Coventry City Council

Agenda

Coventry Health and Well-being Board

Time and Date
2.00 pm on Monday, 23rd January, 2023

Place
Committee Room 3 - Council House

Public Business

1. **Welcome and Apologies for Absence**

2. **Declarations of Interest**

3. **Minutes of Previous Meeting**

   (a) To agree the minutes of the meeting held on 3rd October 2022 (Pages 5 - 12)

   (b) Matters Arising

4. **Chair's Update**

5. **Development Items**

   (a) NHS Capacity

   Report of P Johns, Coventry and Warwickshire Integrated Care Board

   (b) Industrial Action Contingency Plans

   Report of P Johns, Coventry and Warwickshire Integrated Care Board

   (c) ICB Update

   Report of P Johns, Coventry and Warwickshire Integrated Care Board

6. **Integrated Care Strategy** (Pages 13 - 108)

   Report of D Oum, Coventry and Warwickshire Integrated Care Board

7. **Coventry and Warwickshire Integrated Health and Wellbeing Forum** (Pages 109 - 112)

   Report of K Nelson, Chief Partnerships Officer

8. **Draft Suicide Prevention Strategy** (Pages 113 - 146)

Report of A Duggal, Director of Health and Wellbeing

9. **Childrens' System Update**

Report of J Gregg, Director of Children

10. **Director of Health and Wellbeing Annual Report**

Report of A Duggal, Director of Health and Wellbeing

11. **Drugs and Alcohol Strategy Update** (Pages 147 - 186)

Report of A Duggal, Director of Health and Wellbeing

12. **Serious Violence Duty**

Report of A Duggal, Director of Health and Wellbeing

13. **Governance Items**

(a) Better Care Fund Update - Audit Social Care Hospital Discharge Grant (Pages 187 - 192)

Report of P Fahy, Director of Adult Services and Housing

(b) Functions of Health and Wellbeing Board - to request HWBB review the proposed updates to the functions (Pages 193 - 196)

Report of the Chair of Coventry and Warwickshire Health & Wellbeing Board

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

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

Private Business

Nil

Julie Newman, Director of Law and Governance, Council House, Coventry

Friday, 13 January 2023

Note: The person to contact about the agenda and documents for this meeting is Vicky Castree/Caroline Taylor Tel: 024 7697 1699 / 8701 Email: victoria.castree@coventry.gov.uk / caroline.taylor@coventry.gov.uk

Membership: Councillors J Blundell, K Caan (Chair), M Coombes, A Duggal, G Duggins, P Fahy, R Forrester, J Grant, J Gregg, A Hardy, G Hayre (By Invitation), P Henrick, P Johns, D Kendall, R Light, S Linnell, C Meyer, M Mutton, K Nelson, D Oum and P Seaman

By invitation Councillors

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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, 3 October 2022

Present:

Members: Councillor K Caan (Chair)
Councillor M Mutton
Councillor P Seaman
Allison Duggal, Director of Public Health and Wellbeing
Pete Fahy, Director of Adult Services
Ryan Forrester, West Midlands Fire Service
Andy Hardy, University Hospital Coventry and Warwickshire
Peter Henrick, West Midlands Police
Philip Johns, Coventry and Warwickshire Integrated Care Board
Danielle Oum, Coventry and Warwickshire Integrated Care Board
Kirston Nelson, Chief Partnership Officer/Director of Education and Skills

Other Representatives: Emma Bates, Ed Hodson, Marmot Partnership

Employees (by Directorate):

Law and Governance: L Knight, C Taylor

Public Health: V DeSouza, T Wukics

Apologies: Councillor J Blundell
Councillor G Duggins
Alison Cartwright, Coventry and Warwickshire CCG
John Gregg, Director of Children's Services
Ruth Light, Healthwatch Coventry
Stuart Linnell, Healthwatch Coventry
Professor Caroline Meyer, Warwick University

As the meeting was Inquorate, those present received an informal update on the matters listed on the agenda.

Public Business

10. **Welcome and Apologies for Absence**

As the meeting was Inquorate, those present received an informal update on the matters listed on the agenda.

11. **Declarations of Interest**

There were no declarations of interest.

12. **Minutes of Previous Meeting**

The minutes of the meeting held on 4th July 2022 were agreed as a true record.

There were no matters arising.

13. **Chair's Update**

The Chair, Councillor Caan, welcomed everyone to the meeting. He reported a brilliant summer of sport with the Commonwealth Games and the International Children's Games hosted in and around Coventry and Warwickshire. Councillor Caan thanked Councillor M Mutton and the late Councillor J Mutton for their work in bringing the International Children's Games to the city which had been inspirational, inclusive and had great reviews.

The Chair placed on record his encouragement for all Members of the Coventry Health and Wellbeing Board to attend the first Integrated Health and Wellbeing Forum due to be held on 13 October 2022. The Forum would ensure a unity of support for Health and Wellbeing across the area, working very closely with Warwickshire.

14. **Covid-19 Ongoing Response**

The Board received a verbal update by Allison Duggal, Director of Public Health and Wellbeing about Living Safely with Covid-19 and presentations in two parts for the discussion about the Covid-19 Ongoing Response:

a) NHS Capacity
b) Vaccinating Coventry

The verbal update detailed:

- Routine testing for Covid-19 was no longer taking place.
- A recent increase in Covid-19 cases had been noted: 1 in 65 people had the virus equating to 6,000 people in Coventry.
- Covid booster vaccinations had started to roll out for people at greater risk and those over the age of 50. Flu vaccination roll out had also started.
- An increase in other infections such as Scarlet Fever had been noted.
- An increase in old childhood illnesses ie. diptheria had been seen recently. An MMR campaign was about to start.
- Monkey pox cases were decreasing due to changes in behaviour/adequate isolation.

The Board received a presentation by Philip Johns, Coventry and Warwickshire Integrated Care Board to discuss NHS Capacity.

The presentation highlighted:

- Total appointment activity
- Delivery of the Covid-19 vaccination programme
- Patient Survey
- Enhanced Access Service delivered by PCN's

- Winter Planning
- Workforce Wellbeing
- General Practice Nursing Strategy
- Estates/premises future needs

The Board discussed:

- First point of call being A&E rather than GP
- Low percentage of face-to-face GP appointments/ increasing virtual capacity of GP's
- Consultants appointed into Integrated Medicine
- Integration of services in the community via the Integrated Care Strategy
- Improvements in waiting times for children/young people's mental health and wellbeing
- Rebalancing estates expenditure

The Board received a presentation by Valerie De Souza, Public Health to discuss Covid-19 and Flu Vaccination.

The presentation highlighted:

- Eligible cohorts for flu and Covid-19 vaccinations
- Delivery and uptake of autumn booster vaccinations
- Vaccination clinics and sites and coverage by MSOAs
- Communication to local communities regarding understanding/uptake of the vaccine

The Board discussed vaccine supplies and shelf life, confirming there were currently no supply or shelf-life issues.

The Board requested that further information be brought back to the Coventry Health and Wellbeing Board as follows:

1. **Inequality of expenditure on premises.**
2. **Correlation between patients failing to access their GP and those who access A&E.**
3. **Wait times for children and young people's mental health appointments.**

15. **Marmot Update on the Cost of Living Crisis**

The Board received a report by Ed Hodson and Emma Bates on behalf of the Coventry Marmot Partnership regarding the Marmot update on the cost-of-living crisis.

The purpose of the report was to improve the health, well being and life chances of the people of Coventry and reducing inequality was vital. The report highlighted:

- The increase in demand for advice services and the importance of acting now to ensure the 'inequalities gap' in the city does not continue to widen under the cost-of-living crisis

- The call for more action to be taken to support those on lower incomes and the more marginalised groups in the community; specifically, to prevent an intensifying fuel poverty crisis turning into a winter health crisis.

The Board discussed:

- Working in partnership to solve the issues affecting the city.
- Finding collective solutions to ongoing winter-based issues.
- Financing the cost-of-living crisis with limited resources.

The Chair advised whilst he was in support of the four recommendations, they would require partner support to progress.

RESOLVED that the Coventry Health and Wellbeing Board notes that all partners:

1. **Work locally towards a long-term sustainable funding settlement to strengthen and support independent advice services to deliver vital advice and advocacy support to marginalised communities (employment rights, benefits entitlements, debt/money advice, energy advice, housing support, support to apply for grants etc).**

2. **Sufficiently strengthen and resource frontline services to effectively meet the needs of our communities. This is critical for both the Local Authority and for community-based services.**

3. **Support the Council Teams to revise, update and/or develop a 'Cold Weather Plan' that includes, but is not restricted to, current Severe Weather Emergency Protocols (SWEP).**

4. **Use the Marmot Partnership to monitor whether frontline demand is being met.**

16. **Coventry and Warwickshire Pharmaceutical Needs Assessment**

The Board received a comprehensive report and presentation by Allison Duggal on the Coventry and Warwickshire Pharmaceutical Needs Assessment. The purpose of a PNA was to assess local needs and identify gaps for pharmaceutical provision across Coventry and Warwickshire. At the Health and Wellbeing Board on 4 July 2022, the PNA had been discussed and the Board had agreed to provide comments during the formal consultation period. The final document, containing comments from the survey had been publicised on 1 October 2022.

A number of recommendations arising out of the PNA were set out at pages 7-9 of the report submitted and were acknowledged by the Board.

RESOLVED that the Coventry Health and Wellbeing Board notes the Coventry & Warwickshire Pharmaceutical Needs Assessment.

17. **Coventry and Warwickshire Population Health Management Roadmap**

The Board received a briefing note by Liz Gaulton, NHS Coventry and Warwickshire Integrated Care Board regarding the Coventry and Warwickshire Population Health Management Roadmap.

The Board were advised of plans to spread, scale and sustain Population Health Management (PHM) capability at all levels of the Integrated Care System (ICS) over the next 5 years. The appended PHM Roadmap had been approved by the Integrated Care Board on 20 July 2022.

PHM was about creating data-informed, integrated, health and care that embraced the wider determinants of health and helped to design services that better reflected the needs of the communities. Implementation of the Roadmap required a significant shift in culture and every part of the system had a role to play in embedding PHM as 'business as usual' across each level of the ICS.

RESOLVED that the Coventry Health and Wellbeing Board notes the implementation of the PHM Roadmap for Coventry and Warwickshire.

18. **Coventry and Warwickshire Integrated Health and Wellbeing Forum**

The Board received a briefing note of Kirston Nelson, Chief Partnerships Officer, regarding the Coventry and Warwickshire Integrated Health and Wellbeing Forum. Proposals were outlined for the establishment of Coventry and Warwickshire Integrated Health and Wellbeing Forum, which would replace the Coventry and Warwickshire Joint Place Forum.

The Forum would provide system leadership around the wider health and wellbeing agenda and contribute to achievement of the aims of the ICS, specifically tackling inequalities in outcomes, experience and access, and helping the NHS support broader social and economic development.

RESOLVED that the Coventry Health and Wellbeing Board notes the establishment of Coventry and Warwickshire Integrated Health and Wellbeing Forum as outlined in the report, with the two Health and Wellbeing Boards and the Integrated Care Partnership as core members.

19. **Joint Strategic Needs Assessment**

The Board received a briefing note of Valerie De Souza, on behalf of the Director of Health and Wellbeing regarding the delivery of the Joint Strategic Needs Assessment (JSNA).

The JSNA was a statutory requirement for the Health and Wellbeing Board intended to inform and guide the planning and commissioning of health, wellbeing, and social care services within a local area. It provided a snapshot of current and future health and care needs considering factors that impacted on health and wellbeing including economic, education, housing and environmental factors as well as local assets which could improve the area and reduce inequalities.

An evaluation of the previous years' JSNA had been undertaken and based on feedback and to ensure the JSNA could be delivered within current staffing capacity, there would be a citywide profile along with 6 priority areas as follows:

- Foleshill and Longford
- Hillfields
- Binley and Willenhall
- Bell Green and WEHM Area
- Tile Hill
- Canley

The Board discussed:

- Commitment to the JSNA
- Making the JSNA a tool that could be used easily in the future through data sharing/IT solutions
- Providing a JNSA citywide commitment to the priority areas through open data.

RESOLVED that the Coventry Health and Wellbeing Board notes:

1. **The proposals on geographies and phasing**

2. **Local sponsors and lead officers are identified in each geographical area so that areas for development identified through the JSNA can be developed into local priorities and action planning can take place. This must include a formal route to report problems and issues as they arise and address the immediate needs of the communities.**

20. **Coventry and Warwickshire Integrated Care Strategy Update**

The Board received a briefing note of Liz Gaulton, NHS Coventry and Warwickshire Integrated Care Board regarding the Coventry and Warwickshire Integrated Care Strategy update which detailed progress to date in the development of the strategy and the next steps.

The Integrated Health and Wellbeing Forum meeting on 13 October 2022 would provide the opportunity for members of the Health and Wellbeing Boards to inform the development of the Strategy. The outcomes of that meeting would inform recommendations to the Integrated Care Partnership meeting on 31 October 2022 about the overall priorities and core content of the Strategy. Further drafting would be completed in November ahead of consideration of a final draft by the ICP for submission to NHSE in December.

RESOLVED that the Coventry Health and Wellbeing Board notes:

1. **The requirement for the Integrated Care Partnership to develop an Integrated Care Strategy, informed by the Joint Strategic Needs Assessments and Health and Wellbeing Strategies, by December 2022.**

2. **The approach to development of the Strategy in Coventry and Warwickshire, and progress to date.**

The Board received a presentation of Philip Johns, Coventry and Warwickshire ICB and Danielle Oum, Chair of the Coventry and Warwickshire Integrated Care System regarding Integrated Care Development

The presentation highlighted the following:

- The foundations and formal establishment of
  - The Integrated Care Board (ICB)
  - The Integrated Care Partnership (ICP)
  - The Coventry and Warwickshire Integrated Health and Wellbeing Forum
- Developing and Integrated Care Strategy and a 5-year Joint Forward Plan by April 2023.
- Advantages of the system
- Progress since the ICP meeting on 26 July 2022.
- Integrated Care Strategy priority lead areas
- Strategy development and engagement pathways

RESOLVED that the Coventry Health and Wellbeing Board notes the content of the presentation: Integrated Care Development.

21. **Better Care Fund 2022/23**

The Board received a report of the Director of Adult Services and Housing on the Better Care Fund Plan 22/23.

The Better Care Fund commenced in 2015 with the aim of bringing together the NHS, adult social care and housing services so that older people, and those with complex needs, could manage their own health and wellbeing, and live independently in their communities for as long as possible.

The Planning process for 2022/23 was published on 19 July 2022 with the date for submission being 26 September 2022. The submissions were approved by the ICB Finance and Performance committee held on 7 September 2022, followed by the Integrated Care Board meeting on 21 September 2022.

The national process requires the plan to be signed off by the HWBB. If not signed off at the point of submission, details of the next meeting where it would be approved were required to be submitted. Alongside the Narrative Plan and planning template appended, a demand and capacity template would also be required to be submitted however, this was not part of the assurance process that would be completed nationally.

RESOLVED that the Coventry Health and Wellbeing Board notes the content of the Better Care Fund Plan 2022/23 submissions.

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

There were no additional items of public business.

(Meeting closed at 3.35 pm)

Coventry City Council

Briefing note

To: **Coventry Health and Wellbeing Board** **Date: 23 January 2023**

Subject: Coventry and Warwickshire Integrated Care Strategy

1 Purpose

1.1 The paper informs the Board about the draft Coventry and Warwickshire integrated care strategy, which was approved by the Integrated Care Partnership (ICP) on 8 December 2022. This is an interim strategy, with plans for formal publication alongside the Integrated Care Five-Year Plan in April 2023.

1.2 The Health and Care Act 2022 requires integrated care partnerships to write an integrated care strategy, setting out how the assessed needs of the population can be met by the Integrated Care System (ICS). The strategy is a crucial system document that provides a vision for health and care in Coventry and Warwickshire 5 years from now, leveraging the benefits of the system and enabling greater collaboration across partners. It sets the strategic direction and priorities for the system.

1.3 The strategy was co-developed by system partners through a widely inclusive process, and is informed by insight from our diverse communities, especially those with protected characteristics and groups that experience health inequalities.

2 Recommendations

2.1 The Board is recommended to:

1. Note the draft Integrated Care Strategy for Coventry and Warwickshire 2022 and provide feedback on the draft strategy ahead of publication;

2. Consider how the Board could contribute to delivery of the strategy, and how impact and success measures could be shared through regular reporting to the Board; and

3. Consider how the Integrated Care Strategy might inform further development of the Board's Health and Wellbeing Strategy.

3 Background

3.1 The passage of the Health and Care Act (2022) established Coventry and Warwickshire as an Integrated Care System on a statutory basis on 1 July 2022. This included creation of the Integrated Care Board (ICB), a statutory NHS organisation responsible for managing the NHS budget and arranging for the provision of health services in the ICS area to meet the health needs of the population.

3.2 The ICP is a statutory committee that brings together a broad alliance of partners concerned with improving the care, health and wellbeing of the population. The ICP is responsible for producing an integrated care strategy on how to meet the health and wellbeing needs of the population in the ICS area. National guidance recommended that ICPs publish their interim integrated care strategy by the end of December 2022.

3.3 The ICB is responsible for developing a 5-year integrated care forward plan before 31 March 2023, and must build this plan with due regard to the integrated care strategy. The plan will provide the operational detail about how the strategy's vision will be realised.

3.4 The national guidance recognised that time restraints in this transition year may limit the breadth and depth of the initial integrated care strategy, which will mature and develop over time. ICPs are expected to develop and refine the integrated care strategy as part of an annual cycle of planning and review.

4 Developing the strategy

4.1 The ICP's approach to drafting the strategy was as inclusive as possible, with lead 'owners' from across the system identified for each core area of content. Over 40 individuals were involved in developing content, supported by a reference group, working group and core drafting team. A dedicated engagement task and finish group was also established to lead on community and stakeholder engagement. This included representatives from local authorities, NHS organisations, the voluntary and community sector, Healthwatch, faith groups and housing.

4.2 The strategy has been informed by:

- extensive system and partner strategy and engagement mapping, to ensure alignment with and building on existing system-wide activity
- the collation of needs data from across the system, especially from the Joint Strategic Needs Assessments (JSNAs)
- statutory guidance on the preparation of integrated care strategies
- feedback from a range of public and clinical engagement activities running concurrent to the strategy development.

4.3 Engagement with C&W Integrated Health and Wellbeing Forum on 13 October 2022 helped to inform priorities and identify what is most critical to the system now, and resulted in identification of a series of commitments that run through the strategy, aligned to achievement of the core purposes of the ICS.

4.4 Full details of the public and community engagement approach and activity are provided in the engagement report that accompanies the strategy. The strategy has been informed by insight from our diverse communities, with a particular emphasis on those with protected characteristics and groups that experience health inequalities. Key priority areas identified through community engagement included issues relating to digital inclusion, access to primary care and there being an erosion of trust in health services.

5 Strategy framework and content

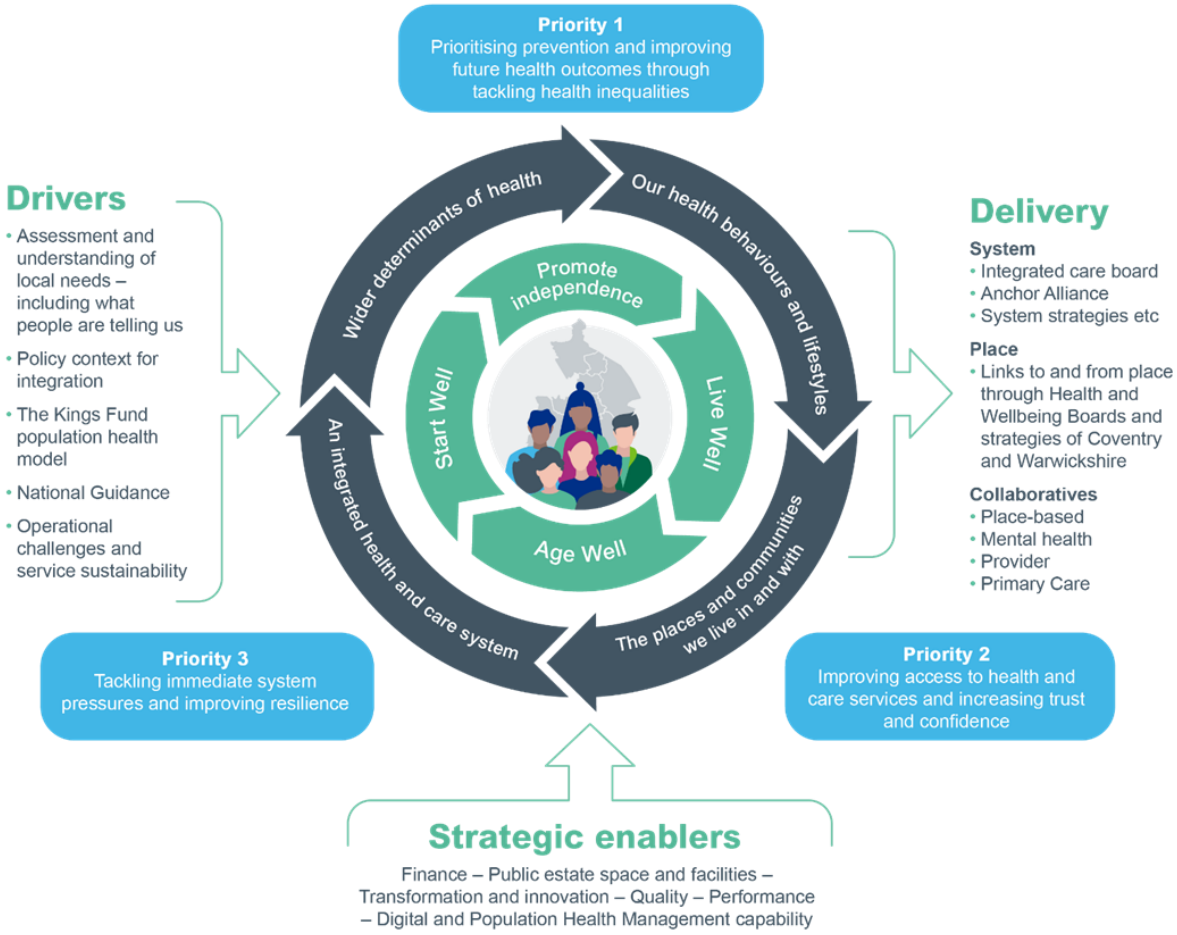
5.1 The final draft strategy includes three core priorities:

- Prioritising prevention and improving future health outcomes through tackling health inequalities
- Improving access to health and care services and increasing trust and confidence
- Tackling immediate system pressures and improving resilience.

5.2 For each of these core priorities we identify specific areas of focus and detail how we will change our ways of working over the next 5 years, and the actions we will prioritise. We have also identified a number of key enablers to delivery of our priorities, and we describe in the strategy where and how we need to integrate for each of these.

5.3 The overall framework for the strategy is described in the diagram below. There is a strong emphasis throughout on harnessing the energy and resource of a wide range of system partners to improve population health outcomes and address health inequalities, highlighting the connections and overlaps between different areas of activity. Like the local health and wellbeing strategies, it has the population health framework developed by The King's Fund at its heart.

5.4 The starting point for identifying our strategy priorities and areas of focus was an analysis of the two Health and Wellbeing Strategies, reflecting the needs identified in the JSNAs. Coventry's strategic ambitions and short-term areas of focus are reflected in particular in priority 1 of the strategy, which focuses on tackling health inequalities and addressing the wider determinants of health, including enabling the best start in life for children and young people.



6 The role of the Health and Wellbeing Board

6.1 National Government guidance for health and wellbeing boards following the creation of statutory integrated care systems states that:

- Health and wellbeing boards (HWBs) will need to consider the integrated care strategies when preparing their own strategy to ensure they are complementary
- HWBs should be active participants in the development of the integrated care strategy and the ICP and HWBs should "work collaboratively and iteratively in the preparation of the system-wide integrated care strategy that will tackle those challenges that are best dealt with at a system level"
- HWBs are required to consider revising their health and wellbeing strategy following the development of the integrated care strategy for their area, but are not required to make changes if they consider that the existing health and wellbeing strategy is sufficient
- The integrated care strategy should build on and complement local health and wellbeing strategies, identifying where needs could be better addressed at the system level
- ICPs should use the insight and data held by HWBs in developing the integrated care strategy, in particular the JSNAs.

- The introduction of integrated care strategies is an opportunity for JSNAs and health and wellbeing strategies to be revised and/or refreshed, to ensure that they remain effective tools for decision making at both place and system levels.

6.2 The guidance also makes clear that in an effective health and care system the ICP should build upon the existing work by HWBs and any place-based partnerships to integrate services. ICB and ICP strategies and priorities should not detract from or undermine the local collaboration at place level.

6.3 Coventry and Warwickshire Integrated Health and Wellbeing Forum is the key mechanism through which both Coventry and Warwickshire HWBs are involved in the preparation of the integrated care strategy and provide collective input to the strategic priorities of the ICP.

7 Timescales and next steps

7.1 The integrated care strategy will be formally published alongside the Integrated Care Five-Year Plan in April 2023. A suite of documents will be developed for publication, including an easy read version and an executive summary.

7.2 The Health and Wellbeing Boards and other key stakeholders, such as the Health and Wellbeing Place Partnerships and emerging Care Collaboratives, have an opportunity before formal publication to provide feedback on the draft strategy.

7.3 ICPs are expected to develop and refine the integrated care strategy as part of an annual cycle of planning and review. When refreshing its strategy the ICP must consider whether the strategy is being delivered by the integrated care board, NHS England and local authorities, including its impact on commissioning and delivery decisions.

7.4 The ICP plans to develop a core set of success measures for each of the three strategic priorities so that progress against intended outcomes can be properly monitored, with oversight through the Integrated Care Partnership and regular reporting to the Health and Wellbeing Boards.

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Appendices
Appendix 1: Draft Coventry and Warwickshire Integrated Care Strategy
Appendix 2: List of contributors
Appendix 3: Local Priorities for Integrated Care – Interim Public and Community Engagement Report 2022
Appendix 4: Equality Impact Assessment

Coventry and Warwickshire
Integrated Care System

Coventry and Warwickshire

Integrated Care Strategy

Contents

Foreword

We will do everything in our power to enable people across Coventry and Warwickshire to pursue happy, healthy lives and put people and communities at the heart of everything we do.

Those are the words at the heart of the Coventry and Warwickshire Health and Wellbeing Concordat, developed in 2018 as a statement of intent for how health and care will work together for the benefit of all of our residents.

The Health and Care Act 2022 formalised the biggest health and care reforms for over a decade, mandating collaboration and cooperation, but working in partnership isn't new to Coventry and Warwickshire. We have a long and productive history of working closely together as local authorities, NHS organisations and with our wider partners for the benefit of the people we serve. The new reforms present a real opportunity for us to go further and faster in collaborating as a system to support everyone in Coventry and Warwickshire to be happier, healthier and more independent.

The purpose and intent of the Concordat vision statement still stands and has shaped the vision statement for our system:

We will enable people across Coventry and Warwickshire to start well, live well and age well, promote independence and put people at the heart of everything we do.

These are difficult times for public services, for people working to deliver those services and for people needing to access to those services. The pandemic has pushed health and care services to the brink of their capacity, it has pushed the health and care workforce to the edges of exhaustion. Communities have suffered greatly too, as have workers in many other sectors. We have huge waiting lists, a growing population and less and less resource.

Despite the challenges I believe that the Integrated Care System, guided by this strategy, can improve people's health and quality of life. We are committed to prioritising prevention and to working with partners and communities to address the wider determinants of health such as socio-economic inclusion, housing, employment and education. We will ensure that services are personalised so that services meet the needs of individual patients and service users and we will strive to tackle inequalities and understand the drivers of population health.

In many ways our system performs well and everything I've seen in my time as the chair of the ICB and ICP has shown me this, as well as the shared commitment to working together to make things

better. It is the will to help each other and to continue to strive for the best for our people that is our greatest strength. Together we can and will build a fit for the future local health and care system.

This strategy, which builds on the great work happening across Coventry and Warwickshire and the two Health and Wellbeing Board Strategies, sets out exactly how we intend, over the next five years, to confront the challenges we face, together, to improve outcomes for local people. It will inform the detailed five-year plan for our Integrated Care Board.

It is Coventry and Warwickshire's strategy, informed by significant engagement with local people and communities, with the health and care workforce, with patients and clinical leaders. This conversation will continue as we turn this strategy into delivery and monitor our progress and impact. I am proud to introduce it to you.

Danielle Oum

Integrated Care Board and Integrated Care Partnership Chair

December 2022

Introduction

Delivering Health and Care in Coventry and Warwickshire

Our new Integrated Care System (ICS) was formalised on 1 July 2022, with the establishment of the new Integrated Care Board and statutory Integrated Care Partnership. One of the most important actions of our new ICS has been the development of this strategy, to set out how we will come together as partners to improve health, care and wellbeing for the people of Coventry and Warwickshire.

We are developing our Integrated Care Strategy at a time of enormous challenge for health and care systems up and down the country. The pressures we face are not unique to Coventry and Warwickshire, but their impact is affected by our local context.

This strategy provides an opportunity for us to set out our ambitions for what we can achieve over the next five years as an ICS. It aims to outline, in high level terms, the difference we can make by working in an integrated way, taking advantage of a new legislative framework – and it sets the tone and focus for how we will work together. It doesn't seek to replace or duplicate existing strategies and activity underway in the system – instead it seeks to link them together by providing an overarching narrative about where we want to get to, and what it is that we are all trying to change and improve together.

Importantly, this is about far more than health and care services. The Integrated Care System has an opportunity to improve population health and wellbeing in its broadest sense, with a wide range of partners working together to improve health outcomes and tackle health inequalities, starting with the root causes by addressing the wider determinants of health.

And equally importantly, this is about working together at all levels and as locally as possible. We intend that much of the activity to integrate care and improve population health will be driven by organisations working together in our places, and through multi-disciplinary teams working together in our neighbourhoods, adopting new targeted and proactive approaches to service delivery, informed by a shared understanding of the needs of our population.

The Covid-19 pandemic brought us together as partners in the face of urgent need and accelerated collaborative working. From protecting and supporting extremely clinically vulnerable people, to implementing vaccinations, to delivering testing, we worked together as partners and with our wider community in ways we hadn't previously, recognising where public sector partners had a different role to play, empowering and facilitating where expertise and capability lies with our communities. We now have an opportunity as an Integrated Care System to embed and build on these new ways of working together. The challenges we face are no less urgent or significant, and demand just as much commitment and ambition in response.

More patients than ever are accessing primary care appointments. However, in our engagement with local people we have heard, loud and clear, concerns about access to health services – especially primary care – and, increasingly, indications that trust in the NHS is beginning to erode.

Challenges

facing the Coventry and Warwickshire Intergrated Care System

Financial strain

£84 Million

Expected effeciency ask equating to 4.7% of the **£1.8 Billion** NHS opening budget for 2022/23***

Deprivation

137,208

of people live in the top **20% most deprived** areas nationally; equating to **14.2%**

CORE20

99,153 (**26.1%**) of the 137,208 people reside in Coventry

38,055 (**6.5%**) in Warwickshire

Living longer with greater need

	Healthy Life Expectancy (years)	Years spent in poor health	Total life expectancy
Coventry			
	61.1 (males)	16.9 years	78 years
	64 (females)	18 years	82 years
Warwickshire			
	62.1 (males)	17.6 years	79.7 years
	64.1 (females)	19.3 years	83.4 years

Population Growth

58,000

Predicted increase of GP registered patients by 2027/28, making the population **1,111,898**

Place-based variation

Willenhall	Warwickshire South
71.3 years	87.8 years

Staff Turnover

Continued increases in staff turnover (**recorded with an average of 15%**) poses a workforce challenge in capacity and service delivery.

Cost of living

Coventry is in the top decile **(10%)** of Local Authorities in the Cost of Living Vulnerability Index.

Health inequalities

The gap in life expectancy between most and least deprived **is widening**

Coventry	10.2 year gap (males)	7.5 year gap (females)
Warwickshire	7.7 year gap (males)	6.7 year gap (females)

Increasing demand

in Emergency Presentations and Primary Care following the COVID-19 pandemic.

*Based on an average increase of 15,800 patients year on year over the past seven years (2022).
**Mapped on Middle Super Output Area (MSOA) level, which on average comprises 7,200 people.
***The NHS Budget does not include Social Care.

Data Sources: Centre for Progressive Policy (2022); Coventry and Warwickshire ICS Internal Systems; 2020 Mid Year Population Estimates (ONS); Fingertips; The Segment Tool (OHID).

These are difficult messages to hear, but as an Integrated Care Partnership we are determined to tackle them head on.

As the local Integrated Care Partnership, we are uniquely placed to address the challenges facing the health and care system in Coventry and Warwickshire, and to harness collective energy and resource to achieve our ambitions for the health and wellbeing of our population. We bring together a wide range of partners – local government, NHS, voluntary and community sector, housing, Healthwatch, universities and others, to lead the system's activity on population health and wellbeing and drive the strategic direction and plans for integration across Coventry and Warwickshire.

Our Integrated Care Strategy charts a path for how we will work together over the next five years to deliver our vision.

Our Vision

'We will enable people across Coventry and Warwickshire to start well, live well and age well, promote independence, and put people at the heart of everything we do'

Improve outcomes in population health and health care

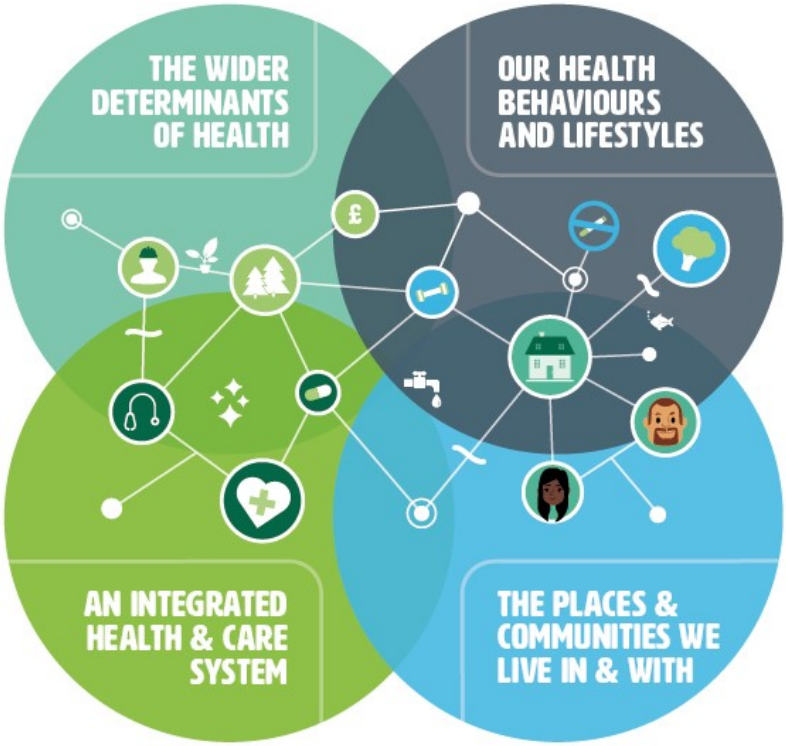
Tackle inequalities in outcomes, experience and access to services

Enhance productivity and value for money

Help the NHS support broader social and economic development

The Framework for our strategy

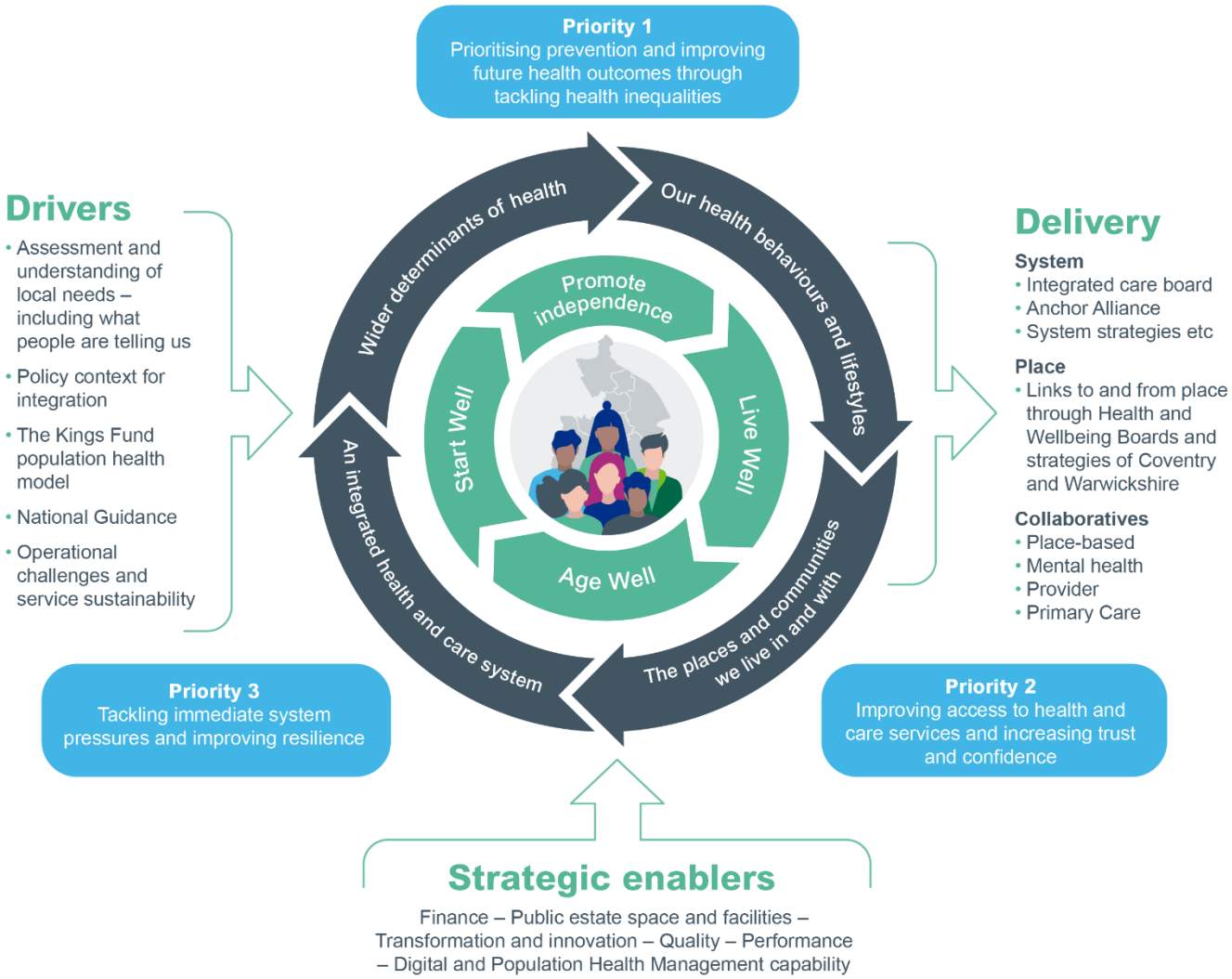
As we have transitioned to statutory ICS arrangements, The King's Fund population health model has framed our ICS strategic direction and underpins an inclusive, integrated approach to health and wellbeing. Both Coventry and Warwickshire Health and Wellbeing Strategies[1] are based around this model, and it is embedded as our strategic approach right across the system. We are committed to ensuring that strategies and plans across our integrated care system consider each of these four components and – importantly – the connections between them. Our integrated care strategy is equally driven by this approach.



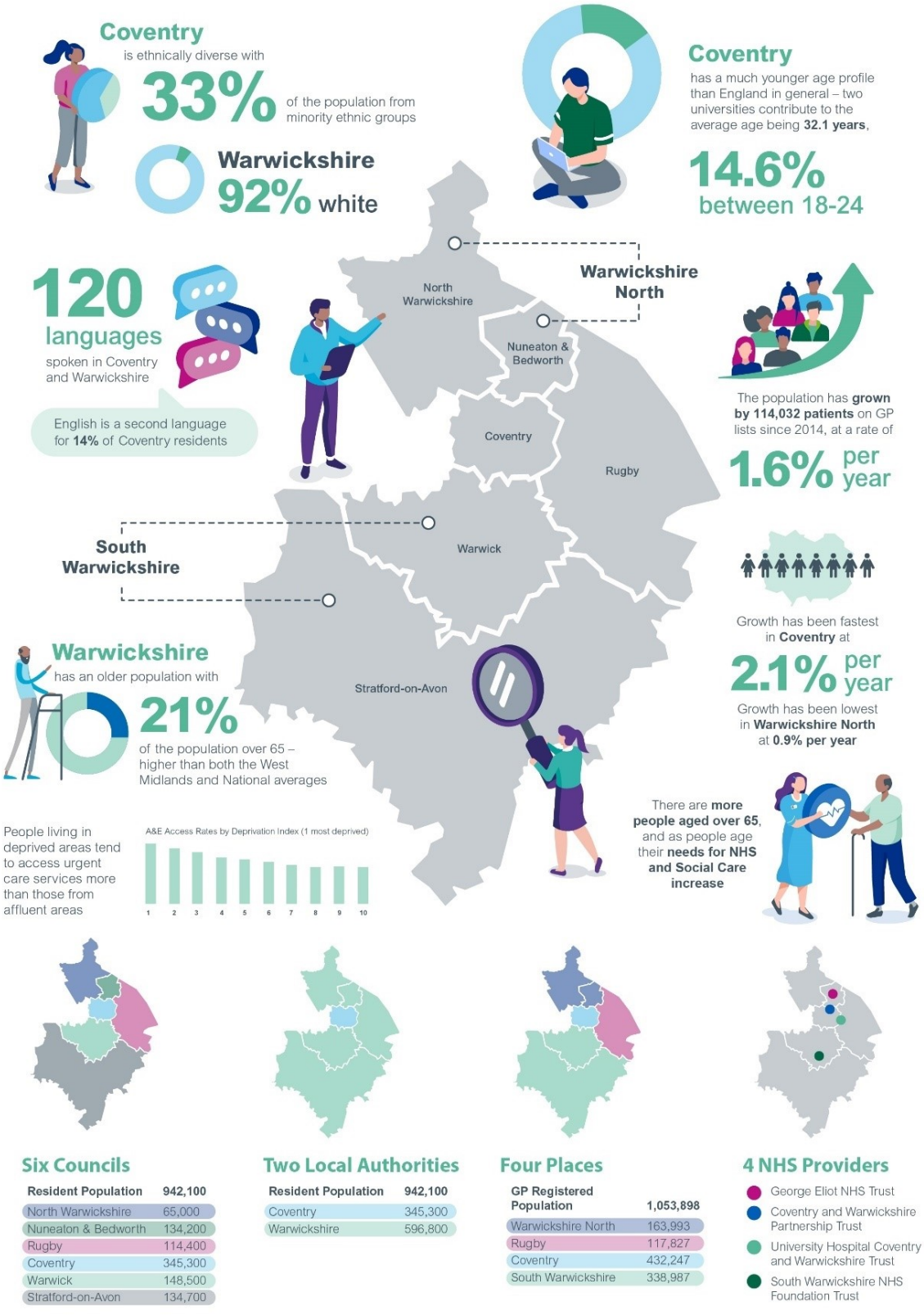
[1] Coventry Health and Wellbeing Strategy, 2019-2023
Warwickshire Health and Wellbeing Strategy 2021-2026

The diagram below sets out the overall framework for our strategy and helps describe the approach we have taken in developing its content.

Our priorities and planned activity are driven by the national and local policy context (and guidance) for integration and our understanding of local population health needs as set out in the Joint Strategic Needs Assessments, informed by local Health and Wellbeing Strategies and embracing the role and contribution of a wide range of partners at Place. And they reflect what we've learned from listening to our communities.



Our local people and communities



Six Councils

Resident Population	942,100
North Warwickshire	65,000
Nuneaton & Bedworth	134,200
Rugby	114,400
Coventry	345,300
Warwick	148,500
Stratford-on-Avon	134,700

Two Local Authorities

Resident Population	942,100
Coventry	345,300
Warwickshire	596,800

Four Places

GP Registered Population	1,053,898
Warwickshire North	163,993
Rugby	117,827
Coventry	432,247
South Warwickshire	338,987

4 NHS Providers

- George Eliot NHS Trust
- Coventry and Warwickshire Partnership Trust
- University Hospital Coventry and Warwickshire Trust
- South Warwickshire NHS Foundation Trust

The Coventry and Warwickshire Integrated Care System provides health, care and wellbeing services and support to a diverse population of over 1 million people, and that population is growing. With population growth concentrated in certain parts of the ICS, and the population profile varying between localities, a place-based approach to service planning remains important.

The Joint Strategic Needs Assessments provide a huge amount of data and evidence about the health and wellbeing of our residents:

- Coventry Joint Strategic Needs Assessment
- Warwickshire Joint Strategic Needs Assessment

More detailed information on health inequalities can be found in the Coventry and Warwickshire Director of Public Health annual reports[2] and Warwickshire's Health Inequalities Dashboard.

[2] Coventry Director of Public Health's Annual Reports
Warwickshire Director of Public Health's Annual Reports

Our opportunities to improve health and care

"ICSs… are part of a fundamental shift in the way the English health and care system is organised.

Following several decades during which the emphasis was on organisational autonomy, competition and the separation of commissioners and providers, ICSs depend instead on collaboration and a focus on places and local populations as the driving forces for improvement".

– The Kings Fund

The statutory basis for Integrated Care Systems (The Health and Care Act 2022) gives us an opportunity to go above and beyond what we have already achieved through collaborative working in Coventry and Warwickshire and to accelerate what has happened to date.

There are a number of empowering elements in the Act which we will seek to harness, especially around finance and tendering, and removal of the competitive environment. As collective stewards of public finance for the benefit of the population we serve, ICS partners have an opportunity to deliver real benefits from integration.

This includes:

- Targeting resource to where it is most needed to tackle health inequalities
- Joining up of currently disconnected services across providers, to deliver more complementary and seamless health and care services to our population
- Working together in our places to build strong community links and relationships
- Sharing best practice and expertise at scale across the system, and offering greater training and OD opportunities for our workforce
- Benefitting from procurement partnerships and economies of scale
- Data sharing and intelligent use of data for population health modelling and proactive and preventative work
- Improving resilience by, for example, providing mutual aid
- Working together to help build and enable a thriving voluntary and community sector, with the public sector changing how it works with communities to build responsive, local, and inclusive capacity
- Ensuring that specialisation and consolidation occur where this will provide better outcomes and value
- Sharing finance and back-office systems, professional expertise and facilities

The wider context and opportunities of integration

Inclusive Economic Growth

Integrated care relates not just to integration within the health sector, but also reaching out further to the integration of health and care to other key sectors.

We recognise the importance of the link between good health and a strong economy – the two are intrinsically connected and mutually dependant on each other.

Income, skills and employment levels all affect people's ability to live healthily. Similarly high levels of health and wellbeing create a strong, diverse and reliable workforce for our businesses and employers.

Whilst Coventry & Warwickshire enjoy both strong economic performance and comparatively strong levels of health and wellbeing, we know there is work to do for particular communities, groups and business sectors – this is a key focus for our shared approached to Levelling Up across the sub-region and our commitment to reduce disparities and increase opportunities.

Focusing on inclusive economic growth within an integrated care strategy allows us to explore issues of connectivity, access, and equality as well as providing a health lens to investment, infrastructure, sustainability which enables economic growth and improved health and wellbeing.

We are also aware of our own collective role on the local economy. Our Coventry and Warwickshire Anchor Alliance seeks to harness the role of local councils, health bodies and our universities as key local employers and contributors to the local economy.

The burning platform of the cost-of-living pressures provides a catalyst for long needed change. We now have an important opportunity to bring together the connected agendas of economy and health as inclusive growth within our developing Coventry and Warwickshire Economic Strategy.

Addressing environmental factors and climate change

"Climate change is the single biggest health threat facing humanity" (WHO)

We cannot consider health and care across our System without giving due attention to the environment and climate crisis. Extreme temperatures and air pollution are just some of the ways in which climate change is already starting to impact upon the health of our population; the severity and range of ways health and wellbeing will be impacted is only going to increase and concerted action is required at local, national and global levels. Sadly, we know that the impacts of climate change will disproportionately affect the most vulnerable in society, thus worsening the health inequalities that we are trying to address; those people living in deprived areas are more likely to experience poor air quality and individuals with underlying health conditions are more severely affected by extreme temperatures.

Not only do we have to be prepared as a System to deal with the consequences of climate change and take steps to mitigate, but we must also take responsibility as a System to reduce our overall

contribution to the climate crisis, including importantly the impact of healthcare. Coventry and Warwickshire ICS Green Plan seeks to embed sustainability and low carbon practice in the way that the system delivers healthcare services. The Green Plan allows our ICS to set out our current position in addition to our goals for the next three years, with a view to helping the NHS to become the first health service in the world with net zero greenhouse gas (GHG) emissions. A wide range of other action is being taken across the System, including through the development of a range of strategies: WM2041 5 Year Plan 2021-2026- West Midlands Combined Authority's plan on carbon emission reduction, Coventry Climate Change Strategy and Taking Action on Climate Change - Warwick District Council's plan to achieve Net Zero

As described by the Office for Health Improvement and Disparities (OHID), there are a number of so-called 'win-win' opportunities, whereby we can reduce greenhouse gas emissions whilst also addressing major public health challenges, focusing on prevention and the wider determinants. Good examples include:

- An increase in active travel by foot or bike will reduce green-house gas emissions and air pollution from private vehicles.
- Making homes more energy efficient will help tackle fuel poverty and the associated negative impacts on health.

Prioritising the wider determinants of health, including housing quality, will not only have an impact on climate change, but also a positive impact on an individual's immediate living environment, including for example damp and mould, that can be very damaging to health and wellbeing.

By all partners across the System committing to being green and sustainability led, we can not only improve the health and wellbeing of our local population, but also join the national and global effort to tackle the climate crisis.

People at the heart of our strategy

From the outset we wanted to ensure the strategy was informed by the people it speaks for –local people and their communities, as well as our health and care workforce.

Key priority areas identified through community engagement included **issues relating to digital inclusion, access to primary care and there being an erosion of trust in health services.** Ensuring a **focus on prevention, health inequalities and workforce** emerged as key themes from stakeholder engagement. Full details of the engagement are included as an appendix to the strategy.

As we develop the Integrated Health and Care five-year Plan, we will ensure we continue to engage and seek feedback and input in an aligned and connected way, local residents, stakeholders and all of those we have communicated with, engaged and involved throughout.

We will make sure this is coordinated with other engagement and involvement planned by local authorities, NHS organisations and others in the system.

Our strategic priorities

Our strategy priorities have evolved through engagement with stakeholders and the communities we serve, and are drawn from:

- the two Health and Wellbeing Strategies, reflecting the needs identified in the Joint Strategic Needs Assessments
- national guidance about the design of ICSs and the development of integrated care strategies
- key themes emerging from public and stakeholder engagement.

We have identified three overarching priorities that will drive our activity as a system over the next five years, with a number of key areas of focus within these. The strongest message we have heard in our public engagement has been about access to and trust in health and care services, and so we are committing to invest our energies in addressing this as one of our system priorities.

The other priorities reflect a shared understanding that there is both an immediate imperative to tackle specific burning issues around system capacity and resilience, and action we need to take now that will have an impact on population health long-term. It is by prioritising prevention across all we do that we have a real opportunity as an integrated care system to shift the dial on population health outcomes and inequalities.

Our priorities

Prioritising prevention and improving future health outcomes through **tackling health inequalities**

- Reducing health inequalities
- Prioritising prevention and wider determinants to protect the health and wellbeing of people and communities
- Enabling the best start in life for children and young people

Improving access to health and care services and increasing trust and confidence

- Enabling personalised care
- Improve access to services especially primary care
- Engaging and involving our people, communities and stakeholders
- Making services more effective through greater collaboration and integration

Tackling immediate system pressures and improving resilience

- Supporting people at home
- Develop, grow and invest in our workforce, culture and clinical and professional leadership

As we have developed these priorities and identified the outcomes and actions for each, we have done so through the lens of our population health model. Whilst each is an important and distinct area of activity, we also seek to highlight the connections and overlaps between them. So, for example:

- personalised care gives power to people to live independently, take greater control of their own care and focus on “what matters to me?” rather than “what’s the matter with me?” This citizen empowerment is key to the prevention of ill health
- protecting the health of people and communities requires culturally competent approaches, which will be underpinned by a deeper understanding and involvement of our communities
- there are opportunities to address the wider determinants of health through our approach to workforce challenges, by recruiting locally and taking action to attract and prepare young people living in areas of deprivation for careers in health and care.

We are determined to see an unswerving commitment to reducing inequalities running through everything we do but have also included this as a specific area of focus, to ensure it is given the attention and scrutiny required to deliver progress and impact over time.

All partners in the system have signed up to the following set of commitments that will define how we work together to achieve the four national aims and our system priorities. These include an underpinning commitment to the primacy of place in our decision-making and activity, whilst recognising the opportunity of system-wide working to deliver value at scale where appropriate.

Our commitments

Priority 1: Prioritising prevention and improving future health outcomes through tackling health inequalities

What this means to me

I will be supported to live a healthy, happy and fulfilled life, being equipped with the knowledge and resources needed to prevent ill health and maintain my independence at home, whilst knowing that effective services are in place for me to access should the need arise. This will include having access to support relating to the wider aspects of my life, including housing, employment and finances.

Context

As a system we want to prioritise supporting our population to remain as independent and healthy as possible, whilst also providing effective, timely and accessible treatment and care when required, from early years through to the end of life.

Informed by engagement, we have identified three key areas that we need to focus on in order to prioritise prevention and improve future health outcomes locally. They are:

- Reducing Health Inequalities
- Prioritising Prevention and Wider Determinants to protect the health and wellbeing of people and communities
- Enabling the Best Start in Life for Children and Young People

Nationally, **prevention** has been placed at the heart of the newly developed Office for Health Improvement and Disparities and forms a key aspect of the NHS Long Term Plan and the Care Act 2014. This focus reflects the ever-increasing evidence base demonstrating the benefits and cost-effectiveness of shifting resources 'upstream' towards prevention. Locally, prevention is not only at the forefront of our vision for Coventry and Warwickshire ICS and a key ICB principle, but more importantly there is a genuine drive across partners within our system, exhibited throughout stakeholder and also community engagement, for prevention to be given the priority it deserves

moving forward. This includes an all age, whole population approach to personalised care, where people are supported to manage their health and wellbeing rather than only receiving treatment when they get ill, which is a key component of the prevention commitment

Unprecedented demand on health and social care services means that protecting public health and preventing physical and mental ill health and disability and the associated need for care have never been more important or relevant and there is arguably no better way of ensuring the sustainability of our services. By focusing on prevention at all levels across the system, future health outcomes for our population, and demand for health and care services of Coventry and Warwickshire can be improved.

As we strive towards equity, some groups will need to have more opportunities to benefit from these improvements in future health outcomes than others. Currently **inequalities** exist in health outcomes and life chances nationally and across Coventry and Warwickshire; these inequalities are well documented and yet have remained largely unchanged. The Covid-19 pandemic highlighted and unfortunately further exacerbated these, which in part has led to a national drive to reduce health inequalities through programmes such as NHS England's National Healthcare Inequalities Improvement Programme (HiQiP) and more locally through our Health Inequalities Strategic Plan. Our public engagement highlighted the negative impact of such inequalities locally, particularly for Black and Minority Ethnic communities.

While the health and care an individual receives is important, we know that as much as 80% of a person's long-term health is related to wider factors, including employment, housing and education. The Integrated Care System is a unique opportunity to provide a more holistic approach to health and care across the system, to enable people to access the support they need relating to these **wider determinants of health,** to create and support healthy communities and environments in Coventry and Warwickshire. Local authorities will be crucial to this work and how we work with VCSE organisations.

We also know that happy and healthy **children and young people** have more chance of becoming happy and healthy adults and that adverse events in childhood can have a life-long impact. There is no better place to start when thinking about prevention and future outcomes than by focusing on children and young people, a time when the foundations of a healthy and fulfilled life are being laid.

Reducing Health Inequalities

We want to be a system that effectively identifies, tracks and takes action to reduce entrenched inequalities in health and the wider determinants, by taking a population health approach, ensuring that Coventry and Warwickshire is a place where everyone starts, lives and ages well. We recognise that some groups who are disadvantaged by current arrangements may need differential access or specific targeted services in order to reduce inequity.

"Everyone should be able to access the same healthcare regardless of their colour, background or culture." (Feedback from an engagement session held with CARAG, Coventry Asylum and Refugee Action Group)

What are we doing already?

Coventry and Warwickshire ICS has a new five-year Health Inequalities Strategic Plan which provides an important basis to shape our work. The Plan sets out our commitments on how we are going to reduce health inequalities in Coventry and Warwickshire, taking account of the delivery of key elements of the NHS Long Term Plan and Core20PLUS5. We have a Population Health Inequalities and Prevention Board, supported by the Inequalities Delivery Group that come together to strategically align and drive forward this work, which is also being supported by the creation of two new Health Inequalities Programme Manager posts aligned to Place.

A range of programmes and strategies relating to health inequalities exist across Warwickshire and Coventry, including Tackling social inequalities in Warwickshire (2021-2030) and the emerging One Coventry Plan and work of the Marmot Partnership. It is hoped that this strategy, alongside the ICS Health Inequalities Strategic Plan will support in aligning work to ensure an integrated and coordinated approach to tackling health inequalities across Coventry and Warwickshire; embedding reducing health inequalities across all programmes of work will be key to achieving our goals.

What will change in our ways of working?

- Action to tackle inequalities will be embedded strategically and operationally across the system, making it core to the work of the ICS and built around Core20Plus5, ensuring it is at the heart of decision making and prioritising.
- We will build a culture of prioritising those in greatest need and an understanding that health inequalities can only be addressed in a systematic system-wide way and by taking a population health approach. This includes reducing inequalities being key to decisions on the prioritisation and allocation of resources.
- Service provision and preventative activities will be aligned with intelligence around the wider determinants of health and existing inequalities.
- All of our services will be planned and delivered in an inclusive way, encouraging innovation and community co-production through design.

What actions are we prioritising?

- Delivery of the Health Inequalities Strategic Plan across place and workstreams.
- Establishing a process to collect and share data and intelligence about health inequalities efficiently and effectively across the system and use them to plan service provision and preventative work.
- Ensuring all partners across the system have a shared understanding of what health inequalities are, how they relate to their work on a day-to-day basis and how to address them – for example by using HEAT (Health Equity Assessment Tool). This will also include supporting the personalisation agenda at a population level.
- Shifting resources to target population groups demonstrating the greatest need to achieve equity in outcomes, taking a gradient approach known as proportionate universalism.

Prioritising Prevention and Wider Determinants to protect the health and wellbeing of people and communities

We want to see prevention being explicitly embedded and resourced across all plans, policies and strategies for our population, supporting a reduction in inequalities and improvement in health and wellbeing outcomes. This includes addressing the impact of the wider determinants of health across the life course, ensuring residents live in affordable and good quality homes, have access to good jobs, feel safe and connected to their communities, utilize green space and are enabled to use active travel.

"More prevention plans and strategies - maybe this will help to save money and resources in the future." (Feedback from an engagement session held at a Hindu Temple)

We also want to be as prepared as possible for the very real threat of future pandemics, but also effectively manage all aspects of health protection, taking a population health and multi-agency approach. This includes ensuring ready access to and high uptake of immunisation and screening opportunities and appropriate and safe antibiotic prescribing. Our public health workforce, leadership and the lessons from Covid-19 will be key.

Within our communities people living in shared accommodation such as care homes, refugee and asylum seeker accommodation are more vulnerable to outbreaks of infectious diseases; we will continue to work collaboratively with partners to ensure additional measures are in place.

"Refugee and asylum seeker's mental and physical health is being affected due to the long delays with paperwork, housing conditions, financial constraints and isolation." (Feedback from an engagement session held at a Coventry and Warwickshire LGBTQI+ Support Group)

We want to deliver a whole system, all-age, person-centred approach to mental health and wellbeing, that is driven by access to physical and mental health and social care in the same place at the same time, with no wrong door, and where prevention is at the heart of all we do.

What are we doing already?

Our system approach based on the population health model not only recognises the interplay between wider determinants of health, our health behaviours and lifestyles, the communities in which we live and the health and care system, but also demonstrates our commitment to addressing these vital dimensions of health across the system. The Coventry and Warwickshire Population Health Inequalities and Prevention Board brings together and aligns local action around Population Health Management, Inequalities and Prevention across the system and is a vital aspect of developing the prevention agenda.

Both Coventry and Warwickshire Health and Wellbeing Boards have Health and Wellbeing Strategies in place that are rooted within the wider determinants of health, including a focus on connected, safe and sustainable communities. Our local authorities – Coventry City, Warwickshire County and our district and boroughs – also have strategies and plans and programmes of work in place around prevention and the wider determinants of health. In the context of significant cost-of-living pressures, with more people struggling to cover even basic bills and food costs, protecting people from the impact wider determinants can have on health and wellbeing is vitally important and will undoubtedly be more effective through an integrated approach across our system.

The nature of wider determinants means scope is broad and several workstreams will be relevant, including but not limited to:

- Domestic abuse and serious violence
- Transport
- Drugs and alcohol
- Homelessness
- Housing
- Employment
- Environment and health

Locally we are harnessing the valuable lessons learnt from the Covid-19 pandemic through an update of the local 2017-2021 Health Protection Strategy. This sets out a partnership approach to our identified priorities including emergency planning, infection control, screening and immunizations and air quality. Working closely in partnership with our UK Health Security Agency colleagues ensures a coordinated response to these key challenges, particularly emergencies and outbreaks.

Identified by the World Health Organization as being one of the biggest threats to global health, antibiotic resistance is also a priority locally and the Coventry and Warwickshire Antimicrobial Resistance (AMR) Strategy is delivered in partnership with colleagues from the ICS, including system prescribing leads. This aims to reduce inappropriate antimicrobial prescribing across primary and secondary care.

What will change in our ways of working?

- A commitment across the system to support prevention activity, recognising the value for money of prevention and early intervention. This includes prevention and early intervention being embedded explicitly across all system, place and neighbourhood plans, policies, strategies and programmes and maximising opportunities for primary, secondary and tertiary prevention across all pathways.
- Prevention of ill-health and promotion of wellbeing will be the first step of every NHS and local government pathway.
- There will be an increased recognition of the need for broad partnerships and the contribution that all partners can make, including academic institutions and voluntary and community sector organisations.
- A 'Health in All Policies' approach embedded across the system, whereby organisations adopt policies that promote health and wellbeing and support people with the rising cost of living, as major local employers.
- Effective coordination of all relevant health partners across the ICS to ensure migrant, refugee and asylum seeker populations receive appropriate physical healthcare, tailored mental health support and access to all services.

What actions are we prioritising?

- Resources will be allocated to reflect our focus on prevention and the wider determinants of health. This will include a systematic shift in resources 'upstream' towards prevention, and Health and Wellbeing Partnerships acting as delivery for the wider determinants of health.
- We will consider how to apply the Midlands Health Inequalities toolkit, including the Health Inequalities Decision Tool, to our decision-making across the system and specifically any targeted health inequalities interventions decisions.
- All system partner policies will be assessed for their contribution (positive or negative) to the health of our population. This will include conducting Health Equity Assessment Tools on new work programmes and policies and conducting Health Impact Assessments, for example by using the HUDU HIA or the WHIASU toolkit.
- We will use population health methodology and the voice of people with lived experience to drive strategic commissioning decisions and plan service changes to address health inequalities and provide more preventative services.
- Health services and partners will be equipped with the knowledge and resources to be able to appropriately signpost to services related to the wider determinants of health, with the aim of systematically addressing social needs within the health and care systems, for example through social prescribing approaches - enabled by linked data.
- Colleagues across the whole ICS will work collaboratively to maximise vaccination uptake via a variety of campaigns, especially relating to childhood vaccines such as MMR and our Core20PLUS5 populations.
- The Coventry and Warwickshire Health Protection Committee will effectively implement the updated Health Protection Strategy, ensuring that there is appropriate representation and involvement from all relevant stakeholders across the whole ICS.

Enabling the Best Start in Life for Children and Young People

We want to be a system that ensures children have the best possible start in life, where seamless, collaborative and evidence-based care is delivered to enable all children and young people to have the best start as a foundation for happy, healthy, safe, and productive lives, with effective and timely interventions in place when expected outcomes are not being met.

Greater focus and attention will be given to the children and young people agenda, ensuring all our young people receive the right support at the right time. This includes children and young people who may be more vulnerable or require additional support, including looked after children and children with special educational needs for example autism or learning disabilities, ensuring that they receive the additional care and support that they need to thrive and make a strong start in life.

What are we doing already?

We are seeing increasing population growth and diversity of needs amongst Coventry and Warwickshire's young children; services will need to expand and adapt to increasing numbers and complexity.

Warwickshire are establishing a Children and Young People Partnership (CYPP) sub-group of the Health and Wellbeing Board, the purpose of which is to provide strategic oversight to the CYP agenda, facilitate integration and collaboration across Warwickshire and take a holistic population health approach. Priorities and activities of the CYPP will be evidence-based and informed by the JSNA.

Coventry has a Children and Young People Partnership Board that reviews the Coventry Children and Young People Plan to deliver and provide the best support possible for children, young people and their families. There is also a multiagency Early Help Strategic Partnership focused on reaching children, young people and families when the need first emerges.

Some children and young people require additional support, care and protection either due to disability or specific vulnerabilities that mean they are at risk. This includes for example those experiencing homelessness or substance misuse, Looked After Children and children or young people on the edge of the youth justice system.

Coventry and Warwickshire are committed to supporting continued quality improvement to ensure that all children and young people are safe as well as healthy and that those with Special Educational Needs and Disabilities achieve the best possible outcomes through having every opportunity to take control of their lives, be as independent as possible and achieve their full potential. This requires strong partnership working across health, education and social care, with staff who take a holistic view of the child or young person that they work with.

The ICS is an opportunity to further align the great work already happening across Coventry and Warwickshire, led by the local authorities, through collaboration and a partnership approach. Ensuring the best start in life begins before conception and involves a wide range of partners and agencies across the system that contribute to children and young people's health and wellbeing. A

focus on perinatal services is particularly important from a prevention perspective, including for example interventions to reduce smoking in pregnancy. There are several key strategies and programmes of work across the system that set out evidence and objectives to progress with the children and young people agenda. These include:

- Coventry and Warwickshire's Child & Adolescent Mental Health Services (CAMHS) Transformation Plan
- Coventry and Warwickshire Joint Strategy for Autistic People (2021-2026)
- Warwickshire Children and Young People Strategy (2021-2030),
- Warwickshire Education Strategy (2018 to 2023)
- Warwickshire SEND & Inclusion Strategy
- Child Friendly Warwickshire
- Coventry Integrated Early Years Strategy (September 2021)
- Coventry Parenting Strategy 2018 – 2023
- Coventry Education Partnership & School Improvement Strategy
- Coventry Children and Young People Plan 2021/22
- Coventry Early Help Strategy (2020-2022)
- Coventry's Children's Services Strategic Plan and Journey to Excellence

Our local activity is informed by national policy, in particular The Early Years Healthy Development Review Report, and First 1000 Days of Life. We are working to implement the CHILDS framework for integration, applying a population health management approach to our health and care provision for children and young people. NHS England's Core20PLUS5 approach has recently been adapted to apply to children and young people, which will support the reduction of health inequalities for this age group.

What will change in our ways of working?

- There will be clear pathways in place across the system for communication and identification of need, with transformation of services to enable re-investment in sufficient capacity in the right place to respond to that need.
- We will ensure all-age pathways are in place across services to support the transition to adulthood and prevent unnecessary or ineffective transfer between services.
- We will adopt a strength-based approach to working with children and families across all services.
- We will invest in evidence-based quality support programmes, create school networks which collaborate to provide effective peer support systems and make a local commitment to workforce development, to improve school readiness and education outcomes.

What actions are we prioritising?

- We will establish a system-wide Children and Young People Board and develop a Children and Young People Health and Wellbeing Strategy.
- We will prioritise investment in children and young people's mental health and wellbeing services, with a specific focus on the current and future needs for 18–25-year-old people.
- We will establish a process to collect and share insight and intelligence efficiently and effectively about health inequalities and the needs of children and young people across the system. This will be used to inform service provision and preventative work.
- Resources will be pooled, through joined up planning and integrated working around children and their families, including across healthcare, children's services & education, pre-maternity and maternity care, peri-natal mental health, health visiting, Early Help, and special educational needs & disability.
- Services will be co-produced to ensure the voices of children, young people and their families are heard and are at the heart of decision making and prioritising.
- We will work with all partners to ensure that services for children and young people are poverty proofed.

Priority 2: Improving access to health and care services and increasing trust and confidence

What this means to me

I will find it easier to access the health and care services that I need wherever I live across Coventry and Warwickshire. Those services will feel more like one service, I will have more say over the services I receive and greater trust in their quality, effectiveness and safety.

Context

The NHS was founded to provide universal access to health care. We know that the pandemic had an impact on access and also on trust and confidence in services. We also know the two are related and both have a strong link to and impact on health inequalities.

This strategy has been informed by extensive engagement with people and patient and community groups across Coventry and Warwickshire. People told us that we need:

- Greater access and quality of access and fairness of treatment for all
- More access to health and care services in our communities
- Greater access to specialists
- More access to screening and diagnostic services locally
- Clearer information about how to access services and support for those that face challenges accessing them

One of the greatest strengths of our health and care services is their accessibility. We know that this is as important as ever and that different people and groups face different barriers and challenges accessing services. We also know that trust in key health and care services is variable across groups and communities and from service to service. We want to tackle this variability and raise levels of trust across the board.

Our mission over the next five years is to improve access to and trust in health and care services across Coventry and Warwickshire. When we say health and care services, we mean this in the

widest possible sense, including those such as housing and active living that impact wellbeing, and those provided by the community and voluntary sector.

We are facing greater demand for health and care services, have an ageing and growing population and like everywhere else across the NHS, a significant elective waiting list to work through. At the same time, we are facing continued financial pressures. We need to find more and better ways to work together, involving people and communities in this as well as partners such as the fire service, police and our many amazing voluntary and community groups.

There are four key areas which we need to focus on in order to improve access and trust informed by our engagement, they are:

- Personalised care
- Improving access to services especially primary care
- Meaningfully engaging people, patients and communities
- Making services more effective through collaboration and integration

Below we go into more detail on each area around what we want to achieve.

Enabling personalised care

Personalised care is all about giving people more choice and control over the way their care is planned and delivered based on “what matters to them” and their individual strengths, needs and preferences.

Our ambition is to achieve better experiences and health outcomes for people by embedding the six components of the universal personalised care model across our health and care services. We want this to be a hallmark of the care we provide and a shared ethos of all practitioners who are committed to shared decision making with people and patients

As we collaborate more as health and care service providers to align what we do, personalised care means:

- putting the care receiver, at the heart of this integration and the centre point of a whole-system approach – ensuring “what matters to you” is listened to and understood
- continuity of care and an all-age approach from maternity and childhood right through to end of life, encompassing both mental and physical health
- a new relationship between care receivers and care providers.

Personalised care has significant links across this strategy and, especially with health inequalities - by focusing on what matters to people, taking account of their circumstances, challenges and assets, and giving everyone the opportunity to lead a healthy life, no matter where they live or who they are. We want to promote and embed a personalised care approach across all of our workforce and reflect personalised care in our integrated care pathways and commissioned services across the Coventry and Warwickshire system. Our aim is to be clear about what this means for practitioners and providers and to empower individuals to be active and prepared participants in their own care.

What are we doing already?

Personalised care is a priority for the NHS nationally. It is one of the five key focus areas for change outlined in the NHS Long Term Plan. There is work underway already in the system, to develop a more consistent understanding of and set of practices around personalised care and a strategy for how this is implemented across Coventry and Warwickshire.

The C&W personalisation programme has produced a strategy for 22/24 setting out the programme's ambitions and approach for embedding personalised care across our system, supporting each of the Trusts, place partnerships, primary care and social care.

The programme has identified five principles of personalised care:

- It starts with the principle of "what matters to you" as opposed to "what's the matter with you?"
- It's about shared power and collaboration between people, families, and health professionals.
- It enables people to have choice and control over their lives.
- It moves people from being passive recipients of services to active citizens.
- It is about getting a life, not a service

We are working towards a universal service standard that builds in personalisation and is flexible enough to accommodate specific needs as well as more common ones. A key part of this will be how we better understand service access, patient experience and personal requirements.

What will change in our ways of working?

- Further integration to deliver enhanced personalisation, choice and flexibility for people accessing health and care services
- Joined up sharing of patient records and information across partners in the system
- Better experiences and health outcomes for people by an embedded universal personalised care (UPC) model across our system, place and neighbourhoods
- A reduction in health inequalities driven by greater access and trust in services and delivery of personalised care
- A population more empowered and supported to manage their health and wellbeing.

What actions are we prioritising?

- Develop and clearly communicate to all health and care practitioners what we mean by personalised care and a set of working practices to support its implementation and adoption
- Support each of our Trusts, place partnerships and primary care colleagues to identify opportunities to embed personalised care approaches
- Support our workforce through training to better understand and be equipped to deliver personalised care
- Support our people and patients to share "what matters to them" in their health care interactions
- Evaluate the impact for people/patients, staff and our system.

Improving access to services especially primary care

Through the engagement that we have undertaken to support the development of this strategy, we have heard a lot from local people about the importance of timely and simple access to joined-up health and care services when they need them. People have told us about the challenges and frustrations that they currently experience accessing a range of different services – in particular, the importance of access to general practice services

We have been honest about the challenges that we are facing as a system. Specifically, rising patient demand, financial pressures and increasing workforce shortages. While these impact on our ability to improve access to services, we remain positive about the opportunities to deliver new and innovative methods of delivering General Practice services through face-to-face, online and telephone appointments from an increasingly varied and professional workforce. In Coventry and Warwickshire, we are clear that the future of General Practice is to adapt and develop, to support the needs of our patients. We believe that the new structure of the NHS creates the opportunity to accelerate work already underway to deliver a much more integrated way of working, enabling partner organisations of the ICP to respond to the needs of local populations within available resources, to improve patient care, outcomes through access to services.

From our engagement with local people, we recognise that everyone wishes to access services in a different way, and we need to adapt to this choice. Many of these new routes into General Practice services were driven by our response to the Covid-19 pandemic. Local Providers of health and care services, including GP practices, rapidly adopted a range of new technologies and, as a result, digital access to services became much more widespread in our system. Whilst we recognise that accessing services through digital channels does not suit everyone, our local vision is to harness digital technology to enable local people to access information, support and care easily and confidently.

Key to our ability to provide the primary health care services that our patients need, will be the workforce. We have already seen significant increases in certain roles, such as pharmacists, physiotherapists, social prescribers and paramedics, who have had enormous value to patients as part of the wider multi-disciplinary team. Key over the coming months and years will be to increase these roles alongside a clear plan to support increased numbers of General Practitioners and the wider nursing team.

If we are successful, we expect to see increased patient satisfaction relating to shared decision making and access to services, including general practice services.

What are we doing already?

Every day in Coventry and Warwickshire tens of thousands of people access services through our 120 local GP practices and 19 Primary Care Networks ('PCNs').

While local GP practices are delivering more appointments than ever before and national GP Patient Survey results continue to demonstrate that they are performing better than the national average across a range of key areas, we also hear from some local people about the difficulties that they experience accessing their local GP practice. We are already using the data available to us, including data relating to GP appointment activity, to understand and tackle variation, and this will continue to be an area of focus for us over the coming years.

As we have set out, we believe that integrated working will be central to improving access. Dr Claire Fuller's recent landmark report, strongly reinforces the direction of travel that we have already set out on to transform our local out of hospital system in Coventry and Warwickshire through greater integration between primary, community and secondary care, social care and the Voluntary Community and Social Enterprise sector. Through our local out of hospital contracts, providers of services are working together to redesign care pathways in a more joined up way which supports our most vulnerable and complex patients to be able to remain safely at home through access to proactive care in the community.

Critical to our success in building a more integrated health and care system will be for us to continue to sustain and nurture the development of our 19 local PCNs, which bring together groups of GP practices to work together, alongside other NHS service providers, to develop services around the needs of local communities. These PCNs will continue to be the building blocks for wider out of hospital service integration.

Local PCNs have engaged with their local populations to develop new 'enhanced access' services which are extending access to general practice services during evenings and at weekends across Coventry and Warwickshire. They have also continued to expand the provision of social prescribing, supporting people to self-care and to access different sources of support in their communities, from creative activities such as art and singing to advice on housing and employment issues.

The delegation of responsibility for commissioning pharmacy, optometry and dental services from NHS England to the ICB in April 2023 offers an opportunity to strengthen the links across the different primary care contractor groups and to further drive integration across the primary care sector.

We have also been working on enhancing the community diagnostic capability and resources across the system to improve access to diagnosis services following the Sir Mike Richard's review of NHS diagnostic capacity. Capital investment in community diagnostics for Coventry and Warwickshire to support this work has been secured.

What will change in our ways of working?

In order to improve access to services and especially general practice services, we will work towards:

- Increased collaborative working across partner organisations of the ICP, driving increasingly integrated models of care/service delivery, including a transformed model of integrated out of hospital care
- Well supported PCNs operating with increasing maturity
- Resilient General Practices delivering accessible, personalised, high quality care
- Increased diagnostic capability and capacity across the workforce and improved access to community diagnostic services
- Improved and increased digital interoperability between primary and secondary care.

What actions are we prioritising?

- Delivering the funding guarantee for primary and community care, and continuing to maximise use of available primary care development funding
- Continuing to support PCN development and delivery of the national PCN services set out in Network Contract Directed Enhanced Service
- Development of the primary care collaborative – a 'guiding coalition' of leaders from within the general practice sector
- Developing our local Fuller Stocktake implementation programme centred on the action areas identified in the Fuller Stocktake Framework for Action
- Working with our primary care collaborative to refresh our Primary Care Strategy in the context of the integrated care strategy and the Fuller Stocktake. To ensure that our plans meet the needs of practices, PCNs and patients
- Working with our local Out of Hospital service providers to better integrate services across primary, community and secondary care, taking a more proactive and preventative approach to health care
- Establishment of three community diagnostic hubs across Coventry and Warwickshire.

Engaging and involving local people, stakeholders and communities

To involve individuals and communities in shaping the services they receive in a way that is both meaningful and representative, working together across the system to make services work for everyone

In order for our ICS to be effective we will have local people and communities at the heart of what we do and how we do it, enabling all those who want to be to be able to be part of identifying the issues and helping to find solutions in ways that work for them and meet the real priorities of local communities. Without the insights and diverse thinking of local people we will not be able to meaningfully tackle health inequalities and the challenges faced by health and care systems.

At the heart of how we work together as an ICS will be an ethos of learning from local people and, where needed, changing the way health and care partners work together, removing the barriers between services and joining up care around people and populations. This engagement will be an ongoing dialogue between the providers of care services and the recipients of those services to drive continuous improvement and involve people in care that is personalised to them.

This engagement and involvement of people is pivotal to improving access to and increasing trust and confidence in the health and care services we provide. Our engagement will always be meaningful, undertaken in culturally competent ways and we will do our best to coordinate engagement and involvement across the system understanding people's priorities and experiences in the context of their lives, not just their health conditions.

What are we doing already?

We have some really strong foundations to build on. The Covid pandemic and delivering the vaccination programme has shown us that when we work together to engage and involve communities with a common purpose, and without barriers between local authorities, NHS providers and commissioners and communities, we can better support and respond to the true priorities of local residents and extend our reach much wider and deeper into local communities, particularly those who may have been or felt excluded in the past.

Across Coventry and Warwickshire, all partner organisations, particularly the two Local Authorities, voluntary sector and Healthwatch, have developed many examples of excellent best practice in working with communities, understanding experiences and championing co-production, and we will build on and learn from their experiences in shaping the ICS approach.

We will adhere to the NHS England principles on how we communicate, engage and involve people and communities.

Our Communities Strategy outlines in detail the steps we will take to deliver these priorities. Throughout the strategy, there are case studies from across the partners of the ICS which demonstrate the breadth and depth of engagement activity that already takes place. We will build on these strong foundations, learning from each other to design how we work together as a system and better collaborate and engage with both individuals and communities.

Engagement is something which must be done *with* local communities not *to* them, and there are many great examples of communities being empowered to look after their own health across our

health and care system. The National Lottery Community Fund and The Kings Fund-supported Healthy Communities Together programme presents an enormous opportunity for us to learn about how best to mobilise communities and redefine the shape and scope of local systems to improve the outcomes for our population.

However, there remain barriers to delivering engagement, both as a system and at local, place and neighbourhood level, which this strategy aims to eradicate as we begin to work as one whole system – working in co-ordination at a system level where appropriate and empowering local communities to lead the way.

What will change in our ways of working?

- Greater levels of personalised care enabled by effective engagement with patients and communities
- An improved methodology and approach to how we engage patients and communities consistently across system partners based on a shared framework
- Developing and maintaining ongoing relationships with our diverse communities

What actions are we prioritising?

- Investing in the community and voluntary sector
- Delivery of our Communities Strategy
- Developing a framework for how we work together as partner organisations within the ICS
- Promoting cultural change across the ICS to put people at the heart of everything we do
- Building trust and relationships through always listening to and learning from our communities
- Equipping everyone with the tools they need and demonstrating the difference that community involvement makes, drawing on learning from across the system

Making services more effective and efficient through collaboration and integration

We want to make health and care services in Coventry and Warwickshire more efficient, effective and ensure they provide better value for everyone.

We will only be able to do this if we develop the ways in which we work together and the organisation of our health and care system so we have right vehicles through which to collaborate and integrate. These should enable us to develop new ways of working, speed up processes, share good practice and resource and align high standards. Clarity is required in the roles and responsibilities across each component and in the links between all parts of our new system.

A more joined-up commissioning and coordinated provision approach, closer to patient communities, will deliver a more efficient health care service. It will also provide a more coherent response to local population needs, supporting improved outcomes for all and reducing inequity in access and outcomes across Coventry and Warwickshire.

Key to achieving this will be the strategic leadership work of our ICP, the leadership and commissioning role of our ICB and the work of our care and provider collaboratives organising local delivery of services. This will enable us to transition to an infrastructure where decisions can be taken closer to communities, with better understanding of those communities and their needs, supporting collaboration between partners to address inequalities and improve outcomes in physical and mental health and wellbeing, and sustaining joined-up value for money services.

What are we doing already?

The Health and Care Act 2022, and other statutory guidance, sets out a clear intention of a more joined-up approach to health and care built on collaborative relations; using collective resources of the local system, NHS, local authorities, the voluntary sector, and others to improve the health of local areas.

Our operating model has a number of core components, which we have been establishing and developing, with specific roles:

- Integrated Care Partnership – as a partnership of key health and care leaders across Coventry and Warwickshire with specific responsibilities to develop this integrated care strategy for the whole population.
- Integrated Care Board - taking responsibility for ‘strategic commissioning’ and leading integration in the NHS to bring together all those involved in the planning and providing NHS services to take a collaborative approach.
- Three provider collaboratives with distinct roles and responsibilities to facilitate the sharing of expertise, knowledge and skills between providers and to draw on the strength of its members to redesign service delivery and develop new models of care:
    - Acute Provider Collaborative
        - Focus on at scale Acute pathway redesign
        - This collaborative will bring together all key stakeholders including Acute and other appropriate stakeholders e.g. Primary Care

- Mental Health Provider Collaborative
    - This collaborative will bring together mental health partner providers to respond collectively to improve delivery of mental health services across the system
- Primary Care Provider Collaborative
    - This collaborative will bring together all core Primary Care providers at a Coventry and Warwickshire level
    - This has commenced with General Practice at present but over time wider core Primary Care providers will also be incorporated.
    - The immediate focus of this collaborative will be to provide strategic direction and support to local PCN programmes

- Two geographical care collaboratives which will have an influencing responsibility on commissioning decisions made by the ICB so that services can be developed and tailored to meet local population needs. As care collaboratives develop and mature, this responsibility may increase to direct commissioning responsibility for an agreed scope of services:
    - One for Coventry, one for Warwickshire. The Care Collaboratives will map to our Local Authority (LA) boundaries recognising the opportunities for deeper integration and collaborative work on health inequalities and the wider determinants of health in the smaller, contained footprints of the local authorities
    - The Warwickshire care collaborative will be made of three equal Place partnerships.

What will change in our ways of working?

- We will have a whole-system approach that is reoriented to focus on keeping people healthy, well and in control of their lives
- We will build a sustainable system in which every resident of our area can expect to receive high-quality health and care services when they need them and barriers that currently prevent or hinder joined up care across services have been broken-down
- Everyone in the health and care system will work together to do the right thing for our population and the right thing for the system, where the health and care workforce feel valued and supported
- We will take collective decisions closer to the patient, based on a shared understanding of the local population and how people live their lives in a system that looks beyond health and care services to the wider determinants.

What actions are we prioritising?

- Getting the structures and governance of our system right, making them lean, effective and efficient
- Developing the strategic leadership capability of our ICB and ICP
- Developing the capability and capacity of our care collaboratives and local care partnerships as vehicles for driving collaboration and innovation
- Setting conditions to create greater collaboration, removing barriers to integrated care to allow local partnerships to thrive, and empowering staff and communities to deliver the ambitious service changes needed within the system
- Empowering the right groups of people with the expertise and evidence to make decisions on how to redesign and reorganise services
- Ensuring that there is agility and pace in decision making to enable transformation to occur at the rate that the system needs.

Priority 3: Tackling immediate system pressures and improving resilience

What this means to me

Everyone works together to make sure I receive appropriate and timely care when I need it, from skilled and valued staff.

Context

As we emerge from the global pandemic, the challenges that health and care services have faced over the last decade have only increased in severity. So, while we have clear ambitions for the future, we recognise that there are some immediate pressures facing our integrated care system that we need to address as a priority. A failure to do so will mean a constant cycle of immediate pressures and an inability to look beyond that and invest in the future.

We are seeing increasing demand for health and care services, complexity of need and challenges around the flow of patients through the system, all at a time of significant financial pressure. Many within our workforce are tired, having moved from the pandemic to recovery of services, and now face the additional stress of increased demand, increased vacancies and higher sickness absence.

Immediate system pressures include increasing demand for urgent and emergency care, a need to restore elective or planned care as quickly as possible, a requirement to manage the impact of winter, and mental health services impacted significantly by the COVID-19 pandemic. As an Integrated Care System, we also need to be able to demonstrate that partners can plan for, and respond to, a wide range of incidents and emergencies that could affect health or patient care.

We need to work together both to reduce immediate demand on services and to secure the system capacity required to meet the current and future health and care needs of our population – which include both physical and mental health care, and social care needs.

Traditional approaches aren't working, and increasingly we recognise a need to do something different as we embrace the opportunity of collaborative working through our integrated care system.

Reducing demand on services means enabling people with complex needs to live independently at home, which we describe in more detail below. Linking to priorities 1 and 2, we also need to minimise avoidable A&E attendances through improved service access and advice upstream – particularly for those in Core20 and priority groups who are overrepresented in urgent and emergency care.

Securing system capacity and building resilience involves:

- Ensuring effective system flow, by having the correct capacity, resource and processes in the system to ensure that we are able to most effectively and efficiently meet current and future service demands in a timely manner
- Working to support the resilience and sustainability of the social care independent, voluntary and community sector market, including support with recruitment, quality improvement and business continuity and making best use of resources through Fair Cost of Care
- Building workforce capacity by maintaining our focus on recruitment, development and support strategies to keep our people happy and safe at work
- Ensuring our limited resources are consumed to best effect through our approach to financial sustainability, productivity and efficiency.

There are two key areas which we need to focus on in order to improve resilience and tackle system pressures. These are:

- Supporting people at home
- Develop, grow and invest in our workforce, culture and clinical and professional leadership

Supporting People at Home

Supporting people to live at home as they develop or encounter health-related difficulties is a core ambition of health and social care. Achieving this requires resilient, responsive, accessible and adaptable health and care services that have personalised care principles at the heart of what they deliver and work in tandem with the individual, their friends and family carers to help people achieve positive outcomes.

The impact of not supporting people effectively at home is experienced both at an individual level and across our health and care system through increased demand on urgent and emergency care services and social care.

There is an important equality aspect to this priority as we know that some cohorts of our population seek support from health and care services earlier on, whereas others delay seeking help until at or close to crisis. This priority is therefore important to improve the experience and effectiveness of care and support within our system.

Through focussing on this priority area our aim is to provide support, across health and care and with wider partners, to enable people to be supported within their own home environment.

This will support the delivery of the ICS vision through:

- Supporting residents to lead an independent life
- Enabling people to remain in their communities for longer
- Improving sustainability of services through helping focus acute services on those who absolutely cannot be supported at home.

What are we doing already?

In Coventry, the Improving Lives programme presents the opportunity to significantly transform how older people are supported through organisations working together across community support, hospital processes and discharge/reablement. Although this programme is focussed on people aged 65 and over there will be benefits to other cohorts of the population

In Warwickshire, the Hospital Discharge Community Recovery Programme presents an opportunity to further develop pathway 1 (support at home) discharge to assess services in Warwickshire to enable all people in an acute hospital, who need further support, to access timely therapeutic intermediate care services on discharge.

Across both Coventry and Warwickshire, the learning from these programmes will be shared as the work progresses – this sharing and learning will enable the interventions with greatest impact to be used to accelerate progress across the whole system.

We are also working on ageing well and specific frailty programmes which have been making progress in our support for older people. We have a Proactive Care at Home workstream which is supporting individuals in their own homes and in care homes. These system wide programmes will

connect with the Coventry and Warwickshire specific programmes to make a step change in how people are supported.

We have recently implemented an Integrated Care Records system which is being rolled out to all organisations. This enables health and care records to be shared, which leads to better informed professionals, who will be better able to support people as a result.

What will change in our ways of working?

- An improved and more responsive coordination and delivery of health and care within an individual's own home when urgent and emergency care is required – this will help prevent people making unnecessary visits to hospitals
- Where ongoing support (health or care or both) is required to enable people to continue to live independently, this will be reliable, sustainable and responsive to change as people's requirements change
- Where people are required to visit hospital for treatment, this will be undertaken in a patient-centred and effective manner, with the focus on returning home as soon as possible
- Where people have had a change in their health as a result of deterioration or a specific episode in their life, they will be supported to recover and re-abled to maximise their individual outcomes

What actions are we prioritising?

- Development and implementation of an integrated model that focusses on support at home and stemming the 'flow' to hospital settings in Coventry and reabling people to regain independence they may have lost as a result of a health episode
- Further development of pathway 1 (support at home) discharge to assess services in Warwickshire to enable all people in an acute hospital, who need further support, to access timely therapeutic intermediate care services on discharge
- Taking the opportunities presented by social care reforms that can form a wider part of our ability as a system to support people to live independently, whether through housing, innovation, or use of technology
- Supporting informal family carers – our ambition to support more people to be independent at home will also require us to consider how we work with and support informal carers who are a critical and integral part of the care and support system

Develop, grow and invest in our workforce, culture and clinical and professional leadership

We have a total workforce of 47,800 in Coventry and Warwickshire. This includes 20,700 employed by NHS providers, 23,500 in adult social care, 3,200 in primary care and around 400 employed by our Integrated Care Board. Staff turnover is high, presenting real challenges in terms of workforce capacity and service delivery.

In order to deliver quality health and care services for our population, we need people with the right skills, the right values, and in the right places. We have an ICB priority to care for and develop our workforce, ensuring they continue to have the resilience and support to deliver the best care to our patients and communities, especially employees from black, Asian and minority ethnic communities who make up 30% of our NHS and social care workforce.

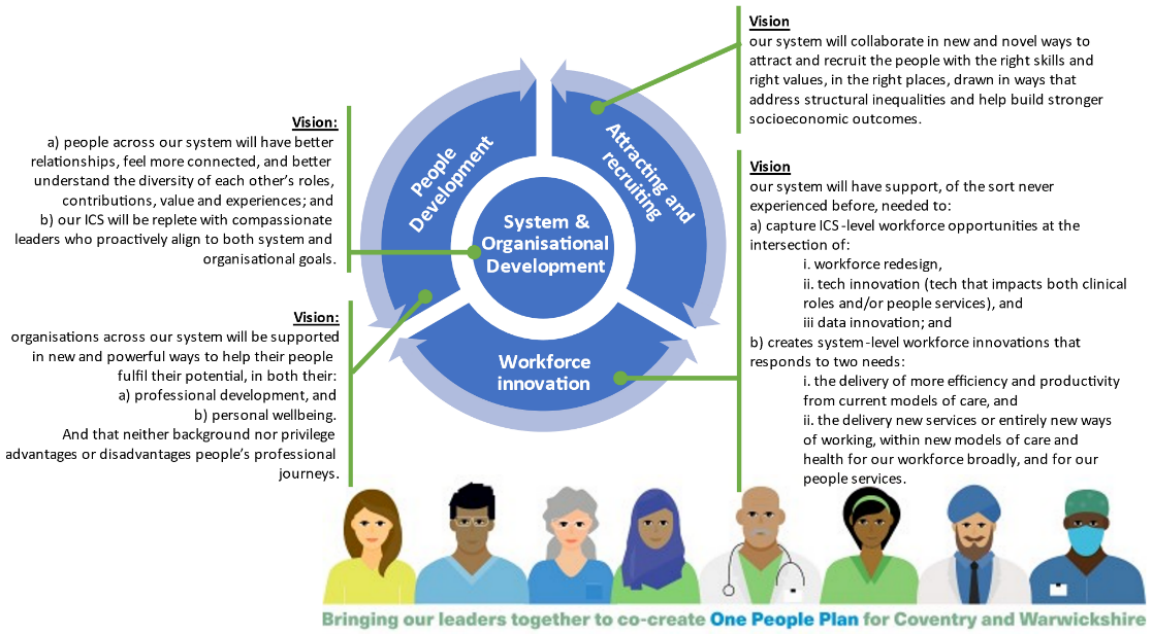
We have a diverse population and a diverse workforce, and to ensure we develop a sense of belonging and inclusion for all staff we must raise the profile of our diversity and inclusion work.

Clinical and Care Professional Leadership (CCPL) needs to be a core foundation of the system and how we act, engage, and make decisions in the future. The system needs buy in from clinical and care professionals to enable effective integrated working. Equally important is a population health mindset, and the expertise and leadership of our public health workforce and their input into decision making in the system will be key.

Our informal workforce is critical to our system too. There are an estimated 34,000 unpaid carers in Coventry and 62,000 in Warwickshire, and there is a strong volunteer sector which supports our services and offers wider community support.

What are we doing already?

Following an extensive programme of engagement, the Coventry and Warwickshire People Plan is now being updated. The NHS People Plan and ICS 10 people outcomes are key drivers for the development of this refreshed strategy.



Nationally there was acknowledgement at the inception of ICBs that clinical and care professional leadership (CCPL) will be critical to success[3] and our local CCPL Framework was developed in preparation. The framework sets out the work so far for a new way of doing multidisciplinary engagement and leadership through a clinical forum function and clinical executive group. The framework will be refreshed to ensure it meets the needs of staff, avoids duplication and builds on the work being done already in constituent organisations.

It is fundamental to have framework to guide us as we change our thinking, ways of working, and collaboration across the system. The part of the framework that will describe how we do this together is called our Philosophy of Care; this will bring staff voices together to aspire to work as one Coventry and Warwickshire team. Other elements focus on how we share learning, improve quality and safety, network, communicate and develop leadership.

What will change in our ways of working?

We want to see an ICS workforce that is aligned to and effectively enables the delivery of our system aims and priorities. This includes:

- People feeling looked after, supported and developed to enable new ways of working to improve services, and a culture of shared learning and collaboration
- An expansion of the substantive workforce, where required to meet service needs, focussing on the local population, increasing uptake of health and care careers and retaining colleagues for longer

[3] https://www.england.nhs.uk/wp-content/uploads/2021/06/B0664-ics-clinical-and-care-professional-leadership.pdf

- Frequent and open system-wide clinical interaction being embedded and supported by a strong clinical and care network in which all ICS members are included.

What actions are we prioritising?

The priorities in our People Plan are:

- **Attracting and recruiting** more staff and ensuring bias is removed from our processes, including launching our employability programme.
- **People development** and in particular the transformation of nurse education to ensure we can meet the requirement to expand the numbers of places and increase other routes into nursing. This priority also covers all other professions in particular AHP, medical, public health, social care and scientific roles. There is an important link with our widening participation priorities.
- **Leadership Capability Building**, through system wide approaches to development and talent management, giving increased opportunity to ICS members.
- **Inclusion and Diversity** – ensuring that our recruitment approach is equitable, diverse and inclusive and raising the profile of our diversity and inclusion work to ensure we attract, retain and improve the working experience of diverse groups
- **Health and Wellbeing** – continued focus on provision of support for our people to ensure they feel supported, valued and able to provide great services to residents.
- **Planning and efficiency –** ensuring we clearly scope and plan workforce needs for the future working, particularly with key system transformation programmes.

We will work with Anchor Alliance partners to improve employability for the Coventry and Warwickshire population and improve access to training, education and employment for our most vulnerable residents, working with local university partners to develop education pathways for our future workforce.

We also plan to undertake wide engagement to secure clinical and professional buy-in for integrated working and development of strong governance and networks to connect clinical and care professional leaders and ensure their voice and influence within the system.

Strategic Enablers

A number of key enablers have been identified to facilitate delivery of our vision and the priorities within our integrated care strategy. These are all areas where we think we can have a real impact on health and wellbeing outcomes by working together on a system-wide basis.

Finance

How we manage and use our resource collectively as an integrated care system is key to the achievement of our aims and ambitions. If we are to progress our priorities around prioritising prevention, improving access and tackling immediate system pressures, we will need to make difficult decisions about shifting resource. If we are serious about tackling health inequalities, where and how we spend resource will need to change.

We will be working with system partners to develop an integrated Finance strategy which will provide the outline framework for more detailed policies and processes to deliver and embed:

- A culture of financial stewardship, including our approach to investment and disinvestment decisions.
- A continuous improvement approach to financial sustainability, incorporating the Healthcare Financial Management Association sustainability checklist and framework, core financial controls and a programme of value-based reviews.
- A robust approach to integrated financial planning and reporting, linked to workforce, demand and capacity, and quality.
- An innovative approach to financial transformation: supporting productivity maximisation, providing professional advice services for business case appraisal and benefits realisation, developing forecasting and modelling capacity and streamlining back-office processes.
- System financial expertise: developing the system finance workforce through education and training, peer to peer reviews and cross system finance staff development supported by participation with Future Focused Finance and One NHS Finance programmes.

Where appropriate and following suitable due diligence, decision-making responsibility may be delegated to a more local level, but with the same approach to delivering and demonstrating sustainability and value.

We will continue to develop integrated working arrangements with system partners, where this allows better cross boundary working such as integrated budgets – and the delegation of functions into places, supporting the principle of subsidiarity and facilitating integration. For example, using Section 75 arrangements to manage or support pooled budgets across the NHS and local authorities.

Our finance strategy will have good regard to the four core aims of the ICS:

- improving outcomes in population health and health care; our value approach to investment and disinvestment will explicitly link resources to expected outcomes.
- tackling inequalities in outcomes, experience and access; we will work to develop a place-based allocation methodology which reflects the needs of the populations served.
- enhancing productivity and value for money; our approach to sustainability and efficiency will seek to ensure our limited resources are consumed to best effect.
- helping the NHS to support broader social and economic development; we will look to work across traditional health boundaries, developing joint working arrangements with local authority partners and VSCE organisations to support our communities leading health lives.

Digital, Data and Technology and Population Health Management capability

Integrated digital, data and technology is a key enabler to proactive, seamless and person-centric care, and to the collective stewardship of public funding for health and care to meet the needs of the population. It is crucial to facilitating evidence-led decision-making in the commissioning, planning, design and delivery of care, with insights from data used to improve quality, efficiency, population health outcomes and to tackle health inequalities.

Our Digital Transformation Strategy sets out an ambitious plan for digital integration aligned to the national 'What Good Looks Like' framework. We also have a Population Health Management (PHM) Roadmap, which sets out how we plan to spread, scale and sustain core PHM capabilities – around infrastructure, intelligence, interventions and incentives - across all levels of our system.

Digital Transformation is using digital, data and technology to reimagine health and care delivery improve our population's wellness. To achieve this, we need to ensure this thinking is central to our decision making, transformation, resourcing and partnerships, and promote the continued development of our leadership, organisational cultures, people and processes to embrace the benefits of the digital age.

Key areas of integration activity include:

- **Improving care**: we are using new technology and innovative digital solutions to enhance services for patients and citizens through consistent digital front door and virtual health and care capabilities. This will facilitate more joined up and personalised care, and improve access and self-support. The expansion of digitally transformed care includes measures to ensure standards for safe care are maintained.
- **Digital literacy**: work to ensure that health and care services suit all literacy and digital inclusion needs, whilst working collaboratively across integrated care partners to build digital literacy that enables access to health and care services digitally where appropriate.

- **Integrated records**: we are building on our electronic patient care records initiatives, shared care record and platforms and services that support research and innovation across health and care providers in Coventry and Warwickshire.
- **Population Health Management infrastructure**: implementation of a local PHM digital platform which will provide a near real-time linked dataset across all Coventry and Warwickshire ICS data systems and analytical tooling, enabling more targeted and proactive care to meet population health needs and address unwarranted variations in outcomes and experience.
- **Supporting our people**: we are working to ensure our workforce is digitally literate and equipped to work optimally with digital workforce tools.
- **Digital and data infrastructure**: working together to create digital, data and infrastructure operating environments that are reliable, modern, secure, sustainable and resilient. This includes ensuring robust digital assurance including information governance, cyber and clinical safety.

Public estates space and facilities

We will work together as partners to ensure our collective estate is managed most effectively to support and enable more joined-up easier to access care, support the aims and priorities of the system and ensure better safer care for patients.

The ICS has developed an Estates Strategy which sets out how we will work together to do this. It presents the collective work undertaken at provider, commissioner, and local authority place level both individually and in partnership with one another to improve the quality and outcomes derived from the public estate. The strategy is iterative to reflect subsequent funding requirements and priorities of an ever-evolving estate which looks to shift care closer to where it is needed and most suitably delivered aligning to many of our ICS priorities. Our Estates Strategy sits within the wider context of national priorities including; Carter Report, NHS Long Term Plan, Net-Zero NHS, Place-Based Systems of Care, One Public Estate, and the Naylor Review.

Our key areas of focus to deliver the priorities of the Estates Strategy are:

Capital Planning and Prioritisation - we will continue to review, update, and evolve our process to prioritise our major capital schemes. Develop a process for the management of Business-as-Usual Schemes. Review any alternative funding opportunities available to the system. Monitor the outputs of the Section 106 & CIL. Look to interface with the Digital Workstream to explore how we can advance our digital capabilities

Greener Delivery aligned to the ICS Green Plan - we will focus on areas such as creating a multi-purpose, biodiverse estate with greenspaces utilized for our local population, staff, and visitors. Transitioning to low/zero carbon solutions for the provision of energy services. Improve local air quality and reduce carbon emissions from travelling sustainably. Create partnership working to improve efficiency and eliminate carbon.

Disposals and Void management - develop, monitor, and keep under review our Strategic Disposals Tracker. Review our system void space to identify potential projects that could support better utilisation of space. Work in conjunction with the Capital workstream to monitor schemes, project, and programmes where opportunity exists to release surplus land. Develop greater partnership and collaborative working with our local authorities to explore opportunities to identify projects to reduce void. To explore alternative ways of delivering our clinical services, including the use of digitisation. Explore opportunities to develop agile working across our system

Effective Asset management - work in conjunction with the Disposal and Void workstream to drive the reduction of Void Space. Develop a systemwide approach to ERIC data recording, analysis, metrification, and reporting. Commit to developing our SHAPE atlas in order to create a single repository for our estates data. Generate a better understanding of backlog maintenance liabilities and continuous management and reduction.

Our key aims are:

- Working towards all Trusts operating with a maximum of 35% non-clinical space and 2.5% unoccupied space with alignment to Trust Premises Assurance Models.
- The NHS Carbon Footprint for the emissions under direct control, net zero by 2040.
- The NHS Carbon Footprint 'Plus' for the emissions under influence, net zero by 2045.

Performance and Assurance

Performance has been impacted significantly over the past two years following the global pandemic, including needing to wait longer to access services and the change in complexity resulting from this. Focusing on performance as a whole across all organisations within the System will be a key enabler for the effective delivery of our Integrated Care System priorities.

There remains the need to respond to the requirements of the NHS Long Term Plan and the annual NHS Operational Plan and we need to understand the current position with regards to how organisations in our System are performing, the areas of challenge, actions in place to address these and to be assured that health outcomes are improving.

The National System Oversight Framework aims to achieve and promote delivery of the metrics under the 5 domains, including:

- Quality of care, access and outcomes
- Preventing ill health and reducing inequalities
- Leadership and capability
- Finance and use of resources
- People

The Framework encompasses the aims of the Operational Plan within these domains. There is now a national dashboard, that shows current performance and ranking information to enable

benchmarking. A local dashboard is being developed to support this and to provide supplementary background information. This will help to drive the programmes of work that are needed to improve performance within agreed timescales and through co-designed action plans.

Meeting the needs of the population and population health is key to performance management and links closely with the Joint Strategic Needs Assessment and also the Health Inequalities Strategy.

Key areas of activity include:

- Develop a **single oversight framework** for the system, that:
    - includes high quality and up-to-date information from all organisations, to improve healthcare and population health and to tackle inequalities in outcomes, experience and access. Integrated performance management and monitoring is essential to enable transformation of services and evidence-based interventions that will improve outcomes across all focus areas.
    - includes broader health metrics, with a focus on outcome measures to transform and improve population health.
    - is open and transparent to enable joint ownership of issues, mutual accountability and collaborative working.
- Ensure a **robust monitoring and tracking system** for performance, that:
    - enables **early detection** of challenged areas, monitoring of progress and understanding of impact to reduce variation and inequalities across the System.
    - includes **granular information** to ensure that inequalities are able to be highlighted down to small geographic locations across the System, to support in service provision and targeting interventions.
- Embed a **mature assurance process** routed in principles of mutual accountability and equal partnership to collaboratively tackle challenged areas and achieve the Integrated Care Aims.
- Increase partnership working, including on **effective performance improvement strategies**, with routes to share good practice within the System.

Quality

Our system needs to be quality focused with a systemic oversight of quality for the population we serve, using a whole pathway approach to future proof prevention, selfcare, direct care and bedded care.

Key areas of activity include:

- Establishing a **Quality Governance Framework** which operates across the whole system, as the quality outcome of our provision is essential to understand and provide a base to improve from. This will be in line with the National Quality Boards (NQB) guidance and escalation levels.

- Embedding the new **Patient Safety Strategy** to ensure the move from serious incident management to The Patient Safety Incident Response Framework (PSIRF) and establish safe systems, structures and an escalation framework within which to operate across the whole System. The use of the DATIX incident reporting system where possible will be important to enhance system learning.
- Further strengthening the established **safeguarding partnerships**, by focussing on system wide working on safer communities and harder to reach communities.
- **Triangulating quality improvement** by establishing an approach which focuses on prevention, health inequalities and a reduction in unwarranted variation. This includes developing an approach that triangulates the wider determinants of health with quality, safety and effectiveness of services.
- Delivering the System **Quality Strategy**, ensuring involvement from broader health partners and developing empowered communities.
- Establishing a **System Quality Group** to work collaboratively across the system on continuous improvement, supporting system learning and development.

Transformation and Innovation

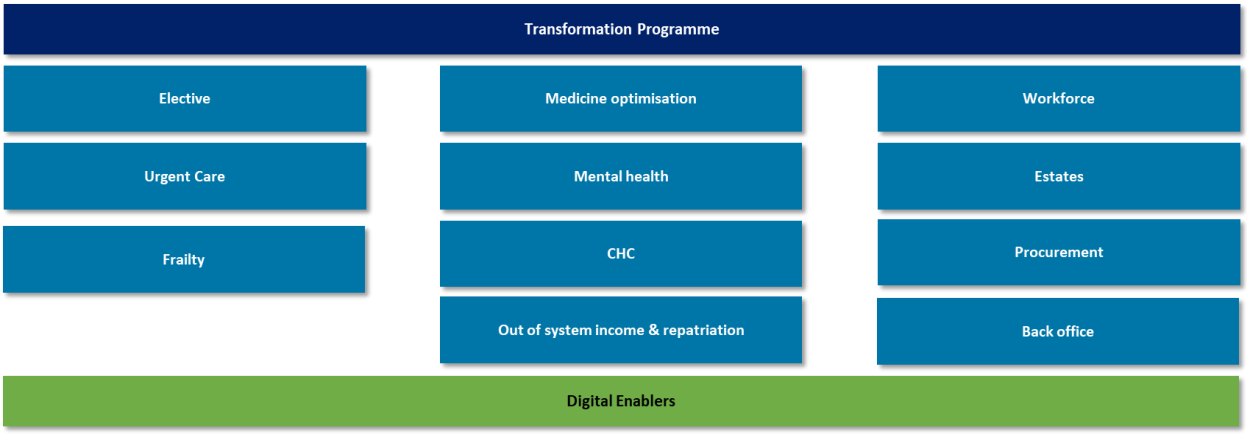
Following the Covid 19 pandemic, the recovery and sustainability of services is critical for our population. The innovations prompted by COVID-19 show the potential for us to revolutionise and transform service delivery and there are huge opportunities for collaboration, enhanced integration and transformation in our system.

Our ongoing approach to transformation will play a key role in determining the extent to which we are able to meet our ICS aims and deliver on our priorities. Transformation will also be a significant determinant of how we innovate to support service recovery and help shift care to better and more efficient, sustainable models.

We have developed a Transformation Programme which will drive system-wide innovation to support clinical, operational, performance, and financial recovery. This Transformation Programme is part of the ICS' six-point Financial Strategy and identifies a number of clinical and enabler work-streams that will:

- transform health and care services for the population of Coventry and Warwickshire to improve health outcomes and meet the needs of our population
- evidence how the ICS will deliver its health and care aims and priorities
- drive high quality and safe service delivery
- drive improved productivity and ensure the delivery of services that are efficient, affordable, convenient and offer high value

Our key focus areas of activity are:



Whilst our system Transformation Programme will deliver the changes that we need to improve patient care in the long-term and develop new service models that better meet the future needs of our patients and communities, we also need to keep driving localised continuous improvement on a daily basis to ensure our patients receive the right care, in the right place at the right time. To achieve this, staff engagement and clinical and care leadership are key components to our transformation approach as are the continuous improvement methodologies adopted across the system.

Our approach to innovation embraces research and the use of practice-based evidence, in assessing and identifying need and improving our understanding of how such need can be effectively met. Similarly, the adoption and spread of proven innovation, working closely with research, innovation and academic partners, supports us to drive transformation and best practice at scale and pace.

Impact

Our strategy sets out bold ambitions for our integrated care system and the difference we can make by working together and leveraging the benefits of the new legislative framework for health and care. We expect it to underpin everything we do as an integrated care system and to drive change in:

- how, as partners, we relate to each other and to our communities
- the way we use our resources
- the design and delivery of our services
- how we plan and make decisions.

Ultimately, we will see the impact of our strategy in improved population health outcomes, reduced health inequalities across Coventry and Warwickshire, and improved quality of health and care services for our population over the next five years and beyond.

If we are successful, people will:

- be supported to live a healthy, happy and fulfilled life, equipped with the knowledge and resources to prevent ill health and maintain their independence at home
- find it easier to access the health and care services they need wherever they live and will have more say over the services they receive and greater trust in their quality, effectiveness and safety; and
- receive appropriate and timely care when they need it, from skilled and valued staff.

This strategy is informed by existing strategies and will inform future strategies and delivery plans across and within Coventry and Warwickshire health and care system; including the ICB integrated care five-year plan which must be in place before 31 March 2023. The plan will provide the operational detail about how the strategy's vision will be realised at an ICB level. We expect to see a clear delivery plan for achievement of the outcomes we have identified for each of our priorities.

For many of the areas of focus and enablers detailed in this strategy, there are existing or emerging strategies and plans which have their own governance mechanisms for delivery and monitoring. We will not create burdensome reporting mechanisms on top of these. However, we do plan to develop a core set of high-level metrics for each of our priorities so that progress against intended outcomes can be properly monitored, with oversight through our Integrated Care Partnership and regular reporting to our Health and Wellbeing Boards.

As we monitor our impact and hold ourselves to account for delivery of this strategy, we will also draw on stories and lived experiences from the people we serve, to understand where we are making a difference and where there is more to be done.

Coventry and Warwickshire Integrated Care Partnership

Coventry and Warwickshire Integrated Care Strategy

Appendix 1: Contributors

Content leads and contributors

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Coventry and Warwickshire
Integrated Care System

Local priorities for Integrated Care

Interim Public and Community Engagement Report 2022

Coventry and Warwickshire Integrated Care Partnership (ICP) is currently developing the Integrated Care Strategy to set out how the assessed needs (from the Joint Strategic Needs Assessments already developed by local authorities) can be met. It will outline the direction of the system, setting out how decision makers in the NHS and local authorities, working with providers and other partners including the voluntary sector, will deliver more joined-up, preventative, and person-centered care for their whole population, across the course of their life.

As a system we needed to make sure that the development of the Integrated Care Strategy and the Integrated Care 5-year Plan is done in an aligned and connected way, with local communities, stakeholders and all other interested groups and individuals in the strategy communicated with, engaged and involved throughout.

From 20 August until 30th November 2022 a group assembled by the ICP to lead on the development of the strategy undertook engagement work with local communities, the ICS workforce, stakeholders and the voluntary and community sector to fill in those gaps identified in the desktop research and hear more about local priorities for health and care. This document provides a summary of this work, the themes emerging from the engagement and recommended actions for the development of the strategy as well as for the upcoming Integrated Care Five Year Forward Plan.

NOTE: This engagement report has been prepared to inform and support the first draft of the Integrated Care Strategy for submission and provides insight into the common, cross-cutting themes which we heard throughout our engagement.

Engagement continued until the 30th November and there remains significant work to do to further interrogate the outputs of this work to fully represent the views which we heard over the course of the engagement, particularly to understand the priorities and experiences of individual communities and to identify the inequalities in experiences and needs.

This information will inform the Integrated Care Five Year Forward Plan development, ensuring it is representative and addresses the needs of all local communities, our workforce and other stakeholders.

Methodology for engagement

This engagement needed to be completed with the support of all ICS partner organisations, as well as those wider partners in the voluntary and community sector and our local communities, in order to ensure our reach was wider than those who the NHS has historically engaged.

An engagement task and finish group was established, including representatives from Local Authorities, NHS organisations, the voluntary and community sector, faith groups and others, to first establish what we already know from previous engagement to feed into the development of the strategy. The group then supported further engagement across the area to ensure that the feedback gathered accurately represents the priorities of residents, particularly those with a protected characteristic.

Identification of audience

As a health and care strategy for the whole of Coventry and Warwickshire, we were aware that the strategy has a potential impact on every person within this area.

The overall intention of our approach is that we only ask our public and stakeholders to become involved in the development of the Integrated Care Strategy and Integrated Care 5-year Plan when it is meaningful, and we strive only to ask for input when we know that we have a gap in our knowledge.

A significant piece of system wide mapping and analysis had already taken place to determine the insight already available within the system in order to avoid duplication and asking people to repeat information they have already shared within the ICS. All ICS partners contributed to this desktop research exercise to ensure a broad reach throughout the population.

Following this analysis work we identified that we already had a wide range of insight into people's priorities around health and care, as well as those issues which may influence their health and wellbeing, the wider determinants of health. Considerable work has been undertaken via the local authorities to engage with their local populations and understand their priorities, such as through the development of the One Coventry Plan and the Community Powered work in Warwickshire as well as the work of the Directors of Public Health, and those learnings were key to the writers of the strategy, particularly in addressing areas of prevention and the wider determinants of health.

The Engagement Task and Finish Group identified that the gap in our knowledge was around the integration of services and priorities for health and care.

As we already had significant information about local people's priorities we focused the majority of our engagement on the following audiences

- Regular users of health and care services
- Carers
- Those with a characteristic which may affect how they perceive and receive health services including

    - Older people
    - Faith groups
    - Those of different genders or sexual orientation
    - Children and young people
    - Users of antenatal and maternity services
    - Local Black, Asian and Minority Ethnic communities
    - Those with a long-term condition / cancer service users
    - Refugees and asylum seekers
- Core 20 plus 5 groups
- Workforce across the ICS
- Voluntary and Community sector workers

However, we wanted to ensure that everyone who wanted to have a say had the opportunity to do so. To support this we promoted our online survey to a much wider audience, supported by the engagement task and finish group. These audiences included

- Housing Association residents
- Patient Participation Groups
- Wider community groups
- Local residents via local authority contact routes, posters and flyers

Targeting methodology

The engagement took two forms

Qualitative – Targeted focus groups and one to one conversations

An engagement calendar was developed to enable us to talk directly to residents of Coventry and Warwickshire and to hear about their priorities for health and care and what integration means to them. These opportunities targeted both those groups who are within the 'Core 20 plus 5' groups and those who are seldom heard or who may not be able to access online services to ensure their voices were heard.

Our primary route for qualitative engagement was through attending group sessions, both on and offline, to give a presentation on the background to the development of the strategy and then run a discussion session where people were able to share their thoughts on integration and their priorities for health care.

The content of our engagement activity was adapted at each session to meet the needs of individual groups, for instance; people with a sight impairment or who had difficulty with their hearing meant adjusting the session, giving extra time to feedback and speaking to individuals on a one-to-one basis.

There were some groups who requested to have the entire session interpreted in their language as English was difficult for them to understand. Volunteers and Co-ordinators who run local support

groups were key in liaising with the engagement team by making sure that we were prepared in advance to meet the needs of community groups.

Representatives from the ICB engagement team also attended a range of community events to have one on one qualitative discussions around their priorities and views on integration.

Quantitative – Survey on Integration and Priorities

We launched an online survey which was being promoted widely through ICS and ICP networks via email, newsletter articles and posters. This survey remained open for a month to enable people to contribute.

The survey incorporated the following questions

- What is the one thing that matters most to you about health and care services?
- What (if anything) stops you from accessing the health and care services you need?
- What is one thing you would change about how organisations provide health and care services for you?
- What do you think is the most important thing for health and care organisations to work together on now as a top priority?
- What other things do you think should be prioritised?
- If all health and care services worked more closely together would it improve the care you receive?
- If all health and care services worked more closely together would it improve the way you can do your job? (Note – this question was for those who work in health and care or with caring responsibilities)
- Is there anything else you'd like to tell us?

We recognised that not everyone is able to access an online survey, so paper copies of the survey were also produced and circulated through community representatives as well as by the engagement team at health events.

Overview of engagement results

Breakdown of audiences reached

Format	Involvement uptake
Online survey	244 people completed the online survey
Face to face	26 engagement sessions took place in various community settings 686 individuals participated in the sessions
Paper surveys	72 paper copies of the survey were completed
Virtual sessions	8 virtual sessions online
One to one	35 individual conversations
Translated sessions	4 individual group sessions translated

Detail of quantitative and qualitative research

Qualitative research

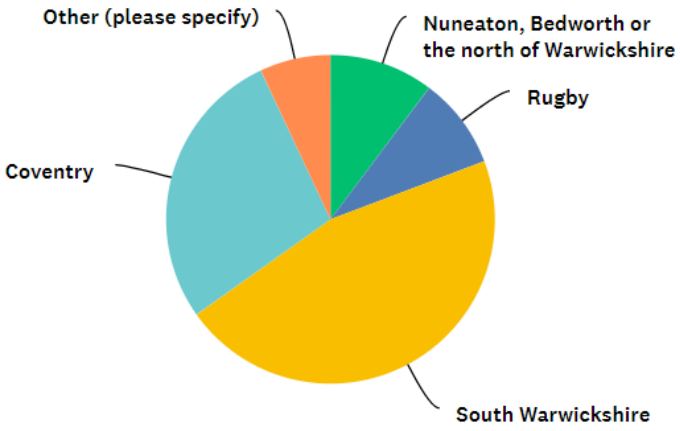
The response we have received from local communities and support groups was encouraging and the willingness by community leads to engage was extremely positive. We engaged with sectors of society who are vulnerable, under-represented and seldomly heard across the NHS system

Groups and communities involved in engagement		
South Asian community groups	Learning disability groups	Men's health support groups
Black and African Caribbean groups	Cancer support groups	Care Homes staff
Ante-natal support group	Charities	NHS and social care staff
Refugee, migrant and asylum seeker groups	Elderly support groups	Roma and gypsy traveller group
Mental health support groups	Housing support groups	LGBTQi+ support groups

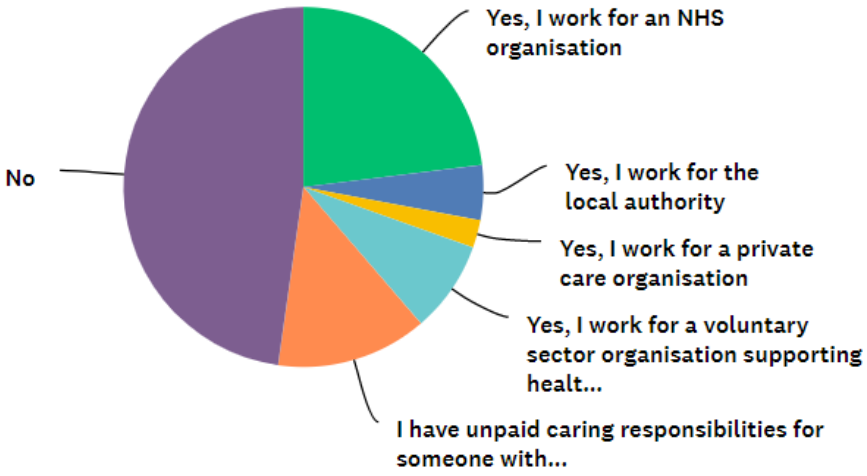
A full calendar of events and list of groups can be found in Appendix A – Engagement calendar

Breakdown of respondents online:

The majority of respondents to our online survey came from South Warwickshire.



The majority of respondents to our online survey were local residents but not employed by the health and care service (Shown here through the no response following the question “Do you work in health and care”)



Online survey equalities responses

The diversity of our survey responses does not reflect the diversity of the population of Coventry and Warwickshire. We have mitigated against this in our face to face work, ensuring that we gathered the views of a diverse range of local communities.

What is your sex?	Is the gender you identify with the same as your sex registered at birth?	What age group do you belong to?	What is your sexual orientation	Do you have caring responsibilities for someone with a physical or mental health care need?
184 - Female	231 – Yes	(18-24) – 5 people	< 5 - Bisexual (both sexes)	66 – Yes
49 - Male	< 5 – No	(25-34) – 18 people	200 - Heterosexual (other sex)	163 – No
5 - Prefer not to say	5 – prefer not to say	(35-44) – 34 people	< 5 - Lesbian woman	8 – Prefer not to say
		(45-54) – 50 people	< 5 - Gay man	
		(55-64) – 47 people	25 - Prefer not to say	
		(65-74) – 52 people		
		(75+) - 29 people		
		< 5 - people prefer not to say		

What is your ethnic background?	Do you consider yourself to have a disability?	Do you consider yourself to have any religion?
122 – White	192 – No	102 - Christianity
86 - Welsh/English/Scottish/Northern Irish/British	40 – Yes	< 5 - Hinduism
8 – Asian, Asian British	6 – Prefer not to say	< 5 - Sikhism
< 5 – Asian and White		< 5 - Islam
< 5 – Mixed		< 5 - Judaism
< 5 – Indian		< 5 - Buddhism
< 5 – Black, Black British		5 - Atheism
< 5 – Chinese		94 - No religion
		24 – Prefer not to say
		5 - Other

Key themes

Throughout our engagement we heard a number of key themes emerge as to what people's priorities were. These are cross-cutting themes which remained consistent regardless of the social-economic, age or other characteristics of the group in discussion.

The themes were

- Access to services
- Digital inclusion
- Trust in services

These themes, which are explored in more detail below, helped shape the overarching strategic structure and focus of the strategy.

Access to services

Overwhelmingly, across all groups, access to primary care services were raised as people's biggest priority for health and care. The GP is seen as the gateway to all other health services, and there was a significant level of concern and distress that these services were not perceived to be accessible, with many noting that this seemed to be a change for the worse since COVID. Although dentistry does not at this stage fall under the remit of the ICB, there was significant concern raised about access to dental services as well.

The focus of feedback was very strongly based around the access to primary care services, with many people reflecting that once they had managed to secure an appointment they were happy with the care they received.

The issues raised with access raised can be broken down into specific areas

- Booking an appointment with a GP practice
- Receptionists as barriers to access
- Face to face appointments
- Ordering prescriptions
- Access to dentistry

GP Services are the services which the majority of people access most often, so it is natural that it is what comes up most in discussion with local communities as the vast majority of people who are broadly healthy do not interact with wider service. However, this does not mean that access is not proving an issue in other areas and is important to reflect the wider picture. Respondents shared many other experiences of struggle to access urgent care services, which are summarised below.

Booking an appointment at a GP practice

Many respondents raised issues with getting through to their GP practice on the telephone to book an appointment. Many reported that the only way to get an appointment at their practice was to call at 8AM and get in an, often long, queue and when they did manage to get through all the appointments for the day were gone.

"GP appointments not available and patients asked to ring following day after 8am. This carries on for days."

"It's important for us from an LGBTQi community that we build trust with one clinician, it's a challenge to even get an appointment when calling the surgery at 8am - there are serious issues in accessing primary care services."

"Trying to get through when you need a GP appointment. e.g. Phoning at 8.30 a.m. and sitting in a queue for 40 minutes with no guarantee of getting an appointment."

'GP Appointments very difficult – problems with language, access to GP services remotely does not work, GP appointments take a long time and the GP call back do not always work – window given is too long and people have to get back to work and for genuine reasons cannot answer the calls with the GP rings.'

'We have to wait for a long time to get through to the Drs - people's phone bills are going up as a result of this long wait!'

Getting through on the telephone - not being number 30 in the queue without speaking to a receptionist. Sometimes I have to wait up to an hour on the phone.'

"Make it easier to contact GP practices/get appointments"

'Accessibility to doctors, we need more appointments either face to face or by phone.'

Receptionists

People also raised issues with dealing with receptionists at their local practice. Many people reflected that they feel that the receptionist is a gatekeeper to GP services and makes the decisions on whether they feel the patient needs an appointment or not. This raised concerns for people about privacy, as well as frustration that the receptionist was able to block them from what they considered to be essential appointments.

‘I get very distressed and anxious when having to call the Drs surgery, I don't like to explain my personal health problems to the receptionist.’

‘Receptionists in GP surgeries are the biggest challenge.’

‘To be able to at least speak to someone if you have to ring for appointments that can offer you effective advice, a lot of the time you have to speak to receptionists who may not have that experience to offer

‘We need a more confidential service at the GP reception desk!’

“We should have medically trained receptionists - this could ease pressure on doctors and nurses.”

Access to face to face GP appointments

Seeing the GP in person is another area where people perceive access has become much more challenging. The reasons behind this varied, but the most common reasons given by people were a lack of trust in digital services, concern they would not get the same level of treatment over the phone or online.

Lack of face-to-face appts and GP services being too quick to assess over the phone which is leaving lives at risk.’

‘We need face-to-face appointments - the Dr tells you to take a picture of your skin condition - how can this to be a true reflection of my condition as my skin colour is black and you can't see a rash on black skin in a photo.’

As an elderly person you want to see someone face to face rather than talking about your health condition over the phone

‘Accessibility to doctors, we need more appointments either face to face or by phone.’

“Face to face means I can get the vibe if they are racist or not – can’t put my finger on it but when you see them [face to face], if you know, you know. How can I trust him if I can’t see him”

Prescription ordering

In Coventry and Warwickshire, many GPs use the "Prescription Ordering Direct" or POD service to facilitate ordering of prescriptions, as part of an initiative to reduce waste and support people to only order what they need. This service was a theme predominantly with older age groups who were often on multiple medications and struggled to use the POD service effectively, reporting long waits on the phone, difficultly with using the callback options on the web or ordering online. This service was not mentioned by any respondents on the online survey, which suggests that those more comfortable with online are better able to navigate the service online and avoid the call center.

'Sometimes we have to wait for over an hour to get through to the POD service to order medications!'

'Is it acceptable to call the POD service 52 times before you get through to a call handler to order one repeat prescription?'

'The POD service is not working for patients, long delays and phone lines are busy all the time.'

The email prescription service only works for people who can get online.

Access to dentistry

Although dental services are not yet a part of the ICB, they are primary care services which do have significant impact of people's wider health and wellbeing and people reported significant issues in access. As we continue our journey to closer integration and are seen as the responsible organization for dentists we expect that the volume of this sort of feedback will increase.

The old dental care system worked better!'

'How will Dentists operate under the new ICB organisation (they will need to work together to fulfil their contracts).'

Access to dentists is another problem for local people.

women in refuge [are] unable to access dentists

We need to have more dentists, GPs, nurses, ambulance and hospital staff so that patients are seen quicker.'

Access to urgent care services

Although GP services received the most commentary about the access issues which people are experiencing, there was significant concern relating to the availability of those services needed when you have an urgent or emergency care need. People are concerned about the waiting times and the availability of urgent care services close to where they live and shared many personal experiences of long wait times.

> Very long waits for ambulances and in A&E departments – sometimes more than 12-15 hours.'
>
> Ambulance waiting times are appalling!
>
> 'Ambulance waiting times are too long and there is staff shortages in the NHS.'

> 'We have to wait for hours at the walk-in centre but at least you can see a doctor.'
>
> 'I waited 6 hours to see a Dr at the [walk-in] centre.'
>
> 'The walk-in centre is helpful but the waiting time is too long.'

> 'Long delays at A&E – 10-12 hours.'
>
> 'Since the A&E service was taken away in Rugby - people are struggling with their health and have to travel out of area.'
>
> 'Admission times at A&E are extremely long waiting hours, I've seen patients vomiting in their waiting chairs.'

Digital Inclusion

This theme was one which was raised, understandably, more within our face-to-face meetings than in our online survey, however within the context of the face-to-face discussions it was one that came up repeatedly and for a variety of different reasons. The move of services from face-to-face and telephone based to online services has caused significant concern to many residents, particularly those who are not used to using digital services or do not have regular access to the internet. A recurrent theme in the feedback was worry about being shut out from services and left behind because they did not have the resources or the ability to access things online. This was not just health services but also services to access support for local authority services such as warm home support or the Department of Work and Pensions.

With regards to the resources to access, what people most commonly referenced was the cost of accessing digital services both in lack of suitable equipment and data costs.

> Too much by mobile – who is going to pay for my WiFi?
>
> 'If you are struggling with your mobility or if you don't have good digital access you easily give up - how can people access the service in a more equitable way?'
>
> Trying to join up support and access is a real challenge for those people who don't have access to digital technology.
>
> We have a very clear digital divide which needs addressing - there needs to be more inclusion for people who do not have technology.

When ability was raised there was considerable concern that, particularly the older generation lacked the knowledge and ability to navigate through online services. Although voluntary sector and local authorities used to provide support in this, it was also noted that many of them had shut down during COVID and not reopened, leaving people feeling more isolated.

People being forced to use technology they don't know how to and the services which used to help them are gone

Some of the elderly Asian people do not know how to use a computer or book appointments online.

Community members particularly the older members lack IT knowledge and how to use technology. Training should be made available and having videos in different languages to educate community members.'

We need more access to blood test services - some people don't know how to book online.

Even if resource and ability are not at issue then there is still reluctance from people to access online services for health as they do not feel they get the same response from clinicians online that they would if seen in person.

Being able to get an appointment and talk Face to Face and not these phone calls and online chats, that's how things are missed.

Digital technology is not for everyone - not many elderly people know how to use a smartphone.

Less online more access to people contact, more concern for the older generation that don't like or do modern technology

What will happen to the older generation who do not use digital technology - how are they supposed to communicate online?

It is also important to note however that, amongst those who can access online services and filled in the online survey, there was considerable support for the extension and implementation of more online services. This was frequently mentioned in the context of improving access to GP services.

> [The one thing I would change would be] Online appointment bookings for routine non urgent situations
>
> Make it more accessible e.g. be able to book appointments on online at suitable time, have online meetings if possible
>
> Better online systems and virtual appointments (triaged by reception first).
>
> Back to being able to book Appointments online.
>
> provide email and online consultation bookings for patients who can use online. there are many things we want to talk to doctor about that are not extremely sensitive, and often it is easier to write things than talk to receptionist
>
> more online access: fill in forms and book appointed call back from a professional. This would allow you to get on with your day e.g. no hanging on for a GP as soon as they open to try and get an appointment only to be asked to call back at another time/day - when you work it is very hard to fit it in

Trust in services

Throughout our engagement we heard from people who are concerned about the sustainability of health and care services and are losing trust in its ability to respond if they have a health or care need. This is partly as a result of the two previous themes as people struggle to access the services that they need and feel shut out from digital services that they may not have the ability or the resource to access. Public perception of services also plays a large part, with several respondents expressing concern that services will not be able to cope with them if they were to attempt access, meaning they were choosing to not even try to make contact to get support.

Fear of how I'd be treated, not able to get an appointment when needed due to having to phone that morning and hope to be high up enough in the phone queue

Long wait times to get through to someone who then stops you accessing the care you need

The system discourages easy access. Services increasingly limited.

There is no link up no who do you go to its assumed families will do it...I'm single? And I haven't even EVER seen any medical person regarding having dementia.

Knowing how swamped NHS staff are, not wanting to add to their workload or inconvenience them

I am concerned that services are under increasing pressure and the quality of provision may suffer as a result.

Lack of understanding of who does what /worried about cost/waiting lists

Distrust of who I might see (due to new jobs introduced especially in mental health services like trainee WP's seeing people for counselling whereas years ago you would have typically seen a trained counsellor)

Difficulty to get appointments, long waiting lists, only seen if emergency - and then only if lucky.

Too much red tape, being told you don't meet an arbitrary invisible criteria when you are begging for help.

Not wishing to be a burden on what appears to be an overstretched service for what would be perceived as relatively petty problems to some people

Conclusions and recommendations

Conclusions

Throughout our engagement we heard from a wide range of local people and communities regarding their priorities and how they felt about services. People were willing to share their experiences and talk openly about what mattered most to them, and though our work we were able to reach a wide range of local communities.

Their key issues were as follows:

Access to services

It was striking that, although there were issues raised with specific services and people's experiences of them, for the most part when people were able to get to a service or speak to a clinician or other relevant health and care worker who was able to support them, people were happy with the service which they received. This highlights that access (and lack of access) is considered to be the biggest priority and concern people have around health and care services.

Access to GP services was something we heard about from every group that we visited, and also formed a large part of the feedback received in the online survey. Although it is important to note that this is likely in some part due to the proportional amount of appointments GPs deliver within the health system, the vast majority of people who raised issues had experienced them personally. This is not something which was caused by negative media or "received wisdom", the issues are very much real and seeing them addressed is a key priority for many of our local communities.

However, it is important to break down the areas which are causing most concern and where people feel things could be improved.

- Booking an appointment
- Receptionists as barriers to access
- Face to face appointments

With booking appointments, the single biggest issue was the need to phone at 8AM and get into a queue, referred to by one respondent as "The 8AM hustle". Several respondents to the online survey offered the solution of re-introducing online booking for appointments while others felt that the ability to book appointments in advance, particularly for long term conditions would help. This issues is something which must be considered, looking at how the Strategy and associated Forward plan can support GP Practices to deliver online or other mechanisms for booking.

Particularly in our face to face conversations respondents raised issues with GP receptionists. This specifically focused on concern of the lack of privacy and dignity in describing a health issue to a non-medical professional but also resentment in feeling that the receptionist was the one making the decision as to whether they thought the condition was serious enough to "need" a GP appointment.

This issue could, in part, be addressed through better patient education, supporting people to understand more clearly the reasons why a receptionist may ask for a brief summary of the reason for wanting an appointment, and informing the patient of the mechanism in place to protect their confidentiality. It will also be important to communicate the scope of the receptionist role to patients, and that the receptionist is not in a position to do any form or medical triage.

The issue with face to face appointments is ongoing despite the number of face to face appointments delivered in Coventry and Warwickshire increasing over the past months. It is important to understand the reasons behind a desire for face to face appointments are both varied and valid and not dismissed as personal preference. There are real concerns among local residents that the service may not be as effective online, one example raised was the doctor asking to send a photo of a rash, but the patient feeling that he needed to see them in person as they have black skin and a rash will not show up well in a photograph. These reasons must be recognized and clearly addressed in order to build confidence in online consultations.

Issues with access are multi-faceted and it would be a mistake to only focus on General Practice when considering a response. Waiting lists and referrals for hospital treatment were also mentioned frequently as well as access to urgent and emergency care. Local communities are fully aware of the extreme pressures on health or care services and this is leading to them making decisions not to access care at all, or in a timely way. This area is picked up further below.

Digital Inclusion

Digital services are part of our future, and this is widely welcomed by many, who see them as the solution to some of the access issues outlined above. However there remains a significant cohort of people who are not able or willing to access these services, either because they lack the resources or ability to do so, or because they do not trust them.

It is important that these concerns are acknowledged and mitigations put in place to support people to access care through other routes. Training and support was suggested as being vital to supporting the uptake of digital services, but this will not be suitable for everyone and it is important to avoid the onus being put upon the service user to learn, without also acknowledging the need for support and alternative routes of accessing care for those who are unable to do so. Many barriers to accessing service digitally were raised across our focus groups, and these barriers must be acknowledged and address as part of the development of the Strategy and Integrated Care Five Year Forward Plan.

Trust in services

Throughout our engagement, both on and offline, we heard a great deal of concern and worry across the full range of health and care services. People are worried that the services won't be there when they need them and they don't want to burden an already overstretched system. This lack of trust is a combination of personal experiences in struggling to access service and the information they hear on the news and from others. Some respondents said that their concerns about the pressure on the health system is one of the biggest barriers to them trying to access care, which can lead to people's conditions escalating and becoming an emergency.

In addition to access issues, there were a cohort of respondents who expressed a wider lack of trust in health services, having little faith that they would be treated equitably and fairly.

Improving trust in services is not something which can happen in isolation and can only be achieved through acknowledging and addressing the reasons which lie behind the lack of trust. This engagement work forms a part of that, and the data must be more fully interrogated to understand the individual priorities and needs of the different communities we serve so that we can begin the process of building trust. It is important that the Strategy and Integrated Care Five Year Forward Plan reflect these priorities and continue to be developed in as inclusive way as possible, allowing all voices to not only be heard, but to influence and lead change.

Recommendations

- Recognise the need of improvement in access to GP appointments and consider where the Strategy and Integrated Care Five Year Forward Plan are able to support the delivery of changes.
- Explore production of information to explain the role of a receptionist in triage and appointment booking.
- Recognise the importance of digital inclusion in the development of the Strategy and Integrated Care Five Year Forward Plan.
- Acknowledge the lack of trust in health and care services to treat people equitably and ensure that inclusive service development is at the heart of the Strategy and Integrated Care Five Year Forward Plan
- Continue the process of ongoing engagement with all groups who have contributed to this work, sharing the findings and continuing the process of involving them in the development of all our work.

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Equality and Quality Impact Assessment Tool

The following assessment screening tool will require judgement against all listed areas of risk in relation to quality. Each proposal will need to be assessed whether it will impact adversely on patients / staff / organisations.

Insert your assessment as positive (P), negative (N) or neutral (N/A) for each area.
Record your reasons for arriving at that conclusion in the comment's column. If the assessment is negative, you must also calculate the score for the impact and likelihood and multiply the two to provide the overall risk score. Insert the total in the appropriate box.

Quality Impact Assessment

Quality and Equality Impact Assessment

Title:	Integrated Care Strategy December 2022		
Lead:	Liz Gaulton, Chief Officer for Health Inequalities and Population Health	**Senior Responsible Officer:**	Danielle Oum, Chair ICP
Intended impact	The strategy sets out bold ambitions for our System and the difference working together and leveraging the benefits of the new legislative framework for health and care can bring. We expect the Strategy, and the forthcoming ICB 5-year Integrated Care Plan will drive change in: • how, as partners, we relate to each other and to our communities • the way we use our resources • the design and delivery of our services • how we plan and make decisions. Ultimately, we want to see the impact of our strategy in improved population health outcomes and reduced health inequalities across Coventry and Warwickshire over the next 5 years and beyond. If we are successful residents of Coventry and Warwickshire will • be supported to live a healthy, happy, and fulfilled life, equipped with the knowledge and resources to prevent ill health, and maintain their independence at home		

	• find it easier to access the health and care services they need wherever they live and will have more say over the services they receive and greater trust in their quality, effectiveness, and safety; and • receive appropriate and timely care when they need it, from skilled and valued staff.
How will it be achieved:	Our Integrated Care Partnership brings together a wide range of partners – local government, NHS, voluntary and community sector, housing, health watch, universities, and others, to lead the system's activity on population health and wellbeing and drive the strategic direction and plans for integration across Coventry and Warwickshire. Its scope of influence extends beyond the integration of health and care services to encompass opportunities to work together to address the wider determinants of health. We adopted some core principles that underpin how we work together and how we will achieve the aims of the Strategy: **Principles** Championing better health for everyone Providing strategic leadership Prioritising prevention Strengthening and empowering communities Championing integration and coordinating services Sharing responsibility and accountability Engaging, listening, and learning

Name of person completing assessment:	**Anita Wilson**
Position:	**Director of Corporate Affairs, Coventry, and Warwickshire ICB**
Date of Assessment:	**30 November 2022**

Equality Impact Assessment

What is the aim of the Integrated Care Strategy?
This strategy provides an opportunity for us to set out our ambitions for what we can achieve over the next 5 years as an Integrated Care System. It aims to outline, in high level terms, the difference we can make by working in an integrated way, taking advantage of a new legislative framework – and setting the tone and focus for how we will work together. It doesn't seek to replace or duplicate existing strategies and activity underway in the system – instead it seeks to link them together by providing an overarching narrative about where we want to get to, and what it is that we are all trying to change and improve together. The Integrated Care System has an opportunity to improve population health and wellbeing in its broadest sense, with a wide range of partners working together to improve health outcomes and tackle health inequalities, starting with the root causes by addressing the wider determinants of health. And equally importantly, this is about working together at all levels and as locally as possible. We intend that much of the activity to integrate care and improve population health will be driven by organisations working together in our places, and through multi-disciplinary teams working together in our neighbourhoods, adopting new targeted and proactive approaches to service delivery, informed by a shared understanding of the needs of our population.

Who will be affected by this work? e.g., staff, patients, service users, partner organisations etc.
The Impact of the strategy on Coventry and Warwickshire will be far reaching. We expect it to underpin everything we do as an integrated care system and to drive change in: • how, as partners, we relate to each other and to our communities • the way we use our resources • the design and delivery of our services • how we plan and make decisions. Therefore, staff living and working in Coventry and Warwickshire, patients and service users, statutory organisations and the voluntary and community sectors may and will be affected by the Strategy.

Is a full Equality Analysis Required for this project?			
Yes	Proceed to complete this form.	No	Explain why further equality analysis is not required.
If no, explain below why further equality analysis is not required. For example, the decision concerned may not have been made by the ICB or it is very clear that it will not have any impact on patients or staff.			

Equality Analysis Form

1. Evidence used

What evidence have you identified and considered? This can include national research, surveys, reports, NICE guidelines, focus groups, pilot activity evaluations, clinical experts or working groups, JSNA or other equality analyses.

This strategy has been informed in several ways; namely

Existing C&W Strategies and plans

- Coventry Health and Wellbeing Strategy 2019-2023
- Warwickshire Health and Wellbeing Strategy 2021-2026
- Joint Strategic Needs Assessments (JSNAs)
- Health Inequalities Strategic Plan
- NHS Trust Organisational Strategies
- ICB Strategies e.g. Local people and Communities, Green, Tackling health inequalities
- Local Council Strategies/Plans e.g., Children and Young People, Levelling up, One Coventry

National Guidance

- NHS Long Term Plan
- NHS England Guidance documents on the role of the ICP
- NHS England National Healthcare inequalities Improvement Programme
- Local Government Association, Dept. Health, and Social Care guidance on ICP engagement
- Public Health England Strategy 2020-2025

Legal Framework

- Health and Care Act 2022

Engagement Activities: Ensuring effective and widespread community and stakeholder engagement to inform the development of this strategy through an inclusive approach has been a priority from the outset. A specific Engagement Task and Finish Group was established early in the process to ensure that engagement and co-production remained at the forefront throughout and got the specialist attention required. The Task and Finish Group included representatives from Local Authorities, NHS organisations, the voluntary and community sector, Healthwatch, faith groups and housing.

Across September, October, and November we have held over 30 community engagement events and launched an online survey widely promoted across the system. In addition, our Joint Integrated Health, and Wellbeing Forum (C&W HWBB) have come together to engage on the drafts as well as out ICP members.

2. Impact and Evidence:

In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should also include any identified health inequalities which exist in relation to this work.

Age: A person belonging to a particular age (e.g., 32-year-old) or a range of ages (e.g., 18–30-year old's)

Across Coventry and Warwickshire there is difference in life expectancy. Overall people living in Coventry have significantly lower life expectancy than the England Average. The average life expectancy of males in Coventry is 76.1 years and for Females 82 years. In Warwickshire the average for males is 79.7yrs and for females 83.4yrs. (England Avg. 74.9 for males and 83.1 Females)

The priority of the Strategy is to prioritise prevention and improve future health outcomes through tackling inequalities. The Strategy promotes the careful consideration of this protected characteristic from design through to implementation of any service changes and policies. In doing this organisations will ensure there is no negative impact on this protected characteristic and where possible, positive impacts are identified and delivered.

Disability: A person has a disability if he/she has a physical, hearing, visual or mental impairment, which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities

60% of those who died from Covid-19 in the first year of the pandemic were disabled. (The Kings Fund, Towards a new partnership between disabled people and health and care services, July 2022). The health inequalities disabled people face were made worse by the pandemic and as such it is important to ensure disabled people feel and are involved and engaged in planning and designing of health and care services.

As part of the ICP strategy development, several groups were engaged including Warwickshire and Coventry Vision, Grapevine (a charity supporting people with Learning Disabilities) employability groups and various smaller groups of which disabled members make up membership.

They told us that there needs to be a better interface between the NHS and social care especially across borders and access to GP face to face appointments. Transport issues were of concern as well as issues of isolation and not being digitally enabled.

The ICP Strategy supports and promotes the careful consideration of this protected characteristic within all three of the Priorities. From design through to implementation of service changes and policies organisations should ensure there is no negative impact on this protected characteristic and where possible, positive impacts are identified and delivered.

Gender reassignment (including transgender): Where a person has proposed, started, or completed a process to change his or her sex.

Existing evidence from sources such as GP patient Surveys, Healthwatch and the CQC point towards poorer health outcomes and poorer access for trans people. Evidence from the GP patient Survey sees younger trans and non-binary patients (Aged 16-44) more likely to report a long-term condition, disability (including physical mobility) or illness compared with patients of the same age.

As we have developed the ICP Strategy priorities and identified the outcomes and actions for each, we have done so through the lens of our population health model. Protecting the health of people and communities requires culturally competent approaches, which will be underpinned by a deeper understanding and involvement of our communities. The ICS as part of its Local People and Communities Strategy will continue to engage with the trans community who can help identify issues and co-produce solutions

The ICP Strategy supports and promotes the careful consideration of this protected characteristic within all three of the Priorities. From design through to implementation of service changes and policies organisations should ensure there is no negative impact on this protected characteristic and where possible, positive impacts are identified and delivered.

Marriage and civil partnership: A person who is married or in a civil partnership.

The ICP Strategy supports and promotes the careful consideration of this protected characteristic within all three of the Priorities. From design through to implementation of service changes and policies organisations should ensure there is no negative impact on this protected characteristic and where possible, positive impacts are identified and delivered.

Pregnancy and maternity: A woman is protected against discrimination on the grounds of pregnancy and maternity. With regard to employment, the woman is protected during the period of her pregnancy and any statutory maternity leave to which she is entitled. Also, it is unlawful to discriminate against women breastfeeding in a public place.

Coventry and Warwickshire have a local Maternity and Neonatal System (LMNS) that operates to work together across providers of maternity care to deliver high quality and consistent care to women and their families. We know that across C&W 8.3 % of babies are born with a low birth weight as compared to the national average of 6.9% (NMPA 2017), Coventry, Rugby and North Warwickshire have higher than average teenage conceptions, smoking at delivery in North Warwickshire is 13.7% which is higher than the national average of 10.6 % and 1 in 5 women in Coventry and Warwickshire will experience issues relating to mental health.

In addition to significant workforce challenges in terms of recruitment and vacancies across Coventry and Warwickshire we need to ensure our workforce feel valued and supported.

The ICP Strategy supports and promotes the careful consideration of this protected characteristic within Priority 1 - Prioritising prevention and improving future health outcomes through tackling inequalities, specifically with a focus on enabling the best start in life for children and young people. Within Priority 3 – tackling immediate system pressures and improving resilience there is a focus on developing & investing in our workforce, culture, and clinical and professional leadership. From design through to implementation of service changes and policies organisations should ensure there is no negative impact on this protected characteristic and where possible, positive impacts are identified and delivered.

Race: A group of people defined by their race, colour, and nationality (including citizenship) ethnic or national origins.

Coventry and Warwickshire have a multicultural population. 15.6% of the population come from a non-white background with the proportion living in the most deprived areas greater than the proportion for white residents. Research published by the Nuffield Trust and the NHS Race and Health observatory (RHO) has found that people from Asian groups experienced a much larger fall in planned hospital care during the pandemic that people from White, Black, or Mixed ethnic groups, worsening ethnic disparities in care. In addition, the RHO infographic 'Ethnic health inequalities in the UK' has some stark contrasts for which the ICS needs to consider.

The engagement activities the ICP undertook in developing the strategy highlighted that people from a migrant and asylum seeker background felt as though they received discrimination and experienced disparities in the care they received.

Asian and Black African and Caribbean people spoke of a lack of cultural awareness and wanting clinicians and professionals to be trained to support better conversations and face to face appointments to build trust.

The ICP Strategy supports and promotes the careful consideration of this protected characteristic within all three of the Priorities. From design through to implementation of service changes and policies organisations should ensure there is no negative impact on this protected characteristic and where possible, positive impacts are identified and delivered.

Religion or belief: A group of people defined by their religious and philosophical beliefs including lack of belief (e.g., atheism). Generally a belief should affect an individual's life choices or the way in which they live.

In 2020 the Office for National Statistics published ' Religion and Health in England and Wales' with a view to add to the growing evidence base on equalities. A finding was that a prevalence of long-standing

impairment, illness or disability was significantly lower among those who identified as Sikh compared with several other religious groups.

Therefore, protecting the health of people and communities requires culturally competent approaches, which will be underpinned by a deeper understanding and involvement of our communities

The ICP Strategy supports and promotes the careful consideration of this protected characteristic within all three of the Priorities. From design through to implementation of service changes and policies organisations should ensure there is no negative impact on this protected characteristic and where possible, positive impacts are identified and delivered.

Sex: A man or a woman

Women can be disadvantaged in the formal labour market by a combination of employment in low pay, low profile, low progression industries and the impact of caring on time and availability for paid work. Relative poverty rates are also highest for single women with children, although this gap is shrinking. (UK Women's Budget Group)

The ICP Strategy supports and promotes the careful consideration of this protected characteristic within all three of the Priorities. From design through to implementation of service changes and policies organisations should ensure there is no negative impact on this protected characteristic and where possible, positive impacts are identified and delivered.

Sexual orientation: Whether a person feels generally attracted to people of the same gender, people of a different gender, or to more than one gender (whether someone is heterosexual, lesbian, gay or bisexual).

LGBTQIA+ groups that were engaged with told us screening programmes were important as well as having Trust in clinicians. Access to talking therapies and counselling was also a key area of importance.
The evidence that LGBT+ people have disproportionately worse health outcomes and experiences of healthcare is consistent (NHS England).
In 2017 a national LGBT survey was completed with over 108,000 responses at least 16% of survey respondents who accessed or tried to access public health services had a negative experience because of their sexual orientation, and at least 38% had a negative experience because of their gender identity.

Following this the Government Equalities Office brought together a national LGBT+ Action Plan.
The ICP Strategy supports and promotes the careful consideration of this protected characteristic within all three of the Priorities. From design through to implementation of service changes and policies organisations should ensure there is no negative impact on this protected characteristic and where possible, positive impacts are identified and delivered.

Carers: A person who cares, unpaid, for a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support

An ageing population combined with economic austerity means an increasing reliance on family carers to support people with long term health conditions (Al-Janabi, 2016).

Most of the care in the UK is provided by family and friends. Recent polling suggests there could be around 8.8 million adult carers in the UK, up from 6.3 million in 2011 (Carers UK, 2019a), which social services and the NHS rely on to function.

Age
Most Carers are below state pension age, and the peak age for caring is 50-64. The number of Carers over the age of 65 is increasing more rapidly than the general carer population.

Sex
Women are more likely to undertake responsibility for caring, often happening at the peak of their careers, and while raising children (Carers UK, 2019a). There numbers of female carers are higher for young carers (Barnardo's, 2017) and for those providing round the clock care. Carers over 85 are more likely to be male. Female carers were found to experience more negative health impacts than male carers. Male carers are more likely to experience less carer burden, and more work interference (Brenna, 2016).

Race
Carers UK found that Black, Asian, and Minority Ethnic carers were less likely to receive financial and practical support, often through difficulty accessing culturally appropriate information, and a lack of engagement with these communities. The Children's Society found that young carers are 1.5 times more likely to be from BAME communities and hidden from services (Barnardo's 2017).

Disability
A 2019 survey (Carers UK, 2019b) found carers are more likely to report having a long term condition, disability or illness than non-carers. More than half of those who considered themselves to have a disability said their financial circumstances were affecting their health. Carers with disabilities are:

- more likely to give up work to care
- less likely to be in paid work alongside caring
- more likely to be on lower incomes when working
- more likely to be the sole earner in their household
- more likely to be in debt and higher levels of debt.

Local engagement with carers reinforces the importance of acknowledging the important role they play within the health system and the need to priortise the health of the carer.

The ICP Strategy supports and promotes the careful consideration of this protected characteristic within all three of the Priorities. From design through to implementation of service changes and policies organisations should ensure there is no negative impact on this protected characteristic and where possible, positive impacts are identified and delivered.

Other disadvantaged groups:

The Strategy outlines the Systems ambition to achieve the vision of the ICS to *do everything in our power to enable people across Coventry and Warwickshire to pursue happy, healthy lives and put people and communities at the heart of everything we do.*

Any impact and evidence on groups experiencing disadvantage and barriers to access and outcomes including lower socio-economic status, resident status (migrants, asylum seekers), homeless, looked after children, single parent households, victims of domestic abuse for example will be given careful consideration within all three of the Priorities. From design through to implementation of service changes and policies, organisations should ensure there is no negative impact on this protected characteristic and where possible, positive impacts are identified and delivered.

3. Human Rights

FREDA Principles / Human Rights	Question	Response

Fairness – Fair and equal access to services	How will this respect a person's entitlement to access this service?	The specific purpose of the Strategy is to achieve fair access to all services for all protected groups. Enhanced access may be needed for some groups to reduce inequity and achieve fairness.
Respect – right to have private and family life respected	How will the person's right to respect for private and family life, confidentiality and consent be upheld?	The personalised care model is core to our strategy and will help to ensure that health and care is shaped around "what matters to me". Through our digital and PHM enabler we will ensure robust information governance and data protection controls in place for the sharing of personal data.
Equality – right not to be discriminated against based on your protected characteristics	How will this process ensure that people are not discriminated against and have their needs met and identified?	The careful consideration of protected characteristics in the creation and implementation of services helps mitigate those observable perverse outcomes for those with protected characteristics, while being mindful that it does not account for those which arise through unconscious bias. We know there is more to do as a system to address institutional and structural inequalities that are the most damaging aspects of inequity. Health inequalities, specifically, is a core area of focus in our strategy.
Dignity – the right not to be treated in a degrading way	How will you ensure that individuals are not being treated in an inhuman or degrading way?	The personalised care model is core to our strategy and will help to ensure that health and care is shaped around "what matters to me". Our strategy also identifies 'quality' as a strategic enabler, which helps ensure that individuals receiving care are safe and treated with dignity.
Autonomy – right to respect for private & family life; being able to make informed decisions and choices	How will individuals have the opportunity to be involved in discussions and decisions about their own healthcare?	The personalised care model is core to our strategy and will help to ensure that health and care is shaped around "what matters to me".

Right to **Life**	Will or could it affect someone's right to life? How?	Through our integrated approach to delivering care outlined in the strategy and our accompanying Quality strategy we will ensure that we take positive steps to safeguard life and carrying out an effective investigation into the death of any adult at risk, identifying and addressing any bias, conscious or unconscious which may have affected decision making. The need to create a culture of continuous quality improvement, where safeguarding and improving care is everyone's responsibility, reducing health inequalities is further outlined in our Quality Strategy and this Integrated Care Strategy will help create the conditions under which this can be delivered across the whole system.
Right to **Liberty**	Will or could someone be deprived of their liberty? How?	Our actions in delivering this strategy will strive to identify and eliminate discriminatory biases against disabled people (including older people with disabilities such as dementia or cognitive conditions), in line with the Mental Capacity Act 2005 deprivation of liberty safeguards (DoLS), and with the new framework of Liberty Protection Safeguards (LPS) due to come into force in 2023. In implementing our system-wide approach to promoting mental wellbeing and resilience, we expect to see people who have experienced problems with their mental health empowered to take greater control over their own care, ensuring they are helped to manage their own conditions more effectively.

4. Engagement, Involvement and Consultation		
If relevant, please state what engagement activity has been undertaken and the date and with which protected groups:		
Engagement Activity	**Protected Characteristic/**	**Date**

	Group/ Community	
Please See Separate Engagement Report		
For each engagement activity, please state the key feedback and how this will shape policy / service decisions (E.g., patient told us …. So we will …..):		
See Engagement Report		

5. Mitigations and Changes
Please give an outline of what you are going to do, based on the gaps, challenges and opportunities you have identified in the summary of analysis section. This might include action(s) to mitigate against any actual or potential adverse impacts, reduce health inequalities, or promote social value. Identify the **recommendations** and any **changes** to the proposal arising from the equality analysis.
The Strategy outlines the Systems ambition to achieve the vision of the ICS to *do everything in our power to enable people across Coventry and Warwickshire to pursue happy, healthy lives and put people and communities at the heart of everything we do.* Coventry and Warwickshire Integrated Care System recognises that action on health inequalities requires improving the lives of those with the worst health outcomes, fastest. The West Midlands InequalitiesnAL toolkit, and in particular the Health Equity Assessment Tool (HEAT) empowers professionals to identify practical action in work programmes. Its 'subscription' across Coventry and Warwickshire will help colleagues to mitigate any negative impacts in collaboration with other system partners. Recommendation is for the ICB to use this EQIA and apply HEAT in developing its 5-year Integrated Care Plan with reference to the engagement feedback around the key themes that were: Access to Primary Care Services, digital inclusion and building trust and confidence in our services.

6. How will you measure how the proposal impacts health inequalities?
e.g., Patients with a learning disability were accessing cancer screening in substantially lower numbers than other patients. By revising the pathway, the ICB can show increased take up from this group, this is a positive impact on health inequalities. You can also detail how and when the service will be monitored and what key equality performance indicators or reporting requirements will be included within the contract.
The Strategy does not relate to the specific implementation of services, and it is therefore not possible to identify specific measures.

7. Is further work required to complete this assessment?
Please state what work is required and to what section. e.g., additional consultation or engagement is required to fully understand the impact on a particular protected group (e.g.,

disability).			
Work needed	**Section**	**When**	**Dare completed**
Further engagement with groups will continue as the 5yr Integrated Care Plan is developed	All sections	Jan- March 2023	July 2023

8. Sign off		
The Equality Analysis will need to go through a process of **quality assurance** by a Senior Manager within the department responsible for the service concerned before being submitted to the Policy, Procedure and Strategy Assurance Group for approval. Committee approval of the policy / project can only be sought once approval has been received from the Policy, Procedure and Strategy Assurance Group.		
Requirement	**Name**	**Date**
Senior Manager Signoff	Liz Gaulton, Chief Officer Health Inequalities and Population Health	30 November 2022
Which committee will be considering the findings and signing off the EA?	Integrated Care Partnership	8 December 2022

Coventry City Council

Briefing note

To: **Coventry Health and Wellbeing Board** **Date: 23 January 2023**

Subject: Coventry and Warwickshire Integrated Health and Wellbeing Forum

1 Purpose

1.1 The first meeting of the new Coventry and Warwickshire Integrated Health and Wellbeing Forum took place on 13 October 2022. This paper updates the Board on the outcomes of that meeting.

1.2 A key focus of the meeting was to inform the development of the Integrated Care Strategy and ensure that this was shaped by leaders from across the wider system, with an emphasis on population health, inequalities and prevention.

2 Recommendations

2.1 Members are requested to **NOTE FOR INFORMATION** the outcomes of the first meeting of the Integrated Health and Wellbeing Forum.

3 Background

3.1 On 3 October 2022 the Board endorsed the establishment of Coventry and Warwickshire Integrated Health and Wellbeing Forum, with the two Health and Wellbeing Boards and the Integrated Care Partnership as core members.

3.2 The purpose of the Forum is to play an advisory role for the ICS and to reflect a breadth of views informed by working with local communities from across Coventry and Warwickshire. It is intended that the Forum will meet 2-3 times per year.

4 Integrated Health and Wellbeing Forum meeting, 13 October 2022

4.1 The first meeting of the Integrated Health and Wellbeing Forum was held in Coventry on 13 October, with around 30 members attending.

4.2 The aims of this session were to:

- Reconnect as an integrated forum face to face
- Update on recent changes to the system and reflect on the role of the Forum in relation to this current context
- Take an active role in engaging in the development of the C&W Integrated Care Strategy and contribute to identifying what is most critical
- Identify a shared ambition for the ICS and the opportunities this presents, building on the success of partnership working to date.

4.3 The meeting was supported by independent facilitators from NHS Elect – Chief Executive, Caroline Dove and Associate, Jan Samuel. This external facilitation helped to ensure the meeting provided a genuine opportunity for engagement of and between system leaders.

5 Outcomes and next steps

5.1 The meeting reflected on the opportunities and benefits of the statutory Integrated Care System, building on the legacy and ambitions of the former Coventry and Warwickshire

Joint Place Forum around improving population health outcomes, tackling inequalities, and embracing the wider determinants of health. It was noted that the core principles of the ICP are based on the joint health and wellbeing concordat agreed by Place Forum partners.

5.2 Group discussions focused on development of the Integrated Care Strategy, and on how partners could contribute to and collectively hold each other to account for its delivery and impact. Members were invited to provide feedback on the draft priorities and enablers – whether they were the right ones, what is most critical for our system now, and how partner organisations might contribute to delivering the strategy.

5.3 Key messages from the meeting include:

- There needs to be a collective commitment to investment in preventative approaches, irrespective of immediate pressures, and an agreement and clarity about what we mean by this (eg. primary prevention, secondary prevention, early intervention etc).
- Agreement that tackling health inequalities is a key driver that runs through everything we do, and something that all partners can commit to.
- The need to identify specific, practical actions that partners can coalesce around, and the importance of using data and evidence to inform priorities and spending decisions and to evaluate the impact of collective action.
- The significance of culture, relationships and trust, and the importance of the ICP principles as the basis for this – especially in face of uncomfortable and challenging decisions.
- People and communities should be at the heart of everything we do and core to how we hold ourselves to account collectively. We should measure our success in terms of impact on communities and use personal stories to engage partners in understanding the impact of collective action.
- There are some particularly burning issues that partners need to focus on together, which include
    - the health and care workforce (including the informal workforce);
    - the wider determinants of health (impacting 80% of people's health and wellbeing); and
    - the role of social care in supporting system resilience and enabling people to live independently at home.

5.4 The Forum noted the next steps in the development of the Integrated Care Strategy, including approval of the final draft Strategy by the Integrated Care Partnership in December, and the opportunity for Health and Wellbeing Boards to align the Health and Wellbeing Strategy development process with Integrated Care Strategy and 5-Year Integrated Care Plan development and engagement at their meetings in January 2023.

5.5 Members commented on the value of meeting together in this format and suggested that more frequent meetings might be considered. The Forum will next meet in person on 2 March 2023 in Warwick.

6 Conclusion

6.1 The successful first meeting of Coventry and Warwickshire Integrated Health and Wellbeing Forum demonstrated its value as a mechanism for continued collaboration that recognises, embraces and enhances the role and contribution of all partners and provides system leadership around the wider health and wellbeing agenda.

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Coventry City Council

Report

To: Coventry Health and Wellbeing Board **Date: 23.01.2023**

From: Jane Fowles, Consultant in Public Health

Title: Suicide Prevention Strategy

1 Purpose

To notify the board of the development of the Coventry and Warwickshire Suicide Prevention Strategy 2023 - 2030. The purpose of the strategy is to ensure that no one in Coventry and Warwickshire ever feels that suicide is their only option. This strategy has been drafted based on Coventry and Warwickshire Mental Health Joint Strategic Needs Assessment (JSNA) recommendations as well as reflecting feedback from engagement sessions.

Coventry City Council and Warwickshire County Council have previously had separate Suicide Prevention Strategy's. The approach was taken to align this strategy to the Mental Health JSNA, creating a system Coventry and Warwickshire system wide strategy.

The strategy will be presented to both Coventry and Warwickshire Health and Wellbeing Boards for endorsement in January 2023.

2 Recommendations

- To endorse the content of the Coventry and Warwickshire Suicide Prevention Strategy 2023 – 2030
- To request that Board members consider their organisational contributions to suicide prevention and identify any governance routes for approving and sharing the Strategy
- To support the delivery of the strategic ambitions and local priorities as set out in strategy and delivery plan through collaboration with the Coventry and Warwickshire Suicide Prevention Partnership
- To request a formal presentation of the Strategy and Delivery Plan at the Coventry and Warwickshire Integrated Health and Wellbeing Forum at its meeting in March 2023. To consider the proposed PNA and provide comments where necessary during the formal consultation period

3 Information/Background

3.1 Following completion of the NHS England (NHSE) funded national suicide prevention programme in Coventry and Warwickshire (2018 – 2021) work has been underway to develop a new partnership work programme that sets out a vision for suicide prevention in Coventry and Warwickshire until 2030.

3.2 Early engagement on this process identified that the new work programme should build on the work developed through the NHSE funded programme and bring together the previously separate (and now out of date) suicide prevention strategies for Coventry and Warwickshire into a single system-wide strategy and approach.

3.3 A significant amount of engagement has been undertaken to test the draft vision, strategic ambitions and local priorities and help shape the content of the strategy.

3.4 In addition, there has been a refresh of the existing partnership arrangements for delivering the suicide prevention work programme and a review of the governance structures that are needed to embed suicide prevention at an organisational and system level.

3.5 As a system-wide strategy, the delivery of the associated work programme will be undertaken as part of the Coventry and Warwickshire Integrated Care System, with partners involved in developing, implementing, and where appropriate resourcing the actions that will help achieve the vision, ambitions and priorities of the strategy.

3.6 The new Strategy promotes taking a zero-suicide approach, with the overall aim **to reduce the rate of suicide across Coventry and Warwickshire**.

3.7 A new and evolving Suicide Prevention Delivery Plan will set out the actions and activity required to achieve the strategy's ambitions. This will also aim to:

- Show activity required or delivered at a system, place and local level
- Outline delivery mechanisms across the whole system
- Demonstrate alignment and association to related activity or programmes of work
- Show lines of accountability and responsible delivery partners.

3.8 Both the Health and Wellbeing Boards in Coventry and Warwickshire will monitor the Suicide Prevention Delivery Plan, with progress and impact reported on an annual basis.

3.9 Highlight reports will also be presented to other appropriate local strategic boards to ensure the suicide prevention programme is reflected in and aligned to other work stream areas. This includes the Boards overseeing Safeguarding, Community Safety, Wider Determinants (eg. Housing, Education, Financial Inclusion), Equalities (eg. Armed Forces) and the Place Partnerships.

3.10 The Strategy and ongoing delivery of the work programme is led and overseen by the Coventry City Council and Warwickshire County Council Public Health Teams on behalf of the Coventry and Warwickshire Suicide Prevention Partnership.

3.11 The Coventry and Warwickshire Suicide Prevention Partnership is the multi-agency mechanism for working together towards the vision that no-one in Coventry and Warwickshire ever feels that suicide is their only option.

3.12 The Partnership is made up of organisations, groups, communities and individuals from across Coventry and Warwickshire, who collectively deliver three distinct functions, each with their own area of responsibility:

- **Network:** enables joint working, information sharing and networking amongst all members to contribute to the vision and ambitions of the Coventry and Warwickshire Suicide Prevention Strategy

- **Steering Group:** provides leadership, expertise and accountability for the wider partnership

- **Learning Panel:** considers the local data on deaths by suicide and suspected suicide as captured through the real time surveillance system to identify learning points to inform local suicide prevention activity. Monthly insight meetings are also scheduled in response to specific groups, patterns, or trends of deaths by suicide.

3.13 The Partnership aims to take a holistic approach to suicide prevention, starting with the individual and building to an environment that supports a suicide aware society.

3.14 There are ongoing conversations regarding the links between suicide and related risk factors, including substance misuse, domestic abuse and self-harm. Further work is planned to identify specific actions that could be explored in relation to this. The Strategy itself also identifies these links and the need for a collective response.

3.15 The final draft of the Coventry and Warwickshire Suicide Prevention Strategy and outline Delivery Plan is being presented to both the local Health and Wellbeing Boards in Coventry and Warwickshire for endorsement as the bodies responsible for encouraging integrated working such as the development of a system-wide partnership strategy for suicide prevention.

3.16 The new Coventry and Warwickshire Suicide Prevention Strategy will contribute directly to the delivery of the Coventry Health and Wellbeing Strategy, both in terms of its long-term ambitions and short-term priority areas.

4 Financial implications

4.1 There are no capital implications related to the delivery of the Coventry and Warwickshire Suicide Prevention Strategy.

4.2 Warwickshire County Council has committed dedicated resource to the development and implementation of suicide prevention activity across Coventry and Warwickshire. This includes the permanent employment of a Suicide Prevention Manager based in Warwickshire County Council's Public Health Team.

4.3 A small project budget was also initially made available (by Warwickshire County Council) for the first 2 years to support the implementation and embedding of the new Suicide Prevention Strategy. This includes a dedicated allocation for suicide prevention activity across Coventry and Warwickshire for 2023-24.

4.4 There will be further resource implications across all partners to support ongoing suicide prevention activity where this cannot be absorbed into existing budgets or as part of ongoing activity. For example:

- Suicide awareness and prevention training
- Awareness campaigns and resources
- Service redesign or transformation
- Sustainability of Real Time Surveillance system
- Exploration of a local Suicide Review process

4.5 There are also opportunities to explore alternative funding streams to meet some of these costs, including: social value commitments, joint prevention programmes (particularly around risk or causal factors) and external or national funding programme.

5 Timescales associated with the decision and next steps

5.1 Once endorsed by the Health and Wellbeing Boards, a final designed version of the Strategy will be presented to the Coventry and Warwickshire Integrated Health and Wellbeing Forum for information.

5.2 This will include a request to partners to consider their organisational contributions to suicide prevention and identify any governance routes for approving and sharing the Strategy.

5.3 It is proposed that the Coventry and Warwickshire Suicide Prevention Partnership hosts a multi-agency Suicide Prevention Conference in spring 2023. This will help shape the delivery plan and gain partnership support for the ongoing delivery and embedding of suicide prevention activity across Coventry and Warwickshire.

5.4 The Suicide Prevention Delivery Plan will be reviewed and refreshed every two years to reflect local circumstances and changes within the national guidance.

5.5 There are ongoing discussions to ensure that the Strategy is presented and available in a variety of formats to ensure it is accessible to the widest audience.

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Directorate: Public Health

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Enquiries should be directed to the above person.

Coventry and Warwickshire
Suicide Prevention Strategy 2023 – 2030

…the world is better with you in it.

No-one in Coventry and Warwickshire should ever feel like suicide is their only option.

Contents

Foreword

To be added:

- signed by portfolio holders for C&W (or H&WB Board chairs)

Coventry Health and Wellbeing Board
Coventry
Cllr Kamran Caan, Public Health and Sport
Cllr Patricia Seaman, Children and Young People

Warwickshire Health and Wellbeing Board
Warwickshire
Cllr Margaret Bell, Adult Social Care and Health
Cllr Jeff Morgan, Children, Families and Education

Introduction

"I lived with a fun guy at university, he was always laughing and messing about and was from a rich family. A year after we left university I found out he died by suicide."

Why is a suicide prevention strategy important?

Every life lost to suicide is a life lost too soon.

Deaths by suicide have complex causes and are rarely due to a single event, but a culmination of factors that may lead to someone feeling hopeless and unable to change their circumstances, with death seen as the only way to end suffering. We are all potentially susceptible to suicidal thoughts, but in the past stigma around mental ill-health and suicide has contributed to a lack of discussion at a societal level and, importantly, preventing people from speaking up and seeking support when it is most needed. It is therefore imperative to normalise talking about mental health and to give individuals the knowledge, skills and confidence to talk about suicide and improve awareness of preventative approaches and support available.

A single death by suicide has a devastating impact on those closest to the individual, as well as wider reaching impacts on members of the community who are affected by the distressing news of such a death of someone they knew. It has been estimated that 15-30 people are directly and severely impacted by a single death by suicide, and around 135 people affected by each death[1]. This broad impact on communities from a single death highlights the need for a shared health approach to preventing and responding to deaths by suicide.

Finally, deaths by suicide contribute to population level life-expectancy figures, given deaths at younger age-groups have a greater impact on this population level indicator of health outcomes, a strategic driver to prioritising suicide prevention activity.

A new national plan for suicide prevention

As part of the development of a new national plan for suicide prevention, Coventry and Warwickshire submitted a joint response to the Government's Call for Evidence to inform longer-term priorities for mental health, wellbeing and suicide prevention. The Call for Evidence closed in July 2022 and a new long-term plan will set out priorities for suicide prevention at a national level. Coventry and Warwickshire are committed to supporting with the delivery of the new national strategy and will align to the national priorities within the local delivery plan, at the same time recognising that there are local needs across the area.

[1] Cerel et. al. 2019 How many people are exposed to suicide? Not Six. Suicide and Life-threatening Behaviour, 49(2), 529-534

A strategy for Coventry and Warwickshire

The Health and Wellbeing Strategies for both Coventry and Warwickshire identify priorities around improving mental health and wellbeing. The Coventry and Warwickshire Suicide Prevention Strategy 2023-2030 is part of the delivery of these priorities. Whilst Coventry and Warwickshire have previously had separate suicide prevention strategies to set out the vision and approach in both areas, the success of the NHSE funded programme and the outcomes of the Mental Health JSNA have demonstrated the need for partnership working when developing a local approach to suicide prevention. This new single Strategy will build on the previous work and ensure that suicide prevention activity is embedded and prioritised across the system. This approach requires ongoing collaboration through the Suicide Prevention Partnership with system wide commitment to the resources and implementation required for the ongoing delivery of a local suicide prevention work programme. There will be elements of the work programme that will be coproduced to utilise key experience, knowledge and skills from a range of stakeholders, including those with lived experience.

The Coventry and Warwickshire Suicide Prevention Strategy is an all-age strategy and is intended to be relevant across the whole life course of an individual or population. The Strategy also represents the principle that preventing suicide is everyone's business.

Long term strategy: (2023-2030)	Coventry and Warwickshire take a zero-suicide approach, with the aim **to reduce the rate of suicide across the local area**. Vision: **to ensure that no one in Coventry and Warwickshire ever feels that suicide is their only option.** Strategic ambitions: **1) People have access to the information, support and services they need** **2) People are confident to talk about suicide**
Early phase delivery: (2023-2025)	Local priorities for 2023-2025: • **target our approach for those groups and communities at a higher risk of suicide** • **increase awareness to help change public attitudes about suicide** • **promote suicide prevention as a priority within the wider health and wellbeing activity of system partners (public, private, VCSE sectors)** • **sharing learning and data to ensure that prevention activity is targeted in response to locally identified priorities**

	• **facilitate coproduction, collaboration and coordination to maximise the impact of suicide prevention activity across Coventry and Warwickshire**

The national and local picture: what the data tells us

Suicide: what we know

- on an average day in the UK, someone dies by suicide every 90 minutes (Samaritans).
- A death by suicide impacts approximately 135 people
- 74% of deaths by suicide are male (Office for National Statistics, ONS 2018)
- Suicide is the biggest killer of under 35s in the UK (ONS 2018)
- Around a third of people who die by suicide have had no contact with mental health or primary care services before their death (*A third of people who die through suicide have been in contact with mental health services before their death, a further third have been in contact with primary care services but the remaining third have had no contact with services. Young men are the most likely to be among the third with no contact with services before their death).*

National guidance identifies a number of factors that can influence the risk of suicide.

Specific factors that increase the risk of suicide:

- Strongest identified predictor of suicide is previous episodes of self-harm
- Mental ill health and substance misuse also contribute to many suicides
- Individuals bereaved by suicide are at increased risk of suicide (also increased risk of suicidal ideation, depression, psychiatric admissions as well as poor social functioning).

One of the priorities within the current Suicide Prevention Strategy for England, is for all local strategies to deliver work to reduce the risk of suicide among the following high-risk groups:

- Men
- People who self-harm
- People who misuse alcohol and drugs
- People in the care of mental health services
- People in contact with the criminal justice systems
- Specific occupational groups (eg. doctors, nurses, veterinary workers, farmers and agricultural workers).

These groups are identified as those where the suicide rate is high and there is a known statistically significant increased risk of death by suicide.

Men remain the highest risk group with a range of factors associated with suicide that are particularly common in males, including: depression (especially untreated or undiagnosed), alcohol and drug misuse, unemployment, family and relationship problems, social isolation and low self-esteem.

Additional vulnerable groups include

- People in financial difficulty or struggling with debt
- Autistic people
- People addicted to gambling
- Women experiencing poor perinatal mental health
- LGBTQ+ individuals

People in the lowest socio-economic group and living in the most deprived geographical areas are 10 times more at risk of suicide than those in the highest socio-economic group living in the most affluent areas.

Local data: trends in suicide rates

The following graphs illustrate the trends in suicide figures in Coventry and Warwickshire over the last 20 years.

Source: Public health profiles - OHID (phe.org.uk)

Coventry and Warwickshire suicide rates compared to England, 2001-2021

Time period	Coventry	Warwickshire	England
2019-21	9.3	11.2	10.4
2018-20	10.0	9.2	10.4
2017-19	10.6	9.4	10.1
2016-18	8.6	10.1	9.6
2015-17	8.8	11.3	9.6
2014-16	8.4	12.2	9.9
2013-15	10.1	11.8	10.1
2012-14	10.1	11.6	10.0
2011-13	11.2	10.4	9.8

2010-12	11.4	10.8	9.5
2009-11	13.0	9.7	9.5
2008-10	12.3	10.0	9.4
2007-09	11.7	8.9	9.3
2006-08	10.2	8.7	9.2
2005-07	11.0	6.8	9.4
2004-06	11.9	7.7	9.8
2003-05	11.0	7.9	10.1
2002-04	9.0	9.2	10.2
2001-03	9.1	10.2	10.3

Source: Suicide prevention profiles, OHID, fingertips, 2022

Significantly worse than the England figure

Significantly better than the England figure

Local data: the current picture

Between January 2021 and September 2022, 111 deaths were concluded as a death by suicide by the Coventry and Warwickshire Coroner. An analysis of these deaths in October 2022 provided the following findings*

*(these figures do not reflect total number of suspected suicides during this period as not all deaths have been heard at inquest).

Demographics of the 111 Coventry and Warwickshire deaths by suicide 2021-2022

Figures contained in infographics relating to real time suicide data from the Coventry and Warwickshire coroner have been subject to disclosure control methodology to avoid the identification of individuals (see Appendix 1). Numbers are rounded to the nearest 5, those between 1 to 7 inclusive are marked *. Numbers may not, therefore, sum to total deaths.

Gender

Male 85

Female 25

Age

13 – 25	10
26 – 45	40
45 – 64	40
65+	25

Marital status

Single	55
Married	30
Divorced	20
Widowed	*

Employment status

Employed	65
Retired	20
Student/employed	10
Self-employed	*
Unemployed	15

Incident location *(may differ to where individual died)

Type of location	Number of deaths
Home	75
Park	*
Railway	*
Woodland	*
Road	*
Other (eg. hotel, place of employment, hospital)	10

Method of death

Hanging	65
Asphyxiation	10
Overdose	10
Railway	*
Fire	*
Self-poisoning	*
Drowning	*
Jump from a height	*
Self-inflicted wound	*
Other (including gunshot wounds and unascertainable methods of death)	*

- Presentation of above – group by place
    - Group 1
        - Hanging
    - Group 2 – Location Specific
        - Railway
        - Drowning
        - Jump from a height

    Group 3

    - Asphyxiation
    - Overdose
    - Fire
    - Self-poisoning
    - Self-inflicted wound
    - Other (including gunshot wounds and unascertainable methods of death)

Due to the geography of Warwickshire, with 5 district/borough areas, the following map illustrates the usual place of residence of the 66 Warwickshire residents.

District/ borough of usual place of residence

DISTRICT OR BOROUGH	NUMBER OF INDIVIDUALS
COVENTRY	35
NORTH WARWICKSHIRE	*
NUNEATON AND BEDWORTH	20
RUGBY	10
STRATFORD	15
WARWICK	20
OUT OF AREA	10

Risk factors evident*

Known risk factors for death by suicide include:

- A previous attempt/a history of self-harm, particularly if the method used was an overdose.
- A diagnosis of depression or anxiety with the strongest risk being attached to people with both depression and anxiety
- Individuals who use illicit substances (drug use is typically around 27% of the population according to real-time surveillance (RTS) data, compared to 8% of the general population according to OHID estimates).
- Chronic pain or long-term conditions
- Relationship breakdown: not just romantic relationships but any relationship breakdown
- Individuals with a history of domestic abuse, whether as a victim, perpetrator, or witness are at increased risk of death by suicide.
- Bereavement
- Financial hardship

*The data here is taken from coronial records so is limited to available data. It is unlikely that the risk factors outlined above are the true extent of risk factors experienced for individuals who die by suicide.

Deprivation

Reflecting on the current national economic climate and the links identified between suicide and financial circumstances the following maps illustrate the relative levels of deprivation across Coventry and Warwickshire using the Index of Multiple Deprivation. This allows users to identify the most and least deprived areas in England and to compare whether one area is more deprived than another. An area has a higher deprivation score than another if there is a higher proportion of people living there who are classed as deprived. However, it is important to note that a geographical area itself is not deprived: it is the circumstances and lifestyles of the people living there that affect its deprivation score. Not everyone living in a deprived area is deprived, and that not all people experiencing deprivation live in deprived areas. The following maps show the areas in Coventry and Warwickshire (by Lower Super Output Areas) ranked from the most to the least deprived. In Coventry, the data shows particular areas of deprivation from the city centre into the North East of the city, as well as in the South East and pockets in the South West. In Warwickshire, there are particular areas of deprivation around North Warwickshire, Nuneaton and Bedworth, and Rugby.

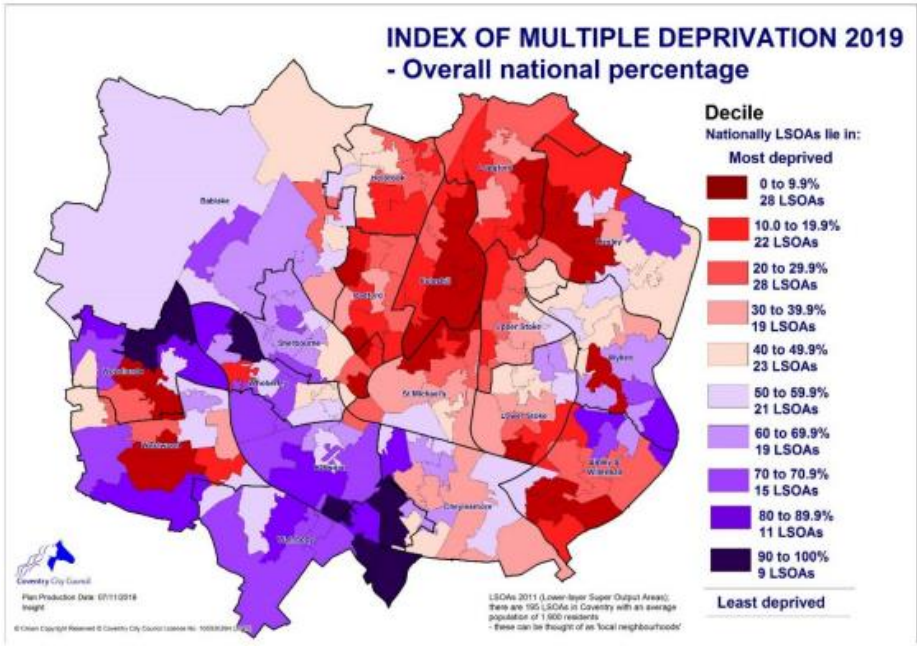


Figure: Coventry LSOAs by deprivation decile
Source: Index of Multiple Deprivation 2019

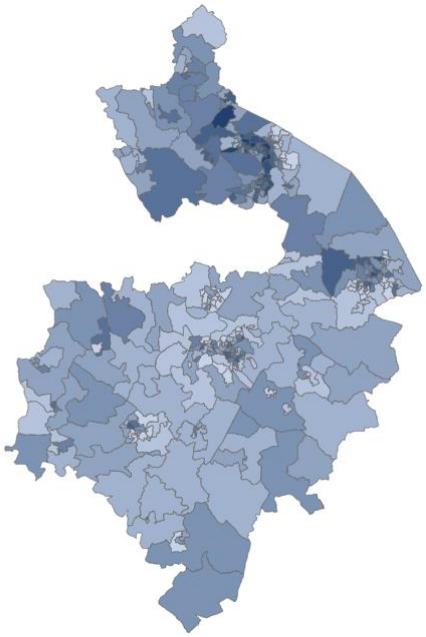


Figure: Warwickshire LSOAs by deprivation decile
Source: Index of Multiple Deprivation 2019

Our approach: starting with strengths

"My boyfriend's dad died by suicide, we were 16 years old at the time. He didn't know anything was wrong with his dad."

Where are now (and how did we get here)

In 2018 the Coventry and Warwickshire system partnership received funding through the NHS England National Suicide Prevention Programme. As an area with higher than average suicide rates at the time, Coventry and Warwickshire was one of the first areas to receive this additional funding to develop suicide prevention and reduction schemes. The programme ran from 2018-2021 and resulted in a partnership action plan which was delivered across the duration of the programme and has provided much of the suicide prevention infrastructure still in place today.

In 2021, a Coventry and Warwickshire Joint Strategic Needs Assessment (JSNA) focussing on Adult Mental Health and Wellbeing was also undertaken. As a result of this, a series of recommendations were made in relation to suicide prevention activity across Coventry and Warwickshire and these have provided the basis for this new strategy.

In 2023, a Warwickshire Mental Health and Wellbeing of Infants, Children and Young People JSNA will be published. This will also help inform future actions relevant to suicide prevention specifically in relation to Coventry and Warwickshire's younger population.

Continuing the legacy

In order to achieve the long-term ambitions for suicide prevention, this strategy aims to develop the infrastructure that has already been established.

Some of the key successes to date across Coventry and Warwickshire are outlined below. We will continue to develop and build on these as part of our ongoing work programme.

- **Dear Life website**
  Dear Life is the local online suicide prevention platform for Coventry and Warwickshire. Initially developed as part of the NHSE funded suicide prevention programme, it was co-produced by local stakeholders including both service providers and people with lived experience. The site offers advice, information and support to those individuals experiencing suicidal crisis or ideation as well as the people who are supporting them. The site is now hosted by Coventry and Warwickshire Partnership Trust and continues to be developed as a key part of the Coventry and Warwickshire suicide prevention work programme.

- **Training the frontline**
  Ensuring that people working on the frontline – whether in paid roles in the public sector, emergency services, voluntary and community sector, or as volunteers supporting groups or individuals – are equipped to support people at risk of suicide or expressing suicide ideation remains a key priority. Two separate Suicide Prevention Gatekeeper Training programmes have been delivered, offering free targeted training for frontline workers. As well as increasing general awareness and providing the necessary knowledge and tools, the aim of the training has been to create a network of suicide prevention gatekeepers who can share their learning and good practice within their workplaces (and beyond). This "community of practice" will help build resilience within the workforce and wider community. There has also been promotion of other suicide awareness and prevention training aimed at whole workforce groups as well as the general population. This includes national on-line training packages, funded suicide prevention sessions and local awareness campaigns.

- **Effective partnership working**
  The commitment to develop and deliver a suicide prevention work programme is demonstrated by the Coventry and Warwickshire Suicide Prevention Partnership. This provides the multi-agency mechanism for working together, contributing to the vision and ambitions of the Coventry and Warwickshire Suicide Prevention Strategy. The Multi Agency Network enables joint working, information sharing and networking. The Learning Panel ensures partners have access to real time information about emerging trends and can develop collective responses when needed. The Steering Group provides leadership, expertise and accountability for the wider partnership. There are also a number of other related strategies, programmes of work and services that complement the suicide prevention agenda and it is recognised that this Strategy is not being delivered in isolation from the wider health, social care and community safety system.

- **Targeting high risk groups**
  Men, children and young people, people who self-harm and those bereaved by suicide remain a key focus for suicide prevention activity both nationally and locally. Evidence also shows that some population groups are at higher risk of dying by suicide, in particular those people who are from groups who may feel marginalised or struggle to access the support they need. This can include individuals, specific population groups or specific job roles and professions. Targeted interventions and addressing inequalities with these groups as early as possible are key to preventing escalation to crisis. Activity undertaken to date, includes: mobilisation of the local suicide bereavement support service, Amparo; and development of a new and targeted Self Harm Policy for educational settings across Coventry and Warwickshire. A proposal to ensure that the voice of people with lived experience is embedded in the development of the Coventry and Warwickshire Suicide Prevention Delivery Plan is also in progress.

- **Prevention and tackling risk factors**
  A recognition of the underlying causes that can lead to suicidal crisis is fundamental to preventing people finding themselves in a situation that they can see no way out of. Working together with partners and providers who tackle known suicide risk factors remains a priority. This includes identifying opportunities to align prevention activity across different workstreams, including: domestic abuse, serious violence, drugs and alcohol, armed forces community, and gambling and financial inclusion.

- **Service provision**
  There are a number of services that have been commissioned or that are being delivered that contribute to the overall aim and ambitions of this Strategy. In particular, those that focus on early help and prevention have a significant role to play in preventing the escalation of individuals to reaching crisis point. As part of the wider system these services will contribute to the overall aim of reducing the rate of suicide across Coventry and Warwickshire.

- **Response to external societal factors**
  The covid pandemic, health and social inequalities, deprivation, financial vulnerability and economic uncertainty can all impact on the mental health and wellbeing of communities. Although unpredictable and often difficult to quantify, anecdotally there is a suspected link between these factors and increased suicide ideation, self-harm, poorer mental health, and negative lifestyle behaviours. In addition, such factors can also lead to isolation, bereavement, financial hardship and trauma – all of which are known suicide risk factors. In some instances, there may be a delay in realising the impact on suicide rates as a result of these circumstances, making access to real time suspected suicide data even more important. The ability to respond to these issues as they arise remains a key part of the local approach to suicide prevention.

Real Time Surveillance

Critical for the successful delivery of the Suicide Prevention Strategy is the continued development of the Coventry and Warwickshire Real Time Surveillance System. Initially developed as part of the NHSE funded programme, the current system continues to evolve with 3 distinct functions to ensure the availability, analysis and response to real time suspected suicide data.

1. <u>Coordination</u>

To provide oversight and analysis of local suspected suicide data, Coventry and Warwickshire have appointed a Real Time Surveillance Co-ordinator. This is a coroner-led function across both Coventry and Warwickshire and has been in place since January 2021. This enables early identification of suspected suicides in advance of the Coroner's conclusion at inquest. The real time

surveillance data ensures timely data collection and analysis which is shared initially with Public Health teams in Coventry and Warwickshire, and then more widely with relevant partners. This allows the system to identify any emerging trends or patterns in the data and respond accordingly, which is key to ensure the most effective intervention.

Learning Panels are held on a quarterly basis to share the data captured with colleagues working as part of the suicide prevention programme. The Panels provide the opportunity to share learning and facilitate discussion around prevention work in response to local trends. In addition, monthly insight meetings are scheduled to enable more focussed discussion around emerging trends or to consider the need for review and discussion of deaths which may require further action due to the increased risk of cluster or contagion.

The coordination role is key to the ongoing development of the response and review process for suspected suicides, providing the data and analysis required to ensure that the learning from both suspected and confirmed suicides is available to help prevent further deaths by suicide.

2. Data Management

To help manage the data collection and analysis process, a data management system is used by the Co-ordinator. This assists with the effective analysis of the data and facilitates the opportunity for multi-agency collaboration for the sharing of data, intelligence and learning.

The current system enables real time collection of suspected suicides. Future ambitions include aligning the real time collection of other related data, including drug related other preventable deaths. Longer term aspirations include capturing data on suicide ideation, suicide attempts and incidents of self-harm.

3. Suicide Bereavement Support

In September 2021 Listening Ear was jointly commissioned to deliver the Amparo postvention service across Coventry and Warwickshire. Postvention refers to specialist support for people bereaved by suicide (family, friends, professionals and peers) and reflects the NHS Long Term Plan commitment. This all-age service provides postvention bereavement support is currently funded until September 2024 and is available to those who have been impacted by suicide in the Coventry and Warwickshire, including proactively contacting the bereaved family within 72 hours, offering short and long term emotional and practical support, and referring to specialist services if needed. Individuals can be referred to Amparo at any point following bereavement and they will receive support to meet their needs.

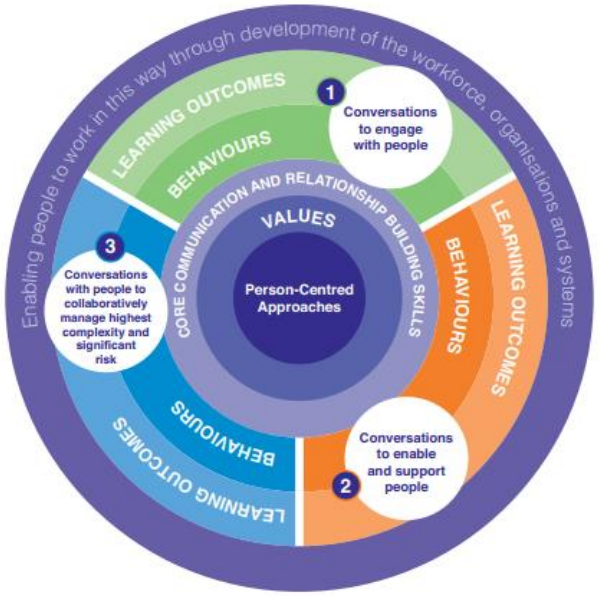
Our approach: what matters to people

"For a time the only thoughts that gave me comfort were thoughts of ending my life. I was coming to terms with a diagnosis of bipolar disorder, no-one understood what it was like to go through this, everyone else was getting on with their lives."

An individual response

The strategy aims to ensure that all individuals who are in crisis or at risk of ending their life, will experience a person-centred approach when accessing support across Coventry and Warwickshire.

Individuals accessing support and services should feel safe, experience a non-judgemental interaction and receive an intervention that is based on trust and respect.



A person-centred approach focusses on the needs of an individual, ensuring that their preferences, needs and values guide clinical decisions. In turn, this ensures that the care and support provided is respectful of and responsive to their individual circumstances.

No two individuals are the same and every suicide is unique. Where someone is in crisis or is at risk of ending their own life, they should expect to be supported and treated as an individual.

Recognition of their specific needs and experiences should be taken into account. The impact of past and present experiences, including trauma, bereavement or mental health is recognised and acknowledged in the support provided. Plans to manage the risks presented should be tailored to reflect these circumstances to ensure they are appropriate to the individual.

Coproduction is an essential part of developing this approach, ensuring that the voices of those individuals requiring support helps shape the type and delivery of support available.

Our approach: a public health response

"On Christmas Eve my brother-in-law told us he wanted to end his life, he said we would all be better off without him, nothing we said seemed to make a difference to his thoughts. None of us as his close family saw this coming, or knew what to do."

What is the public health approach to suicide prevention?

- Suicide is preventable not inevitable
- Prevention is at the core with a focus on causal factors
- Public health is everyone's business – suicide prevention is everyone's business
- Focused on generating long term as well as short term solutions underpinned by public health and partner outcomes
- Informed by local needs assessment with a focus on inequalities
- Rooted in evidence of effectiveness to tackle problems
- Working in and with communities
- Not constrained by organisational and professional boundaries

A population response

Taking a population wide approach to suicide prevention means not only focusing on support for people at crisis point, but also earlier action to reduce the risk factors that contribute to poor mental health and risk of suicide, and even earlier to promote positive wellbeing and coping strategies among population groups at higher risk of poor mental health.

Important risk factors include financial or housing insecurity, relationship breakdown, loneliness and isolation, living with chronic pain, having previously lost a loved one by suicide, substance misuse, living with a mental health condition such as depression, or having recent contact with the criminal justice system. Evidence also shows that some population groups are at higher risk of dying by suicide. These include people from groups who may feel marginalised or struggle to access the support they need. People going through significant life transitions such as teens and young adults, young and new mothers and middle-aged men can also be at higher risk of suicide.

Action on the breadth of factors contributing to risk of suicide requires a "population health approach" to be taken and the consideration of the range of factors that contribute to overall health and wellbeing. This requires all parts of society taking steps to reduce deaths by suicide. Through this approach we aim to harness the power of the public sector, those working in the voluntary and community sector, and residents themselves in a collaborative approach to making our communities and services suicide safer.

Finally, taking a public health approach means ensuring actions are informed by data and evidence. The Real Time Surveillance system for deaths by suspected suicide in Coventry and Warwickshire strengthens our ability to identify and react to changes in patterns of deaths or risk factors in a timely manner. This will inform the local suicide response plan enabling timely identification of possible clusters and preventing further contagion.

Embedding suicide prevention: promoting positive action

Tackling risk and building resilience: the Strategy recognises the impact that different circumstances can have on an individual. The table below outlines some of the circumstances that can increase suicide risk, as well as those that act as protective factors. These risk and protective factors will inform the ongoing suicide prevention work programme and be considered as part of the delivery planning process. These factors should be considered across the whole life course, with a recognition that the impact of these factors will differ between individuals and at different times.

RISK FACTORS		**PROTECTIVE FACTORS**
• Previous suicide attempt • History of depression and other mental illnesses • Serious illness such as chronic pain • Criminal/legal problems • Job/financial problems or loss • Impulsive or aggressive tendencies • Substance misuse • Current or prior history of adverse childhood experiences • Sense of hopelessness • Violence victimisation and/or perpetration	INDIVIDUAL personal factors	• Effective coping and problem-solving skills • Reasons for living (for example, family, friends, pets, etc.) • Strong sense of cultural identity

• Bullying • Family/loved one's history of suicide • Loss of relationships • High conflict or violent relationships • Social isolation	RELATIONSHIP harmful and hurtful or healthy relationship experiences	• Support from partners, friends, and family • Supportive environments • Feeling connected to others
• Lack of access to healthcare • Suicide cluster in the community • Stress of acculturation • Community violence • Historical trauma • Discrimination	COMMUNITY challenging issues or supportive experiences	• Feeling connected to school, community, and other social institutions • Supportive environment • Availability of consistent and high quality physical and behavioural healthcare
• Stigma associated with help-seeking, and mental illness • Easy access to lethal means of suicide among people at risk • Harmful media messaging around suicide	SOCIETY cultural and environmental factors	• Reduced access to lethal means of suicide among people at risk • Suicide and mental health awareness Cultural, religious, or moral objections to suicide

The three pillars of prevention: there are many factors that can influence mental health and whilst it isn't possible to stop all mental ill-health from developing, the right approach can help prevent many mental health problems. The Strategy recognises the need to address the causes of poor mental wellbeing and suicidal crisis as well as improving access to services and treatment for ongoing mental ill health. This can be summarised as follows:

- **Primary Prevention:** stopping mental health problems before they start (tackling the causes) – targeting whole population and benefitting everyone in a community
- **Secondary Prevention:** supporting those at higher risk of experiencing suicide ideation or crisis (early intervention / immediate action) – aimed at groups and individuals at a higher risk due to circumstance and/or experience
- **Tertiary Prevention:** helping people with severe mental illness or complex needs (services) – supporting vulnerable individuals requiring long term support and care

A holistic approach: the Strategy promotes a holistic approach to suicide prevention which supports a suicide aware society. This responsibility lies with individuals, family and friends, local communities and workplaces, and the wider society and services.

The table below illustrates some examples across Coventry and Warwickshire:

RESPONSIBILITY	GOAL	C&W ACTIVITY
INDIVIDUALS	• Awareness of signs and risk of suicide • Awareness of impact of changes through the life course	• Data from real time surveillance for risk factors • C&W support services; perinatal mental health, CYP, adults, older adults
FAMILY AND FRIENDS	• Information and support available to those impacted by suicide • Encourage to talk and seek support • Response to concerns • Supportive networks	• C&W Postvention Bereavement Service – Listening Ear • Local targeted campaigns e.g. world suicide prevention day, wellbeing for life • Signposting for all ages to services • Dear Life website and resources
COMMUNITY AND WORKPLACE	• Resilient and supported workforce • Boost positive mental health and emotional wellbeing • Trained frontline services across all sectors • Increased awareness • Supportive environment	• Mental Health First Aid training • Workplace wellbeing forums • C&W Mental Health JSNA 2021 • Wellbeing 4 Life programme • Suicide awareness/prevention training • Thrive at Work programme • Community networks
SOCIETY AND SERVICES	• Support relevant commissioning of support services • Appropriate pathways to access support • Reducing stigma of suicide • Tackling health inequalities	• Mapping of existing services to ensure appropriate referral pathways • Local awareness raising campaign • Accessing relevant funding to support suicide prevention work

Children and Young People: specific consideration will be given to the needs of and support to children and young people. This will include further work in relation to the:

- levels of self-harm (particularly among teenage girls),
- impact of the pandemic and how this has affected the social and emotional development of younger people, including the local student population.
- significant transition phases during the life course of children and young people, from the very early years (including the perinatal period) right through to early adulthood (including students, those that enter the workforce and those moving from children to adult mental health services)

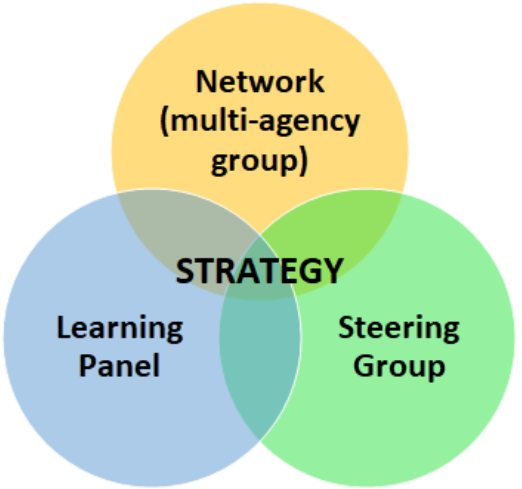
The findings of the Mental Health and Wellbeing of Infants, Children and Young People Joint Strategic Needs Assessment for Warwickshire (due to be published 2023) will help inform a programme of work specifically targeted at Coventry and Warwickshire's younger population.

"Nearly half of 17-19 year-olds with a diagnosable mental health disorder have self-harmed or attempted suicide at some point, rising to 52.7% for young women." Young Minds 2022

Our approach: partnership and engagement

Coventry and Warwickshire Suicide Prevention Partnership

The Coventry and Warwickshire Suicide Prevention Partnership is made up of organisations, groups, communities and individuals from across Coventry and Warwickshire, who collectively support the vision that no one in Coventry and Warwickshire will ever feel that suicide is their only option.



The Partnership is broadly made up of three distinct functions, which together form the basis for the delivery of the Coventry and Warwickshire Suicide Prevention Strategy. The Partnership sits within the wider context of the Coventry and Warwickshire Integrated Care System (ICS) and the desire for a comprehensive approach to suicide prevention across system partners is reflected in the Coventry and Warwickshire Integrated Care Strategy.

This Strategy will help the System and all partners across Coventry and Warwickshire to embed suicide prevention within their priorities and workstreams.

Stakeholder engagement…and what it has told us

Local strategic partnerships: a number of local partnership boards were engaged with developing the vision and approach for the Suicide Prevention strategy. Key outcomes were:

- There is commitment across the system for embedding suicide prevention activity
- There is priority at place around the mental and emotional wellbeing of communities
- There are key themes which may require a priority focus for suicide prevention

Stakeholder workshops: Through a series of workshops, feedback from local organisations and services told us that our approach to suicide prevention across Coventry and Warwickshire needs to:

- have clear and consistent messaging
- raise awareness of suicide prevention within communities and organisations
- ensure that people know where to go for the right support at the right time
- understand and reflect the reasons that may lead to suicide or suicidal thought
- be relevant to all ages and different communities and population groups
- target people and groups at higher risk of suicide
- involve people with lived experience
- provide support to the people who are working with or caring for people who self harm or are at risk of suicide
- use the knowledge and experience of existing networks and groups to share best practice
- enable the sharing of information to support better joint working and coordination of service delivery
- focus on prevention and early intervention to support the emotional wellbeing of people

Public engagement survey: This engagement process concluded that the strategic vision and priorities were largely consistent with what respondents felt was needed. There was an emphasis on societal risk factors and prevention at the earliest opportunity. Where there was disagreement or alternative suggestions put forward, this will be picked up through the delivery planning process. Where appropriate, the feedback from the public engagement survey will be reflected in the suicide prevention work programme, with specific actions developed in response to this.

Specific themes were identified in relation to:

- The need for early intervention and support before crisis is reached
- Ensuring that individual needs are at the centre of any intervention, particularly at crisis point
- Tackling risk factors that might be a causal factor for suicide
- Taking a holistic approach that takes account of the individual and complex nature of suicidal crisis and ideation
- Coproduction and ensuring that lived experience forms the basis of suicide prevention activity
- Funding, service capacity and joined up working locally
- Increasing awareness of suicide so that people are better to equipped to identify and support individuals in suicidal crisis
- Improving the general wellbeing and resilience of individuals and communities

Of those that responded, approximately 70% had been impacted by suicide.

Delivering the Strategy: what are we going to do

"Doing suicide prevention training helped me understand how to spot and manage the risks of suicide in individuals. Whilst this helped me in my work, it is at home where I have applied it most. I live with someone who experiences suicidal thoughts at times. After the training I feel more confident discussing these feelings with my loved one and better able to judge if there is intent to act when these thoughts are expressed".

Local priorities for Coventry and Warwickshire

To bring about the partnerships and transformation required to realise our vision for this strategy five key local priorities have been identified to focus on in the first instance. To have the greatest impact these priorities must be pursued together and build upon the wealth of the good practice already in place. Together these priorities will support the delivery of our long-term strategic ambitions.

LOCAL PRIORITIES (WHAT)	AIM (WHY)
Target our approach for those groups and communities at a higher risk of suicide	*Reducing inequality and addressing gaps*
Increase awareness to help change public attitudes about suicide	*Working towards suicide safer communities*
Promote suicide prevention as a priority within the wider health and wellbeing activity of system partners (public, private, VCSE sectors)	*Influencing workplace practices*
Provide real time data to ensure that prevention activity is targeted in response to locally identified priorities	*Sharing data and learning*
Facilitate coproduction, collaboration and coordination to maximise the impact of suicide prevention activity across Coventry and Warwickshire	*Maintaining effective partnerships*

A two-year delivery plan will be developed by the Suicide Prevention Partnership to deliver on these local priorities. This will include a series of measures to determine the impact of what is being delivered through Task and Finish Groups and wider organisational contributions.

Accountability

The Coventry and Warwickshire Suicide Prevention Strategy is accountable to the two local Health and Wellbeing Boards in Coventry and Warwickshire. The Strategy forms part of the delivery of the wider Health and Wellbeing Strategies for both areas.

The Health and Wellbeing Boards will monitor the Suicide Prevention Delivery Plan, with progress and impact reported on an annual basis to Coventry and Warwickshire Integrated Health and Wellbeing Forum.

Highlight reports will also be presented to other appropriate local strategic boards to ensure the suicide prevention programme is reflected in and aligned to other work stream areas and themes, including:

- Safeguarding
- Community safety
- Mental health and wellbeing
- Social Inequalities
- Children and young people
- Loneliness and social isolation
- Health and social care

Ownership and delivery partners

The Strategy and ongoing delivery of the work programme is led and overseen by the Coventry City Council and Warwickshire County Council Public Health Teams on behalf of the Coventry and Warwickshire Suicide Prevention Partnership.

The Strategy itself has been created in collaboration with: partners of the Integrated Care System, members of the Suicide Prevention Partnership, Voluntary and Community Sector stakeholders, residents and elected representatives from across Coventry and Warwickshire.

With special thanks to:

References and sources

To add…

APPENDIX 1

Number Suppression Approach Used (if required)

While disclosure control is not required as mortality data used is classified as 'discoverable' by ONS, ie they can be obtained from individual death certificates, some data is derived from the real time surveillance service and so not all data will be available on the death certificates at time of publication therefore the following steps are applied to reduce the risk of identifying individuals from small numbers based on NHS Digital Guidance - https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/hospital-episode-statistics/change-to-disclosure-control-methodology-for-hes-and-ecds-from-september-2018

a. Counts between 1 and 7 (inclusive) will be displayed as '*'.

b. Zeroes will be unchanged.

c. All other counts will be rounded to the nearest 5.

Numbers1 to 13 will therefore appear as follows, all other numbers will be rounded to the nearest 5.

Before disclosure control	0	1	2	3	4	5	6	7	8	9	10	11	12	13
After disclosure control	0	*	*	*	*	*	*	*	10	10	10	10	10	15

Coventry City Council

Report

To: Coventry Health and Wellbeing Board **Date: 23rd January 2023**

From: Allison Duggal, Director of Public Health and Wellbeing

Title: Drugs and Alcohol update

1 Purpose

To inform the Health and Wellbeing Board of progress being made on the local response to the National Drugs Strategy "From Harm to Hope" including the:

- West Midlands drugs and alcohol governance structure and the
- Coventry partnership steering group
- Coventry needs assessment and strategic framework outline

2 Recommendations

Health and Wellbeing Board is asked to:

- Note the requirements set out in the National Drugs Strategy
- Note the regional and local governance structures
- Note local progress
- Support attendance at the Coventry Drugs and Alcohol Partnership Steering Group from all identified partners.

3 Background Information

3.1 National substance misuse strategy

The government's new 10-year drug strategy 'From Harm to Hope' sets out an ambition to address substance misuse by:

- breaking drug supply chains
- delivering a world-class treatment and recovery system
- and achieving a generational shift in demand for drugs.

The strategy is based on the findings of the independent review of drug misuse carried out by Dame Carol Black. While the strategy has been developed in response to drug misuse it is intended that it covers broader substance misuse including alcohol.

3.2 Successful delivery of the national strategy relies on co-ordinated action across a range of local partners including in enforcement, treatment, recovery and prevention.

3.3 A National Combating Drugs Outcomes Framework has been developed. This provides a single mechanism for monitoring progress across central government and in local areas

towards delivery of the commitments and ambitions of the drugs strategy. There are six overarching outcomes, which also apply to alcohol misuse:

- Reduce drug and alcohol-related crime
- Reduce drug and alcohol use
- Reduce drug and alcohol-related deaths and harm
- Reduce supply
- Increase engagement in treatment services
- Improve long term recovery

4 Progress to date

4.1 Governance structures

4.1.1 West Midlands Combatting Drugs and Alcohol Partnership (WMCDAP)

HM Government guidance for local delivery partners (Drugs strategy guidance for local delivery partners - GOV.UK (www.gov.uk) set out the requirements for local partnerships. Local areas were asked to:

- form a clearly defined partnership structure based on a geographical extent that is logical to local residents and consistent with existing relevant arrangements
- select a Senior Responsible Owner (SRO) who can represent the partnership nationally, reporting to central government regarding its performance, and who can offer challenge and support to local partners to drive improvement and unblock issues when necessary
- involve all those people and organisations affected by drugs in developing joint solutions to these issues

For the West Midlands Metropolitan area it was agreed that the SRO would be the Police and Crime Commissioner as this would support strong engagement of the police and criminal justice partners in delivery of the strategy, as well as joined up working across the area. The role of the SRO is as the key local “system integrator” responsible for ensuring the right local partners come together, building strong collective engagement, and designing a shared local plan to deliver against the National Combating Drugs Outcomes Framework.

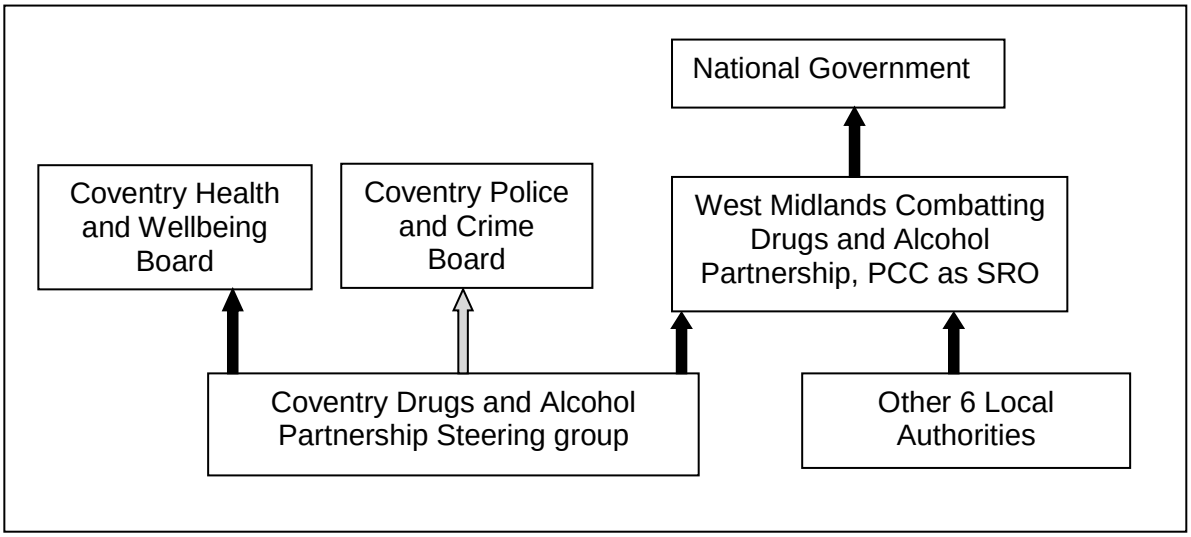
WMCDAP has representation from all 7 local authorities, for Coventry this is Allison Duggal (Director of Public Health) and Rachel Chapman (Consultant in Public Health). A high level needs assessment for the West Midlands has been completed and a strategy is being developed.

4.1.2 Coventry Drugs and Alcohol Partnership Steering Group

As part of the West Midlands arrangements each local authority will also have a multi-agency locality sub-group which will develop a local drug and alcohol strategy, a delivery/commissioning plan, and a local outcomes framework, to ensure the needs of the local population are met. In Coventry we have set up the Coventry Drugs and Alcohol Partnership Steering Group with membership from:

- Coventry City Council (Public Health, Adult Social Care, Children's Services, Community Safety, Education, Safeguarding, Housing)
- Police (local NPU and PCC)
- DWP
- Criminal Justice system
- Providers
- CWPT NHS Trust
- Coventry and Warwickshire ICB
- Universities (Coventry and Warwick)
- UHCW NHS Trust

The Partnership Steering Group is chaired by Allison Duggal (Director of Public Health) and will report into and be accountable to the Coventry Health and Wellbeing Board. The group will also report to the Police and Crime Board. Substance misuse impacts on many other priority areas of work in Coventry including domestic abuse, sexual violence, serious violence, homelessness, mental health etc. Links with relevant groups and boards will continue to be built and strengthened. A summary of the governance structure is shown in the box below:



4.2 Coventry Needs Assessment

A drugs and alcohol needs assessment has been carried out for Coventry. The local needs assessment has had a particular focus on prevention, harm reduction, treatment and recovery as these are the areas that we have the most influence over and commission services for. The draft summary of the needs assessment is attached as appendix 1. A series of recommendations have been made based on the findings of the needs assessment.

4.3 Coventry Substance Misuse Strategy

A substance misuse strategy is being developed for Coventry, using the findings of the needs assessment and the six overarching outcomes from the national outcomes framework (section 3.3). The strategy will take a life course approach and will cover all ages. Task and Finish groups for each of the outcomes are taking place during January, partners have been invited to these groups to contribute to developing strategic objectives

for each outcome. The draft strategy will be discussed at the Coventry Drugs and Alcohol Partnership Steering Group in March 2023

4.4 Public and service user engagement

A full stakeholder engagement took place as part of the local needs assessment. Both group discussions and 'one to one' interviews with staff across the key service areas were conducted.

In addition to this, several service user focus groups and interviews also took place. This included engaging with those currently in drug and alcohol treatment and those that are not currently accessing support.

The findings from this work has been included in the needs assessment. A number of areas were identified that will require further consideration and exploration as part of the development of the strategy delivery plan.

A community survey was also conducted to try to engage the views of the wider community around the subject of drugs and alcohol but received a low response rate. There has been learning around this and one of the recommendations of the local needs assessment is to develop an ongoing programme of meaningful community engagement.

4.5 Commissioning drugs and alcohol services

Responsibility for commissioning health-based services which support the reduction of harm caused by drug and alcohol is spread across a number of agencies including the City Council, ICS, NHSE/I and the Police and Crime Commissioner. The City Council funds local services for adults and children affected by substance misuse and, under the national strategy, will receive additional funds to 'rebuild' the treatment system, increase the number of people accessing treatment and improve continuity of care for offenders released from prison. It is anticipated that this additional grant in 2023/24 will be £0.7m, rising to £1.2m in 2024/25. The spend in 2023/24 will continue to fund additional services commissioned in 2022/23 including:

- Additional capacity and specific support for offenders affected by drug misuse
- Specialist workers embedded into the Caludon Centre
- Specialist staff to develop and embed the prescribing of Opiate Substitute Therapy within UHCW
- Additional capacity to support people misusing drugs or alcohol and experiencing domestic abuse
- Widening of treatment options to include occupational therapy
- Additional capacity for young people's specialist services

Additional spend in 2024/25 will be informed by the needs assessment.

5 Recommendations

Health and Wellbeing Board is asked to:

- Note the requirements set out in the National Drugs Strategy, including the national outcomes framework
- Note the formation of WMCDAP with the regional governance structure with PCC as SRO.
- Note the formation of the local Coventry Drugs and Alcohol Partnership Steering Group with reporting to Health and Wellbeing Board

- Note local progress on the needs assessment and development of the strategy
- Support attendance at the Coventry Drugs and Alcohol Partnership Steering Group from all identified partners.

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COVENTRY

COVENTRY SUBSTANCE MISUSE NEEDS ASSESSMENT

V4.2

1.3 - THE PICTURE IN COVENTRY

SUMMARY

Coventry is a growing city, with the population expected to increase by 11% (to 419,366) by 2030. Births and international migration are driving the growth in the population. The presence of two universities, Coventry and Warwick, is another major reason for the city's increased population, particularly among younger adults.

To reduce the demand for specialist drug and alcohol services and the harms associated with drug and alcohol misuse, **there needs to be a greater focus on preventing people from misusing drugs and alcohol.** Preventing drug misuse is more cost-effective and socially desirable than dealing with the consequences of misuse.`[1] Prevention work should include a focus on addressing recreational drug use.

Mapping prevention services and initiatives in Coventry against United Nations Office on Drugs and Crime prevention standards shows that some life course stages may require more interventions. **More prevention services that focus on middle childhood and early adolescence should be considered**. Within the existing prevention delivery, there are opportunities for some standardisation of approaches across all partners, including schools, who must deliver drug and alcohol education as part of their approach to Relationships, health, and Sexual Education.

Coventry has significant pockets of deprivation, with nearly 19% of Coventry neighbourhoods in England's 10% most deprived neighbourhoods. Deprived areas are more likely to have greater proportions of black and minority ethnic groups and are more likely to suffer from health inequalities. In Coventry, areas such as Foleshill, one of the most deprived neighbourhoods, had an estimated 69% non-White British population.

Additional factors to consider in devising an approach to addressing drug and alcohol needs in deprived areas include higher rates of abstinence and lower drinking levels among minority ethnic groups compared to people from white backgrounds. Abstinence is high amongst South Asians, particularly those from Pakistani, Bangladeshi and Muslim backgrounds. But Pakistani and Muslim men who drink do so more heavily than other non-white minority ethnic and religious groups.[2]

15% of those in treatment during 2021-22 were from a Black or minority ethnic group, lower than the proportion in Coventry (26% - 2011 census data). **Further work should be considered to ensure services are culturally specific and appropriate**. Resources compiled by the Office for Health Inequalities and Disparities may be able to guide this work. **Place-based approaches, described in the Health and Wellbeing Strategy,[3] to drug and alcohol needs should also be considered.**

Parental problem drug use can and does cause serious harm to children at every age, from conception to adulthood. [4] Within Coventry, there were 327 parents in treatment out of a projected number of 3780 (9%). Analysis of hidden harm showed opportunities to develop the response in Coventry. Compared to the Nearest Neighbours, **the number of parents in treatment as a rate of the projected number of children affected by parental alcohol/substance misuse is low.** In addition, the number of parents entering treatment has decreased. The response to hidden harm in Coventry should be informed by existing government guidance on the issue.

[1] DHSC, (2021), Review of drugs part two: prevention, treatment, and recovery

[2] JRF, (2010), Ethnicity and alcohol: a review of the UK literature

[3] Covenry City Counci, (2019), Health and Wellbeing Strategy

[4] X,(2011), Hidden Harm – Responding to the needs of children of problem drug users

In Coventry, there is a disproportionate amount of harm caused by alcohol use. Alcohol-related mortality and hospital admission rates are higher than the national average and amongst its Nearest Neighbours. Despite a decrease in admissions between 2020-21 and 2019-20, alcohol-related hospital admission rates are still high among males and females. There is work to be completed on identifying those with an alcohol need earlier to try and reduce hospital admissions and deaths.

Analysis of unmet need information indicates the work to be done to encourage those with an alcohol need to seek help. Data on unmet needs shows that only 13% of those with a dependent alcohol problem are accessing treatment services, a much lower figure than the England average of 20%.

Over the past year, there has been an increase in the proportion of alcohol users accessing services. The increase in engagement was partially attributed to the new methods of accessing services introduced during the COVID-19 pandemic (phone appointments and virtual access).

In Coventry, unmet needs analysis indicates good engagement with services from those using opiates. 53% of the estimated opiate-using population are accessing treatment services which is the same as the England average.

Coventry has a low age-standardised mortality rate for deaths related to drug poisoning (2019-21) compared to its Nearest Neighbours. There has been an 83% decrease in drug-related deaths related to drug poisoning in Coventry between 2021 and 2020. The decrease is against national trends (+5%) and that of the Nearest Neighbours (+11%). Deaths relating to drug misuse have also reduced from 24 in 2020 to 14 in 2021.

Regarding drug-related hospital admissions, Coventry has lower-than-average rates than its Nearest Neighbours.

In 2021, only 13% of Coventry residents leaving prison in drug or alcohol treatment continued treatment in the community, lower than the national average of 37%. The reasons for low engagement rates following a stay in prison need to be understood. Feedback from those not engaging with services will be difficult to source but should be sought (one way may be speaking to those who return to prison).

There are good examples of joint working between services addressing drug and alcohol needs in Coventry. CGL, the specialist drug and alcohol service provider, have teams working with employment services, rough sleepers, police and probation, and a dual diagnosis worker who links in with patients in the Caludon Centre.

There are opportunities to develop partnership working approaches with services, such as mental health teams. Trauma and mental health needs can be drivers of addiction and require a joined-up approach. An indication of the cross-over between mental health needs and drug or alcohol needs is the 67% on the CGL caseload with an identified mental health need.

The ongoing Mental Health Transformation project will offer chances for more co-located working between mental health and drug and alcohol practitioners at mental health hubs. The development of the IAPT plus model should make accessing treatment easier for those with a drug or alcohol need.

There are opportunities to increase the knowledge regarding the remit of specialist drug and alcohol services. The pathway between Children's Social Care and specialist services was highlighted as one that could be improved. There are opportunities to increase the knowledge and confidence of practitioners across all services regarding identifying those with drug or alcohol needs and working with them. Practitioners across several services highlighted the difficulties they faced in getting individuals to admit a drug or alcohol need and then agreeing to a referral to specialist services. Feedback from those working in front-line services indicates there is still work to be done in identifying and engaging those with a drug or alcohol need.

Over the past four years, the number of new presentations to structured drug and alcohol treatment averaged 906 yearly. 2021-22 saw a decrease in those with opiate-only problems accessing treatment and an increase in alcohol-only clients.

75% of referrals to the specialist drug and alcohol provider are via self-referrals. The high proportion of self-referrals could indicate a need for other partners to be more proactive in referring individuals to the service and undertake more motivational work with individuals before making a referral.

In 2021-22, there were almost 1800 individuals in treatment, a similar figure to the previous year. Roughly two-thirds of those in treatment are male. Looking at the change in age structure over the previous four years, there has been a slight decrease in the 20-29 and the 30-39 age groups. This decrease has been offset by an increase in the 40-49 and 60+ age groups.

Coventry has higher re-presentation rates and lower successful completion rates than the national average and Nearest Neighbours. The rates may be partially attributable to the local approach to risk management with patients.

In Coventry, residential rehabilitation services are jointly commissioned between Coventry and Warwickshire. The uptake in rehabilitation has increased over the previous three years. However, more work still needs to be done to encourage more of those in treatment to choose rehabilitation services.

For those who want to achieve and stay in recovery, CGL offers a range of structured and unstructured group programmes and peer support. Outside of specialist services in Coventry, there appears to be more that can be offered to individuals who want to achieve and stay in recovery. In her review of drugs, Dame Carol Black highlights the need for thriving communities of recovery to be linked to every drug treatment system.

The police response to drugs and alcohol indicates that there may be an increasing need across Coventry. There have been increases in drug and alcohol-related offences over the past two years. These increases can be partially attributable to changes in how crimes are recorded, although this requires further exploration. Drug-related offences are up 44% when comparing the year to June 22 against the previous year. Alcohol-related offences are up 65% when comparing the year to June 22 against the previous year.

A more detailed analysis of drug and alcohol-related crimes shows differences between wards and which wards may be experiencing an emerging issue. For example, the Wainbody ward has seen a high increase in drug-related crimes. However, the crime rate is relatively low compared to the other wards. The links between crime and drug and alcohol need show the importance of the links between services and how services such as the Arrest Referral Service and the Divert initiative can link individuals with specialist services.

1.4 - KEY FINDINGS AND RECOMMENDATIONS

DESCRIPTION OF ICONS

Each recommendation includes additional information relating to the following:

- Whether it relates to children and young people or adults
- The area of the National Combatting Drugs Outcome Framework[5] that it sits under:
  - USE – Reducing Drug Use
  - CRIME – Reducing Drug-Related Crime
  - HARM – Reducing Drug-Related Harm
  - SUPPLY – Reducing Supply
  - TREATMENT – Increase Engagement in Treatment
  - RECOVERY – Improve Recovery Outcomes
- The table below describes how we have displayed information in this document.

This section describes whether the recommendation relates to Children and Young People or Adults. In the example below the recommendation relates to ADULTS.

This section describes which area of the NCDOF the recommendation relates to. In the example below the recommendation relates to REDUCING DRUG USE.

AREA		OUTCOME FRAMEWORK AREA					
C&YP	ADULT	USE	CRIME	HARM	SUPPLY	TREATMENT	RECOVERY
							

RECOMMENDATION NUMBER: #

TITLE: *Summary of the recommendation.*

	*Key finding relating to the recommendation.*
	*The impact of the key finding is on Coventry.*
	*A longer description of the recommendation.*

[5] HM Government, (2022), Guidance for local delivery partners

LIST OF RECOMMENDATIONS

NUMBER	TITLE
1	To take into account projected population changes and demographic differences at a geographical level when planning for future services.
2	To develop the approach to prevention for school-aged children.
3	To evaluate current diversionary activities for children and young people.
4	To improve responses to the physical health problems that impact those with drug and alcohol issues, using the hepatitis C elimination model as a good practice example.
5	To improve service effectiveness by improving data collection from needle exchange in Coventry.
6	To develop recovery options in line with national guidance and with input from those with lived or living experience of drug and alcohol addiction.
7	To review the local response to the 'hidden harms' caused by adverse childhood experiences, such as parents with a drug or alcohol issue.
8	To complete an evaluation on alcohol-related hospital admissions and discharges.
9	To further investigate drug-related deaths to develop strategies and approaches that reduce deaths.
10	To use the mental health transformation project to improve responses to the mental health needs of those with a drug or alcohol need.
11	To review the clinical treatment of opiate users in hospitals to identify improvements to the pathway.
12	To review the continuity of care between prison and community to ensure greater engagement in treatment services for those released from prison.
13	To review treatment services to explore the potential for expansion and collaborative working.
14	To develop a strategy to increase the use of tier 4 services in Coventry.
15	To develop an ongoing programme of engagement with communities to inform service development and delivery.
16	To investigate increases in drug and alcohol-related recorded crimes to inform future planning.
17	To develop joint working between Licensing and Trading Standards and the Partnership Board.
18	To develop the skills and knowledge of the wider workforce concerning drug and alcohol-related needs.
19	To develop the availability of accurate and robust data to inform and develop the drug and alcohol strategy.

COVENTRY

RECOMMENDATIONS

AREA			OUTCOME FRAMEWORK AREA					

RECOMMENDATION NUMBER: 1

TITLE: To take into account projected population changes and demographic differences at a geographical level when planning for future services.

Increase in population numbers.

The population has increased by 13% since 2014 and is projected to increase by a further 11% by 2030.

An increase in the overall population will likely impact the demand for services.

Variances between wards.

There is a huge variance in demographics between wards, including age and deprivation. For example, 46% of the population in Bablake is over 45 compared to 12% in St Michael's.

The demographic profile of the wards will have a bearing on the prevalence of substance misuse.

In Coventry, approximately 20% of the population is under 16. The most recent (2018) survey on Smoking, Drinking, and Drug Use among Young People in England showed that the proportion of 11- to 15-year-olds in England who had taken any drug (excluding new psychoactive substances) in the last year was 14.5%. This was similar to the previous estimate in 2016 (15.2%).[6]

Approximately 35% are aged between 16 and 34. For the year ending March 2020, the prevalence of any drug use in the last year was highest amongst 16- to 19-year-olds and 20- to 24-year-olds (21.1% and 21%, respectively).[7]

Approximately 20% of the Coventry population are aged 55 and over. An estimated 1% of 60- to 74-year-olds had taken a drug in the last year.[8]

As a university city, it is worth noting for Coventry that full-time students (19.7%) were more likely than any other occupation group to have used any drug in the last year.[9]

Future planning should take into account the projected increase in the population and the needs at a ward-based level. The demographic (including age and deprivation) and need analysis in this needs assessment should be considered when deciding where resources should be located.

OHID have a national drive to help improve the responsiveness of services to diverse cultural needs. OHID have created some resources that can be used to improve the responsiveness of

[6] ONS, (2022), Drug misuse in England and Wales: year ending March 2020
[7] ONS, (2022), Drug misuse in England and Wales: year ending March 2020
[8] ONS, (2022), Drug misuse in England and Wales: year ending March 2020
[9] ONS, (2022), Drug misuse in England and Wales: year ending March 2020

	services. As described in the Health & Wellbeing Strategy, place-based responses should be considered.

OTHER KEY FINDINGS

	**Minority ethnic groups account for a smaller percentage of those in the treatment system than the general population.** Based on the latest data, 26% (2011 - potentially greater now) of the Coventry population are from a minority ethnic group. During 2021-22, 15% of those in treatment are from a minority ethnic group.
	The relationship between the city's diversity and treatment services' diversity is unclear. There are numerous factors to consider when drawing comparisons between the two populations, such as cultural views towards drugs and alcohol, abstention rates, and the availability of culturally appropriate services. Coventry has a high proportion of minority ethnic groups with traditionally higher rates of abstinence and lower drinking levels. Abstinence is high amongst South Asians, particularly those from Pakistani, Bangladeshi and Muslim backgrounds, compared to people from white backgrounds. [10] It should also be noted here that research has found that Pakistani and Muslim men who do drink do so more heavily than other non-white minority ethnic and religious groups. [11]

[10] JRF, (2010), Ethnicity and alcohol: a review of the UK literature

[11] JRF, (2010), Ethnicity and alcohol: a review of the UK literature

PREVENTION

RECOMMENDATIONS

AREA			OUTCOME FRAMEWORK AREA					

RECOMMENDATION NUMBER: 2

TITLE: To develop the approach to prevention for school-aged children.

There is an opportunity to develop the approach to school-age prevention activity.

Under the statutory guidance for Relationships, Sex and Health Education (RSHE), schools have a requirement to provide teaching about tobacco, alcohol, prescription drugs and illicit drugs.

In Coventry, as in most other areas, each school has developed its approach to Relationships, Health and Sexual Education (RHSE).

The international experience with prevention shows that support for front-line workers and evaluation of outcomes are critical for success. The Dame Carol Black Review highlights the need for high-quality teacher training programmes to deliver the new drug prevention curriculum.

The school survey highlighted several areas where schools may benefit from assistance with drug and alcohol-related needs. Areas highlighted included better support for families, training for staff, and difficulties in getting parents to engage with specialist services.

It is difficult to measure the current impact of RHSE education in schools concerning drug and alcohol awareness. In addition, there is a knowledge gap about how prevention is approached in schools.

Without a robust evaluation, it is not possible to say whether this key component of the prevention approach in Coventry is having the desired effect on reducing the harm caused by drug and alcohol use among children and young people.

Engagement work should be completed with key stakeholders to develop the approach to prevention in Coventry. The engagement exercise should cover schools' current approach to prevention across all age groups.

The engagement exercise should gather information on what assistance schools require concerning the drug and alcohol aspects of the RHSE curriculum. It should be a goal to have a consistent approach to RHSE across Coventry that can be evaluated regularly.

AREA			OUTCOME FRAMEWORK AREA					

RECOMMENDATION NUMBER: 3

TITLE: To evaluate current diversionary activities for children and young people.

	Evidence shows that the same factors that increase childhood risk for drug use also increase the risk of alcohol and tobacco use, poor academic performance, mental health problems, and harm to self and others. Positive activities for young people outside of school hours are important.[12]
	Several diversionary activities are being funded in Coventry, allowing children and young people to participate in interventions that may otherwise not be available. Coventry City Council has funded Ecotherapy and Boxing classes for children and young people. Funding these activities is important in ensuring that all community members have access to activities promoting health and wellbeing. The effectiveness of these activities is currently being evaluated.
	There should be a further evaluation of the effectiveness of diversionary activities in improving outcomes related to drug and alcohol use. The findings of the evaluation should feed into future planning activity.

KEY FINDINGS

	There is a potential gap in community services for early adolescents. Mapping existing prevention services shows a potential gap in community services for the middle childhood and early adolescence part of an individual's life course.
	There are challenges to measuring the coverage and effectiveness of the prevention approach within schools. This part of the prevention approach has the opportunity to get key messages to a large portion of the community.

[12] DHSC, (2021), Review of drugs part two: prevention, treatment, and recovery

HARM REDUCTION

RECOMMENDATIONS

AREA			OUTCOME FRAMEWORK AREA					

RECOMMENDATION NUMBER: 4

TITLE: To improve responses to the physical health problems that impact those with drug and alcohol issues, using the hepatitis C elimination model as a good practice example.

	As part of NHS England and NHS Improvement's national programme to eliminate hepatitis C as a major public health threat, there has been an increased focus on identifying and treating hepatitis C in Coventry. Other key aspects of the hepatitis C elimination drive that improved outcomes for patients were hospital services in-reaching into CGL, a wider range of partners supporting the delivery of medications to patients, and the training of hepatitis C peer champions.
	CGL data shows that between Quarter 4 2020/21 and Quarter 3 2021/22, an average of 10.4 patients were newly identified as being hepatitis C positive.
	There should be greater joint working between healthcare services and specialist substance misuse services to improve individuals' physical health. There should be on the physical health conditions that are prevalent in those with a drug and alcohol need, such as respiratory diseases and blood borne viruses.

AREA			OUTCOME FRAMEWORK AREA					

RECOMMENDATION NUMBER: 5

TITLE: To improve service effectiveness by improving data collection from needle exchange in Coventry.

	There are various harm reduction initiatives in Coventry. Initiatives in Coventry include Naloxone prescribing and needle exchanges. Approximately 20 pharmacies in Coventry offer needle exchange services. Needle exchanges are an example of an evidence-based harm reduction initiative highlighted in the Dame Carol Black Review. Details of those who use needle exchanges are not currently collected.
	Needle exchanges help stop the spread of infection from drug-related litter and sharing of injecting equipment. The needle and syringe exchange schemes help support the health and wellbeing of the whole community and provide those who inject substances with a confidential service and direct access to a health professional who can help them engage with treatment services to address their drug misuse.
	The collection of information from the needle should be collected. This will help address intelligence gaps, potential unmet needs, and help with future planning.

KEY FINDINGS

	Drug use can cause a range of health-related problems, including:[13] • mental health problems such as anxiety, depression, psychosis, personality disorder and suicide • lung damage • cardiovascular disease • blood-borne viruses • arthritis and immobility among injectors • poor vein health in injectors • liver damage from undiagnosed and untreated hepatitis C virus (HCV) • sexual risk-taking and associated sexually transmitted infections (STIs) • overdose and drug poisoning
	The wide range of health problems caused by drug use means that those experiencing drug-related harms may seek help from various health and care professionals, including acute medical, primary care and psychiatric services. Professionals must follow the Making Every Contact Count approach to support people in making positive changes to their physical and mental health and wellbeing.

[13] OHID, (2022), Misuse of illicit drugs and medicines: applying All Our Health

RECOVERY

RECOMMENDATIONS

AREA			OUTCOME FRAMEWORK AREA					

RECOMMENDATION NUMBER: 6

TITLE: To develop recovery options in line with national guidance and with input from those with lived or living experience of drug and alcohol addiction.

	For those who want to achieve and stay in recovery, CGL offers a range of structured and unstructured group programmes and peer support. Outside of specialist services in Coventry, several other services are aimed at helping individuals recover from their addictive behaviours (e.g., The Bridge, Recovery Academy, and Mutual Aid groups). The first Annual Report by the UK's first Drug Recovery Champion stated: "The creation of a Recovery-Orientated System of Care (ROSC) offers the best chance of helping people move on from drug dependence. At its best, ROSC is built on person-centred services and supports multiple non-linear pathways to recovery".
	The responsibility to help individuals recover from drug and alcohol addiction sits across all partners of the Partnership Board. Currently, the approach to recovery in Coventry is somewhat fragmented, meaning that interventions are not maximising their potential to help individuals achieve and maintain recovery.
	The engagement exercise completed as part of this needs assessment included a number of groups that focussed on the theme of recovery. Some key points from the engagement were: • A 'recovery hub' where all organisations offering recovery interventions could have a presence would be beneficial. Linked to the idea of a recovery hub is the availability of clear information detailing what recovery services are available in Coventry. • More diversionary activities would be appreciated by those in recovery. • The idea of recovery means different things to different people. There needs to be a range of options.
	The engagement exercises highlighted that there are existing services offering recovery options to those recovering from addiction in Coventry. However, these services are fragmented and what they offer is not widely known.

	The practitioner survey highlighted some potential gaps in the recovery offering in Coventry. There are opportunities for more recovery projects that focus on the health and wellbeing of those in recovery.
	The results of the practitioner survey indicate that there is not a full spectrum of recovery options in Coventry. This may impact the success of individuals from minoritised groups in achieving their version of recovery.
	There are opportunities to develop recovery services in Coventry in line with upcoming guidance and best practice. For example, the forthcoming clinical guidance on alcohol use will include a section on recovery and ROSCs. The recommendations and guidelines included in the document should be reviewed and adapted in Coventry. The views of individuals with lived and living experiences of addiction should inform the development of services. The engagement exercise completed as part of this assessment showed that there were individuals and services willing to be part of the recovery agenda in Coventry. Any development of recovery services should ensure that interventions address the needs of those from minoritised groups.

HIDDEN HARM

AREA			OUTCOME FRAMEWORK AREA					

RECOMMENDATION NUMBER: 7

TITLE: To review the local response to the 'hidden harms' caused by adverse childhood experiences, such as parents with a drug or alcohol issue.

	There is no joint protocol between Children's Social Care and specialist substance misuse services in Coventry.
	In Coventry, stronger governance structures regarding parental drug and alcohol use can help inform: • How alcohol and drug treatment services can be part of local safeguarding arrangements • Data and information-sharing arrangements • A focus on early help and prevention for families affected by parental alcohol and drug use • A clear process for reporting and dealing with safeguarding concerns • A commitment to joint training between substance misuse and social services • A commitment to information–sharing by practitioners • A commitment to helping services to evaluate their practice and share good practice
	Compared to the Nearest Neighbours, the number of parents in treatment as a rate of the projected number of children affected by parental alcohol/substance misuse is low. In addition, the number of parents entering treatment has decreased. The school survey highlighted the difficulties in engaging parents with services, with little or no consequences for lack of engagement.
	The analysis completed indicates a potential unmet need for identifying parents with drug or alcohol needs. There is also likely to be an unmet need relating to children negatively impacted by parental dependence on alcohol and drugs. Parents' dependence on alcohol and drug use can negatively impact children's physical and emotional wellbeing, development, and safety. The impacts on children include[14]: • physical maltreatment and neglect • poor physical and mental health • development of health-harming behaviours in later life, for example, using alcohol and drugs at an early age, which predicts more entrenched future use • poor school attendance due to inappropriate caring responsibilities • low educational attainment

[14] Safeguarding children affected by parental alcohol and drug use

	• involvement in anti-social or criminal behaviour It is expected that the same factors are present in Coventry.
	Data from Children's Social Care assessments were analysed. Alcohol misuse relating to the child is less common than alcohol misuse for the parent. Drug misuse relating to the child appears to be less of an issue than drug misuse for the parent.
	In Coventry, "Alcohol misuse: concerns about parent" was identified in almost one-fifth of children's social care assessments, a higher rate than comparable areas and the England average. The high proportion of those with alcohol concerns identifies a need. The high identification rates could also indicate that social care practitioners know the signs of alcohol abuse. However, the low rates of parents engaged in treatment (see above) could indicate that the pathway between children's social care and treatment services needs to be developed. The "Drug misuse: concerns about parent" data shows a similar picture (identified in 17.5% of children's social care assessments). Again, this relatively high rate could indicate that social care practitioners are aware of the signs of drug abuse but that the treatment pathway for those identified should be developed.
	Coventry's response to identifying 'hidden harm' and providing interventions to children and young people impacted by parental drug and alcohol use should be reviewed. More should be done to identify parents misusing drugs or alcohol and encourage them to engage with services. The review should include an investigation of the response of children's social care services to children and families impacted by drug and alcohol use.

THE WIDER HEALTH IMPACTS OF ALCOHOL

RECOMMENDATIONS

AREA			OUTCOME FRAMEWORK AREA					

RECOMMENDATION NUMBER: 8

TITLE: To complete an evaluation on alcohol-related hospital admissions and discharges.

Coventry has high rates of hospital admission episodes for alcohol-related conditions, particularly CVD.

Looking specifically at rates for admission episodes for alcohol-related conditions, Coventry ranks as one of the highest areas when compared to the Nearest Neighbours.

Compared to the Nearest Neighbours, Coventry ranks in the top quartile for alcohol-related cardiovascular disease and mental and behavioural disorders due to the use of alcohol.

Whilst nationally and for the NN, the rate for admissions due to mental and behavioural disorders due to the use of alcohol has seen a decrease when comparing 2020-21 against the previous year, Coventry has seen a slight increase.

The rates for admission episodes for alcoholic liver disease are higher than the national average and the NN average. The longer-term trend shows that in 2018-19, the rate in Coventry was below the NN average; however, the rate in 2020-21 is now greater.

Hospital admissions related to alcohol use indicate opportunities to improve the response to prevention in Coventry. The high rates indicate that individuals are not being identified at an early enough point.

Alcohol-related hospital admissions also have a high-cost implication for all partners, including NHS Trusts.

Coventry has relatively high rates for alcohol-related mortality, however the rates for mortality related to alcoholic liver disease are similar to nearest neighbours. The reasons for this are not known.

To complete an evaluation on alcohol-related hospital admissions and discharges to understand more fully the reasons for admission and opportunities to reduce admissions.

The current focus on the partnership approach to drug and alcohol needs is an opportunity to refresh the aims of all partners regarding identifying opportunities to reduce alcohol-related harm and set appropriate strategic aims.

THE WIDER HEALTH IMPACTS OF DRUGS

RECOMMENDATIONS

AREA			OUTCOME FRAMEWORK AREA					

RECOMMENDATION NUMBER: 9

TITLE: To further investigate drug-related deaths to develop strategies and approaches that reduce deaths.

	A decrease in drug-related deaths. Coventry has seen a decrease in drug-related deaths. This is against the trend exhibited Nationally and by the Nearest Neighbours. In addition, the rate per 100,000 population is low.
	Detailed analysis of the drug-related deaths in Coventry was not available. It is not possible to draw conclusions and recommendations from the currently available data.
	The reasons behind drug-related deaths in Coventry should be investigated in more detail to increase knowledge of the drivers behind mortality and inform future planning activity.

SERVICE PROVISION - MENTAL HEALTH

RECOMMENDATIONS

AREA		OUTCOME FRAMEWORK AREA					

RECOMMENDATION NUMBER: 10

TITLE: To use the mental health transformation project to improve responses to the mental health needs of those with a drug or alcohol need.

	There are opportunities for better joint working between mental health and specialist substance misuse teams regarding treating patients with dual mental health and drug or alcohol needs. Feedback from drug and alcohol practitioners was that patients could be discharged from mental health services if they were not stable in their use of drugs or alcohol. This was also a recurring theme in the Dual Diagnosis Operational group.
	There are strong links between substance misuse and poor mental health. For some people, taking drugs can lead to long-term mental health problems or people with a mental health diagnosis may use drugs to help cope with the symptoms.[15] Release from mental health services can mean that a patient's mental health and trauma needs are unmet, which can impact their use of drugs and alcohol. Drug and alcohol practitioners can work with patients with complex mental health and trauma needs without appropriate training.
	There are high mental health and trauma needs of those with a drug or alcohol dependence. Drug and alcohol practitioners highlighted that they see a high number of patients who have experienced significant traumatic events. This was sometimes given as a reason for using drugs and alcohol to risky/ dangerous levels.
	Trauma (physical, sexual or psychological) and mental ill-health are the drivers and accompaniment of much addiction. Patients who use drugs or alcohol as a coping strategy may require a joined-up approach between mental health and substance misuse practitioners. In Coventry, there were some examples of good joint working between specialist drug and alcohol services and the Caludon Centre.
	The mental health and emotional wellbeing needs of those with a drug or alcohol problem should be part of the mental health transformation work. Opportunities for closer joint working between mental health services and specialist drug and or alcohol services should be explored. Any recommendations in the NHS England/ DHSC Action Plan concerning the mental health care of individuals with drug or alcohol dependence should also be followed.

[15] Mental Health Foundation, Drugs and mental health

SERVICE PROVISION – ACUTE HEALTHCARE

RECOMMENDATIONS

AREA			OUTCOME FRAMEWORK AREA					

RECOMMENDATION NUMBER: 11

TITLE: To review the clinical treatment of opiate users in hospitals to identify improvements to the pathway.

	People who use illicit opioids are more likely to be admitted to hospital than people of the same age in the general population. Many admissions end in a discharge against medical advice, associated with readmission and all-cause mortality. Opioid withdrawal contributes to premature discharge.[16]
	Local data on the management of opioid withdrawal was not available for this needs assessment. However, anecdotal examples were provided of individuals choosing not to seek healthcare interventions because they believed they would not have access to opiate treatment while in hospital.
	There should be a review of the opiate prescribing practices within acute care settings in Coventry. The review should include an investigation of current prescribing practices' impact on patients with opioid addiction.

KEY FINDINGS

	One of the Alcohol Care Team (ACT) aims is to facilitate integrated alcohol care between secondary, primary and community care providers.[17] One of the core service components of the ACT is the planning of safe discharge, including referrals to community services.
	Due to several reasons, those receiving a detox with the ACT do not always engage with community treatment services. This could be related to a delay in referrals being made, the patient choosing not to engage with services, and delays in the treatment service contacting the patient.
	The ACT is a five-day-a-week service. Other services (Optimal Alcohol Care Teams) run a seven-day-a-week service (e.g. in Sandwell and Birmingham).
	Data from the ACT team was not available for inclusion in this document.

[16] Harris, M., Holland, A., Lewer, D. et al. Barriers to management of opioid withdrawal in hospitals in England: a document analysis of hospital policies on the management of substance dependence. BMC Med 20, 151 (2022). https://doi.org/10.1186/s12916-022-02351-y

[17] PHE, (2019), Alcohol Care Teams: Core Service Descriptor

	Anecdotally, it was estimated that 60 to 70% of individuals seen by the ACT were not known to specialist drug and alcohol services.
	While anecdotal, this information illustrates the unmet (treatment) need of individuals drinking to dependent levels.

SERVICE PROVISION - PRISONS

RECOMMENDATIONS

AREA			OUTCOME FRAMEWORK AREA					

RECOMMENDATION NUMBER: 12

TITLE: To review the continuity of care between prison and community to ensure greater engagement in treatment services for those released from prison.

	The continuity of care between prison and the community can be improved. Looking at all releases, only 16% of those continuing substance misuse treatment on release from prison attended their appointment at a community team within three weeks of release.
	In Coventry, low proportions of individuals continue with their drug or alcohol treatment after their release from prison. Lack of engagement with treatment services reduces the risks associated with drug use upon release from prison and is one of the tools to help drug users move away from the cycle of incarceration. Opiate and crack users drive nearly half of all acquisitive crimes and homicides.[18] Engaging with treatment services increases the likelihood that individuals will achieve and maintain recovery from their addictions.
	Several services work with individuals being released from prison. One example highlighted in this needs assessment is the NHS RECONNECT service which will commence in the West Midlands in the next 12 months. NHS RECONNECT services provide continuity of care to individuals with an identified health need between prison and the community.
	The RECONNECT service is one of the services available to individuals approaching release from prison to improve continuity of care. RECONNECT services aim to improve the wellbeing of people leaving prison, reduce inequalities and address health-related drivers of offending behaviours. Whilst not a clinical service, RECONNECT offers liaison, advocacy, signposting, and support to facilitate engagement with community-based health and support services.
	There should be a review of the pathways between prison and the community. The review should look at engaging the maximum number of those with a drug or alcohol need in treatment services upon release from prison. The review should address the difficulties of coordinating the responses of all services that work with offenders and former offenders. Feedback from those with lived experience should form part of the review to understand the barriers to treatment services for individuals leaving prison. The review should also consider the wider criminal justice pathway, including diversionary tools to reduce the number of individuals sent to prison and access to specific drug and alcohol provisions in courts.

[18] DCB

SERVICE PROVISION – TREATMENT SERVICES

RECOMMENDATIONS

AREA			OUTCOME FRAMEWORK AREA					

RECOMMENDATION NUMBER: 13

TITLE: To review treatment services to explore the potential for expansion and collaborative working.

	There has been an increased demand for children and young person services. Positive Choices referrals have increased by 50% between 2020-21 and 2021-22. Feedback from practitioners highlighted the complex needs that those referred to Positive Choices have.
	The increase in the demand for Positive Choices has several impacts. Firstly, waiting times for interventions are increasing, meaning that vulnerable young people can have long periods without help with their needs. Secondly, the increase in demand places increasing pressure on staff members, whose caseloads have increased and are now at maximum capacity.
	Several issues relating to the specialist drug and alcohol workforce were raised as part of the practitioner engagement. Nationally, it has been recognised that the drug treatment and recovery workforce has deteriorated significantly in "quantity, quality and morale" in recent years.[19]
	Practitioners from specialist services fed back that they are working with large caseloads of individuals, impacting the quality of interventions they can provide. Other areas of concern, such as a lack of experience working with individuals suffering from addiction and staff pay levels, were also raised.
	To review and explore the potential for expanding young people and adult services. The review should include the service model, collaborative working opportunities, and referral pathways into the service. The review should cover the accessibility and availability of services to ensure they are available to all sections of the community. The review should also listen to the views of the specialist drug and alcohol workforce regarding service development and consider any workforce development guidance that emerges from the Government's ten-year Drug Plan.

[19] DCB

SERVICE PROVISION – TIER FOUR SERVICES

RECOMMENDATIONS

AREA			OUTCOME FRAMEWORK AREA					

RECOMMENDATION NUMBER: 14

TITLE: To develop a strategy to increase the use of tier 4 services in Coventry.

	**More individuals should be using tier 4 services.** Nationally, there is a target for all local authorities to have 2% of their treatment population complete rehabilitation by 2025. This is the equivalent of c.40 individuals. In 2020-21, 18 individuals successfully completed rehabilitation.
	In Coventry, practitioners believed that there were some challenges associated with getting individuals to apply for residential rehabilitation places.
	A plan should be developed that aims to increase the use of tier 4 services. The plan should include a review of the pathway into residential rehabilitation to ensure that the numbers entering rehabilitation are maximised.

STAKEHOLDER ENGAGEMENT

RECOMMENDATION

AREA			OUTCOME FRAMEWORK AREA					
								

RECOMMENDATION NUMBER: 15

TITLE: To develop an ongoing programme of engagement with communities to inform service development and delivery.

	As part of this needs assessment, a survey was run asking for the views of the wider population of Coventry on alcohol and drug-related topics. The survey received a low response rate.
	Some technical issues on the Let's Talk Coventry consultation hub can partially explain the low response rate.
	A full stakeholder engagement was completed as part of this needs assessment. Comprehensive one-to-one interviews were completed with key stakeholders across Coventry. Focus groups were completed with staff from several key areas, including adult social care, health and wellbeing services, and treatment services. Surveys were completed with practitioners, the wider community, and specialist surveys for GPs and schools. Focus groups were completed with specialist drug and alcohol service users in Coventry, CGL and Positive Choices.
	The engagement provided the needs assessment with additional information that would not have been otherwise available through quantitative data sources. The findings from the engagement have been included throughout the document.
	The practitioner surveys allowed practitioners to provide their views on various areas. The results showed that there are areas where practitioners think needs are not being met.
	While the results are not a definitive guide to unmet needs, they provide a general guide to areas that may require further exploration. It may be worth considering building the re-running of the practitioner survey into the Partnership Board's activity to monitor the impact of any actions on front-line practitioners.
	This needs assessment included various engagement exercises. These have proved invaluable in providing information that was otherwise not collected. There is an opportunity to develop a programme of engagement that can inform the development of treatment and recovery services.

THE TREATMENT SYSTEM

KEY FINDINGS

Individuals in treatment achieve various positive outcomes with housing, health improvements, and harm reduction. The following information is based on an analysis of National Treatment Drug Monitoring System data relating to those starting treatment, those in treatment, and those completing treatment.

	YOUNG PEOPLE
	There has been a significant decrease in the number of Young People in-treatment.
	Commissioners and the service provider are aware of the reduction of young people in (tier 3) treatment. There has been a drive from the young person's service to provide earlier preventative interventions for all those on their caseloads. Positive Choices offer services across various risky behaviours, including drug and alcohol use. Most of the young people the service sees require preventative drug and alcohol interventions. Preventative work may have impacted the numbers requiring a structured treatment intervention.
	Across all substance type groups, the number and rate of new presentations who live with children under 18 decreased in 2021-22 compared to previous years.
	Reducing the number of individuals presenting to treatment services may reduce the number of children and young people falling into the 'hidden harm' cohort.
	The Youth Offending Service saw a decrease in its referrals to Positive Choices. This is despite drug offences being the most common offence type for community resolutions within the YOS.
	Feedback from YOS practitioners for the reduction in referrals was related to the following: • The young person not consenting to a referral. (Potentially due to a Positive Choices worker not being on-site in the YOS). • The substance misuse needs are a secondary need, e.g. a symptom of their mental health/ emotional wellbeing needs.
	PROPORTION IN-TREATMENT
	In Coventry, 13% of the expected alcohol-dependent adults were in treatment during 2021-22, lower than the 20% reported nationally. The estimated unmet need in Coventry has increased from 84% in 2020-21 to 87% in 2021-22.
	A high number of the alcohol-dependent population are not accessing treatment, which potentially means their risks are not being met. Having a lower rate than England would indicate that there are gaps in effective identification.
	In Coventry, 53% of the expected opiate users were in treatment during 2021-22, the same as the rate reported nationally. The estimated unmet need in Coventry has decreased from the 51% in 2018-19 and 2019-20.
	In Coventry, 61% of the expected crack users were in treatment during 2021-22, higher than the 42% reported nationally. The estimated unmet need in Coventry has decreased from 48% in 2018-19 to 39% in 2021-22.

	In Coventry, 54% of the expected opiates and/or crack users were in treatment during 2021-22, higher than the 46% reported nationally. The estimated unmet need in Coventry has decreased from the 50% in 2018-19 and 2019-20.
	The estimated unmet need figures should be used as a guide to inform treatment penetration. The figures should be used alongside other findings to inform how successfully individuals are being identified and engaged in treatment.
	NEW PRESENTATIONS
	The needs assessment included a detailed analysis of new presentations to treatment. For example, the largest source of referrals is from self, family and friends. In 2021-22, this group accounted for 75% of the total referrals and was similar to the previous years.
	DEMOGRAPHICS
	The needs assessment included a detailed analysis of the demographics of those in treatment. For example, 4-5% of new presentations in 2021-22 were recorded on NDTMS as gay/lesbian and bisexual. This rate is slightly higher than in previous years due mainly to a reduction in "not stated".
	IN TREATMENT
	The needs assessment included a detailed analysis of the demographics of those in treatment. For example, females accounted for 33% of those in treatment during 2021-22. This is up from 29% in 2018-19.
	SUCCESSFUL COMPLETIONS
	The needs assessment included a detailed analysis of the demographics of those in treatment. For example, excluding opiate users, successful completions as a proportion of all in treatment has decreased since 2018-19.
	The findings from the needs assessment are useful for forming part of the drug and alcohol-related evidence base in Coventry.

THE WIDER PICTURE – POLICE

RECOMMENDATIONS

AREA		OUTCOME FRAMEWORK AREA					

RECOMMENDATION NUMBER: 16

TITLE: To investigate increases in drug and alcohol-related recorded crimes to inform future planning.

	There have been increases in alcohol-related crimes. Based on the data provided for this Needs Assessment, for the 12 months to June 2022, a total of 4837 offences were recorded with an alcohol marker. There have been significant increases in three years' worth of police data. Incidents have increased from 2040 in 2020 to 4837 in 2022.
	The increase in alcohol-related crimes will impact a wide range of areas in Coventry, including residents' quality of life, demand for police resources, and treatment services. It is unknown if the increase in alcohol-related recorded crime is fully reflective of the true picture in Coventry or a result of changes in how data is recorded.
	There have been increases in drug-related crimes. 2726 drug-marked offences in Coventry were recorded for the 12 months to June 2022. This represents a 44% increase from the previous year and a 130% increase from the recorded number two years ago.
	The Crime Survey for England and Wales found that victims of any crime, including fraud (13.2%) in the last year, were more likely to have used any drug compared with people that were not a victim of crime (8.3%).[20] This highlights a potential drug and alcohol need among the victims of crime in addition to perpetrators. Similar to alcohol-related crimes, it is not known if the increase in crimes is a true reflection of the picture in Coventry.
	Drug and alcohol-related crimes impact many areas in Coventry; however, it is not known if this reflects the true picture in Coventry. The reasons for the increased number of drug and alcohol-tagged offences should be further explored as a true picture is required to reflect future planning.

KEY FINDINGS

	The needs assessment included a detailed analysis of drug and alcohol-flagged crime patterns in Coventry. For example:

[20] ONS, (2022), Drug misuse in England and Wales: year ending March 2020

	Violence without injury, violence with injury, stalking and harassment, criminal damage, and public fear are the five offence types that account for 82% of alcohol-flagged crimes.
	The findings from the needs assessment are useful for forming part of the drug and alcohol-related evidence base in Coventry.
	West Midlands Police are leading on the regional approach to County Lines. Since 2018, West Midlands Police have implemented a partnership approach to combatting County Lines.
	Data on County Lines was not provided for this needs assessment. It should be ensured that individuals arrested by the police as part of their County Lines approach are given appropriate help regarding drug and alcohol needs.

THE WIDER PICTURE – ANTI-SOCIAL BEHAVIOUR

KEY FINDINGS

	The needs assessment included a detailed analysis of drug and alcohol-flagged ASB incidents from the police. For example, alcohol and drug-flagged ASB incidents are down from the previous year.
	In completing this needs assessment, full ASB data could not be provided due to how the information is captured in Coventry. Only needle-find data was provided, and we found that reports of needles have decreased year-on-year. It was also found that St Michael's Ward accounts for 45% of the total amount of needles collected.
	Data collected by ASB teams can provide evidence in addition to that collected by the police regarding drug and alcohol-related activity. This information is not available in Coventry. It would be useful for the ASB team to work jointly with the Drug and Alcohol Partnership Board to discuss how their data collection may be developed to help inform the Partnership's goals.

THE WIDER PICTURE – LICENSING

RECOMMENDATIONS

AREA			OUTCOME FRAMEWORK AREA					

RECOMMENDATION NUMBER: 17

TITLE: To develop joint working between Licensing and Trading Standards and the Partnership Board.

	In Coventry, the Licensing team work closely with licensed premises regarding the responsible selling of alcohol. Licensing data is being collected for use in this document.
	Licensing practitioners highlighted a desire for joint work between themselves, the police, and the Public Health Team to ensure a consistent approach to addressing alcohol and drug needs.
	There are opportunities for more joined-up working between licensing, trading standards and other partners.

THE WIDER PICTURE – HOUSING

KEY FINDINGS

There has been an increase in the number and rate of households owed a prevention or relief duty where drug or alcohol needs were identified.

146 households identified with a drug need were owed a duty in 2020; this increased to 266 in 2021.

There were 80 households identified with an alcohol need in 2020; this increased to 198 in 2021.

In 2020, the rate in Coventry was lower than the average for the Nearest Neighbours. The increase in 2021 now means the Coventry rates are higher than the Nearest Neighbours average.

For Coventry, the increases in those identified with a drug or alcohol need could result from the additional outreach work completed by the rough sleeper team. The outreach work of housing staff in temporary accommodation properties is also likely to increase the identification of those with drug and alcohol needs.

Despite this, housing practitioners still fed back that there are still unidentified drug or alcohol needs among the cohort they work with. Increasing the identification of those engaging with housing services with a drug or alcohol need should be a service goal.

THE WIDER PICTURE – WORKFORCE DEVELOPMENT

RECOMMENDATIONS

AREA			OUTCOME FRAMEWORK AREA					

RECOMMENDATION NUMBER: 18

TITLE: To develop the skills and knowledge of the wider workforce concerning drug and alcohol-related needs.

	There are opportunities to increase the knowledge and confidence of practitioners across all services regarding identifying those with drug or alcohol needs and working with them. Practitioners across several services highlighted the difficulties they faced in getting individuals to admit a drug or alcohol need and then agreeing to a referral to specialist services. Feedback from those working in front-line services indicates there is still work to be done in identifying and engaging those with a drug or alcohol need.
	The Dame Carol Black report highlights the importance of various agencies and areas concerning working with those with a drug or alcohol need. All agencies have an important role in identifying and supporting individuals in treatment and recovery.
	The partnership board should work together to identify the skills and knowledge gap regarding drug and alcohol needs among their workforce. This should lead to developing a robust and effective workforce development and training programme for staff from all partners.

THE WIDER PICTURE – DATA COLLECTION

RECOMMENDATIONS

AREA			OUTCOME FRAMEWORK AREA					
RECOMMENDATION NUMBER: 19 TITLE: To develop the availability of accurate and robust data to inform and develop the drug and alcohol strategy.								
	The needs assessment included a large scoping exercise of data sources that could help describe the drug and alcohol landscape of Coventry.							
	The needs assessment contains a detailed analysis of the data that was supplied. The needs assessment includes an audit of which partners supplied data for the needs assessment.							
	The partnership board should work together to ensure that all relevant data sources are made available to develop and inform the response to drug and alcohol needs in the city.							

Coventry City Council

NHS Coventry and Warwickshire Integrated Care Board

To: Coventry Health and Wellbeing Board **23 January 2023**

From: Peter Fahy – Director of Adult Services and Housing

Madi Parmer – Chief Finance Officer, NHS C&W ICB

Title: Adult Social Care Hospital Discharge Grant 2022/23

1 Purpose

To seek approval of the Coventry Adult Social Care Hospital Discharge Fund allocations and submissions for 2022/23.

This approval is sought retrospectively due to the DHSC submission timescales falling in advance of the required sign-off meetings and the need to make urgent progress with the grant to support the alleviation of system pressures. There is however the opportunity to reprofile or amend spend proposals as the grant period progresses.

2 Recommendations

1. Health and Wellbeing Board is asked to note the content of this report and to support the attached Discharge Fund Grant allocations for 2022/23

3 Information/Background

On 22 September 2022 the government announced a £500 million Adult Social Care Discharge Fund. On 18 November 2022 further detail on the grant allocations and conditions of use were issued via a letter from the Minister for Social Care.

The grant is to be pooled into the Better Care Funds with £300m allocated to ICBs and £200m allocated to Local Authorities.

The relative allocations from this amount are:

- Coventry City Council: £1.292m
- Warwickshire County Council: £1.862m
- Coventry and Warwickshire ICB: £6.715m

The funding will be provided in 2 tranches – the first (40%) in December 2022, and the second (60%) by the end of January 2023 for areas that have provided a planned spending report and fortnightly activity data.

The grant covers the period from 23 September 2022 to 31 March 2023 and required a completed template on usage for each Health and Well Being Board area to be submitted to the Department for Health and Social Care by 16 December 2022.

Prior to submission the template required approval from the CEO of the ICB and the City Council. Health and Well Being Board (HWBB) approval is also required but due to the timescales associated with completing the required usage template this is being sought retrospectively.

Although the funding is non-recurrent, further grant provision for 23/24 and 24/25 was announced on 17 November through the Better Care Fund to support discharge, but no detail is available yet on local allocations or the accompanying conditions.

4. Use of the Grant

The grant is expected to be used to:

'prioritise those approaches that are most effective in freeing up the maximum number of hospital beds, and reducing the bed days lost within the funding available, to the most appropriate setting from hospital, including from mental health inpatient settings. Discharge to Assess (D2A) and provision of homecare is recognised as an effective option for discharging more people in a safe and timely manner. Residential care to meet complex health and care needs may be more appropriate for people who have been waiting to be discharged for a long time boost general adult social care workforce capacity, through staff recruitment and retention, where that will help reduce delayed discharges. This could include, but is not limited to, measures such as retention bonuses or bringing forward pay rises ahead of the new financial year".

A set of appropriate schemes against the grant conditions were identified and agreed between system partners resulting in the below split of funding between HWBB areas:

Place	Allocated	Proportion
Coventry City Council Grant	1,292,552	
C&W ICB Coventry Place	2,616,241	
Total Coventry Place	**3,908,793**	**40%**
Warwickshire County Council	1,862,153	
C&W ICB Warwickshire Place	4,098,443	
Total Warwickshire Place	**5,960,596**	**60%**
Total C&W Allocation	**9,869,389**	

The joint fund is therefore fully committed for this year as proposed and the Health and Well-Being Board split is broadly in line with the notional 'fair share' allocation as calculated using NHSE's national place-based allocation tool methodology.

5. Use of the fund

For Coventry the fund will be used across the following schemes:

5.1 Securing existing discharge capacity

To support the health and care system and enable discharge from hospital both the Local Authority and the ICB has continued to purchase care packages and care home placements to meet discharge demand. This included the continuation of capacity previously funded through the Hospital Discharge Grant which ceased on 31 March 2022 plus capacity above this level.

Colleagues at DHSC have confirmed that funding committed from the date of the policy announcement on 22 September can be set against the grant until 31 March 2023. Doing this is critical as without a funding source such capacity would be withdrawn.

In addition to this Home Support discharge capacity is at risk of being unable to maintain the level of supply required over the winter. An element of the grant will be used to provide an incentive payment to pathway 1 (Discharge to Assess (D2A) capacity providers until 31 March 2023.

5.2 Funding additional packages of care

It is important that where someone is ready for discharge from hospital but requires support from social care or health to enable that discharge that there are resources in place to fund the required package of care.

It is important to not use lack of resources as a reason for a delay, not only does efficiency in discharge support the best outcome for our residents but it secures access to hospital provision for those that need it. On that basis a significant element of the grant will be to fund additional support packages over the period of the grant. This is demand dependent and not a fixed amount and should the initial allocation be reached before the end of March 2023 a process of transferring resources between schemes will take place to maximise the impact and effectiveness.

Within this additionality is extra care and support for an individual if required to enable them to return to their original care location – this could be in the form of 'bridging support' to enable a person to return to their care home or housing with care scheme and/or additional support following returning to a care home to ensure any temporary and additional needs are met.

5.3 Dealing with the practical barriers to discharge

There are several practical issues that can be a barrier to discharge largely associated with ensuring people have a liveable home to return to. Considering that when discharged from hospital people often need a period of recovery at home the practicalities like access to food, credit for gas/electricity meters etc can present a barrier to going home. Additionally, for some people who may not need any care and support following a stay in hospital returning home is not immediately viable and a short stay in bed and breakfast accommodation would be appropriate. An element of

the grant will be allocated to ensuring that the funding of ad hoc support required to facilitate a discharge is not a barrier.

Specific allocation will be made available for equipment enabling people to access this in temporary situations to support recovery, this might include a period of respite with family or in more formal settings.

5.4 Incentivising Care and Support staff

The social care market has high turnover of staff. This is a particular risk to the ability of social care services that support discharge. High levels of vacancies for care staff will reduce the ability to facilitate discharges and to mitigate this and provide an incentive for care and support staff over the grant period a voucher incentive scheme is proposed In Coventry. The detail and application of this is still being determined.

5.5 Providing additional staff resource

The provision of increasing levels of care and support and maintaining existing provision so that performance does not deteriorate is of course a legitimate and important use of the grant. However, making effective use of capacity is also critical.

The additional staffing proposals that will be progressed using the grant and rationale are:

- Integrated Discharge Team (IDT) – this is a UHCW team that support wards with ward led discharges where no or limited social care is required. Additional staff resource will reduce the time taken to achieve hospital led discharges.

- Community Discharge Team – this is the City Council adult social work team based at UHCW working extended hours including weekends. Increasing the capacity in the team, combined with the ability to source additional care where required will help reduce the duration of any delays.

- Occupational Therapy and Physiotherapy support – increasing therapy support will both reduce the length of stay in D2A services (hence creating capacity to provide a service to more people) and reduce the need to source ongoing care and support services

- Mental Health Social Work – increasing the mental health social work support available will enable individuals to be worked with more intensely to arrange a safe and effective discharge and enable further consideration of the potential for discharge to assess models.

- Community social work – increasing capacity specifically focussed on this area of activity will improve move on once in a D2A service. This will free up capacity for further discharges.

6. Contribution to meeting the aims of the ICS

Improving outcomes in population health and healthcare: The Hospital Discharge Grant as part of the BCF underpins a number of integrated schemes in delivering national planning priorities and in improvements on delivery of urgent care.

Tackling unequal outcomes, experience and access: The plan includes schemes to manage accessibility to support tackling unequal outcomes by enabling discharge.

Enhancing Productivity and value for money: An integrated approach to supporting Discharge and Acute performance/productivity with reviews to be undertaken prior to longer term investment decisions. Joint reviews with Councils have been undertaken.

Supporting the broader social and economic development of Coventry and Warwickshire: Plans include work programmes across wider partners and providers.

7. Progress so far

The DHSC have previously confirmed that spending plans could progress as soon as agreed locally and, on that basis, from the point that spend proposals were agreed on completion of the template submission required by 16 December the City Council and the ICB have been working to secure the required resources across all areas of the plan. Due to system pressures some flexibility has been exercised in usage of the grant in order to achieve the overall grant objectives of supporting discharges. These flexibilities have remained broadly within the schemes described in Section 5.

Since the use of the grant was agreed additional care home beds have been secured to support discharge over this period along with additional home support hours. Social Care supply that specifically supports discharges that was at risk over the winter period has also been secured. The availability of staff has been a limiting factor to some proposals however recruitment agencies were engaged early with some additional Occupational Therapist and Social Work capacity secured.

8. Management, Monitoring and Review

The fund will be pooled within the existing Better Care Fund on a ring-fenced basis, with funds budgeted scheme by scheme as contained within the DHSC submission template (appendix 1). All schemes are also included within master tracking workbook held by the ICB which will be used to monitor spend and impact/progress.

For schemes that are funded via the ICB allocation but not delivered by the ICB cash can be drawn down and reimbursed by the delivery organisation against each scheme as proven expenditure is incurred; this process will be managed and authorised by ICB CFO/CEO. For agreed schemes delivered by the ICB an internal fund transfer will be made as spend is incurred. Any slippage against any scheme will be held centrally at ICB level.

For schemes funded through the local authority allocation and delivered by the local authority evidence of spend and impact will be provided to the ICB. Any proposals for reallocation of funding from either the local authority or ICB elements will be jointly agreed as is normal practice for BCF related spend.

Schemes that are delivering significant benefits against the measurable KPIs and likely to overspend against the initial allocation may be considered for additional funds against slippage through a process to be managed by the ICB in conjunction with the Local Authority.

DHSC will also require fortnightly reporting in terms of effective impact against the schemes with the first template for return on 6 January 2023. The completion of the template will be managed via the ICB with the metrics associated with the fund being:

- the number of care packages purchased for care homes, domiciliary care and intermediate care (to be collected via a new template);
- the number of people discharged to their usual place of residence (existing BCF metric);
- the absolute number of people 'not meeting criteria to reside' (and who have not been discharged);
- the number of 'Bed days lost' to delayed discharge by trust (from the weekly acute
  sitrep);
- the proportion (%) of the bed base occupied by patients who do not meet the criteria to reside, by trust.

DHSC have not set overall targets for each of these metrics but will provide a picture during and after winter of the impact of the spend.

As the grant is only confirmed until 31 March 2023 schemes will be managed in a way that minimises the risk of ongoing unbudgeted services being in place beyond this date. A full assessment of recurrent costs and impact will be conducted and a prioritisation process will be undertaken to agree the prioritisation of schemes which can continue beyond 31 March 2023 subject to confirmation of grant provision for 2023/24 and 2024/25.

9. Options Considered and Recommended Proposal

Coventry Health and Well Being Board is recommended to approve the Adult Social Care Hospital Discharge Fund Plan 22/23.

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Coventry City Council

Briefing note

To: Coventry Health and Wellbeing Board **Date: 23rd January 2023**

Subject: Health and Wellbeing Board Membership

1 Purpose of the Note

1.1 The membership of the Health and Wellbeing Board needs to be reviewed following the establishment of the Integrated Care Board. This note asks the Health and Wellbeing Board to review the current constituted membership.

2 Recommendations

2.1 That Health and Wellbeing Board recommend the following to the Coventry City Council Constitution Advisory Panel

1) That the Membership of the Board be updated as outlined in Table 1

2) That the Constitution be amended to enable the Health and Wellbeing Board to approve the removal of members as well appoint additional persons as appropriate.

3 Information/Background

3.1 The Membership of the Health and Wellbeing Board requires reviewing due to the establishment of the Integrated Care Board. This amalgamates the two Coventry and Warwickshire Clinical Commissioning Group seats with the one for Coventry and Warwickshire Integrated Care System.

3.2 There are two seats - Voluntary Action Coventry (VAC) and Coventry and Rugby GP Federation which do not have nominated Members. VAC stepped down from their seat in October 2021 and there is no another organisation which represents the wider voluntary and community sector. The Coventry and Rugby GP Federation has become the Coventry and Rugby GP Alliance. Representatives of the Coventry and Rugby GP Alliance have not attended a meeting since February 2017.

3.3 To enable voluntary and community sector representation at the meetings, an appropriate organisation, based on the agenda items, will be invited to each Health and Wellbeing Board meeting.

3.4 The Cabinet Member for Adult Social Care currently sits on HWBB as a nominee of the Leader. It is suggested this seat be amended from a nominee of the Leader to the Cabinet Member for Adult Services.

3.5 This change aligns with the set up for Public Health and Children's Services whereby the Directors are statutory appointments and the Cabinet Members for Public Health and Sport and Children and Young People are allocated a HWBB seat, as the Director of Adult Services is also a statutory appointment.

3.6 Reprofiling this seat from a nominee of the Leader to Cabinet Member for Adult Services maintain the ratio of Elected Members on the HWBB.

3.7 A full list of Members and suggested recommendation is outlined below in Table 1.

3.8 The quorum is one half of the total number of members plus one member and updating the membership will help the meetings to be quorate. This must include at least one of the following; an Elected Member, Integrated Care Board representative and Local Authority Director.

3.9 The constitution also allows Members to nominate a substitute to attend the meeting providing notice of one hour prior to the meeting start time is given. This would assist in achieving a quorum.

3.10 The constitution allows the Health and Wellbeing board to appoint additional persons as appropriate to the Board. It is recommended that the Health and Wellbeing Board ask the Council to consider amending the constitution to also give the Board the ability to remove existing members where required. This will allow the Board to be responsive to changes.

4 Current Membership

4.1 The current membership is below with recommendations for the eats to be amended:

Table 1

	Position / Organisation	**How Appointed**	**Recommendation**
(a)	Leader of the Council*:	Nominated by Leader	Retain
(b)	Cabinet Member (Public Health and Sport):	Nominated by Leader	Retain
(c)	Cabinet Member (Children and Young People):	Nominated by Leader	Retain
(d)	One additional councillor nominated by the Leader:	Nominated by Leader	Update to: Cabinet Member (Adult Social Care)
(e)	Conservative Group representative:	Nominated by Leader	Retain
(g)	Director of Adult Services**	Statutory appointment	Retain
(h)	Director of Children's Services**	Statutory appointment	Retain
(i)	Director of Public Health and Wellbeing**	Statutory appointment	Retain
(j)	Coventry City Council Chief Partnerships Officer	1 Representative	Retain
(k)	Coventry Healthwatch**	2 representatives	Retain

(l)	Coventry and Warwickshire Clinical Commissioning Group:	2 representatives	Update to: Coventry and Warwickshire Integrated Care Board
(m)	NHS Commissioning Board:	1 representative	Retain
(n)	Voluntary Action Coventry:	1 representative	Remove Following VACs resignation, there is no one organisation that represents the sector. Appropriate representatives from the voluntary and community sector will be invited to Health and Wellbeing Board meetings.
(o)	Coventry University:	Vice-Chancellor (or representative)	Retain
(p)	Warwick University:	Vice-Chancellor (or representative)	Retain
(q)	West Midlands Police:	1 representative	Retain
(r)	West Midlands Fire Service:	Operations Commander Coventry	Retain
(s)	Coventry and Warwickshire Partnership Trust:	1 representative	Retain
(t)	University Hospitals Coventry and Warwickshire:	Chief Executive or representative	Retain
(u)	Coventry and Rugby GP Federation:	Chief Executive or representative	Remove
(v)	Coventry and Warwickshire Integrated Care System:	1 representative	Remove now the ICB is a formal member as at (k).

*- at least one Councillor of the Local Authority must sit on the Board
**Statutory appointments

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