WARRINGTON
Borough Council

To: **Members of the Warrington Health and Wellbeing Board**

Professor Steven Broomhead
Chief Executive

Town Hall
Sankey Street
Warrington
WA1 1UH

22 May 2019

Meeting of the Warrington Health and Wellbeing Board, Thursday, 30 May 2019 at 1.30pm in the Council Chamber, Town Hall, Sankey Street, Warrington, WA1 1UH

Agenda prepared by Christine Oliver, Executive Assistant to the Leader
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Note – In line with The Openness of Local Government Bodies Regulations 2014 this meeting may be recorded. A guide to recording meetings has been produced by the Council and can be found at https://www.warrington.gov.uk/info/201104/council_committees_and_meetings/1003/access_to_council_meetings

AGENDA

Part 1

Items during the consideration of which the meeting is expected to be open to members of the public (including the press) subject to any statutory right of exclusion.

1. Apologies

To receive any apologies for absence.

2. Code of Conduct - Declarations of Interest Relevant Authorities (Disclosable Pecuniary Interests) Regulations 2012

Members are reminded of their responsibility to declare any disclosable pecuniary or non-pecuniary interest which they have in any item of business on the agenda no later than when the item is reached.

3. Minutes 5 - 8

To confirm the minutes of the meeting of the Board held on 28 March 2019 as a correct record.

4.	**Warrington Safeguarding Adult Board and Safeguarding Children Board – 6 monthly update report (2018-19)** Report of Rosie Lyden, Safeguarding Partnerships Manager on behalf of Shirley Williams (WSAB Chair) and Richard Strachan (WSCB Chair).	9 - 30
5.	**Local Transport Plan – presentation** Presentation on the Local Transport Plan by Adam Graham, Principal Transport Planner.	
6.	**Updates from Reference Groups.**	
6a	**Integrated Commissioning and Transformation Board**	
	Warrington Commissioning Prospectus Joint report of Steve Peddie, Executive Director, Families and Wellbeing and Carl Marsh,Chief Commissioner, Warrington CCG attached.	31 – 60
	Better Care Fund Annual Report 2018/19 Report of Rick Howell, Strategic Lead – Commissioning, WBC attached.	61 - 80
6b	**Joint Strategic Needs Assessment**	
	Joint Strategic Needs Assessment (JSNA) Work Plan and 2019 Core Document Report of Dr Muna Abdel Aziz, Director of Public Health attached.	81 - 148
6c	**Warrington Together- Programme Director's Report** Report of S Kenton, Programme Director, Warrington Together attached.	149 – 168
	Warrington Together – Annual Report Report of S Kenton, Programme Director, Warrington Together attached.	169 - 186
7.	**Warrington Together – New Proposed Arrangements for the Delivery of a Partnership to Deliver Integrated Health and Social Care Services in Warrington**	187- 196

Joint report of Simon Barber, Chief Executive, North West Boroughs Healthcare NHS FT, Dr Andrew Davies, Clinical Chief Officer, Warrington CCG, Steve Peddie, Executive Director Families and Wellbeing, WBC, Mel Pickup, Chief Executive, Warrington and Halton Hospitals NHS FT, Colin Scales, Chief Executive, Bridgewater Community Healthcare NHS FT, Michael Sheppard, Representative, Warrington 3rd Sector Health & Social Care Alliance attached.

8. **Work Programme** 197 - 198

To keep under review the Board's Work Programme.

14. **Future Meetings**

Town Hall, Warrington at 1.30pm on Thursdays.

- 18 July 2019
- 12 September 2019
- 14 November 2019
- 23 January 2020
- 26 March 2020

Part 2

NIL.

Membership:

Chairman: Professor Steven Broomhead

Warrington Borough Council
Leader of WBC
Executive Lead Member, Statutory Health and Adult Social Care
Executive Lead Member, Public Health and Wellbeing
Executive Lead Member, Children's Services
Executive Board Member - Culture and Partnerships
Opposition Spokesperson
Steve Peddie, Executive Director, Families and Wellbeing (as Director of Adult Social Care and Director of Children's Services)
Dr Muna Abdel Aziz, Director of Public Health

NHS Warrington Clinical Commissioning Group
Dr Andrew Davies, Chief Clinical Officer, NHS Warrington Clinical Commissioning Group
Dr Dan Bunstone, NHS Warrington Clinical Commissioning Group
David Cooper, Chief Finance Officer, NHS Warrington Clinical Commissioning Group
Carl Marsh, Chief Commissioner, NHS Warrington Clinical Commissioning Group

Joint Appointments
Simon Kenton, Programme Director, Warrington Together

Other Representatives
Ruth Marie Dales, Chair, Healthwatch Warrington
Steve Cullen, Third Sector Network Hub
John McLuckie, Chief Financial Officer, NW Boroughs Healthcare NHS Trust
Colin Scales, Chief Executive, Bridgewater Community Healthcare NHS Trust
Mel Pickup, Chief Executive, Warrington and Halton Hospitals NHS Trust
Nigel Gloudon, Head of Finance, NHS England, Merseyside, Cheshire, Warrington and Wirral, Area Team
Richard Strachan, Independent Chair Warrington Safeguarding Children Board
Michael Sheppard, Chief Executive Officer, Warrington Community Living - Third Sector Provider Representative
Vacancy - Private Care Sector
Gill Healey, Group Head of Social Investment, Torus – Housing
Tim Long, Principal, Bridgewater High School - Education
Mike Larking – Cheshire Fire and Rescue
David Keane, Police and Crime Commissioner
Supt Martin Cleworth, Cheshire Constabulary

Standing Invitees (Not Members of the Board)
Cllr Rebecca Knowles, Chair of Health Overview and Scrutiny Committee

MINUTES
WARRINGTON HEALTH AND WELLBEING BOARD
28 March 2019

Present:-

Professor Steven Broomhead (Chairman), Councillor J Carter, Councillor M McLaughlin, Councillor I Marks, M Abdel-Aziz, K Armstrong (for John McLuckie) D Cooper, S Cullen, R M Dales, L Gardner (for M Pickup), G Healey, S Kenton, S Peddie, M Sheppard, Superintendent M Cleworth and S Meegan (Cheshire Police)

Also in Attendance: Councillor R Knowles, C Hugall, Susan Burton, M Welsh, P Jones, S Caisley.

HWB68 Apologies

Apologies for absence were received from Councillors R Bowden, D Price and P Wright and from Dr A Davies, J McLuckie, M Pickup, D Keane, C Scales, R Strachan, M Larking, T Long, N Glouden, D Bunstone, and C Marsh.

HWB69 Declarations of Interest

There were no declarations of interest submitted at this meeting.

HWB70 Minutes

Resolved – That the minutes of the meeting of the Board held on 24 January 2019 be received as a correct record and be signed by the Chairman subject to the following comments:

- It was noted that, in relation to the performance of A&E falling below the national average – there were around 100 patients in beds who should not be there and not 150 as reported in the previous minutes;
- Councillor Carter commented that, in relation to Priority Theme 6 – *Where children and young people get the best start in life in a child friendly environment*, she could not recall the conversation taking place in relation to the OFSTED Inspection which it was reported that OFSTED had shone a light on the issue;
- It was noted that Dr A Davies would provide further information on the possible case for the development of a UTC in Warrington to the Health Scrutiny Committee;
- It was noted that in relation to the Legacy of Warrington Health Plus and Report from NHS Mersey Internal Audit Agency (MIAA) on Governance Issues from the Prime Minister's Challenge Fund - Dr Davies would take any concerns about the pilot project to the Health Scrutiny Committee.

HWB71 Local Plan - Presentation

The Board received a PowerPoint presentation from Michael Bell, WBC Planning Policy and Programmes Manager. The following key issues were reported on within the presentation:

- Why we need a local plan
- A reminder of work to date
- From PDO to proposed Submission Version Local Plan
  - Key issues from PDO Consultation
  - Preparing the proposed submission version Local Plan
  - Main changes from PDO
- Proposed submission version Local Plan
- Health and wellbeing
  - Confirmed requirements for the new health facilities
  - Cross cutting approach to health and wellbeing in policies
  - Outcome of sustainability appraisal
- Next steps

Resolved, that the Health and Wellbeing Board

(1) Noted the presentation and consultation period; and
(2) thanked Mr Bell for his presentation and attendance at the Board Meeting.

HWB72 Updates from Reference Groups

Steve Peddie informed the Board that the Integrated Commissioning Board meets regularly and is developing a schedule of activity. He reported that he would be happy to provide more details at any future meeting.

It was reported by Lucy Gardner, Director of Strategy, Warrington & Halton Foundation Trust, that a CQC Care Quality Inspection had commenced on Tuesday of this week following a half an hour's notice. The inspection was expected to last for three days with every clinical service being examined. When feedback is received this will be shared with the Board Members and partner organisations. It was anticipated that the inspection schedule will include the need to speak to partner organisations.

Resolved, that the Health and Wellbeing Board noted the update reports and anticipate a feedback report to a future meeting.

HWB73 Warrington Together Update

The Board considered a report of Simon Kenton, Programme Director, Warrington Together, which provided an update in relation to the Warrington Together Programme. Information in the report included:-

- ICT Update.
- Workshops and Events.
- First Contact Practitioner.
- Disability Awareness Day.
- Smart Flat.
- Recruitment Update.
- Annual Report.
- Warrington Together Board Schedule.

The Board also received a PowerPoint presentation from Carole Hugall, Director of Clinical Integration, Warrington Together and Susan Burton, Clinical Project Lead Warrington Together on Integrated Community Teams.

The following key issues were reported on within the presentation:

- Strategic Outline Case
- Key Characteristics
- Development of Model
- MDT Progress
- Barriers
- Improving Outcomes
- Integrated Community Teams
- ICT Phase 1
- Next Stage Roll Out Plan – Central ICT Phase 1
- Future ICT developments
- Risks and Issues

Resolved – the Health and Wellbeing Board

(1) Noted the report and presentation on the Integrated Community Teams;
(2) Noted the progress on the work being driven by the Warrington Together Programme; and
(2) thanked Carole and Susan for their presentation and attendance at the Board Meeting.

HWB74 Update on New Hospital

There was no update provided on this occasion.

HWB75 Warrington Care Record Strategic Appraisal

The Board considered a report of Phill James, Chief Information Officer, Warrington and Halton Foundation Trust/Director of Digital, Warrington Together which informed the Board of the status of a strategic appraisal regarding the Warrington Care Record platform.

The report had been previously supported by the C&M H&SC Partnership Digital Board, WNNFT Executive Team, Warrington Together Senior Change Team and Warrington CCG Senior Management Team.

In discussing this report Health and Wellbeing Board Members commented that the report was overly complex and further asked for clarification in relation to what decisions had been made and what the Board was being asked to do with the report. It was confirmed that a decision only to pause had been made – any decision relating cancelation had not been made yet. Any detailed information in terms of timescales would be established as a consequence of the planning exercise being undertaken.

The Chair, Professor Steven Broomhead, expressed his frustration at the lack of progress and commented that a Warrington focussed shared record system had been identified 6 years ago and also with the delay on a potential move away from this to a regional approach.

Resolved – the Health and Wellbeing Board

(1) Noted the preferred option is to cease the Warrington Care Record procurement and pursue a re-prioritised C&M H&SCP DPB programme. Through combined planning the preferred option contributes to simplicity and efficiency of solutions across the STP;

(2) Noted the funding partner of the programme, the CCG Senior Management Team, has supported the pausing of order placement and the development of two detailed delivery plans (original and C&M H&SCP DPB plans) and financial profiles to demonstrate viability of the preferred option;

(3) Noted the plans/profiles aim to assure the delivery of the business case benefits at a potential lower cost, subject to further financial information from the C&M H&SCP DPB. Only when approved will the existing procurement be formally ceased;

(4) Requested a further detailed report be brought back to a future meeting.

HWB76 Work Programme

Resolved – The Health and Wellbeing Board noted the updated work programme.

HWB77 Date of Next Meeting

Thursday 30 May 2019 at the Town Hall, Warrington, at 1.30pm

Signed:
Date: 30 May 2019

Warrington
Health & Wellbeing Board

30 May 2019

1.30 pm, Council Chamber, Town Hall, Warrington

Report Title	Warrington Safeguarding Adult Board and Safeguarding Children Board 6 monthly update report (2018-19)
Agenda Section	☐ A. Standard Items and Governance Matters ☐ B. Promoting Integration ☐ C. Development and Delivery of Health and Wellbeing Strategy ☒ D. Oversight of Important Strategies and Reports ☐ E. Information and Context ☐ F. Concluding Business
Type of Decision Required	☐ Formal Decision as to a Statutory Function ☐ Non-Statutory Advice, Guidance or Recommendation to Other Body ☒ Note or Endorse a Report or Action by Others
Report Purpose	As required by the Care Act 2014 and Children's Act 2004, the WSAB and WSCB must produce an Annual Report and share with the Health and Wellbeing Board for them to consider the contents of the report and how they can improve their contributions to safeguarding adults and children and support the Boards priorities for the year ahead. This report represents the half yearly update on activity undertaken in the 2018-19 period.
Report author	Rosie Lyden Safeguarding partnerships Manager on behalf of: Shirley Williams & Richard Strachan WSAB Chair WSCB Chair
Confidential or Exempt	This report is not considered to contain information which is confidential or exempt.
Recommendations	The Health and Wellbeing Board is asked to note the report and progress indicated by the statutory Boards. Alongside this members are encouraged to consider any additional scrutiny that may be needed moving forward during this transition period.

1. Report purpose

The purpose of this report is to update the Health and Wellbeing Board on activity of the Safeguarding Adult Board and Safeguarding Children Board against that proposed in their 2017-18 Annual reports. It also seeks to raise awareness and understanding of the transition of the local LSCB into new safeguarding arrangements under the Children and Social Work Act 2017. As of April 1st 2019 the WSCB no longer exists and has been replaced by Warrington Safeguarding Partnership (WSP).

2. Introduction/background

The Safeguarding Adult Board under the Care Act 2014 must publish an annual report that identifies progress against priorities and any new areas of work emerging from local need. Similarly, under the Children's Act 2004 the LSCB was also required to publish an annual report that identifies the effectiveness of the arrangements and their activity to improve the welfare of children and young people. Both of these reports have to be submitted to the Local Authority Chief Executive, Leader of the Council and Police Crime Commissioner and the Health and Wellbeing Board. These reports are shared in quarter 3 of each financial year with these stakeholders and an update given to the Health and Wellbeing Board in quarter 1 on any progress on priority work areas identified within these reports. This report represents that quarter 1 update and will be the final update from the WSCB. Moving forward updates will come from the new WSP arrangements.

The purpose of this report is to ensure partners are informed of emerging safeguarding issues and those areas of focus for the local community. This process also facilitates local scrutiny and challenge for the partnerships from wider stakeholders.

3. Content

Warrington Safeguarding Adult Board

2018-19 has been a challenging year for the SAB as Safeguarding Adult Reviews (SARs) have becoming increasingly challenging in terms of the support and resource needed to support families and professionals to engage as required. Alongside this the support team has been managing the transition of safeguarding children arrangements. The points below represent some of the key progress made in safeguarding adult activity:

- Continued public awareness raising of the "Notice, Care, Tell" campaign to engage our local community to be alert to concerns. We have promoted this at events such as Disability Awareness Day, World Elder Abuse Awareness Day and the local Mela to try and reach out to all of our community groups.
- Exploring victim care pathways for Modern Slavery with Cheshire Colleagues and creation of a local training package for agencies to use to raise awareness with their staff
- Concluding a self-audit with some key housing providers locally to support them to improve their response to safeguarding issues. Alongside this we have worked with

one local housing provider to explore safeguarding data available to them to develop a greater sense of safeguarding issues within people's own homes

- A deep dive of our safeguarding data to seek assurances around the representation of men within safeguarding processes. This was due to a discrepancy in the gender split of section 42 enquiries which prompted us to be concerned about under representation of males. However, our deep dive has indicated that this gender split reflects our local population and a review of cases has found no concerns in relation to decision making in cases involving males that do not reach a section 42 enquiry
- Commencement of a Pan Cheshire project to explore a consistent Safeguarding Adult Review process across our areas
- We have continued to take forward two complex SARs that involve cross border commissioning and placement of patients with complex support needs
- Working with the Coroner to develop awareness of the Safeguarding Review process to improve our joint working
- Developments in relation to feedback from safeguarding processes have also been made by including advocates in feedback processes. This has allowed those not able to speak for themselves to have their experiences heard
- Working with local Prison Governors to seek assurances that they are effectively meeting their safeguarding duties and developing widespread understanding of safeguarding adult responsibilities

The SAB continues to face the same challenges as all of its individual partners; reduced resources at a time of increased demand. This impacts the SAB broadly in terms of partner's ability to ensure consistent representation. However, at the moment the biggest challenge has been predominantly in the demand for SARs. The SAB has seen a significant increase in the number of referrals from families who appear dissatisfied with alternative processes, such as the NHS Incident Framework or Inquest, and seek a SAR as a means to resolve their concerns. Although the SAB is satisfied that there is a robust process in place this cannot prevent the significant resource needed to manage challenges from families who sometimes mistakenly believe that a SAR is appropriate and necessary for their case. This will likely continue to be a challenge and we hope that developing Pan-Cheshire processes and a North West framework alongside better working relationships with the coroner may reduce some of this process burden.

Warrington Safeguarding Children Board / Warrington Safeguarding Partnership

As reported in October 2018 the WSCB is subject of revised legislation in the form of the Children and Social Work Act. The impact of this has been to make the focus for the WSCB transitioning from the old legislation to "New Arrangements" that are in line with the revised statutory guidance. As the new arrangements are less proscriptive than the LSCB model and evidence based models are still in pilot phase the WSCB has been focused on developing a model that suited the local area's needs. Specific detail of the new Warrington Safeguarding Partnership can be found in the additional background paper attached. Core activity this year has been focused on:

- Supporting the Core Statutory partners (LA, Police, CCG) to develop a new model to pilot from April 2019

- Develop a revised team structure to support the SAB and the new children's arrangements
- Lead on consultation processes with the wider stakeholders for safeguarding children on the proposed model and priorities
- Developing a Rapid Review process that allows the partners to screen cases to ascertain if they meet Local Review criteria (the new Serious Case Review title). This included submitting 3 rapid reviews to the national panel which were acknowledged and approved
- Support the transition of Child Death Overview Panel from a subgroup of the LSCB model to an independent group
- Support the local Health Forum to monitor and challenge the robustness of safeguarding processes across the health economy
- Lead a Serious Case Review process in a case of Neglect to ensure all necessary learning in relation to the local case was undertaken, including delivery of a lessons learnt event to front line staff
- Develop and cascade a 7 minute brief in relation to car child locks to care providers to share lessons learnt from a rapid review screening
- Development of a revised Neglect Strategy and promotion of the Early Help and Care Leavers strategies across the partnership
- Monitored the rates of Elective Home Education and sought to understand the challenges for practice and effectiveness of interventions to ensure the wellbeing of children removed from Education
- Monitored concerns in relation to specialist mental health provision locally for young people to seek assurances in relation to their effective discharge of safeguarding duties
- Develop a revised logo and social media presence for the new arrangements

This has been a very challenging time for the WSCB in terms of continuing to seek assurances and challenge partners whilst at the same time transitioning to a new model and support structure. However, targets have been met in terms of launching the new model after significant consultation on April 1st 2019. It is likely that this new model and approach will be tested out in the next 6 months to identify any changes that may be needed going forward. Alongside this the significant team restructure has led to the need for further recruitment to fulfil the changing nature of the roles. This means that for the first part of 2019-20 the support team for the safeguarding partnerships is not at capacity. This is being managed through supporting partners to engage differently with safeguarding duties and take a more active role in leading projects. This will be an ongoing culture change that the team will continue to embed.

4. Summary and Conclusion

Despite a challenging year both the WSAB and WSCB have continued to offer a forum of challenge and scrutiny to local safeguarding practice. The SAB has sought assurances around the inclusivity of safeguarding practice whilst continuing to develop its SAR processes and deliver on a number of complex SARs. The WSCB has been monitoring the challenges of Elective Home Education alongside supporting

partners to come together and plan their approaches to revised statutory duties and the local priority of Neglect. It has also conducted a Serious Case Review within a 6 month timeframe.

Both partnerships are facing a challenging period in 2019-20 as a revised support team is recruited and trained and new ways of working are tested. This is against a backdrop of partner agencies facing their own individual resource challenges. Nevertheless, partners remain committed to coming together to address safeguarding issues effectively.

5. Recommendations

The Health and Wellbeing Board note the content of the report and consider any additional scrutiny they may require during this transition period to assure themselves that statutory duties in relation to safeguarding adults and children are being met.

6. Background Papers

Safeguarding Children New Arrangements overview – see attached.

Warrington Safeguarding Partnership

Working Together (July 2018) states

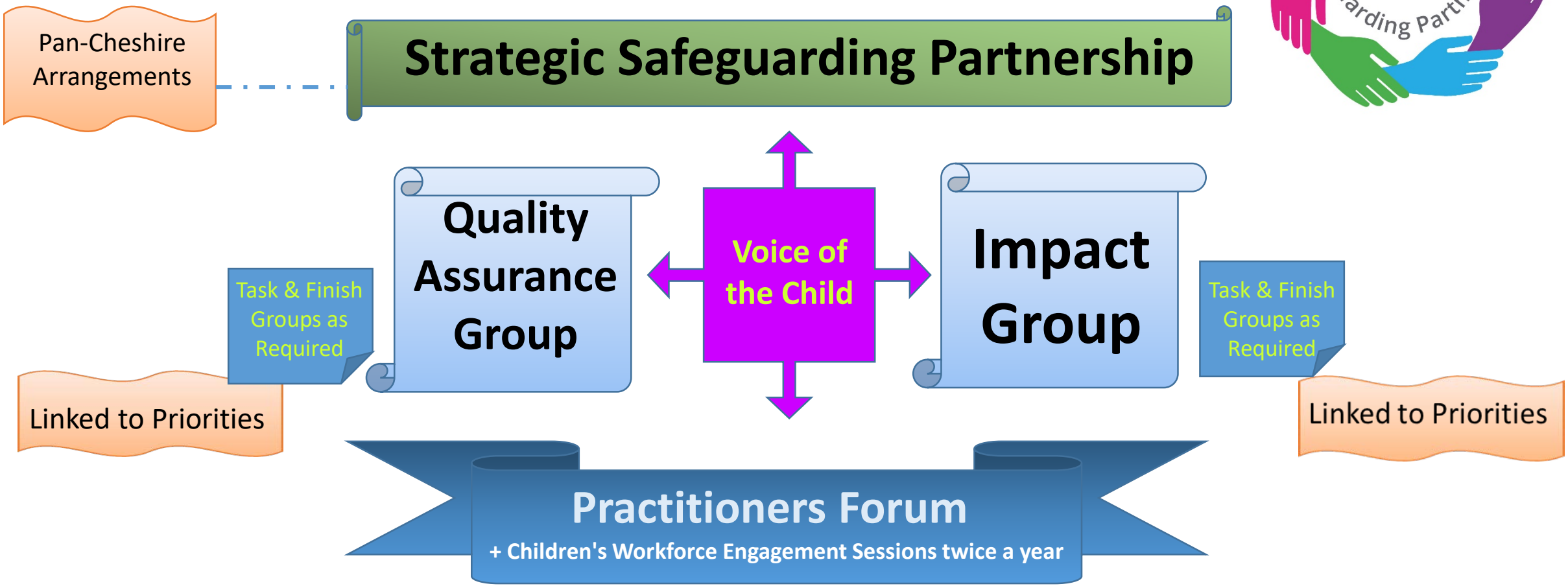
'The three safeguarding partners should agree on ways to coordinate their safeguarding services; act as a strategic leadership group in supporting and engaging others; and implement local and national learning including from serious child safeguarding incidents.

To fulfil this role, the three safeguarding partners must set out how they will work together and with any relevant agencies. Relevant agencies are those organisations and agencies whose involvement the safeguarding partners consider may be required to safeguard and promote the welfare of children with regard to local need'

Working Together to Safeguard Children – A Guide to Inter Agency Working to Safeguard and Promote the Welfare of Children (July 2018) – Chapter 3

The aim is to have Warrington's Safeguarding Partnership in place by 1st April 2019.

Warrington Safeguarding Partnership



Strategic Safeguarding Partnership

Purpose:

- This strategic partnership will create the environment for the safeguarding partners to discharge their responsibilities to safeguard and promote the welfare of all children in the local area in a coordinated way. It will enable the partners to scrutinise the coordination of targeted services to ensure the best possible outcomes for children and their families.

Membership

The membership for this group is:

- Operational Director Children's Social Care- WBC
- Det. Superintendent Police
- Chief Nurse CCG
- Assistant Director Education WBC
- Chief Executive Officer Warrington Voluntary Association
- Children's Advocacy Representative (NYAS)
- Lead Member
- Head of Service Children's Safeguarding & Quality Assurance
- Designated Nurse Safeguarding Children and Children in Care Warrington CCG

Quality Assurance Group

This Group will provide the scrutiny and challenge by leading on the Quality Assurance Framework which will provide data, intelligence and qualitative information. The proposed membership of this group has been deliberately set at a senior level in recognition of its significant role requiring the right level seniority in order to speak for their agencies and make informed decisions. This also links to ability to drive the safeguarding agenda within their own organisation. Part of its remit will be to require the setting up of task and finish groups as required e.g. reviewing specific safeguarding policies.

Membership

The membership for this group is:

- Cheshire Police - Detective Chief Inspector
- Head of Service - Children's Social Care
- Health Agencies - Deputy Chief Nurse
- CCG - Designated Nurse CCG
- Early Help Division - Head of Service
- WASCL & WAPH - Head Teacher
- Youth Justice – Head of Service
- Head of the Virtual School

Impact Group

This group will complement the role of the Quality Assurance Group and will take the lead on embedding learning and will lead on the training plan. Although not be responsible for single agency training and workforce development, this group will seek assurance that the multi-agency children's workforce has the appropriate level of skills and training. The group will also have lead on safeguarding policies and procedures.

Part of this group's remit will be to require the setting up of task and finish groups as required.

Membership

The membership for this group is:

- Cheshire Police - Inspector
- Service Manager - Children's Social Care
- Designated Nurse for Safeguarding
- Service Manager - Early Help Division
- WASCL & WAPH - Head Teacher
- Youth Justice – Manager
- Education Safeguarding Manager

Practitioners Forum

This will be a key forum providing an opportunity to hear directly from frontline practitioners and to cascade significant information. The intention is to have a greater level of understanding and engagement from frontline staff with our local safeguarding arrangements and to ensure that any safeguarding developments are informed by the views of those responsible for the operational delivery.

Wider engagement will be achieved by having a twice yearly whole staff engagement sessions which is open to all frontline staff.

Membership

The membership for this group is:

- Frontline practitioners across the partnership i.e. Social Workers, Health Visitors, Teachers, Nursery Staff, Safeguarding / Children in Care Nurse, Advanced Practitioners, Police Sergeants/Officers.

- Senior Managers from groups to attend and lead sections each time on rotation or required by period focuses.

Independent Scrutiny

The new arrangements (Working Together 2018) includes a requirement for having 'independent scrutiny.'

'The role of independent scrutiny is to provide assurance in judging the effectiveness of multi-agency arrangements to safeguard and promote the welfare of all children in a local area including arrangements to safeguard and promote the welfare of all children in a local area'

The decision about how to deliver on independent scrutiny is left to local determination with the proviso that:

' it is objective, acts as a constructive critical friend and promotes reflection to drive continuous improvement'

WSP Arrangements

- For the period of transition from 1 April 2019 to 1 September 2019 the current Chair of the WSCB will take on the role of Independent Scrutineer for the Safeguarding Partnership.
- Scrutiny will run throughout all activity.
- The role will be developed in detail during the transition period from 1 April 2019 to 1 June 2019.

Safeguarding Partnership Support Team

Safeguarding Partnerships Manager

Safeguarding Arrangements Manager (Impact & Development)

Project Support officer

Admin officer

Safeguarding Arrangements Manager (Performance & Assurance)

Safeguarding Partnership Support Team

A joint team will continue to provide support to the Safeguarding Adult Board and the new Safeguarding Partnership for children which enables strong links and drive for the Think Family approach.

The models propose a Safeguarding Partnerships manager role who will have expertise in relation to intelligence, quality assurance and learning and development. These posts will take on some of the role of independent scrutineer of single agency data and quality assurance activity and report this to the forums.

Safeguarding Partnership Support Team

The new team will be working in a different way to ensure sufficient support to both the Safeguarding Children and Adult arrangements for the area.

The function of this new structure will be to challenge the partners to achieve their set goals.

Communication & Engagement with All Safeguarding Partners

Whilst Working Together demands a streamlined Partnership Arrangement, this does not reduce or remove any children's workforce organisation's safeguarding responsibility.

Warrington Safeguarding Partnership will continue to support the sharing of information with existing WSCB partners. During the transition period, this will be done through virtual communications to keep the partnership informed of development, good practice, learning and effectiveness of the new arrangements. This will be developed to include new partners as we progress with the new arrangements.

Health and Wellbeing Board

Thursday 30 May 2019

Report Title:	Warrington Commissioning Prospectus
Report Purpose:	The purpose of the report is to provide the Health and Wellbeing Board with an update on the Commissioning Prospectus
Report of:	Steve Peddie, Executive Director Families and Wellbeing, WBC Carl Marsh, Chief Commissioner, Warrington CCG
Report author(s):	As above
Recommendations:	This prospectus sets out how commissioners' intentions will support and enable the establishment of an Integrated Care System to provide Health and Care services for the population of Warrington, with the aim of bringing together a range of health, social care, public health and third sector services to be delivered in the community. The prospectus supports the case for change for a new delivery model of care. **The Health and Wellbeing board is recommended to endorse the Prospectus and its priorities in line with the Health and Wellbeing Strategy.**
Decision Required:	The Board is asked to support the above recommendations.

1 Background

1.1 Our shared vision is: "Together, we will enable the people of Warrington to enjoy happier and healthier lives by transforming the way we use our collective resources". This Commissioning Prospectus supports the ambition held by Warrington Health and Wellbeing Board towards the establishment of a single set of commissioning intentions for the population of the Borough, and a move towards commissioners acting as one body. As a system we need to make the most of the funding that comes into Warrington's public services urgently. The existing system is not sustainable.

1.3 Good integrated care is not just about care for older people, but as our older population is growing, it is more important than ever that care systems work together. Older people typically have the most complex care needs and consequently receive care from more than one provider and in multiple settings. Children with SEND needs and their parents and carers also have potentially profound navigational difficulties to overcome if we do not join up education, health and care delivery to match their Education, Health and Care Plans (EHCPs).

1.4 Are ambitions are for every child to get a good start in life and that Warrington is a borough that works for all children. We must keep a relentless focus on the lived experience of and outcomes for children and young people and a focus on closing the disadvantage gap, because every child really does matter.

1.5 Younger adults with very complex disabilities and children and young people with special educational needs and disabilities (SEND) also rely on the very best integration possible between health and social care in order to live their whole lives in a supported way, but this often does not happen effectively and problems are most acute for the parents of children who have multiple neuro-developmental conditions.

1.6 We want all adults to 'live well but too many suffer from chronic conditions. Warrington has a higher rate of spend for Coronary Heart Disease than similar areas. The rate of deaths from Cardiovascular Disease (CVD) for those aged 65 in Warrington are significantly higher than England. Cancer is now the biggest killer in Warrington, recently overtaking cardiovascular disease for numbers of deaths each year, deaths due to respiratory disease are significantly high in Warrington when compared to England and alcohol and smoking affects our more deprived areas disproportionately.

1.7 We are concerned to ensure older citizens live well in old age but Warrington has one of the highest rates of spend in the country on hospital admissions for injuries in people aged 85+, the rate of hospital admissions for those aged 65 years and above due to a hip fracture has increased over the last two years, spend on admissions for unspecified urinary tract infection (UTI) in patients 75+ is higher than similar CCGs and patients aged over 65 more frequently have an extended hospital stay than for similar

areas. All this tends to indicate that health and care solutions are not being accessed in the right settings.

1.8 For all these reasons we are redoubling our efforts to commission better pathways in co-production with families, carers and patients or service users, to truly integrate our delivery.

1.9 This Commissioning Prospectus sets out a range of priorities as the focus for commissioners, based on the Joint Strategic Needs Assessment, but sets out a particularly compelling evidence base for focusing first on people in the 85+ age group who are frail and children with special educational needs and disabilities, as well as the carers of both. Collectively, these members of our community constitute a relatively small percentage of the population (less than 5%) and the provision of more effective pathways and support systems will deliver the highest beneficial impact in outcomes for them and for the sustainability of our system.

Commissioning Prospectus

2018 - 2021

Warringtontogether

Together for a happier and healthier Warrington

Approval

Approved by	Name	Organisation	Date

Document History

Version	Summary of Changes	Document Status	Editor	Date published
1.0	First draft	DRAFT	Steve Peddie/Carl Marsh	15th May 2018
1.1	Various amendments following ICTB meeting	DRAFT	Steve Peddie/Carl Marsh	20th May 2018
1.2-1.7	Various amendments following Warrington Together Board	DRAFT	Steve Peddie/Carl Marsh	14th June 2018
1.8	Various amendments following Health and Wellbeing Board	DRAFT	Steve Peddie/Carl Marsh	6th July 2018
1.9-1.15	Various amendments following Warrington Together Senior Change Team Meeting	DRAFT	Steve Peddie/Carl Marsh	5th March 2018
1.16	Various amendments following meeting with Third Sector Health and Wellbeing Alliance	DRAFT	Steve Peddie/Carl Marsh	17th March 2019
1.17-1.19	Various amendments to incorporate SEND information	DRAFT	Steve Peddie/Carl Marsh	10th May 2019
2.0	Refreshed to reflect NHS Long Term Plan and to reflect 2019/20 Health and Care budgets	FINAL	Steve Peddie/Carl Marsh	14th May 2019

Contents

Foreword

The people of Warrington are well known for their practical approach to life and their willingness to embrace change. Warrington's location between Manchester and Liverpool and its status as a new town has supported its economic growth and its reputation for reliance. As such Warrington is a driving force in the region in a number of sectors and compared to other North West Boroughs many people here enjoy access to good schools, better jobs and lifestyles.

Parts of the Borough also belong to a longer, more established, economically secure history and residents enjoy good homes, beautiful scenery and a more affluent way of life.

At the same time like many other parts of the country there are significant challenges for some people in Warrington, particularly close to the centre of the Borough where disadvantage is highest and the needs for care and support agencies to concentrate on prevention and lifestyle, improving health and the independence of the people who live here – children and adults alike.

The role of health and social care also has wider, latent potential – which must now be realised – in helping children to get the best start in life and people to achieve a full role in their communities.

Having a healthier Warrington can boost the Borough in extraordinary ways – but it is not without its challenges. Making the system suitable, sustainable and affordable is set against a tough financial forecast. If we do not reform the way in which health and social care is provided we will not successfully face the systemic shortfalls in funding levels and the cost of care by 2020/21.

Warrington has a slightly declining younger population and, due to its history as a new town with large numbers of new young families settling in the Borough in the late 1960s and early 1970s, has an unusually high challenge with growing numbers of much older people in the demographic profile. Health and care outcomes among our older population are poorer than average and that many of those residents have multiple health issues and some of the newer issues like childhood obesity are issues that should concern us in terms of potential impact longer term.

We need to meet the needs of today's Warrington with new, innovative ways of working. We can no longer follow historic approaches, which were often reactive. We need to shift the entire system, to one that utilises people's strengths and local assets to build independence, where prevention and self-care becomes a priority, and more care is moved closer to home and out of hospital where possible.

The commitment to Warrington must override any organisational barriers as we concentrate on bringing more care closer to people and the areas where they live and education, health and care closer together for children, so that being and staying healthy is a normal part of daily life and disabled children and adults can fully realise their potential.

This vision for more joined up services is reflected in the Borough's Health and Wellbeing Strategy for the next three years, where health, social care, Public Health and other professionals in the Third Sector (through the Warrington Third Sector Health and Wellbeing Alliance) will work together in partnership as Warrington Together. These teams will work collaboratively with voluntary and community groups to empower people to increasingly self-care and improve wellbeing.

To achieve our ambitions, we are now ready to commission a transformed system that is able to deliver care to support people to live more healthy lives, that understands the needs of our population and is able to deliver new and sustainable models of care. This change will enable system efficiencies to be realised that will allow reinvestment into preventative models of delivery.

Introduction

This Commissioning Prospectus sets out the joint commissioning commitments that will deliver integrated health, social care and, where appropriate, education services. It concentrates on key needs and areas of joint priority for the Local Authority (LA) including Public Health, Warrington Clinical Commissioning Group (CCG) and Warrington Together.

This is a direction-setting document that addresses the need to improve outcomes, manage demand and cost, deliver efficiency and improve operational and strategic integration. Notable in this plan is the emergence and significance of Warrington Together as a way of working that describes how, together we will lead key elements of the Health and Social care economy to align and integrate at pace to ensure 'fuller integration by 2020'.

> Definition
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> **Prospectus:** a statement outlining the main features of a new or proposed enterprise and or activities of established institutions or organisation/s. Commonly in the form of a written document it is made available to all those with interests containing information about plans and activities for the future.

This prospectus potentially covers locally commissioned key health, Public Health and Social Care services provided in Warrington for Warrington people of all ages. It includes those services provided by, or paid for by, NHS provider organisations, some care services delivered by or paid for by Warrington Council, education partners in delivering services to children with special educational needs and disabilities (SEND), services delivered by Warrington voluntary sector providers and the majority of social care services delivered by the private sector, such as care homes, supported housing and domiciliary care.

The scope of the services included in the Prospectus will be stepped and increased over the 3-year period of implementation, increasing as integrated services are delivered, benefits realised, partnerships strengthened and confidence established. These arrangements need to progress at a rate commensurate with all partners' ability to manage and deliver change that is sustainable in terms of quality, performance and finance.

The initial focus will be on specific population cohorts, broadening out over the term of the plan. Implementation will be managed by scaling the work undertaken – i.e. phasing through clusters, neighbourhoods and Primary Care Networks etc.

The Prospectus is informed by, and supports, other key documents including the Warrington Health and Wellbeing Strategy, the Joint Strategic Needs Assessment and other commissioning, business and financial plans of partners.

This Commissioning Prospectus supports the ambition held by Warrington Health and Wellbeing Board towards the establishment of a single set of commissioning intentions for the population of the Borough, and a move towards commissioners acting as one body. Therefore, all reference to 'commissioners' within the prospectus refers to the desire of the local authority and the Clinical Commissioning Group, as statutory commissioners, to act in alignment and eventually as a single commissioning function.

People deserve consistently good care regardless of where they are treated and how complex their needs are. People with complex needs and who need care from a range of different services often say they are very satisfied with the care they receive from each individual care provider. However, given that many of them move between services or care professionals, their care often becomes fragmented. This can have an impact on their experience and their overall care. When staff from different services talk to each other and share information effectively, people experience better, safer care. When they don't, care can become disjointed, leaving people unnecessarily confused and vulnerable.

Good integrated care is not just about care for older people, but as our older population is growing, it is more important than ever that care systems work together. Older people typically have the most complex care needs and consequently receive care from more than one provider and in multiple settings. Children with SEND needs and their parents and carers also have potentially profound navigational difficulties to overcome if we do not join up education, health and care delivery to match their Education, Health and Care Plans (EHCPs).

Effective integrated care has been a national policy ambition and commitment for many years, as expressed by the Secretary of State for Health and Social Care in 2018/19:

'We want to see more power and control devolved to more areas, enabling communities to design and develop new models of care tailored to meet the needs of their local populations. NHS England should support the NHS to achieve the Government's aim that health and social care are integrated across the country by 2020, including through the Better Care Fund. The move towards greater system working in 2018/19 will be reinforced by the voluntary roll-out of Integrated Care Systems.'

NHS bodies and local authorities have been tasked with enabling progress whilst meeting statutory duties. This prospectus sets out how commissioners' intentions will support and enable the establishment of an Integrated Care System to provide Health and Care services for the population of Warrington, with the aim of bringing together a range of health, social care, public health and third sector services to be delivered in the community. The prospectus supports the case for change for a new delivery model which will transform services, delivered by a new model of care.

The Warrington integrated care and health system will have a clear focus on:

- People, place and communities
- Supporting children and young people to have the best start in life, to enjoy and achieve
- Supporting people to be active citizens, and to access community assets that enable them to retain their place in the community
- Seeing the opportunities to make a positive difference
- Being responsible, sustainable and innovative, connecting people, communities and local care teams
- Valuing and celebrating individuality and diversity
- Prevention and helping people to stay well, closer to home
- Caring for those who are at greater risk of having significantly declining health and wellbeing, with the accompanying increased costs to the system
- Aligning hospital and community based services, so they are integrated and accessible
- Working effectively with partners in tackling the wider determinants of health – i.e. housing, education, leisure etc.

The benefits of delivering new models of care through joint approaches in Warrington will be:

- Improved health outcomes
- Improving peoples experience of care
- Local people being independent and able to self-care
- An improvement in meeting rights and needs, choices and dreams
- Better use of resources and financial sustainability

Our plans to support the better health and welfare of the people of Warrington also falls within the context of a wider set of aspirations and plans for the Cheshire and Mersey region. The Cheshire and Merseyside Sustainability and Transformation Plan (STP), now an Integrated Care System (ICS), sets out how the health and care system can remain fit for the future and respond successfully to the growing demands that are being placed on it, alongside ambitious ideas to improve the health of people living and working in the whole region.

The ICS, like this prospectus, sets out a shared core purpose to ensure that the people of Cheshire and Merseyside become healthier than they are now and can continue to have access to safe, good quality and sustainable services. The plan represents the thoughts and ambitions of more than 30 different organisations serving a population of over 2.5 million people.

The government has announced it will eventually publish a green paper on social care for adults, addressing funding for services for older people. The 2017 general election showed that the public are hungry for social care reform and are looking for progress, particularly on issues such as how people with dementia are treated. There is a need to focus on working-age adults too, with financial pressures growing due to the increasing care needs of younger adults with disabilities or mental health problems.

The Government have recognised that we need a long-term sustainable funding solution for adult social care that means everyone has good access to good quality social care when they need it.

Challenges for the Warrington Health and Care System

Changing needs

Warrington is a largely affluent and healthy Borough by comparison to many parts of the region. For example rates of child poverty in Warrington have remained fairly consistent over time, and the percentage of children aged under 16 living in poverty in Warrington is significantly lower than England. As with other indicators there is substantial variation within Warrington.

The resident population of Warrington continues to grow; latest estimates suggest that there are 208,800 people living within the borough. Increases are projected to continue, and it is estimated that the population will rise by an extra 25,200 people over the next 23 years. Our population has increased year on year from 2004 to 2015 and is projected to increase by 13% (an extra 27,600 people) between 2014 and 2039. The largest proportional increases are expected to occur in the older age groups as life expectancy has improved and the new town population growth bulge reveals itself in an additional 23,000 people aged 65+ and 4,300 more under-65s.

National statistical information says that the number of people with learning disabilities who will need social care services is likely to rise 25% by 2030. Sometimes their needs can be complex and expensive to meet. Fewer and fewer of them are receiving public funding. This needs to be addressed.

The pattern of need is changing dramatically as well. Deaths from cancer and heart disease are falling, but more of us experience chronic illness, with 70% of the NHS budget spent on long-term health conditions. Older people aged 75 and over will have at least two long-term conditions. Dementia and frailty in later life is soaring. Many more of us will have a mixture of needs to do with physical health, mental health and perhaps difficulty in making decisions for ourselves. They can only be met by well-coordinated ‘joined-up’ care.

Whilst the population of Warrington has a broadly similar profile to the North West and England there are some slight differences at 5 year age band. The population of children and young people (CYP) aged 0-19 in Warrington is estimated to be 49,000[1]. This accounts for 23% of the total Warrington population. Warrington has a lower proportion of 20-34 year olds, a higher proportion of 40-54 year olds, a growing proportion of older people but a slightly lower proportion aged 80+, compared to England and Wales. The GP-registered population is higher than the resident population and in 2015/16 around 214,000 people were registered at Warrington GP practices. The Joint Strategic Needs Assessment for Warrington identifies the following headlines:

- The average life expectancy at birth of Warrington men and women is improving but the pace of improvement has slowed in recent years, especially so for women. The gap between Warrington and England males has narrowed slightly as Warrington male life expectancy has increased at a faster rate than England; however, the gap between Warrington and England women has widened.
- Internal inequalities in life expectancy are stark and linked to socio-economic deprivation. Comparing the highest and lowest life expectancy at ward level, there is a gap of 9.8 years for males, and 11 years for females.
- Around one-fifth of the 1,920 deaths per year in Warrington are considered preventable. Mortality from causes considered preventable have decreased considerably over the past ten years. Despite these reductions, rates remain higher than the average for England.
- Mortality rates are significantly higher in the more deprived areas of the town (areas that fall into the 20% most deprived areas nationally, based on deprivation scores from the Index of Multiple Deprivation (IMD) 2015) when compared to the remaining areas, and the gap is greatest for premature (people aged under 75) deaths from respiratory disease.
- Many health indicators suggest that the health of older people in Warrington is worse than the England average. Life expectancy at 65 for both males and females remains significantly lower than England. However, whilst male life expectancy has seen consistent increases, the female life expectancy has plateaued in recent years.

Financial Considerations

Public spending in Warrington totals £1.2 billion. Warrington Clinical Commissioning Group and Warrington Council, including Public Health, are the local commissioning organisations in the borough and collectively approximately £550 million (gross) is spent on health and social care. The Council's social care budget is particularly fragile and the collective NHS overspend in the STP region last year stood at £100m. Although the Better Care Fund is now offering some much-needed support, there are still savings of around £9 million to be made in social care for adults

[1] 2016 mid-year estimates, Office for National Statistics

over the next 3 years. Therefore the financial implications for the Warrington organisations over the next three years if we do not transform the system to make better use of our collective resources are unsustainable.

There is unlikely to be significant new funding coming into the health and care system. Achieving sustainability will only be through harnessing the redesign potential of delivery organisations, shifting to less resource-intensive solutions and managing demand.

The longer term financial assessment also takes account of a number of different shared factors including the management of cost, where unit costs are rising and the costs of the workforce – 70% of the total costs of care – also continue to rise. All partners to this Prospectus are committed to the management of cost whilst supporting a stable and sustainable local market. The success of the Boroughs economy significantly supports wellbeing but impacts on the availability and cost of the health and social care workforce. The strength and growth of the services and logistics sector in the town impacts on both the cost and availability of workforce and will be an area for joint action moving forwards.

Market Challenges

Social care in particular suffers from adverse and unstable market conditions. The number of hours of domiciliary care commissioned has continued to rise by around 3% per year for the last 5 years. This is attributed to both a growing number of hours of support per person as well as growing numbers of people needing the service. The increase in demand for domiciliary care, the low use of residential care and the high use of supported accommodation all creates a particular need for more community based social care than currently be sourced. Sufficiency of labour is strongly affected by the availability of alternative employment sectors in the Borough, a general environment of low pay and low status in the care industry. Low sufficiency and low resilience impacts negatively on the whole system, both in keeping people independent and providing flow out of hospital for people who are on a recovery pathway and need to leave hospital.

The rise in rates of dementia and levels of need in people both with early onset dementia, people who have more extreme behavioural challenges due to dementia and people with severe and enduring mental ill-health have also not been met with a commensurate rise in appropriate skilled provision for those people. Appropriate care, health and education provision for children and younger adults with special educational needs and disabilities is also in short supply in the Borough.

In general, the quality of care is good (as judged by CQC ratings) but consistent standard levels of care are falling slightly.

Workforce Challenges

'The Economic Value of the care and health workforce is underestimated. The Gross Value Added (GVA) directly generated by employers including wages paid to workers filling the many different job roles in adult social care, for example is £24.3 billion in the UK. One in four workers leave the care workforce every year, according to figures published by Skills for Care 2017. There are vacancies of around 6.6% of the total workforce with staff turnover at 27.8%. Younger people are not staying in the sector.

The Warrington health and care workforce suffers from shortages of nurses, GPs, therapists, experienced social workers, basic grade care and health care assistants, and in all parts of the sector the age profile is heavily leaning towards the older end.

More could be done to harness the energy and enthusiasm of groups in local communities to make a difference to the experience of people, patients and carers in hospitals and other settings. As in the rest of the country, services and people in need of care and support are heavily dependent on informal carers.

Priorities and opportunities

The 'life cycle' approach has been adopted by the Warrington Health and Wellbeing Board. Transformation priorities were agreed for Starting Well, Living Well, Ageing Well and for Strong and Resilient Communities. The expectation of commissioners is that this approach will be mirrored in the response from delivery organisations.

The biggest challenges for Health and Social care services are:

Starting Well

Our ambition is that Warrington is a borough that works for all children. We must keep a relentless focus on the lived experience of and outcomes for children and young people and a focus on closing the disadvantage gap, because every child really does matter.

In general, many health and education outcomes for children and young people in Warrington are good, but there are stark inequalities for child poverty in the borough and for outcomes such as social mobility, educational attainment and mental wellbeing.

Breastfeeding in Warrington is consistently significantly lower than the England average, and there are stark inequalities between areas of high and low socio-economic deprivation.

In terms of children and young people with SEND needs, the agencies that serve our children and families are generally getting 'the right services to the right children at the right time' and the SEND strategy embraces the spirit of the reforms to transform the quality and effectiveness of services further. Ofsted and the CQC confirm that the local area can demonstrate how we have built capacity to address most weaknesses and are particularly strengthening preparation for adulthood, which has resulted in a significant reduction in the proportion of young people with SEND who are not in education, employment or training (NEET). However we recognise that more needs to be done to develop services for young people with SEND who are aged between 18 and 25.

There is increasing concern nationally in relation to children and young people's mental health. Warrington's levels of self-harm have been significantly higher than the national average, with higher than the national average for admissions into specialist in-patient beds in the context of low levels of access to help and support. Whilst there is a trend of improvement, with increasing numbers of young people being able to access support, further progress is needed. Less progress has been made in relation to neurodevelopmental pathways, with particular attention required in relation to transition across mental health and community services. However, recent work has seen improvements in this provision.

Living Well

Chronic conditions - Warrington has a higher rate of spend for Coronary Heart Disease than similar areas. The rate of deaths from Cardiovascular Disease (CVD) for those aged 65 in Warrington are significantly higher than England. High blood pressure can affect one in four adults but many are unaware of this silent condition (one in ten people in Warrington could have undiagnosed hypertension. There is significant variation between practices in the management of high blood pressure.

Cancer is now the biggest killer in Warrington, recently overtaking cardiovascular disease for numbers of deaths each year. Long-term trends show that premature cancer death rates locally have been reducing steadily and are in keeping with the average for England. However, the rate of new cancers in Warrington is slightly higher than the England average. Survival rates for cancer are much better if cancer is caught earlier and the screening programmes are a vital part of this identification programme.

Deaths due to respiratory disease are significantly high in Warrington when compared to England. The percentage of people in Warrington aged 65 and above who received their flu vaccination is lower than the nationally set target of 75%; there has been a small but consistent downwards trend in the uptake of this vaccination.

Alcohol and smoking - nationally derived estimates for Warrington as a whole suggest that the percentage of Warrington adults drinking to unsafe levels is in keeping with the average for England. However, the proportion binge drinking is significantly higher than England.

Smoking prevalence is significantly lower than the average for England but has remained high in more deprived areas and amongst certain population groups.

Ageing Well

Falls in older people is one index of frailty. Warrington has one of the highest rates of spend in the country on hospital admissions for injuries in people aged 85+. We are in the top decile of all CCG areas for spend on injuries to hip and thigh for patients 85+ and in the top decile and highest of similar CCGs for injuries to elbow and forearm for patients 65+. The rate of hospital admissions for those aged 65 years and above due to a hip fracture has increased over the last two years. Most hip fracture injuries in older people are the result of a fall, Warrington has one of the highest rates of emergency admissions due to a fall (for those aged 65 and above) out of all Local Authorities across England.

Spend on admissions for unspecified urinary tract infection (UTI) in patients 75+ is higher than similar CCGs. There is also a high rate of bed days for unspecified urinary tract infections (UTIs) compared to similar areas. Non-elective spend for flu and pneumonia is also higher than similar areas.

Patients aged over 65 more frequently have an extended hospital stay than for similar areas.

Strong and Resilient Communities

Obesity prevalence is an issue locally. Estimates suggest that 65.7% of Warrington adults are overweight or obese. Although this is slightly higher than the average for North West, the percentage for Warrington is significantly higher than the England average. This illustrates that nearly two thirds of our adult population are at an unhealthy weight.

In terms of childhood obesity we know that In Warrington, 4.4% of Year 6 children are severely obese (slightly higher than England (4.2%) but slightly lower than the North West (4.5%). A higher proportion of boys (5.4%) than girls (3.4%) are severely obese, but in the Central group of wards severe obesity prevalence is significantly higher at 7.7%, i.e. 1 in every 13 children.

For the last three years, the employment gap between those with a long term condition or disability and the general population in Warrington has been widening so that we are now worse than England and the North West. While this may be a symptom of buoyant employment which

is squeezing out those furthest away from the job market, partners in Warrington have pledged more jobs, better health for everyone, and reduced inequalities.

Geographical Inequalities

Reflecting the high levels of economic deprivation, many overarching health outcomes are worse in the central part of the borough. On average, men in the area can expect to live 3.5 years less than the average for Warrington, and women around 3 years less, and there are even more stark differences between individual smaller areas. The rate of premature death from some of the major killers is significantly higher in Central. Health outcomes for older people also show stark variation. The rate of emergency admission to hospital is higher amongst residents of Central; this is the case for all emergency admissions and emergency admissions for mental health conditions. Smoking prevalence, physical inactivity and levels of obesity amongst both adults and children are all higher in Central. 27% of the population in Central have 3 or more lifestyle related behaviours that put them at increased risk of heart disease or stroke. Hospital admissions due to alcohol are almost 90% higher amongst residents of the Central area.

Obesity rates in Children in Orford and Bewsey & Whitecross are significantly higher than elsewhere and Orford has a significantly higher prevalence (11.3%) of 'severe obesity' compared to the Warrington average (4.4%).

In response to some of these challenges, the Central Neighbourhood Renewal Area was created in 2017. Warrington Together is expected to contribute to central neighbourhood renewal by facilitating integration of services, addressing needs and harnessing resources in the central area through a collaborative multi-disciplinary approach in communities.

In addition, Warrington Together can maximise the reach into each of the clusters through a social prescribing offer or referral gateway such as the Wellbeing Hub.

Enablers

Workforce: A healthy workforce in Warrington drives the economy and resilient services in all sectors of health and social care. The priorities for workforce are to collaboratively design new job roles for integrated care in collaborative clusters and the care market that cross organisational boundaries, to promote healthy public sector settings for staff, patients, clients, visitors and residents, and to promote workplace wellbeing across the small and medium businesses that are so vital for the Warrington economy.

ICT: Implementation of the shared care record in Warrington can enhance patient and client experience, improve safety, improve outcomes, save time and resource by enabling patient access and supported access to their record to enable self-care as well as staff access to a more complete record of assessment of needs and current treatments or interventions. The priorities in rolling out the shared care record are to integrate the required functions across the existing IT infrastructure in Warrington in primary care, secondary and community care, social care, assistive technologies in the community and public health. There is a culture shift and training required to achieve this, together with the workforce enabler group.

Estates: Shared space and co-located teams in clusters are a key enabler to increase the opportunities for integrated working and delivery of services, although co-location alone does not deliver integration. The priorities for estates are to set out plans for integrated hubs sited strategically in each of the clusters and in the new proposed development areas in the growing town. The options for a new hospital and options for where that is best sited are being explored and negotiated by the NHS and partners in consultation with stakeholders and residents to meet the needs of Warrington residents across the town. Primary Care services, referred to above, provide the first point of contact in the healthcare system, acting as the 'front door' of the NHS. Primary care includes general practice, community pharmacy, dental, and optometry (eye health) services.

Communications: The detailed delivery plan for Warrington Together requires insulation with residents and highlights specific to each area of the town. This Commissioning Prospectus signals the shift from strategic intent to operational delivery and change management for which collaborative communications are required into the organisations to support culture shift, and to patients, clients, visitors and residents. This Commissioning Prospectus will inform the new Health and Wellbeing Strategy 2019-23 and stakeholders in the various sectors related to the themes, in particular the Strong and Resilient Communities theme as that brings together wider partners than the health and care sectors.

Commissioning Approach

In an integrated care system commissioners and providers work in partnership to take collective responsibility for improving the health and wellbeing of the population they cover. The aim of integrating care is to have a single approach to using resources and to improve the quality and health outcomes for local people.

Commissioners in Warrington (Warrington Council and Warrington CCG) have aligned commissioning intentions, produced a Commissioning Prospectus, and have committed to a single Commissioning Plan, updated annually. Commissioners are moving towards a single commissioning function, which will achieve a co-located status by 2020.

Commissioning is a process with a range of activities, often described as a 'cycle'. Commissioning might be seen as akin to a relay race, with colleagues from different disciplines and organisations needing to deliver on their part of the process and hand on the baton at the appropriate stage.

With patients and service users at the heart of commissioning, as its focus, the responsibility for strategic planning, the procurement of services and the monitoring and evaluation of services will remain with the single commissioning function on behalf of the Health and Wellbeing Board.

Some of the parts of the cycle in which the 'baton' can be handed over to the wider Warrington Together delivery system are:

- Service design / redesign
- Supporting patient choice
- Assessing needs and micro-commissioning (e.g. arranging care packages)

Sometimes this is referred to as 'tactical commissioning'.

New care models have been tested through the national new care models programme (Vanguard sites) which have tested different approaches to the integration of services and provision including the contractual routes to support these models.

Both nationally and locally, we know that more people are living longer and there are more people with disabilities who need care and support, at the same time as funding reductions in real terms for social care.

A 'demand management' approach is a core element of Warrington's approach to transforming Social Care services, ensuring that we provide an efficient and effective customer journey, make the best use of resources available to us, and promote and maximise independence for individuals.

In Warrington we will build on the demand management and asset based models, already in use in adults and children's social care and Public Health, building on the strengths and capabilities of our communities. The system also needs to ensure that choice, personalisation and empowerment is a key driver.

Key Features of Integrated Service Models include:

- Place based care planning, based on local units of integrated primary care provision and financial accountability serving natural communities of 30–50,000 population
- All models build on strong primary care foundations with care provision focused in the community setting around the registered general practice population
- Integrated health and care services to provide joined up care across mental and physical health, social care and voluntary sector, where good mental health has parity of esteem with good physical health

There are two predominant approaches to the integration of services:

- Horizontal integration – tested nationally through the Multispecialty Community Provider models (MCP)
- Vertical integration – tested nationally through the integrated Primary and Acute Care Systems Vanguards (PACS)

A combination of both approaches will be taken in Warrington depending on the service in scope. For example, for some pathways there will be a natural lead provider lending itself to the prime provider or vertically integrated model, whilst for other community delivered services, or support, a more horizontal approach will be required between providers. Both of these models can be supported within the same provider / commissioner alliance and alliance contracting arrangements. This allows for more rapid and agile mobilisation whilst reducing the need for formal tender processes.

Delivery Model and Resources

The delivery model will be predicated on the health and social care economy exploring options around a change to funding and contracting models. Potential new funding models are intended to promote resources being delivered in the most efficient way across the whole system via a dedicated budget based on a given population's needs. A new contracting model will also be required supported by strong risk sharing arrangements between the commissioners and providers, whilst also incentivising integrated care and improving outcomes.

Budgets in scope for the new approach will include:

- Acute care (NHS and private)
- Mental health
- Community healthcare
- Social care for adults and children
- Primary care (national and local)
- Prescribing
- Continuing healthcare
- Public health
- Children with special educational needs and disabilities (SEND)

These budgets are spent in the NHS, social, private and voluntary sector organisations within and outside Warrington. In the case of social care, resources are spent through hundreds of separate organisations through different forms of frameworks or spot contracts. Taking a new approach will present the chance to reduce cost growth whilst improving outcomes by integration of service delivery and adoption of a more comprehensive asset based approach.

Implementation Phases and Governance

It is important that the fact that frail older people are the heaviest users of hospital beds does not dictate that the preoccupation of Warrington Together should be solely to resolve problems of the flow of older people into and out of acute care: some of the most frequent users of acute and community care services are younger adults with a range of substance misuse and mental health problems; people with long term conditions can live long and fulfilling lives with minimum support, as long as it is the right support, and avoid a series of crises in their health.

Younger adults with very complex disabilities and children and young people with special educational needs and disabilities (SEND) also rely on the very best integration possible between health and social care in order to live their whole lives in a supported way; children with SEND and their parents and carers are required to frequently navigate the hand-off points between education, NHS healthcare and social care and more

usually rely heavily on workers in those agencies (and those they commission) to coordinate their help and support effectively. This often does not happen effectively and problems are most acute for the parents of children who have multiple neuro-developmental conditions. This is why we are redoubling our efforts to commission better pathways in co-production with parents, carers and young people, but also to truly integrate our delivery.

As such, there is a compelling evidence base for focusing first on people in the 85+ age group who are frail and children with special educational needs and disabilities, as well as the carers of both. Collectively, these members of our community constitute a relatively small percentage of the population (less than 5%) and the provision of more effective pathways and support systems will deliver the highest beneficial impact in outcomes for them and for the sustainability of our system.

The financial arrangements for the development of a more integrated care system will be developed to reflect the phased scope and remit of the services included and in particular aligned to any Alliance Agreement to be established between Providers and between Commissioners. Finances will remain within the current expenditure levels, utilising a capitated budget model.

The illustration above sets out the current governance arrangements for Warrington Together. Warrington Together represents all the organisations involved, with commissioners being represented via the Integrated Commissioning and Transformation Board.

There is an expectation that Memoranda of Understanding will develop between the constituent provider partners. MOU will detail the services included in the agreement, how the providers will operate and the expected outcomes, key performance measures and quality requirements for the services included. Once agreed Commissioners may vary standard contracts.

The Integrated Commissioning Transformation Board (ICTB), Co-chaired by the senior commissioning directors in the CCG and Warrington Council, will become a fit-for-purpose function to 'own' the Commissioning Prospectus and Commissioning Plan. The delivery functions of Warrington Together will be held to account through the ICTB, through contracts, service level agreements, Memoranda or other appropriate accountability arrangements, and performance managed through an agreed dashboard or scorecard of key performance indicators and to agreed standards.

Our ambition through the Warrington Together partnership is high and the scope of activity to be undertaken is wide, but key integration and service redesign activity needs to be phased and focused. The following table outlines the expectations of those delivering these programmes based on the weight of the evidence in the sections on 'challenges', 'priorities and opportunities'.

Phase	Population Cohort	Current Services in Scope	Approximate Delivery Budget	Outcomes
Phase 1 2018-2020	Coordinated and integrated care for people with and at risk of frailty - e.g. people with	Urgent Care Redesign - Out of Hospital Care – primary,	People 65+ CCG - £72.1m	- Increase in the number of people who feel supported to manage their Long Term Conditions - Reduction in spend on unwarranted variation in hospital based care and conveyance to hospital

	at least 2 comorbidities and people requiring coordinated and integrated support for their complex conditions or other factors impacting health and wellbeing	community and intermediate care - Social work (managed care) - Care at home and residential and nursing care - Extra care Housing & other supported housing - Prevention and wellbeing	WBC - £43.4m (gross) Total £115.5m People 85+ (peak frailty) CCG - £14.8m (approx.) WBC - £24m (approx gross) Total £38.8m (approx.)	- Reduction in spend on long term nursing and residential care - Increase in spend on extra care accommodation and time to assess beds - An increasingly skill mixed workforce which includes expanded use of the voluntary sector - A model of primary and community care which optimises capacity through the use of technology, different roles and integrated MDTs - Appropriate and affordable education, health and care - A pathway to independence and choice
	For Children with Special Educational Needs & Disabilities (SEND) aged 0-25 ensure they can achieve their best at nursery, school and college; find employment; lead happy and fulfilled lives; have greater control over the support they receive; and feel valued. In addition, ensure that the families of children and young people with SEND are appropriately supported to maximise the opportunities of the children they care for.	This excludes system investment into Frailty Assessment Unit of £1.1m and other iBCF schemes aligned to Frailty CCG & Local Authority Services commissioned (and delivered) to SEND children, young people and their families / carers. Includes: - Primary Care - Community Paediatric, Nursing & Therapy Services - Acute Paediatric and Maternity Services	Children & Young People with SEND aged 0-25 years **Estimated** CCG - £4.1m WBC - £9.0m Total £13.1 (approx.) *Fund does not include High Needs block funding on education (£26.3m) or 18-25 CCG Commissioned Services for SEND or 0-19 services for children commissioned by Public Health (total value £3.2m) which includes some	– Reduce delays in identifying and diagnosing children and young people's additional needs – Improve information about what is available and how to access support – Increase the availability of local specialist childcare, holiday and education provision – Ensure support services are provided in a timely way – Fill the 'gaps' when young people move from children's to adults' services in health, education and employment support – Reinforce the role of children and young people and parents and carers in the EHC assessment and planning processes – Ensure all organisations work together effectively to improve the lives of children and young people with SEND and for their families / carers – Strengthen co-production arrangements for children and young people with SEND and their families / carers so that they can directly influence the shape and delivery of services that make up the SEND 'Local Offer'

	Ensure that children and young people with SEND receive support at the earliest point without reliance on diagnoses.	- Services provided to support behaviour, emotional and mental health for 0-25 year olds - Local Authority SEND Services including Social Care for children with disabilities - Health Visiting & School Nursing - Continuing Care, Section 117 Aftercare, Care, Education & Treatment Reviews (CETR's) - Any other commissioned provision for SEND i.e. 3rd Sector	services to children with SEND needs.	
Phase 2 2020-22	Adults with enduring mental health problems and dual diagnoses, requiring specialist services People with learning disabilities and autism Children with CAMHs needs	Adults: - Mental Health day and residential - Specialist services - Substance misuse/Alcohol pathways Children & Young People: - CAMHS		- Taken together, care and support helps people live the life they want to the best of their ability - People are as involved in discussions and decisions about their care, support and treatment as they want to be - When people move between services or care settings, there is a plan in place for what happens next - People have access to a range of support that helps them to live the life they want and remain a contributing member of their community - People have the information, and support to make decisions and choices about their care and support - Carers feel supported and have a good quality of life - More young people have fun and a healthy lifestyle - More young children and young people are safe

		- Self-harm & mental wellbeing services -		- More young people and children achieve their full potential - More young people achieve career success
Phase 3 2020-21	- All Adults - All Children	0-19 healthy child pathway Early help Highly Complex needs/complex safeguarding Tiers 2 and 3		- To be developed

Warrington Together

Our work will be done through an alliance of health and care partners called 'Warrington Together'.

Warrington Health and Wellbeing Board committed to progressing the establishment of an Integrated Care System (ICS) in Warrington in 2017-18. During 2017-18 the main providers and commissioners of health and social care providers in Warrington have collaborated to progress the development of an integrated care system and established the Warrington Together partnership.

Warrington Together describes an alliance of providers and commissioners working together in partnership to improve services based around primary care, focused on prevention and early intervention, bound by a common narrative and approach, and with a stake for each organisation in the scaled reduction of demand across health and social care.

Those involved in the Warrington Together partnership include Warrington Borough Council (WBC), NHS Warrington Clinical Commissioning Group (WCCG), Warrington and Halton Hospitals NHS Foundation Trust (WHH), Bridgewater Community Healthcare NHS Foundation Trust (BW), North West Boroughs NHS Foundation Trust (NWB), the Alliance of Warrington Voluntary Providers, housing providers, Warrington Healthwatch and Primary Care Networks.

Our shared vision is:

"Together, we will enable the people of Warrington to enjoy happier and healthier lives by transforming the way we use our collective resources".

The Warrington Together partnership has agreed a set of principles of operation based upon work by the Kings Fund. These have been further developed in terms of how they have influenced the model design by way of criteria and commitment:

Design Principle (from Kings Fund)	Design Criteria	Design Commitment
Defining a shared population group and care model across a system	Working for a population in a defined place (which may be at a practice or cluster level, neighbourhood, Warrington or the STP area)	We commission our services around populations and not organisational boundaries. Our agreement to align our work across the public sector to achieve the best outcomes and impacts for Warrington citizens
Providing co-ordinated care	Repositioning our workforce to become badgeless and working for Warrington rather the institution on the pay slip	We reposition talent and skills according to our new system requirements and not historic organisational boundaries. We empower our clinicians and practitioners, and value skills which optimise partnership, collaboration and intervention
Creating interdependency which is more likely to enable effective and efficient care	Prioritising Warrington's assets through engagement and encouraging innovation	Develop public services with our local communities. We use collaborative and asset based approaches in our work. We support our staff, partners and citizens to develop innovative solutions, including involving and enabling communities to do more things for themselves to prevent ill-health and promote wellbeing
Sharing care management and predictive modelling	Sharing decision making and concentrating our efforts on a shared stratified patient list	We will promote co-location of multi-disciplinary staff and jointly identify most appropriate intervention based initially on our most needy citizens

The governance and accountability to transform the system ultimately sits with the Warrington Health and Wellbeing Board and this Commissioning Prospectus is an expression of the commissioning intentions of the Health and Wellbeing Board. 'Warrington Together' represents all the organisations involved working to a single system direction.

Warrington
Health & Wellbeing Board

30th May 2019

1.30 pm, Council Chamber, Town Hall, Warrington

Report Title	Better Care Fund (BCF) Annual Report 2018/19
Type of Decision Required	☐ Formal Decision as to a Statutory Function ☐ Non-Statutory Advice, Guidance or Recommendation to Other Body ☒ Note or Endorse a Report or Action by Others
Report Purpose	The purpose is to present the BCF Annual Report for 2018/19. The BCF Annual Report reflects on the local progress of the BCF/iBCF programme during 2018/19 and provides a forward look at the aims and objectives of the programme in Warrington during 2019/20.
Report author	Rick Howell, Strategic Lead - Commissioning
Confidential or Exempt	This report is not considered to contain information which is confidential or exempt.
Recommendations	The report is noted.

1. Report purpose

The purpose of this report is to present the BCF Annual Report for 2018/19. The BCF Annual Report reflects on the local progress of the BCF/iBCF programme during 2018/19 and takes a forward look at the aims and objectives of the programme in Warrington during 2019/20. The BCF Annual Report is provided in Appendix A.

2. Introduction/background

The Better Care Fund (BCF) is a national initiative designed to enable the transformation of integrated local health and social care services with the aim of improving health and care outcomes.

The BCF has been in place since April 2014 and each local area's current BCF plan was effective for a two year period from 1st April 2017 until 31st March 2019. Alongside the BCF, the Improved Better Care Fund (iBCF) was launched in 2017 for a 3 year period (until 31st March 2020) to focus on the local implementation of a number of High Impact Changes aimed at reducing Delayed transfers of Care (DTOC).

Locally, the BCF/iBCF programme is closely aligned with the ambitions of the work programme of Warrington Together. This is to ensure that the objectives of the BCF/iBCF are aligned to local, long term strategic plans for the transformation of health and social care in Warrington and are focused on achieving the same strategic outcomes for the local population.

3. Content

The BCF Annual Report for 2018/19 includes a review of progress against the implementation of the local BCF Plan, 2017 – 2019, including the specific schemes/projects which were delivered during 2018/19. The report sets out the challenges facing the local health and social care system regarding the implementation of the BCF programme. The report also includes a forward look at 2019/20, including the anticipated key priorities for the BCF programme during the year.

In summary, the BCF Annual report includes the following main contents;

- BCF Finance
- Progress against the Local BCF Plan
- Challenges Associated with the Delivery of the BCF Plan
- Progress against BCF Performance Indicators
- Forward View – Looking Ahead to 2019/20

BCF Finance

The report reflects that during 2018/19 the total BCF/iBCF expenditure was £36,906,055 versus a planned budget of £32,838,168. The overspend value of £4,067,887 is attributable to an increase in the cost of joint funded (i.e. jointly funded by Warrington Borough Council and Warrington CCG) complex packages during the year. The number of joint funded complex care packages has increased in recent years and the BCF Steering Group continues to monitor expenditure in this area. Warrington Borough Council and Warrington CCG continue to work together to appropriately understand needs and manage demand for complex care packages.

Progress against the Local BCF Plan

During 2018/19 Warrington's plans to integrate Health and Social Care have progressed well. Local BCF schemes are aligned to the Warrington Together workstreams to ensure delivery is aligned to the longer term strategic ambitions of the local health and social care system.

Overall progress has been positive. 2018/19 saw investment in the mobilisation of a number of new integrated community-based 'out of hospital' models of care. Section 3 of the BCF Annual Report summarises progress against the following main programmes of work;

- Implementation of the Frailty Hub Model
- Implementation of a Rapid Intervention Service, including a Night Sitting Service
- Implementation of a Carecall Response Service
- Opening of the Smart Flat
- Introduction of Trusted Assessors roles within the Hospital Discharge Team (Care Home liaison)
- The Utilisation of Transitional Beds to enable system flow and improve outcomes
- Implementation of the first Integrated Multi-disciplinary Community Teams
- Implementation of a Clinical Skills Hub
- Complex Mental Health Project

Challenges Associated with the Delivery of the BCF Plan

The BCF Annual Report reflects that during 2018/19, three key challenges impacted on the delivery of the BCF Plan during the year;

1) Workforce – Recruitment
2) Workforce – Retention
3) Stabilising the Local Care Market

In relation to workforce, Warrington experienced insufficient capacity for some key care roles due to the challenges of recruiting and retaining appropriate levels of staff. Particular challenges relate to recruiting and retaining therapy staff, Care Workers and Nurses. These challenges have impacted on both delivery of traditional models of care

and also on the mobilisation of new models of community based integrated care delivery during the year.

There has been immense effort and focus on balancing the sustainability of the local care market, whilst at the same time continuing to transform the health and social care landscape through the introduction of new community based models of care. All partners have worked collaboratively to maintain and improve outcomes for local residents. The investment of local resources will continue to be a key factor as we progress into 2019/20.

Progress against BCF Performance Indicators

The BCF Annual Report reflects progress during 2018/19 against four mandatory BCF performance indicators;

1) Reduction in non-elective admissions
2) Residential Admissions - rate of permanent admissions to residential care per 100,000 population (65+)
3) Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
4) Delayed Transfers of Care (delayed days)

With the exception of Delayed Transfers of Care, three of the performance indicators saw improved performance during 2018/19. There are some indications that this improved performance may be as a result of the implementation of the BCF programme's new models of care, such as the implementation of the Frailty Hub model, the Carecall Response Service and increased focus on system flow. However, further work is required during 2019/20 to fully assess the impact of the introduction of the new models of care.

Warrington's performance on delayed discharges continues to be in the bottom quartile and there remains a significant local challenge to improving delayed discharges. Performance in 2018/19 on reducing delayed discharges has been variable and continues to require further effort to deliver long term sustained improvement. Delayed Discharges will continue to be a key priority for the local health and social care system during 2019/20.

Forward View – Looking Ahead to 2019/20

NHS England's BCF Policy Framework confirms that 2019/20 will see minimal change and a focus on continuation with local integration plans for a further year, to align the BCF and iBCF until 31st March 2020. Local areas will be subject to the same National Conditions and performance measures as for the period 2017-2019.

It was expected that BCF Planning Guidance would be issued at the same time as the BCF Policy Framework, however the Planning Guidance has been subject to delay. Once the Planning Guidance has been received, local areas will be required to submit full planning templates for 2019/20, confirming that the Health and Wellbeing Board has signed them off.

Locally, in the forthcoming year the priorities for 2019/20 will continue to focus on preventing avoidable admissions to hospital and further developing community-based 'out of hospital' models of care. Focus will also continue with regard to reducing delayed discharges.

The following initiatives are expected to be key areas of Priority in 2019/20;

- Intermediate care (including all tiers and a particular emphasis on increasing capacity of Intermediate Care at Home).
- Development of a Safe & Well Service (to prevent hospital admission and facilitate discharge).
- Continued development of the Frailty Hub model
- Development of community-based Rapid Response services
- Review of the Stroke pathway
- Continuation of the Carecall Response service
- Reducing Delayed Discharges
- Establishment of a single, co-located Integrated Hospital Discharge team
- Joint Funded Complex Packages of Care

4. Summary and Conclusion

During 2018/19, the BCF programme in Warrington has continued to be a catalyst toward improved integrated working across health and social care as the examples show in section 3 of the BCF Annual Report. The schemes were developed and mobilised as planned and in accordance with the ambitions set out within the 2017-2019 BCF Plan. Key partners across Warrington continue to work well collaboratively to deliver integrated services which deliver improved outcomes for local residents.

However, during 2018/19, there were also some persistent challenges to the mobilisation of new schemes, notably, workforce challenges associated with the recruitment and retention of key care worker roles. These challenges also impacted on the stability of the local market. As a result, some schemes did not operate for the full financial year and their continued implementation and evaluation will be a key areas of focus in 2019/20.

As shown in section 6 of the BCF Annual Report, the priorities for 2019/20 will continue to focus on preventing avoidable admissions to hospital by further developing community-based 'out of hospital' models of care. Focus will also continue with regard to reducing delayed discharges. Manging demand associated with Joint funded Complex care packages will also remain a key priority.

A further update to Health and Wellbeing Board will be presented once the full planning guidance for the 2019/20 year has been received and the local plan for Warrington has been produced.

5. Recommendations

The report is noted.

6. Background Papers

National BCF Policy Framework

Contacts for Background Papers:

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WARRINGTON
Borough Council

NHS
Warrington
Clinical Commissioning Group

Warrington

Better Care Fund
Annual Report

2018/19

1. Introduction

The Better Care Fund (BCF) is a national initiative designed to enable the transformation of local health and social care services with the aim of improving health and care outcomes. Local investment of the BCF is directed towards two main areas, firstly, out of hospital services and secondly, reducing delayed transfers of care.

The BCF has been in place since April 2014 and each local area's current BCF plan was effective for a two year period from 1st April 2017 until 31st March 2019. Alongside the BCF, the Improved Better Care Fund (iBCF) was launched in 2017 for a 3 year period (until 31st March 2020) to focus on the local implementation of a number of High Impact Changes aimed at reducing Delayed transfers of Care (DTOC).

Both the BCF and iBCF are subject to pooled funding arrangements between Local Authorities and their respective Clinical Commissioning Groups. The funding is to be used to enable greater integration across health and social care and is bound by a set of criteria for its use.

Locally, the BCF/iBCF programme has been governed through regular monthly meetings of the BCF Steering Group, together with meetings of the Integrated Commissioning and Transformation Board (ICTB). The latter is a decision making board, which takes responsibility for overseeing and authorising expenditure associated with BCF/iBCF. The BCF Steering Group has responsibility for advising and making recommendations to the ICTB regarding the appropriate use of the BCF/iBCF funds. Members of the Steering Group are predominantly Commissioners and Finance representatives from Warrington Borough Council and Warrington CCG. ICTB membership consists of lead accountable officers.

Quarterly monitoring returns are submitted to NHS England as required within the BCF guidance and are also reported to Warrington's Health and Wellbeing Board as regards local progress and performance.

Locally, the BCF/iBCF programme is closely aligned with the ambitions of the work programme of Warrington Together. This is to ensure that the objectives of the BCF/iBCF are aligned to local, long term strategic plans for the transformation of health and social care in Warrington and are focused on achieving the same strategic outcomes for the local population.

The purpose of this Annual Report is to reflect on the local progress of the BCF/iBCF programme during 2018/19 and to take a forward look at the aims and objectives of the programme in Warrington during 2019/20.

2. BCF Finance

Warrington Borough Council hosts the Better Care Fund pooled budget which has been effective from 1st April 2014. A formal agreement is in place, between Warrington Borough Council and NHS Warrington Clinical Commissioning Group under Section 75 of the National Health Service Act 2006. The Section 75 agreement defines the local pooled budget and risk sharing arrangements.

As well as BCF/iBCF funding, Disabled Facilities (DFG) income is also included in the pooled budget as per BCF guidance. In addition, during 2018/19, income received for winter pressures and income from the regional Sustainability Transformation partnership (STP) was aligned for financial purposes to BCF, to enable oversight of all income and align activity associated with the transformation of local health and social care services.

During 2018/19 the total BCF/iBCF expenditure was £35.254m. The BCF/iBCF expenditure matched the final budget for the year, after a small underspend was carried forward into 2019/20 for utilisation by the BCF Steering Group.

The contributions into the Better Care Fund from Warrington Borough Council and Warrington CCG increased significantly during the year reflecting the growth in spend in Jointly Funded complex packages of care. Following a review of complex packages of care early in 2018/19, an additional requirement of £2.507m was required to meet the increased demand. The additional contributions, combined with an increased allocation of iBCF funding, gave a working budget for the BCF/iBCF of £33.332m for 2018/19.

As the year progressed, and expenditure against all areas of the BCF/iBCF was closely monitored, it was noted that despite the initial increased contributions, the budget for Joint Funded complex packages was still insufficient. As a result, both partners further increased their contribution into the pooled budget, to uplift the closing budget to £35.254m and thus make it sufficient to fully fund the expenditure for the 2018/19 financial year.

The number of joint funded complex care packages has increased in recent years and the BCF Steering Group continues to monitor expenditure in this area. Warrington Borough Council and Warrington CCG continue to work together to appropriately understand needs and manage demand for complex care packages.

iBCF Allocations/Priority Areas

Introduced in 2017, the iBCF income is mandated that the expenditure of the iBCF funding must be spent in accordance with three key areas of priority. As shown in the following table, during 2018/19 the iBCF funding was evenly invested across these three key areas of priority - 33% of iBCF funding was allocated to meeting Adult Social Care Needs, 34% of iBCF funding was spent on reducing pressures on the NHS and 33% of iBCF funding was spent on ensuring the local social care provider market was supported.

Further detail regarding how the iBCF funding has been invested in specific projects is included in Section 3. In addition, some of the iBCF funding allocation has offset increased adult social care costs as a result of growth in demand.

a) Meeting adult social care needs	b) Reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready	c) Ensuring that the local social care provider market is supported
33%	34%	33%

3. Progress against the local BCF Plan

Warrington's BCF plan for the period 1st April 2017 until 31st March 2019 set out the local ambitions for the integration of health and social care. The BCF plan is a detailed plan which sets out the various initiatives which were to be undertaken to enable greater integration across health and social care in Warrington.

Warrington's BCF programme for 2018/19 has continued in line with the BCF Plan (2017-2019) which was agreed by the Health and Wellbeing Board late in 2016. The local BCF plan was signed off by NHS England and has been effective since 1st April 2017.

The ambition set out in Warrington's BCF plan was broadly to;

> ***Develop a delivery model for an integrated system of out of hospital care with a focus on population health. It means empowered patients and residents supported to greater independence; multi-disciplinary team working built around delivering primary care at scale; developing common platforms to secure integration.***

During 2018/19 Warrington's plans to integrate Health and Social Care have progressed well. The Warrington Together workstreams which are focused on tangible transformation continued to make progress in the key areas of Urgent, Emergency and Crisis Care, Integrated Community Teams and Prevention/Self-care.

The Programmes of work are summarised below;

Frailty Hub Model

The implementation of the Frailty Hub model, which includes a Frailty Assessment Unit, two community-based step up beds with wrap-around support, a Rapid Intervention Service and a Night Sitting Service. The model operates as a multi-disciplinary approach to avoiding hospital admission with the right care and support to enable individuals to remain at home. With the exception of the Frailty Assessment Unit, the services operate on a 24/7 basis to support individuals at home.

The Frailty Assessment Unit acts as a pathway for A&E Streaming as well as accepting referrals from a range of community based pathways (e.g. Community matrons, North West Ambulance Service, GP practices) with the aim of reducing avoidable hospital admissions for individuals living with frailty. The impact of the Frailty Hub model from October 18 – March 19 demonstrates:

- An estimated bed day saving of 3,550 bed days for the first 6 months.
- 396 attendances within the Frailty Assessment Unit (FAU) with an overall average direct same day discharge rate of 89%.
- Overall 65+ Non-Elective Bed Day Utilisation shows a significantly improving trajectory from December 2018 through to February 2019. This may suggest a shift in the admission profile but will require further monitoring and analysis.
- Patients and Carers reported an overwhelmingly positive experience of care from all elements of the Frailty Hub model.

Rapid Intervention Service

The Rapid Intervention Service went live in February 2019 and incorporates a night-sitting service. Between the Rapid Intervention and night-sitting services there is operational cover 24/7 to support individuals who require community support at home to prevent a hospital admission. The service is integral to the Frailty Hub model and offers a multi-disciplinary approach to supporting individuals in their own home as an alternative to hospital admission. The services are multi-disciplinary and offer clinical and therapy input.

Carecall Response Service

During 2018/19 the Carecall Response service demonstrated success in managing demand which would otherwise have resulted in Ambulance call-outs and hospital admissions. The Carecall Response service offers a manned Response Service to Carecall alarm calls from Warrington residents. The Response Service incorporates a 'lifting' service, underpinned with next-generation equipment sourced by Occupational Therapists. The service offers the Ambulance Service and the GP Out of Hours (OOH) service a rapid, direct referral pathway for non-medical emergencies and falls, incorporating the latest moving and handling skills and equipment, to be delivered within 20 minutes to any Warrington resident.

Smart Flat

The demonstration 'smart flat' opened to the public at the Centre for Independent Living in 2018/19. The smart flat enables individuals to see assistive technology in operation in a real-home environment. A range of professional staff were trained in the range of assistive technology available and are now able to refer individuals who may benefit from assistive technology. The smart flat has been well received with an increase in referrals for assistive technology as a result.

Trusted Assessors (Care Home liaison)

Two new Trusted Assessors (Care Home liaison) are now in place within the hospital's integrated hospital discharge team and will work closely with local care homes to ensure individuals admitted to hospital are able to return to residential and nursing settings in a timely way. The staff also facilitate home of choice, for those individuals who may need help and support to choose the right care home to meet their needs. The Trusted Assessors have also had a positive impact on the effectiveness of the Red Bag scheme ensuring the Red Bags support positive discharge transfers from hospital to care homes. The Trusted Assessors liaise between the hospital and local care homes to ensure that the Red bags contain the appropriate discharge documentation, as well as ensuring that the red bags are returned to the hospital for their continued use.

Transitional Beds

Investment in Transitional beds to manage winter pressures had a positive impact in managing flow across the system and to enable timely discharges/reduce delayed transfers of care.

Integrated Multi-disciplinary Community Teams

The transformation of primary care saw the commencement in 2018/19 of a multi-disciplinary approach to managing patients within Integrated Community Teams. The Integrated Community Teams are aligned to Primary Care (GP Practices) whereby care is co-ordinated in a much more integrated and co-ordinated model. The model is being tested/implemented in the Central North area of the town and is seeing promising results in terms of using tools to identify individuals most at risk. Multi-disciplinary care plans are being developed to support the management of care for these individuals. Plans are in place for further roll-out of Integrated Community Teams throughout 2019/20 and will incorporate learning from the early stages of the implementation of the model.

Clinical Skills Hub

A Clinical Skills Hub was established during the final quarter of 2018/19 to increase skill and competencies in clinical care across the sector, particularly for those staff who work in domiciliary care. The up-skilling of staff will enable better care for those living in their own home.

Complex Mental Health Project

A project to enhance capacity to undertake timely and targeted reviews to look at optimising patient flow into and out of the inpatient setting and identify individuals currently residing in supported accommodation that can be stepped down and/or moved on into more independent living. The project will also ensure that current packages of care are representing value for money and delivering good outcomes for service users and also evaluate the effectiveness of current commissioning arrangements.

4. Challenges Associated with Delivery of the BCF Plan

Whilst there has been much progress and success in terms of delivering the BCF Plan during 2018/19, three key challenges have impacted on the delivery of the BCF Plan during the year;

1) Workforce – Recruitment
2) Workforce – Retention
3) Stabilising the Local Care Market

Workforce – Recruitment

Also a national issue, during 2018/19 Warrington experienced insufficient capacity for care roles due to the challenges of recruiting appropriate levels of staff. In particular there was a shortage of Therapy staff, Care Workers and Nurses. This impacted on both delivery of traditional models of care and also on the mobilisation of new models of community based integrated care delivery.

Workforce – Retention

The buoyant local economic market in Warrington means care staff can choose to move between organisations and sectors, as organisations compete to recruit staff. Staff often move between organisations to pursue more favourable terms and conditions of employment, making retention of staff a significant challenge for employers.

Stabilising the Local Care Market

During 2018/19, the financial climate and local workforce challenges have led to difficulties associated with provider failure/hand back of care business to the Local Authority. This predominantly relates to the home care market. There has been much effort and focus on balancing the sustainability of the local care market, whilst at the same time continuing to transform the health and social care landscape through the introduction of new community based models of care. The utilisation and distribution of local resources will continue to be a key factor as we progress into 2019/20.

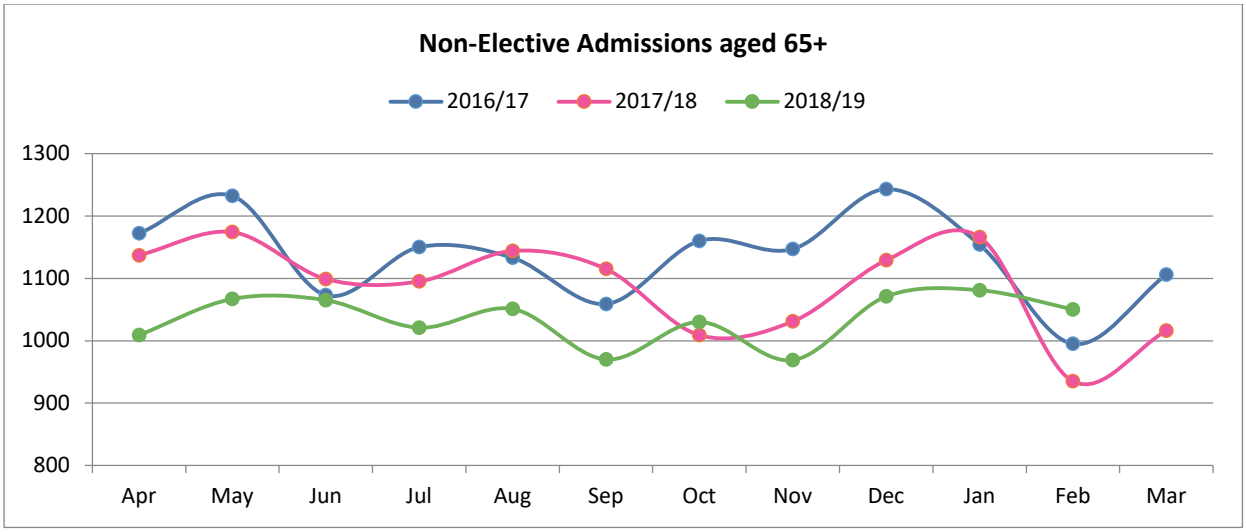
5. Progress against BCF Performance Indicators

Under the BCF requirements, local areas are expected to measure and report performance against the following four key metrics;

1) Reduction in non-elective admissions
2) Residential Admissions - rate of permanent admissions to residential care per 100,000 population (65+)
3) Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
4) Delayed Transfers of Care (delayed days)

Reduction in non-elective admissions

Performance has improved and was lower than the target during 2018/19 - continuing the positive trend of lower non-elective admissions. The association of this improved performance will be evaluated in correlation with the implementation of the Frailty Hub model to understand the impact that the Frailty Hub model is having on reducing hospital admissions. This work will continue throughout 2019/20 alongside further rollout of the frailty hub model.



Residential Admissions - rate of permanent admissions to residential care per 100,000 population (65+)

Performance data shows there were 248 admissions to permanent residential care for those aged 65 and over during the year. Performance was lower than the target (actual rate of 647.5 per 100,000 population versus a target rate of 704.9 per 100,000). Indications are that lower admissions to residential care may be attributable to the implementation of the new community based models of care, e.g. the frailty hub model. However, as the model is still in its infancy, it is expected that the continued rollout of the model in 2019/20 will see further progress regarding reducing the number of permanent admissions to residential care.

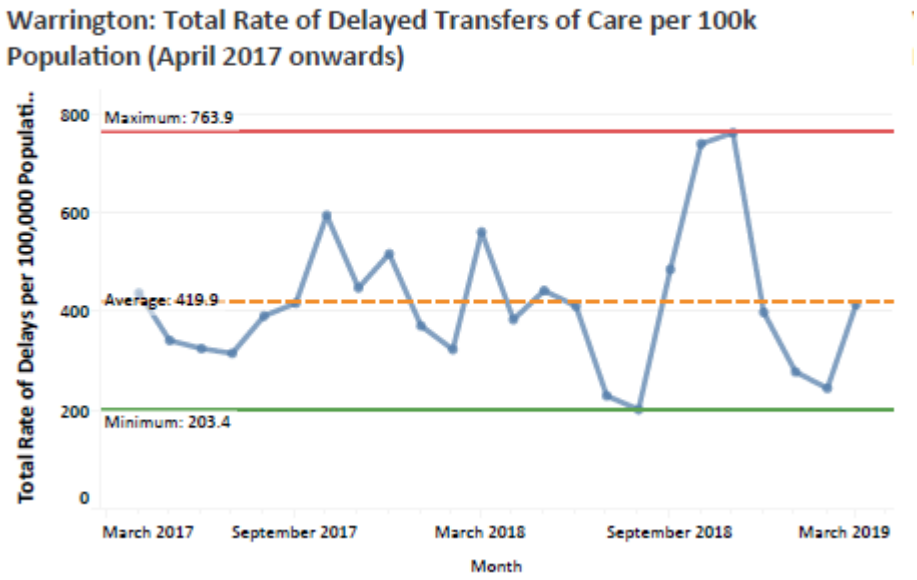
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services

Performance exceeded the target during 2018/19 and the data for Quarter 4 illustrates that of the 146 reablement eligible hospital discharges, 123 were independent after 91 days (84.2% against a target of 83.5%). This reflects positive performance in relation to local efforts to support individuals to live independently within their own home.

Delayed Transfers of Care (delayed days)

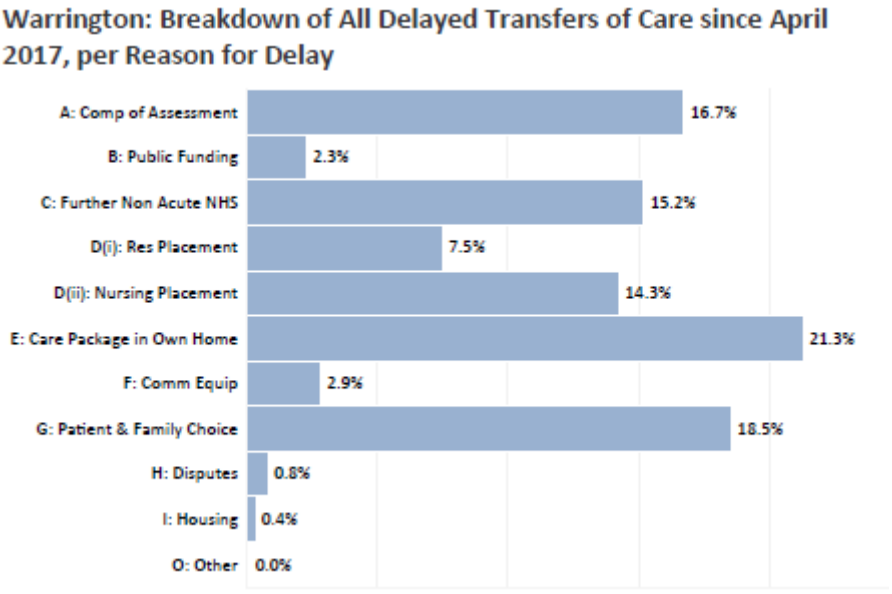
Warrington's performance on delayed discharges continues to be in the bottom quartile and there remains a significant local challenge to improving delayed discharges. Performance in 2018/19 on reducing delayed discharges has been variable and continues to require further effort to improve long term sustained improvement.

Warrington



Improvements were made in relation to enabling better system flow in 2018/19 which has contributed to a reduction in the number of delayed days, however some challenges remain.

During 2018/19, approximately 30% of all delayed discharge days were attributable to Adult Social Care and 60% attributable to NHS delays. The remaining 10% was attributable to both NHS and Adult Social Care. In comparison to the previous year, there were reduced delays as a result of securing home care packages, however, we have seen sustained challenges year on year in terms of home of choice.



Dedicated Delayed Transfers of Care (DTOC) workshops involving all stakeholders were established in 2018/19 and continue to refine processes regarding DTOC data and validation, with the aim of improving data quality to support prioritisation of patients, reduce delays and improve system flow.

During 2019/20 there will continue to be a concerted effort on understanding and tackling the causes of delays (delayed reasons) and in reducing further the number of delayed transfers of care. Some of the BCF/iBCF projects which have had a measurable positive impact during 2018/19 were not fully operational for the full year, therefore it is expected that greater impact of these new initiatives will be demonstrated during the forthcoming year.

6. Forward View – Looking Ahead to 2019/20

National Context

On 10th April 2019, NHS England issued a Policy Framework for BCF which sets out the vision for BCF in the context of the recently published NHS Long Term Plan and the forthcoming Green Paper on Adult Social Care. It was expected that BCF Planning Guidance would be issued at the same time, however the Planning Guidance has been subject to delay.

The BCF Policy Framework confirms that 2019/20 will see minimal change and a focus on continuation with local integration plans for a further year, to align the BCF and iBCF until 31st March 2020. Local areas will be subject to the same National Conditions which have been in place since 2017.

Local Areas are expected to continue to pool grant funding from the iBCF, Winter Pressures funding and the Disabled Facilities Grant to ensure these funding streams are aligned to local aspirations for greater integration across health and social care.

Local Areas will need to submit full planning templates, confirming that the Health and Wellbeing Board has signed them off, in order for the National Conditions to be assured. A further update to Health and Wellbeing Board will be presented once the full planning guidance has been received and the requirements for the 2019/20 Plan are clear.

The NHS Long Term Plan also states that an audit of BCF is to take place during 2019/20 and will inform the future plans for BCF. Whilst 2019/20 will be a year of minimal change, from 1st April 2020 it is expected that there will be a new plan for BCF which reflects the implementation requirements of the NHS Long Term Plan and Green Paper for Adult Social Care – setting clear ambitions for the continued integration of Health and Social Care.

Local Context

During March 2019, a dedicated development session was held with key local stakeholders to reflect learning from 2018/19 and identify how the local BCF programme can be improved in the forthcoming year. A number of recommendations to take forward into 2019/20 were identified, including;

- Evaluate all existing schemes and decommission if appropriate to redirect resources into a smaller number of larger key schemes that have a more direct impact on delivering key priorities, for example bigger enterprise addressing multiple issues with one offer e.g. Intermediate care.
- Schemes will be assessed by their contribution to longer Term Strategic Objectives as set out in key strategies e.g. Commissioning Prospectus, Health and Wellbeing Strategy, market Position Statement.
- Strengthening iBCF Proposals (e.g. identifying clear financial benefits, outcomes and risks)
- Proposal for a maximum 3 -5 year cycle for testing schemes.
- All programmes should have a 'commitment timeframe' whereby it is clear when and how investment will be reviewed.
- Address the challenges of securing sufficient staff resource for new models of care, where funding is fixed term (e.g. explore the creation of transferable posts on a permanent basis).

Key Priorities for 2019/20

Priorities for 2019/20 will focus on preventing avoidable admissions to hospital and further developing community based models of care.

The following initiatives are expected to be key areas of Priority in 2019/20;

- Intermediate care (including all tiers and a particular emphasis on increasing capacity of Intermediate Care at Home).
- Development of a Safe & Well Service (to prevent hospital admission and facilitate discharge).
- Continued development of the Frailty Hub model
- Development of community-based Rapid Response services
- Review of the Stroke pathway
- Continuation of the Carecall Response service
- Establishment of a single, co-located Integrated Hospital Discharge Team
- Reducing Delayed Discharges
- Joint Funded Complex Packages of Care

7. Conclusions

The BCF programme in Warrington has continued to be a catalyst toward improved integrated working across health and social care as the examples show in section 3. The majority of schemes were developed and mobilised as planned in accordance with the ambitions set out within the 2017-2019 BCF Plan.

However, there were also persistent challenges to mobilisation of new schemes, notably, workforce challenges associated with the recruitment and retention of key care worker roles. These challenges also impacted on the stability of the local market.

As a number of schemes were not operational for the full financial year, it is expected that 2019/20 will offer a greater opportunity to evaluate the impact of the schemes.

A further update to Health and Wellbeing Board will be presented once the full planning guidance for the 2019/20 year has been received and the local plan for Warrington has been produced.

Warrington
Health & Wellbeing Board

30 May 2019

1.30 pm, Council Chamber, Town Hall, Warrington

Report Title	**Joint Strategic Needs Assessment (JSNA) Workplan and 2019 Core Document**
Agenda Section	☐ A. Standard Items and Governance Matters ☐ B. Promoting Integration ☐ C. Development and Delivery of Health and Wellbeing Strategy ☒ D. Oversight of Important Strategies and Reports ☐ E. Information and Context ☐ F. Concluding Business
Type of Decision Required	☐ Formal Decision as to a Statutory Function ☐ Non-Statutory Advice, Guidance or Recommendation to Other Body ☒ Note or Endorse a Report or Action by Others
Report Purpose	To provide the Health and Wellbeing Board with an overview of the JSNA work programme during 2018/19, and proposed priorities for 2019/20. To present the refreshed JSNA Core Document. To outline monitoring arrangements for Health and Wellbeing Strategy 2019-2023
Report author	Tracy Flute Acting Principal in Public Health Warrington Borough Council On behalf of Dr Muna Abdel Aziz Director of Public Health Warrington Borough Council

Confidential or Exempt	This report is not considered to contain information which is confidential or exempt.
Recommendations	For the H&WBB to: Review and acknowledge the work undertaken during 2018/19 Review the core document and provide any comment Approve the 2019/20 JSNA work programme Review and agree the proposed monitoring arrangements for the Health and Wellbeing Strategy 2019-23

1. Report purpose

To provide the Health and Wellbeing Board with an overview of the JSNA work programme during 2018/19, and proposed priorities for 2019/20.

To present the refreshed JSNA Core Document.

To outline monitoring arrangements for Health and Wellbeing Strategy 2019-2023.

2. Introduction/background

In 2018 Health and Wellbeing Board agreed that the JSNA Steering Group would lead on the refresh of the Health and Wellbeing Strategy. The JSNA Steering Group Terms of Reference were updated to reflect that, in addition to producing the strategy document, the group have responsibility for overseeing monitoring of the strategy and provide regular updates to Health and Wellbeing Board.

3. JSNA Work Programme 2018/19

Work to refresh the Health and Wellbeing Strategy comprised a substantial component of the JSNA workplan for 2018/19. In addition, a number of further products were finalised, these include some individual topic specific chapters and the annual JSNA 'Core' document.

Chapters were completed on General Demographics, Worklessness, Children in Care, and Adult Safeguarding. Additional deep-dive chapters on Autism, and Alcohol Harm are in the final stages of completion.

The Core document (Appendix 1) provides a wealth of statistical information across all of the JSNA domains. Information is presented as a one or two page summary by topic area giving a succinct overview of recent trends on a range of indicators related to health and wellbeing.

During development of the Health and Wellbeing Strategy it was agreed that in terms of monitoring performance quantitatively, the focus should be on outcomes rather than outputs. In view of this, the JSNA Core document has been updated this year to include a summary page which provides an 'at a glance' overview of the 20 indicators agreed in the Health and Wellbeing Strategy.

4. JSNA Work Programme for 2019/20

As in previous years, the JSNA Steering Group undertook a prioritisation exercise at the start of the year to identify the 'deep dive' chapters to be developed during 2019. The chapters prioritised are:

- CYP Neglect
- Frailty
- Gambling
- Cancer

Work is underway to fully scope these chapters and establish multi-agency task and finish groups to progress the necessary work. On-going work to agree the timescale and process for updating further chapters in the Children and Young People domain is in progress. Leads are keen to ensure that the agreed work programme meets requirements of external inspection.

5. Monitoring the delivery of the strategy

Health and Wellbeing Board agreed that reporting on delivery of the Health and Wellbeing Strategy should be linked to existing mechanisms and governance/oversight structures, and as streamlined and simplified as possible. The final section of the strategy sets out the priorities by thematic area, and identifies the strategic delivery mechanisms. It is proposed that the covering paper for Health and Wellbeing Board reports is amended to include the reference to the relevant Health and Wellbeing Strategy priority, so that members can readily relate action to priority.

Board agreed that receiving a report on one thematic area per meeting would, over the year, provide the necessary high-level overview of delivery, progress and accountability. Appendix 2 provides an overview of the proposed annual schedule, and the outline template that Thematic Leads will use to gather the information for update on their area.

The JSNA Steering Group will oversee this reporting. With support from WBC Business Intelligence team, CCG and Commissioning Support Unit (as relevant), JSNA Thematic Leads will produce update reports for Board.

5. Conclusion

The JSNA is a mandatory requirement and provides valuable evidence and intelligence to support strategic decision making. The intelligence produced through the JSNA

programme informs the development of the Health and Wellbeing Strategy. It has, therefore been a logical step to include strategy development and oversight within the responsibilities of the JSNA Steering Group. The expansion of the annual JSNA Core Document ensures robust high-level reporting of the Strategy key indicators.

6. Recommendations

For Health and Wellbeing Board to review and acknowledge the work undertaken as part of the JSNA Programme during 2018/19.

For Board to review the core document and provide any comment.

For Health and Wellbeing Board to approve the 2019/20 JSNA work programme.

For Health and Wellbeing Board to review and agree the proposed schedule for monitoring the Health and Wellbeing Strategy 2019-23.

6. Background Papers

Appendix 1: JSNA Core Document 2019
Appendix 2: Health and Wellbeing Strategy thematic update reporting overview

Contacts for Background Papers:

Name	E-mail	Telephone

APPENDIX 1

WARRINGTON 2019

Joint Strategic Needs Assessment

Core Document

&

Statistical Supplement to the

Public Health Annual Report

WARRINGTON
Borough Council

Introduction and Contents

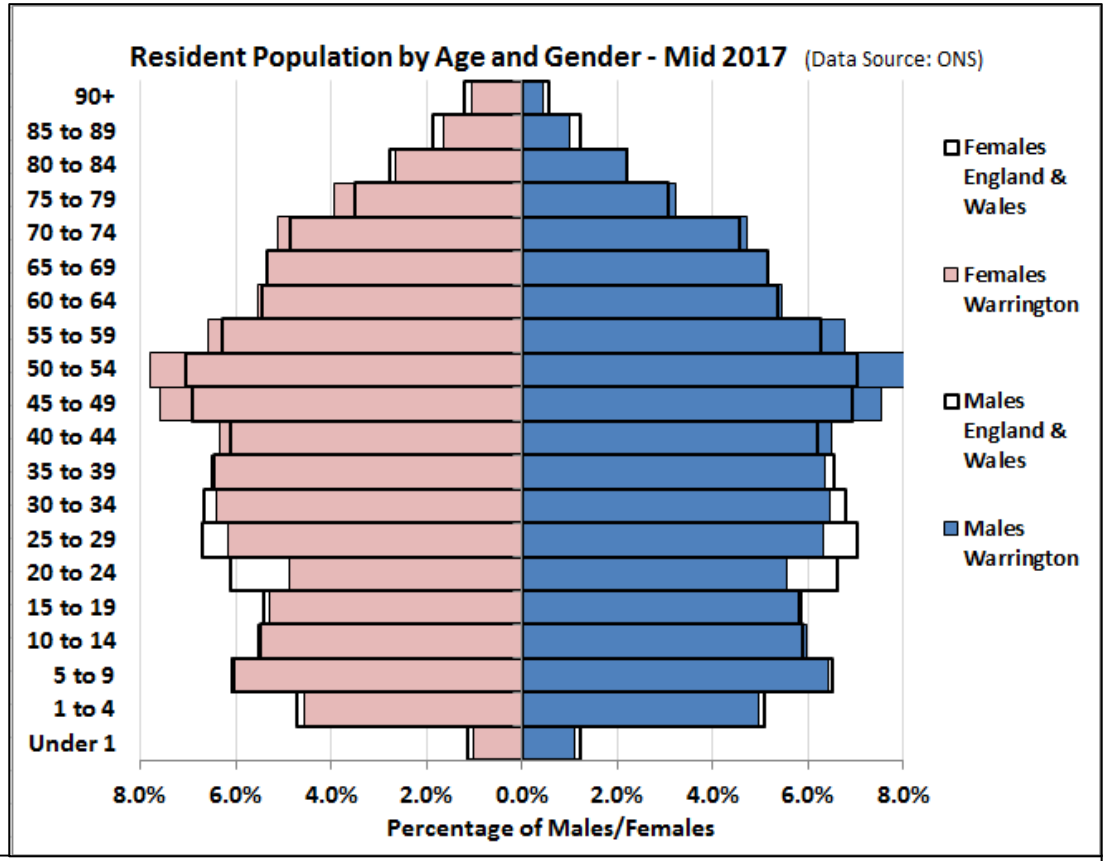
This document is a supplement to the Warrington 2019 Public Health Annual Report.
It is also the 2019 update of the core document of the Warrington Joint Strategic Needs Assessment (JSNA).

It contains a number of summary factsheets which present information on a range of health and wellbeing indicators. In the main, data included in this document is nationally available and can be benchmarked against England. This means, however, that there is often more up to date local data available, which, although this cannot be benchmarked, may be useful to help understand more recent trends.

For further information on any of the information included within the document please contact the Public Health Knowledge and Intelligence Team on 01925 443033.

1.1 Demography – Resident Population

mid-2017	Warrington Population			Warrington Population, %		
Age-band	Persons	Males	Females	Persons	Males	Females
Under 1	2200	1200	1100	1.1%	1.1%	1.0%
1-4	10000	5200	4800	4.8%	5.0%	4.6%
5-9	13100	6700	6400	6.3%	6.4%	6.1%
10-14	12100	6200	5900	5.8%	6.0%	5.5%
15-19	11600	6000	5600	5.5%	5.8%	5.3%
20-24	10900	5800	5100	5.2%	5.6%	4.9%
25-29	13100	6600	6500	6.2%	6.3%	6.2%
30-34	13500	6700	6800	6.4%	6.4%	6.4%
35-39	13500	6600	6900	6.4%	6.4%	6.5%
40-44	13500	6800	6700	6.4%	6.5%	6.3%
45-49	15900	7800	8000	7.6%	7.5%	7.6%
50-54	16600	8400	8200	7.9%	8.0%	7.8%
55-59	14000	7000	6900	6.7%	6.8%	6.6%
60-64	11500	5700	5800	5.5%	5.5%	5.5%
65-69	11000	5400	5600	5.3%	5.2%	5.3%
70-74	10300	4900	5400	4.9%	4.7%	5.1%
75-79	7500	3300	4200	3.6%	3.2%	3.9%
80-84	5100	2300	2800	2.4%	2.2%	2.6%
85-89	2800	1000	1700	1.3%	1.0%	1.6%
90+	1600	500	1100	0.8%	0.4%	1.1%
All Ages	209700	104100	105600	100.0%	100.0%	100.0%



Figures rounded to nearest 100 and may not sum exactly due to rounding error. Source: Office for National Statistics. Figures based on mid-2017 population estimates.

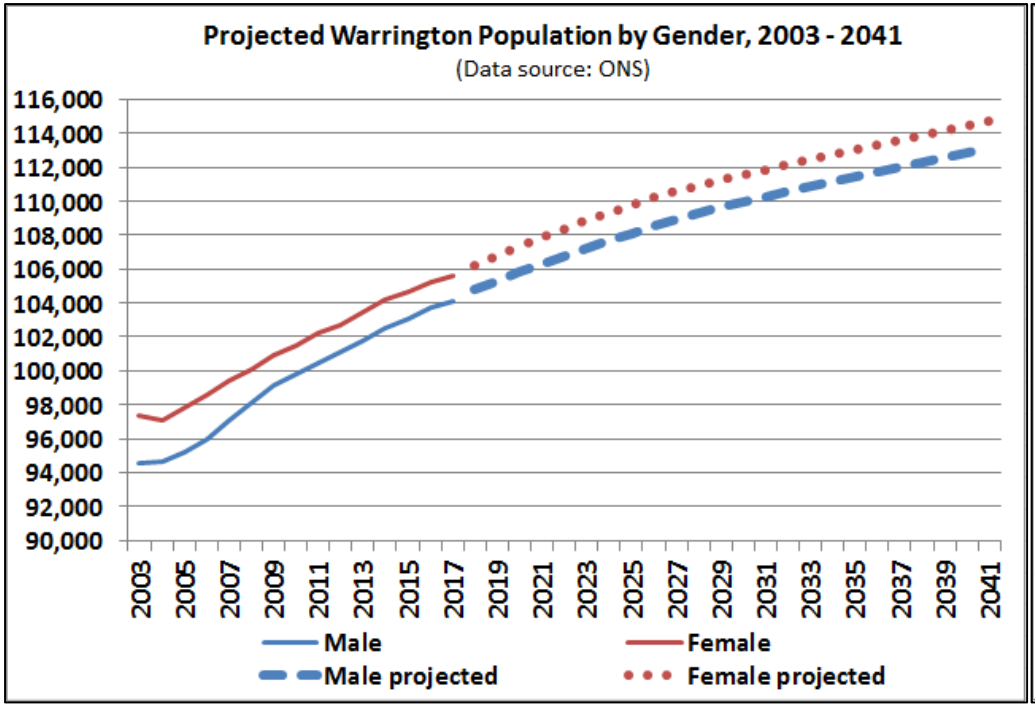
- Warrington's mid-2017 resident population estimate is 209,700 (Office for National Statistics); 49.6% male and 50.4% female.
- 19.0% in Warrington were aged under-16 similar to 19.1% in England and Wales and 19.0% in the North West.
- 62.7% in Warrington were aged 16-64, similar to 62.8% in England and Wales, and 62.5% in the North West.
- 18.3% in Warrington were aged 65 and over, similar to 18.2% in England and Wales, and 18.4% in the North West.
- The chart shows that the main differences in population structure are that Warrington has a much lower proportion of 20-29 year olds, and a higher proportion of 40-59 year olds, compared to England and Wales.
- GP-registered population is different to resident population, and is based on those registered at GP practices. Compared to the mid-2017 resident population, almost 217,300 people were registered at Warrington GP practices in June 2017.

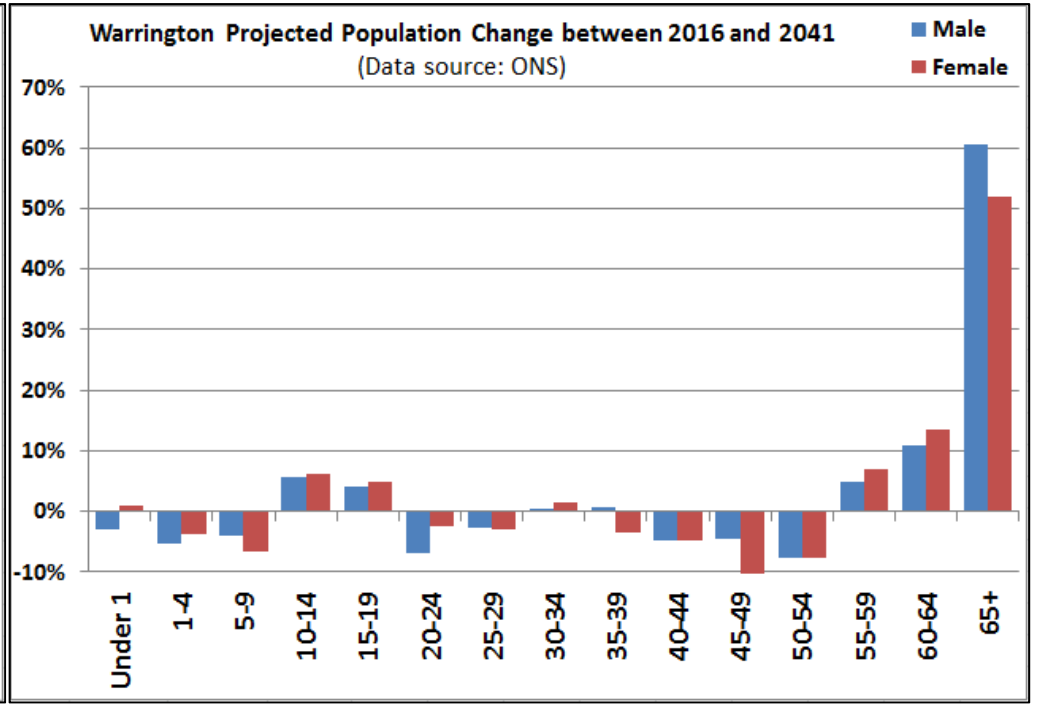
209,700 resident population mid-2017

19.0% aged under-16
62.7% aged 16-64
18.3% aged 65+

(very similar proportions to England & Wales)

1.2 Demography – Projected Population





Warrington's population projected to increase by 9%
(an extra 19,000 people)
between 2016 and 2041

comprising:

- **increase of about 21,000 aged 65+**
- **decrease of about 2,000 under-65s**

Largest proportional increases expected in the older age groups

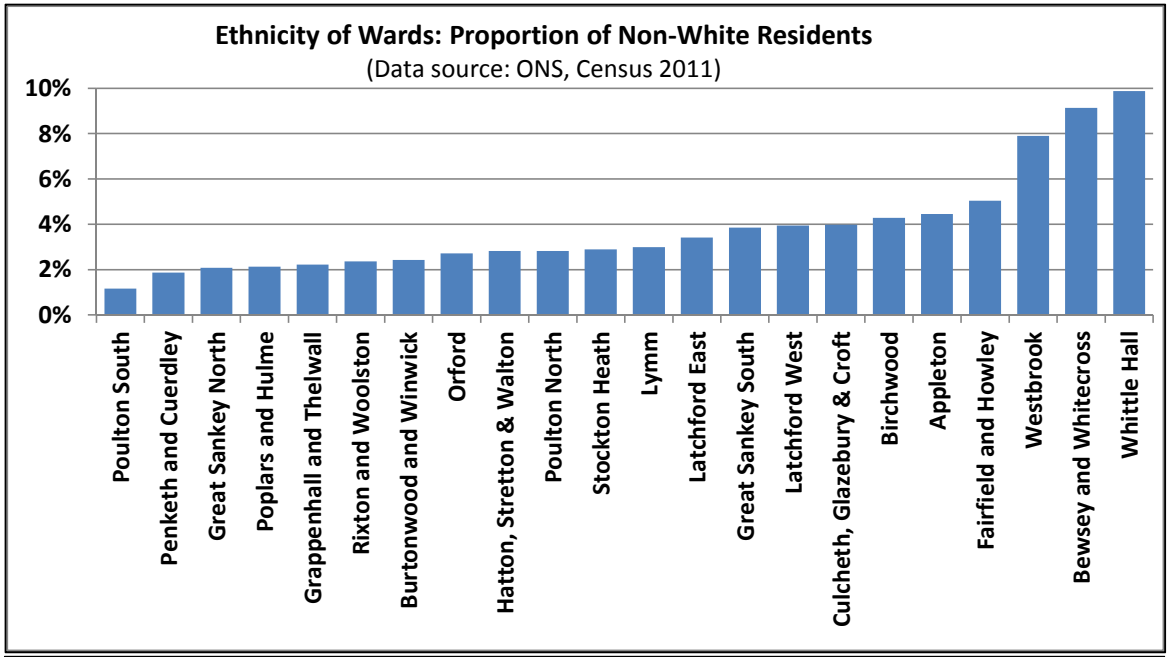
- Warrington's population has increased year on year from 2004 to 2016.
- Future projections (based on 2016 mid-year estimates) show that Warrington's population is estimated to increase over the next 25 years by about an extra 19,050 people (+9%); an extra 9,450 males and 9,600 females.
- Some age-groups are estimated to have a smaller population by 2041; those aged 0-9, 20-29 and 35-54.
- The largest percentage increases are expected in those aged 65 and over; a 56% increase (about 21,000 people).
- In comparison, the number of under-65s is estimated to decrease slightly by about 2,000 people.

See more detail on growth of the older population in the 'Ageing Well' section of this document.

Note: projections are based on recent trends and do not take into account any policy changes that have not yet occurred, nor those that have not yet had an impact on observed trends.

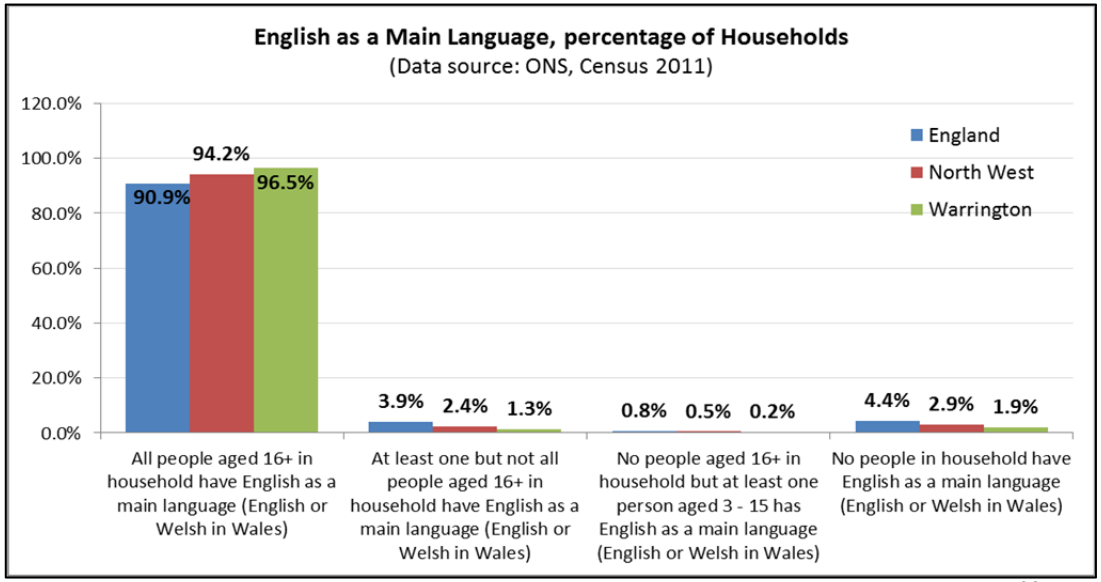
1.3 Demography – Ethnicity

Warrington - Census 2011		
Ethnic Group	**Number**	**%**
White: English / Welsh / Scottish / Northern Irish / British	187,968	92.9
White: Other (incl. Irish, Gypsy/Irish Traveller, Other White)	6,024	3.0
Mixed/multiple ethnic groups	2,144	1.1
Asian/Asian British	4,911	2.4
Black / African / Caribbean / Black British	694	0.3
Other ethnic groups	487	0.2
All usual residents	**202,228**	**100**



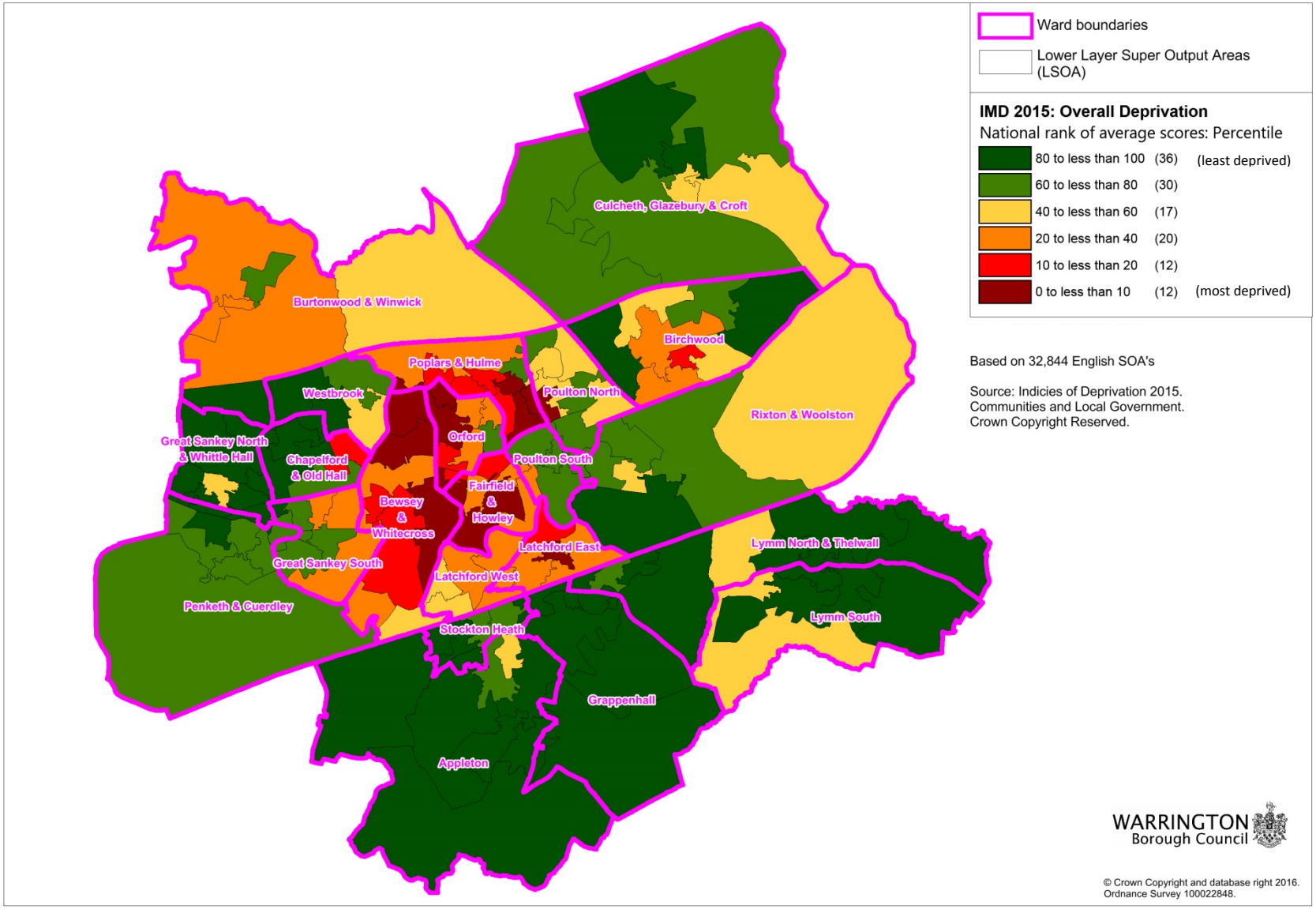
NB: Non-White incorporates the following categories – mixed/multiple ethnic groups; Asian/Asian British; Black/African Caribbean/Black British; other ethnic groups.

- In the latest Census in 2011, 92.9% of Warrington's population classified themselves as White English, Welsh, Scottish, Northern Irish or British.
- Warrington's population is less ethnically diverse than the North West and England. In the 2011 Census, 4.1% were non-white, compared to 14.0% for England and Wales, and 9.8% for the North West.
- Whittle Hall ward has the highest proportion of non-white residents (9.9%) and Poulton South the lowest (1.2%).



- In 96.5% of Warrington households, all residents aged 16 and over have English as a main language, compared to 90.9% in England.
- 1.9% of Warrington households have no people with English as a main language, compared to 4.4% in England.
- At ward level, Bewsey and Whitecross has the highest proportion of households in which no people have English as a main language (7.4%), followed by Fairfield and Howley (5.1%).
- Note: Not having English as a main language does not necessarily mean that someone doesn't speak English.

1.4 Demography – Deprivation



The map shows the spread of deprivation across Warrington. Areas shaded brown and red, together make up Quintile 1, the most deprived quintile (brown areas are the most extremely deprived). Quintile 1 areas tend to be in inner Warrington and the least deprived (quintile 5), shaded green, in outer Warrington.

- Lower Super Output Areas (LSOAs) are small geographical units.
- Deprivation is measured using the Index of Multiple Deprivation (IMD) 2015. For each LSOA, a deprivation score is calculated covering a broad range of issues: income, employment, health and disability, education and skills, housing and services, crime, and living environment.
- All LSOAs in England are ordered by IMD score and then split into 5 equal sized groups (called quintiles). Warrington contains 127 LSOAs; these are grouped according to which national quintile they are in.
- Updated Indices of Deprivation for all LSOAs in England are due to be published in summer 2019.

2.1 Starting Well – Pregnancy and Newborn Screening

Screening during pregnancy

Screening tests are used to find people at higher chance, or risk, of a health problem. This means they can get earlier, potentially more effective treatment or make informed decisions about their health. The screening tests offered during pregnancy in England are either ultrasound scans or blood tests, or a combination of both. Blood tests can show whether a woman has a higher chance of inherited disorders such as sickle cell anaemia and thalassaemia, and whether a woman has infections like HIV, hepatitis B or syphilis (NHS Choices).

Across England during 2017/18 99.6% of pregnant women were screened for HIV and 99.6% of eligible pregnant women were screened for sickle cell anaemia and thalassaemia.

Across England during 2016/17 99.6% of pregnant women were screened for syphilis and 99.6% of pregnant women were screened for hepatitis B.

Public Health England have not published Local Authority data

Newborn Screening

Most babies are healthy and won't have any of the conditions the screening tests are looking for. But for those babies who do have a health problem, the benefits of screening can be enormous. Early treatment can improve their health and prevent severe disability or even death.

Newborn physical examination

Every baby is offered a thorough physical examination soon after birth to check their eyes, heart, hips and, in boys, the testicles (testes). This is to identify babies who may have conditions that need further testing or treatment.

Across England during 2017/18 95.4% of babies received their examination within 72 hours of birth.

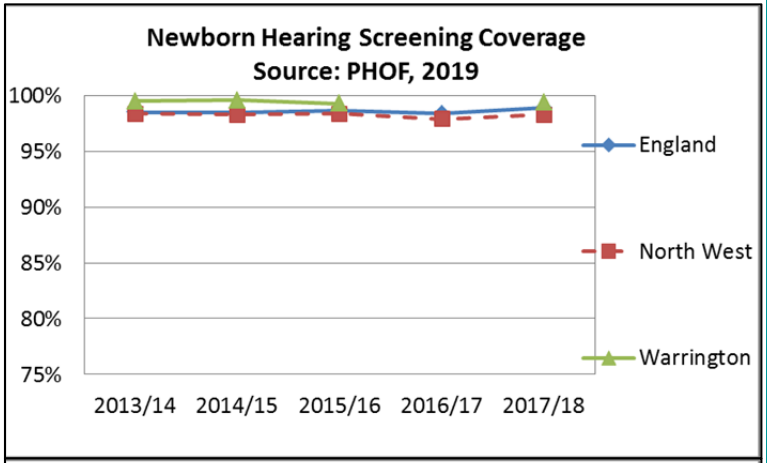
Newborn hearing screening test

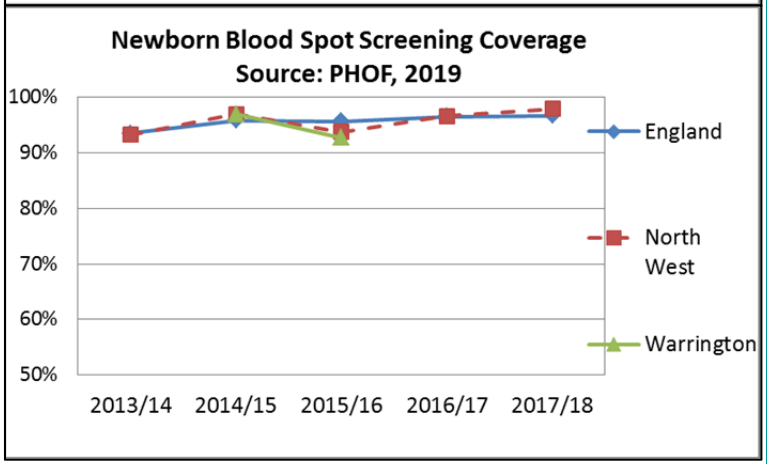
The newborn hearing screening test helps identify babies who have permanent hearing loss as early as possible. Performance in Warrington is higher than England and the North West (2017/18).

Newborn blood spot (heel prick) test

The newborn blood spot test involves taking a small sample of your baby's blood to screen it for nine rare but serious health conditions. Performance in Warrington dipped below England and the North West during 2015/16, although 93% babies were screened.

Data for Warrington is not available for 2016/17 or for 2017/18.





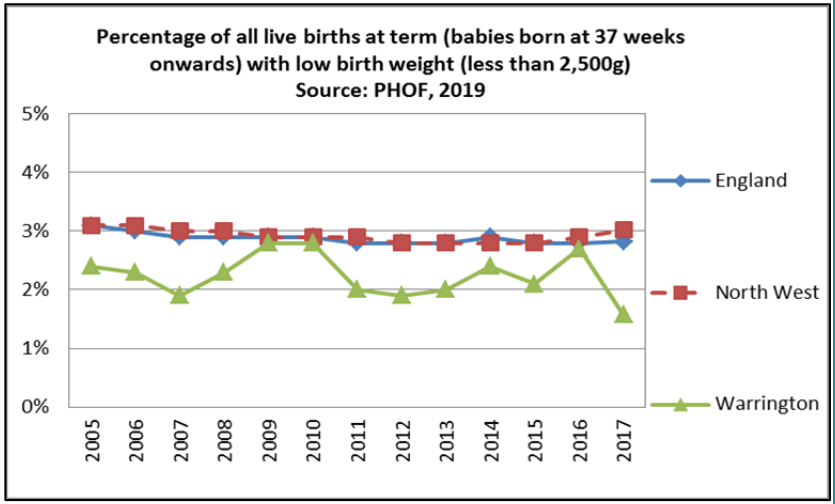
2.2 Starting Well – Low Birth Weight Babies and Smoking at Time of Delivery

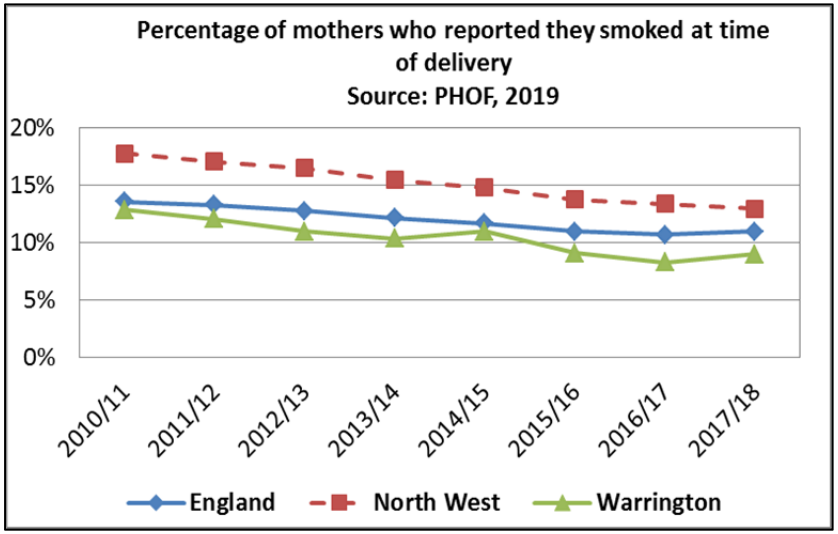
Definition: *live births with a recorded birth weight under 2500g and a gestational age of at least 37 complete weeks.*

Low birth weight increases the risk of childhood mortality and of developmental problems for the child, and is associated with poorer health in later life. At a population level there are inequalities in low birth weight and a high proportion of low birth weight births could indicate lifestyle issues of the mothers and/or issues with the maternity services.

Low Birth Weight (LBW) Babies

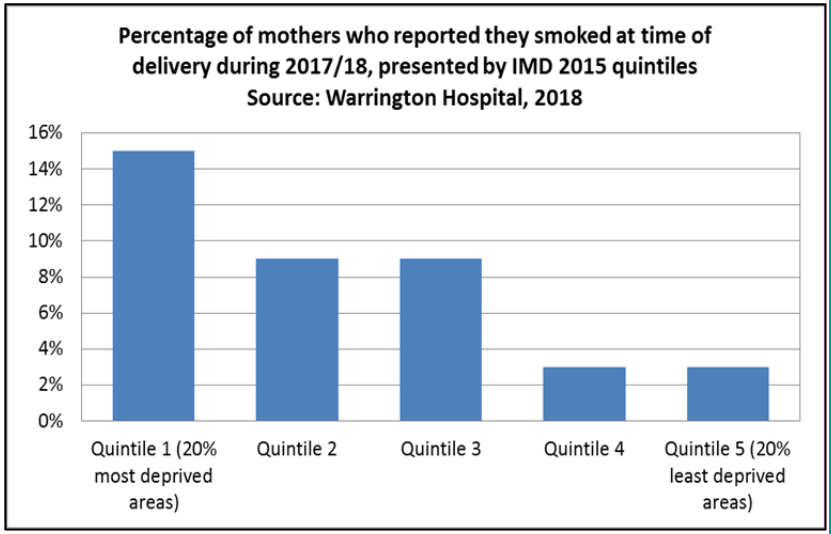
- There were approximately 2,143 births during 2017 in Warrington. Trends show a slight reduction in the number of births each year.
- 1.6% of live births at term were classed as LBW in Warrington in 2017, significantly lower than England and the North West.
- The number and proportion of LBW births has remained fairly stable in Warrington ranging between 31 and 65 babies each year.





Definition of Smoking at Time of Delivery (SATOD): *Women who are regular/ occasional smokers at time of delivery.*

Smoking in pregnancy has well known detrimental effects for the growth and development of the baby and health of the mother. On average, smokers have more complications during pregnancy and labour.



Smoking status at time of delivery

- During 2017/18 in Warrington, 178 women (8.8%) who gave birth said that they smoked at time of delivery (SATOD). This was significantly better than both England and the North West.
- There has been a downward trend in England, the North West and Warrington. Warrington had slight rises in 2014/15 and 2017/18.
- The percentage of mothers SATOD living in the 20% most deprived areas of Warrington (15%) is significantly higher than quintiles 4 and 5, the least deprived areas of Warrington, both of these areas with just 3% of mothers SATOD.

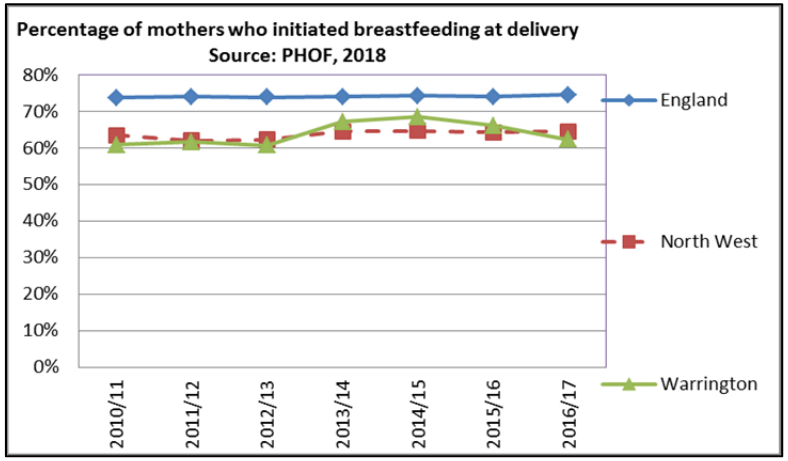
2.3 Starting Well – Breastfeeding Initiation and Continuation at 6 to 8 Weeks

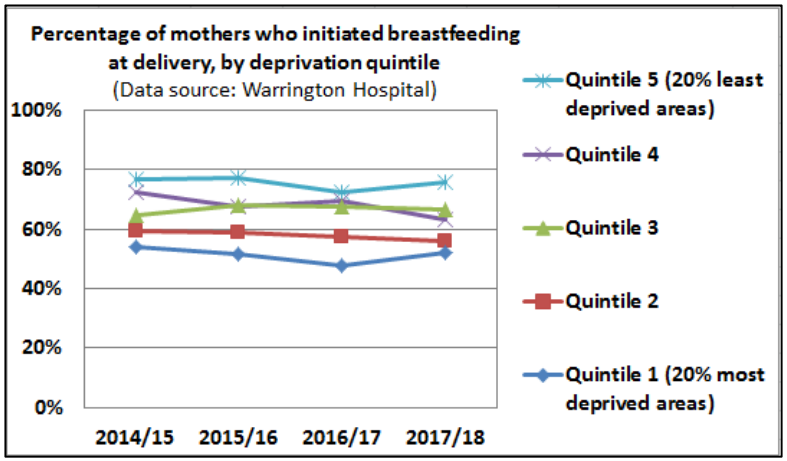
Breastfeeding initiation: i.e. breastfeeding from birth

- Breastfeeding initiation has been consistently and significantly lower in Warrington than in England.
- In Warrington it increased significantly from 61% in 2012/13 to 67% in 2013/14, and increased further to 68.5% in 2014/15. However, this has not been sustained, and in 2016/17, it reduced to 62%, similar to 2012/13.
- Breastfeeding initiation is significantly lower in the 20% most deprived areas of Warrington; in 2017/18 it was 52% in the most deprived areas compared to 76% in the least deprived areas.

Breastfeeding continuation at 6 to 8 weeks

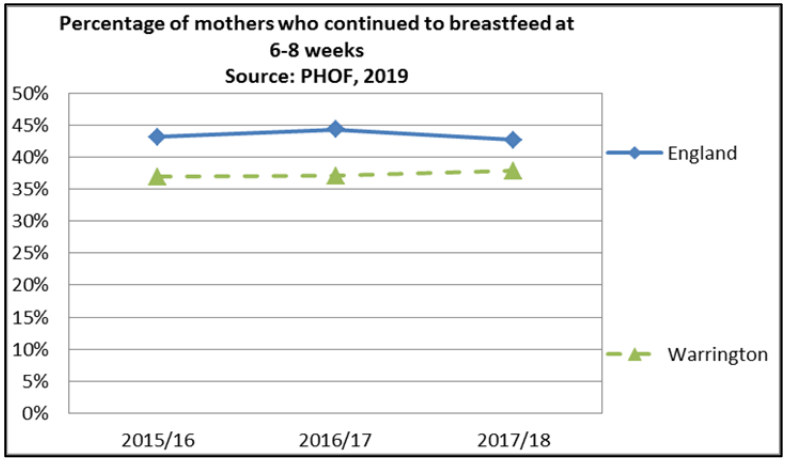
- As with initiation, breastfeeding continuation in Warrington has been significantly lower than England in recent years.
- During 2015/16 a new collection method for breastfeeding continuation was introduced by Public Health England.
- In 2017/18, 37.9% of mothers in Warrington continued to breastfeed at 6 to 8 weeks, very similar to 2016/17. This is significantly lower than England.
- In 2017/18, only 29% of mothers from the 20% most deprived areas and 32% from quintile 2 continued to breastfeed, compared to 54% in the least deprived areas.

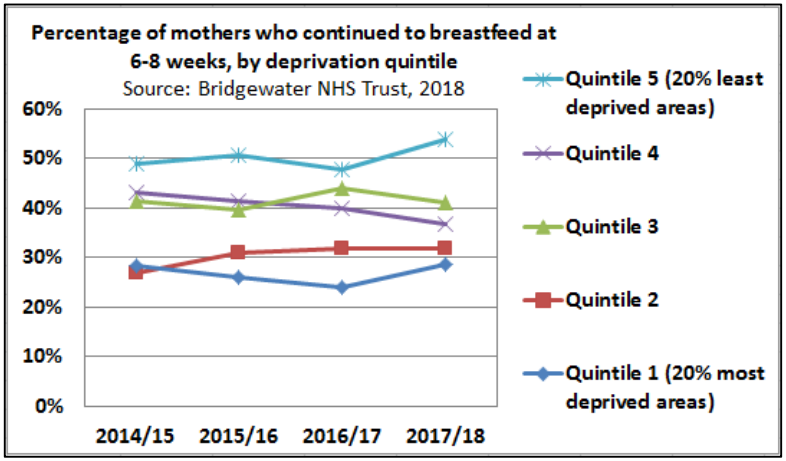




Benefits of Breastfeeding:

Breast milk provides ideal nutrition for infants in the first stages of life. There is evidence that breast-fed babies experience lower levels of gastro-intestinal and respiratory infections. Breastfeeding is also associated with lower levels of child obesity. Some of the benefits to the mother include a faster return to pre-pregnancy weight and possibly lower risk of breast and ovarian cancer.



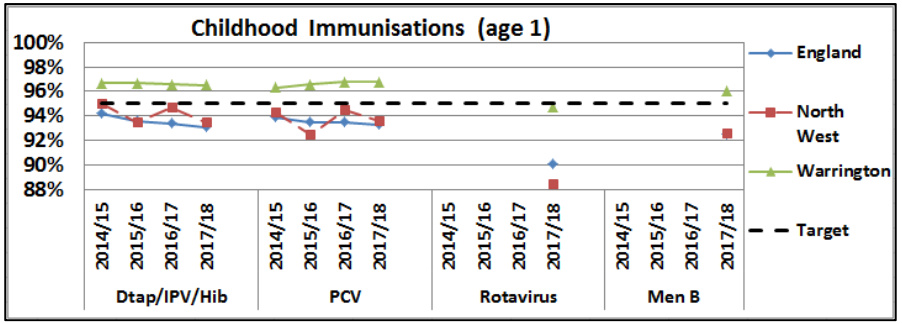


2.4 Starting Well – Childhood Vaccinations and Immunisations

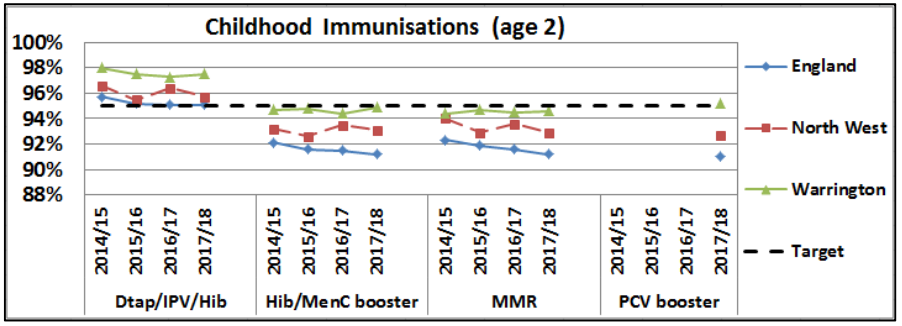
Courses of Immunisation:

- The combined **DTaP/IPV/Hib** is the first in a course of vaccines offered to babies to protect them against diphtheria, whooping cough, tetanus, Haemophilus influenza type B (an important cause of childhood meningitis and pneumonia) and polio.
- **MMR** is the combined vaccine that protects against measles, mumps and rubella.
- The meningococcal C conjugate (**MenC**) vaccine protects against infection by meningococcal group C bacteria, which can cause meningitis and septicaemia.
- The **PCV** vaccine protects against pneumococcal infections that can cause pneumonia, septicaemia or meningitis.
- The **influenza** vaccine is offered to all children aged 2-3 at their GP practice. The programme was extended in 2017/18, with vaccination in schools for children in Reception class and school years 1-4. It will be further extended to all primary school children (i.e. aged 4-11). It is hoped that this extension of the programme to healthy children will reduce transmission of flu to at-risk and elderly patients.
- **Rotavirus** is the most common cause of gastroenteritis among children.
- The **MenB** vaccine protects against infection by meningococcal group B bacteria, which can cause meningitis and sepsis (blood poisoning), and which are responsible for more than 90% of meningococcal infections in young children.

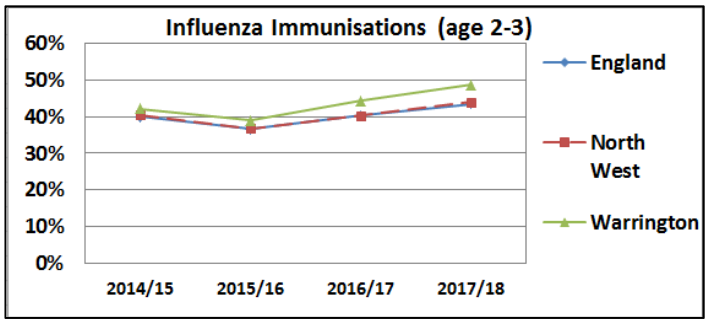
Childhood Immunisations (age 1): The national target for the 4 immunisations in the chart is 95%, which Warrington consistently exceeds, apart from rotavirus (94.7%). Warrington is also consistently higher than England and the North West for all 4 immunisations. In 2017/18, the Warrington rates were: Dtap/IPV/Hib 96.5%, PCV 96.8%, Rotavirus 94.7%, and MenB 96.0%.



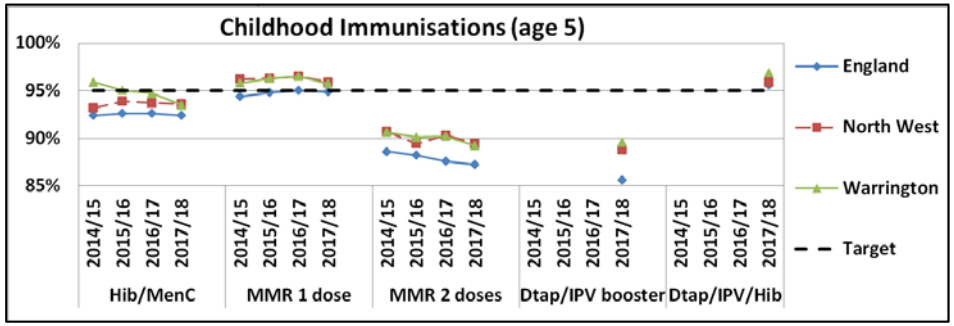
Childhood Immunisations (age 2): The national target for the 4 immunisations in the chart is 95%. Warrington is consistently well above England and the North West for all four. In 2017/18, Warrington exceeded the target for DTaP/IPV/Hib (97.5%) and the PCV booster (95.2%), but was just below the target for the Hib/Men C booster (94.9%) and MMR (94.6%).



Influenza Immunisations (age 2-3): There was not a national target as such, but 40%-65% was considered acceptable in the years 2014/15 to 2017/18. The rate in Warrington in 2017/18 was 48.7%, higher than 44.0% in England and 43.5% in the North West. 4-year-olds are now vaccinated at school instead of at their GP, and the vaccination program has been extended from 2018/19 to include older children at primary school (aged 4-11). The vaccination programme takes place at school.

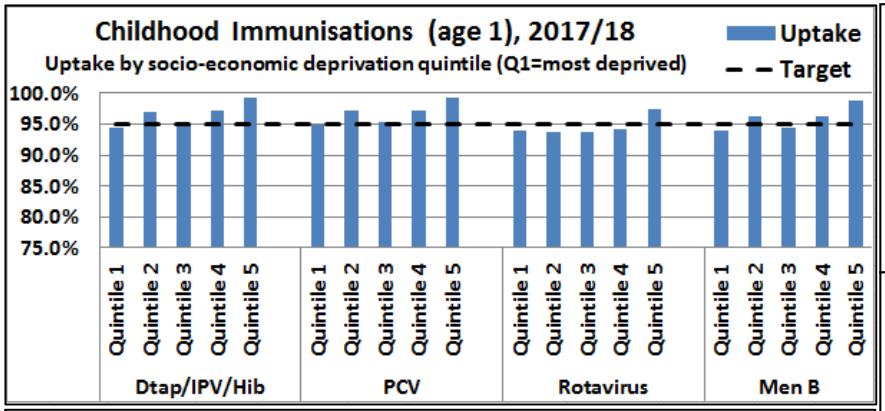


Childhood Immunisations (age 5): Warrington generally has higher rates than England, and similar to the North West, for all immunisations in the chart. In 2017/18, Warrington met the target for 1 dose for MMR (95.7%) and for Dtap/IVP/Hib (96.9%), but not for Hib/Menc (93.5%), 2 doses for MMR (89.2%), Dtap/IPV booster (89.6%).

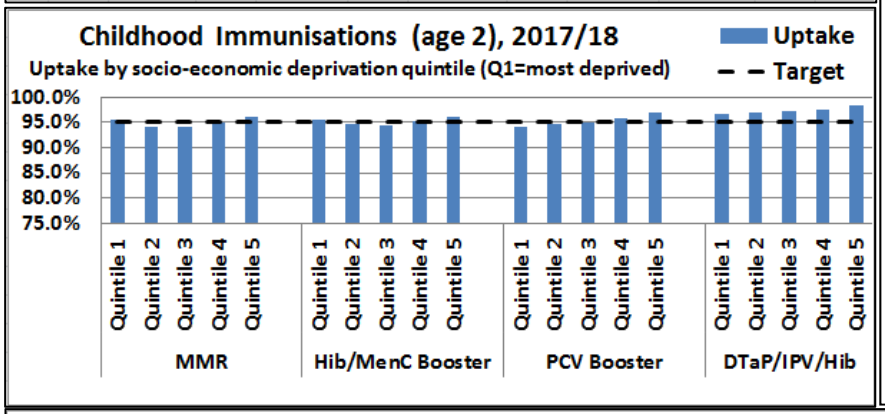


2.4 Starting Well – Childhood Vaccinations and Immunisations

Childhood vaccination uptake by GP Practice Deprivation Quintile. GP practices are grouped by the level of socio-economic deprivation of the areas in which their patients live. Quintile 1 (Q1) contains the most deprived; Quintile 5 (Q5) the least. Generally, immunisation rates are higher in less deprived areas.

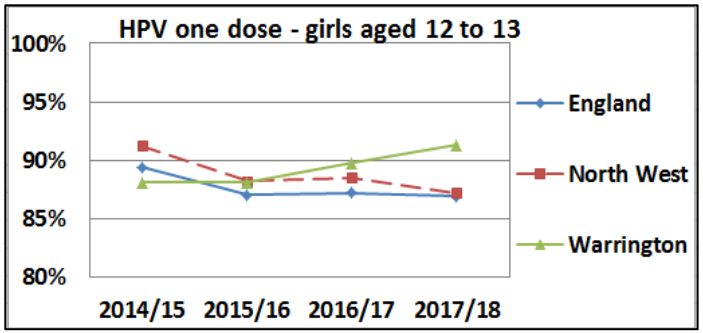


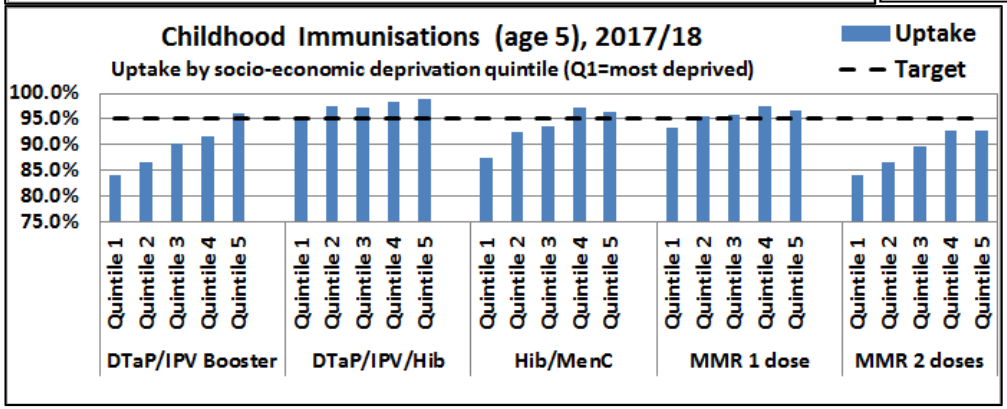
Age 1: The 95% target was met for Dtap/IPV/Hib, PCV and MenB across all deprivation quintiles, except Dtap/IPV/Hib in Q1 (94%), and Meningitis B in Q1 and Q3 (94%). Only Q5 met the 95% target for Rotavirus.



Age 2: Q2 and Q3 didn't meet the 95% target for MMR or the Hib/MenC booster. Only Q4 and Q5 met the target for the PCV booster. All quintiles exceeded the 95% target for Dtap/IPV/Hib. Uptake of the PCV booster and of Dtap/IPV/Hib was lowest in Q1 and steadily increased as deprivation reduced. The MMR and Hib/MenC booster did not fit the usual pattern; uptake in the most deprived quintile was almost as high as in the least deprived.

HPV one dose (girls aged 12 to 13 years):
The HPV (human papilloma virus) vaccine protects against the two high-risk HPV types (16 and 18) that cause over 70% of cervical cancers. There is no national target, although the national goal is 90%. The immunisation rate in Warrington is similar to England (the percentage of girls receiving one dose). The immunisation rate has steadily increased in Warrington from 88.1% in 2015/16 to 93.1% in 2017/18, and is higher than both England (86.9%) and the North West (87.2%).

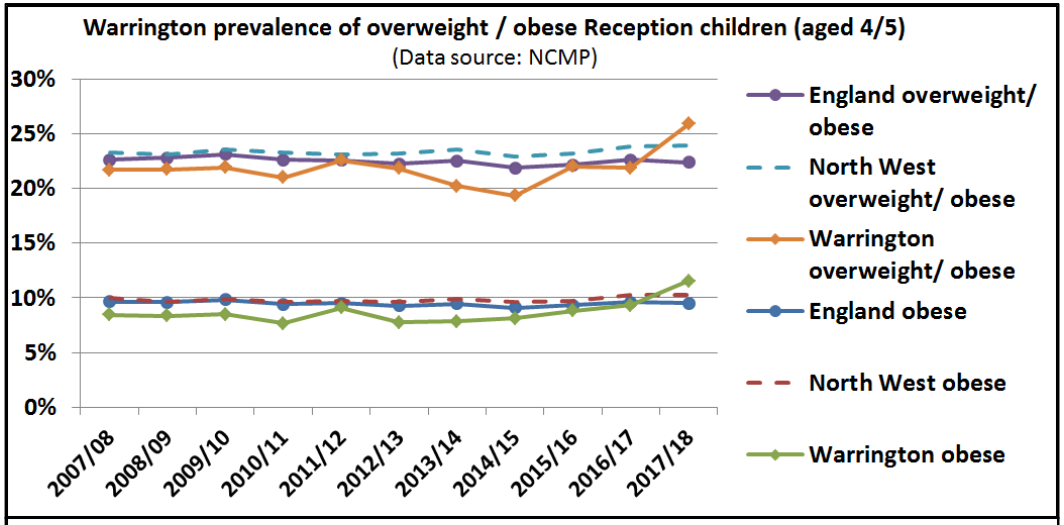


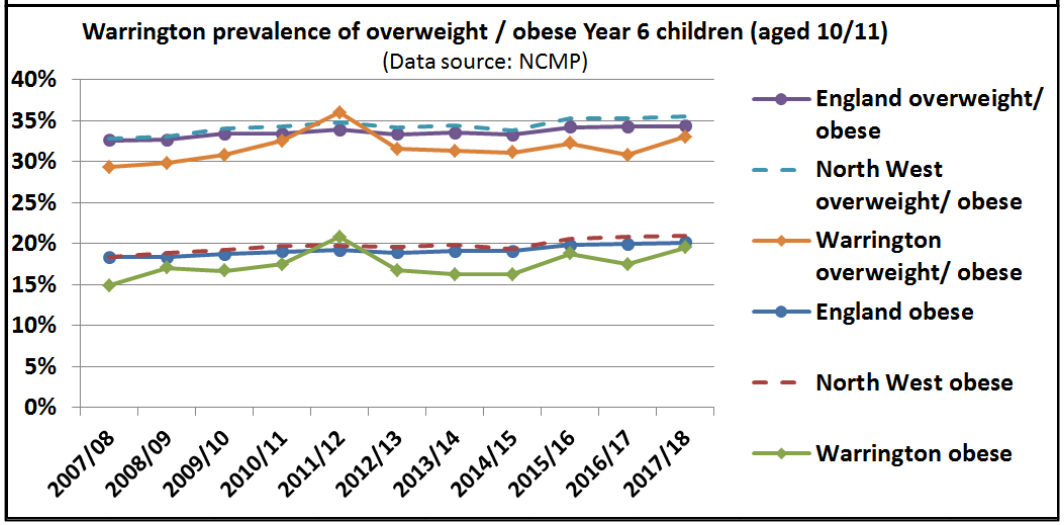


Age 5:
For all immunisations at age 5, there is a very strong relationship with deprivation, with lowest uptake in the most deprived quintile.

- Only Quintile 5 reached the target for DTaP/IPV booster.
- Quintiles 2-5 hit the target for Dtap/IPV/Hib, and Quintile 1 almost did (94.7%).
- Only Quintile 4 and Quintile 5 reached the target for Hib/MenC.
- Only Quintile 1 didn't reach the target for 1 dose of MMR.
- No quintile reached the 95% target for 2 doses of MMR.

2.5 Starting Well – Childhood Obesity





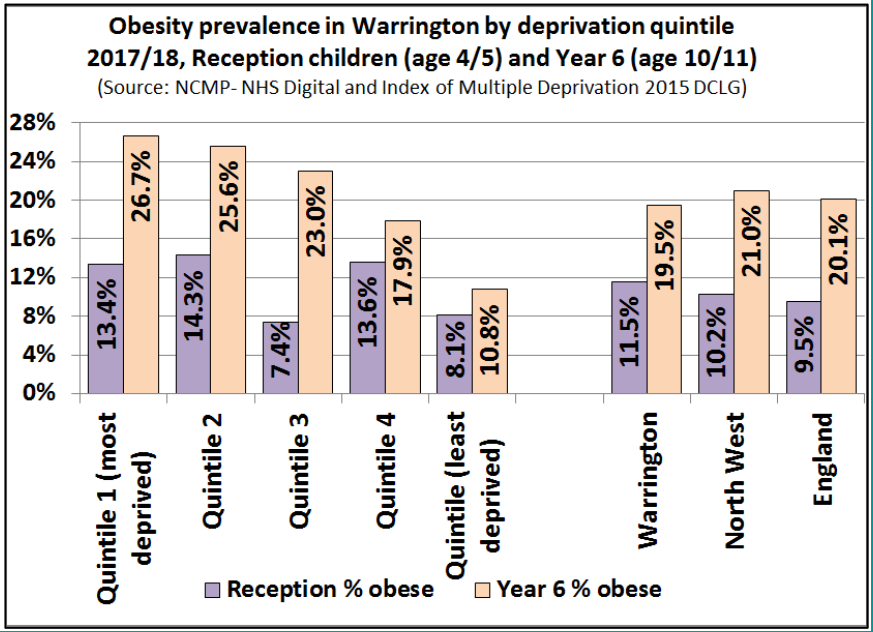
Reception (aged 4/5): In Warrington, prevalence of obesity and of overweight/obesity have generally been lower than England and the North West, but there was a sudden rise in 2017/18, when the overweight/obesity rate rose to 25.9%, significantly higher than 22.4% in England and 23.9% in the North West. Obesity prevalence rose to 11.5%, significantly higher than 9.5% in England and higher than 10.2% in the North West.

Year 6 (aged 10/11): In Warrington, prevalence of obesity and of overweight/obesity have generally been lower than England and the North West. This is still the case, despite a sudden rise in Warrington in 2017/18, when the Warrington overweight/obesity rate rose from 30.8% to 33.0%, (still lower than 34.3% in England and 35.5% in the North West). Obesity prevalence rose from 17.5% to 19.5%, (still lower than 20.1% in England and 21.0% in the North West).

Warrington 2017/18

Reception: almost 1 in 9 obese

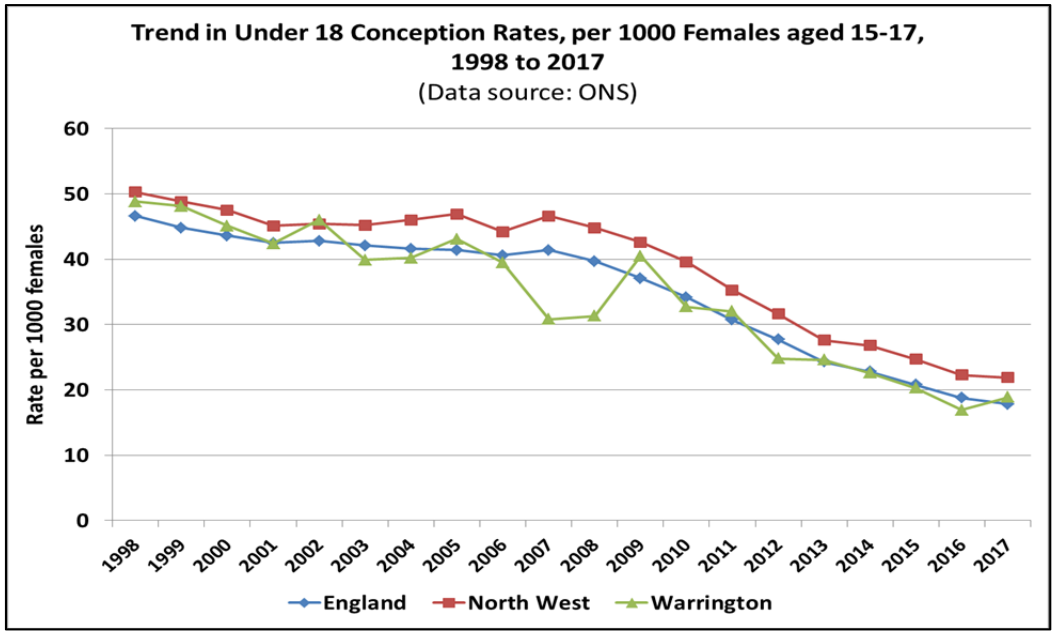
Year 6: 1 in 5 obese



Obesity prevalence by socio-economic deprivation:

- Prevalence estimates vary a lot from year to year, but there is a clear link with deprivation.
- In Year 6, obesity prevalence is highest (26.7%) in Quintile 1 (most deprived) and gradually reduces by quintile to 10.8% in Quintile 5 (least deprived).
- In Reception there is not such an obvious pattern; obesity prevalence is similar in Q1, Q2 and Q4 (13%-14%), which have much higher prevalence than Q3 and Q5 (7%-8%).

2.6 Starting Well – Risky Behaviours - Teenage Conceptions

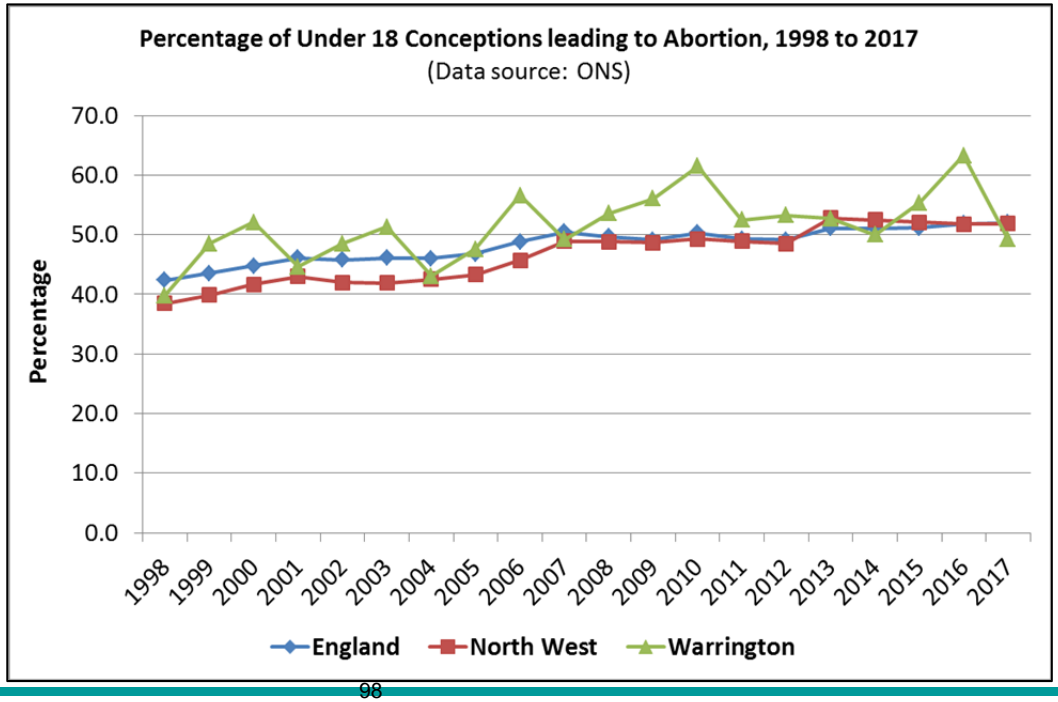


Teenage conceptions:

- There were 65 under-18 conceptions in Warrington during 2017. Whilst this is a slight increase on the previous year (60), it still reflects considerable progress in the long term; in 1998 when this indicator was first introduced, the number of conceptions was approximately 2.5 times higher than in 2017.
- In 2017, the under-18 conception rate for Warrington was 18.9 conceptions per 1,000 girls aged 15-17, compared to 17.8 in England and 21.9 in the North West.
- Rates have been reducing in recent years in Warrington, the North West and England. The fluctuations seen in Warrington's rate reflect the small number of conceptions that the rates per 1,000 are based on.
- Although trends show a reduction in Warrington overall, in the most deprived areas, rates are still significantly higher than the rest of Warrington.

Teenage conceptions leading to termination:

- There has been an increasing trend, since the late 1990s, in the percentage of under-18 conceptions that lead to a termination; this is true locally, regionally and nationally.
- Because numbers of teenage conceptions are usually quite small in Warrington, the percentage leading to a termination is prone to wide fluctuation from year to year, as can be seen in the chart. In Warrington, the percentage leading to a termination fell from 63.3% in 2016 to 49.2% in 2017, although this big drop may be due to the natural variation in the data.
- England and North West rates have remained at a similar level to previous years.



In 2017:

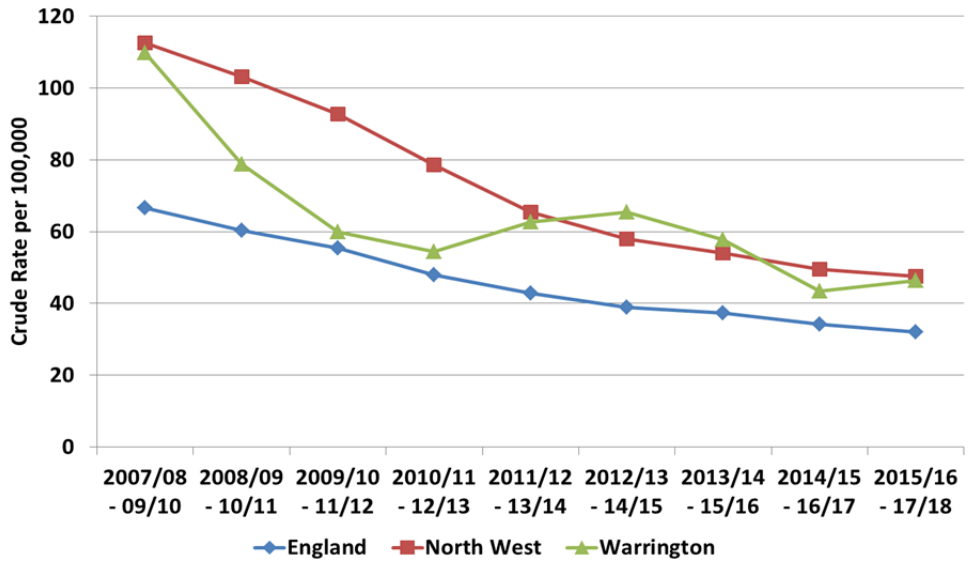
Numbers of teenage conceptions are some of the lowest seen in 19 years

18.9 conceptions per 1,000 girls aged 15-17

A reduction in the percentage of under-18 conceptions leading to termination

2.7 Starting Well – Risky Behaviours - Alcohol and Substance Misuse

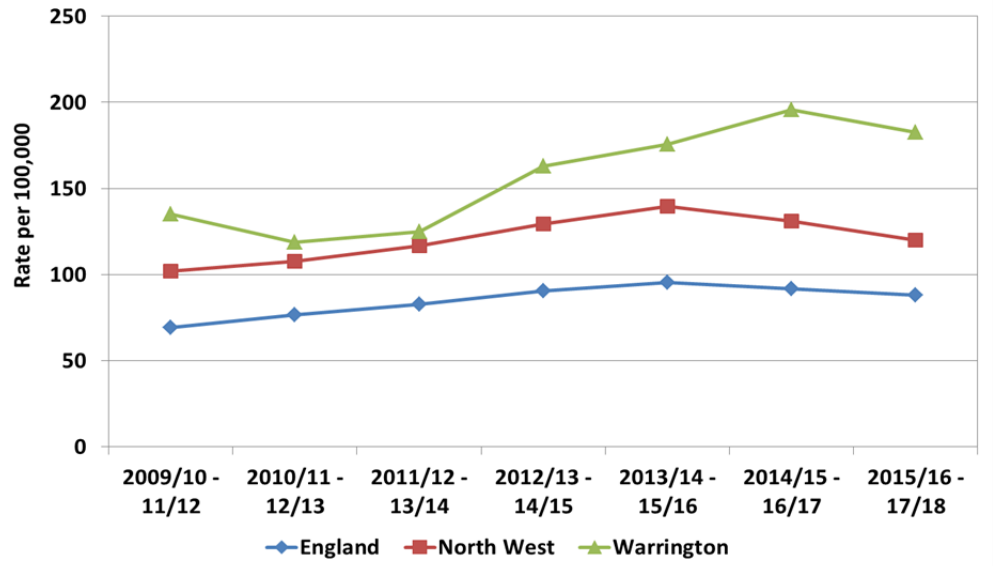
Admission episodes for alcohol-specific conditions - under 18s, crude rate per 100,000: 2007/08 - 09/10 to 2015/16 - 17/18
(Data source: Local Alcohol Profiles, PHE)



Hospital admission episodes due to alcohol in those aged under 18:

- For the most recent data period, 2015/16 to 2017/18, there were 62 admissions to hospital due to alcohol-specific conditions for those aged under 18.
- The Warrington rate was 46.4 per 100,000 population aged under 18, significantly higher than England (32.9).
- The current Warrington rate (and number of admissions) is one of the lowest seen in recent years although there has been a small increase since the last reporting period.
- The overall trend for Warrington shows a reduction although there have been some fluctuations in the rates. Numbers of admissions are small, and small changes in numbers can have a substantial impact on the rates.

Hospital Admissions due to Substance Misuse (15-24 years), Rate per 100,000: 2009/10 - 11/12 to 2015/16 - 17/18
(Data source: Child Health Profiles, PHE)



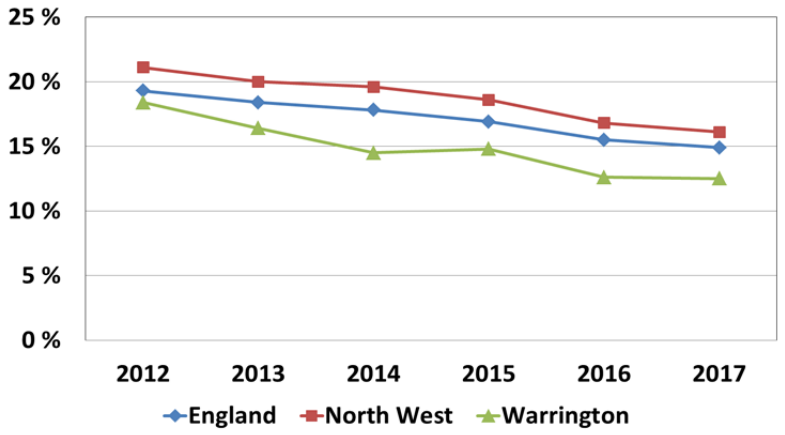
Hospital admissions due to substance misuse in 15-24 year-olds:

- There were 123 hospital admissions due to substance misuse during the most recent 3-year period (2015/16 to 2017/18).
- Between 2015/16 and 2017/18, Warrington had a rate of 182.6 per 100,000 population aged 15-24; this was significantly higher than England's rate of 87.9.
- Warrington has seen an increasing trend since 2010/11 to 2012/13, although in this last reporting period the admission rate has reduced.

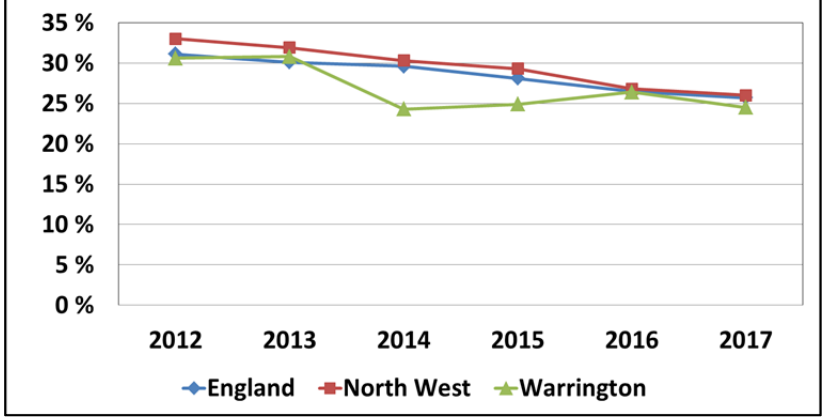
3.1 Living and Working Well, Lifestyle Risk Factors – Smoking

NB The most recent data available for Warrington is for 2017, and there is no up-to-date data at a sub-Warrington level.

Smoking Prevalence, Current Smokers age 18 and over
(Data source: APS/Local Tobacco Control Profiles, PHE)



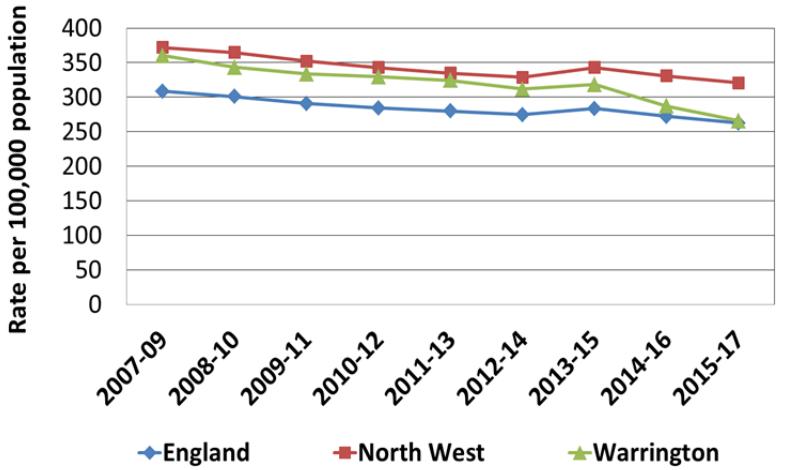
Smoking Prevalence in Adults in Routine & Manual Occupations, Current Smokers aged 18 - 64
(Data source: APS/Local Tobacco Control Profiles, PHE)



Smoking prevalence (the % of people who smoke) (Data source: Public Health England)

- In 2017, prevalence in Warrington was 12.5%, lower than 14.9% in England. Warrington has consistently had lower prevalence rates than England; in 2016 and 2017, the difference between Warrington & England was statistically significant.
- Prevalence is higher in the routine and manual occupation group; 24.5% in Warrington, 25.7% in England and 26.0% in the North West. Prevalence has reduced in Warrington since 2016, following 2 years of increases. Warrington is not statistically significantly lower than England.

Smoking Attributable Mortality, DSR per 100,000
(Data source: Local Tobacco Control Profiles, PHE)



Smoking attributable mortality: (deaths wholly or partially related to smoking – smoking is a contributory factor to deaths from a diverse range of diseases and conditions).

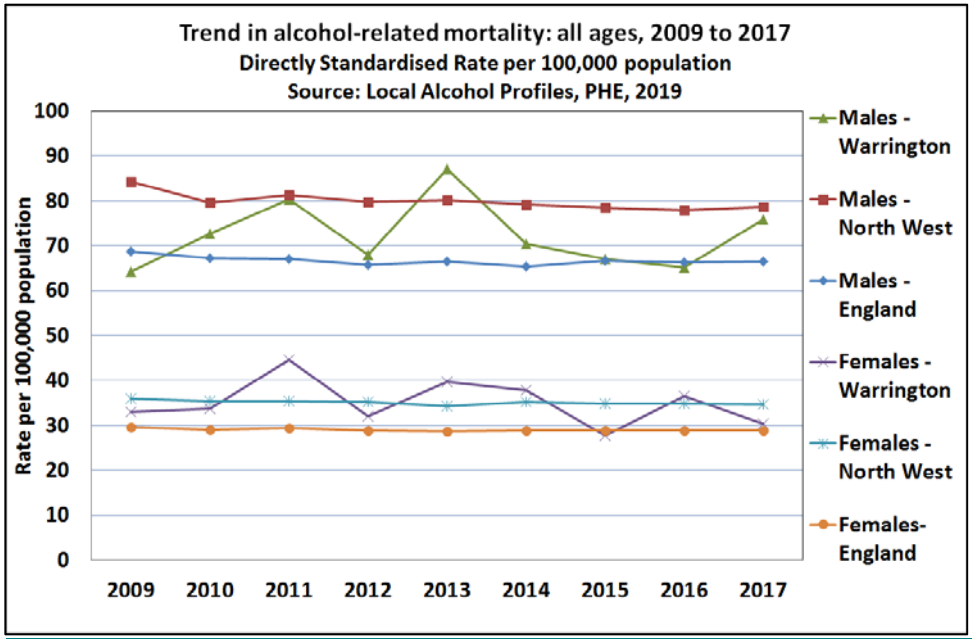
- Warrington has consistently had significantly higher levels of smoking attributable mortality than England.
- The trend in Warrington has been gradually reducing, and in the latest 2 reporting periods Warrington is no longer significantly higher than England.
- In 2015-17, Warrington had a rate of 265.9 deaths per 100,000 population, compared to England's 262.6.

Smoking attributable hospital admissions: Latest data published by Public Health England (2017/18) shows that Warrington had a rate of 1,208 hospital admissions per 100,000 population, compared to 1,530 in England. Warrington has consistently had significantly better rates than England for several years.

Deaths from chronic obstructive pulmonary disease (COPD): Data from Public Health England (2015-17) shows that Warrington had a rate of 53.1 deaths from COPD per 100,000 population compared to 52.7 in England. Warrington's rate is not significantly higher than England and has reduced over the last 2 reporting periods.

3.2 Living and Working Well, Lifestyle Risk Factors - Alcohol

- Regularly drinking more than the recommended daily limits risks damaging your health. There's no guaranteed safe level of drinking, but if you drink less than the recommended daily limits, the risks of harming your health are low (NHS Choices).
- Alcohol consumption is a contributory factor to hospital admissions and deaths from a diverse range of conditions.
- *NB The most recent data available for Warrington is for 2017, and there is no up-to-date data at a sub-Warrington level.*

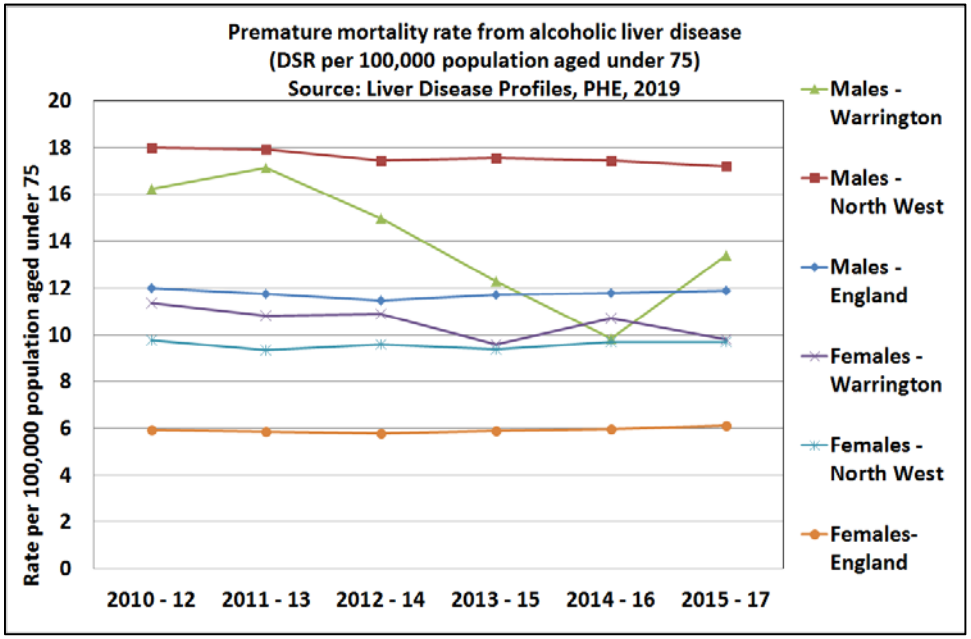


Alcohol-related mortality:

- During 2017, there were 101 deaths due to alcohol-related conditions in Warrington; 69 men and 32 women.
- Warrington had a mortality rate of 75.9 per 100,000 population for men and 30.3 for women.
- Because numbers of deaths are quite small in Warrington, the rate is prone to wide fluctuation from year to year, as can be seen in the chart. In Warrington, from 2016 to 2017 there was a substantial increase in the rate for males, and a decrease in the rate for females, although these may just be due to the natural variation in the data.
- The mortality rate for men was significantly higher than for women. This pattern was seen in Warrington, the North West and England.
- For both men and women, the North West has consistently significantly higher rates than England. Warrington is generally higher than England, but not significantly so.

Premature mortality (aged under-75) from alcoholic liver disease:

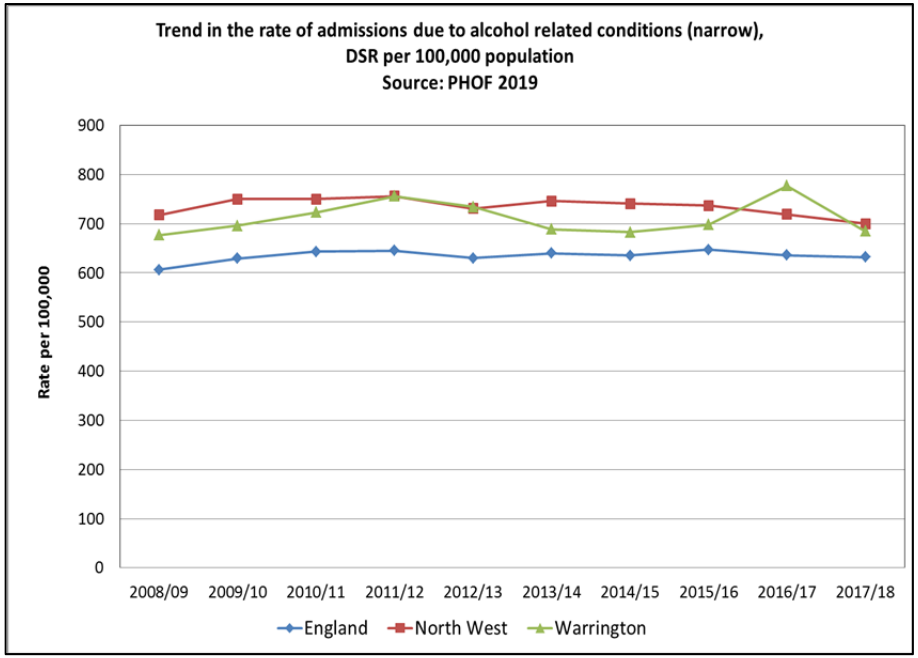
- A high proportion of deaths from liver disease are alcohol-related. Between 2015 and 2017, there were 67 premature deaths from alcoholic liver disease in Warrington; 38 men and 29 women.
- In Warrington, the North West and England, male mortality is generally higher than female. Warrington had a mortality rate of 13.4 per 100,000 population for men, and a rate of 9.8 for women.
- Because numbers of deaths are quite small in Warrington, the rate is prone to wide fluctuation from year to year, as can be seen in the chart. In Warrington, from 2016 to 2017 there was a substantial increase in the rate for males, and a decrease in the rate for females, although these may just be due to the natural variation in the data.
- Warrington's male mortality rates have generally been higher than England, but not significantly so.



3.2 and 3.3 Living and Working Well, Lifestyle Risk Factors – 3.2 Alcohol and 3.3 Substance Misuse

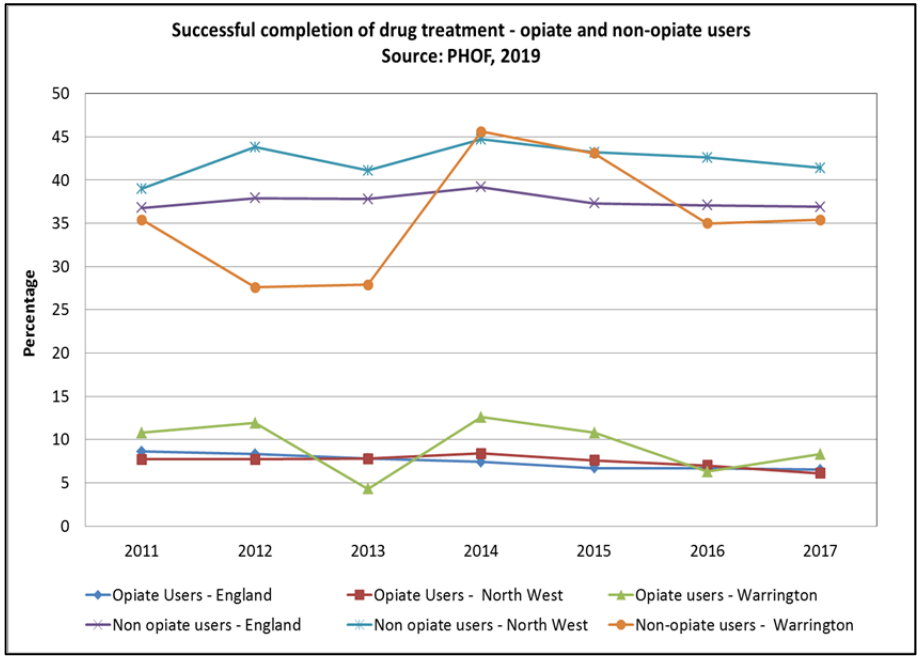
Alcohol-related hospital admissions

- In Warrington, the admissions rate was 685 per 100,000 population in 2017/18, a reduction since the previous year, although higher than England (632).
- Nationally, the rate of hospital admissions due to alcohol has remained fairly static.
- Warrington's trend has fluctuated, and admission rates in Warrington have been consistently and significantly higher than England's rates for a number of years.
- Admission rates in Warrington and in England are substantially higher for men than for women.



Successful completion of drug treatment

- The percentage of opiate users who successfully completed drug treatment (and not returned to treatment 6 months after completing), has increased slightly in Warrington since the previous year and is currently 8.3% (2017). England (6.5%) and the North West (6.1%) have both seen slight reductions since 2016.
- The percentage of non-opiate users who successfully completed drug treatment (and not returned to treatment 6 months after completing), has increased very slightly in Warrington to 35.4% (2017). Warrington is lower than England (36.9%) and the North West (41.4%).



Drug related deaths:

In 2015 to 2017, there were 30 deaths from drug misuse in Warrington. This is equivalent to a rate of 4.8 per 100,000 population, and slightly higher than England (4.3).

Hidden Harm:

As at March 2018, of people in alcohol and drug treatment services, 41.6% stated that they were a parent; equating to 705 children under 18.

Pharmacy services (April 2019):

21 of the 43 pharmacies in Warrington currently provide supervised consumption of methadone / buprenorphine / espranor, and 4 pharmacies provide a needle exchange service.

Alcohol & Drug treatment service:

Warrington Council commissions alcohol & drug treatment services from CGL (Pathways to Recovery). As at March 2018, **827** people were in structured treatment in Warrington.

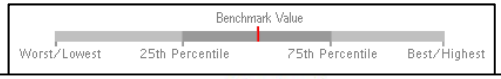
Steroids:

In 2017/18, 1,961 people used the needle exchange service compared to 1,605 the previous year. 24% of people used needle exchange for psychoactive substances (mainly heroin), 41% was for steroids/image and performance enhancing drugs (IPEDs) and 36% of people received a brief intervention (and do not inject).

3.4, 3.5 & 3.6 Living and Working Well, Lifestyle Risk Factors – 3.4 Unhealthy Weight and 3.5 Diet and 3.6 Physical Activity

- Data on diet, physical activity and excess weight is taken from the **Public Health Outcomes Framework (PHOF) Profiles,** produced by Public Health England, published May 2019, and available at: http://www.phoutcomes.info/ The chart shows Warrington, the North West Region and England, as well as the best and worst values across all Local Authorities. There is no up-to-date data at a sub-Warrington level.

Multiple lifestyle risk factors: Cardiovascular disease (CVD) is a family of diseases/conditions including heart disease, stroke, hypertension and diabetes. Having one CVD condition increases the likelihood of developing others. Key modifiable lifestyle risk factors are: smoking, poor diet, obesity, lack of physical activity and high alcohol consumption. These risk factors tend to 'cluster' together.



Period	Warrington			Region	England	England		
	Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Proportion of the population meeting the recommended '5-a-day' on a 'usual day' (adults) (Persons, 16+ yrs)	2017/18	–	-	50.7%	50.7%	54.8%	40.7%	65.9%
Average number of portions of fruit consumed daily (adults) (Persons, 16+ yrs)	2017/18	–	-	2.29	2.41	2.51	2.19	2.95
Average number of portions of vegetables consumed daily (adults) (Persons, 16+ yrs)	2017/18	–	-	2.45	2.51	2.65	2.06	3.17
Percentage of adults (aged 18+) classified as overweight or obese (Persons, 18+ yrs)	2017/18	–	-	66.9%	64.3%	62.0%	74.4%	45.4%
Percentage of physically active adults (Persons, 19+ yrs)	2017/18	–	-	59.6%	64.7%	66.3%	52.1%	79.7%
Percentage of physically inactive adults (Persons, 19+ yrs)	2017/18	–	-	24.6%	23.4%	22.2%	37.1%	11.2%

Diet (PHOF 2017/18): In Warrington, 50.7% of adults said they'd eaten 5 or more portions of fruit and vegetables the day before they were surveyed, slightly worse than England (54.8%). The Warrington average was 2.29 portions of fruit and 2.45 portions of vegetables, both significantly worse than 2.51 and 2.65 nationally.

Obesity and overweight

Body mass index (BMI) is based on a combination of weight and height. A BMI of 25-30 is categorised as overweight, and a BMI of 30 or over as obese.

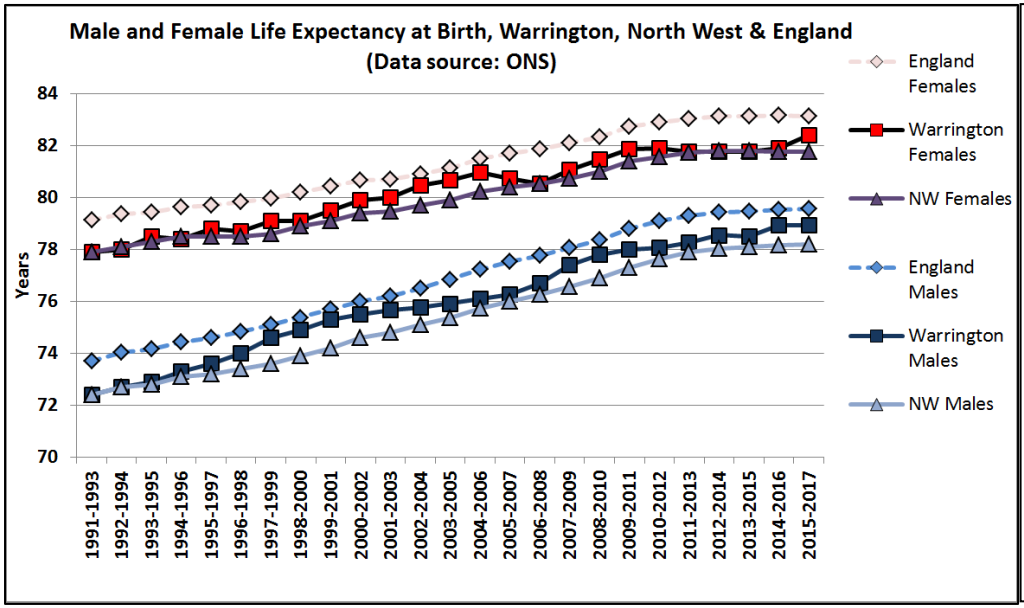
In the latest PHOF data (2017/18), 66.9% of adults in Warrington were overweight or obese, significantly worse than 62.0% nationally. Nationally, there is a strong link between obesity and socio-economic deprivation (although not between overweight prevalence and deprivation).

Physical Activity *The minimum physical activity recommended by the Chief Medical Officer is 150 "equivalent minutes" per week, in bouts of 10 minutes or more. ("Equivalent minutes" = moderate intensity minutes + 2 x vigorous intensity minutes).*

- In the latest PHOF data (2017/18), 59.6% of adults in Warrington did at least 150 "equivalent minutes" of physical activity per week in the 4 weeks before they were surveyed, significantly worse than England (66.3%).
- 24.6% of adults in Warrington did less than 30 "equivalent minutes" per week, slightly worse than England (22.2%).

4.1 Living and Working Well, Burden of Disease – Life Expectancy

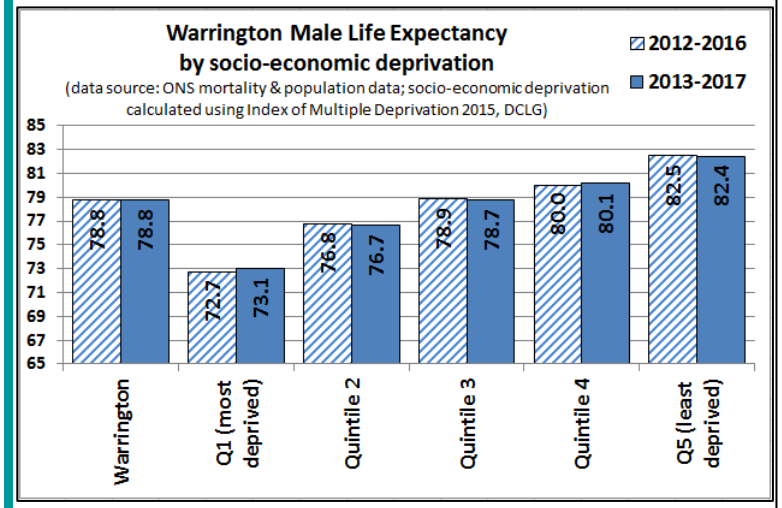
Life Expectancy at Birth Life expectancy is an internationally accepted measure of the overall health of a population. It provides an estimate of the average number of years a new-born baby would live for if s/he experienced the age-specific mortality rates of a particular area throughout his or her life. Life expectancy at birth measures broadly the same thing as all age, all-cause mortality rates, but is often considered a more intuitive and easier to understand indicator.
The most recent 3-year time period available is 2015-2017.



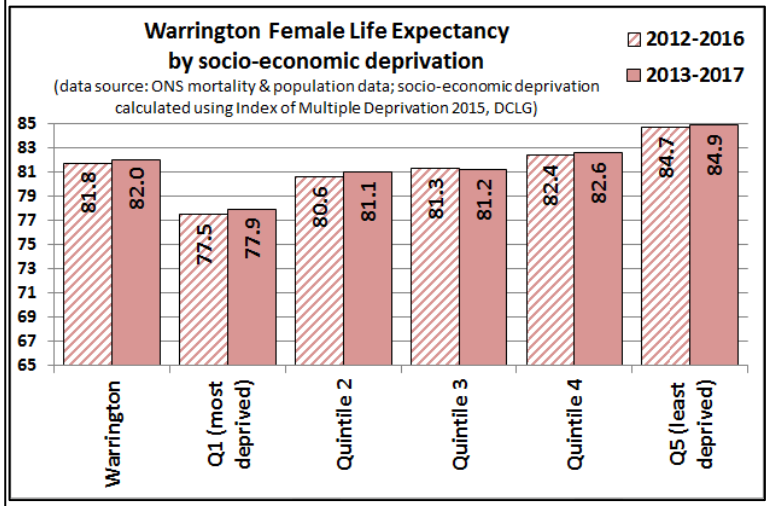
Trends in Life Expectancy (LE) at Birth:

- Life expectancy in Warrington has increased substantially over recent decades, by 6.5 years for men and 4.5 years for women, since 1991. However, male and female life expectancies are both significantly lower than England.
- Long term trends in male and female LE have shown steady increases in England, the North West and Warrington, although they seem to have levelled out in recent years, apart from a sudden jump in Warrington's female LE from 2014-16 to 2015-17. Given the year-to-year fluctuation sometimes seen in Warrington in the past, it remains to be seen whether this will be a sustained increase.
- Both locally and nationally, male LE is consistently much lower than female.

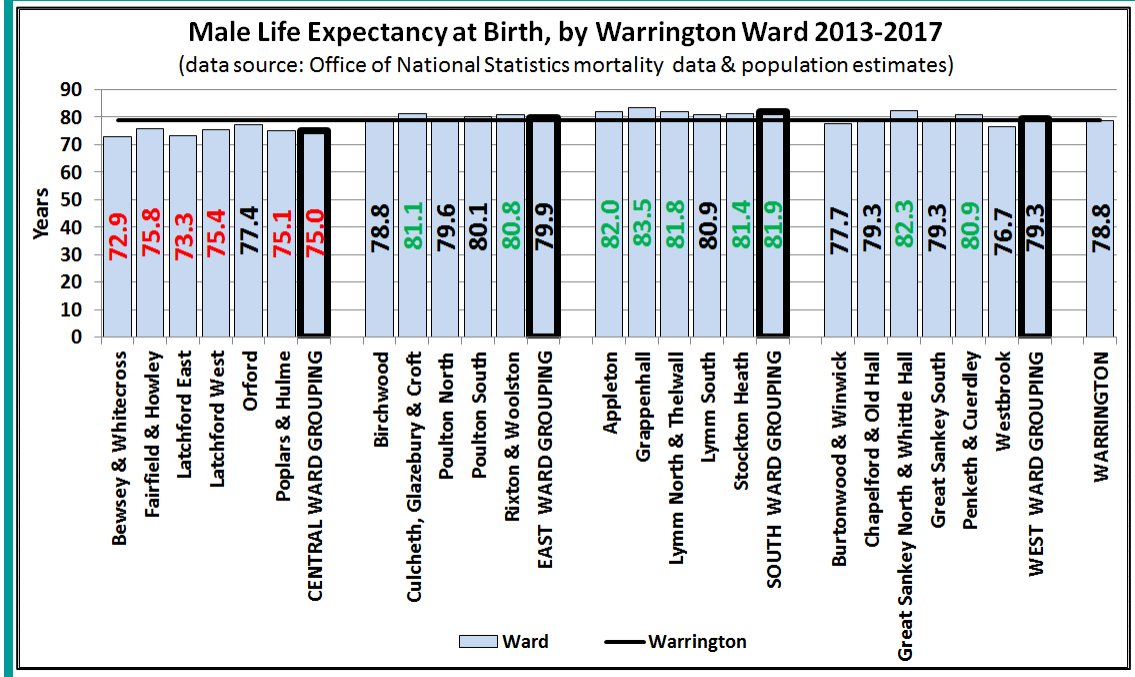
Male LE Over the past 10 data periods (2005-2007 to 2015-2017), male life expectancy in Warrington has increased by 2.6 years, from 76.3 to 78.9 years.
Female LE Over the past 10 data periods (2005-2007 to 2015-2017), female life expectancy in Warrington has increased by 1.7 years, from 80.7 years to 82.4 years.

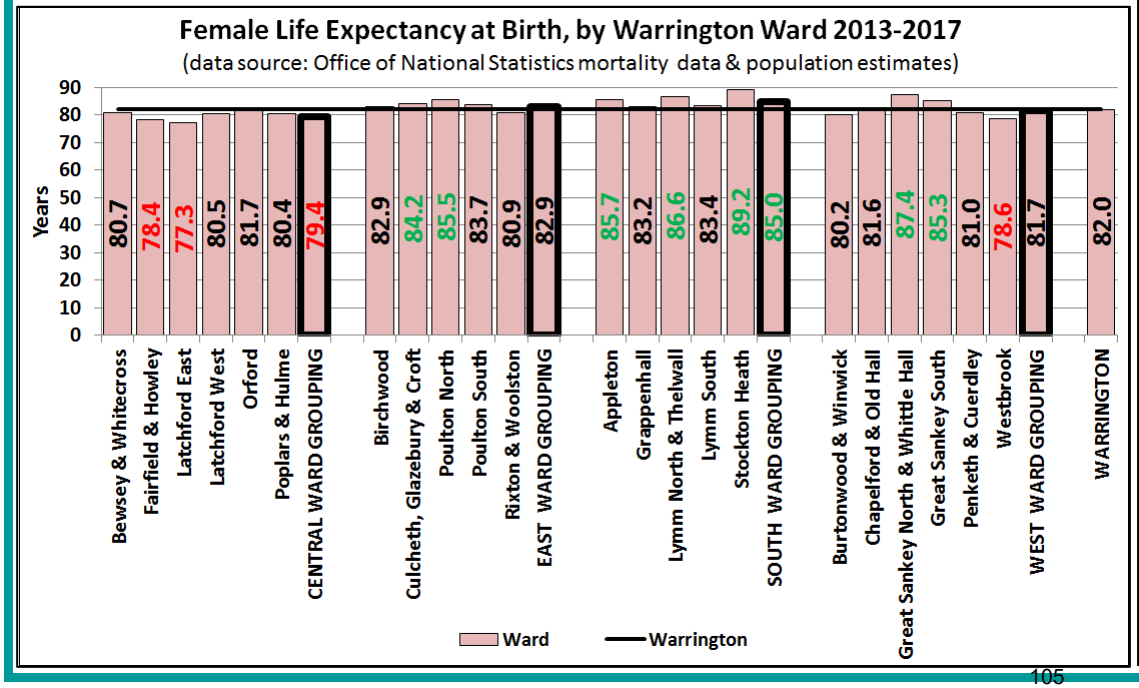


LE by socio-economic deprivation: Male and female LE is consistently lowest in the most deprived areas (Quintile 1), and highest in the least deprived (Quintile 5). There is a large step change from Q1 to Q2, and then a steadily increasing slope from Q2 to Q5.
Female LE (2013-2017) ranged from 77.9 years in the most deprived areas of Warrington (Q1) to 84.9 years in the least deprived (Q5), a difference of 7.0 years.
Male LE (2013-2017) ranged from 73.1 years in the most deprived areas of Warrington (Q1) to 82.4 years in the least deprived (Q5), a difference of 9.3 years.



4.1 Living and Working Well, Burden of Disease – Life Expectancy by Ward





Ward-level LE is calculated over a 5-year period in order to provide a more robust estimate. Even so, ward-level LE estimates can fluctuate over time, especially for smaller wards. The most recent data period available is 2013-2017. NB There can be spurious factors that contribute to a low LE, e.g. if large care homes are located in a particular ward, and so a relatively high proportion live in that ward because they have moved into a care home (and are likely to already be in ill-health, given that they require care). Wards with green text on the charts have significantly higher LE than Warrington overall; red text denotes significantly lower LE.

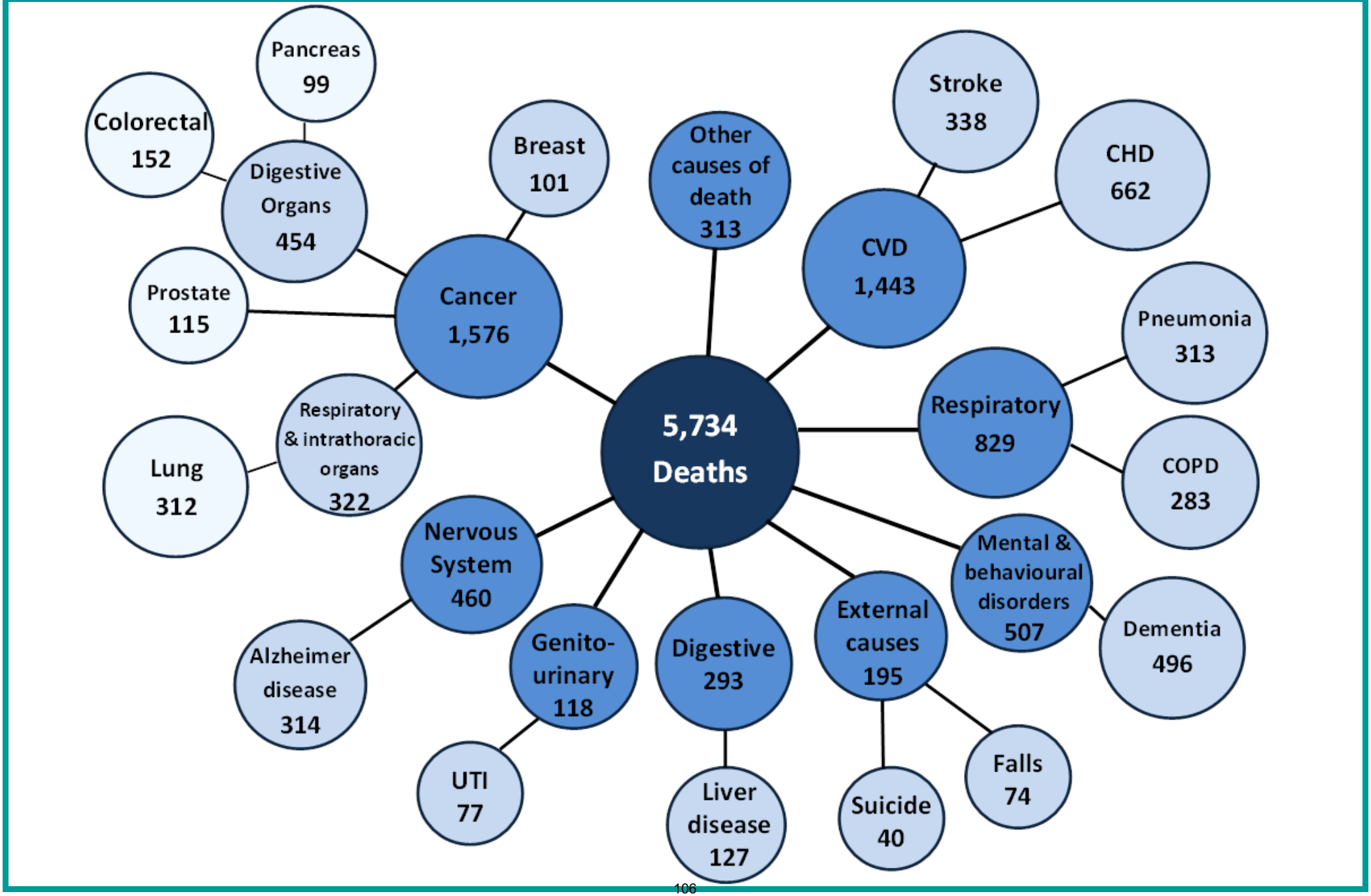
Ward Male Life Expectancy (LE):

- Five wards had statistically significantly lower male LE at birth, compared to Warrington overall (78.8 years). They all lie in the Central ward grouping: Bewsey & Whitecross, Fairfield & Howley, Latchford East, Latchford West and Poplars & Hulme.
- Eight wards had significantly higher male LE at birth: Culcheth, Glazebury & Croft, Rixton & Woolston, Appleton, Grappenhall, Lymm North & Thelwall, Stockton Heath, Great Sankey North & Whittle Hall, and Penketh & Cuerdley.
- The Central ward grouping had significantly lower male LE at birth (75.0 years), and South ward grouping had significantly higher (81.9 years), than Warrington overall (78.8 years).
- The ward with highest male LE at birth was Grappenhall (83.5 years), and Bewsey & Whitecross ward had lowest (72.9 years), i.e. a difference of 10.6 years.

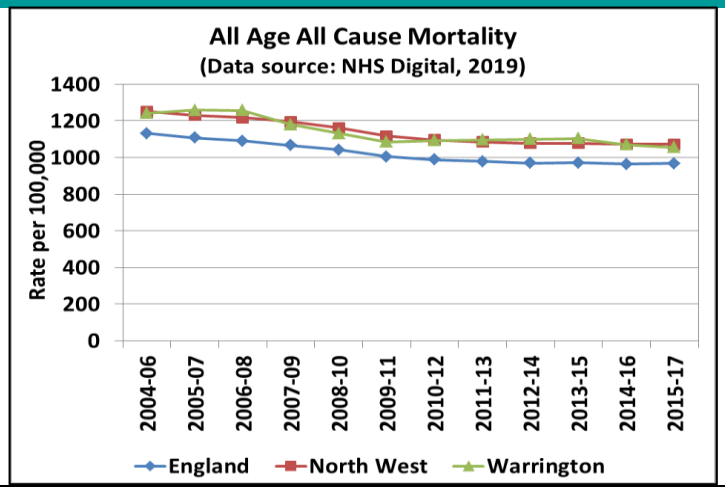
Ward Female Life Expectancy (LE):

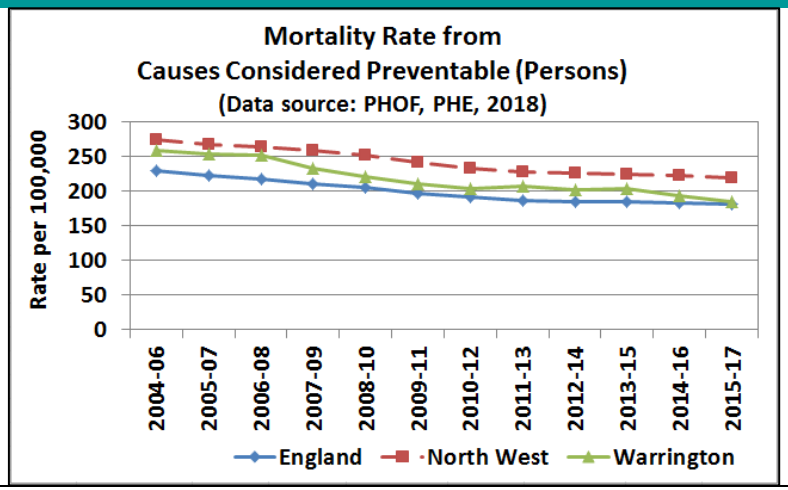
- Fairfield & Howley, Latchford East, and Westbrook had statistically significantly lower female LE at birth than Warrington overall (82.0 years).
- Seven wards had significantly higher female LE at birth: Culcheth, Glazebury & Croft, Poulton North, Appleton, Lymm North & Thelwall, Stockton Heath, Great Sankey North & Whittle Hall, and Great Sankey South. The Central ward grouping had significantly lower female LE at birth (79.4 years), and South ward grouping had significantly higher (85.0 years), than Warrington overall (82.0 years).
- Stockton Heath had the highest female LE at birth (89.2), and Latchford East had lowest (77.3), a difference of 11.9 years.

4.2 Living and Working Well, Burden of Disease – Main Causes of Death, 2016 to 2018



4.3 and 4.4 Living and Working Well, Burden of Disease – 4.3 All-Age All-Cause Mortality and 4.4 Mortality Considered Preventable



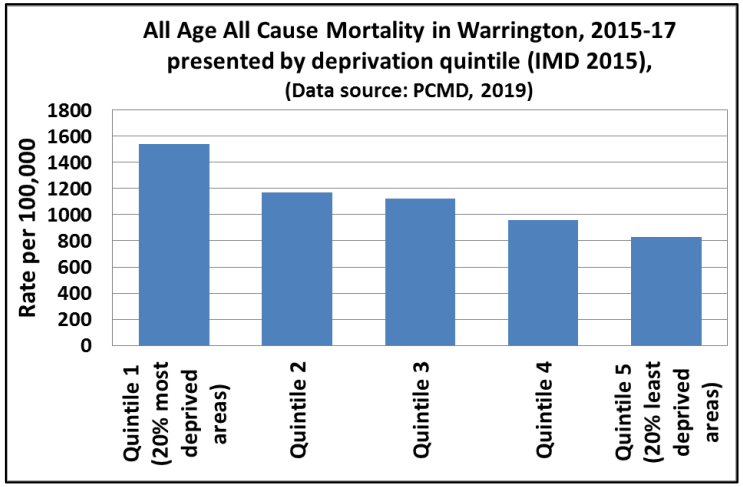


All-Age All-Cause Mortality:

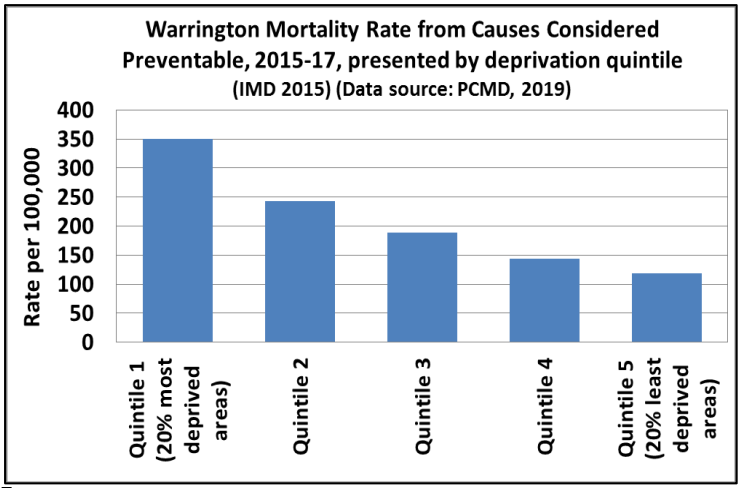
- There were 5,804 deaths in Warrington during the three year period 2015-17, equivalent to a mortality rate of 1053.4 per 100,000 persons.
- In the 11 years since 2004-06 Warrington has seen a 15% reduction in its mortality rate.
- In 2015-17 Warrington had a significantly worse rate than England; 1053.4 compared to 967.9.
- Males have historically had a higher mortality rate than females in Warrington, a pattern also seen nationally. In 2015-17 in Warrington, the rate for males was 1214.3 compared to 924.4 for females.

Mortality from Causes Considered Preventable (CCP):

- There were 1,119 deaths in Warrington from CCP during the three year period 2015-17, equivalent to a mortality rate of 186 per 100,000 persons.
- Mortality from CCP has reduced in Warrington over the past 11 years, and since 2003-05 has seen a 28% reduction.
- Despite year on year reductions, Warrington has remained significantly worse than England each year with the exception of 2014-16 and 2015-17.
- Male mortality rates are significantly higher than females in Warrington, a pattern also seen nationally. In 2015-17 in Warrington, the rate for males was 236.8 compared to 138.3 for females.



All-Age All-Cause Mortality rates in the 20% most deprived areas (Quintile 1) are significantly higher than the remaining areas of Warrington.

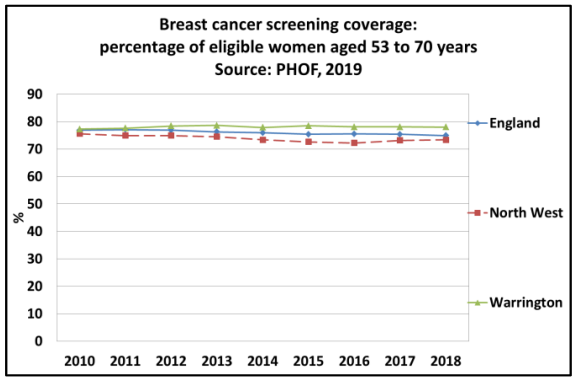


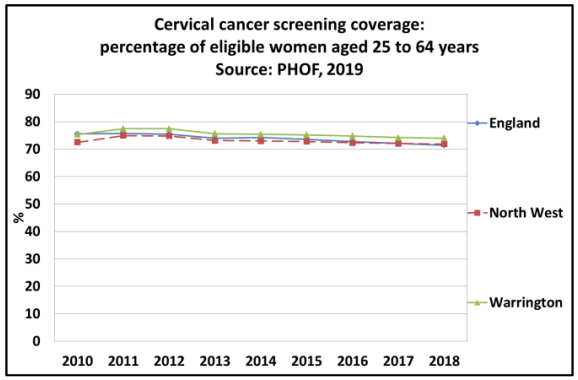
Mortality from causes considered preventable: rates in the 20% most deprived areas (Quintile 1) are significantly higher than each of the other quintiles.

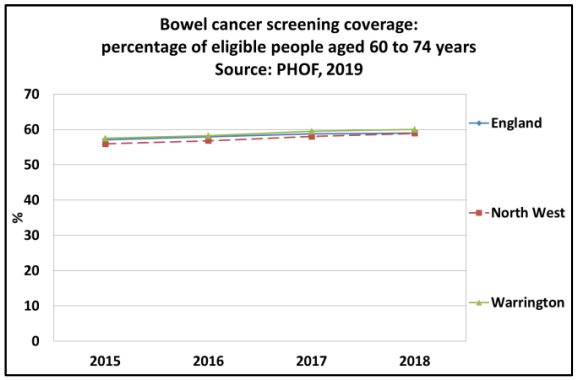
4.5 Living and Working Well, Burden of Disease – Screening Programmes

Abdominal Aortic Aneurysm Screening checks if there's a bulge or swelling in the aorta, the main blood vessel that runs from the heart down through to the stomach. The bulge is called an abdominal aortic aneurysm; if not spotted early it can rupture. The screen is offered to men during the year they turn 65. Women aren't screened, as their risk is much lower. During 2017/18 76.9% of Warrington men aged 65 were screened, significantly lower than England (80.8%) but an increase since 2016/17.

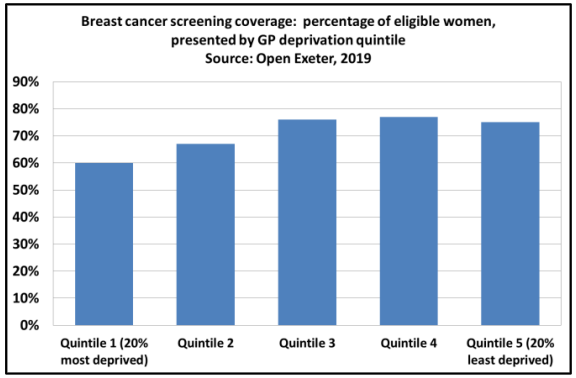
- Cancer screening: Early detection of cancer is vital to increase the chance of survival. In the three years leading up to March 2018, there have been approximately 83,000 cancer screens conducted in Warrington (breast, cervical and bowel).
- The uptake of screening in Warrington has been significantly higher than England for the last few years for both breast and cervical and for the last two years for bowel. As at 31st March 2018, 78.0% of eligible women (aged 53-70) were screened for breast cancer, 74.0% of eligible women (aged 25- 64) for cervical cancer, and 60.0% of eligible adults (aged 60-74) for bowel cancer screening.
- Breast screening uptake has been fairly static since 2008 in Warrington, England and the North West. Warrington is well above the target of 70%.
- Cervical cancer screening uptake has been gradually reducing in recent years in Warrington, England and the North West, and rates are well below the target of 80%.
- Bowel screening is a relatively new screening program and uptake has been gradually increasing in Warrington, England and the North West since it was introduced. Warrington met the target of 60% in 2018.

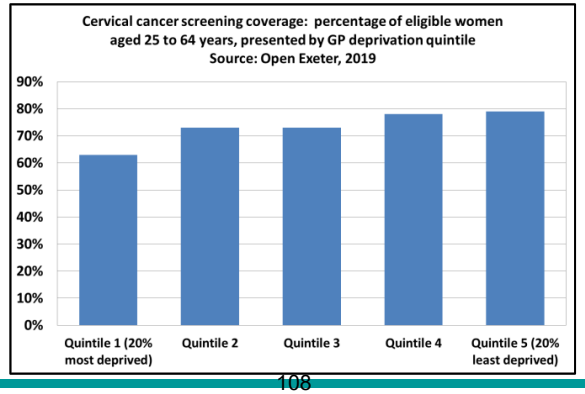


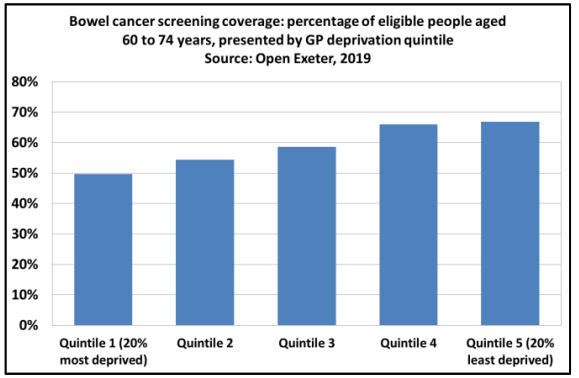




The uptake of breast, cervical and bowel screening is lower in the more deprived GP Practices, with rates increasing as the level of deprivation decreases.





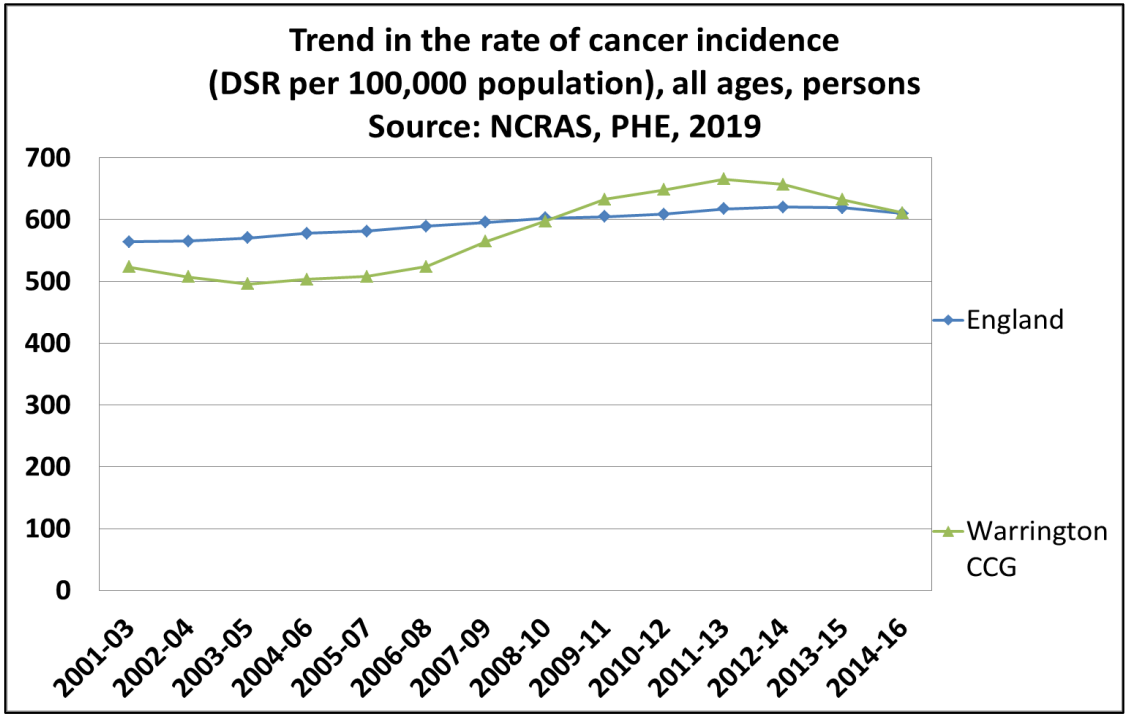


4.6 Living and Working Well, Burden of Disease – Cancer Incidence

Cancer incidence. Over the 3 year period 2014-2016:

- A total of 3,468 new cancers were diagnosed in Warrington residents (excluding skin cancers other than malignant melanoma). This was a slightly higher incidence rate than England.
- The most common types of cancer diagnosed during this time period was breast cancer (515 cases), lung cancer (500 cases), prostate cancer (415 cases) and colorectal cancer (412 cases).
- The rate of new cases of lung cancer diagnosed in Warrington (89.6 per 100,000 population) were significantly higher than the England rate (78.6 per 100,000). Additionally, the rate of new cases of lung cancer diagnosed in women from Warrington (81 per 100,000) was significantly higher than England (66.2 per 100,000).

- Nationally and in Warrington, there is a strong relationship between the incidence rate of lung cancer and levels of socio-economic deprivation. This is likely to be a result of higher smoking rates in the most deprived areas.
- After a sustained period of year on year increases in the cancer incidence rate (2004-06 through to 2011-13), the rate of new cancers diagnosed in Warrington has reduced and is now very similar to the England rate.
- For every type of cancer (other than lung) for which national and Local Authority data is published, Warrington was not significantly different to England in the most recent time period for which data is available.



Early diagnosis of cancer is important in relation to survival.

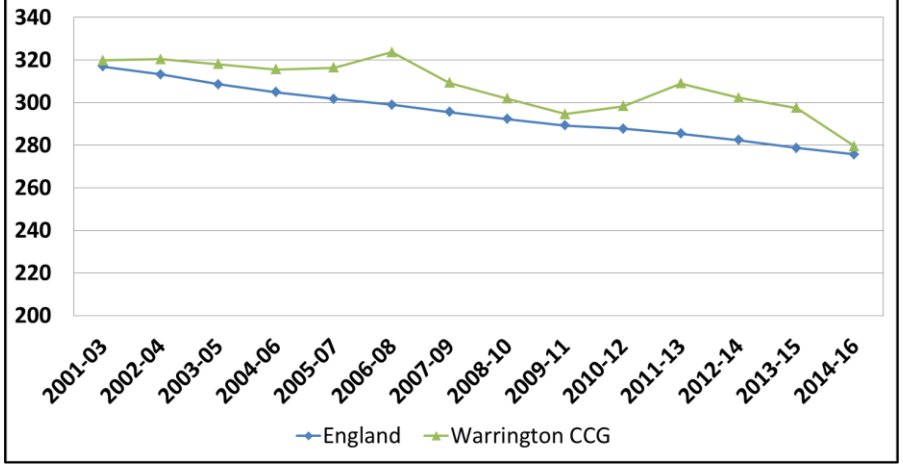
- In Warrington, just less than half (47.7%) of cancers diagnosed during 2016 were identified at an early stage (stage 1 and 2 of those cases where staging data was available). This was lower than England (52.6%) and the North West (51.9%).
- There has been a gradual increase in the percentage of cancers diagnosed early. Public Health England has suggested that this is most likely due to an improvement in data completeness.

4.6 Living and Working Well, Burden of Disease – Cancer Mortality

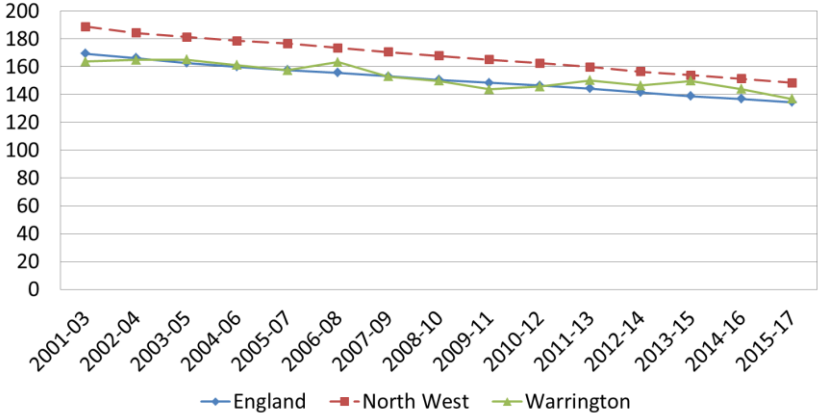
All-age cancer mortality

- Cancer is now the leading cause of death in Warrington, and in the 3 years 2015-2017, there were 1,515 deaths due to cancer and a further 39 deaths from non-malignant neoplasms.
- The trend in the cancer mortality rate in people of all ages has on the whole shown a reduction in Warrington and in England. In Warrington, there was an increase for the three year periods 2010-2012 and 2011-2013, and has since reduced during 2012-2014, 2013-2015 and 2014-2016.
- In Warrington, the most common cancers causing death (2014-2016) were: lung (351 deaths); breast (136 deaths); colorectal (128 deaths); prostate (118 deaths).
- Warrington had significantly higher rates than England (2014-2016) for lung (females only) and breast cancers.
- Warrington had significantly lower rates than England (2014-2016) for Liver and Intrahepatic Bile Duct cancer and pancreatic cancer.

Trend in the rate of mortality from all cancers (DSR per 100,000 population), all ages, persons
Source: NCRAS, 2019



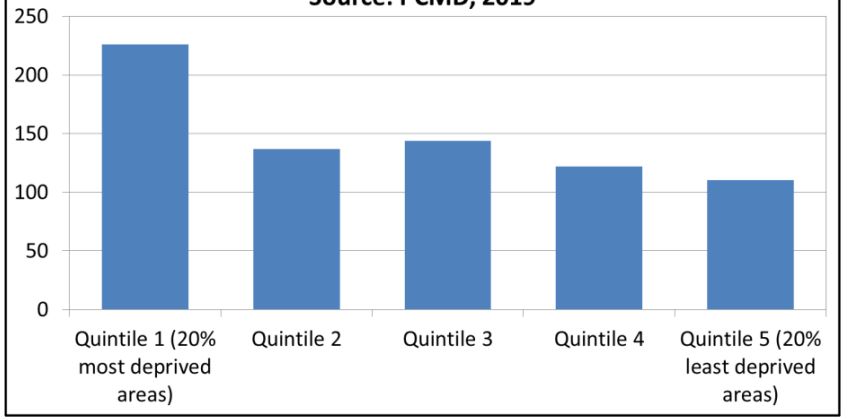
Trend in the rate of mortality from all cancers (DSR per 100,000 population), ages less than 75, persons
Source: PHOF, 2018



Premature cancer mortality (people aged under 75)

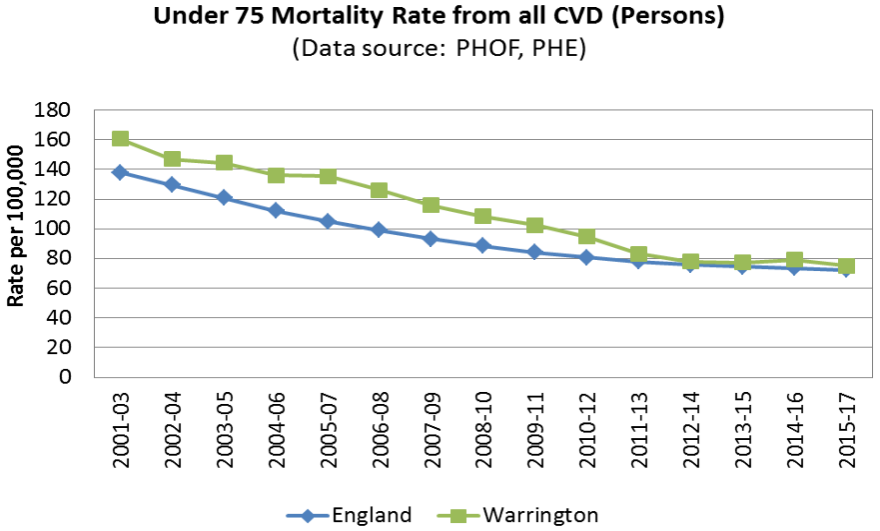
- A similar pattern to the all-age cancer mortality was seen in *premature* deaths from cancer.
- Premature mortality rates are significantly higher in the most deprived areas of Warrington.
- There has been a steady reduction in premature cancer mortality in England, Warrington and the North West.

Mortality from all cancers in persons aged less than 75 years (DSR per 100,000 population), presented by deprivation quintile (IMD 2015)
Source: PCMD, 2019



4.7 Living and Working Well, Burden of Disease - Cardiovascular Disease

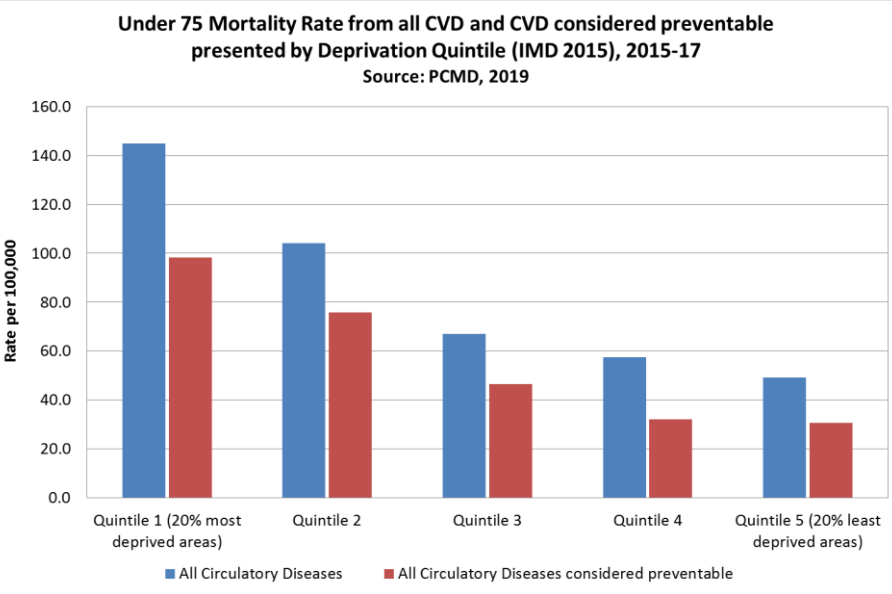
Cardiovascular disease (CVD) is a common condition caused by atherosclerosis (a hardening of the arteries). It represents a single family of diseases and conditions linked by common risk factors. These include coronary heart disease, stroke, diabetes, hypertension (high blood pressure), chronic kidney disease, hypercholesterolemia (high cholesterol), peripheral arterial disease and vascular dementia.



Mortality rate from all CVD in people aged under-75: Warrington currently (2015-17) has an under-75 mortality rate from all CVD of 75.1 per 100,000 people, similar to England (72.5). Trends in Warrington have been downwards since 2001-03 but were significantly worse than England for all time periods until the most recent five (2011-13 to 2015-17).

Under 75 mortality rate from CVD from *causes considered preventable*: in Warrington, on average around 65% of all CVD mortality in under-75s is considered preventable, and the current (2015-17) mortality rate of 49.2 per 100,000 is not significantly different to England (45.9). CVD considered preventable also has a downward trend.

Socio-economic deprivation: mortality from all CVD and CVD considered preventable was significantly high in Quintile 1 (20% most deprived areas) compared to the rest of Warrington.



NHS Health Checks Programme: NHS Health Checks are aimed at people aged 40-74 who are not already diagnosed with heart disease, stroke, diabetes or kidney disease. They will be invited once every 5 years for a health check to assess their risk of CVD, to raise awareness, and to support them to manage that risk.

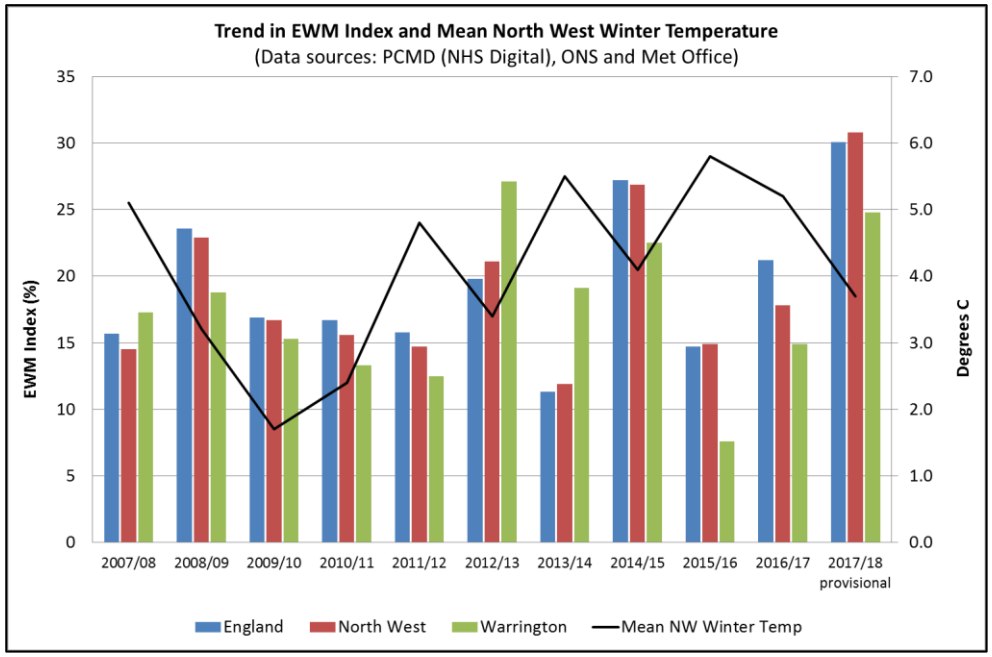
A Public Health England indicator shows that in Warrington between 2013/14 and 2017/18, 50.5% of the Warrington population who were eligible for a health check, received one (PHOF). This is significantly better than England (44.3%).

Quality and Outcomes Framework (QOF), 2017/18 (Source: NHS Digital)				
CVD Risk Factors	Warrington, no. of patients on register	Warrington prevalence rate	England prevalence rate	% higher than England
Coronary Heart Disease	7,787	3.57%	3.13%	14%
Stroke & Transient Ischaemic Attack (TIA)	3,955	1.81%	1.77%	2%
Diabetes Mellitus (17+)	11,839	6.74%	6.79%	-1%
Hypertension	30,460	13.97%	13.94%	0%
Peripheral Arterial Disease (PAD)	1,563	0.72%	0.59%	22%

Quality and Outcomes Framework (QOF) data monitors performance in GP practices. Prevalence of stroke/TIA and hypertension in Warrington for 2017/18, are slightly higher than England. However, compared to England, prevalence of coronary heart disease is 14% higher, and prevalence of PAD is 22% higher in Warrington.

4.8 Living and Working Well, Burden of Disease – Excess Winter Mortality

Excess winter mortality (EWM) is defined as the number of extra deaths in winter compared to the rest of the year. This is the number of deaths that occur between December and March, minus the average number of deaths that occurred in the previous August to November and the following April to July. An EWM Index is then calculated, represented as a percentage, which allows for comparisons.



Excess winter mortality trends:

- In 2017/18 there were 148 excess winter deaths in Warrington resulting in an EWM Index of 24.8% (provisional data), significantly lower than England (30.1%).
- Compared to 2016/17, the EWM Index for 2017/18 had seen an increase. Final data for 2016/17 confirmed a EWM Index of 14.9% or 90 excess winter deaths.
- Increases were also seen regionally and nationally, and thought to be linked to the predominant strain of flu, the effectiveness of the influenza vaccine and below-average winter temperatures.

Causes of death 2017/18:

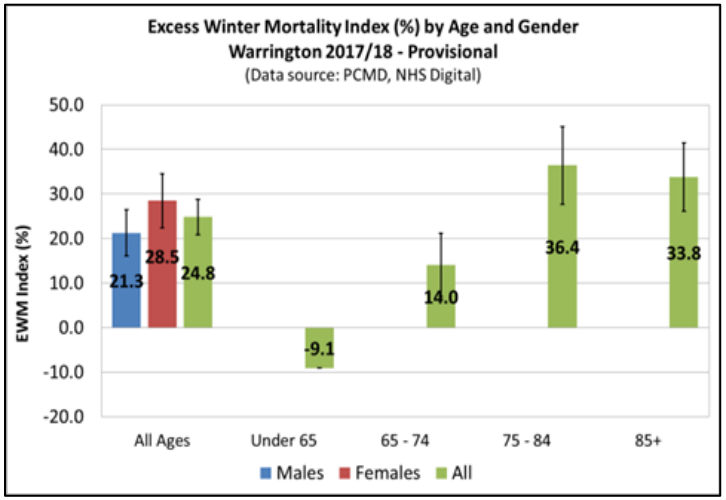
- Circulatory disease (49 excess deaths) and respiratory disease (43 excess deaths) were the main contributors to the number of excess winter deaths in Warrington, accounting for 61% of them.
- Circulatory disease had an EWM Index of 33.1%, and respiratory disease had an EWM Index of 47.5%.

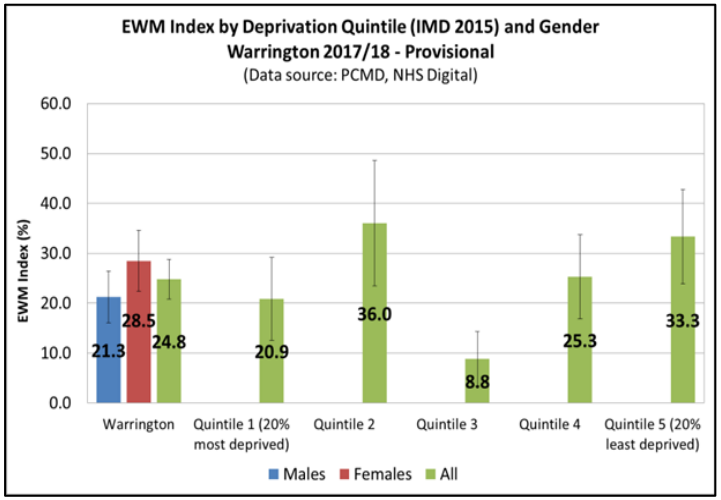
By age and gender:

- In Warrington males had an EWM Index of 21.3% and females were higher with 28.5%.
- Numbers of excess winter deaths were highest in those aged 75+, and the age group 75-84 had the highest EWM Index of 36.4%. It wasn't significantly different to the overall Warrington rate of 24.8%.

By deprivation:

- Deprivation quintile 2 (one of the more deprived areas of Warrington) had the highest EWM Index (36.0%) but not significantly higher than Warrington (24.8%).



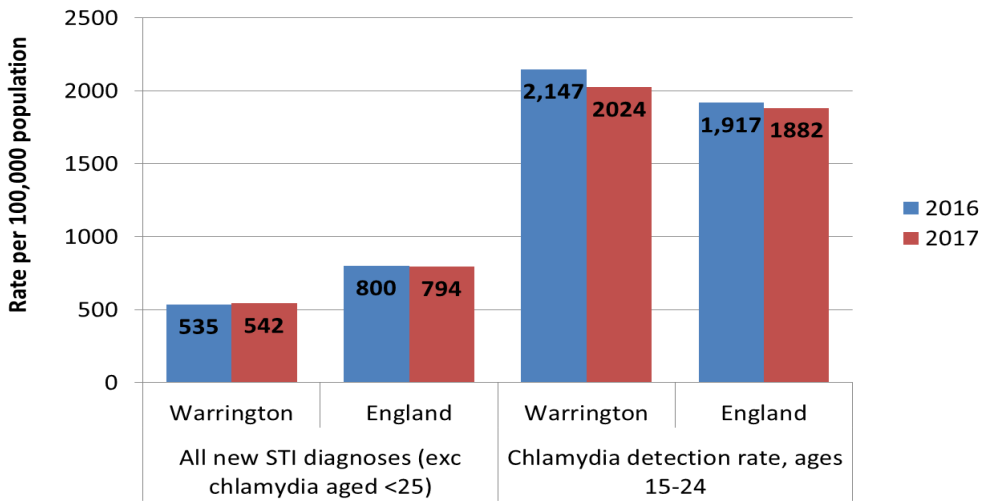


4.9 Living and Working Well, Burden of Disease – Sexual Health

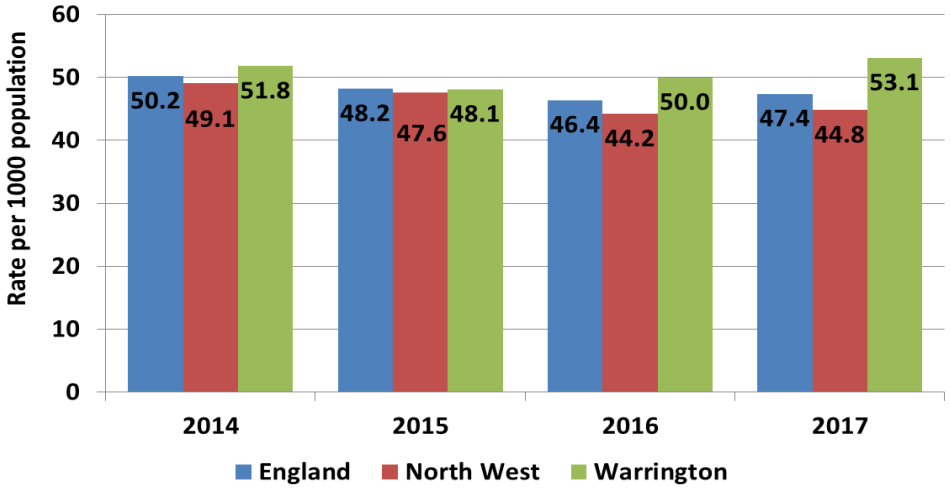
HIV prevalence:

- Latest data (2017) shows that Warrington has an HIV prevalence rate of 0.78 per 1,000 people aged 15-59; this compares with the England rate of 2.32.
- Warrington's prevalence has reduced very slightly since the previous year in which it was 0.96.

Rates of New Diagnoses, per 100,000 population
(Data source: Sexual Health Profiles, PHE)



Total Prescribed LARC excluding Injections
Rate per 1,000 Females aged 15-44
(Data source: Sexual health Profiles, PHE)



Sexually transmitted infections (STIs):

- Warrington has a rate of 542 new STI diagnoses per 100,000 population (excluding any chlamydia diagnosis in those aged <25) in 2017.
- Warrington has a significantly lower rate than England (794).
- Chlamydia is the most commonly diagnosed bacterial STI in England; young adults have substantially higher rates than any other age group (PHE, 2019).
- The chlamydia detection rate for 15-24 year olds is 2,024 per 100,000 population in Warrington, similar to England. It is measured against a national target of 2,300 per 100,000 young people. Higher numbers are considered better, as detecting and treating sufficient chlamydia infections with no noticeable symptoms will result in a decrease in incidence.
- The proportion of the population aged 15-24 screened for chlamydia was 18.2% in Warrington (2017), significantly lower than England's rate of 19.3%.

Long acting reversible contraception (LARC):

LARC methods are highly effective as they do not rely on daily compliance and are more cost effective than condoms and the pill.

- Latest data (2017) shows that Warrington has a rate of 53.1 per 1,000 females aged 15 to 44 who have been prescribed LARC. This rate includes LARC prescribed by GPs and Sexual & Reproductive Health Services.
- Warrington has a higher rate than England (47.4) and the North West (44.8).
- An average of 1,900 females are prescribed LARC each year in Warrington.

Note: GP prescribing data is prescription-item rather than person-based; the number of items prescribed in a year is used as a proxy for the number of individuals prescribed LARC (implants, intra-uterine system (IUS) and intrauterine device (IUD)).

4.10 Living and Working Well, Burden of Disease – Mental Health

Suicide or injury undetermined, Warrington

In Warrington:

- Over the 3 year period 2015 to 2017, there were 47 deaths due to suicide or injury undetermined of Warrington residents (36 male and 11 female), equivalent to a rate of 8.5 per 100,000 population. This is a reduction on 2014-16 when there were 55 deaths (9.8 per 100,000). However, this reduction is not statistically significant.
- Whilst the rates for England and the North West are relatively stable over time, the Warrington rate varies substantially. The Warrington rate had risen over the three time periods of 2010-12 to 2013-15, but it was not significantly different to England or the North West.
- The number of suicides in Warrington fluctuates substantially over time:

2010-12	2011-13	2012-14	2013-15	2014-16	2015-17
41	55	64	69	55	47

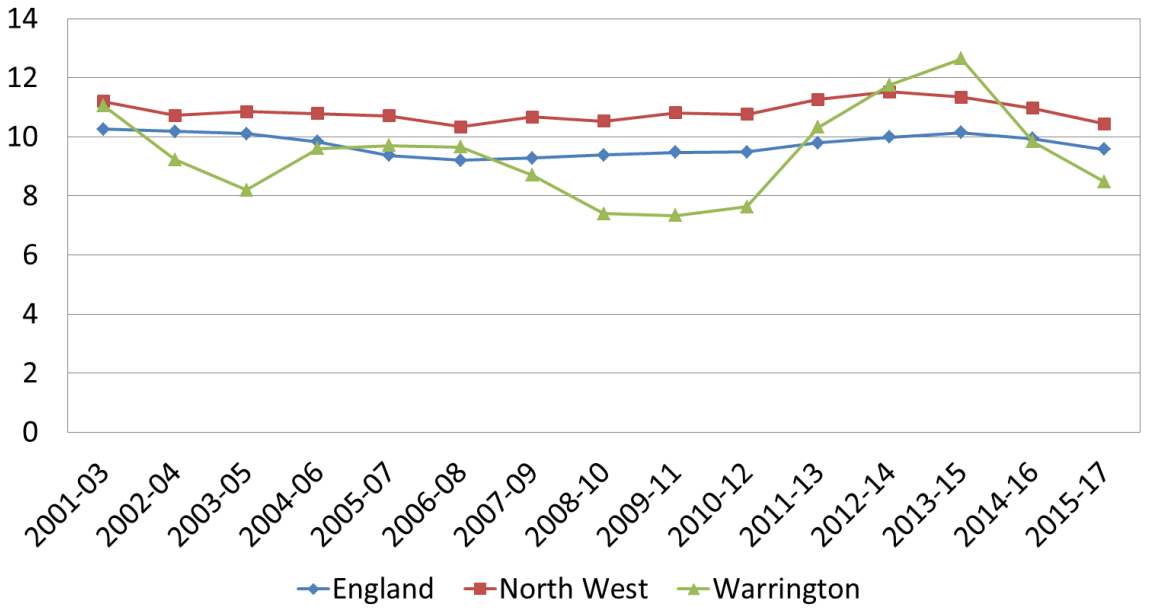
- Higher suicide rates are consistently seen in young or middle-aged males, being in the care of mental health services, having a history of alcohol and/or drug misuse and living alone. These groups also have higher suicide rates nationally.
- Males were less likely than females to have received a mental health diagnosis or be in the care of mental health services, suggesting that males may not be seeking or receiving the support they need.
- During 2015-17, suicide was the leading cause of death in the 10-29 year-old age-band (31% of deaths).
- Almost half of local people who died by suicide had visited their GP within the month before their death.

Warrington's Suicide Audit 2018 can be found at: https://www.warrington.gov.uk/info/201158/public_health/1512/about_the_public_health_service

Suicide or injury undetermined, national evidence

National evidence shows that groups at higher risk of suicide include: young and middle-aged men, people in mental health services or the criminal justice system, those with alcohol/drug misuse or a history of self-harm, and specific professions such as doctors, nurses, veterinary workers, farmers and agricultural workers. Stressful life events can also increase the risk of suicide, including imprisonment, job loss, debt, bereavement, living alone or becoming socially excluded or isolated, and divorce or family breakdown.

Directly standardised mortality rate from suicide and injury of undetermined intent per 100,000 population, 2001-03 to 2015-17
Source: PHOF, 2018



Mental health QOF data 2017/18 (patients on GP registers with certain conditions):

- Mental health (schizophrenia, bipolar affective disorder and other psychoses): 1,913 patients, with a prevalence of 0.88% slightly lower than England (0.94%).
- Depression in 18+ population: 19,651 patients, with a prevalence of 11.34%, higher than England (9.88%).

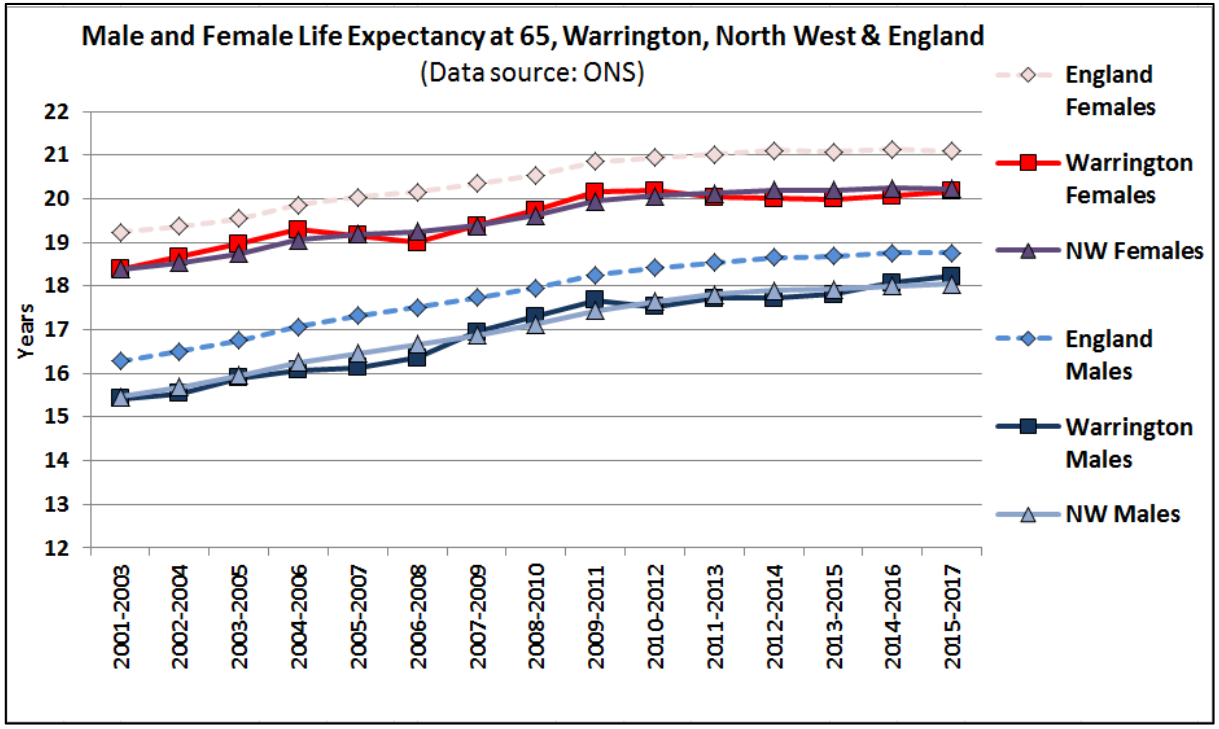
5.1 Ageing Well – Life Expectancy at Age 65

Life Expectancy (LE) at age 65

Life expectancy is an internationally accepted measure of the overall health of a population. It estimates the number of years that a person of a specific age can be expected to live, assuming that current age-specific mortality levels remain the same.

At Local Authority level, the relatively small number of people on which LE at age 65 is calculated, makes reliable trend analysis difficult. For this reason, LE is calculated on a 3-year time period.

- There have been improvements in LE for Warrington residents since 2000.
- In keeping with England, at age 65, female LE is higher than male.
- For both males and females, the long term trend in LE at 65 has shown an increase in England, the North West and Warrington, although the rate of increase seems to have slowed since approximately 2009-2011. Warrington is consistently significantly lower than England as a whole, although it is similar to the North West.



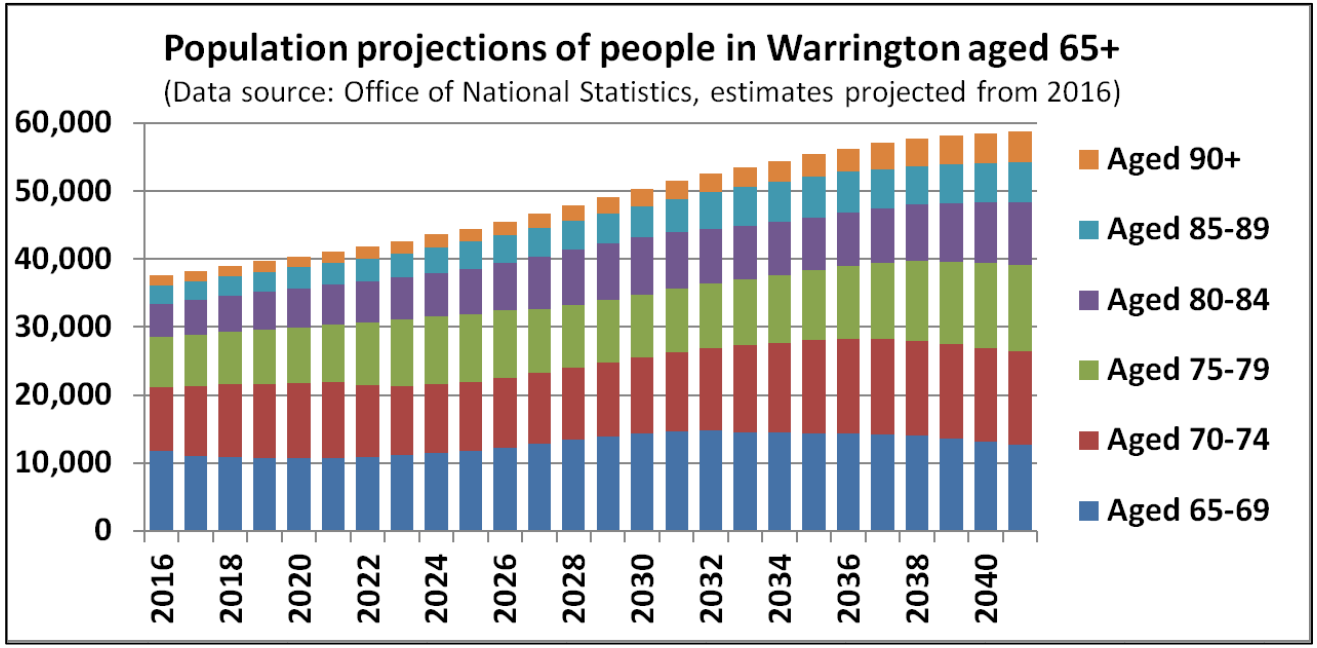
Females

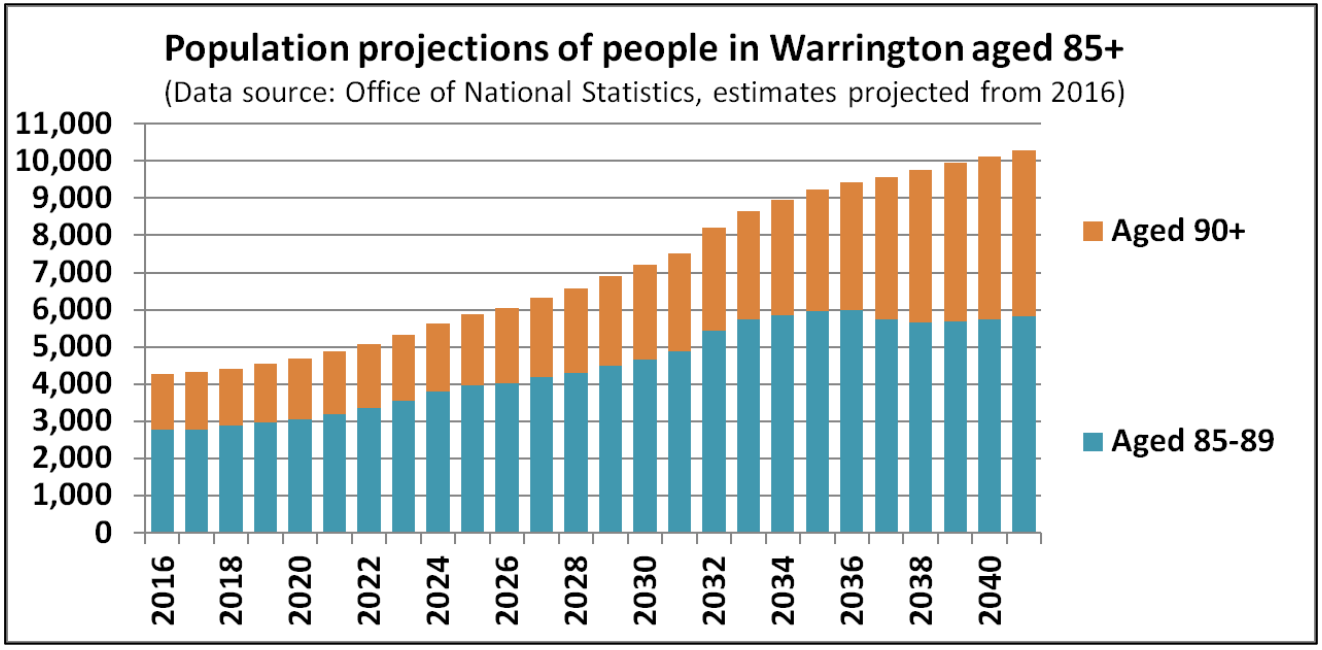
- Female LE at 65 in Warrington is 20.2 years for the latest time period (2015-2017), the same as the North West (20.2), and significantly lower than England (21.1).
- Over the past 10 data periods (2005-2007 to 2015-2017), female LE at 65 in Warrington has increased by 1.0 year, from 19.2 years to 20.2 years. The improvement across England as a whole has been slightly greater, with an increase of 1.1 years from 20.0 to 21.1 years.
- LE figures fluctuate over time as the chart illustrates, and the long term trend has shown an increase in England, the North West and in Warrington. However, the rate of increase seems to have slowed since about 2009-2011, with little change since then in female LE at 65.

Males

- Male LE at 65 in Warrington is 18.2 years for the latest time period (2015-2017), slightly higher than the North West (18.0), but significantly lower than England (18.8).
- Although there are fluctuations over time, improvements in male LE in Warrington have broadly kept pace with that in England as a whole. Over the past 10 data periods (2005-2007 to 2015-2017), male LE at 65 in Warrington increased by 2.1 years, from 16.1 to 18.2 years. In England it increased by 1.5 years (from 17.3 to 18.8), and so the gap between Warrington and England has narrowed.
- LE figures fluctuate over time as the chart illustrates, and the long term trend has shown an increase in England, the North West and in Warrington. However, the rate of increase seems to have slowed since about 2009-2011.

5.2 Ageing Well – Population Projections





The Office of National Statistics produce population projections. The most recent are based on the population at mid-2016, and give estimates up to 2041. NB The further an estimate is in the future, the less reliable it is, and projections do not take into account any future policy changes or those that have not yet had an impact on observed trends.

As well as population growth due to people living longer, Warrington currently has a relatively high proportion of middle-aged people aged 45-59 (see the population pyramid for mid-2017 in 'Demography' section of this document); this large 'bulge' of middle-aged people will turn 65 between 2023 and 2037.

Projections suggest that the population aged 65+ will increase by:

- 21% in the 10 years from 2016 to 2026 (from about 37,650 to about 45,500) and
- 56% in the 25 years from 2016 to 2041 (from about 37,650 to about 58,700),

and that the population aged 85+ will increase by:

- 42% in the 10 years from 2016 to 2026, from about 4,250 to about 6,050 and
- 141% (almost 2-and-a-half times as many) in the 25 years from 2016 to 2041, from about 4,250 to about 10,300.

More of these percentage increases will be accounted for by men.

5.2 Ageing Well – Population Projections

MALES: population growth in older age-bands							Percentage increase	
AGE_GROUP	2016	2021	2026	2031	2036	2041	2016-2026	2016-2041
Aged 65-69	5,695	5,289	6,070	7,197	6,892	6,284	7%	10%
Aged 70-74	4,478	5,267	4,926	5,680	6,752	6,503	10%	45%
Aged 75-79	3,286	3,864	4,609	4,361	5,071	6,057	40%	84%
Aged 80-84	2,185	2,562	3,094	3,746	3,610	4,255	42%	95%
Aged 85-89	1,030	1,354	1,653	2,078	2,581	2,559	60%	148%
Aged 90+	427	544	759	1,009	1,373	1,819	78%	326%
Total aged 65+	17,101	18,879	21,110	24,072	26,279	27,478	23%	61%
Total aged 70+	11,406	13,591	15,040	16,875	19,386	21,193	32%	86%
Total aged 75+	6,928	8,324	10,114	11,195	12,635	14,691	46%	112%
Total aged 80+	3,642	4,460	5,505	6,834	7,564	8,633	51%	137%
Total aged 85+	1,457	1,897	2,412	3,088	3,953	4,379	66%	201%
Aged 90+	427	544	759	1,009	1,373	1,819	78%	326%

FEMALES: population growth in older age-bands							Percentage increase	
AGE_GROUP	2016	2021	2026	2031	2036	2041	2016-2026	2016-2041
Aged 65-69	6,085	5,500	6,233	7,452	7,399	6,436	2%	6%
Aged 70-74	4,967	5,805	5,278	6,000	7,180	7,150	6%	44%
Aged 75-79	4,026	4,580	5,389	4,944	5,652	6,775	34%	68%
Aged 80-84	2,661	3,366	3,879	4,613	4,302	4,967	46%	87%
Aged 85-89	1,738	1,845	2,377	2,804	3,400	3,260	37%	88%
Aged 90+	1,072	1,124	1,259	1,620	2,064	2,645	17%	147%
Total aged 65+	20,549	22,219	24,415	27,434	29,996	31,233	19%	52%
Total aged 70+	14,464	16,720	18,182	19,982	22,597	24,797	26%	71%
Total aged 75+	9,497	10,915	12,905	13,982	15,418	17,647	36%	86%
Total aged 80+	5,471	6,335	7,515	9,038	9,766	10,872	37%	99%
Total aged 85+	2,810	2,969	3,636	4,424	5,464	5,905	29%	110%
Aged 90+	1,072	1,124	1,259	1,620	2,064	2,645	17%	147%

These projected population increases in older people highlight the importance of the ageing well agenda to ensure that extra years of life are lived in good health and enable people to remain independent.

PERSONS: population growth in older age-bands							Percentage increase	
AGE_GROUP	2016	2021	2026	2031	2036	2041	2016-2026	2016-2041
Aged 65-69	11,780	10,788	12,303	14,649	14,291	12,720	4%	8%
Aged 70-74	9,445	11,072	10,204	11,680	13,931	13,653	8%	45%
Aged 75-79	7,312	8,444	9,998	9,305	10,723	12,832	37%	75%
Aged 80-84	4,846	5,929	6,973	8,360	7,912	9,221	44%	90%
Aged 85-89	2,768	3,198	4,030	4,883	5,981	5,820	46%	110%
Aged 90+	1,499	1,668	2,018	2,630	3,436	4,464	35%	198%
Total aged 65+	37,650	41,099	45,525	51,507	56,275	58,710	21%	56%
Total aged 70+	25,870	30,311	33,223	36,857	41,984	45,990	28%	78%
Total aged 75+	16,425	19,239	23,019	25,177	28,053	32,337	40%	97%
Total aged 80+	9,113	10,795	13,021	15,872	17,329	19,505	43%	114%
Total aged 85+	4,267	4,866	6,048	7,512	9,417	10,284	42%	141%
Aged 90+	1,499	1,668	2,018	2,630	3,436	4,464	35%	198%

The tables show Office for National Statistics population projections.

Percentage increases by age-band

From 2016 to 2041 the number of men aged 65+ is expected to increase by 61% and women aged 65+ by 52%; overall an increase of just over 21,000 people.

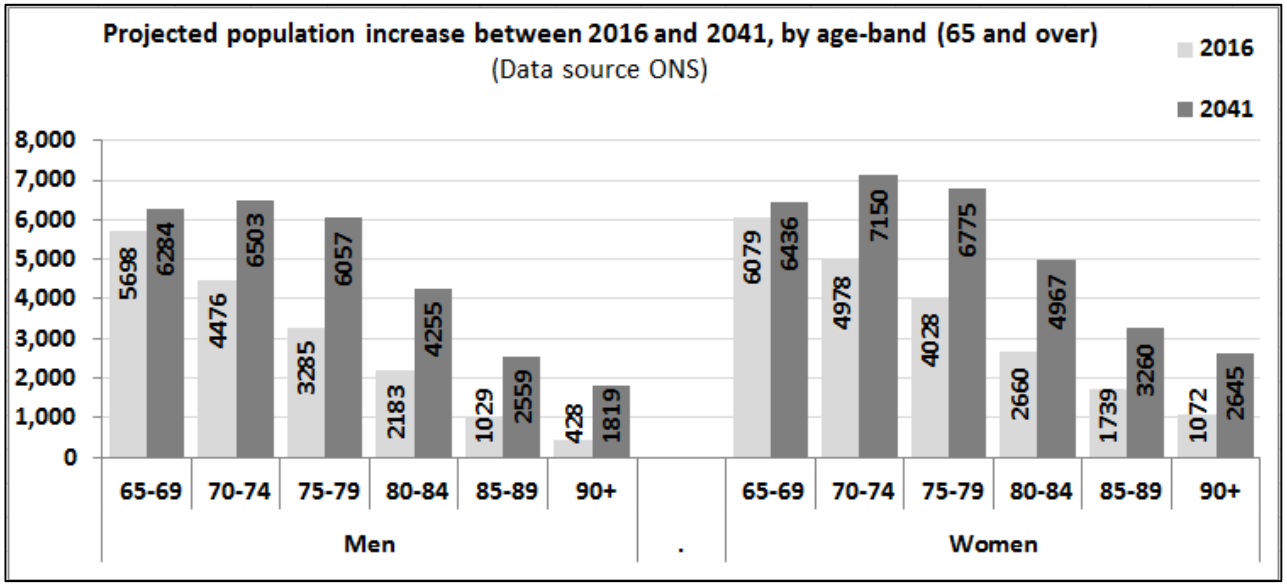
The older the age-band, the bigger the percentage increase is predicted, e.g. from 2016 to 2041:

- a 8% increase in 65-69 year-olds
- a 45% increase in 70-74 year-olds
- a 75% increase in 75-79 year-olds
- a 90% increase (i.e. almost double) in 80-84 year-olds
- a 110% increase (i.e. more than double) in 85-89 year-olds and
- a 198% increase (about 3 times as many) in those aged 90+.

The percentage increases are expected to be higher in men than in women, especially in the very old age-bands, e.g. in the 90+ age-band:

- more than 4 times as many men aged 90+ in 2041 than in 2016 (from about 400 to about 1,800).
- About two-and-a-half times as many women aged 90+ in 2041 than in 2016 (from about 1,100 to about 2,650).

5.2 and 5.3 Ageing Well – 5.2 Population Projections and 5.3 Old Age Dependency Ratio



POPULATION PROJECTIONS, MEN/WOMEN AGED 65+

Population projections suggest that the number of people aged 65 will continue to steadily increase, with:

- a 60% increase in the number of men aged 65+, from about 17,100 in 2016 to 27,500 in 2041.
- a 50% increase in the number of women aged 65+, from about 20,600 in 2016 to 31,200 in 2041.

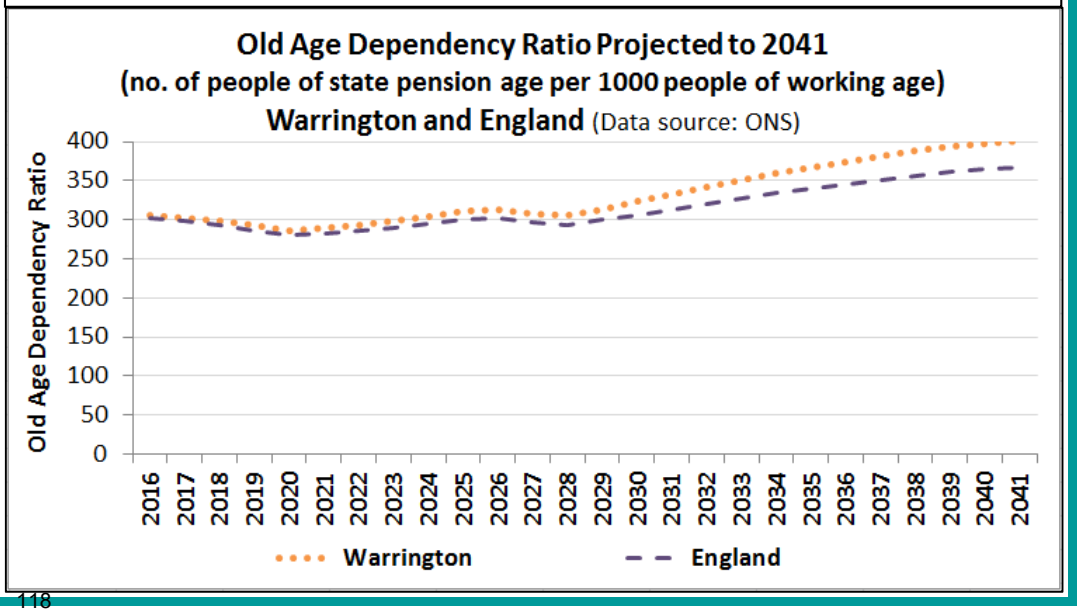
The estimated percentage increases are higher in the older age-bands, e.g.

- Men aged 90+ may increase from 428 in 2016 to 1,819 in 2041 (more than 4 times as many).
- Women aged 90+ may increase 1,072 in 2016 to 2,645 in 2041 (about two-and-a-half times as many).

DEFINITION: OLD AGE DEPENDENCY RATIO (OADR)

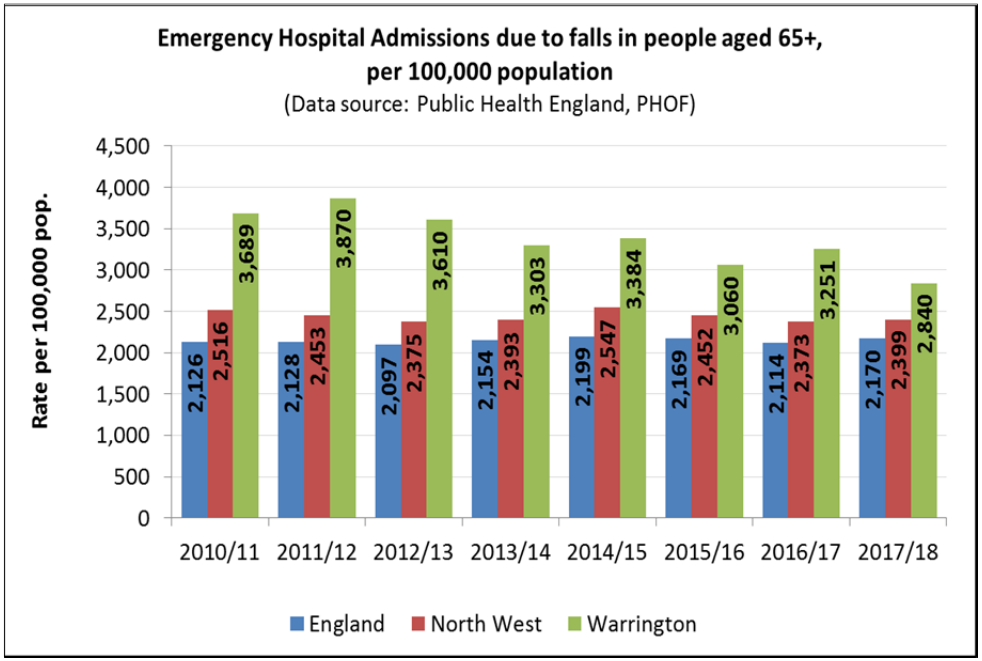
- In the past, the OADR calculation compared the number of people aged 65+ to the number of people of working age. However there has been a change in the methodology due to changes in state pension age (SPA), so values for 2016 onwards can't be compared to previous years.
- The new OADR calculation is the number of people of SPA, per 1000 people of working age. Data in the chart takes into account future changes in SPA; women's SPA will rise to 65 by 2018, then SPA will rise for men and women to 67 by 2027, and to 68 by 2046.
- An increase in the ratio has a range of implications, for instance in terms of pensions and social care.
- Dependency ratios have been calculated using ONS projected populations, which suggest that in Warrington the OADR will rise from 305 people of SPA per 1000 working age people in 2016, to 400 in 2041. The equivalent figures for England are 303 per 1000 in 2016 to 366 in 2042, i.e. from being very similar in 2016, the OADR in Warrington will have a much bigger rise than England.

In England and Warrington, the old age dependency ratio is rising and is expected to do so over the next 25 years. The ratio for Warrington is expected to rise much faster than for England.



5.4 Ageing Well – Falls

Definitions and caveats:
Data shown is based on emergency hospital admissions from the Hospital Episode Statistics inpatient data.
NB: Warrington has historically had high admission rates due to falls in older people; these high rates may be due to lower admission thresholds at the hospital and/or high number of falls in the over 65 population.

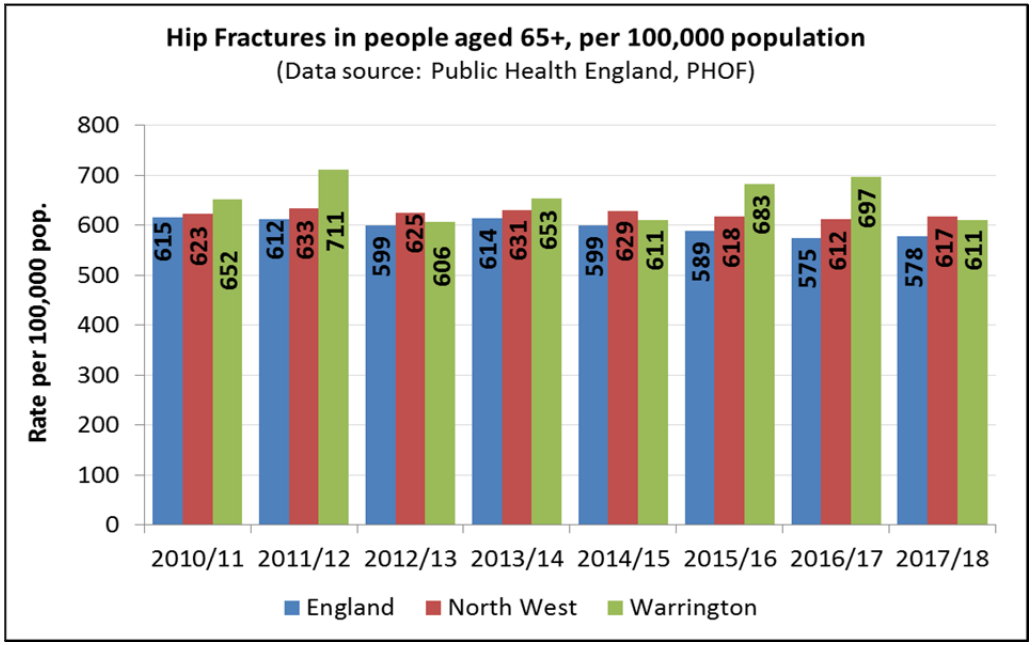


Hospital admissions due to falls in people aged 65 and over:

- There were 1,033 emergency hospital admissions for injuries due to falls of Warrington residents aged 65+. 66% of these were people aged 80 and above, and 34% were aged 65-79.
- Warrington has a very high rate; latest data (2017/18) shows a rate of 2,840 admissions per 100,000 people aged 65 and over, significantly higher than England (2,170).
- The Warrington rate has reduced since 2016/17 by 13%; regional and national rates have slightly increased.

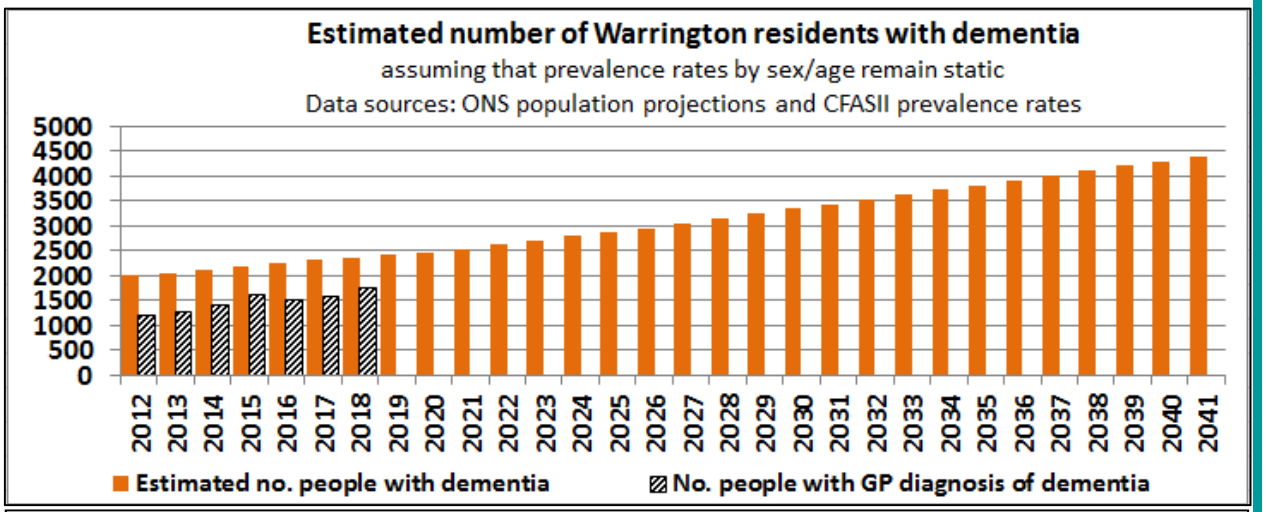
Hip fractures in people aged 65 and over:

- Hip fractures are a common injury associated with a fall (in 2017/18, 21% of emergency admissions due to a fall involved a hip fracture).
- Amongst Warrington residents aged 65 and over, Warrington has around 213 emergency admissions each year due to hip fractures. In 2017/18, 67% of admissions were people aged 80 and above, and 33% were aged 65 – 79.
- Latest data (2017/18) shows that Warrington had an emergency hospital admissions rate of 611 admissions per 100,000 people aged 65 and over, due to hip fractures. Warrington was not significantly higher than England (578).
- There has been a 12.0% reduction in the rate of emergency admissions between 2016/17 and 2017/18.



5.5 and 5.6 Ageing Well – 5.5 Dementia and 5.6 Flu Vaccination

- **Dementia** prevalence rates rise steeply with age as shown in the table below, and are different for men and women. Therefore the estimated number of people with dementia depends on the population structure, in particular the number of men and women in each age-band over 65.
- In the past, prevalence estimates were based on the first Cognitive Function and Ageing Study (2007), but have recently been revised based on more recent research (CFAS II, 2014). On the whole the new estimates are slightly lower.
- Research (University of Cambridge, 2014) suggests that 7 key risk factors associated with dementia are: diabetes, midlife hypertension, midlife obesity, physical inactivity, depression, smoking and low educational attainment.

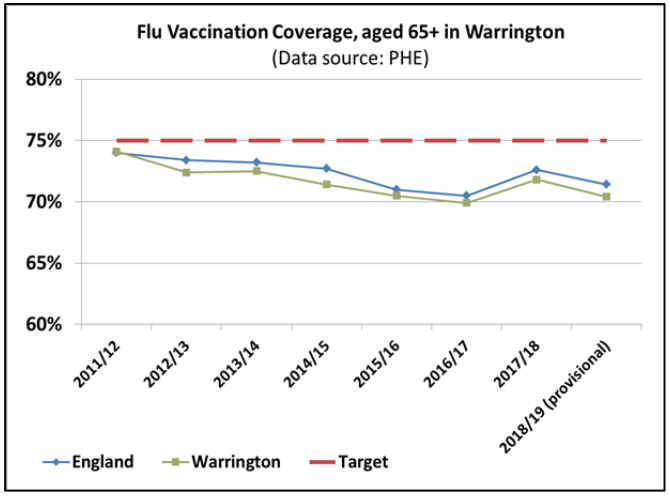


	ESTIMATED DEMENTIA PREVALENCE, %					
Ageband	65-69	70-74	75-79	80-84	85-89	90+
Men	1.2	3	5.2	10.6	12.8	17.1
Women	1.8	2.5	6.2	9.5	18.1	35

Source: Dementia UK update 2014 report, CFAS II prevalence rates (Cognitive Function & Aging Study II)

Assuming age/sex prevalence rates don't change in future, then applying them to population projections, suggests that the estimated number of people with dementia living in Warrington borough could almost double over 25 years from about 2,300 in 2018 to about 4,400 in 2041.

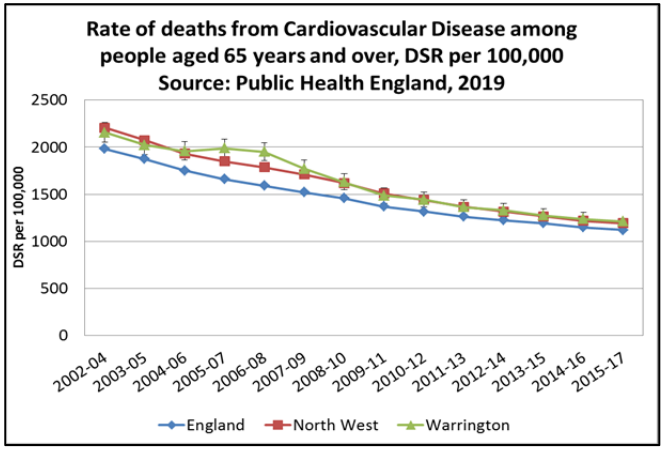
- Nationally and in Warrington, the proportion of people diagnosed with dementia has been rising. The rise is likely to be due in part to higher diagnosis rates, because nationally and locally, there has been a focus on improving diagnosis rates of dementia. However the ageing population is also a factor which is causing overall prevalence to increase. The number of people with early onset (aged under-65) is also increasing.
- Applying the prevalence rates in the table above to the number of patients in each sex/age-band registered at Warrington GP practices, gives an estimated 2317 patients aged 65+ with dementia (NHS Digital, March 2018), though some as yet undiagnosed. 1702 patients have actually been diagnosed, giving a diagnosis rate of 73.5% (higher than 67.5% in England). This implies that there may be about 600 patients with dementia who are as yet still undiagnosed.

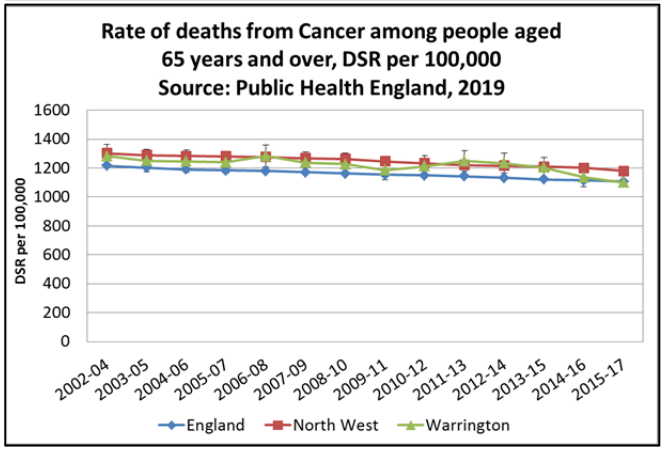


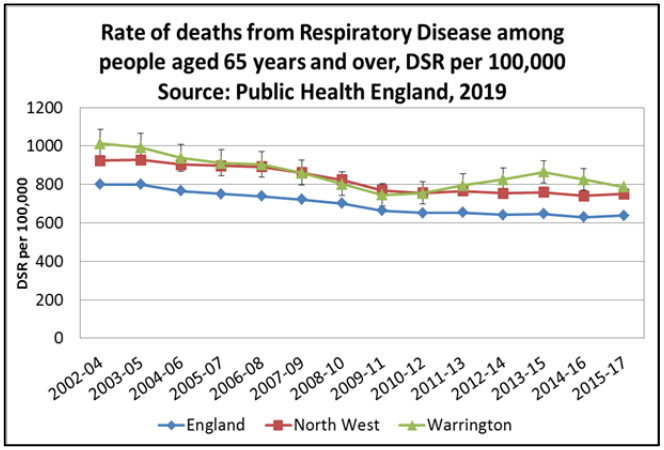
The influenza (flu) vaccination is offered to people in at-risk groups such as pregnant women, people with certain health conditions, and people aged 65 and over. These groups are at greater risk of developing serious complications, such as bronchitis and pneumonia if they catch flu. The Chief Medical Officer's (CMO) target is a vaccination rate of at least 75%.

In the 2018/19 flu season, 70.4% of Warrington residents aged 65 and over were vaccinated, slightly lower than England (71.4%). This rate is below the CMO's 75% target. Both Warrington and England have seen reductions in uptake since the previous year.

5.7 Ageing Well – Deaths in the over 65s







Mortality due to Cardio-Vascular Disease, Cancer and Respiratory Disease

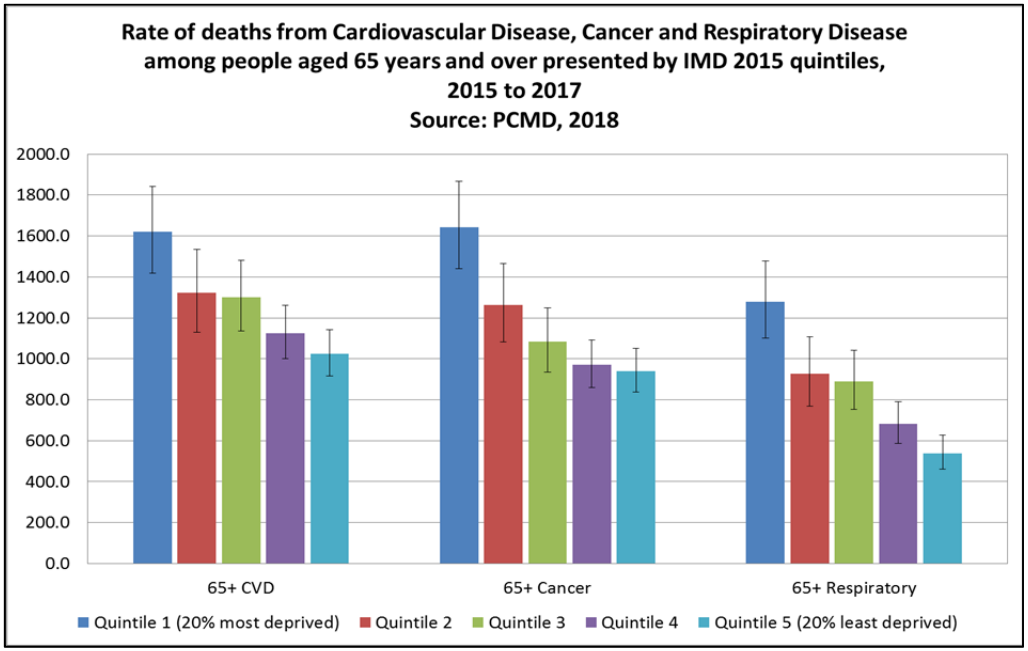
There have been substantial reductions in the rate of mortality from CVD in people aged 65 and over in Warrington (44% reduction between 2002-04 and 2015-17). However the rate of mortality in Warrington has been consistently significantly higher than England.

The mortality rate for cancer in people aged 65+ has been gradually reducing since 2002-04, in Warrington, England and the North West. There has been a 14% reduction in Warrington between 2002-04 and 2015-17, higher than the 9% reduction in both England and the North West.

There has been a downward trend in the mortality rate from respiratory diseases (a 22% reduction between 2002-04 and 2015-17). However, the Warrington mortality rate has remained significantly higher than England.

Deaths in usual place of residence: there has been considerable focus in recent years in improving end of life care, following the publication of the End of Life Care Strategy in 2008. However, evidence suggests that many people still do not receive good quality care which meets their individual needs and wishes (PHE, 2017). During 2016, 704 people aged 65 and above died in their usual place of residence (excludes deaths due to external causes), this equated to 44.6% of all deaths within this age group. This was significantly lower than the average for England (47.2%).

The chart illustrates mortality rates in people aged 65+, by socio-economic deprivation quintile (IMD 2015) for CVD, cancer and respiratory diseases. The chart shows that mortality rates from all 3 causes are highest in the 20% most deprived areas in Warrington, and lowest in the 20% least deprived areas.



6.1 Wider Determinants of Health – Housing

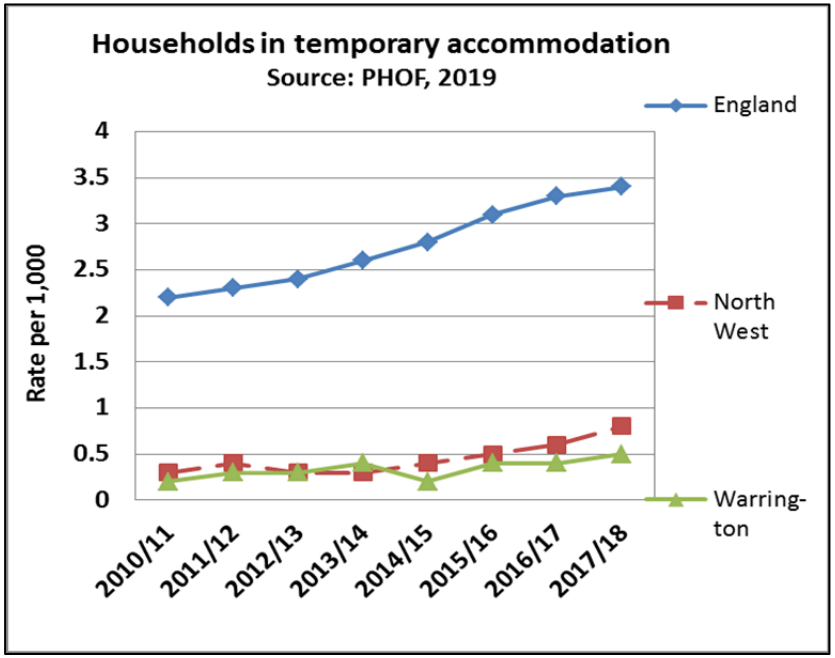
Housing and health: Poor housing and indoor environments cause or contribute to many preventable diseases and injuries, such as respiratory, nervous system and cardiovascular diseases and cancer (WHO, 2016). Homelessness is associated with severe poverty and is a social determinant of health. It is also associated with adverse health, education and social outcomes, particularly for children. Households that are accepted as being homeless or are in temporary accommodation can have greater public health needs than the population as a whole.

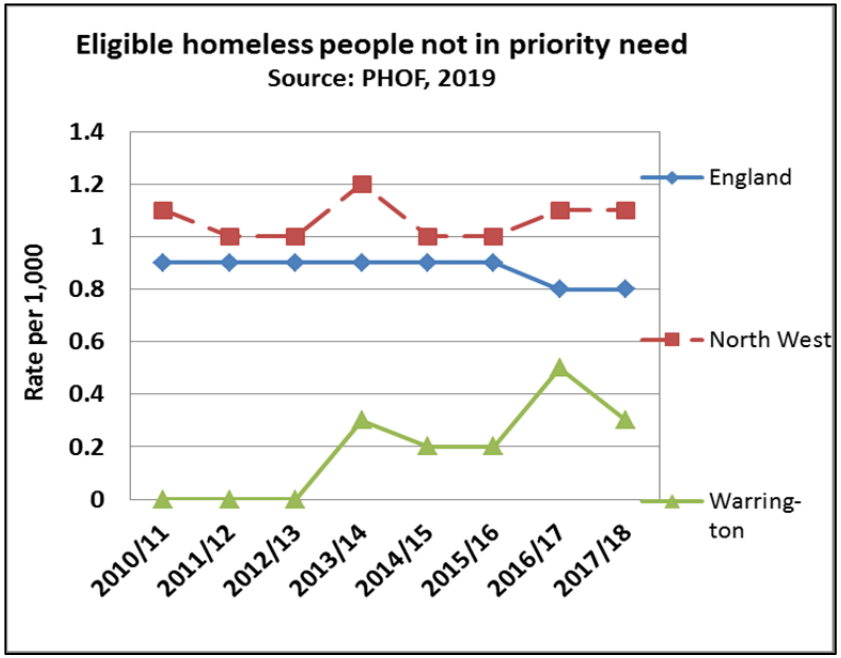
Disabled Facilities Grant:
This is a grant from the council for a disabled person to make changes to their home, e.g. widen doors, install ramps, install stair lifts, provide a suitable heating system. During 2017/18 there were 133 homes across Warrington adapted to meet personal care needs through the use of the Disabled Facilities Grant. This was a substantial decrease from the previous year (2016/17), when 169 homes were adapted.

The Homelessness Reduction Act 2017 came into force during 2018. It is the biggest change to homelessness legislation in 40 years and brings in new duties to prevent and relieve homelessness.

Homelessness – temporary accommodation: The number of households living in temporary accommodation awaiting a settled home is significantly low in Warrington when compared to England. During 2017/18 there were 41 households in temporary accommodation, a rate of 0.5 per 1,000; this was significantly lower than England (3.4 per 1,000).

Homelessness – homeless not in priority need: The number of homeless people not in priority need is significantly low in Warrington when compared to England. Literature has shown that the majority of people in this cohort are single homeless people, who as a group have very high prevalence of mental and physical health issues. During 2017/18 there were 29 households presenting to Warrington Borough Council which were not deemed to be in priority need, according to homelessness legislation.



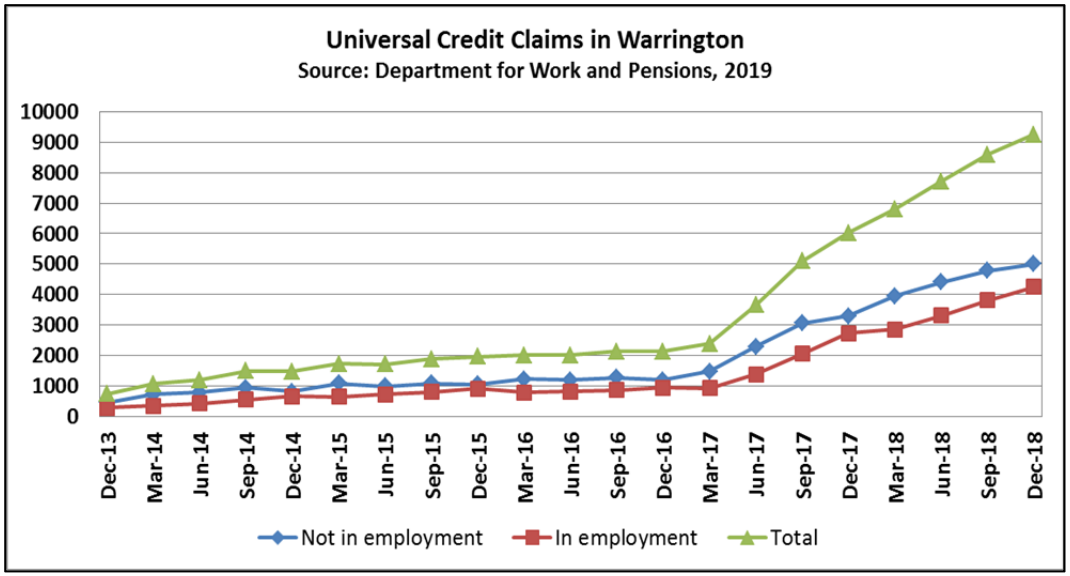


6.2 Wider Determinants of Health - Employment

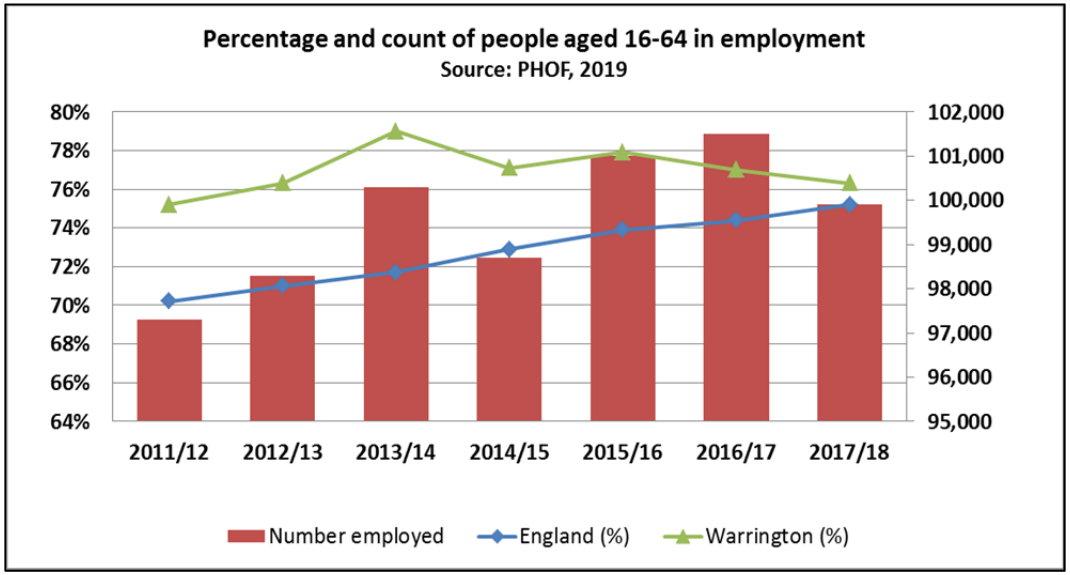
Employment and health: The characteristics of work – activity, social interaction, identity and status – are proven to be beneficial for our physical and mental health. Recent research shows that people in work tend to enjoy happier and healthier lives than people who are out of work (NHS Choices, 2014).

Benefit claimants: Universal Credit was introduced across a small number of Job Centres in 2013, of which Warrington was one. It is being rolled out with the aim of simplifying the benefits system. The plan is that a single Universal Credit payment into a bank, building society or credit union account will replace separate payments for Jobseeker's Allowance, Housing Benefit, Working Tax Credit, Child Tax Credit, Employment and Support Allowance and Income Support.

The number of claimants in Warrington has steadily grown since 2013, as new claimant groups become eligible to apply. The intention is that the process will make it easier for people to find work, as less financial disruption will be caused by the single payment, therefore the proportion of claimants who are employed is expected to increase. In Warrington, the proportion of Universal Credit claims that are made by employed people has increased from 38% in December 2013 to 46% in December 2018.



The percentage of the working age population in employment in Warrington has fluctuated between 75% and 79%. Up until 2015/16 Warrington had a percentage that was significantly higher than England, however as England continues to see an upward trend in employment, Warrington has experienced a slight reduction in the percentage.



6.2 Wider Determinants of Health - Employment

Employment: Over three quarters (76.3%) of people aged 16 to 64 who live in Warrington were in employment during 2017/18. This percentage was slightly higher than England (75.2%) and the North West (73.4%).

Gap in employment rate between vulnerable groups and overall employment:

Long-term health conditions: as at 2017/18, the gap in Warrington was 11.6 percentage points, similar to England (11.5p.p.) and the North West (13.3p.p.).

Learning disability: During 2017/18 the percentage point gap in Warrington was 75.4 percentage points, significantly higher than England (69.2p.p.) and the North West (69.1p.p.).

Contact with secondary mental health services: During 2017/18 the percentage point gap in Warrington was 70.3 percentage points, slightly higher than England (68.2p.p.) and the North West (68.4p.p.).

(A lower percentage point gap indicates lower levels of inequalities).

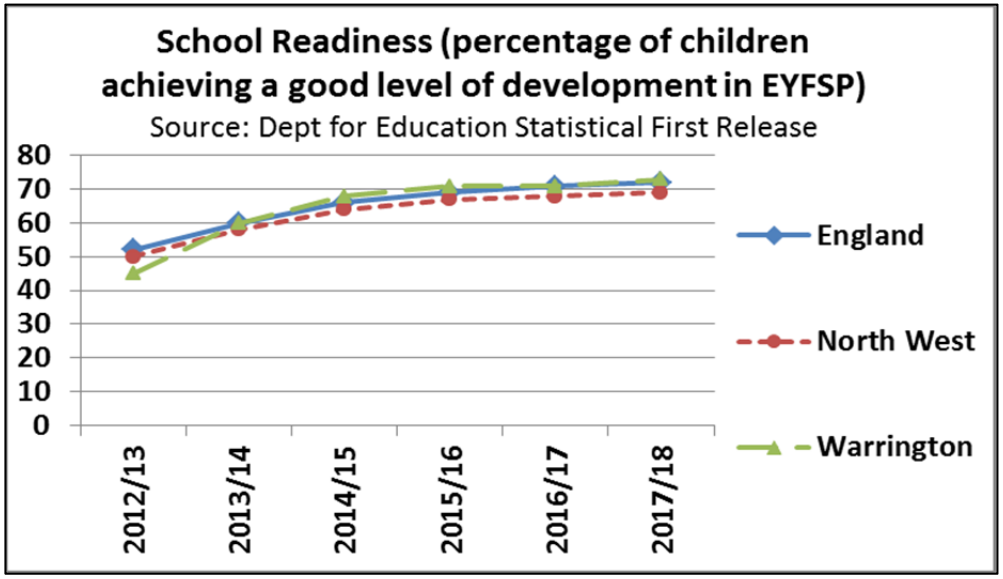
Sickness absence: It is estimated that nationally there are 140 million days lost to sickness absence every year.

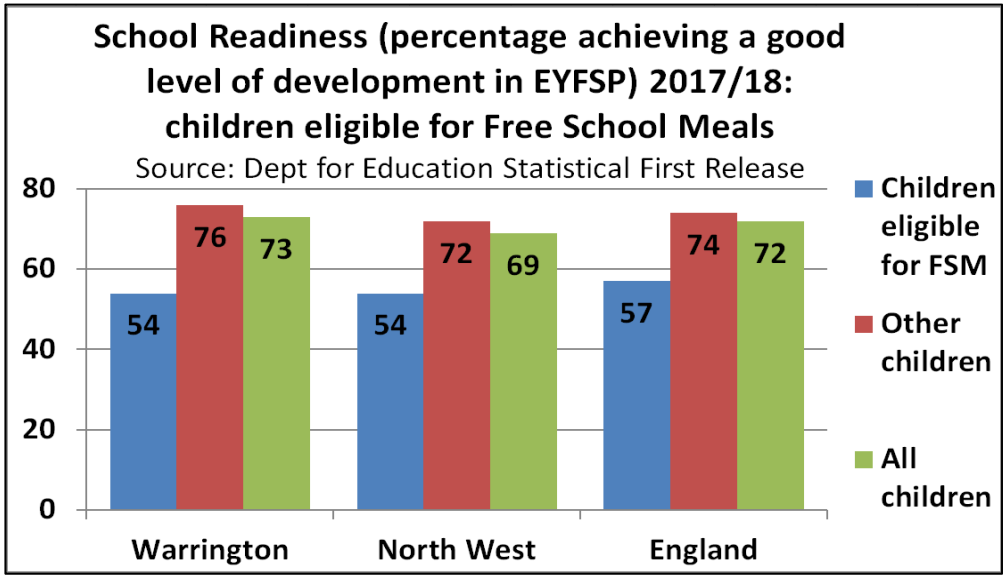
- Between 2015 and 2017, 1.6% of employees in Warrington had at least once day off in the previous week; similar when compared to the previous time period (1.7% during 2014-16). The Warrington percentage was very similar to both the North West (1.8%) and England (2.1%).
- Over the same time period, 0.8% of working days were lost due to sickness absence in Warrington, similar to the previous time period (0.8% during 2014-16). The Warrington percentage was very similar to both the North West (1.1%) and England (1.1%).

6.3 Wider Determinants of Health – Education - School Readiness (age 4/5)

Education and health: Research evidence shows that education and health are closely linked. Pupils with better health and wellbeing are likely to achieve better academically. Effective social and emotional competencies are associated with greater health and wellbeing, and better achievement (PHE, 2014).
The Department for Education monitors the gap between children who are known to be eligible for Free School Meals (FSM), and other children. Eligibility for FSM is based on being in receipt of certain means-tested security benefits, and is used as a proxy for socio-economic deprivation/disadvantage.

'School readiness' (achieving a 'good level of development', GLD) is an indicator used to assess a child's overall development at age 4/5 at the end of Reception class. It is based on teacher assessments, and defined as achieving at least the expected level within the following areas of learning: communication and language, physical development, personal social and emotional development, literacy, and numeracy. Personal, social and emotional development are crucial elements, as are communication skills, as without these, children are less likely to be able to absorb other areas of learning such as literacy and maths. It has an effect far wider than purely education. The foundations of physical, intellectual and emotional development are laid in early childhood. What happens in these early years has lifelong effects on many aspects of health and wellbeing, from obesity, heart disease and mental health, to educational achievement and economic status.





Trend: The proportion assessed as school ready has risen steadily in England, the North West and Warrington. Since 2013/14, the proportion in Warrington has been similar, or slightly higher, than in England and the North West. In 2017/18, 73% of children in Warrington reached a 'good level of development' compared to 72% in England and 69% in the North West.

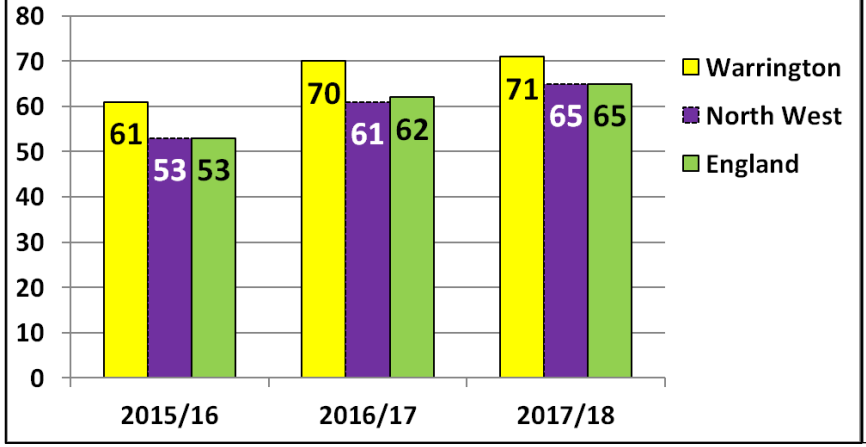
Boys/Girls: In 2017/18 in Warrington, 79% of girls and 67% of boys were assessed as school ready, compared to 78% of girls and 65% of boys in England, and 76% girls and 62% of boys in the North West. The Warrington girl/boy gap of 12 percentage points was slightly lower than the North West (14p.p) and England (13p.p).

Free School Meals (FSM): In Warrington in 2017/18, only 54% of children eligible for FSM were school ready compared to 76% of other children (a 22 percentage point gap). In the past, this gap has been consistently wider (worse) in Warrington than in the North West and England. The percentage of children eligible for FSM who are school ready is consistently lower in Warrington than in England (57% in 2017/18).

6.3 Wider Determinants of Health – Education – Key Stage 2 (age 10/11)

Key stage 2 (children at the end of primary school, aged 10/11): In 2017/18, 71% of Year 6 children in Warrington schools achieved the expected level in reading, writing and maths, substantially higher than 65% in the North West and in England. Warrington has been consistently much higher than England and the North West.

Percentage of children achieving expected standard in Reading, Writing and Maths at Key Stage 2 (age 10/11),
Source: Dept for Education Statistical First Release



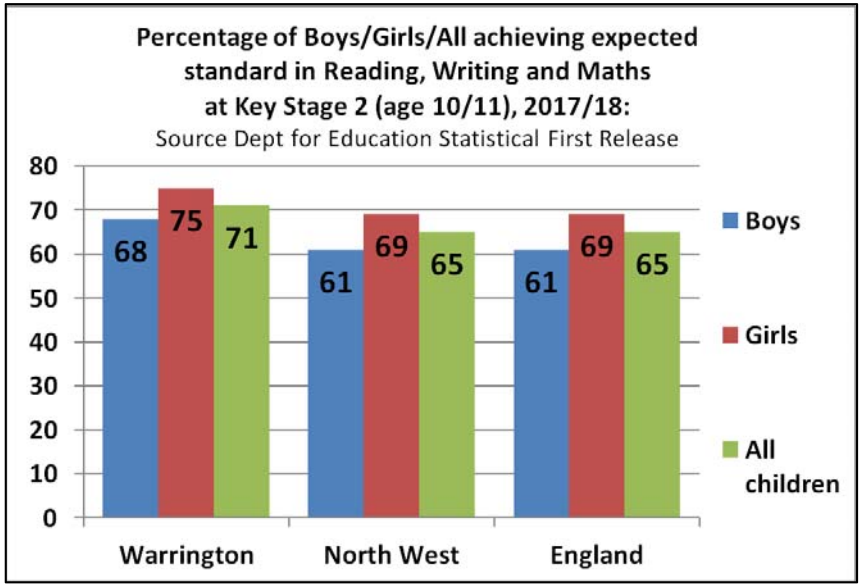
(NB The 2016 KS2 assessments were the first to assess the new, more challenging national curriculum introduced in 2014, and therefore 2015/16 onwards can't be compared to previous years.)

Free School Meals (FSM) attainment gap 2017/18

The Department for Education monitors the gap in attainment between those children who are known to be eligible for FSM, and other children. 11% of Warrington's Year 6 children in 2017/18 were known to be eligible for FSM, much lower than 15% in England and 17% in the North West.

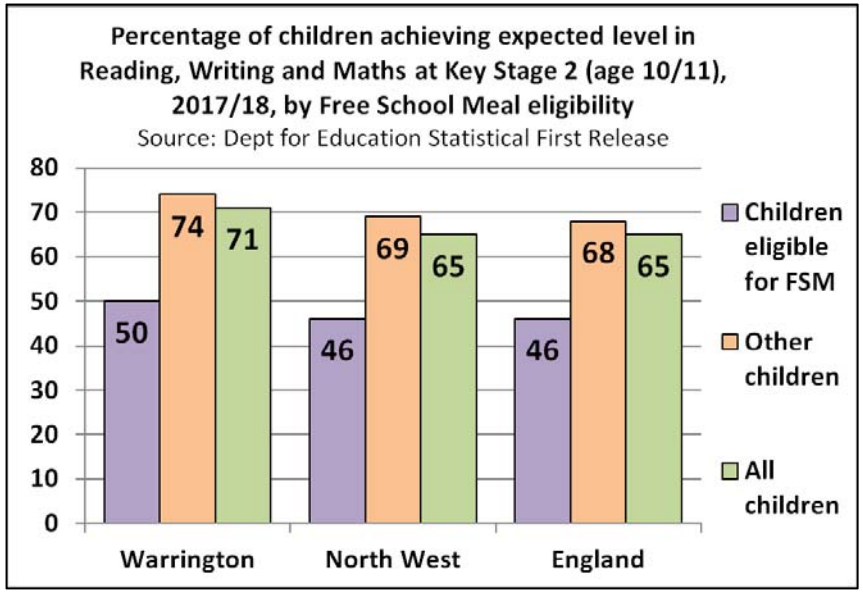
- In Warrington in 2017/18, only 50% of children eligible for FSM achieved the expected level in Reading, Writing and Maths, compared to 74% of other children, i.e. a 24 p.p. gap.
- This was a large improvement from the previous year in Warrington for children eligible for FSM (44%).
- Results in England were lower than Warrington for both FSM and non-FSM; 46% of children eligible for FSM compared to 68% of other (non-FSM) children, i.e. a 22p.p. gap.

Percentage of Boys/Girls/All achieving expected standard in Reading, Writing and Maths at Key Stage 2 (age 10/11), 2017/18:
Source Dept for Education Statistical First Release



Boys/Girls attainment gap: In 2017/18 in Warrington, 75% of girls and 68% of boys achieved the expected level in reading, writing and maths; a gap of 7 percentage points. The gap in the North West and England was slightly higher (8p.p.).

Percentage of children achieving expected level in Reading, Writing and Maths at Key Stage 2 (age 10/11), 2017/18, by Free School Meal eligibility
Source: Dept for Education Statistical First Release

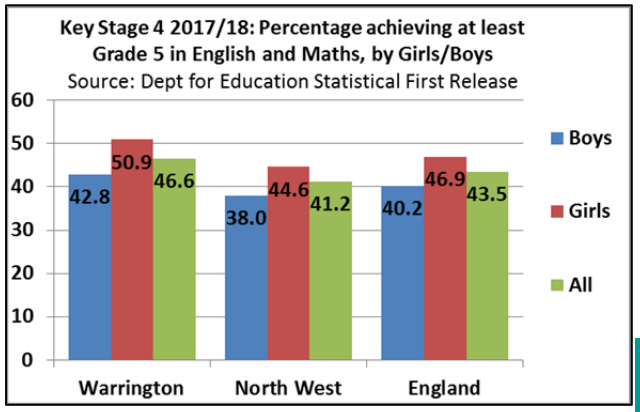


6.3 Wider Determinants of Health – Education – Key Stage 4 (age 15/16)

In 2017, pupils sat reformed GCSEs in English language, English literature and maths for the first time, graded on a 9-1 scale. (Previously, GCSEs were graded A*-G). Grade 4 is considered a pass, and roughly equivalent to a Grade C. Grade 5 is considered 'a good pass'. New GCSEs in other subjects will be phased in. Performance indicators now include: Progress 8 (progress across 8 qualifications), Attainment 8 (sum of the grades of the same 8 qualifications, giving a maximum of 8x9=72 points), and % of pupils achieving grade 5 or above in English and maths. Published data also include the % of pupils achieving grade 4 or above in English and maths, which is roughly similar to the 'Grade C or above in English & Maths' indicator in previous years. *More information is available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/676184/Secondary_accountability_measures_January_2018.pdf*

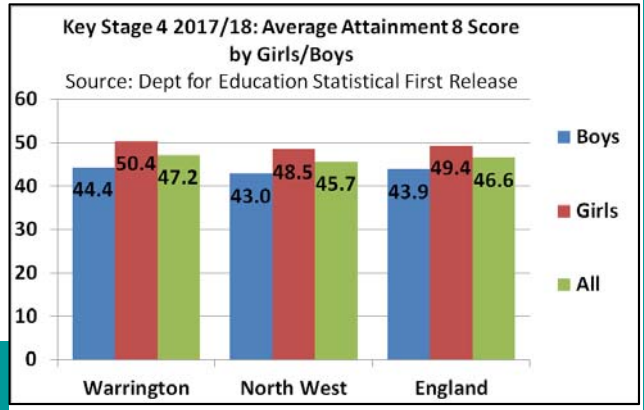
Warrington, the North West and England (2017/18)

- **Grade 4+ in English and Maths** In Warrington 67.2% achieved at least a Grade 4 in both English and Maths, higher than 64.4% in England and 62.9% in the North West.
- **Grade 5+ in English and Maths** In Warrington 46.6% achieved at least a Grade 5 in English and Maths, higher than 43.5% in England and 41.2% in the North West.
- **Attainment 8**: In Warrington the average Attainment 8 score per pupil was 47.2, similar to 46.6 in England and 45.7 in the North West.



Attainment gap between girls and boys (2017/18)

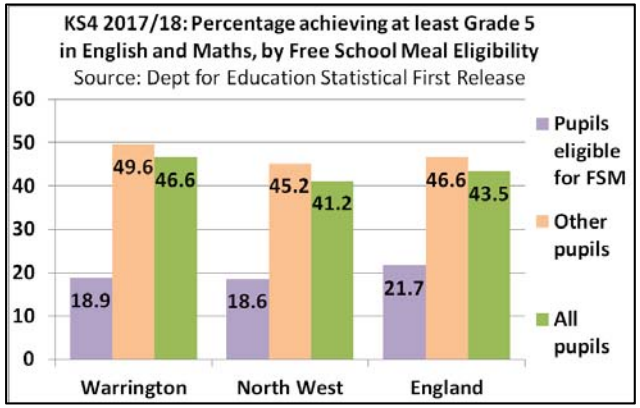
- **Grade 4+ in English and Maths** In Warrington 71.8% of girls and 63.1% of boys achieved a Grade 4+ in both English and Maths, i.e. a gap of 8.7 percentage points.
- **Grade 5+ in English and Maths** In Warrington 50.9% of girls and 42.8% of boys achieved at least a Grade 5 in both English and Maths, i.e. a gap of 8.1 p.p.
- **Attainment 8**: In Warrington, the attainment 8 average score for girls was 50.4; compared to 44.4 for boys.

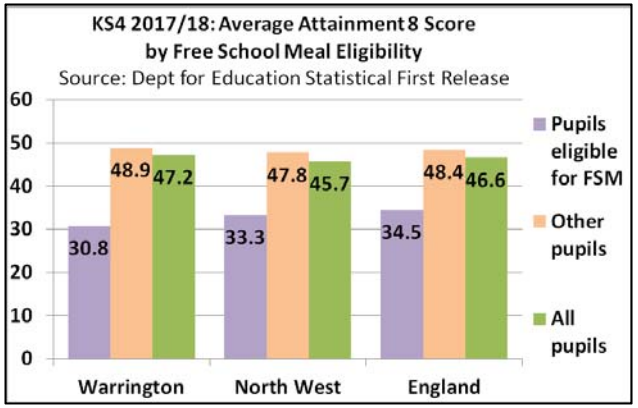


Pupils eligible for Free School Meals (2017/18): Only 10% of Warrington pupils were eligible for FSM compared to 13% in England and 15% in the North West.

Although Warrington results overall are better than England, they are worse than England for FSM pupils:

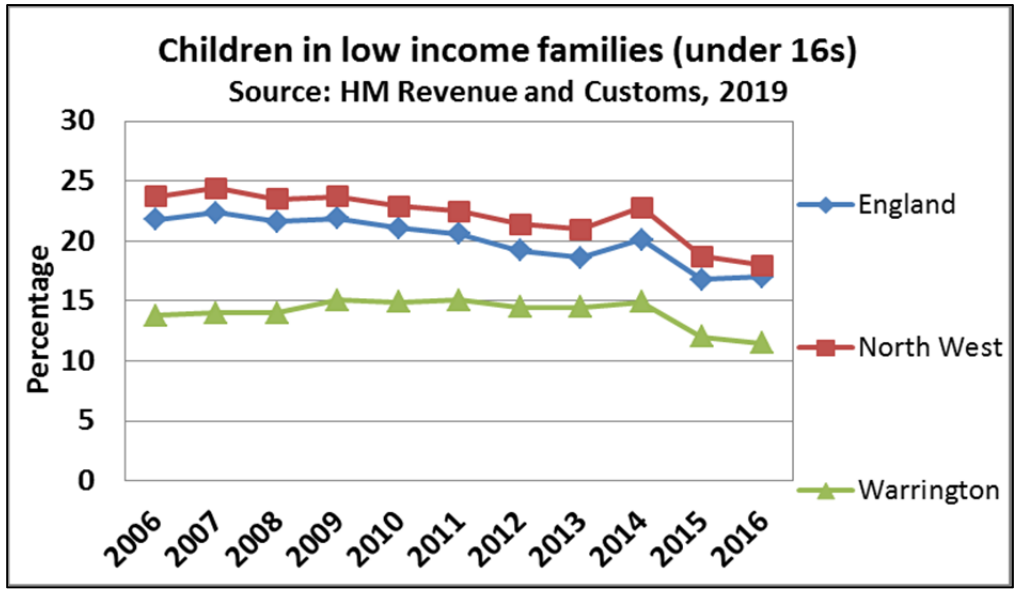
- **Grade 4+ in English and Maths** In Warrington, only 41.2% of pupils eligible for FSM achieved Grade 4 or above in both English and Maths, compared to 70.0% of other pupils, i.e. a gap of 28.8 percentage points.
- **Grade 5+ in English and Maths** In Warrington, only 18.9% of FSM pupils achieved Grade 5+ in both English and Maths, compared to 49.6% of other pupils. In England, FSM pupils fared better (21.7%), but non-FSM pupils fared worse (46.6%), and so the Warrington gap of 30.7p.p. between FSM and non-FSM pupils is much wider than that in England (24.9p.p.)
- **Attainment 8**: In Warrington, the attainment 8 score for pupils eligible for FSM was 30.8 compared to a score of 48.9 for other pupils, i.e. 18.1 p.p. lower.





6.4 & 6.5 Wider Determinants of Health - 6.4 Child Poverty & 6.5 Social Contact (Adult Social Care Users)

Child poverty and health: Evidence shows that childhood poverty leads to premature mortality and poor health outcomes as adults. Reducing the numbers of children who experience poverty should improve their adult health outcomes and increase healthy life expectancy (Marmot Review, 2010).

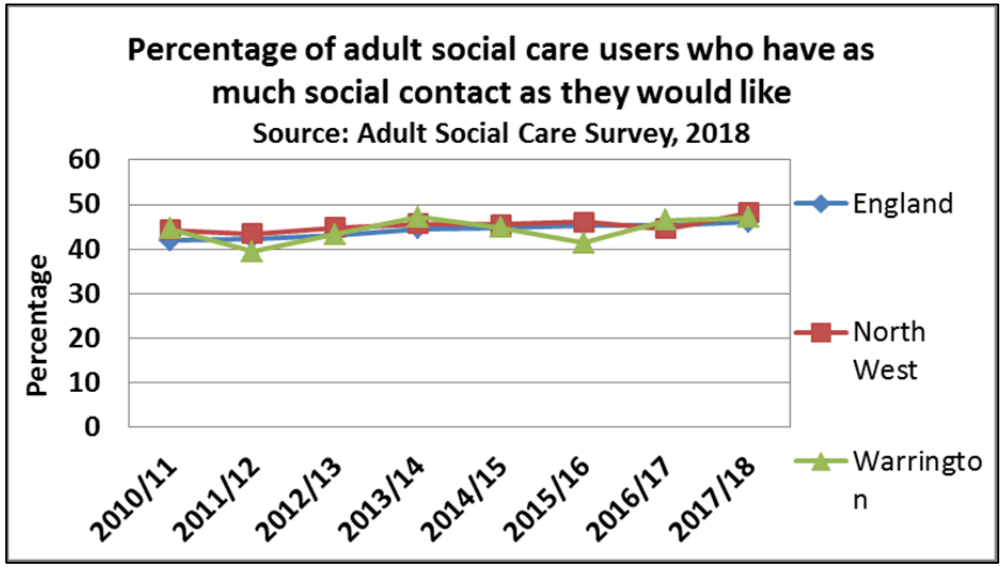


The percentage of children aged under-16 living in poverty in Warrington has reduced slightly during the time period presented in the chart. During 2016 there were 4,370 under 16s living in low income families in Warrington (11.5%); the percentage of children living in poverty in Warrington is significantly lower than England. Nationally and regionally there has been a reduction in the percentage of children living in poverty, with the exception of an increase during 2014.

Social contact and health: There is a clear link between loneliness and poor mental and physical health. A key element of the Government's vision for social care is to tackle loneliness and social isolation, supporting people to remain connected to their communities and to develop and maintain connections to their friends and family (PHE, 2015).

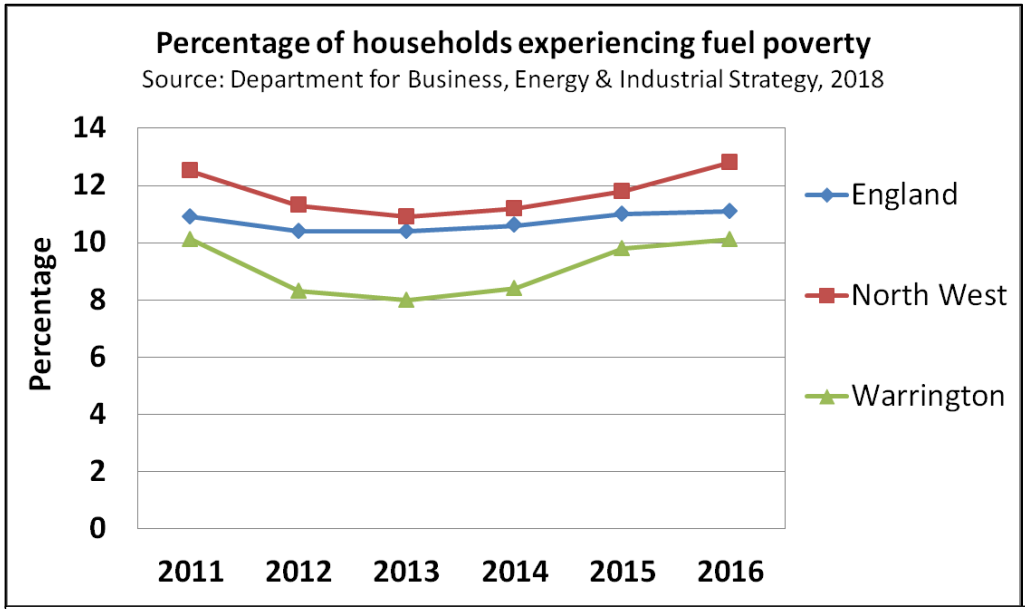
Definition:
The percentage of respondents to the Adult Social Care Users Survey who responded to the question "*Thinking about how much contact you've had with people you like, which of the following statements best describes your social situation?*" with the answer "*I have as much social contact as I want with people I like*".

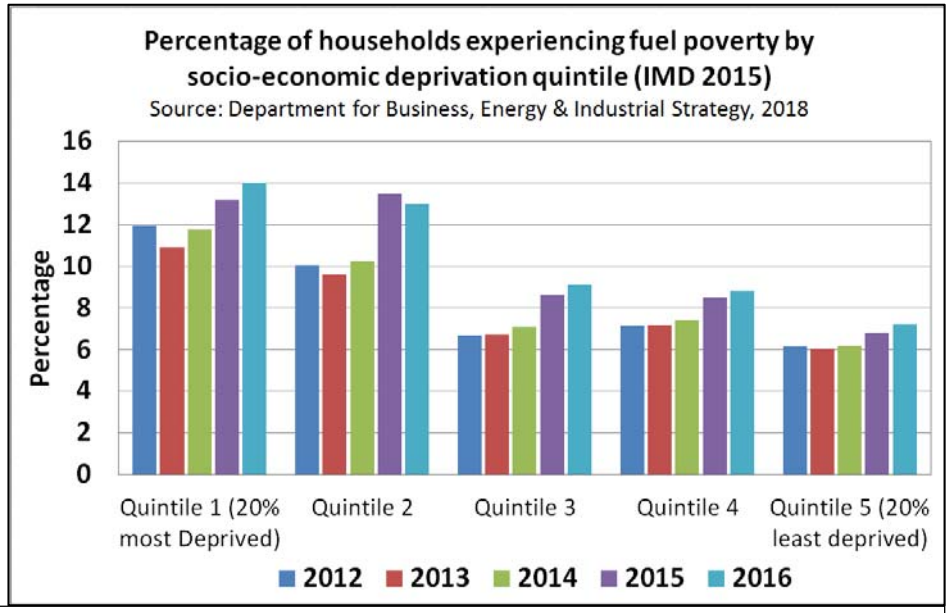
In Warrington, almost half of the respondents to the survey said that have as much social contact as they would like (2017/18). This is a slight increase compared to the previous year (46.5%). Performance in Warrington is slightly higher than England (46.0%) and slightly lower than the North West (48.1%).



6.6 Wider Determinants of Health – Fuel Poverty

Fuel poverty and health: There is compelling evidence that the drivers of fuel poverty (low income, poor energy efficiency and energy prices) are strongly linked to living at low temperatures (Wilkinson et al 2001) and the recent Marmot Review Team report showed that low temperatures are strongly linked to a range of negative health outcomes (PHE, 2015). Research identifies that certain groups are particularly vulnerable with regards to fuel poverty and the adverse effects of cold housing. These include older people, particularly those living on their own, lone parents, young children, disabled people and families where adult members are either unemployed or working on a low income (The Eurowinter Group, 1997; Wilkinson et al, 2004; Kinsella, 2009)





Definition: From 2011 the government produced fuel poverty statistics using the low income high cost (LIHC) definition, which compares households relative to the national median fuel costs and income. A household is considered fuel poor if they have required fuel costs that are above average (the national median level), and were they to spend that amount, they would be left with a residual income below the official poverty line.

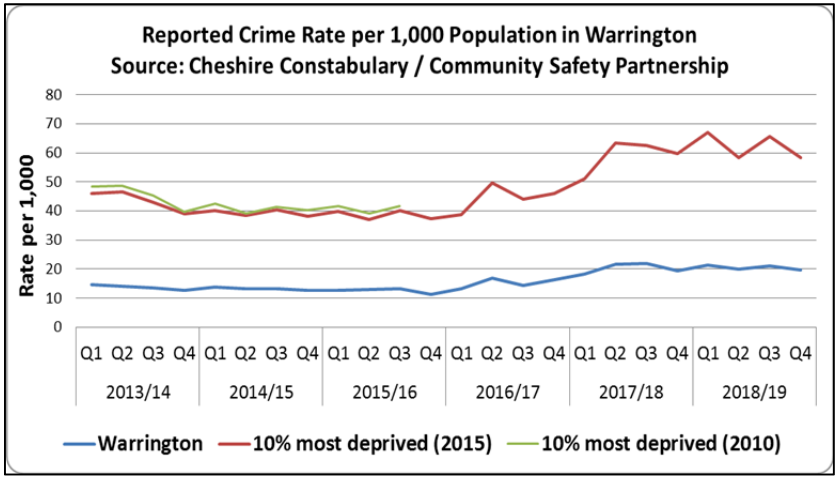
- In 2016, the proportion of fuel poor households in England increased from 11.0% (2.50 million households) in 2015 to 11.1% (2.55 million) in 2016.
- In the North West the estimated percentage of fuel poor households rose from 11.8% in 2015 to 12.8% in 2016.
- There was also an increase in Warrington from 9.8% in 2015 to 10.1% in 2016 (an estimated 8,541 households in 2015, and 8,936 in 2016).
- The proportion of fuel poor households is much higher in the more socio-economically deprived areas (Quintiles 1 and 2) than in the other quintiles. In 2016, 14.0% of households were fuel poor in Quintile 1 (most deprived), compared to 7.2% in Quintile 5 (least deprived).

The Warrington Borough Council Home Energy Conservation Officer developed and implemented the use of innovative low carbon technologies throughout the Borough and continues to be involved in an education programme developed by the Council, delivering energy efficiency and climate change messages to local school children and undertaking a number of talks, surgeries and roadshows throughout the Borough to assist residents locally by maximising income.
See Warrington's Home Energy Conservation Act Report at: https://www.warrington.gov.uk/info/201160/housing-grants-and-assistance/1723/affordable-warmth

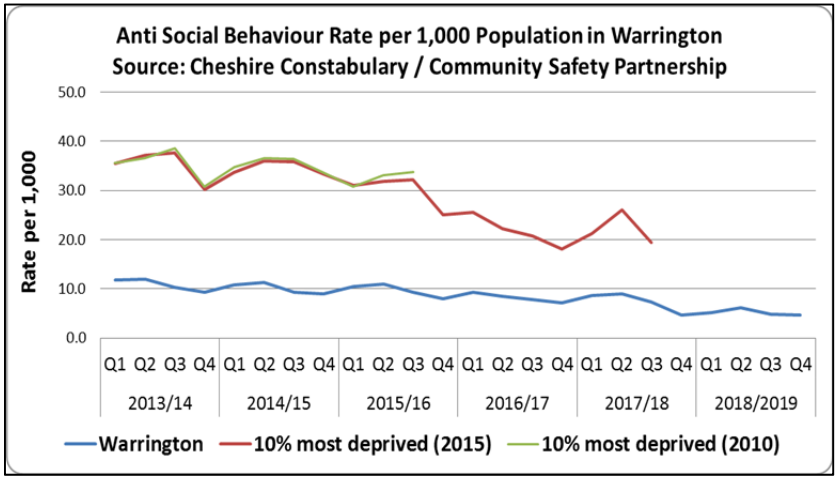
6.7 Wider Determinants of Health - Crime and Anti-Social Behaviour

Crime and health: Tackling a person's offending behaviour is often intrinsically linked to their physical and mental health, and in particular any substance misuse issues. Offenders often also experience significant health inequalities that will need to be identified, examined and addressed locally in partnership with organisations across the criminal justice system. Furthermore, a large proportion of families with multiple needs are managed through the criminal justice system, and their issues are inter-generational (PHE, 2015). Crime, and the fear of crime, is known to impact on health and wellbeing in a number of ways; as well as potentially impacting on the physical health of individuals who are victims of crime, evidence shows that fear of crime can also affect wellbeing, particularly mental wellbeing.

Sources of data: Data and information comes from Warrington Community Safety Partnership (data using Cheshire Constabulary Reported Crime lists and performance console), and from Public Health England's Public Health Outcomes Framework.



Crime: In Warrington, there were 19,184 recorded crimes in 2018/2019. This is equivalent to a rate of 91.5 crimes per 1,000 population, slightly higher than the Cheshire Constabulary force rate of 88.2. Crime has increased by 4.1% since the previous year (18,426). Reported crimes where the offender was affected by alcohol accounted for 7%. Assaults were the highest alcohol related crime type representing 55%. As expected the highest proportion of alcohol related assaults are linked to Warrington town centre's night time economy.
From 2016/2017 improved compliance with crime recording standards meant that incidents are being crimed at first point, which will be reflected in less ASB incidents and increases in offences such as public order or violence without injury. This has contributed to increases in the overall volume of crime. Before these improvements, there had been a very gradual reduction in the crime rate, both in Warrington as a whole, and in the 10% most deprived areas. As volumes have increased, the reported crime rate in the 10% most deprived areas of Warrington is approximately 3 times higher than the rate for the whole of Warrington.



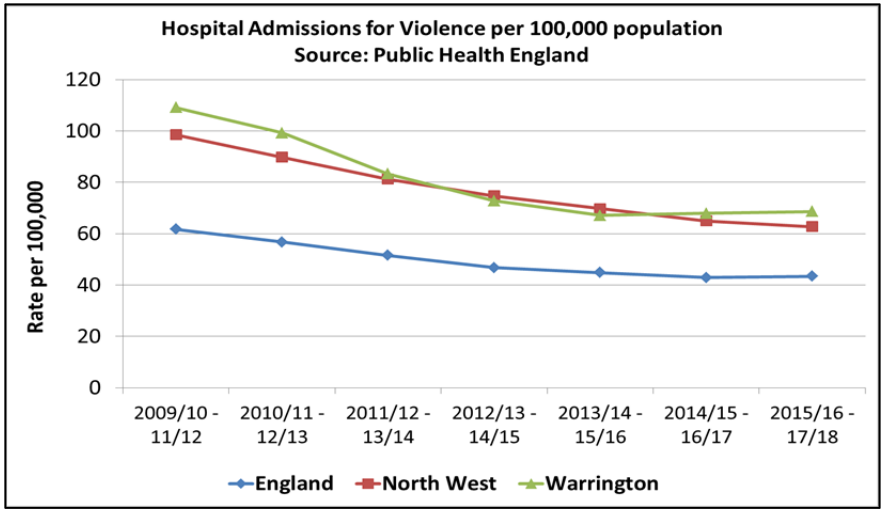
Anti-social behaviour (ASB): ASB covers a wide number of issues from noise, parking, fly tipping, nuisance and aggressive behaviour, and it is a high priority for residents. In 2018/2019, Warrington had a rate of 20.8 ASB incidents per 1,000 population reported to the police (4,369 incidents). ASB has been decreasing over the years, showing a 30% decrease on the previous year. Improved compliance with crime recording standards means that incidents are being recorded as crimes at first point of contact, which will be reflected in less ASB incidents and increases in offences such as public order or violence without injury.
ASB data for the purposes of mapping to a sub-Warrington level is not currently available due to changes and implementation of a new police incident recording system. The most recent quarterly data at a sub-Warrington level is for the end of December 2017; this shows that the 10% most deprived areas of Warrington have much higher rates of ASB than Warrington as a whole, approximately 2.5 times higher.

6.7 Wider Determinants of Health - Crime and Anti-Social Behaviour – Violent Crime

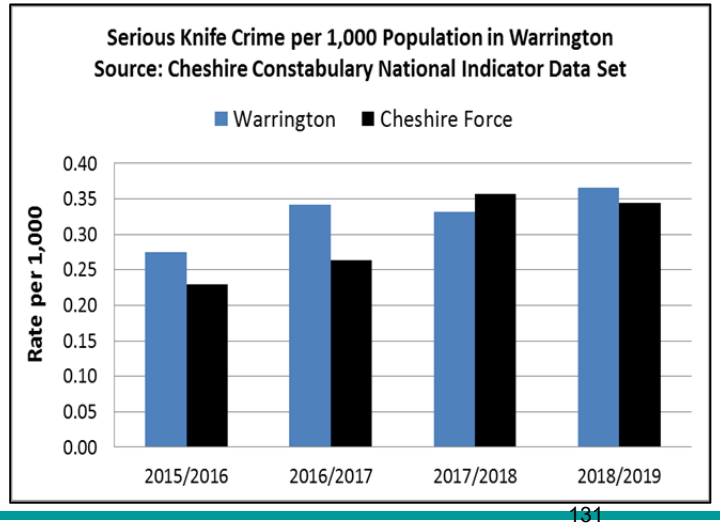
Violence against the person: In 2017/2018 there were 5,438 offences of violence in Warrington, an increase of 45% when compared to the previous year. This is equivalent to a rate of 26.0 violence offences per 1,000 population, higher than the national rate of 23.7, but lower than the North West rate of 28.6 (Source: PHE/Home Office). Local data for 2018/2019 shows 6,458 offences of violence, giving an increase of 19% on 2017/2018.

Offences of violence have increased to the highest operating level over the last 3 years locally and force wide, following changes in crime recording and improved compliance with recording standards. When compared to most similar groups Warrington is currently higher than average for violence and sexual offences, having previously been around the average of the group. This position should be viewed with caution as police operations may have had an impact on volumes over the last year affecting the current benchmarking position. (Most similar groups are local authority areas that are most similar to each other based on an analysis of demographic, social and economic characteristics which relate to crime). Assaults remain the highest crime type affected by alcohol (55%). As expected, the highest proportion of violent offences are committed within Warrington during the weekend night time economy.

Hospital admissions for violence (Source: PHE): Latest data for the 3-year period 2015/16–2017/18 shows that Warrington had 68.6 hospital admissions for violence per 100,000 population, compared to England's rate of 43.4. Warrington had a lower rate than the North West (62.7). On average there were around 140 hospital admissions each year in Warrington due to violence. Warrington has had significantly higher admission rates than England for a number of years. The admission rate had been reducing until 2013/14 – 15/16, since then it has increased very slightly in the past 2 reporting periods. England has experienced a very small increase in the latest reporting period.



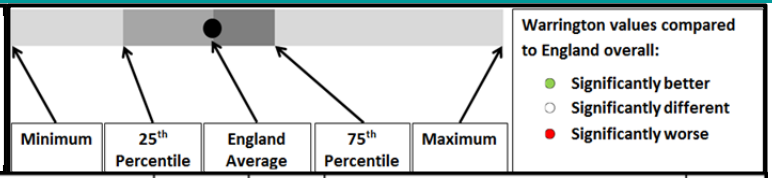
Serious knife crime:
Serious knife crime in Warrington is slightly above the force rate with 0.37 incidents per 1,000 population compared to the force rate of 0.34.
There was a 33% increase in the volume of serious knife crime in Warrington from 57 incidents per 1,000 population in 2015/16 to 76 in 2018/2019, although this was lower than the force increase of 50% (240 offences to 359 offences).



Domestic abuse: In 2018/2019, Warrington's domestic abuse rate was 14.2 per 1,000 population (2,982 offences). This is in line with the Cheshire Constabulary force area of 14.3 incidents per 1,000 population. Warrington has seen an increase of 33% compared to 2017/2018 (2,248 offences). In 2018/2019, offences affected by alcohol represented 19.6% of domestic abuse incidents (584 offences), slightly higher than the force average at 18.6%. Offences affected by drugs represented 2.2% of domestic abuse incidents (66 offences), again similar to the force average of 2.4%.

7.1 Health and Wellbeing Strategy Monitoring

The chart shows indicators selected to monitor the Warrington Health and Wellbeing Strategy 2019-2023. The grey bars show the spread between LAs/CCGs (a quarter of the LAs/CCGs lie on each section of a bar, e.g. a quarter lie between the minimum and the 25th percentile, a quarter lie between the 25th percentile and the average, and so on). The dots show the England average (black) and the Warrington value (with statistical significance compared to England shown in



Health and Wellbeing Strategy Indicators, April 2019	Count	Warrington Value	England Average	Statistical Significance: Warrington vs England Overall	Is a high/ low value good?	Lowest LA Value	Range between England Local Authorities	Highest LA Value
High level outcome Indicators								
Healthy life expectancy at birth (males) Years (2015-17)	-	64.9	63.4	Similar	high	54.7		69.8
Healthy life expectancy at birth (females) Years (2015-17)	-	64.0	63.8	Similar	high	53.5		71.6
Inequality in life expectancy at birth (males) Gap in years (2015-17)	-	11.1	9.4	Worse	low	3.70		14.8
Inequality in life expectancy at birth (females) Gap in years (2015-17)	-	7.3	7.4	Similar	low	2.00		14.3
Starting Well								
School ready at age 5, % (2017/18)	1,844	73%	72%	Similar	high	64%		81%
Excess weight in children (Year 6), % (2017/18)	779	33%	34%	Similar	low	22%		44%
Emotional wellbeing of looked after children aged 5-16, mean score (2016/17)	-	13.7	14.1	Similar	low	0		19.9
Living Well								
Excess weight in adults (18+), % (2016/17)	-	66%	61%	Worse	low	38%		75%
Physically active adults (19+), % (2016/17)	-	70%	66%	Better	high	53%		78%
Alcohol related hospital admissions, DSR per 100,000 (2017/18)	1,402	684.6	632.3	Worse	low	393.8		1096.5
Preventable hospital admissions, ISR per 100,000 (2017/18)	3,110	1492.8	1324.0	Worse	low	189.4		2229.8
Use of hospital beds (bed days) following emergency admission, ISR per 1,000 (Q4 2017/18)	122,018	592.8	504.6	Worse	low	315.3		739.9
People feeling supported to manage their long term condition, % (2017/18)	623	62%	60%	Similar	high	47%		67%
Preventable deaths, DSR per 100,000 (2015-17)	1,119	185.8	181.5	Similar	low	116.3		326.7
Early death for those with serious mental illness, % (2014/15)	-	400%	370%	Similar	low	165%		570%
Deaths attributable to air pollution, % (2017)	-	4%	5%	Similar	low	3%		7%
Ageing Well								
Social care-related quality of life score, aged 65+ (2017/18)	170	18.8	18.9	Similar	high	17.7		20.0
Hospital admissions due to falls in those aged 65+, DSR per 100,000 (2017/18)	1,033	2840.3	2170.4	Worse	low	1352.3		3328.8
Supporting older people (65+) to stay at home for longer after a hospital admission, % (2017/18)	129	86%	83%	Similar	high	50%		100%
Delayed transfer of care per 100,000 population (All delays), 18+, rate per 100,000 (2017/18)	23	13.9	12.4	Similar	low	0.0		33.3
Strong and Resilient								
Percentage in employment, aged 16 to 64 (2017/18)	99,900	76%	75.2%	Similar	high	58.6%		84.5%
People living in fuel poverty, % (2016)	8,936	10%	11.1%	Similar	low	4.9%		17.0%
Housing affordability: Ratio of house price to residence-based earnings, Ratio (2017)	-	6.2	7.9	Similar	low	3.0		28.9

Glossary

Alcohol related conditions: Alcohol causes, or can contribute to the development of, many health conditions. Based on published evidence, researchers have been able to estimate what proportion of a health condition is alcohol-related.

All-Age All-Cause Mortality Rates (AAACM): A measure of the rate at which people are dying in a particular area, over a specified time period.

Anti-social behaviour: behaviour by a person which causes, or is likely to cause, harassment, alarm or distress to persons not of the same household as the person.

Breastfeeding continuation: Measured as infants that are totally or partially breastfed at age 6 to 8 weeks.

Breastfeeding initiation: Measured as mothers who give babies breast milk in the first 48 hours after delivery.

Body Mass Index (BMI): A measure of whether an individual is a healthy weight for their height. For most adults, a BMI of 25 to 29.9 is categorised as overweight, a BMI of 30 to 39.9 is categorised as obese, and a BMI of 40 or above is categorised as severely obese.

Cancer: A condition where cells in a specific part of the body grow and reproduce uncontrollably. The cancerous cells can invade and destroy surrounding healthy tissue, including organs.

Cardiovascular Disease (CVD): A group of diseases that cause reduced blood flow to the heart, body or brain.

CGL/Pathways to Recovery: A free and confidential service that offers treatment and recovery services to anyone experiencing difficulties with drugs or alcohol.

Chronic Obstructive Pulmonary Disease (COPD): A collection of lung diseases including chronic bronchitis, emphysema and chronic obstructive airways disease. The main cause of COPD is smoking, and the condition causes breathing difficulties due to obstructed airflow.

Commissioning: Within the public sector, the term 'commissioning' is used to describe the process in which services are provided by the public sector, and involves planning, agreeing and monitoring of services.

Coronary Heart Disease (CHD): A condition whereby the heart's blood supply is blocked or interrupted by a build-up of fatty substances. It is a major cause of death both in the UK and worldwide.

Dementia: A syndrome associated with an ongoing decline of brain functioning.

Dependency Ratio (DR): A measure showing the number of dependents (aged 0-14 and 65 and over) compared to the working age population (aged 15-64).

Deprivation: Deprivation refers to a range of issues caused by a lack of resources of all kinds, not just financial.

Deprivation quintile: Lower Super Output Areas in Warrington are grouped into five groups according to how they rank on the national deprivation scale (IMD 2015).

Directly Standardised Rate (DSR): Usually expressed as the number of death per 100,000 population, this method of calculating a death rate allows a more precise comparison between two or more populations by controlling for differences in the age structure of the population.

Domestic abuse: Any incidence of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults, aged 16 and over, who are or have been intimate partners or family members, regardless of gender or sexuality.

Early diagnosis of cancer: Cases diagnosed at stage 1 or 2; there are 4 stages of cancer.

Excess Winter Mortality (EWM): EWM measures the ratio of deaths that occur in winter (December to March) compared with non-winter months (April to November).

EYFSP: Early Years Foundation Stage Profile – an assessment of children's development and learning at the end of the reception year.

FSM: Free School Meals – a child may be eligible for FSM if they live in a household which are in receipt of certain benefits (some exclusions apply).

Fuel poverty: when people cannot afford to keep their house adequately warm at a reasonable cost, given their income.

GP Deprivation Quintile: GP Practices are grouped into five groups according to the weighted deprivation scores of where their patients live (IMD 2015).

Glossary

Healthy Life Expectancy (HLE): Provides an estimate of the average number of years a person could expect to live in good health.

Hepatitis B: An infection of the liver caused by a virus that's spread through blood and body fluids.

Human Immunodeficiency Virus (HIV): A virus that attacks the immune system, and weakens your ability to fight infections and disease. There is no cure for HIV, but there are treatments to enable most people with the virus to live a long and healthy life. AIDs is the final stage of HIV infection, when your body can no longer fight life-threatening infections. Early diagnosis and effective treatment means most people with HIV will not go on to develop AIDs.

Incidence: Measures new cases of disease over a particular time period and is expressed in person-time units e.g. 2 per 1,000 people per year.

Index of Multiple Deprivation (IMD): The collective name for a group of 10 indices which all measure different aspects of deprivation including income, employment, health, education, crime, access to services and living environment.

Key stages (education): Groups that have been set up to administer progressive, standardised exams during a child's education in England and Wales. Each key stage consists of a certain range of school years. Key stage 2 = ages 7-11 (Years 3-6); Key stage 4 = ages 14-16 (Years 10-11).

Life Expectancy (LE) at birth: An estimate of the average number of years a new-born baby would live for if s/he experienced the age-specific mortality rates of a particular area throughout his or her life.

Life Expectancy (LE) at age 65: An estimate of the average number of years at age 65 a person would survive if he or she experienced the age-specific mortality rates for that area and time period throughout his or her life after that age.

Local Alcohol Profiles for England (LAPE): Published on an annual basis by Public Health England, the profiles contain 26 alcohol-related indicators for every local authority.

Long Acting Reversible Contraception (LARC): Methods of birth control that provide effective contraception for an extended period of time via an injection or implant.

Long Term Health Conditions: Conditions for which there are currently no cure, and which are managed with drugs and other treatment, for example diabetes, arthritis and hypertension.

Low Birth Weight (LBW): Low Birth Weight relates to babies born weighing less than 2500 grams. This indicator can be expressed as a proportion of all live births, or as a proportion of live births with a gestational age of at least 37 complete weeks.

Lower Super Output Area (LSOA): A small geographical area created for the aggregation of statistical data. There are 127 LSOAs in Warrington and they 'nest' within ward boundaries.

Mortality: The number of deaths in a given population, location or other grouping of interest, usually over a particular period of time.

Mortality considered preventable: Refers to deaths which, in the light of the understanding of the determinants of health at the time of death, all or most deaths from the underlying cause (subject to age limits if appropriate) could potentially be avoided by public health interventions in the broadest sense.

National Child Measurement Programme (NCMP): NCMP measures the weight and height of children in Reception class (aged 4 to 5 years) and Year 6 (aged 10 to 11 years) to assess overweight and obesity levels within primary schools.

Needle exchange: Access to sterile injecting equipment and paraphernalia, sharps boxes and a safe way to dispose of used injecting equipment.

NHS Digital: The national provider of information, data and IT systems for commissioners, analysts and clinicians in health and social care.

NHS Health Checks: Aims to help prevent heart disease, stroke, diabetes, kidney disease and certain types of dementia by inviting everyone between the ages of 40 and 74 to have a check to assess their risk of developing one of the conditions, and to provide support and advice to help reduce or manage that risk.

Old Age Dependency Ratio (OADR): A measure showing the number of dependents aged 65+ compared to the working age population (aged 15-64).

Premature mortality: Deaths amongst people aged under 75 years.

Glossary

Prevalence: Measures existing cases of disease and is expressed as a proportion of the population.

Primary Care Mortality Database (PCMD): Holds data on deaths of residents as provided at the time of registration of the death, along with additional GP details, geographical information and coroner details where applicable.

Public Health England (PHE): An executive agency of the Department of Health, established in 2013 with an aim to protect and improve the nation's health and wellbeing and to reduce inequalities.

Public Health Outcomes Framework (PHOF): Consists of a set of indicators aimed at understanding and monitoring desired outcomes for public health.

Quality Outcomes Framework (QOF): The annual reward and incentive programme detailing GP practice achievement results. The data collected through QOF provides prevalence of various diseases and risk factors, and provides information on how these conditions are managed in Primary Care.

Rate: A rate describes the number of events occurring among the population of a given geographical area during a given year. Rates can be 'standardised' to take account of differences in the age or sex distribution of a population, and expressed per head of population. A rate is calculated in order to compare one area to others, e.g. Warrington to England and to the North West.

Respiratory disease: A group of diseases that affect the respiratory (breathing) system

School readiness: This refers to children achieving a good level of development at the end of reception. It is a key measure of early years development across a wide range of developmental areas. Children from poorer background are more at risk of poorer development and the evidence shows that differences by social background emerge early in life.

Screening/screening programmes: National screening programmes are recommended to test whether an individual is at an increased risk of developing a condition, in order to help to identify and treat serious conditions sooner.

Secondary mental health services: medical care provided by a specialist or facility upon referral by a primary care physician that requires more specialised knowledge, skill, or equipment than the primary care physician has.

Sexually Transmitted Infection (STI): STIs are passed from one person to another through unprotected sex or genital contact. There are various STIs including: Chlamydia, Genital warts, Genital herpes, Gonorrhoea, and Syphilis.

Sickle Cell Anaemia: An inherited condition that affects the red blood cells.

Smoking attributable mortality: Deaths considered to be due to smoking. Causes of death considered to be related to smoking are: various cancers, cardiovascular and respiratory disease, and diseases of the digestive system.

Smoking at time of delivery (SATOD): Women who are regular/occasional smokers at time of delivery. This information is collected of all women giving birth and is used as a public health indicator.

Supervised consumption: This is when a service user receives their opiate substitution prescribed medication, such as methadone, which they are required to take on site of the pharmacy whilst being observed.

Teenage Conceptions: The number and rate of conceptions occurring amongst girls under the age of 18 years is a public health indicator.

Thalassaemia: The name for a group of inherited conditions that affect a substance in the blood called haemoglobin.

Unitary Authority (UA): A local authority that has a single tier and is responsible for all local government functions within its area. Warrington is a UA. In total, there are 351 local authorities in England.

Unsafe drinking levels: The risk of developing a range of illnesses increases with any amount you drink on a regular basis. New weekly guidelines (2016) for both men and women have been issued: you are safest not to drink regularly more than 14 units per week. If you do drink as much as 14 units per week, it is best to spread this evenly over 3 days or more.

Uptake: The proportion of individuals taking or making use of something that is available e.g. the uptake of flu immunisations.

Urinary Tract Infection (UTI): A UTI develops when part of the urinary tract becomes infected, usually by bacteria. UTIs are common, particularly among women, and can cause discomfort and pain.

Vaccination/Immunisation: An injection that can be given to prevent a person being infected with a specific disease.

Further Information

The following provides links to different sources for further information.

Warrington Joint Strategic Needs Assessment (JSNA): considers a wide range of factors that affect the health and wellbeing of the people of Warrington. The JSNA is used to agree key priorities to improve the health and wellbeing of all our communities, at the same time as reducing health inequalities.

http://www.warrington.gov.uk/jsna

Public Health Profiles: developed by Public Health England these profiles provide a range of indicators across various health and wellbeing themes, designed to support the JSNA process and commissioning to improve health and wellbeing, and reduce inequalities. People are able to browse indicators at different geographical levels, benchmark against the regional or England average, and export data to use locally.

http://fingertips.phe.org.uk/

NHS Digital: publishes over a thousand indicators covering quality through to population health and outcomes of treatments.

http://content.digital.nhs.uk/

Office for National Statistics (ONS): collects and publishes official statistics on the economy, population, and society at national, regional and local levels.

http://www.ons.gov.uk/ons/index.html

Nomis: contains official labour market statistics

https://www.nomisweb.co.uk/

List of Data Sources

Adult Social Care Survey - used for feedback from users regarding amount of social contact they have
Bridgewater NHS Trust - used for breastfeeding continuation data
Cheshire Constabulary/Community Safety Partnership - used for crime data
Department for Business, Energy and Industrial Strategy – used for fuel poverty
Department for Communities and Local Government - used for Indices of Deprivation 2015
Department for Education - used for school readiness data
Department of Energy and Climate Change - used for data on fuel poverty, https://www.gov.uk/government/collections/fuel-poverty-sub-regional-statistics
Department for Work and Pensions – used for Universal Credit Claims
HM Revenue and Customs - used for data on children and poverty
National Child Measurement Programme (NCMP) - used for data on children's weight
NHS Digital (http://content.digital.nhs.uk/) - used for some mortality data, Quality Outcomes Framework (QOF), and childhood immunisations by socio-economic deprivation quintile
Office for National Statistics (ONS)(http://www.ons.gov.uk/ons/index.html) - used for population estimates and projections, teenage conceptions, life expectancy, excess winter deaths, and NOMIS (for UK labour market statistics - https://www.nomisweb.co.uk/)
Open Exeter – used for cancer screening coverage by GP deprivation quintile
Primary Care Mortality Database (PCMD) - used for local mortality data analysis
Public Health England (http://fingertips.phe.org.uk/) – used for various performance indicators from the Public Health Outcomes Framework (PHOF), Local Alcohol Profiles, Child Health Profiles, Local Tobacco Control Profiles, Older People Profiles, End of Life Profiles, National Cancer Registration and Analysis Service (NCRAS), Liver Disease Profiles, and Sexual Health and Reproductive Profiles
Warrington Borough Council Housing Services – used for housing data
Warrington Hospital – used for breastfeeding initiation and smoking at time of delivery data

Warrington Joint Strategic Needs Assessment (JSNA) (http://www.warrington.gov.uk/jsna) considers a wide range of factors that affect the health and wellbeing of the people of Warrington. The JSNA is used to agree key priorities to improve the health and wellbeing of all our communities, at the same time as reducing health inequalities.

Health and Wellbeing Strategy thematic update reporting:

Proposed schedule 2019/20

Health and Wellbeing Board, JSNA Steering Group meeting dates 2019/20 and Health and Wellbeing Board reporting schedule

JSNA Steering Group Meeting dates	Health and Wellbeing Board meeting dates	Health and Wellbeing Strategy reporting schedule	Thematic/Update Lead
29th April	30th May	JSNA Work Plan Overview and Core document	Jo Bayliss
	18th July	Starting Well	Elaine Bentley/Steve Tatham
23rd July	12th September	Living Well	Carl Marsh/Dave Bradburn/Dot Finnerty/Tracy Flute
23rd October	14th November	Ageing Well	Sara Garrett/Rick Howell
No dates set for January 2020	23rd January 2020	Strong and Resilient Communities	Chris Skinkis/Nick Armstrong
	26th March 2020	Enablers	Nick Armstrong

Draft Health and Wellbeing Strategy thematic update reporting:

Proposed update template 2019/20

Strong and Resilient Communities

Thematic leads: Nicholas Armstrong (Warrington CCG) and Chris Skinkis (WBC)

Key Strategic Groups: Central Area Neighbourhood Board, Parish Councils, Warrington and Co. Health in Business Steering Group, Welfare Reform Action Partnership, Warrington Housing and Homelessness Partnership, Community Safety Partnership, Safeguarding Partnerships, Quality Assurance sub group (reporting to Children's Partnership), Warrington Domestic Abuse Partnership, MASH Steering Group, Health and Wellbeing partner organisations

Priority Theme	Specific sub-theme commitments	Update on Strategy Progress	Next Steps	Action lead/Accountable Delivery Group
1: Where communities are strong, well connected, and able to influence decisions that affect them	Nurture what works well and help the areas that would benefit from further improvement			
	Ensure fair access to person-centred services, which build on individual and community strengths			
	Work collaboratively to reduce inequalities in opportunities, experience and outcomes between key groups			
2: Where all local people can access and benefit from a strong economy with quality local jobs	Ensure our residents in the most deprived communities benefit from our economic prosperity			
	Work collaboratively to tackle debt and address health-related worklessness			

3: Where housing and the wider built environment promote health and healthy choices	Ensure the development of healthy places and homes			
	Ensure we have sufficient stable appropriate accommodation that meets the needs of our residents			
	Ensure future growth provides adequate quality and accessible open spaces			
4: Where there are low levels of crime and people feel safe	Ensure we prioritise a partnership response to tackling crime and reducing antisocial behaviour			
	Ensure we work collaboratively to identify and protect individuals vulnerable to any form of exploitation or abuse			
	Ensure we work with partners to take a preventative approach and intervene early to address underlying themes			
5: Where we work together to safeguard the most vulnerable	Ensure that those services which are working together to help protect children and adults with care and support needs are effective			
	Ensure we protect children and adults with care and support needs from domestic abuse			
	Work collaboratively to tackle exploitation, including modern slavery			
	Assure the quality of local health and care services and work together to improve the quality and consistency of safeguarding practice			

Starting Well

Thematic leads: Stephen Tatham (Warrington CCG) and Elaine Bentley (WBC)

Key Strategic Groups: Early Help Strategy Group, Healthy Weight Strategy Group, SEND review Board/SEND Improvement Steering Group, Children and Young People's Emotional Health and Wellbeing Board

Priority Theme	Specific sub-theme commitments	Update on Strategy Progress	Next Steps	Action lead/Accountable Delivery Group
6: Where children and young people get the best start in life in a child friendly environment	Ensure Children and Young People have a healthy weight			
	Ensure Children and Young People are safe and stay safe			
	Support Children and Young People to get the most out of learning			
	Help Children and Young People feel OK about themselves and their future			

Living Well

Thematic leads: Carl Marsh (Warrington CCG), Dot Finnerty (Warrington CCG), Tracy Flute (WBC) and Dave Bradburn (WBC)

Key Strategic Groups: Health and Wellbeing Board, Mental Health Prevention and Promotion Partnership, Early Help Strategy Group, Healthy Weight Strategy Group, Active Warrington Strategy Group, Strategic Drug and Alcohol Action Team, Tobacco Control Strategy Group, Health Protection Forum, Warrington CCG and Collaborative Clusters, Warrington Together and Integrated Commissioning Transformation Board, Health and Wellbeing partner organisations.

Priority Theme	Specific sub-theme commitments	Update on Strategy Progress	Next Steps	Action lead/Accountable Delivery Group
7: There is a strong, system-wide focus on promoting wellbeing, preventing ill-health and addressing inequalities	Foster a common understanding across all partners of the prevention agenda			
	Systematically embed prevention at all levels			
	Detect ill-health and risk factors and intervene early with evidence-based interventions			
	Ensure our collective workforce knows that prevention is everyone's business and we 'Make Every Contact Count'			
	Secure whole system commitment to upstream interventions to ad- dress the wider determinants of health			
	Ensure that health and wellbeing is in all policies and social value is maximised			

8: Where there is a sustained focus on addressing lifestyle risk factors and protecting health	Ensure opportunities to deliver evidence-based interventions around a healthy diet are delivered consistently across the life course			
	Ensure the built environment, our policies, infrastructure and services support people of all ages to be physically active and maintain a healthy weight			
	Ensure we work together to reduce the harm caused by alcohol and substance misuse, and use appropriate measures to promote the responsible supply and availability of alcohol			
	Ensure continued sustained focus on addressing entrenched smoking, and on de-normalising smoking			
	Ensure adequate plans are in place to protect the health of the local population and encourage uptake of screening and immunisation programmes			
9: Where both mental and physical health are promoted and valued equally	Promote positive mental health and wellbeing and address wider determinants of health			
	Ensure that our services address the needs of the individual as a whole			
10: Where self-care is supported, with more	Enable people to take greater control over their own health and wellbeing			

people managing their own conditions	Ensure that lifestyle interventions are considered and promoted for people diagnosed with long-term conditions			
	Ensure that there is accessible, coordinated information available to support self-care			
11: Where the best care is provided in the right place at the right time	Ensure that health and care services are effective and efficient			
	Integrate care to ensure we have a single approach to using resources and to improving health outcomes			
	Coordinate the work that GPs, community services and hospital in order to better meet the needs of our population			
	Ensure there is better integration between physical and mental health care			

Ageing Well

Thematic leads: Sara Garratt (Warrington CCG) and Rick Howell (WBC)

Key Strategic Groups: Older People's Partnership Board, Warrington Housing and Homelessness Action Partnership, Falls Steering Group, A&E Delivery Board, Dementia Transformation Board, Health and Wellbeing partner organisations

Priority Theme	Specific sub-theme commitments	Update on Strategy Progress	Next Steps	Action lead/Accountable Delivery Group
12: Where people age well and live healthy fulfilling lives into old age	Promote the evidence-based tips for healthy ageing			
	Ensure housing and other services facilitate and enable independence			
	Reduce the number and impact of falls			
	Minimise excess death and ill-health during the winter			
	Promote and develop dementia friendly environments and services			

Enabling Priorities

Thematic leads: Nick Armstrong

Key Strategic Groups: Warrington Together Workforce Group, Children's DMT, Warrington IT Partnership Board, JSNA Steering Group, Transforming Estates Enabler Group, Warrington Together Finance Group, Systematic practice implementation group, Health and Wellbeing partner organisations

Priority Theme	Specific sub-theme commitments	Update on Strategy Progress	Next Steps	Action lead/Accountable Delivery Group
E1: Where we have a valued, well-trained and supported work-force that is fit for the future	Ensure our collective workforce has shared values and principles and common aims			
	Ensure we have robust collaborative workforce planning which fully harnesses the potential of the third sector			
	Ensure we fully utilise our community assets and volunteering			
E2: Where the benefits from information and technology are maximised	Ensure professionals directly involved in health and social care have access to the most up-to-date patient information			
	Ensure we utilise technology effectively to help support self-care and personal responsibility for health			
E3: Where we invest in the right	Ensure robust evidence and intelligence is available to inform			

intelligence to understand our local population	strategic priorities for health and wellbeing			
	Ensure gaps in knowledge and intelligence are addressed and appropriate insight is generated			
E4: Where we utilise our collective estate so that it best supports local health and social care need	Ensure the best use of land and property assets facilitating joint working or alternative uses where appropriate			
	Ensure our local estate can support the H&SC transformation and integration agenda and respond to developing service models, including the commitment for a new purpose built modern hospital			
E5: Where we get best possible value for our 'Warrington Pound'	Where we get best possible value for our 'Warrington Pound'			

Warrington
Health & Wellbeing Board

30 May 2019

1.30 pm, Council Chamber, Town Hall, Warrington

Report Title	Warrington Together – Programme Director's Update
Type of Decision Required	☐ Formal Decision as to a Statutory Function ☐ Non-Statutory Advice, Guidance or Recommendation to Other Body ☒ Note or Endorse a Report or Action by Others
Report Purpose	To receive the update report on the activities in relation to developing the Warrington Together Programme since the Board meeting in March 2019.
Report author	Simon Kenton, Programme Director, Warrington Together.
Confidential or Exempt	This report is not considered to contain information which is confidential or exempt.
Recommendations	To note the progress on the work being driven by the Warrington Together Programme.

Programme Director's Update

April 2019

Warringtontogether

Together for a happier and healthier Warrington

Table of Contents

Simon Kenton

Programme Director

Warrington Together

April 2019

1. Purpose

1.1 This report covers the activities in relation to developing the Warrington Together Programme since the Board meeting in March 2019.

2. Senior Change Team

2.1 Further workshops have been held with the SCT to continue the work utilising the logic model to develop products in relation to frailty. The final outputs from these sessions will be presented to the Board in the next few months.

3. Primary Care Networks

3.1 The development of the PCNs in Warrington has had an impact on the rollout of MDTs/ICTs. Whilst the GPs in central are working out the configuration of the PCNs they have communicated to us that they are unable to participate in the MDTs. We have therefore taken the pragmatic decision to continue to rollout the MDTs across the central neighbourhood in Warrington by inviting partners within the MDT team to bring residents to the April meeting who live in central and who would benefit from the MDT approach.

3.2 The final configuration of PCNs will not be known until the middle of May and the ICT workstream are currently thinking through potential models dependent upon the final geographical configuration of the PCNs. This will be discussed at the May Board.

4. Provider Alliance

4.1 The paper regarding the development of a provider alliance has been modified following feedback at the March WT Board meeting. The re drafted paper has been circulated to Board members for final comments and will be presented at the May HWB Board.

5. Frailty hub-HSJ Award Nomination

5.1 The frailty hub has been running five days a week since December 2018 accepting referrals from community matrons, GPs and NWAS. A pathway from MAU is currently being developed and this will contribute to reducing admissions and length of stay. The next pathway to be developed will be for patients to be referred directly from Bridgewater's enhanced care team. We have sought feedback from GPs to ensure we can further develop pathways to enhance the positive experience and outcomes for patients.

5.3 The hub currently connects with 3rd sector services and community assets to provide service users and carers with wider health and wellbeing support. When the associate matrons are in post they will connected to further community based assets through the MDTs. Hospital staff working in the hub and the wider workforce working with frail patients have recently undergone training in the asset based approach to health and wellbeing.

5.4 In the first six months of operation (up to the end of Feb 2019) there were 396 attendances to the hub and an overall direct discharge rate of 89%. The estimated bed days saved during these six months is 3550.

5.2 On April 3rd three representatives from across the system Susan Burton (Warrington Together), Amanda Thomas (WHFFT) and Steve Tatham (CCG) attended an interview for the HSJ award Improving Value in the Care of Older Patients award. The other shortlisted candidates care listed below and the award winner will be announced on the 23rd of May 2019.

Warrington Together- HSJ awarc

- Buckinghamshire Healthcare Trust, Buckinghamshire Community Hubs
- Dartford and Gravesham Trust and Guy's and St Thomas' FT, POPS: Improving care of older surgical patients
- Doncaster CCG, Intermediate Care Service: Transforming care to help people stay well at home
- Harrow PACT Project, Planning And Caring Together with Care Homes Residents
- Kingston Hospital FT, Environments of Care
- Lancashire Care FT, Zonal engagement and observations practice in older adult mental health inpatients
- Midlands Partnership FT & University Hospitals of North Midlands Trust, High Intensity Users Service
- North Staffordshire Combined Healthcare Trust, Rapid Falls Improvement
- Tameside and Glossop Integrated Care FT, Using digital technology to deliver place-based care to older frail people
- Tameside and Glossop Integrated Care FT, Extensive Care Service
- Warrington Together, Frailty Hub

6. International Conference on Integrated Care

6.1 Carole Hugall and Rachel Mellor presented their paper entitled "How Warrington has created a new integrated model of care that has been designed and implemented seamlessly by multiple partners across a system" at the conference on April the 3rd. The presentation and poster were very well received and there was good opportunity to network with colleagues working in integration from across the world.

7. Five Year plan

7.1 Cheshire and Merseyside's Health and Care Partnership (C&MH&CP) expects Warrington's 2019-2024 strategy to reflect top-down (i.e. operational/programme responses to the NHS Long term Plan) and bottom-up (i.e. citizen/interest group) responses via engagement. It's still not entirely clear when Warrington's draft five year place plan has to be with C&MH&CP, but there is an expectation of 'robust engagement' on it over the summer (June/July/August) to inform Warrington's final submission. We have asked for more clarity from C&MH&CP on the timescale for publication of draft five year place plans.

7.2 C&MH&CP expects our engagement plan by 16 May. We have set the ball rolling on this, and are aiming to keep our submission high level rather than seek to provide every last detail. We are also proposing that our approach should be imaginative and accessible e.g. feature an animation which would explain what our plan is, and explain how our colleagues, citizens and interest groups can shape proposals. An outline engagement plan is currently being drafted by Andy Donnelly and the draft animation will be shared with the WT Board on the 20th May and a final version signed off by the HWB on the 30th May.

7.3 A draft timetable for Warrington based on what the C&MH&CP has already told us or are asking of us, and what we will need to do to comply is detailed below. This may change slightly depending on any further information from the C&MH&CP.

- 11 April – C&MH&CP publishes system-wide 2019-20 operating plan and narrative
- 26 April – C&MH&CP issues outline framework of C&M health and care five year strategy (reflects unifying themes emerging from across the footprint including Place strategies, our ICS journey and how we can do things differently)
- 16 May – deadline for submitting place engagement plans to C&MH&CP
- 30 May – C&MH&CP publishes draft five year C&M strategy following discussions held at partnership, place, programme, SMB and P&PL events held throughout May
- June – internal engagement on Warrington five year place plan
- July – external engagement on Warrington five year place plan
- w/c 5 August – plan re-drafted to reflect engagement

- 19 August – plan to Warrington Together board
- w/c 19 August – plan amended to incorporate comments from WT board
- 5 September – plan to WBC Health Scrutiny
- 6-10 September – plan amended to incorporate comments from WBC Health Scrutiny
- 12 September – plan to Health and Wellbeing Board (sign off)
- 13 September – Warrington Place Plan to C&MH&CP (31 August deadline does not realistically fit with local timescales)
- 30 October – C&MH&CP publishes final version C&M Five Year Strategy
- 14 November - C&M Five Year Strategy to Health and Wellbeing Board (sign-off and opportunity for last-minute local tweaks)

8. Central 6 Neighbourhood Initiative

8.1 Warrington Together is working through the central 6 neighbourhood initiative, building on the public feedback and developing a narrative that health is not just about access to services but involves connectiveness to communities.

9. Recognition

8.1 We continue to meet with colleagues across Cheshire and Merseyside, the North West and nationally to share best practice and to learn from what others are doing within the field of integration. This last month we have met with colleagues from the Wirral system, Cumbria, Scotland and Bolton.

8.2 The Warrington Together team have given several presentations in the last month to heighten awareness of the work we are doing to integrate health and care across the Warrington system. These have included the Warrington Governors of Bridgewater NHS Trust, the Health and Wellbeing Board, the CCG frailty task and finish group, the GP clusters of Central East and Central West, the enhanced care home team, Andy presented at the Cheshire and Merseyside Health and Care Partnership Accountable Officers meeting and the second ICT workshop on the 16th April

8.3 Andrew Donnelly WT communications lead has made a video showcasing the work of the frailty unit. The video formed part of the presentation to the HSJ award panel and is being used across the system to heighten awareness of the work of the frailty unit and to encourage referrals. The link to the video is below.

https://youtu.be/_YmS1B0nh3o

Programme Director's Update

May 2019

Table of Contents

Simon Kenton

Programme Director

Warrington Together

May 2019

3. Purpose

1.1 This report covers the activities in relation to developing the Warrington Together Programme since the Board meeting in April 2019.

4. C&M HCP Place Improvement Tool

2.1 A self-assessment Place based Matrix (Improvement Tool) was issued by C&M HCP on the 29th April. The intention was to collectively discuss the matrix further at the next Place & Programme Forum meeting, which takes place on the 14th May and ensure that there is full agreement on the proposed elements by the community. We have completed the matrix as far as possible prior to discussion on the 14th and attached the draft copy separately with the papers.

2.2 The matrix is intended to be a means whereby Places self-assess their progress, partnerships, collaborations and more across their priorities and also the strategic Programmes. In addition, the matrix will provide a means of supporting each other and seeking ways for the Health and Care Partnership to support Places and Programmes in their delivery. The C&M partnership stress that it is not an NHS template for performance management purposes.

2.3 The intention is that the matrix, and the supportive elements it brings, will enable us as a whole system to pull together our version on 'what excellent looks like' and how models of placed based care look and the impact it has for the population of Cheshire and Merseyside.

2.4 The matrix suggests nine core elements and a range of sub-elements through which Places can self-assess and perhaps buddy up with other Places/Programmes to peer assess, share good practice and find ways to overcome barriers.

2.5 The C&M partnership say the descriptions of 'what excellent looks like' within the matrix are purposefully ambitious but are ours to interpret.

2.6 It is fully anticipated that this matrix will be a continually developing piece of work that will be built upon and completed as Places continue their work, and as such we will be using the Place and Programme Forum to discuss how best to support each other through this process.

3. Primary Care Networks

3.1 The final configuration of the PCNs should be known by the 15th of May. A presentation will be given at this Board meeting to discuss the approach regarding the future ICT configuration based upon the outcome of the PCN networks.

4. Provider Alliance

4.1 The paper regarding the development of a provider alliance has been modified following further feedback at the April WT Board meeting. The re-drafted paper will be discussed at this Board. It will then be presented to the HWB on the 30th May.

5. Frailty hub-HSJ Award Nomination

5.1 The award ceremony for the HSJ Value wards is on the 23rd of May. We have a table, which has been sponsored by Scan Mobility, with representatives from the Council, the hospital, Bridgewater, WT and the CCG. The results will be tweeted on the night so remember to look out for any twitter announcements.

6. Five Year plan

6.1 The C&M Partnership timescale detailed in the last programme directors report for submission of the place engagement plan seems to have slipped. We are still awaiting the communications pack from C&MH&CP and further information regarding the development of the five year plan.

7. SCT Updates

7.1 The risks identified in the ICT workstream are:

- Delay in go-live for Warrington Shared Care record
- Current investment in MDTs is non-recurrent and due to expire in September 2019
- Investment for remaining out of hospital model components (rapid response, in-reach, step up/virtual ward, asset based approach) is not identified
- The ICT administrator post remains unfilled since the secondee's approval was retracted

7.2 The risks identified in the Emergency, urgent and crisis workstream are detailed below:

- Identification of suitably frail patients resulting in a reduced throughput and reduced system benefit in terms of reduction of admission to the acute bed base. To mitigate this awareness tools and communication plans are in place to improve patient identification and throughput. We are continuing to work with the operational teams and upskill staff to resolve any foreseeable risk.

7.3 The risks identified in the finance enabling group report are concerned with the governance of accessing and transferring STP funds. This will be discussed in this Board under a separate agenda item.

7.4 The risks identified in the estates relate to a request from the ICT work stream for work to be completed by the 10th of May. The risks relate to realistic delivery of timescales and the perceived role of the TEEG. Further discussion is required in relation to this request, which the SRO for estates thinks should be handled by provider operational estates leads.

8. Peoples Panel

8.1 Warrington Together is committed to enabling citizens to play an active role in shaping the future of health and social care in the borough. At its February meeting Board supported in principle the establishing of an independent People's Panel to achieve this. The attached paper (appendix 1) sets out the proposals and timescales and requests Board approval to proceed.

9. Engagement

9.1 We continue to meet with colleagues across Cheshire and Merseyside, the North West and nationally to share best practice and to learn from what others are doing within the field of integration. We have arranged learning visits to Cumbria and Trafford integrated teams for June.

9.2 The Warrington Together team have given several presentations in the last month to heighten awareness of the work we are doing to integrate health and social care across the Warrington system. These have included Livewire (strategic planning subcommittee), the phoenix federation meeting, and Latchford Medical centre who have expressed a desire to implement the FCP model. We also hosted a stand at The Gateway 15 year anniversary event.

Appendix 1

Healthwatch People's Panel: Update

1 Background

Warrington Together is committed to enabling citizens to play an active role in shaping the future of health and social care in the borough. At its February meeting Board supported in principle the establishing of an independent People's Panel to achieve this.

The panel shall be known as the *Healthwatch Warrington People's Panel*. Its aims would be to:

1. support Warrington Together with advice and guidance so that it can meaningfully engage patients, carers and citizens in the planning and shaping of future services and in the development of transformation proposals on behalf of all programme partners;
2. provide an independent view and critical friendship on the development of Warrington's Integrated Care System (ICS); and
3. ensure that Healthwatch, through its People's Panel objectives, meets the requirements of its contract with Warrington Borough Council.

2 Objectives

The panel will act as a consultative body, independent of the Warrington Together programme. Its aims and objectives reflect the statutory functions for local Healthwatch groups developed by the Department of Health and the Local Government Association, and are consistent with Healthwatch's contractual obligations to Warrington Borough Council.

It is proposed that, for the duration of the Healthwatch contract with Warrington Borough Council, the People's Panel will:

- advise, influence and challenge programme partners on a whole-system basis;
- promote and support the involvement of people, including 'seldom heard' groups, in the commissioning and provision of local care services and how services are scrutinised;
- gather the views and understand the experiences of people who use services directly, carers and the wider community;
- comment on whether any transformation proposals amount to *significant* change;
- review, together with Warrington CCG, any stakeholder engagement and/or consultation plans related to *significant* service transformation proposals to ensure engagement activity adequately meets the Cabinet Office's Consultation Principles (2016);
- work proactively with the Warrington Together communications and engagement enabling group to identify areas for engagement; and
- comment on and promote stakeholder engagement and consultation opportunities in conjunction with Warrington CCG.

These objectives are consistent both with Warrington Borough Council's contractual demands and the expectations of the Cheshire & Merseyside Health & Care Partnership (aka STP).

Healthwatch, in partnership with Warrington Voluntary Action (WVA) and Warrington Together, is now working towards establishing a People's Panel to meet these objectives by July 2019.

3 Proposed structure

Healthwatch and WVA are actively developing terms of reference and governance procedures to be shared with Warrington Together partners at the earliest opportunity.

It is envisaged that the panel will be structured as follows.

1. Core panel: 14 people (including chair and co/vice-chair).
2. People's Panel: up to 1,000 people who can be called upon to take part in surveys (digital and face-to-face), focus groups and one-to-one interviews.

Core panel membership will be via a recruitment process focusing on relevant experience and/or special interests. It is suggested that core panel members be invited to attend Warrington Together board meetings and be able to request workstream leads to attend panel meetings.

People's Panel members will be recruited through a range of activities designed to achieve the closest possible representation of the wider borough population.

The panel's formal links with Warrington Together will be clarified during development of the aforementioned terms of reference and governance procedures, although close ties with Warrington Together's communications and engagement enabling group are envisaged.

4 Community engagers

In addition, WVA will recruit and train around 20 'community engagers' whose role will be to undertake frontline engagement as requested by the core panel.

Community engagers will:

- carry out interviews across a wide range of locations such as shopping centres, post offices, third sector premises, public events, housing partners and businesses;
- interact with peers and carry out their volunteering within their chosen locality; and
- develop their own communication skills, increase self-confidence and value being part of a wider project contributing to the borough's health and wellbeing.

Recruitment and training will take place during July and August 2019.

5 Proposed timeline

May – Development work (terms of reference, operating procedures and governance, role descriptions, legal/data, recruitment, volunteer programme etc)

20 May – progress report to WT board

22 May – progress report to Healthwatch board

28 May – progress report to CCG Health Forum

28 May – progress report to NWB Warrington Service User and Carer Forum

30 May – progress report to Warrington Health and Wellbeing Board

June – Core panel recruitment begins

4 June – progress report to Bridgewater board

13 June – progress report to Mental Health Partnership Board

13 June – progress report to WBC Health Scrutiny Committee

July – People's Panel launch

August – first meeting of core panel

July/August – Community engagers recruitment and training

August/September – Citizens' panel recruitment

October/November – Recruitment complete, membership finalised, working arrangements in place

6 Recommendations

i. Board support the proposal above to develop the Warrington peoples panel.
ii. Board support the timeline above.

Warrington
Health & Wellbeing Board

30 May 2019

1.30 pm, Council Chamber, Town Hall, Warrington

Report Title	Warrington Together - Annual Report
Agenda Section	☒ A. Standard Items and Governance Matters ☒ B. Promoting Integration ☐ C. Development and Delivery of Health and Wellbeing Strategy ☐ D. Oversight of Important Strategies and Reports ☐ E. Information and Context ☐ F. Concluding Business
Type of Decision Required	☐ Formal Decision as to a Statutory Function ☐ Non-Statutory Advice, Guidance or Recommendation to Other Body ☐ Note or Endorse a Report or Action by Others
Report Purpose	To raise awareness to the Board of the work of Warrington Together, a collaborative programme to integrated health and social care in Warrington.
Report author	Simon Kenton, Programme Director, Warrington Together
Confidential or Exempt	This report is not considered to contain information which is confidential or exempt.
Recommendations	To note the paper and consolidate/simplify work programmes into a place based focus.

WARRINGTON TOGETHER ANNUAL REPORT 2018

Warringtontogether
Together for a happier and healthier Warrington

Warrington Together Annual Report 2018

CONTENTS

1 Introducing Warrington Together

Warrington Together is Warrington's main health and social care bodies working together to plan and deliver integrated services to the people of Warrington.

These include:

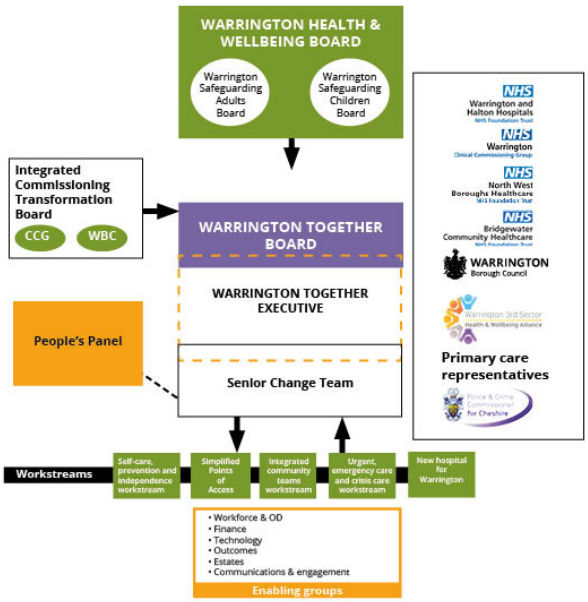
- Warrington and Halton Hospitals NHS Foundation Trust (WHH);
- Warrington Borough Council (WBC);
- Warrington NHS Clinical Commissioning Group (CCG);
- Bridgewater Community Healthcare NHS Foundation Trust (BW);
- North West Boroughs Healthcare NHS Foundation Trust (NWB);
- Police and Crime Commissioner for Cheshire;
- Primary care representatives; and
- Warrington Third Sector Health and Wellbeing Alliance.

An elected member from Warrington Borough Council has observer status.
All have come together under an independently-chaired Warrington Together board.

The Warrington Together programme has been running since November 2017 and has developed its governance structure to bring together executive leaders from the organisations listed above. In time, representatives from the borough's housing and education sectors may also become members.

The Warrington Together board meets monthly and a senior change team (SCT) – including a range of clinical and non-clinical staff from across the borough – meets fortnightly to oversee the activities of the programme's workstreams and enabling groups, as described in the diagram below.

A small programme team consisting of executive staff seconded from partner organisations supports the work of the board and the senior change team. The programme team is responsible for coordinating the smooth running of the programme workstreams and enabling groups.



Warrington Together is accountable to the Warrington Health and Wellbeing Board, which has statutory responsibility for promoting health and wellbeing in the borough.

Health and wellbeing boards are central to the government's vision of a more integrated approach to health and social care.

2 Foreword

Together we will enable the people of Warrington to enjoy happier and healthier lives by transforming the way we use our collective resources

This is the vision of Warrington Together. All board members are focused on this goal as we seek to tackle the many challenges our town faces.

Together we aim to build a health and social care system we can all be proud of, one that is fit for the future and built to last. This is a complex and demanding task.

The current health and social care system in Warrington is under enormous strain as we cope with rising demand, high expectations, staff shortages and unprecedented financial pressures. There can be no doubt that the existing system is unsustainable and in urgent need of reform. The new NHS Long Term Plan recognises this and calls for the type of partnership we have in Warrington to address these challenges.

At Warrington Together, we recognise that there are many determinants of our population's health and wellbeing outside the NHS and social care system. Jobs, housing and feeling connected within our local communities are also key determinants of good mental and physical health, happiness and inclusion. Extra money for the NHS is welcome, of course, but on its own it will not address these wider issues.

Tackling the growing challenges requires fundamental transformation – a culture of collaboration among clinicians and communities, and service integration at every level to promote prevention, wellbeing and self-care.

This is why we are committed to an asset based approach to planning and delivering our services; this means we aim to identify all the resources available - from public services, within families and within communities - that can help Warrington residents enjoy healthier, happier lives. Creating a culture of collaboration among clinicians, staff, volunteers and communities is essential to integrate all our services at every level to promote prevention, wellbeing and self-care.

We want to move from existing ways of working and create an asset based, holistic approach that allows us to pool our resources and coordinate our services. We have defined a new way of working that brings together integrated, multi-disciplinary teams to support people to enjoy improved health, wellbeing and inclusion within our communities.

Our partnership is a coalition of willing volunteers from across the NHS, third sector, primary care, housing and the police, determined to work together to do better for the people of Warrington.

Partners have demonstrated a true commitment to system working, investing time, resources and leadership to create the culture of collaboration that will enable us to integrate our services for the benefit of local people. As we progress in our work, we want to establish more opportunities for local residents to share their views and to feel ownership of our activity.

It is with great optimism that I introduce the 2018 Annual Report for Warrington Together, noting particularly the enthusiasm and commitment that has characterised our last year of collaboration. I am very privileged to serve as the Independent Chair of Warrington Together, and I look forward to continuing to work with partners to achieve our vision.

Sue Musson, Chair, Warrington Together

3 Executive summary

Warrington Together is a public sector partnership based on collaboration and integration, not competition or privatisation. It's all about services coming together to meet the needs of, and to be accountable to, local people.

We are based in Warrington town centre at the Gateway – often described as the 'spiritual home' of partnership working in Warrington. A number of people and organisations integral to the success of our programme are our neighbours at the Gateway, including third sector organisations who make such a valuable contribution to improving health and wellbeing in the borough.

The rationale behind Warrington Together is effectively to deliver – through collaboration, modernisation and innovation – a single, taxpayer-funded and more accountable partnership, working to a single, integrated plan. This is consistent with the expectations of the NHS Long Term Plan and is what has driven our work during 2018.

That work is described in the next part (section 4) of this report.

Back in January 2018 the Warrington Together Strategic Outline Case (SOC) was approved by the board. This document outlined the vision for Warrington Together (as expressed in part 2 above) and set out the early priorities for the programme.

Our work to date has been primarily dedicated to developing and building relationships across the system, to build solid foundations upon which we can work creatively and collaboratively. We have come a long way in a short space of time, but with the NHS Long Term Plan stating that each are must have integrated care systems (ICSs) by 2021, we will need to sharpen our focus on whole system performance and collective responsibility.

Also consistent with the NHS plan is our aim to promote healthy lifestyles, better utilise doctors and hospital, community, social and mental health care, and to strive to keep an entire population well in the most efficient way possible. To this end we are working hard to position primary care, and in particular GPs, at the centre of developments.

We have also sought to recognise the valuable contribution and future potential of Warrington's burgeoning third sector. The creation of the Third Sector Health and Wellbeing Alliance has been critical. This will enable a broad range of providers to come together

offering such diverse care as housing and home repairs, mental health support, and links to local leisure and cultural opportunities. This is not without its challenges but presents some exciting opportunities.

As well as increasingly involving the third sector in the programme, we have sought to increase local democratic stewardship of health and social care service design and provision. Our regular briefings with local councillors, patients' groups and others from across the voluntary sector are just the start. In 2019 and beyond we will go much further, including the launch of a Warrington Together People's Panel, led by Healthwatch.

I'm proud to report that in 2018 Warrington Together became a net beneficiary of financial resources – the only partnership in the region – enabling us to establish multi-disciplinary team working and expand provision at the hospitals' Frailty Assessment Unit (FAU).

Multi- disciplinary teams will work around GP cluster to assess individuals with complex conditions and deliver more innovative and inclusive solutions to care. The hub provides a frailty assessment unit (FAU) with access to a comprehensive geriatric assessment (CGA), diagnostics and pharmacy, rapid intervention service and step up/down intermediate care beds.

These are positive developments and a sign of things to come.

Simon Kenton, Programme Director

4 The story so far

It has been a busy 12 months for Warrington Together. This is what our partnership working has achieved to date.

Team and relationship building. Trust, transparency and positive relationships are the bedrock of any successful partnership programme, and collectively we have invested time and effort into developing a culture of collaboration across Warrington.

We were supported by the NHS Advancing Quality Alliance (AQuA) in developing our senior change team and the vision and direction for Warrington Together. AQuA have also supported with board development sessions.

In recent months, Boo Coaching and Consulting have provided developmental support to the workstreams and a joint board/senior change session.

Left: one of the Boo-facilitated development sessions

Practitioners from Warrington's statutory health and social care providers have also been involved in AQuA-facilitated workshops, and we continue to involve those working or volunteering in health and social care locally at every opportunity.

Role sharing. By facilitating partnership work and fostering an atmosphere of trust across agencies, we have created the platform for establishing joint posts and teams. Warrington now has a joint director of HR, an associate director of integrated care and integrated hospital discharge teams.

System strengthening. We have supported the establishment of Warrington's Third Sector Health and Wellbeing Alliance, a single voice for 12 voluntary providers who can now engage with the system as one and be contracted as a single entity.

Self-care and prevention. The majority of the determinants of health lie outside the health and social care system, so we have encouraged individual self-care by seeking to involve those voluntary and community groups that are well-positioned to address these. We have encouraged the population and promotion of My Life Warrington, an online directory of community assets, and Warrington Wellbeing, a council service which seeks to navigate people through issues affecting their wellbeing, such as housing and debt, with third sector support.

Funding. We have attracted additional investment into the Warrington system through successful bids to the Cheshire & Merseyside Health and Care Partnership (formerly STP). This transformation funding has enabled a number of projects to commence or continue in Warrington, including:

- Integrated community teams;
- Intelligent scheduling;
- Warrington Care Record; and
- Frailty Assessment Unit (FAU) and hub.

The Warrington Care Record has progressed at pace, with go-live expected in 2019. The introduction of a care record will enable professionals to work in a more integrated way and will empower patients to be in charge of their own health information.

In July 2018, a frailty assessment unit (FAU) was opened in Warrington Hospital. This unit is a system-wide attempt to avoid unnecessary inpatient admissions for those who are frail. People attending accident and emergency are selected to attend the FAU and where appropriate, will receive a comprehensive geriatric assessment and/or a medicines review. The FAU has gradually increased the number of days it operates per week and aims to outreach into the community.

Preparatory work has been undertaken on the introduction of a first contact practitioner (FCP) pilot in Warrington. Expected to start in January 2019, an advanced physiotherapist will be based within general practice, providing advice and guidance to patients with musculoskeletal issues. It is expected that this will result in improved outcomes for patients and will relieve some of the pressures on primary care.

In December 2018, the first multi-disciplinary team meeting was held in the Central North area in Warrington. This meeting involved professionals from primary care, community healthcare, mental health and social care, all working together to discuss the care of people with complex heath and care needs.

Local resident Tommy (right) was one of the first people in Warrington to experience the new multi-disciplinary team approach, receiving care in his home from Bridgewater NHS tissue viability nurse Nicola Ashurst.

It is anticipated that this integrated approach will result in a better quality of care and will allow professionals the time to consider the wider determinants of health, thus improving patient wellbeing and increasing independence.

Commissioning. A joint CCG/council commissioning prospectus has been published, influenced by a whole system diagnostic assessment, setting out our collective challenges, priorities and opportunities.

Information sharing. Warrington Together has led on the development of an integrated care record system for Warrington, which will enable agencies to share information on patients and deliver care seamlessly.

Innovating. We have inspired new partnerships with local housing associations to expand social prescribing, Extra Care and supported housing; floating support and community development.

Communicating and engaging. We have adopted an 'inside-out' approach to communication and engagement, recognising that effecting lasting change begins with our workforce and volunteers. They are Warrington's greatest health and social care resource; they are the people who are laying foundations for the future.

Some 250 people involved with the programme – senior organisational leads, GPs and practice managers, members of our workstreams and enabling groups – receive monthly bulletins and are encouraged to share relevant content more widely.

Other communication activities include an 'Introducing Warrington Together' animation (left) which has so far been viewed online more than 1,500 times and the first of what will become a series of Warrington Together podcasts.

We also engage frequently with GPs, holding GP-specific events and visiting practices, and local councillors via regular briefing sessions.

Bespoke events have included the one held at Walton Hall (right) in July 2018 which introduced over 150 colleagues from across the Warrington health and social care system to our work.

We have attended many events and forums to raise awareness of the programme, including patient participations groups (PPGs), community groups, professional development forums and the annual Disability Awareness Day.

Left: Simon Kenton and Andrew Donnelly from Warrington Together are pictured with Pat McLaren, Director of Community Engagement, Warrington and Halton Hospitals NHS Foundation Trust, at 2018 Disability Awareness Day.

Workshops for health and social care staff during 2018 included one in Orford (right) to develop proposals for multidisciplinary team working, and a frailty-specific workshop.

National and International Recognition. Warrington Together has been recognised for the work that has been done to date. In 2018 a paper was submitted to the International Journal of Integrated Care. This was subsequently approved and in April 2019, members of the team presented at the International Conference on Integrated Care in San Sebastian, Basque Country. A bid was also submitted for the HSJ Value awards for the work of the frailty hub. This has been shortlisted in the 'Improving Value in the Care of Older Patients Award' category. In March 2019 the Frailty Assessment Unit also received a visit from Helgerson Solutions Group and the Montefiore Health System in New York. They received a tour of the unit and spoke to clinicians. The visitors commented that they were 'blown away' by the work of the unit and wider hub.

Feedback from our stakeholders. Some of our stakeholders have commented on the benefits of integration and specifically how Warrington Together can help**:**

'Healthcare is all about working together so that the patient gets the best journey through the process' Dr Tim Hudson, Eric Moore Partnership, Warrington.

'For patients, the lack of integration of health and social care can be a maddening experience. Warrington Together offers a potential way forward as a locally appropriate, collaborative model of care – a single taxpayer-funded organisation working to a single integrated plan.' Faisal Rashid MP, Warrington South.

'From the NHS to local government and the third sector, we are all expected to work more closely in a 'pragmatic and practical way' to deliver by 2021 the triple integration of primary and secondary care, physical and mental health services, and health and social care. Through Warrington Together we are well on with this agenda.' Dr Raakhi Raj, Padgate Medical Centre.

5 Next steps

With publication of the NHS Long Term Plan, the imminent publication of a government Green Paper on adult social care, and the creation of a multi-agency steering group to oversee the development of a new hospital for Warrington, there is a very demanding year ahead.

New hospital. Warrington Together is overseeing progress in securing a new hospital for Warrington. It is anticipated that we will attempt to build support from the 'one public estate' programme to identify an inclusive campus which would offer health and social care, alongside education, leisure, culture and housing.
NHS Warrington and Halton Hospitals will lead on engagement and consultation, and a series of engagement events are being planned for 2019, commencing with elected members from Warrington Borough Council.

NHS Long Term Plan. The government expects integrated care systems (ICSs) to be in place across the country by 2021. These will 'grow out' of the regional sustainability and transformation partnerships (STPs), and are to deliver the 'triple integration' of primary and specialist care, physical and mental health care, and health and social care.
ICSs will help align different NHS bodies across local areas to achieve clearer accountability, but it is unclear how they can bridge the gap of accountability, geography and financial responsibility between NHS and local government. Warrington Together, with its local population focus and local democratic stewardship, represents an opportunity to integrate local deliverers and commissioners of health and social care – including GPs, Housing and the voluntary sector. With the Care Quality Commission (CQC) in its regulatory activity placing greater emphasis on partnership working and system-wide quality, Warrington Together's role will be important.

Joint commissioning. Warrington Borough Council and Warrington NHS Clinical Commissioning Group (CCG) last year published joint commissioning proposals for 2019 onwards. NHS England will continue to support local approaches to blending health and social care budgets where councils and CCGs agree, and points to four models:

1. voluntary pooling for some or all functions;

2. pooling in individual health and social care budgets;
3. local authority asks the NHS to oversee a pooled budget for all health and care services, with a joint commissioning team (e.g. Salford model); and
4. CCG and local authority ask the Chief Executive of NHS England to designate the council chief executive or director of adult social services as CCG accountable officer.

Warrington Together partners will support the council and CCG in further strengthening commissioning arrangements in Warrington.

Integrated community teams (ICTs). Early in 2019 we will evaluate the progress of multi-disciplinary team (MDT) working in Central North Warrington, using lessons learned from practitioners and patients alike as the basis for rolling out the MDT model further and faster across Warrington for the benefit of our population.

Communications and engagement. 'Further, faster' are the bywords too our approach to engagement in 2019. A proposal for an independent People's Panel, to be administered by Healthwatch, will be presented to board in February. This will be as representative as possible of the Warrington population, able to advise, influence and challenge programme partners on a whole-system basis, and will complement activities of existing engagement fora such as the Warrington CCG Health Forum.
An enabling group workshop on 28 February will agree communication and engagement priorities for 2019/20 and produce a system-wide forward plan based on comprehensive stakeholder mapping.

Published by Warrington Together, February 2019 (Revised May 2019)

Health and Wellbeing Board

Thursday 30 May 2019

Report Title:	Warrington Together: New Proposed Arrangements for the Delivery of a Partnership to Deliver Integrated Health and Social Care Services in Warrington.
Report Purpose:	The purpose of the report is to provide the Health and Wellbeing Board with a review of current arrangements and a proposal to achieve integration and strengthen accountability to achieve integration by 2020.
Report of:	Simon Barber, Chief Executive, North West Boroughs Healthcare NHS FT Dr Andrew Davies, Clinical Chief Officer, Warrington CCG Steve Peddie, Executive Director Families and Wellbeing, WBC Mel Pickup, Chief Executive, Warrington and Halton Hospitals NHS FT Colin Scales, Chief Executive, Bridgewater Community Healthcare NHS FT Michael Sheppard, Representative, Warrington 3rd Sector Health & Social Care Alliance
Report author(s):	Simon Kenton, Programme Director, Warrington Together
Recommendations:	The Health and Wellbeing Board is asked to: • Note the contents of the report; • Support the enhanced role of Warrington Health and Wellbeing Board in delivering integration and in directing the Warrington Together programme; • Support the establishment of a Provider Alliance; • Note the retention of the Warrington Together Programme Office and team as a system wide resource, • Approve the disestablishment of the Warrington Together Board as an intermediary part of the existing structure.
Decision Required:	The Board is asked to support the above recommendations.

1 Background

1.1 Our Warrington Together journey is predicated on rising to the challenges in Warrington's health and social care system, which is under enormous strain. We are struggling to keep pace with demand for emergency services, social care, hospital inpatient services and primary care such as GPs. In addition, with staff shortages and demand for social care exceeding available budgets, the system is at 'tipping point'. In addition, Warrington's population will grow by around 17% by 2035. It is estimated that in just three years' time the proportion of Warrington residents aged over 65 will have increased by 27%. Warrington is getting bigger – but budgets are not. And we're all living longer, which is good news for our population but also means that we are using health and social care services for longer too.

1.2 In Warrington we spend £360million per year between agencies on health and social care. Unless we work differently, by 2021 we will have a financial black hole of nearly £50million. We need to make the most of the funding that comes into Warrington's public services urgently. The existing system is not sustainable.

1.3 After eight years of austerity, there are growing financial and service pressures within the NHS. NHS funding has grown by slightly more than 1 per cent a year in real terms since 2009/10 and with a 60p in the £1 cut in council funding, social care spending per adult has fallen by 11% in real terms, leading to suppression of pay to providers, instability in the market and patients with more complex needs being supported by staff whose workloads are increasing.

1.4 The cumulative impact of that funding problem has become clear. Winter crises in A&E, the depth and duration of which had not been seen for more than a decade, more people waiting to be diagnosed and treated and waiting for care. Warrington still has the highest rate of <24hr Emergency Admissions aged 75+ compared to similar CCG areas and has one of the highest rates of spend in the country on admissions for injuries in people aged 85+, as well as continuing high rates of stranded and super-stranded patients, exacerbated by a resource shortage in out of hospital services. Just as important are continuing difficulties in ensuring parity of esteem in mental health and deep-rooted problems in linking general practice services, community health and social care to form a supportive primary and community care system.

2 NHS Long Term Plan – Opportunities and Challenges

2.1 The government has announced increases in NHS funding over five years, beginning in 2019/20, and asked the NHS to come up with a long term plan for how this funding will be used. There is now an opportunity to tackle the issues that matter most to patients and communities and to improve health and care.

2.2 Opportunities in the plan are not restricted to improving the journey of patients and service users through complicated pathways of care and health. The new plan is designed to bring about a new commitment to bring about measurable improvements in population health and to reduce health inequalities, with a stronger role for Public Health.

2.3 As the Long Term Plan says, integration is particularly important for older people with frailty and those with complex medical conditions, who are often in contact with different health and care professionals. It is also a priority for children for whom outcomes are not as good in England as in many other countries and whose needs have been identified as a priority by ICSs in Greater Manchester and elsewhere. The aim of the 10-year plan is to support the ambition to 'make the biggest national move to integrate care of any major western country'.

2.4 Integrated care systems need to be built from the bottom up as well as top down, starting in neighbourhoods and extending to places and systems. We need to accelerate integration at primary and community care level. This is reflected in the Council's recent LGA peer review. Social care also needs to be much more future-focused and adept at redefining the challenges that all our systems face - shifting thinking to collaboration and building asset-based partnerships with the wider community, increasing the usage of technology and influencing the wider economic community.

2.5 Primary Care Networks will channel £1.235 billion of new NHS investment, supporting practices of all sizes to work together in neighbourhoods, supporting full integration of primary and community health teams. Networks will cover 30,000 - 50,000 populations and will operate under a Network Agreement outlining the formal basis for working with other community-based organisations. Network contracts will be set to cover a five year period delivering Long Term Plan commitments – commissioned via CCGs and accessible to all practices.

2.6 The plan confirms the shift towards integrated care and place-based systems which has been a defining feature of recent NHS policy. ICSs will be the main mechanism for achieving this; the plan says that ICSs will cover all areas of England by April 2021 – and will increasingly focus on population health.

2.7 The plan outlines several core requirements for ICSs (such as the establishment of a partnership board comprising representatives from across the system) but stops short of setting out a detailed blueprint for their size or structure. Systems will be required to 'streamline' commissioning arrangements. It also recognises that NHS organisations will need to work in partnership with local authorities, the voluntary sector and other local partners to improve population health.

2.8 The move towards a more interconnected NHS will be supported by a 'duty to collaborate' on providers and commissioners, while NHS England and NHS Improvement will continue efforts to streamline their functions.

2.9 The NHS Plan discusses a provisional list of potential legislative changes for Parliament's consideration. These proposals are based on what the authors of the plan have heard from clinicians and NHS leaders, as well as national professional and representative bodies. These proposals support the creation of NHS integrated care trusts. Since the repeal of NHS trust legislation in 2012, local areas have had limited options if they want to create a new integrated care provider (ICP), for example to deliver primary care and community services for the first time under a single, streamlined ICP contract. Remedying this would both reduce administration costs and

help with clinical sustainability. It should also be easier for proposed organisational mergers to progress, without diluting any of the current safeguards on frontline service changes.

3 Warrington's Response - Collective Leadership through Warrington Together

3.1 The establishment of a Warrington Together Programme Office, as a system wide resource, has underlined the importance of an objective, system wide solution to facilitate and enable change. The partnership approach has yielded some important cultural change, the establishment of a vision, new models of care, the frailty hub and the beginnings of Integrated Care Teams, along with other transformational changes. The Warrington Together branding has become established and has traction. But there is much to do and the system would want to retain the Programme Office and team to continue this work on behalf of all system partners including both commissioners and providers.

3.2 Our ability to work together as health and social care leaders under Warrington Together means that this collaborative programme is the best opportunity for system change to improve the lives of Warrington residents. We need transformation in the system, but existing services, whatever their level of funding, can still be improved by greater co-ordination, collaboration and integration. Commissioners and providers of care and health working collectively can agree more flexibility with pooled budgets to tactically commission and redesign services from within so that the money goes into the right places and yields the best health dividends; and people using services get a coordinated and seamless pathway through physical and mental health and care services.

3.3 The Warrington 'system' of providers of health and care comprises Warrington and Halton Hospitals FT, Bridgewater Community Health FT, Northwest Boroughs FT and Warrington Borough Council's Adults, Children and Public Health services, as well as primary care services delivered by General Practice and a host of smaller providers in the not for profit or private sector that are commissioned to deliver services. Those 'not for profit' services are now covered by a collaborative agreement which covers many providers under the Warrington Third Sector Health and Social Care Alliance.

3.4 Warrington's commissioners are Warrington NHS Clinical Commissioning Group (supported by a Commissioning Support Unit) and Warrington Borough Council's Commissioning and Contracting and Public Health teams.

3.5 The establishment of Warrington Together two years ago enabled system leaders to test out their respective strengths and explore opportunities for further collaboration. The programme enabled system leaders to realise that demonstrable progress at pace in relation to joint commissioning and joint delivery of health and care was to a large extent determined by their own efforts and commitment. Hence, the following proposals to drive improvements locally with ultimate accountability being held with the place based system leaders forum – Warrington's Health and Wellbeing Board,

with Warrington Together programme being retained as a system-wide resource for both commissioning and provision.

3.5 Senior Executives have decided to move away from the existing arrangements to establish a Provider Alliance working alongside the existing Integrated Commissioning and Transformation Board and request that the Warrington Health and Wellbeing Board oversee them both and hold them to account in achieving the objectives in the Warrington Health and Wellbeing Strategy.

3.6 Senior Responsible Executives of each of the statutory Health and Social Care providers, representative of the Warrington 3rd Sector Health and Wellbeing Alliance and the Clinical Directors of the emerging five Warrington Primary Care Networks wish to consolidate their working arrangements to act as an Executive team, to exercise collective system-wide leadership team by making integration part of the day job, and accelerate integration and overcome barriers. As demonstrable integration is proven, agencies affecting the wider determinants of health (e.g. Housing) will be invited to attend, as appropriate.

3.7 It is right to refresh and strengthen the governance arrangements affecting integration including the emerging national changes to primary care (e.g. Primary Care Networks) and the need to mainstream and 'industrialise' place based care.

4 Governance

4.1 Role of Health and Wellbeing Board

4.1.1 Under the Warrington Together banner, both Commissioners and Providers would report directly into the Health and Wellbeing Board. In other words, the Health & Wellbeing Board would take on the governance role for these arrangements directly, with support from the Warrington Together programme as a system owned resource, rather than the Warrington Together Board. As a result of these changes to governance, consideration may need to be given to the current terms of reference of the Health and Wellbeing Board. The aim of such consideration will be to enable the Health and Wellbeing Board to:

- Deliver its strategic objectives across Health and Social Care for the population of Warrington
- Ensure appropriate Partner involvement in decision making
- Provide a robust vehicle for democratic input
- Give strength to the voice of the public, patients, clients and service users
- Make best use of the Warrington Pound by exercising strong financial stewardship
- Support decision making with appropriate technical advice
- Maintain an objective leadership

4.1.2 The dis-establishment of a Warrington Together Board removes an intermediary tier of governance between integrated delivery and commissioning, makes the major players directly accountable to the Warrington Health and Wellbeing Board (the place based Partnership Board), necessitating enhanced attention, support and challenge in ensuring sufficient progress is made on both these issues.

4.1.3 The role of the Health Overview and Scrutiny Committee is as set out in the Local Government Act 2000 and the Overview and Scrutiny of Health Guidance 2003. It remains a point for accountability, where the functions of the Committee are seen to be discharged in a transparent manner that holds health and care leaders (Executive and officers) to account, and is seen to boost the confidence of local people in health scrutiny, but where the process builds bridges between local government and the NHS.

4.1.4 The Health Overview and Scrutiny Committee will continue to make a distinct and positive impact through the scrutiny function: topics that are timely and relevant, but not already under review elsewhere and prioritising that health services address the needs of local communities and that local health and health-related issues are being tackled jointly across local agencies.

4.2 Provider Leadership

4.2.1 The 3 Chief Executives of Warrington's NHS Provider organisations, the statutory Director of Social Care, representatives of each of the emerging Primary Care Networks and a representative of the Third Sector Alliance to meet as a Partnership Executive Leadership Team to the Provider Alliance, monthly, to drive real change and accelerate the programme of work under Warrington Together. A nominated member of the above to take the Chair, on a rotational basis, to drive and accelerate integration across deliverers of service. The Programme Director of Warrington Together, supported by the existing Programme Management Function will continue to report to the Chair of the HWB, will support the Provider Alliance and drive integration by aligning Warrington Together programmes to support the system's transformation programme.

4.2.2 A team of the Operational Directors will act in the same way, meeting more frequently to ensure a consistent Senior Change Team that will act with pace and as 'business as usual', - mainstreaming collective leadership as one virtual organisation in real time.

4.2.3 It should be noted that some joint posts for delivery have already been created (with joint lines of accountability) between the Hospital and WBC from 'Associate Director' level downwards. It is proposed that more of these arrangements will be extended across provider organisations, beginning with WBC and Bridgewater NHS FT, at Operational Director level, to develop place based focused teams rather than those focused on institutional sustainability.

4.2.4 The creation of community integrated hubs will continue to be implemented in 5 locations - Central (x 2), East, West and South - with an initial focus on frailty and using

a common set of design principles including the co-location of staff ultimately under single management. The core offer to include WBC, Bridgewater, NWB and WHHFT staff. GPs will need to be central to these arrangements. The NHS Plan talks of 'a move from a GP delivered service to one which is GP led'.

4.2.5 A locality approach to children's (SEND and nursing) services delivery is under development in parallel, with similar joint management arrangements and core delivery characteristics.

4.2.6 Other Ad hoc meetings are to be avoided. Winter management, for example, may require more frequent meetings of the above groups, as required, but operational arrangements should be robust and ongoing.

4.3 Commissioner Leadership

4.3.1 Commissioners already meet monthly as an 'Integrated Commissioning and Transformation Board' (ICTB) as per the agreed governance structure, with senior representation from Elected Members. The Board is currently co-chaired (alternately) by the Executive Director for Families and Wellbeing (WBC) and the Chief Commissioner for Warrington CCG.

4.3.2 Commissioners will meet fortnightly as a single commissioning management team overseeing an inclusive Warrington Commissioning Prospectus, until co-location of the Warrington footprint arrangements in 2020. Commissioners agree to create a single commissioning function for the Warrington footprint in 2019 [1]. A Chief Commissioner post will be jointly accountable to the Executive Director of WBC as well as the existing accountability to the Chief Clinical Officer of the CCG, making a single Chief Commissioning Officer for both organisations. Lead commissioners for social care and public health will become part of the Chief Commissioner's joint team, with dual accountability into the Council. The Programme Director for Warrington Together will attend, as appropriate, to maintain links between commissioning aspirations and practicalities in translating these to practical and tangible examples of integration.

4.3.3 Commissioners will agree the necessary contractual flexibility to secure the appropriate governance for providers to use budgets collectively and imaginatively in the best way to achieve agreed outcomes, including pooling budgets, deployment of staff to accelerate integrated provision, and single commissioning staffing where it makes sense to do so for the people of Warrington.

4.3.4 There will remain some services between Warrington CCG and Halton CCG under joint management – principally, back office functions. The CCG will review its arrangements with the Commissioning Support Unit.

4.3.5 In order to support the progress in provider integration, commissioners will review any opportunities for transferring redesign/tactical resource as the means for providers to support a step-change in pace by aggregating programme offices across organizations, including reviewing the best place for the governance of regional place-based transformation funding, transformational Better Care Fund and other appropriate budgets.

4.3.6 Quarterly joint meetings will be held between the Provider Alliance and Single Commissioning Function.

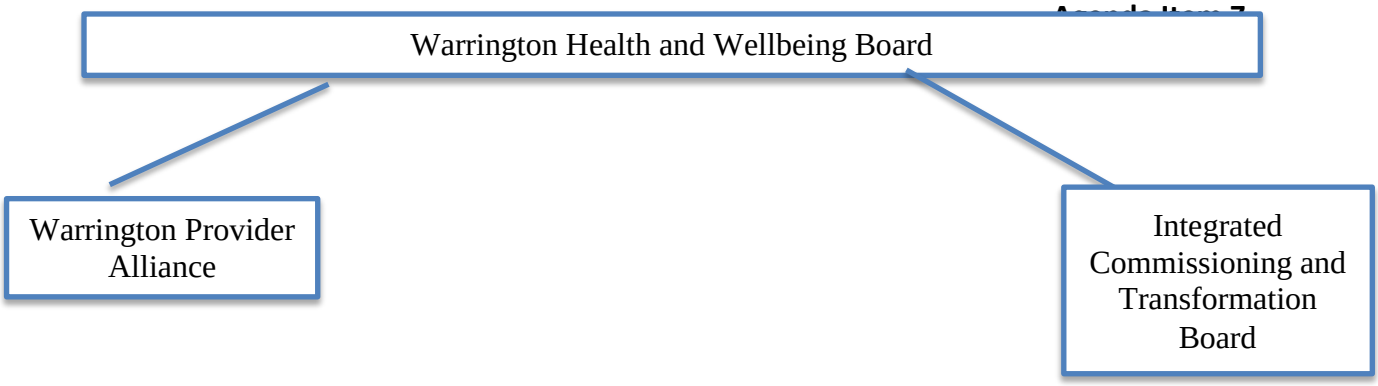
4.4 Impact on Warrington Together

4.4.1 Given all of the above, system leaders are in favour of continuing to brand partnerships as 'Warrington Together' infrastructure. There is a wish to retain a programme office and team, consolidate other system wide programme management functions into it and to renew and refresh existing governance arrangements.

4.4.2 At its last Board, Warrington Together partners did consider potential risks to this approach. For instance, the provider alliance will be chaired by one of the CEOs of the existing statutory providers. It was considered whether this could present a conflict of interest for the Chair and the HWB should be satisfied that these conflicts of interest will be managed appropriately. This is recognised by the Alliance, is minimised by the growing trust of the CEOs operating as a single leadership team and mitigated by a rotational chair. In addition, rather than breaking the momentum that Warrington Together has started to generate, the new arrangements will mainstream and prioritise them.

4.4.3 This paper acknowledges that the Executive leadership of the public sector organisations above have proposed, in addition to the existing sovereign governance arrangements that exist for Warrington NHS organisations and Warrington Council, to the collective leadership arrangements set out above, which are supported by a growing level of trust, co-operation, collaboration and commitment to system-wide joint working. System leaders want to work as a virtual alliance but will review options to formalise it with an integrated care trust being of interest, particularly noting the strong emerging partnerships.

4.4.4 If the HWB board approve the recommendations then the position of Chair of Warrington Together would elapse at the end of her term (end of May 2019) and the existing WT Board stood down; replaced by the Provider Alliance and the already established Integrated Commissioning Transformation Board, reporting directly to the Health and Wellbeing Board, supported by the Warrington Together programme team. The new architecture will be thus:



5 Recommendations

5.1 The Health and Wellbeing Board is asked to:

a. Note the contents of the report;

b. Support the enhanced role of Warrington Health and Wellbeing Board in delivering integration and in directing the Warrington Together Programme;

c. Support the establishment of a Provider Alliance;

d. Note the retention of the Warrington Together Programme Office and team as a system wide resource,

e. Approve the disestablishment of the Warrington Together Board as an intermediary part of the existing structure.

Updated 21 May 2019

Agenda Item 8

HEALTH AND WELLBEING BOARD WORK PROGRAMME 2019/20

18th July 2019 REPORT DEADLINE – 8th July 2019				
Issue	**Methodology, Details, Purpose**	**Lead Officer(s)**	**Further Action(s)**	**Committee coding**
Health and Wellbeing Strategy progress update				
Health and Social Care integration/transformation updates	*Various regular update items – for example STP, ACO, BCF.* *Lead officer: As appropriate – Andy Davies, Simon Kenton, Mike Alsop*			
Standing agenda items	*Update from reference groups* *Update on New Hospital* *Warrington Together Update* *Issues of strategic importance / key policy updates*			
Starting Well	*H&WB Strategy thematic update*	Elaine Bentley/Steve Tatham		
CQC Inspection	As per request at 28 March HWB meeting	Lucy Gardner		
Warrington Care Record Strategic Appraisal	As per request at 28 March HWB meeting	Phill James		

Possible Future Work Programme Items			
Issue	**Rationale**	**Anticipated Timescale**	
New Hospital	*Short update to be added to each meeting going forward*		

Updated 21 May 2019

Report from Healthwatch	*Regular report to be scheduled every 6 months*		
Alcohol Harm Reduction Strategy			
North West Ambulance Service	*Presentation on their local department and performance to how they work with partners (see email from Simon Kenton)*	tbc	
Update on Flu vaccination and flu-pandemic related issues: Reflection on success of the process during winter 2018/19	*As per discussion at meeting on 31st May 2018* *Moved from 30 May 2019 meeting to September Board meeting – see email from Tracy Flute dated 7/5/19 refers*	September 2019	
JSNA Programme	*Annual report – see email from Tracy Flute dated 7/5/19*	May 2020	
Living Well	*H&WB Strategy thematic update – lead officers Carl Marsh/Dave Bradburn/Dot Finnerty/Tracy Flute*	September 2019	
Ageing Well	*H&WB Strategy thematic update – lead officers Sara Garrett/Rick Howell*	November 2019	
WSAB/SCB ½ yearly report	*As per 30 May 2019 meeting – lead officer Rosie Lyden.*	November 2019	
Strong and Resilient Communities	*H&WB Strategy thematic update – lead officers Chris Skinkis/Nick Armstrong*	January 2020	
Enablers	*H&WB Strategy thematic update – lead officer Nick Armstrong*	March 2020	