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Coventry City Council

Agenda

Coventry Health and Well-being Board

Time and Date
2.00 pm on Monday, 7th April, 2014

Place
Committee Rooms 2 and 3 - Council House

Public Business

1. **Welcome and Apologies for Absence**

2. **Declarations of Interest**

3. **Minutes of Previous Meeting**

   (a) To agree the minutes of the meeting held on 24th February, 2014 (Pages 3 - 26)

   A copy of the Health and Wellbeing Peer Challenge findings is attached for Members' information (Minute 33 refers)

   (b) Matters Arising

4. **Health Protection Strategy** (Pages 27 - 32)

   Report of the Director of Public Health

5. **Health and Social Care Integration: update on Better Care and the British Telecom Hot House event & 5 Year Plan**

   Dr Steve Allen, Coventry and Rugby Clinical Commissioning Group, will report at the meeting

6. **2014/15 Work Programme for the Board** (Pages 33 - 36)

   Report of the Deputy Director, Public Health

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

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

Private Business

Nil

Chris West, Executive Director, Resources, Council House Coventry

Friday, 28 March 2014

Note: The person to contact about the agenda and documents for this meeting is Liz Knight

Membership: S Allen, S Banbury, C Bell, Councillor K Caan, A Canale-Parola, G Daly, Councillor G Duggins, Councillor A Gingell (Chair), A Hardy, S Kumar, R Light, Councillor A Lucas, J Mason, J Moore, R Newson, Councillor H Noonan, S Price, B Walsh and J Waterman

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

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

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Minutes of the meeting of the Coventry Health and Well-being Board held at 2.00 p.m. on 24th February, 2014

Present:

Board Members: Councillor Duggins
Councillor Gingell (Chair)
Councillor Mrs Lucas
Councillor Noonan
Jane Moore, Director of Public Health
Brian Walsh, Executive Director, People
Dr Steven Allen, Coventry and Rugby CCG
Stephen Banbury, Voluntary Action Coventry
Claire Bell, West Midlands Police
Professor Guy Daly, Coventry University
Professor Sudesh Kumar, Warwick University
Ruth Light, Coventry Healthwatch
John Mason, Coventry Healthwatch
Sue Price, NHS Local Area Team

Employees (by Directorate):

Chief Executive's: R Tennant

People: I Merrifield, C Parker and H Walker

Resources: L Knight

Other Representatives: Allyson Downes, Coventry and Warwickshire Partnership Trust
Andy Hardy, University Hospitals Coventry and Warwickshire

Apology: Jon Waterman, West Midlands Fire Service

Public business

27. **Welcome**

The Chair, Councillor Gingell, welcomed members to the meeting of the Coventry Health and Well-being Board including Claire Bell, West Midlands Police who was attending her first meeting, Andy Hardy, University Hospitals Coventry and Warwickshire and Allyson Downes, Coventry and Warwickshire Partnership Trust.

28. **Declarations of Interest**

There were no declarations of interest.

29. **Minutes of Previous Meetings**

The minutes of the meetings held on 21st October, 2013 and 27th January, 2014 were agreed as true records. There were no matters arising.

30. **Update on Better Care – Submission and Next Steps**

Further to Minute 25/13, the Board received the Better Care Fund Planning

Template to support integration across health and social care which had been signed off and submitted to the NHS Local Area team on 14th February, 2014. Dr Steven Allen, Coventry and Rugby CCG provided an update on progress.

Attention was drawn to the following three schemes in the submission which were to be initially progressed through the Better Care Fund:

(i) Short Term Support to Maximise Independence – by the development of integrated teams comprising health, social care and professionals and effective use of new technologies
(ii) Long Term Care and Support – including joint packages and NHS Continuing Health Care – initial priorities learning disabilities and mental health and older people
(iii) Dementia – integrated delivery of pre and post diagnostic support, living with dementia and rapid re-entry to services when required.

Additional schemes would be developed in due course. The template provided an excellent basis for the development of quality services.

The Chair, Councillor Gingell informed of the intention to hold an informal development session for both Coventry and Warwickshire Health and Well-being Boards on 28th April, 2014 to discuss health and social care integration and the development of the five year plan.

The Board discussed how the submission was an excellent example of partnership working with agreed priorities that would be of mutual benefit to each organisation and also had the support of Healthwatch. They were reminded of the financial implications since funds were being released from existing services to support the Better Care Fund. There was an acknowledgement that the submission was a 'live' document and would be updated as appropriate and, in due course, would include detailed information for local residents about service improvements and how to keep healthy.

It was agreed that the updated document would be submitted to Integrated Sub-Group of the Board (the Leaders' Group) as appropriate in due course.

31. **Tackling Female Genital Mutilation in Coventry**

The Board received a report of the Director of Public Health which provided an update on the work being undertaken to tackle female genital mutilation (FGM) in Coventry.

FGM procedures were mostly carried out on young girls between infancy and aged 15 and occasionally on adult women. It was illegal in the UK and was also illegal to arrange for a child to be taken abroad for FGM. If caught, offenders faced a large fine and a prison sentence of up to 14 years.

At its meeting of the 3rd December 2013, the City Council approved a motion that condemned the practice of female genital mutilation and called on steps to be taken locally to enforce the law to prevent women and girls being taken out of UK legal jurisdiction with the intention of carrying out FGM. It also called for better enforcement of the law against parents/ guardians who permit FGM and practitioners who carry it out and

better education to support girls to resist FGM, boys to oppose this and to empower communities to confront it. It called upon all the agencies locally to play a part in collective action against FGM.

In 2010 it was estimated that 145 women living in Coventry who gave birth may have undergone FGM.

There were a number of steps that had been taken locally across a range of agencies to address FGM which included:

- The Local Safeguarding Children's Board producing safeguard procedures, guidance sheets and awareness training
- The Meridian Centre routinely asking new registrations about FGM
- West Midlands Police launching Operation Sentinel which protected the most vulnerable members of society
- Coventry University being part of an EU wide programme to evaluate best practice in tackling FGM
- All schools being contacted to make them aware of the risks of FGM.

It was proposed to establish a multi-agency group, led by public health to develop a local action plan to deliver a comprehensive city-wide programme of work to tackle FGM.

Members of the Board outlined their support for the current work and Councillor Lucas informed of the work of the Local Government Association in this area.

RESOLVED that:

(i) The motion approved by Council condemning the practice of FGM be supported.

(ii) The establishment of a working group to develop and implement a local multi-agency action plan to tackle FGM be endorsed.

(iii) Members ensure that agencies represented on the Health and Well-being Board are actively involved in this programme of work.

(iv) Feedback on the work of the multi-agency group be reported to the Health and Well-being Board and also to the Local Government Association Group.

32. **Health and Well-being Strategy Update**

The Board received a report of the Deputy Director of Public Health which provided an update on the development of the Health and Well-being Strategy and proposed next steps. A copy of the existing joint strategy for the city agreed by the Board in December, 2012 was attached at an appendix to the report.

The report detailed the existing key themes and priority areas. The priorities were set following work undertaken as part of the Joint Strategic Needs Assessment in 2012. The high level findings along with updated measures were set out in a second appendix.

Since 2012 there had been a number of changes including the acceleration of

Health and Social Care integration, a smaller public sector and different challenges within communities meaning there was a need to review the strategy. Reference was also made to the recommendations from the recent peer challenge.

It was proposed that the Health Strategy Group act as a sub-Group of the Board, with the remit to lead on the following areas:

- Refresh and update the strategy, with key strategic groups, to ensure that the Board has a clear and over-arching strategy
- Involve wider stakeholders, including the public, in a 'big conversation' on the strategy to ensure it adapts to emerging and changing issues in the city
- Identify and agree key areas, requiring additional in depth investigation, to support the development of the strategy and to ensure it remains fit for purpose.

The next steps for the Health Strategy Group included linking together with other sub-groups of the Board to pull together existing action plans into an over-arching strategy; refreshing lead partnership groups for the priority areas and linking with them to determine key outcomes; developing membership of the Group so it has sufficient expertise to lead on the 'big conversation' and support communities; and to lead on the organisation of a Health and Well-being Board development session towards the end of April.

The Board discussed the importance of encouraging residents to attend screening sessions for cancer to allow for early detection and it was agreed that screening would be a general topic for a future Board meeting. They also discussed how to ensure that the consultation would be meaningful for members of the public and would encourage them to engage. This issue would be considered at the development session.

RESOLVED that:

(i) The approach outlined for the development of an over-arching strategy for the Board be endorsed.

(ii) Medical screening tests to be the subject of a report for a future Board meeting.

33. **Health and Well-being Board Governance Arrangements**

The Board considered a report of the Deputy Director of Public Health which provided an update on the new governance arrangements for the Health and Well-being Board as agreed at the Board's informal development session on 27th January, 2014.

The report referred to the understanding that the structure of the Board would be reviewed during the year to ensure that the Board was working effectively. In October, 2013 the Local Government Association carried out a Health and Well-being Peer Challenge in the city. This review included attending a Board meeting and interviewing members. Key finding of the review were:

- The ambition to improve health was clear and the challenges understood, this needed to be translated into a clear action plan and refreshed Health and Well-being Strategy
- There was strong political and managerial leadership for health and well-being

- The Health and Well-being Board could consider whether it was structured in a way so all partners could contribute effectively
- There was a widely acknowledged need to tackle some of the service based issues that had hampered progress to improve health outcomes.

A revised membership of the Board was set out which included the addition of the Chief Executive Officers from University Hospitals Coventry and Warwickshire and Coventry and Warwickshire Partnership Trust along with the change of the Chair of the Health and Social Care Scrutiny Board (5) for the Deputy Cabinet Member (Health and Adult Services).

As national expectations of Health and Well-being Boards would increase, it was proposed that the frequency of meetings be increased to a maximum of six meetings a year.

The role and responsibilities of the Task and Finish Groups had also been reviewed. The following Groups would now report back on progress at regular intervals to the Board:

- Better Care Leaders' Group
- Health and Well-being Strategy Group
- Marmot Steering Group
- Primary Care Quality Group

In addition, the existing Dementia Strategy Group was to be reviewed and would report directly to the Board. The task and finish group on FGM would also report directly to the Board.

The Peer Challenge had highlighted the need to improve wider engagement with stakeholders and the public to improve transparency in how the Board works. To address this it was proposed to hold a regular schedule of informal development sessions with a wider pool of stakeholders which could include a range of people and organisations not represented on the Board. A list of subjects for development sessions would be agreed by the Board. It was also suggested that a review of how the Board could communicate effectively with the public and wider stakeholders should be carried out on behalf of the Board by key members with expertise in consultation and engagement.

It was proposed that an annual work programme be developed for the next Board meeting, in consultation with key stakeholders and other local groups that had a role around health and well-being. Providing the Board with the opportunity to give early consideration to local commissioning plans at a point where these could be subject to collective challenge was also to be incorporated into the Board's work programme.

The Board were informed of the intention to review the arrangement's in a year's time to ensure that they reflected changing local needs and changing national expectations and responsibilities of Health and Well-being Boards.

The Board discussed their links with the Local Adult's and Children's Safeguarding Boards.

RESOLVED that:

(i) The changes in membership of the Board be approved.
(ii) The changes in the frequency of Board meetings from three meetings a year to up six meetings a year be approved.
(iii) The roles and responsibilities of the Task and Finish Groups be agreed.
(iv) The proposals to improve engagement and communication with key stakeholders, including a programme of development sessions with a wider range of participants and a review of how the board engages with the public and stakeholders be endorsed.
(v) Agreement be given to review membership and delivery arrangements in a year's time to ensure that they continue to be fit for purpose.

34. **Good Engagement Charter**

The Board received the Good Engagement Charter from Healthwatch Coventry which was produced to support meaningful involvement of patients, public and carers in health and social care in Coventry and Warwickshire.

The Charter had been developed following the receipt of the views of local people through a survey and focus groups. It set out what was most important to people when they were asked to give their feedback, views or 'get involved'. It was the intention of Healthwatch to use the Charter to encourage organisations to adopt best practice. They were asking organisations to adopt the Charter as a driver for change and to produce a short pledge document setting out actions to be undertaken to develop their engagement practice in line with the Charter.

The Board were informed that a number of local organisations had already adopted the Charter, although the Board at UHCW, whilst engaging in the process, had not signed and were requesting some minor amendments to wording. There was an acknowledgment that for some issues with very tight timescales there would not be the opportunity for consultation.

RESOLVED that the Board adopt the Good Engagement Charter in order to:

(i) View strategies and plans of all organisations in the light of the good practice points it contains for public patient engagement.

(ii) Ensure Health and Wellbeing Board activities reflect good engagement practice.

35. **Local Safeguarding Children's Annual Report**

The Board received the Coventry Safeguarding Children Board Annual Report 2012-2013 and the Business Plan for 2013-2015. The Board also received a presentation on the work of the Board.

The Annual Report indicated that the Board had recognised and continued to develop new strategies to meet the growing understanding of potential and new risks to children and young people. In particular, they had carried out local research and identified additional services required to improve the local response to child sexual exploitation. The last year had been very challenging for the Board and a great deal of positive work had been undertaken to protect children and young people following the national trend of increased activity. Following several serious case reviews, including the Daniel Pelka

case, the Board was leading the work to ensure that local agencies and professionals learnt from these cases.

The presentation highlighted the key priorities for the Board.

The Board discussed the vital importance of partnership working for safeguarding children and young people and their role to ensure that their individual organisations were performing. Clarification was requested about holding organisations to account and how better interagency reporting should be included in the Health and Well-being Board's strategy along with clear statements highlighting how the different Boards linked together.

36. **Any Other Items of Public Business**

There were no additional items of public business

(Meeting closed at: 3.50 p.m.)

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Martin Reeves
Chief Executive
Coventry City Council
Council House
Earl Street
Coventry
CV1 5RR

11 December 2013

Dear Martin

Health and Wellbeing Peer Challenge - 21st to 24th October 2013

On behalf of the peer team, I would like to say what a pleasure and privilege it was to be invited into Coventry City Council to deliver one of the early pilot health and wellbeing peer challenges as part of the LGA's health and wellbeing system improvement programme. This programme is based on the principles of sector led improvement, i.e. that health and wellbeing boards will be confident in their system wide strategic leadership role, have the capability to deliver transformational change, through the development of effective strategies to drive the successful commissioning and provision of services, to create improvements in the health and wellbeing of the local community.

Peer challenges are delivered by experienced elected member and officer peers. The make-up of the peer team reflected your requirements and the focus of the peer challenge. Peers were selected on the basis of their relevant experience and expertise and agreed with you. The peers who delivered the peer challenge at Coventry City Council were:

- Chris Bull – Lead Peer, Associate and current Chair of the Public Health Systems Group
- Councillor Steve Bedser – Chair of Health and Wellbeing Board, Birmingham City Council
- Dominic Harrison – Director of Public Health, Blackburn with Darwen Borough Council
- Sarah Price – Chief Officer, Haringey Clinical Commissioning Group
- Daniel Ratchford – Chief Executive, Quality Health
- Gill Boston – National Care Forum and Voluntary Organisations Disability Group
- Pete Rentell – Challenge Manager, Local Government Association
- Satvinder Rana – LGA Senior Adviser (Shadow)

Scope and focus of the peer challenge

The LGA's new health and wellbeing system improvement programme has been co-created with a number of national organisations. Health and wellbeing peer challenge is one of the core elements and Coventry City Council is acting as one of the early pilot sites.

The LGA peer review team consisted of 7 team members with a breadth of experience and professional backgrounds. In three days the peer review team attended 36 sessions, met with 6 Councillors; 113 staff and partners; 5 visits and observed the Health and Wellbeing Board meeting.

The purpose of the health peer challenge is to support councils in implementing their new statutory responsibilities in health from 1st April 2013, by way of a systematic challenge through sector peers in order to improve local practice. In this context, the peer challenge has focused on two elements in particular:

- Cultural issues arising from NHS staff coming into the council in terms of how they are welcomed and how well prepared they are to adjust;
- Review of the cultural differences around procurement and joint commissioning and how these drive change

Our framework for the challenge consisted of four headline questions and our response to the two elements detailed above are incorporated under these headings:

1. How well are the health challenges understood and how are they reflected in the Joint Health and Wellbeing Strategy (JHWS) and in commissioning?

2. How strong are governance, leadership, partnerships, voices, and relationships?

3. How well are mandated and discretionary public health functions delivered?

4. How well are the strengths of the Director of Public Health (DPH) and her team being used?

It is important to stress that this was not an inspection. Peer Challenges are improvement focused. The peers used their experience and knowledge to reflect on the information presented to them by people they met, things they saw and material that they read.

This letter provides a summary of the peer team's findings. It builds on the feedback presentation delivered by the team at the end of their on-site visit. In presenting this feedback, the Peer Challenge Team acted as fellow local government and health officers and members, not professional consultants or inspectors. We hope this will help provide recognition of the progress Coventry City Council and its Health and Wellbeing Board (HWB) have made during the last year whilst stimulating debate and thinking about future challenges.

1. Headline messages

Overall the peer challenge team were impressed by the way in which the transition into the new public health system had been managed in Coventry. We were equally impressed by the scale of ambition which we found and, in our feedback, many of our messages relate to the actions which may be needed to achieve those ambitions which were often described to us within the framework of Coventry being a Marmot City. Early in the peer challenge we were told that Coventry was committed to fundamentally changing the health outcomes of people in the City to the point where the City was no longer in the bottom quartile in relation to measures of premature mortality but, rather had moved into the top quartile. There was also a sense of urgency in that both politicians and senior officers wanted to see evidence of real progress over the next eighteen months.

In this context our headline messages were:

- The transfer of the Public Health function to the council had been achieved successfully. There was a real sense that the Council had embraced its new responsibilities and were describing a strategy where health improvement was at the heart of the Council's vision. Public health staff are well integrated into the Council and many of the people we spoke to demonstrated an understanding of the importance of this agenda for the people of Coventry. This is an example of good practice which provides an excellent basis from which Coventry can move forward.
- The ambition to improve the public's health was clear and expressed through the Marmot City framework. The scale of the challenge facing Coventry was well understood and there was a real energy around people wanting to contribute to meeting the challenge. However it was difficult to find the strategy expressed in a single document and therefore to understand how progress was being understood and measured. This will necessitate detailed work to calculate what has to be done to deliver your stated ambition, for example what modelling have you done on the number of deaths you need to avert, the programmes that will underpin this and the trajectories they will work towards.
- Notwithstanding that there was a clear understanding of the needs of the population supporting the ambition. However it may be that the narrative needs to be expressed in a way where the needs of particular black and ethnic minority communities are more easily understood.
- The political and managerial leadership of the Council is well regarded across the local system. This creates an opportunity for the Council through the Health and Wellbeing Board to work with partners to tackle the issues which may prevent Coventry's ambition being realised.
- In doing this the Health and Wellbeing Board may want to consider whether it is structured in a way that means that all partners can contribute effectively.
- There is a widely acknowledged need to tackle some of the service based issues which have the potential to slow progress. The long term viability of

acute services, variability in primary care and the need to accelerate progress on integration are examples of such issues. In the short term there is an opportunity to focus on improving performance in the delivery of mandated public health services, such as health checks, and in further development of Healthwatch.

2. How well are health and wellbeing challenges understood and reflected in the JHWS and in commissioning?

There is a good overall understanding of need and health inequalities in Coventry and the fact that they have been invited to become a Marmot City is recognition that there is a clear vision for Health and Wellbeing locally. Being a Marmot City demonstrates the council's commitment to improving the health of all people living in Coventry so that it compares with the best Nationally. Marmot principles have been incorporated into the HWB priorities and therefore directly into the Board's work and they link into work themes and initiatives of other Directorates within the council to change practice. The intent is to embed Marmot into the DNA of everybody that works in the organisation.

There is a good narrative around how public health relates to economic prosperity, housing, growth, regeneration and job creation. As an example there was a quotation around a cycling initiative *"they are getting healthier but actually all they know is that it's easier for them to now get to work".* Place Directorate have historically been actively involved in public health issues such as smoking and active lifestyles.

Coventry has a good handle on life expectancy gap between males and females in each of its wards using the analogy of a bus route driving through each ward demonstrating the variability and thus greater need in some compared to others. In addition, they are able to show how they compare to other authorities from premature deaths caused by heart disease and strokes, liver disease, cancer and lung disease. This helps to inform the Joint Strategic Needs Assessment (JSNA) which has evolved over a number of years and appears to be meaningful and informing the Joint Health and Wellbeing Strategy (JHWS). The JSNA has also informed other commissioning strategies such as the CCG commissioning strategy which has resulted in reduction in smoking in pregnancy, reducing alcohol related hospital admissions and increasing uptake in cervical screening priorities. Regardless there is still a need to better understand and act on the needs of particular places and communities and this appeared to the peer team to be a gap.

The JSNA process is improving but there is still a way to go in ensuring it is accessible to all and the development of the knowledge hub and better use at turning data into intelligence will greatly assist. The JSNA is in some areas informing prioritisation through pooling of budgets and joint commissioning e.g. historically the Coventry Health Improvement Programme (CHIP), which has now been mainstreamed, and commissioning of TB services, however, this needs further discussion at the HWB to

ensure members are all sighted on commissioning outcomes. More qualitative evaluation is required to drive an outcome focused approach. There is a wealth of data and outcomes available and the council need to ensure that what they are measuring and use is proportionate and meaningful and there is a need to accelerate the performance management of health care system delivery of preventative interventions such as health checks.

Coventry has a strong corporate research capacity, good public health analysts and two Universities with a very strong track record in research, evaluation and teaching in health and wellbeing relevant subjects. The review team felt that more could be made of this capacity through better alignment or integration. The council might benefit from considering whether a City wide (virtual or real) Knowledge management function would bring added value to the existing efforts and capacities of all partners across the city including the two universities. This could include the development of a City–wide CV and Virtual Knowledge Hub for research evaluation, intelligence analysis insight and publication. This capacity would also assist with creating an independent capacity for developing 'monitory democracy' by placing the outcomes of local public services within the public domain. The Academic network can add significant value to the area of qualitative evaluation and are developing a robust evaluation framework and the HWB must get fully engaged in this work programme.

There is a potential conflict between longer term outcomes and political aspiration for short-term achievements along with a perception that the wisdom of Marmot City investment in areas of need is being frustrated by the imperative to make cuts and cost savings. This will need strong and courageous political leadership to ensure the work of the HWB remains a key agenda item corporately and doesn't get reduced to being just the work of a PH department. There is a sense that the HWB is emerging as the centre of decision-making and this momentum must be maintained for effective governance across the statutory bodies.

The HWS along with the Marmot initiative demonstrate that local plans and strategies are ambitious and challenging. There is an issue over the number of local priorities and the number of organisations (CCG, acute providers, council) with competing priorities so this might need to be reviewed and rationalised. Whilst we found supporting evidence for various sub-elements of the work covered by the HWS there was a need to bring these together into a coherent work programme to support the scale of Coventry's ambition. This will require a refreshed HWS and action plan mirroring the ambition of the Marmot City project, which in turn will require stronger integration aspirations in order to achieve this.

We found a coherent story of the Place across stakeholders we met and a long history of strong and effective partnership working. Nevertheless there is a need to ensure that the HWB and other partnership organisations are able to tackle the significant issues in the local system and ensure wide and meaningful engagement. Although we found the voluntary and community sector to be generally well engaged in the health

agenda their contribution, along with other service providers, needs to be further strengthened.

The health and wellbeing challenges are articulated by everyone you meet: the need to reduce health inequalities, to achieve more for residents and deliver the sorts of health outcomes that people across England experience. There is real commitment to this across the partnership and at different levels within organisations. As Coventry have committed to being a Marmot City, the implications of this for policy across the partnership organisations needs to be better understood and clearly set out so each organisation knows what it needs to do and where it fits in the delivery programme.

The CCG are very committed to the HWB and are supportive of the Council in its lead role. The understanding of the scale of the challenge amongst the wider Governing Body does not appear to be as embedded and the commitment to delivery of the prevention agenda needs strengthening, for example in the delivery of the health checks programme. The use of case findings should be a priority for the CCG in delivering shorter term improvements in outcome, but this does not come across clearly in the plans shared with the Peer Review Team.

The development of primary care is recognised as an important part of achieving improved health outcomes, but it is largely seen as a health service issue. The CCG stated that they want to reduce the number of poorly performing practices in the city, and encouraging practices to federate. The Health and Wellbeing Board can support this drive to improve the quality of services offered to citizens in many ways, for example in thinking through the challenges of premises and single handed practices when developing the more deprived areas of the city as part of the regeneration programme.

The Integration Transformation Fund (ITF) is an opportunity to take forward the vision for a Marmot City at scale. The partnership seems unsure what the future of this could be and the engagement of a wider group of partners needs strengthening.

3. How strong are governance, leadership, partnerships, voices and relationships?

There was overwhelming agreement that the political and managerial leadership for Health and Wellbeing is very strong in Coventry and is seen to be both effective and well respected. The Chair of the HWB has considerable experience, knowledge and contacts from working previously in the health sector which coupled with strong leadership from the Chief Executive of the council ensures that this agenda is very high on the corporate priority list. We found a high level of credibility and political capital in the local system.

The Board membership has now been condensed to ensure a more focused view to deliver effective outcomes. There is strong member representation, including the Leader of the Council and Opposition member, and involvement from other key strategic partners such as Fire and Police which is useful in terms of the wider

determinants of health. There is also good involvement from the voluntary and community sector in terms of development of the JSNA, priorities and the Marmot work though it is too early to see what impact this has made. Although representation includes individuals at the right level of seniority there is a view that their role and contribution to the Board needs to be made more explicit. The peer team observed the October HWB meeting and found competent and engaged discussion on key health issues and the meeting was well chaired. Everyone we met spoke highly of the HWB Chair and there is a good foundation for her to lead the Board in transformational change and development into a systems leader.

The removal of providers from the membership has not been well received by some or particularly well managed with them feeling disengaged. It may be challenging for the Board to function effectively without such key partners and we would suggest that a review is undertaken to ensure their voice is heard and they play a role. The key objective is to ensure the Board is strategic and does not just become a 'talking shop' through involvement of too many partners. To date attendance has been variable so commitment from individuals must be addressed to question their prioritisation of the agenda. In addition, we suggest the HWB considers how to recruit more BME members to ensure it reflects the diversity of Coventry.

We are aware that the Shadow Board benefitted from a series of development sessions. It would be useful to consider another Board away day to strengthen the leadership and functioning of the team and also to consider meeting more frequently outside of formal Board meetings to build trust and relationships. This will enable the Board to objectively consider more challenging and controversial issues. There is a need to ensure greater focus on transformation in the local system. The peer team would also question whether the current arrangements for dual membership of Scrutiny and HWB enable clarity of roles and adequate challenge as it appears to be a conflict of interest. However the peer team view was that the scrutiny function was generally considered to be robust and challenging. There is also scope for gaining added value through consolidation of existing knowledge management resources to inform effective outcomes.

Coventry has a good track record of partnership with the voluntary and community sector (VCS) with a range of mechanisms for engagement, for example Coventry Partnership which works with various sector representatives to work on the vision for the City and Here 2 Help (H2H) Consortium owned and run by local voluntary organisations. Under the Shadow HWB providers had a seat on the Board. Following changes to membership they no longer sit on the Board resulting in tensions around the rationale for that decision and a concern over how the voice of providers is heard in that forum. One quotation we received of current VCS involvement was *"after a good start the momentum seems to have slowed down."* As an example of this the new PH commissioning team haven't as yet had any involvement with H2H

If providers are not to be on the HWB there needs to be a coherent strategy that makes them feel engaged with it. It might be helpful to consider using and

experimenting with a range of different engagement mechanisms, given the variety of size and type of local providers. Provider involvement in the design and development of engagement mechanisms will lead to stronger and more successful engagement across a board locality.

In terms of delivering the Joint HWB Strategy a co-operative relationship between commissioners and providers is essential, with providers actively involved in design and development, working closely with commissioners to get the outcomes needed. Some market shaping may be needed to help move it in a direction to effectively deliver the strategy. The mechanisms for making this happen are not clear and would benefit from a more systematic transparent approach.

Healthwatch has its own unique challenge as a Board member to ensure they are not only on the Board to represent their organisation but also to effectively channel and gather the wider community views and feed them into the Board. Healthwatch was commissioned on 1st October 2013 and has been awarded to the Here 2 Help (H2H) Consortium using a cluster of member organisations to deliver different elements. This has caused some confusion given that H2H now have a presence on the HWB and were previously a provider so their role as the consumer champion might be difficult to separate from their other roles. In addition, the amount of grant they received was less than they expected which is causing some operational difficulties. The peer team suggests offering Healthwatch some support around their scrutiny function and need to hold the Board to account which could be done in a number of ways:

- Proactively determine how the entire board will work with the scrutiny function of the local authority to hold commissioner members to account and clarify the specific role of Healthwatch in this process.
- Ensure performance data is more visible and accessible to enable/improve scrutiny and accountability
- The model by which public health staff work with other departments is an example of good practice so consideration could be given to extending this to Healthwatch
- Although Healthwatch may be well placed to act as a critical friend, their resources and reach may be restricted. It may be helpful for a member to be an ‘engagement champion’ to work closely with them to support their engagement and involvement role.

Careful attention needs to be paid to maximising the opportunities created by Healthwatch as an emerging organisation and this should be given immediate attention.

Whilst the challenge and vision is clear there is work to do on ensuring the HWB is clear on its purpose. It should be driving things forward and developing how organisations do things in a different way rather than being a place where things are signed off. There are a number of sub-groups to the HWB, such as the Health Protection Committee as well as other local partnerships such as the Community

Safety Partnership, which will be effective forums to brief and advise the Board on key issues such as drugs and alcohol, chaotic lifestyles and mental health. We suggest you consider strengthening collaborative links with other areas i.e. Warwickshire given that the CCG area includes Rugby. We picked up that joint commissioning for adults was weaker than that for children's and the effective work undertaken by children's services in the 0-5 years project provided transferable learning.

The CCG is in a position as commissioner of acute, mental health and community services to ensure that healthcare services are taking a preventive approach, and working with NHSE to drive up quality in primary care. This could include using their CQUINs to focus trusts in achieving reductions in smoking, alcohol related violence or tackling obesity for example. Given the very ambitious transformation that the HWB wish to see, achieving the top 10% in terms of outcomes, the CCG need to use this commissioning strength to support the ambition and seek alternative ways to focus their providers on these outcomes.

The HWB is seen as the centre of decision-making by the full range of stakeholders, so it has the mandate to provide the strategic direction to deliver their ambition for Coventry. With this very strong leadership, the board will need to tackle some of the bigger issues that will hold them back, like the form of the health landscape in future. They will need to establish ways in which they can engage providers in this discussion. The groups that have been set up to take forward key policy areas, like integration, may be the best way to do this, but will need to ensure that they are inclusive, have clear governance and can make decisions.

Having NHS England at the Health and Wellbeing Board is very positive and an opportunity to think about primary care development in its broadest sense, not least in working through the roles of both CCG and NHSE in driving up practice performance. The core offer of Public Health between the PH department and the CCG appears clear with a memorandum of understanding in place. Relationships with Public Health England are starting to develop and there are regular meetings with DPH and other organisations to share information and ensure culturally that they are moving in the same direction in a joined up manner. However, further work needs to be done to embed clarity on roles and responsibilities of these different organisations.

4. How well are mandated and discretionary public health functions delivered?

The operating model of the Public Health team is, in the view of the peer team, exemplary. There is clear evidence of very significant strengths in health protection and emergency planning (resilience) services and partnerships. Services have been able to continue seamlessly to a good standard and were transferred across safely.

Sexual Health is a large element of the PH budget and a new area of responsibility for the council. Incidence rates of certain diseases are increasing and high in a number of vulnerable groups and there is currently an opportunity to review how this is delivered

in future. There is some innovative work led by the PH department into HIV testing in primary care and Coventry is also part of a national “3Cs and HIV” pilot to support improved prevention and early detection of sexually transmitted disease in primary care for young people.

The PHE Local Area Team have responsibility for screening and immunisation as part of the child health work programme and despite safe handover of contracts and local knowledge there are still some areas where there is confusion around responsibilities, though this will become clearer as the system matures. In terms of NHS healthchecks the uptake is lower than the West Midlands average though performance has improved. Coventry jointly commission Drugs and Alcohol services with Warwickshire County Council as a new arrangement with a new provider involving moving from a treatment service to a recovery service. The peer team visited the team at Walsgrave hospital and were very impressed with the passion and enthusiasm of staff involved and the clear pathway provided.

There is some evidence that the variability in the quality of primary care (including some single handed and other poorly performing GP practices dealing with mainly ethnic minority populations) is struggling with low rates of case finding for chronic disease and with the whole system unsustainably escalating elective and non-elective admissions to the hospital. For instance, the CCG had a 12.7% growth in elective admissions between 2007/8 and 2011 but their ONS cluster average was 3.8% in the same period and they had a 5.1% growth in non-elective with cluster average 1.2%

This outlier position compared to cluster average performance suggests possible problems, in particular sub-optimal disease management in primary care causing avoidable escalation to secondary care admission. The costs of this are likely to drain CCG capacity to re-invest resources on building primary care capacity for community based prevention and early intervention. These primary care challenges in cost, quality and health outcomes terms are likely to ‘hole below the water line’ the longer term Marmot effect and they will cause the wider public health aspirations of the city to stall. They need immediate attention.

It is equally clear that whilst primary care has a clear role to play that the acute trust also needs to come to the table to work with partners to ensure that people are able to receive the right care, at the right time in the right setting. It is likely that the system changes which are required to ensure that Coventry has sustainable and well integrated services will require change by all partners.

The council might wish to consider:

- Clarifying roles and responsibilities for ‘recovery planning’ within the distributed system of primary care quality improvement between the CCG, NHS England, the local Authority Public Health team and the Health and Wellbeing Board.
- Identifying a clear system lead for driving rapid improvement action in poorly performing GP practices in primary care.

- Developing improved data analysis on primary care performance outcomes and costs and a more active strategy for placing this data in the public domain (especially through the HWB Board who are now to be the local system managers and who should be holding the system to account).
- Increasing the access of Health Scrutiny and Healthwatch to GP practice level and hospital costs, outcome and performance data and better communication of 'issues' to the public though the mass media.
- Raising public expectations of the local health and wellbeing services through more vocal civic demand for health improvement has to be a key tool for change but it can only be enabled if clear and accurate data with analytical interpretation is offered. The public health team are well placed to enable this.
- Whether the existing lifestyle services for PH might be better re-configured to provide a new integrated wellbeing service offer across the council and other public services
- Increased professional and partner challenge on performance, outcomes and costs throughout the health and wellbeing system, particularly in relation to wider system deficiencies that are often already known to the key players.
- Further investigation of sub-optimal care in individual outlier general practices with a particular focus on 'case finding' establishing accurate disease registers and the identification of the causes of the rapid rise in elective and non- elective admissions by GP referral to secondary care.
- A more robust culture of outcome reporting and peer challenge by all partners on the HWB Board.
- A specific review of health outcomes in the black and ethnic minority population of the City with particular attention given to the quality and access to good quality primary care and preventative interventions.

Historically joint commissioning in Coventry was robust and monitored through joint commissioning processes, including the Adults Joint Commissioning Board and supported by a number of jointly funded posts between the NHS and Coventry City Council. We found clear internal commissioning processes underpinning mandated services supported by the wider council. The development of a new People Directorate will be an important opportunity to review joint commissioning arrangements and develop a more streamlined approach to commissioning. The example of an integrated Early Help offer for 0-5 years in children's centres is a good example of joint commissioning and there is transferable learning arising from this. Nevertheless, there is still a need to raise awareness and understanding of what procurement and commissioning respectively are to ensure a shared view and to ensure the necessary commissioning skills (contract management, market management, and negotiation) are held internally. This may necessitate a skills gap analysis.

The transition has presented opportunities to do things in a different way working collaboratively with others e.g. Warwickshire County Council to consider market testing for some key service areas. Consistent negotiation strategies with other local commissioners, particularly the CCG, are essential as public health holds a number of

contacts with the same providers. As commissioned public health services need to be targeted effectively to address health and wellbeing priorities of the council and the HWB, services would benefit from agreeing differential outcome indicators for areas with the greatest health inequalities at the ward and neighbourhood level. This would be further enhanced by bringing these indicators into the HWB performance framework.

The 'Core Offer' delivered to the CCG is appreciated and valued by both officers and GPs. The team have worked hard to ensure that the relationship with the CCG has remained strong over the transition period and since the DPH came into post. The CCG are supportive of the Health and Wellbeing Strategy but this could be more strongly linked to their commissioning intentions and their role in prevention and early detection prioritised. Engagement of GPs both on the wider Governing Body and amongst the membership on this agenda should be prioritised by the Public Health team and supported by the CCG Chief Operating Officer, AO and Chair. The Core Offer is a two way agreement and Public Health need to ensure they are getting what they need from the CCG too.

5. How well are the strengths of the Director of Public Health and her team being used?

The Public Health team has been very well integrated into the council and staff clearly understand the issues and feel energised by the current direction of travel. Coventry's early engagement to transfer responsibilities has had clear benefits for the agenda and partner organisations. The Director of Public Health is effectively engaged in the corporate leadership of the council. Placing the team within the Chief Executives Directorate works for Coventry and staff we spoke to could articulate how health was everybody's business and how it was cross-cutting into all service areas. In addition, the health agenda was woven into the corporate plan of the council and the corporate priorities. There is good cross-party support and commitment to the vision for health. Culturally, health staff feel part of the council culture in terms of working with elected members, decision-making and scrutiny role.

We were impressed by the energy and passion of the individual members of the public health team whom we met. There is a clear commitment to their role, and a strong sense of ambition to improve health and wellbeing in the City.

The transition of the public health team from the PCT to the local authority has been handled well, with shadowing arrangements in place for twelve months prior to the formal transfer on 1st April this year. We were impressed with how quickly the public health staff had settled into the local authority environment, and how much they had been welcomed.

Whilst some staff described cultural differences between NHS organisations and the local authority (for example, working directly with elected members), and some differences in language and interpretation (for example, around the word

'commissioning'), we saw no evidence that these differences were causing any practical problems. The council must continue to raise awareness of public health across the whole organisation so that staff are clear as to the role of public health and the challenge will be to influence and drive behavioural change throughout the organisation. There is more work to be done to fully embed this but there are pockets of good activity such as work between the planning and PH team and occupational health services around delivery of the NHS healthcheck to staff. There will be inevitable tensions given that the PH budget is ring-fenced which goes against the HWB having responsibility locally for the prioritisation of tackling the wider health determinants.

The Director of Public Health reports directly to the Chief Executive, and the public health team sits within the Chief Executive's department. This appears to be working well, with the Director clearly engaged in corporate processes, and the public health team positioned to have a positive corporate impact across the authority.

Senior members of the public health team have been 'matched' with each department in the council. They attend management team meetings, and act as advisers on cross-cutting public health issues. This arrangement works very well, and allows the public health impacts of services changes and major projects to be understood at an early stage. It had been in place during the year before transition, and is a key reason behind the excellent understanding that public health staff have of the wider local authority agenda. We saw many examples of this in practice, such as in the Place Directorate, where public health staff have helped the management team to adjust plans for green spaces, transport schemes, planning frameworks and public realm improvements so that they support the wider Marmot agenda. Another early success is the development of asset-based approaches in deprived areas. Though small initiatives at the moment in certain wards, this type of approach can be scaled up to deliver significant benefits but will need strong leadership to have an impact 'at scale'. This approach is also linked to the Troubled Families agenda and is starting to tackle reduced dependency.

The majority of the team are not new to their roles, so there is a good understanding of local issues, and excellent networking and relationships with individuals in the various NHS and stakeholders groups in the City. Staff we met spoke highly of the good use of social media and social marketing (Facebook and twitter) with regard to behavioural change to move away from a sedentary lifestyle. The Godiva festival was very well attended and enabled PH messages to be communicated and active lifestyle work undertaken over the summer was an excellent example of the council/CCG/General Practitioners working together effectively. The "Be Healthy Be Well" campaign was well received and has over 1000 downloads each time it is published. Despite this positive feedback the teams view is that more robust social marketing should target campaigns/intervention based on detailed knowledge of local communities.

The relationship with the CCG is strong and the skills the public health team bring to the work they are doing is valued. The poor performance of the healthchecks

programme is of concern and it is unclear why GPs are reluctant to deliver the checks, particularly in the more deprived areas of the city where unmet need is likely to be high. The Public Health team are working hard to encourage GPs to participate and have identified a GP Champion who is very enthusiastic. Reviewing payments and targeting practices may create some improvement in performance along with reporting at practice level on this and other prevalence data.

The JSNA and other documents show the challenge Coventry faces clearly. With such good relationships and working practice between Public Health and the CCG, the team could ask more of the CCG in supporting their work. While there are examples of focusing effort, using the information they have to target the areas of highest deprivation more consistently, may deliver improvement. Examples would be in the CCGs 'Care Closer to Home' work where they are reviewing care pathways and commissioning services in the community rather than in hospitals.

6. Moving forward

Based on what we saw, heard and read we suggest the Council and HWB consider a number of actions. These are things we think will help improve and develop your effectiveness and capacity to deliver future ambitions and plans and drive integration across health and social care.

Coventry is well placed to meet these challenges. The political and managerial commitment to improving health is exemplary. We would recommend that in order to support this that Coventry:

- Continues to articulate its ambition to improve health as a core component of the corporate strategy for the City.
- Develops a structured programme plan to support the scale of the ambition. This is not to suggest that all change can or should be delivered through a single process but rather to ensure that the milestones which will need to be met and the roles which different organisations will play are understood across the system.
- Delivers a focus on tackling the issues in the local health and care system which could impede progress. In order to achieve this, the Health and Wellbeing Board will need to exercise its system leadership role and ensure that it is structured in a way which enables it to do so.
- Builds on the many examples of innovation and good practice that we saw. The asset based approach of working with communities was just one example of those.

7. Next steps

The Council's political leadership, senior management and members of the HWB will undoubtedly wish to reflect on these findings and suggestions before determining how the Council wishes to take things forward. As part of the Peer Challenge process, there is an offer of continued activity to support this. We made some suggestions about how this might be utilised. I look forward to finalising the detail of that activity as soon as possible.

In the meantime we are keen to continue the relationship we have formed with you and colleagues through the peer challenge to date. Howard Davis, Principal Adviser (West Midlands) is the main contact between your authority and the Local Government Association. Howard can be contacted at Howard.Davis@local.gov.uk (or telephone 07920 061197) and can provide access to our resources and any further support.

We are keen to work with you on producing a short article for publication around the approach used within Coventry as discussed at the feedback session between Howard Davis and Jane Moore, Director of Public Health. I will be in contact shortly to arrange this.

In the meantime, all of us connected with the peer challenge would like to wish the Council every success going forward. Once again, many thanks for inviting the peer challenge and to everyone involved for their participation.

Yours sincerely,

Peter Rentell
Programme Manager – Local Government Support
Local Government Association

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Coventry City Council

Briefing Note

Date: 24th March 2014

To: Health and Well-Being Board

From: Nadia Inglis, Consultant in Public Health, on behalf of Prof Jane Moore, Director of Public Health

Subject: Arden Health Protection Committee

Purpose

To brief Health and Wellbeing Board members with regard to the function of the Arden Health Protection Committee, key current issues being addressed, and to request endorsement of the latter as a subcommittee of the Coventry Health and Wellbeing Board

Recommendations

Health and Well-Being Board is recommended to:

- Endorse the remit of and need for the Arden Health Protection Committee to exercise the responsibilities of the Directors of Public Health in Coventry and Warwickshire with regard to ensuring there are plans in place to protect the health of the population
- Approve the Arden Health Protection Committee as a formal subcommittee of the Health and Wellbeing Board
- Endorse the Arden Health Protection Strategy 2013-15

Background

Since April 2013, the local authority, and the Director of Public Health acting on its behalf, has a pivotal place in protecting the health of its population, being required to ensure that plans are in place to protect the health of the local population from threats ranging from relatively minor outbreaks to full-scale emergencies.

The scope of this duty includes local plans for immunisation and screening, as well as the plans that the local authority and others have in place for the prevention and control of infectious diseases, environmental hazards, and extreme weather events.

Where the Director of Public Health identifies issues it is his or her role to highlight them, and escalate issues as necessary, providing advice, challenge and advocacy to protect the local population. This local authority role in health protection planning is not a managerial, but a local leadership function.

The Arden Health Protection Committee was established in April 2013 (although met prior to this in shadow form) with the following purpose:

- To provide assurance on behalf of the population of Coventry and Warwickshire that there are safe and effective plans in place to protect population health, to include communicable disease control, infection prevention and control, emergency planning, sexual health, environmental health, and screening and immunisation programmes.

The following roles of the Health Protection Committee were established and agreed:

- Quality and risk assure health protection plans on behalf of the local population for Coventry and Warwickshire local authorities.
- Provide a forum for professional discussion of health protection plans, risks and opportunities for joint action
- Provide recommendations (on behalf of local authority Health and Wellbeing Boards and Health Scrutiny) regarding the strategic/operational management of these risks, to complement and feed into current accountability structures of Committee member partners.
- Escalate concerns where necessary
- Provide oversight of health protection public health outcomes.
- Set local health protection strategy and influence local commissioning through Joint Strategic Needs Assessment process to be approved by Coventry and Warwickshire Health and Wellbeing Boards.

Please see the attached presentation for further details regarding Committee membership and proposed governance arrangements. Current terms of reference for the Committee (due to be reviewed, as developed prior to transition) and the current Arden Health Protection Strategy (2013-2015) are also attached for information

The Arden Health Protection Committee is currently a formal subcommittee of the Warwickshire Health and Wellbeing Board (the former currently reporting as required through the Director of Public Health to the Board). It is proposed that the Arden Health Protection Committee is also formally endorsed as a subcommittee of the Coventry Health and Wellbeing Board.

Key issues

Current key challenges affecting Coventry, which are being monitored/addressed through the actions of partner members of the Arden Health Protection Committee:

- Ensuring overall oversight of health protection arrangements, as well as effective management of outbreaks and other significant public health incidents, in the context of the creation of multiple new health organisations

- An increasing rate of diagnoses of sexually transmitted infections, and the highest prevalence of HIV in the West Midlands.
  - There were a total of 2,864 new (non-HIV) infections diagnosed in Genitourinary Medicine (GUM) clinics in Coventry in 2012, significantly higher than the average for the West Midlands
  - HIV prevalence in Coventry is the highest in the West Midlands at 3/1000 population, with a significant proportion of individuals being diagnosed late (60.5% in 2010-2012, compared with an England average of 48.3%)

- Ongoing high rates of TB diagnoses in Coventry, and the need for consideration of national recommendations regarding screening new entrants to the UK for latent tuberculosis.
  - There were 143 people with infectious TB seen by the Arden Community TB Nursing Service (Coventry and Warwickshire) in 2012/13, compared with 119 in 2011/12
  - The incidence (new cases) of TB between 2010 and 2012 was 34.7 per 100,000 population, which is significantly higher than the England average (15.1 per 100,000)

- Seasonal flu uptake rates which remain suboptimal in clinical risk groups, pregnant women and health and social care workers:
  - The uptake of seasonal flu vaccination in Coventry and Rugby (CCG area) for 2013/14 was 73% in over 65s, 57% in clinical risk groups and 44.2% in pregnant women. 38.4% of frontline healthcare workers at Coventry and Warwickshire Partnership Trust and 57.9% at University Hospitals Coventry and Warwickshire were vaccinated in 2013/14.

Some of the key current/ongoing actions of Health Protection Committee partners:

- Surveillance of infectious diseases and outbreaks (e.g. reduction in numbers of whooping cough and measles cases in response to the recent vaccination programmes for pregnant women, and the MMR catch up campaign in 10-16 year olds). Lead: Public Health England.

- Development of a Multiagency Memorandum of Understanding for Service Delivery during health protection incidents (outbreaks). Lead: Local authority, with Public Health England and NHS England.
- Work to reduce the number of cold chain incidents reported in relation to routine childhood immunisation programmes. Lead: NHS England.

- Commissioning and quality assurance of routine childhood immunisation programmes, and adult/antenatal and newborn screening programmes. Lead: NHS England.

- Promotion of uptake of the seasonal flu vaccination, particularly among those with lowest uptake (i.e. those under the age of 65 years in clinical risk groups,

pregnant women and health and social care workers). Lead: NHS England and Local authority.

- Pandemic flu planning (multi-agency). Lead: NHS England.

- Co-ordination of cold and warm weather public campaigns/fuel poverty interventions, and professional communications. Lead: Local authority, CCGs and acute provider trusts.

- Working towards a reduction in transmission of sexually transmitted infections and in late diagnoses of HIV in Coventry. Lead: Local Authority.

- Setting up of a new TB Strategic board to oversee TB prevention and control programmes. Lead: Public Health England and Local authority.

- Ongoing air quality improvement work, given that the City is designated an Air Quality Management Area due to levels of nitrogen dioxide. Lead: Local authority (environmental health).

Queries to:

Nadia Inglis
Consultant in Public Health (Warwickshire County Council/Coventry City Council)
nadiainglis@warwickshire.gov.uk

References:

Department of Health, 2013. Protecting the health of the local population. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/199773/Health_Protection_in_Local_Authorities_Final.pdf

Attachments:

Arden Health Protection Committee – Role and Governance Arrangements

Coventry and Warwickshire Health Protection Committee - Terms of Reference

Arden Health Protection Strategy 2013-15

Arden Health Protection Committee – Role and Governance Arrangements

Coventry Health and Wellbeing Board

7th April 2014

Overview

- Background
- Purpose of Health Protection Committee
- Governance Arrangements
- Key Challenges
- Key Actions
- Request for endorsement as subcommittee of Health and Wellbeing Board

Overview of DPH role in Health Protection

- The local authority, and the Director of Public Health acting on its behalf, has a pivotal place in protecting the health of its population.
- Under this duty, local authorities (and Directors of Public Health on their behalf) are required to ensure that plans are in place to protect the health of the local population from threats ranging from relatively minor outbreaks to full-scale emergencies.
- The scope of this duty includes plans for immunisation and screening, as well as the plans that the local authority and others have in place for the prevention and control of infectious diseases, environmental hazards, and extreme weather events.
- Where the Director of Public Health identifies issues it will be his or her role to highlight them, and escalate issues as necessary, providing advice, challenge and advocacy to protect the local population.
- This local authority role in health protection planning is not a managerial, but a local leadership function.

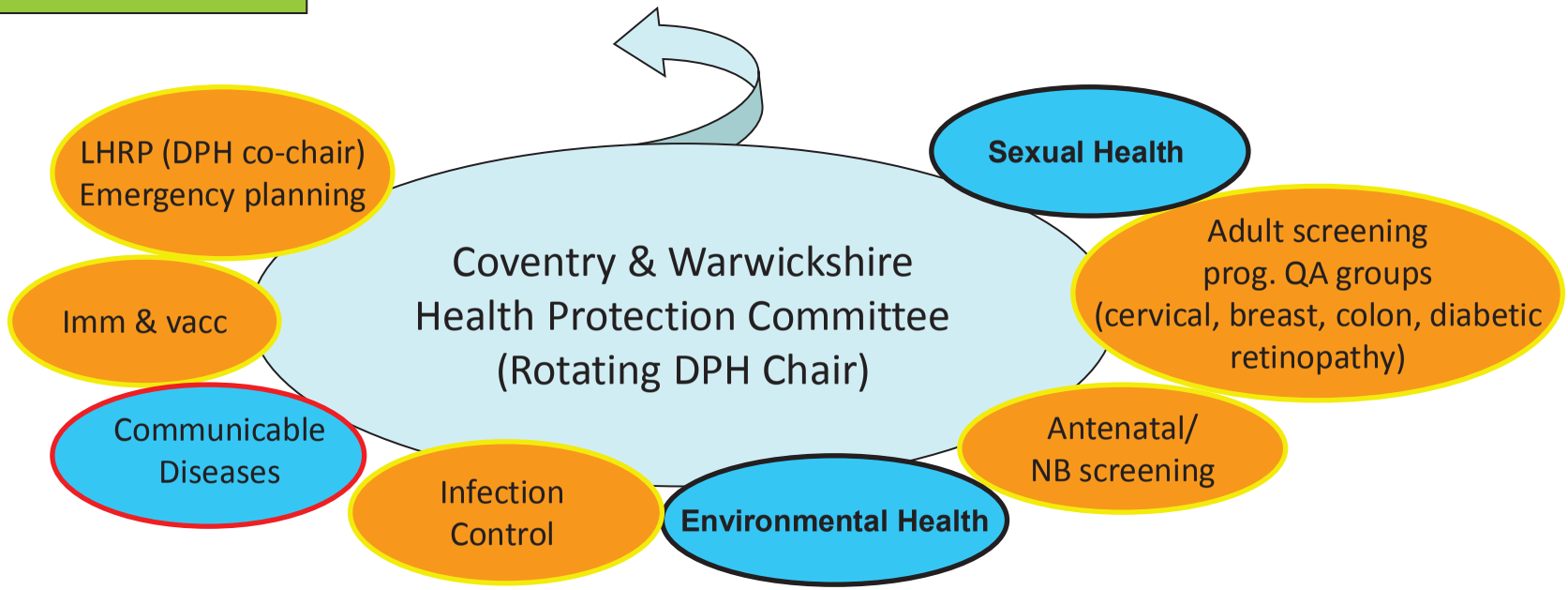
Protecting the health of the local population, DH, 2013

An integrated model of Health Protection in Coventry & Warwickshire

Key relationships
PHE
NHSCB
CCGs
Public Protection (CCC/ DCs)
CWS Resilience

Key roles
Quality Assurance
Risk assurance
Surveillance/ HP strategy
HP link to JSNA

JSNA/HWS/HWBBs



Key

Existing

New

HPU (to March 2013) /PHE (April 2013) lead

PCT (to March 2013) /LA (April 2013) lead

PCT (to March 2013) /NHsE (April 2013) lead

Purpose of Health Protection Committee

To provide assurance on behalf of the population of Coventry and Warwickshire that there are safe and effective plans in place to protect population health, to include communicable disease control, infection prevention and control, emergency planning, sexual health, environmental health, and screening and immunisation programmes.

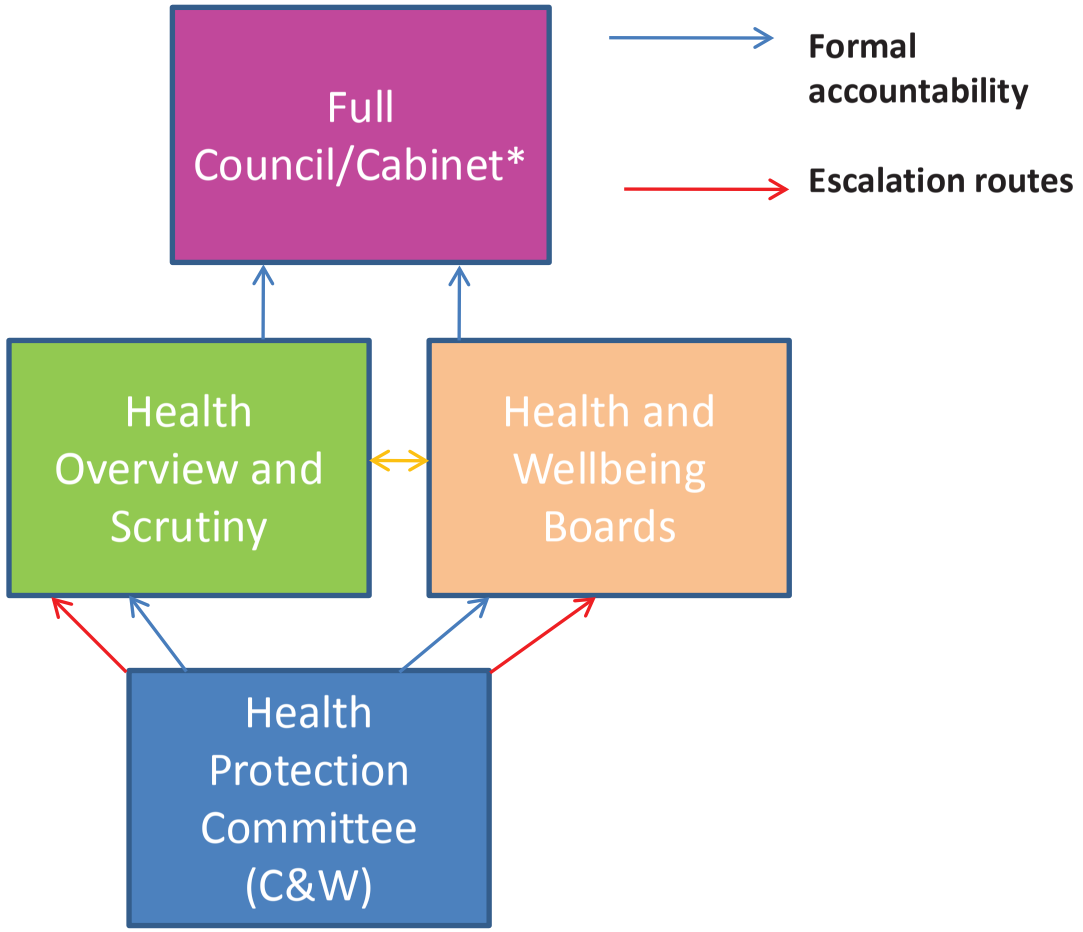
Role of Health Protection Committee

- Co-ordinate the transition of health protection functions to partner organisations and to mitigate against associated risks
- Quality and risk assure health protection plans on behalf of the local population for Coventry and Warwickshire local authorities.
- Provide a forum for professional discussion of health protection plans, risks and opportunities for joint action
- Provide recommendations (on behalf of local authority Health and Wellbeing Boards and Health Scrutiny) regarding the strategic/operational management of these risks, to complement and feed into current accountability structures of Committee member partners.
- Escalate concerns where necessary
- Provide oversight of health protection public health outcomes.
- Set local health protection strategy and influence local commissioning through Joint Strategic Needs Assessment process to be approved by Coventry and Warwickshire Health and Wellbeing Boards.

Specific assurance role of the Health Protection Committee

- The assurance role of the Committee will be executed through professional discussion with partner members and recommendations made by Committee/Director of Public Health Chair to partner members, to be considered through the accountability structures of partner members.
- Recommendations regarding strategic/operational management of risks will be made on behalf of the Shadow Health and Wellbeing Board/Health Scrutiny. Complex risk management issues/concerns about risks will be escalated to the Health and Wellbeing Board and/or Overview and Scrutiny as appropriate.
- Partner members will also put forward recommendations to be acted on by Committee members and influence local commissioning strategy through contributing to the JSNA process. JSNA contributions of the Committee and the Health Protection Strategy will be signed off by the Health and Wellbeing Board.

Accountabilities and escalation routes of HPC for local authority health protection function



***NB Local authorities also have external accountabilities with regard to health protection function**

Key Health Protection Challenges

- Ensuring overall oversight of health protection arrangements, as well as effective management of outbreaks and other significant public health incidents, in the context of the creation of multiple new health organisations
- An increasing rate of diagnoses of sexually transmitted infections, and the highest prevalence of HIV in the West Midlands.
- Ongoing high rates of TB diagnoses in Coventry, and the need for consideration of national recommendations regarding screening new entrants to the UK for latent tuberculosis.
- Seasonal flu uptake rates which remain suboptimal in clinical risk groups, pregnant women and health and social care workers:

Key Actions of Committee Partners

- Surveillance of infectious diseases and outbreaks Lead: Public Health England.
- Development of a Multiagency Memorandum of Understanding for Service Delivery during health protection incidents (outbreaks). Lead: Local authority, with Public Health England and NHS England.
- Work to reduce the number of cold chain incidents reported in relation to routine childhood immunisation programmes. Lead: NHS England.
- Commissioning and quality assurance of routine childhood immunisation programmes, and adult/antenatal and newborn screening programmes. Lead: NHS England.
- Promotion of uptake of the seasonal flu vaccination, particularly among those with lowest uptake. Lead: NHS England and Local authority.

Key Actions of Committee Partners

- Pandemic flu planning (multi-agency). Lead: NHS England.
- Co-ordination of cold and warm weather public campaigns/fuel poverty interventions, and professional communications. Lead: Local authority, CCGs and acute provider trusts.
- Working towards a reduction in transmission of sexually transmitted infections and in late diagnoses of HIV in Coventry. Lead: Local Authority.
- Setting up of a new TB Strategic board to oversee TB prevention and control programmes. Lead: Public Health England and Local authority.
- Ongoing air quality improvement work, given that the City is designated an Air Quality Management Area due to levels of nitrogen dioxide. Lead: Local authority (environmental health).

Recommendations

- Endorse the remit of and need for the Arden Health Protection Committee to exercise the responsibilities of the Directors of Public Health in Coventry and Warwickshire with regard to ensuring there are plans in place to protect the health of the population

- Approve the Arden Health Protection Committee as a formal subcommittee of the Health and Wellbeing Board

- Endorse the Arden Health Protection Strategy 2013-15

Thank you!

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COVENTRY & WARWICKSHIRE HEALTH PROTECTION COMMITTEE

TERMS OF REFERENCE

(to be reviewed prior to April 2013)

V 7.0

July 2012

Purpose

The collective purpose of the Coventry and Warwickshire Health Protection Committee is to provide assurance on behalf of the population of Coventry and Warwickshire that there are safe and effective plans in place to protect population health, to include communicable disease control, infection prevention and control, emergency planning, sexual health, environmental health, and screening and immunisation programmes.

The Committee will comprise a number of professional partner members who hold health protection responsibilities to include the following groups: communicable diseases (Health Protection Agency), local health resilience partnership, local authority emergency planning, infection prevention and control, sexual health, environmental health, antenatal/newborn and adult screening quality assurance groups, and an immunisation and vaccination group.

The Health Protection Committee will carry out a health protection assurance function on behalf of Coventry and Warwickshire Shadow Health and Wellbeing Boards, Health Overview and Scrutiny and the Arden Cluster Board. However, the Committee will work alongside the formal accountability structures of partner organisations. The Committee will:

1) Co-ordinate the transition of health protection functions to partner organisations.
2) Provide strategic health protection input into the Joint Strategic Needs Assessment processes (Warwickshire County and Coventry City Councils) and agree a Health Protection Strategy for Coventry and Warwickshire, to be approved by the Health and Wellbeing Boards and by partner member organisations.
3) Receive short reports from partner members for discussion at Committee meetings to include the following: current situation, progress against health protection outcomes (activity/quality data/plans developed/epidemiological summaries), incidents managed and measures taken, and suggestions for process improvement.
4) Ensure that appropriate plans and testing arrangements are in place for all partner member programmes.
5) Review all significant incidents / outbreaks to identify and share lessons learnt and make recommendations to commissioners / providers / partners (to be considered through existing accountability structures of these organisations) regarding necessary changes.
6) Receive and review risk registers held by partner members, and make recommendations to partners regarding mitigating actions and to commissioners where appropriate (to be considered through existing accountability structures of these organisations).

7) Provide a forum for professional discussion of health protection plans, risks and opportunities for joint action.
8) Encourage continuous quality improvement through receiving and reviewing suggestions from partner members regarding process improvements.
9) Provide oversight of health protection outcomes.
10) Promote the importance of the health protection agenda among partner health organisations.

Membership

The Core membership of the group will be as listed below. At least one representative of each partner member group will form the membership of the Health Protection Committee, alongside a number of other stakeholder members, to include local authority and Clinical Commissioning Group members. Other stakeholders will be co-opted onto the Committee as and when appropriate.

Title	Organisation
Director of Public Health	Arden Cluster/Warwickshire County Council/Coventry City Council
Emergency Planning Lead	Coventry City Council, Warwickshire County Council
Director of Infection Prevention and Control	Arden Cluster
Consultants in Public Health	Arden Cluster
Consultant in Communicable Disease Control	Health Protection Unit West Midlands East
Chair of Cluster Immunisation and Vaccination Group	Arden Cluster
Screening Co-ordinator	Arden Cluster
Head of Coventry/Warwickshire/Solihull Resilience Team	Solihull Metropolitan Borough Council
Director of Performance and Governance (Responsible for Emergency Planning and Resilience)	Arden Cluster
Assistant Director, Public Safety & Housing	Coventry County Council
Emergency Planning Managers	Arden Cluster
Heads of Environmental Services	Coventry City Council/Warwickshire Borough and District Councils
Assistant Director Policy and Performance	Coventry City Council
Chief Operating Officer – Inspires Clinical Commissioning Group	On behalf of Clinical Commissioning Group Confederation (Coventry)

General Practitioner and Clinical Commissioning Group Member	Inspires Clinical Commissioning Group On behalf of Clinical Commissioning Group Confederation (Coventry)

Quorum

For the group to be quorate, there will need to be representation from at least 50% of all partner groups including the Chair always present.

Communication of Committee recommendations

All members will assume responsibility for communicating Committee recommendations to appropriate colleagues following each meeting.

Accountability and reporting framework

The group is accountable to the Shadow Health and Wellbeing Boards and Health Overview and Scrutiny at Warwickshire County Council and Coventry City Council and to the Arden Cluster Board, and will report to the former and latter of these Boards on a quarterly basis. Extraordinary risk concerns and complex risk management issues will be escalated to the Shadow Health and Wellbeing Boards, Arden Cluster Board, Overview and Scrutiny or the Executive Team within local authorities, as well as through partner organisations as appropriate.

The Committee will oversee health protection input into the Joint Strategic Needs Assessment process.

Frequency of Meetings

The group will meet on a quarterly basis unless otherwise required to meet.

Committee Chair

Meetings will be chaired by the Director of Public Health from either Coventry or Warwickshire. The chair of the group will rotate annually between the Directors of Public Health from Coventry and Warwickshire.

Notes/action logs will be produced by the administrative team of the Director of Public Health who is chairing the group for that year. Meeting papers will be circulated 7 days ahead of meetings, with minutes also circulated in a timely fashion to Committee members following each meeting.

Reports

Short reports and risk registers for discussion at the Health Protection Committee will be submitted by each partner member at least 10 days ahead of the meeting date to allow time for collation and circulation to the group.

Standing Items

Standing agenda items will include (for each partner member): current situation summary, progress against outcomes (activity/quality data/plans developed/epidemiological summaries), incidents managed and measures taken, risk register discussion and suggestions for process improvement.

Annual review and Joint Strategic Needs Assessment

On an annual basis, representatives from each of the partner members will be invited to present (verbally and in written form) an annual review report. This will include information as outlined for the short report structure. The timing of the report request and format of the report will be aligned to the Joint Strategic Needs Assessment process for the local authorities.

Review

Terms of Reference should be reviewed prior to April 2013 when accountabilities of the Committee will change (i.e. will become accountable to the Health and Wellbeing Board proper, and cease being accountable to the Arden Cluster Board), and as health protection functions migrate to partner organisations. Subsequently, terms of reference should be reviewed on an annual basis.

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ARDEN HEALTH PROTECTION STRATEGY

Coventry and Warwickshire

2013-2015

Contents

Members of the Working Group and Contributors

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Nicola Wright	Specialty Registrar In Public Health, NHS Warwickshire/Warwickshire County Council

Introduction

Clear and integrated strategies are necessary to protect the health of populations and prevent disease. After publication of the NHS White Paper, Equity and excellence: Liberating the NHS in 2010 the healthcare sector has undergone significant organisational change. It is recognised that successful implementation of this strategy will require effective relationships and partnerships across health and local authorities.

As the structure, functions, roles and relationships are being defined, the key challenge for agencies is to maintain the health of the population through the period of change and in the future.

Both Coventry and Warwickshire have a long history of effective relationships and collaborative approaches to delivery of services for health protection. We are confronted with new challenges to population health, such as the health effects of climate change; emerging epidemics and drug resistance; changing environments and demographics as well as the escalated risks of chemical and biological incidents, it is clear that the continued assessment and application of health protection issues and challenges is necessary.

The purpose of developing this strategy is to produce a shared vision and an integrated three year strategy for health protection for the Coventry and Warwickshire population during a transitional period. The strategy is structured around the remit of the Arden Health Protection Committee (Figure 1).

The strategy sets out the priorities agreed by the Committee in terms of the areas of health protection that, if achieved, will bring the biggest benefits to the populations of Coventry and Warwickshire, and it is the responsibility of the Health Protection Committee to monitor its progress against this strategy and the subsequent action plans from the specialist groups.

The aim is to:

- Reduce avoidable health inequalities and the burden of disease.
- Provide strategic direction for the planning and provision of high quality and evidence-based services that meet the needs locally.
- Guide involvement and education of people from across all sectors and communities, to improve the provision of health protection information and to promote empowerment among communities.
- Regularly review and appropriately modify the strategy to maintain quality and relevance.

Who is the strategy for?

Local Health and Wellbeing Boards, Executive Teams of City, County, District and Borough Councils, local NHS organisations, Clinical Commissioning Groups, voluntary sector partner organisations and Public Health England in the West Midlands.
This strategy has links with other key local strategies such as the Joint Strategic Needs Assessments (JSNA), Health and Wellbeing Strategies and Prevention and Early Intervention Strategies.

Accountability & Governance arrangements

Health Protection arrangements within Coventry and Warwickshire are overseen by the Arden Health Protection Committee. Its role is to:

- Coordinate the transition of health protection functions to partner organisations and to mitigate associated risks
- Quality and risk assure health protection plans on behalf of the local population for Coventry and Warwickshire local authorities
- Provide a forum for professional discussion of health protection plans, risks and opportunities for joint action

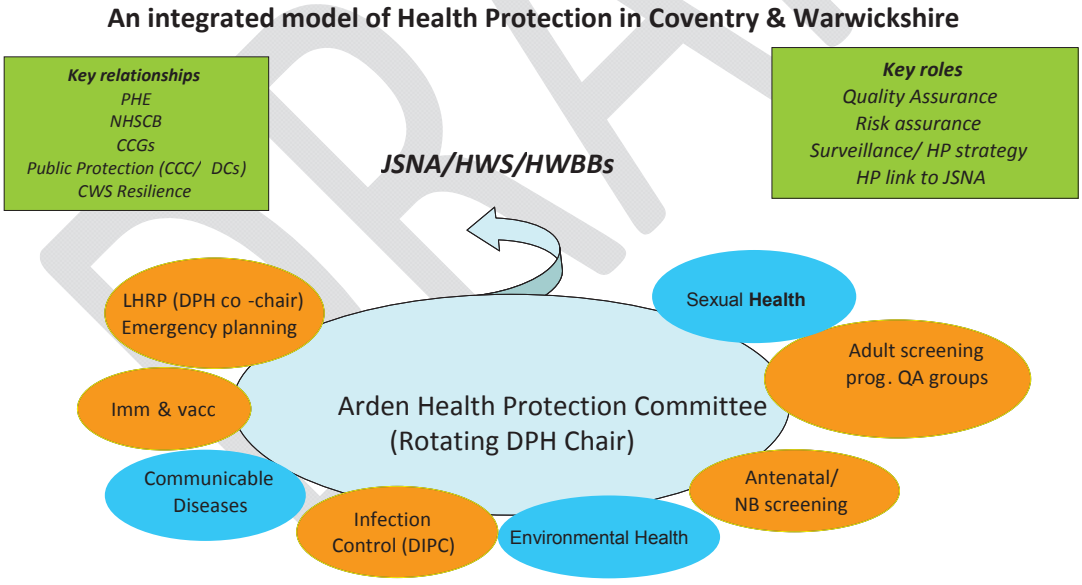
- Provide recommendations (on behalf of local authority Health and Wellbeing Boards and Health Scrutiny) regarding the strategic/operational management of these risks, to complement and feed into current accountability structures of committee member partners
- Escalate concerns where necessary
- Provide oversight of health protection public health outcomes
- Agree local health protection strategy and influence local commissioning through Joint Strategic Needs Assessment process to be approved by Coventry and Warwickshire Health and Wellbeing Boards.

The implementation of the strategy will be carried out by the network and strategy implementation groups where set up already such as Directors of Infection Prevention and Control Group, Sexual Health Implementation Groups, Coventry and Warwickshire Hepatitis Strategic Groups and the Coventry & Warwickshire TB Strategic Group.

The groups will submit the action plans including indicators and progress in achieving the objectives using the agreed indicators to the Health Protection Committee annually.

The transition to new organisations – National Commissioning Board, Public Health England, Clinical Commissioning Groups and Local Authorities - with new areas of responsibility and accountability provides an opportunity for us all to pledge our commitment to review performance, identify ways to improve efficiency and effectiveness of services, prioritise prevention and work in a coordinated and integrated manner.

Figure 1: Structure of the Health Protection Committee



Coventry and Warwickshire Population Profile

Figure 2: Age structure of the local population

	Persons All Ages (thousands)	Persons 0-15 years	Persons 16-64 years	Persons 65 years and over
Coventry	316.9	63.0	207.5	46.5
North Warwickshire	62.1	11.0	39.6	11.5
Nuneaton and Bedworth	125.4	24.0	80.3	21.1
Rugby	100.5	19.4	63.6	17.5
Stratford-on-Avon	120.8	20.4	73.4	27.0
Warwick	137.7	23.6	90.9	23.2

Source: ONS Mid-Year Population estimates 2011

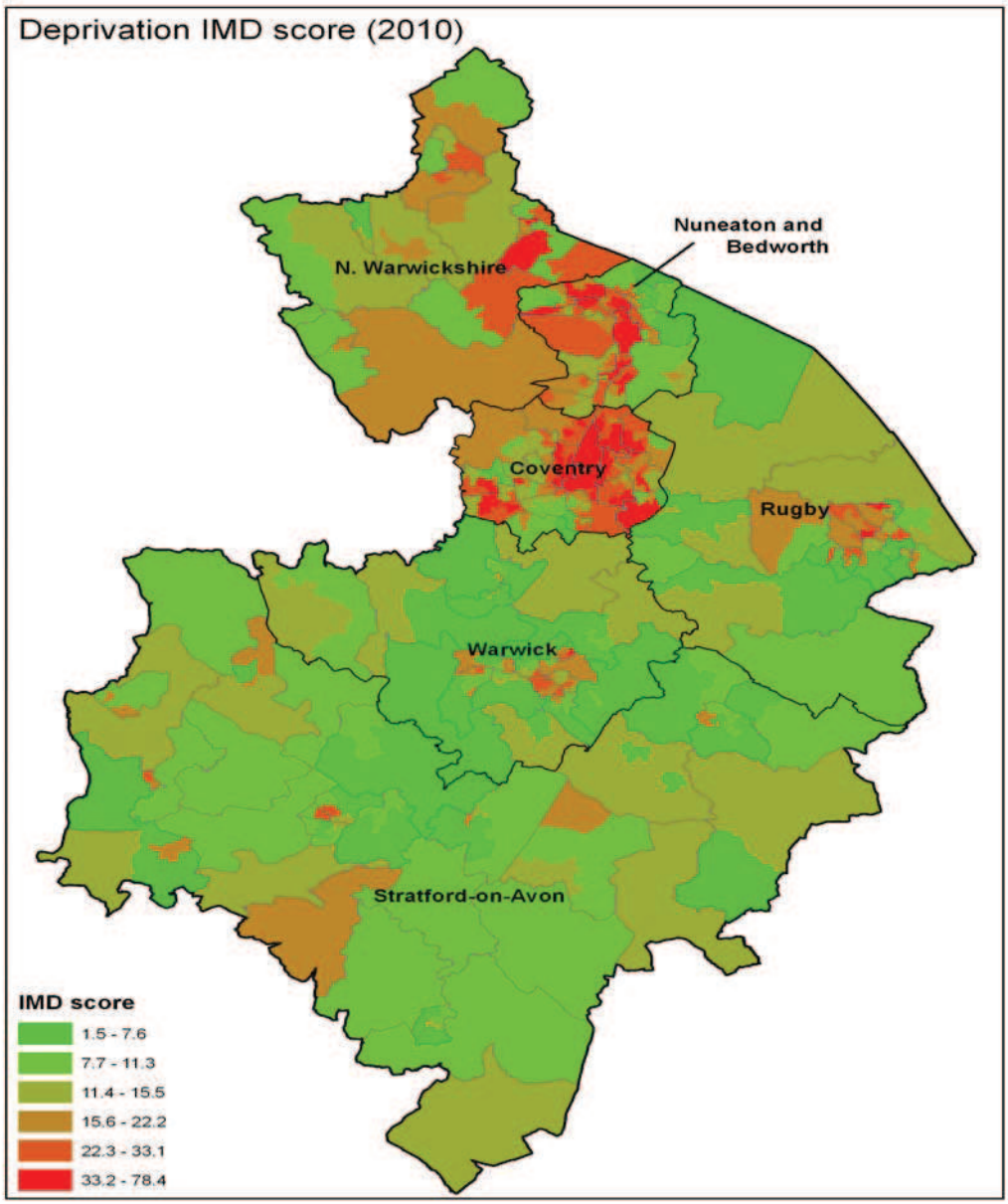
- In 2011 Warwickshire had an estimated population of 546,600 people and Coventry 315,700.
- Coventry's growth rate was faster than the West Midlands regional average and the West Midlands metropolitan average
- The population of Coventry is young which is reflected in higher fertility rates
- Warwickshire population is older in south of county compared to the north.
- Ethnic minorities form a quarter of the Coventry population. Immigrant health is a key issue across the area.

Deprivation

Deprivation disproportionately affects the health outcomes of population – those living in poverty have a shorter life-expectancy and suffer more from chronic conditions than those living in affluent areas.

Deprivation is measured by the Index of Multiple Deprivation (IMD) score. The IMD brings together several indicators which cover specific domains of deprivation such as income, employment, health and disability, education, environment etc. These are weighted and combined to create the overall IMD 2010 scores. Figure 3 demonstrates deprivation scores within Coventry and Warwickshire, the areas of high deprivation are coloured red and low deprivation green.

Figure 3: Deprivation in Coventry and Warwickshire



Communicable Disease Control

Communicable disease control is a key component in protecting the health of the local population. Outbreaks of infectious diseases have a potential to cause severe disease, disruption and even death. The Arden Health Protection Committee has agreed the following to be local priorities for this strategy.

Gastrointestinal (GI) Diseases

Why is this important?
GI diseases impact on local economies through days lost working and put a burden on local health services. In general, for most diarrhoeal diseases people have to stay away from work/ education for a minimum of 48 hours after symptoms have ceased and for some diseases or occupations, exclusions can be for longer periods. This results in loss of working/ study time.

Early recognition and reporting by general practitioners, other clinicians and laboratories are key to prevention and control of outbreaks.

What does the data tell us?
Areas which have a notified incidence rate of over 330 cases per 100,000 population in 2010 are higher than the national average. Both Coventry and Warwickshire are below the national average notification rate.

The two commonest notified causes of gastrointestinal illness are Salmonella and Campylobacter.

Figure 4: Salmonella cases notified in Coventry and Warwickshire 2007-12

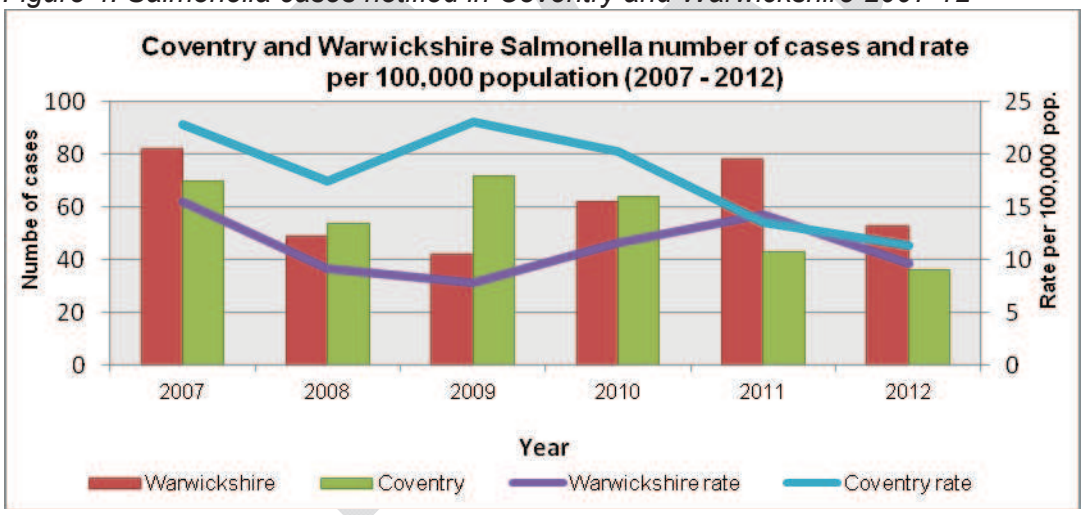
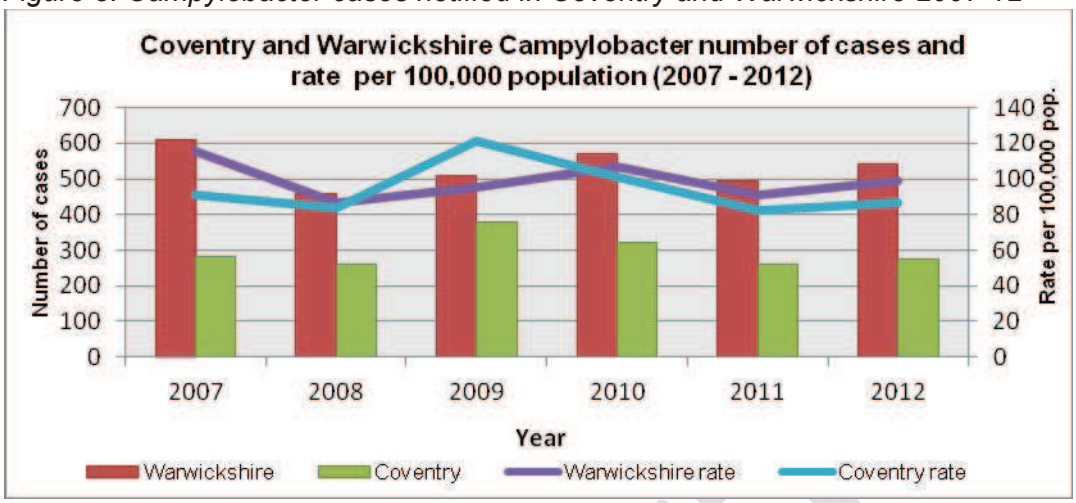


Figure 5: Campylobacter cases notified in Coventry and Warwickshire 2007-12



What should we be doing about this?

Revised guidance to underpin enhanced surveillance has been produced by HPA and recommendations for follow up and exclusion have been revised and include:

- Continue and improve on real time surveillance, to improve on standards of investigation of single cases with timely communication to and from partner agencies. Public Health England (PHE) to be the lead organisation for this.
- Clinicians should notify disease in a timely manner (numbers currently notified are smaller than numbers diagnosed).
- Laboratories are also required to notify and their IT systems should be improved.
- The relevant commissioning leads need to ensure appropriate services are available for supply, storage and administration of prophylaxis, clinical diagnosis (including domiciliary visits if necessary), laboratory diagnosis and logistical arrangements for samples and therapeutics both during and out of working hours.
- Local authority environmental health departments are central to investigation and control of single cases and outbreaks. This requires an urgent response where appropriate or necessary, from appropriately skilled personnel and capacity to provide this response should be ensured in and out of working hours.

What is the local plan?

- Reorganisation is affecting most of the responsible organisations and it would be advisable to safeguard the response capability in each of the organisation so that efficient control of disease can be maintained.
- The Warwickshire and Coventry Food Liaison Group to continue and strengthen their arrangements for collaboration and sharing of good practice.
- Partners should continue to develop public awareness of food hygiene and personal precautions with initiatives targeting children and young persons, food business operators and food handlers etc and increased awareness amongst professionals.
- Proprietors of animal recreational and farming facilities should be aware of the risk of E. coli O157 and ensure they minimise those risks and improve safety on the premises.
- Raising awareness in the general population about consulting the GP or the pharmacist prior to travelling so that timely advice and immunisations can be obtained is crucial to reducing the number of infections.
- Clinicians need to continue to investigate early and notify any suspicion of infectious gastrointestinal disease in a timely manner.

Viral Hepatitis (Hepatitis B and Hepatitis C)

Why is this important?
Hepatitis B virus (HBV) and hepatitis C virus (HCV) are both blood borne viruses which cause liver infection. Both viruses are spread by contact with blood or body fluids from an infected person, with HBV being more infectious than HCV. Many people who carry the viruses are unaware of this and can thus spread the infection. Untreated hepatitis can lead to cirrhosis and liver cancer.

What does the data tell us?
In the UK, the commonest reported risk factor for acute cases of HBV is heterosexual exposure followed by injecting drug use (IDU) and homosexual exposure. In contrast, more than 90% of all newly diagnosed HCV infections for which the source of infection is reported, are acquired via IDU.

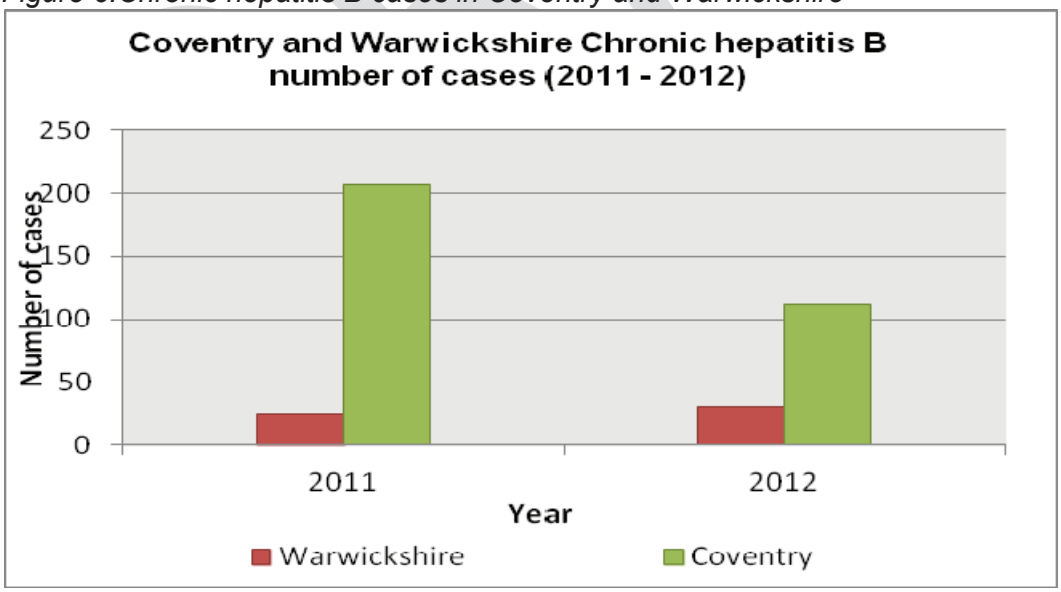
Other groups at increased risk of infection include individuals originating from countries where the prevalence of hepatitis B and C is high (such as South Asia and Africa).

Overall numbers of cases of acute HBV are small in Coventry and Warwickshire (17/year). This represents an incidence of 1.97 cases per 100,000, which is higher than the regional rate 0.7/100,000 population in 2012.

There were a total of 143 laboratory reports of confirmed cases of chronic HBV living in Coventry and Warwickshire reported in 2012 and 230 cases in 2011. The incidence rate of chronic hepatitis B in Coventry was 35/100,000 population in 2012 compared to 65/100,000 population in 2011.

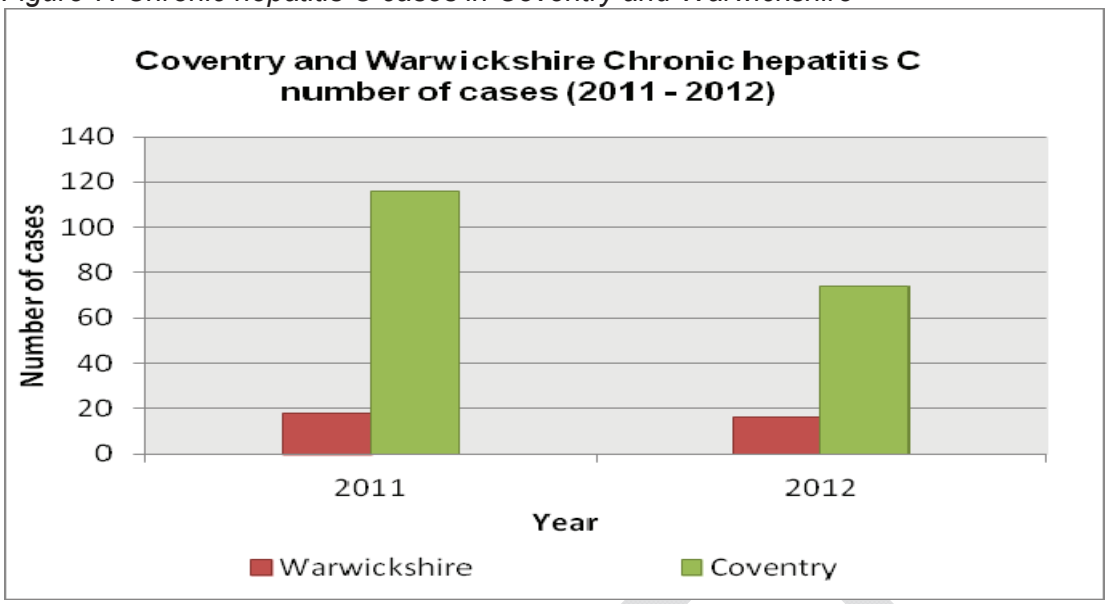
There is a substantial variation in the number of mothers identified with hepatitis B infection in Coventry and in Warwickshire. Consequently the immunisation programmes are different but both aim to completely vaccinate 100% of the babies identified as at risk.

Figure 6:Chronic hepatitis B cases in Coventry and Warwickshire



Coventry has seen a decrease in cases of Hepatitis C which may be a reflection of reduced ascertainment and/or true decrease. Warwickshire cases have remained the same. Most cases of hepatitis C are amongst those aged 30-44 years. Cases are also seen amongst the 15-29 year old and 45-64 year old age groups.

Figure 7: Chronic hepatitis C cases in Coventry and Warwickshire



What should we be doing about this?
The overall aim is to reduce burden of Hepatitis B and C by focusing on reducing the pool of unidentified cases, increasing the number of cases receiving treatment and being monitored, and ending onward transmission. Improve the quality of life for people living with infection.

Post exposure prophylaxis is recommended for babies born to mothers who are chronically infected with hepatitis B virus or who have had acute hepatitis B during pregnancy and for sexual and other household contacts of infected individuals. Babies acquiring infection at this time have a high risk of becoming chronically infected with the virus. The development of the carrier state after perinatal transmission can be prevented in over 90% of cases by appropriate vaccination

What is the local plan?
National best practice recommends coordinated services and managed Hepatitis networks:

- PHE to facilitate the development and strengthening of integrated care pathways and services and ensure coordination between all hepatitis care stakeholders.
- Improve the quality of care for patients including access to testing and high quality laboratory testing and treatment services.
- Partners to promote public awareness about hepatitis B and C infection, particularly in younger age groups and hard to reach groups and professionals including general practice.
- Increase knowledge and skills among health professional and others providing services for people at increased risk of hepatitis and liver disease.
- Increase identification of individuals with hepatitis infection in general practice, GUM clinics and Drug services.
- Commissioners should review needle exchange and harm minimisation services.
- Commissioners, where appropriate, to standardise care between Drug and Alcohol Action Teams (DAAT) in Coventry and Warwickshire.
- Environmental Health Teams and PHE to review skin piercing activities and effective sharing of intelligence to identify and deal with unregistered practitioners.
- The Coventry and Warwickshire Hepatitis B pathway for neonatal vaccination of babies born to Hepatitis B infected women must be fully implemented. This involves the antenatal screening midwives, UHCW virology department, Child Health Information System managers, General Practice, the Coventry Immunisation team and health visiting services.

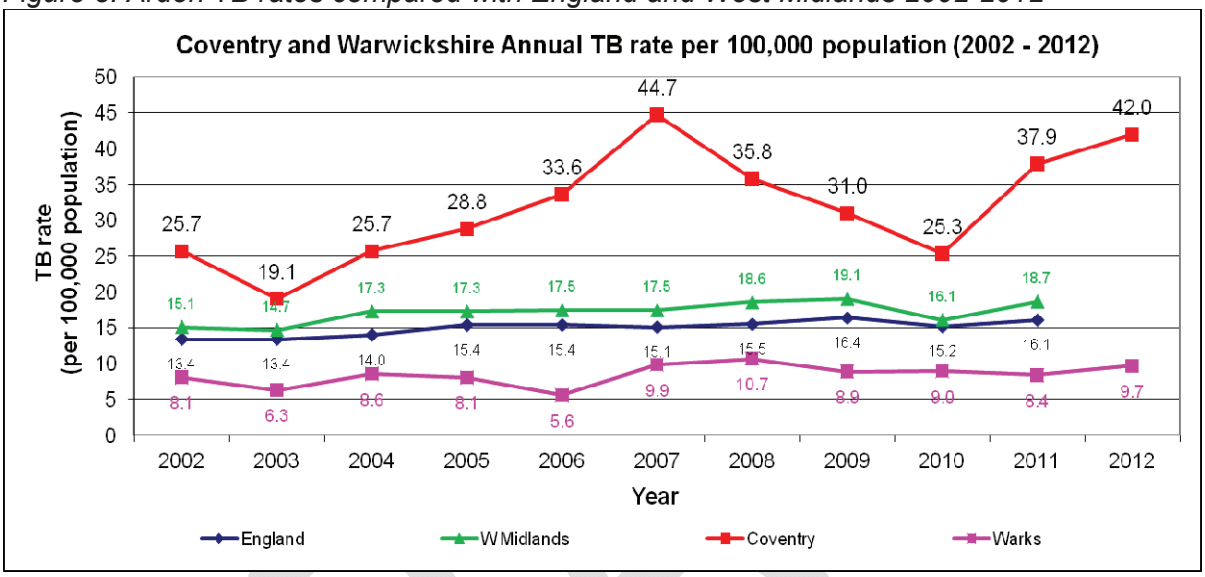
Tuberculosis

Why is this important?

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

What does the data tell us?

Figure 8: Arden TB rates compared with England and West Midlands 2002-2012



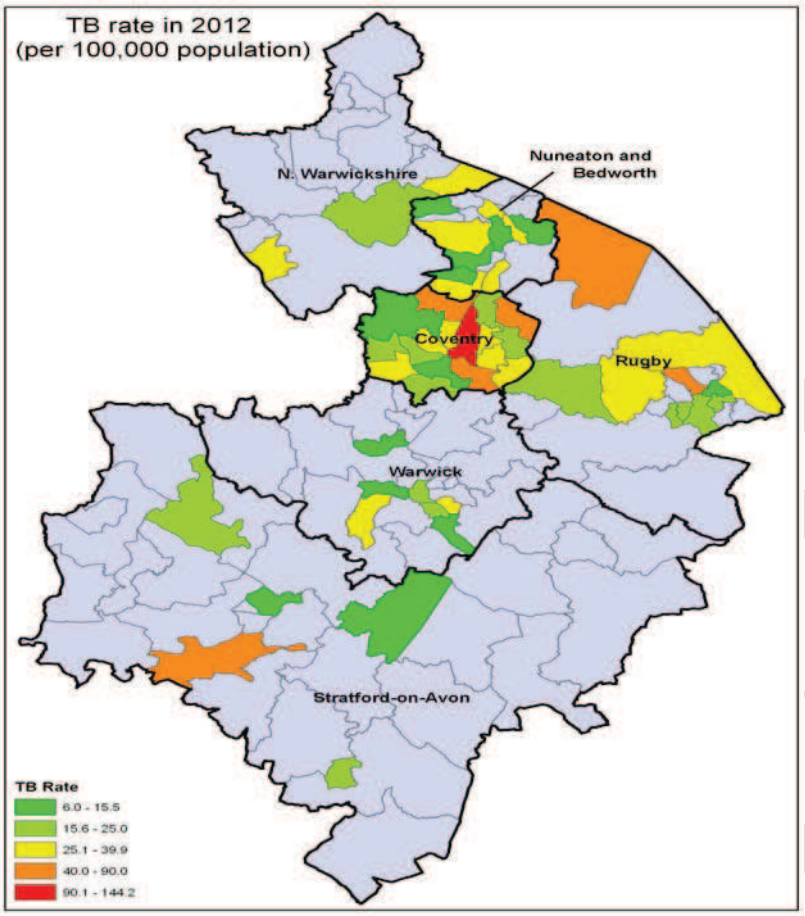
Coventry

- There were more cases of TB in Coventry in 2012 (133 cases) compared to 2011 (120 cases). TB incidence rate in Coventry is 42/100,000 population in 2012. The incidence rate is increasing after a temporary decrease in 2010 and remains well above the regional and national average.
- The number of new cases among South Asians was almost three times higher than those among the White ethnic group. Of the 133 cases in 2012, at least 72% were born overseas. More than one third (37%) of the 133 cases in 2012 were from two electoral wards – St Michael's and Foleshill Wards.

Warwickshire

- There were 53 cases of TB in Warwickshire in 2012, which was similar to the number of cases in 2011 (46 cases). In 2012, TB rates in Warwickshire of 6.7 cases per 100,000 populations continued to be substantially lower than the regional and national rate.
- In 2012 in Warwickshire, white ethnic group contributed to 32% (17 cases) of cases; 60% of the cases were born overseas.
- Other groups at increased risk include those who are homeless, alcohol and drug misusers and there is also an on-going issue of TB among hard to reach groups (alcoholics, drug addicts and homeless people) mainly in the Leamington Spa area.

Figure 9: TB rates in Arden



What should be done about this?

- Increased awareness: Maintain high awareness of TB, particularly among health professionals, high risk groups and people who work with them, teachers, and the public.
- Strong commitment and leadership: Create a strongly led, well coordinated and adequately resourced TB programme (standardised treatment with supervision and patient support).
- High quality surveillance: Provide the information required to: identify outbreaks; monitor trends; inform policy; inform development of services, and monitor the success of the TB programme.
- Excellence in clinical care: Commission and provide uniformly high quality, evidence based treatment and care for patients with suspected and diagnosed TB.
- Well organised and coordinated patient services: Commission and provide high quality coordinated services for TB diagnosis, treatment and continuing care, which also meet the needs of individual patients.
- First class laboratory services: Provide laboratory services of consistent high quality which support clinical and public health needs.
- Highly effective disease control at population level: Increase the evidence base for, and the consistency of the application of public health interventions for TB.
- An expert workforce: Ensure TB control has an appropriately skilled workforce and that physicians and nurses with expertise in TB continue to be recruited, trained and retained.
- Leading edge research: Increase understanding of TB and its control; improve the evidence base for its control; and develop better tools for its diagnosis, treatment and prevention.

What is the local plan?

- The strategic group should work towards establishing regular TB cohort review meetings to monitor whether patients have access to expert clinical services including advice from a physician with expertise in TB, treatment that adheres to national guidance and high standards of diagnostic microbiology facilities.
- The strategic group should work with TB commissioners to strengthen new entrant screening initiatives amongst high risk communities through innovative primary care and hospital-based schemes.
- TB commissioners should ensure effective directly observed therapies commissioned from appropriate agencies including community pharmacists and community organisations.
- PHE-employed immunisation staff working in the NHS Commissioning Board Area Team should work with partners to establish a robust BCG vaccination programme including monitoring of coverage.
- Local authority TB commissioners should ensure effective community awareness is continued and strengthened further through a range of targeted means and channels.
- The strategic group should develop a programme of education and training for primary care professionals working in communities at increased risk of TB.

Healthcare-acquired Infection

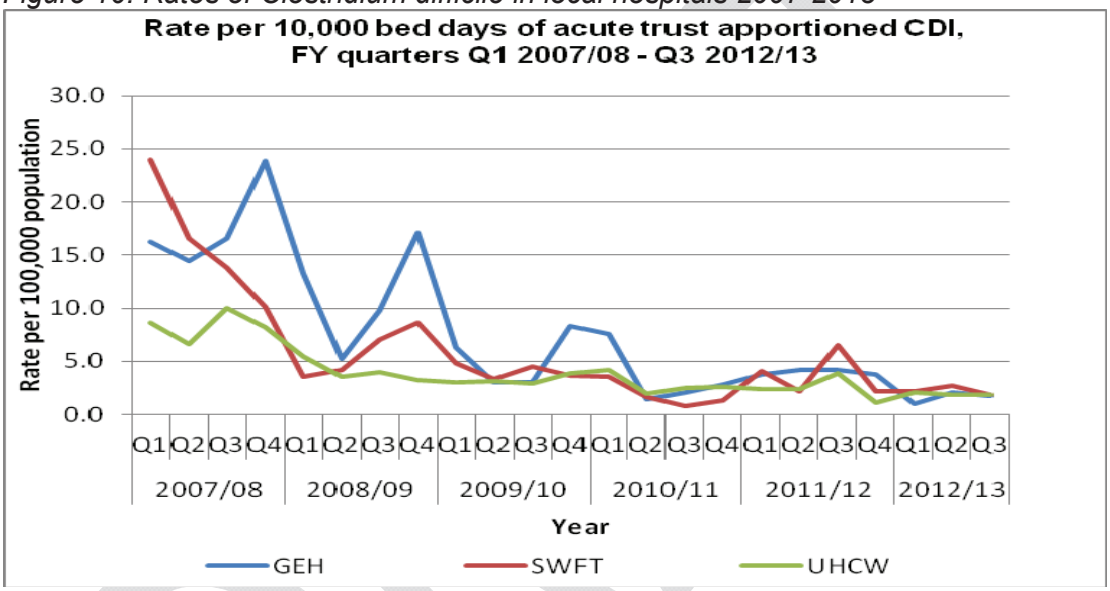
Why is this important?

Healthcare associated infections (HCAIs) are infections transmitted to and from patients (and healthcare workers) as a result of healthcare procedures, in hospitals and other healthcare settings. These infections can cause a significant amount of illness, increase the length of hospital stay and sometimes even lead to death. Many are preventable by effective infection prevention and control arrangements. Surveillance of certain infection such as *C.difficile* and MRSA is compulsory

What does the data tell us?

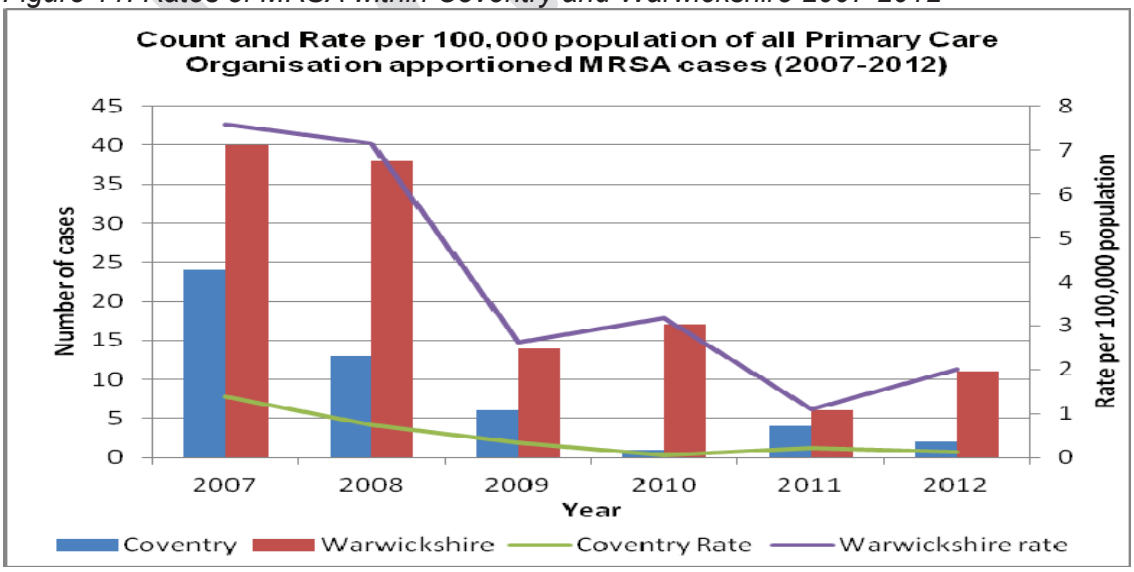
There has been a steady decline in Clostridium difficile infection (CDI) reported from local hospitals.

Figure 10: Rates of Clostridium difficile in local hospitals 2007-2013



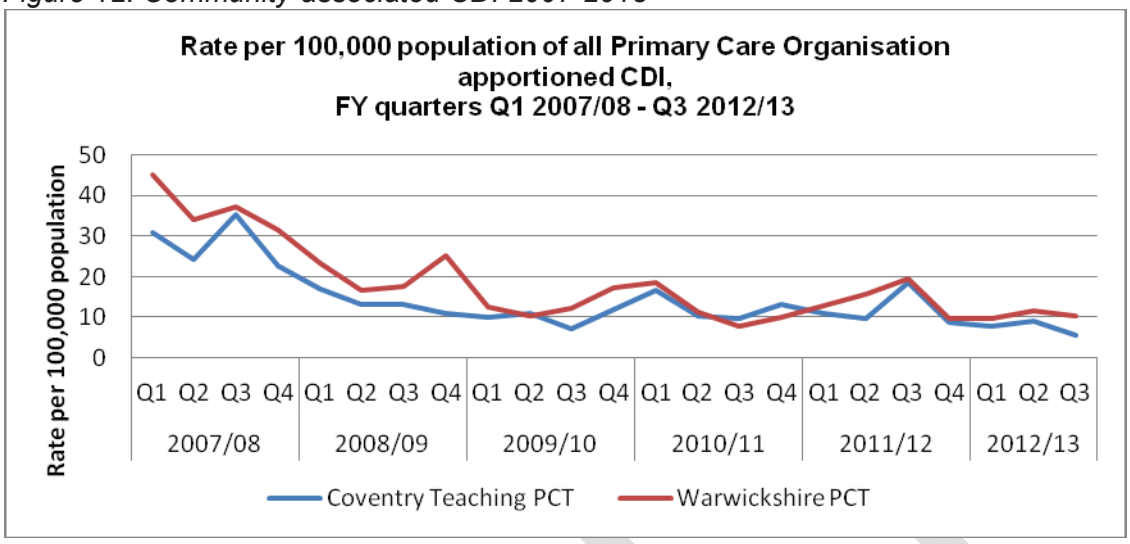
Similarly the reported cases of MRSA have reduced in the recent years.

Figure 11: Rates of MRSA within Coventry and Warwickshire 2007-2012



The decline in these infections could be attributed to a heightened awareness, an increased and impoved surveillance and infection prevention and control procedures. However, Community-associated infections are still an issue.

Figure 12: Community-associated CDI 2007-2013



What should be done about this?

In the new system CCGs and the Local Authorities (LAs) will work closely with the new Public Health England (PHE) to reduce HCAI within the community. It is not clear as yet how these roles will be organised, however some prior understanding of the issues within the community need to be addressed:

- Developing LA, CCG and Provider Trusts understanding of HCAI and their role in preventing and monitoring rates of HCAI within their boundaries.
- CCGs, as commissioners, must obtain assurance of effective arrangements for infection prevention and control from the providers.
- The DPH using existing frameworks, and guidance to develop a strategy for the LA to set their own targets for the reduction of HCAI.
- Working together LA, CCGs and PHE identify and set priorities for the reduction of HCAI in the community with emphasis on the following areas:
    - Outbreak control management in educational establishments and residential and care homes.
    - Provision of infection control training, advice and audit for health care and educational establishments.
    - The management of community HCAI cases e.g. PVL *Staphylococcus.*

What is the local plan?

- The CCG's and LA to develop a mutually agreed Infection Prevention strategy to inform the assessment and development of an assurance framework for Infection Prevention & Control ensuring providers deliver HCAI reductions.
- PHE, CCG's and LA to develop clear guidance on the roles and responsibilities of each organisation in the management of outbreaks of Norovirus, Clostridium difficile etc.
- Develop the local provision of infection prevention and control, training and audit to support educational establishments and Local Authority licensed premises.

Community Infection Prevention and Control

Why is this important?

Community Infection Prevention and Control (CIPC) is concerned with preventing the spread of infection in primary and community care settings. A wide variety of healthcare is delivered in these settings thus it is becoming increasingly important that CIPC services are available and imbedded in the local delivery of healthcare. Healthcare-associated infections arise across a wide range of clinical conditions and can affect patients of all ages. Healthcare workers, family members and carers are also at risk of acquiring infections when caring for patients. All providers of healthcare services are expected to have provision for infection prevention and control.

There is also a significant need for effective infection prevention outside the healthcare sector for example in residential care, within schools or within cosmetics industry. Provision of CIPC is a joint effort between Community Infection Prevention & Control Nurses, Health Protection Units and Environmental Health Departments.

What is the local plan?

As CIPC services are delivered and commissioned by several partners, it has been agreed that a Memorandum of Understanding should be developed locally to define the accountability for these services.

It is expected that the Directors of Public Health will received assurance of effective service provision through the Health Protection Committee.

Population Screening Programmes

Why is this important?
Screening is offered to healthy people who show no signs of illness, but may be at increased risk of a disease or condition. The current UK population screening programmes include antenatal and newborn, as well as young person and adult screening programmes (i.e., cancer and vascular screening). They have a significant effect on population health by identifying cases of illness at an early stage when treatment is more likely to be successful, thus preventing complications and death.

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

All national programmes are currently undergoing transition as commissioning responsibilities are transferring from local PCTs to the NHS Commissioning Board and quality assurance responsibilities are taken up by Public Health England.

Screening has been identified as a high risk area during the transition on a local, regional and national level; it is therefore vital that Directors of Public Health in Coventry and Warwickshire maintain an oversight of the delivery of the programmes through the Health Protection Committee.

Sexually Transmitted Infections

Why is this important?

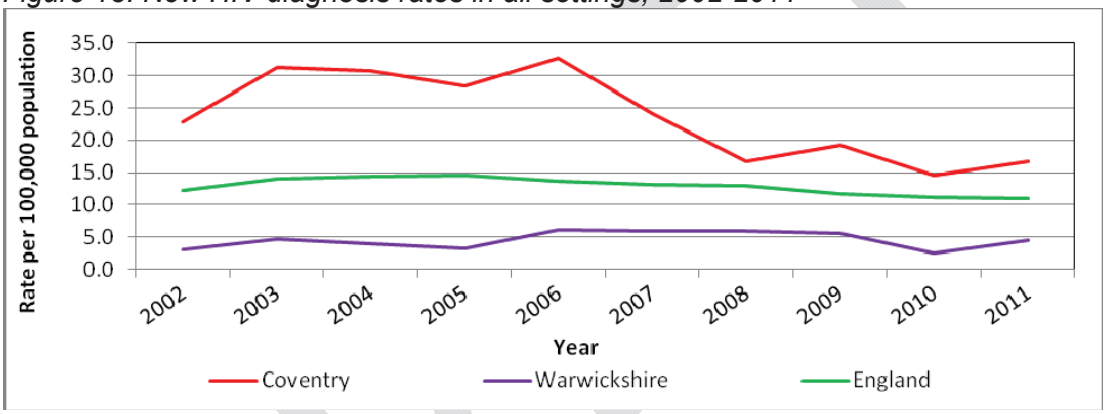
HIV and sexually transmitted infections (STIs) have a significant public health impact due to the burden of disease, long-term complications and deaths, and cost to the health service. In addition to causing physical illness, there are often adverse psychosocial implications for affected individuals.

HIV is now a treatable medical condition, but is still frequently regarded as stigmatising, is a risk factor for chronic medical conditions and consequently potential years of life lost from HIV are significant. An estimated quarter of infected individuals in the UK are unaware of their diagnosis. Late diagnosis is the most important factor associated with HIV-related morbidity and mortality and increased treatment costs.

What does the data tell us?

HIV

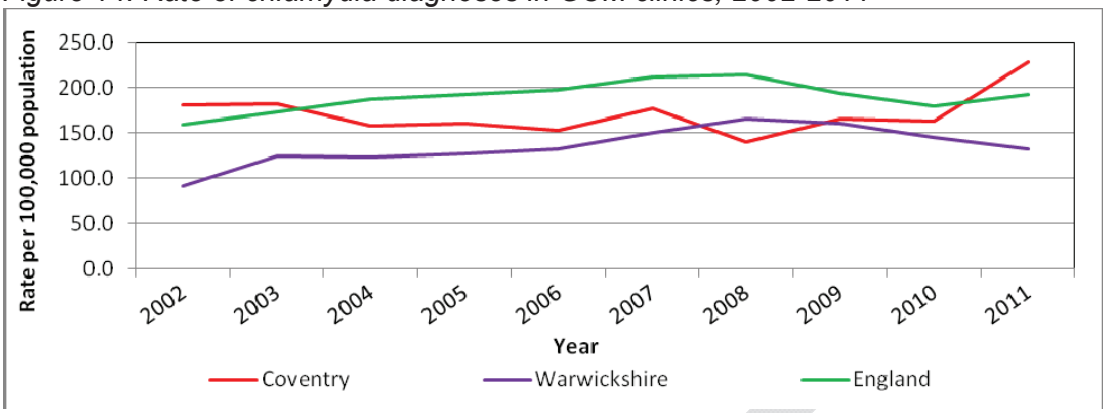
Figure 13: New HIV diagnosis rates in all settings, 2002-2011



- In Coventry, rates of new HIV diagnoses have been well above the England average for the last ten years, despite having fallen from their 2006 peak. Rates remain high at 15-20 new diagnoses per 100,000 population. Almost two-thirds (61.5%) of new HIV diagnoses in Coventry from 2009 to 2011 were diagnosed late.
- The prevalence of diagnosed HIV infection in Coventry in 2011 was 2.8 per 1000 population, above the high prevalence threshold at which expanded testing for HIV is recommended (2 per 1000 population).
- In Warwickshire, rates of new HIV diagnoses have been relatively low for the last ten years compared to national rates. Half of new HIV diagnoses in Warwickshire from 2009 to 2011 were diagnosed late.

Other STIs

Figure 14: Rate of chlamydia diagnoses in GUM clinics, 2002-2011



Coventry

- Over the last ten years, there have been considerable overall increases in diagnoses of the five main STIs genitourinary medicine (GUM) clinics, generally reflecting national trends (see graphs for individual trends). In particular, gonorrhoea diagnoses have more than doubled in the last five years and are approaching the peak levels observed in 2003.
- The Public Health Outcomes Framework includes a target diagnosis rate for chlamydia screening of 15-24 year olds in all settings (in GUM and the community) of 2,400 diagnoses per 100,000 population aged 15-24. In 2011/12, the diagnosis rate for Coventry was 1664 diagnoses per 100,000 population, well below the regional and national rates (both ~2000 per 100,000 population).

Warwickshire

- Although diagnosis rates of the five main STIs in Warwickshire are mostly lower than the national average, they have still seen overall increases in the last ten years. Diagnoses of anogenital herpes have trebled since 2007.
- In 2011/12, the chlamydia diagnosis rate in 15-24 year olds in all settings in Warwickshire was 1481 diagnoses per 100,000 population aged 15-24, well below the target and regional and national rates (see above).

What should be done about this?

The national strategy for sexual health was published in 2001, supported by development of recommended standards for services. Important national guidelines have also been published, such as that from the National Institute for Health and Clinical Excellence (NICE).

What is the local plan?

Further innovative solutions should be sought to help deal with this health issue which has escalated in recent years.

- PHE to facilitate the strengthening of surveillance, particularly for infections diagnosed in primary care.
- Sexual Health Commissioners should strengthen routine HIV testing to improve detection of infection among individuals at risk – early diagnosis will be of enormous benefit to the individuals themselves, and will help reduce spread of infection to others.
- Partner organisations of the Arden Health Protection Committee to develop a multi-faceted approach to improve the uptake of testing among partners of individuals infected with any STI.
- Sexual Health Commissioners to ensure robust evaluation of health promotion services to identify what works locally; this will help inform future provision of effective services aimed at those most at risk to influence their knowledge, attitude and behaviour, and consequently interrupt the chain of transmission.

Immunisation and Vaccination

Why is this important?

Worldwide vaccination and immunisation programmes are the second most effective public health intervention after clean water and have saved many lives. It is important to emphasise the need to achieve high uptake of vaccines in order to prevent the re-emergence of vaccine preventable diseases in our local communities. National evidence shows that inequalities in immunisation uptake are persistent. Evidence shows that children with incomplete immunisations are more likely to live in disadvantaged areas and are less likely to use primary care services. They also tend to have younger mothers or lone parents, come from larger families, and as babies had a least one hospital admission.

Immunisation programmes will be commissioned by the NHS Commissioning Board from April 2013.

What does the data tell us?

Figure 18: Primary childhood immunisation coverage at 12 months in Arden 2006-2012 with regional and national comparison

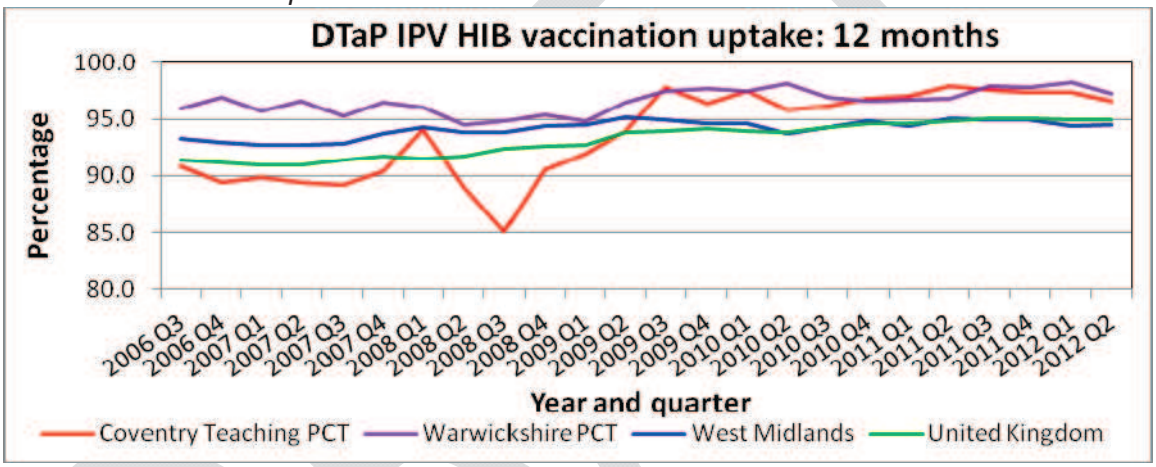
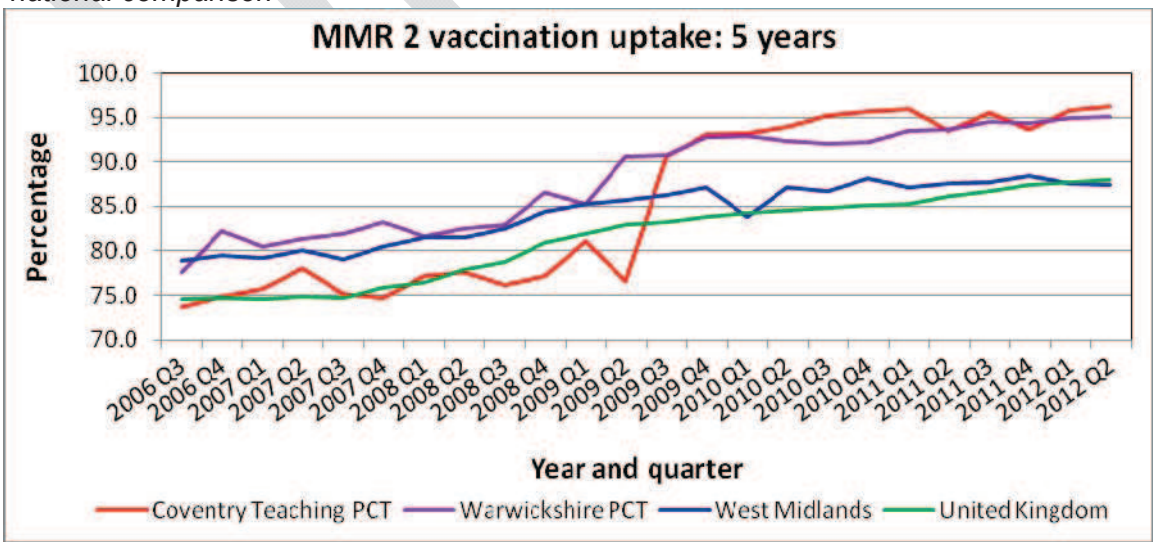


Figure 19: MMR vaccination coverage trends at five years in Arden 2006-2012 with regional and national comparison



- Coventry has come far with its performance on immunisation over the last 2 years from being one of the bottom performers in the UK to one of the top, so it is vitally important that

this good work continues and Coventry leads the way in protecting its children from vaccine preventable diseases.

- Warwickshire has poor data for the school leaver booster. Child Health data suggests that 60% of 14-15 year olds have been vaccinated by the school immunisation team, but many more are likely to have been vaccinated at the GP surgery and the data not supplied to Child Health. In Coventry, one fifth of diphtheria, tetanus and polio is given in schools between 13 and 18 years of age. Teenage immunisations are higher than the national average with school leaver booster for children in school year 10 (2011/12) at 88.5% uptake.
- Human Papillomavirus Vaccination (HPV) is a vaccine to protect girls from cervical cancer and it is administered routinely to Year 8 girls (12-13 year olds) via a school based programme. In 2011/12, Warwickshire achieved an uptake of 95.7% of girls having received one dose of HPV vaccine (85.4% were fully vaccinated with three doses of vaccine). Coventry achieved 92% receiving the first dose (91.3% all three doses).
- Travellers and other hard-to-reach groups have lower levels of vaccination coverage which can exacerbate existing inequalities. However it is difficult to assess genuine levels of uptake as there is no available data on immunisation in unregistered practice populations.
- A recent audit in Coventry showed that data flows between GP Practices and CHIS are still not robust and many children who are immunised are not reported. Some children are missing out on immunisation because demographic data is not routinely updated to CHIS.

What should be done about this?

The aims of those responsible for immunisation programmes are to:

- Reduce the risk of vaccine preventable disease by maximising the uptake of vaccinations achieving national targets.
- Reduce health inequalities in relation to accessibility to vaccine services.
- Ensure that the uptake of new immunisation programmes is maximised.
- Improve rates of influenza vaccination among health and social care workers
- Effective immunisation programmes rely upon the accurate identification of eligible populations, efficient call and recall systems and well informed immunisers.
- For influenza, to identify and vaccinate the eligible population as recommended by the Department of Health

What is the local plan?

- The work of the Arden Immunisation Committee needs to continue beyond the transition to ensure that there is a cohesive plan across the immunisation programmes. Very few immunisation programmes are delivered by one single provider.
- Coventry and Warwickshire have a strong and effective training programme. This work needs to be preserved and protected beyond the transition.
- Improve data collection on all immunisation programmes to ensure accurate local data.

Environmental Health

Environmental health aims to protect against environmental factors that may adversely impact human health or the ecological balances essential to long-term human health and environmental quality. Such factors include, but are not limited to: air, food and water contaminants; radiation; toxic chemicals; disease vectors; safety hazards; and habitat alterations.

The Arden Health Protection Committee has agreed air quality as an environmental health priority for this strategy.

Air Quality

Why is this important?

Air quality is a key issue with major implications for the health of the population across both Coventry and Warwickshire. Poor air quality can lead to significant adverse health effects, particularly in those sections of the population that are more susceptible such as the young, the elderly, or those suffering from heart or lung related disease (WHO, 2004).

What does the data tell us?

Figure 20: Nitrogen Dioxide Concentration monitored at Coventry and Warwickshire's Automatic Monitoring Stations (2005-2009)

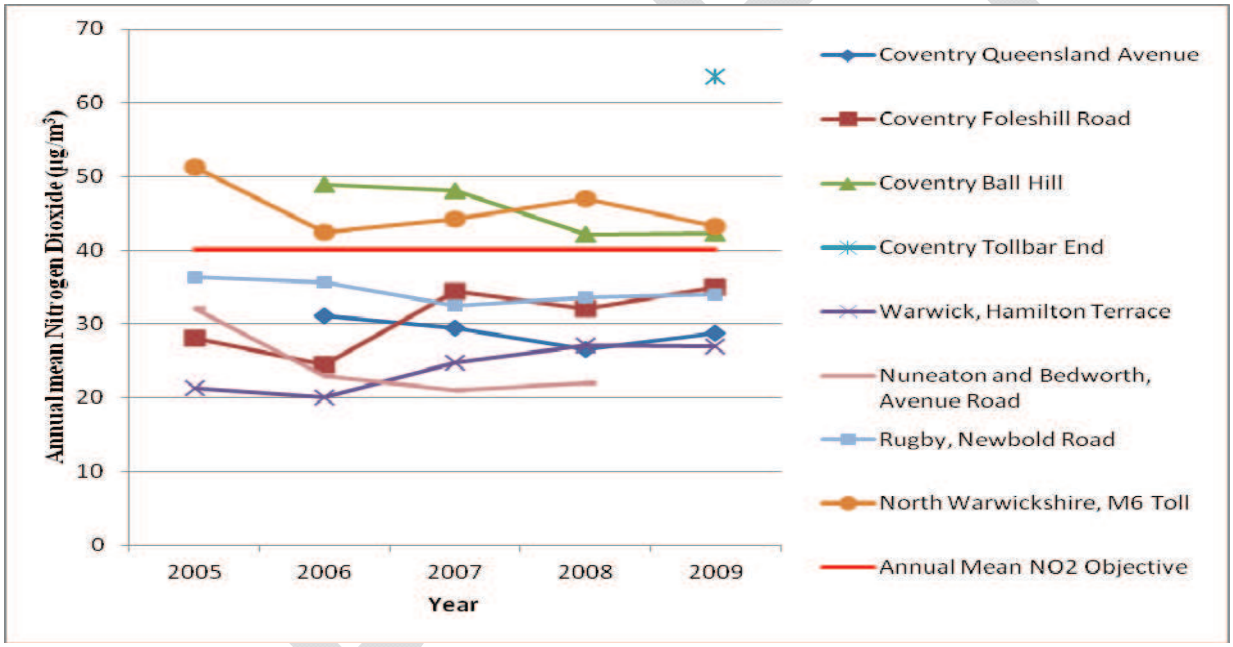
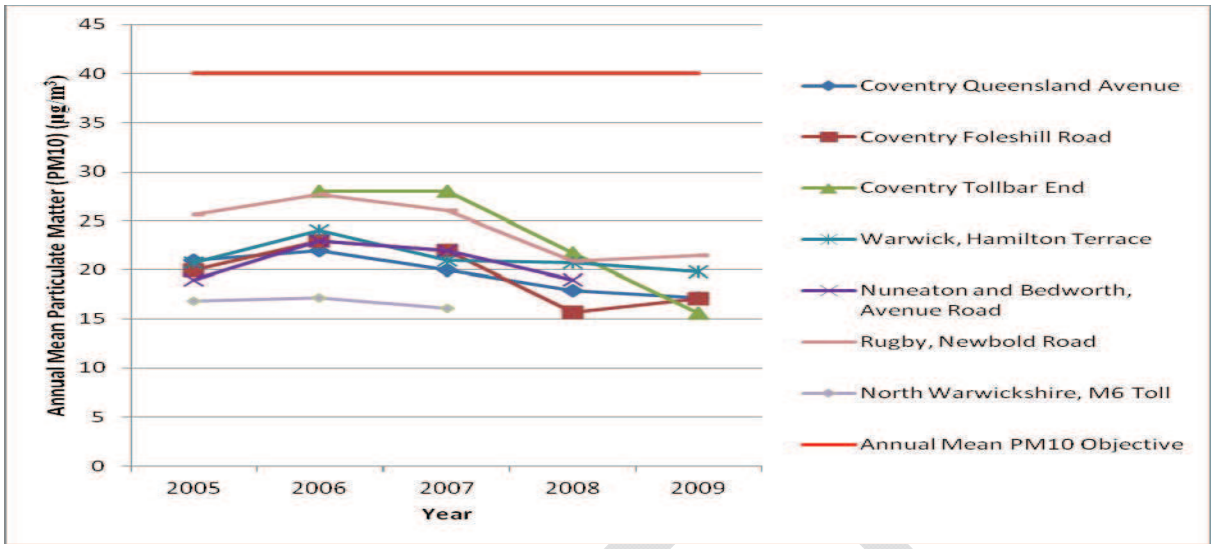


Figure 21: Particulate Matter (PM_{10}) Concentrations monitored at Coventry and Warwickshire's Automatic Monitoring Stations (2005-2009)



Note: Data presented for illustration of trends only. Monitoring stations are located for specific purposes e.g. background locations, high pollution areas and consequently are not directly comparable. It should be noted that there have been some issues in relation to the performance of Coventry's automatic monitoring equipment, data capture at some stations in certain years is low and consequently not all data can be considered robust.

In common with most other areas in the country hourly peak air quality standards are not generally exceeded

- In each of the local authority areas annual mean NO_2 levels are exceeded in some areas. The main cause of this is traffic pollution.
- Air Quality Management Areas (AQMAs) have been declared in each area related to NO_2 exceedance. Action Plans are in place for these and a few AQMAs have subsequently been revoked.
- There is a direct link between health impacts and particulate levels, with $PM_{2.5}$ levels being particularly relevant. Further data in relation to $PM_{2.5}$ levels in the Coventry and Warwickshire area is needed.

What should be done about this?

- Improvement in air quality is heavily dependent upon traffic management. Increased collaboration between stakeholders is required to ensure improvement.
- Raising the importance of air quality in the decision making process of transport planning.
- Increased understanding and health impacts of $PM_{2.5}$ levels in each local authority area.

What is being done locally?

- Air Quality Management Areas declared where pollutants exceed national air quality objectives.
- Air Quality Action Plans produced by all authorities in conjunction with Warwickshire County Council (as highway authority) and Highways Agency (major roads).
- Innovative solutions being investigated, e.g. Low Emission Zone pilot (Warwick), use of real time monitoring during trials with altering traffic lights (Coventry).

List of Abbreviations

AQMA	Air Quality Management Area
AT	Area Team (of the NHS Commissioning Board)
CCG	Clinical Commissioning Group
CDI	Clostridium difficile infection
CIPC	Community Infection Prevention & Control
DAAT	Drug and Alcohol Action Team
DPH	Director of Public Health
GEH	George Eliot Hospital
GP	General Practitioner
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus
HPA	Health Protection Agency
IDU	Injecting drug user
JSNA	Joint Strategic Needs Assessment
LA	Local Authority
NHS	National Health Service
NHS CB	NHS Commissioning Board
NICE	National Institute for Health and Clinical Excellence
NO_2	Nitrogen dioxide
PCT	Primary Care Trust
PHE	Public Health England
$PM_{2.5}$	Particulate matter of aerodynamic diameter less than or equal to 2.5µm
STI	Sexually transmitted infection
SWFT	South Warwickshire Foundation Trust
TB	Tuberculosis
UHCW	University Hospitals Coventry and Warwickshire
WHO	World Health Organisation

Coventry City Council

Briefing note

Date: 7th April 2014

To: Health & Well Being Board

From: Ruth Tennant, Deputy Director of Public Health

Subject: 2014/15 Draft Work Programme

1 Purpose of the Note

1.1 To update the Board on the draft Work Programme for the coming year.

2 Recommendations

2.1 The Health & Well Being Board is recommended to:

- Endorse the draft Work Programme for 2014/15.
- Ensure that additional items for the work programme are added to this plan as the year progresses and the work of the Board evolves.

3 Draft Work Programme

3.1 Based on previous discussions with the board, including the informal board development session held on the 27th January, the work programme has been developed to reflect the following principles:

- Responsibility for delivering the key elements of the Health and Well-being Strategy rests with the responsible partnership or group (e.g. children and adults' joint commissioning boards) with regular updates to the board on progress. The first of these is scheduled for June 2014. A summary of the key groups and their relationship to the Health and Well-being Board is set out in appendix 1. This is not exhaustive but reflects the main groups that have responsibility for delivering elements of the Health and Well-being Strategy.
- Informal board development sessions will be scheduled alongside formal board meetings. This will include joint sessions with Warwickshire's Health and Well-being Board on matters of collective interest, such as health and social care integration. The first of these will take place on the 28th April.

3.2 Following discussions at development sessions and suggestions from partners the current draft of the Health & Well Being Board Work Programme is detailed below.

Meeting Date/Month	Work Programme Item
June 2014	5 Year Strategic Plan (Health and Social Care integration)

	Update from Primary Care Quality Group
	HWB engagement strategy
	Health & Well Being Strategy Update
	Annual Quality Updates from partners
September 2014	Female Genital Mutilation Update
	'**Toxic triangle':** Update from Police and Crime Board Alcohol & Drugs Strategy
October 2014	2015/16 Priorities/Plans/Commissioning - Alignment with local health needs
	Director of Public Health Annual Report
December 2014	**Older people**: Living well with Dementia/ Age Friendly City Adult joint commissioning board work programme
February 2015	Marmot City Update Health Protection Update

3.3 The Work Programme will be a live document and continually updated as new work areas develop and additional reports need to be considered by the Board.

3.4 Meeting dates from June 2014 will be confirmed following the Council elections and Annual General Meeting in May 2014.

4 Recommendations

4.1 The Health & Well Being Board is recommended to:

- Endorse the draft Work Programme for 2014/15.
- Ensure that additional Work Programme Items are added to this plan as the year progresses and the work of the Board evolves.

Ruth Tennant, Deputy Director of Public Health
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Appendix 1 – Health and Well-being Board key partnerships

Group	Relationship to Health and Well-being Board/ HWS
Children and adults joint commissioning board	Delivery of children and adults' elements of HWS. Adult joint commissioning board is lead partnership for delivering 'Better Care'
Children and adults safeguarding boards	Independent but HWB commitment to review quality issues on annual basis.
Police and Crime Board	Independent of HWB but has oversight of community safety issues including sexual violence and domestic violence
Health Protection Committee	Reports to HWB on health protection issues, including infectious diseases, screening & immunisation.
Marmot steering group	Reports to HWB on action to reduce health inequalities.
Dementia strategy group	Reports to HWB on action to improve support with people on dementia
FGM group	Reports to HWB on action to reduce FGM and support victims of FGM
Coventry and Warwickshire Local Enterprise Partnership	No direct relationship but significant role in promoting wider determinants of health (employment and economic development)
Coventry Partnership	No direct relationship but significant role in promoting wider determinants of health (including welfare reform)

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