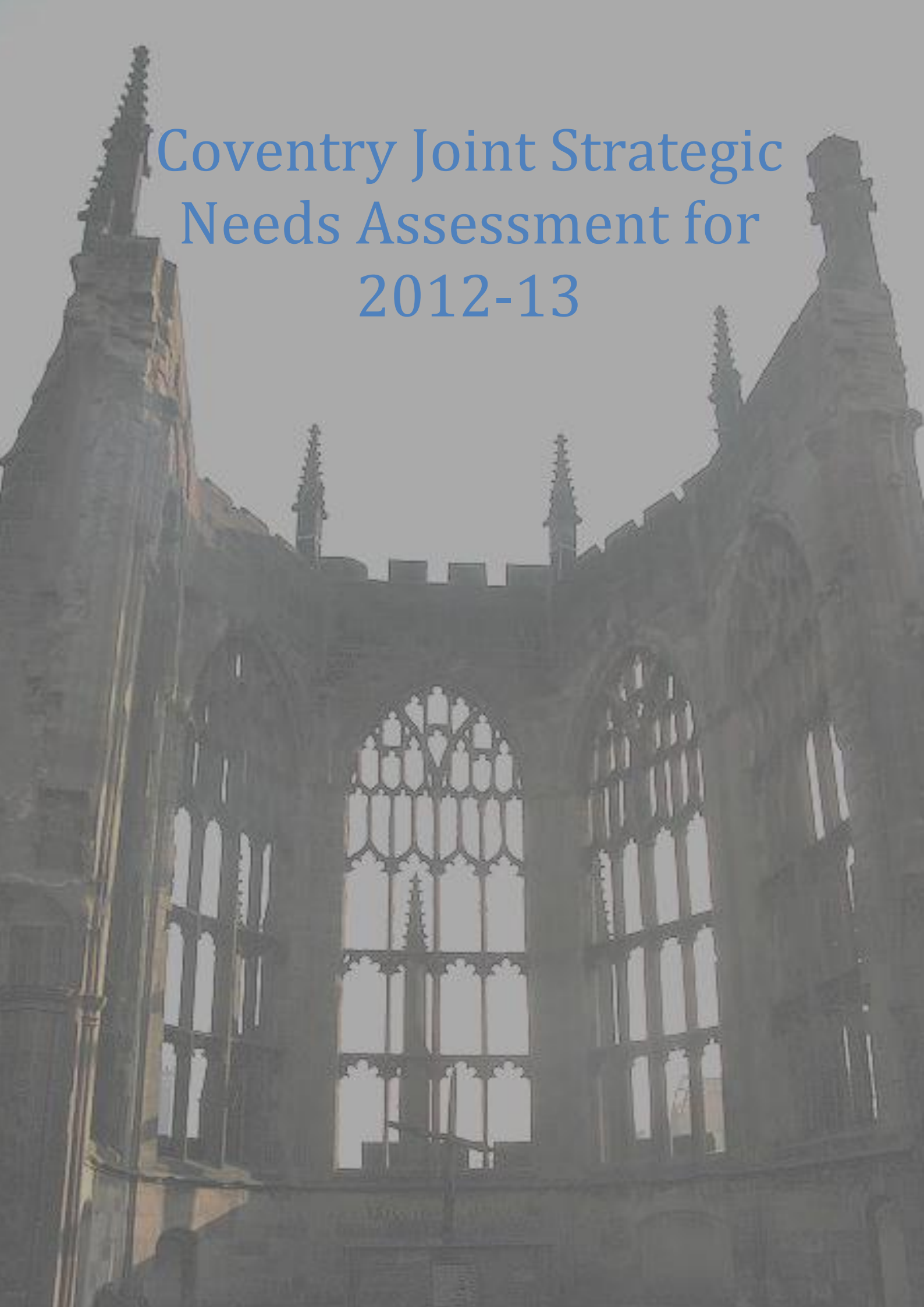
Coventry Joint Strategic Needs Assessment for 2012-13



Contents

This document is intended as a technical document to support the development of the Health and Wellbeing Board's Health and Wellbeing Strategy.

Executive Summary

The Task and Finish Group has developed a prioritisation process to assess each of the issues arising from the Joint Strategic Needs Assessment (JSNA). This process was used to form a recommendation as to those priorities that should be included in the Health and Wellbeing Strategy. The prioritisation process uses the key questions;

1. Is there more that could be done to tackle this issue?
2. Is the delivery of this important to all partners?
3. Is it of strategic importance? (e.g. does it influence health inequalities, is it an area where outcomes are poor)
4. Is there considerable impact? (in terms of health impact and number of people adversely affected)

The Task and Finish Group recommend that there are four themes that form the basis for the Health and Wellbeing Strategy;

<u>Theme One -Healthy people</u>

Enabling all to maximise their health and wellbeing outcomes across the lifecourse, and the entire care pathway. There is a particular focus on early years, where there is the most scope for prevention, and older people, who carry the largest burden of ill health. Both the general population outcomes and those for particular high risk groups will be improved through a partnership approach.

Initial priorities;

- Early Years (prenatal to age 2)
- Older people

<u>Theme Two - Healthy Communities</u>

Working with our communities to empower them to sustain good health and well-being, and address the broader determinants of health, using asset-based approaches.

Initial priorities;

- Obesity (maternal and childhood)
- Mental Wellbeing
- Domestic Violence and abuse
- Sexual Violence

Theme Three - Reduce variation

Identifying and intervening for disadvantaged groups; those at high risk of poor outcomes. For example, it covers migrant health, disabilities and looked after children. Variations in outcomes across the population will be addressed.

Initial priorities;

- Smoking
- Alcohol
- Infectious Diseases

Theme Four - Improve outcomes

Maximising the health and wellbeing outcomes for the population of Coventry, by focusing on those areas where there are major opportunities to raise the health and wellbeing up to the level of the most healthy people in England.

Initial priorities;

- Cancer (for Year 1)
- Variation in primary care
- Lifestyle risk management (Making every contact count)

Cross-cutting themes

In addition, the following cross-cutting themes are highlighted as ways of tackling these issues;

- Prevention - in line with Marmot, there should be a focus on prevention and early intervention.
- Partnership working – though identified as a key strength in Coventry, more could and should be done to join up services; services should be aligned, and designed around the needs of the service user.
- Community engagement - an asset-based approach should be used; Coventry has many strengths and we need to ensure that those strengths are identified and built upon, rather than focusing on problems.

Chapter 1. Introduction

This document forms part of the Joint Strategic Needs Assessment (JSNA) for Coventry 2012. It is complemented by the website www.facts-about-coventry.com which provides a comprehensive data set covering a wide range of indicators that are relevant to health outcomes or determinants of health in the City.

The purpose of the JSNA is to inform the commissioning of public services across the city; with the move of Public Health from the NHS into the Local Authority, the previous focus on health and social care has been broadened to include the wider determinants of health. This is carried out through the Health and Well-Being Board (HWBB), which is currently in Shadow form and will be in place from April 2013.

The HWBB will consider the JSNA and develop a Health and Wellbeing Strategy which will highlight those key priorities that;

- Are strategic and take account of the current and future health and social care needs of the entire population.
- Look beyond *needs* to examine how local ***assets***, can be used to meet identified needs.
- Are key to understanding inequalities in the local area and the factors that influence them.
- Focus on the things that can be done together.
- Are the issues requiring the greatest attention.
- Are the issues that make the biggest difference in improving outcomes

This marks the first year of the development of the JSNA to become a comprehensive tool to meet the needs of the HWBB. Due to rapid timescales for this first year (following on within six months from last year's JSNA), the 2012 JSNA has been developed largely from the stakeholder views gathered in September/ October 2011. A development plan is in place to build the JSNA into a robust process that gathers suggestions for priorities from a wide range of stakeholders and systematically considers these issues, using agreed criteria. It will also include more of a focus on assets – the resources that a community has that can be developed to solve local issues – rather than the current approach which focuses on identifying deficits.

This year's JSNA focuses attention on Healthy People, Healthy Communities, Improving Outcomes and Reducing Variation.

Chapter 2. Causes of the causes of ill health

The term 'health inequalities' refers to the fact that significant outcomes in health, such as life expectancy, and disability-free life expectancy, show a gradient with socio-economic class, with those living in the poorest circumstances likely to become ill and disabled at an earlier age and to die earlier than those in the wealthiest. Health inequalities are evident in Coventry; life expectancy for a resident born in Coventry is lower than for England as a whole. Within Coventry, the life expectancy for a man born into Foleshill or Willenhall areas is 11.6 years less than a man born in Wainbody (2006-10 data).

Over the past decade or so, attention has been focussed on this issue. Coventry has had a specific target to reduce the gap between the average life expectancy for Coventry and for England. Life expectancy has significantly increased in Coventry during this period; however it has also increased for England as a whole, and the gap has shown little change. Health inequalities are produced from a complex array of interdependent factors, and there are few straightforward evidence-based solutions.

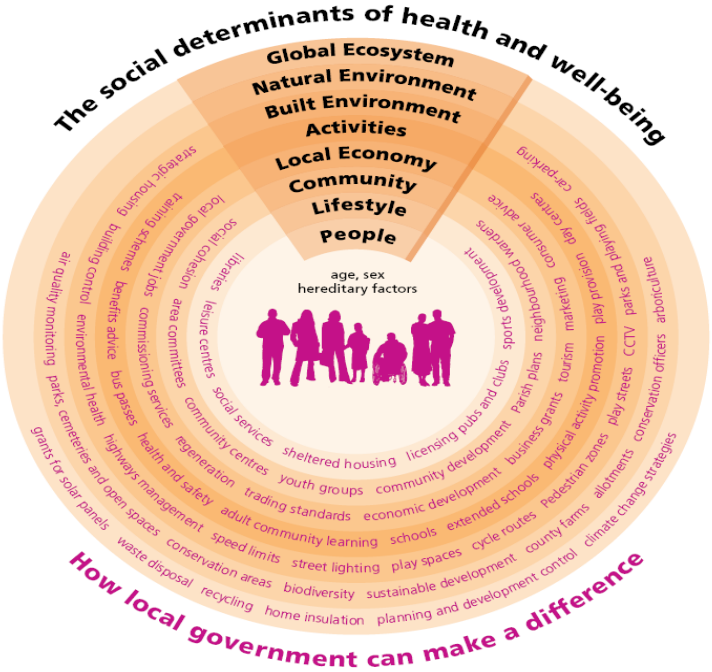
Life Expectancy

Travelling in an easterly direction along the B4101, male life expectancy drops 10.8 years between the Banner Lane Area and the City Centre Area. Travelling South on the B4082 female life expectancy drops 10.8 years between the Hipswell-Ansty Roads Area and the Willenhall Area (2006-10 data)

Early in 2010 The Marmot Review 'Fair Society, Healthy Lives' was published; this focused on tackling the wider social determinants of health inequalities. The review provides a range of evidence-based recommendations for interventions to tackle health inequalities that reflect a 'life course' approach. This means addressing factors that can adversely affect health at each stage of life. Over the life course, starting before conception, these factors accumulate either positively or negatively to affect health.

The Marmot report emphasises that the health and wellbeing outcomes for all but the most wealthy show the impact of health inequalities, with the largest impact in the most deprived groups. Health inequalities should be reduced by increasing the health of all to the level of the wealthiest. This will be achieved through a combination of universal services and targeted services for those most in need.

Figure 1 Social determinants of health and well-being mapped to local government



The Social Determinants of Health and the role of Local Government, I&DeA,

Figure 2 Opportunities to consider health inequalities across the life course

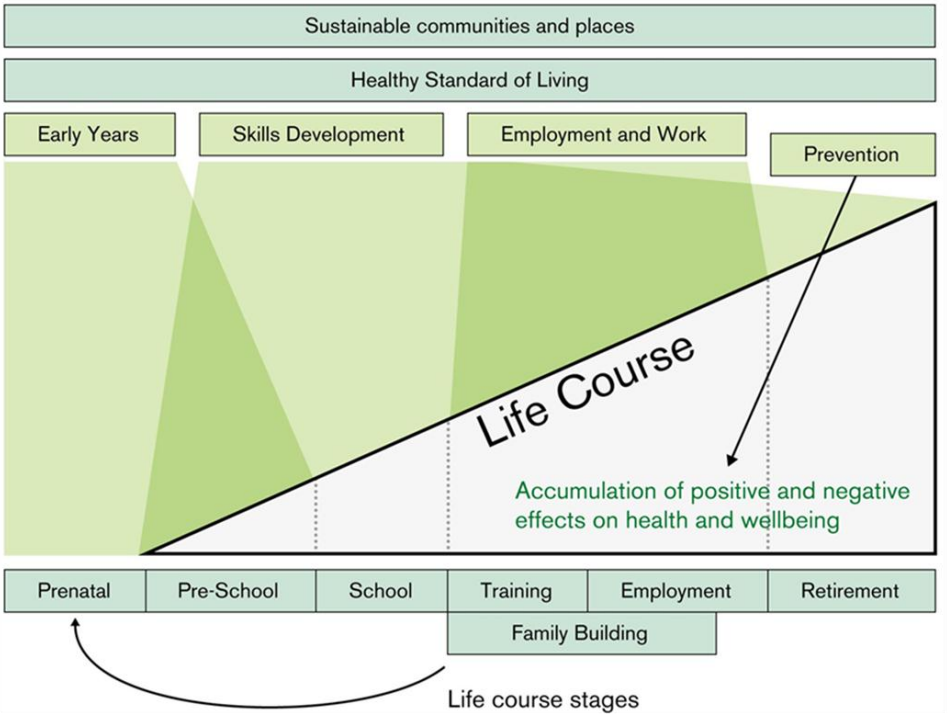


Figure taken from 'Fair Society, Healthy Lives'

The Policy Objectives from the Marmot Review , which have been agreed as local objectives in Coventry through the Health Inequalities Strategy, are;

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

These underpin all approaches to improving the health and wellbeing of the population of Coventry, and therefore underpin the JSNA and Health and Wellbeing Strategy.

A review of health inequalities in Coventry demonstrated that there was a broad range of interventions in place that are largely consistent with the evidence base; no specific gaps were identified. It is recognised that as there has been no narrowing of health inequalities in the city, some change must be required. The review raised the following questions:

Is Coventry providing enough support, through targeted and universal interventions, or are there groups that we are missing?

- For example, considering the first Marmot recommendation 'Give every child the best start in life', the MAMTA Project, based at Foleshill Women's Training Centre, provides pre-conception care aimed at ethnic minority women of child bearing age. This reflects a targeted service to a group identified as being in need. However, it might be that a wider group would benefit from a similar intervention, in different areas of the city, and this might include groups not typically considered as deprived.

Where a targeted service is being provided, are the right people accessing the right services at the right time?

- If we have identified a need for a targeted service, it is important to ensure that the targeting has worked. For example, it is known that there are a higher proportion of smokers in the most deprived groups, but that these people are less likely to access stop smoking services. Stop smoking service providers receive incentives to work with people in the most deprived groups, and are closely monitoring how successful their targeting is.

Could the same services be delivered differently – to make them more accessible, more effective and more cost- effective?

- Ensuring that services are delivered in the best way for the population that need them will make them more effective. For example, if an individual very rarely sees anyone who can advise them on health matters, then it is important to make the most of every encounter to identify and meet their needs; this may be more efficient than trying to attract them on multiple occasions. Examples here could include Health Checks, projects with the Citizens Advice Bureau (where the individual may seek support for financial needs) and the Work and Health programme.

As part of the Strategy, a set of indicators were developed to monitor progress against each of the recommendations. The key actions were;

- Health inequalities should be explicitly considered within all health and social care strategies as these are developed and / or reviewed.
- There should be development of community engagement mechanisms particularly in the most deprived communities.
- There should be reduced variation in primary care services, ensuring all practices meet important public health targets and deliver high quality care for those with chronic diseases.
- All frontline staff should be trained to ensure 'Every Contact Counts' in promoting healthy lifestyles.

Chapter 3. Causes of ill-health and death in Coventry

This chapter details differences in the main causes of ill health and death in the Coventry population compared to England as a whole.

Mortality rates for people of all ages (2008-10)

Coventry has significantly higher mortality rates than England for the following diseases for people of all ages:

- All causes
- All cancers
- Acute myocardial infarction
- Asthma
- Bronchitis, emphysema and other COPD
- Chronic liver disease including cirrhosis
- Diabetes
- Epilepsy
- Hypertensive disease
- Infectious and parasitic disease
- Stomach cancer
- Tuberculosis
- Suicide and injury undetermined

Coventry has significantly lower mortality rates than England in people of all ages for:

- Coronary heart disease
- Ischaemic disease other than acute myocardial infarction
- Stroke
- Pneumonia

Mortality rates for people aged under 75

Coventry has significantly higher mortality rates than England in people aged under 75 for:

- All causes
- All circulatory diseases
- All cancers
- Acute myocardial infarction
- Lung cancer
- Bronchitis, emphysema and other COPD

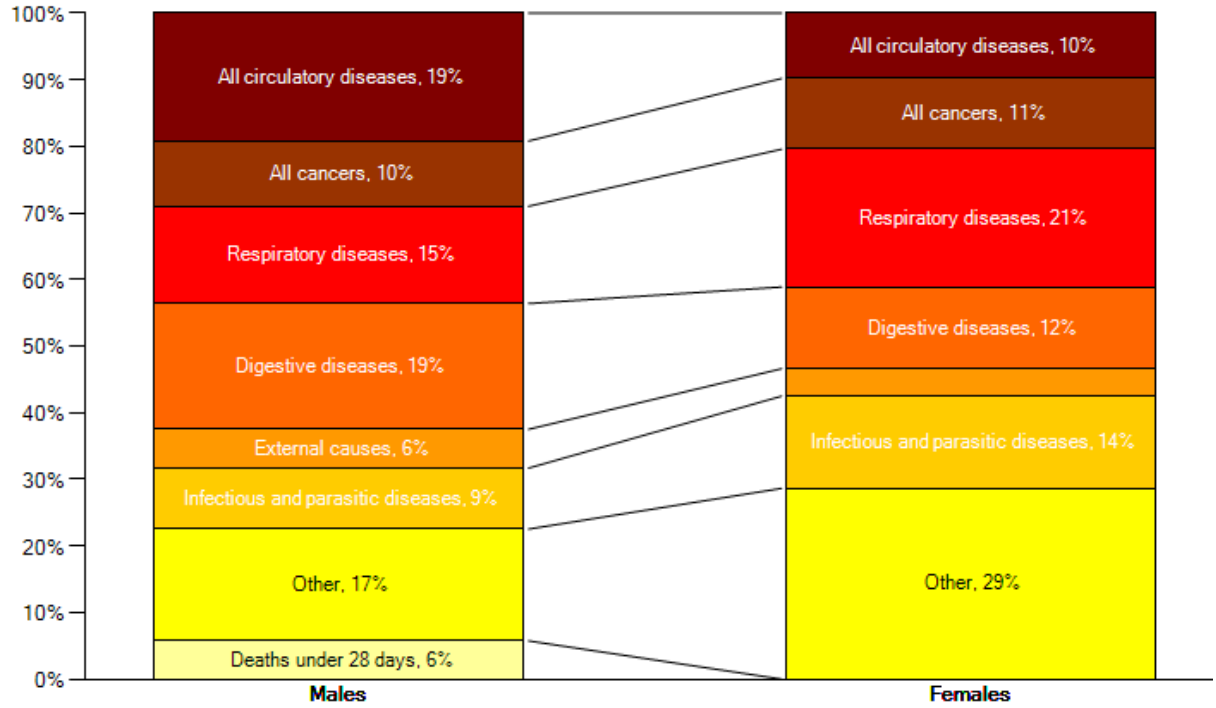
- Chronic liver disease including cirrhosis
- Diabetes
- Epilepsy
- Infectious and parasitic disease
- Pneumonia
- Stomach cancer
- Suicide and injury undetermined
- Tuberculosis

There are no mortality causes that are significantly lower in Coventry than in England for the under 75's.

The JSNA website has replaced the annual compendium as it now hosts health data that can be displayed in instant atlas. This site can be accessed here: http://www.coventrypartnership.com/JSNA

In the figure below, the 'excess' deaths that occur in the Coventry population compared to the population of England as a whole are shown by cause of death for men and for women.

Breakdown of the life expectancy gap between Coventry and England, by cause, 2006-08



http://www.lho.org.uk/NHII/Spearhead/LifeExpectancyChart.aspx?areaCode=00CQ&datatype=4

Chapter 4. Mental wellbeing; Feeling good and doing well in Coventry

Much of this years JSNA considers the problems faced by particular individuals and their communities; such as poverty, poor access to services, poor health and shorter life expectancy. By definition, it focuses on 'need'.

However, the Public Health White Paper, *Healthy Lives, Healthy People* sets out a greater emphasis on well-being and prevention, building people's self-esteem, confidence and resilience, 'shifting power to local communities' and tackling the wider determinants of health.

The North West region have been piloting an approach to the JSNA commonly referred to as the asset based approach. This seeks to identify the assets (capacity, skills, knowledge, connections and potential) available within the community.

It is anticipated that Coventry will work towards the development of a strategic asset analysis to be incorporated within the JSNA.

Further information on this approach can be found here; A glass half-full: how an asset approach can improve community health and well-being, IDEA, http://www.local.gov.uk/c/document_library/get_file?uuid=fc927d14-e25d-4be7-920c-1add80bb1d4e&groupId=10171

Within the city, the asset-based approach is used in small-scale work with communities, such as through the community development team. We have 2 pilots in Coventry, working with the Neighbourhood Action Team.

One is using the 'Connecting Communities' approach and is based in Foleshill, working with residents on their priorities for their neighbourhood, with the aim of setting up an equal decision making partnership between local residents, agencies and services. A key focus is to support resident leaders as they form a partnership.

A second pilot is underway in Bell Green using the 10 ways for feeling good and doing well in Coventry, engaging with residents to find out what is good about where they live and what they want to do to improve wellbeing through working with their neighbours and community. There is a small fund to supporting them to turn their ideas into action and this is currently supporting the following projects;

- Bell Green Silver Surfers – Stay Connected – Support older people to stay connected with family and friends through making use of the Internet

- Bell Green History Group - promote a positive relationship between all generations of the area through developing and talking about their history in the area, collecting stories and photos across the generations about living in Bell Green
- The Next Generation Grandparents - A group to enable Grandparents looking after pre-school age children to meet up in the local area and share their experiences and gain mutual support and wellbeing and to reduce their isolation
- Websdale Community Get Together – to secure space for residents to meet and find out what is happening in their area
- Shanti Bavan Ladies Group – lifestyle and wellbeing group
- The Big Clean Up - to clean up rubbish, alley ways, green space , local streets, promote tidy healthy streets , a place for people to promote feeling good about themselves and where they live

Closely associated with this approach, results from the Coventry Household Survey, which used a number of questions to measure mental wellbeing, demonstrated that the relationship of mental wellbeing is not strongly related to deprivation. This indicates that in some groups have higher mental wellbeing than might be expected from their deprivation levels. The reasons for this are poorly understood, but in these groups their higher mental wellbeing is an asset which may have positive benefits for their health. Understanding the reasons for this (and similarly for lower mental wellbeing in some groups than you might expect from their higher socio-economic status) may help to promote mental wellbeing, which in turn may help to shift towards healthier lifestyles and health outcomes.

Chapter 5. Vulnerable groups across the life course

This section considers specific groups of the Coventry population that may be more likely to suffer poor outcomes, due to an accumulation of effects across the lifecourse.

Born into and growing up in poverty

The total number of births in Coventry has increased by 29% since 2001. The majority of births occur in the most deprived quintile of the population and this result is becoming more extreme over time. Analysis of the mother's country of birth shows that, compared to 2001, there have been significant increases in births to parents originating in Africa, and Europe, while those to UK-born mothers remain fairly stable. This shows that, of the 31% increase in births since 2001, almost all of that increase is due to births among the most recently immigrated ethnic groups.

As well as being born into poverty, there may be additional harm due to lack of access to services (for example, through language barriers, lack of awareness of services or factors such as no permanent address).

As highlighted by the Coventry Child Poverty Needs Assessment (which can be found here), poverty has a negative impact on the health and education outcomes of children and young people in Coventry. This is illustrated by poorer educational attainment, more likely to be born prematurely and die in their first year of life, be obese, have poor dental health – all factors that have an impact across the life course and will lead to lower life expectancy on average.

Coventry has a higher percentage of child poverty (as defined by the Child Poverty Act) than both the national and the West Midlands average, making the authority the 47th highest local authority with child poverty in England. In addition, there are a further 19,600 children in families affected by 'in-work poverty' - these children are in families where one or more people are working, but their income is not enough to take them above the poverty line.

Geographically, child poverty is concentrated in certain areas of the city; Foleshill (44%); St Michael's (45%); Henley (40%) and Binley and Willenhall (39%) (2009 figures).

Looked after children

In Coventry at September 2011 there were almost 600 looked after children. In general, the majority of children in the care of local authorities have suffered abuse

or neglect. Outcomes are generally poor, including underachievement at school and unemployment, social, emotional or behavioural issues, and they are more likely to be homeless or imprisoned than the general population. These factors are all related closely to poor health outcomes.

Asylum seeking, refugee and newly arrived families

Asylum seeking, refugee and newly arrived families do not have recourse to public funds and are particularly vulnerable to poverty, poor health and anxiety. There may also be considerable barriers to accessing services that they are entitled to. Coventry currently supports a number of such families, as these families are disbursed to Coventry through the Government's National Asylum Seeker Support Service (NASS).

Complex social care needs

Due to successes in treatments for conditions which may previously have been life-limiting, there are growing numbers of people with complex social care needs; younger people moving into adult services, people with disabilities living longer, and a background of increasing numbers of older people.

These are examples of the specific groups that will be considered within the themes of Healthy People, Healthy Communities, Improving Outcomes and Reducing Variation.

Demographics; A full population report can be found here, further information on Country of Birth is available here, and on Birth Ethnicity here.

Chapter 6. Key Areas for Action in Coventry

This chapter presents three cross cutting themes which should guide the approach taken to improving health and wellbeing in Coventry. The key themes which form the basis of the Health and Wellbeing Strategy for Coventry are then presented, highlighting initial priorities.

Cross-cutting themes

In addition, through consultation with key stakeholders (including professional groups, voluntary/third sector providers and the public, patients and their representatives), three cross cutting themes emerged to guide the approach to tackling these issues;

1. Prevention

In line with Marmot, there should be a focus on prevention and early intervention. It was recognized that Coventry has made considerable advances in some areas (such as parenting programmes and educational attainment, and through Coventry Health Improvement Programmes). These approaches could be broadened further, ensuring that opportunities for improving health and wellbeing are taken. Childhood obesity was highlighted as a key priority.

2. Partnership working

Partnership working was identified as a key strength in Coventry. This included partnership working across public and voluntary services, as well as working in partnership with our communities. However, while recognizing the progress that had been made, each theme group identified that more could and should be done to join up services; services should be aligned, and designed around the needs of the service user. This should start with a shared strategic vision from the Health and Wellbeing Board. Resources should be pooled where appropriate to allow services to be built around the person/family.

3. Community engagement

Strong community engagement is vital to ensure that services that are put in place will meet the needs of the community. An asset-based approach should be used; Coventry has many strengths and we need to ensure that those strengths are identified and built upon, rather than focusing on problems. Identifying these will help to place services in such a way that they are seen as integrated, relevant and accessible to the communities that need them.

Themes

Theme One - Healthy people

Initial priorities;

- Early Years (prenatal to age 2)
- Older people

Theme Two - Healthy Communities

Initial priorities;

- Obesity (maternal and childhood)
- Mental Wellbeing
- Domestic Violence and abuse
- Sexual Violence

Theme Three - Reduce variation

Initial priorities;

- Smoking
- Alcohol
- Infectious Diseases

Theme Four - Improve outcomes

Initial priorities;

- Cancer (for Year 1)
- Variations in primary care
- Lifestyle risk management (Making every contact count)

1. Healthy People

This theme focuses on enabling all to maximise their health and wellbeing outcomes across the lifecourse, and the entire care pathway.

This area reflects the majority of the Marmot Policy Objectives, which emphasise the role that the wider determinants of health have on individuals' health and wellbeing. The particular objectives are;

A. Give every child the best start in life
B. Enable all children, young people and adults to maximise their capabilities and have control over their lives.
C. Create fair employment and good work for all
D. Ensure healthy standard of living for all
F. Strengthen the role and impact of ill health prevention

The Initial priorities highlighted in this year's JSNA are Early Years and Older People.

In the early years, there is the most scope for prevention, particularly in the wider determinants. It should be noted that this includes working with families even before a child is conceived, and that factors such as the education and employment, income, housing and other social factors of the parents have a strong impact on the eventual outcomes for the child.

Older people carry the largest burden of ill health, since the accumulation of factors across the lifecourse lead to increasing poor health. This poor health can occur at different ages and generally those in the lower socioeconomic group spend more years of their shorter life in disability. The wider determinants of health across the lifecourse are therefore important to prevent ill health in older people in the future, though for those currently in this group the focus is on maintaining health, identifying and intervening for poor health to maintain independence and quality of life.

<u>Initial priorities;</u>

- Early Years (prenatal to age 2)
- Older people

Early Years

It is clear that the childhood environment is closely linked to the child's outcomes, including their health outcomes (such as life expectancy). Reducing inequalities in the early years (prenatal to the age of 2) is expected to have an impact on health inequalities, and is a key recommendation of the Marmot Review.

1. What are the health impacts of the issue (short/medium/long term)?

Gaps (e.g. in cognitive development) emerge early in the life course, and they are then replicated throughout a wide range of indicators such as readiness for school, educational attainment, qualifications on leaving school, employment and the income that employment brings. These wider determinants form complex pathways that lead to health inequalities (years of life lost through disability, life expectancy etc).

2. Who does it impact?

At the population level, there is a gradient of health outcomes with deprivation; this means that although those born into poverty face the worse outcomes, all groups other than the least deprived feel some impact.

There are also specific groups who may require further support to fully realise their potential; for example, Looked After Children and children with disabilities (including learning disabilities).

Health outcomes can occur at any point across the life course, but evidence is emerging that the early years set the scene for the development of future lifestyles that lead to ill health. Successful intervention in the early years offers the potential to change the life course through prevention.

3. What is happening with time?

Although there are some indicators showing promising results (for example educational attainment), the increase in births in the more deprived population suggests that this will be a growing challenge for the city

4. What actions should be taken?

Though the Healthy Child Programme is core to this age group, the Marmot recommendations go further than this.

There is a detailed action plan linked to the Coventry Children and Young Peoples Plan (details available at www.coventrycypsp.org.uk/). These actions are centred around; Family Poverty (including families supported into work, and in safe and affordable housing), Achievement (educational attainment, high aspirations), Improving Health (emotionally healthy, lifestyle choices) and Supportive Families (safe from harm, parenting skills).

A Fundamental Service Review (FSR) is taking place to review the key services of the Children's and Young People's (CLYP) Directorate within the City Council, which is focusing

on finding efficient and effective ways of keeping children in Coventry safe. This is carried out through three separate work streams: social care case work, provision of Children's Centres and fostering & adoption.

A review of the health visiting service is underway and the staff resource is being increased to enable the effective implementation of the Healthy Child Programme (HCP). This will allow the service to take on an expanded role in reducing inequalities within the City. Health visiting services are being integrated into children's centres. The FNP (Family-Nurse Partnership) programme has been introduced to offer intensive support for first-time teenage mothers.

An Early Intervention Strategy is currently under development.

5. What (or where) are the gaps?

Though there are few specific gaps, there is a question of whether more could be done. The Marmot report highlighted that '*in the UK, spending is higher in later childhood years, contrary to many non-English speaking countries with low rates of child poverty, where more than 1% of GDP is spent on early childhood services.'*

Though there is emerging evidence regarding what interventions are effective, which is being acted upon in Coventry, there are some gaps in the evidence base.

The recent Health Needs Assessment has highlighted new communities as a group where specific interventions may be required.

6. Why is it of strategic importance for the HWBB?

Does the issue require partnership working across organisations in the HWBB to tackle? Yes

A wide range of outcomes measures are linked to this , including health inequalities

7. Data sources

Range of measures that are relevant are available at the facts about Coventry internet site.

A health needs assessment for Children aged 0-2 has recently been produced and will shortly be publicly available.

What are the relevant stages in the life course for this specific issue?

	Risk factors	**Interventions**	**Health outcomes**
Prenatal	Maternal behaviours such as smoking, alcohol, obesity, poor nutrition.	Good peri natal care Lifestyle interventions Parenting courses, Health visiting.	Immediate such as miscarriage, still birth, some physical/mental disabilities
Preschool		Breastfeeding & weaning Range of interventions; Health visiting, Parent and family support, Children's Centres, preparation for school etc	e.g. accidents and injuries, obesity,
School			
Training			
Employment			Poor health likely to emerge in adulthood; Mental Health and Physical Health
Family building	Parents educational attainment, income etc Wider determinants of environment (physical and social)	Maternity care Smoking cessation, healthy weight, alcohol etc advice for parents Wider determinant work relevant (jobs, housing, environment)	May be experiencing poorer health – e.g. obesity impacting health in pregnancy
Retirement			Poorest 20% may not live to see retirement; disabled at a far younger age.

Older People

Although there is a focus on prevention in the early years, the burden of disease is experienced by older people. Often, they may have combinations of conditions which require treatment and other forms of support, such as social care. It is a priority to 'improve the way services are designed and delivered for people with long-term chronic conditions who are often frail and elderly with a particular emphasis on early identification of risk, early intervention and integrated team working across community nursing and general practice' as stated in the Arden Cluster System Plan.

1. What are the health impacts of the issue?

The proportion of people with physical and mental health conditions increases with age. The burden of physical health problems (such as diabetes, cardiovascular disease, osteoarthritis and respiratory diseases) is often combined with declining mental health; 30% of the over 85's have Alzheimer's disease, and 10-15% of the over 65's are thought to suffer from depression. This has an impact on families as well as the affected individuals. Upwards of 50% of unplanned admissions to hospital are in the over 75 age group. Through better coordination and collaboration between primary, community, mental health and social care services it should be possible to prevent some admissions completely (e.g. through better control of long term conditions, or providing treatment in their own home) or enable people to regain their independence more quickly, both of which provide better patient experience.

2. Who does it impact?

There is a population-wide increase in illnesses at older ages. The more deprived groups are likely to experience poor health at an early age and so at a given age would tend to have more advanced or complex conditions. They may also be at higher risk of a range of wider determinants that impact on health and wellbeing, such as fuel poverty and social isolation.

The term 'frail elderly' refers to those older people who have multiple limitations and impairments, and this group are at particular risk of rapid decline in physical and mental health.

3. What is happening with time?

The number of over 75's is increasing, and the number of emergency admissions is increasing by around 10% every year.

4. What actions should be taken?

Service redesign across the whole care pathway (health and social care) is planned (as detailed in the Arden Cluster System Plan). This should take into account the differing needs of different groups, and aim to encourage equitable access to services and support.

Coventry's Older People Partnership (comprised of local public, private, community and voluntary sector organisations) is working on a range of objectives for older people such as;

• Health and wellbeing into old age • Inclusion and equality throughout life • Freedom from discrimination and harassment in older age • Economic wellbeing • Exercising choice and control throughout life
5. What (or where) are the gaps?
The main identified gap is integration of different services that are required by elderly people, with the aim of preventing episodes of poor health that lead to emergency admissions and of ensuring that patient are cared for outside hospital where appropriate.
6. Why is it of strategic importance for the HWBB?
Partnership working is required to coordinate and collaborate between the different provider and commissioner organisations.
7. Data sources
Range of measures that are relevant are available at the facts about Coventry internet site.

What are the relevant stages in the life course for this specific issue?

This specifically considers those in the 'Retirement' stage of the life course; the accumulation of risk factors across the life course are manifested by poorer health (it should be noted that the poorest 20% may not live to see retirement; as they are likely to be disabled at a far younger age)

2. Healthy Communities

Healthy communities focuses on building and strengthening communities, using asset-based approaches. 'Healthy communities' contain both the physical and social characteristics needed to promote health and wellbeing. This is strongly aligned to the Marmot Policy Objective E (Create and develop healthy and sustainable places and communities), as well as those that support the Healthy People theme.

This includes a wide range of factors; from the built infrastructure (such as roads, shops, housing, schools) through to social capital (links between individuals, that bind and connect people in their communities). Many of the factors that are recommended for reducing health inequalities are linked to the community; such as active travel (walking or cycling), public transport, energy efficient housing, healthy eating, reduced pollution and availability of green spaces. Building healthier communities centres around the asset-based approach to community development.

In this year's JSNA the initial priorities focus on the outcomes associated with communities.

Initial priorities;

- Obesity (maternal and childhood)
- Mental Wellbeing
- Domestic Violence and abuse
- Sexual Violence

Obesity; prenatal to childhood

Obesity presents significant challenges to health and is a particular concern in pregnancy. Women who are obese during pregnancy suffer from more complications and their babies are more likely to have birth defects and other health problems. Children born to obese mothers are more likely to develop childhood obesity themselves.

1. What are the health impacts of the issue (short/medium/long term)?

Maternal obesity is associated with poor outcomes for both the mother and the child; this can be as serious as stillbirth and neonatal death.

Obesity in childhood can cause a number of physical and mental health conditions for the child (sleep apnoea, lower limb joint problems, gallstones, hypertension, high blood cholesterol, and diabetes) as well as being a significant risk factor for adult obesity and the range of health conditions, including reduced life expectancy, which that brings.

2. Who does it impact?

There is a gradient of increasing obesity levels with deprivation across the population.

3. What is happening with time?

In the UK the prevalence of obesity in pregnancy (BMI 30+) has been increasing, rising from 9–10% in the early 1990s to 16-19% in the 2000s. Coventry has higher levels (7.3%) of morbid obesity in pregnancy (BMI greater than or equal to 35) than either England (5%) or the West Midlands (4.3%).

For childhood obesity, data has been collected for five years through the NCMP. In 2010/11 10.7% of Reception children (age 4-5) were obese increasing to 20.2% of Year 6 children (age 10-11) . Obesity in Coventry also shows a direct correlation to deprivation with a child living in a priority area twice as likely to be obese as a child living in a more affluent area. In Coventry there have been no real differences in levels of obesity with time. The national data is more sensitive to changes and this suggests that obesity in Reception is showing a slightly reducing trend in boys with no change in girls. At Year 6 there is an increasing trend for both boys and girls.

4. What actions should be taken?

This is a multifactorial problem, and there a few evidence –based interventions that have been shown to make a difference, particularly at the population level. Within the Coventry Healthy Weight Strategy interventions have been reviewed and pathways developed. This looks at population level interventions such as Change4Life, but also considers the impact of the built environment, and wider social determinants impacting on physical activity and eating habits. There is a strong focus on childhood obesity in this work. There are also a range of interventions targeted to particular groups or communities that need additional support in achieving or maintaining a healthy weight.

Targeted interventions are being developed with local services to define the care that pregnant women require around healthy weight. This will include services specifically for obese pregnant women.

In addition, programmes such as Make Every Contact Count will train a wide variety of people (NHS, local authority and other staff), giving them the basic skills to introduce lifestyle behaviour change into the conversation with the people that they come into contact with through their work.

5. What (or where) are the gaps?

There is a lack of evidence for cost effective interventions particularly at the population level (improving everyone's diet, increasing activity levels across the population, and reducing the average BMI). We are awaiting NICE recommendations for good practice around cost effective interventions relating to obesity and communities, and lifestyle interventions for adults and children

Local data is needed on maternal weight and complications of pregnancy and birth to be used to promote awareness of the advantages of healthy weight during pregnancy for the general population, health care professionals and policy makers.

The maternal obesity care pathway needs to be agreed and implemented.

6. Why is it of strategic importance for the HWBB?

Does the issue require partnership working across organisations in the HWBB to tackle? Yes – particularly the wider issue of tackling population levels of obesity.

PH outcomes - Excess weight in adults, Excess weight in four to five and ten to 11 year-olds

(link to Infant mortality (PH and NHS outcomes),Low birth weight of term babies (PH Outcomes),Neonatal mortality and still births & Admission of full-term babies to neonatal care (NHS Outcomes)

7. Data sources

Data is available on obesity levels in Coventry via Health Survey for England for adults, and primary care QOF data (underestimate). Specific information on obesity in pregnancy is not available currently

Data is available on childhood obesity levels in Coventry via National Child Measurement Programme for children see www.noo.org.uk for comprehensive resources.

What are the relevant stages in the life course for this specific issue?

	Risk factors	**Interventions** **See here for strategy & pathways**	**Health outcomes**
Prenatal	(multiple risk factors leading to mother's obesity)	Maternal Obesity Pathway	Birth trauma, congenital anomaly, predisposition to obesity in later life
Preschool	Breastfeeding Weaning , diet, portion size Physical activity	Breastfeeding promotion Better access to fruit and veg Portion size advice Coventry Healthy Early Years Setting Award (CHEYSA)	Health impact often seen in childhood
School	Available foods Education Physical activity	Identification through NCMP Healthy weight interventions such as OBOL Compliance with national School Meal guidance Healthy Schools Food Dudes Cook and Eat Well	
Mother's obesity is likely to have developed through her life, from pre-natal environment and early childhood accumulating to result in obesity when pregnant. Weight gained in pregnancy can be hard to lose meaning that women enter successive pregnancies with a higher BMI			
Family building	Lower socio economic status strongly linked to obesity	Maternal Obesity Pathway	Gestational diabetes, high blood pressure, C-section and birth complications. Significant risk for maternal mortality

Mental Wellbeing

Mental wellbeing is one aspect of wellbeing generally which also includes physical and social wellbeing. Mental wellbeing consists of positive psychological functioning, satisfaction with life, happiness, fulfilment, enjoyment and resilience in the face of hardship. There are gaps in the UK knowledge base for understanding and measurement of overall wellbeing, and there is evidence which suggests that mental wellbeing is a very good indicator of how people and populations are able to function and thrive.
Recently, levels of wellbeing have been measured through the Coventry Household Survey (see The Coventry Wellbeing Report 2011)

1. What are the health impacts of the issue (short / medium / long term)?

Higher levels of wellbeing are associated with better physical functioning at older age, self-reported health and other factors.

2. Who does it impact?

The following are examples of factors associated with higher levels of mental wellbeing;

- Being employed
- Higher levels of education
- Disability (major limitations)
- Average and good levels of sleep
- Good levels of self rated health
- Physical activity

It is of interest that deprivation is not significantly associated with mental wellbeing; though those who are deprived may also have a number of factors above contributing to poorer mental wellbeing. Further investigation may be required to understand whether certain factors promote mental wellbeing in spite of deprivation (e.g. living in a supportive community).

3. What is happening with time?

Mental wellbeing was measured as part of the Coventry Household Survey in 2010 and in 2011 using the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS). Between the two years there was no significant difference between average scores (as might be expected over a small time).

4. What actions should be taken?

Mental wellbeing is a combination of the effects of the wider social determinants of health and those closely associated with health.
A Foresight review into mental capital and wellbeing developed five evidence based actions that people can take in their daily lives to improve their wellbeing. In addition, Coventry has adopted five more ways based on findings from the Coventry Household Surveys.
Coventry has a well being project to promote mental wellbeing in communities. As part of this a number of community-led projects are being supported, mainly in the Bell Green

and Foleshill areas of the city.
5. What (or where) are the gaps?
The projects mentioned above (using the asset-based approach to supporting communities to develop) are both relatively small scale pilot projects. These will be evaluated and spread if successful.
6. Why is it of strategic importance for the HWBB?
Does the issue require partnership working across organisations in the HWBB to tackle? Yes – mental wellbeing links to many of the wider social determinants What are the drivers? PH Outcomes - Self-reported well being
7. Data sources
Data on mental wellbeing is reported in the Coventry Household Survey

Sexual Violence

Sexual violence is a broad definition which encompasses a wide range of unwanted sexual activities, including, but not limited to, rape and sexual assault, sexual abuse of children, trafficking of women and children for sexual exploitation. People living in Coventry are more likely to be the victims of rape and sexual assault than people living in the rest of the West Midlands and the UK as a whole (In 2007/8 Coventry's rate of reported rapes was 71.3 per 100,000 population).

1. What are the health impacts of the issue (short/medium/long term)?

There are a wide range of short, medium and long term impacts from direct injury to long-term psychological conditions.

2. Who does it impact?

Within the city, young white women represent the largest group but Black and Black British people appear to be over-represented relative to their population size. Although rapes and serious sexual assaults occur across the whole city, they are most likely to occur in the city centre. Children and young people are also at risk of sexual exploitation.

3. What is happening with time?

Police records of sexual offences shows that sexual offences appear to be largely stable between 2008 and the first quarter of 2010. This data is likely to be an under-estimate of the true level of sexual violence: only around 11% of victims of serious sexual offences are thought to report these to the police.

Establishing the overall levels of sexual violence nationally and locally is difficult as robust data is not available on many of these categories and because of the sensitive and difficult nature of the subject, often go unreported. Consultation is underway as part of the development of a Public Health Outcome Framework about monitoring local areas against their rates of violent crime, including sexual violence and how this indicator should be measured.

4. What actions should be taken?

In Coventry, multi-agency work around sexual violence is led by the Sexual Violence Forum. In 2010, this group held a multi-agency conference to review progress to tackle sexual violence across the city and to develop a set of recommendations for different partner agencies. Actions were identified to support each recommendation.

This includes providing access to a Sexual Assault Referral Centre (SARC), to help support victims through the criminal justice systems. Work is currently underway to collect users' experiences of the support and help they received in the aftermath of rape and serious sexual assault and to review pathways for both children and adults who have been the victims of rape and serious sexual assault. This information will be used to further develop pathways for new and historic victims of rape and sexual assault and to develop a local

Coventry and Warwickshire SARC, due to open in 2012. A particular focus is the sexual exploitation of children and young people.

Locally, CRASAC (Coventry Rape and Sexual Abuse Centre) has been commissioned to extend 'Safe Haven' training workshops that they have developed to improve the knowledge of staff working in health and social care about how to deal sensitively and appropriately with victims of rape and sexual assault and to raise awareness of what services are available to support victims.

5. What (or where) are the gaps?

Data collection.

6. Why is it of strategic importance for the HWBB?

Does the issue require partnership working across organisations in the HWBB to tackle? Yes

7. Data sources

In addition to the national consultation, further work is being carried out to improve the quality of data collected by local agencies and to share aggregate data across partner organisations to develop an accurate picture of the local situation. This work will be needed to monitor the proposed national outcome on sexual violence.

What are the relevant stages in the life course for this specific issue?

People are affected across the life stages with around half being under 24. Interventions can happen immediately, though often those receiving counselling report that the incident happened (or incidents began) some years before.

Domestic Violence and Abuse

Domestic violence and abuse (DVA) involves a pattern of physical, sexual, emotional and financial abuse and intimidation that escalates in frequency and severity over time. It is the misuse of power and the exercise of control by one partner over another in an intimate relationship or between adult family members.

Police data demonstrates that Coventry has the highest rate of reported DV in the West Midlands at 7.02 per 1000 of the population, and across agencies providing support to victims this totals 5,728 DV related contacts over a year; 18 cases per 1000 residents.

1. What are the health impacts of the issue (short / medium / long term)?

It has a profound consequence in the lives of individuals, children, families and communities. Health needs may be immediate (for example due to injury) or longer term such as mental health conditions.

The effects of domestic violence and abuse on children can be far-reaching and lead to a range of emotional, behavioural and developmental problems (which are strongly associated with poorer health outcomes). As they reach adulthood these children are more likely to become victims or offenders themselves, perpetuating the cycle.

2. Who does it impact?

Approximately 88% of victims of DVA reporting to the police are female. 80% of (Police recorded) crime victims are aged between 17 and 43; the core age lies between 18 and 34 years of age (63.4% victims). Certain providers such as Safeguarding Adults team report different patterns with age and gender, with older adults and a higher percentage (29%) of males.

Victims of Black / African-Caribbean ethnicity are over-represented against their population proportion, Asians under-represented against theirs and the White population is represented as might be broadly expected.

There is generally a trend of increasing DV with increasing deprivation, and approximately half of DVA clients are resident in housing association accommodation. Stoke Aldermoor, Wood End/Manor Farm and Willenhall had particularly high rates for repeat victims. Drugs and alcohol often complicate and exacerbate the problem for both the victim and the offender, as well as act as a trigger for offending.

3. What is happening with time?

There has been a general reduction in violent crime across the city but the percentage of domestic abuse/violence has remained similar.

4. What actions should be taken?

Coventry Domestic Violence and Abuse Partnership (CDVAP) Group has undertaken a

thorough data collection and needs assessment of DVA in Coventry during the spring and summer of 2010 and agreed four key strategic themes to guide its approach to DVA:

- Early Intervention, support and workforce development
- Multi-agency working
- Cultural Change, all leading to
- Sustainability and Evidencing Outcomes

The actions include working with children and young people as victims of Domestic Violence and for adolescents as perpetrators.

5. What (or where) are the gaps?

A number of gaps were identified through the CDVAP Group. For example, that victims were unclear on where to look for help and what services existed

6. Why is it of strategic importance for the HWBB?

Does the issue require partnership working across organisations in the HWBB to tackle? Yes

PH Outcomes framework (direct plus secondary measures around children such as readiness for school)

7. Data sources

Some data is available to inform our understanding of the epidemiology; however this requires the victim to be known to a service such as the Police and therefore will significantly underestimate the extent of the problem.

What are the relevant stages in the life course for this specific issue?

	Risk factors	**Interventions**	**health outcomes**
Prenatal			Damage to mother/foetus in pregnancy
Preschool			developmental delays
School		Cultural shift reducing acceptance of DVA Detecting victims and supporting them	Reduced attainment
Training			
Employment			
Family building		Supporting families	Damage to mother/ foetus in pregnancy
Retirement			

3. Reduce variation

Identifying and intervening for disadvantaged groups; those at high risk of poor outcomes. For example, it covers migrant health, disabilities and looked after children. Variations in outcomes across the population will be addressed.

Variations in outcomes are driven by variation in exposure to the wider determinants of health across the life course. All of the Marmot Policy Objectives are relevant to this theme.

Initial priorities;

- Smoking
- Alcohol
- Infectious Diseases

Smoking

The use of tobacco products has severe impacts on health of those who smoke as well as those exposed to passive smoking. It is also a major driver of health inequalities.

1. What are the health impacts of the issue (short/medium/long term)?

Smoking continues to claim the lives of 1 in 6 of all Coventry residents. There were 445 smoking-attributable deaths in 2009, and smoking remains the single greatest cause of preventable death in the city and is the major factor behind the health inequalities that exist between our poorest and most affluent wards.

Coventry has a higher rate of smoking (27% 2009) compared with England (21% 2008). This has resulted in Coventry recording higher mortality rates from lung cancer and Chronic Obstructive Pulmonary Disease (COPD), which includes conditions such as chronic bronchitis and emphysema, than the national average.

2. Who does it impact?

The 2011 Coventry Household Survey suggests that 24% of the Coventry population smoke. This increases to 48% of routine and manual workers (e.g. factory workers, cleaners, retail staff, general labours, drivers).

Smoking during pregnancy is the single most important modifiable risk factor for adverse outcomes in pregnancy, and increases the risk of infant mortality by an estimated 40%. Smoking prevalence at delivery in Coventry is about 15%

3. What is happening with time?

Smoking levels had been dropping but have recently remain fairly constant.

There appear to be increases in forms of smoking such as the use of shisha.

4. What actions should be taken?

Smoking cessation and tobacco control are the main two approaches to reducing smoking and the harms associated with it.

Coventry's Stop Smoking services are delivered by a range of providers to widen access to services. Though services are open to all, those in the lowest socioeconomic classes are specifically targeted. Early indications suggest that this model is having a positive impact on the number of smoking quitters in total, and the proportion in the lowest socioeconomic groups.

In April 2010, Coventry re-launched its Smokefree Alliance - a partnership of public, private and voluntary representatives, supported by NHS Coventry and Coventry Council. The Alliance provides a forum at a local level to tackle issues relating to tobacco and in June 2010 Coventry's first Tobacco Control Strategy was published.

A range of objectives were agreed and progress is being made against these.

5. What (or where) are the gaps?

The strategy specifically aimed to identify groups with high rates of smoking, higher levels of impact (such as pregnant women) and inequity in access.

6. Why is it of strategic importance for the HWBB?

Does the issue require partnership working across organisations in the HWBB to tackle?
Yes

PH outcomes (smoking prevalence in 15 year olds and over 18s) and NHS Outcomes (through reducing mortality amenable to healthcare) Frameworks.

Reducing smoking prevalence is a strategic priority for NHS Coventry with a local target to reduce smoking prevalence from 29% in 2007 to 22% by 2012.

The Department of Health released its new Tobacco Control Plan for England in March 2011, which has set a target to reduce the prevalence of smoking to 18.5% by 2015.

7. Data sources

Range of data sources available e.g.;
Coventry Household Survey http://www.coventrypartnership.com/Householdsurvey
Modelled estimates by MSOA facts-about-coventry smoking by MSOA

What are the relevant stages in the life course for this specific issue?

	Risk factors	**Interventions**	**Health outcomes**
Prenatal	Maternal smoking	Reducing smoking in the population (tobacco control) Smoking cessation in pregnancy	Harm to foetus, including still birth
Preschool	Passive smoking	Reducing smoking in the population (tobacco control) Smoking cessation	Respiratory infections, Asthma, Ear infections etc
School	Passive smoking Smoking – risk factors for initiation include poor academic success, having parent or friends who smoke	As above Awareness of risks Reduce access to tobacco Reduce/eliminate	As above

		marketing	
Training		Reducing smoking in the population (tobacco control) Smoking cessation	
Employment		Reducing smoking in the population (tobacco control) Smoking cessation	Lung cancer Heart disease Respiratory diseases such as COPD
Family building		Reducing smoking in the population (tobacco control) Smoking cessation – targeted	
Retirement		Reducing smoking in the population (tobacco control) Smoking cessation	Life expectancy of smokers is reduced by at least 10 years Lung cancer Heart disease Respiratory diseases such as COPD

Alcohol

Excessive consumption of alcohol is associated with a wide range of behavioural, physical health and mental health problems. Excessive consumption is widespread.

1. What are the health impacts of the issue (short/medium/long term)?

Alcohol misuse may result in a number of acute conditions such as alcohol or ethanol poisoning, mental or psychiatric emergencies (including self-harm), as well as involvement in accidents or violence.

In the longer term, alcohol misuse can lead to chronic liver disease, pancreatitis, a number of cancers and a range of other conditions.

An estimated 4.4% of male deaths in England were attributable to alcohol compared to 2.0% of female deaths. This difference arises because males have higher levels of alcohol consumption.

Data for Coventry shows that hospital admissions, alcohol specific mortality for males and alcohol-attributable mortality for females were significantly worse than for England.

In addition there are a wide range of impacts that will contribute to an overall impact on health through the wider determinants – such as increased crime, disorder and anti-social behaviour

2. Who does it impact?

Mortality attributable to alcohol is more likely to occur in the more deprived groups. In England, in the 25-44 year age group, those in the most deprived group were around 4.5 times more likely to die from a condition attributable to alcohol.

Young people were disproportionably affected by their alcohol use, for example, among 16-24 year old males, 26.6% of all deaths were estimated to be attributable to alcohol consumption compared to 1.4% among those aged 75 and over.

3. What is happening with time?

There has been a sharp increase in admissions due to alcohol related harm in Coventry between 07/08 and 08/09, with a smaller percentage increase between 08/09 and 09/10. It is likely that part, but not all, of this increase can be attributed to a change in recording and coding practices at UHCW. Recent data indicates that there are also concerning increases in the consumption and availability of alcohol in the city

4. What actions should be taken?

Tackling alcohol misuse requires a multi-partnership approach, and through the Alcohol Harm Reduction Programme Delivery Group, the Coventry Community Safety Partnership has developed a strategy and supporting action plan. This includes treatment and care (with capacity to get 15% of the City's estimated alcohol-using population in treatment, in

line with recent DH Guidance), crime and community safety (focussing on reducing alcohol related crime and anti-social behaviour), licensing and the alcohol industry (developing a firmer approach to licensing and building relationships with licensees) and there is also a focus on young people.

5. What (or where) are the gaps?

Further work is needed to address the issues with coding and recording at UHCW.

Further work is needed to ensure that all healthcare professionals offer brief interventions to help people reduce their alcohol consumption where this is required.

The PCT should continue to work closely with the LA to reduce the availability of alcohol.

6. Why is it of strategic importance for the HWBB?

Does the issue require partnership working across organisations in the HWBB to tackle?
Yes

PH Outcomes - Alcohol related admissions to hospital

Also impacts a range of other measures such as Violent crime, Domestic abuse, Mortality from liver disease (also an NHS Outcome)

7. Data sources

Coventry Household Survey data for lifestyle factors here

Binge Drinking Map of Coventry MSOA here

Alcohol profiles (Public Health Observatory) here

What are the relevant stages in the life course for this specific issue?

	Risk factors	**Interventions**	**Health outcomes**
Prenatal	Maternal alcohol use	Advice Treatment if required	Risk of miscarriage Foetal alcohol syndrome (restricted growth, facial abnormalities, and behavioural problems)
Preschool			
School **Training** **Employment**	Socioeconomic deprivation particularly in younger men	Population wide interventions (licensing, price, advertising restrictions) Treatment for certain groups (hazardous drinkers)	Alcohol toxicity, accidents and assault, self-harm significant in younger groups Chronic effects (liver disease, cancers) more significant in older groups
Family building			Early miscarriage
Retirement			Chronic effects (liver disease, cancers) more significant in older groups

Infectious diseases; Tuberculosis

Tuberculosis is a common infection, with one third of the world's population infected with TB. The majority have latent TB (where the bacteria is present in the body but is well controlled by the immune system) but some have active TB, which is a serious illness requiring long term treatment. Some of these active cases may be infectious and therefore TB may be spread in certain circumstances usually to close contacts such as household members.

1. What are the health impacts of the issue (short/medium/long term)?

People with active TB may be very unwell, and untreated TB may result in death. It can produce a wide range of symptoms depending on where in the body the bacteria are growing. The most well-known form (around half of active TB cases) is pulmonary where the lungs are affected. If severe, this form may be transmitted to others through coughing.

People with latent TB will be well though at some point in the future around 10% of them may develop active TB.

2. Who does it impact?

There were 96 cases of TB in Coventry in 2010 – 31 cases per 100 000 of the population. 73% of cases were non UK born; these are in predominantly Black African and Asian people. A slightly higher rate of TB was recorded in Coventry in 2011 – 39 cases per 100 000 of the population. There are particularly high rates in certain wards in Coventry. Rates of TB are far higher in some countries (Asia and parts of Africa) and people born in or regularly visiting high prevalence countries are more likely to have been exposed to TB. However, the poor housing conditions and deprivation often experienced by recent arrivals may trigger the development of active TB. It is difficult currently to estimate the proportion of cases that are caused by transmission in the UK.

Cases in the white UK born population are often linked to deprivation, and factors such as homelessness, imprisonment, alcohol and drug misuse. The vast majority of these cases will have been caused by transmission in the UK.

3. What is happening with time?

Rates of active TB are remaining roughly constant but needs to be monitored.

4. What actions should be taken?

Screening for TB is offered to asylum seekers, refugees and some new arrivals from abroad but there is strong local evidence that the screening could be improved. The new T spot blood test for TB means that the identification of cases and latent disease is now easier and more effective. A local strategy should be developed to screen and treat individuals aged less than 16 years from countries with an incidence of 40 per 100,000 or greater and 16–35-year-olds from countries with an incidence of 150 per 100,000 or

greater.

5. What (or where) are the gaps?

Working with public health, primary care and the Coventry TB Service need to put together a plan to prioritise screening of new entrants, refugees and asylum seekers to identify cases of tuberculosis and latent disease.

A repeat audit of the uptake of BCG vaccination is required in newborns to make sure that the eligible population is receiving it appropriately.

Work needs to be carried out to raise public and professional awareness about TB, particularly in those areas with the highest rates.

6. Why is it of strategic importance for the HWBB?

Does the issue require partnership working across organisations in the HWBB to tackle?
Yes

PH Outcomes framework - Treatment completion for TB

7. Data sources

Overview for TB available from the HPA here

Infectious diseases; Human Immunodeficiency Virus (HIV)

Coventry has a high incidence and prevalence of HIV infection, the second highest in the West Midlands.

1. What are the health impacts of the issue (short/medium/long term)?

HIV/AIDS contributes to relatively few deaths in Coventry but the incidence is high compared to other PCTs in the West Midlands. Stage of presentation is important in HIV: nationally 24% of deaths in HIV positive patients were due to the diagnosis being too late for effective treatment, and amongst these 10.8% were in patients under the age of 30. Late diagnosis of HIV also increases morbidity with a greater risk of developing complications, greater possibilities of acquiring infections and a greater chance of progression to AIDS. Early knowledge of HIV infection has been reported to result in reduced onwards transmission because it is associated with a reduction in risk behaviour. A local study has shown that the numbers presenting late in Coventry is lower than nationally.

Coinfection with Hepatitis B and/or C is also has a significant impact on prognosis for HIV patients, and is becoming an important cause of death in HIV positive patients.

2. Who does it impact?

There are some key differences between the epidemiology in Coventry and in the West Midlands as a whole. In Coventry:

- Transmission is more likely to be heterosexual
- A higher proportion of cases are in Black-Africans
- The majority of people affected are female.
- The majority of cases were acquired abroad.

Late presenters; 60% of late presenters in Coventry were female, 92% were heterosexual, 71% were of Black-African origin, 17% were of white origin, and 40% were within the age band 45-49.

The majority (88%) of these co-infected with both HIV and Hepatitis B were Black-African and were born within Africa.

3. What is happening with time?

A local needs assessment shows that the number of new cases in Coventry is falling from a peak in 2004-6.

4. What actions should be taken?

HIV testing at GUM clinic is currently above the West Midlands average.

In areas where more than 2 in 1000 people in the general population have HIV NICE guidelines recommend that an HIV test is considered for everyone at GP registration and on hospital admission. This guidance applies in Coventry where 2.7 per 1000 people aged 15-59 are infected with HIV.

Further work is required with the HPA to make sure that HIV and Hepatitis data records are validated between the HPA and GUM to allow accurate surveillance.

Regular reporting to the PCT of the immune status of newly diagnosed HIV patients and after one year of treatment need to be implemented.

There should be a continued emphasis on safe sex education. The high prevalence of HIV in Coventry means there is a large reservoir for onward transmission.

5. What (or where) are the gaps?

As above – HIV testing should be implemented at GP registration and on hospital admission.

Those with new diagnosis of HIV should also be tested for Hepatitis B and C coinfection.

6. Why is it of strategic importance for the HWBB?

Does the issue require partnership working to tackle? Yes

PH Outcomes – contributes to Mortality from causes considered preventable

NHS Outcomes – contributes to Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare

7. Data sources

Data is available through the HPA website here
A local Needs Assessment on prevention of HIV will be available shortly

Infectious diseases; Seasonal influenza vaccinations

Seasonal influenza poses considerable risk to particular groups in the population. Vaccination offers a cost effective preventative intervention for these groups. However, take up of the vaccination is variable. The CMO's target for uptake of 75% in over 65s and 60% uptake in clinical risk groups in under 65s was not met in 2011/12. Additionally there is considerable variation in take up across GP practices in Coventry.

1. What are the health impacts of the issue (short/medium/long term)?

In at-risk groups, influenza (and complications such as pneumonia) can be an extremely serious illness. There are up to 20,000 extra deaths from influenza in England each year. Vaccination offers considerable protection against flu and its complications.

2. Who does it impact?

The high risk groups are defined as; People aged 65 years and over, those in a clinical risk group, pregnant women, people living in long-stay residential care homes and carers. In addition, frontline health and social care workers should be vaccinated.

3. What is happening with time?

Uptake in 2011/12 in over 65s was about the same as in the previous year (71% compared to 69%). Uptake in clinical risk groups in under 65s was 55%. There has been a trajectory for increasing the uptake set by the CMO which requires a considerable year-on-year increase.

4. What actions should be taken?

As well as ensuring that all practices are appropriately sending out notices to those eligible (and providing opportunities for vaccination to take place), there are a range of methods for raising awareness and increasing uptake that might be considered, including use of pharmacies to deliver vaccinations.

Campaigns should focus on improving uptake in under 65s in clinical risk groups, and particularly those in younger age groups in whom uptake is poorest.

Increasing the uptake in health and social care workers and in care homes is likely to

require collaboration between the employer/commissioning organisation and the provider for vaccination.

5. What (or where) are the gaps?

There are a range of reasons that may lead to lower take up by certain groups in the population, such as lack of awareness of eligibility, not responding to letters due to language or other barriers, or difficulties in accessing the service. Further work needs to be carried out to understand these issues.

Wider uptake for health and social care staff should be promoted, as well as uptake in under 65s in clinical risk groups.

6. Why is it of strategic importance for the HWBB?

Does the issue require partnership working across organisations in the HWBB to tackle?
Yes, particularly social care and primary care

PH Outcomes - Excess winter deaths

7. Data sources

DH report available here
Latest data available here

What are the relevant stages in the life course for this specific issue?

People of any age may be in an at-risk group, and all over 65's are considered at heightened risk. For this issue the health impact occurs within a short timescale of the intervention (flu vaccination is given every year to provide protection for that winter's dominant flu viruses).

4. Improve outcomes

This theme focuses on how we maximise health and wellbeing outcomes across the population of Coventry. One focus is the prevention and management of long term conditions; including early identification, prevention of emergency admissions and maintaining independence.

Initial priorities;

- Cancer (for Year 1)
- Variations in primary care
- Lifestyle risk management (Making every contact count)

Cancer

Cancer mortality rates in Coventry for all ages and for under 75 years of age are significantly higher in Coventry compared to England.

Strategies for reducing this focus in three areas;

- The primary prevention of cancer (this includes reducing smoking, obesity and promoting healthy weight)
- The early detection of disease (through screening to detect changes before any symptoms are present, or through encouraging early presentation through awareness of symptoms)
- Treatment of cancer

In Coventry, screening uptake is low (below national targets), and awareness of cancer signs and symptoms is poor; one in five (20%) of respondents to a recent survey were unable to name any signs or symptoms of cancer.

1. What are the health impacts of the issue (short/medium/long term)?

Generally the earlier a cancer (or pre-cancerous change) is detected and treated, the better the outcome, increasing the proportion of cancers that are curable. Screening detects changes at a very early stage, before symptoms are present. Even when symptoms are present, rapid presentation and detection is highly likely to lead to better outcomes.

2. Who does it impact?

Screening uptake is particularly low in more deprived areas and in ethnic minority groups. Awareness of the signs and symptoms of cancer is lower in men, those with a lower socioeconomic status and ethnic minority groups.

3. What is happening with time?

For screening, both local and national screening rates have declined.

For awareness, historical data is not available - as part of the Local Awareness and Early Detection Initiative (LAEDI) campaign, awareness has been measured and this will be repeated to assess the impact of the campaign.

4. What actions should be taken?

There is a local cancer screening awareness campaign, which also includes improving access and working with other partners such as GPs to increase the promotion of screening to the eligible population.

The principal aim of the Arden LAEDI was to promote the earlier presentation of cancer symptoms in order to facilitate the earlier diagnosis and treatment of the common cancers including Lung, Bowel, Breast, Prostate and Skin cancer with a particular focus within areas of high deprivation and "hard to reach" communities and should therefore contribute to the reduction of inequalities.

5. What (or where) are the gaps?

Although community engagement is underway to promote screening locally, this component of the programme could be significantly increased.

6. Why is it of strategic importance for the HWBB?

Does the issue require partnership working across organisations in the HWBB to tackle? – Yes

Public Health outcomes framework; Cancer diagnosed at stage 1 and 2 as proportion of all cancers diagnosed, mortality (also number of measures in NHS outcomes framework)

7. Data sources

http://www.ncin.org.uk/equalities/atlases_1_0/Deprivation/atlas.html?select=5MD&indicator=i0
Screening equity audits;
http://www.coventrypct.nhs.uk/OurWork/PublicHealth/PublicHealthReports.aspx

What are the relevant stages in the life course for this specific issue?

The issue of lack of awareness has been identified across all age groups, and the resulting campaign is also aimed across age groups. The outcome is more common with increasing age.

Primary Care in Coventry

Evidence suggests that there is significant variation in the quality of Primary Care across Coventry. This can be measured in a number of ways, and one piece of work underway is agree an appropriate system for measuring quality based as much as possible on outcomes.

1. What are the health impacts of the issue (short/medium/long term)?

As is detailed in the Arden Cluster System Plan, the impact on patients of this variation can be significant. The early identification, timely treatment, regular monitoring and early detection of complications for long term conditions may have a considerable impact on patients. Good quality recording of patient information, such as disease registers, allows patients to be monitored and to be called in for specific tests or screening as required (for example, identification of those eligible for seasonal flu vaccinations).

2. Who does it impact?

In general, poorer performing practices tend to be located in more deprived areas of the city. It should be recognised that higher rates of deprivation are often associated with high prevalence of patients with specific risk factors affecting either their health or their ability or willingness to engage with health services. Therefore reducing the variation will require multiple approaches.

3. What is happening with time?

There is some evidence of improvements with time (as measured by QOF scores).

4. What actions should be taken?

Royal College of General Practitioners (RCGP) Practice Accreditation will commence in April 2011 which will support QOF achievement over the next 1-3 years.

A GP mentor scheme is in place and the worst performing practices are receiving considerable support to improve.

5. What (or where) are the gaps?

Multiple interventions are in place; no gaps currently identified, but monitoring using the new quality system will be carried out.

6. Why is it of strategic importance for the HWBB?

Does the issue require partnership working across organisations in the HWBB to tackle? Yes

Many outcome measures are linked to Primary Care (NHS and PH)

7. Data sources

QOF scores are publicly available by GP practice here

General practice profiles (Public Health Observatories) are available here

Lifestyle risk management (Making every contact count)

The impacts of a number of lifestyle behaviours have been highlighted in the JSNA – obesity, smoking, alcohol misuse as examples. The 'Making Every Contact Count' programme (MECC) is aimed at training a wide variety of people to deliver healthy lifestyle advice, and signpost people to the services that can help them in achieving lifestyle change.

1. What are the health impacts of the issue (short/medium/long term)?

Health impacts from a range of lifestyle behaviours can result in short, medium and longer term poor health and wellbeing outcomes.

2. Who does it impact?

In general, those at higher risk tend to be in the lower socioeconomic groups, with a gradient across the population. People in lower socioeconomic groups tend to be less likely to seek help, especially at an earlier stage (before the risk behaviour has resulted in poor health or wellbeing). This may be for many reasons, including being unaware of the risks, or unable to access services.

By training people who work across a wide range of organisations in Coventry to identify lifestyle risks to discuss them with people and to offer advice and support (including where to access further help), those most at risk are more likely to receive the advice and information that they need to make healthier choices.

3. What is happening with time?

In general trends for unhealthy behaviours are either increasing (e.g. obesity) or are not reducing as fast as would be hoped (e.g. smoking).

4. What actions should be taken?

Training has been developed and commissioned and is being rolled out across the NHS, and for a large number of Coventry City Council staff. It is hoped that this will be broadened to include other organisations across the Coventry Partnership in the near future.

A Lifestyle Risk Management Strategy is currently under development.

5. What (or where) are the gaps?

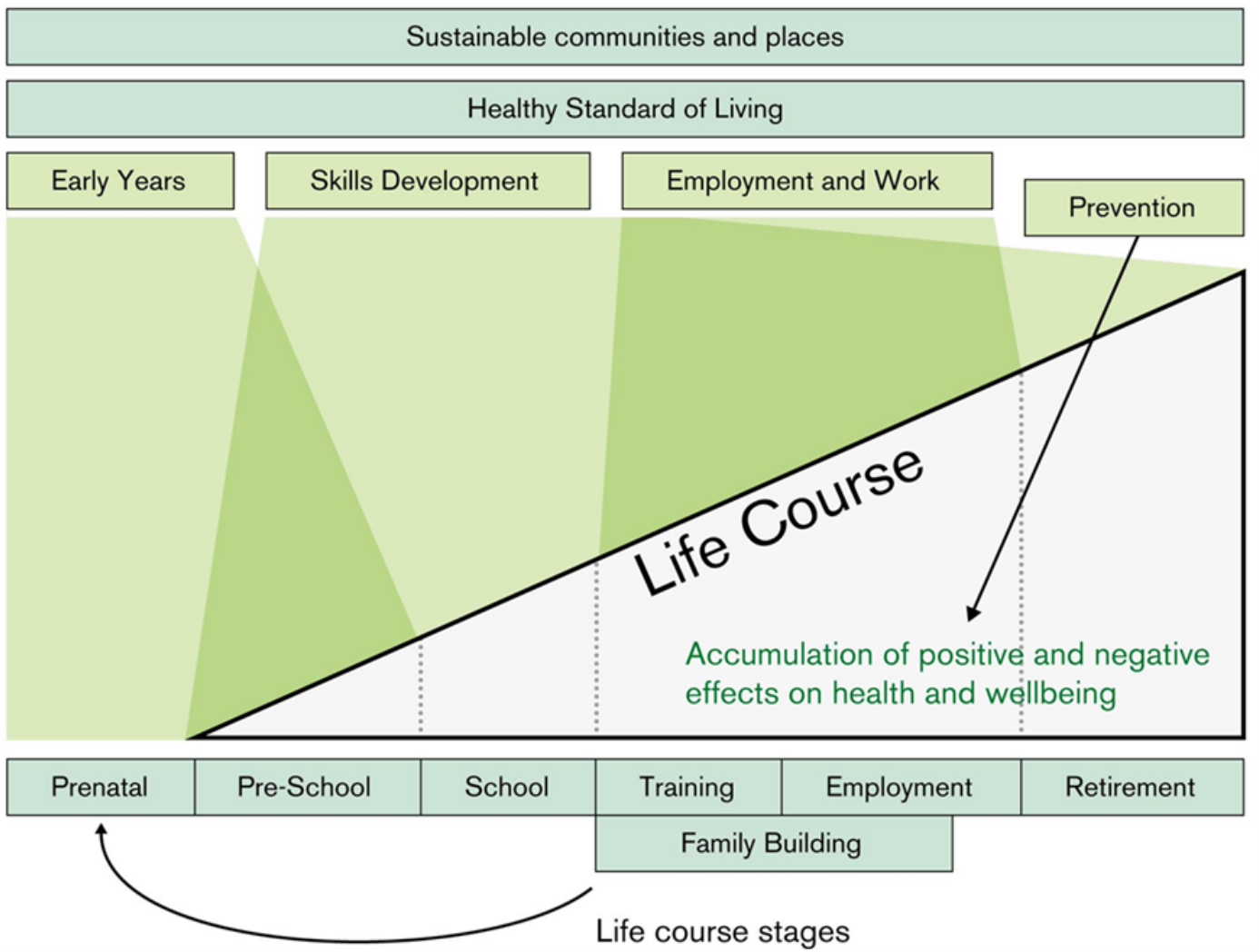
Gaps and evidence base are currently being reviewed as part of the development of the Lifestyle Risk Management strategy.

6. Why is it of strategic importance for the HWBB?

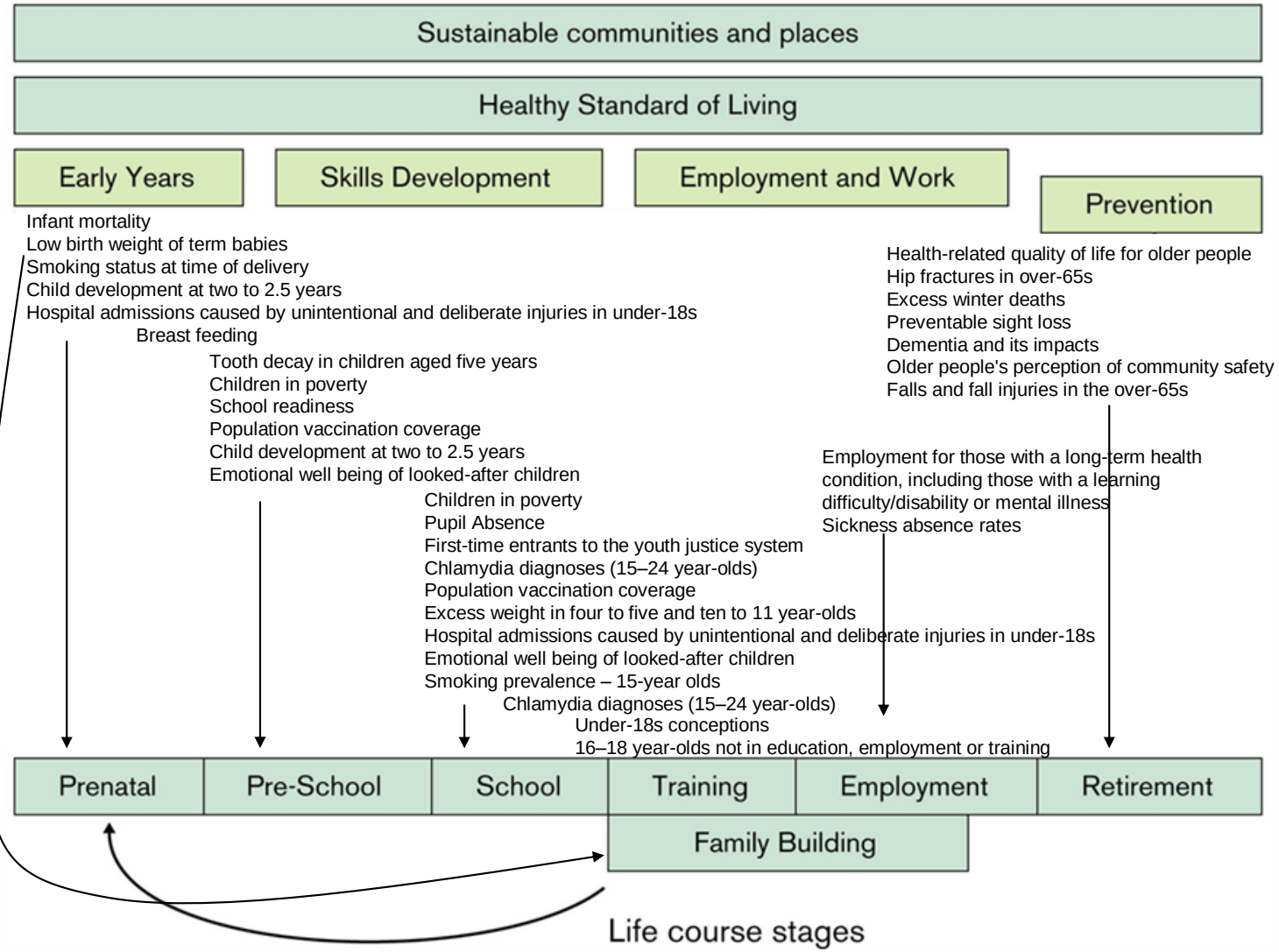
Does the issue require partnership working across organisations in the HWBB to tackle? Yes

Many outcome measures are linked to lifestyle risk factors across the PH and NHS outcomes frameworks in particular.

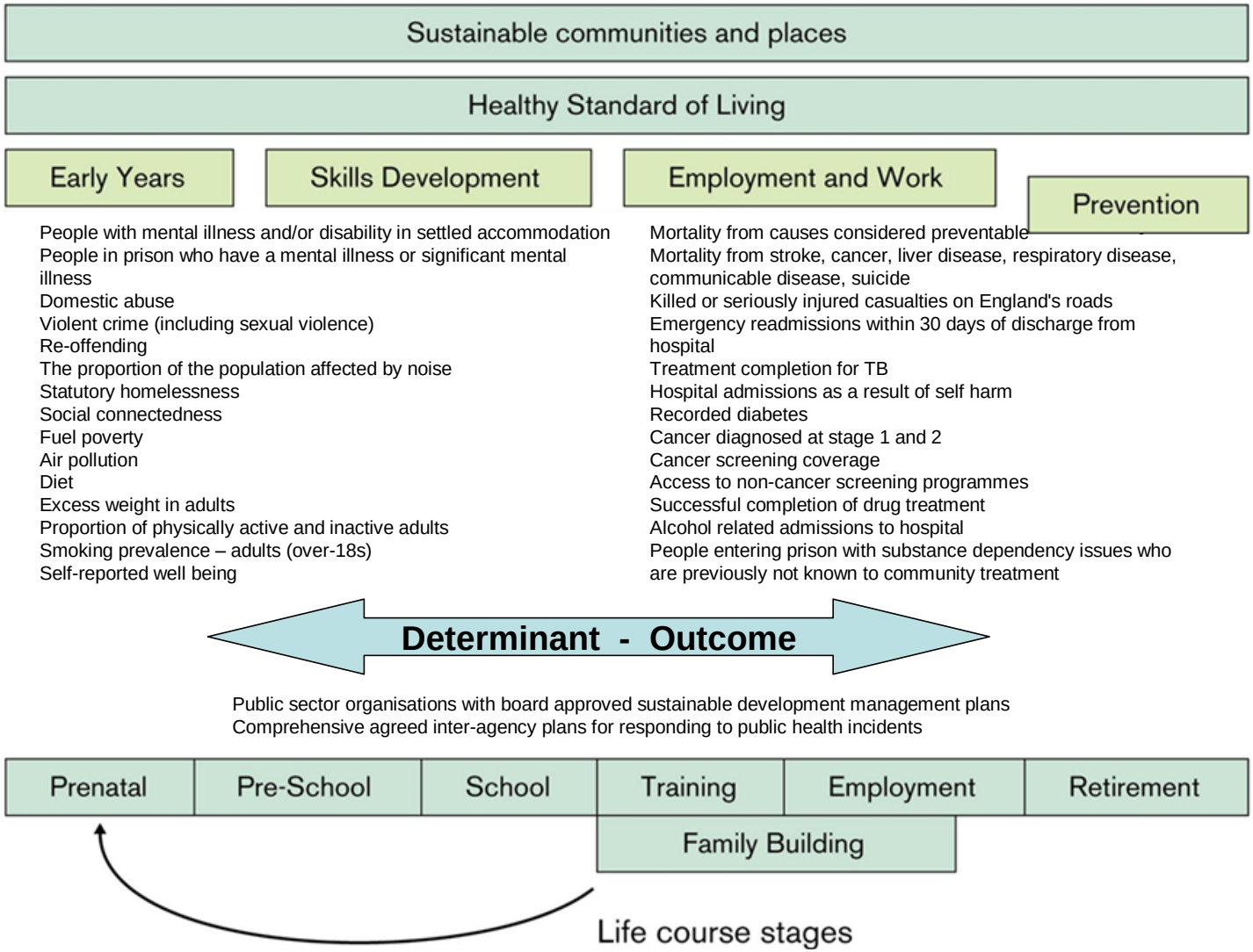
Appendix 1. Outcomes Framework against the Life Course



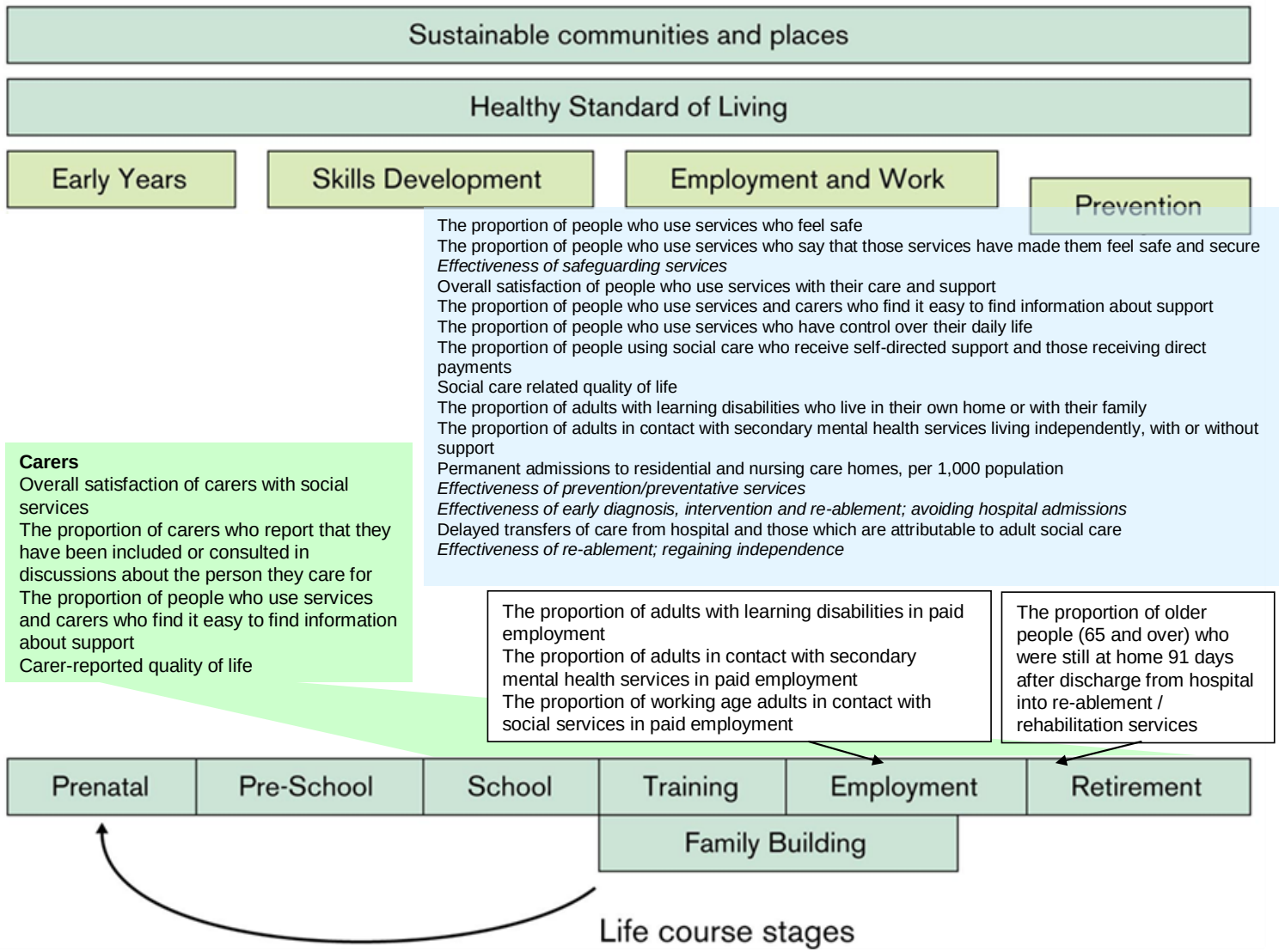
Public Health Outcomes Framework – specific life course stages



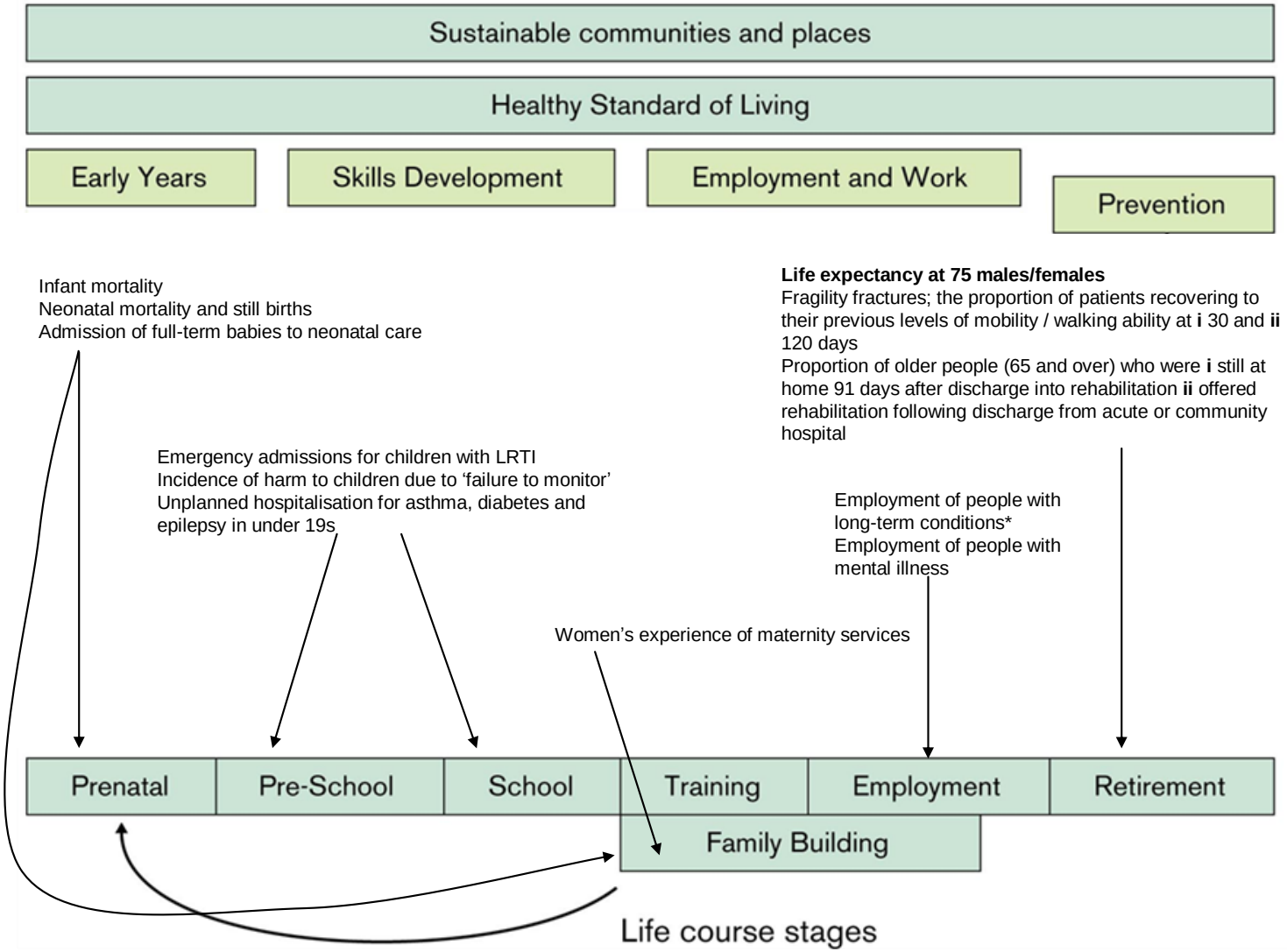
Public Health Outcomes Framework – across the life course



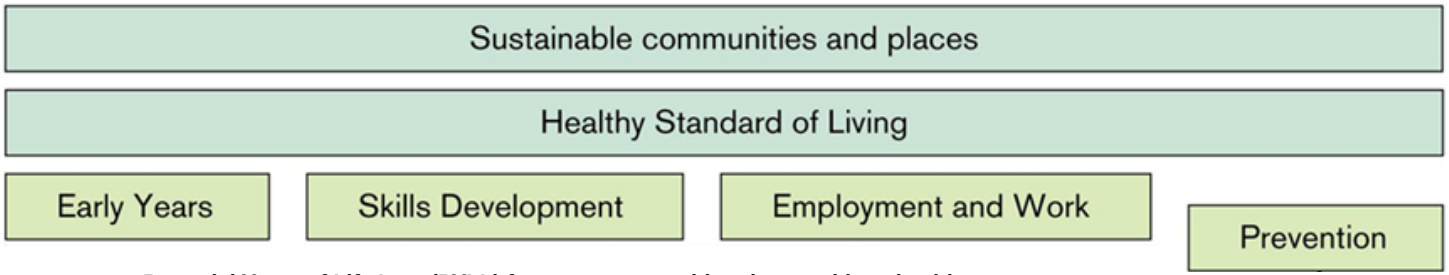
Adult Social Care Outcomes Framework – specific life course stages



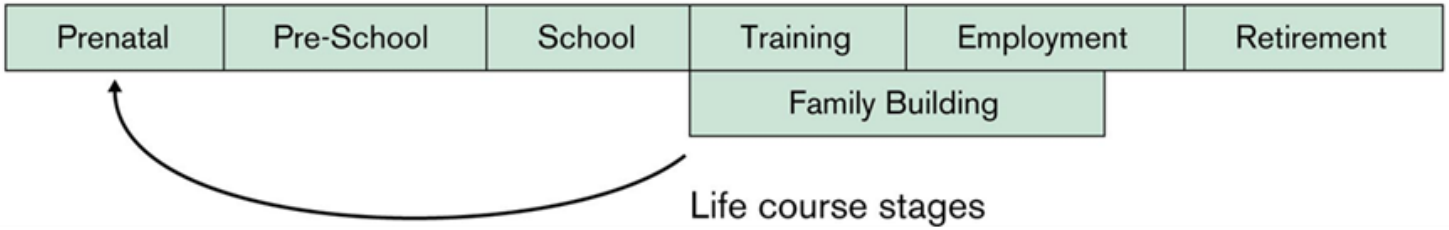
NHS Outcomes Framework – specific life course stages



NHS Outcomes Framework – across life course stages



Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare
Under 75 mortality rate from cardiovascular, respiratory and liver diseases, and cancer
i One-and **ii** five-year survival from colorectal, breast and lung cancer
*Excess under 75 mortality rate in adults with serious mental illness**
Health-related quality of life for people with long-term conditions**
Proportion of people feeling supported to manage their condition**
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)
Health-related quality of life for carers**
Emergency admissions for acute conditions that should not usually require hospital admission
Emergency readmissions within 30 days of discharge from hospital
Patient Reported Outcomes Measures (PROMs) for elective procedures **i** Hip replacement **ii** Knee replacement **iii** Groin hernia **iv** Varicose veins
Patient experience of primary care and of Hospital care
Patient experience of outpatient services
Responsiveness to in-patients' personal needs
Patient experience of A&E services
Access to **i** GP services and **ii** NHS dental services
Patient experience of community mental health services
Patient safety incidents reported & safety incidents involving severe harm or death
Incidence of hospital-related venous thromboembolism (VTE), MRSA, C. difficile, newly-acquired category 2, 3 and 4 pressure ulcers
Incidence of medication errors causing serious harm



Appendix 2. Needs assessments and related documents

A number of needs assessments and similar documents have been produced during the year that are relevant to the JSNA.

Pharmaceutical Needs Assessment

The PNA regulations require the PCT to consider whether current services are:

- Necessary services – these are pharmaceutical services that the regulations describe as necessary to meet a current need
- Relevant services – these are services which while not necessary, secure improvements or better access to pharmaceutical services

In making this assessment we have tried to balance the need for a high quality, accessible network of pharmacies with the needs of our patients for services when and where they are needed.

Our assessment has found that our population currently enjoys good access to pharmaceutical services with a broad range of services available when and where they are needed. We have concluded that there is no requirement for additional pharmacies in Coventry at this time.

We have identified areas where we could improve access to some of the services we currently commission and opportunities for future commissioning which we will explore as part of our commissioning planning process.

The full report can be found here;

http://www.coventrypct.nhs.uk/HealthServices/Pharmacists/Professionals

Oral Health Needs Assessment

The key recommendations from this year's Oral HNA are

- Advocate the continuation of the fluoridation of the water supply in Coventry to help with reducing the existing dental health inequalities
- Develop and implement an oral health promotion programme targeted at children of pre-school age in high risk groups in the City.
- Promote the common risk factor approach to health promotion and integrate oral health promotion into other health promotion campaigns such as smoking cessation, healthy eating and healthy weights programmes.
- Encourage more dental practices to be health promoting practices through active participation in the smoking cessation and healthy weights programmes
- Promote the inclusion of oral health in the care plans for care home residents

- Encourage early attendance of children to dental services to benefit from preventive measures such as F varnish applications and oral hygiene advice
- Commission an education campaign on the risk factors, signs and symptoms of oral cancer and the benefits of early detection.

Children's Needs Assessment – focus on children 0-2.

The aim of this work was to understand the reasons and implications of the increasing birthrate. A considerable proportion (44%) of births take place in the most deprived quintile and over a third of births occur to women who are not UK-born. The new communities in Coventry are most affected by deprivation. Roma-communities are highlighted as particularly deprived. The HNA is in its final stages and recommendations will be discussed in a working group. One key recommendation is that a full needs assessment focusing on new communities should be carried out.

Drug treatment resources and outcomes; JSNA support pack

(produced by NHS National Treatment Agency for Substance Abuse)

- Figures for prevalence of drug abuse are similar to national
- Treatment outcomes are similar or better than national