Coventry City Council

Agenda

Coventry Health and Well-being Board

Time and Date
2.00 pm on Monday, 8th July, 2019

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 - 20)

   (a) To agree the minutes of the meeting held on 8th April 2019

   (b) Matters Arising

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

   To confirm the appointment of Dr Sarah Raistrick, Coventry and Rugby CCG, as Deputy Chair of the Health and Wellbeing Board for 2019/20

5. **Chair's Update**

   The Chair, Councillor Caan will report at the meeting

Development Items

6. **Housing and Homelessness One Coventry Approach** (Pages 21 - 22)

   Report and presentation of Jim Crawshaw, Head of Housing

7. **Draft Coventry Joint Health and Wellbeing Strategy 2019-23** (Pages 23 - 114)

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

Delivery Items

8. **Governance Arrangements for the Coventry and Warwickshire Health and Care Partnership** (Pages 115 - 120)

   Report of Professor Sir Chris Ham, Better Health, Better Care, Better Value

9. **Coventry and Warwickshire Place Forum and Year of Wellbeing 2019 Update** (Pages 121 - 126)

   Report of Liz Gaulton, Director of Public Health and Wellbeing

Governance Items

10. **Multiple Complex Needs Evaluation and Future Governance** (Pages 127 - 168)

    Report of Chief Superintendent Mike O'Hara, West Midlands Police and Chair of Coventry Multiple Complex Needs Board

11. **Community Projects Proof of Concept Evaluations** (Pages 169 - 212)

    Report of Valerie de Souza, Public Health Consultant

12. **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 June 2019

Note: The person to contact about the agenda and documents for this meeting is Liz Knight Tel: 024 7697 2644 Email: liz.knight@coventry.gov.uk

Membership: Cllr J Blundell, Cllr K Caan (Chair), G Daly, Cllr G Duggins, P Fahy, L Gaulton, S Gilby, J Grant, A Green, J Gregg, A Hardy, R Light, S Linnell, C Meyer, Cllr M Mutton, M O'Hara, S Ogle, G Quinton, S Raistrick, Cllr P Seaman and R Stanton

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, 8 April 2019

Present:

Board Members: Councillor Abbott
Councillor Caan (Chair)
Councillor Duggins
Councillor Seaman
Councillor Taylor
Liz Gaulton, Director of Public Health and Wellbeing
Simon Gilby, Coventry and Warwickshire Partnership Trust
Andrea Green, Coventry and Rugby CCG
Andy Hardy, University Hospitals Coventry and Warwickshire
Ruth Light, Coventry Healthwatch
Stuart Linnell, Coventry Healthwatch
Sue Ogle, Voluntary Action Coventry
Mike O'Hara, West Midlands Police
Dr Sarah Raistrick, Coventry and Rugby CCG (Deputy Chair)

Other representatives: Rashid Bayat, Positive Youth Foundation
Rachael Danter, Better Health, Better Care, Better Value
Professor Sir Chris Ham, Better Health, Better Care, Better Value

Employees (by Directorate):

Place: L Knight

People: D Dawson
P Fahy
J Gregg
S C Lam
K Nelson

Apologies: Professor Guy Daly, Coventry University
Gail Quinton, Deputy Chief Executive (Place)

Public Business

40. **Declarations of Interest**

There were no declarations of interest.

41. **Minutes of Previous Meeting**

The minutes of the meeting held on 14th January, 2019 were signed as a true record. There were no matters arising.

42. **Stuart Linnell and Sue Ogle**

The Chair, Councillor Caan, welcomed Stuart Linnell, Chair of Healthwatch Coventry and Sue Ogle, Chief Executive of Voluntary Action Coventry who were attending their first formal meeting of the Board.

The Chair informed the Board that Rachael Danter had recently been appointed as the fulltime Transformation Director for the STP, so would no longer be representing NHS England on the Board. The Board would be working with Rachael in her new role.

43. **Chair's Update**

The Chair, Councillor Caan, informed of the successful Year of Wellbeing Community Leaders event held in St. Mary's Guildhall on 7th March for people from community and faith groups working to improve health and wellbeing outcomes in the city. There was the opportunity to meet service providers supporting the Year of Wellbeing. Reference was also made to the successful Kings Fund event held on 6th March, Minute 47 below also refers.

Councillor Caan reported on the busy start to the European City of Sport 2019 with involvement in over 30 events. Particular reference was made to just under 4,000 people taking part in the Coventry Half Marathon on 24th March which also included a new 5km race and a 2.5km wheelchair race. In addition, over 2,000 children from local schools took part in the Children's Mile at the War Memorial Park on 17th March. Takeover Games at Coventry Blaze, Wasps, Coventry City Football Club and Wasps Netball had also taken place. He informed the Board that over 60 applications had been made to the Sport and Culture Innovation Fund, which encouraged clubs to do things differently to get more people active in the city.

Councillor Caan informed of the launch of the Good Gym project which was launched on 19th March in partnership with the West Midlands Combined Authority and the City Council. This combined physical activity and fitness with helping people in need and social projects.

An update was provided on recent meetings of the West Midlands Combined Authority and the Chair informed how he was leading the work on Sports and Physical activity.

Dr Sarah Raistrick, Deputy Chair, reported on the values based care through the STP communities of value including an event held on 21st March. She also referred to the Cervical Screening Campaign launched on 6th April which had been supported by Healthy Lifestyles, MacMillan and STP representatives along with Wasps Netball. Opportunities were also taken to get people to sign pledges for the Year of Wellbeing.

44. **Young People and Violence**

The Board considered a report and presentation of Chief Superintendent Mike O'Hara, West Midlands Police concerning youth violence in the city and the

existing activity to address the problems. Rashid Bhayat, Chief Executive Officer, Positive Youth Foundation attended the meeting for the consideration of this item.

The report indicated that there was increasing concern and profile around youth violence in the city and, whilst lots of activity was already in place to address this, there was recognition that there was a need for a coordinated approach to tackling the issue. Coventry's senior leaders had acknowledged that violence in the city should be approached as a public health issue, in that it had root causes, it could be treated, but most importantly it could be prevented.

The drivers of violence were identified as poverty, deprivation, substance misuse, adverse childhood experiences, mental health issues, urban environments, organised crime, county lines and having a large population of young people. To make an impact on violence over the long term all these factors needed to be addressed by taking a systematic 'public health approach'. Data and intelligence was to be used to assess the scope of the problem, identifying who was at risk and what common risk factors they shared to inform evidence based approaches over the short, medium and long term.

A Violence Summit for city leaders was held at the end of January, focused around identifying root causes, key priorities and resources, and laying the foundations for follow-up work to further develop and operationalise these. The Board were informed that further events were planned to engage the voluntary sector and the local community.

The presentation provided information on the figures for national and West Midlands violent crime for 2010-2018, and regional and violent crime and knife crime for 2002 to 2019, which showed that violence was continuing to increase. The Board were informed that it was children and young people who were particularly at risk.

Attention was drawn to the ongoing good work currently being carried out to tackle violence, including violence prevention activity. The board noted that there was a good foundation in this area but it wasn't particularly clear, co-ordinated or focused. Reference was made to the police response and the broader developing partnership response.

The presentation concluded with the proposed partnership next steps which included the development of a City Strategy on Youth Violence with a public health approach throughout. It was proposed to establish a partnership governance structure and monitoring framework with the setting up of a Youth Violence Reduction Board.

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

- What would success look like
- The importance of having measurable goals
- An explanation as to the peaks and troughs in violent crime and the impact of austerity
- Support for the City Strategy on Youth Violence
- The importance of moving on with the here and now, not just waiting for a finalised strategy

- An acknowledgment of the strong supportive partnership approach committed to dealing with the issues concerning young people and violence
- The importance of ensuring the young people have aspirations and job opportunities allowing them to have positive choices to make about their futures
- What was being done to address the issue in collaboration with neighbouring forces and at a regional level
- An acknowledgement of the Board's role: that prevention and breaking the cycle of youth violence sits within the remit of the Board, particularly as solutions require a cross cutting approach, for example mental health, domestic abuse and parenting support

RESOLVED that:

(1) The proposed approach to tackling young people and violence by developing a strategy, taking a public health approach and establishing a partnership, governance structure and monitoring framework be endorsed and supported.

(2) Officers be requested to give further consideration to the governance arrangements, with particular reference to the Youth Violence Reduction Board.

(3) Further reports be submitted to future meetings of the Board as appropriate.

45. **Coventry Physical Activity Framework 2019 - 2024**

The Board considered a report of Liz Gaulton, Director of Public Health and Wellbeing which provided an overview of the Coventry Physical Activity Framework 2019 – 2024, the consultation findings and the proposed implementation. A copy of the framework was attached as an appendix to the report.

The report referred to the aim to make sure that Coventry was a far more active city by 2024 with everyone moving more and levels of inactivity reduced. Currently only just over half of the city's adult population undertook regular physical activity with almost two thirds classed as obese. Lifestyle indicators such as smoking, alcohol and healthy eating were also below the England comparators. Collective action was required to improve this. The draft Coventry on the Move framework 2019 – 2024 had been developed by stakeholders across the NHS, voluntary sector, Universities, WMCA, sports and culture organisations as well as City Council officers. It aimed to involve residents in a collective campaign to increase movement and physical activity and to support stakeholders in recognising their role in enabling and promoting this. The ambition was to ignite a social movement that made physical activity and getting involved in local communities a part of daily life in Coventry.

The Board were informed that the four key priorities in the strategy were defined by the stakeholders who were engaged between July and October last year to scope and test the priorities and objectives as they developed. Public consultation

during February and March 2019 had confirmed support for these priorities as the focus going forwards as follows:

- Enhance our places and spaces for all
- Improve how we communicate
- Movement for life
- Develop leadership and skills at all levels

The report detailed the areas highlighted for further development which has arisen during the public consultation.

The Board noted that feedback from Sport England was that the framework would benefit from setting out stronger leadership and advocacy for physical activity both within the sector and the wider (influencing) system. Community empowerment, social action and a clear call to action were also areas that Sport England felt could be strengthened. The background data and information were seen as one of the strongest elements of the framework and it was recommended that this be used further not only to 'paint the picture' of physical inactivity but to identify targeted action and then grow the momentum based on the first tranche of achievements.

West Midlands Combined Authority had echoed their support for a clear leadership and governance structure and the need to particularly focus on the levels of physical inactivity and inequalities in those who take part. A recommendation was that Coventry sought to develop the data and information report to understand residents and their barriers and motivations to take part.

The framework was not intended to be a standalone programme, it was developed to provide an overarching set of priorities that brought together existing work on sports, culture and destination that would support Coventry in becoming a more active City by 2024. Through the development of the framework a number of gaps and areas for development had emerged. It was proposed that a delivery plan would be drawn up during 2019 that identified where existing programmes were being implemented and owned, and that a task and finish approach was taken to developing actions with partners to address key gaps. The oversight of the delivery plan was to sit within destination management and the Health and Wellbeing Board governance structures. The public health team would provide the organisational support.

RESOLVED that:

(1) The Coventry Physical Activity Framework 2019-2024 be approved.

(2) The implementation approach be approved as follows:

(i) To align governance, reporting and delivery of the objectives with planning already underway around sports, culture and destination, infrastructure, travel and greenspace.

(ii) To establish an overarching work programme that combines existing delivery with new requirements identified in the framework.

46. **Joint Strategic Needs Assessment (JSNA) Update**

Further to Minute 31/18, the Board considered a report of Liz Gaulton, Director of Public Health and Wellbeing, which provided an update on progress with the development of the place-based Joint Strategic Needs Assessment (JSNA). The Board also received a corresponding presentation from Si Chun Lam, Coventry Council, highlighting the approach to the JSNA; setting out the key messages; and informing of further information and resources.

The report indicated that the new place-based JSNA was being developed for the period 2019 to 2022 to help partners understand needs and assets at a local level. The refreshed Health and Wellbeing Strategy would translate the emerging JSNA findings into priorities for what the Board wanted to achieve over the next three to four years. The Board had previously agreed to take a place-based approach to the JSNA, based around the 8 family hub geographies.

The Board noted that the JSNA is being used as a vehicle for engaging and involving local partners and stakeholders, to give more in-depth understanding of the assets and needs of geographical areas within the City and support programmes and strategies which are founded on community resilience and service delivery at locality level. The process involved the collection of 'hard' evidence from data sources, as well as consultation with local stakeholders - organisations and individuals - to understand the key issues facing local communities.

Since the previous update, recent progress included:

(i) The final content of the data profiling tool had now been agreed and look and usability of the tool was being tested by Coventry City Council insight team and with partners. This tool would include data about Coventry under four themes: Demographics and Communities, Health and Wellbeing, Prospects and Environment.

(ii) A range of engagement activity has taken place including place-based enagement with residents in two family hub-based localities (Moat and Foleshill); engagement with a large range of community and voluntary sectors organisations both working across the city and within specific localities; and engagement with communities of interest, particularly those representing individuals with protected characteristics.

(iii) A city-wide profile was being designed which would incorporate analysis of data via the data profiling tool and analysis of outputs from the engagement work. This profile would highlight key issues in the city, using both data and the reflections captured through engagement with residents and communities. The profile would also identify assets which were currently addressing some of these issues and how these assets might be supported and grown to do more. Finally, there were recommendations for further action and gaps which required more support. These findings would be used to shape the new Health and Wellbeing Strategy.

The report referred to the next steps in the process which included the continued development of the data profiler tool, which was expected to be available for

general use by June. The first phase of engagement, as set out above, was currently being analysed and results would be shared with partners once this analysis was complete. The Board were informed that following analysis and dissemination of outputs, this first phase of engagement would be reviewed and a decision made whether further specific engagement events were to be held in each of the other family hub areas, or if outputs from existing engagement forums were used to inform locality-based profiles. As with the City-wide profile, locality based profiles would be produced for each of the eight family hub areas using both data and engagement outputs. It was anticipated that a final draft of the City-wide profile would be available by mid-May, with profiles for Foleshill and Moat following shortly after. The timeline for the completion of the other six locality profiles would depend on the approach taken to local engagement going forward.

The Board would continue to receive updates as the place-based profiles emerged and would play an important role in ensuring that the local health and care economy was being shaped by the outputs and recommendations of these profiles.

The presentation provided additional data on the four main themes: Demographics and Community, Prospects, Environment and Health and Wellbeing.

Members were offered the option of a training session to provide partners with an understanding the data profiling tool so allowing them to include their data on the system.

Clarification was sought as to the opportunities to use the data to see trends over time and to undertake comparisons with other similar areas across the country.

RESOLVED that:

(1) The progress in the development of a place-based Joint Strategic Needs Assessment for Coventry be noted.

(2) The structure and content of the City wide and eight locality profiles be agreed.

(3) The emerging outputs from the JSNA be noted, including how these were shaping the new Health and Wellbeing Strategy.

47. **Coventry Joint Health and Wellbeing Strategy Refresh Update**

The Board considered a report of Liz Gaulton, Director of Public Health and Wellbeing, which detailed a stock-take of progress against the 2016 Joint Health and Wellbeing Strategy; summarised the outcomes of a senior partner workshop held in March on the new strategy; and outlined the plan for the development of the new Joint Health and Wellbeing Strategy including the Consultation Plan. Copies of the stocktake of progress at March 2019 and the Consultation Plan were set out at appendices to the report.

The report indicated that the current Health and Wellbeing Strategy covered the period 2016-19 and work was underway to produce a revised Strategy for approval and publication in autumn 2019.

The existing Health and Wellbeing Strategy 2016-19 identified three priorities:
(i) Working together as a Marmot City: reducing health and wellbeing inequalities
(ii) Improving the health and wellbeing of individuals with multiple complex needs
(iii) Developing an integrated health and care system that provides the right help and support to enable people to live their lives well

Both the Marmot and Multiple Complex Needs programmes were being evaluated formally and comprehensively. However, both the impact and learning were required to inform the refreshed Health and Wellbeing Strategy and so a light touch stocktake of key outcomes and learning from the current Strategy had been undertaken, the details of which were set out in an appendix to the report. The report referred to the successful work undertaken by both the Marmot Steering Group and the Multiple Complex Needs (MCN) Board. Reference was also made to the integration of health and care which had continued to evolve at pace in a context of a policy shift towards even closer collaboration through Integrated Care Systems.

Key learning from the current Strategy to inform the refresh included:
i) Inclusion of priorities had raised their profile and galvanised commitment around addressing health inequalities and supporting individuals with multiple complex needs
ii) Partnerships had been brought together to address the priorities and the benefits of stronger partnership working had been realised
iii) There remained a need for more active engagement of wider partners, and this was needed at an early stage in Strategy development
iv) A lack of dedicated resource to support the Strategy priorities had restricted impact in some areas
v) Opportunities had been lost as a result of the three priorities being implemented and monitored separately, so that links and synergies had not been identified and exploited
vi) There was no overarching performance framework to monitor progress of the Strategy and there was a need to find more tangible ways of measuring and demonstrating impact.

The report referred to a workshop for senior leaders from across the system held on 6 March, facilitated by the King's Fund, which provided an early opportunity to engage senior partners in shaping the new Health and Wellbeing Strategy. The purpose was to test the King's Fund's population health model as a framework for reviewing current activity and developing the Strategy, and to hear from senior leaders about their ideas for future health and wellbeing priorities.

Key themes and messages arising from the workshop were:

- There were already strong partnerships to build on in the city
- The new Strategy should form part of the Year of Wellbeing legacy and reflect the opportunities arising from the UK City of Culture 2021 programme, which falls within the timeframe of the new Strategy
- The system needed to facilitate community leadership – through investment in communities and having a flexible offer that empowers and enables community leadership, but also by engaging in more meaningful dialogue with communities

- Outcomes and impact – an evidence base was needed, especially around stronger communities and wider determinants, and to develop capacity to research, evaluate, demonstrate and grow good practice and draw on learning from elsewhere
- Communication – the power of personal stories in demonstrating impact and building trust in services, and the need for more effective messaging about self-care, and potential digital opportunities around signposting
- Interconnectedness ("job, house, friend") – wider determinants and where I live / my community impact on lifestyle choices / healthy behaviours. We need to recognise the contribution of all services and consider the health and wellbeing impact of all policies
- Concern about gaps in services – and people falling through gaps – and a need to be more joined up and strategic
- Facilities – issues around access to services and availability of facilities locally; opportunities to bring community assets (eg. schools) into use
- Focus on prevention – need to take bold decisions to move resources upstream.

There was a strong view that as a system there needed to be a clear focus on two or three priorities where we could make a difference by channelling resource and energy over the next few years, and a number of potential priorities were proposed. At the same time there was recognition that there were some key enablers (such as empowering community leaders or building stronger partnerships around wider determinants) where investment and change was also needed.

The Board noted the intention to bring a final draft of the Strategy in June/July for consideration and endorsement, with approval and publication taking place in the autumn.

The Board discussed the public health approach to issues including knife crime and suicide prevention along with the importance of the inclusion of tackling inequalities within the strategy. The importance of engagement with young people and their families and communities to understand their concerns was highlighted.

Discussion also centred on how the locality data obtained for the Joint Strategic Needs Assessment would be used to inform a city-wide strategy, rather than a number of different strategies for different communities. It was acknowledged that a better impact was achieved by having just one strategy.

Members questioned whether the two face to face public consultation sessions held in one location were sufficient to obtain feedback from a variety of communities. All of the groups and organisations involved in the JSNA would be invited to contribute to the consultation.

RESOLVED that, having considered the outcomes and learning from the current Health and Wellbeing Strategy to inform the Strategy refresh:

(1) The outcomes of the Health and Wellbeing Strategy workshop held on 6th March 2019 be noted.

(2) The proposed approach to the Health and Wellbeing Strategy refresh, including the Consultation Plan and timeline, be endorsed.

48. **Better Health, Better Care, Better Value Programme Update**

The Board considered a report of Rachael Danter, Programme Director, which provided an update on progress with the Better Health, Better Care, Better Value (BHBCBV) programme.

The report referred to the Integrated Care System. Following the publication of the NHS Long Term Plan, along with a 5 year investment schedule to support delivery, work was underway to respond. Systems were asked to develop a 5 year plan (5 year refresh) which would highlight what activities would be delivered over the next 5 years in what timescales, in order to meet the LTP requirements. This plan would need to be underpinned by a 5-year system-wide financial strategy and a capacity and resource plan. The Board were informed that this 5 year Plan would be a refresh of the previous BHBCBV plan and provided the opportunity to identify what part that the BHBCBV programme would play over the next five years in supporting successful delivery of 'the Vision for Population Health' as well as detailing how the Coventry and Warwickshire NHS system, working with partner organisations would deliver the NHS LTP requirements.

The Board were informed that the Transformation Plan needed to be developed and owned by the system leaders, the clinicians, staff, partners and patients and the public. The Plan would need to identify all the activities that would be undertaken at Place, System and Network in order to maximise the opportunities as a system. The report highlighted the key work-streams that would need to work with the wider system to identify opportunities and reflect these in their individual work-stream plans.

Reference was made to the Place Based planning for 2019/20. The NHS Long Term Plan described 2019/20 as a transition year for the NHS moving from traditional, competitive ways of working towards a more collaborative and integrated approach. During this period, the Coventry and Warwickshire health and social care system, would focus on three key priorities; continue to deliver great care for patients; to develop, test and embed the building blocks which would allow transformation of the way commissioning takes place and provide services in the future; and to refresh the system Health and Well Being Strategy and develop an associated five year Transformational Delivery Plan that ensured the delivery of the best quality and outcomes for residents, within the resources available. The report detailed the three priorities.

Additional information was provided on progress with the three priorities under the Clinical Strategy: frailty, mental health and emotional wellbeing and musculoskeletal.

The report also 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 and Digital Health
Workforce

Related programmes of work concerned both cancer and stroke. The report highlighted the key priorities for cancer within the NHS Long Term Plan. Transformation funding for 2018/19 for this area of £8.8m capital and £6.5m revenue had been secured and the Cancer Alliance would also receive an additional £2.04m. Additional information was provided on proposals for living with and beyond cancer.

The report set out progress and the current status of the pre-consultation business case for stroke. Once the proposed rehabilitation workforce had been considered by the expert stroke clinical network, then final costings of proposals could be concluded and the financial option appraisal completed. The pre-consultation case would then be presented for sign off and would then be ready for submission to NHS England for assurance testing.

A question was asked about the plans for obtaining the views of residents to feed into the Transformation Plan, including 'fit and healthy' people along with residents with health issues.

RESOLVED that the content of the report be noted.

49. **Coventry and Warwickshire Place Forum**

The Board considered a report of Liz Gaulton, Director of Public Health and Wellbeing concerning the outcomes of the Place Forum meeting held on 6th March and the initial plans for the next Forum meeting on 11th June. Endorsement was also sought for the Outcomes Framework which had been adopted by the Place Forum, a copy of which was set out at an appendix to the report.

The report set out the aims of the March meeting and highlighted the acknowledgement that collaboration between the Boards had reached a level of maturity and there was a real opportunity for the Forum to play a key role in the future, reviewing its position in light of the NHS Long Term Plan and the refresh of the STP Plan by autumn 2019.

At the meeting the Place Forum:

- Received an update on the Year of Wellbeing and encouraged members to increase its impact within their own organisations.
- Supported the approach taken in the updated outcome framework and the application to the four 'places' (Coventry, Rugby, North Warwickshire and South Warwickshire), and agreed that the indicators around 'effective services' were heavily focused on hospitals and should include a measure about people supported to live at home.

- Received a presentation from Sean Russell, West Midlands Combined Authority, about the Thrive at Work workplace wellbeing programme and undertook a table exercise to encourage further actions and commitment.
- Received interactive updates on the place-based JSNA, Carers Week 2019, Integrated Care System (ICS) and NHS Long Term Plan.

The following actions were agreed as part of the Place Plan, a copy of which was set out at a second appendix to the report:

- Continue to lead and support the Year of Wellbeing
- Further develop the outcome framework for oversight of performance across the system and to mobilise action by partners to address identified challenges
- Consider the opportunities to further improve workplace wellbeing, including applying the Thrive at Work framework
- Form a sub-group to explore synergies between Thrive at Work and the STP mental health and community resilience strategy
- Health and Wellbeing Board Chairs to meet the new independent chair of the STP (Better Health Better Care Better Value) to explore the future role of the Place Forum
- Continue to update each other on changes which impact on the work of the Place Forum, including ICS and the STP refresh.

The Board noted the anticipated items for the next Place Forum on 11th June which included a session on the social isolation theme of the Year of Wellbeing; Integrated Care System governance; engagement on ICS strategic framework development; and updates and briefings on other key developments impacting on the Place Forum.

The Board discussed potential changes to the indicators contained within the Outcomes Framework. Several suggested changes had been requested by the Place Forum and these were being reviewed.

RESOLVED that:

(1) The outcomes on the Place Forum meeting held on 6th March be noted.

(2) The use of the Place Forum Outcomes Framework for oversight of performance across the system and to mobilise action by partners to address identified challenges be endorsed, noting the intention to review the indicators.

(3) The outline agenda items for the Place Forum on 11th June be noted.

50. **Housing and Homelessness Strategy**

The Board considered a brief report concerning the City Council's new Housing and Homelessness Strategy that was adopted at the Council meeting on 19th March 2019, along with the corresponding action plan.

The report indicated that the new Housing and Homelessness Strategy covered the period 2019-2024 and was divided into four themes:

(i) Preventing Homelessness and Supporting Homeless Households
(ii) Housing Development
(iii) Improving the Use of Existing Homes
(iv) Supporting People and Communities

The Housing Strategy and the Homelessness Strategy had been combined into one document, which reflected the fact that activities to prevent homelessness were dependent on the availability of additional housing, an improvement in the management and quality of existing housing, and the advice and support available to people who needed it to successfully maintain their home. The Strategy had been informed by a period of consultation in November and December 2018.

The Board were informed that the Council wanted to work with partners to further develop the Strategy and Action Plan, with joint ownership across public, private, voluntary and community organisations in the city. The Council was also required to create a Rough Sleeping Strategy by Winter 2019, providing a further opportunity for partnership working.

Members expressed support for the strategy and acknowledged the work already taking place in connection with rough sleepers and the winter night shelters. It was requested that when the Board give future consideration to the Housing and Homelessness priorities, members be provided with a steer as to where the Board could add value to the work that is already taking place.

RESOLVED that:

(1) The partnership approach to further developing the city's response to Housing and Homelessness be supported.

(2) The overlap and synergies between Housing and Homelessness priorities and the work of the Board be considered at a future Board meeting.

51. **'I' Statements for Health and Social Care**

The Board considered a report of Andrea Green, Coventry and Rugby CCG which provided an update on the development of a suite of I Statements with people aged 65+ who used health and social care services, to form a benchmark against which improvement could be measured. The 'I' Statement development was inclusive of all groups within the city.

The report indicated that in January 2018, the Care Quality Commission (CQC) conducted a local system review to understand how well people aged 65+ moved through the health and social care system, with a focus on the interfaces between services. To launch the process, an event involving partners was held on 30th May, the purpose was to involve representatives of older people in exploring the feedback from the CQC on the quality of services for older people and in generating suggestions that would support improvements and promote collaboration. Participants' views about what good health and social care looked like and how improvements would be known about were turned into aspirational statements that would be used to test future service changes against the expectations of residents.

The draft statements were then tested and validated through engagement sessions with groups aimed at those aged 65+ across Coventry. Details of the gender and ethnicity of those groups involved in the sessions and details of the views from the face to face sessions were set out in appendices to the report. In addition, a survey was sent to Healthwatch Coventry members and 32 responses were received. The details were set out in a further appendix. The report set out the 'I' statements that were subsequently produced.

The Board were informed that all attendees at the events and respondents from the survey had helped to shape the final suite of 'I' Statements. Further information was provided on the views that had been received that had led to the development of these 'I' statements. It was important that members of the Board ensured that the views of older people were reflected in shaping improvements in health and social care and local commissioning decisions.

Members expressed support for the opportunity to hear the 'voices' of local people at the Board meeting.

RESOLVED that the adoption of the 'I' Statements by Health and Social Care partners to form a benchmark for improvement when commissioning or recommissioning health and social services for older people be endorsed.

52. **Care Quality Commission (CQC) Local System Review - Improvement Plan Completion**

The Board considered a report of Pete Fahy, Director of Adult Services, which summarised progress against the improvement plan arising from the Care Quality Commission (CQC) System Review. Further to the routine monitoring reports, this was the final report which sought approval of completion, with outstanding actions to be taken forward and monitored through other mechanisms.

Further to Minute 38, the report indicated that the improvement plan, resulting from the CQC system wide review of health and care for people aged 65 and over in Coventry, was intended to give focus and drive to areas of activity and improvement already in progress across the system. The intention had been to complete work on the plan by March 2019 and ensure that this focus was embedded in programmes and activities across the system beyond that date. The plan was owned by the Board, who had maintained oversight through routine progress reports over the past year.

The CQC had carried out a light touch follow up process in autumn 2018. Their progress monitoring report was set out at an appendix to the report. This report highlighted the achievements and progress since the review in January 2018 and reflected positively on the direction of travel, whilst acknowledging further work was required, in particular around clinical pathways and local workforce strategy.

The report indicated that progress against each of the actions had been reviewed and a progress update was provided in the plan set out at a second appendix. The Board were informed that good progress had been made in many areas and some key achievements were highlighted. Inevitably there were actions that had slipped for reasons of capacity and in order to ensure effective stakeholder engagement.

For these actions the progress update indicated how they would be embedded into system improvements in programmes and activities going forward.

The report set out a brief summary of progress and achievements to date against the following themes: vision and strategy; engagement and involvement; performance, pace and drive; flow and use of capacity; market development; workforce; and information sharing and system navigation.

The Board noted that the Local System Review in January 2018 had offered clarity, focus and reassurance that the areas, acknowledged locally as needing to develop and improve, were the right areas of focus. This enabled the system to move forward with renewed purpose to address those issues that were impacting on people receiving consistently good health and care services. There was good evidence to support system progress since the local system review was completed, with improvement in delayed transfers of care being a key measureable outcome and many other achievements detailed in the report. The overall impact of these actions would, in many cases, take longer than the time elapsed to take effect and the key challenge for the health and care system remained turning the progress made into greater, and then sustained, improvement.

The Board sought clarification that the remaining incomplete actions were being considered within the correct work streams/plans. There was an acknowledgement that there shouldn't be any new governance set up for monitoring purposes.

RESOLVED that:

(1) The progress made and the areas still to be addressed against the actions in the improvement plan arising from the CQC local system review be noted.

(2) The CQC progress monitoring report produced further to their light touch follow up in autumn 2018 be noted.

(3) The completion of the improvement plan and the outlined arrangements for taking forward outstanding actions be approved.

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

There were no additional items of public business.

(Meeting closed at 4.00 pm)

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Coventry City Council

Report

To: Coventry Health and Wellbeing Board **Date: 8 July 2019**

From: Jim Crawshaw, Head of Housing Coventry City Council

Title: Housing and Homelessness One Coventry Approach

1 Purpose

This paper provides background information about the Housing and Homelessness item and outlines the recommendations for that item.

2 Recommendations

The Health and Wellbeing Board is asked to:

1. Consider the impact of Housing and Homelessness issues on the wider health and wellbeing of Coventry residents.
2. Endorse the development of greater partnership working on Housing and Homelessness issues.
3. Contribute to the creation of a city-wide 'One Coventry' Housing and Homelessness Strategy, and the Rough Sleeping Strategy.

3 Background

The Housing and Homelessness Strategy 2019-2024 was adopted by Coventry City Council on 19 March 2019 following a period of consultation with partners and service users in winter 2018/19. The Strategy and the associated Action Plan are now being implemented by the Council with support from existing partners.

It has been noted that the current strategy and action plan largely relates to Council activity, with all actions assigned to internal Council departments. There are opportunities to take a more overt One Coventry approach to the delivery of the Housing & Homelessness Strategy, which already requires partnership working between the Council, other public sector organisations, Registered Providers and the voluntary/community sector.

At the same time the need to develop a Rough Sleeping strategy by winter 2019 provides an opportunity to work with partners on a key issue facing the city.

Report Author(s):

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Jim Crawshaw, Head of Housing

Directorate: People

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Coventry City Council

Report

To: Coventry Health and Wellbeing Board **Date: 8 July 2019**

From: Liz Gaulton, Director of Public Health and Wellbeing

Title: Draft Coventry Joint Health and Wellbeing Strategy 2019-2023

1 Purpose

This paper reports on the outcomes of the public consultation on the Joint Health and Wellbeing Strategy proposals and presents an initial draft Health and Wellbeing Strategy for consideration and endorsement by the Board.

2 Recommendations

The Health and Wellbeing Board is asked to:

1. Note the Coventry Joint Strategic Needs Assessment Citywide Profile;
2. Consider the outcomes of the public consultation on the Joint Health and Wellbeing Strategy proposals;
3. Consider the comments on the consultation proposals from the Council's Scrutiny Coordination Committee;
4. Consider and endorse the draft Coventry Health and Wellbeing Strategy 2019-23; and
5. Note the process and timeline for finalising, approving and adopting the Health and Wellbeing Strategy.

3 Background

The Council and the Clinical Commissioning Group have a statutory duty, through the Health and Wellbeing Board, to develop a Joint Strategic Needs Assessment (JSNA) for the city and a Health and Wellbeing Strategy that translates these findings into clear outcomes the Board wants to achieve

The core aim of the JSNA and Health and Wellbeing Strategy is to develop local, evidence-based priorities for commissioning local services which will improve the public's health and reduce inequalities. The outcomes of this work will help to determine what actions the Council, the local NHS and other partners need to take to meet health and social care needs, and to address the wider determinants that impact on health and wellbeing

The current Health and Wellbeing Strategy covers the period 2016-19. A new Strategy for 2019-23 is being developed for approval and adoption in autumn 2019.

4 Coventry Joint Strategic Needs Assessment Citywide Profile

As reported to the Board previously, work has been underway since October 2018 to develop a new place-based Joint Strategic Needs Assessment for the city. The JSNA has been used as a vehicle for engaging and involving local partners and stakeholders, to give more in-depth understanding of the assets and needs of geographical areas within the city and to support programmes and strategies which are founded on community resilience and service delivery at locality level. The process has involved the collection of 'hard' evidence from data sources, as well as consultation with local stakeholders - organisations and individuals - to understand the key issues facing local communities.

The full citywide profile has now been published, and was a key source of evidence to inform the draft Health and Wellbeing Strategy. It draws particularly on engagement evidence from communities of interest across the city, including those representing people who share protected characteristics. The citywide profile is attached at appendix 1 for noting.

Pilot place-based JSNAs have been undertaken in the Moat and Families for All (Foleshill) Family Hub areas, and these locality profiles will be shared with the Board when finalised.

Locality based profiles will be produced for each of the eight family hub areas using both data and engagement outputs. The timeline for the completion of the other six locality profiles will depend on the approach taken to local engagement going forward.

5 Developing a new Health and Wellbeing Strategy 2019-23

At its meeting on 8 April the Board endorsed the proposed approach to developing the new Health and Wellbeing Strategy. Following this meeting, evidence from key sources was triangulated by a core officer steering group and a further prioritisation event was held on 29 April for officers from partner organisations to review the evidence and emerging themes. This meeting agreed the proposed framework and priorities for the refreshed Strategy for public consultation.

The evidence that informed the proposals included:

- data and engagement evidence from the JSNA
- outcomes of a senior partner workshop facilitated by the King's Fund held in March 2019, (around 50 participants, including Health and Wellbeing Board members, overview and scrutiny committee (SB5) members, Public Health Consultants, and strategic leaders both from within the Council and the wider public and voluntary and community sector).
- learning from the stocktake of the current Health and Wellbeing Strategy (reported to Board 8 April 2019).

The consultation proposals included:

- a long-term vision for change: **3 strategic ambitions** for the next 4 years
- how we will do this – our **population health framework**
- making it real – **specific priorities / areas of focus** where together we can make a tangible difference in short-term and learn how to do things differently

The consultation leaflet summarising the proposals is attached at appendix 2 for reference.

6 Consultation process

6.1 Consultation activity

The consultation and engagement process for the refreshed Strategy was an extension of the JSNA engagement activity over the previous 6 months. Through the JSNA engagement we had talked to over 200 residents and 70 community organisations to understand the key issues facing local communities and identify community assets.

The consultation on the Strategy proposals was in part an opportunity to go back to those we had engaged with previously and test with them our understanding of the needs and assets in the city and start to work together to mobilise solutions. It was also an opportunity to test our proposed approach and priorities more widely and begin to galvanise energy and resource around the Strategy.

The public consultation period ran from 10 May to 3 June 2019 and was widely promoted. The communications and engagement process included opportunities for online and face-to-face consultation with stakeholders, as detailed below.

Activity	Audience	Details
Media release to promote survey	Residents	Generated interview on Free Radio and article in Coventry Evening Telegraph
Online survey promoted through: • CCC website • Coventry and Rugby CCG website • CCC Intranet • Social media • Insight Engagement residents contact list (3.5k) • Health and Wellbeing Board members • STP comms and engagement network • Direct invitation to identified stakeholders Paper version also made available	All stakeholders	133 survey responses received, plus several other emailed comments.
Community events: on the same day, same venue, 3-5pm and 6-8pm with networking buffet served between 5 and 6pm.	Community groups and organisations targeted for JSNA engagement Elected members	22 participants attended, predominantly from a range of community groups and organisations
3 lunchtime seminars – to provide information and encourage responses to survey.	Frontline staff (CCC and partners) Staff in identified service areas	17 participants in total, including a number of colleagues and frontline staff from partner organisations.

6.2 Consultation outcomes

In total we received over 130 survey responses from both individuals and groups / organisations – including 77 members of the public – and engaged with around 40 individuals at community and staff events, many of whom were also representing groups and organisations. The proposals were also considered by a number of formal partner boards.

The consultation feedback demonstrated broad support for each of the 3 proposed strategic ambitions. There were some common views about some of the terminology used – for example, the terms 'successful' and 'sustainable' were felt to be too ambiguous, and 'independent' could imply lack of support.

There was also support for the proposed population health framework, with 88% of those responding to the survey agreeing that we need to change the way we work together as set out in the proposed framework. 90% of survey respondents agreed that public sector organisations should work differently with communities.

The majority who responded thought the proposals would have a positive impact on people who share protected characteristics, by 'providing an opportunity to engage populations that are normally hard to engage with'.

Participants in both the survey and community events were asked to identify 3 initial priorities that partners should focus on in the short-term. From the options presented, two priorities stood out as having greatest resonance across the consultation responses: Young People's Mental Health & Loneliness and Social Isolation. There was a strong view that many of the proposed priorities impacted on each other, and that these two areas of focus would have the potential to impact positively on some of the other areas suggested.

Some of the key themes and messages emerging from the consultation included:

- Communication: demand for better communication between public sector and communities and more accessible information about available support and activities

- Networks: there is a need for networks to facilitate connections between small community and voluntary sector groups and organisations and a forum for engagement between the third sector and public sector leads.

- Making it happen: a challenge to demonstrate how the Strategy will be delivered and impact measured

A full report on the outcomes of the consultation is attached at appendix 3. The feedback received has informed the draft Strategy that is now being presented to the Board. There will be opportunity to reflect further on the detailed feedback and specific suggestions and ideas as the implementation and action plans are further developed.

7 Comments from Scrutiny Coordination Committee

The Scrutiny Coordination Committee considered the consultation proposals on 19 June 2019. As well as receiving details of the consultation process, at that stage headline messages from the consultation feedback were also presented to the Committee. A working draft of the high level 'plan on a page' for the new Health and Wellbeing Strategy was also shared.

The Committee requested that their comments in relation to the following be taken on board:-

a) Embedding climate change issues in the Strategy
b) Consultation and, in particular, engaging directly with Councillors in relation to any future consultations
c) Encompassing Licensing and Planning issues as a way of tackling health inequalities

8 Proposed Health and Wellbeing Strategy

A draft Health and Wellbeing Strategy 2019-23 has been developed, building on the consultation proposals and informed by the consultation feedback. The draft is attached at appendix 4 for consideration and endorsement by the Board.

The table below outlines some of the key points of feedback from the consultation and how these have been reflected in the draft Strategy, and what has changed from the consultation proposals as a result of the feedback received.

Consultation feedback	**How is this reflected in the draft Strategy?**
Strategic ambitions: 'people will be healthy and independent for longer' – the term 'healthy' is unrealistic as this is not the case for everyone, and 'independent' could imply lack of support.	Changed to 'healthier' as a more realistic relative ambition, and draft Strategy clarifies that independence incudes provision of effective, timely and appropriate support where it is needed.
Strategic ambitions: 'children and young people will lead successful lives' – the term successful is ambiguous and difficult to measure. More inclusive terminology suggested.	Changed to 'children and young people fulfil their potential'.
Strategic ambitions: 'people will live in connected, safe and sustainable communities' – the term sustainable is ambiguous, need to clarify what is meant by this.	The draft Strategy articulates what is meant by this ambition, with the word 'sustainable' encompassing social, economic and environmental sustainability.
Strategic ambitions: the word 'will' has a directive tone which is not appropriate	This word has been removed, with each of the ambitions now articulated as outcomes we aspire to.
Short-term priorities – 2 clearly resonated (loneliness and social isolation and young people's mental health), with more even spread of support for others. Clear linkages between priorities and potential for these 2 to impact on others.	The draft Strategy proposes 3 'areas of focus' to include loneliness and social isolation, young people's mental health and a specific focus on working differently with our communities.
Need for more detail about what we're going to do to deliver change and measure impact.	Section in the draft Strategy on 'making it happen' with details of leadership and accountability. A performance framework will be developed for the Strategy, with potential 'direction of travel' indicators for each of the strategic ambitions identified. Further detail of implementation plans to be developed.
Strong support for public sector organisations working differently with communities and rich feedback in terms of suggestions about what needs to change.	Draft Strategy includes 'working differently with our communities' as a specific area of focus, with opportunity to take forward suggestions from consultation feedback as part of implementation planning.
Importance of embedding climate change into the Strategy.	This is articulated within the 'people live in safe, connected and sustainable communities' ambition, with the intention to include air quality

	as a ‘direction of travel’ indicator. The ‘Marmot’ component of the public health framework will include the role of public sector organisations as anchor institutions and the contribution they can make to sustainability agenda.
The consultation was not inclusive enough of under-represented groups.	The way we engage with our diverse communities will be addressed through the focus on ‘working differently with our communities’. Task groups will also seek to will engage with partners and communities on their specific area of focus as implementation plans are developed.
The Strategy should build on existing networks and activity in the city to support health and wellbeing.	Task groups will engage with partners and communities on their specific area of focus and explore further any related ideas and suggestions put forward through the Health and Wellbeing Strategy consultation. The population health approach seeks to identify and maximise the connections and contribution of all partners within the health and wellbeing system.
Poverty, and the legacy of austerity, is a key cause of health inequalities in the city and should be explicitly addressed in the Strategy.	The wider determinants component of the population health framework articulates an aim to break the link between poverty and poor health through embedding the Marmot approach.
The language needs to be simplified, it is difficult to see what the Strategy will mean to people living in Coventry.	The draft Strategy attempts to bring the population health framework to life with specific examples of how it could be applied to each of the areas of focus.

9 Equalities

Part 1 of the Equality and Consultation Analysis was completed prior to consultation and is attached at appendix 5. Part 2 will be completed when the final strategy is presented to Board in October.

In summary, part 1 concluded that the approach outlined in the consultation proposals was expected to have a positive equalities impact and lead to a much better understanding of the needs of people with protected characteristics. A population health approach means we will be concerned to improve outcomes for everyone, and will lead to a particular focus on health inequalities and tackling the causes of these. A renewed focus on working with our communities to mobilise solutions will cause us to talk to, and work more closely with, representative groups and organisations.

During the consultation, participants were specifically asked about how the proposed approach would affect people who share protected characteristics or belong to our local priority groups. Of those who responded to this question, 61% agreed that it would have a positive impact as it “provides an opportunity to engage populations that are normally hard to engage with” which would empower the most marginalised people in Coventry. Discussions in the community events

centred around the need to ensure the Strategy is accessible to all and in clear, simple language, and that it should be fair and inclusive, as one size does not necessarily fit all.

Equalities data was requested from those completing the survey as individuals, to enable an understanding of the representativeness of responses. It was clear from this that, despite efforts to target our consultation communications and invitations to under-represented groups, the most prevalent characteristics of respondents were White British, Women and ages 45 to 64.

There is more to be done to engage more effectively with people who share protected characteristics and were under-represented in our consultation and we will be addressing this as part of our specific focus on 'working differently with our communities'. It is also intended that the task groups that will develop action plans on the areas of focus will consider the needs of and seek to engage with these groups.

10 Next steps

The draft Strategy is now presented to the Board for consideration and endorsement, enabling further development of plans for implementation over the summer and the approval and publication of the final Strategy in the autumn. This will be agreed by the Health and Wellbeing Board before going to the Council's Cabinet and Coventry and Rugby CCG's Governing Board for approval and adoption.

The next steps in the development of the Strategy are summarised in the table below.

When	Action
8 July	Draft Health and Wellbeing Strategy considered and endorsed by Health and Wellbeing Board
July - September	Mobilisation, action planning and design of final Strategy
October - December	Final Health and Wellbeing Strategy approved by HWBB and adopted by CCC Cabinet and Coventry and Rugby CCG

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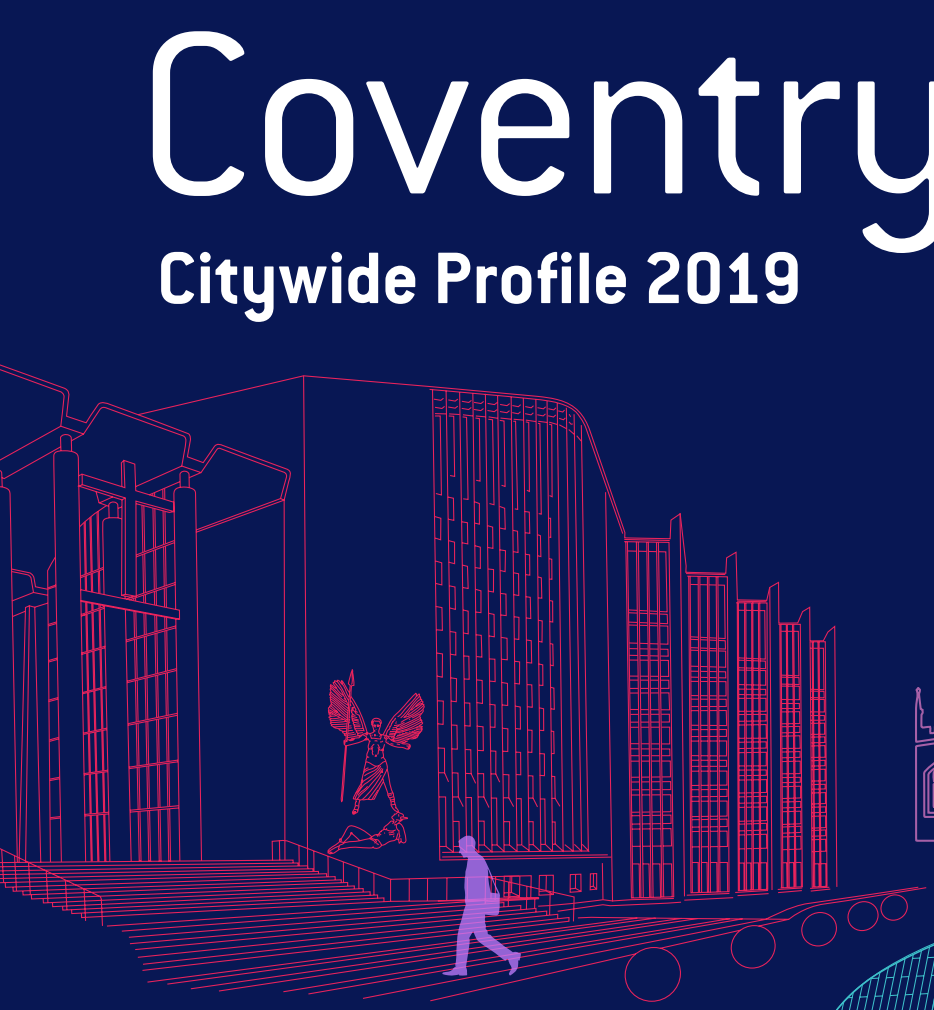
Appendices

Appendix 1: Coventry Joint Strategic Needs Assessment Citywide Profile
Appendix 2: Coventry Health and Wellbeing Strategy 2019-23 - Have your say leaflet
Appendix 3: Coventry Health and Wellbeing Strategy 2019-23 Consultation Report
Appendix 4: Draft Coventry Health and Wellbeing Strategy 2019-23
Appendix 5: Equality and Consultation Analysis, Part 1

COVENTRY JOINT STRATEGIC NEEDS ASSESSMENT

Coventry

Citywide Profile 2019

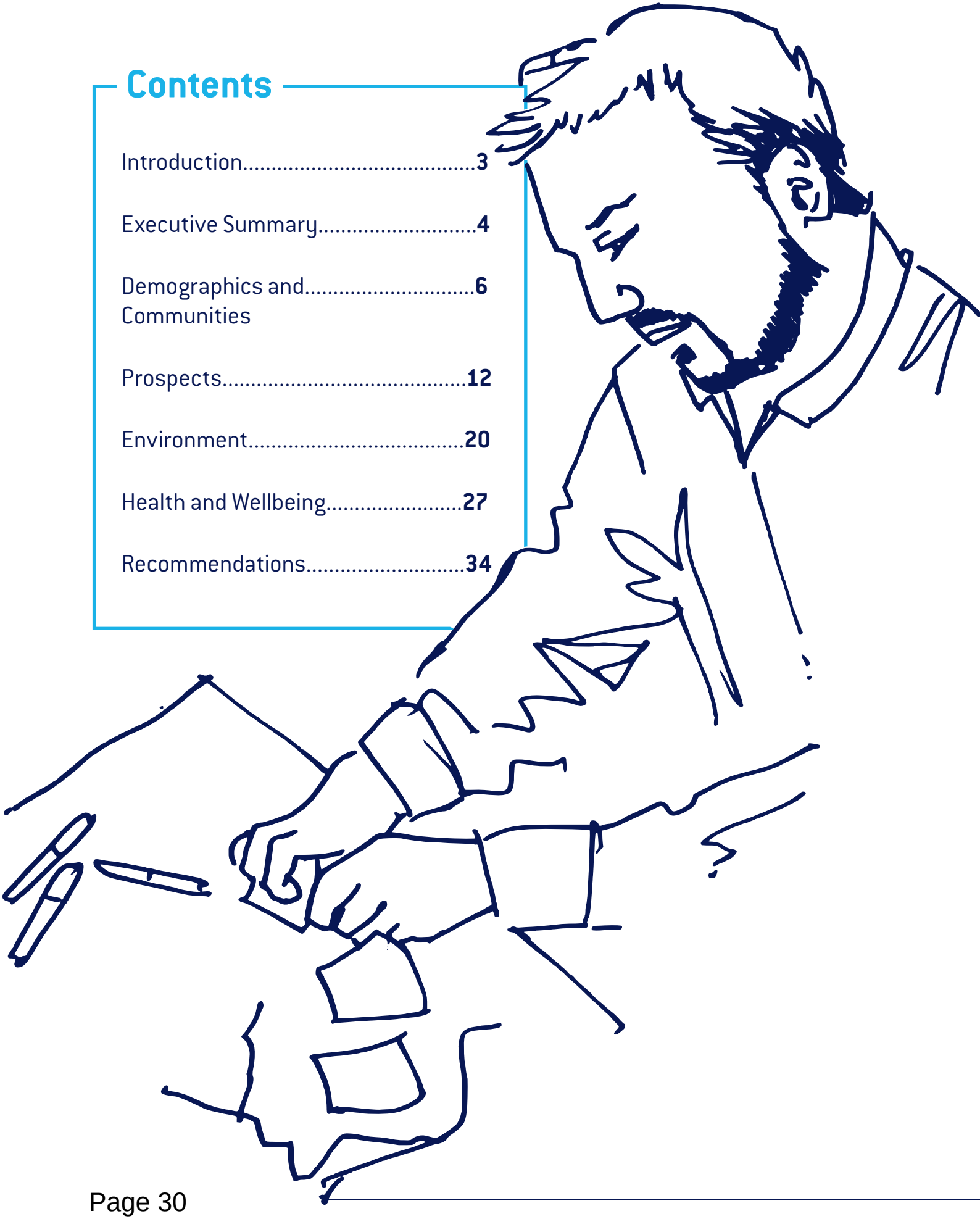


Coventry City Council

COVENTRY & WARWICKSHIRE
YEAR OF WELLBEING
2019

Coventry
Health and Wellbeing

Contents



Introduction

What is the Coventry Joint Strategic Needs Assessment (JSNA)?

Welcome to the Coventry Joint Strategic Needs Assessment (JSNA). The JSNA brings together evidence about the health and wellbeing of Coventry residents, to help leaders across health and care understand and work together to improve the health and wellbeing of the people of Coventry.

Health is more than the healthcare system: it is not just about NHS hospitals, doctors or nurses. Instead, health is about people's lives. Indeed, people's health is determined by their economic and social circumstances, such as:

- their communities; for example, whether they have access to a good network of family and friends;
- their prospects; such as whether they have access to good jobs and education; and
- their environment; such as whether they live in a good neighbourhood with access to green spaces.

These social circumstances determine people's health and wellbeing, and therefore, are known as social determinants of health.

This JSNA contains a full range of evidence to provide decision-makers with an understanding of local people and communities. It contains a lot of numbers and statistics, because these are essential to show the trends of how things have changed, as well as comparisons with other places. However, because health is about people, this JSNA also contains a lot of evidence from local people and local community groups.

About this JSNA

The Health and Social Care Act of 2012 places a duty on Health and Wellbeing Boards to produce a Joint Strategic Needs Assessment. In April 2018, the Coventry Health and Wellbeing Board authorised a move towards a place-based approach to the JSNA, with the production of a citywide JSNA analytical profile, plus JSNA analytical profiles for each of the city's eight Family Hub reach areas.

This JSNA is produced in 2019 by Coventry City Council with co-operation from partners across the Coventry Health and Wellbeing Board and ideas contributed by 70 community organisations and over 200 residents.

Each JSNA analytical profile is structured as follows:

- demographics and community;
- prospects;
- environment; and
- health and wellbeing.

For each topic area covered, the JSNA explores:

- Why is this an issue?
- What is the local picture? How does it compare?
- What is happening in the city? What else can be done?

In addition to the JSNA analytical profiles, detailed statistical data and evidence is available in the citywide intelligence hub at **www.coventry.gov.uk/jsna**. The hub provides tools to compare and contrast metrics and indicators of all kinds.

Executive summary

Demographics and community

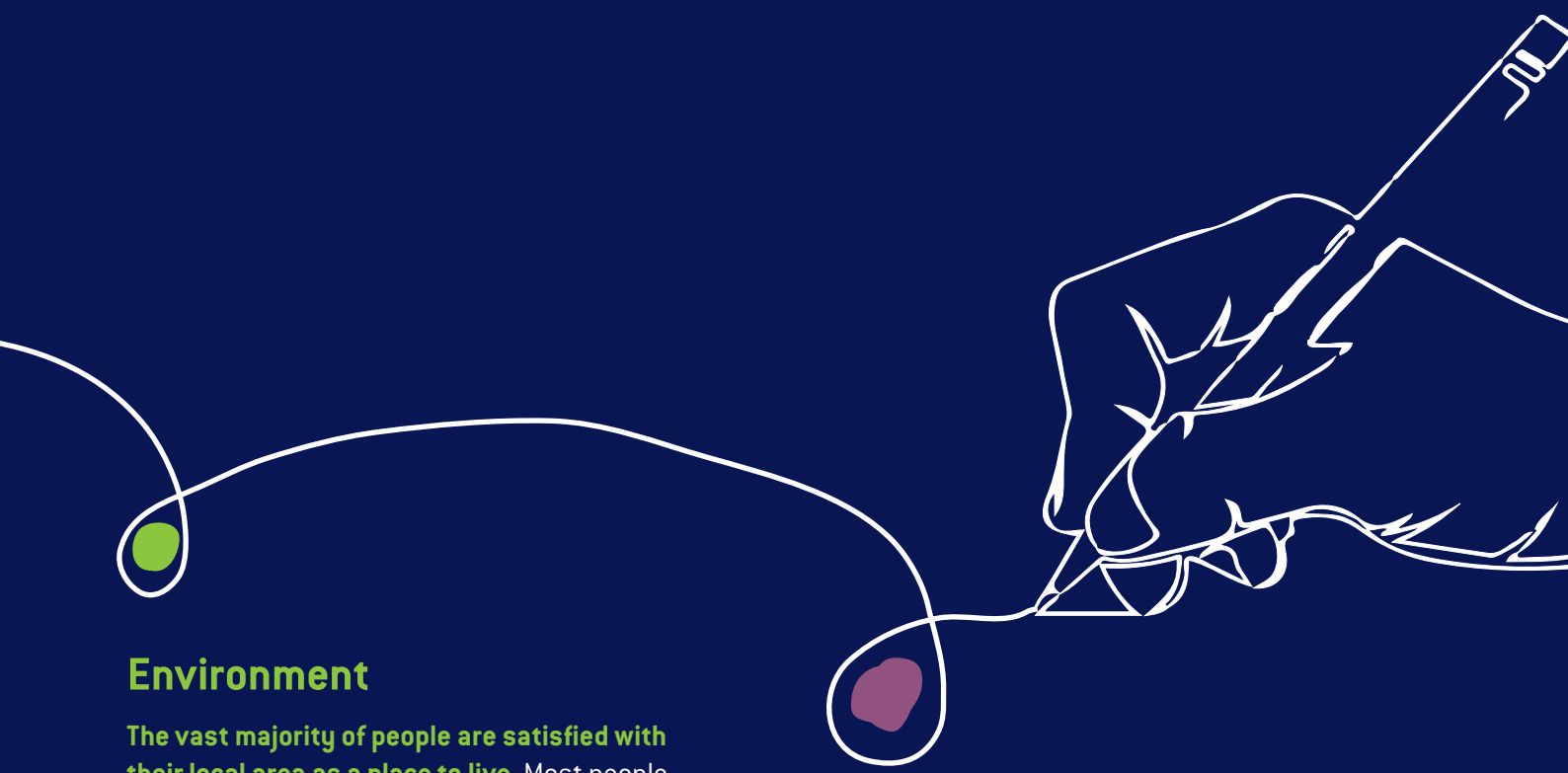
Organisations need to plan for a growing, changing and increasingly diverse population. The city has experienced a high rate of population growth in recent years, particularly amongst 18-29 year olds. However, the growth of over-65s is expected to accelerate and outpace other groups within 10-15 years. As the city grows, it is also becoming increasingly diverse. This is fuelled by births and international migration. In schools, about half of Coventry pupils are from Black and Minority Ethnic backgrounds.

Although the city is cohesive, people do not feel they have influence over local decisions. The city's diversity and cohesion are assets to Coventry. People from different backgrounds report that they mix and get on well with one another. More emphasis on increasing participation will reduce barriers to cohesion.

Prospects

Employment and skills have continued to increase, particularly in highly skilled jobs. Employment has increased and unemployment has reduced. The city's advanced manufacturing sector is growing, helped by the increase in the city's working age population that is highly skilled and highly qualified. Education standards have also increased, with 94% of primary and 74% of secondary students attending a good/outstanding school; and fewer young people not in education, employment or training.

However, significant pockets of deprivation limit people's opportunities to succeed in life. Nearly 19% of Coventry neighbourhoods are amongst the 10% most deprived neighbourhoods in England. 10% of the population has no qualifications at all, limiting their ability to gain more rewarding employment in the city. To transform life chances in these areas and thereby increasing everybody's opportunity to succeed in life requires ensuring every child achieves a good level of development by the age of five. This is because **social inequalities are already established from the early years of life.**



Environment

The vast majority of people are satisfied with their local area as a place to live. Most people live within walking distance of a general/grocery shop, public transport links, parks, pubs, GP surgery/health centre, or a place of worship, providing opportunities to socialise, exercise and enjoy their lives. However, **this masks pockets of dissatisfaction which could be further explored through a more detailed understanding of local needs**. The place-based JSNA profiles will explore these in more detail, for instance, addressing issues around access and affordability of housing; and local air quality.

Increasing fear of crime impacts on local residents' health and wellbeing. Violent crime has increased, reflecting the national trend. The coverage in the media and social media impacts on residents' perceptions of safety, which, in turn, affects people's mental wellbeing. Consideration should be given to increasing social media presence to communicate with communities, with families and young people in particular.

Health and wellbeing

Overall health in the city is below average, **with residents living in more deprived parts of the city not only living shorter lives**, but also spending a greater proportion of their shorter lives in poor health than those living in less deprived parts of the city. However, focusing solely on the most deprived areas is ineffective and may stigmatise people. Making things fairer requires **improving the health of all social groups, in a way that reflects each group's assets and needs.** This is called a "social gradient" approach. Examples of where a social gradient approach can be adopted include hospital accident and emergency, where vulnerable groups are more likely to be users of emergency admitted care services, and less likely to take up vaccinations and screenings.

Communities are best placed to address health challenges. This is because they have networks, understanding and legitimacy. However, their resources are limited and capacity is stretched. The public sector must, therefore, **change how it works with communities, by shifting to an 'enabling' leadership style; pooling engagement resources and building capacity.**

Demographics and Communities


Coventry City Centre

Population

Why is this an issue?

By understanding Coventry's changing demography and communities (that is, the characteristics of the city's population), local communities and organisations can ensure that the city has the right mix of services to meet the needs of its people.

What is the local picture?
How does it compare?

Coventry's population is growing, changing and increasingly diverse. In the past ten years, Coventry's population has grown by a fifth, making it the second-fastest growing local authority outside of London. In 2016-17, its growth rate is the seventh highest.

The city's growth is particularly high amongst 18-29 year olds. The biggest rate of growth is amongst 25-29 year olds across the city. This is followed by 18-24 year olds who are concentrated in the city centre and surrounding neighbourhoods. This includes an increase in the student population.

Coventry residents are, on average, eight years younger. The increase in young adults has continued to lower Coventry's median age. It is 32 years in 2017, compared to 40 in England or the region.

The number of older people is increasing – and this is expected to accelerate and outpace other groups. In 2017, 14% of Coventry's residents (nearly 50,000 people) were aged over 65, and 2% (7,000 people) were aged over 85. In a decade by 2029, the city should expect to have an additional 8,900 people aged over 65 and an additional 2,000 people aged over 85.

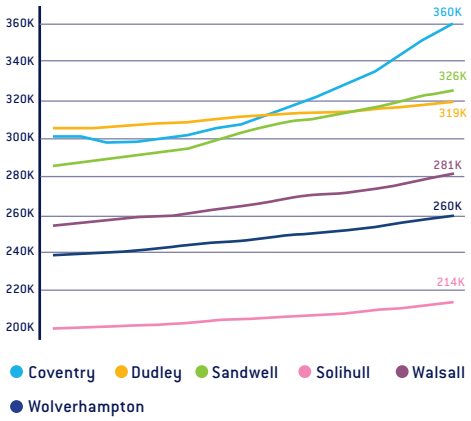
A third of the city's population growth is concentrated in one-tenth of the city, so local organisations may need to review the location of its services. Population growth has been concentrated in and around the city centre and a few new housing developments such as around Banner Lane, Lower Stoke and Wood End.

MEDIAN AGE, 2017

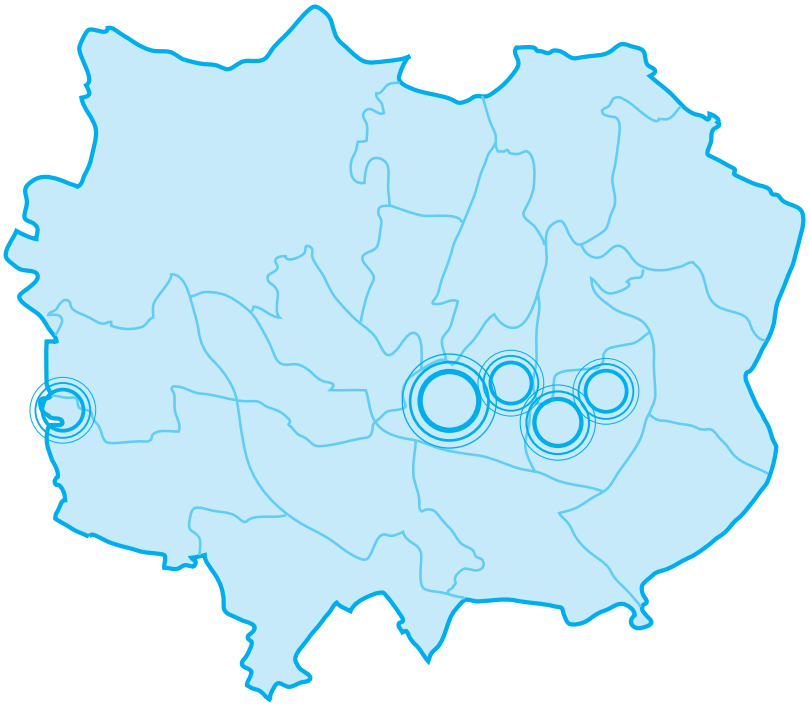
32 years in Coventry

40 years Nationally

POPULATION GROWTH



POPULATION GROWTH HOTSPOTS



What is happening in the city?
What else can be done?

With a growing young population, the city has had successes with adopting a partnership approach to increase opportunities for young people. The Coventry Youth Partnership has brought together 33 youth-focused organisations across the city, ranging from small local agencies to large national organisations, to leverage external funding to put on activities for young people. Many of these partners had not previously known of each other or been able to collaborate successfully. Equally there were significant challenges and complexities regarding bringing organisations together who had formerly competed for resources. By working in partnership, rather than in competition with each other, the city's youth organisations can pool and co-ordinate resources and speak with one voice to external funders. They reached out to a range of funders to secure investment to undertake youth work and have been successful in securing significant funding not accessible to the Council.

There is, however, opportunity to to do even more, by getting the public sector, universities, colleges, schools and others to share their volunteers, resources and venues to increase the number of activities availbale for young people. 72% of young people said they did not take part in youth activities in their area, and almost two-thirds said they were not aware of activities for youth in their area.

Partners across Coventry must consider appropriate messaging to address local anxieties about the growing student population. While many residents agree that the city benefits from the expansion of the city's two universities, the feelings are mixed, with some describing feeling 'overwhelmed' by the extent of student housing in the city centre, as if the city centre is no longer 'for them'.

> Local people don't feel the city centre is for them anymore. Show them what there actually is in the city centre, show that it is not just the university. **Local resident**

Grassroot organisations help to bring the community together. They would be able to do more if there was investment into building their capacity and sharing expertise. The city has a range of local peer support groups that address specific needs and protected groups, e.g. age, gender, culture, religion, sexuality, and health needs. To individuals, these peer support groups form the bedrock of their social networks and interaction. For some, they may be their only form of social contact.

> I used to go to the library but now I'm completely blind. I can't do it on my own. The group leader brings me here.
>
> **Blind and visually impaired group user**
>
> A lot of people are alone and they have no family. This group is the only time they see other people.
>
> **Mental health peer support group**
>
> If I don't come here, I don't speak to anyone for the next 4-5 days.
>
> **Older people friendship group**

Diversity

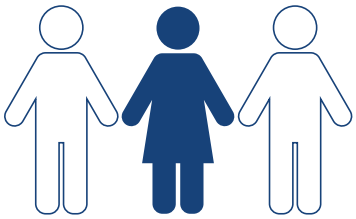
Why is this an issue?

The growth of new communities can change the age and ethnic profile of the city, which can have an impact on demand for local services such as schools and GP surgeries.

What is the local picture? How does it compare?

The city's growth is a consequence of international migration as well as births. As a result, the city is becoming increasingly diverse. In the 2011 census, 33% of the population identified as people of Black and Minority Ethnic (BME) background, compared to 22% in 2001. It is likely that the population has become even more diverse in recent years since 2011. Of the BME population, Asian Indian forms the biggest group. The most notable increases are amongst Black African, Asian Other and White Other groups. The biggest factor for population growth in Coventry is international migration. There have also been significantly more births (4,400) than deaths (2,900) in the city. The growth of the city's two universities contributed to the increase, but it is by no means the whole story.

A DIVERSE POPULATION

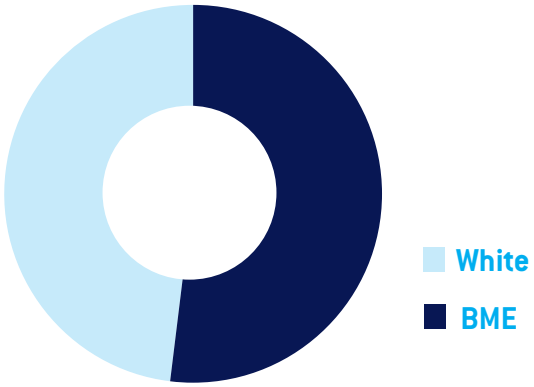


33%

of Coventry population are BME

The city is expected to become even more diverse, with nearly half of Coventry pupils from BME backgrounds. According to the latest school census, 52% of Coventry's school children are from a BME background, up from 38% in 2011. The biggest population growth in school children is seen in Black African, Asian Other and White Other groups.

COVENTRY'S SCHOOL POPULATION



The composition of migrants is changing. In recent years, there has been an increase in new students coming from China and a decrease in new workers coming from Poland. In the last few years, the most common countries of origin for GP registrations for people newly resident in Coventry are, in order, China, India and Romania; but for National Insurance Number (NINo) registrations, they are, in order, Romania, India and Poland. The fact that China is significantly the highest out of GP registrations but not amongst the highest amongst NINo registrations suggests that a large number of the new arrivals from China are students. The number of people from Poland newly registering for a NINo has been on a decreasing trend recently.

Newly arrived communities do not change the city's overall health profile; however, there may be a number of specific health needs. Barriers to access should be delivered by a culturally competent health and social care workforce, one that makes use of the rich community assets in the city.

What is happening in the city? What else can be done?

As it becomes more diverse, the city remains cohesive. 95% of residents have chatted with their neighbours (more than to say hello), with 72% chatting as often as more than once a week. 88% of adults think their neighbourhood is a place where people get on well together despite differences in ethnicity, faith, social backgrounds, and countries of origin. It is notable though, that this indicated a 6% drop from 2016 figures. Coventry residents have a good sense of belonging. 83% of adults felt a sense of belonging to Coventry, and 77% felt they belonged to their immediate neighbourhood. 27% have lived in the same neighbourhood for over 20 years.

GOOD NEIGHBOURS

However, the city must not become complacent and must be ready to stamp out signs of radicalisation and extremism. Some migrants reported feeling less safe and less welcome following the referendum to leave the European Union in 2016. In addition, some groups of people feel left behind by the rest of society and there are concerns that this may fuel the rise of extremist views and behaviours. Projects, such as Building Bridges, are an example of how a partnership approach of pooling resources between the public sector and voluntary/community organisations can help empower and build capacity/skills within local populations and newly arrived communities. These projects help to promote community cohesion.

Although the city is cohesive, people do not feel they have influence over local decisions. 61% felt they had no influence over decisions affecting their local area. Furthermore, there is a sense of negativity or resignation, with 55% saying that even if given the opportunity, they would probably not get involved to make improvements to their local area.

As the city becomes the UK City of Culture, there is a once-in-a-generation opportunity to bring communities together. In 2018, 22% of adults attended less than three cultural events in the city. The successful bid for the City of Culture title has improved perceptions of the city and there is an opportunity to convert this into sustained and lasting improvements for cohesion and engagement. Through the events programme for the European City of Sport 2019, Year of Wellbeing 2019 and City of Culture 2021, as well as the continuation of the volunteer-led Positive Images Festival, there is opportunity to improve connectivity and inclusion by identifying and building a pipeline of local talent within the city's diverse communities.

> There are tons of good stuff that people don't know about. Lots of hidden gems that you don't know until you find them.
>
> **Local community organiser**

There are barriers around communication and awareness in the city, but there are also examples where working together has improved matters. The city has a wealth of voluntary and community groups addressing specific issues – but these are often un-coordinated, which results in duplication of work, diluting the resource and capacity of these groups.

For example, in recent years the city experienced a growth in the number of foodbanks. This has meant each foodbank has less food to give and without co-ordination, signposting people to help has become more difficult. To address this, community organisers, academics, City Council representatives, and local business people worked together to form Feeding Coventry, which has grown a network of food providers working together to address the problems of malnutrition, food poverty, and limited access to nutritional food. Feeding Coventry also created a space for different groups to discuss and develop co-ordinated approaches to food poverty and food security.

There is appetite across local and voluntary organisations for more joined-up working to improve awareness and communication of the activities and networks available in the city. The **public sector has a responsibility to change how it works with community groups across and between sectors.** For example, the Coventry Women's Partnership, a partnership between Foleshill Women's Training, Coventry Haven Women's Aid, Coventry Rape and Sexual Abuse Centre (CRASAC), Coventry Law Centre, and Kairos Women Working Together, helps women so they only have to tell their story once, while the partner organisations share the information amongst themselves to provide co-ordinated support.

Coventry SkyRide

Prospects

Dol-y-moch Mile

Best start in life

Why is this an issue?

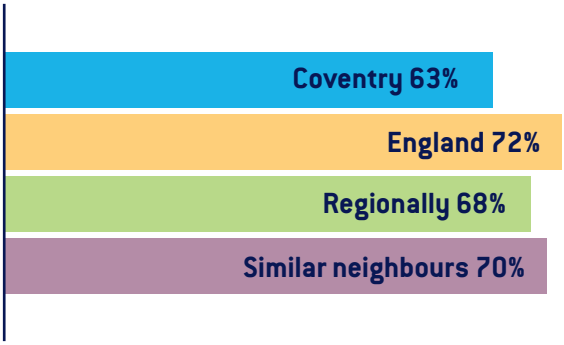
Avoidable differences in health that appear during pregnancy, birth and the early years impact on a person's lifelong health, happiness and productivity in society.

What is the local picture? How does it compare?

Avoidable differences in health emerge by the time a child reaches the age of five. At birth, Coventry appears to be better than the national average, with high rates of breastfeeding initiation, however by the age of five, fewer achieve a good level of development than in other similar places.

Breastfeeding rates in the city are significantly higher than average. 78% of mothers in Coventry initiated breastfeeding in the first 48 hours after delivery (2016/17) and 48% were still breastfeeding six to eight weeks after birth (2017/18) – both significantly higher than the national average.

FREE EARLY EDUCATION TAKE UP RATES



By the age of two-and-a-half, 82% of Coventry toddlers are at the expected level of development. This is similar to the national average. Only 83% of Coventry toddlers were offered the tests though, which was lower than the national average (90%).

However, a relatively low proportion of parents of two-, three- and four-year olds in the city take up their entitlements for free education. All two-year olds whose parents claim certain benefits are entitled to 15 hours of free early education per week. Yet fewer than two-thirds (63%) of Coventry parents take up their entitlements – compared to 72% in

Coventry City of Sport 2019

England, 68% regionally, and 70% in places similar to Coventry. All three- to four-year olds are entitled to 15 hours free education, but only 89% of parents in Coventry take up their entitlements – compared to 94% in England, 96% regionally, and 94% in places similar to Coventry.

By the age of five, fewer children achieve a good level of development (68%) than nationally (72%) or in similar places. A child achieves a "good level of development" if they perform at the expected level in all the early learning goals: communication and language, physical development, personal, social and emotional development, and literacy and mathematics.

Not only do fewer of the city's children achieve a good level of development, but the most disadvantaged five-year olds in Coventry are also further behind. The city's lowest performing 20% of five-year-olds lag behind the rest by 37%. That is five percent wider than the gap nationally. Amongst children in receipt of free school meals, 55% achieve a good level of development, compared to 70% for all children.

Girls do better than boys – but are still behind the national average. In addition, only 64% of children of mixed ethnicity achieve a good level of development. While it is important to support the most vulnerable groups, it is essential to support all groups in a targeted way.

% ACHIEVING A GOOD RATE OF DEVELOPMENT

68% Coventry

72% Nationally

What is happening in the city?
What else can be done?

The city's family hubs help co-ordinate early intervention and support. Family hubs have brought together health visitors, social care, midwives, police and others to identify vulnerable families and put together a collaborative package of support. This will help to ensure that families have access to the support they need, including addressing maternal isolation, accessing activities to improve their children's life chances, and providing help with finances.

"Many families eat junk food over healthy food because it is cheaper. The popularity of Coventry's breakfast clubs reflects this type of poverty." – **engagement professional**

"The choice between heating and eating is a real issue for many people."

"The benefits system is stressful and detrimental to mental health and wellbeing. There is a perceived lack of support around assessments."

There are ambitions for joint working between the public sector and voluntary sector. Family hubs and the out of hospital programme want to work collaboratively with community groups. Meanwhile, community/voluntary groups want to grow their impact – and see working with the public sector as one way to do so.

CASE STUDY

The Real Junk Food Project is a pop-up café that takes place every week at the Families for All Family Hub. The café provides local families with fresh meals on a 'pay-as-you-feel' basis. Through this, families can make social connections, find activities for their children, and access help from Family Hub staff informally. This partnership is increasing the capacity and reach of both the Family Hub & the Real Junk Food Project, enabling both parties to help more vulnerable families.

An example of partnership working is the MAMTA service, a culturally-sensitive child and maternal health programme for BME women. The service works with midwives, health visiting teams and other health professionals to educate women on health improvement in Foleshill and St Michael's by using bilingual peer support and community engagement. The centre has also partnered with Coventry University on a research project called Learning about Infant Feeding Together (LIFT) aimed at improving support for parents.

Education and skills

Why is this an issue?

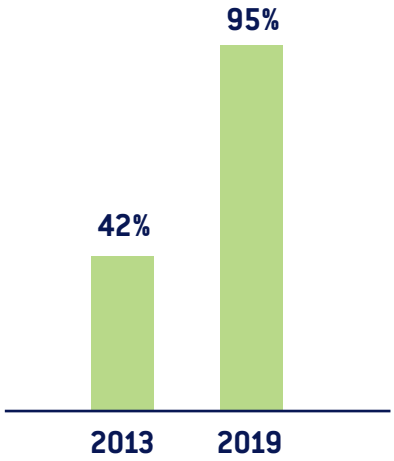
Lack of educational attainment and low aspirations are major causes of a wide range of social disadvantages later in life, including poor employment prospects, social alienation and mental and physical health problems. To help children and young people realise their full potential in life, these barriers should be addressed through championing high levels of educational attainment and raising their aspirations.

What is the local picture? How does it compare?

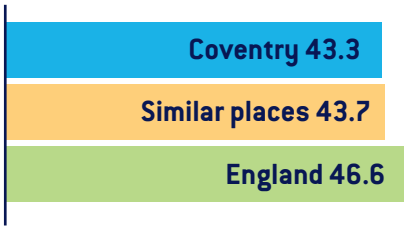
95% of the city's primary school pupils attend a good or outstanding school – but there is no room for complacency. Primary school ratings by Ofsted, the inspector for schools, show that Coventry primary schools have consistently improved over the years, rising from 42% in 2013, to 95% in 2019.

However, Coventry's performance at the end of year 2 (key stage 1) is below that of similar places. Overall, Coventry's performance in writing and maths has improved in 2018; Coventry is at the same level as the England average for maths but is marginally lower for writing.

% OF GOOD OR OUTSTANDING PRIMARY SCHOOLS IN COVENTRY



COVENTRY'S PUPIL ACHIEVEMENT SCORES (END OF YEAR 11)



10% of workers have no qualifications

UNIVERSITY STUDENT NUMBERS

35% of workers have a degree

At the end of year 6 (key stage 2), 62% of Coventry children met the expected standard in reading, writing and maths. This is slightly better than the 61% in similar places, and Coventry is making improvements at a faster rate than nationally, narrowing the gap with the England average (64%). However, there is still room for improvement: the city's negative expected progress score suggests that on average, pupils in Coventry perform worse at the end of year 6 than expected, compared to those with similar prior attainment nationally.

In 2018, the higher performing groups in key stage 2 include: pupils with a Bangladeshi, Indian, Pakistani or Other Asian background; and pupils whose first language is not English. The lower performing groups in key stage 2 include: pupils with an education health and care plan, pupils receiving special educational needs support, pupils eligible for free school meals; pupils who joined the school in year 5 or year 6, and pupil with a Black Caribbean ethnic background.

In secondary education, pupils in Coventry achieve a lower level of attainment and progress than average. 74% of Coventry's secondary school pupils attend a school that is rated good or outstanding by Ofsted. This is 9 percentage points below the England average.

In 2018, the city's progress 8 score, which is the government's value-added measure of progress made by pupils in secondary school up to year 11 (key stage 4), was below average (-0.08). However, Coventry's progress 8 measure is ahead of similar areas (-0.14) and improved from 2017 (-0.12). Recent research into the progress 8 measure, however, suggests concerns around its reliability and potential for bias because it does not take context into account.

Coventry's attainment 8 score, which is the government's preferred measure of pupil achievement at the end of year 11 (key stage 4), was 43.3 in 2018. This has increased from 42.8 in 2017; but remains lower than the figure of 43.7 for similar places, and 46.6 for England. From 2017 to 2018, Coventry's attainment 8 score improved by 0.5, faster than England's rate of improvement of 0.2, therefore closing the gap by 0.3. Attainment 8 scores are calculated for each pupil, by adding up the points achieved in their eight English Baccalaureate subjects taken at GCSE and dividing by 10. A school or city's attainment 8 score is then calculated by averaging all the pupil's scores.

37.5% of pupils in Coventry achieved a "strong pass" of grades 9-5 in English and Maths in 2018, up from 36.2% in 2017. This compares to 38.6% in similar places and 43.3% in England.

60.2% of pupils in Coventry achieved a "standard pass" of grades 9-4 in English and Maths in 2018, up from 58.3% in 2017 and better than the 59.5% in similar places. However, this is below the national average of 64.2%.

In 2018, the higher performing groups in key stage 4 include: pupils with an Indian, Bangladeshi, Other Asian or Any Other background; and pupils whose first language is not English. The lower performing groups in key stage 4 include: pupils who joined in year 10 or year 11, pupils with an education health and care plan, pupils receiving special educational needs support, and pupils eligible for free school meals and/or have accessed free school meals at some point in the last six years.

For 16-18 year olds (at key stage 5), Coventry's average point score is Grade C, which is slightly below the average of Grade C+.

More young people in Coventry finishing school or college progressed into sustained education, employment or training. Fewer young people are not in education, employment or training (NEET). It is estimated that 380 Coventry 16-17 year olds are NEET or whose activity is not known. This is equivalent to 5.4% of that age group and is lower than the regional or England rates. The city continues to have a slightly higher than average percentage of young people proceeding from school or college to a sustained education, employment or training destination in the year after completing their key stage 3 qualifications.

Coventry is home to two successful universities. There were 56,700 students at Coventry University and the University of Warwick in 2016/17 – with the number of full-time students more than doubling since 2004/05. The proportion of students from outside of the European Union (EU) has grown, rising from less than one in six in 2004/05 to one in four in 2016/17.

Over one-third of the city's working age population is highly qualified. However, there are significant pockets of deprivation which limit people's opportunities to succeed in life. In 2018, 35% of Coventry's working age population is qualified to level 4 or above, which means they have a foundation degree or above. This has increased by over 10 percentage points over the past decade and the city is the second highest within the West Midlands


SUNRISE at Coventry Cathedral

10% of the city's working age population has no qualifications at all. This may limit their ability to gain more rewarding employment in the city or push them to be redeployed as the city's jobs increasingly require qualified people.

What is happening in the city? What else can be done?

Despite the presence of two top universities and the network of prestigious companies based in the city and region, there is pessimism amongst some young people regarding their career opportunities. Some young people are unaware of the city's growing advanced manufacturing sector and the successful games industry in the sub-region.

Young people's aspirations could be raised by improving their awareness of the significant and growing opportunities in highly paid jobs available in the city, and the companies' need for people with the right skills and qualifications.

Innovative approaches can be used to help adults learn skills from one another and build a sense of community at the same time. The city's Time Union is a system of mutual exchange, where members share their time, assets, and skills on an hour to hour basis. So far, members have exchanged cinema trips and lessons in areas such as languages, fitness, DIY, career and life coaching, filmmaking and crafts.

Economy and growth

Why is this an issue?

Being in meaningful paid employment is a protective factor for health. Increasing the quality and quantity of work, and thereby addressing the unequal distribution of income, wealth and power, will contribute to reduce avoidable health inequalities.

What is the local picture? How does it compare?

In recent history, while Coventry has been a major population centre, business activity has lagged, limiting the prosperity of residents. In the past thirty years, given its size, the city has performed below average according to measures of local economic performance, such as gross value added (GVA).

In more recent years, the city has experienced good growth, which has led to increased job opportunities. In recent years, growth in Coventry's GVA has been healthy, rising faster than the national average. Indeed, the city's GVA per head is now above that of similar places, so overall economic performance is no longer low relative to similar places. This has increased opportunities, with the number of jobs, productivity, and the number of small to medium sized enterprises (SMEs) all improving faster than the national rate, albeit from a low base.

Coventry residents are taking advantage of the growing opportunities, with more residents in employment and fewer unemployed. The number of Coventry residents in employment has been increasing strongly for last few years. The employment rate is 72%, with 169,900 of 236,000 working age residents in paid work. This rate is lower than the England average, but is in line with other similar areas with a high number of full-time students. Unemployment rate stands at 4.5%, which is lower than pre-recession levels but in line with the regional and England figures. There appears to be inequalities in employment, with residents of White British ethnicity having higher employment rates than amongst residents from BME backgrounds overall.

EMPLOYMENT

72%
of working-aged people in Coventry are employed

INNOVATION - NUMBER OF PATENTS
(per 100,000 residents)

The city is now home to some world-class, innovative business clusters. Successful, world-class business sectors in the city and region include advanced manufacturing and engineering (particularly in aerospace and automotive industries); energy and low carbon; connected autonomous vehicles; business, professional & financial services; and digital, creative and gaming. In 2017, the city is ranked second of 63 city clusters across the UK for the rate of patent applications per population, an indication that the city is innovative.

However, this has yet to translate into higher average incomes for Coventry residents. While GVA per head is higher than the average for similar places, gross disposable household income (GDHI) per head is lower than the average for similar places. This means that Coventry residents have lower incomes than expected given the level of business activity in the city.

There are significant pockets of multiple deprivation in the city and not everybody is taking advantage of the city's growth and transformation. 18.5% of the city's neighbourhoods are amongst the 10% most deprived areas in England. In total the city is the 46th most deprived local authority area out of 326 across England. Furthermore, the city has a notably higher proportion of households with no working age adult works (17%). One-third of Coventry households with children are regarded as low-income families (33%).

What is happening in the city?
What else can be done?

Uncertainty over Brexit, the departure of the United Kingdom from the European Union (EU), is affecting business confidence and investment. This may have an impact on the recent improvements to the local economy. According to the local Chamber of Commerce, 47% of exports from the West Midlands go to the EU and 62% of goods imported into the West Midlands come from the EU. The majority of businesses in the region (96%) are not supportive of a "no deal" Brexit; with 47% of businesses looking for an EU deal which would enable the UK to stay in both the single market and customs union.

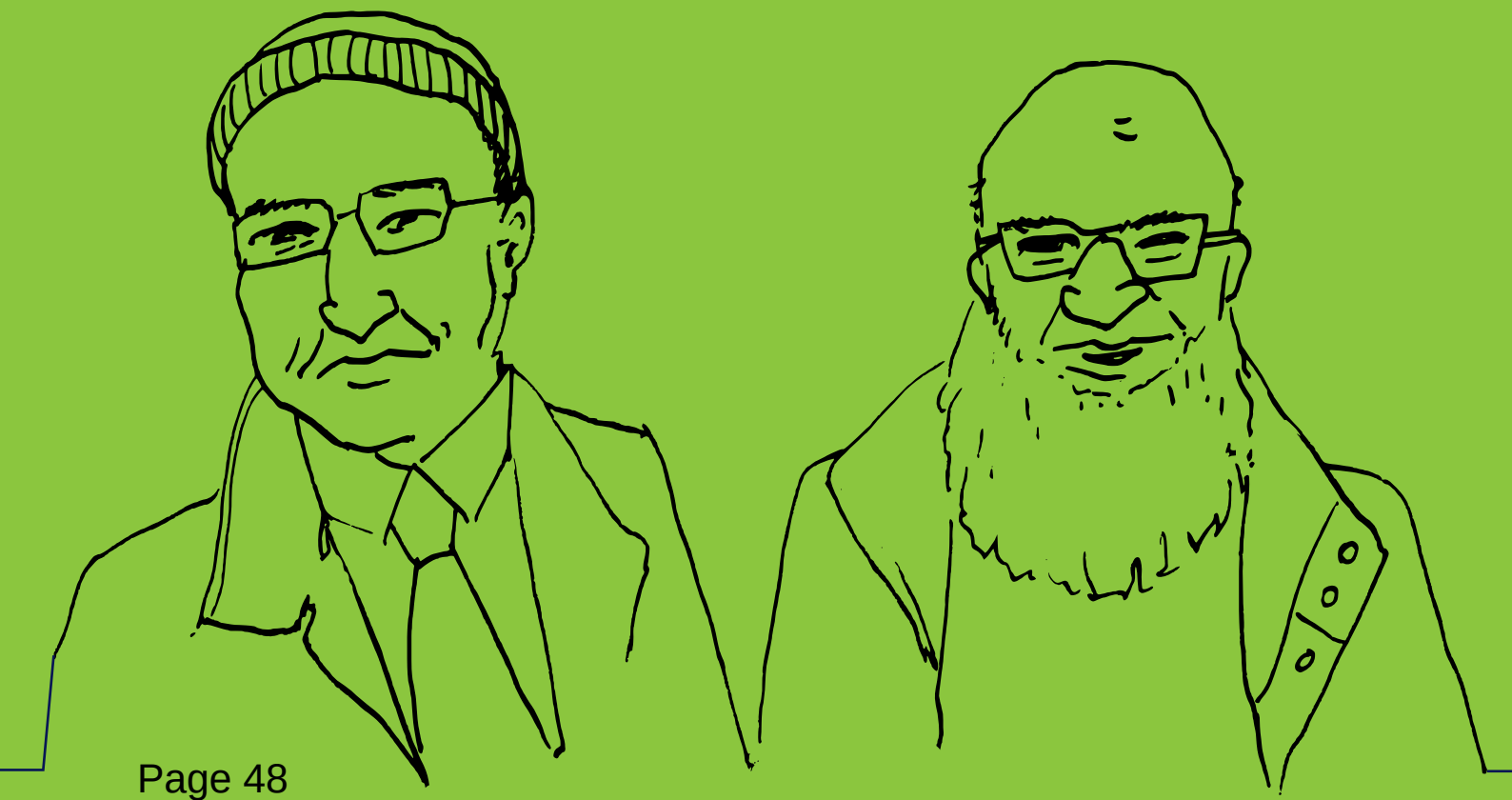
While more residents are employed, data does not shed light on Coventry residents' job security nor job quality. Supporting businesses to improve their workplace wellbeing will improve health. The improving employment rate has been driven by increases in both full-time and part-time work, suggesting there has been more choice for people seeking employment. While having a job is an important protective factor for health, the quality of the job, such as fair pay, work-life balance and opportunities for progression, also makes a difference on health and productivity. In the West Midlands, the Thrive at Work workplace health and wellbeing awards are the region's standard of good practice and a quality mark for health and wellbeing in the workplace. The awards support employers across the West Midlands to improve the health and wellbeing of their staff, engage and communicate with employees more effectively, and help to achieve a range of business and organisational outcomes.

By working in partnership, advice and support agencies can be more effective in helping the city's most vulnerable residents share in the benefits of the city's growth. For example, the city's Universal Credit working group and Welfare Reform Working Together Group brings together local advice agencies supporting some of the most vulnerable residents in the city to share updates, learning and collaborate on best practices.

> "Losing benefits is almost the difference between life and death [£] – if they get sanctioned if they are late or miss an appointment and money stops straight away.
>
> Government sanctions mean people cannot afford food to feed their families. Kids were going to school tired because they weren't getting proper nutrition."

Many community and voluntary groups, including a substantial number of faith-based groups, are addressing the needs of the city's most vulnerable residents such as rough sleepers and refugees, by providing food, clothes and charitable donations. A number of these groups feel that they would benefit from co-ordinating resources, better collaboration and having a networked approach.

Environment




War Memorial Park

Localities and neighbourhoods

Why is this an issue?

The quality of the built and natural environment, such as the local neighbourhood, access to local shops and services, and access to parks and green spaces, affects the health and wellbeing of everyone.

What is the local picture? How does it compare?

The majority of residents (84%) are satisfied with their local areas as a place to live. Most Coventry residents live within a 20-minute walk of a general/ grocery shop, public transport links, parks, pubs, GP surgery/health centre, and a place of worship. However, half of the residents did not think their area had changed much in the last two years; a quarter felt it had become worse to live in, and only 9% thought their area had improved.

There are 2,000 hectares of green spaces in the city. However, there is considerable variation across the city. Over 20% of Coventry's total area are green spaces, and 430 green spaces across the city have no entry restriction. Despite this, Coventry trails behind regional average for green space provision by population.

Some residents have no access to green spaces nearby, and there is a lack of access to outdoor sports facilities. Residents in the Mosaic and Moat family hub areas enjoy more access to green spaces than others. By ward, residents in Henley and Wainbody enjoy access to over 100 hectares of green space. In contrast, those in Upper Stoke, Lower Stoke, Radford, and Foleshill have access to levels below the average of 62.3 hectares. The three most frequently visited green spaces in Coventry are War Memorial Park, Allesley Park, and Coombe Abbey Park.

Certain parts of the city have poorer air quality than EU and international standards. Poor air quality is a big contributor to mortality and exacerbates certain health conditions. Research suggests that long-term exposure to particulate air pollution contributes to

SATISFACTION WITH LOCAL AREA

of local residents are satisfied with where they live

GREEN SPACE

FUEL POVERTY

NITROGEN DIOXIDE LEVELS

SUSTAINABLE TRANSPORT

smart, hybrid low-emission buses

death rates at a similar level as obesity and alcohol. Air quality particularly affects the most vulnerable, including elderly people, pregnant women, children, and people with cardiovascular and/or respiratory disease. In Coventry, nitrogen dioxide (NO_2) is one of the pollutants of concern. While 85% of locations measured had a safe level of NO_2, there are areas beyond safe levels, including Ball Hill, Foleshill and the Holyhead Road/ring road junction.

What is happening in the city? What else can be done?

Cleanliness has an impact on residents' perception of safety and community cohesion. In some areas, littering, fly-tipping and dog fouling were major issues.

Public transport companies can help encourage people to shift to more environmentally friendly forms of transport, helping reduce carbon emissions. National Express's Platinum service offer more comfortable seats, free Wi-Fi and on-board USB power to encourage non-bus users to make use of the new, smart hybrid low-emission buses that are compliant to Euro 6 standards. 17 such buses are now in operation in Coventry.

Housing and homelessness

Why is this an issue?

Historically, housing is only considered in relation to health in terms of support to help vulnerable people to live healthy, independent lives and reduce the pressure on families and carers. However, it is now recognised that good quality housing for all leads to better health and wellbeing, as it indirectly affects early years outcomes, educational achievement, economic prosperity and community safety.

Conversely, rough sleeping and homelessness significantly impacts on a person's mental and physical health, and the longer someone experiences rough sleeping, the more likely they will develop additional mental and physical health needs, develop substance misuse issues and have contact with the criminal justice system.

What is the local picture? How does it compare?

While house prices tend to be lower than the regional level, rental prices appear to be slightly higher. Just over half (51%) of residents live in privately-owned

properties. The city's house prices on average have increased by £9,400 (+7%) per year over the last five years. This increase is higher than West Midlands region's (+£7,600 per year), but lower than England's (+£10,200 per year). Despite such increase, house prices remained lower than the regional (by £13,000) and national (by £64,000) median prices.

Just over a quarter of residents rent from private landlords. In October 2017-September 2018, the mid-point of available rental prices in Coventry was £625 per month. Rental prices in Coventry appear to be slightly higher than the regional levels and are rising slowly towards the national levels. The differences in purchase and rental prices may reflect the demand for student accommodation in the city – and may eventually be offset as purpose-built student accommodation blocks come on stream.

Fuel poverty is more prevalent in Coventry than in the region or England. 15% of all households are considered to be in fuel poverty. Fuel poverty is concentrated around parts of the city with higher levels of privately rented housing.

The city has a high level of homelessness, particularly amongst young people and families. This is putting sustained and significant pressures on the local housing system. At 3.9 households per 1,000 in 2017/18 (555 households), the statutory homelessness rate in the city has dropped to the lowest level in a decade but remains higher than the region and England.

In addition to statutory homelessness, the Council helped prevent 650 households from becoming homeless through advice and support. Furthermore, 2,300 households sought help from the Council as they had nowhere to return to spend the night.

A lot of families are struggling. At any one night in 2017/18, between 190 to 250 Coventry families with dependent children spent the night living in emergency or temporary accommodation.

What is happening in the city? What else can be done?

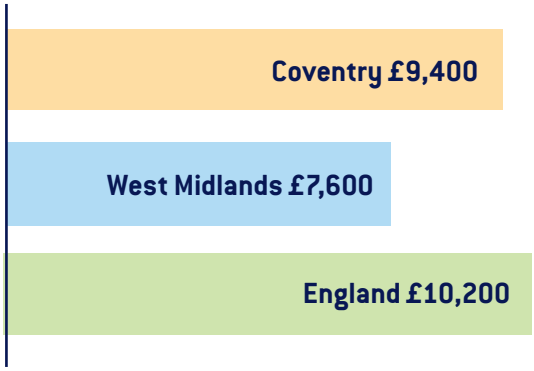
There are concerns around the poor quality of some privately rented accommodation. Residents spoke of poor conditions, and the difficulty of communicating with certain landlords and feeling a lack of control over the situation. In particular, vulnerable adults did not always receive the support they needed.

> The condition of the house is really bad and I had to empty the toilet myself with buckets for six months. We reported it to the Council and the landlord did the minimum repairs.
>
> **Tenant attending event at a family hub**

HOME OWNERSHIP

of local residents live in privately owned proprties

HOUSE PRICE INCREASE



HOMELESSNESS

555
households are homeless

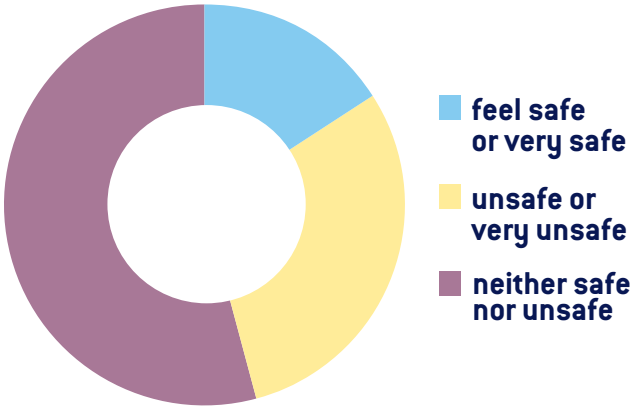
> If they give you a flat they should ensure it is clean and safe. I was left with broken furniture. They left me some drawers. **Refugee**
>
> A couple with four children are living in a two-bedroom flat with one bathroom; with the four children aged from 3 months to 12 years old sharing one bedroom. This is particularly hard in mornings when the children have to get ready for school and parents for work.
>
> **Worker at the Real Junk Food Project**
>
> I've been living in a hotel for nine months in the city centre. It is very hard for the children.
>
> **Mother of six, attending Stay and Play at a family hub**

Rough sleepers may be prevented from accessing support for fear of losing their 'spot'. Rough sleepers may sometimes be disinclined to engage with services or attend night shelters for fear of losing their spot on the street. The cost of travel has also been a barrier for homeless people to access support. Rough sleepers, particularly those who are at multiple disadvantage, may be furthermore disinclined to reach out for help due to fear and distrust of services.

People with lived experiences of homelessness have a unique and essential role to play in helping to prepare people to accept and receive support. The Ayriss Recovery Coventry (The Arc CIC) is a drug and alcohol outreach/support service in Coventry. The Arc is made up of experts by experience – that is, people with first-hand, lived experiences of being at "rock bottom", such as rough sleeping or misusing drugs and alcohol. They understand the pain and desperation of having been there and are able to use their empathy and understanding to build connections between local services and people who are rough sleeping or misusing drugs and alcohol. The Arc CIC is one of the founding partners of the STEPS for Change street homelessness hub in Coventry City Centre, a drop-in facility where rough sleepers and those at risk of homelessness can seek support from a variety of partner agencies.

> Some people are becoming homeless because they've been sanctioned. They can't take loans because they can't pay it back.
>
> **Mental health support group**

YOUNG PEOPLE'S PERCEPTION OF SAFETY




Knife Angel sculpture

Crime

Why is this an issue?

Being a victim of crime, and being worried about crime, impacts on a person's perception of their quality of life in the neighbourhood and has a negative effect on a person's mental and physical wellbeing.

What is the local picture? How does it compare?

There has been an increase in violent crime. Recorded crime and recorded violent crime against the person have increased, echoing the national trend. In Coventry, violence against the person increased by about a quarter in the last year. Over the last two years, the increase in Coventry has been lower than that of England. Against a national surge of violent crime against the person, Coventry's rate remained lower than regional and is average amongst similar places.

People in the city report feeling increasingly unsafe. In 2018, fewer Coventry residents (74%) said they felt safe in the neighbourhood at night than two years ago (85%). This is not unique to Coventry and is in line with the national average. Perception of safety is important, as people who said they felt safe also tended to be more satisfied with their neighbourhood, with the city centre, and feel more strongly that they could influence their local area.

Coventry residents appreciate the city's parks and open spaces, yet some do not feel safe and therefore do not use them as often as they would like. Some families reported preferring their children to stay indoors as they were worried about safety in parks. There is an element of 'safety in numbers' where families tended to feel more comfortable with using a park when an organised event or activity was taking place.

Coventry's youth offending rates are low. In 2018/19, there has been a further reduction in first time entrants to the youth justice system (93, down from 126); and reduction in the number of substantive offences (479, down from 582). However, many of the young people known to youth offending face complex needs including mental health issues, poor educational attainment. and poor school attendance. This will have an impact on their life chances.

However, nearly a third of young people feel unsafe in the city. In 2018, only 16% of the city's young people felt very safe or safe in the city; and 30% said they felt very unsafe or unsafe in the city. The remainder were in-between and did not feel strongly either way.

Young people voiced concerns about knife crime, and some alluded to postcode gangs, citing fear about stepping on another gang's turf. Almost a third of young people said it was easy to buy illegal drugs in their area. There is a perception that social media may be disproportionately affecting

Godiva Festival

perceptions of safety and facilitate crime; for instance, it was pointed out that Instagram was used to sell illegal drugs.

What is happening in the city? What else can be done?

Organised events can help address and improve perceptions of safety. Organised events in parks have helped transform the perceptions of safety in local parks, encouraging people to make use of local green spaces and thus helping to improve their health and wellbeing. In Canley, the local community put on a series of daily events in the park during the school holidays, which helped residents build a sense of ownership of their park and keep out gangs. Similarly, in Edgwick Park, volunteers from the local church helped to clean up the park and host activities, successfully attracting residents to the park.

Local groups, young people and people with lived experience have vast insights and expertise. They should have more opportunities to shape services. Local groups report that young people do not feel they can influence services. To appropriately tackle issues such as knife crime and substance misuse requires the voice of young people: holding young people and adults accountable, without demonising anyone. This also requires working beyond city boundaries particularly in relation to issues around County Lines, substance misuse, knife crime and criminal exploitation.

> Train police officers to speak to young people, with young people in attendance! **Youth survey participant**
>
> Adults do not always see things through young people's eyes. **Young person professional**

Coventry has had success in working this way: volunteers with lived experiences of drug and alcohol misuse are members of the city's Multiple Complex Needs Board. As experts by experience, these volunteers worked closely with the police and the Council to influence the city's approach to working with rough sleepers who misuse drug and alcohol, and to shape the city's housing and homelessness strategy.

Dealing with 'challenging' behaviour requires partnership working. Young people with behaviours regarded as 'challenging' may fall outside the family hub support system. Some ethnic minority communities fed back that they did not know where to access help to guide their younger children. There is scope for developing partnerships with schools, colleges and universities to address this in local areas, for instance: making use of the facilities of the city's two universities to provide a space for youth groups and simultaneously raise aspirations; making use of student volunteering networks already in place, such as Warwick Volunteers; and connecting businesses across the city with youth mentoring schemes such as One Million Mentors.

Violent crime is a public health problem, not solely a police enforcement problem. National and international evidence suggests that violence is a consequence of preventable factors such as adverse childhood experiences and harmful social influences. A public health approach to tackling knife crime will be beneficial. Addressing social influences through the better use of social media will also help, as it is where most young people and families get their news and information.

Health and Wellbeing

Life expectancy

Why is this an issue?

Life expectancy and healthy life expectancy are extremely important summary measures of overall population health. The Marmot Review, Fair Society, Healthy Lives, demonstrates clear and significant links between avoidable differences in health outcomes and deprivation, where people experiencing multiple deprivation not only living shorter lives, but spend a greater portion of their shorter lives with a disability or in poor health. As a Marmot city, Coventry has adopted and embedded the principles of Marmot, tackling the social conditions that can lead to health inequalities, and working to improve the areas in which people are born, grow, live, work and age.

What is the local picture? How does it compare?

Overall health in the city is below average. The increase in life expectancy has stalled. Life expectancy in the city is currently 82.4 years for females and 78.3 for males. It has consistently remained below the regional and national averages.

Healthy life expectancy, which is the number of years a person can expect to live in good health, is at 63.5 years for females and 62.9 for males. This is just below the regional and national averages but is not significantly different.

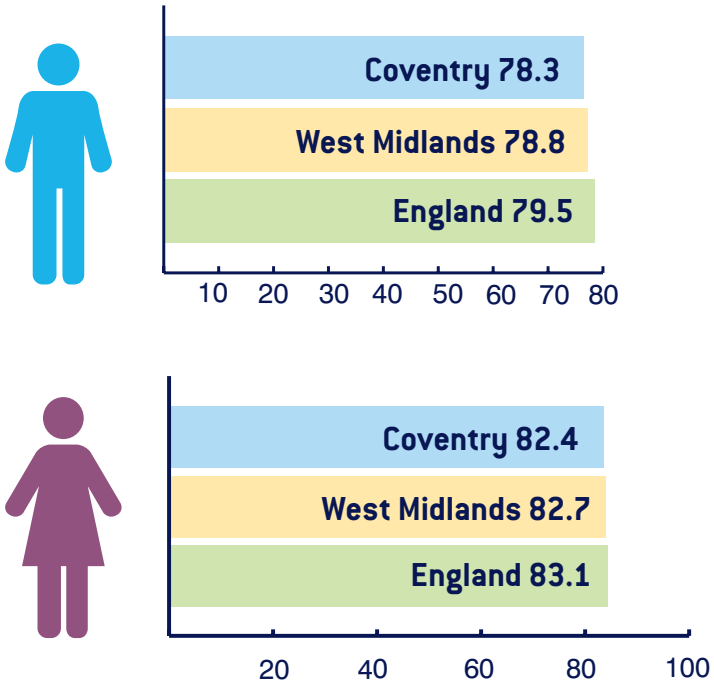
The gap between healthy life expectancy and life expectancy is referred to as the 'window of need'. It is the average number of years that a person can expect to live with poor health, during which they will be likely to need support from the health and care system.

In Coventry, females can expect to live almost a quarter of their lives in poor health (18.9 years) whilst males can expect to live just over a fifth of their lives in poor health (15.4 years).

There are significant inequalities across Coventry's neighbourhoods and the extent of the inequality is relatively large compared to other areas. Indeed, the level of inequality in Coventry is amongst the highest in the region and the highest when compared to similar places. Males living in less deprived parts of the city can expect to live up to 10 years longer; and for females, the gap is 8 years. Furthermore, the 'window of need' is wider in the city's most deprived areas. **This means that people in more deprived parts of the city not only live shorter lives, but also spend a greater proportion of their shorter lives in poor health compared to those living in less deprived parts of the city.**

Comparing Coventry's health outcomes to other areas', premature mortality (deaths amongst residents aged under 75 years) is higher than average, particularly for cardiovascular diseases amongst males. Males and females in Coventry tend to be affected by different causes of premature death. The differences are most significant in causes of death that are considered preventable, where the deaths could potentially be prevented by public health interventions. A comparison of premature mortality for males and females is set out in the table on page 29.

LIFE EXPECTANCY AT BIRTH



Cause of premature mortality	Coventry males		Coventry females	
	Compared to the region	Compared to England	Compared to the region	Compared to England
All preventable causes	Worse	Worse		Worse
Cardiovascular disease (including heart disease and stroke) – preventable	Worse	Worse		
Cancer – preventable		Worse	Worse	Worse
Cancer (in over 65-year olds)		Worse	Worse	Worse
Liver disease (including alcoholic liver disease) – preventable		Worse		
Respiratory diseases – preventable		Worse	Worse	Worse
Communicable diseases (including influenza)		Worse	Worse	Worse

What is happening in the city? What else can be done?

Preventable deaths can be avoided by addressing the social conditions that lead to poor health, such as people's prospects and opportunities; housing and environment; as well as behavioural and lifestyle changes. These are explored throughout this JSNA.

Health protection

Why is this an issue?

Before the introduction of widespread immunisation and vaccinations, infectious and communicable diseases (diseases that can spread from one person or living organism to another) were a major and widespread cause of death and permanent disability, especially among children.

To stop the spread of vaccine-preventable diseases and ensure herd immunity, it is important to maintain 95% vaccination coverage. Monitoring health protection coverage helps to identify possible drops in immunity before levels of disease rise.

What is the local picture? How does it compare?

Coventry has high rates for some communicable diseases. Coventry has one of the highest rates of Tuberculosis (TB) but this is improving. It is higher than national and regional averages and high compared to similar places. There are some local populations with higher rates of TB, for example, some of the city's newly arrived communities from countries with high rates of TB, as well as vulnerable groups facing severe and multiple disadvantage including rough sleepers, people who misuse drugs and sex workers.

Coventry also has a higher prevalence of diagnosed HIV. This may be a result of recent migration from countries with higher rates of HIV. Areas of the city with comparatively higher prevalence of diagnosed HIV include Wood End, Henley Green, Manor Farm and Willenhall.

Childhood vaccination take-up rates in Coventry dropped notably in 2017/18. Several different childhood vaccinations including DTaP/IPV/Hib (a vaccination that protects babies against six serious childhood diseases: diphtheria, hepatitis B, Hib

[Haemophilus influenzae type b], polio, tetanus and whooping cough [pertussis]) and measles, mumps and rubella (MMR) saw a notable drop to well below the 95% threshold. This needs to be investigated, as to whether this is a data quality issue, or a reflection of actual low take-up.

Cancer screenings for at-risk populations are low. The coverage of screening for cancers such as breast cancer, cervical cancer and bowel cancer across at-risk populations are below the national average.

What is happening in the city? What else can be done?

A culturally competent approach that recognises the city's diverse communities is essential. With the help of partner organisations, the city's health services have been able to reach out to communities with greater prevalence of certain conditions. For example, Foleshill Women's Training (FWT) has partnered with local GP practices to increase cervical screening rates for BME women aged 25-64; and the Highlife Centre is working with local community and religious groups to encourage people to get tested for HIV, Hepatitis B and C and TB.

Demand and access

Why is this an issue?

The demand for health and care services is expected to increase as the city's population grows and ages. To manage this growth, there is a need to shift the emphasis to proactive and preventative care. This means ensuring people have better general health regardless of where they live, requiring fewer visits to hospital and shorter stays if they need inpatient care; and remodelling urgent and emergency and planned care, so that it can cater to the expected increase in demand.

What is the local picture? How does it compare?

Hospital data suggests that Coventry residents do not appear to have unusually high numbers attending accident and emergency. However, Coventry residents appear to be relatively heavy users of emergency admitted care services when compared both nationally and regionally, particularly amongst vulnerable people, such as young people, older people, people with mental health issues and behavioural risk issues. Further research is needed to determine how much of this is avoidable, and how much is due to admission thresholds at University Hospital Coventry and Warwickshire (UHCW).

What is happening in the city? What else can be done?

Improving people's awareness of support groups and available activities can be a more efficient and effective way to help them meet their health needs. However, these groups need support to build their capacity and to ensure their sustainability. The city has a range of peer support groups, where people use their own experiences to help each other. These include groups aligned to people's gender, ethnicity, religion, sexual orientation and health condition, as well as groups bringing different people together. Forms of peer support include community groups; mentoring; befriending; self-help groups; online communities and support groups. Through peer support groups, people can talk to others who have faced similar situations, allowing them to share their feelings and experience; share ideas to cope; build confidence; and build a sense of community and belonging. Peer support groups empower people to take control of their health and wellbeing.

Examples include Grapevine Coventry and Warwickshire, a charity which, amongst other activities, supports a peer-led project for people with learning disabilities and/or autism to run sessions for themselves. Carriers of Hope, a volunteer-led service that offers parenting skills training to pregnant asylum seekers, refugees, and migrant families, and a baby bag to help them with hospital stays.

Community groups are best placed to address health challenges, because they are trusted, and have the networks, understanding and legitimacy to do so. The health and care system needs to recognise this and change the way they work with them by:

- shifting to an 'enabling' leadership style to support communities in maintaining their health and wellbeing;
- pooling engagement resources to maximise public sector resources and recognise that community groups are even more poorly resourced; and
- helping to build capacity by sharing skills, facilities and resources with communities.

Only by doing so – shifting to a social model of health – will the city truly be able to shift resources and meet the demand for health and care.

"I want to be able to access support when I need it but how can I find that information? Unless you get a referral from a professional, you can't find it. **Resident**

I visited a White British retired couple – they did not know how to access services. It is not just new communities that have difficulty with this. **Health visitor**

Proof of identity can hinder access to services - not everybody has photo ID. **Asylum seeker**

I still get confused about who to talk to, who is the right person; by the time I get to the right person and gain their confidence, they change their responsibility or will have left. **Local person accessing service**"

"In so many situations, services ask so many questions and, if people don't answer, that's where it stops. People don't want to talk so personally to someone they just met so don't get the support. On the spot sometimes, it's hard to say spontaneously.

Local person reflecting on access to services

It is getting better, but GPs don't know enough about learning difficulties and making reasonable adjustments.
Person with learning disabilities reflecting on health services"

> Staff are aware of the system of hospital passports [for a person with learning disability to give hospital staff helpful information about their interests, likes and dislikes] but don't use them. A man became dehydrated in hospital as he wouldn't drink anything offered: staff labelled him as presenting with 'challenging behaviours' because they hadn't checked his hospital passport, which would have told him that his favourite colour was red. Luckily he was hydrated before things got really serious, but this situation could have been avoided if it was the norm to read a person's hospital passport.
> **Professional, reflecting on support for people with learning disabilities in hospital**

Year of Wellbeing 2019

Lifestyles

Why is this an issue?

Individual behaviours, such as eating enough fruits and vegetables, smoking, alcohol consumption, and physical activity can affect health. These lifestyle behaviours are strongly influenced by the environment in which people live. For example, people living in a 'food desert', with limited access to affordable and healthy food, are more likely to eat unhealthily; an unsafe environment is likely to discourage people from walking or cycling; and social and cultural influences, including friendship groups, advertising and media, play an important role in determining people's lifestyles.

These lifestyle risk factors – poor diet, physical inactivity, excessive alcohol consumption and smoking – are all linked to ill health and premature death. Having a combination of the risk factors contributes to greater ill health. People facing poorer social circumstances are more at risk of having multiple risk factors, exacerbating avoidable differences in health.

What is the local picture? How does it compare?

Between one-in-five and one-in-six Coventry adults smoke. While deaths caused by smoking is relatively high in the city (283 per 1,000 in 2015-17 compared to 262.6 in England), there has been evidence of improvement as smoking prevalence continues to decrease and the recorded quit rate in Coventry is relatively high.

At city level, alcohol consumption is not especially high. This may be due to the cultural mix of the city, where some may be less likely to drink or do not drink at all. Further research at a local level is needed to explore whether acute problems of alcohol consumption amongst smaller groups of residents are masked.

However, alcohol is causing disproportionate harm. Alcohol-related mortality and health problems are relatively high in Coventry. The premature mortality rate due to alcohol-related causes is higher than the

national average and similar places. It is particularly high amongst men. The rate of admissions to hospital that were broadly related to alcohol is also high.

Levels of physical activity in Coventry are relatively low and are declining. In 2017/18, just over half (53%) of adults in Coventry took part in 150 minutes of moderate intensity activity per week, which is the level amount of physical activity recommended by the chief medical officer. This is significantly lower than that of similar areas, and West Midlands (58%) and England (62%) averages.

Almost a quarter of children in year 6 are obese. In 2017/18, nearly a quarter (23.5%) of Coventry children in year 6 were measured as 'obese' (956 children), an increase from one in ten (10.5%) in reception year (454 children). At reception, Coventry's obesity rate is slightly higher than the England average; but by year six, the city's obesity rate is much higher. This has consequences on a person's future quality of life, as obesity can lead to serious and potentially life-threatening conditions including type 2 diabetes, coronary heart disease, breast cancer, bowel cancer and stroke.

There is some indication that sexual health is an issue in Coventry. The city has relatively high rates of abortion and high prevalence for some sexually transmitted infections (STIs). Abortion rates per 1,000 female population aged 15-44 are higher in Coventry than regionally or nationally. The city has a particularly high rate of abortions amongst females aged 25 years and over; and a lower rate of abortions that occur under 10 weeks' gestation.

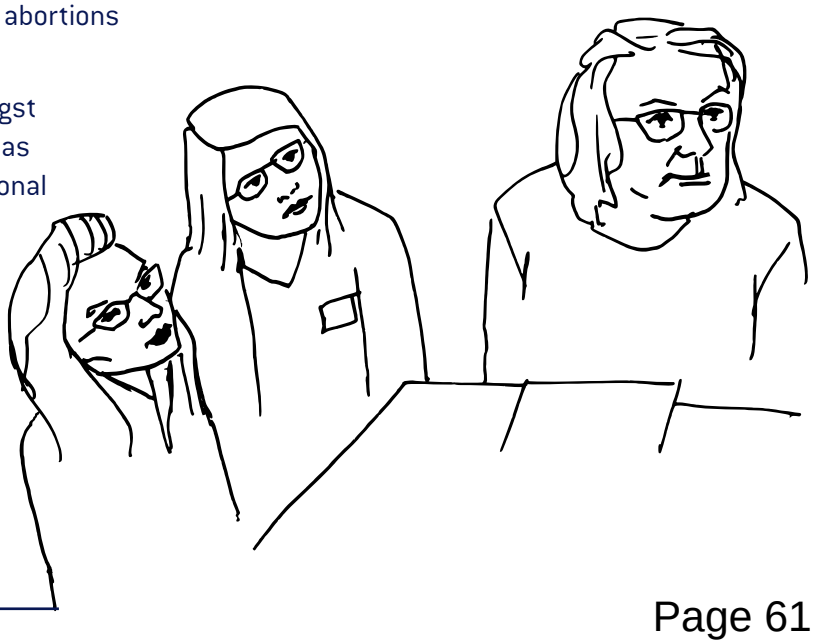
There were over 2,100 STI diagnoses amongst Coventry residents in 2017; the local rate has remained consistently higher than the national and regional average for several years.

Teenage conception rate is still higher than the national average but have fallen significantly. Coventry used to be one of the areas in the country with the highest rate of teenage conceptions. This is no longer true, and Coventry's current rate is not regarded as especially high.

What is happening in the city? What else can be done?

Recognising that lifestyle factors are rooted in socio-economic conditions means taking a citywide, integrated working approach to tackle health inequalities and to create health-sustaining, health-promoting environments. For instance, this may include:

- Addressing food deserts by creating better public transport links to/from sources of affordable and nutritious food;
- Reducing risky behaviours by shifting social norms and linking people to peer support groups, such as encouraging them to use health check services, sexual health check services, stop smoking services, and improving their access to psychological therapy drop-in sessions and baby clinics within the community; and
- Developing integrated strategies that bring together the promotion of physical activity, transport infrastructure investment, active travel plans and air quality improvements.



Recommendations

DEMOGRAPHICS AND COMMUNITY Harnessing the city's growth and diversity

- The city must be prepared for a growing, changing and increasingly diverse population.
- With the anticipated growth in older people, there is a need to focus on preventative health amongst the working age population.
- As population growth is concentrated in certain parts of the city, access to services should be reviewed.
- The city's rich community assets can help address specific needs related to newly arrived communities.
- Increasing participation and involvement will help maintain cohesion and reduce radicalisation and extremism.

PROSPECTS Helping people to access opportunities and thrive

- Good growth in the city has created many well-paid jobs. There is a need to address skills shortages – from raising aspirations amongst schoolchildren to retaining skilled professionals and graduates in the city.
- As a person's lifelong health, happiness and productivity in society are influenced by their early years, continued investment into early identification and intervention is critical.
- Young people's aspirations may be raised by improving their awareness of the significant and growing opportunities in highly paid jobs available in the city, which require people with the right skills and qualifications.
- Organisations working together can help to address poverty and its impacts, and to ensure inclusive growth for the city's most vulnerable residents.

ENVIRONMENT Connected, safe and sustainable communities

- A more detailed understanding of local needs should be developed through the place-based JSNA profiles, to address pockets of dissatisfaction with local neighbourhoods, and issues such as access and affordability of housing and local air quality.
- Perceptions of safety should be addressed through a partnership approach.
- Partners in the city should make better use of social media, which is how an increasing number of families and young people obtain and consume news and information.
- A joined-up approach is essential for tackling the city's homelessness and rough sleeping problem, recognising the intersection of severe and multiple disadvantages faced by people.
- Partners should look to provide more opportunities for people to shape services, including involving people with lived experiences.
- The city should champion the emerging public health approach to tackling knife crime.

HEALTH AND WELLBEING Healthy and independent for longer

- As life expectancy is below average and health outcomes are worse in more deprived areas, a targeted approach of appropriate support to each group is essential to improve health and wellbeing for all groups.
- Further investigation at a locality level as to whether avoidable differences in health are widening – and the reasons for it – will help identify local priorities.
- In line with the shift to focus onto prevention, a community-informed and culturally competent approach is essential to increasing screening and vaccination rates.
- The city's rates to emergency admitted care services appear high especially for some vulnerable groups, and further investigation will help determine how much of this is down to admission thresholds.
- Further work is required at a local level, through the place-based profiles, to understand the city's avoidable differences in health outcomes, particularly around issues such as alcohol use, obesity/ physical activity, Tuberculosis, sexual health (including HIV) – and the consequential impacts on the demand for health and care services.

APPROACH Working together in our places and with our communities

Health is determined by people's social circumstances such as their communities, prospects and environment; and similarly, this approach to addressing and improving these circumstances must also be rooted in local people and communities. Growing this capacity in the communities require improving connectivity. This can be done by:

- distributing leadership – valuing the community leaders that are already working in this space as they have the trust, networks, understanding and legitimacy, and getting behind existing partnerships;
- joining forces – getting the public sector to work together by pooling resources to build capacity and connections, investing resources to enable communities to maximise social action;
- grassroots activities – making social action activities across the different sectors more visible; and
- forging links – building links and generating connectivity by helping partners and communities share what they do, and helping them learn from, and build partnerships, with each other.

Further information

Further information, which includes the citywide intelligence hub data profiling tool and the data correlation tool, book of indicator definitions, and place-based profiles will be available online **at www.coventry.gov.uk/jsna**

Coventry Health and Wellbeing Board

Insight Team
Coventry City Council
June 2019
www.coventry.gov.uk/jsna

Coventry Health and Wellbeing Strategy 2019-2023

Have your say

COVENTRY & WARWICKSHIRE YEAR OF WELLBEING 2019

ONE COVENTRY

Coventry Health and Wellbeing

What is our Health and Wellbeing Strategy?

"Our Health and Wellbeing Strategy is a plan for reducing health inequalities and improving health and wellbeing for our residents. Together with other local health and care partners we want to use the strategy to guide a range of local services.

"We rely on all of our partners to play a part in improving the quality of life for all our residents. That's why our strategy will also look for more opportunities to work together, share resources and build upon examples of good work across all of our organisations."

Cllr Kamran Caan, Cabinet Member,
Chair of the Coventry Health and Wellbeing Board

What's in place now?

Coventry has been tackling health inequalities as a Marmot City since 2013. This is one of the priorities in the current Health and Wellbeing Strategy 2016-19, which is helping create more integrated services across different agencies. This includes agencies that in the past may not have regarded themselves as providing health and wellbeing services and has led to better outcomes.

In the strategy for future years this will be expanded upon.

Expanding our work - The case for change

For the past six months we have been talking to over 200 residents and 70 community organisations to understand the key issues facing local communities.

Coventry has a growing, changing and increasingly diverse population and particularly the expected growth of over-65s means there is a need to focus on preventative health amongst the working age population now to help manage future demand on health and care services. Population growth is concentrated in certain parts of the city, so place based service planning will need to be considered.

Overall health in the city is below the national average, with residents living in more deprived parts of the city not only living shorter lives but also spending a greater proportion of their lives in poor health. Males living in some parts of the city can expect to live up to 10 years longer; and for females, the gap is eight years. The difference is linked to a number of inequalities related to deprivation.

Premature mortality is also higher than average in the city.

There are avoidable differences in health outcomes, particularly around issues such as alcohol use, obesity / physical activity, Tuberculosis and sexual health.

Significant pockets of deprivation limit people's opportunities to succeed in life. 19% of Coventry neighbourhoods are amongst the 10% most deprived nationally. By the age of five, fewer children achieve a good level of development (68%) than nationally (72%) or in similar places.

Fear of crime also impacts on residents' health and wellbeing. Most notably nearly a third of young people feel unsafe in the city, with only 16% of the city's young people saying they feel very safe or safe in the city in 2018.

Reducing the high levels of homelessness, particularly amongst young people and families, is a key priority in Coventry.

We know that social inequalities and life chances are already established from the early years of life and that educational achievement; economic prosperity; good quality housing; and community safety all impact on health and wellbeing.

How to tackle this?

Community organisations we spoke to said that communities are best placed to address health challenges. This is because they have networks, understand issues on the ground and are trusted advocates of residents.

However, their resources are limited and capacity is stretched so the public sector must enable community organisations to take a more leadership style role, by joining forces and building capacity.

More information about the findings from our Joint Strategic Needs Assessment (JSNA) can be found at www.coventry.gov.uk/jsna/.

What do we want to achieve over the next four years?

1. People will be healthy and independent for longer
2. Children and young people will lead successful lives
3. People will live in connected, safe and sustainable communities

How we will do this - Our population health framework

There is consensus nationally that to reduce health inequalities and improve health outcomes, we need a population health approach.

We are proposing a population health framework for Coventry which will underpin everything we do as a health and wellbeing system to achieve change. Taken from a model developed by the King's Fund (a national health and care think tank), this is based on four components that impact on people's health and wellbeing. For us in Coventry this means:

- **Wider determinants** – embedding the Marmot City approach by working in partnership to tackle health inequalities through addressing the social determinants of health
- **Our health behaviours and lifestyles** – aligning and coordinating prevention programmes across the system to maximise impact and tackle barriers to healthy lifestyle choices
- **The places and communities we live in and with** – working together in our places and with our communities to mobilise solutions, informed by our understanding of local needs and assets from our place-based JSNAs
- **An integrated health and care system** – health and social care commissioners and providers working together to commission and deliver services in Coventry

We will make sure that all of our plans and activities consider each of these components and – most importantly – the connections between them. We recognise that we have particular work to do around 'the places and communities we live in, and with' – by fundamentally changing the way we work with communities and we plan to include a specific priority in our Health and Wellbeing Strategy to reflect this.

We will require that every item brought to the Health and Wellbeing Board can be clearly mapped onto our population health framework.

We anticipate that using this framework will help us to improve outcomes for everyone, and will lead to a particular focus on health inequalities and tackling the causes of these.

Making it real

We want to focus on **three priorities** where we can make a tangible difference in the short-term by working together in partnership. We will use these to bring our population health framework to life – they will be our test bed for learning how to do things differently and change the culture of how we work.

The potential priorities are below and we want to hear from you about which you think we should focus on:

- Loneliness and social isolation
- Screening and immunisation uptake
- Young people and violence and exploitation
- Young people's mental health
- Giving every child the best start in life
- Temporary housing and homelessness
- Health impact of air quality
- Access to urgent care

For each priority we will develop a detailed action plan, with clear performance measures, and we will monitor and report progress against the plans to the Health and Wellbeing Board.

We propose to evaluate the impact made and review these priorities after 18 months to two years.

Our ways of working will include the principles of:

- **prioritising prevention;**
- **listening and strengthening communities;**
- **co-ordinating services;**
- and **sharing responsibility by** pooling resources, budgets and accountabilities where it will improve services for the public.

The Coventry Health and Wellbeing Board brings together senior leaders from Coventry City Council, West Midlands Police, West Midlands Fire Service, voluntary sector organisations, Coventry and Rugby Clinical Commissioning Group, acute and community NHS trusts, and local universities

How to have your say

We would like to hear from partner organisations, community groups and frontline staff involved in delivering health and care services and working in the city to improve health and wellbeing, as well as individual residents with an interest in how the Strategy affects you and your communities. Please visit our website to complete the survey by 3 June 2019: www.coventry.gov.uk/hwbstrategy

To request a paper copy of the survey or for further information, please contact:

Debbie Dawson Tel: 024 7697 1406 email: debbie.dawson@coventry.gov.uk

Coventry Health and Wellbeing Strategy 2019-23 – Consultation Report

1. Purpose

This document summarises findings from a range of consultation activities, which took part during the period from 10 May to 3 June 2019. These have been used to inform development of a final proposed model for consideration at the Health and Wellbeing Board on 8th of July. The final Joint Health and Wellbeing Strategy will be endorsed by the Health and Wellbeing Board and adopted by Coventry City Council Cabinet and Coventry and Rugby Clinical Commissioning Group Governing Body in autumn 2019.

2. About the consultation

Extensive pre-consultation engagement had already taken place during the development of the proposed new strategy, which directly contributed to its development. This included workshops with a wide range of community-based organisations through the Joint Strategic Needs Assessment, and strategy development and prioritisation workshops with senior executive and community leaders from public, private and third sector partners.

Formal consultation activities included:

- A city-wide survey of residents and organisations
- Two workshops involving a range of community-based organisations at St Peters Centre
- Three stakeholder briefing sessions to encourage participation in the survey

Responses to the formal consultation have been received from:

- 77 members of the public
- 19 organisations responding to the survey, including: Coventry Green Space Forum, The Amethyst Centre, Three Spires Family Support Trust (Coffee Tots), Residents Association, Watch Charity, Coventry Adult Education Service, University of Warwick, Coventry Citizens Advice, Amba Care Solutions CIC, Coventry Family Health & Lifestyle Service, NHS, Early Help, Coventry Libraries and Information Service, Stoke Heath Older Peoples Club at Stoke Heath Community Centre, Shine A Light Support Service, Coventry Older Voices, Coventry Safeguarding Board, Coventry Cyrenians, and a local business
- Organisations represented at the workshops, including Hope Coventry, Coventry Older Voices, Coventry Mens Shed, Arthritis Association, Hope in Unity, WM Housing, Inini Initiative Ltd, Piparia Consulting Ltd, Historic Coventry, Disabled Equality Action Partnership, University of Warwick, Coventry Walking for Health, Grapevine, Art-Folks, The Asian Christian Welfare Society, Family Hubs
- 3 partnerships:

  Welfare Reform Working Together Group
  Social Isolation Strategy Working Group
  Accident & Emergency Delivery Group

Analysis of formal consultation findings has been conducted and the headline messages are set out below. Fuller analysis of the city-wide survey and the community workshops are appended to this report.

In addition, Voluntary Action Coventry proactively held a workshop with the VCSE Alliance Network in March 2019 to explore awareness of the Coventry Health and Wellbeing Strategy, and shared their findings.

3. Summary of Key Findings

3.1 The Health and Wellbeing Strategy Proposals

Strategic ambitions

Overall, participants of each consultation reacted positively to the proposed strategic ambitions. However, suggestions from the consultations showed that there was a need for a more "*radical"* approach and for these goals to be more long term to see the full impact.

There was also a view that the ambitions were very broad, with some of the questions raised being "*would this mean anything to the average person living in Coventry?"* and *"where is the focus on the person as a whole?"*

Short-term priorities

The top 3 initial priorities identified through the survey and St Peters Consultation were:

- Young People's Mental Health, Loneliness and Social Isolation and Giving every child the best start in life

Additionally, key priorities identified for the new Strategy through the VCSE Alliance Network meeting (prior to publication of the consultation proposals) were**:**

- Housing and Early help and support

The table below explores some of the reasons for these choices.

Young people's mental health	Important because *"mental health is the foundation for everyone's behaviour".* it is becoming a sector of increasing importance yet severely under resourced which puts pressure on health care providers.
Loneliness and isolation	Loneliness and Isolation is something that can affect everyone. *"Isolation can have devastating effects on someone's physical and mental health which in turn puts pressures on health providers".*
Giving every child the best start in life	Everyone should have a fair start – we need to focus support/interventions around children/young people. • Prevents future long term problems. • Need to address the impact of low-level skills/qualifications • The impact of parent's lifestyle choices on children.

	• Children are the future.
Homelessness and Temporary housing	• Young people are stuck in violent/abusive situations as they cannot afford to leave the family home • The homelessness strategy needs to be "*braver"*. • Housing/living conditions and basic needs such as access to food are essential.

Despite identifying three main priorities, it should also be noted the increasing difficulty participants had in choosing just three. It was felt that each priority interlinked and had an impact on each other.

3.2 Key consultation themes

Access to information / Communication

Across all three consultations the distribution of information and communication was a prominent theme. One of the main problems was where to find out about information regarding services/organisations. The feedback was about:

- Lack of communication between different sectors.

- Sectors need to share knowledge and expertise instead of working in isolation; this would improve relationships.

- From the survey and the community events at St Peters it was clear that people did not know where they could gain access to their personal records and information or information about other organisations and support. Suggestions to combat this were:

    - A register of small voluntary/community sector organisation.
    - Access to information on a central hub.
    - A referral system so that the support available to individuals is easily accessible.

- This was also reflected in VCSE consultation, suggesting we should share responsibility and strive to become a "*trauma informed"* city.

Working together to make it happen

Throughout each consultation there was a consensus that there is a need to facilitate collaboration between and within the public and voluntary and community sectors. Suggestions to address this included:

- Become clearer in which objectives to strive for. One suggestion was to clarify each organisation's role in how they can help deliver key priorities.

An example given in the survey was:

- *"What elements of demand are we most motivated to reduce? Demand at A&E, demand on GPs, demand for social care – then do we believe we can reduce demand, or should we focus on that demand is dealt with once it arises."* - by defining goals and outcomes and working together there will be measurable effects of how successful the strategy is.

- Involve key experts and professionals from organisations who can give insight and policy steer on issues around poverty and inequality.

- More support for the work of advice agencies by creating a formal link between them, this was also reflected in VCSE consultation where it was suggested that the 3rd sector could become a way of supporting people with multiple issues in a way that is right for them.

- Finance emerged as a key priority in how successful services can become to reach their full potential. It was felt that we are losing variety and breadth of voluntary sector organisations due to core funding cuts that negatively affects ability to support plans for change. This was also reflected in survey comments that suggested more investment be put into 3rd sector.

- There needs to be better collaboration and communication amongst the voluntary and community sector itself and with the public sector.

- Support needed to address barriers the voluntary and community sector face in working with the public sector.

Terminology and clarity of language

Across the consultation responses, there was a common theme about terminology and clarity of language used: it was felt that the approach to the strategies was too broad "*with no clear measurable out comes".*

- The meaning of the words used in the questions could be open to different interpretations, particularly regarding "sustainable", "successful" and "equality".

- The use of "successful" in the strategic ambition for children and young people was the most disputed word throughout the responses. Suggestions were to replace it with "*fulfilled*" or *"reach their full potential"*.

- Need to ensure the strategy is accessible to all and uses clear simple language. Feedback from VCSE consultation supports this as there was a lack of awareness of the phrase 'Marmot city' - where it comes from and what it means.

Poverty and the impacts of austerity

- Poverty is the overarching factor that affects each of the priorities; one of the main criticisms is that there is no reference to affordability.

- It was felt that some ill-health and poor well-being is determined by 'social factors' and can be prevented with the right support.

- People in employment are in crisis but not meeting statutory thresholds -nowhere to get support

- There is a serious issue of food crisis/food poverty in Coventry. There was a demand and *"urgent need for the City Council to create and deliver an 'emergency food programme' to address this."*

Environmental Impacts

- Despite the health impact of air quality not being identified as a key priority, there was significant discussions surrounding the wider implications this has.

- Growing infrastructure was seen to have a direct effect on health and the impact of air quality which caused fears for long term illness and the impact this would have on health providers.

- Working together to integrate individuals into their community which would lower crime rates and make the overall living environments more enjoyable.

Appendices:

Health and Wellbeing Strategy 2019-2023, Community Event

22nd May St Peters

Purpose of Event

The purpose was to test the proposals with community representatives and to galvanise energy around the city's Health and Wellbeing Strategy.

The proposals have been informed by extensive engagement that was undertaken with local people and community groups as part of the development of the place based Joint Strategic Needs Assessment.

Attendees

2 sessions were held

3.00pm – 5.00pm 17 attendees

6.00pm – 8.00pm 5 attendees

Both sessions followed the same format with an overview presentation and then table discussions.

Discussion 1

Priorities

Are the 3 ambitions the right ones?

1. People will be healthy and independent for longer
2. Children and young people will lead successful lives
3. People will live in connected, safe and sustainable communities

There was agreement that the ambitions made sense although there was a general feeling that they were broad and high level and the question was raised *would this mean anything to the average person living in Coventry?*

A large part of the discussion centred on the use of language concerning the meaning of the words as they could be open to different interpretations.

Some felt that "independent" could have negative connotations although there was a feeling that independent was a better term than "resilient".

The use of "successful" had the most adverse reaction, suggestions were to replace it with "fulfilled" as that would remove the judgement associated with successful.

"Successful reflects targets in education, fulfilling is a better word or achieving potential/thriving"

Again, the word "sustainable" was felt open to many interpretations a suggestion was to change it to "*stable*"

Discussion 2

Population Health Framework

There was overall agreement with the proposed diagram, but the overarching question was how was it going to be achieved?

"Who owns this strategy, it should be a shared responsibility – strong partnerships are needed"

"How does this plan link into other plans, we need a coherent city plan joining up all aspects of health and wellbeing … as well as large organisation's social responsibility e.g. the Universities.

The language needs to be simplified.

Public Sector Organisations Work Differently

A lot of positives were stressed by the attendees highlighting the energy and willingness of the sector to work together but a recognition that often they are called upon too late, there needs to be better collaboration and communication between the sector itself and with the public sector.

"*there is a need for the public sector to recognise the professional value of the Voluntary and Community Sector in the city and build it into the commissioning of services"*

There is a widespread silo mentality that needs overcoming and a disconnect between larger and smaller voluntary and community sector organisations.

"Groups want to work together but find it difficult to link into each other – can there be a single forum to engage with the sector and public sector leads"

A lot of the discussions around this section focussed on barriers that the voluntary and community sector face in working with the public sector. A key theme was the need for the sector to get support in terms of training/sharing best practice/marketing/meeting spaces

"A community development 101 based on SME federation model"

Council actions such as tendering out services results in a much more fragmented system as opposed to the integrated system that is being proposed.

Protected Characteristics

Discussions centred around the need to ensure the strategy is accessible to all and in clear, simple language.

The strategy needs to be fair and inclusive; one size does not necessarily fit all.

In Conclusion

Organisations were happy to give their time sharing their insights and valuable feedback but want to play an ongoing role.

"We want to continue this dialogue and keep engaged and be part of this change, but we don't know how?"

Specific Priorities to Focus on – sticker exercise

Young people's mental health	13
Social isolation and loneliness	12
Giving every child the best start in life	9
Temporary housing and homelessness	8
Young people and violence and exploitation	7
Health impact of air quality	5
Screening and immunisation uptake	3
Access to urgent care	3

Themes

Information	Issue of where to go to find out information about services/organisations A register of small voluntary/community sector organisations was suggested – successfully been achieved in homeless forum Difficult to navigate the health sector – need a mediator
Networks	Keen for opportunities for the sector to network and share good practice Bring smaller and larger organisations together Strong partnerships are needed
Corporate social responsibility	Lot of large organisations that can be doing more for the health and wellbeing of Coventry residents
Family hubs	Good practice that can be shared to Out of Hospital hubs – should be consistent practice
Volunteers	Lots of services relying on being volunteer led from an ever-shrinking pool as people are working for longer – need to think through implications before cutting services
Action Plan	How is this plan going to be delivered and measured? Will there be funding associated with delivering it? 4-year strategy needs breaking down – six monthly reviews to evaluate how we are doing things differently Will strategy target those that have less
Communication	Coventry relies on word of mouth – it's who you know
Support	Skills sharing sessions – how to market your organisation/social media training/business planning
Young People	Do we differentiate between students and young people?

	Young people need to be a priority they are the future
Community Engagement	Community identify needs and act upon it don't need the Council to lead Lots of engagement being undertaken need to join it up
Inequalities	People accessing services changing now people in employment in crisis but not meeting statutory thresholds -nowhere to get support Grassroots disengaged /division in the city - loss of sense of community Poverty is the overarching factor that affects all the priorities, there is no reference to affordability, levelling the playing field.

Health and Wellbeing Survey Analysis

Main themes

- The data gathered is more reflective of individual opinions (112) than that of organisations (19).

- Most respondents were either a Member of the General Public (77) or a Coventry City Council employee (25).

- Overall, participants reacted positively to the proposed strategic ambitions, with 95%, 81% and 91% agreeing with the three ambitions respectively.

- 112 (88%) respondents agreed we need to change the way we work together.

- 113 (90%) agreed that public sector organisations should work differently with communities.

- The majority of respondents thought the ambitions and health framework would have a positive impact by 'providing an opportunity to engage populations that are normally hard to engage with.'

- Young People's Mental Health & Loneliness and Social Isolation were identified as top initial priorities.

- The most prevalent characteristics of respondents are; White British, women and ages 45 to 64.

About the Survey

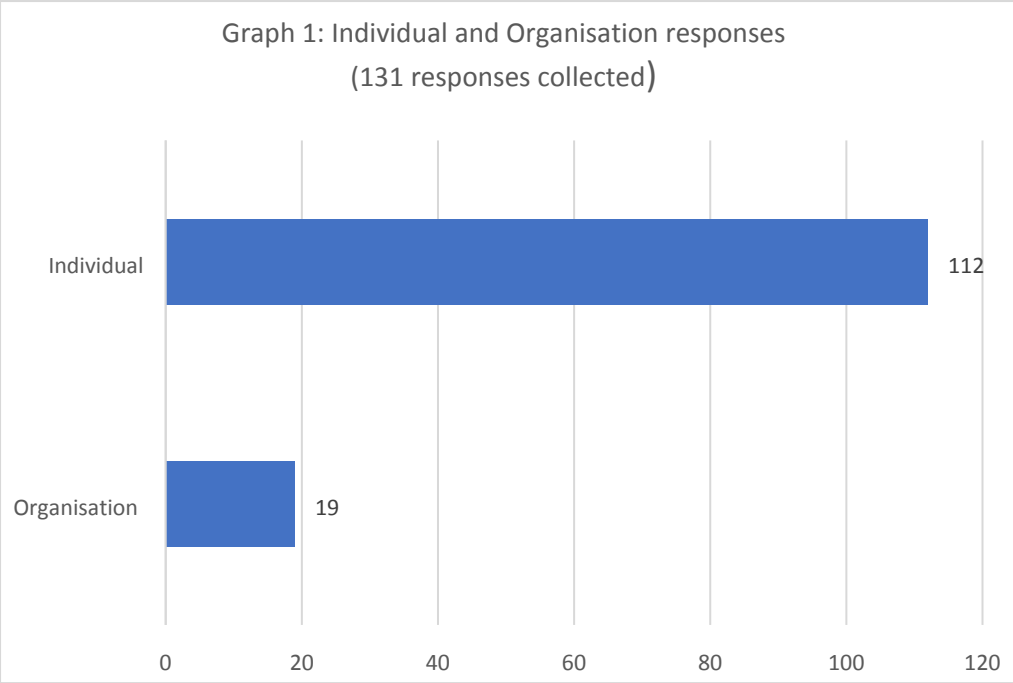
The purpose of this survey was to test the proposed population health framework, confirm our priorities, build consensus and galvanise energy and resource around the city's strategy for improving health and wellbeing.

The Health and Wellbeing Survey was available online between 10/05/19 – 03/06/19. Paper copies were available on request

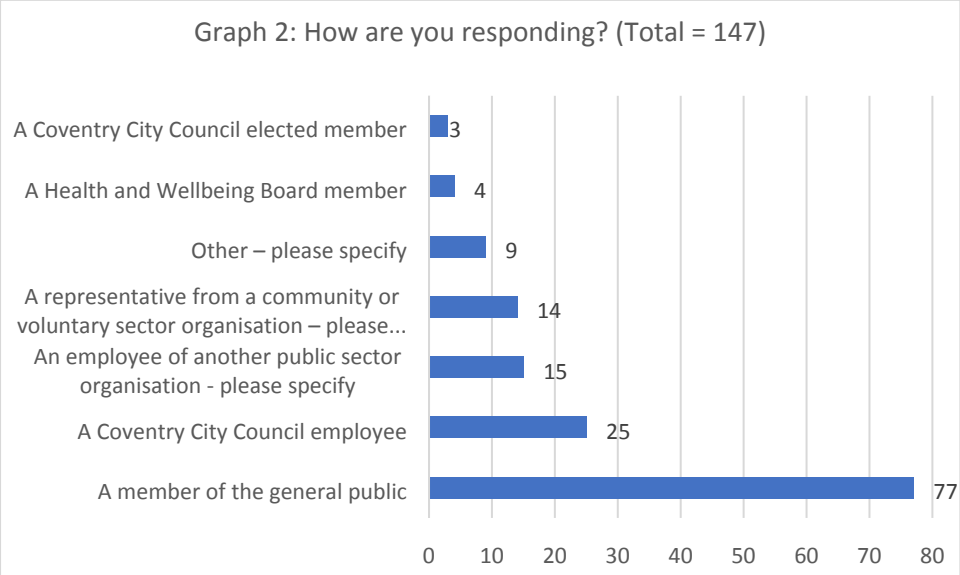
Respondents (Q1, Q2)

A total of 133 people completed the survey online and via postal votes.

The following graph shows whether participants were responding as an individual or as an organisation. The graph shows that the data gathered is more reflective of individual opinions than that of organisations.



As a follow up question, participants were asked to specify how they were responding to the survey, providing insight as to which organisations they belong to. Graph 2 presents the results.



As the total number of data entries to this question (147) is higher than the total of 133 participants, several respondents did select more than 1 answer. The companies listed in the 'other – please

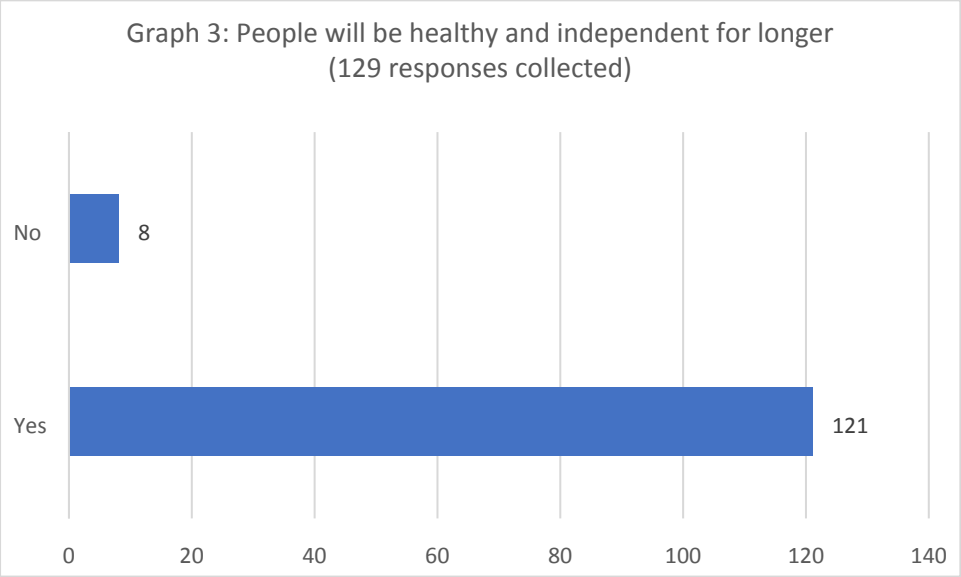
specify' were: Welfare Reform Working Together Group, Multiagency Social Isolation and Loneliness group, NHS employee, A Resident, Coventry Green Space forum, A Local business providing health and wellbeing support and The Amethyst Centre.

What do we want to achieve? (Q3)

The survey addressed key priorities within the Health and Wellbeing Strategy. Participants were asked about three main ambitions and whether they felt these were the right ones. The proposed strategies were:

I. People will be healthy and independent for longer
II. Children and young people will lead successful lives
III. People will live in connected, safe and sustainable communities

<u>People will be healthy and independent for longer</u>



Among the 8 respondents who disagreed the two main reasons were:

- Concerns for the environment.
- Concerns as to how realistic these goals may be.

The following insights are from 8 respondents leaving direct comments on this question.

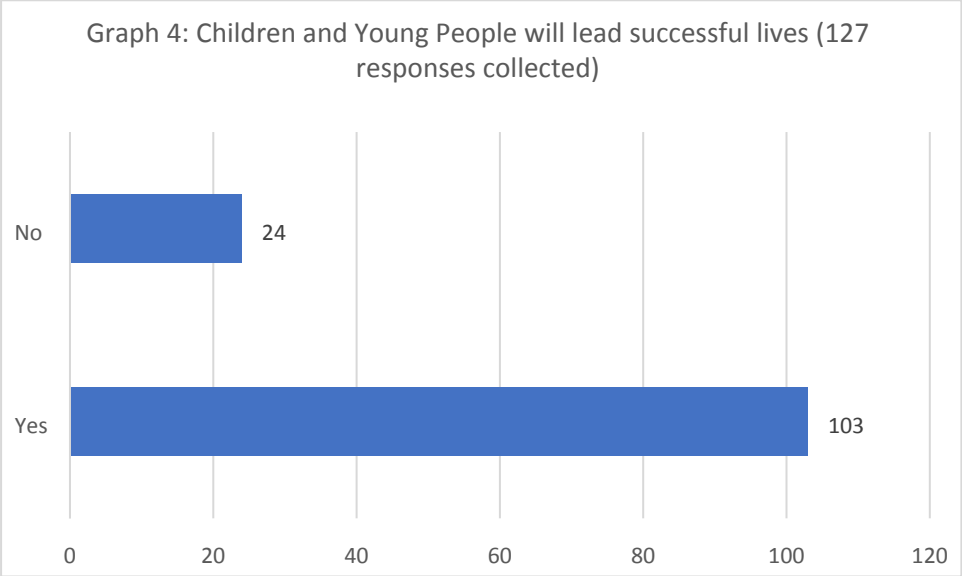
- 2 respondents discussed air pollution and the quality of air within the city having a direct impact on individuals living healthy and independent lives – 1 respondent felt that car fumes and infrastructures being built would have a direct impact on individuals.

- 1 respondent felt that the rapid growth of convenience food and fast food outlets contributed to unrealistic aims of enabling people to be healthy and independent for longer.

- 4 participants suggested that it is not possible to *"eradicate health inequalities*". Reducing health harming behaviours through education and service provision would be more beneficial.

- 1 response referred to accessibility to "*empower"* people to take control of their own health care.

Children and young people will lead successful lives



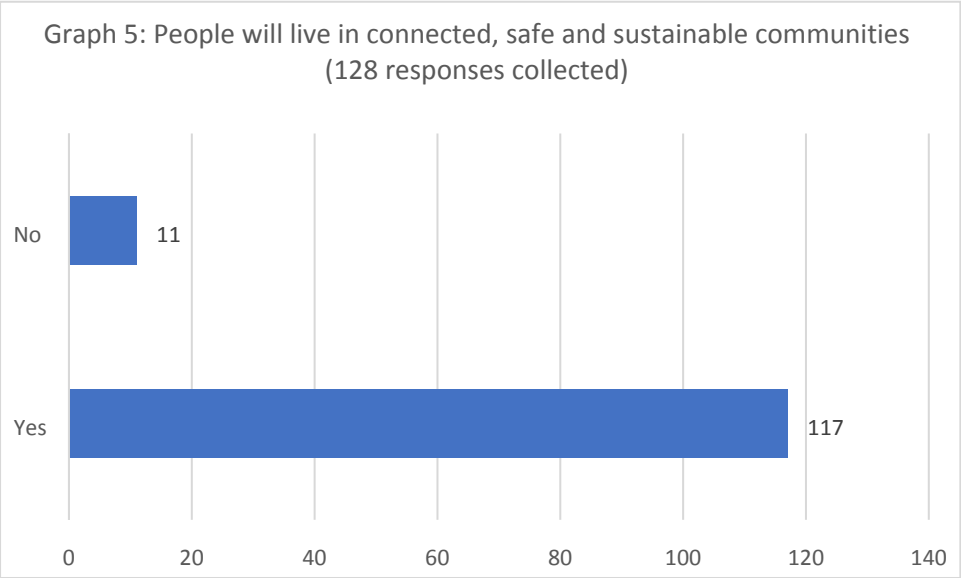
Out of the 24 (18%) respondents who disagreed with the proposed strategic ambition, the following were the reasons why not:

- 20 (77%) felt that the term "s*uccessful*" was too ambiguous and were uncertain as to how this could "*translate into measurable, specific goals for the council to achieve*". Instead of leading successful lives, participants suggested that children should *"reach their full potential"* as every child is different, and success is a subjective term.

- 5 (19%) responses concerned access to available services. Early intervention was a key priority; however, it is felt that due to a lack of coordination of resources and finances this area was not performing as well as it could be, giving way to crime and harmful behaviours. This also extended to provision of support during school holidays and *"addressing other issues like unemployment and parental conflict".*

- 1 (4%) respondent felt that the focus should not just be on children and young people and that provisions should be made to ensure that **everyone** will have the opportunity to lead successful lives.

People will live in connected, safe and sustainable communities



11 people (9%) disagreed that people will live in connected safe and sustainable communities. This is due to the lack of deep and meaningful connections made by individuals within a community.

- There was a disparity into how much time and support individuals invest in communities and that although the goals are achievable it will "*take a long time to embed this"*.

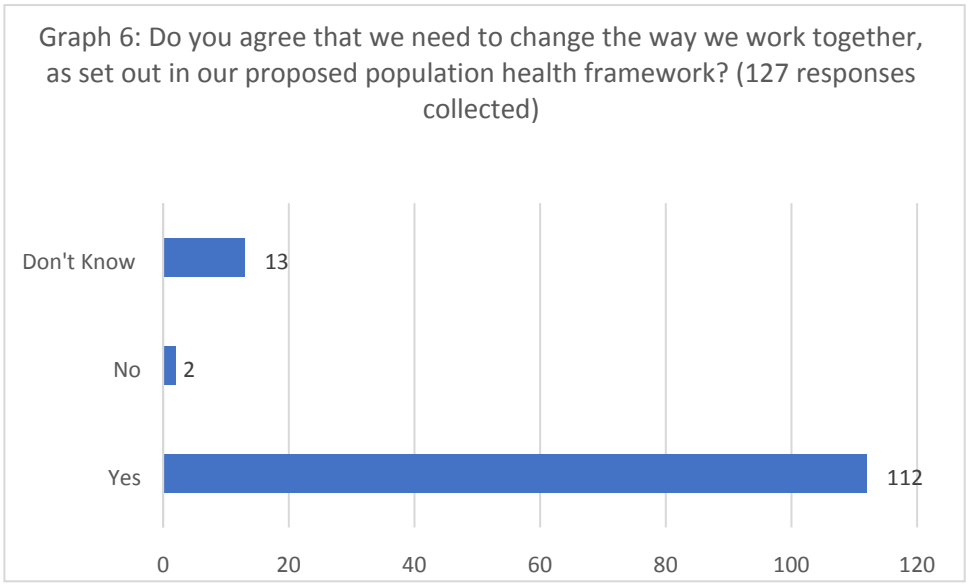
- It was also highlighted that there were a lack of communication and people did not feel connected to their communities.

- 2 respondents said that the lack of police presence and communities working together directly influenced how safe they felt within their communities.

- 3 respondents felt that there was too much focus on "*periphery issues*" and that direct action needs to be taken to combat unemployment, housing and welfare which is damaging the city and its visitors.

- 2 participants stated that 'connected, safe and sustainable' were too subjective and suggested that clearer definition was needed to fully answer the question.

Our population health framework (Q4)



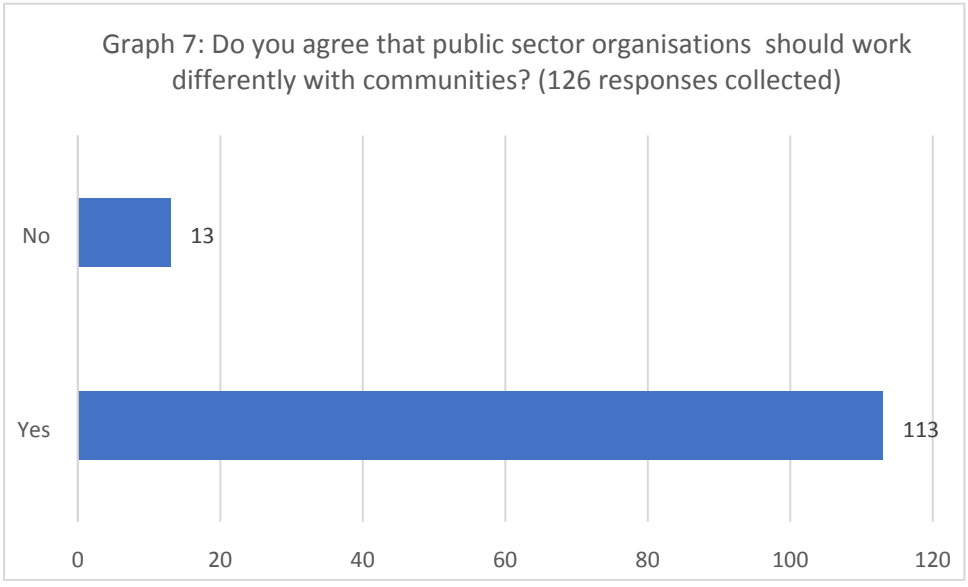
The following are insights from 47 people commenting why they agreed:

- Significant links were made to the ways in which different sectors of Coventry communicate with each other, both internally and externally.

- A key concern for 26 (55%) respondents was having knowledge and an **access point** in gaining information about their records and meeting their needs. A suggestion to combat this was through partnership working, it is felt that this *"is a key factor in creating cost efficient synergies"*.

- 12 (26%) participants suggested that the ways in which voluntary and public sectors engage with one another do not always make most use of "*resources and time*".

Public sector organisations working differently with communities (Q5)



The large majority 113 (90%) agreed on this question. Of the various ideas people had how to work differently, the following were the most prevalent themes:

- Accessibility – respondents called for a need to support people in referring themselves to services. This would cut waiting time and avoid further deterioration of health.

- Communication - People felt it was "*done to them*" rather than with them. Therefore, within the responses there was a demand for "*Open communication spaces between public sector and communities need to exist to build trust, understanding of roles, and relationships*".

- Communities - Participants felt *"individuals, families and communities have many of the answers to the vulnerabilities within our population and can, if supported in the right way, strengthen and support each other".* This was also seen as a way to reduce the cost of other sectors and to promote what public sector organisations have to offer.

How do you think our strategic ambitions and proposed population health framework would affect people who share protected characteristics? (Q6)

A total of 70 people responded to this question.

- 43 (61%) respondents felt that it would have a positive impact as it *"provides an opportunity to engage populations that are normally hard to engage with"* which would empower the most marginalised people in Coventry.

- 12 (17%) respondents felt that irrespective of protected characteristics the strategy should work towards helping everyone ensuring that more people's needs are met.

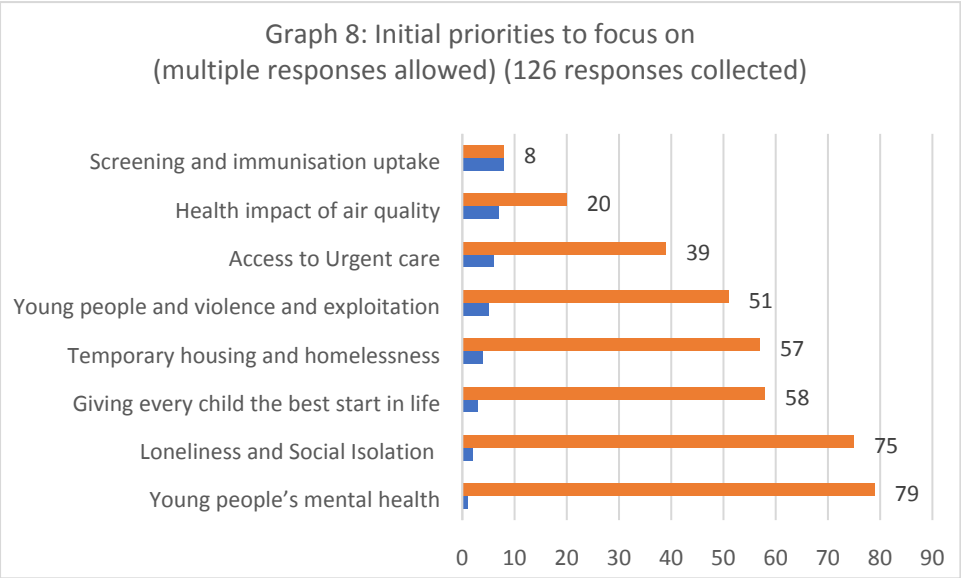
- 12 (17%) respondents felt that the question was too broad to give a definitive response suggesting that "*equality means different things to different people".*

- 5 (7%) respondents felt the strategy will have no impact, the main reason being *"money needs to be used more wisely and put into strategic ambitions,"* and that breakdown of communication between all agencies has made it impossible to build connections with people with protected characteristics.

- Communication - The third sector played a pivotal role in improving communication as it was felt these partnerships would be able to identify where services are lacking at a much faster rate. With this, respondents suggested that this would bring a more "*cohesive community and reduced isolation"*.

Identifying initial priorities (Q7)

Participants were asked to identify 3 initial priorities from a predetermined list to have some input on what to focus on and were then asked to explain why. The results are shown in the chart below.



The most important priority with 79 (63%) of respondents choosing it as one of their top 3 priorities, was young people's mental health. The main reasoning for this was that *"mental health is the foundation for everyone's behaviour".* It is also noteworthy that it was felt this sector is becoming increasingly important but is also one with minimal resources. Long waiting lists and a lack of access to urgent care were key concerns, especially when crossing the barrier between adolescent mental health and adult mental health. One respondent stressed a need for *"a more imaginative and joined up approach including preventative strategies"* which would provide a solution to some of the difficulties the current strategies face.

The next key priority was addressing loneliness and social isolation, 75 (60%) respondents chose this priority as one of their top three. This also had direct links with poor mental health. One respondent suggested "*Loneliness and social isolation can have devastating effects on someone's physical and mental health which in turn puts pressures on health providers".*
Empowering communities and individuals to act in other areas of their lives, became a second theme within these responses as loneliness and isolation was an issue that effected people of all ages. One respondent suggested that communication and advertisement of support groups that are locally available to more isolated groups could reduce the impact of loneliness and isolation.

58 (46%) respondents felt that giving every child the best start in life was a key priority. The most common reasoning for this was because "*children are our future*". Nurturing children from an early age creates stable and responsible adults and prevents future long term problems. One respondent suggested that "*giving children the education and tools to live fulfilling lives where they can contribute to society*" which enables children to become empowered adults.

A recurring theme throughout the survey was the problem of temporary housing and homelessness, 57 (45%) of respondents felt that this was a crucial priority. 7 respondents referred to the increasing visual impacts homelessness has on the streets suggesting that it *"tolerance of long-term visible homelessness negatively affects the whole community".* 15 respondents suggested that temporary housing and homelessness has a detrimental effect on all aspects of an individual's life, particularly their mental health, and directly impacts the safety of other members of the community.

51 (40%) of respondents felt that young people and violence and exploitation needs to be a priority with the assumption that knife crime in the city has risen due to the failure of other strategies. Respondents stressed the importance of creating a positive community to engage young people and encourage them to take responsibility. One preventative suggestion made was that more funding to

support more youth groups and ensure that children and young people feel part of their community as it was felt that "*Gang culture develops where there is boredom and mischief."* A second recommendation was that more local policing and the community work together to combat crime.

39 (31%) of respondents suggested that access to urgent care was a top priority with respondents suggesting that waiting lists are too long and can have a negative impact on individuals. It was felt that with "*more immediate and urgent care will reduce the number of fatalities and ease the strain on NHS staff"* which in turn can prevent future poor health.

The categories with the fewest responses were health impact of air quality, with 20 (16%) respondents choosing it as a priority and screening and immunisation uptake with 8 (6%) respondents making it a priority. It was felt that screening and immunisation uptakes were crucial in preventing local epidemics however to do this the health service needed to "*reach out to minorities and reduce health inequalities".* Growing infrastructure was seen to have a direct effect on health and the impact of air quality which caused fears for long term illness and the impact this would have on health providers.

Respondents strongly felt that all 8 of these priorities impacted each other and found it difficult to disassociate them from one another.

Additional comments from participants (Q8)

The final question gave individuals the opportunity to share their opinion on the plans for health and wellbeing in Coventry. Of the 53 people who responded two clear themes could be distinguished.

- A need for support between organisations to build working relationships that allow individuals to access advice and support.

- Working more collaboratively and pooling resources and data.

- Investment into the 3rd sector and communities, particularly into supportive activities and services to help *"empower the community to be the best they can be*".
  Suggestions included:

    - More youth groups and support for families
    - Integrating the elderly into their communities, particularly those with dementia. One respondent suggested dances and young people visiting the elderly.
    - Providing services to "create a safe, engaging and vibrant place to live and work".
    - Early intervention, addressing food poverty.
    - Find creative solutions to break down isolation.
    - Improved support for sports and wellness activities, especially free ones.
    - Outside of working hours support for those in full time employment.

<u>Suggestions for action</u>

- One of the proposals for action was to invoke a new volunteer-based approach to care. It was suggested that the British Red Cross in Coventry launches a local scheme which:
    - Registers with the care quality commission
    - Is supported by the council and chairmen of the NHS hospital trust
    - Referral only by the hospital and is free of charge to all patients
    - Volunteer recruits who are organised, trained and have the appropriate equipment

    - Invoke a cost per mile basis for individuals who are hard to reach.

- Include key experts and professionals from organisations who can give insight and policy steer on issues around poverty and inequality and support the work of advice agencies by creating a formal link between them.

- One respondent suggested more social media and email-based communication, particularly for young people around suicide prevention.

- Remove bus lanes and encourage walking, cycling and the use of public transport.

- Pilot a multi -agency team approach within the community so that people are not *"exasperated with telling their story".*

- One respondent proposed that less is spent on projects such a music festivals and the funds that would have been generated could be used for improving resident's health and life style.

- One connected platform that helps navigate what is available in the area, map current activities and identify gaps.

- Practical work in primary schools regarding healthy eating, schools should grow herbs, fruit and vegetables.

- 4 respondents suggested a clear referral system to community-based organisations and a collaboration across sectors.

- Establish ways / forums where voices can be heard, but anonymity protected.

- Adopt initiatives used by Universities to tackle loneliness.

- Replicate national campaigns on screening and immunisation.

- Create and deliver an emergency food programme.

Equalities Data

The following is an overview of the equalities data. The corresponding graphs are presented thereafter.

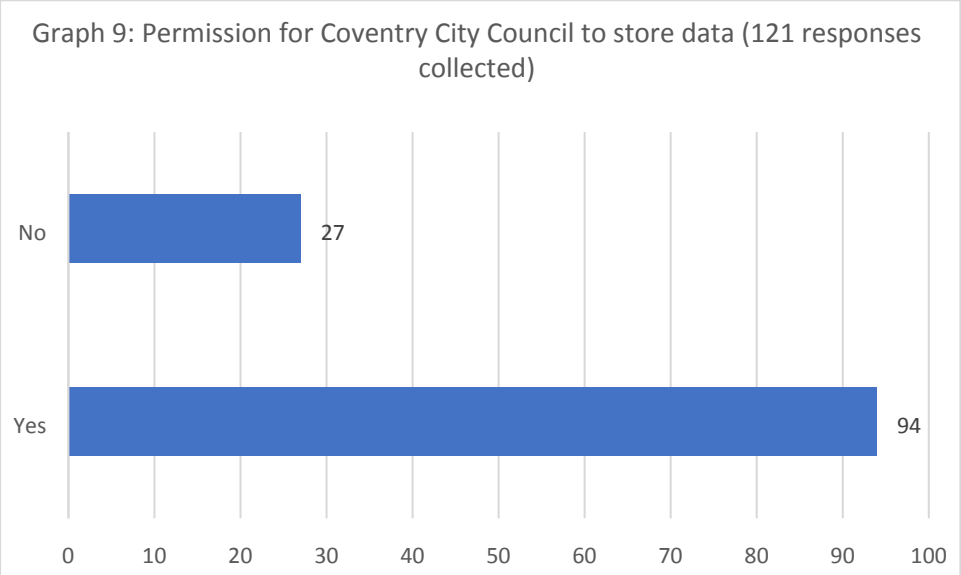
- 94 (78%) of the 121 respondents gave permission for the Coventry City Council to store their data.

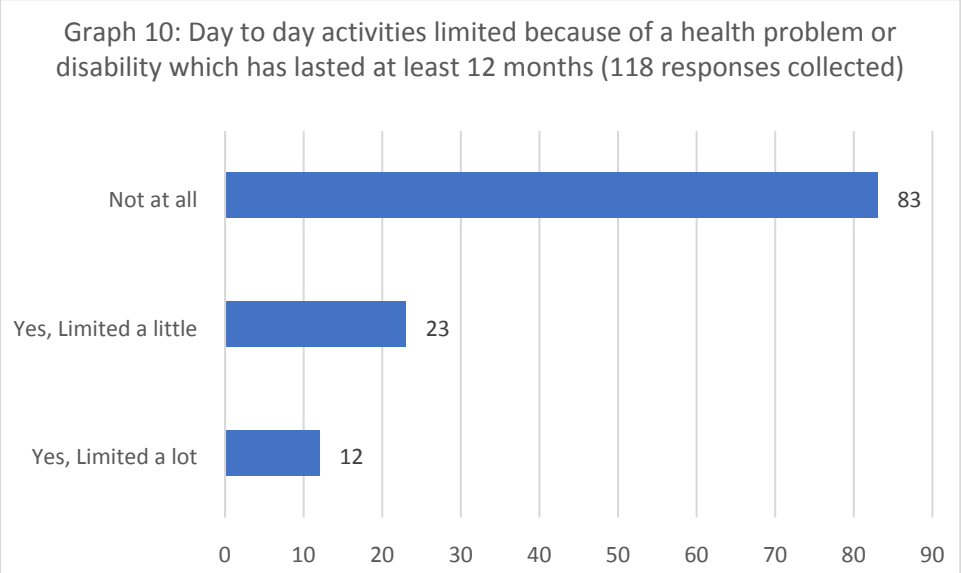
- Most participants' (70%) day to day activities were not limited because of a health problem or disability in the last 12 months.

- The most popular age range was those between 45 and 64 with those under 34 being the least represented.

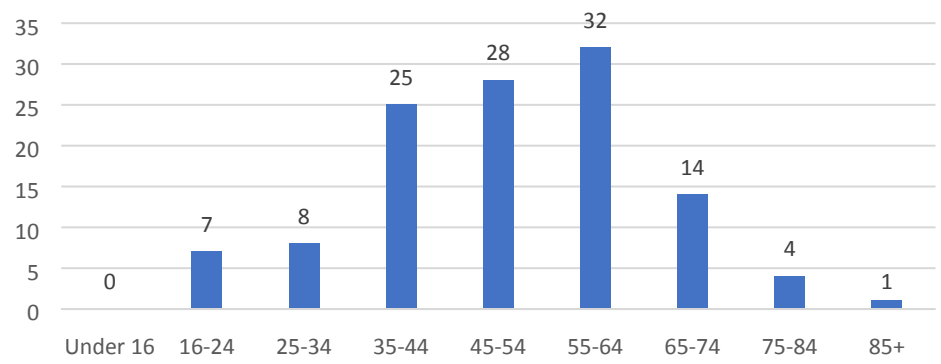
- 64% of respondents were female.

- 98 (87%) respondents identity matched their sex registered at birth.
- 82 participants (80%) described their ethnicity as white British.
- Christianity (46%) was the most common religious belief.
- Most respondent's sexual orientation (77%) was straight heterosexual.

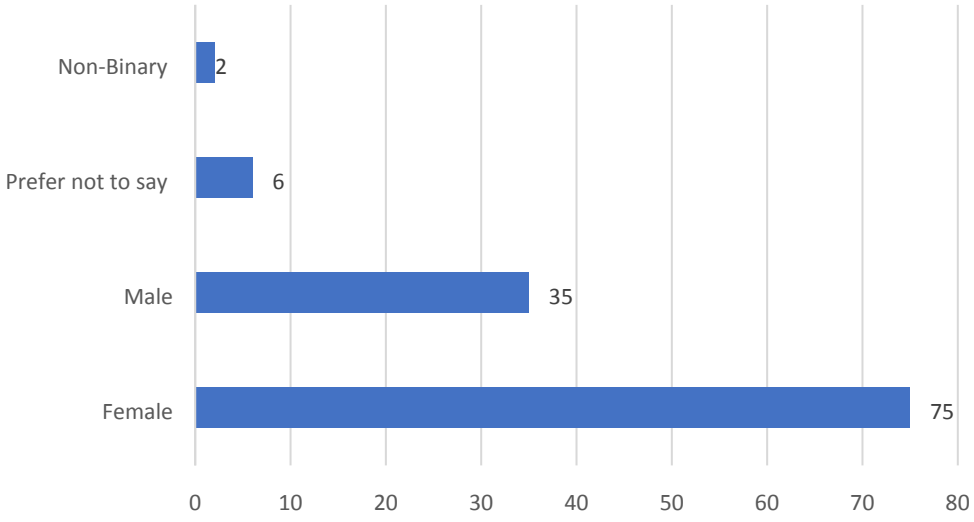




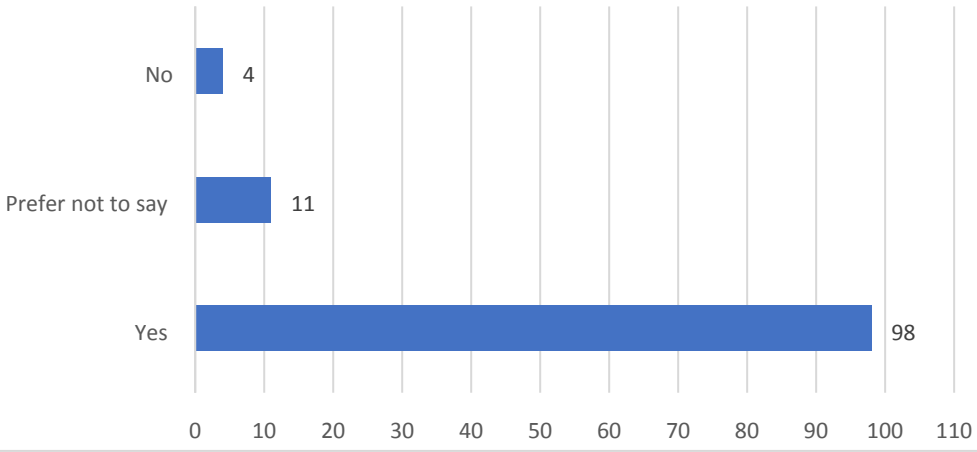
Graph 11: Age of respondents (119 responses collected)

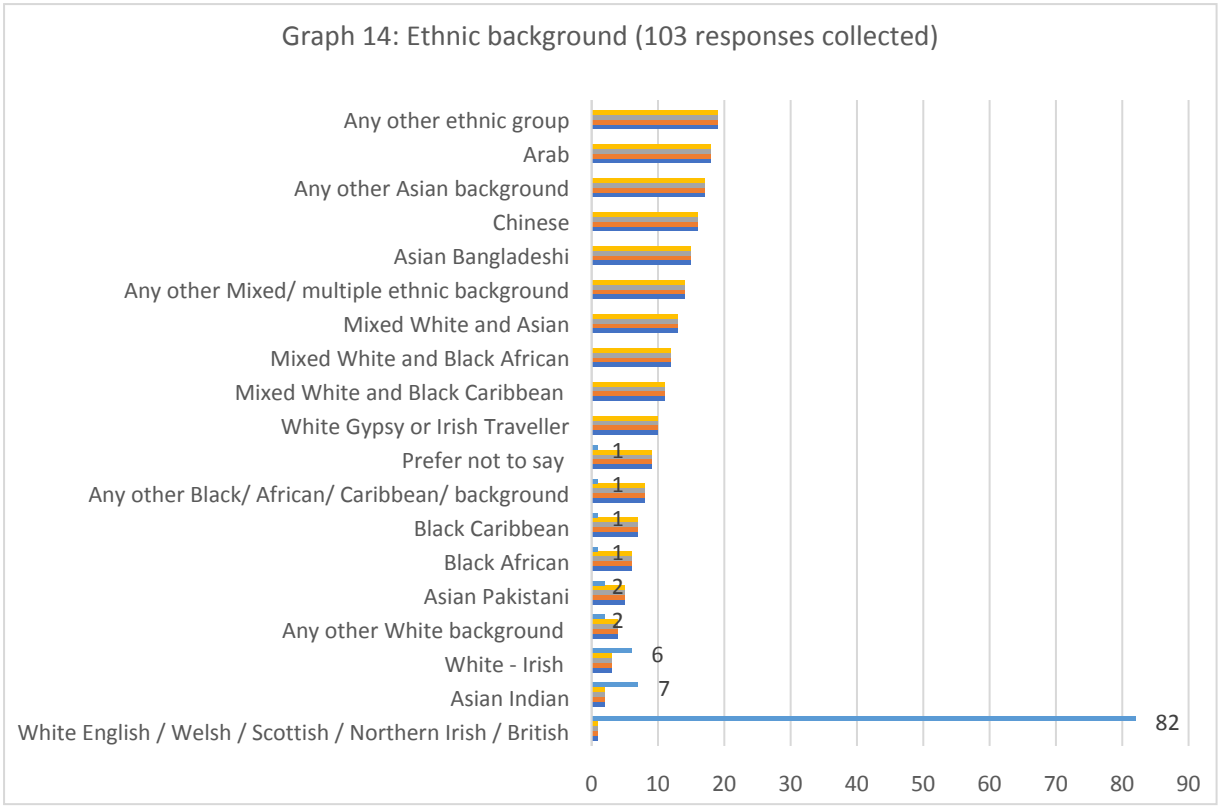


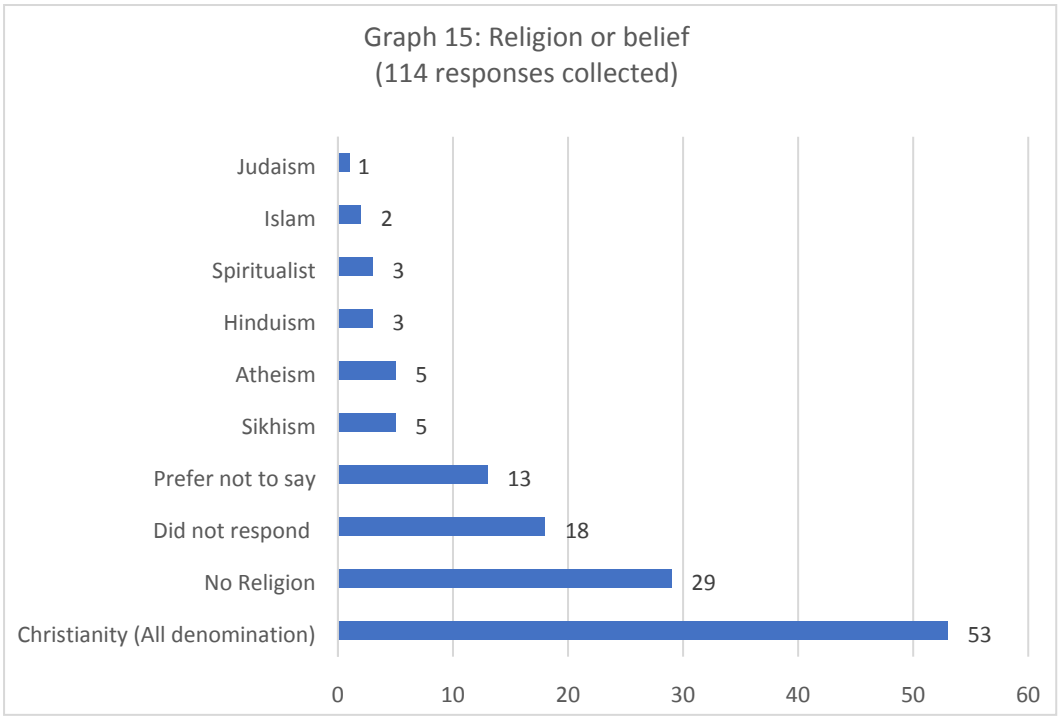
Graph 12: Sex of respondents (118 responses collected)

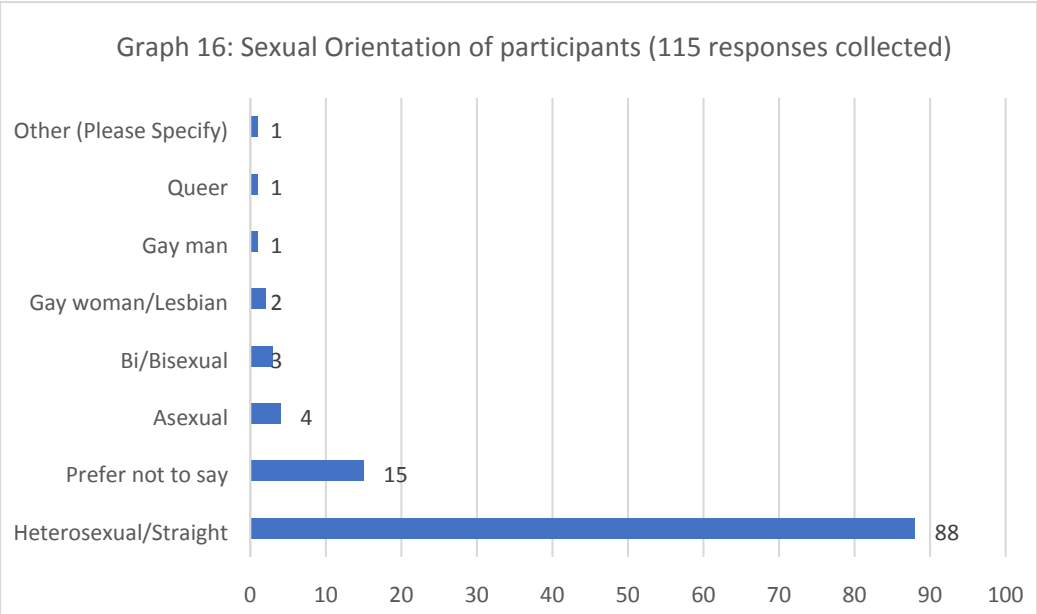


Graph 13: Does your identity match your sex as registered at birth? (113 responses collected)




Graph 14: Ethnic background (103 responses collected)
Any other ethnic group
Arab
Any other Asian background
Chinese
Asian Bangladeshi
Any other Mixed/ multiple ethnic background
Mixed White and Asian
Mixed White and Black African
Mixed White and Black Caribbean
White Gypsy or Irish Traveller
Prefer not to say
Any other Black/ African/ Caribbean/ background
Black Caribbean
Black African
Asian Pakistani
Any other White background
White - Irish
Asian Indian
White English / Welsh / Scottish / Northern Irish / British
1
1
1
1
2
2
6
7
82
0
10
20
30
40
50
60
70
80
90


Graph 15: Religion or belief
(114 responses collected)
Judaism
Islam
Spiritualist
Hinduism
Atheism
Sikhism
Prefer not to say
Did not respond
No Religion
Christianity (All denomination)
1
2
3
3
5
5
13
18
29
53
0
10
20
30
40
50
60


Graph 16: Sexual Orientation of participants (115 responses collected)
Other (Please Specify)
1
Queer
1
Gay man
1
Gay woman/Lesbian
2
Bi/Bisexual
3
Asexual
4
Prefer not to say
15
Heterosexual/Straight
88
0
10
20
30
40
50
60
70
80
90
100

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Draft Coventry Health and Wellbeing Strategy 2019-2023

1. Introduction

Our new Health and Wellbeing Strategy presents a real opportunity to make a difference to the health and wellbeing of everyone in our city. We have developed our Strategy in a context of change and uncertainty which brings both challenges and opportunities. Within our communities we see the legacy of austerity, most evident in the stubborn inequalities in our city, as well as the impact of ongoing economic uncertainty. Nationally, public policy is shifting – the NHS long-term plan confirms a greater focus on prevention, whilst health and social care integration is moving at pace, with changes to organisational structures emerging as local areas move towards new 'integrated care systems'.

Within Coventry, the four years of our Strategy are framed by significant opportunities to promote and improve health and wellbeing in the city; the Coventry and Warwickshire Year of Wellbeing and Coventry European City of Sport in 2019, and Coventry UK City of Culture in 2021. Already the Year of Wellbeing is building momentum and commitment around health and wellbeing, and the European City of Sport is contributing to the physical activity agenda. The UK City of Culture programme is recognised as an opportunity to improve health and wellbeing outcomes for the city and accelerate efforts to address the wider determinants of health, such as jobs and economic growth, community cohesion and a sense of place, and raised aspirations and school attainment.

To address the challenges we are facing, and build on these opportunities, we are setting out a radically new approach in this Health and Wellbeing Strategy. The Strategy covers a period of 4 years, but we see this as an approach that could shape our work for the longer term. We set out high level ambitions that we think will stand the test of time, but with the ability to adapt our specific focus and evolve our approach to reflect the rapidly changing context in which we are working.

2. What is our Health and Wellbeing Strategy?

The Coventry Health and Wellbeing Strategy is the city's high level plan for reducing health inequalities and improving health and wellbeing for Coventry residents.

The Strategy is owned by the Coventry Health and Wellbeing Board, which brings together senior leaders from Coventry City Council, West Midlands Police, West Midlands Fire Service, voluntary sector organisations, Coventry and Rugby Clinical Commissioning Group, acute and community NHS trusts, and local universities. The Health and Wellbeing Board has a statutory responsibility to understand current and future health and social care needs and to translate these findings into clear outcomes the Board wants to achieve.

This Strategy has been developed in partnership with senior leaders from across the public and voluntary and community sectors. It is informed by data and engagement evidence from our Joint Strategic Needs Assessment and learning from our 2016-19 Joint Health and Wellbeing Strategy, as well as drawing on national research and good practice. We consulted with

stakeholders, communities and the public on our proposals and have reflected the feedback in this final plan.

The Strategy sets out a four-year vision for health and wellbeing in Coventry and will be used by local health and care partners to inform plans for commissioning services and shape how we work together to meet health and social care needs and address the social determinants of health.

3. Our journey

Coventry has been tackling health inequalities as a Marmot City since 2013. Our Health and Wellbeing Strategy 2016-19 galvanised commitment to work in partnership around key priorities and clear benefits were realised through new partnership structures and collaborations with organisations that may not historically have recognised their role in contributing to health and wellbeing outcomes. Partnership is now in our DNA as a city.

However, we have recognised that although we have strong partnership working around specific priorities, we don't always join up what we do and make the connections between different areas of work and we don't always work as closely with our communities as we could. This means we miss opportunities to identify synergies and complementary activity and do not always get the best outcomes as a result.

To do this better we need to move to a 'population health' approach which takes a holistic view of everything that impacts on people's health and wellbeing across the whole population, with an emphasis on reducing inequalities in health as well as improving health overall.

4. Expanding our work – The case for change

We know from our analysis of evidence from data sources and from our engagement with residents and community organisations that:

- **Coventry has a growing, changing and increasingly diverse population.** Whilst population growth has been highest amongst 18-29 year olds, the growth of over-65s is expected to accelerate and outpace other groups within 10-15 years. This means there is a need to focus on preventative health amongst the working age population now to help manage future demand on health and care services. With population growth concentrated in certain parts of the city, there is an increasing imperative to take a place-based approach to service planning.

- **Overall health in the city is below average, with residents living in more deprived parts of the city not only living shorter lives but also spending a greater proportion of their lives in poor health.** Males living in some parts of the city can expect to live up to 10 years longer; and for females, the gap is 8 years. This difference is linked to a number of inequalities related to poverty. Premature mortality is also higher than average in the city and there are avoidable differences in health outcomes, particularly around issues such as alcohol use, obesity / physical activity, Tuberculosis and sexual health.

- **Despite the city's comparatively good performance in the areas of education and skills and economic growth, significant pockets of deprivation limit people's opportunities to succeed in life.** 19% of Coventry neighbourhoods are amongst the 10% most deprived nationally and by the age of five, fewer children achieve a good level of development (68%) than nationally (72%) or in similar places, with the more disadvantaged even further behind. We know that social inequalities and life chances are already established from these early years of life.

- **Increasing fear of crime impacts on residents' health and wellbeing**, with an increase in violent crime (reflecting national trends) and people in the city reporting feeling increasingly unsafe. **Most notably nearly a third of young people feel unsafe in the city**, with only 16% of the city's young people saying they felt very safe or safe in the city in 2018.

- **The city has a high level of homelessness, particularly amongst young people and families.** This is putting sustained and significant pressures on the local housing system. At any one night in 2017/18, between 190 to 250 Coventry families with dependent children spent the night living in emergency or temporary accommodation. We know that good quality housing for all leads to better health and wellbeing, as it affects early years outcomes, educational achievement, economic prosperity and community safety.

A significant part of the challenge in Coventry, as elsewhere, is to break the link between poor health and poverty.

Community organisations we spoke to told us that communities are best placed to address health challenges. This is because they have networks, understanding and legitimacy. However, their resources are limited and capacity is stretched. The public sector must therefore change how it works with communities, by shifting to an 'enabling' leadership style, joining forces and building capacity.

More information about the findings from our Joint Strategic Needs Assessment can be found at www.coventry.gov.uk/jsna/.

5. Our long-term vision for change: what do we want to achieve over the next 4 years?

We are proposing **three strategic ambitions** for the health and wellbeing of our residents which together encompass our **long-term vision for change** for health and wellbeing in Coventry.

The outcomes we hope to achieve are:

1. People are healthier and independent for longer

By this we mean promoting healthy lifestyles and behaviours to help people stay healthy and well and prevent limiting long-term health conditions. This also means, where people have existing health problems, preventing these from escalating to the point where they require significant, complex and specialist health and care interventions. It means helping people to age well, with health and social care working together to prevent long term health conditions and

slow the development of older people's frailty. The focus is on empowering people to take action to improve health and wellbeing for themselves and others (our Year of Wellbeing vision) and providing effective, timely and appropriate support where it is needed.

We will monitor our direction of travel against this ambition through key performance indicators, for example:

- Healthy life expectancy
- Physically active adults
- Screening and immunisations take-up
- Emergency readmissions
- Dementia diagnosis
- Premature mortality / morbidity (years lived with disease)

2. Children and young people fulfil their potential

By this we mean we want to work together as partners to make sure that every child in the city has the same opportunity to thrive. We want to make sure that every child has the best possible start in life because we know that getting this right is key to tackling health and social inequalities and preventing poor outcomes. This also means that all children are supported to reach their potential in school, further education and employment, and that families are supported to make healthy lifestyle choices. Improving opportunities for children and young people will help address concerns in the city around violence and exploitation and young people's mental health. With a younger than average population in the city, we know that a specific focus on children and young people in Coventry is important.

We will monitor our direction of travel against this ambition through key performance indicators, for example:

- Good level of development (5 year olds)
- Healthy weight Year 6 (childhood obesity)
- Young people feeling safe
- Proportion of young people progressing into sustainable education, employment or training
- Child and Adolescent Mental Health Services – demand / performance
- Children living in poverty

3. People live in connected, safe and sustainable communities

By this we mean working together to create communities that have a healthy environment, economic prosperity and where the social needs of people are met. This includes action to address climate change and improve air quality, for example through promoting active travel. It is also about working together in local places to build community resilience and promote community cohesion. It means building communities where everyone in our diverse population has a stake and has the opportunity to thrive – where people have access to jobs, secure housing, feel safe and are connected with people around them.

We will monitor our direction of travel against this ambition through key performance indicators, for example:

- Families in temporary accommodation
- Fuel poverty
- Self-reported wellbeing
- Gross Disposable Household Income
- Air quality (NO_2)
- Residents' self-reported ability to influence / improve local area

6. How we will do this – our population health framework

There is consensus nationally that to reduce health inequalities and improve health outcomes, we need a population health approach.

Our population health framework will underpin everything we do as a health and wellbeing system in Coventry to achieve our long-term vision for change. Taken from a model developed by the King's Fund (a national health and care think tank), this is based on four components that impact on people's health and wellbeing. For us in Coventry this means:

- **Wider determinants** – embedding the Marmot City approach by working in partnership across different services and organisations to tackle health inequalities through addressing the social determinants of health such as income and wealth, education, housing, transport, environment and leisure; to break the link between poverty and poor health
- **Our health behaviours and lifestyles** – aligning and coordinating prevention programmes across the system to maximise impact and tackle barriers to healthy lifestyle, including around mental wellbeing, diet, exercise, smoking and drugs and alcohol
- **The places and communities we live in and with** – working together in our places and with our communities to mobilise solutions for improved health and wellbeing, informed by our understanding of local needs and assets from our place-based JSNAs
- **An integrated health and care system** – health and social care commissioners and providers working together in a joined-up way to commission and deliver seamless local services in Coventry

We plan to invest our energies and resources in making sure we get these foundations right and we will make sure that all of our plans and activities consider each of these components and – most importantly – the connections between them. The Health and Wellbeing Board will be the place where these connections are made at a strategic level.

7. Our short-term focus

We have identified **three areas of focus** that we will use to bring our population health framework to life – they will be our test bed for learning how to do things differently and change the culture of how we work.

These are specific areas where we want to make a tangible difference in the next 12-18 months by working together in partnership. We know that there is a wealth of great work already being done in these areas and our challenge is to add value as partners by making connections and creating energy and momentum to upscale existing activity. We will look at each area through the lens of our population health framework, identifying how each component contributes to addressing the issue and links to the others.

We think that these are all areas that – if we make a difference here – will impact positively on other health and wellbeing issues and priorities for the city.

1. Loneliness and social isolation

The Campaign to End Loneliness cites growing research evidence about the detrimental impact of loneliness and social isolation on health and wellbeing:

"Loneliness and social isolation are harmful to our health: research shows that lacking social connections is as damaging to our health as smoking 15 cigarettes a day (Holt-Lunstad, 2015). Social networks and friendships not only have an impact *on reducing the risk of mortality or developing certain diseases, but they also help individuals to recover when they do fall ill (Marmot, 2010). Loneliness increases the likelihood of mortality by 26%."*

Tackling loneliness and social isolation can also help to reduce the burden on health and care services, building resilience that enables people to remain independent for longer and addressing social needs outside of formal settings.

We know from our engagement that loneliness and social isolation affects people of all ages and there is a real opportunity for partners to work together differently to empower communities and individuals to become better connected and more resilient in combating loneliness and isolation.

This could mean:

- tackling the social, economic and environmental barriers to connectedness throughout the life course, including poverty
- Facilitating, empowering and working with existing networks and social activities that promote healthy lifestyles
- understanding, mobilising and strengthening local community assets to prevent loneliness and social isolation
- building on community-based integrated care models such as Out of Hospital care models (including care navigators) and social prescribing

2. Young people's mental health

Nationally the latest evidence suggests that one in ten young people has some form of diagnosable mental health condition and that children with a mental health problem face unequal chances in their lives. According to Coventry and Warwickshire Children and Young People's Child and Adolescent Mental Health Services (CAMHS) Transformation Plan 2015 – 2020, children's mental health problems are four times more common in the poorest income

households than the highest, especially among boys. The citywide Joint Strategic Needs Assessment highlights mental health issues amongst the complex needs facing many young people known to youth offending services.

Long waiting lists and a lack of access to specialist and urgent care are key concerns locally, especially when crossing the barrier between adolescent mental health and adult mental health, and there are known pressures on acute child and adolescent mental health services at University Hospital. The CAMHS Transformation Plan also reports that, in Coventry, mental health problems are presenting at younger ages, offering opportunities for intervention, resilience building and practical support which will have lifelong impact.

There are real opportunities for partners to work together differently to develop preventative strategies to tackle the causes of mental ill health amongst children and young people, as well as provide more effective support to young people at risk of or experiencing mental ill health.

This could mean:

- tackling the social, economic and environmental causes that can trigger mental ill health at an early age
- investing in programmes and activities for children and young people that promote healthy lifestyle choices and prevent harmful behaviours
- working with communities to facilitate positive networks and activities for young people
- public sector partners working together to target resources and invest in early intervention in a more coordinated way to prevent crisis and provide timely and appropriate support for children's mental health.

3. Working differently with our communities

Our engagement with communities and community organisations during the JSNA and Health and Wellbeing Strategy development has revealed an appetite for a change in approach to how we work together in our places and with our communities. Communities want to be part of the change and want to work *with* statutory partners, not to be "done to".

There is a real opportunity to mobilise health and wellbeing solutions through assets that already exist in our communities. We want to see a shift in culture and behaviours amongst statutory partners which will include:

- **Empowering and enabling community solutions** by valuing the community leaders who have trust, networks, understanding and legitimacy; and getting behind existing partnerships
- Facilitating forums and networks to **enable better collaboration and communication** between public and third sector partners and within the third sector, by helping partners and communities share what they do and learn from - and build partnerships with - each other
- Taking forward work to change the way we **commission services to better recognise social value**
- Providing **practical support to strengthen the community sector**, including by pooling resources to build capacity and connections and enable communities to maximise social action

Central to this area of focus will be ensuring more effective engagement with and involvement of groups and populations that may be under-represented and more difficult to engage with within our diverse communities. A renewed focus on working with our communities to mobilise solutions will cause us to talk to, and work more closely with, representative groups and organisations.

What difference can partners make?

Place-based Joint Strategic Needs Assessments

In 2018, Coventry Health and Wellbeing Board agreed to take a place-based approach to the JSNA, based around the 8 family hub geographies, reflecting both national policy direction towards population-based health and care systems (based on populations of 30-50k) and a sub-regional move in Warwickshire towards a place-based approach. The JSNA is also being used as a vehicle for engaging and involving local partners and stakeholders, to give more in-depth understanding of the assets and needs of geographical areas within the City and support programmes and strategies which are founded on community resilience and service delivery at locality level.

Over the next 2 years locality profiles will be developed, based on the collection of 'hard' evidence from data sources, as well as consultation with local stakeholders - organisations and individuals - to understand the key issues facing local communities. The first two locality profiles – for the 'Moat' and 'Families for All' Family Hub areas – will be published summer 2019.

This local community focus and understanding provides a valuable basis through which to mobilise community solutions by building networks and increasing the visibility and connections between existing activities.

8. Making it happen - leadership and accountability

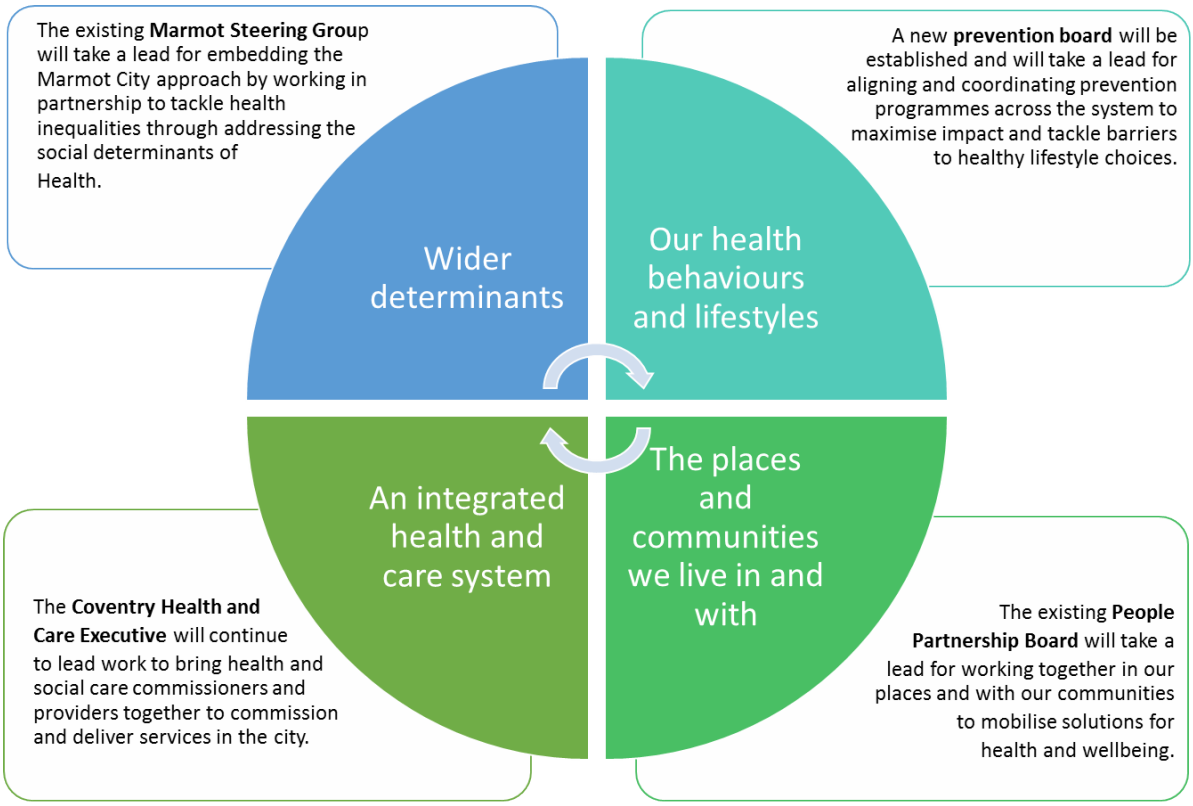
We are putting in place clear leadership and accountability for turning the Strategy into reality.

- **Our strategic ambitions**

The Health and Wellbeing Board will have oversight of progress against our strategic ambitions. The direction of travel indicators will be developed into a performance dashboard for the Board and the Board will receive an annual performance report on progress.

- **Our population health framework**

To ensure we get the foundations right, we have identified groups and boards to lead on each of the four components of our population health framework:



These groups and Boards will report to the Health and Wellbeing Board on work in relation to each component of the population health framework, and on the extent to which each component is being considered and reflected in the plans and activities of health and wellbeing partners.

In addition, we will require that it is clear how every item brought to the Health and Wellbeing Board relates to our population health framework.

- **Our areas of focus**

For each area of focus a senior sponsor will be identified from the Health and Wellbeing Board, and a task group will be formed to progress activity. These task groups will develop detailed action plans, with clear performance measures, based around the four components of our population health framework.

In developing their action plans, the task groups will engage with partners and communities on their specific area of focus and explore further any related ideas and suggestions put forward through the Health and Wellbeing Strategy consultation. The approach will be to build on and make connections between existing activity and mobilise resource across the health and wellbeing system.

We will routinely monitor and report progress against the plans to the Health and Wellbeing Board. The intention is to evaluate the overall impact made and review these areas of focus after 12-18 months.

9. Our ways of working

The following principles, which form part of the Coventry and Warwickshire Health and Wellbeing Concordat, will underpin the way we work as Health and Wellbeing Board partners:

- **Prioritising prevention:** we will tackle the causes of health-related problems to reduce the impact of ill-health on people's lives, their families and communities. We will seek to address the root causes of problems, listening to local people's priorities and acting on their concerns.
- **Strengthening communities:** we will support strong and stable communities. We will listen to residents to understand what their want from the services we provide and encourage the, to lead change themselves where possible.
- **Co-ordinating services:** we will work together to design service which take account of the complexity of people's lives and their over-lapping health and social needs. We will focus on the best way to achieve good outcomes for people, reducing the number of interactions people have with our services and avoiding multiple interventions from different providers.
- **Sharing responsibility:** we value the distinct contributions by all organisations that are represented on the Health and Wellbeing Board. We will maintain partnerships between the public sector, voluntary and community sector, local business and residents, recognising that we share a responsibility to transform the health and wellbeing of our communities. We will pool resources, budgets and accountabilities where it will improve services for the public.

Coventry Health and Wellbeing Strategy 2019-23: Plan on a Page

Coventry Health and Wellbeing Strategy 2019-2023

Strategic Ambitions

- People are healthier and independent for longer
- Children and young people fulfil their potential
- People live in connected, safe and sustainable communities

Our population health framework

Embedding the Marmot City approach by working in partnership to tackle health inequalities through addressing the social determinants of health

Aligning and coordinating prevention programmes across the system to maximise impact and tackle barriers to healthy lifestyle choices

Health and social care commissioners and providers working together to commission and deliver services in Coventry

Working together in our places and with our communities to mobilise solutions, informed by our understanding of local needs and assets from our place-based JSNAs

Taken from the King's Fund *Vision for Population Health*, Nov 2018

Short-term focus

- Loneliness and social isolation
- Young people's mental health
- Working differently with communities

Our shared values and behaviours

Prioritising prevention | Listening and strengthening communities | Co-ordinating services | Sharing responsibility

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In line with the principles of decision making outlined in the City Council Constitution, the Council will ensure that its decision making is open and transparent, and that due regard is given to the Council's obligations and desire to promote equality of opportunity and equal treatment.

Form 1

This part must be completed and before formal consultation is undertaken and must be available during the consultation stage.

Author of this document: Debbie Dawson

Name of ECA and Service: Coventry Health and Wellbeing Strategy (Public Health and Insight)

Head of Service: Liz Gaulton / Valerie De Souza

Date of completion: May 2019

Background to the planned changes

1. **What is the background to the planned changes? Why is this change being considered?** *If further information is available on the different scenarios that have been considered as part of this work, provide a link to the public document which contains this information.*

The production of a Joint Strategic Needs Assessment (JSNA), along with a Joint Health and Wellbeing Strategy (HWBS), is a statutory requirement placed upon the Health and Wellbeing Board (HWBB) under the Health and Social Care Act 2012.

The Health and Wellbeing Strategy is a high level plan for reducing health inequalities and improving health and wellbeing for Coventry residents. The refreshed Strategy for 2019-2022 will translate the emerging findings from the city's place-based Joint Strategic Needs Assessment into clear priorities for what the Health and Wellbeing Board – through its members and wider partners - wants to achieve over the next 3-4 years.

The Health and Wellbeing Strategy will be used by the Council and local health commissioners to inform and influence their plans for commissioning services and will help to determine what actions local authorities, the local NHS and other partners need to take to meet health and social care needs and to address the wider determinants that impact on health and wellbeing.

We are proposing:

- a population health framework (based on wider determinants, our health behaviors and lifestyle, integrated health and care, and the places and communities we live in and with – and the interconnections between these four elements)

- a long-term vision for change encompassed in three strategic ambitions:

1. People will be healthy and independent for longer
2. Children and young people will lead successful lives
3. People will live in connected, safe and sustainable communities

- Specific initial priorities where a tangible difference can be made quickly by working together – these are subject to consultation.

2. Who do you need to consider as part of this ECA?stakeholder analysis***

Coventry & Rugby Clinical Commissoning Group Coventry and Warwickshire Partnership Trust University Hospitals Coventry & Warwickshire Better Health Better Care Better Value Universities Healthwatch Voluntary sector City of Culture Trust WM Police WM Fire and Rescue Police and Crime Partnership People Partnership Board Harm Reduction Partnership	Community organisations Business (representatives) CW Local Enterprise Partnership Pharmacists GPs Dentists West Midlands Ambulance Service Out of Hospital Place-based teams Health Visitors School nurses Other public health commissioned services Care Homes	Residents: • Protected characteristics • Carers • Children and young people • Older people • Students

Pre-Consultation Engagement

This section refers to any activities that took place (such as briefings, meetings, workshops, scoping exercises etc) with stakeholders before the formal consultation period.

3. What engagement activities took place prior to formal consultation and what feedback (if any) was received in relation to equality issues?

Over the past 6-9 months we have been building our understanding of assets and needs in the city, through analysis of evidence from data sources and by talking to over 200 residents and 70 community organisations about the key issues facing local communities.

A range of engagement activity has taken place including:

- Place-based engagement with residents in two family hub-based localities (Moat and Foleshill)
- Engagement with a large range of community and voluntary sectors organisations both working across the city and within specific localities
- Engagement with communities of interest, particularly those representing individuals with protected characteristics

The JSNA has also considered evidence from the Household Survey and Youth Survey which were conducted in 2018.

Key equality issues identified through these engagement activities include:

- accessibility of services
- digital literacy and access to services
- poverty
- dignity and privacy
- young people feeling safe and youth violence
- interpreter services
- housing needs of people in poverty and newly arrived communities.

The engagement findings and data have been analysed to produce a city-wide Joint Strategic Needs Assessment profile, and this has informed the proposed Health and Wellbeing Strategy priorities and strategic approach (population health framework) for addressing these needs that we are consulting on.

Analysis of Impact

In this section please ensure that you consider the three aims of the general duty as they affect **protected groups**. These groups are:

Age
Disability
Gender reassignment
Marriage/Civil Partnership
Pregnancy/Maternity
Race
Religion/Belief
Sex
Sexual Orientation

The **three aims of the general duty** require that a public authority, in the exercise of its functions, must have due regard to the need to:

- Eliminate discrimination, harassment and victimisation
- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it

Show for each how planning to improve lives etc.

4. **Outline below how this proposal/review could impact on protected groups positively or negatively, and what steps/mitigations (if any) could be taken to reduce any negative impact that has been identified.**

Note – when identifying potential impacts below, please only include impacts that may exist over and above general impacts that may affect the wider community/population. (For example, a reduction in grant to Coventry Citizens Advice would affect all service users through a reduced level of first line advice being available to all – but it would affect the following groups more; age, disability, gender and race as they represent a larger proportion of the clients who use the advice service.)

We anticipate that using the population health framework proposed for the Health and Wellbeing Strategy would have a **positive equalities impact** and that by focusing on the four components of that framework (wider determinants, our health behaviours and lifestyle, integrated health and care, and the places and communities we live in and with) we will have a much better understanding of the needs of people with protected characteristics. A population health approach means we will be concerned to improve outcomes for everyone, and will lead to a particular focus on health inequalities and tackling the causes of these. A renewed focus on working with our communities to mobilise solutions will cause us to talk to, and work more closely with, representative groups and organisations.

Age

The strategy has a focus on all Coventry citizens, from young to old.

There is a particular focus on outcomes for children and young people, recognising specific issues raised through the Joint Strategic Needs Assessment around school readiness, childhood obesity, youth violence, young people's mental health and young people feeling unsafe.

The strategy also addresses the preventative health needs of the growing older population, with over-65s expected to accelerate and outpace other groups within 10-15 years, and seeks to respond to the potential impacts on health and wellbeing. It proposes a particular focus on people being healthy and independent for longer.

Disability

The strategy has a focus on helping and supporting the disadvantaged and improving access to services. The outcomes: 'People will be healthy and independent for longer'; and 'People will live in connected, safe and sustainable communities', both speak directly to addressing the needs of people with disabilities and long-term conditions.

The JSNA engagement has identified a range peer support groups in the city, where people use their own experiences to help each other. The new health and wellbeing strategy will seek to empower and mobilise existing assets within communities to improve the lives of people with disabilities.

Gender reassignment

The strategy is clear that it will assist and support those who are disadvantaged, which may be those who are Transgender. Those who are LGBT experience health inequalities, which the strategy seeks to address.

Marriage/Civil Partnership

There is nothing proposed in the Strategy that will impact either positively or negatively on people as a result of their being married or in a Civil Partnership.

Pregnancy/Maternity

The strategy explicitly seeks to improve outcomes for children and young people, taking an approach that prioritises prevention and seeks to address the social determinants of health, such as housing and education.

We know that social inequalities are already established from the early years of life and the strategy therefore seeks to build on existing service models such as Family Hubs, which have brought together health visitors, social care, midwives, police and others to identify vulnerable families and put together a collaborative package of support. This will help to ensure that families have access to the support they need, including addressing maternal isolation, accessing activities to improve their children's life chances, and providing help with finances.

Race

In the 2011 census, 33% of the population identified as people of Black and Minority Ethnic (BME) background, compared to 22% in 2001 and it is likely that the population has become even more diverse in recent years since 2011. The city is expected to become more diverse, with nearly half of Coventry pupils from BME backgrounds. According to the latest school census, 52% of Coventry's school children are from a BME background, up from 38% in 2011.

The strategy seeks to address inequalities, which sometimes relate to race. For example the JSNA identified pupils with a Black Caribbean ethnic background are amongst the groups that are lower performing at KS2; and there are inequalities in employment, with residents of White British ethnicity having higher employment rates than amongst residents from BME backgrounds overall.

The JSNA calls for a culturally competent approach to health and care that recognises the city's diverse communities. The proposed population health framework will build on existing good practice – for example the city's health services working with partner organisations to reach out to communities with greater prevalence of certain conditions. Foleshill Women's Training (FWT) has partnered with local GP practices to increase cervical screening rates for BME women aged 25-64; and the Highlife Centre is working with local community and religious groups to encourage people to get tested for HIV, Hepatitis B and C and TB.

The strategy seeks to achieve the outcome that 'People will live in connected, safe and sustainable communities'.

Religion/Belief

The strategy does not impact on religion/belief specifically, but we would not expect the impact to be negative. Those of particular religions/beliefs may find themselves fitting other categories, such as pregnancy/maternity, disability or race.

The strategy seeks to achieve the outcome that 'People will live in connected, safe and sustainable communities'. The JSNA has identified a range of local peer support groups in the city that address specific needs and protected groups, e.g. age, gender, culture, religion, sexuality, and health needs. To individuals, these peer support groups form the bedrock of their social networks and interaction and for some, they may be their only form of social contact. A key focus of the strategy is to work differently with communities and build capacity in grassroot organisations.

Sex

The Joint Strategic Needs Assessment highlighted the difference in life expectancy and in healthy life expectancy between males and females. Life expectancy in the city is currently 82.4 years for females and 78.3 for males; healthy life expectancy is at 63.5 years for females and 62.9 for males. In Coventry, females can expect to live almost a quarter of their lives in poor health (18.9 years) whilst males can expect to live just over a fifth of their lives in poor health (15.4 years). Males living in less deprived parts of the city can expect to live up to 10 years longer; and for females, the gap is 8 years.

Males and females in Coventry tend to be affected by different causes of premature death. The differences are most significant in causes of death that are considered preventable, where the deaths could potentially be prevented by public health interventions.

Our proposed population health approach will seek to tailor interventions to address inequalities based on our understanding of needs.

Sexual Orientation

The strategy is clear that it will assist and support those who are disadvantaged, which may be those of a particular sexual orientation. Those who are LGBT experience health inequalities, which the strategy seeks to address.

5. **Are there any other vulnerable groups that could be affected?** i.e. deprivation, looked after children, carers.
   Also include any information about the health inequalities/Marmot implications of this proposal. Contact Caroline Ryder (caroline.ryder@coventry.gov.uk) or Hannah Watts (hannah.watts@coventry.gov.uk) in Public Health for more information.

   The Marmot review; 'Fair Society, Healthy Lives', published in 2010, confirmed that health inequalities result from social inequalities and that action is required across all the wider determinants. The review identified the need for action to focus on reducing the gradient in health by focusing on those most in need.

In Coventry we have a strong commitment to promoting equality, tackling disadvantage and improving the life chances of our residents. We are aware that many factors combine to affect the health and wellbeing of individuals and communities. While health care services have an impact, other factors such as where people live, income, education, life experiences, behaviours and choices, along with relationships with friends and family, all have a considerable impact. People facing poorer social circumstances are more at risk of having multiple risk factors, exacerbating avoidable differences in health.

The population health framework proposed for the Health and Wellbeing Strategy includes embedding the Marmot City approach by working in partnership to tackle health inequalities through addressing the social determinants of health. The strategy is specifically intended to have a **positive impact** on vulnerable groups.

6. **What are the gaps in evidence? Can this be addressed during the consultation stage?**
   In this section, re-state those protected characteristics for which there is no data available. In addition, outline if there are any plans to collect further data during the consultation stage (through surveys, on-site sampling etc). If it is unlikely that additional data will be available to inform this ECA, then include a commitment statement in this section along the lines of 'following on from this ECA, once the new service is implemented/commissioning process undertaken, a specific requirement to collect and analyse relevant equalities data will be included in management information processes / service specifications*'.* *delete as appropriate

There are no identified gaps in evidence. There is a need for a more detailed understanding of population health needs and assets at a local place level, and this is being addressed through the development of place-based JSNAs (for populations of 30-50K, based on the Family Hib geographies).

7. **What are the likely impacts of this project/review on staff from protected groups?**

   Outline below how this proposal/review could impact on staff from protected groups positively or negatively, and what steps/mitigations (if any) could be taken to reduce any negative impact that has been identified.

   Data you should include related to the staff impacted:

- *Employee headcount / Total Contract Count / Total FTE*
- *Status (Part time/Full time)*
- *Age band*
- *Sex*
- *Ethnicity*
- *Disability*
- *Grade*
- *Sexual Orientation*
  Religion/Belief

This information can be obtained from Andy Hyland – Andy.Hyland@coventry.gov.uk 02476 83 3426

The Health and Wellbeing Strategy does not make any proposals that impact directly on staff.

To: Coventry Health and Wellbeing Board **Date: 8 July 2019**

Governance Arrangements for the Coventry and Warwickshire Health and Care Partnership

Background and Context

1.1 In preparing to become an accredited Integrated Care System (ICS), it was agreed that there would be a review of governance arrangements in the Coventry and Warwickshire Health and Care Partnership. The objective of this review was to ensure that any future architecture would enable efficient and effective decision making (as close to our communities as possible) and that there was alignment across the system with regards to our agreed vision and purpose.

1.2 In order to undertake this review, a Task and Finish group was established comprising the following membership:

a) Chair – the Independent Chair of the Partnership

b) NW and C&R CCG Accountable Officer

c) CWPT CEO

d) CEO deputies from Coventry City Council and Warwickshire County Council

e) Chair of the Clinical Design Authority

f) Chief Strategy Officer UHCW

g) System Transformation Director

1.3 The group has held 4 formal meetings, supplemented with several informal conversations between the Chair and various leaders across the system to ensure that a wide range of views and experiences were fed into the discussions. The proposals in this paper have been discussed at the Place Forum and at the Better Health, Better Care, Better Value board.

1.4 The group agreed the following principles to inform and steer the discussions:

a) there will be no change to the legal powers or duties of partner organisations

b) we will build on and utilise existing work and structures where possible and not ‘re-invent the wheel’;

c) we will learn from the experience of other ICSs and use their learning to inform our discussions and proposals;

d) future governance should be based on the principle of subsidiarity with the Partnership focusing only on those issues that cannot better be dealt with in the four places that make up Coventry and Warwickshire

e) each of the four places will establish its own governance arrangements to support partnership working

f) governance across the system and in the four places should be transparent and inclusive of all relevant organisations and interests

2 Building on our existing arrangements to develop new, collaborative relationships

2.1 Our approach begins in each of the 19 neighbourhoods/primary care networks which make up Coventry and Warwickshire, in which GP practices work together with community and social care services to offer integrated health and care services for populations of 30-50,000 people. These integrated neighbourhood services focus on preventing ill health, supporting people to stay well, and providing them with high quality care and treatment when they need it.

2.2 Neighbourhood services sit within each of our four local Places (Coventry, Rugby, South Warwickshire and Warwickshire North). These places are the primary units for partnerships between NHS services, local authorities, charities and community groups. These place-based partnerships work together to agree how to improve people's health and improve the quality of their health and care services.

2.3 The focus of these partnerships will be to increasingly move away from simply treating ill health to preventing it, and to tackling the wider determinants of health, such as housing, employment, social inclusion and the physical environment. In doing so, they will draw on the work of local authorities and other public sector agencies. Place-based partnerships, overseen by the Coventry and Warwickshire Health and Care Partnership Board, are key to achieving the ambitious improvements we want to see.

2.4 We recognise that place-based partnerships need to be complemented with a common vision and shared plan for Coventry and Warwickshire as a whole system. System working is likely to be beneficial in order to:

a) achieve better outcomes for people by tackling issues that require action at scale, such as delivering some specialist services and implementing a shared care record
b) collaborate on issues of common concern that would benefit from collective action, such as workforce planning and the use of the estate
c) use all the resources in the system to achieve common goals and support each other in improving health and care for our population

d) speak with one voice to regulators and agree a single version of the truth about the performance of the Coventry and Warwickshire Partnership

2.5 The arrangements described below highlight how we propose to organise ourselves across Coventry and Warwickshire to provide the best health and care, ensuring that decisions are always taken in the interest of the patients, communities and populations we serve.

3 Partnership Governance

3.1 The proposed Partnership governance arrangements build on existing system arrangements, particularly the work undertaken by the Coventry and Warwickshire Joint Health and Wellbeing Board (the Place Forum).

3.2 The Coventry and Warwickshire Partnership Board does not replace or override the authority of the boards and governing bodies of partner organisations. Each organisation retains its statutory responsibilities and Councils remain directly accountable to their electorates. The proposed Partnership Board provides a mechanism for collaborative action on those issues which are best tackled across Coventry and Warwickshire and a forum for agreeing the direction to be taken across the system.

4 Partnership Board

4.1 A new Partnership Board will be established to provide the formal leadership for the Health and Care Partnership. This will be strongly aligned to and heavily influenced by the Health and Wellbeing Boards, their Concordat and the Place Forum. The Partnership Board will meet in public at least four times each year.

4.2 The Partnership Board will be responsible for setting strategic direction. It will provide oversight of all Partnership business, and a forum to debate issues and make recommendations as partners on collaborative action. These issues include plans for using resources to improve health and care and proposals to align organisational and service arrangements to support implementation of these plans.

4.3 It is proposed that The Partnership Board works alongside the Place Forum which provides leadership across Coventry and Warwickshire on population health and wellbeing. The developmental work of the Place Forum will continue under the leadership of the chairs of the two Health and Wellbeing Boards with support from public health directors and their NHS colleagues.

4.4 The Partnership Board will oversee the emergence of the Coventry and Warwickshire Integrated Care System and will be chaired by the independent chair of the Partnership. It is proposed that meetings of the Place Forum and the Partnership Board take place on the same day and in the same place with separate agendas to signify their distinctive but

complementary roles. Membership of the Place Forum and Partnership Board will be closely aligned.

4.5 The Partnership Board will be made up of chairs and chief executives from all NHS organisations, elected member Chairs of Health and Wellbeing Boards, and chief executives or designated deputies of Local Authorities. Other members will include primary care leaders, senior representatives of other relevant partner organisations such as universities, Healthwatch, voluntary and community sector organisations, independent sector providers, NHS England, NHS Improvement, Health Education England, and Public Health England.

4.6 The Partnership Board has no formal delegated powers from the organisations in the Partnership. It will work by building agreement with leaders across partner organisations to take forward the ambitions of the Integrated Care System and in so doing to improve the health and care of the population of Coventry and Warwickshire.

5 Partnership Executive Group

5.1 The current Better Health, Better Care, Better Value board will be replaced by a new Partnership Executive Group (PEG) whose members will be drawn from NHS organisations, Warwickshire County Council and Coventry City Council. PEG will report to the Partnership Board.

5.2 Each organisation will be represented by its chief executive or accountable officer Members will be responsible for nominating an empowered deputy to attend meetings of the group if they are unable to do so personally. PEG will also require attendance from the System Clinical Lead, the System Finance Lead and the System Transformation Director and will invite NHSE/I representation.

5.3 Members of PEG will be expected to recommend that their organisations support agreements and decisions made, always subject to each Partner's compliance with internal governance and approval procedure.

6 Place Based Partnerships

6.1 Partnerships arrangements for the four places that make up Coventry and Warwickshire bring together the councils, voluntary and community sector organisations, and NHS commissioners and providers in each Place, including GPs and other primary care providers, to take responsibility for the cost and quality of care for the whole population.

6.2 The extent and scope of these arrangements is a matter for local determination. They should provide a greater focus on population health management, integration between providers of services around the individual's needs, and a focus on care provided much

closer to where people live in primary and community settings. They will be a means of involving elected members, members of NHS boards and others in providing local leadership of the Partnership with the support of executive leaders.

6.3 Arrangements at place build on existing partnership working by bringing those commissioning and providing services into even stronger alignment with each other and with a wide range of other partners. The four places are where most of the ambitions of the Coventry and Warwickshire Health and Care Partnership will be delivered. The four places will report to the Partnership Board and over time will be expected to meet in public like the Partnership Board where they do not already do so.

7 Clinical Forum

7.1 Clinical leadership is central to all we do. Clinical leadership is built into each of our programmes, and our Clinical Forum provides formal clinical advice and expertise to all of the workstreams. The Forum will supersede the Clinical Design Authority and will report to the PEG and the Partnership Board.

7.2 The purpose of the Clinical Forum is to be the primary forum for clinical leadership, advice and challenge for the work of the partnership in meeting the Triple Aim: improving health and wellbeing; improving care and the quality of services; and ensuring that services are financially sustainable.

7.3 The Clinical Forum ensures that the voice of clinicians, from across the range of clinical professions and partner organisations, drives the development of new clinical models and proposals for the transformation of services. It also takes an overview of system performance on quality.

7.4 The Clinical Forum operates at two levels with a core Executive membership overseeing the development of all proposals that are shared with either place or the system and a wider membership who provide the clinical expertise and input into designing any proposals. The wider membership includes clinical leaders from NHS trusts, CCGs and primary care networks together with public health and social care leaders from local authorities. It will include clinicians from a wide range of professional backgrounds.

8 Other governance arrangements between Partners

8.1 The three local CCGs in Coventry and Warwickshire have established a Joint Strategic Commissioning Committee, which has delegated authority to take decisions collectively. The Joint Committee is a sub-committee of the CCGs, and each CCG retains its

statutory powers and accountability. The Collaborative Commissioning Forum brings together CCGs with local authority commissioners.

8.2 NHS providers meet together as the Provider Alliance which is governed by a Memorandum of Understanding (MOU) which defines the objectives and principles for collaboration. The arrangement provides the forum for working together and making recommendations that are then formally approved by each Trust Board individually in accordance with their own internal procedures. Coventry and Warwickshire providers also meet with providers in Hereford and Worcestershire to discuss issues of common concern.

9 Next Steps

9.1 Subject to the agreement of Health and Wellbeing Boards and NHS boards, it is suggested that these new arrangements are adopted from September 2019, alongside the 5-year system plan and the overarching System Framework being developed under the aegis of the Place Forum. The new arrangements will be reviewed after 12 months to ensure that they are fit for purpose.

Professor Sir Chris Ham

Independent Chair

Coventry and Warwickshire Health and Care Partnership

26 June 2019.

Coventry City Council

Report

To: Coventry Health and Wellbeing Board **Date: 8 July 2019**

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

Title: Coventry and Warwickshire Place Forum and Year of Wellbeing 2019 Update

1 Purpose

This paper updates the Health and Wellbeing Board on the outcomes of the Place Forum meeting on 11 June 2019 and informs Board members about Year of Wellbeing activities and plans.

2 Recommendations

The Health and Wellbeing Board is asked to:

1. Note the outcomes of the Place Forum meeting held on 11 June;
2. Note the ongoing activity as part of the Coventry and Warwickshire Year of Wellbeing 2019; and
3. Support the recommended actions for Health and Wellbeing Board partners (section 5.2) to further promote and progress the Year of Wellbeing 2019.

3 Background

Coventry and Warwickshire's two Health and Wellbeing Boards met together as the Place Forum on 11 June 2019 in One Friargate, Coventry. This was the sixth joint meeting, and the Forum continues to be well supported, with over 40 members of the Health and Wellbeing Boards and BHBCBV Board attending.

The main aims of this session were to:

- Update members on the work of the Coventry and Warwickshire STP (Better Health Better Care Better Value) and consider proposals for its future governance and the role of the Place Forum;
- Engage members in development of a vision for population health across Coventry and Warwickshire, including a strategic framework and place delivery plans;
- Share learning from JSNA engagement and local community capacity pilot projects about new ways of mobilising community solutions, focusing on the social isolation theme of the Year of Wellbeing; and
- review the impact to date of the Coventry and Warwickshire Year of Wellbeing.

4 Outcomes of June Place Forum

It was acknowledged that the collaboration had made significant progress and has now reached a watershed in its development, with a need to increase pace and focus on key areas to move from 'good' to 'great'. There is a real opportunity for the Place Forum to play a key role in the future.

At the meeting, the Place Forum:

- Received an update from Professor Sir Chris Ham on progress being made in the STP (now to be called the 'Coventry and Warwickshire Health and Care Partnership'), including proposed changes to system level governance and arrangements to develop a five-year plan in partnership with leaders at system and place level over the next 3-4 months. Members supported in principle the proposal to establish a System Partnership Board, with further detail of the proposed governance arrangements to be brought to the Health and Wellbeing Boards for consideration.

- Discussed proposals, outlined by Gail Quinton (CCC) and Anna Hargrave (SWCCG), to develop a shared vision for population health, based around the high-level ambitions and outcomes in the Coventry & Warwickshire Health and Wellbeing Concordat which would be built into a population health model and strategic framework. Members endorsed the need for a strategic framework to give coherence to the plans and activities in the Coventry and Warwickshire health and wellbeing system and supported the population health model.

- Received presentations from Moat House Community Trust and Grapevine on different approaches they have been piloting of engaging with and mobilising communities, using an asset-based approach. Key messages from JSNA engagement activity about ways of mobilising community solutions were also presented. Members noted the potential power of the 'anchor institutions' represented in the Place Forum to work differently to strengthen and mobilise community assets (eg. through use of estates and procurement practices), and considered how partners could enable and empower third sector solutions and support local sustainability.

- Heard about progress and impact to date of the Year of Wellbeing and considered ways of securing the legacy of the Year, with the 5-year partnership plan identified as a potential vehicle for taking forward this commitment.

The following actions were agreed as part of the Place Plan (see appendix 1):

- Continue to lead and support the Year of Wellbeing and plan for its legacy.
- Develop the detail of the STP governance proposals and bring to Health and Wellbeing Boards for endorsement.
- Further develop the outcome framework as part of the Strategic Framework, for oversight of performance across the system and to mobilise action by partners to address identified challenges.
- Proactive and Preventative group to further develop the Strategic Framework, with the involvement of the 4 places.
- More detailed proposals on the Strategic Framework and STP 5-year plan to go to the Health and Wellbeing Boards in September / October ahead of the Place Forum in November.
- Take forward work on mobilising communities and maximising the social impact of anchor institutions as part of population health management work.

- Continue to update each other on changes which impact on the work of the Place Forum, including ICS and the STP refresh.

5 Place Forum 5 November 2019

The next meeting of the Place Forum is scheduled to take place in Warwick on 5 November 2019. The focus of partner activity up to the next Place Forum meeting will be on:

- Confirming the governance arrangements for the STP (Coventry and Warwickshire Health and Care Partnership) and the role of the Place Forum;
- Progressing work on the vision for population health, including the strategic framework and place delivery plans;
- Continuing to support and deliver the Year of Wellbeing, monitor impact and plan for its legacy; and
- Progressing work on mobilising communities and maximising the social impact of anchor institutions as part of population health management work.

6. Coventry and Warwickshire Year of Wellbeing 2019

6.1 Year of Wellbeing activity and impact

Activity to increase the visibility of the Year of Wellbeing campaign in Coventry is progressing well. We are investing time to develop our social media presence on Twitter (348 followers) and Instagram (127 followers). We are broadly confident about the visibility of the campaign and associated wellbeing messaging to staff working in the majority of our partners. We continue to rely on local teams to develop and share content with us to assist the measurement and understanding of activity throughout the year. We will collate this activity towards the end of 2019 to indicate the size and visibility of participation in the campaign. All partners will be asked to contribute to this.

There has been a slow-down in sign-ups for the Year of Wellbeing newsletter, which is our primary vehicle of sharing news and advance notice of activity. As of 15.5.19 there are 810 registered recipients. It would be helpful if partners could encourage staff and customers to sign up. There has been a marked slow-down in pledging activity which could see us falling short of our target of 1,000 pledges during 2019. Excluding pledges made at the One Thing website we are in the region of low 600s. Wipeable boards and postcards are available to support partners to pledge independently as part of local team building activity.

Interviews to recruit 2 Coventry University Masters students to support evaluation activity for the Year of Wellbeing were unsuccessful. We are unlikely to pursue a second attempt to recruit through this route and we are therefore considering alternatives for evaluation of our activity as part of our wider legacy.

Following the discussion on WMCA's Thrive at Work accreditation programme at March Place Forum we can report positive progress in sign-ups and developing the approach. Of the 13 bodies comprising Coventry Health and Wellbeing Board, 7 have to date signed up to Thrive.

In relation to increasing child physical activity in primary schools, our strategy to maximise reach into schools has developed to capitalise on a new relationship with Schools Games Organisers, who are supporting PE premiums and school games activity. By aligning our messaging with theirs we have been able to multiply our projected capacity to get into schools by three. Our

target to increase physical activity in 100 Coventry and Warwickshire primary schools by the end of 2019 is challenging but we believe achievable with the right approach, which we have varied from our original plan.

Clarity is developing in relation to the most logical approach to reviewing loneliness and social isolation activity in the city. A multi-partner group has been meeting for some months to outline the challenges and the size of the existing offer. The Year of Wellbeing is adding value to local activity by shining a spotlight on innovative and successful ventures, particularly where led by third sector and community partners. This includes our support for Creativity and Wellbeing Week and a free event hosted at the Herbert Art Gallery in June, the Arts for Health symposium at the Belgrade Theatre in May, and the Nations Football tournament led by Positive Youth Foundation in June as part of the 'Coventry Welcomes' event.

6.2 Next steps and role of partners

With the summer event calendar already started, partners are reminded that the Year of Wellbeing has shareable resources to give out from market stalls that will engage the community and raise awareness of wellbeing. Please encourage engagement staff to contact us to receive materials for promotion during your summer events.

Partners are asked to:

- Link Year of Wellbeing social media content to your corporate Twitter feeds and ask your relevant staff to tweet/retweet content;
- Pursue opportunities to promote the Year of Wellbeing and your prevention services in public-facing media materials;
- Encourage newsletter sign-up and individual pledges;
- Register for the Thrive at Work workplace wellbeing accreditation programme;
- Request Year of Wellbeing materials for market stalls at your local events.

Report Author(s):

Name and Job Title:
Debbie Dawson, Policy and Partnerships Transformation Officer, Coventry City Council

Telephone and E-mail Contact:

debbie.dawson@coventry.gov.uk
024 7697 1406

Enquiries should be directed to the above person.

Appendices

Appendix 1 – Place Plan Rolling Actions as at June 2019

Appendix 1

Place Plan – rolling actions June 2019

Trust and Behaviours	Products
Meet as a Place Forum to build trust; create a place wide model of care and outcomes; and hold each other to account	☑ Place Forum established ☑ System Partnership Board
Develop an update process which covers all Forum members	☑ Forum-wide updates
Refresh the Concordat and use it to capture priorities for improving health & wellbeing and ways of working together	☑ Concordat v2

Translatable vision	Products
Create a health and care system design for our Place	☑ Place System Design
Develop a common narrative	☑ Common narrative
Rollout a place-based approach to Joint Strategic Needs Assessments to inform services at a local level	☑ Place-based JSNA

☑ Complete ☑ In Progress

Place Plan – rolling actions June 2019

Getting it done	Products
Build one strategic, place based plan that is owned by all and uses the means we have at our disposal (STP, BCF etc.)	☑ Place Plan ☑ Vision for Population Health
Develop a Year of Wellbeing to promote wellbeing and healthy lives, and make prevention/self help the 1st chapter of all change programmes	☑ Year of Wellbeing Plan ☑ Year of Wellbeing Logic Model

Holding to account	Products
Strengthen the place based governance and working arrangements to deliver against our Concordat	☑ Outcome framework ☑ Strategic Framework
Take collective ownership (coordinated through the Proactive & Preventative Executive) to ensure actions happen	☑ P&P Exec & Delivery groups
Strengthen communication and engagement between Forums to keep people updated	☑ Forum-wide updates

☑ Complete ☑ To be further developed

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Coventry City Council

Report

To: Coventry Health and Wellbeing Board **Date: 8th July 2019**

From: Mike O'Hara, Chief Superintendent, Coventry Police

Title: Multiple Complex Needs evaluation and future governance

1 Purpose

This paper updates the Health and Wellbeing Board on the evaluation of the Multiple Complex Needs programme within Coventry and informs Board members about plans for future governance.

2 Recommendations

The Health and Wellbeing Board is asked to:

1. Note the findings of the evaluation;
2. Note the context around this work has changed significantly since the inception of the Multiple Complex Needs Board in 2016;
3. Note the proposal for future governance of Multiple Complex Needs, including consideration of both the Operational Group and the Multiple Complex Needs Board.

3 Information/Background

The Multiple Complex Needs Board is chaired by the Police Commander and supported by public health colleagues. The purpose of this Board is to set the strategic direction and report to the Health and Wellbeing Board, as one of the priorities in Coventry's 2016-19 health and wellbeing strategy was to improve the health and wellbeing of individuals with multiple complex needs. This Board was picking up work around rough sleepers in the council.

The Multiple Complex Needs Operational Group reports to the Board and is overseen by Public Health and Insight. The role is to ensure delivery of the projects and identify, manage and flag risks. The projects covered include:

- Case management forum (now forming part of the Vulnerable Persons forum) – where individuals are discussed using a person-centred asset-based approach.
- Experts by Experience – developing an approach to meaningfully working with people with lived experiences and establishing a co-production approach in Coventry
- Making Every Adult Matter (MEAM) – cross-sector approach that aims to ensure people receive coordinated support, helping individuals to reach their full potential and to contribute positively to their communities by flexing the system and undertaking systems change

- Steps for Change – a multi-agency weekly drop in advice & information shop to address problems of homelessness, begging & drug/alcohol addiction in the city centre
- Evaluation – a project to establish the extent to which the programme improved outcomes from an individual, organisational and system perspective
- Housing First – a pilot with support for up to 109 individuals who are rough sleepers with multiple needs

An evaluation of the Multiple Complex Needs project was carried out in late 2018/early 2019 and was largely positively reported on, with respondents in agreement it has influenced the way organisations work with the bringing together of experts and professionals leading to better working relationships and outcomes. The success of STEPS and Experts by Experience in particular was highlighted. Challenges noted included difficulties of improving outcomes through available resources, referencing both the lack of funding and lack of a MEAM coordinator.

Future points mentioned to consider included:

- Engaging with other organisations, in particular expanding out from the voluntary sector to include involvement from mental health and social care
- More explicit consideration of housing
- Sustaining Steps for Change
- Embedding multiple complex needs thinking in more panels and Council strategies
- Refreshing the vulnerable persons forum

It is noted that since the evaluation was carried out, there have been a number of strategic and operational changes which have addressed some of the points raised by the evaluation. This includes a review of the vulnerable persons forum and additional funding secured to support homelessness. The Strategic Housing Board is chaired by the Chief Executive, where Housing and Homelessness is considered from a City Council perspective and the strategy is set and supported by the Housing and Homelessness Operational Group. Delivery of Housing First is now being overseen by the Housing Commissioner and Head of Housing, with support as required provided by Public Health and reporting into the Strategic Housing Board.

Moving forward, following the refresh of the Health and Wellbeing Strategy and consideration of the evaluation findings, it is proposed to integrate and mainstream multiple complex needs work across programmes and initiatives in the council. New housing contracts are currently being revised and it is envisaged a complex needs panel will be established, addressing the work currently overseen by this operational group and Board.

4 Options Considered and Recommended Proposal

In light of these strategic and operational changes, options considered for future governance around Multiple Complex Needs included:

1) To retain the current Multiple Complex Needs governance and structure
2) To dissolve the Multiple Complex Needs Operational Group and Multiple Complex Needs Board
3) to dissolve the Multiple Complex Needs Board and retain the operational group in a transitional state while housing contracts are being revised.

The recommended proposal from the Multiple Complex Needs Board is to adopt number 3.

It is proposed the Multiple Complex Needs Operational Group continues to oversee the remaining projects (case management forum, Experts by Experience, Making Every Adult Matter and Steps for Change) in a transitional phase in the form of a transformation group, addressing the ongoing development points raised above. It will be held by, and be accountable to Public

Health and Insight, within the Council while the new housing contracts are established, and the complex needs panel set up. Following on from this, the work will be overseen by Housing with support as required by Public Health and Insight and reporting into the Strategic Housing Board.

It is proposed the Multiple Complex Needs Board is dissolved and the Transformational group, evolved from the Multiple Complex Needs Operational Group will report by exception into the Head of Housing.

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Directorate: People

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Enquiries should be directed to the above person.

Appendices

Appendix 1 - Multiple Complex Needs Programme in Coventry - Evaluation

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Multiple Complex Needs Programme in Coventry - Evaluation

Report for Coventry Council

Dr Clair Clifford

Assistant Professor

19 March 2019

Contents

Author

Dr Clair Clifford is a Consultant Clinical Psychologist who specialises in complex trauma.

She is an Associate Fellow (AFBPsS) and Chartered Psychologist (C.Psychol.) and Chartered Scientist (C.Sci.) with the British Psychological Society and is registered with the Health & Care Professions Council in the U.K. She has a background in clinical psychology with adults across a range of NHS, private practice and military settings, and is an accredited Cognitive Behavioural Therapist and Supervisor and Eye Movement Desensitization & Reprocessing Practitioner and Consultant Supervisor.

Clair was engaged by Professor Jane Coad, Professor Anne Coufopoulos and Professor Guy Daly at Coventry University, to complete this report for Coventry City Council.

Contributors

Coventry City Council	Head of Planning and Regulation MCN Programme Co-ordinator Community Safety Officer Planning & Housing Policy Assistant Director Public Health and Wellbeing Head of Environmental Services Insight Development Manager (Place and Public Sector Transformation) Director of Adult Services General Manager MH
Coventry Citizens Advice	Research & Campaigns Co-ordinator
West Midlands Combined Authority & West Midlands Fire Service	Watch Commander / WMCA MCN Officer
WhiteFriars	Assistant Director of specialist housing
West Midlands Police	Chief Superintendent
Salvation Army	(Interim) Service Manager
Midlandheart	Team Leader
SWMCRC	Housing & Welfare Officer
Ayriss Recovery Centre (ARC)	Directors
Hope Coventry	Project Coordinator, Coventry Winter Night Shelter
Probation Services / Community Rehabilitation Company	Performance Development Manager
EBE	Experts By Experience

Acronyms

ACEs	Adverse Childhood Experiences
BAU	Business As Usual
CCC	Coventry City Council
DV	Domestic Violence
DWP	Department of Work & Pensions
EBE	Experts By Experience
HARP	Harm and Abuse Reduction Partnership
HWB	Health & Wellbeing Board
Ignite	Ignite – Central England Law Centre & Grapevine Programme
JSNA	Joint Strategic Needs Assessment
MAPPA	Multi-agency Public Protection Arrangements
MCN	Multiple Complex Needs
MEAM	Make Every Adult Matter
PU	Public Health
PHE	Public Health England
SMD	Severe Multiple Disadvantage
VP	Vulnerable Persons
WMCA	West Midlands Combined Authority

Context

Multiple complex needs (MCN) are defined by Coventry City Council's Health & Wellbeing strategy 2016-19 as people experiencing at least two of the following: substance misuse, mental ill health, physical ill health and domestic abuse. Individuals facing MCN often rotate through various welfare and justice systems and can find it hard to engage with mainstream support services. They cycle deepens, with costs to the individuals and wider society, leaving them on the margins of society. The Lankelly Chase research found that quality of life for these vulnerable groups featured experiences of social isolation, trauma, exclusion and poverty in childhood and adulthood. Of those engaged with criminal justice, drug and alcohol treatment and homelessness services, 55% also have a diagnosed mental health issue.

Coventry City Council's Health & Wellbeing strategy 2016-19 reported an estimated 60,000 people in England are facing multiple/complex needs. Similarly, Making Every Adult Matter also estimate the number of people in England with 'multiple needs and exclusions' at 56,000 in the prison and homeless populations alone. Lankelly Chase Foundation's research indicated that 58,000 people have contact with homelessness, substance misuse and criminal justice services annually, and a further 164,000 people are in contact with two of these services. Within the West Midlands, it is estimated that there are nearly 13,000 people who suffer from at least two issues (e.g. homelessness, offending and substance misuse); 4,000 people who suffer from all three issues and a further 1,800 people who require contact with relevant agencies.

As well the moral case for improving outcomes for people with MCN, the Lankelly Chase work highlights a financial case. As more people find themselves on the margins of society facing these challenges, the cost to public services increases: recent research indicates that £19,000 per person per year is spent on individuals with a combination of problems, at a total estimated annual cost of £4.3 billion. This spending is focused on expensive crisis care, rather than co-ordinated and preventative support. It has been estimated that better coordinated interventions from statutory and voluntary agencies can reduce the cost of wider service use for people with MCN by up to 26%, which is the rationale for reform.

A West Midlands Combined Authority (WMCA) consultation with individuals with MCN concluded:

- Current systems are too complicated and need to be made simper for all to understand
- Services are often focused on a single problem and can't provide multi-faceted help needed
- Information is often not shared resulting in the need to 'tell your story' several times
- The best approaches are those which empower individuals and enable them to build their confidence and self-esteem

The WMCA pledged to improve the lives of the most excluded people with the most complex needs by:

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

- Encouraging individuals with multiple complex needs to share their experiences so that future processes can be designed and delivered sustainably, and learning can be shared amongst service providers

The stated focus was:

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

The rationale is to help individuals who face substantial challenges and have MCN live healthier lives, free from addiction, substance dependency and fear of harm. It will help enable individuals with MCN to retain a sense of independence, self-worth and self-esteem, so that everyone in Coventry is able to take personal responsibility for their future and make a positive contribution to their community. Improving the health and wellbeing of individuals with MCN will also lead to a reduction in offending, anti-social behaviour and demand for services. Through managing demand, delivering better co-ordinated services and empowering and enabling individuals to maximise control over their lives, this work can deliver financial savings for public services as well as improved outcomes for the most vulnerable individuals in Coventry.

The Project Initiation Document for Multiple/Complex Needs (undated) identified the following context to this Evaluation:

The Lankelly Chase 2015 report Hard Edges found that Coventry had a higher than average prevalence of adults at Severe and Multiple Disadvantage (SMD), given the relative levels of poverty seen in the city. Coventry's rate per 1,000 population is 28.9 compared to an England average of 17.4. Coventry has the 19th highest rate out of all upper tier local authorities. People with SMD are mainly male and most age groups have some people experiencing SMD, although numbers are very low in the over 65 age category. Within Coventry, SMD is most prevalent amongst 25-44 year olds. The research also demonstrates that quality of life for those individuals with complex needs tends to be much poorer than that reported by other low income and vulnerable groups. Coventry's Health and Well-being Board identified as one of its key priorities as 'improving health and well-being of individuals with multiple complex needs'. The Board recognises the significant challenges that this vulnerable group of the city's population faces and is keen to stimulate thought and action on whether single issue systems and services are any longer the most effective response, and to shift the focus of policies and plans from organisations to places.

An individual with MCN

For the purpose of this evaluation, an individual with MCN is likely to be experiencing two of more factors such as, but not exclusively:

- homelessness
- offending behaviour
- mental ill health
- substance misuse
- worklessness

Methodology

There were two data sources analysed in this evaluation: a) a survey conducted using the online platform SurveyMonkey and b) face to face interviews

Survey

The survey was conducted using the Survey Monkey platform, with a range of stakeholders invited, including those listed on Page 4 as Contributors and Experts by Experience (EBE). These are summarized in the table below and can be grouped by i) practical questions. The survey was undertaken during November 2018.

Which category, if any, does your organisation offer specialist support in? (Please tick all that apply)	Homelessness
	Substance misuse
	Offending behavior
	Mental ill-health
	Worklessness
	Universal provision
	Other (please specify)
I am / have been involved in the following parts / stages of the MCN programme. (Please tick all that apply)	MCN Board (Phase I) - determining current needs and service provision
	MCN Board (Phase II) - adopting the Making Every Adult Matter (MEAM) approach (Phase II)
	MCN Operational Group
	MCN Co-production Meeting
	Steps for Change
	Vulnerable Persons Forum
Why did your organisation choose to become involved in the MCN programme? (Please tick all that apply)	Seeking improved co-ordination
	To encourage better partnership working
	To improve outcomes for MCN cohorts
	As a way to share limited resources
	Because it is a priority in the Coventry Health and Wellbeing Strategy
	To adopt the MEAM approach
	We were asked to participate
	Other (please specify)
In your opinion, what were the challenges that people facing multiple complex needs experienced prior to the MCN programme's existence? (Please tick all that apply)	Services were not designed around individuals with complex needs
	Clients failed to engage with services
	Services were designed to be focused on a single issue so complex needs fall between the gaps
	Strategic decisions were not always informed by what was happening in practice
	Other (please specify)
To what extent do you agree / disagree with the following statement? (Strongly agree, agree, neutral, disagree, strongly disagree, I don't know)	*"I think the MCN programme's effective working relationships have improved service co-ordination."*
	"We now work better with MCN cohorts because the vulnerable persons forum and MCN operational group case-manage and discuss vulnerable individuals."
	"The city centre Steps for Change shop has improved working relationships between organisations."
	"The city centre Steps for Change shop has led to better outcomes for people facing multiple complex needs."
	"Being part of the MCN programme has influenced the way my organisation works with people facing multiple complex needs."

	"The MCN programme has started to influence the way other organisations in Coventry work with people facing multiple complex needs."
	"Bringing experts by experience and professionals together has led to better working relationships."
	"Bringing experts by experience and professionals together has led to better outcomes for people facing multiple complex needs."
	"The MCN Board's involvement of experts by experience has begun to transform strategic thinking around multiple complex needs in Coventry."
	"The MCN operational group's involvement of experts by experience has begun to transform the way we work with people facing multiple complex needs in Coventry."

iii) questions on the Making Every Adult Matter (MEAM) initiative:

Does your organisation use the MEAM approach?	Yes
	No
	I don't know
How can we develop the role of MEAM? (Including any suggestions on the way we can embed the MEAM approach throughout partner organisations)	Free text

iv) personal view questions

Overall, how would you rate the current MCN programme?	Low quality
	2
	3
	4
	High quality
To what extent do you agree / disagree with the following statement? (Strongly agree, agree, neutral, disagree, strongly disagree, I don't know - option to explain your answer)	"I feel that my opinion has been respected throughout my time working on the programme."
	"I feel like I am making a difference to people facing multiple complex needs."
Do you understand your role as part of the MCN programme?	Yes
	No
	I don't know
	Please explain your answer (optional)
What did you, as an individual, hope to achieve by taking part in the MCN programme?	Free text

v) outcomes

What are the biggest challenges and / or weaknesses associated with the MCN programme?	Free text
What are the biggest successes and / or benefits of the MCN programme?	Free text

vi) future developments

Do you know any other organisations that should be a part of the MCN programme?	Free text
How can we improve the way we work with experts by experience in the design and / or delivery of services?	Free text

There was also an option to provide any further comments

Would you like to add any further comments or elaborate on your answer to a previous question?	Free text

Interviews

All members of the MCN Board and Operational Groups were invited, via email, to participate in a focused interview, which expanded on the results of the survey. Following initial responses to the email, members of these groups who had not responded were then approached and asked to contribute to ensure that we interviewed representatives from the Board and Operational Groups, as well as from statutory services, the voluntary sector and frontline volunteers. Those who were interviewed had been involved in MCN for varying lengths of time. The interviews were undertaken on a 1 to 1 basis, or a 1 to 2 basis when there was an interviewer and a scribe present. Three members of the ARC CIC were interviewed together. Interviews took during December 2018 and January 2019. The Contributors are listed on Page 4.

The interviews were structured with the same questions asked of each individual. The questions had been selected following survey responses, with the reasons identified in the questions asked to help provide context for the individual(s) being interviewed.

The interview comprised the following questions:

Question theme	**What was asked**
1. What worked well	*Questionnaire respondents suggest that the most positive outcomes from the MCN programme were the STEPS for Change one-stop shop, and engaging with Experts by Experience.* • *Do you share this view?* • *How can we build on this work and continue to develop STEPS and EBE?*
2. What didn't work so well	*Results from the questionnaire suggest that the biggest struggles were around improving outcomes for individuals with MCN. The questionnaire responses identify lack of resources, in terms of dedicated resource and a MCN fund to support the work, suitable accommodation as well as engagement from key partners for this.* • *What is the biggest missed opportunity in your view?* • *Are there other barriers you have identified regarding improved outcomes for MCN clients?* • *How could we build on what we've achieved and do things differently in future to achieve better outcomes for individuals?*

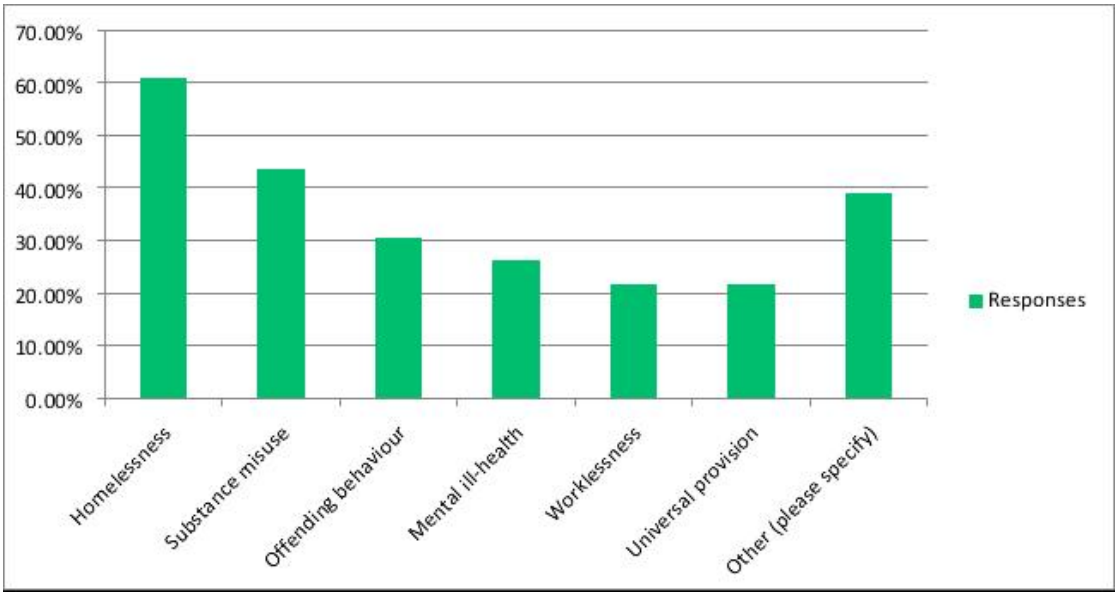
3. Strategic future	*The MCN programme wanted to not just improve outcomes for individuals with MCN, but look at having a more strategic, systems approach to helping people by bringing people from different disciplines together.* *To what extent has the programme helped transform strategic thinking around improving outcomes for people with MCN? What should we be doing to engage different organisations / teams / services / managers to think beyond the priorities of your organisation, to enact systems change?*
4. MEAM	*Respondents to the questionnaire suggested mixed responses to being a Making Every Adult Matter (MEAM) approach area.* • *To what extent do you feel the Coventry system understands what we have signed up to?Is MEAM still the right opportunity for the city? Can we enable system change and flex without being a MEAM approach area?*
5. The future	*Where do you see Multiple Complex Needs work in the future?*

Analysis

Survey

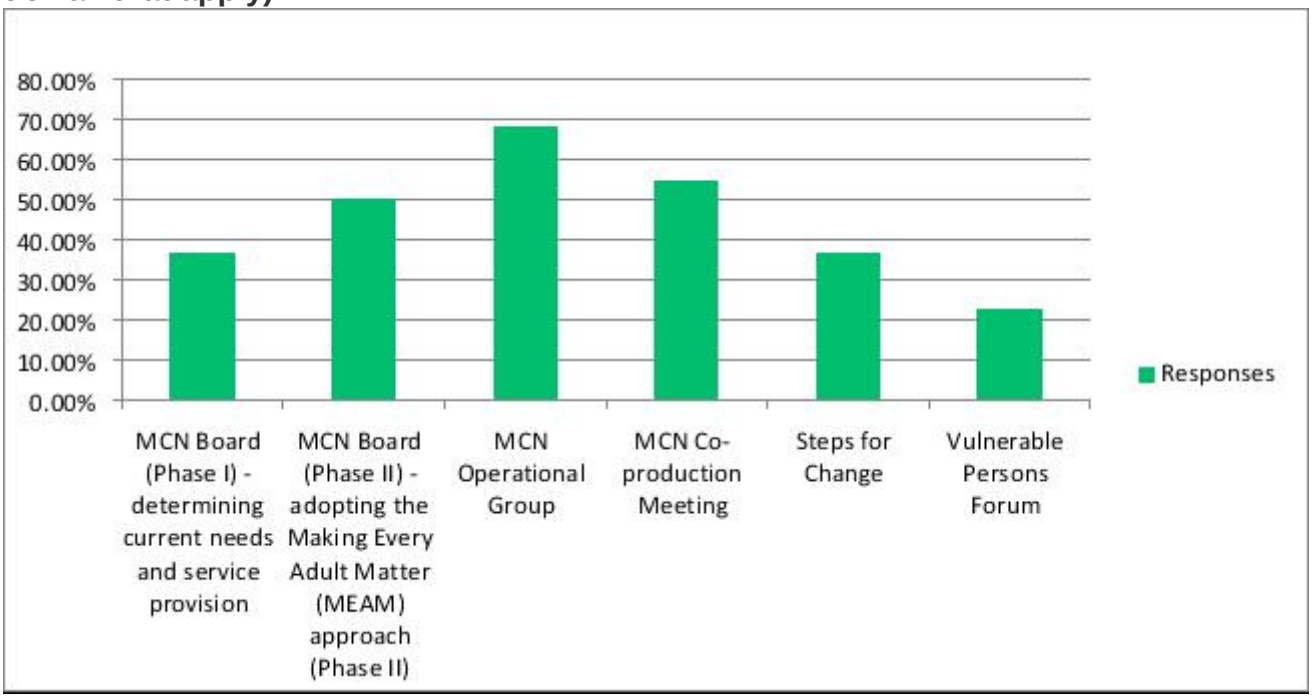
Practical questions

Which category (Homelessness, Substance misuse, Offending behaviour, Mental ill-health, Worklessness, Universal provision or Other) does your organisation offer specialist support in? (Please tick all that apply)



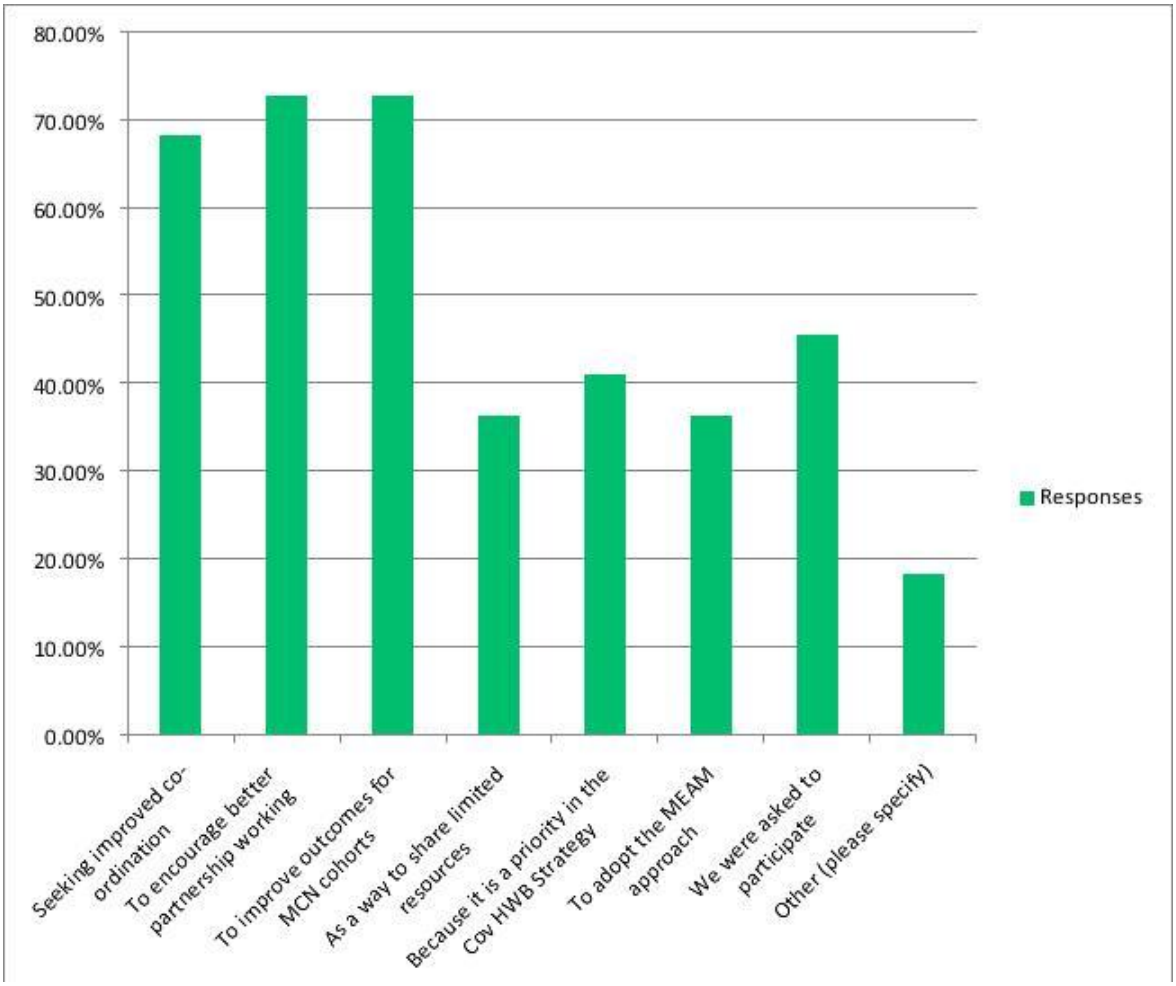
Where specified, the majority of responses indicated homelessness was the main category in which specialist support was offered by organisations, followed by substance misuse and offending behavior.

I am / have been involved in the following parts / stages of the MCN programme. (Please tick all that apply)



Where specified, the majority of responses indicated the MCN Operational group was the main stage in which responders were involved in, followed by the MCN co-production meeting and phase II of the MCN Board.

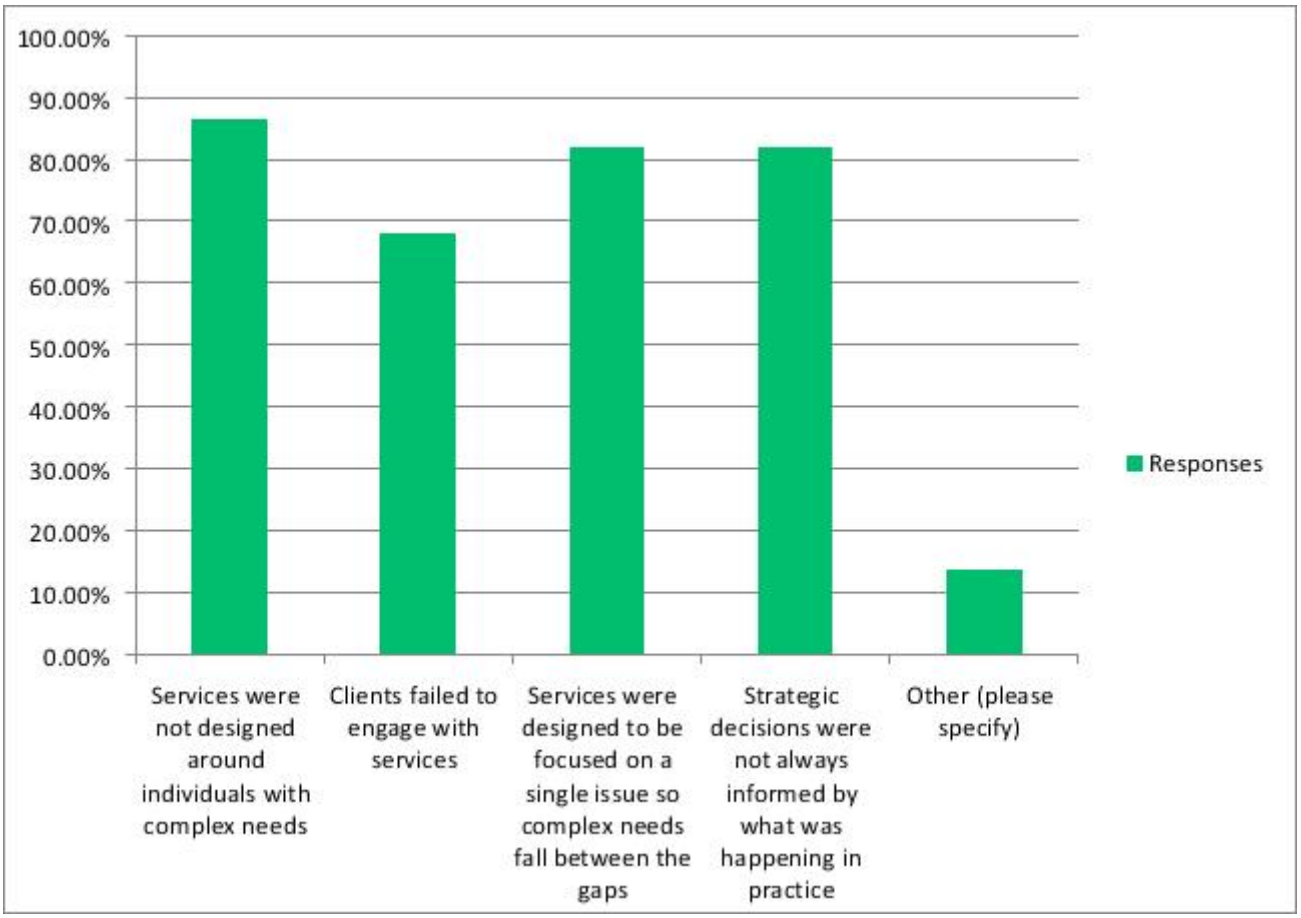
Why did your organisation choose to become involved in the MCN programme? (Please tick all that apply)



Where specified, the main reason for an organization wanting to become involved in the MCN programme was to encourage better partnership working and to improve outcomes for MCN cohorts, closely followed by seeking improved coordination.

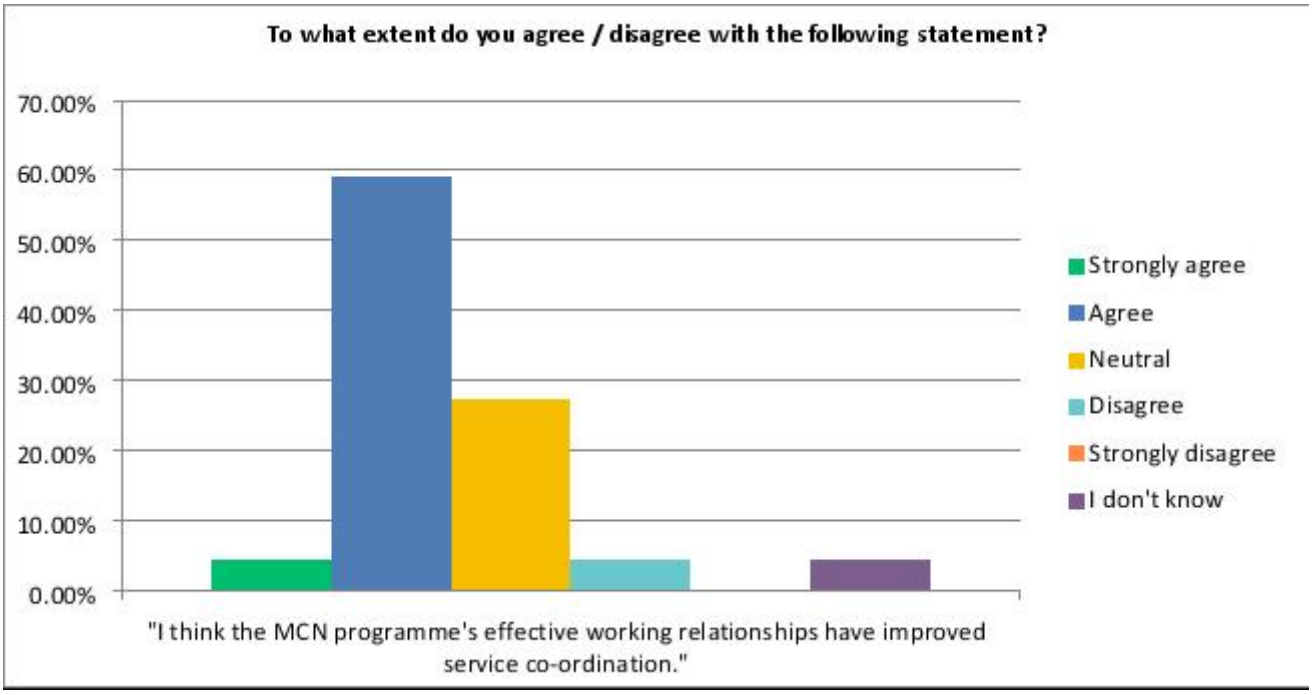
Opinion questions

In your opinion, what were the challenges that people facing multiple complex needs experienced prior to the MCN programme's existence? (Please tick all that apply)



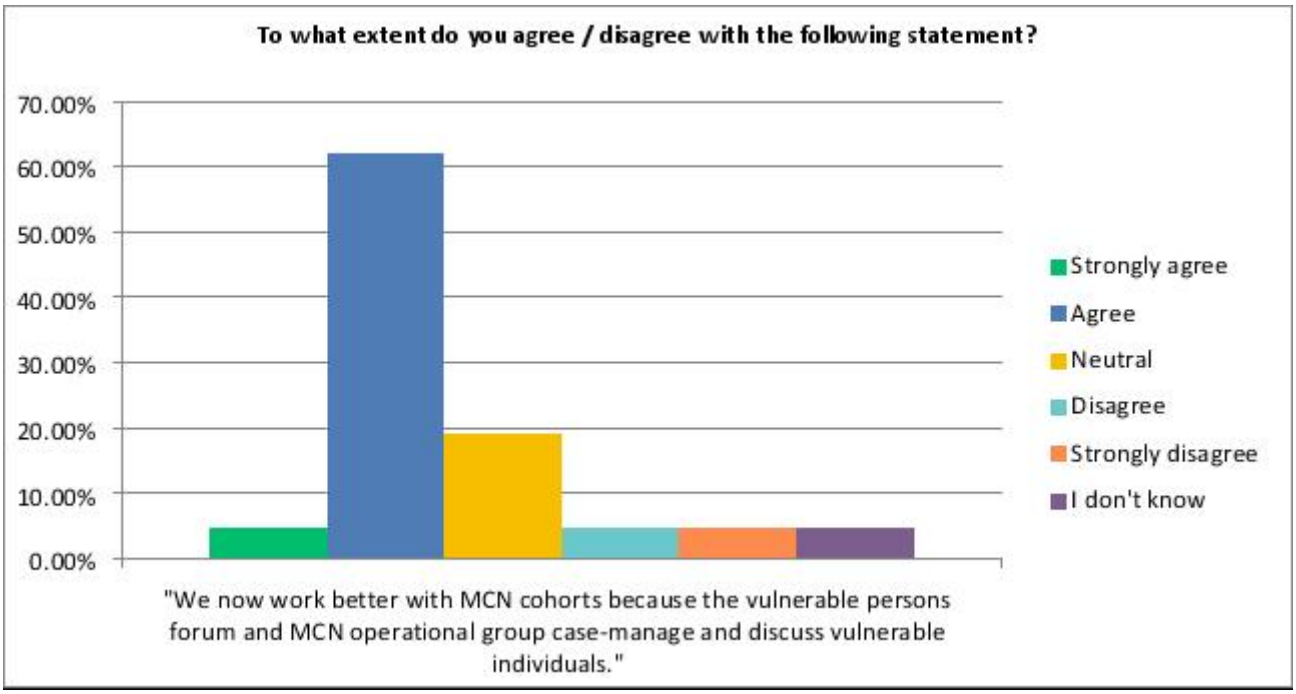
The majority of responders reported key challenges faced by people with multiple complex needs included services not designed around individuals, services focused on a single issue and strategic decisions not always informed by what was happening in practice, with clients failing to engage with services also identified as a challenge.

“I think the MCN programme’s effective working relationships have improved service co-ordination”



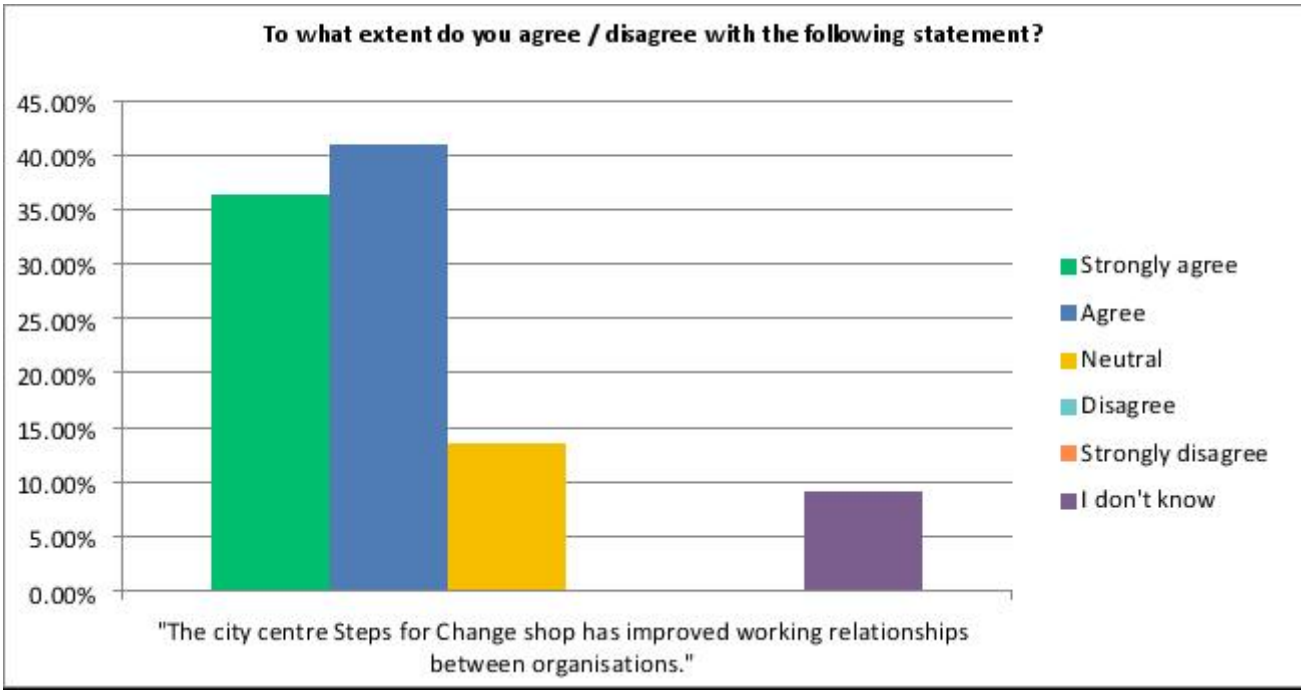
64% of respondents agree or strongly agree the MCN programme’s effective working relationships have improved service co-ordination, with 27% neutral.

“We now work better with MCN cohorts because the vulnerable persons forum and MCN operational group case-manage and discuss vulnerable groups”



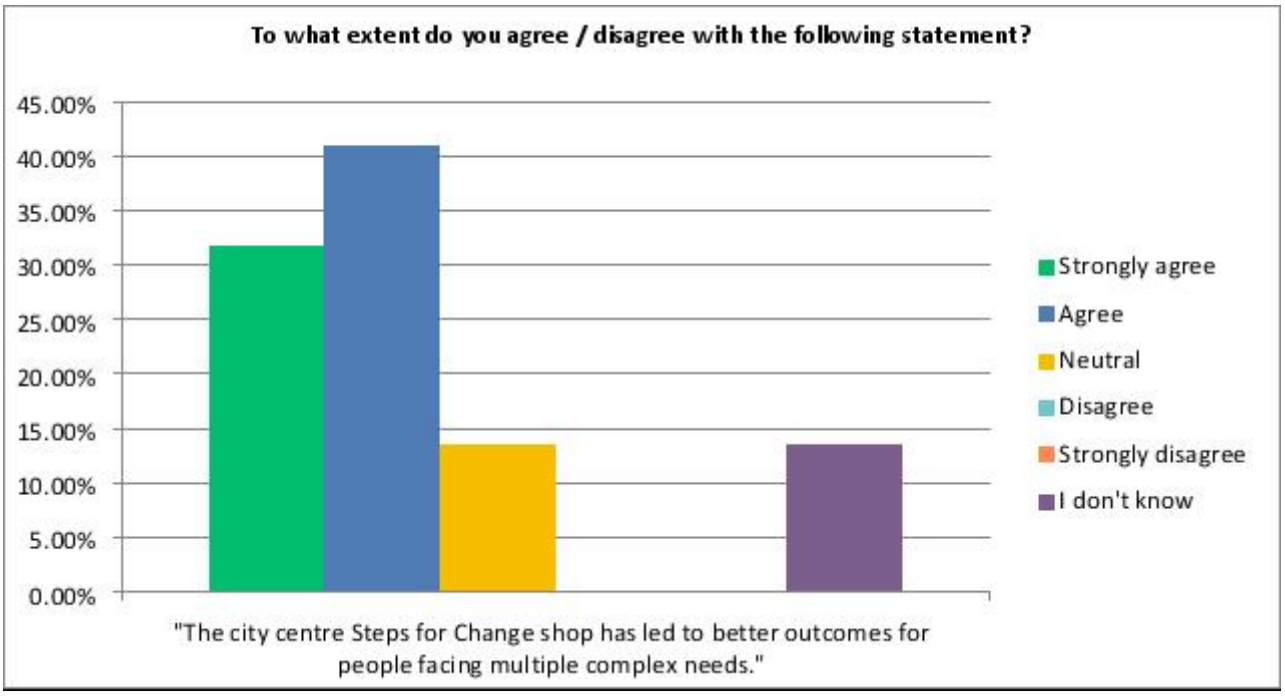
67% of respondents agree or strongly agree they now work better with MCN cohorts because of the case management by the vulnerable persons forum and MCN operational group, with 19% neutral.

“The city centre Steps for Change shop has improved working relationships between organisations”



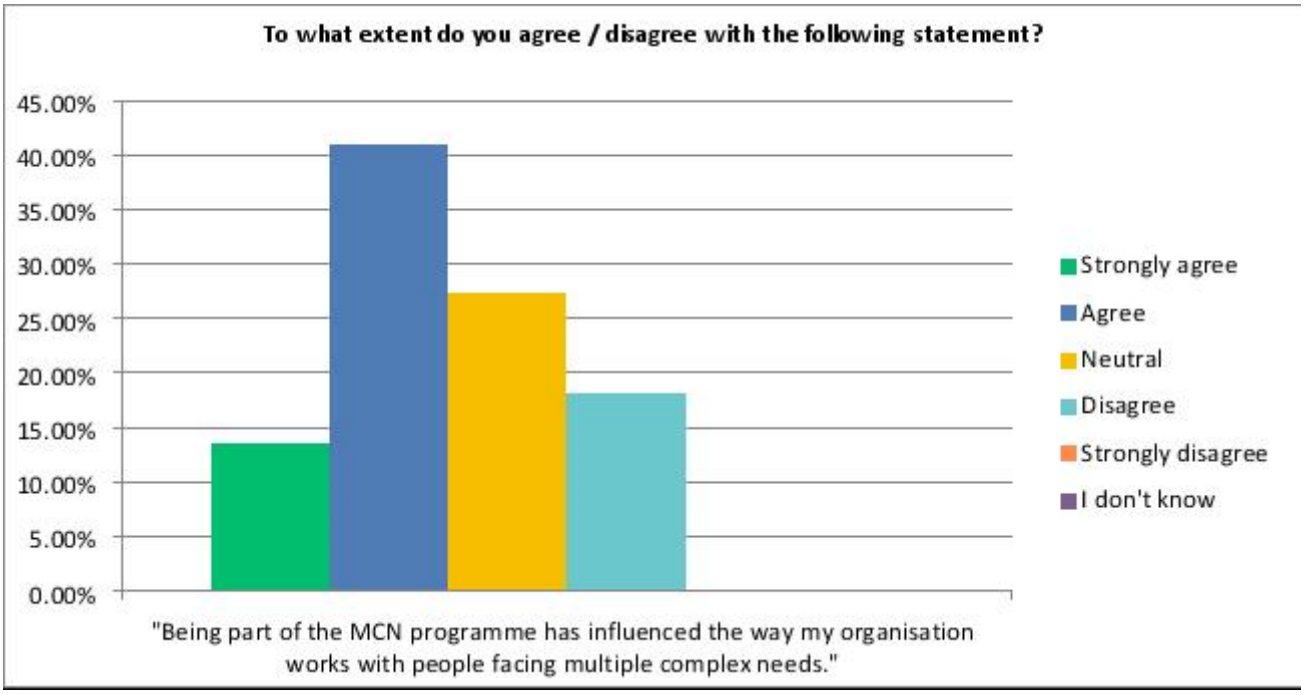
77% of respondents agree or strongly agree the Steps for Change shop has improved working relationships between organisations, with 14% neutral.

“The city centre Steps for Change shop has led to better outcomes for people facing multiple complex needs”



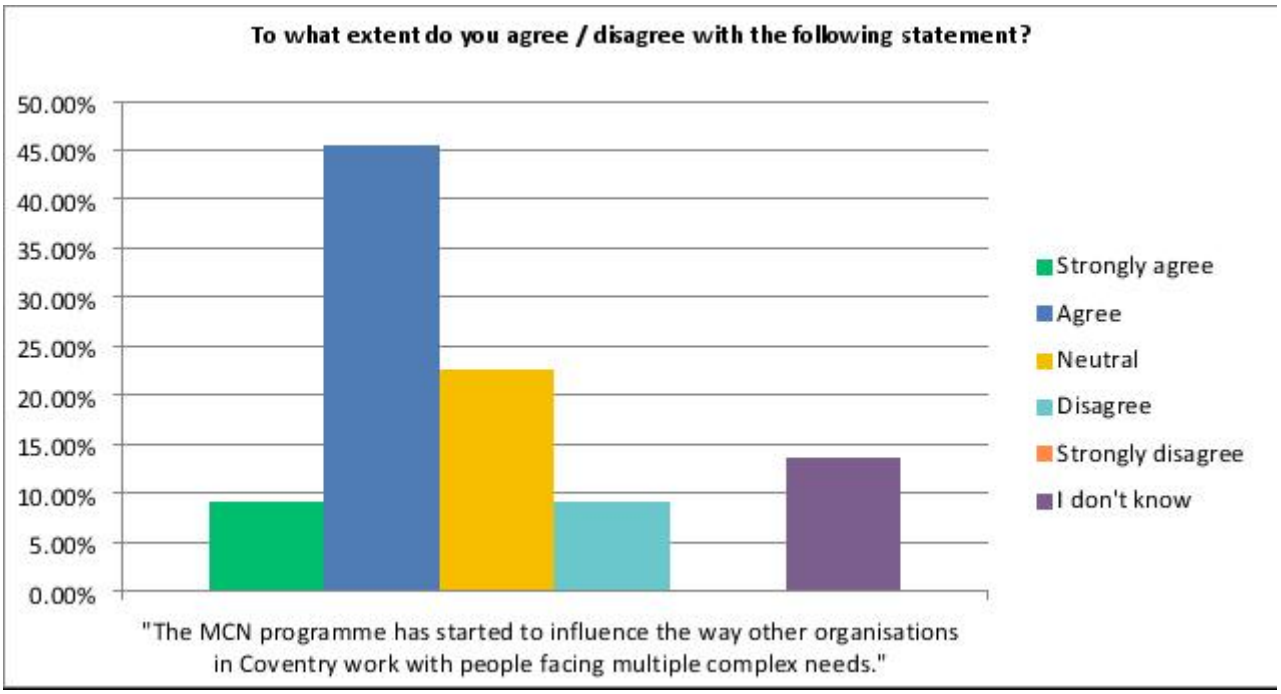
73% of respondents agree or strongly agree the Steps for Change shop has led to better outcomes for people facing multiple complex needs, with 14% neutral.

“Being part of the MCN programme has influenced the way my organisation works with people facing multiple complex needs”



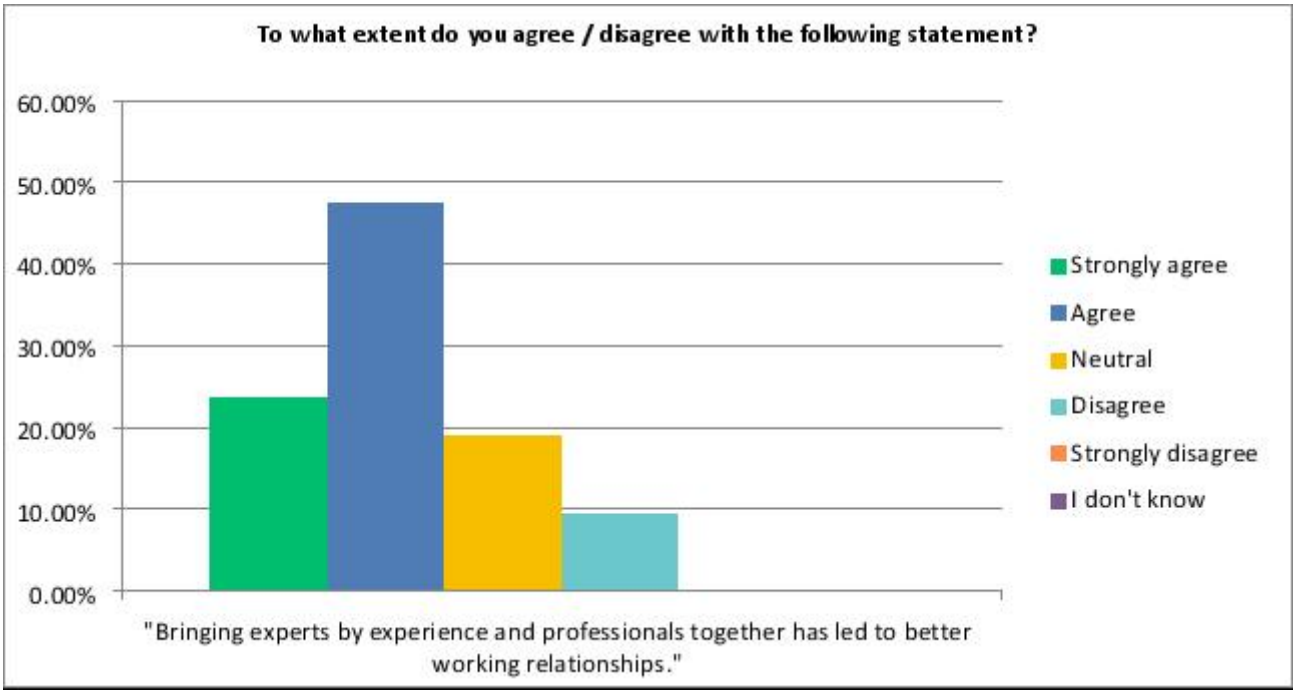
55% of respondents agree or strongly agree being part of the MCN programme has influenced the way their organization works with people facing multiple complex needs, with 27% neutral.

“The MCN programme has started to influence the way other organisations in Coventry work with people facing multiple complex needs”



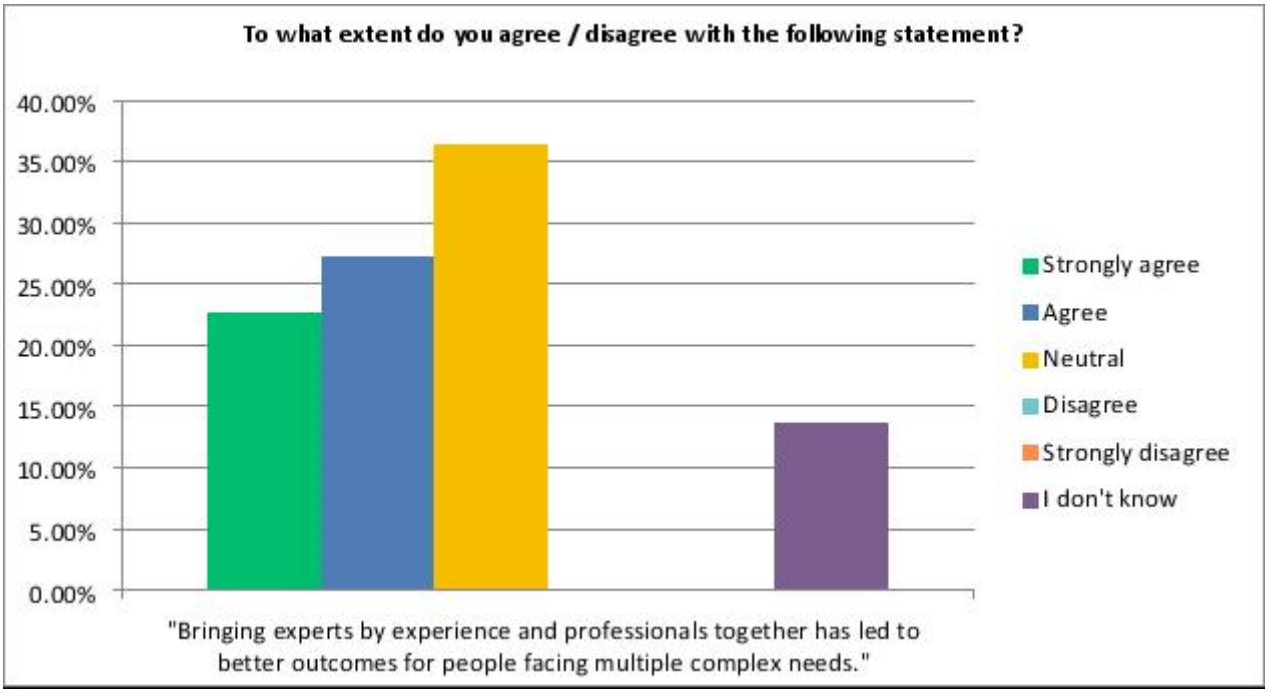
55% of respondents agree or strongly agree the MCN programme has started to influence the way other organisations in Coventry work with people facing multiple complex needs, with 23% neutral.

“Bringing experts by experience and professionals together has led to better working relationships”



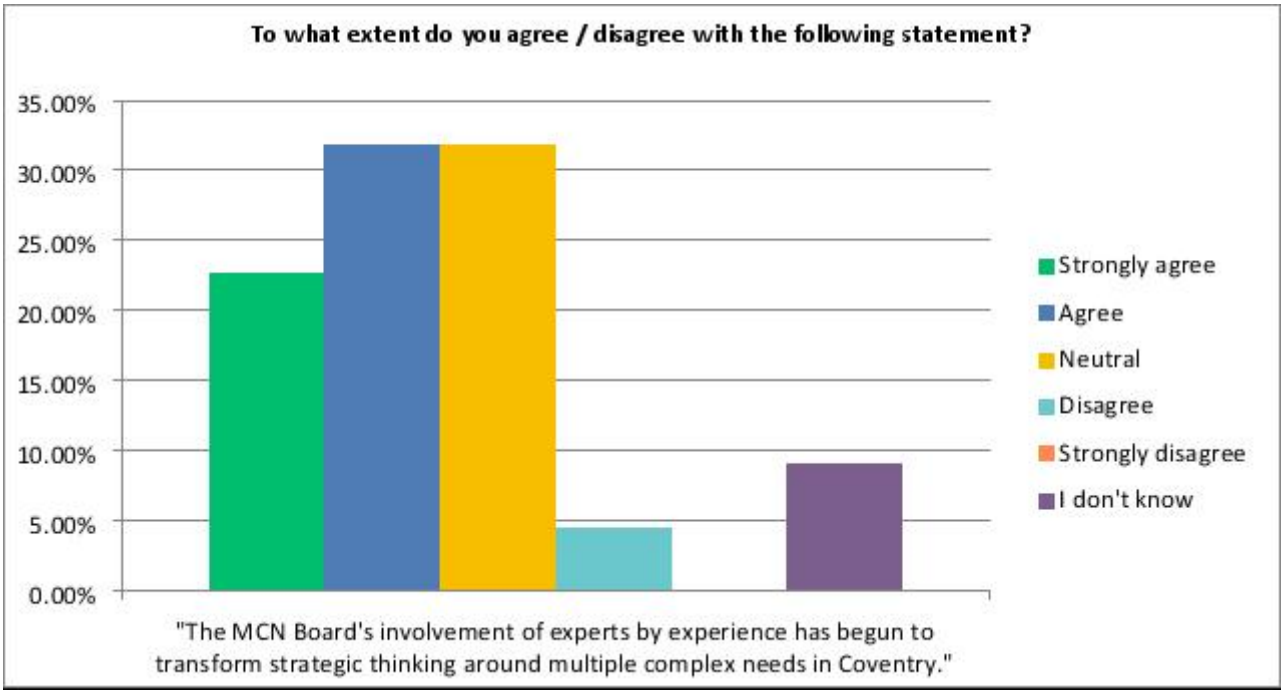
71% of respondents agree or strongly agree bringing experts by experience and professionals together has led to better working relationships, with 19% neutral.

“Bringing experts by experience and professionals together has led to better outcomes for people facing multiple complex needs”



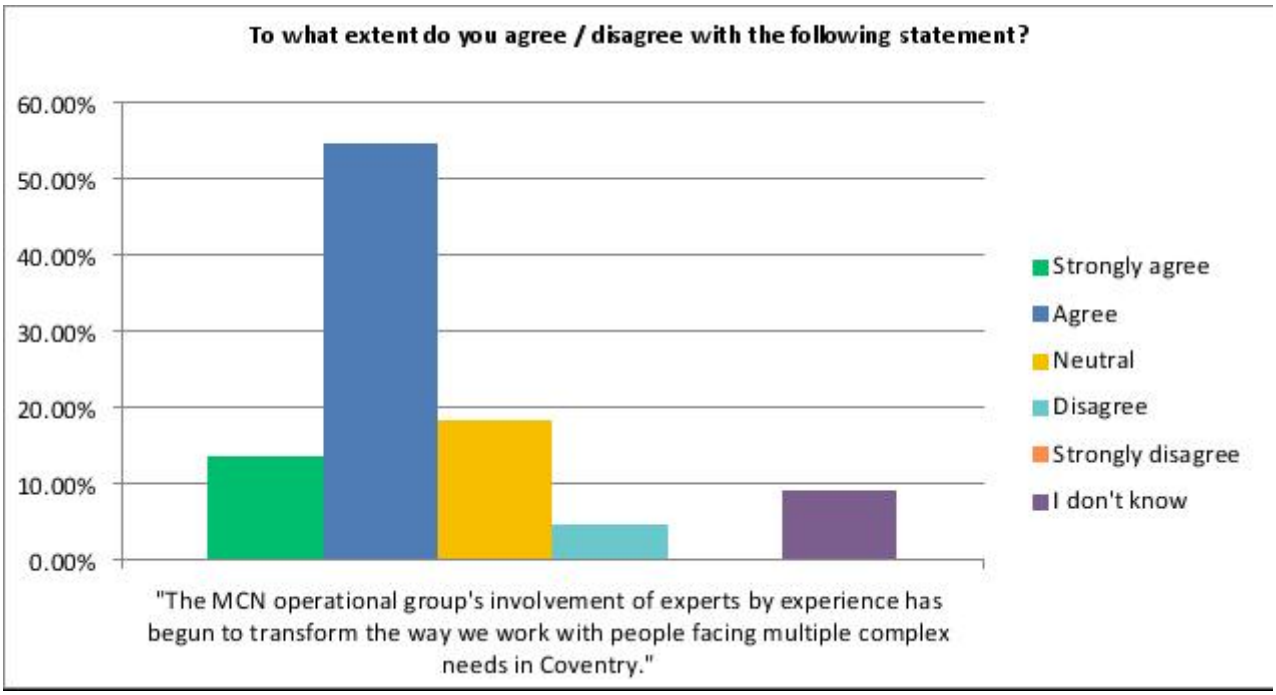
50% of respondents agree or strongly agree bringing experts by experience and professionals together has led to better outcomes for people facing multiple complex needs, with 36% neutral.

“The MCN Board’s involvement of experts by experience had begun to transform strategic thinking around multiple complex needs in Coventry”



55% of respondents agree or strongly agree the MCN Board’s involvement of experts by experience has begun to transform strategic thinking around multiple complex needs in Coventry, with 32% neutral.

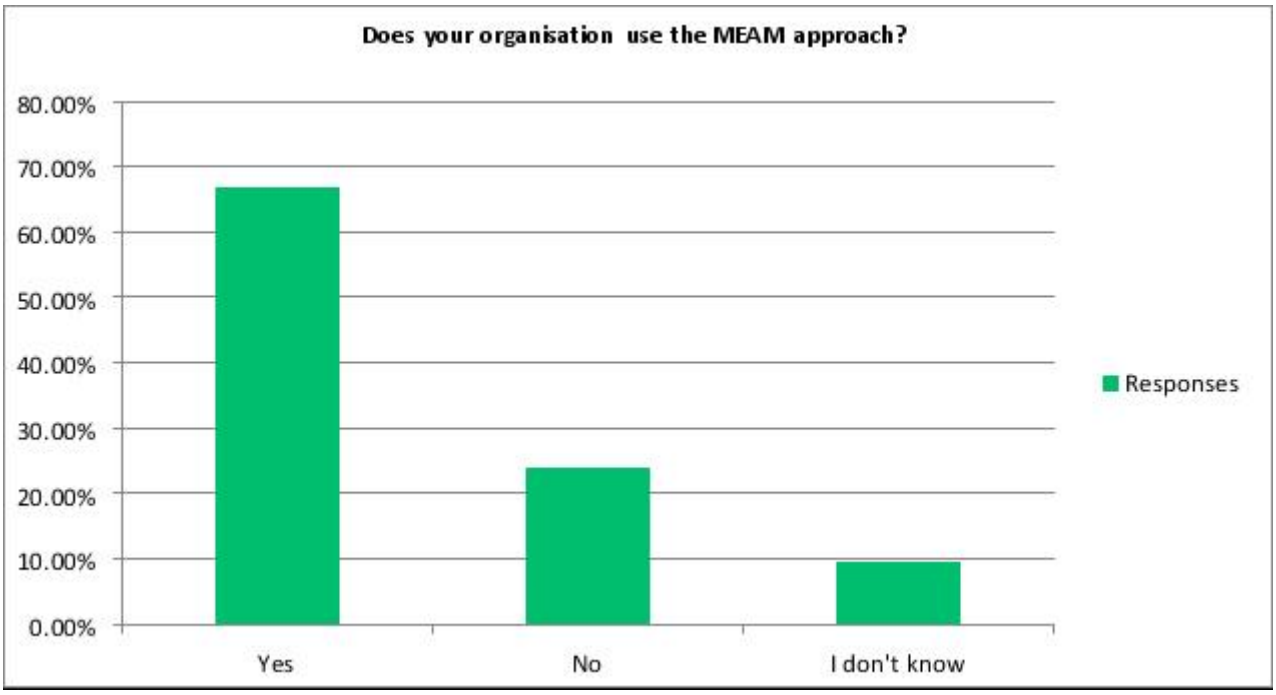
"The MCN operational group's involvement of experts by experience has begun to transform the way we work with people facing multiple complex needs in Coventry."



68% of respondents agree or strongly agree the MCN operational group’s involvement of experts by experience has begun to transform the way we work with people facing multiple complex needs in Coventry, with 18% neutral.

MEAM questions

Does your organisation use the MEAM approach?



The majority of responding organisations used the MEAM approach (67%).

How can we develop the role of MEAM? (Including any suggestions on the way we can embed the MEAM approach throughout partner organisations)

Commission/employ/appoint a local MEAM Champion/co-ordinator

Develop jointly held system change priorities; obtain senior managers support

Embed MEAM as a requirement in all Council and partner agencies' contracts with suppliers

Increase understanding of opportunities MEAM offers; MEAM awareness strategy to voluntary groups

Importance of Housing and Mental Health Services as Key partners at the table

Better funding and recognition for STEPS for Change

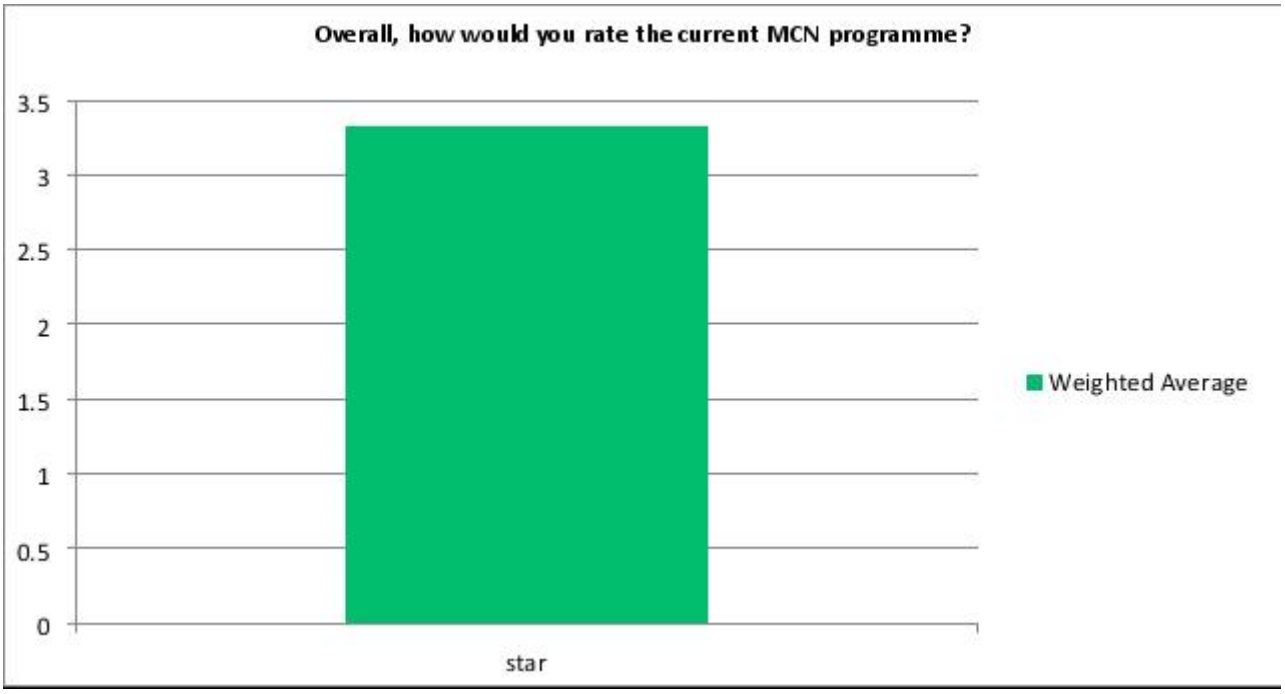
Co-ordination with other forums (e.g. MAPPA, DV, Vulnerable victims)

Awareness that capacity issues impact using MEAM approach

Sign up more organisations to the MEAM approach

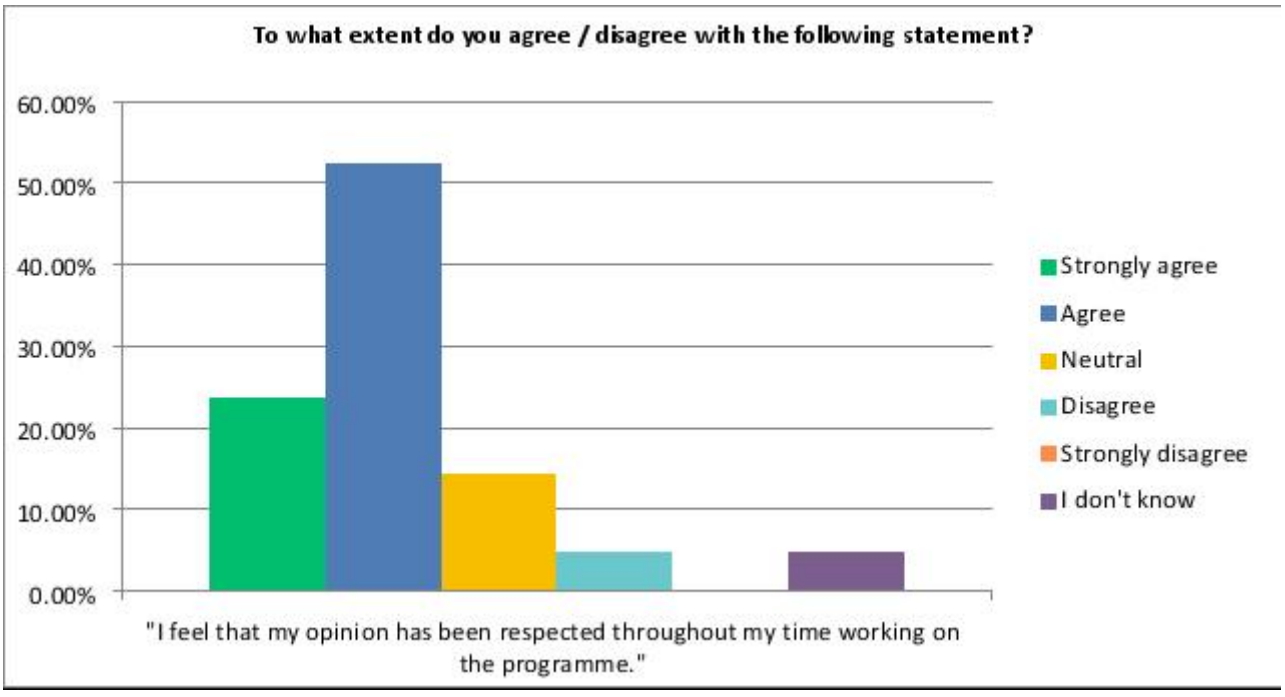
Personal view questions:

Overall, how would you rate the current MCN programme?



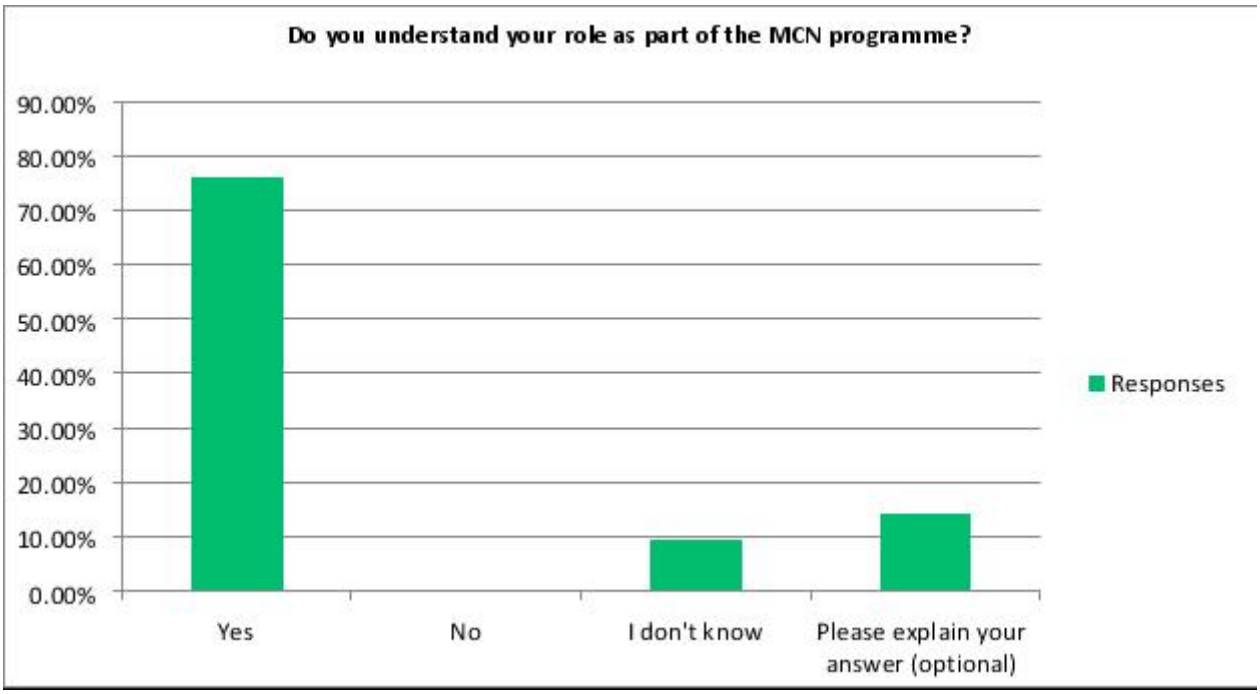
From a scale of 1 (low quality) to 5 (high quality), the current MCN programme was rated on average 3.3.

"I feel that my opinion has been respected throughout my time working on the programme."



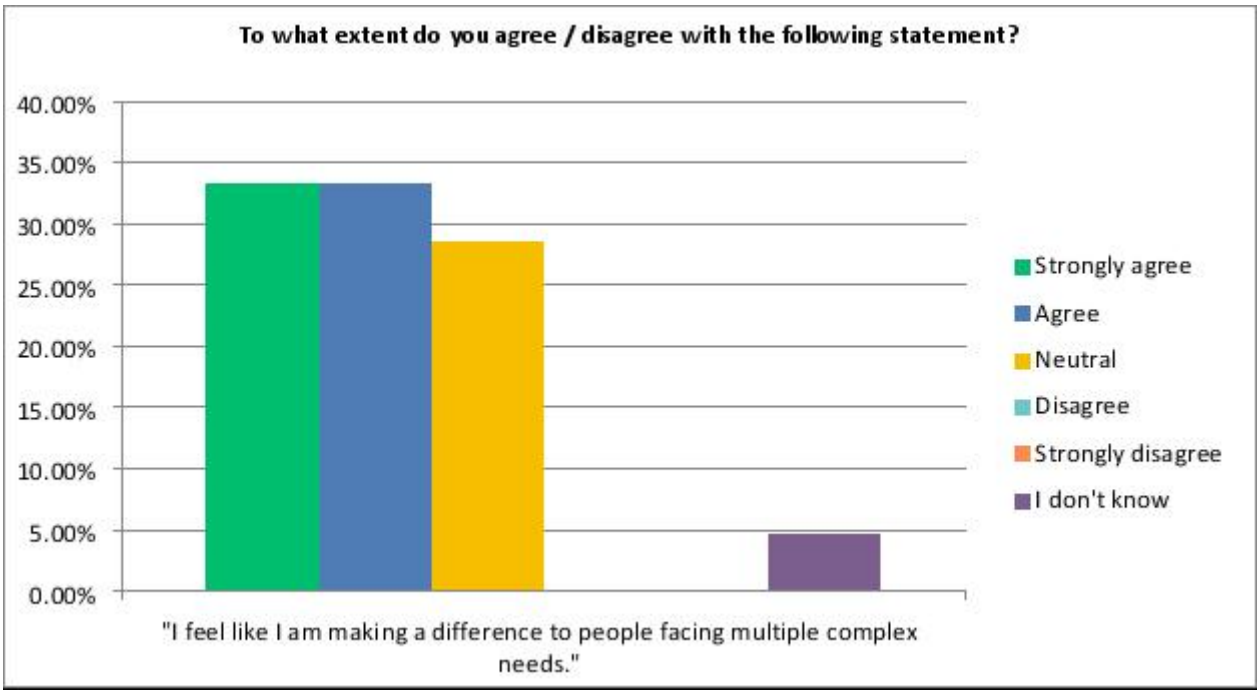
76% of respondents agree or strongly agree their opinion has been respected through their time working on the programme, with 14% neutral.

Do you understand your role as part of the MCN programme?



76% of respondents reported they understand their role as part of the MCN programme.

"I feel like I am making a difference to people facing multiple complex needs."



66% of respondents agree or strongly agree they are making a difference to people facing multiple complex needs, with 29% neutral.

What did you, as an individual, hope to achieve by taking part in the MCN programme?

Service Development (System) - support Coventry to design and deliver better coordinated services for people; opportunity to improve the system; to share wider learning and bring about system change within the locality for people with MCN; contribute to trialling systems change and reflective learning to improve outcomes for people; join up services, reduce vulnerability and reduce demand; far all agencies to work together.

Shape an approach, and influence working practices that help to unlock issues that people have consistently failed to address, through the inability of existing services to acknowledge the set of circumstances a person is experiencing and work differently. That said, there are also some societal norms and expectations that it is reasonable for the wider community to expect people to adhere to and that needs to be acknowledged.

Being in a strategic role it is important to understand the barriers and issues experienced by people with MCN and the organisations that work with them so we can start to change things at a strategic level and remove some of these barriers.

The solutions for [people with MCN] are complex, but I hope that the Board and its membership have the answers to the problems that we need to solve. Not solving them is inhumane, takes increased levels of resource and is consequently more expensive.

I had [personal experience in services] and saw how much deprivation and problems there were with rough sleeping in the city… so I joined the MCN programme to better understand what the problems were, and how we can solve them.

Learn from EBE to improve the service we provide. Work to enhance the options for our most vulnerable group in order to make a difference for them and offer opportunities.

Better relationships with partnership organisations working with the same client group; better services that are more person centred and fit for purpose within Coventry; to reach more homeless people and improve my own knowledge of what services are around.

To show that partnership working can work on an unprecedented scale.

Housing and stabilizing vulnerable offenders in supported accommodation to reduce risk of reoffending and harm to selves and public.

What are the biggest challenges and / or weaknesses associated with the MCN programme?

Lack of a MEAM co-ordinator.

Capacity, resources (cash) and suitable accommodation.

Lack of strategic oversight by Board (few meetings; lack of guidance to Operational group).

Key organisations not attending the meetings leading to a sense that they are not necessarily committed to programme; some members not buying into the programme; requires better co-operation from some services.

Longer timescale.

Lack of investment by CCC.

Complexity and absence of existing frameworks.

Difficulty engaging the right people; getting other services involved; ensuring coproduction with other agencies.

Duplication of effort.

Unrealistic expectations

What are the biggest successes and / or benefits of the MCN programme?

EBE influencing policy (EBEs described as 'incredible').

Laying foundations for work growing around the city; creating conversations between organisations, EBEs and professionals, and creating system flex for the benefit of people with MCN; bringing on MEAM and various partners to co-design an approach; being able to influence and shape the City-wide approach to poverty and homelessness

STEPS for change real impact in city and street community; 'massive success'. It fostered relationships and trust with many people who previously failed to engage. Steps for Change; Ops Group & Vulnerability Forum as a success.

Some individuals who have been outside of the system for a long time are starting to engage as changes are made to remove barriers (e.g. rough sleeper with dog now accommodated in hostel).

Now need to make sure that this type of flexibility is embedded and ensure it is not just a one off. Partners talking and sharing the problem, information and knowledge; we just need to turn it into something more concrete.

Raising profile of EBE, Steps for change and Crisis work; attention to the issues and complexities associated with the cohort of people.

Getting some professionals to work well with EBEs.

Better communication, collaboration between services, forward thinking, collective responsibility and systems change.

Reduction in re-offending and harm, stabilisation of offenders and appropriate support in place to address specific needs.

Do you know any other organisations that should be a part of the MCN programme?

Womens' services.

Strengthen the programme with great engagement from Adult Social Care and Mental Health.

Engaging the CCG would provide the programme to shape how services for MCN are commissioned and delivered in future.

Mental Health and Drugs/Alcohol treatment providers need to get more involved. The MEAM approach promotes innovative thinking whereas because of the demands on these services already they do not appear to feel in a position to do so, which is ironic as by unlocking these issues will relieve demand on their services.

The relevant ones are invited, the important thing now is to increase regular attendance/ commitment; they just need to attend!

DWP and Probation.

Mental health and Adult Social Care.

Housing Associations (e.g. Midlandheart and Stonewater)

NHS; CWPT partnership reps

3rd party sector

How can we improve the way we work with experts by experience (EBEs) in the design and / or delivery of services?

Continue to develop transformational activity group of experts and professionals.

Consultation at all stages, involvement, invest, evaluate and structure

Need to ensure we find opportunities to engage professionals and EBEs which are timely, to enable the EBE views to have maximum impact.

Need to be careful to not put too much faith in a limited number of EBEs, their views may be personal to them and not indicative of a range of people's experiences; look for EBEs to demonstrate that the advice they are offering is on behalf of a wider cohort rather than it being their own opinion; a range of people who are EBE.

Links need to be made with commissioners of services to ensure that EBEs can feed into that process. Senior management (through the MCN Board and Health & Wellbeing Board?) need to ensure that it is a priority for service areas to engage with EBEs when reviewing or setting up services (including the time and resources to do so).

Start to place a value on them and not to take their input for granted; a lot do this for free - how can we in turn value them and help them?

Continue to test service user experience to highlight blockages in the system and then ensure this is escalated and the system can be improved.

[Regarding rough sleeping] we know we have the expertise, but the resources needed to tackle this issue are not there. We are all relying on the good will of Steps for Change, but we really need to get behind this organisation of partners. It has the potential to provide the foundation of solving this problem.

It would help to have a brief form online that can be used to fill in examples of good or bad practice and comments.

Briefings / news sheets / higher profile?

Provide a clear resource focus and understand that compromises between ideals and realities of resources need to be made.

Don't over-estimate what can be done. Be realistic. Respect for what has been tried before.....don't single out agency's due to over expectation.

Include EBEs with meetings with decision makers.

Would you like to add any further comments or elaborate on your answer to a previous question?

I agree that good things are happening, but there is potential for it to be much more powerful/effective if more services/organisations were committed to long term systems change.

Thanks to a number of dedicated officers from different organisations who have gone the extra mile to help this work progress.

[Regarding question on future Service Improvement]: sometimes I encounter situations and people that I'm not sure how to help, or see what is wrong but cannot do anything about it. In those instances, writing quickly a form with basic details of the situation and suggested improvement can be helpful.

Analysis

Interviews

Interview data and free-text survey material were subject to a thematic analysis, identifying emerging themes.

Questionnaire respondents suggest that the most positive outcomes from the MCN programme were the STEPS for Change one-stop shop and engaging with Experts by Experience.

a) *Do you share this view?*

- A general consensus of agreement is noted, with support for its structure within the HWB and supported by the police and housing, and the broader collaboration across services.
- Although some felt positive outcomes were due to individuals (a PC and the crisis team at ARC) and strongly endorsed STEPS for change.
- It was noted that the challenge is one of public health relating to addiction and mental health.
- Also, understanding the community and raising the profile of the community and the level of need and building partnerships, collaborative working within the council.
- EBE are excellent and essential in keeping this process working. MCN adopted the STEPs for change project on a short term and kept on longer term because it's working well. This was under a different police lead.
- Calls for closer links with mental health.

b) *How can we build on this work and continue to develop STEPS and EBE?*

- Appreciating the multiplicity of vulnerabilities and complexity of needs.
- Dovetailing with council's homelessness strategy - secure housing for the homeless, possibly with Housing First.
- More EBE on the strategic Board and developing a bottom up rather than top down approach to embed the culture. Sustainability and engagement to ensure EBE feel they can make a real difference to statutory services.
- Acknowledge the success of getting the right people around the table, and having EBE challenge every step of process and professionals willing to listen to EBE. The next development being from consultation to co-production.
- We need representatives from all organisations and a greater response from each of the services is needed. Linking also to more grass-roots services.
- Some duplication in forums starting to be corrected.
- Advertising and promoting services more, suggested via Hub meetings and bite-size sessions.
- The developing of EBEs roles as more come onboard, and upskilling EBEs to a cycle of giving back into the organisation for wider benefit.

Results from the questionnaire suggest that the biggest struggles were around improving outcomes for individuals with MCN. The questionnaire responses identify lack of resources, in terms of dedicated resource and a MCN fund to support the work, suitable accommodation as well as engagement from key partners for this.

a) What is the biggest missed opportunity in your view?

- Several comments about the absence of a budget attached to this project. There was never any resource attached to it and we have no sustainable resources for MCN. The vision was right but we needed commitment to resources, which was naïve. Related to this not having an operational co-ordinator to bring it together and oversee the work or being able to provide intensive recovery package (funding needed to get a CPA). Acknowledgement that the resourcing issue is wider than not having a MEAM coordinator, it's the impact of reduced public sector funding too. Also noted mismatch between the Board and the OPS group, the latter who have been steering the Board, as opposed to vice versa.
- Also comments about no flex within contracts or at operational level, and taking so long for the housing colleagues to come on board, and then losing key personnel at pivotal points, and absence of meetings in a 6 month period. Passion is lost as well as the accountability. The need also to have someone who can communicate with politicians.
- Comment that the outcomes have been only small improvements to individuals' lives, even in a 3 year programme which is attributed to not providing funding for the programme, which would have made a difference
- We could have made more use of the MEAM network resource to provide the external challenge needed as a system.
- The Customer journey hasn't been sufficiently explored enough and to understand what the challenges are for EBE when we speak to them
- Although 3rd sector organisations do get involved, there is no presence statutory organisations e.g. community mental health teams and because of the sheer level of need in the MCN cohort, these statutory orgs are needed (e.g. crisis, community mental health teams) and a need for mental health capacity assessments. Mention of social work input would be helpful.
- Aftercare is lacking, it needs more money, e.g. bus passes for hospital appointments – Arc provide these unlike other orgs. They need mobile phones, ones that are not worth anything if they were to try and sell them (e.g. £10).
- Awareness that if you ban a group of homeless people from the city centre, others will replace them.
- Awareness that students in the city are very generous and offer money (to homeless).

b) *Are there other barriers you have identified regarding improved outcomes for MCN clients?*

- Inconsistency in leadership across senior and sense of some taking a back seat on it (e.g. police and programme officers).
- MCN is a challenge and if it were easily solved, we would copy others' techniques, but we are getting traction and moving in the right direction.
- Systems-wise housing pathways seems to be the biggest barrier in Coventry and the pathways into accommodation are still quite rigid, requiring going through a hostel.
- On a daily level, there is the challenge of engaging new people with MCN.

c) *How could we build on what we've achieved and do things differently in future to achieve better outcomes for individuals?*

- There needs to be a cultural change, and the timing has come together (Housing First and Board together is a good thing; political investment is now high.
- STEPS for change must be sustained.
- MCN needs a structured budget and a Housing First member.
- We should develop an action plan and embed it into bigger structures. The big money is in Housing First (HF), and it feels like MCN is being side-lined.
- With Ops group police changes came the aim to get some outcomes and this came about through discussing individual cases.
- Note there was some going round in circles in summer 2017, trying to define MCN and identify which cohort to help, eventually just went out and helped someone.
- Sense that MCN is not a waste of time and there's nothing else like it in Coventry, what else could it be? Now the right people are round the table to come up with the solution (housing and homelessness presence).
- The operational work has come a long way in 18 months and identified the key partners and starting to see outcomes. Need is to embed MCN thinking across more forums, so they become more MCN friendly in their thinking.
- On a practical level, storage space is needed and each individual should have a personal fund to buy small things (e.g. pyjamas).

The MCN programme wanted to not just improve outcomes for individuals with MCN, but look at having a more strategic, systems approach to helping people by bringing people from different disciplines together.

a) To what extent has the programme helped transform strategic thinking around improving outcomes for people with MCN?

- Views ranging from optimistic that it has been an uphill struggle, but we're on the cusp of changes to a sense of there being no one prepared to financially support it and no political will.
- Others felt that Housing First, having come on board now, is focussed on MCN nationally, but questioning the support provided to them.
- Strategic leaders buy in on paper, but there is disconnect between strategic and operations. There has been buy in operationally. Where's the strategic steer to say MCN is the priority, so housing should flex, for example?
- General note by most members about the lack of financial support and two suggestions of using Housing First money. With only a budget of £1,200 to support the engagement work – if this is the priority - where's the resource for it? It hasn't been sufficiently high profile across key agencies, it is the less well known priority for the health and wellbeing board.
- Part of the programme is to have a task force (which is what STEPS for change, is) but in order to work, STEPS should be operating more than one day a week
- Everyone in the room has it on their agenda and not just when they come to an MCN meeting – hopefully they're now making decisions in their organisations with MCN in mind and

embedding it in their own organisations – although not sure how you would measure that. It's about the timing being right to shape Housing First too, several noted.

- Description of MCN as a Trojan Mouse – starting to slowly influence the system from the bottom up (opposite of breaking down the door with a Trojan Horse).
- Suggestion to do more to bring customer experience to life for the perspective of the relevant agency, through training, CPD.
- There's a mismatch between the strategic buy in and operational staff feeling empowered to flex the system. It need more communications that they are empowered, as the strategic buy in is there. If the buy in is there at strategic level, the operational results should come more easily.
- Suggestion of launch events every quarter, setting up group exercises and encouraging communication and importance of core groups' presence.

b) What should we be doing to engage different organisations / teams / services / managers to think beyond the priorities of your organisation, to enact systems change?

- Rough sleepers are visible in the city centre and there are now concerns that they might affect external investors from plugging money into city. Caring communities are ineffective because MCN cohorts are dysfunctional, they can't just live in neighbourhoods straight from being homeless.
- Links to law centre would be beneficial and migrant centre, CGL, Midlands Heart but since they are pulling out of the MCN housing, we should work with whoever will replace them. The Vulnerable Persons team doesn't come frequently enough, only quarterly.
- The focus is on the type of approach where you identify particular people is a good approach - if there was a smaller group/panel made up of social care to case-manage, for individual needs assessments, this would be better than having too many people in groups, which is the case now. The huge cost of not case managing, is noted.
- It is missing the clinical input and police, community reps from mental health, crisis should be brought together to become a much smaller panel.
- We need to change the focus of the board and re-launch, we are coming to the end of the 3 year programme and there's still stuff to build on which links to the housing and homelessness strategy; keep EBE and STEPS for change but build on it.

Respondents to the questionnaire suggested mixed responses to being a Making Every Adult Matter (MEAM) approach area.

a) To what extent do you feel the Coventry system understands what we have signed up to?

- Some frustrations expressed by several members who felt Coventry hadn't understood, or helped shape what is delivered, and comment that officers who initially signed up to it are no longer part of the authority, set up without co-ordinator and we still don't have a co-ordinator.
- There is value in being part of a national coalition. Perhaps more work is needed to help Coventry find what the right version of MEAM is for the City.
- Comment about conflicts between parties at the table – e.g. police think public health should be doing more, PH think police are making violence a PH issue. Perception of animosity between organisations also mentioned.
- A comment that 'Make Every Child Matter' and 'Make Every Contact Count' are more well-known compared to MEAM.
- A suggestion received that there should be a day when you invite everyone in to show what MEAM really is.

b) Is MEAM still the right opportunity for the city?

- Comments about the lack of funding for MEAM. Statement that it's a great concept but not right for Coventry, due to the absence of a funded co-ordinator. Another felt that Coventry is taking a hybrid approach, without a co-ordinator, so there may be limited benefit.
- MEAM is keen to have a west midlands site.
- Much more awareness-raising needs to be done for MEAM.
- Some felt it is the right option for the city: necessary for the people who are disengaged and who have fell through the gaps for years, and a call for better understanding of the criteria for what makes a person suitable for MEAM. Some qualified their support of MEAM that it needs the right political will and senior leadership.

- Also pride expressed in the collaborative working achieved.
- MEAM is good branding because of its strapline – there may be a place for it but it's not necessary. What is necessary is to pull services together to work in a meaningful way.
- There was a common sense of needing to raise the profile of MEAM still further.

c) Can we enable system change and flex without being a MEAM approach area?

- There was a sense that MEAM is just spreadsheets, and the important thing was to just get out and work with people who need help, and a suggestion to get a cohort of 15-20 and get them onto Housing First. Another suggestion of hostels with shooting up services, so they can't do it on the street. Hostels where we can wrap services around them, but acknowledging the issue with this is if people die there, and the organisation had endorsed it, there would be blame.
- There was a comment that MEAM provides helpful external challenge and external scrutiny. There is an issue though on the impact and perception of others going through the system, that there is preferential treatment. The aim is that flex should be offered to everyone as it

saves money, implication that this is more costly to some organisations but cheaper to system.

- Ultimately, MCN has been ignored by the system and statement that One Coventry reluctantly became involved. A MEAM awareness strategy for voluntary groups to strengthen knowledge, is suggested.
- Some felt that the MEAM approach could bring in assistance and there is an example of another city that adopted a MEAM approach, and were able to employ a district nurse who acts as a MEAM coordinator. They are trusted, know who to call and can get resources to people when they need it and when they want to change.
- A further example of Cambridge is cited, and this area has been doing MEAM for a while but have their own brand, Counting Every Adult, which adopts the MEAM principles.

Where do you see Multiple Complex Needs work in the future?

- Comments about integrating into mainstream BAU homelessness, drug and alcohol strategy

- Support for EBE as a really valuable model and strong appreciation for those engaged in the strategy and comment that the Board have worked well with them.

- Comments to engage sexual health and other services; refresh vulnerable persons group, importance of housing and need for hotels to meet certain criteria.
- Suggestion to link into structures under police and crime board rather than health and wellbeing board. The Link with Housing first makes sense as that is where the funding sits and provides WMCA scrutiny.
- Suggestion that case management needs to go to Vulnerable Persons forum with right people around the table. Perhaps it should be a multiple disadvantage forum instead of VP and established under HARP. Current Operational group has no adult social care, or mental health, on it, which should be introduced.
- Suggestion it should dovetail into housing, in case it is no longer a Health and Wellbeing Priority – that's down to the JSNA. Relaunching it through the housing and homelessness work to get MCN the support and funding it needs.
- Comments to house rough sleepers, and deal with repeat causes, listening to VPs groups and make sure it happens as there is a problem around housing: when housing MCN cohorts in neighbourhoods, the area and people already living there are affected and VPs mixed with other VPs can cause issues. Suggestion that this can be managed through purpose built accommodation. Everyone in the homeless community knows one another (they owe each other money, sleep with one another etc.) so there needs to be a collection of hostels including female-only hostels. Suggests a sufficient choice of hostels, and a MEAM coordinator (in ARC), not necessarily a health professional - just someone who is trusted by the cohort.

- MCN can't sit in any one place, it needs to be held by the system, whether that is by the Health and Wellbeing Board, a Police and Crime Board or another partnership board. It cannot be just held by the Council and it needs statutory and particularly voluntary sector partners, to engage as they do most of the contact with MCN individuals.

- The MCN programme is necessary, and is voluntary sector heavy, so needs more presence from the health and community mental health team, who could use their computers to discuss the individuals during the board meetings.

- Suggestion that MCN clients are lost to follow up when they disengage which might reflect a lack of understanding, because addiction is not a choice. Housing needs to have certain criteria and the care needs to be there. Example of making sure of a whole service such as if an individual needs prescription medication, but they don't have access to a 7 day chemist, their needs aren't met.

Discussion and conclusions

The Interview and free text of the Survey thematic analyses have been combined to identify the following key themes:

1. Who is involved

The majority of individuals questioned as part of the evaluation were part of organisations offering specialist support for homeless individuals and were involved in the Ops group and the co-production meeting. Frequent statements were made about the requirement to include other services which have a role in MCN (as noted by the main research by Lankelly Chase). This included mental health, drug/alcohol services, some housing associations and adult social care – these were all highlighted as areas of absence in the current programme of work, and ripe for future development.

2. Operational structure and governance

Ops group and Board

A range of reasons for being part of the MCN project were provided, with the strongest motivations being wanting to raise the profile of and meet the strategic aims of improving outcomes for people living with MCN.

Challenges in getting the right people around the table initially were noted, and also the lack of a model of which service should lead. There was reference to models in other cities but a general need expressed for more co-ordinated services for Coventry's MCN population.

There was also a disconnect reported between the strategic and the ops group, with a lack of operational flex and no statutory organizational presence meaning only small outcome improvements were made. While the vulnerable persons forum has taken on the case management, it is felt it does not meet frequently enough and often needs clinical and mental health input. It was felt that review of the format was needed and it might benefit from a smaller more focused panel, with duplication of panels across the system noted.

STEPS for Change and Experts by Experience

Many comments were shared valuing the contributions of the Experts By Experience who had participated in shaping the MCN agenda, commenting they were transforming strategic thinking and ways of working through appreciation of multiple vulnerabilities There was a strong keenness to maintain and develop this engagement further, as a wider base and an ongoing role in the work. Similarly, the work from STEPS for Change was commented on very positively and consistently, with agreement that STEPs has improved working relationships and lead to better outcomes.

Areas for improvement for development of Experts by Experience included finding timely opportunities for their involvement and potential to consult at all stages, with a need to ensure their contribution is a priority for service areas. This includes considering their views at a strategic level and ideally moving from consultation to co-production. Also mentioned were having appropriate EBE (through widening representation), continuing to develop them and collecting examples of good practice.

3. MEAM

The majority of individuals reported their organisations using the MEAM approach. However, the most frequently occurring comment was regarding the lack of financial investment for MCN and a MEAM co-ordinator role, reflecting some level of frustration. It was felt that it provided helpful external challenge, though there was a concern it could result in preferential treatment for individuals on the MEAM cohort. Suggestions aside from this for further developing approaches included embedding the principles in contracts, coordination with other forums, signing up more organisations to the MEAM approach and increasing understanding of the opportunities it offers, for example through an awareness strategy to voluntary groups. More awareness and clear criteria of eligibility are needed. Furthermore, it was recommended that if there is to be no co-ordinator in Coventry, there needs to be a review of other ways to approach it.

4. Objectives

Successes

Generally, respondents were in agreement that the MCN programme has influenced the way organisations work, with the bringing together of experts and professionals leading to better working relationships and outcomes. The original challenges noted were that services were not designed around individuals with a focus on single issues. The work done by the MCN programme was reported to result in improved service coordination and better working because of the case management.

Aside from the previously mentioned successes of STEPS and Experts by Experience working with professionals, other areas of success included attention to complexity, engaging people outside of the system, creating conversations to flex the system and a reported reduction in reoffending.

Challenges

It was noted the difficulties of improving outcomes through available resources and engagement of individuals. The challenge of available capacity (referencing both the coordinator and funding) meant there was a reliance on individuals going the extra mile reported. Additional barriers included inconsistent leadership, systems wide housing barriers and engaging new individuals with MCN.

5. Future direction

Whilst the MCN project was largely positively reported on, concerns for the future direction were expressed, particularly in regards to the complexity of needs, and specifically maintaining the involvement of all parties required to meet the needs of those with MCN. Explicit consideration of housing was mentioned, with comments made on the importance of expanding housing options and continuing to engage with the existing and developing providers.

Future points identified to consider included:

- Other organisations
    - Engage sexual health
    - Link to police and crime structures
    - Dovetail into housing
    - Expand out from voluntary sector to include involvement from mental health and social care
- Exploration of the customer journey
- Sustaining STEPs

- Developing an Action Plan
- Not sidelining the work of multiple complex needs with the implementation of Housing First
- Embedding multiple complex needs thinking in more panels
- Integrating the work into mainstream Council strategies (e.g. homelessness, drugs and alcohol)
- Refresh the vulnerable persons forum (e.g. multiple disadvantage forum and case management)

6. How these findings fit with the current context

The work done for this report was towards the end of 2018 and beginning of 2019. Since then (as of June 2019), there have been a number of strategic and operational changes that have taken place in the council which will go some way to address some of the points raised in this evaluation. This includes a review of the vulnerable persons forum and additional funding secured to support the homeless, including a rough sleeper co-ordinator and navigator. Work has been done to get representation from services outside of the voluntary sector and to dovetail into Housing. The Strategic Housing Board has been established and is chaired by the Chief Executive, where Housing and Homelessness is considered from a City Council perspective and the strategy is set and supported by the Housing and Homelessness Operational Group. Delivery of Housing First is now being overseen by the Housing Commissioner and Head of Housing, with support as required provided by Public Health and reporting into the Strategic Housing Board.

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Coventry City Council

Report

To: Coventry Health and Wellbeing Board **Date: 8th July, 2019**

From: Valerie de Souza

Title: Community projects proof of concept evaluations

1 Purpose

1.1 This paper will update on two projects co-funded by Better Care Fund (BCF) and Public Health-Insight (PH-I) and being delivered by two community organisations in Coventry.

2 Recommendations

2.1 That the Health and Wellbeing Board endorse the work and the findings so far and support the development of a systemwide approach to mobilising community assets to improve health and wellbeing and reduce demand

2.2 That individual board members consider their organisation's current relationship with the community and voluntary sector and how this might become more collaborative to unlock the support required to meaningfully embed prevention at scale

3 Information/Background

3.1 Since 2017 two community organisations (Moathouse Community Trust and Grapevine) have been funded to work with individuals in a non-programmatic way with the aim of learning what works to mobilise community assets, re-orientate formal services to work as a whole system, and boost prevention to produce better health and wellbeing outcomes for communities.

3.2 The work takes place in the context of the Upscaling Prevention Programme the vision of which is to "galvanise effort, expertise and resource to stimulate a step change in commitment to prevention across the health and wellbeing system". This will be achieved partly by taking a place-based approach to systems change, creating and fostering the conditions necessary to support a system wide uplift in prevention.

3.3 The two projects are being funded through a combination of BCF and PH-I funding:

3.3.1 Grapevine Community Capacity and Resilience project seeks to take practical steps to strengthen community-based action focussing on prevention and building stronger, self-sufficient communities. The project aims to ensure that those who are vulnerable to ill-health or health inequalities are better supported to develop resilience and reduce the need for crisis-level services. This project is wholly funded through the BCF programme and has received a total of £37,500 per year, with funding committed until March 2020. Approximately two hundred individuals a year have been reached through Grapevine activity through this project, all of whom either have long term health conditions or care for those with long term health conditions.

3.3.2 Moathouse Community Development Trust-Community Navigator aims to develop a deep understanding of the local environment and community in order to gather intelligence and build connections from the ground up. It aims to proactively reach out to vulnerable older people and identify system failures and opportunities to support positive outcomes for individuals. This project received £6,000 from BCF in 17/18, £18,000 from BCF and £18,000 from PH-I in 18/19 and £18,000 from BCF and £4,000 from PH-Insight has been committed for 19/20. To date support has been provided to 180 senior, vulnerable community residents (the cohort which the project focussed on) but by providing holistic, whole-family support to these individuals, Moathouse have also engaged with over 600 children.

3.4 Evaluation has shown that the community approaches taken by Grapevine and Moat House Community Trust are contributing to the following deliverables of the BCF programme, however measuring the scale of this contribution is challenging:

3.4.1 Improved joint working between health, social care and the community sector so that activities intended to improve health and resilience (by statutory and non-statutory providers) are more tailored to the local area, resulting in a greater coordination of activities and more efficient and effective use of resources.

3.4.2 Reduced hospital admissions and prevention or delay of re-entry to the health and social care system through increased individual resilience and access to support networks and through people feeling more in control of their own health and wellbeing

3.4.3 Reduced social isolation of people through the development of supportive networks

3.4.4 Connecting isolated and vulnerable individuals to activities that will increase their resilience

3.4.5 Improved quality and patient/service user satisfaction

3.5 Key components that both projects demonstrate are needed to mobilise community assets and re-orientate formal services to produce better health and wellbeing outcomes for communities include:

3.5.1 Established and trusted infrastructure. The results gained are building on work and relationships developed over time. It is important that this is valued, and not put at risk as a gap in services could impact detrimentally on service users and is hard to fill once it is lost.

3.5.2 The skill set and experience of staff are critical in shaping the activities, mobilising and supporting people. They are key to the outcomes achieved and well qualified but are often not seen as 'professional' by the statutory sector. There needs to be a recognition that without this workforce the most vulnerable people may not get the support they need in a timely way and therefore their health and support needs may escalate.

3.5.3 There is a skill and structure to building relationships in a way that creates meaningful connections, trust and a deep understanding of the community that enables the development of sustainable networks. Investment needs to support creating the conditions for this as well as the activities themselves.

3.5.4 A holistic and asset-based approach: Grapevine do not use standard definitions of 'long term illness' instead anyone who self identifies as having a long-term health condition is welcome to attend the self-care socials. The people who attend are treated as "more than your illness" and supported to discover nascent skills and talents. The approach is also used at Moat House who support all of the needs a person presents with as well as supporting them to take the lead in addressing their own challenges or supporting others with theirs.

3.5.5 Equality of power, devolved decision-making and mutual accountability, where people take responsibility for their own change, form part of the conditions for effectiveness, as do open and trusting relationships, and valuing leadership in those experiencing interlocking disadvantages

3.6 Added Value: the approach taken by the two projects goes beyond the outcomes tested. Both projects demonstrate an approach to creating better health outcomes for people which includes generating economic and social value through volunteering, getting people (often long term unemployed) into jobs or creating new products and services. The fact that the two organisations have invested over the long-term in building skills and relationships means they are often able to reduce the time it takes to achieve outcomes. This investment is not factored into any evaluation process but is a key factor in the projects' success. There are substantial health and wellbeing outcomes that are generated through building community, including through increased community connections, social capital, and sense of power and self-efficacy.

4 Recommended Proposal

The full complete independent evaluation is included as an appendix to this report. It is recommended that H+WBB endorses and commits to building on these findings to develop a collaborative relationship with community and voluntary sector organisations so that the whole system can achieve improved health and wellbeing, decrease demand and reduce health inequalities.

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Appendices

Proof of Concept_FINAL.PDF

locality
the power of community

Proof of concept for Grapevine and Moat House Community Trust

March 2019

Coventry City Council

Better Care Coventry

NHS
Coventry and Rugby
Clinical Commissioning Group

70 YEARS OF THE NHS 1948 - 2018

Contents

Introduction

In 2018, Locality was commissioned to undertake a proof of concept for two community projects to capture the value of working in non-programmatic ways, where individuals are in the lead. The aim of this proof of concept is to learn what works to mobilise community assets, re-orient formal services to work as a whole system, and boost prevention to produce better health and wellbeing outcomes for communities. The conclusions are intended to support decisions about future ways of working, including future Improved Better Care Fund (iBCF) investment.

It focusses on two community organisations, Moat House Community Trust and Grapevine. Both organisations are carrying out pilot projects under the Community Capacity and Resilience workstream for the Better Care, Better Value programme funded jointly by the iBCF, Coventry and a Public Health Grant via Coventry City Council. This initial feasibility assessment has been carried out whilst both initiatives are still in fairly early stages.

The work takes place in the context of the Upscaling Prevention Programme, which aims to translate the commitment set out in the Alliance Concordat for the Health and Wellbeing Boards throughout Coventry and Warwickshire to work together. This programme's vision is to "galvanise effort, expertise and resource to stimulate a step change in commitment to prevention across the health and wellbeing system"[1] It plans to achieve this partly by taking a place-based approach to systems change, creating and fostering the conditions necessary to support a system wide uplift in prevention.

Fig .1 Alliance Concordat

[1] The Upscaling Prevention Programme Mandate: iBCF; 22/03/2018

In developing the proof of concept, one of the areas we were keen to measure is the impact of both programmes on growing the capacity for action and leadership in a community, both key components of social capital. As highlighted in the Marmot Review,[2] social capital creates a buffer against ill health; building resilience and agency a lever to address health inequalities. When people have a say in what happens locally, they feel more in control of their own lives, and behaviours change accordingly. We are also interested in capturing the impact that working in non-programmatic ways, where people are in the lead, can have on formal services.

We have explored the impact of the projects on residents' health and wellbeing and started to understand the plausible contributions these initiatives are making to formal service outcomes., This includes the iBCF outcomes, however it also focuses on the broader early help/prevention measures in line with the emerging Coventry Early Help Strategy,[3] . We also aimed to expose critical success factors, including inhibitors and facilitators for working as a whole system at the local level. In capturing broad outcomes, were interested in successful ways building sustainable communities and the wider benefits that can be realised from partnership working across sectors.

The proof of concept outlines the methodology and overall approach, the case for change and aims of the pilot projects, before examining their impacts and approach. The key findings identify critical success factors and improvements, and finish with final conclusions and recommendations.

Locality would like to thank all those that participated in workshops, interviews and meetings and gave their time and insights to this work.

Methodology

We have used our experience of evaluation and measurement in demonstrating the value of these approaches alongside the intelligence from our network of members, local authorities and partners such as the What Works Centre for Wellbeing and Public Health England to inform this work. Our focus is on the feasibility of the projects to work within an integrated model of health and social care.

We have appraised existing methodologies to measure impact at an individual, organisational and wider community level and conducted a rapid literature review on preventative health measures and indicators. Meetings and workshops have been held with both Grapevine and Moat House to co-design the indicators

[2] http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review

[3] Coventry Early Help Strategy 2019 – 2020 Right Help Right Time, accountable to Children's Joint Partnership Board and the Children's Safeguarding Board

and methods used, and a series of stakeholder and service user semi-structured interviews were also carried out.

A theory of change has been produced with each organisation which articulates the relational and asset-based nature of their approaches and how this leads to the outcomes and impacts defined. This proof of concept develops this further in aiming to understand how and why interventions lead to short and long-term change and what those changes are. Above all it recognises that the approaches being piloted are not transactional, but relational.

An asset-based approach to the research has been adopted, with principles of Appreciative Inquiry applied alongside a listening approach as demonstrated within the Community Organising field of work.

The Case for Change – context and aims of the pilot projects

The business case[4] for each of the pilots recognises the unsustainable nature of the current model of health and social care, with the gap between the cost of the service and levels of income widening. They also highlight the fact that the burden of ill-health falls to a much greater extent on the most vulnerable in society, and those living with higher levels of deprivation.

The challenge therefore falls into two categories: to improve healthy life expectancy, and to reduce health inequalities, thereby instigating a change in demand for services. The current focus across Coventry's health and social care system is "to significantly improve pathways and interventions by working together to provide a better level of care and keep people healthy and well".

The Upscaling Prevention Programme aims to manage population and individual health risks by focusing on early intervention to prevent ill-health and, where people have health problems, to stop those health problems escalating to the point where they require significant, complex and specialist health and care interventions. The programme is aimed at individuals who are 'at risk' and takes an early intervention/prevention approach. The focus and vision is to galvanise effort, expertise and resources to stimulate a step change in commitment to prevention across the health and care system.

The success of the workstream relies on its ability to influence behaviour within the wider Better Health, Better Care, Better Value programme and leadership, as well as across the wider health and care system and public service system activity.

Some of the ways it seeks to achieve this are:

[4] iBCF Business Case: Community Capacity and Resilience Moat House neighbourhood pilot, and iBCF Business Case: Community Capacity and Resilience Grapevine citywide pilot

- Taking a place-based approach to system change;

- Creating and fostering the conditions necessary to support a system-wide uplift in commitment to and action on prevention;

- Coordinating effort and expertise across the wider system in support of an uplift in prevention, recognising that we are not starting from a zero base and instead seek to build and capitalise on existing good practice and assets.

There was an intentional differentiation of the models invested in: a place-based community anchor model[5] (Moat House) operating at the neighbourhood level with a focus on vulnerable older people; and a more fluid community organisation (Grapevine) that operates at a city wide level, working with people accessing social care, with disabilities and those living with a long-term illness among others.

Both projects take practical steps to strengthen community-based action and ensure that greater value is placed on the contribution of the informal sector and non-service solutions.

The stated overall aims and outcomes of both the initiatives are as follows:

- Identifying people with support needs and preventing them from entering crisis;
- Growing capability at individual and community level reducing as much as possible the support needs of people who might otherwise require social care;
- Building the web of individual, family and community relationships, to support people to enable to take a more active role in managing their own health and well-being in the community.

Resulting in:

- Reducing social isolation and loneliness;
- Increasing physical activity;
- Preventing / delaying re-entry to health and social care system;
- Reduction in A & E and GP attendances;
- Improving independent living;
- Improving lifestyle behaviours.

[5] Community anchor organisations are place-based, multi-purpose organisations, which are locally-led and deeply rooted in their neighbourhoods

Moat House Community Trust – Community Navigator

Moat House Community Trust has a clear vision for creating a prosperous and powerful community where they are proud to say they live or work. Their mission is to act as an independent and trusted voice of the community, to be a catalyst for positive change.

The Trust delivers a range of engagement activities including weekly tea and talk peer support, activities for families and children, get active sessions such as healthy walks and armchair exercise classes as well as large scale events such as family fun days.

It has developed strong partnerships with agencies working in the area including social landlords, the police, children's centre, faith organisations and a local GP surgery. The pilot aims to identify and provide targeted support to vulnerable older individuals living in bungalows within the Moat House reach.

The navigator service aims to understand the local environment and community in order to gather intelligence and build connections from the ground up. This enables them to proactively reach out to the most vulnerable and to identify system failures and opportunities to support good outcomes for local people.

A community capacity worker is employed part time (0.5 FTE) to work with others and proactively visit the bungalows to build trust and relationships. Where isolated individuals can be encouraged to attend a session, this can help grow confidence, and improve wellbeing. In some cases, engaged residents have become active volunteers and support others. There are also 3 part-time community navigators (one each for older people, families and young people) bringing value to each age group.

A steering group is in place to cascade good practice, ensure coordination with other work taking place, increase community outreach, encourage participants to shape services and build trust in the community hub.

The project aims to reach 320 vulnerable residents over 12 months. To date, 157 senior residents have already been engaged, along with over 400 children.

Grapevine - Community Capacity and Resilience

Grapevine works with people facing isolation, poverty and disadvantage to help them to build better lives. They help people with finding, developing and growing networks. In particular, this project aims to strengthen support networks through generating community action, with an established pool of community activities to which they will add during the course of the project.

The Community Capacity and Resilience Grapevine project is based on the successful Good to Go[6] programme and focusses on the recognition that connections matter[7]. 'Good to Go', an umbrella term encompassing working with local residents to enable them to manage their own health, and engaging them to care for neighbours, friends and others in their community. This project seeks to take practical steps to strengthen community-based action focussing on prevention and building stronger, self-sufficient communities. It aims to ensure those who are vulnerable to ill health or health inequalities are better supported to develop resilience and reduce the need for crisis level services.

Central to this is mobilising people in activities and causes they are passionate about, so there is a united commitment to change.

Examples include the Slow Roll community cycle rides for all abilities, and Wave Rave, an afterhours disco in a swimming pool for all ages. The key is to bring different people together, those with vulnerabilities and those without, to exchange skills, aspirations and knowledge. This has been 're-evaluated'[8] and an excerpt appears below:

Capacitate

What could not have been foreseen at the outset was the way Good to Go would create capacity for change of all kinds. Deep, extensive, networked relationships have been created that provide the infrastructure for innovation, and naturally regenerate in the face of challenges and in response to demand. These networks – Innovation Factory, Ideas factory, CovMindtheGap are fully integrated – no distinctions are felt or drawn between people who are living with disabilities and anyone else; or between public service providers and public service users. Through these networks over 200 people have been involved in creating the conditions for changing how public services are designed and delivered. More than 80 people have been trained in change leadership.

Perhaps most significantly of all Good to Go has started to create a roadmap for the transformation of service delivery, especially for social care, starting with Coventry. What we see in #CovMindtheGap and its test beds, for example, amounts to a blueprint for a 'third and half sector' – co-created in the gap between the state and civil society.

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[6] http://www.grapevinecovandwarks.org.gridhosted.co.uk/wp-content/uploads/Grapevine-Good-to-Go-revaluation.pdf

[7] Positive social relations are included in many models and scales for the measurement of individual wellbeing and quality of life (see Seligman, 2012; Keyes, 1998; Ryff & Keyes, 1995; WHOQOL. group).

[8] http://www.grapevinecovandwarks.org.gridhosted.co.uk/wp-content/uploads/Grapevine-Good-to-Go-revaluation.pdf

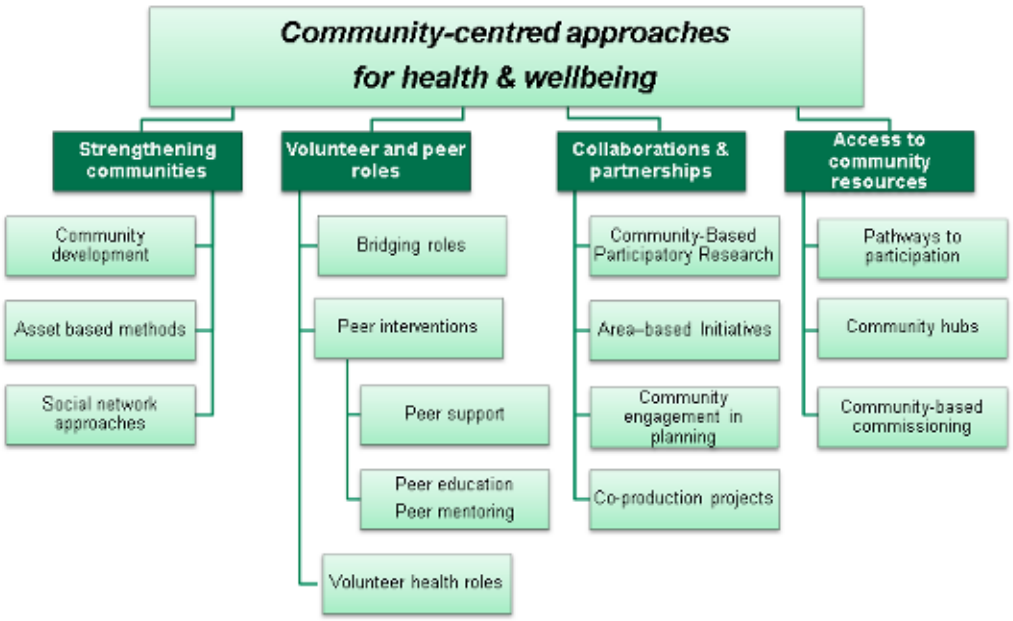
Grapevine's business case states that the pilot will share good practice from the Ignite programme that they established with the Central England Law Centre to change how public services are delivered and needs met. They aim to embed learning from their movements in community hubs, so they can build on community strengths and ambitions. They employ community organisers to deliver this project which aims to reach 500 people living with long term illness over two years. To date they have already reached 269 in 2018 and a further 96 in 2019.

Community Led Approaches

A growing body of evidence has been noted by Public Health England[9] who have endorsed such approaches to health care in their guide to community-centred approaches where they recommend that health leaders and commissioners consider the following:

- use the family of community-centred approaches as a tool to consider potential options for commissioning health improvement and preventive services;
- involve those at risk of social exclusion in designing and delivering solutions that address inequalities in health;
- celebrate, support and develop volunteering as the bedrock of community action.

They have also produced the following diagram to illustrate the family of community-centred approaches to health and wellbeing.



The Health as a Social Movement[10] collaboration between NHS England, New Economics Foundation and the RSA has also affirmed the benefits of this way of working, as has the final report in the Connected Communities programme

[9] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/768979/A_guide_to_community-centred_approaches_for_health_and_wellbeing_full_report_.pdf

[10] https://www.thersa.org/globalassets/hasm-final-report.pdf

produced in partnership with the University of Central Lancashire, the London School of Economics and the RSA.[11] This last report identifies four key 'dividends' of connected communities:

- **A wellbeing dividend.** The research suggests that social connectedness correlates more strongly with wellbeing than social or economic characteristics such as long-term illness, unemployment or being a single parent.
- **A citizenship dividend.** There is latent power within local communities that lies in the potential of relationships between people, and it can be activated through the methods that are advocated in this paper.
- **A capacity dividend.** Concentrating resources on networks and relationships, rather than on the 'troubled' individual as an end-user can have beneficial effects which ripple out through social networks, having positive effects on people's children, partners, friends and others.
- **An economic dividend.** There is evidence that investing in interventions which build social relationships can improve employability, improve health (which has positive economic impacts) and create savings in health and welfare expenditure.

The two community projects are demonstrating use of these approaches and an appreciation of the key principles and values behind them.

Grapevine

Grapevine works with people experiencing isolation, poverty and disadvantage to build better lives through practical guidance, advocacy and support centred around the person.

Using practical tools and training Grapevine helps people build their collective power to tackle the problems they're facing and spark and sustain movements for change. Grapevine aims to solve complex, deep rooted issues with partners by working with systems and services like the NHS and local authorities.

Their work is multi-faceted and aims to build social movements that put people in the lead through various activities including community organising, ideas and innovation factories, training, leadership development and peer support through self-care socials.

[11] https://www.thersa.org/discover/publications-and-articles/reports/community-capital-the-value-of-connected-communities

Ideas and Innovation Factories are two related activities through which they co-create innovative actions and solutions, building the capacity of 'leaders' from all sectors and communities across Coventry.

Self-Care Social stemmed from a Feel Good Community[12] event and aims to create a culture of self-care across communities, with individuals suffering from a long-term illness. By starting conversations on what loneliness and good self-care looks like, they are then helped to look at what they can do together to address it.

Central to their work is story-telling. As Marshall Ganz[13] and others have evidenced, story-telling can be a powerful way to shape identity and can become what Charles Taylor calls our "moral sources" – sources of emotional learning we can access for the courage, love, and hope we need to deal with the fear, loneliness and despair that can inhibit action.

> **"Storytelling is central to social movements because it constructs agency, shapes identity, and motivates action. Story telling is how we learn to exercise agency to deal with new challenges, mindful of the past, yet conscious of alternative futures."**

Grapevine's work is about movement building where those who have needs are also those who provide the support. This builds meaningful connections and sustains activity rather than a service that 'provides help to people who need it'.

People first connect through common values and concerns, then are supported and trained to take ownership of a group. Participants develop stronger ties as they work together, tackling shared challenges, and experience less loneliness as they collectively organise and participate in events. The work is structured with 1:1s[14], calls to action and pledges of commitment to transform participants into leaders.

Three key principles are applied in their work: they are beneficiary driven; they empower members to take the lead and self-organise, building capacity and leadership; and they keep things open and accessible to all, using social media and technology as a way of supporting meaningful connection, rather than a substitute for it.[15]

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[12] The Feel Good Community brings people together through shared experiences and a collective desire to feel connected, feel strong and Feel Good

[13] http://marshallganz.usmblogs.com/files/2012/08/Power_of_Story-in-Social-Movements.pdf

[14] Structured 1:1s using the Citizen UK model, Act, Build, Change. https://www.citizensuk.org/our_training

[15] Reaching Communities bid, Grapevine

Moat House Community Trust

The Moat House model is inclusive and fully integrated, taking each individual as a whole with a range of differing strengths, skills, experience and needs. It is multifaceted and intergenerational by design. For example, grandparents may attend holiday clubs with their grandchildren and disclose health and wellbeing issues whilst at the Centre. These can then start to be addressed.

The role of the community capacity builder is to understand and gather local intelligence, to proactively reach out and connect with the most vulnerable and work with them to develop activities and solutions to the problems they are facing. The navigator works to identify isolated and /or vulnerable older people and work with them to build connections as well as to raise awareness around 'winter wellness' and other issues.

After an initial approach of door-knocking, Moat House have found and reported that word of mouth from trusted individuals is now becoming the most popular and effective source of referrals.

Community Navigator schemes have been endorsed through the Social Care Institute for Excellence briefing[16] on preventing loneliness and social isolation.

An evaluation of care navigation in the Isle of Wight[17] identifies seven individual active components of care navigation work:

- Respond quickly to the needs of people
- Repeated problem solving
- New referral processes with local agencies and services
- Tailored help at the time it's needed.
- Providing the tools to self-manage
- Coordinating with other teams
- Manage the fine line between dependency and self-management.

[16] https://www.scie.org.uk/publications/briefings/briefing39/
[17] https://wessexahsn.org.uk/img/projects/Isle%20of%20Wight%20Care%20Navigators%20Evaluation%20Report%20FINAL.pdf

Summary of Key Findings

What have you enjoyed most?

> **"Gaining deep understanding of people's needs and directing them towards each other without making it obvious."**
>
> **- Clinical Nurse, stakeholder interview**

What's working well

We have found evidence that the community approaches taken by Grapevine and Moat House Community Trust are contributing to the deliverables of the overall programme, which are as follows:

- Improved joint working between health, social care and the community sector so that activities intended to improve health and resilience (by statutory and non-statutory providers) are more tailored to the local area, resulting in a greater coordination of activities and more efficient and effective use of resources.
- Reduced hospital admissions and prevention or delaying re-entry to the health and social care system through increased individual resilience and access to support networks and through people feeling more in control of their own health and wellbeing.
- Reduced social isolation of people through the development of supportive networks.
- Connecting isolated and vulnerable individuals to activities that will increase their resilience.
- Improved quality and patient/service user satisfaction.

Measuring the scale of that contribution is challenging. Cost reductions and social impacts are often measured over a longer time frame. For example, the New Economy Manchester[18] cost benefit analysis model's primary time frame is a five-year assessment of costs and benefits.

However, the data we do have, does show encouraging trends and early impacts that have the potential to go beyond these measures and influence systems change.

[18] http://neweconomymanchester.com/media/1443/2765-pu1617-cba-guidance-020414-1312-final.pdf

Improved joint working, more tailored services

There is evidence that increased levels of service coordination are taking place, and that these are predicated on existing relationships that have been developed over time. This is evident in the Moat House setting where the physical siting of statutory services enable the observation and opportunity to work with their clients in a more informal setting, gaining deeper understanding of the whole individual.

Moat House navigators have also facilitated a partnership network, of service providers and agencies within the locality, to improve quality of life and well-being for older people. Partners include local authority (including Councillors) Whitefriars, local GPs, Family Hubs, social care services, the police service, European City of Sport, City of Culture and public health service providers.

This group is reported to be growing in reputation and reach, with new agencies continuing using it as a means to reach the community with key health messages.

Grapevine are also collaborating with statutory services, as this written feedback illustrates:

> **"Grapevine and health services are working together and engaged locally through the recognition that people with a LTC, social isolation, loneliness are frequent users of primary care to provide social and emotional support, as well as physical reviews and diagnostic services.**
>
> **"Any person with a long-term condition will require much more support than 2 or 3 ten minute GP or nurse appointments per year, and with growing demand on primary care services, and the need to develop the person's self-management skills, Grapevine provides a wide range of opportunities for our residents to improve their mental health and physical wellbeing.**
>
> **"By recognising the value Grapevine can bring, we are developing closer links between GP networks and Grapevine activities, to bring services right to the heart of our communities, identifying where need is greatest, and listening to those who are engaged with Grapevine to shape and influence what is provided."**
>
> **Anna Wheatley Diabetes Transformation Education Lead NHS Coventry and Rugby and NHS Warwickshire North Clinical Commissioning Groups**

Asset based approaches are starting to become more widespread, for example Asset Based Community Development in action in adult social care can be found in Birmingham in their neighbourhood network schemes.[19] Sharing learning between such schemes could be beneficial to continue to influence statutory providers.

NHS England recently announced a plan[20] to invest in 'specialist' link workers to support GPs to use social prescribing to support people living with conditions such as diabetes and depression. The aim is to reduce costs, decrease the burden on GPs and move towards personalised care.

> **"When they then interviewed a GP it was just like listening to Dr Shiv [Moat House partner GP] who said exactly this to me!"**
>
> **GP interviewed said "that link worker is actually curing those conditions, I can't as a GP cure them, because I can only patch them up and that's why social prescribing is fundamental to the future of the NHS, we can't carry on doing what we're doing … that's why it is so exciting"**
>
> **CEO Moat House Community Trust**

The work MHCT and Grapevine are doing could inform the development/recruitment of such posts. For example, a place-based role linking to a number of different surgeries, adopting key principles around meaningful connection.

Both organisations have been gathering intelligence with people who are living with long term health conditions and/or are vulnerable to isolation and can feed this back to service providers to enable them to improve and better tailor services and social prescribing.

Reduced hospital admissions/delayed re-entry to the system through increased personal resilience, access to support and people feeling more in control of their wellbeing

Service users interviewed at Grapevine reported that they had accessed statutory services less since accessing the activities and being connected with

[19] https://brumnns.wordpress.com/2019/02/05/learning-from-leeds-asset-based-community-development-abcd-in-adult-social-care-health-and-neighbourhood-network-schemes/
[20] https://www.england.nhs.uk/2019/01/army-of-workers-to-support-family-doctors/

each other. Others stated that they were more likely to access appropriate services, due to increased awareness and confidence. This is positive, in that accessing appropriate services at an earlier stage may lead to a decreased need to access more acute services in future

An impact of the work done through the community navigator was a reduction in accessing health services. One participant reported accessing health services monthly following this intervention where they had been accessing weekly interventions previously.

Reduced social isolation through development of networks

A clinical stakeholder interviewed about the work felt that the Grapevine project's ability to create a deep understanding of people's needs meant that they were supported in a more meaningful way through connections with other people.

This approach also has a strong element of sustainability in the creation of peer support networks and activities where people take the lead.

Grapevine are using Kumu or Dandelion maps to illustrate the connectedness of individuals participating in the programme (see p22 for an example) which show the scale of the web of social interactions.

Moat House interviewees were very positive about their increased social networks:

> **"I've gained more friends and connections - it helps to bring people out of themselves".**
>
> **"Everything is great - trips, the people, the fact that we can think of our own projects"**
>
> **"The sense of belonging and that whatever I bring is appreciated".**
>
> **"Helps me to help others - so many people have helped me that I wanted to help other people."**

Increased customer satisfaction

The quality of the engagement appears high and 100% of all those questioned at Moat House and Grapevine would recommend it, and the majority (90%) had already done so. Soft data on satisfaction is also being collected and this is being fed back to GP services and others.

The skills of staff and volunteers have a significant impact on engaging and building resilience in communities. At Grapevine the coordinator had set up a project previously and is building on the learning and from building social capital through that project. A key finding from the interviews for both projects is that the lived experience of the staff contributed to the success of both the engagement and the activities.

> **"staff are able to relate to people and have an understanding of people's need because they have lived experience"**
>
> **Grapevine participant**

More widespread recognition of the skills base needed to engage and build resilience would be beneficial, as the perception in the statutory sector can be that these are not 'professional' qualifications. However, the community organising training, for example, has proved highly valuable in moving people from recipients of services to an increased level of agency and an ability to help themselves and others.

Connecting isolated and vulnerable people to activities to increase resilience

The numbers of people engaged in the activities for both projects are well on target, and we have found that further to this engagement, many participants are moving beyond passive engagement towards influencing and establishing their own activities based upon their interests.

100% of the interviewed participants in the Grapevine initiative reported greater agency, confidence and motivation for self-care and many have gone on to volunteer and provide care to others.

As natural networks disappear, there is evidence that a place-based approach works to engage all people, not just a targeted demographic. For example, Moat House has found through targeting the older generation they are also engaging with young people and families, finding it unhelpful to disconnect one group as all are interrelated. In this way the project engagement targets are being exceeded. This is further explored in the case studies which show that when a participant presents with a need, they often then disclose other issues that may have contributed to that need, enabling the community to address solutions to the root cause rather than the symptom.

> **"I think what is unique about the community anchor model is that it works both in and of its community / it generates its own income and brings in local**

residents and others to support the community, forging a sense of collective purpose and responsibility."

CCG

Long-term relationship building is also a key factor in the Grapevine model, with six of the nine people interviewed having been involved with the initiative through earlier involvement with the organisation or knowledge of other activities.

Both organisations are building on existing strengths and connections. Achievements of this programme are a result of a continuum of activity that requires key skills, resources and time to develop. This existing infrastructure constitutes an added value, therefore there is a risk if there is a gap in provision, this infrastructure will be eroded.

Grapevine have found through their work that "'o gain understanding of individual strengths depends upon a relational dynamic that builds over time, who is going to step up (to lead activities) at any one time changes, it's hard to map it as it depends on a number of other variables working together." CEO Grapevine

The approach adopted by both organisations means that services are able to be flexible and respond to emerging need. For example, older people in the Moat House neighbourhood were offered trips and events in the summer but really need them in the winter when they tend to feel more lonely. This knowledge has facilitated a shift in provision.

Where people have taken the lead in initiatives it has led to reporting greater wellbeing. Partly demonstrated by the quote below, from a Grapevine participant who feels inspired and enabled to lead projects that then lead to change.

"Feeling uplifted, inspired & full of encouragement after today's Collective Leadership Workshop, focusing on how we can create people-powered social movements & improve wellbeing for all within the city of *#Coventry* 😃🙌💙✨Thank you"[21]

What could be improved, issues and barriers

"The real win is to get attitude change in the public sector through mobilising community assets"

[2] Grapevine iBCF report September 2018

Workshop participant

With reduced capacity and resources in the statutory sector to take risks on different, sometimes unproven, ways of working requires a re-balancing of control and a genuine belief in better outcomes for service users. Moving from a dependency relationship to a partnership relationship is a cultural shift that require good relationships and trust built over a period of time and which have a mutual understanding of the solution.

Contracted services could be improved if seen as more of a negotiation, based on a shared understanding and shared risks. This also require a parity of esteem, that is community-based and clinical services should be treated in the same way. Toby Lowe from Collaborate talks about the need to become an 'eco-system engineer'. This requires a focus on relationships, unrestricted funding, workforce development and moving from monitoring to learning.

The iBCF evaluation framework developed as part of this commission aims to create a parity amongst the projects in their achievement of outcomes. One way to mitigate against the perceived risk of working across the different sectors is to highlight the quality assurance systems in place in community-based activity and for the statutory sector to understand and recognise the value of non-clinical skill sets and experience.

The challenge posed by the integration of community-led approaches and health interventions can be described using complexity theory. Community development is an iterative process based on interactions and a constant feedback loop. This uncertainty can prove challenging for a system designed to put together a **complicated** process with an understanding of what the output/outcome will be.

> **"The complexity of systems means it is difficult to plan to achieve all the changes we want to see, but a good starting point is to think about what can be done, and just do it, in an opportunistic way. It is not always appropriate to apply project management systems to a community."**
>
> **Interview with Grapevine and Moat House**

Learning from good practice elsewhere and sharing learning can be very beneficial; for example, the integrated health and social care services in Bradford and Bristol[22].

[22] http://www.bradfordcityccg.nhs.uk/news/what-is-integrated-care/ https://www.bristol.gov.uk/policies-plans-strategies/better-care

Participants in both the Grapevine and Moat House initiatives were keen to spread the word about the work being done, therefore further outreach, pop-ups and work with different types of groups may be beneficial using a mix of communication methods. That said, the target numbers engaged are on track to be achieved.

It's been shown that increased diversity can provide multiple benefits both in terms of addressing inequality and individual outcomes, and increasing community resilience. Analysis of Grapevine participants shows that they are not currently as diverse in terms of ethnic background as with their other initiatives. It is however important to note that there might be multiple reasons to explain this; including a cultural acceptance of long term health conditions, and how to/ willingness to access support.

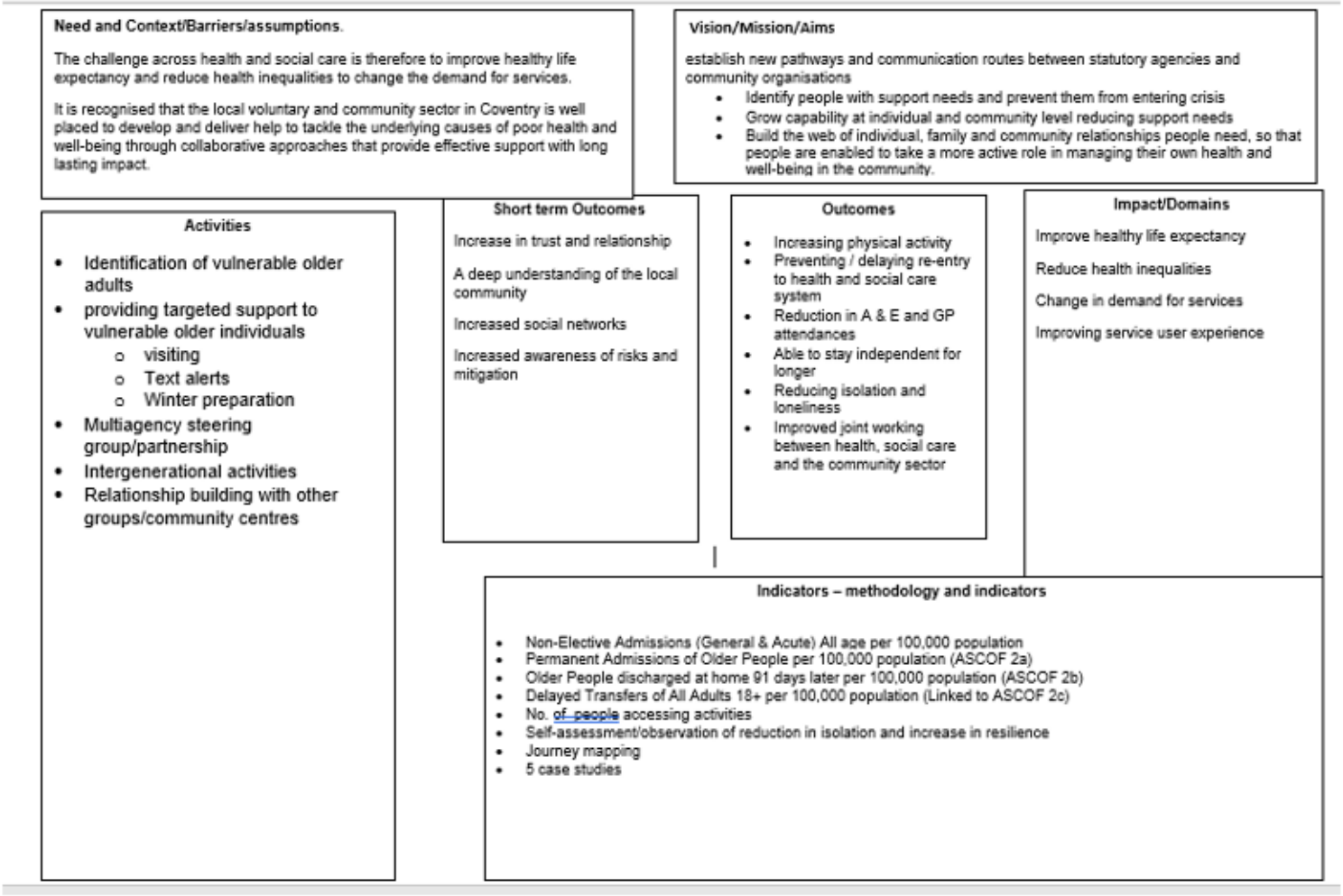
One stakeholder interviewed suggested an in-reach approach into communities (rather than a central location) may address this. It is worth noting that other Grapevine activities that are place-based attract a more ethnically diverse group of people.[23] One of the findings from this research was that Grapevine participants were mixed in respect to gender. This may be seen to be unusual because of the assumption women are more likely to access health support than men.

[23] Social movement work done in Stoke Aldemoor by Grapevine has built community resilience and leadership across different ethnic groups in the community.

Data Analysis and Case Studies

Moat House Community Trust

The Theory of Change helps to identify the relational aspect of this work.



The project aims to reach 320 vulnerable residents, who have support needs and to prevent them from entering crisis. To date 157 senior residents have been engaged, along with over 400 children.

Following a 'Cards on the table' event at Moat House two years ago, partnerships were developed and the community gained the confidence to trial new activities including food poverty (Fareshare and holiday hunger), Community Navigator (outreach & loneliness) and tackling anti-social behaviour (youth provision) which are now delivering multiple services to families.

Case studies

The below case studies demonstrate the impact of Moat House and their interventions on individuals, including through increasing their physical activity and reducing isolation and loneliness.

M – 68, recent widow and heart bypass

M, 68, recently lost her husband after two years of nursing him through cancer. Following his death, she became depressed and felt isolated and very lonely. She wasn't sleeping well and had a diminished appetite.

She came to Moat House through a chance meeting when she was voting at the polling station based at the community centre. She spoke about how lonely she was feeling and was invited to come to MHCT to join their 'healthy walks' on Tuesdays.

Getting out, walking in green spaces with fellow neighbours helped M in sleeping better. Often she would stay for tea and a chat after the walks, making friends with other residents. Encouraged by her new friends, she joined other clubs and outings, including an 'armchair exercise' class. Over 3 months, M's confidence and wellbeing improved, and she has taken on volunteering roles for MHCT, including a leading role in their summer event. M reports that her appetite has returned, and her energy levels have vastly improved. She now makes sure she goes out each day instead of staying in the house.

J and C, elderly couple in 70s. J has bad mobility and C has dementia.

J and C are in their 70s; J has mobility issues and is a wheelchair user and C has dementia. They act as one another's carers. Their sons live far away and do not visit frequently; they had been increasingly isolated and housebound. They did not have many friendships in the area and felt vulnerable. Inactivity was causing J's mobility to become worse.

J joined MHCT to take part in 'armchair exercise' classes. After 6 months, he no longer arrives to classes in a wheelchair, and reports being much more flexible and active. J and C both attend the centre for coffee, chatting with new friends, and have attended one of the day trips, on a canal boat. C has taken up baking again, with support from J, and they will often share their baking with their new friends at MHCT. Despite living in the area for many years, this is the first time they have felt part of the community.

C's dementia is progressing rapidly, and J is under strain to manage his own health and care for C. They both hold strong religious beliefs which restrict their engagement with health services.

However, through their relationships at MHCT, they have a new support network. The staff now have their mobile numbers, and their new friends will notice when they are not there and check up on how they are. Staff have also attended meetings with other local agencies and public services – to advocate with them and support them to navigate services.

The interviews Locality carried out with project participants demonstrated outcomes across the range of stated aims in the theory of change, and in the project documentation. These findings are presented thematically under the headings below. In addition to the formal outcomes, we have included increased agency and capacity for leadership, which was emerging from the conversations. Some of the comments could map across several outcomes, as the case studies show, so these examples are illustrative only.

In particular, the data does indicate a growing capability at individual and community level, reducing support needs and increasing resilience. Our research also shows that building the web of individual, family and community relationships

to enable people to take more responsibility is also taking place and is valued by the participants.

Quality of service

Participants valued the skills, time and approach that staff and volunteers brought to their work. The inclusivity of the environment, and the types of activities, alongside the opportunity to shape these was appreciated by those we interviewed.

> **"Excellent - they really listen to people here. The people here are always happy. They provide a service that no one else provides. I like the opportunity to give something back."**
>
> **"I lost my husband so felt very down. I was expecting some things for me to do but not the amazing support I've had. It's felt like a new family for me - like a second home. Everyone makes you feel so welcome."**
>
> **"I don't know what I'd do without them. It's really accessible. They really welcomed me with open arms and they call me when I'm not there - which is really nice. The trips and Tea and Talk sessions have been the best. Feels a great place - not intimidating in any way. Everyone talks to you. All ages and parts of the community there."**
>
> **"Everything is great - trips, the people, the fact that we can think of our own projects. It's evolving - there's an open dialogue about how to improve things."**

Reduced access to formal medical care

This is one of the measures that would benefit from a longer timeframe to evaluate fully, but early results are encouraging. There are multiple stories that the initiative has provided a lifeline and a way back into the community.

> **"I rely less on medication. I had a hard life but now it's easier. I have more confidence to go out on my own (felt difficult without husband). I used to access medical services weekly, now I go monthly."**

"I've gained mental stimulation and stability - I was on a very rocky road"

Reduction in social isolation

All participants we interviewed reported increased connection, and feeling less isolated. This shows that MHCT are identifying those who might otherwise be lonely, and vulnerable within their community and are successfully connecting them to others. A number of participants were pleased to have follow up calls if they did not turn up to an event, for example, or have themselves initiated checking up on others in the neighbourhood.

"I've made long term friends here, and I'm more in the know"

"I've gained more friends and connections - it helps to bring people out of themselves. I like working with young people especially."

"2-3 years after retiring (working as a housing officer) - I was becoming a recluse, needed something. Enticed by the trips. It gives me a daily routine and I've opened up to new things."

Increased Agency, capacity for leadership

At least three of the participants interviewed had initiated activities of their own or started volunteering elsewhere as a response to their engagement.

"I used to be very shy - but now I'm vocal in meetings. I'm doing a canal history project"

"Came to a residents meeting about young people causing problems - got more involved from there. Getting my husband involved was a real moment"

"Got me more involved in my church's community work"

Increased physical activity

The activities on offer have led to increased levels of physical activity, and MHCT has taken over the healthy walks provision from a previously PHE funded project which has enabled them to enhance their existing provision.

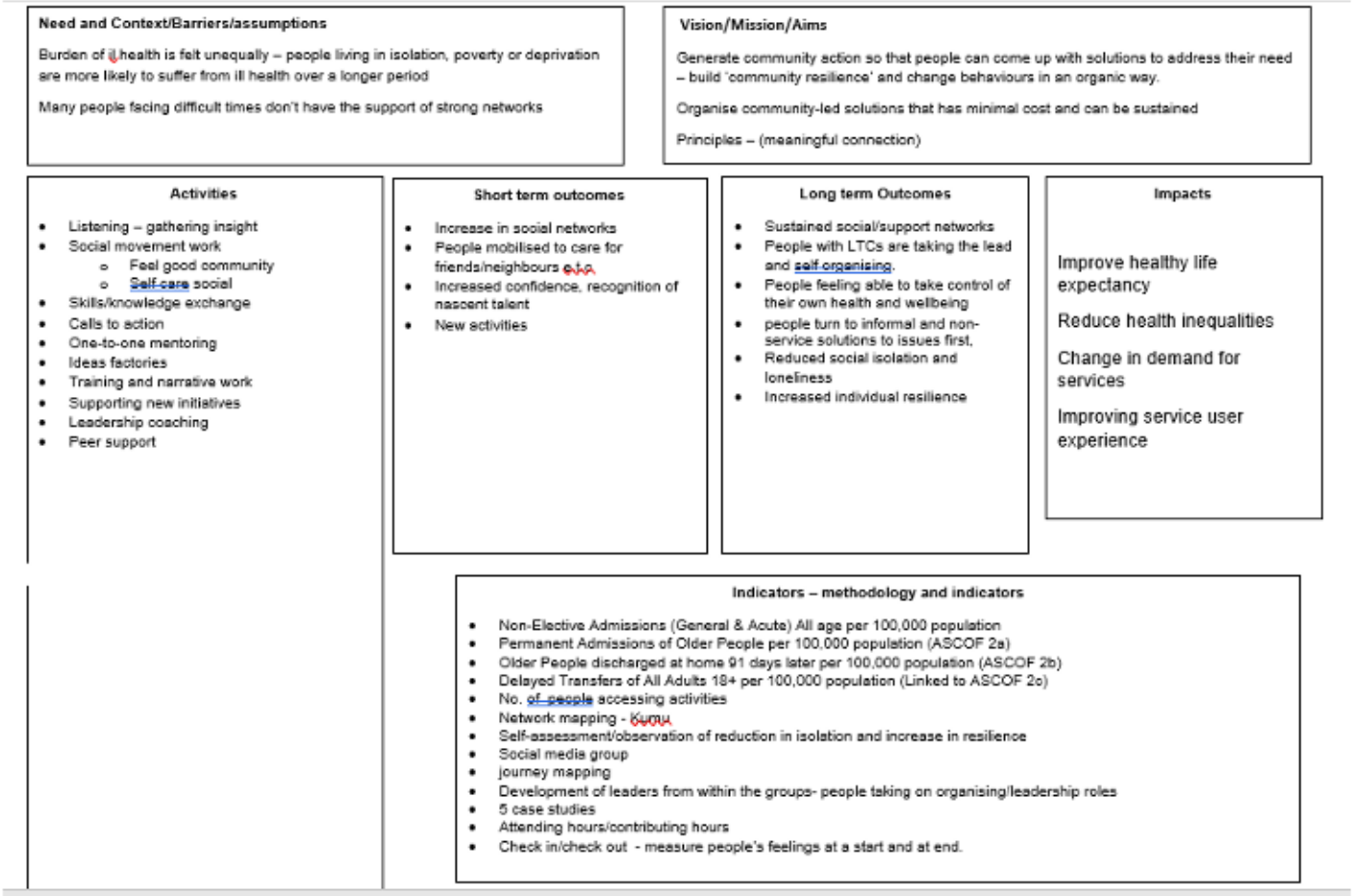
"Armchair exercise, healthy walks, trips, events. Love the social side more than the activity. It gets me out of the house (or the bed) – especially in the winter, and I help design new activities."

"I do more exercise – feel a bit more confident"

Overall the project is showing results at this early stage against their stated aims and is having enhanced impacts around lifestyle behaviours and personal agency. The value of their approach is being demonstrated by the data we have gathered and by research within our literature review, and the benefits of the navigator role in forming trusted connections are clear.

Grapevine

Final Theory of Change



Outputs

269 participants were engaged up to December 2018 with a further 67 attendees in 2019 to date. The overall target for the initiative is 500 so these are encouraging early results. The team have also logged over 1000 hours contributed so far.

Overall our interviews and workshops demonstrated that the Grapevine approach is working to generate community action so people can come up with their own solutions and address needs. Examples of individuals establishing new behaviours, and building resilience were found and are detailed below in the case studies. The key principle of meaningful connection runs through their interventions and the skills of the staff and volunteers are valued by participants.

One issue that Grapevine have learnt is that people sometimes do not present with what they see as a long-term health condition (LTHC). Instead, discussions

about conditions and symptoms at the first Self Care Social helped to open up the conversations. People understand the term chronic or invisible illness better. Also, people often initially engage better with prompts to think about health and wellbeing more broadly.[24]

"In 1-1s when we ask people about if they know anyone with a LTHC they often stumble, when we break it down into conditions they are able to relate to, such as poor mental health, diabetes, or high blood pressure." CEO Grapevine

There are also positive indications that Grapevine are influencing improved services and systems change through partnership working:

> **"Grapevine and health services are working together and engaged locally through the recognition that people with a LTC, social isolation, loneliness are frequent users of primary care to provide social and emotional support, as well as physical reviews and diagnostic services.**
>
> **"Any person with a long term condition will require much more support than 2 or 3 ten minute GP or nurse appointments per year, and with growing demand on primary care services, and the need to develop the persons self-management skills, Grapevine provides a wide range of opportunities for our residents to improve their mental health and physical wellbeing.**
>
> **"By recognising the value Grapevine can bring, we are developing closer links between GP networks and Grapevine activities, to bring services right to the heart of our communities, identifying where need is greatest, and listening to those who are engaged with Grapevine to shape and influence what is provided."**
>
> **Diabetes Transformation Education Lead.**

[24] https://www.facebook.com/SelfCareSocial/videos/533829357038006/ https://www.facebook.com/SelfCareSocial/videos/1838631186221280/

Grapevine

The following case studies show the impact that Grapevine is having on individuals, including in supporting people to take the lead and self-organise, reducing feelings of loneliness and social isolation, and increasing individual resilience.

Experience from participant in the project

Taking part in the programme at Grapevine has increased their social contact with other people and increased their feelings of a positive outlook, as well as supporting them to be more knowledgeable to make choices about her own health.

Prior to their involvement in the programme, they experienced feelings of shame, isolation and sense of failure associated with having a long-term condition. Their engagement with the programme has had a motivating and mobilising effect. It has also opened up new opportunities for other social activities, hobbies, and new friendships.

On their experience and understanding of self-care since the programme:

> **"The concept of self-care hadn't been on my radar. But it is on the forefront of my mind now. Now feels achievable and collectively has an impact…You deserve care, don't wait for that care to be from someone else.**
>
> **I've had a light bulb moment, but I know it's not an instinctive behaviour and want to develop this as something more natural. Prioritise myself more [take] small steps to put myself first. And talk to people about self-care, introducing the concept of self-care to someone else and I feel very confident to do that. Feels like a natural part of a conversation – a tool in my life that I can share with other people too."**

Case Study, Grapevine

E is in his 60s and recovering from a stroke in 2005. His brain injuries have impacted his speech and mobility, and he has experienced feelings of isolation, despondency and suicidal thoughts. He had gone back to college to do basic English and Maths and had started volunteering at a local centre, however he also struggled with fatigue and a sense of lack of purpose from not being able to be employed anymore.

Since being involved with the Grapevine project he has experienced an increased sense of purpose, and has valued the social interaction with others and the mutual encouragement. His contribution has been through art classes, and he will sometimes go out for meals with other people too:

"It helps me to help others. So many people have helped me that I wanted to help other people."

E reports that since joining the programme he accesses health services less frequently (from weekly to monthly). It has increased his knowledge about the choices available to him and his access to services in the community; he feels more independent and has a more positive outlook.

GL has been attending the Collective Leaders sessions.

"I have become a Self-Care Champion. This would not have been possible without the encouragement, help, support and patience that you have both [Grapevine staff]invested in me. Thank you.

Prior to the first Innovation factory I attended in 2016, I would not have believed this would have been possible for someone like me. I was so out of my depth and comfort zone on the first course and I struggled so much, but as I have repeatedly said to anyone who will listen, it really did change my thinking.

Since you both involved me in last year's Self-Care week, I have found a way to incorporate everything I have learnt from Grapevine into my Lymphoedema support group and I am slowly adding the same principles to my website."

Quality of service

Feedback from service user interviews asked about what they enjoyed about the service illustrates the impact that the Grapevine ways of working are having on the participants in this initiative. They value the strengths-based approach and space for creativity within the activities.

> **"Space for ideas and creativity – human."**
>
> **"Sense of belonging – whatever I bring is appreciated."**
>
> **"A lot of different thinking - notice a lot more now about what I can do. Even with big problems you feel like you can do something about it."**

Reduction in social isolation

> **"I became isolated when I retired but now I have a massive network of friends. I now feel able to use my skills and knowledge to help others."**

Kumu or dandelion maps are used to demonstrate the increase in social engagement by participants. This is a relationships map that can be viewed differently by everyone, not just the creator. It demonstrates the power of relationships, as well as giving options to be able to see how different people have moved between different activities, which includes ones they have started themselves. The viewer can 'cluster' the dots (people or activities) based on what they would like to see. Cluster options include 'self/family/carer/work' (which is how the individual identifies with LTC) or 'tags' which is the activities they have attended.

An example of a map appears below.

Increased Agency, capacity for leadership

Grapevine's approach challenges traditional power relationships within communities and, as a consequence, people attending activities are supported with a platform to take on the operation and decision-making of the work. The interviews undertaken show the level of meaningful connections made as well as individual agency and resilience developed.

Grapevine has developed unique indicators that highlight the increase in someone's social network as a result of participation and demonstrate the increased leadership of participants[25] and thus their increased agency.

> **"Helps me to help others – so many people have helped me that I wanted to help other people. Gained a sense of purpose - social interaction with other people and encouragement."**
>
> **"Got some ideas of my own want to tell my own stories. Collective leadership meeting was 4 hours and I felt energised and activated as a result."**
>
> **"This takes you out of clinical service – taps into something you didn't know you had e.g. storytelling. Makes you realise that there's more to you than your illness."**

Participants have also accessed volunteer and paid employment through this intervention and set up new projects:

"I'm taking forward a project about the history of disability. Making new friends. Experiencing a non-traditional type of service."

Increased physical activity

Through engagement with swimming sessions, mindfulness and happiness walks, and attending craft and other sessions, participants have increased their physical activity while accessing the social side of the interventions.

[25] The shift from participating hours to contribution hours shows the shift in people's leadership.

Reduced access to formal medical care

Participants reported increased confidence whilst accessing health care, and a reduced need to access it:

> **"I'm less likely to access health and social care services as my mental health is in a better position. Because of the authentic approach if I was having a bad day, I could just say it and then feel better about it. Don't have to put a mask on and will be isolated.**

> **"Removing the shame about poor health and isolation – paid people who have health condition means you are not a failure. Representing that you are a well-rounded successful person. Very motivating and mobilising."**

Conclusion

Both approaches show a significant impact on addressing loneliness and social isolation, a deep understanding of communities, an ability to simplify and integrate multiple services and systems and act as a catalyst and platform to develop networks and leadership within communities.

Furthermore this proof of concept identifies key components that both projects demonstrate in relation to mobilising community assets, re-orienting formal service to produce better health and wellbeing outcomes for communities. These are:

Established and trusted infrastructure. The results gained are building on work and relationships developed over time. It is important that this is valued, and not put at risk as a gap in services could impact detrimentally on service users and is hard to fill later.

The skill sets and experience of the staff are critical in shaping the activities, mobilising and supporting people. They are key to the outcomes achieved and well qualified but are often not seen as 'professional' by statutory sector. There needs to be a recognition that without this workforce the most vulnerable people may not get the support they need in a timely way and therefore their health and support needs may escalate.

There is a skill and structure to **building relationships in a way that creates meaningful connections, trust and a deep understanding of the community** that enables the development of sustainable networks. The theory behind this methodology is evidence based and should be recognised and adopted where possible. Investment needs to support creating the conditions for this as well as the activities themselves.

A holistic and asset-based approach: Grapevine do not use standard GP definitions of 'long term illness' instead anyone who self identifies as having a long-term health condition is welcome to attend the self-care socials. The people who attend are treated as "more than your illness" and supported to discover nascent skills and talents. The approach is also used at Moat House who support all of the needs a person presents with as well as supporting them to take the lead in addressing their own challenges or supporting others with theirs.

The community-led approach links to the core system behaviours observed by Lankelly Chase[26] where people are facing multiple disadvantage and exercise power, perspective and participation. Where people view themselves as part of an interconnected whole, are viewed as resourceful, bringing strengths and

[26] https://lankellychase.org.uk/our-approach/system-behaviours/

sharing a common vision, this perspective helps to create and build effective systems.

Equality of power, devolved decision-making and mutual accountability, where people take responsibility for their own change, form part of the conditions for effectiveness, as do open and trusting relationships, and valuing leadership in those experiencing interlocking disadvantages. Lankelly Chase argue that feedback and collective learning drive adaptation, so people can see a learning loop between the actions they take, and their understanding of problem they are trying to solve, so that each is being continually refined and adapted.

Added Value: the approach taken by the two projects goes beyond the two outcomes tested through this proof of concept. Both projects demonstrate an approach to creating better health outcomes for people including generating economic and social value through volunteering, getting people (often long term unemployed) into jobs or creating new products and services.

The fact that the two organisations have invested over the long-term in building skills and relationships mean they are often able to reduce the time it takes to achieve outcomes. This investment is not factored into any evaluation process but is a key factor in the projects' success.

There are substantial health and wellbeing outcomes that are generated through building community, including through increased community connections, social capital[27], and sense of power and self-efficacy. An independent review of a Patient Empowerment Programme (PEP) facilitated by Locality member BARCA Leeds, for example, states 'responses indicate positive change in levels of self-efficacy to self-manage their long term conditions, in this sample, depression. Review data shows a 16-18% increase in those very or totally confident in each of the five questions asked. Support provided by PEP is enabling participants to consider routines, coping strategies and activities to help themselves on a day to day basis.'[28]

The financial costs are relatively low in both cases, and whilst it is too early to conduct a cost benefit analysis, based on the trends and other evidence and evaluations such as this one from the What Works Centre for Wellbeing[29] that if the projects continue to perform, positive economic returns on the initial investment may be realised.

[27] Social capital broadly refers to those factors of effectively functioning social groups that include such things as interpersonal relationships, a shared sense of identity, a shared understanding, shared norms, shared values, trust, cooperation, and reciprocity.
[28] Leeds West CCG Review Patient Empowerment Programme, BARCA Leeds (2014-5 data)
[29] https://whatworkswellbeing.org/product/a-guide-to-wellbeing-economic-evaluation/

Co-location provides opportunities for statutory service workers to observe and relate to their clients in informal settings helping them to form more insightful views of the individuals being helped. However, a formal mechanism to feed back may be a further opportunity to capture learning about what works. As was pointed out in the project interviews there is "no current mechanism to influence the system".

Experiential learning is important to change the culture of formal services. There is an opportunity for this to happen through social work and clinical training as well as an opportunity to recruit people with lived experience in to health professions. This has shown to shift the culture within formal services in Hull where a community-led doula project led to the recruitment of volunteer doulas to midwifery courses.[59]

Our findings are that both community initiatives are delivering services that are needed within their localities and co-designed with the people they are serving. Building on trusted relationships, referrals and word of mouth the initiatives are reaching new participants weekly and are likely to achieve or exceed their engagement targets.

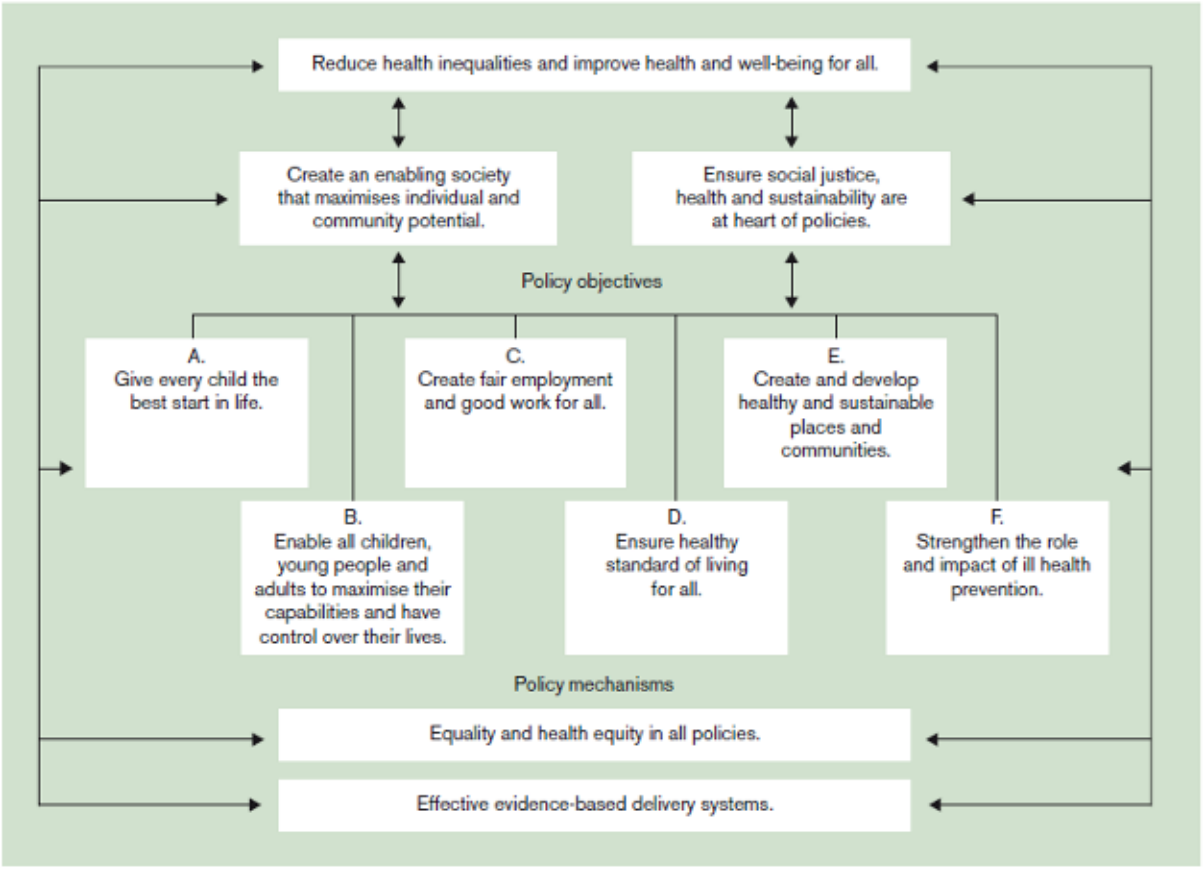
We have used a number of examples and case studies from those impacted by this work, and this body of evidence can be built upon through use of the evaluation framework and related back to the Theory of Change for each organisation. Both approaches allow space for creativity and innovation which can add further value to the interventions.

[59] https://goodwintrust.org/doula-project-breast-feeding/

Appendix

The Marmot Review provides a key source of evidence on health inequalities and addressing the wider social determinants of health such as education, employment, gender, race and the environment. We revisited this evidence as part of the proof of concept and its conceptual framework is included for reference below.

Figure 4 The Conceptual framework



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