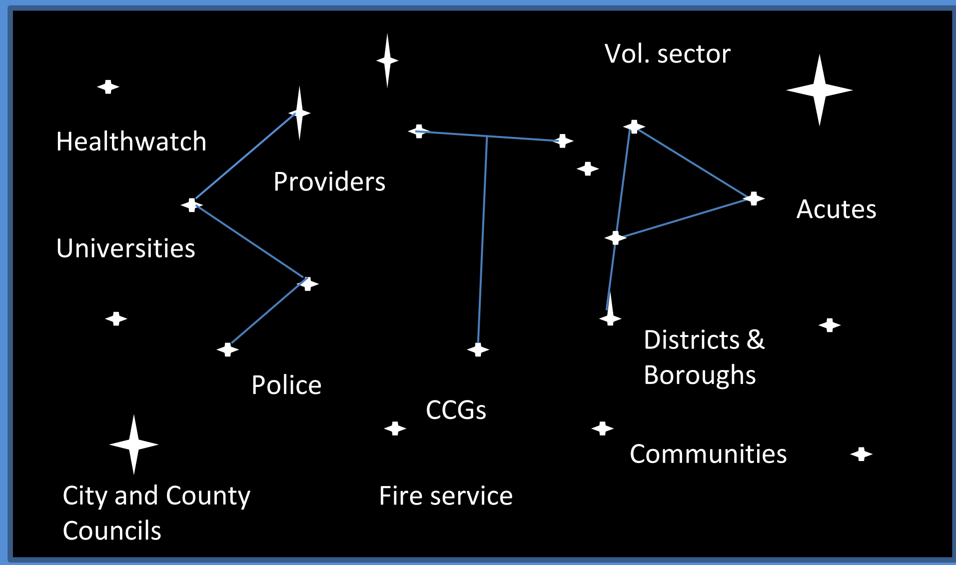
- Align/influence CCG commissioning intentions to the STP agenda
- Look towards an accountable care organisation
- Hold further development sessions between Coventry & Warwickshire HWBBs
- Merge STP and HWB Comms & Engagement work/groups to ensure one message
- Bring District & Boroughs into the STP
- Share the STP with the HWBB
- Develop a shared narrative that is understandable to communities
- Bust the urban myths
- Maintain a joint HWB/STP conversation
- Focus on End of Life care

Bold steps we could take

- Embed the Concordat in our organisations
- Set up a joint non-executive body to govern/scrutinise the STP across C&W
- Bring inspectors and regulators into the process
- Develop a new financial incentives model
- Do whatever we need to prevent hospital attendance
- Be explicit about what we need regarding A&E provision and implement it
- More control at a local level
- Pool resources
- More STP board influence over health/LA budget decisions and vice versa
- End to purchaser/provider split
- Agree a system control total
- Change payments to focus on outcomes

These now need further consideration by the HWB and STP Boards……

In conversation people made several links between HWB and the STP.....

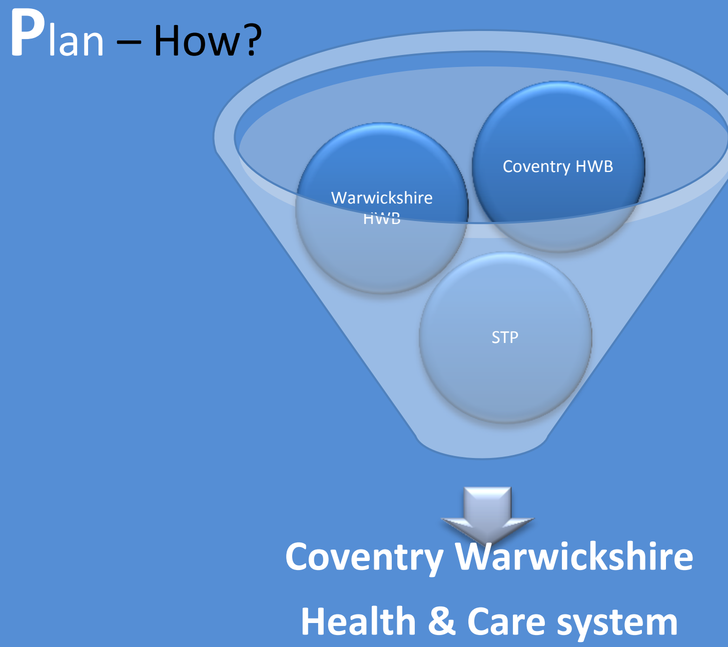


If Health & Wellbeing is the solar system, the STP is the constellation that is shining the brightest at the moment

Sustainable – Why? (narrative)

Transformation – What?

Plan – How?



Its clear we are talking about the same thing in different ways . . .

To summarise, the themes we covered were. . .

New conversations

Multiple perspectives

Public voice

Integration

Place based working

Personal responsibility

Demand mang’t

Access

Coherent Narrative

Person centred

Local need

Prevention

Translation into action

Behavioural change

These will now form the basis of our system’s consistent narrative and feature in the Big Conversation

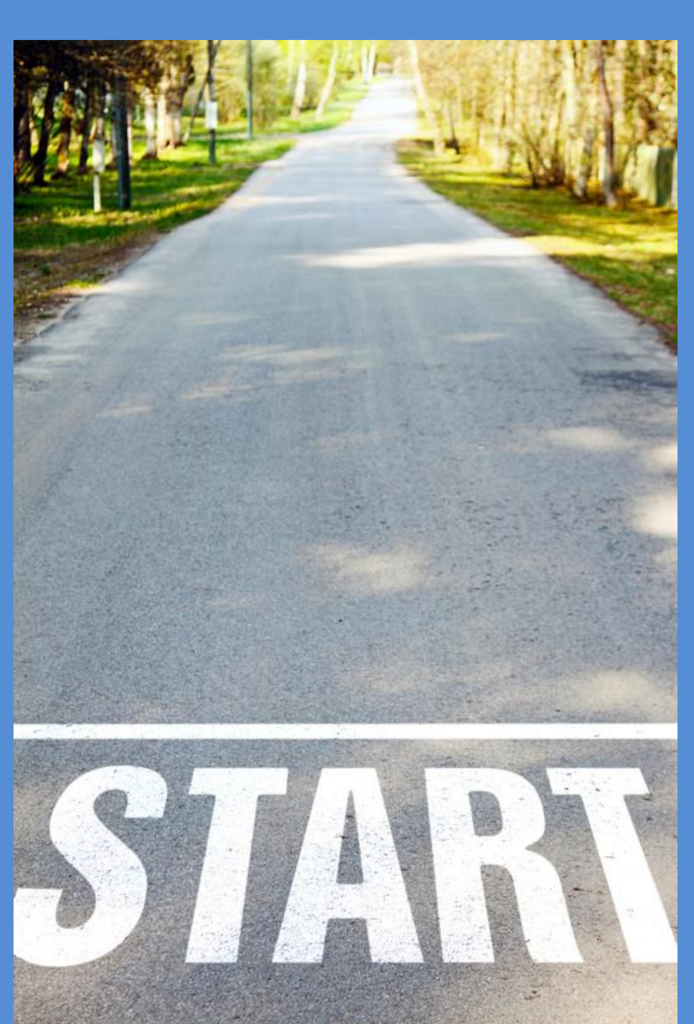
The joint summit for the two HWB Boards and the STP are just the start of our journey

The STP submission on 21st October is just the start of the process . .

- Summit feedback to be reviewed by STP Board
- Big Conversation with the public
- Shaping of the detailed workstreams
- Buy in from key partners
- Delivery plans

This needs to be complemented and be integrated with our HWB infrastructure

We need a core narrative for our system which is meaningful for us all, but is flexible to place and organisational differences



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