Health and Wellbeing Board

Date: Wednesday 7 July 2021
Time: 1.30 pm
Venue: Shire Hall, Warwick - Shire Hall

Membership
Councillor Margaret Bell (Chair)
Councillor Jeff Morgan
Councillor Jerry Roodhouse
Councillor Isobel Seccombe OBE
Councillor Marian Humphreys
Councillor Julian Gutteridge
Councillor Howard Roberts
Councillor Jo Barker
Councillor Jan Matecki

Warwickshire County Council Officers: Shade Agboola and Nigel Minns

Coventry and Warwickshire Clinical Commissioning Group: Sarah Raistrick

Provider Representatives:
Russell Hardy (South Warwickshire NHS Foundation Trust and George Eliot Hospital NHS Trust), Dame Stella Manzie (University Hospitals Coventry & Warwickshire), Dianne Whitfield (Coventry and Warwickshire Partnership Trust)

Healthwatch Warwickshire: Elizabeth Hancock

NHS England: Julie Grant

Police and Crime Commissioner: Richard Long (Office of the PCC)

Items on the agenda: -

1. General

(1) Apologies

(2) Members' Disclosures of Pecuniary and Non-Pecuniary Interests

(3) Minutes of the Meeting of the Warwickshire Health and Wellbeing Board on 3 March 2021 and Matters Arising 5 - 12

Draft minutes of the previous meeting are attached for approval.

(4) Chair's Announcements

Discussion items

2. An evaluation of Creative Care Commissions 13 - 76

To consider the evaluation of the creative care commissions and the key principles for future commissioning – *Kate Sahota and Emily van de Venter*

3. Mental Health and Wellbeing 77 - 102

A system presentation on Community Mental Health Transformation and the Mental Wellbeing & Resilience Fund – *Emily van de Venter and Richard Onyon*

Updates to the Board

4. JSNA Update 103 - 326

This paper provides an update on the delivery of the JSNA programme since January 2021 - *Duncan Vernon*

5. Pharmaceutical Needs Assessment (PNA) Update 327 - 336

To provide an update on the Pharmaceutical Needs Assessment in Warwickshire - *Duncan Vernon*

6. Coventry and Warwickshire Place Forum 337 - 340

Updates to the Board on the outcomes of Joint Place Forum and Coventry and Warwickshire Health and Care Partnership Board meeting held on the 2 March 2021, with a verbal update from the meetings held on 17 June 2021 - *Sir Chris Ham*

7. Better Care Fund Plan Progress Report 341 - 346

An update to the Board on progress with the Better Together Programme - *Becky Hale and Rachel Briden*

8. Health and Wellbeing Partnerships

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Updates from the three Health and Wellbeing Partnerships in Warwickshire

Board Management

9. Forward Plan

355 - 356

An update will be provided on future items for the Board and Joint Place Forum Meetings – *Gemma McKinnon*

Monica Fogarty
Chief Executive
Warwickshire County Council
Shire Hall, Warwick

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A member attending a meeting where a matter arises in which they have a disclosable pecuniary interest must (unless they have a dispensation):

- Declare the interest if they have not already registered it
- Not participate in any discussion or vote
- Leave the meeting room until the matter has been dealt with
- Give written notice of any unregistered interest to the Monitoring Officer within 28 days of the meeting

Non-pecuniary interests relevant to the agenda should be declared at the commencement of the meeting.

The public reports referred to are available on the Warwickshire Web https://democracy.warwickshire.gov.uk/uuCoverPage.aspx?bcr=1

Health and Wellbeing Board

Wednesday 3 March 2021

Minutes

Attendance

Committee Members

Warwickshire County Council (WCC)
Councillor Les Caborn (Chair)
Councillor Jeff Morgan
Councillor Dave Parsons
Councillor Isobel Seccombe
Nigel Minns, Strategic Director for People Directorate
Dr Shade Agboola, Director of Public Health

Clinical Commissioning Groups (CCGs)
Sarah Raistrick, Coventry and Rugby and Warwickshire North CCGs
David Spraggett, South Warwickshire CCG

Provider Trusts
Dame Stella Manzie DBE, University Hospitals Coventry and Warwickshire (UHCW)
Jagtar Singh and Dianne Whitfield, Coventry and Warwickshire Partnership Trust (CWPT)

Healthwatch Warwickshire (HWW)
Elizabeth Hancock

Borough/District Councillors
Councillor Jo Barker, Stratford-on-Avon District Council
Councillor John Beaumont, Nuneaton and Bedworth Borough Council (NBBC)
Councillor Sally Bragg, Rugby Borough Council
Councillor Judy Falp, Warwick District Council
Councillor Marian Humphreys, North Warwickshire Borough Council

Other Attendees

Emma Adams (SWCCG), Chris Bain (HWW), Councillor Margaret Bell (WCC), Sir Chris Ham (Coventry and Warwickshire Health and Care Partnership), Lisa Barker, Raj Chand, Angela Coates and Jane Grant, (district and borough council heads of housing),
Ibidolapo Ijarotimi and Ansari Muhammed (GP trainees in Public Health placements), Jagdeep Birring, Marina Davidson, Ruby Dillon, Emily Fernandez, Becky Hale, Isher Kehal, Gemma Mckinnon, Catherine Shuttleworth, Pete Sidgwick, Ashley Simpson, Hayley Sparks, Paul Spencer and Katie Wilson (WCC Officers).

1. General

(1) Apologies

Russell Hardy South Warwickshire Foundation Trust and George Eliot Hospital Trust and Julie Grant NHS England and Improvement. Councillor Parsons advised that he needed to leave the meeting early.

(2) Members' Disclosures of Pecuniary and Non-Pecuniary Interests

None.

(3) Minutes of the Meeting of the Warwickshire Health and Wellbeing Board on 6 January and Matters Arising.

The Minutes of the Health and Wellbeing Board held on 6 January 2021 were approved.

(4) Chair's Announcements

The Chair welcomed everyone to this additional meeting of the Board, outlining the key items to be considered.

It was reported that this was the last meeting of the Board before the County Council elections. The Chair, Councillor Les Caborn was retiring from office and tributes for his service were led by Councillor Izzi Seccombe, Leader of the County Council. She spoke of the way the board and partnership working had been developed under his leadership, including the alignment with Coventry. There were many contributions from Board members paying tribute to Councillor Caborn for his service to the area, both verbally and through the meeting's chat dialogue. Nigel Minns advised that his service spanned over thirty years, with numerous roles undertaken for children's services, health scrutiny, the place forum, its underpinning Concordat and the year of wellbeing. More recently his role as portfolio holder during the Covid-19 pandemic and leadership of a member engagement board. His leadership of meetings, ensuring all parties were heard, and numerous examples were given of the initiatives he had championed. Tributes were paid by Sir Chris Ham on behalf of the Health and Care Partnership and by Chris Bain for Healthwatch Warwickshire, who considered Councillor Caborn a consistent champion for partnership working and patient voice. Councillor Judy Falp spoke of his work at Warwick District Council and the engagement with all councils. Further contributions from Councillor Dave Parsons and Dame Stella Manzie who spoke on behalf of the NHS partners. The Chair responded thanking everyone for their kind comments and the support received from partners.

2. Director of Public Health's Annual Report

It was reported that the Director of Public Health (DPH) had a statutory requirement to write an annual report on the health and wellbeing of the population, and the local authority was required to publish it. The theme of this year's report was the impact of Covid-19 on health inequalities in Warwickshire.

The covering report provided key headlines with an update on the health and wellbeing of the Warwickshire population, the impact of Covid-19 on health inequalities and progress on the 2019 recommendations. It was supplemented by a presentation from Dr Shade Agboola, Warwickshire DPH. The presentation covered the following areas:

- Overview – it was confirmed that this was a draft report at this stage
- Progress on 2019 recommendations
- Picture of health and wellbeing in Warwickshire
- Healthy life expectancy
- Deprivation
- Warwickshire continued to face several public health challenges
- Covid-19 in Warwickshire
- Covid-19 and impact on health inequalities
- Experience of testing positive with Covid-19 in Warwickshire
- Living through lockdown in Warwickshire
- Amidst all the challenges, there had been some positives
- Challenges of lockdown
- Homelessness
- Loneliness and social isolation in older adults
- Young people with mental health needs
- Family poverty
- Adults with learning disabilities
- The Director of Public Health's recommendations for 2021
    - 'Health in all' policies
    - Health inequalities
    - Community engagement
    - Prevention
    - Communication
- Next steps – the final report would be published in the week commencing 22 March

Further sections set out the proposals for dissemination of the report and an audit process, including a peer review by external public health colleagues.

The Chair thanked Dr Shade Agboola for the excellent report and paid tribute to her for the response to the Covid-19 Pandemic, during her first year as DPH. Questions and comments were invited, with responses provided as indicated:

- It was agreed that the presentation slides and the final DPH report would be circulated.
- The focus on health inequalities was commended.
- In responding to the pandemic, reference had been made to the joined up working of the public sector. There was also recognition of the private sector contribution, an example being the food supply chain services. These comments were noted.
- It was questioned if the impact on peoples' health could be quantified for other medical conditions such as cancer and heart disease, due to delayed diagnosis resulting from Covid-19. The annual report did reference wider issues such as cancelled elective procedures and reduced access to dentistry services. Other issues were beyond the scope of the annual report but were important and needed to be considered.

- It would be useful to draw out the learning from the pandemic to inform the response to future pandemics. This point would be raised with the project board, to see how it could be incorporated.

Resolved

That the Health and Wellbeing Board:

1. Notes and supports the draft Director of Public Health Annual Report 2020/21.

2. Agrees to endorse the recommendations stated in the report.

3. Health and Wellbeing Strategy

The Board gave consideration to the final draft of its Health and Wellbeing Strategy (HWBS). It had been drafted using findings from the most recent Joint Strategic Needs Assessment (JSNA), a Covid-19 recovery survey and a health impact assessment (HIA).

A survey was undertaken to consult with Warwickshire residents on the draft HWBS, with details provided of the mechanisms used and Appendix 1 to the report detailed the outcomes from the survey. The executive summary pulled out key data from the consultation. Specifically, responses were sought to the following ambitions:

- People will lead a healthy and independent life
- People will be part of a strong community.
- People will have access to effective and sustainable services

The feedback against each ambition was reported, together with some concerns around partnership and ensuring that the voluntary and community sector was involved fully. The executive summary and appendix provided more detail on this. Working collaboratively with a wide range of diverse communities was recognised as a key to success. Consultee feedback was provided on the proposed focuses for the Board.

The draft strategy was reviewed in light of the consultation findings and examples were provided of the changes made, strengthening partnership aspects, inclusion of the voluntary and community sector and in relation to implementation and monitoring. The draft HWBS had been updated to reflect the ambition to work with communities, to ensure cultural competence and to develop accessible, responsive, and high-quality services designed in a way to reduce inequalities in health.

Next steps were reported in terms of sharing feedback and subject to approval, the development of delivery and local implementation plans and an outcomes framework.

The report was accompanied by a presentation from Nigel Minns on the consultation findings and the final draft of the HWBS, which covered the following areas:

- Consultation – process and responses; there were 562 responses to the surveys.
- Headline findings, with the majority of respondents supporting the three ambitions and priorities for the next two years.

- Key findings and response. This outlined feedback on partnership and collaboration aspects, implementation/monitoring and the review of priorities after two years, together with the reviews made to the draft strategy.
- A plan on a page showing Warwickshire's population health framework.
- Next steps in response to the consultation and in delivering the strategy.

The Chair commended the document as a step change, providing a positive way forward. It had also been endorsed by the leaders of all district and borough councils in Warwickshire. Discussion took place on the following areas:

- A key aspect would be linking both the Warwickshire and Coventry HWBSs to the Integrated Care System / Health and Care Partnership work. There were complex structures in place. To achieve desired outcomes, a need to trace lines of action and their impacts in the short and longer term, to show the outcomes to the public and the anticipated timescales. It was agreed this was important, with reference to the implementation plan which should be a combination of the three implementation plans at place level, which were already multi-agency plans. The aim was for a single set of priorities and to deliver them effectively. Both HWBSs had been developed against the same principles and there would be many similarities, but necessarily some variations across each of the 'places', including Coventry.
- The document was complimented. There would be complex issues to resolve and a need to ensure freedom at the place level within an overarching framework. Coventry would have a different overall strategy and may feel they had a different place-based direction.
- The Chair had met recently with chairs and executives for each of the places and there would be a continued dialogue between them. This could involve Coventry too.
- Nigel Minns agreed that there did need to be freedom at place to implement the strategy appropriately for each area. There would be individual initiatives at the place level which were not within the strategy and were a matter for that place. There were clear ambitions and priorities within the HWBS and relevant aspects from each place plan could be included too. This was a genuine partnership effort.

Thanks were recorded to those involved in developing the strategy.

Resolved

That the Health and Wellbeing Board:

1. Notes the outcomes from the five-week public consultation.

2. Approves the final Health and Wellbeing Strategy 2021-2026 and the three priority areas, as shown in Appendix 2 to the report.

3. Supports the mechanism for annual reviews of the Health and Wellbeing Strategy to the Board.

4. Supports the development of local place-based implementation plans (through the Health and Wellbeing Partnerships).

4. Homelessness Strategy

It was reported that in 2019, the Board approved formation of a Homelessness Strategic Group which commenced work on a countywide strategy on tackling and reducing homelessness.

An update was provided, which included a presentation from Lisa Barker Head of Housing at Warwick District Council and Emily Fernandez from WCC Public Health. The presentation covered the following areas:

- Countywide homelessness conference
- The approvals given previously by the Board
- Partners involved
- Engagement and collaboration
- Chapter themes
- Homeless strategy strategic vision and priorities
- Homelessness and health – what the evidence tells us
- Health recommendations
- Challenges for delivery
- Next steps

The Warwickshire Homeless Strategic Group had been working collaboratively across a wide range of partners, writing a countywide strategy on preventing homelessness. Development of the strategy had been delayed for several months due to Covid-19. A concerted effort had been made to bring it to fruition. The completed strategy had been taken through district and borough council governance processes, ahead of this report being submitted.

A section of the report focussed on the development of the strategy, including the strategic priorities of health, financial inclusion, young people, domestic abuse and offending. Countywide strategy engagement was undertaken. The recommendations and content had been refined following this engagement, to ensure relevant comments were reflected within the strategy. An appendix to the report provided a detailed analysis of the feedback. The covering report highlighted this feedback and the support for proposed priorities / recommendations either in total, or to some extent. Qualitative feedback from the engagement had resulted in further changes to the strategy.

In terms of next steps, the homelessness strategic group would continue to work collaboratively and to develop an action plan to underpin the strategic recommendations. This would result in the development of workstreams, to achieve the strategic vision and periodic updates would be provided.

The Chair thanked the officers for the presentation. Questions and comments were invited, with responses provided as indicated:

- Councillor Falp welcomed the strategy and particularly the section on tackling domestic abuse. A question on the arrangements for refuge provision and how the strategy would align if those placements were out of County. Reference also to the Government Bill on domestic abuse and the duty of care for authorities to assist people from any area balanced against the limits on available accommodation.

- Emily Fernandez spoke of the plans for a working group on safe accommodation. This would look at the issues referenced, such as cross border arrangements. The Bill provided a good opportunity to look at the challenges from domestic abuse and homelessness across partnerships and organisational boundaries.
- Lisa Barker added that the vast majority of abuse was against women and at times relocation out of county, even temporarily, may be appropriate, especially if cases involved stalking. Not all people needed refuge accommodation, but it was crucial to provide help and support. It was correct that people could approach any council to receive support to escape domestic abuse.
- Becky Hale updated on the recommissioning of domestic abuse support services, including accommodation-based support. Additional financial support had been received and it was timely in response to the Bill, to consider how best to use the resources to support people. Further engagement on this would take place in the months ahead.
- The pathway project presented an opportunity to assess the wider needs of homeless people when they were in hospital. However, pressures on acute hospitals required an early discharge. It was questioned if there was a 'step down' care solution.
- The pathway needs assessment sought to quantify the number of people considered to be homeless, who accessed acute services. There were real challenges. A hospital liaison service was working across acute trusts and housing, providing an intermediary service to tackle the challenges which may prevent discharge and building support for those individuals.
- Councillor Bell asked if people could be discharged to a setting, rather than returning to the streets. There were step down care facilities, but there still needed to be longer term options. Districts and boroughs did all they could to accommodate individuals, but people could have additional challenges. There were excellent partnership arrangements, including with the community and voluntary sector.
- Councillor Beaumont spoke about future resource challenges associated with WCC cuts of £1m to housing related support, which would impact on homelessness prevention. He quoted from a report on the redesign of the support offer and sought a detailed response on how this cut would be overcome by other means. The Chair responded that a review would take place of this service and enable reassessment of the funding required for it. A pause had been included in the budget for two years. He added that there would be wide involvement in the review, that it was not a statutory service and the service needed to align with the other work referred to in this item.
- There was pride in the collaborative work across authorities, to address homelessness. The budget provision needed to be monitored closely to ensure services could be delivered in the future.
- Via the meeting chat dialogue, Dianne Whitfield of CWPT recognised the true partnership approach, thanking officers for the clear and moving presentation.
- Chris Bain advised that Healthwatch's final report on its Rights Access Project (rights of homeless people to access primary care) was available on its website.

Resolved

That the Health and Wellbeing Board:

1. Notes the contents of the report.

2. Agrees to the strategic vision and recommendations within the strategy; Preventing Homelessness in Warwickshire: a multiagency approach.

3. Supports the Homelessness Strategic Group to develop the action plan underpinning these recommendations and continues to work towards preventing homelessness in 2021/22.

5. Health and Wellbeing Board Sub-Committee

It was reported that, at its meeting on 6 January 2021, the Board received an update on the Better Care Fund (BCF) Plan. It delegated authority to a sub-committee to give final consideration to the BCF Plan for 2020/21.

The sub-committee met for this purpose on 29 January 2021. A copy of the meeting documents were publicised to all members of the Board. The Minutes of the meeting were submitted.

Resolved

That the Board notes the decisions taken by the Health and Wellbeing Board Sub-Committee at its meeting on 29 January 2021.

……..
Councillor Les Caborn, Chair

The meeting closed at 3.30pm

Agenda Item 2

Health and Wellbeing Board

An evaluation of Creative care commissions - Covid-19 response

7 July 2021

Recommendation(s)

1. That the Health and Wellbeing Board notes and comments upon the evaluation of the creative care commissions and the key principles for future commissioning.

1. Executive Summary

1.1 The Coventry and Warwickshire Creative Health Alliance (CWCHA) was established in 2019 to strengthen the links between the creative, health and care sectors across the sub-region. It is comprised of representatives from the creative sector, NHS, and local authorities who develop and oversee a programme of work to address local health and wellbeing priorities using creative health approaches.

1.2 In March 2020, Warwickshire County Council's Cabinet approved a bid to the Early Intervention, Prevention and Community Capacity Fund for £187,500 per annum for 3 financial years (total £562,500) to develop a creative health social prescribing system. This fund was further enhanced to include an offer for children and young people and the total value of the fund was increased by a further £110,000 per annum. The total fund available for this programme over the 3 years is £891,000.

1.3 Shortly after the allocation of the funding, the Covid-19 pandemic prevented the start of the programme development in line with the original proposals. In response to the pandemic, WCC worked with the CWCHA to commission eight creative projects to support Warwickshire residents' health and wellbeing particularly affected by the restrictions placed on residents, such as shielding for the clinically vulnerable.

1.4 Through the CWCHA, submissions of proposals up to an estimated value of £10,000 per project were invited. The successful commissions included a variety of art forms, target audiences, and engagement methods, however all aimed to support wellbeing, happiness, and connectedness, and to be widely accessible to participants.

1.5 The organisations were partnered where possible with WCC commissioned services to ensure vulnerable residents were reached. All the projects successfully delivered a mixture of offline and online engagement opportunities. In total 15,000 residents across Warwickshire benefitted from engaging with the projects, of which there were 485 direct engagements,

10,000 activity packs distributed to residents and health and social care staff and many more engagements online recorded. A full breakdown of the engagements per project are outlined in Appendix 1 (*Evaluation of Creative Health Projects During Covid-19, Jan 2021)*

1.6 Projects were largely delivered between July and October 2020 and included various formats such as online group video calls and the provision of physical resources to participants. A brief overview of each creative project is shown below.

- **Armonico Consort:** Artists recorded videos of singing workshops which were shared with individuals, residential homes, and care homes to watch and engage with.
- **Arts Uplift:** Four subprojects, with online and offline aspects, supported groups of people through dance, creative writing, music and song writing, and hand sewing.
- **Escape Arts and Sitting Rooms of Culture**: Production of a physical booklet and digital resources to facilitate creativity, delivered to participants including hospital patients and staff.
- **Live & Local:** Ten creative partnerships were facilitated between artists and Warwickshire communities with various creative outputs (e.g. a short film and a book).
- **My Voice Lifts My Soul:** A series of weekly group online sessions focussed around Singing for Lung Health, attended by participants living with respiratory conditions.
- **Open Theatre:** A series of weekly group online sessions for young people with learning disabilities focussed around drama and resulting in the creation of a short film.
- **Starfish Collaborative:** An online group journaling project for new mothers, online digital media sessions for a group of young people, and an offline collation of community art.
- **Sundragon Pottery:** Individuals and charity organisations were provided with the resources needed to create with clay, along with provision of a second follow-on box.

1.7 Coventry University have evaluated these programmes and produced a report: *Evaluation of Creative Health Projects During Covid-19, Jan 2021 (Appendix 1)*. The evaluation found that COVID-19 required creative health projects to adapt to novel methods of mobilisation and delivery. Whilst these changes brought substantial challenges, participants interviewed in this research identified that creative projects positively impacted health, psychological, and social wellbeing during an uncertain period.

1.8 Research findings and the process of this evaluation identified further important considerations for evaluating creative health projects, particularly with regards to collecting quantitative evaluation measures from a larger sample. These findings have guided recommendations to support the development and evaluation of creative health projects in the context of COVID-19 and beyond and have been used to support the commissioning of a suite of 6 larger creative health programmes that are being between

January 2021 and March 2023.

2. Financial Implications

2.1 The cost for the creative health programmes commissioned during this period totalled £80,000. The funding was made available from a larger fund of money awarded by Warwickshire County Council from the Early Intervention and Community Capacity Fund to develop a suite of 6 creative health programmes as part of a social prescribing creative health system. The total funding allocated to the overall delivery of creative health programmes is £891,000 over 3 financial years (2020/21, 2021/22 and 2022/23).

3. Environmental Implications

3.1 All the interventions were either locally provided or online due to Covid-19, which enabled travel to be reduced and for activity to be localised.

3.2 Consideration was given to ensuring packaging and resources were kept to a minimum and could be recycled by some of the artists during the project.

4. Supporting Information

4.1 A summary of the evaluation findings is detailed below.

4.2 **Theme 1: Impact of creative arts on health and wellbeing:** participants described how the creative health projects have impacted health and wellbeing around three main themes: creating connections, providing hope and positivity and health benefits. Whilst most findings were identified from the project participants, the perceptions, observations, and experiences of artists also contributed to understanding about how creativity can support wellbeing. Taken together, the participants described the importance of continuity and access to creative projects to maintain these benefits to health and wellbeing. Benefits to physical health were also reported by participants attending a singing for lung health project.

4.3 **Theme 2: Mobilising, delivery and evaluating creative health projects:** findings were organised into five inter-related themes: responding to the challenges of Covid-19, collaborative partnerships, achieving accessibility, lessons and project legacy and measuring impact. Whilst most findings were identified from project artists, project participants including those who performed volunteer roles, also contributed perspectives about how projects could be successfully and accessibly delivered during Covid-19.

4.4 **Lessons learnt and project legacy:** the creative outputs produced by the individuals and communities served as an impressive reminder and legacy for the future, “we’ve all been amazed at what we’ve produced, especially the people in the planning group because suddenly there is this astonishing video that we’ve done” (project artist). The pride and enjoyment from the projects encouraged individuals and communities to seek further creative

opportunities. Relatedly, artists reflected that the experiences of adapting projects for the Covid-19 delivery had initiated new and useful ways of working, this is both in relation to adapting to technologies but forming new partnerships with commissioning services and charities supporting vulnerable residents.

4.5 **Measuring the impact:** measuring the holistic impact of the creative projects on participants and communities was a notable part of the commissions. There were a number of challenges to collecting and evidencing the impact and these are reflected in the recommendations in next steps. Evaluation methods need to be collaborative, coordinated and transparent to appropriately measure the holistic impact of creative projects on health and wellbeing.

5. Timescales associated with the decision and next steps

5.1 A further report will be provided to the Health and Wellbeing Board on the progress of the broader suite of commissioned creative health services in November 2021.

5.2 Using the key areas of good practice for creative health delivery, we will embed these into new commissions for short-term projects and longer-term commissioned creative health services.

5.3 We will develop guidance on how to establish a coordinated evaluation structure, which can be communicated at an early stage and embedded into the creative project process for both short-term projects and longer-term commissioned creative health services.

5.4 We will use the intelligence gathered to help inform future creative health commissions, drawing on the experience of this activity.

Appendices

1. Coventry University Creative Health Evaluation Report

Background Papers

None

	Name	Contact Information
Report Author	Karen Higgins, Gemma Mckinnon, Kate Sahota	karenhiggins@warwickshire.gov.uk, gemmamckinnon@warwickshire.gov.uk, katesahota@warwickshire.gov.uk
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Lead Director	Strategic Director for	nigelminns@warwickshire.gov.uk

	People	
Lead Member	Portfolio Holder for Adult Social Care & Health	margaretbell@warwickshire.gov.uk

The report was circulated to the following members prior to publication:

Local Member(s): None
Other members: Councillors Bell, Golby, Holland, Drew and Rolfe

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Evaluation of Creative Health Projects During COVID-19

Commissioned by the Creative Health Alliance Coventry and Warwickshire

Evaluation by Coventry University

January 2021

Abstract

Background. In response to COVID-19, eight creative projects were commissioned by the Creative Health Alliance to support Warwickshire residents' health and wellbeing. Whilst the evidence base for creative health has been developed, further research was required particularly due to the novel considerations of COVID-19.

Aims. Two main aims guided this evaluation. The first aim was to examine the impact of creative participation on health and wellbeing during COVID-19. Second, this research aimed to explore issues relating to the mobilisation, delivery, and evaluation of creative projects.

Methods. A mixed-methods evaluation was conducted with these aims. Participants completed quantitative surveys prior to and following projects, to explore associations between engagement and wellbeing. Qualitative data were collated through interviews with project participants and artists who shared in more depth about their experiences.

Findings. Qualitative analysis identified three themes which discussed the benefits of creative participation on wellbeing: *Creating Connections*, *Providing Hope and Positivity, and Health Benefits*. However, methodological limitations prevented conclusions from quantitative methods. Regarding project delivery, five themes were identified which were contextualised by COVID-19: *Responding to the Challenges of COVID-19, Collaborative Partnerships, Achieving Accessibility, Lessons and Project Legacy, and Measuring Impact.*

Conclusion. Qualitative findings suggested that the benefits of creative health can be achieved from remote and socially-distanced projects, however there may be additional considerations for recruitment, accessibility, and evaluation. Recommendations for creative health delivery and evaluation are proposed from the findings and limitations presented.

Introduction

As the World Health Organisation (WHO) declared a pandemic of COVID-19 in March 2020 (WHO, 2020), social distancing and other infection-prevention measures were introduced, particularly for those deemed clinically vulnerable (Public Health England, 2020). Though social distancing was essential to decrease infection transmission, concerns arose as to the impact of isolation on mental and physical wellbeing (Li & Huynh, 2020). Recent research has indicated increased loneliness and decreased wellbeing during COVID-19 (Groarke et al., 2020; Li & Wang, 2020), and a body of previous research has evidenced associations between social isolation and outcomes including depressive symptoms, cardiovascular disease, cognitive impairment, and reduced subjective wellbeing (Leigh-Hunt et al., 2017). Consequently, efforts which aimed to reduce the impact of COVID-19 on health and wellbeing were warranted.

Engagement with art is one area of intervention which has been implemented to provide therapeutic benefits and reduce feelings of loneliness (Chia et al., 2018). The field of creative health has developed in recent years, together with the formation of an All-Party Parliamentary Group (APPG; APPG for Arts, Health and Wellbeing, 2017) and recent reports commissioned by the WHO and United Kingdom (UK) Government which evidenced benefits for social cohesion and psychological wellbeing (Fancourt et al., 2020; Fancourt & Finn, 2019). Utilised as a social prescribing tool in healthcare, creative health projects have also been devised to promote individual wellbeing, social engagement, and reduce mental health issues such as depression and anxiety (Bungay & Clift, 2010; van de Venter & Buller, 2015; Wang & Li, 2016; Wilson et al., 2017).

Consistent with this evidence, articles published with respect to COVID-19 have also

advocated for the use of creative interventions to support wellbeing. Using evidence acquired during Ebola and SARS, art therapies were posited to facilitate expression of emotion, increase solidarity and connection, and provide hope and motivation during COVID-19 (Potash et al., 2020). Similarly, art engagement was hypothesised as a healthy coping mechanism to support self-compassion and reduce stress among all age groups during this period (Braus & Morton, 2020). However, given that COVID-19 presented challenging and novel contexts, both for daily living and the delivery of creative projects, empirical evidence was also required to explore how creativity could impact health and wellbeing.

Aims and Objectives

In the context of COVID-19, the Coventry and Warwickshire Creative Health Alliance locally commissioned eight projects which aimed to promote wellbeing and social connections through creativity. A mixed-methods evaluation was conducted across the projects and was devised to address two primary aims. First, this research aimed to explore the impact of the creative projects on participant's psychological wellbeing, health, and loneliness during COVID-19. Second, this research aimed to explore issues relating to the mobilisation, delivery, and evaluation of creative health projects in the context of COVID-19 and more broadly. In addition, aspects relating to accessibility, inclusivity, and the digital or remote delivery of creative projects, were of contextual interest to both aims. The following objectives were identified:

1) To conduct surveys and interviews with project participants to explore how engaging with a creative project during COVID-19 could impact health and wellbeing.

2) To conduct interviews with project artists to explore their experiences and reflections about mobilising, delivering, and evaluating creative health projects during COVID-19.

Overview of Creative Health Commissions

The commissions included a variety of art forms, target audiences, and engagement methods, however all aimed to support wellbeing, happiness, and connectedness, and to be widely accessible to participants. Projects were largely delivered between July and October 2020 and included various formats such as online group video calls and the provision of physical resources to participants. A brief overview of each creative project is shown below.

- Armonico Consort: Artists recorded videos of singing workshops which were shared with individuals, residential homes, and care homes to watch and engage with.
- Arts Uplift: Four subprojects, with online and offline aspects, supported groups of people through dance, creative writing, music and song writing, and hand sewing.
- Escape Arts and Sitting Rooms of Culture: Production of a physical booklet and digital resources to facilitate creativity, delivered to participants including hospital patients and staff.
- Live & Local: Ten creative partnerships were facilitated between artists and Warwickshire communities with various creative outputs (e.g. a short film and a book).
- My Voice Lifts My Soul: A series of weekly group online sessions focussed around Singing for Lung Health, attended by participants living with respiratory conditions.
- Open Theatre: A series of weekly group online sessions for young people with learning disabilities focussed around drama and resulting in the creation of a short

film.

- Starfish Collaborative: An online group journaling project for new mothers, online digital media sessions for a group of young people, and an offline collation of community art.
- Sundragon Pottery: Individuals and charity organisations were provided with the resources needed to create with clay, along with provision of a second follow-on box.

Methodology

Participants

Participants in this research were involved with the creative projects in various ways. Participants denoted as ‘‘project participants’’ were attendees of the creative projects who contributed to, or engaged with, creative outputs. These participants were primarily Warwickshire residents, though further eligibility criteria varied between projects. Across projects, participants were diverse in age, including children and older adults, and included individuals with mental health conditions, learning disabilities, substance misuse issues, caring responsibilities, and long-term health conditions.

Participants denoted in this research as ‘‘artists’’ were involved in areas such as submitting the funding application for the creative commission, recruiting partnering organisations and participants, directly delivering the creative activities, or a combination of these roles. These participants were adults ordinarily employed by one of the eight commissions, or were artists recruited by a commissioned project to deliver creative activities with participants.

Prior ethical approval was sought from Coventry University for all aspects of the research (P108406, P109261, and P110055). Participants were individuals with capacity to consent to and understand the purpose of this research. Children over the age of 13 years were eligible to consent to the post-project survey, where parent/carer consent was also obtained, though only participants over 18 years were eligible to be interviewed.

Procedure

Project Participants.

Multiple methods of data collection were included to address the research aims, including the use of surveys and interviews. All participants read participant information sheets, completed prior consent forms, and were debriefed for each aspect of the research detailed below. Participants could volunteer for any, or all, of these evaluation methods, and completion of an evaluation was not required for participation in the creative project.

The first stage of evaluation was dissemination of a licensed online survey tool to measure wellbeing (Happiness Pulse, 2019). The Happiness Pulse was intended as a repeated-measures evaluation of cohort wellbeing at the start and end of the projects. Project-specific links were used so that projects could disseminate surveys, via communications or social media, at timepoints appropriate to the project's specific timeframe. Project participants completed consent forms at both time points via Qualtrics, an online survey platform, and were then diverted to the Happiness Pulse website. These surveys were anonymous, and responses were not linked over time. Project participants may have volunteered for either or both time-points.

Whilst the Happiness Pulse provided an indication of population-level (i.e. project-level) wellbeing, it was recognised that multiple variables such as different samples and

changes to COVID-19 restrictions may contribute to differences across time. Therefore, project participants were invited to complete a post-project survey designed for this research and hosted in Qualtrics. This survey incorporated quantitative measures of demographics, wellbeing, creativity, behavioural and subjective engagement, and the option of providing qualitative feedback.

During the post-project survey, participants could also indicate interest in a follow-up interview by providing contact details. Project artists were also able to share information about the interviews separately, to increase accessibility to participants who did not complete a survey. Participants chose between a telephone or online call (with or without video) to complete interviews with a researcher from Coventry University. Interviews were audio-recorded, transcribed verbatim, and anonymised to remove any personal-identifiers (e.g. names of individuals and projects).

Project Artists.

As projects completed, project artists were invited to take part in an interview with a Coventry University researcher about their experiences of mobilising, delivering, and evaluating the projects, as relevant to their role. Participant information sheets were disseminated to the primary contacts of each commissioned project, and a snowballing approach was used to invite further eligible individuals. Interviews were conducted via online calls (with or without video), and were audio-recorded, transcribed verbatim, and anonymised. Whilst specific names of individuals and projects were redacted, participants were aware that due to the unique nature of projects, some quotes may identify an individual project or subset of projects.

Measures

1. Happiness Pulse (Project Participants).

The Happiness Pulse is an online wellbeing survey which evaluates general wellbeing (2 items), emotional (7 items), behavioural (6 items), and social domains (7 items). For participants, these domains are termed ''General Wellbeing'', ''Be'', ''Do'', and ''Connect'' (Happiness Pulse, 2019). Participants responded to items (e.g. ''*Overall, how satisfied are you with your life nowadays''* and ''*I've been feeling close to other people''*) via relevant Likert scales. Participants also reported their gender, age, ethnicity, and disability, which included ''*prefer not to say''* options. After completing the survey, participants were shown their score in each domain and could access a website with information about their score, and support and ideas to improve wellbeing (Centre for Thriving Places, 2020).

2) Post-Project Survey (Project Participants).

The post-project survey was primarily completed in Qualtrics but was available as a pre-stamped postal version where requested by projects.

***Demographics*.** Participants provided their age, gender, ethnicity, and current living situation at the start of the survey.

***Behavioural Engagement*.** As relevant to each project, participants reported how many online workshops they had attended and/or how many hours they had engaged independently with the project from 1 (*not at all)* to 5 (*more than 10 hours)*. Participants also reported over what time period they had been involved, from 1 (*less than one week*) to 5 (*longer than 8 weeks*), and whether they had, or intended to, continue with the creative activities.

***Subjective Engagement*.** Subjective engagement aimed to measure cognitive and emotional engagement with the project. A modified nine-item version of the User Engagement Scale (O'Brien et al., 2018) measured focussed attention (feeling absorbed and losing track of time), perceived usability (the level of negative effort or frustration), and a reward factor (how interesting, worthwhile, and rewarding the project was). Participants selected how much they agreed with each statement (e.g. ''*I felt interested in this experience''*) from 1 (*strongly disagree*) to 5 (*strongly agree*).

***Mental Wellbeing*.** The 14-item Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) was used to measure mental wellbeing (Tennant et al., 2007) and has been validated in settings including health services and community creative projects (Warwick Medical School, 2019). Participants reported about wellbeing over the previous two weeks (e.g. ''*I've been feeling relaxed'*) using a 5-point scale from 1 (*none of the time)* to 5 (*all of the time)*.

***Health-Related Quality of Life*.** The EQ-5D-5L was included as a self-report measure of health-related quality of life, including mobility, self-care, usual activities, pain/discomfort, and anxiety/depression domains (Herdman et al., 2011). In each domain, participants selected which of 5 statements was most applicable to them (e.g. ''*I am [not/ slightly/ moderately/ severely/ extremely] anxious or depressed*''). Participants also rated their health on a visual analogue scale (VAS) between 0 (*the worst health you can imagine*) and 100 (*the best health you can imagine*).

***Loneliness*.** Loneliness was measured consistent with the UK Government's Loneliness Strategy (Office for National Statistics, 2018) The direct measure was chosen to reduce survey length, and participants responded to the question ''*how often do you feel*

lonely?'' from 1 (*never*) to 5 (*often/always*).

***Creativity*.** Creativity was conceptualized as a measure of active engagement with arts activities ordinarily. Participants were asked about the 12 months prior to COVID-19, and how often they engaged with 11 different activities such as ''*play an instrument*'' or ''*paint, draw or sculpt*''. Items were modified from similar surveys (Węziak-Białowolska et al., 2019) and response options were from 1 (*daily)* to 6 (*less than once a year or never)*.

***Self-Reported Respiratory Outcomes*.** Participants in the Singing for Lung Health project completed additional questions from the impact component of the St George's Respiratory Questionnaire as a measure of disturbance to psycho-social function (Jones et al., 1991). Participants reported categorically about 20 items, for example ''*I am breathless when I talk*'' with true or false response options. Impact domain scores were weighted, summed, and transformed according to guidance (Jones & Forde, 2012) and situated on a scale of 0 (*no impairment*) to 100 (*worst possible impairment*).

Qualitative Feedback. Participants could also provide any additional comments about their experiences with the creative project in an open-ended text box for qualitative analysis.

3) Interviews with Project Participants

Online and telephone interviews with participants were conducted according to a semi-structured schedule. Participants were asked how they engaged with the creative project, their experiences engaging remotely or digitally, their feelings and wellbeing during and after the project, aspects of the project which could be improved, and whether and why participants may continue with the activities.

4) Interviews with Project Artists

Within semi-structured interviews, artists were asked about their role, the nature of the creative project(s), and their experiences of delivering the projects remotely or digitally. Artists were also asked about recruitment and accessible they perceived the project to be, along with any resources which would have been beneficial, their experiences working with young people, their experiences with the funder and bidding process, and their reflections on the evaluations.

Analytical Plan

Qualitative Analysis

Interviews with project participants and artists were analysed using inductive Thematic Analysis (Braun & Clarke, 2006). Interviews were conducted with a Coventry University Research Assistant, who transcribed, anonymised, and re-read the interviews to develop familiarity with the data. Transcripts were inductively coded for comments, feelings, and experiences which related to the research aims. These initial codes, along with participant and line numbers, were then combined inductively into broader codes relating to shared underlying features. Broader codes were checked alongside the dataset and then organised into themes, which were discussed and agreed by the research team. Exemplary quotes were chosen to illustrate the meanings and nuances of themes.

Results

The quantitative results reported below are based on analysis from participants who completed each evaluation measure. These results reflect a sample of project participants. Artists also reported the numbers of participants who were involved in the creative projects

to the commissioner, and this information is provided in Appendix A. Taken together, artists reported direct interventions with 485 beneficiaries, an additional 10,000 beneficiaries received activity packs, and at least 5,000 interactions were estimated in relation to online creative outputs.

Repeated-Measure of Population Wellbeing

Participants.

Across both time points, 179 Happiness Pulse responses were received, though the tool cannot identify how many unique participants completed the Happiness Pulse at either or both time points. More responses were received during the first time period (*n* = 114) than the second time period (*n* = 65), and responses were received for seven projects (range 4 - 72 responses). Timelines varied across projects, but for most projects the first time period occurred between July and August 2020, and the second time period occurred between September and October 2020. Five projects received responses during both time periods. Across both time periods and excluding prefer not to say responses, participants were female (85.4%), White (95.4%), aged under 50 years (37.0%), 50 – 74 years (52.6%) or older than 75 years (10.4%), and 15.4% of participants reported having a disability. Participant characteristics reported during each time period are shown in Table 2.

Mental Wellbeing

To explore wellbeing at each time period, mean scores with 95% confidence intervals were observed for each wellbeing domain (see Figure 1), and descriptive statistics are shown in Table 1. Confidence intervals indicated that scores in Be and Do domains were higher at the second time period compared to the first time period. Confidence intervals for

Connect and General domains had some overlap across time periods, providing less evidence for a difference in these wellbeing domains.

Whilst wellbeing scores were higher for Be and Do domains during the second time period, methodological limitations meant that reasons for this change could not be deduced, and confounding variables may have explained or also contributed to change in wellbeing. In particular, the easing of lockdown restrictions for the population occurred during this time and could account for an improvement in mood. To explore whether demographics may have contributed to differences (owing to the potential for different samples across time periods), multiple regressions were conducted with each wellbeing domain as an outcome. Time point was entered in the first block of analysis, followed by age (dichotomised to over 65 years/under 65 years), gender (male/female), ethnicity (White/Ethnic Minority), and disability (yes/no) in a second block.

The difference between the first and second time points significantly predicted Be scores (B = .67, SE = .24, 95% CI [0.20, 1.14]), and explained 4.0% of variance, $F(1,160)$ = 7.79, p = .006. Demographics did not significantly improve the model in Block 2, nor predict Be scores. Similarly, time period predicted Do scores (B = .73, SE = .26, 95% CI [0.21, 1.25]), though this model explained only 3.9% of variance, ($F(1,160)$ = 7.62, p = .006) and was not subsequently improved or associated with any demographics. Time period also predicted general wellbeing scores (B = .76, SE = .28, 95% CI [0.21, 1.30]), and explained 4.0% of variance, $F(1,160)$ = 7.54, p = .01); the model was not improved by, or associated with, demographics. Finally, time period did not predict Connect scores (B = .55, SE = .40, 95% CI [-0.23, 1.34). This model was not significant, $F(1,160)$ = 1.93, p = .17) and was not improved or associated with participant demographics.

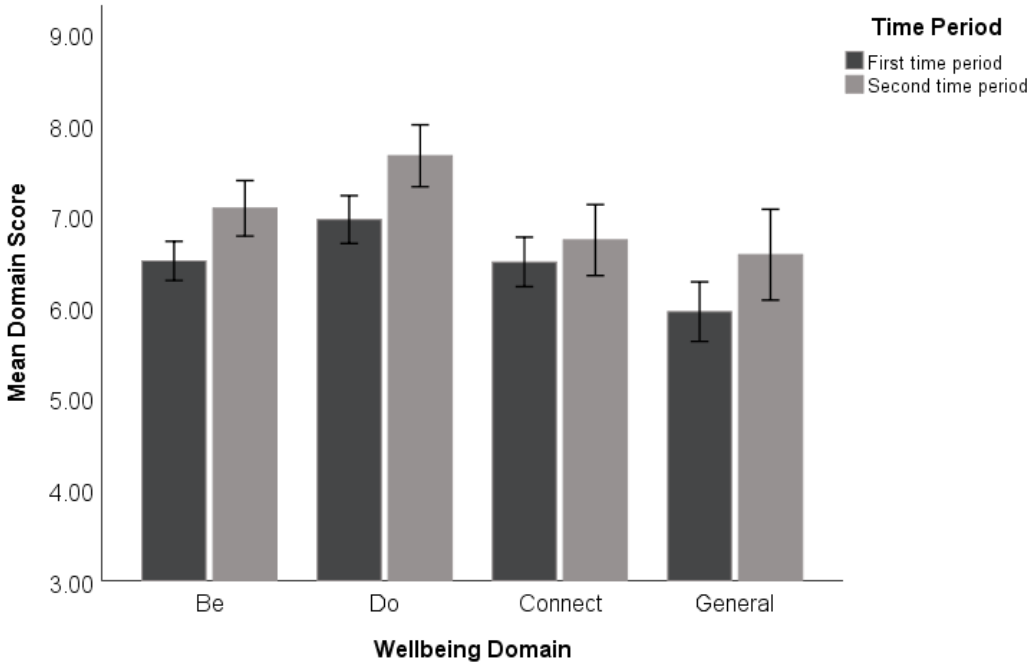

Figure 1. Mean domain wellbeing scores at first and second time periods. Error bars show 95% confidence intervals.

Table 1

Means and standard deviations for wellbeing domains across demographics and time periods

Wellbeing Domain	First time period *M(SD)*	Second time period *M(SD)*
Be	5.95 (1.36)	6.69 (1.68)
Do	6.74 (1.73)	7.59 (1.58)
Connect	8.51 (2.50)	9.00 (2.62)
General	5.95 (1.76)	6.57 (2.01)

Table 2

Numbers and percentages of participant characteristics at each time period

Characteristic	First time period *n* (%)	Second time period *n* (%)
Age		
Under 16	9 (7.9%)	1 (1.5%)
18 - 25	3 (2.6%)	0 (0.0%)
25 - 34	11 (9.6%)	2 (3.1%)
35 - 49	21 (18.4%)	17 (26.2%)
50 - 64	37 (32.5%)	18 (27.7%)
65 - 74	19 (16.7%)	17 (26.2%)
75+	11 (9.6%)	7 (10.8%)
Prefer not to say	3 (2.6%)	3 (4.6%)
Gender		
Male	18 (15.8%)	7 (10.8%)
Female	92 (80.7%)	54 (83.1%)
Prefer not to say	4 (3.5%)	4 (6.3%)
Ethnicity		
White	106 (93.0%)	59 (90.8%)
Ethnic Minority	4 (3.5%)	4 (6.2%)
Prefer not to say	4 (3.5%)	2 (3.1%)
Disability		
Disability	16 (14.0%)	10 (15.4%)
No Disability	92 (80.7%)	51 (78.5%)
Prefer not to say	6 (5.3%)	4 (6.2%)

Note. The data cannot ascertain how many participants completed the survey during both time points.

Taken together, although most wellbeing scores were indicated as higher during the second time period, a small amount of variance in these outcomes was explained. The Happiness Pulse data also did not include measures relating to participation in the evaluated creative projects (e.g. measures of engagement), and the reasons for this change in wellbeing cannot be established from these data. As described above, reduction of Covid-19 restrictions, participation in unrelated projects, or different participant characteristics may have confounded wellbeing, and the change in wellbeing cannot be attributed to the creative projects based on these data.

Post-Project Survey

Participants

A total of 34 participants completed the post project survey in October and November 2020 with responses from five projects (range 1 - 13 participants per project). All responses were received online. Paper surveys were posted to one group, however a subsequent COVID-19 lockdown may have hindered the group receiving or returning these surveys. Participants were aged 19 to 81 years old (*M* = 54.5 years, *SD* = 15.3 years), and mostly White (88.2%) and female (85.3%). More participants were sharing a home with other people (73.5%) than living alone (26.5%). Due to the sample size obtained, descriptive statistics are collated from participants across projects.

Health and Wellbeing

According to WEMWBS classifications (Warwick Medical School, 2020) participants were categorised as indicating low (*n* = 7), medium (*n* = 23), and high (*n* =4) mental wellbeing. Overall, participants scored *M* = 49.5, (S*D* = 9.3) with a range of 28 – 70. Self-

reporting about loneliness, a slight majority of participants (55.9%) reported feeling at least occasionally lonely over the previous two weeks. Reporting about overall health on the EQ-5D-5L VAS, participants scored *M* = 71.6, *SD* = 22.8. Self-reported problems in health domains indicated that more participants experienced problems with anxiety/depression and pain/discomfort than with mobility, self-care, and usual activity domains. When coded according to Index Values for England (Devlin et al., 2018), participants scored *M* = 0.79, *SD* = 0.25, range 0.03 – 1.00. Participants who completed the SGRQ impact component about lung health (*n* = 9) scored *M* = 23.7, *SD* = 10.0, range 10.9– 40.3. For comparison, scores in a healthy population have been reported as *M* = 4.7, *SD* = 9.9 (Ferrer et al., 2002) and individuals with Stage 1 COPD have scored *M* = 27.8, *SD*=19.8 (Jones et al., 2011).

Creativity

In the 12 months before COVID-19, reading for pleasure was most often engaged in daily (*n* = 16), and singing (*n* = 15), craftwork (*n* = 15), and photography (*n* =13) were most often performed at least monthly. In addition, 82.4% of participants engaged in at least one creative activity weekly, which reduced to 64.7% when reading for pleasure was excluded. Participants engaged in an average of 3.3 of the creative activities at least monthly (range 0 – 10).

Subjective Engagement

Mean scores were calculated for each subscale of subjective engagement. Overall, participants highly agreed that the creative project was rewarding (*M* = 4.7, *SD* = 0.5), and focussed attention scores indicated that participants felt absorbed in the projects (*M* = 4.0, *SD* = 0.6). Participants disagreed that projects were confusing, taxing, or frustrating according to the perceived usability subscale (*M* = 1.6, *SD* = 0.5).

Behavioural Engagement and Wellbeing

A majority of participants (58.8%) had engaged with the creative project for longer than 8 weeks, and many participants (70.6%) had attended at least one group workshop as part of the projects (*M* = 7 workshops, range 1 to 12+ workshops). Most participants had already continued (35.3%) or intended to continue (55.9%) with creative activities from the projects. The time period and number of hours participants engaged with the creative projects are shown in Figures 2 and 3, respectively.

Scatterplots were also observed to explore any indications of an association between behavioural engagement and wellbeing. Behavioural engagement was calculated by the addition of the number of workshops and attended and the categorical mean of the number of hours participants reported they had engaged independently with projects. As displayed in Figures 4 and 5, scatterplots did not suggest an association between behavioural engagement and mental wellbeing or self-reported health scores in this sample. Multiple regressions also supported this observation. Predictors were also conducted to evaluate whether the number of group workshops, number of independent hours engaged, and length of time of engagement predicted mental wellbeing, loneliness, and health outcomes. No associations were found between these measures of behavioural engagement and health and wellbeing outcomes, and these are reported in Appendix B. Potential limitations of this analysis, such as the limited sample of 34 participants, and the cross-sectional nature of the data are considered in the discussion.

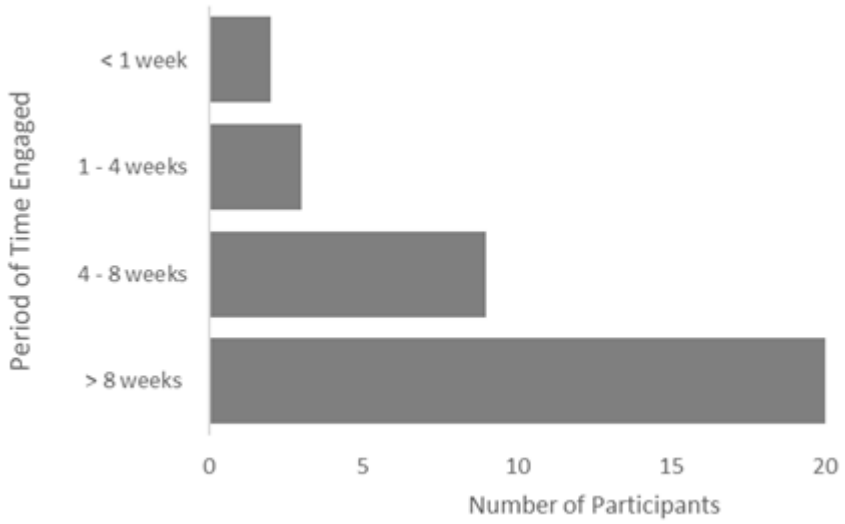

Figure 2. Time period participants engaged with the creative

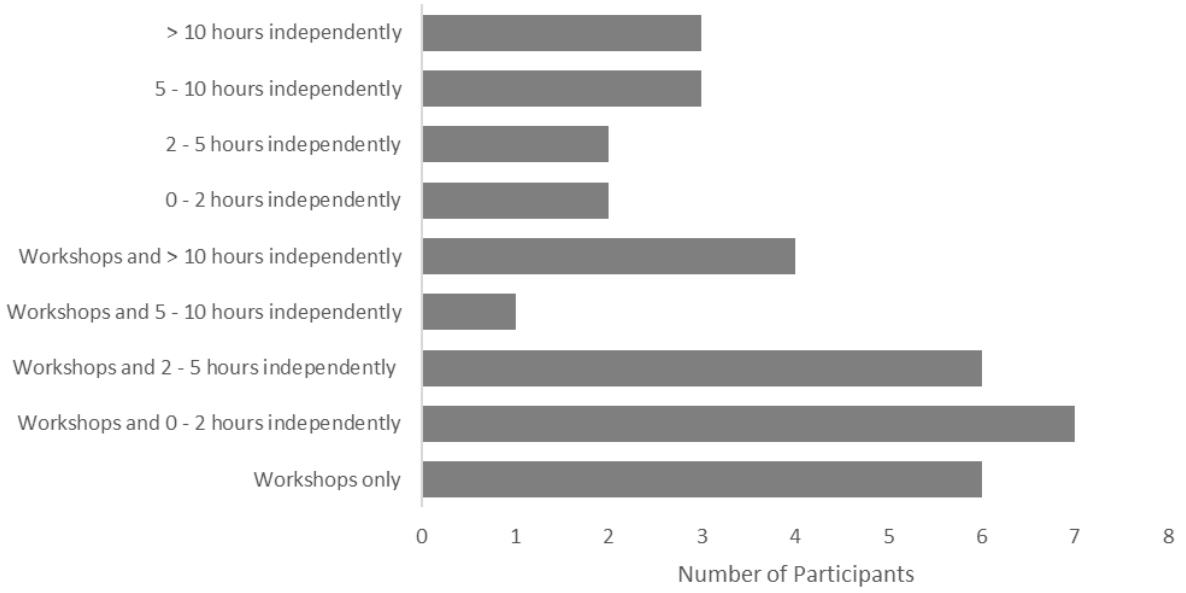

Figure 3. Number of workshops and/or hours participants spent engaging with projects.

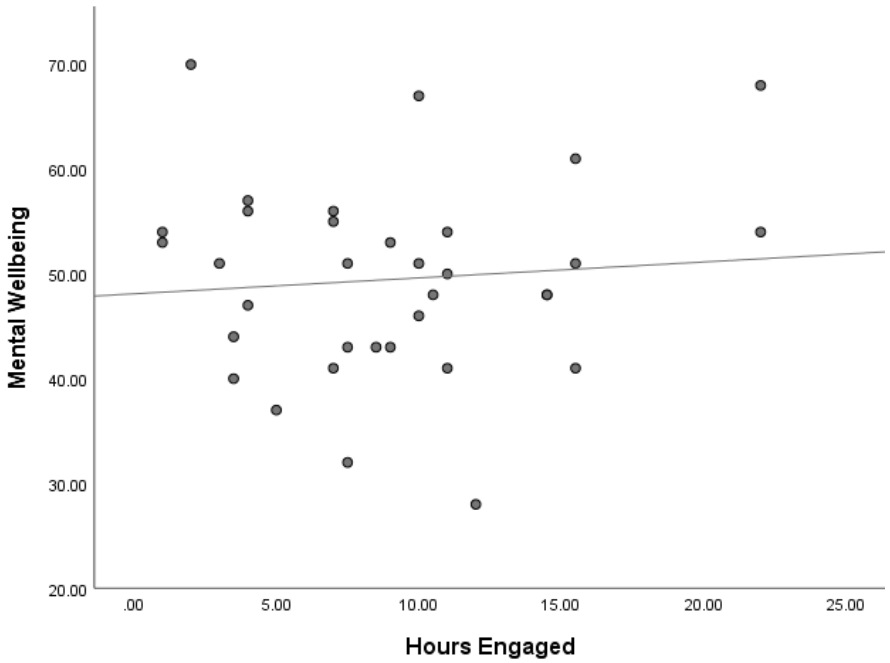

Figure 4. Scatterplot showing the association between mental wellbeing, measured by the WEMWBS, and behavioural engagement, measured by the approximate number of hours engaged.

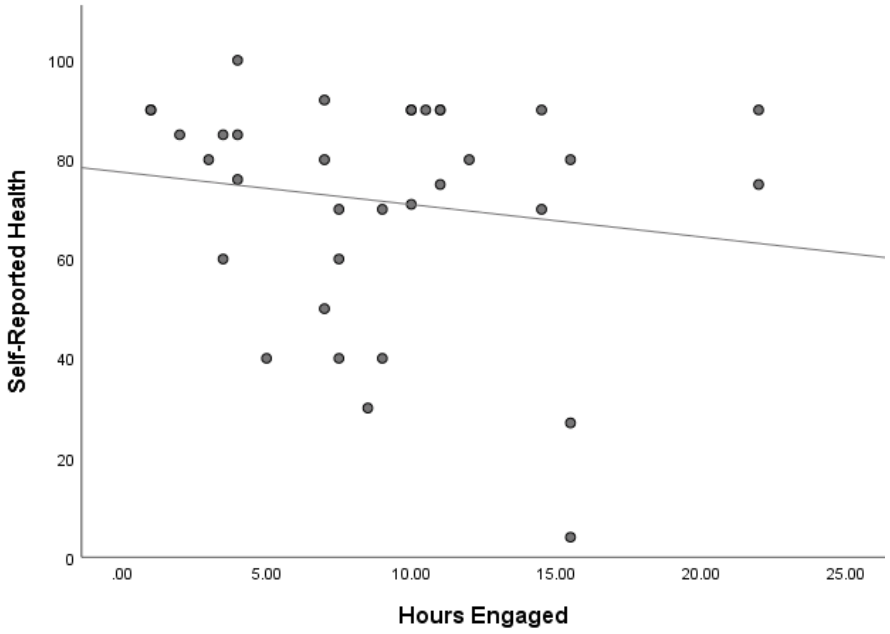

Figure 5. Scatterplot showing the association between self-reported health, measured by the EQ-5D VAS, and behavioural engagement, measured by the approximate number of hours engaged.

Qualitative Findings

Participants

Project participants.

Of participants who completed the survey, 12 (35.3%) were interested in being interviewed, and successful contact was made with 8 participants who were interviewed. An additional participant, who did not complete the survey, was also interviewed. Interviewed project participants (*N* = 9) were 3 males and 6 females, aged 40 to 71 years, who had taken part in one of four of the creative projects. A minority of the participants were also volunteers in the projects, and supported the project artists with activities such as recruitment and dissemination or collation of resources. Interviews were 32 minutes on average (range 24 – 50 minutes) and conducted via telephone (*n* = 7) and Skype (*n* = 2).

Project artists.

A total of 13 project artists were interviewed during October and November 2020 about their experiences of delivering the creative projects, either as projects had completed or were approaching completion. Project artists were represented from all eight creative projects and had various roles and responsibilities in the projects. Some participants managed the project and funding submission, other artists were responsible for delivering the projects with participants, and some participants performed a combination of these roles.

Findings

Whilst project participants and artists were asked different interview questions, shared and complimentary perspectives relating to the research aims were identified from

both groups. The findings are organised into two sections. The first section presents themes which relate to the impact of creativity on health and wellbeing. The second section presents themes relating to the mobilisation, delivery and evaluation of creative health projects during COVID-19. Themes are supported by quotes from project participants and artists, who are represented by pseudonyms. Broader codes obtained for each theme are included in Appendix C.

1) The Impact of Creativity on Health and Wellbeing During COVID-19.

Participants described how the creative projects had impacted health and wellbeing around three main themes: C*reating Connections*, *Providing Hope and Positivity*, and *Health Benefits*. Whilst most findings were identified from project participants, the perceptions, observations, and experiences of artists also contributed to understanding about how creativity can support wellbeing. Taken together, participants described the importance of continuity and access to creative projects to maintain these benefits to health and wellbeing.

Creating Connections.

Social connections were an important and valuable aspect of the project for participants, and these connections reduced the harmful impact of COVID-19 isolation, ''*I live alone so I'm used to my own company, but I have a lot of friends and I'm used to socialising, doing things, singing and playing. So, this has been very impactful…I really really loved it*'' (Margaret, project participant). Some participants also described that meeting others with similar health conditions contributed to peer support for living with a health condition, *''you meet different people and they're all at different stages of different things, so you can bounce your ideas and complaints off them*'' (Barry, project participant). Whilst

many artists and participants were looking forward to in-person activities with body language, physical contact, and casual chat, most participants were positively surprised with how connections developed through remote projects, described as ‘’*a good half-way*’’ (Heather, project participant).

Although strong connections were developed through group collaboration, individuals creating independently also connected to their community through learning about their area’s history or sharing their creations with others. However, this was often enhanced by, or reliant on, online technologies.

> *I'm able to post them myself on to the Facebook page we have, and we get to see what everybody else has been doing as well. And that’s nice cause that's where you begin to feel like you're not on your own, you’re part of something. (*Victoria, project participant)

In this way, it was important that artists purposefully facilitated time and space for social connections aside from the creative activities. One participant offered, ‘’*one of the limitations of Zoom is that you can’t have, or it’s much more difficult to have, casual chats with people that you would in a real-life setting*’’ (Heather, project participant). Responding to this issue, some artists carved out social time during the sessions to foster group connections. Quotes such as, ‘’*we had three kind of chat breaks and I think it just gave me an opportunity to get to know everyone on a more personal level*’’ and ‘’*I didn't know that you could build such a strong bond having never met people in real life*’’ from Michelle (project artist), suggested that dedicating time in sessions to casual chat could reduce the potential social limitations of online groups.

Similarly, supporting social connections to be self-sustaining after projects end was

recognised as an important aspect to maintain the project's benefits. One artist deliberated, ''*how do we offer it to them in a way that says, 'hey I'm the practitioner, I'm not going to be around anymore but you guys are free to meet on'?'' (Ian, project artist).* Whilst this reflection could apply to both in-person and remote projects, Ian highlighted how delivering projects during COVID-19 instigated further considerations for how connections could be supported to be maintained remotely or digitally in the longer-term.

Providing Hope and Positivity.

For many project participants, the creative project was ''*a light of positivity*'' (Robert, project participant) during the challenges and uncertainty of COVID-19, ''*you've got to look on the positive side as well, which is what this group give us*'' (Barry, project participant). Participants described how partaking in creativity provided learning, enjoyment, and was an escape from the stressors and events of daily life, ''*for me it's about taking part and enjoying yourself, and it just makes you feel happy and lifts your spirits and stops you feeling down*'' (Linda, project participant).

Participants also valued that projects had been willing, ambitious, and able to adapt to new formats, particularly when other former activities had to pause for the pandemic, ''*it's rather a nice feeling, takes away some of the fear of the future, to feel that, [the creative organisation] is thinking ahead and creating something*'' (Victoria, project participant). As illustrated here, that participants had successfully enjoyed creating remotely also provided hope and reassurance that creativity could continue through the uncertainty ahead. Several artists also described how this commission had benefitted their own wellbeing.

All of my energy for months had all been going into creating the show, and then

suddenly just bang nothing…what I was feeling was grief…to have an actual creative project to do which was to do with other people…was a complete lifeline. (Lisa, project artist)

As described here, the arts suffered substantial disruption to planned work during the pandemic, which was associated with financial and personal loss. As a result, both project artists and participants valued the hope and positivity of these creative projects being supported to adapt and continue.

Health benefits.

Amidst an uncertain and changing period, participants described how the creative activities benefitted mental and physical health. Specific benefits were to mood and feeling happier, and one participant reported that creating and sharing art was a beneficial form of self-expression, ‘‘*low self-esteem is a big problem in mental health I think, and via art you can portray your feelings’’* (Robert, project participant). Participants also endorsed that creativity was comparable to more traditional guidance for wellbeing, *‘‘we all do these things that the adverts encourage us to do, but actually doing something where you learn, you meet people, that’s creative, that’s interesting. For me, I think it would improve many people’s lives’’* (Heather, project participant). In these ways, many participants were advocates for promoting the benefits of creativity for health and wellbeing.

Artists also recognised these benefits through their experiences and observations of delivering creative projects. However, some artists preferred to avoid language associated with mental health because artists were not professionals in this field.

We've been careful about using the word therapeutic because we don't want to give the

> *impression that we can offer formalized help and support with it, because we can't. But we often talk about how calming it is...it's a very useful focusing activity*. (Elaine, project artist)

Some artists also avoided naming mental health conditions during the project and/or recruitment, so as to include individuals who did not identify with specific diagnoses, but may otherwise benefit, ''*a lot of people are not necessarily at a position where they are articulating or identifying that their mental health is necessarily poor''* (Helen, project artist).

Benefits to physical health were also reported by participants attending a singing for lung health project. These participants felt more knowledgeable about, and in control of, their breathing issues, ''*when I'm out walking now and get out of breath, there was ideas from this group with the breathing exercises that I use'' (Barry, project participant).* Participants reported using the techniques in their daily life, where the activities were a healthy coping behaviour for the sedentariness associated with shielding, ''*gave me such a lift physically helped to strengthen my lungs which had become unfit like the rest of me during Lockdown''* (surveyed participant). Participants further depicted the importance of feeling motivated and supported to continue the activities.

> *While we're actually doing the program, that's great… the minute you stop doing, or actually physically going to it. You start to pull back again and you forget to do things as often as you should. And that's why I think it's really important to be able to continue this.* (Sharon, project participant)

In this way, participants desired external motivation from the group to continue with the exercises. Similarly, many project participants wanted to continue to be able to access creative projects to maintain the benefits to health, wellbeing, and social connections which

they had experienced.

2) Mobilisation, Delivery and Evaluation of Creative Health Projects During COVID-19.

Findings related to the mobilisation, delivery, and evaluation of creative health projects during COVID-19 were organised into five inter-related themes: *Responding to the Challenges of COVID-19, Collaborative Partnerships, Achieving Accessibility, Lessons and Project Legacy,* and *Measuring Impact*. Whilst most findings were identified from project artists, project participants, including those who performed volunteer roles, also contributed perspectives about how projects could be successfully and accessibly delivered during COVID-19.

Responding to the challenges of COVID-19.

The context of COVID-19 presented numerous changes and challenges for which projects had to continually adapt. A common challenge was recruiting participants, where novel methods of recruitment were often required to respond to the socially-distanced restrictions of COVID-19. Several projects attempted numerous approaches to recruitment, ''*all of them were a little delayed 'cause we didn't have a lot of time to recruit… it took quite a long time, it sort of trickled in, we couldn't start straight away*'' (Rachel, project artist). Although artists noted the timely response required for COVID-19, artists often described that longer lead-times would have increased participation and the project's ability to fully prepare and mobilise for delivery.

In addition, creative activities ordinarily delivered face to face had to be adapted for remote or digital delivery, including devising policies for online working and preparing

written or offline materials, ‘‘*I've never, ever written any content in 17 years...I wrote the content and ended up writing reams, because you don't realise you've become an expert in something*!’’ (Ian, project artist.) These adjustments were often new ways of working for artists, and whilst resulting in materials transferable to other projects, artists described considerable workloads in adapting to these novel circumstances. In addition, some participants described how delivering projects in an online setting required confidence and a different skillset compared to in-person delivery, ‘’*they [commissioned artists] all found it really difficult to adjust to this new way of working and they've got round it, but I think they would prefer to be in person and to get back to actual real life again*’’ (Alison, project artist). Similarly, many artists described favouring the atmosphere and participant feedback associated with face to face delivery, and adjusting to building rapport and demonstrating enthusiasm online sometimes required skill development.

Problem solving in relation to recruitment, project development and delivery during COVID-19 meant that initial expectations for time requirements, workload, and budgetary plans were often exceeded. One artist commented, ‘’*in the future, we would be able to more successfully gauge, you know, how much time it's actually going to take to do*’’ (Elaine, project artist). This quote summarised how artists and projects had navigated through the unprecedented nature of the pandemic, and that delivering the creative projects had required substantial adaptability, hard work, and perseverance.

Collaborative Partnerships.

Partnerships with charities, organisations, and community volunteers. Whilst projects were often delivered by teams of varying roles and responsibilities, engaging with external organisations was highly beneficial to project mobilisation and delivery. Networking

with charities and community organisations was often central to project recruitment, ‘‘*in the end it [recruitment] was easy, but it was about finding the right partner organisation to work with*’’ (Rachel, project artist). Charities and other organisations were well placed to promote the project to their existing beneficiaries and were intermediaries who could disseminate information and physical resources to individuals without internet access in particular. One artist suggested, ‘‘*I think sometimes you have to really make those links and build those relationships with organizations that do have access to people that might really benefit from it*’’ (Michelle, project artist).

In addition to increased accessibility of the creative projects, charities also provided expert knowledge and support throughout delivery.

> *We had regular meetings with the leaders from [the charity] about how the young people are engaged and because they had the contact details for the young people. So, if we needed to go*, ‘Oh you missed this session this week. Is everything alright at home’?’’ [Kim, project artist).

As described here, continued collaboration with organisations provided an additional layer of support and safeguarding, as charities could offer expert advice and help to project artists and participants. One artist described how learning from knowledgeable professionals provided understanding and confidence for working with a particular group, ‘‘*we were like nervous, haven’t worked with folks with alcoholism before, … [we had] a chat with a guy who’d been working with folks with abuse issues for 20 years, and we felt like we could go ahead*’’ (Ian, project artist). As indicated here, artists did not always have experience supporting specific needs, and collaborating with charities was an important aspect to devise appropriate and beneficial sessions.

In addition to partnering with external organisations, some projects were also supported by volunteers who were situated within communities to assist the project's development, ''*I relied very much on [volunteer contact] in the community. That was her role, really, to engage people and to get them involved*'' (Lisa, project artist). Although community volunteers enjoyed being a part of the project, some project participants who performed this role acknowledged the additional demands, ''*as a volunteer to sort of manage it, it did take up more time than I kind of had anticipated at the start*'' (Jodie, project participant and volunteer). Whilst volunteers could be instrumental in mobilisation and delivery, particularly when COVID-19 restricted direct contact between artists and other participants, the demands associated with this role sometimes exceeded expectations.

Partnership with the Commissioner. Project artists described the relationship with the Creative Health Alliance as ''*supportive*'', communicative, and collaborative, ''*we had plenty of meetings to update, to discuss things… they introduced me to quite a wide range of organisations that I'd never worked with before*'' *(*Rachel, project artist*)*. The collaborative approach was particularly valued as participants described how traditionally separated health and arts fields may otherwise approach projects with contrasting ideas or language, *''I think it works best where you have arts involvement in the commissioning process… it enabled a bridge between the language of health commissioning and the language of arts commissioning'' (Mark, project artist).* However some participants did note how potential differences in the structures of health and art fields could impact creative health collaborations, *''often when you're in an organization, you're being paid to have that meeting 'cause you're salaried, but actually artists or as an organization you may not be'' (Michelle, project artist).* Consequently, artists relayed the importance of clear expectations and plans from the offset, so artists can effectively organise multiple organisational projects.

Speaking about the early stages of the funding process, the funding brief was described as *''clear''* by participants with varying experience of writing funding bids, and the collaborative relationship was appreciated to develop projects at this stage. Extending upon this collaboration, one artist suggested that future funding commissions could include more explicit discussions around issues such as safeguarding policies and ensuring inclusivity, *''I would recommend that there is like a conversation around inclusivity and what that means for people'' (*Helen, project artist*).* In this way, whilst COVID-19 challenges and timelines were perceived to have limited inter-project collaboration in this commission, artists reflected preferences for transparently sharing knowledge and best practice with the funder and other projects.

Achieving Accessibility

The requirement for social distancing also provided additional areas of consideration for achieving accessibility of projects. Recruiting from existing creative groups identified that not all participants transferred to remote or online projects during COVID-19, *''there was a lot of people who were eligible who didn't access the project and that would be interesting to know*'' (Michelle, project artist). Whilst there are challenges identifying reasons for non-participation through interviewing participants, one participant offered the following insight about peers from an art group, ''*it gets a bit more difficult when we have to rely on technology because with this particular group we don't all have the equipment at home or even a familiarity with it, but I'm very lucky that I do*'' (Victoria, project participant). Access and confidence with technology was a substantial consideration for achieving accessibility during COVID-19, ''*there was a huge amount of our beneficiary population who really needed something physical*'' (Nicole, project artist). As demonstrated here, most projects

identified a need for alternative methods of engagement, such as providing physical resources which did not require technology.

In further evaluating the accessibility of online methods of engagement, artists identified several advantages and disadvantages. Some artists observed that online methods could encourage participants to attend in ways which felt comfortable, ‘’*you can have your camera off, you can have your microphone off, you can choose what you want, even your identities… that's actually been really beneficial because actually getting somebody physically into a session at times is really hard*’’ (Helen, project artist). These signals also provided means for artists to interpret how participants may be feeling in sessions, akin to reading body language, and the choice to turn off video or microphone was perceived as particularly reassuring for participants who were anxious or uncertain about joining sessions.

For some groups of participants, artists also identified that online sessions could be more accessible than attending projects in-person. Examples included mothers with babies, ‘’*being able for them to just flick the computer on, and whatever context then at that moment, whether they're feeding their baby, trying to get it to sleep*’’ (Helen, project artist), and young people, ‘’*some of them were so committed to come and they'd be like in the supermarket or in the car joining in*’’ *(*Kim, project artist*).* In this way, online access removed the barriers associated with physically travelling to locations and increased the likelihood that participants could attend alongside competing demands. However, another artist learned that online sessions could be more challenging than attending in-person for a group of participants with substance misuse needs, ‘’*if our sessions were offline...what could take an entire day, and be lots of [time] credit, now was 30-40 minutes. And so that they found*

tremendously difficult'' (Ian, project artist). To respond to this issue during COVID-19, the artist devised additional offline activities for participants to engage with in-between sessions, highlighting the benefits of multiple methods of engagement.

Taken together, achieving accessibility was found to be a complex consideration where optimally accessible projects differed across individuals. Within the constraints of COVID-19, the provision of online and offline activities was beneficial to include individuals without access to, or confidence with, technology, as well supporting flexibility for individuals with differing mental and physical health needs and caring responsibilities.

Lessons and Project Legacy.

The creative outputs produced by individuals and communities themselves served as an impressive reminder and legacy for the future, ''w*e've all been amazed at what we've produced, especially the people in the planning group because suddenly there is this astonishing video that we've done*'' (Bridget, project artist). The pride and enjoyment from the projects also encouraged individuals and communities to seek further creative opportunities. One project participant described how the community had independently built upon the core project to produce additional creative outputs, ''*what we decided to do was to, as a parallel project, invite people to produce a piece of art that we could display on the walls of the library*'' (Mick, participant project and volunteer). As exemplified here, many project participants and artists hoped to continue creative activities to maintain the described benefits, and participants were seeking further financially accessible and interesting projects.

Relatedly, project artists reflected that the experiences of adapting their projects for COVID-19 delivery had initiated new and useful ways of working. Many artists had

networked throughout the project and had plans to continue these collaborations, ‘’*it's sort of given us momentum I think, to carry on our work in carehomes...now I've built up this database so we know we've got access to the to the right people*’’ (Alison, project artist). Through developing these networks, some artists had also discovered new avenues to deliver projects, ‘’*it sort of opens up a whole new, you know, social prescribing, a whole new world*’’ *(*Stacey, project artist*).* As described here, some artists had increased awareness of the potential for their creative projects to be more formally delivered within the field of health.

Rewarding and successful experiences also supported artists who were developing newer organisations to continue expanding their projects, ‘’*it has given me so much more confidence and I just feel empowered now to crack on and do more fun stuff*’’ (Donna, project artist). As well as instigating new ideas, confidence and partnerships, delivering remotely also reinforced the importance of in-person delivery for some artists, ‘’*I'm so keen to get back out and do it actually in person and I think it's just shown how important contact is and physical contact and being with people in the flesh*’’ (Kim, project artist). To summarise, whilst delivering the projects during COVID-19 required hard work for projects to quickly adjust and adapt, the learning, networking, and impressive creative outputs achieved had inspired and motivated artists to continue developing creative health projects.

***Measuring impact*.**

Measuring the holistic impact of creative projects on participants and communities was a notable part of the commission. Artists were familiar with evaluating projects, and often preferred continual evaluation so that projects could be adapted throughout delivery, ‘’*tailoring things where people give responses*’’ Ian (project artist). However, because the

funded evaluation expanded on initial plans in the funding brief, artists were not aware of the evaluation structure from the beginning, ‘’*I can understand how that sort of evolved in a reaction to the situation. But yes, it certainly would have been great to know that right at the beginning, to put it all in our welcome packs*’’. These changes impeded sample recruitment for some projects, along with challenges of disseminating evaluations remotely, ‘’*I've always felt throughout the whole thing that we're a little bit removed from the people taking part in our project*’’ (Alison, project artist). Many artists described that gaining feedback during COVID-19 was more difficult compared to in-person projects, and these challenges were enhanced due to the short timescales, indirect participant contact, and difficulties implementing more creative evaluation techniques.

Many artists also devised project-specific evaluations alongside the funded evaluation, ‘’*I did my own survey ‘cause I wanted to get some feedback, some more data I suppose. So, I felt it was a bit overkill having another survey to give people*’’ (Rachel, project artist). The development of the evaluation into multiple surveys contributed to concerns about asking too much from participants, which also reduced promotion of the evaluations. To prevent these concerns and achieve a more coordinated approach, artists described that evaluations co-developed ahead of projects commencing would be beneficial, *’I would almost like to work with someone who is skilled in the technical aspects of evaluation and what the purpose of evaluation is and what we need*’’ (Helen, project artist). Expected benefits included increased suitability of the evaluations for different participant groups, appropriate methods of recruitment and data collection, and evaluations relevant for the structure and timelines of projects and subprojects.

In addition, it was also depicted that creative project evaluations should be capable

of flexibility, consistent with the nature of creative development, ‘‘*at the beginning, it's all quite nebulous. It's like we're gonna partner this artist with this community, but we don't really know what the outcome of that is going to be…there's no quantifiable target there at the start’’* (Mark, project artist). This artist suggested potential differences between traditional health research, where a research design may be structured from the offset, compared to creative evaluations which may be more responsive to the creative journey and outputs. Another artist highlighted an ethical preference for a staged-model of consent for sharing outputs, in respect of the personal or emotive journey participants may experience.

> *We don't gain consent at the start of anything. We get their consent to say can we take images of you ... we will go back to them and say, 'we've got these particular images or this particular quote...it will go here, here and here. How do you feel about that*? (Helen, project artist).

Overall, artists valued the importance of effective evaluations, but it was important that evaluation methods were collaborative, coordinated, and transparent to appropriately measure the holistic impact of creative projects on health and wellbeing.

Discussion

The aims of this research, within the context of COVID-19, were twofold. First, to explore the impact of participating in a creative project on mental wellbeing, health, and loneliness. Second, to explore issues relating to the mobilisation, delivery, and evaluation of creative health projects. Whilst the findings of this research contributed understanding to these research aims, the process of this evaluation also highlighted broader considerations for evaluating creative health projects, which will be further discussed.

With regards to the first research aim, qualitative findings from this research indicated that participating in a creative project during COVID-19 supported the development of social connections, provided positivity and hope during a period of uncertainty, and improved aspects of mental and physical health. These findings supported previous research which has found that creative programmes can promote wellbeing and social relationships through facilitating conversation, shared interests, and personal development (Dadswell et al., 2020; Malyn et al., 2020; Pearce & Lillyman, 2015), and through utilising the positive impact of hope (Quaglietti, 2020). Similarly, existing research has established that participation in arts can holistically support individuals with physical illnesses and mental health conditions, with associations to increased self-esteem, reduced anxiety and depression, and improved physical symptoms (Jensen & Bonde, 2018; Redmond et al., 2019).

There is currently less research which has examined the impact of online arts participation, particularly in the context of COVID-19. This research therefore contributed knowledge that the described benefits of creativity can also be experienced in remote, online, and socially distanced projects. However, the importance of dedicating time and means for social connections to develop online was also noted, such as ascribing social time during online workshops or using social media to share outputs. Similarly, previous ethnographic research reported positive impacts to personal and social wellbeing among women who shared craft outputs in a Facebook group (Mayne, 2016). Mixed-methods research into an online creative intervention also found increases in mental wellbeing scores and benefits to social connections of sharing creative outputs online (Tribe & 64 Million Artists, 2018). Recent research has also explored participant's experiences when a Singing for Lung Health group was transferred online during COVID-19 (Philip et al., 2020).

Consistent with the findings in this study, these participants identified benefits to lung health and noted that accessing online was beneficial for days participants did not feel well. However, these participants also reflected that the online format reduced interpersonal interactions compared to the former in-person sessions. Interviewed participants in the current research, however, enthusiastically described forging new and beneficial social relationships online. Further research among a broader participant group would therefore be beneficial to understand preferences and implications of online versus in-person formats, and whether these differences relate to how established groups are before moving online.

The understanding which could be gained from quantitative measures in this research was more limited, and this is further described in the limitations section below. Consequently, the findings from this research are predominantly from those participants who self-selected to be interviewed, who provided a contextualised, holistic, and useful insight into how the creative projects impacted them. The understanding gained around the impact of creativity on wellbeing have contributed to the recommendations for creative health delivery further below. It should also be noted, however, that understanding about the impact on the overall cohort of participants was less established.

Relating to the second research aim, artists often contextualised issues of mobilisation and delivery of the creative projects within the challenges of COVID-19. A vast majority of projects were ordinarily delivered in-person and adjusting recruitment and delivery methods to remote formats required adaptability, problem solving, and perseverance. There were also novel considerations for inclusivity and accessibility. Incorporation of multiple methods of engagement appeared beneficial to increase accessibility to prospective participants with a broad range of needs. Offline methods meant

participants could continue creating independently, as well as being accessible to participants without access to, or confidence with, technology. Online methods were beneficial in fostering group connections, along with providing participants comfort and flexibility in how they chose to engage with, and present in, online sessions. Benefiting recruitment, accessibility, and participant wellbeing, artists also indicated that collaborating with partner organisations was beneficial to reach further participants, provide an additional layer of support, and ensure activities are appropriate to participants' needs. Taken together, responding to these new challenges meant that many artists had extended their networks, and had developed new techniques, skills, or activities to strengthen future projects.

Artists also explained challenges associated with evaluating the projects. Disseminating evaluations and receiving feedback was found to be more difficult compared to in-person projects, and artists identified that a more co-ordinated evaluation, co-designed by project stakeholders, funders, and researchers, would increase the suitability of evaluations for all projects. Proposed benefits of co-designed research include more appropriate research materials, increased understanding about research processes, and stakeholders reporting positive emotional outcomes, which together can increase research recruitment and dissemination (Slattery et al., 2020). However, the potential requirements for increased resources and need to abide by methodological rigour means that the co-design process requires clear expectations and sufficient time ahead of projects commencing (Slattery et al., 2020). These considerations, together with the evaluation limitations previously discussed, have guided the recommendations for creative health evaluations further below.

Strengths and Limitations

This evaluation was devised to incorporate mixed-methods towards the research aims. However, the methodological and sample limitations meant that this evaluation could not form robust conclusions about the wider cohort of participants from quantitative data. The Happiness Pulse was limited to measure population-level wellbeing, and the survey tool is unable to link individual responses over time. The Happiness Pulse data was also unable to be interpreted alongside measures such as engagement with the projects, and therefore the findings from the Happiness Pulse may be confounded by a number of variables such as reduced COVID-19 restrictions and participation in external activities, rather than reflecting the impact of these creative projects. In addition, it is unknown how far different samples, response rates, and responder bias contributed bias to the Happiness Pulse at each period.

The post-project survey aimed to overcome some of the limitations of the Happiness Pulse by incorporating measures of wellbeing, subjective and behavioural engagement, demographics and creativity to allow examination of the associations between these variables. However, a small sample size of 34 participants prevented more robust inferential analyses. Findings are limited to descriptive results, and regression analyses may have been underpowered to identify any associations. Moreover, this survey also relied on participants self-reporting about how much time they spent engaging in projects during workshops or independently, and this retrospective measure may have been a less valid measure than more objective measures such as artist attendance registers. Additionally any indication of association could not be taken as an indicator of causality as the cross-sectional nature of the data cannot give an indication of direction of the association, i.e. if more engagement in activity was associated with higher well-being scores, does that mean more engagement leads to better well-being or better well-being leads to more engagement?

In addition, project artists were gatekeepers for recruitment, and artists disseminated information about the evaluation measures to prospective participants. This process raises the potential for recruitment bias or conflict of interest, for example sharing evaluation materials with participants who were more engaged with the project. The limitations of this approach relate to It should also be considered that this research collected findings soon after project-participation and cannot indicate how wellbeing may have been impacted over subsequent weeks or months. Participants in this study indicated the importance of project continuation to sustain the benefits to wellbeing, and future research may usefully examine the impact on wellbeing over a longer period.

Whilst the qualitative findings provided informative understanding about how the projects impacted these participants' wellbeing, findings from these interviews were not intended to be extrapolated across project participants. Interviewed participants did not represent all creative projects and subprojects, nor all participant groups; for example, the impact of these projects on young people and residents living in care homes was not evidenced in this evaluation. Moreover, responder bias may have meant that participants who appraised the projects more positively were more likely to have participated in the research, and this evaluation was not able to establish reasons for non-participation either in the creative projects or in the evaluation. These limitations do not detract from the impact and experiences reported by interviewed participants, however these findings should be considered in line with the contexts in which the data were collected.

The strengths of this evaluation relate to the understanding gained about delivering creative health projects in the novel contexts of COVID-19. Most projects were not ordinarily delivered remotely or online, and the findings of this research indicated positive

potential in that the creative projects benefitted interviewed participants in this research. Findings relating to mobilisation, delivery and evaluation provided further insight and recommendations for the delivery of creative health projects, particularly as many artists were adjusting to novel contexts during this commission. These findings may also provide a foundation for the development of future creative health projects and research in this area.

Recommendations for Creative Health Delivery

The findings of this evaluation have contributed to recommendations for creative health delivery, including for remote delivery formats, which are summarised below:

- Social connections were found to be successfully formed and/or sustained in remote creative projects. However, it appeared beneficial for artists to purposefully provide time and space to develop these social connections, as social chat can otherwise be more limited than face to face sessions. Moreover, projects may consider how to support participants to sustain social connections after projects end to maintain the benefits to social wellbeing.
- Participants identified the importance of continuation of creative engagement to maintain benefits to physical health, mental wellbeing, and social connections. Many participants aimed to seek further accessible opportunities and may benefit from signposting or other support to continue with beneficial creative activities.
- Collaborations between creative projects and community or charity organisations may increase recruitment, accessibility, and support available to participants. Professional experience and knowledge about participants' needs (e.g. substance misuse or learning disabilities) may also support artists to

appropriately devise activities and support safeguarding and participant wellbeing.

- The incorporation of multiple methods of engagement can increase accessibility to participants with different resources and needs. These findings apply beyond the context of COVID-19, as advantages of online methods were also identified (e.g. by reducing physical barriers to attendance and allowing participants to turn off videos to reduce anxiety about joining).

Recommendations for Evaluating Creative Health Projects

Findings from artist interviews, limitations of this evaluation, and existing research have guided the below recommendations for evaluating creative health projects.

- Robust evaluation methods appropriate across project's varying timelines, engagement methods, and participant groups are important to increase promotion, recruitment, and the validity of collected data. These methods should include validated before and after measures of wellbeing, where participant's individual responses are linked over time. Measures of behavioural engagement appropriate for project structures (e.g. how many workshops participants attended and over what time period) should also be incorporated, and this would support more robust conclusions about the impact of the creative projects. For example, projects with scheduled sessions/workshops may collect attendance registers which can be shared for data analysis purposes. The collection of demographic variables is also required for understanding the participant sample, statistical modelling, and to explore how groups may be differently impacted by the creative projects. Identification of an appropriate control group would also be beneficial to more confidently form

conclusions about the projects, aside from potential confounding factors. Consideration of the participant group to identify whether online or offline evaluation measures may be more appropriate could also improve recruitment.

- Recruitment methods should also be designed to promote methodological rigour and effective dissemination (e.g. where evaluations are disseminated more independently from those delivering the projects). For example, for some projects it may be feasible and appropriate for researchers to recruit participants directly, rather than reliance on project artists as gatekeepers which could increase recruitment bias. Such recruitment processes should be considered alongside protection and data sharing agreements required to facilitate this.
- A co-created evaluation, including stakeholders from creative projects, researchers, and funders, may support evaluations to be more effectively devised, and this process may also support dissemination and recruitment to the evaluations.
- A co-ordinated evaluation structure should be communicated at any early stage and embedded into the creative project process. This clarity may increase effective dissemination of measures and offer a more streamlined evaluation from the participant's perspective. However, creative projects can also be fluid, and an evaluation design which allows for flexibility (e.g. if the focus of a project or participant group changes) may be beneficial.
- Mixed-methods evaluations may be beneficial to incorporate valid quantitative measures of wellbeing across a larger sample of participants, whilst qualitative measures are suitable to understand the contexts and nuances of experiences at a more individual level.

Conclusion

COVID-19 required creative health projects to adapt to novel methods of mobilisation and delivery. Whilst these changes brought substantial challenges, participants interviewed in this research identified that creative projects positively impacted health, psychological, and social wellbeing during an uncertain period. Research findings and the process of this evaluation identified further important considerations for evaluating creative health projects, particularly with regards to collecting quantitative evaluation measures from a larger sample. These findings have guided recommendations to support the development and evaluation of creative health projects in the context of COVID-19 and beyond.

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Appendices

Appendix A

Number of participants reported by artists to the commissioner.

Project	Number of participants	Details about participant group
Armonico Consort	6 with direct involvement 646 online interactions	Older residents in care homes, older residents in Extra Care housing settings, adults shielding, residents accessing online videos.
Arts Uplift		
Dance project	9 with direct involvement	Adults older than 65 years
Music project	9 with direct involvement	11 – 14 year olds
Creative writing	9 with direct involvement	Partnership with CGL
Hand sewing	11 with direct involvement	Partnership with Asian women's group
Escape arts	10,000 booklets distributed	Adults shielding, adults and young people in temporary accommodation, adults previously homeless, patients and staff in hospitals, residents in Warwickshire.
Live & Local	250 with direct involvement 4,000 online interactions	Residents and communities across Warwickshire.
My Voice Lifts My Soul	15 with direct involvement	Adults 25 – 80 years old. Included adults living with respiratory conditions, referred through local NHS trust and physiotherapists.
Open Theatre	13 with direct involvement	Young people aged 17 to 19 years.
Starfish Collaborative	40 with direct involvement 544 online interactions	Adults referred via perinatal mental health service, young carers, and Warwickshire residents.

Sundragon Pottery	123 packs distributed	Distributed to children and young people, young adults and adults in supported accommodation, children and young people with learning disabilities, young carer, and individuals shielding.

Appendix B

Multiple regressions exploring engagement measures as predictors of health and wellbeing outcomes

Outcome	Predictor	*β*	*SE*	95% CI	R^2
Mental wellbeing					.04
	Group workshops	.15	.37	-0.62, 0.91	
	Independent hours	.99	1.23	-1.50, 3.50	
	Time period	-3.03	3.3	-9.94, 3.88	
					.04
Loneliness	Group workshops	-0.05	.05	-0.15, 0.05	
	Independent hours	-0.01	.16	-0.34, 0.32	
	Time period	-0.07	.45	-0.98, 0.84	
Self-reported health					.03
	Group workshops	-0.87	0.91	-2.74, 1.00	.
	Independent hours	-0.59	3.02	-6.76, 5.57	
	Time period	-0.47	8.31	-17.44, 16.5	

Note. CI = Confidence Interval. Independent hours was entered as the original 5-point Likert scale. Time period was entered as a binary variable of less than 8 weeks (*n* = 14) and longer than 8 weeks (*n* = 20)

Appendix C

Broader Codes Identified for Each Theme

Theme	Code
Impact of Creativity on Health and Wellbeing	
Creating Connections	
	Social connections and peer support were boosted through creative activities.
	Social connections were successfully achieved online or remotely.
	Social connections have been sustained after the end of the project.
	Social connections increased confidence accessing creativity or technology.
	Existing support networks were negatively impacted by the lockdown.
	A limit of connecting online is reduced social chat and physical contact.
	Connections between artists and communities or artists and individuals were valued.
	Lack of technology access may limit social connection.
	Artist's initial concerns about building relationships online did not materialise.
	Importance of artists facilitating time and means for social connections.
Providing Hope and Positivity	
	Creativity as a positive activity (during lockdown).
	Project provided hope and reassurance during COVID-19 and an uncertain period.
	Project inspired creativity lost to daily life/adulthood.
	Enjoyed learning something new and positive.
	Creativity as escapism or distraction.
	Participation inspired further creativity.
	Other projects/hobbies had stopped due to COVID-19.
	Project facilitated continuation of creativity despite lockdown.
	Projects supported artist's wellbeing during a challenging period.

Health Benefits

Creativity was a positive activity for physical health (breathing).

Importance of project continuity for maintained physical and mental health benefits.

Lockdown/shielding hindered mental and physical health (sedentariness).

Creativity boosted mood and self-esteem.

Creativity facilitated emotional expression.

Project provided motivation and guidance for activities with health benefits.

Experiences of Mobilising, Delivering, and Evaluating Creative Health Projects

Responding to COVID-19 Challenges

Barriers to recruitment: competing life demands and social distancing requirements.

High workloads and time commitments exceeded expectations and budgetary plans.

Adjusting to new ways of working online: gaining skills, confidence, technical issues.

Remote/online methods as making the best of Covid-19.

Adapting guidelines/risk assessments for new projects and online working.

Time scales were short and hindered recruitment and evaluation.

Challenges recruiting participants and/or accessing gatekeepers.

Projects had to modify in relation to challenges (often with recruitment).

Collaborative Partnerships

Benefits to recruitment working with community volunteers/organisations.

Increasing inclusivity and accessibility by working with organisations.

Benefits of working with partners for safeguarding and participant (and artist) support.

Preference for transparent conversations about inclusivity, accessibility, and policies.

Clear and flexible funding brief.

Artists had varied roles and responsibilities (and level of communication with funder).

Differences between traditional health and art fields.

Supportive, communicative and collaborative relationship with funder.

Achieving Accessibility

Access means different things for different people.

Lack of technology/confidence as a barrier to online methods.

Online increased reach of creative outputs.

Benefits of multiple methods of engagement (on and offline).

Benefit of not explicitly naming e.g. mental health can increase inclusivity.

Guidelines for accessing zoom/tech may have supported participants to access.

Understanding participants individual needs to devise activities.

Budget may not have allowed for full accessibility (e.g. funding for closed-captioning films).

Online projects can increase accessibility by removing geographical, physical access barriers, and competing demands.

Online/remote could limit how provision of physical support.

Online/remote could facilitate increased confidence with creating (increased privacy).

Face to face was necessary to engage with some participants.

Lessons and Project Legacy

Desire for project or creative continuity to maintain wellbeing benefits.

Project instigated new ways of working or professional networks.

Development of new skills, project formats, or transferable materials.

Impressive creative outputs provide a legacy (for future generations).

Increased ideas and confidence with online delivery.

Motivation and confidence to continue creative projects.

Preference to return to socially distanced face to face methods.

Measuring Impact

Artists received positive feedback from participants.

Challenges with timelines (too short or inappropriate for creative project structure).

Remote evaluation harder than in-person evaluations.

Structure of evaluation not stated from the beginning of projects.

Multiple surveys reduced promotion or engagement in evaluation.

Quantitative data was limited in capturing the journey/community collaboration.

Cocreated evaluation methods would have increased suitability for project structures and participant groups.

Artist familiar with using evaluations (to adapt/tailor sessions).

Ethical considerations for staged consent for sharing outputs.

Hard to establish why people didn't sign up to projects.

Item 3 Coventry & Warwickshire Health & Care Partnership

Community Mental Health Transformation

2021/22 – 2023/24

Better Health, Better Care, Better Value
COVENTRY AND WARWICKSHIRE

Community Mental Health Transformation

- Substantial funding is being made available to transform and modernise Community Mental Health Services
- Aim – to deliver **NHS Long Term Plan** (LTP) ambitions for **new models of integrated primary and community care** for adults and older adults with severe and enduring mental illness, as close to home as possible
- LTP describes a "**new community-based offer** [that] will include access to **psychological therapies**, improved **physical health** care, **employment support**, **personalised** and **trauma informed care**, **medicines management** and support for **self-harm** and **coexisting substance use** … and proactive work to **address racial disparities**."
- Local new model being co-produced and developed to underpin bid for transformational funding – multi-sector team with leads from mental health, social care, VCSE and Lived Experience

Since November 2020 … We Have Been Listening

- **Service users / Experts by Experience, carers and local communities**
- **Elected Members** across Coventry and Warwickshire
- **Primary Care Network** Clinical Directors (proposals shared and supported by PCN Clinical Directors across Coventry and South Warwickshire; PCN Clinical Directors meeting being arranged for Warwickshire North)
- **Directors of Adult Social Services** – using this as opportunity to strengthen existing S75 Agreement
- **Directors of Public Health & Housing**
- **Local VCSE organisations** about how to build community infrastructure
- **National VCSE organisations** about how to galvanise and implement change driven by Experts by Experience
- **Early Implementer sites** about what to do and what not to do
- **Exemplars of good practice** – e.g BSol around co-production

Building On Transformation Across our Local Pathways

Enhancing Psychiatry Liaison/ CORE24	Safe Havens, Suicide Prevention & RTS	Expansion of Street Triage	MHIS Uplifts
MH Access Hubs	Locality Pathway Allocation	New MH Liaison Roles in Primary Care	S75 Agreement & Review
Community Based Alternatives to Crisis	HEE Peer Support Worker Initiative	Changing Futures EOI	Kings Fund VCSE Bid
MH Needs Assessment	Alliance Work with the VCSE	Health Inequalities	Housing

Leading us to our design principles …

Opportunity to be ***brave*** and ***bold***

No doors / easy access for people with SMI

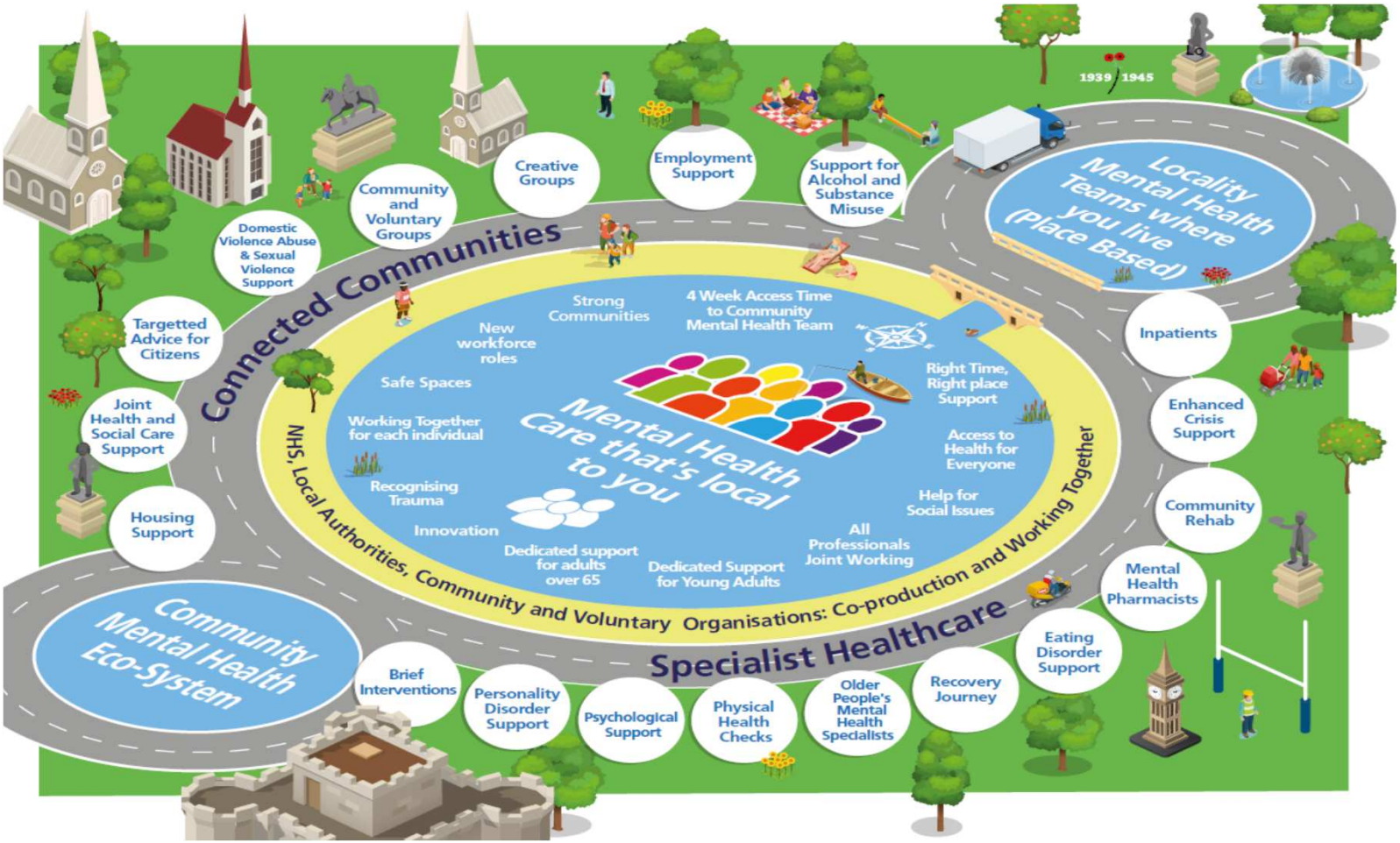
Trauma informed throughout

Based on **care** and **compassion**

Building on / up ***community infrastructure***

Biopsychosocial model – addressing **mental health**/**physical health**/**socio-environment** issues

… and our vision for the future …



Connected care for connected communities

Integrated / proactive care across health, social care and VCSE

Co-designed by Experts by Experience

Aligned to place / local communities

VCSE innovation fund to develop new roles/ideas

Specialist mental health pathways

Peer Recovery Workers embedded in model

Increased access to psychological interventions

Additional Funding

- Additional investment into local community mental health – both as part of **Mental Health Investment Standard** into baseline funding and additional **transformation funding**

Year	CCG Baseline Funding	Transformation Funding
2021/22	£2.0m	£1.8m
2022/23	£4.0m	£4.5m
2023/24	£6.0m	£5.6m
2024/25	£6.0m	£0

- Excludes NHSE/I funding for Primary Care Additional Roles
- Proportion of funding to be used to support small, micro, grassroots, local community and user-led MH organisations, and to address inequalities
- Further funding of £800,000+ for 21/22 has been agreed

Key Focus of the Proposals

- ***SMI***

- ***Core Offer***

  - Aligned to PCNs
  - Liaison workers/ARRS
  - Improved access and waiting times
  - Improving quality (improved access to psychological therapies)
  - Physical health in SMI
  - IPS

- ***Focussed Pathways***

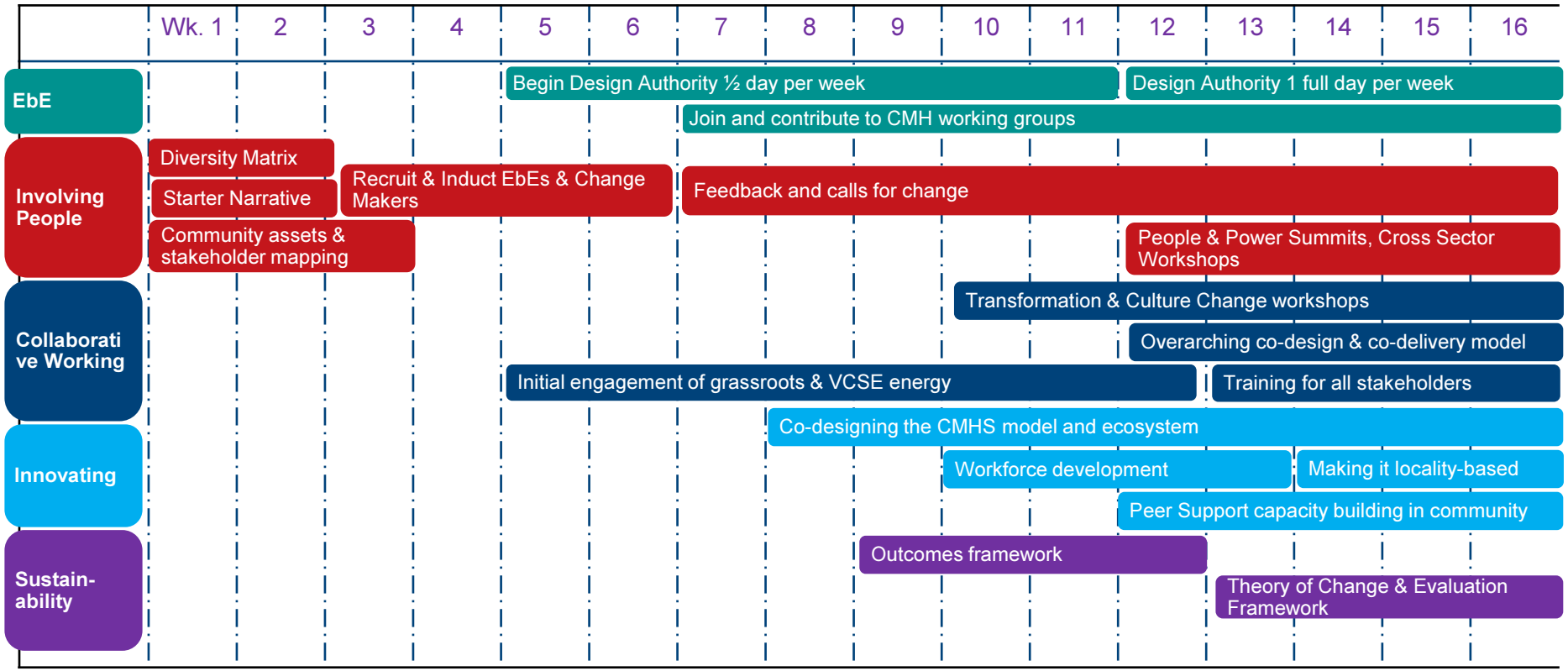
  - Personality Disorder
  - Community Rehab
  - Eating Disorders

CWPT

Community Mental Health Transformation: Co-Production Strategy

Better Health, Better Care, Better Value
COVENTRY AND WARWICKSHIRE

Project Plan – 1st four months

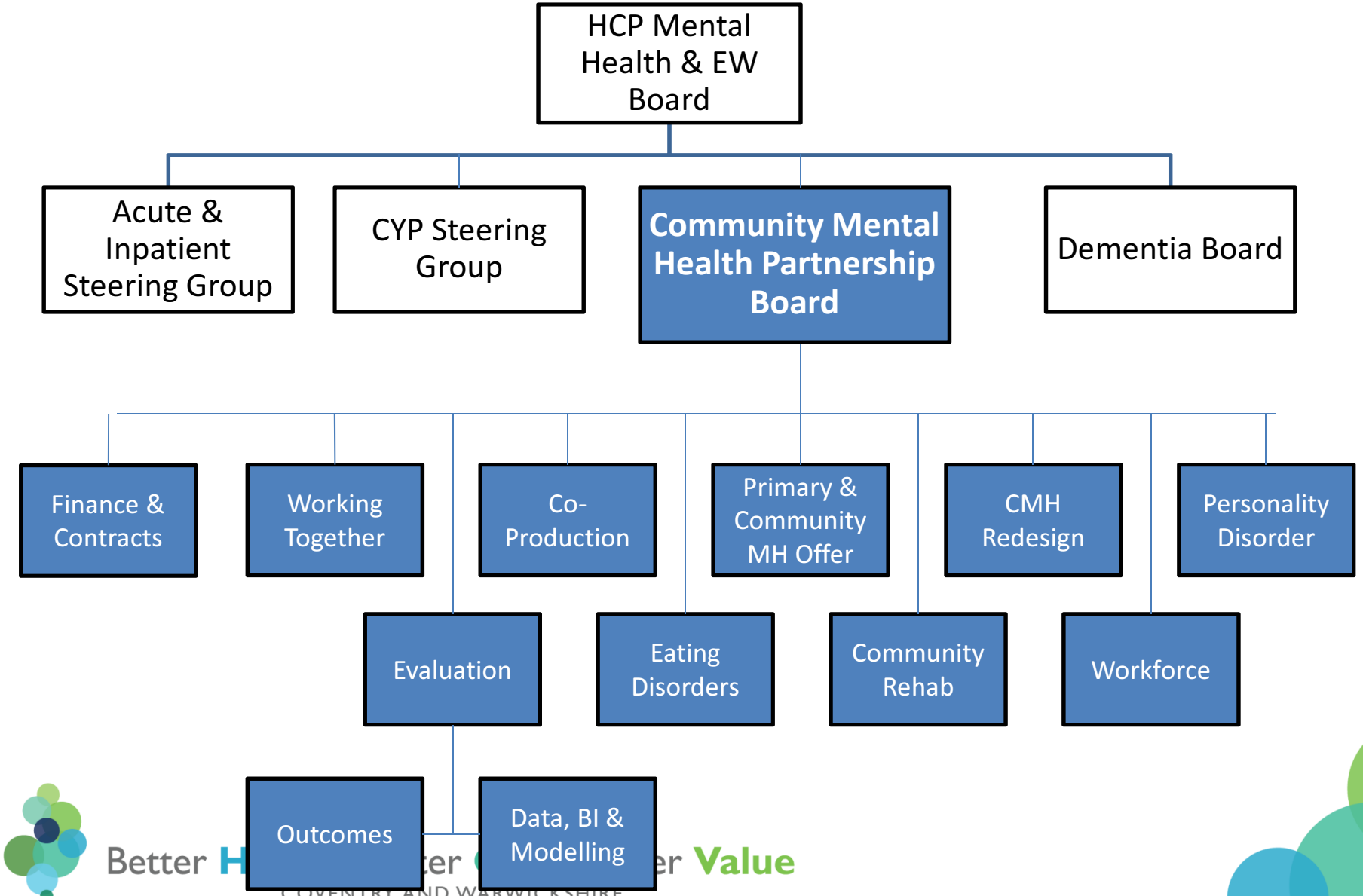


What Else is Happening?

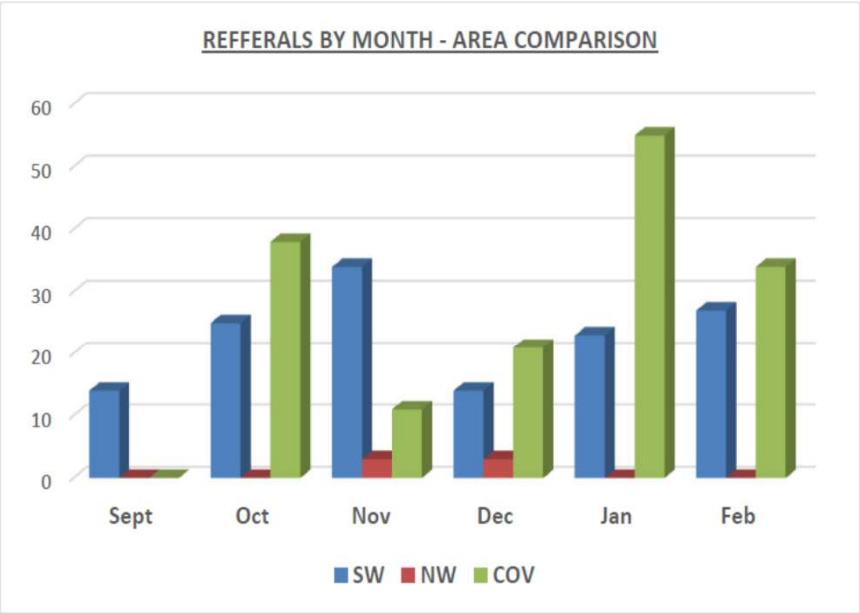
- ***New locality access arrangements***
- ***Co-production infrastructure in place***
- ***Warwick Business School as a learning partner***
- ***Evaluation of liaison workers and role out of ARRS***
- ***Recruitment***
  - Peer Recovery workers
  - Liaison workers/ARRS
  - EbE role in PD pathway

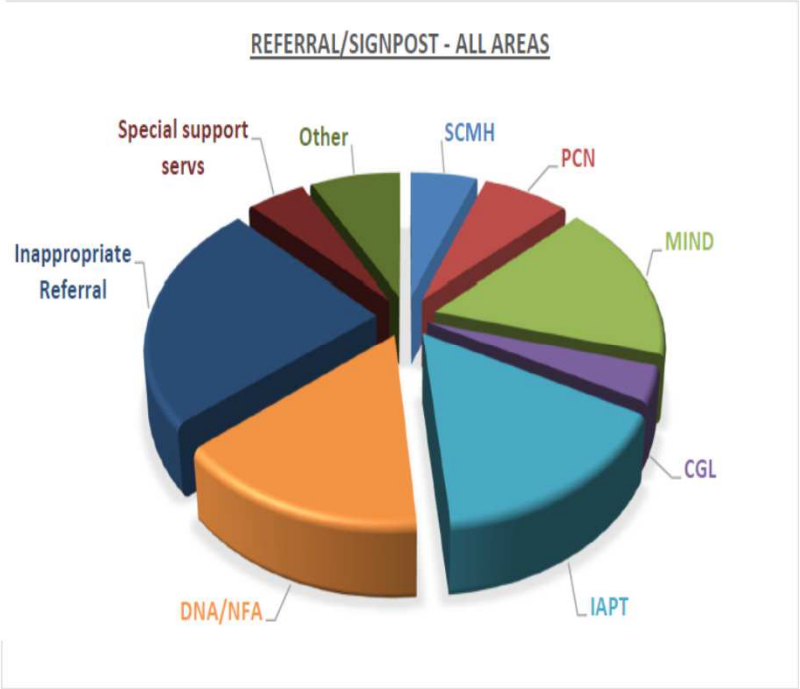
- ***Next steps***

Community Mental Health Transformation Governance Structure



Evaluation of Liaison Worker





- In Sowe Valley Liaison worker did 80% direct patient intervention (the role described for ARRS) and 20% liaison about patients already open to CWPT.
- In 19/20 in Sowe Valley referrals have fallen by 4.4% compared to a fall of 20.1% for the other Coventry PCNs
- In Leamington the referrals have fallen by 42.5% in Leamington South and 6.9% in Leamington North compared to an increase in referrals of 4.5% for the other South Warwickshire PCNs

Mental Health Practitioner Role

- Indicative Agenda for Change Band 5 / 6 / 7 / 8a (depending on the individual registered clinician providing the service)
- Employed and provided under a **local service agreement** by the PCN's local provider of community mental health services
- Any registered clinical role operating at Agenda for Change Band 5 or above including, but not limited to:
  - Community Psychiatric Nurse
  - Clinical Psychologist
  - Mental Health Occupational Therapist
  - other clinical registered role (as agreed between the PCN and community mental health service provider)
- **In addition** to the adult and older adults' role, PCNs may also choose to embed a children and young people practitioner with the agreement of the mental health provider (funded on the same joint basis)
- Entitlement to increase to 2 WTE in 2022/23 and 3 WTE by 2023/24 (double if over 100,000 – 63 wte across Coventry and Warwickshire by 23/24)
- 50:50 joint funding between PCN (ARRS) and provider
- Workshop on 27th May 3pm to 5pm on Primary Care Mental Health and ARRS

… and look forward to the future …

Statement from Claire Handy, Lived by Experience Representative – CMH Transformation Board Member

I am truly excited to be helping with this transformation project; it has covered all the problems I encountered when I was within mental health services myself. Instead of being compartmentalised by a diagnosis and cared for using models that very few people fitted, with life outside of mental health being dealt with as other problems entirely, this holistic approach and the focus on the patient as being their own expert is an amazing change.

Bringing carers and the wider community into the patient's care allows for a broader view of what is happening for that person and may offer a glimpse into other support that under the current system might be missed. I look forward to helping to bring about a new service that will allow the service user to feel valued for who they are, rather than being viewed in the lens of 'what' they are, and be supported in all areas they are struggling with; a service that will respond to the service user in the right place at the right time with the right intervention, and will support them with care and empathy as we walk alongside them in their own journey back to well health. It will make a difference to so many people's lives – and ripple out to many more.

As I said. Truly exciting!

Warwickshire Covid-19 Mental Wellbeing & Resilience Fund

Paula Mawson - Strategy and Commissioning Manager (Health, Wellbeing & Self-Care)

Emily van de Venter – Associate Director of Public Health

Warwickshire County Council

Improving Mental Wellbeing in Warwickshire

- The Council's Covid-19 Recovery and Restoration plan includes an explicit priority to support the mental health of Warwickshire's residents.
- The Warwickshire Covid-19 Mental Wellbeing & Resilience Fund will provide grant funding to organisations to support Warwickshire resident's mental health and wellbeing both during and through the aftermath of the Covid-19 pandemic and respond to the predicted mental health and LSI surge.
  - Eligible applicants: voluntary & community sector organisations, parish and town councils and small to medium businesses
- The Resilience Fund forms a key part of the £1.34m of WCC Covid-19 monies allocated to mental health and wellbeing

Warwickshire County Council

WARWICKSHIRE SKILLS HUB

Funding available

- The overall total value of the fund is **£750,000** of which £250,000 is provisionally allocated for capital spending.
- The fund was open to applications for projects which require investment under three thresholds.
  - Threshold 1: Minimum of £6,000 to a maximum of £10,000
  - Threshold 2: Over £10,000 to a maximum of £25,000
  - Threshold 3: Over £25,000 to a maximum of £50,000
- This is one off funding which must be spent within 12 months of the funding award date.

Warwickshire County Council

WARWICKSHIRE SKILLS HUB

Intended outcomes and benefits

The **Warwickshire Covid-19 Mental Wellbeing & Resilience Fund** is designed to support community and business projects and initiatives at a local level that aim to achieve the following:

- **Improve the mental health, wellbeing, and resilience of residents** and local workforces by responding to the pressures of the pandemic.
- Provide **support to residents with mental health concerns**, whether this is a pre-existing mental health diagnosis, that has been exacerbated due to the pandemic, mental health illness from a Covid-19 diagnosis, or providing support for those with new and emerging needs as a result of the pandemic.
- Provide a range of **support encouraging residents to return/begin to engage with activities** which support the development of resilience and wellbeing and establishing a sense of **social connection**
- Create **safe spaces in the community** where people experiencing mental distress whilst out in the community can go to for a period to unwind, de-escalate and feel safe before they continue with their activities.
- Create physical environments where people can **reconnect with nature** and enhance their sense of wellbeing.
- Support specific **trauma, suicide, self-harm prevention and bereavement interventions**.
- Work in **partnership with people with lived experience** in the design and delivery of the support.

Warwickshire County Council

WARWICKSHIRE SKILLS HUB

Warwickshire Covid-19 Mental Wellbeing & Resilience Fund

- Two virtual meet the funder events took place in May to promote the fund
  - One aimed at the community and voluntary sector, supported by WCAVA and one aimed at small to medium businesses, supported by WCC Skills Hub which saw attendance of 85 and 21 respectively
- The funding was launched Friday 21 May and closed Monday 21 June at noon.
- **134** expression of interest were made and **67** applications submitted
- A scoring panel of 8 county council and external partners will evaluate the applications
- Evaluation of applications will commence w/c 28 June until 22 July

Warwickshire County Council

WARWICKSHIRE SKILLS HUB

WELLBEING FOR LIFE 2021/22

Our Vision: Making self help the first and instinctive choice for Coventry & Warwickshire residents to improve their physical and mental wellbeing and to stay well

Our Aims: Supporting the region to work towards a healthier lifestyle and to be a healthy place to live, work and visit. To significantly raise the profile of the opportunities available to residents and reduce health inequalities by providing better access to information, self help & support around the key areas of obesity/mental health

Our programmes	Local Ownership	Key Outcomes
Promote Thrive at Work	**Sign up to Thrive at Work and achieve accreditation**	**Increase in number of contacts to commissioned services (weight management, mental health) – or decrease in some areas.**
Advocating a change to health inequalities through employers, the Call To Action and Hepp programme	**Make a commitment to the Call to Action**	**Increase in 'at risk' groups accessing health checks/lifestyle services**
Maintaining the Wellbeing4Life website, a place to celebrate and share personal stories, provide signposting information, resources and community events	**Support national/local wellbeing events using Wellbeing for Life branding and resources**	**Number of employers making a commitment to the Call to Action and sharing changes made/benefits found**
Supporting the Healthy Weight programme within primary schools	**Get involved in Wellbeing for Life festivals/roadshows**	**Employers signed up and achieving Thrive at Work accreditation**
Improving mental wellbeing particularly through promoting and embedding the 5 ways to wellbeing	**Primary schools engage with the Sugarsmart initiative to support the Healthy Weight in Schools programme**	**Number of Primary schools signed to and engaging with Sugarsmart**
Create and support a 'Wellbeing at Work' forum	**Workplaces join and participate in the 'Wellbeing at Work' Forum**	

www.wellbeing4life.co.uk

Wellbeing for Life so far

- Launched with Active April calendar and photo competition
- W4L steering group
- Involved in Health Equity Partnership Project (HEPP)
- Events – Changing Workplaces (Call To Action on tackling health inequalities in the workplace)
  - Planned events Godiva, Sportsfest, Market day across Warks, Thrive in Schools
- Digital Inclusion project
- Workplace Wellbeing Forum
- Website and social media
- Piloting micro-business support for workplace wellbeing accreditation
- 'Start well, Live Well, Age Well' (Name to be confirmed) W4L map of services/5 ways to wellbeing promotion

COVENTRY & WARWICKSHIRE WELLBEING FOR LIFE

@Wellbeing4_life **www.wellbeing4life.co.uk**

Warwickshire Creative Health programmes

'*Creative Health: The Arts for Health and Wellbeing'* report, published by the All-Party Parliamentary Group in July 2017 concluded the arts can:
help keep us well, aid our recovery and support longer lives better lived
help meet major challenges facing health and social care: ageing, long-term conditions, loneliness and mental health.

Warwickshire County Council are commissioning a suite of six creative health programmes, using the arts to promote social connectivity and improve wellbeing across the lifecourse.
Funding from Warwickshire County Council Early Intervention and Prevention and Community Capacity fund £300,000 a year for 2.5 years.

An evaluation framework has been created in collaboration with Coventry University. All six programmes will be evaluated over the 2.5 years.




Warwickshire County Council

Warwickshire Creative Health programmes

Arts on Referral for Adults (Arty-Folks): to support wellbeing for adults in Warwickshire with mild to moderate mental health issues using a variety of art courses. The art programmes aim to bring people together to share life experience and through the creative process strengthen identity and control over their lives and futures.

Arts and Nature (Escape Arts): a range of 6-week programmes for adults with mild to moderate mental health challenges and those wanting to support their wellbeing, to improve engagement with the natural environment and wellbeing of residents.

Singing for Lung Health (Breathe Arts Health Research): 10-week programmes for adults with chronic respiratory conditions. This will consist of courses of group-based sessions led by an experienced singing specialist.

Warwickshire Creative Health programmes

Arts on Referral for Children and Young People (Barnardo's and Arts Connect):
a range of 6-week creative arts programmes for children and young people with mild to moderate mental health challenges and those wanting to support their wellbeing.

Arts on Referral for Parents and Infants (Contract starts 1st Aug 2021): A range of 6 week programmes will be developed for new parents who may be experiencing mental health challenges. The aim is to reduce the risk of poor mental health outcomes for parents and improve long-term outcomes for children by improving the development of secure attachment relationships within the 'Critical 1001 Days'.

Dementia Arts Programme (Contract starts 1st Aug 2021):
A range of 6-week creative arts programmes within the community, selected care homes and inpatient wards. Activities are for those living in with Dementia and their carers.

Believe in children Barnardo's

arts connect

Warwickshire County Council

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Agenda Item 4

Health and Wellbeing Board

Joint Strategic Needs Assessment Update

7 July 2021

Recommendation(s)

That the Health and Wellbeing Board:

1. Notes and comments upon the progress of the Joint Strategic Needs Assessment (JSNA) programme to date;

2. Supports the promotion and dissemination of findings and recommendations of the mental health needs assessment, implementing them where appropriate;

3. Notes the outlined thematic JSNA workplan for 2021/22 – 2022/23;

4. Supports the development of future needs assessments through promoting the work of the JSNA and supporting requests for resource to support the analysis and development of assessments.

1. Executive Summary

1.1 This paper provides an update on the delivery of the JSNA programme since January 2021.

Mental Health Needs Assessment

1.2 The JSNA Strategic Group has previously agreed to proceed with thematic based needs assessments following the completion of the place based JSNAs. One area that was agreed to trial the thematic needs assessments was mental health, given that the draft Joint Health and Wellbeing Strategy had this as a priority, and due to commissioning plans in both CCG and Local Authority.

1.3 It was agreed in October 2020 that the needs assessment would be a joint piece of work between Coventry and Warwickshire.

1.4 A Task and Finish group has been developing the mental health needs assessment since September 2020. This is made up of local authority, CCG, CWPT, police and third sector representatives.

1.5 A survey and focus groups were conducted in March and April 2021 to obtain qualitative information from both residents and professionals working in the area of mental health. The findings have been incorporated into the final needs assessment and will be included as appendices.

1.6 The survey included: a general screening (using SWEMWBS); questions about the impact of Covid-19; questions about services (access and awareness); and wider determinants that impact people's mental health and wellbeing.

1.7 A total of 975 individuals responded to the survey (581 respondents to the Ask Warwickshire full version of the survey; 394 respondents to the SurveyMonkey Easy Read version). The Ask Warwickshire responses were analysed for the purposes of the needs assessment, with Easy Read findings incorporated where appropriate.

1.8 Key findings from the survey are outlined below.

1.8.1 A third of all respondents (33.4%/n=192) indicated they felt confident talking about their mental health 'some of the time'. However, around 1 in 4 respondents felt like this only 'rarely' or 'none of the time'.

1.8.2 Around 3 in 4 of respondents who are currently employed (75.1%/n=343) felt that their workplace actively promoted the mental health and wellbeing of employees.

1.8.3 The most well-known types of service answered by all respondents (except those answering as professionals) were in the category "NHS Services". These included GPs (97.5%/n=425) and Accident and Emergency (97.0%/n=423). Services that were less well known tended to be those in the voluntary, community and charity sector.

1.8.4 Professionals working in health and other organisations highlighted service inequalities among protected characteristic groups, those at financial disadvantage, including digital disadvantage, and those with other conditions/circumstances in addition to a mental health need.

1.8.5 The COVID-19 pandemic was extensively mentioned for its wide-reaching impacts including disruption to services, an increase in waiting times, and access issues including the ability of people to cope with the shift to digital services and it was noted that some groups were especially disadvantaged by this. The isolation that lockdown brought was a particular issue for mental health (especially some groups) as was the anxiety around the pandemic generally. There was an expectation that demand for services would increase.

1.8.6 Difficulties meeting service thresholds/criteria were often highlighted and there was a repeated feeling people had to reach crisis point before a service was offered. Additionally, there appeared to be problems when people presented with additional conditions (e.g. autism, dementia, or alcohol related problems) and didn't 'fit' service criteria.

1.8.7 Wider issues affecting mental health such as social isolation, lack of community support, discrimination, housing, and disadvantage were also mentioned as a significant part of promoting mental health and wellbeing.

1.9 Focus groups were conducted with the following groups: WCC Commissioners and Public Health; Coventry and Warwickshire Partnership Trust Staff; voluntary and community sector organisations; unemployed individuals; carers of people with mental health difficulties; WCC Communities and Localities team.

1.10 A total of 98 individuals took part in one of 10 focus groups.

1.11 Key findings from the focus groups are outlined below:

1.11.1 COVID-19 has increased the complexity and acuity of presentations, particularly for individuals with severe and enduring mental illness.

1.11.2 Partnership working between the NHS and Voluntary and Community Sector is seen as beneficial.

1.11.3 Remote working has had some benefits but also some drawbacks including: reduction in quality, increased DNAs / cancellations and a negative impact on therapists' wellbeing.

1.11.4 Remote working has highlighted digital exclusion of those without IT skills or equipment.

1.11.5 Co-production and peer support were highlighted as important to service development and service users' recovery.

1.11.6 Easily accessible information about services was a key theme for both professionals and individuals wanting to find out about available support.

1.12 Headline findings from the needs assessment will be presented to the board on 7th July.

1.13 A dissemination plan has been created to share the findings and recommendations of the needs assessment with relevant internal and external stakeholders.

1.14 As this needs assessment was the pilot of the thematic programme, an evaluation exercise will take place to understand which elements of the process worked well and which did not and would therefore require a different approach for future needs assessments.

Thematic Work Programme

1.15 Following a prioritisation process that took place in December 2020 and January 202,1 a two year thematic work programme was developed which is outlined below.

Theme	Provisional Timescales	Comments
Mental health	October 2020 – June 2021	Pilot is currently underway and due to be completed in July 2021.
Pharmaceutical Needs Assessment	September 2021 – October 2022	Following a decision from NHS England this needs assessment (which is a statutory requirement) was pushed back by 1 year with a refreshed deadline of April 2022.
Health visiting 0-5	June 2021 – September 2021	This needs assessment will inform the recommissioning of the Health Visiting contract. Final approval of an extension option was approved on 20th January. This will result in a contract start date of 1/1/2023.
End of Life care	April 2022 – October 2022	A needs assessment will help identify where to best allocate support within the hospice sector and also look at wider system support.
Children and young people's mental health and wellbeing	July 2022 – June 2023	This needs assessment will inform the recommissioning of the CAMHS/Rise service. The current contract will end July 2022 and an extension option taken up to July 2024. The needs assessment will be required by July 2023 to inform specification development for the new contract that will commence in July 2024.
Substance Misuse	October 2022 – April 2023	This needs assessment will inform the recommissioning of the drugs and alcohol contract. The new contract will go live in April 2024.

Table 1. Proposed JSNA Work Programme (2021/22 – 2022/23)

1.16 It should be noted that these timescales are proposed and may be adjusted slightly as work is progressed over the two-year period. This may include changes required if additional requests are made for needs assessments during this time. The Health and Wellbeing Board will be informed of any changes to the work programme.

1.17 Children and young people's mental health and wellbeing was also proposed as an item to be included in the workplan between July and December 2021 to inform an extension to the current contract. However, it was felt that it would be more beneficial to conduct a broader piece of work prior to the new contract due to start in July 2024. Scoping work will be undertaken to identify whether this will be a joint needs assessment with Coventry, reflecting the adult mental health needs assessment. Therefore, this theme has been scheduled to take place between July 2022 and July 2023.

1.18 Through the prioritisation exercise a number of themes were identified for 2023/24. These themes will be kept on a "horizon scanning" list and scoped over the next two years to identify whether they will be included in a future JSNA work programme. The themes identified are as follows:

- Domestic violence and abuse
- Social inequalities and deprivation
- Care homes

1.19 In addition to the items above, it is proposed that a desktop exercise (rather than a full needs assessment) is undertaken to cover the theme of bereavement services. This exercise will aim to understand what services are currently available across Warwickshire and an estimate of current need. This will be undertaken with Strategy and Commissioning colleagues.

1.20 Scoping work has started for the Health Visiting 0-5 needs assessment. A range of indicators have been identified and South Warwickshire Foundation Trust have been engaged to clarify what data they can provide as part of the needs assessment.

1.21 An update of progress on the Health Visiting 0-5 needs assessment will be provided at the next Health and Wellbeing Board.

Grapevine Project

1.22 WCC commissioned Grapevine to mobilise and engage communities in action planning. A Community Organiser started in February 2020 to work in Lighthorne Heath, Shipston, Wolston and Camp Hill initially for 12 months.

1.23 Due to the COVID-19 pandemic the project was put on hold and the officer placed on furlough. The officer commenced work again in September and began working with communities whilst observing social distancing. However, following further restrictions in the winter months it was agreed that the project would be placed on hold and Grapevine would recommence work once restrictions were eased.

1.24 At the time of writing this report, a meeting is being set up with Grapevine to develop a plan for restarting this project. Further updates will be provided at the next Health and Wellbeing Board.

Director of Public Health Annual Report 2021

1.25 The Director of Public Health Annual Report 2020/21 focused on Warwickshire residents and their experiences of living through the COVID-19 pandemic, helping to understand how it has impacted on their health along with other challenges they have faced and where they have found support.

1.26 The report includes a section providing an update on the JSNA programme. This includes the place based needs assessments, the COVID-19 Health Impact Assessment, and information about the future approach of the JSNA programme.

1.27 A Monitoring Health Inequalities Dashboard has been created to sit alongside the Annual Report. It contains a range of indicators in relation to health inequalities, using the four quadrants of the Population Health model approach, and includes data at a JSNA area level where possible.

1.28 At this stage, a number of the measures do not yet show the impact of the virus but are ones that we want to monitor. The indicators do not reflect the full spectrum of health inequalities but moving forwards, relevant indicators will be added following prioritisation by the health and care system and agreed by the Director of Public Health.

2. Financial Implications

2.1 None

3. Environmental Implications

3.1 None

Appendices

1. None

Background Papers

1. None

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Other Members: Councillors Drew, Golby, Holland and Rolfe

NEEDS ASSESSMENT

ADULT MENTAL HEALTH AND WELLBEING

Coventry and Warwickshire Joint Strategic Needs Assessment

2021

Coventry City Council

Warwickshire County Council

REPORT DETAILS

Lead	Duncan Vernon, Public Health Consultant, South Warwickshire NHS Foundation Trust / Warwickshire County Council Emily van de Venter, Associate Director of Public Health, South Warwickshire CCG / Warwickshire County Council
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Date published	XX/XX/XXXX

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EXECUTIVE SUMMARY

Poor mental health and wellbeing has a large impact on people's lives in Warwickshire and Coventry. This needs assessment has highlighted several key themes across the several of the chapters:

- **High levels of poor wellbeing and mental ill health**. All services and organisations in Coventry and Warwickshire will be seeing patients, clients or service users with mental health issues. This means that mental health is an issue that every organisation deals with, and organisations need to consider how they support staff and service users with mental health issues.

- **Difficulty in accessing or understanding available services or support.** This finding was particularly true amongst groups with protected characteristics or living in more deprived areas. This means that there are people who could benefit from services and support who are not currently doing so.

- **Growing future demand.** This is either due to better diagnosis and recognition of mental health issues, and a general increased level of poor mental health. This shows the need to take preventative approaches to reducing mental ill health and intervene early to prevent it from worsening. It is also a challenge to the health and care system about managing that increased need.

- **The short and long term impact of the pandemic**. There have been changes to society which influence mental health, such as increased unemployment, and social isolation. These have impacted on how people access services, as well as leading to worsening of the mental wellbeing of young people and women in particular. Including mental health in organisational recovery plans is crucial to respond to this.

The need to act on mental health is highlighted through several key documents nationally and locally. This includes The Five Year Forward View for Mental Health and the NHS Long Term Plan, as well as the National Suicide Prevention Strategy.

Local demographics

The populations of Coventry and Warwickshire are different however, and this means we might expect to see differences in what mental health services and support is

needed for people. Coventry is broadly a younger city, with around 80,000 residents aged 20 to 29. Warwickshire has a larger population than Coventry and also a much greater proportion of residents over the age of 65.

There are also lower life expectancies and healthy life expectancies in Coventry than Warwickshire. In Coventry life expectancy (2017-19) is 82.2 years for females and 78.7 years for males. In Warwickshire it is 83.9 years for females and 80.1 years for males. This difference is reflected in the healthy life expectancies in both areas too.

There are parts of Coventry and Warwickshire that are ethnically diverse. Around 67% of residents in Coventry and 88.5% of residents in Warwickshire identified themselves as having a White British heritage at the time of the Census in 2011. The diversity within both areas is expected to grow in 2022 and therefore understanding the barriers to accessing services and support from these groups is critical.

Research shows that there is a gradient in the inequalities in mental health, based on socioeconomic status. There are again differences in deprivation, with Coventry being the most deprived Local Authority area, followed by Nuneaton and Bedworth and North Warwickshire.

Good mental wellbeing

Good mental health is not just the absence of a diagnosed mental illness, and other factors will influence people's wellbeing. The Office for National Statistics defines wellbeing as 'how we're doing' and has been carrying out a survey of national wellbeing since 2012.

Since the national wellbeing survey started there were improvements in people's reported life satisfaction, happiness and how worthwhile people found their life. Similarly, there were reductions in people's anxiety. These trends lasted until 2019, and in the year prior to the pandemic there were reductions across all of those four indicators. Since the pandemic there have been large reductions in mental wellbeing across the four indicators. Compared to before the pandemic twice as many women reported low life satisfaction in April 2021, and at 10.8% is one in every 10 women. This increase was particularly seen in women with non-managerial roles.

There were big impacts on the wellbeing of younger people from the pandemic. One in every ten people aged 16-24 now have low self-worth, which is a three-fold increase since before the pandemic. There is the same level of low self-worth in 25 to 34 year olds, although for this age group this represents a six-fold increase.

Being able to take time to relax, and healthy coping strategies were related to increased wellbeing during the pandemic, whereas increased eating or alcohol use were related to lower wellbeing.

Common mental illnesses

Diagnosed mental health conditions such as depression or anxiety are a common experience in adulthood. The rates are higher in adults under 65, and in some areas around 1 in every 5 adults is estimated to have a diagnosable mental health condition.

By developing a local metric to estimate relative access to local IAPT services, a relatively low uptake of services was seen. Women were more likely to access IAPT than men, and younger people were more likely to access than older. The highest uptake rates were seen in women aged 16-24 (just under 1 in 5) lowest in men 65-74 (just over 1 in 20).

Access rates appeared to be lowest in Coventry and highest in Rugby. Broadly access seems to be higher in local authorities with lower levels of deprivation. People who are likely to describe themselves as having White British ethnicities had higher access rates than people from most other heritages. Some of the mental health professionals who were surveyed also felt that their patients are not generally representative of the population

Severe and Enduring Mental Ill Health

Severe and enduring mental illness (SMI) refers to the long-term experience of bipolar disorder, schizophrenia and psychosis. Those in contact with secondary mental health services have higher mortality rates than the rest of the population in general.

People with SMI will receive support from secondary and/or tertiary mental health services, and since 2018 the trend has been for a larger number of people under the age of 25 to access these services each year, although the numbers each year have remained similar overall. This is contrasted with a year on year growth in the number of people on GP registers diagnosed with SMI.

There is a significant gradient in admission rates by deprivation. People living in the 20% most deprived areas in Coventry and Warwickshire were three times likely to be admitted to hospital with an SMI than people living in the most affluent.

Parent and Infant Mental Health

National evidence shows that up to 20% of women experience a mental health problem in the perinatal period. The mental health needs assessment survey carried out across Coventry and Warwickshire found that new mothers had felt particularly isolated during the pandemic.

Personality Disorders

People with so-named ‘personality disorders’ experience considerable distress, suffering, and stigma. The definition itself remains open to some debate and the pejorative term used to bring with it a tacit admission that there was unlikely to be any effective recovery made.

Applying national estimates over 10,000 people in C&W are likely to have an Emotionally Unstable Personality Disorder, and over 80,000 people would likely meet the criteria for other personality disorders.

Eating Disorders

Eating disorders are complex mental health conditions that are characterised by a person having a difficult relationship with food. Nationally 90% of people admitted with an eating disorder are female, although some national data indicates an increasing number of men have eating disorders, this isn't yet reflected in local inpatient data

Learning Disability

A learning disability affects the way a person learns new things throughout their lifetime and also affects the way a person understands information and how they communicate. On average, adults with a learning disability die 16 years earlier than the general population – 20 years for men, 13 years for women. There are estimated to be 7,000 people with a learning disability in Coventry and 11,000 in Warwickshire

Autism

Autism is defined as a lifelong neurodevelopmental condition that affects how a person develops, communicates and socially interacts with people. Every Autistic person is different and like the general population autistic people can have good mental health. The UK does not have administration processes or surveys that capture data on the number of autistic children and adults, however there are estimated to be 3,000 people living with autism in Coventry, and nearly 4,700 in Warwickshire.

Suicide

Suicide behaviours are complex; there is no single explanation of why people take their own life and multiple factors usually contribute to each death. Around 10 people died by suicide in every 100,000 people in Coventry and Warwickshire between 2017 and 2019.

Similar to the national picture of deaths from suicide, around 3 in every 4 deaths were male. Higher numbers of deaths of men were aged 40 to 59. For women the highest numbers are seen aged 20 to 29. The majority of deaths occurred at the home address of the deceased.

Nationally the pandemic does not seem to have changed the number of deaths from suicide, however, local data is being monitored to understand any changes in the trend.

Wider determinants of mental health

The wider determinants of mental health describe the range of social, economic and environmental factors which influences mental and physical health.

For some of these factors there is a close relationship with mental health. Housing quality is a determinant of mental health and 9.5% of households in Warwickshire and 12.1% in Coventry live in fuel poverty. There has also been a trend in recent years that an increasing proportion of homeless households owed a main duty to house is due to a household member who is vulnerable with a mental health condition.

Poor mental health is also a cause and consequence of homelessness, and 44% of people experiencing homelessness and rough sleeping have been diagnosed with a mental health condition and 86% reporting mental health difficulties.

Good employment can be beneficial for mental health and wellbeing, whereas both stressful or poor employment and unemployment contributes to mental ill health. In a Warwickshire survey around 75% or respondents said that their workplace actively promotes mental health and wellbeing, although only 60% agreed that their workplace was supportive of people with mental health difficulties.

There has been an increase in unemployment since the start of the pandemic on some indicators, with national surveys showing that young adults, and adults close to retirement have been most impacted. The number of jobs advertised nationally has also fallen during the pandemic showing potential difficulties in getting back into work. Since the start of the pandemic, a growing proportion of businesses in Coventry and Warwickshire think that the economic outlook is positive, although this has not yet returned to pre-pandemic levels.

Access to green space is known to be beneficial for mental wellbeing, however, access to private gardens or similar is own green space lower than the West Midlands average in Coventry and Rugby. There was less park use during the January 2021 lockdown than over the summer, and home schooling was also an additional stress for many residents during that lock down. Fewer people have been commuting to work during the pandemic, and this can also be a source of stress.

Ethnically Diverse Communities

People from ethnically diverse backgrounds are highlighted to potentially have greater rates of mental health illness compared to White British people. A recent survey conducted by CWPT identified challenges such as the complexity of health care system, difficulties in access, lack of empathy, compassion or general support, and a lack of resources alongside a lack of awareness and sensitivity to the specific issues experienced by people from ethnically diverse backgrounds.

These themes were emphasised by the survey carried out to inform this assessment, where issues also emerged around translation and the need to actively work with communities of under-represented groups.

LGBTIQ+

LGBTIQ+ stands for lesbian, gay, bisexual, trans, intersex, queer or questioning. In 2017 Stonewall carried out a survey of over 5,000 LGBT people across England, Scotland and Wales to understand their experiences of mental health, which identified higher levels of depression or self harm. Being LGBTIQ+ doesn't cause these problems. But some things LGBTIQ+ people go through can affect their mental health, such as discrimination, homophobia or transphobia, social isolation, rejection, and difficult experiences of coming out.

Veterans

A military veteran is any person that has served at least one day in HM British Armed Forces (Regular or Reserve) or Merchant Mariners who have seen duty on legally defined military operations. There are approximately 2.5 million military veterans in the UK.

Most veterans enjoy good mental health after a rewarding and challenging career and research has shown that help seeking 'veterans' as an overall group are at broadly similar levels of risk in terms of clinical depression and anxiety disorders as the general population. However, serving in conflicts can increase the risk of Post-Traumatic Stress Disorders (PTSD), which was seen amongst 9% of members of the UK Armed Forces who deployed, compared to 5% for veterans who did not deploy.

Carers

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

Locally it is estimated that there are approximately 34,000 unpaid carers in Coventry and 62,000 in Warwickshire. In Coventry there are approximately 2,500 young carers (0-24 years old) and 3,500 in Warwickshire.

One hundred and ninety one people responding to the local Mental Health Needs Assessment Survey reported having caring responsibilities. Comments included reports of carers feeling confused and sometimes unsupported when relatives were experiencing a mental health problem.

In addition, carers face barriers in getting support for their own wellbeing. A recent Healthwatch survey in Warwickshire found that 55% of respondents reported barriers to accessing support such as not having the time, not being sure where to go for help or support, and that the person or people they care for only want the carer (and no one else) to look after them.

Asylum seekers

Asylum seekers and refugees face unique and complex challenges related to their mental health and are often at greater risk of developing a mental health problem, with

research suggesting they are five times more likely to have mental health needs than the general population.

In Coventry there are around 600 asylum seekers at any time (this is a constantly changing population as it is dependent on legal status). This includes unaccompanied asylum seeking children. There are approximately 400 refugees resettled under home office schemes, with around 120 per year coming into the city. There are approximately 2,000 other refugees and asylum seekers with unsuccessful applications.

Since November 2016, 36 Syrian refugee families have been resettled across Warwickshire through the Syrian Vulnerable Persons Resettlement Scheme. A separate needs assessment for this group found a lack of expertise and understanding amongst mainstream health and mental health providers, as well as inconsistent use of interpreters by services, and a cultural stigma around mental illness.

RECOMMENDATIONS

The following recommendations have been identified throughout the report:

Wellbeing

- In light of the evidence that wellbeing is not a fixed state, multiple determinants contribute to it and the economic case for prevention and early intervention in mental health and wellbeing, it is recommended that, locally, investment in this area is continued and strengthened where possible
- Given the impact of the COVID-19 pandemic, organisations should ensure that mental health is a key theme of recovery planning

Common mental disorders

- Work with referrers to understand what engagement will be appropriate to improve footfall
- Improve community engagement with partners including the voluntary and community sector, faith-based groups, large HR organisations and NHS providers
- Develop appropriate methods to provide support to care home residents

Severe and enduring mental ill health

- Improve community engagement with partners to raise awareness of mental health and strengthen the prevention response (including the voluntary and community sector, faith-based groups, large HR organisations and NHS providers), particularly in areas of high deprivation
- Create and implement a fully integrated pathway for people with SMI in terms of both ongoing treatment and comprehensive annual physical health reviews
- Promotion of parity of esteem and understanding of importance of physical health reviews
- Local audits to be undertaken in relation to polypharmacy

Parent and infant mental health

- Raise awareness of and promote support for fathers experiencing post-natal mental health difficulties
- Continue to work with MAMTA to reduce health inequalities experienced by those from ethnically diverse communities

Personality disorders

- Improvements are needed across the health and social care system in compassionate understanding about personality disorders, their prevalence and treatment.

- Reduce gaps in commissioning and service provision for people with personality disorder
- Improve pathways for people with personality disorders to ensure their needs are fully met

Learning disability

- Promote Oliver McGowan training across Coventry and Warwickshire to raise awareness of the mental health needs of people with a learning disability
- Promote the aims of the STOMP project to reduce over-medication of people with learning disabilities (encouraging regular medication reviews, involvement of people and their families or support staff in decisions on medicines and informing people about non-drug therapies and other practical ways of supporting people to reduce the amount or need for medicine)

Autism

- Raise awareness of autism and appropriate mental health interventions for people with autism
- Work with mental health services to improve access to services for people with autism (focusing on eligibility for support and improving skills to identify autistic traits)

Suicide

- Develop knowledge, skills and confidence within primary care to enquire about mental health challenges and respond to distress.
- Improve timely access to support, including promoting and strengthen pathways to and from community assets such as Safe Havens, and other services that tackle loneliness and social isolation.
- Improve access to community-based support for those at risk of mental health crises
- Continue to embed and strengthen surveillance of suspected suicides to enhance learning and preventative approaches, - review future funding opportunities for January 2022 onwards.
- Use the findings of this JSNA to inform Suicide Prevention Strategy updates and action plans.
- Commission an all age postvention service for residents of Coventry and Warwickshire bereaved by suicide by the end of 2021
- Continue to embed and strengthen the work developed under the NHSE 3-year programme around crisis support, dual diagnosis, coproduction, marketing and communications
- Develop further insights into the experiences and needs of men and young people;

- Develop the work programme on self-harm and engaging health and non-healthcare sectors in suicide prevention training and awareness raising.

Wider determinants

Housing and Homelessness

- Promote Act on Energy services across Coventry and Warwickshire to support a reduction in fuel poverty
- Continue to support and expand (where required) mental health support services for homeless people

Employment

- Promote Mental Health First Aid courses and encourage all organisations across Coventry and Warwickshire to have at least one mental health first aider
- Ensure appropriate support is available for service users that do not have access to online services
- Ensure that appropriate support is targeted towards young people who have been disproportionately impacted by COVID-19
- Continue to promote the IPS service across Coventry and Warwickshire

Access to outside/green space

- Undertake community engagement activity to understand barriers to accessing green space
- Promote green spaces across Coventry and Warwickshire, particularly amongst communities that are not in close proximity to green spaces

Impact on family relationships

- Following the impacts of the COVID-19 pandemic, promote mental health and wellbeing resources including relationship focused resources
- Support the recommendations of local domestic violence and abuse needs assessments
- Continue to support and expand (where required) mental health support services for people who abuse drugs and/or alcohol

Travel

- Promote the physical and mental health benefits of active travel
- Promote the importance of road safety to avoid negative physical and psychological impact of road traffic injuries

High risk groups

Ethnically diverse communities

- Disseminate digital outputs developed from artists into ethnically diverse communities in Warwickshire to promote talking about mental health and accessing mental health services
- Improve engagement with ethnically diverse communities to improve trust and relationships, with the aim of improving access to mental health services

LGBTIQ+

- Improve engagement with LGBTIQ+ communities to improve trust and relationships, with the aim of improving access to mental health services
- Identify the specific mental health needs of LGBTIQ+ service users to ensure that services meet their needs

Veterans

- It is recommended that all organisations (both in the statutory and voluntary/community sector) ask and record the veteran status of every referred person and have adjustments in place to ensure that the entitlements of the Armed Forces Community are met. These commitments and formalised adjustments to normal provision must be written down and binding if we are to better meet the needs of the Armed Forces Community.
- It is also recommended that PCNs investigate veteran accreditation for GP surgeries

Carers

- Signposting carers to mental health provision available; this includes increasing awareness through multi-agency support
- Highlighting the importance of focusing on carer's own physical and mental wellbeing

Transition Period 16-25

- Develop a service model that meets the needs of the young adult population in Coventry and Warwickshire
- Raise awareness of available services available for people aged 16-25

Inclusion Health

- Improve engagement with marginalised and vulnerable communities to improve trust and relationships, with the aim of improving access to mental health services

- Identify the specific mental health needs of marginalised and vulnerable service users to ensure that services meet their needs

Local services

- Responding to the impact of COVID-19 in the design of services, including workforce support and support for the wider determinants of health.
- Development of system knowledge (including among non-MH providers) to raise awareness of available support for all-ages particularly for those with specific needs e.g. housing and domestic abuse services. This could be through a clear, and integrated communications approach relating to local service provision.
- Improving access to support and information - The majority of respondents to the engagement survey had heard of at least one support service, and if people are in contact with a service then they can be supported to access further support through signposting. The specific needs of certain groups such as children and young people, people with autism, and Carers should also be taken into account.
- Commissioners and Providers to ensure there are feedback mechanisms for service user experience to inform future service design to build upon what was learned from the MHNA engagement

INTRODUCTION

We all have mental health. It is not a permanent state but may fluctuate over time. The World Health Organisation defines positive mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community". This means that even with a diagnosis of a mental illness it is possible to have good mental health and wellbeing, and also the opposite. The dual continuum model of mental health (as outlined in Figure 1) demonstrates this concept.

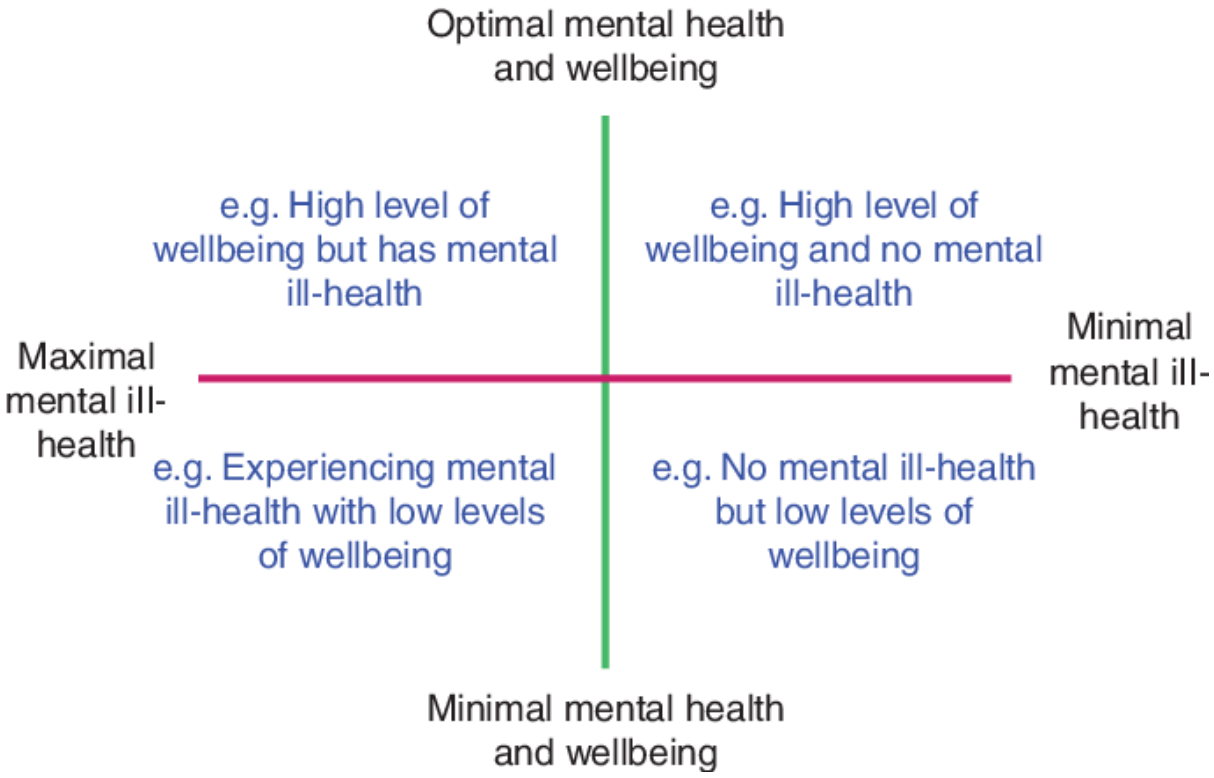


Figure 1. The dual continuum model of mental health
Source: Jay et al.[1]

As with our physical health there are things we can all do to look after our mental health and wellbeing. There will also be inevitable challenges and times when support from friends, family, voluntary services or health services are needed. This report considers the range of influences on our mental health and wellbeing and reviews of local services, in order to determine key areas for action within Coventry and Warwickshire.

NATIONAL AND LOCAL CONTEXT

Awareness and understanding of mental health and wellbeing has increased significantly over past decade. Government and NHS policies have made significant commitments to improve support for people with mental health difficulties.

Since 2012 a number of important national policy documents have focused on improving mental health outcomes, preventative approaches, reducing inequalities, reforming services and mental health legislation and preventing deaths by suicide. These include:

- The Five Year Forward View for Mental Health[2]
- NHS Long Term Plan[3]
- White Paper Reforming the Mental Health Act[4]
- National Suicide Prevention Strategy[5]
- Cross government suicide prevention workplan[6]

Locally, the Coventry and Warwickshire Health and Care Partnership (HCP) established a work programme in response to national strategies to improve mental health outcomes[7]. which responded to the Five Year Forward View for Mental Health. This built upon Coventry's Suicide Prevention Plan[8,9] and Health and Wellbeing Strategy[10] as well as Warwickshire's Suicide Prevention Strategy[11] and Mental Health and Wellbeing Strategy[12].

Coventry and Warwickshire Health and Wellbeing Boards have signed up to the Public Health England (PHE) Prevention Concordat for Better Mental Health[13] which promotes evidence-based planning and commissioning to increase the impact on reducing health inequalities. One of the domains within the concordat's framework is "understanding local needs and assets". Coventry City Council last produced a mental health needs assessment in 2015[14]. In Warwickshire 22 geographical "place-based" needs assessments[15] were completed throughout 2018-2020. Each included an analysis of population mental health needs and key factors influencing mental health.

IMPACT OF COVID-19 ON MENTAL HEALTH AND WELLBEING

It is no understatement to say that the COVID-19 pandemic has changed how society functions and impacted on the population's mental health and wellbeing. This is reflected in the prominence of the issue nationally and locally in relation to pandemic recovery plans.

A local rapid COVID-19 Health Impact Assessment[16] was completed in July 2020 to highlight the impact of the first few months of the pandemic. The assessment identified some impacts in relation to mental health and wellbeing (e.g. locally, referrals to mental health services reduced) but findings were limited due to data availability at that stage. Subsequently, a COVID-19 impacts and recovery survey

was undertaken in Warwickshire in August and September 2020, with responses from over 2,500 residents providing insight into COVID-19 stressors and wellbeing impacts. Unsurprisingly the pandemic negatively influenced mental wellbeing and loneliness, with effects felt more strongly among some population groups. This effect was significantly influenced by the types of coping strategies used, for instance taking time to relax helped improve wellbeing, whereas increased alcohol and food consumption decreased wellbeing.

National research has demonstrated a worsening self-reported mental health and wellbeing during the first national lockdown of the COVID-19 pandemic; with symptoms peaking in April 2020[17]. This was followed by come improvement by July 2020 which was sustained until September. Subsequent data suggests self-reported mental health and wellbeing worsened again between October 2020 and January 2021.

The Health Foundation launched a COVID-19 impact inquiry in October 2020 which highlights that high levels of anxiety and depression in April 2020 lessened for some groups (attributed to resilience and coping mechanisms), while others experienced sustained distress or deterioration in mental health[18]. This reflects accounts of lived experience; where some people benefited from the removal stressors, such as school classrooms or the daily commute, and experienced unexpected benefits such as enjoying more time in nature or new family routines. However, others experienced negative impacts from bereavement, furlough and unemployment, disruption to schooling, loneliness, digital exclusion and domestic abuse.

Certain groups experienced more of an impact on their mental health and wellbeing than others; in particular people who are unemployed, from an ethnic minority or LGBTIQ+, young people, older adults and those living with existing physical or mental health conditions.

INEQUALITIES IN MENTAL HEALTH AND WELLBEING

Inequalities in health exist when there are avoidable, unfair and systematic differences in health across the population and between different groups of people within society. For the purposes of this report these inequalities have been grouped into three broad categories: determinants of mental health and wellbeing; access to services and support; and experience and outcomes.

Determinants of Mental Health and Wellbeing

There are many determinants (factors) that influence mental health and wellbeing. Some of these include: parenting, oppression, discrimination, poverty and adverse childhood experiences e.g. abuse. These determinants can interact with inequalities

in society putting some people at higher risk of poor mental health than others. Examples of such inequalities include:

- Within African-Caribbean communities in the UK there are higher rates of post-traumatic stress disorder and suicide risk and are more likely to be diagnosed with schizophrenia. Some of this increased risk is linked to experiences of discrimination and immigration (i.e. moving to a new country with a lack of existing support networks) rather than individuals' ethnicity directly.
- Children from the poorest 20% of households are four times as likely to have serious mental health difficulties by the age of 11 as those from the wealthiest 20%
- People living with hearing loss/deafness are twice as likely to experience mental health difficulties

Access to services and support

Evidence suggests that only one in three people experiencing a mental health problem are able to access the support they need. Access to mental health support is not equally distributed across the population; those facing particularly high levels of poor mental health often experience the greatest difficulty in accessing services. Examples of inequalities in access include:

- 85% of older people with depression receive no NHS support
- Black adults are the least likely ethnic group to report being in receipt of medication for mental health, or counselling, or therapy[18]
- Black people in the UK are less likely to have the involvement of GPs leading up to a first episode of psychosis than white patients

Locally, the Coventry and Warwickshire mental health needs assessment survey found around half of professional respondents considered there to be inequalities in access to the services they represented. Additionally, a number of respondents felt that the diversity of local populations were not reflected in those accessing their services.

Experience and Outcomes

Differences in experiences of mental health care are particularly evident across a number of dimensions that often intersect with each other (e.g. income and wealth, gender, ethnicity, age, sexuality and gender identity).

- LGBTQ+ people who have experienced multiple disadvantage report that mental health professionals often fail to understand their experiences and, as a result, were unsupportive or unlikely to meet their needs
- Black people are more likely to experience police involvement in their first contact with mental health services

- Black people are eight times more likely than White British people to be given a community treatment order after being treated in hospital under the Mental Health Act[19]

There are also stark inequalities in the physical health of those with mental health difficulties. Those experiencing severe and enduring mental health problems die, on average, 15–20 years earlier than the general population, are over 3 times as likely to attend A&E and 4.9 times more likely to be admitted for urgent physical care needs. Conversely they have lower rates of planned hospital admissions. Additionally, people living with depression have a life expectancy 7–10 years less than the general population[20].

THIS JSNA

This Joint Strategic Needs Assessment (JSNA) aims to provide an understanding of adult mental health and wellbeing needs across Coventry and Warwickshire. The assessment incorporates national and local evidence to support local priority setting and action.

As part of the needs assessment process, local engagement was undertaken with the public and local stakeholders. An online survey (February – March 2021) received 969 responses from members of the public, service users and professionals. Focus groups were also held to obtain in depth information from service users, carers and professionals. Reports outlining the full findings of the survey and focus groups can be found in Appendices 1 and 2.

LOCAL CONTEXT

POPULATION

Locally, the Joint Strategic Needs Assessment (JSNA) analyses the current and future health and wellbeing needs of the population. Demographic information of the local population is important to understand those needs, and this chapter outlines information about the populations of Coventry and Warwickshire.

Further demographic information can be found on the Coventry and Warwickshire JSNA webpages:

- https://www.coventry.gov.uk/jsna
- https://www.warwickshire.gov.uk/joint-strategic-needs-assessments-1

AGE AND GENDER

As this report will show, mental health and wellbeing can vary across the life course for people and stressful, traumatic or transitional points can impact if the right support is not available. It is therefore important to ensure that appropriate support is available for populations across the life course.

Coventry

Figure 1 highlights that the population in Coventry is relatively young, with largest numbers between the ages of 20 – 29 (79,291 people). There are slightly more men than women in this age group, and men account for 53% of this group.

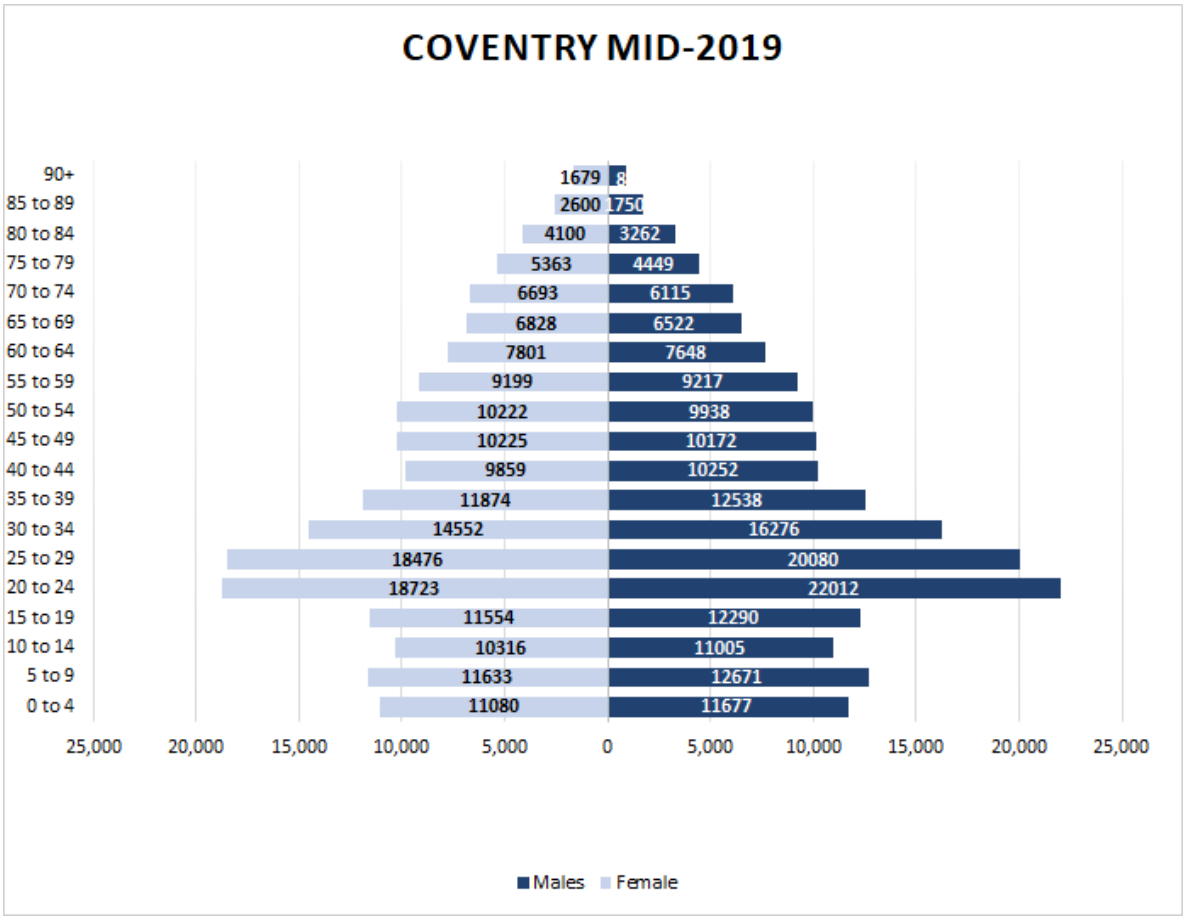


Figure 1: The number of male and female persons in Coventry broken down by age and gender (mid-year estimates, 2019)
Source: Office for National Statistics mid-year population estimates / Insight Team, Coventry City Council

Warwickshire

In comparison the spread of age across the Warwickshire population is more uniform with smaller peaks between the ages 20 – 29 and 45 – 59 (Figure 2). Compared to Coventry a higher proportion of people are aged over 65.

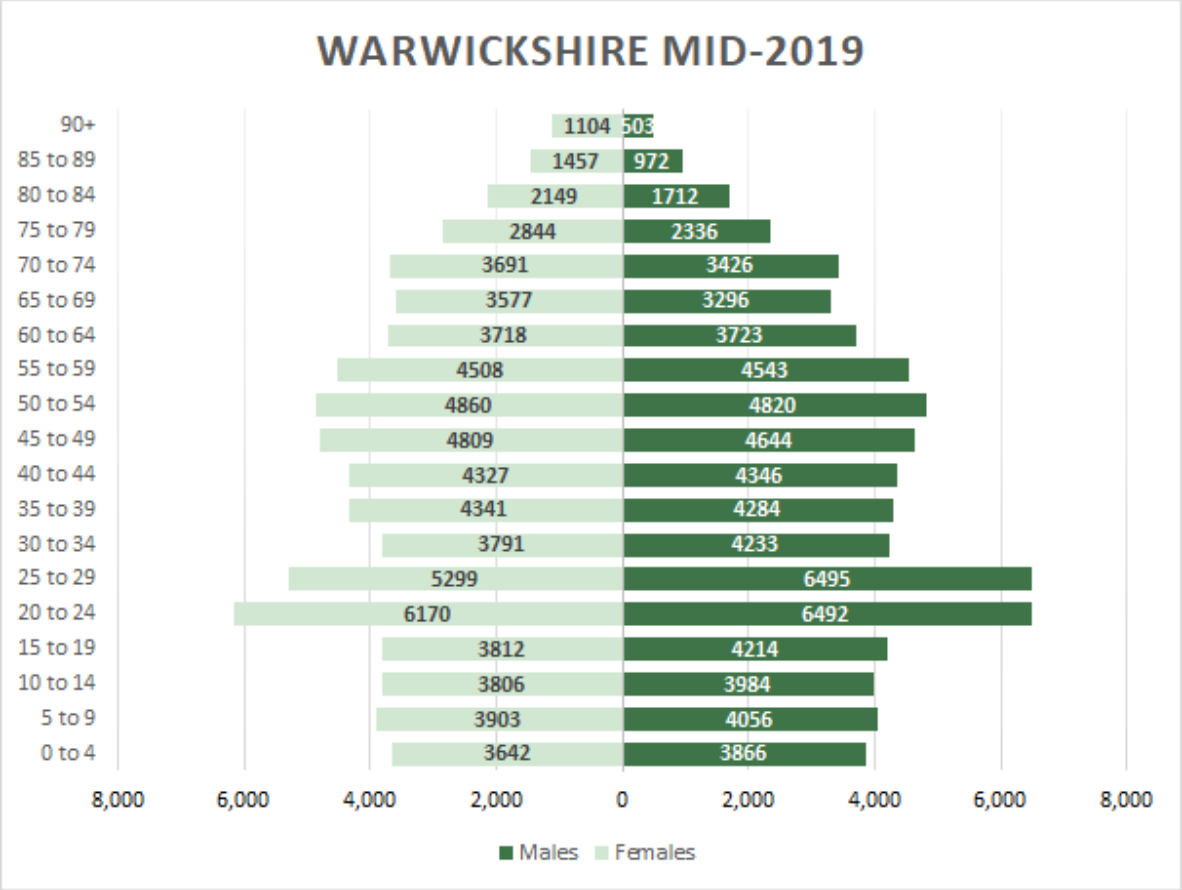


Figure 2: The percentage of male and female persons in Warwickshire broken down by age and gender (mid-year estimates, 2019)
Source: Office for National Statistics mid-year population estimates / Business Intelligence Team, Warwickshire County Council

LIFE EXPECTANCY

In Coventry life expectancy (2017-19) is 82.2 years for females and 78.7 years for males. In Warwickshire it is 83.9 years for females and 80.1 years for males. This compares to an England average of 83.4 years for females and 79.8 years for males. The Coventry population therefore has a life expectancy slightly below the England average whereas Warwickshire's population performs slightly better than the England average.

Healthy life expectancy (HLE) is an indicator of the average number of years that a person is expected to live in a state of self-assessed good or very good health. Figures 3 and 4 illustrate that there are significant differences between HLE and life expectancy, meaning a large proportion of the population will be living in a state of poor health.

Physical health problems can significantly increase the risk of poor mental health with approximately 30% of people with a long-term physical health condition also having a mental health problem, most commonly depression or anxiety[21]. Therefore,

those in Warwickshire who live beyond a healthy life expectancy are potentially at risk of mental health problems. This gap between healthy life expectancy and life expectancy is greatest in females in Coventry and is 18 years on average.

Conversely, poor mental health can also increase the risk of poor physical health. Research demonstrates that those experiencing severe and enduring mental health problems die, on average, 15–20 years earlier than the general population, while those with depression die 7–10 years earlier[19].

Coventry

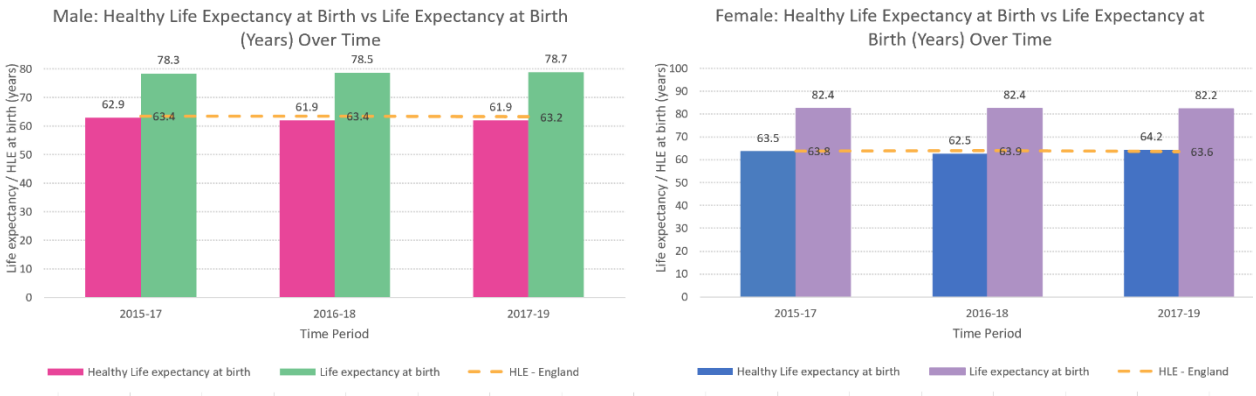


Figure 3: Healthy life expectancy at birth vs life expectancy at birth (years) over time between 2015 and 2019 for male and females in Coventry
Source: Office for National Statistics mid-year population estimates / Business Intelligence Team, Warwickshire County Council

Warwickshire

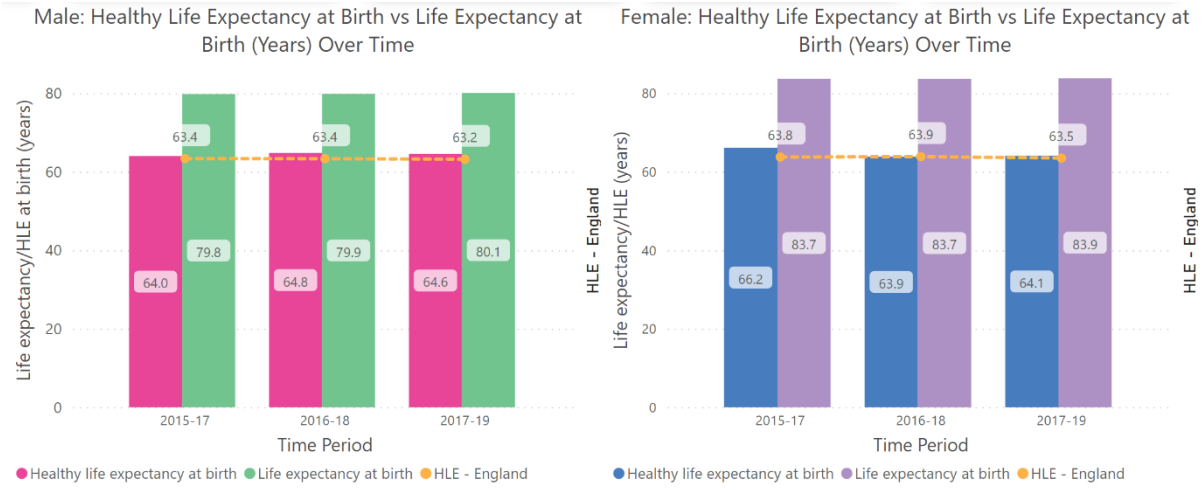


Figure 4: Healthy life expectancy at birth vs life expectancy at birth (years) over time between 2015 and 2019 for male and females in Warwickshire
Source: Office for National Statistics mid-year population estimates / Business Intelligence Team, Warwickshire County Council

North Warwickshire

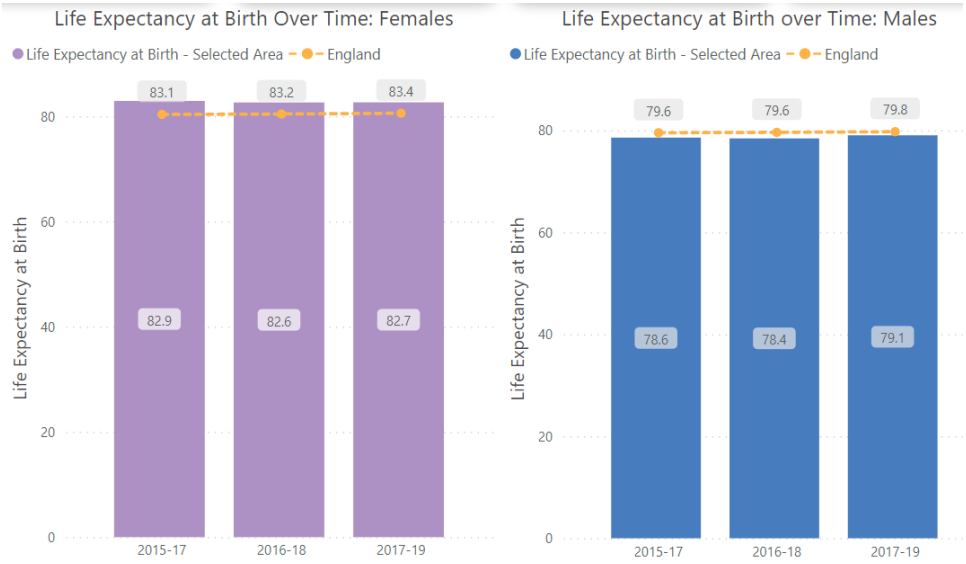


Figure 5: Healthy life expectancy at birth vs life expectancy at birth (years) over time between 2015 and 2019 for male and females in North Warwickshire
Source: Office for National Statistics mid-year population estimates / Business Intelligence Team, Warwickshire County Council

Nuneaton and Bedworth

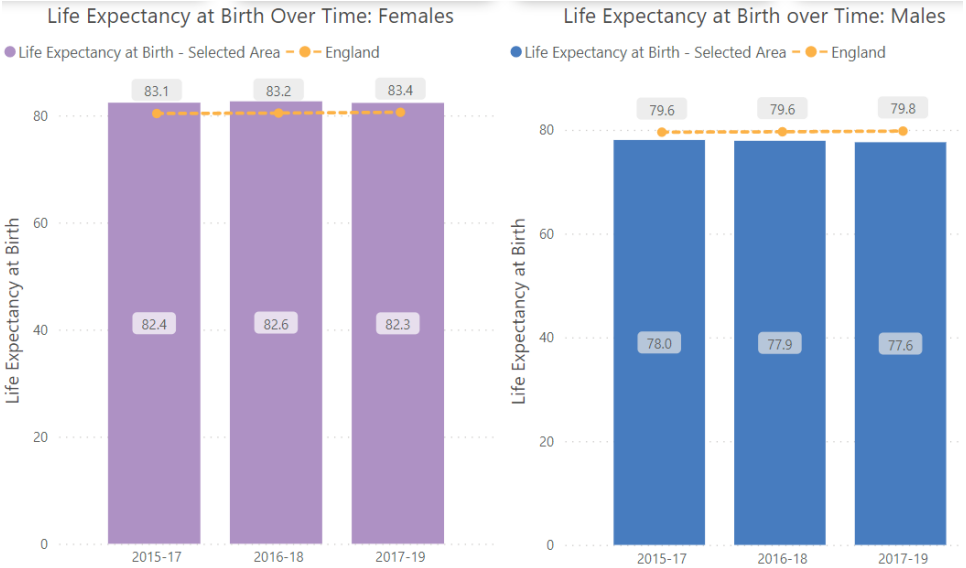


Figure 6: Healthy life expectancy at birth vs life expectancy at birth (years) over time between 2015 and 2019 for male and females in Nuneaton and Bedworth
Source: Office for National Statistics mid-year population estimates / Business Intelligence Team, Warwickshire County Council

Rugby

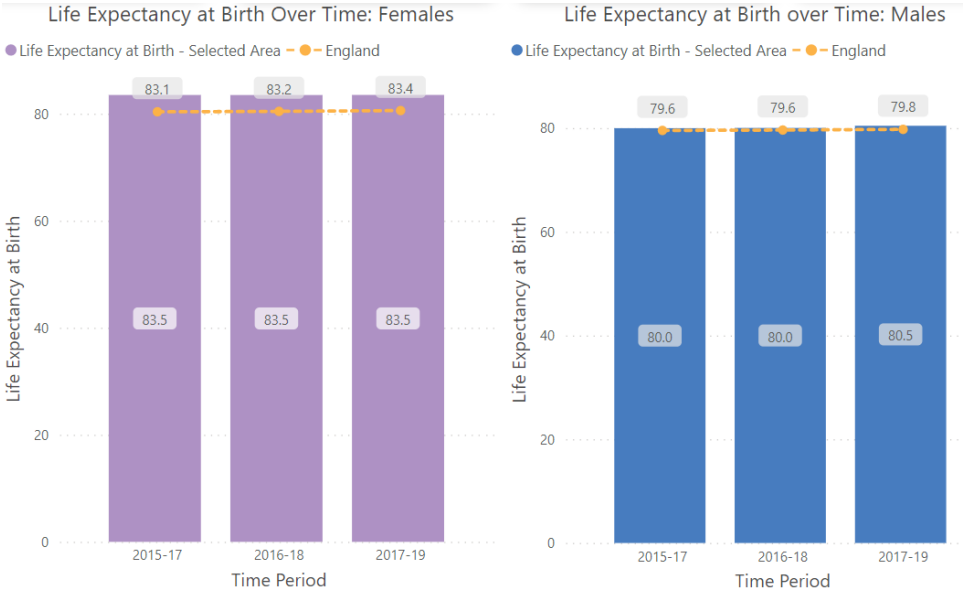


Figure 7: Healthy life expectancy at birth vs life expectancy at birth (years) over time between 2015 and 2019 for male and females in Rugby

Source: Office for National Statistics mid-year population estimates / Business Intelligence Team, Warwickshire County Council

Stratford-on-Avon

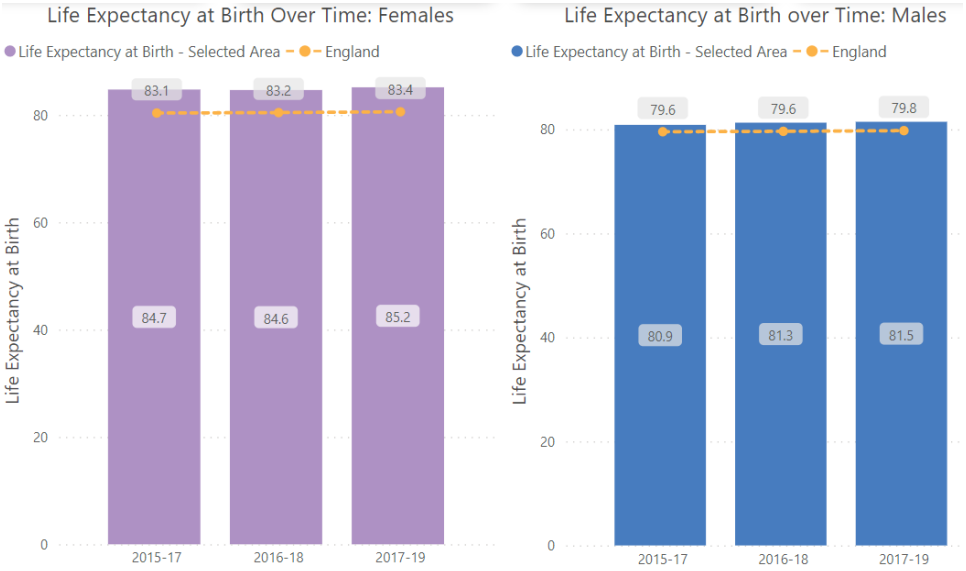


Figure 8: Healthy life expectancy at birth vs life expectancy at birth (years) over time between 2015 and 2019 for male and females in Stratford

Source: Office for National Statistics mid-year population estimates / Business Intelligence Team, Warwickshire County Council

Warwick

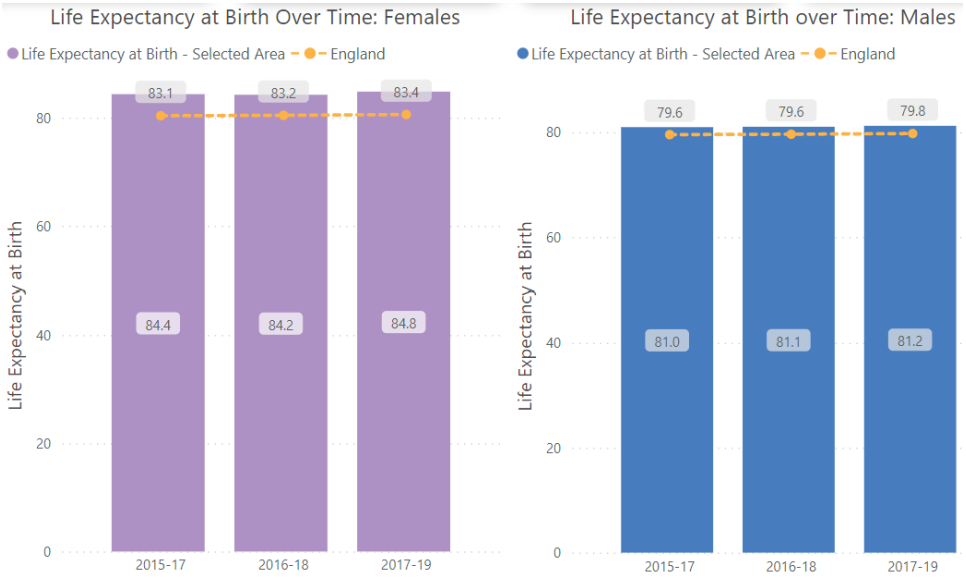


Figure 9: Healthy life expectancy at birth vs life expectancy at birth (years) over time between 2015 and 2019 for male and females in Warwick
Source: Office for National Statistics mid-year population estimates / Business Intelligence Team, Warwickshire County Council

ETHNICITY

Whilst the term people from "Black, Asian and Minority Ethnic" (BAME) groups is used in this report, it should be acknowledged that this encompasses a wide range of people of different heritages who may all encounter racism in some form. Where possible the mental health of people of different heritages has been presented separately, although much of the source material also uses the term BAME and so this is not always possible. Elsewhere the term "ethnically diverse" is used by the #BAMEover campaign and is based on individuals' lived experience[22].

As highlighted in the introduction, people from an ethnically diverse background may experience different rates of mental illness than the white population. People from these communities often face individual and societal challenges that can affect access to healthcare and overall mental and physical health.

There are a number of factors that can influence ethnically diverse communities' mental health which include:

- Racism and discrimination – research suggests that experiencing racism is highly stressful and has a negative impact on mental health; research also suggests that those exposed to racism are more likely to experience mental health problems such as psychosis and depression

- Social and economic inequalities – people from ethnically diverse communities are more likely to experience poverty, have poorer educational outcomes and higher unemployment.
- Mental health stigma – in some communities mental health problems are rarely spoken about and can be seen in a negative light. This can discourage people within those communities from talking about their mental health and may be a barrier to engagement with services.
- Interaction with the criminal justice system – evidence suggests that there are unmet mental health needs among people from ethnically diverse communities within the criminal justice system, particularly in the youth justice system[23].
- Migration – this is a key one influencing psychiatric conditions due the trauma that can be experienced as an asylum seeker or refugee (forced migration), but also the stress of going through immigration procedures (whether refugee/asylum seeker or voluntary migration) and lack of social networks in new country[24].

Locally, ethnicity figures are taken from the 2011 Census. These numbers are expected to have changed in the recent years and should be interpreted with some caution. Updated data is expected early 2022 following publication of the 2021 Census data.

Table 1 demonstrates that Coventry has a larger percentage of people who are from an ethnically diverse community compared to Warwickshire (26.2% and 7.3% respectively). Therefore a higher proportion of the population in Coventry are at risk of mental health difficulties; this proportion is also higher than the England average.

School census data from spring 2021 outlined in Table 2 illustrates a more diverse picture across Coventry and Warwickshire compared to the population ethnicity estimates in Table 1. In Coventry, there are notably higher percentages of White Other, Mixed, Asian and Black in the school ethnicity data compared to 2011 census data. Warwickshire data shows a similar picture, with notably higher percentages of White Other, Mixed and Asian populations.

Table 1. Population ethnicity estimates for Coventry and Warwickshire

	England	Coventry	Warwickshire
Population Size	55,977,200	366,785	577,933
White English / Welsh / Scottish / Northern Irish / British	79.8%	67%	88.5%
White Irish	1.0%	2.3%	1.0%
White Gypsy or Irish Traveller	0.1%	0.0%	0.1%
White Other	4.6%	4.9%	3.2%
Mixed	2.3%	2.6%	1.5%
Asian	7.8%	16.3%	4.6%
Black	3.5%	5.6%	0.8%
Other	1.0%	1.7%	0.4%

Sources: Office for National Statistics mid-year population estimates / Insight Team, Coventry City Council; Business Intelligence Team, Warwickshire County Council

Table 2. School Census Ethnicity Data in Spring 2021

	Coventry	Warwickshire
Population Size	56,062	86,191
White English / Welsh / Scottish / Northern Irish / British	45.26%	76.9%
White Irish	0.37%	0.2%
White Gypsy or Irish Traveller	0.83%	0.3%
White Other	8.76%	6.4%
Mixed	7.35%	5.3%
Asian	21.11%	7.0%
Black	12.94%	1.5%
Other	2%	0.9%
Unknown / Refused	0.97%	1.4%

Source: Warwickshire School Census Spring 2021 (note that this includes state schools only)

DEPRIVATION

There is strong evidence for a link between income and mental health. This can work both ways: being poor can lead to mental health problems (most commonly anxiety and depression), but mental health problems can also lead people into poverty due to discrimination in employment and reduced ability to work. Further research has

also demonstrated a 'social gradient' of mental health – inequalities in mental health are not just about poverty, those in the lowest socioeconomic groups have worse health than those in the middle groups, who in turn have worse health than those in the highest. It should be noted that the social gradient does not just focus on economics but also encompasses cultural, relational and environmental influences[18].

Figure 10 highlights areas of deprivation in Coventry and Warwickshire. This suggests that populations in Coventry and Nuneaton and Bedworth are at most risk of developing mental health difficulties as a result of determinants associated with deprivation.

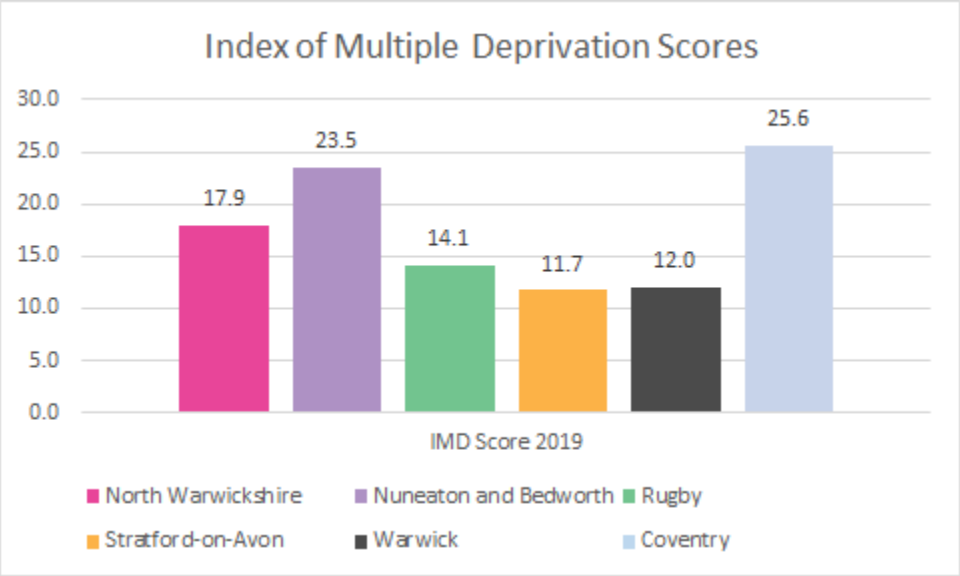


Figure 10. Index of multiple deprivation scores across Coventry and Warwickshire
Source: Ministry of Housing, Communities and Local Government / Insight Team, Coventry City Council / Business Intelligence Team, Warwickshire County Council

Coventry

In 2019 14.4% of Coventry's Lower Super Output Areas (LSOA) were amongst the 10% most deprived in England and 26.7% of LSOAs were amongst the 30% most deprived in England. Figure 3 highlights areas of higher deprivation. The majority of areas with high deprivation are in the central north east and north east of the city with pockets in the south west and south east.

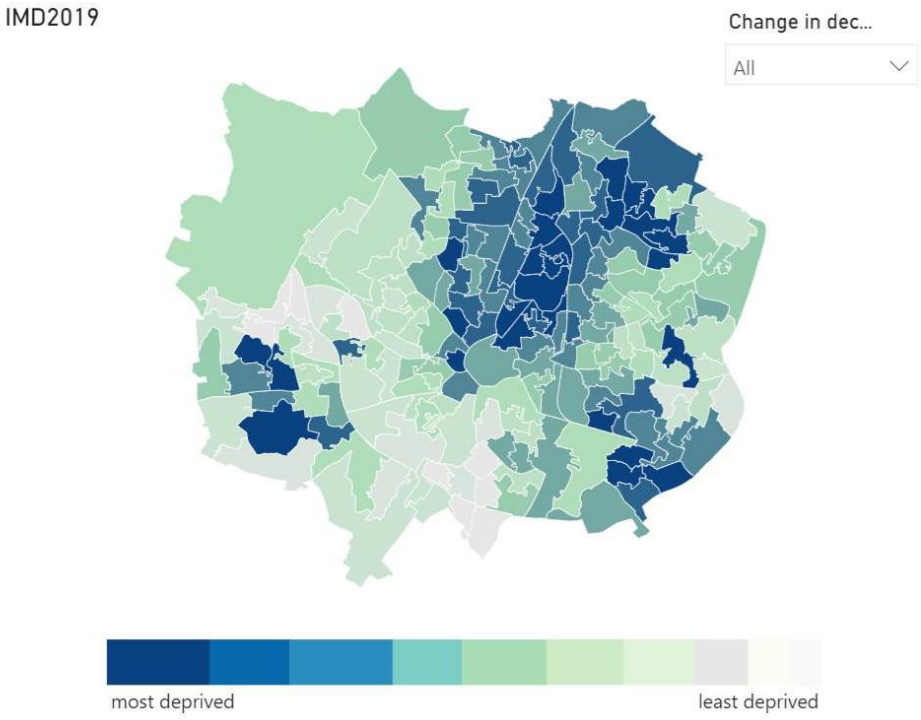


Figure 11. Heat map illustrating deprivation in Coventry
Source: Ministry of Housing, Communities and Local Government; Insight Team, Coventry City Council

Warwickshire

In 2019 Warwickshire ranked 121 out of 151 local authorities for deprivation, with 151 being least deprived. However, there are areas of deprivation across the county and each district or borough contains at least one LSOA amongst the 30% most deprived in England. As illustrated in Figure 4, five LSOAS in Nuneaton & Bedworth Borough and one in North Warwickshire Borough are in the 10% most deprived nationally.

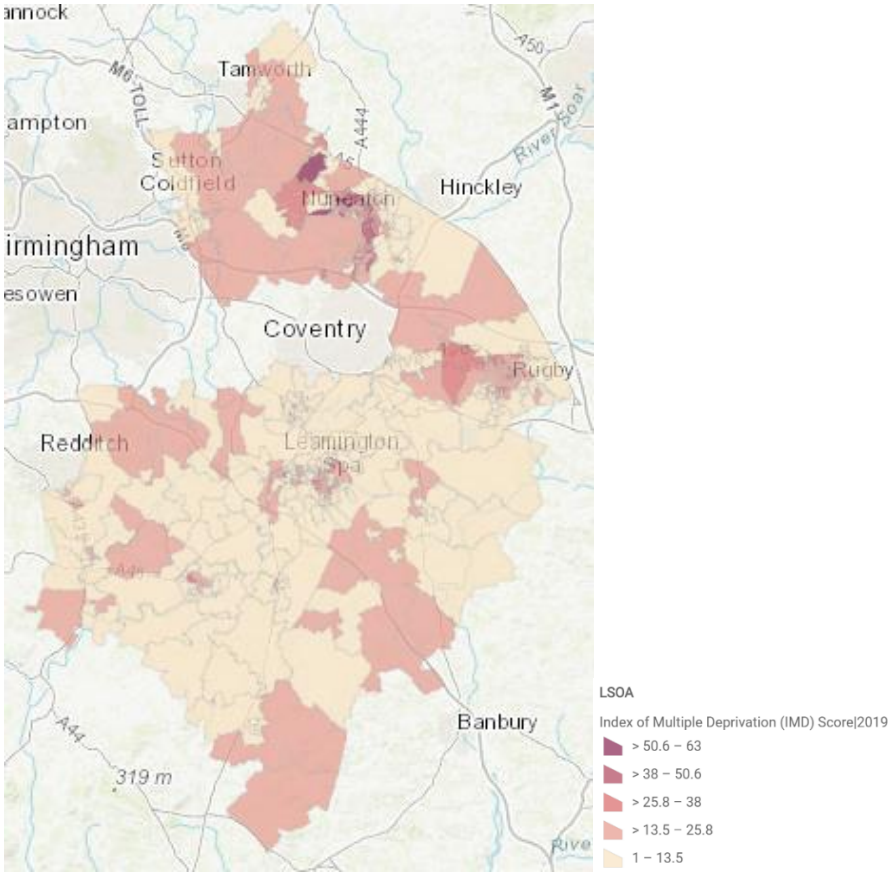


Figure 12. Heat map illustrating deprivation in Warwickshire
Source: Ministry of Housing, Communities and Local Government; Business Intelligence Team, Warwickshire County Council

WELLBEING AND MENTAL HEALTH

WELLBEING

Wellbeing is not solely the absence of disease or illness; it is a complex combination of a person's physical, mental, emotional and social health factors. The Office for National Statistics (ONS) defines wellbeing as "how we're doing" as individuals, communities and as a nation, and how sustainable that is for the future.' It looks beyond what we produce, and considers our 'health, relationships, education and skills, what we do, where we live, our finances and the environment.'[25] Whilst all people will have some level of wellbeing, the 2010 Marmot Review identified a social gradient in health whereby those experiencing the most social deprivation, the worse his or her health and wellbeing[26].

The Department of Health has reported the benefits of wellbeing which include increased life expectancy and better physical health[27]. Other benefits include reductions in health-damaging behaviour, greater educational achievement, improved productivity, reduced absenteeism and reduced crime[28].

The benefits of good wellbeing and in turn the disadvantages of poor wellbeing can have significant impacts on the economy and health and social care system. The wider economic costs of mental illness in England have been estimated at £105.2 billion each year (includes direct costs of services, lost productivity and reduced quality of life)[29]. Therefore, investing in preventative approaches and improving wellbeing can reduce wider costs, reduce pressure on the health and care system and improve outcomes for individuals, communities and populations[30].

Areas for potential intervention include:

- Early identification and intervention as soon as mental health problems emerge
- The promotion of positive mental health and prevention of mental health problems in childhood and adolescence
- The promotion of positive mental health and prevention of mental health problems in adults
- Addressing the social determinants and consequences of mental health problems
- Improving the quality and efficiency of current services[27]

Five Ways to Wellbeing

The Five Ways to Mental Wellbeing is an evidence based framework outlining five steps that people can take to improve personal wellbeing[31]. These have been adopted locally[32] and are used in promotional activities as well as informing the

service delivery of some commissioned wellbeing services. The Five Ways to Wellbeing are:

1. **Connect -** Spending time building positive relationships and social connections with family, friends, neighbours and colleagues can increase a person's sense of happiness and wellbeing
2. **Be active –** Being physically active means moving your body and working your muscles; physical activity can directly improve mental wellbeing
3. **Take notice –** Being mindful, bringing attention and interest to one's surroundings and looking for things that bring happiness can all improve wellbeing.
4. **Keep learning -** Learning new skills can build a sense of achievement, confidence and self-esteem - and helps to keep the mind active.
5. **Give -** Giving time freely to help others builds a sense of community and belonging. This can be done through random acts of kindness, volunteering or simply showing gratitude to those around you.

Coventry and Warwickshire Year of Wellbeing

The Coventry and Warwickshire Year of Wellbeing campaign set out to raise the profile of local prevention opportunities and to encourage people to be proactive about their own health and wellbeing. An estimated 900,000 people engaged with the campaign and from the 4 main themes for the year of child physical activity; workforce wellbeing; loneliness and social isolation, and celebrating personal successes we saw:

- 130 schools across the area engaging with more activity in and around school
- 111 businesses & organisation sign up to Thrive at Work accreditation
- 680 frontline staff contacted to highlight the health & wellbeing impacts of social isolation and loneliness
- 52 people shared their wellbeing stories to the wider public
- 3,020 pledges were made by people on how they would improve their wellbeing

Wellbeing for Life

Wellbeing for Life is an initiative running across Coventry & Warwickshire that has evolved from the success of the Year of Wellbeing. Its aim is to continue raising the profile of prevention opportunities and encourage people to be proactive about their own health & wellbeing.

The themes for 2021/22 tie into the local Health & Wellbeing Strategies focusing on:

- Promotion of health equality
- Supporting better mental health
- Overall healthier lifestyles for everyone

Wellbeing for Life aims to achieve these by continuing to engage with local communities, schools and workplace settings to provide support to deliver Wellbeing for Life initiatives.

MEASURING WELLBEING

ONS Annual Population Survey

The ONS Annual Population Survey asks respondents to evaluate, on a scale of 0-10:

- Overall, how satisfied are you with your life nowadays? (Where 0 is “Not at all satisfied” and 10 is “completely satisfied”)
- Overall, to what extent do you feel the things you do in your life are worthwhile? (Where 0 is “Not at all worthwhile” and 10 is “completely worthwhile”)
- Overall, how happy did you feel yesterday? (Where 0 is “Not at all happy” and 10 is ”completely happy”)
- Overall, how anxious did you feel yesterday? (Where 0 is “Not at all anxious” and 10 is “completely anxious”)

In the year ending March 2020, average ratings of life satisfaction, happiness and anxiety in the UK all deteriorated significantly compared to the year before, for the first time since 2011 (ONS Annual Population Survey). Therefore, there was already a decrease that was seen before the impacts of COVID-19.

Sadly information for many of these indicators is not available with a detailed breakdown at local authority level, however the national picture gives important insights into how people in Coventry and Warwickshire will be feeling and the trends triangulate with the data that is available at a local level.

WEMWBS

The Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) was developed to enable the monitoring of mental wellbeing in the general population and the evaluation of projects, programmes and policies which aim to improve mental wellbeing. A shortened version, Short Warwick- Edinburgh Mental Wellbeing Scale (SWEMWBS) uses seven of the WEMWBS’s 14 statements about thoughts and feelings, which relate more to functioning than feelings and so offer a slightly different perspective on mental wellbeing[33].

As part of the Coventry and Warwickshire mental health needs assessment survey all respondents were asked to complete SWEMWBS. The following statements were presented and scored between 1 and 5, where 1 is none of the time and 5 is all of the time (time period being the past two weeks).

- I’ve been feeling optimistic about the future

- I've been feeling useful
- I've been feeling relaxed
- I've been dealing with problems well
- I've been thinking clearly
- I've been feeling close to other people
- I've been able to make up my own mind about things

A scoring system for analysing SWEMWBS was used to calculate and allocate respondents to wellbeing categories. In the short version, individual average scores are always somewhere between 7 and 35. Scores can be interpreted in different ways but are frequently compared with the population norms in the Health Survey for England 2011 or allocated to wellbeing categories.

Scores have been allocated to wellbeing categories as depicted in Table 5.

Table 3. SWEMWBS Mental wellbeing categories

SWEMWBS mean score	Mental wellbeing
17 or less	Probable depression
18-20	Possible depression
21-27	Average mental wellbeing
28-35	High mental wellbeing

HOW WELLBEING HAS CHANGED OVER TIME

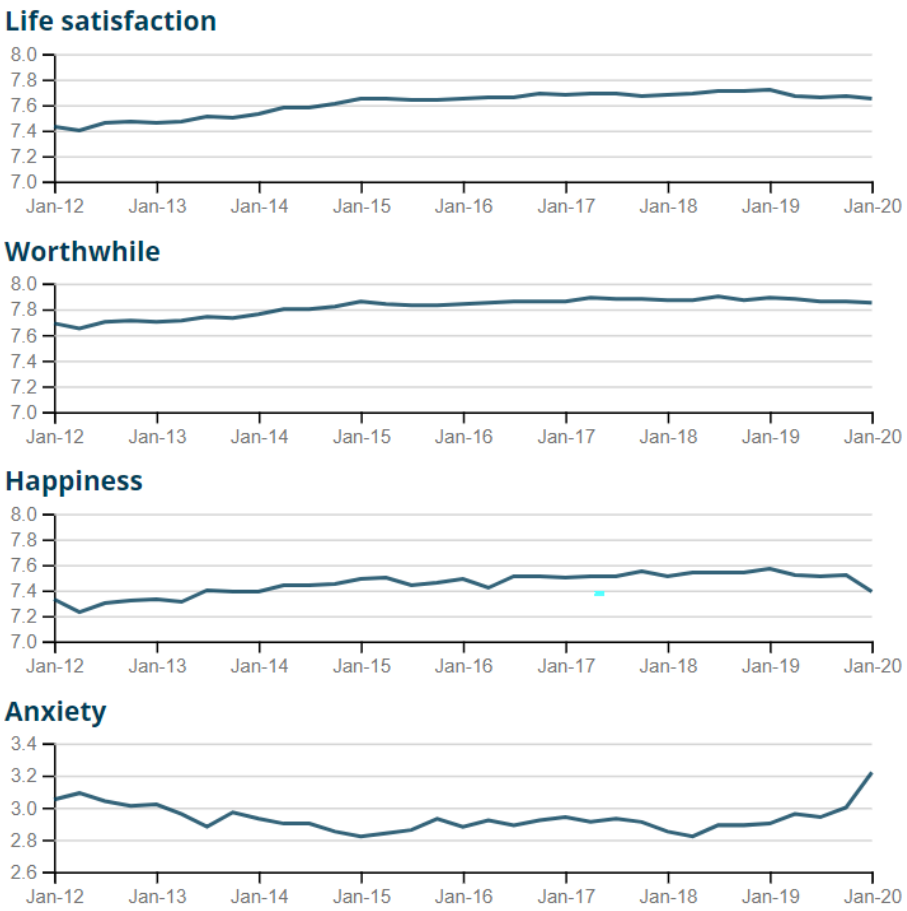


Figure 13. Wellbeing scores in the United Kingdom between 2012 and 2020
Source: ONS – Annual Population Survey

Broadly, mental wellbeing across all four of the indicators has been improving since data collection started in 2012. Average scores had year on year increases, and in this time period they established themselves as reliable indicators due to their consistency over time.

However, the year between March 2019 and March 2020 showed a potential inflection point and a change in the trend. At this point, average life satisfaction, happiness and self-worth began to drop, changes in averages in this way would typically imply that more people were reporting significantly worse mental wellbeing, rather than it being a general shift in the population as a whole which would be difficult to perceive. The indicator for anxiety also saw a significant change with more people reporting they had higher levels of anxiety.

Although the survey period ended with the start of the pandemic, the surveys were carried out throughout the year and the change had started before March 2021, and so such a significant change across all indicators is unlikely to be related to COVID-19[34].

The surveys continued to run over the pandemic and used Feb 2020 as a baseline to understand how mental wellbeing has been affected since the first lockdown.

Unsurprisingly there was a significant impact on anxiety, particularly at the point of the first lockdown, with a large increase in March 2020 – comparing it to the lowest point on record in 2015 on average people reported to being twice as anxious. Happiness also dropped at this point, although satisfaction and self worth remained fairly similar to before the pandemic.

The second important pandemic related impact to note occurred in around January 2021, after rates had increased the previous month. This was the important factor on mental wellbeing at the time as it's difficult in the data to pick out any other positive trends that may have been related to the December holidays.

In January, lower levels of life satisfaction, happiness and self-worth were seen than at any time since the data started to be collected. Similarly, anxiety rose. The January lockdown had the biggest impact on mental wellbeing to date therefore, although there were some signs of improving wellbeing by March.

A critical question will be the length of time and interventions needed to return the population to pre-pandemic levels of good mental wellbeing, and which groups may need targeted support. This needs to be seen alongside other factors that contribute to people's resilience and will help people to improve their mental health.

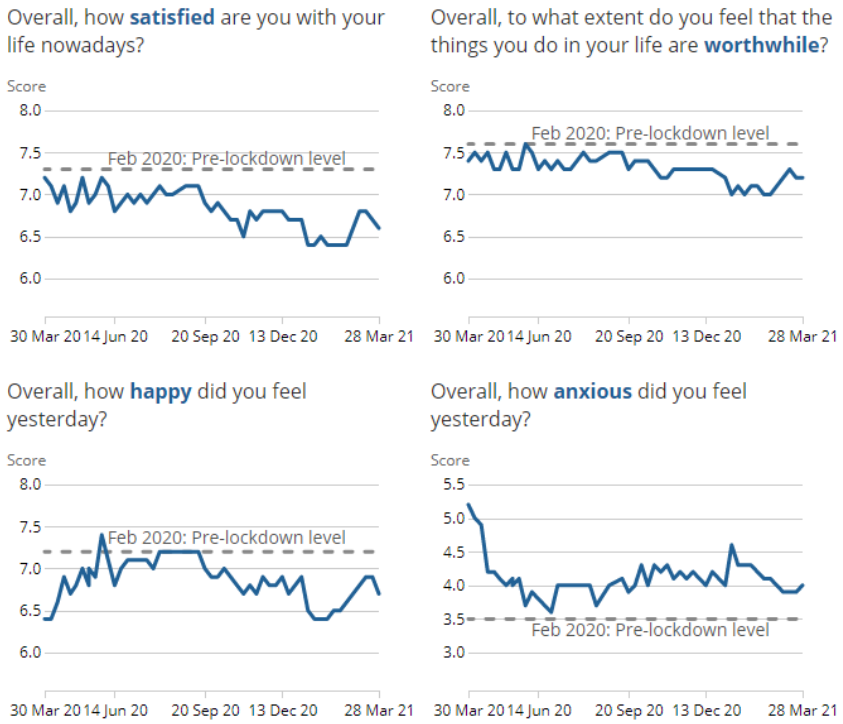


Figure 14. Wellbeing scores in the United Kingdom between March 2020 and March 2021
Source: ONS – Opinions and Lifestyles Survey

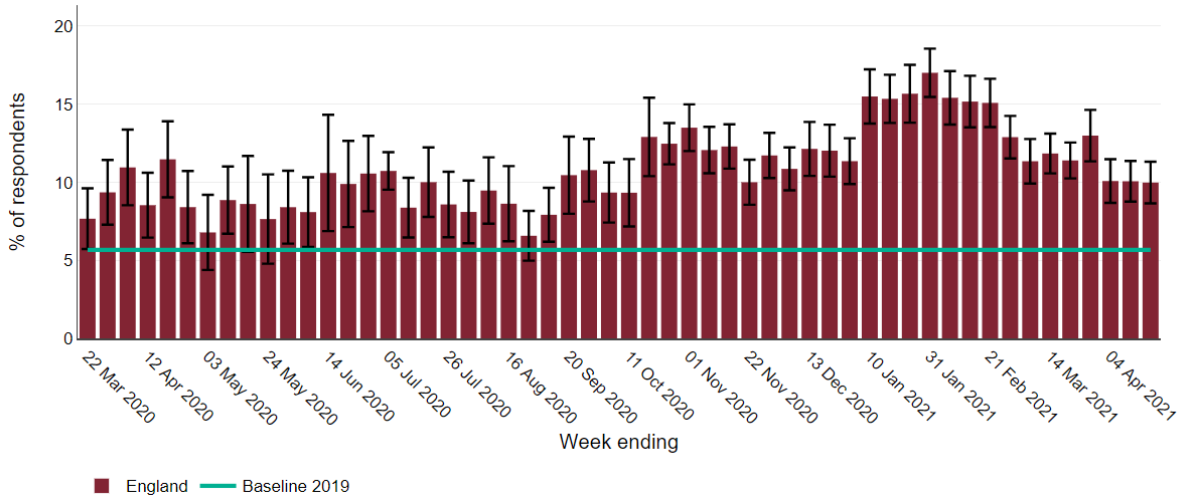


Figure 15. Trend in percentage of respondents with low life satisfaction (score 0-4 out of 10) in England
Source: PHE Fingertips

A survey by the Mental Health Foundation and university partners conducted by YouGov across the UK showed worsening mental health during the pandemic from March to November, with the extent of loneliness rising from 10% in March to 25% in November 2020. Those saying they were "coping well with the stress of the pandemic" fell from 73% to 62% in the same time period. However, those reporting feeling anxious or worried over the previous week because of the pandemic fell from 62% in March to 45% in November[35].

WHAT INFLUENCES PERSONAL WELLBEING

With an aim to understanding the factors that contribute to personal resilience, analysis was conducted of the wellbeing survey looking at personal characteristics, and comparing against a baseline from 2019.

Some of this analysis suggests at factors that can help to improve resilience and mental wellbeing.

Gender

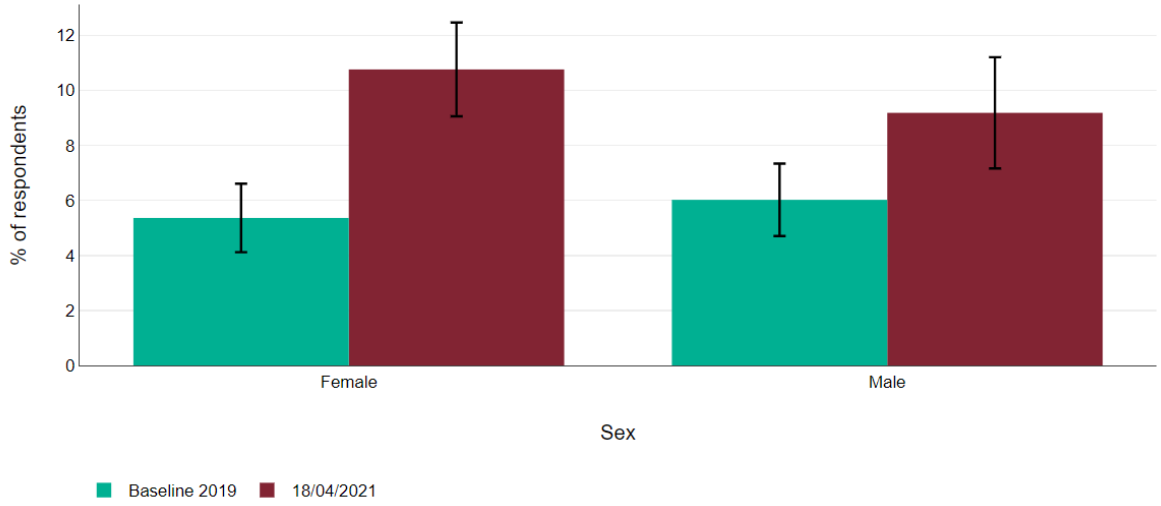


Figure 16. Percentage of respondents with low life satisfaction (score 0-4) in England, by sex – 2019 compared with most recent time period
Source: PHE Fingertips

Prior to the pandemic, life satisfaction was broadly the same between men and women, although men were ranked slightly worse. About 6.0% of men and 5.4% of women reported low life satisfaction, although it is hard to statistically differentiate between the two.

However, the pandemic reduced life satisfaction for both genders, the impact was not even. Compared to before the pandemic twice as many women reported low life satisfaction in April 2021, and at 10.8% is one in every 10 women. Statistically this was unlikely to be due to chance. There was an impact on men too with 9.2% reporting low life-satisfaction.

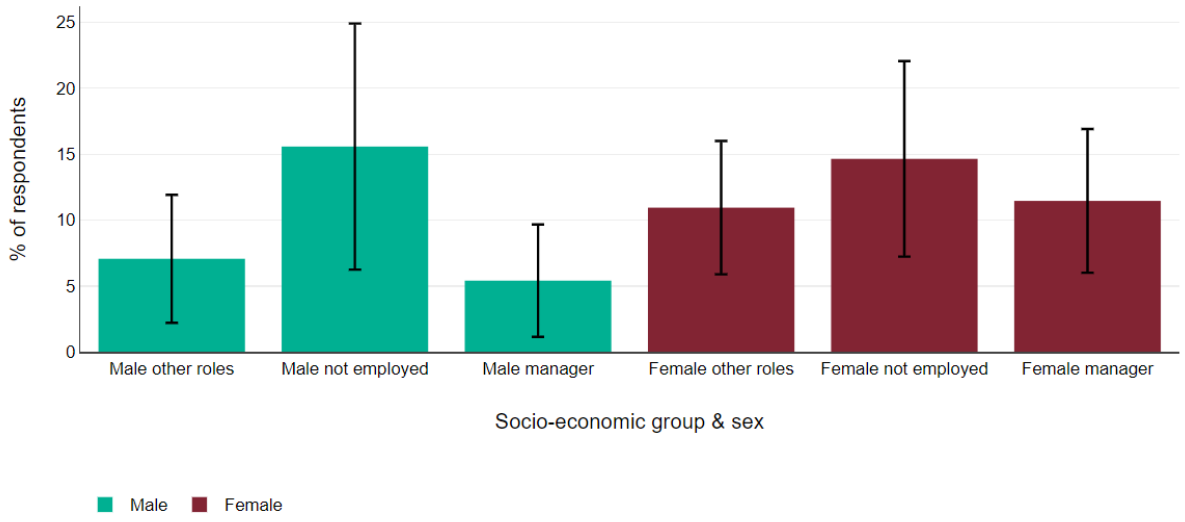


Figure 17. Percentage of respondents with low life satisfaction (score 0-4) in England, by socio-economic group and sex – for the last time period
Source: PHE Fingertips

Some further insight can be found by looking at the employment status of men and women in April 2021 and how that impacted on life satisfaction. The largest differences between the genders is amongst women in employment, where there were higher levels of life satisfaction than similarly employed men.

This may be related to differences in the types of roles that men and women do, or relate to the additional impact of traditional gender roles. Certainly, being in a managerial position was not protective against the reduced low life satisfaction amongst working women compared to men.

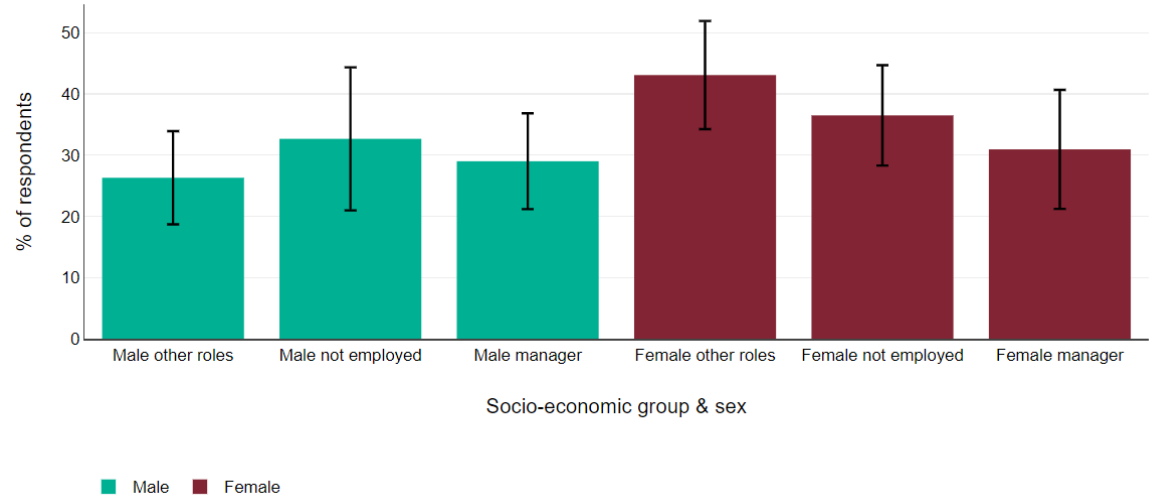


Figure 18. Percentage of respondents with high anxiety (score 6-10) in England, by sex – 2019 compared with most recent time period
Source: PHE Fingertips

The difference in impact of working during the pandemic on the wellbeing of women can also be seen when looking at anxiety. In this instance there is a difference between men and women working in roles that are not managerial with women reporting much higher anxiety levels. 43.1% of all women in these roles report high anxiety compared to 26.3% of men.

Age

There are also differences in mental wellbeing by age due to the pandemic. Similar to the overall trend, all age groups appear to have worsening mental wellbeing across all indicators.

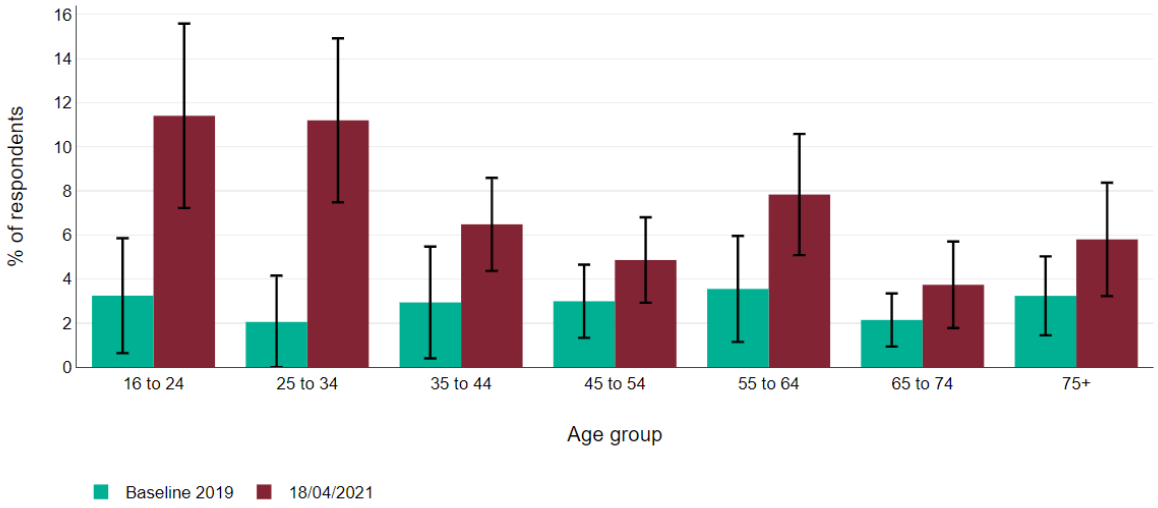


Figure 19. Percentage of respondents with low self-worth (score 0-4) in England, by sex – 2019 compared with most recent time period
Source: PHE Fingertips

Historically there were higher levels of low self-worth amongst working age adults between the ages of 55 to 64, with 25 to 34 year olds having the highest levels. However, there are indications that the pandemic has had a much deeper impact on the wellbeing of adolescents and young adults.

Compared with 2019, around three times as many 16 to 24 year olds have low self worth. This is now one in every ten adults of this age group. The sharp rise has also been seen in 25 to 34 year olds where there is the same prevalence of low self worth, although in this instance the rise was six-fold.

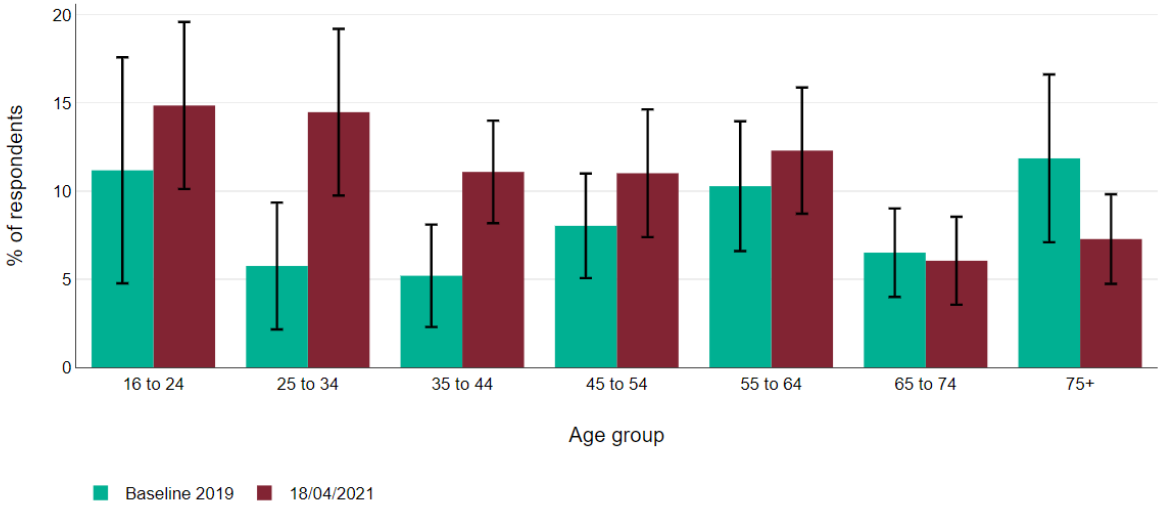


Figure 20. Percentage of respondents with low happiness (score 0-4) in England, by sex – 2019 compared with most recent time period
Source: PHE Fingertips

This impact is shown in other measures, and there was an increase in unhappiness amongst 25 to 34 year olds. To some extent it seems that being older was protective against increasing unhappiness during the pandemic.

Socioeconomic Status

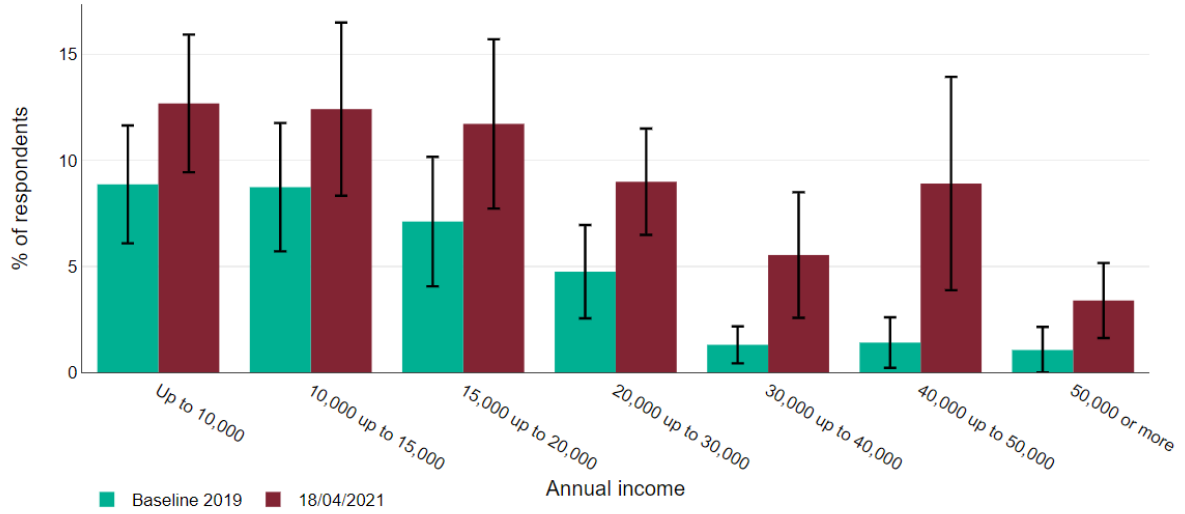


Figure 21. Percentage of respondents with low life satisfaction (score 0-4) in England, by annual income – 2019 compared with most recent time period
Source: PHE Fingertips

Historically people who earn less have had worse mental wellbeing, with life satisfaction being strongly related to income. Only 1.3% of people earning above £30,000 in 2019 reported low life satisfaction. This compared against 8.4% of people who earnt less than £20,000.

The pandemic seems to have changed that relationship - although a gradient still prevails, and having a higher salary during the pandemic was not as protective. Of people earning £30,000 or more typically indicated a 5.5% reported low life satisfaction, compared to 12.3% of those earning less than £20,000.

House ownership also shows some of the reasons behind worse mental wellbeing. Prior to the pandemic, levels of anxiety were similar across people who owned their houses outright, had a mortgage on a property, or rented a property, at around 1 in every 5 people reporting high anxiety. There has been an increase across all groups, but with anxiety in renters almost doubling to 2 in every 5 people reporting high levels of anxiety.

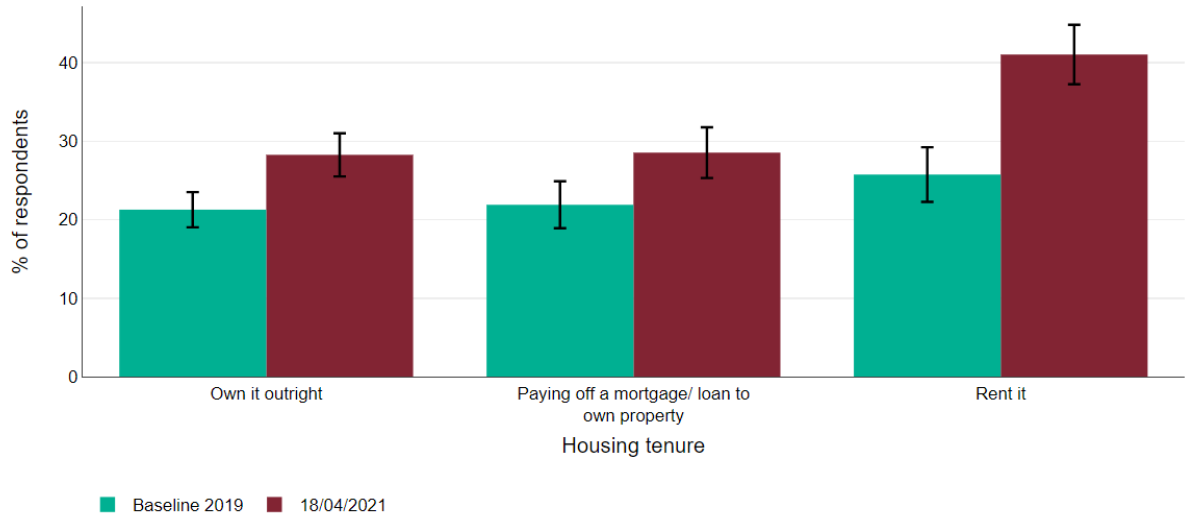


Figure 22. Percentage of respondents with high anxiety (score 6-10) in England, by housing tenure – 2019 compared with most recent time period
Source: PHE Fingertips

Similarly other surveys carried out specifically during the pandemic identified that people who were unemployed were more likely to report that they weren't coping with stress related to the pandemic. By November 2020, around half of everyone who was unemployed reported they were not coping with the stress.

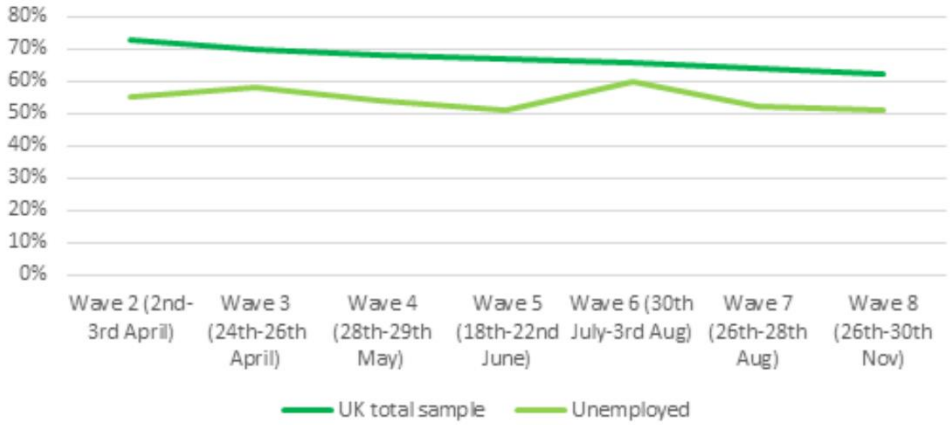


Figure 23. Percentage of respondents who felt they were coping with COVID-19 pandemic related stress fairly or very well.
Source: YouGov Plc

UNDERLYING HEALTH CONDITIONS

Underlying Health Conditions

There is a close relationship between mental wellbeing and health. Having an underlying health condition can be both a cause and consequence of poor mental health.

Again, this can be seen in some of the data from April 2021, and around 40% of people with an underlying health condition reported high levels of anxiety, compared with 30% of people without.

Notably this comparison is not on a like-for-like basis, and it might be expected that people with underlying health conditions are older. Similarly this chapter has already presented some of the higher anxiety levels seen in younger people.

Although the survey data is not available in a format where a like-for-like comparison can be presented, it may be that there the difference in anxiety levels are more pronounced comparing between older age groups with and without an underlying health issue.

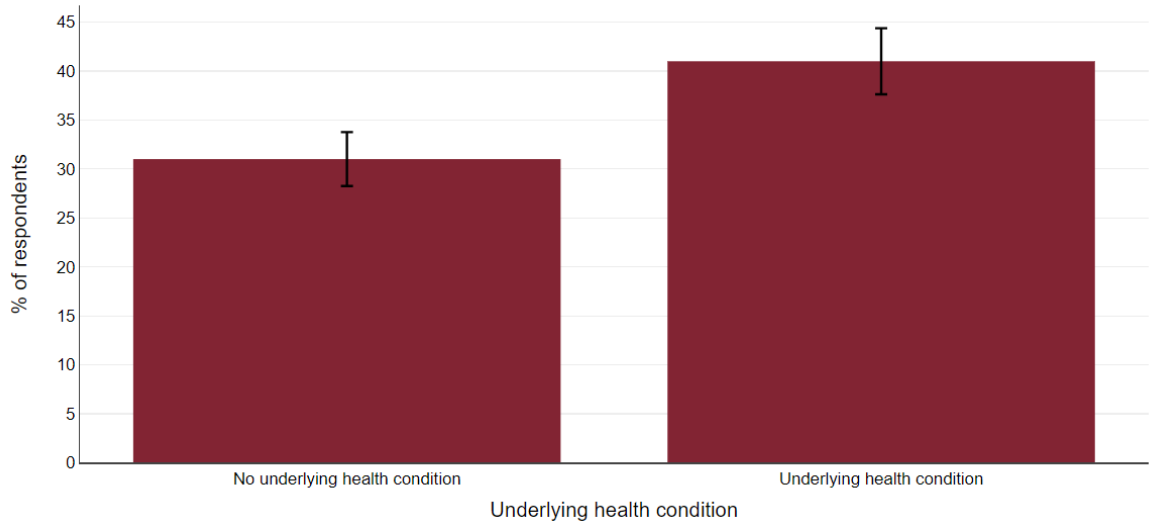


Figure 24. Percentage of respondents with high anxiety (score 6-10) in England, by underlying health condition – for the latest time period
Source: PHE Fingertips

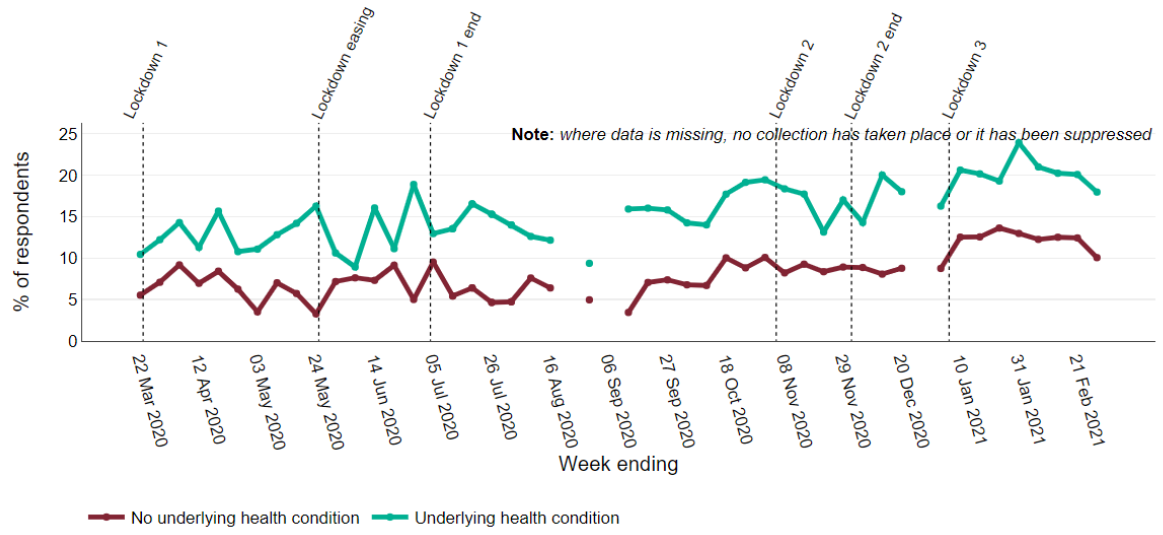


Figure 25. Trend in percentage of respondents with low life satisfaction (score 0-4) in England, by underlying health condition
Source: PHE Fingertips

People with underpinning health conditions have lower life satisfaction too, similar to the rest of the population this was exacerbated throughout the pandemic, and is particularly high during the January lockdown.

Physical Activity

Physical activity has been shown to improve mental wellbeing. This can be through improved sleep, the release of certain hormones, reducing stress, improving self-esteem and providing opportunities to connect with others[36].

Table 4 illustrates shows that, on the whole, a smaller percentage of both Coventry and Nuneaton and Bedworth populations have engaged in at least 150 minutes of moderate intensity exercise per week than the English average and other areas of Warwickshire.

Table 4. Weighted number of respondents aged 19 and over, with valid responses to questions on physical activity, doing at least 150 moderate intensity exercise minutes physical activity per week in bouts of 10 minutes or more in the previous 28 days.

Area	2015/16	2016/17	2017/18	2018/19
North Warwickshire	62.2%	62.9%	63.0%	66.5%
Nuneaton and Bedworth	62.6%	60.4%	61.1%	60.2%
Rugby	65.2%	64.0%	66.2%	66.6%
Stratford-on-Avon	68.1%	71.7%	69.8%	69.6%
Warwick	74.1%	68.4%	72.1%	71.9%
Warwickshire	67.2%	65.9%	67.0%	67.1%
Coventry	62.3%	59.3%	60.6%	61.1%
West Midlands	63.8%	62.6%	63.2%	64.0%
England	66.1%	66.0%	66.3%	67.2%

Source: Fingertips PHE, Sport England Active Lives Survey
Compared with England, green = better 95%, amber = similar, red = worse 95%

Sport England reported that their survey at the beginning of the pandemic suggests that 3 million people in England were less active during March to May 2020 than they were during March to May 2019, however there were increases in some activities, particularly cycling for leisure, running and walking for leisure. Sport England report linked the increase in inactivity with a decrease in wellbeing, showing that the biggest decrease in happiness score (out of 10) from 2019 to 2020 was for those who were inactive. Therefore with more people inactive in the period in 2020, fewer are getting the benefits associated with being active or fairly active. (“active” = 150 minutes a week, “fairly active” = 30-149 minutes a week, and “inactive” = less than 30 minutes a week)

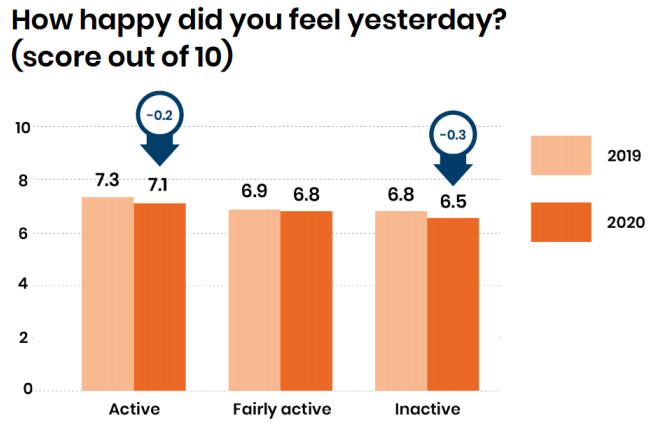


Figure 26. Average self-reported happiness scores of individuals by activity level
Source: Sport England

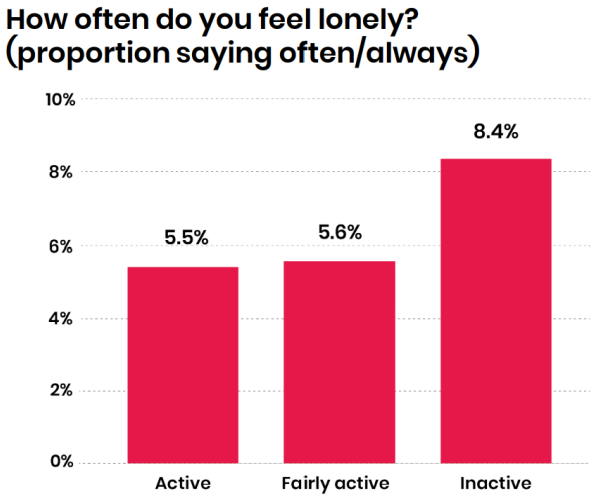


Figure 27. Proportion of individuals reporting loneliness by activity level
Source: Sport England

HOW DOES WELLBEING VARY BETWEEN PLACE

The ONS Annual Population Survey ratings for personal wellbeing can be compared across place and do demonstrate some trends. However, fluctuations in the data mean that findings should be interpreted with caution.

Table 5 shows that North Warwickshire and Stratford-on-Avon have the highest levels of life satisfaction, Rugby residents have the highest rating of their lives being worthwhile, Warwick residents have the highest ratings of happiness and North Warwickshire has the highest average ratings of anxiety.

Table 5. Average ratings for Personal Wellbeing, 2019/20

Area	Life Satisfaction	Worthwhile	Happiness	Anxiety
North Warwickshire	7.89	8.02	7.69	3.16
Nuneaton and Bedworth	7.59	7.80	7.24	2.78
Rugby	7.87	8.26	7.59	2.96
Stratford-on-Avon	7.89	8.08	7.74	2.52
Warwick	7.75	7.86	7.88	2.33
Warwickshire	7.78	7.99	7.63	2.69
Coventry	7.57	7.71	7.46	2.99
England	7.66	7.86	7.48	3.05

Source: ONS

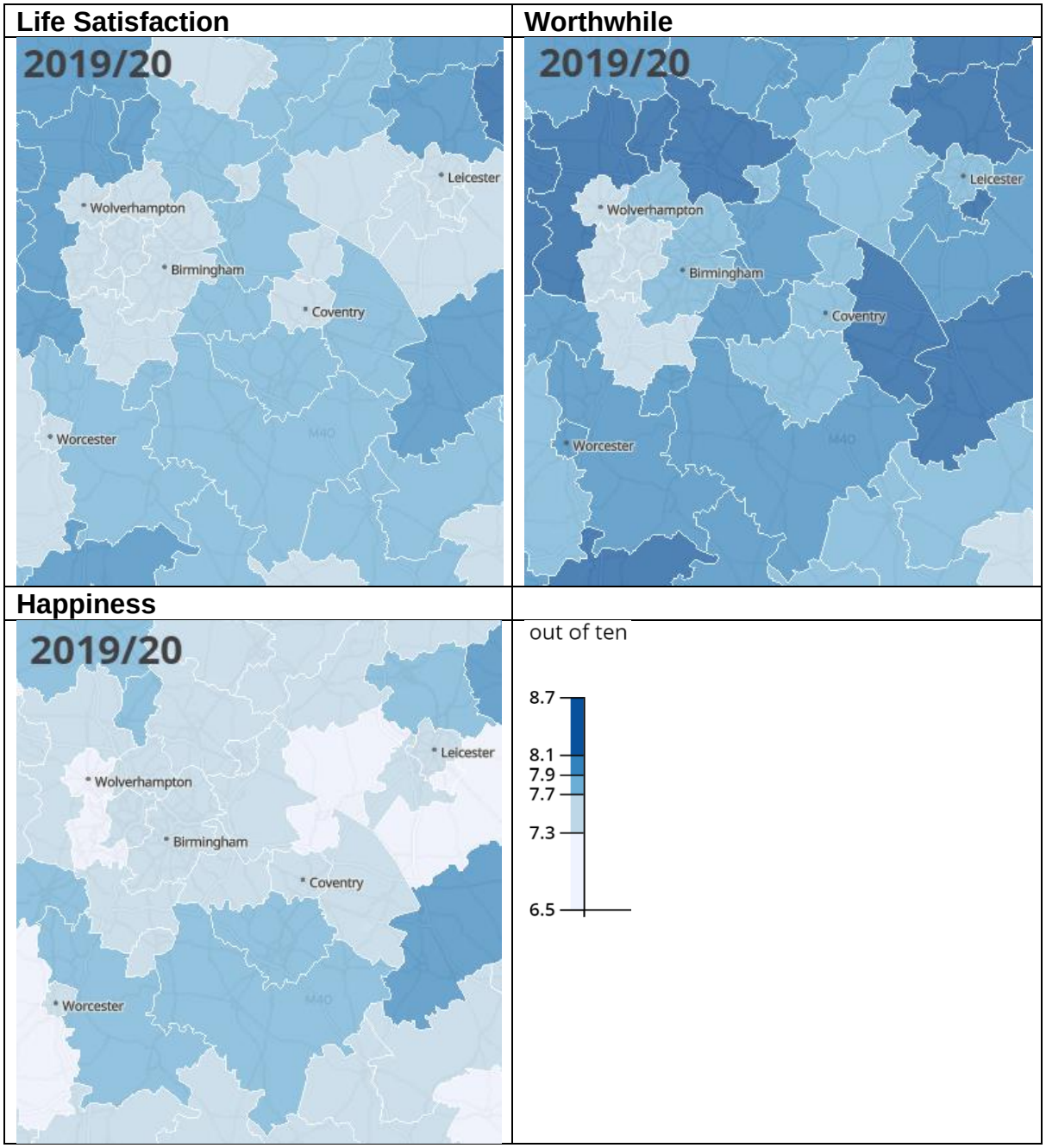


Figure 28. Average ratings of personal wellbeing (life satisfaction, worthwhile and happiness) taken from the Annual Population Survey in Coventry and Warwickshire in 2019/20
Source: ONS

Anxiety

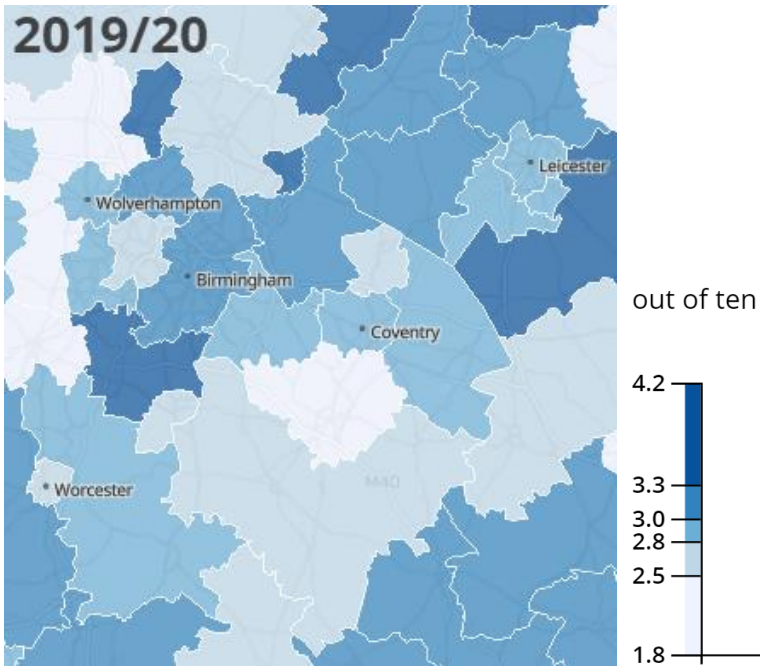


Figure 29. Anxiety levels taken from the Annual Population Survey in Coventry and Warwickshire in 2019/20
Source: ONS

Trends in life satisfaction by place

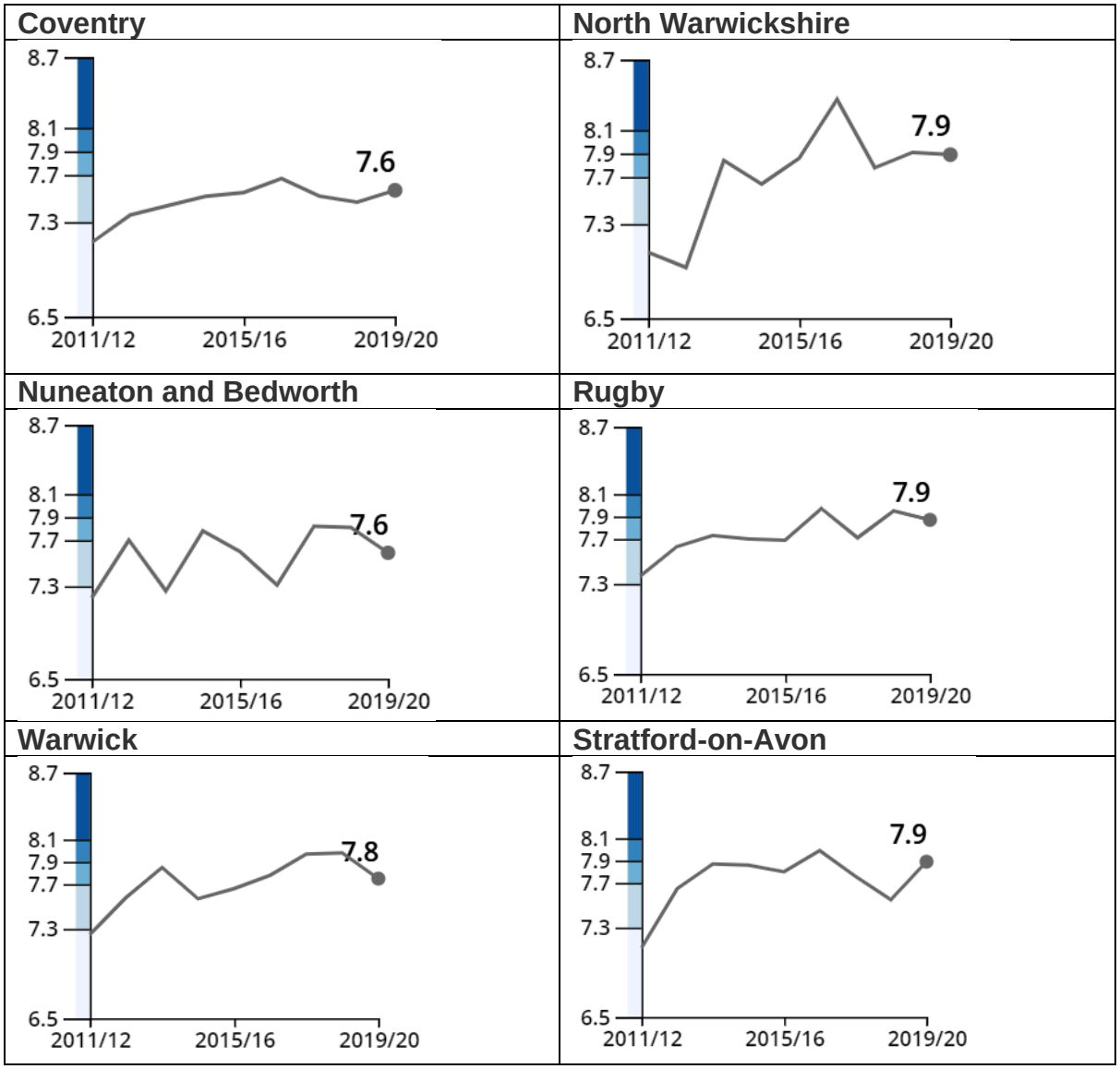


Figure 30. Trends in life satisfaction taken from the Annual Population Survey in Coventry and Warwickshire in 2019/20
Source: ONS

Similar to the national trends, life satisfaction in Coventry and Warwickshire has increased since 2011/12. The improving life satisfaction seems to have been less pronounced in Nuneaton and Bedworth, and Coventry. Both of these local authority areas are also in the 40% of areas with lowest life satisfactions in England.

The national reductions in life satisfaction in 2019/20 have been reflected locally, and all areas have seen a plateau or decline which visually looks to have started earlier than the national reduction.

Trends in self-worth by place

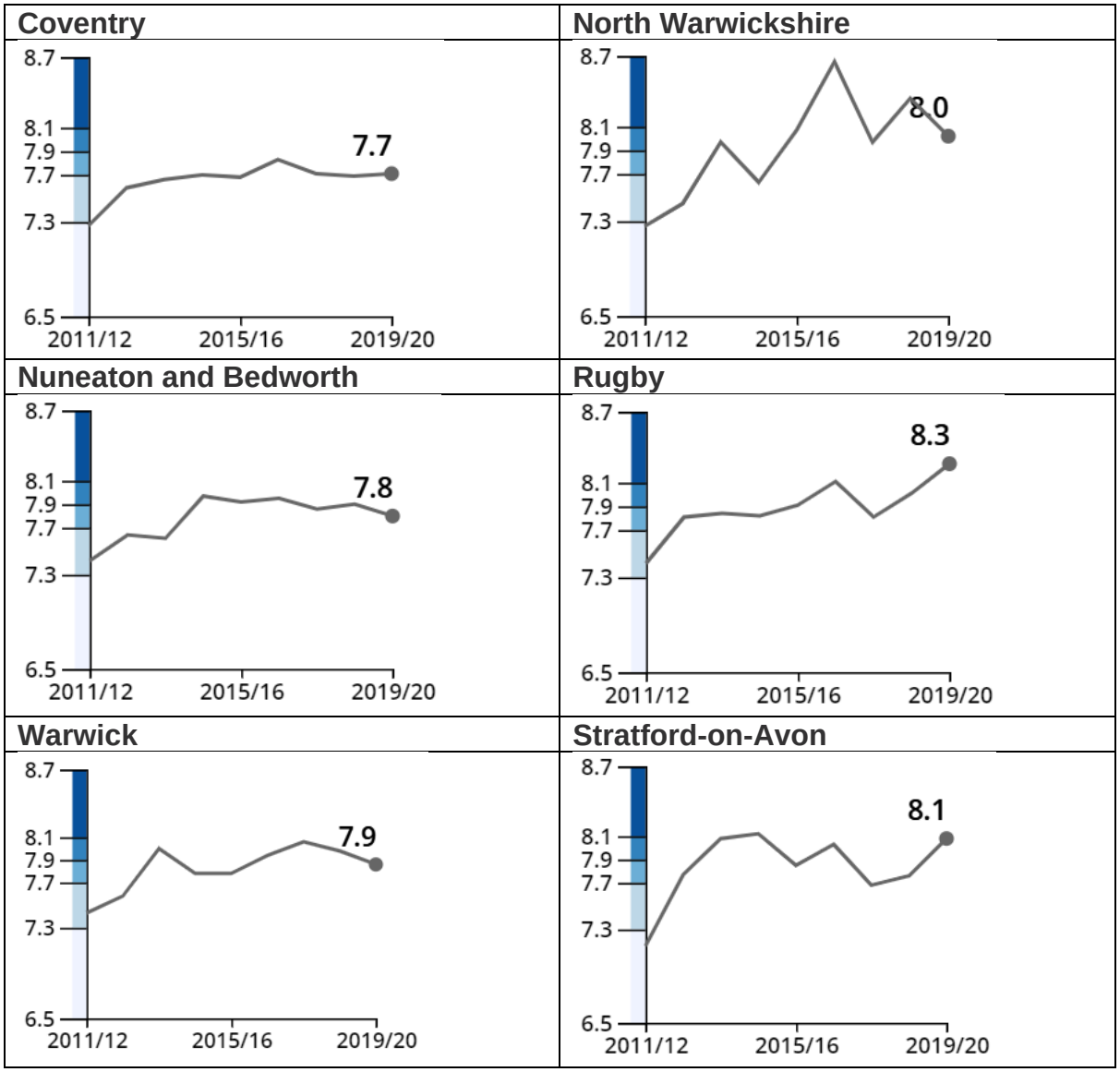


Figure 31. Trends in self-worth taken from the Annual Population Survey in Coventry and Warwickshire in 2019/20
Source: ONS

There was far more variation in self-worth between places than in life satisfaction. Even though there has been a general national improvement over time, Coventry, Nuneaton and Bedworth, and Warwick Local Authority areas have broadly plateaued – however they have done so at around national average levels of self-worth.

Despite all areas having broadly similar levels of self-worth in 2011/12, Rugby has seen larger improvements over time and is in the 20% of areas where residents report the highest self-worth.

Trends in happiness by place

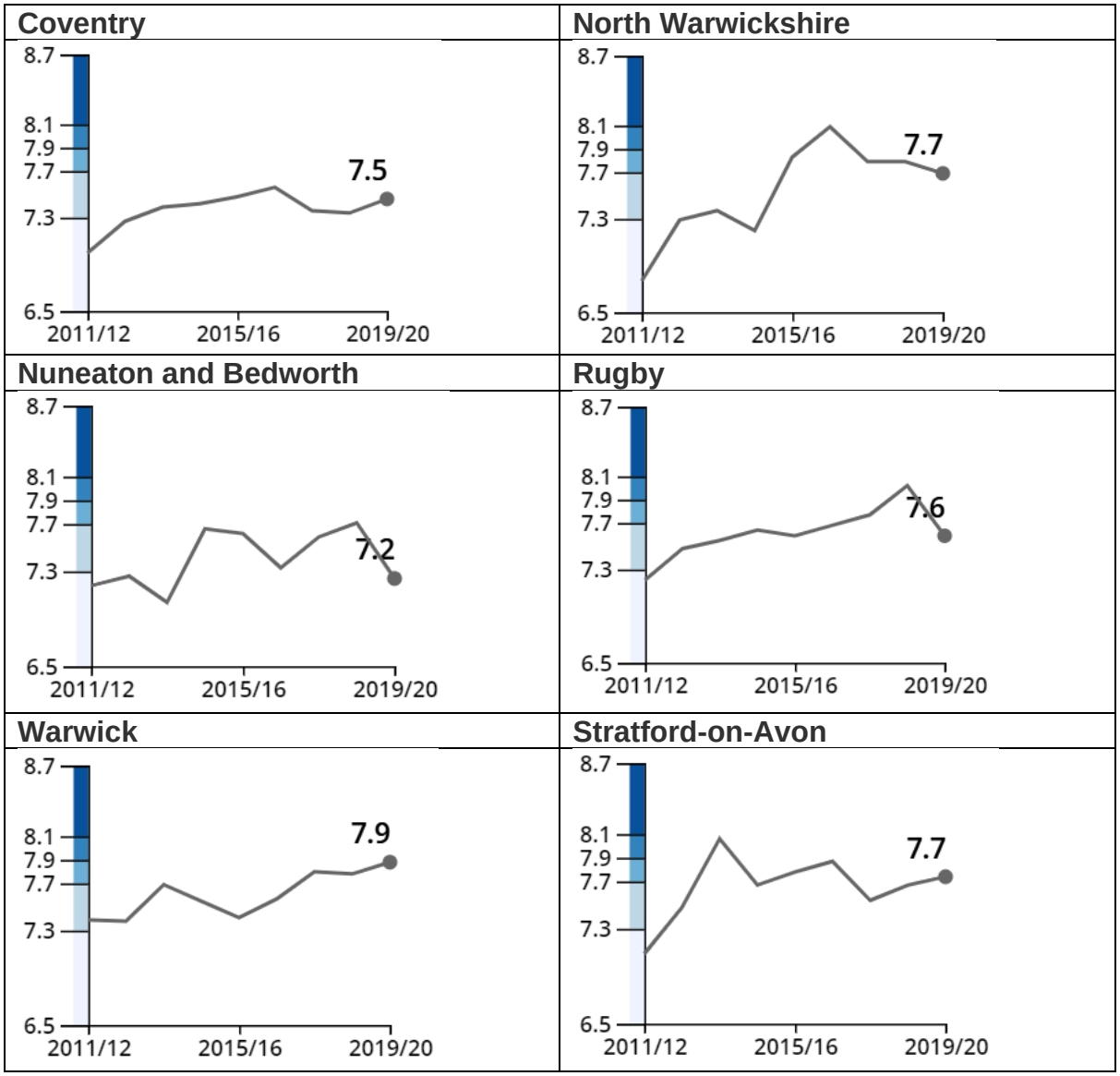


Figure 32. Trends in happiness taken from the Annual Population Survey in Coventry and Warwickshire in 2019/20
Source: ONS

In 2019/20 there appeared to be less variation between regions although the trends over the last 10 years were different. Coventry and Warwickshire generally had lower levels of happiness than the national average, and everywhere other than Warwick is in the bottom 40% of all Local Authority areas.

The national decrease in happiness was also reflected locally, with significant drops in both Nuneaton and Bedworth, and Rugby in 2019/21.

Trends in anxiety by place

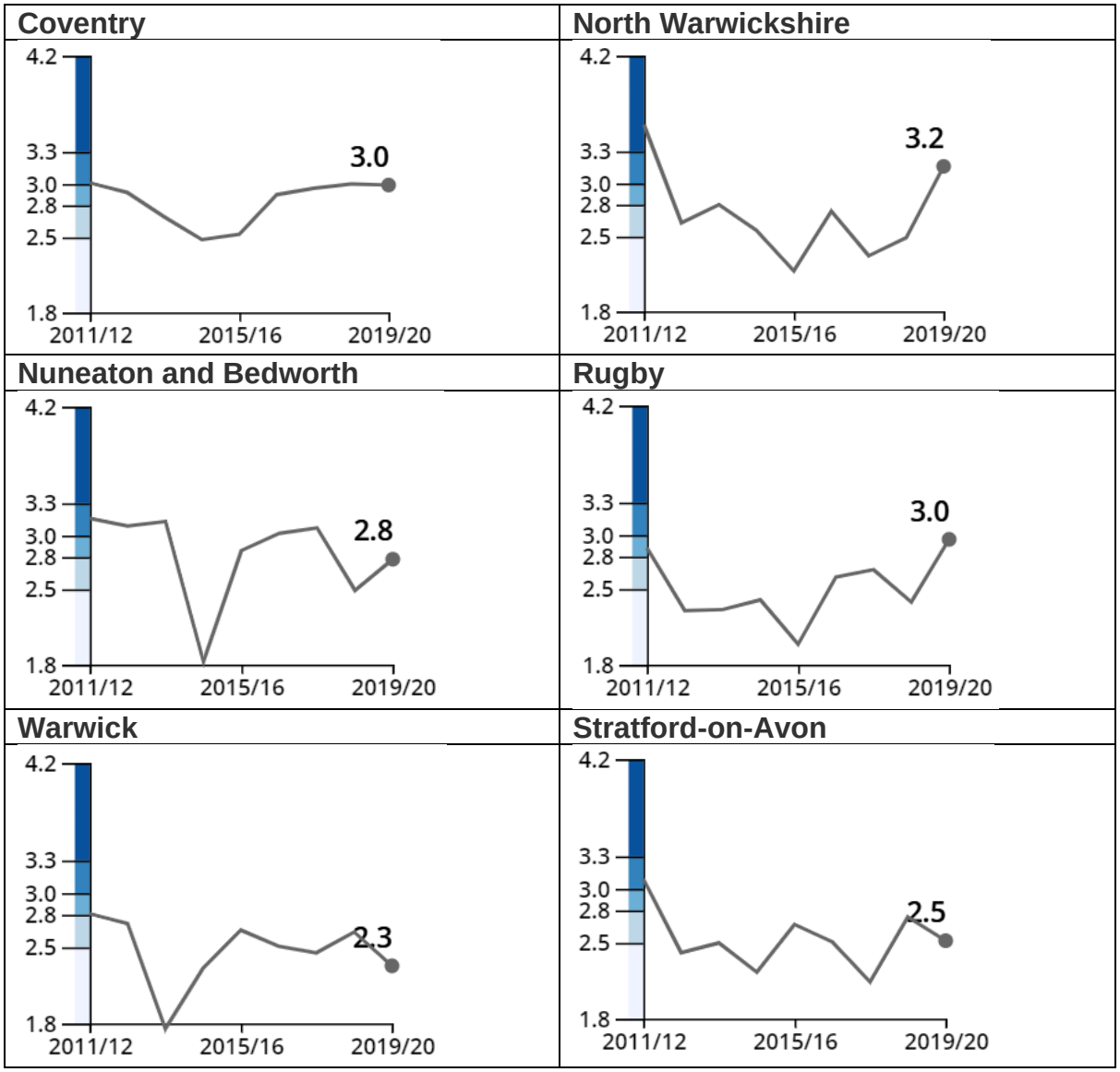


Figure 33. Trends in anxiety taken from the Annual Population Survey in Coventry and Warwickshire in 2019/20
Source: ONS

There was variation in anxiety across Coventry and Warwickshire. Although the region has compared poorly to other places on other measures of wellbeing, some areas did show lower levels of anxiety, and Warwick and Stratford were in the 20% of areas with lowest levels of reported anxiety.

In line with the national sharp increase in anxiety in 2019/20, both Rugby and North Warwickshire also saw large increases, although this was not reflected in other areas.

WCC COVID-19 RECOVERY SURVEY

In August and September 2020 a COVID-19 Impacts and Recovery Survey was launched by Warwickshire County Council to gain insight into the impact of the pandemic on the health behaviours and wellbeing of local residents. A range of questions were asked about knowledge of COVID-19, Test and trace, health, employment, volunteering and future priorities. The survey had 2,500 respondents from across Warwickshire. An outline of the findings can be found in Appendix 3.

Respondents were asked about how worried they felt in relation to a number of different COVID-19 stressors e.g. risk of becoming infected with COVID-19, loss of current job security or income. Nearly 50% of people surveyed were very or extremely worried about the risk of someone becoming infected with COVID-19. Over 40% of people were very or extremely worried about changes to social routines (e.g. spending free time with loved ones/friends) and potential changes to the national or global economy (e.g. future job prospects).

Specific groups were more likely to report increased COVID-19 stressors as follows:

- Younger people (18-29 year olds) reporting of stressors was 24% higher than in over 75s
- Women reporting of stressors was 13.2% higher than in men
- People with self reported pre existing mental health conditions reporting of stressors was 15.6% higher than in people without
- Self employed or not in employment (excl. retired) reporting of stressors was 9.6% higher
- Working, but not living, in Warwickshire reporting of stressors was 17.5% higher

COVID-19 stressors were found to impact wellbeing and loneliness:

- Increased COVID 19 stressors negatively impacted mental wellbeing and loneliness
- Stressors were measured from 1 (not at all stressful) to 4 (extremely stressful) and average scores were calculated across questions
- An increase of 1 on the COVID stressors score was associated with a 4 point decrease* in wellbeing scores (total possible score 7 - 35) and a 1.1 point increase in loneliness (total possible score 1 - 5).

*adjusting for pre existing mental health condition, shielding status, age, gender, ethnicity, religion, employment status, and Warwickshire district

When asked about loneliness and mental wellbeing half of respondents stated that they experienced loneliness; with 15% of participants reported feeling lonely “always” and 35 % reported feeling lonely occasionally or “some of the time.”

People who reported increased loneliness and reduced mental wellbeing were significantly more likely to be: younger, women, people with pre-existing mental health conditions, not in employment (excl. retired).

Participants living in Rugby, Nuneaton and Bedworth and those working (but not living) in Warwickshire also reported significantly lower mental wellbeing than other districts/boroughs.

The association between COVID-19 stressors and wellbeing was significantly mediated by some health behaviours

- Engaging in healthy behaviours 1.1 point increase in wellbeing
- Taking time to relax 1.4 point increase in wellbeing
- Increasing alcohol 0.6 point decrease in wellbeing
- Increasing eating 0.6 point decrease in wellbeing
- Increasing high fat and sugar foods 0.8 point decrease in wellbeing

Helping others was associated with a 0.3 point decrease in loneliness and a 0.8 point increase in wellbeing (after controlling for COVID-19 stressors and demographics).

COVENTRY AND WARWICKSHIRE MENTAL HEALTH NEEDS ASSESSMENT SURVEY

The local mental health needs assessment survey, carried out in March 2021, asked residents and professionals a range of questions about mental wellbeing and also the impact of COVID-19 on wellbeing. High level findings include:

- Around 3 in 4 of respondents who are currently employed (75.1%/n=343) felt that their workplace actively promoted the mental health and wellbeing of employees.
- Nearly two thirds (62.6%/n=290) of respondents who are currently employed felt that their workplace was supportive of employees who have mental health difficulties.
- One of the positive impacts of COVID-19 on mental health for some people was spending more time with people in their family with 60.2% (n=293) of respondents indicating that the impact was either positive or very positive.

Table 6. SWEMWBS mean scores by respondent type

Respondent category	SWEMWBS mean score
All	**21.05**
Public	21.92
Professionals	21.77
Public mental health service users	19.49

Table 6 shows the mean scores by respondent type. The overall average score for all respondents corresponded with the category 'average mental wellbeing' but is lower than the population mean (23.61) found in the Health Survey for England 2011[37]. According to the responses, the professional and public categories of respondents had scores which corresponded with, 'average mental wellbeing', while public mental health service users had a lower mean score. Additionally, respondents who were professionals had a lower mean score than respondents categorised as public. Care should be taken in comparing these scores because of differences in the sample size and profiles of the categories being compared.

When asked "How often do you feel confident talking to people about your mental health and wellbeing?" A third of respondents who answered this question (33.4%/n=192) indicated that they felt confident talking to people about their mental health and wellbeing 'some of the time'. However, just over 1 in 4 respondents (26.0%/n=150), only felt confident talking about their mental health either 'rarely' or 'none of the time'.

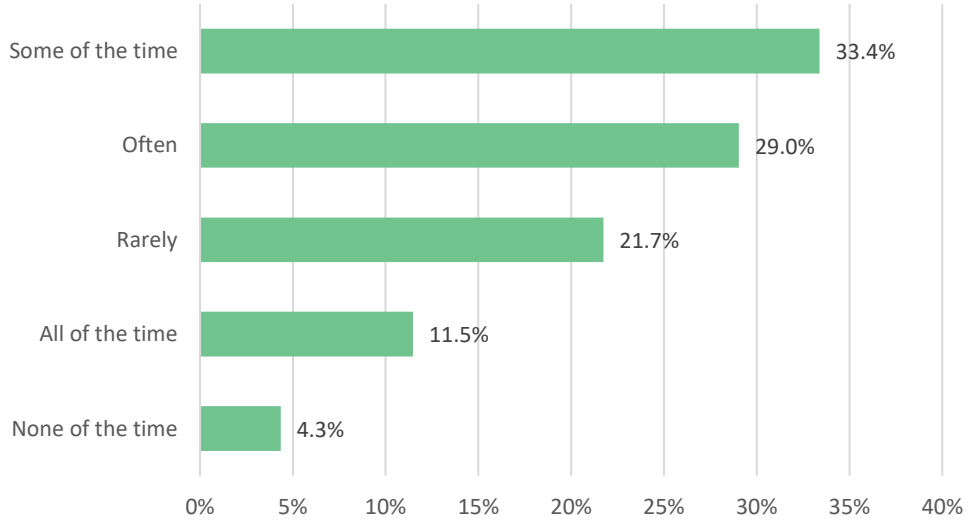


Figure 34. How often respondents feel confident talking to people about their mental health and wellbeing
Source: Coventry and Warwickshire Mental Health Needs Assessment Survey

Impacts on mental health and wellbeing

All respondents were asked about the impact that certain changes have had on their mental health and wellbeing since March 2020. Respondents who did not answer or respondents who answered 'not applicable' were not included in the analysis of this question. The results are illustrated in Figure 35 below.

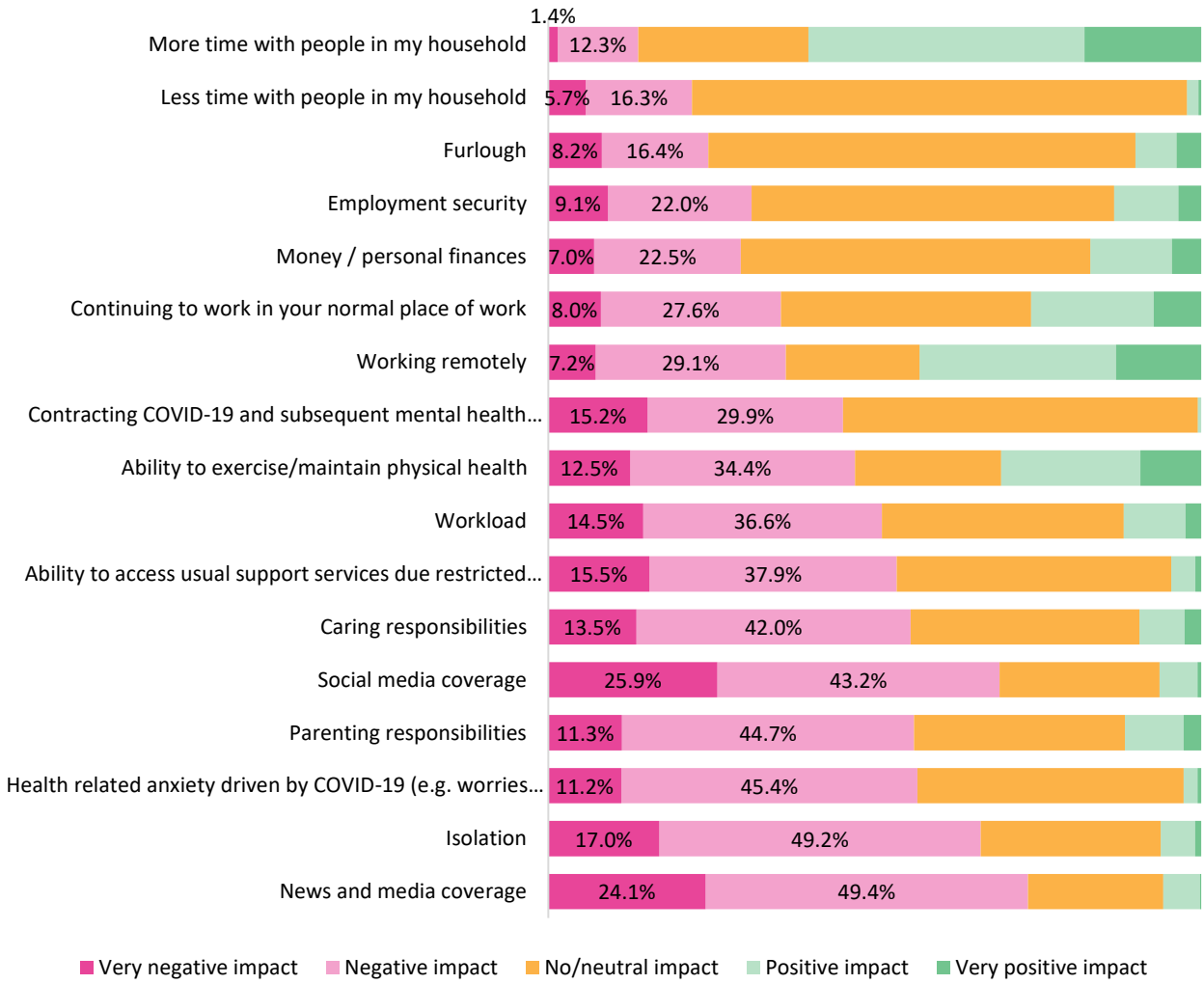


Figure 35. "What impact have the following had on your mental health and wellbeing since March 2020?" - All respondents
Source: Coventry and Warwickshire Mental Health Needs Assessment Survey

As Figure 35 shows, almost three quarters of all respondents who answered this question (73.5%, n=415) stated news and media coverage had a negative impact (either negative or very negative) on their mental health and wellbeing. Respondents talked about having to actively manage or limit their exposure to news content. Furthermore, social media coverage (69.1%, n=358) and isolation experienced from COVID-19 restrictions (66.2%, n=351) were also perceived to have had a very negative or negative impact on respondents' mental health and wellbeing since

March 2020. One respondent noted *"there is no doubt that social isolation because of Covid has made things worse for many people."*

On the other hand, 60.2% (n=293) respondents suggested that more time with people in their household, 43.1% (n=185) stated working remotely, and 30.6% (n=171) felt the ability to exercise and/or maintain physical health had a positive or very positive impact on their mental health and wellbeing.
A number of respondents reflected on the impact of the COVID-19 pandemic and its impact upon individuals:

"Encourage general public to be aware of people who are isolated or in need and offer help, friendship, chat or simple kindness"

"I think following the covid-19 pandemic a lot of people are going to struggle with mental health problems."

"Life has been very strange, and sometimes difficult, and I do think it will take a little time for people to get used to going out, socialising and being able to behave normally"

Respondents were also asked to expand on their answers to the above question and these are summarised below by respondent type (although there were several overlapping themes).

Public - non-service users

- Reference was made to the content of news and social media. Mostly this related to feeling overloaded by COVID-19 coverage – constant negative or 'depressing' coverage, concern about misinformation/trusted sources of information and a sense of conflicting and frequently changing information being presented.
- The usual coping strategies people had for maintaining mental health and wellbeing were disrupted during the pandemic e.g. Meeting friends, absence of team sports etc. and this in turn impacted on people's mental health.
- Impact of having to change plans for major events like weddings and the stress this caused were also highlighted.

Public – Mental health service users

- News and social media content were highlighted as impacting on mental health in similar ways to that noted above. Respondents talked about actively managing their exposure to the news and social media, being selective about what they watched or listened to or even avoiding news broadcasts altogether.

- Concerns about COVID-19 safety measures – their implementation and enforcement while out and about or back at work were noted.
- Discrimination while in lockdown was mentioned as were the difficulties of home schooling while trying to work and stress of the uncertainty about how long restrictions would continue.

Health professionals and other organisations

- Reference to news and social media were mentioned; Limiting news and social media sites to a trusted few was a chosen option for several respondents. Criticism of news content regarding the pandemic was evident.
- The pressure/risks of work during the pandemic was mentioned as well as sometimes having to home school.
- COVID-19 anxiety from other household members and the loss of usual coping strategies were also highlighted.

Carers/family

- Home schooling and looking after children with special educational needs were mentioned as was the lack of access to greenspace for mental health benefits.

Respondents categorised as public mental health service users and public were then asked about their general mental health. This question focused on factors not relating to the COVID-19 pandemic (Figure 35).

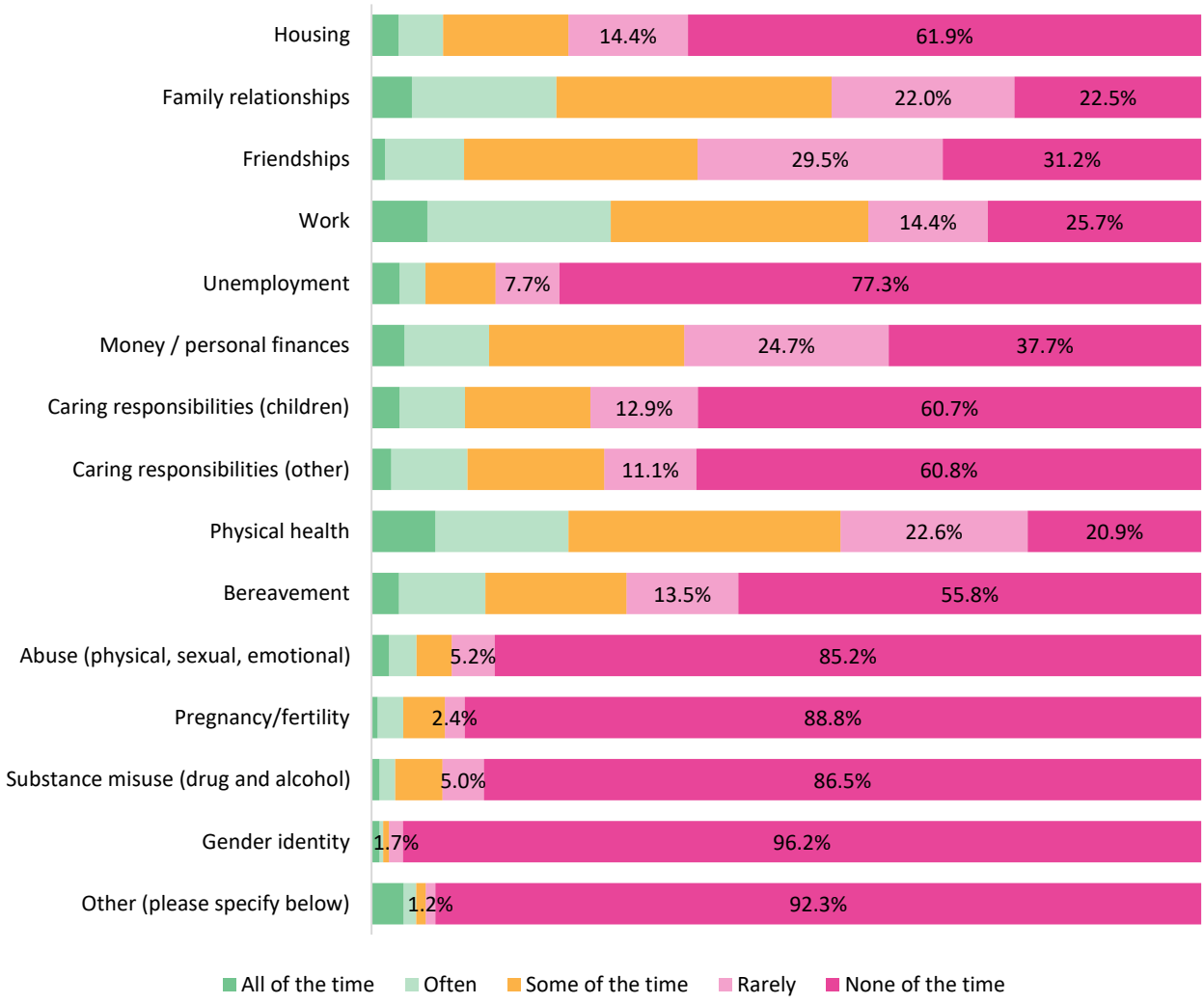


Figure 36. "Over the past 2 years how has your mental health been impacted by the following (i.e. not related to COVID-19)" - Public service users and Public
Source: Coventry and Warwickshire Mental Health Needs Assessment Survey

As Figure 36 shows, work (59.9% / n=249), physical health (56.5% / n=243) and family relationships (55.5% / n=239) were the options selected most frequently by respondents as impacting on their mental health either some of the time, often or all of the time. In contrast, just 2.1% (n=9) of public mental health service users and public suggested their mental health had been impacted by their gender identity.

Professionals were also asked about their general mental health. It should be stated here that not all the options given to public mental health service users and public respondents were presented to professionals – professionals were not asked about pregnancy/fertility and abuse (sexual, physical or emotional).

Generally, the responses from public service users/public non-service users were similar to the responses given by professionals. In terms of professionals, work (66.9%/n=91), physical health (53.7%/n=73) and family relationships (50.4%/n=69)

were the three most frequently selected options considered to be impacting on their mental health either some of the time, often or all of the time.

Recommendations

- In light of the evidence that wellbeing is not a fixed state, multiple determinants contribute to it and the economic case for prevention and early intervention in mental health and wellbeing, it is recommended that, locally, investment in this area is continued and strengthened where possible
- Given the impact of the COVID-19 pandemic, organisations should ensure that mental health is a key theme of recovery planning

COMMON MENTAL HEALTH PROBLEMS

Common mental health (CMH) problems, or Common Mental Disorders (CMD), include depression and anxiety disorders such as generalised anxiety disorder, panic disorder, obsessive-compulsive disorder (OCD), phobias and post-traumatic stress disorder (PTSD). These mental health problems are called 'common' because combined they affect more people than other mental health problems (up to 15% of people at any one time in the UK). Some people may have more than one mental health problem (such as depression and anxiety)[38].

The NHS Long Term Plan re-enforces that nine out of ten adults with mental health problems are supported in primary care. For many people, GPs are the first point of call for accessing support for mental health in the NHS.

National guidance on 'co-locating mental health therapists in primary care[39], acknowledges the number of patients needing help with mental health problems is increasing. A survey of more than 1,000 GPs by the charity Mind (June 2018) found two in five appointments involved mental health, while two in three GPs said the proportion of patients needing help with their mental health had increased in the previous 12 months; as shown in the previous chapter, the COVID-19 pandemic has only compounded these issues.

Research (pre-pandemic) also shows that every week one in six adults experiences symptoms of a common mental health problem, such as anxiety or depression, and one in five has considered taking their own life at some point. The Adult Psychiatric Morbidity Survey (2014)[40] also found nearly half of adults believe, in their lifetime, they have had a diagnosable mental health problem, yet only a third have received a diagnosis.

Approximately 25% percent of the adult population in England will experience a mental health problem at some point in their life and one in six adults has a mental health problem at any given time, with depression and anxiety the most common. Depression and anxiety disorders are serious and debilitating conditions and have significant impacts on the quality of life for people and their families and wider economic costs. The relevant NICE guidelines state that people diagnosed with these conditions should be offered evidence-based talking therapies as an effective treatment; this is also a service that most people experiencing difficulties with these conditions want.

The IAPT service supports our local population by providing NICE approved, evidence-based psychological therapies for people with depression and anxiety disorders.

The IAPT service supports our local population in delivering:

- Increased health and well-being, with at least 50% of those completing treatment moving to recovery and most experiencing a meaningful improvement in their condition;

- Improved employment, benefit, and social inclusion status including help for people to retain employment, return to work, improve their vocational situation and participate in the activities of daily living.

Locally, the mental health needs assessment survey illustrated that, for service users who had accessed mental health services, 31.7% had accessed services for mild mental health problems and 35.2% had accessed services for short-term support; this was the most frequently cited reason for accessing services.

Depression and anxiety

Depression affects different people in different ways and can be treated with medication and talking treatments. Self-help techniques, peer support groups and coping strategies can also help. Some signs of depression are feeling low, feeling bad about yourself and not wanting to do things. Different things can make depression more likely, such as adverse childhood experiences, stressful events and a person's lifestyle.

Anxiety can make someone feel worried or scared and can cause physical symptoms such as a fast heartbeat or sweating. It is a normal human response to be anxious in certain situations, but someone may have an anxiety disorder if they feel anxious all or most of the time.

People can and do recover from depression and anxiety disorders, and treatment and support is available in Coventry and Warwickshire.

Local Rates of Common Mental Health Problems

Rates of CMDs identified in the national Adult Psychiatric Morbidity Survey have been applied to Coventry and Warwickshire populations according to age, gender and deprivation and are published on PHE fingertips as rates for 16+ and 65+.

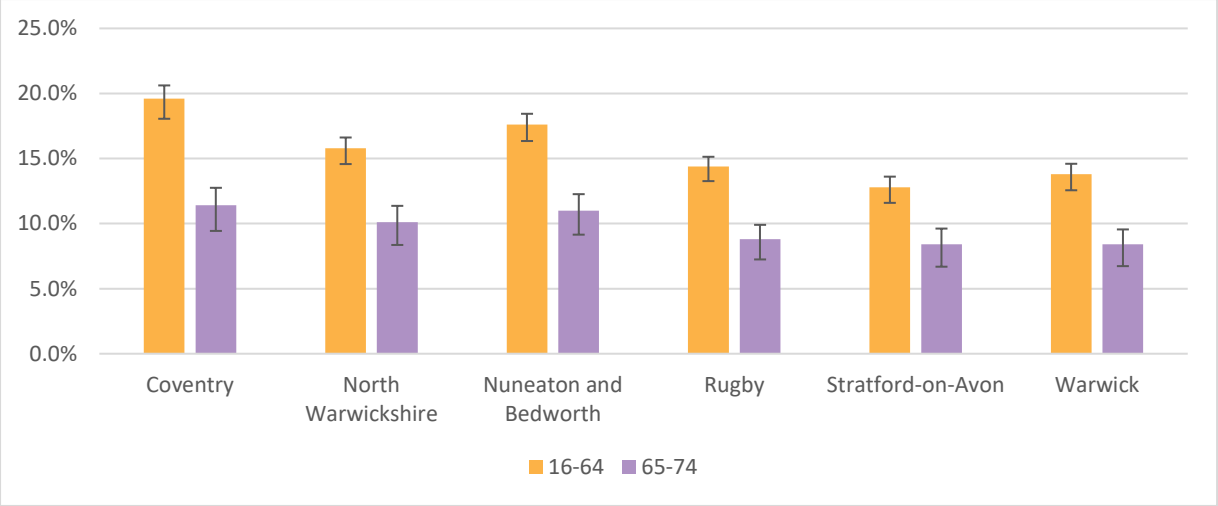


Figure 37. Common mental disorder prevalence estimates across Coventry and Warwickshire, 2017
Source: PHE Fingertips

Figure 37 illustrates local rates of CMD prevalence across Coventry and Warwickshire for people aged 16 – 64 and 65 – 74. Rates are estimated to be higher for both age groups in Coventry, North Warwickshire and Nuneaton and Bedworth when compared to Rugby, Stratford-on-Avon and Warwick districts. Compared to over 65 year olds, Figure 37 also illustrates how rates of diagnosed CMDs are higher in the working age population, with around one in five estimated to have a mental health condition in Coventry.

The Mental Health Five Year Forward View Implementation Plan set out the ambition to increase access to integrated evidence-based psychological therapies, defined as:

"The proportion of people that enter treatment against the level of need in the general population i.e. the proportion of people who have depression and/or anxiety disorders who receive psychological therapies."

Therefore, local analysis has used the following when analysing IAPT data for this needs assessment:

- **Numerator:** The number of people who receive psychological therapies (annual average based on 2.75 years data 2018/19, 2019/20, 2020/21 to month 9).
- **Denominator:** The local number of people who have a CMD in the CCG population.
- This results in an estimate of the percentage of people with CMDs accessing treatment, and also helps to understand unmet need for support. These percentages are shown in Figure 38 to 49.

It should be noted that the denominator population within the CCG targets has remained static over the last few years and it is this that forms the denominator population for the GP Practice / PCN analysis in the figures below. The geographical analysis however which compares Local Authorities/ Deprivation Quintiles/ Ethnicity Grouping derives its denominator from the Common Mental Disorder % prevalence populations stated in PHE Fingertips at the Local Authority level.

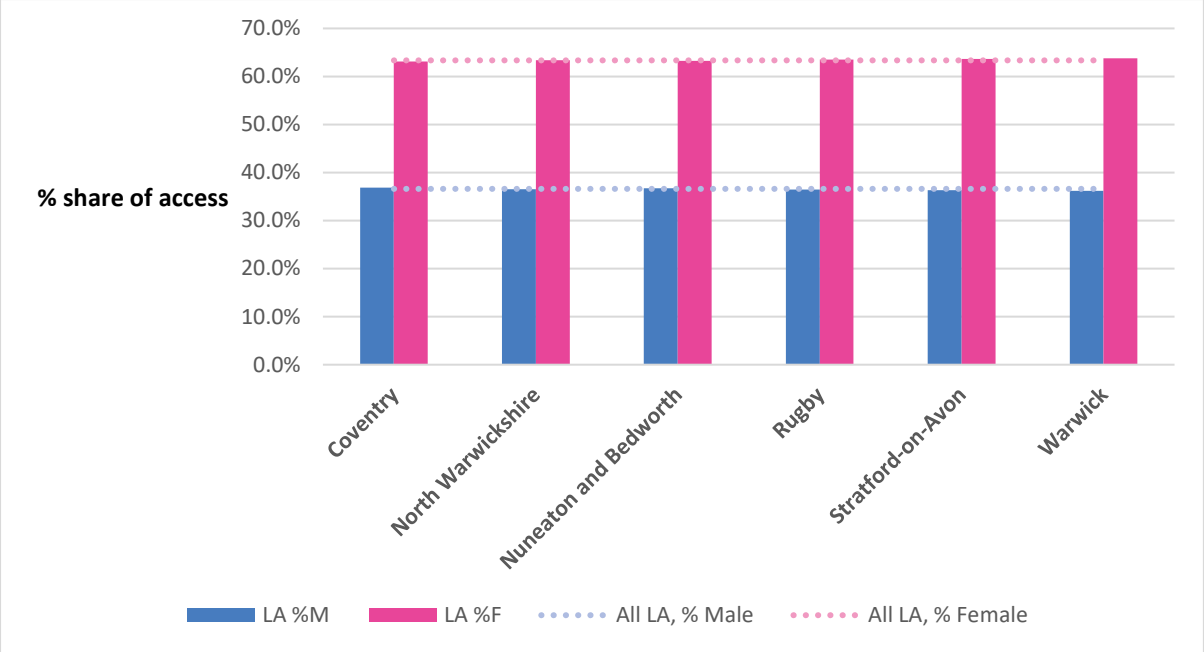


Figure 38. IAPT access in Coventry and Warwickshire split by gender
Source: NHS Digital, Arden and GEM CSU

Figure 38 shows the gender split presenting to IAPT services as first treatments. It illustrates a 63%:37% female to male split consistent across each local authority (LA) area.

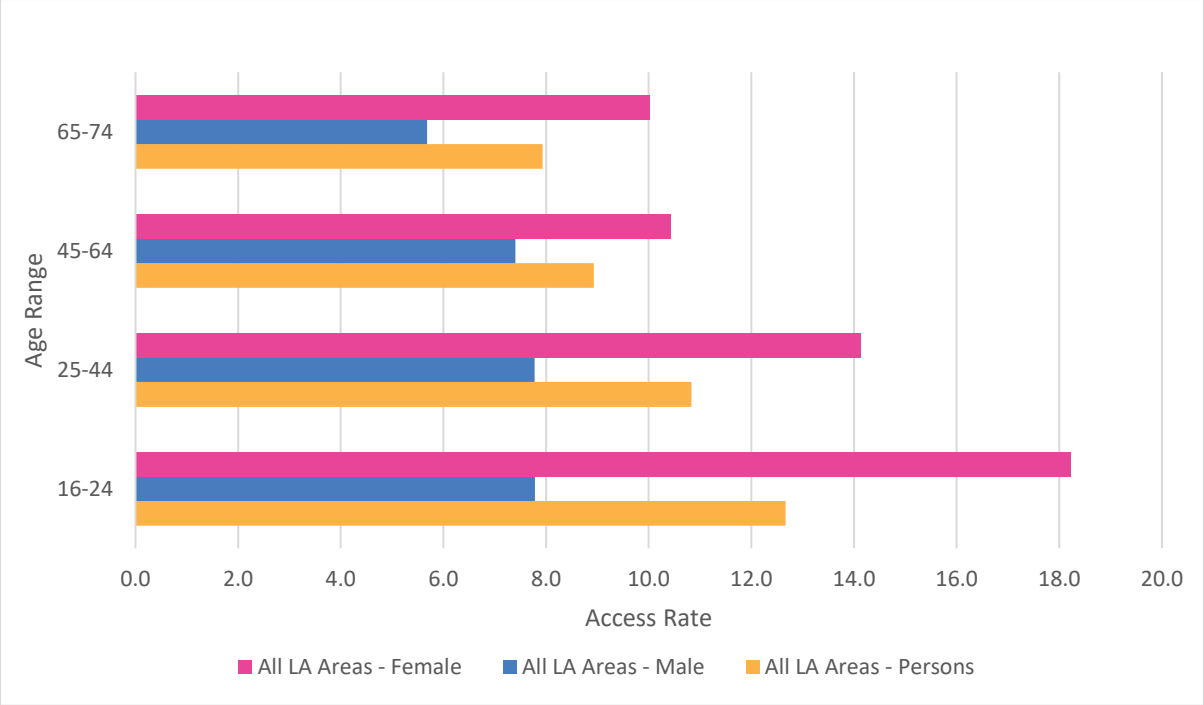


Figure 39. IAPT access in Coventry and Warwickshire local authority (LA) areas by age and gender
Source: NHS Digital, Arden and GEM CSU

Figure 39 illustrates access rates within the Coventry and Warwickshire i.e. First Treatments per head of CMD population within each age band. Rates are annualised based on 2.75 years data.

Access rates are highest in the 16-24 population, reducing as you move up through the age bands with lowest access rates in the 65-74 population. Across all age bands there are higher rates in the female population and this is most marked in the 16-24 population.

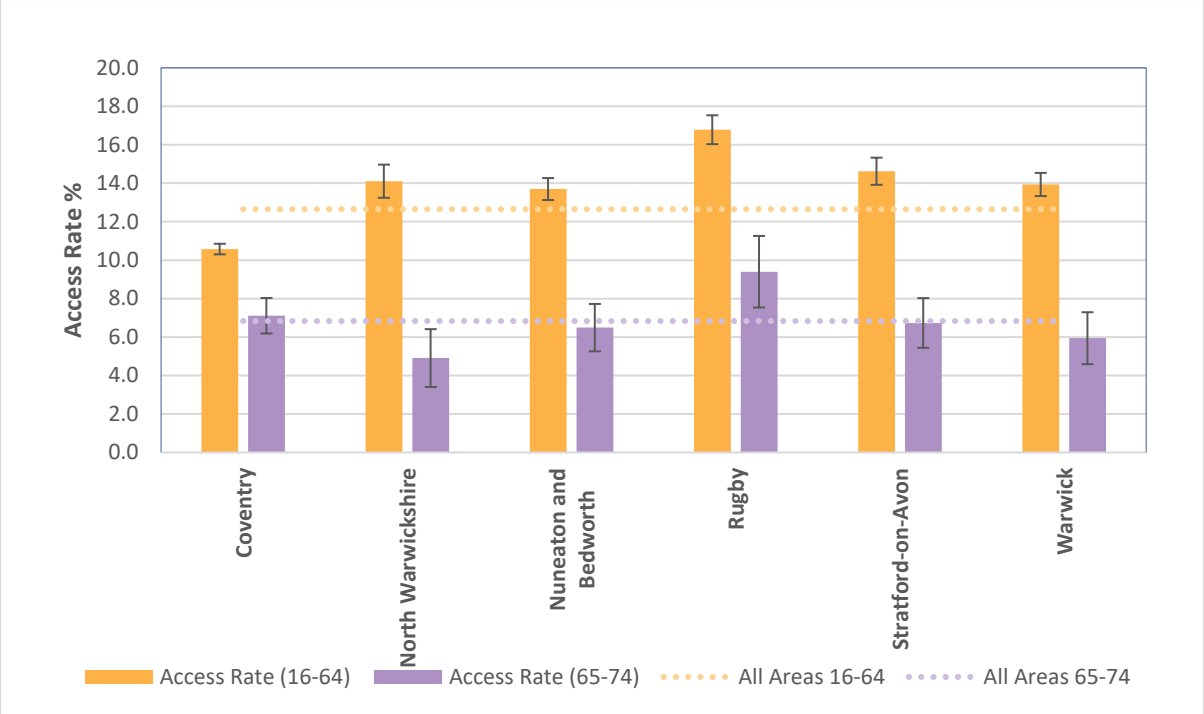


Figure 40. IAPT access rates in Coventry and Warwickshire by age
Source: NHS Digital, Arden and GEM CSU

Figure 40 shows IAPT Access rates by local authority area and age (16-64 and 65-74). Rates are highest in Rugby for both age groups. Coventry has the lowest access rate in the 16-64 population and North Warwickshire has the lowest access rate in the 65-74 population. 65-74 rates are considerably lower than in 16-64 across both age groups. Rates are annualised based on 2.75 years of data.

It should be noted that the low access rate in the 16-64 Coventry population (compared to other areas) may be masked within the Coventry and Rugby CCG access rates (noting that Rugby Access is somewhat higher in the Local Authority Analysis). However, another key factor to consider is the growth in the Coventry population in recent years and its impact on the prevalence estimate. For the local authority prevalence, this is based on the recent 2019 mid-year estimate, whereas the CCG prevalence appears to be based on historical (lower) population numbers. Because of this, access based on the (higher) more recent Coventry estimate gives rise to somewhat lower rates than they would be if based on historical population estimates.

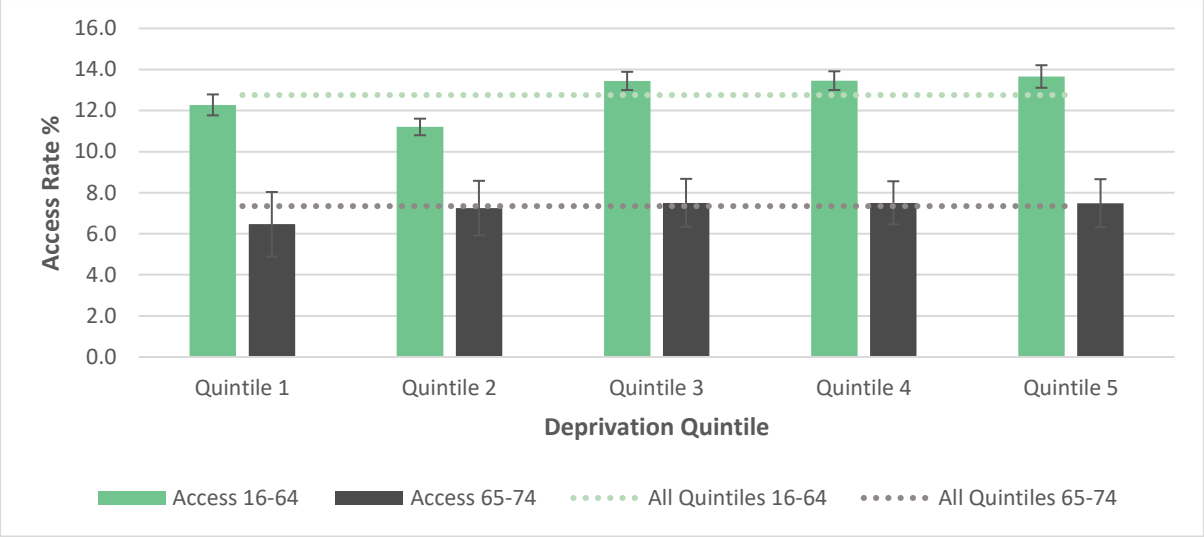


Figure 41. IAPT access rates in Coventry and Warwickshire by deprivation quintiles
Source: NHS Digital, Arden and GEM CSU

Figure 41 shows IAPT access rates across all Coventry and Warwickshire local authority areas according to deprivation quintile. Quintile 1 represents 20% of areas most deprived nationally, Quintile 5 the 20% least deprived.

16-64 access rates appear to be generally higher in Quintiles 3-5 (least deprived) than in Quintile 1-2 (most deprived).

Lower 16-64 access rates in quintiles 1-2 are likely to be heavily influenced by relatively lower access observed in Coventry, noting Coventry has disproportionately higher quintile 1 and 2 populations than other Local authority areas in Coventry and Warwickshire.

There appears to be little variation in 65-74 rates across the quintiles, although quintile 1 is slightly lower.

The Adult Psychiatric Morbidity Survey indicates higher CMD rates in deprived populations, but this does not appear to be mirrored in IAPT access across C&W. However, the picture may be different at the individual local authority level (i.e. district and borough level).

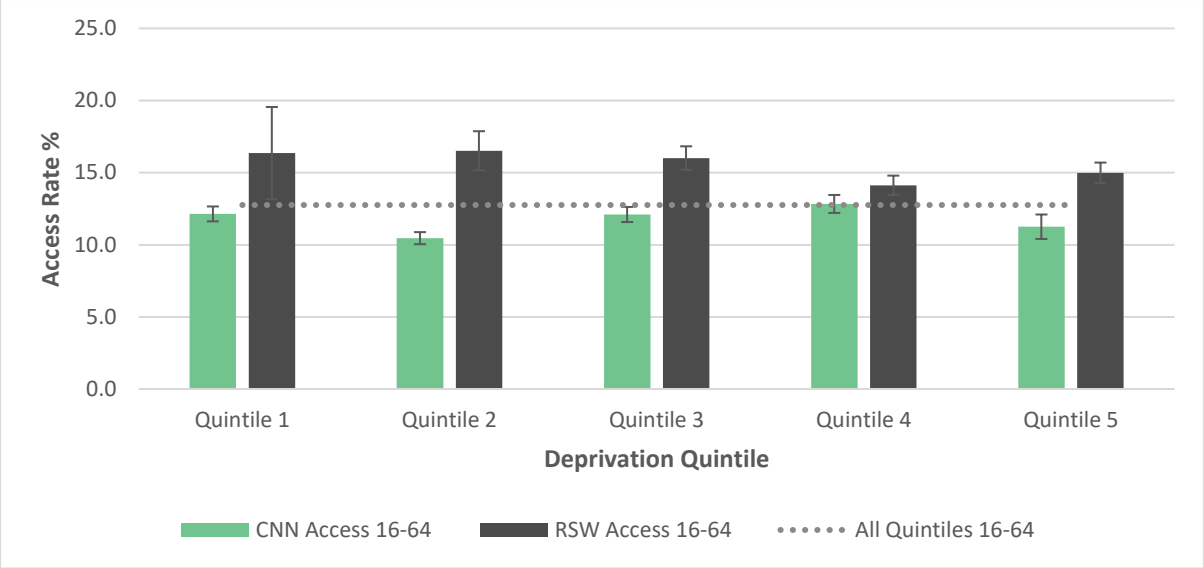


Figure 42. IAPT access rates in Coventry and Warwickshire (grouped) by deprivation quintiles for ages 16-64
Source: NHS Digital, Arden and GEM CSU

In Figure 42 local authority areas have been grouped into the 3 most deprived areas (CNN, Coventry, Nuneaton and Bedworth, North Warwickshire) and 3 most affluent areas (RSW, Rugby, Stratford-on-Avon, Warwick). These grouped areas are then compared by quintile for ages 16-64.

RSW access is higher than CNN i.e. better access in more affluent local authority areas. However it should be noted that Coventry appears to be reducing 16-64 rates in the CNN area.

In the more affluent RSW, better access appears to be slightly tilted towards more deprived. In more deprived CNN, access appears to be slightly tilted towards more affluent.

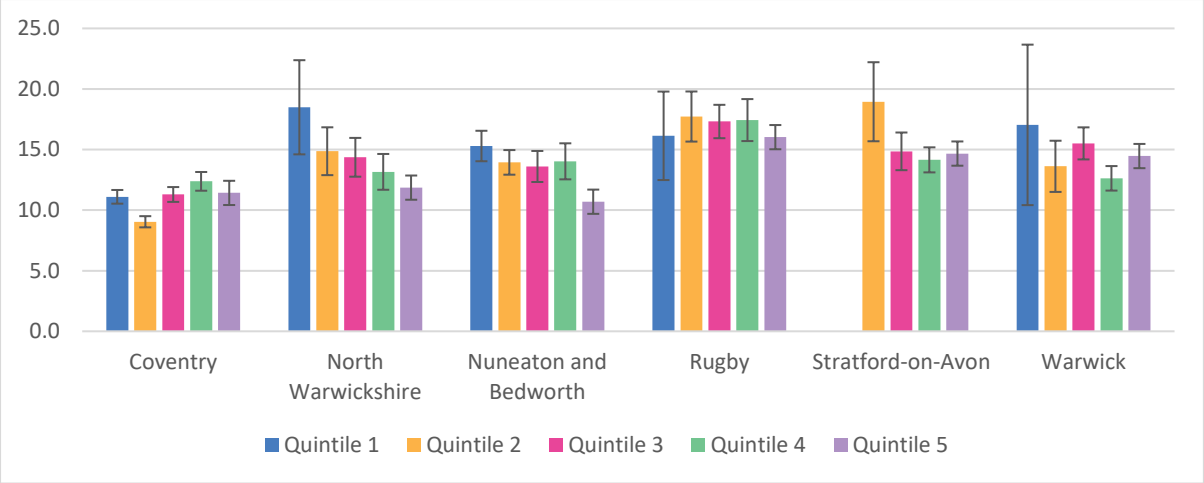


Figure 43. IAPT access rates in Coventry and Warwickshire local authorities by deprivation quintiles for ages 16-64
Source: NHS Digital, Arden and GEM CSU

Figure 43 compares across and within local authority areas, by deprivation quintile, 16-64 only.

Access rates do appear to be higher in more deprived areas in 4 out of the 6 Local Authority Areas. In Coventry or Rugby however, access rates in less deprived quintiles at least exceed those rates in quintiles 1 and 2 where there may be greater need. As indicated previously, rates in Coventry are lower than other local authority areas.

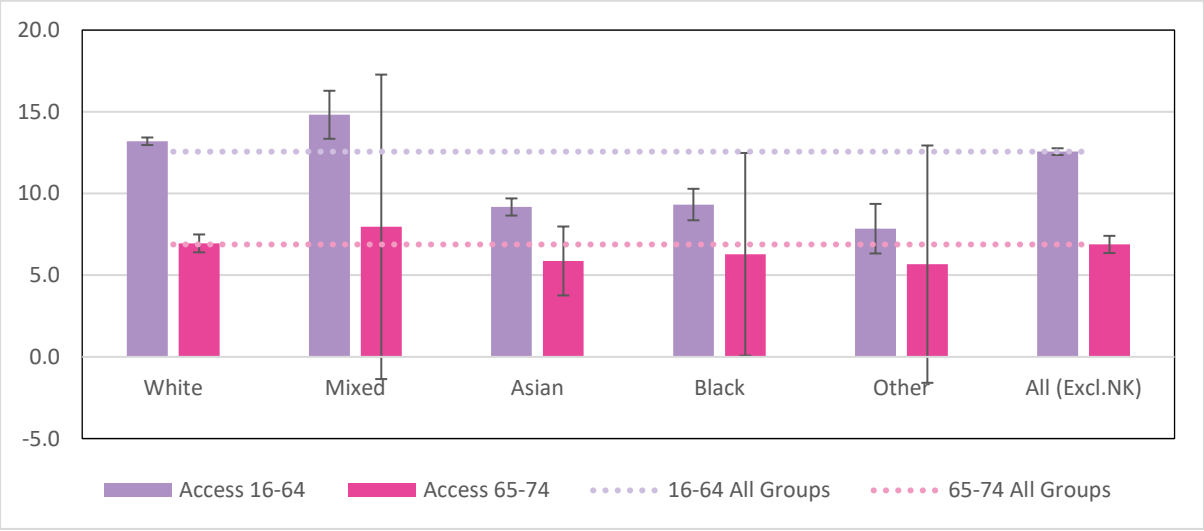


Figure 44. IAPT access rates in Coventry and Warwickshire by ethnicity
Source: NHS Digital, Arden and GEM CSU

Figure 44 shows IAPT access by ethnic groupings. It should be noted that the population baseline relates to the 2011 Census populations applied to 2019 ONS Mid-Year Population Estimates. As such any changes in the ethnic composition

since 2011 will not be reflected in the ethnic grouping denominator populations, although the total change in the overall population is taken into account (i.e. from 2011 to 2019) in the rates calculated.

Figure 44 shows lower 16-64 rates in Asian/ Black/other Ethnic Groupings 16-64. Higher Rates in White and Mixed groupings. Confidence intervals are wider in 65-74 populations, although rates tend to be more even across ethnic groupings in this age band.

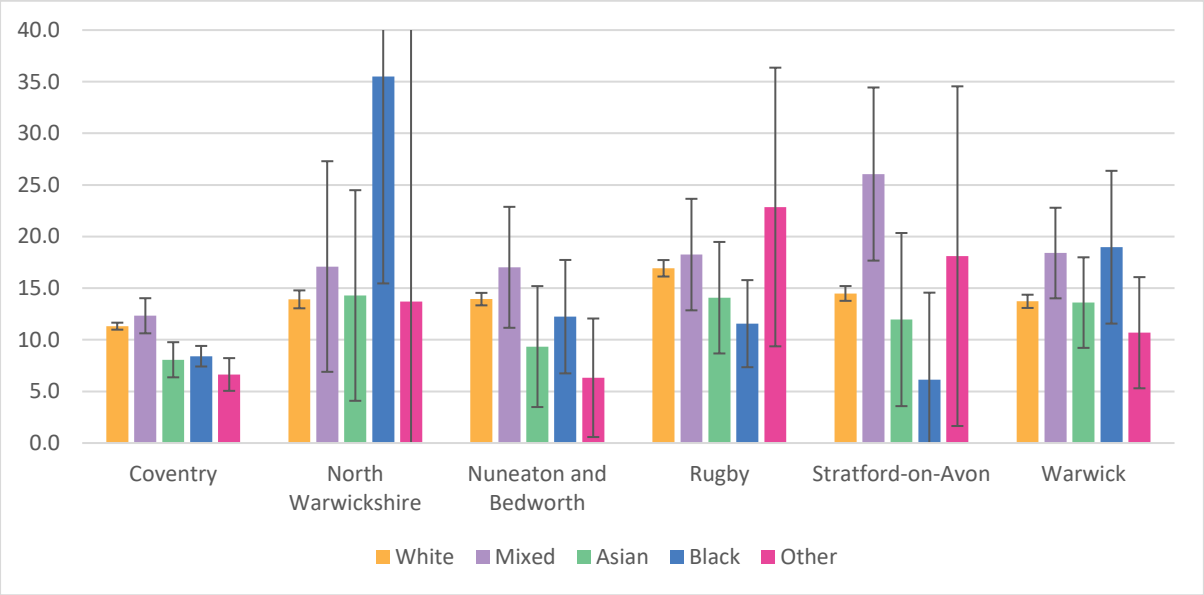


Figure 45. IAPT access rates in Coventry and Warwickshire local authorities by ethnicity
Source: NHS Digital, Arden and GEM CSU

Figure 45 shows 16-64 Access Rates by ethnic grouping in each local authority. Again, data is based on the 2011 Census so should be interpreted with caution as any population changes are not reflected.

There are relatively low Black, Asian and Other Ethnicity rates in Coventry compared to White and Mixed.

In Nuneaton and Bedworth and Rugby there are relatively low Black and Asian rates to some extent, but these data have wider confidence intervals. This means that this finding should be interpreted with caution.

There are higher access rates in Black populations in North Warwickshire and Warwick, but confidence limits are large for these data so this should be interpreted with caution.

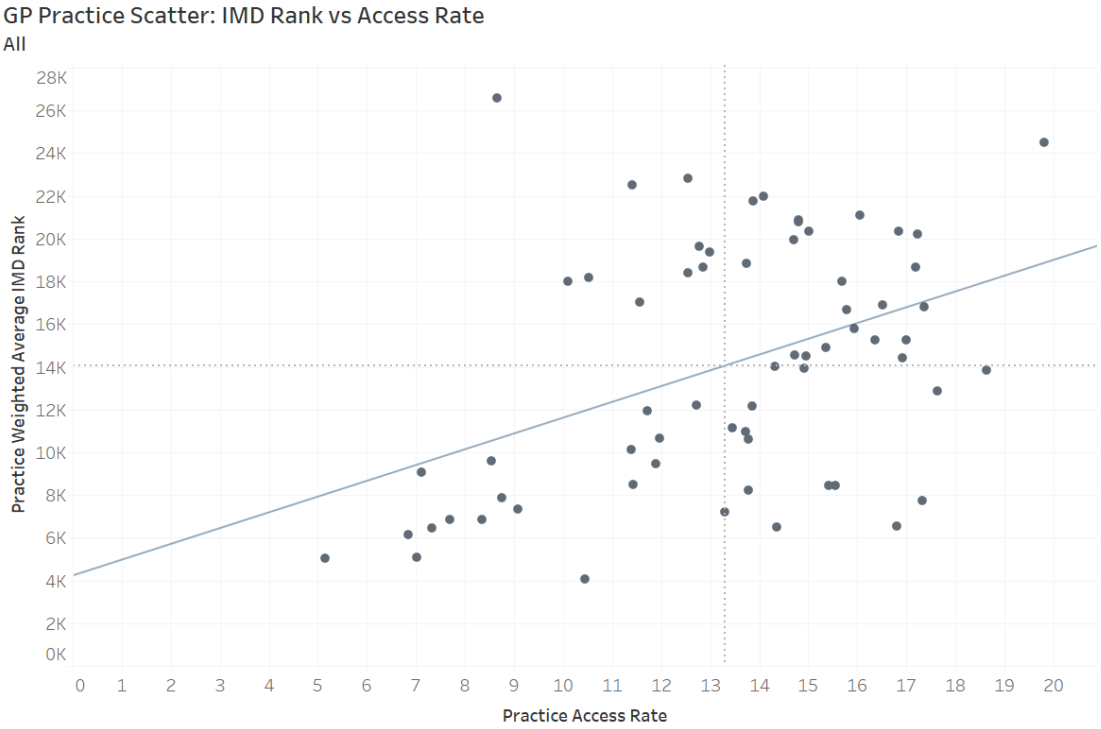


Figure 46. GP Practice access rate for IAPT services against deprivation across Coventry and Rugby
Source: NHS Digital, Arden and GEM CSU

Figure 46 shows a scatterplot of Coventry and Rugby GP practices where IAPT Access Rates (X-Axis) and IMD rank (Y-Axis) are compared. Average deprivation ranks range from 4k (most deprived) to 26K (least deprived).

Practices to the left of the chart have lower IAPT access rates. Practices to the bottom of the chart have populations which are relatively more deprived.

The scatterplot demonstrates a positive correlation between deprivation and GP Practice IAPT access rate i.e. the most deprived communities have the worse access. This may suggest these populations are under-represented in access to IAPT Services.

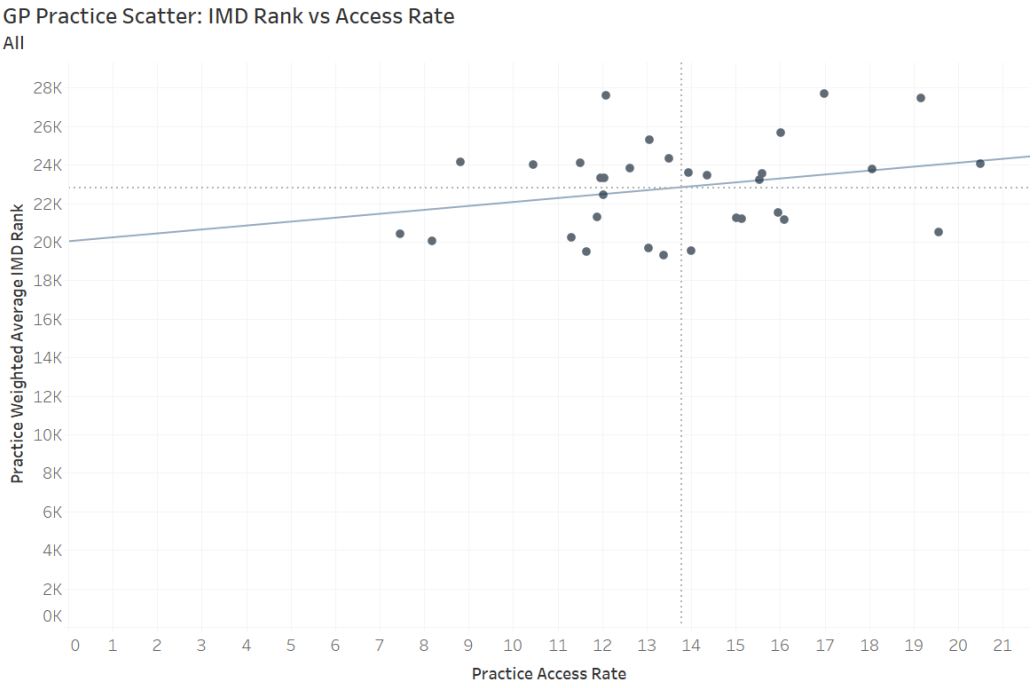


Figure 47. GP Practice access rate for IAPT services against deprivation across South Warwickshire
NHS Digital, Arden and GEM CSU

Figure 47 shows a scatterplot of South Warwickshire CCG GP practices where IAPT Access Rates (X-Axis) and IMD rank (Y-Axis) are compared. Average deprivation ranks range from 20k (most deprived) to 28K (least deprived).

Practices to the left of the chart have lower IAPT access rates. Practices to the bottom of the chart have populations which are relatively more deprived.

The scatterplot demonstrates a small, positive correlation between deprivation and GP Practice IAPT access rate i.e. the most deprived communities have the worse access.

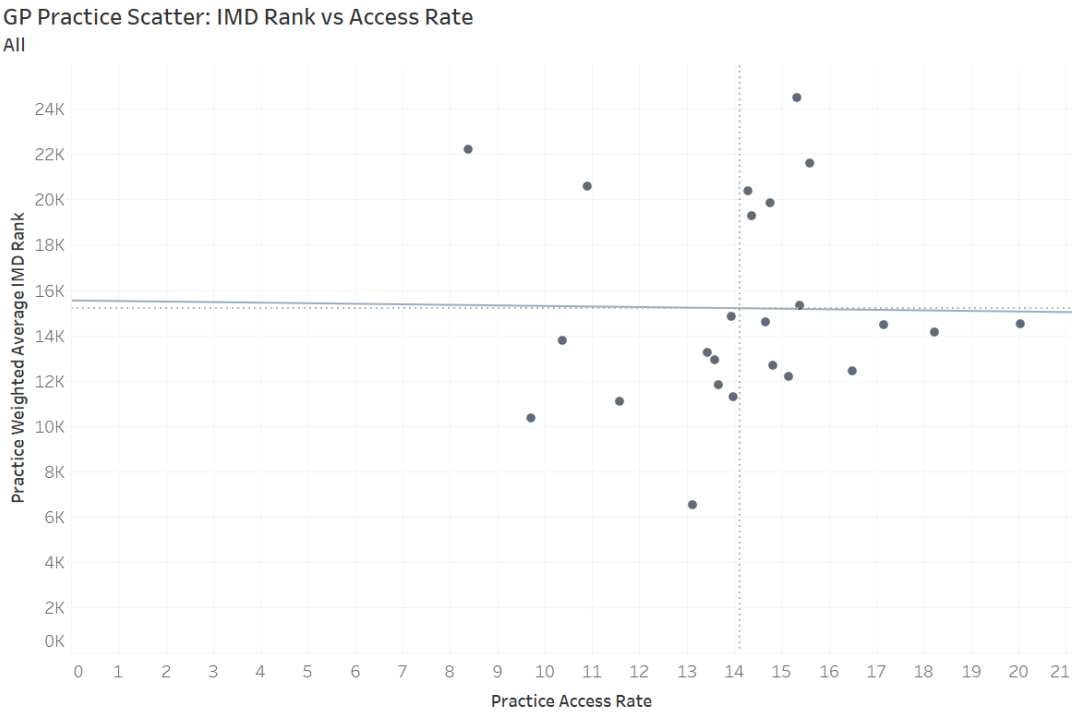


Figure 48. GP Practice access rate for IAPT services against deprivation across Warwickshire North
NHS Digital, Arden and GEM CSU

In Warwickshire North average deprivation ranks range from 6K (most deprived) to 24K least deprived (Coventry and Rugby range is 4k to 26k).

Figure 48 shows a scatterplot of Warwickshire North CCG GP practices where IAPT Access Rates (X-Axis) and IMD rank (Y-Axis) are compared. Average deprivation ranks range from 6K (most deprived) to 24K (least deprived).

Practices to the left of the chart have lower IAPT access rates. Practices to the bottom of the chart have populations which are relatively more deprived.

The scatterplot demonstrates that a small number of practices appear to have relatively lower access combined with a relatively deprived population.

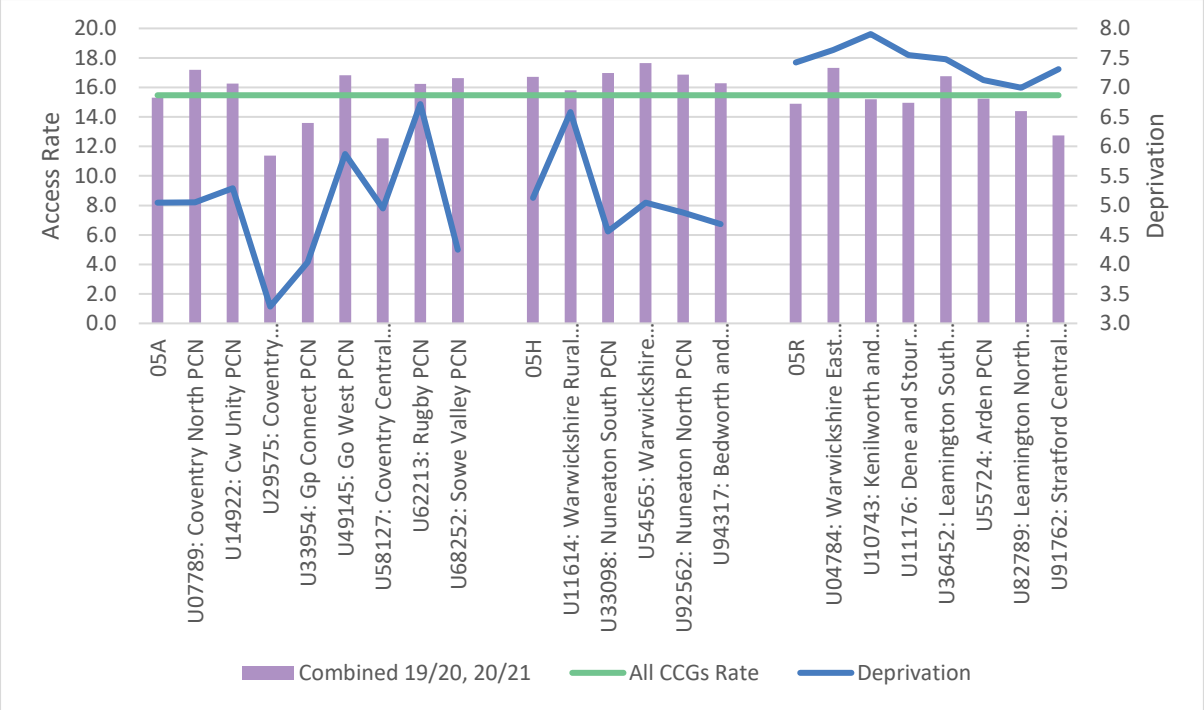


Figure 49. GP Practice access rate for IAPT services by Primary Care Network (PCN) and deprivation
NHS Digital, Arden and GEM CSU

Figure 49 shows the Primary Care Network PCN level IAPT access rates compared to deprivation.

High Deprivation and low access appears to be present in Coventry Navigation, GP Connect, Coventry Central. Lower access is also observed in Stratford Central PCN, although this may reflect lower need within the population which is relatively affluent.

Some PCNs in North Warwickshire, although with average access, do appear to have relatively deprived populations and so may be under-represented in access if not reflective of need.

Impact of COVID-19

Professionals working in health and other organisations who attended mental health needs assessment focus groups highlighted an increased complexity of presentations to services. In particular, IAPT colleagues noted that, possibly as a result of remote working, therapy is taking longer i.e. more sessions are required to reach treatment outcomes than before remote working.

It was also noted in mental health needs assessment focus groups that people have accessed the IAPT service for support with long-COVID effects. For some people, coronavirus (COVID-19) can cause symptoms that last weeks or months after the

infection has gone. This is sometimes called post-COVID-19 syndrome or "long COVID". Reported symptoms include depression and anxiety[41].

The COVID-19 recovery survey indicated that feelings of loneliness were higher in those who indicated a previous mental health condition prior to the pandemic. We also know that social isolation and loneliness can increase the risk of mental health problems and guidance on self-isolation and social distancing during the pandemic has caused some people to experience acute feelings of loneliness and social isolation.

Data provided by the Samaritans suggests that during the pandemic, volunteers provided support over 700,000 times to men over the nine months since the social distancing restrictions began (April to December 2020). Three themes were identified as the drivers, including:

- loneliness or social isolation;
- concerns about the financial and economic future; and
- strain on existing relationships.

Indeed, 30% of men raised concerns about loneliness or social isolation, compared to 26.5% the previous year, whilst multiple men also talked about feelings of fear and uncertainty about the future - in particular losing their standard of living, a fear of loss of employment, or losing their business for those men who are self-employed.

Inequalities

Professionals working in health and other organisations who responded to the C&W MHNA survey (2021) reported inequalities in access to the services they represented particularly among protected characteristic groups, those at financial/digital disadvantage (made worse during the COVID-19 pandemic as services shifted online) and where mental health problems were combined with other conditions (e.g. dementia or autism). One respondent noted *"the patients we see are not representative of the diverse local population".*

There are also a number of inequalities outlined in the Advancing Mental Health Equalities Strategy[42]:

- Older people are a fifth as likely as younger age groups to have access to talking therapies but six times as likely to be on medication and less likely to be in receipt of talking therapies.
- Older people have better recovery outcomes in IAPT than working-age adults, but access is a challenge.
- Many black-African and Caribbean people, particularly men, do not have access to psychological treatment at an early stage of their mental health problem.

- Though there have been gradual improvements, the IAPT recovery rate for BAME service users is below that of their white-British counterparts.
- People of the Muslim faith experience poorer recovery rates in IAPT services than any other faith group.
- Men are less likely to be referred to IAPT services, and to enter IAPT treatment, than women.
- LGB people experience poorer recovery outcomes in IAPT services than their heterosexual counterparts.
- People with disabilities experience poorer recovery outcomes in IAPT services than those without a disability.
- IAPT recovery rates are generally poorer in the most deprived localities compared to the least deprived.

Recommendations

The following recommendations are proposed:

- Work with referrers to understand what engagement will be appropriate to improve footfall
- Improve community engagement with partners including the voluntary and community sector, faith-based groups, large HR organisations and NHS providers
- Develop appropriate methods to provide support to care home residents

SEVERE AND ENDURING MENTAL ILL HEALTH

Severe and enduring mental illness (SMI) refers to the long-term experience of bipolar disorder, schizophrenia and psychosis.

Psychosis and the specific diagnosis of schizophrenia represent a major psychiatric disorder (or cluster of disorders) in which a person's perception, thoughts, mood and behaviour are significantly altered. The symptoms of psychosis and schizophrenia are usually divided into 'positive symptoms', including hallucinations (perception in the absence of any stimulus) and delusions (fixed or falsely held beliefs), and 'negative symptoms' (such as emotional apathy, lack of drive, poverty of speech, social withdrawal and self-neglect). Each person will have a unique combination of symptoms and experiences[43].

Bipolar disorder is characterised by episodes of mania (abnormally elevated mood or irritability and related symptoms with severe functional impairment or psychotic symptoms for 7 days or more) or hypomania (abnormally elevated mood or irritability and related symptoms with decreased or increased function for 4 days or more) and episodes of depressed mood. It is often comorbid with other disorders such as anxiety disorders, substance misuse, personality disorders and attention deficit hyperactivity disorder (ADHD)[44].

People with SMI will receive support from secondary and/or tertiary mental health services. Locally, our new model (outlined in figure 50) will provide people with SMI with easier and faster access to evidence based interventions that best meet their needs, delivered at neighbourhood level by an alliance of health, social care and voluntary and community sector (VCSE) organisations - equal partners working to shared principles, to deliver compassionate care.

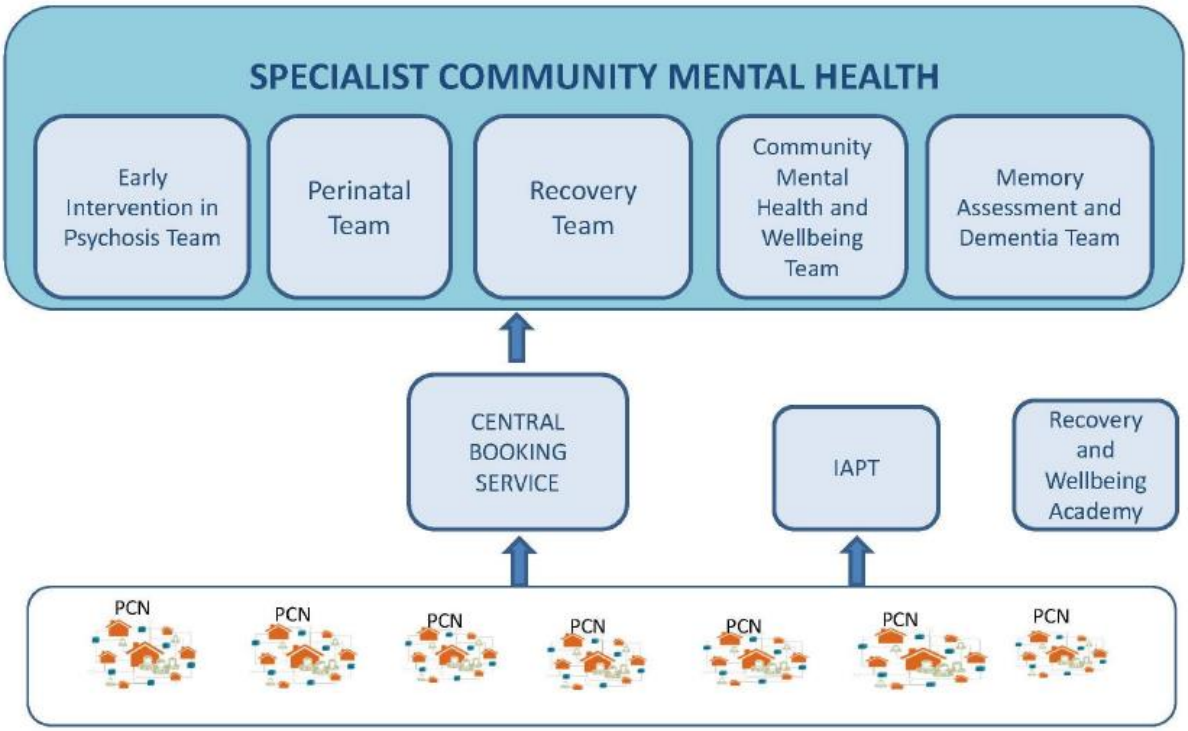


Figure 50. Current model of access to secondary mental health services in Coventry and Warwickshire

Coventry and Warwickshire Partnership NHS Trust (CWPT) provide the majority of secondary mental health services across Coventry and Warwickshire. Data outlining people who have accessed CWPT services and the number of appointments that have been attended. Patients accessing per month is a monthly average count of patients with at least 1 attended appointment per month (either face to face, Zoom or Telephone Consultation) where the appointment was direct activity with the patient (e.g. not including multi disciplinary team/Professional meetings, administration). Attendances is a monthly average of all appointments attended per month (either a face to face, Zoom or Telephone Consultation) where the appointment was direct activity with the patient (e.g. not including MDT/Professional meetings, administration).

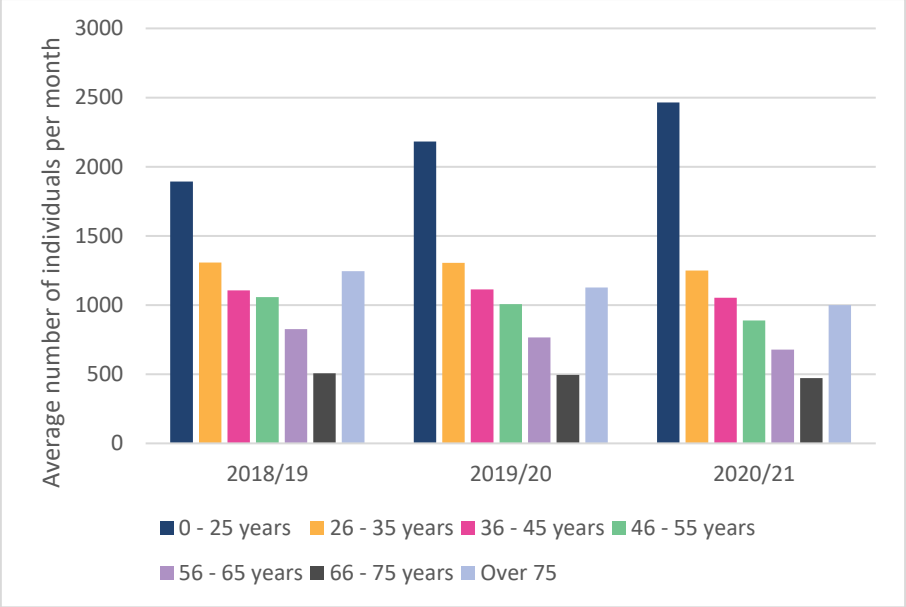


Figure 51. Monthly average number of people accessing CWPT services between 2018/19 and 2020/21
Source: Coventry and Warwickshire Partnership NHS Trust

Figure 51 demonstrates an increase in people aged 0-25 accessing CWPT services between 2018/19 and 2020/21. At the same time there is a decrease in people aged over 75 accessing support over the same period. There is also a slight decrease in those aged 46-55 years. There has been a slight decrease in average monthly attendances in 2020/21; average monthly attendances were 7943.3, 7998.6 and 7807.3) for 2018/19, 2019/20 and 2020/21 respectively.

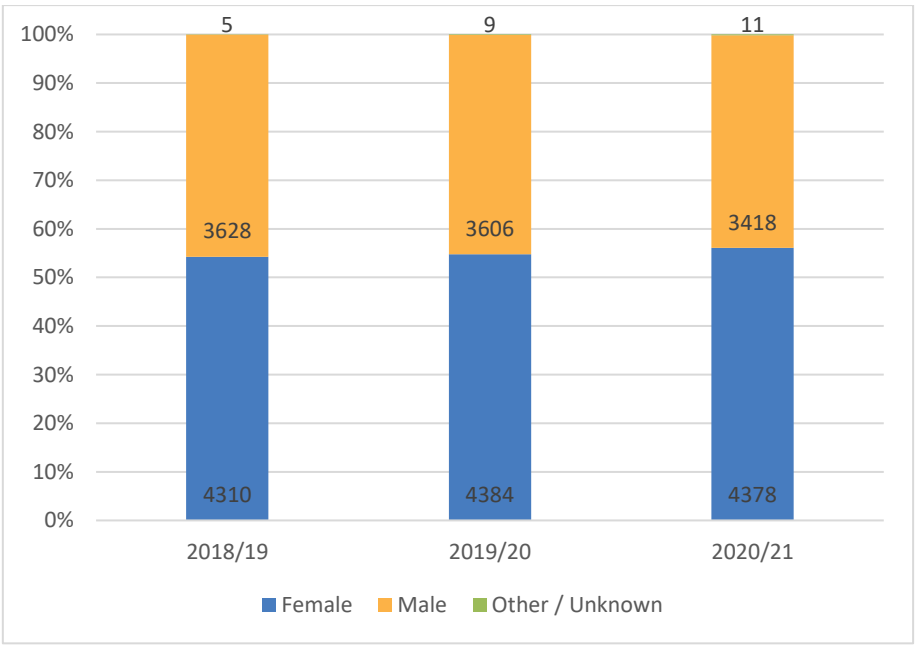


Figure 52. Monthly average percentage of people accessing CWPT services by gender between 2018/19 and 2020/21
Source: Coventry and Warwickshire Partnership NHS Trust

Figure 52 shows that more women than men are accessing support from CWPT. This finding is consistent across 2018/19 to 2020/21.

Table 7. Monthly average of people accessing CWPT services by ethnicity between 2018/19 and 2020/21

	2018/19		2019/20		2020/21	
Ethnicity	**Number**	**%**	**Number**	**%**	**Number**	**%**
White English / Welsh / Scottish / Northern Irish / British	6270	78.9%	6153	76.9%	5808	74.4%
White Irish	73	0.9%	68	0.9%	67	0.9%
White Other	180	2.3%	208	2.6%	211	2.7%
Mixed	168	2.1%	183	2.3%	186	2.4%
Asian	448	5.6%	462	5.8%	425	5.4%
Black	188	2.4%	197	2.5%	204	2.6%
Other / Unknown	617	7.8%	727	9.1%	906	11.6%
Total	7943	100.0%	7999	100.0%	7807	100.0%

Source: Coventry and Warwickshire Partnership NHS Trust

Table 7 shows that the percentage of White English / Welsh / Scottish / Northern Irish / British people accessing CWPT services has dropped between 2018/19 to 2020/21 (78.9% to 74.4% respectively). People of "Other / Unknown" ethnicity has increased over the same period (7.8% to 11.6% respectively).

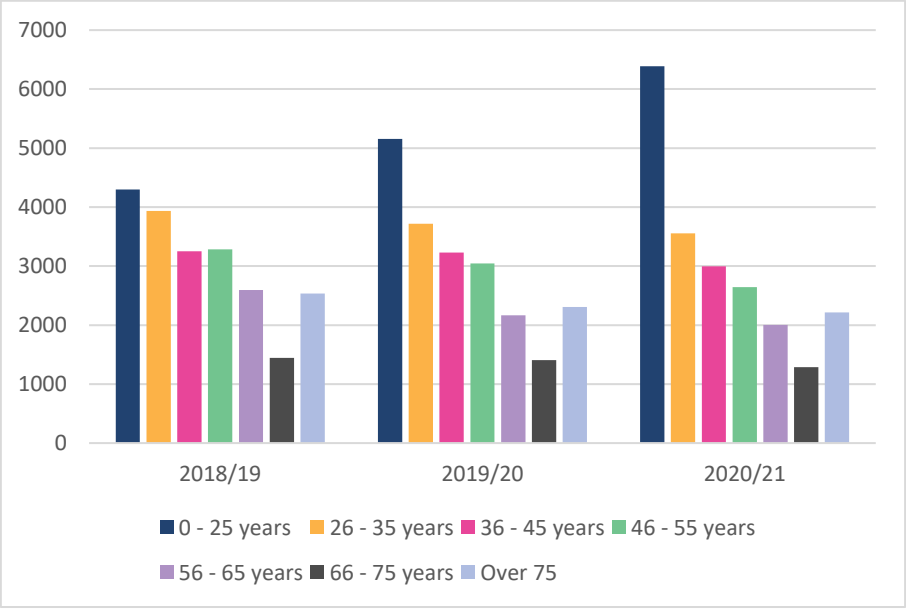


Figure 53. Monthly average attendances in CWPT services by age between 2018/19 and 2020/21

Source: Coventry and Warwickshire Partnership NHS Trust

The average number of monthly attendances in CWPT has dropped slightly overall with an average of 21,345 monthly attendances in 2018/19 to 21,089 in 2020/21. When looking at age (Figure 53), monthly average attendances have increased in those aged 0-25 years but dropped (to differing degrees) in all other age groups.

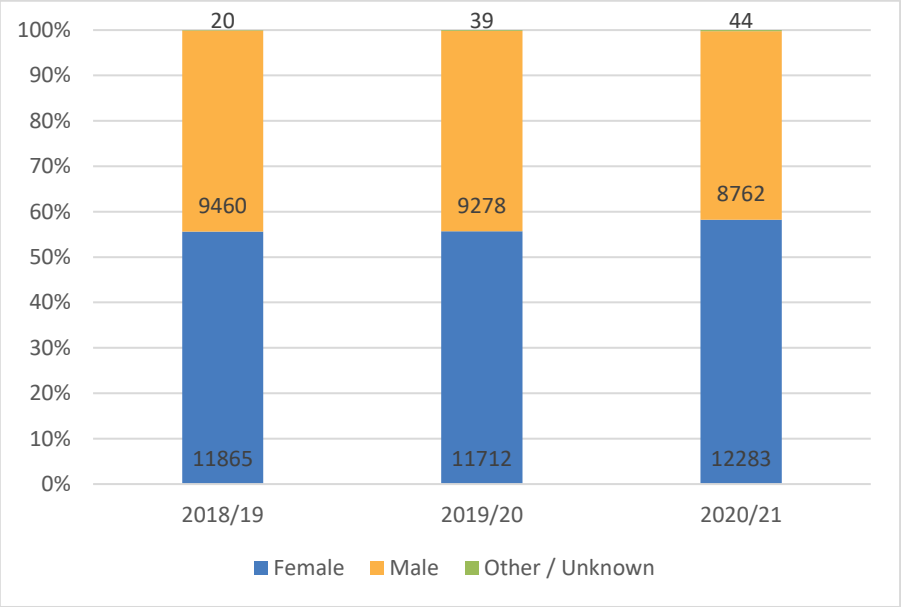


Figure 54. Monthly average percentage of attendances to CWPT services by gender between 2018/19 and 2020/21
Source: Coventry and Warwickshire Partnership NHS Trust

Table 8. Monthly average attendances to CWPT services by ethnicity between 2018/19 and 2020/21

	2018/19		2019/20		2020/21	
Ethnicity	**Number**	**%**	**Number**	**%**	**Number**	**%**
White English / Welsh / Scottish / Northern Irish / British	17,041	79.8%	16,408	78.0%	15,946	75.6%
White Irish	189	0.9%	173	0.8%	198	0.9%
White Other	466	2.2%	558	2.7%	618	2.9%
Mixed	450	2.1%	486	2.3%	505	2.4%
Asian	1,311	6.1%	1,246	5.9%	1,163	5.5%
Black	639	3.0%	626	3.0%	640	3.0%
Other / Not Known	1,248	5.8%	1,533	7.3%	2,018	9.6%
Total	21,345	100.0%	21,029	100.0%	21,089	100.0%

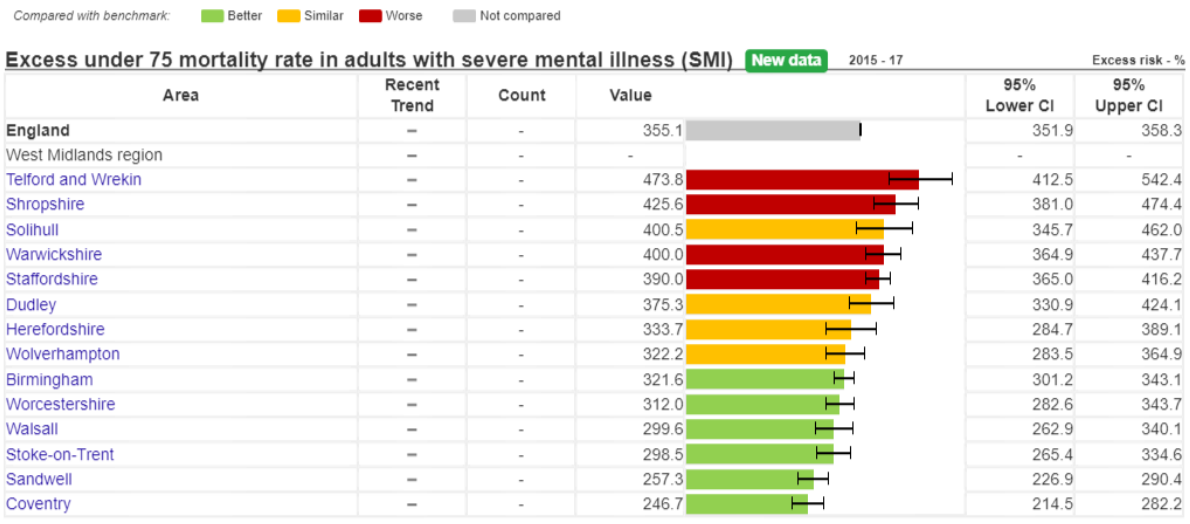
Source: Coventry and Warwickshire Partnership NHS Trust

Table 8 shows that the monthly average attendances of White English / Welsh / Scottish / Northern Irish / British people accessing CWPT services has dropped between 2018/19 to 2020/21 (79.8% to 75.6% respectively). Attendances by those of Asian ethnicity have also dropped (6.1% to 5.5% respectively). People of "Other / Unknown" ethnicity has increased over the same period (5.8% to 9.6% respectively).

Outcomes

People with SMI have a life expectancy of 15 to 20 years less than the general population – the population of people aged under 75 with SMI, who are in contact with secondary mental health services face a 3.7 times higher mortality rate than the general population[45]. There are a number of factors that may contribute to this disparity. People with a long-standing mental health problem are twice as likely to smoke, with the highest rates among people with psychosis or bipolar disorder. Compared with the general patient population, patients with SMI are at substantially higher risk of obesity, asthma, diabetes, chronic obstructive pulmonary disease (COPD) and cardiovascular disease. Also, people with SMI make more use of secondary urgent and emergency care, and experience higher premature mortality rates[46].

The local picture for excess premature mortality for those in contact with secondary MH services (within 5 years of death compared to the general population) is detailed in Figure 55. This illustrates that risk rates in Warwickshire (400%) are in line with the England average (355.1%) but Coventry performs better than the England average, with a risk rate of 246.7%; this is also the lowest rate in the West Midlands area.



Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	-	355.1	351.9	358.3
West Midlands region	–	-	-	-	-
Telford and Wrekin	–	-	473.8	412.5	542.4
Shropshire	–	-	425.6	381.0	474.4
Solihull	–	-	400.5	345.7	462.0
Warwickshire	–	-	400.0	364.9	437.7
Staffordshire	–	-	390.0	365.0	416.2
Dudley	–	-	375.3	330.9	424.1
Herefordshire	–	-	333.7	284.7	389.1
Wolverhampton	–	-	322.2	283.5	364.9
Birmingham	–	-	321.6	301.2	343.1
Worcestershire	–	-	312.0	282.6	343.7
Walsall	–	-	299.6	262.9	340.1
Stoke-on-Trent	–	-	298.5	265.4	334.6
Sandwell	–	-	257.3	226.9	290.4
Coventry	–	-	246.7	214.5	282.2

Figure 55. Excess under 75 mortality risk rate in adults with severe mental illness (SMI) in the West Midlands region (percentage)
Source: PHE Fingertips

Locally, the mental health needs assessment survey illustrated that, for service users who had accessed mental health services, 17.6% had accessed services for severe mental health problems and 13.6% had accessed services for long-term support. Some reported challenges with the connectivity between services: *"Better connections between acute mental health provision and GPs: I was discharged from Hospital and the community mental health team in quick succession, without proper communication with my GP"*

Inequalities

People living with SMI also face inequalities in the wider determinants of health, for example:

- **Employment:** For those in contact with secondary Mental Health services, the employment rate was 67.4 percentage points lower than the overall rate
- **Benefits:** 50.9% of Employment Support Allowance Claimants have a primary condition of a mental and behavioural problem
- **Social Isolation:** Psychotic disorder is more common in people living alone. Evidence suggests links between mental ill health, social isolation and the challenges that people with psychotic disorder may face with maintaining relationships.
- **Housing:** 54% of adults (age 18 – 69) receiving secondary mental health services on the Care Programme Approach were recorded as living independently, with or without support.

Impact of COVID-19

Professionals working in health and other organisations who attended mental health needs assessment focus groups highlighted an increased complexity of presentations to services, particularly for people with SMI.

Local Analysis – QoF Register Analysis

Rank	Regional CCG	Prevalence
1	NHS Warwickshire North CCG	0.71
2	NHS Herefordshire and Worcestershire CCG	0.75
3	NHS South Warwickshire CCG	0.78
4	NHS Dudley CCG	0.84
5	NHS Coventry and Rugby CCG	0.87
6	NHS Wolverhampton CCG	0.98
7	NHS Walsall CCG	1.00
8	NHS Sandwell and West Birmingham CCG	1.08
9	NHS Birmingham and Solihull CCG	1.11

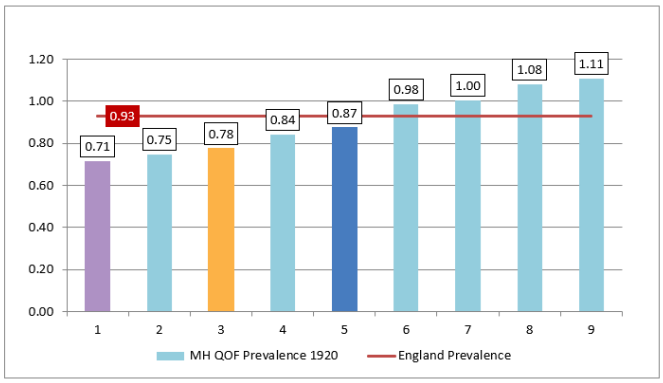
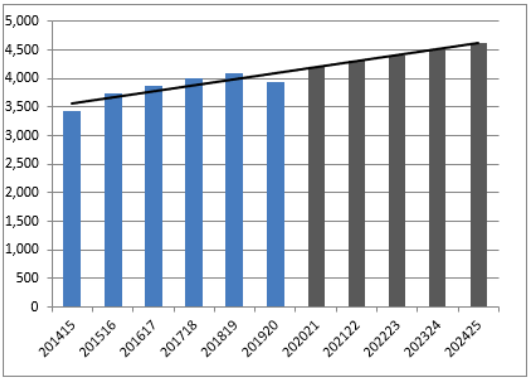
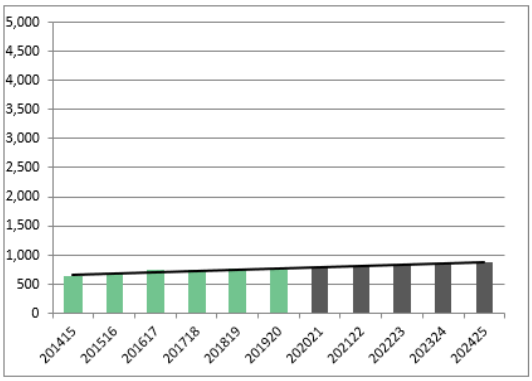


Figure 56. Regional CCG benchmarking comparison of Mental Health QoF Prevalence for 2019/20
Source: NHS Digital, Coventry and Warwickshire CCG

Figure 56 illustrates a benchmarking comparison of Mental Health QoF prevalence for 2019/20. Warwickshire North has the lowest mental health prevalence in the West Midlands region, with South Warwickshire having the third lowest prevalence. Coventry and Rugby has the median prevalence for the region.





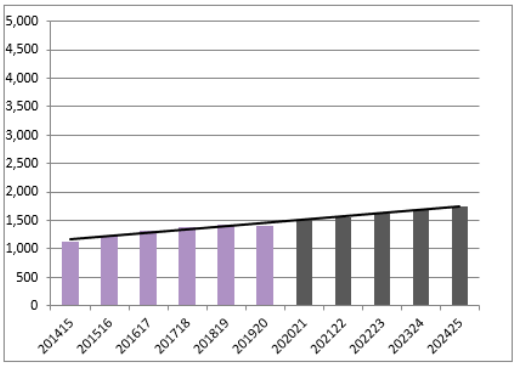
Coventry	201415	201516	201617	201718	201819	201920
MH Registers	3,420	3,720	3,862	3,979	4,079	3,916
Prevalence %	1.18	1.15	1.16	1.21	1.18	1.07
Register Growth	0%	9%	4%	3%	3%	-4%
Actuals Growth	0	300	142	117	100	-163
5yr Avg Reg Growth	2.8%					
5yr Avg Prevalence	1.16					

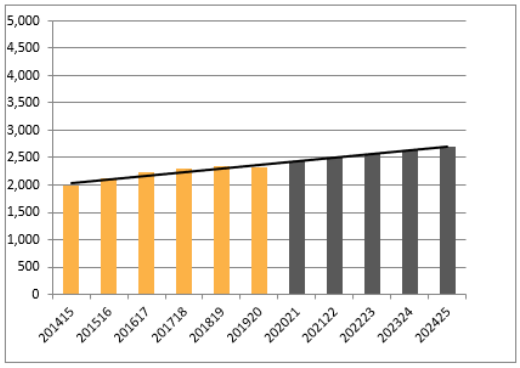
Projection	202021	202122	202223	202324	202425
MH Registers	4,197	4,302	4,407	4,512	4,617

Rugby	201415	201516	201617	201718	201819	201920
MH Registers	620	689	734	747	762	735
Prevalence %	0.65	0.66	0.67	0.67	0.68	0.64
Register Growth	0%	11%	7%	2%	2%	-4%
Actuals Growth	0	69	45	13	15	-27
5yr Avg Reg Growth	3.6%					
5yr Avg Prevalence	0.66					

Projection	202021	202122	202223	202324	202425
	795	818	841	864	887

Figure 57. QoF Mental Health Register Size Predictions by Place for Coventry and Rugby
Source: NHS Digital, Coventry and Warwickshire CCG





North Warwickshire	201415	201516	201617	201718	201819	201920
MH Registers	1,123	1,212	1,304	1,382	1,415	1,389
Prevalence %	0.67	0.70	0.75	0.78	0.79	0.79
Register Growth	0%	8%	8%	6%	2%	-2%
Actuals Growth	0	89	92	78	33	-26
5yr Avg Reg Growth	4.4%					
5yr Avg Prevalence	0.74					

Projection	202021	202122	202223	202324	202425
	1,506	1,563	1,621	1,679	1,736

South Warwickshire	201415	201516	201617	201718	201819	201920
MH Registers	1,981	2,114	2,216	2,286	2,338	2,301
Prevalence %	0.72	0.76	0.79	0.79	0.78	0.74
Register Growth	0%	7%	5%	3%	2%	-2%
Actuals Growth	0	133	102	70	52	-37
5yr Avg Reg Growth	3.1%					
5yr Avg Prevalence	0.76					

Projection	202021	202122	202223	202324	202425
	2,440	2,507	2,574	2,641	2,708

Figure 58. QoF Mental Health Register Size Predictions by Place for Warwickshire North and South Warwickshire
Source: NHS Digital, Coventry and Warwickshire CCG

Figure 57 demonstrates that Coventry is projected to experience the largest growth in the local MH register sizes over the next 5 years, from 3,916 to 4,617 (by 2025), which is an increase of 701 patients. Rugby has the smallest projected growth with 152 patients added to the register sizes by 2025.

In totality, the growth projections to the mental health registers in the next 5 years across Coventry and Warwickshire are estimated at 1,607

SMI Inpatient Admission Analysis

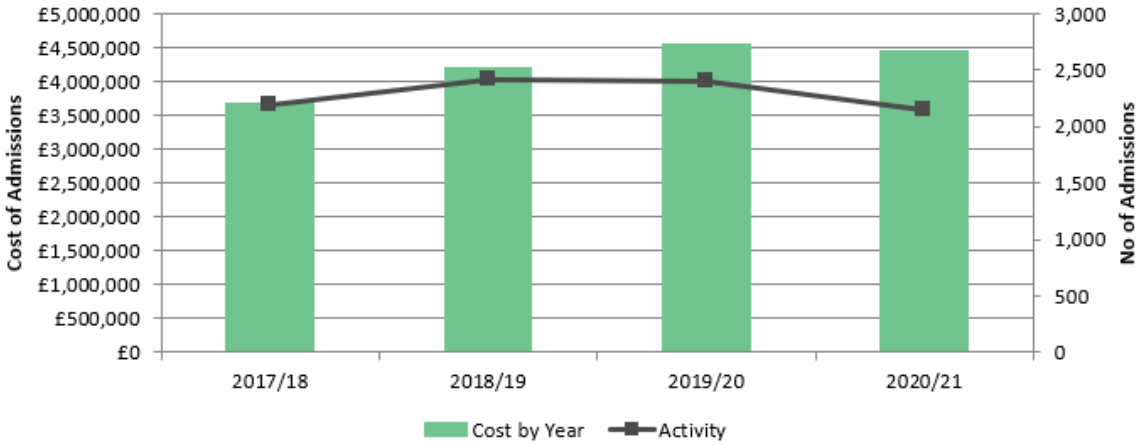


Figure 59. Cost of emergency hospital admissions by people with a severe mental illness in Coventry and Warwickshire, 2017/18 to 2020/21
Source: NHS Digital, Coventry and Warwickshire CCG

SMI acute admissions activity has grown from 2,192 (in 17/18) to 2,420 (18/19), 2,398 (19/20) and then decreased to 2,140 in 2021 for all age groups. This decrease is likely due to the impacts of the COVID-19 pandemic.

Costs have also grown from £3.6m in 17/18, to £4.1m in 18/19, to £4.5m 19/20 however, have tapered to £4.4m in 2021. Again, this is likely due to the impacts of the COVID-19 pandemic.

Table 9. Emergency admissions during 2017/19 to 2020/21 for patients with severe mental illness across Coventry and Warwickshire

	Coventry		Rugby		North Warwickshire		South Warwickshire		Total	
Fin. Year	Acti-vity	Cost (£)	Acti-vity	Cost (£)	Acti-vity	Cost (£)	Acti-vity	Cost (£)	Acti-vity	Cost (£)
2017/18	1,250	1,929,561	165	221,364	325	531,616	452	995,147	2,192	3,677,689
2018/19	1,365	2,229,244	209	300,377	345	631,491	501	1,036,863	2,420	4,197,975
2019/20	1,351	2,276,607	201	325,814	346	657,336	500	1,278,478	2,398	4,538,236
2020/21	1,178	2,283,285	190	308,383	324	732,356	448	1,136,346	2,140	4,460,371
Grand Total	5,144	8,718,697	765	1,155,939	1,340	2,552,799	1,901	4,446,835	9,150	16,874,270

Source: NHS Digital, Coventry and Warwickshire CCG

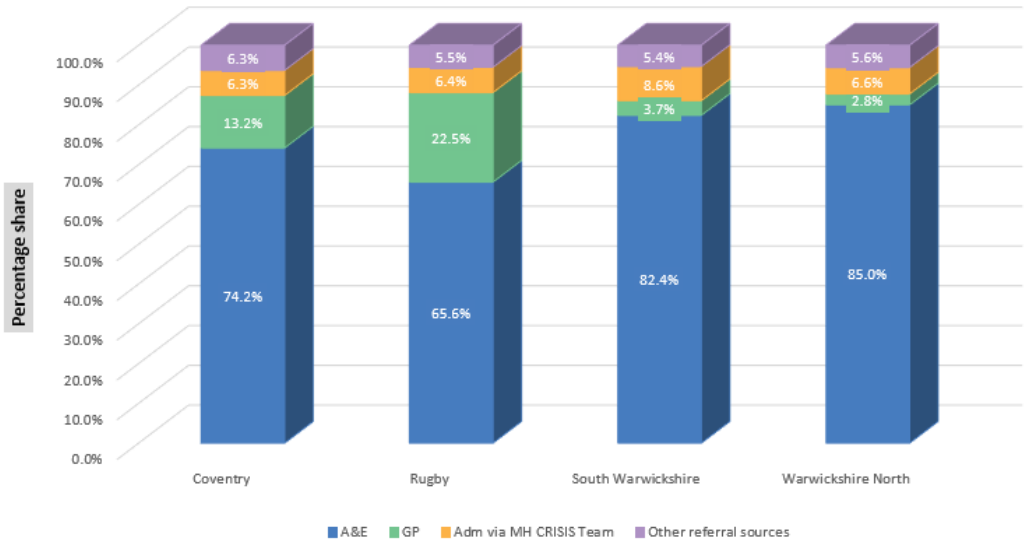


Figure 60. Percentage share of acute admissions by referral source across Coventry and Warwickshire
Source: NHS Digital, Coventry and Warwickshire CCG

Figure 60 shows the percentage share of referral routes for patients in Coventry and Warwickshire. 76.5% of all referrals are generated by A&E as the source.

GP referrals are the second highest referral source with Rugby place having the highest number of GP referrals, at 22.5% with 13.2% for Coventry, 3.7% for South Warwickshire and 2.8% for Warwickshire North respectively.

Interestingly, 8.6% of emergency admission referrals are generated from the Mental Health Crisis Team in South Warwickshire slightly higher than the average 6.4% across all other places.

Table 10. Emergency admissions between 2017/18 and 2020/21 for patients with severe mental illness in Coventry and Rugby

Coventry	2017/18	2018/19	2019/20	2020/21
No of Admissions	No of patients	No of patients	No of patients	No of patients
1	491	536	519	347
2	149	166	148	120
3	65	58	55	49
4	26	27	22	24
5	11	11	20	17
6	6	8	9	3
7	3	6	5	6
8	0	4	4	6
9	0	3	1	2
10+	4	1	4	9
Grand Total	755	820	787	583
Max No of Admissions	16	11	15	17

Rugby	2017/18	2018/19	2019/20	2020/21
No of Admissions	No of patients	No of patients	No of patients	No of patients
1	67	106	90	78
2	31	22	33	24
3	7	6	6	6
4	2	5	2	3
5	0	0	1	2
6	0	1	1	3
7	1	1	0	0
8	0	1	1	0
9	0	0	0	0
10+	0	0	0	6
Grand Total	108	142	134	122
Max No of Admissions	7	8	8	101

Source: NHS Digital, Coventry and Warwickshire CCG

Table 11. Emergency admissions between 2017/18 and 2020/21 for patients with severe mental illness in North Warwickshire and South Warwickshire

North Warwickshire	2017/18	2018/19	2019/20	2020/21
No of Admissions	No of patients	No of patients	No of patients	No of patients
1	151	183	145	126
2	38	44	39	29
3	15	9	11	14
4	5	5	8	6
5	2	2	4	0
6	1	0	2	0
7	1	1	1	1
8	0	0	1	0
9	0	0	0	1
10+	1	1	1	0
Grand Total	214	245	212	177
Max No of Admission	10	10	11	9

South Warwickshire	2017/18	2018/19	2019/20	2020/21
No of Admissions	No of patients	No of patients	No of patients	No of patients
1	241	257	249	102
2	50	52	54	20
3	22	21	23	6
4	4	4	6	1
5	1	6	5	1
6	1	2	1	0
7	0	0	1	1
8	1	1	0	1
9	0	0	0	0
10+	1	1	1	1
Grand Total	321	344	340	133
Max No of Admissions	10	11	12	10

Source: NHS Digital, Coventry and Warwickshire CCG

Tables 10 and 11 shows the number of patients with multiple admissions by place with an SMI diagnosis. Coventry place has the most significant number of SMI admissions and this is consistent across the financial years, apart from 20/21 where a reduction of admissions is likely due to the impacts of the COVID-19 pandemic. Rugby place had a significant “spike” in 2021 which is explained by 1 patient having a high number (101) of emergency admissions in 20/21.

In North Warwickshire and South Warwickshire the numbers are consistent across financial years with a reduction in admissions during 20/21, again likely due to the impacts of the COVID-19 pandemic.

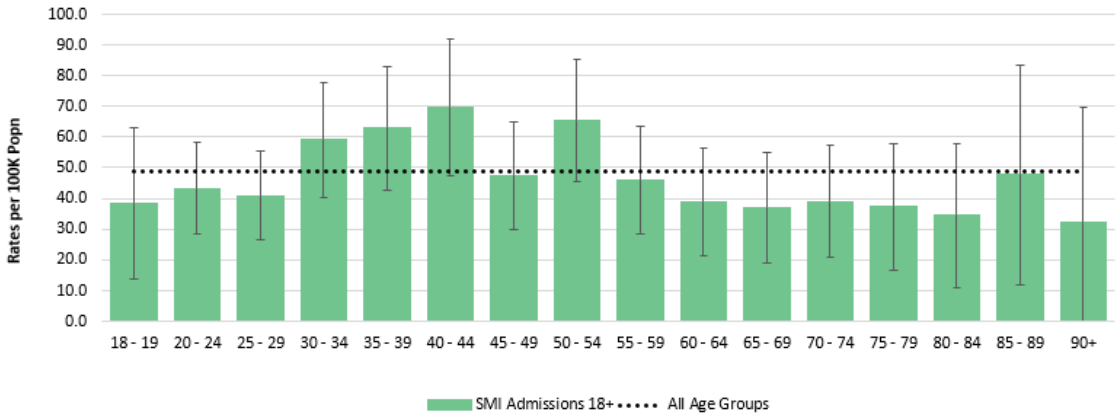


Figure 61. SMI annualised admission rates for people with a primary diagnosis of SMI by age band in Coventry and Warwickshire
Source: NHS Digital, Coventry and Warwickshire CCG

Figure 61 shows emergency admission rates by age band for patients with a SMI primary diagnosis only across Coventry and Warwickshire. The highest admission rates are for patients aged between 30-34, 35-39 and 40-44 years followed by 50-54 years.

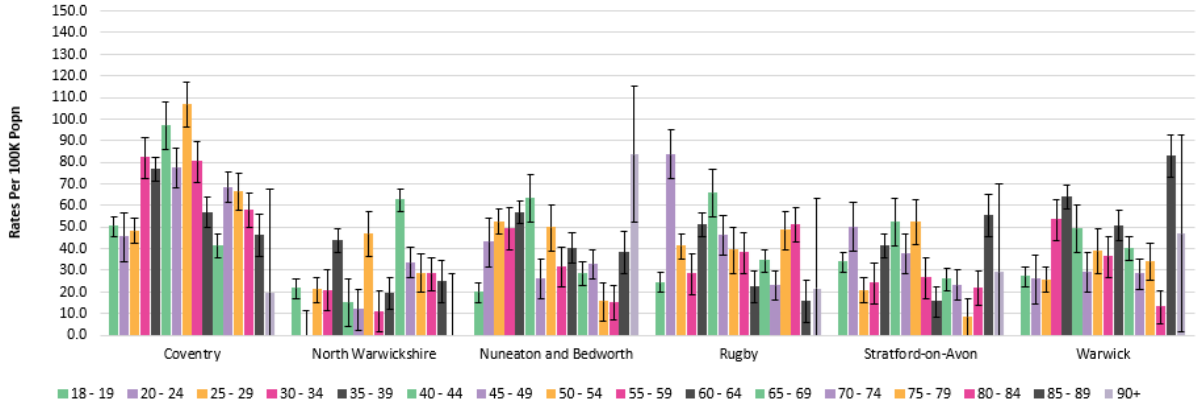


Figure 62. Annualised Admission Rates by Age Band with a SMI Primary Diagnosis in Coventry and Warwickshire
Source: NHS Digital, Coventry and Warwickshire CCG

Figure 62 shows admission rates for patients with a SMI primary diagnosis across Coventry and Warwickshire. The highest admissions rates across Coventry and Warwickshire are for 50-54 years, 40-44 years and 30-34 years age groups

However, there are some nuances based on individual places:

- Rugby: The highest admissions rates are for 20-24 years
- Warwick: The highest admissions rates are for 85-89 years
- Stratford-Upon-Avon: The highest admissions rates are for 85-89 years
- North Warwickshire: The highest admissions rates are for 65-69 years
- Nuneaton and Bedworth: The highest admissions rates are for 90+yrs

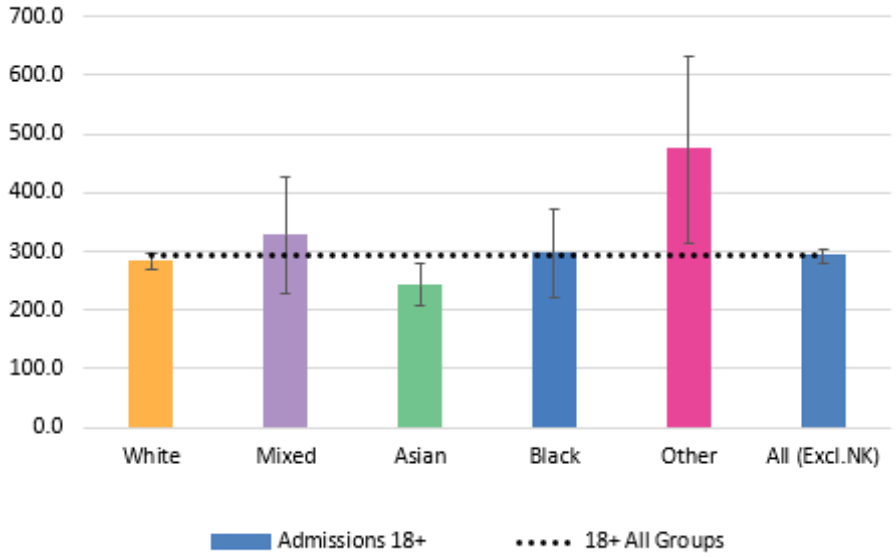


Figure 63. SMI Admission Rates (per 100,000) by ethnicity in Coventry and Warwickshire
Source: NHS Digital, Coventry and Warwickshire CCG

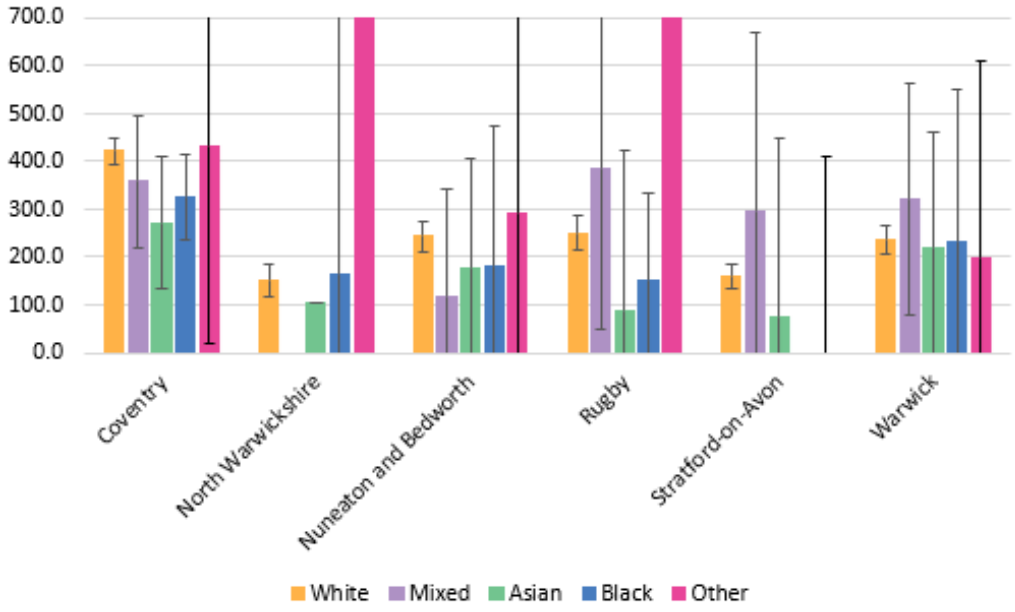


Figure 64. SMI Admission Rates (per 100,000) by ethnicity in Coventry and Warwickshire
Source: NHS Digital, Coventry and Warwickshire CCG

It should be noted that the population baseline relate to the 2011 Census populations applied to 2019 ONS Mid Year Estimates. As such any changes in the ethnic composition since 2011 will not be reflected in the ethnic grouping denominator populations, although the total change in the overall population is considered (i.e. from 2011 to 2019) in the rates calculated.

Figure 64 shows lower SMI admission rates in the Asian ethnic group and higher rates in White, Black and Mixed groupings. Confidence intervals are wider in Other ethnic populations as numbers are low.

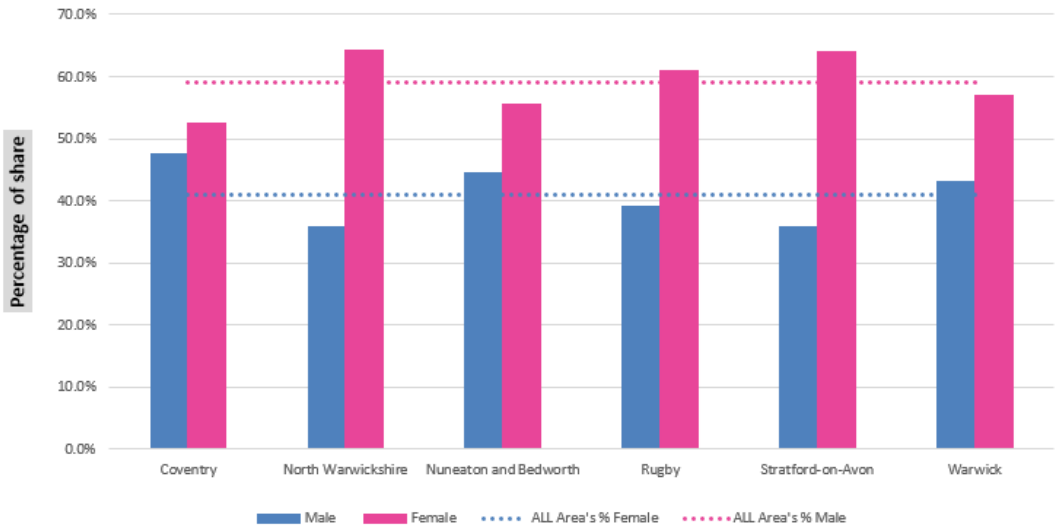


Figure 65. Percentage share of SMI admissions by gender and local authority area in Coventry and Warwickshire
Source: NHS Digital

Figure 65 shows an overall 59%:41% female to male split across Coventry and Warwickshire. North Warwickshire and Stratford-on-Avon have slightly higher percentages of female SMI admissions than the Coventry and Warwickshire average, with Coventry having the lowest female admission rate. Coventry has the highest percentage of male SMI admissions with North Warwickshire and Stratford-on-Avon having the lowest.

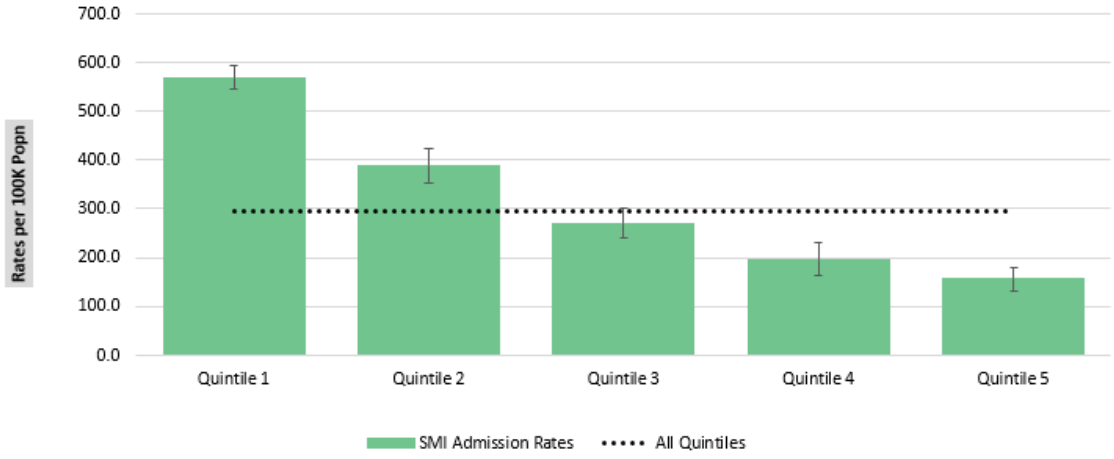


Figure 66. SMI admission rates by deprivation quintiles in Coventry and Warwickshire
Source: NHS Digital

Figure 66 shows SMI acute admission rates across all Coventry and Warwickshire Local Authority areas according to deprivation quintile. Quintile 1 represents 20% of areas most deprived nationally, Quintile 5 least deprived. This figure clearly demonstrates the social deprivation gradient, with the highest rate of admissions found in the most deprived areas and the lowest rate in the least deprived areas.

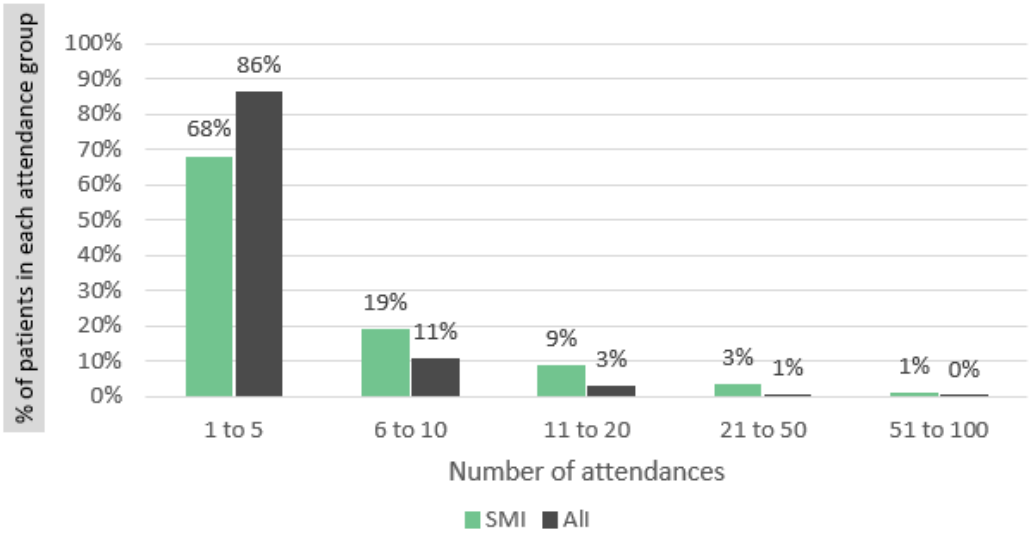


Figure 67. A&E attendances for patients with emergency admissions by SMI diagnosis in Coventry and Warwickshire grouped by number of attendances (2017/18 to 2020/21)
Source: NHS Digital

Figure 67 shows that 86% of all patients admitted as an emergency had between one and five A&E attendances whilst 68% of those with SMI conditions are in this group. 19% of SMI patients have had between six and ten A&E attendances

compared to 11% for all admitted patients. 9% of SMI patients have had between eleven and twenty A & E attendances compared to only 3% for all admitted patients. This shows that people with SMI conditions are more likely to have higher numbers of A&E attendances than those without an SMI condition.

Recommendations

The following recommendations are proposed:

- Improve community engagement with partners to raise awareness of mental health and strengthen the prevention response (including the voluntary and community sector, faith-based groups, large HR organisations and NHS providers), particularly in areas of high deprivation
- Creation and implementation of a fully integrated pathway for people with SMI in terms of both ongoing treatment and comprehensive annual physical health reviews
- Promotion of parity of esteem and understanding of importance of physical health reviews
- Local audits to be undertaken in relation to polypharmacy

PARENT AND INFANT MENTAL HEALTH

All women have the potential to experience a range of perinatal disorders of differing types and severities. Up to 20% of women experience a mental health problem in the perinatal period. They range from mild to extremely severe, requiring different pathways, management and care. They include antenatal and postnatal depression, anxiety disorders including obsessive compulsive disorder and panic disorder, eating disorders, OCD, specific relevant phobia (such as fear of needles or childbirth), trauma resulting from a previous delivery, post-traumatic stress disorder, relapse of known severe mental illnesses including schizophrenia, schizoaffective disorder and bipolar affective disorder and postpartum psychosis. Women with a previous history of serious illness, even if recovered, are at high risk of recurrence or relapse in pregnancy and after delivery.

It is estimated that approximately 3−5% of pregnant women will be referred to psychiatric services.

The epidemiology of postpartum psychiatric disorders and their service uptake is well established (Kendal et al 1987[47]; Oates 1997[48]; Kumar and Robson, 1984[49]; Munk-Olsen, 2009[50], 2011[51]). 2 per 1000 women delivered will suffer from a postpartum psychosis and are admitted to a Psychiatric Unit. A further 2 per 1000 delivered women will be admitted suffering from other serious/complex disorders. All of these require Specialised MBUs and subsequent follow-up by a specialist perinatal community team. 3% of women in the perinatal period will be referred to secondary psychiatric services; 10 to 15% of all delivered women will suffer from mild to moderate postnatal depression, the majority of whom will be cared for in Primary Care.

While treatment is also just as effective for women in the perinatal period as at other times, what is different is the heightened need for prompt and effective care. This is because a mental health problem during the perinatal period not only has the potential to adversely affect the mother, but also to have lasting consequences for her developing child. These may include emotional and behavioural problems, delayed physical development, reduced cognitive development, impaired mother-baby interactions and an increased risk of parental conflict and relationship breakdown. Linked to this, the separation of mother and infant can have serious effects on the mother-infant relationship.

For women, inadequate or absent treatment can result in a range of adverse psychological, social and employment outcomes, including increased risk of relapse.

Although maternal deaths are generally low in the UK, perinatal mental illness is associated with maternal mortality: 10% of women who died in the perinatal period, died as a result of completed suicide, and 23% of women who died in the postnatal period (6 weeks – 12 months postpartum) had a mental disorder.

Postpartum serious mental illness has a number of distinctive clinical features including acute onset in the early days and weeks following delivery, rapid deterioration and severe symptoms and behavioural disturbance. Intervention therefore requires specialist perinatal knowledge and expertise.

Access to support

Specialised perinatal community mental health teams provide assessment, intensive support and treatment for childbearing women with serious mental illness who cannot be managed effectively by primary care services.

They also assist in the detection and proactive management of women who are at risk of developing a serious perinatal postnatal mental illness and provide advice and assistance to primary care, maternity and psychiatric services on the treatment and management of serious perinatal mental illness. This includes appropriate training.

The core principle of specialised perinatal community mental health teams is to safely and effectively meet the special needs and requirements of mothers and infants in a community setting.

Outcomes

Perinatal mental health problems that are not treated effectively are also associated with substantial economic and social costs to both the NHS and public services, and society. The 2014 London School of Economics/Centre for Mental Health report highlights a long-term cost to society of £8.1 billion for each birth cohort, with £1.2bn falling directly on health and social care[52].

Evidence shows that the treatment of serious mental illness in pregnancy and following childbirth by specialised perinatal mental health services (in-patient MBUs and/or perinatal community mental health teams) results in improved mental health outcomes for women, their children and wider family, compared to standard psychiatric care. These benefits are well recognised in the short, medium and long-term. The economic cost to the public sector and society as a whole of failing to provide services to support women with perinatal mental illness is significant.

Perinatal mental health

Women who require specialist treatment for mental health problems, or experiencing loss in the perinatal period need different facilities and service response from those provided by general adult mental health services. This has been acknowledged and promoted in a range of evidence-based publications, particularly the NICE clinical management and service guidance on antenatal and postnatal mental health (2014)[53] and associated quality standard (2016)[54].

Key recent national strategies have also outlined perinatal mental health as a priority where improvements in access and outcomes for women and families are required. These include NHS England's Five Year Forward View for Mental Health and the maternity review report Better Births, Improving Outcomes of Maternity Services in England.

Therefore our perinatal mental health service is not commissioned in isolation but as part of a comprehensive pathway of care including the extended primary care team, maternity services health visiting, and perinatal IAPT, with practitioners who have knowledge and competence to treat perinatal mental health.

Services and the provision of care for women who develop mental health disorders during pregnancy and following childbirth are organised in such a way that they are able to access the right level of care at the right time, proportional to the severity of the illness. Mild to moderate disorders should usually be managed by primary care services or IAPT. The intervention of specialist perinatal mental health services will be required for the more serious and/or complex illnesses or where there are significant risks.

Research undertaken in Warwickshire (2017) engaged 1,100 families of 0-5 year old children (including expectant parents) and 275 frontline workers – which highlighted unmet perinatal and infant mental health needs; 23% of workless and 10% of parents in working households didn't know where to go to get support if they were feeling low. And, workless parents reported poorer social support.

In response, a 5-year (2019-24) Coventry & Warwickshire Parent-Infant Mental Health & Wellbeing Strategic Action Plan is now being implemented to address local health inequalities, strengthen pathway and harness coproduction with people with lived experience.

Infant Mental Health

Early years brain development is a key factor for a child's future, with evidence suggesting links between brain development and a range of outcomes, including mental and physical health.

The home environment, and parent/carer-child relationships, are central to early development and wellbeing. The influence of the parent/family is central; therefore, parent outcomes (such as parenting styles, mental health, domestic abuse, other vulnerabilities) are key drivers of mental health and wellbeing of infants and young children.

The role of midwives and health visiting teams to support parental and infant mental health is central in the Early Years Healthy Development Review's report 'The Best Start for Life: A Vision for the 1,001 Critical Days'[55]. The report will inform future work in this area and the government's 'levelling up' agenda.

Miscarriage, maternal loss and conception issues

The NHS Long Term Plan has set a clear ambition to establish a Maternal Mental Health services, to integrate maternity, reproductive health and psychological therapy. These will be for women experiencing mental health difficulties directly arising from, or related to, the maternity experience, which will:

- Respond to gaps in existing care provision (by broadening the eligibility criteria), and complement and add to existing services, to enable the needs of this cohort to be met, with clear pathways identified to existing services i.e. bereavement pathways, mental health services, IAPT, maternity, midwifery, health visiting, neonatal, Primary care, social workers and social services, VCSE and our local parent and infant mental health pathways etc.
- Strive to deliver effective and integrated pathways considering interdependencies across system partners
- Deliver trauma informed care, as an integral part of our local MH transformation programme.

Unplanned pregnancies

At least 50% of pregnancies are unplanned (often 70% in mental health populations), general mental health services are commissioned to discuss risks related to mental illness/medication and pregnancy routinely at reviews.

Impact of COVID-19

Reference made in the Coventry and Warwickshire mental health needs assessment survey 2021, captured the following comments from parents about the impact of the pandemic on pregnant women and new parents:

“My experience as a first-time mum was how astoundingly lonely parenting is”

“The lockdown restrictions have significantly increased referrals to our service, as the impact on maternal mental health has been huge: many pregnant women have felt utterly let down and abandoned”

In the survey, parents were asked, *“what impact have the following had upon your mental health and wellbeing since March 2020?”* Parenting responsibilities had the fifth highest number of respondents selecting “very negative impact” (11.3%) or “negative impact” (44.7%) (see Figure 35, page 52).

In addition, the impact of COVID-19 has been detrimental on partners not being able attend appointments/births.

It has been widely documented that the Coronavirus pandemic has caused an increase in parent and mental health issues nationally. Topical reports such as

'Working for Babies' (2021)[56] and 'Maternal mental health during a pandemic – A rapid evidence review of COVID-19's impact' (2021)[57] highlight an expected decrease in mental wellbeing for parents during the pandemic with increased stress, worries and concerns not only about health and wellbeing, but with added layers of financial, family, relationship and socioeconomic concerns. These reports, and others, provide clear evidence of increased need, whilst also highlighting services that are pivotal in supporting these families were impacted detrimentally. In addition, the Maternal Mental Health Alliance report highlights the concerns for those staff working within these workforces and the emotional impact that this period has had.

At a local level, the picture echoes that of the national reports. Dr Alexandra Eriksson (CT3 Psychiatry, Coventry and Warwickshire Partnership Trust) conducted a survey amongst new mums highlighting:

- 86.7% received less practical support from family or friends than expected
- 93.7% of mums surveyed felt they had missed out on social groups and experiences
- 56.9% had felt lockdown had negatively impacted on their mental health and
- 75.5% had struggled to access services to support them and their baby.

Local frontline staff report an increase in parent and infant mental health issues during the pandemic, such as increased anxiety and depression. COVID-related anxiety and an increase in OCD and intrusive thoughts were also areas of growing concern and staff attributed social isolation and loneliness as key triggers for the increase in poor mental health.

Preliminary data from The Royal College of Psychiatrists shows that only 3.6% of mothers accessed perinatal mental health support in 2020/21 compared to an expected rate of 7%. This equates to 16,000 mothers across the UK not accessing support. Locally, however, the perinatal mental health team has met the access rate for 2020/21 of 7.1%.

Inequalities

One in five mothers suffers from depression, anxiety or in some cases psychosis during pregnancy or in the first year after childbirth. Suicide is the second leading cause of maternal death, after cardiovascular disease. It is also thought that up to one in ten fathers experience mental health challenges around the perinatal period but often do not seek support.

In terms of inequalities experienced by ethnically diverse communities, research has highlighted that:

- Women from ethnically diverse communities are more likely to live in the most deprived communities, poorer access to health care
- Knowledge about perinatal mental health is low in ethnically diverse communities.
- Existence of stigma associated with mental health in ethnically diverse communities can hinder actions to seek help or present early
- When help is accessed, women from minority ethnic backgrounds felt they encountered significant barriers when requesting translators, or felt unable to disclose feelings due to differences in ethnic backgrounds of health and care professionals and not receiving perceived culturally appropriate support
- There is a lack of 'culturally-sensitive' care pathways or support, with personal and cultural factors

Unfortunately as a result of the above factors, women from ethnically diverse communities are underrepresented in Perinatal services, but FWT (a local VCSE organisation) is commissioned to work alongside the award winning MAMTA team who have a long track record of addressing barriers and offering culturally sensitive support around child and maternal health – providing crucial access to women from ethnically diverse communities across Coventry and Warwickshire.

Recommendations

- Raise awareness of and promote support for fathers experiencing post-natal mental health difficulties
- Continue to work with MAMTA to reduce health inequalities experienced by those from ethnically diverse communities

PERSONALITY DISORDERS

People with so-named 'personality disorders' experience considerable distress, suffering, and stigma. The definition itself remains open to some debate and the pejorative term used to bring with it a tacit admission that there was unlikely to be any effective recovery made.

There is increasing evidence that treatment for personality disorders can be effective and its recent NHS classification as a severe mental illness brings welcome acknowledgment to the suffering that those who meet the criteria endure, as well as the considerable difficulties and costs in providing effective management and treatment.

People with personality disorders have persistent and pervasive levels of problem in social relationships and functioning and have other co-morbid mental health conditions. As with other mental health problems, personality disorders are the result of multiple interacting genetic and environmental factors.

Epidemiological studies show that 4-12% (*8% mean) of the adult population meet the criteria for a formal diagnosis of personality disorder. There are different clusters of personality disorder and different types within those clusters. It is imperative that this fact becomes better understood as there is a widely held misapprehension that there is just one personality disorder. People with personality disorder have the highest rate of A&E use compared to other groups of people with mental health problems.

The most discussed personality disorder in mental health is the classification known in as Emotionally Unstable Personality Disorder (EUPD). EUPD is characterised by very high levels of personal and emotional instability associated with significant impairment. People with EUPD have severe difficulties in sustaining relationships and self-harm and suicidal behaviour is common, where 10% of people take their own lives (Paris & Zweig-Frank 2001[58]).

A trauma-informed psychological understanding of personality disorder might describe the mental health condition as *Complex Trauma* as opposed to EUPD as traumatic experiences including abuse will most usually be part of the history of sufferers.

Most people with EUPD will have first shown symptoms in late adolescence or early adult life. The symptoms fluctuate hugely as is characteristic of the dramatic and erratic nature of EUPD, but generally longitudinal studies demonstrate an improvement over a long period of time (Newton-Howes et al. 2015). Among those receiving treatment, as many as half recover (Zanarini et al. 2003[59]).

Estimates of the prevalence of EUPD vary and it is important to note that many people who meet the criteria for a diagnosis often do not actually receive one. According to the NICE Quality Standard QS88 Personality Disorders Anti-Social and Borderline (2015)[60] summarised evidence and indicated that figures equate to 1%* for EUPD in the general population.

Whilst evaluative research is not yet published, people with a personality disorder's mental health may have been disproportionately adversely affected in COVID-19, as it has hit their key problem areas of emotional, behavioural, interpersonal, and identity-related issues (Preti et al, 2020[61]).

Applying the 1% and 8% rates* to the population of Coventry and Warwickshire registered with a GP we might therefore expect the following numbers:

Table 12. Estimated numbers of people meeting criteria of personality disorders across Coventry and Warwickshire

	Estimated number of people meeting a criteria of EUPD in Coventry & Warwickshire	Estimated number of people meeting a criteria of all personality disorders in Coventry & Warwickshire
Males	5,207	41,653
Females	5,058	40,464
Total	**10,265**	**82,117**

Source: Population data sourced from ONS

People with EUPD and other personality disorders access different parts of our overall mental health system. Some will not be in any specific mental health service at all and not be help-seeking. A significant proportion of people will be engaging with the VCSE sector in different ways, for example one of the larger charities in Coventry & Warwickshire estimated that up to 50% of their cohort had a personality disorder. Many will be engaging with NHS services in primary care and others will be in secondary care, including urgent and inpatient services. People with personality disorders' care is often fragmented and gaps in service provision and commissioning are recognised, which Coventry & Warwickshire mental health system sis seeking to improve through the community mental transformation underway.

The NHS Long Term Plan has committed to an integrated primary and secondary care approaches to provide improved care and choice for up to 370,000 adults and older adults with severe mental illness by 2023.

Recommendations

The following improvement actions have been identified by clinical leads:

- Improvements are needed across the health and social care system in compassionate understanding about personality disorders, their prevalence and treatment.
- Reduce gaps in commissioning and service provision for people with personality disorder

- Improve pathways for people with personality disorders to ensure their needs are fully met

EATING DISORDERS

Eating disorders are complex mental health conditions that are characterised by a person having a difficult relationship with food. There are several types of eating disorder including:

- Anorexia nervosa – where people try to keep their weight as low as possible for example by not eating enough or over exercising
- Bulimia nervosa – where people have an unhealthy cycle of eating a lot of food and then doing something to try to stop weight gain, such as vomiting or taking laxatives
- Binge eating – where people eat a lot of food in a short period of time on a regular basis

Estimated Prevalence of Eating Disorders

Approximately 1.25 million people in the UK have an eating disorder.

Analysis undertaken across the West Midlands suggests that across all Eating Disorders projections for 2024 are largely static (see Figure 68):

- Coventry and Warwickshire - +0.3% increase in prevalence by 2024
- Staffordshire and Shropshire - -0.1% increase in prevalence by 2024
- Birmingham and Black Country - +0.3% increase in prevalence by 2024

With a fairly static prevalence rate this should not create additional demand on services across the West Midlands.

The projected estimated prevalence for Coventry of all eating disorders for adults aged 18 is summarised below.

Patients with anorexia nervosa, have the highest mortality of any psychiatric illness. Both their physical state and suicidal behaviours contribute to this risk.

	2016	2017	2018	2019	2020	2021	2022	2023	2024
Anorexia	302	309	315	319	323	326	328	330	333
Anorexia % Change		+2.4%	+1.8%	+1.5%	+1.1%	+0.8%	+0.8%	+0.6%	+0.6%
Bulimia	1,613	1,644	1,671	1,694	1,715	1,731	1,749	1,764	1,782
Bulimia % Change		+1.9%	+1.6%	+1.4%	+1.2%	+1.0%	+1.0%	+0.9%	+1.0%
EDNOS	4,205	4,282	4,348	4,406	4,452	4,491	4,530	4,565	4,606
EDNOS % Change		+1.9%	+1.5%	+1.3%	+1.1%	+0.9%	+0.9%	+0.8%	+0.9%
Population (All Ages)	353,215	359,945	366,219	372,025	377,380	382,253	387,052	391,689	396,323
Total Population 18+	276,628	281,859	286,482	290,608	294,250	297,552	300,900	304,062	307,474
Anorexia	*302*	*309*	*315*	*319*	*323*	*326*	*328*	*330*	*333*
Bulimia	*1,613*	*1,644*	*1,671*	*1,694*	*1,715*	*1,731*	*1,749*	*1,764*	*1,782*
EDNOS	*4,205*	*4,282*	*4,348*	*4,406*	*4,452*	*4,491*	*4,530*	*4,565*	*4,606*
Total ED	6,120	6,236	6,334	6,420	6,490	6,548	6,607	6,660	6,720
% Change		+1.9%	+1.6%	+1.4%	+1.1%	+0.9%	+0.9%	+0.8%	+0.9%
% of Total Population	1.73%	1.73%	1.73%	1.73%	1.72%	1.71%	1.71%	1.70%	1.70%
% of Adult Population	2.21%	2.21%	2.21%	2.21%	2.21%	2.20%	2.20%	2.19%	2.19%

Figure 68: Coventry Adult eating disorder estimated prevalence
Source: https://www.beateatingdisorders.org.uk/how-many-people-eating-disorder-uk

Patient profile

The below table outlines the adult ED patient profile for three key demographics.

Table 13: Adult eating disorder demographics

Indicator	
Gender	• In 2018/19 90% of local ED inpatients were female, reflecting national presentations. (Hospital Episode Statistics; 2017-2018). • Nationally there is a noticeable increase in identification of men with eating disorders in recent years. (Micali, 2013[62]) • Local activity data doesn't indicate an increase in male inpatient activity across the West Midlands but there does appear to be an increase in male outpatient referrals.
Age	• In 2018/19 54% of inpatients were age 18-29 years old across the West Midlands, which is comparable to national admissions for this age range at 50% • The average age of inpatients was 30 years old. • Almost 12% of service users who were hospitalised were aged 50 or older.
Ethnicity	• Risks are significantly increased for BAME patients who are less likely to be diagnosed/ referred to a specialist eating disorder service.

Adult ED Admission Patterns

Across the West Midlands for the last two years, the average length of stay (LOS), cost and distance is outlined in the table below.

Table 14. West Midlands Adult ED inpatient admission data for 2017/18 – 2018/19

Adult ED inpatient admission	Average LOS	Average cost	Maximum and average distance travelled
In area	116 days	£50,000	Average distance 12 miles Maximum distance 60 miles
Out of area	161 days (+ 45 days)	£63,000 (+ £13,000)	Average distance 117 miles Maximum distance 269 miles

Source: NHS Digital

The national average LOS is 103 days, which our region exceeds.
The LOS for Coventry patients is 136 days, above regional and national averages.

It is known from research undertaken that placements far from home impede recovery and can cause stress for those using the service and their loved ones. Regular home visits also play an important role in maintaining and building the skills necessary for a successful discharge and to reduce length of stay, along with the reassurance provided when able to meet the community teams responsible for care post-discharge.

NHS Long Term Plan Ambitions for Adult Eating Disorders

As set out in the NHS Long Term Plan, local areas will be supported to redesign and reorganise community mental health services to move towards a new place-based, multidisciplinary service across health and social care aligned with primary care networks.

"By 2023/ 24, new models of care, underpinned by improved information sharing, will give 370,000 adults and older adults, including those living with eating disorders, greater choice and control over their care, and support them to live well in their communities. Through a rebalancing of provision, from a focus on inpatient services to expansion of community based specialist services, adults with eating disorders will be able to access treatment earlier, and closer to home, leading to better outcomes for them and their families".

Currently we have inequity in our local adult ED pathway. Coventry have a psychology led service for Adults with a mild to moderate ED) and Warwickshire has a Psychiatry led service for patients with a severe ED. As a system, we are committed to support the ambition as set out in the Long Term Plan to meet the needs of our local population who need to access specialist and community based treatment and care for Eating Disorders.

Advancing Health Inequalities for ED service users (CYP and Adults)

There are specific inequalities within eating disorder services, which require focused attention. For example, eating disorders in males and transgender people may not be recognised or clearly identified, which may lead to difficulties or delays in accessing appropriate treatment.

Community ED (CED) services can advance mental health equality by:

- Ensuring appropriate facilities are provided for people of all genders which is clearly right to ensure men and people of other identities (including people who are transgender and who identify as non-binary) can all access services.
- Recognising that transgender and non-binary people may experience body dysmorphic issues that are related to their gender identity rather than their eating disorder, and being mindful of and sensitive to this distinction.

The available evidence suggests that there are specific factors to consider for people who present with an eating disorder and identify as transgender and non-binary.

- Disordered eating and striving for thinness among people who identify as transgender or non-binary may be related to a desire to either highlight or

suppress features of their biological sex in order to better align their physique with their gender.

- Hormone therapy that a person who identifies as transgender or non-binary may be undertaking in order to physically transition can induce weight gain, which may lead to distress and introduce further complexity in providing treatment for an eating disorder.
- People with an eating disorder who identify as transgender or non-binary may experience body dysmorphic issues that are related to discordance between their biological sex and gender identity, rather than their eating disorder. For this reason, a treatment approach that places significant emphasis on body positivity may be perceived as dismissive of the distress they experience around unwanted aspects of their physiology.

Staff in a CED service providing care to people with eating disorders who identify as transgender or non-binary should make efforts to understand the person's feelings around transition, as this may offer insights into the aetiology of their eating disorder, the distinction between body dysmorphic issues, and the likelihood of facing complicating factors. All such information has the potential to be highly valuable when developing a formulation and delivering appropriate, effective care. Importantly, all staff interacting with people who identify as transgender or non-binary should be respectful of the person's preferred pronouns and be mindful of the detrimental effects that dismissing someone's gender identity or mis-gendering them can have on treatment and recovery.

Children and Young People (CYP) Eating Disorders

Eating Disorders are serious mental health problems. They can have severe psychological, physical and social consequences. It is vital that children and young people with eating disorders and their families and carers access effective help quickly. Offering evidence-based, high-quality care and support as soon as possible can improve recovery rates, lead to fewer relapses and reduce the need for inpatient admissions. (DoH 2015, 2019)

There has been a programme of investment by the Government to support the development of dedicated community Eating Disorders Teams, with the overall aim to deliver early access to effective, evidence-based and outcome-focused treatment, working in partnership with children, young people and families. Rising referral numbers were recognised in the NHS Long Term Plan and from 2019, additional investment was made.

Table 15. Government investment for childrens eating disorders

Year	Government investment for Childrens Eating Disorder (Nationally)
2014/2015	£30 Million
2019/2020	£11 Million
2020/2021	£11 Million

Further guidance has been provided for the commissioning of Children and Young People's Eating Disorder Teams in the Children and Young People's Eating Disorder Access and Waiting Time Commissioning Guide (2015)[63] and an addendum[64] with helpful resources (2019)[65].

The commissioning guide sets out a range of standards and timeliness targets. This includes a requirement that by 2020/21, 95 per cent of children and young people in need begin treatment within 1 week for urgent cases and 4 weeks for non-urgent cases. There is also the need to have a range of treatment options and service interventions to support a broad range of clinical presentation.

Coventry and Warwickshire has a dedicated Eating Disorder Team formed in 2016 following direct funding from the CAMHS Transformation monies. The Eating Disorder Team receives referrals for a range of eating disorders and supports a range of clinical severity. The Team has worked to foster a model of early referral but still receives a high number of patients with high levels of needs at the outset.

Types of Eating Disorder treated by the Children's Eating Disorders Team in Coventry and Warwickshire include anorexia nervosa, bulimia and binge eating disorder (BED).

The 2020 COVID-19 pandemic has resulted in the biggest change in the structure of everyday life for people across the nation. The impact of this on Children and Young people is yet to be fully understood; however eating disorders is an area where the impact of the changes to our daily lives may have negatively impacted those at risk of developing a disorder.

Between April 20-April 21 there has been an increased number of CYP with Eating Disorders supported by the Crisis Team, often with additional diagnoses or complexity. The 2021/22 priority will be to develop intensive support options alongside the treatment intervention pathway to support crisis and urgent presentation is critical for patient outcomes, reduced length of stay, alternative to admission, enhanced community package of care, smoother transition between services which includes in reach and step down from bedded provision either in tier 4 or acute paediatrics.

All Mental health and paediatric services have seen an increase in demand for services for those with a food intake disorder. The teams across RISE have seen increasing numbers of young people referred with suspected ARFID and there is currently no clear treatment pathway in the system and as a result, many CYP are passed between different services and do not receive appropriate treatment, often over many years. NHSE have highlighted that CYP with ARFID are often inadequately served by existing services and have set an expectation, alongside additional funding, that Children & Adolescent Eating Disorder Services (CAEDS) will transform to provide support for CYP with ARFID. In line with NHSE expectations, Commissioner and providers propose to expand the current CYP ED service to

include assessment and treatment for appropriate forms of ARFID whereby there are significant and severe eating difficulties.

Plans are currently progressing for the CYP ED service to expand its operational age and workforce to accept and provide intervention pathways for 18-19-year olds as part early adopter of an age independent pathway that will be the focus of both CYP and Adult ED transformation plans.

Recommendations

- Work to create equity of access to services across Coventry and Warwickshire
- Raise awareness of eating disorders in men and people of other identities (e.g. people who are transgender and those who identify as non-binary)
- Ensure appropriate facilities are provided for people of all genders to ensure men and people of other identities (including people who are transgender and who identify as non-binary) can all access services.

LEARNING DISABILITY

A learning disability affects the way a person learns new things throughout their lifetime and also affects the way a person understands information and how they communicate. This means that people with a learning disability can have difficulty:

- understanding new or complex information
- learning new skills
- coping independently.[66]

People with a learning disability have worse physical and mental health than people without a learning disability[67]. On average, adults with a learning disability die 16 years earlier than the general population – 20 years for men, 13 years for women[3]. There are several reasons for this including associated health conditions including epilepsy and weight concerns, physical health and the medication for health conditions, however the poor-quality healthcare experienced by people with a learning disability is suggested to be a key contributory factor.[68]

Prevalence

Approximately 2.16% of adults and 2.5% of children in the UK are believed to have a learning disability. According to this data there are 1.5 million people in the UK with a learning disability.[69]

Table 16 shows the estimated number of adults in Coventry and Warwickshire who have a Learning Disability in 2021.

Table 16. Estimated figures of those with a Learning Disability according to PANSI prevalence data for 2021.

Area	Estimated number of people aged 18 and over with a Learning Disability
Coventry	7,268
Warwickshire	10,930

Research suggests that the prevalence of mental health problems is higher in people with a learning disability than in those without a learning disability. A study based on Scotland's 2011 Census data indicated that 21.7% of people with learning disabilities reported mental health conditions in comparison to 4.3% of the general population.[70]

Research has identified that the rate of psychiatric disorder also varies dependent upon the level of learning disability[71], as shown in Table 17.

Table 17. The prevalence of psychiatric disorders (percent) in adults with intellectual disabilities (ID) by severity of ID.

Diagnosis	Mild	Moderate	Severe	Profound
Psychiatric disorder of any type	24.2%	27.4%	34.3%	44.8%

Several reasons for the higher prevalence rate of mental health problems for people with a learning disability are suggested, which include:

- Biological factors: the association of some genetic syndromes associated with mental health problems, the impact of physical ill health and treatments for these contributing to poor mental health. The link between mental health conditions and poor general health supports this as people with learning disabilities can often have poor physical health.[70]
- Negative life events: research has shown that those with a learning disability may be more likely to experience trauma such as sexual and physical abuse or be exposed to negative life events and inequalities such as deprivation and poverty.[72]
- Fewer resources: the statutory support, social support and coping skills to respond to negative live events may not be available for people with a learning disability.
- Attitudes of others: stigma and discrimination around both disabilities and mental health may result in psychological distress.[73]

Access to services

Across the United Kingdom the point of access for mental health care for people with learning disabilities is within generic mental health services with additional specialist mental health services for those with more complex needs which require a greater level of support.[74]

Reasonable Adjustments

The NHS Long Term Plan outlined that despite often having greater ill-health, people with a learning disability will often experience poorer access to healthcare[3].

Under the Equality Act 2010 it is a legal duty to make reasonable adjustments to ensure that people with a learning disability are as able to access services including healthcare, as those without disabilities are.

Reasonable adjustments can include the availability of accessible information such as in an easy read format, longer appointment times and being able to choose specific times for appointments.

To support access to health services, people are encouraged to complete a hospital/ communication passport which includes the important information needed to provide care and support such as communication needs, level of support required and mobility needs.

Diagnostic Overshadowing

A potential barrier to access of available mental health support and services is diagnostic overshadowing where conditions are not identified or misattributed to the persons' learning disabilities or as behaviours that challenge.[70]

As people with learning disabilities have a higher risk of experiencing several other health conditions it is important for any changes in behaviour to be explored and not assumed to be due to their learning disability as a primary health condition. If not, people with learning disabilities can suffer poor care with a lack of support being offered or delays in treatment.[75]

These issues suggest the need for both reasonable adjustments and workforce development in mental health support and services. To ensure that mental health staff have the training and skills to identify when conditions are not attributed to a person's learning disability and be able to adapt the support appropriately.

A current training pilot (Oliver McGowan training) across Coventry and Warwickshire intends to develop the awareness and understanding of Learning Disability and Autism with health staff. This aims to share the skills required to ensure people with a learning disability and autistic people have positive health and social care outcomes. This training will become mandatory for all working in health and social care.

Annual Health Checks

People with a learning disability are entitled to an annual health check with their GP. This assesses emotional mental health alongside physical health checks by allowing people time to discuss any worries they may have with their GP who can signpost to available services. Whilst local uptake figures have improved during the pandemic, it is recommended that annual health checks continue to be promoted to people with a learning disability.

Arden Transforming Care Programme

The transforming care programme works with people with learning disabilities and mental health conditions or behaviours that could be described as challenging and who are inpatients or at risk of admission. Table 18 shows snapshot data from the Arden transforming care programme, across Coventry and Warwickshire, which identifies at the end of May 2021 that 23 adults with Learning Disabilities are inpatients.

With the Transforming Care Programme's focus on admission avoidance, more people with complex needs are living in the community and will need access to services, including mental health services.

Outcomes

With reasonable adjustments in place people with a learning disability should be able to access the appropriate support and, if required, treatment for their mental health needs.

Treatment Options

Psychological interventions as a treatment option for people with learning disabilities has grown as the understanding of the mental health needs of this population has increased.[76] The broad aim of psychological interventions is to work in partnership with service users to modify undesirable thoughts and behaviours.[77]

Psychological interventions for mental health conditions include positive behaviour support, cognitive behavioural approaches, art and music therapy and dialectical behavioural therapy approaches. These interventions are currently available locally in Coventry and Warwickshire, delivered by Coventry & Warwickshire Partnership Trust.

An additional treatment option for severe mental health conditions is psychotropic medication. For people with learning disabilities this medication is similarly effective as it is to the general population for treatment however, evidence suggests that this medication is often inappropriately prescribed for people with a learning disability[78].

It was estimated in 2015 that between 30,000 and 35,000 adults with a learning disability in England were prescribed psychotropic medication when they did not have the conditions these medications were intended for.[79] To stop this overuse a national project was set up in 2016 called STOMP (Stopping Over-Medication of People with a Learning Disability and/or Autism with psychotropic medicines). The aims of STOMP include encouraging regular medication reviews, involvement of people and their families or support staff in decisions on medicines and informing people about non-drug therapies and other practical ways of supporting people to reduce the amount or need for medicine.[80]

Impact of COVID-19

The impact of COVID-19 on people with learning disabilities was significant. Research finding that during Spring 2020 the number of people with learning disabilities who passed away was substantially higher than the general population; the death rate between 2.3- 6.3 times that of the general population.[81]

Support across Coventry & Warwickshire

Alongside the risks to health, COVID-19 impacted people with learning disabilities through:

- Reduced access to health care, a recent research study finding that over 60% of people involved in the UK study had seen healthcare professionals less or not at all since March 2020. Of the same group several had medical tests or hospital appointments cancelled[82].
- Increased social isolation which was further exaggerated by the instruction to shield for many people with a learning disability.
- Reduced social care support. Across Coventry and Warwickshire community services including respite, day services and wellbeing hubs had to reduce their offer due to social distancing restrictions. Many services responded with a virtual offer however, digital inequalities for people with learning disabilities resulted in this not being an available offer for all.

These changes to support and daily life for people with learning disabilities increased the feeling of social isolation and heightened feelings of concern and anxiety[84].

Recommendations

- Promote Oliver McGowan training across Coventry and Warwickshire to raise awareness of the mental health needs of people with a learning disability
- Promote the aims of the STOMP project to reduce over-medication of people with learning disabilities (encouraging regular medication reviews, involvement of people and their families or support staff in decisions on medicines and informing people about non-drug therapies and other practical ways of supporting people to reduce the amount or need for medicine)

AUTISM

Autism is defined as a lifelong neurodevelopmental condition that affects how a person develops, communicates and socially interacts with people[83]. Every Autistic person is different and like the general population autistic people can have good mental health[84]. However the prevalence statistics below show that more autistic people experience co-occurring mental health problems than other people.

Prevalence

The UK does not have administration processes or surveys that capture data on the number of autistic children and adults, making it difficult to measure the prevalence of autism both nationally and locally. Nevertheless, several sources provide prevalence estimates that range between 0.8% to 1.1% autistic people in England. With the current rate of diagnosis across the sexes being 1:3 for men and women respectively. Again, this rate across sexes does not reflect the true picture of autism and both the National Autistic Society and Autistica state that autism is likely to be under-diagnosed in women.

The joint needs assessment for children and adults with neurodevelopmental needs (2019) highlights the predicted prevalence of autistic people in Coventry and Warwickshire, which reflects the national estimates. Presenting an estimate of 4,770 autistic people in Warwickshire and 3,197 in Coventry in 2019. Table 19 shows the predicted prevalence of autistic people (2017) across Coventry and Warwickshire, split by age and gender. The lack of actual prevalence data has driven the recommendation for more efforts to improve data collection locally.

Table 19. Predicted prevalence of Autism by age and gender (2017)

	Age 0-17			Age 18+			All
Area	**Female**	**Male**	**Total**	**Female**	**Male**	**Total**	**Total**
North Warwickshire	12	95	108	53	378	431	538
Nuneaton & Bedworth	27	211	239	103	738	841	1,080
Rugby	23	183	206	84	613	696	902
Stratford-on-Avon	23	181	204	105	735	840	1,044
Warwick	26	208	234	114	847	960	1,195
Warwickshire	112	879	990	459	3,309	3,768	4,759
Coventry	75	598	673	280	2,136	2,417	3,090
Total	187	1,476	1,664	739	5,446	6,185	7,849

Mental health conditions are common within the autistic people, with suicidality and suicide rates that are significantly higher than the general population. Autistica state that 70% of autistic adults also live with a mental health condition. The Transforming Care Programme leads the work to prevent avoidable admissions to mental health inpatient services. The number of mental health admissions for autistic people are seen in Table 20. The TCP is not currently meeting planned trajectories for in-patient numbers.

Table 20: Number of total mental health inpatient admission in Coventry and Warwickshire, as of 27/05/2021 (snapshot)

Inpatients In/Out of area			
Cohort	**Out of area**	**In the area**	**Grand Total**
Adult	**23**	**13**	**36**
Autism	9	4	13
LD	14	9	23
Children	**11**	**0**	**11**
Autism	11	0	11
LD	0	0	0
Grand Total	**34**	**13**	**47**

Access

Access to the commissioned support and services has positively increased since the last 2013 Coventry and Warwickshire joint needs assessment (2013). However more work is required to increase access as indicated by autistic people who have reported issues with the availability, accessibility and/or specificity of support.

Evidence shows that there are known barriers to accessing mental health services in Coventry and Warwickshire for autistic people with mental health needs. Difficulty in accessing mental health services was associated with issues such as eligibility for support, skills to identify autistic traits and core mental health services refusing support because mental health issues appear to link to autism.

Continued work is in place to transform existing support offer, including universal services, to make it more accessible and responsive to people's needs, this includes support for mental health. Difficulty in accessing mental health services was associated with the support service criteria issues such as autistic people not appearing to be meeting and mental health professionals and other professionals not identifying and skilled to work with autistic people with mental health needs or who are emotionally distress. These issues indicate a need for reasonable adjustment in mental health services, collaborative working and to ensure mental health service workforce have the required training, skills and confidence to recognise co-occurring autism and choose and tailor support appropriately.

A key theme in the mental health needs assessment survey was that it was difficult to access mental health services if it was combined with another condition like autism. There was a sense that when people presented with additional conditions they didn't 'fit' the criteria see key messages. This was highlighted by a professional commenting: there is a *"lack of provision for individuals with autism, they tend to be excluded from mental health care via places such as CMHT/IPU teams, due to professionals feeling that their difficulties are autism related."*

Outcomes

With the right support and a suitable environment, majority of autistic people can live independently and without specialist help. The disproportionate rate of mental health needs in autistic people to the general public reinforce the need to improve mental health outcomes for Autistic people.

Impact of COVID-19

The coronavirus pandemic has had devastating impact on the mental health of autistic people. The Left stranded report (2020) that 9 out of 10 autistic people were worried about their mental health during the pandemic and that they were 7 more times more likely to be chronically lonely than the general public[85]. Autistic people who need support all of the time were found to be significantly more affected by the national lockdown. Negative impact on children was observed in the change to school structures and access as 70% of UK parents of autistic children said their child had difficulty understanding or completing schoolwork and around 50% said their child's academic progress suffered.

A key theme in the Coventry and Warwickshire mental health needs assessment survey was that it was difficult to access mental health services if it was combined with another condition such as autism. There was a sense that when people presented with additional conditions they didn't 'fit' the criteria. One professional noted that there is a *"lack of provision for individuals with autism, they tend to be excluded from mental health care via places such as CMHT/IPU teams, due to professionals feeling that their difficulties are autism related."*

Recommendations

The following recommendation is made:

- Raise awareness of autism and appropriate mental health interventions for people with autism
- Work with mental health services to improve access to services for people with autism (focusing on eligibility for support and improving skills to identify autistic traits)

SUICIDE

In 2012, the Government published the Cross-Government National Suicide Prevention Strategy, updated in 2017 to incorporate self-harm reduction and a Cross-Government Workplan to support delivery of the strategy. This commits every area of Government to acting on suicide and sets out clear deliverables and timescales to monitor progress against key commitments.

The Five Year Forward View for Mental Health and NHS Long-term Plan reaffirm the NHS's commitment to suicide prevention. National actions include funding for mental health care and support for those bereaved by suicide, alongside implementation of a new Mental Health Safety Improvement Programme.

The profile of deaths by suicide in the population within Coventry and Warwickshire is outlined below. This does not include data from the pandemic period. Whilst the number of deaths by suicide are small each death has a broad impact on bereaved families, friends and wider communities and are an indicator of broader patterns of the mental health needs of communities. National data is available up to September 2020; 5.3% of the 1,334 suicides registered in the period occurred in the same period (71 deaths), with the remaining deaths occurring in the first quarter of 2020 (34.9% or 466 deaths), the second quarter of 2020 (28.3% or 378 deaths) or prior to 2020 (31.4% or 419 deaths).

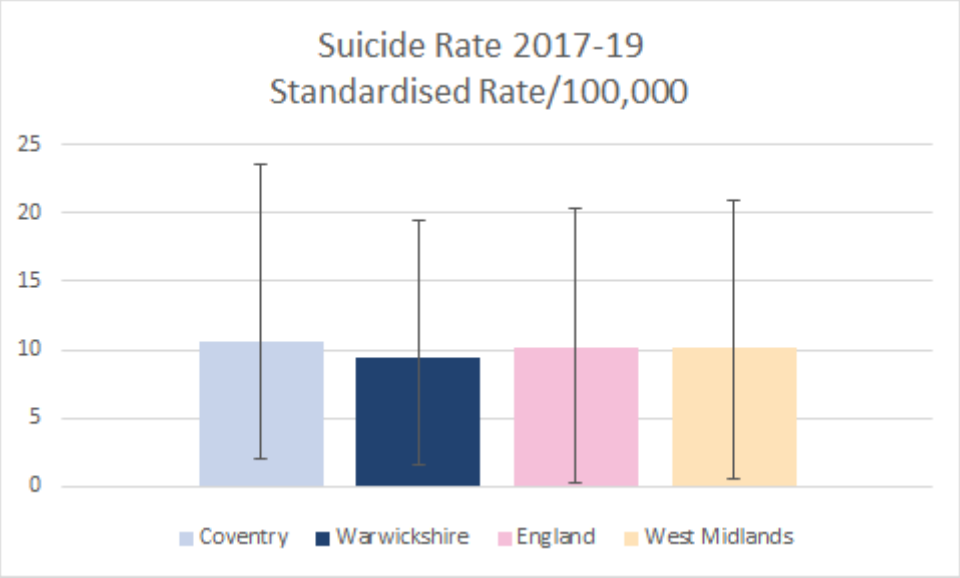


Figure 69. Rates of suicide in Coventry and Warwickshire (per 100,000) compared with England and West Midlands averages

Source: PHE Fingertips

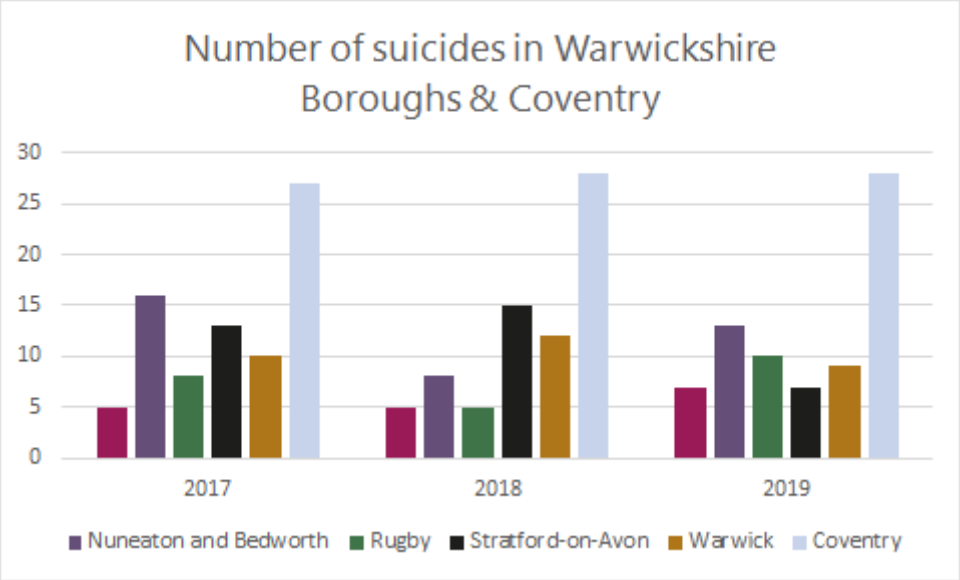


Figure 70. Number of suicides in Warwickshire & Coventry 2017-2019
Source: PHE Fingertips

Risk Factors

Suicide behaviours are complex; there is no single explanation of why people take their own life and multiple factors usually contribute to each death. Social, psychological, and cultural factors can all interact to lead a person to suicidal thoughts or behaviour. Feedback from the mental health needs assessment survey found that in terms of current service thresholds, waiting times and quality of service, there was a lack of early intervention available prior to reaching a crisis point. Some respondents reported difficulties accessing services when thresholds had been reached and long waiting times contributed to deterioration of mental health for some and an increased risk of suicidal ideation or attempt.

Risk factors and corresponding data are identified and available on the public health fingertips online tool. A snapshot of local level data based on mental health prevalence (primary care), hospital admissions for self-harm and alcohol related conditions are included below to highlight where prevention and intervention activity may have the greatest impact.

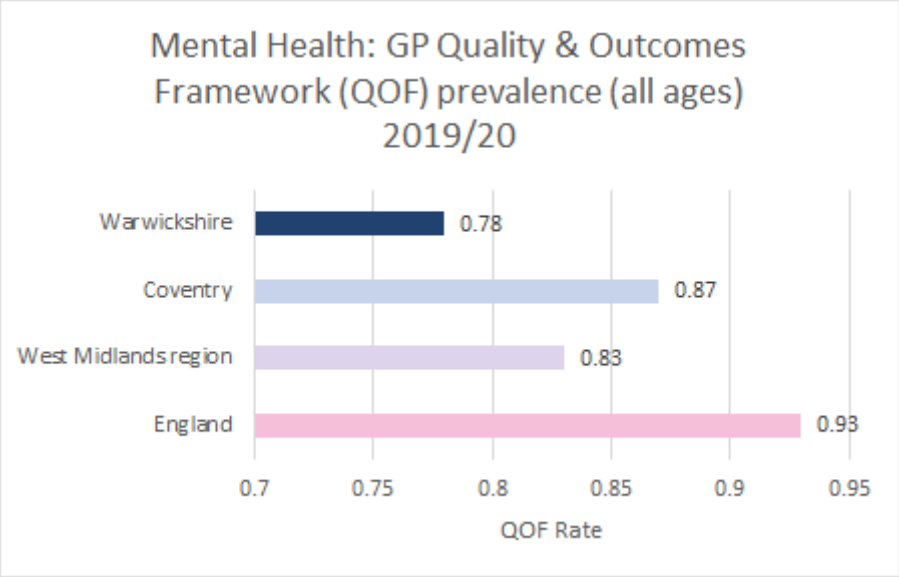


Figure 71. GP QOF data
Source: GP Quality and Outcomes Framework

Note: A QOF-reported prevalence rate is the total number of patients on the register with a recorded health condition, expressed as a proportion or percentage of the total number of patients registered.

Self-harming behaviours are not a strong predictor of suicide attempts; a National Confidential Inquiry report found that only 2% of people who self-harm go on to make a suicide attempt. However, 66% of people who have died by suicide have previously self-harmed[86].

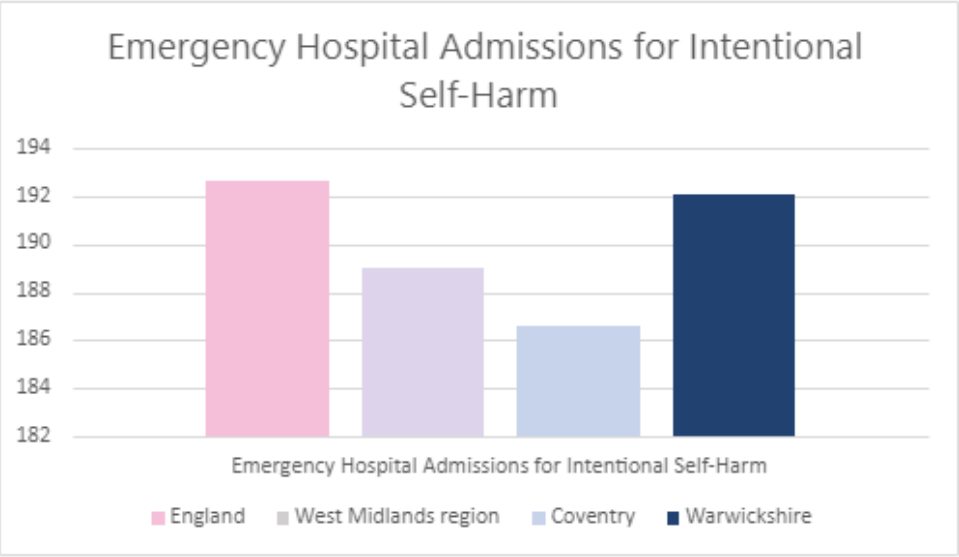


Figure 72. Emergency hospital admissions (Intentional self-harm) Directly standardised rate per 100,000 (2019/20)
Source: PHE Fingertips

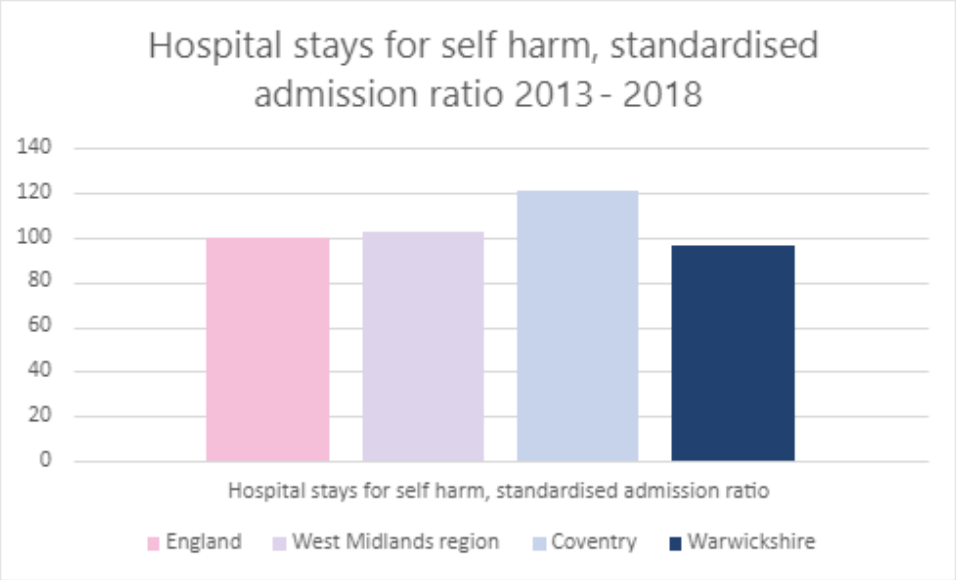


Figure 73. Hospital stays (Self harm, standardised)
Source: PHE Fingertips

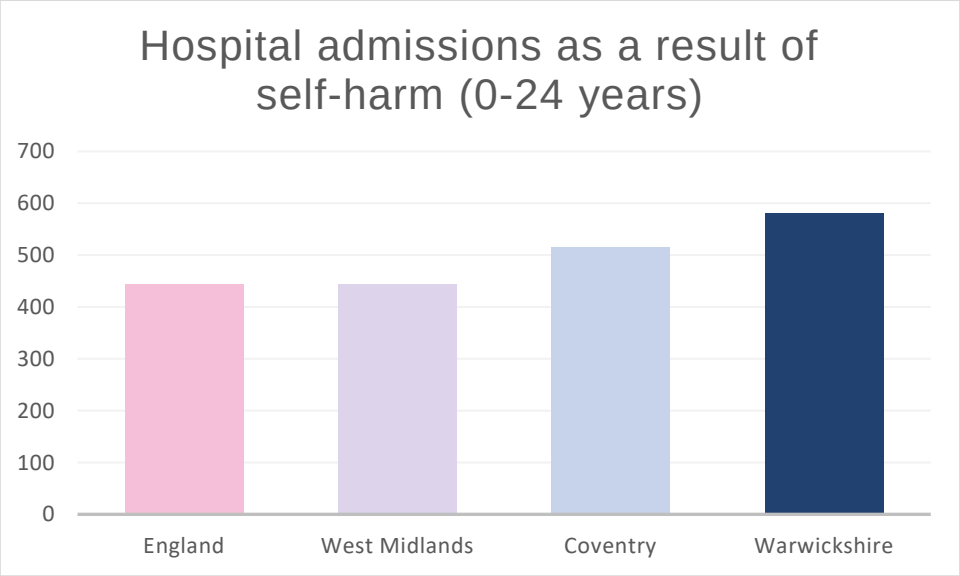


Figure 74. Hospital admissions as a result of self-harm (10-24 years), rate per 100,000

Alcohol misuse is a common risk factor for poor mental health outcomes, given it's effects as a depressant and tendency to be used as a coping mechanism, albeit an unhelpful one in terms of mental health and self-care.

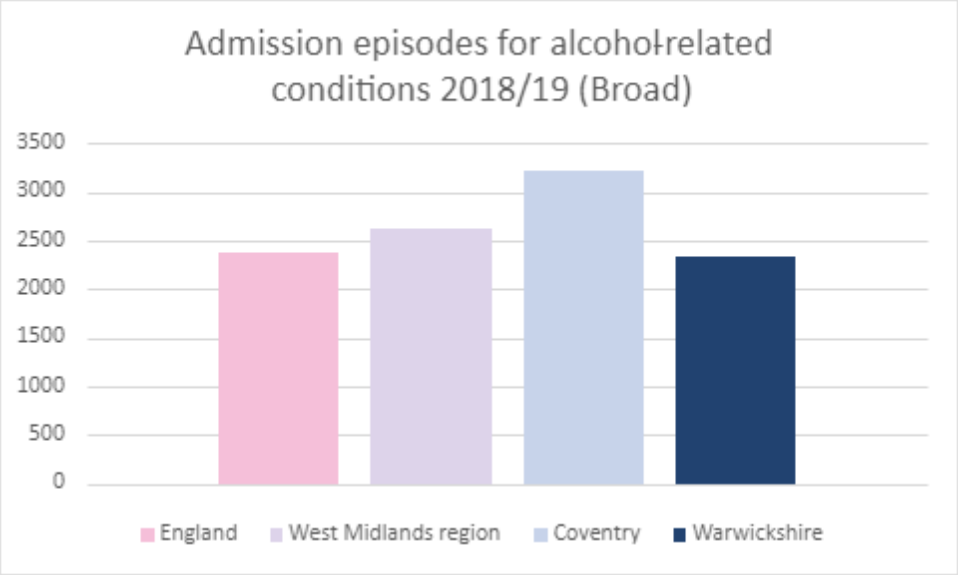


Fig 75. Alcohol related hospital admissions. Directly standardised rate per 100,000
Source: PHE Fingertips

Coventry and Warwickshire Real Time Surveillance System (RTS)

In 20/1920 a 'Real Time Surveillance' system (RTS) was established across Coventry and Warwickshire, improving early access to information on suspected suicides (prior to the final outcome of Coroners Inquests). This was set up to facilitate identification of current patterns of deaths to inform suicide prevention approaches and respond more swiftly support those bereaved.

A dedicated Officer is based in the Coroners Offices and notifications of suspected suicides are sent weekly to Warwickshire and Coventry public health teams to enable the monitoring of trends, clusters and the identification of emerging risk factors.

Coroner records audits 2018 - 2021

Data presented below relates to deaths in September 2018 to March 2021 within Coventry and Warwickshire., incorporating a combination of confirmed deaths by suicides and suspected suicides (cause of death not yet confirmed through Corners Inquests). Coroners records include information from GP records, mental health services, West Midlands and Warwickshire Police reports, and West Midlands Ambulance Service reports. In some cases, information included regarding the background of the deceased was provided by their next of kin. A total of 193 cases occurring in the Coventry and Warwickshire area have been included.

Date of death

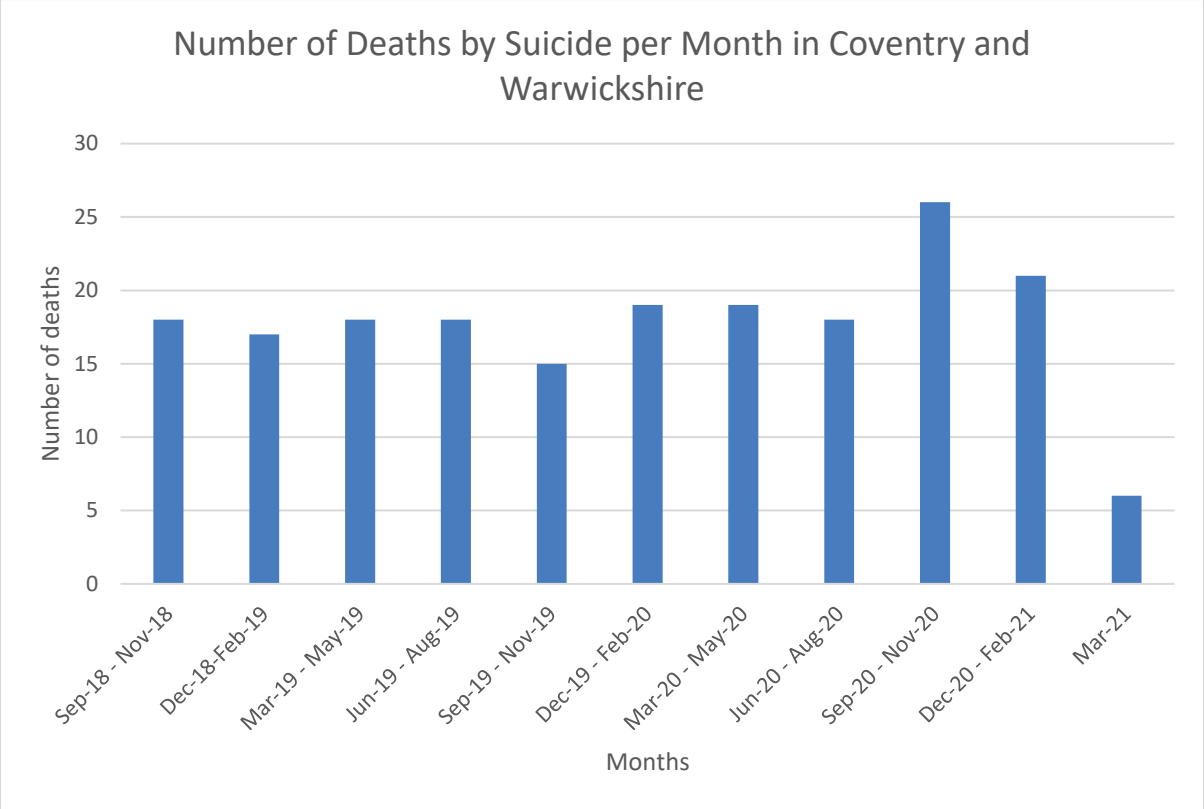


Figure 76. Number of deaths per month in Coventry and Warwickshire (September 2018 – March 2021)
Source: Coroners Records

There is natural variance in the dates on which deaths occur. As England went into national lockdown in March 2020 and November 2020, and February 2021 increases in cases are seen, - it should be notedmore recent cases have not yet been confirmed as death by suicide following a Coroners inquest.

Demographics of the deceased

As displayed in the pie chart below, 46 of the 193 people who died by suicide (24%) were female. 147 of 193 were male (76%), similar to the national pattern.

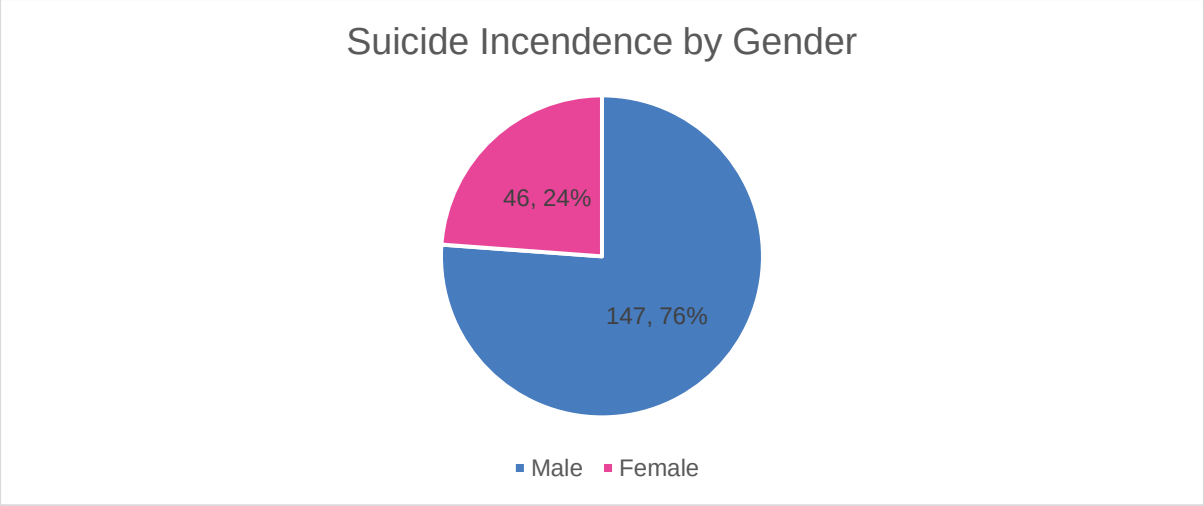


Figure 77. Suicide incidence by gender across Coventry and Warwickshire from September 2018 – March 2021.
Source: Coroners Records

During September 2018 – March 2021, most deaths occurred in people aged 20-59, with the largest peaks among men aged 30-49. Among females, peaks are seen in those aged 20-29 and 30-49.

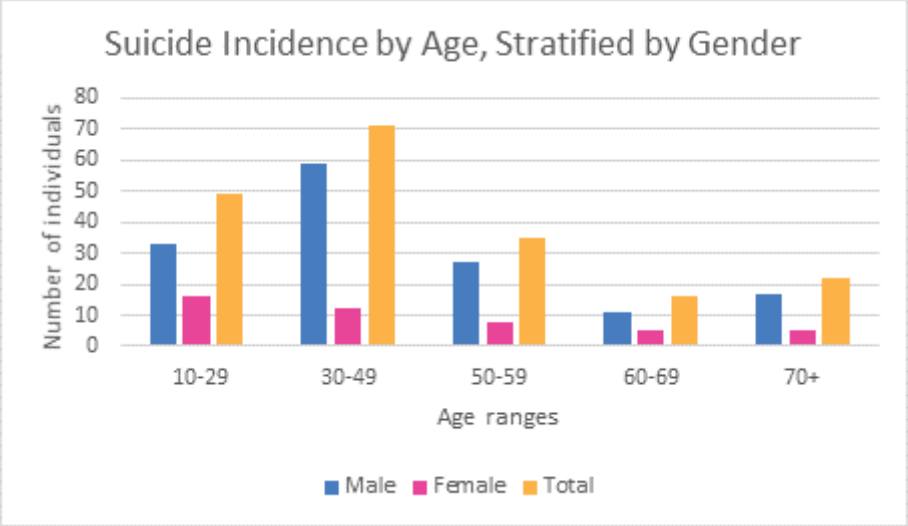


Figure 78. Numbers of deaths by suicide by age group in Coventry and Warwickshire, stratified by gender.
Source: Coroners Records

Ethnicity remains inconsistently reported and so has not been included in this audit due to the lack of complete data.

Location of death

The majority of deaths 64% occurred within the home address of the deceased, 10% occurred on railways,6% in parks or woodland and 4% occurred on roads or laybys.

Previous attempts

In 10% of deaths there was a known history of suicidal ideation with 28% having previous suicide attempts.

28 people (15%) had a history of self-harm indicting self-harm could be an important indicator of risk of suicide. This figure would be higher increase if previous overdoses were included as a method of self-harm.

Parental status

79 people (41%) were known to be parents. This included children of any age, including adult children. Whilst the age of a child is likely to influence how strong a protective factor they are, overall, in this cohort children did not appear to act as protective factors, even if stated as such.

Mental health diagnoses

36 people (19%) had a mental health diagnosis on their medical records; most commonly depression, anxiety and alcohol dependency syndromes.

Contact with services

34 people (18%) had been known to mental health services at some point in their lives, but to varying degrees. The majority were not accessing mental health services at the time of their death.

113 people (59%) were known to have had contact with a health care provider in the 12 months before their death. 18 people (9%) did not have contact with health services in the 12 months before their deaths.

Data was incomplete for 62 people (32%) and it is not known whether they had contacted any services in the 12 months leading up to their death. Of those with records available

Around 60% had seen a GP in the 3 months before their death, not necessarily for mental health support.

Most people who took their own lives in this audit did not ever have any contact with specialist mental health services; only 44% were known to mental health services at some point during their life. 21% had contact with crisis teams and 13% had spent time as an mental health inpatient at some point. 15% had attended an emergency department either following an episode of self-harm, an attempt on their life, or

suicidal ideation. 27 of these 29 (93%) were assessed by AMHAT following their presentation at the emergency department.

This suggests that when engagement with secondary mental health services does occur, it is often when mental health problems have become severe.

Substance Misuse

52 people (27%) had identified some form of drug misuse on their records at some point in their life. The most common illicit drugs used were cannabis (24), cocaine (25), crack cocaine (3), heroin (8), stimulant drugs including methamphetamine, ecstasy, and MDMA (5).

Other drugs which had been reported included ketamine and nitrous oxide and in two cases it had been reported the deceased had used illicit substances, but it was not known what type. It should be considered that the majority of this information was taken from toxicology reports or reports from family/ friends who had informed emergency service personnel. If the deceased had used in the past but not recently or family/ friends had not disclosed this information or were unaware and so could not disclose, it would not have been captured. Therefore, it is likely that there are more people who had used illicit substances at some point during their lives but did not have it captured here.

Unfortunately, reporting regarding alcohol consumption was inconsistent and whilst some had weekly units consumed on their records on a date close to their date of death, others did not have any recent information, and the majority of people (105, 54%) had no information recorded at all regarding alcohol consumption. 21 (11%) did not drink any alcohol, 24 (12%) would drink alcohol socially or occasionally, 14 (7%) were heavy drinkers but not the extent of it being harmful, 12 (6%) consumed alcohol at harmful levels, and 17 (9%) were dependent on alcohol. Due to the extent to which data is incomplete here, it is not feasible to draw any information regarding whether level of alcohol consumption is a risk factor for suicide.

Bereavement by suicide

10 people (5%) had lost a friend or family member to suicide indicating that losing a loved one to suicide makes someone more vulnerable to suicide themselves.

Police contact

40 people (20%) had had contact with the police at some point, 15 of these had criminal records. 7 had police contact for concerns regarding their welfare or their mental health but had not committed or been suspected of committing any crimes.

Conclusion

Having examined the local data, it appears the following are risk factors for death by suicide:

- Being male
- Being aged 20-59
- Having experienced bereavement by suicide of a loved one
- Substance misuse
- Having recent police contact
- Mental health diagnoses of depression or anxiety
- Having access to prescription medication
- Having recent contact with a GP

Other risk factors noted in local audits and national literature include relationship breakdown, financial insecurity, chronic pain. Nationally we can also see transition between services as a risk factor i.e. discharge from inpatient, referral from GP & waiting for specialist services.

Service availability and access

Safe Havens Coventry and Warwickshire

Safe Havens (services specifically aimed at providing support when core mental health service provision is closed) are in place across the health care partnership geography and are crucial in mitigating suicide risks. The services offer:

- Community-based crisis alternatives to complement crisis resolution and home treatment teams, acute psychiatric liaison and inpatient care
- Compassionate, strengths-based, non-clinical de-escalation and guided self-help services for people experiencing mental health crisis
- Individualised functions to meet the different needs and preferences of our local communities.

The Safe Havens are an integral part of the HCP Acute and Urgent Care pathway, reducing the burden on other acute and crisis services. Performance reports demonstrate a varied range of referral sources and onward signposting, and the Coventry service reported reductions in presentations to core services during April-September 2020:

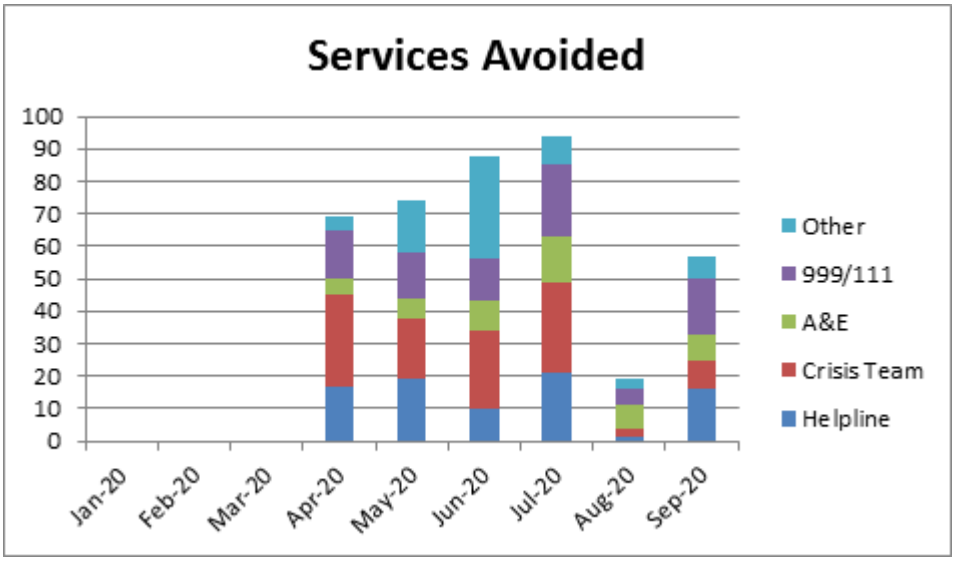


Figure 79: Coventry Safe Haven estimated reduction in presentations
Source: NHS Coventry and Warwickshire Clinical Commissioning Group, Equality and Quality Impact Assessment: Safe Havens December 2020

The service evaluation over the same period has demonstrated that COVID-19 significantly impacted both Coventry and Warwickshire Safe Haven providers' ability to deliver and develop the service, and reduced opportunities to develop links with system partners and stakeholders. Both providers adapted to restrictions quickly and effectively whilst ensuring plans were in place to open their sites as soon as regulations allowed. COVID-19 has been an obstacle to signposting into other services and this has been reflected in feedback from service users who were thankful the safe havens were open when other services were closed.

The safe havens were designed to be delivered in-line with the principle of non-dependency however service data has indicated that a high proportion of contacts are from a small number of repeat users. The evaluation has demonstrated a local need for the services however adaptations need to be made to increase the reach and awareness of the safe havens in both the general population as well as all health and care providers.

The safe havens rely on potential service users being aware of the service prior to times of crisis. In order to achieve this, significant focus needs to be placed on promotion and development of pathways and networks. Both providers have been able to demonstrate demand for the service in both a virtual and face-to-face format.

Crisis Plus Initiative

Coventry and Warwickshire Partnership NHS Trust has been successful in obtaining funding for 3 years from NHS England/Improvement to strengthen the mental health

crisis pathway by establishing a Crisis Plus Initiative. Across Coventry and Warwickshire, a Crisis Plus Initiative will be developed which will include the implementation of:

- **Collaborative Intensive Outreach**; a Multi-Disciplinary Team (MDT) to work with people who frequently need to use mental health crisis services. This team will develop prevention and care treatment plans with people to reduce the time they need to spend in hospital and help them to identify their strengths to reach their own life goals.
- **Social Intervention Collective**; support for people whose mental health crises come about as a result of a variety of social issues.
- **Crisis House**; short-term overnight accommodation for people who are in crisis. The facility will offer intensive support to help manage a mental health crisis over a short period of time, usually as an alternative to hospital admission.

For the people of Coventry and Warwickshire, the Crisis Plus Initiative will mean increased access to local support and less dependency on mental health inpatient admission or Crisis services. For those who have complex care needs, crisis planning will be strengthened by producing support plans with the person by a multi-disciplinary team working across urgent mental health care services, Social Care, Local Authority services and the voluntary and community sector (VCSE).

Papyrus (National charity dedicated to the prevention of young suicide)

PAPYRUS runs the national helpline service, HOPELINE UK. The service responds to support needs from those with thoughts of suicide (under 35), those who are worried about them, and provides a debriefing service for professionals. During the pandemic, callers reported that lockdowns and social distancing measures often compounded issues that were already present. In addition, relationships and family environments were reported to have been impacted negatively. A loss of community was reported by some who identified as LGBTQIA+. Access to services has been difficult, particularly for those experiencing digital poverty, or who have not been able to seek privacy within their home environment. Some callers reported that this increased their risk and vulnerability to thoughts of suicide.

As part of a response to recent deaths in the region, PAPYRUS published local media articles to promote their funded training. The organisation had a great response, with 40 contacts in the days after the article was published. Of the contacts who shared why they were interested in the training, the majority were parents or grandparents, there were also school and college staff, hostel workers, and other organisations that work with young people. The themes in these contacts were:

- Concerns about the impact that lockdown/covid/furlough has had on their young people (including being away from school where the support might be)
- Their child, or young people they know, self-harming or have attempted suicide, or have known young people who have taken their own lives
- Feeling the need for extra support and information around suicide prevention

The Kaleidoscope+ Group (National Mental Health and Wellbeing charity)

In Coventry and Warwickshire, the Kaleidoscope group (KPG) provide postvention support to those affected by suicide. Based on the current offer the service has identified a gap in postvention support (currently offered to 18+) for 15-25 age groups, male only forums and workplace interventions.

From user feedback the service reports that clients commonly struggle with feelings of suicidal ideation, self-harm behaviours and post-traumatic stress disorder. Some identify that a negative experience in their initial interactions with Police and first responders has an exacerbating effect on their mental wellbeing. The service has also observed that there is currently limited access to 'help is at hand' literature for the bereaved via Warwickshire and West Midlands Police. KPG have a training offer to support Police, first responders and other organisations around awareness of suicide and postvention.

More extensive research on postvention bereavement support needs carried out for the HCP by KPG during 2018/19 identified that;

- The HCP geography reflects the national picture around postvention services/support in terms of there being no standardised, specialist offer but a mix of third sector support from which the offer differs slightly between Coventry and Warwickshire.
- Stakeholders and third parties are not aware of or are unable to refer to local appropriate support
- There are no bespoke packages of care being coordinated for families/affected others directly after a death by suicide
- Consultation with 50 respondents with lived experience of a bereavement found that 68% had received no specialist support. Take up depended on how the family/individual felt at the time and the type of support offered; nonspecific counselling often with long waits and, or prescribed medication were most common but without specifically addressing the issues around suicide bereavement
- Peer support, more information about the death (from Police), practical, task-based day to day support, choice of group or individual specialist support, whole family programmes were advocated
- Feedback from professionals/services – lack of awareness of services and what action to take. GP referral predominantly identified as appropriate; some evidence of help is at hand leaflet being distributed by Police

- As well as those directly impacted by a suicide in the family/immediate relationship there is little or nothing available for suicide exposed groups (workplaces, social media, witnesses, faith and other peer groups) and variable support for first responders (suicide affected) based on organisational policies etc.

Coventry and Warwickshire postvention suicide bereavement support service

To address the needs highlighted by the research, and as part of NHSE's 3-year suicide postvention funding roll out, a new service is being commissioned to commence in September 2021. This will be for all age residents of Coventry and Warwickshire. The service will operate in conjunction with the HCP's real time surveillance system, and referrals will be coordinated through the coroner's office. Family and friends affected by suicide will be referred by consent to the service within 72 hours of a death by suicide. The service will offer immediate practical and emotional support with access or referral to trauma informed intervention based on the person's needs.

Suicide Prevention Plans Coventry and Warwickshire

Across the HCP area, Coventry City Council and Warwickshire County Council have separate suicide prevention strategies supported by multi agency groups. Both groups work to the priorities in the national strategy;

- **Reach High risk Groups:** Target our approach to focus on inpatient safety and vulnerable groups
- **Improve Mental Health:** Build our community assets, workplace health offer and VCSE support networks
- **Manage Access to Means:** Identify and address our environmental social and clinical risks
- **Reduce Impact:** Develop our bereavement and workforce support offer
- **Improve Data:** Embed our partnership plans for systematic reporting and analysis
- **Adopt a Safe Media Approach:** Communicate our support offer and manage local and national messaging
- **Work Together:** Invest in learning, development and partnership activities

Coventry's suicide prevention strategy action plan was refreshed for 2020/21 to extend the strategy that was in place between 2016 - 2019. The plan was signed off and agreed as a rolling update by the Health and Wellbeing Board in January 2020. The Steering Group meets quarterly and with Warwickshire every six months.

The Warwickshire suicide prevention strategy has been in place since 2016, and Warwickshire County Council made a strategic decision to focus on suicide prevention operational delivery in response to the pandemic rather than a refresh of

the strategy in 2020 but this is planned to commence this later this year. The multi-agency group continues to meet bi-monthly, with a joint meeting with Coventry's group every six months. The action plan has been regularly reviewed and updated throughout this period, with a particular focus on mitigating the impacts of the pandemic.

The Coventry and Warwickshire Health and Care partnership have also taken part in the national evaluation of the NHSE funded suicide prevention programme, wave 1. Interim findings from the 8 sites show that;

- There is a clear need emerging for more relationship-based services, and services which tackle loneliness and isolation.
- New skills may be needed to work most effectively with local businesses and small community organisations, for example local sports clubs, as this has been a new experience and requirement for many.
- Communications materials should be future proofed, where possible, so they can be used in future campaigns (for example not using dates on printed material that could be used again).
- There is a need for clarity, when implementing training, as to why sites are targeting the people they are targeting and being clear about what they expect from them afterwards.
- For projects using non mental health workers to support people at risk of suicide – services should ensure good staff training, staff supervision and ongoing support is in place.
- Good and ongoing marketing and publicity will be needed to ensure people are aware of support services.
- Suicide prevention services should consider the relevant age range for referrals.
- Projects should consider being more proactive when deciding who to work with, for example by looking at how they could respond to specific local issues such as businesses who are making large scale redundancies.

Impact of COVID-19

Because of the time it takes to register suicides, it's too early to know the effect of the pandemic on national suicide rates. Evidence from the National Confidential Inquiry (NCISH) and the University of Manchester suggests that suicide rates during the first national lockdown in England have not been impacted. The effects of the pandemic are however being disproportionately felt by the most vulnerable people in society and are exacerbating factors we know are related to suicide.

In Coventry and Warwickshire, we have seen a slight increase in suspected suicides (c14) in the period March 2020 – February 2021 compared with the two previous years. It is not clear whether this is a reflection of the impact of COVID-19. As this is

the first year we have had RTS in place the numbers presented may also decrease once full evidence has been heard at inquest and an official verdict by a Coroner.

Inequalities

Suicide data highlights both gender and social inequalities, evidenced by the Samaritans' Men Suicide and Society' and 'Dying from Inequality' research reports. The research shows that in the UK and Ireland men are three to four times more likely to die by suicide than women. The research also identifies that men who are less well-off and living in the most deprived areas are up to 10 times more likely to die by suicide than more well-off men from affluent areas. Middle-aged men in the UK and Ireland also experience higher suicide rates than other groups, a fact that has persisted for decades.

Critical moments such as the point of job loss, contact with healthcare professionals or the criminal justice system are often not taken advantage of to engage men, despite these factors being well-documented risk factors for suicide. Services often only become involved when men are a risk to themselves or others. Statutory services dealing with issues such as substance misuse, housing issues or employment have an opportunity to engage men and work with other services to manage suicide risks. Work to address male suicide should be centred around engaging with men with lived experience to co-design and test approaches.

Recommendations

There are key opportunities within the healthcare system for proactive suicide prevention and intervention. These are linked to primary care presentations for mental health, repeat male presentations, as well as hospital admissions for self-harm and alcohol related conditions.

- Develop knowledge, skills and confidence within primary care to enquire about mental health challenges and respond to distress.
- Improve timely access to support, including promoting and strengthen pathways to and from community assets such as Safe Havens, and other services that tackle loneliness and social isolation.
- Improve access to community-based support for those at risk of mental health crises
- Continue to embed and strengthen surveillance of suspected suicides to enhance learning and preventative approaches, - review future funding opportunities for January 2022 onwards.
- Use the findings of this JSNA to inform Suicide Prevention Strategy updates and action plans.
- Commission an all age postvention service for residents of Coventry and Warwickshire bereaved by suicide by the end of 2021

- Continue to embed and strengthen the work developed under the NHSE 3-year programme around crisis support, dual diagnosis, coproduction, marketing and communications
- Develop further insights into the experiences and needs of men and young people;
- Develop the work programme on self-harm and engaging health and non-healthcare sectors in suicide prevention training and awareness raising.

WIDER DETERMINANTS

The wider determinants of health are a range of social, economic and environmental factors which influences mental and physical health. Strong associations between social inequalities and health outcomes have been documented [23]. In addition, growing evidence demonstrates the impact of wider determinants of health on mental health[87]. This has been highlighted by professionals through a local survey in Coventry and Warwickshire, particularly the wider impacts on people's mental health beyond immediate mental health services and the need to tackle these (see Appendix 1). Key wider determinants of health were identified as a significant part of promoting mental health and wellbeing, "*Stress, social isolation, financial worries, poor housing, unemployment, drugs, lack of safety in their neighbourhoods all contribute to mental health issue*."

Figure 79 from the Mapping Severe and Multiple Disadvantage in England report [88] provides a composite picture of the prevalence of mental health problems recorded across the SMD (severe and multiple disadvantage) spectrum. This graph demonstrates the stronger correlation with substance misuse and mental health than there is with offending or being homeless. However, it is also noted that there is likely to be significant under-recording of at least some specific mental health problems amongst this population.

Figure 80. Prevalence of Mental Health Problems by SMD category
Source: Mapping severe and multiple disadvantage report, Lakelly Chase Foundation; https://lankellychase.org.uk/wp-content/uploads/2015/07/Hard-Edges-Mapping-SMD-2015.pdf

In the local survey, respondents identified the importance of wider factors on someone's mental health: particularly social isolation, lack of community support, discrimination, housing and poverty. The impact of the COVID-19 pandemic on these wider determinants were reported as having a knock-on effect on mental health, further exacerbating already existing issues.

In this chapter, the wider determinants are grouped under the following headings: housing conditions and homelessness, employment, access to outside/greenspace, impact on family relationships and travel.

HOUSING AND HOMELESSNESS

As a determinant of mental health, housing places a crucial role as a place where people spend a significant amount of time. Living with problems that are related to housing conditions can increase the risk for poorer mental health. A plethora of evidence suggests that housing with poor physical characteristics is associated with poorer mental health[89]. Mental health is negatively impacted by fuel poverty and coldness across all age groups[90]. In addition, more recent evidence suggests poor financial aspects of housing (e.g. foreclosure and home eviction) is also negatively associated with poor mental health, including depression and anxiety[91,92].

In addition to impacting physical health, cold and damp housing conditions can impact mental wellbeing. Factors such as thermal discomfort and a constant worry about affordability and damage to possession as a result of insufficient heating have been associated with poorer mental health. Similarly, social isolation and stigma associated with homes with inadequate heating strongly impacted mental health[93].

Of the 23.5 million homes in England, one in five (18%) have been identified as being in a 'non-decent state'[94] (Ministry of Housing, Communities & Local Government 2020). Research findings reported in 2019 indicated that approximately 2.5m people in England were unable to afford their rent or mortgages[95]. More than 1 in 4 adolescents living in cold housing are at greater risk of multiple mental health problems compared to 1 in 20 adolescents not living in fuel poverty[96].

Coventry City Council and Warwickshire County Council commission Act On Energy to provide energy information, advice and guidance to residents, this includes support to switch providers and dealing with fuel poverty. The service is also funded to support residents with long term health conditions including those with mental health conditions to access physical interventions to enable the resident to live in a warmer home such as boiler repair or replacement.

Table 21: Fuel poverty across Coventry and Warwickshire (percentage) in 2018

Area	2018 (%)
North Warwickshire	10.6
Nuneaton and Bedworth	9.6
Rugby	9.2
Stratford-on-Avon	10.2
Warwick	8.6
Warwickshire	9.5
Coventry	12.1
England	10.3

Source: PHE Fingertips

The COVID-19 pandemic has highlighted the role of housing in supporting mental health. Throughout the lockdowns and self-isolation rules, many people have had to spend greater amounts of time in homes that might be overcrowded, damp or unsafe. In addition, housing situations will have greatly impacted individual abilities to adapt to and responded to the challenges posed by lockdowns. This includes open and private space for working from home where permitted[97]. In particular, overcrowding poses an increased health risk for those living in multigenerational households or ethnically diverse groups, demonstrating poorer health outcomes associated with COVID-19 through the pandemic[98]. However, for those living alone through the pandemic, loneliness has been highlighted as a key issue, which can impact poorer mental health[97].

Recent estimates show nearly 44% of the homeless population in England had been diagnosed with a mental health condition, a staggering 86% reported difficulties with their mental health with most common issue being depression[99]. Poor physical and mental health of this population is exacerbated due to lack of access to health services and low adherence to medication[100]. A systematic review examining mental health disorders in the homeless population reported the most common mental health disorders were alcohol (37.9% prevalence) and drug dependence (24.4%), and the prevalence estimates for psychosis were equal to or greater than the prevalence for depression. This is a significant contrast to that of the general population[101].

In 2019, analysis of support needs of households owed a homelessness duty reported the three most common reasons: “A history of mental health problems”; “Physical ill health and disability”; and “At risk of / has experienced domestic abuse”. These three reasons accounted for roughly half of all cases (53% in Warwickshire and 49% in the West Midlands). A history of mental health problems accounted for 27% (n=714)[102].

The proportion number of households owed a main duty with a household member vulnerable as a result of mental health problems has slowly increased since 2009/10.

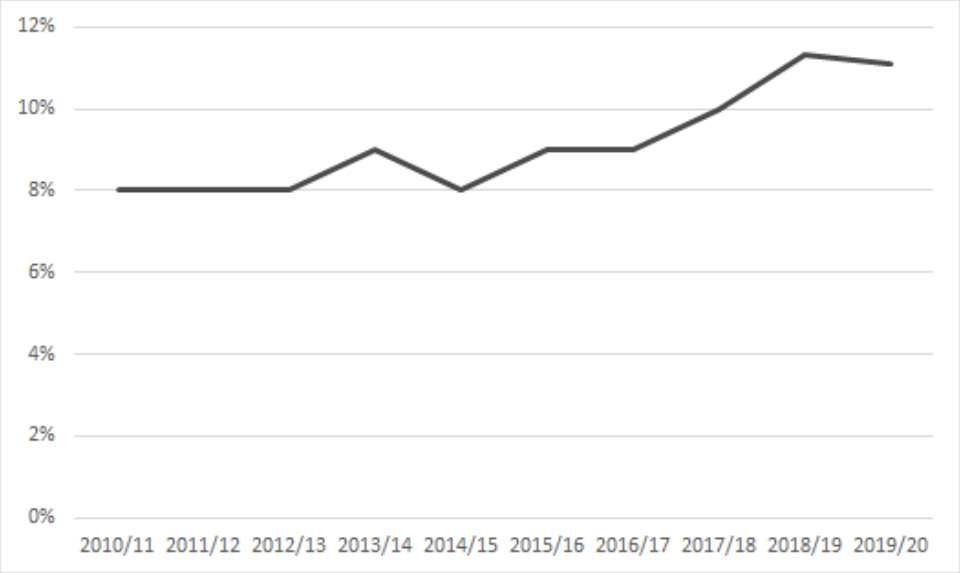


Figure 81. Percentage of all households owed a main duty with a household member vulnerable as a result of mental health problems
Source: Gov.uk; https://www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness#contents

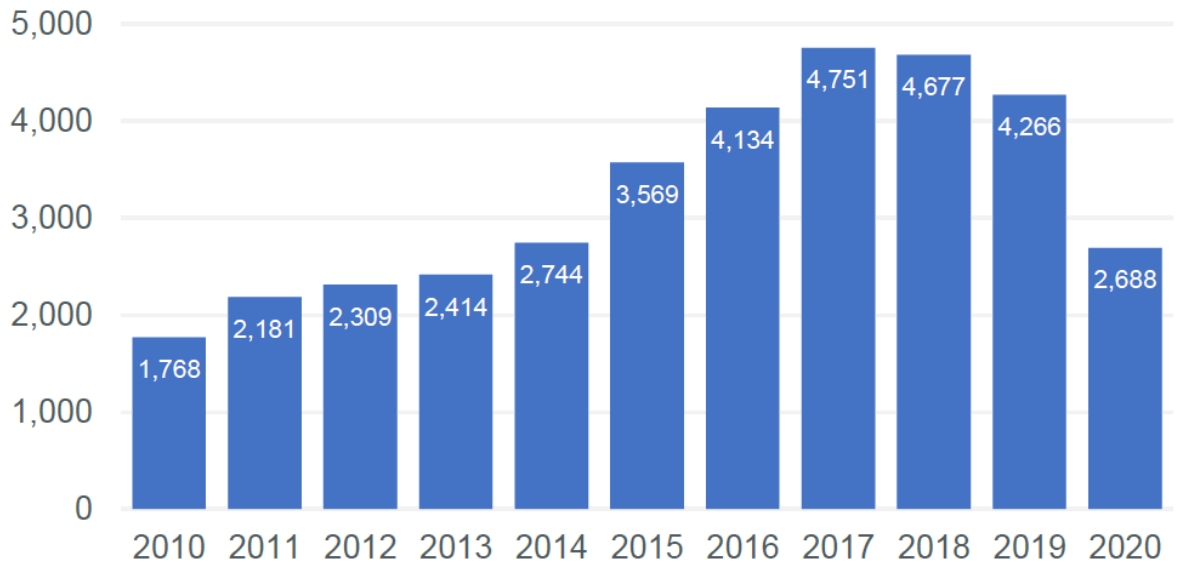


Figure 82. The number of people sleeping rough on a single night in the UK, 2010-2020
Source: Ministry of Housing, Communities and Local Government, Rough Sleeping Snapshot in England, Autumn 2020

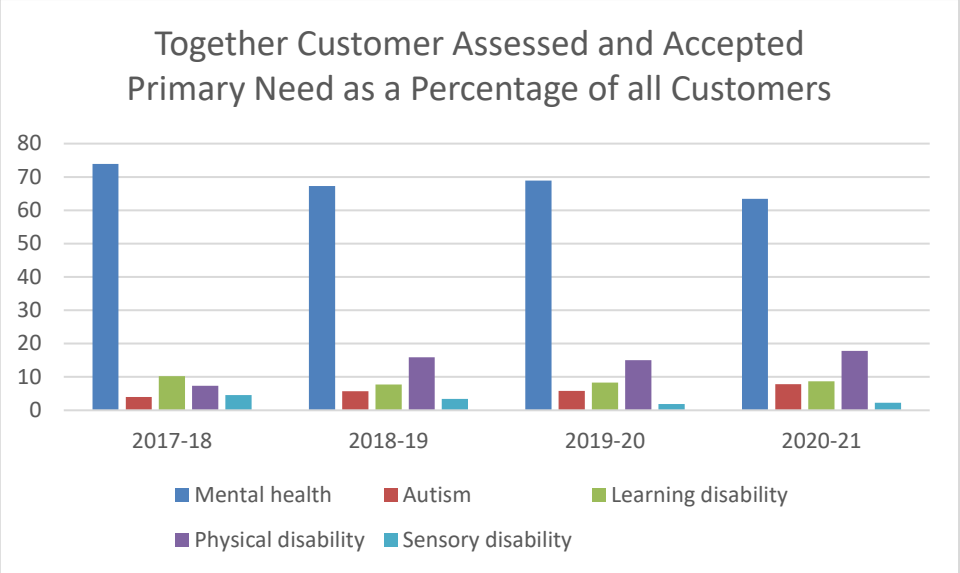


Figure 83. Primary need of Together Floating Support Customers (assessed and accepted) as a percentage

Figure 83 demonstrates that mental health has been a re-occurring primary need for Together Floating Support customers (Warwickshire County Council).

Figure 84 illustrates all housing related support providers for adults and young people (n=568) demonstrating the range of vulnerabilities faced. Mental illness has been highlighted as a significant vulnerability for both males and females.

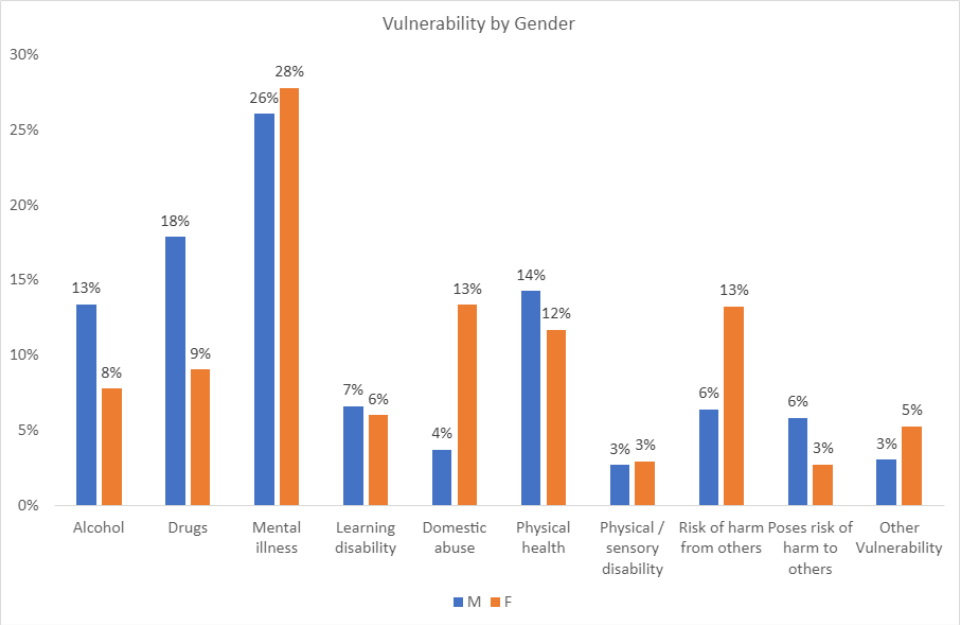


Figure 84. Housing Related Support in Warwickshire: Vulnerabilities by Gender

Respondents from the Coventry and Warwickshire Mental Health Needs Assessment Survey disclosed a range of circumstances that resulted in inequalities and a lack of access to services, which included homelessness or risk of homelessness. There was a sense that when mental health issues were combined with other circumstances, it tended to preclude access to services due to difficulties in managing more complex situations. In addition, health professionals staff working in mental health and wellbeing reported insufficient support in some housing settings when mental health needs are high, suggesting a lack of supported housing/staff training, "*Housing has seen a large increase in discharge from hospitals for patients with high mental health needs…Unfortunately these customers put extra pressure on B&B staff that are not trained to manage customer with these needs and end up with large call outs to paramedics or the police to manage the situation*."

Work has taken place to adopt an integrated approach by appointing a Community Mental Health Link Worker for Coventry City Council co-located between the Mental Health services and the housing and rough sleepers' team. The primary roles and responsibilities are to work with complex clients on a one to one basis to support mental health needs and to facilitate connections with Approved Mental Health Professionals and Social Workers: *The primary needs for my client base are to manage their Mental Health condition within the community that my client group are living in, and to also understand what is preventing my clients to access Mental Health provision*.

Feedback from the Mental Health Link Worker detailed that many clients have had previous trauma which has caused them to misuse drugs and alcohol and/or commit crime.

Although this hasn't solved all the problems, this approach has highlighted the benefits of appointing a link worker to work across teams in a multidisciplinary style: *"I have also managed to facilitate and ensure that my client group are getting face to face appointments rather than telephone appointments as most of the clients and due to their complexities refer face to face appointments…"*

Furthermore, in 2018, WCC committed to funding over two years to work collaboratively with District and Borough's in order to identify a gap in services and pilot a project to support Warwickshire's homeless population (Mental Health Enhanced Care pathway). After several meetings discussing current gaps and challenges, it was decided that a lack of flexible mental health outreach for people who sleep rough, in particular, those who struggle with drug and alcohol addictions. A steering group was established to look at various models of good practice around high dependency users of health and social care. WCC worked collaboratively with CWPT and arranged for two Advanced Nurse Practitioners to be seconded into the P3 street outreach team. The aim of the Mental Health Enhanced Care Pathway is to provide mental health outreach to people who sleep rough in Warwickshire, in a flexible way that meets their needs. It is also about helping to support people who

sleep rough who also have mental health challenges, to consider appropriate treatment sooner, to help avoid crisis scenarios whereby people might access acute health services, as opposed to services that can support them earlier. As a result of this pilot, CWPT have committed to permanent funding of these posts, and plan to recruit two additional nurses to work with the Coventry homeless population. A mental health nurse has highlighted an experience of working with a homeless person and colleagues in Warwickshire, "*As a mental health nurse, aware of their background and risks, managed to link the individual back into mental health, as they already had a good relationship with the professional, they agreed to continue to offer follow up care by monitoring his mood, mental state and also behaviour in terms of risk to others and himself*."

More locally, rough sleeping numbers in WCC have gone from 39 in 2016 to 49 in 2017 and 78 in 2018 before falling back to 47 in 2019[99]. Figure 85 demonstrates latest figures from WCC. (North Warwickshire – 0, Nuneaton & Bedworth – 6, Rugby – 5, Stratford – 4, Warwick – 4, Coventry - 8)

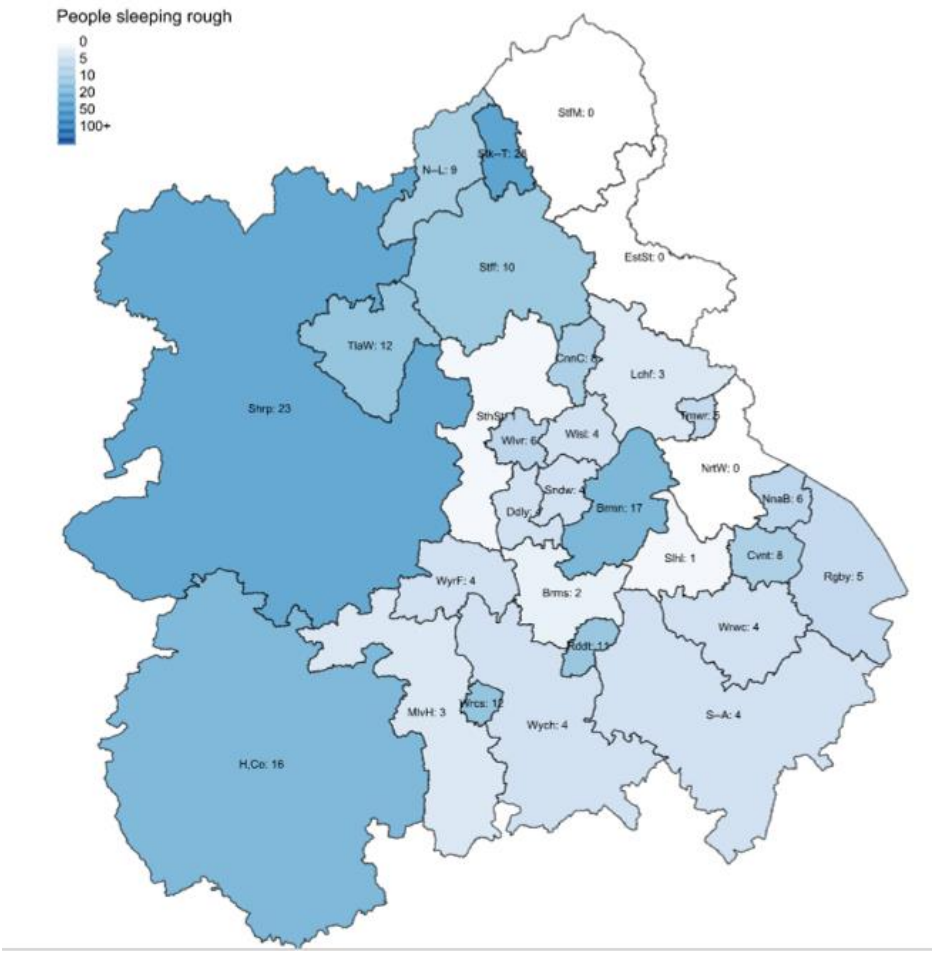


Figure 85. Heatmap of people sleeping rough in Warwickshire
Source: Business Intelligence, WCC

Table 22. Total number of people sleeping rough or at risk of sleeping rough who are currently being provided emergency accommodation in response to COVID-19 pandemic, by local authority district

Area	Sep-20	Nov-20	Dec-20	Jan-21
North Warwickshire	0	0	0	0
Nuneaton and Bedworth	1	4	5	6
Rugby	29	25	22	20
Stratford-on-Avon	23	23	21	23
Warwick	62	64	52	39
Warwickshire	115	116	100	88
Coventry	101	71	75	73
England	10,509	9,809	9,673	11,263

Source: https://www.gov.uk/government/publications/coronavirus-covid-19-emergency-accommodation-survey-data-january-2021

Table 23. Numbers of Domestic Abuse placements into interim/temporary accommodation between August 2020 and January 2021

Domestic Abuse Placements into Interim/Temporary Accommodation	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21
Rugby Borough Council						
Nuneaton and Bedworth Borough Council	2	2	2	0	2	3
North Warwicks Borough Council	0	0	0	0	0	0
Stratford District Council	2	1	1	3	2	3
Warwick District Council	1	3	5	2	0	1

Source: Warwickshire Domestic Abuse partnership report (no data provided by Rugby Borough Council)

Table 24. Total number of people who have moved into settled accommodation or supported housing since the COVID-19 response began

Area	Jan-21
North Warwickshire	0
Nuneaton and Bedworth	20
Rugby	12
Stratford-on-Avon	13
Warwick	31
Warwickshire	76
Coventry	251
England	26,167

Source: MHCLG, https://www.gov.uk/government/publications/coronavirus-covid-19-emergency-accommodation-survey-data-january-2021

Figure 85 shows the number of individuals on the homeless/rough sleeping dashboard in Warwickshire which have been identified as having a mental health condition/complexity by housing officers in March 2021. However, the estimate is not a definitive mental health diagnosis, and this is information known by housing officers or other support organisations.

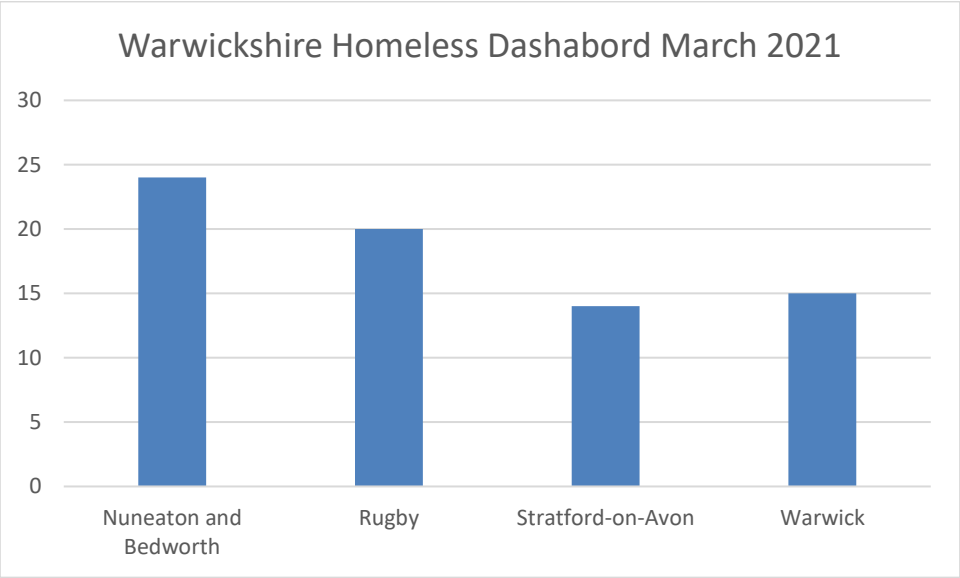


Figure 85. Warwickshire Homeless Dashboard March 2021

Recommendation

The following recommendations have been identified:

- Promote Act on Energy services across Coventry and Warwickshire to support a reduction in fuel poverty
- Continue to support and expand (where required) mental health support services for homeless people

EMPLOYMENT

The 2010 Marmot Review concluded that being in good employment is usually protective of health while unemployment, particularly long-term unemployment, contributes significantly to poor health[26]. However, this is dependent on quality of work as poor quality and stressful work can be more detrimental than being employed[103,104,105].The 2020 Marmot Review[90] has reported an increase in poor quality work, including part-time, insecure employment. The incidence of stress caused by work has increased since 2010. There has been an increase in people living in poverty living in a working household.

Unemployment and job loss have been associated with health and wellbeing, with particular influence between unemployment and mortality[106]. Job loss influences mental health and wellbeing; and also increase in health risk behaviours such as increase in alcohol consumption, drug misuse leading to weight gain. There are also wider implications of job loss on family members that also include poor mental health and relationship stress. Furthermore, systematic review evidence has identified a higher prevalence of mental health problems as a result of an increase of unemployment rates[107].

Mass Unemployment Events have a significant direct and indirect impact on health and wellbeing. There has been a gradual increase in claimants among working age claimants across Coventry and Warwickshire since April 2019. The highest rates in Warwickshire have been in Nuneaton and Bedworth Brough and the lowest in Warwick and Stratford Districts[108].

As part of the C&W MHNA focus group, findings from 13 people from Warwickshire in employment reported that, generally, they experienced increased levels of stress when unemployed compared to being in employment. Being in employment can also be associated with stress, however, having an open and honest relationship with managers positively impacted in being able to manage this (see Appendix 2). Participants also highlighted DWP should provide more support in the process rather than pressurizing people to find jobs they can't retain (Making Space summary-appendix 4). However, findings also indicated a lack of awareness of the Individual Placement and Support service (IPS) as not many people had heard of the IPS model provided by Rethink. IPS supports people with severe mental health difficulties into employment. It involves intensive, individual support, a rapid job search followed by placement in paid employment, and time-unlimited in-work support for both the employee and the employer[109]. Those that had were concerned to engage due to fear of judgement and discrimination as felt it was associated with disclosing ill-mental health. Participants also suggested more support within the workplace would be beneficial to retain employment. This could be done with supervisions and mental health champions that are approachable. Participants also stated that it should be mandatory to have a mental health first aider in workplaces.

The Coventry and Warwickshire Mental Health Needs Assessment Survey findings highlighted financially disadvantaged communities in relation to inequalities in service access and/or underrepresented groups accessing services. Professionals referenced those who were financially marginalised and not able to access services, especially private mental health services, "*I am a private counsellor, so only those with sufficient finances can access my service. This is predominantly white, middle-class members of the community. Minoritised groups are less able to access private counselling."* Financial disadvantage also impacted on people's ability to access support digitally and this was a particular issue during the pandemic due to greater amounts digital/virtual services. For example, qualitative findings from professionals highlighted, "*limited or no technology knowledge or equipment, through age or financial reasons*." This impacted ability to access service provisions. Furthermore, reference was made to COVID-19 and digital technology disadvantage and issues related to the shift of many services to online only. Disadvantaged groups were sometimes less able to access services this way. leading to inequality in provision. Qualitative findings included, "*Over the last 12 months with everything being online it has impacted those with:*

- *limited literacy skills to enquire (no walk-in facility available)*
- *limited or no technology knowledge or equipment, through age or financial reasons*
- *issues at home where they are not in a safe environment to speak to someone with others in the house at the same time*"

All respondents were asked about their confidence talking about mental health and workplace wellbeing (see Figure 86). Of those respondents to Statement 1 who indicated they were in employment, 3 out of 4 (75.1%/n=343) agreed that their workplace actively promotes the mental health and wellbeing of employees. Two thirds (66.7%/n=290) of respondents to Statement 2 who indicated they were in employment, agreed that their workplace was supportive of employees who have mental health difficulties.

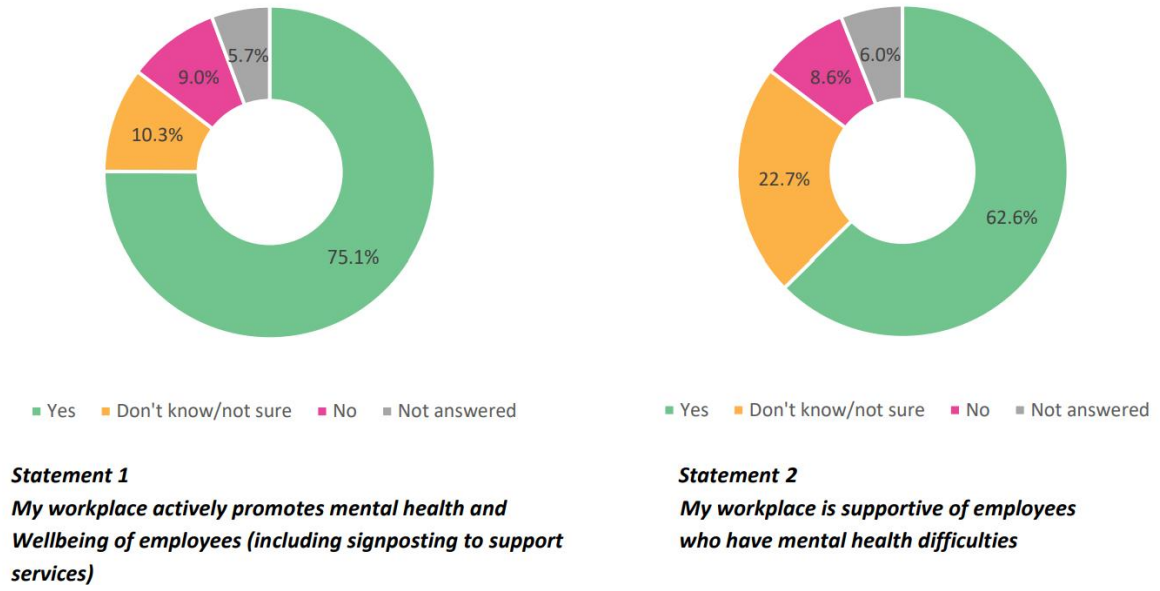


Figure 86. Percentage of survey respondents that believe their employer is supportive of mental health
Source: Business Intelligence, Warwickshire County Council

Since the start of the pandemic, young people have been more likely to have lost working hours, experienced lower pay, been put on furlough or have lost their jobs than their middle-aged counterparts. young workers (those aged 16-24) have accounted for nearly two-thirds of the total fall in pay rolled employment that occurred in the year to February. This has exacerbated pre-existing intergenerational inequalities: during the decade before the pandemic, younger people had experienced lower rates of pay growth and higher rates of working in the country's lowest-paid sectors, compared to their predecessors while the same age[110]. Furthermore, a survey with a sample of 6,389 adults aged 18 to 65 found evidence of a U shape across age distribution in relation to those in employment in February 2020 who in January 2021 were either no longer working, were furloughed, or were working and not furloughed but with at least 10 per cent lower earnings than February 2020[111]. Twenty-five per cent were either no longer working by January 2021, were employed but furloughed, or were employed but had seen their earnings fall by at least 10 per cent compared to February 2020. The proportion of workers facing one of those impacts rises to 41 per cent among the youngest workers (age 18 to 24), but is also high among the older workers (27 per cent among those aged 55 to 59, and 35 per cent among those aged 60 to 65).

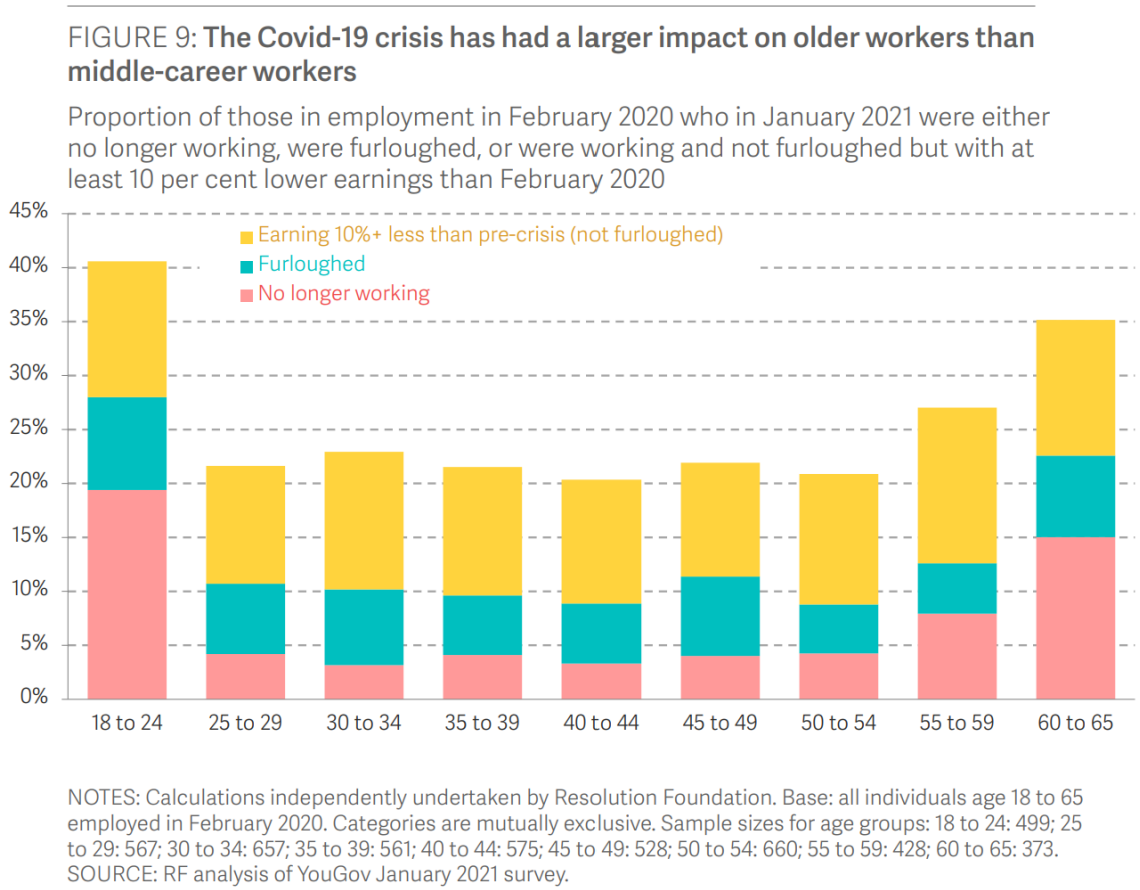


Figure 87. Impact of the COVID-19 pandemic on employment by age group
Source: Resolution Foundation

NEETS (Not in Education, Employment or Training)

In October to December 2020, an estimated 11.6% of all people aged 16 to 24 years in the UK were not in education, employment or training (NEET). The proportion was up by 0.6 percentage points from October to December 2019 and increased on the quarter by 0.6 percentage points. An estimated 13.2% of men aged 16 to 24 years were NEET, which was the highest since October to December 2013, and for women the proportion was at 10.0%.

The percentage of young people who are not in education, employment or training (NEET) had been decreasing since 2011 but has been relatively flat since 2017.

Figure 88. People aged 16 to 24 years NEET as a percentage of all people aged 16 to 24 years, seasonally adjusted, UK, October to December 2010 to October to December 2020
Source: ONS

The most recent available local NEET data is from 2017 and for ages 16-17. In Coventry 5.4% and in Warwickshire 3.8% of 16 and 17 year olds are NEET. These are both significantly lower than the England average of 6.0%.

Focus groups (see appendix 2) about service user feedback from Rethink Mental Illness Individual Placement Support Employment Service in Coventry reported that being unemployed has significantly impacted mental health and wellbeing, "*It's been hard, my last job ended because of Covid, I don't see or speak to many people to get another, I have bills and my family rely on me to support them, the worry of the bills has made me very ill*." Findings indicate the negative impact on mental wellbeing due to unemployment, specifically when the changes in situation occurred due to the pandmeic.

Rethink IPS Employment Support had provided significant beneficial support to those accessing the service. Some other services had been accessed for support including Mind and the Jobshop. People reported barriers to returning to work including a lack of work experience; reduced confidence; childcare issues; and medication side effects i.e. tiredness. In addition, previous experiences in employment also impacted feelings of anxiety about future prospects, "… *I experienced workplace bullying in previous roles and I feel extremely anxious about returning to work*."

Support for people once they move back into employment was highlighted in focus groups, to help build confidence and talk through any anxieties. Contact with friends and family were reported as important for mental health.

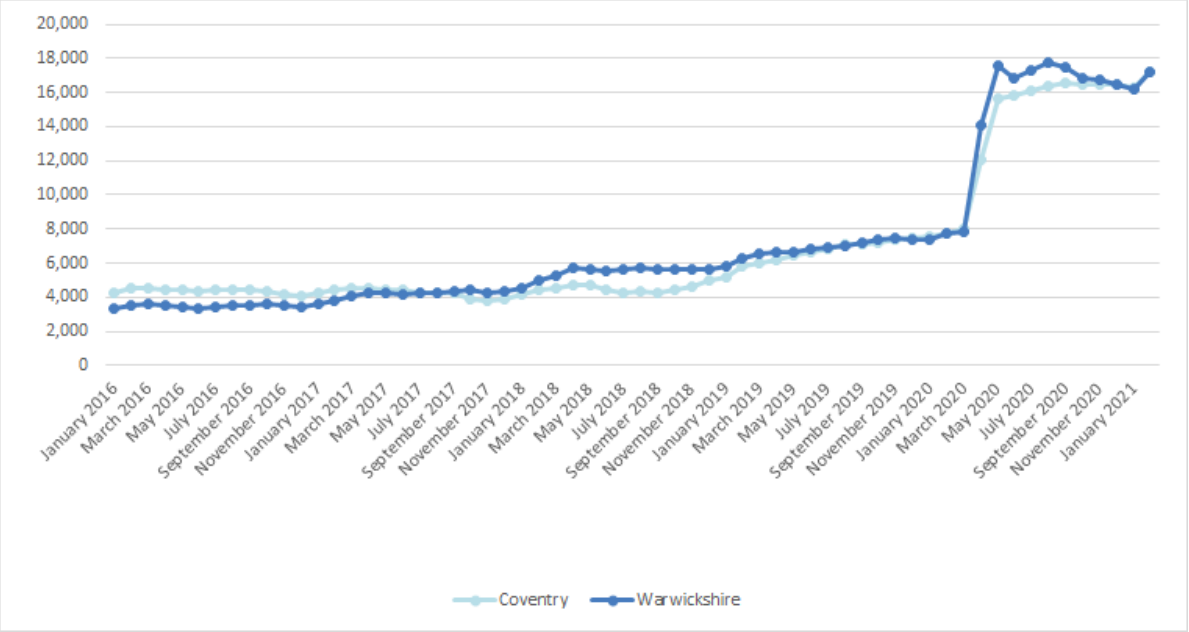


Figure 89. Claimant count (Coventry and Warwickshire), January 2016 to February 2021
Source: ONS from NOMIS 29th March 2021

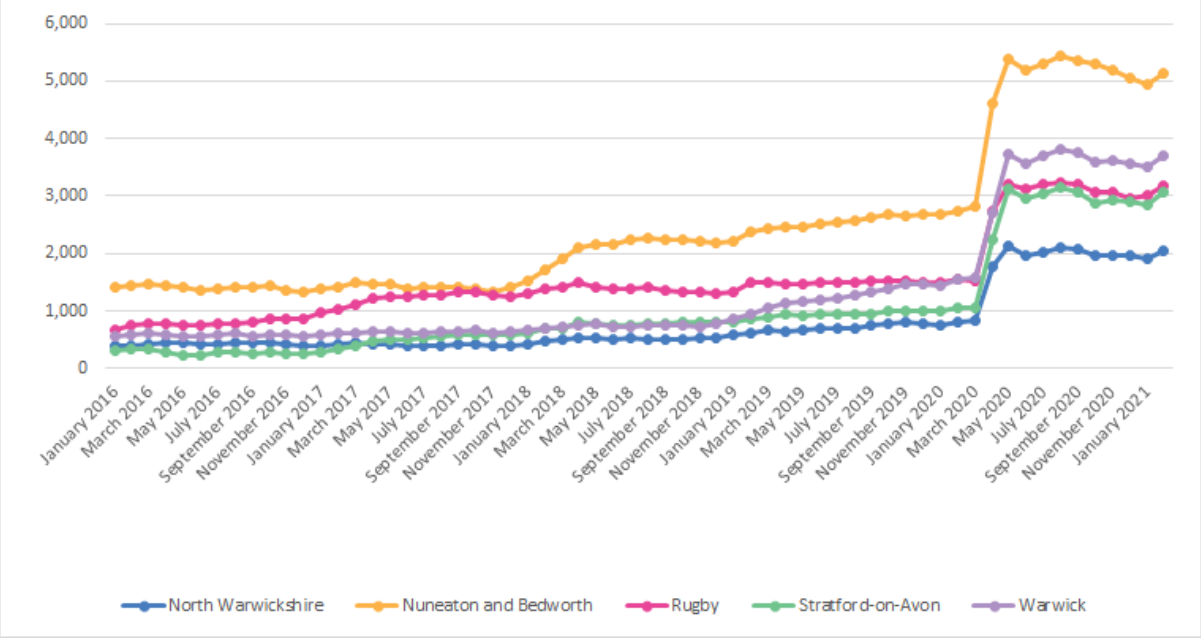


Figure 90. Claimant Count (Districts and Boroughs within Warwickshire), January 2016 to February 2021
Source: Business Intelligence, Warwickshire County Council

The data on claimant count (a measure of the number of people claiming unemployment related benefits) shows a large increase in numbers, coinciding with the first Lockdown in March 2020. That March there were around 16,000 people within Coventry and Warwickshire who were claiming these benefits. By May 2020 this had doubled to over 32,000. Interpretation of employment and unemployment statistics should be undertaken with caution due to the likelihood that the impact of the pandemic has not yet been fully reflected. In particular, the 'furlough' scheme is a new concept which has not been previously defined or measured and may lead to apparent contradictions or unexpected trends. This increase however means the risk of a large additional cohort of people vulnerable to the mental health impact of becoming unemployed, and in particular some of the long-term challenges caused by a mass unemployment event.

There is a difference in the proportion of the population affected by this highlighting the risk of an unequal impact of this mass unemployment event. In February 2021, 6.9% of the population in Coventry and 4.9% of the population in Warwickshire aged 16+ were claimants (West Midlands region 7.4%, England 6.6%).

There is variation within Warwickshire also (NW 5.2%, N&B 6.5%, Rugby 4.8%, Stratford 4.1%, Warwick 4.0% for February 2021).

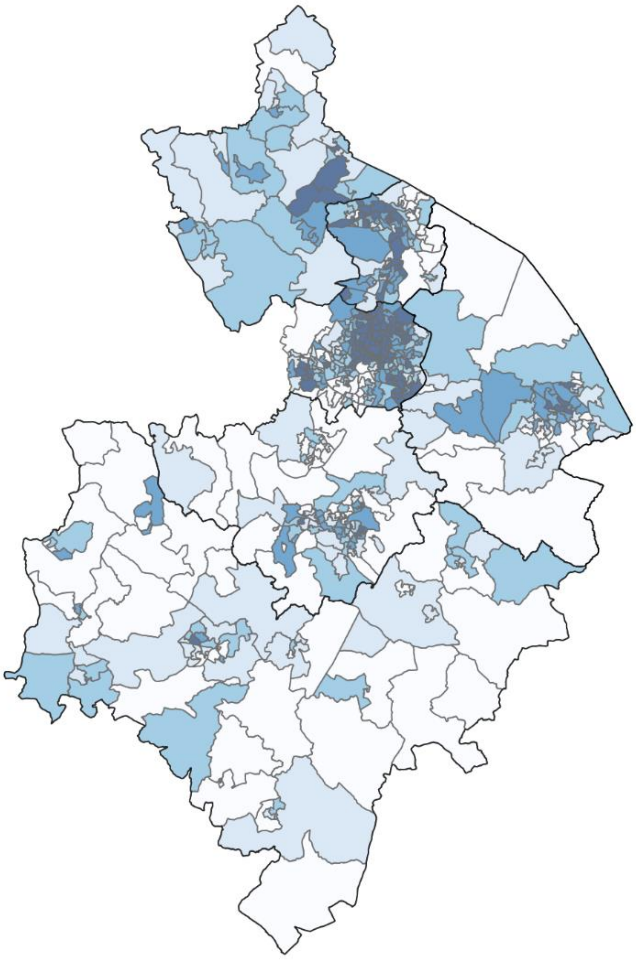


Figure 91. Claimant Count by LSOA for Coventry and Warwickshire, February 2021
Source: ONS from NOMIS

In Coventry, the Claimant Count numbers increased from 8,030 in March to 15,700 in May. When compared to May 2019, the percentage of the population who were claimants has increased from 2.6% in May 2019 to 6.4% in May 2020. In Warwickshire, the numbers have more than doubled from 7,830 in March to 17,625 in May, which is higher than the England increase of 114.1%. As above, it is likely that the full impact of the pandemic is not yet fully reflected, in particular these figures do not include those participating in the Government furlough scheme, therefore the true impact of COVID-19 on employment may be greater than the figures reported[16].

Access to the Citizens Advice Bureau is another way of understanding the health impacts of benefits and unemployment, and which groups have been impacted. In 2019/20, Coventry Citizens Advice Bureau helped 10,850 different citizens, with a 56% increase in issues on the previous year. 38% of enquiries were for benefit-related issues.

Top five benefits issues facing our clients were: (in descending order)

1 2 3 4 5

Benefits	
1	Universal Credit
2	Personal Independence Payments
3	Employment Support Allowance
4	Attendance Allowance
5	Council Tax Support

Figure 92. Top five benefits issues facing Coventry Citizens Advice Bureau clients in 2019/20
Source: Coventry Citizens Advice

The top three employment issues were pay and entitlement, terms and conditions, and access to jobs. Since March 2020, Coventry Citizens advice saw a younger cohort of clients, who were more likely to be homeowners or mortgage payers, and in full time employment and were more likely to be couples rather than individuals. Coventry Citizens advice reported that many just wanted to talk, and "combating social isolation became just as important as resolving material disputes over benefits and debts".

Within Warwickshire, the Citizens Advice Bureaus also reported groups approaching for advice since March 2020 who have not previously accessed the service, meaning there were more enquiries about initial benefit claims. Across the three Citizens Advice Bureaus, the main issues overall remain benefits and tax credits, universal credit and debt.

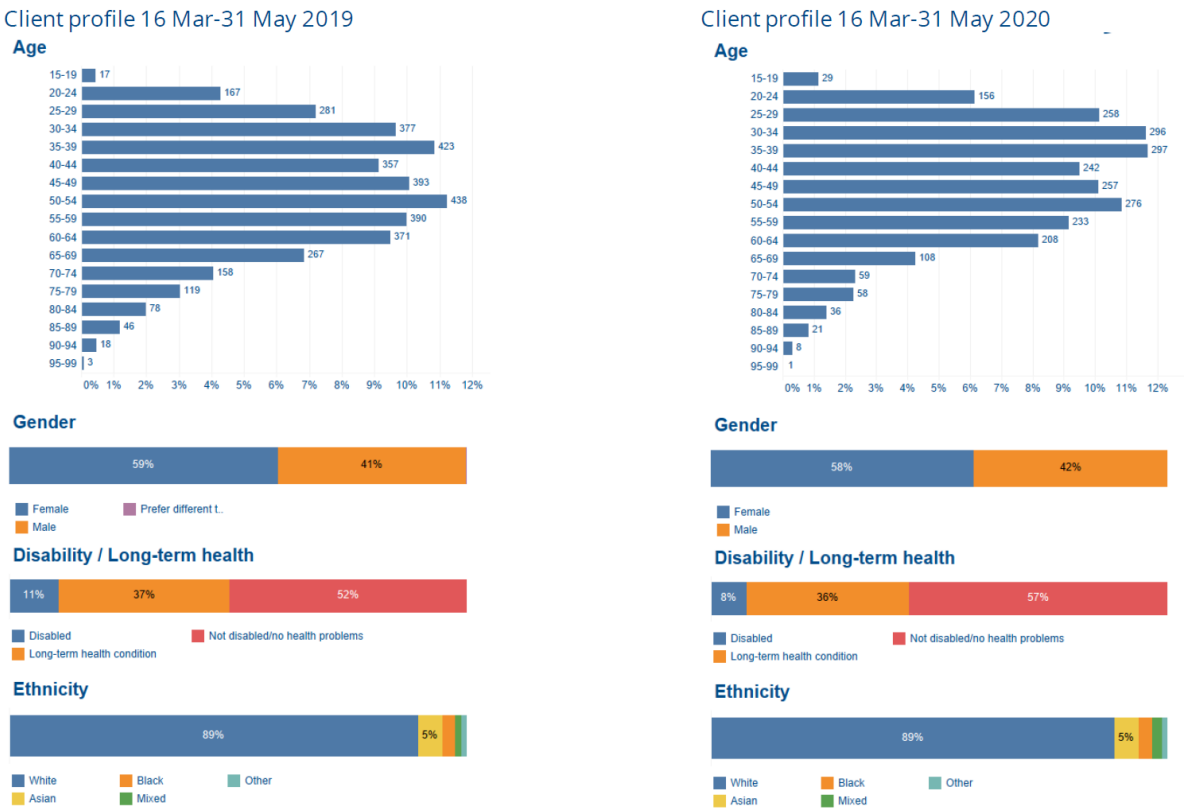


Figure 93. Client profiles across Warwickshire Citizens Advice, 2019 vs 2020
Source: Warwickshire Citizens Advice

Changes in unemployment rates are another local measure to understand the impact of COVID-19 on mental health issues. The Office for National Statistics have adopted the International Labour Organisation definition of unemployment "people without a job, have been actively seeking work in the past four weeks and are available to start work in the next two weeks" or "out of work, have found a job and are waiting to start it in the next two weeks"[112].

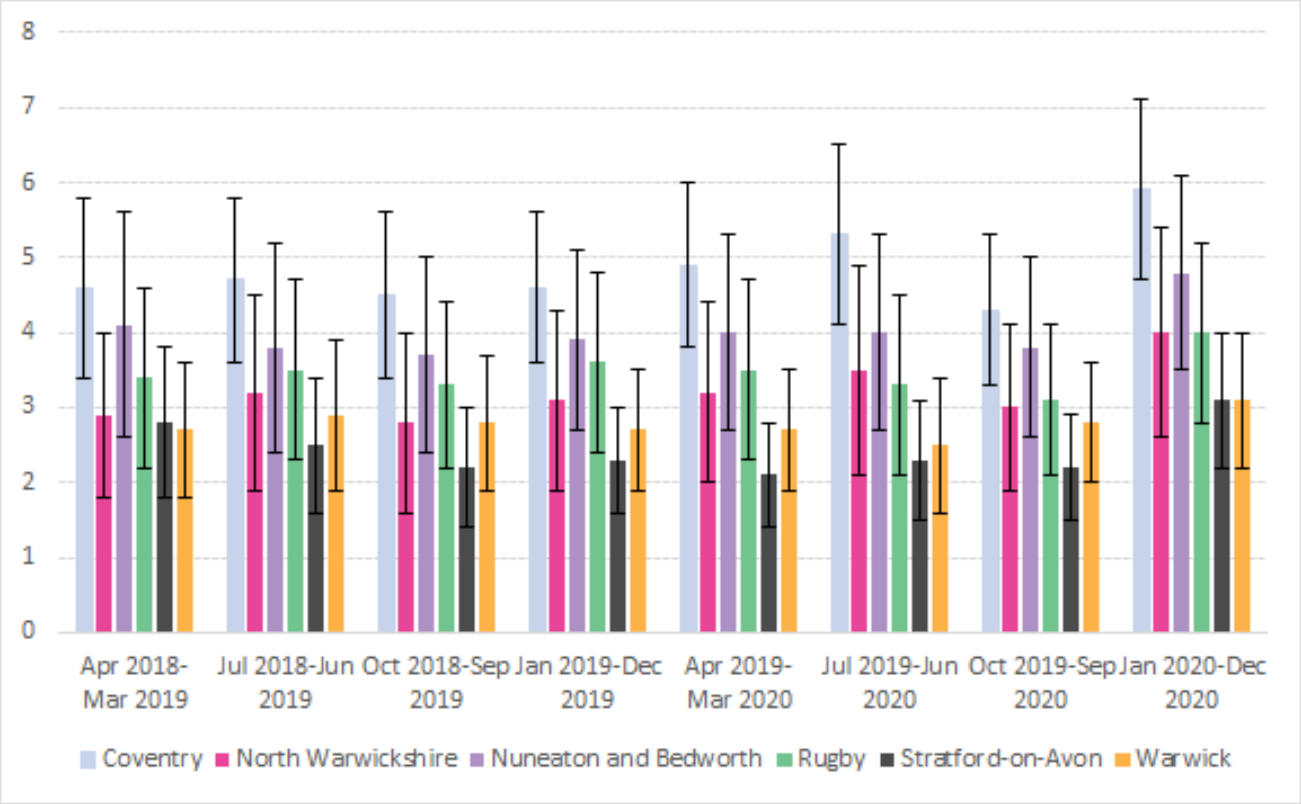


Figure 94. Unemployment rate – Districts and Boroughs in Warwickshire (percentage)
Source: NOMIS

Table 25. Unemployment rate, Coventry (percentage)

Quarter	Unemployment rate
Q1 2019	5.4
Q2 2019	5.3
Q3 2019	5.3
Q4 2019	5.4
Q1 2020	5.5
Q2 2020	6.1
Q3 2020	6.6

Source: NOMIS

There are a large number of people currently on Coronavirus Job Retention (furlough) scheme. This is a government scheme which applies across the UK and covers up to 80% of an employee's salary, up to a maximum of £2,500 per month. It is intended for those who cannot work due to Coronavirus restrictions, however can also apply to those needing to stay at home to look after children or people who are clinically extremely vulnerable and cannot work safely. As of March 2021, the scheme is due to continue until 30th September 2021.

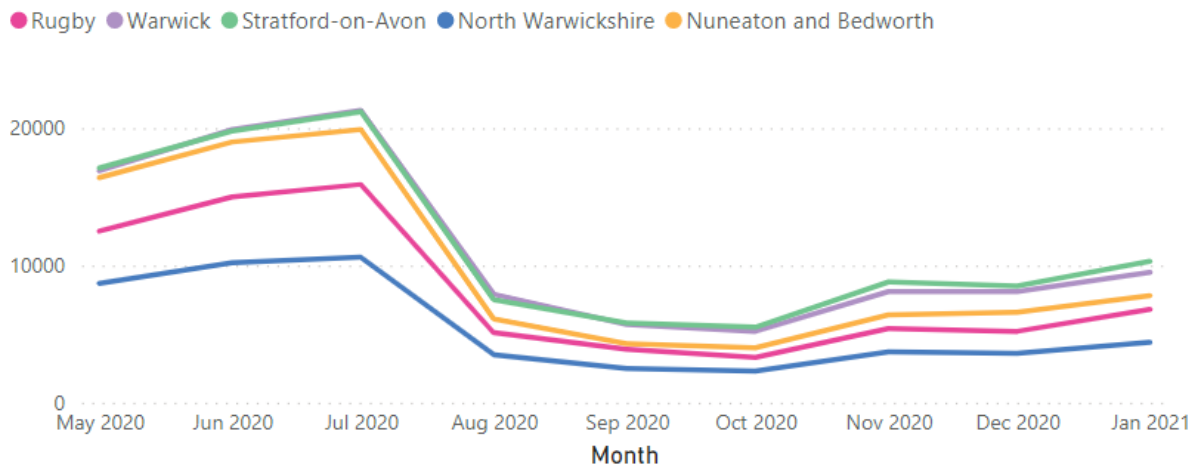


Figure 95. Employees on furlough by District and Borough
Source: gov.uk

In Coventry, the number of people in the Coronavirus Job Retention (furlough) scheme have dropped from 26,200 in July 2020 to 16,500 in December 2020. Although there are various reasons why people may be on the furlough scheme, and whether they will return to their employment afterwards, one risk for the health and social care system is if a proportion of people on furlough become unemployed when the scheme finishes. At the moment there isn't an estimate of how many this might impact.

The number of job vacancies dropped dramatically in the early part of 2020, and are not yet back to pre-pandemic levels. This means that there are fewer opportunities for those who are unemployed to return to employment.

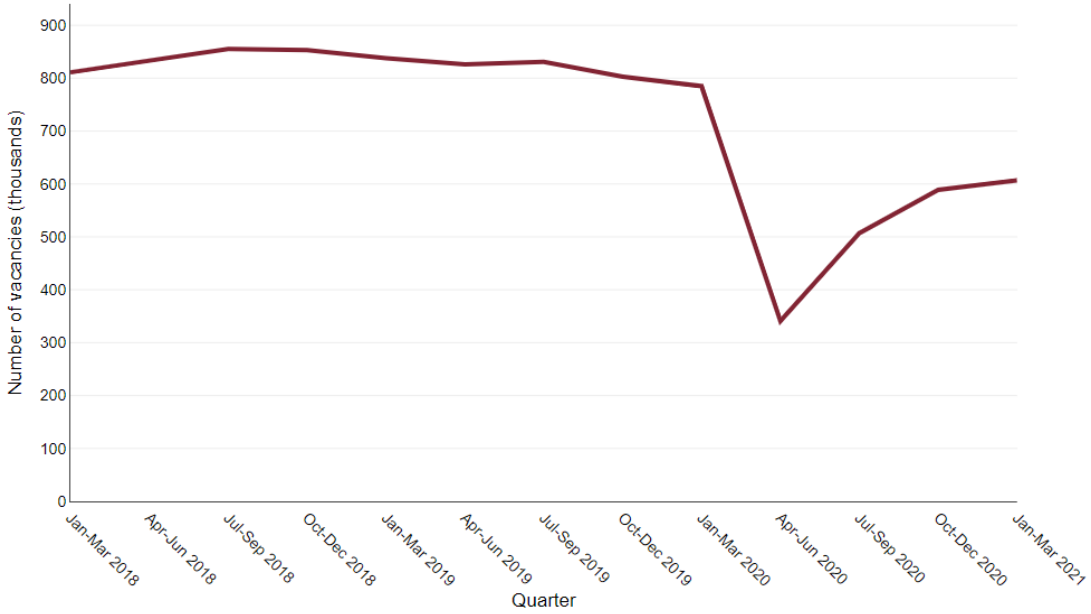


Figure 96. Number of Job Vacancies in the UK (Thousands), seasonally adjusted
Source: PHE Wider Impacts of COVID 19 Tool, PHE

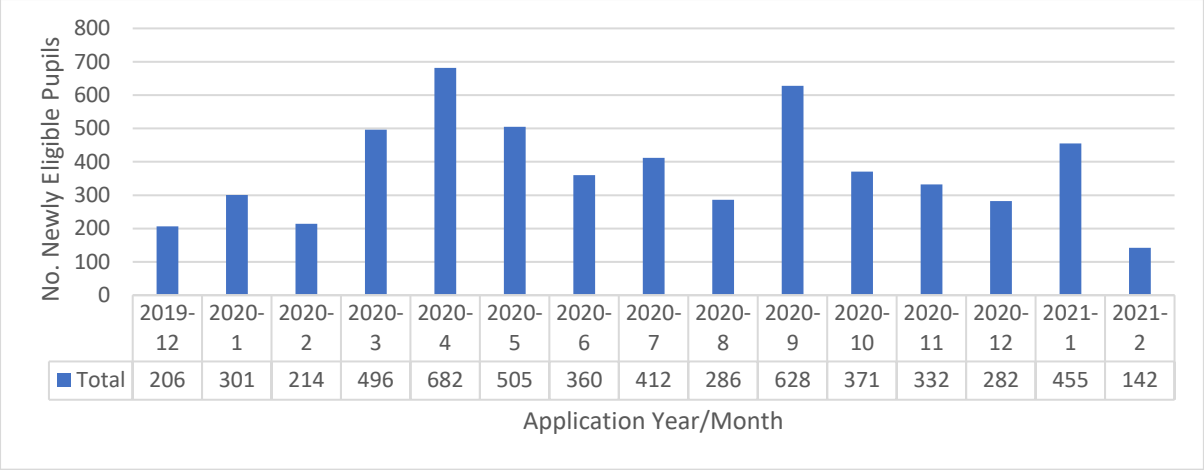


Figure 97. Free School Meals, Warwickshire – number of newly eligible pupils by month
Source: Education team, Warwickshire County Council

In Coventry, 17% of school pupils were eligible for a free school meal in 2019/20. For Warwickshire, Figure 96 illustrates spikes in pupils eligible for school meals in March/April 2020 and January 2021 which correspond with COVID-19 lockdowns (September 2020 spike may be a result of return to school). This increase in eligibility is likely to be related to significant change in parent/guardian income (e.g. loss of employment).

According to the Trussell Trust (who run a nationwide network of foodbanks, including in Coventry and Warwickshire), in the six-month period from 1st April 2019 to 30th September 2019, 9,456 food parcels were distributed in Warwickshire. In the same period in 2020, 15,788 parcels were distributed, an increase of 70%. In Coventry, in the six-month period from 1st April 2019 to 30th September 2019, 13,265 parcels were distributed. In the same period in 2020, 19,778 parcels were distributed, an increase of 49%.

The Coventry and Warwickshire Quarterly Economic Survey asks local businesses if they feel that things are getting better, worse or staying the same. If all respondents feel that things were getting better, then the score would be 100. If everyone felt things were getting worse, then the score would be 0. A score of 50 is where there is a balance between the two. In the second quarter of 2020, the score dropped to 29, this corresponds to the first lockdown. There was some improvement to 43 in the third quarter of 2020, and since then the score has been just over 50, suggesting that business optimism has increased amongst local businesses.

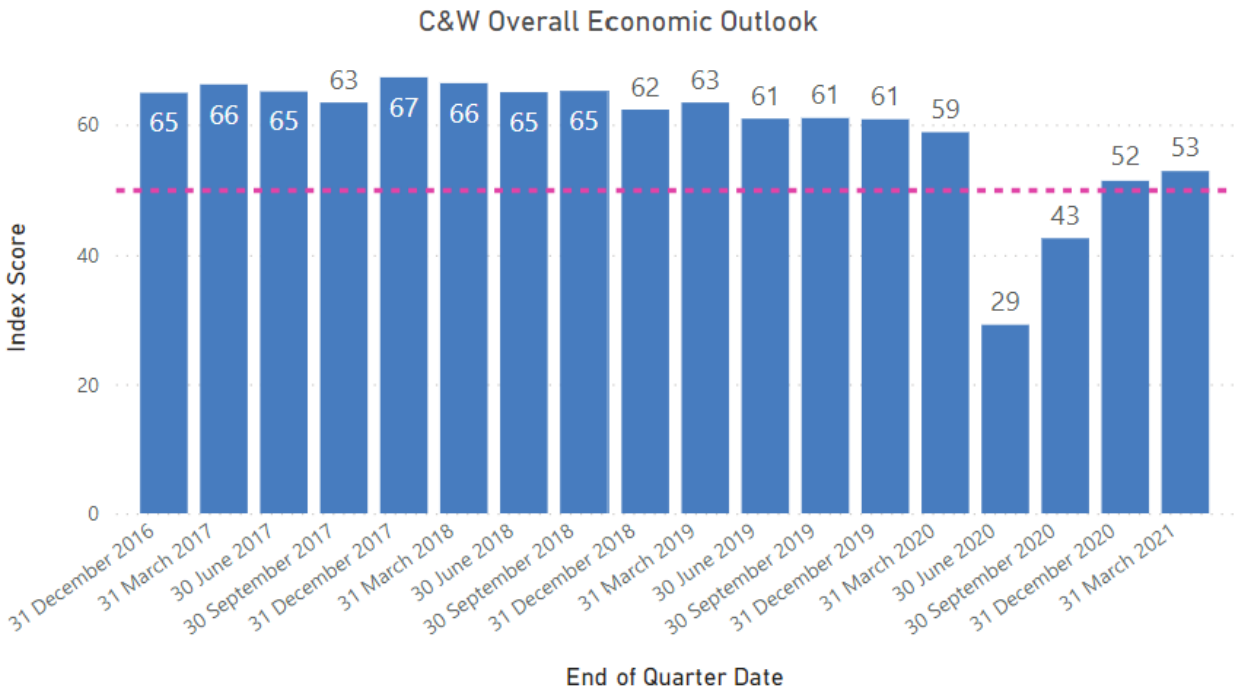


Figure 98. Coventry and Warwickshire overall economic outlook
Source: Business Intelligence, Warwickshire County Council

Employment

The following recommendations are proposed:

- Promote Mental Health First Aid courses and encourage all organisations across Coventry and Warwickshire to have at least one mental health first aider
- Ensure appropriate support is available for service users that do not have access to online services
- Ensure that appropriate support is targeted towards young people who have been disproportionately impacted by COVID-19
- Continue to promote the IPS service across Coventry and Warwickshire

ACCESS TO OUTSIDE/GREEN SPACE

Green space is term used to describe either maintained or unmaintained environmental areas, which can include nature reserves, wilderness environments and urban parks. Green spaces are often designed and designated for their recreational or aesthetic merits. This is particularly the case in urban contexts as urbanisation has significantly reduced the access to green spaces. There is strong and growing evidence that access to parks and open spaces and nature can help to maintain or improve mental health. People have been shown to report less mental distress, less anxiety and depression, greater wellbeing and healthier cortisol profiles when living in urban areas with more green space compared with less green space[113]. Other supporting evidence demonstrates that the quality of nearby greenspace reduces stress; this has been demonstrated across age and cultures[114] [115]. A recent study based in the UK with over 20,000 participants estimated that people may only need to spend two hours each week outdoors in green spaces to derive significant wellbeing benefits[116].

The pandemic has highlighted the underlying inequalities in access to parks and green space across populations[117]. A recent study across nine countries with over 5000 survey respondents reported that lockdown severity significantly impacted on mental health, but access and contact with nature reduced the impact, especially for those in stricter lockdown[118]. Those able to spend lockdown in a home with access to outdoor space were more likely to report a pleasant experience, especially at the height of lockdown when time outside was strictly limited. Furthermore, the Health Foundation reported inequalities in access to outdoor space by age, and 21% of those aged 25–34 had no access at all[97]. Given the significant impact the pandemic has had on mental health, and the clear benefits of green space, understanding the access and use of green space in Coventry and Warwickshire is important.

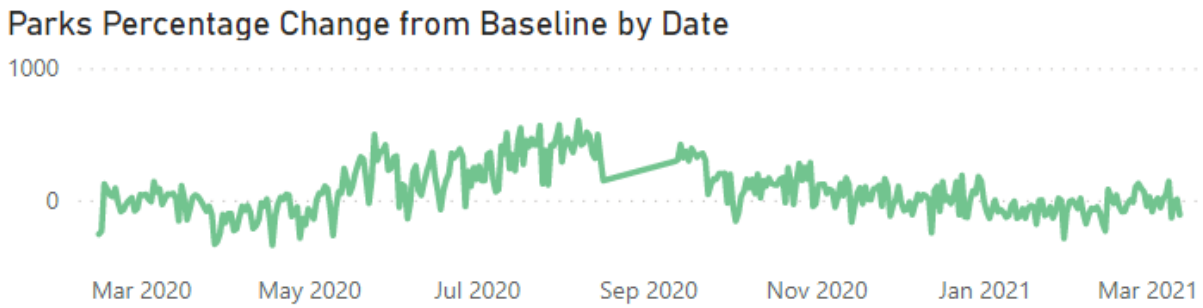


Figure 99. Attendance at parks in Warwickshire (percentage change over time)
Source: Google mobility reports

Data from google mobility reports shows how the use of parks has changed over the pandemic. During the March 2020 lockdown, and into April and May, the access to parks was low. This increased over the summer and then declined through Autumn. This could be read as coinciding with the good weather as well as lockdown, but the

low use in Winter 2021 highlights an additional contributor to and poor mental health in the lockdown in January 2021. The baseline is the corresponding week of the previous year.

Table 26. Access to Garden space, April 2020

Area	Percentage of properties with private outdoor space
North Warwickshire	94%
Nuneaton and Bedworth	94%
Rugby	89%
Stratford-on-Avon	90%
Warwick	90%
Warwickshire	91%
Coventry	85%
West Midlands	90%
England	88%

Source: ONS

There is variation in the number of households with access to private outdoor space, whether as a household garden or shared residential private space. In Coventry the numbers are lower than in Warwickshire, and the England average, as only 85% of properties have outdoor space, showing the importance of communal parks for the wellbeing of the population.

Compared to the England average, more properties have access to outdoor space in all areas in Warwickshire, however there is variation. Rugby has the lowest with 89% of properties having private space, compares to North Warwickshire and Nuneaton and Bedworth where and 5% more properties have access to this space.

Recommendations

The following recommendations are proposed:

- Undertake community engagement activity to understand barriers to accessing green space
- Promote green spaces across Coventry and Warwickshire, particularly amongst communities that are not in close proximity to green spaces

IMPACT ON FAMILY RELATIONSHIPS

In July 2020, a COVID-19 Social study[119] stated 12% of people reported a relationship breakdown with any family member, friend, colleague or neighbour since COVID-19 lockdown was introduced. This study reported this figure was highest amongst adults under 30 (21%) compared to adults over 60 (5%), and amongst people with a diagnosed mental illness (22% vs 10%). It was also slightly higher amongst people living alone (14% vs 11%), people with lower household income (14% vs 10%), ethnic minorities (19% vs 10%), keyworkers (14% vs 11%), people living with children (15% vs 11%), and people in urban areas (13% vs 10%).

Home working rates (according to the ONS) in April 2020 were 35.3% for the West Midlands, lower than the UK average of 46.6%[120]. However, increased working from home during the pandemic has highlighted a significant negative impact on mental health. Higher levels of anxiety and stress have been reported from those working from home, potentially impacted by the perception that there is a requirement to constantly be at computers for prompt responses. Twenty-five percent of those working from home have reported difficulties in coping with mental health highlighting challenges related to loneliness and isolation from colleagues. Thirty percent of those working from home have also reported challenges in separating home life and work life, with 27% reporting difficulties in switching off from work at the end of the day and week[121]. In addition, over a third of respondents to the C&W MHNA survey (see appendix 1) reported a negative impact of working remotely while the remainder were either positive or neutral. Qualitative responses confirmed combining work from home and home-schooling was described as stressful.

Between 13 January and 7 February, the Office of National Statistics reported that 90% of parents had a child at home to be home-schooled due to the pandemic[122]. However, there is a contrast in home-schooling responsibilities from the start of the pandemic; in April 2020 there was no difference between men and women who reported home-schooling in comparison to February 2021 where women with a school-aged child were more likely to personally home-school a child in their home[122]. Furthermore, half of parents agreed that home-schooling was negatively affecting their wellbeing, with a significant increase from earlier in the pandemic. At the time of the survey in March 2021, a significant 63% of home-schooling parents said that it was negatively affecting their children's well-being, compared with 43% in April 2020. In addition, over half of parents reported home-schooling was negatively impacting their relationship compared to 36% in April 2020. Over a third of parents reported home-schooling negatively impacted their jobs. Of those in employment, 47% reported a negative impact from home-schooling compared to 30% in April 2020.

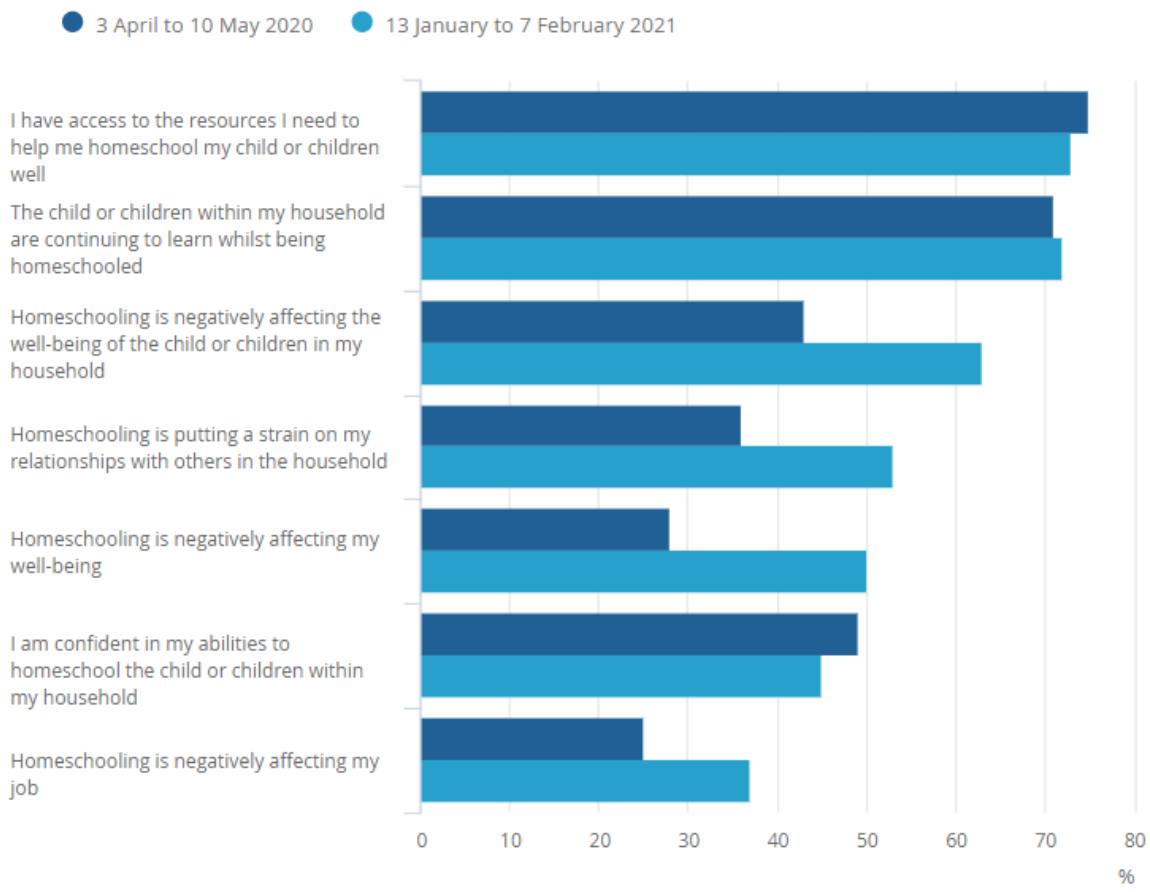


Figure 100. Percentage of homeschooling parents who agreed with the statement on homeschooling in Great Britain (3 April to 10 May 2020 and 13 January to 7 February 2021)
Source: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandwellbeing/bulletins/coronavirusandthesocialimpactsongreatbritain/19february2021

The C&W MHNA survey also asked about factors impacting mental health in previous two years (i.e. not related to COVID-19), work (59.9%/n=249), physical health (56.5%/n=243) and family relationships (55.5%/n=239) were the options selected most frequently by respondents as impacting on their mental health either some of the time, often or all of the time (see appendix 1).

The responses from public service users and the wider public were similar to the responses given by professionals, for who, work (66.9%/n=91), physical health (53.7%/n=73) and family relationships (50.4%/n=69) were the three most frequently selected options considered to be impacting on their mental health either some of the time, often or all of the time.

In relation to mental health services, focus groups conducted as part of the MHNA with CWPT professionals highlighted the impact of remote working during lockdowns. Whilst remote working has had some benefits, drawbacks include therapy taking longer (i.e. more sessions required to reach the same outcome),

possibly due to the reduction in quality of therapy. There was also an increase in DNAs and cancellations as respondents reported "*people don't take the digital way of working as seriously*"). Furthermore, findings revealed negative impacts on therapists' wellbeing including an increase in anxiety, "*unprecedented levels of pressure on workforce to support mental health pressures*".

Focus groups with WCC Communities and Partnerships and the Voluntary and Community Sector highlighted the impact of COVID-19 on wider determinants of health, including family relationships, financial and employment concerns, bereavement, gambling, isolation and availability of services. "*There's a need to address the social determinants of health rather than focusing only on the downstream effects on mental health - prevention rather than cure*." Participants also reported accessibility of services, including digital inclusion and transport.

Domestic and Sexual Abuse

The relationship between mental health and domestic violence and abuse (DVA) is bidirectional; people who have mental health problems are more likely to experience DVA compared to those who don't[123], and DVA itself can cause mental health difficulties[124]. It is estimated that more women take their own lives due to DVA than those who are murdered by their abuser; whilst two women a week are killed by an abuser, 30 women every day attempt suicide as a result of experiencing DVA, and three women a week take their own lives[125].

Children growing up with DVA have a higher rate of mental health difficulties compared to those who don't[126] [127]. In the SafeLives National Dataset on children and young people accessing DVA services, 21% experienced anxiety or depression and 33% felt unhappy[128]. Some groups, including disabled people and those identifying as LGBTQ+, are more likely to have mental health needs when accessing DVA services[129]. Despite the high co-occurrence of DVA and mental health problems, DVA is often undetected in mental health services, with just 10-30% of DVA cases identified[130].

During 2019/20, 17% of victim-survivors supported by Warwickshire's Domestic Violence Service stated that they had mental health issues, and 13% reported that they felt suicidal.

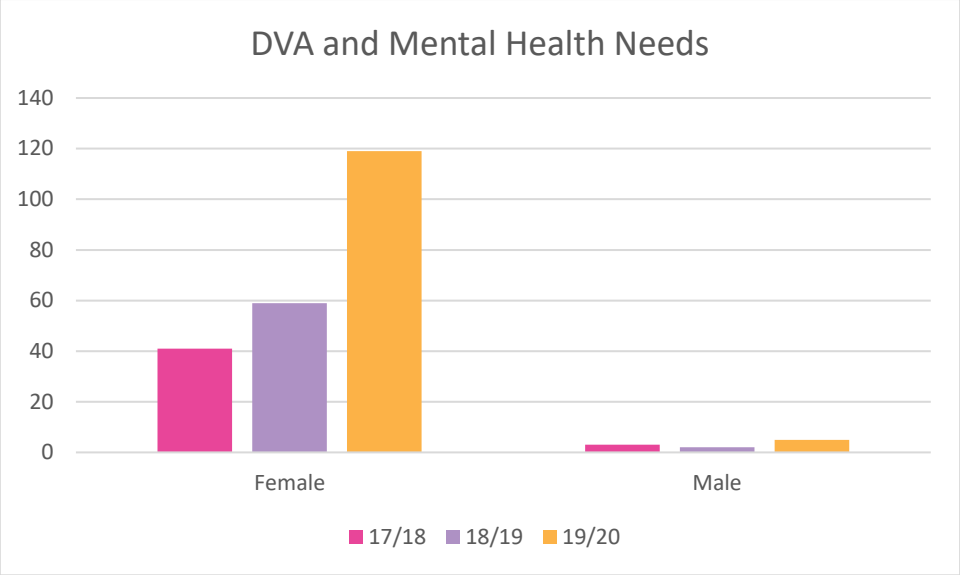


Figure 101: Mental health needs of people given long-term support from community-based services and independent domestic violence advisors in Warwickshire.

Within the Warwickshire Refuges, this figure was even higher with 42% of women stating they had mental health issues. In Warwickshire, mental health difficulties increased in 2019/20 compared to 2017/18, which may reflect an increase in severity of DVA being experienced, recording or service factors, or it may reflect the reducing stigma surrounding mental health difficulties (Figure 101). Mental health issues are also prevalent amongst perpetrators. A Multi Agency Risk Assessment Conference (MARAC) is a victim focused information sharing and risk management meeting attended by all key agencies, where high risk cases are discussed. Since April 2017, between 14% and 20% of cases discussed in Warwickshire, the perpetrator was identified as having mental health issues[131].

During engagement with professionals for the DVA holistic needs assessment from a variety of agencies across Warwickshire about the current and future DVA service offer, Mental health provision was consistently raised as a current gap and priority for improvement. Specifically:

- More dedicated DVA counselling and trauma informed therapy
- There's a lack of understanding of trauma (across agencies in Warwickshire) and the effects on the individual
- There is not a clear service offer for children and young people who have witnessed or experienced abuse:
    - Gap in provision when abuse ends, which would aid recovery and teach healthy relationships
    - Gap in provision for pre-school children with psychological / behavioural effects

There are challenges around accessing appropriate, timely and targeted mental support, that is trauma informed. The level of need and types of provision required, may vary substantially. There may be further work required to understand the types of support that should be provided for the differing level and type of need. For example, whether it is clinical support, group therapy, and the likely duration of support required.

Crime data has shown an increase in offenses flagged as domestic abuse during the pandemic. However, due to the gradual increase in recorded domestic abuse offences in recent years, it is unclear whether the increase is a result of the restrictions in place due to the pandemic[132]. However, there has been a general increase in demand in domestic abuse services for domestic abuse victims, such as support helplines. However, this may be an indication of severity of abuse being experienced and unable to engage in actions such as leaving home to escape abuse or counselling, as opposed to a rise in incidents. In addition, there was a reported decrease in April to June 2020 for of cases discussed at multi-agency risk assessment conferences compared to January to March 2020. These figures demonstrate the potential difficulty in safely contacting the police during the lockdown period.

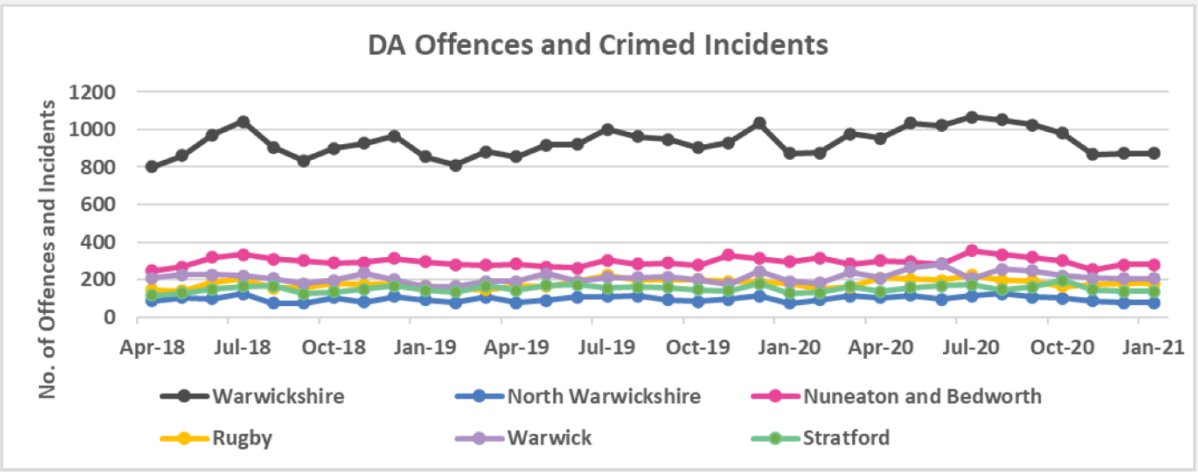


Figure 102 Domestic Violence and Abuse (Warwickshire)
Source: Warwickshire Domestic Abuse Partnership report, February 2021

DA Offences and Crimed Incidents	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 20	Jan 20 19 vs Jan 21	Q3 19/20 vs 20/21
Warwickshire	1045	1024	973	859	873	887	2%	-5.9%
North Warwickshire	123	107	102	83	73	97	29%	-10.3%
Nuneaton and Bedworth	331	318	300	247	280	287	-2%	-10.0%
Rugby	195	193	162	174	177	158	-13%	-11.2%
Warwick	253	247	220	209	204	206	8%	1.8%
Stratford	143	159	189	146	139	139	9%	1.5%

Figure 103. Domestic Violence Offences and crimed incidents across Warwickshire
Source: Warwickshire Domestic Abuse Partnership report, February 2021

Recorded Domestic abuse offences and crimed incidents in Warwickshire remain slightly higher than last year. The majority are classed as medium risk. Those classed as high risk have reduced compared to January 2020.[133]

There has been a large increase in the number of domestic violence and abuse offences in Coventry, with 3,299 offences reported in 1 January 2020 to 1 December 2020 compared to 2,291 over the same time period in 2019; a 44% increase.

There has been an increase in domestic violence and abuse offences in 16 of 18 wards of the city; with the increase ranging from 17% to 100%.

Wards with the highest number of domestic abuse crimes include St Michael's in the city centre; plus Longford, Foleshill and Henley - in Coventry north east. Wards with the highest increase in crimes are Henley, Longford; as well as Binley and Willenhall in the south east.[134]

COVENTRY	YTD	PER MONTH		
	% Change	Average (no. of DA crimes)	Highest (no. of DA crimes)	When Highest?
Bablake	74.29%	10.9	29	Jun-20
Binley and Willenhall	54.84%	19.3	50	Sep-20
Cheylesmore	27.59%	12.1	28	Jul-20
Earlsdon	-13.33%	5.3	9	Jul-20
Foleshill	25.22%	30.8	52	Aug-20
Henley	58.66%	26.9	51	Aug-20
Holbrook	48.74%	14.5	38	Aug-20
Longford	50.49%	30.3	54	Aug-20
Lower Stoke	39.69%	21.1	35	Jun-20
Radford	37.64%	24.1	40	Aug-20
Sherbourne	26.32%	8.1	16	Feb-20
St Michael's	42.42%	39.4	64	Oct-20
Upper Stoke	37.18%	21.7	35	Jul-20
Wainbody	-15.79%	3.3	10	Oct-20
Westwood	100.00%	17.4	42	Aug-20
Whoberley	75.64%	11.6	34	Aug-20
Woodlands	17.65%	19.4	30	Jun-20
Wyken	60.00%	13.3	32	Jul-20

Figure 104. Coventry Domestic Recorded Crimes, 2020
Source: West Midlands Police

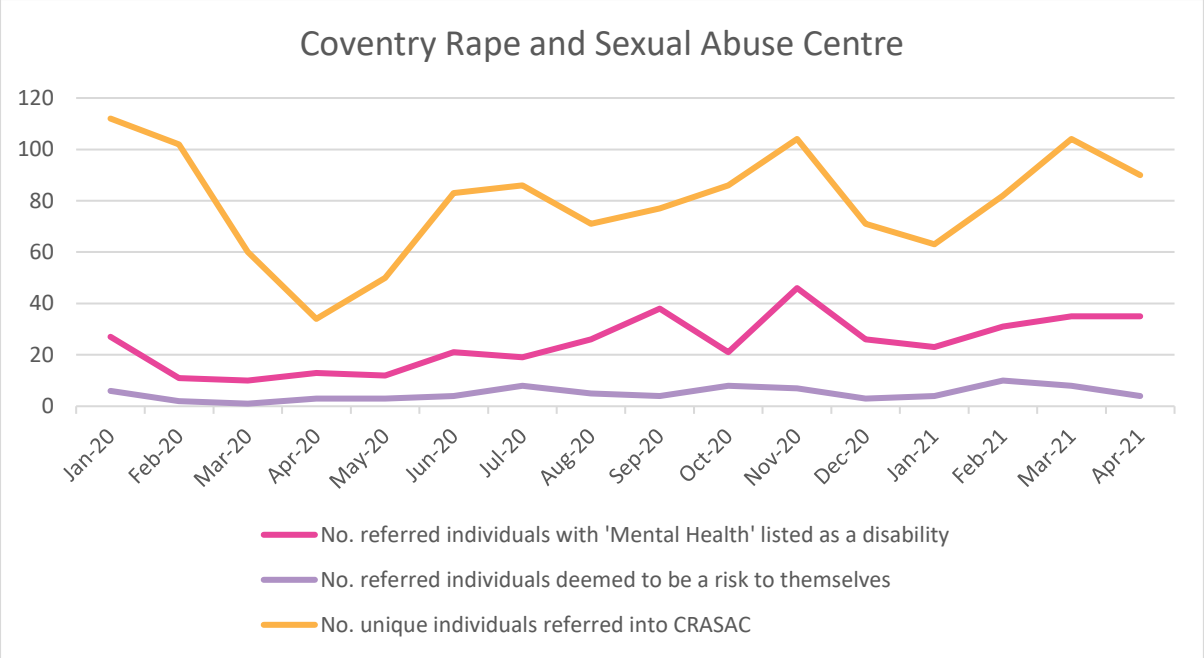


Figure 105. Coventry Rape and Sexual Abuse Centre
Source: CRASAC

Figure 105 shows data from Coventry Rape and Sexual Abuse Centre. However, please note that the counselling team at CRASAC will only identify a client has having mental Health issue if there has been a formal diagnosis. However, feedback from the service suggests that a much higher proportion of clients experience a variety of mental health difficulties, which may not be diagnosed.

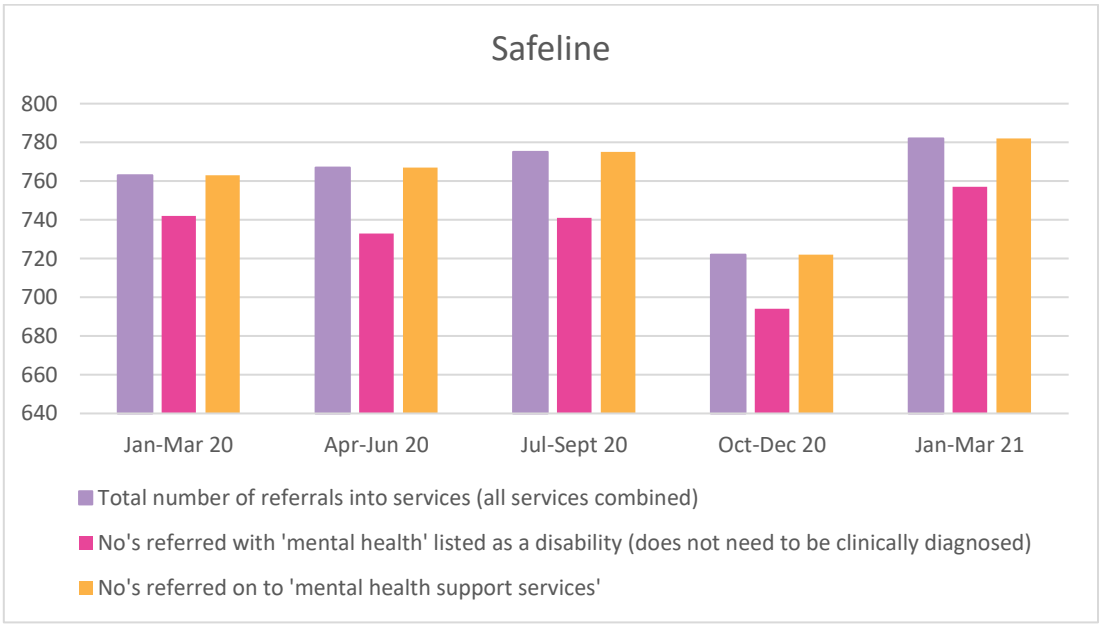


Figure 106. SafeLine referrals in Warwickshire with a mental health condition and referred to mental health services
Source: SafeLine

Figure 106 demonstrates local data from Safeline, who provide support for those affected by sexual abuse and rape. Safeline reports this data quarterly to it's commissioners. Services include Face-to-Face, telephone and online counselling and creative therapies; Prevention and Early Intervention services; The Warwickshire Helpline and online support service; ISVA, Specialist counselling (all of the clients who access specialist counselling services do so because they have severe mental health problems). Safeline have a number of online services available to support victims/survivors; this has been enhanced due to the pandemic to ensure all those that required support were offered it. The number shown in Figure XX highlight that victims/survivors were, and continue to, engage in this method of support.

Helpline and Online support: The total number of referrals includes those accessing our Warwickshire Helpline and Online support service. All self-refer to the service and 95% of all users have been sexually abused or rape and are accessing the service for emotional support because of mental health issues.

Prevention and Early Intervention: The total number of referrals includes children and young people who are accessing our prevention and Early Intervention services. Many of the children who have accessed this service have either been sexually abused or are at severe risk of abuse. All of the children and young people have mental health issues and need specialist support.

ISVA: Some referrals to this service do not indicate a mental health issue, this relates primarily to small children. Once assessed however, every client is found to have mental health issues. The ISVA figures excludes support provided to parents and siblings who are equally devastated by the abuse of a loved one.

Very few victims of sexual violence and abuse crimes ever disclose what has happened to them and this needs to be taken into account. Significant efforts are being made to raise awareness about support services available to victims, if successful, demand for mental health support will increase. These figures exclude existing client numbers.

RoSA offers free confidential support for anyone who has experienced the trauma of rape, sexual abuse or sexual violence in Warwickshire. The charity work with women, men, young people and children from the age of five. Figure 107 shows the total number of new referrals into services and numbers referred with mental health listed as a disability. Feedback from RoSA highlights that mental health data is hard to quantify as by nature of the service, all clients have some mental health needs. The data is an estimate of those with more complex needs (this is most likely higher), but mental health issues are uncovered/disclosed when trust in therapy is built or other circumstances change for the client.

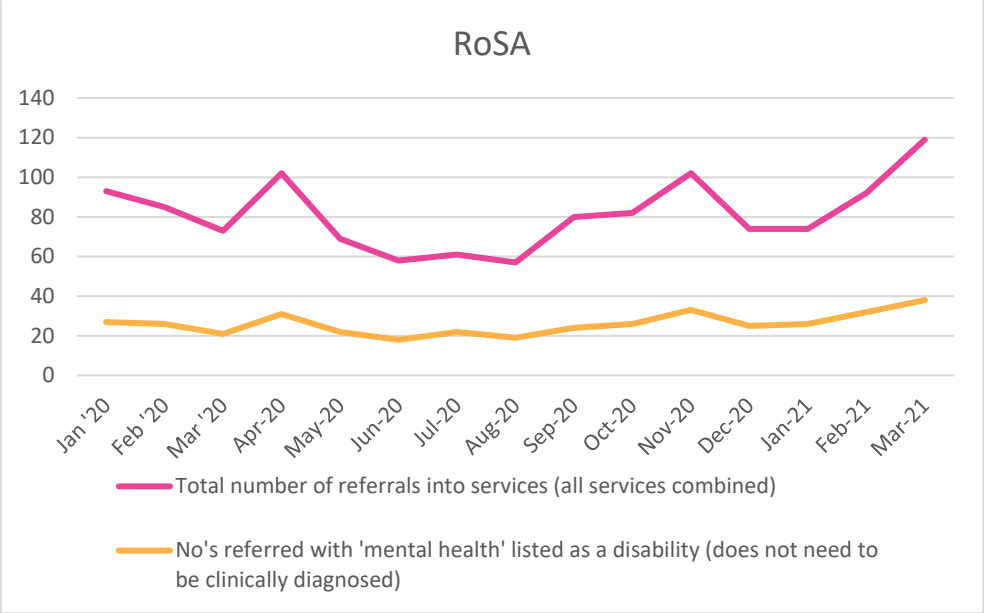


Figure 107 Warwickshire RoSA
Source: RoSA

Drugs and Alcohol

While drug use can increase the risk associated with COVID-19, social distancing, isolation and lockdown have been impacted by poorer mental health and wellbeing including negative emotions, such as irritability, anxiety, fear, sadness, anger or boredom[135]. These conditions are known to trigger relapse or intensify drug consumption[136,137].

A survey for Alcohol Awareness Week (16-22 November) commissioned by Alcohol Change UK showed that drinking worsened mental health for over four in ten drinkers (44%)[138]. Drinking in the last 6 months had a negative impact on feeling anxious, stressed or worried (30%), trouble getting to sleep (29%), waking during the night or not sleeping well (35%), memory loss (22%), feeling sad or low (29%), and feeling irritable or angry (28%). The survey also showed that the stigma around alcohol problems has stayed the same in recent years, whereas there has been a concerted effort to challenge the stigma around mental health. In addition, the Warwickshire COVID-19 recovery survey reported 1 in 5 increased alcohol consumption (see Appendix 3). This is consistent with national evidence from the UCL alcohol toolkit study, which showed increases in high risk drinking following the first lockdown in March 2020, which have persisted since[139].

Access to mental health support for people using alcohol was seen as more difficult, as reported in the C&W MHNA survey (see appendix 1). For example, if people presented with mental health and alcohol problems, they didn't 'fit' the criteria for a service.

Figure 108 shows the number of alcohol clients in Coventry and Warwickshire who started treatment in 2019-20 who were identified as having a mental health treatment need and, of those, the number who were receiving treatment from mental health services, and those not in treatment.

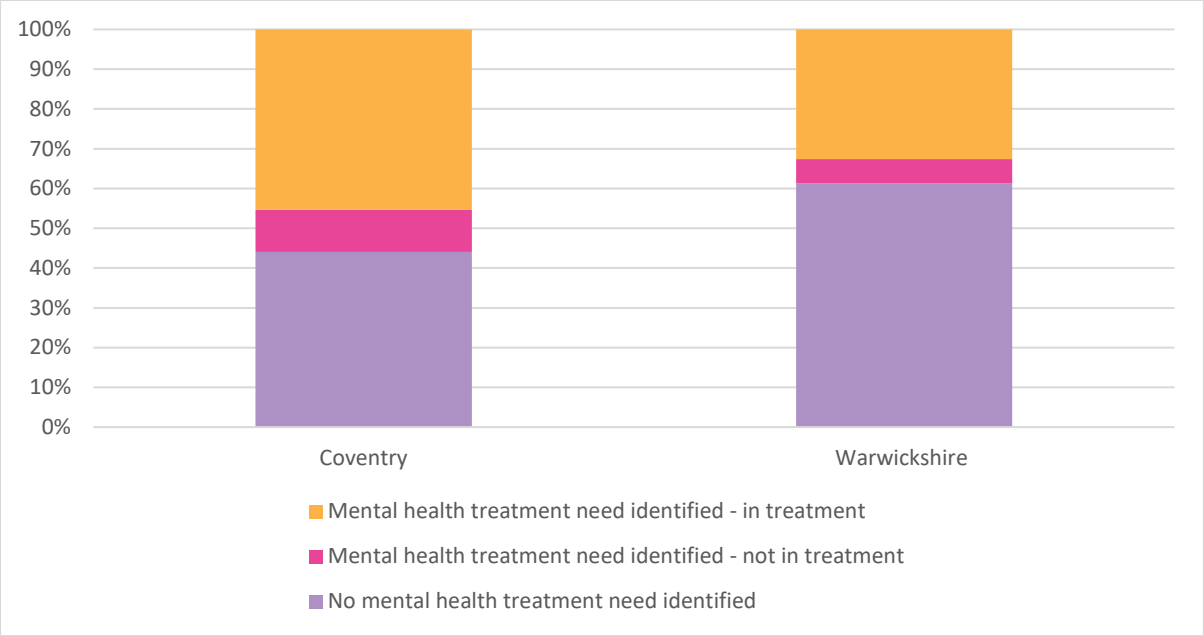


Figure 108. Coventry and Warwickshire Alcohol Treatment and Mental Health needs 2019/20
Source: Change Grow Live

Figure 109 shows the number of drug clients who started treatment in 2019-20 (opiate, non-opiate, non-opiate and alcohol) who were identified as having a mental health treatment need and, of those, the number who were receiving treatment from mental health services, and those not in treatment.

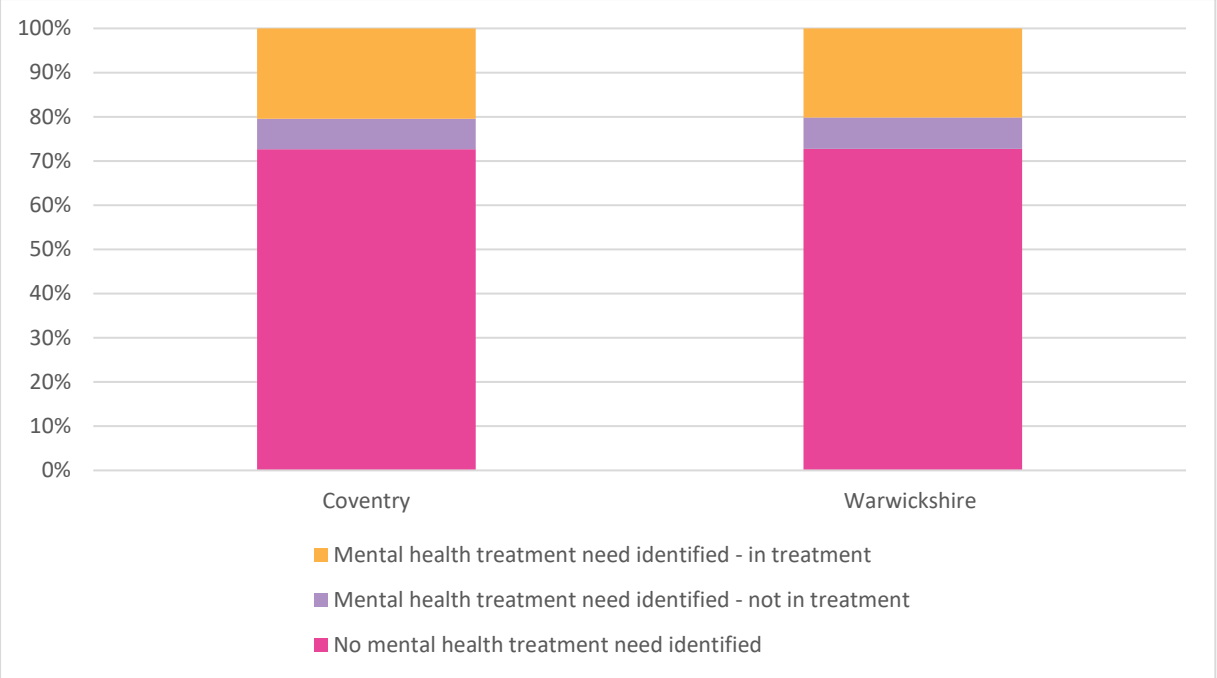


Figure 109. Coventry and Warwickshire Drug Treatment and Mental Health needs 2019/20
Source: Change Grow Live

New referrals to Change Grow Live show an increase during 2020 for both Coventry and Warwickshire

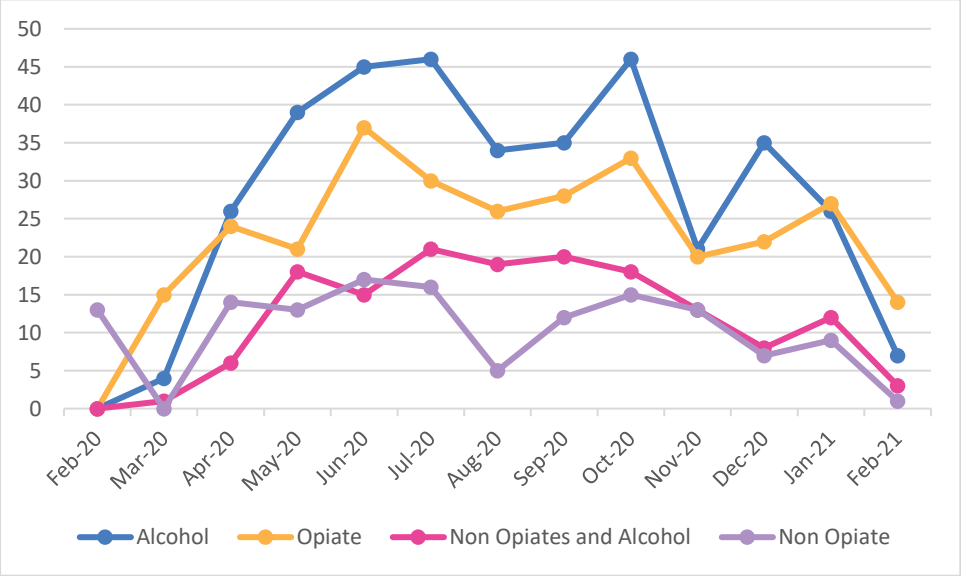


Figure 110. Warwickshire referrals to Change Grow Live
Source: Change Grow Live

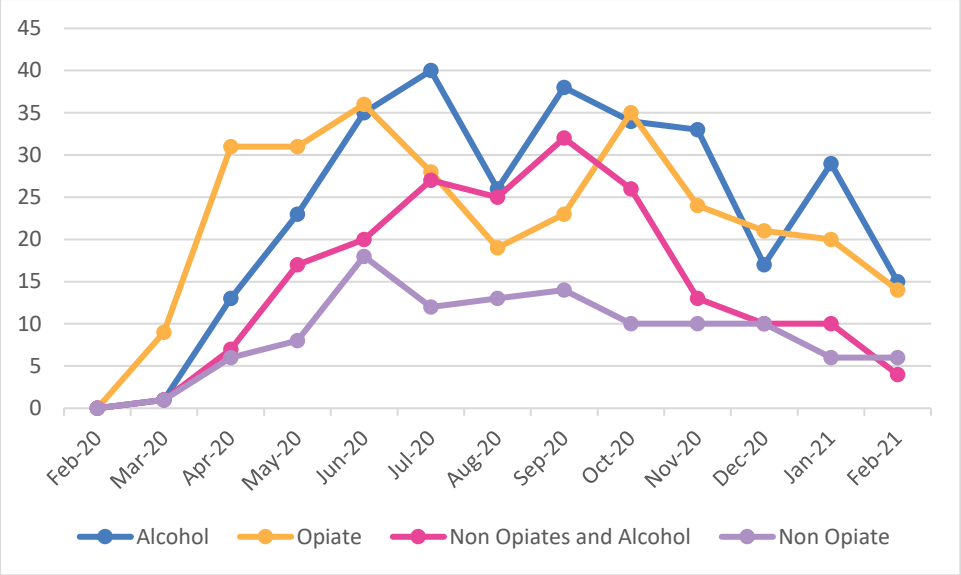


Figure 111. Coventry referrals to Change Grow Live
Source: Change Grow Live

Recommendations

The following recommendations are proposed:

- Following the impacts of the COVID-19 pandemic, promote mental health and wellbeing resources including relationship focused resources
- Support the recommendations of local domestic violence and abuse needs assessments
- Continue to support and expand (where required) mental health support services for people who abuse drugs and/or alcohol

TRAVEL

The association between physical activity and mental health, such as anxiety and depression, is well established. Physically active people are likely to report fewer symptoms of anxiety or emotional distressed compared to those who are relatively inactive[140]. The health benefits of cycling and walking, relative to driving, are well-documented[141 142]. Active travel improves mental health and wellbeing as a result of physical activity[143]. Active travel has been reported as less stressful mode of transport and report less dissatisfaction about their commutes, e.g. in comparison to private motor vehicle. Public transport journeys typically include aspects of physical activity (i.e. when accessing bus stops or railway stations; therefore, providing a positive impact on mental health. Those commuting by cars find their commutes more stressful than other ways of travelling. In particular, delays, traffic congestion and other commuters are sources of stressors. They have been associated with many factors associated with wellbeing such as negative moods when arriving at work or home and negative effect on overall life satisfaction[140,144].

In general, adult active travel has increased over the last decade. There was a 12% increase in walking trips overall each year in England between 2010 and 2018, 5% increase among those on lowest income and 14% for those on highest income. However, there were lower rates of cycling trips recorded with an increase of 15 per year in 2010 to 17 per year in 2017[145]. As 42% of all journeys made in 2017 are less than two miles in distance, there is an opportunity to encourage and enable active modes of travel[90].

As well as having an impact on the person travelling, transport use also impacts on mental health of communities. Streets with less traffic allow for larger social networks and places that allow people to stop and chat. Those on streets with less traffic are more likely to have more friends and acquaintances[146]. High traffic flow can prevent people from accessing local shops and visiting friends. Furthermore, a safe systems approach is incorporating 20mph limits in areas where pedestrians are at risk[147]. This reduces the speed of traffic, but also improves people's perceptions of safety and increases people's confidence to cycle and walk[148]. Traffic injuries can cause long term psychological distress or other mental health issues for up to three years following a traffic accident[149 150]. Greater severe physical injuries have shown to lead to increased levels of psychological distress[151].

Although social distancing measures have been enforced to control the spread of COVID-19, they are likely to have a negative impact on health and inequalities, but also has the potential for public health opportunities[152]. COVID-19 has highlighted the advantages of walking and cycling. For those without access to a private vehicle and where accessing public transport presents a risk, walking and cycling have become increasingly popular to access essential services such as accessing grocery shops and pharmacies[153]. In addition, reducing car use has a positive impact on the safety and perceived safety of the environment, potentially reducing road traffic and

other transport accidents, and also encouraging active travel[154]. The ongoing need for social distancing risks leading to an increase in car use and moving away from public transport. This can potentially reduce physical activity and increased air pollution, with negative impacts on mental well-being. There is an opportunity to address this through increased public transport, which enables social distancing and promotes opportunities for active travel by building and enhancing cycling and walking infrastructure[154].

The Department for Transport produces data on vehicle travel in Coventry and Warwickshire. The long-term trend has been a growth in vehicle use in the years leading up to 2012. More recently there have been increases in the number of miles travelled. In 2019 in Warwickshire 4,843.6 million miles were travelled by car or taxi– on average 23 miles per person per day! Between 2012 and 2019 there has been an 9.9% increase in the number of vehicle miles travelled by residents.

Coventry has seen a clearer plateau in car use leading up to 2012. However, since then it has seen an 15.9% increase in the number of miles travelled and in 2019 1,125 million miles were travelled by residents in cars and taxis.

This trend will have had an impact on mental health, especially of residents in areas where traffic volumes on the road has made it a less liveable environment and reduced the opportunity for social contact with neighbours.

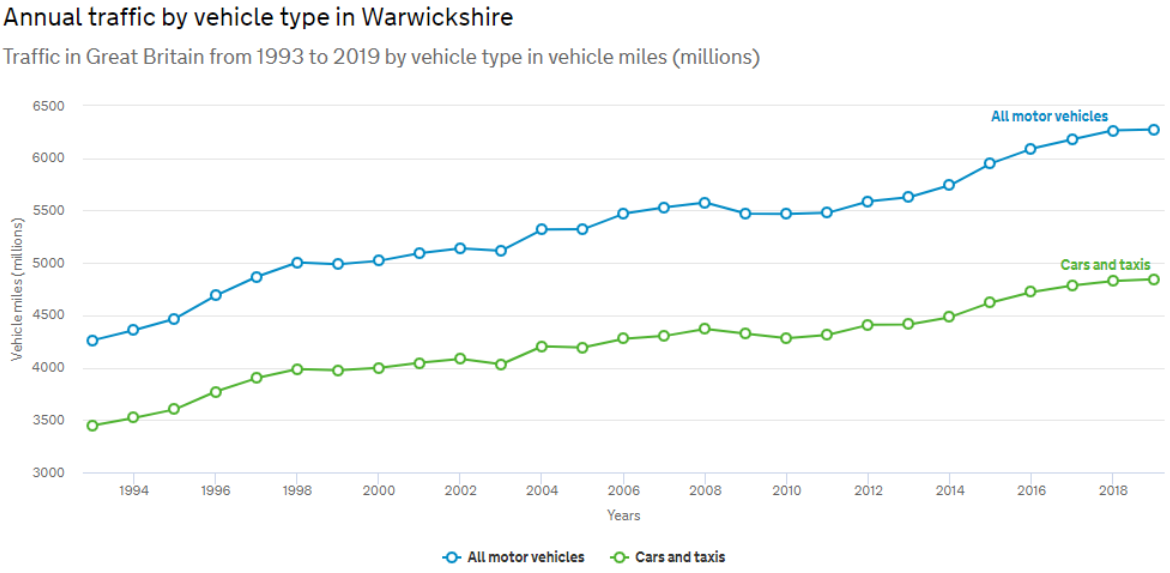


Figure 112. Annual traffic by vehicle type in Warwickshire
Source: Department for Transport

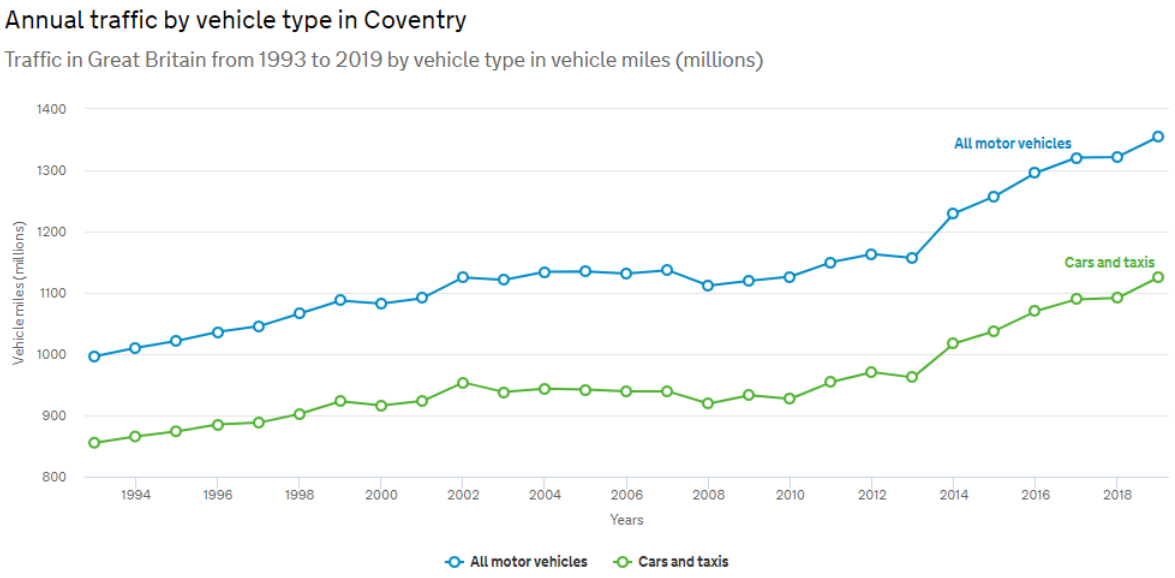


Figure 113. Annual traffic by vehicle type in Coventry
Source: Department for Transport

The evidence on the proportion of people in Coventry and Warwickshire who have been able to work from home previously discussed in this chapter also needs to be considered. Given the evidence on how commuting can negatively impact on mental health it is likely that some will benefit from greater working from home. However, this will be balanced against some of the stresses identified from working from home.

Table 27. Percentage of people who walked or cycled, for any reason, 2018/19

Area	Once per month	Once per week	Three times per week	Five times per week
North Warwickshire	77.3	69.4	43.4	30.2
Nuneaton and Bedworth	74.1	67.1	39.6	28.6
Rugby	75.9	69.1	47.1	33.5
Stratford-on-Avon	81.5	74.6	50.1	35.8
Warwick	79.9	71.0	46.8	36.3
Warwickshire	78.0	70.4	45.6	33.3
Coventry	72.4	66.1	38.5	28.7

Source: Department for Transport

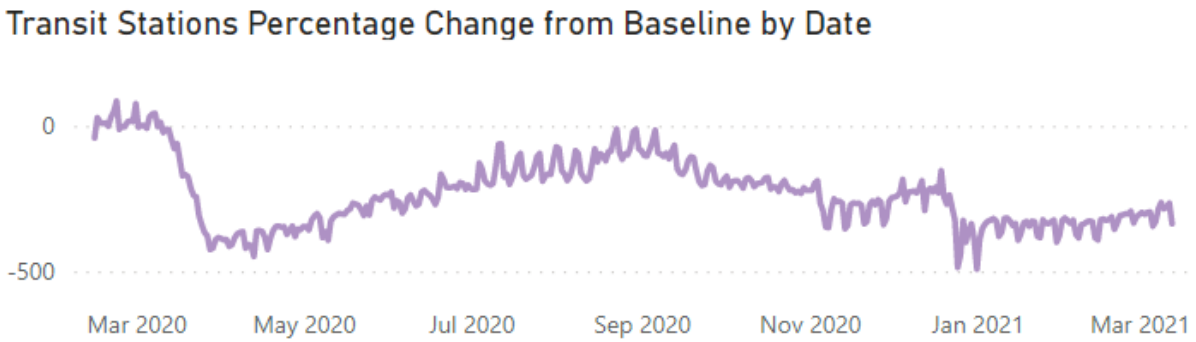


Figure 114. Transit stations percentage change from baseline by date (Warwickshire only)
Source: Google Mobility reports

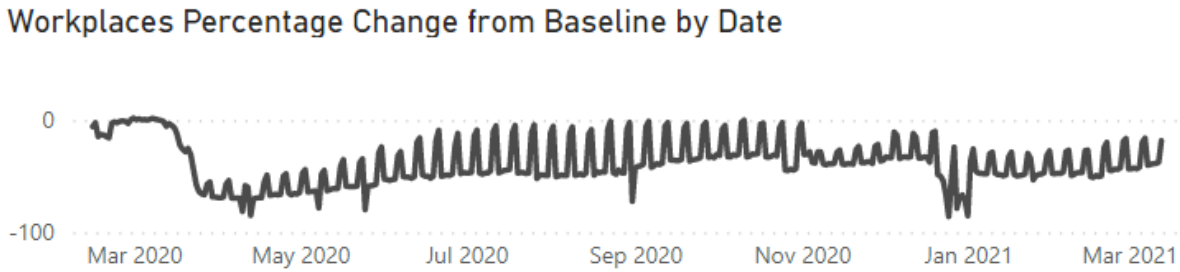


Figure 115. Workplaces percentage change from baseline by date (Warwickshire only)
Source: Google Mobility reports

Recommendations

The following recommendations are proposed:

- Promote the physical and mental health benefits of active travel
- Promote the importance of road safety to avoid negative physical and psychological impact of road traffic injuries

HIGH RISK GROUPS

Certain groups can be at higher risk of developing mental health problems. The following groups are considered in this report but is not exhaustive:

- Ethnically diverse communities
- LGBTIQ+
- Veterans
- Carers
- Transition period 16-25
- Inclusion health

ETHNICALLY DIVERSE COMMUNITIES

People from ethnically diverse backgrounds are highlighted to potentially have greater rates of mental health illness compared to White British people. Women of ethnically diverse backgrounds have been previously highlighted as a key risk group. Evidence indicates that Black women are more likely to experience anxiety disorders or depression compared to White British people[155] and older South Asian women have been identified as an at-risk group for suicide[156]. In addition, Black males are more likely to experience psychosis and Black people are more likely to be detained under the Mental Health Act[155,23].

There are many factors that have been identified to contribute to mental health rates in ethnically diverse communities. These include inequalities in income and living standards, experiences of discrimination and racism and stigma surrounding mental health illness[23]. Mental health is often seen as a taboo subject and is rarely spoken about[157]. This can discourage people from talking about experiences with friends, families and health care professionals and prevent them accessing mental health services. Other barriers for accessing mental health care include feeling ashamed about mental health, distrust and not feeling confident in health care professional's ability to understand ethnically diverse backgrounds and understanding discrimination, racism, and stereotyping[156].

CWPT: Survey on use of mental health services, detentions under the Mental Health Act and ethnically diverse communities

It is well documented that some ethnically diverse populations are significantly more likely to be detained under the Mental Health Act when compared with White British people. A recent survey conducted by CWPT investigated why certain sections are over-represented or why other sections are significantly under-represented, and sought feedback on mental health, mental health services in general and with regard to the use of the Mental Health Act. Of the 65 responses, 25 were of Asian background (38%), 23 Black (35%), 4 mixed race/heritage (6%), 7 white British (11%), 1 other ethnicity (2%) and 5 wished not to identify (8%). Females were

significantly over-represented in this sample indicated low up-take of male patients/service users. Nationally and locally females are less likely to be sectioned under the Mental Health Act and we have specifically identified that we need to understand why men, young men and men from ethnically diverse backgrounds, especially black and mixed, are disproportionately represented in detention numbers. Commons themes emerged about:

- complexity of system
- difficulties in access
- lack of empathy
- compassion or general support
- lack of resources
- lack of awareness and sensitivity to the specific issues experienced by people from ethnically diverse backgrounds

Respondents were also concerned about the over reliance on prescribing medication compared with talking therapies. Although 62% of respondents reported being confident to contact mental health services, for those less confident in contacting mental health services, issues included fear of consequences such as being “locked up”, over medicated, losing family, jobs and income. Difficulty talking about their condition when feeling unwell was highlighted, leading to difficulties in accessing the help and support they need and/or navigate/negotiate themselves around “the system”.

Respondents identified specific factors to improve services and the system:

- a simpler system
- quicker access
- reduced waiting times
- more compassion
- empathy and understanding
- greater understanding and appreciation of how mental health impacts much wider issues and to involve patients/service users in decisions about their care and treatment

When respondents were asked if they were treated fairly when accessing mental health services, 37 out of 65 (57%) replied “yes”; 28 (43%) replied “no”. Further feedback for this question focused on racism and discrimination felt and experienced by people accessing and using services. There was an important point highlighted about the need to treat service users as individuals, “*Racism, judgemental attitudes, lack of real awareness and understanding, unwilling to think outside of own personal bias so extremely quick to form the wrong judgement, not seeing people as individuals with their own stories, lumping a whole demographic together based on own prejudices and bias*”.

Comments from respondents from Black or Mixed backgrounds included themes around fear and ignorance of their communities, lack of understanding their social norms and natural behaviour, racism, discrimination and hostility towards them from services and not treating them as individuals with empathy and compassion. There was an implicit theme in that the issues are leading to a form of public order response (expressed as detention under the Mental Health Act) to black people presenting to services, fear of violence and other criminality leading to a lack of compassionate individual treatment responses in favour of a containment "locking up" response until the immediate concerning situation has passed. Furthermore, some comments from Asian participants included either perceptions or realities that some Asian communities are self-contained and either do not recognise mental illness, or successfully manage and contain it without having to access services. For example, "*mental health is not really seen as a health issue or a struggle within the Indian community. In my experience Indians will never admit to being depresses or struggling as the very notion of this will bring too many questions 'what's he got to be depressed about he has everything*'.

Impact of COVID-19

More recently, COVID-19 has been shown to negatively impact mental health across the UK as mental health has deteriorated significantly from pre-COVID-19 trends[158]. In particular, the pandemic has disproportionately affected those from ethnically diverse communities with higher rates of infections and deaths compared to non-BAME communities[159]. Given these findings, and the likelihood people from ethnically diverse communities are more likely to experience bereavement, the pandemic may have a significant impact on mental health[160]. Recent findings have also highlighted gender differences such that males from ethnically diverse communities have experienced a significantly larger decrease in mental wellbeing compared to White British people[161].

Capturing mental health experiences of ethnically diverse communities

In the local MHNA survey, findings indicated that ethnically diverse groups are underrepresented in accessing mental health services (see appendix 1), "*The patients we see are not representative of the diverse local population. We are under-represented in the younger and BAME communities*." Respondents mentioned facilities for those where English is not a first language, and availability of interpreters was not always timely or affordable for the service, "*Non-English speaking individuals would find it difficult, as we would struggle to fund interpreters too with our limited budget*." Furthermore, reference was also made to a lack of active targeting of services to under-represented groups, "*We need more community champions to help with overcoming barriers (e.g. culture differences, language and trust issues).*"

To address some of these findings and commons themes surrounding mental health and ethnically diverse communities, Warwickshire County Council have funded 3 artists to work on projects with ethnically diverse communities residing in Warwickshire. Projects aim to address themes identified in playing a role in disengagement of mental health conversations and services in these communities; specifically, Asian/Asian British, Black/Black British, 16-18 years across ethnically diverse communities. The main objective is to gather evidence related to mental health experiences and mental health challenges from ethnically diverse residents in Warwickshire. This will allow people from different cultures to express their mental health challenges. Shared experiences will be collated and presented in appealing media outlets such as videos (audio videos for those not wanting to appear in front of camera). The aim of the deliverables is to help normalise sharing experiences, seeking help earlier and having the confidence to talk about experiences.

An artist partitioner has highlighted their experience of working with ethnically diverse communities about mental health and wellbeing, "*My initial curiosity lies, not with the mental health issue itself, but everything around it. It seems that we do not know much about people's feelings around their diagnosis and people's feelings about other's reactions. I feel this is important to look into as the support system and environment around an individual is crucial to their wellbeing. The influence from surroundings seems more fragile amongst South Asians, a community which traditionally lacks a dialogue around mental health. I have found that individuals actually do want to speak about what they are going through but need to be an environment where they will not be criticised, judged or belittled."*

Recommendations

The following recommendations are proposed:

- Disseminate digital outputs developed from artists into ethnically diverse communities in Warwickshire to promote talking about mental health and accessing mental health services
- Improve engagement with ethnically diverse communities to improve trust and relationships, with the aim of improving access to mental health services

LGBTIQ+

LGBTIQ+ stands for lesbian, gay, bisexual, trans, intersex, queer or questioning. Whilst mental health problems can affect anyone, they are more common amongst people who are LGBTIQ+. Being LGBTIQ+ doesn't cause these problems. But some things LGBTIQ+ people go through can affect their mental health, such as discrimination, homophobia or transphobia, social isolation, rejection, and difficult experiences of coming out. It is important to note that embracing being LGBTIQ+ can have a positive impact on someone's wellbeing too. It might mean they have more confidence, a sense of belonging to a community, feelings of relief and self-acceptance, and better relationships with friends and family[162].

In 2017 Stonewall carried out a survey of over 5,000 LGBT people across England, Scotland and Wales to understand their experiences of mental health. Key findings

- 52% of respondents said they had experienced depression in the previous year. The rate was higher for people who are trans (67%) and non-binary (70%).
- One in eight LGBT people aged 18-24 (13%) said they had attempted to take their own life in the previous year
- 41% of non-binary people said they had harmed themselves in the previous year compared to 20% of LGBT women and 12% of GBT men
- One in eight LGBT people (13%) had experienced some form of unequal treatment from healthcare staff because they're LGBT
- Almost one in four LGBT people (23%) had witnessed discriminatory or negative remarks against LGBT people by healthcare staff. In the previous year, 6% of LGBT people – including 20% of trans people – had witnessed these remarks[163].

Locally, professional respondents to the Coventry and Warwickshire Mental Health Needs Assessment Survey highlighted that LGBTIQ+ groups were underrepresented in services and that services did not meet the needs of this group. One individual reported *"Current mental health services do not serve or meet the needs of LGBT+ people…There is a huge knowledge and confidence gap, coupled with a lot of prejudice and discrimination".*

A December 2020 community engagement project led by Warwickshire Pride the majority of participants reported feeling lonely, isolated and unsupported during the COVID-19 pandemic. However, it was also reported that when support groups began running face to face again, participants felt their mental health began to improve as a result of being able to socialise properly with other LGBTIQ+ people and access support from Warwickshire Pride.

Across Coventry and Warwickshire, the NHS Equality, Diversity and Inclusion network works to reduce LGBTQ inequalities and have implemented the following:

- The adoption and implementation of the National Rainbow Badges Scheme across all GP practices in Coventry, Warwickshire North and Rugby areas (as well as CCG staff). One of the key aims of this scheme is to let patients feel more comfortable in approaching members of Primary Care staff to assist in areas relating to LGBTQ issues. The network has also provided extensive organisation information to GPs for signposting relating to different areas around LGBTQ community.
- LGBT awareness Training provided by Warwickshire Pride to Primary Care Colleagues
- Report Hate Crime Training delivered to staff across CCGs
- Awareness of LGBT History Month displays and information circulated to Primary Care Team
- National Coming Out Day Awareness, supported by the 'It gets better Project'

Recommendations

The following recommendations are proposed:

- Improve engagement with LGBTIQ+ communities to improve trust and relationships, with the aim of improving access to mental health services
- Identify the specific mental health needs of LGBTIQ+ service users to ensure that services meet their needs

VETERANS

A military veteran is any person that has served at least one day in HM British Armed Forces (Regular or Reserve) or Merchant Mariners who have seen duty on legally defined military operations. There are approximately 2.5 million military veterans in the UK making up approximately 5% of households aged 16 and above, with 40% of veterans aged 16-64 and 60% over 65 years[164,165].

The Armed Forces Community is those that have served and dependents thereof, to whom the Armed Forces Covenant (AFC) entitlements of no disadvantage apply, is therefore approaching 1 in 10 of households of people aged 16 and over. AFC special considerations (including priority treatment) are appropriate for those who are injured and bereaved, with the Government, local authorities, the wider public sector, charities, commercial organisations and civil society all have a moral and legal obligation to support the Armed Forces community through AFC including in employment, healthcare, housing, education, and finances.

Although difficult to be precise until 2021 census data is summarised (the first census that veteran status will be counted as such) a conservative estimate based on receipt of war pensions is that there are at least 3,500 veterans in Coventry and Warwickshire. The actual number is likely to be considerably higher as many veterans do not draw a war pension.

Most veterans enjoy good mental health after a rewarding and challenging career and research has shown that help seeking 'veterans' as an overall group are at broadly similar levels of risk in terms of clinical depression and anxiety disorders as the general population (Kings Centre for Military Health Research – KCMHR, 2009, 2021[166]), but there are crucial distinctions and risk factors within groups of veterans, meaning that it is essential they are classed as a vulnerable group in the context of this needs assessment.

New research demonstrates that Iraq and Afghanistan conflicts have led to an increase in probable Post-Traumatic Stress Disorders (PTSD) among members of the UK Armed Forces to 9% compared to 5% for veterans who did not deploy. Those veterans who are deployed are also at a 31% risk of common mental disorder compared to 22% in the general population.

The suicide risk in veterans is a very high-profile matter of public scrutiny and concern and the UK Office for Veterans Affairs has commissioned an empirical investigation, now underway, to address learning in this key and controversial area. It is already known that for the group of veterans identified as Early Service Leavers (those who leave before their minimum term of four years) there is a two to three times higher risk of completed suicide than for the same age groups in the general and serving populations.

Whilst significant gains have been made through the NHS' Transition, Intervention and Liaison (TIL), Complex Treatment (CTS), and High Intensity Services (HIS) (brought together under the banner "OpCourage"), veterans are known to have particular help seeking difficulties, accessing appropriate NHS services, and often do not obtain the best psychological treatments as a minority of ex-service personnel with mental health problems seek help – mostly due to the perceived stigma attached to doing so.

Families of veterans and serving personnel are often vulnerable and regularly deal with a number of disadvantages including access to healthcare, continuity of care, access to screening & immunisation, access to diagnostics, local variation in commissioning and provision, change of care providers, transitional issues, young carers issues, family separation, domestic abuse and alcohol related issues (victims or perpetrators) and dealing with a plethora of non-health related issues (housing, social isolation/moves, education and employment).

The rates of problematic alcohol misuse rates in veterans (who had deployed) is significant: 22% compared to 11% in those not deployed, which is a figure already significantly higher than the general population. Alcohol misusers are also the least likely to seek help (KCMHR).

In Coventry and Warwickshire, CWPT leads a regional NHS service under 'OpCourage' covering the entire Midlands and the East of England area that has meant over 3,508* veterans have been seen since 2017. This has enabled strides forward in the coming together of service charities and statutory provision and initiatives such as the GP Veteran Accreditation Scheme. Seeing this number of veterans and their families has highlighted the adverse impacts of all organisations lack of awareness of military veterans' mental health. This in turn maintains marked and serious mental health inequality, which is regularly impeding veteran access to the right services and causing disadvantage.

Armed Forces Community Covenant

An Armed Forces Community Covenant is a voluntary pledge of mutual support between a local community and its Armed Forces community. Locally the Armed Forces Community Covenant was signed by a range of partners across Coventry, Solihull and Warwickshire in 2012.

"The armed forces covenant sets out the relationship between the nation, the government and the armed forces. It recognises that the whole nation has a moral obligation to members of the armed forces and their families. It exists to redress the disadvantages that the armed forces community may face in comparison to other citizens, and to recognise sacrifices made. The community covenant encourages local communities to support the armed forces community in their area and promote public understanding and awareness".

The aims of the Covenant are to:

- Encourage local communities to support the Armed Forces community in their area
- Nurture public understanding and awareness amongst the public of issues affecting the Armed Forces community
- Recognise and remember the sacrifices faced by the Armed Forces community
- Encourage activities which help to integrate the Armed Forces community into local life
- Encourage the Armed Forces community to help and support the wider community, whether through participation in events and joint projects, or other forms of engagement

Across Coventry, Solihull and Warwickshire a sub-regional Armed Forces Community Covenant was signed in 2012 and a Strategic Partnership, Chaired by a Warwickshire County Council Member, established to oversee and give direction to the work of the Covenant. All organisations involved work to make sure the armed forces community have access to help and support they need.

An operational group, the AFCC Co-ordination Group was set up in September 2015 to drive forward the AFCC agenda, meeting every 2 months to deliver key activities in an agreed annual action plan and report progress to the Strategic Partnership.

Recommendations

- It is recommended that all organisations (both in the statutory and voluntary/community sector) ask and record the veteran status of every referred person and have adjustments in place to ensure that the entitlements of the Armed Forces Community are met. These commitments and formalised adjustments to normal provision must be written down and binding if we are to better meet the needs of the Armed Forces Community.
- It is also recommended that PCNs investigate veteran accreditation for GP surgeries[167].

CARERS

A carer is anyone who cares, unpaid, for a family member or friend who due to illness, disability, a mental health problem or an addiction, cannot cope without their support. Many people do not see themselves as family carers and it takes them an average of two years to acknowledge their role as a carer. The sort of roles and responsibilities that carers have to provide varies widely. They can range from help with everyday tasks such as getting out of bed and personal care such as bathing, to emotional support such as helping someone cope with the symptoms of a mental illness[168].

The estimated number of unpaid carers in England is 5.5 million. Significant evidence exists of potential negative impacts on employment, health and wellbeing which have individual and societal consequences[169]. Research shows that around 71% of carers have poor physical or mental health[170].

Locally it is estimated that there are approximately 34,000 unpaid carers in Coventry and 62,000 in Warwickshire. In Coventry there are approximately 2,500 young carers (0-24 years old) and 3,500 in Warwickshire.

Carer reported quality of life score for people caring for someone with dementia (2018/19) is in line with the English average, with Coventry and Warwickshire reporting a score of 7.4 compared to 7.3 for England (source: PHE Fingertips).

A focus group with carers of people with mental health difficulties reflected national findings, with participants reporting depression and low mood as a result of their caring role. However, peer support groups were reported to be helpful; providing connection and support with other people with similar experiences (see Appendix 2 for further information).

191 people responding to the local Mental Health Needs Assessment Survey (see Appendix 1) reported having caring responsibilities. Comments included reports of carers feeling confused and sometimes unsupported when relatives were experiencing a mental health problem. One carer reported "*there was virtually no support available for me as his carer – I felt very lost and didn't know where to find information or guidance on how to support him*".

Access to information on how to help was reportedly limited adding to an already stressful situation. It was felt that COVID-19 exacerbated existing problems with support and access to services.

In Coventry and Warwickshire the Carers Trust Heart of England provide support for carers. In 2020 a survey was conducted with 86 clients responding. 37% of respondents were extremely or very concerned about their mental health following the COVID-19 pandemic.

Healthwatch Warwickshire undertook a survey starting 30th March until 28th May. Interim findings covering the period 30th March – 23rd April 2021 found that the majority of carers had not spend as much time focusing on their own mental, emotional or physical health and wellbeing (see figure 116).

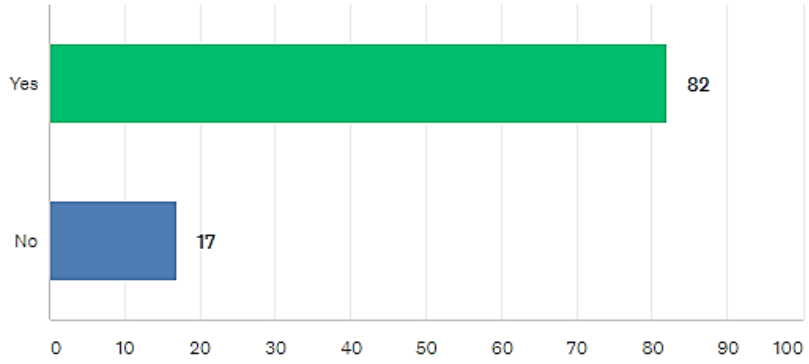


Figure 116. Carers responding to the question "Do you feel that because of your caring role you have not spent as much time focusing on your own mental, emotional or physical health and wellbeing?"
Source: Healthwatch Warwickshire

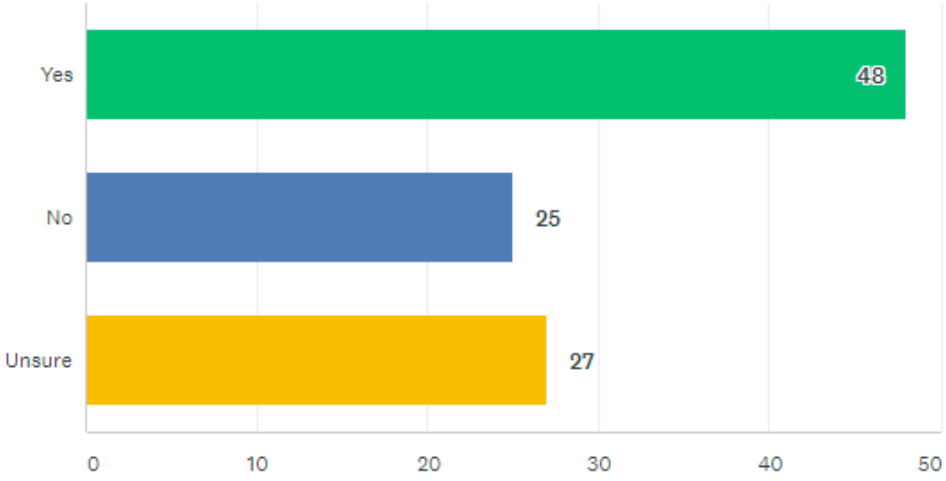


Figure 117. Carers responding to the question "Do you feel that you need any emotional support?"
Source: Healthwatch Warwickshire

55% of respondents reported barriers to accessing support for their mental or physical health. The main barriers reported were: not having the time; not sure where to go for help or support; and the person/people I care for only wants me (and no one else) to look after them.

Recommendations

The following recommendations are proposed:

- Signposting carers to mental health provision available; this includes increasing awareness through multi-agency support
- Highlighting the importance of focusing on carer's own physical and mental wellbeing

TRANSITION PERIOD 16-25

The 2019 NHS Long-Term plan sets out the intentions of work over the next 10 years which includes a clear national direction to develop an 18-25 offer (page 51, section 3.30): 'A new approach to young adult mental health services for people aged 18-25 will support the transition to adulthood. Between the ages of 16-18, young people are more susceptible to mental illness, undergoing physiological change and making important transitions in their lives. The structure of mental health services often creates gaps for young people undergoing the transition from children and young people's mental health services to appropriate support including adult mental health services. We will extend current service models to create a comprehensive offer for 0-25 year olds that reaches across mental health services for children, young people and adults. The new model will deliver an integrated approach across health, social care, education and the voluntary sector, such as the evidenced based 'iThrive' operating model which currently covers around 47% of the 0-18 population and can be expanded to 25 year olds…"

In addition, section 3.47 states the ambition of moving to a '0-25 years' service will improve children's experience of care, outcomes and continuity of care. By 2028 there is a national aim to have moved towards service models for young people that offer person-centred and age-appropriate care for mental and physical health needs, rather than an arbitrary transition to adult services based on age not need.

The Local Transformation Plan October 2019 to October 2020 – Action 1 D - Priority – is to improve the breadth of access, timeliness and effectiveness of emotional well-being and mental health support available to children and young people 0 – 25.

Mental Health is also a key priority for Coventry and Warwickshire Health and Care Partnership and both Coventry & Warwickshire's Health and Wellbeing Boards as outlined in Coventry's 2019-2023 Health and Wellbeing Strategy and Warwickshire's 2020-2025 Strategy.

In response to this, the Commissioning Intentions of both Warwickshire County Council, Coventry City Council and Coventry and Warwickshire CCG include a review the current 0-25 pathway in line with the requirement to enhance transitions for those aged 18-25 and clarify the offer for this age group whether in receipt of services or currently not. Commissioners have therefore been tasked with reviewing the 0-25 offer and developing an integrated pathway for those aged 18-25.

There is no obvious pathway, co-ordinated approach or transition for those aged 18 either in receipt of CAMHS services and support, or for those who are no longer in receipt of services or support or have never been.

Whilst there are a number of separate adult mental health services which support the 18-25 age group, the synergies between these services and the appropriateness of each is not clear and therefore would benefit from being mapped and clarified.

There are a number of known existing gaps e.g. relating to eating disorders and carer leavers which could be prioritised for early implementation.

The current structure of mental health services often creates gaps for young people undergoing the transition from children and young people's mental health services to appropriate support including adult mental health services.

It is also recognised that if Commissioners are unclear of the services on offer, which of these are being accessed by the 18-25 cohort and the appropriateness of current arrangements, it is reasonable to assume that organisations with a role in referring or signposting C&YP to these services and support, will also be unclear. This could be masking unmet demand and potentially increasing risk by delaying access to services/support.

Partners across the system are undertaking work to evaluate best practice models, collate and analyse data and engage in co-production activities in order to develop a proposed service model that meets the needs of the young adult population in Warwickshire and Coventry. In addition to this Commissioners have identified resources to plan, develop and implement a Peer Mentoring Programme for those aged 18 – 25 transitioning from CAMHS to AMHS and for those not currently accessing mental health services.

In the local mental health needs assessment survey, Services for young people and the issue of service thresholds and waiting times was a key theme in the C&W MHNA survey. They were often mentioned as a specific group needing support especially during and post pandemic. This was highlighted by carers of people with mental health difficulties:

"Better support for teenagers and young adults….. We found it difficult to access a range of services which she could engage with"

"When younger people are struggling…. unless that person is in a severe crisis, no help is offered……Need counselling services for people before they hit crisis."

Recommendations

The following recommendations are proposed:

- Develop a service model that meets the needs of the young adult population in Coventry and Warwickshire
- Raise awareness of available services available for people aged 16-25

INCLUSION HEALTH

Inclusion health is a research, service and policy agenda that aims to prevent and redress health and social inequalities among the most vulnerable and marginalised people in a community. This includes people who are homeless, Gypsies and travellers, sex workers, vulnerable migrants, people in contact with the justice system and other socially excluded groups.

People in these groups often experience multiple overlapping risk factors for poor health (such as poverty, violence and complex trauma), experience stigma and discrimination, and are not consistently accounted for in electronic records (such as healthcare databases). These experiences frequently lead to barriers in access to healthcare and extremely poor health outcomes. People belonging to inclusion health groups frequently suffer from multiple health issues, which can include mental and physical ill health and substance dependence issues. This leads to extremely poor health outcomes, often much worse than the general population, lower average age of death, and it contributes considerably to increasing health inequalities[171].

The 'All Our Health' framework[172] provides guidance for working with inclusion health groups and these should be applied to mental health services across Coventry and Warwickshire. The four core principals of the guidance are:

- Understand how the concepts of inclusion health and social exclusion can be useful for professional practice
- Know about health issues that socially excluded people living in local areas are more likely to encounter
- Understand specific activities and interventions that all health and care professionals can do to support the health and wellbeing of inclusion health groups
- Consider the resources and services available locally that can help people from inclusion health groups[173]

Whilst this report does not cover inclusion health in depth it is recommended that services consider the needs of people experiencing these vulnerabilities and apply the principals of the All Our Health guidance. Local information gathered about asylum seekers and refugees and sex workers are outlined below.

Asylum seekers and refugees

Asylum seekers and refugees face unique and complex challenges related to their mental health and are often at greater risk of developing a mental health problem, with research suggesting they are five times more likely to have mental health needs than the general population. In particular, this group is more likely to experience depression, post traumatic stress disorder and other anxiety disorders. The increased vulnerability to mental health problems that refugees and asylum seekers face is linked to pre-migration experiences (such as war trauma) and post-migration

conditions (such as separation from family, difficulties with asylum procedures and poor housing)[174].

Coventry

In Coventry there are around 600 asylum seekers at any time (this is a constantly changing population as it is dependent on legal status). This includes unaccompanied asylum seeking children. There are approximately 400 refugees resettled under home office schemes, with around 120 per year coming into the city. There are approximately 2,000 other refugees and asylum seekers with unsuccessful applications.

The Meridian Practice provides GP services for asylum seekers and refugees in Coventry. A local asylum seeker and refugee mental health needs assessment highlighted some of the key themes that they have encountered when working with asylum seekers and refugees. The themes are as follows:

- Multiple cumulative stresses are experienced by asylum seekers and refugees: exposure to conflict, life in refugee camps, deaths of family members
- Parents struggle to cope, particularly when they are traumatised or depressed themselves
- Cultural issues are evident: for example, sometimes there is a desire to hide histories of sexual assault – both for themselves and for children
- Referrals to mental health services are difficult: IAPT consider cases “too complex” but secondary care do not always see difficulties as a mental illness but an appropriate response to trauma and difficult experiences meaning they do not get support

Citizen’s Advice Bureau (CAB) have been commissioned by Coventry City Council to coordinate the welcome of Syrian refugees. A local asylum seeker and refugee mental health needs assessment highlighted some of the key themes that they have encountered when working with the refugees:

- Almost all of the refugees seen have mental health problems of some degree on arrival in Coventry. These are often latent for the first 8 weeks following arrival.
- Most of the issues are known in advance, but little is done to prepare with regards to providing support/services.
- There are excessively long waiting times from referral to services to being seen.
- CAB staff can provide mental health checks, but lack training on how respond beyond advising a visit to the GP.
- Services for young people and children are particularly poor.

Warwickshire

Since November 2016, 36 Syrian refugee families have been resettled across Warwickshire through the Syrian Vulnerable Persons Resettlement Scheme. This is the first time that the county has participated in a resettlement scheme.

A 2020 asylum seeker and refugee mental health needs assessment report highlighted the following themes:

- There is a lack of expertise and understanding amongst mainstream health and mental health providers about working with refugees and refugees therefore feeling that services do not always meet their needs;
- There is inconsistent use of interpreters with some refugees being told that they cannot access services if they do not speak English;
- There is a cultural stigma attached to the concept of mental illness and a reluctance to discuss issues and seek help;
- There is a lack of understanding amongst refugees about mental health support available and what to expect;
- There is a lack of specialist mental health support for refugee children.

On Street Sex Workers

Coventry has four services of differing sizes supporting sex workers to stay safe and healthy. As part of a locally conducted On Street Sex Worker Needs Assessment a series of interviews has been undertaken with professionals working with the cohort to identify the key issues they are dealing with on a regular basis. Every interview has suggested that poor mental health, often as a result of childhood or adult abuse, is a prevalent key issue and in most cases, there is a dual diagnosis of poor mental health and substance misuse. For example, of a cohort of 107 cases managed by one service, 100% had either diagnosed or suspected mental health issues, 86% had high level drug and alcohol issues and 88% had a history of homelessness. The services have stated that they struggle to access mental health support as the cohort struggle to attend appointments due to their complex needs and/or are refused mental health support because of their substance misuse. All services are keen to engage with mental health and drug and alcohol services to establish a way forward to enable this vulnerable cohort to engage with services to enable them to exit the industry.

Warwickshire does not currently have any equivalent services directly supporting sex workers. Therefore, comparable data is not available.

Recommendations

The following recommendations are proposed:

- Improve engagement with marginalised and vulnerable communities to improve trust and relationships, with the aim of improving access to mental health services
- Identify the specific mental health needs of marginalised and vulnerable service users to ensure that services meet their needs

LOCAL SERVICES

OVERVIEW

Across Coventry and Warwickshire, there are a number of statutory and non-statutory services working together to provide mental health and wellbeing services and support.

Clinical Commissioning Groups (CCGs) are responsible for planning, organising and buying NHS-funded healthcare for people in Coventry and Warwickshire. This includes most hospital and community NHS-funded services.

Coventry and Warwickshire Partnership NHS Trust (CWPT) provides a range of NHS services across the whole of Coventry and Warwickshire for people with mental health issues and learning disabilities. Staff are based in Coventry, Rugby, North Warwickshire and South Warwickshire. CWPT has professionally trained staff to offer a range of psychological therapies and aims to provides support closer to home and tailored to meet the specific needs of people. For example:

- Improving Access to Psychological Therapies (IAPT)
- Community assessment and treatment for people living with a non-psychotic disorder such as anxiety and depression, obsessive compulsive disorder (OCD), personality disorder
- Early intervention team who work with those who are at risk of or experiencing the first onset of psychosis
- Community mental health Recovery Team for people experiencing psychosis
- Crisis home treatment and support
- Dementia and cognitive disorders (organic)

Community mental health teams are multi-disciplinary, including Medics, Nurses, Psychologists, Social Workers, Occupational Therapists, and Support Workers. CWPT Has Section 75 partnership agreements with Warwickshire County Council and Coventry City Council to meet Care Act (2014)[175] responsibilities for people with mental health-related needs. Approved Mental Health Professionals (AMHPs) co-ordinate assessments under the Mental Health Act, this is a statutory responsibility of the local authority. Users of services can be allocated a care-coordinator within the Care Programme Approach (CPA) and a care plan which might cover support with medicines, money problems, housing, and support at home[176].

There are other specialist mental health services within CWPT:

- Perinatal mental health service
- Learning disability community and inpatient services
- Eating disorder services
- Liaison and Diversion Service (Criminal Justice)

- Children and Adolescent Mental Health Services

There are mental health inpatient units at the Caludon Centre (Coventry), St Michael's Hospital (Warwick), Woodloes House (Warwick) and the Manor Site (Nuneaton). People may be admitted formally (Mental Health Act) or informally (voluntary basis). On occasions there may be admissions to hospital beds out of area.

There are also services that can offer an out-of-hours or an acute level of support. CWPT provide locality-based Mental Health Access Hubs are responsible for clinically triaging all patients and dealing with those in urgent need of care. Following triage, if a patient is in need an urgent assessment, the Hub will arrange to see them within 4 or 24 hours depending on their presentation. Patients who are not urgent but need mental health support will be onward referred to the right team. There are a number of initiatives across Coventry and Warwickshire to improve the crisis pathway, such as Safe Havens which offer an out-of-hours community-based service for people experiencing emotional distress (see above section "Suicide").

It is known that people attending acute hospital emergency departments with physical health needs may also have mental health needs. AMHAT (Arden Mental Health Acute Team) offers a psychiatric and risk assessment service in acute healthcare settings, like the Accident and Emergency (A&E) department or wards of local hospitals. This ensures timely care and treatment for patients who have acute mental health issues, when they attend physical healthcare settings, like hospital.

Street Triage is an evening service (1700 - 0200) in liaison with local Police Forces. Mental health nurses accompany police officers to incidents where police believe people need immediate mental health support.

Warwickshire County Council commissions a range of mental health and wellbeing support services for Warwickshire residents, or those registered with a Warwickshire GP. The commissioned provision offers the following elements:

- 24/7 telephone and webchat support
- Anonymous online peer-support guided platform
- Regular group support and drop-in sessions
- One-to-one sessions
- Outreach and promotion
- Wellbeing courses and workshops
- Practical and emotional support to build links into the community and reduce loneliness and social isolation
- Community-based support
- Self-guided courses and resources.

Coventry City Council commissions:

- Drop-in advice and signposting services
- A recovery academy to provide groups and courses and one-to-one support
- 3 tiers of community short-term and intensive support
- Outreach mental health support for Black, Minority Ethnic & Asian communities

Coventry City Council runs some 'in-house' services which provide support to people with mental health needs. The Pod is a service which helps people in their journey towards mental health recovery. In partnership with service users it runs a number of different community-based projects.

People can also access mental health support via Primary Care – GPs, practice nurses, pharmacists and others – in settings such as GP practices and community pharmacies. Primary care staff can refer into secondary care mental health services or signpost towards support provided in the community. Social prescribing provides an opportunity at primary care level to interact with a broader range of agencies concerned with the wider determinants of mental health.

Commissioning organisations work closely with Voluntary, Community and Social Enterprise (VCSE) sector organisations in the area and have established strong links through its local infrastructure organisations:

- Warwickshire Community and Voluntary Action (WCAVA) in Warwickshire
- Voluntary Action Coventry (VAC) in Coventry

CWPT, Coventry City Council, Warwickshire County Council, and Coventry and Warwickshire CCG, in collaboration with other key partners, are working to deliver a local response to the Five Year Forward View for Mental Health and form the Coventry and Warwickshire Health and Care Partnership (HCP)[177]. The aim of the partnership is to share knowledge and resources to improve health and care. The HCP are working closely together to help everyone lead healthier and more fulfilled lives, be part of a strong community and benefit from effective and sustainable health and care services where and when they need them most.

There are a number of partnership network groups, such as the Coventry and Warwickshire Suicide Prevention Multi-Agency Group that come together to deliver against the local suicide prevention strategies[178][179] and the Creative Health Alliance[180].

People can also choose to see a private nurse, doctor, psychiatrist, or therapist – either alongside NHS support, or instead of it. Support can be found through organisations such as the British Association for Counselling and Psychotherapy (BACP) or via an NHS HP to find qualified and registered support.

In terms of wider support available, people can be supported by non-mental health services with their mental health and emotional wellbeing needs. Examples of these include:

- Citizen's Advice Bureau
- Housing Support
- Welfare and debt provision
- Community support (e.g. places of worship, community groups)
- School / college
- University
- Friends and family
- Workplace support
- The Job Centre / Department for Work and Pensions
- Online/self-help
- Mental health employment service
- Specialist mental health carers support
- Other, including:
    - Online resources
    - Domestic abuse services
    - Shout
    - Samaritans
    - Get Self Help
    - Childline
    - Family Information Service
    - Voluntary sector services

ACCESS AND OUTCOMES

The way that people interact with services may vary person-to-person. A number of the local mental health support services accept self-referrals, meaning that people do not need to be referred by their GP. As a result, there are a number of access points into the Coventry and Warwickshire health and care system.

The findings from a recent engagement survey showed that the most well-known types of service for mental health support answered by all respondents (except those answering as professionals) were in the category "NHS Services". These included GPs and Accident and Emergency. Services that were less well known tended to be those in the voluntary, community and charity sector.

The data indicates that 91.7% of respondents (n=400 out of 436) indicated they had heard of at least one (1 or more) of the organisations listed in the survey, and so of the 436 respondents, only 36 had not heard of any services.

However, 17.5% (n=75) of respondents had heard of only one organisation. This would confirm the assertion that most respondents had heard of at least 1 organisation/scheme of those listed in the survey.

Figure 4."Are you aware of the services listed?"

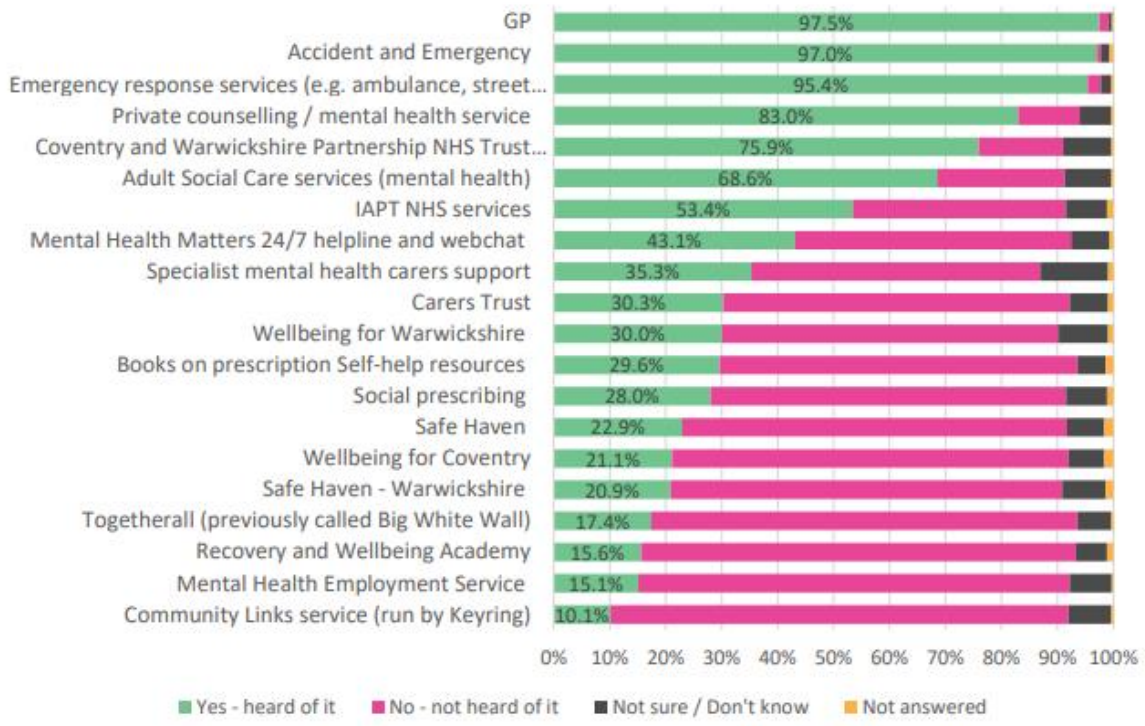


Figure 118. Survey respondents' awareness of services
Source: Business Intelligence, WCC

The most common reasons that the public respondents who had not accessed or weren't sure if they had accessed any of the mental health services listed did not access these services was either because they didn't want to access them or they were not aware of them. Indeed, a common theme throughout the data was a lack of awareness of mental health services.

The need for a more joined-up approach between services e.g. primary and secondary care was referenced especially between GPs and specialist services.

Respondents who had selected "yes – heard of it" for each service were asked to rate their experience if they had used these services for mental health support in the last 2 years. However, the numbers who had used the full range of services was limited and were often too small to make meaningful comparisons between services. Data for services used by at least 15 respondents is presented in Figure 119 below.

Figure 5. "If you have used any of these services in the last 2 years for your mental health please rate your experience."

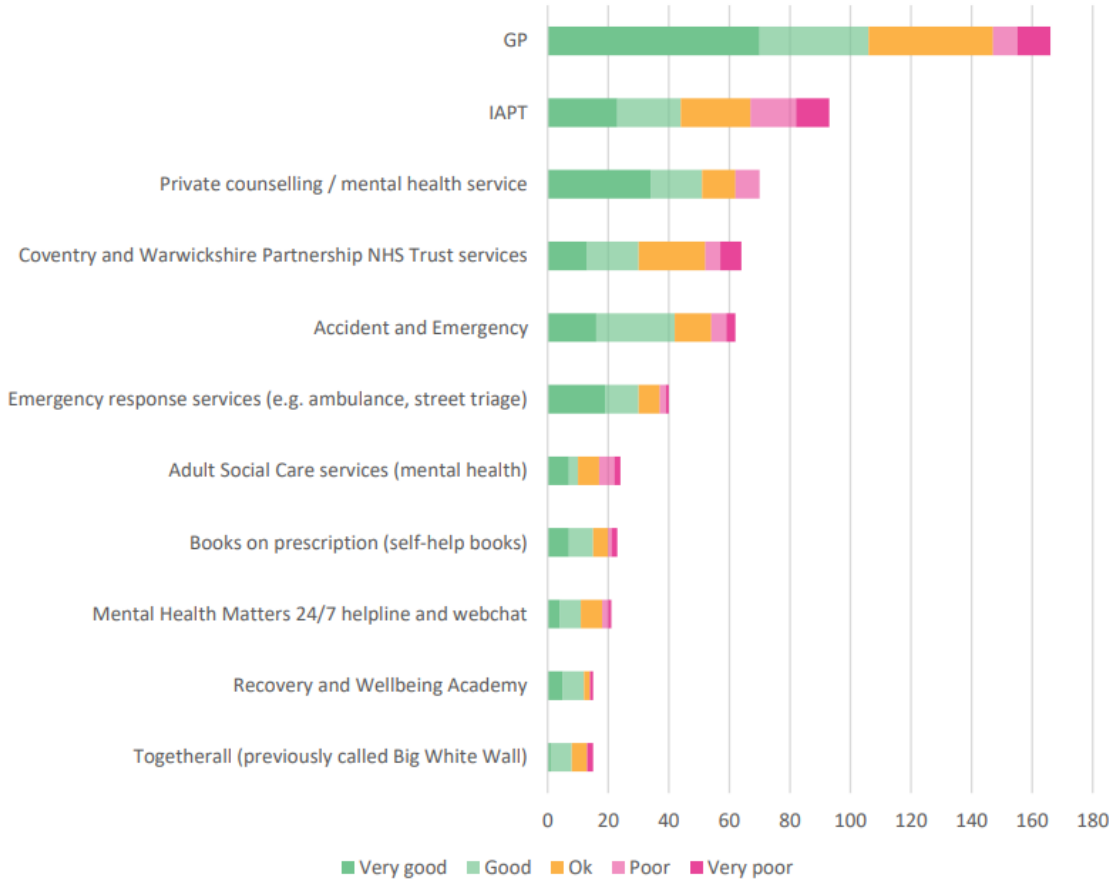


Figure 119. Survey respondents' rating of accessed services
Source: Business Intelligence, WCC

Given the small numbers involved, assessments about people's experience of each of these services may be better achieved by more dedicated customer satisfaction surveys, service reviews, or research at some future point.

Respondents of the recent engagement survey commented that much of the service offer was short term/medical model in approach and there was a desire to see wider and longer-term support available. Indeed, respondents noted the most common reason for accessing mental health services by those who were current or previous service users was for short term support (35.2%/n=70). Difficulties meeting service thresholds/criteria were often highlighted and there was a repeated feeling people had to reach crisis point before a service was offered. Additionally, there appeared problems when people presented with additional conditions (e.g. autism, dementia, or alcohol related problems) and didn't 'fit' service criteria. This is supported by the following quote:

"We are seeing a lot of requests to support young people with ASD/Autism although there are no specific services within MH teams to provide for this client group so gap

appear between LD and MH services and neither service specialises in this area" (Focus Group – Social Care)

Respondents were asked whether they had been referred to other services. Almost 1 in 4 had been signposted or referred to another service. Of the respondents who had been referred/signposted, commonly mentioned services included other local voluntary sector groups (e.g. NCT Parents in Mind), local counsellors, and a range of helplines/online apps and websites. Respondents to this question were also asked what impact this 'other' support had had on their mental health. Most were very positive and complementary about what it had done for them finding the apps, counselling, helplines, organisations offered a useful listening ear and a place where skills could be developed, or wider support obtained to sustain mental health and well-being. Those comments which were more negative related to mostly the waiting lists, disjointed services or where the support offered was not appropriate. Stakeholders reported that involvement in local networks and partnership programmes enabled them to have a good knowledge of local support which enabled effective signposting, as supported by this quote:

"Attending local multi-agency groups enables me to find out more about local services and type of support available, enables more effective signposting." (Focus Group – Voluntary and Community Sector)

Those respondents who stated they were professionals were asked a different set of questions in relation to mental health and wellbeing services. First, professionals were asked whether they had referred or signposted someone to specific services in the last 2 years for their mental health or wellbeing. The results of this are presented in Figure 120 below.

Figure 8 - "Have you referred or signposted someone to the services below in the last 2 years, for their mental health/wellbeing?"

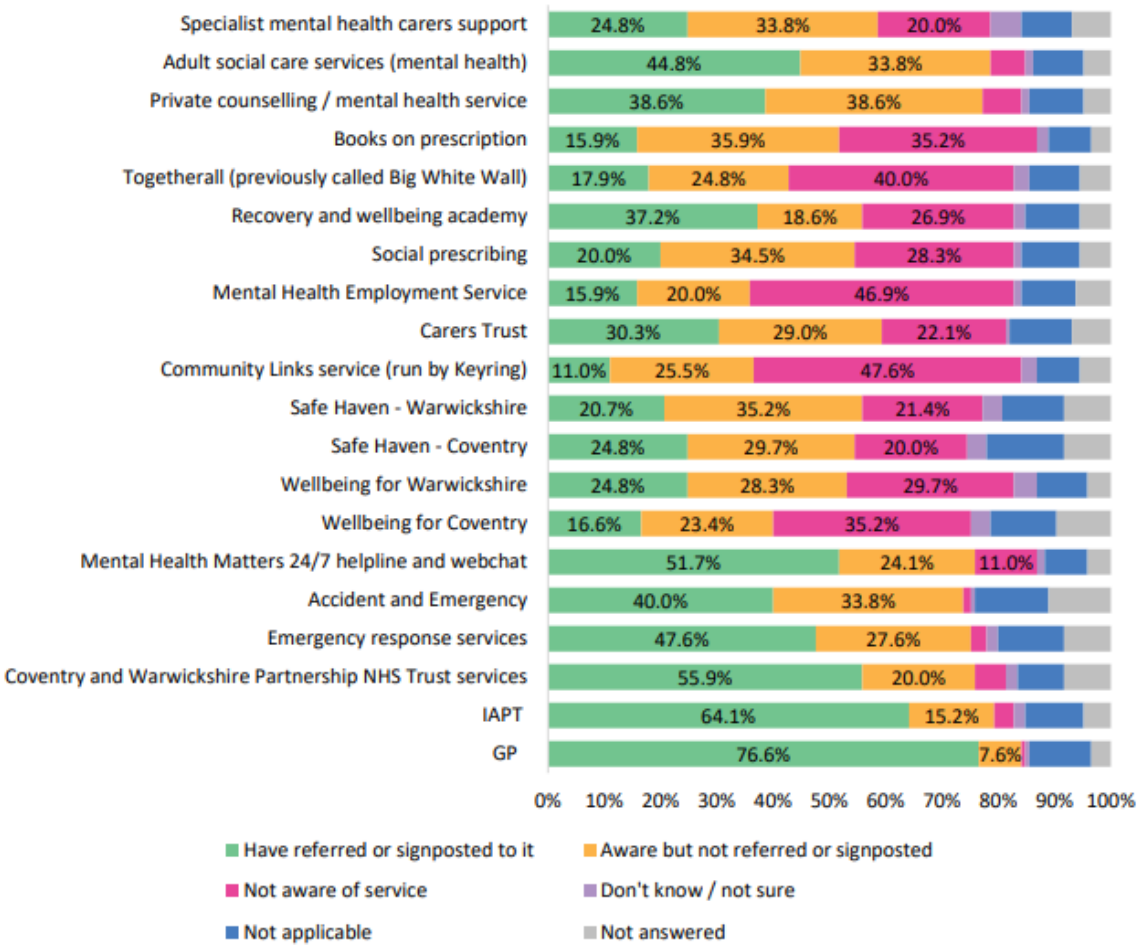


Figure 120. Survey respondents' (professionals) referral / signposting rates
Source: Business Intelligence, WCC

Figure 120 indicates that 76.6% (n=111) of professionals responding had referred or signposted to GPs. Similarly, more than half of professionals responding had referred or signposted to IAPT (64.1%, n=93) and Coventry and Warwickshire Partnership NHS Trust services (55.9%, n=81). 'Other' services that respondents had referred or signposted to included MIND, domestic abuse charities, peri-natal mental health services, Childline, Age UK, and Carers Trust. The responses to this question suggest that some services in the voluntary, community and charity sector were less well known than the NHS services.

Of those professionals who did refer to these services, the referral process for emergency response services (ambulance, street triage) was rated either 'very good' or 'good' by 78.3% (n=47). Furthermore, the referral process for Mental Health Matters 24/7 helpline and webchat (70.6%, n=48) and Recovery and Wellbeing Academy (69.1%, n=38) were also rated either 'very good' or 'good' by more than

65% of those professionals who had experienced the referral process of these services. In contrast, around half of respondents who had experienced the referral process(es) to GPs (52.9%, n=54) and adult social care services (mental health) (51.7%, n=31) rated the process as either 'very poor', 'poor' or 'ok'. Professionals commenting on the referral process mentioned long waiting times and high thresholds for some services. Following this, professionals were provided with a list of formal and informal sources of support and asked if they had signposted anyone with a mental health need to any of these for support. 65.5% (n=95) of professionals suggested they had signposted to friends and family. Online/self-help (61.4%, n=89), Citizen's Advice Bureau (58.6%, n=85) and housing support (52.4%, n=76) were also sources of support that had been signposted to by more than half of professionals responding.

"It can be a bit of a minefield for customers the route into MH services can take many diversions usually the quickest route is via A&E or the Place of safety Suite" (Focus Group – Social Care).

"One thing which has come up where I am currently based is the fact that we are a priory group hospital so privately run. However, all of our beds are currently contracted out to the NHS who fund them. As the hospital itself is not an NHS hospital however, the professionals have real difficulties in referring patients into other pathways for mental health support as there is no clear pathway in from our hospital." (Focus group)

The final question in this section asked professionals if they had seen any differences or changes in demand for services in the last six months. 68.3% (n=99) of professionals stated there had been an increase (either significant or slight) in demand over the last six months. Just 9.0% (n=13) felt that there had been a reduction in demand (either significant or slight) during this time. Similarly, insights from the NHS Benchmarking activity carried out in September 2020, showed that referrals to crisis referrals to CWPT showed an upward trend from the beginning of COVID-19, in excess of the national trend for 2019 from June.[181]

In a 2018 report on Mental Health Act activity in Warwickshire[182], it was noted that the total number of assessments were up slightly (just under 1.5%) from the previous year– 944 to 958 -an average of 2.6 a day. Although continuing an upward trend, the rate of increase appears to have slowed over the last couple of years from the steep increases experienced between 2014 and 2016 to only 0.5% in 2017 and 1.5% in 2018. A national reform of the Mental Health Act is currently underway[183].

The COVID-19 pandemic impacted local service provision in a number of ways as guidance restricted face-to-face contact. Providers and Commissioners have reported that they are learning from the experience of adapting the service to meet the needs of the population during the pandemic and incorporate this into the service model going forward. This will involve a "blended" combination of face-to-face,

telephone, and online contact. It should be noted, however, that professionals working in health and other organisations highlighted service inequalities among protected characteristic groups, those at financial disadvantage, including digital disadvantage, and those with other conditions/circumstances in addition to a mental health need.

"I think seeing people face to face should be seen as the gold standard for care of any kind" (Focus Group - CWPT)

In terms of wider support, the areas where support was most likely to be regarded as helpful by public respondents included friends and family (82.2%/n=287), community support (80.2%/n=65), and online/self-help (68.1%/n=143). Workplace support was considered helpful by almost two thirds (62.1% /n=105) of those accessing this type of support. Staff training in mental health matters across organisations with a public facing role was suggested to ensure knowledge of the mental health system and sensitivity in dealing with mental health matters.

"Adults need to help YP to understand that suffering in a mental way is ok. Sharing your story can help others struggling with their story." (Focus Group – Communities and Partnerships)

A third of all respondents (33.4%/n=192) indicated they felt confident talking about their mental health 'some of the time'. However, around 1 in 4 respondents felt like this only 'rarely' or 'none of the time'

A series of focus groups were held in March 2021 to obtain the experiences of professionals and service users. Common themes included:

- The need for joining up services, resources, and information to make it easier to navigate. Provide clarity on what to expect from mental health services. Indeed, examples of joint working between statutory and voluntary sector services were commended.
- Support and guidance for non-MH professionals to help people with their mental health, and more support from statutory services welcomed. Specifically, support with increased complexities of people presenting to services and being referred by statutory services.
- Accessibility of services, including digital inclusion and transport.
- Integrated communications and promotion of services, e.g a map of support available and referral criteria
- Promotion of prevention, wellbeing, Making Every Contact Count (MECC), and resilience important for population health and younger groups.

When asked about information about mental health support and opportunities for improvements, quotes included the following:

"Definitely easier to read documents - making language easier to understand. Having information more readily available. There is often an assumption that people have knowledge of mental health services but lots of our mums have no experience with services and don't understand a lot of the terminology such as what is a CPN, what does a psychiatrist do etc and this can put them off seeking support." (Focus Group – Voluntary and Community Sector)

"Lots of online resources seem to be available. However not normally accessed by those that need it most. Due to IT, lack equipment/internet/knowledge and confidence (Coventry)" (Focus Group – Communities and Partnerships)

"as a MH sufferer the services are so much more accessible which is great, it is still the stigma that holds people back and might stop them accessing services - again say it is ok to not be ok" (Focus Group – Communities and Partnerships)

"A joint MH comms strategy and shared MH comms resource between key Adult, children and infant MH services and pathways." (Focus Group – Commissioners)

Respondents to the engagement survey were asked about any further thoughts about mental health and wellbeing in Coventry and Warwickshire. Comments were analysed by respondent type although there was considerable overlap in the themes identified among them. Responses included suggestions about future support and services, with a link to changes/issues brought about by COVID-19, raising awareness of support available, service thresholds and early support, resourcing and capacity, and training/staffing considerations. This feedback can be viewed in full in Appendix 1. The comments provided in the easy read survey to the question asking for any additional comments about mental health services were similar in sentiment to those highlighted above and are summarised below:

- Respondents referred to the quality of service experienced sometimes citing insufficient crisis support and/or a lack of understanding and sensitivity which contributed to people's distress.
- Some respondents simply felt there were too few services available. Difficulties accessing or referring to services were highlighted; a lack of joined up support and clear pathway to gaining a service especially if someone has more than one need was noted.
- Waiting lists and the timeliness of services were a feature of several comments. Access to services because of geography/transport was mentioned and a view that some areas were better served than others when it came to the provision of services.
- Some respondents commented that the support that is available was not always widely known about or promoted. Challenging stigma and discrimination associated with mental health was suggested.
- Young people were mentioned as in particular need of support

- The impact of COVID-19 on people's mental health was referred to; the expectation was that the pandemic and lockdown would increase demand for mental health services.
- Several positive comments were made about service experience across NHS and voluntary sector.

Feedback and Recommendations:

- Responding to the impact of COVID-19 in the design of services, including workforce support and support for the wider determinants of health.
- Development of system knowledge (including among non-MH providers) to raise awareness of available support for all-ages particularly for those with specific needs e.g. housing and domestic abuse services. This could be through a clear, and integrated communications approach relating to local service provision.
- Improving access to support and information - The majority of respondents to the engagement survey had heard of at least one support service, and if people are in contact with a service then they can be supported to access further support through signposting. The specific needs of certain groups such as children and young people, people with autism, and Carers should also be taken into account.
- Commissioners and Providers to ensure there are feedback mechanisms for service user experience to inform future service design to build upon what was learned from the MHNA engagement

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Agenda Item 5

Health and Wellbeing Board

Pharmaceutical Needs Assessment (PNA) Update

7 July 2021

Recommendation(s)

1. The Board notes and comments upon the production of the Pharmaceutical Needs Assessment (PNA) Supplementary Statement for Coventry and Warwickshire

2. The Board notes and comments upon the proposals for the full PNA in partnership with Coventry City Council; noting the potential impact of the COVID-19 response on timescales.

1. Executive Summary

1.1 This report provides an update on the PNA in Warwickshire. The Health and Wellbeing Board has a legal responsibility to maintain an up to date statement around the needs for services from community pharmacies. The purpose of the PNA is to assess local needs for pharmacy provision, to identify any gaps in service or unmet needs, and to highlight any services that community pharmacies could provide to address these needs.

1.2 The last PNA was published in March 2018 and was due for refresh by March 2021. However, in light of the COVID-19 pandemic and subsequent pressure on resources NHS England has extended the deadline for publication of the PNA to October 2022.

1.3 In the interim, a supplementary statement has been prepared and submitted to NHS England to provide an update on current service provision and review findings from the 2018 assessment. This statement can be found in Appendix 1.

1.4 The last PNA concluded that the number and distribution of the current pharmaceutical service provision in Warwickshire was sufficient but it highlighted that an estimated 13,600 houses were due to be built in Warwickshire between 2018 and 2021. In areas of significant housing development and population growth, additional future pharmacy provision will need to be considered.

1.5 To maximise the resources available and to align with local planning footprints, it is proposed to work with Coventry City Council on the upcoming PNA, as previously. This aligns with the Coventry and Warwickshire Concordat where both Health and Wellbeing Boards have agreed to work together on areas that will improve outcomes for the public. The key

milestones for the proposed consultation and production of the new PNA are outlined below (Table 1):

Drafting surveys/initial consultation	September / October 2021
Initial public survey	November 2021 – January 2022
Pharmacy survey	November / December 2021
Mapping of needs	January / February 2021
Write PNA document	February - March 2021
Formal consultation	16th April to 18th June 2021
Drafting final document and recommendations	June / July 2022
Final draft to JSNA Strategic Group for sign off	July 2022
Final document submitted to Health and Wellbeing Board	September 2022
Document live	1st October 2022

Table 1: Proposed Process for Production of the Coventry and Warwickshire PNA

1.6 The timescales highlighted in Table 1 may be subject to change if there are further impacts of COVID-19.

1.7 The process will be led by the Directors of Public Health and their teams from both Warwickshire and Coventry, with a small steering group in place.

2. Financial Implications

2.1 It is currently anticipated that any costs incurred as a result of taking the recommended actions will be managed within operational budgets, working together with Coventry City Council to maximise the resources available.

3. Environmental Implications

3.1 None

4. Timescales associated with the decision and next steps

The timescales for the proposed process are outlined in Table 1. An update will be brought to a future Health and Wellbeing Board meeting with a final draft for approval in July 2022.

Appendices

1. Appendix 1 – Coventry and Warwickshire Pharmaceutical Needs Assessment Supplementary Statement 2021

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The report was circulated to the following members prior to publication:

Local Member(s): Councillors Drew, Golby, Holland and Rolfe

Appendix 1 – Coventry and Warwickshire Pharmaceutical Needs Assessment Supplementary Statement 2021

Coventry and Warwickshire Pharmaceutical Needs Assessment: Supplementary Statement – April 2021

PHARMACEUTICAL NEEDS ASSESSMENT SUPPLEMENTARY STATEMENT

This supplementary statement:

- has been prepared by the Public Health teams at Coventry City Council and Warwickshire County Council, in collaboration with the Community Pharmacy Steering Group (CPSG) on behalf of the Coventry and Warwickshire Health and Wellbeing Boards;
- is issued in accordance with Part 2; (6) 3 of the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013[1];
- provides updates to the PNA published in March 2018[2]
- provides information which supersedes some of the original PNA information, so should be read in conjunction with the original PNA
- relates to changes in population and pharmacy provision between the end of data collection for the 2018 PNA to November 2020.
- Summarises the impacts of COVID 19 on community pharmacy to date

[1] http://www.legislation.gov.uk/uksi/2013/349/regulation/6/made
[2] https://www.coventry.gov.uk/info/175/data_and_reports/3161/pharmaceutical_needs_assessment_pna / https://www.warwickshire.gov.uk/directory-record/2165/pharmaceutical-needs-assessment-2018-

Summary
This Supplementary Statement takes into account the supply of and demand for Community Pharmacy Services in Coventry and Warwickshire as at January 2021. The data included in this was collated up to December 2020. Analysis of change in population and changes in community pharmacy provision leads to the conclusion that there have not been sufficient changes to require new community pharmacy services at this time.

Background
The Pharmaceutical Needs Assessment 2018 (2018 PNA) identified no additional needs for the provision of pharmaceutical services. This supplementary statement serves as an update on current service provision and review of findings of the 2018 PNA. A full PNA revision is expected to be published prior to the 1st October 2022, as required by the regulations.

Population
Assessment of the latest population projections have not identified any major changes to demography or infrastructure that will impact on pharmaceutical service need as set out in the 2018 PNA and which would be relevant to the granting of control of entry applications.

Since 2016, the estimated population of Coventry has increased by 5%, from 352,900 in mid-2016 to 371,520 in mid-2019. The population of Warwickshire has seen a smaller increase of 3%, from 558,910 in mid-2016 to 577,930 in mid-2019.[i]

Housing
We have also considered the potential impact of large housing developments on the need for community pharmacy. Between 2016 and 2019, the number of dwellings in Coventry has risen by 3%, totaling 142,100. The number of dwellings in Warwickshire has risen by 5%, totaling 259,300.

Demand for new housing in Coventry and Warwickshire remains high and this will need to be accounted for in the planning of community pharmaceutical services to match new house building in future. Changes to national guidance on development announced in December 2020 will need to be taken into account in the next full Pharmaceutical Needs Assessment.

Service Provision
The changes which have taken place in the service provision since the 2018 PNA, i.e. between April 2018 to end November 2020, are summarised in the table below. Full details of these changes are included in Appendix 2.

Changes to Contracts, April 2018 – November 2020

Coventry

Type of Change	Description of Change
New Pharmacy Contracts	3 new contracts - distance selling only
Pharmacy Closures	2 Distance selling, 2 '100 hours' contracts and 3 standard contracts
Consolidations	1 standard contract

Warwickshire

Type of Change	Description of Change
New Pharmacy Contracts	2 new contracts – community pharmacies
Pharmacy Closures	1 Distance selling and 3 standard contracts
Consolidations	2 standard contracts

In Coventry at the time of the 2018 PNA there were 91 community pharmacies, of which 10 were 100 hours. There were also 6 internet/distance selling pharmacies. As of November 2020, there are 85 community pharmacies, of which 8 are 100 hours, and 7 internet/distance selling pharmacies.

In Warwickshire at the time of the PNA there were 105 community pharmacies, of which 9 were 100 hours. There were an additional 6 internet/distance selling pharmacies. As of November 2020, there are 102 community pharmacies, of which 9 are 100 hours, and 5 internet/distance selling pharmacies.

Consolidations

The Coventry and Warwickshire Community Pharmacy Steering Group has considered several consolidations of provision since 2018 and believe that these have not led to any diminution of service provision as a result.

On 5 December 2016, **amendments** to the 2013 Regulations come into force which facilitate pharmacy business consolidations from two sites on to a single existing site. Importantly, a new pharmacy would be prevented from stepping in straight away if a chain closes a branch or two pharmacy businesses merge and one closes. This would protect two pharmacies that choose to consolidate on a single existing site – where this does not create a gap in provision.

Pharmacy opening hours

In addition to the material changes above there have also been some changes in

supplementary opening hours which are not covered within this statement. As the picture is fast changing the most up to date opening hours for each pharmacy can be found on the nhs.uk website.

Tightening Financial Circumstances for Community Pharmacies

The Coventry and Warwickshire Community Pharmacy Steering Group has noted the impact of tightening contractual and business conditions on the provision of community pharmaceutical services and recommends that this is considered in the next full Pharmaceutical Needs Assessment

Effects of Covid-19

Community Pharmacy Services have been under huge pressure throughout the pandemic, dealing with more requests for prescriptions, advice and support along with adapting to COVID secure working including social distancing and have faced business continuity challenges as a result of staff sickness or isolation requirements. A large number of pharmacy staff are from the BAME community and / or have other risk factors for Covid19 - meaning that additional precautions have been necessary and at times reducing the number of staff available to work in the pharmacy. Some services had to be prioritised over others and for a period consultation rooms were not in use until PPE was more readily available.

Pharmacies also provided more support over the phone and in some cases via video consultations. Some services were adapted in conjunction with Commissioners to support clients and pharmacies in managing risk. They did not however, close their doors except during a short period when allowed under the flexible working regulations. This was automatically allowed for up to 2.5 hours a day in the first national lockdown and following approval for some pharmacies in difficulty during the second national lockdown. Pharmacies were for the first time funded to provide or facilitate deliveries for the shielded group but only during parts of the national lockdown. Pharmacies were also supported by local council teams and volunteers to support patients with medicine deliveries.

Many people have praised the way Community Pharmacies have stood up to the pressure and supported their patients, through a variety of means including face to face throughout. More information is included in Appendix 2. Some examples are also available on the Pharmaceutical Services Negotiating Committee (PSNC) website. COVID-19 Hub : PSNC Main site.

National changes:

On 20th October 2020 **new NHS regulations were laid** to introduce changes to the Terms of Service for pharmacy contractors.

Some of these changes relate to the coronavirus pandemic, but most are changes which were previously agreed as part of the **5-year Community Pharmacy Contractual Framework (CPCF)** and were originally planned to be introduced in July 2020.

Key changes are that all pharmacies will be Healthy Living Pharmacies, all will be required to keep NHS website and DoS up to date and use SCR as and when

appropriate. More details are included in Appendix 2 and available on PSNC website.

Conclusion:

There have not been sufficient changes to the local population, taking into account population projections, large housing developments and rate of pharmacists per 10,000, to create a need for a new community pharmacy. The changes to the local service provision, taking into account closure of pharmacies and change in hours, are not sufficient to create the need for a new community pharmacy. Therefore, we conclude there are no gaps in access to pharmaceutical services in Coventry/Warwickshire.

Pharmacy provision will be reviewed next through the 2022 Pharmaceutical Needs Assessment, expected to be published by October 2022.

[i] Source: ONS mid-year population estimates

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Agenda Item 6

Health and Wellbeing Board

Coventry and Warwickshire Place Forum

7 July 2021

Recommendation

1. The Health and Wellbeing Board notes and comments upon the contents of the report and the next steps and actions resulting from the Joint Place Forum and Health and Care Partnership Board meeting held on 2 March 2020.

1. Executive Summary

1.1 This paper updates the Health and Wellbeing Board on the outcomes of Joint Place Forum and Coventry and Warwickshire Health and Care Partnership Board meeting held on the 2 March 2021.

1.2 An online joint meeting of the Coventry and Warwickshire Place Forum and the Health and Care Partnership Board was held on 2 March 2021. The meeting was joined by around 70 partners from across the health and wellbeing system. This was the third meeting held jointly during the pandemic period and, as previously, focused on addressing health inequalities and exploring potential collaborative action to address the negative impacts and capitalise on the opportunities arising from the pandemic.

1.3 The meeting included:

- Updates from the Health and Care Partnership about: the C&W Integrated Care System (ICS) application; progress on merger of the 3 CCGs to become a single commissioning organisation on 1st April 2021; and implications of the Government White Paper and forthcoming legislation on health and social care.
- Information about how partners are responding to COVID-19, including: the vaccination programme and work to tackle inequalities in uptake; the work of the local authorities on the community testing programme and how this is being targeted at need; and work to support staff health and wellbeing across NHS, local authority partners and independent and VCS care providers.
- Tackling health inequalities and improving health and wellbeing outcomes for communities, with a particular focus on mental health and wellbeing which had been highlighted as a particular concern for members at the previous meeting. This item included:

- Tackling the mental health impacts of the pandemic, including the community mental health transformation programme led by Coventry and Warwickshire Partnership Trust
- Update on the Healthy Communities Together programme, following a successful bid to national King's Fund / National Lottery Community Fund programme
- Details of the forthcoming Call to Action on health inequalities across Coventry and Warwickshire
- Information about the relaunch of the Wellbeing for Life campaign.

1.4 There were opportunities for discussion about how members could support these agendas within their communities and organisations, and a MentiMeter poll was used to capture feedback and commitments.

1.5 Key themes emerging from discussion included:

- There are opportunities, through forthcoming legislation on integrated care, to extend collective working and build on strong existing partnerships. It is important that a population health-based approach drives our system change and that we harness the full breadth of influence of partners in improving health outcomes and tackling stubborn inequalities.
- Efforts to ensure inequalities are not reinforced through access and uptake of vaccination and community testing programmes are critically important, and there are opportunities for wider partners to support in this.
- Supporting staff wellbeing is crucial to the recovery of services and aligns closely to work to address healthcare workforce challenges that existed pre-COVID, with potential for a positive impact on inequalities.
- Mental health is likely to be one of the most difficult and enduring impacts of the pandemic and there are significant opportunities emerging to mobilise the collective energies of partners to promote mental wellbeing, taking a wider determinants approach.
- Partners need to translate shared agendas into tangible, practical action and the Call to Action and Wellbeing for Life campaigns offer real opportunities to make an impact by working together and demonstrating collective vision and leadership.

2. Financial Implications

2.1 None.

3. Environmental Implications

3.1 None.

4. Supporting Information

4.1 The agenda, presentations and outcomes of the Mentimeter poll are available at https://www.happyhealthylives.uk/about-us/our-partnership-board/.

5. Timescales associated with the decision and next steps

5.1 The following actions were proposed for partners:

- Ensure the implications of the Health and Social Care White Paper are understood at an organisational level and embedded within plans for Place
- Continue to support and champion the dissemination of COVID-19 response information to people within our communities to:
    - Ensure equal uptake of the COVID-19 vaccination programme in line with national guidance; and
    - Promote community testing to target audiences
- Take opportunities to work collaboratively and use a population health approach to best address the mental health impacts of the pandemic in our communities
- Respond to and champion the Call to Action to address health inequalities
- Champion and progress workforce wellbeing within organisations, including commitment to THRIVE at Work.

5.2 The next Place Forum meeting is scheduled for 17 June 2021 and it is planned that this will again be a joint, online meeting with the C&W Health and Care Partnership Board. A verbal update from this meeting will be provided at the Board meeting on the 7 July.

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The report was circulated to the following members prior to publication:

Local Member(s): Councillors Bell, Drew, Golby, Holland and Rolfe

Agenda Item 7

Health and Wellbeing Board

Better Care Fund Plan Progress Report

7 July 2021

Recommendation(s)

1. The Board notes and comments upon the progress of the Better Together Programme in 2020/21 including reasons for changes in performance, against the national Better Care Fund areas of focus.

2. The Board notes and comments upon the update on the 2020/21 end of year report on the Better Care Fund.

3. The Board notes and comments upon the update on the Better Care Fund Policy Framework and Guidance for 2021/22.

1. Executive Summary

1.1 The Better Care Fund Plan, known locally as the Better Together Programme, includes the plan for resources made available through the additional social care monies (iBCF), Disabled Facilities Grant (DFG) and Clinical Commissioning Group contribution.

Better Together Programme Performance Update (Quarter 4 2020/21)

1.2 Locally our plan for 2020/21 focussed activities on improving our performance in the key areas which are measured against the National Performance Metrics. These being:

a. Reducing Non-Elective Admissions (General and Acute)
b. Reducing admissions to residential and care homes; and
c. Increasing effectiveness of reablement

1.3 A summary of performance against the national areas of focus, using the most recent data available, is provided below:

Metric	Q4 20/21 performance	Target	Status
Non-Elective Admissions	Quarter 4 Actual: 14,133	14,912	5.2% below (better than) target
Admissions to residential and	Quarter 4 Actual: 209	182	14.8% above target

care homes			
Effectiveness of reablement	2020/21 Actual: 93.6%	89%	5.1% below (better than) target

Discharge Policy Requirements

1.4 As previously advised the Better Together programme has continued to support implementation of the updated NHS 'Hospital Discharge Service: Policy and Requirements' published on the 21st August 2020. This updated Policy set out the operational discharge requirements to 31st March 2021, for all NHS trusts, community interest companies, private care providers of acute, community beds and community health services and social care staff in England; and requirements around discharge for health and social care commissioners (including Clinical Commissioning Groups and local authorities). The programme will continue to support NHS and social care colleagues to deliver the requirements as well as implement any further changes required in the 2021/22 guidance.

Better Care Fund 2020/21 End of Year requirements

1.5 The Health and Wellbeing Board at its meeting on the 29th January 2021, approved the Better Care Fund Plan for 2020/21, and noted that whilst formal BCF plans did not have to be submitted to NHS England and NHS Improvement for approval, Health and Wellbeing Boards would for the first time, be required to provide an end of year reconciliation to NHS England / Improvement, confirming that the national conditions have been met, with total spend from the mandatory funding sources and a breakdown of agreed spending on social care from the CCG minimum contribution.

1.6 The Better Care Fund 2020/21 End of Year Template published on the 14th April 2021, set out the template for Health and Wellbeing Boards (HWBs) to provide a summary end of year report on their Better Care Fund (BCF) plans. Our report was reviewed and approved prior to submission before the deadline of the 24th May 2021 by the following:

a. Warwickshire County Council, People Directorate Leadership Team;
b. Coventry and Warwickshire Clinical Commissioning Group; Executive Leadership Team
c. Warwickshire Joint Commissioning Board; and
d. Councillor Caborn, Chair of the Health and Wellbeing Board

Better Care Fund Policy Framework and Guidance for 2021/22

1.7 The Policy Framework is expected to be published during quarter 1 2021, although this is subject to change. At present whilst it is unclear what changes there will be to the current conditions and metrics, it has been confirmed that Health and Wellbeing Board areas will be required to submit Better Care Fund plans for approval by NHS England and Improvement.

Better Care Fund Plan for 2021/22

1.8 As well as continuing with existing schemes from the 2020/21 Better Care Fund plan, the Warwickshire Joint Commissioning Board have agreed that the following new schemes will be piloted in 2021/22:

- piloting a Mental Health / Learning Disability / Autism practitioner or professional resource in the Quality Assurance Team (c£42k); and
- following implementation of a new falls prevention pathway in December 2020, a contribution of £34k for the new falls care-coordination and Multi-Factorial Assessments approach delivered via the Integrated Single Point of Access for patients at moderate to high risk of falls.

2. Financial Implications

2.1 The programme and initiatives for its success are in part funded through national grants: Better Care Fund, Improved Better Care Fund and Winter Pressures Grant (2020/21: £59.2m). The former comes from the Department of Health and Social Care through Clinical Commissioning Groups, while the latter two are received by the local authority from the Ministry for Housing, Communities and Local Government. All three are dependent on meeting conditions that they contribute towards the programme and the targets, and that plans to this effect are jointly agreed between Clinical Commissioning Groups and the Local Authority under a pooled budget arrangement.

3. Environmental Implications

None.

4. Supporting Information

Performance against the three national areas of focus, using the latest confirmed data available, is provided below

It should be noted that performance across the four quarters in 2020/21 has been impacted by the associated phase/wave of the Covid 19 pandemic.

4.1 Reducing Non-Elective Admissions (General and Acute)

i) In quarter 4 2020/21, Warwickshire non-elective admissions were 3% higher than the same period last year and 5.2% below (better than) target.

Non-Elective Admissions performance:

Quarter	**Actual** (lower is better)	**Target**	**% over/below target**

Q1 2020/21	11,481	14,912	-23.0%
Q2 2020/21	14,249	14,912	-0.1%
Q3 2020/21	14,403	14,912	-3.4%
Q4 2020/21	14,133	14,912	-5.2%

NHS	**65+ NEAs**	**All Age NEAs**
SWCCG	3,540	6,785
WNCCG	2,466	4,888
Rugby	1,097	2,460
Total	**7,103**	**14,133**

ii) SWCCG saw a 2.2% increase in all age admissions compared to the same quarter last year, however there was a minimal decrease in 65+ admissions (0.75% decrease). WNCCG also saw an increase in all age admissions against Q4 19/20 with a 4.5% increase, which was mainly due to an increase in 65+ admissions (+3.4%). Rugby also saw a +2.5% increase for all age admissions and a 2.4% increase in 65+ admissions compared to the same period last year.

iii) Noting the impact of the Covid pandemic, the Health and Wellbeing Board is requested to consider how partners could support the identification and sharing of other reasons behind performance changes including, for example, increases in all age admissions.

4.2 Reducing long term admissions to residential and nursing care 65+

i) Permanent admissions were 2.5% higher than quarter 4 19/20 and 14.8% above target in quarter 4 2020/21.

ii) The target for 2020/21 was 732 admissions per 100k population, which equates to a quarterly target of 182.

Quarter	**Actual**	**Target** (lower is better)	**% over/below target**
Q1 20/21	144	182	-20.8%
Q2 20/21	155	182	-14.8%
Q3 20/21	196	182	7.6%
Q4 20/21	209	182	14.8%

4.3 Increasing the effectiveness of reablement

i) This target measures the percentage of older people (65 and over) who are still at home 91 days after discharge from hospital into reablement or rehabilitative services. This target is an annual measure and performance for 2020/21 was 93.6% which was 5.1% better than target.

Year	Actual	Target (higher is better)	% over/below target
2017/18	93.0%	89%	4%
2018/19	96.8%	89%	8%
2019/20	94.5%	89%	5.8%
2020/21	93.6%	89%	5.1%

5 Timescales associated with the decision and next steps

5.1 Members are requested to note the latest update on implementing the Better Care Fund in Warwickshire.

Appendices

None

Background Papers

None

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The report was circulated to the following members prior to publication:
Local Member(s): None
Other members: Councillors Golby, Holland, Drew and Rolfe

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Agenda Item 8

Health and Wellbeing Board

Health and Wellbeing Place-based Partnerships

7 July 2021

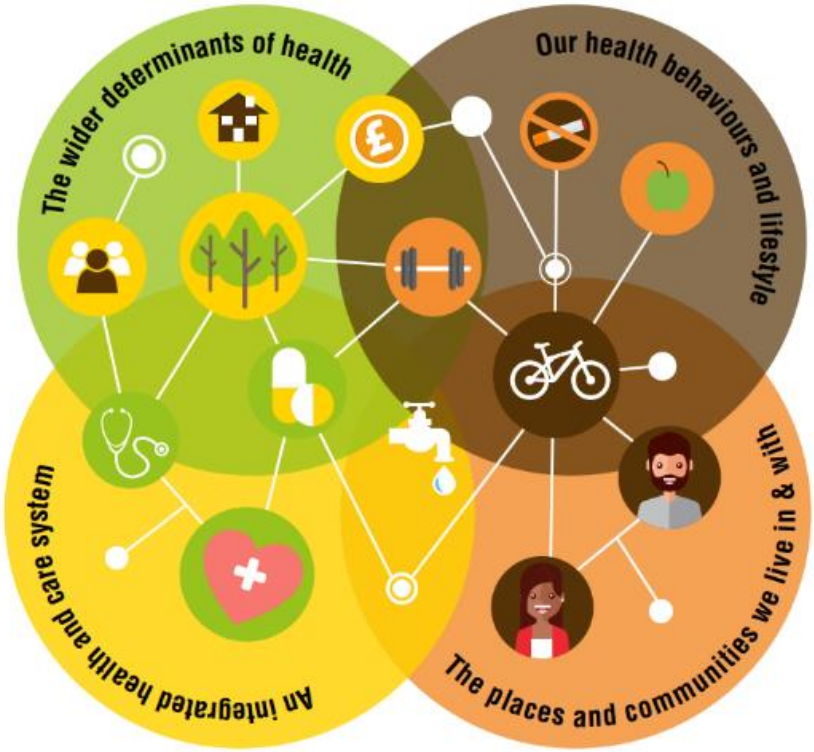
Recommendation

The Health and Wellbeing Board notes and supports the progress made by the three Health and Wellbeing partnerships in Warwickshire

1. Background

1.1. The Health and Wellbeing Partnerships (HWP) in the three places of Warwickshire North, Rugby and South Warwickshire are critical to the successful delivery of the Health and Wellbeing Strategy, the new Coventry and Warwickshire Health and Care Partnership and the place-based Joint Strategic Needs Assessment (JSNA).

1.2. We are working on a population health framework for Warwickshire to underpin everything we do as a health and wellbeing system to achieve our long-term vision for change



1.3. We have identified three initial priorities where we can make a tangible difference in the short-term by working together in partnership. We have

chosen these priorities because we know that they are areas where we could do better. The first two priorities were identified through the JSNA findings and workshops with senior leaders and remain relevant now. Reducing health inequalities has long been a priority underpinning our work and now deserves more prominence due to the 'double-impact' of the pandemic. The three priorities within the Health and Wellbeing Strategy are:

- Help our children and young people have the best start in life
- Help people improve their mental health and wellbeing, particularly around prevention and early intervention
- Reduce inequalities in health outcomes and the wider determinants of health.

1.4. Progress against each priority is shown in appendix 1.

2. Financial Implications

2.1 None.

3. Environmental Implications

3.1 None.

4. Next steps

4.1 A forward plan of items for each partnership is being developed through the Place Coordination Group.

Appendices:
Appendix 1: Health and Wellbeing Partnerships

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The report was circulated to the following members prior to publication:

Other members: Councillors Bell, Drew, Golby, Holland and Rolfe.

Appendix 1: Health and Wellbeing Partnerships

Priority 1: helping our children and young people have the best start in life		
	Outline of activity	**Progress update**
North Place	As part of the Wider Determinants of Health priority, we will drive to address health inequalities for children in year six who are overweight or obese. Furthermore, Warwickshire North Place has set up programmes of work around infant mortality rates, mental health in schools, and suicide rates in 10+ year olds.	A Task and Finish Group has been established to investigate data behind rates of infant mortality in Warwickshire North and to scope programmes of work to address this. An expression of interest has been submitted for mental health in school teams.
Rugby Place	Engagement session on the Family Poverty Strategy. Self-harm in young people is a key priority for Rugby place and was the theme of a mental health and wellbeing partnership meeting this quarter.	Partners given the opportunity to feed into the strategy development and partners agreed to work with WCC colleagues who led on the strategy to deliver on the priorities at Rugby place. Presentations from partners from WCC, CWPT were well received. The Rugby place delivery group are to follow up with actions at place.
South Place	Engagement session on the Family Poverty Strategy.	Partners given the opportunity to feed into the strategy development.

Priority 2: Help people improve their mental health and wellbeing, particularly around prevention and early intervention in our communities		
	Outline of activity	**Progress update**
North Place	Launch of Creative Health – Arts on Referral schemes. Partners supported Muslim community to have a safe Ramadan. Partners involved in supporting surge testing in Nuneaton (Abbey and Wembrook Wards).	To be promoted at future meetings. Mosque distributing Lateral Flow Test Kits, WCC support to improve ventilation and Covid-Secure arrangements. No known cases linked to Mosque attendance during Ramadan period. Surge testing underway, good uptake and response by locall community.
Rugby Place	Launch of Creative Health – Arts on Referral schemes Mental health and wellbeing was theme of the meeting and partners presented updates across the system. Compassionate communities Rugby has launched the new website - compassionaterugby.co.uk.	To be promoted at future meetings. Presentations were well received and follow up actions through the place delivery group. Engagement with HCP MH lead to plan translation of strategy at Place. Website is being communicated widely to encourage people to get involved or access support.
South Place	Engagement sessions on a Mental Health Needs Assessment, an Alcohol Health Needs Assessment and a Domestic Abuse Needs Assessment. Promotion of Wellbeing for Life Campaign On-going updates from CWPT on Access Hubs and Community Transformation Programme. Launch of Creative Health – Arts on Referral schemes	Partners given the opportunity to feed into needs assessment and population engagement processes. Awareness raising to harness partnership involvement. Partners kept aware of developments and opportunities to strengthen links with wider services and support. To be promoted at future meetings

Priority 3: Reduce inequalities in health outcomes and the wider determinants of health		
	Outline of activity	**Progress update**
North Place	Homelessness Strategy launched. As part of the Warwickshire North Place Plan, four priority areas for addressing health inequalities have been identified: smoking cessation, obesity, mental health, learning disability, and end of life care.	Promoted to Partnership. Three cohorts have been identified for the social isolation programme of work. These include low income/deprived, older and male, and carers. Social Prescribers in PCNs are addressing social isolation by engaging with carers.
Rugby Place	Homelessness Strategy launched. Homelessness is a priority for Rugby place. Director of public health annual report presented to partners exploring impact of COVID-19 on health inequalities.	Homelessness sub-group with key leads around homelessness are working together to implement improving lives of people who are homeless at place. Progress includes: • Further referral routes to be agreed and cascaded out to referral agencies. • Improving access to GP services by linking in with work done by Healthwatch Warwickshire. • Understanding personal resilience and personal development amongst the cohort to proactive and prevention strategy. Report was well received and agree to deliver on recommendations as per HWB endorsement – read the report online – warwickshire.gov.uk/publichealthannualreport.

	COVID-19 and BAME work programme was presented to the partnership.	Benn Partnership in Rugby has been commissioned to engage with communities, countywide community development officers have been appointed and funding opportunities are going to be available for organisations/groups to bid
South Place	Homelessness Strategy launched. Ongoing partnership support to the Fred Winter Centre development. Overview of Covid-19 recovery survey findings. Initiated digital inclusion pilot for refurbishing donated laptops (in partnership with Coventry and Warwickshire Co-operative Development Agency).	Promoted to Partnership. Delay in progress caused by the pandemic, WCC funding secured for roll-over into 2021/22. Findings shared to feed into South response and recovery plans. Funding secured for Countywide process, priority given to people with mental health diagnoses and families.

Updates on place-based delivery of JSNA action plans/Place Priorities (not captured in HWB Priorities)		
	Outline of activity	**Progress update**
North Place	The overarching themes from the JSNA in Warwickshire North include: • Deprivation – home ownership, child poverty, financial inclusion, and regeneration (planning and transport). • Mental Health and Wellbeing • Children and Young People – early years, education, and young mothers. • Living with Long Term Conditions – self-management, CVD, COPD, support for families, presenting late, and screening uptake. • Ageing Population • Access to Services • Homelessness and Vulnerable Adults	The JSNA themes have been used to identify key themes for Warwickshire North Place, including: • Long Term Conditions – the priorities of work include MSK, Heart Failure, Blood Pressure, Diabetes and COPD. Key achievements include the establishment of a multi-disciplinary diabetes foot clinic; a COPD telehealth service in care homes; and MSK First Contact Practitioners service in four PCNs. • Maternity, Children, and Young People – the priorities include maternal mental health, suicide in 10+ year olds, and infant mortality rates. • Wider Determinants of Health – there is a focus on homeless support, mental health, and learning disability. Key achievements include PCN recruitment of mental health link workers and mental health practitioners. Also, one social prescribers dealing with social isolation by engaging with carers. Community Capacity and Rapid Response – the priorities include telehealth/digital services; falls prevention; frailty; and enhanced care home offers. Overall this priority aims to improve access to services by providing joined-up care in the community with care available in hospital settings. We are in the final stage of agreeing the recruitment of Physician Associates into General Practice to support frailty.

Rugby Place	Tobacco control – smoking is priority for Rugby place.	Updates have been presented to the Rugby place delivery group including – creation of a Coventry and Warwickshire wide action plan to address the national ambitions to create a smoke free generation by 2030. Developed a position statement on the current picture of tobacco control across Coventry and Warwickshire. Set up a Coventry and Warwickshire wide tobacco control meeting including public health leads and commissioners and a draft tobacco control plan is being created which will also include addressing the NHS Long Term Plan priorities around smoking cessation. The next TC partnership meeting in June will focus on the NHS Long Term plan priorities and key colleagues from across the system have been invited to attend.
South Place	South Health and Wellbeing Group workshop on Climate Change. On-going collaboration with Place Partners to support the pandemic response and recovery, key involvement of partners in Community Engagement, testing and vaccination workstreams.	Completed – links between programmes of work between DCs & WCC, and internal WCC collaboration, strengthened. Current focus on improving vaccination uptake among under-represented groups and joining up cross-organisational discussions on pandemic memorial plans.

Agenda Item 9

Agenda Item 9

HWB Board *07/07/21*	**Discussion items**	
	An evaluation of Creative Care Commissions – *to consider the evaluation for future commissioning*	Kate Sahota
	Mental health and wellbeing – *an update on system transformation*	Richard Onyon / Emily van de Venter
	Updates to the Board	
	JSNA update including mental health needs assessment (MHNA) – *approval of the MHNA and update on JSNA programme*	Duncan Vernon
	Pharmaceutical Needs Assessment (PNA) – update on progress	Duncan Vernon
	Coventry and Warwickshire Joint Place Forum and Health and Care Partnership Board - u*pdate report*	Sir Chris Ham
	Warwickshire Better Together programme - p*rogress update.*	Becky Hale
	Health and Wellbeing Partnerships – *update on progress across the three place-based partnerships*	Shade Agboola/Emily van de Venter/Duncan Vernon
HWB Board *03/11/21*	**Discussion items**	
	Health and Wellbeing Partnerships: place and JSNA action plans – *presentation and progress update*	Leads for Place
	Dementia Strategy – *approval of strategy*	Claire Taylor
	Healthwatch Annual Review – *progress report*	Chris Bain
	Annual Reports from the Safeguarding Boards – *from Adults and Children's Safeguarding Boards*	Amrita Sharma
	RISE Local Transformation Plan – *presentation and progress report*	Rob Sabin
	Updates to the Board	
	Warwickshire Better Together programme. *Progress update.*	Becky Hale
	JSNA Update – *update on the Children's 0-5 needs assessment*	Duncan Vernon
	Pharmaceutical Needs Assessment – *update on progress*	Duncan Vernon
Place Forum *17/11/21*	**Joint meeting of HWBBs and Executive Team.** *Meeting location TBC*	
HWB Board *03/03/21*	**Discussion items**	
	Director of Public Health Annual Report 2022 – *presentation and endorsement of annual report*	Shade Agboola
	Health and Wellbeing Strategy Annual Report – *presentation and progress update*	Gemma McKinnon
	Health and Wellbeing Partnerships: place and JSNA action plans – *progress update*	Leads for Place
	JSNA 0-5 needs assessment – *for approval*	Duncan Vernon
	Updates to the Board	
	Warwickshire Better Together programme - *progress update.*	Becky Hale
	Pharmaceutical needs assessment - p*rogress report*	Duncan Vernon
Place Forum *09/03/21*	**Joint meeting of HWBBs and Executive Team.** *Meeting location TBC*	

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