Coventry City Council

Agenda

Coventry Health and Well-being Board

Time and Date
2.00 pm on Monday, 19th October, 2015

Place
Diamond Room 2 - 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 7th September 2015 (Pages 3 - 10)

   (b) Matters Arising

4. **Update on Joint Strategic Needs Assessment and Development of the Health and Well-being Board** (Pages 11 - 90)

   Report of Dr Jane Moore, Director of Public Health

5. **Continuing as a Marmot City** (Pages 91 - 98)

   Report of Dr Jane Moore, Director of Public Health

6. **Joint Health and Social Care Action Plan 2014 / 2015** (Pages 99 - 112)

   Report of Jon Reading, Head of Strategic Commissioning

7. **System Wide Transformation Programme Progress Report** (Pages 113 - 118)

   Report of Phil Evans, Coventry and Rugby Clinical Commissioning Group

8. **Deprivation of Liberty Safeguards** (Pages 119 - 122)

   Report of Patrick Finnegan, Principal Social Worker, Adults

9. **Joint Meeting with Warwickshire Health & Well-being Board**

   Discussion to be led by the Chair.

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

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

Private Business

Nil

Chris West, Executive Director, Resources, Council House Coventry

Friday, 9 October 2015

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

Membership: S Allen, S Banbury, S Brake, K Caan (Chair), A Canale-Parola (Deputy Chair), J Clifford, G Daly, S Gilby, A Hardy, S Kumar, R Light, D Long, A Lucas, J Mason, J Moore, Quinton, M Reeves, E Ruane, K Taylor, J Waterman and D Williams

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

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

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Coventry City Council
Minutes of the Meeting of Coventry Health and Well-being Board held at 2.00 pm on Monday, 7 September 2015

Present:

Board Members:	Councillor Caan (Deputy Chair) Councillor Lucas Dr Steve Allen, Coventry and Rugby CCG Stephen Banbury, Voluntary Action Coventry Simon Brake, Coventry and Rugby GP Federation Dr Adrian Canale-Parola, Coventry and Rugby CCG Simon Gilby, Coventry and Warwickshire Partnership Trust Juliet Hancox, Coventry and Rugby CCG Andy Hardy, University Hospitals Coventry and Warwickshire Professor Sudhesh Kumar, Warwick University Jane Hodge, Warwick University Danny Long, West Midlands Police John Mason, Coventry Healthwatch Dr Jane Moore, Director of Public Health Brian Walsh, Executive Director of People David Williams, NHS Area Team
By Invitation:	Councillor Clifford
Other representatives:	Phil Evans, Coventry and Rugby CCG Kevin O'Leary, Coventry and Warwickshire Partnership Trust Alec Price-Forbes, University Hospitals Coventry and Warwickshire

Employees (by Directorate):

Chief Executive's:	V De-Souza
People:	M Greenwood
Resources:	L Knight
Apologies:	Councillor Ruane Councillor Taylor Professor Guy Daly, Coventry University Martin Reeves, Coventry City Council

Public Business

10. **Welcome and Apologies for Absence**

The Deputy Chair, Councillor Caan welcomed members to the second Board meeting in the current municipal year including Simon Gilby, Coventry and Warwickshire Partnership Trust, who was attending his first Board meeting. He referred to Brain Walsh, Executive Director of People, who was attending his last Board meeting prior to retiring from the City Council. Councillor Caan thanked Brian for all his hard work and support since the Board had been established.

Councillor Alison Gingell

Councillor Caan informed that Councillor Gingell had resigned from her position as Chair and member of the Board. He placed on record his thanks for all her experience and dedication that she had committed to the Board whilst serving as Chair.

Dr Jane Moore, Director of Public Health informed of Councillor Gingell's long and distinguished career working within the city's health service which included being an advocate for sex education in the 1970s and being responsible for Coventry appointing the first HIV prevention worker outside of London. Reference was made to her service on many of the city's Health Boards including being Chair of the Primary Care Trust. Dr Moore referred to the crucial role she played during the development of this Board and, in particular her recent influential work to support Coventry being a leading Marmot City and leading on the prevention work for Female Genital Mutilation.

Juliet Hancox, Coventry and Rugby CCG, referred to Councillor Gingell's amazing influence across the health economy of the city, including mentoring junior managers, which had resulted in a lasting legacy for the city. Councillor Lucas drew attention to her clear vision for moving the health economy forward and how the Board would continue to drive forward her good works.

11. **Declarations of Interest**

There were no declarations of interest.

12. **Minutes of Previous Meeting**

The minutes of the meeting held on 6th July, 2015 were sign as a true record. There were no matters arising.

13. **Electronic Patient Record Systems**

The Board considered a report of Juliet Hancox, Coventry and Rugby CCG on behalf of the Information Sharing Board which informed of the activities undertaken by the Information Sharing Board and demonstrated the opportunities that would arise from the new electronic patient record systems that were being put in place by University Hospital Coventry and Warwickshire (UHCW) and Coventry and Warwickshire Partnership Trust (CWPT). The Board also received presentations from Alec Price-Forbes, UHCW and Kevin O'Leary, CWPT.

The report indicated that Coventry and Rugby CCG, the City Council, UHCW and CWPT had developed a programme with the key aim to facilitate the sharing of information between partner organisations to improve the level of service to the patient/ client. The sharing of this patient information between health and social care organisations was seen as a key enabler to improve their care and support. Key benefits included improving patient experience as the patient doesn't have to keep repeating their story; reducing duplication; reducing medication errors; and enabling true integrated working.

The Board were informed of the national requirements, with a number of publications from national bodies having set out the aspiration to use electronic records to support improved patient care.

The report set out the governance structure for the programme. Across the four partner organisations there were hundreds of patient or client electronic record systems which created a major challenge for the project. A vision had been agreed to underpin the partnership work going forward which included 'To deliver a system that enables us to become the healthiest community in the UK'.

Reference was made to the long timescale to be able to move from all the different electronic record systems to the goal of having a single shared patient record. The Programme Board had agreed that work would be undertaken in phases over time. Key work streams for initial development were:

- Federated GP Practices
- Discharge from hospital
- Integrated Neighbourhood Teams
- Urgent Care

Early implementation of the work streams had been part funded by the Better Care Fund. There were some interim solutions which allowed some of the existing systems to share information and information governance and patient consent to share data were now key considerations. Both UHCW and CWPT had progressed with renewing their electronic patient record systems which would give the opportunity to move towards more sharing of patient information and the use of patient portals.

Kevin O'Leary, CWPT, gave a presentation 'It's not about the system, its about interoperability' which highlighted the difficulties of finding a system to interact with all the health and social care services in the area. Attention was drawn to the Interoperability Toolkit which included having a system with the capacity for different computer systems to 'talk to each other' having a common language; reducing NHS expenditure through standardisation; and reduction in time to delivery by reducing the complexities of integration. The Trust had taken the decision to purchase a new clinical system now as from 6th July, 2016 iPM would no longer be supported and Trusts were to be responsible for providing their own clinical information systems. The benefits of having a single electronic patient record system were set out. CWPT had joined the NHS London Procurement Partnership Framework. Following a formal mini competition with three suppliers, the preferred system supplier was chosen. The Board were informed of the benefits to both CWPT teams and service users. The presentation concluded with the main timescales for the project, with had a go live date of April, 2016 for Community and Children Services and October 2016 for Mental Health Services.

Alex Price-Forbes, UHCW gave a presentation on 'Electronic Patient Records (EPR) Overview – enabling transformation and population health management'. The presentation referred to the current position and what was wrong with the current over complicated system; highlighted the global/ national drivers for change; and informed of what could be done to enable the procurement of a fully integrated electronic patient record system. There was a triple aim to improve patient experience of care, including quality and satisfaction; improving the health

of the population; and reducing the per capita cost of health care. Attention was drawn to the need to focus on citizen/patient experience; the need to have a more holistic view of the patient; and the need to focus on health and wellbeing, leading on ill health prevention. The transformation was not just IT. Reference was made to the role of the Health and Well-being Board.

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

- Support for the vision for Coventry 'to be the healthiest community in the UK'
- Concerns about the legislative barriers relating to data protection, particularly in relation to safeguarding
- The importance of the Board working together to overcome potential barriers
- How to engage with all the necessary stakeholders to get people on board
- The requirement for an action plan for moving forward
- The importance of pooling funds to move the project forward
- The issue of patient health data belonging to the individual and the need to ensure people take responsibility for their own health
- The potential to secure support and funding from the city's universities
- The importance of deciding how the information was to be used
- Clarification about the role of the patient.

RESOLVED that:

(1) It be noted that there is a national requirement to develop digital records to support patient centred care.

(2) The Health and Well-being Board support the on-going work and vision of the Information Sharing Board.

(3) Consideration be given to the involvement of both Coventry and Warwick universities in the project.

(4) Consideration be given to the development of a protocol around how to work with the public to ensure their involvement with the project.

14. **System Wide Transformation - Progress Report**

The Board considered a report of Phil Evans, Coventry and Rugby CCG which provided an update on progress for the System Wide Transformation Programme, the purpose of which was to provide an overarching, high-level description of the transformation method and the governance arrangements that would be used to deliver the planned and urgent care programme.

The report indicated that the 'Five Year Forward View' described the position that without transformative system change, the local health and social care economy would not be able to address the key challenges to be faced which including reduced financial resource, increased demand for services and more pressure on community and mental health services. The system wide transformation programme was tasked with designing and delivering fundamental changes across the local health and social care economy. The programme would encompass

existing change programmes including the local Better Care Coventry programme and the Urgent Care programme.

The Transformation Programme was made up of the following four key workstreams, the aims of which were detailed:

- People, Presentation and Planning – No-one comes to hospital who can be managed elsewhere
- Urgent Care Urgent Need – No-one is admitted to hospital without an acute hospital need
- Home First – No-one waits more than 24 hours to leave hospital once they are medically fit for discharge
- Resilience and Support – Reduce the number of people requiring long term care

The Board were informed of the senior responsible officer for each workstream.

The programme placed the patient at the centre of what was being done and ensured that there would be a single view of the patient throughout their health and social care journey. It was anticipated that there would be an improvement in health and well-being, demonstrated through increased life expectancy, improved clinical indicators and increased disability free life years.

Each workstream was supported by a programme management office which fed into the programme director. The Board were informed of their responsibility to provide strategic direction. The next steps for the programme were highlighted.

Members raised a number of issues including:

- how the workstreams were linked
- clarification about how the Board were to fulfil their role of providing strategic direction.
- details about the intentions to ensure the involvement of the public
- concerns about the potential for decisions to be taken in isolation by individual partner organisations in the current challenging financial climate.

RESOLVED that:

(1) The strategic aims of the System Wide Transformation Programme be approved.

(2) Agreement be given for the Board to provide strategic direction going forward.

15. **Appointments of the City Council - Coventry Health and Well-being Board**

Further to Minute 6/15 and following the resignation of Councillor Alison Gingell from the Health and Well-being Board, the Board considered a report of the Executive Director of Resources which sought approval for a nomination from one of the partner organisations to serve as Deputy Chair of the Board for the remainder of the current municipal year. The report was also to be considered by

Council at their meeting the following day when the appointment would be approved.

Arising from Councillor Gingell's resignation, it was necessary to seek a new Chair for the Board and to seek a replacement Council Member, on the nomination of the Leader of the Council, Councillor Lucas. At the Council meeting on 8th September, the City Council would be recommended to appoint Councillor Kamran Caan, the Cabinet Member for Health and Adult Services and current Deputy Chair, as Chair of the Board for the remainder of the year. Council would also be recommended to appoint Councillor Joseph Clifford as a member of the Board. The nomination of a representative from the partner organisations to serve as Deputy Chair was to be reported orally to the Council meeting.

RESOLVED that Dr Adrian Canale-Parola, the Chair of the Coventry and Rugby CCG Governing Body, be nominated as the Deputy Chair of the Health and Well-being Board for the remainder of the current municipal year and Council be informed accordingly.

16. **Quarter 1 2015-16 Better Care Fund Submission**

The Board considered a report of Mark Greenwood, Coventry Council on behalf of the Better Care Programme Board, which provided an overview of the quarter 1 2015/16 Better Care Fund submission as required by the Department of Health and NHS England. A copy of the submission which had been submitted by the required deadline of 28th August was set out at an appendix to the report.

The submission covered the following six key areas:

- Budget arrangements
- National conditions
- Non-elective admissions and payment for performance calculations
- Income and expenditure profile
- Performance against local metrics
- Understanding support needs.

The primary aims of this submission was to provide assurance to the Department of Health, Local Government Association and NHS England that local areas had arrangements for managing joint budgets and improvements, as measured against the national conditions, and that they were beginning to be delivered.

The eight national conditions were set at the beginning of the Better Care Fund process. The Board were informed that good progress had been made in delivering against these in Coventry. Five were now in place and the following three were currently being developed:

- Delivery of 7 day services to support discharge and prevent unnecessary admission
- Use of the NHS number as the primary identifier across all partner organisations
- The development of a joint assessment and care planning approach with a lead accountable professional.

It was anticipated that these conditions would be met by the end of the calendar year.

The Board noted that overall the submission demonstrated positive progress locally towards delivery of the Better Care Fund priorities.

Members raised several issues including that the actual submission document was quite difficult to read; further clarification about the progress that Coventry was making; and information about the local defined patient experience metric where it was proposed to use family and friends scores for A and E and inpatients until a new system had been developed. It was clarified that Coventry was moving ahead quite quickly compared to some areas, where plans were still being signed off.

RESOLVED that the current status of the Better Care Coventry Programme be noted.

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

There were no additional items of public business.

(Meeting closed at 3.50 pm)

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Coventry City Council

Report

To: Coventry Health and Wellbeing Board **Date:**

From: Director of Public Health

Subject: Update on Joint Strategic Needs Assessment and Development of the Health and Well-being Strategy

1 Purpose

1.1 The current Health and Wellbeing Strategy for Coventry was published in December 2012, at this time the Health and Wellbeing Board existed in shadow form and became a statutory function in April 2013. Since then there have been a number of developments both in the city and nationally. Coventry has recently confirmed a partnership with the National Marmot team for the next three years and initiatives such as the Better Care Fund have provided a stimulus for further integration of health and social care.

1.2 This report provides an update on the Joint Strategic Needs Assessment (JSNA) process and the development of the new Health and Well-being Strategy for Coventry.

2 Recommendations

The Board is asked to:

- consider the progress made to date on the JSNA;
- consider the list of topics identified through the review of evidence, the prioritisation matrix and feedback from Marmot Steering Group;
- Consider and agree Collaborate's proposal to support the further development of the Board.

3 Background

3.1 The JSNA looks at the current and future health and care needs of the local population to inform and guide the planning and commissioning of health, well-being and social care services within a local authority area. The JSNA should consider the needs arising from all factors that impact of the health and well-being of the local population including economic, education, housing and environmental factors.

3.2 National guidance suggests that the refresh of the JSNA should be a process that runs alongside and is linked to the development of the Health and Well-being Strategy. This process provides an opportunity for the Board to work together to understand and agree the needs of the local populations, whilst setting priorities for collective action.

4 Current Progress on JSNA

4.1 The JSNA process started in April 2015, with a review of the 2012 Health and Well-being Strategy to understand what outcomes have been delivered. Alongside this, a wide range of data and information resources have been reviewed to identify the key health and social care issues affecting Coventry residents. This exercise has been largely desk based but has involved a number of stakeholders to this point, to ensure that this is as comprehensive as possible (the results of the review of evidence is attached at Appendix 1).

4.2 Between August and September, a Stakeholder Call for Evidence was undertaken. The purpose of this was to provide stakeholders with an opportunity to review the evidence collated so far, and to include additional issues for consideration in the JSNA. As part of the Call for Evidence, we received 53 responses from 28 separate organisations. Respondents showed support for the existing topics identified and also suggested three topics that they felt need further consideration. These were as follows:

- Education inequalities
- Infant mental health
- Premature deaths of people with learning disabilities.

5 Key messages from the JSNA so far

5.1 The population of Coventry continues to increase:

- The City's total population is 337,400 (mid 2014). This is 7,600 more people than in 2013 when the population was estimated to be 329,800. This is an increase of 2.3%, compared to the England average of 0.8%.
- Between June 2013 and June 2014 Coventry's population was growing at the 6th fastest rate out of all councils in Great Britain.
- The main cause of population growth in Coventry between mid-2013 and mid-2014, as in recent years, was net international immigration – more people move to Coventry from overseas than move abroad from Coventry
- Coventry has a younger population than the average for England, the average age of a Coventry resident is 34 years old compared to 40 years old nationally
- The city is ethnically diverse, with some 33% of Coventry's inhabitants coming from ethnic minority communities compared to 20% for England as a whole

5.2 Life expectancy gaps:

- Overall, life expectancy in Coventry is increasing and the city currently has about 7,000 residents aged over 85, a group that is expected to grow. However, the city is still worse when compared to the West Midlands and England. Male life expectancy at birth in Coventry is 78.2 years, compared to 78.8 years in the West Midlands and 79.4 in England. Meanwhile, female life expectancy at birth in the city is 82.4 years, compared to 82.8 years in West Midlands and 83.1 in England.
- There is also much inequality in life expectancy within Coventry. There is a large difference in life expectancy between men and women and those living in the least and most deprived wards in the city (a gap of 10.1 years for males and 8.7 years for females).

5.3 Quality of life indicators:

- 18.3% of Coventry's residents live in neighbourhoods that are amongst the 10% most deprived in England. This is higher than the both the West Midlands and England rates.
- 7.5% of the city's working age population are unemployed, which is higher when compared to West Midlands and England

- There has been a rise in the proportion of the working age population without a formal qualification, from 14.4% in 2010 to 15.8% in 2013.
- 52.3% of key stage 4 pupils achieved 5 GCSEs A*-C inc. English & Maths in 2013/14, compared to 56.8% in England

6 Priorities for Consideration

6.1 Due to the complex, multi-faceted nature of health and well-being, the different issues identified through the review of evidence and call for evidence require consideration as potential priority topics. In order to focus on the areas of 'greatest' need, a more robust, transparent and inclusive means of determining the City's health and wellbeing priorities has been developed. This has involved the use of a prioritisation matrix whereby each of the suggested topics was run through a 'prioritisation framework' and scored against a number of indicators, including the numbers of the population affected, scale of the impact and the economic costs associated with the issue (the prioritisation framework is attached at appendix 2).

6.2 The outcome of the prioritisation process highlighted the following as key areas of focus:

6.3 Health and care priorities:

Mental health and well-being	-Mental health children & adults -Dementia -Self-harm
Long-term Conditions	- Cancer - Cardiovascular disease - COPD
Physical well-being	- Obesity – diet & physical inactivity - Substance misuse (smoking and alcohol)
Infectious diseases	- HIV - TB - Immunisations
Resilience of health and social care system	- Admissions to hospital - Winter deaths - Falls prevention

Wider determinants priorities:

Children and Young people	- Teenage parents - Vulnerable children and young people - Educational attainment/employment opportunities
Economy and Health	- Jobs and economy
Housing and Health	- Homelessness - Fuel poverty

6.4 As part of the JSNA development process a workshop was held with the Marmot Steering Group to understand what topics they felt were important. Feedback from the Steering Group indicates that improving outcomes for children and young people, ensuring that economic growth in Coventry benefits everyone, and embracing the cities diversity and improving outcomes across ethnicities were the most important areas to focus upon.

6.5 While outcomes have improved in Coventry and are now in line with or above the national average for a range of indicators affecting children aged 0-5 (e.g. breastfeeding initiation, school readiness at age 5), outcomes for older children and young people are below national and regional averages (e.g. NEETs, teenage pregnancy). The group felt that the focus for the next three years therefore needs to include children and young people aged 5-19.

6.6 Similarly, although there has been a slight increase in the proportion of working aged adults in employment in Coventry, overall employment rates are lower than regional or national averages, and there has been a rise in the proportion of the working age population without formal qualifications. The Steering Group felt that while getting people into work is critical to reducing health inequalities (particularly around mental illness), jobs need to be sustainable and offer a minimum level of quality, pay the living wage, offer opportunities for in-work development and flexibility to enable people to balance work and family life.

6.7 The main cause of recent population growth in Coventry is net international immigration – more people move to Coventry from overseas than move abroad from Coventry. As a result of recent and historic migration the city is ethnically diverse, with some 33% of Coventry's inhabitants coming from ethnic minority communities compared to 20% for England as a whole.

6.8 The Board is asked to consider the above topics and the feedback from the Marmot Steering Group.

6.9 A similar prioritisation discussion is planned with Health and Social Care Stakeholders and other partner organisations.

7 Next steps: Development of the Health & Well-Being Strategy

7.1 Collaborate, an independent policy and practice hub, has been working in Coventry over the last few months on a project looking at systems change and collaboration for those facing multiple complex needs. Collaborate has been commissioned by Coventry City Council to support the Board to develop a place-based approach to health which aims to put place, people and outcomes above institutions, sectors and silos. Collaborate has proposed holding a full day workshop with Board members to support the Board to reconceptualise its future role by agreeing its vision, principles, priority outcomes, and any supporting infrastructure and support the Board to consider what its role should be as system conveners and enablers. The outputs of the workshop, as well as the key priorities arising from the JSNA will be used to develop the new Health and Well-being Strategy. The Board are asked to consider and agree Collaborate's proposal. Collaborate's offer of support is set out in Appendix 3.

8 Timescales

8.1 The timescales for Board development and production of the Health and Well-being Strategy are as follows:

What	When
Discuss and agree approach to Board development	19th Oct 2015
Board Development Day	Late Nov 2015
JSNA signed off and Board agree/sign off their priorities	7th Dec 2015
Delivery Clinic	w/c 7th Dec 2015
H& WB Strategy drafted	Dec 2015
Consultation on H&WB Strategy	Jan 2016
H&WB Strategy signed off	3rd Feb 2016

Report Author(s):

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Appendices
Appendix 1: Health and Wellbeing Strategy 2012 Review
Appendix 2: Prioritisation Framework
Appendix 3: Collaborate Offer of Support to the Health & Well-being Board

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Insight

Joint Health and Wellbeing Strategy for Coventry 2012 – Review

Introduction

The Joint Health and Wellbeing Strategy for Coventry 2012 – 2016 has been the driving force in improving the health and wellbeing of the people of Coventry over the past 4 years.

It challenged services to make improvements to the City's health in 12 carefully chosen topic areas grouped into 4 major themes. Each topic area contained priorities and targets and in the time since then the Health and Wellbeing Board has overseen a wide range of activities from agencies in public, private and voluntary sectors which seek to deliver against this challenge.

This report distils this work and evaluates what has taken place against the targets set in 2012. In some cases the Board has changed tack over this period and placed different emphases in the light of the changing world, including further embedding of Public Health onto local government and a greater drive towards health and social care integration. In many areas clear progress has been made, and in others progress has been more difficult.

For each topic area a summary of the activities which have been taking place is presented and where available, data and statistics are presented which seek to illustrate how well the activities are achieving the targets set.

This evaluation forms the starting point of the process to create the next Joint Health and Wellbeing Strategy for Coventry. This will be one element contributing to the process of Joint Strategic Needs Assessment (JSNA) which will take place during the Summer and Autumn of 2015. The JSNA will add detailed analysis from deep-dives in service areas as well as statistics and data on the overall needs of our changing population. It is from this evaluation and the JSNA process that the next Health and Wellbeing Strategy will be drawn.

Theme 1: Healthy People

Early years (pre-natal to 2 years)

PRIORITIES IDENTIFIED IN 2012

- Reduce the number of families living in poverty by supporting them into work and for them to access safe and affordable housing
- Join up all of the services that work with young children and their families through the Healthy Child Programme
- Helping communities to develop and flourish

TARGETS

- Reduce the percentage of children living in Poverty
- Increase the level of Child Development at age 2
- Increase the % of children ready for school - early years foundation stage profile
- Have fewer children taken into care

WHAT IS BEING DONE TO ADDRESS THIS ISSUE?

FAMILY NURSE PARTNERSHIP

The Family Nurse Partnership is an evidence-based licensed programme. The team in Coventry provides a high level of support and advice to young, first time parents, throughout pregnancy up until their child reaches two years of age.

A team of specially trained nurses deliver individual care, guidance and support to first time parents in their home, as soon as their pregnancy is confirmed. The service is not designed to replace other services provided by health professionals, such as Midwives and GPs, but to complement existing services through a high level of support that enables the mother, father and child to achieve the best health and wellbeing outcomes for themselves.

ACTING EARLY

The Acting Early Programme seeks to bring together the range of agencies who work with children aged 0-5 – Maternity services, Health Visiting, General Practice, Sure Start Children's Centres, local authority Children's teams and the voluntary sector to work as a single team in neighbourhoods across the city. The project works in 6 neighbourhoods in the City

- Tile Hill
- Hillfields
- Foleshill
- Wood End and Henley Green

- Longford
- Willenhall

INFORMATION SHARING

Paucity in information sharing has previously been recognised as a barrier to providing joined-up care and the introduction of obtaining explicit consent for sharing data from parents at their appointment booking ensures families are provided with a timely and seamless service from professionals who truly understand their needs.

We now have in place for the first time an information sharing agreement signed off by the three partner agencies (Coventry City Council, University Hospital Coventry and Warwickshire and Coventry and Warwickshire Partnership NHS Trust). The information sharing agreement will help enable integrated teams to identify those families who are vulnerable and intervene earlier.

EARLY ACTION NEIGHBOURHOOD FUND

Coventry has been successful in being awarded £1.5M by the Early Action Neighbourhood Fund to support parents and families in Bell Green and Willenhall. The Willenhall Pathfinder project focuses on making Children's services work very differently – placing child caseworkers at the forefront of multi-agency working.

DATA AND STATISTICS

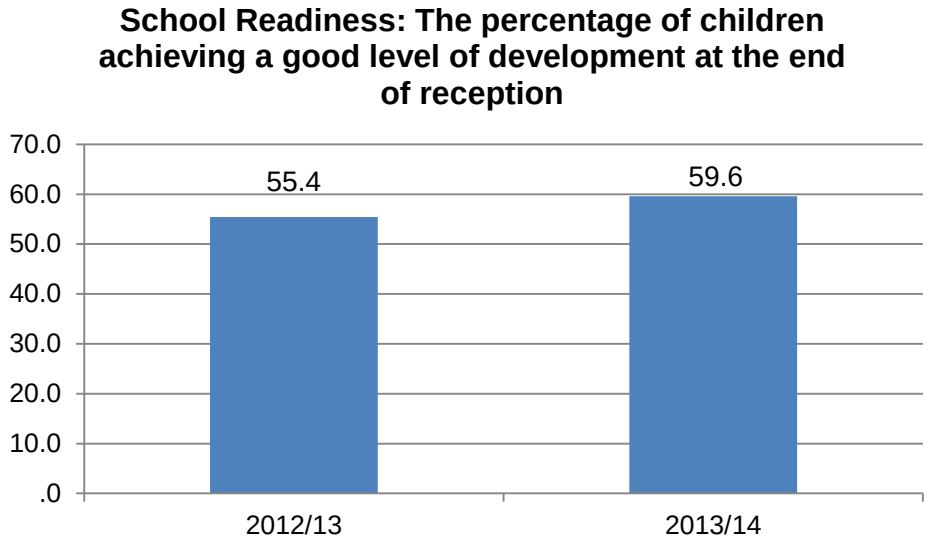
REDUCE THE PERCENTAGE OF CHILDREN LIVING IN POVERTY

The latest available data on Child Poverty shows a reduction to 23.1% in 2012 down from 26% in 2011.

INCREASE THE LEVEL OF CHILD DEVELOPMENT AT AGE 2

The national collection of data under this heading has not been delivered.

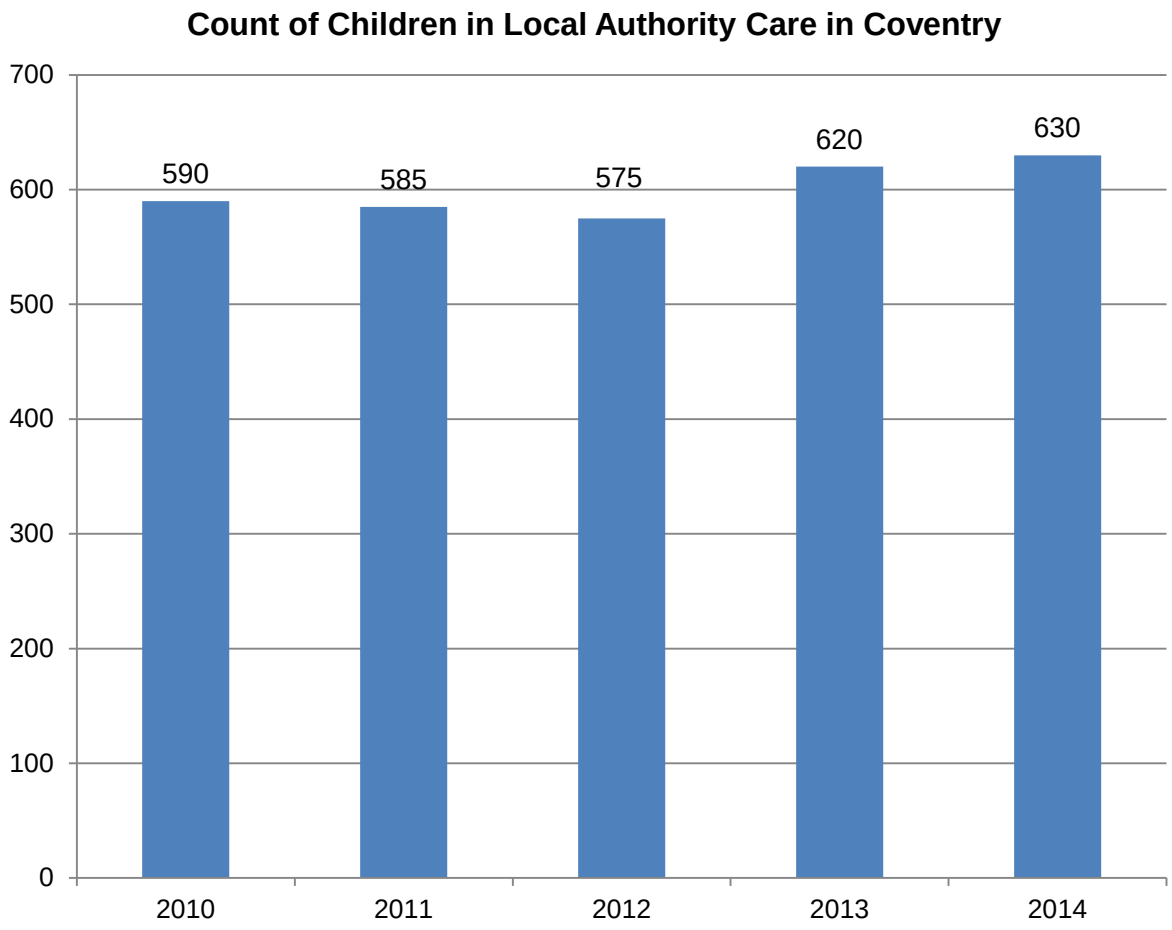
INCREASE THE % OF CHILDREN READY FOR SCHOOL - EARLY YEARS FOUNDATION STAGE PROFILE

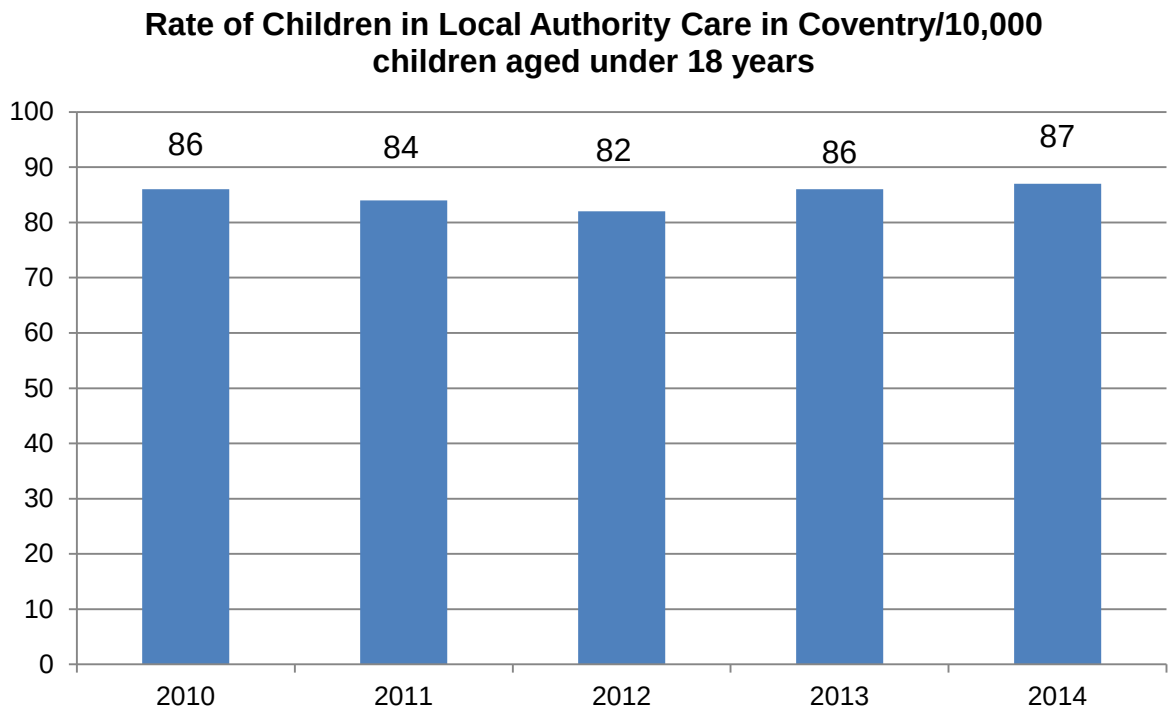


Detailed analysis of this data has been made possible since the 2013 release of the Early years foundation stage profile by the Office for National Statistics. On all of the reported areas of learning the proportion of Coventry children achieving the expected level at foundation stage has either remained constant (Physical Development and Understanding the World) or increased.

Children achieving at least the expected level in the areas of learning								
	Communication and language		Physical development		Personal, social and emotional development			
	Count	%	Count	%	Count	%		
2014	3,239	75%	3,643	85%	3,457	81%		
2013	3,212	73%	3,704	85%	3,497	80%		
	Literacy		Mathematics		Understanding the World		Expressive arts, designing and making	
	Count	%	Count	%	Count	%	Count	%
2014	2,791	65%	3,025	70%	3,310	77%	3,474	81%
2013	2,722	62%	2,955	68%	3,348	77%	3,483	80%

HAVE FEWER CHILDREN TAKEN INTO CARE





Both the numbers of children taken into care and the rate per 10,000 children have increased since 2012. This follows a national pattern of a general increase in the proportion of children in care across the country. Coventry has witnessed a considerable increase in the numbers of children on Child Protection Plans since 2012 and it is suspected that this can be in part attributed to the Daniel Pelka case and associated risk aversion in all agencies. However the rise in child protection cases has not driven a similar rise in the numbers of children entering care.

Older People

PRIORITIES IDENTIFIED IN 2012

- Support older people to live independently for as long as possible
- Ensure we are better at joining up services across health, social care and the voluntary and community sector
- Improve the perception of community safety amongst older residents

TARGETS

- Increase the proportion of older people successfully supported to remain at home following hospital stay
- Improve health related quality of life for older people
- Reducing Excess Winter Deaths

WHAT IS BEING DONE TO ADDRESS THIS ISSUE?

OLDER PEOPLE'S NEEDS ASSESSMENT

A detailed Health Needs Assessment for Older People in Coventry was conducted in 2013. This process identified

- Coventry has a growing population of older people
- The numbers of over 85's in the population will grow even more quickly
- Coventry has a lower life expectancy than England in general.
- Life expectancy for females aged 65 and over in Coventry is the same as it is for England and slightly higher than those in the West Midlands
- For males, life expectancy is 6 months shorter than it is for England, but similar to that of the West Midlands.
- Disability Free Life Expectancy (DFLE) in Coventry is slightly worse than that for the West Midlands and England
- Older people in Coventry are more deprived than older people in England and West Midlands as a whole and both mortality and morbidity, Life Expectancy and Disability Free Life Expectancy are worse for more deprived older people across the City.
- With increasing numbers of older people population living alone, social exclusion will have significant impact on mental and social wellbeing of the older people in Coventry
- Need for carers and carers support will increase with increasing older people population.

An asset based community development model should be considered to empower older people and support each other. This will lead to providing multiple solutions including improving social cohesion, independence and carers support amongst older people. This can help reduce demand on health and social care

COVENTRY – AN AGE-FRIENDLY CITY

In 2014 Coventry City Council and partners through the Health and Well Being Board supported a proposal for Coventry to become and Age Friendly City. An Age Friendly City is a World Health Organisation international Programme that focuses on active ageing: ageing well and staying well.

To oversee this programme of work a sub group of the Health and Wellbeing Board has been established and its membership is made up of the major partners in the city.

The first year of the pprogramme will focus closely on specific issues which impact on older people in Coventry

- transport,
- social participation,
- communication and information.

These three areas have been prioritised following feedback from the initial stakeholder engagement event on the 15th December 2014.

BETTER CARE COVENTRY

Coventry's Better Care Vision is "*Through integrated and improved working, people will receive personalised support that enables them to be as independent as possible for as long as possible*". Four core projects are now operating.

- Urgent care - delivering a reduction in emergency admissions to hospital
- Home First (short-term support to maximise independence) - providing a single point of access to short-term support at home
- Long-term care - integrated working that ensures people receive personalised support that enables them to be as independent as possible for as long as possible within their local community
- Dementia - enabling people and their carers to live as independently as possible, and to 'live well'

In addition to these specific work streams, other shared priorities were included such as information sharing, support for the implementation of the Care Act 2014 and protecting adult social care services.

HOME FIRST: SUPPORTED DISCHARGE PROJECT

The Home First: Supported Discharge Project, based at University Hospitals Coventry and Warwickshire Trust seeks to improve the process of patient discharge through working in a more collaborative and integrated way between hospital and social care staff.

The project, initially a pilot and now rolled out to 21 Wards, has focused on

- Developing a single, integrated Supported Discharge Team to plan for discharge from the day of admission and to attend all Board Rounds
- Removing the issue of transfers of responsibility between agencies involved in care after discharge
- Providing proactive advice to ward staff to maximise the opportunity for patients to be discharged Home First
- Implementing the use of telecare to support Home First discharge
- Delivering integrated discharge assessment on a trusted assessor model

INTEGRATED NEIGHBOURHOOD TEAMS

Two GP Practices in Coventry have been piloting Integrated Neighbourhood Teams (INT) since July 2014. At the heart of this model was the establishment of multi-disciplinary teams.

The teams consist of a GP, Community Matron, Community Nurse, Social Worker, Community Development Worker, Occupational Therapist, Mental Health Worker, along with some support from the voluntary sector (Age UK). While detailed evidence is currently being collated, initial feedback shows benefits from working in this way have been

- People are benefiting from having to tell their story only once, as staff from different agencies share information between them

- People are benefitting from having joined-up resources working on their behalf.

- GPs have reported that they spend less time dealing with people with complex needs, as work is undertaken by the INT, and have also made less home visits to this group of people

Work is now being undertaken to scope the scale-up of this model, and how the concept of INTs can be implemented across the city.

COVENTRY'S LIVING WELL WITH DEMENTIA STRATEGY 2014-17

This strategy has been developed following a detailed Dementia Needs Assessment in 2012 identifying current and future prevalence of dementia, current service provision for people with dementia, and possible gaps.

The strategy seeks to enable people with dementia and their carers to be as independent as possible, for as long as possible, and for people with dementia to 'live well' with the condition. The aim is to fully engage people with dementia and their carers in the design and evaluation of services and support. The needs and wishes of people with dementia and their carers will be at the heart of action planning and delivery of this Strategy.

Actions taking place under the strategy include:

- Discharge to Asses – a pilot designed to support people with dementia / suspected dementia to return home from being in hospital, enabling them to be as independent as possible and avoiding admission to a care home
- Increased capacity in the memory assessment clinic which has reduced waiting times
- Dementia friendly communities and dementia friends – delivered through the independent Coventry and Warwickshire Dementia Action Alliance
- New technology - innovative pieces of technology have been trialled with people with dementia, in order to support them to maintain their independence, including GPS trackers to support safer walking, apps to aid memory, an app to identify dementia as early as possible, and Canary Care, a system that tracks movement and activity around a person's home.
- Dementia CQUIN- in reach. Coventry and Warwickshire Partnership trust have been commissioned by Coventry and Rugby CCG to provide an in-reach service to a number of care homes across Coventry and Warwickshire. They offer support to individuals displaying behaviour that challenges, and also, providing learning and development opportunities for staff members.
- Dementia-friendly Hospital - University Hospital Coventry and Warwickshire has signed up to work to become a 'dementia friendly' hospital. At the fifth National Dementia Care Awards, held in November 2014, the Trust's Frail and Older People's Team came out on top in the 'Best Dementia-Friendly Hospital' category

There are thought to be around 3,600 people living with dementia in Coventry, and by 2016, this is set to rise to approximately 3,900.

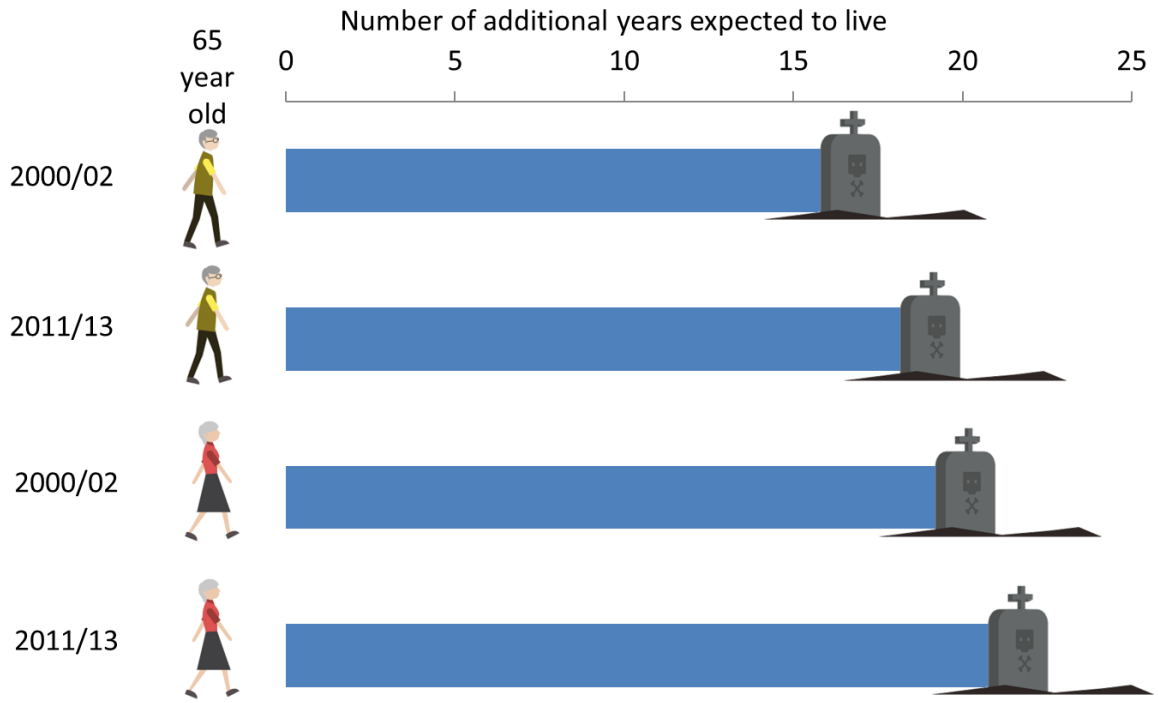
DATA AND STATISTICS

LIFE EXPECTANCY CONTINUES TO INCREASE

During the twentieth century, life expectancy rose dramatically amongst the world's wealthiest populations from around 50 to over 75 years. This increase can be attributed to a number of factors including improvements in public health, nutrition and medicine. Vaccinations and antibiotics greatly reduced deaths in childhood, health and safety in manual workplaces improved and fewer people smoked.

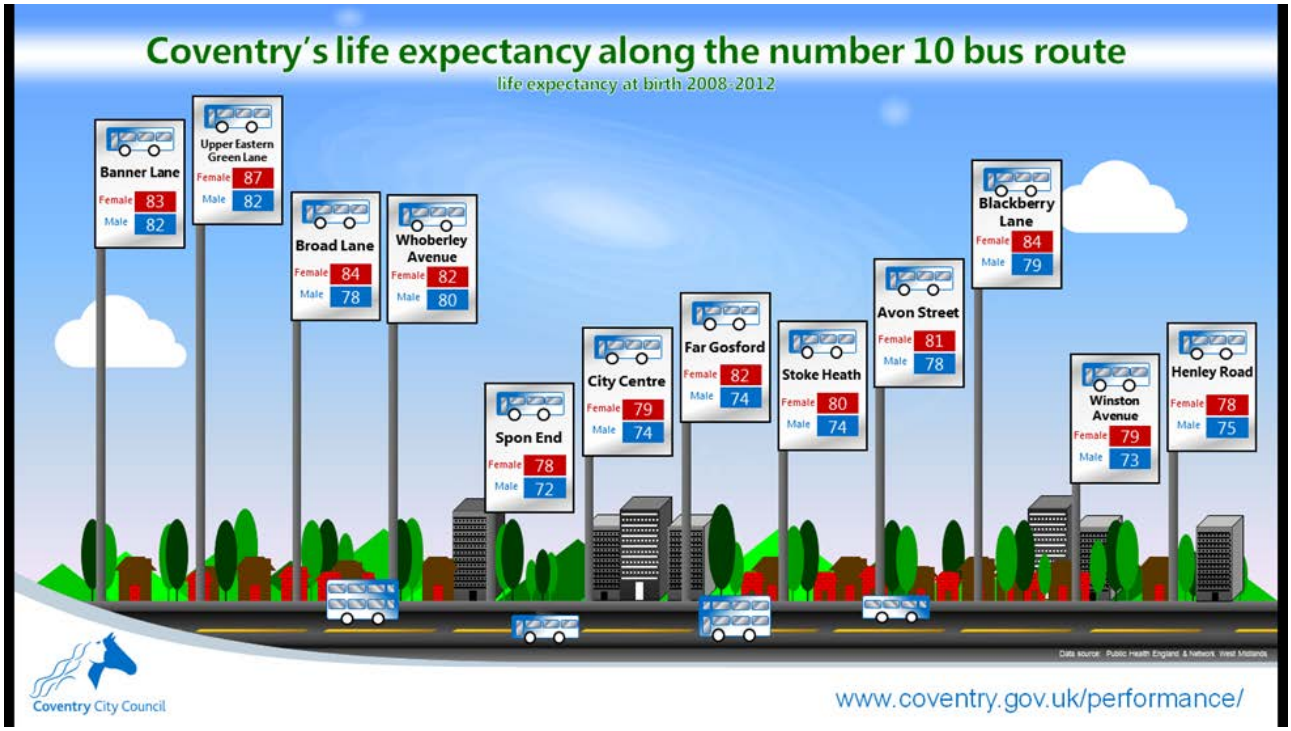
In Coventry since 2000, this effect has continued to raise life expectancy at age 65 for both men and women.

- In 2000/02 a 65 year old Male could expect to live another 15.8 years = 80.8 years
- In 2011/13 a 65 year old Male could expect to live another 18.2 years = 83.2 years
- In 2000/02 a 65 year old Female could expect to live another 19.3 years = 84.3 years
- In 2011/13 a 65 year old Female could expect to live another 20.8 years = 85.8 years



HEALTH INEQUALITIES IMPACT ON LIFE EXPECTANCY ACROSS THE CITY

While there have been improvements in the overall life expectancy for men and women in Coventry as whole, considerable differences appear when we look at where people live. In parts of the City where deprivation is lowest, we see longer life expectancy than in places where deprivation is high. This has been illustrated (overleaf) using a cross-City bus route as an illustration showing the variation in life expectancy as it travels through areas with higher and lower deprivation



The variation is even more apparent if we consider areas with the highest and lowest life expectancy across the City.

- Lowest Male Life Expectancy at birth by MSOA (Willenhall) 70.9 years
- Lowest Female Expectancy at birth by MSOA (Radford and Canal Basin) 77.7years
- Highest Male Life Expectancy at birth by MSOA (Finham, South Cheylesmore) 84.8 years
- Highest Female Life Expectancy at birth by MSOA (Hipswell Highway and Ansty Road) 86.7 years

ADDING LIFE TO ADDED YEARS

As well as the variation in life expectancy across the City, we are able to gain further insights into the headline figures by considering Disability-free Life Expectancy. This indicator shows us how many of the years we are adding to life are lived without significant disability. These are of course different for men and women. The latest figures for this data from before the launch of the Health and Wellbeing Strategy and whilst life expectancy had been increasing for males across this period, Disability-free life expectancy had been decreasing, increasing the number of years and proportion of life lived with disability. A similar but less extreme effect for women in Coventry was evident. It will be important moving forward to monitor whether this widening gap continues to widen.

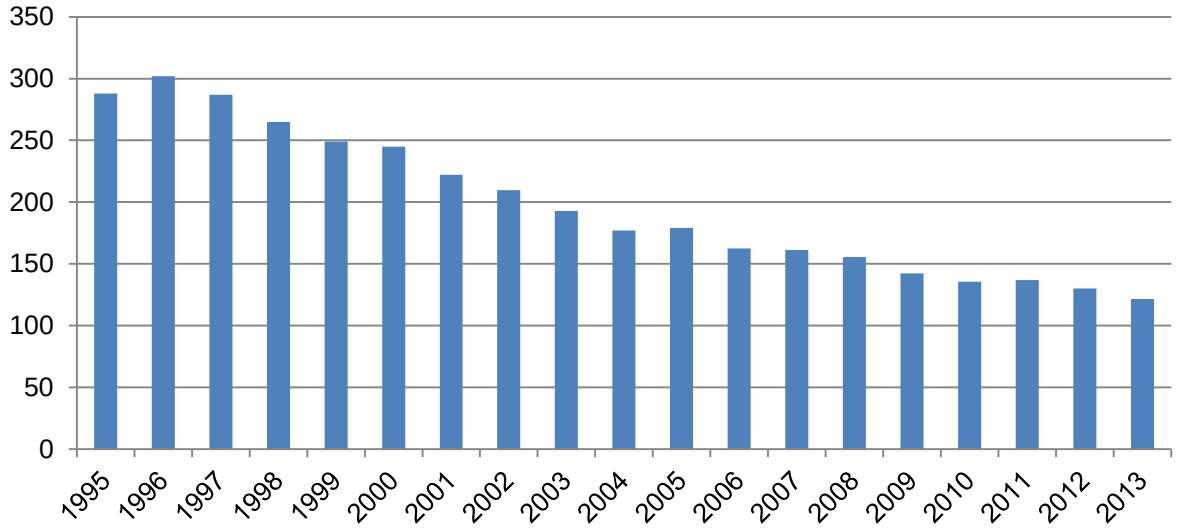
Males in Coventry	2006-08	2007-09	2008-10	2009-11
Life expectancy	76.3	76.7	77.1	77.6
Disability-free life expectancy	62.6	63.1	61.0	59.4
DFLE lower 95 % confidence interval	61.0	61.6	59.4	57.7
DFLE upper 95 % confidence interval	64.2	64.6	62.6	61.1
Expected years with a disability	13.7	13.5	16.0	18.2
Proportion of life disability-free %	82.1	82.3	79.2	76.6
Proportion of life with a disability %	17.9	17.7	20.8	23.4
Females in Coventry	**2006-08**	**2007-09**	**2008-10**	**2009-11**
Life expectancy	80.9	81.2	81.4	81.9
Disability-free life expectancy	62.1	61.8	63.4	61.0
DFLE lower 95 % confidence interval	60.4	60.1	61.8	59.2
DFLE upper 95 % confidence interval	63.9	63.5	65.1	62.8
Expected years with a disability	18.8	19.4	18.0	20.9
Proportion of life disability-free %	76.8	76.1	77.9	74.5
Proportion of life with a disability %	23.2	23.9	22.1	25.5

AVOIDABLE MORTALITY

Mortality from causes considered amenable to health care is an internationally accepted indicator of the overall quality of healthcare in a particular place and is now part of the Public Health Outcome Framework here in the UK.

The data below shows that the numbers of Coventrians dying from conditions they shouldn't normally die from is reducing year-on-year and is now half the than in 1995 having fallen to 121 deaths per 100,000 population in 2013.

Mortality from causes considered amenable to health care: directly standardised rate/100,000



POPULATION PROJECTION

The Office for National Statistics calculates projections of population for Coventry and this clearly shows that by 2022 the overall population, and the population of over 65s and over 85s continues to increase.

Population Projection (Count)	2012	2022
All Persons	323,100	365,200
65-84 year olds	40,500	44,300
85+	6,800	8,200

Population Estimate and Projection	1981	2013	2037
Over 65's	43,100	48,200	71,300
Over 85's	2,700	6,900	14,300

Taking a broader view over a longer period and by combining population estimates from 1981 and projections to 2037, in 1981 there were 43,100 people aged over 65 in Coventry. This had risen to 48,200 by 2013. ONS project that this number will have risen to 71,300 by 2037 an increase of 28,200 or 65% over this period.

For over 85's the baseline figure is 2,700 in 1981, rising to 6,900 by 2013 and reaching 14,300 in 2037. This is an increase of 11,600 or 429% over this period.

OLDER PEOPLE FEELING SAFE AT HOME

Coventry's Household Survey asks respondents how safe they feel at home – and we can examine how older people specifically feel. The data shows an encouraging increase in the percentage of older people who feel safe – from 69% in 2010 to 79% in 2013

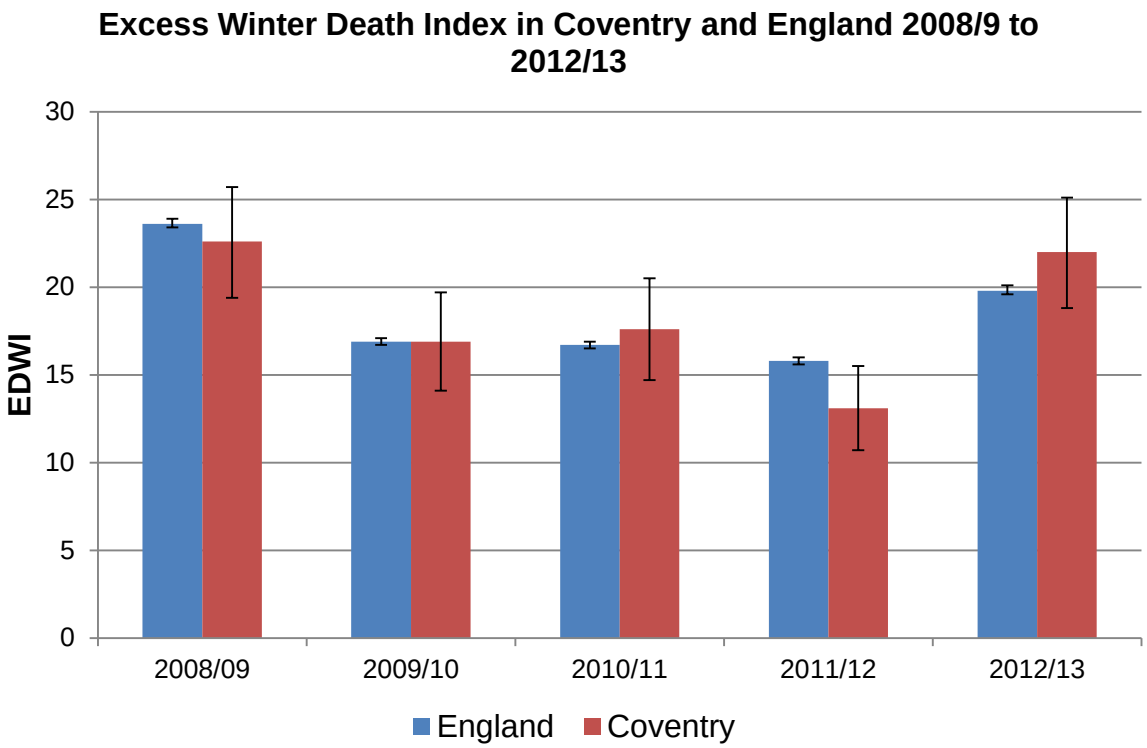
Coventry Household Survey Feel Safe or Very Safe at Night - Over 65's				
	2010	**2011**	**2012**	**2013**
%	69%	72%	78%	79%

SUCCESSFUL HOSPITAL DISCHARGE FOR OLDER PEOPLE

Supporting older people to live independently for as long as possible and increasing the proportion of older people successfully supported to remain at home following hospital stay are key elements of the Health and Wellbeing Strategy 2012. This is measured through the calculation of the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services. In the 3 years from 2011/12 until 2013/14, this has improved from 70% to 81%.

Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services			
	11/12	**12/13**	**13/14**
%	70%	76%	81%

EXCESS WINTER DEATHS



The graph above shows the pattern of Excess Winter Deaths over time using the ONS Excess Winter Deaths Index. This takes the excess of deaths in winter compared with non-winter expressed as a percentage. The graph shows that in 2012/13 22% more people (190 persons) in Coventry died in winter compared to those who die in summer. In 2011/2012 the index was 13.1% showing a statistically significant increase for Coventry between 2011/12 and 2012/13.

However the 2012/13 figure is not statistically any better or worse than the figure for England as a whole.

HEALTH RELATED QUALITY OF LIFE FOR OLDER PEOPLE

The Public Health Outcome Framework contains an indicator of overall health-related quality of life for older people. This is an average health status score for adults aged 65 and over as measured using the EQ-5D scale in the range zero to one.

Two years of figures are available and these show an increase from 0.69 in 2011/12 to 0.71 in 2012/13. However, as this is derived from survey data there is sampling error in these numbers and they are not statistically significant for Coventry.

Theme Two - Healthy Communities

Obesity (maternal and childhood)

PRIORITIES IDENTIFIED IN 2012

- Reduce numbers becoming overweight
- Targeting Pregnant Women
- Encourage breast feeding and give dietary advice on weaning
- Help families to encourage children to eat healthily
- Encourage Schools to offer healthy meals and promote healthy eating and physical activity
- Train people in how to raise the issue of healthy weight and how to support those wanting to change
- Improve access to healthy food options
- Promotion of sustainable travel
- Promotion of physical exercise in Communities

TARGETS

- Increase the % who are a healthy weight
- Increase the % who maintain a healthy diet
- Increase the % who participate in physical activity
- Reduce count of children obese at age 6
- Reduce count of children obese at age 11

WHAT IS BEING DONE TO ADDRESS THIS ISSUE?

JUST4MUMS

Just4mums is a unique six week free ante- natal healthy lifestyle programme. It helps mums-to-be to safely manage their weight during their pregnancy. Each session includes a healthy eating workshop and some gentle ante-natal exercise to finish. During the course we also help mums to set realistic goals for during and post pregnancy. Classes take place at Coventry Sports Centre and Sidney Stringer School

ONE BODY ONE LIFE (OBOL)

One Body One Life (OBOL) is a community based weight management programme for families and individuals who want to lead a healthier lifestyle. The programme meets the NICE recommendations. It's a FREE 8 - 10 week programme across Coventry aimed at helping people to make real changes to their lives by looking at their eating and exercise habits.

Specialist psychological support has been introduced to the OBOL team to ensure staff have the skills and knowledge to deal with the complex issues presented by clients.

Specialist sessions for young children and parents include

- Family OBOL
- OBOL for 2-4's
- OBOL for 0-2's

BUGGY WORKOUTS

The buggy workout is a fitness class for new mums wanting to get back in shape after their new arrival. It is a fun and enjoyable post natal outdoor circuit class where mum and baby can enjoy the fresh air. A small fee is charged for this service.

FOOD DUDES

Food Dudes is an evidence-based programme designed to improve children's consumption of fruit and vegetables. It has been shown to be consistently effective at changing the eating habits of 4- to 11-year-olds. The programme comprises three key elements:

- DVD adventures featuring hero figures, "Food Dudes", who like fruit/vegetables and provide social models for children to imitate
- Small rewards to ensure children begin to taste new foods
- Repeated tasting of fruit and vegetables so that children develop a liking for these foods

Food Dudes letters and home packs provide on-going home support to ensure the behaviour change transfers from school to family and is maintained over time.

EATING OUT COVENTRY

One in six meals are eaten out of the home – making it more difficult for people to control their food intake. Eating Out Coventry is a new Public Health project being run by Coventry University to work with independent takeaways in the city and introduce either healthier options or change cooking practices to make meals more healthy. The project will also introduce tools to help businesses provide nutritional information to staff and demonstrate the commercial advantage of providing healthier foods.

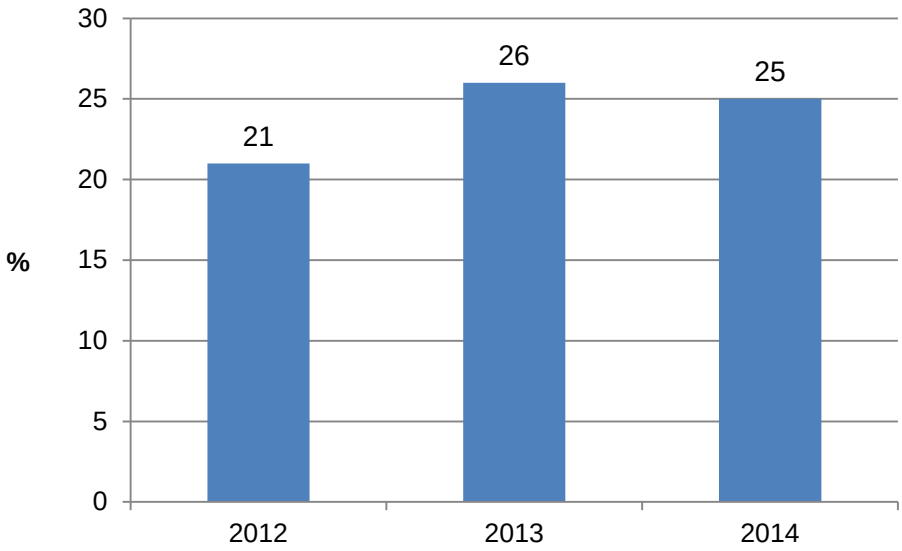
WORKFORCE DEVELOPMENT

Eating habits are established at a young age, so we have been training Acting Early site (combined teams of midwives, health visitors and childrens' centre staff) in core obesity messages to ensure parents are given consistent advice right from the birth of their child.

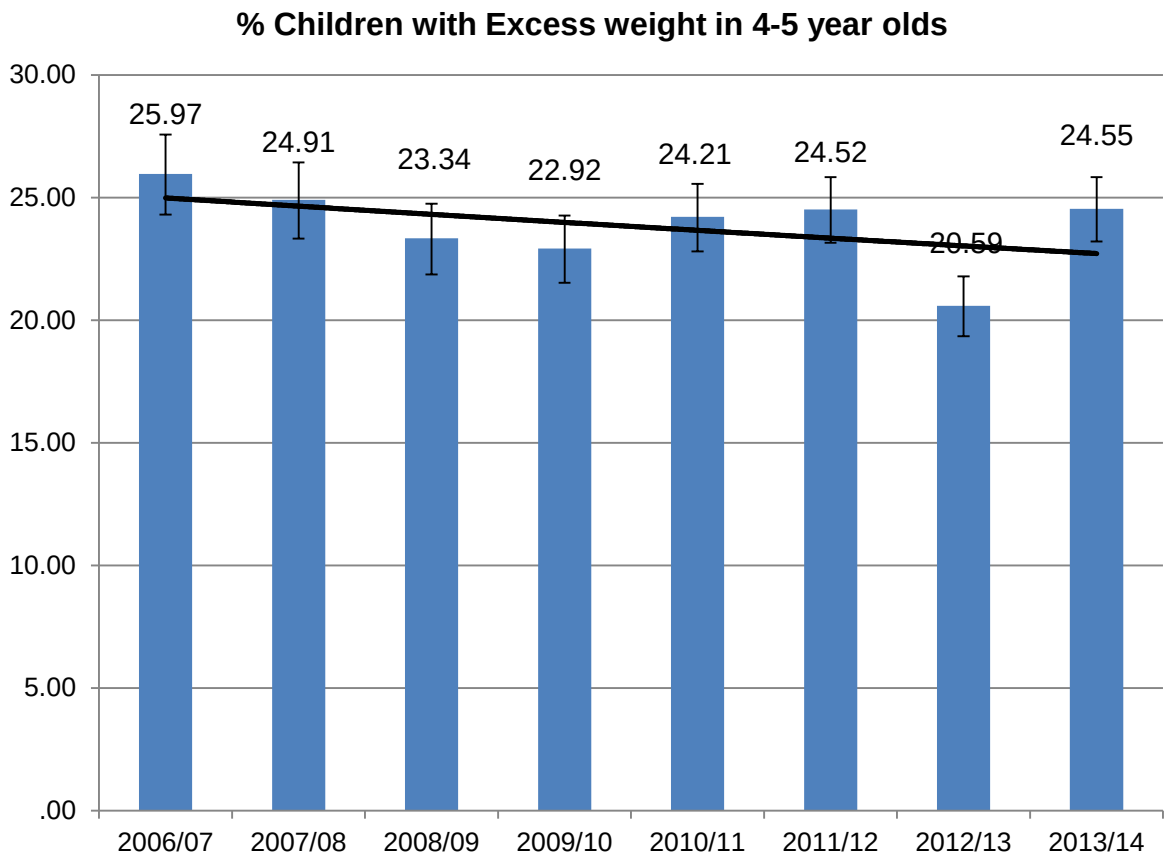
DATA AND STATISTICS

INCREASE THE % WHO PARTICIPATE IN PHYSICAL ACTIVITY

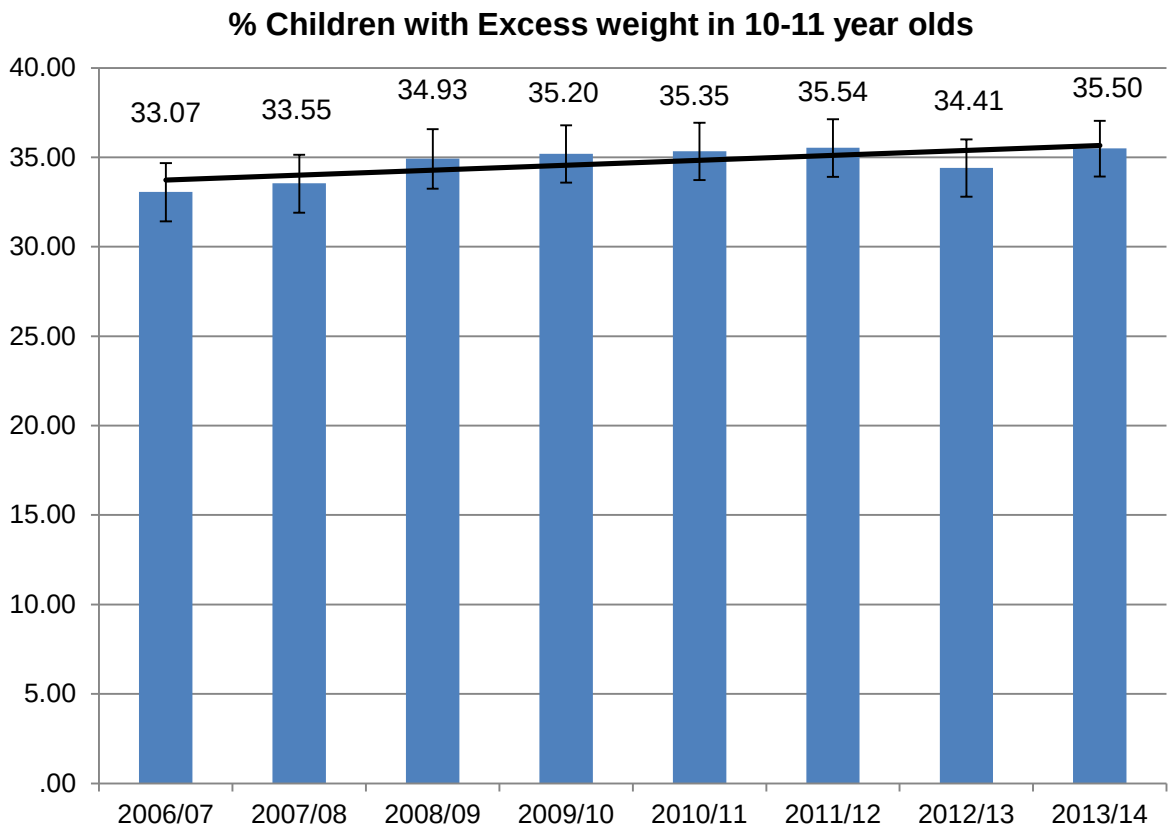
% Persons aged 16+ in Coventry participating in Sport and active recreation Three (or more) times a week



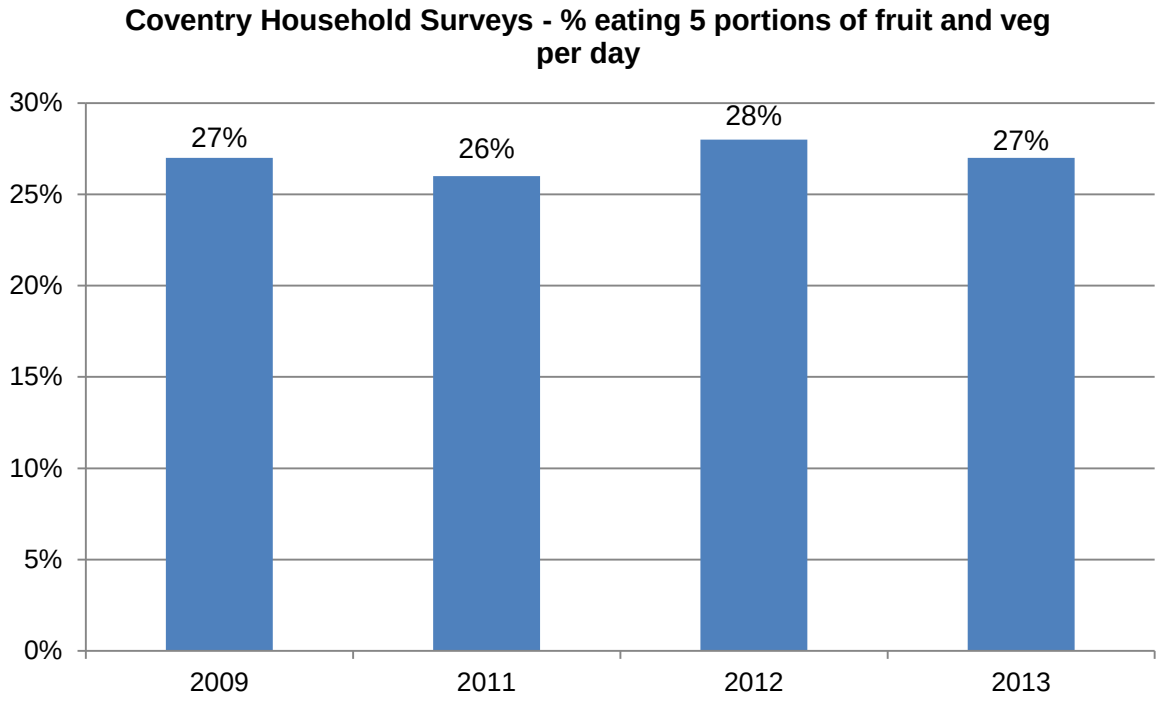
REDUCE COUNT OF CHILDREN OBESE AT AGE 6



REDUCE COUNT OF CHILDREN OBESE AT AGE 11



The preceding two charts illustrate how progress in being made reducing obesity in younger children – but less in older children. However the confidence limits set for this data are very wide and these trends could be due to statistical anomaly.



The chart above uses Coventry Household Survey data and shows a consistent pattern over time of the proportion of persons eating 5 or more portions of fruit and veg per day.

INCREASE THE % WHO ARE A HEALTHY WEIGHT

The Public Health Outcome Framework shows no data across the years covered by the Health and Wellbeing Strategy – only a single figure excess weight in adults for 2012. 56.5% of Coventrians were considered of excess weight compared to 63.8% for England – a statistically valid difference.

Mental Wellbeing

TARGETS

- Improvements in Wellbeing

WHAT IS BEING DONE TO ADDRESS THIS ISSUE?

ASSET BASED WORKING

Coventry's Asset Based Working Strategy for 2015-16 sets out ways to improve health and quality of life for local citizens, while making the city globally connected and attractive to businesses and investors. It recognises the limitations of public services that encourage dependency, and promotes a working culture that supports and enables people to find solutions to their problems.

In communities, there is a focus on promoting social engagement and cohesion, celebrating diverse achievements and successes, and improving wellbeing and resilience. In services, the emphasis is on reducing demand through implementing real change, supporting prevention and early intervention, and co-producing services with local people. Examples of current initiatives to improve wellbeing and promote asset based working are described below.

10 WAYS TO WELLBEING

The Wellbeing Project in Coventry identified '10 Ways to Wellbeing' based on the two themes of feeling good (i.e. happiness and life satisfaction) and functioning well. These expand on the New Economics Foundation's Five Ways to Wellbeing by suggesting ways that individuals can improve their wellbeing.

The 10 Ways to Wellbeing are as follows:

1. Connect with family, friends, colleagues and neighbours
2. Be active
3. Take notice - be aware of the world around you and what you are feeling
4. Keep learning
5. Give. Try something new
6. Have rewarding work
7. Feel safe and good about where I live
8. Feel good physically
9. Eat and drink healthily
10. Sleep well

THE WARWICK-EDINBURGH MENTAL WELLBEING SCALE (WEMWBS)

The Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) is a validated tool for measuring self-reported mental wellbeing that focuses on the positive aspects of mental health and wellbeing.

Coventry City Council has commissioned the University of Warwick to provide training for local professionals and practitioners on the use of WEMWBS to evaluate interventions which might have an impact on wellbeing. The training was delivered as workshops that included a mix of presentations and group work, and were accompanied by a workbook containing examples and exercises.

WORKPLACE WELLBEING CHARTER

NICE guidelines have been set out to promote mental wellbeing through productive and healthy working conditions. The Workplace Well-being Charter is a framework of standards that define healthy business practice.

The Charter covers a broad range of dimensions relating to workplace health and well-being, including a distinct Mental Health and Wellbeing standard which asks employers to provide information to reduce stigma around mental health, and raise awareness of mental health, including work-related stress.

At present, 14 local organisations have been awarded Charter status with an additional organisation working towards an award.

BUILDING A BETTER WORKFORCE

Mental Health First Aid is a nationally recognised training programme, providing a first aid approach to mental illness. A programme of training has been commissioned for front line staff across the council, equipping them with the knowledge and confidence to recognise signs of mental health problems, encourage someone to seek the right help and reduce the stigma around mental illness. Following MHFA training with staff from the Job Shop, a mental health professional was embedded into the team to mentor staff – helping them put their training into practice – while also reviewing how working practices could be adapted to make the Job Shop more welcoming for people experiencing mental health issues.

COVENTRY ON THE MOVE!

Coventry on the Move! is a local initiative that encourages people to take the first steps towards a more active lifestyle, focusing on activities that are enjoyable and easily incorporated into daily routines. The Coventry on the Move! team has been present at a number of local events including the Godiva Homecoming parade in August 2013, where passers-by were encouraged to try hula-hooping, skipping and hopscotch, and the Godiva Festival in July 2014, where over 1,500 people took part in skipping, hula-hooping or frisbee-ing. Participants were able to take their kit away with them so they could continue their activities at home.

The recently established Magic Mile event, held on the third Sunday of every month at Longford Park, is a 1-mile route where people of all ages and abilities are invited to get around the course in any way they can – walking, jogging, running, cycling or even on mobility scooters. The emphasis is on being outdoors and having fun with friends and family. Over 60 people took part in the first event. To encourage local residents to do more walking, route maps in printed and electronic formats have been produced for the city centre, Foleshill, Tile Hill & Canley, and Willenhall.

Employees in Coventry are being encouraged to be more active at work through Coventry Workplaces on the Move, which has included promoting active travel through the Rush Hour Challenge and encouraging people to compete against other local organisations by signing up to the Workplace Challenge.

COVENTRY TIME UNION

Coventry Time Union is a ‘time bank’ initiative that enables local people to support each other by exchanging time and skills. Members can offer one hour of whatever they wish to share with other members, and gain an hour of something in return. For example, a person could offer an hour of gardening and gain one Time Credit, which could then be used to get an hour of music tuition from another member. It is not an alternative to professional services, so personal care and childcare are not accepted, and participating does not affect taxes or benefits. Instead, it offers Coventry residents the opportunity to develop their existing skills, learn new ones and build social networks.

COMMUNITY WELLBEING PROJECT

Public Health commissions Valley House to deliver a project promoting wellbeing. In particular, this project works with grassroots community groups to encourage activity which promotes and uses the '10 Ways to Wellbeing' and to facilitate connections between them. To achieve this, the project helps grassroots groups understand the 10 ways to wellbeing and supports the development of new ideas to promote their use among the community; to help make this happen, Valley House also offer small 'seed' funding grants.

- #### CANLEY DADS KITCHEN GARDEN

  This is a new group involving Malaysian Muslim men who were meeting informally for coffee and a chat before the project but, with funding and support, now meet 2-3 times a week on a theme of growing food and cooking. The Dads have set up a WhatsApp group called ‘The Farmers’ to talk about the project and share photos of their progress.

- #### KNITTING NEEDLES

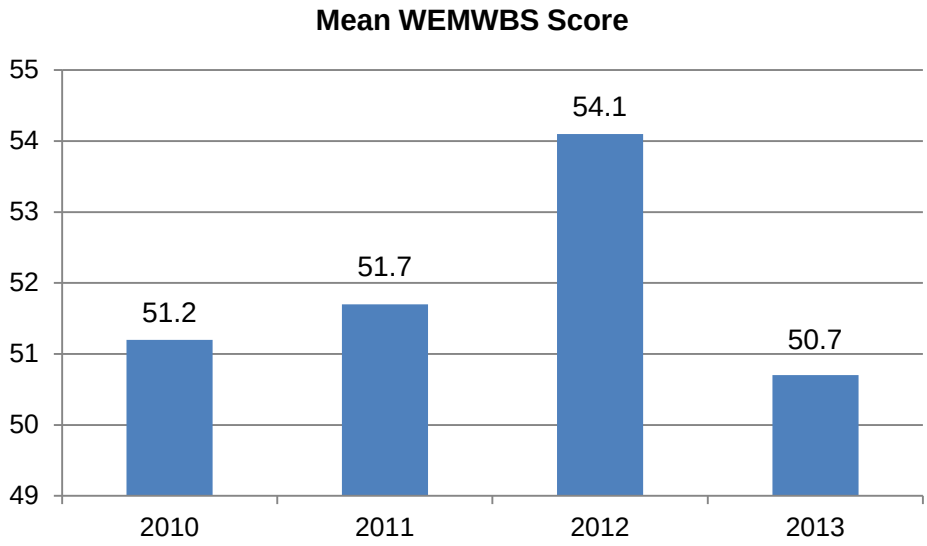
  This was an existing community based craft group which receiving funding for a lockable cupboard, patterns and wool, which has enabled the group to expand and take on new members unable to afford the equipment and have also run sessions on wellbeing. The sessions have led to 2 members joining a slimming class, one

member volunteering at a older people's home and improved wellbeing / informal care among themselves.

- TILE HILL YOUTH CAFÉ

  This is a new project which received support in initiating and shaping the group around wellbeing themes and also receiving funding for basic sports equipment and a juicer. The group has expanded to be running two sessions weekly for local children.

DATA AND STATISTICS



The Warwick-Edinburgh Mental Well-being Scale (WEMWBS) is a 14-question, validated scale used to measure levels of mental wellbeing and the Coventry Household Survey has measured this in its last 4 surveys. The average WEMWBS score in 2013 (50.7) indicates worse mental wellbeing compared to 2010 (51.2), 2011 (51.9) and 2012 (54). However the academics from Warwick University who analyse and interpret the survey data suggest that the result in 2012 is presumed to be higher due to "a systematic measurement bias" rather than being a "real" change in mental wellbeing.

WEMWBS item	*Proportion of respondents (%)*			Mean item score
	None of the time/ rarely	Some of the time	All of the time/ often	
I've been feeling optimistic about the future	21	41	38	3.2
I've been feeling useful	12	30	57	3.6
I've been feeling relaxed	18	38	44	3.3
I've been feeling interested in other people	16	33	51	3.5
I've had energy to spare	33	38	29	3.0
I've been dealing with problems well	8	33	59	3.7
I've been thinking clearly	5	23	72	3.9
I've been feeling good about myself	8	29	63	3.8
I've been feeling close to other people	9	27	64	3.8
I've been feeling confident	8	26	67	3.8
I've been able to make up my own mind about things	4	19	77	4.1
I've been feeling loved	7	21	72	4.0
I've been interested in new things	13	31	56	3.6
I've been feeling cheerful	6	28	66	3.8

The table above shows how Coventry residents responded to individual items on the WEMWBS scale in the 2013 Household Survey. Overall a relatively high proportion responded positively to most items, and a relatively low proportion responded negatively. However, there was less of a clear divide on some of the items. There was a more even mix of responses regarding feelings of energy and optimism, and items that described feeling relaxed, useful and interested in other people or new things also had a higher proportion of negative responses than other items. While this may indicate a tendency towards positive or neutral wellbeing states among the Coventry population, it also highlights possible areas of concern where additional support may be needed.

Sexual Violence

PRIORITIES IDENTIFIED IN 2012

- Improve quality of data collected
- Share aggregate data across partner organisations

TARGETS

- Reduce the number of sexual crimes

WHAT IS BEING DONE TO ADDRESS THIS ISSUE?

COVENTRY SEXUAL VIOLENCE NEEDS ASSESSMENT 2014

Coventry is experiencing significant sexual violence issues which results in longer term issues on child protection, mental health and vulnerable adults. A detailed health needs assessment was conducted in 2014 to examine the issue of sexual violence in Coventry and the effects on victims, determine what the gaps in service provision are and make recommendations to improve services through any future commissioning processes and to make recommendations to improve support and reduce sexual violence.

SEXUAL VIOLENCE SUPPORT SERVICE

The Sexual Violence Needs Assessment undertaken in 2014 informed the commissioning of the Sexual Violence Support service in 2015. The service is delivered by a specialist third sector organisations and provides a range of interventions to support victims of sexual violence, including:

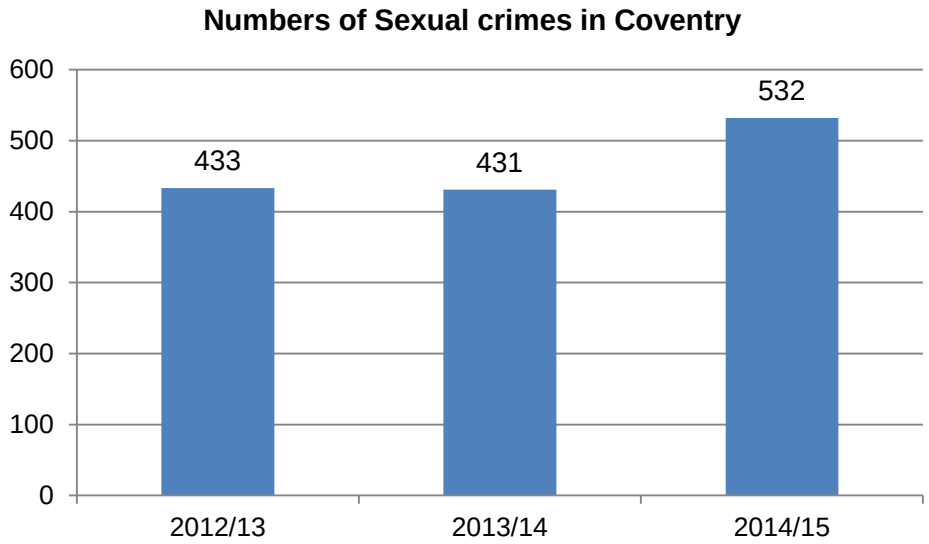
- Telephone helpline
- Website
- Counselling
- Therapy including Creative art therapy & play therapy
- Separate provision for Male support
- Specialist children's support
- Family support
- Independent Sexual Violence Advisors (ISVAs)
- Specialist support for vulnerable people including those with a Learning Disability and Mental Health condition
- Awareness raising of Sexual Violence & how to get support
- Sexual Violence prevention through education
- Targeted awareness raising at specific populations / communities such as non-English speaking and Black and Minority Ethnic and Refugees (BAMER)
- Support and signposting to other key agencies for additional, on-going, long term support such as mental health, substance misuse & therapy

Specific outcomes from this service include:

- Improved mental health outcomes for victims of sexual violence due to the provision and access of timely, appropriate long term support
- Prevention of sexual violence through education and awareness raising amongst young people and vulnerable people as to what is sexual violence and what is acceptable behaviour

DATA AND STATISTICS

REDUCE THE NUMBER OF SEXUAL CRIMES



The chart above shows an increase in reported and recorded sexual crimes. This is due to a range of potential factors, including the younger age profile of Coventry residents, as national evidence shows that younger people are at the greatest risk of sexual violence. In Coventry, 58.3% of people are under 40 compared to 50.1% in the West Midlands, which is partly due to the presence of two local Universities.

In addition, rising reports of sexual offences may be partly due to the 'Jimmy Saville' effect, with the revelations about high profile figures encouraging victims to come forward with crimes that previously went unreported.

Current provider data shows that there has been an increase in disclosures of historic abuse and this continued significant increase in calls to their helpline and counselling service as being correlated with post-Saville and the Police Operation Yewtree investigation.

Consequently, an increase in numbers can be seen as an improving situation and, it is not appropriate to conclude that actual abuse is increasing because the reported numbers are increasing.

Domestic Violence and Abuse

PRIORITIES IDENTIFIED IN 2012

- Raising awareness of domestic violence and abuse
- Providing services to support victims and children
- Supporting those who leave an abusive relationship
- Working with perpetrators to change behaviour
- One call to connect to all services

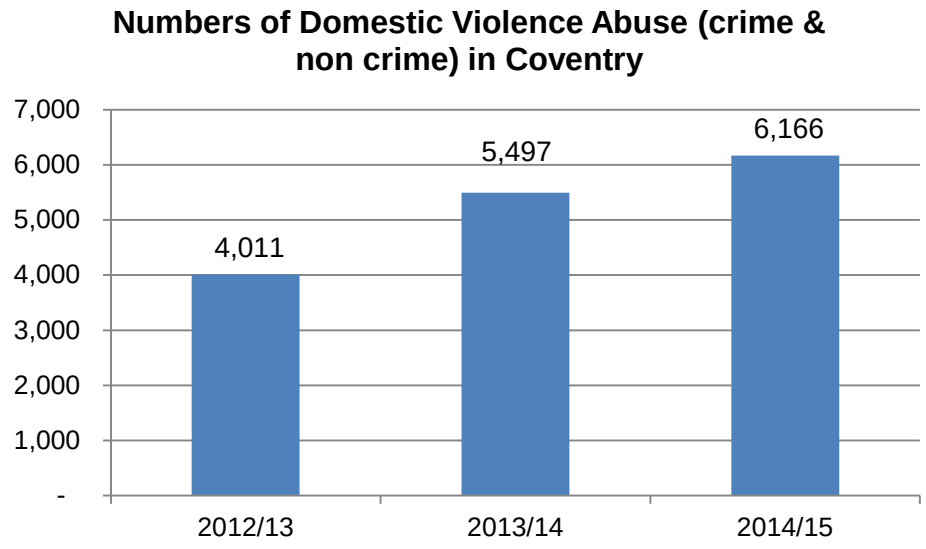
TARGETS

- Reductions in domestic abuse
- Improving child readiness for school

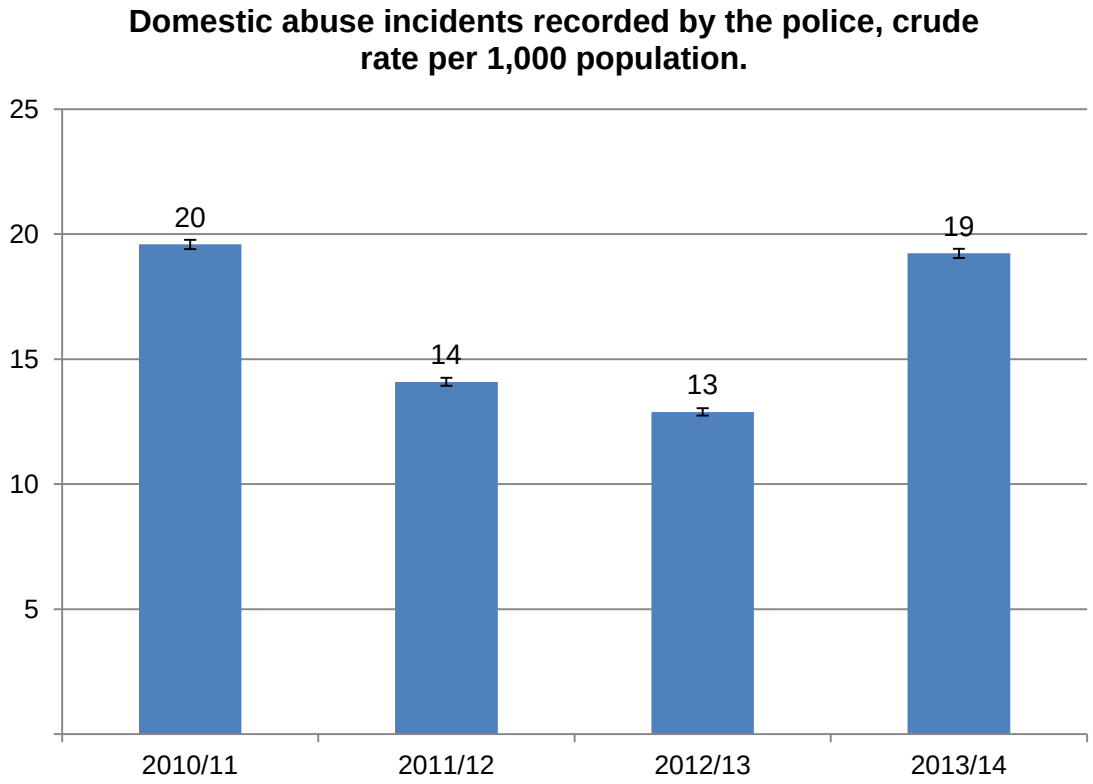
WHAT IS BEING DONE TO ADDRESS THIS ISSUE?

- Helpline, single point of access and victim community based support
- Victim supported accommodation
- Perpetrator services
- Children's services

DATA AND STATISTICS



The chart above shows a year on year increase in domestic violence abuse incidents (crime & non-crime) reported to Coventry Police. Increases are a result of improvements in identification and recording of incidents logs as well as a drive to encourage victims to report domestic violence abuse to the Police. It is acknowledged that domestic violence abuse is greatly under reported therefore increases are considered positive. Domestic violence abuse is a priority for the Police & Crime Board.



The chart above expresses this increase as a rate per 1,000 adult population sourced from the Public Health Outcome Framework.

Theme Three - Reduce variation

Smoking

PRIORITIES IDENTIFIED IN 2012

- Enforcement of tobacco control legislation
- Work with pregnant women and parents of young children who smoke
- Reduce the number of children who start smoking
- Identify smokers, make them aware of dangers, offer support in stopping
- Work with communities to identify opportunities to stop smoking

TARGETS

- Reduce smoking prevalence in 15 year olds
- Reduce smoking prevalence in over 18 year olds
- Increase numbers of 4 week quitters
- Increase numbers of 12 week quitters

WHAT IS BEING DONE TO ADDRESS THIS ISSUE?

COVENTRY SMOKEFREE STRATEGY

Coventry's Smokefree Alliance, a partnership of public, voluntary and private organisations, has produced a Smokefree strategy for the city with a renewed vision, a clear direction and the mandate to move forward ensure the people of Coventry make informed decisions about using tobacco products. We cannot afford to be complacent; we must continue to build upon the successes of the last 10 years and work together to reduce the number of people who smoke in Coventry

STOP SMOKING SERVICES

Stop Smoking services for the general population are widely available across the city, and can be accessed at more than 100 delivery points, including GPs, pharmacists and other settings.

Stop Smoking Services are commissioned in Coventry on a tariff system - rewarding providers for each smoker they help achieve a 4-week quit. Nationally and locally, around half of smokers who set a quit date go on to be abstinent at 4 weeks, and around half of those progress to be Smokefree three months after their quit date. We recognise that recovery from any addiction represents a journey punctuated by steps forward and relapse and we will commission Stop Smoking Services to improve longer term quit rates. Our current providers are:

- Coventry and Warwickshire Partnership NHS Trust – provides a stop smoking service for the general population mainly via GPs and community pharmacists
- Stop4Life – provides a stop smoking service for the general population which predominantly delivers via workplaces and community outreach
- University Hospitals Coventry and Warwickshire NHS Trust – provides a stop smoking services for the general population and predominantly delivers within the hospital
- Coventry and Warwickshire Partnership NHS Trust – provides a specialist stop smoking service for pregnant women
- A pilot scheme providing a harm reduction and stop smoking service for people with mental health conditions is currently being developed by Coventry and Warwickshire Mind
- To further support BME communities in the city to access these services, Foleshill Women's Training were commissioned to run a project from September 2012 – March 2013. The Health Support Workers raised awareness of the dangers of smoking (Paan and Shisha) and passive smoking during their outreach and reinforced key health messages. The providers also developed a BME-specific stop smoking resource booklet which includes information on all these tobacco related behaviours.

A new approach to target parents who smoke by working closely with primary schools and other services had recently been commissioned. The service will design and pilot approaches in a minimum of 10 schools to effectively engage with parents, deliver key smoking messages and support parents who smoke to access a cessation service. This service will:

- Promote smokefree parenting
- Identify effective ways of engaging with parents who smoke via schools to promote smoking cessation via effective self-help or connecting parents with stop smoking services
- Inform parents of the smoking-related messages provided in school to children

Services in Coventry are among the most effective in the country – in 2013/14, one in 16 smokers kicked the habit with the help of local services, compared to a national average of one in 28 smokers.

ILLICIT TOBACCO AND SMOKEFREE ENFORCEMENT

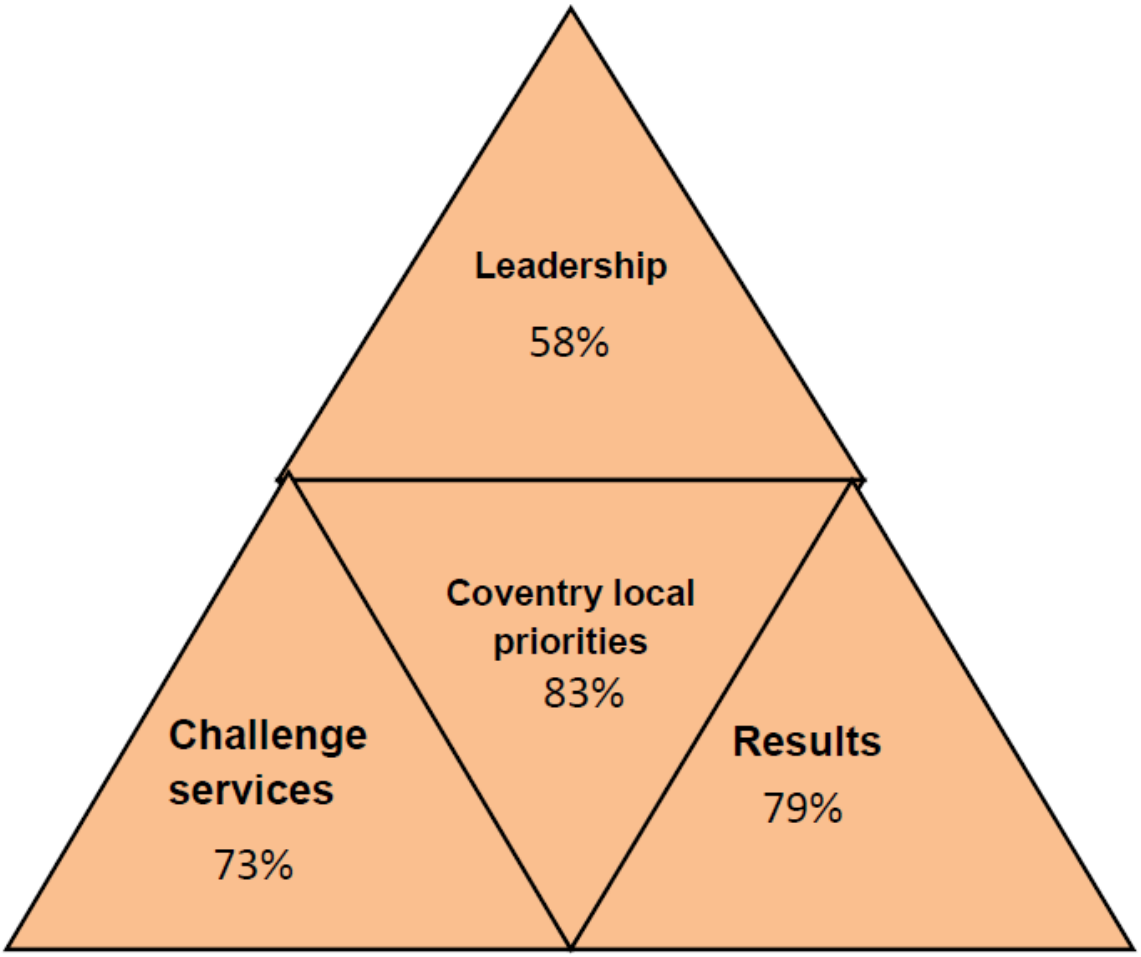
The Council's regulatory service is active in enforcement action against traders selling illicit tobacco, often smuggled into the UK without duty being paid, and maintains a high level of compliance of the indoor smoking ban across the city. Several traders selling illicit tobacco have been prosecuted and hundreds of thousands of pounds of smoking products have been seized.

More areas are becoming 'smokefree' - all city primary schools have signed up to the Alliance's smokefree school gates scheme and UHCW went smokefree in 2015, with CWPT scheduled to adopt a similar smokefree policy in summer 2015.

PEER ASSESSMENT FOR EXCELLENCE IN LOCAL TOBACCO CONTROL

A CLeaR peer assessment is an improvement tool which provides local government and its partners with a structured, evidence-based approach to achieving excellence in local tobacco control.

The model comprises a self-assessment questionnaire, backed by challenge and assessment process from a team of expert and peer assessors. The purpose of the assessment is to provide objective feedback on performance and local strategies and suggest ways for further improvement.



Coventry scored well in 3 of the 4 areas of the evaluation. In the area of leadership the evaluation noted

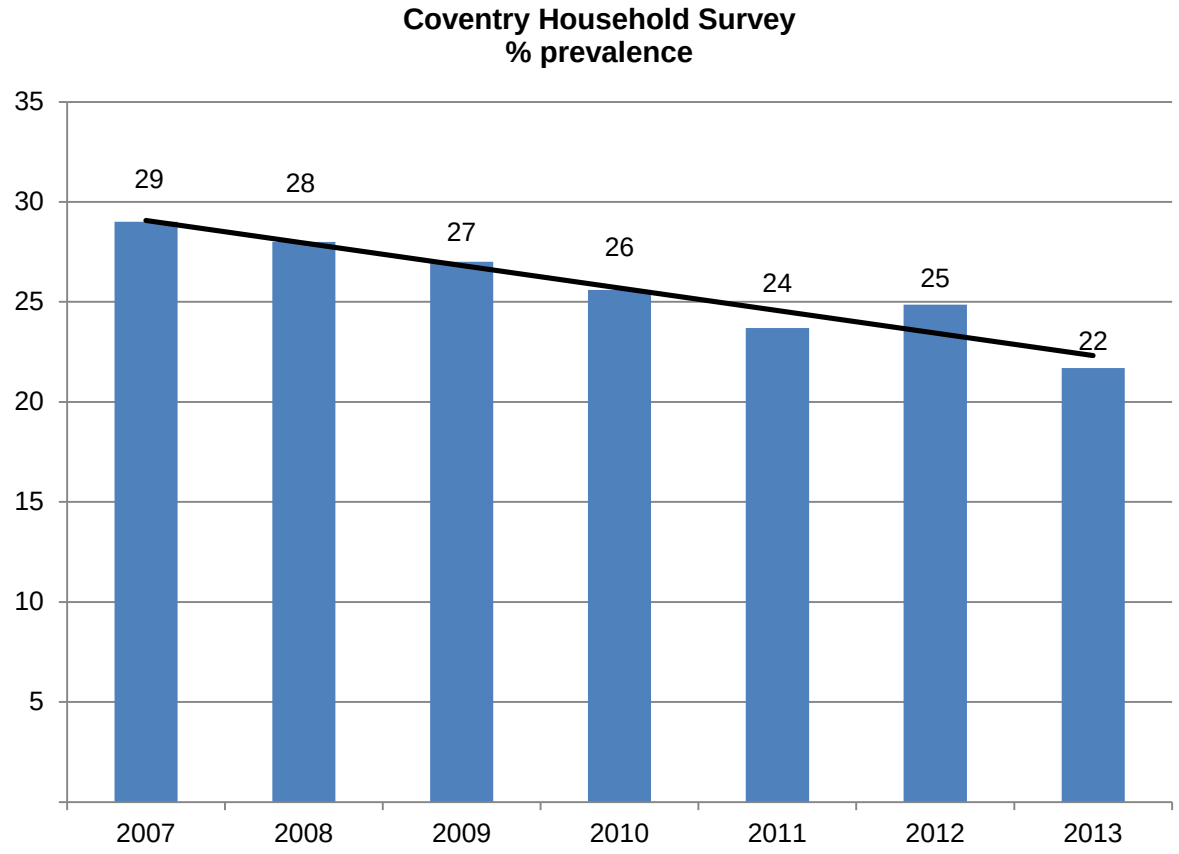
- The reduction in the hours of the Tobacco Control Co-ordinator from full-time to part-time
- The former Tobacco Control Strategy had now expired
- No formal Tobacco Control Communications Plan for Coventry
- Smoking prevalence in Coventry has fallen substantially over the last decade; however smoking rates remains high amongst the more deprived socio-economic groups. Specific interventions targeting this group will be needed in order to reduce smoking prevalence amongst routine and manual smokers
- A stronger relationship could be developed with clinical leaders in Coventry, including the CCG including the identification of Smokefree Clinical Champions
- It is evident that there is some excellent work being done across a variety of areas. However, it is difficult to assess the quality and impact of some of the work due to a lack of evaluation

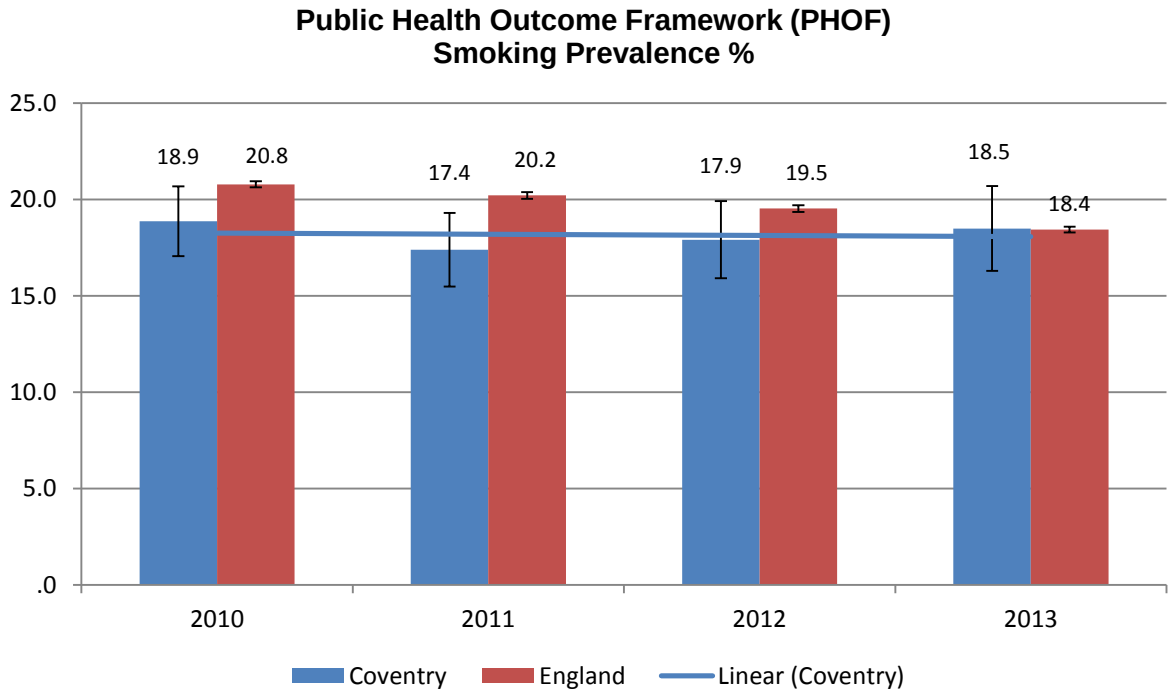
DATA AND STATISTICS

REDUCE SMOKING PREVALENCE IN 15 YEAR OLDS

Coventry Children and Young People's Survey	% Ever smoked a cigarette	% Smoke Regularly
2013	19	1
2008	25	3

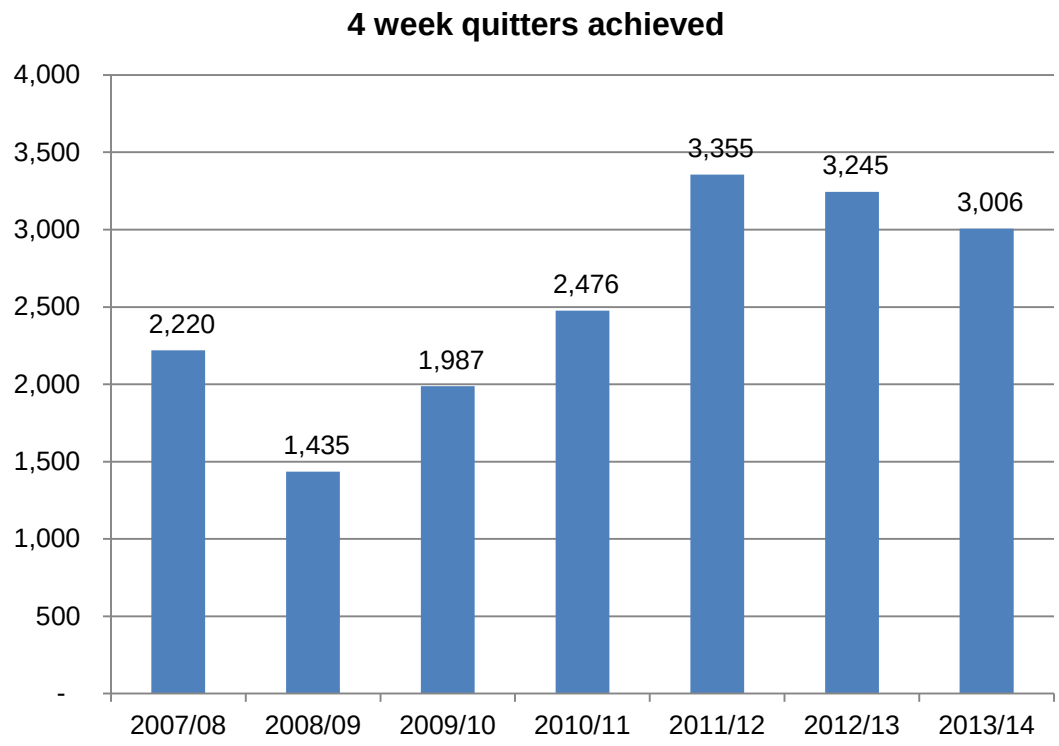
REDUCE SMOKING PREVALENCE IN OVER 18 YEAR OLDS





The two charts above show differing pictures of smoking prevalence in Coventry. The Coventry Household Survey (HSS) shows higher overall reported prevalence than that from the Public Health Outcomes Framework (PHOF) – but it is thought that all surveys of smoking behaviour underestimate smoking prevalence – so possibly the Coventry HHS is more accurate. The HHS data shows a decrease in prevalence over time – although this is right at the edge of being statistically significant from 2012 to 2013. This means that while the probability of this **not** being a real decrease is high, it might still be a statistical error. The PHOF data shows no significant decrease either – but the probability of it not being real is greater.

INCREASE NUMBERS OF 4 WEEK QUITTERS



The main reason for the falling numbers of 4 week quitters is that the marketplace has significantly changed in the last few years with the emergence of e-cigarettes; nationally there is also a reduction of smokers engaging with stop smoking services for the same reason.

INCREASE NUMBERS OF 12 WEEK QUITTERS

The numbers for 12 week quitters are not published in the Public Health Outcome Framework. This is because they have been seen to largely duplicate the pattern of 4 week quitters. There are fewer 12 week quitters than 4 week quitters but when used to compare place to place and compare over time as above, the overall pattern remains the same.

Alcohol

PRIORITIES IDENTIFIED IN 2012

- Develop an alcohol harm reduction strategy and supporting action plan
- Raise awareness of the harms of alcohol, help people know safe limits and stick to them
- Work with licensees and the alcohol industry to promote a culture of safe drinking

TARGETS

- Reduce alcohol related crime and anti-social behaviour
- Reductions in alcohol related admissions to hospital
- Reductions in mortality from liver disease
- Reductions in crime and domestic abuse

WHAT IS BEING DONE TO ADDRESS THIS ISSUE?

COVENTRY ALCOHOL STRATEGY 2013

The Coventry Drug and Alcohol Steering Group is responsible for the development of the Coventry Alcohol Strategy 2013 which brings together the activity which seeks to deliver the priorities for alcohol set by both the Health and Wellbeing Board and the Police and Crime Board.

Activities commissioned under the strategy include

- Alcohol Liaison Nurse Service at University Hospital Coventry and Warwickshire (UHCW)
- Creation of alternatives to structured treatment, including self-help and computer assisted therapies, e.g. Breaking Free, and access to mutual aid
- Review pathways between mental health and alcohol treatment services and other alcohol-support services
- Develop linkages between treatment services, criminal justice services and others with the aim of improving Coventry's response to domestic abuse and violence
- Late night, city centre Alcohol Triage Service to prevent ambulance call outs and A&E attendances for minor injuries on a Friday and Saturday night
- Involvement and Advocacy Service for service users, ex-service users and recovery champions so they can continue to work with clients, staff and the public in changing attitudes and behaviour
- Promote the use of Identification and Brief Advice (IBA) in a range of primary care settings, e.g. by working with the Police, Fire Service, nurses, healthcare assistants, pharmacists
- Targeted work with pregnant females to promote message of abstinence or low risk drinking during pregnancy

- Work with street drinkers and homeless people to try and motivate them to engage with treatment and support services
- Review the number and type of alcohol licences in key locations to identify if further licencing control is needed in line with the licensing objectives
- Trading Standards to undertake intelligence led, underage test purchasing exercises for alcohol and take appropriate action where necessary

TREATMENT SERVICES

Public Health also commission a number of evidence based services that deliver prevention, advice, treatment, support, advocacy, training, communications / marketing and service user involvement, including:

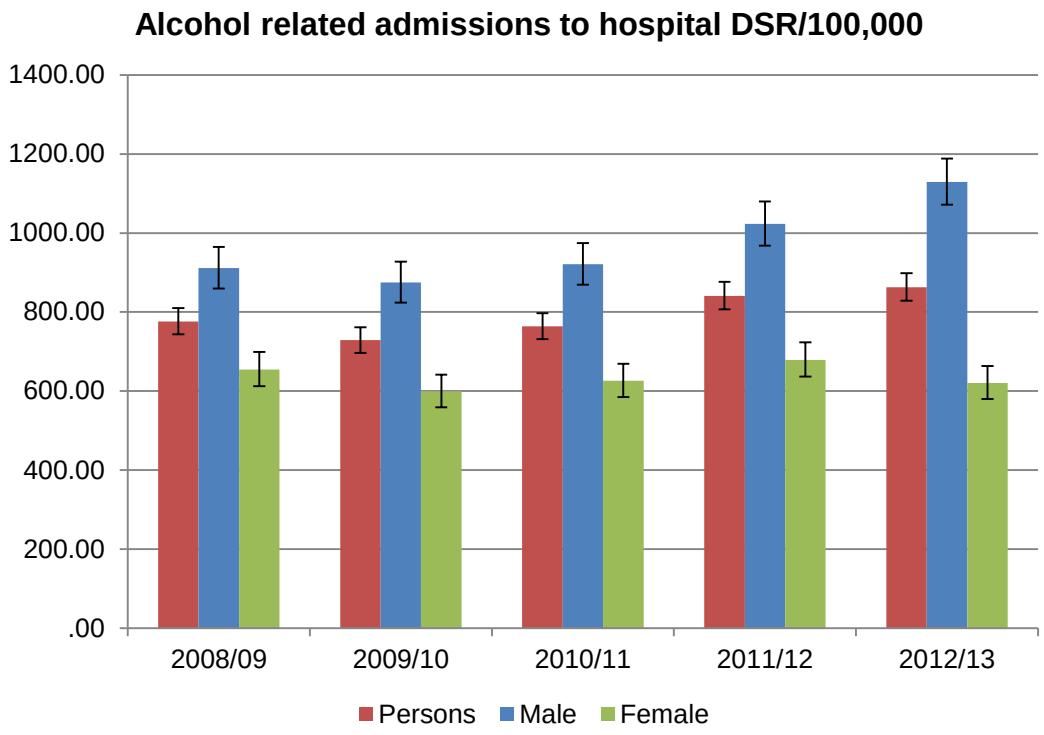
- Drug and alcohol treatment service commissioned with Warwickshire County Council
- Independent living service
- Service user involvement scheme
- Late night triage service
- Identification and brief advice in primary care
- Residential rehabilitation placements

DATA AND STATISTICS

REDUCTIONS IN DRINKING IN COVENTRY

- Coventry Household Survey - all persons drinking 5+ days down from 8.4% in 2009 to 4.7% 2013
- Coventry Household Survey - all persons drinking more than recommended amounts on 4+ days down from 7.4% in 2009 to 5.6% in 2013

ALCOHOL RELATED ADMISSIONS TO HOSPITAL



The chart above shows that in Coventry whilst the rate of alcohol related hospital admissions for women has remained constant since 2008/09, the position for men and a result for persons is significantly worse in 2012/13 than it was in 2010/11 – latest available figures.

MORTALITY FROM LIVER DISEASE

Mortality from liver disease overall and from liver disease considered preventable show an absolute reduction for men from the period 2010-2012 to 2011-2013 for women the position is reversed showing a small increase. However, the small numbers of actual cases in Coventry and the statistical methods of compiling these numbers mean that this pattern is not statistically significant and may be due to statistical error.

DOMESTIC VIOLENCE

This is a cross-cutting theme and has been considered in its own section above.

ALCOHOL RELATED CRIME AND ANTI-SOCIAL BEHAVIOUR

The British Crime Survey (2013/14) states that 53% of violent incidents involving adults were alcohol-related. However, local recording of whether Police Officers consider alcohol to have been involved in a reported crime is inconsistent and thought to be under-reported – locally as few as 8% are recorded as such. Consequently, while this indicator is recorded locally it is not felt to be a reliable reflection of the amount of crimes where alcohol has been involved.

Infectious Diseases

PRIORITIES IDENTIFIED IN 2012

- Flu – Vaccination each year is successful in reducing deaths from flu and the aim is to increase this for those at risk of complications from flu and those who work with them
- Tuberculosis – increase awareness of TB in communities most at risk and offer early screening to detect illness and reduce infection
- HIV – promote safe sex through education and easy access to services. Increase early detection through increasing HIV testing in the general population.

TARGETS

- Fewer deaths caused by flu through increased immunisation
- Earlier detection of TB, HIV and other infectious diseases, leading to improved health for those who live with the disease
- Reduced number of new cases of HIV and TB through reducing transmission

WHAT IS BEING DONE TO ADDRESS THIS ISSUE?

LOCAL SEASONAL FLU CAMPAIGNS

Local seasonal flu campaigns have been run every year, making a wide range of promotional resources available to partners across Coventry and Warwickshire. A detailed review and evaluation of the campaign run in 2013/14 was conducted by Coventry University (commissioned by Public Health) which included interviewing practice managers and GPs from practices with both highest uptake and lowest uptake, as well as midwives and heads of midwifery across Coventry and Warwickshire. Recommendations from this are being implemented.

A Coventry University PhD student will be working with Public Health to examine interventions seeking to increase uptake of seasonal flu vaccination in pregnant women.

TUBERCULOSIS

A multi-agency local TB programme board has been established, in line with the national TB strategy published in January 2015, which is focusing on 10 evidence-based areas for action identified in the national strategy. As part of this, a rolling programme of TB awareness-raising (related specifically to the recognition of symptoms of active TB) is being put together.

Coventry Rugby CCG has been identified as an area of high incidence of TB and eligible for new NHS England funding to establish a new entrant latent TB screening programme from 2015/16 onwards.

HIV

A point of care HIV testing pilot in primary care started on 1st May 2015 (to run for a year), involving 10 GP practice sites in high prevalence areas in Coventry

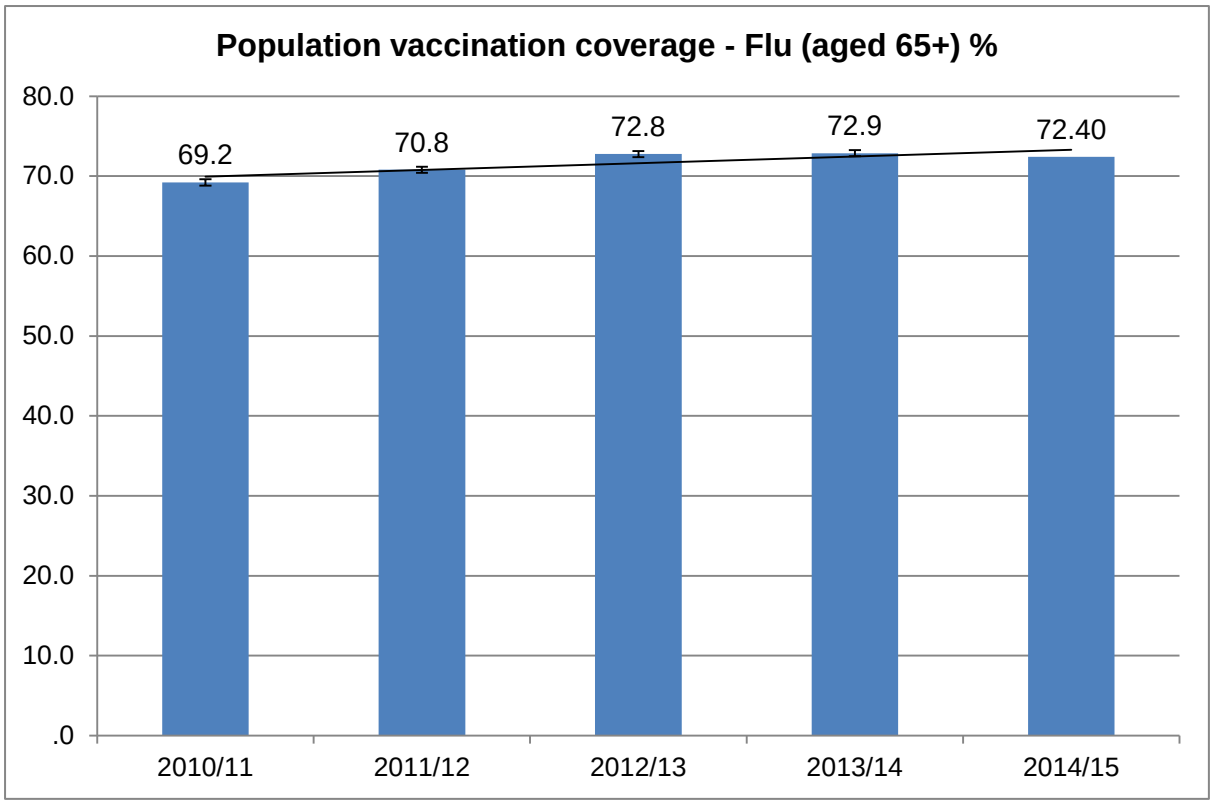
A community organisation grant scheme was established in 2014/15, which involved raising awareness, busting myths and reducing the stigma associated with HIV and the facilitation of access to HIV testing.

91 volunteers were recruited as part of this grant programme and 9 condom distribution schemes were set up in African Barber shop settings, where on-going promotional work is taking place.

A new sexual health programme board has been convened to oversee the above work as part of the wider sexual health agenda.

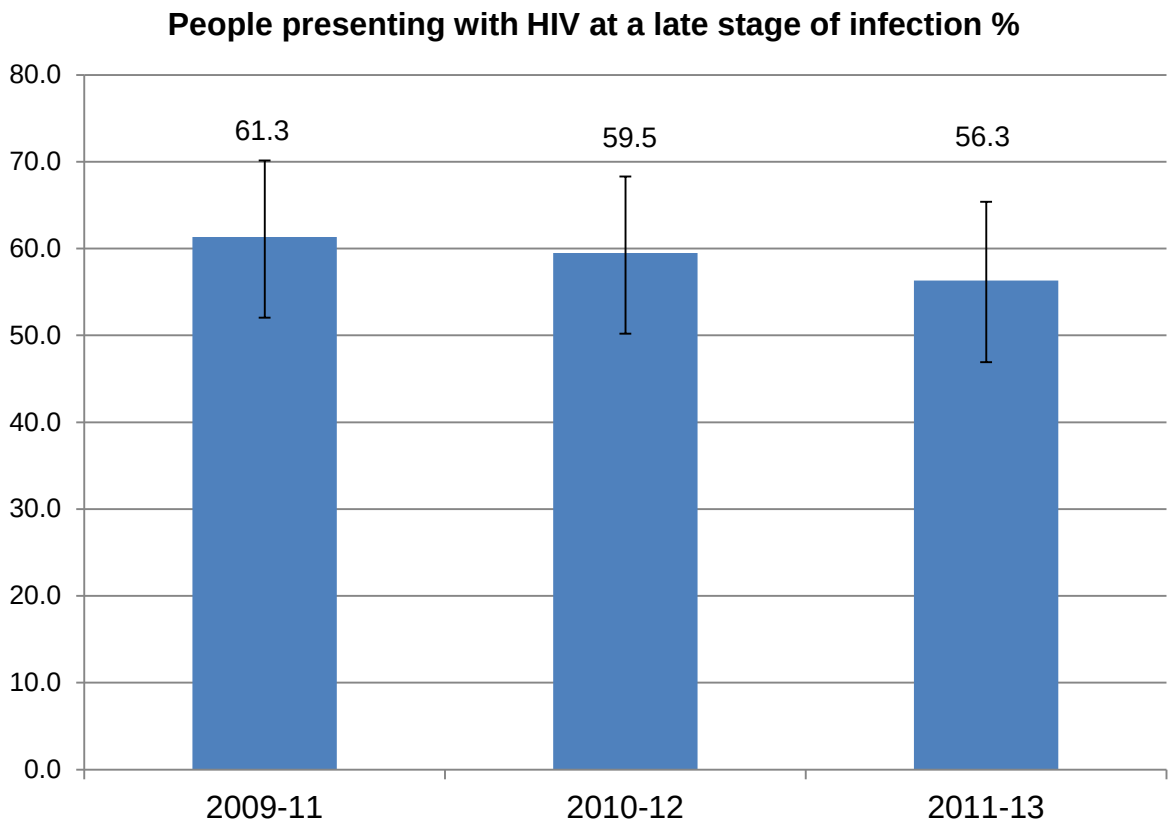
DATA AND STATISTICS

FLU VACCINATION



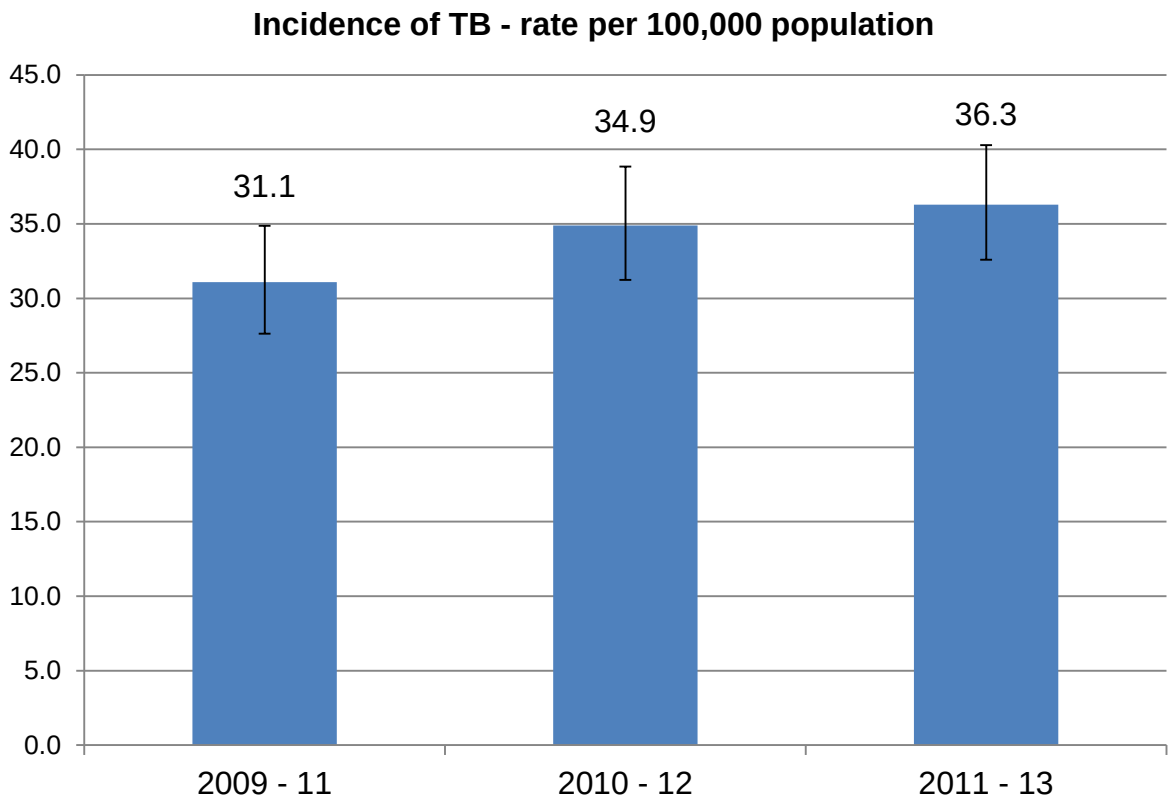
Although there have been increases in vaccination uptake in people aged 65 and over, this has now plateaued. In 2014/15 54% of GP registered patients in clinical risk groups under the age of 65 were vaccinated compared to 57% in the same period in 2013/14. For pregnant women, 47.5% were vaccinated in 2014/15 compared to 44.2% in the same period in 2013/14 in the CCG area.

EARLY DETECTION OF HIV



Despite showing a downward trend, which is encouraging, the change over time in late presentation of HIV cannot be said to be statistically significant due to relatively small numbers of cases. Coventry remains to have the highest prevalence of HIV in the West Midlands.

INCIDENCE OF TB



Despite showing an upward trend over time this cannot be said to be statistically significant due to relatively small numbers of cases. Coventry has the 3rd highest incidence of TB in the West Midlands behind Birmingham and Sandwell.

Theme Four - Improve Outcomes

Cancer (for year 1)

PRIORITIES IDENTIFIED IN 2012

- Help people to understand the causes of cancer –particularly those which can be altered such as smoking, alcohol and bad diet – and help them to find support to change their lifestyle.
- Help people to recognise early signs and symptoms of common cancers
- Faster access to cancer screening, diagnosis, referral and treatment
- Change services to make sure they meet the needs of the patient
- Targeting communities where cancer outcomes or the use of screening services are particularly poor.

TARGETS

- Increase 1 year survival rate for all Cancers over the next 3 years to the level of the best in England
- Reduce variation in uptake of all cancer screening programmes across the City and ensure uptake matches the best in England
- Reduce prevalence of smoking in the City to no more than the England average

WHAT IS BEING DONE TO ADDRESS THIS ISSUE?

COVENTRY CITY COUNCIL/MACMILLAN PARTNERSHIP

The Partnership agreed 4 aims at the outset:

- To improve the accessibility and coordination of services
- To remove barriers between services
- To fill in gaps in provision
- To inspire and empower people

In order to achieve these aims a range of activities have been set in train.

- City-wide audit of information and advice provision
- Boots Macmillan Information Pharmacists (BMIP) - volunteer Pharmacists who undertake bespoke Macmillan training to help support and signpost customers affected by cancer. Now 12 BMIPs across the City with the ambition being to have one in every Boots store.
- Library Information - work within the Library service to develop 4 information access points within the city's libraries. Macmillan is funding a temporary (18 months) project manager to develop this service.

CITY COUNCIL SUPPORT TO EMPLOYEES AFFECTED BY CANCER

- Macmillan learning and development activities for line managers, Occupational Health, Human Resources and Trade Union representatives
- Re-branding and re-launching the Cancer Buddy Scheme
- Bite-size e-learning for line managers
- Research into employee experience in the workplace funded my Macmillan

LEARNING AND NETWORKING EVENTS

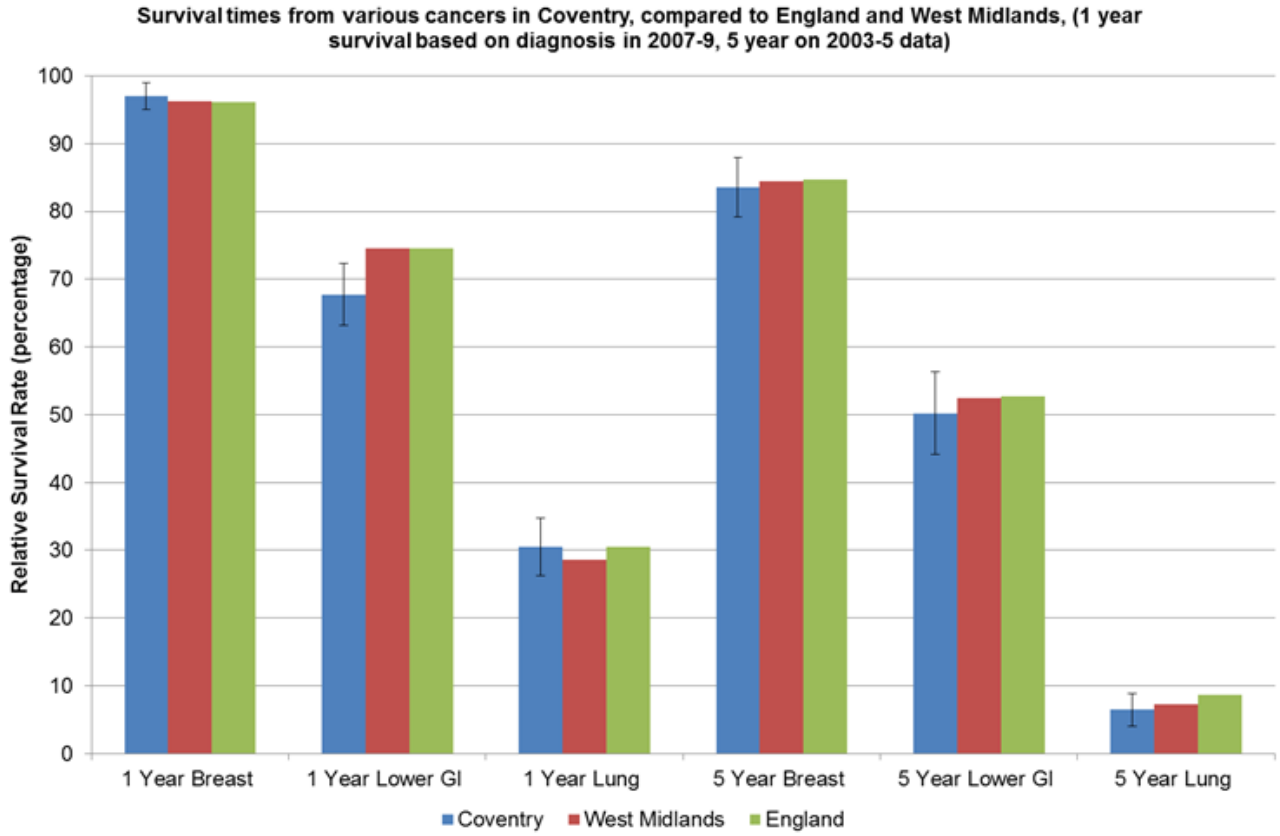
Macmillan has delivered a rolling programme of learning and networking events across the NHS, Social Care and third sector to improve individual and organisational understanding of roles, remits and referral pathways.

DATA AND STATISTICS

SURVIVAL RATES FOR CANCER

Data for survival at 1 year and 5 year post diagnosis for Cancer has not been updated since 2012 so it is not possible to determine progress on this target. The table and chart below show the latest data to 2012.

		One-year relative survival			Five-year relative survival		
		Diagnosed 2007-2011, followed up to end 2012			Diagnosed 2003-2007, followed up to end 2012		
		Rate	LCI	UCI	Rate	LCI	UCI
Males	Colorectal	72%	68%	76%	48%	43%	53%
	Lung	29%	25%	33%	5%	3%	7%
	Prostate	97%	96%	99%	90%	86%	93%
Females	Colorectal	71%	67%	76%	55%	49%	61%
	Lung	31%	26%	35%	9%	6%	13%
	Breast	97%	95%	98%	83%	80%	86%



REDUCE SMOKING PREVALENCE IN OVER 18 YEAR OLDS

As this is a cross cutting issue the topic of smoking reduction is covered in the smoking section above.

CERVICAL CANCER SCREENING

The percentage of women in the target age group who have been screened in the last five years has increased from 71.5% in 2012/13 to 76.6% in 2013/14

Variation in Primary Care

PRIORITIES IDENTIFIED IN 2012

- Setting and monitoring Primary Care Standards
- Establishing robust medical appraisal systems
- Informing patients about practice performance
- Managing long –term conditions more at home and with self-management

TARGETS

- Reduce unnecessary A&E Visits, inpatient admissions and hospital based outpatient appointments
- Increase uptake of specialist care and activity in the community and support patient self-management through promoting access to disease-specific education and exercise programmes
- Increase uptake of Primary Care based screening and immunisation programmes
- Reduce deaths at an early age where prevention, early detection and treatment can be effective.

WHAT IS BEING DONE TO ADDRESS THIS ISSUE?

PRIMARY CARE QUALITY GROUP

The Primary Care Quality Group was established in 2014 at the request of the Health and Wellbeing Board to work in partnership to develop and implement an action plan to improve the quality of primary care and reduce inequalities in primary care. Members of the Primary Care Quality Group include Public Health, Coventry and Rugby Clinical Commissioning Group, the NHS England Area Team, Healthwatch Coventry, the Local Medical Committee, the GP Alliance and the Local Pharmaceutical Committee. The work of the group and its wider partners to date has included:

- The collaborative production of the 2014 Director of Public Health's Annual Report 'Primary care at the heart of our health', which aimed to celebrate the progress and achievements of primary care in Coventry, as well as to ensure that primary care can adapt to the challenges of the future.
- The development of an NHS England Area Team dashboard to set and monitor primary care standards, provide feedback to GP practices, to identify and manage performance, to learn from others and identify good practice.
- The development of a Coventry and Rugby CCG dashboard to show where practices sit on a range of indicators relative to others. This will be available for both practices and the public to view, to enable patients to make informed choices about the practice they belong to and to encourage improvement in practices.

- The development of an online directory to provide an overview of community initiatives and lifestyle services within Coventry.
- Organisation of workshops and development of a Coventry and Rugby CCG primary care strategy to ensure the primary care system that is fit for the future.
- Support to the Coventry GP Alliance to protect, improve and enhance primary care in the city. In 2015, the GP Alliance was successful in securing funding from the Prime Minister's Challenge Fund for their bid 'Best Care, Anywhere: Integrating Primary care in Coventry'.
- Engagement with patients and recording of patient views to influence the future vision of primary care in Coventry and to help define a bench mark for good quality GP services in the city.
- The exploration of asset-based development approaches to encourage and empower people to have a greater role in managing their own health.
- Taking forward the recommendations from the Pharmaceutical Needs Assessment as approved by the Health and Wellbeing Board in February 2015. To ensure pharmacy provision is adequate in the city and to ensure people are enabled to access the appropriate service for their needs.
- Research into the issues affecting recruitment and retention in general practice and recommendations for further action.

URGENT CARE BOARD

The Urgent Care Board (which reports to the Health and Wellbeing Board) has placed a focus on unnecessary A&E Visits, inpatient admissions and hospital based outpatient appointments. To this, the NHS Coventry and Rugby CCG produce and distribute a detailed weekly monitoring dashboard and the Board has been analysing data on frequent attenders at Accident and Emergency Departments who are self-referrals who are subsequently discharged with GP follow up treatment or no follow up treatment.

IMMUNISATION

In 2008/2009 Coventry Primary Care Trust was one of the poorest performing PCTs for the uptake of childhood immunisations outside of London. A shared vision was embedded with NHS Coventry's Primary Care Strategy to improve immunisation uptake rates. A number of initiatives were undertaken in partnership with key stakeholders, including:

- commissioning a data cleansing exercise with GP practices and the Child Health Information System,
- workshops for practice nurses highlighting best practice,
- the development of a 'Top Tips' sheet for all practices with information on what works in improving immunisation uptake,
- a review of the needs of the workforce in relation to capacity, roles, responsibility and training, and
- the development of a database system.

Coventry GPs are now amongst the best performing in the country for immunisation uptake. The immunisation rates have continued to improve since December 2009 and should be sustainable given the development work that has been undertaken and embedded.

DATA AND STATISTICS

In 2014, the Primary Care Quality Group contributed to and commented on the Director of Public Health's 2014 Annual Report, Primary Care at the heart of our health. The recommendations from the report have effectively superseded the targets and objectives set by the Health and Wellbeing Strategy 2012.

- supported approximately 3,000 smokers to quit within 4 weeks in 2014/15
- In 2014/15, approximately 11,000 people completed a health check and of these, 5.5% were subsequently placed on disease risk registers and 16% referred to an appropriate lifestyle service.
- This was an increase of 15% compared to 13/14, which in itself was an increase of 100% compared to 12/13.
- 91 community pharmacies offer a good level of provision of pharmaceutical services across Coventry
- Cervical screening: the percentage of women in the target age group who have been screened in the last five years has increased from 71.5% (2012/13) to 76.6% in 2013/14
- MMR: the percentage of children receiving their second dose by age 5 has increased from 74% (2012/13) to 93% (2014/15)
- DPT (diphtheria, pertussis (whooping cough), and tetanus) The percentage of children receiving DPT booster aged 5 has increased from 76% (2008/9) to 95% (2014/15).

Lifestyle Risk Management (Making every contact count)

PRIORITIES IDENTIFIED IN 2012

- Large number of staff in a range of areas having received MECC - starting with NHS, CC and V&CS

TARGETS

- Increase in persons accessing services which support lifestyle change

WHAT IS BEING DONE TO ADDRESS THIS ISSUE?

MAKING EVERY CONTACT COUNT (MECC)

The aim of MECC training is to provide all frontline staff with the skills and relevant information to raise the discussion around a healthy lifestyle, signposting towards information to change behaviour or referring to services when required.

The training encourages staff to have a short conversation about healthy lifestyles which should

- Take 30 seconds or longer
- Follow a simple structure
- Be supportive
- be encouraging
- Provide information including signposting to other services when appropriate

The focus is on help with

- stopping smoking
- alcohol intake
- being active and
- eating well

In addition the programme has been adjusted to include The 10 Ways to Wellbeing

The programme has been delivered to a wide range of partners in the City including

- Coventry and Warwickshire Partnership Trust – with a focus on Mental Health and Learning Disabilities – and rolled out to other providers
- University Hospitals Coventry and Warwickshire NHS Trust
- MECC in the Community – training champions to cascade
- Coventry City Council – working with front line services e.g. contact centre, job shop, park wardens
- Other public services – PCSO's, HA's Fire Services

SINGLE POINT OF ACCESS

A new website www.coventry.gov.uk/healthylifestyles has been developed to provide easy access to the resources which can support the delivery of MECC – and putting all of the information anyone needs who might wish to make a difference to their own health. It provides links to

- A Healthy Lifestyle Checker
- Heart Age Checker
- A directory of Healthy Lifestyle services
- A list of NHS recommended mobile apps

The site also links to a range of information about specific services such as

- Alcohol, drugs and substance misuse
- Health advice, screening and vaccinations.
- Healthy weight
- Physical activity
- Local activities you can take part in.
- Mental wellbeing
- NHS Health Checks
- Stop smoking
- Sexual health and contraception and
- Pregnancy

DATA AND STATISTICS

MAKING EVERY CONTACT COUNT (MECC)

Face-to-face training					
Year	**NHS**	**City Council**	**Other Public Services**	**Voluntary Sector/Other**	**TOTAL**
2012/13	536	82	210	975	**1,803**
2013/14	1,749	242	17	33	**2,041**
2014/15	8,137	341	33	88	**8,599**
TOTALS	10,422	665	260	1,096	**12,443**
Online training					
2010 to date	65	97	0	1	**163**

Prioritisation Matrix

As part of the JSNA Review process, a prioritisation matrix has been developed to evaluate the level of 'need' and strength of evidence behind the range of suggested priority topics.

There is no single 'best' way of prioritising inherently complex and varied health and wellbeing issues and any such process involves a certain degree of subjectivity. However, the matrix introduces objectivity, robustness and transparency into the process so that stakeholders can hold more informed discussions on what should be the key focus of Coventry's JSNA.

The table below outlines the key criteria to be used to assess each topic against, with a 'high', 'medium' or 'low' scores being given for each particular criterion.

Criteria	**Red** **3**	**Amber** **2**	**Green** **1**	**White** **0**
Magnitude/size of population affected	Topic covers an estimated 'in need' population (>25,000 people)	Topic covers an estimated medium sized 'in need' population (10,000 -24,999 people)	Topic covers an estimated small 'in need' population (<10,000 people)	-
Trend	Available evidence suggests rapidly worsening situation over time.	Available evidence suggests worsening situation over time.	Available evidence suggests situation has remained stable over time.	Available evidence suggests improving situation over time
Benchmark against England/West Midlands/ONS 1.2	Available evidence suggests very high prevalence relative to comparator areas	Available evidence suggests above average prevalence relative to comparator areas	Available evidence suggests prevalence in-line with comparator areas	Available evidence suggests relatively low prevalence relative to comparator areas.
What is the scale of inequality?	Persistent, wide scale geographic and population-based inequalities are clearly apparent.	Some notable geographic or population-based inequalities are apparent.	Some minor inequalities exist	No evidence of inequalities
What is the current annual spend on this area in Coventry? Is this an area of potential savings?	High annual spend (multi millions of £) /high potential area of saving	Medium level of spend (c.£5 million) / some efficiency saving possible	Low level of spend (<£1million of spend)/ little opportunity for efficiency savings	-
Is there an opportunity for the H&WB Board to take action in relation to this issue? What evidence is there that the scale or impact of the issue can be effectively reduced?	Yes	Maybe	No	Cannot be determined

Criteria	**Red** **3**	**Amber** **2**	**Green** **1**	**White** **0**
Does the issue have early intervention implications?	Clear, demonstrable evidence that there is a strong case for early intervention.	Some evidence which highlights areas suitable early intervention.	Weak evidence that the topic has areas suitable early intervention.	No evidence to suggest that the topic contains areas suitable early intervention.

Coventry Health and Wellbeing Board
19th October 2015

What role should the HWBB play in a systems approach to a healthy Coventry?

Applying Collaborate's work on systems change and collaboration in Coventry

Sarah Billiald
Saira George

www.collaboratei.com

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A bit about **Collaborate**? Building cross sector collaboration in the delivery of better services to the public

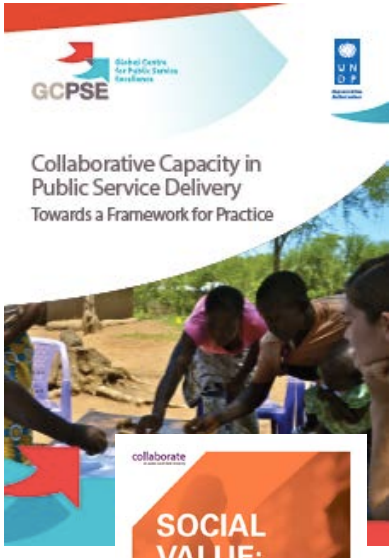
Collaborate CIC is an independent policy and practice hub based at London South Bank University. We were established in 2012 to support the development of collaborative models of public service delivery - helping leaders to work better across sectors for the benefit of citizens.

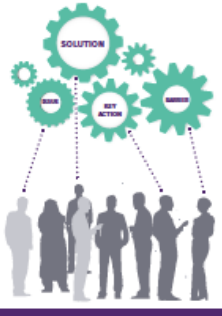
We are chaired by Lord Victor Adebowale CBE, and are governed by a board drawn from across the public, social and business sectors. Henry and Sarah are the two senior executive directors, running the business day to day.

Our work starts from the premise that today's complex problems need a more adaptive and collaborative approach - and we work with our partners to develop thinking, culture and practice to address this. We start with the needs of the citizen (or service user), involve them in coproducing and co owning the solutions in their communities.

We are currently working in a across the UK to support public service partners to deliver better services to the public in the context of austerity, devolution, changing demographics and rising expectations. We are also leading a Commission on “place-based health” to explore what an approach to health would look like that put place, people and outcomes above institutions, sectors and silos.

We have just completed a piece of work in Coventry, funded by Lankelly Chase, on systems change and collaboration for those facing multiple complex needs. We believe the nine preconditions for systems change we have developed in Coventry could be helpful in reconceptualising the role of the HWBB.





An overview of our proposed approach with HWBB

Our understanding is that Coventry HWBB is at a pivotal point in its development – a new Chair, a review of the three year strategy, a discussion on priorities based on JSNA all catalysts for this discussion. Devolution and the Marmot review providing crucial backdrops to much of your thinking.

Our work both with Coventry on systems change but also leading a Commission this Autumn on "place-based health" has shown us that taking a systemic approach to any transformation is critical and that combination of System Preconditions and then Collaborative Delivery are crucial.

Some money has been allocated (as follow on from our initial work funded by Lankelly Chase) that allows us to work with you to apply the thinking we did in develop our preconditions for systems change (see next slide) and support you to think through your role in enable a systemic approach to health which has a focus on delivery (not just nice conversations and relationships which we know are good and in place).

We suggest a 4 step process:

1). Consider the preconditions framework (slide 4) and the extent to which those preconditions are present in your system. Using this to agree the vision, principles, priority outcomes, and any supporting infrastructure (November)

2). Work together to apply the collaborative delivery framework (slide 7) to HWBB remit and consider therefore what your role should be as system conveners, enablers, incentivisors, delivery catalysts and accountants (November)

3). Use this thinking about your role and where you can add most value (combined with the JSNA) to decide the HWBB priority focus for the year(s) and how you want to spend your time together as system leaders (December)

4.) Pilot the application of this on one of those priority areas by kick starting it with a one day delivery clinic (January)

By going on this journey with us over the next three months we will also build collaborative capacity between you as a group of people – we can hold any tension while you do this.

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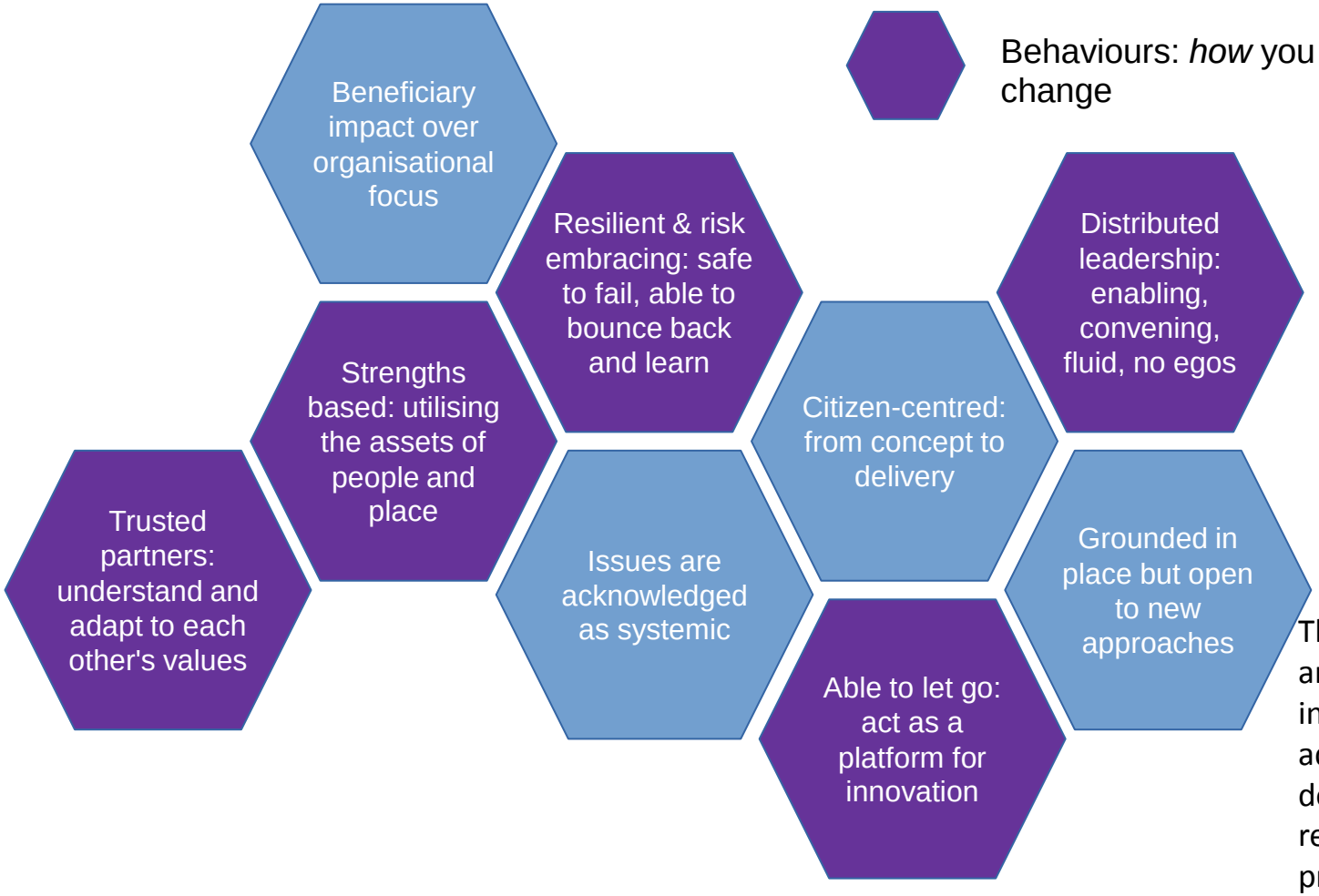
Introducing our pre-conditions for systems change (developed with Coventry): A focus on vision and behaviours…

Having spent time in Coventry understanding what makes it tick, we believe these preconditions underpin whether systems change is likely to happen. We believe, they will apply equally well to health outcomes as to our work with people facing multiple complex needs

Vision: the ambition of the system

Behaviours: *how* you go about systems change



These pre-conditions are neither linear nor independent: they are adaptive and inter-dependent as people, relationships and priorities change.

Summary of nine pre-conditions for systems change:

Beneficiary impact over organisation focus: setting aside the boundaries of organisations and focusing on the outcomes for the place and people, above and beyond what it might mean for you and your organisation.

Citizen-centred: from concept to delivery: getting under the skin of what we really mean by 'citizen-centred', where the system challenges itself to put the clients at the centre of its decisions and business approach.

Issues are acknowledged as systemic and requiring collaboration: a genuine acknowledgement early on that the change being sought is systemic and will require multiple actors to work together.

Grounded in place but open to new approaches: harnessing the assets of the place as the starting point but without being constrained by 'the way things are done around here' in order to learn, try new things and leapfrog traditional routes to change.

Trusted partners: understand and adapt to each others values: supportive partnerships, relationships and ways of working that can aid delivery – honesty and trust being key – this is not about sharing values but about understanding each other's values and adapting accordingly.

Strengths based: utilising the assets of people and place: focusing on the positive capacity of individuals and communities – rather than on their needs, deficits and problems – applying this way of thinking to the whole system and considering the place as well as the people.

Distributed leadership: enabling, convening, fluid, no egos: leading from behind and building guiding coalitions across the system – rather than being 'owned' by a single person or organisation – recognising that this will change over time as the system evolves.

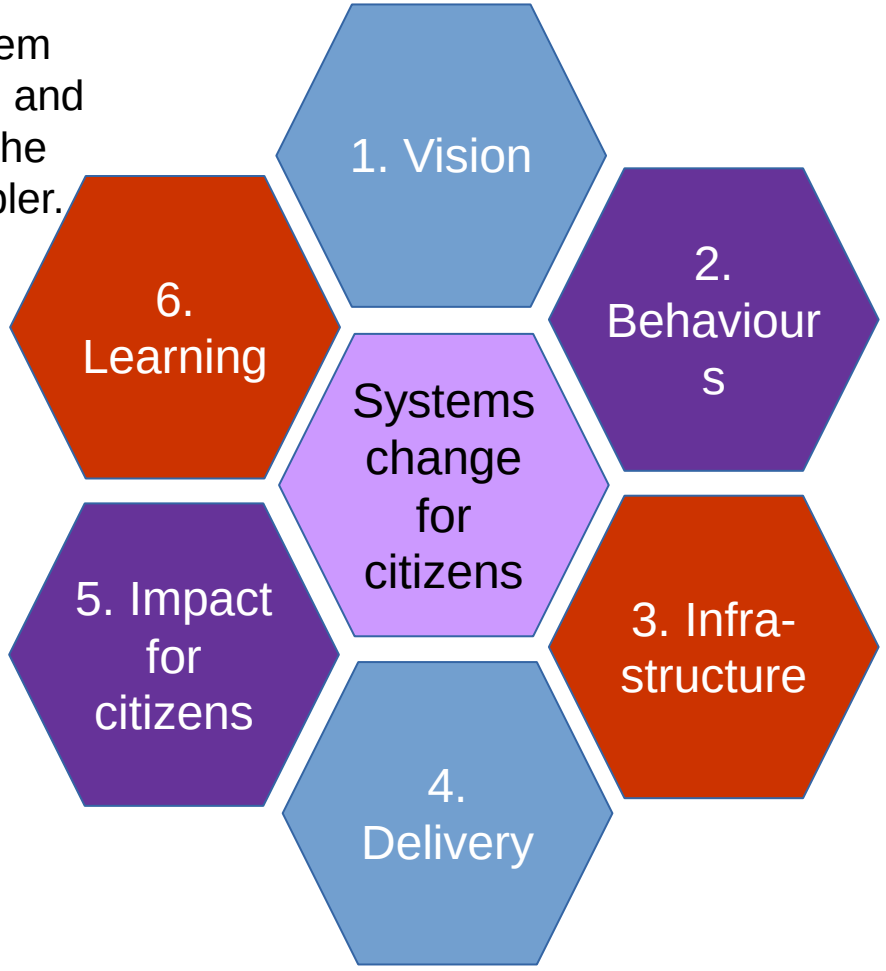
Resilient & risk embracing: safe to fail, able to bounce back and learn: acting as a multiplier for other pre-conditions, this is about the ability to take risks – to fail fast, to learn and to try again – not letting individual or collective resilience be drained.

Able to let go: act as a platform for innovation: moving from public servants as bureaucrats to public servants as entrepreneurs – receptive to disruption, able to seed and support innovation, sharing control and acting as a platform – rather than always delivering.

But system vision and system behaviours alone don't equal delivery…

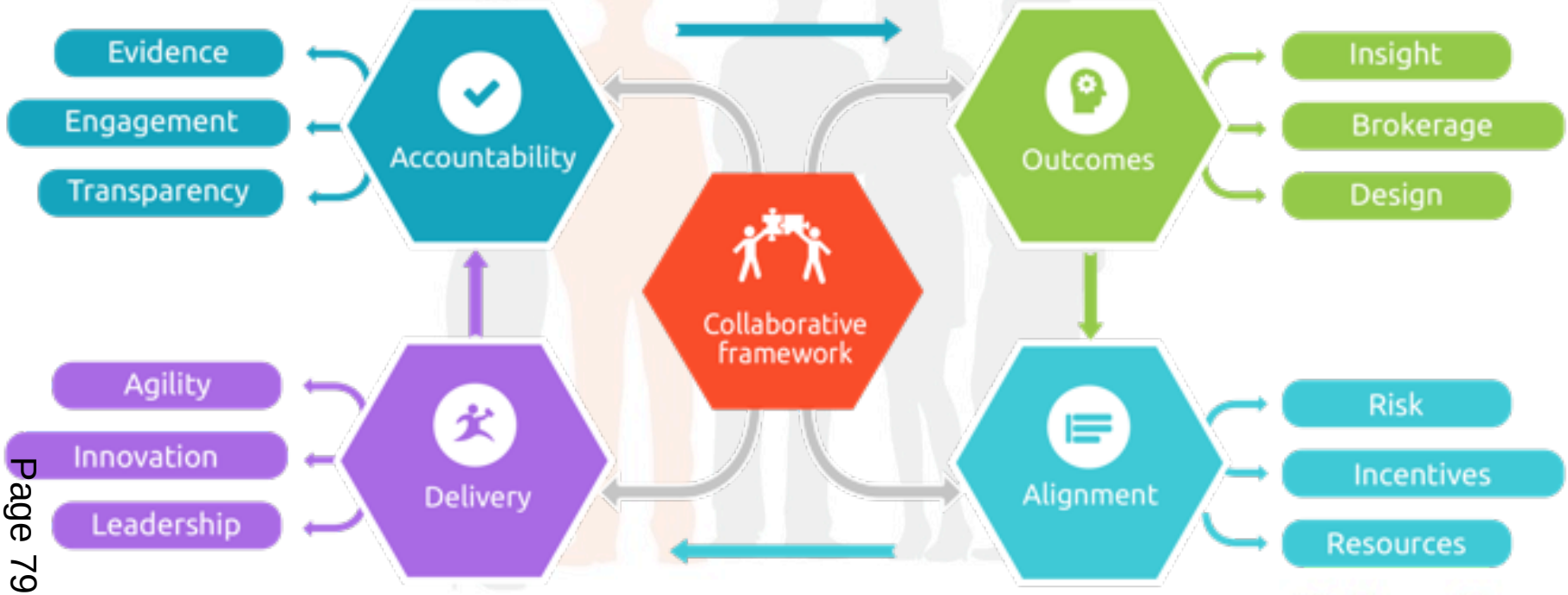
Our work with Coventry demonstrated that beyond the preconditions for system change (vision and behaviours) you also require systems or collaborative infrastructure and delivery. System Governance is a key part of that infrastructure and this is where we believe we can add value to the HWBB to consider their role as a system enabler.

1. Vision – the ambition of and for the system
2. Behaviours – of all those in the system, as individuals and parts of the system
3. Infrastructure – to support systems change particularly: Resources (human and financial), Incentives (commissioning, performance management) and Accountability (governance, risk and regulation)
4. Delivery – is the system vision delivered or just talked about.
5. Impact for citizens – is the system vision delivered in a way that has a positive impact for the citizens of that place
6. Does the system learn, adapt, and continually evolve to meet the changing needs of all those within it



Creating the right climate for collaborative delivery and then doing it!

Our Collaborative Delivery Framework (developed with the UNDP) takes us through a four stage process to ensure collaborative delivery. We would apply this framework with the HWBB at a workshop in November and then consider, therefore, what role the HWBB should be playing to enable the priority outcomes to be delivered. Having done this and agreed priority areas we would pick one of those areas a do a one day delivery clinic (in January) to apply this thinking to one bit of the system



Plan on a page: Key activities and timeline

Key outputs and timeline	1. Flip the starting point: agree the opportunity to reframe the HWBB's approach. 19th Oct.	2. Full day Workshop: apply preconditions framework and delivery framework to Health outcomes – what role should HWBB be playing to achieve these outcomes Late November (w/c 23rd Nov)	3. Refine workshop outputs, apply to possible priority areas and bring paper to HWBB to agree. For 7th December HWBB	4. Collaborative delivery clinic: For one priority area do a one day delivery clinic to reconfigure approach. Pilot methodology which could then be applied more widely. Early January 2016
Description of activity	Discuss to what extent the preconditions exist in the health space and how they might be used to support the development of a new strategy.	Develop answers to the following questions: a) What are our key outcomes? b) Are they aligned (risks, incentives, resources)? c) What accountability mechanisms do we need? d) Therefore what should HWBB role be?	Bring together workshop outputs with JSNA to identify likely priority areas in paper for discussion and decision at HWBB	Summary feedback/next steps after each session plus final report with recommendations – published something as a commitment device perhaps?
Collaborate role Sarah (MD) Saira (Programme associate)	Support Robina and attend HWBB to discuss and agree approach	Design and deliver one day workshop. Brief Diagnostic phase to build on HWBB work do date and key focus e.g. inequalities, better care fund etc.	Apply workshop thinking with Robina to what HWBB priorities and roles should be for her paper.	Design and deliver one day delivery clinic (CCC will need to lead of logistics and Robina co facilitate)
HWBB role	Agree approach on 19th October	Attend workshop in November and come prepared to consider a different approach and maybe way of working…	Robina work with Collaborate to iterate thinking post workshop and produce paper for 7th Dec. Board. HWBB agree focus of first delivery clinic	Support attendance at delivery clinic by identifying right people. Identify in whom (alongside Robina) we should build capability to repeat this in other parts of the system without Collaborate.

Collaborate operating principles

1. We care about outcomes and values, not sectors
Our work actively promotes services to the public that engage government, business and civil society, blurring traditional boundaries and prioritising outcomes over sector preconceptions

2. We support collaborative citizens
Our starting point is the voice of the citizen, family and community, and our approach will always look for ways to support their capability, independence and resilience

3. We work with people who want genuine collaboration
Our clients and partners are people who want to collaborate to deliver better outcomes - we help them to make it happen through different thinking, culture and practice

4. We offer honest relationships, not pre-baked solutions
Our way of working is different - we believe that the best approaches are co-created; we work hard to convene networks, broker relationships and be 'comfortable with uncomfortable'

5. We build readiness and unlock capacity
Our approach is to enable others to find their own solutions; we use independent evidence and diagnostic insight, then build capability in others to make delivery sustainable

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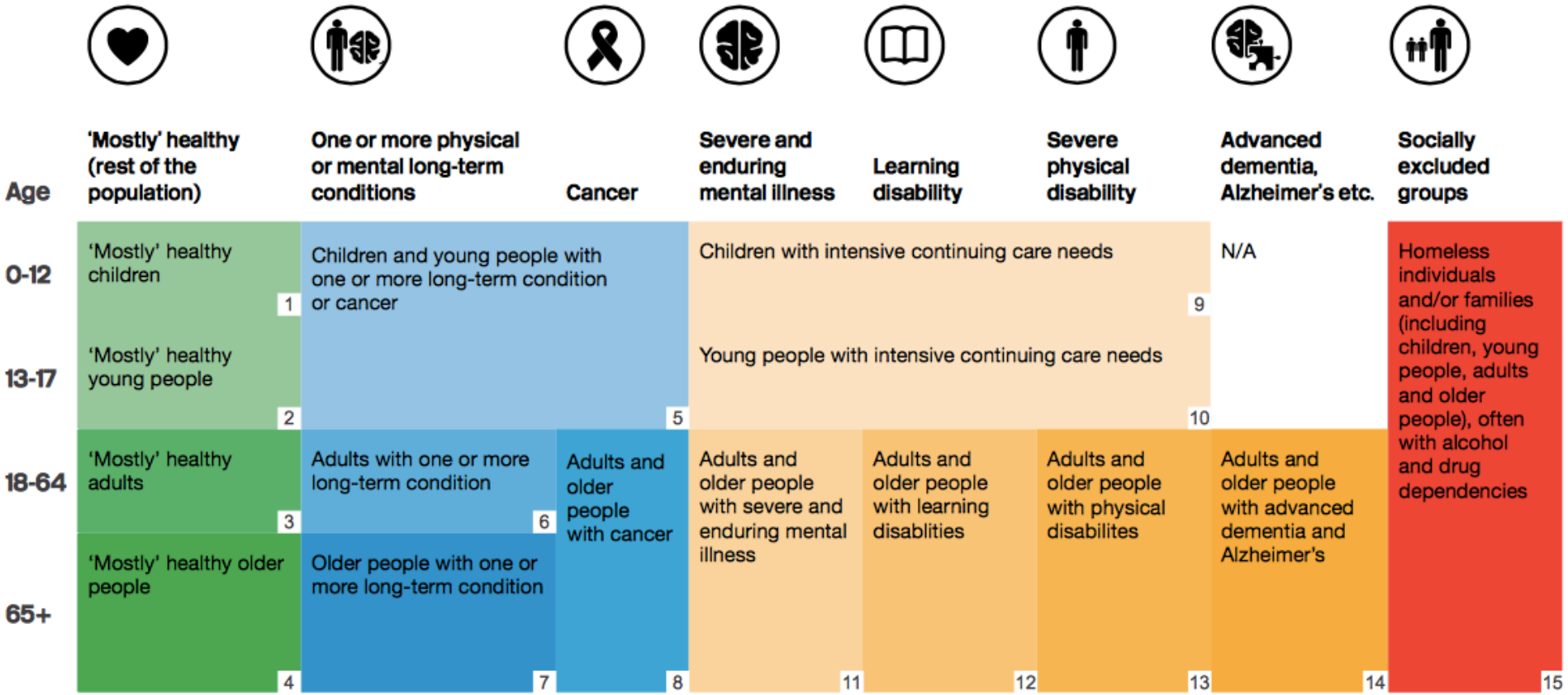
Food for thought: how are others approaching this

We wouldn't suggest a lift and shift of any of the next four slides, but it is interesting to see what others are doing as a catalyst for our conversations and work together in November. We would seek to develop, with you, your system vision and priorities to underpin your next HWBB strategy.

Below is how Lord Darzi categorises different aspects but this doesn't include the wider determinants of health so feels quite healthcare rather than health focussed.



Food for thought: how are others approaching this (2)

This approach from Devon is quite similar to where your JSNA work would naturally lead you…

However how would this fit with the wider system integration role for the HWBB – what should the Board be doing to enable integration, provider side innovation, creative commissioning, community resilience or whatever is important to you?

APPENDIX 2

Health and Wellbeing Board Outcomes Report

June 2015

Priority	RAG	Indicator	Type	Trend	Dev/SW/Eng
1. A Focus on Children and Families	A	Children in Poverty	Chall		
	G	Early Years Foundation Score	Chall		
	G	Smoking at Time of Delivery	Watch		
	A	Teenage Conception Rate	Watch		
	-	Child/Adolescent Mental Health Access Measure	Improve	-	-
	R	Hospital Admissions for Self-Harm, Aged 10-24	Improve		
2. Healthy Lifestyle Choices	G	Proportion of Physically Active Adults	Chall		
	A	Excess Weight in Four / Five Year Olds	Chall		
	A	Excess Weight in 10 / 11 Year Olds	Chall		
	A	Alcohol-Related Admissions	Watch		
	G	Adult Smoking Prevalence	Watch		
	G	Under 75 Mortality Rate - All Cancers	Improve		
	G	Under 75 Mortality Rate - Circulatory Diseases	Improve		
3. Good Health and Wellbeing in Older Age	A	Incidence of Clostridium Difficile	Chall		
	G	Injuries Due to Falls	Chall		
	A	Dementia Diagnosis Rate *	Chall		
	G	Feel Supported to Manage Own Condition	Watch		
	G	Re-ablement Services (Effectiveness)	Watch		
	A	Re-ablement Services (Coverage)	Watch		
	A	Readmissions to Hospital Within 30 Days	Improve		
4. Strong and Supportive Communities	A	Suicide Rate	Chall		
	G	Male Life Expectancy Gap	Chall		
	G	Female Life Expectancy Gap	Chall		
	G	Self-Reported Wellbeing (low happiness score)	Watch		
	G	Social Contentedness	Watch		
	G	Carer Reported Quality of Life	Watch	-	
	A	Stable/Appropriate Accommodation (Learn. Dis.)	Improve		
	G	Stable/Appropriate Accommodation (Mental Hlth)	Improve		

RAG Ratings

Red	R	Major cause for concern in Devon, benchmarking poor / off-target
Amber	A	Possible cause for concern in Devon, benchmarking average / target at risk
Green	G	No major cause for concern in Devon, benchmarking good / on-target

Food for thought: how are others approaching this (3)

This model from the Kinds Fund provides a useful system framework for conceptualising an approach to population health but again it is quite healthcare rather than health focussed and maybe doesn't support the shift to either prevention or the wider determinants of health (housing, transport, parks) or health inequalities that you may wish to encompass as a result of Marmot

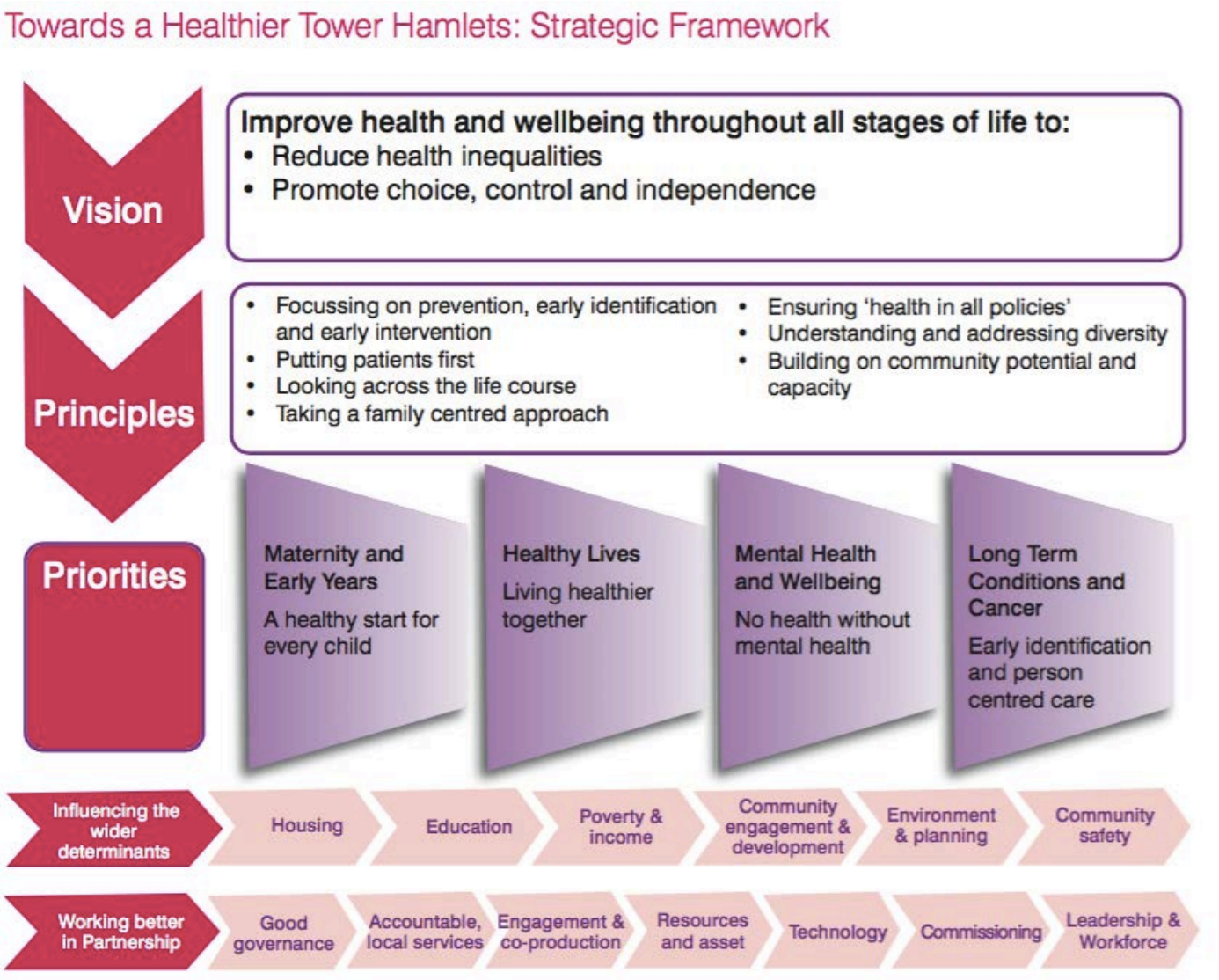
Figure 1 The focus of population health systems

Food for thought: how are others approaching this (4)

We quite like this from Tower Hamlets, which combines priorities that emerge from the JSNA work but sits these beneath a vision and set of principles to give strategic systems focus, underpinned by some thinking on wider determinants and some of the infrastructure to support delivery.

This obviously is a top level framework and requires detail beneath it.

What isn't clear from others approach is an articulation of the HWBB role in achieving place-based health – this would be something for discussion in November.



Food for thought: how are others approaching this (5)

In Suffolk their three step approach: Strategic outcomes, priority areas and key measures encompasses several of the things that are important in a systems shift. They have supported this with thinking about leadership, commissioning and integrated care organisations.

Strategic Outcomes, Priority Areas and Key Indicators

Strategic outcome	Priority areas	Key measures (Indicators)
Outcome 1 **Every child in Suffolk has the best start in life**	**1.1** Early intervention and prevention	**1.1.1** Decreased prevalence of smoking at delivery **1.1.2** Decreased under 18 conception **1.1.3** Increased breast feeding rates **1.1.4** Increased uptake of free early learning for disadvantaged 2yr olds and universal offer for 3 and 4 yr olds **1.1.5** Increased "good level of attainment " at age 5 **1.1.6** Increased level of attainment at Key stage 3&4 **1.1.7** Decreased prevalence of overweight and obesity in 4-5 yr olds **1.1.8** Decreased prevalence of overweight and obesity in 10-11 yr olds **1.1.9** Decreased tooth decay in children aged five
	1.2 Promoting family focus across the work of agencies including the "Suffolk family focus" initiative	**1.2.1** Improved school attendance **1.2.2** Reduced crime and antisocial behaviour **1.2.3** Reduced NEET in 16-18 yr olds **1.2.4** Reduction in reoffending
	1.3 Supporting parents to improve their own circumstances	**1.3.1** Increased uptake of evidence based parenting programmes

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Food for thought: how are others approaching this (5)

Outcome 2 **Suffolk residents have access to a healthy environment and take responsibility for their health and wellbeing**	**2.1** Creating an environment where it is easy to make healthy choices and take responsibility for own health	**2.1.1** Decreased smoking prevalence in adults > 18 yrs **2.1.2** Increased uptake of NHS health checks in those eligible **2.1.3** Increased detection and treatment of Chlamydia infection (15-24 yr olds) **2.1.4** Increased uptake in cancer screening **2.1.5** Decreased killed or seriously injured casualties on Suffolk roads
	2.2 Increasing the levels of physical activity and encouraging greater use of our natural environment This will also contribute to achieving 1.1.7, 1.1.8, 1.2.2, 3.2.1 and 3.2.3	**2.2.1** Reduction in prevalence of obese adults **2.2.2** Increase in the proportion of physically active adults **2.2.3** Increased utilization of green space for exercise/health reasons
	2.3 Decreasing the harm caused by alcohol to individuals and communities	**2.3.1** Decreasing the rate of alcohol related hospital admissions **2.3.2** Reduced crime and antisocial behavior **2.3.3** Reduction in reoffending
	2.4 Improving access to suitable housing	**2.4.1** Decreased No. of households in fuel poverty **2.4.2** Increased proportion of affordable homes available **2.4.3** Less Statutory homelessness **2.4.4** Decreased proportion of households in temporary accommodation **2.4.5** Decreasing excess winter deaths

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Food for thought: how are others approaching this (5)

Strategic Outcomes, Priority Areas and Key Indicators		
Strategic outcome	**Priority areas**	**Key measures (Indicators)**
Outcome 3 **Older people in Suffolk have a good quality of life**	**3.1** Ensuring that health and social care services are integrated at the point of delivery	**3.1.1** Decreasing emergency admissions within 30 days of discharge from hospital **3.1.2** Proportion of people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services. **3.1.3** Proportion of people who use services and their carers who reported that they had as much social contact as they would like. **3.1.4** Increased proportion of people with long term conditions supported to manage their condition. **3.1.5** Increased proportion of people who are able to die at home.
	3.2 A focus on prevention including the promotion of healthy lifestyles and self care	**3.2.1** Decreasing falls and injuries in the over 65s **3.2.2** Decreasing hip fractures in over 65s **3.2.3** Increased proportion of over 65s receiving self directed support **3.2.4** Increased proportion of vulnerable people achieving independent living **3.2.5** Increased community-based opportunities to promote personal wellbeing indicative measures **3.2.6** Decreasing permanent admissions to residential and nursing care homes
	3.3 A focus on reducing loneliness and social isolation for older people	**3.3.1** Increased self reported wellbeing

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Food for thought: how are others approaching this (5)

Outcome 4 **People in Suffolk have the opportunity to improve their mental health and wellbeing**	**4.1** Ensure that mental health is everyone's business not just health, social care and the voluntary sector but employers, education, and the criminal justice system	**4.1.1** Increased rates of employment for those with a long-term health condition including those with a learning difficulty/disability or mental illness **4.1.2** An increase in the proportion of people with mental illness or disability in appropriate settled accommodation **4.1.3** An increase in the proportion of people assessed for substance dependency issues when entering Suffolk prisons **4.1.4** Decreasing people in prison who have a mental illness or significant mental illness **4.1.5** Increased rates of adults in contact with mental health service in employment
	4.2 Increase access to support for improving the emotional health and wellbeing of children including access to child and adolescent mental health services.	**4.2.1** Improved emotional wellbeing of looked after children **4.2.2** Decreased hospital admissions caused by unintentional and deliberate injuries in under 18s
	4.3 Ensure that there is seamless mental health provision across agencies but also for those with multiple problems (drugs & alcohol misuse and mental ill health)	**4.3.1** Increasing successful completion of drug treatment **4.3.2** Increased young people in drug or alcohol treatment referred from child and families service **4.3.3** Increasing adults in alcohol treatment referred from criminal justice
	4.4 Bringing together all elements of physical and mental wellbeing in recognition that physical and mental health are inter-dependent	**4.4.1** The above indicators and **4.4.2** Decreased under 75 mortality in adults with serious mental illness **4.4.3** Decreased rates of suicide

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Coventry City Council

Public report
Cabinet Report

Health and Wellbeing Board	19 October 2015
Cabinet	24 November 2015
Council	1 December 2015

Name of Cabinet Member: Cabinet Member for Health and Adult Services – Councillor Caan

Director Approving Submission of the report: Director of Public Health

Ward(s) affected: All

Title: Continuing as a Marmot City

Is this a key decision?
No – although this decision will affect more than two wards in the City, it is a continuation of an existing policy.

Executive Summary:

Coventry was one of seven cities in the UK chosen in 2013 to participate in the UK Marmot Network and become a Marmot City and develop a 'Marmot' approach to tackling health inequalities. In March 2015, Professor Sir Michael Marmot from University College London's Institute of Health Equity and key leaders from Public Health England recognised the progress Coventry has made over the last two years and achievements to date, and committed to working in partnership for a further three years, with Coventry acting as an exemplar City for its approach to reducing health inequalities.

This partnership will enable Coventry to accelerate the progress that has been made in reducing health inequalities over the last two years and to develop a more focused, multi-agency approach to ensure that resources and efforts are concentrated where they can make the biggest difference. As an exemplar City, Coventry will share learning with the wider system and disseminate findings to other areas. Public Health England and University College London will provide expertise and knowledge to support Coventry, and to develop Coventry's capability to measure the impact of the Marmot City programme.

As part of this, partners are working together to develop a Marmot strategy, which will form part of Coventry's overall Health and Wellbeing strategy and be overseen by Coventry's Health and Wellbeing Board. The strategy will consider the conditions which determine health, including: housing, employment, income, environment, and community, as well as access to health services and the overall health of the population, with a particular focus on young people, jobs and the economy, and improving outcomes for people from diverse backgrounds.

Recommendations:

1. Health and Wellbeing Board is requested to:

   (i) Approve the proposed partnership arrangement and approach

   (ii) Make any comments or recommendations to Cabinet about the report and its proposed approach

2. Cabinet is requested to:

   (i) Consider comments from the Health and Wellbeing Board

   (ii) Approve the proposed partnership arrangement and approach

   (iii) Make any comments or recommendations to Council about the report and its proposed approach

   (iv) Ask Council to approve the proposed partnership arrangement and approach

3. Council is recommended to:

   (i) Consider comments from the Health and Wellbeing Board and Cabinet

   (ii) Approve the proposed partnership arrangement and approach

List of Appendices included:
None

Other useful background papers:

'Fair Society, Healthy Lives' (The Marmot Review):
http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

'Making a Difference in Tough Times (case study report):
http://www.coventry.gov.uk/downloads/file/16043/coventry_a_marmot_city_-_making_a_difference_in_tough_times

'How Marmot Makes a Difference' (video): https://www.youtube.com/watch?v=Bsul-ayjElw

Has it been or will it be considered by Scrutiny?
Yes – Coventry's proposed approach to tackle health inequalities was considered by Scrutiny Board 5 on 1 July 2015.

Has it been or will it be considered by any other Council Committee, Advisory Panel or other body?
Yes – Health and Wellbeing Board on 19 October 2015

Will this report go to Council?
Yes – on 1 December 2015

Report title: Coventry continuing as a Marmot City

1. Context and background

1.1 Tackling health inequalities will improve the health, wellbeing and life chances of the people of Coventry. Where someone is born, where they live, whether they work or not and what they do all affect how long someone will live, how healthy they will be and the quality of life they will experience.

1.2 Inequalities are unfair: people in lower socio-economic groups are more likely to experience chronic ill health and die earlier than those who are more advantaged, and inequalities affect everyone, as there is a social gradient to health: the better the conditions in which you are born, grow up and live, the more likely you are to enjoy better health and a longer life.[1] [2] Statistics from Public Health England show that men in the most affluent areas of Coventry will live, on average 9.8 years longer than men in the most deprived areas, while for women the difference is 8.5 years, and the difference is even greater for those who are homeless or who suffer from a mental health condition.

1.3 Tackling health inequalities will reduce social, economic and financial costs. As well as the human cost, every year health inequalities cost the UK £31-£33 billion in lost productivity (estimated at £170 million in Coventry), £20-£32 billion in lost taxes and higher welfare payments, and an additional £5.5 billion in healthcare costs.[3] Spending on late intervention (youth economic inactivity, crime and anti-social behaviour, child protection and safeguarding, youth substance misuse) is estimated at £6.5bn for local government nationally (£117m in Coventry), compared to £800m on early intervention (£4m in Coventry)[4]. Reducing health inequalities, targeting resources based on need and investing in prevention and early intervention can:

- Improve health outcomes, wellbeing, mental health and community and social relations
- Increase productivity and improve educational attainment, which will ensure the area is attractive to employers and develop the local economy
- Reduce the costs of welfare and healthcare
- Reduce future demand for council services and associated costs including social care, child protection, housing, domestic and sexual violence and substance misuse.

1.4 Tackling the causes of health inequalities cannot be done through health services alone. The transfer of public health services to local authorities in April 2013 provided Coventry with an opportunity to continue to broaden the ownership of the health inequalities agenda. Coventry committed to delivering rapid change in health inequalities by 2015 and was one of seven cities in the UK invited to participate in the UK Marmot Network and become a Marmot City. Being part of the Marmot Network has provided Coventry with access to the international expertise of the Marmot Team based at University College London.

1.5 Being a Marmot City has brought together partners from different parts of Coventry City Council and from other public sector and voluntary organisations, whose decisions and activities have an impact on health. Since Coventry became a Marmot City in 2013, there has been progress in outcomes across health and across society.[5] The life expectancy gap in Coventry between the most affluent and most deprived has narrowed (from 11.2 years to 9.8 years for men and from 8.6 years to 8.5 years for women), and there have been there

[1]Acheson, *Independent inquiry into inequalities in health report*, London: The Stationery Office, 1998
[2]Dahlgren, Whitehead, *Policies and strategies to promote social equity in health*, Stockholm: Institute of Futures Studies, 1991
[3]Chi Onwurah, 'MP urges action on health inequalities', *Westminster Briefing*, 2010
[4]Hardoon Chowdy and Carey Oppenheim, 'Spending on late intervention: how we can do better for less', Early Intervention Foundation
[5] More information on progress to date can be found in the report *Making a Difference in Tough Times*, and video *How Marmot Makes a Difference*, which can be accessed via the following link: http://www.coventry.gov.uk/info/176/policy/2457/coventry_a_marmot_city

have been improvements in educational development, health outcomes, life satisfaction, employment and reductions in crime in priority locations:

- Breastfeeding initiation has increased from 74.9% to 75.9%, and is better than the national average (73.9%).
- Nearly 60% of reception pupils in 2014 left their first year of education with a 'good level of development'. This is an increase of 4% compared to 2013, and Coventry is now above the regional average and in line with the national average.
- 42.3% of reception pupils with free school meal status left their first year of education with a 'good level of development', significantly above the regional and England average of 36%.
- 5.5% of those who completed an NHS Health Check were identified as having a long term condition and placed on a disease risk register with their GP, and over 58% of health checks have been delivered in GP practices in the two most deprived quintiles in the city.
- In 2014/15 3,000 smokers were supported to achieve a 4-week quit and Coventry is in the top 5 authorities nationally in terms of the proportion of smokers that it reaches through these services.
- There has been an increase in the number of physically active adults (from 49.4 to 52%), and the number of physically active adults in Coventry is now similar to the national average.
- There has been a 22.5% reduction in crime in priority locations.

1.6 A national conference 'Making a Difference in Tough Times' was held in Coventry on the 26th March to share the city's achievements as a Marmot City, where Professor Sir Michael Marmot congratulated Coventry on its approach and progress achieved so far. Partners also worked together to develop a case study report and film.

2. Options considered and recommended proposal

2.1 In March 2015, the Institute of Health Equity committed to continue to work with Coventry in principle for a further three years. In April 2015, Public Health England also indicated a willingness to support Coventry for this period. The main purpose of this partnership is to continue to develop and embed the approaches that have been introduced over the last two years, enable Coventry to measure progress against local and national indicators, provide Coventry with access to learning from other areas and raise the profile of Coventry as an exemplar city for reducing health inequalities.

2.2 As further planned spending cuts to services and welfare reforms create challenges for Coventry's most vulnerable residents, the council must continue to work with the NHS, police, fire service, voluntary sector, and private sector over the next three years to continue to accelerate progress made to date and improve the health, wellbeing and life chances of the people of Coventry. Working together as a Marmot City with partners at Public Health England and the Institute of Health Equity will:

- Facilitate partnership working between the Council's Place, People, Resources and Chief Executive's Directorates as well as wider public and voluntary sector partners and businesses.
- Provide Coventry with expertise to develop Coventry's capability to reduce health inequalities through:
  - Ensuring health and social value are reflected in council policies and decision making
  - Ensuring services and interventions are evidence based and commissioned for outcomes

- Ensuring resources are targeted based on need and that proportionate universalism[6] is embedded throughout the council and its partners so that interventions and projects are targeted at the right people and in the right places to have maximum impact on health inequalities in Coventry

- Provide Coventry with access to learning from other areas and raising the profile of Coventry as an exemplar city for reducing health inequalities.
- Enable Coventry to measure progress against local and national indicators.

2.3 Coventry will continue to work with Sir Michael's team at University College London and with Public Health England to ensure that the Marmot principles which aim to reduce inequality and improve health outcomes for all have been embedded into the core functions of the council and its partners. Public Health will be working with partners to develop a Marmot Strategy, which will form part of Coventry's Health and Wellbeing Strategy, as well as further indicators for the next three years based on the Marmot policy objectives outlined in 'Fair Society, Healthy Lives'.

2.4 Over the next three years, the strategy will focus on improving outcomes for young people, and on ensuring that economic growth in Coventry is 'good growth' which benefits the most disadvantaged citizens and improves both health and economic benefits to businesses. As the strategy is developed, the health outcomes and wider outcomes which the partnership hopes to achieve will be clarified in further detail, but initial analysis suggests that the programme will concentrate on the following Marmot policy objectives and, as well as reducing the life expectancy and healthy life expectancy gap, will aim to achieve the following outcomes:

- **Enable all children, young people and adults to maximise their capabilities and have control over their lives** (Reduction in the number of young people aged 16-18 who are not in education, employment or training, reduction in under 18 conceptions, increase in the proportion of children achieving five A*-C grades at GCSE, improvements in young people's mental health and a reduction in the number of young people admitted to hospital for self harm, with an aim to see particularly rapid improvements in the most deprived areas of the city).
- **Create fair employment and good work for all** (Increase in the proportion of working age adults in employment, reduction in employment inequality, improvements in the health of employees, increased productivity, increased income for Coventry residents, with an aim to see particularly rapid improvements in the most deprived areas of the city).
- **Improving health outcomes for a diverse population** (understanding and addressing the health, wellbeing and wider needs of migrant populations, including asylum seekers and refugees, supporting diverse communities and ensuring people from diverse backgrounds are able to access a full range of services).

3. Results of consultation undertaken

3.1 The strategic direction of Coventry's Marmot City programme for the next three years has been established through consultation with the Public Health department, representatives from the Council's People, Place and Resources directorates and wider partners including West Midlands Police, West Midlands Fire Service, Voluntary Action Coventry, Coventry and Warwickshire Local Enterprise Partnership and Coventry and Rugby Clinical Commissioning Group. In addition, as part of the 2015 JSNA process, a call-for-evidence went out to stakeholders in Coventry to enable wider agencies and individuals to contribute to the process.

[6] Actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage

3.2 Further consultation is planned over the next month to enable both internal and external partners to contribute to the further development of the strategy and action plan, including a stakeholder workshop which is planned for November.

4. Timetable for implementing this decision

4.1 A launch event is provisionally planned for 27 January 2016 for Coventry City Council to launch its intention to partner with UCL's Institute of Health Equity and Public Health England (PHE) for a further three years. Professor Sir Michael Marmot, Director of UCL's Institute of Health Equity will be attending as well as Dr Annmarie Connolly, Director of Health Equity and Impact at Public Health England and Councillor Ann Lucas and Dr Martin Reeves from Coventry City Council.

4.2 Once developed, the Marmot Strategy will then run from April 2016 – March 2019 and be published on the Council's internet pages and shared with partners. The Marmot Steering Group, directly accountable to Coventry's Health and Wellbeing Board, will provide strategic leadership to oversee the further development and implementation of the strategy, driving forward an action plan in collaboration with wider stakeholders.

5. Comments from Executive Director, Resources

5.1 Financial implications

5.1.1 Over the last two years, individual 'Marmot' projects and initiatives have been funded via a number of different routes, and this will continue for the next three years.

5.1.2 Funding and support has been and will continue to be provided by partner organisations (such as West Midlands Police, West Midlands Fire Service, Voluntary Action Coventry, Coventry and Rugby CCG), and opportunities for external funding are being assessed.

5.1.3 As part of the partnership arrangement between UCL's Institute of Health Equity and Public Health England, both organisations have agreed to provide support and expertise to Coventry to ensure actions taken to reduce health inequalities are as effective as possible. Public Health England have also agreed to provide some resource in the form of a secondment to develop indicators to ensure Coventry is able to measure the impact of the Marmot City programme.

5.1.4 Part of the purpose of the Marmot City work is to make a difference within existing resources, and release funding through doing things differently. This ensures the work is sustainable and can be rolled out to other areas, even while there are funding challenges within the public sector.

5.1.5 Other costs (such as staff time to co-ordinate the programme and communications costs) will be met within the existing Public Health budget. Therefore, no new money is being requested from Coventry City Council budgets for this programme.

5.2 Legal implications

5.2.1 In April 2013 when the Health and Social Care Act 2012 came into force, local authorities took on a new legal responsibility for protecting and improving the health of the people in their areas, including reducing health inequalities. The new role of local authorities complemented existing Council functions which aim to improve the wellbeing and life chances of local people.

6. Other implications

6.1 How will this contribute to achievement of the Council's key objectives / corporate priorities (corporate plan/scorecard) / organisational blueprint / Local Area Agreement (or Coventry Sustainable Community Strategy)?

6.1.1 Continuing as a Marmot City for a further three years will contribute to the achievement to a wide range of key objectives for Coventry City Council, including:

- Reducing health inequalities
- Promoting the growth of a sustainable Coventry economy
- Helping local people into jobs
- Reducing the impact of poverty
- Improving the quality of life for Coventry people
- Making communities safer, cleaner and greener
- Improving educational outcomes
- Improving the health and wellbeing of local residents
- Protecting and supporting the most vulnerable people
- Maximising the use of assets and empowering strong and involved communities

6.2 How is risk being managed?

6.2.1 There are no specific risks identified in this report. However, risks associated with the delivery of relevant services are managed through the directorate and corporate risk registers, in conjunction with partners across the city. Regular reviews of each risk are undertaken, and mitigating actions put in place to ensure the overall risks are reduced as much as possible.

6.3 What is the impact on the organisation?

6.3.1 None – the Marmot City programme is already on-going within the Council. Extending this for a further three years does not require substantial changes that would impact on the organisation.

6.4 Equalities / EIA

6.4.1 An Equalities Impact Assessment is not appropriate for this work, although the aim of the Marmot partnership and strategy for the next three years is to reduce health inequalities across the City.

6.5 Implications for (or impact on) the environment

6.5.1 No significant impact to note at this stage.

6.6 Implications for partner organisations?

6.6.1 Partner organisations in Coventry and nationally are committed to reducing health Inequalities. Partner organisations form the multi-agency Steering Group which oversees the Marmot City programme in the City. The re-launch of Coventry's Marmot City programme and new partnership arrangements reaffirm the commitment of partners (including statutory, non-statutory and third sector) to working together and sharing information.

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Members: Councillor Camran Caan	Cabinet Member (Health and Adult Services)		6.10.15	6.10.15

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Coventry City Council

Report

To: Coventry Health and Wellbeing Board **Date:19th October 2015**

From: Pete Fahy, Director of Adult Services
Sue Davies, Head of Partnerships

Subject: Joint Health and Social Care Action Plan 2014 / 2015

1 Purpose

The purpose of this report is to outline the results of the Learning Disability Joint Health and Social Care Self Assessment (2013/14); to seek endorsement of the Action Plan for 2014/15.

2. Background

The Learning Disabilities Health Self-Assessment (SAF) was first introduced in 2007/8 alongside a separate self-assessment in relation to social care. Both of these assessments were combined in 2013 to form the Joint Learning Disabilities Self-assessment Framework as part of the Transforming Care programme, post Winterbourne View, for people with learning disabilities.

The joint assessment has become an important guide for the NHS and Local Authorities to recognise the overall needs, experiences and wishes of young people and adults with learning disabilities and their carers within their local partnership board areas. The questionnaire collates views and demographic data and is used to help determine local commissioning priorities and monitoring of services. The return requires significant data collection across a range of agencies.

As well as data collection the primary purpose of the assessment is to identify areas for improvement and then use this as a tool to measure this improvement on an annual basis. Since its introduction we have seen an improvement in services through raising awareness of health needs, driving health and local authority resources and improving interagency working. This has led to a wide range of improved outcomes ranging from people feeling empowered to travel and live more independently, accessing more community based activities, being involved in quality assurance and benchmarking reasonable adjustments across a range of provision within the City and a reduction in the number of out of city placements.

This self assessment provides an integrated response from Coventry and Rugby Clinical Commissioning Group (CRCCG) and Coventry City Council. The evidence to support the return has been collated from a number of key stakeholders including, but not limited to, the Clinical Commissioning Group, Arden and GEM Commissioning Support Unit (AGCS),

the Local Authority and a number of providers including Coventry & Warwickshire Partnership Trust (CWPT) and Grapevine.

3 Structure of the Self-Assessment

The self-assessment is divided into two sections, the first focuses on demographic data while the second focuses on the following three:

- Section A – Staying Healthy
- Section B – Being Safe
- Section C – Living Well

In completing the return supporting evidence and a self-assessed score are to be submitted along with an explanatory rationale.

4. Completion Methodology

The assessment was completed by a review panel with representatives from Coventry and Rugby Clinical Commissioning Group, Coventry and Warwickshire Partnership Trust, the Local Authority, voluntary organisations and service user representation. The review panel considered the evidence provided for each measure of the self-assessment framework and allocated a rating of either; green amber or red. To supplement data real life stories of experiences of people that use services, their carers and relatives, were used to provide a more rounded view of progress and areas for further improvement. A completed report was then presented and quality assured through the Learning Disability Partnership Board on 16th January 2015. As part of our internal governance arrangements this was further presented at Adult Joint Commissioning Board on 23rd July.

The overall ratings are as follows:

Attribute / Score	Red	Amber	Green	N/A
A – Staying Healthy	3	3	1	2
B – Being Safe	2	4	2	1
C – Living Well	0	4	4	1
Totals	5	11	7	4

It should be noted that a red rating can be attributed as a result of data collection issues as opposed to evidence of unsafe or poor practice locally. Where items are N/A this is due to measures not being applicable to Coventry, for example, where they related to areas with Foundation Trust provision. The completed Joint Health and Social Care Health Self-assessment were uploaded on the 31st January 2015 onto The Improving Health and Lives website which is part of Public Health England. A West Midlands Peer review was convened in Birmingham on the 27th February 2015. An action plan has subsequently been developed to address priorities for improvement; in addition to this a Joint Coventry and Warwickshire Joint Health Self-Assessment group has been initiated to take this agenda forward.

5. Key achievements

As the self-assessment is an annual exercise evidence of improvement between years is an important measure of progress. Key progress since the 2013/14 SAF include:

- Introduction of a risk based approach to contract monitoring which enables prioritisation of reviews and focuses both Social work and commissioning resource more effectively.
- The development and approval of Coventry's refreshed learning disability strategy and action plan to monitor progress against delivery which outlines priorities and gives direction for future improvements.
- Development of a business proposal for an enhanced community support team to prevent admission to assessment and treatment units and to facilitate discharges and support proposals for a reduction in the numbers of beds locally.
- Programme of Clinical Treatment Review's has been completed and is on track to reduce the numbers placed in assessment and treatment beds with active discharge plans in place.
- Commissioning of specialist supported living and residential units – new core and cluster development of 16 units in total comprising 12 residential and 4 supported living specifically for people with autism presenting with challenging behaviours. The scheme which has increased our capacity to support people in more personalised setting and avoid placements outside of city.

6. Areas for Improvement

Section A: Staying healthy. The three areas rated as "Red" are largely where we do not currently collect data in a format which is reportable in the SAF. This does not necessarily mean that we are not meeting the needs of our local learning disability population, but rather that we are unable to report our performance in this respect. To obtain the level of data requested would require custom searches in individual GP practices to this end we are proposing to write to the Local Medical Council to advise them of the information required in order to support 2014/2015 return.

More specifically improvement is required in the following areas:

- It has not proved possible to obtain the following statistical data for the learning disabilities population: (i) age bandings (ii) autism (iii) challenging behaviour (iv) screening (v) mortality (vi) health action plans
- Learning Disability Liaison nurse plays a fundamental role in supporting patients with a learning disability when they are admitted to hospital, and there is place the use of health passports, however there is currently no formal communication system for General Practitioners to alert other health care providers / professionals of learning disability status and reasonable adjustments required particularly prevalent in emergency situations / un-planned admissions.

Section B: Being safe. In respect of Contract compliance during 2013/14 100% of in city social care commissioned services for people with a learning disability have had a full scheduled contract/service review. This level of review gives a good level of assurance that we are robustly managing contracts within our City. With regard to out of city placements, all providers were sent out the self-assessment form for completion and we had a return rate of 56%.

In order to achieve a green rating an outturn of 100% is required. Amber requires an outturn of 90%. We have introduced a risk based monitoring approach across all service provision including out of city placements which triangulates information from a number of sources: Care Quality Commission (CQC) / host local authorities / placement stops / spend profile / last review date / social work feedback. These attributes are then weighted and potential areas of high risk identified. These individual placements are then flagged to

operational teams for review priority. Through the Long term Care programme a dedicated social work / NHS Continuing Healthcare (NHS CHC) team has been set up since April 2015 whose remit is to review Out of City (OOC) placements which will further contribute to the delivery of this target.

7. Progress reporting

Progress against actions in the plan will be reported 6 monthly to the Learning Disability Partnership Board and Adult Joint Commissioning Board.

8. Regional Activity

At the Learning Disability Peer Review event we all shared examples of good practice and the steps taken to achieve this for each of the three domains, and also examples of major challenges and the barriers to achieving change. Consistent themes across Authorities were evident, primarily around data sharing / collection and collation two key examples include access to GP data, and electronic flagging in systems between primary and secondary health care.

9 Recommendations

Health and Wellbeing Board are asked to:

1. Note and comment on performance
2. Endorse the action plan attached in appendix 1

Report Author(s): Paul McConnell

Name and Job Title: Joint Commissioning Manager

Directorate: People Directorate

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Enquiries should be directed to the above person.

Appendices:

JHSCHSAF Action Plan:
(Appendix 1)

A plan has been developed which highlights what actions have been undertaken to date in each section and specifically identifies those areas which will require further improvement. This will ensure a targeted approach to improving health inequalities and achieving equal and fulfilling citizenship helping commissioners and local people to assess how well people with a learning disability are being supported to STAY HEALTHY, BE SAFE and LIVE WELL.

Learning Disabilities Health and Social Care Health Self Assessment Action Plan					
Section	**Measures**	**Current Rating 2013/14**	**Comment / Agreed Actions / Progress**	**By whom**	**By When**
	A1: Learning disabilities Quality Outcomes Framework (QOF) register in primary care		Comment: It is difficult to demonstrate that QOF registers are reflective of the prevalence in the general population, as the best estimates we have available indicate large discrepancies in these figures. The estimates made available through PANSI at the institute of public care indicate that there are expected to be 6,197 people in Coventry with a learning disability in 2014. Therefore we estimate that 23% of these people are on QOF registers and 13% on LA registers. Action: In order to move this forward each practice will need to ensure that Learning Disability and Down Syndrome Registers reflect prevalence data and this stratified in every required data set (e.g. age / complexity / Autism diagnosis / BME etc.) and is reported through to Commissioners to satisfy the requirements JHSCHSAF	Local Area Team / Arden CSU	Dec-15
	A2: Finding and managing long term health conditions:		Comment: We can use the QOF registers to compare where people appear on both a learning disability register and a register for a specific condition. For instance, in the latest extract 83% of those with a learning disability were also on an obesity register. However, the treatment and outcomes for these conditions, compared to the general population is not systematically recorded. Additionally, the desired treatment and outcomes would either need to be defined nationally, or local areas would need to decide on what this would be. Many of the conditions listed do not have only one correct treatment and there are a range of outcomes that could be used to measure success. Action: Agree a set of standardised set of outcomes / measures which can be reported (it has to be recognised that this is a much wider national issue which is not going to be solved locally).	CCG / Local Area Team	TBC
	A3: Annual health checks and annual health check registers		To work alongside Public Health Observatory to improve the uptake of annual health checks at GP surgeries.	CCG / Local Area Team	Dec-15
	A4: Specific health improvement targets (Health Action Plans) are generated at the time of the Annual Health Checks in primary care		Local Area Team / CCG's must ensure that GP HAP contain specific health improvement activities and are contained within a template for 80% of patients.	CCG / Local Area Team	Dec-15
	A5: National Cancer Screening Programmes (bowel, breast and cervical)		CCG to commission reliable reporting mechanism to regularly produce numbers of completed health screening for eligible people who have a learning disability in every screening group: Cervical / Breast / Bowel for comparison with the wider population	CCG / Local Area Team	TBC

A6: Primary care communication of learning disability status to other healthcare providers		Develop an electronic alert system with secondary care and other healthcare providers for identifying LD status on referrals based upon the L.D identification in primary care and acting on any reasonable adjustments suggested. Also ensuring that both an individual's capacity and consent are inherent to the system employed. Sub regional collaboration on developing an electronic flagging system to be further explored	CCG / Local Area Team	TBC
A7: Learning disability liaison function or equivalent process in acute setting		No further Action required		
A8:NHS commissioned primary care: dentistry, optometry, community pharmacy, podiatry		Action: Local Area Team /CCG / CWPT must ensure that all people with learning disability accessing / using services are known and patient experience is captured. In addition we must be able to evidence that reasonable adjustments are been implemented and are effective.	CCG / Local Area Team / CWPT	Dec-15
A9: Offender health and the Criminal Justice System		Action: Through NHS England we have commissioned CWPT to provide a LD practitioner role this excludes prison as there are none with CWPT boundaries but does include: Advice to police and probation in working with those with LD e.g. adapting communication, understanding nature of disability Provide screening and assessment for those with LD known to criminal justice system (excluding courts) Divert into health and social care system, where appropriate, and assertively engage with mainstream services Provide support to health and social care staff in liaising with criminal justice service staff Provide training to criminal justice and health and social care staff on LD and criminal justice system Advice to local MAPPA arrangements We record how many individuals have been identified with LD within criminal justice liaison service, regardless of whether seen by LD practitioner, and also record whether they have engaged with LD services (health) if referral was made. The service is commissioned by NHS England until at least the end of March 2016	CCG / CWPT	On-going

	B1: Individual health and social care package reviews		Comment: Last years social care review target was 66% which was achieved. In order to improve the scoring for this attribute further would require our reviewing target to change to 90% to achieve amber and 100% to attain green and would have ramifications in terms of staff resource. Action: Through the Long term Care programme a dedicated social work / CHC team has been set up since April 2015 whose focus will be on reviewing OOC placements who will further contribute to the delivery of this target, at present no performance target has been agreed. The new target will have to take account of Care Act principles.	CCG / CCC	Dec-15
	B2: Learning disability services contract compliance		Comment: During 2013/14 100% of in city social care commissioned services for people with a learning disability have had a full scheduled contract/service review. With regard to out of city placements all providers were sent out the self-assessment form for completion and we had a return rate of 56%. In order to achieve an improvement in this score would require a score of 90% to achieve amber and green would be 100% compliance. Action: We have introduced a risk based monitoring approach across all service provision including out of city placements which triangulates information from a number of sources: CQC / host local authorities / placement stops / Spend profile / last review date / social work feedback. These attributes are then weighted and potential areas of high risk identified. These individual placements are then flagged to operational teams for review priority.	CCG / CCC	Dec-15
	B3: Monitor assurances	N/A			Dec-15
	B4: Adult safeguarding		Action: We will continue to have representation from all Chief Officers on our Board. User/carer input will continue via the Partnership and the Practice Sub group which is now a consultation group will continue to meet in a task and finish capacity to support the work of the Board. The Safeguarding coordinator will continue to visit the Learning Disability Partnership Board once a year to give updates about safeguarding.	CCG / CCC	Dec-15
	B5: Self-advocates and carers in training and recruitment		Comment: At present there are areas of excellence in this area, however we are unsure how widespread this best practice is, as this is not an area we routinely monitor. During transition planning the commissioning team will work closely with new providers to ensure that families and carers views are taken into account. Action: As part of the new approved list we have incorporated this requirment into the service specification and this is an area we intend to monitor. This requirement will also be considered in respect of future service specification development for both home support and residential care.	CCC	Dec-15

	B6: Compassion, dignity and respect. To be answered by self advocates and family carers		Action: We will continue to ensure that we support this attribute through continuing to fund: • Independent Quality Audit project which employs a worker with a LD. • The H Team train frontline health staff and GPs in helping them to work with people with LD • CCC funds an independent Advocacy service for support to people in case things go wrong or they need to make a complaint or challenge a service. • Help and Connect which helps support people with LD who may not be eligible for services and part of their role is to work with people who need support or signposting if things go wrong. • The LD Partnership Board in Coventry recently held a review of its existing LD Strategy and developed the new Strategy for 2014-2016. The strategy was co-produced with people with LD and places values at the centre of everything. • People with LD are also included in meetings and recruitment.	CCG / CCC	On-going
	B7: Commissioning strategy impact assessments		No further Action required		
	B8: Complaints lead to changes		No further Action required		
	B9: Mental Capacity Act and Deprivation of Liberty Safeguards. Appropriate use of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)		Action: We will continue to support this attribute through our quality assurance processes and ensure that both DOLs and MCA is properly addressed. Through our annual monitoring visits we will continue to check that appropriate policies and procedures are in place, and that training matrix's reflect this area and it is upto date. Health colleagues will continue to check that MCA's are on file and that DNR's are included within end of life planning and that the overall process is inclusive of an individuals dignity and respect. Coventry City Council provide an electronic manual that contains all the guidance providers need for MCA and DoLS and a policy and procedure document. Documents are on the city councils web pages the learning forum website. Training for providers is on-going and delivered by Social Care Development Centre regularly, and by Coventry Cares Network and by the MCA/DoLS/AMHP Development Lead on request.	CCC	Dec-15
	C1: Effective joint working		No further Action required		
	C2: Local amenities and transport		No further Action required		
	C3: Arts and culture		No further Action required		
	C4: Sports and leisure		W are continuing to Support people with a learning disability to access local sport and leisure amenities and are currently working on updating our "Whats out their Guide for People with Learning Disabilities" to enable people to understand what is available in the local community and the reasonable adjustments that exist. Furthermore we are exploring an initiative with an organisation called CredAbility.	CCC	Dec-15

C5: Employment		Comment: Coventry's LD Strategy 2014-17 identifies key actions to increase employment through greater collaboration and engagement with employers. Our progress and performance in respect of these measures will be reported through to the Learning Disability Partnership Board. The specialist Employment Support Service has dedicated resources to support people with LD to gain and retain employment. Support for vulnerable people including people with LD is also included in the Council's Jobs and Growth Strategy. People with learning disabilities can also access support through the Council's City Centre Job Shop. Action: The Employment Support Service will continue to support individuals to receive appropriate support from both mainstream and specialist services, including DWP's Work Choice Programme. Raising Expectations – Coventry's Employment Pathway explains this and a Transitions Pathway for disabled young people as part of Preparing for Adulthood.	CCC	Dec-15
C6: Preparing for adulthood		Comment: Through the following key actions, the LA has prepared strong foundations to ensure that we are committed to whole life planning and to this end an All age disability service has been established and implemented. Staff are working across the age range 15-25 to ensure a smooth transition between children and adults services. Coventry's Local Offer has been produced which covers transitions support. The LO website is being monitored and reviewed on an on-going basis. The Local Authority's SEN team now covers the age range 0-25 to support these processes and the new requirements of the Children and Families Act 2014. Action: The SEND programme Board will continue to monitor performance of the SEND work plan.	CCC	On-going
C7: Involvement in service planning and decision making		No further Action required		
C8: Carer satisfaction rating. To be answered by family carers		Action: The Local Authority will continue to support carer representatives on the Learning Disability Partnership Board to hold a carers group so that other LD carers can have their voice and contribute to the shaping of services and policy. The group meets in the central library every quarter although the intention this year is to increase the frequency of meetings as carers have found it very beneficial. The local Carers' Centre is now also supporting more carers to attend and there are a number of carers from black, ethnic minority backgrounds attending on a regular basis which ensures the group is more representative of the local community.	CCC	Dec-15
C9: Overall rating for the assessment. To be answered by IHAL				

Health Self Assessment Standard	Objective	Agreed Action	Progress	By whom
Health Self Assessment Action Plan: Standard A - Access to Health Action Status: RED	Objective A5: Annual Health Checks: Less than 25% of people with learning disability on the GP DES register had an annual health check	1. To reintroduce the GP learning disability register. 2. To audit the methodology and quality of data collection. 3. To look at GP practice training across Coventry / Warwickshire / Solihull to improve and standardise the training package. 4. To support practises to make reasonable adjustment for people with a learning disability. 5. To set up a steering group across Coventry / Warwickshire / Solihull to address and share good practice resources. 6. To re-launch the health sub-group to include these objectives.		CWPT - P Humphries
	Objective A6: Annual Health Check Action Plans: No evidence that annual health check and health action plans are integrated	1. To agree a standardised approach for annual health check and Health Action Plans across Coventry, Warwickshire and Solihull to ensure that everybody is clear about what an annual health check looks like and subsequently agree a process for a standardised health action plan		CWPT - P Humphries
	Objective A7: Screening of comparative data of people with a learning disability against non-learning disabled population.	1. Review QOF register data recording and reporting.		Primary care - Kerry Wood

Health Self Assessment Action Plan: Standard B - People with Complex Needs Action Status: RED	Objective B4: Commissioners are working in partnership with local and regional teams to ensure that people with learning disabilities in the criminal justice system have access to a full range of health care provision – in line with legislation, policy and best practice: There is no systematic collection of data about the numbers of people with a learning disability in the criminal justice system. There is no systematic learning disability awareness training for staff within the criminal justice system. The local offender health team does not yet have informed representation of the views and needs of people with learning disabilities.	1. To identify numbers of people currently in the criminal justice system. 2. To identify the key health providers. 3. The adapt GP & Hospital training pack to meet their training needs		CWPT - P Humphries
Health Self Assessment Action Plan: Standard C - Safeguarding, Governance, Assurance and Quality. Action Status: RED	Objective C2: Commissioners have assurance that the four outcomes of the Equality Act 2010 include people with learning disabilities. SHA found that there was insufficient evidence that people with learning disabilities are included throughout the Equality Delivery System.			Jacqueline Barnes /Helen Bunters
	Objective C6: The provider has assurance that the four outcomes of the Equality Act include people with learning disabilities, the SHA found no evidence that EDS is published in an accessible format			Jacqueline Barnes /Helen Bunters

Health Self Assessment Action Plan: Standard A - Access to Health Action Status: Amber	Objective A1: LD QOF Register – insufficient evidence of people on the registers who have profound and multiple LD and / or are from BME Communities and / or have autism.	1. QOF registers to include coding for people with a learning disability / BME / Autism.		Kerry Woods
	Objective A3: Access to disease prevention, health screening and health promotion. Limited comparative data available.	1. QOF registers to include coding to ensure comparison with access by the general population.		Public health - John Ford
Health Self Assessment Action Plan: Standard B - People with Complex Needs Action Status: Amber	Objective B2: The local JSNA includes needs assessment and corresponding plans are in place which reflect policy and best practice guidelines for people with: • with learning disability and Profound and Multiple Learning Disability (PMLD), • Autism, • challenging behaviour, • Mental Health needs, • Older adults, • Dementia	1. Public Health to review JSNA and incorporate the health needs of people with learning disabilities at the next review.		Public health - John Ford
	Objective B3: Plans in place to ensure local availability of the future mainstream and specialist health services needed to support young people approaching adulthood. Additional work required for 14 – 25 planning.	1. Develop and implement a robust integrated plan to ensure improved availability of services to meet agreed outcomes.		CCG and Public Health
Health Self Assessment Action Plan: Standard C - Safeguarding, Governance, Assurance and Quality Action Status: Amber	Objective C1: All Commissioners can assure that quality safety and safeguarding is being addressed. SHA unable to ascertain the position for all commissioners.	C1 – C16 response: Review how safeguarding, governance arrangements maintain and assure quality and equity.		Jacqueline Barnes

Objective C4: Commissioners are assured that each provider routinely monitors implementation of the Mental Capacity Act and can evidence improvement in practice. SHA found limited evidence through contract monitoring.	C1 – C16 response: Review how safeguarding, governance arrangements maintain and assure quality and equity.		Jacqueline Barnes
Objective C5: Each provider has assured their board and others that quality, safety and safeguarding for people with learning disabilities is a clinical strategic priority within all health services. The SHA were not presented with any evidence from the Trusts.	C1 – C16 response: Review how safeguarding, governance arrangements maintain and assure quality and equity.		Jacqueline Barnes
Objective C9: The Commissioners know of all NHS funded individual care packages and have mechanisms in place for on-going monitoring and review. The SHA found that information is currently stored in several different locations	C1 – C16 response: Review how safeguarding, governance arrangements maintain and assure quality and equity.		Jacqueline Barnes / Andy Bennett
Objective C11: The Commissioner can demonstrate that the local safeguarding adult board is assured of all providers safeguarding practice. The SHA found that the information exists but is not always received by the Board from NHS organisations.	C1 – C16 response: Review how safeguarding, governance arrangements maintain and assure quality and equity.		Jacqueline Barnes

	Objective C12: The Commissioner can demonstrate that the PCT / CCG / Health and Wellbeing Board and Learning Disability partnership Board have been informed of the services commissioned and assured that safe services of acceptable quality are delivered. The SHA found insufficient evidence of service user / carer involvement	C1 – C16 response: Review how safeguarding, governance arrangements maintain and assure quality and equity.		Public health - John Ford/ Jacqueline Barnes
	Objective C13: The Commissioner can demonstrate that people with learning disabilities and their families are involved in recruitment and training and monitoring of services. The SHA evidence of involvement in monitoring is limited.	C1 – C16 response: Review how safeguarding, governance arrangements maintain and assure quality and equity.		Ester Peppel
	Objective C16: Health and Wellbeing Board, Clinical Commissioning Groups and Commissioning Support Units can demonstrate that any plans include people with learning disabilities. The SHA are looking to see evidence of the involvement of CCG / CSU in the development of the Joint Commissioning Plan	C1 – C16 response: Review how safeguarding, governance arrangements maintain and assure quality and equity.		Paul Mconnell /Sue Davis

Coventry City Council

Report

To: Coventry Health and Wellbeing Board **Date: August 2015**

From: System Wide Transformation

Subject: System Wide Transformation Programme Progress Report

1 Purpose

This report provides the Coventry Health and Wellbeing Board with an update on progress for the System Wide Transformation Programme provide an overarching, high-level description of the transformation that will be used to deliver the planned and urgent care programme.

2 Recommendations

The Coventry Health and Wellbeing Board is asked to:

- Approve the strategic aims of the System Wide Transformation Programme;
- Provide strategic direction going forward

3 Background

3.1 The 'Five Year Forward View', describes a position that without transformative system change, the local health and social care economy will not be able to address the key challenges we are experiencing. The NHS is going through the biggest financial squeeze in its history. The delivery of productivity improvements between 2010 and 2015 has proved challenging and previous 'go to' options are largely exhausted. The Association of Directors of Adult Social Services published "Distinctive, Valued & Personal: Why Social Care Matters", setting out the significant challenges already experienced within social care and evaluating future challenges that compound the difficulties in delivering transformational change under increasingly challenged health and social care economies.

3.2 At the same time, demand for services has sky rocketed; key targets, such as Referral To Treatment Time or the 4 hour A&E waiting time, are being missed across the country and the pressure on community and mental health services is mounting. This is highlighted by the current delayed Transfers of Care pressures on the local health and social care system that are being experienced by all partners.

3.3 With this comes the opportunity to fundamentally think differently about how health and social care organisations can address the challenges collectively and in more integrated ways. As a consequence, a radical refocus of the way health and social care partners work together has been proposed. A system wide transformation programme has been conceived that is tasked with designing and delivering fundamental changes across the

local health and social care economy. The programme encompasses existing change programmes that are being delivered across health and social care, including the Better Care Coventry programme and the urgent care programme.

3.4 Chief Officers from across the five health and social care organisations (Coventry City Council, UHCW, CWPT, CWCCG and Coventry and Rugby GP Alliance) have signed up to this approach. The following outlines the vision for the programme, how this vision will be achieved.

3.5 As a system leadership team we believe that to achieve our strategic aims and system wide objectives to improve patient care and outcomes the following should be our stretch ambitions –

- **No-one comes to hospital who can be managed elsewhere**
- **No-one is admitted to hospital without an acute hospital need**
- **No-one waits more than 24 hours to leave hospital once they are medically fit for discharge**
- **No one receives on-going care and support when they don't need it and when care and support is required it promotes independence, choice and control**

3.6 We must **transform** the way that its people think and how they deliver services in the future **–** taking a **'bottom-up',** empowered and process focused approach to change. The leadership team believes that by focusing on quality, patient value and embedding a culture of team-based continuous improvement, underpinned by Systems Thinking, we will:

- **Improve patient outcomes.**
- **Empower our people to take ownership of continuous improvement so that it becomes 'the way we do things around here'.**
- **Ensure is the improvements we make are sustainable in the long term and;**
- **Improve performance across the system**

4 Our Vision – what we will be like in 2019

- Better connected with our communities so that they will be more confident, sustainable and do more for themselves – embracing the underlying principles of both The Five Year Forward View and Distinctive, Valued & Personal in that we will have 'a new relationship with patients and communities'

- A quality-led system of collaborating organisations that balance the needs of our communities -patients, carers and families.

- Our processes will be flexible and responsive to the needs of our community and the things that people value.

- Our staff will be empowered, trusted and have ownership of continuous improvement – using their skills and knowledge to improve what we do and releasing more time to care.

4.1 *Our strategy – to achieve our vision we will:*

- Understand our communities, citizens and patients - what they need and value most.

- Focus on improving **quality** and increasing **value** in the end-to-end patient and citizen journey, system pathways and processes. We know that by focusing on **quality** and **value** we will remove waste and improve **productivity** – **releasing and reinvesting time to care** and where appropriate, reduce costs so that we are a sustainable system.

- Engage with our partners in whole system redesign so that together we **prevent** our shared **demand** that is rooted in complex social problems.

- Develop our pathways so that they are, **flexible** and **responsive** to changes in need and demand so that valuable resources are used more efficiently and effectively.

- Where appropriate be bold and radical in redesigning areas of our system – starting with a blank sheet of paper.

- **Empower** and **trust** our people and their teams to take ownership of **Continuous Improvement** - giving them the skills, tools and time to succeed. We will give our people permission to test things and learn, always asking what, when, where, why and how?

- We will sustain our commitment to a quality approach and empowerment through our sustained **leadership** – modelling our own behaviour and by being visible.

- We will move positively together towards our shared vision with the confidence to react less to external events and stakeholders.

4.2 *What success will look like*

- Our communities are more confident, independent, have choice and control, more satisfied with our services and national indicators tell us we are in the top 10 percentile for patient and citizen satisfaction.

- Our services are more flexible and responsive to patient and citizen needs, more productive and cost less to provide.

- Our staff have two jobs – to do their job and improve their job.

- Our staff say they feel empowered, fully engaged and valued. We are seen as an employers of choice.

5 System Transformation

5.1 The integrated transformation programme SRO's have recognised that whilst a large number of ideas and potential changes have been identified to date, they are largely focused on addressing the immediate problems – and are therefore more closely aligned to business as usual elements of organisational resilience plans.

5.2 To ensure that the Integrated Transformation Programme does not solely deliver business as usual changes, each workstream was tasked with identifying three schemes that would deliver system wide transformational change and subsequently those were distilled down to the three priority projects for the system.

6 Delivering Transformational Change

6.1 Establishment of a trusted geriatric assessment process

6.1.1 The current assessment process for frail elderly patients does not utilise available resources in an optimum manner, particularly as there is no consistency in assessment between acute and community settings.

6.1.2 The establishment of a trusted assessment process will ensure that all professionals involved in the care delivery for particular patient will assess patients in a consistent manner, ensuring that their care and treatment can centre on what matters to them.

6.1.3 This will improve the efficiency and effectiveness of community and hospital services, aligned to the getting emergency care right principles, by ensuring that unnecessary procedures can be eliminated and that patients are only admitted when absolutely necessary.

6.1.4 The scale and scope of when and how a CGA will be undertaken in comparison to a proportionate screening assessment will be considered as will consideration of the "must haves" that individual organisations may require within their own assessment requirements.

6.2 *Creation of an integrated community therapeutic based pull model*

6.2.1 Therapy services perform a crucial role in assisting the recovery of patients following an acute medical episode –for example a stroke or an operation – in order to maximise their independence. It is recognised that there is currently insufficient capacity within hospital therapy teams to meet the needs of patients.

6.2.2 An integrated community therapy pull team would be in a position to provide therapy input to a patient's recovery both in community and hospital settings. This team would also be able to facilitate discharge of patients from a hospital to community settings, when the patient is medically fit. This would therefore improve both the patient's recovery and flow through the hospital.

6.2.3 Whilst the model is a therapy pull model – there will be exploration of how existing resources can be aligned for the model. Whilst described as a "therapy pull model", the model will not necessarily be staffed with therapists but will also consider the role of skilled but non-professionally qualified workers and the role of commissioned services in delivering therapy plans and reablement

6.3 *Establishment of step up community response and crisis reduction capacity*

6.3.1 Current support mechanisms are mainly focused on ensuring patients can be effectively discharged from hospital. Both the common assessment process and integrated

community therapy team will continue to support people to leave hospital as soon as possible.

6.3.2 The creation of and/or reconfiguration of existing capacity to provide step up community capacity will enable targeted support to be provided to individuals at risk of admission by providing intermediate care services that are able to resolve potential crisis situations and also avoid hospital admissions.

6.3.3 Consideration of how primary and secondary care models need to align to support step up provision will form an important part of the outputs form this priority area.

6.3.4 The GE Finamore analysis and model will be utilised to inform requirements, however the model, being based on national best practice may need to be considered as a medium to long-term transformational piece in order to be delivered in a financially sustainable way

7 Next steps

- Agree high level timeline and milestones for the programmes
- Agree common metrics for defining success by programme, and monitoring performance against them on a regular basis, we can them move towards and develop system KPI's that feed into mouthy dashboards shared with all organisations in the system.

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Coventry City Council

Report

To: Coventry Health and Wellbeing Board **Date:6th October 2015**

From: Kaye Drury (MCA/DoLS/AMHP Development Lead)

Subject: Deprivation of Liberty Safeguards

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1 Purpose

1.1 To provide Board Members with background information about the current DoLS scheme
1.2 To highlight the challenges which DoLS presents to Coventry
1.3 To provide an overview of the proposed changes to the DoLS scheme

2 Recommendations

2.1 That Board members note the contents of this report

3 Information/Background

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3.1 DOLS were an amendment to the 2005 Mental Capacity Act which were introduced in 2009. They provide a legal process for authorising a deprivation of liberty for people who lack capacity to make decisions about their care and accommodation arrangements. DOLS up until March 2014 applied only to people residing in **registered care homes** and to those in **hospitals settings**.

3.2 The rationale for DOLS was to ensure compliance with Human Rights legislation and Article 5 of the European Convention on Human Rights. Article 5 stipulates that any deprivation of liberty must be authorised by a procedure prescribed in law

3.3 Under DOLS legislation local authorities are known as '**Supervisory Bodies'** and have the responsibility for assessing and authorising deprivations. Hospitals and registered care homes are known as '**Managing Authorities'** and are responsible for not depriving someone of their liberty without an authorisation. A Managing Authority should request an authorisation from the Supervisory Body if they think someone in their care is deprived of their liberty. Timescales are set in the legislation for responding to these requests.

3.4 The DOLS process involves six separate assessments with the purpose of establishing that any deprivation of liberty is in the person's best interests. If it is not it should be ended. The lengthiest of the assessments are the **Best Interests** and the **Capacity** assessments, both usually undertaken by specially trained social worker (BIA). Local authorities have a responsibility to authorise the BIA's assessment, and this function is carried out by social care managers who have undergone relevant training.

4 The 'Cheshire West' ruling and its impact on Local Authorities

Until March 2014 the number of requests for DOLS authorisations was relatively low: in Coventry around 120 per year. There then followed a landmark Supreme Court ruling which effectively redefined what constituted a deprivation of liberty. A new '**acid test'** for determining deprivations was established, and this considerably lowered the threshold for applying DOLS. A deprivation of liberty of a person lacking capacity was said to exist whenever he or she was:

- Subject to continuous supervision and control
- Not free to leave the care home or hospital.

4.1 Other factors such as the person being compliant with their care, or the purpose of the placement were deemed to be irrelevant. Following the Cheshire West ruling the volume of DOLS applications increased dramatically, both nationally and in Coventry. In Coventry numbers of applications in 2014/15 was 681; an increase of 458%. Nationally the number increased tenfold between 2013/14 and 2014/15.

4.2 The upsurge in DOLS applications has meant that required timescales for assessing and authorising deprivations are not being met. As a result of these delays individuals' Article 5 human rights are being breached. Some Councils are facing litigation and damages have been awarded in a number of cases. Courts are tending to distinguish between 'procedural' and 'substantive' breaches. For substantive breaches the awards have been set at 3.5.to 4.5K per month of unauthorised Deprivation of Liberty plus full refund of any care home costs the person may have incurred.

4.3 The risk to the Council is increased by a further growth in the rate of DOLS applications in 2015/16 so far, and the need to review deprivations within a twelve month period.

5 Risks to Coventry City Council

- Breaches of individuals' Article 5 Human Rights due to delays in assessing/ authorising deprivations
- Potential deprivations of self-funders in private homes and hospitals which we do not know about
- Unauthorised community deprivations of liberty.

5.1 The added impact of reviews – the authorisation only lasts maximum one year – so need to be reassessed every year, financial cost to Council of agency staff, training staff – Courses have to be approved by the Secretary of State, process unclear now abolition of TCSW, courses oversubscribed, length of course very variable, quality variable medical assessments, impact on our legal services time and expertise, impact upon other areas of ASC activity such as Safeguarding, Care At, AMHP work.

6 <u>Actions taken or being taken by the Directorate</u>

- Establishment of dedicated BIA team of 5.5 staff. In practice it has been difficult to recruit BIA's
- We have put in place a contract with a specialist company called Liquid – but this has been costly £235K (approx. for 500 cases)
- We are increasing internal capacity by identifying further staff to be trained as assessors

- We are increasing the number of team leaders and managers who can act as authorisers
- Currently in process of identifying deprivation in the community cases for sending to the Court of Protection. Process for the Court remains unclear as are costs.
- Prioritising referrals.
- Improving DOLS administration

7 Summary of the challenges presented by DOLS going forward.

- As referral rates continue to increase so too do the costs incurred by the Council. Each medical assessment alone (required as part of the DOLS process) costs £170.
- Devoting staff time and financial resources to DOLS-related activity detracts from other key areas of social care work.
- Outside the DOLS framework deprivations in 'community settings', such as in one's own home or supported living schemes, now require authorisation by the Court of Protection. Scoping of this work is needed, but legal costs will be a minimum of £400 per case.
- With BIAs in high demand it is difficult for local authorities to recruit them to Council contracts. Many BIAs are operating independently or through social care agencies. This escalates costs.
- There is a shortage of BIA courses in Higher Education establishments. This impedes the Council's ability to speedily train up its social workers as BIAs. Discussions are currently being held with University of Warwick and the University of Bournemouth about delivering a 'fast-track' qualifying course for Coventry and our local authorities in early 2016..
- Although there is a Law Commission led review of DOLS commencing in July 2015 any changes in the law are unlikely to happen before 2017 at the earliest.
- The future, a new proposed scheme called protective care and will encompass all settings for people who lack capacity e.g. hospices, shared lives, own home.
- Estimated National cost £600 million
- Hospital patients will have a separate form of assessment and authorisation
- Amendment to Mental Health Act to cover hospital authorisations and the extension of tribunals to all clients and statutory rights of appeal (This duty will fall on the Local Authority)
- Creation of Approved Mental Capacity Professional, who will authorise care plans involving a deprivation of liberty, oversee appeals and oversee case managers who are creating these care plans
- Greater role for Tribunals in place of Court of Protection for appeals
- Will involve need for more statutory advocates as well as a role for Care Act advocates
- The new protective care scheme will remain complex, challenging and costly to Local Authorities

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Appendices