Agenda

Coventry Health and Well-being Board

Time and Date
2.00 pm on Monday, 21st October, 2013

Place
Diamond Room 2 - Council House

Public Business

1. **Welcome and Apologies for Absence**

2. **Declarations of Interest**

3. **Minutes of Previous Meeting**

    (a) To agree the minutes of the meeting held on 24th June, 2013 (Pages 3 - 10)

    (b) Matters Arising

4. **Dementia Development Session Follow-up: Feedback and the Health and Well-being Board Commitment**

    The Chair, Councillor Alison Gingell will report at the meeting

5. **Health and Social Care Integration: Update and Next Steps** (Pages 11 - 12)

    Briefing note of Brian Walsh, Executive Director, People

6. **NHS Coventry and Rugby Clinical Commissioning Group Commissioning Intentions 2014-16** (Pages 13 - 30)

    Report of Clare Hollingworth, Chief Finance Officer
    Presentation by Dr Steve Allen, Accountable Officer

7. **Director of Public Health Annual Reports 2012 and 2013** (Pages 31 - 56)

    Report and presentation of Dr Jane Moore, Director of Public Health

8. **Reducing Health Inequalities: Marmot DVD**

    Introduction by Dr Jane Moore, Director of Public Health

9. **Signing of the Local Government Declaration on Tobacco Control** (Pages 57 - 62)

    The Chair, Councillor Alison Gingell will report at the meeting
    Briefing note of Alex Angus, Tobacco Control Co-ordinator

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

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

Private Business

Nil

Chris West, Executive Director, Resources, Council House Coventry

Friday, 11 October 2013

Note: The person to contact about the agenda and documents for this meeting is Liz Knight

Membership: S Allen, S Banbury, A Canale-Parola, G Daly, G Duggins, A Gingell (Chair), S Kumar, R Light, A Lucas, J Moore, A Nicholson, H Noonan, S Price, D Spurgeon, S Taylor, S Thomas and B Walsh

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

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

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e-mail: liz.knight@coventry.gov.uk

Minutes of the meeting of the Coventry Health and Well-being Board held at 2.00 p.m. on 24th June, 2013

Present:

Board Members: Councillor Gingell (Chair)
Councillor Duggins
Councillor Taylor (substitute for Councillor Noonan)
Councillor Thomas
Colin Green, Director of Children, Learning and Young People
Jane Moore, Director of Public Health
Brain Walsh, Director of Community Services
Dr Steve Allen, Coventry and Rugby CCG
Stephen Banbury, Voluntary Action Coventry
Professor Howard Davis, Coventry University
Ruth Light, Coventry Healthwatch
Andy Nicholson, West Midlands Police
Sue Price, NHS Commissioning
David Spurgeon, Coventry Healthwatch
Steve Taylor, West Midlands Fire Service

Employees (by Directorate):

Chief Executive's: R Tennant

Community Services: S Brake, C Parker

Customer & Workforce Services: L Knight

Apologies: Councillor Noonan
Dr Adrian Canale-Parola, Coventry and Rugby CCG
Professor Sudesh Kumar, Warwick University

Public business

1. **Welcome**

The Chair, Councillor Gingell, welcomed members to the first meeting of the Coventry Health and Well-being Board. She placed on record her thanks to members of the former Shadow Board and in particular to Councillor Jim O'Boyle, the Chair of the Shadow Board

2. **Declarations of Interest**

There were no declarations of interest.

3. **Minutes**

The minutes of the meeting of the Coventry Shadow Health and Well-being Board held on 11th March, 2013 were signed as a true record. In relation to Minute 33 headed 'Clinical Commissioning Group – Plan on a Page' it was clarified that the CCG Operating Plan for 2013-14 had been completed by 31st March, 2013. Further to Minute 34 headed 'Health and Well-being Strategy – Implementation and Monitoring' a request was made for a copy of the finalised strategy to be

circulated to all members.

RESOLVED that copies of the CCG Operating Plan for 2013-14 and the Health and Well-being Strategy be circulated to all members of the Board.

4. **Meeting the Challenges of the Francis Report: Quality in Local Health and Social Care Services**

Further to Minute 41/12 of the Shadow Health and Well-being Board, the Board noted reports from a number of local Health providers on their actions taken in response to the recommendations contained in the report by Robert Francis QC on the Failings at Mid Staffordshire Hospital. The Chair, Councillor Gingell informed that what action local providers take around quality would be monitored by the City Council's Health Overview and Scrutiny Committee.

a) Coventry and Rugby Clinical Commissioning Group (CCG)

The Francis report highlighted several recommendations that were applicable to CCGs as commissioners of health care. The report from the CCG listed the key actions being undertaken and also included a more detailed current position statement. The Board noted that a CCG Board development session had been arranged for Board Members and the Senior Management Team on 1st July to discuss the recommendations in more detail and produce an action plan of key gaps. Additionally an assurance framework that outlined CCG meetings with all commissioned services for the assessment of quality and safety of services was being developed.

Dr Allen drew attention to the emphasis that was placed on continually talking with both staff and patients to hear their views.

b) National Health Service (NHS) England Local Area Team

Sue Price, National Health Service Commissioning Board Area Team provided an update on the response from the Local Area Team to the recommendations of the Francis report.

She referred to the development of a new plan with the priority for putting patients first and to the introduction of an 11 point score card. The importance of working alongside the CCG was highlighted, there was a sharing of quality measuring and this was managed with as little duplication as possible.

An excellent quality assurance framework had been developed for local GPs and it was intended to use this to develop frameworks for other health services. Much activity was taking place and the Team were awaiting the appointment of the Chief Inspector of GPs who would also have responsibility for monitoring quality. Members questioned the cross cutting roles for measuring and monitoring quality and it was suggested that an annual report on quality be submitted to the Health and Well-being Board which would provide clarification and an overview of the whole system.

c) Monitoring and Improving Quality in Adult Social Care

The report of Brain Walsh, Director of Community Services, indicated that Adult Social Care currently supported approximately 8500 residents in Coventry with a range of services. The service was committed to the delivery of personalisation where care and support was tailored around individuals specific support requirements and the outcomes they wanted to achieve. In relation to commissioning services, quality standards were defined through the commissioning service and set out within contracts. There was a move towards outcome based contracts to help meet individuals' requirements and the importance of monitoring contracts and the use of action plans were highlighted. Reference was made to the roles of the Coventry Safeguarding Adults Board, the Council's Health and Social Care Scrutiny Board (5), the Care Quality Commission and Healthwatch Coventry and to arrangements for reporting performance.

d) Monitoring and Improving Quality in Children's Services

The report of Colin Green, Director of Children, Learning and Young People indicated that the Children, Learning and People's Service delivered services directly to families and children through a range of services. The Directorate also commissioned services for children and their families. Arising from the Francis report, in March 2013 there was a peer review of all agencies involved in Safeguarding in the city and this review and the auditing of casework prompted a refresh of the approach to planning and auditing of cases to ensure that cases were being progressed promptly and that outcomes were being identified and achieved. Reference was made to Ofsted inspections and to the role of the Children and Young People Scrutiny Board (2). There was a strong thread of multi-agency support for quality which included the work of the Local Safeguarding Board and the Joint Commissioning Board. The arrangements for reporting performance and monitoring quality in casework were set out.

e) Monitoring and Improving Quality in Health and Social Care: Public Health Services

The report of Jane Moore, Director of Public Health indicated that Public Health had two key areas of responsibility around quality, ensuring that public health commissioned services were safe and high quality and providing leadership for the public health system within their local area.

The public health commissioned services were set out and the processes in place to monitor the quality of public health services were detailed. Although the Francis report did not explicitly refer to public health services, many of the findings and its recommendations were applicable. These included the need to share data about quality organisations, the importance of having an open culture and being open to criticism, the need to put in place fundamental, enhanced and developmental standards to drive up quality and putting patient and service users' experience at the heart of services. Reference was made to the mechanisms being developed for reporting and escalating quality issues in public health and related Council services and to the key priorities for the next twelve months.

The Board questioned the officer on the issue of adequate resources and how to capture data from people's individual experiences.

RESOLVED that:

(i) Following the consideration of what the Francis report and quality means to local trusts by the Health and Social Care Scrutiny Board (5) at their meeting on 25th September, any findings be circulate to all members of the Health and Well-being Board.

(ii) An annual report on Quality be submitted to a future Board meeting.

5. **New Governance and Delivery Arrangements for the Health and Well-being Board**

The Board considered a report of Ruth Tennant, Deputy Director of Public Health which provided an update on changes to membership and outlined new delivery arrangements for the Board's work. From 1st April, 2013 the Health and Well-being Board had become a statutory Committee of the City Council.

Membership of the new Board and the meeting schedule of three meetings a year were agreed at the Annual Meeting of the City Council on 16th May, 2013. Membership details were set out in the report. It was the intention that other organisations including NHS providers would be invited to meetings as required.

In view of the wide remit of the Board and the need to maintain good working relations with a range of other key stakeholder Boards, a strong delivery structure was required. It was proposed to establish a new Delivery Board to oversee the delivery of the Health and Well-being Board's programme and to consider development sessions on specific topics. Membership was set out. It was intended that the Delivery Board would meet as required. An officer support group had also been set up to provide cross-agency support for both the Board and Delivery Group. It was intended that Task and Finish or Steering Groups be set up for specific areas of work. Reference was made to the work of the Marmot Steering Group. Structures would be reviewed after a year to ensure that they were fit for purpose. Further information was provided on future relationships with other key partners and the Council's Health Overview and Scrutiny Committee.

The report highlighted the issue of voting rights. The 2013 Regulations provided that all members of the Board, whether co-opted or elected members had voting rights unless the Council directed otherwise having first consulted with the Board. Members of the Board would be subject to the Standard provisions of the Localism Act 2011 if they had voting rights.

Members discussed the relationship between the Board and the new Delivery Board; the problems associated with the potential amount of business for this Board; and the role of voluntary sector representatives in the new structure. A question was asked about how national reports would feed into the Board giving the example of a recent article on the estimated numbers of women affected by perinatal mental illnesses in England each year. It was clarified that the arrangements would be monitored and reviewed and that it might be necessary to circulate reports to Board members in between the scheduled meetings. It was suggested that the Delivery Board be referred to as the Deliver Group rather than a Board. It was felt appropriate for all members to be able to exercise a vote at meetings, although it was not anticipated that this situation would occur very often. A request was made for new members to be given some initial support to help

them with their understanding of the work of the Board.

RESOLVED that:

(i) The changes to membership be noted and the new delivery arrangements be endorsed.

(ii) Agreement be given to review membership and delivery arrangements in a year's time to ensure that they continue to be fit for purpose.

(iii) All members of the Board to have voting rights.

6. **Measuring Progress Against the Health and Well-being Board and Marmot Priorities**

The Board considered a report of Jane Moore, Director of Public Health which provided an overview of the indicator set and work programme that had been developed to monitor and improve progress against both the Health and Well-being Board priorities as well as the Marmot work programme.

The report referred to the Marmot Steering Group formed in March, 2013 to act as the central vehicle for ensuring that Coventry maximised the life opportunities for the residents of Coventry.

Appendices to the report set out an inequality key indicator set for the Health and Well-being Board along with the national marmot indicators which compared Coventry's performance with that of the West Midlands and England.

During the development of the Marmot indicators, Directorates across the City Council had been reviewing their contributions to improve life chances for the people of Coventry. The indicators had all been assigned a lead organisation or Directorate. The report detailed the key areas of work and the ownership of indicators across the Council and the Coventry and Rugby CCG.

Reference was made to the support for the Marmot agenda from Voluntary Action Coventry.

The next steps included the National Marmot Team reviewing Coventry's contribution to the Marmot agenda and providing expertise around measuring inequalities in the city over the next two years. Further work was to be done to establish a reporting structure and a way in which performance against the indicators could be presented.

RESOLVED that the approach that has been taken so far in identifying indicators to measure progress against the Health and Well-being Board and Marmot priorities be endorsed.

7. **Physical Inactivity and Sedentary Lifestyles: The Coventry System Leadership Challenge**

The Board considered a joint report of Jane Moore, Director of Public Health and Sarah Smith, Specialist Registrar in Public Health which provided an update on work that was taking place to reduce physical inactivity and sedentary lifestyles.

Funding had recently been secured from The Department of Health for a Coventry Systems Leadership Exemplar Project. Physical Activity and Sedentary Lifestyles was chosen as the return of public health to local government meant that there was renewed opportunity to develop a systemic approach to this issue, rather than leaving the focus on the responsibility of the individual. Information was provided on the levels of physical inactivity in the city from information taken from the Coventry Household Survey, 2012.

Reference was made to the work undertaken to identify new approaches to bring about population change in levels of physical inactivity and sedentary behaviour in the city. There was a consensus of the need to establish a new social norm in the city around regular health – enhancing physical activity for everyone regardless of age and body weight. It was the intention to have an early focus on major summer events in the city (Godiva Festival and Godiva Returns). The objectives of the project were set out along with the following five complimentary work streams:

(i) A social movement for change by building leadership and capacity with agencies and citizens to achieve change
(ii) Understanding and targeting high risk populations with the most to gain (using the household survey data)
(iii) Partnering with local GPs to develop a physical activity offer initially for patients included on primary care hypertension registers with a view to this being offered to all patients on the practice list.
(iv) A workplace 'responsibility deal' around physical inactivity and sedentary behaviour building on the Coventry and Warwickshire Workplace Charter. The aim was to start with the major employers in the city but to encourage all employers to pursue the charter commitment to physical activity.
(v) Encouraging the development of social enterprise to support and sustain behaviour change in terms of physical activity and sedentary lifestyles in workplaces and in communities.

Members of the Board expressed support for the project.

RESOLVED that:

(i) The objectives and key workstreams of the project be noted

(ii) A review of progress with the project be submitted to the next Board meeting in October.

8. **Coventry and Rugby Clinical Group Prospectus**

The Board noted the Coventry and Rugby Clinical Commissioning Group (CCG) Prospectus for 2013-14 which aimed to explain the role of the CCG and how the Group was working on behalf of the local residents to improve local health services. The document had been produced in a user friendly manner for the benefit of local people.

The CCG's vision and values were set out along with challenges and priorities for improving the health and well-being of the community. How the CCG would ensure value for money and high quality care and provide the best possible patient experience were also outlined. Opportunities for patient involvement and becoming a health champion were detailed.

Members of the Board expressed support for the prospectus.

9. **Joint Social Care and Health (Section 256) Grant Proposal for 2013-14**

The Board noted a joint report of the Coventry and Rugby CCG, the NHS Commissioning Board Area Team and Coventry City Council informing the Board how the City Council was planning to use the monies transferred under joint social care and health monies for 2013/14. A copy of the letter advising of the arrangements from Shaun Gallagher, Department of Health Director General, Social Care, Local Government and Care Partnerships was set out at an appendix to the report.

Coventry was to receive £5,551,509 for 2013/14. The Department of Health had specified that this funding must be used to support adult social care services in each local authority, which also had a health benefit and considered that Health and Well-being Boards were the natural place for discussions between the Boards, CCGs and local authorities on how funding should be spent. The role of the NHS Commissioning Board was also outlined in the report.

It was proposed that the monies for Coventry was transferred to the local authority under an NHS Act (2006) S 256 agreement and that expenditure was committed in line with existing priorities, those outlined in the Joint Strategic Needs Assessment of the Board and the Health and Well-being Strategy and was monitored by the Adult Commissioning Board. This Board would monitor expenditure regularly in order to ensure that it demonstrated an improvement in the support to adult social care services in Coventry and that it would make a positive difference to social care services and outcomes for service users across the city. The Board were informed that they would receive an annual report from the Adult Commissioning Board describing the expenditure and outcomes. This report would also be submitted to the CCG Board, the City Council and the NHS England Area Team. The S256 agreement would be the subject of audit by the relevant organisational Audit Committees.

10. **Disabled Children's Charter**

The Board gave consideration to signing up to the Disabled Children's Charter produced for Health and Well-being Boards to show their commitment and support to disabled children, young people and their families. It encouraged Boards to work in partnership with these children, young people and their families to improve universal and specialised services, ensuring they received the support they needed, when they needed it and were supported to fulfil their potential.

RESOLVED that:

(i) The Board give approval for the Chair, Councillor Gingell to sign the Charter on behalf of the Board.

(ii) A progress report be submitted to the Board in twelve months.

11. **Any Other Public Business – Letter to Chairs of Health and Well-being Boards**

Sue Price, National Health Service Commissioning Board Area Team drew attention to a letter that had been sent to the Chairs of Health and Well-being Boards from Norman Lamb MP, Minister of State for Care and Support, which highlighted the pivotal local leadership role that Health and Well-being Boards could play in delivering the commitments made in the Winterbourne View Concordat. This represented a commitment from over 50 organisations to reform how care was provided to people with learning disabilities or autism who also had mental health conditions or behaviours viewed as challenging.

(Meeting closed at: 3.55 p.m.)

Briefing note

To Health and Wellbeing Board Date: 21st October 2013

Subject: Progressing Integration

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1 Purpose of the Note

1.1 To report on the progress of the integration workstream, and agree the reporting mechanisms to the Health and Wellbeing Board (HWB).

2 Recommendations

2.1 Agree membership (and make additions where required) of the Integration Leaders' Group and working group.

2.2 Endorse the approach taken by the working group.

2.3 Agree method of reporting to the HWB.

3 Information/Background

3.1 The HWB agreed that working groups would be established to progress the aims and objectives of the Board. Integration of Health and Social Care services is a key priority for the city. The Leaders' Group is chaired by Councillor Alison Gingell and comprises of Chief Officer representatives from Coventry City Council, Coventry and Rugby Clinical Commissioning Group, Coventry and Warwickshire Partnership NHS Trust, and University Hospital Coventry and Warwickshire NHS Trust. It has been agreed that further representatives from West Midlands Ambulance Service will be invited. A working group has also been established to progress the plans.

3.2 The working group have explored possible areas for integration, where the work of the HWB can add value. The Leaders' Group agreed that older people (including long term conditions) and safeguarding children would be areas of focus. An event will be held (December 2013) with representatives from organisations across health and social care to formulate plans for integration in these areas, and develop an overarching vision for integration. Progress will be reported to the HWB in February and closely monitored by the Leaders' Group.

3.3 The Integrated Transformation Fund was announced in June 2013, it is a single pooled budget for health and social care. Significantly, this brings together existing expenditure to support transformation. Plans must be agreed by March 2014. The Integration Leaders'

Group have requested that Simon Brake, in conjunction with the Adult Commissioning Board, progress the plans for the fund, which will need to be agreed in due course by the HWB. Funding will be linked to outcomes achieved.

3.4 Plans must include:

- 7-day working in health and social care
- better data sharing, including universal use of the NHS number as a unique identifier
- a joint approach to assessment and care planning
- implications for acute service redesign
- support for accountable lead professionals in respect of joint care packages

Cat Parker, People Directorate, 024 7683 3507

Briefing note

To Health and Wellbeing Board

Date: 21st October, 2013

Subject: NHS Coventry and Rugby CCG Commissioning Intentions 2014/16

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1 Purpose of the Note

1.1 To inform members of the group of the progress and outcomes of the 2013/14 commissioning intentions process

2 Recommendations

2.1 The Health and Wellbeing Board is asked to note and comment on the appended commissioning intentions document.

Report Author: Clare Hollingworth, Chief Finance Officer, Coventry & Rugby Clinical Commissioning Group. Clare,Hollingworth@coventryrugbyccg.nhs.uk

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NHS COVENTRY & RUGBY CLINICAL COMMISSIONING GROUP

COMMISSIONING INTENTIONS 2014/16

DRAFT

Date: 30th September 2013

Status: Draft – For further review by Members subject to submission to Governing Body in November for approval.

INTRODUCTION

This year (2013/14) is the CCG's first year of operation as a statutory commissioning body and in line with the ethos of CCGs as membership organisations, local priorities for action have been developed in partnership with member practices and their localities and patients and public from across the CCG area. The process through which these priorities were developed included consideration of the Health and Wellbeing Strategies for Coventry and Warwickshire, the plans and proposals in respect of People services in Coventry City Council and Warwickshire County Council and the emerging priorities for NHS England.

Through an on-going process of engagement, over 1000 patients and members of the public have identified their priorities for action in respect of the five strategic priorities of the CCG:

- Best practice in acute hospital care
- Wellbeing of people with mental health needs
- Health of (frail) older people
- Healthy living and lifestyle choices
- High quality, safe GP practices

During August 2013, the process was repeated at three separate workshops involving representatives from member practices in each of the CCGs three localities along with CCG staff and key staff from the two local authorities.

From these engagement activities, six work programmes have been selected as those likely to make the most significant contribution to improving health outcomes for our population. Over the coming months, the CCG will engage with a wide range of stakeholders to develop ideas as to what changes should be made to existing services within each of these seven work programmes in order to improve the health outcome secured. These ideas will then be reviewed for do-ability and likely impact and the resultant prioritized set of actions will be detailed within the CCG's Operational Plan 2014-16.

Whilst this document details our priority workstreams, we will of course continue to make progress across our entire service portfolio as we seek to secure the best possible mix of services to meet the needs of the population we serve. Further we will work closely with Public Health and Local Authority colleagues to make every effort to reduce acknowledged health inequalities.

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Given the continued constraint on public sector spending, the financial context for 2014/15 and future years will be extremely challenging. Meeting increasing demand with a static resource will require the CCG to work with its members its public and service providers (new and existing) to innovate and to deliver services differently. At the same time we are adamant that reducing costs will not be at the expense of maintaining acceptable levels of safety, quality and patient experience. Locally and nationally, the NHS is managing the impact of constrained public spending and a funding settlement that is more challenging than many can remember. It is likely that all organisations will need to make bold and difficult decisions. CRCCG will ensure that any such decisions are taken only after an explicit consideration of the impact on quality, safety and patient experience and an open discussion with our public and our other local stakeholders.

All of the above combine to create a significant challenge for a relatively new organisation but one that we are committed to facing with boldness, integrity and endeavour.

Our six selected priority work programmes are as follows:

	HEALTHY LIVING & LIFESTYLE CHOICES	PRIMARY CARE QUALITY	FRAIL OLDER PEOPLE	MENTAL HEALTH	ACUTE HOSPITAL CARE
Diabetes	√	√			√
End of Life		√	√	√	√
Dementia		√	√	√	√
24/7 Urgent Care	√	√	√	√	√
Stroke Care	√	√	√	√	√
Children 0-5 years	√	√		√	

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CRCCG COMMISSIONING PRIORITIES FOR 2014/16

1. CRCCG Work Programme: Diabetes Management

In 2002, the Department of Health estimated that 5% of total NHS expenditure is used for care of people with diabetes. This figure is now believed to be closer to 10% of total NHS expenditure which equates to £9 billion per year. People with type 2 diabetes have a risk of death from cardiovascular causes that is two to six times that among people without diabetes.

Structured, systematic care for people with type 2 diabetes aims to minimise the risks from disease – related vascular complications such as cardiovascular, eye, foot and kidney disease. The National Institute for Health and Care Excellence (NICE) has produced quality standards for the clinical management of diabetes in adults which map onto the five key areas of care i.e. structured education, lifestyle and self care, blood glucose control and insulin therapy, management of complications, hospital and emergencies.

Desired changes:

- Enhanced patient awareness and greater support for Self-Care
- 9 annual checks – improved primary care attainment
- Community consultant led diabetes service – providing support to improve the quality of diabetes care in primary care and reducing variation
- Reduction in out-patient activity that will be delivered via a different model in the community
- Use of technology (Diabetes Manager) to risk stratify diabetes patients and provide virtual clinics

2. CRCCG Work Programme: Dementia Care

Dementia is increasingly one of the most important causes of disability in older people. There are around 800,000 people with dementia in the UK, and the condition costs the economy £23 billion a year. By 2040, the number of people affected is expected to double - and the costs are likely to treble. A quarter of hospital beds are occupied by people with dementia. Early identification can

dramatically improve quality of life for people with dementia but at the moment, the diagnosis rate is less than 50%.

The Prime Minister's Dementia Challenge launched in March 2012. It sets out plans to go further and faster in improving dementia care, focusing on raising diagnosis rates and improving the skills and awareness needed to support people with dementia - and their carers.

Both Coventry and Warwickshire have 'Living well with Dementia' strategies and the CCG will work with its two Local Authority partners and other stakeholders to develop implementation plans to secure the desired outcomes detailed in those strategies.

Our focus will be on:

- Increased early diagnosis and intervention
- Automatic contact from post-diagnostic support services
- Greater use of assisted technology
- Enhanced support for Carers
- Improved end of life planning and care
- A consistent specification and quality framework for dementia care providers

3. CRCCG Work Programme: 24/7 Urgent Care

NHS urgent and emergency care services provide life-saving and life-changing care for patients who need medical help quickly and unexpectedly. We know our accident and emergency departments are under increasing pressure and we want to improve the urgent and emergency care system so patients get safe and effective care whenever they need it.

Initial reports from the national review of urgent and emergency care have identified a number of issues which we believe are also pertinent to modernising and improving our local urgent care system. For example, the national review identifies that in some cases, such as heart attack and stroke patients get better outcomes by going straight to specialist centres and not to A&E.

The review also highlights that some people who present at A&E, and who we treat there, would have more appropriate care and a better patient experience if they were seen in a primary or community care setting. These may be people with long term conditions that need careful management, or people who are having problems getting an appointment at their local GP surgery.

The review further acknowledges that patients find it hard to navigate between primary care, our hospitals and social care services. In many cases some of our most vulnerable patients e.g. frail elderly, need careful management and input from a number of different agencies and sometimes they, or their carers, are just not able to understand and work with this range of services, and find themselves in A&E as a last resort.

All of these issues featured large in the engagement events with member practices, patients and the public.

Our focus is likely to be on:

- Increased emphasis on prevention and self-care
- Further development of our integrated practice teams with their focus on keeping people out of hospital
- Assurance that clinical safety within our hospitals is maintained throughout the 24 hour period, seven days a week
- Sharing of clinical information to support better decision making by emergency teams
- Working with our CCG members to ensure maximum benefit is secured from available primary care resource
- Increased access to community and social care services in the evening and at weekends
- Increased support to care homes to avoid unnecessary hospital attendance
- Re-specification of Out of Hours services
- Work with Primary Care commissioners to review the role of the Coventry Walk in Centre.
- Review of the Rugby Urgent Care Centre

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4. CRCCG Work Programme: End of Life

The CCG is committed to supporting every individual and their family to retain their personal dignity, autonomy and choice throughout the care pathway towards the end of their life.

Nationally, there is a disparity between preferences expressed by the majority to die at home or in a hospice and the numbers actually dying in hospital (58% of all deaths); this is replicated locally (59.1% Coventry and 55% Warwickshire). In the case of people with dementia, the vast majority die in a care home whilst the vast majority of deaths from heart disease or pulmonary disease occur in hospital and the majority of these will have been admitted from their own home (including a residential care home) in the final week of life.

Care at the end of life has been recognised as making up a significant proportion of all health care expenditure in the NHS; research indicates that inpatient hospital care increases sharply at the end of life, particularly in the final two months.

Our focus is likely to be on:

- Extended use of advance care planning
- Implementation of shared care plans accessible by all service providers to ensure good co-ordination of care
- Extension of Hospice at Home to provide support to community (and patients in care homes)
- Strengthening of integration across health, social care and voluntary sector

5. CRCCG Work Programme: Stroke Care

Stroke is the third biggest cause of death in the UK and the largest single cause of severe disability. Each year more than 110,000 people in England will have a stroke, which costs the NHS over £2.8 billion.

The most important care for people with any form of stroke is prompt admission to a specialist stroke unit. Everyone who could benefit from urgent care should be transferred to an acute stroke service that provides 24-hour access to scans and specialist stroke care, including thrombolysis.

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Successful stroke services are built around a stroke-skilled multi-disciplinary team that is able to meet the needs of the individuals. Intensive rehabilitation immediately after stroke, operating seven days per week, can limit disability and improve recovery. Specialised rehabilitation needs to continue across the transition to home or care home, ensuring that health, social care and voluntary services together provide the long-term support people need, as well as access to advocacy, care navigation, practical and peer support.

Improvements we are looking to secure:

- Improved primary prevention
- Improved outcomes of stroke patients, by reducing the levels of death and disability following a stroke
- Reduced length of stay of stroke patients in bed based services
- Social care staff better supported to care for stroke survivors

6. CCG Work Programme: Children 0-5 years

Our Coventry population is a relatively young one (compared to the national average) and there has been a rapid increase in the birth-rate both within the most deprived communities of Coventry and within Rugby.

Focussing on the first few years of life is crucial to preventing many of the problems that will affect children as they grow up and in their later life. Working with other commissioners of children's services, most notably Public Health, we want to support families to help their children to have the best chances for a long and healthy life. We need to provide this support early as we know that the earlier it is provided, the bigger the impact.

Subject to further dialogue with commissioning partners, our focus as a CCG is likely to be on:

- Further reductions in smoking in pregnancy
- Reducing other antenatal risk factors (including alcohol, mental health and domestic violence)
- Strengthen safe guarding arrangements including the sharing of information across agencies
- Looked After Children
- Reduction in avoidable short stay emergency admissions

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OUR CORE COMMISSIONING PRINCIPLES

All of our commissioning activities will be undertaken with the intention of assuring Quality & Safety, promoting Integration and securing Best Value.

I) Quality & Safety

The quality and safety of clinical services is an essential element of all service reviews and developments. The learning from recent independent inquiry's such as Francis have highlighted the importance of Q & S being central to the development and monitoring of care delivery. To drive up quality we propose that each commissioning priority has an identified clinical lead and GP commissioning lead, this will also support the drive for greater integration. It is also essential that all developments meet NICE quality standards and follow NICE clinical guidelines. It is the intention to establish clinical networks to support the development and implementation of commissioning priorities.

CRCCG believes the highest quality care is often the most cost effective. Focussing on quality and safety – for example minimising health acquired infections, drug errors and delayed discharges – can improve cost effectiveness. Further, there is still much unexplained variation in clinical practice and clinical outcomes and we will be working with our provider organisations to reduce this variation and to implement acknowledged best practice within available resource. Where appropriate we will use CQUIN and other contractual levers to incentivize quality improvements / desired changes in clinical practice.

II) Integration

National Voices, a coalition of health and social care charities, has identified the lack of joined-up care as a source of huge frustration for patients and carers and has said that "achieving integrated care would be the biggest contribution that health and social care services could make to improving quality and safety". National Voices has reported that "people want to experience seamless care, where it comes from is secondary". Linked to this, a key recurring theme from our local discussions with our members and our public has been the need to share patient records and care plans to improve the co-ordination of care.

The June 2013 Spending Round was extremely challenging for local government, handing councils reduced budgets at a time of significant demand

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driven pressures on services. Any reduction on local social services is likely to result in an increased pressure on health services. To make a real improvement to the care people receive, and to secure maximum benefit from the combined health and social care spend, we have to change the way we do things in the future, and ensure care is provided at the right time, in the right place.

As a CCG we will intend to support integrated care by:

- bringing together providers and commissioners to look at how we can spend our money to the best effect
- promoting the appropriate sharing of clinical records
- Further development of our integrated practice teams
- increasingly contracting for integrated pathways of care

The Integration Transformation Fund announced in the Spending Round should provide an additional focus to making integrated working a reality. The ITF is intended to 'provide an opportunity to transform care so that people are provided with better integrated care and support'. In their joint statement on the ITF, NHS England and the Local Government Association state that "Unless we seize this opportunity to do something radically different, then services will get worse, costs to taxpayers will rise, and those who suffer the most will be people who could otherwise lead more independent lives." The £3.8bn of NHS resources that will transfer into the ITF nationally is not new money; it is money that is already being spent on a range of services. Our joint challenge over the next 12 to 18 months is to agree the system/pathway changes that will enable spending to be redirected from treatment services to preventative care and hence reduce the overall cost of provision. To achieve this, statutory partners need to work together to make finance an enabler rather than a barrier to change. As above, as a CCG we are committed to providing resources to pump-prime agreed service changes but we will only be able to do this if our service providers work with us and accept a joint responsibility for overall cost containment.

III) Best Value

The CCG is aiming to achieve a position where it is assured that its level of investment in each service type is appropriate to the quantity and quality of service being delivered. At the same time, we recognise the need to reduce the reliance on urgent care systems and to better manage activity flows into and out of secondary care. Accordingly, we want to move to a position where there

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is a common understanding of the relative cost and productivity of each service and a joint commitment to using that knowledge to shape a more sustainable system for the future. This will of course require a high degree of trust and transparency and may require investment in some services and disinvestment in others. Within this context, we appreciate the need for each organisation to deliver its own financial duties and risk rating. It is not in our interest to create instability within a key partner organisation. Our belief is that long term financial sustainability is best achieved through all health and social care organisations working in a more collaborative and transparent manner, recognising a mutual dependency. This approach is consistent with the emerging Integration agenda.

The CCG will expect Providers to absorb all internal cost pressures within existing funding levels (less the national tariff adjustment).

We would discourage Providers from pursuing counting and charging changes which would result in a net effect that commissioners pay more for the same. Whilst we understand the attraction of this approach, our joint emphasis must be on reducing not maintaining or increasing overall costs. The CCG would wish to use any available investment funds to support pathway redesign and associated non-recurrent restructuring costs.

CRCCG PROPOSED QIPP SCHEMES FOR 2014/15

We will be maintaining and where possible, up-scaling the QIPP schemes we have been pursuing in 2013/14. However, the scale of financial challenge facing the CCG for the foreseeable future requires additional schemes to be identified. Proposed schemes for 2014/15 (in addition to our six priority work programmes) are shown below; these will be revised as detailed project plans are developed and tested.

We would also invite Providers (new and potential) and other Stakeholders to put forward proposals as to how services could be delivered more cost effectively. Funding for new investments is limited but all Invest to Save proposals that have the potential to deliver savings to commissioners will be given due consideration.

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Existing Schemes	Proposed Schemes
• GP Referral Management • GP Prescribing • Specialist Prescribing • MH Out of Area Placements • Continuing Healthcare • Procedures of Low Clinical Value • Orthopaedic Procedures • Effective Discharge (XBDs) • Avoidable Admissions ➢ Integrated Practice Teams ➢ COPD ➢ Heart Failure	• Falls Prevention • Surgical Thresholds • Dermatology • Pathology • Outpatient Pathways • CCG Running Costs • Avoidable Admissions ➢ End of Life ➢ Care Homes ➢ Vaccine Preventable

CRCCG POTENTIAL PROCUREMENT ACTIVITIES FOR 2014/15

Planned Procurements:

- Termination of Pregnancy Services
- Primary Care Enhanced Services
- Individual Patient Packages (Residential and Home Based nursing care)
- Pathology
- NHS 111 (regionally led)

The CCG is currently reviewing the following services. The outcome of those reviews will inform in-year procurement decisions and timelines:

- Improving Access to Psychological Therapies
- iMSK
- Out of Hours
- Walk In Centre (potentially via NHS England)

The CCG reserves the right to initiate additional procurements at any time.

The three CCGs within Coventry & Warwickshire have articulated a joint intention to explore and implement new approaches to contracting and procurement in order to encourage innovation and collaboration within and

across the Provider landscape. We will be looking to develop service specifications based on outcomes (see below) and to using, where appropriate, approaches such as competitive dialogue and lead contractor models to secure effective supply chains capable of delivering these outcomes in a patient centred and cost effective manner.

COMMISSIONING FOR QUALITY & IMPROVED HEALTH OUTCOMES

CCG commissioners are held to account for improving health through the NHS outcome frameworks. We believe that our six priority workstreams will deliver significantly improved outcomes across each the five domains:

NHS Outcomes Framework

	Preventing people from dying prematurely	Enhancing quality of life for people with long term conditions	Ensuring that people have a positive experience of care	Helping people to recover from episodes of ill health or following injury	Treating and caring for people in a safe environment and protecting them from avoidable harm.
Diabetes Care	√	√	√		
Dementia Care		√	√		√
End of Life Care		√	√		
24/7 Urgent Care		√	√		
Children 0-5	√		√		√
Stroke Care	√			√	√

It is understood that the role of CQUIN payments is being reviewed nationally and that they may not necessarily operate in the same way as previous years. Assuming that locally determined quality payments continue in some form, our intention is to focus on a small number of high impact schemes for each Provider contract.

It is anticipated that as in 2013-14, the majority of CQUIN schemes will support the implementation of agreed QIPP initiatives and key areas of clinical need identified in year as requiring major improvement.

Subject to any emerging national guidance, Coventry & Rugby CCG would wish to see at least one collaborative CQUIN where achievement is dependent upon collaboration across the Acute and Community interface and delivery of an economy-wide quality improvement.

INFORMATION & COMMUNICATIONS TECHNOLOGY (ICT)

Providers are expected to work collaboratively with commissioners to progress information technology developments that improve the efficiency and quality of care. These include collaborative developments across the health economy and provider-specific developments.

Providers are expected to work collaboratively with commissioners to:

Ensure that key national and local systems currently being implemented are fully exploited to deliver efficiency and quality benefits. These include:

- Electronic Palliative Care Co-ordination System Summary Care Record
- Electronic communications between Trusts and GP Practices
- the IT products of the Warwickshire Common Assessment Framework programme

Develop and implement new national IT solutions, and comply with national IT targets and guidelines including:

- NHS e-referrals service (Choose and Book replacement), to make e-referrals available to patients and health professionals for all secondary care by 2015
- safe digital record keeping as a precursor to achieving integrated digital care records across the health and care system – using the approaches and standards set out in 'Safer Hospitals, Safer Wards: Achieving an Integrated Digital Care Record'. This should include implementation of electronic prescribing capabilities consistent with Section 5.2 of 'Safer Hospitals, Safer Wards' which will also enable the sharing of patient medication records across care transitions
- where Providers proceed to implement Lorenzo, maximise opportunities for Lorenzo to support integrated care

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- wherever possible digital access to services, in particular the 10 high impact digital initiatives set out in 'Digital first: The delivery choice for England's population'
- appropriate use of digital technologies to improve efficiency including those set out in the 'Digital Technology Essentials Guide'

Continue to work with LHE partners to identify and implement solutions to:

- wider sharing of patient records across care settings to support integrated care, working towards national target of ensuring that integrated digital care records (IDCRs) become universally available at the point of care for all clinical and care professionals by 2018
- patient / carer tools to support self care, collaborative care and healthy lifestyle, including access to records
- shared business intelligence / analytics across commissioners and providers where practical
- consistent approach to messaging and infrastructure.

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Public report
Cabinet Report

Health and Well-being Board — 21 October 2013
Health, Social Care and Welfare Reform Scrutiny Board (5) — 6 November 2013
Cabinet — 19 November 2013

Name of Cabinet Member:
Cabinet Member (Health and Adult Services) – Councillor Gingell

Director Approving Submission of the report:
Director of Public Health

Ward(s) affected:
All

Title:
Director of Public Health Annual Reports 2012 and 2013

Is this a key decision?
No – This is a review of health across the city and does not directly impact on current services, although the conclusions of the report will be used to inform how services are delivered in the future.

Executive Summary:

The Director of Public Health Annual Report is a statutory and independent report produced each year. This describes key health issues in the city and focuses on areas that are of particular importance in the city.

As this is the first year that the City Council has had legal responsibility for health and well-being, two reports are presented for consideration. The first of these reviews looks back to when public health was last in local government in 1974 and considers how health has changed since then. The second looks forward to the major challenges that need to be tackled to improve health in the 21st century.

The findings of the report are to be used by the City Council and other key partners in the NHS and voluntary sector to focus action on the particular health needs of Coventry and the groups in the city with the lowest life expectancy. It shows the need for continued effort to improve issues that affect people's health including education and employment which, in Coventry are being tackled through the city's status as a Marmot City. It also highlights the need to focus on lifestyle issues such as smoking, alcohol, poor diet and physical activity which are the biggest health challenges for the 21st century.

Information from these reports will be shared with local people through ward forums and will also be shared more widely with partner agencies and the voluntary sector.

Recommendations:

1. The Health and Well-being Board is asked to:

   (i) Endorse the findings of this report and review progress in implementing its findings across local partners.

2. Health, Social Care and Welfare Reform Scrutiny Board (5) is asked to:

   (i) Consider comments from the Health and Well-being Board and advise Cabinet of their agreement of the proposals and recommendations.

3. Cabinet is asked to:

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

   (ii) Support the publication of the report.

List of Appendices included:

Director of Public Health Annual Report Executive Summary 2012
Director of Public Health Annual Report Executive Summary 2013

Background papers:

None

Has it been or will it be considered by Scrutiny?

Yes - Health, Social Care and Welfare Reform Scrutiny Board (5) – 6th November 2013.
In addition, the Scrutiny Co-ordination Committee received a briefing note on the Annual Report at their meeting on 8th October 2013

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

Health and Well-being Board – 21st October 2013

Will this report go to Council?

No

Report title: Director of Public Health Annual Report Context (or background)

1.1 The NHS Act 2006 as amended by the Health and Social Care Act 2012 set out a legal duty on the Director of Public Health to produce a report each year on the health of their population and to publish the report. The content and structure of the report is determined locally and can cover any aspect of local health that is locally relevant or important.

1.2 The findings of the DPH Annual Report are used to

1.2.1 Raise awareness and understanding of how healthy the population is and how this is changing, with local partners and the public
1.2.2 Inform the provision of local services and actions plans that can affect the health of the population
1.2.3 Inform the development of key priorities for the Health and Well-being Strategy, which the Health and Well-being Board has a duty to produce.

2. Options considered and recommended proposal

2.1 This year, it has been agreed to publish two reports for 2012 and 2013 at the same time. This is because the first report, which was produced during the period of transition before the enactment of the Health and Social Care Act, describes how health has changed in Coventry since 1974, when responsibilities for public health moved from local councils to the NHS. The second report describes what needs to be done to improve healthy lifestyles in the city, which are one of the biggest challenges to health in Coventry. Taken together, the two reports answer the questions “what has changed?” and “what do we need to do next?”

2.2 The DPH Annual Report draws on a range of data sources many of which are not easily available or accessible to partners and the public. This includes national and local health datasets and Coventry’s Household Survey. The reports are produced in the format of an executive summary, which sets out the key messages and recommendations in an accessible format. Detailed reports and appendices which set out the technical data that underpins the key messages have also been produced and will be made available to the public once Cabinet have approved this report.

2.3 The Director of Public Health has independent statutory responsibilities of which the production of an Annual Report is one. It is considered that this gives the assurance that issues affecting the health of the population can be raised freely and objectively.

3. Results of consultation undertaken

3.1 The DPH Annual Report is intended to give an overview of the major health challenges in the city, based on national and local data-sources. The Joint Strategic Needs Assessment offers the opportunity to investigate specific issues identified in this report in more detail and to consult on these more broadly with key local stakeholders.

3.2 The report also highlights areas where consultation with local communities and stakeholder groups will be needed to understand what more can be done to better understand local needs and what more can be done across the city to drive improvements in lifestyles. This is outlined in the recommendations section of the DPH Annual Report for 2013.

4. Timetable for implementing this decision

4.1 Once approved, the Annual Report will be published on the Council's internet pages and shared with partners. The recommendations will be supported by a more detailed action plan, setting out which agency or organisation has responsibility for delivering each recommendation and the timescales for achieving this.

5. Comments from the Executive Director, Resources

5.1 Financial implications

There are no direct financial implications arising from the report. The cost of publishing the report will be met from within existing budgets.

5.2 Legal implications

5.3 The National Health Service Act 2006 as amended stipulates that the director of public health must prepare an annual report on the health of people in the area of the local authority. The local authority must publish the report.

6. Other implications

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

These Annual Reports set out key actions to improve the health of Coventry people. It contributes to the Council’s Marmot City plan and to the Council's core aim of citizens living longer, healthier, independent lives and also to the priorities in the Council Plan to protect the city's most vulnerable residents.

6.2 How is risk being managed?

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

6.3 What is the impact on the organisation?

There is no direct impact on the organisation.

6.4 Equalities / EIA

An Equalities Impact Assessment is not appropriate for these reports although the reports themselves consider health status across a range of different population groups.

6.5 Implications for (or impact on) the environment

N/A

6.6 Implications for partner organisations?

The Annual Reports raise a number of issues for consideration by partner organisations. These will be discussed and overseen by the Health and Well-being Board which includes representation from these organisations, or commissions the services provided by these organisations.

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Dr Jane Moore	Director of Public Health	Chief Executive's	09.10.13	10.10.13
Councillor Gingell	Cabinet Member (Health and Adult Services)			07.10.13

This report is published on the Council's website: www.coventry.gov.uk/meetings

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Changing for the better:

healthy lifestyles in Coventry 2007-12

Report of the Director of Public Health

Coventry City Council

www.coventry.gov.uk

Forward

This is my first report as Director of Public Health for Coventry City Council. It is a national requirement for me to report each year on the major health issues facing the city. This year, I have looked at healthy behaviours in the city and how these have changed over time.

We know more and more about the impact of how we live our lives, on how healthy we are, and how long we can expect to live for. Advances in medical science and technology, improved access to health care and better overall living standards mean that life expectancy is rising in the UK, as in most other Western countries. But we are now facing a situation in which the biggest threat to health comes from the day to day decisions about how we live our life and the environment in which we live.

We now know that four factors: a poor diet, smoking, excessive alcohol consumption and low levels of exercise globally account for nearly a third of the disease burden, preventable deaths and years spent in poor health. In the UK, more than 100,000 smokers die from smoking related causes every year. Nearly 7,000 people die as a result of liver disease caused by alcohol abuse and around 34,000 people die each year as a result of illness due to obesity, caused by a poor diet and physical inactivity.

Coventry is no exception. Over the three years from 2009-11, 2,904 people died prematurely from diseases which could have been prevented. As a city, we rank 126th out of 150 councils and 10th out of 15 cities with similar populations. As a city, we do particularly badly for cancer, lung disease and liver disease, all of which are heavily affected by lifestyle factors such as smoking, diet, exercise and alcohol.

We know that someone who exhibits all four of these unhealthy behaviours has the same chance of dying as someone 12 to 14 years older, who exhibits none of these unhealthy behaviours.

In the past, it was assumed that if you gave people information about the impact that smoking or a poor diet would have on their health, this would be enough to make them change. Although we need to understand what impact our choices are having on our health, we know that this is not enough. Our own experience tells us that making changes is not easy. For example, the environment in which we live does not help. It is often easier and cheaper to buy poor quality food than it is to buy healthy food and, in a throw-back to times when food was scarce, we are genetically pre-disposed to prefer high-calorie, high carbohydrate food to healthier options.

But collectively we can make a change. Smoking rates have fallen across the UK and in Coventry. This is down to a combination of national action (such as the ban on smoking in public places and increases in duty on cigarettes), local action (including increasing access to stop smoking services, local

campaigns such as Coventry's Smokefree Playgrounds) and most importantly, the will-power and determination of smokers themselves who have made a tough decision to quit and stuck with it.

And it's not just about what each individual does; the action of one person can have a huge ripple-effect. We know that we're all influenced by what our friends, family and peers do. Each person that makes a change, whether it's stopping smoking, taking up exercise or cutting down on fizzy drinks acts as a role model for the people around them, helping to make healthy choices the norm across society.

There is much more to be done but this example shows that the right collective action can have a massive impact on health. The proof is there; across the UK we now have lower rates of lung cancer and heart disease than we did when smoking was at its peak, all of which is contributing to the rise in life expectancy that we are seeing. European countries, which have not taken the sort of action to tackle smoking we have seen in the UK, are not seeing the same improvements in these diseases.

My report shows that collective effort may be starting to have an impact in Coventry. Smoking rates are falling, fewer people are drinking excessively, and there are early signs that more people may be taking more exercise and eating healthier diets. Big changes to the face of the city, including new investment in cycle lanes and the new Friargate scheme are all helping to build a healthier environment, making it easier for us all to do the right thing, without having to make difficult decisions.

This is good news. But there is a lot more to be done, and as a city we have a long way to go. We are now in a similar position to where the rest of the UK was five years ago and the positive changes we have seen have not affected some of the people in the city with the worst health status.

My report sets out what we have done to tackle this and what we need to do next. With the leadership of the Health and Well-being Board and working with the people of Coventry, we need to redouble our efforts to make Coventry a healthy place to live and to support people who have the most to gain, to make the most of their health.

Finally, I would like to thank the thousands of people across the city who, over the last five years, have shown that it can be done. To all those people who have quit smoking, who got on their bicycles and joined us on the ring-road to welcome Lady Godiva back to the city earlier this year or who have taken one small step to improve their health, you are the people who are making this happen.

Dr Jane Moore
Director of Public Health for Coventry

Key findings

Changing behaviours

We know that the more healthy and less unhealthy behaviours someone has, the healthier they are likely to be. We also know that if people smoke, have a poor diet, do not exercise and drink excessively, they are more likely to have particularly poor health, with the same chance of dying as someone 12-14 years older. We also know that these factors do not work in isolation. A smoker may worry that, if they quit, they will snack more and might gain weight and this may be a significant disincentive to them in making a change. But we also know that some people have developed successful strategies for dealing with this, for example by making sure that they have healthy snacks so that they can actually improve their diet, while they stop smoking. We know that making a change can be a powerful incentive to do more, someone who has just done their first ever 5k Race for Life or parkrun may feel empowered to improve their diet.

In order to target services at the right people and create the right environment to help people make the change, we need to understand whether people are actually making several changes – and which ones.

How many people have several unhealthy behaviours?

We looked at how many people had several unhealthy behaviours (out of smoking, poor diet, low levels of exercise and excessive drinking) and how this has changed over time. We looked at the number of unhealthy behaviours people had and those who were high risk (3 or 4 unhealthy behaviours). We found that the proportion of people with four unhealthy behaviours had fallen from 10% to 5% from 2007 to 2012. The biggest decrease was in men, from 12% to 6%. By 2012, the number of people reporting just one unhealthy behaviour had increased from 19% to 27%.

Overall, there was a reduction in those people with high risk from 38% to 24% between 2007 and 2012. Additionally, the proportion of people reporting none of the unhealthy behaviours more than doubled from 3.1% to 6.9%. In the long term, this is likely to translate into significant health benefits.

There are early, and welcome, signs that we are improving quicker than the rest of England, but we still have a long way to go. The improvements we have seen to date put us where England, as a whole, was five years ago. We know that there is a strong link between deprivation and healthy behaviours and the picture in Coventry is similar to other deprived areas but we need to make sure that the accelerated change we have seen continues.

A note on the data

We have used data from Coventry's Household Survey to look at changes over five years from 2007 to 2012 and we compare these to the national position. We look at which parts of the city and which people have made the most progress and where we still have more work to do. We then describe what has been done to try and improve health in the city and what more needs to be done.

Because we cannot speak to everyone, we use data from a sample of people from across the city to estimate the actual picture in Coventry. Although this is the only sensible way to collect data it means that we cannot always be 100% sure that what we have found is true. Once we start looking at specific groups or areas of the city it becomes harder to be sure that the picture we have found is accurate. And sometimes statistical flukes can throw up findings one year, which are not there the next. We use statistical techniques to make sure the conclusions we draw from the data are as robust as possible but in the real world we are not always able to act on the basis of perfect information. We need to draw conclusions based on the best-available data, combined with sensible judgements and this is what we attempt to do in this report.

Are we closing the health inequality gap?

As a city which faces significant health inequalities and large gaps in life expectancy between different parts of the city, we need to understand not just whether healthy behaviours are changing across the city but also whether these changes are affecting groups with the worst health outcomes.

We have therefore looked at how changes have affected different people across the city.

We found that:

- Men are currently twice as likely to have several unhealthy behaviours as women
- There have been reductions in the number of people with three or more unhealthy behaviours in all age groups. However, this change had not been seen in older age groups, particularly those aged 55-64
- The level of unhealthy behaviours in those of White ethnic background is higher than for other groups. There have been particularly large improvements across a range of other ethnicities.
- Improvements in healthy behaviours have not been seen in people who are unemployed or economically inactive
- Improvements in healthy behaviours across all socio-economic groups (or deprivation quintiles). However, the biggest changes have been in the least deprived section of society and the smallest changes in the most deprived. So although health may be improving across the city, more progress will be needed to close the inequality gap
- There is an association between unhealthy behaviours and the most deprived parts of the city (measured by Middle Super Output Areas - an area smaller than wards) with a clustering of deprivation and unhealthy behaviours in Wood End, Henley and Manor Farm and Willenhall in particular
- However, some of the greatest areas of deprivation in the city do not have a very high level of unhealthy behaviours, including Upper Foleshill. This may be because of the high proportion of certain ethnic minority communities who do not drink for religious and cultural reasons

Smoking

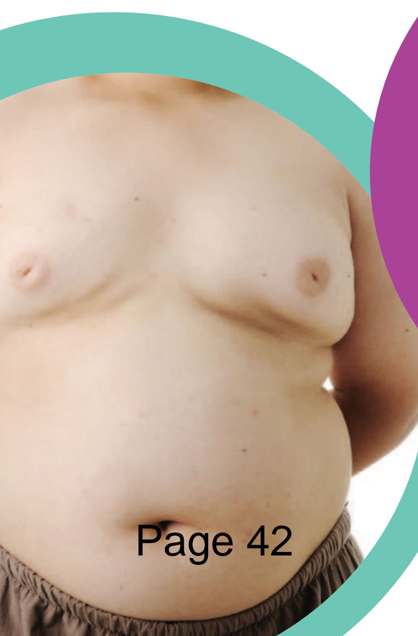
During the five years we looked at, smoking rates in the city fell by 3.6%, from 28.1% of adults in the city to 24.5%, around 4,400 less smokers. We estimate that 17 lives each year will be saved as a result of this improvement. This is similar to the national picture but may be slightly better than the rest of the West Midlands which saw a 2% fall from 2006 to 2011. This fall has been particularly significant in men, where smoking fell from 31% in 2007 to 26% in 2012, with particularly large falls in younger men and middle-aged men but there may have been a rise in the 55-64 age group.

Excessive drinking

Low and moderate levels of drinking are known to be associated with some health benefits. However, drinking more than three units of alcohol for women or four for men, on at least one day per week is associated with worsening health and this risk increases as the overall weekly consumption goes up. Coventry has historically had high levels of excessive drinking, above the average for the West Midlands and for England.

Over the last five years, the city has seen big improvements in the percentage of people drinking within healthy limits, with a drop in excessive drinking from 46.8% in 2007 to 30.5% in 2012. In 2007, 55% of men were drinking too much: by 2012 this had fallen to 38%. Women have always had lower levels of excessive drinking but have also seen a big fall, from 38% to 23%. Although there have been falls in the rest of England, Coventry has seen a more rapid change than England or the West Midlands where alcohol consumption has fallen by 7%. The biggest improvement has been in men and women aged between 25 and 44, but all ages have seen a fall in excessive drinking.

This is good news and overall translates into an estimated 16 fewer deaths each year in Coventry. However, we still have a long way to go as, despite making rapid progress, drinking levels for both men and women appear to still be higher than in England as a whole.



Healthy weight: diet and physical activity in Coventry

There is increasing evidence of the impact of a healthy diet on health. Five portions of fruit and vegetables is the key measure for assessing a healthy diet, although other factors such as low meat consumption (particularly processed meat), low salt and a diet low in saturated fat are all important. Poor diet, coupled with low levels of physical activity, is associated with a range of health conditions, including certain cancers and cardiovascular disease. Physical activity (30 minutes of physical activity which raises your heartbeat five times a week) is associated with a range of health benefits, including improvements in mental well-being. We estimate that the improvements we have seen in diet and physical activity over the last five years will save around 14 lives each year.

Are we getting our five a day?

Our analysis shows that from 2007 to 2012, the proportion of people having a healthy diet (which we measured by assessing how many people ate five or more portions of fruit and vegetables a day) increased from 21% in 2007 to 28% in 2012. We do not have up-to-date comparative data for England or the West Midlands but this suggests that Coventry is now at a similar level to the rest of England. Women tend to have a better diet than men, suggesting that more needs to be done to encourage healthy eating in men. Locally, we have seen particular improvements in people in middle-age with a 15% increase in the number of men aged 45-54 who are eating five a day and a 24% improvement in women. This is the group which had the lowest levels of healthy eating in 2007, so this improvement is encouraging.

Physical activity

There are signs that there has been an increase in the number of people in the city taking regular exercise. In 2007, 31% of people were reaching recommended levels, compared to 39% in 2012. Women tend to have higher levels of exercise than men, although there has been an increase in both men and women. There is evidence of particular improvements in women aged 25-44 and men aged 16-24. There are some signs of slight improvements in men and women aged 65 and over, although this group has the lowest levels of exercise overall. Older people should continue to be a priority, as this is likely to have benefits for older people's physical and mental health, help reduce social isolation and help older people maintain an independent life for as long as possible.

What are we doing to tackle these issues?

The issues outlined in this report are not new and there has been a lot of work carried out across the city to drive change.

This includes:

- **Smoking:** from 2009 to 2012, the city's smoking services have supported more than 11,000 people to stop smoking. Coventry's Smokefree Alliance have led the way in promoting local services, running campaigns and developing smokefree spaces, including smokefree playgrounds

- **Alcohol:** around 1,650 people have been treated through the alcohol service during 2011 and 2012. There have also been a number of campaigns promoting healthy drinking, the harms of drinking in pregnancy. Coventry and Rugby Clinical Commissioning Group have set up a dedicated team in A&E, to identify problem drinkers and sign-post them to appropriate support. Local GPs also provided alcohol screening to their patients

- **Healthy Weight:** through the Coventry Health Improvement Programme, the NHS and City Council have run a series of programmes to promote physical activity and healthy eating, including the 'One Body One Life' programme, 'Food Dudes' schools programme and local cooking clubs. Other schemes, such as the National Child Measurement Programme and school nursing service help support weight management in children and the local breastfeeding team support new mothers to get the best nutritional start in life

- **NHS Health Checks:** A new responsibility for local councils, the NHS Health Checks programme, provided by GPs and an outreach team, screen people aged 40 and over for early signs of cardiovascular disease and diabetes and also offer general lifestyle advice

- **Health trainers:** Coventry's Health Trainer service provides outreach support to communities to improve their health and well-being. During 2012/13 around 570 people were supported

- **Coventry as a Marmot City:** Since health and well-being became a responsibility for the City Council and partners, part of the Health and Well-being Board, a new programme of work has been developed to identify practical steps that can be taken to reduce health inequalities across the city

Five key challenges for the City

Recommendations

This report provides a snapshot of what progress we are making as a city to improve healthy behaviours. Although we are making progress, much more remains to be done. In particular, we need to understand why some parts of our city, and some groups, have not been affected by the changes we have seen across the city as a whole. We need to make sure that the services we provide locally, to support people to make a change, are fit for purpose for the people who need them most. We need to use the Coventry Household Survey to measure future progress.

There are five key challenges for the city. I set out 10 key actions to address these challenges which, if implemented, with the support of the Health and Well-being Board will drive progress over the next five years.

1. **Focus on closing the health gap**. Although healthy behaviours have improved across the board, they have improved most in the most affluent parts of the city. If this pattern continues, the health inequality gap will continue to widen. We know that healthy behaviours are closely linked to people's life chances and that factors such as whether children get a good start in life and go on to meaningful employment set the preconditions for their healthy behaviours. The city's Marmot programme, which is overseen by our Health and Well-being Board, contains a detailed action plan to improve life chances and reduce health inequalities. Implementing this is a key priority

2. **Target the areas of the city and the people where we have seen the least improvement**. Local services, such as stop smoking services, must be open to everyone but should be incentivised to particularly target the eight areas of the city and in the specific groups where we have seen the least improvement. The eight areas are Longford Village, Wood End, Henley and Manor Farm, Stoke and Stoke Heath, Upper Stoke, Wyken Sowe Valley, Torrington and Canley and Lime Tree Park

3. **Work with local communities to empower them to change.** We need to talk to local people and local community and voluntary groups to understand their lifestyles, what would help them to make a change and how we can co-design and co-produce services with local people. We need to recognise and work with the assets that lie in our communities, through rolling out asset-based working

4. **Use social marketing, social media & technology to support behaviour change**. We need to make better use of social marketing and social media to target specific health messages at our key audiences. Drawing on the large number of people across the city who have made a change over the last five years, we also need to identify local champions who can act as advocates in their local communities

5. **Make it easier for people to make the change.** We need to make sure that when people want to make a change, it is easy for them to do so, that services are easy and convenient to access either face-to-face or on-line, and that front-line staff from across the city are trained and able to support people into the right services at the right time

Top 10 actions to improve health behaviours

Challenge 1	Challenge 2	Challenge 3	Challenge 4	Challenge 5
Closing the health gap	Target areas of the city and groups where there has been least improvement	Working with local communities empower them to change	Using social media to drive behaviour change	Making it easier for people to make a change
1. Work across the City Council and with partners to tackle the broader determinants of health by implementing the local 'Marmot' Plan.	2. Work with local lifestyle services to incentivise the uptake of services in priority parts of the city and in priority groups.	3. Carry out engagement work with people in the following groups to understand the barriers to improving health: • People with multiple unhealthy behaviours • Physically inactive older people • People who are unemployed 4. Use social mobilisation techniques to galvanise communities to increase physical activity 5. Recognise the assets that life in local communities and embed asset-based ways of working across Coventry	6. Identify people who have successfully made changes to their health and use social media to pr mote their stories. 7. Develop bespoke local campaigns to target priority communities.	8. Develop a 'single point of access' for lifestyle services which is integrated with council customer contact points, including the call centre. 9. Roll out the 'Making Every Contact Count' training programme to support front line staff to promote healthy behaviours. 10. Roll out the NHS Health Checks programme to support people age 40 or over to change their behaviour and identify preventable disease early.

If you need this information in another format or language please contact:

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Public Health BACK TO THE FUTURE

Like the famous film trilogy of the '80s, this report is going Back to the Future.

The hero of the film found his future fate was directly affected by events from his past – and we look at how the same is true for the health of our city.

And, like the films, the report is visiting the past, the present and the future.

In the first part of the report we go back in time to the Coventry of 1970 to look at the health of the people of the city. This was just before Public Health left the council to become part of the NHS. Using data from the Annual Report of the Medical Officer of 1970 we compare and contrast the health of the city then and now.

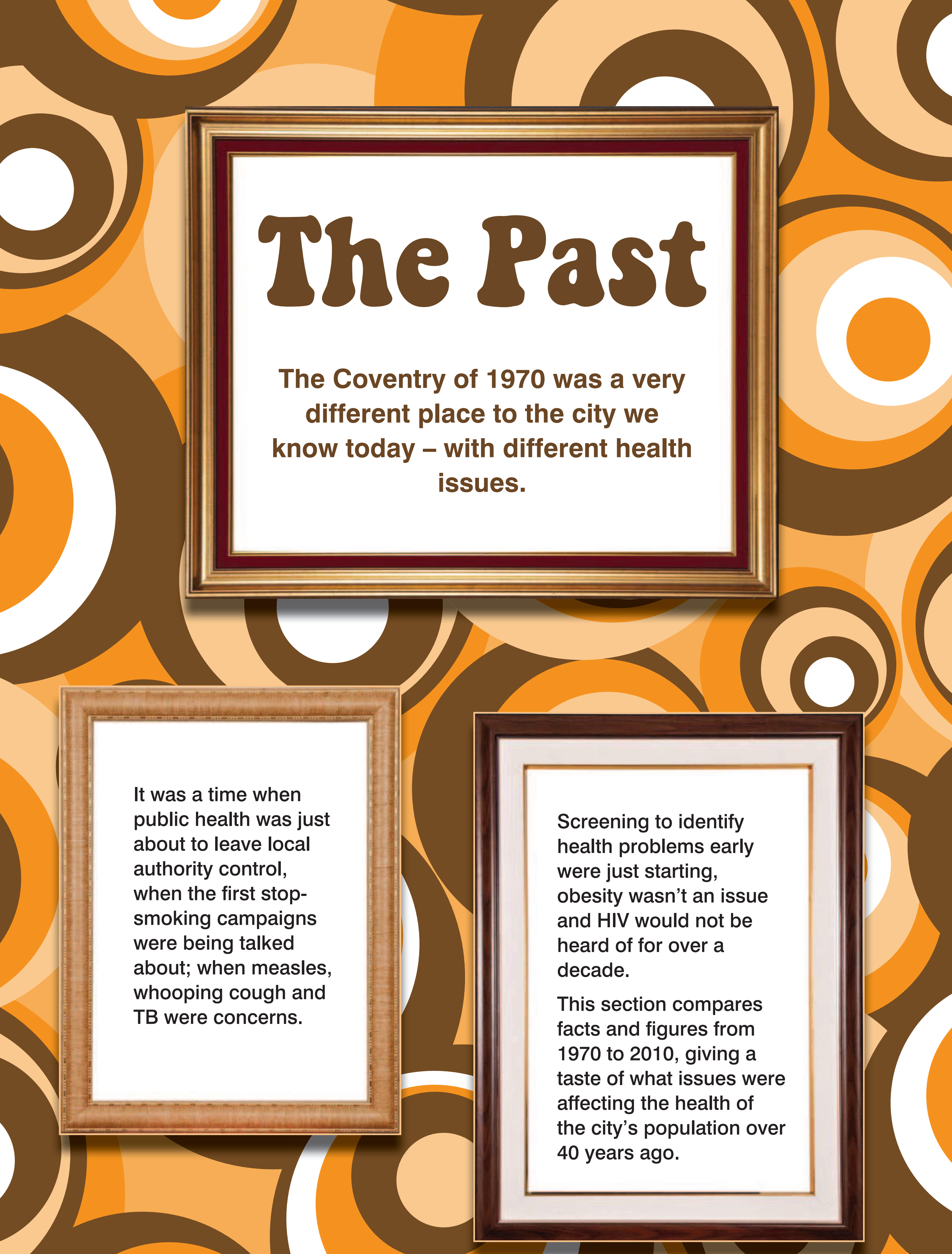
The second part examines the health of Coventry today, looking at issues such as inequalities between different areas of the city.

Finally, the report will look to the future and identify the health challenges that face children born in the city in 2012 that will affect their health in the years to come. We look at what needs to be done now to avoid problems in the future.

And Back to the Future is a fitting title for a Public Health report this year.

From its birth in the 19th century until 1974, Public Health was a key element of local government and now government reforms have brought us back home.

Now, as part of the City Council we will continue our work in promoting and protecting the city's health.



The Past

The Coventry of 1970 was a very different place to the city we know today – with different health issues.

It was a time when public health was just about to leave local authority control, when the first stop-smoking campaigns were being talked about; when measles, whooping cough and TB were concerns.

Screening to identify health problems early were just starting, obesity wasn't an issue and HIV would not be heard of for over a decade.

This section compares facts and figures from 1970 to 2010, giving a taste of what issues were affecting the health of the city's population over 40 years ago.

Let us start with how long you would live back then….

In 1970 Coventry had a younger population – more children aged under 15 and fewer people living over 65 and into old age.

Overall life expectancy has improved for men and for women in Coventry over the past 40 years, but remains less than the rest of England.

The main causes of death in Coventry have stayed the same over the 40 years - circulatory (heart) disease and cancer, followed by respiratory disease – only the proportions have changed.

What were the main health problems back then?

1. In 1970 deaths from circulatory accounted for 48% and 51% of all deaths in men and women respectively. This proportion fell to 29% of all deaths by 2010 for both genders.

2. This fall is, as a result of better diets, surgical advances, new drugs and health prevention are now cutting the numbers of heart disease deaths and strokes.

3. Improvements in healthcare account for probably the biggest impact in reducing these numbers, most notably in pregnancy and childhood.

Cancer accounted for 21% and 20% of all deaths in men and women, this increased in 2010 to 29% for men and 27% for women.

Today there are more cases of prostate and breast cancer – partly due to people living longer.

What was childhood like?

In 1970 just 3 out of 10 children under 14 were surviving cancer for 5 years or more following diagnosis. Today that figure has improved to almost 8 out of 10 under 14s surviving for five years

Improved health care in pregnancy and early childhood, has dramatically cut deaths of new-borns and children in the first year of life.

In 1970 there were 3,121 reported cases of measles compared to 24 cases in 2010.

A total of 49% of children aged one-two-years had the measles jab in 1970, compared to 95% receiving the MMR jab in 2010.

Smallpox was one of the routine vaccinations in 1970, with 2,791 primary vaccinations. The disease was declared eradicated in 1980.

There were 140 cases of whooping cough reported in Coventry in 1970 – 0 in 2010.

Cases of TB (tuberculosis) have reduced from 208 to 61.

In 1970 a total of 2,486 people attended the 'special clinic' for sexually transmitted diseases. In 2010 that figure was 15,730.

Infectious disease was a big issue in 1970 and it remains one still with the appearance of new infectious like HIV which has added to a slight increase in infectious diseases deaths.

In 1970 treating the causes of ill health was starting to become more important.

The truth about the harmful effects of smoking was beginning to filter through into the public's consciousness and Coventry was launching one of its first city-wide campaigns.

Fast-forward to today and smoke-free laws have banned smoking in almost all enclosed public spaces; the age of sale for tobacco has been increased from 16 to 18 years; and there are graphic health warnings are on all cigarette packets and bans on most advertising. But still, smoking remains an issue in Coventry.

In 1970, 1,859 Coventry women took part in the cervical screening programme run by the Local Authority.

In 2010, 63,908 – three quarters of the women eligible for cervical screening - attended for their test.

There are now national programmes in place for Breast, Cervical and Bowel Cancer; Diabetic Eye and Abdominal Aortic Aneurysm and six antenatal and newborn screening programmes.

The Present

Coventry is a healthier place now than 1970, but still the city has a lot of work to do to match national and regional standards.

Work is already underway in many areas and has seen great improvements, but action is still needed to help reduce deaths from major causes such as heart attacks and cancers, as well as from infectious diseases and other causes.

Many of the city's health problems are made worse by inequalities across the city – caused by the circumstance in which people are born, grow, live, work, and age.

The fact that in Coventry today people in different social circumstances experience avoidable differences in health, well-being and length of life is, quite simply, unfair.

For a man in Coventry the life expectancy is 77.2 (UK average 78.6) and for a woman 82.6 (UK average 82.6).

But a man born in the Banner Lane area can expect to live 12.1 years longer than one born in the city centre - 82.7 years compared to 70.6. While a woman born in the Hipswell area lives 11.3 years longer than one born in the Willenhall area - 87.4 years compared to 76.1.

In the city those inequalities contribute to figures such as:

- 19,000 children and young people (26.9%) are living in poverty
- 680 16-19-year-olds are Not in Employment, Education or Training

Taking action to reduce inequalities in health needs action across the whole of society including: fair employment and good work for all, improved access to good jobs and reduced long-term unemployment as well as a healthy standard of living.

Other issues affecting the health of the city and the action being taken include:

Fuel poverty

16.2% of Coventry households are in fuel poverty (40% of households in some parts of the city) – spending more than 10% of their income on heating. The national average is 14.6%.

Coventry's "winter warmth campaigns" include a Helping Hands Service by Age UK and extra heaters, food and clothing as well as free loft and cavity wall insulation for vulnerable people.

Obesity

25.7% of Coventry people are obese compared to 24.2% in England. Nearly a quarter of 4-5 year olds start school overweight or obese, rising to over a third of 10-11 years olds leaving primary school. A 10-11 year old in the most deprived area of Coventry is almost twice as likely to be obese as a child in the least deprived area.

Excess weight can lead to Type 2 diabetes, cancer and heart disease and can reduce life expectancy by 9 years.

The Healthy Weight Programme and Coventry Health Improvement Project (CHIP) have already introduced cooking clubs, school meals programmes, walking to school campaigns and many other initiatives. More work is needed to encourage healthy eating and increased exercise.

Alcohol

In the period since 1970 Liver disease has quadrupled in the city – linked to an increase in alcohol consumption.

More men and women in Coventry die earlier from alcohol related issues than the UK average and the city has high numbers of alcohol-related hospital admissions – in 2011, 2,408 adults per 100,000 population.

Action includes trialling treatment as part of a sentence for offenders. There has also been work to reduce drinking at home, a triage in the city centre and nurses in A&E targeting alcohol related admissions.

What are the key issues for childhood now?

Breastfeeding can prevent many childhood illnesses. Coventry's infant feeding team offers one-to-one support to mums in their own home, or at one of 14 groups city-wide. Around 200 mums attend the support groups each month and over 1,000 women have been supported by the team. More work is needed with midwives, health visitors, Children's Centres, GPs, the voluntary sector and parents.

A childhood immunisation programme offers protection against Diphtheria, Polio, Pertusis, Tetanus, Meningitis (C, Hib, Pneumococcal), Measles, Mumps, Rubella and Human Papiloma Virus (HPV) – Cervical Cancer. Coventry has moved from being one of the worst performers outside London to one of the best. We need to continue this excellent work and target areas where children are still at risk.

However new challenges have emerged….HIV

Coventry has the second highest rate of HIV in the West Midlands with around with 2.7 per 1000 people living with HIV in the city. The city also has a larger percentage of women with HIV than nationally.

HIV testing is available in sexual health services and at some GPs. All women are screened on an 'opt-out' basis at antenatal services. Funding has been made available to develop screening in community venues and community groups are promoting HIV testing. There is also an extensive and successful C-Card scheme promoting the use of condoms.

The Future

Looking back into our past we can see that the health of future generations will be helped by work now to reduce smoking, excessive drinking, poor diet and low levels of physical activity.

Studies have found that if a person is a non-smoker, physically active, only has a moderate alcohol intake and eats their five portions of fruit and veg' a day, they have the same chance of dying as someone 12-14 years younger.

People with just one unhealthy behaviour are 39% more likely to die early than those with no unhealthy behaviours whilst those with all four unhealthy behaviours are four times as likey to die early as those with none.

The situation is getting better - with more people changing to a healthy lifestyle - but those with no qualifications or in unskilled jobs are still more likely to slip into a poor lifestyle. Therefore, the other major focus going forward needs to be how we ensure people have the best opportunities in life. So….

We need to:

- Give every child the best start in life
- Enable all children young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill health prevention

We need to ensure that any child born today in Coventry has an equal chance of a long and healthy life whichever part of the city they live in.

The city's future health needs action now in all areas of a person's life – from before birth by giving advice to mums-to-be, to encouraging breastfeeding, creating high-performing schools and attracting quality sustainable jobs, through to care in later life.

Three major areas that can affect lifestyle opportunities and choices and lead to problems such as smoking, heavy drinking and obesity at

- Education
- Employment
- Transport

Coventry is already tackling these issues – but more needs to be done.

Education:

Working with parents in getting their children ready for school lays the foundation stone to giving every child born in Coventry the best possible start in life and for their future life chances.

In education, children need good quality primary and secondary schools. A good education is linked with healthy lifestyle and low mortality rates.

The Council is working with primary schools to bring in improvements and make sure schools achieve good Ofsted levels, with schools working together to spread good ways of working.

And the city's secondary schools are performing well, with 78% of secondary schools, 75% of special schools and 63% of post-16 provision are good or outstanding. There has been a great improvement in academic results in the city.

Employment

Unemployment is a major cause of ill-health, as are jobs with long hours and low levels of support. It is estimated that 13,900 Coventry residents were unemployed between October 2010 to September 2011 – higher than the national average.

The Council's Jobs Strategy has three aims to help everyone in the city into a secure job:

- Bringing in high profile projects and marketing Coventry as the right place to invest and grow
- 'Helping people to get jobs' by targeting help to jobseekers to match their skills
- helping people to improve their skills and become more attractive to employers

The Council is also running a successful apprenticeship programme to help 16-24-year-olds into work and encouraging businesses across the city to follow their lead.

And the Local Enterprise Partnership (LEP) will have a key strategic role in supporting the right developments and attracting organisations to Coventry and the sub region that will provide sustainable quality jobs.

Transport:

Greener ways of travelling are being promoted through initiatives such as the new cycling and walking route from Coventry station to the city centre and the Cycle Coventry project has been awarded a government grant of over £6 million to improve cycle routes so Coventry is on the right road to a healthier future.

And Coventry has already made the entire city centre within the Ring Road a 20mph zone and created shared-space junctions to encourage more active travel.

However, we need to be more ambitious in future and build on the strengths and capabilities of the people of Coventry, so that we can be a more active, capable and positive city and one they can fulfil their potential life chances.

e.g. Over the next year we want to work with the people of Coventry on how we can create a more active friendly city. We will be doing this under the banner of

' Coventry on the move' and what we want is your ideas and involvement in how we do this

A healthy future?

In this look back over the past 42 years, we have seen how the health of the city has improved.

Life expectancy has increased for both men and women, infant mortality has been greatly reduced and many previous infectious diseases have been contained. Overall the health of people in Coventry has not improved and remains poor compared to other parts of the West Midlands and the rest of England.

But there are now different threats and different priorities and more work is needed to make the city healthier and give the children of today a better future.

But if we take the action needed to tackle issues such as obesity and high level of smoking and drinking and introduce the social changes needed to bring in health equality for all, no matter what part of the city they live in, the health of the city of the future will be much improved. As importantly, peoples' well-being and the sense of Coventry as a good city in which to live will be enhanced.

We should focus on what we can change and what is within the city's gift to change.

This report has made it clear that there is much that is being done, but there is still more to be done, if we want to improve the health, wellbeing and overall quality of life of everyone in the city – from birth through to later life.

There is work ahead for public bodies in areas such as education, transport and employment, but communities need to be given the power and the ability to help make choices and take action for themselves.

We need to work together as a city to allow us to look towards a healthier future for ourselves, our children and our children's children.

Briefing note

To: Health and Well-Being Board

Date: **21st October 2013**

Subject: Signing of the Local Government Declaration on Tobacco Control

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1 Purpose of the Note

1.1 To provide the Board with background information about the Tobacco Control Declaration and set out why Coventry should be one of the early signatories.

2 Recommendations

2.1 Health and Well-Being Board is recommended to:

a) Note the background paper.
b) Approve the signing of the Tobacco Control Declaration.

3 Information/Background

3.1 **What is the Local Government Declaration on Tobacco Control**

3.2 The Declaration was initially developed by Newcastle City Council in early 2013 as a way of securing high level, local authority commitment to the importance of tackling issues relating to smoking. It is based on the highly successful Nottingham Declaration on Climate Change and has been endorsed by the Health Minister, Chief Executive of Public Health England and the Chief Medical Officer.

3.3 *"As the Minister responsible for public health, both I and the Chief Medical Officer applaud the initiative of Newcastle City Council in bringing forward their Declaration on Tobacco Control. We endorse this approach and encourage every local authority to sign-up and make a clear commitment to take action to reduce the rate of smoking tobacco in their local area."* Anna Soubry, Public Health Minister, June 2013

3.4 The Declaration includes a number of specific commitments which will enable Councils to take a strong leadership approach and champion the importance of tackling smoking right across local communities.

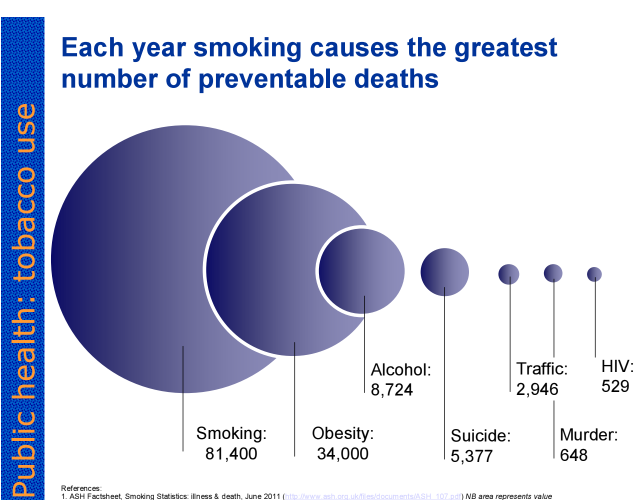
3.5 So far, eight local authorities have signed the declaration: Newcastle, Salford, Swindon, Manchester, Hartlepool, St Helens, Warwickshire and Bristol.

3.6 **The smoking issue has not been solved**

3.7 Over the last 15 years, great strides have been taken to reduce smoking rates across England. The Smokefree Law, introduced in 2007, has removed smoking from nearly all enclosed public spaces; the age of sale for tobacco has increased from 16 to 18 and there are now wide ranging bans on almost all aspects of tobacco advertising. Tobacco control measures like these have helped to protect millions from the harm of second hand smoke and there are over 2 million fewer smokers than there were a decade ago.

3.8 However, despite huge progress, the smoking issue has not been solved:

- Smoking remains the single greatest cause of preventable death.
- Over 400 people in Coventry die prematurely ever year because of smoking related diseases (equivalent to a jumbo jet full).
- Smoking is a childhood addiction – hardly anyone starts after the age of 21.
- Treating smoking-related illnesses costs the NHS £2.7 billion every year.
- While rates of smoking have continued to decline over past decades, 19% of adults in England still smoke (22% in Coventry).



3.9 **Progress in Coventry in recent years**

- Coventry's smoking prevalence has fallen from 29% to 22% over the last 6 years.
- Since 2010 Coventry has employed a new delivery model for Smoking Cessation Services in which we commission multiple providers with payment by results. Since this change we are seeing around an extra 2000 local people per year access our local services and an extra 1200, 4 week quitters per annum.
- In 2012 Coventry was the only Olympic City to create a designated 'Smokefree Zone' in the heart of the city for local people to watch highlights of the games on a big screen.
- As part of this Olympic Smokefree legacy, in July this year Coventry made all its Children's Playgrounds completely smokefree. This campaign will help to change social norms and create clean, smokefree places for children to play. All primary and nursery school gates in the city are to be made smokefree in November 2013.
- Coventry's Shisha Awareness Campaign was 'highly commended' in the 2012 MJ local gov't awards and has been used by numerous local authorities across the country.
- Coventry has a well-established 'Smokefree Alliance' which brings together a range of public, private and voluntary partners together to tackle issues relating to tobacco at a local level (chaired by Cllr Clifford).

3.10 **Significant & growing role for local authorities**

3.11 The local authority already plays an important role in reducing tobacco use in Coventry. The Environmental Health team enforces the Smokefree Law across the city and the Trading Standards department work to reduce the availability of smuggled and counterfeit tobacco as well as ensuring local shops are not allowing under-age sales.

3.12 The local authority's role increased even further in April 2013 when it took over Public Heath responsibilities from the Primary Care Trust – part of which includes the commissioning of the city's Stop Smoking Services.

3.13 **Building on the momentum**

3.14 Through the work of The Smokefree Alliance, Coventry is already in the process of undertaking and implementing the commitments set out in the declaration.

3.15 However, more needs to be done. We cannot afford to be complacent. As a city we must continue to build on the successes of recent years and work together with our partners to make tobacco control 'everybody's business'.

3.16 Having the local authority fully behind the fight to reduce smoking prevalence across the city will play a huge part in helping the people of Coventry live healthier and longer lives – and with the signing of the Declaration we have a clear mandate to move forward.

3.17 Queries to:

Alex Angus
Tobacco Control Co-ordinator
024 7683 3074
alex.angus@coventry.gov.uk

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Local Government Declaration on Tobacco Control

We acknowledge that:

- Smoking is the single greatest cause of premature death and disease in our communities;
- Reducing smoking in our communities significantly increases household incomes and benefits the local economy;
- Reducing smoking amongst the most disadvantaged in our communities is the single most important means of reducing health inequalities;
- Smoking is an addiction largely taken up by children and young people, two thirds of smokers start before the age of 18;
- Smoking is an epidemic created and sustained by the tobacco industry, which promotes uptake of smoking to replace the 80,000 people its products kill in England every year; and
- The illicit trade in tobacco funds the activities of organised criminal gangs and gives children access to cheap tobacco.

As local leaders in public health we welcome the:

- Opportunity for local government to lead local action to tackle smoking and secure the health, welfare, social, economic and environmental benefits that come from reducing smoking prevalence;
- Commitment by the government to live up to its obligations as a party to the World Health Organization's Framework Convention on Tobacco Control (FCTC) and in particular to protect the development of public health policy from the vested interests of the tobacco industry; and
- Endorsement of this declaration by the Department of Health, Public Health England and professional bodies.

We commit our Council from this date ....to:

- Act at a local level to reduce smoking prevalence and health inequalities and to raise the profile of the harm caused by smoking to our communities;
- Develop plans with our partners and local communities to address the causes and impacts of tobacco use;
- Participate in local and regional networks for support;
- Support the government in taking action at national level to help local authorities reduce smoking prevalence and health inequalities in our communities;
- Protect our tobacco control work from the commercial and vested interests of the tobacco industry by not accepting any partnerships, payments, gifts and services, monetary or in kind or research funding offered by the tobacco industry to officials or employees;
- Monitor the progress of our plans against our commitments and publish the results; and
- Publicly declare our commitment to reducing smoking in our communities by joining the Smokefree Action Coalition, the alliance of organisations working to reduce the harm caused by tobacco.

Signatories

Leader of Council	Chief Executive	Director of Public Health

Endorsed by

Anna Soubry, Public Health Minister, Department of Health

Duncan Selbie, Chief Executive, Public Health England

Professor Dame Sally Davies, Chief Medical Officer, Department of Health

Dr Janet Atherton, President, Association of Directors of Public Health

Dr Lindsey Davies, President, UK Faculty of Public Health

Graham Jukes, Chief Executive, Chartered Institute of Environmental Health

Leon Livermore, Chief Executive, Trading Standards Institute

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