Coventry City Council

Agenda

Coventry Health and Well-being Board

Time and Date
2.00 pm on Monday, 8th October, 2018

Place
Committee Room 3 - Council House

Public Business

1. **Welcome and Apologies for Absence**

2. **Declarations of Interest**

3. **Minutes of Previous Meeting** (Pages 5 - 14)

   (a) To agree the minutes of the meeting held on 2nd July, 2018

   (b) Matters Arising

4. **Chair's Update**

   The Chair, Councillor Caan will report at the meeting

Governance Items

5. **Better Care Fund Plan - Update** (Pages 15 - 18)

   Report of Pete Fahy, Director of Adult Services

6. **Care Quality Commission (CQC) Local System Review - Improvement Plan Progress** (Pages 19 - 52)

   Report of Pete Fahy, Director of Adult Services

7. **Adult Social Care Annual Report 2017/18** (Pages 53 - 94)

   Report of Gail Quinton, Deputy Chief Executive (People)

8. **2017/18 Director of Public Health's Annual Report** (Pages 95 - 142)

   Report and presentation of Liz Gaulton, Director of Public Health and Wellbeing

9. **Coventry and Rugby CCG 2019/20 Commissioning Intentions and 2018/19 Annual Report** (Pages 143 - 146)

Report and presentation of Andrea Green, Accountable Officer, Coventry and Rugby CCG and Matt Gilks, Director of Commissioning

(Please see the following link for additional information https://www.coventryrugbyccg.nhs.uk/)

Development Items

10. **Progress Update on Coventry's Marmot City Strategy 2016-2019** (Pages 147 - 160)

Report of Richard Stanton, West Midlands Fire Service and Co-Chair of the Marmot Steering Group

11. **Coventry and Warwickshire Place Forum and Year of Wellbeing** (Pages 161 - 180)

Report and presentation of Liz Gaulton, Director of Public Health and Wellbeing

12. **Better Health, Better Care, Better Value Programme Update** (Pages 181 - 186)

Report of Rachael Danter, Programme Director, Better Health, Better Care, Better Value

13. **Local Government Association Green Paper 'The Lives We Want to Lead' - Response to Consultation** (Pages 187 - 218)

Report of Gail Quinton, Deputy Chief Executive (People)

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

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

Private Business

Nil

Martin Yardley, Deputy Chief Executive (Place), Council House Coventry

Friday, 28 September 2018

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

Membership: Cllr F Abbott, S Banbury, Cllr K Caan (Chair), G Daly, R Danter, Cllr G Duggins, L Gaulton, S Gilby, A Green, A Hardy, R Light, J Mason, C Meyer, M O'Hara, G Quinton, S Raistrick, M Reeves, Cllr P Seaman, R Stanton and Cllr K Taylor

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

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

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Coventry City Council
Minutes of the Meeting of Coventry Health and Well-being Board held at 2.00 pm on Monday, 2 July 2018

Present:

Board Members: Councillor Caan (Chair)
Councillor Duggins
Councillor Seaman
Councillor Taylor
Stephen Banbury, Voluntary Action Coventry
Professor Guy Daly, Coventry University
Rachael Danter, NHS England
Pete Fahy, Director of Adult Services
Liz Gaulton, Director of Public Health and Wellbeing
Simon Gilby, Coventry and Warwickshire Partnership Trust
Andy Hardy, University Hospitals Coventry and Warwickshire
Ruth Light, Coventry Healthwatch
John Mason, Coventry Healthwatch
Mike O'Hara, West Midlands Police
Dr Sarah Raistrick, Coventry and Rugby CCG

Employees (by Directorate):

Place: L Knight
D Nuttall
People: D Dawson

Apologies: Councillor Abbott
Steve Banbury, Voluntary Action Coventry
Andrea Green, Coventry and Rugby CCG
Professor Caroline Meyer, Warwick University
Gail Quinton, Deputy Chief Executive (People)

Public Business

1. **Declarations of Interest**

There were no declarations of interest.

2. **Minutes of Previous Meeting**

The minutes of the meeting held on 9th April, 2018 were signed as a true record. There were no matters arising.

3. **Appointment of the Deputy Chair of the Health and Wellbeing Board**

RESOLVED that Dr Sarah Raistrick be appointed as Deputy Chair of the Health and Wellbeing Board for 2018/19.

4. **Chair's Update**

The Chair, Councillor Caan informed the Board that Rachael Danter, the new NHS England representative on the Board had recently taken on a second role as Programme Director for the Better Health, Better Care, Better Value programme. Rachael informed the Board about her ambitions for her two roles. Councillor Caan also congratulated Liz Gaulton on her recent appointment as Director of Public Health and Wellbeing. Liz's new job title had been extended to include wellbeing emphasising the importance placed by the Council on their responsibility to local people in this area.

Councillor Caan reported on the excellent news that the new Science and Health building at Coventry University had been named in memory of the late Councillor Alison Gingell as a fitting tribute to her tireless leadership on health and social care for more than 40 years. He placed on record his thanks to Professor Guy Daly for his support in enabling this to happen.

The Chair also informed that Coventry had been successful in its bid to become the European City of Sport 2019. He referred to the opportunities that this would bring to raise the profile of physical activity in the city and support activity in the lead up to the City of Culture 2021. He also mentioned the following successful launches which had taken place over the past few weeks: Coventry Healthy Living Service; MiFriendly Cities project; and the Domestic Abuse Strategy.

Members were reminded of their decision to hold quarterly Health and Wellbeing Board meetings with Place Forums in between which had been reflected in the timetable of meetings for the year.

5. **Coventry City of Culture 2021: The Health and Wellbeing Board Contribution and Benefits to the Health and Wellbeing of Coventry Citizens**

The Board considered a report and presentation of Liz Gaulton, Director of Public Health and Wellbeing and David Nuttall, Head of Sports, Culture, Destination and Business Relationships on the opportunities provided by the City of Culture 2021, the European City of Sport 2019 and the Year of Wellbeing 2019 to improve health and wellbeing outcomes for the City and accelerate efforts to address the wider determinants of health, for example jobs and economic growth, community cohesions and a sense of place, raised aspirations and school attainment.

The report indicated that the City of Culture was part of a wider Coventry's Cultural Strategy for 2017-2027 which outlined the cultural aspirations for the city for the next ten years. The strategy outlined five goals, one of which was to improve health and wellbeing. Key commitments made as part of the City of Culture bid included reducing obesity and improving mental health.

The Board were informed that their collective leadership would be invaluable in order to maximise the opportunities associated with the City of Culture and to minimise potential risks. With opportunities across the health and wellbeing economy created by the Year of Wellbeing and the European City of Sport there was the option to work as a Board to ensure these acted as an accelerant to the City of Culture. There was also the opportunity to begin to develop a sense of place amongst Coventry citizens and Coventry's workforce. The Board would be

key to providing leadership around the Marmot agenda ensuring that the health inequalities agenda was at the centre of the health and wellbeing offer.

A key aim of the City of Culture year would be to ensure that the health and wellbeing workforce acknowledge, value and support the delivery of cultural opportunities as a means of improving health and wellbeing. As employers of a significant proportion of Coventry residents, engaging staff in the design and development of a City of Culture offer would contribute towards enhancing the pride in the city. The role of staff in supporting the engagement of communities would also be critical.

The Board were informed of the importance of understanding the health impact of the City of Culture activities to be able to maximise opportunities. Public Health were committing capacity and expertise to complete a formal Health Impact Assessment. There were also considerable risks that would need to be managed and minimised which involved support from partner organisations.

The cultural strategy and sports strategy outlined a ten year vision for the city, moving beyond 2021. Maintaining momentum and raising aspirations would be a key challenge.

The presentation highlighted how arts and culture improved health and wellbeing and set out the vision for the City by 2027. The five key goals of the cultural strategy, including health and wellbeing, were set out along with outline targets. Attention was drawn to the views of Professor Sir Michael Marmot on culture and to the opportunities for Coventry as a Marmot City and the Year of Wellbeing 2019. Additional information was provided on health and wellbeing benefits.
The presentation referred to the learning from Hull in respect of health and wellbeing and culture, including the outcomes achieved. The key learning for Coventry was also discussed. There was a focus on the opportunities for the Health and Wellbeing Board to provide leadership in a number of areas and to the collective opportunity that the Board could bring to the City of Culture.

Members discussed a number of issues in response to the report and presentation, matters raised included:

- The significant opportunities available for the partner organisations to become involved with the City of Culture, the Year of Wellbeing and the European City of Sport
- The importance of being able to engage with all communities in the city
- The options to involve the students from both Coventry and Warwick Universities
- A concern about the significant number of objectives to be achieved and the significant level of support that would be required to achieve success in all areas
- What monitoring arrangements had been put in place to ensure delivery
- What would the expected legacy of the three events be, what difference would there be for Coventry residents in ten years?
- A concern about being able to involve the whole city in the different events, particularly the hard to engage communities
- An acknowledgement of the important volunteer role to be played by the Coventry ambassadors.

RESOLVED that:

(1) The content of the report and presentation be noted.

(2) The opportunities and challenges the City of Culture presents to health and wellbeing of Coventry citizens be acknowledged.

(3) The opportunities and challenges the City of Culture presents to organisations within Coventry's health and wellbeing economy be acknowledged.

(4) The role of the Board in providing strategic leadership around the health and wellbeing agenda of the City of Culture be endorsed.

6. **Coventry and Warwickshire Place Forum**

The Board considered a joint report of Liz Gaulton, Director of Public Health and Wellbeing and Dr John Linnane, Director of Public Health and Head of Strategic Commissioning, Warwickshire County Council concerning the forthcoming meeting of the Coventry and Warwickshire Place Forum on 16th July, providing members with the opportunity to consider the key documents for discussion. The report was also to be shared virtually with the members of the Warwickshire Health and Wellbeing Board.

The report indicated that the meeting on 16th July was to be facilitated by John Bewick from the Local Government Association who was supporting the work on Upscaling Prevention. The proposed agenda would include an opportunity to understand more about the developing Integrated Care Systems and the implications for the local health and care system, and an update on progress across the Better Health, Better Care, Better Value programme. It was also intended to circulate the Concordat and Place Design for endorsement as well as providing the opportunity for partners to learn more about and pledge their support towards the plan for delivery of the Year of Wellbeing.

The report indicated that at the first meeting of the Place Forum on 7th March 2018 a revised Concordat and the draft Place Design were shared with members and it was agreed that these would be further developed taking on Board the feedback on the day, with a view to signing them off at the next Place Forum. The updated documents had been shared with members through the Proactive and Preventative workstream. The updated documents were set out at appendices to the report.

At the March Place Forum meeting it was agreed that consideration be given as to how members could keep each other informed and involved between meetings. The Coventry and Warwickshire Place Forum Update had been circulated to members by e-mail to address this issue. A copy was set out at a second appendix to the report and feedback was requested.

Members discussed the draft documents and it was suggested that the draft Place Design should include reference to carers and further consideration needed to be given to early intervention since work was still ongoing in this area. A further

comment was made highlighting that the Concordat needed to be in plain English so it could be fully understood by everyone.

RESOLVED that:

(1) The proposed agenda items for the Place Forum on 16th July be noted.

(2) Consideration to be given to the comments detailed above for inclusion in the revised Concordat and Place Design prior to their submission to the Place Forum on 16th July for endorsement.

(3) The Coventry and Warwickshire Place Forum Update that has been developed to improve information and communication between meetings be noted.

7. **Health and Wellbeing Strategy Update: Coventry Multiple Complex Needs Programme Progress Update**

The Board considered a report and presentation of Chief Superintendent Mike O'Hara, West Midlands Police and Chair of the Coventry Multiple Complex Needs Board which set out the progress made by the Multiple Complex Needs Programme to improve the outcomes of people experiencing multiple complex needs in Coventry. Copies of the programme's plan-on-a-page', the project initiation document; and the evaluation framework were attached at appendices to the report.

The Coventry Multiple Complex Needs Programme intended to respond to the Joint Health and Wellbeing Strategy priority to improve the health and wellbeing of individuals with multiple complex needs by looking at ways services could be co-ordinated to deliver better results as well as value for money by reducing demand pressures on services. In particular the programme aimed to pilot new interventions and help bring about system change.

The report indicated that the programme initiation document had been substantially revised with the primary objective now being to pilot and evaluate new interventions that would lead to cultural and systematic change, rather than developing a new service. There were now three stages to the programme as follows:
1 – Determine current needs and service provision
2 – Pilot new interventions for people facing multiple complex needs
3 – Evaluate interventions and make recommendations for system change.
The appropriate timescales for delivery were highlighted.

The report informed that in the past year the programme had made significant progress. In November, 2017 the city became one of 25 'Making Every Adult Matter' approach areas across the country. (A copy of the Make Every Adult Matter First Quarter Progress report was set out at a further appendix to the report). In February, 2018 the programme began case-managing a small cohort of people experiencing severe and multiple disadvantage in co-ordination with the city's Harm Reduction and Vulnerable Persons Forum. Then in April, 2018 the programme established a working relationship with people with lived experience of homelessness, substance misuse and offending management as 'experts by

experience' to co-design service transformation. There was by-in to the programme from partners across the public and voluntary sector in the city, as well as co-ordination and support with the West Midlands Combined Authority public sector reform programme.

A multi-agency weekly drop in advice and information shop to address problems of homelessness, begging and drug/alcohol addiction in the city centre had been established. This 'Steps for Change' had been adopted as one of the projects of the programme. The programme would also be supporting the pilot implementation of Housing First in Coventry. This was designed to provide long term, open ended support for tenants' on-going needs.

The presentation set out the three stages of the programme, highlighted the accountability structure; informed of the arrangements for monitoring progress and performance; and referred to the evaluation process for making recommendations for system change which would be supported by experts from Coventry University.

Attention was drawn to the programme 'Plan-on-a-Page' with a summary being provided of the progress to date. The presentation concluded with the next steps for the programme.

The Chair, Councillor Caan expressed appreciation for the work undertaken to date. Clarification was sought as to how people were referred to the programme and it was explained that the work used existing funds to work with a small cohort who were already known to the system. Referrals were not being sought.

RESOLVED that:

(1) The significant progress made on the Coventry Multiple Complex Needs programme be acknowledged.

(2) Consideration to be given as to how approaches being tested and piloted in the Multiple Complex Needs programme may be adopted.

(3) The 'Making Every Adult Matter' approach be embedded and mainstreamed across all partners – a priority for the Health and Wellbeing Board

(4) It be ensured that Multiple Complex Needs continues to be a Health and Wellbeing Strategy priority post 2019, in line with the city's agreement as a Making Every Adult Matter approach area from 2018-2022.

8. **Coventry Joint Strategic Needs Assessment Progress Update**

Further to Minute 48/17, the Board considered a report of Liz Gaulton, Director of Public Health and Wellbeing which set out the recent progress that had been made towards the refresh of the Joint Strategic Needs Assessment (JSNA).

The report indicated that at their last meeting in April, 2018 the Board had agreed to work towards a place-based JSNA to inform the next update of the Joint Health and Wellbeing Strategy and to identify local sponsors and lead officers in each geographical area so that areas for development identified through the JSNA

could be developed into local priorities and action plans. The refreshed JSNA would cover the 2019-2022 period. The move towards a place-based approach would offer populations a much more complete and less fragmented service.

Recently a JSNA roadshow presentation setting out the latest 2018 refresh of the JSNA was held with all services that requested one, with services being given the opportunity to be involved with the production of the new JSNA. An initial Working Group had been set up to develop a project plan and a plan-on-a-page, copies of which were set out at appendices to the report.

Health and Wellbeing Board members had been invited to join, or to make a nomination, to attend the Executive Steering Group and make decisions on behalf of the Board and to nominate an analyst/ officer to represent them on the Working Group.

The Board were informed that initial scoping work had taken place to determine the boundaries for each of the place-based JSNA and this was to be shared at the first meeting of the Executive Steering Group which was taking place at the conclusion of the Board meeting. There was an acknowledgement of the partner organisations working to different geographical boundaries and it was suggested that any boundaries needed to feel right for local communities.

RESOLVED that the progress made, including the development of a plan – on-a-page, the project initiation document, the project initiation document, the call for membership of the Executive Strategic Group and Working Group and the progress in identifying suitable boundaries, be noted.

9. **Better Health, Better Care and Better Value Programme Update**

The Board considered a report of Andy Hardy, University Hospitals Coventry and Warwickshire (UHCW) which provided an update on the Better Health, Better Care, Better Value programme and workstreams.

The report indicated that the STP and NHS England recognised that additional support was required to deliver the transformation of the Coventry and Warwickshire system to a Shadow Integrated Care System by 2019. NHS England had invested in a large system-wide capabilities development programme for senior leaders and their teams across the next 15 months. A twelve week programme aimed to develop the leadership capability of senior teams using the following learning streams: building a whole system strategy and plan; system level financial planning; integrated governance; and execution and implementation. Following the intensive 12 week development programme, a plan was to be produced highlighting the actions required with relevant timescales to reach Shadow Integrated Care System by April, 2019.

Reference was made to the support provided by NHS England which included Rachael Danter, Locality Director for NHS England also taking up the role of Programme Director for Better Health, Better Care, Better Value.

The report set out progress with the following transformational and enabling programmes of work:

Transformational
Proactive and Preventative
Maternity and Paediatrics
Mental Health and Emotional Wellbeing
Planned Care
Productivity and Efficiency
Urgent and Emergency Care

Enabling
Estates
Digital Transformation
Workforce

The Board were provided with an update on the review of Stroke Services in Coventry and Warwickshire. A Regional Assurance Panel of the 'Pre Consultation Business Case' (PCBC) took place on 24th May. The case was well received, however, the Panel identified a number of areas where further evidence was required to ensure all the NHS requirements for service reconfiguration had been met. Work was underway to address the points raised and gather the required information prior to submission to a Formal Review Panel.

The Board discussed the importance of engagement with employees so they were aware of what was to be progressed and also keeping local residents informed so the community knew about new proposals. Work was to be undertaken to produce a brief information document on the different work streams and where decisions would be made and members expressed support for this approach.

Members were informed about the work of the Clinical Design Authority and development of a clinical strategy including joint working and outcomes for patients. Further information was to be submitted to the Board in due course.

RESOLVED that the content of the report be noted.

10. **Care Quality Commission (CQC) Local System Review - Improved Plan Progress**

Further to Minute 52/17, the Board considered a report of Pete Fahy, Director of Adult Services which summarised the progress to date against the improvement plan arising from the Care Quality Commission (CQC) System Review as agreed by the Board at their last meeting on 9th April, 2018.

The report indicated that following approval of the improvement plan by the Board, the plan was submitted to the CQC and the Department of Health and Social Care (DHSC) on 10th April, 2018. Progress against the plan was being monitored by the DHSC through monthly telephone calls.

The action plan contained seven sections which grouped together the areas for improvement arising from the CQC review and the report set out the key progress under these following sections:

Vision and Strategy
Engagement and Involvement

Performance, Pace and Drive
Flow and Use of Capacity
Market Development
Workforce
Information Sharing and System Navigation.

Under the performance, pace and drive section, the Coventry and Rugby Accident and Emergency Delivery Group had developed a draft Urgent and Emergency Care dashboard, a copy of which was set out at an appendix to the report. This contained key elements of activity and flow across the system and would be used by the Group to monitor and manage performance. It could also be used to provide information to the Board.

The Board were informed that two monitoring phone calls had taken place with the DHSC to date and it was clear that there remained ministerial interest in the ongoing impact of the reviews. The DHSC had offered to undertake a follow up summit in the autumn as an opportunity for the Board to showcase progress and for the DHSC to discuss policy and the connectivity of different initiatives with the Board.

It was the intention to complete the work on the improvement plan by March 2019 and ensure this focus was embedded in programmes and activities across the system beyond this date.

Members sought clarification about the information contained within the dashboard, requesting the inclusion of additional data. It was acknowledged that this was developed to enable monitoring and managing by the Accident and Emergency Delivery Group. Different dash board indicators could be used to show system progress for the Board and this would be raised at the next Place Forum on 16th July.

RESOLVED that:

(1) The Board note the progress made and support the ambition to conclude the work on the action plan by March 2019.

(2) The Board invite the Department of Health and Social Care to provide a follow up seminar in autumn 2018 to summarise progress and challenges and support in understanding the linkages of different policy initiatives and programmes.

(3) The Board received monitoring reports on progress against the improvement plan at future Board meetings.

11. **Any other items of public business - Cabinet Member Portfolio Change**

The Chair, Councillor Caan, informed the Board that for the new municipal year, poverty had been included in his Cabinet Member for Public Health and Sport portfolio. He outlined his intention to work to tackle this issue and was planning to hold a seminar on the subject.

(Meeting closed at 3.30 pm)

Coventry City Council

Report

To: **Coventry Health and Wellbeing Board** **Date: 8 October 2018**

From: **Cathi Sacco – Programme Manager, Better Care**
Pete Fahy - Director of Adult Services

Title: **Better Care Fund Plan - Update**

1 Purpose

1.1 The purpose of this paper is to report progress against the Better Care Fund (BCF) Plan and inform HWBB of changes to BCF requirements.

2 Recommendations

2.1 Coventry HWBB are recommended to:

- Note the BCF performance against the national metrics
- Support the approach towards meeting the revised expectations as announced in July 2018

3 Background

3.1 In March 2017 a new policy framework for the Better Care Fund covering the period 2017 to 2019 was issued at the same time as significant additional funding being made available to councils related to supporting adult social care. These sums arise from the 2015 spending review and the 2017 spring budget. Taken together these sums comprise the Improved Better Care Fund (iBCF).

3.2 The Health and Wellbeing Board approved the Coventry Better Care Plan 2017-2019 in October 2017. Formal approval of the plan by the NHS England was received on 21 December 2017.

3.3 The BCF remains the primary policy tool to deliver integration of health and social care. The Better Care Plan is a local plan that brings together ring-fenced budgets from the CRCCG and the City Council including specific areas of funding such as the Disabled Facilities Grant (DFG) and funding received as part of the Improved Better Care Fund (iBCF). The total value of the 2017-19 pooled budget is £179.502m made up of £63.897m of local authority resources and £115.605m of CCG resources spread over the 2 year period.

3.4 The BCF is supported by a section 75 partnership agreement between Coventry City Council and Coventry and Rugby Clinical Commissioning Group (CRCCG).

3.5 The additional investment provided through the iBCF enabled investment in a number of initiatives intended to reduce system demand and improve flow. These schemes covered areas of activity including prevention, hospital discharge support, system flow and community promoting independence. Resources from the iBCF were also identified to support social care pressures particularly in relation to costs of care.

3.6 The governance arrangements associated with the BCF require oversight from the HWBB. The delivery responsibility for the programme of work is the responsibility of the Adult Joint Commissioning Board (AJCB) with links to the Coventry Accident and Emergency Delivery Group and the Proactive and Preventative workstream of the STP to ensure BCF and its associated projects and priorities are aligned.

4 Performance against Plan

4.1 The Department of Health and Social Care and the Ministry for Housing, Communities and Local Government published national conditions and metrics in relation to BCF key policy areas. Each quarter performance against targets related to these metrics, the High Impact Change Model and iBCF initiatives are reported to these Departments.

4.2 Planned activity against all metrics is included in the Coventry BCF Plan and progress against plan is set out in the table below.

Performance	Q2 2017-2018	Q3 2017-2018	Q4 2017-2018	Q1 2018-2019	Comments
Reduction in non-elective admissions *Actuals*	9605	9314	9147	9376	17/18 did not meet annual target. Continued increase in acuity of patients attending A&E has led to pressure on admissions.
Planned Activity	9426	9426	9220	9188	
	Not on track to meet quarterly target	On track to meet quarterly target	On track to meet quarterly target	Not on track to meet quarterly target	
Rate of permanent admissions to residential care *Actuals*	73	74	62	97	17/18 met annual target. Performance in Q1 regularly dips. Strengthening of community prevention and therapies and improved flow from discharge pathways has been effective.
Planned Activity	82	75	75	75	
	On track to meet quarterly target	On track to meet quarterly target	On track to meet quarterly target	Not on track to meet quarterly target	
Reablement – number of people home after reablement period following hospitalisation *Actual*	Data not available to access progress	Data not available to access progress	81.2%	Data not available to access progress	17/18 did not meet annual target. Measured annually as a snapshot. Changes to measurement caused performance dip. Increase in number of people receiving reablement.
Planned Activity	NA	NA	85.7%	83%	
			Off target		
Delayed transfers of care *Actuals*	3792	3075	2360	2904	17/18 met annual target with substantial progress made over the year. Challenge in sustaining progress.

Planned Activity	4788	3684	3433	3470	
	On track to meet target	On track to meet target	On track to meet target	On track to meet target	

4.3 The above performance reflects the national picture, with improved performance in DToC (Delayed Transfer of Care), and Residential Admissions and continued challenges to reduce Non-Elective Admissions.

4.4 Improving Delayed Transfers of Care

The Better Care Fund has a significant focus on reducing Delayed Transfers of Care. In order to support systems in achieving the reductions, a 'High Impact Change Model' was developed which identifies eight system changes which will have the greatest impact on reducing delayed discharge. Department of Health and Social Care returns require areas to self-assess their progress against the eight changes. Performance for Coventry has been self-assessed as shown in the table below:

	Q2 2017-2018	Q3 2017-2018	Q4 2017-2018	Q1 2018-2019	Comments
Early discharge planning	Established	Established	Established	Established	
Systems to monitor patient flow	Established	Established	Established	Established	
Multi-disciplinary/agency discharge teams	Mature	Mature	Mature	Mature	
Home first/discharge to assess	Established	Established	Established	Mature	
Seven day service	Plans in Place	Plans in Place	Plans in Place	Plans in Place	Work in progress.
Trusted assessors	Plans in Place	Plans in Place	Plans in Place	Plans in Place	Pilots in place.
Focus on choice	Plans in Place	Plans in Place	Plans in Place	Plans in Place	Established as of Q2
Enhanced health in care homes	Established	Established	Established	Established	
Red bag scheme	Plans in Place	Plans in Place	Plans in Place	Established	

4.5 The position in respect of the High Impact Change Model is generally in line with other areas in that seven-day service, trusted assessors and focus on choice present particular challenges. These areas, however, are now progressing.

4.6 Beyond the metrics, delivery of the Coventry BCF Plan has resulted in a number of significant and positive shifts in bringing together health and social care. The joint working and clear focus for staff involved in discharge processes has been a key factor in delivering improvement and we have also progressed initiatives including the implementation of a Red Bag Scheme that will be rolled out further in 2018 and 2019 (Red Bag scheme ensures relevant information on an individual is passed on in their journey from a care home to hospital and back). The investments in prevention projects are also scheduled to be formally evaluated through work led in Public Health.

5 Revised Operational Guidance and Ambitions

5.1 In July 2018 the Department of Health and Social Care published new ***Integration and Better Care Fund Operating Guidance 2017-2019.*** The guidance set out new expectations that:

- all areas reach 'Established' in relation to each of the 8 High Impact Changes by March 2019 – based on self assessment there is high level of confidence in achieving this

- all areas implement the Red Bag Scheme by March 2019 – in place and to be rolled out

- all areas achieve new Delayed Transfers of Care expectations by September 2018 – significant challenges (see below)

5.2 Delayed Transfers of Care expectations were allocated to areas based on third quarter 2017/2018 performance in order to reach the Department of Health and Social Care's national ambition of an overall reduction of 4,000 days by September 2018 and to sustain this performance throughout the year.

5.3 For Coventry the formal notification of DToC expectation was received 31 August 2018, and is to achieve 25.7 Delayed Transfer of Care per day. In June 2018 Coventry had an average of 31.0 patients delays each day. The new target is challenging as is the timescales in which to meet it. The Coventry A&E Delivery Group have taken the approach that rather than develop a new set of plans to continue with progress against the High Impact Change Model and understanding in more forensic detail the actual issues underpinning delays at a patient level. The new target, however, represents a significant challenge.

6 Future of the Better Care Fund

6.1 The future of the Better Care Fund and the additional funding provided by the BCF in the form of the iBCF grant to social services are uncertain and are linked to the spending review and the long-term funding of NHS.

6.2 The level of funding to Adult Social Care is significant, and any future reductions will have an impact on delivering core and preventative services and sustaining the care market in Coventry which is likely to have a wider system impact.

Report Author(s): Cathi Sacco, Joint Commissioning Manager – Better Care Fund

Directorate: People Directorate

E-mail Contact: cathi.sacco@coventry.gov.uk

Enquiries should be directed to the above person.

Coventry City Council

Report

To: Coventry Health and Wellbeing Board **Date: 8 October 2018**

From: Pete Fahy – Director of Adult Services
Debbie Dawson – Policy and Partnerships Transformation Officer, Insight

Title: Care Quality Commission (CQC) Local System Review – Improvement Plan Progress

1 Purpose

This report summarises progress against the improvement plan arising from the Care Quality Commission System Review. The improvement plan is owned by the HWBB and will receive routine monitoring reports on progress against the plan until its completion (March 2019).

2 Recommendations

The following recommendations are made to Coventry Health and Wellbeing Board:

a. That HWBB note the progress made and areas still to be addressed against the actions in the improvement plan arising from the CQC local system review; and

b. That HWBB continue to maintain oversight of progress against the improvement plan at future meetings.

3 Background

The CQC undertook a system wide review of health and care for people aged 65 and over in Coventry between December 2017 and March 2018. As a result of this review the Coventry HWBB agreed an improvement plan which was closely linked to work already underway across the system. This plan was approved by the HWBB on 9 April 2018 and submitted to CQC and the DHSC on 10 April 2018.

Progress against the plan is monitored by the Department of Health and Social Care through monthly telephone calls with the Director of Adult Services, Accountable Officer for Coventry and Rugby Clinical Commissioning Group and the Deputy Chief Executive (People) where available. A number of these telephone calls have been postponed or cancelled at the request of DHSC and no concerns have been raised through this route regarding Coventry performance or progress.

A representative from the Department for Health and Social Care is attending a meeting of the Coventry and Warwickshire Place Forum on 7 November with a view to observing, in action, how we are trying to progress health and care in the region. They will also provide a short session on the CQC review and a national perspective on key findings from the other local system reviews.

The improvement plan is owned by the Coventry Health and Wellbeing Board and this report provides an update on progress to date to enable the Board to maintain oversight of the plan.

4 Local Health and Social Care System Coventry – Improvement Plan 2018

Progress against each of the actions has been reviewed, and a progress update is provided in the attached plan (appendix 1). We are currently on track to complete work on the improvement plan by March 2019 and to embed system improvements in programmes and activities thereafter. Good progress is being made on many of the actions, however some actions have slipped due to resourcing factors and capacity.

A brief summary of progress against each theme is given below.

Section 1: Vision and strategy
A Place Design (high level system model) and revised Concordat were approved by Coventry and Warwickshire Place Forum in July 2018, marking an important step in embedding a consistent vision and strategy across the health and social care system.

Progress has also been made on joint strategic planning and delivery, with GP clusters in place, the out of hospital delivery model being implemented, and work towards a place-based JSNA now in progress. An Integrated Care System roadmap is being developed to move the STP towards shadow ICS status and system governance is an agreed workstream of the roadmap.

Section 2: Engagement and involvement
Good progress is being made to develop 'I' statements with people who use Health and Social Care to form a benchmark for improvement. Coventry and Rugby CCG have reviewed stakeholder engagement plans and have developed new arrangements for improved engagement with GPs through the new GP clusters.

Section 3: Performance, pace and drive
A dashboard of key indicators is now being used to understand flow into and out of hospital and capacity of services supporting step up and discharge. A draft outcomes framework will be considered by Coventry and Warwickshire Place Forum in November, to support mutual accountability and assurance as well as engagement and leadership on specific health and wellbeing priorities across the place.

Section 4: Flow and use of capacity
A number of measures have been taken to reduce unavoidable admissions to hospital and ensure people are discharged promptly with appropriate support. For example, the Care Home

Enhanced scheme has been implemented, the Red Bag scheme was launched in August 2018 and ‘Red to Green’ bed days has been expanded across University Hospital.

Section 5: Market development
A Market Position Statement has been prepared for sign off in October and this will underpin a market development plan for support and care service providers by January 2019. Social prescribing is being remodelled to align with the new GP clusters and Discharge to Assess pathways are being evaluated.

Section 6: Workforce
Work is now in progress to develop a system wide workforce strategy which will be aligned to the STP Plan. A plan will sit alongside this, enabling the Local Workforce Action Board to monitor and track evidence of impact.

Section 7: Information sharing and system navigation
The Digital Transformation Board is leading work to improve accessibility of information for people accessing care and support. A refresh of the Local Digital Roadmap has taken place and will be available by early October. The roadmap covers ideas for standardising the ICT capability of health and care partners whilst introducing opportunities for system interoperability.

A project is underway to redesign the provision of the front door. Coventry and Warwickshire Partnership Trust have implemented their Integrated Single Point of Access (ISPA) and work is ongoing to establish closer links between the CWPT ISPA and the Council Adult Social Care front door, which is being redesigned.

4. Key Risks

Although good progress has been made, it is important that the completion of the improvement plan continues, to enable full Health and Wellbeing Board sign off in March 2019.

Although no specific concerns have been raised regarding progress since the system review, CQC have announced further reviews, of which Stoke on Trent has been announced for a follow up review.

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Appendices

Appendix One: CQC review, Local Health and Social Care System Coventry Improvement Plan 2018 – Progress update September 2018

Care Quality Commission (CQC) Review

Local Health and Social Care System – Coventry

Improvement Plan 2018

Final Version - April 2018; Progress update September 2018

Background

On 4th December 2017, the Care Quality Commission commenced a local review of the Coventry health and social care system. The main review week took place between 22nd and 26th January 2018, with the Health and Wellbeing Board feedback summit taking place on 14th March 2018.

The Coventry Health and Well Being Board welcomes the opportunities provided by the review to improve the way Coventry supports people that come into contact with the health and care system. This Action Plan has been developed in response to the issues highlighted within the report following its publication of the Coventry on 15 March 2017 recognising that the improvement journey was underway before the review and will continue beyond it.

The issues highlighted within the report have been reviewed and themed under the following headings:-

1. Vision and strategy
2. Engagement and involvement
3. Performance, pace and drive
4. Flow and use of capacity
5. Market development
6. Workforce
7. Information sharing and system navigation

The development of this Action Plan has been led by Pete Fahy, Director of Adult Services, Coventry City Council with support from the following individuals identified in the HWBB summit on 14 March 2018:

- Coventry and Rugby Clinical Commissioning Group (CRCCG)
    - Jo Galloway, Director of Nursing
- Coventry City Council Council
    - Gail Quinton, Deputy Chief Executive
    - Ian Bowering, Head of Social Work Service (Prevention and Health)
    - Jon Reading, Head of Commissioning and Provision
- University Hospital Coventry and Warwickshire (UHCW)
    - Lisa Kelly, Chief Operating Officer
- Coventry and Warwickshire Partnership Trust (CWPT)
    - Tracey Wrench, Chief Nurse and Interim Chief Operating Officer

- Coventry University
    - Professor Guy Daly, Pro Vice Chancellor (Health and Life Sciences)

In addition to the above, Andrea Green – Accountable Officer (CRCCG) has input to the production of the action plan and is the Health and Well-Being Board lead for its production.

The Group has been supported in its development by Richard Humphries, Senior Associate from the Social Care Institute for Excellence.

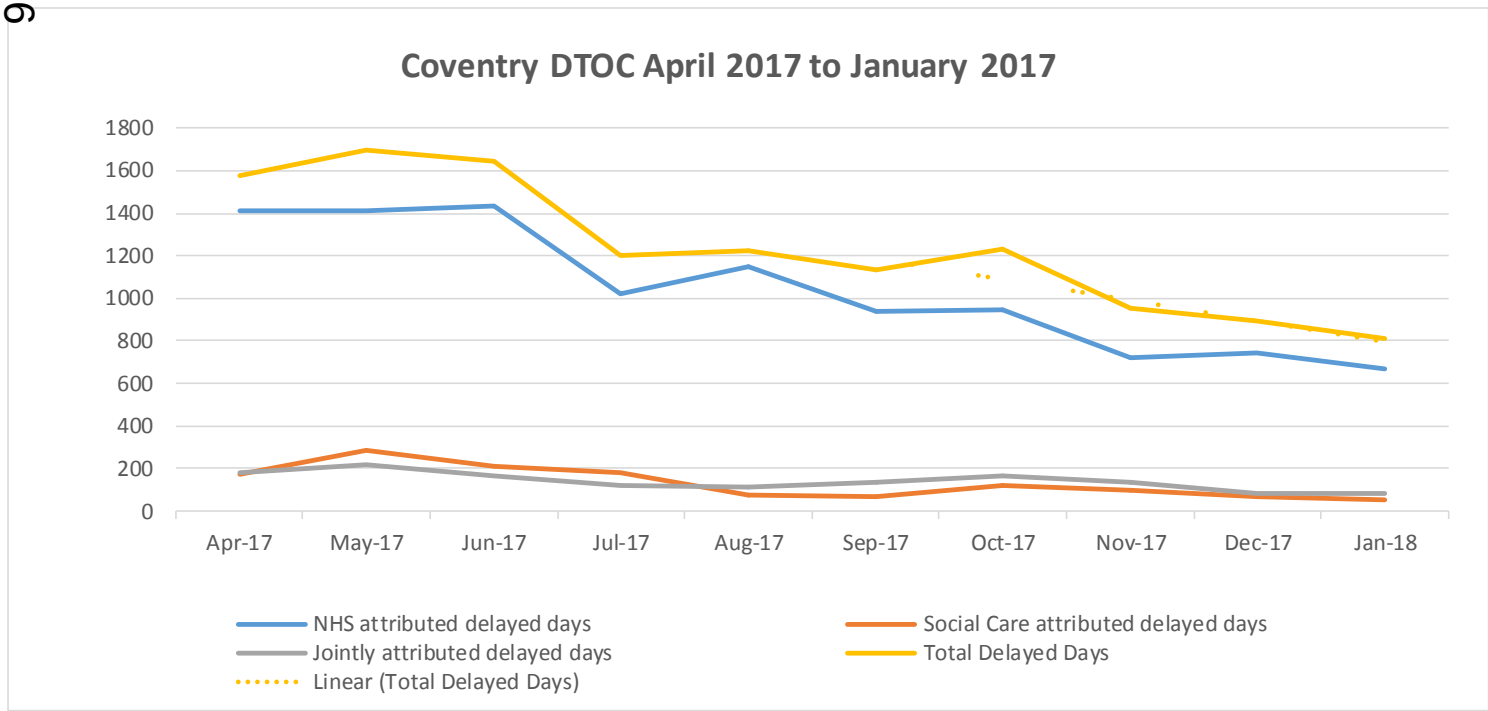
This action plan has been developed to support focus and drive on areas of activity and improvement already in progress across the system, it is therefore very much interlinked with existing plans as opposed to creating a separate and standalone action plan. As required by the CQC review the action plan will be owned through Coventry's Health and Wellbeing Board with responsibility for delivery through the relevant identified body.

Overall progress and current position:

Prior to review of the Coventry system being announced, during the review period and beyond we have continued to work as a system to address the issues that are impacting on people receiving consistently good health and care services. The review has provided a welcome opportunity for an external view on the issues we are dealing with and how we are responding.

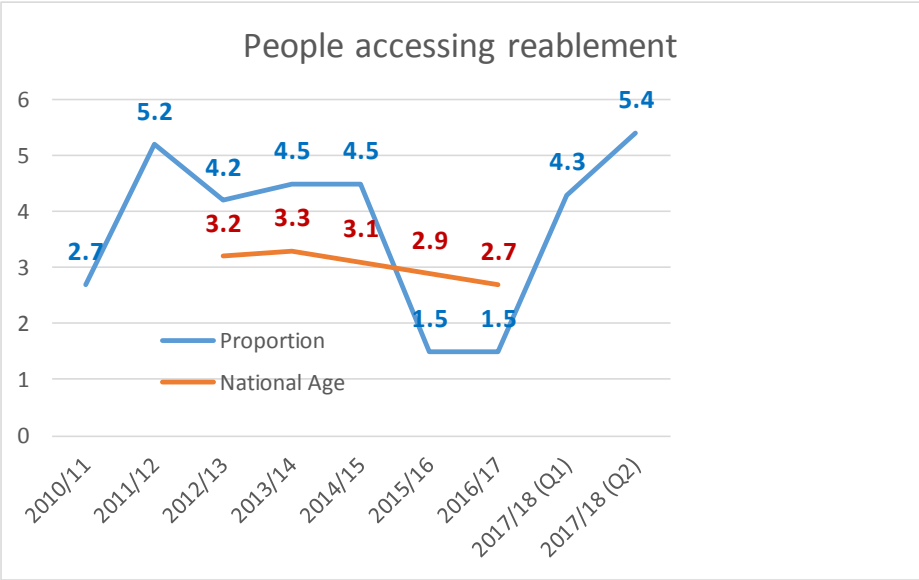
One particular measure we are proud of is our improvement in respect of Delayed Transfers of Care which has been achieved through taking a system approach as opposed to looking at the issue from a number of single agency perspectives. In the period between the announcement of the review and its commencement the position improved, the most recent data published for January 2018 shows continued improvement which is shown in Figure One (below).

Figure One: Delayed Transfer of Care to January 2017



Although improving further from this position remains a key system objective much of our effort is placed into improving the system to prevent admissions in the first place and, where they occur, avoiding readmissions. The improvement in access to reablement (Figure Two and based on provisional data for 2017/18 pending completion of the Short and Long Term Statutory Return (SALT)) demonstrates this improvement.

Figure Two: Access to Reablement



Despite the progress on Delayed Transfers of Care and Access to Reablement the Coventry system remains close to full capacity with A&E attendances, emergency hospital admissions and bed occupancy rates remaining high. This indicates that a focus on what happens when preparing for and achieving discharge is only part of the issue and is why many of the actions contained within this plan complement and add focus to the wider work taking place across the system to achieve our broader system aim of improving population health and reducing system demand across the board.

Specific examples of how we progressing this include our Upscaling Prevention programme and our 'year of well-being' which will provide some of the strategic impetus required to make a long term and sustainable difference in Coventry. These strategic approaches will be complemented by addressing a number of performance management, flow, market and workforce issues that the review identified and are contained within this plan.

We would of course welcome further feedback from CQC and/or Department of Health regarding how our plan could be further strengthened in order to achieve our ambitions at a faster rate.

Theme 1 – Vision and strategy

Lead responsibility – Coventry and Warwickshire Place Forum

Outcomes we will achieve: Ensure a consistent vision and strategy across the Health and Social Care system with links to how it's delivered.

CQC Recommendations:

- Ensure there is effective joint strategic planning and delivery for the people of Coventry based on the current and predicted needs of the local older population, to include BAME and hard to reach groups, and which harnesses all the local assets available in the wider system.
- While acknowledging that there is a concordat between Coventry HWB and Warwickshire HWB, the system leaders in Coventry need to build on the concordat and become more engaged with the development of the STP's Better Care, Better Health, Better Value programme.

Theme 1 – Vision and strategy							
Action Number	**Action required**	**Delivery Lead Organisation**	**System Governance Body**	**Timescale**		**Success measures**	**Progress to date**
				From	**To**		
1.1	Develop a clear system strategy with a single supporting narrative for the whole system	Place Forum – Cov and Warks	Health and Wellbeing Board	ongoing	Sept 2018	All stakeholders are clear on the system strategy	System model agreed at Place Forum in July – ACTION COMPLETE
1.2	Define the governance arrangements that exist between STP, HWBB and ICS so that reporting arrangements and decision making remits are clear	Place Forum – Cov and Warks	Health and Wellbeing Board	TBC	TBC	Written and agreed system governance protocols in place	System governance an agreed workstream of Integrated Care System roadmap which will own, ensuring the system governance arrangements are clear.

Theme 1 – Vision and strategy							
Action Number	**Action required**	**Delivery Lead Organisation**	**System Governance Body**	**Timescale**		**Success measures**	**Progress to date**
				From	**To**		
1.3	Define the model for local integration of services within ICS policy framework	STP (Preventative and Proactive workstream)	STP Board	ongoing	TBC	Clarity on what integrated health and care means for Coventry	Will be progressed through ICS development work
1.4	Develop the Coventry operating model for locality delivery so that all stakeholders are clear how the locality model will work operationally	STP (Proactive and Preventative workstream)	STP Board	ongoing	March 2019	Clarity on how the locality model will deliver on the ground following pilot work and review	Proposals developed for how both the city council (Adult Social Care and Support) plus CWPT will align resources with the Out of Hospital delivery model.
1.5	Clearly identify the geography for locality based services for populations of 30k-50k) as the vehicle through which to drive improvement and equitable in community based health and care	CRCCG	STP (Proactive and Preventative workstream)	ongoing	March 2019	Clear locations and geography in place for 30-50k	GP Clusters of practices are now in place, clinical leads identified and the out of hospital delivery model is being implemented with Community Place-based Teams from end September 2018
	Development of Joint Strategic Needs Assessment on locality basis so the population needs	Coventry City Council	Health and Wellbeing	July 2018	March 2019	Locality based JSNA signed off	Data in JSNA updated in January 2018. Work is underway to develop

Theme 1 – Vision and strategy							
Action Number	Action required	Delivery Lead Organisation	System Governance Body	Timescale		Success measures	Progress to date
				From	To		
	being served by each locality are clearly understood		Board			by HWBB	a new place-based JSNA – 8 localities (plus one citywide) have been approved by the Steering Group and plans are in place to deliver a data profiling tool and pilot asset-based JSNA in two localities by March 2019.
1.7	Develop the clinical strategy for the city including frailty so there is clarity on how clinical needs will be met	Coventry and Rugby Clinical Commissioning Group	Health and Wellbeing Board	ongoing	Sept 2018	Clinical strategy signed off by BHBCBV Board	The Clinical Strategy is being finalised in September for submission to the BHBCBV Board in October.

Theme 2 – Engagement and Involvement

Lead Responsibility – Engagement workstream of Better Care, Better Health, Better Value programme

Outcomes we will achieve: Clear mechanisms in place for engagement with professionals and people who either use or may use services

CQC Recommendations:

- Create and deliver a joint public engagement strategy which includes how the system will reach seldom heard groups.
- Improve the working relationships between the CCG and GP providers.
- Develop a shared view of risk across health and social care by identifying forums where staff groups can come together, build relationships and identify ways to establish a consistent approach to the process of risk assessment and positive risk taking.

Theme 2 – Engagement and Involvement							
Action number	**Action required**	**Delivery Lead Organisation**	**System Governance Body**	**Timescale**		**Success measures**	**Progress to date**
				From	**To**		
2.1	Develop a set of 'I' statements with people who use Health and Social Care to form a benchmark for improvement, which are inclusive of all groups within the city	STP (Communication and Engagement workstream)	STP	ongoing	Sept 2018	Set of 'I' statements agreed through co-production	'I statements' drafted following session with Coventry Older Voices and Healthwatch on 30 May. These are being tested with other forums with a view to taking to Place Forum and HWBB for endorsement.

Theme 2 – Engagement and Involvement							
Action number	**Action required**	**Delivery Lead Organisation**	**System Governance Body**	**Timescale**		**Success measures**	**Progress to date**
				From	**To**		
2.2	Engage with GPs through locality and membership forums to understand the issues impacting on effective partnerships with GPs.	CRCCG	CRCCG	ongoing	TBC	Understanding of issues and agreed actions to address where appropriate	There is a nominated GP clinical lead and a co-ordinator for each of the new GP clusters, which come together as groups of practices to work on specific joint priorities and resilience issues. Each Cluster Lead has a nominated Governing Body Clinical lead link – so issues can be raised through the CCG governance at our clinical executive group. Cluster Leads are also members of the CCG Primary Care Development Group which is a forum for raising issues / concerns and feeding back views from local GPs.

Theme 2 – Engagement and Involvement							
Action number	**Action required**	**Delivery Lead Organisation**	**System Governance Body**	**Timescale**		**Success measures**	**Progress to date**
				From	**To**		
2.2.1	Following completion of action 2.2 to develop a set of measures to understand if the relationship is improving	Clinical Commissioning Group	Clinical Commissioning Group	TBC	TBC	GP and CRCCG both able to evidence improvements in relationship	The CCG have reviewed stakeholder engagement plans and are utilising the cluster arrangements, Protected Learning Time and specific forums where Cluster Leads represent their constituent practices to improve communication and build primary care engagement. They have established regular meetings with LMC as the representation for general practice delivery of primary care contracts. There is a specific section in the new Commissioning

Theme 2 – Engagement and Involvement							
Action number	**Action required**	**Delivery Lead Organisation**	**System Governance Body**	**Timescale**		**Success measures**	**Progress to date**
				From	**To**		
							Intentions on primary care priorities which reflect engagement with members and stakeholders with an interest in primary care
2.3	Engaging Health & Social Care professionals in developing consistent approach to management of risk and embed this in practice	Local Workforce Groups	Local Workforce Action Board	Ongoing	March 2019	A single risk management framework and evidence of this multi-disciplinary settings/place based teams	Local STP partners have their local workforce strategies in place. Risks will therefore be managed in association with this locally. From a system wide perspective, LWAB will be pulling a STP workforce strategy together and will look to develop a single risk management framework (and risk register) to ensure active risk management at LWAB/system level. This will ensure the monitoring of

Theme 2 – Engagement and Involvement							
Action number	**Action required**	**Delivery Lead Organisation**	**System Governance Body**	**Timescale**		**Success measures**	**Progress to date**
				From	**To**		
							mitigating actions and subsequent solutions.

Theme 3 – Performance, pace and drive

Lead Responsibility – as described in actions

Outcomes we will achieve: Delivery of agreed change programmes in a timely way.

CQC Recommendations:

- Ensure system wide performance data is used to drive improvements, implementing solutions and setting targets in which all parts of the system have a shared responsibility, and providing opportunities for collaborative reflection and learning

Theme 3 – Performance, Pace and Drive							
Action number	**Actions**	**Delivery Lead Organisation**	**System Governance Body**	**Timescale**		**Success measures**	**Progress to date**
				From	**To**		
3.1	Establish system-wide data set / dashboard on flow into and out of hospital and capacity of services supporting step up and discharge	A&E Delivery Group	STP (Urgent and Emergency Care)	ongoing	Sept 2018	Fully operational dashboard of key indicators of flow and capacity to monitor activity / inform action	Dashboard in place and being used – ACTION COMPLETE
3.2	Establish a system-wide Performance dashboard to monitor progress in the delivery of agreed vision and strategy	CRCCG linking with partners	Health and Wellbeing Board	Not yet commenced	Dec 2018	System wide focus on key areas of strategic delivery enabling pace and drive to be maintained	Further to completion of action 1.1 in previous section, this can now be progressed. Coventry and Warwickshire Place Forum have agreed to consider a draft outcomes framework and performance dashboard in November

							2018.
3.3	CQC Local System Review Action Plan to be monitored, on an ongoing basis, by the HWBB.	Health and Wellbeing Board	Health and Wellbeing Board	ongoing	June 2018	Delivery of action plan delivered with appropriate escalation to unblock areas of non-delivery	Update provided to each HWBB with the aim for full sign off in March 2019 - ACTION COMPLETE

Theme 4 – Flow and use of capacity

Lead Responsibility – Coventry Accident and Emergency Delivery Group

Outcomes we will achieve: Reducing unavoidable admissions to hospital. For those who need to be admitted to ensure that people only stay in hospital for as long as they need to and, when ready to leave, are discharged promptly with appropriate support.

CQC Recommendations:

- Reduce numbers of avoidable admissions from care homes by extending successful initiatives such as the React to Red scheme, introducing pharmacist led medication reviews and increasing coverage of GP input into care homes.
- Ensure discharge planning is started at the beginning of a person's journey through hospital and remains a key focus during their stay. 'Red and green bed days' to be implemented and embedded across all wards. Care home and home with care providers to be involved in discharge planning at an early stage of the person's stay in hospital.
- Improve the processes around medicines on discharge to reduce delays and improve the safety of those who have been discharged to care homes.
- Improve the ability to discharge patients from hospital at weekends by increasing senior clinical decision makers and ensuring the presence of the discharge teams at weekends.
- Increase the utilisation of trusted assessors in each D2A pathway to improve the speed of transfers from hospital by increasing provider's confidence. Include in any jointly developed protocol for assessments and the review process, a clear feedback mechanism for learning and improvement.

Theme 4 – Flow and use of capacity							
Action number	**Actions**	**Delivery Lead Organisation**	**System Governance Body**	**Timescale**		**Success measures**	**Progress to date**
				From	**To**		
4.1	**Support to care homes** Increase coverage of dedicated GP support into care homes through implementation of the Care Home Enhanced Support (CHES) scheme	CRCCG	STP (Urgent and Emergency Care)	Complete	Complete	Increase coverage above current level of 66% of care homes Reduction in avoidable admissions, readmissions and improved DTOC	Commissioned service with GPs to commence 1 April 2018. 90% of homes supported within the scheme. Evidence of reduced admissions from care homes.– ACTION COMPLETE
4.2	**Support to care homes** Care home and housing with care providers to be involved in discharge planning at an early stage of the person's stay in hospital	CRCCG	STP (Urgent and Emergency Care)	Ongoing	TBC	Evidence of early involvement by care providers in discharge planning working with IDT in UHCW Improved weekend discharges to care homes including new residents	IDT / REACT attending the Care Home provider forum to relaunch Trusted Assessment. IDT working with Commissioning and providers to re-establish trusted assessment. CHES scheme in place which will enable this action to be delivered.
4.3	**Support to care homes** Implement Red Bag scheme	AJCB	STP (Urgent and Emergency Care)	Ongoing	September 2018	Red Bag scheme in place for identified cohort Reduction in avoidable admissions, readmissions and improved DTOC	Red Bag scheme launched on 7 August 2018 and to be further developed based on learning – ACTION COMPLETE
4.4	**Increase coverage and effectiveness of 'Red to Green'**		STP (Urgent and Emergency	Ongoing		Increase coverage within wards at University Hospital	"Red to Green" in place across all adult inpatient wards.

Theme 4 – Flow and use of capacity							
Action number	**Actions**	**Delivery Lead Organisation**	**System Governance Body**	**Timescale**		**Success measures**	**Progress to date**
				From	**To**		
	'Red to Green bed days' to be implemented and embedded across all wards and into D2A community settings	A&E Delivery Group - Coventry	Care)		TBC	Overall reduction in lengths of stay / improvement in DToC	Patient status at a glance board monitored via central data programme and "Red to Green" data being used to support innovations across the Trust
4.5	**Increase coverage of Trusted Assessor** Increase care home provider's confidence in assessments completed e.g. by reviewing trusted assessment approach and evaluating need for Care Home Assessor post	CRCCG via A&E Delivery Group - Coventry	STP (Urgent and Emergency Care)	Ongoing	Novemb er 2018	Understanding factors to improve care home confidence leading to reduced number of refusals and delays attributable to care homes	In place for some providers in P2. Trialled in 2 care homes Pathway 3. Further Trusted Assessor scheme being implemented in P3 where IDT is trusted assessor for CCG.
4.6	**Improving Discharge** Review role of Community Discharge Hub to ensure continued effectiveness and clear mechanisms in place for learning and improvement	A&E Delivery Group - Coventry	STP (Urgent and Emergency Care)	June 2018	August 2018	Review complete with proposals for future development Overall reduction in lengths of stay / improvement in DToC	Review complete which demonstrated efficacy of approach, contributed to sustained improvement in DToC and will continue - ACTION COMPLETE

Theme 4 – Flow and use of capacity							
Action number	**Actions**	**Delivery Lead Organisation**	**System Governance Body**	**Timescale**		**Success measures**	**Progress to date**
				From	**To**		
4.7	**Improving Discharge** Review what is required to deliver 7 day services to impact on weekend discharges e.g. Increase senior clinical decision makers at weekends Presence of the discharge teams at weekends	A&E Delivery Group - Coventry	STP (Urgent and Emergency Care)	May 2018	March 2019	Resourced plan implemented to deliver 7 day discharges leading to increased discharge activity at weekends without impacting on Mon-Fri activity	Adult Social Care and UHCW are undertaking a review of the costs, benefits and impacts of moving to 7day services. For weekend discharges to be improved significantly, all areas need to contribute UHCW continues to make good progress towards 7DS provision along many paths including the 10 Clinical Standards.
4.8	**Prevention, Ambulatory Care, Zero length of stay** Review of ambulatory care pathways redirecting / supporting patients with alternative sources of support i.e. falls prevention and Back	A&E Delivery Group - Coventry	STP (Urgent and Emergency Care)	Ongoing	TBC	Overall reduction in number of admissions	Baseline completed, working in collaboration with NHS Elect and ECIP to progress this area. Joint audit between UHCW and CRCCG completed.

Theme 4 – Flow and use of capacity							
Action number	**Actions**	**Delivery Lead Organisation**	**System Governance Body**	**Timescale**		**Success measures**	**Progress to date**
				From	**To**		
	Home Safe and Well						

Theme 5 – Market development

Lead Responsibility – Adult Joint Commissioning Board

Outcomes we will achieve: Ensuring the right level of market capacity and optimising its utilisation.

CQC Recommendations:

- Roll out and evaluate a programme of social prescribing.
- Identify and supply the necessary support needed for care homes to accept weekend discharges for new residents – *see actions under flow and use of capacity.*

Theme 5 – Market development							
Action number	**Actions**	**Delivery Lead Organisation**	**System Governance Body**	**Timescale**		**Success measures**	**Progress to date**
				From	**To**		
5.1	Refresh Market Position Statement and utilise with support and care service providers	Adult Joint Commissioning Board	Collaborative Commissioning Board	Ongoing	Sept 2018	Market position statement published with associated provider engagement	Market Position Statement drafted and final version to be signed off on 11 October 2018
5.2	Produce a market development plan for support and care service providers in consultation with providers	Adult Joint Commissioning Board	Collaborative Commissioning Board	Ongoing	Dec 2018	Market development plan in place and shared	Action underway as was dependant on completion of 5.1 above. On track for sign off in January 2019.
5.3	Evaluate programme of social prescribing and then rollout. (dependent on outcome of	Adult Joint Commissioning Board	Collaborative Commissioning Board	Ongoing	TBC	Evaluation complete and optimum social prescribing capacity in place	Working with current provider to re-model the service to align with the newly evolving GP Clusters. Currently

Theme 5 – Market development							
Action number	**Actions**	**Delivery Lead Organisation**	**System Governance Body**	**Timescale**		**Success measures**	**Progress to date**
				From	**To**		
	evaluation)						piloting new ways of working with two of the Clusters, and support is being sought through the Primary Care Officers Group to start working with remaining GP Clusters. It is intended that in future Social Prescribing will be closely aligned with the Placed Based Teams for Out of Hospital.
5.4	Evaluate D2A pathway provision to ensure it remains fit for purpose	Adult Joint Commissioning Board	Collaborative Commissioning Board	Ongoing	July 2018	Optimum and sustainable D2A provision in place	Pathway 3 evaluation commenced and evaluation of P1 and P2 scoped. Due to capacity the timescales for completion of this are being reviewed.
5.5	Develop step-up capacity to support people more effectively in the community	Adult Joint Commissioning Board	Collaborative Commissioning Board	Ongoing	Mar 2018	Increased step up capacity in place to assist with management of system demand	Capacity in place. Will be extended to people with change in needs – ACTION COMPLETE

Theme 6 – Workforce

Lead Responsibility – Local Workforce Action Board

Outcomes we will achieve: A clear approach to ensuring how the local workforce will be developed to meet population needs for health and care

CQC Recommendations:

- Develop a strategic plan for the health and social care workforce in Coventry linked to the STP's wider Better Care, Better Health, Better Value programme that takes account of the national health and social care workforce strategy (once developed)

Theme 6 - Workforce							
Action number	**Actions**	**Delivery Lead Organisation**	**System Governance Body**	**Timescale**		**Success measures**	**Progress to date**
				From	**To**		
6.1	Develop system wide workforce strategy to support delivery of strategy and vision	Local Workforce Action Board	STP Board	Ongoing	Mar 2019	Clear and resourced workforce strategy in place	Work underway through Local Workforce Action Board but in its early stages – this action will largely take place subsequent to strategy and vision work. Organisations to share their strategies and this will support the development of a system wide workforce strategy which will be aligned to the STP Plan. Work in progress.
6.2	System wide training and development plan to cover issues including: Risk management Shared assessment	Local Workforce Action Board	STP Board	Ongoing	Mar 2019	Training programme developed, delivered with evidence of impact	Currently looking at different ways to ensure workforce supply across our LWAB/STP. A plan will be pulled together to enable LWAB to monitor and track evidence of impact. The plan will be in line with the STP

Theme 6 - Workforce							
Action number	**Actions**	**Delivery Lead Organisation**	**System Governance Body**	**Timescale**		**Success measures**	**Progress to date**
				From	**To**		
	Care support provider skills						workforce strategy and risks will be monitored by LWAB. Work in progress

Theme 7 – Information sharing and system navigation

Lead Responsibility – Digital Transformation Board

Outcomes we will achieve: Improved accessibility of information for people accessing care and support and professionals

CQC Recommendations:

- Accelerate the delivery of the Digital Transformation Board to provide digital interoperability and shared care records across the system.
- Provide a single point of access health and social care navigation system for people and carers to easily find the support and advice they need.

Theme 7 – Information sharing and system navigation							
Action number	**Actions**	**Delivery Lead Organisation**	**System Governance Body**	**Timescale**		**Success measures**	**Progress to date**
				From	**To**		
7.1	Improve Adult Social Care "front door" to enhance accessibility of information and advice	CCC	Digital Transformation Board	Underway	Ongoing	Reported improvement in accessibility of information and advice (ASCOF)	A project is underway to redesign the provision of the Adult Social Care front door. This phase of work will create the detailed design of a new operating model. This project is being supported by Capita who are providing external expertise to challenge existing practices and introduce a model of effective front door interventions. The

Theme 7 – Information sharing and system navigation							
Action number	Actions	Delivery Lead Organisation	System Governance Body	Timescale		Success measures	Progress to date
				From	To		
							redesign of services will align with improvements to models of social work practice, with the introduction of strengths based practice. The detailed design phase of the project will run until the end of October, after which implementation plans will be developed.
7.2	Consolidate CWPT access points into Integrated Single Point of Access (ISPA)	Out of Hospital Design Board	Proactive and Preventative workstream of STP	Underway	September 2018	Health ISPA implemented	CWPT have implemented their ISPA. Work is ongoing to establish closer links between the CWPT ISPA and the Council front door with the objective of providing a more co-ordinated response to people requiring support. ACTION COMPLETE but further work to do.
7.4	Undertake interoperability scoping workshop across	Digital Transformation	STP Board	underway	Sept	Clear plan agreed by partners on how to improve with	An interoperability workshop was held in May

Theme 7 – Information sharing and system navigation							
Action number	**Actions**	**Delivery Lead Organisation**	**System Governance Body**	**Timescale**		**Success measures**	**Progress to date**
				From	**To**		
	Coventry and Warwickshire system partners to identify ideas and opportunities for improving system flow.	Board			2018	timescale for delivery	and action plans to improve this area are being developed by health and social care technology leads. A refresh of the Local Digital Roadmap has taken place and will be available by early October. The roadmap covers ideas for standardising the ICT capability of health and care partners whilst introducing opportunities for system interoperability. ACTION COMPLETED
7.5	Hold Assistive Technology workshop to develop shared Coventry and Warwickshire strategy that supports delivery of health and social care priorities.	Coventry City Council	Digital Transformation Board	underway	Sept 2018	Wider use of technology to support health and care	A system wide Assistive Technology workshop was held in May, the output of which is leading to the development of targeted areas of work that will test out the use of assistive technology to reduce demand on traditional models of care.

Theme 7 – Information sharing and system navigation							
Action number	**Actions**	**Delivery Lead Organisation**	**System Governance Body**	**Timescale**		**Success measures**	**Progress to date**
				From	**To**		
							After the successful delivery of the AT workshop the CCC team have been designing an AT strategy that will encompass the full adult social care customer journey. This will be shared with partners involved at different parts of the journey to ensure opportunities for joint working are capitalised. ACTION COMPLETED
7.6	Undertake review of existing Information Governance support and guidance arrangements to ensure processes are simplified.	Sub regional Information Governance group	Digital Transformation Board	underway	Sept 2018	Clear information governance arrangements in place	The review of processes relating to informing IG responsibilities and requirements for health and care projects has been undertaken. The changes are being monitored to ensure processes effectively support system wide projects. ACTION COMPLETED and work ongoing to ensure changes are embedded.

Abbreviations:

CRCCG	Coventry and Rugby Clinical Commissioning Group
CCC	Coventry City Council
UHCW	University Hospital Coventry and Warwickshire
CWPT	Coventry and Warwickshire Partnership Trust
AJCB	Adult Joint Commissioning Board
DTB	Digital Transformation Board
LWAB	Local Workforce Action Board
STP	Sustainability and Transformation Programme
BCBVBH	Better Care, Better Value, Better Health (the local STP programme)
ECIP	Emergency Care Improvement Partnership
MDT	Multi-Disciplinary Team
CHES	Care Home Enhanced Support
ISPA	Integrated Single Point of Access
JSNA	Joint Strategic Needs Assessment

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Coventry City Council

Report

To: Coventry Health and Wellbeing Board **Date: 8 October 2018**

From: Cllr Faye Abbott, Cabinet Member for Adult Services
Pete Fahy, Director of Adult Services, Coventry City Council

Title: Adult Social Care Annual Report 2017/18

1 Purpose

The Adult Social Care Annual Report 2017/18 (also referred to as Local Account) describes the performance of Adult Social Care and the progress made against the priorities for the year. This has been considered by Health and Social Care Scrutiny Board (5) on 19 September 2018 and will be considered by Cabinet for approval on 2 October 2018.

This is presented to the Health and Wellbeing Board for information.

2 Recommendations

The Health and Wellbeing Board is asked to note the Adult Social Care Annual Report 2017/18.

3 Background

The Adult Social Care Annual Report 2017/18 (also referred to as Local Account) describes the performance of Adult Social Care and the progress made against the priorities for the year. It also provides specific examples of the operational activities to support service users and carers. As with the report for 2016/17 it is aligned around the Adult Social Care values and principles as a mechanism of demonstrating what we are doing in practice to put what we sign up to strategically into practice.

Although there is not a statutory requirement to produce an annual report, it is considered good practice as it provides an opportunity to be open and transparent about the successes and challenges facing Adult Social Care and to show what is being done to improve outcomes for those that come into contact with Adult Social Care. The production of an annual report is part of the Local Government Associations (LGA) approach to Sector Led Improvement. This approach was launched following the removal of national targets and assessments for Adult Social Care.

The production of the 2017/18 report has drawn on the pool of feedback and information that was gathered over the year from a range of sources including social care staff, Partnership Boards, Adult Social Care Stakeholder Reference Group, providers, partner organisations and people that have been in contact with Adult Social Care along with their families and carers.

Report Author(s):

Name and Job Title:
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Appendices

Cabinet report, 2 October 2018: Adult Social Care Annual Report 2017/18

Coventry City Council

Public report
Cabinet Report

Health and Social Care Scrutiny Board (5) — 19 September 2018
Cabinet — 2 October 2018

Name of Cabinet Member:
Cabinet Member for Adult Services – Councillor F. Abbott

Director Approving Submission of the Report:
Deputy Chief Executive (People)

Ward(s) affected:
All

Title:
Adult Social Care Annual Report 2017/18

Is this a key decision?
No.

This is a report of performance for 2017/18 and no recommendations are made that have significant financial or service implications.

Executive Summary:

The Adult Social Care Annual Report 2017/18 (also referred to as Local Account) describes the performance of Adult Social Care and the progress made against the priorities for the year. It also provides specific examples of the operational activities to support service users and carers. As with the report for 2016/17 it is aligned around the Adult Social Care values and principles as a mechanism of demonstrating what we are doing in practice to put what we sign up to strategically into practice.

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The production of the 2017/18 report has drawn on the pool of feedback and information that was gathered over the year from a range of sources including social care staff, Partnership Boards, Adult Social Care Stakeholder Reference Group, providers, partner organisations and people that have been in contact with Adult Social Care along with their families and carers.

Recommendations:

1. Health and Social Care Scrutiny Board (5) is asked to:

    (i) Consider the report and submit any comments to Cabinet for their consideration on the content of the report

2. Cabinet is asked to:

    (i) Consider comments from the Health and Social Care Scrutiny Board (5)

    (ii) Approve the Adult Social Care Annual Report 2017/18 (Local Account)

List of Appendices included:

Appendix One - Adult Social Care Annual Report 2017/18 (Local Account)

Background papers:

None

Has it been or will it be considered by Scrutiny?

Yes – Health and Social Care Scrutiny Board (5) on 19 September 2018.

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

No

Will this report go to Council?

No

Report title: Adult Social Care Annual Report 2017/18 (Local Account)

1. Context (or background)

1.1 The Local Government Association (LGA) launched its approach to Sector Led Improvement in 2011. This approach was introduced following the removal of national targets and assessments and with the aim of driving improvement through self-regulation, improvement and innovation. As part of this approach to Sector Led Improvement the expectation is that an Annual Report is produced by all local authorities with Adult Social Care responsibilities. The production of an Annual Report is not a statutory requirement, nor has any statutory guidance been issued on its content or style.

1.2 The Annual Report describes the performance and achievements along with considering the challenges for Adult Social Care in Coventry. It is intended to provide assurance to stakeholders that Adult Social Care is delivering its objectives and is achieving positive outcomes for people in Coventry within the resources available.

1.3 In producing the report it is important that the Council understands whether the support offered to people is making a difference. The focus of Adult Social Care is to provide personal and practical support to help people live their lives by promoting their independence and wellbeing. The Annual Report is structured around the ten themes that contribute to the Adult Social Care vision and provides commentary on what has been done to make progress against each of these themes.

1.4 The content of the Annual Report is informed by feedback on the experiences of people who come into contact with Adult Social Care, this feedback may be given in person, through groups or in response to surveys. A number of case studies and direct quotes have been used to demonstrate the impact that Adult Social Care has on individuals and their families. Those who have commented on previous reports have consistently stated that case studies are an important aspect of the report, as they help to demonstrate outcomes for individuals and the difference it has made to their lives.

1.5 Some of the key improvements delivered over 2017/18 identified in the report that have had a positive impact on people are as follows:

- The city has a new facility offering a purpose-built specialist Housing with Care Scheme (HWC) for people either living with dementia or with a cognitive impairment. This model moves away from the traditional HWC models of support and provides a more structured approach to enable people living with dementia to live independently in a safe environment. This is a new approach for which there are a very limited number of such schemes across England.

- In June 2017 new home support arrangements came into effect within Coventry. The New Home Support framework was recommissioned with the aim of improving quality and performance. This has led to a reduction in waiting times for services to start and locality based provision supporting a greater understanding of the needs of local communities.

1.6 The Annual Report also identifies the key challenges for Adult Social Care and the key areas of activity that are being progressed. Although an annual report is produced it needs to be recognised that the work of Adult Social Care does not fit neatly within a twelve-month period and delivery of the Adult Social Care vision through promoting independence and providing personalised care and support is very much an ongoing endeavour.

1.7 It also needs to be recognised that although this is an Adult Social Care report the successful delivery of Adult Social Care is increasingly intertwined with health services, and, as we progress, how support is brought together across health and adult social care to deliver positive outcomes will be an increasing focus.

1.8 Some of the key challenges we are addressing include:

- Increasing demand for services resulting from an ageing population. The number of over-85s is expected to grow by 22 per cent in the next ten years and this group of people are more likely to live with multiple health conditions that require support.

- Increasing costs of care as a result of external factors including National Living Wage and the complexity of the care needs that people are experiencing.

1.9 Some of the ways we are seeking to address these challenges include:

Improving our approach to promoting independence.
To meet the challenge of increasing demand we have developed our approach for older people and adults with a physical disability to provide short term support to help individuals regain their independence e.g. after a period of illness. After receiving support, we have found that many people don't need any further help, or only a little, so they can carry on living independently in their own homes. This approach helps improve outcomes and reduces demand.

Improving the experience at initial contact
The implementation of an appointment booking system for social workers. When a member of the public requires a visit from a social worker they are given an appointment date and time. The benefit for the public is that people know when they can expect a visit, this reduces follow up calls and ensures appointments are scheduled at a time convenient for the customer.

2. Options considered and recommended proposal

2.1 An Annual Report provides the opportunity to evidence and communicate Adult Social Care's performance in an accessible and transparent way as part of an overall approach to Sector Led Improvement. It is therefore recommended that the Annual Report for 2017/18 is endorsed by the Cabinet.

3. Results of Consultation undertaken

3.1 Although the Annual Report for 2017/18 was not subject to specific consultation, the content has been drawn from feedback gathered from people who come into contact with Adult Social Care together with comments from other partner organisations and stakeholders in the City.

4. Timetable for implementing this decision

4.1 Once approved, the Annual Report will be published on the Council's internet pages and shared with partners and stakeholders

5. Comments from the Director of Finance and Corporate Services

5.1 Financial implications

Whilst there are no direct financial implications arising from the production of the report, the performance of Adult Social Care continues to be impacted by changes to Council resources and national legislation changes.

The report highlights the £81.8m Adult Social Care Spend in 2017/18 compared to £78.1m in 2016/17 (4.7% increase), which has largely been driven by the increased costs associated with National Living Wage and increases in complexity of packages. This increase was resourced from the additional Council investment in Adult Social Care in the 2016 Budget report (partly funded through the Adult Social Care precept) as well as the extra resources identified in the Governments Spring Budget 2017. The additional Spring Budget funding led to the overall underspend of £1.2m across the Adult Social Care Division's budgets last year.

5.2 Legal implications

There are no direct legal implications arising from the publication of the Annual Report.

The publication of the report is in accordance with the 2011 Department of Health recommendation that all local authorities' Adult Social Care directorates publish an Annual Report. This shows how the local authority performed against quality standards, and what plans have been agreed with local people for the future.

6. Other Implications

6.1 **How will this contribute to achievement of the Council's Plan?**

This Annual Report demonstrates the progress of Adult Social Care in maintaining and improving outcomes for the population of Coventry. This progress contributes to the Council's objectives of citizens living longer, healthier, independent lives and contributes to the priorities in the Council Plan to protect the city's most vulnerable people.

6.2 **How is risk being managed?**

A range of risks are presented in the delivery of Adult Social Care services which are managed through the directorate and corporate risk registers.

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 this report. Equality Impact Assessments have been built into the development and delivery of work within Adult Social Care. There has been a continued drive to embed equality and diversity within operational practice, commissioning plans and performance monitoring.

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

None

6.6 **Implications for partner organisations?**

There are no direct impacts for partner organisations. The Annual Report provides an overview of Adult Social Care's performance and provides assurance to partners that progress in being made.

Report author(s):

Name and job title:
Andrew Errington, Adults Principal Social Worker

Directorate:
People

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Enquiries should be directed to the above people.

Contributor/approver name	Title	Directorate	Date doc sent out	Date response received or approved
Contributors:				
Andrew Errington	Adults Principal Social Worker	People	13/07/2018	18/07/2018
Pete Fahy	Director of Adult Services	People	01/08/2018	06/09/2018
Timothy Etherton	Programme Support Officer	People	13/07/2018	18/07/2018
Lara Knight	Governance Services Co-ordinator	Place	21/08/2018	21/08/2018
Ian Bowering	Head of Social Work (Prevention and Health)	People	24/08/2018	28/08/2018
Sally Caren	Head of Social Work-Mental Health and Sustainability	People	24/08/2018	24/08/2018
Marc Greenwood	Head of Business Systems	People	24/08/2018	28/08/2018
Jon Reading	Head of Commissioning and Provision	People	24/08/2018	28/08/2018
Names of approvers for submission: (Officers and Members)				
Barry Hastie	Director of Finance and Corporate Resources	Place	04/09/2018	05/09/2018
Janice White	Team Leader, Legal Services	Place	04/09/2018	05/09/2018
Gail Quinton	Deputy Chief Executive	People	04/09/2018	04/09/2018
Councillor F. Abbott	Cabinet Member (Adult Services)		0309/2018	06/09/2018

This report is published on the Council's website:

www.coventry.gov.uk/meetings

Appendices
Adult Social Care Annual Report Summary 2017/18 (Local Account)

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ADULT SOCIAL CARE ANNUAL REPORT 2017/18

(LOCAL ACCOUNT)

Coventry City Council

www.coventry.gov.uk

CONTENTS

WHAT IS THE LOCAL ACCOUNT?

Every year Coventry City Council produces a report which tells people what its Adult Social Care service is doing to help improve the lives of vulnerable people and how well as a service it is performing.

This report is usually referred to as the 'Local Account' but is also referred to as the 'Annual Report' for Adult Social Care.

We hope you find this account of interest and that it provides you with an insight into Adult Social Care in Coventry and the work that is being done to further improve.

FOREWORD

PETE FAHY

DIRECTOR OF ADULT SERVICES

The production of this Report remains an important landmark in the annual cycle of Adult Social Care. It provides an opportunity for honest reflection on the achievements and challenges we face in delivering Social Care within the City.

In producing this annual report we have deliberately focussed on what we have done and are doing to improve – this is important and deliberate within an environment where much of the debate on Adult Social Care is dominated at a national level by debates on funding and financial sustainability or issues such as Delayed Transfers of Care (DTOC). Of course these are important issues but we should also highlight and reflect on the many examples of what is done to support people to live independently that will never reach the headlines.

As well as looking back over 2017/18 we also need to be cognisant of what lies ahead: in particular the impact of the expected Green Paper and the continued drive for closer working with our health partners, plus the future of the Better Care Fund which has provided an essential injection of resources for Adult Social Care nationwide. As always it is practically impossible to predict what the future holds but whatever is in store for the sector we will continue to work to provide the best possible support available to people within the resources we have available.

I hope you find this Annual Report informative and as always myself and my team are happy for any feedback.

COUNCILLOR FAYE ABBOTT

CABINET MEMBER FOR ADULT SERVICES

I am pleased to introduce this Annual Report for Adult Social Care. Social care is an important issue for everyone and Coventry City Council is committed to helping our most vulnerable people, their families and carers to get help as soon as they can.

This report has been written so that local residents, people with care and support needs and carers can understand more about the support provided to adults and older people and their carers in Coventry.

In this report we take the opportunity to tell you about what we have done in the last year, how we have spent our budget, and what you have said about the services and advice we provide. We have set out our future plans for improvement and you will see that there is a lot of great work going on.

This report includes some incredibly positive stories, but we continue to face financial pressures and have seen an increasing complexity in people's needs. We continue to work hard to find new and innovative ways to enable people to get the right support that meets their needs. To meet the challenges we face we will need to focus more on prevention and well-being. Access to universal services and early help and preventative support will be an important part of this approach. This will improve outcomes for local people and promote better use of Adult Social Care resources.

Please do get in touch if you would like to provide feedback on the Annual Report by emailing **abpd@coventry.gov.uk**

INTRODUCTION: ABOUT ADULT SOCIAL CARE

Adult Social Care is part of the People Directorate within Coventry City Council. The People Directorate's vision is 'working in partnership to improve the life chances of all and protect the most vulnerable'.

In 2016 we established a simple vision and strategy which underpins the principles of Adult Social Care, and we continue to work in support of this. This describes what we are trying to achieve, our purpose and our approach.

In a simple sense all of our work, at whatever level should continue to support the strategy of: 'Providing support, in the least intrusive manner possible, based on the assets, resources and abilities that are available to people'.

A significant event for social care and its health partners in 2017/18 was the system review undertaken by the Care Quality Commission. There is more on this later in the report but one of the findings was that staff understood their role in supporting people to be independent at home – this is a real positive in confirming that our simple approach to strategy is understood and creates a meaningful purpose for those who work in Adult Social Care.

ASC VISION

Adult Social Care supports people aged 18 and over who have care and support needs as a result of an illness or impairment.

Support is also provided to carers who spend time providing necessary care to someone else. We continue to work in accordance with our primary legislation the Care Act (2014) and the required changes to practice and policy set out by the Act. The Act required improvements when people first make contact with us, and how we assess people and plan their support.

The delivery of Adult Social Care in Coventry, as embodied in our vision is that we focus on approaches that promote well-being and independence to prevent, reduce or delay the need for long term support and to enable people to achieve their outcomes. In performance terms this means that we would expect to see a relatively smaller number of people in receipt of ongoing social care, and where ongoing social care is required that this is mainly provided in peoples own homes. We would also expect that the short term services we have in place to enable people to be independent are successful in reducing demand for ongoing Adult Social Care.

FACTS AND FIGURES

SUPPORTING PEOPLE WITH ONGOING CARE AND SUPPORT NEEDS

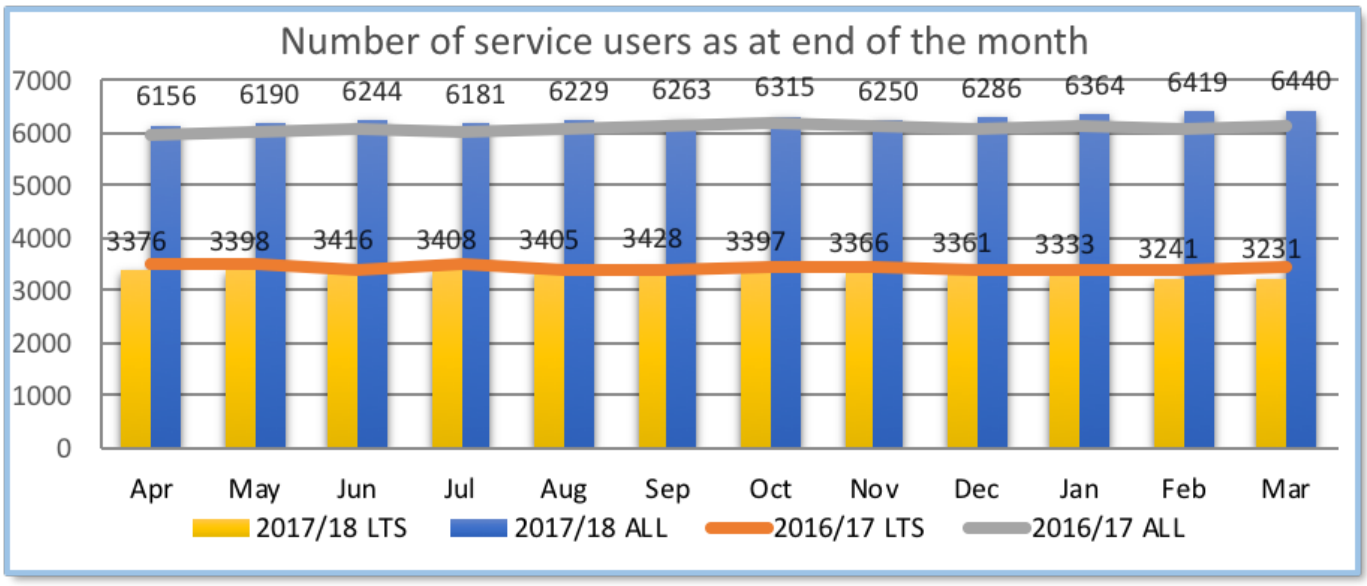
There has been an increase of 6% in new requests for Adult Social Care support from 9,691 in 2016/17 to 10,330 in 2017/18. However there has been a reduction in numbers of people supported during the year (down 4% from 4,531 to 4,343) which continues the downward trend over the past three years.

There is no single identified reason for this but it is likely to be explained by a combination of factors, including increased awareness of Adult Social Care and taking an approach that works with people to meet eligible needs in ways other than the provision of services.

Another reason behind this is that there has been a continued increase in people who received Short Term Support to Maximise Independence (STSMI) in comparison to 2016/17, with the same proportion of people continuing to live at home following the end of this support (75%).

Over the same period the level of delays from hospital that are due to Adult Social Care have also reduced. Our performance has remained below the national targets we are expected to work to.

TABLE 1: PEOPLE IN RECEIPT OF ONGOING SUPPORT



Based on CareDirector data only. LTS = people receiving long term support only. ALL - includes low level support and excludes carer services

The number of people accessing any level of support has seen a 3% increase over the course of 2017/18. However there has been a decrease of 2% in the number of people accessing long term ongoing support, which over the past three years is a continued downward trend.

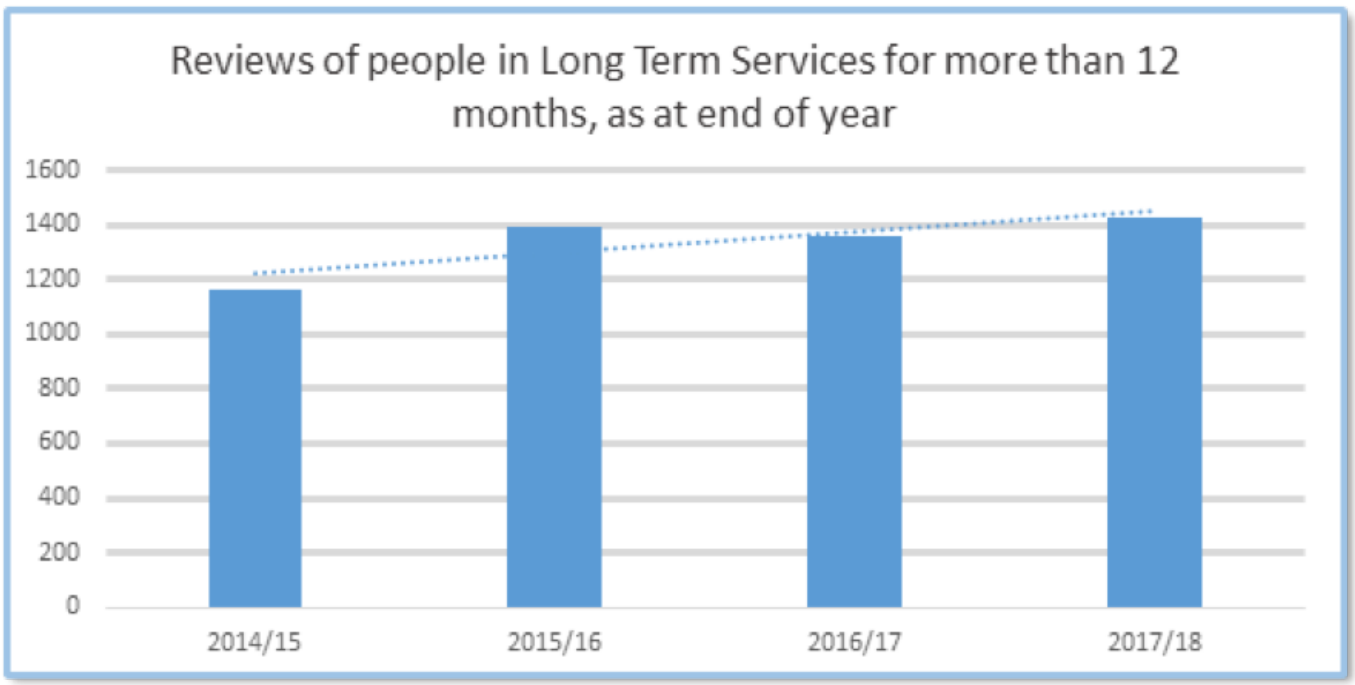
There were 3,230 people receiving ongoing long term adult social care support as at 31 March 2018, of which 75% (2431 people) had received support for over 12 months.

The number of planned transitions from Children's Social Care continued to increase over the past three years, with 59 young adults transitioning in 2017/18 compared to 55 in 2016/17.

COMPLETION OF REVIEWS

The proportion of people in ongoing support for over 12 months who were reviewed increased from 51% to 59% in 2017/18. We have ensured we respond to reviews concerning any changes in circumstances, which are often more challenging than a review undertaken where nothing has changed.

TABLE 2: REVIEWS OF PEOPLE IN RECEIPT OF ONGOING SUPPORT

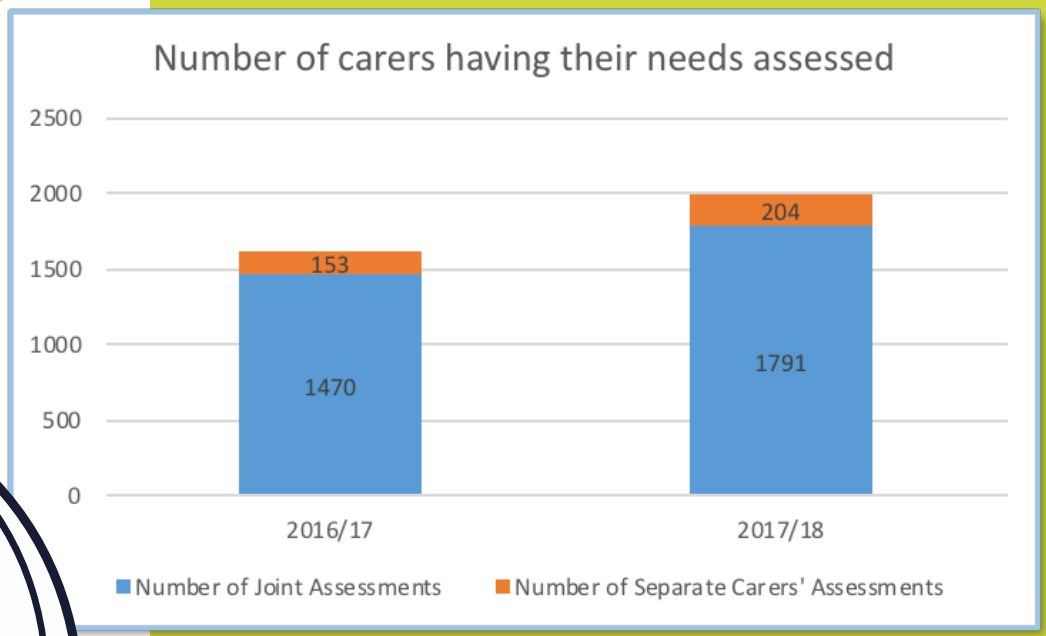


SUPPORTING CARERS

Carers are one of the greatest assets of Coventry and supporting carers to get the support they need, when they need it, is integral to the delivery of effective Adult Social Care.

This year there has been an increase in both the amount of Joint Assessments (where a carers' needs have been assessed alongside the needs of the person they care for) and a rise in separate Carers' Assessments, which is reflective of the overall increase in requests for initial support. The increase in separate carers' assessments is a positive reflection that carers' needs are being considered and planned for on an individual basis.

TABLE 3: NUMBER OF CARERS HAVING THEIR NEEDS ASSESSED



PEOPLE ACCESSING ANY LEVEL OF SUPPORT HAS SEEN A

3%

INCREASE OVER THE COURSE OF 2017/18.

There continues to be a change in how carers' needs are met with a continued reduction in the provision of Carers' Direct Payments and evidence of many carers' needs being met with the provision of good quality and robust advice and information. Working closely with the Carers Trust Heart of England has been key to making sure this is delivered.

AN INCREASE OF

8%

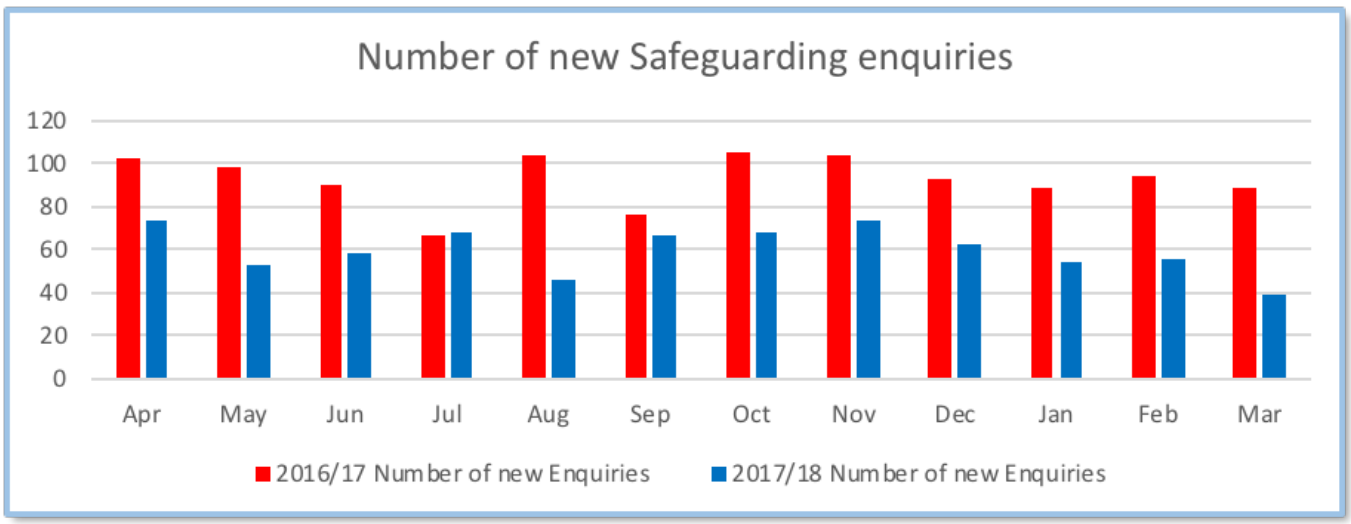
IN SAFEGUARDING CONCERNS

SAFEGUARDING

The number of safeguarding concerns continues to rise year on year to 3359 in 2017/18, an increase of 8% in comparison with last year. Coventry has a higher rate of safeguarding concerns per 100,000 population than comparators. The number of new safeguarding enquiries started in the year has reduced by 35% from 1106 in 2016/17 to 717 in 2017/18. As a result, the conversion rate from concern to enquiry, (where further investigation is required) has reduced from 36% in 2016/17 to 21% in 2017/18. The number of enquiries that has been completed during the year has decreased by 41% from 965 in 2016/17 to 570 in 2017/18, due to the reduced number of enquiries started in the year. This indicates that we are addressing more safeguarding issues at the point they are raised therefore not requiring further investigation.

There was an increase in the proportion of people asked about their desired safeguarding outcomes from 55% in 2016/17 to 78% in 2017/18, which is above the 2016/17 England rate of 67%. Coventry has increased the percentage of fully achieved/ partially achieved outcomes from 89% in 2016/17 to 97% in 2017/18 which is slightly above the 2016/17 England rate of 95%.

TABLE 4: SAFEGUARDING ENQUIRIES



DEPRIVATION OF LIBERTY SAFEGUARDS (DoLS)

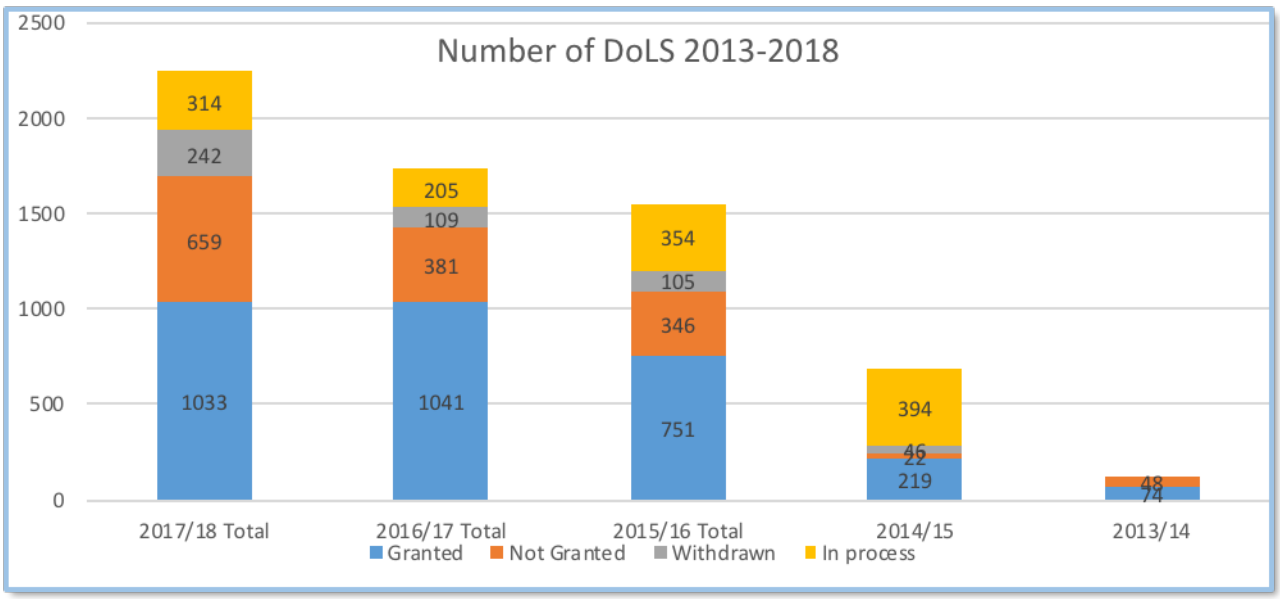
The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. The safeguards aim to make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom.

There has been a 29% rise in the number of DoLS applications from 1736 in 2016/17 to 2248 in 2017/18. Of these, 314 (14%) are in due process compared to 205 (12%) in 2016/17. There is a significant increase in number of applications, but considering higher number of applications received, the percentage of not completed applications remained similar.

In total in 2017/18 1934 applications were completed which is a 26% increase on 1531 in 2016/17. Despite the demand for DoLS increasing and the subsequent resource challenges, we had relatively low rates of decisions outstanding and cases open at the end of the year.

As well as new DoLS applications there is also the requirement to review existing DoLS arrangements on an annual basis. The review requirement grows year on year as new applications grow. Resourcing this area of activity is of ongoing concern and will be subject to review to ensure we are meeting our legal duties in the most effective manner possible.

TABLE 5: DoLS TRENDS AND DIFFERENCES FROM 2013/14 – 2017/18

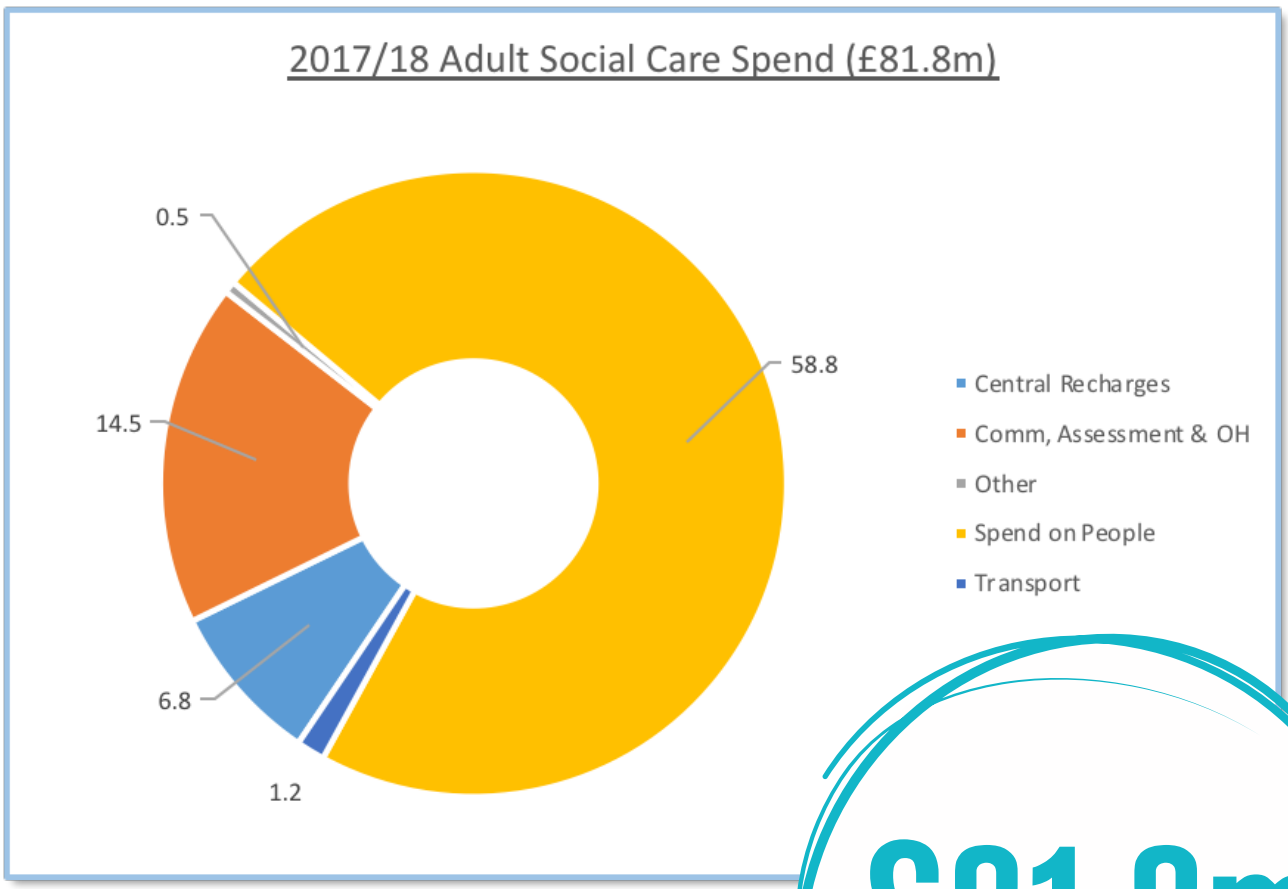


MONEY - COVENTRY CITY COUNCIL

The Council is a large organisation spending a net £230.9m on revenue activity during 2017/18.

The Adult Social Care spend in 2017/18 net of service user contributions was £81.8m as shown below.

TABLE 6: 2017/18 ADULT SOCIAL CARE SPEND (£81.8M)



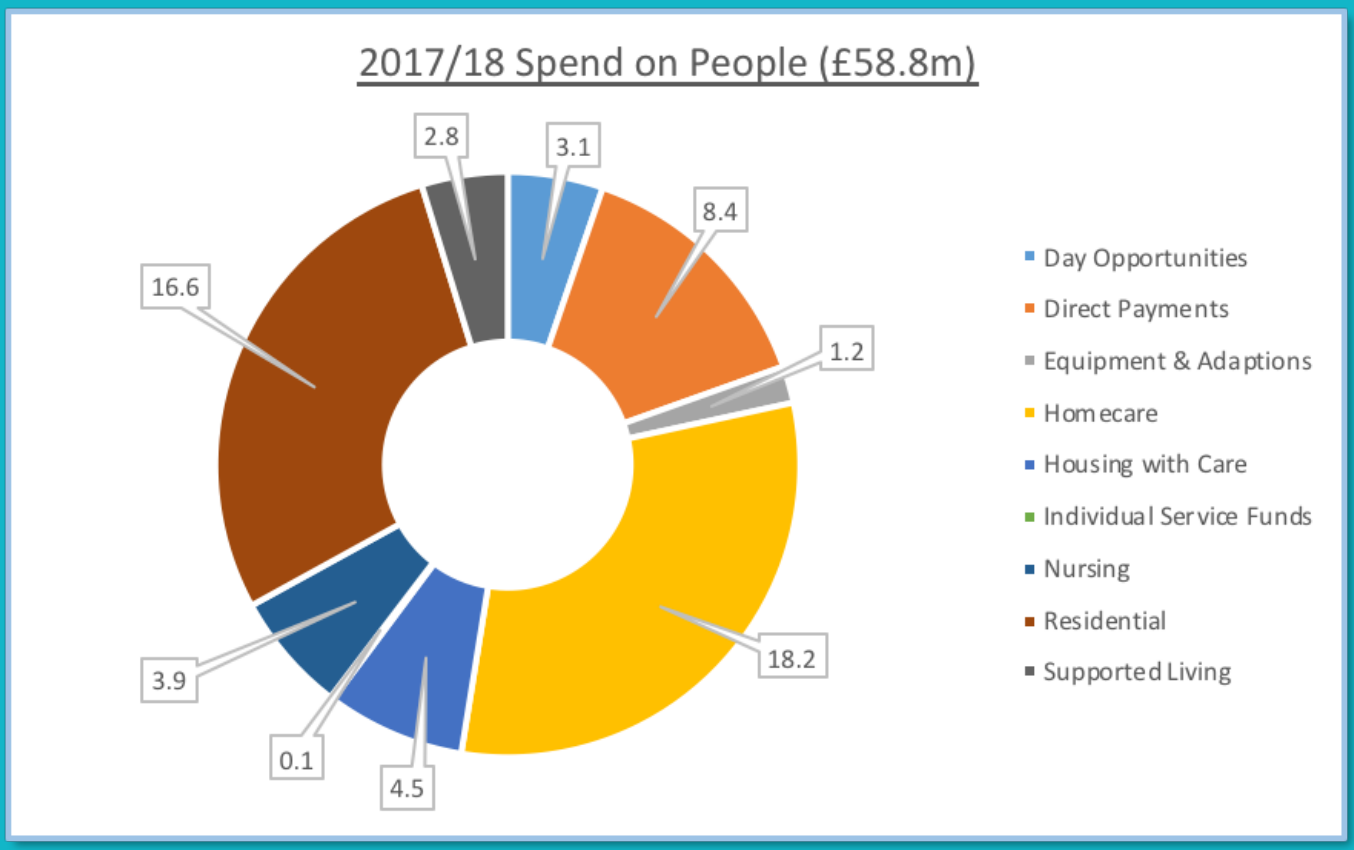
£81.8m

2017/18 NET ADULT SOCIAL CARE SPEND

This compares to a spend of £78.1m in 2016/17. The increase was largely due to increases in care costs brought about by the National Living Wage.

The 'Spend on People' referred to in the above chart has increased from £56.5m in 2016/17. 'Spend on People' is money spent directly on the following services:

TABLE 7: 2017/18 SPEND ON PEOPLE (£58.8M)



This increase in spend was incurred despite the reduction in total numbers of people in receipt of ongoing care and support and is a result of increasing costs of care as a result of external factors including National Living Wage and the complexity of the care needs that people are experiencing.

In 2017/18 the Council underspent its Adult Social Care Budgets by £1.2m.

DRIVERS OF DEMAND

Understanding potential demand for Adult Social Care is important in understanding what is required to meet the changing needs of our population.

Other key publications such as the Joint Strategic Needs Assessment (JSNA) helps identify future need, which is generally driven by a number of factors including:

- Coventry has a relatively young population but the number of older residents is increasing and the age of the population will start to increase. In particular, those aged over 85 and over is expected to grow by 22% in the next 10 years.
- The increasing number of older residents is related to increasing life expectancy amongst Coventry residents. However, on average Coventry residents are living a significant period at the end of their life in poor health.
- As the population ages more people will be living with multiple health conditions that require support.
- The numbers of people with severe physical or learning disabilities living into adulthood will continue to increase as life expectancy increases.
- The levels of deprivation in the city, although improving will remain relatively high and those living with lower levels of wealth are more likely to develop poor health.
- There is a projected 21% increase in the number of those aged 75 years and over between 2017 and 2025 who will be living alone. Those who are socially isolated are between two and five times more likely to die prematurely than those with stronger social ties.

PROJECTED

21%

INCREASE IN THE NUMBER OF THOSE AGED 75 YEARS AND OVER BETWEEN 2017 AND 2025 WHO WILL BE LIVING ALONE

With demand expected to increase we will continue to look for ways to manage this demand and deliver the aspirations of our strategy through developing initiatives.

Approaches such as greater use of technology, focusing on people's strengths and what they can do for themselves, or be supported to do by families, friends and relatives along with the increasing the use of promoting independence models in order to reduce requirements for ongoing care and support.

WORKFORCE
AS AT 31 AUGUST 2017

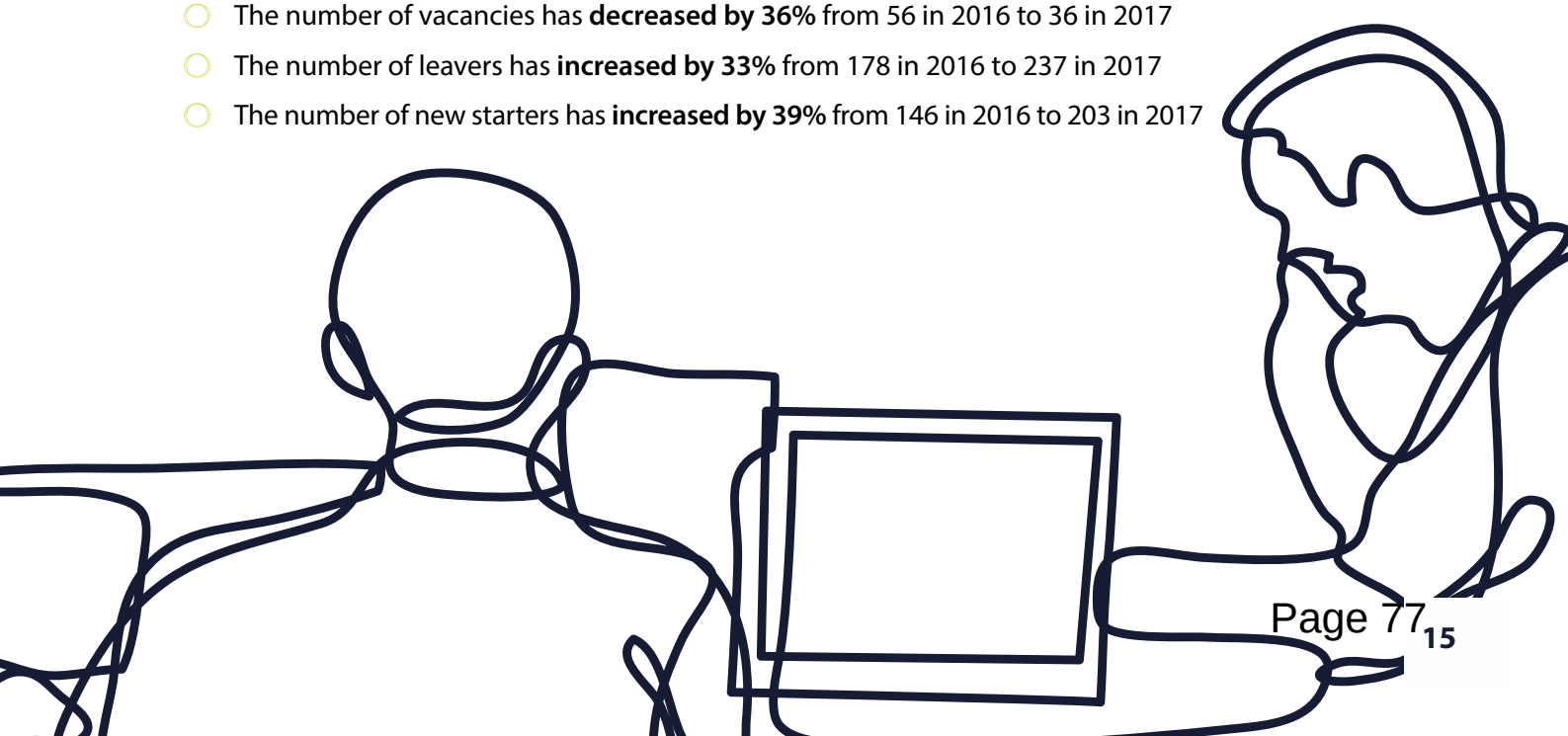
The number of people in the Council's internal Adult Social Care workforce has reduced by 9.6% from 952 to 861 in 2017, this reflects an 8% reduction when compared with the Full Time Equivalent (FTE) figure. This reduction in workforce is consistent with the national profile where since 2009, local authority jobs have moved to the independent sector.

Demographically the make-up of the Council's Adult Social Care workforce has stayed approximately the same as in 2016, with 82% being female, (the same percentage as the Personal Social Services: Staff of Social Services Departments, England national statistics.) and 3% disabled (no comparison national statistic available). There has been an increase in the workforce aged over 50 years of age from 46% in 2016 to 52% in 2017. However, overall the average age of the adult social care workforce is 48 years, similar to the average age of workers in adult social care departments within Local Authorities which was 47 years, and has not changed since 2011.

Ethnicity breakdown remains similar to 2016 with 77% of the workforce being white, 21% from a black or minority ethnic (BME) background and 2% are not known. This compares with 26.9% of Coventry's 18-64 population being BME (2011 Census). Ethnicity varies significantly between regions- from 50% of London local authority adult social care workforce to 2% in the North East- so comparison with the local population is more relevant than the national average of 85% white and 13% BME.

Other information:

- The number of vacancies has **decreased by 36%** from 56 in 2016 to 36 in 2017
- The number of leavers has **increased by 33%** from 178 in 2016 to 237 in 2017
- The number of new starters has **increased by 39%** from 146 in 2016 to 203 in 2017



KEY ACHIEVEMENTS
BASED ON THE ADULT SOCIAL CARE VISION AND OUR PRIORITIES FOR 2017/18

1. ADULTS AND CARERS AT THE HEART OF EVERYTHING WE DO

ADULT SOCIAL CARE STAKEHOLDER REFERENCE GROUP

Our Stakeholder Reference Group was created in 2016. The role of the group is to get involved in shaping future service delivery.

During the last year, a key focus of the group has been to work with our strategic commissioning team to recommission support provided by voluntary sector agencies to help people live well and independently. The group has been involved in evaluating the applications received and providing vital feedback on proposals for future services. Where the group had questions about proposals these were put to the providers and the responses informed the decision-making process. The new voluntary sector support arrangements will last for five years and offer greater flexibility of support to meet people's needs.

A recent meeting of the Adult Social Care Stakeholder Reference Group

Looking forward to 2018/19 the group will be involved in improving service delivery through contributing to the implementation of the Care Quality Commission Local System Review action plan.

The group is keen to encourage more people to be involved. If you currently receive support from Adult Social Care or are a Carer and might be interested in joining the group please read our leaflet **www.coventry.gov.uk/getinvolvedasc** or contact us by email to **getinvolvedasc@coventry.gov.uk**

DEVELOPING OUR APPROACH TO CARERS

In 2017/18 voluntary sector services were reviewed with the scope of offering support at the earliest possible opportunity to those most requiring it. Carers were integral to the recommissioning process and a key priority area. The Carers Trust continue to provide services for carers rebranding their service as the Coventry Carers Wellbeing Service, marking a reflection in their focus on wellbeing and their holistic approach to meeting carers' needs. They have increased their opening hours to further meet the needs of Coventry's carers who may struggle to access their services during working hours. The Alzheimer's Society now have additional capacity to facilitate the Carers Information and Support Programme, a very valued programme for carers of adults with dementia.

2. HIGH QUALITY, PERSON-CENTRED AND EFFECTIVE SUPPORT

MAKING SAFEGUARDING PERSONAL

In 2016/17 a "Making Safeguarding Personal" (MSP) project was undertaken in Adult Social Care, which included developing a MSP Toolkit for staff. An evaluation of the project was undertaken by Coventry University. Both the toolkit and the evaluation are available on the Council website: **http://www.coventry.gov.uk/info/158/safeguarding_adults/2785/my_safeguarding_experience**

The evaluation identified that there had been a positive impact on practice in relation to mental capacity and the use of advocates. We received feedback though that we needed to ensure our forms were more supportive of person centred practice so in 2017 we introduced a new suite of safeguarding forms developed in conjunction with our practitioners. We also heard that we needed to promote more timely and appropriate referrals for advocacy. We therefore held a number of training sessions with Adult Social Care teams alongside one of our Advocacy Providers; Grapevine. In 2018/19 we intend to develop Risk Enablement Panels and Family Group Conferencing to support the Making Safeguarding Personal agenda.

As a local authority we are also a key statutory partner of the Coventry Safeguarding Adults Board. We work closely with other Board members and have supported the development of a Coventry wide Safeguarding Workforce Strategy.

The Board also organises conferences to raise the profile of Adult Safeguarding. On 9 November 2017 the Board held a conference entitled 'Safeguarding at the heart of everything we do'. This event provided a great opportunity to reflect on how all partners are working together to make safeguarding personal. **http://www.coventry.gov.uk/info/233/coventry_safeguarding_adults_board/3168/workforce_development/4**

TRANSFORMING CARE

Adult Social Care has continued to work in partnership with other agencies to take forward the Transforming Care agenda supporting adults with learning disabilities. This has included signing up to Care and Treatment Reviews (CTRs). These form part of NHS England's commitment to transforming services for people with learning disabilities, autism or both.

The All Age Disability Service has assisted in both discharge and admission avoidance for adults with complex health and social care needs and continues to play a key role in the multi-agency process that exists in Coventry.

New processes and services have been introduced during the last 12 months to support individuals with a focus on professional staff working together to reduce the risk of hospitalisation and to ensure that discharge arrangements are robust and achieve the required outcomes.

Delivering the requirements of the Transforming Care Programme is a key challenge for social care and its health partners. Although 10 people have been discharged in 2017/18 there were 12 admitted. As a result of this, along with size of the original baseline, we are not meeting the trajectory required by NHS England. There are, however, recovery plans in place, the delivery of which is closely monitored through the programme board in place to oversee this work.

THERAPY AND ENABLEMENT SERVICES

Our Occupational Therapy and Visual and Hearing Impairment (VHI) teams play a key role in helping people of all ages to overcome the effects of disability caused by illness, ageing or accident, so that they can carry out everyday tasks or activities important to them. Often before someone has a need for traditional forms of care and support our staff will provide practical solutions to support recovery and overcome any barriers that prevent them from doing the activities that matter to them. This may be achieved by simply helping to identify local support networks, by providing a period of rehabilitation, provision of equipment or adaptation of the home. Our goal is to support people to live as fulfilled lives as possible and not to just exist!

CASE STUDY 1 – MRS H

Mrs H has acquired hearing loss and is unable to hear speech over the telephone. She uses lip reading and speech to communicate. Mrs H contacted the Visual and Hearing Impairment (VHI) team asking for provision of a minicom/text phone to enable her to contact her GP herself rather than asking her family to do so.

A member of the VHI team advised her of the Next Generation Text Service (NGTS). This allows users to make text calls through an application on tablets/mobile phones and they arranged to visit to explain how the service worked.

With support from the VHI Team to install the NGTS application on her mobile phone and to practice using the service Mrs H has been able to contact her GP surgery independently. Mrs H plans to use the NGTS application to contact other services like the bank and utility companies.

Support from the VHI team enabled Mrs H to utilise equipment she already owns to increase her independence. This is an example how technology is progressing rapidly and simple things like a smart phone can unlock a whole new breadth of support.

3. REFLECTIVE AND RESPONSIVE TO CHANGE

VOLUNTARY AND THIRD SECTOR SUPPORT

During the year a major reshaping of preventative health and social care services provided by the voluntary sector was undertaken with the new arrangements commencing on 1 April 2018. The grant funded arrangements are more outcome focussed and based on longer term agreements giving more certainty to customers and providers. There are also opportunities for closer partnership working between the Council, Coventry and Rugby Clinical Commissioning Group and providers. The new arrangements also enabled the commissioning of a new service to improve the lives of people with compulsive hoarding behaviours.

NEW HOME SUPPORT ARRANGEMENTS

In June 2017 new home support arrangements came into effect within Coventry. Nationally it is recognised that the home support industry faces significant challenges especially with recruitment and retention of their workforce. Coventry also face the same challenges locally. The New Home Support framework was recommissioned with the aim of improving quality and performance. This has led to a reduction in waiting times for services to start. The new services are based in local areas, meaning a greater understanding of the needs of local communities. Providers are required to use Electronic Call Monitoring Systems, which enables the provider and the local authority to monitor care workers visits, duration of visit and timeliness.

In order to ensure continued quality and improvement we are working closely with our providers. These arrangements include regular provider forums and contract meetings. In 2018/19 the aim is to embed accreditation approaches such as React to Red within home support.

4. OUTCOME DRIVEN AND MEANINGFUL

INITIAL CONTACT WITH SOCIAL CARE

Building on the successes of last year, with the launch of the online self-assessment tool, an online Carers' self-assessment was launched in January 2018. Working closely with the Carers Trust Heart of England, processes have been developed to ensure carers are linked to the most appropriate support at the earliest opportunity. The online support is aligned to the pre-existing Adult Social Care information directory, ensuring the public have consistent access to information about services available in the city.

Internal improvements have seen the implementation of the social worker appointment booking system. When a member of the public requires a visit from a social worker they are given an appointment date and time. The benefit for the public is that people know when they can expect a visit, reducing any anxiety they may have when they are waiting for a social worker to make contact. The system has initially been implemented with the older people social work teams with plans for 2018/19 to include Occupational Therapy and the Adults Disability Team.

THE POD

'The Pod' uses social brokerage as a means to support and transform the lives of people with severe mental illness whilst also benefitting the wider community with its cutting edge and ambitious programming. This year it relocated from its base at Lamb Street to a Grade 2 Listed medieval building in Far Gosford Street. This new location in Far Gosford Street is perfect for The Pod – it's a cultural corridor where creativity can underpin practical help for citizens and inspire social activism. The building and its location supports all aspects of the work that The Pod team do – facilitating mental health recovery, promoting cohesion, addressing food poverty and stimulating regeneration. It is street facing and the space alone creates a reason for people to feel optimistic and believe in themselves and the city.

In 2017 Think Local Act Personal (TLAP) and the National Development Team for Inclusion published a report detailing The Pod's evolution since 2009 and continued commitment to transformative practice: **https://www.thinklocalactpersonal.org.uk/Latest/Lamb-Street-to-the-Pod-The-Journey-from-Service-Users-to-Citizen/**

5. SUPPORT AROUND PEOPLE AND THEIR FAMILIES

TRAVEL TRAINING

The Independent Travel Team has been established in Coventry since 2006. They are a small team with four Travel Trainers offering travel training to young people from 11 years old onwards with Education, Health and Care Plans, and people over 18 with identified care and support needs.

The Independent Travel Team offers a city-wide service, working in schools, colleges and in the community.

Starting in 2017/18 the Team now supports the Promoting Independence Service that has been introduced for Adults with a Learning Disability and has supported individuals to achieve independence within and outside of the city boundary. The service has successfully supported adults with learning disabilities to engage in employment, activities, volunteering and supported carers to return to work.

The service works with 48 people (12 Adults/36 young people) at any one time and in 2017/18 has supported approximately 30 people to travel independently. In many cases this has transformed people's lives.

CARE CLOSER TO HOME

The Council's All Age Disability Team has continued to extend the principles of supporting individuals to consider care options nearer to home and families. This has built on the good practice outcomes from the long term care initiative funded though the Better Care Fund. We have worked across services to develop local options and now have in place a plan to assist users back into Coventry and into supported living. We have seen the benefits of this in terms of the impact on emotional wellbeing and more independent living.

CASE STUDY 2 – MR B

Mr B is a 19-year-old man with learning disabilities and autism who attends a local college. He worked extensively with a Travel Trainer to learn the bus route from his home to college. The support included learning about the practicalities of independent travel, recognising the bus stop, using a bus pass and flagging down a bus. This also included supporting him around keeping himself safe, who are safe people to offer help if required and contingency planning for "what if" scenarios that might affect his journey.

The team supported Mr B for six months. His mother previously drove him daily to get to and from school and then college. Following the period of support from the travel training team Mr B was independent with the route to college and his mother was able to seek employment for the first time in 16 years.

The Travel Trainers worked again with Mr B as part of the Learning Disability Promoting Independence Service. Mr B is learning a new bus route from his home address to a local gym. This will support him to participate in activities outside of college, in his leisure time, improving his fitness and enabling him to make friends and make good use of community facilities.

The outcomes for Mr B and his mother have been hugely positive. Travel training with Mr B has reduced transport costs to college and will continue to promote his future independence as he develops his skills further.

IN 2017/18 THE SERVICE HAS SUPPORTED APPROXIMATELY

30 PEOPLE

TO TRAVEL INDEPENDENTLY

6. EFFECTIVE ENABLEMENT, PREVENTION AND WELL-BEING

PROMOTING INDEPENDENCE PATHWAYS

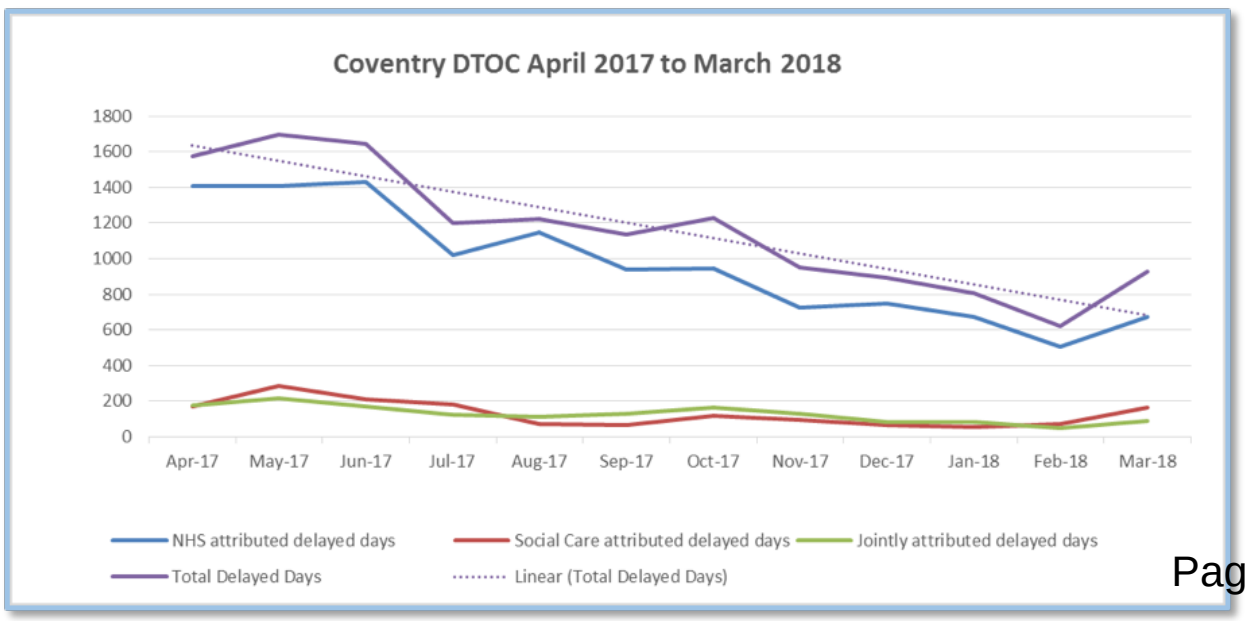
We have established a new service for older people and adults with a physical disability which provides short term support to help individuals regain their independence e.g. after a period of illness. We all want to carry on doing things for ourselves so a team of Occupational Therapists, Social Workers and home support workers help individuals to regain confidence in carrying out specific essential tasks of everyday daily living. After receiving support, we have found that many people don't need any further help, or only a little, so they can carry on living independently in their own homes. In the first six months since the service started there have been 108 people referred. A total of 66 people referred to the service did not go on to receive long term care. The service uses kitchen facilities at Gilbert Richards Centre that have recently been modified, to enable the Occupational Therapists to carry out kitchen assessments where appropriate and promote the person's independence.

We have established a new service for adults with a learning disability that supports the assessment of need and supports people to develop new skills. The principles we apply are very much the same as for all adults but the service is more specifically tailored to adults with learning disabilities. Delivering this is a 'whole service' approach across Occupational Therapy, Travel Training and internal provider services such as Jenner8 to support adults to try new things and to live as independently as possible. Since the pilot started in July 2017, in the first twelve months 88 people have been referred into the service and so far 12 people have successfully accessed support from the service.

DELAYED TRANSFERS OF CARE (DTOC) AND ADMISSION PREVENTION

Once a person is admitted to hospital and they have finished their treatment, it is really important that they leave hospital in a timely manner before an individual risks losing essential skills. Working with partners we have improved our Delayed Transfers of Care performance and achieved national targets set for Coventry. Schemes including the Community Discharge Hub, Red2Green Campaign and new contracts with reablement providers helped us improve our performance. We have supported care homes with good primary care services and initiatives including "React to Red Skin". The aim of this campaign is to educate as many people as possible about the dangers of pressure ulcers and the simple steps that can be taken to avoid them and to ensure these are put in place to avoid unnecessary hospital admissions.

TABLE 8: COVENTRY DELAYED TRANSFERS OF CARE



7. MATURE PARTNERSHIPS

WORKING WITH HEALTH PARTNERS TO DELIVER A SUSTAINABLE HEALTH AND SOCIAL CARE ECONOMY

We have continued our work to develop services and relationships with our key health partners and work in collaboration to develop joint solutions. Our work in relation to Delayed Transfers of Care has impacted positively on discharge activity so that people leave hospital as soon as they are able to the most appropriate setting for them.

We have well established discharge pathways from hospital and regular multi-disciplinary meetings to ensure that people get appropriate support when discharged, receiving the right short term services in order to reach their full potential in the longer term.

This, together with new preventative services, have supported people to avoid unnecessary admissions to hospital. This targeted use of the Integrated Better Care Fund has allowed us to develop, or extend, a number of initiatives to help people to remain safe and well in their own home and include transport services, home safety checks, services to improve nutrition, community support, and home heating services.

Targeted use of Integrated Better Care Funding has also supported sustainability of the local care market to ensure viable and good quality services.

We have also progressed discharges under the Transforming Care Programme which has benefitted adults with a learning disability. We have established processes that support our staff to work across organisational boundaries for adults with a disability. Two new posts have been developed specifically to work with those most at risk of hospital admission as part of a multi-disciplinary team.

CARE QUALITY COMMISSION (CQC) LOCAL SYSTEM REVIEW

The Care Quality Commission (CQC) completed a review of the health and social care system between December 2017 and March 2018 within Coventry, to answer the question "How well do people move through the health and social care system, with a particular focus on the interface between the two, and what improvements could be made?"

The review concluded that Coventry is well situated to make further improvements given the already existing commitment from partners to work together. There was good evidence of effective leadership and commitment to improve services and support integration between Health and Social Care. The full report can be found on the CQC website at **Local system review: Coventry**. The Coventry Health and Wellbeing Board has led the development of an improvement plan to take on board the findings of the CQC review and ensure these are embedded as other system work progresses.

8. COMMITTED WORKFORCE

SUPPORTING OUR WORKFORCE

During 2017/18 we have developing a Workforce Strategy for Adult Services to ensure an increased focus on the workforce development needs within adult services. This is much more than training and includes recruitment, retention, development, workforce planning and practice development activities. **https://www.coventry.gov.uk/info/192/adult_social_care_strategies_policies_and_plans**

In support of practice development, we developed a new role of a Practice Development Social Worker. This role now co-ordinates and provides support to newly qualified social workers on the Assessed and Supported Year in Employment (ASYE). It also co-ordinates and supports social work student placements and the learning of those students within Adult Services.

Having specific capacity dedicated to practice development will help to strengthen the practice skills and knowledge of front line staff and managers, providing onsite learning and coaching. The role will also establish any existing gaps in knowledge and support for continued workforce development.

PRACTICE QUALITY ASSURANCE AND ENGAGING WITH OUR STAFF

In early 2017 we commenced the implementation of our Practice Quality Assurance Framework. This is a Framework which focuses on self-assessment and quality assessment methods at practitioner and organisational levels. Our practitioners now receive annual observations of their practice and dedicated time to reflect on their practice with their manager.

The aim of this work is to achieve greater consistency and accountability in the quality of the service we provide and put the right support and challenge in place to improve practice.

Our Framework also included the requirement to undertake an annual 'Organisational Health Check'. This was undertaken using a survey and focus groups with staff in the summer of 2017. This is an important way of ensuring that staff are listened to and that as an employer we are pro-active in tackling the issues that affect them. The Health check was well received and identified a number of strengths with staff positive about their supervision and being able to raise issues and concerns with their managers. We did however receive feedback that we needed to look at our assessment forms as these were felt to be too long. We have planned to look at this next year in 2018/19.

9. INNOVATIVE

NEW SERVICE FOR PEOPLE WITH DEMENTIA

The city has a new facility offering a purpose-built specialist Housing with Care Scheme (HWC) specifically for people either living with dementia or with a cognitive impairment. The scheme consists of 33 self-contained flats. Each flat consists of lounge, kitchen and a single bedroom with ensuite bathroom. The scheme also has communal living facilities to enable social interaction, one of the key principles of the Eden Alternative care model which underpins the scheme.

More information of the care model can be found here: **http://www.edenalt.org/about-the-eden-alternative/mission-vision-values/ https://www.thegreenhouseproject.org**

This innovative model moves away from the traditional HWC models of support and provides a more structured approach to enable people living with dementia to live independently in a safe environment. There are a very limited number of such schemes across England adopting this approach, putting Coventry in the forefront of innovative services for people living with dementia.

CASE STUDY 3 – MRS C

Mrs C has Alzheimer's disease. She lived at home on her own with her dog and has a supportive son.

Mrs C often became very anxious resulting in her contacting her son up to 40-50 times every day, including during the night. This had a huge impact on his working life. Mrs C had stopped cooking and wasn't reliably taking medication. Telecare and homecare was unsuccessful. The main issue was the high levels of anxiety which impacted on Mrs C's level of confusion and her need for constant reassurance.

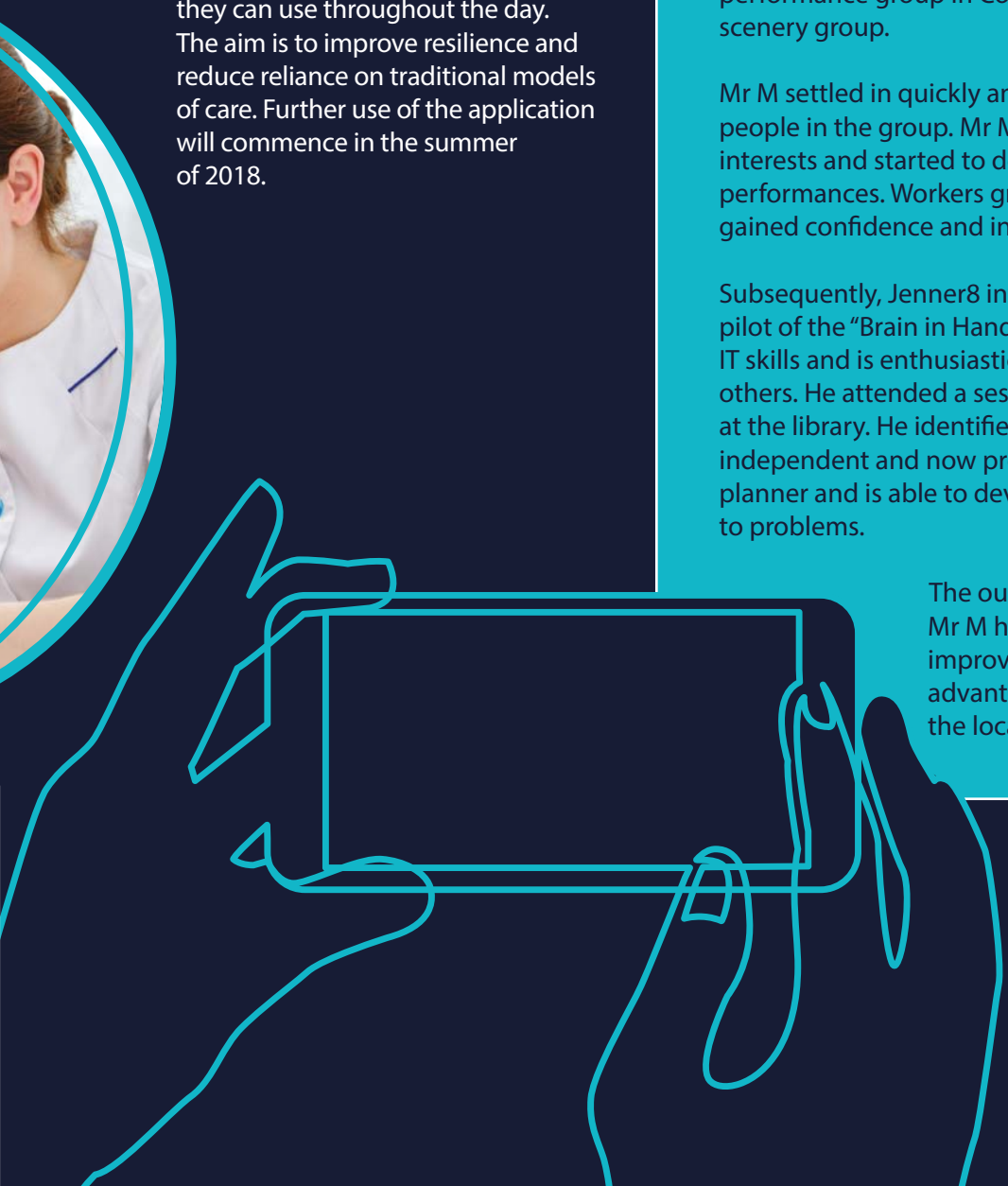
Her son felt the only option was residential care. The specialist Housing with Care (HWC) provision was suggested as an alternative as Mrs C wished to be more independent. Residential care would have also meant her no longer living with her dog which is very important to her.

Mrs C and her dog moved into the specialist HWC. Her son has stated the change has been "unbelievable" & "incredible". Since moving, Mrs C no longer rings her son as regularly. She states she is really happy and a lot less anxious. Living with her dog has been vital and the dog is much loved by other tenants, supporting Mrs C to make new friendships.

Mrs C has started cooking again and getting her own meals and is now taking her medication with the aid of a telecare medication dispenser. Mrs C and her son feel her mental health and memory have actually improved as she is a lot less anxious. She states she is reassured by the presence of staff and she knows they are there if she needs them. She is now far more independent, has regained skills and is a lot happier.

INNOVATIVE USE OF TECHNOLOGY

The use and benefit of technology in the social care sector is increasing. With the introduction of smart technology that enables real time monitoring and assessment of an individual's condition there is a significant opportunity to expand the way we use digital innovations to support the people of Coventry. In early 2018 software known as "Brain in Hand" was identified as an alternative support mechanism to more traditional arrangements. The application enables people who have cognitive impairments to create prompts and coping strategies that they can use throughout the day. The aim is to improve resilience and reduce reliance on traditional models of care. Further use of the application will commence in the summer of 2018.



CASE STUDY 4 – MR M

Mr M has a mild learning disability. He was referred to the Jenner8 Project, a promoting independence service. He was described as socially isolated during his days off from college. Mr M preferred to stay upstairs, researching his favourite hobbies on his tablet computer. He did not travel independently.

Jenner8 staff met with Mr M and his family, to explore what he wanted to achieve. He was restricted because he couldn't travel independently. He wanted to get involved in the performing arts.

Mr M commenced travel training with the Independent Travel Training Team alongside the support of Jenner8 so that he could attend a theatre performance group in Coventry, joining the stage scenery group.

Mr M settled in quickly and started to talk with other people in the group. Mr M met people with common interests and started to develop ideas for the next performances. Workers gradually withdrew as he gained confidence and independence.

Subsequently, Jenner8 invited him to take part in the pilot of the "Brain in Hand" application. He has good IT skills and is enthusiastic about sharing them with others. He attended a session about the application at the library. He identified that he wanted to be more independent and now programmes his own personal planner and is able to develop his own solutions to problems.

The outcome of the support is that Mr M has been able make choices to improve his independence and take advantage of opportunities within the local community.

10. HIGH PERFORMING

ADULT SOCIAL CARE OUTCOMES FRAMEWORK (ASCOF)

Coventry's performance across the Adult Social Care Outcomes Framework (ASCOF), which reports across a range of national annual indicators, has been maintained. There has been improvement in four performance measures, 12 have remained at a similar rate to last year or had declined slightly in line with the target set for the year and four measures have declined and are below target.

Performance has improved in four measures:

- Reducing the number of admissions into nursing/residential care for people aged 65+
- Reducing the rate of delayed transfers of care from hospital per 100,000 population for all delays
- Reducing the rate of delayed transfers of care from hospital per 100,000 population for adult social care/joint delays;
- Increasing the proportion of people still living at home, following Short Term Services to Maximise Independence

These four key performance measures monitored through the Better Care Fund programme, evidences that our focus for 2017/18 has been successful in driving through improvement in these areas. Performance has improved as a result of our focused attention on effective enablement, prevention and well-being and continued effective working with health partners.

Performance has declined and we have not met our target in the following four measures:

- Proportion of people who use services who have control over their daily life
- Proportion of carers receiving self-directed support
- Proportion of carers receiving direct payments for support direct to carer
- Proportion of people who use services who find it easy to find information about services.

A key action identified for 2018/19 is to improve the customer experience at initial points of contact and to update all our public information which we hope will impact positively on the results of people who use our support satisfaction surveys.

IMPROVED INTERNAL PROVISION AND RATINGS

The Council continued to receive "good" ratings from the Care Quality Commission across its internal directly provided care services. These services include two care homes (one for people with dementia and one for adults with learning disabilities), six housing with care schemes, a 'Promoting Independent Living Service' that supports people with learning disabilities in their own homes and an established Shared Lives Scheme that provides support for a number of adults and older people to reside within a family home environment.

Services have been inspected against the five key areas: i.e. Safe; Effective; Caring; Responsive and Well-Led. All of our internally proved services have achieved "good" ratings in all of these areas in recent inspections.

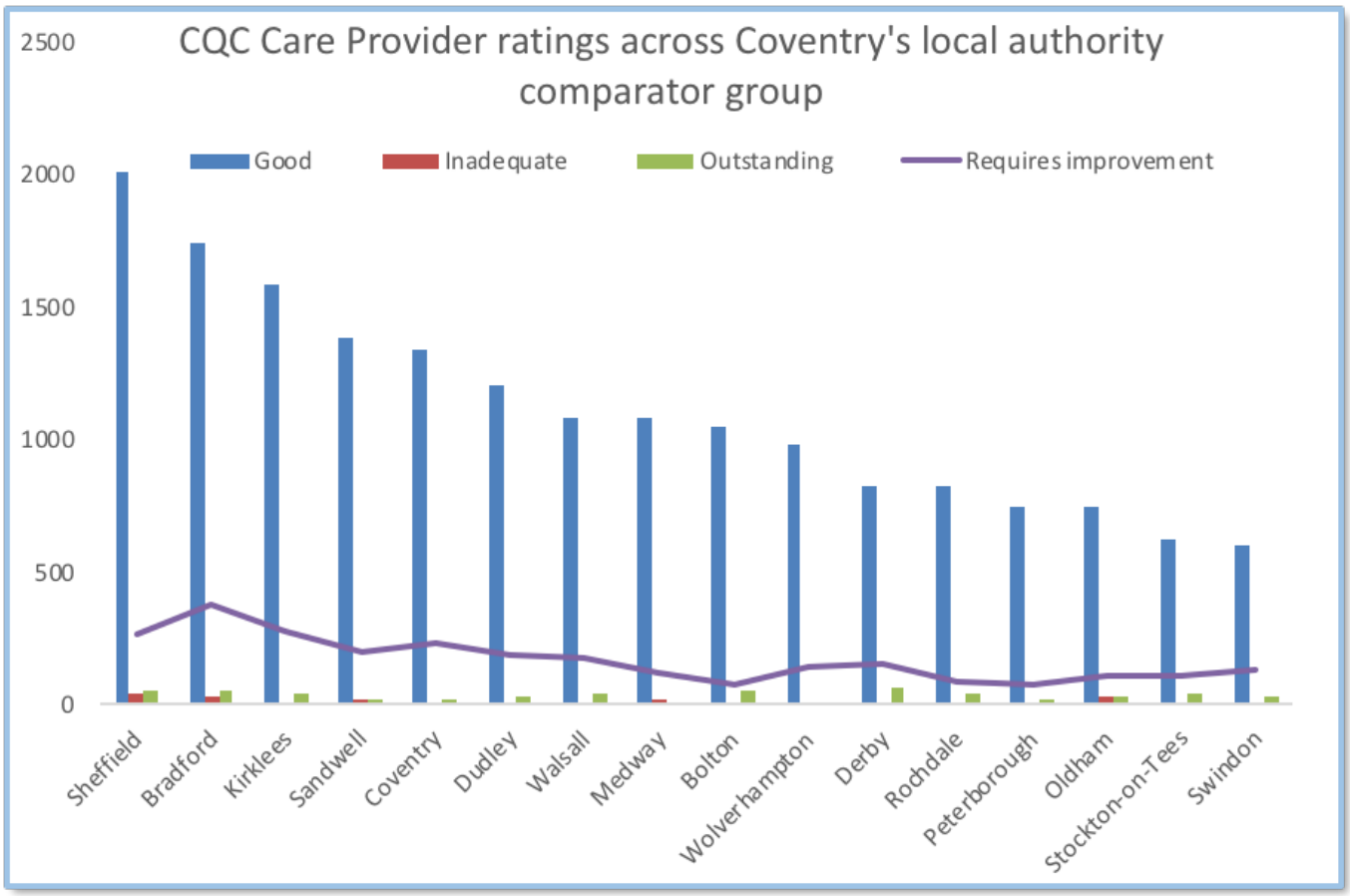
Whilst there are some challenges in improving and maintaining good quality in contracted provision, CQC care directory data shows that the quality of providers in Coventry compares well against the national picture and local authority comparator averages . The proportion of care providers in Coventry rated as 'Good' is 83.4% with the national (England) rate being 84.1%.

Some comments from inspections that took place in 2017/18:

"YES I FEEL VERY SAFE AND SECURE HERE."
(Housing with Care Scheme tenant)

"NONE AT ALL (CONCERNS) IT IS ABSOLUTELY EXCELLENT; THEY ARE MARVELLOUS."
(Care home resident's relative)

TABLE 9: CQC CARE PROVIDER RATINGS ACROSS COVENTRY'S LOCAL AUTHORITY COMPARATOR GROUP



[1]The local authority comparator group is drawn from the Chartered Institute of Public Finance and Accountancy's Nearest Neighbours model that identifies 15 local authority areas most similar to Coventry.

The data also shows that 0.6% of providers in Coventry are rated as 'inadequate.' This is lower than the national rate and local authority comparator group average of 1%. The focus for Coventry is around the group of providers that are rated as 'Requires Improvement.'

A key challenge is recruitment and retention of care staff. The Council is working with providers to think creatively about how to attract and retain good staff through a number of initiatives such as the care home provider forum which encourages sharing of ideas around best practice. However, according to the Skills For Care West Midlands Regional Report the staff turnover rate in Coventry is 27%, the sixth lowest of the 14 local authorities in the West Midlands.

The care home sector-led registered managers' forum has also been re-established and meets regularly facilitated by Skills for Care and supported by the Council. A number of care home improvement initiatives are in place in collaboration with our NHS partners including 'React to Red' skin pressure ulcer prevention and treatment accreditation and 'Say No to Infection', a programme which accredits homes for infection prevention and control.

React-to-Red' has 24 care homes accredited along with 'Say No to Infection' that has 9 care homes accredited. All accredited homes have been avoidable pressure ulcer free since accreditation.

AWARDS AND GOOD NEWS

SUPPORTING OUR NEWLY QUALIFIED SOCIAL WORKERS

In Coventry we are fortunate to have a very good retention rate, with most of our social workers having worked in Coventry for a number of years.

We do though recruit new social workers and some of these are newly qualified. A newly qualified social worker has an initial 'Assessed and Supported Year in Employment' and we are pleased that this year both Otis Hinds and Grace Boahene-Darfour completed this successfully.

ON THE MOVE TO ONE FRIARGATE

In October 2017 Adult Social Care began moving into a new 11 storey building called "One Friargate". This building offers a modern working environment in an open plan layout. For the first time most of adult social care are now based within three floors of the building supporting collaborative working and greater integration with commissioning, Public Health and the rest of the Council. It's an exciting time for Adult Social Care introducing new ways of working.

PHOENIX AWARDS

Adult Services continued to support the Council's annual award scheme. Shortlisted entries included Kelly Boyce, a Community Case Worker in the category of "Rising Star" and Carol Chapman, a Support Assistant at Brandon Wood Farm in the category of "Role Model."

WHAT'S NEXT

KEY AREAS OF DEVELOPMENT FOR ADULT SOCIAL CARE 2018/19

Continuous improvement is key for Adult Social Care to enable us to provide support based around the individual and carers within the resources available.

We will be further strengthening our links with health colleagues, joining up and collaborating wherever this will give better outcomes for those people we support during 2018/19.

The key areas for development and improvement are:

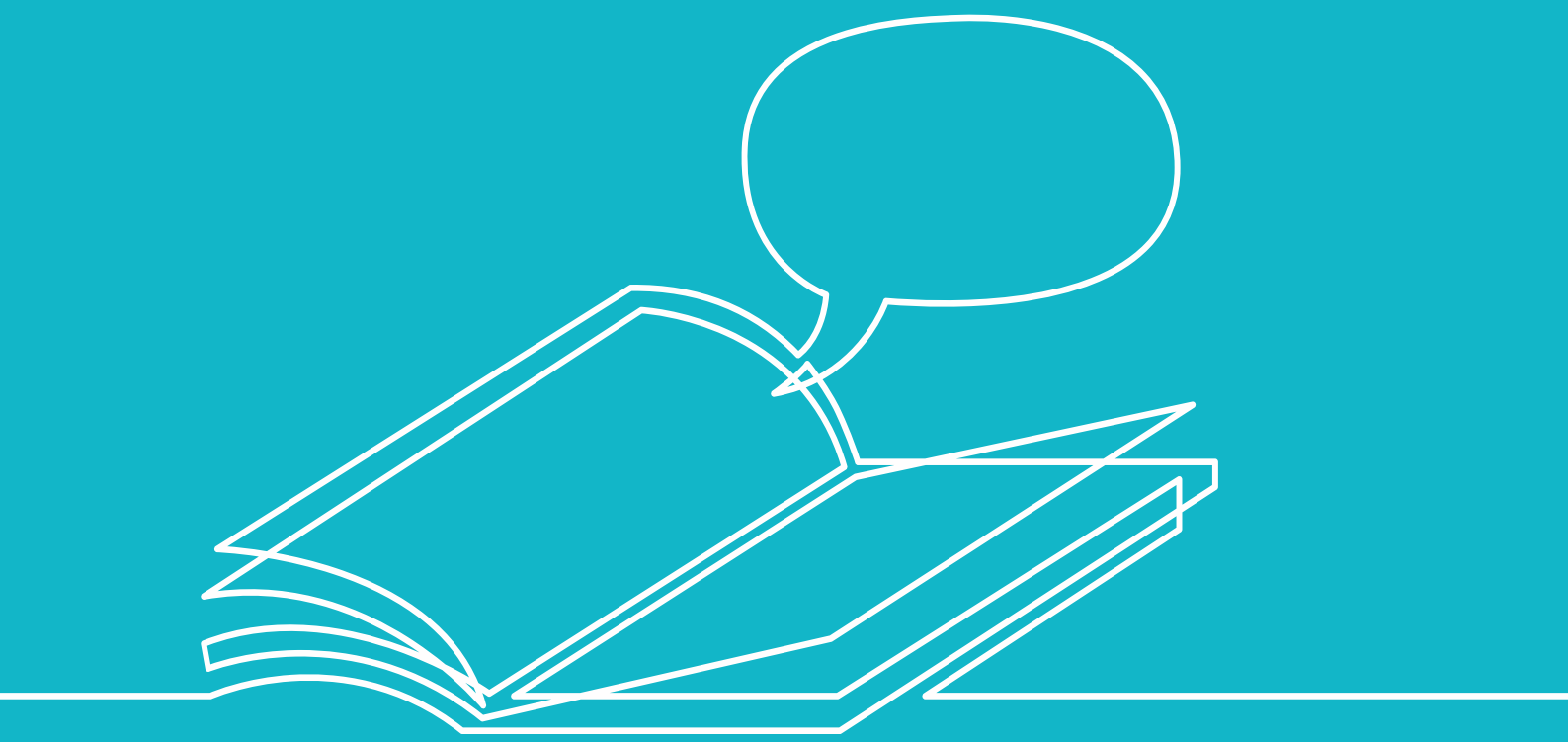
- Building on the success of our community promoting independence approach to enable more people to remain independent and wherever possible to continue to live in their own homes
- Exploring a range of Assistive Technology options to support people in new ways ensuring individual needs are met through a person centred approach
- Working with the provider market to ensure stable and varied living options are available to meet the future needs of the people we support within the resources available
- Improving the customer experience at initial points of contact used by the public to enhance the opportunities for people to manage their own care requirements
- A continued focus on the quality of practice and the workforce
- Working with health colleagues to ensure that Adult Social Care supports the effective delivery of the Out of Hospital model of support
- Continuing to contribute to the delivery of the improvement plan arising from the CQC system review

GLOSSARY

This section provides an explanation of some definitions and terms that appear throughout this document.

Delayed Transfers of Care (DTOC)	Page 4	A Delayed Transfer of Care refers to a situation when a patient is ready to leave hospital but is still occupying a bed.
Better Care Fund (BCF)	Page 4	The Better Care Fund is a programme spanning both the NHS and local government which seeks to join-up health and care services, so that people can manage their own health and wellbeing, and live independently in their communities for as long as possible.
Care Quality Commission (CQC)	Page 5	This is the independent regulator of all health and social care services in England.
Short-term support to maximise independence	Page 7	Support that is intended to be time limited, with the aim of maximising the independence of the individual and reducing or eliminating their need for ongoing support by the Council. At the end of the time limited support package a review or assessment for ongoing future need will take place to determine what will follow.
Ongoing Support	Page 8	Any service or support which is provided with the intention of maintaining quality of life for an individual on an ongoing basis, and which has been allocated on the basis of national eligibility criteria and policies (i.e. an assessment of need has taken place) and is subject to annual review.
Direct Payments	Page 9	A Direct Payment is the sum of money that you (or someone acting on your behalf) receive on a regular basis from your Council so you can arrange your own care and support instead of the Council arranging it for you.
Safeguarding Concern	Page 10	A Safeguarding Concern is an alert regarding suspicions or allegations of abuse or neglect.
Safeguarding Enquiry	Page 10	A Safeguarding Enquiry is any action that is taken (or instigated) by a local authority, under Section 42 of the Care Act 2014, in response to indications of abuse or neglect in relation to an adult.
Deprivation of Liberty Safeguards (DoLS)	Page 11	The Deprivation of Liberty Safeguards are an amendment to the Mental Capacity Act 2005. They apply in England and Wales only. The Mental Capacity Act 2005 allows restraint and restrictions to be used – but only if they are in a person's best interests.
Joint Strategic Needs Assessment (JSNA)	Page 14	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.

Making Safeguarding Personal	Page 17	Engaging the person in a conversation about how best to respond to their safeguarding situation in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety.
Safeguarding Adults Board	Page 17	A Board which represents the various organisations in a local authority area who are involved in adult safeguarding.
Transforming Care	Page 17	A national programme aimed at supporting people with learning disabilities, autism and behaviours that challenge who are either in hospital or a risk of admission by developing community services and prevent unnecessary admissions to hospital settings.
Care and Treatment Review (CTR)	Page 17	Care and Treatment Reviews are multi-disciplinary meetings for adults with learning disabilities, autism and mental health who are at risk of hospitalisation under the Mental Health Act due to escalated behaviours.
Clinical Commissioning Groups	Page 19	Clinically Led statutory NHS Bodies responsible for the planning and commissioning of health care services in a local area.
React to Red	Page 19	A campaign, raising awareness of pressure sores, how to prevent them and how to identify those most at risk of developing them by delivering training and support to those involved in care.
Think Local Act Personal (TLAP)	Page 19	A national partnership transforming health and social care through personalisation and community based support
Promoting Independence Service	Page 20	A service which works with people for a time-limited period to maximise their independence with everyday living skills.
Assessed and Supported Year in Employment (ASYE)	Page 23	This is a 12 month employer-led programme of support and assessment for newly qualified social workers.
Housing with Care	Page 24	A housing scheme which can provide the varying levels of care and support that people may need whilst living within their own tenancy.
Adult Social Care Outcomes Framework (ASCOF)	Page 26	ASCOF measures how well care and support services achieve the outcomes that matter most to people. The framework supports councils to improve the quality of care and support services they provide and gives a national overview of adult social care outcomes.
Skills for Care	Page 27	An organisation which supports workforce development in Adult Social Care.
Say No to Infection	Page 27	A campaign that aims to reduce and prevent infections within care home and domiciliary care settings by providing training and educational assistance for anyone involved in care.



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www.coventry.gov.uk/adultsocialcare

Coventry City Council

Report

To: Coventry Health and Wellbeing Board **Date: 8 October 2018**

From: Liz Gaulton, Director of Public Health and Wellbeing, Coventry City Council

Title: 2017/18 Director of Public Health's Annual Report

1 Purpose

This paper updates the Health and Wellbeing Board on the 2017/18 Director of Public Health's Annual Report. The report includes recommendations for health and wellbeing partners across Coventry.

2 Recommendations

The Health and Wellbeing Board is asked to:

1. Note the content and recommendations of the 2017/18 DPH Annual Report;
2. Support the dissemination of the report; and
3. Endorse the actions proposed.

3 Background

This year's DPH Annual Report is entitled: 'Healthier for Longer: Ensuring healthier futures for our communities'. The report focuses on healthy ageing and the health of older people. It has been produced in partnership with the Adult Social Care directorate at Coventry City Council.

4 The health of Coventry's older population

Coventry has an estimated 50,400 residents aged 65 and over and 7,000 residents aged 85 an over. This population has been growing in recent years and is set to increase. By 2028, there will be an estimated 58,200 residents aged over 65 and 8,600 aged over 85. The population of those over the age of 75 is projected to increase by nearly 50% over the next 20 years.

The gap between healthy life expectancy and life expectancy is commonly referred to as the 'window of need' and tells us that individuals can expect to live significant periods of their life in poorer health. In Coventry, men can expect to live just over a fifth of their lives in poor health (16.3 years), whilst women can expect to live almost a quarter of their lives in poor health (19.5 years). These figures are comparable to the national averages and support findings from self reported health ratings.

5 Promoting prevention

The report takes the opportunity to highlight the importance of prevention and early intervention in promoting good health in later years, and managing the demand for health and social care services. Coventry is still behind the England average on many healthy behaviours and risk factors:

- 16.3% of Coventry residents over 16 smoke compared to the national benchmark of 15.5%.
- Adults meeting the recommended '5 a day' on a usual day is 51.2% in Coventry, which is worse than the national benchmark of 56.8.
- Percentage of physically active adults in Coventry is 59.3%, worse than the national benchmark of 66%.
- 64% of Coventry adults are classified as overweight or obese compared to the national benchmark of 61.3%.
- Compared to the national benchmark, Coventry has worse uptake of breast (70.7% vs 75.4%), cervical (70.1% vs 72%), bowel (56.4% vs 58.8%). The uptake for abdominal aortic aneurysm screening is similar (79.4% vs 80.9%).
- Coventry has a lower uptake of flu vaccination for older adults (69.3% vs 75.5%) and children (33.6% vs 38.1%). Uptake of the flu vaccination in at-risk groups is higher than the national benchmark (51.6% vs 48.6%). Update of the shingles vaccine is also lower (44.9% vs 48.9%). Uptake of the pneumococcal vaccine for older adults is similar to the national benchmark (69.3% vs 69.8%).

6 Actions to promote better physical and mental health of adults in Coventry

The report highlights activities across Coventry to promote good health and prevent ill-health across all age groups to support increases in healthy life expectancy. These include:

- Tackling loneliness and social isolation
- The new Healthy Lifestyles Coventry service commissioned by the Public Health team
- Supporting those at risk of fuel poverty
- Interventions from the Adult Social care team to promote early help and maintain independence
- Reducing delayed transfers from hospital

Progress has been achieved following the Living Well With Dementia Strategy 2014-17, with improvement in key outcomes for people living with dementia in Coventry.

7. Integrating health and care services

The report highlights the progress and commitment and across health and wellbeing providers to make sure that people receive the right care when they need it and in a way that meets their needs, and achieves their outcomes.

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Appendices
Coventry Director of Public Health Annual Report 2017/18

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Healthier for Longer

Securing healthy futures for our communities

Coventry City Council

Director of Public Health's Annual Report 2017/18

Coventry
Health and Wellbeing

Introduction

by the Director of Public Health and Wellbeing

I am pleased to present my first annual report as Director of Public Health and Wellbeing for Coventry. In this year's report we spend time with the older members of the family introduced in our last two reports. Our focus is on older people and managing the demand for health and care services.

We still have many myths about ageing and older people and it is important to dispel these myths so that we all have a shared understanding about what it means to be older in Coventry today. Our older residents are valuable assets within the community.

Health and wellbeing is a key ingredient for enjoying one's later years in life. Good health in older age is an achievable goal. As we get older we are more likely to experience ill-health and disability, but illness and loss of function is not an inevitable part of ageing. It is possible to maintain good health and independence well into older life. I believe that public health has an important role to play in helping populations remain well and independent for longer.

The determinants of health start from when we are younger, meaning people approaching their middle age are in a good position to start making and maintaining healthy lifestyles to increase their chances of experiencing a healthy, happy and productive later life.

Although Coventry is seen as a young city, the growth of the older population is accelerating. The population of those over the age of 75 is projected to increase by almost 50% over the next 20 years. There is a worrying stall to the gains in improving life expectancy, which is replicated nationally. The cause for this reversal of gains seen since records began in the 19th century is not completely understood, but there are suggestions that prolonged austerity and cuts to public services may be contributing.

In Coventry there is a large gap between healthy life expectancy and life expectancy, representing a large window of need when people start to require more and more support from health and care services. This gap is 16.2 years in men and 19.2 years in women on average.

In this report I champion a focus on prevention and early intervention to address the inevitable pressures on health and social care. These pressures will only get worse as the risk factors for diseases such as low physical activity, poor diet and household poverty increases.

We have made great strides over the past year to bring health and social care services closer together within Coventry and we must continue to endeavour to deliver joined up, cost effective care for the benefit of all those who need it.

Liz Gaulton

Director of Public Health and Wellbeing

Foreword

Welcome to the Director of Public Health's Annual Report for 2017/18. I am pleased we are focusing on our older generation this year. The number of people in Coventry who are aged over 65 years is growing and therefore it is vital that we make the right choices now to secure the right future for our residents.

Within Coventry, we are working together across the city to improve the impact of our services on people's lives. Enabling people to stay healthier and independent for longer requires a concerted effort across many Council functions, including public health, social care, sport and leisure and education services, as well as our many partners.

We are conscious the older population is as diverse as any other group in society. People age differently as they grow older and older residents have a wide range of interests, hobbies, social networks, as well as a wide range of health and social care needs. We are working across the city to bring services together and coordinate care so our older generation can live healthier for longer. In 2017/18 we placed a focus on building services with residents to ensure they are as adaptable, efficient and effective in delivering successful services.

Achieving this will not only help residents enjoy a healthier, longer life, but will also reduce the demand for existing services. We all know the vast difference changes in lifestyle can make to our overall health, especially in older age. Keeping active, eating well and not smoking are some of the key things we can all concentrate on in achieving a healthier, happy life for everyone.

I'd like to thank everyone who has put this report together and who has worked so hard this year. We have exciting opportunities to improve health and wellbeing ahead of us with 2019 being Year of Wellbeing across Coventry and Warwickshire; and the recent announcement of Coventry as European City of Sport 2019 and UK City of Culture 2021. Finally I'd like to thank everyone who continues to work tirelessly in delivering essential services to residents of Coventry every day of the year.

Councillor Kamran Caan

Cabinet Member for Public Health and Sport

Foreword

by the Director of Adult Social Services

It is really encouraging to see the annual report bringing together the evidence on the health and wellbeing of adults in Coventry and express some of the challenges faced by our population in terms of its health.

It is also really interesting to read how seemingly small changes to lifestyles and the everyday decisions we make, which may seem insignificant at the time, can have a significant and long term impact on our health and quality of life.

As Director of Adult Services most of my time and that of my teams is spent working with people and their families to remain as independent as possible within the community, whether this is through support to carers to continue in their caring role, arranging support that helps people regain a level of independence that they may have recently lost or in supporting people to make decisions in respect of ongoing care and support arrangements.

This is challenging work and although good health does have an element of good luck through the decisions we make, we can all increase our chances of living with good health and a high level of independence for a greater proportion of our lives.

In reading this report I would urge you to consider the small changes you could make and how you might be able to influence people you come into contact with to make positive changes too.

Peter Fahy

Director of Adult Social Services

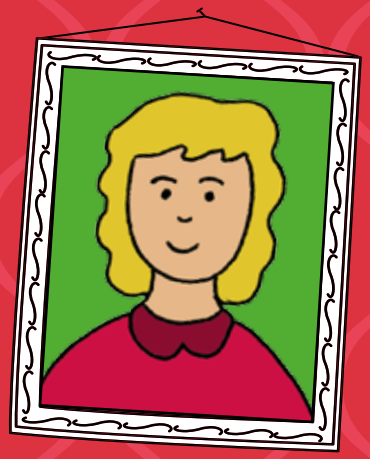
Contents

Meet the family

Last time, we were introduced to a family focused on 'shaping up'. This year, we are revisiting the family and other members of the community to look at living longer in good health.

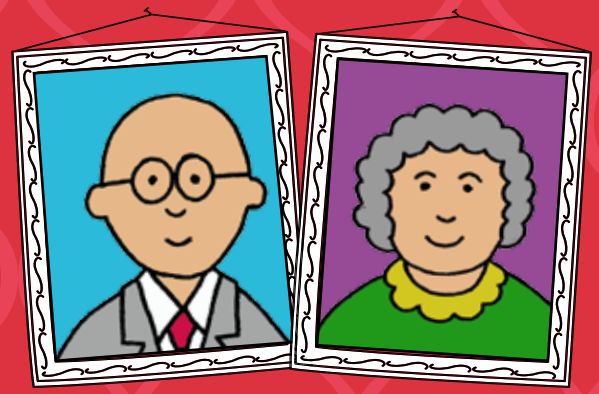
Watch out for updates throughout the report as we join Alan and Cathy on a visit to Cathy's parents and meet other local residents along the way!

Dad Alan has continued healthy eating and enjoys regular exercise.



Mum Cathy has struggled to keep up with the lifestyle changes she had begun to make. Cathy is finding it difficult to exercise, more so as of late given the time she has to dedicate to her parents, Geoffrey and Susan.

Geoffrey and Susan are both in their late 60s. Susan, Cathy's mother, requires minimum support, though Geoffrey, Cathy's father, has multiple health conditions that require Cathy and Alan to visit their home every couple of days.



Chapter 1
Ageing in good health

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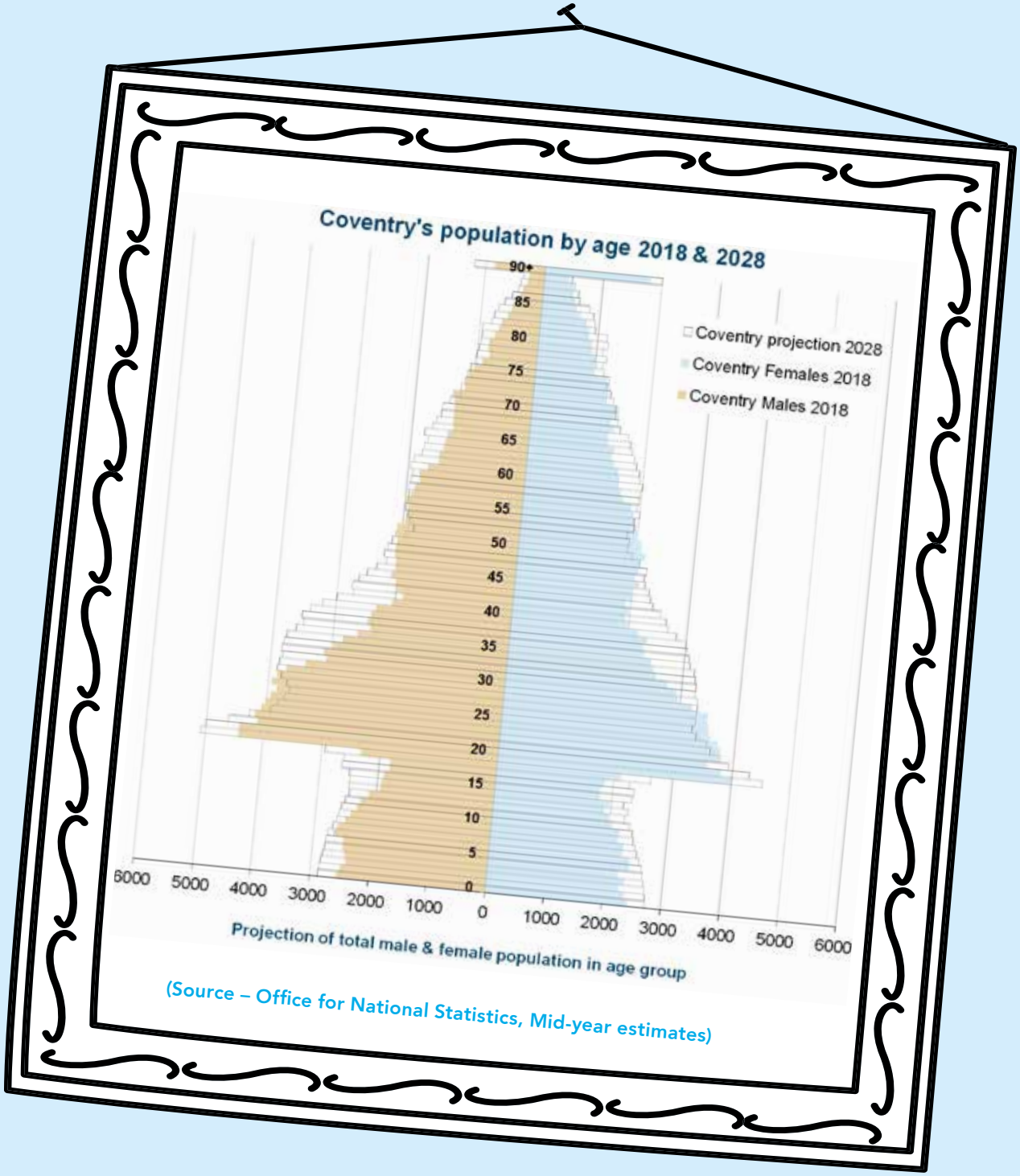
1. Coventry's Older Population

Coventry is a city with a diverse population and is home to people of all ages. Although Coventry is a young city with a large population between the ages of 20 and 40, many residents are aged 65 years and over.

Coventry has an estimated 50,400 residents aged 65 and over and 7,000 residents aged 85 and over. This population has been growing in recent years and is set to increase. By 2028, there will be an estimated 58,200 residents aged over 65 and 8,600 aged over 85. The population of those over the age of 75 is projected to increase by nearly 50% over the next 20 years.



(Source – Office for National Statistics, Mid-year estimates)

Key Definitions

Life expectancy: The average number of years a person would expect to live based on mortality rates; an estimate of the average number of years a new born baby would survive if he or she experienced the current age-specific mortality rates for their area and time period throughout his or her life.

Activities of daily living:
The tasks of everyday life. These activities include eating, dressing, getting into or out of a bed or chair, taking a bath or shower and using the toilet.

Healthy life expectancy:
The average number of years a person would expect to live in good health based on mortality rates and self-reported good health.

Window of need:
The period of time between life expectancy and healthy life expectancy. It refers to the average time a person can expect to live in poor health.

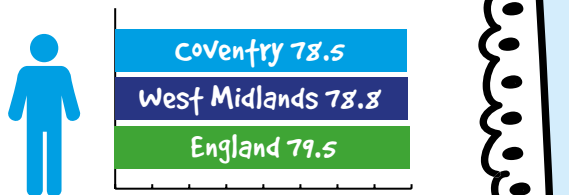
Disability-free life expectancy:
Estimates lifetime free from a limiting illness or disability; based upon a self-rated assessment of how health conditions and illnesses limit the ability to carry out day-to-day activities.

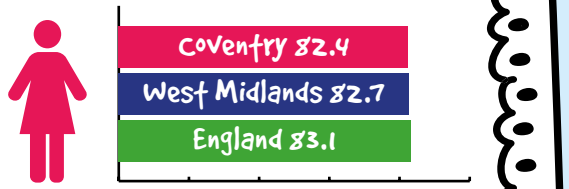
Life expectancy (LE) is a general measure of population health and gives an estimate of how long people can expect to live on average. It can be influenced by how a society attempts to reduce avoidable causes of death at all ages. Over the past 30 years, life expectancy has been increasing in the UK. This is one of the reasons why we have seen an increase in the number of older people.

Similar to the national picture, life expectancy amongst Coventry residents has stayed about the same in the last few years following this long period of improvement, although the cause of this stagnation remains unknown. Life expectancy in Coventry has remained lower than the England and West Midland averages for many years and is currently 82.4 for females and 78.5 for males; this suggests that on average the health of Coventry's population is poorer than the national average.

Another way of understanding the general health of older residents is to measure the life expectancy of those who have reached the age of 65 today. Life expectancy at 65 refers to the number of further years a Coventry resident can expect on average to live upon reaching the age of 65. The latest data shows this to be 18.3 for males and 20.6 for females. This means that a 65 year old male can expect to live to 83 and a 65 year old female can expect to live to 85.

Life Expectancy at Birth, Coventry compared to the West Midlands and England 2014 - 2016



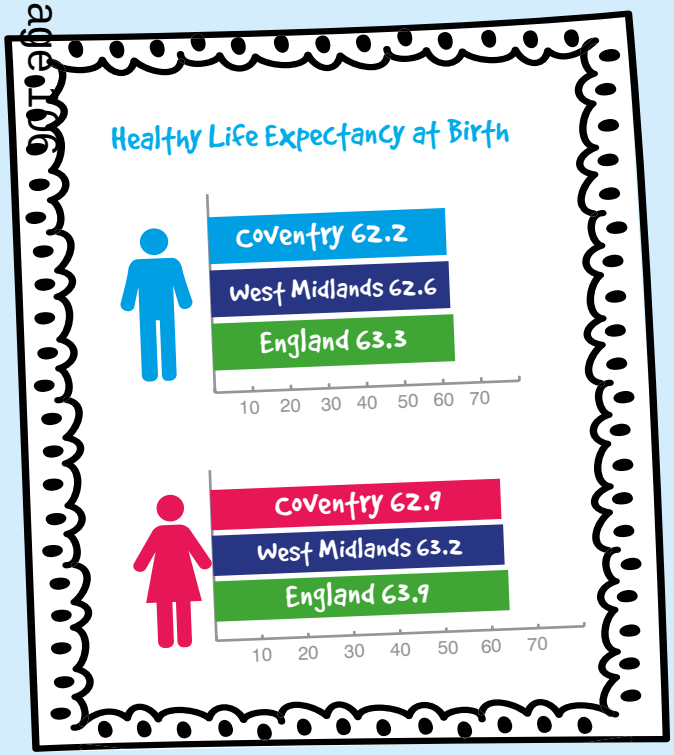


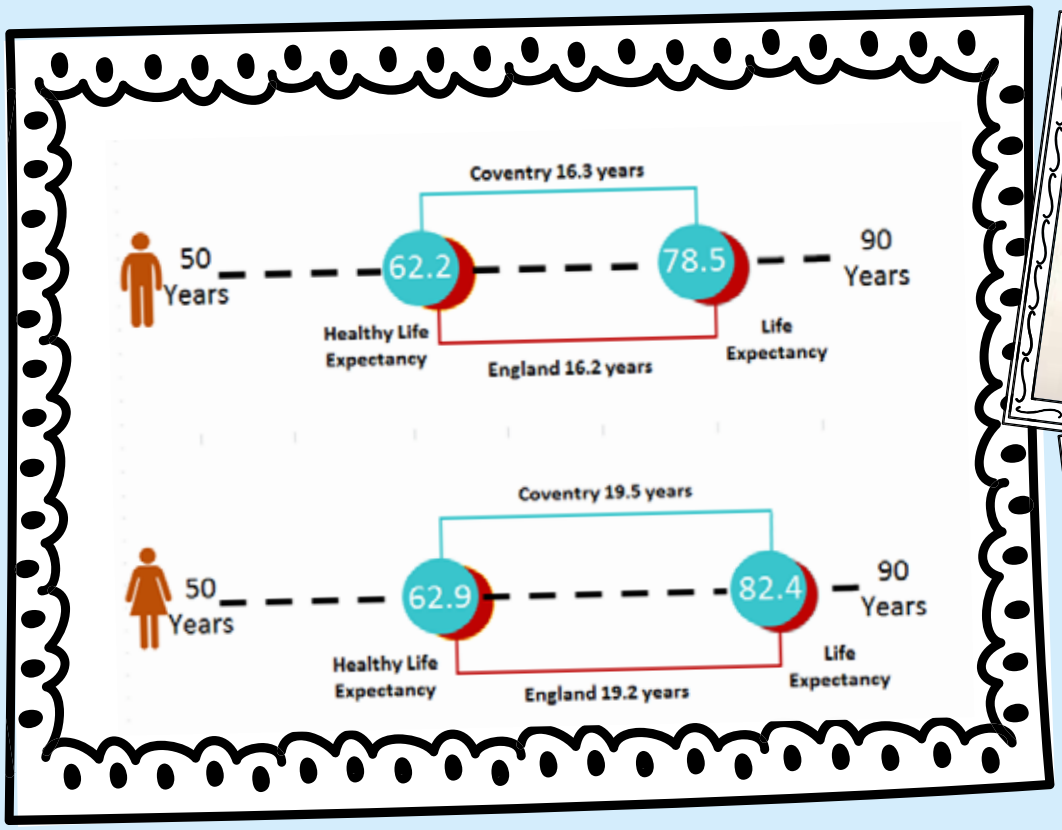
2. The Window of Need

Many older people enjoy good health. However, as people get older they experience more health conditions and require more support in the activities of daily living (ADL). In Coventry, people in older age groups report increasing levels of bad or very bad health. A fifth of people aged 75-84 report being in poor health, rising to almost a third in those aged over 85.

% of Coventry residents self-reporting to be in bad or very bad health by age

16-34	35-49	50-64	65-74	75-84	85+
2%	5%	11%	14%	20%	28%





This draws attention to the importance of healthy life expectancy (HLE). Healthy life expectancy is the number of years a Coventry resident can expect to live in good health. The latest data shows that the average healthy life expectancy in Coventry is 62.2 for males and 62.9 for females, which is just below regional and national averages.

The gap between healthy life expectancy and life expectancy is commonly referred to as the 'window of need' and tells us that individuals can expect to live significant periods of their life in poorer health.

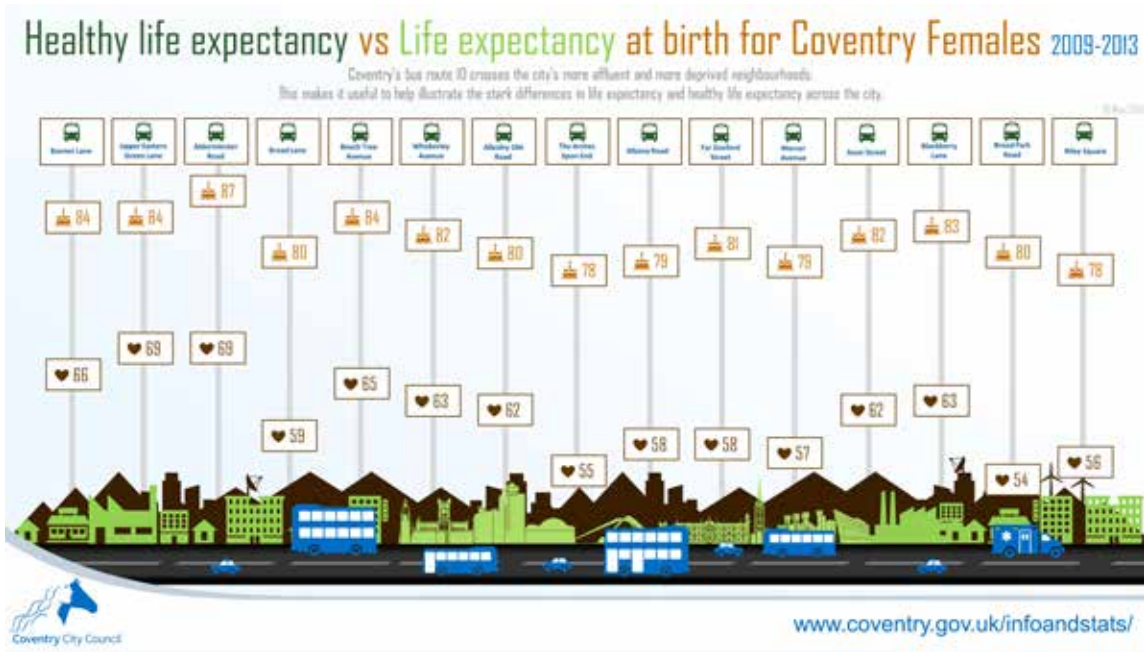
In Coventry, men can expect to live just over a fifth of their lives in poor health (16.3 years), whilst women can expect to live almost a quarter of their lives in poor health (19.5 years). The window of need is wider within the female population due to women having a higher life expectancy, despite men and women having a similar average healthy life expectancy. These figures are comparable to the national averages and support findings from self-reported health ratings.

National figures show that disability-free life expectancy is reducing, which means that more people are spending their later years with disability. Disability-free life expectancy is the age at which an average person in a population can live without any limiting disabilities. In Coventry it is 60.7 years for men and 61.7 years for women. This means men can expect to live 17.8 years and women can expect to live 20.7 years with a disability. For men, Coventry's figures are notably lower than the national and regional averages of 62.8 and 62.6 respectively. This too can of course contribute to living a longer period of one's life in poorer health.

3. Health Inequalities

There is a clear 'social gradient' in the variation of life expectancy and healthy life expectancy across the country, whereby residents of the most deprived areas have the lowest life expectancy and healthy life expectancy and residents of the least deprived areas have the highest life expectancy and healthy life expectancy. The link with deprivation may explain why Coventry's residents have a lower than average life expectancy and healthy life expectancy, given Coventry's level of deprivation is higher than the national average.

Locally, differences can be seen when looking at life expectancy and healthy life expectancy along a single Coventry bus route. For example, around Alderminster Road in Eastern Green, female life expectancy is 87 compared to 78 in Spon End. Healthy life expectancy for females is 69 in Eastern Green compared to 54 around Broad Park Road in Henley Green.



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Links to useful resource

Coventry data on Older People's Health and Wellbeing from the Public Health England Fingertips tool

The life expectancy gap between the most and least deprived areas in Coventry is larger for men than it is for women. The life expectancy gap for males and females in Coventry is higher than the West Midlands and England averages. Residents in Coventry's most deprived areas also have a wider 'window of need'; meaning they are living shorter lives and more of their life in poor health.

In 2013 Coventry committed to delivering rapid change in health inequalities and was one of seven cities in the UK invited to become a Marmot City. In 2016, Professor Sir Michael Marmot and Public Health England committed to working with Coventry for a further three years to enable Coventry to build on progress made in tackling health inequalities.

As a result of the Marmot partnership work there have been improvements in the health and life chances of residents within Coventry. More health checks are being delivered in the most deprived areas and more people report they are satisfied with their lives in priority locations.

Despite this, many challenges still remain and it is therefore crucial for us to understand the issues and factors contributing to Coventry's window of need.

Family Update

Cathy went to see her parents, Susan and Geoffrey. Geoffrey was not having a great day. Geoffrey has a number of health conditions that require support from Cathy and her mother.

Geoffrey suffered a stroke two years ago. This has limited Geoffrey's overall mobility. Geoffrey is also diabetic and suffers from depression and high-blood pressure, meaning he requires daily medication. Cathy regularly worries about her father's health, as well as the impact of his condition on her mother's wellbeing.

Interesting fact

In the most deprived areas of England residents can expect to live to 74 on average. In the least deprived areas residents can expect to live in good health until they are 70 and go on to live to 83, on average.

Recommendation

Work with community partners to establish a narrative around older people as assets, which gives a rounded sense of the contributions older people give to Coventry as a city.

Chapter 2
What influences healthy life expectancy?

Life expectancy, healthy life expectancy and disability-free life expectancy are influenced by a wide range of factors. These factors include not only a person's genetics and lifestyle, but also the environment in which they live, work and socialise, known as the social determinants of health. These determinants of health are illustrated by the model developed by Goran Dahlgren and Margaret Whitehead.

The Dahlgren-Whitehead model showing the broad range of factors that influence health (Dahlgren G, Whitehead M. 1991. Policies and Strategies to Promote Social Equity in Health. Stockholm, Sweden: Institute for Futures Studies).

1. Long term health conditions

Long term health conditions (LTHC) are those that cannot, at present, be cured but can be controlled by medication and other therapies. They are an important cause of illness and disability in later life. Examples include heart disease, diabetes, dementia and cancer. Many people will have more than one LTHC and people are more likely to develop one or more conditions as they age.

Across the population, LTHC reduce life expectancy and healthy life expectancy. In 2012 the Department of Health (now the Department of Health and Social Care) estimated that in England, LTHC accounted for approximately 70% of health and social care spending (**National Audit office. 2018. The health and social care interface**). In Coventry, just over a fifth of residents live with a limiting long term illness or disability, corresponding to an estimated 59,800 residents over 16 years old and 27,300 residents over the age of 65. The proportion becomes progressively higher with older age, with 13% of working age (16-64) residents reporting this outcome compared to 55% of those aged over 65.

Evidence from the UK suggests that, stroke in men and diabetes in women have the greatest impact on life expectancy. For men and women, stroke has the greatest effect on disability-free life expectancy (**The burden of diseases on disability-free life expectancy in later life. Jagger et al. 2007. 408-414**), followed by dementia and cognitive impairment (i.e. problems with thinking, communicating, understanding or memory) and diabetes (**The burden of diseases on disability-free life expectancy in later life. Jagger et al. 2007. 408-414**).

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Causes of death in Coventry by type (2012-2014)

Source: PHE Segment tool

Causes of Death	Male	Female
Circulatory	1,072	979
Cancer	1,151	1,026
Respiratory	549	602
Digestive	206	244
Mental and Behavioural	252	497

*External causes are not shown in the table.

In men, cancer was the biggest contributor to the difference in life expectancy between Coventry and England. It was responsible for 1,151 deaths and life expectancy in the city would have increased by 0.23 years if the rate of death from cancer in Coventry was the same as that in England. This was followed by circulatory disease such as stroke and heart disease (1072 deaths, 0.20 years of life gained). In females, cancer (1026 deaths, 0.20 years of life gained) was the second biggest contributor after external causes* (i.e. those other than diseases of the circulation, digestive and respiratory systems, cancer, mental and behavioural conditions such as Alzheimer's and external causes such as poisoning and suicide. These are not shown in the table below) (**PHE Segment Tool**).

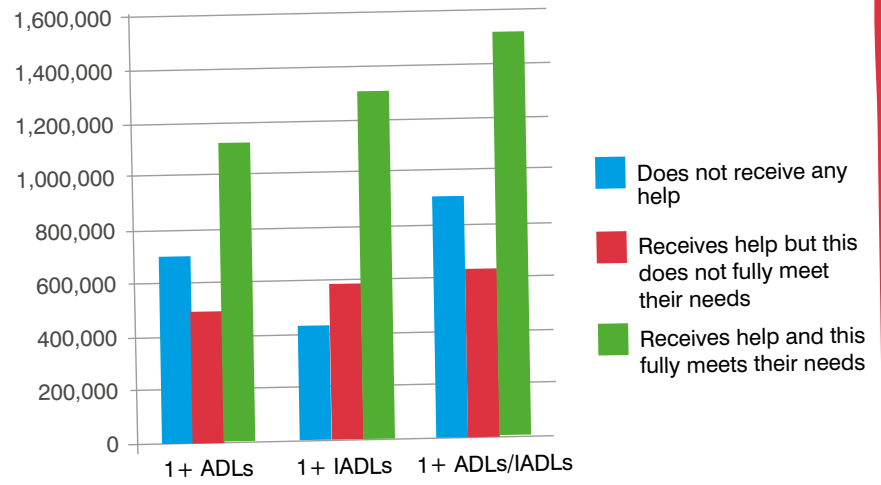
Mental and behavioural causes, including dementia, accounted for 252 deaths in men and 497 deaths in women. The percentage of adults in Coventry aged 65+ with a recorded diagnosis of dementia is 3.9% (2116 diagnoses) and has remained stable over the last two years (**Dementia: Recorded prevalence aged 65+. PHE Fingertips**).

In the UK, between 2005 and 2015, the percentage of all adults with diagnosed dementia has increased from 0.42% to 0.82% (**Trends in diagnosis and treatment of people with dementia in the UK from 2005 to 2015: a longitudinal retrospective cohort study. Donegan et al. 2017. Vol 2, issue 3. PE149-E156**). This is thought to be the result of the ageing population but also greater clinical awareness (**Donegan et al. 2017**).

An increase in research into dementia has increased understanding of the condition. The disease process can start in middle age or earlier, though symptoms may not be present until later life. Attempts to prevent and delay the onset of dementia will, therefore, be most effective when started as early as possible, with an increased focus on people aged 40-60. Through lifestyle improvements and reducing risk factors within a population, it is predicted that over a third of cases of dementia could be prevented (**Dementia prevention, intervention, and care. 2017. Vol 3. Issue 10113. P2673-2734**).

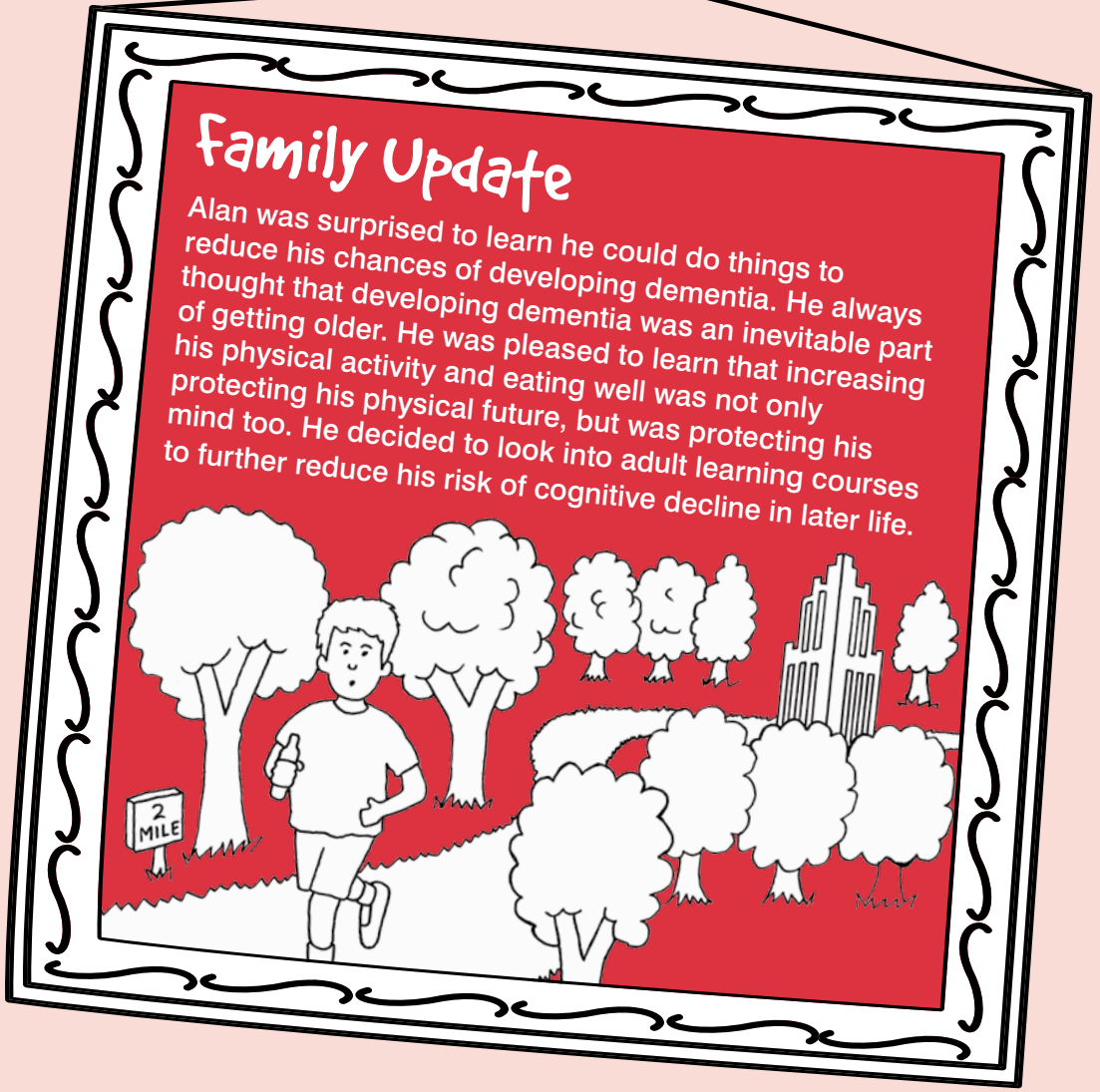
Pushing back the onset of dementia by just one year could prevent more than 9 million cases across the world and delaying by 5 years could halve the prevalence globally.

(Dementia prevention, intervention, and care. 2017. Vol 3. Issue 10113. P2673-2734).



Number of activities of daily living/instrumental activities of daily living

Source: Age UK, Briefing: Health and Care of older People in England 2017, February 2017.



2. Physical impairment and falls

Physical impairments and activities of daily living

As people age, conditions that limit wellbeing and reduce the ability to live a full life are more common. Evidence shows that a decline in functional status, which is a person's ability to carry out the normal day-to-day activities needed to meet their basic needs, fulfil their usual roles and maintain their health and wellbeing is associated with a decrease in life expectancy (**Leidy, 1994; Wilson and Cleary, 1995; Keeler, 2010**). For example, a study showed a 70 year old person considered independent (i.e. able to carry out day-to-day activities without help from others) had a life expectancy of 16.7 years. This fell to 15.7 for a person with specific mobility problems (i.e. unable to walk half a mile and/ or walk with no help up and down stairs to the second floor) and to 11.5 years in those who could not carry out the daily activities required for self-care without help (**Keeler, 2010**).

Across the country, more people are requiring support to achieve the Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADLs), both of which relate to our ability to live in a dignified and independent manner.

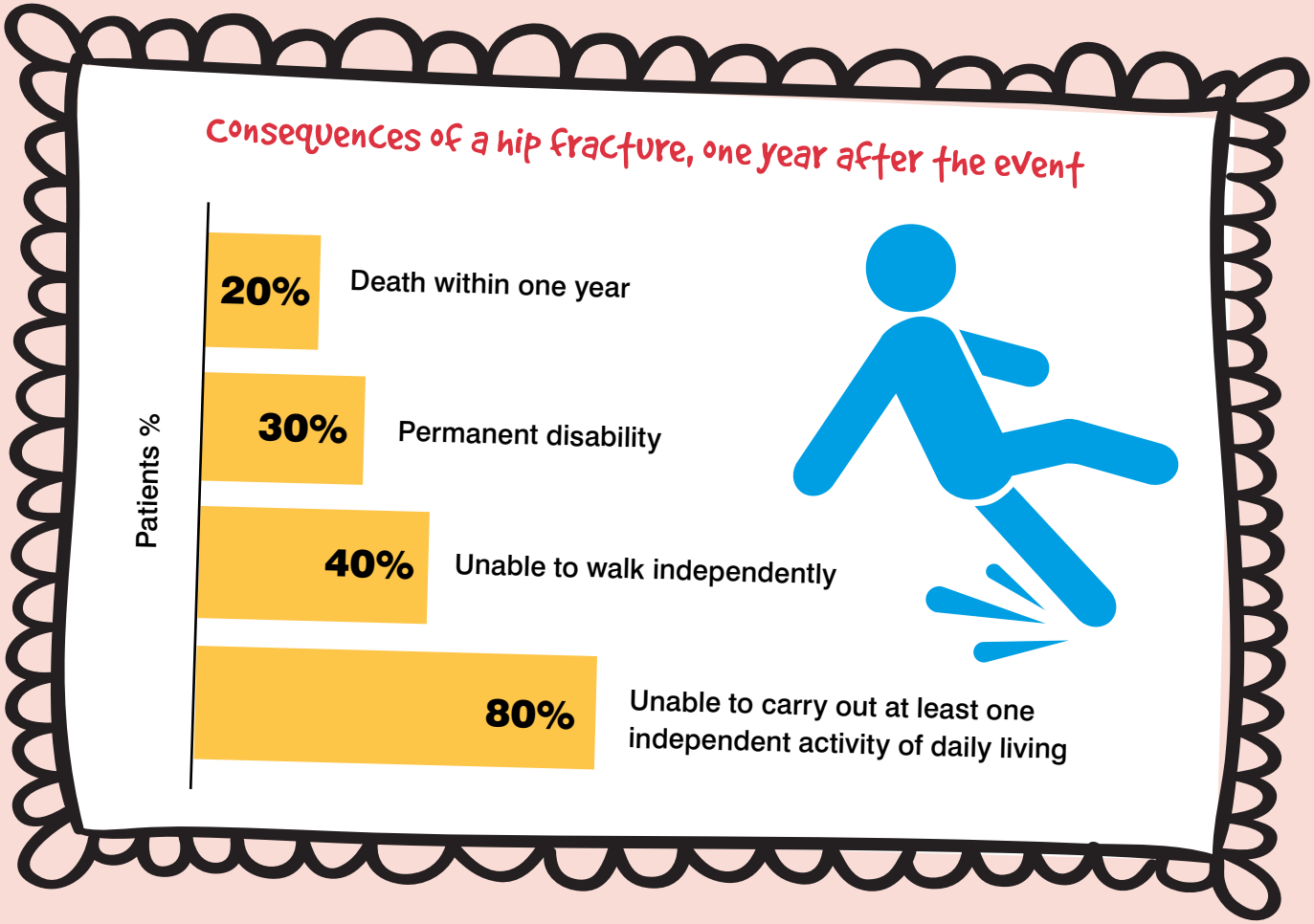
Falls

Falls are an important cause of physical disability and health care need. Almost 15% of all Coventry unplanned admissions in the over 75s are due to falls and frailty. Older people and people living in care homes are at an increased risk of falling. Those aged 65 and over who live in their own home have a 30% chance of having at least one fall in a year. This rises to 50% of those aged over 80 or those living in a care home (**Falls in older people – Assessing Risk and Prevention NICE Guidelines**).

Experiencing a fall can have a significant impact on a person's quality of life. Almost one-third of people who suffer a hip fracture will die within the following year; others will experience significant loss in function, reduced mobility and increased dependency on others (**The impact of falls in the elderly. Boye, Va Lieshout, Van Beeck et al. 2102**). In addition to injury, falls can lead to a loss of confidence and fear of further falls. The loss of mobility and increased dependency can also be a cause of social isolation and depression.

Particular groups of people have a higher rate of falls and also of suffering adversely from a fall:

- Increasing age
- People who have fallen before
- People with dementia
- Sight loss
- People with learning disabilities
- People living in care homes



3. Loneliness and social isolation

Social isolation and loneliness are an often overlooked cause of poor health. Loneliness is due to the difference between the quantity and quality of social relationships (e.g. friendships) that people have and want (**About loneliness, Campaign to End Loneliness**). Social isolation on the other hand comes from being distanced from social networks, for example due to poor health or mobility (**Windle et al., 2011**). This means that an individual who is lonely may not be socially isolated and someone who is socially isolated may not necessarily be lonely.

Social isolation and loneliness can negatively affect health and wellbeing, putting additional pressure on health and social care services. Some research suggests that loneliness is as bad for our health as smoking 15 cigarettes a day (**Holt-Lunstad 2010**). Loneliness and social isolation are associated with a number of health risks including an increased risk of depression, dementia, mental decline, raised blood

Family Update

At her parents' house, Cathy notices an elderly gentleman standing in the window of a neighbouring property. The gentleman's name is Alfred and he moved to the area around 6 months ago. Alfred rarely leaves the house and never has visitors. Susan decided to speak to Alfred. Alfred took some time to come to the door, but was more than happy for Susan to come in for a chat.

Alfred is in his late 70s. Since the passing of his wife he has felt lonely. Alfred has no children and moved to the area to downsize. Before retirement he was a local factory worker and now has little disposable income.

pressure and death (**Landeiro et al. 2017; Davidson and Rossall. 2015**). Individuals who are socially isolated have been found to be more likely to go to the GP and A&E, be admitted to hospital as an emergency and enter publicly funded residential care (**Griffith, n.d.**).

There are also financial benefits to tackling loneliness, the national Campaign to End Loneliness was launched in 2011 and found that every £1 invested in tackling loneliness saves £3 in health costs. With the launch of the Jo Cox Commission on Loneliness in 2017 and the appointment of a Minister for Loneliness by the Government in 2018, it is evident that reducing social isolation and loneliness is now a national priority.

(https://www.gov.uk/news/pm-commits-to-government-wide-drive-to-tackle-loneliness)

An estimated 6,380 people over the age of 60 in Coventry are lonely.

(Coventry City Council Insight, 2018).

The following are risk factors for loneliness in older people

(Age UK, campaign to end Loneliness):

Personal circumstances

- Living alone
- Being divorced or never married
- Living on a low income
- Living in residential care

Life transitions

- Bereavement
- Becoming a carer or giving up caring
- Retirement
- Giving up driving

Physical environment

- Living in a deprived area
- Living in an area of high levels of crime
- Living where there is a lack of public toilets
- Living where there is poor public transport

Personal characteristics

- Aged 75 and over
- Being an ethnic minority
- Being gay or lesbian

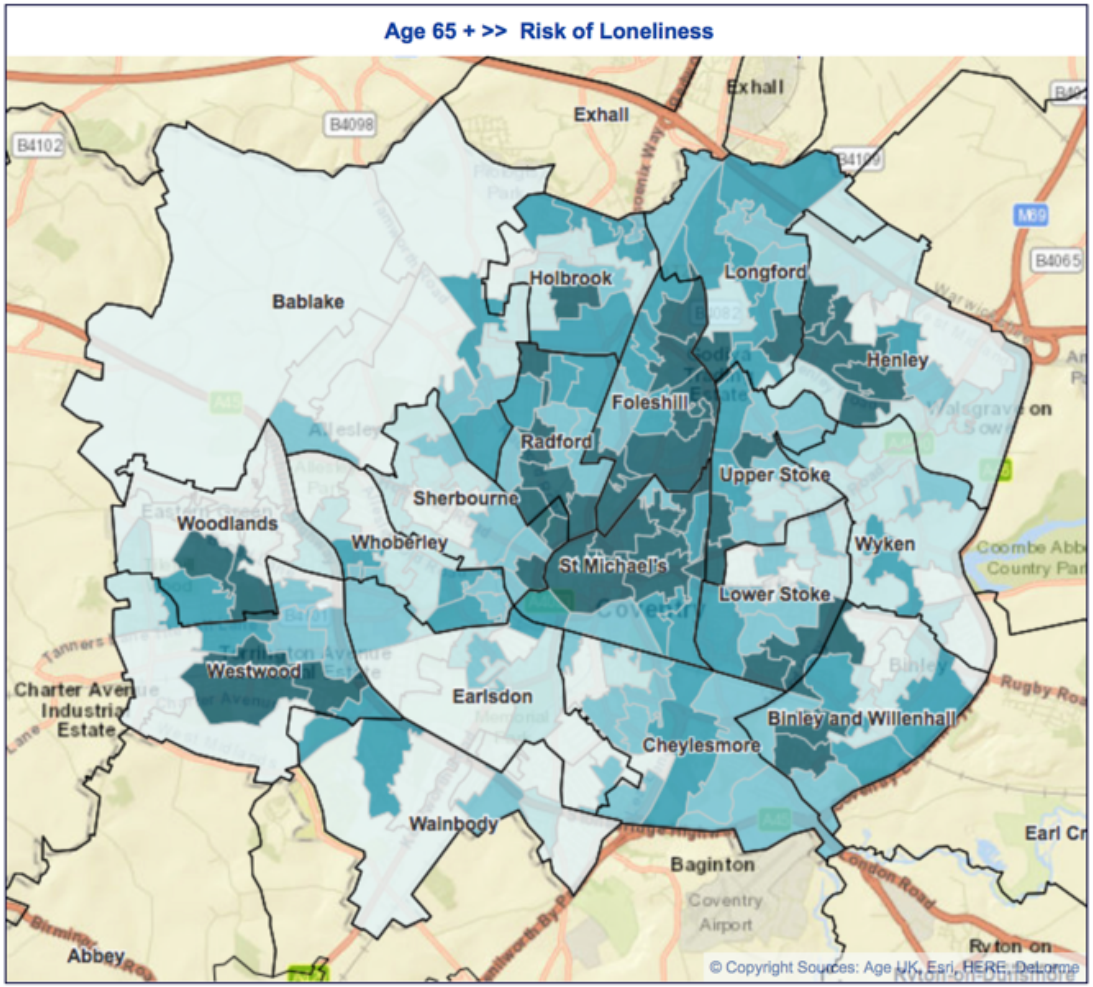
Health and disability

- Poor health
- Poor mobility
- Cognitive impairment
- Sensory impairment
- Dual sensory impairment

According to data from the 2011 census, people aged 65 and over in Coventry are affected by a number of these risk factors (**Coventry Local Authority Local Area Report**):

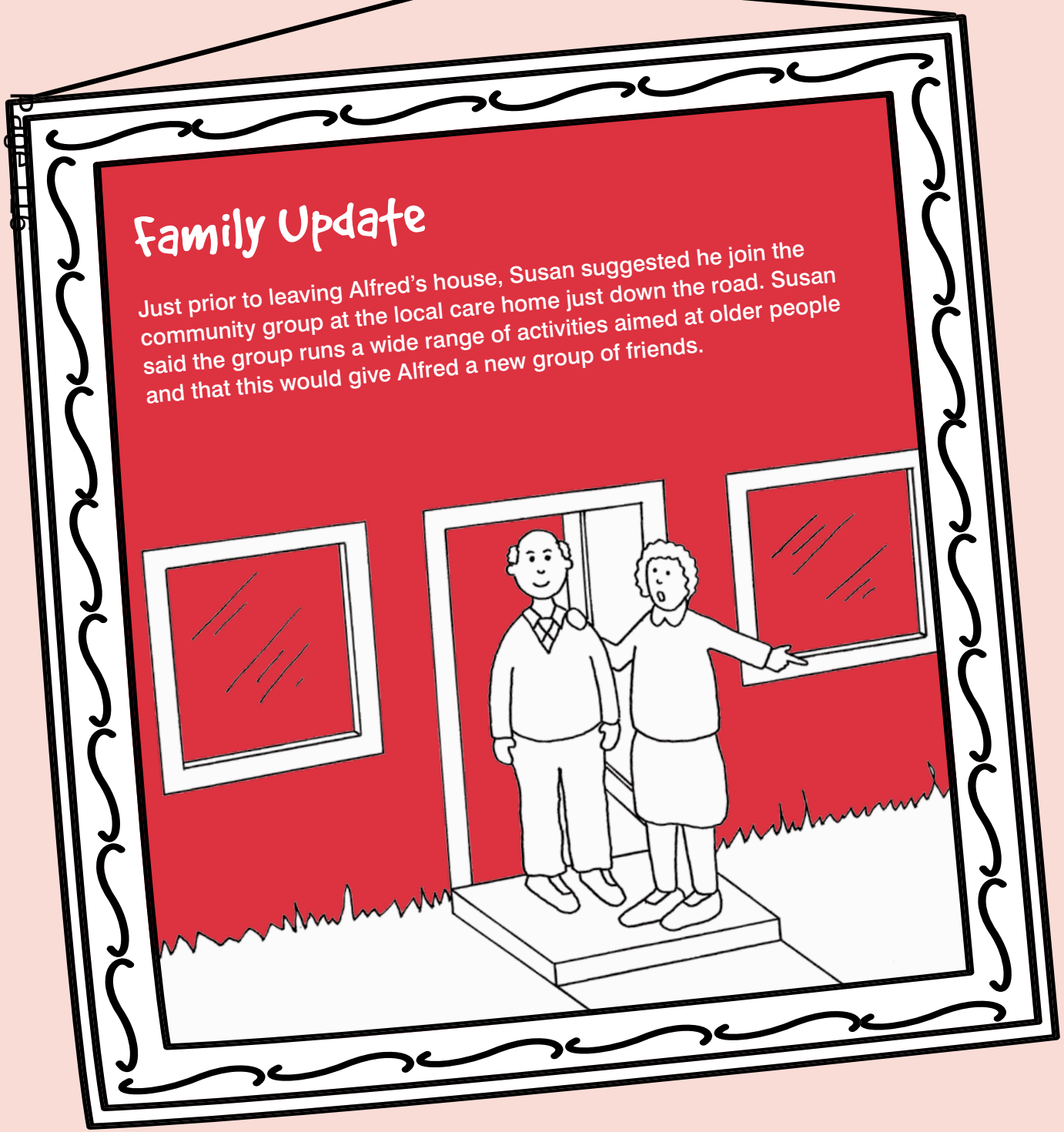
- More than than 15,000 people aged 65+ lived alone. This equates to 33% of all over 65s resident in Coventry. In addition, over 1000 people aged 65+ were estimated to be living in residential care homes.
- Residents aged 65 and over were more likely than others to provide some unpaid care (14% vs 10%).
- 18% of residents over the age of 65 said that they were in bad or very bad health compared with 6% of all others.

Age UK has developed a map comparing the risk of loneliness in different areas across England, based on data from the 2011 census on marital status, health (as reported by the individual), age and the size of the household.



This map shows the risk of loneliness at neighbourhood level within Coventry

Source: Age UK 2016



4. Lifestyles

A healthy lifestyle is essential for achieving healthy ageing. Healthy life expectancy tends to be lower in areas where there are more smokers, higher levels of harmful drinking, a lower percentage of healthy eaters and fewer people meeting the recommendations for physical activity.

A study in Canada of behavioural risk factors in adults - smoking, unhealthy alcohol intake, a lack of physical activity, poor diet and high stress - found that men and women with all five risk factors had a life expectancy more than 20 years lower than those who had none of the risk factors (68.5 vs. 88.6 years in men; 71.5 vs. 92.5 years in women). Smoking, lack of physical activity and poor diet each reduced life expectancy by 2 to 2.5 years. Reducing or removing all five of the risk factors led to gains of 7.8 years in life expectancy and 9.7 years in healthy life expectancy (**ICES Seven more years**).

Smoking

Stopping people from smoking reduces the length of time that people spend in poor health (**Jagger, C. 2015**). The Office for National Statistics has used data to show that if 10 in 100 male and female smokers quit, healthy life expectancy could increase by 6 years and 1 month in men and 7 years and 1 month in women (**What affects an area's healthy life expectancy? 2017**).

Alcohol

If there were 100 fewer hospital admissions due to alcohol in 100,000 men and women, healthy life expectancy could increase by 1 year and 6 months in men and 1 year and 3 months in women (**What affects an area's healthy life expectancy? 2017**). Coventry has a higher rate of hospital admissions due to alcohol that the national average (the data is 766.7 vs 634.7 per 100,000).

Diet

If 10 in 100 men and women ate 5 portions of fruit and vegetables a day healthy life expectancy could increase by 3 years and 11 months in men and 4 years and 4 months in women (**What affects an area's healthy life expectancy? 2017**).

Coventry performs worse than England having a lower proportion of people who eat five portions of fruit and vegetables a day (46.3% vs. 52.3%).

Inactivity

If 10 in 100 men and women did the recommended amount of exercise, healthy life expectancy could increase by 4 years and 3 months in men and 4 years and 6 months in women (**What affects an area's healthy life expectancy? 2017**).

Wider determinants of health

Deprivation is known to be negatively associated with life expectancy and disability-free life expectancy at birth. The association is weaker after the age of 85. People in the most deprived areas have a lower life expectancy and healthy life expectancy than those living in the least deprived areas (**ONS. An overview of lifestyles and wider characteristics linked to Healthy Life Expectancy in England: June 2017**).

Having considered factors contributing to life expectancy and healthy life expectancy in more detail, let us now turn our attention to how we can all take better care of our body and mind.

Recommendations

- **Promote community-based groups and activities to combat social isolation and loneliness**
- **Encourage the further reduction of health inequalities by embedding the Marmot City approach across the work of the Council and its partners**

Chapter 3
Taking care of your body and mind

> "Take care of your body. It's the only place you have to live."
>
> Jim Rohn

As the age at which people receive their state pension increases and pressures on health care resources grow, improving the healthy life expectancy of Coventry residents will become ever more important.

Thus, it is vital we explore new, sustainable and effective ways of promoting good health and preventing ill-health across all age groups to support increases in healthy life expectancy.

1. Healthy behaviours

The challenge is to balance what organisations can do to promote healthy ageing and individual responsibility to adopt healthy behaviours.

There are steps people can take throughout their life to reduce the risk of developing a LTHC. Many of these steps rely on people making proactive choices, such as taking up the opportunity to have an NHS Health Check or a flu jab, or adopting healthier behaviours, such as quitting smoking.

Public Health England states that to achieve a reduction in LTHC, we must promote the concept of healthy life expectancy and healthy ageing. This involves:

Reduce your risk of developing a long term health condition such as diabetes and heart disease:

Get physically active
walking, cycling, dancing, gardening, sport or playing active games for 2.5 hours per week

Maintain a healthy weigh
(BMI lower than 25)

Maintain a healthy diet
high in fruit, vegetables and whole grains, low in salt, sugar and red meat

Give up smoking

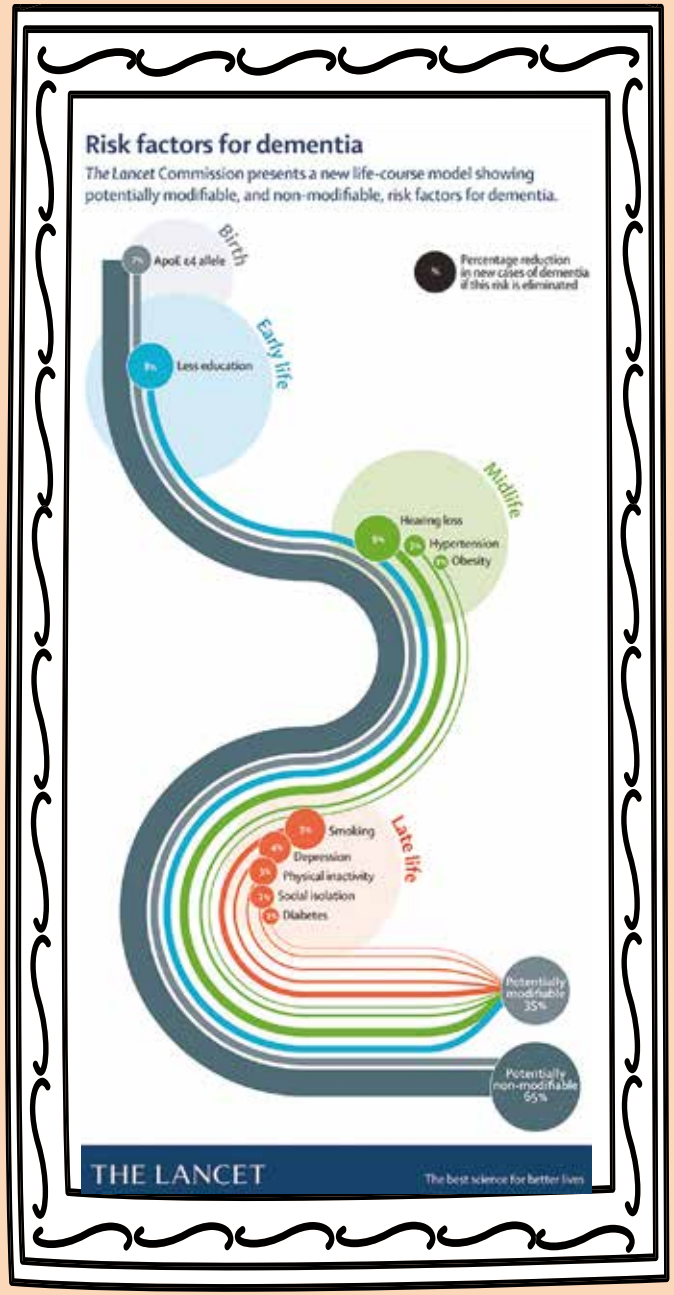
Drink responsibly
Drink no more than 14 units of alcohol per week

As stated, the good news is that adopting healthy behaviours can prevent the development of some LTHCs and may reduce the impact of those that already exist, such as Type 2 diabetes, heart disease, stroke, some cancers and dementia.

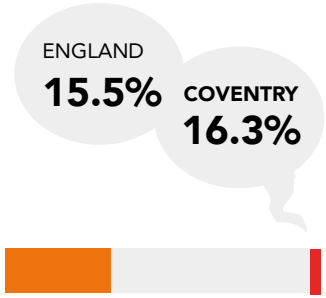
Many cases of Type 2 diabetes can be delayed or even prevented by making simple lifestyle changes such as eating well, moving more and losing weight. There are lots of resources online that can support people to make these changes - diabetes UK (**https://www.diabetes.org.uk**) or HLS Coventry (**https://hlscoventry.org**).

Some people at higher risk of diabetes may be eligible for the Healthier You Diabetes Prevention Programme which has started in Coventry and Warwickshire this year. For those who are diagnosed with diabetes (either Type 1 or 2) learning how to better manage your diabetes is a positive step to make, whether that is by attending a diabetes education session such as DESMOND, peer support or accessing online learning. There is a range of checks everyone with diabetes should receive: these are the 15 Healthcare Essentials (on the Diabetes UK site).

It is never too late to make positive lifestyle changes. Losing weight can reduce or even reverse the need for medication and quitting smoking will significantly reduce the risk of longer term complications. Making positive lifestyles changes and ensuring the 15 Healthcare Essentials are received will improve control of diabetes, reduce the risk of complications (heart, kidney, nerve, foot or eye problems and strokes) and reduce the chances of having a longer term disability.

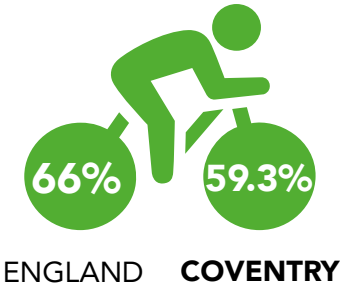


Coventry's healthy habits:



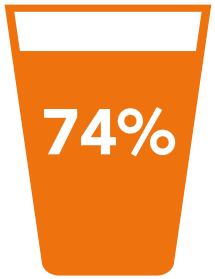
SMOKING

Percentage of adults (over 18 years) who smoke, similar to the national benchmark 2016



PHYSICAL ACTIVITY

% of physically active adults 2016/7, worse than national benchmark



ALCOHOL

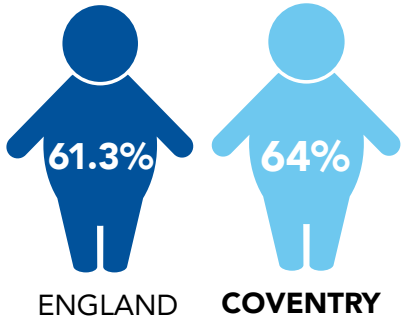
An estimated 22% of residents drink alcohol. Of those, 74% drink more than the recommended daily amount of 2-3 units at least once a week.

ENGLAND
56.8%

COVENTRY
51.2%

HEALTHY EATING

Percentage of adults (aged over 16) meeting the recommended '5 a day' on a usual day



HEALTHY WEIGHT

Percentage of adults (aged 18+) classified as overweight or obese 2015/6

An estimated 22% of residents drink alcohol, and of those who drink, 74% drink more than the recommended daily amount of 2-3 units at least once a week.

As a city we are less likely to take up behaviours proven to reduce the risk of illness and disability. We also know there is more that can be done to help Coventry residents adopt healthier behaviours.

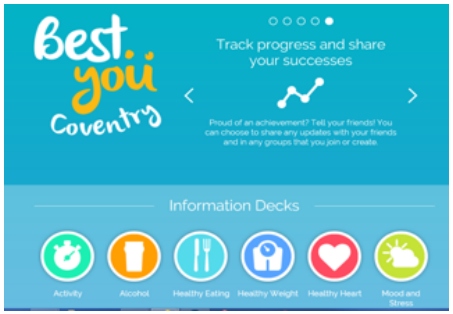
The Public Health team commissions services to support people to adopt healthy behaviours. These services have traditionally been separate, but they are now being delivered in one place.

The new service is called Healthy Lifestyles Coventry and provides flexible and person-centred support to empower people to adopt a range of healthy behaviours.

The aim is to give people the tools they need to increase their healthy life expectancy and increase their chances of remaining independent as they age. It provides services including NHS Health Checks for eligible people aged 40-74, help to stop smoking and support to increase healthy eating and physical activity.

In recognition of the potential negative impact of social and economic factors on healthy life expectancy, Healthy Lifestyles Coventry will target and provide the most intensive support to:

- People with multiple unhealthy behaviours (e.g. people who have low levels of physical activity and smoke)
- People with mental health conditions
- People at risk of developing LTHC such as cancer, heart disease and Type 2 diabetes
- People living in areas with high levels of deprivation



The service has a new website at www.hlscoventry.org and offers an online support platform called 'Best You' (this can be accessed for free via the main website). The service has a freephone 0800 122 3780 and the email contact is info@hlscoventry.org. People wishing to access support through the service can either refer themselves or be referred by a health care professional.

Coventry on the Move in Parks

Coventry City Council encourages physical activity as a way of life. Over the past year we have launched Coventry on the Move in Parks.

Coventry on the Move is aimed at encouraging people to get up, be active and have some fun in the process.

Coventry on the Move in Parks encourages more people to get active in parks and green spaces across the city. This includes around 44 walking and running routes. Among the first of these being developed is Stoke Heath Sports Ground (Morris Common). Each route has a series of distance marker posts so that people can check how far they have been travelling.

Coventry One Body One Life

Coventry One Body One Life is a free 10 week programme to help people make real changes to eating and exercise habits, to be fitter, healthier and more active.

What you said you did:

"Less snacking and more fruit."

"I've been doing more walking and walking faster to get my heart rate up".

"Giving up biscuits - changing to a less sugary treat."

"...quick and easy ways to exercise which are fun with the kids."

Adult education

Learning something new can be a great way to develop a social life and broaden one's horizons.

Coventry City Council has a thriving Adult Education programme, delivered from 26 venues in some of the most deprived areas of the city such as Hillfields and Bell Green.

The programme offers a range of apprenticeships, traineeships, courses with qualifications such as childcare, supporting teaching and learning in schools, accounting and bookkeeping, not to mention English, Maths and ESOL.

For many, engagement with a leisure course such as dancing can lead to increased confidence and further study. Through the Passport to Leisure and Learning (PTLL) scheme, the local authority supports those in the most need of gaining qualifications to access courses and activities. The scheme also supports people to secure a new job or promotion. Residents who qualify for a Passport to Leisure can also save money as they improve their health, fitness and learning by joining the scheme.

Immunisations

Individuals with LTHC and those aged 65 and over are more likely to experience serious and long term negative health impacts as a result of infectious diseases such as flu, which is a serious illness that can be fatal, even in people who were previously fit and healthy.

Vaccination can help to protect against some infectious diseases. There are three programmes available for adults:

- Influenza for those aged 65 and over, people with LTHC such as asthma and those working with vulnerable people (e.g. health care workers, care home staff and carers)
- Pneumococcal Polysaccharide Vaccine (PPV) for those aged 65 and over
- Shingles for those aged over 65

The childhood flu vaccination programme equally aims to protect the whole population, especially the elderly and those with long term health conditions, as children are one of main ways flu is passed onto others.

Flu vaccination coverage

Just over two thirds of older people in Coventry protect themselves with a flu vaccine. Only half of eligible people who are at most risk protect themselves with the flu vaccine. Less than half of children in the eligible range are protected by a flu vaccine.

	2016/17		
	Age 65+	Clinical at risk (under 65)	Age 2-4
Coventry and Rugby CCG	**69.3**	**51.6**	**33.6**
England	**76.5**	**48.6**	**38.1**

Adult vaccination coverage

Under half of Coventry older people are protected from shingles (varicella zoster) through vaccination. Over two thirds of older people take up the vaccine for pneumococcal disease, which is similar to national rates.

	2016/17	
	Shingles	Pneumoccocal (PPV) (over 65)
Coventry and Rugby CCG	**44.9**	**69.3**
England	**48.9**	**69.8**

Source: PHE Fingertips

Cold homes

Older people and those with long term health conditions such as heart disease are at risk of health problems relating to living in a cold home. Some may have a cold home due to the costs of heating, but 'fuel poverty' is also related to the energy efficiency of housing. In 2017/18 Coventry City Council partnership programmes enabled 21 people with a long term health condition to have a new boiler or central heating system fitted. A further six people were supported because they were elderly or because there was a child living in the property. Energy efficiency measures were also fitted for 11 people with a long term health condition.

2. Social isolation and loneliness

The Age-friendly Coventry Programme is an international effort to help cities prepare for a rapidly ageing population. An Age-friendly city is an inclusive and accessible urban environment that promotes active ageing. The research identifies eight domains of the urban environment that support active and healthy ageing:

- outdoor spaces and buildings
- transportation
- housing
- social participation
- respect and social inclusion
- civic participation and employment
- communication and information
- community support and health services

The five year programme involves assessing the 'age-friendliness' of a city against the eight domains with stakeholders and development of a three year plan of action based on the assessment findings. In Coventry, Information, Social Participation, Transport and Communication have been identified as priority areas following the baseline assessment and stakeholder engagement.

Coventry City Council is supporting a call to action to end social isolation and loneliness across the city and complete further work with partners focusing on the following areas:

- Ensure our limited resources are utilised in a way which maximises the benefit to adults who are at risk or are socially isolated / lonely in Coventry
- Coordinate the activities offered by all partners in the city working within this area, including voluntary organisations and statutory agencies, clearly understanding where their support fits into the overall support system
- Identify opportunities to tackle loneliness and build more integrated and resilient communities
- Use evidence based programmes to tackle social isolation and loneliness and ensure these are being accessed by the right users

Case study

Book Lovers' Vintage Tea Parties

For Older People's Day 2017, the Coventry Library Service decided to take an approach designed to gently encourage socialisation and connectivity by encouraging conversations around reading in a welcoming and informal environment. The service held Vintage Tea Parties at Bell Green Library and Allesley Park Library. These events attracted over 65 people and proved popular with older people and their families. For many attendees, the event was a good introduction to reading clubs and other activities as a way to increase their social interaction.

Images from older People's Day, provided by Library Services

Case study

Good Neighbours Coventry

The Good Neighbours Coventry scheme was developed by local churches in partnership with Age UK Coventry to tackle isolation and loneliness amongst older people in the city through developing local, community-based, 'neighbourly' support, both with one-to-one befriending and through new social groups such as a fortnightly cream tea. The one-to-one element of the project recruited 168 volunteers in the first eight months who were supported to engage with 228 older people living in Coventry.

Family Update

A month later, Alfred seems much brighter. Speaking of the community group, Alfred said 'it's been a fantastic experience; I wish I'd found out about it sooner.' Alfred explained he was now part of a local reading group and has been on group walks in the countryside, all organised through the home. Alfred enjoyed his time at the home. He now volunteers at the home every week to sit and speak with residents.

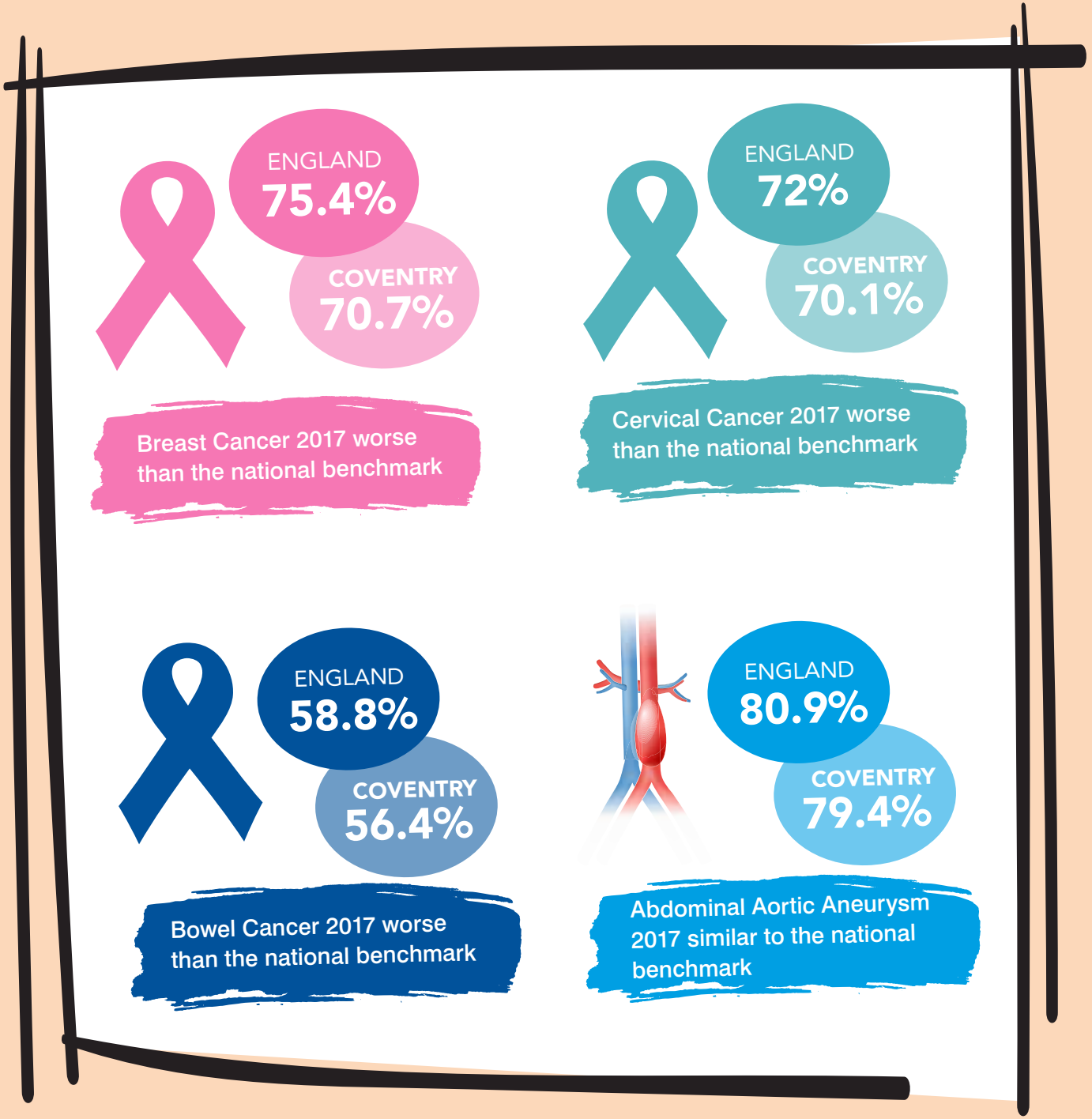
3. Early identification

Many serious diseases such as cancer and heart disease can be treated effectively if caught early enough. The identification of a disease or its constituent risk factors is an essential tool in increasing healthy life expectancy.

Health checks

58% of eligible Coventry residents had a health check between 2013 - 2018

Health checks aim to help people manage their risk factors for disease. Everyone aged 45 to 74 should be invited for a health check by their GP. The results may indicate if someone has or is at risk of developing certain health conditions such as heart disease, Type 2 diabetes and stroke. The health professional will provide advice on issues such as increasing the level of physical activity or medication to lower the risk of developing a long term health condition. The health check now includes supporting people aged over 65 to recognise the signs and symptoms of dementia. Over half (58%) the eligible Coventry population had a health check in the period 2013/14 to 2017/18, which is better than the national average. Coventry ranks 18th nationally out of 152 local authorities for the uptake of health checks. (**Source: PHE Fingertips**).

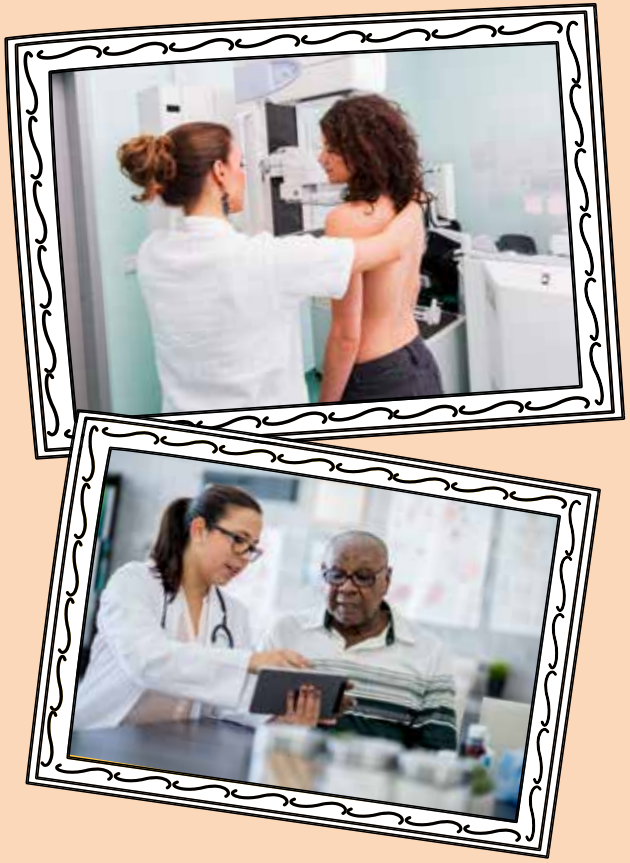


Screening

Screening aims to identify health conditions at an earlier stage than when a person would have sought help for any presenting symptoms. Early identification of these health issues improves the likelihood of a good long term outcome.

There are four screening programmes available to identify people at risk of breast, bowel, cervical cancer and abdominal aortic aneurysms:

- **Breast screening:** for women aged between 50 and 70 who have not had a breast cancer screen for three years or more. Those aged over 70 can arrange a screen through their GP.
- **Bowel screening:** all men and women aged 60 to 74 registered with a GP in England are automatically sent a bowel cancer screening kit every two years. Those aged over 70 can arrange a screen through their GP.
- **Cervical screening:** for women who have not had a cervical screen as detailed below:
  - aged 25 - 49 and not had a screen for three years or more
  - aged 50 - 64 and not had a screen for five years or more
  - over 65 and not been screened since they turned 50
- **Abdominal Aortic Aneurysm:** screening for men aged 65 to 74 who have not had a previous screen.



On average, people in Coventry do not take up the offer of screening as much as across England as a whole. Screening rates for Coventry are below the national average for breast, bowel and cervical cancer. The rate for abdominal aortic aneurysm screening is similar to the national average.

Clearly, there is much that we as individuals and community groups can do to increase the likelihood of living healthier for longer. However, there are times where further support and intervention will be required and it is important to recognise this, as well as the wider challenges facing health and care services.

Links to useful resources

www.uhcw.nhs.uk/our-services-and-people/our-departments/bowel-cancer-screening/

www.uhcw.nhs.uk/our-services-and-people/our-departments/abdominal-aortic-aneurysm-aaa-screening/

www.uhcw.nhs.uk/our-services-and-people/our-specialities/breast-screening-specialty-imaging/

Recommendations

- **Increase the profile of ill health prevention through innovative opportunities to promote health and wellbeing across the work of the Council and its partners**
- **Further develop partnership working across primary care, Public Health, secondary care and social care to improve immunisation rates, particularly for at risk groups**

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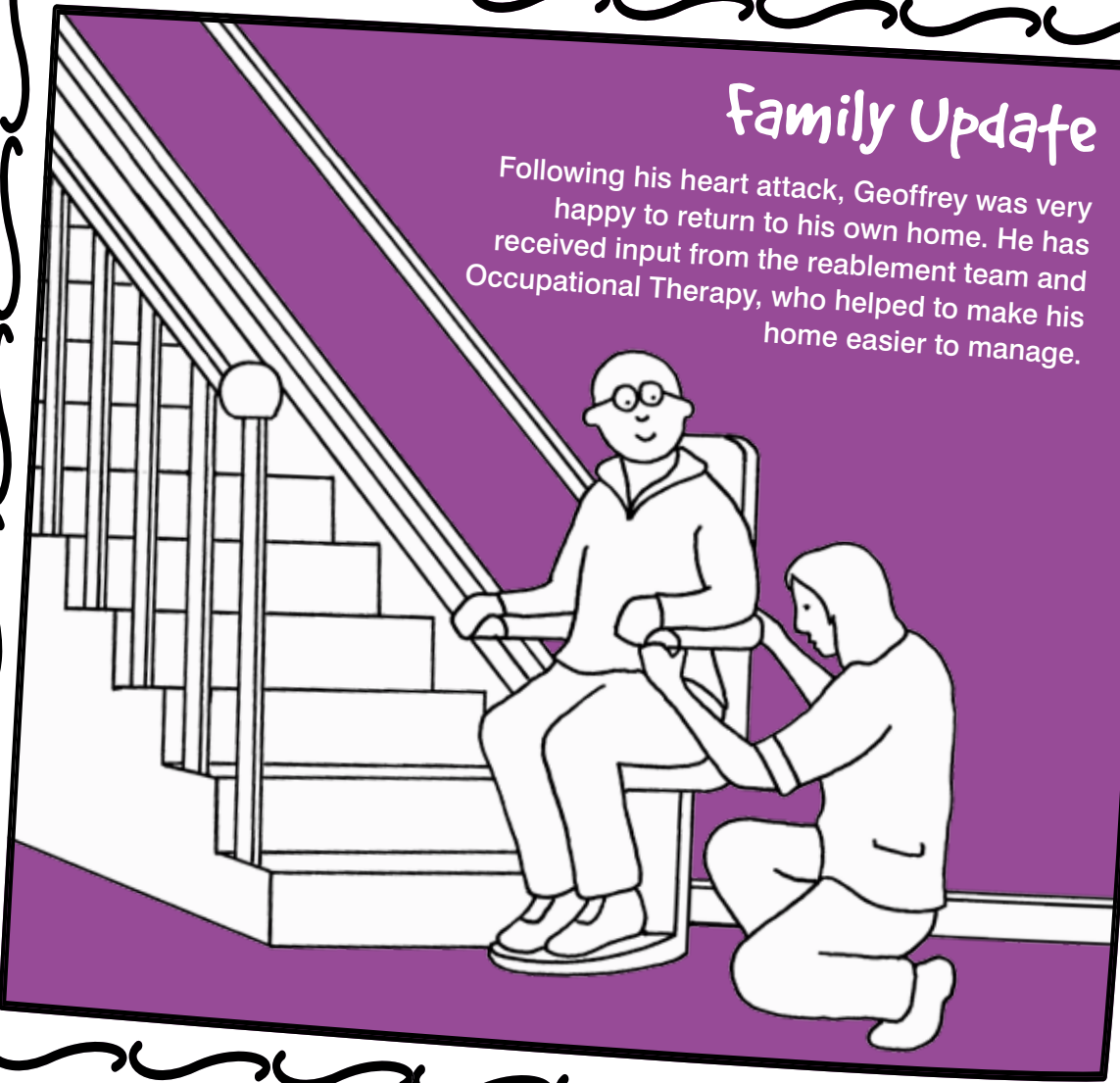
Chapter 4
Health and Care Services for the older Population of Coventry

Health and Care services in Coventry are close to full capacity, with pressures on the system growing every year. Keeping Coventry residents as independent as possible for as long as possible is the cornerstone of the Council's strategy to reduce demand on services. The vision for Adult Social Care in Coventry is to enable those people most in need to live independent and fulfilled lives with stronger networks and personalised support.

Family Update

Following his heart attack, Geoffrey was very happy to return to his own home. He has received input from the reablement team and Occupational Therapy, who helped to make his home easier to manage.



1. Remaining independent

Health and social care providers in Coventry are committed to making sure that people receive the right care when they need it and in a way that meets their needs and achieves their outcomes.

Across Coventry, organisations have come together to design services that work better, are more aligned with the needs of individuals and communities and provides a high standard of support.

Supporting people to retain their independence at home allows people to keep their existing social and support networks. It contributes to a sense of wellbeing and helps people feel in control of their choices and outcomes. Evidence tells us that people who are independent and can stay in their own home maintain their physical and psychological health for longer. The provision of early support and advice can play an important part in this.

An example of how people are supported to live independently is through the community Promoting Independence service (PI), whose main objective is to promote independence and prevent or delay the need for ongoing services. Our approach to promoting independence works through enabling the person to continue carrying out essential activities independently or with minimal support. Similarly, after a period in hospital the Discharge to Assess service in place, funded by both the CCG and Coventry City Council, helps to ensure that people are reabled to maximise their independence.

When a person starts to experience difficulties and it appears there is a need for support, it can be counter-productive to provide a lot of care support at this stage, even if this is what the person is

asking for. Too much care and support can have a detrimental effect on the person's health and wellbeing, as they become less functionally active. It is, therefore, essential to appropriately target support where it can have the greatest benefit.

The PI service starts with an assessment by an Occupational Therapist with a promoting independence focus. This ensures the person has access to therapy at an early stage which could include advice on different techniques to carry out tasks, provision of equipment or more significant household applications, for example, a stair lift or level access shower. Through our PI service people may be supported for up to six weeks to help them regain the skills needed to live independently or to practice new ways of carrying out a daily living task, it also allows for a period of assessment to gain a clear picture of any ongoing care needs.

If it is identified that there is ongoing care support

Data on Promoting Independence from January to June 2018:

- **108 people referred to the service**
- **66 people (67%) referred to the service, did not go on to receive a long term service**

required, the Social Worker can use the evidence gathered during the PI service to ensure an appropriate level of support is in place to support the individual to achieve their outcomes and promote their health and wellbeing.

The kitchen facilities at Gilbert Richards Centre, a Coventry City Council facility, have recently been modified to enable the Occupational Therapists to carry out kitchen assessments where appropriate. The City Council and health partners also work with the voluntary and third sector to support people in ways that reduce the need for formal care and support and which improves their health and wellbeing.

2. The vital role of carers

The contribution of carers is hugely important to the health and care system. The overall number of carers is rising, but the proportion is shrinking because the number of people who need care is growing faster than the number of people who can provide informal care. It is estimated that in Coventry alone, those providing informal care and support save the Social and Health Care Economy £680 million (**Valuing Care 2015**).

Key Definition

Carer: A carer is anyone who cares, unpaid, for a friend or family member who due to illness, disability, a mental health problem or an addiction, cannot cope without their support.

For many people, being a carer is an important part of their life, with some not even realising they are a carer. The average age when people start to become carers is between 50 and 60 years old, although for many people their caring experience starts when they are much older or far younger. Caring is usually incremental, meaning carers are more likely to increase their responsibilities over time.

Caring for a loved one can be very rewarding, but carers can face lots of challenges and struggle to receive the right amount of support themselves. They dedicate a huge amount of time to meet their caring responsibilities and often experience increased personal challenges as a result of this, such as remaining in employment and financial hardship. Carers are also at increased risk of social isolation and their own health may suffer.

According to the last census in 2011, 32,102 people in Coventry self-identified as a carer.

Caring is getting complex. As our population ages, more people are taking on informal caring roles with sandwich caring being more prevalent, where people care for their children as well as their parents. There are also more people in mutual caring relationships where both partners have care needs themselves.

Coventry launched its Carers Strategy in 2016. This multi-disciplinary strategy was developed with key partners. The strategy seeks to improve the overall experience of carers within Coventry.

Early identification and recognition of carers (even at the point of contemplation of being a carer) is essential to the delivery of effective carer support. Getting support from the outset or early on is likely to sustain a caring relationship and have better outcomes for the person they are caring for. Crucial to this within Coventry is the role of awareness-raising and engagement activities with wider organisations and carers.

Information and Advice

Within Coventry, the Carers Trust Heart of England is key to the delivery of carer support services, delivering the Coventry Carers' Wellbeing Service, which offers information and advice, carers peer support groups, primary care support, hospital outreach, social activities, awareness raising courses and training. The Carers Trust Heart of England also holds a delegated responsibility from the local authority to undertake Carers Assessments under the Care Act 2014.

Carers Assessments

A Carers Assessment is a good way for a carer to talk to someone about their caring role, the impact this has on their wellbeing, their strengths and aspirations. It will identify areas of support where a carer may be experiencing difficulties and how these needs might be met, whether it is through effective signposting, knowing their rights, support with contingency planning or support services arranged through the Council, which could include replacement care so that the carer can take a break.

3. Integrating Health and Care Services

The health and social care system is made up of services to treat illness, support people with long term conditions and to provide care and support for people who need help with their activities of daily living. All health and care organisations in Coventry strive to improve the quality of the service they provide in order to make sure people are given the care and support they need when they need it.

Coventry's Health and Social Care System

Like the rest of the country, health and care services are facing more pressure than ever before to deal with increasing demands. There is an increase in the amount of chronic conditions people face and more and more people are living with more than one serious illness. As people get older, they are more likely to have a long term condition, more likely to have more than one condition at a time and also more likely to experience complications as a result of their conditions.

Meeting increasing demand is a challenge across health and care. This is compounded by challenges in recruiting and retaining staff, with some care and support providers choosing to exit the market for a range of sustainability issues. Access to A&E by older people is increasing and in older people A&E attendances are more likely to result in inpatient admissions.

Using technology to improve care

Coventry Adult Social Care has an ambition to increase the availability and use of technology to improve the care offered to residents and their carers. They are exploring how different technologies can more proactively be introduced into the care and support planning process. Examples of how the Council is currently utilising technology to support people include:

'Brain in Hand' pilot - Living with autism, a mental health condition, a learning difficulty or a brain

During the 2017/18 financial year, hospitals within the Coventry and Rugby CCG handled:

- **60,903 planned admissions**
- **51,594 unplanned admissions**
- **211,103 attendances in A&E**
- **556,105 outpatient appointments**

In addition:

- **3,043 people over 65 years old received ongoing long term services from Adult Social Care, 1,980 people received short term services in their own home and 1,063 people received nursing or residential support funded by Adult Social Care**

injury can lead to difficulties in making decisions, controlling emotions and choosing appropriate behaviour. Brain in Hand compensates for the impairment in executive function that goes alongside those conditions. The APP for mobile devices provides people with personalised activities and coping strategies which they can access anywhere at any time and also monitors their anxiety levels. The system also provides data about use of the APP and the person's status (OK/Coping/High Anxiety) and operates a 'traffic light' system linked to Responders who have been identified as being able to support the user.

'Just Checking' activity monitoring – The Council is working with a company called Just Checking to introduce a system that gives greater insight into an individual's behaviour and their changing care and support needs. This information helps care professionals understand how a person naturally behaves in their own home in the most objective and unobtrusive way possible.

Caring for people with dementia

There are an estimated 4,885 people living with dementia in Coventry and Rugby in 2017 of which 2912 have a formal diagnosis (**Dementia Partnerships Dementia Prevalence Tool**). As described in Chapter Two, the number of people living with dementia is expected to rise as the number of older people living in Coventry increases and the risk factors associated with dementia also increase. It should, however, be noted that dementia is not confined to older people.

Coventry City Council and Coventry and Rugby Clinical Commissioning Group launched its first dementia strategy in 2014 (**Living Well With Dementia Strategy, 2014-2017**), in partnership with the Coventry and Warwickshire Dementia Alliance. The strategy sets out Coventry's commitment to supporting people to live well with dementia.

The lives of people with dementia and their carers can be improved by approaches that put the individual and their family at the heart of their care and support. Planning for the future, particularly in the earlier stages of the condition can significantly help families navigate future challenges and obstacles. Maintaining autonomy and independence whilst ensuring risks are managed can be a difficult balance to achieve, but one that can be made easier through open communication with families and the support of relevant organisations.

Family Update

Cathy joined Alfred on a visit to the care home. Cathy was interested in the day centre and the activities available, thinking about the longer-term care of her father Geoffrey. Alfred introduced Cathy to Mavis, who at 87, suffers from dementia and requires assistance with daily activities.

Alfred explained whilst he cannot assist in the provision of formal care, he can provide informal support, such as sitting and talking to Mavis, which can help ease some of the behavioral changes brought on by her condition.

Progress on actions from the 2014 strategy has improved key outcomes for people living with dementia in Coventry:

- Waiting times for a Memory Assessment Service (MAS) memory assessment have reduced significantly, with 95% of patients receiving an assessment within the 12 week target
- Diagnosis rates for Coventry and Rugby have increased from 48% in 2013 to 60% in 2017
- There is more support available for people living with dementia and their carers
- Community Promoting Independence (formerly D2A) offers intensive reablement for people with dementia coming out of hospital, enabling 73% of service users to return home
- Arden Grove is a new 33 bed specialist Housing with Care Scheme which offers an innovative model of person-centred care and promotes the use of meaningful engagement activities based on the Eden Alternative Care Model
- The 630 residential dementia beds across 21 care homes are regularly visited by CCG nurses who offer support in making care homes more dementia friendly, including OT student placements to develop individual activity programmes

Responding to falls and fractures

The Coventry and Warwickshire Clinical Commissioning Group population has a higher rate of admissions for fractures compared to similar CCGs. The CCG also has a higher rate of elective and non-spend on osteoporosis and fragility fractures. Collective action across health services in Coventry could contribute to a reduction on hospital admissions in older people due to falls and fractures.

Presenting to health services following a fall presents an opportunity for preventing future falls. In 2010 The Royal College of Physicians national audit of falls and bone health in older people found that healthcare professionals often miss the best, or only opportunity to identify the falls and fracture risk for high-risk patients (whether they attend A&E or are admitted as inpatients); and most primary care organisations lack adequate services for preventing secondary falls and fractures. (**Royal College of Physicians. Falling Standards Broken Promises: Report of the National Audit of Falls and Bone Health in older People 2010. 2011**) In addition, establishing links between services that see patients with risk factors for falls may help identify those who would benefit most from early intervention.

Adult Social Care

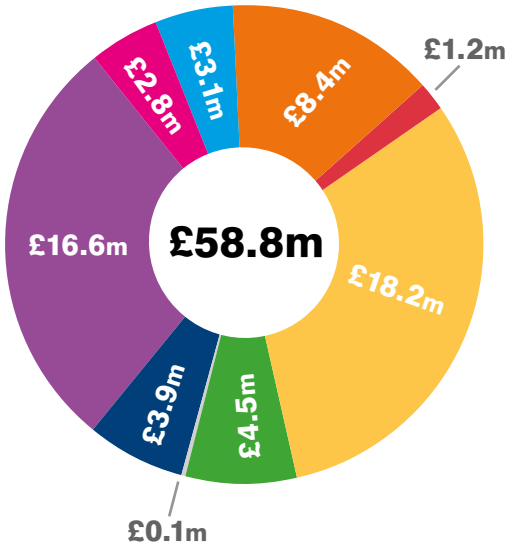
Adult Social Care is the single biggest area of spend for Coventry City Council, with a budget of £71.8 million in 2017/18, compared to £78.1 million in 2016/17. Of this, £58.8 million is spent directly on people to provide support (**Coventry City Council Adult Social Care Local Account 2017/18**).

Integrating Health and Care services

A key priority for Coventry and Warwickshire is to increase the integration of health and care services. Integration is not a means in and of itself and integration activity will be pursued with the intention of people receiving more seamless care and support. This means residents will find it easier to access the care they need and that this care is delivered in a joined up way. Current research suggests this makes the use of health care resources more efficient.

Engagement with Coventry residents tells us that people who use health and care services want to see services that are more joined up, work well together and meet expectations.

2017/18 Spend on People



The Sustainability and Transformation Partnership (STP) across Coventry and Warwickshire is the main planning forum for the future of health and care services. It is made up of:

- Coventry City Council
- Warwickshire County Council
- NHS Coventry and Rugby Clinical Commissioning Group
- NHS Warwickshire North Clinical Commissioning Group
- Coventry and Warwickshire NHS Partnership Trust
- NHS George Eliot Hospital NHS Trust
- NHS South Warwickshire Clinical Commissioning Group
- NHS South Warwickshire NHS Foundation Trust
- University Hospitals Coventry and Warwickshire NHS Trust

Over the past two years, the Better Health, Better Care, Better Value (formerly the Sustainable Transformation Partnership) has been working to improve population health and health and care services across Coventry and Warwickshire.

Case study

Male suicide

Suicide continues to be three times more common in men than in women and is the single most common cause of death in men under 45. The STP made a successful bid for additional funding aimed at reducing suicides in this cohort, from which a number of initiatives came into being or were expanded, such as increasing effort to tackle stigma and isolation, improved support services, ensuring effective access to services for those with mental health problems predisposing them to thoughts of suicide and developing the 'It Takes Balls to Talk' campaign, amongst other things.

Improving the transfer of care

Coventry is taking a system-wide approach to improving the transfer of care from hospital to community settings. The Council and its health partners have taken a specific focus on reducing the delay of discharges from hospital.

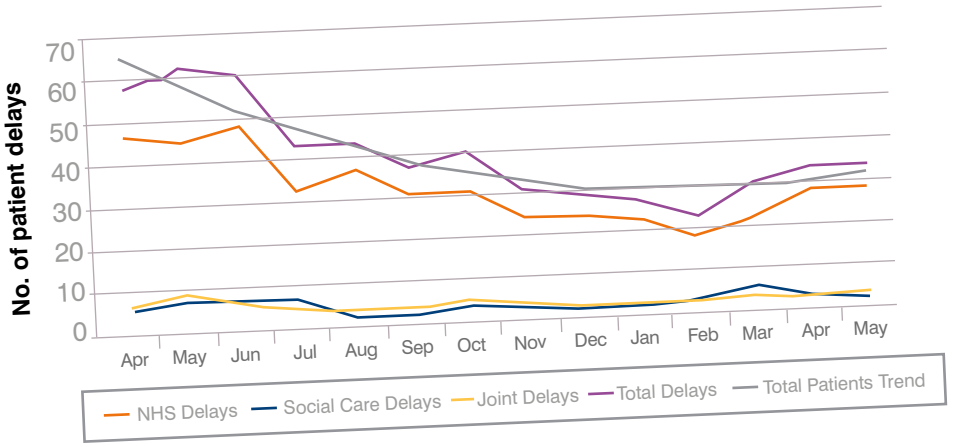
Data shows significant improvements in patient delays and the number of days patients are delayed between April 2017 and May 2018. Locally, the ranking for Delayed Transfers of Care has improved to 91 nationally out of 152 in March 2018, which was an improvement on the previous year. For Adult Social Care delays only, Coventry was ranked 29th lowest as of May 2018, putting us into the top quartile for national performance.

Case study

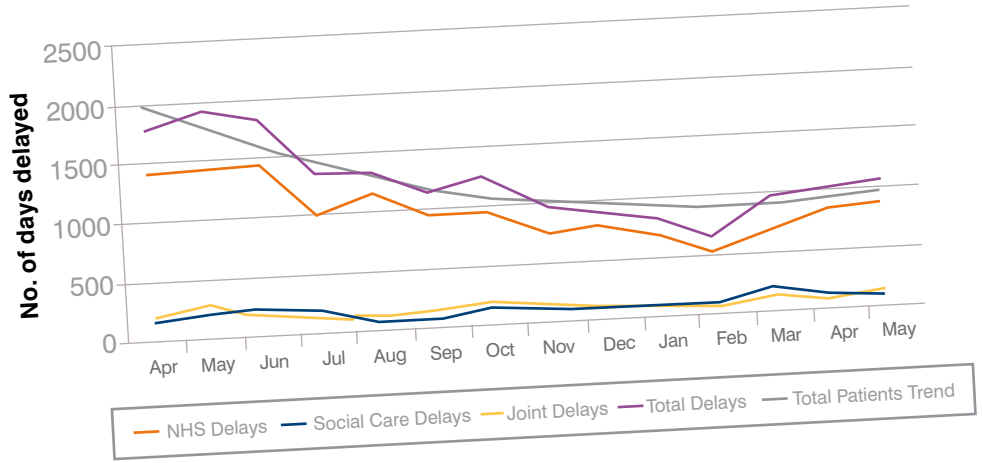
React to Red

React to Red Skin is a campaign across health and social care that trains carers to recognise people at risk and to take steps to prevent pressure ulcers developing. The programme recognises care homes, nursing homes and domiciliary care agencies that have demonstrated they have all the necessary steps in place to care effectively for residents and minimise the risk of pressure ulcers developing.

Coventry - Patient delays by type over last 12 months



Coventry - Number of days delayed by type over last 12 months



Work to improve the robustness of the system includes increasing GP coverage of care homes and strengthening the input of pharmacies.

Link to useful resource

Valuing Carers 2015 – Carers UK

https://www.carersuk.org/for-professionals/policy/policy-library/valuing-carers-2015

Recommendations

- Encourage co-design of services, particularly during re-commissioning, by incorporating what good would look like to older people
- Work with established and emerging organisers of services within the region to design integrated health and care pathways to deliver high quality care for older people that make best use of available resources

Summary and Recommendations

Life expectancy and Healthy life expectancy

- As seen nationally, life expectancy in Coventry is stalling and showing a reversal of a previously unbroken trend of continued improvement.
- Men and women in Coventry can expect to live for almost a year less when compared to the average in England. Life expectancy in Coventry is 82.4 for women and 78.5 for men, compared to the England figures of 83.1 for women and 79.5 for men.

- This slowing down of the gains adding years to life is not inevitable. Of more concern, is the slowing down and reversal of gains made to healthy life expectancy.
- As people get older, they are more likely to have a long term health condition, have more than one health condition at a time and experience complications as a result of their illnesses.
- In Coventry the gap between life expectancy and healthy life expectancy is 16.3 years for men and 19.5 years for women, meaning the average person in Coventry can expect to live many of their later years in poor health.

Prevention

- There is more that can be done to promote positive lifestyles and measures to prevent poor health in later life.
- Coventry lags behind national outcomes for uptake of breast, bowel and cervical cancer screening. The uptake of abdominal aortic screening is similar to national rates, limiting opportunities for early identification.
- Coventry does worse in protecting older people and high risk groups with vaccination against influenza.

Maintaining independence

- Coventry City Council provides social care services to help people remain independent for as long as possible.
- A key aim of the city is to ensure that people who receive support get the right information they need at the right time.

- Care pathways are designed so that the appropriate amount of support is given to residents in response to their needs.

Delivering high quality care for older residents

- There is an increase in demand for services.
- Coventry has specialist services for helping people improve their lifestyles, reduce admissions to hospital, regain independence after a period of illness, support those living with dementia and to support those with caring responsibilities.

Integrating services for better health and care outcomes

- A key priority for Coventry and its neighbouring areas is to increase integration of health and social care services.
- This means residents will find it easier to access the care they need and that care is delivered in a joined up way.

Recommendations

1. Work with community partners to establish a narrative around older people as assets, which gives a rounded sense of the contributions older people give to Coventry as a city
2. Promote community-based groups and activities to combat social isolation and loneliness
3. Encourage the further reduction of health inequalities by embedding the Marmot City approach across the work of the Council and partners
4. Increase the profile of ill health prevention through innovative opportunities to promote health and wellbeing across the work of the Council and its partners
5. Develop partnership working across primary care, Public Health, secondary care and social care to improve immunisation rates, particularly for at risk groups
6. Encourage co-design of services, particularly during re-commissioning, by incorporating what good would look like to older people
7. Work with established and emerging organisers of services within the region to design integrated health and care pathways, to deliver high quality care for older people that maximises the use of available resources

Family Update

Cathy shared that she had started to make some minor lifestyle changes and was beginning to feel the difference; 'This time', Cathy said, 'I'm in it for the long-haul'. Cathy also mentioned her parents were doing well, Alfred was now a consistent visitor at her parent's home and this has given both Alfred and her father a fresh outlet. Cathy was 'more optimistic about the future', in her words, but recognised the challenges we all face in maintaining health in later life, particularly for older people like her parents.

Update from last annual report

The Childhood Obesity Alliance was established to support development of the last annual report and continues to meet following report publication. The Alliance brought together a range of partners and generated two key subgroups to progress actions from the report focussing on Early Years and schools. The DPH Annual Report was presented to a range of audiences and championed by Alliance members across their networks. It has also influenced the approach of a wider range of programmes in support of a whole systems approach to childhood obesity. It is only through whole systems approaches, long term actions and sustained focus that we will see a shift in childhood obesity rates.

Some key activities and achievements since publication and ongoing opportunities include:

Early Years and schools

- Creation of Family Hubs across the city transforming how we support children, young people and families
- Redesign and commissioning of an Integrated Family Health and Lifestyles Service from September 2018, bringing together a range of services and aligning our Family Hubs – including antenatal lifestyles support and advice, breast feeding and infant feeding support, the National Childhood Measurement Programme and family healthy lifestyles programmes.
- Local schools pilot between school nurses and Food 4 Life on whole school approaches to food
- Working with primary schools to promote the Daily Mile initiative and establish childhood obesity champions

Families and communities

- Alliance partnership for a bid to the Sport England Families Fund
- Redesign and commissioning of adult lifestyles services through Healthy Lifestyles Service Coventry launched April 2018
- Working through the Place Forum to promote the Year of Wellbeing 2019 supporting workplace wellbeing, promoting simple wellbeing messages to our population including the Daily Mile and embedding Making Every Contact Count approaches across our workforce

Physical activity environment

- Collaboration through Leading Places pilot and the Coventry Sports Network to develop a Local Delivery Pilot Sport England bid
- Creation of physical activity routes in a range of parks across the city – launched in January 2018 in partnership with Stoke Heath Primary School
- Renewal of our partnership with British Cycling and local Bikeability programmes
- Launch of Choose How you Move active travel planning resource across Coventry and Warwickshire
- Wider planning and place collaborations to support active travel and improvements in air quality

Food environment

- Collaboration with Severn Trent to support availability of free drinking water in the city 'Refill'
- Ongoing development of a Hot Food Takeaway Supplementary Planning Document to support planning policy to limit and apply restrictions to new hot food takeaways

There are significant opportunities in the near future to further strengthen our whole system approach to childhood obesity, particularly through the Year of Wellbeing 2019, European City of Sport 2019 and City of Culture 2021. The Childhood Obesity Alliance is keen to capitalise on these opportunities to ensure they support healthy lifestyles and healthy weight.

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Coventry
Health and Wellbeing

Coventry City Council

Report

To: Coventry Health and Wellbeing Board **Date: 8 October 2018**

From: Andrea Green, Accountable Officer
Matt Gilks, Director of Commissioning
Coventry and Rugby Clinical Commissioning Group

Title: Coventry and Rugby CCG 2019/20 Commissioning Intentions and 2018/19 Annual Report

1 Purpose

The purpose of this report is to provide the board with an update on the 2018/19 Annual report and the process to develop 2019/20 Commissioning Intentions. In particular, it covers:

- Performance against the NHS constitutional standards
- Updates on work programmes to enhance health and wellbeing and improve outcomes
- The process to developing a refreshed set of commissioning intentions following extensive engagement and feedback

2 Recommendations

The Coventry Health and Wellbeing board is asked to

1. Note progress being made to deliver the CCG 2018/19 commissioning intentions for Coventry

2. Note the key messages from the 2018/19 Annual Report.

3 Information/Background

All CCGs are required to review and outline the actions they will take to improve the health and wellbeing of their local population on a yearly basis

The plans are summarised in documents called ‘Commissioning Intentions’ which set out the priorities for the CCG in line with national and statutory requirements. For 2019/20 they are set in the context of ongoing and significant financial and clinical workforce challenges.

The 2019/20 commissioning intentions have been developed in line with:

- Extensive engagement with clinicians, stakeholders and the public
- The health needs of our local population, as defined in local Joint Strategic Needs Assessments (JSNA)
- National health deliverables for 2019/20, focusing on areas of key performance challenges for the CCGs

Our commissioning intentions will also set out the strategic direction for the CCG with the context of the local system, looking for ways for all health and care providers to work more closely together for the benefit of our population, whilst keeping a focus on the local needs and priorities. To reflect this more collaborative approach, we are working closely with Warwickshire North CCG and South Warwickshire CCG to develop 2019/20 commissioning intentions that benefit everyone across Coventry and Warwickshire.

The resulting refreshed commissioning intentions were published in September 2018 which have been divided into groupings based on the 'Better Health, Better Care Better Value' workstreams.

Work stream Priorities areas for 2018/19

- Primary Care
- Out of Hospital
- Maternity and Paediatrics
- Urgent Care
- Planned Care
- Mental Health
- Self-Care

Progress made against priority work stream areas

As part of the process to produce commissioning intentions for 2019/20, a full stocktake of progress against the milestones has been undertaken.

A summary of the progress against each programme area and key achievements to date are included with the commissioning intentions documents which will be available to download from our website.

4 Recommended Proposal

Members are asked to review the commissioning Intentions documents and to:

1. Note progress being made to deliver the CCG 2018/19 commissioning intentions for Coventry

2. Note the key messages from the 2018/19 Annual Report.

Report Author(s): Matt Gilks

Name and Job Title: Director of Commissioning

Directorate: Strategy and Primary Care

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Enquiries should be directed to the above person.

Appendices

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Coventry City Council

Report

To: Coventry Health and Wellbeing Board **Date:** 8th October 2018

From: Richard Stanton, West Midlands Fire Service (Co-Chair Marmot Steering Group)

Subject: Progress update on Coventry's Marmot City Strategy 2016-2019

1. Purpose

The purpose of this paper is to present an update to Coventry Health and Wellbeing Board on the progress made against the first priority of the Coventry Health and Wellbeing Strategy (Working together as a Marmot City to reduce health and wellbeing inequalities).

2. Recommendations

Coventry Health and Wellbeing Board is recommended to:

i) Endorse progress made to date against the Marmot Action Plan and contribute comments and suggestions to reduce inequalities and address poverty in Coventry

ii) Agree to receive further progress updates from the Marmot Steering Group every six months

3. Background and context

In 2016, Professor Sir Michael Marmot and his 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 in tackling health inequalities. In October 2016, the Action Plan was presented to the Coventry Health and Wellbeing Board for their endorsement of the progress made to date. It was agreed that further progress updates from the Marmot Steering Group would be made every six months.

Partners are continuing to work together on a number of projects initiated as part of the first two years of Coventry's Marmot City programme. In addition, for the following 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.

An additional priority has recently been added to the Marmot City programme, which is the mitigation and prevention of poverty across the city. Work has been carried out to map existing programmes and workstreams which contribute to this priority. As part of this programme, a working group has been established to explore the issues and opportunities related to in-work poverty and worklessness.

A Poverty Summit is currently being planned which will provide an opportunity to bring together a range of stakeholders to discuss the key issues and identify new ways of working.

A wide ranging and robust evaluation of the Marmot Programme in Coventry will be started in November and is expected to take 6-9 months to complete. This evaluation will be overseen by the Institute of Health Equity, Public Health (Coventry City Council) and Public Health England and will focus on the impact of the Marmot programme and how the partnership approach has affected health inequalities across the city.

4. Options Considered and Recommended Proposals

This update covers the progress made against the programme indicators for past year. The Marmot Steering Group meets once per quarter to receive updates from partners, discuss progress and identify areas for development and partnership working.

There remains strong commitment to the Marmot programme from the City Council and its partners on the Steering Groups (People and Place directorates in Coventry City Council, West Midlands Police, West Midlands Fire Service, Coventry and Rugby Clinical Commissioning Group, Voluntary Action Coventry, the Coventry and Warwickshire Chamber of Commerce, Coventry and Warwickshire LEP and the Department for Work and Pensions). The Institute of Health Equity and Public Health England have both confirmed their commitment to continue working with Coventry to take forward the health inequalities agenda post 2019, when the current agreement runs out. Positive Youth Foundation have recently agreed to be a member of the Steering Group, and an invitation has been extended to the Chief Executive of the City of Culture Trust and Foleshill Women's Trust.

The Marmot City Action Plan sets out the ways in which partners and other stakeholders will work to achieve the key priorities of tackling inequalities disproportionately affecting young people, and driving good growth in Coventry.

The action plan is currently being revised to reflect new projects and the new theme of poverty in the city, and as such, there has not been an update for quarter one in 2018/19. The plan below shows delivery up to the end of quarter four, 2017/18 and demonstrates progress against the programme indicators through a range of projects, including:

- 187 young people with disabilities or health problems accessing Ambition Coventry work coaches (against a target of 170)

- 254 young people supported by Ambition Coventry into employment, education or training (against a target of 214)

- 392 new clients accessing CRASAC's counselling service and helpline, aged 25 and under (against a target of 183)

- 982 people supported into employment by the Coventry Job Shop (against a target of 1200)

- Coventry and Warwickshire Chamber of Commerce working with local businesses to address issues around domestic violence and its impact on the workplace

The next steps for the Marmot Group will be to:

- Work with Public Health England and University College London to carry out a wide ranging evaluation of the impact of the Marmot work and how it has influenced work to address health inequalities across the city.
- Take forward the poverty work-stream and explore ways in which the impact of poverty in Coventry can be mitigated against or prevented, including running a Poverty Summit (details below).
- Continue to monitor progress against the action plan and identify new ways in which the Marmot priorities can be progressed.
- Continue to review the action plan in light of the emerging poverty work stream.

Tackling Poverty in Coventry

A Poverty Summit is planned and will be held on November 12th, 2018. Sir Michael Marmot will attend as key note speaker, and David Buck, Senior Fellow at The Kings Fund, will also attend. The event will bring together a range of strategic leads from a variety of settings, including the City Council, CCG, third sector organisations and business organisations. It is intended that the event will help to agree the key priorities that the City should focus on to preventing and mitigating against the impact of poverty, as well as securing commitments to action from the organisations represented.

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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 affect 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 are to build resilience, aspiration and mental health in young people and improve levels of education, employment and training so that young people are supported to live happy, healthy lives, whatever their background.

Action Plan: Tackling inequalities disproportionately affecting young people			
Aim	**Actions**	**Lead**	**Progress / barriers**
1. Develop an integrated model for school age children which builds on the *Acting Early* model for 0-5 year olds	• Evaluate the effectiveness of the *Acting Early* model • Work with schools and other partners to implement 'perfect week' cycles to continuously improve team performance and integration • Integrate *Acting Early* with the family hub model	Public Health in partnership with Education, Coventry City Council	Refresh activities completed (where possible) - focusing on maintaining core activities during the family hub implementation and ensuring acting early is at the core of family hub working processes. The Acting Early model for school aged children has been subsumed into the Family Hub work with public health still maintaining its position in driving forward change in this area.
2. Support young people who are not in education, employment or training through a range of ways, including the *Ambition Coventry* programme	• Ambition coaches will support young people through their journey into sustained employment or learning • Employer led programmes will strengthen young people's employability skills • Personal development and support programmes will be delivered, such as the 'Boot Camp' delivered by Valley House • Valley House and Positive Youth Foundation will use activities such as sports and peer-to-peer	Economy and Jobs Team, Coventry City Council, in partnership with other partners	Ambition Coventry's target was to register 1700 up until March 2018. Of those registered, 32% have moved into a positive destination, e.g. education, training and employment. Ambition Coventry have exceeded or almost reached its targets set against the Programme targets to date. Ambition Coventry was due to end as of July 2018, however the programme has been extended until December 2020.

	networking to conduct outreach to those who are disengaged		
3. Support young people who are at risk of becoming NEET through extending the *Ambition Coventry* programme	• Submit a bid to the ESIF Growth programme to extend provision of *Ambition Coventry* to young people who are at risk of leaving education, employment or training • If successful, implement extended provision and support	Economy and Jobs Team, Coventry City Council, in partnership with other partners	The Routes to Ambition programme is underway and a performance report will be available soon.
4.Change attitudes and behaviour and prevent sexual violence through introducing a prevention programme in schools	• Raise awareness and provide definitions of sexual violence, CSE and other grooming • Address attitudes to women, educate about consent, identify appropriate behaviour and keep safe online • Raise awareness of intimate partner violence amongst young people	Public Health, Coventry City Council, in partnership with CRASAC and Barnados	CRASAC have delivered a year-long programme to address intimate partner violence. Workshops and resources have been specifically designed for under 18s and over 18s. Train the trainer sessions have been run to ensure sustainability of the programme. A celebration event has been held to share the learning from this project and the sexual violence prevention in schools programme.
5. Improve mental health in young people and build resilience and self-esteem at an earlier stage	• Extend the scope of the Early Intervention Service beyond secondary schools to support primary school children and tackle issues at an earlier age • Improve and extend primary mental health services for young people • Implement a tool to measure wellbeing in schools	Public Health and Education, Coventry City Council in partnership with Compass and Coventry and Rugby CCG	Single point of contact reviewed and rolled out to High schools. Met with pastoral and safeguarding leads to share Compass service provision and to discuss referral pathways, local needs and work force training.

Programme Indicators: Tackling inequalities disproportionately affecting young people							
Indicator & Definition	**Organisation / Directorate** **Contact**	**Baseline data (15/16)**	**Actual 16/17**	**Target 17/18**	**Target 18/19**	**Actual Q4 17/18**	**Year to date 17/18**
PI1: Number of young people supported by Ambition Coventry into employment, education or training The Ambition Coventry programme supports young people who are not in education, employment or training to access Ambition coaches who will work with them to support them into education, employment or training.	Coventry City Council Place Directorate Kim Mawby	0	558 *Target: 232*	452	214 Ambition Coventry target: 898 young people over three years	53	**254**
PI2: Number of young people with disabilities or health problems accessing Ambition coaches This indicator focuses on young people who are not in education, employment or training and have learning disabilities and / or special educational needs and who are supported by the Ambition Coventry programme	Coventry City Council Place Directorate Kim Mawby	0	257 *Target: 93*	170	68 Ambition Coventry target: 254 young people over three years	10	**187**
PI3: Number of 16-24 year olds not in education, employment or training who are supported by the Ambition Coventry programme This indicator focuses on all young people aged 16-24 who are not in education, employment or training and receive support from the Ambition Coventry programme.	Coventry City Council Place Directorate Kim Mawby	0	806 *Target: 401*	777	331	1	**607**
PI4: Implementation of system or tool to measure mental wellbeing in schools Further indicator to follow around mental wellbeing once tool is implemented	Coventry City Council Public Health Sue Frossell	Indicators to be agreed once system is in place	System in develop-ment	**Target to be agreed once system is in place**	Target to be agreed once system is in place	System signed off by schools, to be implemented Sep 2018	

Programme Indicators: Tackling inequalities disproportionately affecting young people							
Indicator & Definition	**Organisation / Directorate** **Contact**	**Baseline data (15/16)**	**Actual 16/17**	**Target 17/18**	**Target 18/19**	**Actual Q4 17/18**	**Year to date 17/18**
PI5: Percentage of all children who are accessing Compass' Early Intervention Service who are aged 11 and under Compass Aspire (Early Intervention Service) is a service for young people who are affected by substance misuse, poor sexual health, teenage pregnancy and / or poor and abusive relationships	Compass	8%	23% *Target: 15%*	**17%**	20%	22%	**18%**
PI6: Number of new clients accessing CRASAC's counselling service and helpline, aged 25 and under CRASAC provide information, advice and support for anyone affected by sexual violence	Crasac	183	443 *Target: 183*	**183**	183	52	**392**
PI7: Reporting of sexual violence in young people Reporting of sexual violence in young people (aged 24 and under) to West Midlands Police	West Midlands Police	77 incidents (Q1 2016)	363 *Target: 308*	**308**	308	133	**521**

Outcome Indicators: Tackling inequalities disproportionately affecting young people						
Indicator	**Definition**	**Baseline data (15/16)**	**2016/17 Actual**	**17/18 Actual**	**17/18 Target**	**18/19 Target**
OI1: Percentage of children achieving a good level of development at age 5		63.9%	65.4%	**66.1%** ↑ Improving	Better than or equal to national average: 70.7%	66.3% (Target may change if national average changes)
			The percentage of children achieving a good level of development at age 5 has been steadily improving in Coventry since 2012/13. We are falling slightly short of both the England and the West Midlands average.			
OI2: Percentage of children achieving expected level of progress (national standard) in reading, writing and mathematics at the end of primary school	https://www.gov.uk/government/statistics/national-curriculum-assessments-key-stage-2-2017-revised	78%	49% (new assessment)	**58%** ↑ Improving	Better than or equal to national average: 61%	80% (Target may change if national average changes)
			Increase on last year, still falling slightly short of national average. Only one point off West Midlands average (59%).			
OI3: Percentage gap between the lowest achieving 20% children and the average child in the same area in the early years (age 5)	http://standards.esd.org.uk/?uri=metricType%2F3657&tab=details	36%	35.1%	**37.3%** ↓ Getting worse	Better than or equal to national average: 35.4%	30% (Target may change if national average changes)
			Moving closer to the national average (less than two points difference, compared with four points difference last year), however the gap has increased slightly, showing a move in the wrong direction			
OI4: Hospital admissions as a result of self-harm (10-24 years)	http://www.phoutcomes.info/search/self%20harm	552 per 100,000Ma	525 per 100,000	**438 per 100,000** ↑ Improving	450	399

			Considerable decrease over past two years. Still slightly above national average of 404 per 100,000, but Coventry has shown a decrease in past 4 years, whilst national average has plateaued or increased slightly over that time.			
OI5: Percentage of 16-18 year olds not in education, employment or training	http://www.phoutcomes.info/search/NEET#pat/6/ati/102/par/E12000005	4.7%	**3.0%**	**5.0%**  New assessment	Better than or equal to national average: 5.6%	4.0% (Better than national average)
			Method of data collection has changed from last year, resulting in a significantly different figure. Coventry is lower (better than) the national average and the regional average of 5.4%			

Good Growth

Inequalities in employment, pay below the living wage, the decline in intermediate occupations and the rise of lower paid jobs are likely to lead to increases in inequalities of 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 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.

Action Plan: Ensuring that all Coventry people, including vulnerable residents, can benefit from 'good growth', which will bring jobs, housing and other benefits to the city			
Aim	**Actions**	**Lead**	**Progress**
6. Act as organisational exemplars of good employment practices to drive up standards across the city and demonstrate economic benefits	• Devise and disseminate a 'social value' toolkit that enables other employers in Coventry to adopt the Council's approach to social value • Act as champions for the workplace wellbeing charter • Offer work experience placements to vulnerable people • Update the Council's Equality and Consultation Analysis process to ensure Marmot implications are considered when decisions are made • Embed a 'health in all policies' approach at West Midlands Fire Service	All organisations, led by Resources Directorate, Coventry City Council and West Midlands Fire Service	CCC and Marmot partners hosted visit from Norwegian public health professionals. Social value toolkit being considered and included as specific action on revised action plan. Continue to work with employers to promote the Workplace Wellbeing Charter
7. Provide employers with information, skills and support to provide and promote good quality jobs in Coventry	• Create more supportive and productive work environments • Understand the benefits (including economic) of recruiting locally • Provide good quality jobs	Coventry and Warwickshire Chamber of Commerce	Working with Chamber to explore ways in which employers and employees can be made more aware of support available through Access to Work

	• Increase opportunities for people with disabilities and maximise take-up of Access to Work fund • Work with employers to increase the number of apprenticeship opportunities		
8. Continue to develop the reach and effectiveness of the workplace wellbeing charter	• Roll out the charter to all organisations who express an interest • Adapt the evidence requirements of the charter to meet the needs of small businesses • Evaluate the impact of the charter	Economy and Jobs Team, Coventry City Council	Due to the Charter delivery being put on hold there have been no new organisations signed up to the Charter. Currently working closely with the WMCA in developing a new local framework. This will be ready by the end of April. Have engaged with 59 organisations with the Charter service this quarter. This is either attendance at workshops, generating new enquiries or continuation of support.

Programme Indicators: Ensuring that all Coventry people, including vulnerable residents, can benefit from 'good growth', which will bring jobs, housing and other benefits to the city							
Indicator & Definition	**Organisation / Directorate** **Contact**	**Baseline data (15/16)**	**Actual 16/17**	**Target 17/18**	**Target 18/19**	**Actual Q4 17/18**	**Year to date 17/18**
PI8: Percentage of people recorded as unfit for work claiming ESA (and comparison with regional / national rate) Fit notes are known as a 'statement of fitness for work'	DWP Iona Old	6.8% (15,010)	6.5% *Target: 6.5%*	**6.1%** (Current UK average)	6.2% (Better than or equal to national average)	%	**6.4%**
PI9: Percentage of residents claiming Job Seekers Allowance	DWP Iona Old	1.9%	1.7% *Target: 1.8%*	**1.7%** (Current UK average: 1.1%)	1.6%	%	**1.3%**
PI10: Number of people supported into employment by the Coventry Job Shop Support provided through the Job Shop to enable people into employment	Coventry City Council Place Directorate Kim Mawby	1,844	1,641 *Target: 1,420*	**1,200**	1,200	168	**982**
PI11: Number of workplaces signed up to workplace wellbeing charter The award of a Workplace Wellbeing Charter is clear recognition of the positive way in which organisations run their businesses and support their work forces	Coventry City Council Place Directorate Sharon Lindop	25	13 *Target: 25*	**25**	25	0	**14**
PI12: Number of interactions and engagements with businesses to improve employment practices Coventry and Warwickshire Chamber of Commerce are engaging businesses to improve working practices, workplace wellbeing, recruitment and retention	Chamber of Commerce Martyne Manning	0	2,220 *Target: 1,000*	**1,000**	1,000	300	**4,858**

Outcome Indicators: Ensuring that all Coventry people, including vulnerable residents, can benefit from 'good growth', which will bring jobs, housing and other benefits to the city						
Indicator	**Definition**	**Baseline data (15/16)**	**2016/17 Actual**	**17/18 Actual**	**17/18 Target**	**18/19 Target**
OI6: Gap in the employment rate between those with a long-term health condition and the overall employment rate	http://www.phoutcomes.info/search/employment#page/3/gid/1/pat/6/par/E12000005/ati/102/are/E08000026/iid/90282/age/204/sex/4	30.5%	24%	**Data unavailable**	28.9% (Target may change if national average changes)	28.9% (Target may change if national average changes)
			Publication of health and disability variable from the Annual Population Survey have been suspended from the October 2016 to September 2017 period onwards, whilst further quality assurance of the estimates takes place			
OI7: Gap in the JSA claimant rate between the most affluent and most disadvantaged areas.	Gap in the JSA claimant rate between wards with the highest and lowest employment rates in Coventry	3.2%	3.2%	**3.1%** ↑ Improving	3.0%	2.9%
			In March 2018 the ward with the highest rate was Foleshill with a rate of 2.5% and the ward with the lowest rate was Wainbody with a rate of 0.4%. For the last two years, the claimant count in Coventry overall and the gap in the count rate between wards with the highest and lowest rates has been static			
OI8: Gap in earnings between those living and working in the city	Average earnings of those living in the city compared with average earnings of those working in the city	£506.20 average earning of residents / 94.8% of city workers	£539 average earnings of residents / 96.5% of city workers	**£535.70 average earnings of residents / 95.4% of city workers** ↓ Getting worse	£526.20 / 95.8%	£536.20 / 96.3%
			In recent years, average pay for Coventry residents has been increasing, closing the gap on average pay at Coventry workplaces. However, pay growth for Coventry residents has been low in 2017, and the gap is slightly larger than reported in 2016/17, and slightly below target.			
OI9: Investment in training across organisations in Coventry	Average investment in staff training. Number of staff trained as a % of total staff and training days per year	62.8% of staff trained as a percentage of total staff / 5.46 average	Not available	Not available	64.8% / 6.46	65.8% / 6.96

		training days per year	Not available

Coventry City Council

Report

To: Coventry Health and Wellbeing Board **Date: 8 October 2018**

From: Liz Gaulton, Director of Public Health and Wellbeing, Coventry City Council

Title: Coventry and Warwickshire Place Forum and Year of Wellbeing

1 Purpose

This paper updates the Health and Wellbeing Board on the outcomes of the Place Forum meeting on 16 July and informs Board members about plans for the 7 November meeting of the Place Forum.

It also outlines the delivery profile for the Year of Wellbeing 2019 for consideration by the Coventry and Warwickshire Health and Wellbeing Boards, for sign off and launch at the Place Forum meeting in November.

2 Recommendations

The Health and Wellbeing Board is asked to:

1. Note the outcomes of the Place Forum meeting held on 16 July;
2. Note the proposed agenda items for the Place Forum on 7 November; and
3. Consider the delivery profile for the Year of Wellbeing, for sign off and launch at the Place Forum meeting on 7 November.

3 Information/Background

Coventry and Warwickshire's Health and Wellbeing Boards met as the 'Place Forum' on 16 July 2018 in Northgate House, Warwick. This was the third joint meeting, with over 40 attendees from a wide range of organisations.

The main aims of the session were to:

- endorse the updated Concordat and place system model;
- agree the high level plan for the Year of Wellbeing and common narrative, and commit support from each partner organisation;
- update each other on changes affecting the Place Forum; and
- agree actions to be completed ahead of the next meeting on 7th November.

4. Outcomes of July Place Forum

The Place Forum endorsed the refreshed Concordat and system design; agreed a high level plan for the Year of Wellbeing; and noted updates on Integrated Care Systems (ICS) and the Better Health, Better Care, Better Value programme.

The Place Forum agreed a series of actions as part of the Place Plan (as outlined in Appendix 1). It was agreed to:

- Publish and share the updated Concordat and Place System Design;
- Submit pledges of support for Year of Wellbeing;
- Agree a plan and resources for Year of Wellbeing at Health and Wellbeing Boards in Coventry and Warwickshire in September/October;
- Adopt the Year of Wellbeing branding in all related areas;
- Continue to update each other on changes which impact on the work of the Place Forum, including ICS and the STP; and
- Develop governance arrangements and a draft outcomes framework for discussion at the next meeting on 7th November.

Significant progress has been made, and the Place Plan will be continually reviewed and updated as the work of the Place Forum develops.

5. Place Forum 7 November 2018

The focus of activity up to the next Place Forum on 7 November 2018 is on the following areas:

- Preparations for the Year of Wellbeing;
- Progressing the place-based JSNA rollout;
- Embedding prevention and early intervention in other areas; and
- Developing an outcome framework and performance dashboard.

The proposed agenda for 7 November includes:

- Launch of the Year of Wellbeing 2019
- Place Forum outcomes framework and governance
- Update on progress towards a shadow integrated care system
- Input from the Department for Health and Social Care on the CQC local system review in Coventry and the national learning from these reviews

The meeting will be facilitated by John Bewick from the Local Government Association (LGA), who is supporting work on the Upscaling Prevention pilot programme. This pilot ends in November 2018.

6. Year of Wellbeing

6.1 Role of Place Forum

The Year of Wellbeing 2019 is a key deliverable for the Place Forum and the current focus of proactive and preventative work in Coventry and Warwickshire. The Place Forum meeting in July took some important steps in preparation for the Year, including:

- endorsement of the health and social care system design and common narrative about prevention, for sharing across organisations and applying locally
- approval of a high level plan for the Year of Wellbeing, including three early themes: Daily Mile (promoting exercise), Workplace Wellbeing, and Start a Conversation
- agreement of members to pledge their ideas and commitment to the Year of Wellbeing.

6.2 Progress and preparations

Since July, considerable progress has been made. A logo and branding for the Year of Wellbeing have been developed (see below) and this is beginning to be used by partners. A communications strategy has been drafted in consultation with STP Communications Leads and, as part of their commitment to the Year, Coventry and Warwickshire Partnership Trust have allocated a communications officer to help develop the communications campaign. As part of this campaign, storytelling training has been delivered to a cohort of wellbeing champions to equip them to share their stories online and inspire others during the Year. Further training is planned for September–November, to accommodate a high level of interest from potential champions.

Elected members at the July Place Forum requested opportunities to develop their wellbeing and prevention awareness. In response, it is intended to develop an ambassador-style programme of learning and information for elected members – which will include delivery of LGA Prevention Matters training to members in Coventry and Warwickshire. Further elements of the ambassador programme are yet to be finalised.

6.3 Year of Wellbeing Delivery Profile

A number of pledges of support have been collated from Place Forum partners, though not from all, and responses continue to be sought. These have informed a delivery profile for the Year of Wellbeing, which is attached at appendix 2. This is being presented for consideration by the Board, for sign off and launch at the Place Forum on 7 November. This is also being shared virtually with members of the Warwickshire Health and Wellbeing Board and Executive.

The details of the delivery plan will evolve over the coming months as further pledges of support are received and firm commitments of resource and action from partner organisations are secured.

6.4 Logo and branding

It is intended that the logo and branding for the Year of Wellbeing will play a central part in mobilising activity and promoting key messages during the year. The colours are a vibrant combination, often associated with happiness, and the yin and yang interlocking shapes represent the complementary natures of Coventry and Warwickshire as well as the 'embracing nature' of our shared border. The working strapline is "Let's do this together".

The logo is designed to be used for a range of marketing purposes, from enamel pins to information leaflets. The logo and branding will be part of a toolkit available to communications colleagues in all partner organisation, to build momentum and recognition around Year of Wellbeing activity. It will be formally launched at the Place Forum on 7 November although visible prior to this to support awareness raising in preparation for the Year.

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Appendices

1. Place Plan – Rolling Actions at August 2018
2. Year of Wellbeing Delivery Profile

APPENDIX 1: Place Plan – Rolling Actions at August 2018

Trust and behaviours:	**Products Delivered**
Meet as a Place Forum every quarter to build trust; create a place wide model of care, outcomes and hold to account	☑ Place Forum established
Develop a simple update process for Forum members	☑ Forum-wide update
Refresh the Concordat and use it to capture priorities for improving health and wellbeing and working together	☑ Updated Concordat
Translatable Vision:	**Products**
Create a health and care system design for our place	☑ System Design
Use the Upscaling prevention pilot to develop the common narrative and catalyst for the place	☑ Year of Wellbeing and narrative
Deliver place-based JSNA to inform service delivery	☑ Place-based JSNA rollout *(NB this is a 2 year programme)*
Getting it done:	Products
Make prevention and self-help the first chapter of all change programmes, pathway redesigns etc.	☑ Year of Wellbeing and narrative *NB Embedding prevention in other programmes is still work in progress*
Build one strategic, place based plan that is delivered coherently by various means (STP, BCF etc.)	☑ Place Plan *(NB This is still work in progress)*
Holding to account:	**Products**
Strengthen place based governance and working arrangements to deliver against the Concordat	*Governance model and outcome framework- to be developed/agreed*
Take collective ownership (coordinated through the Proactive & Preventative Executive) for making sure actions happen	☑ P&P Delivery group
Strengthen communication and engagement between forums to keep people updated and engaged in product design	☑ Forum-wide update *NB This area is still work in progress*

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DRAFT

Place Forum delivery profile for the Year of Wellbeing 2019

Let's do this together

This profile is based on the pledges and ideas submitted by Place Forum members between July and September 2018. It describes the main activities - those areas of focus that most Place Forum members commit to delivering or upscaling during 2019. It is not a definitive list of every activity.

The intention is to use the Year to extend the reach of existing good practice. This means that no organisation should need to find additional money in future years to continue delivery.

It is recognised that not all organisations will deliver or participate in every activity although the Place Forum's expectation is that every organisation will contribute in some way.

Who will deliver the action plans

This profile is aimed at **Place Forum members**. We have made a firm commitment to work as a whole health and wellbeing system to value what we are already doing well and make better use of available resources. Collaborative solutions to prevention problems are a desired outcome.

There is a strong emphasis within the communications key messages on the role of **people and communities** in consolidating their knowledge and skills to nurture personal health and wellbeing. This approach reflects our system design model (shown here).

In addition to this we recognise and welcome contributions to the Year of Wellbeing 2019 from **delivery partners across the Third and Private Sectors**.

Staff resourcing commitment required to deliver the action plans

The action plans require organisations to release and prioritise staff capacity to support specific activities. The amount of capacity made available will directly influence the scale and impact of the Year of Wellbeing 2019.

The sorts of staff capacity contributions required include:

- ownership and project management of a nominated activity (e.g. the Daily Mile – Fit For Life rollout to businesses, community asset collation);
- research and drafting of wellbeing materials for specific groups (e.g. Elected Members, top tips for the public);
- collation of a monthly wellbeing update reflecting content and progress across all stakeholders (to support the Health & Wellbeing Champions programme rollout);
- webpage hosting and updating;
- Communications Team local ownership of the brand and its application;
- ad hoc social media support for inspirational storytellers.

Evolving and embedding activity

The Year of Wellbeing 2019 is one stage in the overarching Proactive and Preventative workstream of the Better Health Better Care Better Value programme for Coventry and Warwickshire. The clear intention is that this profile evolves during 2019, particularly to embrace additional prevention themes on which Place Forum members can collaborate.

With the exception of the new communications elements of the Year, the focus is on upscaling existing activity and spreading best practice. This means that the activity described will continue post-2019 and act as a foundation for further collaborative prevention work in the future.

About the brand for the Year of Wellbeing

The brand will play a central part in mobilising activity and promoting key messages during the year by providing a consistent and memorable connection between different types of wellbeing-related activity. All Communications Teams will receive brand guidelines to explain how and when to apply the brand in-house, and it will appear on a range of marketing materials.

The composition of the logo intends to represent the complementary aspects of Coventry and Warwickshire and references the way the Warwickshire border wraps around Coventry. The vibrant colours are associated with warmth, happiness and a sense of fun: the logo is intended to 'stand out

from the crowd'. The working strapline is 'Let's do this together'.

Accountability for delivery

Place Forum members will hold themselves and each other accountable for delivering on the areas of activity they have committed to support.

Oversight

The Coventry and Warwickshire Place Forum is the body that agrees system-wide priorities and shapes the delivery profile for the Year of Wellbeing 2019.

The Proactive and Preventative Executive Group is accountable for the delivery of the over-arching system approach to prevention including the Year of Wellbeing 2019.

Activity area 1: Celebrating success and promoting wellbeing throughout 2019

The Year of Wellbeing incorporates a publicity campaign to raise awareness of the benefits of enjoying good wellbeing, to encourage people to take personal responsibility to stay well, and be proactive about managing health and wellbeing at the earliest point in time.

What we will do

The Year of Wellbeing brand and communication campaign will showcase and raise awareness of the incredible variety of wellbeing and self-help services being delivered by Place Forum members and our partners in other sectors and the community. The Year will also embrace and amplify real, positive stories from local people with lived experience with the aim of reaching new audiences in accessible voices.

Our long-term vision

By celebrating success and promoting wellbeing we aim to:

- Build community capacity to champion health and wellbeing
- Increase individuals' personal ownership of keeping well and feeling contented
- Increase healthy life expectancy: 'living well for longer'

See Appendix 1 for action plan.

Activity area 2: The Daily Mile

The Daily Mile is a national campaign targeting primary school children with the purpose of increasing fitness during 15 minutes of running or jogging. It provides a free downloadable resource pack and advice to schools on how to establish the Daily Mile as a normal part of the school day.

The Daily Mile – Fit For Life is a national campaign targeting young people and adults. The campaign encourages all people to walk to raise their heart rate over the distance of a mile.

We recognise the place of the Daily Mile campaign within the wider approach to increasing exercise amongst our population, and all activity aimed at increasing physical activity can be branded throughout the Year of Wellbeing 2019, including the Coventry European City of Sport award.

What we will do

We will adopt a collaborative approach to supporting more primary schools to adopt the Daily Mile. We will do this by engaging with primary school stakeholders who are in a position to support the establishment of schemes, and signposting them to the relevant support information. We will offer additional support in identified schools.

We will also promote uptake of the Daily Mile – Fit For Life to workplaces to encourage them to embed a positive approach to staff physical activity in the workplace.

Our long-term vision

By increasing sign-up to the Daily Mile across Coventry and Warwickshire we aim to:

- Support the development of good behaviours in children around being physically active
- Contribute to improvements in health and wellbeing
- Increase levels of physical activity in adults

See Appendix 2 for action plan.

Activity area 3: Workforce wellbeing

With higher than average rates of employment across Coventry and Warwickshire much of our working-aged population can benefit from workplace approaches to health and wellbeing. 90% of local businesses employ a small fraction of the working population so it is important to consider how the health and wellbeing of small business owners and their employees is promoted.

Around 18% of the population of Coventry and Warwickshire work for public sector employers, giving us the opportunity to positively impact staff at scale. We can also share best practice and learning with our largest employers.

What we will do

We will make best use of the West Midlands Combined Authority programme *Thrive at Work*, which has been piloted recently across the region as a framework for reviewing and evolving good practice. We will also offer practical advice and information to employers to help them consider the right wellbeing offer for their workforce.

Our long-term vision

By focusing on workforce wellbeing across Coventry and Warwickshire we aim to:

- Improve work-based health and wellbeing offers for employees
- Increase workforce attendance and productivity

See Appendix 3 for action plan.

Activity area 4: Start a conversation

Start a Conversation has a unique breadth within the campaign activity for the Year of Wellbeing 2019. It encapsulates all activities associated with engagement, ranging from promoting community involvement and social opportunities to informing, advising or guiding people to make effective early decisions.

Our partners in the Third Sector will play a significant role in starting conversations given their reach and acceptance as trusted voices.

What we will do

We will work in partnership across sectors to upscale and share effective methods of engaging with people across Coventry and Warwickshire. We will promote mental health as fundamental to wellbeing, and encourage social connectivity on an individual basis to help loneliness become a thing of the past.

Our long-term vision

By focusing on opportunities to engage people we aim to:

- Increase the number of people feeling socially connected and mentally well
- Increase the number of people asking for advice or support at the earliest opportunity
- Increase knowledge of what's on in our communities

See Appendix 4 for action plan.

Next steps

The delivery profile for the Year of Wellbeing 2019 has always been intended to be iterative so that it can respond to new opportunities arising throughout the year. One or more additional activity areas will be adopted based on priorities agreed by the Place Forum.

A 'handbook', drafted for public and partner use to describe the Year of Wellbeing and its activities, will accompany this delivery profile and will be presented at the Place Forum in November 2018.

Possible areas of future focus

Scrutiny of fingertip data has identified some areas common to both Coventry and Warwickshire in which collaborative prevention approaches could play an improvement role:

- Dementia diagnosis
- Hospital admissions for injuries
- Obesity
- Health check take-up
- Flu vaccination take-up
- Alcohol-related hospital stays

Author

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Appendix 1 – Action plan – Celebrating success and promoting wellbeing throughout 2019				
No.	**Activity**	**Intended impact**	**Measure of success**	**Deliverers**
1	Dispersed launch programme between November 2018 and early 2019	Multiple opportunities to find out about the Year of Wellbeing increases awareness	Launch activities completed	All Place Forum members All participating delivery partners
2	Apply Year of Wellbeing logo and key messages in all communication streams relating to prevention and wellbeing throughout 2019	Strong associations between branded activities and wellbeing Strengthen links and relationships across sector-led wellbeing activity	Number of times brand is used by Place Forum partners in 2019 Number of delivery partners applying logo and key messages to their activities	All Place Forum members All participating delivery partners
3	Opportunities to extend the brand reach to additional events and activities are pursued independently by Place Forum members	Members co-lead the Year of Wellbeing Involve new partners so that Year of Wellbeing reaches a wider audience Make prevention and wellbeing everyone's business	Number of new partners applying logo and key messages to their activities	All Place Forum members
4	Train a minimum of 50 'inspirational storytellers' to develop and use social media platforms by June 2019	Wellbeing messages reach a different audience through non-public sector channels Increase storyteller confidence in becoming a wellbeing advocate Embeds message that wellbeing is person-led not organisation-led	Number of storytellers blogging positively about wellbeing during 2019 Number of hits/likes/retweets	Sound Delivery (commissioned provider) Individual storytellers (volunteers) All participating Place Forum members
5	Public facing information on Place Forum members' own prevention and wellbeing services is highly visible and branded by early 2019	People can easily find the information they need to maintain good health and wellbeing	Number of page hits	All Place Forum members
6	Establish a network of 'delivery partners' outside the Place Forum delivering independent wellbeing focused activity	Wellbeing will become part of the wider community dialogue, embedded outside the public sector	Number of endorsed partner activities Case studies	All participating Place Forum members All participating delivery partners
7	Establish a sustainable microsite/ landing page to act as a 'directory' for all Year of Wellbeing stakeholders	Online information relating to the Year of Wellbeing is easy to find	Number of page hits Number of member activities linked to the microsite	Lead Place Forum member and web host All Place Forum members

8	Collate an accessible programme of development and learning activity to support independent wellbeing Champions and Ambassadors	People will learn more about wellbeing People will promote and advocate good wellbeing independent of the public sector	Programme collated and made available online Number of Champions/ Ambassadors created through the programme	All participating Place Forum members All participating delivery partners
9	Extend the #onething campaign through social media to facilitate organisational and individual pledges	People pledge to behaviour changes improve wellbeing	Number of uses of #onething online Organisation engagement in #onething Case studies	All Place Forum members
10	Evaluation of the overall impact of the Year of Wellbeing	Place Forum members will increase understanding of what works in upscaling prevention	Report produced with recommendations for learning	All Place Forum members

Appendix 2 – Action plan – The Daily Mile				
No.	**Activity**	**Intended impact**	**Measure of success**	**Deliverers**
11	Engage with primary school stakeholders to promote the benefits of the Daily Mile	Primary schools sign up to participate in the Daily Mile	Number of primary schools signed up to the Daily Mile	All participating Place Forum members All participating delivery partners
12	Delivery of the Daily Mile in primary schools	Child health is improved	Number of primary school children participating in the Daily Mile	Primary school All participating delivery partners
13	Place Forum members join the Daily Mile – Fit For Life campaign and establish positive organisational attitudes to exercise	Staff health is improved	Number of members signed up	All Place Forum members
14	All public sector buildings organise at least one publicised Daily Mile route and open walking group	Increased number of staff exercising	Number of buildings signed up Number of mile routes per building base Number of staff participating Number of miles walked by staff during 2019	All Place Forum members
15	Promote the Daily Mile – Fit For Life to Third and Public Sector employers, and communities	Increased exercise across the whole population	Number of groups, employers and people self-reporting take-up of the Daily Mile Number of organisations registering affiliation to the Daily Mile – Fit For Life national programme	All participating Place Forum members All participating delivery partners
16	Connect the Year of Wellbeing to the Coventry European City of Sport programme	Increase awareness of sport as a contributor to wellbeing Increase level of physical activity during 2019	Footfall figures from Coventry City Council contracted sport provision compared to previous years Case studies	Coventry City Council All participating delivery partners
17	Evaluation of the impact of the Daily Mile in primary schools	Identify good practice	Evaluation report completed	All participating Place Forum members All participating delivery partners

Appendix 3 – Action plan – Workforce wellbeing				
No.	**Activity**	**Intended impact**	**Measure of success**	**Deliverers**
18	Place Forum members sign up to the bronze award level of the Thrive at Work – Workplace Wellbeing Award scheme by the end of 2019	Improved health and wellbeing approaches in Place Forum member workplaces	Number of members signed up Number of members achieving bronze or higher award	West Midlands Combined Authority All Place Forum members
19	Place Forum members make wellbeing a standalone and compulsory element of inductions for new starters, and ensure training offer identifies wellbeing learning	All new starters benefit from a prevention approach to wellbeing	Wellbeing elearning package produced Number of members introducing this or another standalone wellbeing induction activity	All Place Forum members
20	Staff Health and Wellbeing Champions are trained and supported to promote health and wellbeing to colleagues	People find information and support quickly and informally	Number of members with Champion training schemes operational Total number of Champions Case studies	All participating Place Forum members Commissioned training provider
21	Work alongside the third and private sectors to promote Thrive and workplace wellbeing uptake	Improved health and wellbeing approaches in workplaces	Number of organisations signed up Case studies	West Midlands Combined Authority All participating Place Forum members All participating delivery partners
22	Corporate challenge opportunities are offered to staff	Improved health and wellbeing approaches in workplaces	Number of organisations signed up Number of staff participating	All participating Place Forum members All participating delivery partners
23	Embed behaviour insights approaches into Place Forum member HR processes to promote positive action at key touch points between staff and the organisation	Staff benefit from earlier advice and information	Number of participating organisations Case studies	All participating Place Forum members All participating delivery partners
24	Activity-specific evaluation undertaken	Organisations learn what works and make improvements	Scheduled review takes place	All Place Forum members All participating delivery partners

Appendix 4 – Action plan – Start a conversation				
No.	**Activity**	**Intended impact**	**Measure of success**	**Deliverers**
25	Place Forum members will apply the brand to and actively promote their own community engagement and mental health offers throughout 2019	Increased benefit from involvement in mental health and engagement offers	Number of activities promoted Case studies	All Place Forum members All participating delivery partners
26	A 'core' menu of preventative mental health offers will be promoted to Place Forum members and communities	Increased officer awareness of mental health prevention offers	Case studies	All participating Place Forum members All participating delivery partners
27	Information on where to find community resources and services will be promoted throughout 2019	Increased benefit from the use of social groups and community opportunities	Survey	All Place Forum members
28	The Third Sector will be supported to develop a collective response and programme of action for the Year of Wellbeing	Raised awareness of and participation in the Year of Wellbeing by the Third Sector	Workshop is held and a response is produced and adopted by Third Sector delivery partners	All participating Place Forum members All participating delivery partners
29	Community based delivery partners will use the Year of Wellbeing brand to endorse specific activities	Community support for wellbeing and prevention is recognised by Place Forum partners	Number of delivery partners using the Year of Wellbeing brand	All participating delivery partners
30	Develop an arts and culture-based response to loneliness and social isolation	People enjoy an increased range of arts and culture-based wellbeing opportunities	Arts and culture for health symposium held Activity programme developed collaboratively	All participating Place Forum members All participating delivery partners
31	MECC/ motivational interviewing skills training offered to Place Forum members' staff and other front-facing workers to promote skills and confidence to start a conversation	More staff feel skilled and confident to start a conversation with a 'customer', colleague or other person	Number of staff trained Case studies	All participating Place Forum members All participating delivery partners Commissioned trainer
32	Activity-specific evaluation undertaken	Organisations learn what works and make improvements	Scheduled review takes place	All participating Place Forum members

Coventry City Council

Report

To: Coventry Health and Wellbeing Board **Date: 8 October 2018**

From: Rachael Danter, Programme Director, Better Care Better Health Better Value

Title: Better Health, Better Care, Better Value programme update

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1 Purpose

The purpose of this report is to provide Coventry Health and Wellbeing Board with an update on progress to date on the Better Health, Better Care, Better Value programme, highlighting any key points as necessary.

2 Recommendations

The Board is asked to note this report and its contents.

3 Information/Background

3.1 Integrated Care System update

As previously mentioned, the 12-week development programme offered to all localities across the West Midlands has recently concluded. This is aimed at supporting the senior leaders and their teams to further develop capability in the following areas:

- Building a whole system strategy and plan
- System level financial planning
- Integrated governance
- Execution and implementation

A draft plan that starts to identify what actions will be required to allow the Coventry and Warwickshire STP to reach Shadow ICS status was presented to NHS England on 24 August. Formal feedback is awaited. This plan will continue to be developed and once it has been signed off by all the respective organisations it will be circulated.

3.2 Transformational Programmes of Work

Proactive and Preventative

Preparations for the Year of Wellbeing are making good progress. Work is focusing on three ‘early examples’: Daily Mile, Workplace Wellbeing, and Start a Conversation. A communications and engagement strategy has been prepared, together with campaign

material, including branding. Pledges of support have been collated from Place Forum partners.

Suicide prevention work has included promoting Suicide Prevention Day in September, procuring safe haven pilots, and 'It Takes Balls to Talk' activities.

A number of Better Care Fund prevention projects are moving forward in Coventry. These include the Affordable Warmth projects (funded by Public Health), which aims to support vulnerable householders with long-term conditions to keep their homes warm, and the Moathouse place-based community navigator model, which is supporting prevention and self-care for older people.

Maternity and Paediatrics

Plans have been agreed to deliver continuity of carer for 20 per cent of women by March 2019. Engagement sessions have previously been held with midwives at University Hospitals Coventry and Warwickshire NHS Trust and South Warwickshire NHS Foundation Trust about new ways of working, to enable this to happen. Further sessions are planned at George Eliot Hospital NHS Trust.

The Provider Alliance is now established, with confirmation that Maternity and Paediatrics is a priority work programme.

Work is taking place to consider the Paediatrics element of the workstream.

The West Midlands Neonatal Review is being implemented. This is overseen by the Choice and Personalisation sub-group, which was relaunched in early June.

Mental Health and Emotional Wellbeing

An engagement event is being held at Coventry Rugby Club on World Mental Health Day, 10 October. This will update on the programme plans and progress to date and is aimed at service users, partners and other stakeholders. It will feature a market place and there will be breakout sessions to discuss specific elements, such as crisis cafes and the Psychiatric Decision Unit. An easy-read document is being produced.

Work is progressing to deliver the work programme for physical health checks for people with serious mental illness. A stakeholder workshop was held to map the pilot pathway for the NHS England-funded project place-based model.

A suicide prevention stakeholder workshop was held in July and attended by a wide range of organisations, including West Midlands Police, West Midlands Fire Service, and suicide bereavement services. This has helped to develop the ideas for projects for delivery of the NHS England/Public Heath England funding received for the programme.

A primary care offer workshop was also held in July, to link the primary care work with the Out of Hospital programme. Next steps will include alignment of the Out of Hospital work with primary care clusters to deliver the outcomes and address the priorities.

Planned Care

The STP Planned Care delivery plan, which focuses on high-quality, sustainable care for residents of Coventry and Warwickshire, has been submitted to NHS England. It includes a transformation plan and narrative, which incorporate national priorities.

The main areas of focus are:

- Managing demand – including implementing referral triage and treatment services in specialties including ophthalmology and dermatology
- Reviewing system wide specialty capacity and workforce requirements to consider potential specialty consolidation across Coventry and Warwickshire
- Implementing outcomes-based lead provider contracts for planned care.

Productivity and Efficiency

Work is continuing to identify and explore opportunities where collaboration and/or consolidation of back office functions and clinical support functions could deliver better productivity and efficiencies across the system.

This includes exploring a shared finance system across the four NHS Trusts in Coventry and Warwickshire. A solutions workshop will be held to identify what services will be required. A proposal on options and pricing will follow.

Urgent and Emergency Care

University Hospitals Coventry and Warwickshire NHS Trust has undertaken a community hub review and action plans are being developed to drive improvements in discharges and delayed transfers of care.

George Eliot Hospital NHS Trust has reported good performance in reducing delayed transfers of care and has been consistently under target since February.

Work is on track to ensure that all handovers between ambulance and Emergency Departments take place within 15 minutes, with none waiting more than 30 minutes, by the end of September.

Work is continuing across the system to scope future provision of Urgent Treatment Centres.

The Better Health, Better Care, Better Value programme has instigated several peer reviews across the system to identify and implement best practice in the following areas:

- Outpatient Parenteral Antimicrobial Therapy (delivery of intravenous antibiotics in out-of-hospital settings)
- Discharge to Assess
- Frailty
- Arden Mental Health Acute Team (AMHAT)
- Ambulance arrivals from care homes

A single, comprehensive plan for the STP was presented at Coventry and Warwickshire A&E Delivery Board in July. The objectives include developing an integrated Urgent and Emergency Care provision, which is aligned to the standards outlined in the Urgent and Emergency Care national delivery plan.

All the Better Health, Better Care, Better Value partner organisations have worked together to prepare a system-wide communications and engagement campaign to help alleviate winter pressures. This includes raising public awareness of the importance of choosing the right health service, helping to increase flu vaccinations and advising people on how to stay well during the cold weather. It complements an existing all-year communications and engagement campaign to help reduce demand on A&E by focusing on prevention and staying well.

3.3 Enabling Programmes of Work

Estates

A draft estates strategy has been submitted to NHS England/Improvement, together with five capital funding bids.

The work programme is being refreshed to create a new estates strategy that reflects the clinical strategy, is aligned to the transformation workstreams and follows the financial principles.

There are opportunities to identify estates needs within other STP programmes. The timing of activity is to be aligned.

Digital Transformation

The programme team is preparing a bid for £6.7m from the Health System Led Investment Fund to improve the digital maturity of provider organisations and deliver technology solutions that will improve patient care over the next three financial years.

A programme plan is being drafted in conjunction with key stakeholders from partner organisations.

An initial refreshed Local Digital Roadmap has also been drafted.

Workforce

A local audit of programmes to identify workforce needs has begun.

A new workforce lead started in September, to support the programme's long-term workforce aspirations.

The Local Workforce Action Board in Coventry and Warwickshire is being reconfigured to support the delivery of the workforce priorities.

3.4 Related Programmes of Work

Cancer

A separate work programme has been set up for cancer. It will include the following:

- Primary care and prevention
- Rapid access/diagnostic pathways
- Living with and beyond cancer
- Waiting time standards
- Radiotherapy

Stroke configuration

Programme leads participated in a next stage NHS England Assurance Panel on 25 May. The Panel was impressed by the progress that the programme had made since the strategic sense check in May 2017. They assessed that the programme had partially met the requirements, but further work and evidence was required prior to being ready for consultation.

The key factors they require further evidence of are:

- Workforce planning: the Panel asked for greater detail, to include plans for sustainability of the workforce proposals and more details on the overall impact on providers.
- Further evidence of “stress-testing” the proposals for times of peak demand on hospitals. We provided evidence in the usual sensitivity analysis, but they asked for further evidence.
- Confirmation that the West Midlands Clinical Senate are satisfied that we have met the recommendations from their comprehensive review in 2016.

A meeting was held with the West Midlands Clinical Senate in July to present progress against the recommendations. The Senate have been assured that the recommendations have been actioned, and that the programme has already made improvements in our *Sentinel Stroke National Audit (SSNAP) data and Speech and Language therapy.

The next NHSE Assurance Panel is expected to take place in November.

A preferred option to develop a centralised centre of excellence at University Hospital, Coventry, for the immediate stages after having a stroke, the hyper acute and acute stages, has been proposed. Initial feedback has been obtained from patients and the public on this proposal.

The three CCGs held four public engagement events during September to gather views on stroke rehabilitation services. They are now bringing together a group of experts and interested individuals/organisations, including patients, carers, councillors, Healthwatch and the Stroke Association, to listen to the feedback and help to assess the proposals for stroke rehabilitation services.

*Note: The Sentinel Stroke National Audit Programme (SSNAP) is the single source of stroke data in England, Wales and Northern Ireland. There are three main components of SSNAP: clinical audit, acute organisational audit and post-acute organisational audit.

Report Author(s):

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Enquiries should be directed to the above person.

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Coventry City Council

Report

To: Coventry Health and Wellbeing Board **Date: 8 October 2018**

From: Cllr Faye Abbott, Cabinet Member for Adult Services
Pete Fahy, Director of Adult Services, Coventry City Council

Title: Local Government Association Green Paper 'The Lives We Want to Lead' – Response to Consultation

1 Purpose

This paper informs the Health and Wellbeing Board about the Local Government Association (LGA) green paper for adult social care and wellbeing, and shares the Council's response for information.

2 Recommendations

The Health and Wellbeing Board is asked to note the Council's response to the LGA green paper.

3 Background

Cllr Faye Abbott, Cabinet Member for Adult Services, and Pete Fahy, Director of Adult Services, wrote to Health and Wellbeing Board members by email on 3 August 2018, advising of the launch of the LGA's green paper for adult social care and wellbeing and suggesting that members may wish to respond as key stakeholders.

The City Council has prepared its own response to the consultation which will be considered by Cabinet for approval on 2 October. The Cabinet report and draft response to the consultation is shared with the Board for information

Report Author(s):

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Enquiries should be directed to the above person.

Appendices

Cabinet report, 2 October 2018: Local Government Association Green Paper 'The lives we want to lead' – Response to Consultation

Coventry City Council

Public report
Cabinet

2 October 2018

Name of Cabinet Member:
Cabinet Member for Public Health and Sport – Cllr K Caan
Cabinet Member for Adult Services – Cllr F Abbott

Director Approving Submission of the report:
Deputy Chief Executive (People)

Ward(s) affected:
All

Title:
Local Government Association Green Paper 'The lives we want to lead' – Response to Consultation

Is this a key decision?

No – Although this matter affects all wards, it is not considered to be significant

Executive Summary:

On 31 July 2018 the Local Government Association (LGA) launched its own green paper for adult social care and well-being for consultation. The publication of this paper is as a result of the Government's recent decision to delay its long-awaited green paper on Adult Social Care until the autumn.

Important issues are raised in the consultation in terms of the role of Adult Social Care in helping people live the life they want to lead and how this is funded. These issues affect all stakeholders in Adult Social Care and it is important that the City Council contributes to the national debate on these issues. It is particularly important in the context of resourcing challenges facing Adult Social Care. The short term funding arrangements from central government currently in place through the Better Care Fund and improved Better Care Fund come to an end in 2020/21.

As well as the issue of achieving sustainability in Adult Social Care much of the consultation seeks views on the role of local government in improving the well-being of its population. The responses given emphasise that local government is fundamental to achieving this goal. This needs to be considered in the wider role of local government by including public health, housing and leisure.

Throughout the consultation response, and to demonstrate the points made, examples are provided of work underway in Coventry that demonstrates the progress being made to improve well-being. Examples include the Health and Well Being Concordat, year of well-being, our work

on improving Delayed Transfers of Care and the Community Promoting Independence programmes.

Recommendations:

Cabinet is requested to:

1) Approve the submission of the consultation response to the LGA green paper

List of Appendices included:

Appendix One: Consultation response to LGA green paper

Background papers:

None

Other useful documents

The green paper and supplementary information and be viewed by following the link: http://www.futureofadultsocialcare.co.uk/

Has it been or will it be considered by Scrutiny?

No

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

No

Will this report go to Council?

No

Report title: Local Government Association Green Paper 'The lives we want to lead' – Response to Consultation

1. Context (or background)

1.1 On 31 July 2018 the Local Government Association (LGA) launched its own green paper for Adult Social Care and Well-being for consultation. The publication of this paper is as a result of the Government's recent decision to delay its long-awaited green paper on Adult Social Care until the autumn. The LGA green paper is endorsed by a range of organisations including the Society of Local Authority Chief Executives (SOLACE), the Association of Directors of Adult Services (ADASS), NHS Confederation, Care Quality Commission (CQC), Public Health England, provider representatives and the voluntary sector.

1.2 Important issues are raised in the consultation in terms of the role of Adult Social Care in helping people live the life they want to lead, and how this is funded. These issues affect all stakeholders in Adult Social Care and it is important that the City Council contributes to the national debate on these issues for which the LGA consultation is a first step. Equally, the outcome of the LGA consultation is intended to influence the forthcoming Government green paper and as such provides an opportunity to influence policy from inception.

1.3 Why these issues are important to Coventry

1.4 The issues raised in the green paper are important to Coventry Adult Social Care. Despite being a low spend service compared to similar local authorities, and having delivered significant savings over the past few years, the service remains financially challenged. If it had not been for the short term resources provided through the improved Better Care Fund (£8.1m 17/18), and the continuing support of the Coventry and Rugby Clinical Commissioning Group (CRCCG) in the use of this resource, alongside resources required to be transferred to the Council by the CCG (£8.3m 17/18), the position would be significantly worse. In addition the Council Tax Precept has raised £3.7m that has provided additional essential resources to meet cost pressures in the market.

1.5 In terms of our demand we have not seen increases in overall numbers of people supported by Adult Social Care but within this there has been an increase in the number of working age adults compared to older people. Furthermore, the costs of supporting working age adults are often greater, as is the period of time over which support is required.

1.6 The effective relationships between health and care agencies in the City were highlighted in the CQC system review completed in 2018 and these relationships have enabled us to make significant progress on key performance measures including Delayed Transfers of Care. However this progress is underpinned by BCF resource which currently expires in 2019/20. These relationships are also enabling the health and care system to make positive progress in developing preventative approaches and tackling long term demand. This is observed both through health and active lifestyle approaches and community capacity building, all of which is underpinned by a Health and Well-Being Concordat across Coventry and Warwickshire.

1.7 The Green Paper – Key Content

1.8 In summary the contents of each key section of the paper along with the issues raised for consideration are as follows:

1.9 Chapter 1 – The voice of people who use services

This section contains a number of case studies or stories from people who use social care and support services. There are no specific consultation questions associated with Chapter 1.

1.10 Chapter 2 - Delivering and Improving Well-Being

The section considers the role of local government more broadly in helping improve health and well-being. This goes beyond Adult Social Care and implies the whole of local government having responsibility for working with partners and stakeholders to improve wellbeing. The section seeks views on the role of local government in improving health and well-being within the City.

1.11 The consultation responses within this section stress the point that local government is best placed to improve the local population's well-being. Not just through social care and public health but also through its wider remit in respect of housing, education, leisure, parks and green spaces. The role of health and other public sector partners are also important in improving wellbeing. The importance of local government's role as an enabler in stimulating resilient communities that can use local assets to support themselves including wider voluntary and third sector support is referenced. Examples demonstrating the City Council's commitment to improving the health and wellbeing of local people are given.

1.12 Chapter 3 - Setting the scene

This section sets out the key challenges facing Adult Social Care in respect of funding, workforce and the ability to deliver the intentions of the Care Act 2014 in the context of reducing funding. The section also highlights the role of social care in helping sustain the NHS and the economic benefits of Adult Social Care through the employment it creates. Within this section are references to innovations delivered in Adult Social Care including the use of technology and data sharing. The funding issues facing Adult Social Care are described along with the consequences of underfunding. Reference is made to the Care Act 2014 Part II reforms that have not been implemented. These would introduce a cap on the amount people might have to pay along with an extension to the financial means test limits. The section also seeks views on the importance of decisions in respect of Adult Social Care being made at a local level.

1.13 The responses to this section are wide ranging but in summary examples are provided of how social care is supporting the NHS through approaches that both prevent admission to hospital and facilitate discharge. The work led by the City Council to support carers and invest in the voluntary and third sector also plays a key role in sustaining the health and care system. In terms of decision making this is considered key in order to ensure local needs are met and there is local accountability for doing so. Issues facing the local delivery of Adult Social Care, including changing demographics and increasingly complex service user needs, are also highlighted. The importance of a longer term funding announcement to aid planning and ensure impact of long term programmes of work is emphasised within the response to this section.

1.14 Chapter 4 - Options for change

This section starts by describing some of the complexities of Adult Social Care particularly in respect of resourcing and how the system can be difficult to navigate. A set of options are described to help improve Adult Social Care with estimated costings. Views are sought on these options along with seeking alternative suggestions.

Views on a number of options for funding these changes are also sought along with opinions on what the Government should take into account in judging the merits of any proposed funding solution.

1.15 Responses in this section identify that urgent attention needs to be given to sustaining the care market and ensuring that Adult Social Care and support is sufficiently resourced to ensure care and support is provided to everyone who needs it. In respect of options for funding no specific preference is given as no information on impact is provided and it is suggested that there is already sufficient resources at a national level but we are facing a shortfall due to national prioritisation decisions As a principle it is indicated that any proposal to raise additional resources through taxation should not impact disproportionately on those that are less able to pay. In respect of the suggested tests the notion of fairness should play a key part in the eventual option due to the inherent unfairness experienced by many people who require social care as a result of the current regime for personal contributions. Any proposals to bring wider benefits together with adult social care i.e. Attendance Allowance require careful consideration.

1.16 Chapter 5 - Adult Social Care and wider well being
This section sets out the proposition that a shift in focus to prevention and well-being is required in order to tackle long term system demands. The essential role of Public Health and contribution of partners if this shift is to be achieved is described. Views are sought on the role of Public Health services in improving population health and well-being and supporting examples of where local services have improved health and well-being.

1.17 The responses within this section confirm the essential role of Public Health in tackling long term demands with examples provided of how this is taking place in Coventry through initiatives such as “Coventry on the Move” and upscaling prevention. This does, however, also raise the point that to achieve system ambitions there is a need to ensure Public Health as well as Adult Social Care are appropriately resourced.

1.18 Chapter 6 - Adult Social Care and the NHS
The need to improve the system so that people experience more seamless care and support is the fundamental proposition put forward in this section. Integration is seen as a means to delivering improved health and well-being, by improving planning and making the best use of resources. The paper suggests the primary role of central government and national bodies is to support and enable local leaders by removing barriers – whether these are financial, structural or cultural. Views are sought on the principles that should underpin how health and social care organisations work together. This section also describes the benefits of care being centred on the person and the role of local leadership in delivering improvements.

1.19 The consultation responses to this section are supportive of integration where it improves outcomes for people but not integration for its own sake. References are made to NHS led programmes that impact on local government but in which local government is not involved from the outset. The Sustainability and Transformation Programme is one such example that should not be repeated. Care and support centred on the person is of course supported and it is suggested that greater responsibility and ability to effect improvement across organisations should rest with local Health and Well Being boards. The requirement for investment over a period of time in order for results to be achieved is highlighted.

2. Options considered and recommended proposal

2.1 As the LGA Green Paper is a consultation document there is no requirement on the City Council to respond. However, the issues raised are significant and impact on core functions of the City Council which include Public Health as well as Adult Social Care both in terms of funding and expectations.

2.2 It is, therefore, recommended that the City Council responds to the consultation and 'joins the debate on these important issues.

3. Results of consultation undertaken

3.1 There are 30 questions that the LGA are seeking responses to through the consultation. In order to compile a consultation response the following was undertaken:

- A member seminar was held on **Friday 7 September 2018**. This seminar provided background to the LGA green paper, shared draft responses, obtained views from those in attendance and fed these into the proposed response to the LGA.

- Members that wished to provide comment for consideration in the consultation response but were unable to attend the seminar were provided with a consultation question template and invited to input comment to be considered in the response.

3.2 Although the report is in respect of a Council response it should be noted that the LGA were inviting contributions from all stakeholders, whether individuals or organisations. The LGA consultation has also been brought to the attention of Coventry Health and Well-Being Board members and providers of social care services.

4. Timetable for implementing this decision

4.1 The consultation closed on 26 September 2018 and the LGA has allowed a Coventry response to be submitted following Cabinet on 2 October 2018. The responses received by the LGA will feed into the Green Paper on Adult Social Care and Support expected from the Department of Health and Social Care in Autumn 2018.

5. Comments from Director of Finance and Customer Services

5.1 Financial implications

There are no specific financial implications associated with responding to the consultation. However, many of the themes raised in the consultation relate to ongoing resourcing of Adult Social Care and as such, dependant on how proposals are progressed, significant financial implications could arise. The consultation looks at both the level of care provided as well as the resourcing options, from a perspective of resourcing the existing system to moving to a system of free personal care which could potentially cost up to £10 billion nationally by 2024/25.

The report makes no specific recommendation for how the system is resourced and this will be a key aspect of the proposed Government green paper now expected in the autumn.

5.2 Legal implications

The Care Act 2014 makes it clear that in performing its functions under the Act,

"The general duty of a local authority, in exercising a function … in the case of an individual, is to promote that individual's well-being".

Subject to certain specific requirements, the local authority has considerable discretion in how it chooses to meet this responsibility so as to be able to flexibly respond to the specific requirements of adults and carers in its area. In addition, the Act and its supporting Statutory Guidance, encourages co-operation between the Local Authority and its relevant partners and the integration of services where possible and appropriate to achieve this objective.

Whilst there are no specific legal implications associated with responding to the consultation, the consultation itself considers issues regarding how the authority's duties are met and resourced as opposed to proposing any fundamental changes to the duties.

The consultation addresses issues regarding how these duties are met and resourced as opposed to proposing any fundamental changes to the duties.

6. Other implications

6.1 How will this contribute to the Council Plan

Delivering effective Adult Social Care makes a positive contribution to the delivery of the Council's priorities, particularly in relation to: citizens living longer, healthier, independent lives; support improved health and wellbeing and support the City to reduce health inequalities.

6.2 How is risk being managed?

There are no specific risks associated with the consultation at this point, however, risks may emerge as work progresses on the long term future and funding of Adult Social Care. Key risks to Adult Social Care are contained in a risk management plan and escalated accordingly.

6.3 What is the impact on the organisation?

There are no direct implications at this stage.

6.4 Equalities / EIA

Adult Social Care services in Coventry support people with a range of protected characteristics. No specific analysis of equality impacts was completed in the course of responding to this consultation.

6.5 Implications for (or impact on) the environment

None

6.6 Implications for partner organisations?

The consultation raises a number of issues regarding adult social care and support. Dependant on how these issues are progressed there may be implications on partner organisations. Partner organisations have been made aware of the consultation through the Coventry Health and Well Being Board and the City Council response to the consultation will be shared with the Health and Well Being Board on 8 October 2018.

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This report is published on the council's website:
www.coventry.gov.uk/councilmeetings

Appendices

Appendix One: **Local Government Association Green Paper 'The lives we want to lead' – Response to Consultation**

The lives we want to lead: Local Government Association Green Paper for adult social care and wellbeing

Table of consultation questions in full Green Paper

To read the green paper or a summary see http://www.futureofadultsocialcare.co.uk/

Question Number	Consultation Question	Response
Chapter 2 Delivering and improving wellbeing		
1.	What role, if any, do you think local government should have in helping to improve health and wellbeing in local areas?	Promoting the health and wellbeing of people and communities is already fundamental in the role of local government. Local authorities develop and implement solutions that empower people to live better and more fulfilling lives improving outcomes, enabling access to a wide range of universal support that improve wellbeing across a range of areas including housing, parks and greenspaces, licensing, planning etc. Local government in working with other organisations in an area can have a profound impact on health and wellbeing. However, the need to apply thresholds in order to prioritise resources means that the full potential benefit to improve wellbeing is not currently being met. The challenge within this role continues to centre on how local authorities maintain the investment that strengthens local health and wellbeing whilst facing the realities of reductions in public spending. Coventry City Council is committed to improving the health and wellbeing of local people and discharges this responsibility in a number of ways: • Health and Wellbeing Board arrangements that bring leaders together from across health, Public Health and social care together with Elected Members and representatives of the community and patient groups to develop a shared understanding of local health and wellbeing needs, including health inequalities, and how they can be addressed through collaborative leadership. • Warwickshire and Coventry Sustainability and Transformation Plan (STP) Better Care, Better Health, Better Value that acts as the overarching framework for integration between health and social care across Coventry and Warwickshire. The STP programme reports through the Coventry Health and Wellbeing Board. The Council recognises the important role the STP continues to play in bringing organisations together to manage very challenging health and social care demands and deliver on a broad agenda to improve the health and wellbeing of the whole population. • The Coventry and Warwickshire Place Forum - made up of the two Health and Wellbeing Boards and drives key health and wellbeing initiatives including the 2019 Year of Wellbeing.
Chapter 3 Setting the scene –the case for change		

2.	In what ways, if any, is adult social care and support important?	Social care is important as it provides care, support, and safeguards for those people in our communities who have the highest level of need and for their carers. Good adult social care and support transforms lives and helps people to live the best live they can in a variety of circumstances. It enhances health and wellbeing, increasing independence, choice and control. One of the major success stories of our age is that people are living longer - we should celebrate this and also recognise that this increases the important of social care and support in providing the kind of care and health services we need in the future. Social care responds to a wide range of needs - from an 18-year-old with autism who needs support to leave home to an 80-year-old with dementia who needs protection as well as personal care. It touches the lives of millions of people – almost one fifth of the adult population of England has experience of social care - as part of the paid workforce, as unpaid informal carers or as a recipient of services. Social care and support is also a 'connector' to other public services, especially the NHS but also local housing and community services. It works in partnership with community groups, voluntary and private providers and organisations that represent people who use services. Social care also contributes to economic growth as well as meeting social needs. Most care providers are small businesses that form a sizeable chunk of the local economy. The value and importance of adult social care in Coventry is highlighted in the following examples: **Enable people to be remain independent and well, and lead fulfilling lives** The Council provides short-term support to help individuals regain their independence after a period of ill health or when facing a change in circumstances. A team of Occupational Therapists, Social Workers and home support care workers help individuals to regain confidence in carrying out essential tasks to enable everyday daily living. After receiving this support we have found that many people don't need any further help, or only a little. In the first six months since the service started there have been 108 people referred. A total of 66 people referred to the service did not go on to receive long term care. For people with learning disabilities and their family's primary prevention strategies are being used to reduce the negative impacts of learning disability in society, improve people's access to community and universal services, tackle disablist perspectives and prevent abuse. **Investing in community preventative and Discharge to Assess services help to reduce demand on health service** Under jointly commissioned arrangements with Coventry & Rugby Clinical Commissioning Group (CRCCG) social care has been instrumental in the design and delivery of short-term reablement pathways that seek to enable people to leave hospital in a timely manner and continue their recovery from illness within their own home and community; maximising independent living and preventing premature admission to long-term residential care in the longer-term.

		Support carers to stay healthy and well while maintaining their role Carers are one of the greatest assets of Coventry and supporting carers to get the support they need, when they need it, is integral to the delivery of effective Adult Social Care. This year there has been an increase in both the amount of Joint Assessments (where a carers' needs have been assessed alongside the needs of the person they care for) and a rise in separate Carers' Assessments, which is reflective of the overall increase in requests for initial support. The increase in separate carers' assessments is a positive reflection that carers' needs are being considered and planned for on an individual basis.
3.	How important or not do you think it is that decisions about adult social care and support are made at a local level?	It is vital that decisions (strategic priorities, service architecture, operational practice and commissioning/contracting) about adults social care delivery are taken at a local level based on knowledge and evidence across a range of factors including statutory responsibilities, population growth and trends, care and support need and demand, the supply and configuration of care provision including acute healthcare and community preventative support, availability of housing and accommodation, availability of universal services and community assets and voluntary and third sector support arrangements. Furthermore, in the context of changing social care needs, particularly increasing complex needs, control of decision-making through local authorities underpins the ability to liaise with other agencies to ensure appropriate safeguarding and protection of the most vulnerable adults. As highlighted above local approaches such as the Community Promoting Independence scheme are effective in utilising the assets available to enable people to live as independently as possible, achieve better outcomes and avoid unnecessary reliance upon services. Decision making at a local level creates local accountability and enables decisions to be made in the context of local circumstances and needs. The Care Act 2014 places the statutory responsibility to meet needs in the local area and it is important that this existing, and recent statutory requirement is maintained.

4.	What evidence or examples can you provide, if any, that demonstrate improvement and innovation in adult social care and support in recent years in local areas?	Examples include: **Community Preventative Support – Voluntary and Third Sector** In April 2018 the Council and CRCCG implemented a new range of community preventative support arrangements to enable people most in need to maintain their independence and live well in the community with access to universal services. The model has been designed to offer outcome-focused and flexible preventative support around four priority groups (carers, people with physical impairments or dementia, people with mental ill health and adults with learning disabilities) so that people can actively take steps towards maintaining their health, wellbeing and independence. This work has delivered innovation in the preventative support made available to people in the community. For example, a collaborative model of support for people with mental ill-health is enabling flexible approaches to target support more effectively, including housing-related support and community interventions, alongside an entirely original form of targeted early help for people with hoarding behaviours. **Dementia Promoting Independence** This service is a specialist short-term home support service for people living with dementia. This may include support from a dedicated dementia specialist and therapist. This service was tendered, following a successful pilot, with new contracts commencing April 2018 for the duration of up to 5 years. This short term service has been specifically designed to support people living with dementia to go directly home following a hospital stay or to help prevent an admission. **Housing with Care dementia specialist scheme – Arden Grove** The scheme consists of 33 self-contained flats offering a modern living space, kitchen and bedroom with en-suite facilities. The scheme also has communal living facilities to enable social interaction underpinned by the 'Eden Alternative' care model, which moves away from traditional HwC models of support and provides a more structured approach to enable people living with dementia to live independently in a safe environment. There are a very limited number of such schemes across England adopting this approach. **Improving quality of care services** A number of care home improvement initiatives are in place in collaboration with our NHS partners including "React to Red Skin" pressure ulcer prevention and treatment accreditation and 'Say No to Infection', a programme which accredits homes for infection prevention and control. React-to-Red' has 24 care homes accredited along with 'Say No to Infection' that has 9 care homes accredited. All accredited homes have been avoidable pressure ulcer free since accreditation.

5.	What evidence or examples can you provide, if any, that demonstrate the funding challenges in adult social care and support in recent years in local areas?	Adult Social Care consistently had a £2m+ overspend per annum in Coventry for the 3 years up to 2016/17 and even with the significant additional resources the Council approved in its budget (see below), was only underspent in 2017/18 due to the introduction of the iBCF and Spring Budget resources.

	2016/17 £m	*2017/18 £m*	*2018/19 £m*	*2019/20 £m*
ASC additional Council Investment	6.6	9.9	13.9	18.0
Partly Funded by Adult Social Care Precept	(2.1)	(5.5)	(9.2)	(9.4)

Funding challenges have arisen largely as a result of supporting people with care and support needs, the increasing costs of care and the impact of legislative change, for example, Deprivation of Liberty Safeguards (DOLS). Gross spend on packages in 2017/18 increased by 2.3% compared with 2016/17 with approximately 40% being spent on residential and nursing care and 36% on home support.

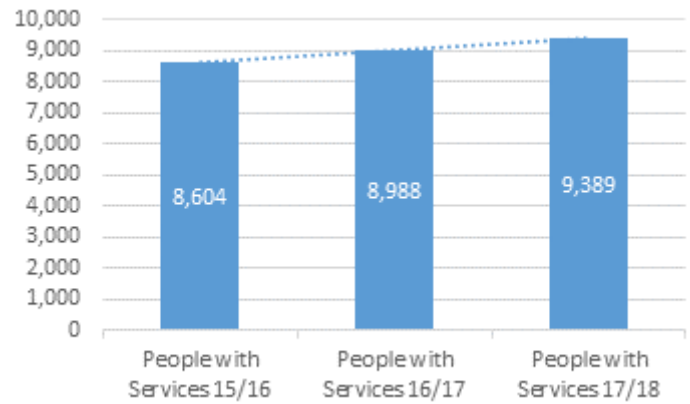


Figure 1: People Supported by Adult Social Care in Coventry

		The adult social care gross budget for 2018/19 is £117M of which circa £24M is funded through Grant income and transfers from health therefore unsecure. In terms of impact the Council spend on home support and housing with care combined for 2017/18 was £22.7m net – should grants cease the impact would therefore be beyond significant. Looking forward, the Budget Report 2018/19, approved by Council in February 2018, incorporates anticipated reductions in funding over the next 3 years. The position is particularly uncertain for financial year 2020/21 which could be subject to the combination of a new national Spending Review, a revised allocation model within the Local Government sector and a new national Business Rates model. As a result there is huge uncertainty around Local Government funding which makes it impossible to provide a robust financial forecast at this stage. Nevertheless, initial assumptions and existing trends are sufficiently firm to indicate that there will in all certainty be a substantial gap for that year (£21m) and as the largest single area of budget Adult Social Care is likely to experience additional impact as a result of this.
6.	What, if anything, has been the impact of funding challenges on local government's efforts to improve adult social care?	One of the core requirements on the local authority is to ensure that eligible needs assessed under the Care Act 2014 are met. In the context of funding challenges faced this has resulted in a reduced investment in preventative services that contribute in the longer term to reduced needs. It could be argued that this is short term thinking, however, with a reality of having to ensure eligible needs are met, increasing demand and complexity of demand and reducing resources there are few other options. The funding challenges have also helped to stimulate different service models – for example, we have worked hard to develop services that have a more enabling focus and reviewed our approach to how we support people when they first make contact. The iBCF and social care precept provided essential funds but with short term timescales cannot be used to underpin improvements which required resources over a longer period. The uncertainty of future funding plus the continued funding challenges also make proper engagement with the provider marker on improvements challenging as providers are less willing to invest in improvement when they are uncertain of the future financial context.

7.	What, if anything, are you most concerned about if adult social care and support continues to be underfunded?	The growing demand for services for adults with complex needs coupled with limited and high cost of available provision continues to be a concern. The trajectory indicates the demand for long term care and support will continue to rise. As local authorities are required to set a balanced budget in the absence of a sustainable and realistic funding solution this will mean either a scale back of other services, and, noting that these are also under pressure and issues of resourcing Childrens Social Care are also growing in national recognition there are limited places left to go. In respect of use of reserves these can only be spent once and using reserves to underpin revenue spend is simply not sustainable and further destabilises the social care and support system. Fundamentally, continuing to underfund adult social care and support risks the financial viability of local government and is likely to have impact ultimately on all people living in the local area and partners. The local factors driving this concern include: • Coventry has a relatively young population but the number of older residents is increasing and the age of the population will start to increase. In particular, those aged over 85 and over is expected to grow by 22% in the next 10 years. • The increasing number of older residents is related to increasing life expectancy amongst Coventry residents. However, on average Coventry residents are living a significant period at the end of their life in poor health. • As the population ages more people will be living with multiple health conditions that require support. • The numbers of working age people with complex physical or learning disabilities living into adulthood will continue to increase as life expectancy increases. Having a workforce and providers who employ staff with the specialist skills required to provide care and support for those people with complex needs remains a challenge to be addressed. • The levels of deprivation in the city, although improving is likely to remain relatively high and those living with lower levels of wealth are more likely to develop poor health. • There is a projected 21% increase in the number of those aged 75 years and over between 2017 and 2025 who will be living alone. Those who are socially isolated are between two and five times more likely to die prematurely than those with stronger social ties.

8.	Do you agree or disagree that the Care Act 2014 remains fit for purpose?	Agree. Introduction of the Care Act 14 as a single legislative framework enabled some important and much needed changes in the delivery of adult social care. The legislation (although only partly implemented) remains fit for purpose but the issues in meeting the aspirations of the care act remain at least as challenging as when it was implemented. Some of the particularly positive elements of the Act included: • Placing prevention and well-being at the core as a whole council responsibility • Placing the needs of carers on the same footing as people needing care and support • Requiring social care delivery, including information and advice, to prevent, delay and reduce the need for care and support, which has led to investment in short-term care and reablement services • A greater emphasis on personalising care and support including ensuring everyone understands the cost of their care through the use of Personal Budgets and how they can have more control by using all or part in other ways i.e. Direct Payments • The right to request an assessment of care and support needs and how these can be met regardless of whether people are eligible for local authority funded care or if they pay for it themselves • New national eligibility criteria that confirms the financial threshold and assessment process for determining who is responsible for meeting the cost of social care
9.	What, if any, do you believe are the main barriers to fully implementing the Care Act 2014?	The most significant element of the Care Act that has neither been funded nor fully implemented relates to the prevention agenda. As described in Q6 above, investment in preventative services have reduced and whilst this may not have the same impact as cuts to mainstream day to day support services in the first instance, the long term impact of reductions may be substantial with the impact not felt for a number of years. While the Act is fit for purpose it is a legislative framework that was not fully funded and therefore expectations around implementation cannot be met from the current resources made available to adult social care.
Chapter 4. The options for change		

10.	Beyond the issue of funding what, if any, are the other key issues which must be resolved to improve the adult social care and support system?	Beyond the issue of funding the following key issues should be resolved: 1. The path to further integration is clearly important and valuable as a means to improve outcomes – so much feedback is based on how difficult the system is to navigate and how confusing all of the different organisations involved are. This is not just a challenge that exists between health and social care but also between the number of health organisations that exist. 2. The limitations of integration also need to be understood and accepted, or measures put in place to address – for example, health services are free at the point of use whereas social care is chargeable. Health and Care are also on different legislative footings and therefore operate to different requirements. As long as these structural differences remain achieving full integration will always be constrained. 3. The impact of Brexit on the care sector will only be truly understood post event, however with a significant proportion of people working in the care sector coming from overseas the impact of Brexit could see more challenges around workforce resourcing, which funding for social care on its own will not resolve. 4. In an environment of resource scarcity much of adult social care and support has focussed on assessment against eligibility criteria and finding cost effective means of meeting eligible needs. There are various ways in which local authorities have approached the delivery of adult social and support and the absence of any national view on 'what good looks like' or agreed best practice models means that large local variances will continue to exist. 5. The concept of a single social care and health record is an important one and will probably be the single biggest step to integration and seamlessness – it will required investment over time and effort over time. Taking whatever steps necessary to enable the investment and the time to reap the benefits would be a significant advantage. 6. Managing public expectation in light of significant numbers of people not planning for old age and having a presumed reliance on the state must be resolved. If funds cannot be made available then people will have to take a greater responsibility for their future health and care.

11.	Of the above options for changing the system for the better, which if any, do you think are the most urgent to implement now?	All six options described are with merit however the focus in terms of urgency should be on ensuring that people who are eligible for care and support can have these needs met – this is a legal requirement on local authorities enshrined within the Care Act 2014. Once these fundamental issues are addressed then issues of cap and floor and free personal care can be considered. Therefore, in terms of the options for urgent implementation we would suggest: Option 1: Pay providers a fair price for care – this is important as so much of the discussion is dominated by fees and simple year to year financial sustainability. Only when there is some stability brought to fees and providers have a level of confidence that they have financially viable businesses can we really embark on a serious discussion regarding long term improvement. We would suggest that the ambition be reframed as a 'locally sustainable price for care' to recognise that local care economies are varied and what is a sustainable market price in one may not be in another. Elements within this option should include guidelines on how care fees are apportioned to different costs centres including: staff pay, development, infrastructure, management, overheads and profit/central contributions. The importance of ensuring a fair wage is paid to support a stable workforce and encourage more people to commence careers in social care should also be incorporated into this option. Options 3 and 4 combined: We would not support the provision of care for older people above the provision of care for working age adults so both options should be combined. All people who require care and support should have equality of access. We would support the sentiment that in dealing with the availability issue people's independence would improve as would a reduction in the deterioration of people's conditions. This would in turn support informal carers to continue their caring role. We would also affirm that local authorities should not just be 'organisers of care' but should work with people to enable them to reduce the need for ongoing care and support and use their own assets and strengths to meet as much of their needs as possible.
12.	Of the above options for changing the system for the better, which if any, do you think are the most important to implement for 2024/25?	We do not consider that the issues of funding social care and support to a point where there are sustainable local markets and there is resource to meet the care and support needs of people that require it can be left in abeyance until 2024/25. The wider issues regarding personal contributions to the cost of care – whether this be cap and ceiling, free personal care or any other proposal yet to emerge need to be tackled and cannot be put off forever more. Setting a clear timescale for addressing the issue of personal contribution so that it is resolved by 2024/25 should be the longer term imperative. Any extension of entitlements would need to be accompanied by a clear and agreed resource plan with clear demonstration of the benefits to be achieved.

13.	Thinking longer-term, and about the type of changes to the system that the above options would help deliver, which options do you think are most important for the future?	None of the options in their current form would deliver what is important for the future as they are focussed on immediate issues of sustainability and ensuring that resource is available to meet needs. These issues are clearly critical but when thinking about a possible future for adult social care and support the focus should be on enabling people to meet their needs in ways that do not rely in the long term provision of care and support through a traditional supply market. This is not just a social care and support issue but an issue for local government in using the totality of its resource to enable effective communities. The core principles of the care act are well-being and prevention and what is important for the future is to develop the adult social care and support system to have the capacity and resources to work with people to enable them to remain healthy for longer and where support is required this is provided in a way that supports people to maintain and, where required, regain the maximum possible degree or independence. Supporting informal networks – whether families or carers or wider social support networks is critical to this as is investing in community resilience and capacity building activities so that alternatives to traditional services exist. The role of technology as an integral part of both prevention and meeting care and support needs where they arise needs to be fundamental to a future system.
14.	Aside from the options given for improving the adult social care and support system in local areas, do you have any other suggestions to add?	As so much of the provision of effective social care and support is dependent on workforce a comprehensive sector wide workforce development and career progression programme should be considered. This should not just be concentrated for care staff, care managers and social workers and therapists but also commissioners and contract managers who are fundamental to shaping future systems. Taking a workforce approach is also likely to make social care and support more attractive as a career and set some clear expectations for providers of care and support regarding the development and career progression models they are to have in place. There needs to be a significant communication plan that resets realistic expectations linked to the future delivery option so for example if free personal care is the option being pursued this must be set within a realistic expectation of what is free and what is expected to be supported by the individual friends/family/community.

15.	What is the role of individuals, families and communities in supporting people's wellbeing, in your opinion?	The role of individuals, families and communities in supporting wellbeing is critical, often understated, and frequently taken for granted – the existence and importance of these networks are demonstrated through most people generally only approaching adult social care when these informal networks and arrangements become too stretched and start to breakdown. It is often the quality of the social care response at this point that determines the ongoing relationships with services. Through taking strength based approaches to social work the role and contributions of the individual, families and communities is likely to become more transparent. However, the role should not be for the local authority to try and step in and 'manage' these networks, rather to know they exist and support them in their critical role. In terms of broader wellbeing the links between isolation and poor health outcomes (including mental health) are proven. Supportive families and communities are essential for all of us in terms of our wellbeing and not just in the context of social care.
16.	Which, if any, of the options given for raising additional funding would you favour to pay for the proposed changes to the adult social care and support system?	Based on the information provided the Council consider it premature to express a 'preferred option' from those described and more detail would be required on impact before a considered view could be given. The pre-cept level setting process is complex and the impact varies upon people across the local area. The Council has already increased Council Tax by 6% and this has not resolved the ongoing issue of pressure on social care therefore this approach should not be seen as a national funding solution Whilst arguably there is sufficient resources at a national level to fund adult social care, the funding issues we are experiencing is as a result of decisions at a national level to prioritise other areas of government spend. Should additional taxation be used as a means to raise additional funds it is imperative that this is progressive taxation. As an alternative to additional taxation the government could consider tackling issues associated with tax avoidance.

17.	Aside from the options given for raising additional funding for the adult social care and support system in local areas, do you have any other suggestions to add?	The funding streams that enabled the iBCF to be put in place has supported short term sustainability and mainstreaming this to local government could be a means of ongoing additional resource. The most important requirement is long term sustainable funding to enable longer term planning and development of services as opposed to the current short term funding solutions which impact negatively on attempts to stabilise and improve services.
18.	What, if any, are your views on bringing wider welfare benefits (such as Attendance Allowance) together with other funding to help meet lower levels of need for adult social care and support?	Such initiatives may sound attractive at first consideration, however careful consideration needs to be given to the actual as opposed to intended consequences. Lessons can be learnt from the closure of the Independent Living Fund (ILF) where on implementation it was found that large amounts of ILF funding were supporting social care needs. The recent outcome of the consultation on Housing Benefit payments for Supported Housing indicates that proposals to change funding mechanisms need to be carefully thought through and consulted on with an open mind. In respect of Attendance Allowance a specific consultation would be required to understand the impacts and if an eventual shift to local government was the outcome then the additional costs to administer such payments would also need to be accounted for and not an automatic assumption of 'savings' simply through a transfer of responsibility. In terms of 'lower level needs' the definition of this needs to be thought through as the concept of low level need was removed to coincide with the introduction of the care act and national eligibility. It would be good to bring together the wider benefits to reduce complexity, however with the problems seen with universal credit this would need to be done in a clear and transparent manner which does not reduce the overall benefit. There could be a benefit in local management of welfare benefits in the opportunity to offer a system which is less complex and one which supports people who find it difficult to access benefits and services currently.

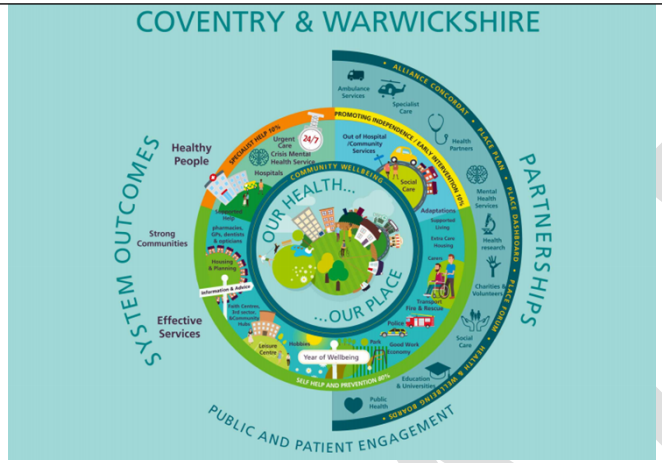
19.	What are your views on the suggested tests for judging the merits of any solution/s the Government puts forward in its green paper?	The tests of Wellbeing, Fairness, Sufficiency, Sustainability, Clarity and Subsidiarity are balanced and considered. However, it may be appropriate to consider the prioritisation of fairness within this set of tests. The reasons for this being the inherent injustice people feel when they need to significantly deplete their savings and property due to a social care condition, i.e. dementia. Whereas free at the point of use care is available for health related conditions. The notion of Wellbeing is welcomed **'do the solution/s help advance the core aims of improving and supporting people's wellbeing, putting the individual at the centre of their care and support, and investing in the social and economic outcomes of our communities?'** but perhaps some more thought to how this test is applied would be helpful to ensure expectations were realistically set. This point is worth consideration as the immediacy issues are in respect of resourcing social care and support to meet the needs of people within localities – this what we have to do. This often falls short of the broader improving well-being aspiration which may require additional resourcing, at least in the medium term. The links with public health are significant here and consideration then needs to be given to the extent to which this is an issue confined to the resourcing of Adult Social Care and Support or an issue equally spread across Public Health funding.
20.	In your opinion, to achieve a long-term funding solution for adult social care and support, to what extent is cross-party co-operation and/or cross-party consensus needed?	There appears to be a general acceptance that adult social care funding needs to be a non-partisan issue. Adult Social Care funding is an issue that no party alone has been able to resolve to date. Any solution is unlikely to take effect overnight and may span more than one election period so cross party support is essential to deliver the level of change and reform required to make the system both sufficient and sustainable. Strategic cross party thinking is needed to consider the crisis in the system.
Chapter 5. Adult social care and wider wellbeing		

21.	What role, if any, do you think public health services should have in helping to improve health and wellbeing in local areas?	The LA is responsible through the Director of Public Health for the health and wellbeing of the population. Public Health Services should continue to play a vital role in supporting the prevention of ill health and improving the health and wellbeing of communities. The work of Public Health encourages people to remain healthy and remain able and independent for longer, reducing the need for care and support services. Failure to take prevention seriously will reduce healthy life expectancy and increase the demand on social care services. Public Health possess local knowledge and understanding of need. This is particularly important in the context of community engagement and ensuring hard to reach groups are supported to live well and have access to the various programmes and services available. Public Health departments are concerned with a system wide approach to the prevention of ill health and the increase in population wide mental and physical health. This plays a critical role in the reduction in the demand for services, both now and in the future. This focus needs strengthening, and it is essential that any financial response to the issues within social care and support include a commitment to securing resources for strengthening the role of prevention. Without a clear strategy and commitment to the role of prevention, demand will continue to rise. Public Health commissioned services include treatment and prevention programmes, which already significantly impact on the health and wellbeing of our population, such as Drug and Alcohol Services, Sexual Health Services and 0 to 19's Childrens health services and adult healthy lifestyles services. Public Health commissioned services play a significant role in supporting health and wellbeing throughout the life course, supporting economic productivity and managing demand on health and social care. We support the recognition in the green paper that local authorities should consider how they can use all their resources (not just the ring fenced budget) to improve the health and wellbeing of their residents. It must be recognised that the health and wellbeing of local residents is not the sole responsibility of local government and the funding of other local services also impacts on the population's wellbeing. Other local authority services must also receive adequate funding to support a local approach to improving health and wellbeing.

22.	What evidence or examples, if any, can you provide that demonstrate the impact of other local services (both council services outside of adult social care and support, and those provided by other organisations) on improving health and wellbeing?	Through a variety of programmes, working in partnership the local authority and voluntary and third sector organisations continue to have an impact on the health and wellbeing of the population. Some examples of the work undertaken recently are set out below; • Ignite programme – involving Coventry Law Centre to support families living in poverty with health and wellbeing and financial/benefits advice and guidance to achieve better outcomes for families. • MAMTA Child and Maternal Health Programme, supporting minority ethnic women during and after pregnancy. • Healthy lifestyles - supporting families to live healthier lives as part of a wider prevention approach. • Coventry on the move! Coventry on the move is aimed at encouraging people to get up and active and have some fun thus creating healthier lifestyles and improved wellbeing. • Change Grow Live are a charitable organisation who work with children and young people in Coventry around making positive choices. Supporting young people who might be experiencing difficulties and/or facing risks around sexual health, substance misuse and difficult relationships with their peers by intervening early and delivering supportive interventions they help young people identify their strengths and build their resilience in the hope that they realise their full potential. • Carers Trust Heart of England is commissioned to deliver the Coventry Carers' Wellbeing service to over 2,000 cares, a "one-stop" shop for carers taking a holistic approach towards the improving the wellbeing of carers. The service provides information and advice, training including holistic training at relieving stress and prioritising one's own health, counselling, carer peer support groups, including recreational activities and support applying for grants and holidays. The service also facilitates the CRESS the Carers Emergency Response Service, a service supporting carers to develop a contingency plan and the provision of support if there is a crisis. The service has historically been good at engaging the local BAME population with a heavily attended carer peer support group. The service works closely with GP surgeries and the local hospital with a dual aim of supporting the overall health of carers in these settings. The Carers Trust Heart of England also deliver the Young Carers Project, a project dedicated to providing support for circa 1,500 Young Carers, such as activities and 1:1 emotional support. They also support schools in developing their approach towards young carers, identification of young carers and support within school settings. They are currently working with 34 schools in the Coventry area. • The Marmot Programme is a programme of work that undertakes to reduce health inequalities through a multi-agency approach within the city. • Initiatives such as The Year of Wellbeing 2019 and The City of Culture 2021 demonstrate the impact the local authority and other local organisations working in partnership can have on the health and wellbeing of the community. • Whole systems approaches to health and wellbeing challenges such as childhood obesity and physical activity, that recognise the contribution that services, communities and our place can have on improving health and wellbeing. • Other Council Services; Housing, Libraries, recreation and sport, Community Safety, Environmental Health and Protection and Community Development all have an impact on the health and wellbeing of our citizens.

23.	To what extent, if any, are you seeing a reduction in these other local services?	The significant cuts in resources to local authorities has led to reductions in universal services to focus resource on individual packages of support. This applies to services across the Council that ultimately support community development, cohesion and wellbeing. In 2017/18 the Council and the Coventry and Rugby Clinical Commissioning Group working in partnership jointly reduced the grant funding of community preventative support, achieving a saving of £0.5m. The grant funds the following types of support within the community; support to Carers, support to people with dementia and their Carers, support for mental ill health issues, e.g. complex behaviours (hoarding), community based support for people with learning disabilities. Following a programme of change titled Connecting Communities, also achieving savings, reductions and closures in the following local authority services were implemented: Library Services, Youth Services, Children's Centres. The Community Development Fund Grant managed by Coventry City Council Community Development Service has ceased this ran for 2 years 2014/2015 and 2015/2016 and provide £100k per year to support small community groups often connecting and supporting older people, families and community life.
Chapter 6. Adult social care and the NHS		

24.	What principles, if any, do you believe should underpin the way the adult social care and support service and the NHS work together?	The fundamental principal of care and support organised around the individual and their family and carers should underpin the way care and support is provided. Essentially, this is the principle of personalised support which has been the default model in adult social care and support for approximately 15 years. In Coventry and Warwickshire our Health and Wellbeing Boards have developed a joint Health and Wellbeing Concordat which sets out the principles governing the way health and social care organisations are working together to improve the health and wellbeing of our local residents: http://www.coventry.gov.uk/downloads/download/5184/coventry_and_warwickshire_health_and_wellbeing_concordat_2018.  COVENTRY & WARWICKSHIRE HEALTH & WELLBEING CONCORDAT OUR VISION WHAT THIS MEANS FOR RESIDENTS OF COVENTRY & WARWICKSHIRE OUR PRINCIPLES OUR WAYS OF WORKING In summary the principles are: • Prioritising prevention • Strengthening communities • Coordinating services • Sharing responsibility. A new model of health and care services for Coventry and Warwickshire is also being developed to transform the way that services for our local communities are designed, delivered and used: http://www.coventry.gov.uk/downloads/file/27607/coventry_and_warwickshire_-_helping_you_to_help_yourself



We are aiming for most of our work to be focussed on helping people stay well – providing guidance and support, encouraging the use of leisure opportunities, parks and other community assets and tailoring our efforts to take account of local needs and health inequalities. We recognise the importance of education, good work and affordable, decent housing in underpinning our quality of life. We want to make self- help the first and natural choice for everyone who is capable of it, rather than waiting for intervention when things go wrong. Investment in a workforce development approach is essential in making new models work so should therefore be an integral part of the work from the outset.

25.	In your opinion, how important or unimportant is it that decisions made by local health services are understood by local people, and the decision-makers are answerable to them?	It is important that decisions are made in a transparent manner. It will not always be possible for all people to understand the reasons for all decisions but proportionate efforts should be made. The role of local councillors is critical in this as the democratically elected representatives of the communities they serve. Local authorities and their partners have varied routes into local communities that can be used to strengthen involvement and engagement of communities in key decisions. Engagement with our communities needs to extend beyond communication of decisions and should recognise that our communities are assets in their own right that can be mobilised as part of the solution to public service challenges and to develop strong, resilient communities. Many decisions are not universally popular and in these circumstances it is still important that this is done in a transparent way, incorporating appropriate consultation and engagement so that local people understand, although may not agree. Decision makers do need to be answerable, but on a basis that recognises the merit of the decision. A decision maker being criticised for closing a service just because local people may like it and want one nearby would not be an appropriate basis of accountability.
26.	Do you think the role of health and wellbeing boards should be strengthened or not?	The governance and decision-making landscape for health and social care at the local level is complex with a lack of clarity and consensus about the role and authority of the health and wellbeing board in the context of other governance bodies, particularly the STP Board and accountabilities towards different bodies including National Health Service England, Care Quality Commission and Department of Health and Social Care vs local accountabilities to Health and Well-Being Board and Health Overview Scrutiny Committee. Health and Well-Being Boards provide a structure and governance within which decisions can be made across health and social care with the involvement of wider partners. However, in such a complex decision making environment and in the absence of any effective statutory power Health and wellbeing boards risk becoming diluted from their originally intended role. Locally our Health and Wellbeing Boards for Coventry and Warwickshire are meeting regularly as the Place Forum with a strong focus on Upscaling Prevention and recognising that leadership for whole systems approaches to health and wellbeing is best provided by our collective partners. The development of the Place Forum is a significant one and presents a real opportunity to strengthen our approach to health and wellbeing across our geography alongside existing STP governance structures.

27.	Which, if any, of the options for strengthening the role of health and wellbeing boards do you support?	Comments on the three options presented are as follows: Option 1 – STPs required to engage with HWBs in the development of STP plans This is strongly supported. In Coventry, one of the priorities in our Health and Wellbeing Strategy is around promoting health and social care integration, and progress in the development of STP plans is routinely reported to the Health and Wellbeing Board in this respect. However, engagement is a very interpretive word – therefore should this option progress what is specifically meant by engagement needs to be addressed and STPs mandated to do this, for example, would STP plans require approval from HWBB in order to meet NHSE assurance? Option 2 – HWBs could be given a statutory duty and powers to lead the integration agenda at the local level The overlap with this and STPs would need to be clarified along with how a possible statutory duty would interface with existing statutory duties held by individual organisations Option 3 – HWBs could assume responsibility for commissioning primary and community care As HWBBs are whole system it is unclear why responsibility would be specifically given for these services and not others. The mechanisms for enacting this responsibility also required clarity – for example, would HWBBs be budget holders and become directly accountable to regulators
28.	Do you have any suggestions as to how the accountability of the health service locally could be strengthened?	Health service accountabilities are complex with structural accountability to NHSE and CQC and DHSC plus local accountabilities to HOSC and HWBB. It would appear that strengthening local accountability would require a shift of responsibility from national health structure to more local means. Simply adding a more rigorous layer of local accountability to what already exists would be confusing and would probably add to the existing costs of servicing accountability mechanisms.

29.	Which, if any, of the options for spending new NHS funding on the adult social care and support system would you favour?	All of the suggestions would provide benefits to different parts of the system. Due to the different structure of the health and social care economies across the country it would be appropriate to leave decisions regarding which elements delivered the greatest impact to be made locally. Following initial consideration Coventry would favour; • invest in prevention, primary care and community health services, to put in place early help and support that is targeted in a manner that reduces system demand • invest in joined-up infrastructure, such as ICT and assistive technologies, and shared information to support the delivery of joined up support joint workforce development activity to enable this is practice In respect of investing it should be noted that investment would need to be over a period of time required to see results
30.	Do you have any other comments or stories from your own experience to add?	There are numerous examples the Coventry City Council has from people who have not had a good experience of health and social care. However, in proportion to the number of people supported the number is small indicating that despite the immense challenges many people do actually receive good support.