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### Scrutiny Co-ordination Committee

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**Time and Date**

10.00 am on Wednesday, 12th October, 2016

**Place**

Committee Rooms 2 and 3 - Council House

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**Public Business****1. Apologies and Substitutions****2. Declarations of Interest****3. Minutes**

(a) To agree the minutes of the previous meetings held on 7 and 22 September, 2016 (Pages 3 - 10)

(b) Matters Arising

**4. Reshaping Drug and Alcohol Services in Coventry (Pages 11 - 20)**

Briefing Note of the Director of Public Health

Councillors K Caan and R Ali, Cabinet Member and Deputy Cabinet Member for Public Health and Sport, have been invited to the meeting for the consideration of this item

**5. Joint Strategic Needs Assessment (2016) and Joint Health and Well Being Strategy (2016-2019) (Pages 21 - 106)**

Report and Presentation of the Director of Public Health

Councillors K Caan and R Ali, Cabinet Member and Deputy Cabinet Member for Public Health and Sport, have been invited to the meeting for the consideration of this item

**6. Outstanding Issues (Pages 107 - 110)**

Briefing Note of the Executive Director of Resources

**7. Scrutiny Co-ordination Committee Work Programme 2016/2017 (Pages 111 - 114)**

Report of the Executive Director of Resources

## 8. Any Other Items of Public Business

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

### Private Business

Nil

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Chris West, Executive Director, Resources, Council House Coventry

Tuesday, 4 October 2016

- Notes:1) The person to contact about the agenda and documents for this meeting is Suzanne Bennett, Democratic Services, Council House, Coventry, telephone 7683 3072, alternatively E-mail: [suzanne.bennett@coventry.gov.uk](mailto:suzanne.bennett@coventry.gov.uk)/[liz.knight@coventry.gov.uk](mailto:liz.knight@coventry.gov.uk)
- 2) Council Members who are not able to attend the meeting should notify Suzanne Bennett no later than 9.00 a.m. on the day of the meeting, giving their reasons for absence and the name of the Council Member (if any) who will be attending the meeting as their substitute.
- 3) Scrutiny Board Members who have an interest in any report referred to this meeting, but who are not Members of this Committee, have been invited to notify the Chair by 12 noon on the day before the meeting that they wish to speak on a particular item. The Member must indicate to the Chair their reason for wishing to speak and the issue(s) they wish to raise.

Membership: Councillors N Akhtar, J Blundell, G Crookes, D Gannon, L Kelly, R Lancaster (Chair), J McNicholas, M Mutton and R Singh (Deputy Chair)

By invitation Councillors

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

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

**Suzanne Bennett/Liz Knight, Governance Services - Telephone: 024 7683 3072/3073**

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**Coventry City Council**  
**Minutes of the Meeting of Scrutiny Co-ordination Committee held at 10.00 am on**  
**Wednesday, 7 September 2016**

Present:

Members: Councillor R Lancaster (Chair)  
Councillor N Akhtar  
Councillor J Blundell  
Councillor G Crookes  
Councillor D Gannon  
Councillor L Kelly  
Councillor A Lucas  
Councillor J McNicholas  
Councillor R Singh (Deputy Chair)

Other Members: Councillor G Duggins

Employees:

G Holmes, Resources Directorate  
P Jennings, Resources Directorate  
L Knight, Resources Directorate  
M Reeves, Chief Executive  
A West, Resources Directorate

Other Representatives: Alan Markey, Coventry Independent Advice Service

Apologies: Councillor M Mutton, substitute Councillor Lucas

## **Public Business**

### **13. Declarations of Interest**

There were no declarations of interest declared.

### **14. Minutes**

The minutes of the meeting held on 13<sup>th</sup> July, 2016 were signed as a true record subject to the inclusion of Councillor J McNicholas in the attendance for the meeting and the inclusion of the following bullet point in the seventh paragraph of Minute 7 headed 'Crime and Community Safety Performance': How the funding was allocated according to evidence and identified need.

There were no matters arising.

### **15. Business Rates Reform**

The Committee considered a briefing note and received a presentation of the Executive Director of Resources on the national changes to Business Rates (BR) that were expected to be introduced from 2020 including 100% local retention of

Business Rates. Information was provided on the potential impact on Coventry as well as key issues relating to students and the university sector. Councillor Duggins, Cabinet Member for Policy and Leadership attended the meeting for the consideration of this item along with Alan Markey, Director of Coventry Independent Advice Service.

The briefing note indicated that the fundamental change proposed by the Government related to local councils retaining 100% of BR income compared to the 49% retained currently. The Government was currently consulting on changes and had invited views on the future running on the BR scheme. This covered a number of aspects that would influence the financial impact on local government as a whole as well as the allocation of funding between individual authorities. The outcome would dictate whether the early years of the changes would result in a positive, negative or broadly neutral impact on Coventry's financial position.

Information was provided on the key financial aspects likely to be determined. The briefing note highlighted a 20/21 model which showed some of the factors involved and how these could affect Coventry's position including the current system position with 49% retained BR and grants, the new system 'optimistic' position with 100% retained BR and grants the new system 'pessimistic' position with 100% retained BR and no grants.

The presentation referred to the current position, the headline changes and to the consultation responses which were still being developed and were to be submitted as a Combined Authority response.

In relation to the university/ student sector, the Board were informed that any properties providing student accommodation were not liable for a business rate charge and that Council tax legislation allowed for full time students to be exempt for Council Tax purposes. This affected approximately 3,800 properties in the city. Further information was provided on the mandatory (charitable) relief on the non-dwelling properties owned by the city's two universities.

Alan Markey provided an explanation about the current position relating to Attendance Allowance that was paid at two rates and was used to improve an individual's quality of life. There was a possibility that the responsibility for payment could transfer from the Department of Work and Pensions to Local Authority control.

Members questioned the officers and the Cabinet Member on a number of issues and responses were provided, matters raised included:

- A concern about the lack of information relating to the 36 consultation questions and proposed responses with a request for an additional meeting to provide the opportunity to consider these
- A concern about the inclusion of the reference to the two universities and their students, with an acknowledgement of the partnership relationship with the Council and the major economic impact they bring to the city
- Clarification about how the revenue support grant was assessed, including the compensation element for students
- A detailed explanation about the financial model set out in the briefing note

- An acknowledgement of the importance of getting the right consultation responses back to the Government and the potential of the new system to bring further cuts to the Council's finances
- Details about the possible impact of Attendance Allowance, including the current number of claimants in the city and the associated costs
- The potential financial impact of having a directly elected mayor for the Combined Authority area
- A request for further information about the potential for BR pooling within the Combined Authority area and what the Council was doing to maximise BR growth.

**RESOLVED that:**

**(1) The content of the briefing note and presentation be noted.**

**(2) An additional meeting of Scrutiny Co-ordination Committee be held in the week commencing 19<sup>th</sup> September, 2016 to allow members the opportunity to consider the Government consultation questions and the relevant responses.**

**(3) A further report with the consultation questions and any available responses as well as the potential for the pooling of business rates within the West Midlands Combined Authority and the Council's strategy for maximising business rates income be submitted to the additional meeting.**

**16. West Midlands Combined Authority**

The Committee considered a briefing note of the Chief Executive which informed about the scrutiny and audit arrangements of the West Midlands Combined Authority (WMCA) and the Strategic Economic Plan (SEP). Cllr Duggins, Cabinet Member for Policy and Leadership attended the meeting for the consideration of this item.

The briefing note indicated that the WMCA was establishing a scrutiny function alongside an Audit Committee with representation on both from the member councils. Appendices to the note detailed the governance structure for the WMCA with the links to the Overview and Scrutiny Committee and the Audit Committee; the terms of reference for these Committees; and the minutes from the first meeting of the of the Overview and Scrutiny Committee held on 15<sup>th</sup> July. The Committee were informed that Councillor Bains had attended this meeting, however, following changes to the finalised constitution for the WMCA concerning appointments, Councillor John Mutton had subsequently been appointed as the Council's nominated representative with Councillor Rupinder Singh as the nominated substitute. The issues being considered by this Committee were highlighted.

The Committee noted that, alongside the regular reports provided to all Members at Council meetings by Councillor Duggins, it was expected that Coventry members of the Committees would report back to the relevant Scrutiny Boards to ensure that there was a full overview of WMCA activities.

An executive summary of the Strategic Economic Plan was set out at a further appendix to the report. Councillor Duggins held the key portfolio of productivity and

skills and would provide regular feedback to Members on this priority action in the SEP. He was a member of the SEP Board which monitored progress against the SEP actions.

Members questioned the officers and the Cabinet Member on a number of issues and responses were provided, matters raised included:

- The potential complexities for any call-in arrangements for the Scrutiny function
- The Council's representation on the audit and overview and scrutiny committees
- How the Council representatives could feedback information and how this could be managed and shared
- The priority actions in the Strategic Economic Plan, specifically that HS2 growth should also prioritise the wider transport network and infrastructure to support economic growth
- The timescales for delivery of the SEP and performance management of progress delivery.

Members were concerned that by appointing a Cabinet Member to either the Audit Committee or Overview and Scrutiny Committee of the WMCA there could possibly be a conflict of interest and it would be more transparent to appoint a Member from Scrutiny.

**RESOLVED that:**

**(1) The governance structure of the WMCA including the scrutiny function be noted.**

**(2) Regular updates from the Council's representatives on the Overview and Scrutiny Committee be submitted to future meetings of the Committee.**

**(3) Progress reports on the WMCA Strategic Economic Plan be submitted to future meetings of the Committee.**

**(4) Councillor Duggins, Cabinet Member for Policy and Leadership be requested to make future City Council appointments to the Overview and Scrutiny Committee and Audit Committee of the WMCA from non-executive Members of the Council.**

**(5) Feedback from any Forums set up to consider Scrutiny across the WMCA be reported back to Scrutiny Co-ordination Committee or the appropriate Scrutiny Board for discussion.**

**17. Report Back on Conference - Civic Visit to Kiel Week, 17 to 20 June, 2016**

The Committee considered a report of the Lord Mayor, Councillor L Harvard concerning his visit to Kiel, Germany from 17<sup>th</sup> to 20<sup>th</sup> June, 2016 and the associated Kieler Woche (Kiel Week) celebrations. The report detailed the costs and benefits of attendance.

**RESOLVED that the report of the Lord Mayor's civic visit to Kiel and the Kieler Woche celebrations be endorsed.**

**18. Scrutiny Management**

In accordance with the Constitution, the Committee were informed that Councillor Lancaster, Chair of the Scrutiny Co-ordination Committee attended the Cabinet meeting on 2 August, 2016 for the item relating to "Coventry City Council Response to InterCity West Coast Rail Franchise Consultation" and agreed that the decision was urgent and that call in should not apply. The Committee were informed that the reason for the urgency was that the City Council's response to the Consultation needed to be sent to the Department of Transport before the closing date for submissions which was 11.45 p.m. on 2<sup>nd</sup> August 2016.

In addition, Councillor McNicholas, acting as nominee of the Chair of the Scrutiny Co-ordination Committee, attended the meeting of the Cabinet Member for City Services on 15<sup>th</sup> August, 2016 for the item relating to "Part Closure of Cox Street Car Park - Objection" and agreed that the decision was urgent and that call in should not apply. The Committee noted that the reason for the urgency was that, to enable the first phase of the development to open for the academic year commencing September 2017, a planning application needed to be submitted in early September, 2016 for consideration at Planning Committee on 29<sup>th</sup> September, 2016. If the application was not submitted in time, then the programme of works would be delayed and the timescales for opening would not be achievable.

**19. Outstanding Issues**

The Committee considered a briefing note of the Scrutiny Co-ordinator the purpose of which was to bring to the Committee's attention the responses received from Cabinet Members and officers in regard to recommendations and actions from previous meetings.

Appendix 1 to the note detailed the recommendations and actions from the last Board meeting on 16<sup>th</sup> July, 2016.

At the start of the year, the opportunity was introduced for members of the public to suggest topics that Members of the Committee could consider adding to the Committee or Scrutiny Boards work programmes. Details of the four suggestions received to date were set out in a second appendix. The Committee considered each issue determining whether the items were appropriate for Scrutiny to consider or if they could be dealt with in another way as follows:

- To debate/ investigate the rise of the extreme right wing in Coventry - a report from Superintendent Chief Inspector Danny Long, West Midlands Police be submitted to a future meeting of Scrutiny Co-ordination Committee
- Improvements to the Upper Precinct and Market Way/ Smithford Way – current position noted and officers to be requested to consider potential discussions with future new building owners of the Upper Precinct
- Review the regularity and promotion of Ward Forums – Refer to the current review of Ward Forums and to the meeting of the Communities and Neighbourhoods Scrutiny Board (4) on 16<sup>th</sup> November, 2016 when the Board

would be considering the Empowered Citizen's Programme, engaging with residents

- The permission to build Finham Park 2 within two miles of Tile Hill Wood and Woodlands Academy – Refer to the Education and Children's Services Scrutiny Board (2) who would be considering Academisation suggesting the Board also consider the wider issue of Free Schools across the city.

**RESOLVED that:**

**(1) The outstanding issues set out at Appendix 1 be noted.**

**(2) Arising from the Committee's considerations of the four suggested Scrutiny topics as summarised above, the Scrutiny Co-ordinator be requested to provide a written response to the persons submitting the requests.**

**20. Scrutiny Co-ordination Committee Work Programme 2016/2017**

The Committee considered their Work Programme for the current municipal year.

**RESOLVED that the Work Programme be updated to include the Joint Strategic Needs Assessment, the Health and Wellbeing Strategy and Drugs and Alcohol Re-Commissioning being considered at the Board meeting on 12<sup>th</sup> October, 2016.**

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

There were no additional items of business.

(Meeting closed at 11.40 am)



**Coventry City Council**  
**Minutes of the Meeting of Scrutiny Co-ordination Committee held at 2.00 pm on**  
**Thursday, 22 September 2016**

Present:

Members: Councillor R Lancaster (Chair)  
Councillor N Akhtar  
Councillor S Bains (Sub for Councillor M Mutton)  
Councillor J Blundell  
Councillor G Crookes  
Councillor Gannon  
Councillor J McNicholas  
Councillor R Singh (Deputy Chair)

Other Members: Councillor J O'Boyle, Cabinet Member for Jobs and  
Regeneration

Employees By Directorate:-

Resources S Bennett, G Holmes, P Jennings, C West

Apologies: Councillor L Kelly  
Councillor M Mutton  
  
Councillor G Duggins, Cabinet Member for Policy and  
Leadership  
Councillor J Mutton, Cabinet Member for Strategic Finance  
and Resources

## **Public Business**

### **22. Declarations of Interest**

There were no declaration of interest.

Further to media reports following the last meeting, Councillor Gannon clarified that he does not work for either University in the City.

### **23. Business Rates Reform and Consultation**

Further to Minute 15, the Committee considered a Briefing Note of the Executive Director of Resources appended to which were two Appendices detailing proposed responses to two consultation papers published by the Government regarding proposals for 100% localisation of Business Rates.

At the request of the Committee, the Briefing Note also provided information on the potential for pooling of business rates within the Combined Authority and the

Council's strategy for maximising business rates income. The Committee noted that since the production of the Briefing Note, the situation had changed and it was now possible for the Council to remain within the Coventry and Warwickshire Business Rate pool and join the WMCA Business Rate pilot.

The Committee asked officers questions and sought clarification on a number of issues including:-

- The position regarding Universities (which was not mentioned in the consultation)
- Initial consideration regarding the range of associated budgets that could be pooled at the Combined Authority level
- The role of LEP's in relation to the process for approving levies
- How funding/budgets would be calculated and reset post 2020
- Matters relating to "fair funding" and the complexities of issues relating to this matter
- Coventry's ability to grow Business Rate in the future given its geographical constraints

The Committee recognised that the two consultations documents were only the first stages of the Business Rates Reform and that there would be a series of further consultations on this matter.

The Committee did not identify any substantive amendments to the proposed consultation responses and thanked the officers for their attendance and comprehensive responses.

**RESOLVED:-**

- 1) **That the responses to the consultation documents appended to the report be noted.**
- 2) **That officers be requested to submit further consultation documents in relation to Business Rates Reform to the Committee as and when they become available.**

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

There were no other items of public business.

(Meeting closed at 3.00 pm)



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**To:** Scrutiny Co-ordination Committee

**Date:** 12 October 2016

**From:** Jane Moore, Director of Public Health, Coventry City Council

**Subject:** Reshaping Drug and Alcohol Services in Coventry

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### 1. Purpose

- 1.1 Coventry City Council is responsible for commissioning drug and alcohol recovery services for adults and young people, which forms part of a wider programme of activity to reduce drug and alcohol related harm. The current contract for adult drug and alcohol recovery services is due to end in November 2017. This provides an opportunity to review and reshape the services to ensure that they are fit for the future.
- 1.2 Coventry City Council has developed a potential future treatment model for November 2017 onwards, based on the needs of the Coventry population, evidence of what works and findings from engagement and consultation undertaken to date with service users, wider stakeholders and the general public.
- 1.3 The purpose of this paper is to inform Scrutiny Co-ordination Committee of the findings from work undertaken to date, and to provide an opportunity for Scrutiny Co-ordination Committee to provide comments and suggestions for future drug and alcohol treatment services in Coventry.

### 2. Recommendations

- 2.1 Scrutiny Co-ordination Committee are requested to:
  - i) Review the proposed future treatment model and supporting documentation
  - ii) Endorse the proposed approach to drug and alcohol treatment in Coventry
  - iii) Contribute comments and suggestions for future drug and alcohol treatment services in Coventry

### 3 Background and context

- 3.1 Alcohol is the most widely available drug in the UK and is used sensibly by the majority of the population. It is part of our social fabric and a major contributor to the economic vibrancy of the

community. Whilst most people do not use drugs, drug misuse can be found across all communities in society. From heroin and crack use among adults, to cannabis use amongst young people, to the use of novel psychoactive substances (previously aka “legal highs”) by clubbers, drugs are available and misused by a wide range of people.

**3.2** Alcohol and drug misuse is a significant issue for individuals and communities alike. The harms caused by excessive drinking and drug taking are complex and wide ranging. Using drugs or alcohol may cause or exacerbate existing problems, harms may be acute or chronic and issues may arise from recreational use or binge drinking as well as problematic use or dependency.

**3.3** While drinking is most common among many of Coventry’s more affluent communities, those who drink at the greatest levels, and suffer the greatest health harms live in some of the city’s most deprived neighbourhoods. Alcohol and substance misuse can be found amongst homeless populations and those with mental health problems. Problematic drug use is associated with unemployment, domestic abuse, poor living conditions, ill-health and safeguarding concerns.

**3.4** The Coventry vision is to reduce the harms caused by alcohol and drug misuse and make Coventry a healthier, wealthier and happier place to live, where less alcohol and fewer drugs are consumed and where professionals are confident and well-equipped to challenge behaviour and support change.

**3.5** Coventry’s vision is to:

- Take a holistic approach that focuses on the whole person and whole family
- Support people to choose not to drink alcohol and take drugs
- Reduce the impact of alcohol and drug use on others
- Empower individuals and communities to have resilience and strength
- Focus on diversion, early intervention, treatment and recovery
- Identify, challenge and prevent substance misuse where possible
- Provide treatment and help for people when they want it
- Help people recover fully and rebuild healthy, positive lives

**3.6** Coventry City Council is responsible for commissioning drug and alcohol recovery services for adults and young people, which forms part of a wider programme of activity to reduce drug and alcohol related harm. The current contract for adult drug and alcohol recovery services is due to end in November 2017. Through analysing current need in Coventry, reviewing what works to treat drug and alcohol addiction and engaging with service users, stakeholders and the general public, Coventry City Council has developed a proposal for future drug and alcohol services in Coventry. The future treatment model is being developed alongside the Drug and Alcohol strategy for 2017-2020, which will be presented to Scrutiny Co-ordination Committee next year.

## **4 Future service model and treatment system**

**4.1** The future drug and alcohol service model for Coventry is a key component of Coventry’s Health and Wellbeing Strategy and links to all three of the Priorities:-

- Reducing health and wellbeing inequalities (the health and wellbeing gap) – with a specific focus on building young people resilience and good economic growth for the city
- Improving the health and wellbeing of individuals with multiple complex needs
- Developing an integrated health and care system that provides the right help and support to enable people to live their lives well

## 4.2 Adults

- 4.2.2 Since the existing adult treatment model was commissioned national evidence and thinking has evolved. The clinical based treatment for opiate users is still an important element however there is now renewed emphasis on a coproduced recovery system with the user at the centre, online support, peer to peer support, family support, those with multiple complex needs including drug and alcohol harm and the availability and misuse of an emerging variety of substances.
- 4.2.3 The impact of alcohol harm pre-birth and on older people consistently drinking to a hazardous level also needs greater consideration.
- 4.2.4 The future services will take a whole system approach and will be outcome based and recovery focused. It will be ambitious and characterised by its ability to motivate and support people to achieve both short and longer term goals of recovery through evidence based and innovative approaches. It will need to adopt a whole system approach and recovery must be explicit in everything it does to support people to make the changes they need to lead purposeful and fulfilling lives.
- 4.2.5 **It is therefore recommended to commission an Adult Drug and Alcohol Service that is recovery led; incorporating both prevention and treatment within a wider recovery system**

## 4.3 Family

- 4.3.1 For some individuals their family will be key to recovery. Families have a role in both supporting individuals through recovery and also require support themselves; to promote resilience and reduce likelihood of future problematic drug or alcohol use.
- 4.3.2 **It is therefore recommended to commission a family support along with service user advocacy within the wider recovery system.**

## 4.4 Children and Young People

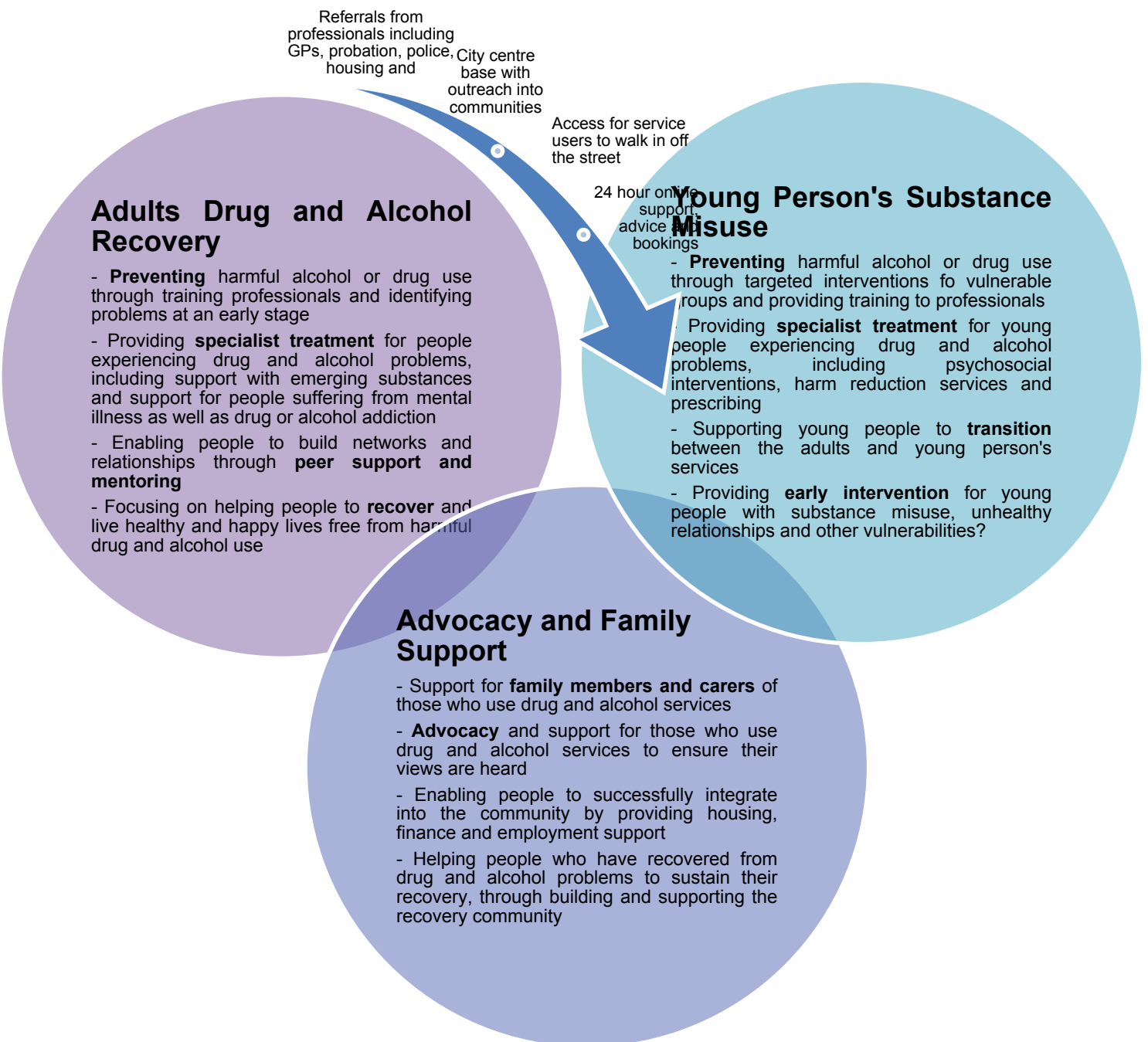
- 4.4.4 Young people's substance misuse is complex, and children of a younger age are requiring support for substance misuse, it links to other risky behaviours and risk of vulnerability. Aligning the young person's substance misuse service to the children and young person's early intervention service, rather than the adult service has been an effective way of delivering services to young people.

- 4.4.5 It is recognised that the needs of children and young people vulnerable to drug and alcohol related harm are different to those of adults.
- 4.4.6 **It is therefore recommended to commission young people’s substance misuse services as an integrated offer with wider young people’s early intervention services linked to the wider drug and alcohol recovery system.**
- 4.4.7 By commissioning young person’s drug and alcohol services as part of a wider 0-19 service offer focussing on risky behaviour and protecting vulnerable children it is anticipated it will lead to a better integration across services accessed by children, young people and their families. Both the children and young peoples and adult services will have an emphasis on safeguarding those at risk of harm and robust transition pathways will be in place with some flexibility for age criteria. The children and young people’s service will support children and young people who are at risk of harm, either from their own substance misuse or that of their parents or carers to reduce intergenerational substance misuse.
- 4.4.8 **Appendix 1** gives a visual image of the proposed drug and alcohol recovery model / system, and an outline of proposed system objectives and priority groups.

## **5 Next steps**

- 5.1 The proposed future drug and alcohol treatment model is out to consultation until the end of September 2016. The consultation includes a further survey, available in both electronic and hard copy, and service users will be supported by volunteers to complete the survey. Several stakeholder engagement events are planned for September, after which the treatment model will be finalised and proceed as per the Council decision making process. Once agreed, a service specification will be developed and Coventry City Council will tender for the new drug and alcohol services.

## Appendix 1: Future model of drug and alcohol recovery services



## **Appendix 2: Coventry drug and alcohol needs assessment 2016**

The 2016 Coventry Drug and Alcohol Needs Assessment, which can be accessed in full at: [http://www.coventry.gov.uk/downloads/file/21620/coventry\\_alcohol\\_and\\_drugs\\_needs\\_assessment\\_2016](http://www.coventry.gov.uk/downloads/file/21620/coventry_alcohol_and_drugs_needs_assessment_2016) found that nationally, there has been a fall in the proportion of men and women who are frequent drinkers over the last ten years, and the number of alcohol related deaths is decreasing. There has also been a long term downward trend in drug use over the last decade.

Coventry has a considerably larger abstinent population than many other areas. Almost 21% of the adult population do not consume alcohol, which is likely to be due to the cultural diversity in Coventry. Trend data across the city also indicates that drug use is falling, and the proportion of Coventry school children who reported trying drugs fell from 20% to 10% over the last 15 years. Offences where alcohol is a factor has shown marked falls in recent years in Coventry. However, there are still sections of the population who are drinking at harmful levels. Coventry's Household Survey shows an increase in older adults drinking five or more days a week, with men three times more likely than women to drink on at least three days per week. Coventry's rate of hospital admissions for alcohol related conditions is significantly worse than the average for England, but similar to comparable areas of deprivation, and has reduced year-on-year for the last three years faster than the national average.

Approximately 14,000 people in Coventry are high risk drinkers, however only 6% of high risk drinkers access treatment services. In addition, it is estimated that only 46% of opiate and / or crack users in Coventry are in treatment, which is below the national average (52%), and there are indications that the average age of those accessing treatment services is increasing.

Although the number of people using alcohol and taking drugs is reducing nationally and locally, the needs of alcohol and drug users are becoming increasingly complex, and there is a strong link between high risk substance use and deprivation. There is evidence that problems of alcohol and drug dependence are significantly less prevalent in the population working full time than in the unemployed and economically inactive, and many higher risk drinkers come from fractured family backgrounds, with a history of alcohol abuse in the family. The proportion of the population drinking more frequently is most prevalent among less affluent neighbourhoods in Coventry. There are also strong links between homelessness, offending and substance misuse, and Coventry has a significantly higher than average prevalence of people who have issues with substance misuse, homelessness and offending behaviours (multiple complex needs).

In addition, while the use of opiate and crack substances is falling, the use of new and emerging substances, such as novel psychoactive substances, synthetic cannabinoids and anabolic steroids are on the rise. Nationally synthetic cannabinoids were most likely to leave people needing to seek emergency medical treatment, and in 2014, the number of drug poisoning related deaths was the highest since records began.



### Appendix 3: Evidence and best practice

Coventry City Council carried out a review of national evidence and best practice, the findings of which are summarised below:

- **No single treatment approach is appropriate for all individuals.** While structured treatment has a key role to play, it is only part of the support that most people will need. Ongoing support in the community is essential for the ongoing recovery journey and often includes mutual aid and other peer support. Recovery is not just about the individual, but impacts on families and communities.
- **Social and human capital** (also sometimes characterised as **recovery capital**) play a key role in recovery from addiction. Families are a significant source of social and recovery capital. Where recovering addicts maintain strong social networks that include people who continue to use, the impact can be negative. The provision of stable accommodation is a key element in recovery capital.
- **Families can benefit from help** in providing supportive relationships, reducing levels of conflict and reducing the emotional strain on recovering addicts caused by perceptions that their families are worried. Including families in therapeutic and other recovery processes can help them support addicts effectively.
- **Peer-supported community programmes** focused on improving self-determination can have a significant positive impact on recovery from addiction. Recovering addicts can benefit from support with other aspects of their lives that enable them to improve self-determination, such as financial management skills and adopting healthy lifestyles.
- People given more general support tend to improve their levels of self-determination and enhance their prospects for sustained recovery.
- **Community-based health promotion networks** can increase success rates of established interventions such as Alcoholics Anonymous (AA).
- The provision of **vocational activity**, including training and employment, is significantly associated with greater probability of sustained recovery.
- **Barriers to recovery** include psychological problems (mental illnesses and the absence of strengths, such as self-esteem and self-efficacy), significant physical morbidities (including blood borne viruses), social isolation and ongoing chaotic substance use.

## **Appendix 4: Engagement with service users and other stakeholders**

Coventry City Council gathered views on future services from service users, professionals and members of the public via online and paper surveys and focus groups. 281 surveys were completed, of which 82 were from service users and 25 were from family members and carers. The overall findings from the engagement exercises were that:

- Respondents wanted better access to services when they were needed
- Respondents wanted better information about what services are available and how to access them
- Respondents wanted support for family and friends of service users
- Respondents wanted support for the wider issues which affect service users, their family and carers
- Respondents wanted specialist drug and alcohol support for young people

Based on these responses, it is proposed that the future drug and alcohol services will:

- Accept referrals from a variety of sources, including GPs, probation, the Police, and housing, as well as self-referrals
- Provide online advice and support, which is accessible 24 hours a day
- Accept online bookings and referrals
- Be based in Coventry city centre, but will be accessible at multiple venues and will provide outreach into communities
- Provide health promotion and publicity materials to raise awareness about what support, advice and training is available and how to access it
- Deliver training programmes to professionals to ensure they understand what advice and support is available, and how they can support those who need services to access them
- Provide advocacy and support for service users to enable them to access and engage with services
- Provide support, advice and training for family, friends and carers of those who use drug and alcohol services about substance misuse and about how to live with and support service users
- Provide a mentoring programme, so that carers can build friendships and support networks to help each other through the recovery process
- Provide housing, finance and employment support
- Provide advocacy for service users
- Provide peer mentoring and buddying
- Provide separate, specialist support for adults and young people
- Provide transition support for young people aged 18-24 to help them access the appropriate services for their needs
- Provide early intervention for young people with substance misuse, unhealthy relationships and other vulnerabilities



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Scrutiny Co-ordination Committee  
Cabinet

12 October 2016  
1 November 2016

**Name of Cabinet Member:**

Cabinet Member for Public Health and Sport – Councillor K Caan

**Director Approving Submission of the report:**

Director of Public Health

**Ward(s) affected:**

All

**Title:**

Joint Strategic Needs Assessment (2016) and Joint Health and Wellbeing Strategy (2016-2019)

---

**Is this a key decision?**

Yes – The Joint Strategic Needs Assessment is a summary of the current and future health and care needs of the local population, while the Health and Wellbeing Strategy is a summary of what the Coventry Health and Wellbeing Board will need to deliver over the next three years. The Joint Strategic Needs Assessment and Health and Wellbeing Strategy will guide the planning and commissioning of health, wellbeing and social care services across the city.

---

**Executive Summary:**

Coventry Health and Wellbeing Board has a statutory responsibility to produce a Joint Strategic Needs Assessment (JSNA) for the local authority area. 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, wellbeing and social care services within a local authority area. The key messages from the JSNA are summarised later in this report and the full document is attached as Appendix 1.

Coventry Health and Wellbeing Board is also responsible for producing a Joint Health and Wellbeing Strategy (JHWBS), which provides Coventry with a picture of what the Health and Wellbeing Board will deliver over the next three years and how partners will work together to achieve this. The Coventry Health and Wellbeing Board's vision for Coventry is that local people live happier, healthier, longer lives and have improved health and wellbeing during their lives. The three priorities agreed by the Board to help deliver its vision are:

- Working together as a Marmot City to reduce health and wellbeing inequalities
- Improving the health and wellbeing of individuals with multiple complex needs
- Developing an integrated health and care system that provides the right help and support to enable people to live their lives well.

The full document is attached as Appendix 2.

**Recommendations:**

1. Scrutiny Co-ordination Committee is requested to:
  - (i) Endorse the Joint Strategic Needs Assessment (2016) and Joint Health and Wellbeing Strategy (2016-2019)
  - (ii) Make any comments or recommendations to Cabinet about the report
  
2. Cabinet is recommended to:
  - (i) Consider comments from Scrutiny Co-ordination Committee and make any comments and recommendations about the implementation of the Health and Wellbeing Strategy (2016-2019)
  - (ii) Endorse the Joint Strategic Needs Assessment (2016) and Joint Health and Wellbeing Strategy (2016-2019)

**List of Appendices included:**

Appendix 1: Joint Strategic Needs Assessment – 2016  
Appendix 2: Joint Health and Wellbeing Strategy – 2016-2019

**Background papers:**

None

**Has it been or will it be considered by Scrutiny?**

Yes – Scrutiny Co-ordination Committee on 12 October 2016.

**Has it been or will it be considered by any other Council Committee, Advisory Panel or other body?**

Yes – Health and Wellbeing Board on 5 September 2016.

**Will this report go to Council?**

No

**Report title:** Coventry Joint Strategic Needs Assessment (2016) and Coventry Health and Wellbeing Strategy (2016-2019)

## **1. Context (or background)**

- 1.1 The Health and Social Care Act 2012 gives Health and Wellbeing Boards specific functions, one of which is to prepare Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JWBSs).
- 1.2 The Joint Strategic Needs Assessment (JSNA) looks at the current and future health and care needs of the local community. It is intended to inform and guide the planning and commissioning of health, wellbeing and social care services within a local area. It considers factors that impact on the health and wellbeing of the local community including economic, education, housing and environmental factors; as well as local assets that can help improve health and reduce inequalities.
- 1.3 The Health and Wellbeing Strategy (JHWBS) provides Coventry residents and organisations with a picture of what the Health and Wellbeing Board, through its members and wider partners, will deliver over the next three years.
- 1.4 The 2016 JHWBS reflects the progress made towards achieving the objectives originally agreed in 2013, and responds to the rapidly changing and increasingly challenging context for the wider determinants of health and the health and care system.

## **2. Options considered and recommended proposal**

- 2.1 Developing the JSNA and JHWBS is a statutory responsibility of the Coventry Health and Wellbeing Board.
- 2.2 In order to develop the JSNA and identify the priorities in the JHWBS, officers undertook a review of the 2012 Health and Wellbeing Strategy, alongside a wide ranging study of data, information and resources about the health and social care issues affecting Coventry residents. A stakeholder call to evidence was also carried out. To focus on the areas of greatest need, a prioritisation matrix was used to identify potential priorities, which considered a range of factors including size of the population affected, scale of the impact, associated economic costs and the scale of inequality. Together, this work produced a list of potential priorities, and three final priorities were chosen by the Coventry Health and Wellbeing Board:
  - Working together as a Marmot City to reduce health and wellbeing inequalities
  - Improving the health and wellbeing of individuals with multiple complex needs
  - Developing an integrated health and care system that provides the right help and support to enable people to live their lives well

### **3. Results of consultation undertaken**

- 3.1 The Coventry JSNA and JHWBS have been prepared in consultation with, and endorsed by, all members of the Coventry Health and Wellbeing Board. This includes: Coventry City Council, Coventry University, the University of Warwick, Voluntary Action Coventry, West Midlands Fire Service, West Midlands Police, Coventry and Rugby Clinical Commissioning Group, University Hospital Coventry and Warwickshire NHS Trust, Coventry and Warwickshire Partnership NHS Trust and Healthwatch Coventry.
- 3.2 In addition, from August to October 2015, a stakeholder call for evidence was undertaken. This gave various organisations working for the health and care of Coventry people an opportunity to review evidence collated to date, and to suggest additional issues for consideration. Coventry City Council received 53 responses from 28 organisations as part of the Call for Evidence, and these were taken into account when issues were prioritised.
- 3.3 The three priorities within the JHWBS have also been subject to different levels of consultation with stakeholders, professionals, current service users, potential service users and the general public in order to develop detailed work streams and action plans.

### **4. Timetable for implementing this decision**

- 4.1 The JSNA is a resource to be used by anyone working to improve the health and wellbeing of the city. It can be accessed online at [www.coventry.gov.uk/jsna](http://www.coventry.gov.uk/jsna). It is a live document which will be updated as new evidence and data is published.
- 4.2 The JHWBS is also a resource to be used to influence planning and commissioning decisions. It can be accessed online at [www.coventry.gov.uk/jhwbs](http://www.coventry.gov.uk/jhwbs). In addition, action plans are being developed against each of the priority areas which will be endorsed by the Health and Wellbeing Board at the next meeting on 17 October.

### **5. Comments from the Executive Director, Resources**

#### **5.1 Financial implications**

There are no direct financial implications for the Council arising from the JSNA and JHWBS. The Strategy commits the City Council and other partners to deliver against its priorities using existing resources.

#### **5.2 Legal implications**

The Health and Social Care Act 2012 amends the Local Government and Public Involvement in Health Act 2007 to introduce duties and powers for health and wellbeing



boards in relation to Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs).

When preparing JSNAs and JHWSs health and wellbeing boards must have regard to the Statutory Guidance and as such boards have to be able to justify departing from it.

Section 192 of the Health and Social Care Act 2012 amends Section 116 of the Local Government and Public Involvement in Health Act 2007 so that local authorities and each of its partner clinical commissioning groups must undertake a Joint Strategic Needs Assessment and a Joint Health and Wellbeing Strategy.

In preparing its strategy, consideration must be given to the extent to which the needs could be met more effectively by the making of arrangements under s75 National Health Service 2006 (rather than in any other way), any guidance issues by the Secretary of State and must involve in the preparation the Local Healthwatch organisation and the people who live or work in the area.

Local authorities and each of its partner clinical commissioning groups must when exercising any functions have regard to any relevant Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy prepared by them (s193 of the Health and Social Care Act 2012).

Health and wellbeing boards must meet the Public Sector Equality Duty under the Equality Act 2010, and consideration should be given to this throughout the JSNA and JHWS process.

## **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)?**

The JSNA and JHWBS will support the delivery of key objectives through making a positive contribution to the health and wellbeing of residents in the city.

It contributes to the Council plan objectives through:

- Improving the quality of life for Coventry people
- Improving health and wellbeing
- Reducing health inequalities
- Protecting our most vulnerable people
- Delivering our priorities with fewer resources through making the most of our assets and empowering our citizens

### **6.2 How is risk being managed?**

The JSNA and JHWBS will be accompanied by action plans against each priority which seek to ensure that progress is made and the risks associated with each area of activity are managed.

### **6.3 What is the impact on the organisation?**

There is no direct impact on the organisation.

### **6.4 Equalities / EIA**

An Equalities Impact Assessment is not appropriate for the JSNA and JHWBS, although equality impacts will be considered in advance of any changes proposed in line with the documents.

Both documents consider health status across a range of different population groups and the priorities in the JHWBS include reducing health inequalities and improving outcomes for individuals with multiple complex needs. The JHWBS also contributes towards Coventry City Council's equality objectives. Therefore, the work of the JHWBS will have a positive impact on inequalities in the city.

### **6.5 Implications for (or impact on) the environment**

N/A

### **6.6 Implications for partner organisations?**

The Health and Wellbeing Board has membership across a range of partners, including Coventry City Council, Coventry University, the University of Warwick, Voluntary Action Coventry, West Midlands Fire Service, West Midlands Police, Coventry and Rugby Clinical Commissioning Group, University Hospital Coventry and Warwickshire NHS Trust, Coventry and Warwickshire Partnership NHS Trust and Healthwatch Coventry. The Strategy commits these organisations to deliver against the identified priorities.

#### **Report author(s):**

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People

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This report is published on the Council's website: [www.coventry.gov.uk/meetings](http://www.coventry.gov.uk/meetings)

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# Coventry

## Joint Strategic Needs Assessment 2016



# COVENTRY JOINT STRATEGIC NEEDS ASSESSMENT 2016

[www.coventry.gov.uk/jsna/](http://www.coventry.gov.uk/jsna/)



WEST MIDLANDS FIRE SERVICE



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## About the Joint Strategic Needs Assessment (JSNA)

### Purpose

The Joint Strategic Needs Assessment (JSNA) looks at the current and future health and care needs of the local community. It is intended to inform and guide the planning and commissioning of health, wellbeing and social care services within a local area. It considers factors that impact on the health and wellbeing of the local community including economic, education, housing and environmental factors; as well as local assets that can help improve things and reduce inequalities.

### Ownership

The JSNA is owned by Coventry's Health and Wellbeing Board (HWBB), a meeting place for local commissioners across the NHS, people in public health and social care, councillors and representatives of HealthWatch. The group work to improve the health and wellbeing of local people and reduce health inequalities through the development of the Health and Wellbeing Strategy. Board members work together to understand their local community's needs, agree priorities and encourage commissioners to work together in order which results in better services. Coventry's Health and Wellbeing Board meets every two months. The Board is supported by a Delivery Group and has regular development sessions with a wider range of stakeholders.

- Find out more about the Health and Wellbeing Board at [www.coventry.gov.uk/hwbb/](http://www.coventry.gov.uk/hwbb/).

### Priorities

The Council's overall priorities are set out in the Council Plan, Coventry: A Top Ten City. The priorities of the Council Plan are delivered through key strategies – of which the Health and Wellbeing Strategy is one of those strategies.

- Find out about the Council Plan at [www.coventry.gov.uk/councilplan/](http://www.coventry.gov.uk/councilplan/).

### Process

National guidance recommends that the process of developing the JSNA runs alongside and is linked to the development of the Health and Wellbeing Strategy. In Coventry, we are updating the JSNA alongside a new Health and Wellbeing Strategy. Together, this gives the HWBB information that they need to work together to understand and agree the needs of the local populations, whilst setting priorities for collective action.

The current JSNA process started in April 2015. It started with a review of the 2012 Health and Wellbeing Strategy, alongside a wide ranging study of data, information and resources about the key health and social care issues affecting Coventry residents. This exercise was largely desk based; but involved representatives from across health and care to ensure it was as comprehensive as possible.

In August to October 2015, a stakeholder call to evidence was undertaken. This gave various organisations working for the health and care of Coventry people 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 organisations. The

priorities and themes that emerged from this process were incorporated into a long list of potential topics that were then rationalised.

Due to the complex, multi-faceted nature of health and wellbeing, the different issues identified through the review of evidence and call for evidence required 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 involved the use of a prioritisation matrix whereby each of the suggested topics was 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.

- Find out about the prioritisation matrix at <http://democraticservices.coventry.gov.uk/documents/s25824/Update on Joint Strategic Needs Assessment and Development of the Health and Wellbeing Board- Appe.pdf>

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

Themes	Sub-themes
<b>Mental health and wellbeing</b>	Children and adults mental health Dementia Self-harm
<b>Long-term conditions</b>	Cancer Cardiovascular disease COPD
<b>Physical wellbeing</b>	Obesity – diet & physical activity Substance misuse (smoking and alcohol)
<b>Infectious diseases</b>	HIV Tuberculosis Immunisations
<b>Resilience of health and social care system</b>	Admissions to hospital Winter deaths Falls prevention
<b>Children and young people</b>	Teenage pregnancy and teenage parents Vulnerable children and young people, including looked after children Educational attainment / employment opportunities
<b>Economy and health</b>	Jobs and economy
<b>Housing and health</b>	Homelessness Fuel poverty

## Prioritisation

In November 2015 to January 2016, a number of Health and Wellbeing Board sessions were held to present the outcomes of the prioritisation process. These sessions identified a manageable number of priority health and wellbeing needs to be addressed through the Health and Wellbeing Strategy. The above topics were discussed at these sessions, with attendees receiving short evidence-based presentations around why these topics should be considered as a priority in Coventry. Health and Wellbeing Board members then debated the case for final selection and ranked those topics that they felt needed to be addressed

through the revised Health and Wellbeing Strategy. The following topics were chosen by the Board:

- working together as a Marmot City to reduce health and wellbeing inequalities;
- improving the health and wellbeing of individuals with multiple complex needs; and
- developing an integrated health and care system that provides the right help and support to enable people to live their lives well.

These issues have been integrated into the new Health and Wellbeing Strategy for 2016-2019, and will be reviewed again in 2019-2020.

## Overview of Coventry

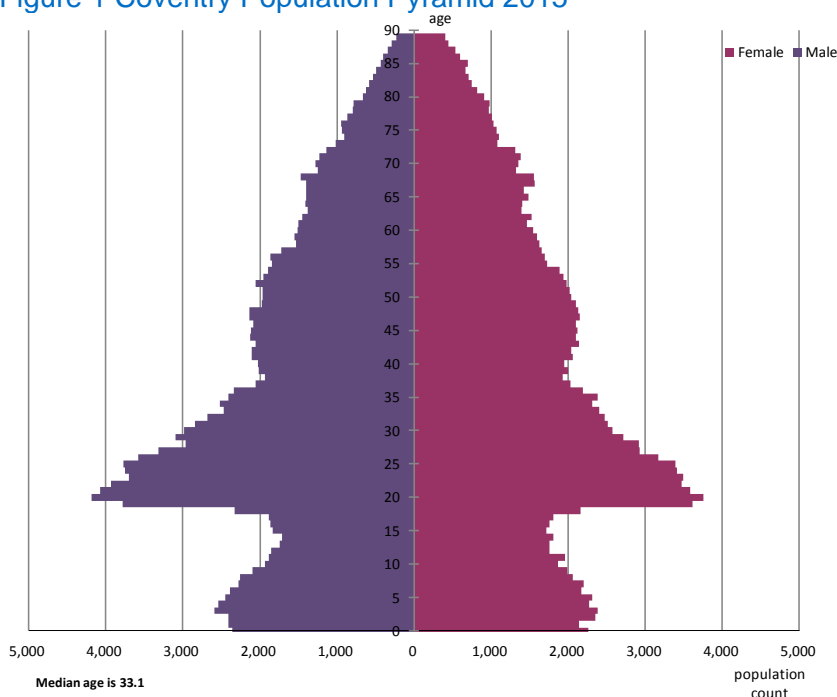
### Population

#### Latest estimates

The latest Office of National Statistics (ONS) population estimate for Coventry is 345,385 people in 2015; compared to 337,428 in 2014; a 2.3% year on year increase. As has been the case in recent years, the annual population increase between mid-2014 and mid-2015 in Coventry was estimated to be amongst the highest in the UK. Coventry's growth rate since 2000 is now slightly higher than the national average, and the main factors causing population growth in Coventry are international migration and the number of births in the city.

Coventry is a relatively young city and has been becoming younger on average in recent years; with an average age of 33.5 years; lower than England's average of 40 years, see Figure 1 Coventry Population Pyramid 2015. Specifically, Coventry has a large proportion of people between 20 and 25 years, in part due to the presence of two large universities, Coventry University and the University of Warwick. However, using the most recent ONS estimates, there is still a significant number of older people, with 35,000 aged over 70.<sup>1</sup> Coventry has a large proportion of people from black and minority ethnic (BME) communities. The most recent census recorded that 26.2% of Coventry residents were from BME backgrounds, compared to the 14.6% average across England.<sup>2</sup>

Figure 1 Coventry Population Pyramid 2015



The main cause of population growth in Coventry can be linked to net international migration. This means that there are less people migrating abroad from the city than there are people migrating to the city from abroad. This can be seen as a result of the number of international students studying at local universities in the Midlands. <sup>3</sup> ONS data suggests that over 78,000 Coventry residents were born abroad.<sup>4</sup>

- Read the population estimate 2015 report at <http://www.coventry.gov.uk/downloads/download/3597/>.

### Migrant Health Needs Assessment

The Migrant Health Needs Assessment estimates that over 80% of recent migrants in Coventry are aged between 15 and 44 years and have broadly similar general health needs to people of a similar age born in the UK, although some issues affecting particular communities within primary care were identified.

It is important to consider that migrants are a diverse group and health needs will vary significantly and, additionally, that migration is a dynamic process which is influenced by a myriad of geopolitical, social and economic factors. Furthermore, the term ‘migrant’ is a far-reaching term, encompassing a range of experiences, for instance, it includes economic migrants, international students, asylum seekers and refugees and each group is likely to have different health needs.

The Migrant Health Needs Assessment identifies that over 100 languages are spoken in Coventry and 9% of households do not have a single person within the home who speaks English as a first language. It is also identified that barriers to accessing appropriate services, discrimination, income inequality and potential social isolation may have an impact on health inequality. It is also noted that the importance of health promotion and disease

prevention measures are often overlooked when considering the specific health needs of the diverse migrant community.<sup>5</sup>

- Read the Migrant Health Needs Assessment at <http://www.coventry.gov.uk/downloads/download/3774/>.

### Population projections

Population projections from the ONS are calculated by casting forward the patterns of change in births, deaths and migration from today. Using this methodology, Coventry's population is projected to increase to 361,400 in 2021, a 7.2% increase from 2015. The ONS, however, emphasise that these estimated projections do not take into account changes in government policy or economic factors which may have an impact on population levels.<sup>6</sup>

No official population projections based on ethnicity are produced which limits modelling on this topic.<sup>7</sup>

### Ageing population

When projections from 2015 and 2020 are compared, there is an increase in the number of people aged 65 years and older (49,500 to 52,500 in 2020). However, the proportion of Coventry's population aged 65 years and older is projected to stay constant from 2015 to 2020 (14.7%) as an increase in Coventry's population is also predicted.<sup>8</sup>

Improvements in mortality rates have been greater for men than women, with the number of men aged 75 years and older increasing by 149% since mid-1974. By comparison, the number of women in the same age group has increased by 61%.<sup>9</sup> This difference is also represented in population projections where it is estimated that the number of males aged over 65 years will increase by 8% when projections for 2015 and 2020 are compared (22,200 and 24,000 respectively). In contrast, the number of females aged over 65 years is projected to increase by 4% when 2015 projections (27,200) are compared to 2020 estimates (28,400).<sup>10</sup>

Furthermore, the live birth rate (per 1,000 females aged 15-44 years) has reduced from 68.8 in 2011 to 61.1 in 2014, and has been predicted to remain constant in the near future.<sup>11</sup> This again suggests that Coventry will follow predicted national trends and will have an increasing population aged over 65 years.

### Age friendly cities

Coventry has received designation as an age friendly city. Age friendly cities is an international initiative led by the World Health Organisation (WHO) to engage cities to be more age friendly, value older people and ensure that older people have a good quality of life. The initiative provides a vehicle for a variety of organisations to work together to promote and improve the health and well-being of older people, whilst also valuing the positive contribution they can make to the city.

The work continues to improve our understanding of issues facing older people such as social participation, transport and communication.

- Read the age friendly cities baseline assessment for Coventry at <http://www.coventry.gov.uk/downloads/file/17176/>.

### Impact of an ageing population: potential social isolation

While just under a third of households in Coventry were reported in 2011 to be single-person households, there are also projected increases in people aged 65 years and older who are living alone. This may indicate a potential increase in possible levels of social isolation; however the number of people aged over 65 years living alone can only be considered to be a proxy measure. Nevertheless, it may be relevant to consider how this could impact the provision of future services. The King's Fund notes the importance of working to reduce social isolation and supporting people to maintain their independence.<sup>12</sup>

In 2015, 6,550 of the population of Coventry aged 65-74 years were projected to live alone and this is projected to increase to 6,640 in 2020, an increase of 1.4%. For the proportion of the population aged 75 years and older, the number of people living alone is projected to increase from 11,689 to 12,836 in 2020, an increase of 9.8%.<sup>13</sup>

The impact of this on future service provision and health outcomes is an area for further consideration. The *Marmot Review: Fair Society, Healthy Lives* considers that social networks and social participation can be considered protective factors against dementia or cognitive decline for those aged over 65 years.<sup>14</sup> It is also referenced that those who are socially isolated are between two and five times more likely to die prematurely than those who have stronger social ties. Social networks are also seen to have a greater effect on the risk of mortality, in that they help people to recover once they have become ill.

The Adult Social Care Outcomes Framework reports results from the annual Adult Social Care Survey (2013/14) and the biannual Carers Survey (2014/15) which asks whether social care users and carers have as much social contact with others as they would like.<sup>15</sup> Under half, 43.1%, of adult social care users are reported to have as much social contact as they would like. This stands slightly lower than reported rates for the West Midlands (44.2%) and England (44.8%). In terms of those providing care, 38.4% of carers aged 18 years and over state they have as much contact as they would like which stands at a similar proportion to the West Midlands (38.4%) and England (38.5%). However, there will be a number of factors which could influence individuals' response to this question such as the severity of health and social care needs of the person for which care is provided, along with the level of demand that is placed on carers.

Age Friendly City Initiative and its governance board are prioritised social isolation because it recognises that it is a serious issue for many older residents in Coventry. In terms of the loneliness index Coventry ranks 59 out of 326 (1 being the worst and 326 being the best) at a Local Authority level. Nobody is immune to being socially isolated, but some older people are at greater risk than others, due to personal or wider societal barriers such as personal health, mobility, income, retirement (other changes such as caring, giving up driving), transport, physical environment (lack of public toilets), housing, fear of crime etc.

The evidence is overwhelming in terms of its impact; it can have a detrimental effect on a person's mental and physical health. It also impacts on a person wellbeing and increase the onset of frailty and functional decline. It can have far reaching consequences the wider

communities. Research shows that lacking social connections is as damaging to our health as smoking 15 cigarettes a day (Holt-Lunstad, 2010). Social networks and friendships not only have an impact on reducing the risk of mortality or developing certain diseases, but they also help individuals to recover when they do fall ill (Marmot, 2010).

### Increasing demand for residential care home places

Along with projected increases in the Coventry population aged over 65 years old, it is also projected that there will be an increase in the population who will be in residential care homes. In 2015, it was projected that 1,324 people will reside in a care home with or without nursing provision and in 2020 this number is projected to increase to 1,454, an increase of ten percentage points.<sup>16</sup> It should be considered that this would also include those who self-fund their care as well as those accessing local authority support. The Adult Social Care Outcomes Framework notes there are 768 permanent admissions to residential and nursing care homes per 100,000 of the population aged 65 years and older.<sup>17</sup>

### Unpaid care

With a projected increase in the population aged 65 years and older, it is also relevant to consider the role of informal and unpaid care in filling potential gaps in health and social care service provision. Projected numbers of people providing unpaid care are estimated to increase and there is a notable projected increase in the number of people aged 65 years and older providing 50 hours or more of care a week. Of the projected 3,199 people in 2020 aged over 65 who are estimated to provide more than 50 hours of care a week, it is projected that 457 will be aged over 85 years (14%).<sup>18</sup> Consequently, it is relevant to consider how the system responds to the needs of ageing carers and Coventry City Council's Carers' Strategy should be considered as part of this.<sup>19</sup>

### Better care

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 – reducing emergency admissions to hospital;
  - home first – providing short-term support to maximise independence (and therefore reduce pressures on residential care by 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; and
  - dementia – enabling people and their carers to live as independently as possible, and to 'live well'.
- Find out more about better care at <http://www.coventry.gov.uk/info/192/0/2330/>.



## Children aged 0-15 years

The latest population estimate for 2015 suggests there are 67,767 children aged 0-15 living in Coventry.<sup>20</sup> These include: 23,714 aged 0-4; 26,016 of primary school age (aged 5-10); 18,037 of secondary school age (aged 11-15).

### Children aged under 5

There are relatively more households with dependent children in Foleshill – and in particular, 1 in 10 children in that ward are aged under 5, comprising 11% of the total population of the ward. Radford, Henley, Holbrook and Longford wards are also noted to have higher populations of children aged under 5 and it is notable that the wards with higher populations of under 5 years tend to be in those wards with higher levels of deprivation. A more even distribution of children aged 5-14 years is seen across Coventry.

Population projections for those aged between 0-15 show that increases across all age ranges are predicted; see Table 1 Population projection children aged 0-14, 2015 compared to 2021.<sup>21</sup>

Table 1 Population projection children aged 0-14, 2015 compared to 2021

Age	2015	2021
0-4	24,000	26,000
5-9	22,000	24,000
10-14	18,000	22,000
<b>Total &lt;15s</b>	<b>64,000</b>	<b>72,000</b>

## Housing

### Household composition

In the 2011 census, 31% of households in the city were one person households, with a similar proportion (31%) having dependent children. This figure is slightly higher than the rate of households including children in England (29%). Of these households, 12,400 are lone parent households (10% of all households with children) and this is higher than the rate for England (7%).

At a ward level, Foleshill has the highest number of households with dependent children (44%). Both Wainbody and Whoberley have lower levels of households which include dependent children (30% and 23% respectively) and both of these areas are known to have a high number of students residing there.<sup>22</sup>

### Housing demand

In 2013-2015, Coventry was the fastest-growing city in terms of population outside of London and the South East, with a 2.3% increase in the population per year. Combined with continuing job growth, there is an on-going demand for housing.

As part of the Council's evidence gathering for the local plan, it commissioned a strategic housing market assessment which surveyed housing supply and demand. In 2011, the vast majority (82%) of the 133,185 homes in Coventry were in private ownership<sup>23</sup>, while around one in five (18%) of homes in 2011 were considered affordable housing and were mainly owned by registered providers. Affordable housing is strongly concentrated in areas such as Tile Hill, Hillfields, Willenhall, Bell Green and Alderman's Green and that there was over-

provision of housing in council tax bands A and B (71% of the total housing stock) and an under-provision of properties in bands E and above. An over-representation of terraced housing is also reported and this is supported by the 2011 Census where it is noted that 43% of housing in Coventry was terraced.<sup>24</sup> In contrast, 10% of households in the city are detached and over a quarter (28%) are semi-detached.

It is known that poor housing conditions, including overcrowding and homelessness, are associated with an increased health risk, specifically of cardiovascular diseases, respiratory conditions and mental health problems.<sup>25</sup> In Coventry, as of the 2011 census, 61% of homes were owner occupied (69% in 2001) and 17% were rented from the Housing Association or a Social Landlord (18% in 2001).<sup>26</sup> In addition, 9.5% of housing was deemed overcrowded. This is defined as those households that have at least one less room than required based on the size and profile of the household.<sup>27</sup>

Increasing the supply, choice and quality of housing is a key priority of the Council set out in the Council Plan, and while it is unable to build its own housing, the Council is supportive of developers to build larger family homes in the city.<sup>28</sup>

### Housing requirement

Coventry is part of the Coventry and Warwickshire Housing Market Area. Based on the most recent population projections, the housing requirement for Coventry and Warwickshire from 2011-2031 is for just over 88,000 dwellings – including 42,400 to meet Coventry's need. An assessment of land availability indicates that Coventry has enough land for just 24,600 houses; so the Council has entered into formal agreements with the Warwickshire districts (except Nuneaton and Bedworth) to redistribute the remaining 17,800 houses required outside of the city's boundaries. Of the 24,600 houses, around 17,000 can be accommodated on brownfield sites, with the remaining 7,000 needing to be on previously undeveloped, greenfield land.<sup>29</sup>

### Homelessness

In 2015/16, 533 households were statutorily homeless, compared to 635 in 2014/15 and 551 in 2013/14.<sup>30</sup> The latest comparator, for 2014/15, shows that at 4.7 per 1,000 households, Coventry's level of statutorily homelessness is higher than both the rates in the West Midlands and England (3.4 and 2.4 per 1,000 households, respectively).<sup>31</sup>

Predominant reasons for homelessness include the loss of rented accommodation due to termination of a short hold tenancy (27%), the violent breakdown of a relationship (16%), and parents no longer willing or able to accommodate their offspring (14%, 2012 figures). The most common reason for being deemed a priority need is where a household contains dependent children (67%), and the predominant household composition is a lone female parent (52%, 2012 figures).<sup>32</sup>

Research from Shelter, a housing and homelessness charity, shows that low income, unemployment and poverty are almost universal factors in homelessness.<sup>33</sup> Certain groups of people in society are more likely to be economically and socially disadvantaged; groups such as lone parents, people with mental health problems, care leavers and other people leaving institutions, and people from ethnic minorities are suggested to be more likely to experience homelessness.

Income deprivation is associated with homelessness, as is alcohol and substance misuse.<sup>34</sup> Consequently, homelessness deepens an existing inequality. Nationally, the average age of death of someone who is homeless is 47 years. Being homeless is associated with a 3-fold risk of chronic lung disease, a 3-fold risk of suicide and a 7-fold increased risk of HIV and hepatitis compared to the general population.<sup>35</sup> Identifying and managing those vulnerable to homelessness can prevent the consequences of housing loss.

Medical students from Warwick Medical School carried out a health needs audit of 44 people who sleep rough in Coventry. The results of this audit indicated that the most commonly reported health issues were dental and joint problems. In addition, high levels of depression and anxiety were also reported.<sup>36</sup>

Barriers restricting the access of appropriate healthcare were also identified and included difficulty in obtaining primary care appointments when people did not have a fixed address, along with difficult relationships with healthcare professionals and the problem of accessing appropriate mental health support when there is also a dual diagnosis of substance misuse. Patients who are homeless are also noted to have a tendency to present late with advanced illnesses.

### Fuel poverty

A household is said to be in fuel poverty if it has fuel costs that are above the national median average level and, were that amount to be spent, the household would be left with an income below the official poverty line.<sup>37</sup> Around 20,600 households in Coventry were fuel poor in 2013. This equates to 16% of all households, and is significantly higher than rates in the West Midlands and England (14% and 10% respectively).<sup>38</sup> There has been little change in the proportion of fuel poor households in Coventry since 2011. Within Coventry, the proportion of homes with central heating ranges from 94.9% in Longford to 98.9% in Wainbody.<sup>39</sup>

Fuel poverty is associated with income deprivation, and the majority of those who are fuel poor are in the lowest deprivation deciles.<sup>40</sup> The elderly are particularly vulnerable to ill health when living in a cold home. Interventions for fuel poverty, such as utilising energy efficient measures, and providing central heating, can prevent cold-related ill health and reduce hospital admissions and excess winter deaths.<sup>41</sup>

See also:

- Fuel poverty and the Council at [www.coventry.gov.uk/fuelpoverty/](http://www.coventry.gov.uk/fuelpoverty/).
- Fuel poverty profile at <http://fingertips.phe.org.uk/search/low%20income#gid/1/pat/6/ati/101/page/0/par/E12000005/are/E08000026>.

### Winter deaths

Excess winter deaths are the additional deaths from all causes that occur during the winter months over and above what would be expected in the non-winter months. The number of excess winter deaths is dependent upon factors such as the ambient outdoor temperature and the level of disease in the population. Around 130 excess winter deaths occur in Coventry every year. The excess winter mortality index is a measure of the excess winter

mortality compared to the average non-winter mortality for that year. The excess winter mortality index in Coventry was 17.8% from 2010-2013 (this means that the death rate was 17.8% higher during the winter months). This was slightly higher than it had been at 16.8% from 2006-2009.<sup>42</sup> There is little difference in the excess winter mortality index between Coventry, the West Midlands and England as a whole.

The majority of excess winter deaths are due to cardiovascular and respiratory diseases, such as influenza, and most deaths occur in those aged over 75 years.<sup>43</sup> Addressing fuel poverty and improving influenza vaccination rates in eligible people may help reduce excess winter deaths.

## Skills and education

### Educational attainment

Children's educational attainment is primarily monitored at age 5, 7, 11, 16 and 18. That is, the early years foundation stage and school readiness at age 5; key stage 1 assessments at age 7; key stage 2 assessments at age 11; GCSE (Key stage 4) examinations at age 16, and A-Levels (key stage 5) examinations at age 18. The information below sets out the latest available information, for 2015; but going forward the government is changing the way that educational attainment is reported and new targets will be established later in 2016. However, future data will not be comparable to existing data.

### Early years

In 2015 there was strong improvement in the proportion of children aged five at a good level of development, with 63.9% of Coventry children achieving this level. However improvement across England overall was greater (66.3%) and Coventry's performance remains worse than the national average. That said, Coventry's performance is comparable to local areas with a similar level of need and deprivation as Coventry (63.3%).<sup>44</sup>

A measure of deprivation is the number of children eligible for free school meals (FSM). While children eligible for FSM do not do as well as others (53.2%), it is encouraging that they do better on the whole than the national average for children eligible for FSM (51.2%)<sup>45</sup>. The areas with the lowest rates of good development at age five are Edgwick in Foleshill (46%) and Wood End, Henley Green & Manor Farm (49%).

### Primary education

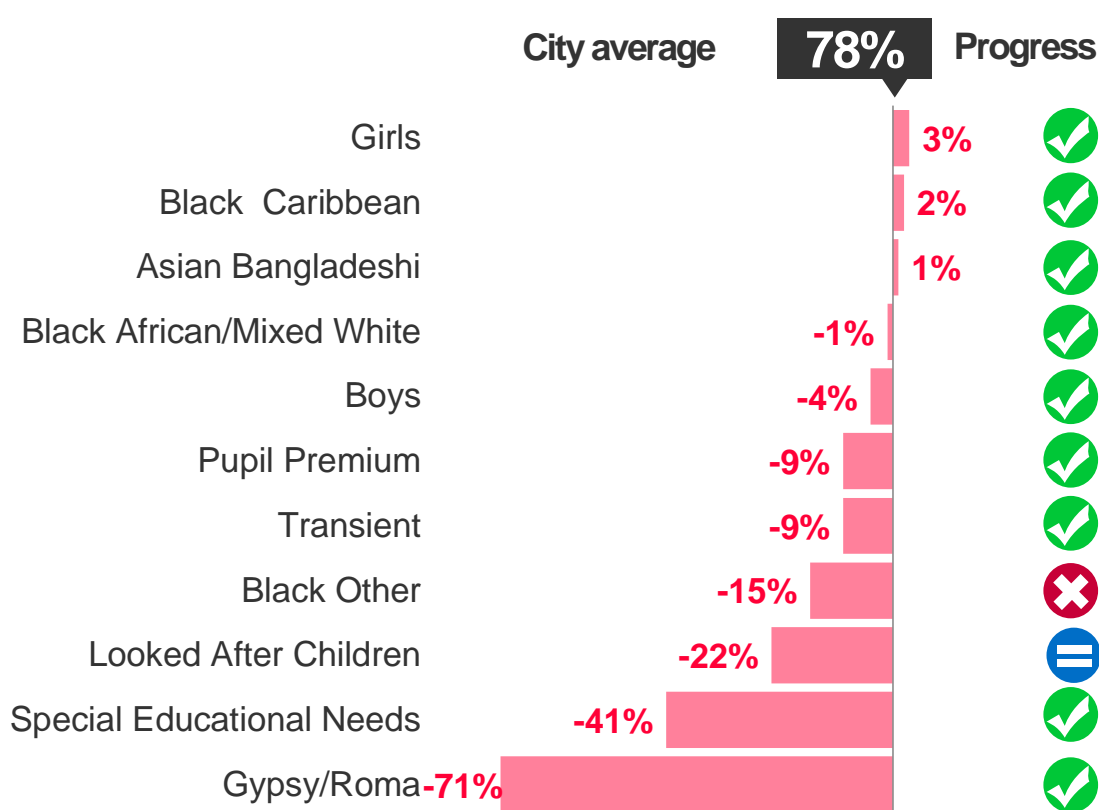
Education, children's services and schools are regulated and inspected by Ofsted. Coventry's primary school performance in the Ofsted league tables of local authorities have significantly improved over the past few years: in 2011/12, Coventry came bottom overall with 42% of pupils attending a school that was rated good or outstanding; and by May 2016, this has improved to 88%, better than the national average of 86% and the statistical neighbour average of 83%.

This was achieved through continued and sustained work: in early 2013, an area inspection of Coventry schools found that "there is still some way to go in establishing a widely understood and methodically delivered strategy for improvement"<sup>46</sup> while in 2013-2015, Coventry's education improvement strategy set out a series of school improvement

networks, that is, peer-led and peer-supported networks to raise standards in Coventry’s schools and academies.<sup>47</sup>

There was a small improvement in 2015 in attainment at the end of primary school with nearly 4 in 5 (78%) achieving the expected level, that is, Level 4 or above in reading, writing and mathematics at the end of key stage 2 (Year 6). This continued the trend from the previous two years of narrowing the gap with the national average. There are clear inequalities with some key groups, set out below, with notably lower attainment rates than average. These inequalities have persisted from last year, although the performance of disadvantaged pupils is no different from the national average and attainment rates amongst looked after children (LAC) is slightly better than average for LAC across England.

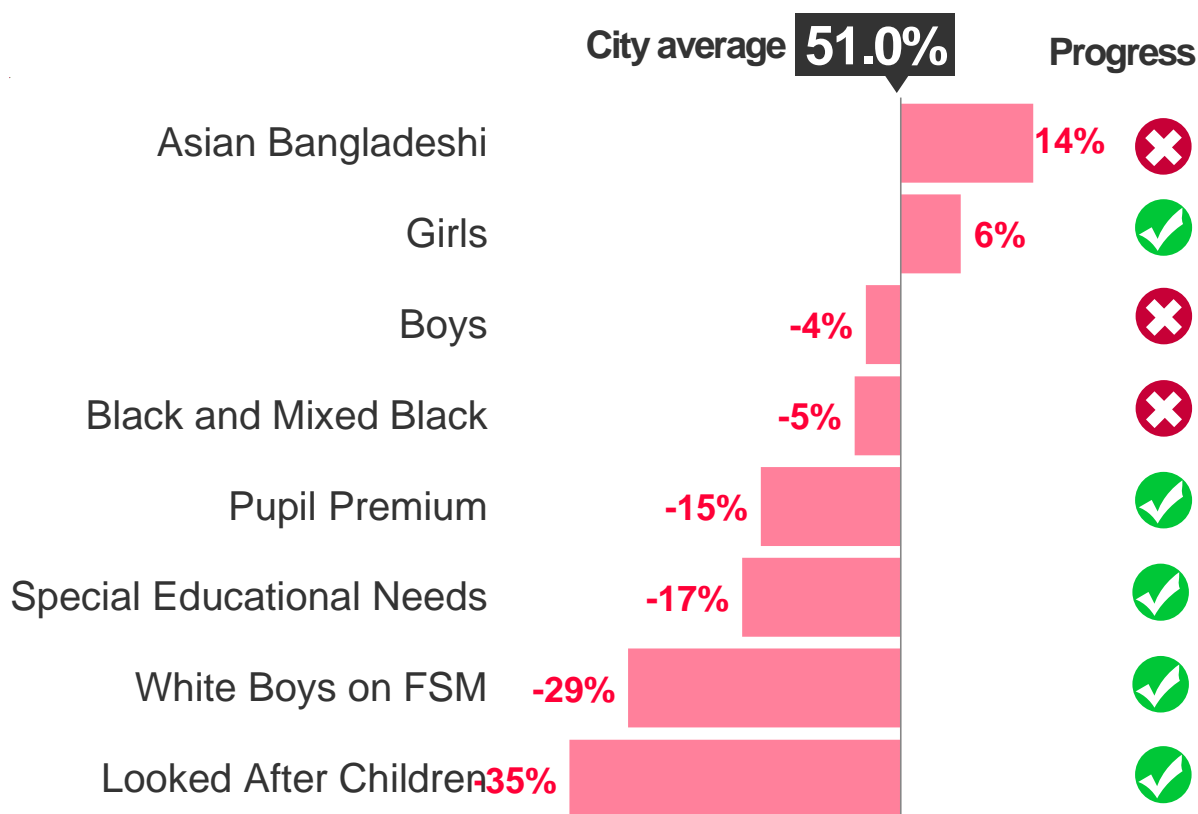
Figure 2 Key stage 2 gaps in attainment between key groups and the city average



**Secondary education**

In May 2016, 59% of Coventry children are attending a school rated good or outstanding by Ofsted. While this is an improvement from 53% in May 2015, it remains significantly worse than the statistical neighbour average of 77% and the national average of 79%. This poor performance is reflected in GCSE results too: results in 2015 was slightly lower than 2014 (51.0% compared to 52.3%) whereas the statistical neighbour and national attainment rate improved (to 53.4% and 57.1% respectively), so Coventry has fallen a little further behind the England average.

Figure 3 Key stage 4 gaps in attainment between key groups and the city average



Like at key stage 2, inequalities between groups are evident: it is notable that the inequalities have widened by key stage 4 for disadvantaged pupils and looked after children.

### Economy and business

There is a clear association between being in good quality employment and better health. As a proportion of the economically active population, 66% of people in Coventry are employed (compared to 73% in Great Britain nationally and 70% across the West Midlands) and 6.5% are self-employed. There is also a gender difference within the city with 71% of economically active males in employment compared to 60% of females. The gross weekly pay for males living in Coventry and working full-time is £553.50 and £435.90 for females. While higher than the gross weekly pay rates for the West Midlands, the weekly pay rates are lower than compared to Great Britain (£570.40 for males and £471.60 for females). In 2014, 31% of employee jobs in Coventry were part-time and this is a similar level to that seen in the West Midlands and Great Britain.<sup>48</sup>

Across Coventry, 6.2% of economically active working-age people are unemployed which is higher than that seen within the West Midlands (5.7%) and Great Britain (5.4%). This equates to 9,600 people. Coventry City Council's Council Plan Performance Report states that in the twelve months to June 2015, there were 144,500 economically active residents in employment and this is the highest number of people in employment since quarterly records began in 2004. However, it is also reported that female unemployment has increased and now stands at 6.4% and this is higher than the national average of 5.4%.<sup>49</sup>

Of the economically inactive population (29.5%) in the city, 38% are students and the number of economically inactive students in the city has increased by 13,000 over the last ten years (October 2004 to September 2005 compared to October 2014 to September 2015). In addition, there has also been an increase of approximately 4,700 economically inactive people who look after the family or home over the same time period.<sup>50</sup>

### Employment and support allowance

There are three levels of employment and support allowance (ESA): support group, assessment rate and work related activity group (WRAG). Those in the work related activity group are considered capable of work at some point in the future and able to take steps towards moving into work.<sup>51</sup> Just over a fifth (21.3%) of the 13,910 people claiming ESA are in this group as of May 2015, with 25.7% of claimants having their assessment processed. In contrast, just under half (49.9%) are in the support group and are those whose illness or disability means that their ability to work is severely limited.<sup>52</sup>

Across those who are claiming ESA, just under half (47.7%) are claiming due to mental and behavioural disorders with 14.4% claiming due to diseases of the musculoskeletal system and connective tissue. Of those in the work related activity group, 48.6% of claims are recorded to be due to mental health or behavioural conditions.

Research from the Institute for Fiscal Studies notes there is systematic growth in the proportion of ESA claimants in any age group with mental and behavioural disorders as the principal health condition behind their claim.<sup>53</sup> Perhaps to be expected, the report indicates that physical health problems become more prevalent as claimants age and a higher proportion of ESA claims of younger men and women relate to mental and behavioural disorders. This demonstrates the importance of focusing on interventions that support mental wellbeing when people are progressing towards the labour market.

### Jobseekers allowance

As of May 2015, there were 4,430 people claiming jobseekers allowance (JSA).<sup>54</sup> However, this is not considered an official measure of unemployment as not all people who are unemployed will claim JSA and this is further complicated by welfare reform which has meant that a proportion of ESA claimants have been found fit to work and moved onto JSA, along with the effects of claimant commitments required to access JSA which has seen an increase in the number of sanctions limiting access to this benefit. Looking at data from January to December 2015, it can be seen that 44% of those who no longer claimed JSA are recorded as having found a new job, or a role that involved working more than 16 hours a week. In contrast, 32% were recorded as not claiming without further explanation. While the reasons for this cannot be determined by the data, it is relevant to consider how those who are no longer claiming are supporting themselves.

There is clear employment inequality within the city, with 23% of Binley and Willenhall working-age residents claiming out-of-work benefits (including Employment and Support Allowance) compared to 4% of those in Wainbody.<sup>55</sup>

### Impact of welfare reform

Since April 2013 there has been a series of on-going reforms to welfare and it has been difficult to demonstrate the impact of these reforms to Coventry due to accessibility of data. Nevertheless, the total value of benefits that can be claimed had previously been capped at £26,000 which affected 127 households (as of July 2015). There are plans to reduce the cap to £20,000. It is unknown how many households across the city will be affected as it is not known how many households receive benefits between £20,000 and £26,000 in total.<sup>56</sup>

It has already been noted that 21.3% of those claiming ESA are in the work related activity group and there are proposals for the level of benefit claimed by this group of claimants to be aligned to the rate claimed for JSA. This will represent a 30% cut in benefits.

Furthermore, it has also been suggested that those aged between 18 and 21 will not be automatically entitled to claim housing benefit. As of July 2015, there were 832 housing benefit claimants aged between 18-21 years across the city.<sup>57</sup> This offers only an indication of the possible impact of this welfare reform and it has been suggested that vulnerable people will be excluded from this reform, consequently, the impact of this on Coventry is not yet known.

While the effects of the full package of welfare reform cannot be demonstrated as yet, this is something that will need to be monitored to understand the impact on the social determinants of health and inequality in the city.

### Wider economic performance

Coventry's 2015 Economic Review notes that after the recession, job creation broadly had little impact on employment levels in the city. However, from 2012 to 2015, resident employment levels have increased which suggests more residents have moved from unemployment into employment rather than becoming economically inactive.<sup>58</sup>

There has also been an 11.3% year-on-year growth of enterprises in Coventry and this is a faster rate of growth than that in the West Midlands and England. Many of these are small business, with 77% employing fewer than 5 people.<sup>59</sup> Nevertheless, the city still has a low number of businesses per 10,000 of the population compared to England (326.2 and 480.8 respectively).<sup>60</sup>

The Council's Jobs and Growth Strategy has the objective of ensuring that businesses continue to recognise Coventry as the right place for them to invest.<sup>61</sup> In particular, there is also a focus on young people and improving the skills levels of local residents. Within Coventry, 15% of working age residents do not have qualifications and this is higher than that of the West Midlands (13%) and England (9%). However, just under a third (32%) are qualified to higher education level (January-December 2014), while this is higher than the level seen in the West Midlands (29%), it is lower than that seen in England (36%).<sup>62</sup>

### Crime and violence

#### Reported and recorded incidents of violence

Data from 2014/15 indicate that there were 13.1 recorded violent crime incidents per 1,000 people. Broadly, the rates are similar to England (13.5) and the West Midlands (12.8).<sup>63</sup>



When looking at hospital admissions for violent crime, including sexual violence, it can be seen that rates for Coventry (87.5 per 100,000 of the population) are higher than that seen in the West Midlands (48.5) and England (52.4). When compared to areas of a similar level of deprivation, it can be seen that Coventry has the 7<sup>th</sup> highest rate of hospital admissions for violent crime (out of 33 local authorities).

### Domestic violence and abuse

Domestic abuse is defined as incidents of threatening behaviour, violence or abuse between adults aged 16 years and older who are family members, or previous and current partners.

There has historically been under-reporting of domestic violence and abuse, and improved working by the police and other agencies are encouraging people to report the crime. There has been an increase in domestic violence and abuse cases involving children and this is thought to be the result of better recording – the risk, harms and threats to children are better identified and recorded, enabling agencies to respond to the needs of families and intervene earlier as required.

In 2015/16, there were 5,972 domestic violence offences (crime and non-crime) reported to the police, a 2.16% decrease from 6,104 in 2014/15.<sup>64</sup>

When looking at the rates of domestic violence and abuse recorded by the police, this stands at 19 recorded crimes per 1,000 of the adult population in 2013/14 compared to 13 in 2012/13 and this level is broadly similar to the reported level for England and the West Midlands.<sup>65</sup>

Coventry City Council's 2014/15 end of year performance report notes there were 5,849 victims of domestic violence and abuse, an increase from 5,359 in 2013/14.<sup>66</sup>

An increase in these figures is seen to be a result of improvements in the identification and recording of incidents and may also be attributed to activity to encourage reporting. Such an increase is also seen in other areas of the West Midlands and at a national level.

- Find out more on the profile for domestic violence and abuse at <http://www.coventry.gov.uk/downloads/file/17116/>.

### Sexual violence

When data from 2014/15 is compared to 2013/14, there is an increase from 431 reported and recorded incidents of sexual violence to 532 in 2014/15.<sup>67</sup> It should be considered that this captures crimes that were both reported and recorded by the police.

As noted in the review of the Health and Wellbeing Strategy for Coventry, this increase can be attributed to a range of possible factors. It has been noted that the population of Coventry has a younger age profile when compared to both a regional and national level. In addition, there has also been wider encouragement for those who have experienced sexual violence to report these crimes. It has also been noted that there has been an increase of disclosures of historic sexual abuse and so an increase in the reported numbers should be seen as an improvement as crimes which may have gone unrecognised are now being reported.

- Find out more on the profile for violence and sexual violence at <http://www.coventry.gov.uk/downloads/file/17122/>.

### Inequalities

People who live in some parts of Coventry have worse health prospects than those who live in other parts of the city. Reducing these variations across the city is the key component of Coventry's participation as a Marmot city.

### Marmot

The Marmot Review, *Fair Society: Healthy Lives*, notes that "people with a higher socioeconomic position in society have a greater array of life chances and more opportunities to lead a flourishing life".<sup>68</sup> The social determinants of health refers to the conditions in which people live, including where someone is born, where they live and whether they are in employment; these conditions are influenced by an array of external factors, including social and economic policies and have an impact on the health and social outcomes attained.<sup>69</sup>

Coventry is one of seven cities in the UK which was invited to participate in the UK Marmot Network and become a Marmot city, ensuring the activities of Coventry City Council and our partners are focused on reducing health inequalities across the city. Coventry City Council has committed to work with partners across the city and revise its Marmot strategy which will be progressed over the next three years.

Reducing inequality across Coventry will have an impact on the life chances and health outcomes of people across the city. Understanding inequality, both its impact and what contributes to inequality across the city, will help support the identification of priorities and ensure that resources are effectively targeted. The following sections intend to explore the nature of inequality across the city.

- Find out more about Marmot at <http://www.coventry.gov.uk/info/176/policy/2457/>.

### English indices of deprivation

The English indices of deprivation is a measure of relative deprivation in small areas in England. It looks at deprivation across a set of various domains, including employment, income, health, education, crime, access to services and the living environment.<sup>70</sup> It is important to note that this measure only acts as a broad indication of which areas could be prioritised to address multiple deprivation. An area has a higher deprivation score than another if it has a higher proportion of people who are considered deprived.

When English local authorities are ranked in terms of 'how deprived' the most deprived 10% of the local population are, Coventry is ranked as 38<sup>th</sup> most deprived. When considering the proportion of small neighbourhoods that are identified as the most deprived 10% in the England, Coventry is the 46<sup>th</sup> most deprived local authority. When looking at rankings, Coventry is ranked lower when looking at the proportion of most deprived neighbourhoods in each area, while the city is ranked higher when an average across the whole city is used. This demonstrates inequality across the city. For example, when looking at an average of scores across the city, Coventry is ranked 54<sup>th</sup>, demonstrating a 'better performance' than

when looking at the proportion of neighbourhood's population considered to be the most deprived 10% in England.

- Read the English indices of deprivation reports at <http://www.coventry.gov.uk/downloads/download/135/>.

## Life expectancy

### Life expectancy at birth

Coventry's life expectancy at birth is 82.3 years for females and 78.6 years for males.<sup>71</sup> Life expectancy in Coventry is lower than the national average, but it is at the level expected given the city's level of deprivation. However there remains a wide inequality gap: a man from the most deprived area can expect to die 9.4 years younger than one from the least deprived area; and for a woman, the difference is 8.7 years. This compares to national figures of 9.2 and 7.0 respectively. Premature mortality (deaths under the age of 75) is higher in Coventry because of higher rates of premature mortality from cardiovascular disease, cancer and respiratory disease.

When Coventry's life expectancy is ranked against other local authorities in the West Midlands, female life expectancy is ranked 25 out of 30 areas and 23 for male life expectancy. However, when compared to areas with a similar level of deprivation, Coventry is ranked 9<sup>th</sup> out of 33 areas for female life expectancy and 8<sup>th</sup> for male life expectancy. As can be seen by the image below, wards with poorer outcomes include, Longford, Lower Stoke, Upper Stoke, Binley and Willenhall, Radford, St. Michael's and Foleshill.

See also:

- Male life expectancy at birth infographic at [http://www.coventry.gov.uk/info/10/performance/1732/infographics\\_and\\_visualisations/2](http://www.coventry.gov.uk/info/10/performance/1732/infographics_and_visualisations/2).
- Female life expectancy at birth infographic at [http://www.coventry.gov.uk/info/10/performance/1732/infographics\\_and\\_visualisations/3](http://www.coventry.gov.uk/info/10/performance/1732/infographics_and_visualisations/3).

### Disability-free life expectancy

While life expectancy is increasing, data indicate that for males, disability-free life expectancy is decreasing and a similar trend has been demonstrated for women, however the difference is not as great.<sup>72</sup> This indicates that while there have been improvements in life expectancy rates, these have not been matched by increasing the amount of time people spend in good health which may have an impact on service demand and quality of life. Further work to understand the relationship between increasing disability-free life expectancy and the effects this has on life expectancy may be a further area of analysis.

### Healthy life expectancy at birth

In terms of healthy life expectancy, that is, years a person would expect to live in good health based on mortality rates and self-reported good health, the figures are 60.6 years for males and 62.7 for females. While this is above the combined authority area figures of 61.5

and 62.3 years, it is below the England figures of 63.4 and 64.0 respectively. The West Midlands Combined Authority is committed to increase healthy life expectancy to 62.3 years for males and 63.9 years for females by 2030.<sup>73</sup>

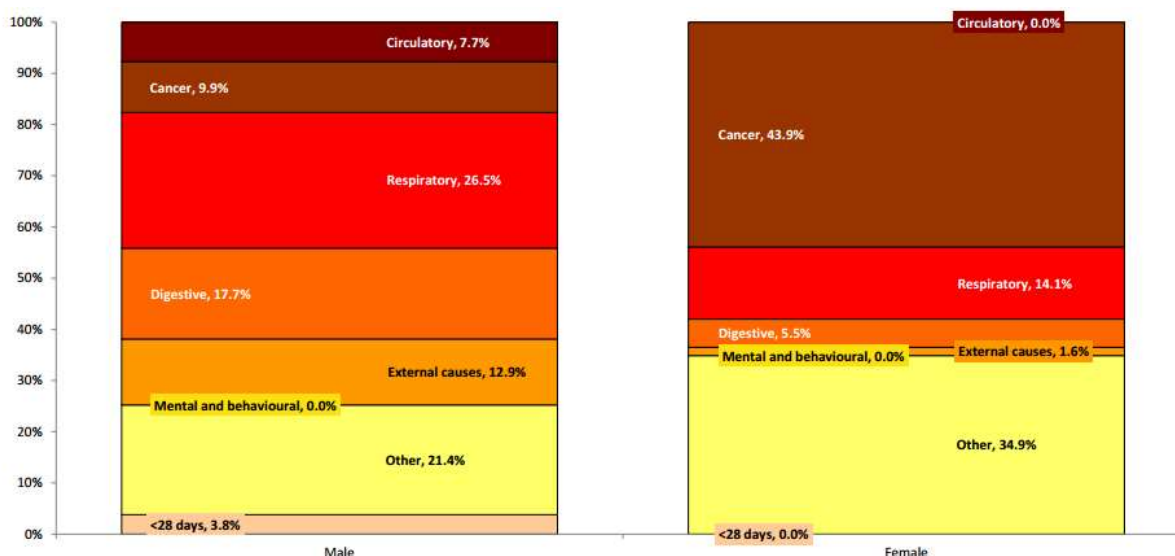
### What drives inequality in life expectancy?

By looking at data about the causes of death, it is possible to identify priorities that can have the greatest impact on reducing health inequalities.

Figure 4 Life expectancy gap between Coventry as a whole and England by broad cause of death 2010-2012 below indicates the contribution each broad cause of death has on the discrepancy in life expectancy between Coventry and England. When comparing Coventry with England, it can be seen that cancer has the greatest contribution to the gap in life expectancy for females, 43.9% of the gap in life expectancy is attributed to cancer, with respiratory disease contributing to 14.1% of the life expectancy gap.

Compared to females in Coventry, circulatory disease, including coronary heart disease and stroke, has a bigger effect on the life expectancy gap between males in Coventry and England. Cancer also has a smaller impact when compared to females at 9.9%. However, respiratory disease has a greater contribution at 26.5%.

Figure 4 Life expectancy gap between Coventry as a whole and England by broad cause of death 2010-2012



Source: Public Health England Segment Tool

Data is also available to show the conditions that contribute to the life expectancy gap between the most deprived and least deprived 20% in Coventry. Understanding these differences will help to challenge the life expectancy gap within Coventry. This is set out in Figure 5 and Figure 6.

For females, it can be seen that the greatest contribution to the gap in life expectancy is circulatory disease at 29.5%. If the most deprived quintile had the same mortality rates as the least deprived quintile then data indicate that 1.72 years could be added to life

expectancy. Respiratory disease explains 22.4% of the gap in life expectancy and would add 1.30 years to life expectancy if levels were the same as in the least deprived 20%.

Figure 5 Life expectancy gap between the most deprived 20% of Coventry compared to the least deprived 20% by broad cause of death 2010-2012

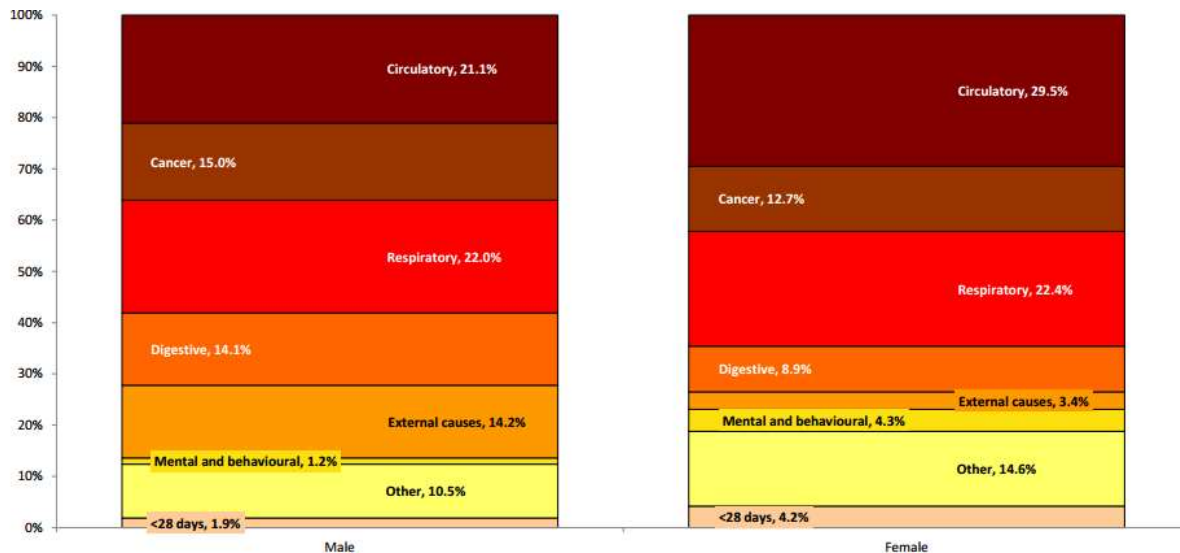
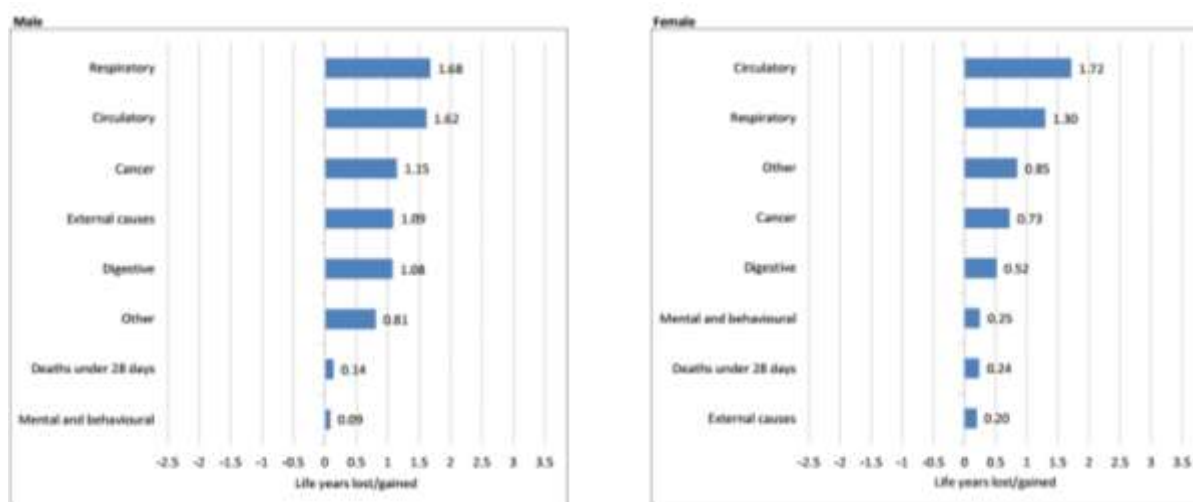


Figure 6 Life expectancy years gained if the most deprived 20% of Coventry had the same mortality rates as the least deprived-by broad cause of death 2010-2012



When looking at the factors that contribute to the gap in life expectancy for males, if the most deprived quintile had the same mortality rates attributed to respiratory diseases as the least deprived quintile then data indicate that 1.68 years could be added to life expectancy.

It can be seen that digestive diseases, which also include alcohol-related conditions such as chronic liver disease and cirrhosis, explain 14.1% of the gap in life expectancy, which is higher than that seen for females (8.9%). If rates of digestive disease were the same in the most deprived quintile as the least then this would add 1.1 years to life expectancy for males across the city.

This is also supported by looking at data which identifies the life expectancy gained if the most deprived 20% of neighbourhoods had the same mortality rates for causes of death that are wholly attributable to alcohol as the least deprived 20%. It can be seen that males would benefit from an average of 0.59 years gained compared to 0.23 years gained for females.<sup>74</sup>

In line with the Marmot principle that health is socially determined, there are greater gains to be made in life expectancy if the gaps between the most and least deprived quintile in the city are addressed.

## Vulnerable children and young people

### Looked after children and safeguarding

#### Looked after children

Looked after children are children in the care of the local authority, either under a care order issued by the court, or voluntarily accommodated under arrangements with their parents/guardians. They may be placed in a number of settings for instance, with parents or relatives; with foster carers; or in a residential setting.

As of 31 March 2016, there were 582 looked after children; a rate of 78.5 per 10,000 children. This compares to 79.8 in the West Midlands Region and 64.6 in England. 74% of looked after children are in fostering; broadly consistent with the regional and national picture.<sup>75</sup>

#### Children subject of a child protection plan

Children are made the subject of a child protection plan (CPP) when they are considered to be at risk of physical, sexual or emotional harm or neglect. Nationally the numbers have increased. It is unclear whether the rise in numbers is due to changes in the thresholds, increased awareness & referrals to social care due to the media coverage of high profile cases or whether there has been an increase in the neglect, abuse or misuse of children.

Of the 488 children with a child protection plan, 49% was due to emotional abuse; 41% due to neglect; 5% due to sexual abuse; and 4% due to physical abuse.<sup>76</sup>

#### Educational attainment and employment outcomes

In 2015, 16% of Coventry children looked after continuously for at least twelve months achieved five or more A\*-C GCSEs including English & Maths at first entry; similar to regionally and nationally.<sup>77</sup>

In Coventry, 36% of those now aged 19-21 years who were previously looked after were in education, employment or training in 2014.<sup>78</sup> This is lower than the overall proportion in England (45%) and the West Midlands (41%).

In 2014, of those care leavers in Coventry not in education or employment, 6% reported illness and 9% reported parenting responsibilities. Data were unavailable for 13%.

It is suggested that placement moves, and related placement instability can impact on the psychological, social and academic outcomes achieved by a looked after child and can also inhibit the development of secure attachments.<sup>79</sup> Therefore, further understanding of the

experiences of those who previously have been looked after children will identify the impact this has had on their outcomes.

### Health assessments

Under the performance assessment framework, local authorities in England are monitored on the uptake of annual health checks for children who were being 'looked after'. Children who have been looked after for 12 or more months are expected to have a health assessment. The health checks are a key tool in ensuring the health needs of all looked after children are identified. Initial and annual health assessments are important to ensure prompt identification of pre-existing, emerging and changing health needs.

In 2015/16, 85.4% of children looked after continuously for 12 months or more had up-to-date health assessments, down from 94.7% in 2014/15. This, however, may represent an administrative delay. The equivalent figures for dental assessments is 77.9%, down from 92.2% in 2014/15.<sup>80</sup>

In terms of immunisation, 2014/15 data show that 84.8% of looked after children who have been looked after for at least 12 months were up to date in terms of their immunisations compared to 84.1% in the West Midlands and 87.8% in England.<sup>81</sup>

### Pupils receiving free school meals

In 2014, universal free school meals were introduced for all pupils in reception or years 1 and 2 in state-funded schools and this has meant that parents of infants do not have to register to get free school meals, nevertheless, schools and parents are still urged to register as eligible for Free School Meals as this is a criterion for the pupil premium payment.

17.9% of pupils in Coventry are eligible for, and claiming Free School Meals compared to 17.8% in the West Midlands and 15.2% in England.<sup>82</sup>

In terms of educational attainment, the Council monitors the result of white boys on free school meals as they are identified as a key priority group. In 2015, only 22% achieved 5+ A\*-C GCSEs including English and Maths at first entry – a 29% gap from the city average of 51%.<sup>83</sup>

### Special educational needs (SEN)

Nationally, the number of pupils with special educational needs has reduced from 1,301,445 in 2015 to 1,228,785 in 2016. The reduction is due to a continuing decline in the number of pupils with special educational needs without a statement or education, health and care (EHC) plan. The most common primary types of needs have remained the same as in 2015, that is, 26.8% of pupils on SEN support have Moderate Learning Difficulty as a primary type of need; and 25.9% of pupils with a statement or EHC plan have Autistic Spectrum Disorder as a primary type of need.<sup>84</sup>

In Coventry, 15.6% of pupils have a have a statutory plan of SEN (statement or EHC plan) or are receiving SEN support (previously school action and school action plus). This compares to an average of 15.3% across All English metropolitan boroughs.<sup>85</sup>

Across all English metropolitan boroughs, the proportion of pupils with statements or education, health and care (EHC) plans ranges from 1.7% to 3.9%. Coventry has a value of 2.3%, compared to an average of 2.8% in All English metropolitan boroughs.

### Looked after children with SEN

In Coventry, looked after children that are on SEN support stands at 48% compared to 38.1% in all English Metropolitan boroughs. Looked after children that have a statement of SEN or EHCP stands at 25.3% compared to 25.9% in all English Metropolitan boroughs.

### Children in need with SEN

Children in need are legally defined as children who need local authority services to achieve and maintain a reasonable standard of health or development. These are also children who need local authority services to prevent further harm to their health and development and also children who are disabled.

In all English metropolitan boroughs, 28.7% of children in need are on SEN support and 20.3% have a statement of SEN or EHC plan. In Coventry, 34.2% of children in need are on SEN support and 16.1% of children in need have a statement of SEN or EHC plan.

### SEN support primary need

A child or young person has SEN if they have a learning difficulty or disability which calls for special educational provision to be made for them. All pupils with SEN have an assessment of their primary need. The following charts show the breakdown of need in Coventry by primary (Figure 7), secondary (Figure 8) and special schools (Figure 9), compared to the national averages and ranked by prevalence.



Figure 7 SEN Primary Need: Primary Schools

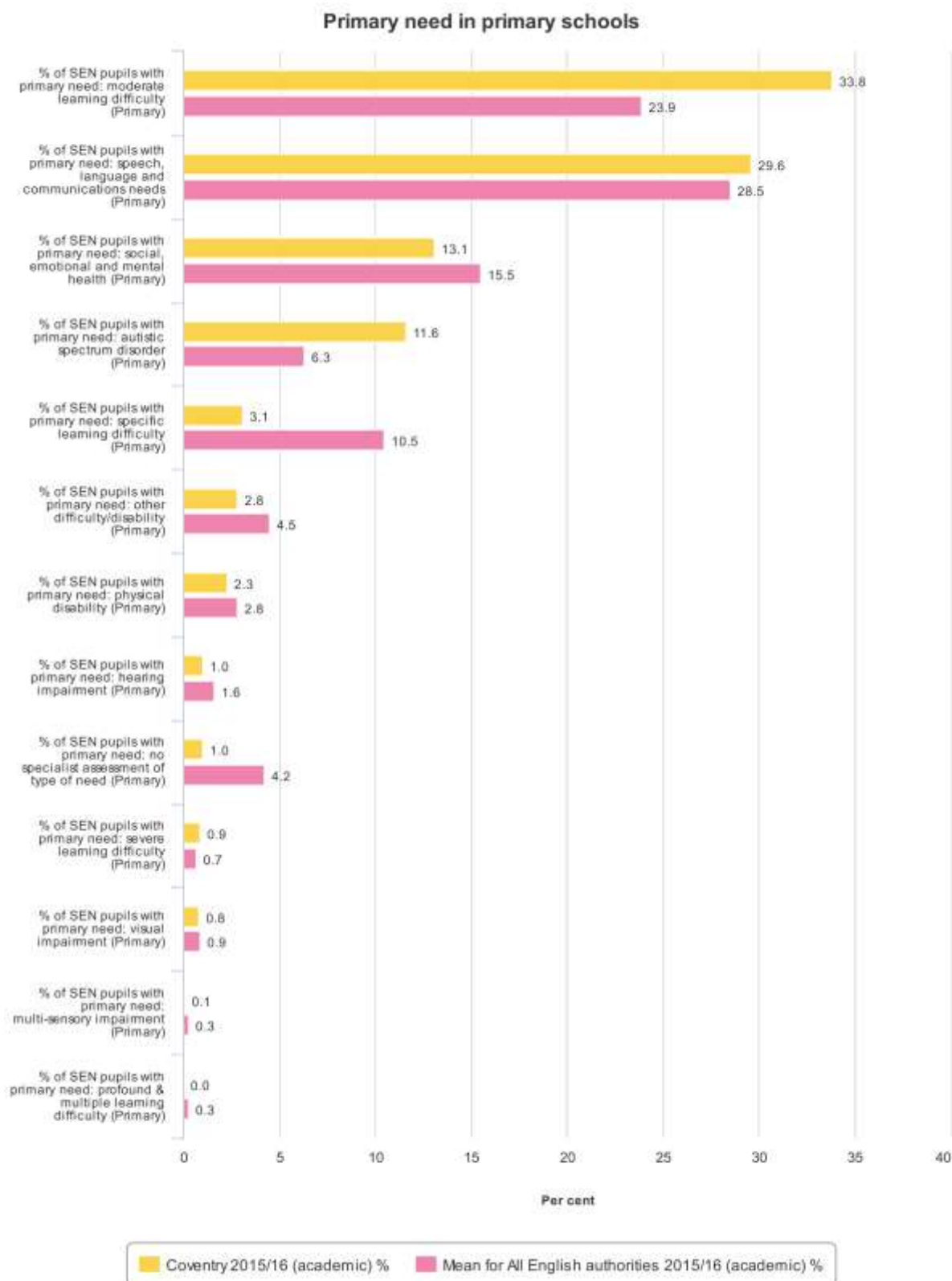


Figure 8 SEN Primary Need: Secondary Schools

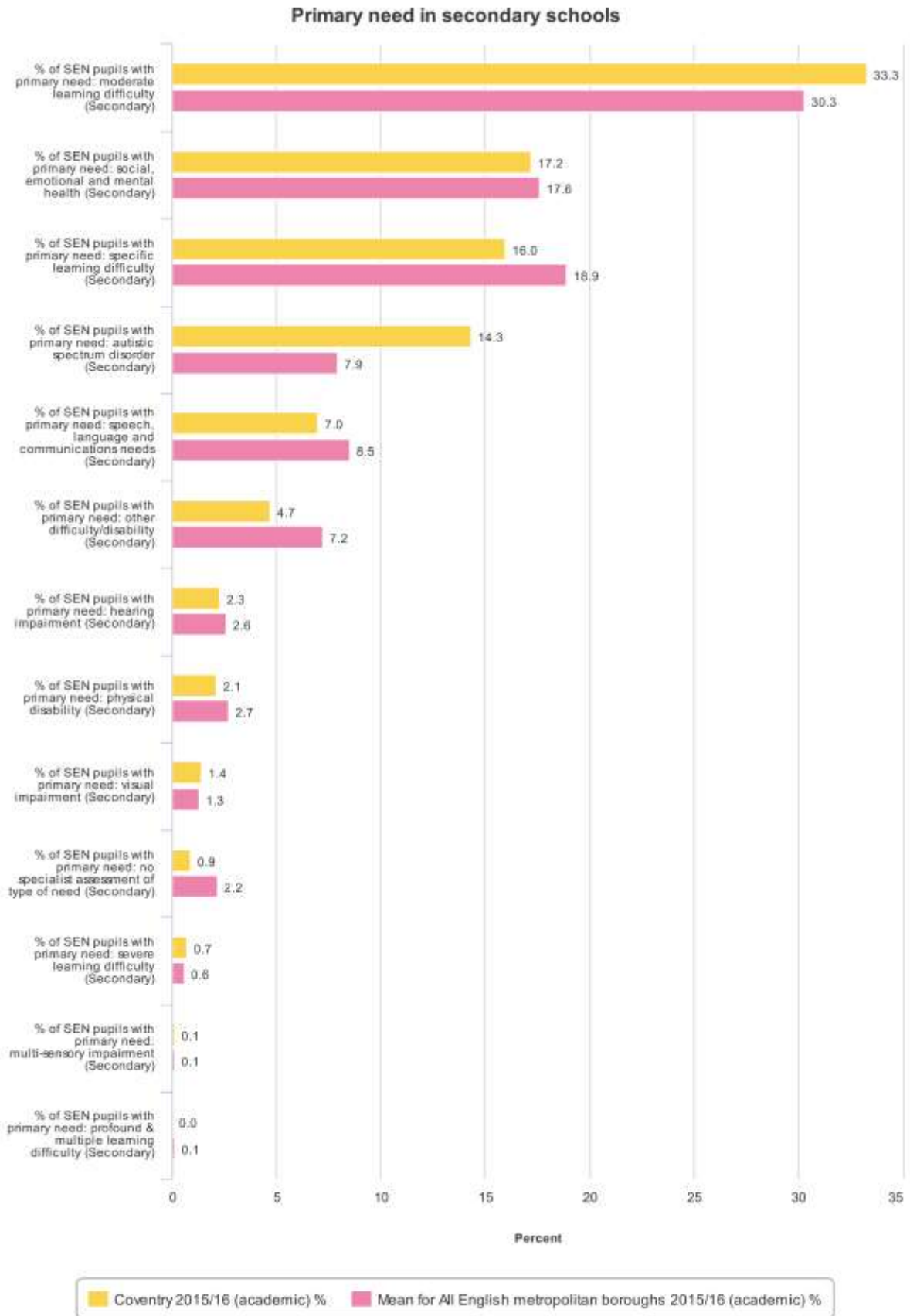
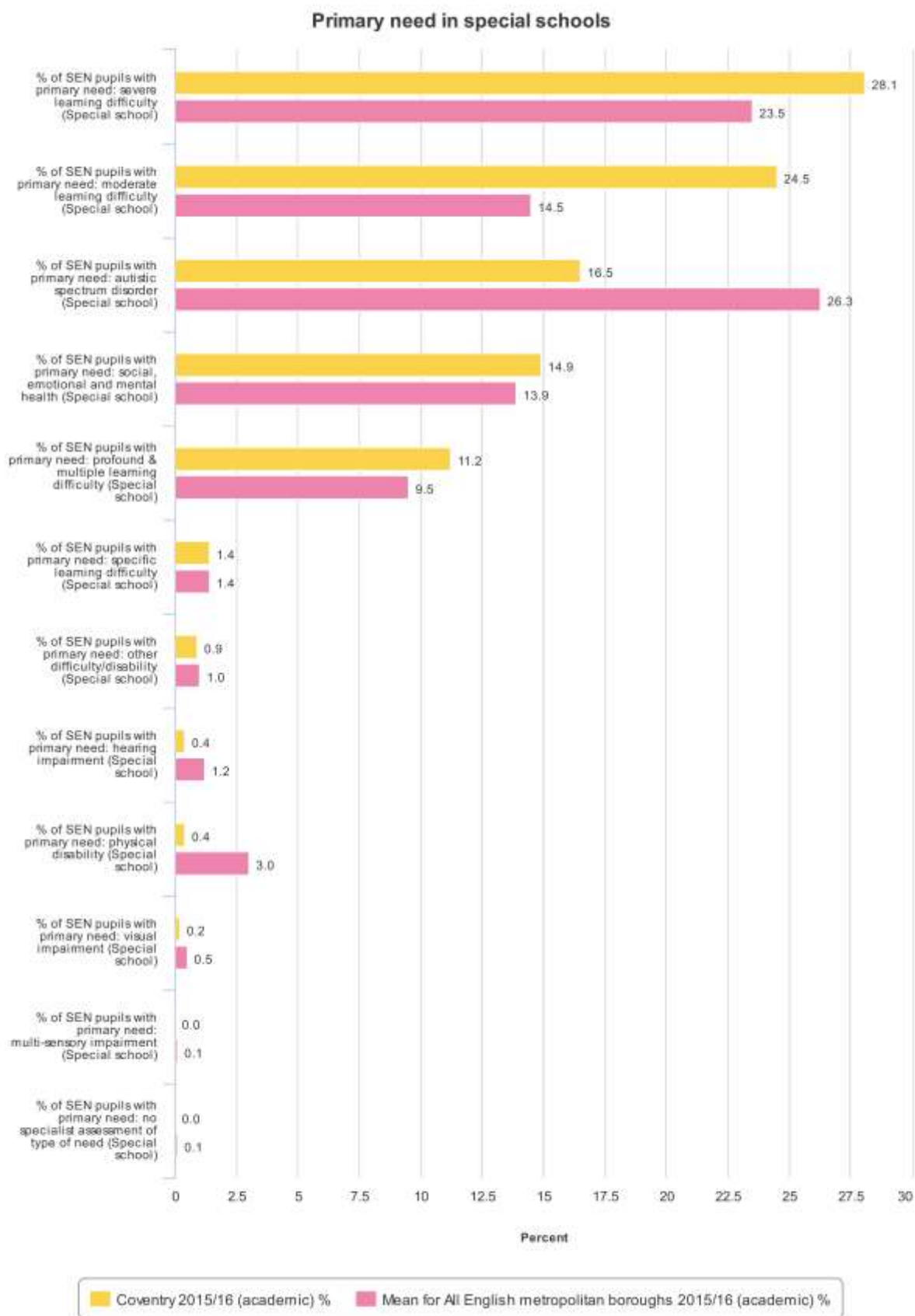


Figure 9 SEN Primary Need: Special Schools



## Child poverty

Marmot suggests there is evidence that childhood poverty leads to premature mortality and poor health outcomes for adults. Reducing the numbers of children who experience poverty should improve these adult health outcomes and increase healthy life expectancy.

Under the Child Poverty Act (2010), a household is said to be in relative poverty when their income is less than 60% of the current median income.<sup>86</sup> This figure stands at 18.4% before housing costs have been considered.<sup>87</sup> Child poverty differs significantly between wards: in St Michael's, 47% of children are in relative poverty after housing costs; whereas in Earlsdon, 9% meet this criteria.

More up-to-date figures about child poverty are available from the End Child Poverty campaign. This suggests that 29% of children in Coventry are in relative poverty after housing costs in 2014, the latest year for which data is available.

See also:

- Child poverty infographics and visualisations at [http://www.coventry.gov.uk/info/10/performance/1732/infographics\\_and\\_visualisations/5](http://www.coventry.gov.uk/info/10/performance/1732/infographics_and_visualisations/5).
- Profile on child poverty at <http://fingertips.phe.org.uk/search/child%20poverty#gid/1/pat/6/ati/102/page/0/par/E12000005/are/E08000026>.

## Teenage pregnancy and teenage parents

Teenage pregnancy are associated with negative impacts on outcomes, not just for the parent but also the children. Teenage parents are prone to poor antenatal health, lower birth weight babies and higher infant mortality rates; and their health, and that of their children, is likely to be worse than average. National research shows that the majority of teenage parents and their children live in deprived areas and often exhibit multiple risk factors for poverty, experiencing poor health, social and economic outcomes and inter-generational patterns of deprivation.<sup>88</sup> Teenagers who become pregnant are more likely to drop out of school, missing a key phase of their education, leading to low educational attainment and no or low-paying, insecure jobs without training.<sup>89</sup> In addition, the children themselves run a much greater risk of poor health, and have a much higher chance of becoming teenage mothers themselves.<sup>90</sup>

In Coventry, 2013 data indicates that there are 39.5 conceptions in women aged under 18 years per 1,000 females aged 15-17 years, in total this equates to 227 teenage conceptions in Coventry which is the ninth highest for any local authority in England and Wales.<sup>91</sup> This is higher than the levels seen in the West Midlands (28.9) and England as a whole (24.3), however, the teenage conception rate has reduced significantly over the previous years. The rate of teenage conceptions is known to be ten times higher in the most deprived areas. There are 7.3 conceptions per 1,000 females aged 13-15 years compared to 4.8 for England. Following national trends, the under 18s (Figure 10) and under 16s (Figure 11) conception rate, and in particular, the decrease in under 16s conceptions are closing on the national rate.

Figure 10 Conceptions to under 18s

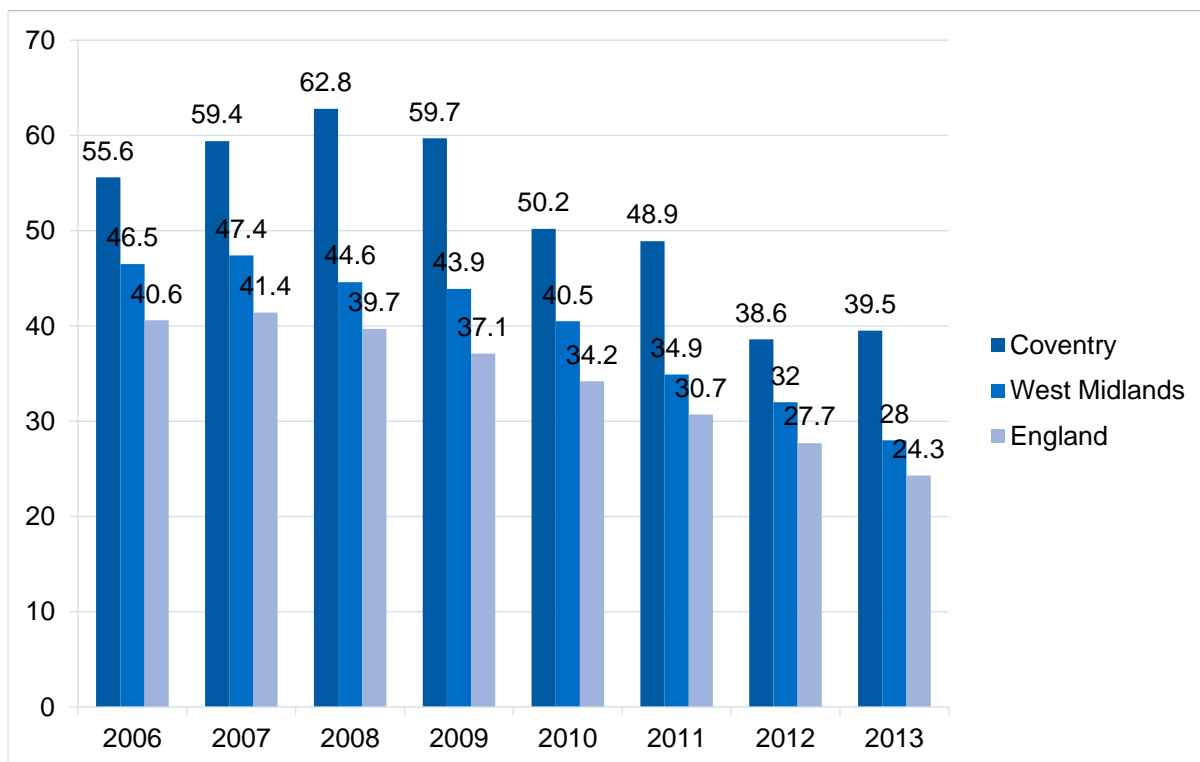
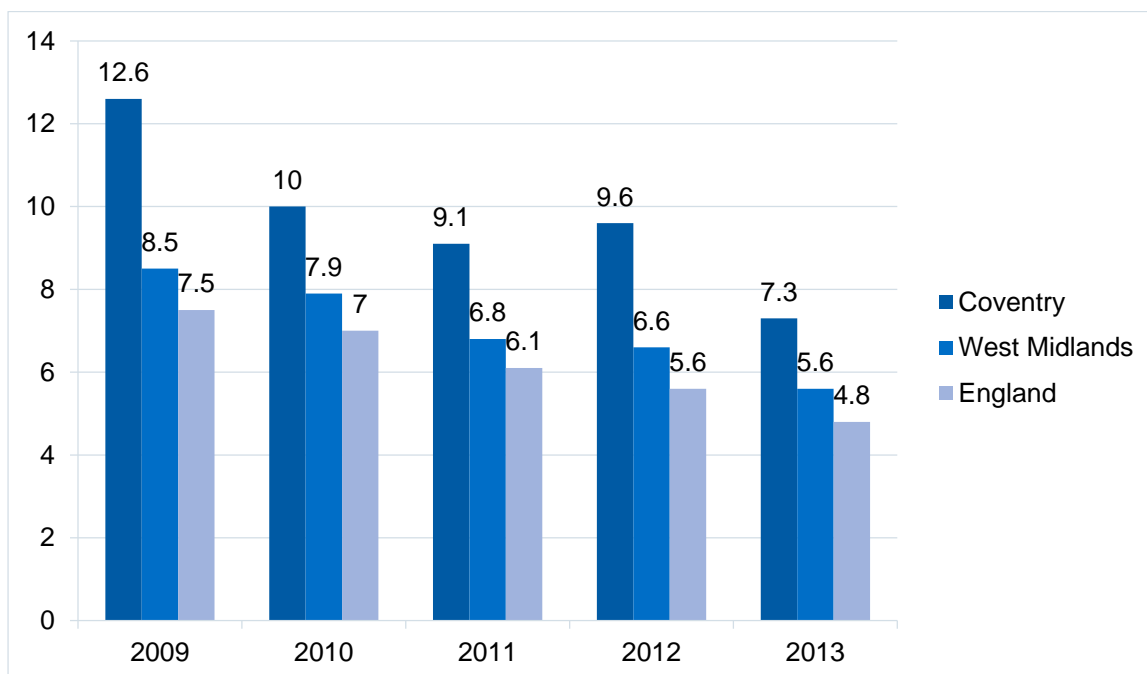


Figure 11 Conceptions to under 16s



### Young people not in education, employment or training (NEET)

The proportion of 16-18 year olds estimated to be not to be in education, employment or training (NEET) have decreased, from 7.4% in 2013 to 6.8% in 2014 and 4.7% in 2015. The rate however is still higher than the West Midlands Region (4.3%) and England (4.2%).<sup>92</sup>

Note that young people not known to their local authority are excluded from these figures, nor are young people who are taking a gap year or who are in custody.<sup>93</sup> Consequently, in areas where there is a high number of 'unknowns' such estimates are likely to be less accurate.

School leavers who are NEET are no longer developing their skills and thus are more likely to suffer from low pay at work, both now and in the future. Having poor, or no, qualifications have a significant impact on future employability. It is known that being NEET for longer than 6 months is associated with an increased risk of having a criminal record, and of poor health and depression in the future.<sup>94</sup> There are greater levels of young people who are NEET in more deprived areas; while other factors that increase the risk include learning disabilities, parenthood and having responsibilities as a carer.<sup>95</sup>

In April 2016, Prospects, a careers guidance organisation, was jointly commissioned by Coventry City Council and Warwickshire County Council to monitor and respond to the needs of NEETs.<sup>96</sup>

### Child sexual exploitation and female genital mutilation

Although the true extent of sexual violence, exploitation and female genital mutilation (FGM) is unknown, Coventry has the highest number of reported sexual assault offences per person in the West Midlands, 8.5% more than the second most affected regional area (Birmingham). It is estimated that approximately 42,460 adults living in Coventry have been victims of sexual violence at some stage of their adult lives, and there are an estimated 10,000 victims of rape and sexual abuse in the 0-16 year age band. Data for the prevalence of FGM is limited, but according to the 2011 Census data 3% (868) children aged 0-15 and 7% (5,422) women aged 16-49 living in Coventry were born in regions likely to be affected by FGM, and approximately 1.2% of women accessing UHCW's delivery services in 2014/15 were affected by FGM.

Sexual violence and exploitation, FGM and domestic violence have serious and long term health and social impacts on individuals and the Council deliver a range of programmes, services and interventions to prevent sexual violence, exploitation and FGM taking place and to support victims of domestic violence, sexual violence and FGM.<sup>97</sup>

### Child sexual exploitation

Child sexual exploitation (CSE) is a form of sexual abuse where a child or young person is exploited and receives something in 'exchange' for sexual activity. There is no specific criminal offence of CSE, however it can include other offences such as sexual assault, trafficking and abduction.<sup>98</sup> Across the West Midlands region, 754 children have been identified as being at risk of CSE and 15% of children identified were seen to be at the highest level of risk.

The Council commission a sexual violence support service, which is provided by CRASAC and provides free and confidential support and information to anyone from the age of 5 years old who has been affected by sexual violence, including victims, parents, partners, supporters and professionals. The service provides a telephone helpline, counselling provision, independent sexual violence advisor (ISVA) support, and befriending and

mentoring. Support from CRASAC enables victims of sexual violence to improve their confidence, know their rights, where to access help and support and results in a reduction of symptoms such as panic attacks, sleeping difficulties and improvements in other aspects of health and wellbeing.<sup>99</sup>

Since March 2015 there has been a multi-agency CSE team, Horizon<sup>100</sup>, which is made up of social workers, children and family workers, police and more recently a health worker. Horizon have been involved in awareness raising sessions for neighbourhood policing teams, taxi drivers, hotel staff, licensed premises staff, pharmacist and GPs. Training has also been delivered to place based services within the local authority to encourage a more joined up approach, with CSE now being a standing item at several place based meetings. In March 2016, Horizon also launched the CSE pledge urging both organisations and individuals to know the signs of CSE and how to report concerns. The awareness raising is critical as there is a need to understand the scale of the problem in order to tackle it effectively. Over the past 12 months, due to the success of the awareness raising, there has been a steep upward trajectory in relation to the number of children that are being identified as being at risk, or experiencing CSE. Where young people are identified Horizon staff work with the young person to build an enduring relationship to reduce the risk around that young person. Changes in risk are carefully monitored to ensure that the work of the team is effective; between May 2016 and June 2016 the risk for 55 young people reduced.

Disruption of locations and offenders is critical if CSE is to be tackled. The team have secured a number of innovative civil orders by working closely with the police and community safety, including: securing a Public Space Protection Order (PSPO) at a known local hotspot. This was reported positively by the local media and re-enforced the message that CSE will not be tolerated in Coventry; and securing a risk of sexual harm order in respect of an individual who was deemed to be risky to children.

- Learn about Coventry Horizon at [www.coventry.gov.uk/coventryhorizon/](http://www.coventry.gov.uk/coventryhorizon/).

### Female genital mutilation (FGM)

FGM is a complex issue. It is illegal in the UK to undertake FGM, or to take a British national or a permanent resident abroad for FGM to be carried out. However, despite the harm it causes, some people from practising communities see it as a part of their cultural identity.<sup>101</sup>

Estimates suggest that, at a national level, 137,000 females live with FGM and it is suggested there are 60,000 girls aged 13 and under who are at risk of FGM.<sup>102</sup>

Between April 2014 and March 2015, it was identified that 77 women who accessed University Hospitals Coventry and Warwickshire midwifery services had been affected by FGM. This equates to 1.2% of births, out of a total of 6,218 births during that time period.<sup>103</sup>

In addition, since October 2015, regulated health and social care professionals and teachers in England and Wales have been required to report known cases of FGM in those aged under 18 years. From January 2015 to September 2015, West Midlands Police received 70 such referrals, with 25 of these referrals originating from Coventry.<sup>104</sup>

Coventry City Council was the first Council to support a motion to condemn FGM. Since then a number of actions have been taken to gather knowledge and intelligence on the extent of FGM in Coventry and to tackle FGM through addressing the barriers faced by professionals and engaging with communities to change attitudes.

Coventry City Council commissioned Coventry Haven (in partnership with CRASAC and Birmingham and Solihull Women's Aid) to provide a specialist FGM service, which is designed to prevent FGM through: the development of a city wide FGM awareness campaign, designed by community members and young people, which includes information leaflets and electronic resources; providing bespoke training to professionals, young people and communities practising FGM; focusing on asset building within communities to develop their skills to tackle FGM; and empowering frontline professionals, affected girls and young women through developing support groups, community engagement and training.

The service has now been running for one year, and from June 2015 to February 2016 recruited 21 volunteer community champions from ten different countries of origin who are working with communities to raise awareness and change attitudes to FGM. The service has also attended over 50 community groups and provided over 20 training sessions to around 400 professionals and community group members. The service has also provided one to one support to 26 people who have experienced FGM. The service will run until the end of May 2017, with an evaluation planned to take place next year.

The Council's public health team have worked along with the CCG and safeguarding board to update policies and procedures to ensure that consistent messages are cascaded to frontline staff, and to develop and implement FGM risk assessment tools.

In addition, the Council have supported Coventry University in their development of a web app, 'Petals', for young people. Researchers at Coventry University have created the new app, endorsed by the NSPCC, to help protect young girls and women from female genital mutilation (FGM). The app, which works across most mobile devices such as smartphones, tablets and lap tops via an internet browser, is aimed primarily at young girls living in affected communities and at risk from FGM. Coventry City Council have now commissioned Coventry University to produce a new web app, 'Petals for professionals' which includes information on the signs that someone may be at risk of FGM, how to have appropriate conversations, and more information about the mandatory reporting requirements.

## Mental health and wellbeing

Good mental wellbeing plays an important role in the promotion of both physical and mental health.

Wellbeing and good mental health are fundamental in helping individuals achieve their potential, whether that is in education, employment or socially. It is also a key part of good physical health. Poor mental health is associated with various experiences that cause problems in people's lives. This includes substance abuse, poorer employment prospects and worsening social disadvantage.



Mental health and many common mental disorders are influenced by a wide range of social, economic and environmental factors. Mental health problems are increasing and they place an enormous strain on individuals, families and even the local community. Because of this, national policy now demands that mental health be treated on the same level as physical health.

See also:

- Mental health and wellbeing assets and needs analysis at <http://www.coventry.gov.uk/downloads/file/17145/>.
- Data appendices for the mental health and wellbeing assets and needs analysis at <http://www.coventry.gov.uk/downloads/file/17144/>.

### Adult mental wellbeing

At least one in four British adults will experience some form of mental health problem in any given year. Those who live in more deprived conditions are twice as likely to be affected by mental health. There are many factors that can be caused by or be a consequence of mental health problems such as unemployment, deprived income, substance and alcohol misuse and crime and violence. Addressing mental health needs can result in positive implications elsewhere. The estimated annual costs of tackling mental health in the UK, including spending in health and social care, is now over £20 billion.<sup>105</sup>

Approximately 1 in 6 people in Coventry are estimated to be affected by a common mental health condition at any one time.<sup>106</sup> Common mental health disorders include conditions such as depression, anxiety, phobias, obsessive-compulsive disorder (OCD), eating disorders and post-traumatic stress disorder (PTSD). The mental health and wellbeing assets and needs assessment for Coventry and Rugby estimated that there are over 67,000 noted common mental health disorders in the Coventry population aged between 16-74 years.<sup>107</sup> However, it is expected that the total number of people who are affected by a common mental health condition will be lower as there may be an overlap as it may be possible that someone could experience more than one mental health disorder.<sup>108</sup> Included in this figure are 25,000 people with a depressive or anxiety disorder, and a further 500 with a psychotic disorder. 5% of people in Coventry report low life satisfaction on direct questioning. Given that many mental health problems are not formally diagnosed, and that not all people will actively seek or engage with services, these figures are likely to be an underestimation. The King's Fund estimates that 35% of those with depression and 51% of those with anxiety disorders do not seek support from services.<sup>109</sup>

The prevalence of common mental health diagnoses in Coventry is higher than in both England and in cities with similar deprivation. For example, 10.4% of 16-74 year olds in Coventry are estimated to suffer from mixed anxiety and depressive disorders, compared with 8.9% nationally.<sup>110</sup> The assessment provided a snapshot of activity over a two-month period (October-November 2014) at a single GP surgery which identified that approximately 7-8% of consultations related to mental health, providing an indication of the high level of need across the city.

Mental health disorders can impact on an individual's ability to sustain employment, as demonstrated by the employment rate of people experiencing mental health problems, which for Coventry stands at 23.3%. This is established from responses to the Labour Force Survey which indicates the proportion of respondents who report that they have a mental illness and are in employment as a percentage of all respondents who report that they have a mental illness, in contrast the current employment rate in Coventry stands at 66%, showing the variance in employment rates for those experiencing a common mental health disorder.<sup>111</sup> This indicator is based on those who have self-identified as having a mental health disorder and so would include people with more severe mental health disorders.

Furthermore, it is also relevant to consider the interaction between mental health and physical health, in particular the mental health needs of people with long-term conditions. Nationally, it is estimated that at least 30% of people with a long-term physical health condition have a co-morbid mental health problem with 12-18% of NHS expenditure on long-term conditions linked to poor mental health and wellbeing. It is estimated that there are approximately 99,000 people (30%) in Coventry with a long-term condition, with 30% of people with a long-term condition affected by co-morbid mental health problems. This co-morbidity is estimated in Coventry to cost at least £6.1m per annum.<sup>112</sup>

### Severe mental illness

Severe mental illness is generally used to refer to conditions that include psychotic symptoms and includes bipolar disorder, schizophrenia, along with other psychotic conditions.

Psychosis is a serious mental health problem which can cause hallucinations or delusions which mean that people can perceive things differently to others and this can severely disrupt emotions and behaviour.<sup>113</sup> Rather than being a condition on its own, psychosis is a result of other conditions. Across Coventry, there are 30.2 cases of first episodes of psychosis among people aged 16-64 years old; this is compared to 24.2 per 100,000 of the population at a national level.<sup>114</sup> It is estimated that approximately 20% of people with psychosis will attempt to commit suicide at some point in their life and 1 in 25 people with psychosis will commit suicide.<sup>115</sup> Coventry's Mental Health Needs and Assets Assessment estimates that 516 people aged 18 to 64 live with a psychotic disorder.

The prevalence of borderline personality disorder is estimated to be 0.3% in males and 0.6% in females aged between 18-64 years, if these prevalence rates are applied to Coventry, this equates to 940 adults in 2014 estimated to have this condition.<sup>116</sup>

The average life expectancy of people with serious mental illness is 20 years shorter than the average and this excess premature mortality is largely attributed to cardiovascular disease and the increased prevalence of lifestyle risks that can contribute to cardiovascular disease (including higher rates of inactivity and higher rates of smoking and obesity).

### Dementia

As the numbers of people living to old age increase in Coventry (despite the continued fall in the city's average age) the number of people with dementia will be increasing too. People with dementia typically experience a progressive decline in their memory, reasoning, communication skills and the ability to carry out daily activities. Alongside this, individuals

may also experience behavioural and emotional symptoms. Most people with dementia in Coventry live at home, with support from friends and family members and caring for someone with dementia can increase the risk of depression and physical illness. As a result, dementia causes distress and upheaval for the lives of many family members and carers, so the impact of increases in the numbers of people suffering from dementia has an impact right across the community.

An estimated 3,600 people in Coventry have dementia, although approximately only half of these will have a formal diagnosis, and thus have access to related services.<sup>117</sup> There is a current national target for 67% of cases of dementia to be diagnosed.<sup>118</sup>

The prevalence of dementia in the city is increasing, from 0.45% in 2010/11 to 0.57% in 2014/15, and this is reflective of the increasing proportion of older people.<sup>119</sup> When the prevalence in the population aged 65 years and older is considered, this increases to 3.82%, compared to 4.27% nationally. These data reflects the number of people recorded as having dementia by their GP as a proportion of all patients registered at the GP surgery.

In line with global trends, the prevalence of dementia is expected to double by 2030.<sup>120</sup> National prevalence estimated for males aged 70-74 stands at 3.1% and for females this is 2.4%. This increases to 16.7% for males and 22.2% for females aged 85-89 and for those aged 90 years and older, the increase is even starker at 27.9% for males and 30.7% for females.<sup>121</sup>

The estimated annual cost of supporting each person with dementia is £32,250, and this is in addition to the potential difficulties that are met by family and carers.<sup>122</sup> Coventry's Living Well with Dementia Strategy 2014-17 notes that most people with dementia in Coventry live at home and are supported by friends and family.<sup>123</sup>

Early diagnosis of dementia would allow timely access to services that can help maintain quality of life. It is known that dementia is under diagnosed in some BME communities, and measures to increase awareness of the condition may encourage prompt diagnosis and the access of appropriate support.<sup>124</sup>

To ensure support remains appropriate, it is relevant to consider the proportion of people diagnosed with dementia who receive a face-to-face review of the needs of their, and potentially, their carer's needs. In Coventry and Rugby, 76.5% of patients living with dementia have had their care reviewed in a face-to-face review in the preceding 12 months.<sup>125</sup>

See also:

- Coventry Living Well with Dementia Strategy at <https://www.coventry.gov.uk/downloads/download/3783/>.
- Health-related quality of life for older people indicator at <http://fingertips.phe.org.uk/search/dementia#gid/1/pat/6/ati/101/page/0/par/E12000005/are/E08000026>.

## Children and young people mental wellbeing

The most common mental health issues in childhood and adolescence include emotional disorders, such as anxiety, and conduct disorders, including antisocial or aggressive behaviours, and these particularly affect children with learning disabilities.<sup>126</sup> This can result in poor social functioning, impaired academic performance, and an increased risk of smoking and drug use. In the UK, 10% of 5 to 16 year olds are estimated to have a mental health disorder and this is based on the prevalence from an ONS survey, mental health of children and young people in Great Britain (2004).<sup>127</sup> Consequently, this only provides an approximation of prevalence. Child and adolescent admissions for mental health in Coventry are reducing but are still of concern, with 72 admissions per 100,000 children per year.<sup>128</sup>

Given that half of mental illness begins before the age of 14 years,<sup>129</sup> 130 70% of children and young people who experience a mental health problem have not had appropriate interventions at a sufficiently early age.<sup>131</sup>

- Read the children and young people's mental health profile at <http://fingertips.phe.org.uk/profile-group/mental-health/profile/cypmh/data#gid/1938132752/pat/6/ati/102/page/1/par/E12000005/are/E08000026>.

## Self-harm and suicide

The incidence of reported self-harm in the UK has risen over the last 20 years, especially among young people.<sup>132</sup> It is unclear the extent to which self-harm is increasing and to what extent the growth could be attributable to increased recognition and recording.

Self-harm rates are closely linked with deprivation within Coventry, with a four-fold difference in hospital admissions for self-harm between the least and most deprived wards. Suicide rates in Coventry averaged 10 per 100,000 of the population per year over the previous decade. This figure has been falling but local rates are higher than the regional and national rates (9.1 and 8.9 per 100,000, respectively), although not significantly so. Even though the overall numbers are small, the consequences of suicide impact on surviving family and friends, and can greatly damage social networks.

## Physical wellbeing

### Substance misuse

Illicit drugs are known to have a variety of detrimental effects on physical and mental wellbeing.<sup>133</sup> <sup>134</sup>

The Coventry drugs strategy estimated 2,000 adults in Coventry use opiates and/or crack cocaine on a regular basis.<sup>135</sup> The prevalence of opiate or crack users amongst 15 to 64 year olds in the city is 9.2 per 1000, lower than cities of a similar deprivation profile, but still higher than the England average of 8.4 per 1000. The number of hospital admissions due to substance misuse in young people aged 15 to 24 years is significantly lower than the country's average (65.8 compared to 88.8 per 100,000 respectively).<sup>136</sup>

Early intervention in substance misuse can prevent loss of employment and income, decrease drug-associated crime, and limit the risk of further physical and mental health conditions as a result of substance misuse, such as blood borne virus infection. Treatment data from 2014 notes the percentage of opiate users who completed treatment and who did not re-present within 6 months and this stands at 6.4% in Coventry, compared to 6.2% in the West Midlands and 7.4% in England.<sup>137</sup> Nevertheless, it should be considered that these data would not record those individuals who have not re-engaged with services but who may potentially be misusing drugs.

See also:

- Our drugs strategy at <http://www.coventry.gov.uk/downloads/file/16838/>.
- The alcohol and drugs needs assessment at <http://www.coventry.gov.uk/downloads/file/21620/>.

### Alcohol

Alcohol is the most widely available drug in the UK and is used sensibly by the majority of the population. It is part of our social fabric and a major contributor to the economic vibrancy of the community.

While many people enjoy alcohol responsibly, it is estimated that approximately nine million adults in England drink alcohol at levels that may pose a risk to their health.<sup>138</sup> The widespread harms of excessive or chronic alcohol overconsumption range from liver disease to an increase in domestic violence and other crimes. The direct annual costs to the NHS are £3.5 billion, with the indirect societal costs approaching £21 billion.

There are over 13,000 high-risk drinkers in Coventry, defined by the consumption of 50 or more units per week for men and 35 or more units per week for women.<sup>139</sup> Within the city, alcohol is estimated to be a contributing factor in 38,000 emergency department attendances and 3,100 crimes annually and is cited as an issue in one in five child protection cases.

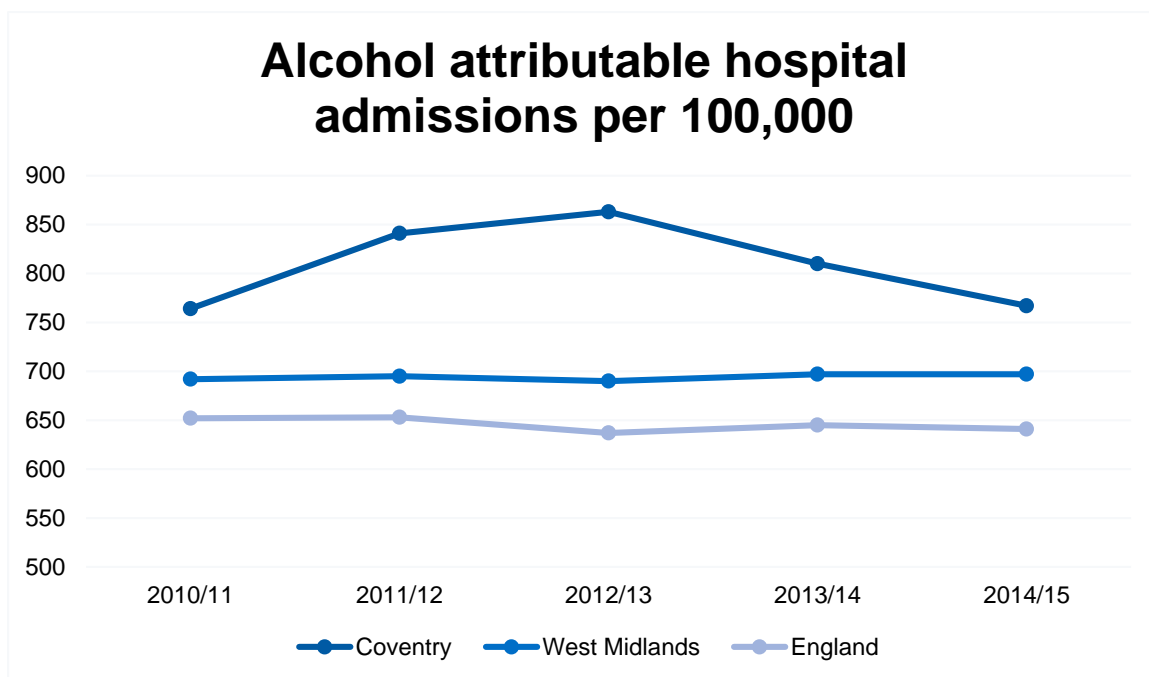
There were 2,348 alcohol-related hospital admissions in 2014/15 at a rate of 767 per 100,000. This is significantly higher than in the West Midlands and England (697 and 641 per 100,000 respectively), but hospital admission rates have been reducing year-on-year for the last three years faster than the national average. (Figure 12).<sup>140</sup> Within Coventry, alcohol-related hospital admissions vary considerably; for example, admissions are twice as likely in Foleshill compared to Wainbody. Furthermore, Coventry's alcohol strategy indicates that alcohol-related health harms increase with age and that almost 60% of patients admitted to hospital to receive treatment for alcohol-related conditions were aged 55 years or older.

See also:

- Our alcohol strategy at <http://www.coventry.gov.uk/downloads/download/3702/>.
- The alcohol and drugs needs assessment at <http://www.coventry.gov.uk/downloads/file/21620/>.
- Alcohol profile at <http://www.coventry.gov.uk/downloads/file/17105/>.

- Liver disease profile at <http://fingertips.phe.org.uk/search/liver%20disease#page/0/gid/1/pat/6/par/E1200005/ati/102/are/E08000026/iid/40601/age/163/sex/4>.

Figure 12 Alcohol-Related Hospital Admissions



Interventions are available to reduce the levels of harmful drinking. Specialist alcohol treatments for those with alcohol dependence, including detox programmes and group therapy, can reduce drinking levels, with knock-on effects on health, healthcare costs and behaviour.<sup>141</sup>

The number of people reported to be in treatment at specialist alcohol misuse services in 2014/15 stands at 582, with 36.5% of those receiving a service recorded as having successfully completed treatment according to 2014 data.<sup>142</sup> This is defined as those who left treatment who do not re-present within 6 months and is lower than the rate for the West Midlands (39.6%) and England (38.4%). Similar to reported outcomes for drug treatment services, this would not record those individuals who may have relapsed and not re-engaged with services.

At the time of writing, the UK chief medical officers have proposed that guidelines on recommended levels of alcohol consumption are modified so that both men and women are advised that they are safest not to drink regularly more than 14 units of alcohol a week and, if this amount is consumed, that this should be spread across three days or more.

Coventry’s alcohol strategy 2013-16 notes that around 1 in 5 adults in Coventry (around 52,500 people) drink above recommended safe levels of alcohol (using previous chief medical officer guidelines). The results of Coventry’s household survey also suggests that 29% of respondents drank more than the recommended amount one day a week and this is lower than 2012 where 33% indicated they drank more than the recommended amount one

day a week (based on guidelines current in 2013). Nevertheless, 41% of respondents suggested they did not consume more than the recommended amount on any day in the week.<sup>143</sup>

### Smoking

Tobacco is the biggest contributor towards premature and preventable mortality, accounting for approximately 100,000 deaths a year in the UK.<sup>144</sup> It accounts for 1 in 6 deaths in England, and annually costs the NHS £2 billion.<sup>145</sup> The risk of a young person starting smoking is significantly increased if their parents smoke.<sup>146</sup> Furthermore, Coventry's smoke-free strategy highlights that the vast majority of smokers started using tobacco products while still a teenager, with national research indicating that 80% of smokers started smoking before the age of 16.<sup>147</sup> Smoking is also linked with an increased risk of alcohol and substance misuse.

See also:

- Smoke-free strategy 2015-2020 at <http://moderngov.coventry.gov.uk/documents/s23073/Coventry%20Smokefree%20Strategy%20-%20Appendix.pdf>.
- Smoking profile at <http://fingertips.phe.org.uk/search/smoking#gid/1/pat/6/ati/102/page/0/par/E12000005/are/E08000026>.

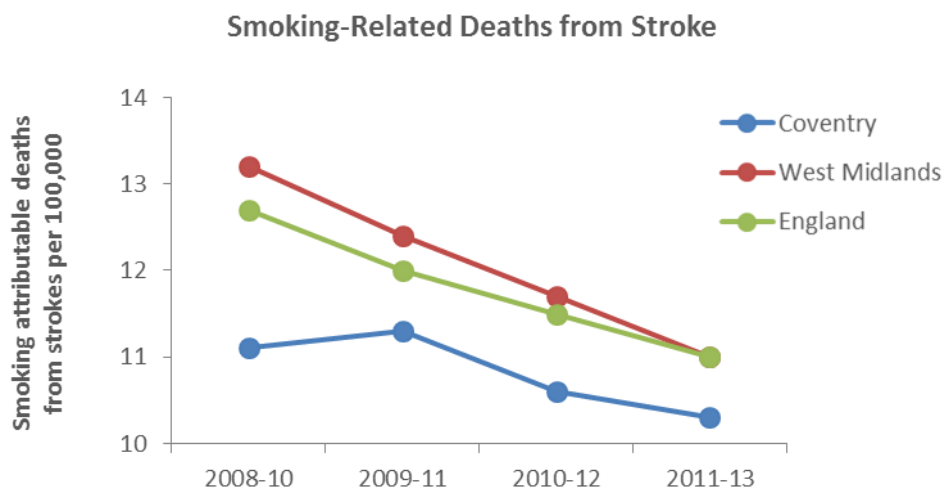
There are around 50,000 smokers in Coventry. The prevalence of adult smokers stands at 15.6% which has decreased from 18.5% in 2013 and an estimated 5.8% of 15-year-olds self-identify as regular smokers.<sup>148</sup> In addition, 13.5% of 15 year olds state that they currently use, have previously used, or tried e-cigarettes. Smoking prevalence figures are lower than that reported for England (18%) and broadly lower than in cities of a similar level of deprivation. Nevertheless, these data do not identify how many cigarettes are smoked and so identify both heavy smokers and those who are occasional smokers and are also based on self-reported use of cigarettes.

Nationally, there is an increased prevalence of smoking in areas of greater deprivation. Although accurate data are not available, there is estimated to be a wide range of teenage smoking rates within Coventry, from 3% in Foleshill to 12% in St Michael's.<sup>149</sup>

Furthermore, there is also an economic impact of smoking as, on average, smokers take eight days more sick leave a year compared to non-smokers.<sup>150</sup>

Smoking-related hospital admission rates in Coventry in 2014/15 were 16 per 1,000 and are slightly lower than the figures for the West Midlands as a whole (16.7 per 1,000). However, this rate has increased significantly from 15.3 per 1,000 in 2010/11.<sup>151</sup> Encouragingly, smoking-related deaths from heart disease and stroke have been reducing in Coventry (Figure 13), in line with national figures, although lung cancer deaths are higher compared to England (70.7 compared to 59.5 deaths per 100,000 of the population respectively).

Figure 13 Deaths from stroke attributable to smoking



Stop-smoking interventions can help reduce smoking-related morbidity and mortality.<sup>152</sup> In Coventry, the 4-week quit rates are higher than those seen nationally, with 5,055 self-declared successful four-week quits per 100,000 smokers aged over 16 years compared to 2,829 per 100,000 smokers nationally, although it will take some time before this translates to an improvement in longer-term outcomes.<sup>153</sup>

## Physical activity

### Active lifestyle

People with a physically active lifestyle, defined as doing more than 150 minutes of moderate physical activity per week, have a 20-30% lower risk of cardiovascular disease compared to those who are not active.<sup>154</sup> Research suggests that levels of physical inactivity are greater in more socio-economically deprived areas, in men and in older people (over 65 years).<sup>155</sup>

### Obesity and excess weight

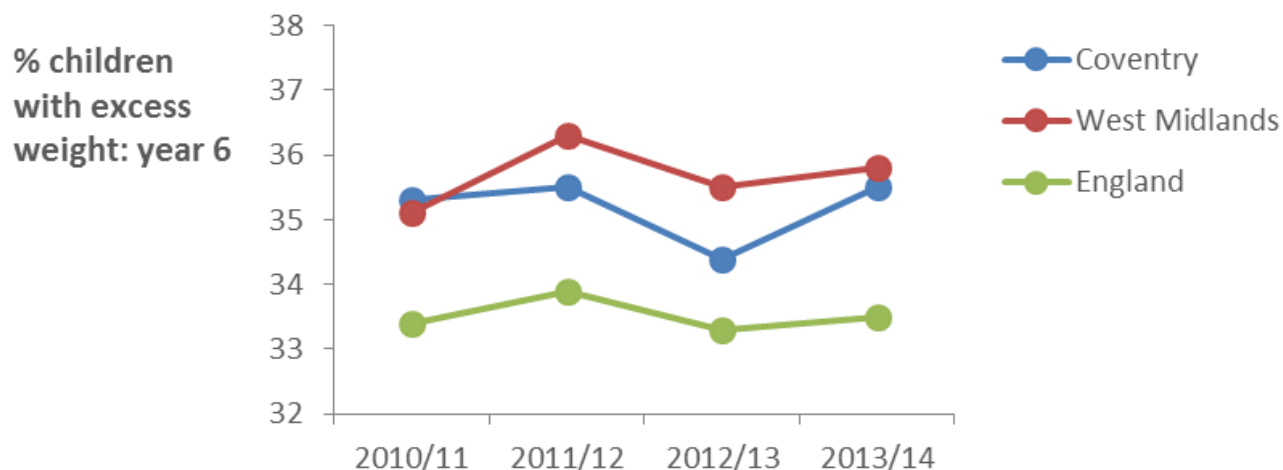
Excess weight (defined as weight that is in excess of the ideal body weight) and obesity are associated with a myriad of health problems. These include heart disease, stroke, high blood pressure, diabetes and arthritis.<sup>156</sup> For instance, 90% of adults with type 2 diabetes are estimated to be overweight or obese.<sup>157</sup> The consequences of obesity and excess weight cost the NHS £6 billion annually.<sup>158</sup> Data from 2012-2014 indicate that in Coventry, 62.4% of adults in the city have excess weight and this is lower than the national average (64.6%), but the prevalence of excess weight and obesity is known to be rising overall. There is a clear deprivation-related inequality within the city, with proportions of obesity ranging from 17% in Wainbody to 30% in Longford.<sup>159</sup> Certain ethnic groups also display increased proportions of obesity, particularly those of South Asian origin.<sup>160</sup>

Being overweight or obese in early life increases the risk of adult obesity, along with a higher risk of premature mortality in adulthood.<sup>161</sup> Of children in reception, 22.4% have excess weight in Coventry, higher than the national level of 21.9%. By year 6 of school, these proportions have increased, with 35.4% of children having excess weight (compared to 33.2% nationally, Figure 14). As with adults, there is a significant inequality in childhood



excess weight across the city, with some wards having levels 50% higher than others. The local proportions of excess weight in children have remained stable over the previous five years. Early interventions are available to tackle childhood obesity and there is the opportunity to encourage participation.<sup>162</sup> Reducing excess weight and obesity will not only improve health outcomes, but also quality of life.

Figure 14 Proportion of 10-11 year olds with excess weight



- Find out more on about childhood obesity at [http://www.noo.org.uk/NOO\\_about\\_obesity/child\\_obesity](http://www.noo.org.uk/NOO_about_obesity/child_obesity).

### Predictors of lifestyle risk

It is estimated that two thirds of the Coventry population (66%) have two or more lifestyle risks, these are defined as displaying one or more of the following behaviours: *smoking at least one cigarette a day; being physically inactive; excessive consumption of alcohol; or consuming fewer than five portions of fruit or vegetables a day.*<sup>163</sup>

Comparing data from 2012 to 2007 indicated an improvement as 77% of the population were estimated to have two or more lifestyle risks in 2007.<sup>164</sup> However, these improvements were not distributed equally, with men more likely to display several unhealthy behaviours compared to women. Furthermore, improvements in risk factors were not seen in people who are economically inactive and those who identify with a white ethnic background were also more likely to display higher levels of unhealthy behaviours.

## Long-term conditions

### Overview

At a national level, it is estimated that approximately 15 million people have a long-term condition.<sup>165</sup> Research indicates the high-level resource implications of providing care to people with long-term conditions, with estimates made that approximately 70% of health

spend is accounted for by 30% of the population with 50% of all GP appointments, 64% of appointments as an outpatient and 70% of bed days attributed to long-term conditions.

Also, relevant to the analysis on long-term conditions is the fact that people will often have two or more long-term conditions simultaneously. While the number of people with one long term condition is projected to be relatively stable at a national level over the next ten years, the number of people with multiple conditions is projected to rise to 2.9 million in 2018, from 1.9 million in 2008.<sup>166</sup>

## Premature mortality

Premature mortality is defined as deaths in the population aged under 75 years.<sup>167</sup> In terms of all premature deaths, Coventry is ranked as the 114<sup>th</sup> local authority (out of 150) with 398 deaths per 100,000 of the population in 2012-2014. Comparing the rate of premature deaths in Coventry with local authorities that have a similar level of deprivation, Coventry has a better performance and is ranked 5<sup>th</sup> out of 15 local authorities.<sup>168</sup> Nevertheless, as noted below, there are areas where Coventry’s performance (deaths per 100,000 population) could be improved compared to data at a national level and such data could support the identification of future priorities.

## National comparisons<sup>169</sup>

The graphics below in Figure 15 and Figure 16 set out some national comparators.

Figure 15 Number of premature deaths by cause compared to all local authorities in England

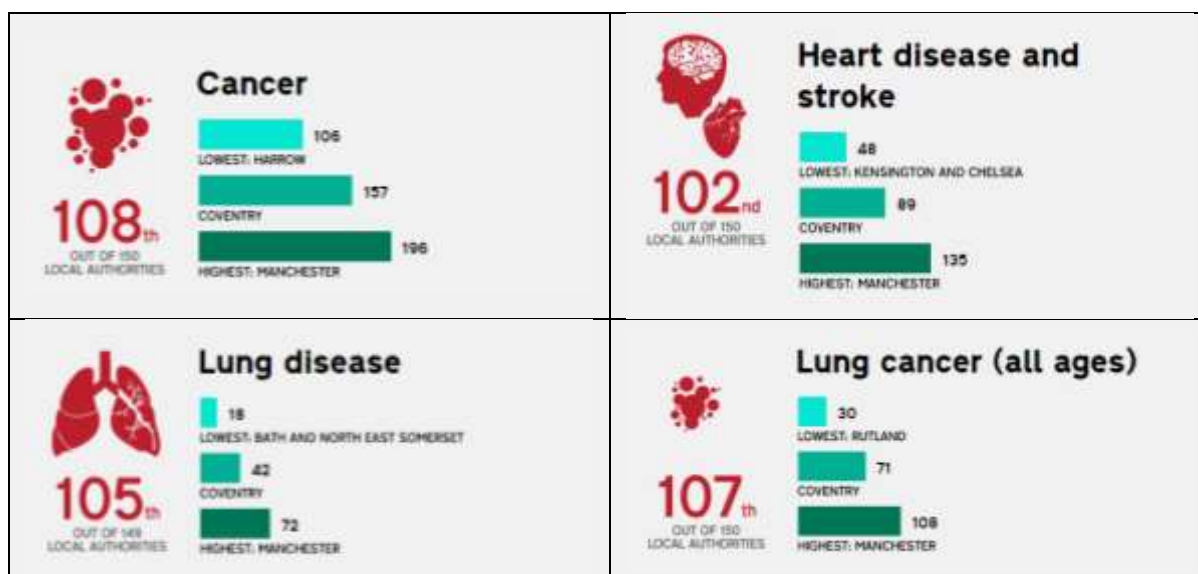
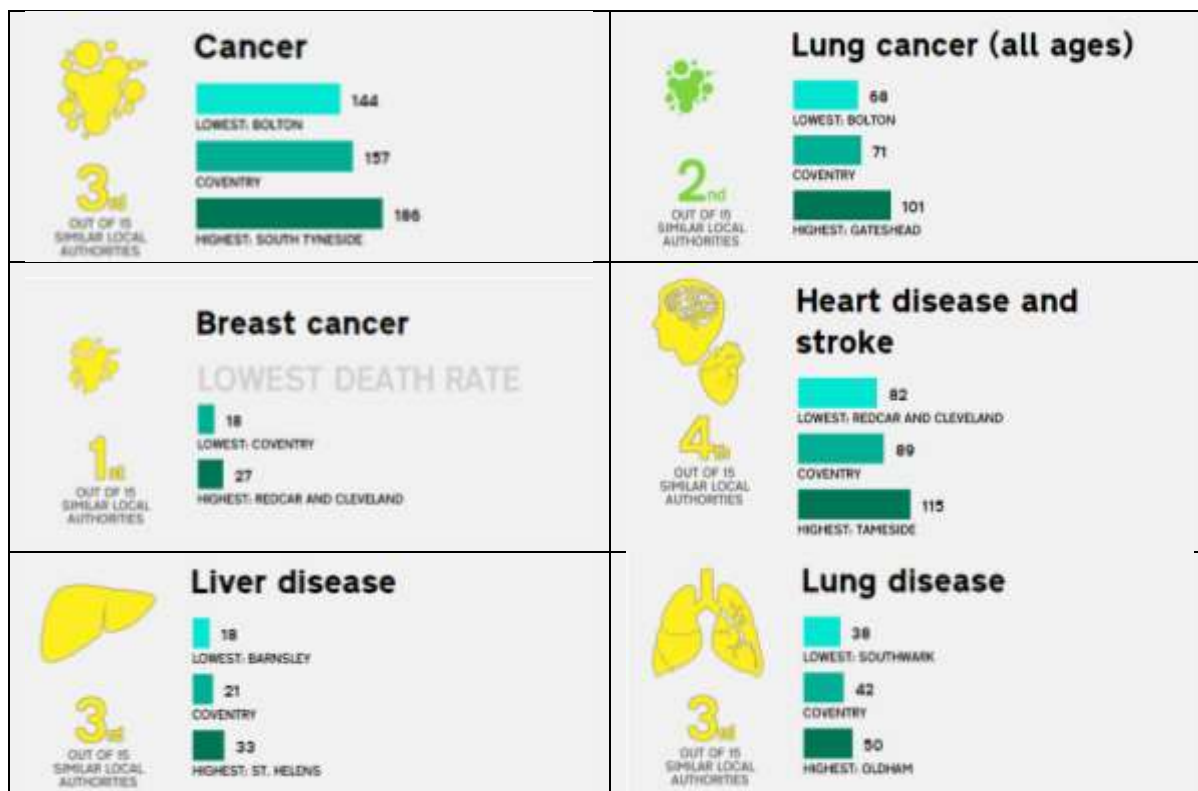


Figure 16 Number of premature deaths by cause compared to local authorities with a similar level of socioeconomic deprivation



## Cancer

Cancer can affect a diverse range of tissues and organs, and thus is a heterogeneous group of conditions. The overall incidence of cancer is increasing. The NHS spends almost £6 billion on the diagnosis and treatment of cancer annually, and the cost is expected to rise.<sup>170</sup>

In Coventry, there are approximately 1,000 cancer deaths per year. Mortality is not the inevitable end-point of cancer and, whilst survival patterns depend on the location and type of cancer, overall survival from most forms of cancer are improving nationally.<sup>171</sup> Early diagnosis and treatment improves the chances of survival from any cancer and in Coventry, 43.6% of cancers are diagnosed at stages 1 or 2, compared to 45.7% for England and 44.3% for the West Midlands. This is defined as new cases of cancer diagnosed at stage 1 or 2 as a proportion of new cases of cancer diagnosed.<sup>172</sup> Nevertheless, there are concerns surrounding the robustness of these data as the staging data of cancer is sometimes not recorded and where this is the case, a lower proportion of cases diagnosed at stage 1 or 2 will be suggested.

Preventable cancer mortality rates in the under-75s (per 100,000 per year) is decreasing in Coventry, from 103.9 in 2010-12 to 94.6 in 2012-14, although rates are significantly higher than in England overall (83 per 100,000 per year). There is also wide variation in deaths from cancer in those aged under 75 years, per 100,000 of the population from 148.2 in St Michael's, to 79.4 in Earlsdon.<sup>173</sup>

Screening rates for breast cancer and cervical cancer are significantly lower than the regional and national figures, with only 71.7% of women attending screening appointments (compared with 75.4% nationally).

Specific cancers vary in their incidence, but the most common cause of cancer mortality, both locally and nationally, is lung cancer. Smoking is the major risk factor for developing lung cancer, and hence a vast proportion of lung cancer deaths is deemed preventable (89%).<sup>174</sup> The premature mortality rate from lung cancer is 71 per 100,000 of the population in Coventry, which is significantly higher than both the West Midlands and England (which have mortality rates of 59 and 60 per 100,000 of the population per year, respectively). The incidence of lung cancer is variable within Coventry; for example, there is more than twice the incidence in Longford and Upper Stoke compared to Wainbody and Earlsdon. Many factors have been associated with the development of lung cancer and other cancers, such as age, smoking, alcohol, obesity and poor diet, and the variations in lung cancer rates seen both within Coventry, and between Coventry and the rest of England, may in part be due to differences in the prevalence of these risk factors.

See also:

- Local data on cancers detected at an early stage at <http://www.coventry.gov.uk/downloads/file/17115/>.
- Cancer information tools at [http://www.ncin.org.uk/cancer\\_information\\_tools/](http://www.ncin.org.uk/cancer_information_tools/).

### Cardiovascular disease

Cardiovascular disease (CVD) is a general term that encompasses a disease of the heart or blood vessels.<sup>175</sup> It is the cause of more than a quarter of all deaths in the UK, with annual costs to the NHS and the economy estimated at over £15 billion.<sup>176</sup> Many modifiable risk factors exist for this condition, including hypertension, high cholesterol, obesity and diabetes.<sup>177</sup>

In Coventry, the mortality rate from cardiovascular disease in the under-75s is 89 per 100,000 per year according to 2012-14 data, although cardiovascular mortality has generally been decreasing over the previous decade, both locally and nationally. Across Coventry, there is also a difference between the mortality rates for males and females with a rate of 125.3 deaths per 100,000 within the male population and 53.8 per 100,000 within the female population.<sup>178</sup>

In addition, within the UK, CVD mortality is 50% higher in the most deprived communities compared to the least deprived.<sup>179</sup> This inequality is apparent within Coventry. For example, there are more than twice the number of emergency admissions for heart attacks in Foleshill compared to Earlsdon.<sup>180</sup> When looking at levels of deaths from coronary heart disease in those aged under 75 across the city, it can be seen that St. Michael's ward has the highest rate at 205 deaths per 100,000 of the population, with Earlsdon having the lowest rate at 58 deaths.

Many cardiovascular deaths can be prevented or delayed by simple lifestyle interventions. The preventable mortality rate in under-75s from CVD in the city is 58.6 per 100,000 of the population per year – significantly worse than the national rate of 49.2 per 100,000 of the

population per year. Again, there is a difference between preventable mortality rates in Coventry between males and females, with a rate of 87.8 per 100,000 of the population for males and 30.7 for females.<sup>181</sup>

- Find out more on the cardiovascular disease profile for Coventry and Rugby at [http://fingertips.phe.org.uk/profile/cardiovascular/data#gid/8000061/pat/110/ati/19/page/0/par/ONS\\_1.02/are/E38000038](http://fingertips.phe.org.uk/profile/cardiovascular/data#gid/8000061/pat/110/ati/19/page/0/par/ONS_1.02/are/E38000038).

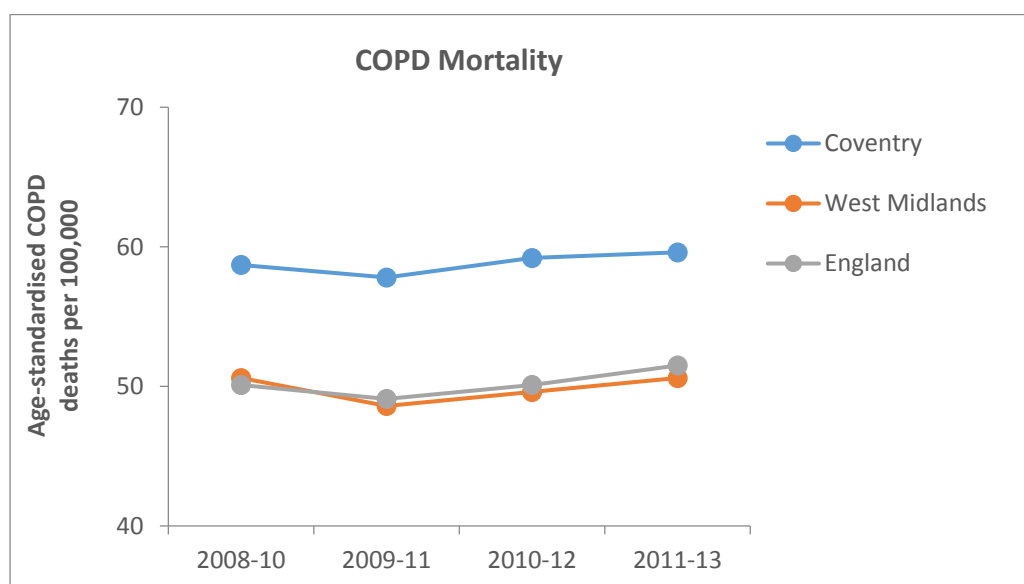
## Chronic obstructive pulmonary disease

Chronic obstructive pulmonary disease (COPD) occurs secondary to long-term smoking, predominantly affects people over the age of 40, and is characterised by shortness of breath, a persistent cough and frequent chest infections and includes conditions such as chronic bronchitis, emphysema and chronic obstructive airways disease.<sup>182</sup> COPD is associated with a reduced quality of life, frequent hospital admissions and significant mortality.<sup>183</sup>

Data from the Coventry and Rugby Clinical Commissioning Group suggest that 1.6% of GP-registered patients have documented COPD, compared to the national proportion of 1.8%. Emergency admissions for COPD are four times more common within residents of Binley and Willenhall compared to Earlsdon, and this difference may well be due to the underlying variations in smoking rates.<sup>184</sup> Improvements in the medical management of COPD are estimated to reduce admissions by 5%, but smoking interventions and the prevention of respiratory infections (for example via influenza vaccinations) will have a greater benefit on reducing the prevalence and admission rates of COPD.<sup>185</sup>

There has been little change in the incidence of COPD-related mortality locally or nationally over the previous five years. COPD mortality rates in Coventry are significantly higher than in England overall (60 compared to 52 per 100,000 per year – see Figure 17).

Figure 17 Deaths from chronic obstructive pulmonary disease (per 100,000 of the population)



Looking at deaths from *all respiratory diseases* at all ages across the city, a wide variation can be seen from 158.2 deaths per 100,000 of the population in Foleshill compared to 62.6 in Wainbody.

### Diabetes

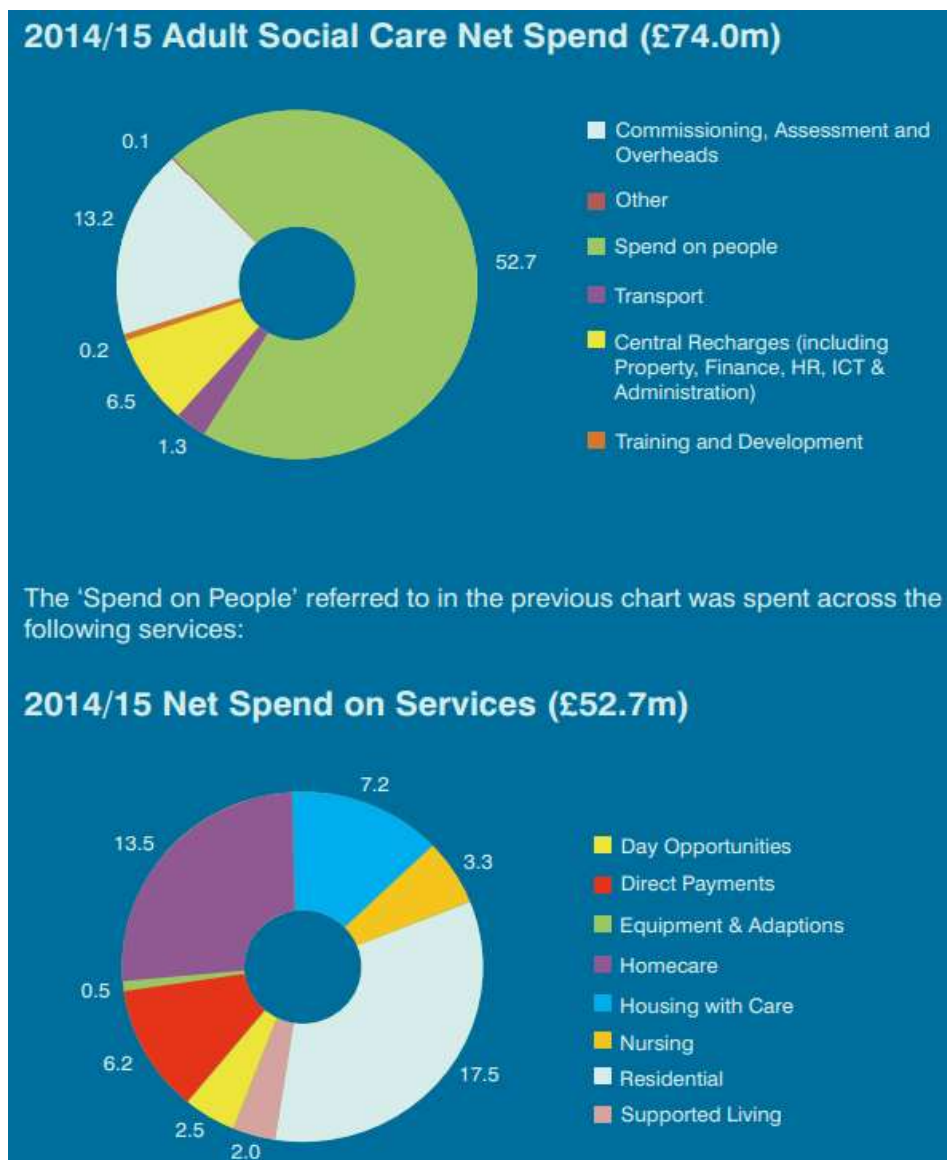
Diabetes affects almost 3.5 million people in the UK, with a further half a million people likely to have the condition but be unaware of it.<sup>186</sup> Type 2 diabetes (adult-onset) is the most common form. Diabetes can lead to a multitude of other medical problems, including heart disease, renal failure, amputations and blindness, and this condition is associated with an annual NHS spend of £9.8 billion.<sup>187</sup> The proportion of those aged 17 years and older registered with a GP who have been diagnosed with diabetes has increased from 5.6% in 2010/11 to 6.5% in 2014/15, and these figures are similar to the national average (6.4%).<sup>188</sup> Type 2 diabetes is up to six times more common in people of South-Asian origin and three times more common in people of Afro-Caribbean origin.<sup>189,190</sup>

### Demand for care

#### Adult social care

Needs and demands for adult social care (ASC) are constantly evolving, due to influencing factors such as (but not limited to) an ageing population, changes in approaches to care and expectations of services. The council spend on ASC is relatively significant, accounting for approximately 30% of the total council budget in 2014/15 was spent on ASC (Figure 18), equating to a net spend of £74m.<sup>191</sup> Therefore it is important to understand the demand for care and attempt to predict this going forward, in an attempt to best allocate decreasing Government funding and increase efficiency of service.

Figure 18 Allocation of net spend for adult social care in 2014-15



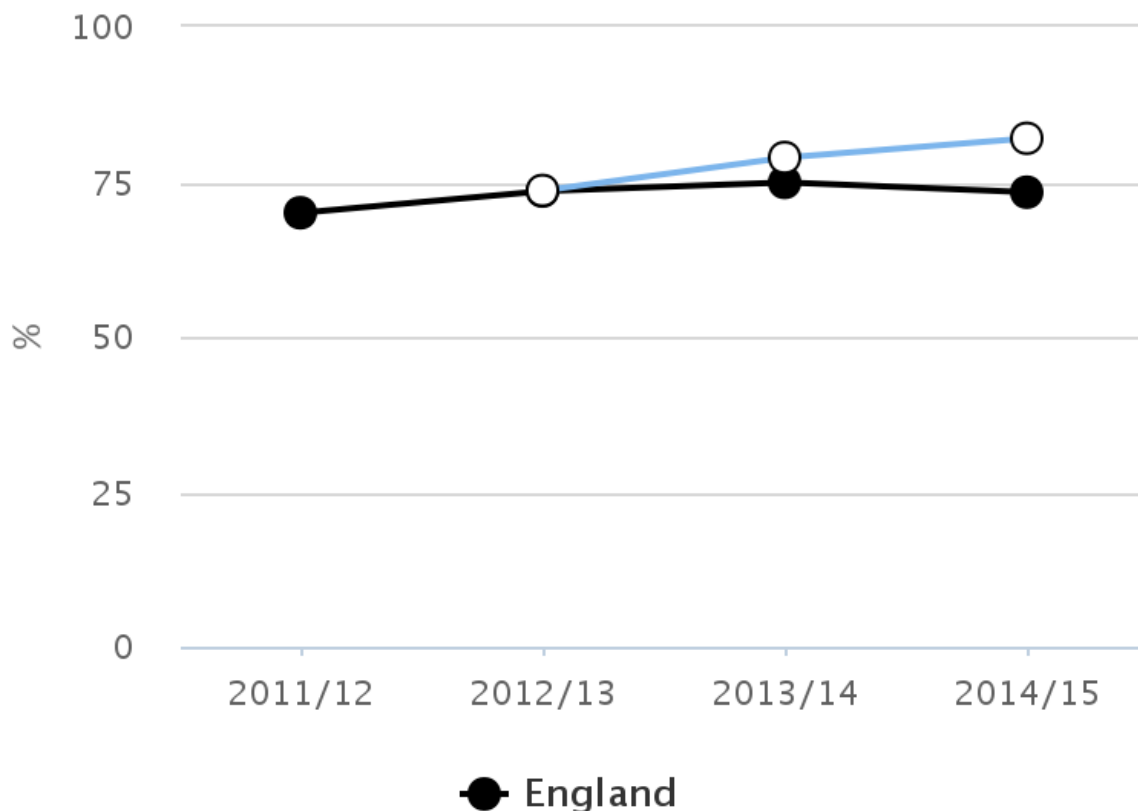
## Disabilities

Adults who consider that their day-to-day activities limited due to a health problem or disability which has lasted, or is expected to last, at least 12 months, are far less likely to report their general health as good (35% compared to 89% for those who don't).<sup>192</sup>

According to the 2011 census, 56,274 people of all ages declared that their everyday activities are limited a little or a lot by a long-term health problem or disability. Within adult social care, the top 2 services used by type of disability or impairment in 2013-14 were those for mental health (59%) and learning disabilities (32%).<sup>193</sup> Over the last 3 years, Coventry has overtook both the West Midlands and England in the proportion of adults with a learning disability who live in a stable and appropriate accommodation (Figure 19).<sup>194</sup>

Figure 19 Proportion of adults with a learning disability who live in stable and appropriate accommodation-Coventry

**1.06i – Adults with a learning disability who live in stable and appropriate accommodation (Persons) – Coventry**



**Falls and frailties**

Falls pose a particular issue for older people, with over 65 year olds at most risk. Falls and related injuries are a major cause of disability and a leading cause of mortality in people aged 75 and over in the UK.<sup>195</sup> In terms of the impact this has, it is estimated that around 30% of people aged 65+ and living at home, and about 50% of people aged 80+ and living at home or in residential care, will experience at least one fall a year. It has been noted that falls prevention services are amongst the strongest sets of evidence for their effectiveness. If help is offered after a first accident, the likelihood of that person having a second fall is reduced by 75%, thus saving money for NHS and social care, and achieving better outcomes for people.<sup>196</sup> Coventry has increased preventative approaches and also increased the use of technology to enable people to live independently in their own home. Part of this is an enhance Telecare offer across the city, providing support in the community and enabling people to maximise their independence.<sup>197</sup>



## Infectious diseases

### Immunisations

The primary aim of immunisation is to protect the individual who receives the vaccine and this makes them less likely to be a source of infection to others. In the UK diseases which once caused significant morbidity and mortality are now only seen in relatively small numbers as a result of effective immunisation campaigns.

Widespread immunisation decreases the risk of communicable disease in the individual and to the population, and thus prevents subsequent morbidity.

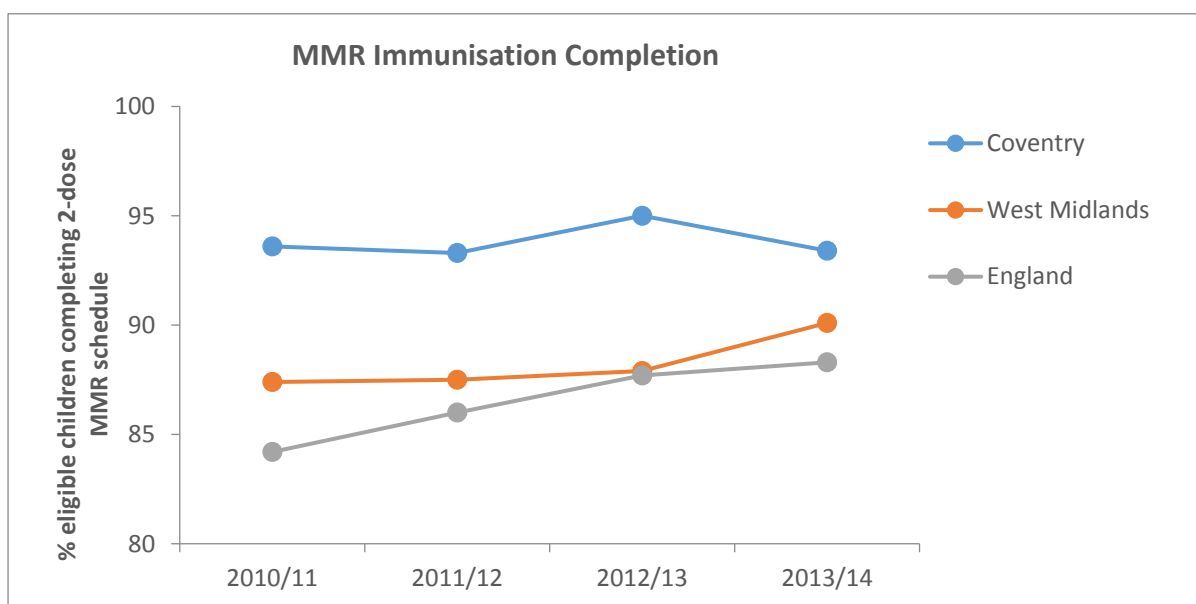
### Childhood immunisations

It is important that new parents remain aware of the need to protect their children against diseases such as whooping cough, measles, rubella and diphtheria which can cause significant morbidity. Advances in medical research and vaccine technology result in more potentially life threatening disease being protected against, for example the introduction of a vaccine against HPV for teenage girls in 2008.

All children are eligible for the national childhood immunisation schedule, with additional vaccines given to specific high-risk groups. For example, measles, mumps and rubella used to be common childhood diseases. Following the introduction of the MMR numbers of cases were low. However in recent years coverage of the MMR reduced, again because of ill-founded concerns about safety, and there continues to be outbreaks of measles across the country.

Fortunately, Coventry continues to achieve the >90% target for all childhood vaccines.<sup>198</sup> For example, the completion rate for the measles, mumps and rubella (MMR) vaccination schedule, a good proxy indicator for the whole vaccination programme, is 94.9%-significantly better than the 88.6% national average (Figure 20).

Figure 20 Measles, mumps and rubella vaccination coverage for two doses (at 5 years old)



## Influenza

Influenza vaccinations have the potential to reduce morbidity and mortality in those infected with the virus, as well as to prevent the spread to those who are not immunised. Currently, the influenza vaccine is available to the over-65s, to children aged 2 to 7, to pregnant women and to other high-risk groups. In Coventry, around 37,500 people are eligible for the 'flu vaccine. In the over-65s, 72.4% received the vaccine in 2014/15. This has risen from 70.8% in 2011/12 and is currently similar to the national vaccination rates. Fewer eligible people under the age of 65 are successfully vaccinated, with only 54.8% receiving the vaccine in 2014/15. This is higher than the national average (50.3%), but more needs to be done to attract the large proportion of eligible under-65s who did not attend for immunisation in previous years.

## Tuberculosis

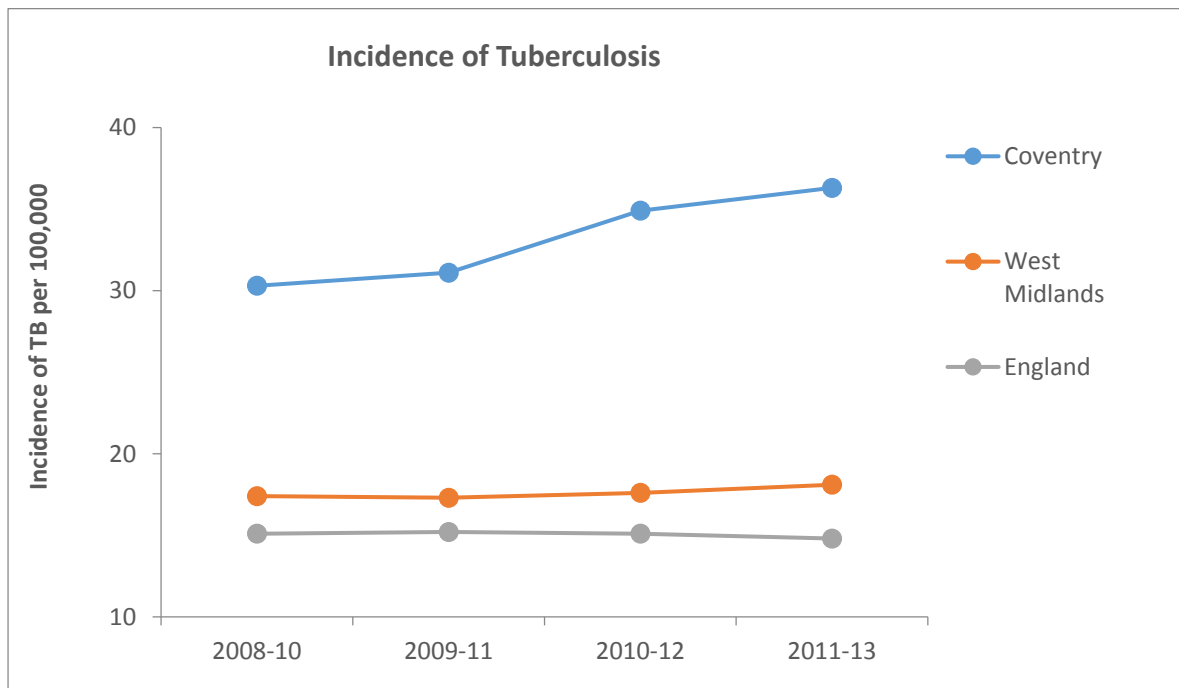
The incidence of tuberculosis (TB) has been relatively stable across the UK over the previous few years.<sup>199</sup> However, the incidence of TB in the UK is much higher than in most Western European countries despite widespread efforts to improve prevention, treatment and control. In Coventry, around 120 new cases of TB are diagnosed every year. This equates to an incidence of 32.5 per 100,000 – significantly higher than the incidence in the West Midlands and England (16.7 and 13.5 per 100,000 respectively). Indeed, locally the incidence of TB is rising, having increased from 30 per 100,000 in 2008-10 (Figure 21). Geographically, Foleshill and St Michaels electoral wards had higher rates of tuberculosis when compared with the average for the City.<sup>200</sup>

TB infection is associated with certain ethnic groups (e.g. South Asian and African communities), especially in those born abroad.<sup>201</sup> The Migrant Health Needs Assessment indicates that 73% of diagnosed TB cases were in individuals who were non-UK born, this is similar to the national level where 75% of all notifications for tuberculosis are in individuals from countries with a higher prevalence of TB.

Risk factors related to TB include poor nutrition, alcohol and substance misuse, and poor housing conditions. Vaccinations of high-risk groups can reduce the infection rate, and the disease is less likely to spread if those that are infected are diagnosed promptly and receive appropriate treatment.<sup>202</sup> In Coventry, the treatment completion rate for people diagnosed with TB is 85.4%.<sup>203</sup> This is better than the national average of 84.8%, but still means that a proportion of those diagnosed do not complete treatment and are thus still potentially able to transmit the disease to others.

- Find out more on the infectious diseases profile at <http://www.coventry.gov.uk/downloads/file/17118/>.

Figure 21 Incidence of tuberculosis (three-year average number of reported new cases per 100,000 population)



## Sexually transmitted infections

### HIV

Human immunodeficiency virus (HIV) infection is an important public health issue as it is currently incurable and is associated with significant morbidity. Coventry has the highest prevalence of HIV infection in the West Midlands, and there are 640 people with a known diagnosis of HIV in the city. The rate of new diagnoses of HIV in adults in Coventry is 23.3 per 100,000 per year – significantly higher than the West Midlands and England (which have rates of 9 and 12.3 per 100,000 year).<sup>204</sup> A major concern is the late diagnosis of the disease in many cases, as a good life expectancy can be achieved if antiretroviral therapy is instituted early.<sup>205</sup> The proportion of people with HIV in Coventry presenting late in the disease process (as defined by a low concentration of the specific white blood cells that are attacked by the virus) has reduced from 61% in 2009-11 to 54.1% in 2012-14. However, this is significantly worse than in England as a whole, where 42% of HIV diagnoses present late.

The prevalence of HIV is 30 times higher in black-African communities than in the general UK population, and this may be contributed to by infections acquired abroad coupled with HIV-related stigma.<sup>206</sup> HIV is also associated with deprivation, with infection being three times more common in the most deprived areas. The early diagnosis and management of HIV significantly improves both quality of life and survival, and reduces the risk of disease transmission. More, therefore, needs to be done to improve the early detection of HIV infection.

- Find out more on the HIV profile at <http://fingertips.phe.org.uk/search/hiv#gid/1/pat/6/ati/102/page/0/par/E12000005/are/E08000026>.

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# Coventry Health and Wellbeing Strategy 2016-2019





## Health and Wellbeing Board members





# Introduction

**Coventry has the potential to become one of the most inventive, diverse, integrated and successful cities in modern Britain. To achieve this, we are committed to making big changes in how we work together across the public, private and voluntary sectors. We will work alongside local people to change the face of the city for the better and ensure that everyone can share in the benefits of economic growth, including our most vulnerable residents.**

Creating health, wealth and happiness in Coventry requires more than simply managing people's health problems. People who have jobs, good housing and are connected to families and their communities feel and stay healthier, and live longer lives. A wealth of skills and capabilities lie within communities and individuals, which can be used and developed to improve health and wellbeing.

The Health and Wellbeing Strategy provides Coventry residents and organisations with a picture of what the Health and Wellbeing Board, through its members and wider partners, will deliver over the next three years and how we will work together to achieve this.

To ensure that the Health and Wellbeing Strategy and the work of the Health and Wellbeing Board maximises health, wealth and happiness, the strategy for 2016-2019 will focus on three priorities where the Health and Wellbeing Board believes it will make the biggest difference to the lives of Coventry people.

These are:

- Working together as a Marmot City to reduce health and wellbeing inequalities
- Improving the health and wellbeing of individuals with multiple complex needs
- Developing an integrated health and care system that provides the right help and support to enable people to live their lives well

## What is the Coventry Health and Wellbeing Strategy?

The Coventry Health and Wellbeing Strategy, also known as the Joint Health and Wellbeing Strategy, is the city's overarching plan for reducing health inequalities and improving health and wellbeing outcomes for Coventry residents. It sets out our three year vision for health and wellbeing, and the strategic priorities which have been identified to support this vision.


The strategy is owned by Coventry's Health and Wellbeing Board, a collaborative partnership which brings together senior leaders from Coventry City Council, West Midlands Police, West Midlands Fire Service, Coventry and Rugby Clinical Commissioning Group, acute and community NHS trusts, Coventry University, the

University of Warwick, Voluntary Action Coventry and Coventry Healthwatch. The Health and Wellbeing Board has a statutory responsibility to understand current and future health and social care needs through the Joint Strategic Needs Assessment, to promote partnership working and integration, and to improve commissioning and delivery arrangements.

The 2016 refresh of the Joint Health and Wellbeing Strategy reflects the progress made towards achieving the objectives originally agreed in 2013, and responds to the rapidly changing and increasingly challenging context for the wider determinants of health and the health and social care system.

# The Coventry context and why we need to change

Coventry is a young, growing and diverse city

  
2.3%  
**345,000**

Recent population estimates put Coventry's population at 345,500, an increase of 2.3% which is estimated to be amongst the highest in the UK.

Average age  
**33.5**  
years

The average age in Coventry is 33 and a half years, lower than England's average of 40 years, and a quarter of the population are aged under 25, which is in part due to the presence of two large universities, although there is still a significant number of older people.

**6.5**

years  
lower than  
England  
average

**26%**  
from BME  
backgrounds

Coventry has a large proportion of people from black and minority ethnic (BME) communities. According to the most recent census, 26.2% of Coventry residents were from BME backgrounds, compared to the 14.6% average across England.

## Coventry is also a city facing significant challenges

According to the Indices of Multiple Deprivation, a measure based on income, education, housing, employment, crime, health, access to services and the living environment, Coventry is amongst the most deprived fifth of all local authorities in England, and some wards in Coventry are among the most deprived in the country.

There is also considerable variation between different wards in the city, and high levels of inequality, which is reflected by variation in life expectancy and health outcomes.

This has a direct impact on the health and wellbeing needs of the city. Life expectancy for women is 82.3 years, and women can expect to live in good health for 62.7 years, which is similar to the average for England. Life expectancy for men is 78.6 years, and men in Coventry can be expected to live in good health for 60.8 years, which is lower than the average for England. Life expectancy and healthy life expectancy for both women and men is higher than for areas with similar levels of deprivation to Coventry. There are large inequalities in life expectancy across the city, reflecting inequalities in income, education, housing and employment.

Coventry's 2016 Joint Strategic Needs Assessment (JSNA) identifies the health and wellbeing needs of the city in detail, but key areas of need were identified through a review of data and information, a public call for evidence, a prioritization exercise workshops with stakeholders, which are covered in detail in the JSNA. Further analysis and work with stakeholders resulted in the identification of the three priorities in this Health and Wellbeing Strategy.

### The Joint Strategic Needs Assessment (JSNA)

A more detailed health profile for Coventry, which provides data for each stage of the life-course, as well as detailed analysis of a number of health conditions, is available within Coventry's Joint Strategic Needs Assessment (JSNA). The JSNA also outlines the process through which the priorities of the Health and Wellbeing Strategy were developed.

Read the JSNA online at  
[www.coventry.gov.uk/jsna](http://www.coventry.gov.uk/jsna)

# 1. Working together as a Marmot City: reducing health and wellbeing inequalities

## The case for change

**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.

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

## How we are making a difference

In April 2013, the transfer of Public Health to local government provided Coventry with an opportunity 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.

Over the last two years, partners across the city have worked together as part of the Marmot Programme to reduce health inequalities. In 2016, Professor Sir Michael Marmot's Team at University College London

and Public Health England committed to working with Coventry for a further three years to enable Coventry to build on progress made so far in tackling health inequalities.

As further planned spending cuts to services and welfare reforms create challenges for Coventry's most vulnerable residents, the Council is continuing to work with partners 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.

Men in the most affluent areas of Coventry will live, on average 9.4 years longer than men in the most deprived areas, while for women the difference is 8.7 years. The difference is even greater for those who are homeless or who suffer from a mental health condition.



## Continuing to work together as a Marmot City for the next three years 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 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

Provide Coventry with expertise to develop Coventry's capability to tackle health inequalities



Partners are working together on a number of projects initiated as part of the first two years of Coventry's Marmot City programme. In addition, for the next three years, the Marmot City priorities are tackling inequalities disproportionately affecting young people and ensuring that all Coventry people, including vulnerable residents, can benefit from 'good growth', which will bring jobs, housing and other benefits to the city.

## Areas of focus and what we hope to achieve

### Tackling inequalities disproportionately affecting young people

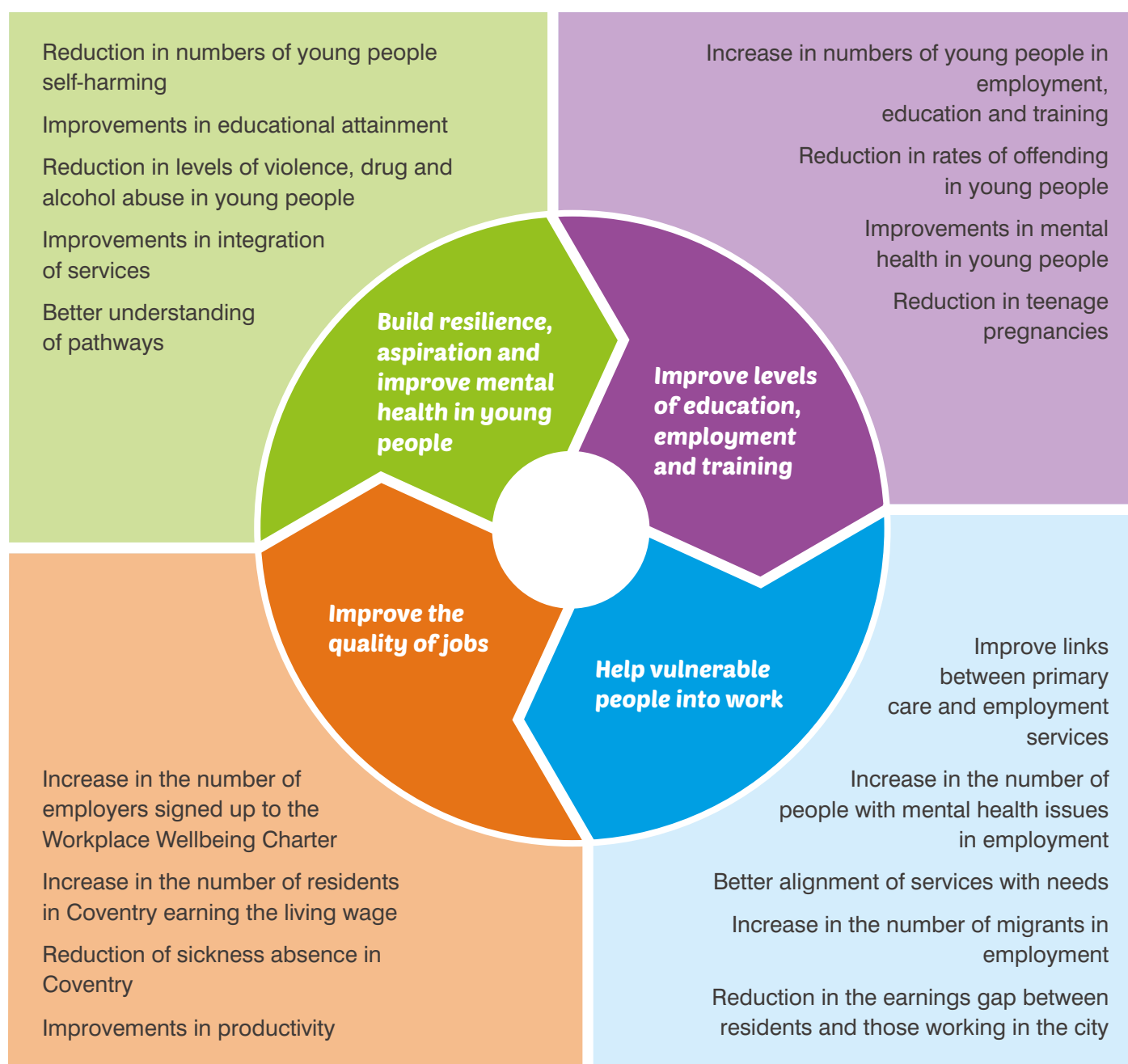
Inequalities in educational attainment, high numbers of 16-18 year olds not in education, employment and training and poor mental health in young people can lead to increases in health inequalities and poorer health and social outcomes for the people of Coventry. In addition, high rates of teenage pregnancy can lead to poorer outcomes for both teen parents and their children, creating a cyclical effect which promotes further inequalities. Tackling these issues involves

building resilience in young people, so that they are able to cope with the pressures they face and develop the skills that will help them to flourish. The key areas of focus for the next three years will be to build resilience, aspiration and improve mental health in young people and improve levels of education, employment and training so that young people are supported to live happy and healthy lives, whatever their background.

## Ensuring that all Coventry people, including vulnerable residents, can benefit from 'good growth', which will bring jobs, housing and other benefits to the city

Inequalities in employment, pay below the living wage, the decline in intermediate occupations and rise of lower paid jobs are likely to lead to increases in health inequalities and poorer health and social outcomes for the people of Coventry. There are economic as well as social benefits to addressing these issues. Investing in the workforce through paying employees a competitive wage, recruiting locally, providing attractive benefits, career progression, a good working environment and looking after the health of employees will increase recruitment and retention and improve productivity for

businesses in Coventry. Tackling these issues requires a broadening of the Marmot agenda to the private sector and businesses. Working with organisations such as the Local Enterprise Partnership, the Chamber of Commerce and businesses across the City is essential in order to nurture 'Good Growth' in Coventry. The key areas of the focus for the next three years are to help vulnerable people into work, to improve the quality of jobs, and to create health promoting workplaces, so that growth in Coventry benefits everyone and contributes to a reduction, rather than an increase, in inequalities.



## 2. Improving the health and wellbeing of individuals with multiple complex needs

### Case for change

There are an estimated 60,000 people in England facing multiple/complex needs. People with multiple, complex needs are defined as those experiencing at least two of the following: substance misuse, mental ill health, physical ill health and domestic abuse.

Research by the Lankelly Chase Foundation suggests that 58,000 people have contact with homelessness, substance misuse and criminal justice services each year, and a further 164,000 people are in contact with two of these service groups. Within the West Midlands, it is estimated that there are 12,870 people who suffer from at least two issues (e.g homelessness, offending and substance misuse); 3,940 people who suffer from all three issues and a further 1,729 people who require contact with relevant agencies. Similarly, Making Every Adult Matter estimate the number of individuals in England with 'multiple needs and exclusions' was 56,000 in the prison and homeless populations alone.

Individuals facing multiple/complex needs often rotate through various welfare and justice systems. This can deepen the problems in their lives at a cost to them and society; being affected by multiple issues means that this group often struggle to engage with everyday life and mainstream services. They can often feel on

the margins of society. The Lankelly Chase research found that quality of life for those facing complex needs tends to be much poorer than that reported by other low income and vulnerable groups. Experiences of social isolation, trauma, exclusion and poverty in childhood and adulthood are all too common. Of those engaged with criminal justice, drug and alcohol treatment and homelessness services, 55% also have a diagnosed mental health issue.

In addition to the moral case, there is a compelling financial case to improving outcomes for people with multiple needs. As more people find themselves on the margins of society facing a number of problems, this imposes a greater cost on public services, with recent research finding that £19,000 per person per year is spent on individuals with a combination of problems, at a total estimated annual cost of £4.3 billion. Spending still tends to be focused on expensive crisis care services, rather than co-ordinated and preventative support. One recent study found that better coordinated interventions from statutory and voluntary agencies can reduce the cost of wider service use for people with multiple needs by up to 26%.

### How we are making a difference

This is a real opportunity to reduce vulnerability and the number of people who are not able to make a positive contribution to their communities and societies. People with multiple and complex needs are a significant source of repeat demand for public services and also amongst the 'hardest to help'. Consultation conducted by the WMCA with individuals with complex needs suggests:

- Current systems are too complicated and need to be made simpler for all to understand
- Services are often focused on a single problem and can't provide multi-faceted help needed

- Information is often not shared resulting in the need to 'tell your story' several times
- The best approaches are those which empower individuals and enable them to build their confidence and self-esteem

Services are also focused on expensive crisis care, rather than on coordinated and preventative support that would deliver better results as well as value for money. Savings cannot be made, and outcomes cannot be improved, unless action is taken to reform the services that vulnerable and disadvantaged people rely on.

Service providers and commissioners will work together to improve the lives of the most excluded people with the most complex needs by:

- Enabling people with multiple and complex needs to manage their lives better through access to services that are more person-centred and co-ordinated. Services will be built on the strengths of individuals - presuming that people can improve their own circumstances and life chances with the right support
- Tailoring and better connecting services and empowering users to take part fully in effective service design. Services will take a whole person approach and address the combination of factors that affect the individual in a way that is simple and straightforward for individuals to navigate
- Working together to deliver and commission services for groups of people with complex needs across the city. Better co-ordination of service provision between those delivering and commissioning services
- Facilitating and promoting interagency collaboration to bring together the best levels of expertise, knowledge and resources
- Encouraging individuals with multiple complex needs to share their experiences so that future processes can be designed and delivered sustainably and learning can be shared amongst service providers

## Areas of focus and what we hope to achieve

This work aims to improve the health and wellbeing of those individuals experiencing multiple, complex needs, which can be defined as a combination of:

- mental ill health;
- substance misuse;
- violence and sexual abuse;
- reducing the risk of people developing complex multiple needs (focus on adverse childhood experiences).

This will help to ensure that individuals who face substantial challenges and have multiple complex needs can live healthier lives, free from addiction, substance dependency and fear of harm. It will help enable individuals with multiple complex needs to retain a sense of independence, self-worth and self-esteem, so that everyone in Coventry is able to take personal responsibility for their future and make a positive contribution to their community.



Improving the health and wellbeing of individuals with multiple complex needs will also lead to a reduction in offending, anti-social behaviour and demand for services. Through managing demand, delivering better co-ordinated services and empowering and enabling individuals to maximize control over their lives, this work can deliver financial savings for public services as well as improved outcomes for the most vulnerable individuals in Coventry.

### 3. Developing an integrated health and care system that provides the right help and support to enable people to live their lives well

#### Case for change

The health and care system locally and nationally faces real challenges. Rising patient expectations, an ageing population, the rising prevalence of chronic disease, combined with shrinking resources is

putting real pressure on the health and care system. Organisations are taking a systems approach to reducing demand and delivering care that is fit for the future in this challenging environment.

#### How we are making a difference

The development of the Sustainability and Transformation Plan (STP) in Coventry and Warwickshire provides an opportunity for collaboration to tackle these challenges, through shifting the focus of policies and plans from organisations to places. The aim of the STP is to create a future health and social care system in which people are enabled to stay well and are supported to manage their health and care as independently as possible. Integration of health and care to improve outcomes for local people and manage demand at a time of reducing public

sector resource will necessitate working more closely across organizational and geographical boundaries.

Coventry and Warwickshire Health and Wellbeing Boards are working together to develop and deliver the Sustainability and Transformation plan, and organisations are harnessing voluntary sector resources in system transformation through working with Voluntary Action Coventry to develop solutions with focus on early help, proactive and preventive care and building resilience.

#### Areas of focus and what we hope to achieve

The key components of the STP are:

**Proactive and preventative care** that focuses on keeping people well and providing ongoing support to patients and service users through integrated teams that bring together different professionals from health, social care and beyond. By keeping patients well and improving their outcomes, demand and pressure on more expensive parts of the health and social care system will be reduced.

We will work with a range of agencies, including the public, voluntary and community sectors to proactively manage patients with different needs. We will enable people most in need to live independent and fulfilled lives by working

with them and local communities to develop stronger networks and personalised support. This approach will facilitate strengthened links with community groups and the voluntary sector and connect people to their local networks to promote independence and self-care.

We will develop a preventative health offer across the city, which is adapted for each locality based on health priorities and needs of each locality.

**Planned care** (treatment that is planned in advance, not carried out in an emergency) will be delivered as effectively and efficiently as possible, underpinned by effective co-ordination across the system. Patients will be supported in the most appropriate setting and will be helped to



access their care in a planned way through earlier intervention where appropriate.

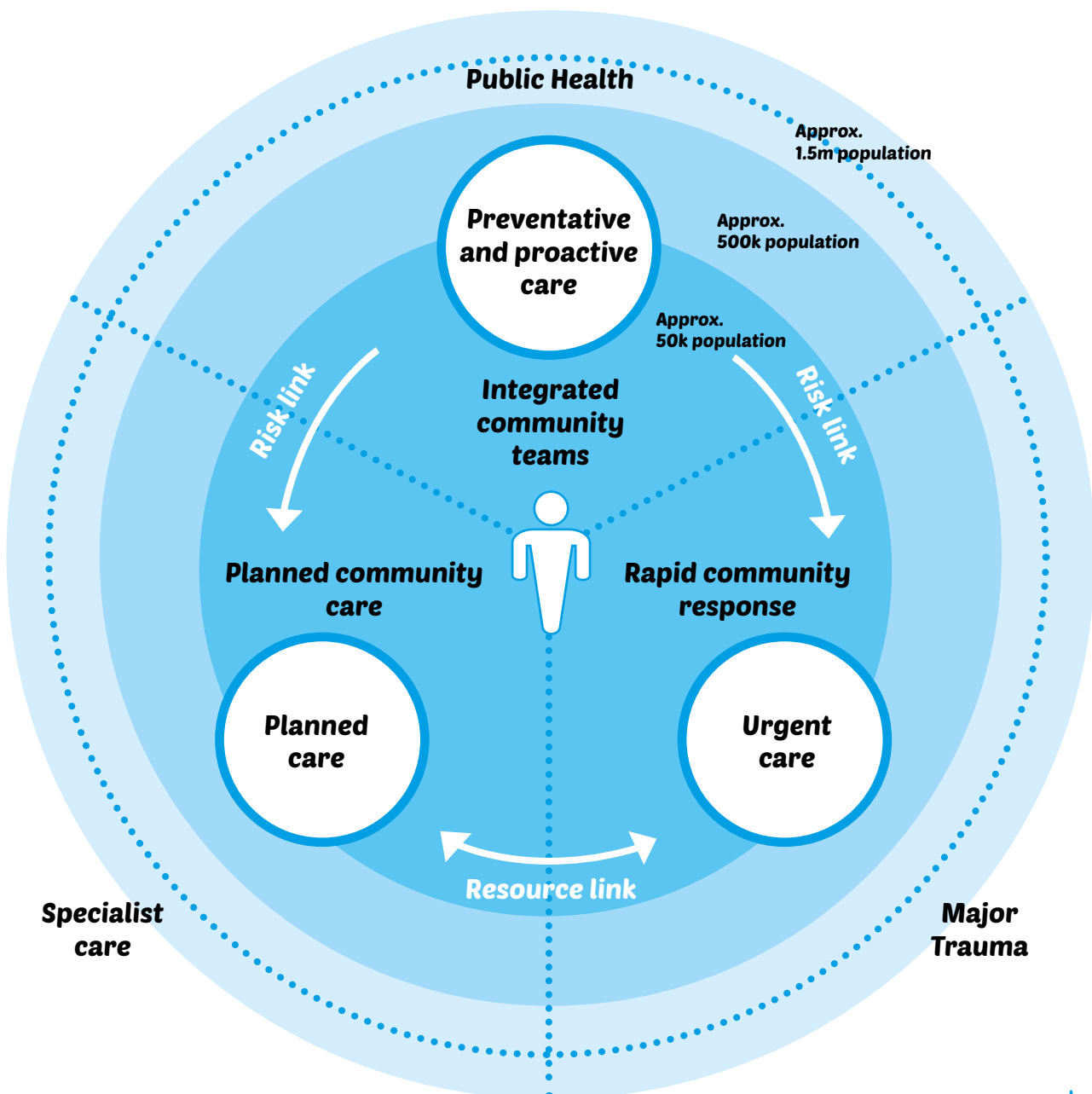
We will ensure that planned care is delivered across a range of settings, and will be co-ordinated care across all services, so that services are delivered in a joined-up way and are centred around the needs of patients.

We will ensure that patients are discharged in a safe and timely manner back to their chosen setting, with care provided seamlessly from hospital to the community.

**Urgent and emergency care** provision is safe, efficient and easily accessible. We will

develop models of care and support which provide alternatives to hospital for people with urgent but non-life threatening needs. These services will be delivered as close to people's homes as possible, minimising disruption and inconvenience for patients and their families.

Our current support mechanisms are mainly focused on ensuring patients can be effectively discharged from hospital. However, we know that to avoid hospital re-admissions, targeted support for individuals who are at risk of admission is needed. We will provide a rapid response within community settings that are able to resolve potential crisis situations and avoid hospital admissions.



# A transformational approach

**To create a healthy, wealthy and happy city, we are going further and wider in our approach. We are transforming the way work as organisations and as a city, so that everything we do helps to improve health and wellbeing and to reduce inequalities.**

We are:

**Ensuring health, and the conditions which affect health, are considered in policies and decision making across Coventry City Council and other organisations in Coventry.**

Considering health, and health inequalities in all decision making helps avoid harmful health impacts, particularly on the most vulnerable people in the city.

**Commissioning in new ways, which maximises health outcomes and social value from investments.** Commissioning for social value encourages contracted organisations to recruit local people, offer apprenticeships and training opportunities, pay the living wage, support the most vulnerable people, and to promote environmental, social and economic sustainability.

**Enabling and empowering local people, communities and groups to use and develop their own skills and potential to take control over their own lives.** Enabling people to feel empowered to take control builds resilience

and social capital in communities, helps people to remain economically secure, reduces pressure on services and ultimately improves health and wellbeing outcomes.

**Targeting resources based on need, and targeting interventions in the right places** – providing universal services and interventions which are open to all, but with a scale and intensity that is proportionate to the level of disadvantage that our residents face. Targeting resources in this way will ensure that we have maximum impact where it is most needed, and will contribute to a reduction in health inequalities.

**Prioritising prevention and early intervention.** By intervening before something happens, and responding quickly to problems we improve health and social outcomes for Coventry people and manage demand for health and care services.

## Across everything we do:



Ensure health, social value and asset based approaches are reflected in policies and decision making



Ensure prevention and early intervention are prioritised



Ensure resources are targeted based on need and that interventions are targeted in the right places



Coventry City Council

## Briefing note

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**To: Scrutiny Co-ordination Committee**  
**Date: 12<sup>th</sup> October 2016**

**Subject: Outstanding Issues Report**

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### **1 Purpose of the Note**

- 1.1 To inform Members of the approach to be taken on progress, outcomes and responses to recommendations and substantial actions made by the Scrutiny Board.

### **2 Recommendations**

- 2.1 Members are recommended to:

- 1) Note the attached outstanding issues at Appendix 1

### **3 Information/Background**

- 3.1 When recommendations and actions are made following a scrutiny meeting, they are circulated to the relevant Cabinet Member and officer, and recorded on a recommendations tracker.
- 3.2 The purpose of this report is to bring to the Boards attention the responses received from Cabinet Members and officers in regard to recommendations and actions from previous meetings.
- 3.3 Once a response has been received or an action dealt with, it will be removed from this report and kept in the full recommendations tracker. The complete tracker can be viewed by contacting the Scrutiny Team on the details below.

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Scrutiny Co-ordinator  
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024 7683 1122

## Appendix 1 - Outstanding Issues

Meeting Date	Agenda Item	Cabinet Member/ Responsible Officer	Rec', Action or Information	Recommendations/ Actions	Officer contact	Response/ Status
13th July 16	Police, Crime and Community Safety	Chair of Police, Crime and Community Safety Partnership (Cllr A Khan)	R	(1) The scope of the planned review of the Coventry Police Crime and Community Safety Partnership Board be acknowledged and supported and the Committee's concerns relating to ensuring that there is clarity about the future role of members and a clear accountability of organisations receiving funding be taken into account during the review. (2) The performance data detailed in Appendix 9 be noted and for future performance reports information be included on the impact of PCC spend and outcomes on priority areas.	Craig Hickin Gennie Holmes	Briefing note sent to Cllr A Khan 10/8/16
13th July 16	Police, Crime and Community Safety	Cabinet Member Policing and Equalities	R	The Cabinet Member for Policing and Equalities be recommended to receive a report on performance in relation to hidden crimes and convictions at a future Cabinet Member meeting	Gennie Homes	Briefing note sent to Cllr A Khan 10/8/16
7th September 2016	Business Rates Reform		A	An additional meeting of Scrutiny Co-ordination Committee be held in the week commencing 19th September to allow members the opportunity to consider the Government consultation questions and the relevant responses with a further report with the consultation questions and any available responses as well as the potential for the pooling of business rates within the Combined Authority and the Council's strategy for maximising business rates income be submitted to the additional meeting.	Paul Jennings, Rebecca Young, Gennie Holmes, Liz Knight	An additional meeting has been arranged for the 22nd September to consider a further report. COMPLETE

7th September 2016	West Midlands Combined Authority		A	Regular updates from the Council's representatives on the Overview and Scrutiny Committee be submitted to future meetings of the Committees and progress reports on the WMCA Strategic Economic Plan be submitted to future meetings of the Committee Also feedback from any Forums set up to consider Scrutiny across the West Midlands Combined Authority be reported back to Scrutiny Co-ordination Committee or the appropriate Scrutiny Board for discussion.	Gennie Homes	
7th September 2016	West Midlands Combined Authority	Cabinet Member Policy and Leadership	R	The Cabinet Member for Policy and Leadership is recommended that: 1) Any future City Council appointments to the Overview and Scrutiny Committee and Audit Committee of the West Midlands Combined Authority are made from non-executive Members of the Council.	Gennie Homes	Response from Cllr Duggins received 9/9/16 Dear Gennie I did indicate I would consider the views expressed by Srcu-Co. Appointments are the preserve of the Leader.
7th September 2016	Outstanding Issues		A	Arising from the Committee's considerations of the four scrutiny suggestions from members of the public, the Scrutiny Co-ordinator be requested to provide a formal written response to the individuals concerned	Gennie Homes	COMPLETE 9/9/16 Email sent
22 <sup>nd</sup> September 2016	Business Rates Reform		A	That officers be requested to submit further consultation documents in relation to Business Rates Reform to the Committee as and when they become available	Gennie Holmes	COMPLETE

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## Scrutiny Co-ordination Committee

Scrutiny Work Programme 2016/17

13 <sup>th</sup> July 16
Crime and Community Safety performance Council Plan progress Outside Bodies Report
7 <sup>th</sup> Sept 16
West Midlands Combined Authority Business Rates Consultation
22 <sup>nd</sup> September 2016
Business Rates Retention Consultation
12 <sup>th</sup> October 16
Joint Strategic Needs Assessment and Health and Well-being Strategy Drugs and Alcohol Service re-commissioning
9 <sup>th</sup> November 16
Connecting Communities
7 <sup>th</sup> December 16
Welfare Reform
11 <sup>th</sup> January 17
Selective Licensing for the Private Rented Sector – consultation outcomes Local Plan
8 <sup>th</sup> February 17
Prevent Strategy Electoral Registration and Voter Engagement
15 <sup>th</sup> March 17 12 <sup>th</sup> April 17 Date to be allocated
Progress on commissioned DVA services Air Quality Climate Change Female Genital Mutilation European Union Exit City of Culture Business Rates retention
“If required” meetings also scheduled for 19 <sup>th</sup> October 16, 16 <sup>th</sup> November 16, 25 <sup>th</sup> January 17, 22 <sup>nd</sup> February 17, 29 <sup>th</sup> March 17

<b>Date</b>	<b>Title</b>	<b>Detail</b>	<b>Cabinet Member/ Lead Officer</b>
<b>13<sup>th</sup> July 16</b>	Crime and Community Safety performance	To review: <ul style="list-style-type: none"> <li>• Work of the Police, Crime and Community Safety Board;</li> <li>• Information on funding that is distributed to which services.</li> <li>• Membership and representation</li> <li>• Sub-group and remit and Chairs</li> <li>• Involvement of the third sector</li> <li>• Scope of the planned review of the Board</li> <li>• End of year performance</li> <li>• PCP questionnaire on his plan priorities</li> </ul>	Cllr A Khan
	Council Plan progress	An opportunity for members of the Board to look at Council performance across all areas and identify any areas that may need further scrutiny. Including equalities action.	Si Chun Lam Cllr Duggins
	Outside Bodies Report	Scrucoco can decide which outside bodies they receive reports on at their meetings. This report provides opportunities to identify the criteria for which reports are submitted throughout the year.	Gennie Holmes
<b>7<sup>th</sup> Sept 16</b>	West Midlands Combined Authority	To consider information available on the devolution deal and how information on the work of the Combined Authority can be cascaded to Coventry citizens.	Martin Reeves Cllr Duggins
	Business Rates Consultation	Members of the Board to consider the response to the Business Rates consultation taking place over the summer which proposed 100% retention by Councils.	Paul Jennings Cllr J Mutton
<b>22<sup>nd</sup> September 2016</b>	Business Rates Retention Consultation	A more in depth look at the consultation questions and responses on the Government consultation on Business Rates Retention. To look at potential pooling of rates across the Combined Authority area and also the Council's strategy to maximise business rates income	Paul Jennings Cllr J Mutton Cllr O'Boyle
<b>12<sup>th</sup> October 16</b>			
	Joint Strategic Needs	The Health and Well-being Strategy and Joint Strategic Needs	Jane Moore



<b>Date</b>	<b>Title</b>	<b>Detail</b>	<b>Cabinet Member/ Lead Officer</b>
	Assessment and Health and Well-being Strategy	Assessment review of the current and future health and care needs of the local community. This report will be going to Cabinet on 1 <sup>st</sup> November	Cllr Kamran Caan
	Drugs and Alcohol Service re-commissioning	Public Health is currently re-commissioning drug and alcohol services in the city and have developed a new service model. The model is currently out for consultation and will be going to Cabinet for a decision on 1 November	Georgia Flaherty Jane Moore Cllr Kamran Caan
<b>9<sup>th</sup> November 16</b>	Connecting Communities	An opportunity for Members to discuss emerging themes from the consultation and contribute to the consultation themselves. To include the findings from the Phase 1 consultation.	Michelle McGinty Cllr Maton/Ruane
<b>7<sup>th</sup> December 16</b>	Welfare Reform	Further review of impacts of changes to welfare provision and the services provided by partners in the city. Including most recent changes announced.	Glenda Cowley/ Welfare Reform Working Together Group Alan Markey – Coventry Independent Advice Service Richard Sharp - The DWP Coventry and Warwickshire Operational Leader Cllr Bigham
<b>11<sup>th</sup> January 17</b>	Selective Licensing for the Private Rented Sector – consultation outcomes	To consider the outcomes of the consultation and recommendations to the Cabinet Member following a scrutiny task and finish group recommending implementation in St. Michael's Ward.	Tracy Miller/ Davina Blackburn Cllr O'Boyle
	Local Plan	An update following the hearings on the plan and the outcome of the Inspector's report.	Mark Andrews
<b>8<sup>th</sup> February 17</b>	Prevent Strategy	Following from a suggestion by a member of the public that Scrutiny should look at the rise of the far-right in the city and what is being done to address this	Chief Superintendent Danny Long Geoff Thomas
	Electoral Registration and Voter Engagement	To consider the Council's engagement plan and to follow up on actions from the previous Board meeting. (expand)	Liz Read
<b>15<sup>th</sup> March 17</b>			
<b>12<sup>th</sup> April 17</b>			

<b>Date</b>	<b>Title</b>	<b>Detail</b>	<b>Cabinet Member/ Lead Officer</b>
<b>Date to be allocated</b>	Progress on commissioned DVA services	Following their meeting on 14 <sup>th</sup> October 2015, Board Members agreed to receive annual progress updates, including October 2016. To include contributions from the Police and Whitefriar's Housing and any information on a regional perpetrators programme.	Cllr A Khan
	Air Quality		
	Climate Change		
	Female Genital Mutilation		
	European Union Exit	A task and finish group of SB3 to look in more detail at the impact of withdrawal of the European Union and any contingency that the Council needs to put in place.	Cllr Lucas chair Rebecca Young
	City of Culture	To receive an update on the City of Culture bid.	Cllr Bigham David Nuttall
	Business Rates retention	Following the meeting on 22 <sup>nd</sup> September Members requested regular updates when information becomes available.	Paul Jennings Cllr J Mutton
"If required" meetings also scheduled for 19 <sup>th</sup> October 16, 16 <sup>th</sup> November 16, 25 <sup>th</sup> January 17, 22 <sup>nd</sup> February 17, 29 <sup>th</sup> March 17			