Coventry City Council

# Agenda

## Coventry Health and Well-being Board

**Time and Date**
10.00 am on Wednesday, 8th July, 2026

**Place**
Committee Room 3 - Council House

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**Public Business**

1. **Welcome and Apologies for Absence**

2. **Declarations of Interest**

3. **Minutes of Previous Meeting**

   (a) To agree the minutes of the meeting held on 4th March, 2026 (Pages 3 - 6)

   (b) Matters Arising

4. **Chair's Update**

   Verbal Update of the Chair

5. **Director of Public Health and Wellbeing Update**

   Verbal Report of the Director of Public Health and Wellbeing

6. **Integrated Care Board Update**

   Verbal Update from the Integrated Care Board

7. **Joint Strategic Needs Assessment Citywide Profile 2026-2029** (Pages 7 - 106)

   Briefing Note of Consultant in Public Health, Valerie De Souza

8. **Developing the role of the Health and Wellbeing Board 2026/27** (Pages 107 - 120)

   Briefing Note of Consultant in Public Health, Valerie De Souza

9. **Best Start in Life Strategy and Area Action Plan and the Best Start Family Hubs** (Pages 121 - 136)

Joint Briefing Note

10. **SEND Local Reform Plan, System Governance and Reform Delivery** (Pages 137 - 200)

Briefing Note of Strategic Lead Education

11. **Better Care Fund (BCF) 2025/26 review and 2026/27 planning approval** (Pages 201 - 226)

Report of the Director of Adult Care, Health and Housing

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

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

**Private Business**

Nil

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

Tuesday, 30 June 2026

Note: The person to contact about the agenda and documents for this meeting is Caroline Taylor Email: caroline.taylor@coventry.gov.uk

Membership: Councillors L Bigham, K Caan (Chair), G Duggins, J Gardiner, M Mutton A Duggal, P Fahy, A Hardy, L-A Howat, D Howat, P Joyce, S Linnell, M Mumvuri, G Perkins, S Sen, M Stanton, S Trickett and C Waring

By invitation Councillor G Hayre

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**Caroline Taylor**
**Email: caroline.taylor@coventry.gov.uk**

**Coventry City Council**
**Minutes of the Meeting of Coventry Health and Well-being Board held at 9.30 am on Wednesday, 4 March 2026**

Present:

| | |
|---|---|
| Members: | Councillor K Caan (Chair)<br>Councillor L Bigham<br>Councillor B Mosterman<br>Councillor P Seaman<br>H Bahur<br>A Duggal<br>P Fahy<br>A Hardy<br>L Howatt<br>P Joyce<br>G Lavery<br>M Mumvuri<br>S Trickett<br>C Waring |
| In attendance: | A Cartwright, C Healy, H Kelly, A Morgan, J Richards |
| Employees (by Directorate): | |
| Law and Governance: | C Sinclair |
| Public Health: | V Castree, V DeSouza, T Hewitt |
| Apologies: | Councillor G Duggins<br>R Bhayat, D Howat (substitute G Lavery), S Sen and M Stanton |

**Public Business**

36. **Welcome and Apologies for Absence**

The Chair, Councillor K Caan, welcomed all attendees to the meeting and introduced and welcomed Crishni Waring and Simon Trickett (ICB) to their first meeting.

37. **Declarations of Interest**

There were no declarations of interest.

38. **Minutes of Previous Meeting**

The minutes of the meeting held on 7 January 2026 were agreed and signed as a true record. There were no matters arising.

39. **Chair's Update**

There was no update.

40. **Coventry Neighbourhood Health Programme (NNHIP) - Finalised Neighbourhood Geographies**

At the meeting held on 7 January, the Board agreed oversight of Neighbourhood Health in Coventry (Minute 32 refers). The report was presented to support them in undertaking this role.

Appendix 1 of the report provided information on the finalised geographies for the Neighbourhood Model in Coventry. This model had been endorsed by Primary Care, Coventry Care Collaborative Forum and the Coventry Collaborative Committee.

Officers provided an update on the development of the Neighbourhood Model. Members were informed that the model and geographies had now been endorsed by all partners and noted:

- The programme was recognised as a long-term piece of work, but significant progress was being made at pace.
- Primary Care colleagues were fully engaged and supportive of the approach.
- Work was progressing towards the second INT going live, as illustrated through the colour-coded slides.
- INTs were being developed in pairs, reflecting differing levels of local need.
- The model ensured alignment of geographies with Mental Health colleagues, supporting a consistent approach.
- INTs represented one element of the wider neighbourhood model, which would expand to incorporate additional teams over time.
- Further work was required to consider the wider system.

The recommendation as presented was accepted and agreed.

41. **Children's Neighbourhood Health**

The Board considered a briefing note which described the Coventry approach to the implementation of Neighbourhood Health for children and to seek input and leadership from the Board as the Neighbourhood Health programme commences and seeking views as to the possibility of integrating Families Fist work with the NHS MDT programme.

The briefing note set out the definition of neighbourhood health, the aims of the neighbourhood MDT and listed the groups of more vulnerable children which the MDT could prioritise for targeted support.

The Board noted a presentation on developing a Neighbourhood Child Health MDT model. The presentation provided examples from other areas, outlined potential areas of focus, and highlighted opportunities for alignment across local services.

Members discussed the importance of improving children's health data, agreeing that better information is needed to understand local need and measure impact. The Board noted significant levels of neurodevelopmental need locally and emphasised the importance of early intervention, shared learning across agencies, and aligning resources to support the model.

Air quality and wider environmental factors were recognised as key influences on children's health. Ongoing local work to improve outdoor and indoor air quality was noted.

Members stressed the importance of prioritising children and young people, ensuring that the work supports long-term outcomes and addresses wider determinants of health. The Board acknowledged resourcing challenges and the need for further discussion on data availability, system capacity and partnership working.

Future work will include consideration of early intervention data, youth justice contact, and transitions from children's to adult services.

**The Board noted the briefing note and presentation and agreed that the presentation slides by circulated to all attendees.**

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

There were no other items of business.

(Meeting closed at 10.30 am)

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Coventry City Council

# Briefing note

**To: Health and Wellbeing Board** **Date: 8 July 2026**

**Title: Joint Strategic Needs Assessment Citywide Profile 2026-2029**

## 1 Purpose of the Note

1.1 To share the draft Joint Strategic Needs Assessment (JSNA) Citywide profile with the Health and Wellbeing Board and request feedback to enable the document to be finalised and published.

## 2 Recommendations

2.1 It is recommended that Health and Wellbeing Board:

2.2 review the draft Joint Strategic Needs Assessment Citywide profile and provide feedback; and

2.3 note the proposals to develop place-based profiles to support decision-making and planning across various programmes including neighbourhood health.

## 3 Information/Background

3.1 The production of the JSNA is a statutory requirement for the Health and Wellbeing Board. It is intended to inform and guide the planning and commissioning of health, wellbeing, and social care services within a local area. It provides a snapshot of current and future health and care needs of the local community, considering factors that impact on health and wellbeing from a population health approach, including economic, education, housing, and environmental factors; as well as local assets that can help improve the area and reduce inequalities.

3.2 The information in the JSNA is used to help inform the priorities of the Health and Wellbeing Board, which focus on reducing health inequalities and improving health and wellbeing for Coventry residents.

3.3 The draft of the JSNA citywide profile is attached at Appendix 1. The key findings from the profile show that addressing Coventry's inequalities requires place-based, preventative, and proportionate action, focused on:

- Early childhood and families
- Mental health and wellbeing
- Poverty, housing security, and employment quality
- Supporting communities experiencing long term deprivation

3.4 Further to feedback from the Board, it is intended to finalise the citywide profile for publication over the summer and develop a suite of supporting materials to enable dissemination of key messages and support the use of the JSNA by partners and stakeholders.

3.5 In addition to the JSNA Citywide profile, it is intended that place-based profiles will be developed over the next 12 months to support planning for neighbourhood health and other work to support health and wellbeing. These will provide deeper insight into local communities and will be shared with Health and Wellbeing Board as available.

## 4 How does this work contribute to the delivery of the Health and Wellbeing Strategy?

4.1 The JSNA is the key document used to inform the Health and Wellbeing Board priorities and planning.

## 5 How does this work align to Coventry's Marmot approach?

As a Marmot city, Coventry organisations and services work collaboratively to reduce health inequalities by three key areas of action, which have been reflected in the development of the JSNA:

1) **Focusing on strengthening and improving the conditions in which Coventry residents are born, live, work, grow and age**. Such as good quality homes and jobs, good education, good access to healthcare and green spaces. These are known as the wider determinants of health.
2) **Allocation of what resources we have, to be fairly distributed to improve the health of all residents.** This can be done by identifying whose health is good, whose health is the poorest, and everyone else across the gradient in between, allocating resources proportionate to their levels of need.
3) **Identification of opportunities to take action across the Marmot Principles.** The eight Marmot Principles are:
    1. Give every child the best start in life
    2. Enable all children, young people and adults to maximise their capabilities and have control over t…
    3. Ensure a healthy standard of living for all
    4. Create fair employment and good work for all
    5. Create and develop healthy and sustainable places and communities
    6. Strengthen the role and impact of ill health prevention
    7. Tackle racism, discrimination and their outcomes
    8. Pursue environmental sustainability and health equity together

**Appendices**

Appendix 1 – Draft JSNA Citywide Profile 2026-2029

**Valerie De Souza**
**Consultant in Public Health**
**Valerie.DeSouza@coventry.gov.uk**

# Joint Strategic Needs Assessment

# Citywide Profile

## 2026-2029

Coventry City Council

coventry.gov.uk

# CONTENTS

# INTRODUCTION

## What is the Coventry Joint Strategic Needs Assessment?

Welcome to the Coventry Joint Strategic Needs Assessment (JSNA) 2026-2029. The JSNA brings together evidence about the health and wellbeing of Coventry residents, to help leaders across health and care understand and work together to improve the health and wellbeing of Coventry residents.

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

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

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

This JSNA contains a full range of evidence to provide stakeholders with an understanding of local people and communities. It contains a lot of numbers and statistics, essential in demonstrating the trends of how things have changed, as well as comparisons with other places. However, because health is about people, this JSNA also contains insights from local people and communities.

## About this JSNA

The Health and Social Care Act of 2012 places a duty on Health and Wellbeing Boards to produce a Joint Strategic Needs Assessment.

In April 2018, the Coventry Health and Wellbeing Board authorised a move towards a place-based approach to the JSNA, with the production of a citywide JSNA profile and JSNA profiles for each of the city's eight Family Hub reach areas. In 2023 an updated citywide JSNA profile was published, followed by a series of further place-based profiles for priority areas in the city: Binley and Willenhall; Bell Green and Wood End, Henley Green, Manor Farm; Canley; Foleshill and Longford; Hillfields; and Tile Hill. These place-based profiles offer a rich understanding of these local neighbourhoods, underpinned by local insight and reflecting the community assets within the area.

This JSNA citywide profile was produced in 2026 by Coventry City Council with cooperation from partners across the Coventry Health and Wellbeing Board. It builds on learning and feedback from partners about how the JSNA is used and how it could be improved, including new intelligence to support wider application of the insight provided and enhance its relevance and impact.

Each JSNA profile is structured as follows:

- Demographics and Communities

- Prospects
- Housing and Environment
- Health and Wellbeing

For each topic area covered, the JSNA explores:

- Why is this important?
- What is the local picture? How does it compare?
- What does this mean for Coventry?

In addition to the JSNA profiles, other supporting documents are available here.

## EXECUTIVE SUMMARY

### Demographics and communities

- Coventry's population is growing, changing and becoming increasingly diverse, driven by international migration and natural population change.
- Coventry has a younger population than the rest of England, but the number of older residents is increasing.
- Population growth is uneven across the city, with the fastest increases in central and eastern neighbourhoods.
- Ethnic, cultural, linguistic and religious diversity has increased significantly, particularly among children and young people.
- Coventry's population profile includes higher proportions of renters, younger adults and households experiencing financial pressures than the UK average.
- Most residents report a strong sense of belonging to their community and the city, although neighbourhood trust and participation levels remain slightly below national averages.
- Understanding these demographic, social and economic characteristics is essential for planning services, reducing inequalities and supporting healthy communities.

### Prospects

- Early life experiences strongly influence lifelong health, wellbeing and opportunity.
- Early antenatal engagement has declined, but smoking in pregnancy has fallen and breastfeeding rates are above average.
- Infant mortality, stillbirth and premature birth rates remain higher than national levels, with significant inequalities.
- School readiness and early years outcomes lag behind national averages, particularly for disadvantaged children and those with SEND.
- SEND numbers and free school meal eligibility continue to rise.
- Educational attainment is improving but remains below national averages, with persistent attainment gaps.
- School absence, exclusions and suspensions are increasing.
- Mental health demand among children and young people continues to grow.
- Risky behaviours have declined, but smoking, sexual health and teenage conception rates remain concerns.
- Youth justice entry rates remain comparatively low.
- Economic growth has not been felt equally, with falling employment, rising unemployment and ethnic inequalities.
- Child poverty, fuel poverty, deprivation and digital exclusion remain key challenges.

### Housing and Environment

- Coventry is the fourth most densely populated local authority area in the West Midlands.

- There is generally good access to services, although lower-than-average access to some amenities such as Post Offices, supermarkets and sports facilities.
- Coventry has many green spaces, including several high-quality sites, but overall provision is limited, unevenly distributed, and residents report low satisfaction. This includes poor access to green and blue (water) spaces, garden space and parks and play areas.
- Public transport connectivity is good, and the percentage of adults who engage in active travel is above the average for metropolitan areas. However there has been an increase in people commuting to and from work by car.
- Air quality in Coventry has improved, but it continues to affect health, particularly for vulnerable groups and residents in more deprived areas.
- Resident satisfaction with the local area as a place to live is well below the national average and has declined over time, with worsening perceptions of safety contributing to this trend.
- Recorded crime in Coventry has fallen markedly in recent years, although levels remain above the national average. Hospital admissions related to violent crime have declined substantially over the past decade, though rates remain higher than average.
- Domestic abuse is a significant issue in Coventry, with serious impacts on health and wellbeing and indications of substantial under-reporting and unmet need.
- Coventry has a total of 148,000 domestic dwellings and the number of houses has been growing annually. Coventry's housing stock is characterised by a high proportion of lower-value and older properties. Housing quality and energy efficiency remain significant challenges.
- The private rented sector has grown substantially in Coventry in recent years, comprising around a quarter of households, compared with one fifth nationally.
- Housing in Coventry remains more affordable than the England average, but affordability has steadily worsened over time.
- Coventry has a much higher rate of homelessness or families at risk of homelessness than national and regional averages and homelessness pressures in Coventry have intensified in recent years.
- Coventry now has a significantly higher rate of temporary accommodation than both England and the West Midlands. The number of people sleeping rough in Coventry also appears to be increasing.

**Health and Wellbeing**

- The overall health of residents in the city is below average, with life expectancy consistently lower than regional and national levels.
- There are significant health inequalities across Coventry's neighbourhoods that disproportionately affect certain communities, with some groups experiencing preventable and systemic disparities.
- Premature mortality in Coventry is higher than both the regional and national averages for males and females and has consistently remained this way.
- Cancer, cardiovascular disease, respiratory disease and chronic liver disease are driving premature mortality.
- There has been a notable increase in mortality from COPD (chronic obstructive pulmonary disease), now higher than regional and national averages.
- Across all major conditions, deprivation is strongly associated with higher prevalence, earlier onset and poorer outcomes.

- Preventable risk factors such as diet, smoking, alcohol consumption, and physical activity drive premature mortality and health inequalities.
- Alcohol causes disproportionately high harm in Coventry; the city continues to experience higher-than-average hospital admissions, mortality, and premature deaths linked to alcohol, particularly among men and older adults.
- A quarter of adults are inactive, and over two-thirds are overweight or obese. While rates in younger children are relatively better, obesity rises sharply by Year 6 and remains high in adulthood.
- Overall mental wellbeing in Coventry was affected by COVID-19 and was worse in 2022 than in 2018. Since then, there has been some improvement but not to 2018 levels.
- Coventry has declining rates of childhood and annual flu vaccinations uptake, and HIV testing. Childhood immunisation is Coventry's weakest area in the ONS Health Index for England.
- Coverage of screening for cancers such as breast cancer, cervical cancer, and bowel cancer are below the national average.
- Coventry residents have relatively good access to health services overall. However, A&E waiting times and cancer treatment timelines at the local hospital are below average.

## CHAPTER 1 - DEMOGRAPHICS & COMMUNITIES

**Key Messages**

- Coventry's population is growing, changing and becoming increasingly diverse, driven by international migration and natural population change.
- Coventry has a younger population than the rest of England, but the number of older residents is increasing.
- Population growth is uneven across the city, with the fastest increases in central and eastern neighbourhoods.
- Ethnic, cultural, linguistic and religious diversity has increased significantly, particularly among children and young people.
- Coventry's population profile includes higher proportions of renters, younger adults and households experiencing financial pressures than the UK average.
- Most residents report a strong sense of belonging to their community and the city, although neighbourhood trust and participation levels remain slightly below national averages.
- Understanding these demographic, social and economic characteristics is essential for planning services, reducing inequalities and supporting healthy communities.

**What this means for Coventry**

Understanding Coventry's population characteristics is essential for ensuring that services, infrastructure and community support systems develop in ways that:

- respond to population growth and diversity
- address health inequalities
- strengthen community resilience and social cohesion

While many residents feel a strong sense of belonging to their communities, work should be undertaken to improve levels of trust, participation and social connection as these remain below national averages.

The city's communities contribute to a rich cultural environment and strong economic potential, but it should be recognised that demographic and socioeconomic differences across neighbourhoods also shape health outcomes and inequalities. Services need to respond to Coventry's changing population and work together to address inequalities.

## POPULATION OVERVIEW

### Why is this important?

It is important to understand how Coventry's population and demographics are changing so that local communities and organisations can ensure the city has the right services to meet the needs of its people. Population growth creates opportunities for economic development, cultural diversity and workforce expansion, but it also increases demand for housing, education, healthcare, transport and

community infrastructure. Planning for this growth is therefore essential to ensure Coventry remains a healthy, inclusive and sustainable city.

**What is the local picture? How does it compare?**

**Coventry's population is growing, changing and increasingly diverse; the total population is growing faster than regional and national averages**. According to the 2021 Census, Coventry had a population of 345,325 residents. Between 2011 and 2021, the population increased by 8.9% (28,000 people), compared with 6.6% across England and 6.2% across the West Midlands.

**Coventry's population is growing, but it is hard to predict how much it will increase in the future. This makes it difficult to plan services.** The uncertainty is caused by changing migration patterns, instability, and changes to how population is measured nationally.

**The latest official figures (Office for National Statistics, 2024) estimate that Coventry's population has reached 369,000**. This means it grew by an average of 2.4% per year over three years—about twice the national rate and faster than elsewhere in the West Midlands.

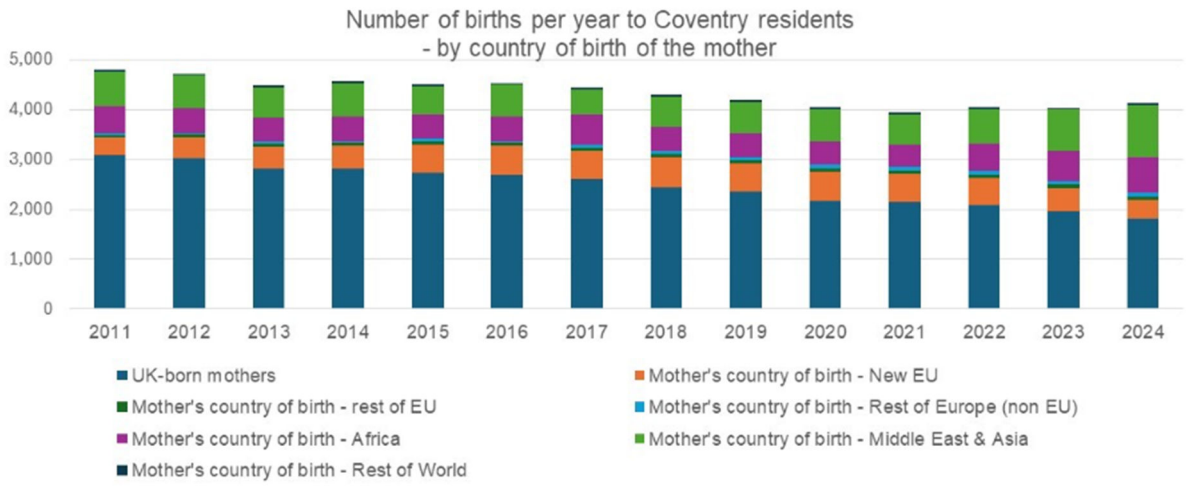
However, ONS alternative 'admin-based population estimates' suggest slower growth. These indicate the population increased by about 15,000 people to around 361,500 in 2024, with an average growth rate of 1.7% per year since 2021. This is still slightly higher than the regional and national averages.

## DRIVERS OF POPULATION CHANGE

**Population change in Coventry is shaped by natural population change and migration.** Natural population change refers to the difference between births and deaths. In Coventry, there have been around 1,000 more births than deaths each year on average, contributing to population growth.

**The total number of births to mothers living in Coventry is increasing, having previously fallen**. Birth numbers have increased slightly in recent years, rising from **3,948 births in 2021 to 4,136 births in 2024**. This increase contrasts with national trends, where birth numbers across England have continued to fall. Birth numbers in Coventry remain below the 2011 peak of 4,801, and future growth is uncertain. Declining births between 2011 and 2021 led to a reduction in children aged 0–4, but the recent increase means this age group is now growing again.

**The rise in the number of births between 2021 and 2024 was driven by increases in the number of births to Coventry mothers who were born outside of the UK, reflecting the city's increasingly diverse population.** In 2024, 56% (2,318 of 4,136) of live births in Coventry were to mothers born outside the UK. The chart below illustrates how the country of birth of mothers changed between 2011 and 2024.



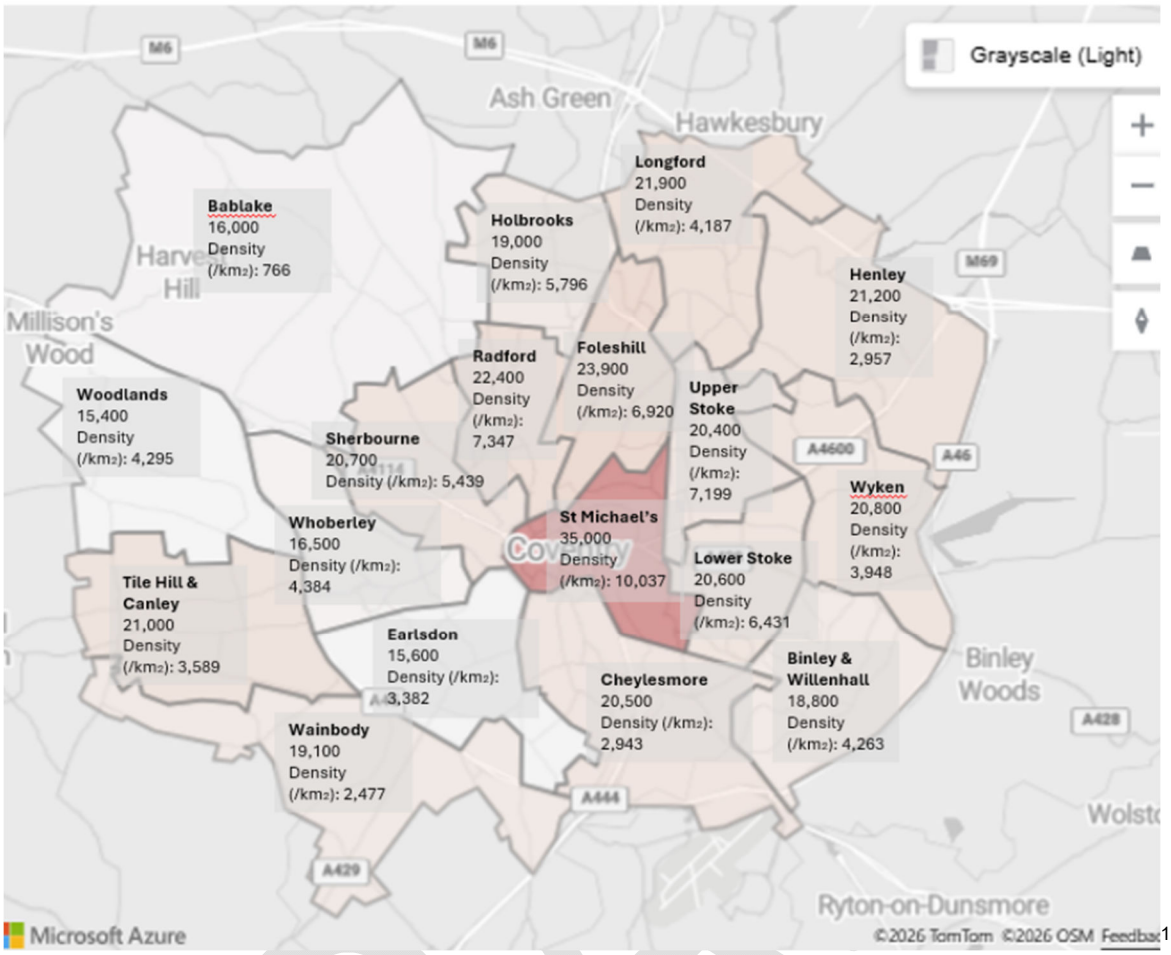

**The number of deaths among Coventry residents has remained relatively stable in recent years, with 3,092 deaths recorded in 2024**.

**As across the UK, international migration to Coventry has increased in recent years and is a one of the main drivers in Coventry's population growth.**

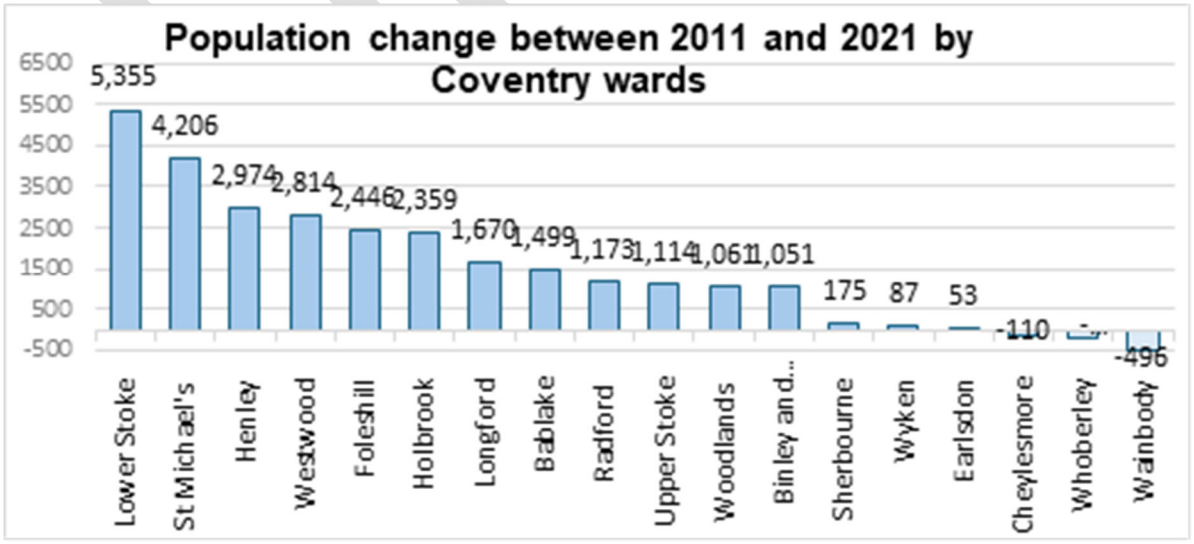
Between 2021 and 2024, an estimated average of 22,000 people per year moved to Coventry from overseas, resulting in an annual net international migration level of around 15,000 people per year once outward migration (people moving abroad from Coventry) is accounted for. These figures mark an increase from the pre-2021 average of 13,000 arrivals per year and a net gain of around 7,000; although uncertainties in estimating the size of these flows may mean the scale of this step change is exaggerated.

Many people move to Coventry for employment, higher education or family reasons, reflecting the city's role as a global city attracting students, skilled workers, and families from diverse backgrounds.

**Total population size, density, and demographic profile varies considerably across Coventry.** Based on 2024 mid-year population estimates, wards in the north and east of the city generally have higher populations and are more densely populated as shown in the map below. St. Michael's, the central ward that includes the City Centre, Hillfields, and surrounding neighbourhoods, has notably the highest population, followed by Foleshill, and then Radford.




**Population growth in Coventry hasn't been evenly distributed; some areas have experienced much more growth than others.** The graph below illustrates the growth of total population by ward between 2011 and 2021; Lower Stoke and St. Michael's experienced the most significant population growth. These are the Coventry wards as they were defined at the time of the Census 2021.



Understanding population and communities is often better using more local areas. For this we use ONS statistical boundary areas, LSOAs (Lower Layer Super Output Areas) and MSOAs (Middle Layer Super Output Areas) [2]. These boundaries can be seen on maps here.

The fastest-growing areas between 2011 and 2021 were Whitley & Toll Bar End (45% growth), Henley Green & Wood End (36%), and Central Coventry (27%). Of Coventry's 42 MSOAs, 20 experienced growth above the England average.

For further information see:

- Briefing note on Census 2021 data for Coventry: Coventry Residents - Census 2021 – Coventry City Council
- Coventry Census 2021 data profile: Nomis - 2021 Census Area Profile - Coventry Local Authority, West Midlands Region and England Country
- More insight and census data tools on Coventry's City Council's website, at Facts about Coventry: Population and demographics – Coventry City Council

## AGE PROFILE

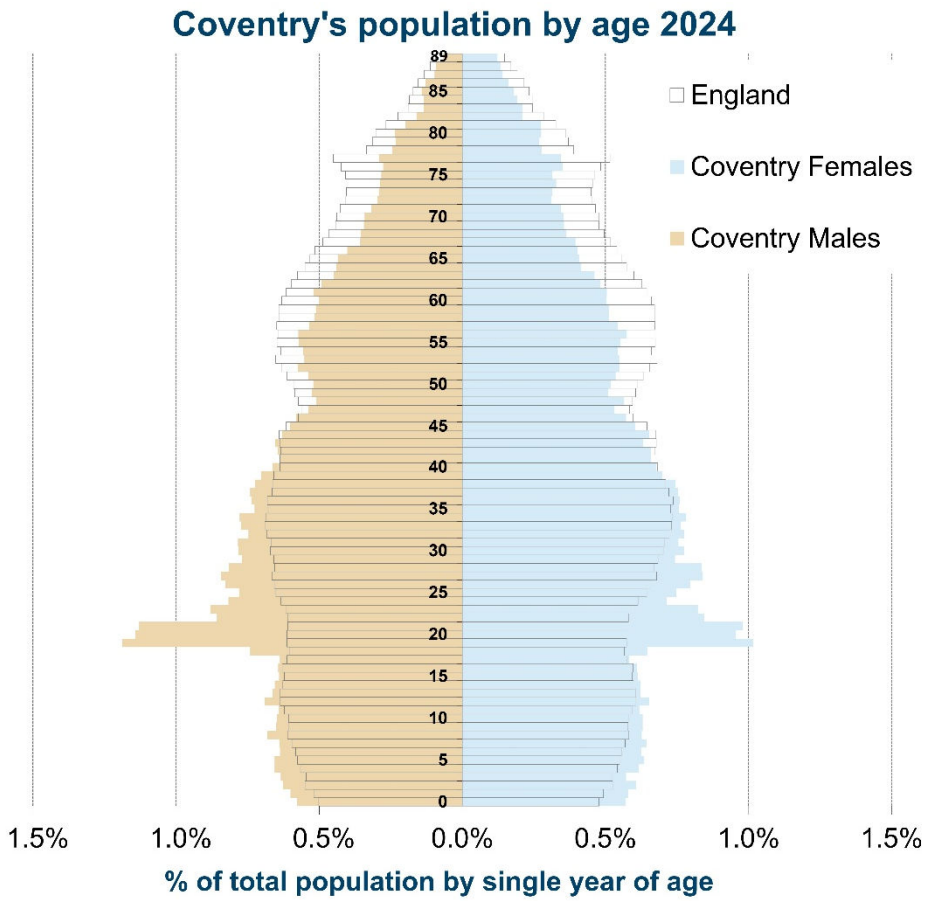
**Coventry has a younger population than England overall. The median age is 35 years, compared with 40 years nationally.**

| **Age Structure** | | |
|---|---|---|
| | **Coventry** | **England** |
| **Under 18** | 23% | 21% |
| **18-64** | 63% | 60% |
| **65+** | 14% | 19% |

This reflects:

- a larger proportion of children and young adults
- a large working-age population
- a smaller proportion of older residents

The 'population pyramid' diagram below illustrates Coventry's age profile in comparison with England as a whole.




**Population growth has differed notably by age group, with population growth being the fastest among children and the population aged 25 to 44.** Between 2021 and 2024, the fastest growing age groups in Coventry are estimated to be 25-34s and 35-44s, with estimated growth rates of 14% and 13%.

**Although growth among older residents has been slower than among younger groups, the total number of older Coventry residents is steadily increasing.** The total number of residents aged 85 increased from 6,700 in 2011 to 7,100 in 2021 and is estimated to have increased further to 7,300 by 2024. This trend indicates growing demand for health services and social care; planning must anticipate accelerated growth in older age groups over the next 10-15 years.

## STUDENT POPULATION

**Coventry's demographic profile is strongly influenced by its two universities.** Coventry University and the University of Warwick have contributed to its relatively high share of residents aged 18–24, including both undergraduates and postgraduate students.

Around 13% of Coventry residents are aged 18–24, compared with 8% nationally. Recent enrolment and population data suggest that the student-aged population in Coventry has fallen slightly since 2021, following a decade of steady growth.

**The most recent estimates are that 33,000 students live within the city.** Between 2010/11 and 2020/21, total enrolments across the city's two universities rose from 56,100 to 67,255. However, by 2024/25 this had fallen to 57,385, primarily due to reduced numbers at Coventry University. The decline at Coventry University was largely among UK students, while international student numbers remained relatively stable.

## HOUSEHOLD STRUCTURE & LIVING ARRANGEMENTS

Household composition is an important factor influencing housing demand, community infrastructure and social support needs.

Between the 2011 and 2021 Census, the number of households in Coventry increased by 4.3%, rising from 128,592 to 134,138 households. This reflects both population growth and housing development across the city.

The most common household types in Coventry are:

- One-person households - 30.4%
- Couples with dependent children - 19.3%
- Couples without children - 13.3%

This reflects a mix of demographic and lifestyle factors.

Between 2011 and 2021 the main changes in household composition were

- Lone parent households with non-dependent children increased (+28.4%)
- Other household types with dependent children increased (+19%)
- Lone parent households with dependent children decreased (-10.4%)
- Two-person households decreased slightly

These changes may reflect wider social trends, including young adults remaining in the parental home longer, increased shared housing, and financial pressures affecting household formation.

## DIVERSITY

**Why is this important?**

The growth of new communities can change the age and ethnic profile of the city, which impacts on demand for local services such as schools and GP surgeries. Demand for services is influenced by many complex factors, such as living and working conditions, social inclusion, ethnicity, socioeconomic position, education, and cultural factors. One of the 6 Marmot principles is to tackle racism and discrimination. The ***Marmot Build Back Fairer*** report summarises how the pandemic has 'revealed the stark inequalities in health and socio-economic factors for many of the UK's minority ethnic communities'.

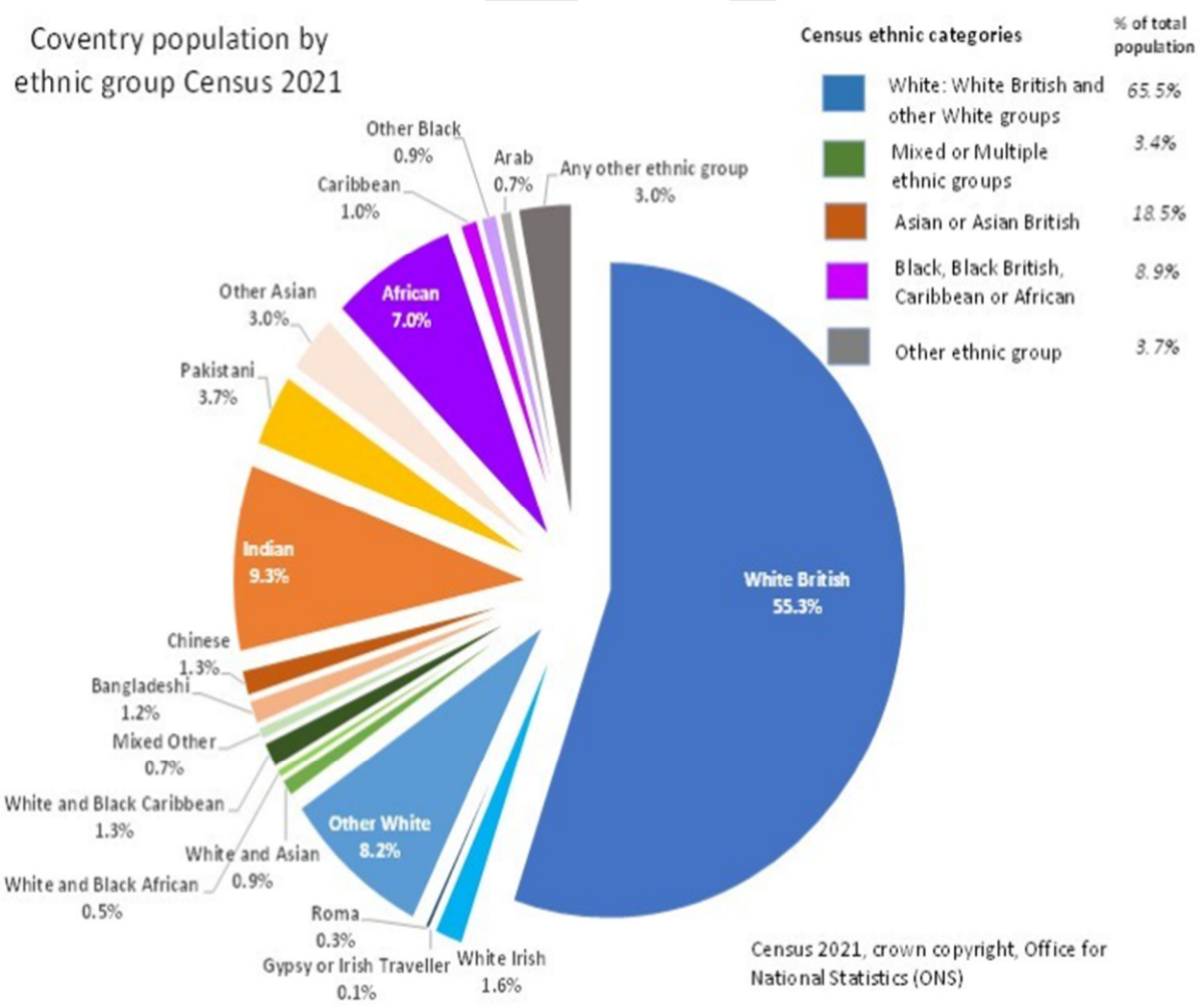
**What is the local picture? How does it compare?**

**Coventry is becoming increasingly diverse, with 45% of residents being part of a minority ethnic group in 2021, up from 33% in 2011.** This is above the national average (26%) and regional average (28%). We use 'minority ethnic' to refer to all ethnic groups except the White British group. 'Minority ethnic' includes white minorities, such as Gypsy, Roma, and Irish Traveller groups, as well as those who identify as White Irish and 'White Other' (often people who have moved here from other European countries).

Of the minority ethnic population, Asian Indian formed the largest group, making up 9% of Coventry's total population compared to 3% in England and 5% in the West Midlands.

Diversity varies across the city. Some neighbourhoods have very high proportions of minority ethnic residents. Foleshill West, Foleshill East, and Hillfields had the largest percentage of their population identifying as a minority ethnic (>80%).

The chart below illustrates the profile of Coventry population by ethnic group categories.



**Coventry's school population is more diverse than the population overall, indicating that the city will continue to become more diverse over time.**

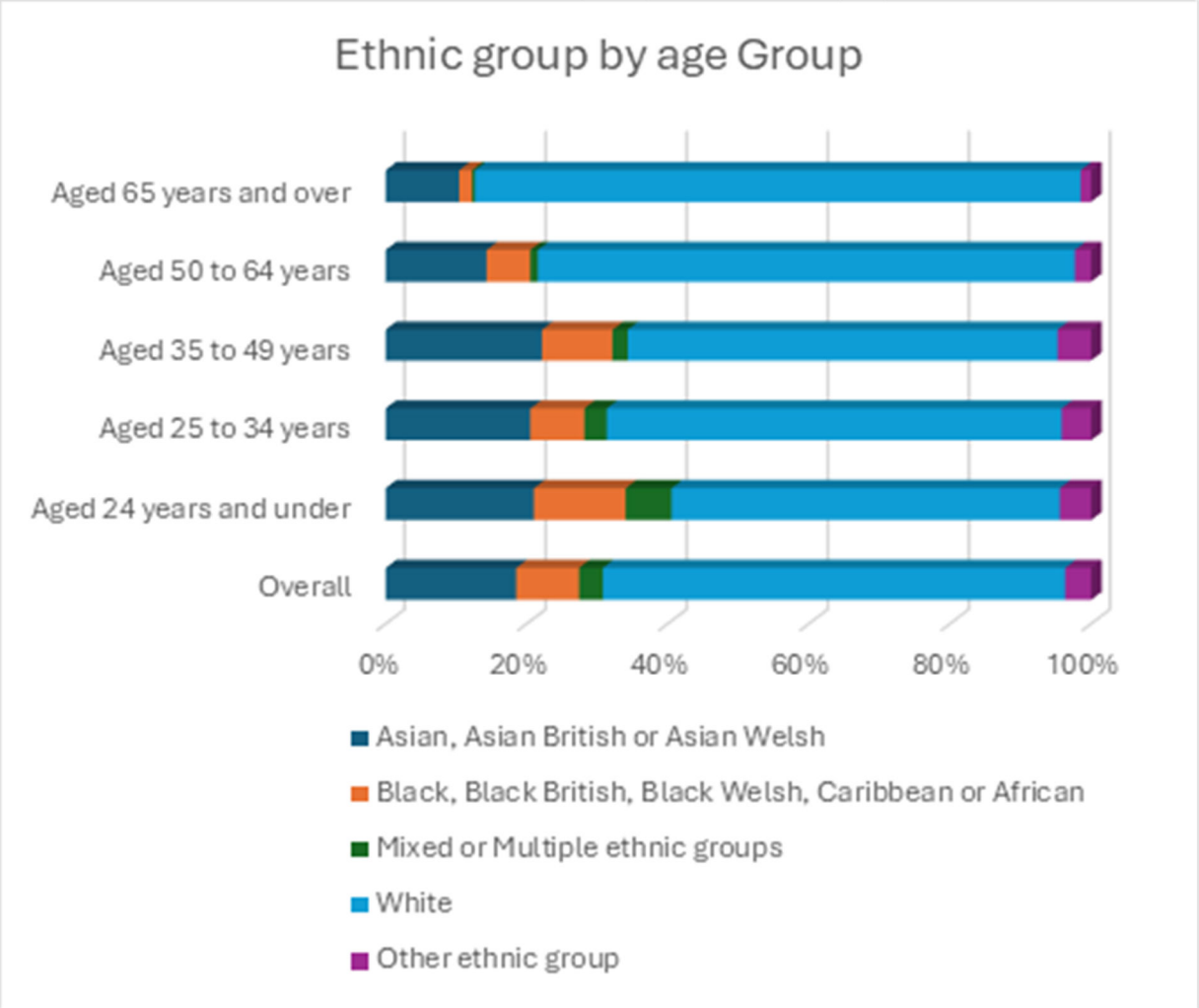
According to the 2024/25 School Census, 61.4% of pupils are from minority ethnic groups, compared with 54.3% in 2020/21.

The largest minority ethnic groups among pupils are:

- Black African (14.2%)
- Asian Indian (10.8%)
- White Other (9.7%)

Over the same period, the proportion of White British pupils has declined from 45.7% in 2020/21 to 38.6% in 2024/25, reflecting demographic change and migration.

**Coventry's population profile varies by age, with older residents more likely to be White British and younger residents more likely to belong to other minority ethnic groups.**




**Coventry has an increasing diversity of languages.** In 2021, 82.5% of residents reported English as their main language (down from 86.1% in 2011), compared with 90.8% nationally. More than 100 languages and dialects are spoken by residents

across the city. The most spoken languages after English include Polish (2.3%), Panjabi (2.3%) and Romanian (2.1%).

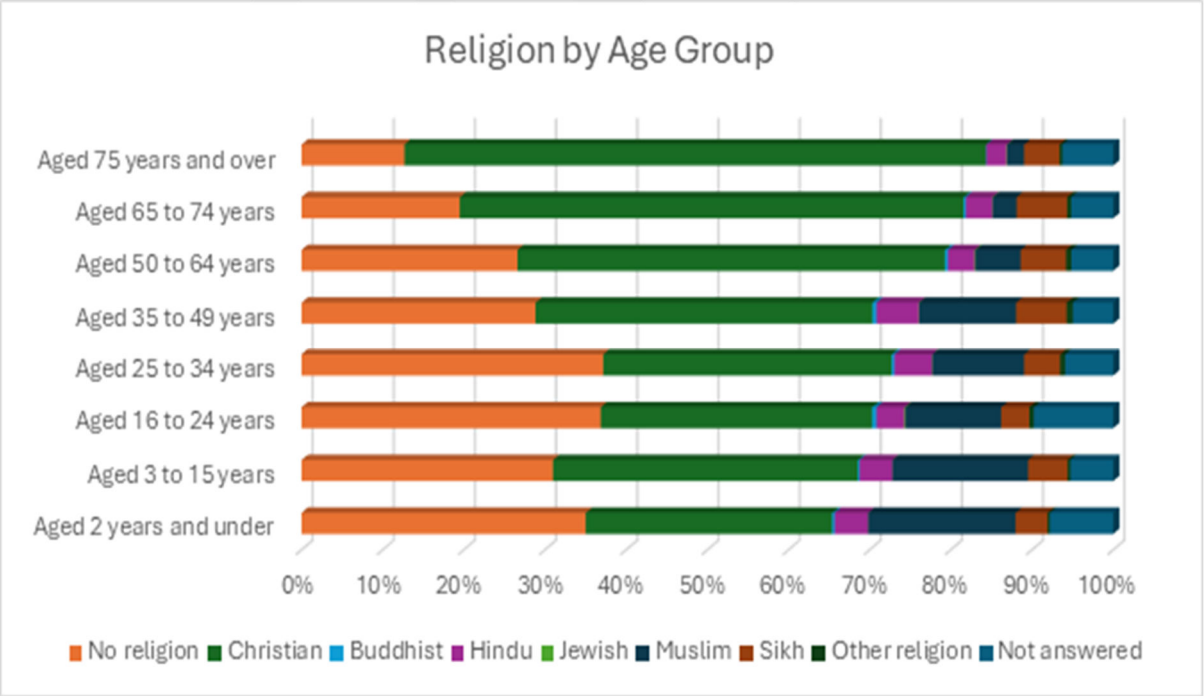
**Despite this growing diversity, English language proficiency among non-native speakers has improved**: in 2021,16.9% reported not speaking English well and 2.6% not at all, compared with 18.7% and 3.3% in 2011.

**According to the 2024/25 School Census, 36.9% of pupils speak English as an additional language, compared with 21.5% nationally.** While 62.6% of children speak English as their first language, down from 66.3% in 2021, the majority of multilingual pupils are able to speak English well or fluently.

**Religious affiliation provides another perspective on Coventry's diversity, with a notable increase in residents reporting no religion.**
**In 2021**:

- **44% of residents identified as Christian**
- **30% reported no religion**
- **10% identified as Muslim**
- **5% identified as Sikh**
- **4% identified as Hindu**

The proportion reporting no religion has increased significantly since 2011 (23%), particularly among younger residents. Younger residents are more likely to report no religious affiliation, while older residents are more likely to identify as Christian. These patterns reflect changing social attitudes and generational differences in religious identity.



## MIGRATION & NEWLY ARRIVED COMMUNITIES

**Newly arrived communities form an increasingly important part of Coventry's population.** According to the Office for National Statistics, between 2021 and 2024, most of the net migration to the UK was driven by people coming for work or study. The Coventry Director of Public Health annual report for 2024 explores in depth the complex social, economic, and global factors influencing migration to Coventry and the health and wellbeing of the city's migrant communities.

**According to the 2021 Census, 27.9% of Coventry residents were born outside the UK.** The most common countries of birth outside the UK are:

- **India (4.5%)**
- **Poland (2.6%)**
- **Romania (2.4%)**

**In 2024, the number of people moving to the UK for work or study declined nationally, though remained well above pre-2021 levels. Local data indicates a similar trend in Coventry**. More recent national data indicates that the falling trend may have continued in 2025. Work-related migration was the main driver behind the significant increase in net migration between 2020 and 2023, reaching relatively high levels. While most recent arrivals have come for work or study, there have also been people arriving for humanitarian reasons.

National Insurance Number (NINo) registrations for overseas nationals in Coventry follow a clear trend, especially for people moving to the city for work. Registrations dropped to 3,097 in 2020/21 during the pandemic, after averaging around 8,500 per year in the previous five years. They then rose sharply to 12,008 in 2021/22 and peaked at 17,654 in 2022/23. Since then, numbers have fallen to 14,170 in 2023/24 and 9,467 in 2024/25 and slight increase of 9,808 as of December 2025 but they are still higher than before 2021.

Coventry has consistently had higher NINo registration rates than most other local authorities, and the recent increase has been larger than the overall increase across England. Comparing NINo registrations in 2022/23 and 2023/24 with estimates of around 22,000 people moving to Coventry from overseas each year (between 2021 and 2024) suggests that most migration to the city is for work.

**The nationality profile of Coventry's overseas workforce has also changed markedly.** For many years prior to 2019/20, people from EU countries, particularly people from Romania, made up a large portion of Coventry economic migrants. Since 2019/20 however, numbers from EU countries has fallen significantly. The largest increases in recent years have been amongst people from India; Nigeria; China and Pakistan. The changing profile of economic migrants in recent years should be considered so that any specific health needs can be provided for.

**Coventry has a long history of providing safety to those fleeing conflict and persecution.** Since 2014, the city has welcomed around 1,500 refugees through UK Government-funded resettlement programmes for vulnerable individuals fleeing

conflict in countries such as Afghanistan, Iraq, Sudan, and Syria - most recently with arrivals from Afghanistan.

In addition, as of March 2026, Coventry has welcomed approximately 746 people through the *Homes for Ukraine* scheme, with an estimated 380 residing in the city, though numbers fluctuate as individuals move between locations. Around 300 British Nationals Overseas ('BNOs') from Hong Kong have also settled in Coventry, though new arrivals from Hong Kong have slowed considerably.

As of March 2026, there were an estimated 1,712 asylum seekers receiving Home Office support living in Coventry - the 4th highest number of all local authorities. By September 2025, it is estimated that this figure has have fallen to around 1,600, yet Coventry continues to have the highest proportion of asylum seekers per capita in the West Midlands region. However, the actual number of asylum seekers residing in Coventry is a transient figure, due to the fluid and changing nature of this population.

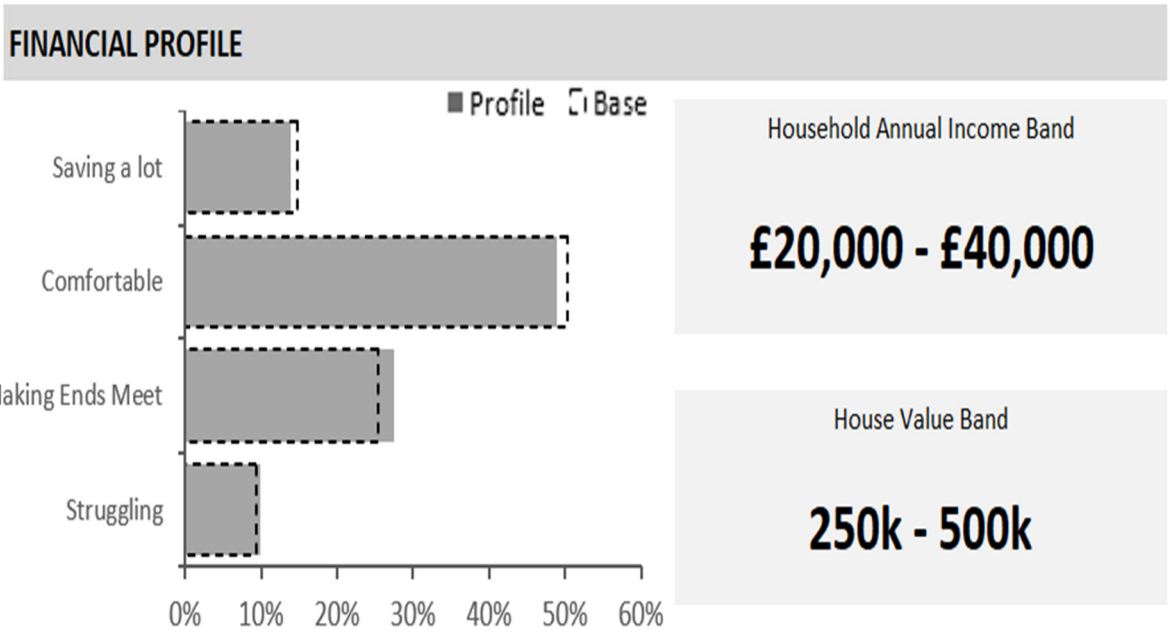
**These newly arrived communities contribute to the city's economic growth, cultural diversity and workforce, while also highlighting the importance of accessible services and support networks**.

## SOCIOECONOMIC PROFILE (ACORN)

**Geodemographic analysis using the Acorn tool provides insight into the social and economic characteristics of Coventry households.**

Compared with the UK overall, Coventry households are:

- less likely to be financially comfortable
- more likely to be making ends meet or experiencing financial pressure



The top 3 Acorn Groups in the profile are

- Younger working families with average incomes, living in socially rented houses (4.M.Family Renters)
- Younger families struggling on low incomes in rented terraces (5.R. Hard-up Households)
- Students and young adults starting out, privately renting in house shares (5.P. Tenant Living)

These groups reflect Coventry's relatively high proportion of renting households, younger adults and families with moderate incomes.

Groups with smaller proportions in the city but exceptional compared to the UK include

- Single people across all ages, often living in high rise estates (6.U. Challenging Circumstances)
- Secure older adults in semi-detached houses (4.L. Traditional Homeowners)
- Young families and students in ethnically diverse urban centres (4.N. Urban Diversity)

These patterns help explain some of the social and health inequalities observed across the city.

## NEIGHBOURHOOD INCLUSION & PERCEPTION

**Community relationships and social connections are important determinants of health and wellbeing.**

**The Coventry Household Survey 2024/25 found that 61% of residents feel a strong sense of belonging to their local area, an increase from 54% in 2022.** Those in Earlsdon (78%), Bablake (76%) and Cheylesmore (73%) wards are significantly more likely to have a strong sense of belonging at neighbourhood level.

62% of residents report a strong sense of belonging to Coventry as a whole. Those in Lower Stoke (76%), Sherbourne (75%), Upper Stoke (75%) and St. Michael's (74%) wards are significantly more likely to have a strong sense of belonging to Coventry as an area overall. This highlights a growing sense of civic pride and local connection among residents across Coventry.

Around 65% of residents agreed that people from different backgrounds get along well in their area, reflecting generally positive community relationships. Data from the Community Life Survey indicates that **28% of Coventry residents say they trust many of their neighbours**. **This is well below the national average of 41%.** Building trust and mutual understanding at neighbourhood level is essential for strengthening community resilience, particularly in communities experiencing rapid population turnover.

**Despite strong feelings of belonging, residents are less likely to participate in community activities**. In the Coventry Household Survey:

- **36% of residents said they would be likely to get involved in improving their local community**

- **64% said they would be unlikely to participate.**

This represents a decline from earlier surveys and suggests a gap between **feeling connected to communities and actively participating in them**. Barriers may include:

- time pressures
- limited awareness of opportunities
- lack of accessible community spaces.

Social connections play an important role in supporting wellbeing. According to the Community Life Survey, **9% of adults in Coventry report feeling lonely often or always**, slightly higher than the **England average of 7%**.

Most residents report having people they can rely on for support, although levels of social support are **slightly lower than national averages**.

Groups more likely to experience weaker support networks include:

- younger adults
- men
- residents in more deprived neighbourhoods.

Loneliness and social isolation was identified as a strategic priority in Coventry's Health and Wellbeing Strategy 2023-26. Interventions include Connecting for Good and Chatty Cafes, as well as community-led projects such as Moat House Community Trust and Operation Shield. Libraries, creative networks, and groups such as Grapevine's Kindness Group play an important role in fostering social connections. Strengthening community infrastructure and early help services remains vital, alongside targeted support for groups at higher risk of loneliness, including disabled adults, younger people, and some minority ethnic communities.

Ongoing monitoring and evaluation will ensure these initiatives reduce pressure on health services and build community resilience.

**Coventry residents report lower levels of collective action and volunteering than national averages, though they show a strong desire to influence local decisions.** According to the Community Life Survey 2023/24:

- 46% of residents agreed that people in their neighbourhood "pull together to improve the area," below the national average of 56%.
- However, 25% felt they could influence local decisions, slightly *above* the England average of 23%.
- 33% volunteered at least once a month, broadly matching national levels, while 52% volunteered at least once in the past year.
- 50% of respondents said it is important to influence local decisions, and 31% would like to be more involved, higher than the national average of 28%.

This indicates a strong appetite for people to be more involved in their community, even if opportunities to participate are unevenly distributed. Developing inclusive, co-produced approaches to decision making could help harness this enthusiasm and ensure that all residents have a voice in shaping their city's future.

## CHAPTER 2 - PROSPECTS

**Key Messages**

- Early life experiences strongly influence lifelong health, wellbeing and opportunity.
- Early antenatal engagement has declined, but smoking in pregnancy has fallen and breastfeeding rates are above average.
- Infant mortality, stillbirth and premature birth rates remain higher than national levels, with significant inequalities.
- School readiness and early years outcomes lag behind national averages, particularly for disadvantaged children and those with SEND.
- SEND numbers and free school meal eligibility continue to rise.
- Educational attainment is improving but remains below national averages, with persistent attainment gaps.
- School absence, exclusions and suspensions are increasing.
- Mental health demand among children and young people continues to grow.
- Risky behaviours have declined, but smoking, sexual health and teenage conception rates remain concerns.
- Youth justice entry rates remain comparatively low.
- Economic growth has not been felt equally, with falling employment, rising unemployment and ethnic inequalities.
- Child poverty, fuel poverty, deprivation and digital exclusion remain key challenges.

**What this means for Coventry**

Prospects across the life course are a key determinant of health and wellbeing. The opportunities people have in childhood and early adulthood including education, employment, income, housing, and digital access shape their long-term health outcomes and quality of life. Good prospects support financial security, social participation, and independence, while limited opportunities increase the risk of poverty, poor health, and social exclusion.

Early childhood represents one of the most important opportunities to improve long-term health and wellbeing.

Coventry shows strengths in several areas, including:

- reductions in smoking during pregnancy
- improving breastfeeding rates
- strong developmental outcomes at age two
- reducing rates of A&E attendances, and
- improvements in oral health.

However, challenges remain:

- lower engagement with some early year's health services
- declining childcare participation
- lower development outcomes at age five
- inequalities linked to deprivation, ethnicity and special educational needs

- higher infant mortality and prematurity rates

Addressing these issues will require continued collaboration between health services, early years education, community organisations and families. Strengthening support during pregnancy and the early years remains one of the most effective ways to improve life chances and reduce health inequalities across Coventry's population.

Increasing numbers of pupils with Special Educational Needs and Disabilities (SEND) are placing growing pressure on assessment processes and support services. This is leading to delays and potential inequalities in access to timely support.

A persistent attainment gap between the most and least disadvantaged children continues to impact overall educational standards across the city. Addressing low school attendance, reducing rates of suspensions and permanent exclusions would help improve standards.

Many indicators show that the economy in Coventry is resilient and often succeeding compared to similar Cities. However, the benefits flowing from this are not evenly distributed across our communities and this compounds the health inequalities seen across Coventry.

Cost of living pressures are being felt across the city and this will impact the health and wellbeing of citizens. Fuel poverty is a factor for many people in deprived circumstances and cold, damp, difficult and expensive-to-heat homes will have a detrimental effect on those living in them.

Digital connectivity overall is good in Coventry but the benefits of this are not evenly distributed across our communities, with digital exclusion affecting particular groups who could benefit most from digital services.

## BEST START IN LIFE

**Why this is important?**

The earliest years of life are critical for human development. Experiences during pregnancy, infancy and early childhood shape:

- physical health
- brain development
- learning ability
- emotional wellbeing
- long-term social and economic outcomes

Health inequalities often begin during pregnancy and early childhood and can persist throughout life. Improving outcomes during this stage is therefore one of the most effective ways to reduce health inequalities and improve population wellbeing.

*"Giving every child the best start in life is crucial for securing health and reducing health inequalities across the life course. The foundations for virtually every aspect of human development – physical, intellectual, and emotional – are laid in early childhood. What happens during these early years, starting in the womb, has life-long effects on many aspects of health and wellbeing".* - Sir Michael Marmot

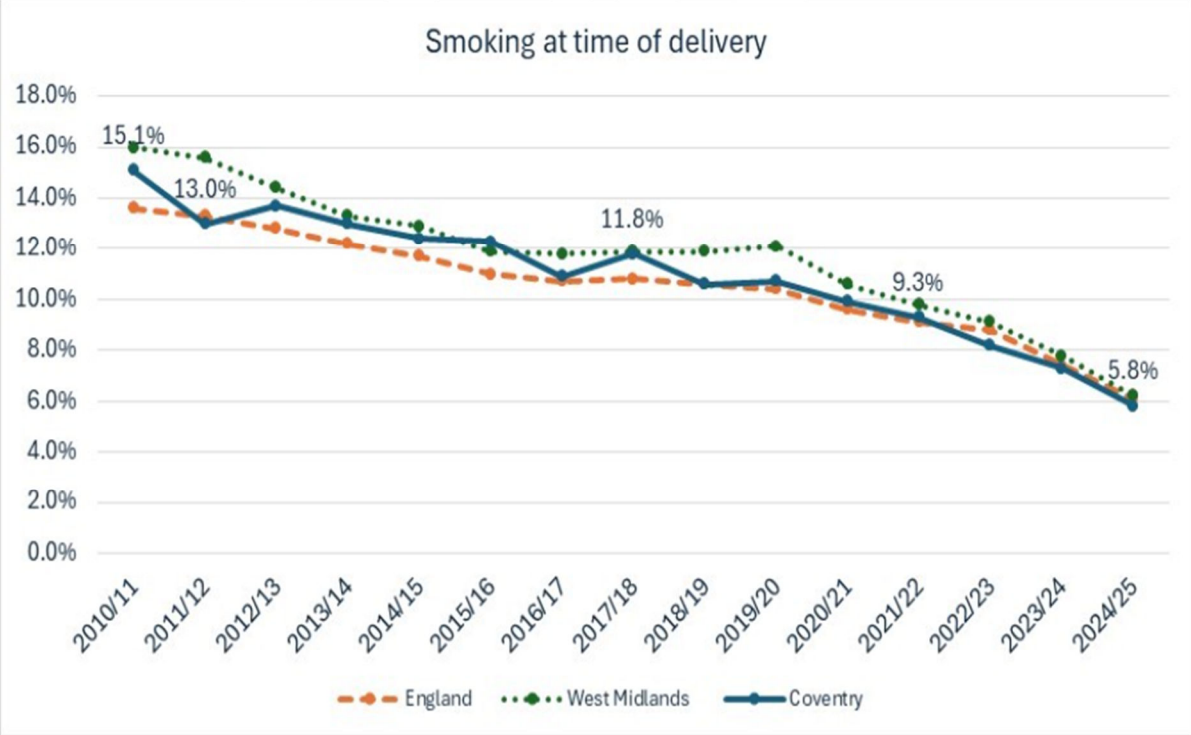
**What is the local picture? How does it compare?**

The sections below outline the local picture relating to the Best Start in Life.

## PREGNANCY & MATERNITY

**Since 2019/20, Coventry has seen a decline in early antenatal bookings, remaining below regional and national levels.** Early antenatal booking allows timely access to screening, advice, scans and specialist support, all important for identifying health risks and supporting maternal wellbeing. In Coventry, early antenatal booking rates have declined in recent years, from 63% of pregnant Coventry women having their first appointment within 10 weeks in 2019/20, to 56% in 2023/24, lower than the national average of 64%.

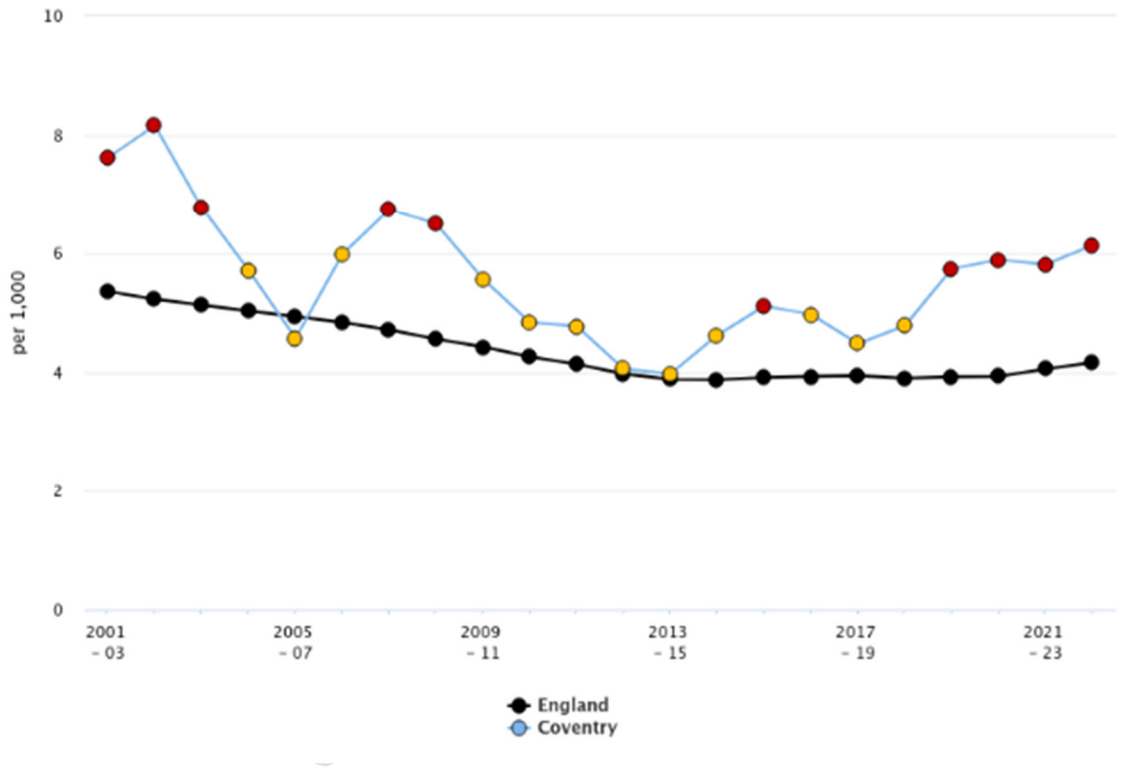
**Smoking at time of delivery has seen a continued downward trend**. The rate has fallen significantly from 15.1% in 2010/11 to 5.8% in 2024/25. Coventry's rate is now lower than both the England average (6.1%) and the regional average (6.6%). This reflects successful smoking cessation support provided through maternity services.



**Breastfeeding is more prevalent in Coventry than average. In 2023/24, 75.8% of Coventry newborns received breast milk as their first feed, higher than both regional (69.7%) and national averages (71.9%).** Higher rates in Coventry are sustained. 60.7% of infants were breastfed (either fully or partially) at 6 to 8 weeks in 2024/25 compared to England's rate of 55.6%. Breastfeeding rates have improved in recent years. The rate at 6 to 8 weeks, now 6 in 10 babies (60.7%), has increased from 48.3% in 2017/18.

**Infant mortality in Coventry is higher than the national and regional average and is rising.** Infant mortality measures deaths among babies under one year of age and is widely used as an indicator of population health. The West Midlands has the highest infant mortality in England, and Coventry has the 5th highest rate in the region, significantly above the England average and higher than similar areas. Between 2022 and 2024, there were 75 infant deaths in Coventry, equivalent to a rate of 6.1 per 1,000 live births. The Infant Mortality rate for England was 4.2.

Infant mortality Rate per 1,000 live births for England and Coventry




Coventry's stillbirth rate is also higher than national and regional averages and has been rising since 2017-19.

**Between 2022 and 2024, Coventry recorded 1,082 premature births, a rate of 88.0 per 1,000 births, higher than both England (79.6) and the West Midlands (83.2).** Prematurity is a big factor determining low birth weight. While overall low birth weight rates are stable, extreme prematurity and extremely low birth weight births are increasing; and extreme prematurity is a significant factor in Infant Mortality.

**Health visitors play an important role in monitoring child development and supporting families as part of the Healthy Child Programme delivered through NHS England. Completion of the New Birth Visit within 14 days is increasing again since a low of 71% in 2023/24, to 82% in 2024/25,** remaining below the England average (85%).

**The proportion of infants receiving the 6–8-week review is increasing but remains below the national average.** This review provides an opportunity to assess breastfeeding, maternal mental health, postnatal and infant checks, and connecting families to support and vaccination services. Coverage has increased to 83% in 2024/25, narrowing the gap with national (85%) and regional averages (87%). Coverage of the 12-month developmental review has also declined slightly in recent years, with Coventry performing slightly below national and regional levels.

## DEVELOPMENT IN THE EARLY YEARS

**Coventry has a lower coverage rate for the mandated 2-2½-year developmental review compared to both national and regional averages.** In 2024/25, coverage in Coventry was lower than national and regional averages:

| Area | Coverage |
|---|---|
| Coventry | 74.8% |
| West Midlands | 77.9% |
| England | 80.8% |

Among children who did receive the review in 2024/25, 94.6% completed the Ages and Stages Questionnaire 3 (ASQ-3), measuring key developmental domains, which is slightly higher than the national rate of 93.9% and comparable to the West Midlands at 94.3%.

**Coventry performs well in terms of developmental outcomes at age 2-2½-years.** At this stage of development, a higher proportion of toddlers in Coventry achieve a “good” level of development compared to national and regional averages.

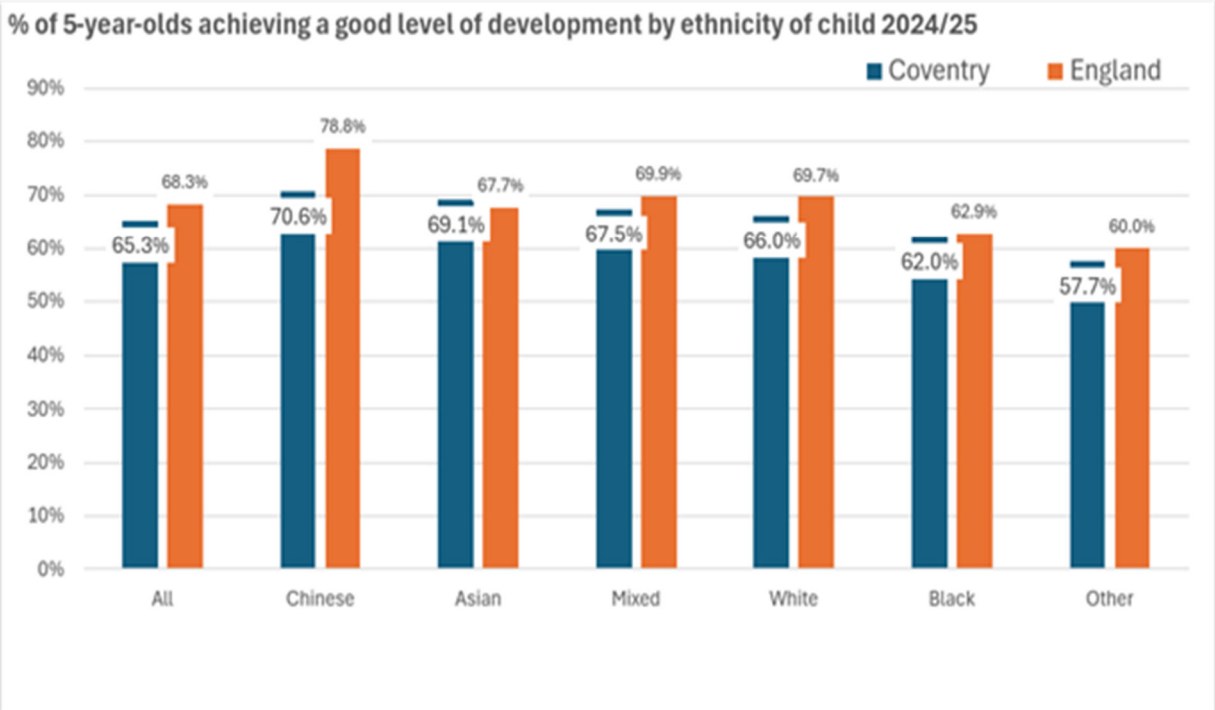
**In Coventry, uptake of funded early years childcare for 2, 3 and 4-year-olds has fallen.** In 2025, uptake of free early education for 2-year-olds dropped to 60.0%, below the national (65.2%) and regional (62.4%) averages. The decline is partly linked to misclassification between children eligible for both Families Receiving Additional Support entitlement (FRAS) and the new working-parent entitlement. Uptake for 3- and 4-year-olds also fell to 86.2%, below the national (93.1%) and regional (94.5%) average, continuing a decline from its 2019 peak of 97.6%.

**Fewer children in Coventry reach a good level of development (GLD) by age five** compared to national and regional averages. In 2024/25, 65.3% achieved GLD in Coventry compared to 68.3% England and 66.9% West Midlands[1]. Inequalities in reaching GLD within the city have already established themselves by the age of 5.

[1] measured using Early Years Foundation Stage (EYFS)

50.5% of children eligible for Free School Meals achieve GLD compared with 69.3% of those not eligible.

**There are varying levels of early years attainment across ethnic groups, with most performing below national averages.** Early years attainment in Coventry varies by ethnicity, with most groups performing below national levels. Children from 'Black' and 'Other' groups have lower outcomes locally. While most groups do worse than their national peers, 'Asian' children perform above the national average, and 'Chinese' children do relatively well in Coventry but below their national counterparts.




**By Key Stage 1, a lower-than-average proportion of Coventry pupils are at the expected standard, and inequalities are presenting.**
In 2024/25 in the statutory phonics screening check at the end of Year 1:

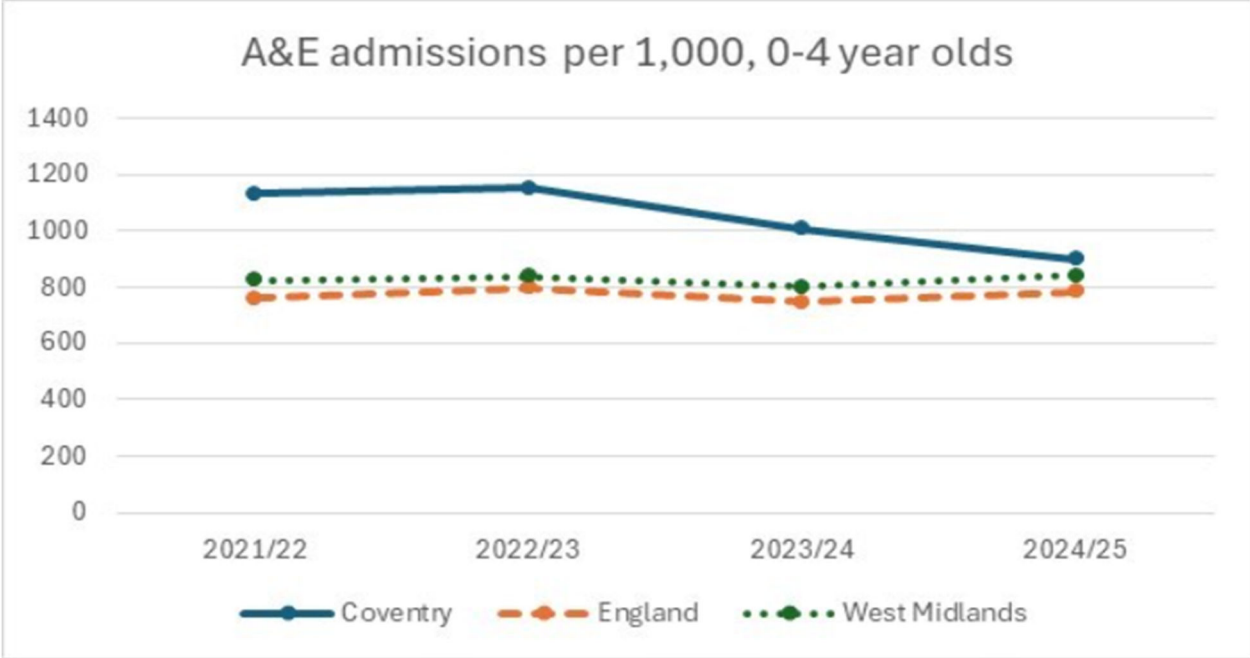
| Area | Achieving expected standard |
|---|---|
| Coventry | 77% |
| West Midlands | 79% |
| England | 80% |

By Year 2, 86% of Coventry pupils meet the standard, compared with 89% nationally. Large gaps exist for children with:

- Free School Meal eligibility (79%) (England 81%)
- Special Educational Needs (SEN) Support (69%) (England 71%)
- SEN: Education, Health and Care (EHC) Plan (15%) (England 31%)

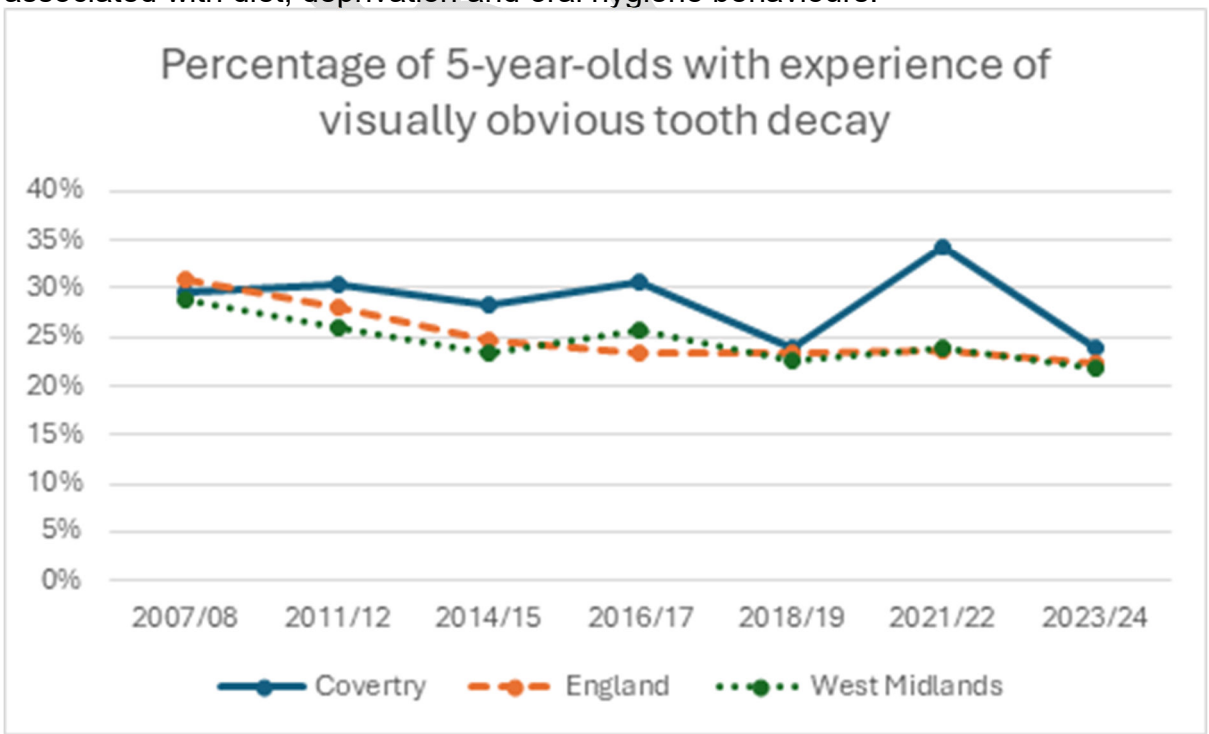
**Coventry has higher rates of A&E attendance among children aged 0–4 than national and regional averages, although the rate has reduced in recent years, closing the gap.** A&E attendances for children under five are often preventable and

are usually caused by accidental injuries (such as playground incidents) or by illnesses considered minor enough to be treated in the primary care setting by a General Practitioner.




**Data Source:** Fingertips | Department of Health and Social Care

**Oral health is an important indicator of child wellbeing. Data from the Office for Health Improvement and Disparities shows Coventry has historically had higher prevalence of tooth decay among children, although the gap has closed in most recent figures**. Coventry has lower hospital admission rates for dental decay compared with England and the West Midlands. Tooth decay remains strongly associated with diet, deprivation and oral hygiene behaviours.




**Data Source:** Fingertips | Department of Health and Social Care

## EDUCATION & SKILLS

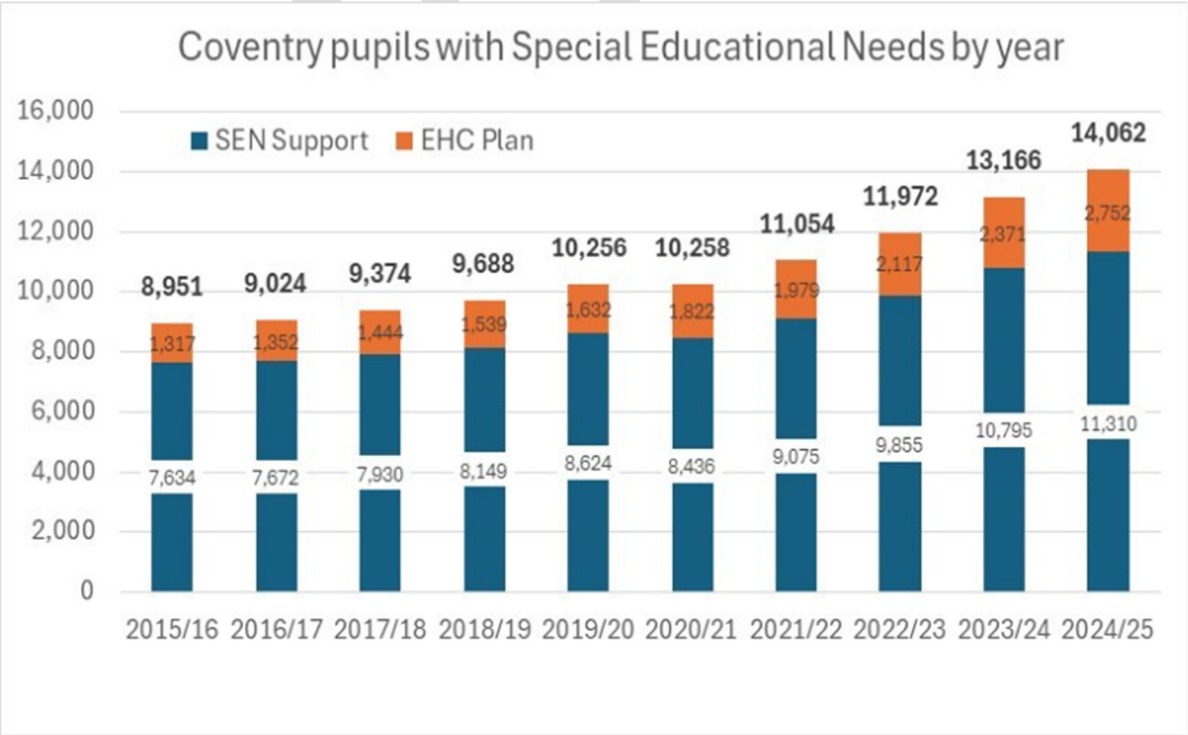
**Why is this important?**

Poor work chances, social isolation, and difficulties with mental and physical health are just a few of the social disadvantages that people could face later in life because of low educational attainment and low expectations and aspirations. By supporting high levels of educational attainment and boosting expectations these barriers can be removed so that children and young people achieve their full potential and promote social mobility.

**What is the local picture? How does it compare?**

During the COVID-19 pandemic, education was significantly disrupted impacting on school readiness and attainment. This should be considered when reviewing attainment statistics between 2019-2022.

**The number of pupils with Special Educational Needs (SEN) in Coventry has continued to rise, reflecting a similar trend across England.** In 2024/25, there were 14,062 pupils with SEN in Coventry, representing 22.1% of all pupils, higher than the national average of 19.6%. SEN is categorised into two groups: pupils with a Statement or an Education, Health and Care (EHC) plan, and those receiving SEN support. Between 2015/16 and 2024/25, the proportion of all Coventry pupils who have an EHC plan increased from 2.3% to 4.3%, while those receiving SEN support rose from 13.3% to 17.7%. These trends are broadly in line with national trends, although in Coventry a lower proportion have an EHC plan (England 5.3%) and more have SEN support (England 14.2%).



The most notable increases since 2015/16 have been among pupils with 'Speech, Language and Communication Needs' (SLCN) (from 1,679 to 3,803), 'Autistic Spectrum Disorder '(from 1,137 to 2,879), and 'Social, Emotional and Mental Health needs' (from 1,323 to 1,958).

**SEN numbers have grown in both mainstream and special schools, but the increase has been a little more pronounced in mainstream settings, consistent with national patterns.** In 2024/25, 89.9% of Coventry's SEN pupils attended mainstream schools. All pupils receiving SEN support were in mainstream schools, while those with an EHC plan were split between mainstream and special schools. The proportion of pupils with an EHC plan that attend mainstream schools has increased from just over a third in 2015/16 (36.6%) to just over half in 2024/25 (51.5%).

**Eligibility for free school meals in Coventry continues to rise, reaching 28% across all school years in 2025**, amounting to a total of 17,221 Coventry pupils across all phases of education. Both number of pupils, and proportion of all pupils, is increasing, as it is both nationally and regionally. Coventry's rate has remained higher than the England rate, but lower than West Midlands regional rate.

| Percentage of pupils for Free School Meals Eligibility (2021 -2025) | | | |
|---|---|---|---|
| **Year** | **Coventry** | **England** | **West Midlands** |
| **2021** | 23.0% | 20.8% | 24.5% |
| **2022** | 24.8% | 22.5% | 26.5% |
| **2023** | 26.3% | 23.8% | 27.9% |
| **2024** | 26.9% | 24.6% | 28.9% |
| **2025** | 28.0% | 25.7% | 30.9% |

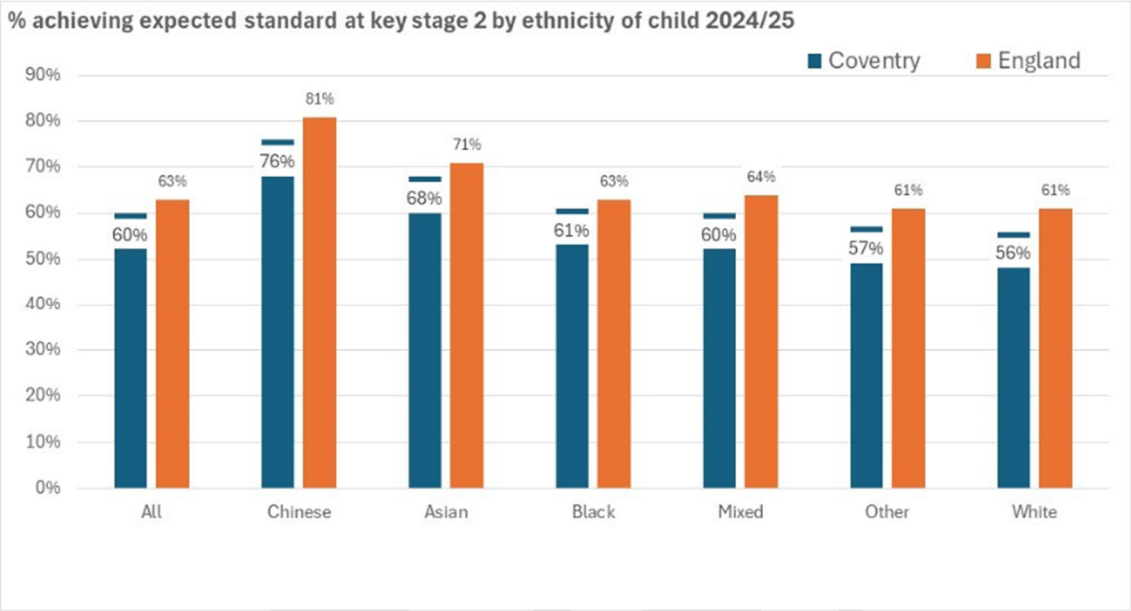
**In 2025, 60% of Coventry pupils met the expected standard in reading, writing, and maths at the end of key stage 2, remaining lower than England overall (63%).** This has improved since 2022 when 54% met the expected standard in Coventry, compared to 59% nationally. The Coventry rate has remained slightly below the average for similar areas (2025 statistical neighbour average 61%).

**There are many factors that impact attainment and there are inequalities between some groups of pupils, although the trend of improvement has been seen amongst most groups.** In 2025, 45% of disadvantaged pupils[2] achieved the expected standard in reading, writing, and maths, compared with 67% of non-disadvantaged pupils. The trend of gradual improvement since 2022 has been seen amongst both groups of pupils to a similar extent so the gap has remained the same (2022: disadvantaged pupils 40%; non-disadvantaged pupils 61%).

[2] Pupils are defined as disadvantaged if they are known to have been eligible for free school meals at any point in the past six years (from year 6 to year 11), if they are recorded as having been looked after for at least one day or if they are recorded as having been adopted from care.

Attainment among pupils receiving SEN support has also improved from 22% in 2022 to 28% achieving the expected standard at key stage 2 in 2025, similar to the England average, 29%. However, it remains significantly lower than non-SEN pupils in Coventry at 73%. In 2025 only 2% of pupils with an EHC plan achieved the standard.

**There are differences in the proportion achieving the expected standard at key stage 2 between children from different ethnic groups.** Attainment rates across all ethnic groups are below their peers across England overall.




Rates have improved as a trend since 2022 across most ethnic groups, but some groups have improved by more than others. The volatility in the rates amongst 'Chinese' and 'Other' ethnic groups may be related to being based on relatively small numbers of pupils in any particular year.

| % achieving expected standard at key stage 2 by ethnicity of child 2022 - 2025 | | | | |
|---|---|---|---|---|
| Year | 2022 | 2023 | 2024 | 2025 |
| All pupils | 54% | 56% | 57% | 60% |
| | | | | |
| Chinese | 78% | 60% | 62% | 76% |
| Asian | 66% | 67% | 65% | 68% |
| Black | 52% | 59% | 58% | 61% |
| Mixed | 47% | 51% | 55% | 60% |
| White | 51% | 51% | 54% | 56% |
| Other | 48% | 56% | 61% | 53% |

**The number of pupils achieving at least a 'standard pass' (grades 9-4) in English and Maths at the end of key stage 4 is below the national average**. In 2025, 61.1% of Coventry students received a "standard pass," compared to 64.8%

across England overall. However, Coventry's rate is slightly better than the average amongst Coventry's statistical neighbour areas, 59.9%

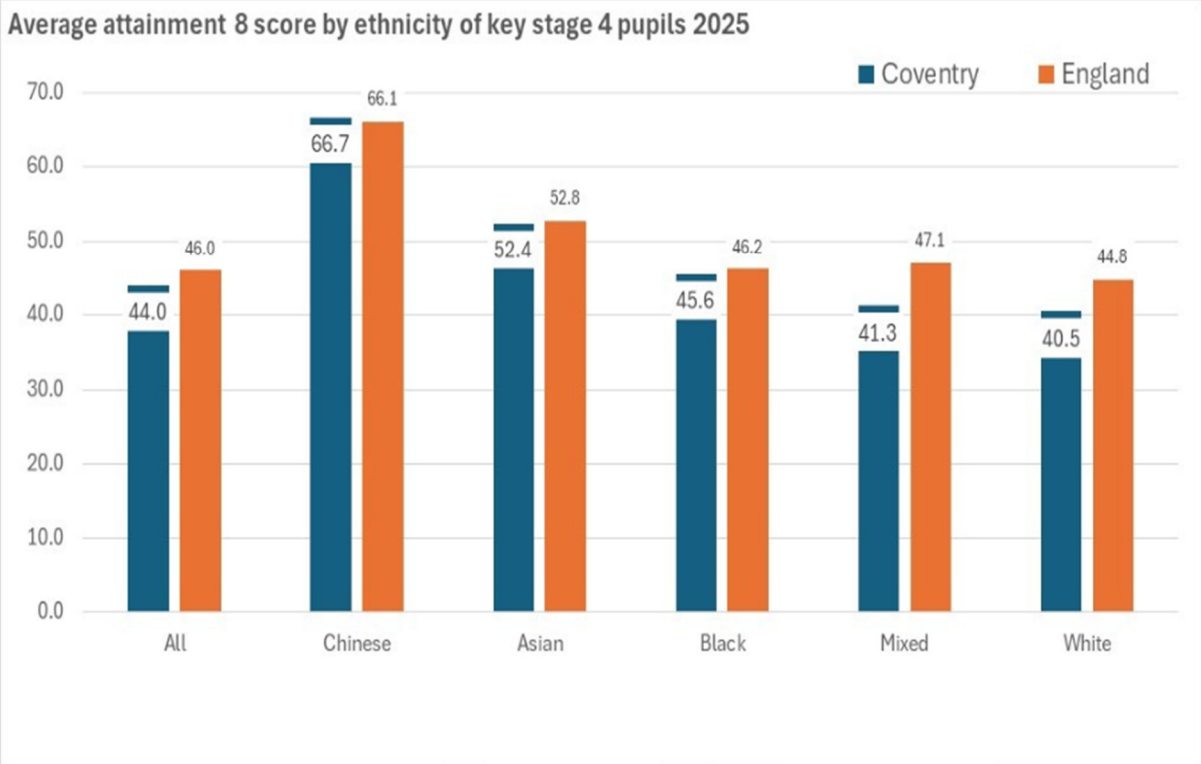
**Attainment 8 scores amongst Coventry pupils are also lower than the national average.** The average attainment 8 score[3] for pupils in Coventry was 44.0 in 2025, compared to 46.0 for England overall, but slightly higher than the statistical neighbours' average, 43.3.

**There are inequalities in attainment in key stage 4.** In 2025, overall attainment levels for disadvantaged pupils are lower, with an average attainment 8 score of 34.6 compared to 48.5 amongst non-disadvantaged pupils in Coventry (England 50.4). The average score amongst Coventry disadvantaged pupils is similar to the national average for this group (England 34.9).

| Average Attainment 8 score per pupil at KS4 - Vulnerable groups 2025 | | |
|---|---|---|
| **Vulnerable groups** | **Coventry** | **England** |
| **Disadvantaged** | 34.6 | 34.9 |
| **Pupils with an Education, Health and Care (EHC) Plan** | 10.4 | 14.8 |
| **Pupils with Special Educational Needs (SEN) Support** | 33.5 | 33.8 |
| **Children in Care** | 18.0 | 17.3 |

**The are notable differences between the average Attainment 8 scores of pupils by ethnic group.** Pupils from 'White' and 'Mixed' ethnic groups have the lowest average scores, and all ethnic groups perform below the England average.

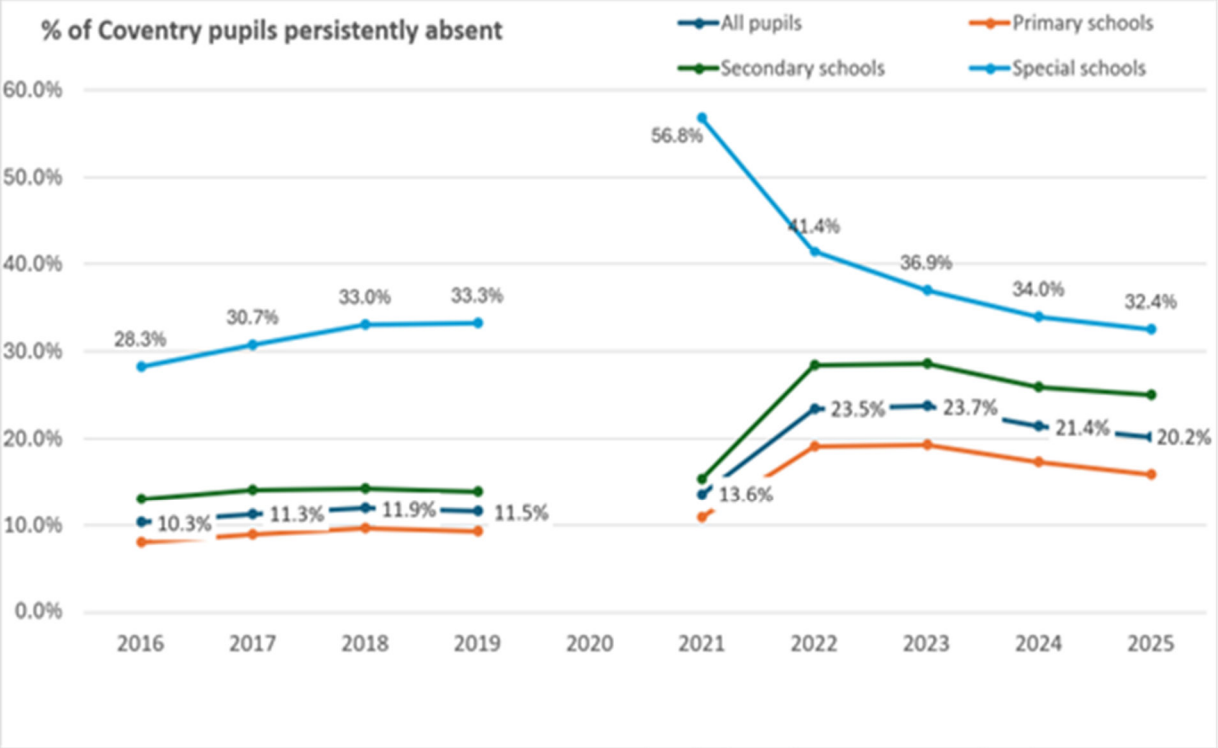
[3] an average score used to measure an individual student's progress across their 8 best performing subjects taken at GCSE level




**By Key Stage 5 (16- to 18-year-old) attainment is slightly below the national average, but in line with other areas similar to Coventry.** Coventry's average point score in 2024 was 32.55, similar to our statistical neighbours, but below the national average which is 34.99.

**School attendance rates in Coventry have declined in recent years, following national patterns.** Total attendance fell from 95.2% in 2018/19 to 92.8% in 2024/25, with the sharpest drop during the 2021/22 academic year, coinciding with COVID-19 disruptions. In 2024/25, attendance stood at 94.4% in primary schools (England 94.8%), 91.0% in secondary schools (England 91.6%), and 88.6% in special schools (England 87.2%).

**Persistent absence (defined as missing 10% or more of sessions) remains a challenge.** In 2024/25 20.2%, or one-fifth of all pupils across all school phases, were persistently absent, higher than the national average of 18.1%. As with overall absence, persistent absence saw a sharp rise after the end of the lockdowns, but whilst rates have been gradually reducing since then, they have yet to return to pre-Covid levels.




**Absence levels are notably higher among vulnerable groups.** Pupils eligible for Free School Meals recorded an overall absence rate of 10.0% in 2024/25, almost double the rate of pupils not eligible at 5.4%, and persistent absence rates at 29.7% compared to 14.3% amongst non-eligible pupils. Pupils with Special Educational Needs also experience disproportionately high levels of absence. Among those with an Education, Health and Care (EHC) plan, overall absence reached 12.7%, while persistent absence was 34.3%. Rates were lower among pupils receiving SEN support (9.3% and 26.2%) but still significantly higher than those with no SEN (5.8% and 16.3%).

**In Coventry, both permanent exclusions and suspensions in schools have been increasing over recent years, following a sharp rise after the end of lockdowns; Coventry's trends have mirrored England.** In 2023/24 0.15% of all Coventry pupils were permanently excluded (England 0.13%), up from 0.03% in 2020/21. Exclusion rates are highest in secondary schools at 0.27% (England 0.25%). The number of suspensions amounted to 10.0% of all pupil enrolment (England 11.3%), up from 4.2% in 2020/21.

**Whilst a growing proportion of the city's residents are achieving qualifications, there are still many who have no qualifications.** In 2025, 45% of Coventry's working-age population was qualified to level 4 or above, which means they have a foundation degree or above; this rate is similar to the national average (England 48%). However, 11% of the city's working-age population has no qualifications at all, an estimated 27,300 residents aged 16-64, which is higher than the national average (England 6%). A lack of qualifications may make it more difficult for someone to find more fulfilling work in the city or reduce their chances of getting positions based in Coventry as the city's jobs become more competitive and demand higher-skilled workers.

**The English Indices of Deprivation 2025 (IoD) shows that many neighbourhoods in Coventry are amongst the most deprived in England when it comes to Education, Skills and Training.**

**Adult education offers opportunities across the city for adults to engage and learn.** In 2023-24, the Adult Education Service supported 4,062 adults and young people, resulting in 8,852 total enrolments across a broad range of programmes. Community Learning made up the largest share of enrolments at 49%, closely followed by Adult Skills at 47%.

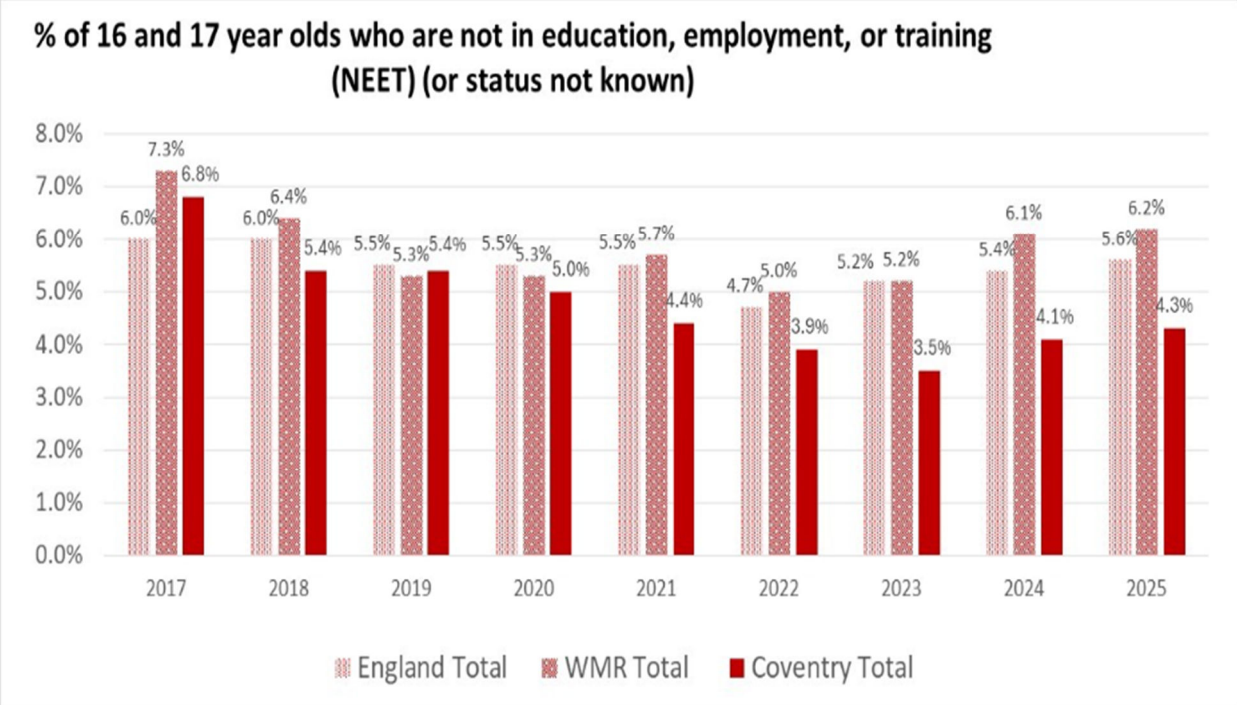
The learner profile demonstrates significant diversity and social impact. Nearly half of all learners (47%) were from minority ethnic groups, and 49% came from the lowest 30% of deprived areas nationally, underscoring the service's role in widening participation. Additionally, 18% of learners declared a learning difficulty and/or disability. Most learners were women (76%).

**Apprenticeship starts in Coventry for learners aged 19 to 25+ fell to 1,780 in 2024/25, down from 2,180 in 2023/24, the lowest level in five years.** This downward trend mirrors patterns seen across the West Midlands Combined Authority (WMCA). The rate for Coventry of apprenticeship starts is 749 per 100,000 residents, which is around the WMCA average, but notably lower than the 1,002 starts per 100,000 recorded in 2019/20.

| Apprenticeship starts between 2019 to 2025 (Coventry) | | | | | | |
|---|---|---|---|---|---|---|
| | **2019/2020** | **2020/2021** | **2021/2022** | **2022/2023** | **2023/2024** | **2024/25** |
| **Under 19** | 510 | 390 | 460 | 520 | 510 | 450 |
| **19 to 24** | 580 | 520 | 610 | 580 | 580 | 430 |
| **25+** | 1,170 | 1,100 | 1,100 | 1,160 | 1,080 | 900 |
| **Total** | **2,250** | **2,010** | **2,170** | **2,260** | **2,180** | **1,780** |

## YOUNG PEOPLE: NOT IN EDUCATION, EMPLOYMENT OR TRAINING, VULNERABLE & CHILDREN IN CARE, CARE LEAVERS & RISKY BEHAVIOURS

**In 2025, 4.3% of Coventry 16–17-year-olds were NEET (or activity not known), up from 3.5% in 2023 but still below regional and national averages.** Coventry's NEET rate has remained better than both England and West Midlands averages, but rates have started to increase. The rate is made up of young people confirmed as NEET, and those for whom activity is unknown. The Coventry rate is better than average because of a relatively low number with an unknown status; in 2025 3.6% of Coventry 16–17-year-olds were known to be NEET (England 3.4%; West Midlands 3.6%) and 0.7% had unknown status (England 2.2%; West Midlands 2.9%).



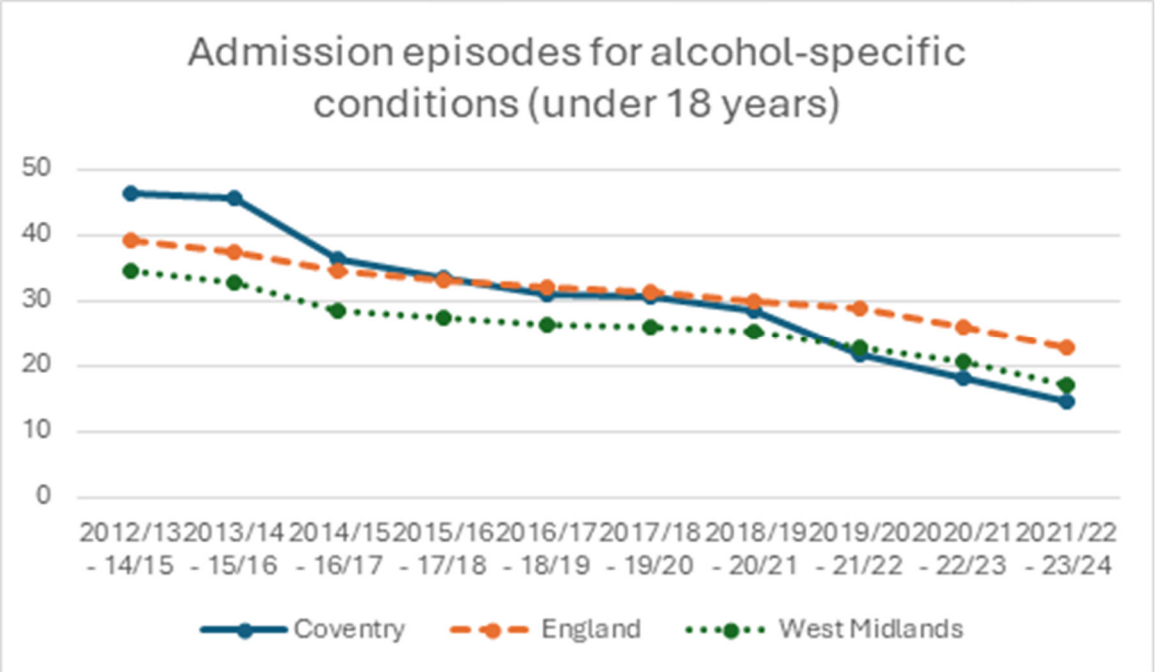

**Coventry hosts two large universities, resulting in a high proportion of economically inactive full-time students.** Census 2021 data shows 48.2% of Coventry 16-24s as inactive full-time students, versus 37.9% in England and 42.7% in the West Midlands mayoral authority area (WMCA). In 2021, excluding students, 70.3% of young people were employed, 12.4% unemployed, and 17.3% economically inactive. Employment is slightly below the England average (74.0%) but above the WMCA average (64.8%), with unemployment and inactivity for other reasons lower in Coventry than across the WMCA area. However, young people are more likely to be unemployed than older age groups in Coventry.

**Coventry Care Leavers exceed national averages in Education, Employment and Training.** Engagement in education, employment or training (EET) is strong among younger Care Leavers. 65% of those aged 16 to 18 are currently in EET. Across the wider Care Leaver cohort, 57% were in EET in 2024, an improvement from 55% in 2023. Coventry performs better than national and regional comparators, exceeding the England average of 54%, as well as the averages for statistical neighbours and the West Midlands, both at 52%.

**Accommodation outcomes for Care Leavers remain positive overall. Among those aged 19 to 21, 97% are living in suitable accommodation**. When looking at all Care Leavers, 86% were in suitable accommodation in 2024. This represents a slight decrease from 87% in 2023 and is marginally below the averages for England, the West Midlands and Coventry's statistical neighbours, which all sit around 87% to 88%.

**Overall, trends show a general decline in traditional risky behaviours among adolescents, including smoking, drinking, and drug use[4].** A new set of emerging risks is becoming increasingly prevalent - vaping and the use of novel psychoactive substances such as nitrous oxide are rising, and young people are increasingly exposed to a range of online harms. However, these trends are largely based on survey-data from young people attending school and therefore may under-report usage and will not represent certain groups, for example those excluded from school or home educated. Furthermore, these data are not available at a local level, although we have no reason to believe trends in Coventry are different to those seen nationally.

**Alcohol consumption among young people in Coventry appears lower overall than the national average.** When school pupils across the country were asked if they had ever had an alcoholic drink, 52.4% of Coventry pupils had, compared with 62.4% in England. However, this is self-reported, survey data and so may be biased. Coventry does have lower than the national average hospital admissions for alcohol-specific conditions among under-18s.



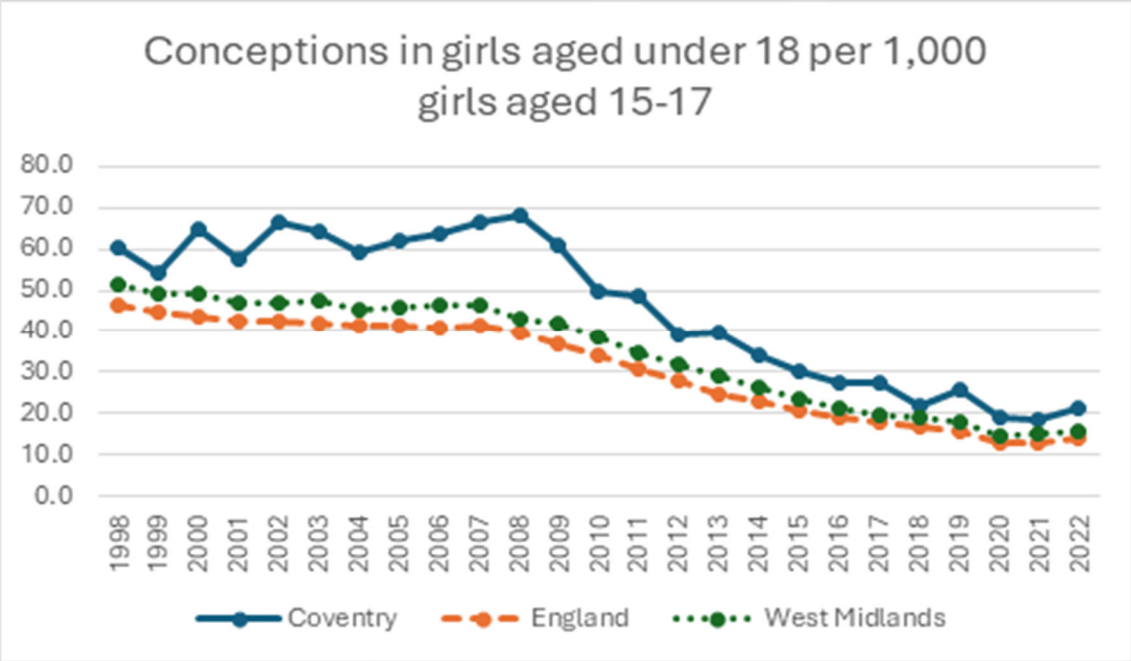

**Data Source:** Fingertips | Department of Health and Social Care

Very limited local, up to date data exists on prevalence of smoking or use of e-cigarettes among young people. Survey data from 2014/15 shows that in Coventry the prevalence of current smokers amongst 15-year-olds was 8.1% (very similar to the England value of 8.2%). 5.8% of those surveyed were classified as regular

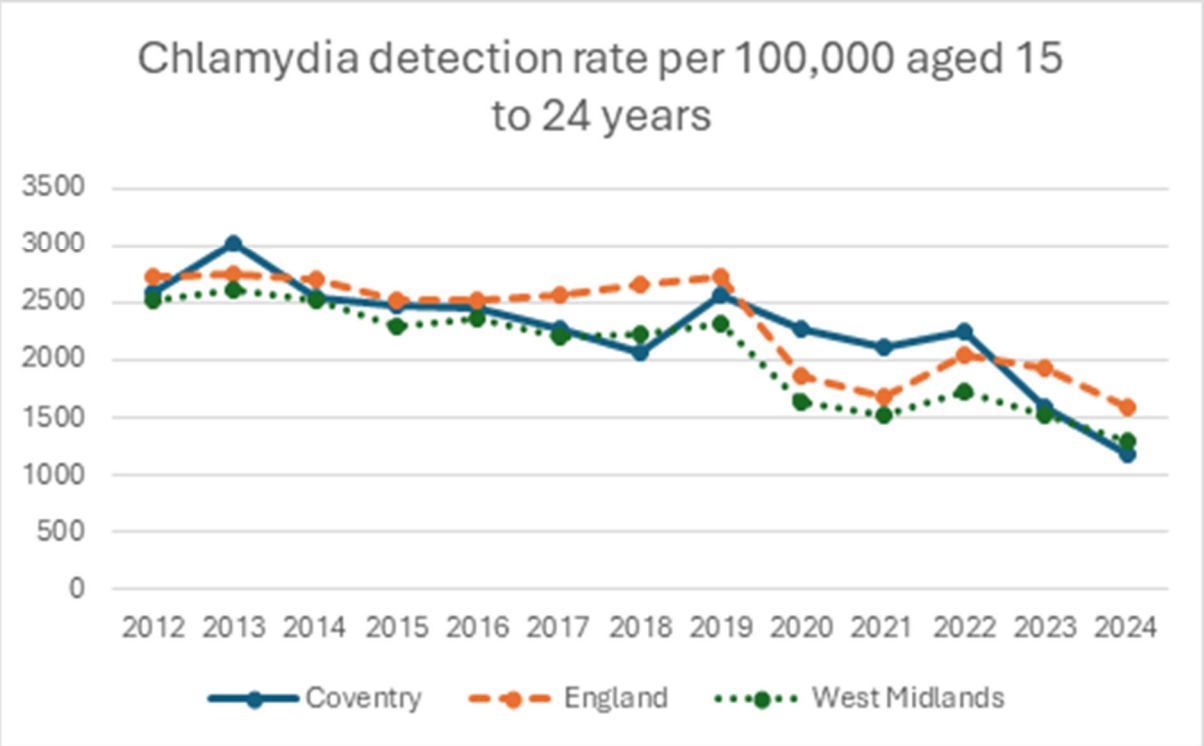
[4] See Smoking, drinking and drug use among young people in England - NHS England Digital. Available from: https://digital.nhs.uk/data-and-information/areas-of-interest/public-health/smoking-drinking-and-drug-use-among-young-people-in-england; and Mytton OT, Donaldson L, Goddings AL, Mathews G, Ward JL, Greaves F, et al. Changing patterns of health risk in adolescence: implications for health policy. Lancet Public Health. Available from: http://www.thelancet.com/article/S2468266724001257/fulltext

smokers, compared to a national prevalence of 5.5%. More up-to-date regional survey data shows that smoking prevalence amongst 11–15-year-olds has been decreasing since the survey started in 1982; indicating that in 2023 around 10% of the 11–15-year-old pupil population of the West Midlands have ever smoked. National survey data show that percentage of 15-year-olds currently using e-cigarettes has steadily risen from 4% in 2014 to over 8% in 2023. This trend can be seen in both girls and boys, with trend in girls growing faster. There is no reason to believe that that this trend would be different in Coventry.

**Sexual health indicators present some areas of concern for Coventry. The city continues to report above-average under-18 conception rates and elevated levels of repeat abortions among women under 25.** Although the under-18 conception rate has been falling since 2008 and remains on a downward trend, it remains higher than regional and national levels.

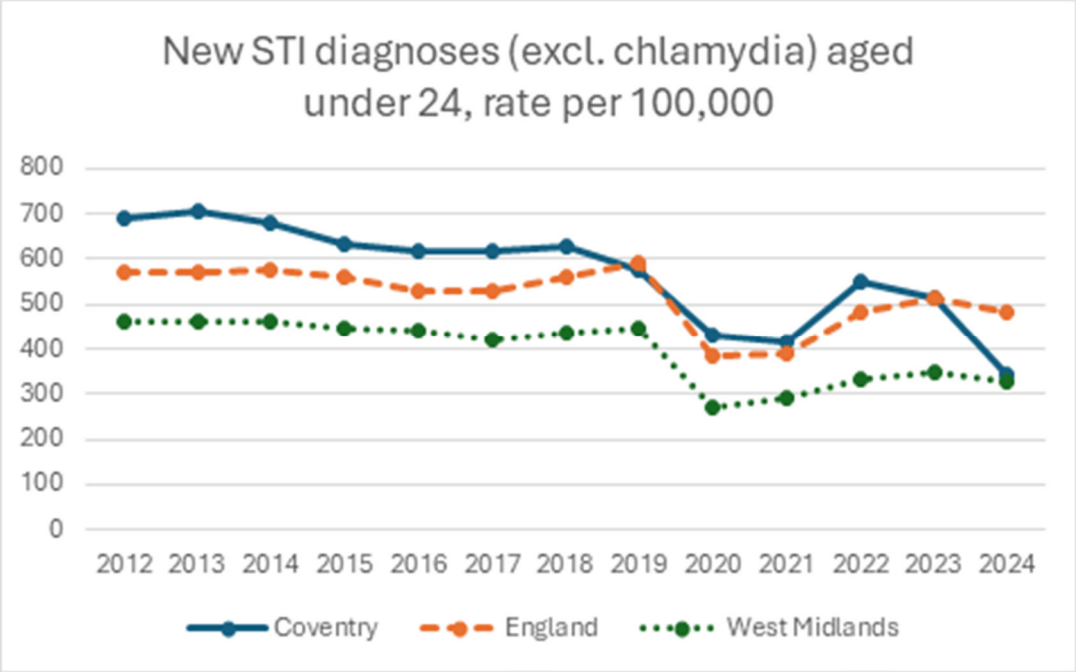


**Chlamydia remains the most common bacterial STI among young adults.** Coventry's chlamydia detection rate among young people aged 15-24 years is on a sustained downward trend and is now lower than both regional and national rates, placing the city among the lowest performers locally. Chlamydia is often asymptomatic, and therefore rates of diagnosis are used to reflect the success of this screening programme, although may also reflect differences in prevalence. This means that there are targets for higher rates. The detection rate in Coventry was lower than this target in 2022, and just 20.2% of 15–24-year-old females were tested, compared to 21.2% nationally.




**Data source: Fingertips | Department of Health and Social Care**

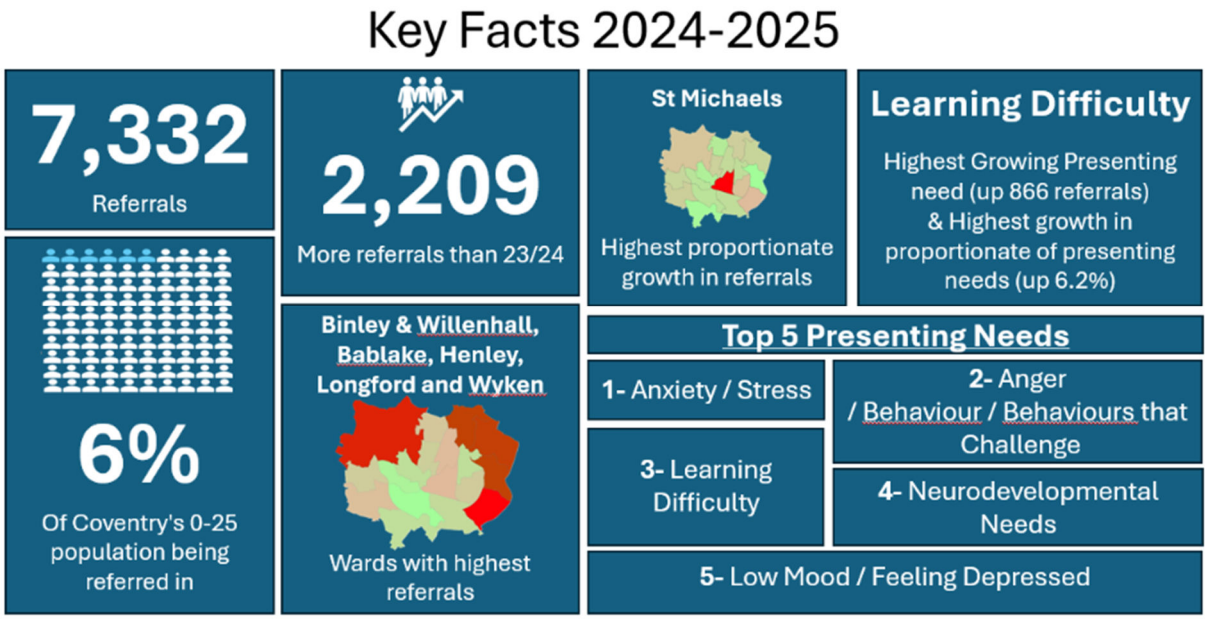
The overall new STI diagnosis rate in Coventry has fallen to its lowest level since 2021 and is below the national average. This may be attributable to a decline in screening coverage.




**Data source: Fingertips | Department of Health and Social Care**

These patterns underline the need for strengthened sexual health education, targeted outreach, and improved screening and testing pathways across the city.

**Children and young people in Coventry face significant mental health challenges, with demand for services continuing to rise.** Between April 2024 and March 2025, there were 7,332 referrals to mental health services, representing roughly 6% of the city's young population. This figure is likely an underestimate of need due to persistent limitations in available data, underscoring the need for ongoing improvements in monitoring and reporting.

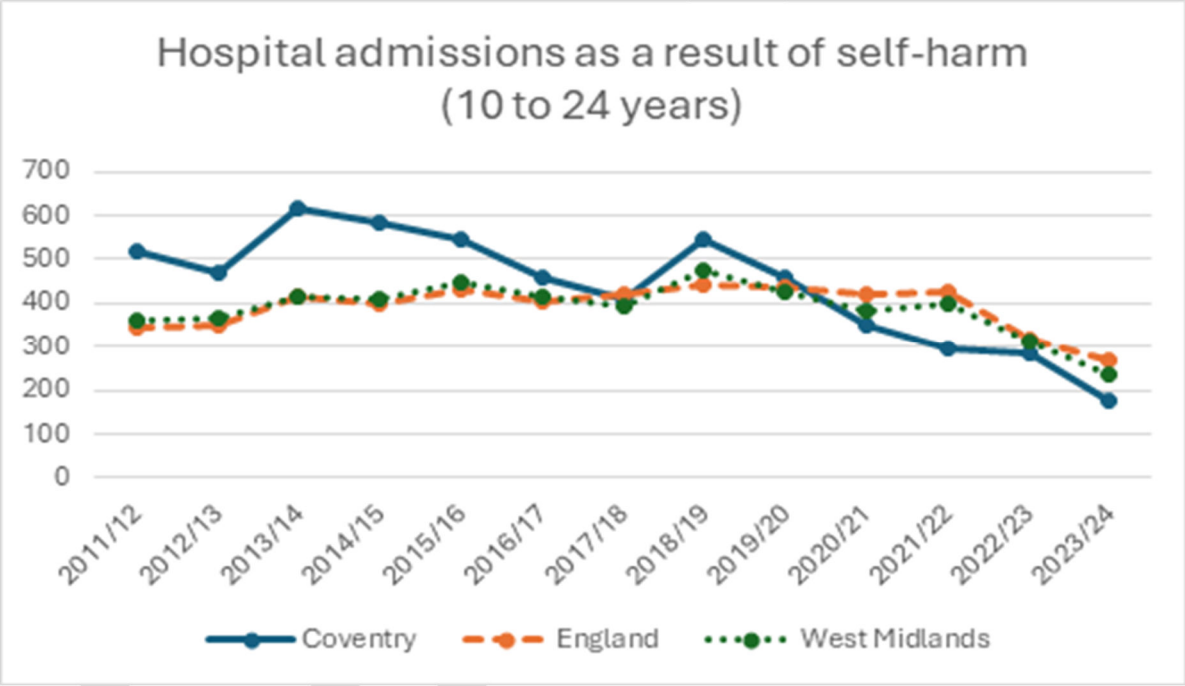



**Data source: Children's mental health – Coventry City Council**

The significant increase in referrals seen in 25/26 was driven by increasing demand for support with anxiety and stress, behavioural difficulties, learning challenges, neurodevelopmental needs, and low mood or depression. This surge in demand was most pronounced in St Michaels, one of Coventry's most deprived areas, suggesting a link between socioeconomic deprivation and the need for mental health support.

In terms of demographics, the gender breakdown of service users was 46.37% male, 51.05% female, 1.08% other, and 2.5% non-binary.

**Rates of hospital admissions for self-harm in Coventry are broadly comparable to national averages.** In 2023/24, there were 625 acute mental health-related admissions, highlighting the severity of mental health needs among some young people.




**Data source: Children's mental health – Coventry City Council**

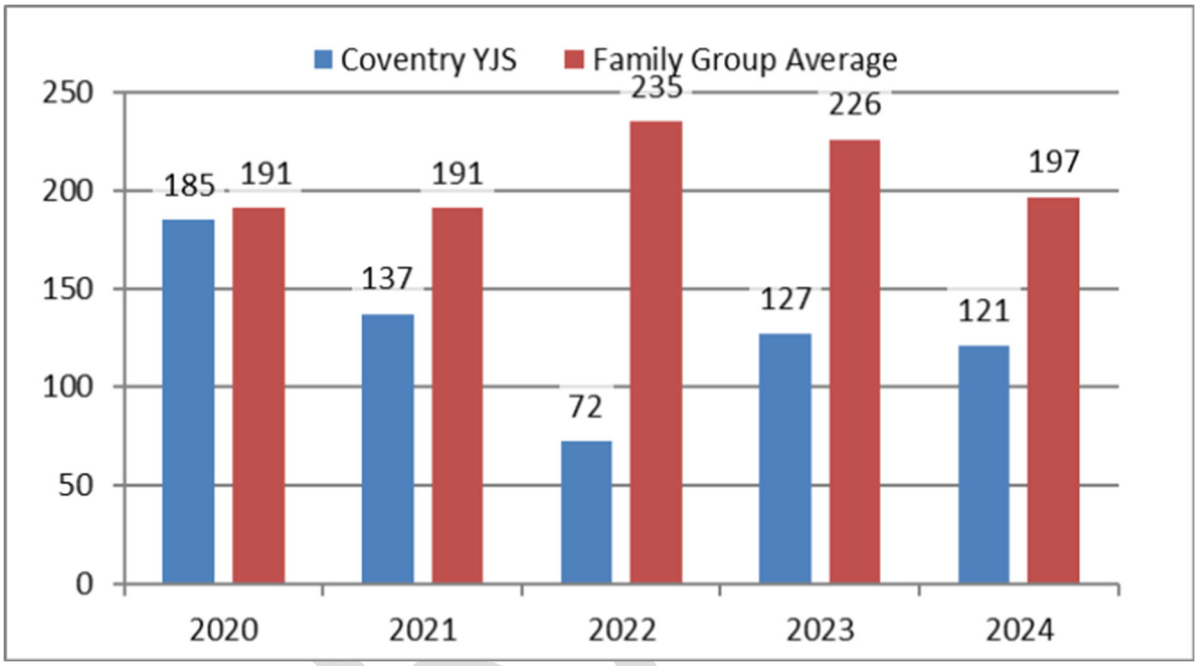
The above chart illustrates an overall downward trend in the admission rate (directly standardised) for both Coventry and its comparators.

This data collectively illustrates the substantial and growing demand for child and adolescent mental health services in Coventry. They highlight the urgent need for accessible, inclusive, and integrated approaches that can respond effectively to both immediate and long-term mental health challenges among young people. Mental health difficulties often overlap with other risky behaviours, which can exacerbate vulnerabilities and negatively affect long-term outcomes. These patterns emphasise the importance of early intervention, integrated support across services, and targeted strategies in areas of higher need.

**Within the youth justice system (YJS), Coventry has maintained a comparatively low level of first-time entrants.** These are children above the age of 10 who receive a caution or court sentence, creating a criminal record. Coventry's

rate of 121 per 100,000 young people aged 10-17, (a count of 50 young people in 2024), has remained below the Youth Justice Family Group average (197). The most common offence among first-time entrants is Violence Against the Person, which includes all offences of weapon or bladed article possession.
Reoffending remains a concern. The most recently released data shows that 34.6% of children who offended went on to commit at least one re-offence within 12 months, slightly above the 30% average among Family Group members.

**Chart: First time entrants to youth justice system - rate per 100,000 young people aged 10-17**




**The relationship between school exclusion and youth offending has shifted significantly since the pandemic.** Prior to 2020/21, there was little correlation between girls' exclusion and offending rates, with analysis showing a weak negative correlation. From 2020/21 onwards, however, this changed dramatically, with a very strong positive correlation emerging over four years. This likely reflects the impact of COVID-19 on girls' behaviour in both school and wider society. Boys display a similar pattern, though the correlations are weaker, suggesting the pandemic and its aftermath had a stronger influence on girls.

There has also been a marked change in the types of offences committed by girls. A decade ago, most offences were related to theft, particularly shoplifting. Since the pandemic, theft offences have declined sharply, falling below 10%, while the proportion of offences categorised as Violence Against the Person has risen substantially, peaking at over 70% in 2022/23. Analysis also shows that 6.9% of girls excluded in 2022/23, who had no previous offending history, went on to commit an offence within a year, although this is likely an underestimate as it does not include offences committed outside Coventry.

**The West Midlands records the lowest rate of cautions or sentences per 10,000 children among comparable areas such as Greater Manchester, West**

**Yorkshire and Merseyside.** In 2023/24, 582 children were cautioned or sentenced across the West Midlands, a 20% decrease from the previous year. Coventry recorded 61 children cautioned or sentenced, equating to 17.9 per 10,000, a 13% increase compared with the previous year but still the third-lowest rate in the region. Of those children, 42% were from a minority ethnic background, 85% were aged 15 to 17, and boys accounted for 90% of cases.

Coventry recorded 131 proven offences for children aged 10 -17 years in 2023/24, equating to 38.35 offences per 10,000 children, with individuals sometimes responsible for multiple offences. Most offences had low to moderate gravity scores, though nearly a quarter fell into the more serious categories. Violence Against. the Person was the most common offence type, accounting for 37% of incidents, followed by theft at 17%. In total, 89 cautions and court sentences were issued in Coventry during the year, representing a 9% compared to March 2023.

## ECONOMY & EMPLOYMENT

**Why is this important?**

A protective factor for health is having meaningful employment. Reducing avoidable health disparities will involve tackling the unequal distribution of money, wealth, and power by improving opportunities and skills. Employment is strongly associated with improved health outcomes. Meaningful work provides income, stability, purpose, and social connection. Conversely, unemployment, low pay, and insecure work are linked with poorer physical and mental health. Reducing health inequalities therefore requires addressing the unequal distribution of opportunities, income, and resources across the population.

**What is the local picture? How does it compare?**

The sections below outline the local picture relating to the economy and employment.

### ECONOMY

**The local economy has demonstrated resilience in recent years amongst challenges in the national economy, with growth in economic output of Coventry businesses, measured in Gross Domestic Product (GDP), and more importantly for residents, an increase in the number of jobs in Coventry since 2020.** After several years of strong growth, Coventry's economic expansion slowed between 2016 and 2019, leaving the city more exposed to the impacts of the pandemic and the cost-of-living crisis. However, between 2020 and 2023, growth resumed, showing resilience amid global uncertainty, high energy costs, trade tariffs, and other challenges. Nationally, growth has remained steady but moderate, with an annual rate of 1.4% for 2025.

Employment at Coventry businesses rose from 157,900 in 2016 to 169,350 in 2023, before falling to 164,600 in 2024 (excluding some self-employed roles). Businesses

continue to face challenges, including high operating costs, taxation concerns, and potential trade tariffs, which may affect future growth and job creation.

**GDP per head, and productivity, is higher in Coventry than regional averages; but real growth has been relatively flat.**

Total GDP generated by Coventry businesses was estimated to total £12.9 billion in 2023**,** with annual growth averaging 7% a year (between 2020 and 2023). GDP per head has averaged 5% a year, similar to national and regional growth rates. However, high inflation over this period has meant that real growth has been relatively flat. Coventry's GDP per head stood at £35,719 in 2023, below the national (£40,382) and Warwickshire (£45,518) averages, but above the West Midlands regional (£32,077) and metropolitan area[1] (£31,012) figures. The deficit with the national figure is wider than it has been and the gap with regional averages has closed.

**Productivity, measured by Gross Value Added (GVA) per hour worked in 2023, remains above regional levels (£40.39 in Coventry vs £36.02 in the West Midlands region and £35.79 WMCA average), though below the England average (£42.39)**. Higher productivity supports slightly higher average wages locally; however, once inflation is accounted for, real productivity and wages have been largely flat or slightly declined since 2016.

**Coventry has fewer businesses per capita than national and regional averages, with 9,825 businesses in 2025, 89% of which are small companies with less than 10 employees.** This represents 345 businesses per 10,000 adult residents, compared with 391 in the West Midlands metropolitan area and 503 nationally. It is estimated that 50 Coventry companies were high growth businesses in 2024, with average annual growth in employment of at least 20% per year over three years. The amounts to 0.4% of all businesses in Coventry, the same proportion as the WMCA area, but lower than 0.5% of all across England; Coventry has remained persistently below the national average for this measure in recent years.

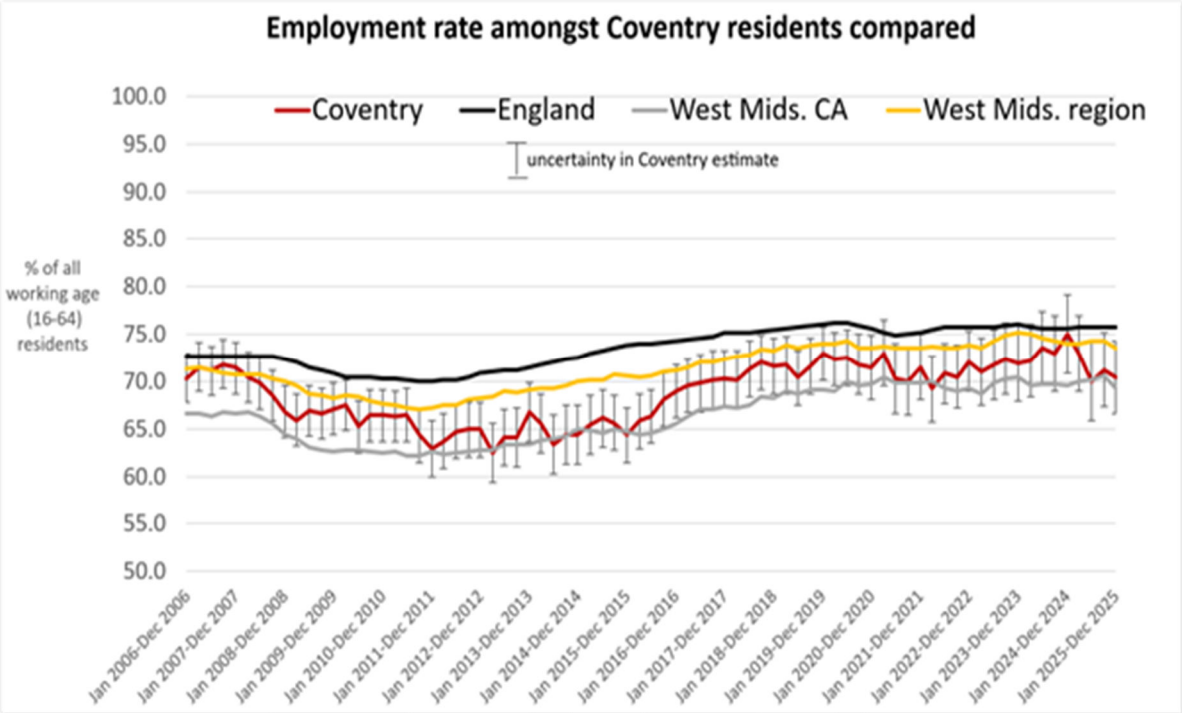
**Despite strong business performance, prosperity is not shared evenly among Coventry residents**. Gross Disposable Household Income (GDHI) per head remains comparatively low. In 2023, Coventry's GDHI totalled £6.9 billion, or £19,057 per head - well below England (£25,425), Warwickshire (£25,774), and the wider West Midlands region (£21,141), though slightly above the WMCA metropolitan average (£18,900). This shows that the value generated by Coventry's productive firms does not fully translate into higher household incomes for residents.

## EMPLOYMENT

**Employment is critical to residents' well-being, however the employment rate fell in 2025.**

**Across the calendar year 2025, Coventry's employment rate was 70%, below the national average of 76% and the West Midlands regional average of 74%, but similar to the West Midlands metropolitan area (69%).** Just over three quarters of Coventry people in employment are full-time (77%) and just under a

quarter (23%) are part time. Employment rose steadily from 2021/22 to 2024, peaking at 75%, before declining to 70% in 2025. Long-term trends show growth from just over 130,000 employed residents in 2011 (63% employment rate) to just over 190,000 in 2024 (75%), partly related to population growth; though recent declines have widened the gap with national and regional averages.

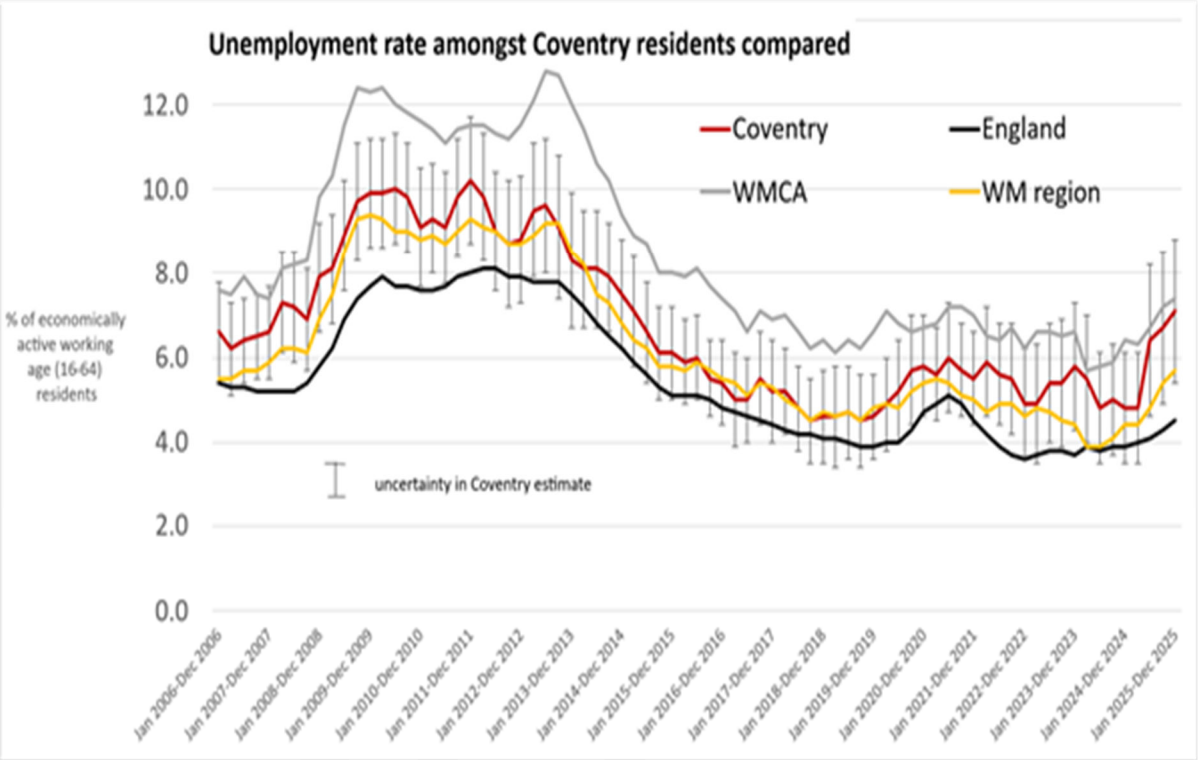



**There are disparities amongst Coventry residents in the employment rate, and by type of occupation.** The employment rate is lower among women than men. In 2025 66% of working-age women were employed (England: 73%), compared with 74% of men (England: 79%).

There are also notable disparities by ethnicity. 2024/25 estimates show a 75% employment rate among White residents, compared with 66% among residents from minority ethnic backgrounds. However, minority ethnic encompasses diverse communities with differing outcomes. Census 2021 data highlights this variation: while ‘White British’ residents had higher-than-average employment rates, groups such as ‘Other White’, ‘White Irish’, and ‘Asian/Asian British: Indian’ had even higher rates. In contrast, unemployment was highest among ‘Black/Black British: Caribbean’ and ‘Black/Black British: African’ residents, while economic inactivity was most common among ‘Asian/Asian British: Bangladeshi’, ‘Asian/Asian British: Pakistani’, and ‘Other ethnic group: Arab’ communities.

In terms of occupations, Coventry has a broadly similar proportion of residents in higher-paid roles (‘managers, directors and senior officials’ or ‘professional occupations’) compared with England (51% vs 54%), but a higher proportion in lower-paid roles (34% vs 28% nationally).

Census 2021 data reveal disparities in occupation type by ethnic group of Coventry residents. ‘White Other’ and ‘Black or Black British’ Coventry residents are less likely to be in managerial positions and more likely to be in occupations that are likely to be less well paid. ‘Asian or Asian British’ Coventry residents are more likely to be in ‘professional occupations’. ‘Black or Black British’ Coventry residents are more likely to be in ‘caring, leisure and other service occupations (many of which are poorly paid)’.




**Unemployment in Coventry has risen in line with the fall in overall employment. An estimated 14,100 residents were unemployed across the calendar year 2025, giving a rate of 7.1%, well above the national average of 4.5%.** This is an increase from 4.8% during 2024. The gap with national and regional averages has widened, bringing Coventry closer to the WMCA average.

**In April 2026, around 14,000 Coventry residents were in the unemployment benefit “claimant count.”** This measure is different from the official unemployment rate. It mainly includes people claiming Universal Credit who must look for work. While many are unemployed, it also includes people in low-paid or part-time jobs who do not earn enough. This equals 5.8% of working-age residents, which is higher than England (4.1%) and the West Midlands (5.3%), but lower than the WMCA average (7.4%). Coventry ranks 4th highest among similar local areas. The number of people claiming has risen since 2024. At the same time, employment has increased and inactivity has fallen. This suggests some people have moved into insecure or part-time work rather than stable jobs. The claimant count is also much higher than before the pandemic (7,900 in September 2019). Although changes to welfare rules may explain some of this rise, it also indicates growth in low-paid, part-time, or insecure jobs. For some households, even full-time work is not enough to stop needing Universal Credit.

**Youth unemployment remains considerably higher than for older adults.** The claimant count for 18-24-year-olds has risen steadily for more than two years, from 1,970 in January 2023 to 2,865 in April 2026. Census 2021 data show that, among young adults not in full-time education, 12.5% were unemployed, one in eight, significantly above the rate for older age groups.

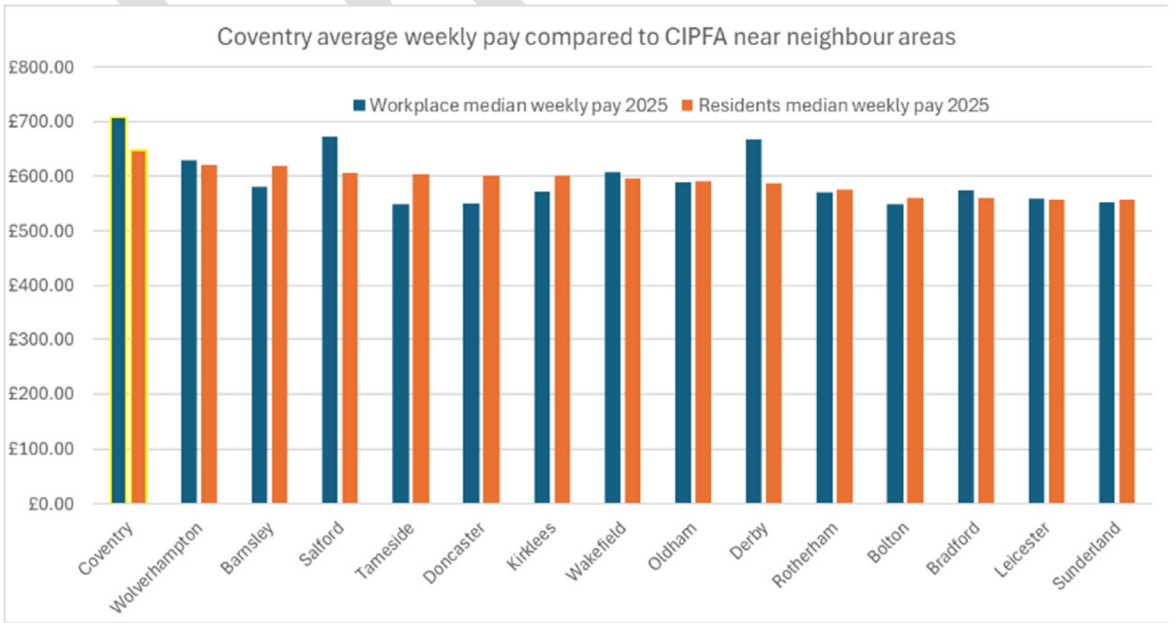
**Economic inactivity increased between 2024 and 2025 after several years of decline.** Across the calendar year 2025, an estimated 57,300 working-age residents were inactive (22.4%), above the national (20.5%) and West Midlands regional averages (21.8%). Inactivity peaked in 2020/21 at 65,100 and had been on a generally reducing, but fluctuating trend up until 2024, partly influenced by a small reduction in the number full-time students in that time, but increased from 20.4% in 2024.

The reasons for inactivity - of working-age residents were retired (2%), full-time students (7%), looking after home or family (5%), illness or disability (6%), and inactive for other reasons (2%). The proportion of working-age residents who are inactive full-time students is higher than the national average (England 5%).

**Coventry has a higher-than-average number of neighbourhoods where people are in employment deprivation.** The recently published English Indices of Deprivation 2025 (IoD) puts Coventry amongst the most deprived 20% of local authorities (LA) when it comes to Employment deprivation.

## WAGES & INCOME

**Average wages in Coventry workplaces are relatively high, but resident wages lag behind**, **reflecting commuting patterns as some higher-paid roles are filled by non-residents.** Amongst similar areas, Coventry has both the highest workplace wages and the highest resident wages, yet also one of the largest gaps between the two.



In 2025, the average (median) annual wage for full-time workers for Coventry businesses was £41,278, above England (£39,298), the West Midlands region (£39,298) and the WMCA (£37,775). However, the median wage for Coventry residents in work, who don't necessarily work in the city, was much lower at £37,759. Wages have grown in recent years, but only modestly in real terms. Inflation has eased from its 2022 peak (11.1%) to 2.8% in April 2026, still above the Bank of England's 2% target. Between 2021 and 2025, the median wage for working residents rose from £30,663 to £37,759, a 23% increase (around 6% per year), only slightly above average annual inflation (about 5%) and broadly in line with national and regional wage growth.

**Despite wage growth, cost-of-living pressures remain significant, especially for lower-paid workers.** The Living Wage Foundation and the Resolution Foundation have recently updated the estimate of the real living wage, at £13.45 per hour for 2025/26. While the average hourly wage for Coventry residents is £17.44, according to the Annual Survey of Hours and Earnings for 2025, distribution data estimates a quarter of all Coventry residents in work earned less than £13.49 an hour.

**Financial stress remains a concern.** In the 2024/25 Coventry Household Survey Residents were asked how often they have been worried about money during the last few weeks. 13% of residents reported worrying about money almost all the time (a 4-percentage point decrease since 2022), and 23% worried quite often. Around a quarter (26%) never felt worried, a stable figure since 2022. Worry was higher among residents aged 45-54 (18%), those aged 35-44 (29%), and residents with a disability (35% vs. 16% for those without).

## DEPRIVATION

**It remains the case that there are many neighbourhoods in Coventry where the residents live in high levels of multiple deprivation; Coventry has a higher-than-average proportion of areas with high deprivation.**

This is shown by the English Indices of Deprivation (IoD) 2025, which measures multiple dimensions of deprivation across seven individual domains[5].

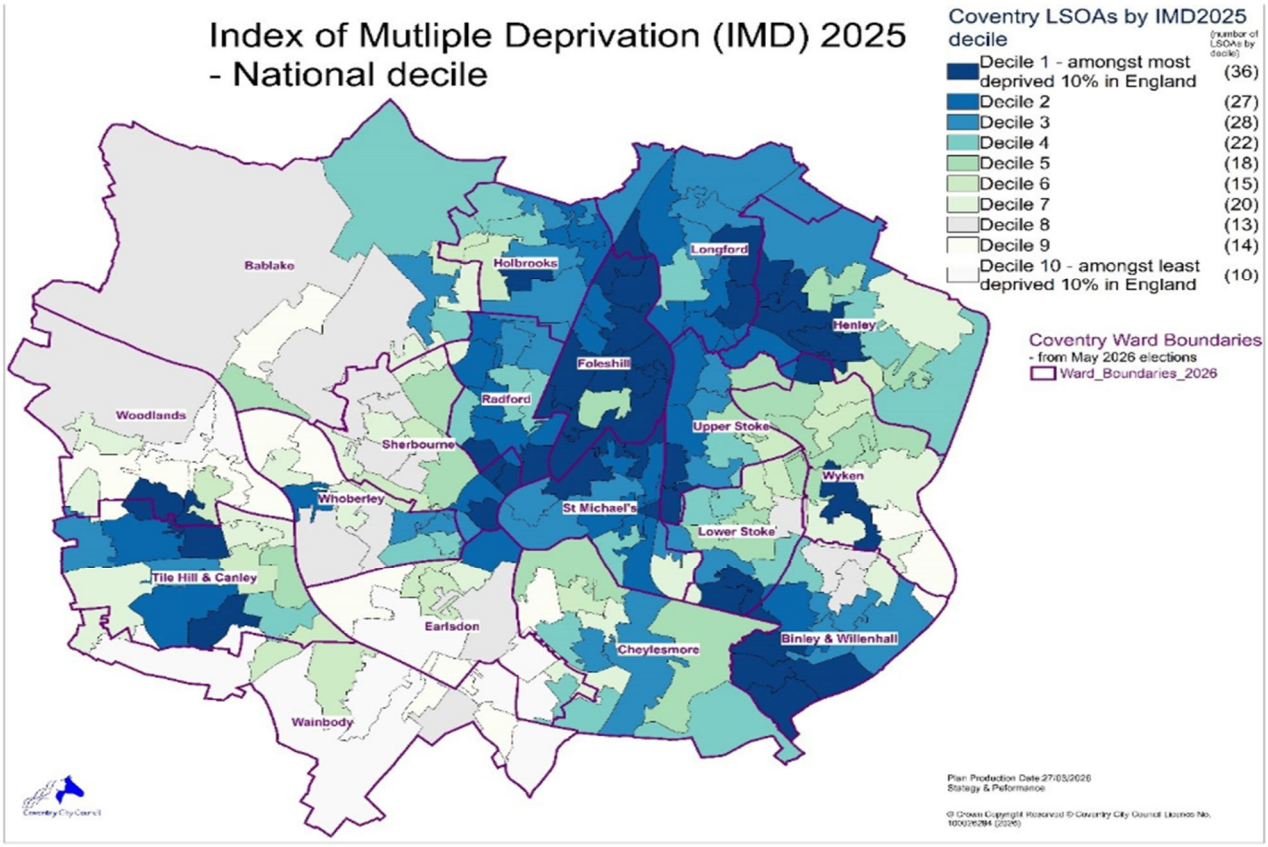
When ranked against all other English local authority areas, Coventry is 48$^{th}$ most deprived out of 296 in terms of proportion of LSOAs in most deprived 10% and 57$^{th}$ in terms of the average deprivation score of all LSOAs.

Of the seven domains, Income and Health deprivation remain the most significant challenges.

[5] The Index of Multiple Deprivation (IMD) is the official measure of relative deprivation at neighbourhood level (LSOA[3]) in England, it combines a wide range of aspects of an individual's living conditions, using basket of datasets across the seven domains: Income, Employment, Education, Skills and Training, Health Deprivation and Disability, Crime, Barriers to Housing and Services and Living Environment.

Coventry has some of the most deprived neighbourhoods in England, particularly in the north, north-eastern and central parts of the city. 31% of Coventry's LSOAs are among the most deprived 20% nationally. This means an estimated 111,900 Coventry residents live in neighbourhoods amongst the most deprived 20% in England and, of these 64,100 in the most deprived 10%.

The map below shows the coverage of deprivation from the IMD across Coventry neighbourhoods.




Whilst changes in methodology over time make comparisons problematic, research[6] identifies 10 key localities in Coventry where deprivation has been persistent and high.

| LSOA name and code | | LSOA local name | Area name (MSOA) |
|---|---|---|---|
| Coventry 004C | E01009607 | Bell Green - Roseberry Ave | Bell Green |
| Coventry 024C | E01009638 | Hillfields Village & Motor Museum | Hillfields |
| Coventry 039A | E01009539 | Willenhall Wood - Middle Ride | Willenhall |
| Coventry 015C | E01009571 | Paradise - Awson Street | Foleshill East |

[6] Nuffield Foundation funded research led by Prof. Chris Lloyd of Queen's University Belfast "Trajectories of Deprivation"

| | | | |
|---|---|---|---|
| Coventry 015F | E01009574 | Swanswell - Leicester Causeway | Foleshill East |
| Coventry 007A | E01009577 | Aldermans Green - Deedmore Road W | Henley Green & Wood End |
| Coventry 007B | E01009579 | Henley Green West | Henley Green & Wood End |
| Coventry 039D | E01009542 | Willenhall - Chace Stretton | Willenhall |
| Coventry 039B | E01009540 | Willenhall - Robin Hood & Mary Slessor | Willenhall |
| Coventry 007F | E01009709 | Manor Farm | Henley Green & Wood End |

**Coventry has a relatively high number of neighbourhoods where people are in income deprivation, particularly for children and older people.** The recently published English Indices of Deprivation 2025 (IoD) puts Coventry amongst the most deprived 16% of local authorities (LA) when it comes to Income deprivation.

**The Income Deprivation Affecting Children Index (IDACI) is Coventry's worst-performing deprivation measure within the Indices of Deprivation.** Coventry is among the 10% most deprived local authorities in England for this indicator, ranking 29th out of 296, with 46 of its 203 neighbourhoods (22.7%) in the most deprived 10% nationally. Coventry also shows high deprivation for older people (IDAOPI), ranking 35th, with 39 neighbourhoods in the most deprived 10% in England.

**Child poverty in Coventry remains relatively high.** In 2024/25, around 18,900 children aged 0-15 were living in relative low-income families (before housing costs), representing 25.5% of all children in this age group. This is above the England average of 19.8%, though slightly lower than the West Midlands average of 27.1%. When housing costs are taken into account, the number rises to approximately 24,000 children. This means nearly one in three children (32.2%) aged 0-15 in Coventry are living in relative low-income households, higher than the England average (27.1%) and in line with the West Midlands average (32.2%).

**Coventry has high rates of fuel poverty, an estimated 18.9% of all households in 2023 means Coventry ranks 3rd highest of all local authorities in England.** This amounts to an estimated 25,700[7] fuel poor households in Coventry. That Coventry ranks so high shows how Coventry has both income deprivation and housing challenges.

Fuel poverty fell slightly in 2023 in Coventry and across England, down from 22.2% in 2022. This likely reflects modest improvements in home energy efficiency, a small drop in energy prices from their 2022 peak, and targeted government support. However, the data is lagged, and rates remain high in Coventry. While estimates suggest further declines in 2024, future increases are possible due to rising global energy pressures.

[7] Low-Income Low Energy Efficiency (LILEE) fuel poverty metric, a modelled estimate of the number of Coventry households with a low energy efficiency rating and a disposable income below the poverty rate after housing and energy costs.

**The household survey found that food security has improved slightly**. Three-quarters (74%) of residents state that in the last 12 months they and their household have always had enough of the kind of food they wanted (up from 69% in 2022). 22% had enough to eat but not always the foods they preferred, down from 26%, while 4% said sometimes and 1% often that they did not have enough to eat (unchanged from 2022). Although a minority, these figures highlight ongoing health and wellbeing risks for those affected.

## DIGITAL EXCLUSION

**Access to fast internet in the city is relatively good, but this doesn't mean people do access it, and many are at risk of digital exclusion**. The availability of high-speed internet is an important consideration for residents and businesses when considering living, working, or investing here, and is an asset for the city. Coventry is the top ranked local authority in the West Midlands region for gigabit broadband coverage and is ranked 5th in the UK. The telecoms regulator Ofcom measures access to, and the performance of, fixed broadband and the mobile network in its Connected Nations Reports. 99% of Coventry households can access good quality fixed internet connectivity, defined as a data service that provides fixed download speeds of at least 10Mbit/s and upload speeds of a least Mbit/s. In May 2026, gigabit availability covered 98% of households in Coventry, with 96% of households able to access Full-Fibre.

**Digital accessibility and inclusion are increasingly important, and Coventry residents are using digital channels to access Council services more frequently:** in 2024/25, 570,077 self-service transactions were completed, up from 455,612 in 2023/24. However, the Council recognises that not all residents can or want to interact digitally. **Key drivers of digital exclusion in the city include cost-of-living pressures, device affordability, language barriers, older age, and gaps in basic digital skills.** While broadband coverage is generally good, affordability and fear of online scams remain barriers for some.

The Coventry Household Survey 2024/25 provides a useful estimate of digital exclusion. Respondents were asked about confidence using digital services on a four-point scale from 'Not confident at all' to 'Very confident'. Across four questions, 16% of adults reported being 'Not confident at all' in at least one area. Risk of digital exclusion is higher among residents aged 75+ and those living in deprived areas.

Coventry has developed several initiatives to address these challenges, which is led by the **#COVConnects** programme.

## CHAPTER 3 - HOUSING & ENVIRONMENT

**Key Messages**

- Coventry is the fourth most densely populated local authority area in the West Midlands.
- There is generally good access to services, although lower-than-average access to some amenities such as Post Offices, supermarkets and sports facilities.
- Coventry has many green spaces, including several high-quality sites, but overall provision is limited, unevenly distributed, and residents report low satisfaction. This includes poor access to green and blue (water) spaces, garden space and parks and play areas.
- Public transport connectivity is good, and the percentage of adults who engage in active travel is above the average for metropolitan areas. However there has been an increase in people commuting to and from work by car.
- Air quality in Coventry has improved, but it continues to affect health, particularly for vulnerable groups and residents in more deprived areas.
- Resident satisfaction with the local area as a place to live is well below the national average and has declined over time, with worsening perceptions of safety contributing to this trend.
- Recorded crime in Coventry has fallen markedly in recent years, although levels remain above the national average. Hospital admissions related to violent crime have declined substantially over the past decade, though rates remain higher than average.
- Domestic abuse is a significant issue in Coventry, with serious impacts on health and wellbeing and indications of substantial under-reporting and unmet need.
- Coventry has a total of 148,000 domestic dwellings and the number of houses has been growing annually. Coventry's housing stock is characterised by a high proportion of lower-value and older properties. Housing quality and energy efficiency remain significant challenges.
- The private rented sector has grown substantially in Coventry in recent years, comprising around a quarter of households, compared with one fifth nationally.
- Housing in Coventry remains more affordable than the England average, but affordability has steadily worsened over time.
- Coventry has a much higher rate of homelessness or families at risk of homelessness than national and regional averages and homelessness pressures in Coventry have intensified in recent years.
- Coventry now has a significantly higher rate of temporary accommodation than both England and the West Midlands. The number of people sleeping rough in Coventry also appears to be increasing.

**What this means for Coventry**

Coventry is a densely populated city with a lot of green spaces – but the green spaces are not where the population is most dense. Making best use of green space for recreation and exercise has benefits for health and wellbeing and partners should prioritise creating and improving parks, play areas, and biodiversity in central and high-density neighbourhoods.

Increasing active travel is a success story for Coventry and will have a positive impact – both in terms of personal health improvements through more exercise and reduced air pollution from vehicles. There are opportunities to build on good connectivity and active travel by reducing reliance on cars, improving local access to services, and promoting walking, cycling, and public transport.

There is an opportunity to align housing, planning, transport, public health, and community safety services to address the combined drivers of poor health and wellbeing in neighbourhoods. This includes strengthening prevention of health risks in local environments, for example by reducing exposure to unhealthy outlets and improving access to healthy amenities.

Housing quality and energy efficiency remain significant challenges in Coventry, especially in the large private rented sector, with implications for health, wellbeing and fuel costs. Coventry's old housing stock has a detrimental effect on the health of families living in deprived areas of the city and will benefit from work to improve heating, insulation, and resistance to damp. Homelessness, families at risk of homelessness and rough sleeping are all too high in Coventry and individuals and families affected by this will have worse health outcomes than others.

Crime and violent crime are reducing in the city but remain comparatively high and continued work on bringing these rates down further will have a positive impact on health in the city. In particular, domestic abuse is a significant issue, with serious impacts on health and wellbeing.

## LOCALITIES & NEIGHBOURHOODS

**Why is this important?**

The quality of the built and natural environment, such as the local neighbourhoods, access to local shops, services, parks, and green spaces, transport infrastructure and air quality, affect the health and wellbeing of everyone and contribute to health inequalities.

**What is the local picture? How does it compare?**

**Coventry is the fourth most densely populated area of the West Midlands[8].** Coventry has around 26 people living on each football pitch-sized area of land (3,665 people per square kilometre). Only Birmingham (4,426), Sandwell (4,173) and Wolverhampton (4,046) are more densely populated. This is far denser than England overall (449 people per square km) and ranks 49th most densely populated local authority in England and Wales.

**Population density varies widely across the city.** Brownshill Green is the least dense area at 461 people per square kilometre, close to the national average, while Hillfields is the densest at 12,289 people per square kilometre - over 20 times higher and among the most densely populated neighbourhoods in the West Midlands.

[8] 4th of 30 West Midlands local authority areas

**As a densely populated urban area, Coventry generally has good access to services, although there is a mixed picture, with lower-than-average access to some amenities.** For the Geographical Barriers sub-domain of the Indices of Deprivation 2025, which measures connectivity to key services, only 2 of Coventry's 203 LSOAs fall within the 20% most deprived nationally.

Despite generally good access to services, **Coventry has higher exposure to some premises associated with public health risks**. The Access to Healthy Assets and Hazards (AHAH) 2024 indices rank Coventry at 76th highest local authority in England and Wales for combined scores on drive time to fast food outlets, gambling outlets, alcohol venues and tobacconist or vape shops.

According to Office for National Statistics (ONS) data on 'access to local amenities', there are fewer than average Post Offices and 'Community Facilities' per head in Coventry, and relatively few supermarkets. The number of Sports facilities is also below the national average, although better than the West Midlands metropolitan average. On the other hand, there are a relatively many ATMs and, more importantly, Coventry has relatively good access to GP surgeries and pharmacies.

**Transport links and access to community spaces varies**. 40% of residents live within a 30-minute walk of a railway station and 89% within 60 minutes, which is lower-than-average for urban areas. Library access is better, with 81% of residents within a 30-minute walk and 99% within 60 minutes. Childcare accessibility is below average (265th nationally), though broadly in line with expectations given local income levels and comparable metropolitan areas.

## TRANSPORT

**The Department for Transport's new public transport connectivity score shows Coventry at 72.96, above the metropolitan districts average of 71.61**. This score reflects how easily residents can access key destinations—such as jobs, schools, hospitals, and shops—using various transport options.

**Coventry Transport Strategy sets out plans to create a city where it is easy, convenient, and safe to walk, cycle and travel on public transport, and where most people do not need to use a car to access essential services**. Currently there are high levels of car ownership, with 72.4% of households owning at least one car. The 2024/25 Coventry Residents' Survey indicated that driving a car remains the most common form of transport for commuting to and from work (71%) or a place of study (37%), and escorting children to school (53%). We have seen an increase in those commuting to and from work by car from 61% in 2022.

Despite the large proportions of car drivers, **84% of respondents also indicated that Coventry was an easy place to travel around on foot and the city performs well for active travel**: it ranks 8th of 36 metropolitan boroughs for adults walking or cycling at least weekly (39.9%) in 2023. In 2024/25, 60% said it was easy to get around by bike compared to 52% in 2021. Sport England's Active Travel Survey estimated that in 2025 the percentage of adults who engaged in active travel at least

twice in the last 28 days in Coventry was 32.7%, above the average for English metropolitan districts of 30.9%.

**Coventry has one of the lowest rates of road deaths and serious injuries amongst urban areas**, ranking 6th lowest out of 36 English metropolitan areas for the rate of killed and seriously injured (KSI) casualties on the road per billion vehicle miles: 62.6 in 2024. This is well below the mean of 99.9 for all metropolitan boroughs.

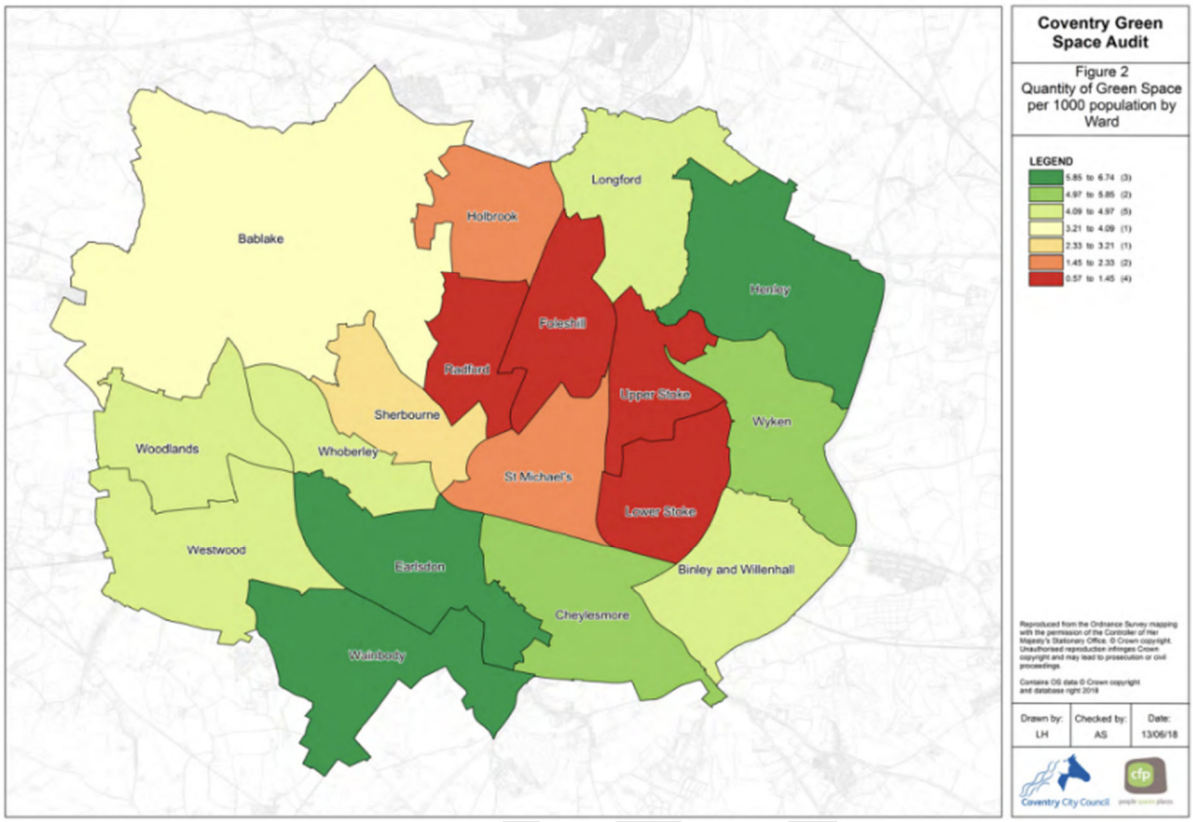
Building on the city's reputation as a leader in innovation, **Coventry has the highest rate of publicly available electric vehicle charging devices per 100.000 population (674 per 100k),** more than three times higher than the next highest metropolitan district in England (Solihull, 210 per 100k population)**.**

## GREEN SPACES

**Coventry has many green spaces covering around one fifth of the city, including several high-quality 'Green Flag' sites, but overall provision is relatively low and unevenly distributed.** The Coventry Green Space Strategy 2019-24 identified 1,997 hectares of green space, two-thirds of which are unrestricted public spaces, across 430 sites. Six parks and open spaces are recognised for their excellence with the 'Green Flag Award': War Memorial Park, Allesley Park, Longford Park, Caludon Castle Park, London Road Cemetery and Coombe Abbey Country Park.

Despite this, unrestricted green space amounts to only 3.05 hectares per 1,000 residents, lower than in many neighbouring West Midlands authorities. There are large inequalities between neighbourhoods and central areas have the poorest provision, as shown on the map below. Foleshill, with 11.4 hectares (0.5 per 1,000 residents), has more than 10 times lower coverage than Henley, the ward with the highest, with 123.4 hectares at 6.0 per 1,000 residents.

**Coventry Green Space Strategy 2019-24 – Green Space Audit**

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**More recent data reinforces this picture, indicating relatively low volumes of biodiversity, access to green and blue spaces, garden space and parks and play areas**.

Coventry's Climate Change Strategy highlights low biodiversity, with only 11% of land conserved, against the UN target of 30%. The Access to Healthy Assets and Hazards (AHAH) 2024 indices rank Coventry 63rd lowest of all England and Wales local authorities for access to green and blue spaces, well below the average rank for metropolitan districts in England. 29% of neighbourhoods fall within the lowest 20% nationally, particularly in Foleshill, Hillfields, the city centre, Gosford Park, and parts of Radford and Chapelfields.

ONS data (2024) shows Coventry has fewer parks and play areas per head than average (32 per 100,000 residents), ranking 314th nationally. The 2025 Index of Deprivation Living Environment domain also shows higher levels of housing without private outdoor space (gardens etc.) than elsewhere in the West Midlands, and those neighbourhoods with less garden space are often also those with lower green space access.

**Resident satisfaction with green spaces is low.** The Community Life Survey 2023/24 found only 61% of Coventry residents were satisfied with local green and natural spaces, compared with 76% nationally. In the 2024/25 Coventry Household

[9] These were the Coventry wards as they were when the Green Space Audit for the Coventry Green Space Strategy 2019-24 took place – the boundaries have since been revised with slightly changed boundaries live as from the May 2026 elections.

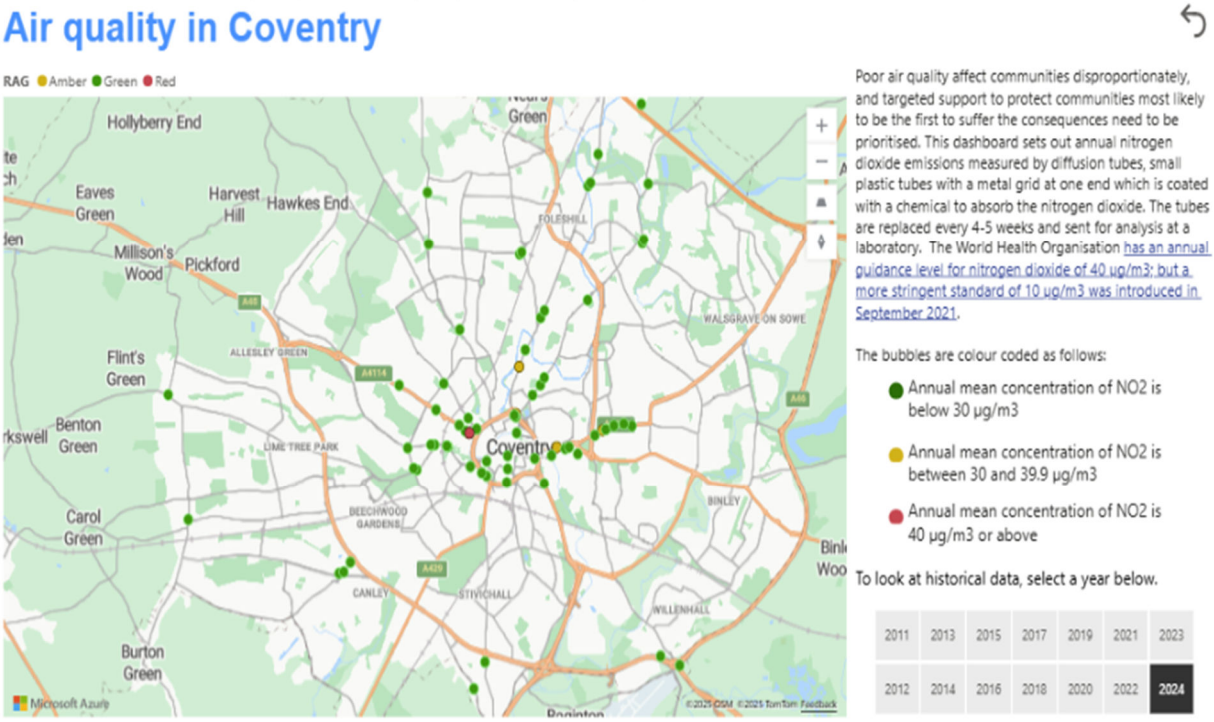
Survey residents were asked how they would rate the quality of their local green space, and how often they use it. 42% of residents rated their local green space positively, while 23% rated it poorly. Usage is mixed: 43% of residents said they use their local green space on a weekly basis or more often, whereas 36% said they use it less often than monthly and 15% said they did not use it at all.

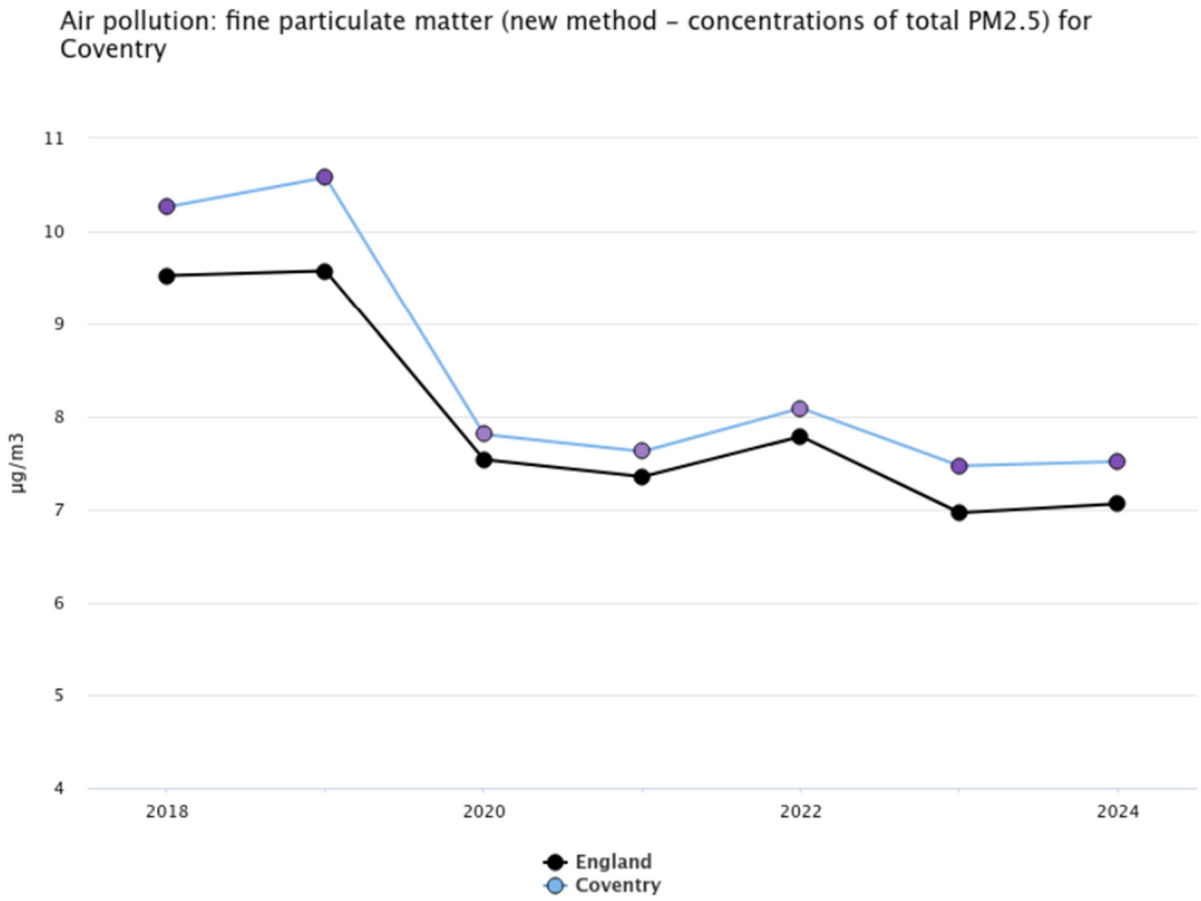
## AIR QUALITY

**Air quality in Coventry has improved in recent years, but it continues to affect health, particularly for vulnerable groups and residents in more deprived areas**. The main pollutants of concern in Coventry are nitrogen dioxide ($NO_2$) and particulate matter (PM10 and PM2.5). These pollutants are largely linked to road traffic and congestion.

Levels of $NO_2$ are measured at 73 roadside locations across Coventry. In 2024, only 1 location in Coventry exceeded the limit of an annual mean concentration of 40 µg/m3, compared with 21 in 2014 and 14 in 2019. A map showing those locations is shown below, those with the highest recorded levels of $NO_2$ are coloured in red and amber. A location on Holyhead Road near to central Coventry has persistently recorded the highest level. **In general, across all locations, including the areas that have consistently seen the highest levels, $NO_2$ levels have been falling as a trend, with some annual fluctuations.**

The World Health Organization (WHO) updated their guideline level for annual nitrogen dioxide in 2021, recommending a more stringent 10 µg/m3; none of the locations have yet to reach this low level.






**Fine particulate matter (PM2.5) is more of a concern.** Modelled estimates of the average annual concentrations of PM2.5 across Coventry overall in 2024 are 7.5 µg/m3 compared to the England average of 7.1. While concentrations have reduced since 2018, they have been relatively flat since 2020. The UK Health Security Agency modelling estimates that 5.6% of mortality in Coventry is 'attributable' to the impact of exposure to PM2.5.

The Indices of Deprivation 2025 (IoD) Living Environment Outdoors sub-domain uses DEFRA modelled background pollution data by small area to score and rank all local neighbourhoods on levels of air pollution. Coventry's average air pollution levels are lower than the average for all metropolitan areas in England. Within the city, pollution is highest in central, traffic-heavy areas, including parts of Radford (near Holyhead Road), Hillfields, Foleshill East, Stoke Heath and Gosford Park.

**Air pollution disproportionately affects older people, children, pregnant women, those with existing health conditions and low-income communities**. The neighbourhoods with the poorest air quality often overlap with those that have the least access to green space.

Several measures have been taken to reduce air pollution levels in Coventry, including upgrading much of the local bus fleet to be electric, new cycling routes, road improvements and promotion of electric vehicles including the installation of a high number of charging points.

## COMMUNITY PERCEPTION & SAFETY

**Why is this important?**

How people feel about the place they live in has an impact on their quality of life and their wellbeing. Being a victim of crime, and being worried about crime, impacts on a person's perception of their quality of life in the neighbourhood and has a negative effect on a person's mental and physical wellbeing.

**What is the local picture? How does it compare?**

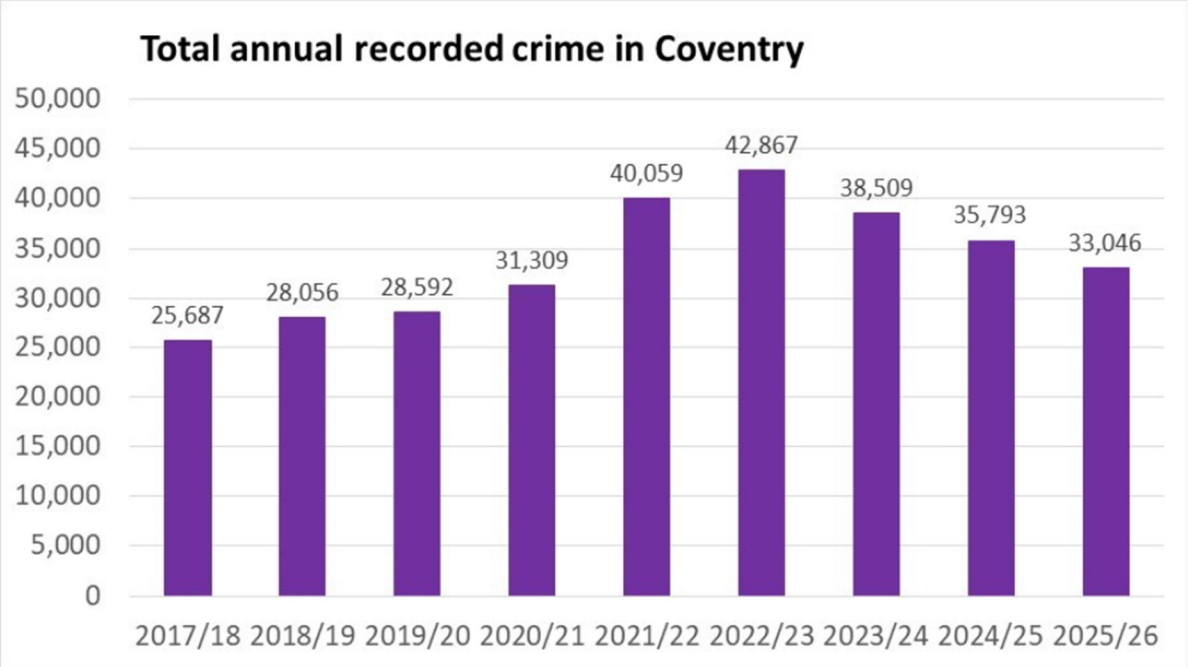
**Residents' satisfaction with their local area in Coventry remains well below the national average and has declined over the longer term.** In the 2024/25 Coventry Household Survey, 67% of residents said they were satisfied with their local area as a place to live. While this is a small increase since 2022, it is lower than both the national average (74%) and previous levels in Coventry (particularly 84% in 2018). Perceptions of change reflect this pattern. Nearly half of residents (46%) felt their local area had not changed much over the past two years, while one third (33%) believed it had worsened and only 7% felt it had improved. Findings from the national Community Life Survey 2023/24 are similar: 12% of Coventry residents felt their area had improved, broadly in line with the national average (11%).

Broader indicators of community sentiment from the Community Life Survey, are also weaker than nationally. Only 47% of Coventry residents said they were proud to live in their local area, compared with 59% nationally, and 54% would recommend their area as a good place to live (66% nationally). Overall satisfaction with the local area stood at 62% in Coventry versus 74% nationally, and just 40% of residents felt their area was attractive, well below the national figure of 57%.

**Feelings of safety have declined markedly and are a key factor underpinning lower satisfaction.** In 2024/25, the Coventry Household Survey found that 75% of residents reported feeling safe during the day, down from 77% in 2022 and significantly below the 94% in 2018 and the national level of 91%. Safety during the day is particularly low in Binley and Willenhall (61%), Foleshill (60%) and Radford (51%). Perceptions of safety after dark are much poorer: only 39% of residents felt safe at night, down from 45% in 2022 and far below 74% in 2018, as well as the national figure of 71%. Residents in Radford (68%) and Foleshill (63%) reported especially low levels of safety after dark.

**Recorded crime in Coventry has fallen markedly in recent years, although levels remain above the national average.** For April 2025 to March 2026, Coventry recorded 33,046 crimes, down from 35,783 the year before (2024/25). This is a crime rate for 2025/26 of 89.5 per 1,000 residents, down from 122.0 in 2022/23. While this remains higher than the England average (83.5; Jan-Dec 2025), it is lower than the West Midlands metropolitan area average (98.6), and Coventry's overall and violent crime rates are comparatively lower than many other local authorities in the West Midlands region.

Since 2022/3, overall recorded crime has decreased by 23%, representing a stronger decline than seen nationally.




**Violence against the person has declined significantly, after being on an increasing trend up to 2021/22, but the rate remains above 2019/20 levels (27 per 1,000)**. It has fallen by 23% since 2021 and by 6% since 2024. Despite this progress, the violent crime rate remains above the national average (35 per 1,000 in Coventry compared with 31 in England). Theft offences, violent offences (with and without injury), shoplifting offences, stalking and harassment and vehicle-related offences were the most common types of police recorded crime in the year ending June 2025.

In 2024/25, the top four of all offences in Coventry were Violence without injury (17.7%), Shoplifting (10.7%), Violence with injury (10.4%) and Stalking and Harassment (10.2%).

While overall crime is falling, some offence types have increased since 2021, notably shoplifting, theft-related offences (including non-residential burglary and bicycle theft), sexual offences, death or serious injury caused by illegal driving, and homicide. **Sexual offences are a particular concern: the recorded crime rate has more than doubled in the past decade**, increasing significantly from 1.5 per 1,000 residents to 3.5 per 1,000 in 2021/22 and remaining at that level. This is above both national (3.1) and regional (3.2) averages.

**There has been an increasing number of Modern Slavery[10] cases**. A total of 197 cases were reported in Coventry during 2025, up from 166 in 2024. Most of the cases in Coventry have been under the categories of Labour, Criminal or Sexual Exploitation.

[10] The Modern Slavery Act 2015 defines this crime as the recruitment, movement, harbouring or receiving of adults or children through force, coercion, abuse of vulnerability, deception or other means for the purpose of exploitation.

**Domestic abuse is a significant issue in Coventry, with serious impacts on health and wellbeing.** It is associated with increased risks of mental health problems, self-harm and suicide, and the number of people affected each year far exceeds those known to the police or support services. While women make up the majority of victims, men are also affected.

Responses to the Crime Survey for England and Wales allows an estimate of total prevalence nationally. Nationally, 7.8% of all residents aged 16+ said they that had experienced any domestic abuse, which includes many different types, in the year ending March 2025. There were higher rates among women (9.1%) than men (6.5%), and higher prevalence among younger adults. Given Coventry's relatively young population, prevalence is likely to be higher than average. Applying these overall prevalence estimates to Coventry's population, it can be estimated there are around 24,700 domestic abuse incidents each year.

**5,953 domestic abuse crimes were reported to police in 2023/24, and 2,560 individuals received support from services commissioned by Coventry City Council in 2024/25, highlighting substantial under-reporting and unmet need**. Across the West Midlands Police area, domestic abuse rates are higher than the national average, and Coventry Domestic Abuse Needs Assessment[11] indicates that Coventry has higher referral and refuge bedspace provision per 1,000 residents than both the regional and national averages, reflecting both demand and service capacity.

**Hospital admissions related to violent crime in Coventry have declined substantially over the past decade, but rates remain higher than the national average.** Between 2021/22 and 2023/24, the rate fell to 38.5 per 100,000 population, down from 48.2 (2018/19 - 2020/2021). Despite this improvement, Coventry's rate remains above the England average (34.2), though lower than the West Midlands average (40.6), indicating a continued need for prevention and victim support.

**Hospital admissions for violence disproportionately affect young males and deprived communities**. Between 2021/2022 to 2023/2024, Hospital Episode Statistics (HES) for West Midlands Violence Reduction Unit (VRU) found that 85.1% of emergency admissions for violence involved males, and admissions were highest among those aged 20–29 (31.8%). 41.4% of admissions came from the most deprived areas (decile 1) which, whilst lower than the regional proportion (67.8%), still highlights persistent inequalities. Most admissions involved people from White ethnic groups (64.4%), and the most common cause was assault by bodily force (45.1% in Coventry compared to 52.3% regionally), followed by sharp object assaults.

Knife-related harm remains a concern. Admissions for assault with a sharp object in Coventry rose from 25 in 2021/22 to 40 in 2023/24, although levels remain below the 2019/20 peak (50) and are broadly in line with other West Midlands authorities. Regionally, knife-related violence is concentrated among males aged 15-24, reinforcing the importance of early intervention programmes.

[11] Domestic Abuse Strategy 2018-2025 – Coventry City Council

**Coventry has made strong progress in reducing serious youth violence (SYV)**. The city has the second lowest SYV victim rate in the West Midlands and recorded a 3.8% reduction in incidents between 2022 and 2024. However, Coventry still contains several neighbourhoods with high levels of knife crime, and the city sits within a region that continues to have one of the highest knife crime rates nationally, despite recent reductions.

## HOUSING & HOMELESSNESS

### Why is this important?

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

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

### What is the local picture? How does it compare?

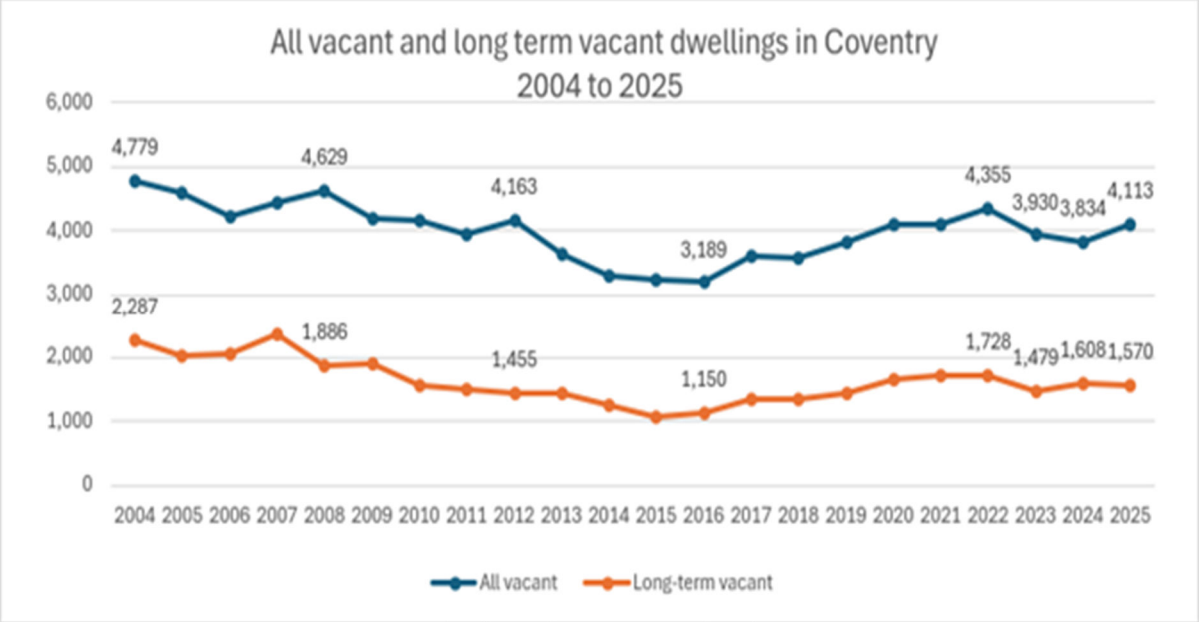
**Coventry has a total of 148,000 domestic dwellings and the number of houses has been growing annually**. Coventry's population has been increasing and Coventry City Council's Local Plan 2011 – 2031, adopted in 2017, identified a need to increase house building in Coventry, with provision for a minimum of 24,600 additional dwellings between 2011 and 2031. This required an average of 1,300 new homes per year from 2017.

The table below shows the total number of new houses built per year (net additions, new houses minus demolitions) for the last five years, in line with this plan. Planning permission is in place for a net additional 11,800 dwellings over the next 10 years.

| Period | Net additions to dwelling stock |
|---|---|
| 2019/20 | 2,088 |
| 2020/21 | 436 |
| 2021/22 | 1,851 |
| 2022/23 | 1,446 |
| 2023/24 | 1,301 |
| 2024/25 | 697 |

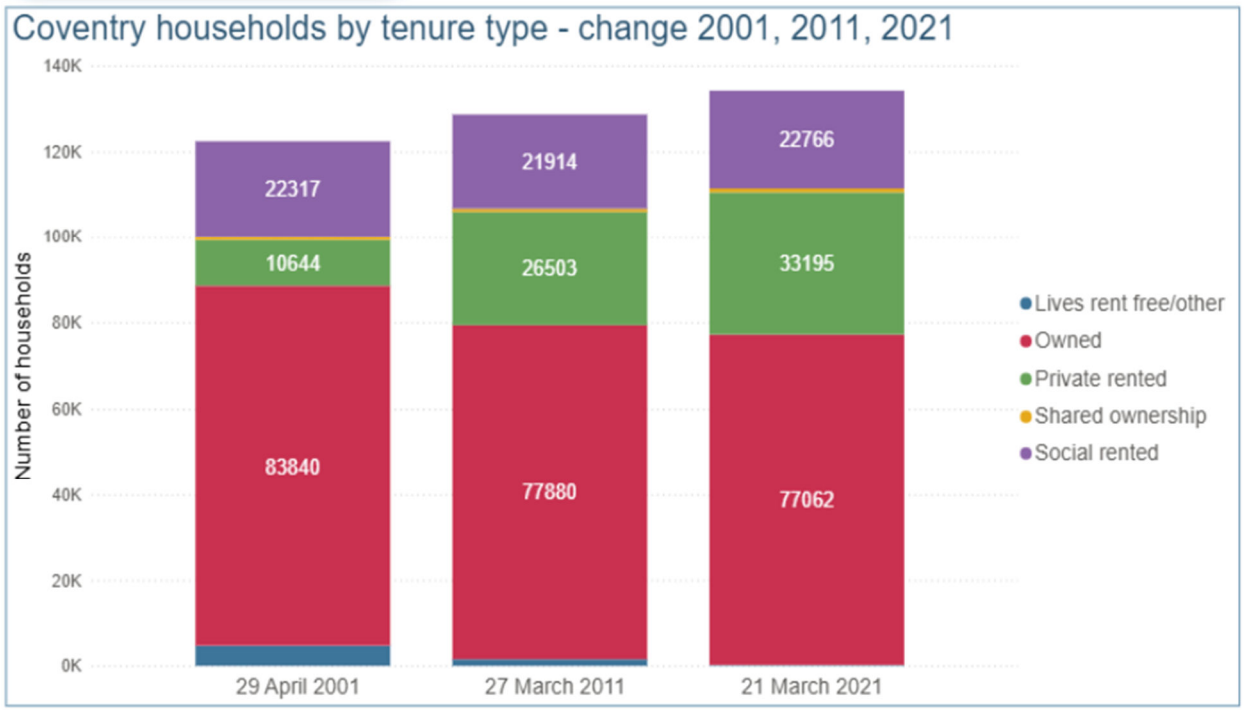
**The number of vacant houses in the city has reduced over the long term, performing better than both national and regional trends.** In 2025, there were 4,113 vacant properties in the city, less than 4,355 in 2022, whereas over that period there have been rising vacancy levels across England and the West Midlands. As a percentage of all dwellings, those vacant in Coventry make up 2.78%, lower

proportions than the rest of the West Midlands metropolitan area (2.95%) and England overall (2.94%). This suggests stronger local housing demand and effective action to bring homes back into use. The chart below illustrates the longer-term trend of a reduced number of vacant dwellings.




**Coventry's housing stock is characterised by a high proportion of lower-value and older properties.** As of 2025 Valuation Office Agency data, 70% of Coventry's properties were in the lower Council Tax Bands A & B, significantly higher than national (43%) and regional (55%) averages. Around two-thirds (63%) of Coventry homes were built before 1965, compared to 51% nationally, reflecting an ageing housing stock and reinforcing the importance of investment in quality, energy efficiency and renewal. Census 2021 data highlights distinctive features of Coventry's housing stock. Terraced housing is much more common than nationally, accounting for 40% of dwellings compared with 23% in England, while detached housing is less prevalent

**The private rented sector has grown substantially in Coventry in recent years, although owner occupation remains more prevalent. The comparatively large private rented sector comprises around a quarter of households, compared with one fifth nationally**.




| Census 2021 - Tenure of household | Coventry | | England | West Midlands |
|---|---|---|---|---|
| | number | % of total | % of total | % of total |
| Total: All households | 134,140 | 100.0 | 100.0 | 100.0 |
| Owned | 77,062 | 57.4 | 61.3 | 62.8 |
| Shared ownership | 906 | 0.7 | 1.0 | 0.8 |
| Social rented | 22,766 | 17.0 | 17.1 | 18.2 |
| Private rented | 33,195 | 24.7 | 20.5 | 17.9 |
| Lives rent free | 211 | 0.2 | 0.1 | 0.2 |

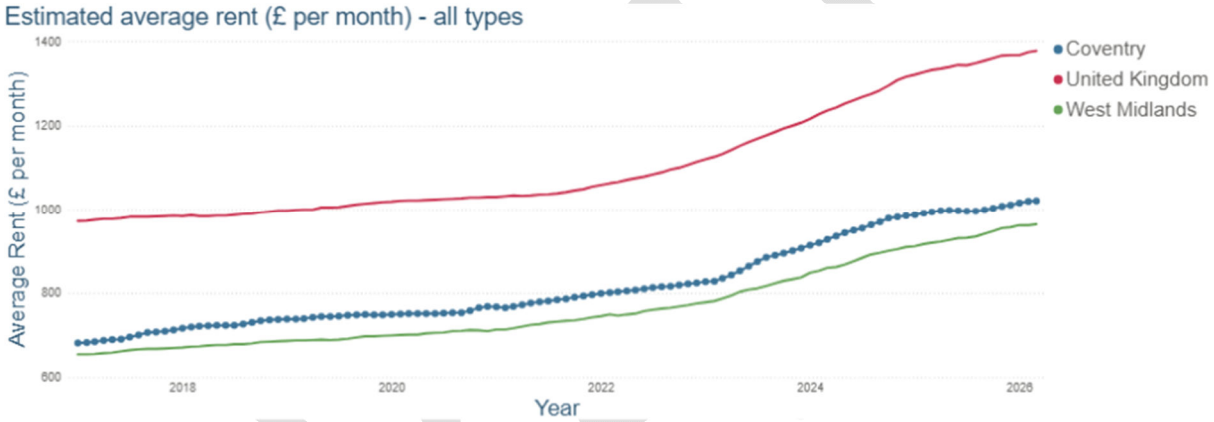
**Housing pressures are reflected in higher levels of overcrowding**. In 2021, 7.7% of Coventry households were overcrowded, above both national and regional averages. Overcrowding is more common in rented housing, particularly in the social rented sector, highlighting ongoing challenges around housing quality, affordability and space.

**Housing quality and energy efficiency remain significant challenges in Coventry, with implications for health, wellbeing and fuel costs.** In 2024/25, 50.5% of homes in Coventry achieved an EPC rating of C or above, so a lower proportion of homes have good energy efficiency than the national average (53.3%), although similar to the West Midlands region (50.0%), and Coventry's rate is the same as the average for all metropolitan English local authority areas.

**Despite progress since 2019, Coventry continues to face significant housing quality issues, with Category 1 hazards and damp problems concentrated in specific property types and tenure categories.** According to the English Housing Survey (EHS) data modelled for the local authority area,16.6% of all dwellings in

Coventry were estimated to be non-decent in 2023 (1 in 6 of all occupied dwellings), down from an estimated 18.7% in 2019, but higher than both England (14.5%) and the West Midlands (15.7%). Notably, Coventry's rate is higher than the average for all metropolitan English local authority areas (15.2%). Non-decent homes are most common in the private rented sector, where a quarter of properties fail to meet standards, and are more prevalent in flats and terraced housing.

**The average monthly rent of privately rented houses in Coventry is higher than the regional average and has been increasing notably, faster than the increase in house prices.** The estimated average rent in March 2026 was £1,021 per month, higher than the West Midlands regional average (£964), lower than the UK average (£1,377). Between January 2022 and March 2026 average rent levels in Coventry increased by 27.8% (from £799) compared to 30.0% across the UK overall, highlighting growing pressure on renters. The chart below shows how rents have increased over time.

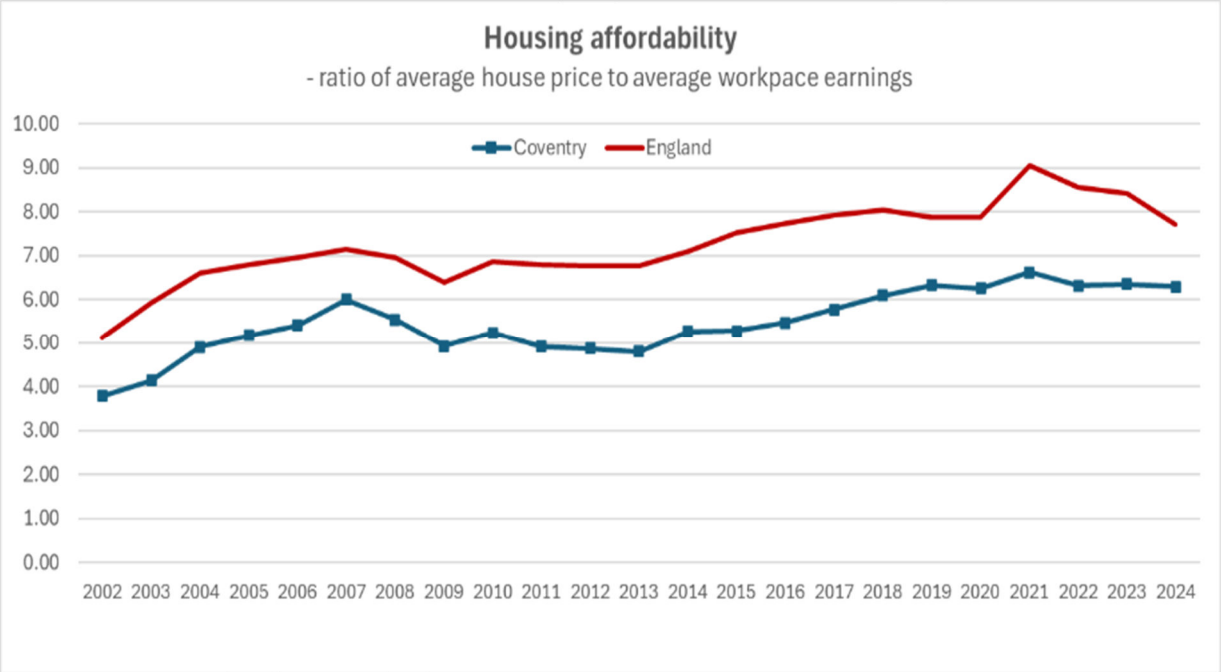



**House prices in Coventry have also risen, increasing by 9.9% between January 2022 and February 2026, slightly faster than the UK average increase (8.0%).** Despite this, average prices remain lower than national and regional averages, as shown in the table below.

| Area | Average Price February 2026 |
|---|---|
| Birmingham | £232,266 |
| Coventry | £223,243 |
| Dudley | £230,554 |
| Sandwell | £205,094 |
| Solihull | £327,817 |
| Walsall | £217,948 |
| Wolverhampton | £213,623 |
| | |
| West Midlands region | £248,507 |
| England | £290,001 |
| UK | £267,957 |

**Housing in Coventry remains more affordable than the England average, but affordability has declined over time.** The cost of living crisis has seen increasing inflation, which has had negative impacts on people's spending power, further reducing the affordability of housing. People have seen their rents increase, along with the price of food and energy bills, putting some in the position of having to do without one or more of these essentials. The ratio of house prices to earnings has risen, making home ownership increasingly difficult in the city. In 2024, the average house price in Coventry was 6.3 times the median workplace wage, lower than the England average ratio of 7.7.

Coventry remains slightly more affordable than other West Midlands metropolitan areas and sits around the middle of English metropolitan authorities. However, workplace wages in Coventry are higher than the earnings of many residents, meaning local people do not fully benefit from these higher salaries. As a result, housing is less affordable for current residents, particularly those on lower incomes with the cheapest homes were 6.9 times the lowest quartile wage in 2024, highlighting continued pressure on lower-income households.



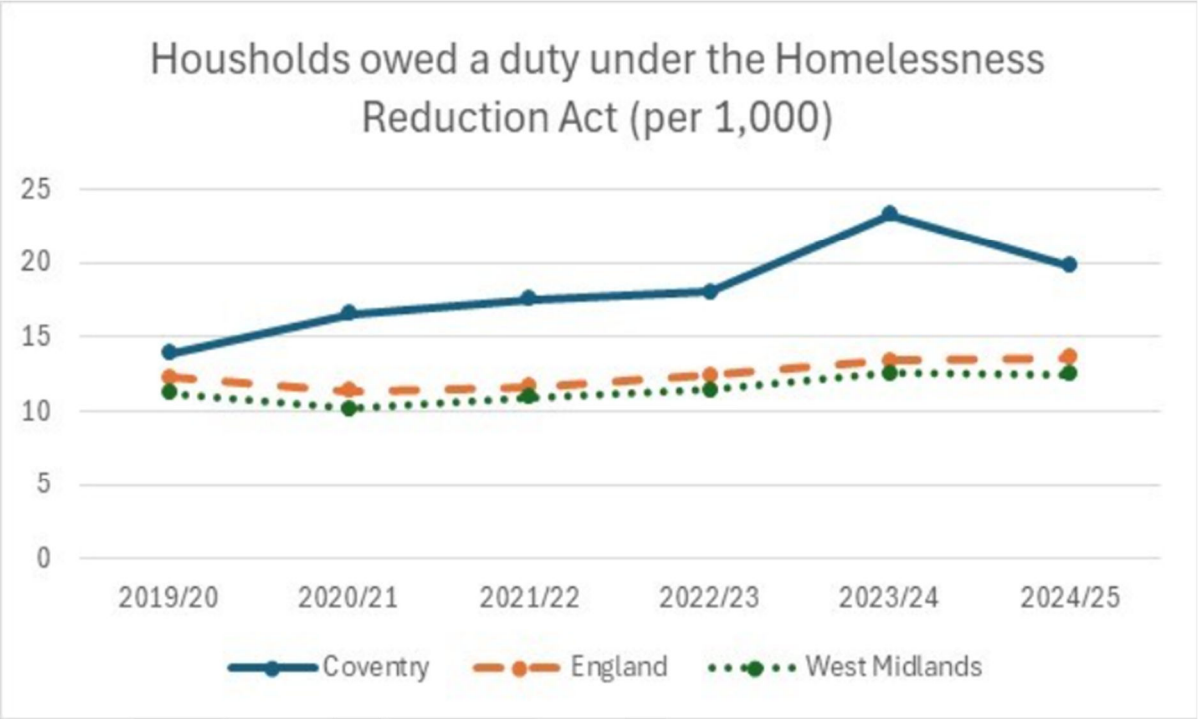

## HOMELESSNESS

H**omelessness has increased both locally and nationally since 2019**, with the COVID pandemic having a devastating impact on our communities and neighbourhoods, through social, health and economic disruption.

Under the Homelessness Reduction Act (HRA) 2017, local authorities have duties to prevent and relieve homelessness, including providing advice, developing personalised housing plans, supporting people at risk within 56 days, securing accommodation for those already homeless, and receiving referrals from partner agencies. Coventry City Council's Homelessness and Rough Sleeping Strategy

2025-2029 builds on earlier strategies and recognises homelessness as ranging from rough sleeping to insecure or inadequate housing.

**Coventry has a much higher rate of households owed a homelessness duty than national and regional averages, particularly for the relief duty, indicating a greater proportion of households already homeless when they present.** 3,133 Coventry households were owed a duty under the HRA during 2024/25, a rate of 19.8 per 1,000 households in Coventry, notably higher than the England average of 13.6.




Out of all owed a duty in 2024/25, 69% were already homeless and owed a relief duty (England 55%), so Coventry has a particular problem with people already being homeless.

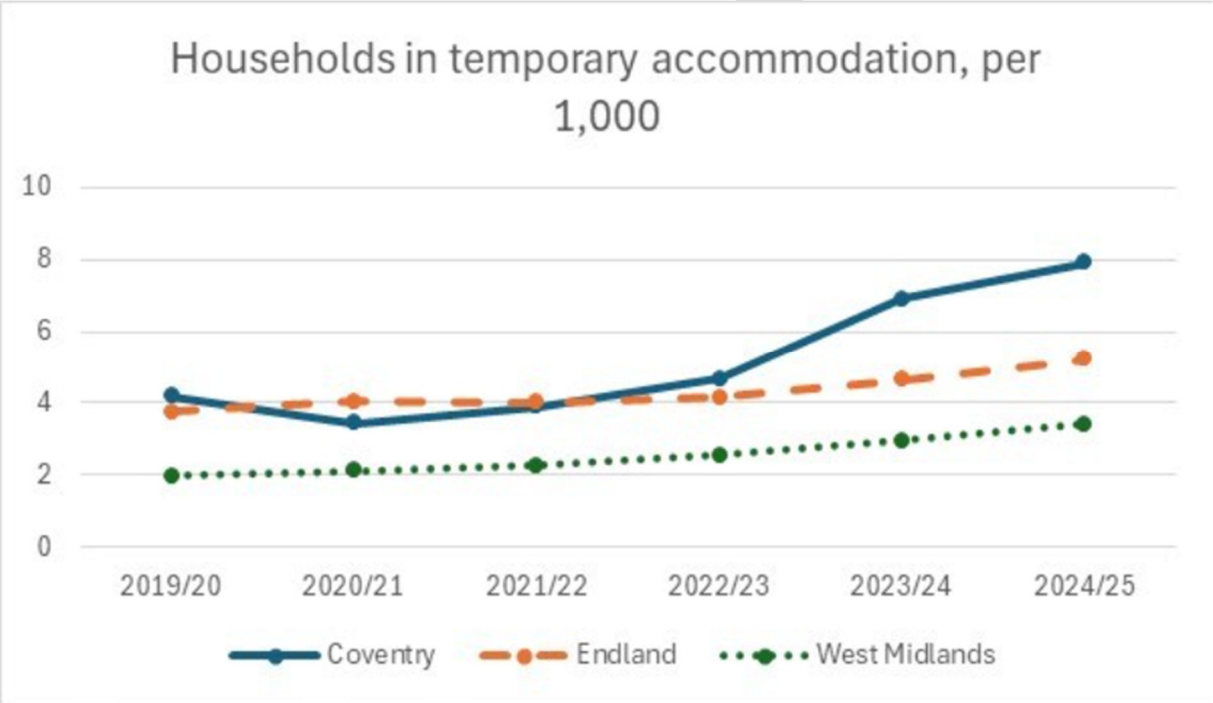
For those owed a relief duty, the most common reasons include family or friends no longer willing or able to accommodate them (26%), followed by domestic abuse (16%), being required to leave accommodation provided by the Home Office as asylum support had ended (12%) and eviction from supported housing (12%).
The main driver of homelessness prevention cases is the end of assured shorthold tenancies (40%), with two-thirds of these due to the landlord wishing to sell or re-let the property.

**Out of the 3,133 households owed a duty in 2024/25, 922 included children**. The number with children has followed similar trends to the total number, generally making up about a third of households owed in duty in Coventry – and at a rate of 21.3 per 1,000 households with children in Coventry. **The local rate is notably higher than the England average of 16.2**.

In 2025/26, 52% of Coventry households at risk of homelessness were successfully prevented from becoming homeless, while 32% of homeless households were

successfully rehoused. Comparative data for Q3 2025/26[12] shows Coventry's overall success rate (39% of cases prevented or relieved) is below the English metropolitan average of 43%. This partly reflects Coventry's higher proportion of relief cases, which typically have lower success rates than prevention cases.

**Homelessness pressures in Coventry have intensified in recent years. While rates of temporary accommodation (TA) were previously broadly in line with national levels, Coventry now has a significantly higher rate than both England and the West Midlands.** An average of 1,244 Coventry households were in TA throughout 2024/25, a rate of 7.9 per 1,000 households, much higher than the England rate of 5.2.




Local data indicates that by April 2026 there were 851 households currently residing in TA, indicating that the total in TA may have come down in the last year. Of these, 44% are single parent households, and a total of 1,822 children are currently living in TA.

Comparative data shows that **Coventry has a significantly higher rate of households with children in temporary accommodation** compared with national, regional, and other metropolitan averages. **The average length of time households with children have been in temporary accommodation is 300 days**, highlighting the prolonged nature of TA placements for families. However, no families with children were placed in bed and breakfast accommodation for longer than six weeks.

**The number of people sleeping rough in Coventry appears to be increasing. It was estimated that 29 people were sleeping rough in Coventry, taken from a**

[12] lginform.local.gov.uk

**snapshot survey on a night in Autumn 2025[13].** While it is acknowledged that this is unlikely to represent the totality of people who sleep rough at any one time, or for a period during a year, this is the highest number of all snapshots since 2010. The total has fluctuated over this period with an increasing trend since 2020 – the trend can be seen in an LG Inform report here.



[13] Ministry of Housing, Communities and Local Government request annual snapshot counts of how many people are sleeping rough in each local authority area on a given night every Autumn, collated by outreach workers, local charities and community groups and is independently verified by Homeless Link

## CHAPTER 4 - HEALTH & WELLBEING

**Key Messages**

- The overall health of residents in the city is below average, with life expectancy consistently lower than regional and national levels.
- There are significant health inequalities across Coventry's neighbourhoods that disproportionately affect certain communities, with some groups experiencing preventable and systemic disparities.
- Premature mortality in Coventry is higher than both the regional and national averages for males and females and has consistently remained this way.
- Cancer, cardiovascular disease, respiratory disease and chronic liver disease are driving premature mortality.
- There has been a notable increase in mortality from COPD (chronic obstructive pulmonary disease), now higher than regional and national averages.
- Across all major conditions, deprivation is strongly associated with higher prevalence, earlier onset and poorer outcomes.
- Preventable risk factors such as diet, smoking, alcohol consumption, and physical activity drive premature mortality and health inequalities.
- Alcohol causes disproportionately high harm in Coventry; the city continues to experience higher-than-average hospital admissions, mortality, and premature deaths linked to alcohol, particularly among men and older adults.
- A quarter of adults are inactive, and over two-thirds are overweight or obese. While rates in younger children are relatively better, obesity rises sharply by Year 6 and remains high in adulthood.
- Overall mental wellbeing in Coventry was affected by COVID-19 and was worse in 2022 than in 2018. Since then, there has been some improvement but not to 2018 levels.
- Coventry has declining rates of childhood and annual flu vaccinations uptake, and HIV testing. Childhood immunisation is Coventry's weakest area in the ONS Health Index for England.
- Coverage of screening for cancers such as breast cancer, cervical cancer, and bowel cancer are below the national average.
- Coventry residents have relatively good access to health services overall. However, A&E waiting times and cancer treatment timelines at the local hospital are below average.

**What this means for Coventry**

People living in more deprived areas of the city are more likely to develop major health conditions, be diagnosed later, and have worse outcomes, highlighting the need for prevention and early support in disadvantaged communities. The Marmot approach seeks to address this gradient, and services should continue to use the Marmot principle of proportionate universalism, where the intensity and level of support are scaled proportionally to the level of disadvantage or need.

Coventry residents' health is affected by their behaviours. Too many people drink alcohol at harmful levels, smoke, eat unhealthy diets, and do not get enough physical activity. Public services should continue to address these behaviours by offering support to individuals where appropriate and providing opportunities for

citizens to help themselves. There are also opportunities for public services to address the social determinants of health that influence these behaviours.

Alongside this, improvements can also be made to protective health behaviours and interventions, such as vaccination uptake, HIV testing and cancer screening.

COVID-19 negatively affected the mental wellbeing of Coventry residents, but recovery to pre-pandemic levels has not yet happened, suggesting that mental health pressures remain a key issue to be addressed by local partners.

Demand for health and care services is expected to increase as the city's population increases and ages, with more people living with complex multi-morbidity. This requires a population health response, and a shift to more proactive, preventative care. Integrated, place-based planning is needed to address inequalities in access to health services and reduce avoidable hospital activity.

## LIFE EXPECTANCY

**Why is this important?**

Life expectancy and healthy life expectancy are important indicators of a population's overall health. The Marmot Review, *Fair Society, Healthy Lives,* highlights strong links between preventable differences in health outcomes and deprivation. It shows that people who are experiencing multiple forms of deprivation not only have shorter lives but spend a greater portion of those shorter lives in poor health. As a Marmot City, Coventry has adopted and embedded the principles of Marmot, tackling the social conditions that can lead to health inequalities, and working to improve the areas in which people are born, grow, live, work, and age.

**What is the local picture? How does it compare?**

**Overall health in the city is below average, with life expectancy consistently lower than regional and national levels.** Recent data shows a further decline; this is partly due to the inclusion of COVID-19 deaths. Life expectancy provides a broad overview of population health and should be interpreted with caution, as pandemic-related excess deaths may not have a lasting impact on long-term trends. However, improvements in life expectancy had already stalled before 2020.

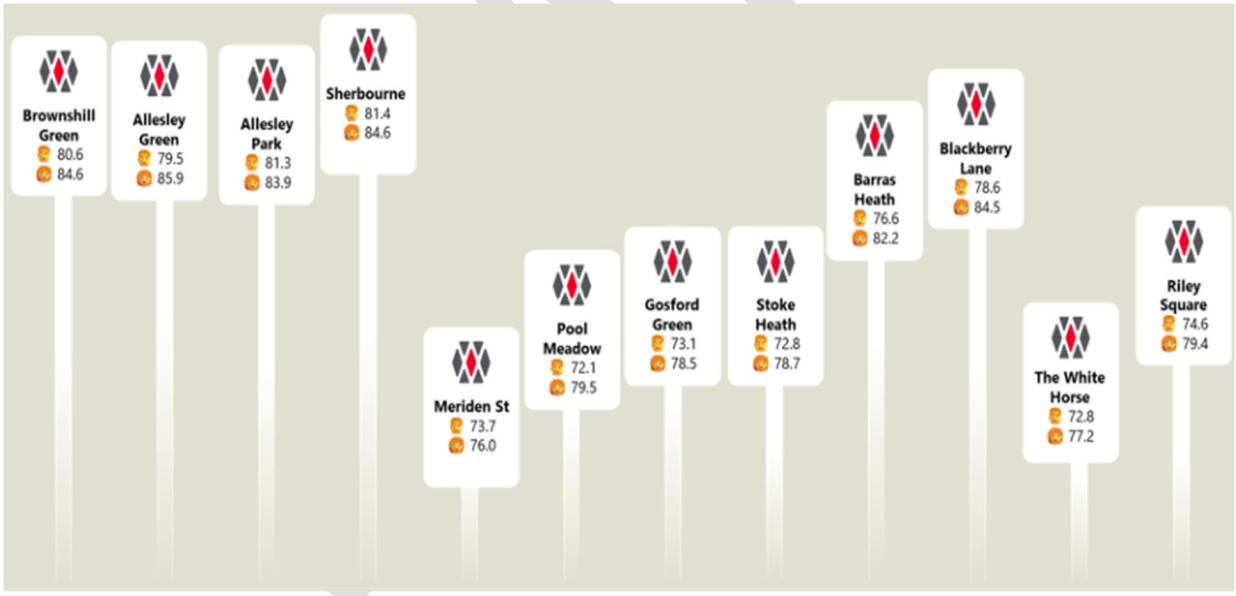
**Life expectancy for females in Coventry is 81.8 years and for males is 77.4** (2022-2024). This is below the national average of 83.3 for women and 79.5 for men. The trends for life expectancy show a slight increase in recent years for females. **Healthy life expectancy (the number of years a person can expect to live in good health) is 58.1 years for females and 58.5 for males.** Healthy life expectancy for Coventry females is lower than the national (61.9) and regional (60) averages. Coventry males are also slightly lower than the national (61.5) and regional (60.3) averages. Looking at the data over time shows a decreasing trend for both females and males.

The gap between healthy life expectancy and life expectancy is referred to as the 'window of need'. It is the average number of years that a person is likely to live in poor health and may require support from the health and care system. This gap is widening.

**In Coventry, females can expect to live more than a quarter of their lives in poor health (23.7 years) whilst males can expect to live 18.9 years in poor health.**

**There are significant health inequalities across Coventry's neighbourhoods that affect certain communities disproportionately.** Males living in less deprived areas of the city can expect to live up to 11.7 years longer than those living in the most deprived areas of Coventry; for females the gap is 9.5 years. These differences are wider than the regional averages (10.5 years for males and 8.5 years for females). Coventry has the second largest inequality gap for males and the third largest for females among West Midlands districts. Coventry's Number 7 bus route runs through some of the most affluent and most deprived areas in Coventry and we use it to illustrate inequalities in life expectancy.

Life Expectancy in Coventry on the Number 7 bus route.




People in more deprived parts of the city not only live shorter lives but also spend a greater proportion of their shorter lives in poor health compared to those living in less deprived parts of the city.

## MORTALITY & MAJOR CAUSES OF DEATH IN COVENTRY

**Why is this important?**

Understanding patterns of premature death and long-term illness helps target action where it is most needed. High mortality rates and widening inequalities place

pressure on individuals, families and services, reinforcing the need for prevention and earlier intervention, particularly in the most deprived communities. Identifying the conditions affecting our population enables more effective commissioning and better allocation of resources. Life expectancy data already shows clear geographic inequalities across Coventry, and these are reflected in variations in disease prevalence, age of diagnosis and outcomes between different areas of the city.

**What is the local picture? How does it compare?**

**Premature mortality (deaths amongst residents aged under 75 years) in Coventry is higher than both the regional and national averages for both male and females and has remained consistently so**. Within the West Midlands, Coventry ranks 4th out of 15 authorities for males and 5th out of 15 authorities amongst females for premature mortality.

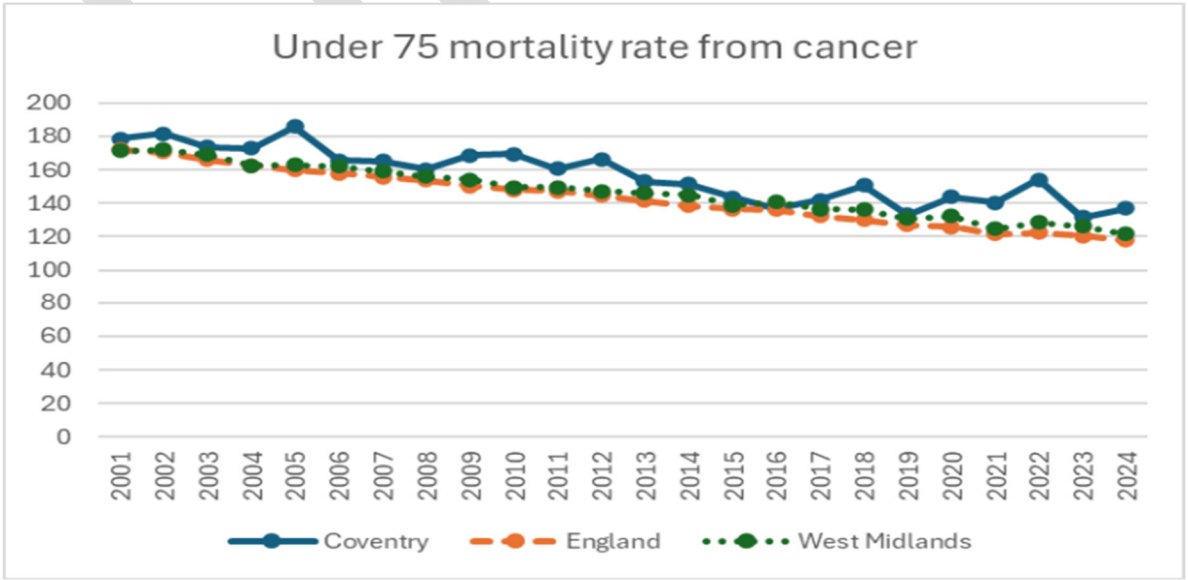
**According to the Global Burden of Disease (GBD) data from the Institute for Health Metrics and Evaluation (IHME), the four biggest causes of death in the under 70 population of the West Midlands in 2023 were:**

- Neoplasms (37.9%)
- Cardiovascular Disease (CVD, 21.8%),
- Digestive Diseases (9%)
- Respiratory Diseases (5.5%)

Local data reflects similar patterns and highlights significant inequalities by deprivation.

## CANCER

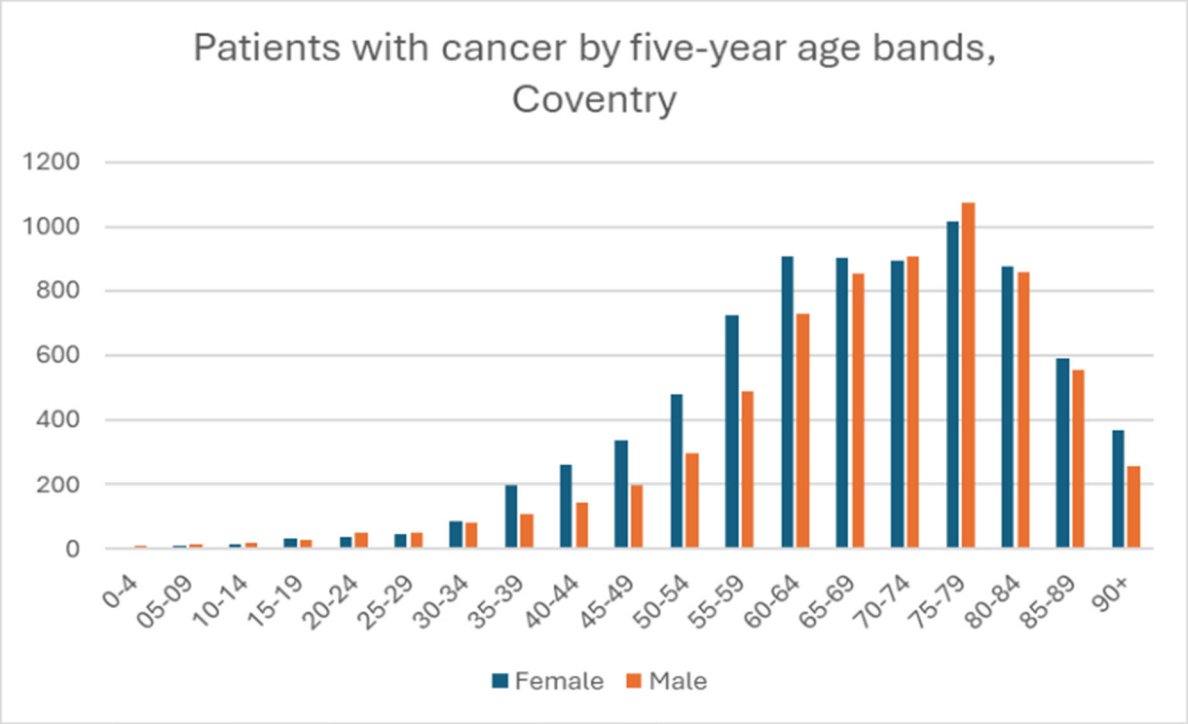
**Despite a slight increase in 2024 and a higher rate than comparators, the overall trend for deaths from cancer is steadily declining in Coventry.**




**Fingertips | Department of Health and Social Care**

Locally available data shows that half of the people with cancer in Coventry are aged 70+, with prevalence increasing sharply with age (1-in-10 people aged 65-69; 1-in-5 people by the ages 80-84). Females are almost twice as likely as males to have cancer from age 35 onwards.

**20.2% of all people with cancer in Coventry live in the top quintile of the most deprived areas of the city** (the Core20), compared to 13.9% who live in the least deprived areas. Those in the Core20 are diagnosed five years earlier on average (median age 61 vs 66).




**Data source: HDI**

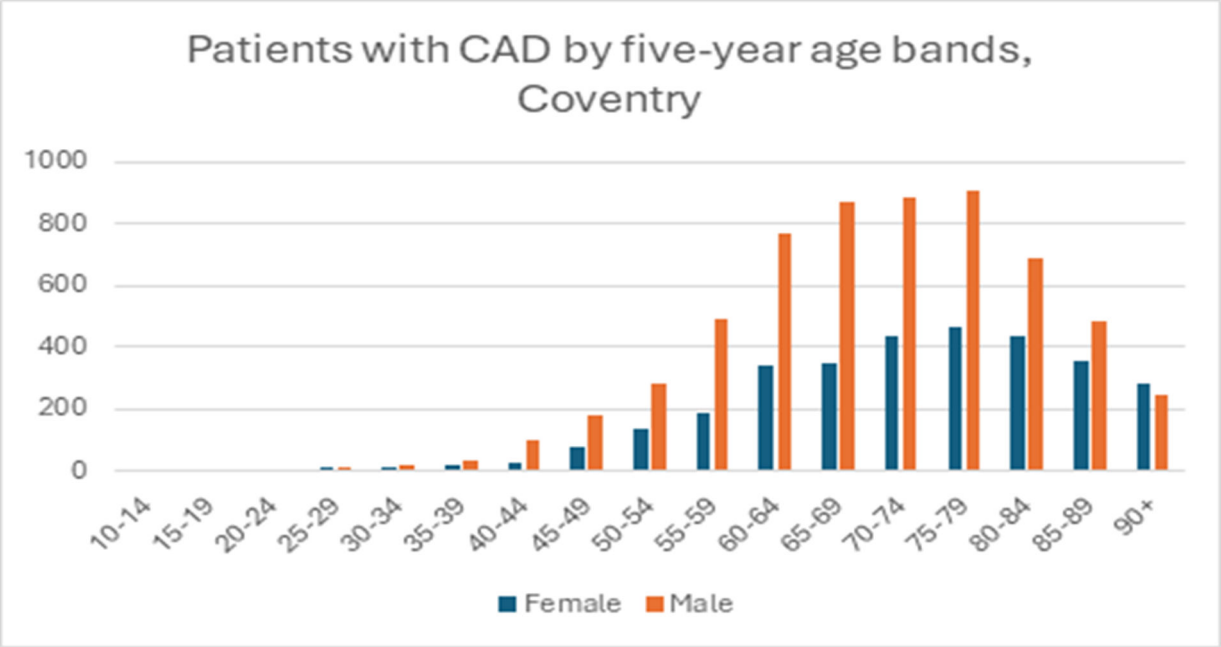
## CARDIOVASCULAR DISEASE (CVD)

**Mortality from CVD in Coventry remains stable (109.2/10,000 population) but higher than for England.** There are a range of conditions covered by CVD.

Coronary artery disease (CAD), which can be linked to lifestyle factors such as smoking, excess alcohol use and hypertension, accounts for a significant burden. Local data also shows that males are significantly more likely than females to have coronary artery disease (CAD), with the gap emerging from around age 40, when males are nearly four times as likely to be affected.

Although hypertension prevalence remains below regional and national averages, it is increasing locally.

**Over a quarter (25.4%) of people with CAD live in the Core20** – this refers to people living in the 20% most deprived neighbourhoods as part of the health inequalities framework used by the NHS. Inequalities are evident in age at diagnosis: 64 in the most deprived areas (Core20) compared to 71 in the least deprived.




**Data source: HDI**

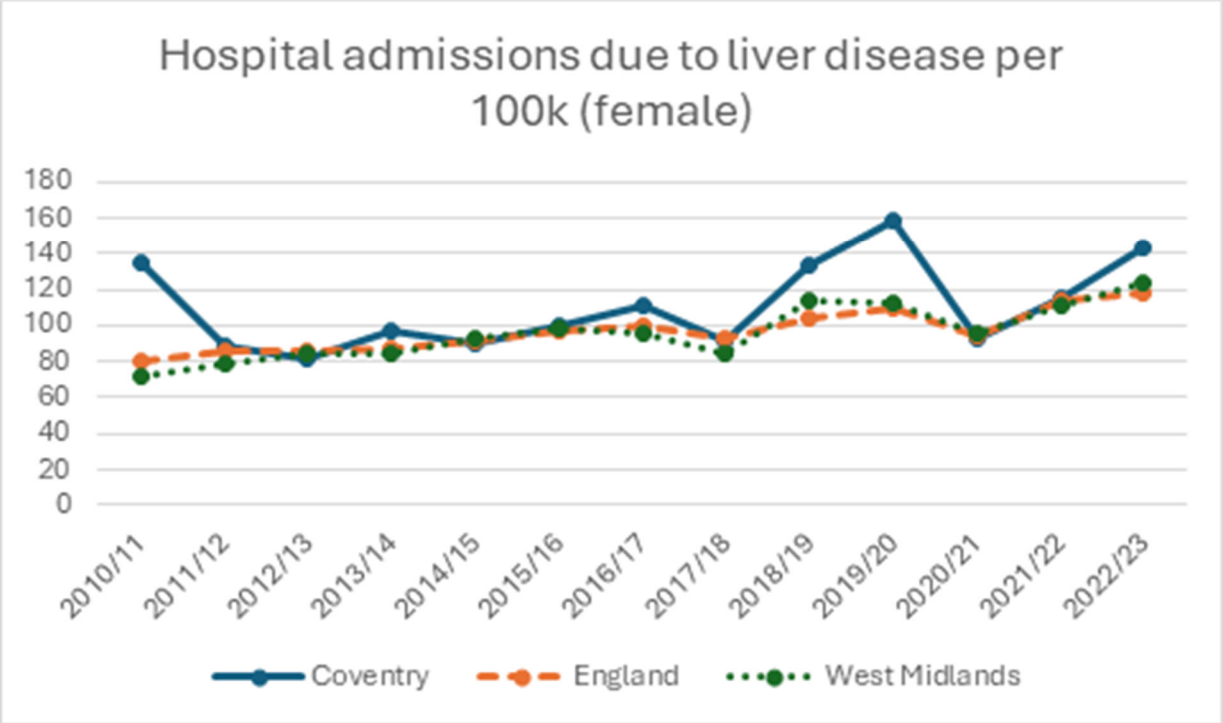
## CHRONIC LIVER DISEASE

Liver disease includes conditions such as alcohol-related liver disease, non-alcoholic fatty liver disease, hepatitis, haemochromatosis and primary biliary cholangitis. It often presents without symptoms until significant damage has occurred, known as cirrhosis.

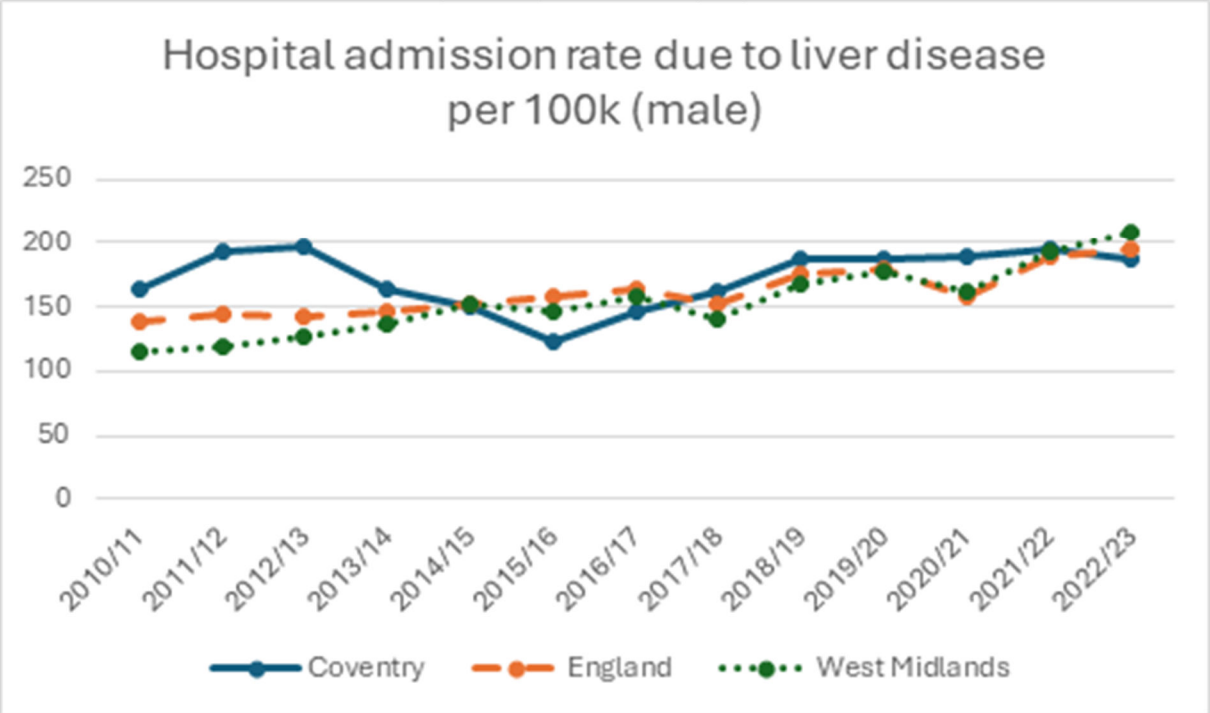
**Hospital admissions for liver disease are higher in males and increasing for both sexes.** Although admission rates are similar to comparators, Coventry has higher mortality from chronic liver disease.

**Local data shows that liver disease disproportionately affects males between age 35 and 54**, despite there being an almost equal split between the overall number of people with the condition (48% female; 52% male).

**Greater numbers of people with chronic liver disease live in the Core20**, with 29.8% vs only 7.8% in the least deprived areas. Diagnosis occurs eight years earlier in the most deprived communities (median age 47 vs 55).




**Data source: Fingertips | Department of Health and Social Care**

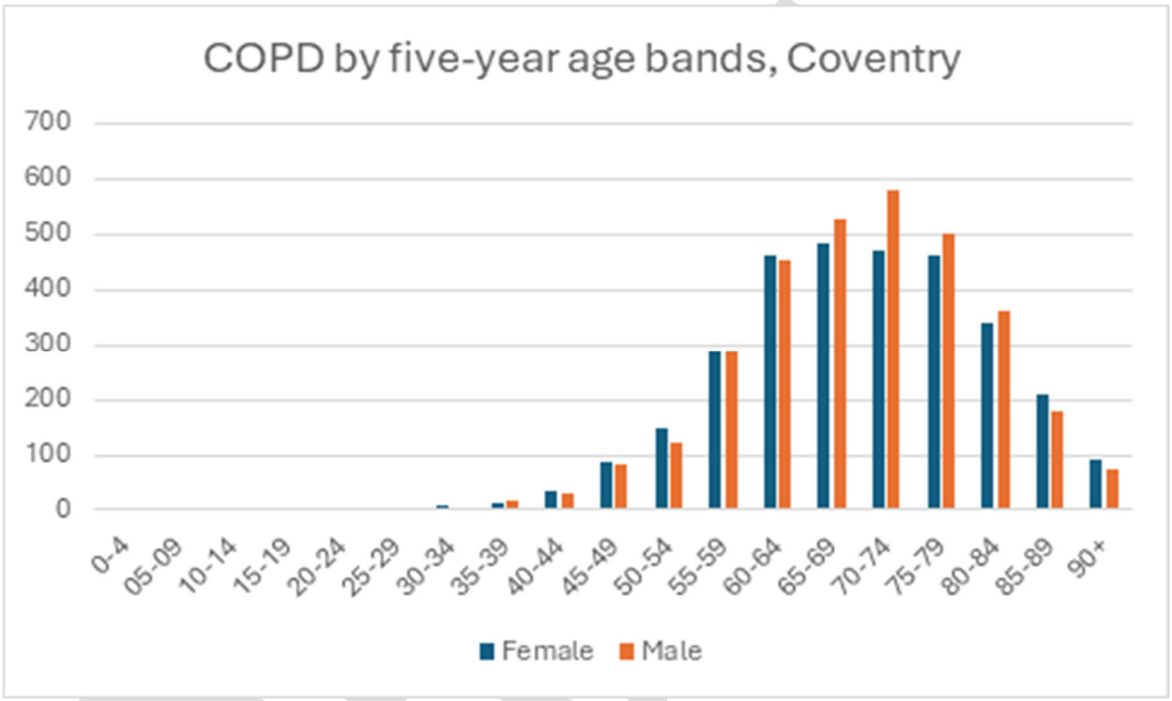



**Data source: Fingertips | Department of Health and Social Care**

## RESPIRATORY DISEASE (COPD)

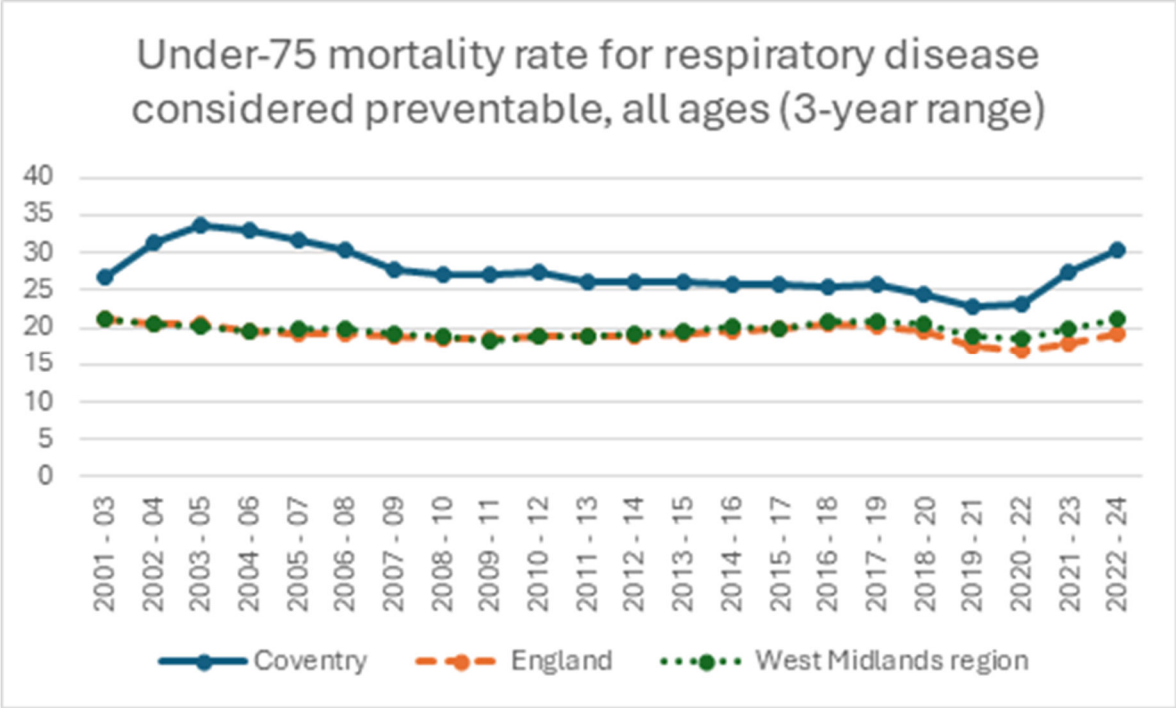
**Mortality from chronic obstructive pulmonary disease (COPD) has risen since 2020 and is now higher than regional and national averages** (62.6 per 100,000 compared with 47.6 in the West Midlands and 45.5 in England). Although rates stabilised briefly before the pandemic, they have continued to increase, with a widening gap between Coventry and comparators.

COPD predominantly affects older adults: 73% of patients are aged 60-84. Only 16% of the GP-registered population in our dataset are between these ages.




**Data source: HDI**

**Inequalities are stark; 34.1% of people with COPD live in the Core20, compared with 5.9% in the least deprived areas.** Diagnosis occurs eight years earlier in the most deprived communities (median age 65 vs 73).




**Data source: Fingertips | Department of Health and Social Care**

## INEQUALITIES IN PREVENTABLE MORTALITY

**Across all major conditions, deprivation is strongly associated with higher prevalence, earlier onset and poorer outcomes**, reinforcing the need to target prevention and early intervention in the most disadvantaged communities.

Some groups within Coventry's population experience avoidable and systemic health inequalities[14]:

- **People living in deprived areas** have lower life expectancy and are diagnosed with conditions earlier.
- **People from some minority ethnic groups** experience higher risk of certain health conditions. For example, black and Asian ethnic groups often have higher instances of diabetes[15].
- **People with disabilities or long-term conditions** often experience poorer health outcomes and shorter life expectancy. In Coventry, life expectancy for someone with a learning disability is 63 years. People with a learning disability are also more likely to engage in risk behaviours such as smoking and have higher rates of obesity and cardiovascular disease than the wider population.
- **People experiencing homelessness** face barriers to GP registration and ongoing care.
- **Armed forces veterans** experience higher rates of physical and mental health conditions. including back pain and depression. Veterans are more

[14] The Kings Fund – Health Inequalities in a nutshell https://www.kingsfund.org.uk/insight-and-analysis/data-and-charts/health-inequalities-nutshell

[15] DiabetesUK – Ethnicity and type 2 diabetes https://www.diabetes.org.uk/about-diabetes/type-2-diabetes/diabetes-ethnicity

than twice as likely to suffer from lower back pain than non-veterans and almost three times as likely to have depression.

- **Inclusion Health Groups:** vulnerable migrants, refugees and asylum seekers; Gypsy, Roma and Traveller communities; people with alcohol and drug dependence; sex workers; those in contact with the judicial system; victims of modern slavery.

## HEALTHY BEHAVIOURS & LIFESTYLE

**Why is this important?**

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

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

**What is the local picture? How does it compare?**

The Household Survey 2022, the latest data on general health available, showed that 7 in 10 Coventry residents (71%) considered that their general health is either very good (29%) or good (42%). Under 1 in 10 (7%) considered it to be bad. The proportion that rated their health as either very good or good has decreased over time (78% in 2018 and 73% in 2022). The proportion rating their health as bad has decreased from 8% in 2021 but is higher than the 1% recorded in 2018. Specific lifestyle factors are detailed below.

## SMOKING

**Smoking prevalence in Coventry shows mixed trends. Although rates have fallen from 18.8% in 2013, recent years have fluctuated, with an increase reported in 2024.** The Coventry Household Survey 2024/25 found 14% of residents smoke (up from 11% in 2022), while the Annual Population Survey (APS) estimated prevalence at 10.6%, slightly above England (10.4%) and below the West Midlands (11.3%). Overall, rates remain close to but slightly above the national average.

**Smoking is significantly higher among working adults (aged 18-64) in routine and manual occupations** (19.4%), who are twice as likely to smoke as those in other occupations. The GP Patient Survey (2024/25) found prevalence is **also much higher among people with long-term mental health conditions** (31.1%), over

three times the rate of those without such conditions and above regional and national averages.

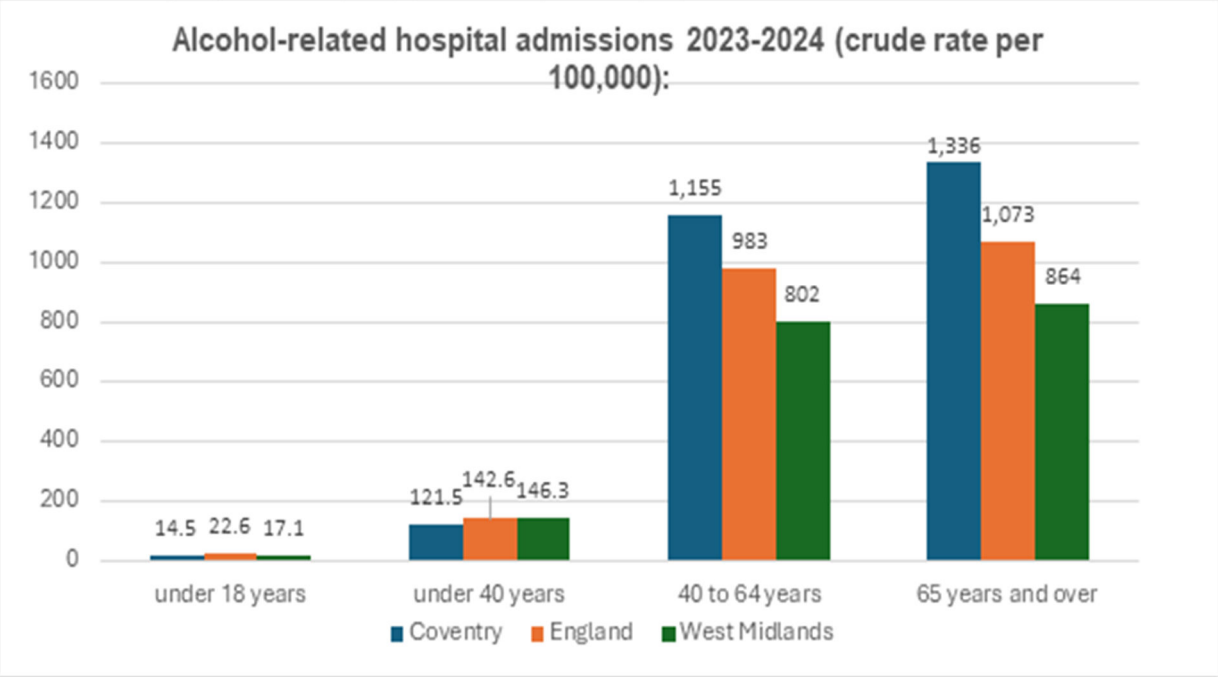
**E-cigarette use is rising, with 9% of residents reporting use in 2024/25 (up from 4% in 2021).**

**Quit activity is slightly below average, with 4.1% setting a quit date in 2024/25 compared to 4.5% for national and regional averages.** However, quit success rates are strong: 56.9% of those who set a quit date successfully stopped smoking, higher than both England (53.6%) and West Midlands (42.3%) averages. Overall, 2.3% of Coventry's smoking population quit successfully, similar to national (2.4%) and regional (1.9%) levels.

## ALCOHOL CONSUMPTION

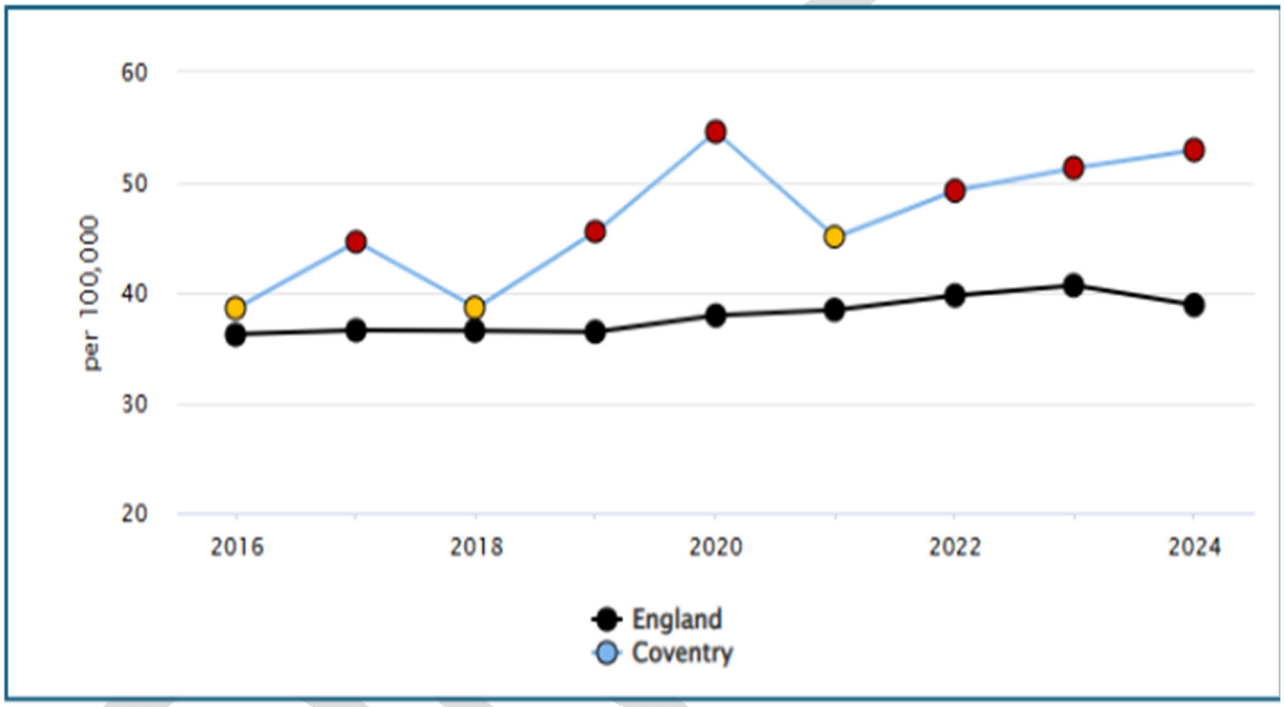
**Alcohol causes disproportionately higher levels of harm in Coventry. Although more residents report not drinking, the city continues to experience higher-than-average hospital admissions, mortality, and premature deaths linked to alcohol, particularly among men and older adults.** The 2024/25 Coventry Household Survey indicates a shift in drinking behaviour. 44% of respondents report not drinking alcohol, up from 34% in 2022. Most respondents consumed alcohol once a week or less, though 28% report drinking more than 2–3 units on two or more days per week.

Despite this, alcohol continues to have a significant health impact. In 2023/24, Coventry recorded 705 alcohol-related hospital admissions per 100,000 residents, well above England (504) and the West Midlands (607), with the highest rates among those aged 40+.



**Alcohol-related mortality is also higher than regional and national averages (53.0 per 100,000 compared with 38.9 in England and 43.6 for West Midlands) and has increased since 2021.** Alcohol-specific mortality (19.7 per 100,000 residents) remains above comparators (13.8 per 100,000 England, 16.5 per 100,000 West Midlands). Premature mortality and potential years of life lost are particularly high among males. Deaths from alcoholic liver disease (15.5 per 100,000) exceed England (11.4) and regional rates (14.0), although they have fallen slightly since 2022.

**Alcohol-related mortality rate 2016-2024 (per 100,000 population):**




An estimated 18.2 per 1,000 adults were alcohol dependent in 2019/20, the third highest rate in the West Midlands[16]. 16.1 per 10,000 adults were treated for alcohol addiction in 2024/25[17]. Coventry's rate for treatment for alcohol dependence was lowest in the West Midlands.

## HEALTHY WEIGHT

**Dietary habits in Coventry are constrained by cost, time, and the local food environment. While most residents value healthy eating, fewer than a quarter meet the five-a-day recommendation, takeaway consumption is common, and food insecurity affects a small but significant proportion of households.**

Coventry has a higher density of fast-food outlets (124.5 per 100,000) than both the West Midlands and England averages. According to the Active Lives Adult Survey (ALAS), 25.5% of adults are meeting the five-a-day fruit and vegetable consumption

[16] Office for Health Improvement and Disparities
[17] National Drug Monitoring System (NDTMS)

recommendations in Coventry in 2023/24, below England (31.3%) and the West Midlands (28.7%), and this has declined slightly in recent years.

The Coventry Household Survey 2024/25 found that whilst 93% of respondents recognise the importance of healthy eating, cost and time are key barriers. 72% say price is the most important factor when buying food (up from 64% in 2022), reflecting cost-of-living pressures. Over a quarter (26%) eat takeaways at least once or twice a week.

**Physical inactivity is improving, but excess weight remains a major challenge in Coventry. A quarter of adults are inactive, and over two-thirds are overweight or obese. While rates in younger children are relatively better, obesity rises sharply by Year 6 and remains high in adulthood, highlighting the need for sustained prevention across the life course.** In 2023/24, 64.8% of adults in Coventry were physically active (150+ minutes per week) - below England (67.4%) but slightly above the West Midlands average (64.1%). Activity levels have improved from 58.4% in 2021/22. Younger adults are more active than older groups, with participation declining steadily with age. Walking for travel is increasing, with 18.5% of adults reporting this in 2022/23 - similar to England (18.6%) and above the regional average (15.4%).

However, 24.1% of adults remain physically inactive, higher than England (22.0%) but slightly lower than the West Midlands (24.9%). Inactivity rises sharply in older age, affecting over half (51.6%) of those aged 75+.

**Coventry's obesity rate is lower than England and the West Midlands in Reception year children, but by Year 6 it rises above the national average.** In 2024/25, 22.7% of Reception children (aged 4–5) were overweight or obese, below England (23.5%) and the West Midlands (24.4%). This continues an overall decline since 2020/21 (27.7%).

By Year 6 (aged 10–11), 38.8% were overweight or obese, above England (36.2%) and just below the West Midlands (38.9%). Although this reflects improvement since 2020/21(45.8%) and 2023/24 (40.8%), levels remain high.

Obesity alone follows a similar pattern: Reception rates (10.7%) are close to national levels and below the regional average, while Year 6 obesity (24.8%) exceeds England and is broadly in line with the West Midlands.

In 2023/24, 67.7% of adults in Coventry were overweight or obese, higher than England (64.5%) and slightly above the West Midlands (67.1%). Rates have fluctuated in recent years but remain high overall. Additionally, 27.1% of adults were classified as obese, above the national average (26.5%) but below the regional rate (29.7%).

Overall, while physical activity is improving, inactivity in older adults and high levels of excess weight, particularly in older children and adults, remain key public health challenges.

## LIFESTYLE RISKS – HEALTH & WELLBEING SEGMENTATION

The Wellbeing Acorn classification identifies population groups based on health behaviours and wellbeing risks. **Several groups with higher health risks are more common in Coventry** than in the UK, including:

- **Unhealthy routines** – (6.3%of Households) Adults are more likely to neglect their physical health through unhealthy eating, inactivity, smoking, and alcohol use. As a result, they may have significant health issues like obesity, cardiovascular diseases, diabetes, mental health problems, and a lower quality of life.
- **Multi-generational strains** – (5.2% of Households) Households where multiple generations live together often experience stress due to differing needs and responsibilities. This can include care for elderly family members and young children at the same time, leading to financial and emotional burdens. These households may benefit from support systems that address the needs of all generations.
- **Burdened Lifestyles** – (7.1% of Households) Younger populations facing significant life burdens, including financial stress, health issues, and demanding responsibilities. This group often experiences reduced quality of life and wellbeing, struggling to manage the pressures of daily life.
- **Detrimental Practices** – (8.4% of Households) Inactive individuals, working in lower-income occupations, and usually renting. Their excesses, including a higher likelihood to be smoking and/or binge drinking, add to their stress.
- **Urban Isolation** – (12% of Households) Primarily middle-aged singles and large families living in cities and urban areas, with a relatively high proportion in rented accommodation. There are associated pressures characterised by low incomes, poor dietary habits and health and wellbeing. They are less likely to feel part of a community or know their neighbours, despite living in densely populated areas.
- **Balanced Behaviours** – (9.6% of Households) Families with young children maintaining a middle-income lifestyle. Supervisory occupations provide stability. Whilst health is generally good, they have some concerns which come from their lifestyle.
- **Midlife Moderation** – (6.7% of Households) Typically aged 45-64, moderation guides this cohort as they are relatively stable, both economically and socially, with a balanced lifestyle and good overall health, but some bad habits.

Understanding these groups helps target public health interventions and prevention programmes.

## MENTAL HEALTH & EMOTIONAL WELLBEING

**Why is this important?**

Mental health is a state of wellbeing that enables people to cope with everyday stresses, work, learn and contribute to their communities[18]**.** Mental health conditions

[18] https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response

are as varied as ones which affect our physical bodies, including mental disorders and psychological disabilities.

Risk factors include individual factors such as genetics, emotional skills and substance misuse, as well as social and environmental influences including poverty, violence and deprivation. Risks are particularly significant in sensitive developmental periods like early childhood, when experiences can have lasting effects.

However, protective factors, such as strong relationships and social networks, good emotional foundations, stable housing and employment, and access to education all help build resilience and support positive mental wellbeing.

**What is the local picture? How does it compare?**

**The Household Survey includes a short version of the Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS) and data indicated that there has been a general downward trend in the mean score for Coventry.** After a steady decline from 26.41 in 2018 down to 21.75 in 2022, it has subsequently risen to 22.78. With a score of >18-20 indicating a possible mild depression, the current score for Coventry suggests that mental health pressures are being experienced by residents.

Children and young people's mental health is detailed in chapter 3. Coventry and Warwickshire Mental Health Needs Assessment, published in 2021, provides a detailed assessment of mental health needs.

## ANXIETY

Anxiety disorders are linked to a range of social, biological and environmental factors. Experiences such as trauma, loss and abuse increase risk, and anxiety is also associated with poorer physical health outcomes, including cardiovascular disease[19].

In Coventry, **17% of the GP-registered population has a recorded diagnosis of anxiety.** The condition affects all ages, from early childhood to older adulthood. Females are 56% more likely than males to have a recorded diagnosis, and there are twice as many younger females aged 15-24 with a recorded diagnosis than males of the same age.

Inequalities are evident across the city. **Over a quarter (28.1%) of people with anxiety live in the most deprived areas (Core20)**, compared with 8.3% in the least deprived areas. Diagnosis also occurs earlier in more deprived communities (median age 36 vs 40), highlighting the impact of socioeconomic factors on mental health.

## DEPRESSION

Much like anxiety, depression is a common mental health disorder which affects an estimated 4% of the global population. Depression is approximately 1.5 times more

[19] https://www.who.int/news-room/fact-sheets/detail/anxiety-disorders

common in females than males[20]. Our local data shows that Coventry is no exception, with females 1.57 times more likely to have a recording of depression than males.

**In Coventry, 13.3% of adults have a recorded diagnosis of depression** - lower than the West Midlands (15.1%) and England (14.3%). However, prevalence has more than doubled since 2012/13 and continues to rise. **Almost 1 in 3 people (30%) with depression live in the most deprived areas** (Core20), compared with 7.6% in the least deprived areas. Diagnosis also occurs earlier in more deprived communities (median age 38 vs 42), reinforcing the link between deprivation and mental health.

## HEALTH PROTECTION

**Why is this important?**

Health Protection is a term used to cover a set of activities within public health. It is defined as protecting individuals, groups, and populations from single cases of infectious disease, incidents and outbreaks, and non-infectious environmental hazards such as chemicals and radiation. Monitoring health protection coverage helps to identify possible drops in immunity before levels of disease rise.

**What is the local picture? How does it compare?**

**Childhood vaccination uptake in Coventry continues to fall and remains below the 95% target for several key vaccines.**

In 2024/25, uptake was below national and regional averages for routine immunisations, including: DTaP/IPV/Hib at age 1 (88.1%); rotavirus vaccination (86.0%); and MMR at age 2 (84.6%), all falling since 2021/22. However, uptake is stronger for some adolescent vaccines, including: HPV vaccine (dose 1) for males aged 12-13 (69.3% vs 67.7% nationally, 66.0% regionally); HPV dose 1 for females aged 12-13 (74.0% vs 72.9% nationally and 70.8% regionally); and Meningococcal ACWY Conjugate (MenACWY) vaccines for 14 to 15-year-olds (79.9% vs 73.0% nationally and 71.9% regionally).

The Office for National Statistics (ONS) Health Index for England combines 56 indicators to assess overall health and enables comparison with national performance. **The Index identifies childhood immunisation as Coventry's weakest area.** While the child immunisation score improved, it remains below the England benchmark (where 100 represents the 2015 national average).

| Area | 2020 | 2021 |
|---|---|---|
| England | 98.3 | 100.1 |
| Coventry | 79.4 | 93.8 |
| West Midlands | 95.3 | 99.7 |

[20] https://www.who.int/news-room/fact-sheets/detail/depression

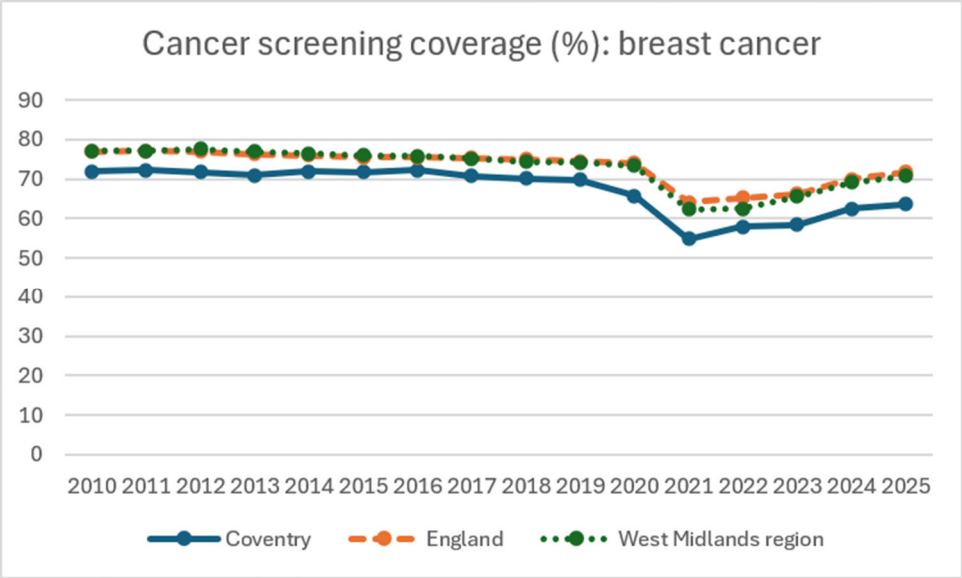
**According to the UK Health Security Agency (UKHSA), flu vaccination uptake in Coventry is below national and regional averages and continues to decline.**

Among adults aged 65+, uptake was 71.6% in 2024/25, down from 81.0% in 2021/22 and below the WHO 75% target, as well as below England (74.9%) and the West Midlands (73.5%).

For under-65s in at-risk groups, uptake fell to 37.4%, below England (40.0%) and the West Midlands (38.5%), and significantly lower than 50.2% in 2021/22.

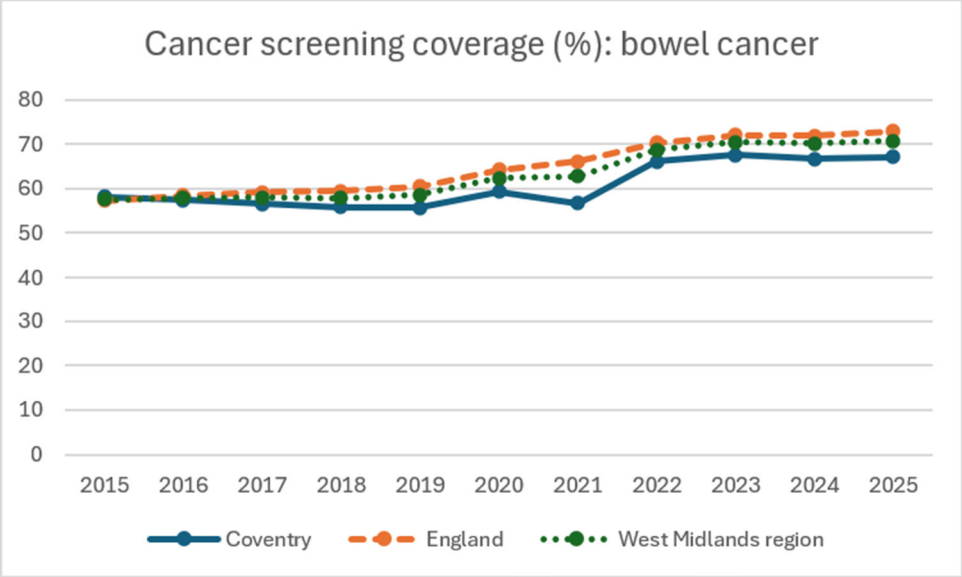
Uptake among children has also declined. Coverage for 2–3-year-olds (36.8%), primary school pupils (42.5%) and secondary school pupils (30.8%) is below national and regional averages, with sustained downward trends in recent years.

**Coverage of screening for cancers such as breast cancer, cervical cancer, and bowel cancer are below the national average.**



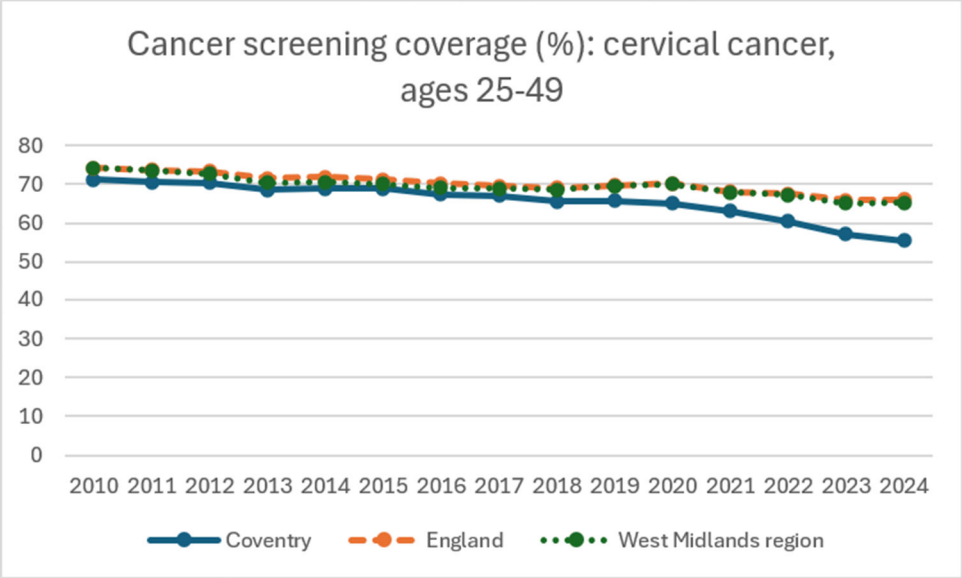

**Data source:** [Fingertips | Department of Health and Social Care]

Breast cancer screening coverage has remained under both the national and regional averages since 2010, though it has been increasing since 2021 in line with comparator groups.

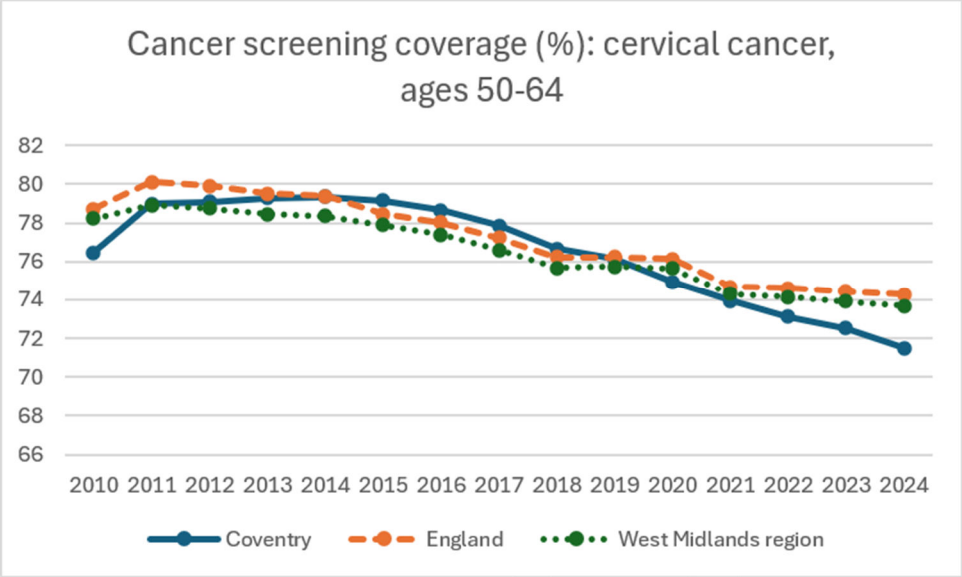



**Data source:** Fingertips | Department of Health and Social Care

Cancer screening for bowel cancer is below regional and national comparators; it is more closely aligned than breast cancer. This is also seeing an increasing trend across the board.



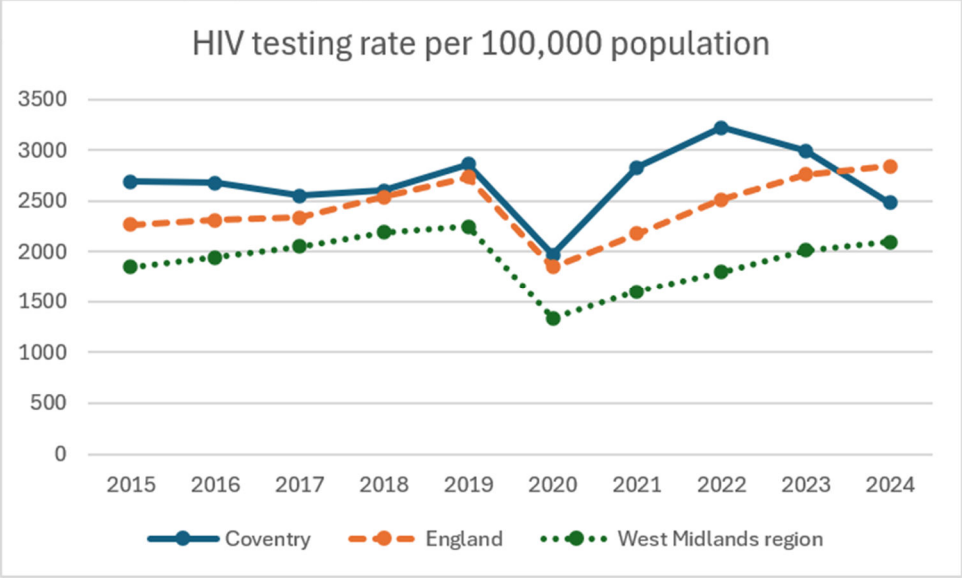

**Data source:** Fingertips | Department of Health and Social Care



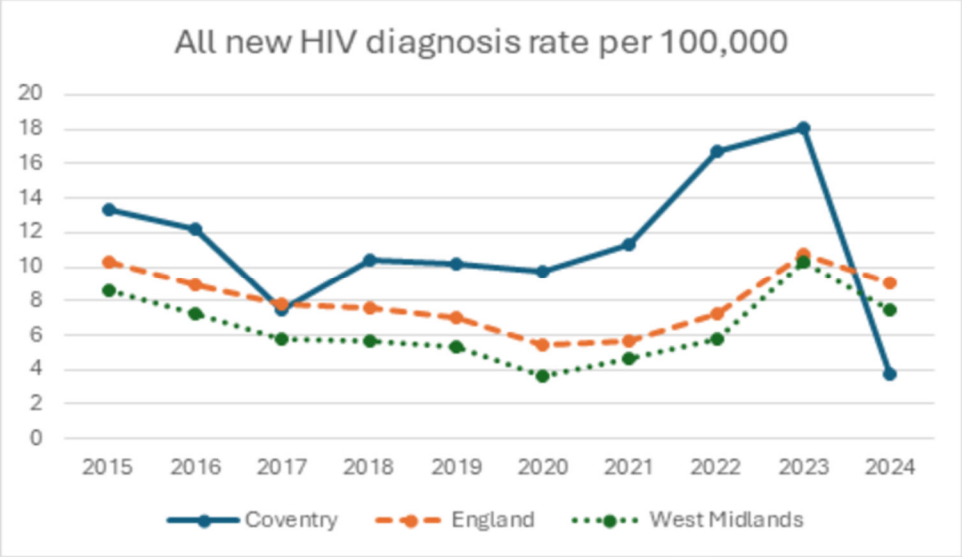

**Data source:** [Fingertips | Department of Health and Social Care]

Cervical cancer screening, although closely aligning with national and regional figures up to 2015 for both age groups, has seen a steady decline in coverage and is at its lowest level since 2010. While regional and national rates have also dropped, Coventry has dropped to worst in the West Midlands for those aged 25-49, and 11th in the West Midlands for those aged 50-64.

**HIV testing remains essential for early diagnosis and prevention.** Coventry has historically tested at higher rates than both regional and national averages. However, **in 2024, testing fell below the national rate for the first time**, though it remains above the regional average.




**Data source:** [Fingertips | Department of Health and Social Care]




**Data source:** Fingertips | Department of Health and Social Care

There has been a **large drop in the new HIV diagnosis rate**, as shown in the figure above.

## DEMAND & ACCESS

**Why is this important?**

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

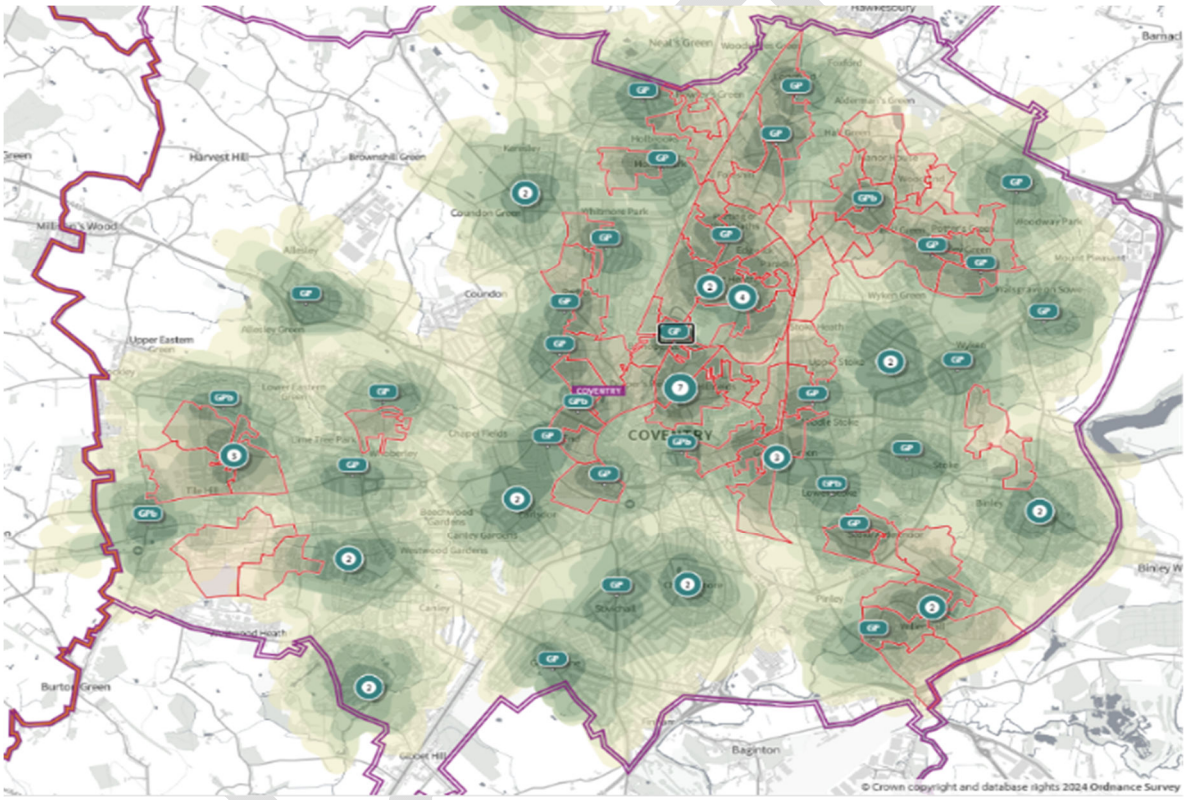
**What is the local picture? How does it compare?**

**Compared to other places, Coventry residents have relatively good access to health services, in terms of the number of facilities, proximity and travel time.**

Office for National Statistics (ONS) data from 2024 on 'access to local amenities' indicates that the number of GP surgeries and the number of Pharmacies per head of is relatively high in Coventry. At 16.6 surgeries per 100,000 population Coventry ranks 33rd highest out of 317 local authority areas in England and Wales, and 23.0 pharmacies per 100,000, ranking 29th. Coventry has slightly better than average ratios for these services amongst all other metropolitan areas. **However, Coventry has a relatively low number of dental practices; at 11.1 per 100,000 population this is lower than the metropolitan local authority average (14.8) and ranks 279$^{th}$ in of local authority areas in England & Wales.**

The 2024 Access to Healthy Assets and Hazards (AHAH) Index ranks Coventry 61st out of local authorities in England and Wales for drive-time access to GPs, pharmacies, dentists and hospitals. On average, residents live closer to health services than in most parts of the country and slightly closer than in comparable metropolitan areas.

There are 49 GP practices in Coventry, but access varies between neighbourhoods. The map below, from the Shape Place tool, illustrates the location of Coventry GP surgeries and walking time to the nearest. (The yellow areas are with a 20-minute walk, and the dark green areas are less than 5 minutes). Most areas are within a 20-minute walk. The red boundaries illustrate the Coventry neighbourhoods that are amongst the most deprived 20% in England. All people living in these areas are within a 20-minute walk, although not all residents will be able to travel this easily.




Coventry & Warwickshire Pharmaceutical Needs Assessment 2025-2028 **highlights that Coventry has a higher-than-average number of pharmacies, concluding there is sufficient access to pharmacies in Coventry and no gaps in pharmaceutical provision.** There are 82 pharmacies in the city, a rate of 2.27 per 10,000 population compared with 1.85 nationally.

Access to out-of-hours provision is also strong: all residents live within a 15-minute drive of a pharmacy open outside standard weekday hours. Beyond essential services, many pharmacies provide a wide range of advanced services - such as the New Medicines Service, Appliance Use Services, Seasonal Flu Vaccinations, and

Pharmacy First. While availability varies by service, overall provision across the city is good.

**Data on walking time to dental practices in Coventry indicates that many people live further than a 20-minute walk from their nearest dentist.'**

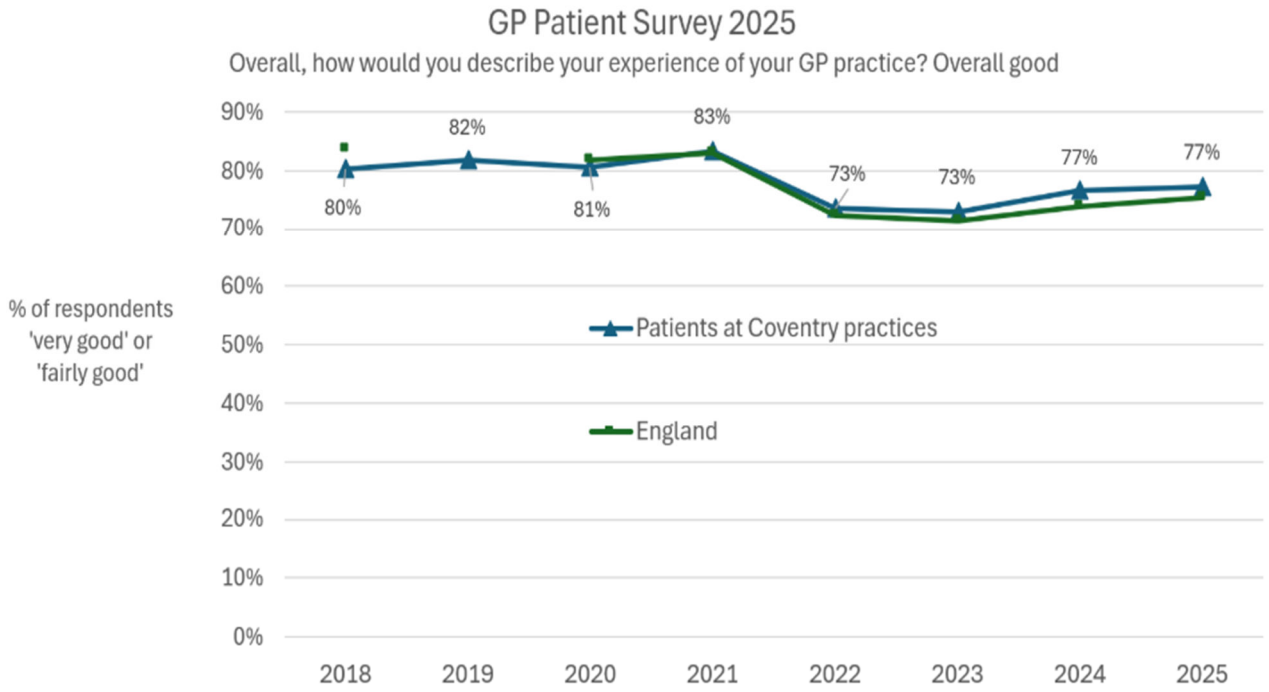
**Although GP practice coverage is strong, staffing levels per patient are lower-than-average**. As a rate of FTE staff per 100,000 registered patients at these practices, for all types of staff the Coventry numbers are comparatively lower:

| General Practice Workforce - NHS England: December 2025 | Coventry | | | | Coventry & Warwickshire | England |
|---|---|---|---|---|---|---|
| Staff group | Headcount | FTE | Ratio: FTE per 100,000 patients | | | |
| GP | 362 | 279 | 40* | | 45* | 45* |
| Nurse | 112 | 75 | 16 | | 26 | 21 |
| Other Direct Patient Care staff | 81 | 48 | 10 | | 28 | 16 |
| Admin/Non-Clinical staff | 595 | 415 | 89 | | 120 | 104 |

*GP – General Practitioner – the ratio is calculated not including GP trainees

**Results from the 2025 national GP Patient Survey suggest overall satisfaction in Coventry is in line with, or slightly above, the national average.**

77% of the 4,956 Coventry respondents rated their GP experience as "very good" or "fairly good", compared with 75% nationally. While this indicates marginally higher satisfaction locally, differences may reflect sampling variation. As seen nationally, satisfaction has improved since 2023 following a marked decline in 2022.




**Several other findings from the 2025 national GP Patient Survey suggest that patients in Coventry report a slightly better-than-average experience compared to England overall.** In 2025, 63% of respondents from Coventry practices said it was “very” or “fairly” easy to contact their GP by phone, compared with 53% nationally, though this has broadly declined over time. Overall, 75% of Coventry respondents described their most recent experience of contacting their GP as “very” or “fairly” good, compared with 70% nationally. Similarly, 72% felt the waiting time for their last appointment was “about right” (67% nationally), and 90% said their needs were met at their last appointment - in line with the England average.

**Local hospital services in Coventry are provided by University Hospitals Coventry and Warwickshire (UHCW) NHS Trust, which ranks at 101 out of 134 acute trusts as per the recently developed league tables of acute trusts under the NHS oversight framework[21].** These quarterly measures combine multiple performance indicators but should be interpreted with caution as they do not necessarily reflect individual patient experience and are most meaningful when comparing similar types of trusts.

**Although University Hospitals Coventry and Warwickshire NHS Trust (UHCW) performs relatively well overall in the 2025/26 Q2 league table for Access to Services, there are specific areas where performance is below average - particularly A&E waiting times and cancer treatment timelines.**

[21] https://www.england.nhs.uk/long-read/acute-trust-league-table/

Across the 2025 calendar year, 72.4% of A&E patients at UHCW were seen within four hours, meaning more than one in four waited longer. This is lower than the England average (74.7%) and slightly below the NHS Midlands trusts average (72.9%).

Performance is stronger once a decision to admit has been made, 5% of emergency admissions waited more than four hours from decision to admit to being admitted, compared with 24% nationally.

Cancer waiting times remain a challenge. Based on data from September 2024 to August 2025, UHCW ranked 108th out of 121 trusts in an analysis of three national cancer targets.

- 72.8% of patients were diagnosed or had cancer ruled out within 28 days of urgent referral (target 75%; England 76.6%).
- 95.8% began treatment within 31 days of a decision to treat (target 96%; England 91.3%).
- 60.2% completed the full referral-to-treatment pathway within 62 days (target 85%; England 68.9%).

Overall, while access measures show some strengths, A&E and cancer waiting times remain key areas for improvement.

## CONCLUSIONS

### Demographics and Communities

Understanding Coventry's population characteristics is essential for ensuring that services, infrastructure and community support systems develop in ways that:

- respond to population growth and diversity
- address health inequalities
- strengthen community resilience and social cohesion.

While many residents feel a strong sense of belonging to their communities, work should be undertaken to improve levels of trust, participation and social connection as these remain below national averages.

The city's communities contribute to a rich cultural environment and strong economic potential, but it should be recognised that demographic and socioeconomic differences across neighbourhoods also shape health outcomes and inequalities. Services need to respond to Coventry's changing population and work together to address inequalities.

### Prospects

Prospects across the life course are a key determinant of health and wellbeing. The opportunities people have in childhood and early adulthood including education, employment, income, housing, and digital access shape their long-term health outcomes and quality of life. Good prospects support financial security, social participation, and independence, while limited opportunities increase the risk of poverty, poor health, and social exclusion.

Early childhood represents one of the most important opportunities to improve long-term health and wellbeing. Coventry shows strengths in several areas, including:

- reductions in smoking during pregnancy
- improving breastfeeding rates
- strong developmental outcomes at age two
- reducing rates of A&E attendances, and
- improvements in oral health.

However, challenges remain:

- lower engagement with some early year's health services
- declining childcare participation
- lower development outcomes at age five
- inequalities linked to deprivation, ethnicity and special educational needs
- higher infant mortality and prematurity rates

Addressing these issues will require continued collaboration between health services, early years education, community organisations and families. Strengthening support during pregnancy and the early years remains one of the

most effective ways to improve life chances and reduce health inequalities across Coventry's population.

Increasing numbers of pupils with Special Educational Needs and Disabilities (SEND) are placing growing pressure on assessment processes and support services. This is leading to delays and potential inequalities in access to timely support.

A persistent attainment gap between the most and least disadvantaged children continues to impact overall educational standards across the city. Addressing low school attendance, reducing rates of suspensions and permanent exclusions would help improve standards.

Many indicators show that the economy in Coventry is resilient and often succeeding compared to similar cities. However, the benefits flowing from this are not evenly distributed across our communities and this compounds the health inequalities seen across Coventry.

Cost of living pressures are being felt across the city and this will impact the health and wellbeing of citizens. Fuel poverty is a factor for many people in deprived circumstances and cold, damp, difficult and expensive-to-heat homes will have a detrimental effect on those living in them.

Digital connectivity overall is good in Coventry but the benefits of this are not evenly distributed across our communities, with digital exclusion affecting particular groups who could benefit most from digital services.

**Housing and Environment**

Coventry is a densely populated city with a lot of green spaces – but the green spaces are not where the population is most dense. Making best use of green space for recreation and exercise has benefits for health and wellbeing and partners should prioritise creating and improving parks, play areas, and biodiversity in central and high-density neighbourhoods.

Increasing active travel is a success story for Coventry and will have a positive impact – both in terms of personal health improvements through more exercise and reduced air pollution from vehicles. There are opportunities to build on good connectivity and active travel by reducing reliance on cars, improving local access to services, and promoting walking, cycling, and public transport.

There is an opportunity to align housing, planning, transport, public health, and community safety services to address the combined drivers of poor health and wellbeing in neighbourhoods. This includes strengthening prevention of health risks in local environments, for example by reducing exposure to unhealthy outlets and improving access to healthy amenities.

Housing quality and energy efficiency remain significant challenges in Coventry, especially in the large private rented sector, with implications for health, wellbeing and fuel costs. Coventry's old housing stock has a detrimental effect on the health of families living in deprived areas of the city and will benefit from work to improve heating, insulation, and resistance to damp. Homelessness, families at risk of homelessness and rough sleeping are all too high in Coventry and individuals and families affected by this will have worse health outcomes than others.

Crime and violent crime are reducing in the city but remain comparatively high and continued work on bringing these rates down further will have a positive impact on health in the city. In particular, domestic abuse is a significant issue, with serious impacts on health and wellbeing.

**Health and Wellbeing**

People living in more deprived areas of the city are more likely to develop major health conditions, be diagnosed later, and have worse outcomes, highlighting the need for prevention and early support in disadvantaged communities. The Marmot approach seeks to address this gradient, and services should continue to use the Marmot principle of proportionate universalism, where the intensity and level of support are scaled proportionally to the level of disadvantage or need.

Coventry residents' health is affected by their behaviours. Too many people drink alcohol at harmful levels, smoke, eat unhealthy diets, and do not get enough physical activity. Public services should continue to address these behaviours by offering support to individuals where appropriate and providing opportunities for citizens to help themselves. There are also opportunities for public services to address the social determinants of health that influence these behaviours.

Alongside this, improvements can also be made to protective health behaviours and interventions, such as vaccination uptake, HIV testing and cancer screening.

COVID-19 negatively affected the mental wellbeing of Coventry residents, but recovery to pre-pandemic levels has not yet happened, suggesting that mental health pressures remain a key issue to be addressed by local partners.

Demand for health and care services is expected to increase as the city's population increases and ages, with more people living with complex multi-morbidity. This requires a population health response, and a shift to more proactive, preventative care. Integrated, place-based planning is needed to address inequalities in access to health services and reduce avoidable hospital activity.

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Coventry City Council

# Briefing note

**To: Health and Wellbeing Board** **Date: 8 July 2026**

**Title: Developing the role of Health and Wellbeing Board 2026-2027**

## 1 Purpose of the Note

1.1 This briefing note sets out the proposed approach to developing the role of Health and Wellbeing Board and its priorities during 2026-2027.

## 2 Recommendations

2.1 It is recommended that Health and Wellbeing Board

1) Note the emerging role of Health and Wellbeing Board in the context of the Neighbourhood Health Framework and Health Bill
2) Approve the continued use of King's Fund Model as the framework for the work of the Health and Wellbeing Board
3) Reflect on the system mapping undertaken based on the King's Fund Model (Appendix 1) and identify gaps to inform Health and Wellbeing Board priorities in 2026-2027

## 3 Information/Background

3.1 In light of the Health Bill, published May 2026, we are seeking clarity about the statutory requirements of the Health and Wellbeing Board. However, it is important that the Board continues to develop its role – both in response to the development session and the emerging leadership role for Health and Wellbeing as set out in the Neighbourhood Health Framework.

3.2 The Health Bill retains the statutory requirement for the development of a Joint Strategic Needs Assessment.

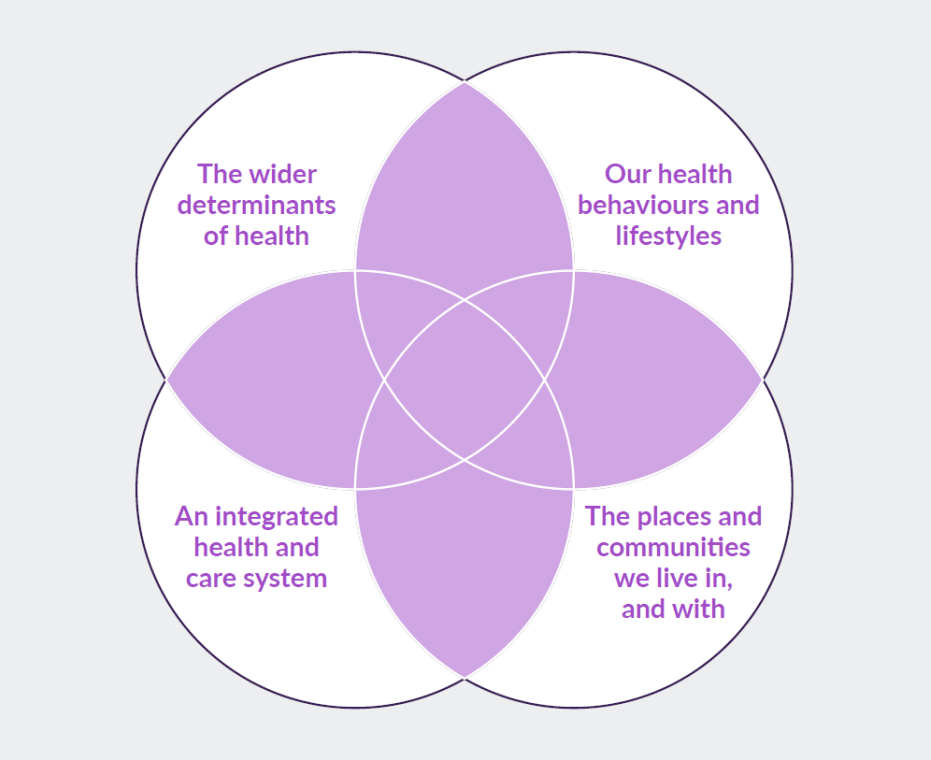
3.3 **Joint Strategic Needs Assessment**

3.4 The JSNA informs and guides the planning and commissioning of health, wellbeing, and social care services within a local area by collating available insight and data. It provides a snapshot of current and future health and care needs of the local community, considering factors that impact on health and wellbeing from a population health approach, including economic, education, housing, and environmental factors; as well as local assets that can help improve the area and reduce inequalities.

3.5 The draft JSNA Citywide profile is on the agenda for Health and Wellbeing Board on 8 July 2026.

3.6 **Kings Fund Model**

3.7 Since 2019, Coventry's Health and Wellbeing Strategies have been framed around the King's Fund population health model.




Taken from *A vision for population health: Towards a healthier future,* The King's Fund, November 2018

3.8 The framework provides an opportunity to bring together the relevant strategies and activities across the partnership and for the Board to work with partners to strengthen delivery and accountability around the intersects and connections. It recognises that health is wider than healthcare.

3.9 It is proposed that the Board retains this framework as a basis for its work programme and priorities.

3.10 **The opportunities for Health and Wellbeing Board**

3.11 The strength of the Health and Wellbeing Board lies in its unique position in the system as a partnership board consisting of representatives from across Coventry who can enact and champion change to reduce health inequalities. It is a place for challenge and robust, rigorous discussion and where partnerships can be mobilised. There should be trust and cohesion between the organisations.

3.12 The HWBB does not directly deliver activity. Its role is as a convenor, enabler and facilitator. It can hold partners to account to enact change and is a mechanism for unblocking issues which impact on health inequalities. It provides a forum to hold partners to account for their role in delivering change and includes elected members on the Board to provide democratic accountability.

3.13 **JSNA Headlines and System Mapping**

3.14 The headline issues from the JSNA have been mapped against activity taking place across the City, using the King's Find model as a framework for this mapping. This will enable the Board to identify priority areas for focus.

3.15 The mapping also includes Marmot Partnership and One Coventry Partnership priorities to ensure joining up across the system and to reduce duplication.

3.16 **National Alignment**

3.17 **Neighbourhood Health Framework**

3.18 The Neighbourhood Health Framework was published in March 2026.

3.19 The Neighbourhood Health Framework is based on priorities to

- Improve people's health and care outcomes, reduce health inequalities and help them stay well at home
- Organise services around the person with more convenient, personalised and joined-up care
- Reduce pressure on more acute services - including hospitals and care homes
- Cut waste and duplication
- Help the NHS deliver against core targets

3.20 The role of Health and Wellbeing Board evolves through this framework, to work alongside ICBs and local authorities to use their shared focus on improving local health outcomes to improve relevant outcomes across adult social care, Best Start in Life and neighbourhood health and integration and to build strong links between neighbourhood health and wider public service reform. However, the final requirements will not be ratified until the Health Bill 2026 is approved.

3.21 **The Health Bill 2026**

3.22 The Health Bill 2026 is currently going through Parliament. This will result in changes to the health system as it seeks to

- Remove the legal requirement for Integrated Care Partnership and Integrated Care Strategy
- Retain the JSNA, developed by Health and Wellbeing Board
- Ensure the JSNA informs the Neighbourhood Health Plan which replaces the Health and Wellbeing Strategy
- Makes Neighbourhood Health Plans statutory
- Puts a timescale on Neighbourhood Health Plans which will need to be prepared for 2027/28

3.23 **Monitoring**

3.24 Each Health and Wellbeing Board meeting will focus on a priority and theme.

3.25 It will be an opportunity to review the progress made towards the priority and identify opportunities to strengthen delivery through existing forums. Collective learning and narrative will be used to monitor progress alongside metrics as discussed below.

3.26 The HWB will be monitoring Local Outcome Framework metrics as outlined in the Neighbourhood Health Framework on health and wellbeing, adult social care, Best Start in Life and neighbourhood health and integration.

3.27 HWB will identify local priorities and appropriate monitoring including where they expect to see improvement in future JSNAs.

3.28 **Health and Wellbeing Board Development Day**

3.29 Feedback from the Health and Wellbeing Board development day, which was held in September 2025, will be taken into account.

3.30 The headlines from the session were

1) The HWB focus should be concise, focused and used frequently to improve outcomes. There should be clear expectations, achievements and actions, but flexibility to work within a changing landscape.
2) There was agreement that The King's Fund Model was still considered a useful tool for integration
3) The need to further develop HWBB into a space for challenge and rigorous discussion, actively feeding insights into decision-making processes.
4) There would be benefits across the system for using HWBB to increase the visibility of wider determinants of health, aligned with Marmot principles.
5) For HWBB items to have a clear ask of the Partnership to enable robust discussion and outcomes
6) Themed Health and Wellbeing Board meetings were seen as good practice, enabling joined-up conversations and showing interconnections across the City.
7) It was felt there is a need to embed consistent VCSE representation into the Board and agenda setting
8) It was felt improving mechanisms for feeding ground-level insights upwards and input from hard-to-reach communities would improve the function of the Board.
9) There are opportunities to strengthen work and alignment with the Care Collaborative
10) It would be helpful to understand and map how individual strategies and plans across organisations connect and add value, increasing the opportunity to create links across the system and break down silos.
11) There are opportunities to provide clarity between the different and distinct roles of HWBB, Marmot Partnership and scrutiny and how the strategy intersects with other plans and strategies in the system.

3.31 There are opportunities to link in through the VCSE Leadership Alliance Group, Coventry Women's Partnership and Coventry Voice work within NH.

3.32 **Next Steps**

3.33 The proposed next steps are to seek input from relevant partnership forums, including Marmot Partnership, One Coventry Partnership, Care Collaborative Forum, and VCFSE forums to inform key priorities for the Health and Wellbeing Board.

## 4 How does this work contribute to the delivery of the Health and Wellbeing Strategy?

4.1 *Provide a brief description of how this work contributes to the delivery of the Health and Wellbeing Strategy 2023-2026*

## 5 How does this work align to Coventry's Marmot approach?

As a Marmot city, Coventry organisations and services work collaboratively to reduce health inequalities by three key areas of action, all of which feature in the development of the Health and Wellbeing Strategy:

1) **Focusing on strengthening and improving the conditions in which Coventry residents are born, live, work, grow and age**. Such as good quality homes and jobs, good education, good access to healthcare and green spaces. These are known as the wider determinants of health.
2) **Allocation of what resources we have, to be fairly distributed to improve the health of all residents.** This can be done by identifying whose health is good, whose health is the poorest, and everyone else across the gradient in between, allocating resources proportionate to their levels of need.
3) **Identifying of work, where action across the Marmot Principles can be taken.**
   The eight Marmot Principles are:
   1. Give every child the best start in life
   2. Enable all children, young people and adults to maximise their capabilities and have control over t…
   3. Ensure a healthy standard of living for all
   4. Create fair employment and good work for all
   5. Create and develop healthy and sustainable places and communities
   6. Strengthen the role and impact of ill health prevention
   7. Tackle racism, discrimination and their outcomes
   8. Pursue environmental sustainability and health equity together

**Appendices**
Appendix 1 – JSNA Headlines mapped against the King's Fund Model

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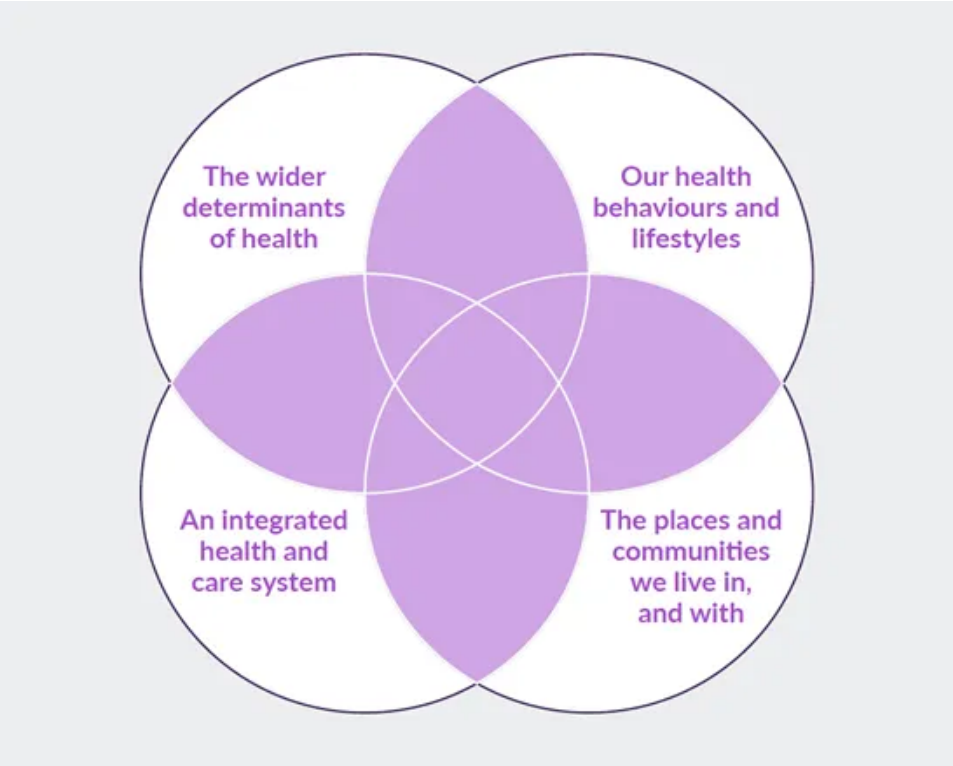
# Appendix 1 - Proposed approach to developing the Health and Wellbeing Board

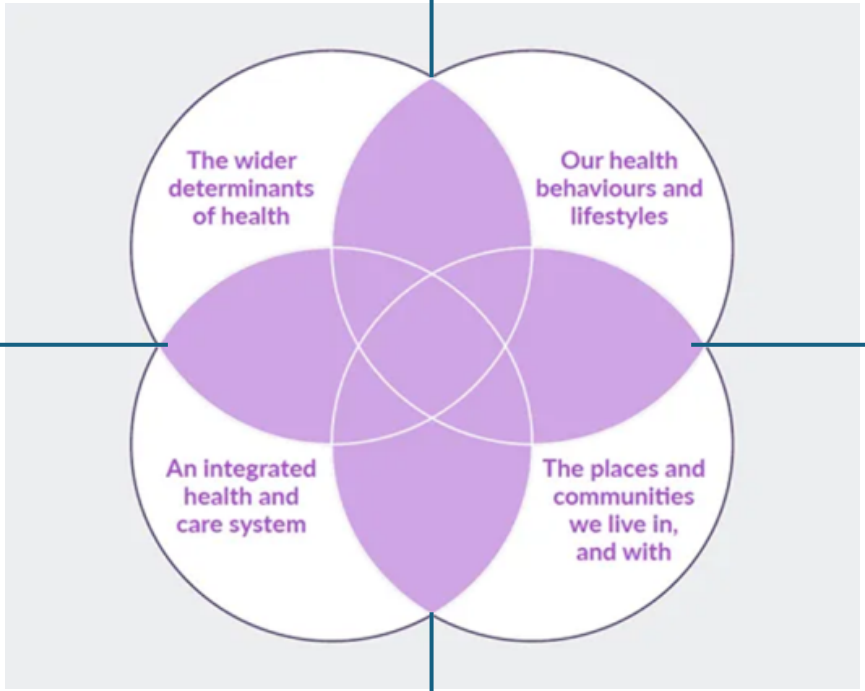



- Use the Health and Wellbeing Board to connect different programmes and strategies using the King's Fund model – focus on the overlaps
- Mapping against JSNA emerging findings to understand where we have strong partnerships / activity and where we need to do more
- Mechanism to mobilise partnerships and hold partners to account around the intersects and connections

# Making the most of connections

Better understanding of industries with a high prevalence of smoking

PHM work on long term conditions & worklessness




Requirement for providers to work with communities to co-deliver services

Infrastructure to enable funding to left shift to community sector

# JSNA Citywide profile – emerging key messages

Addressing Coventry's challenges requires place-based, preventative, and proportionate action, focused on:

- Early childhood and families
- Mental health and wellbeing
- Poverty, housing security, and employment quality
- Supporting communities experiencing long term deprivation.

# Wider determinants of health



Working in partnership across the city to strengthen the Marmot approach, including applying principles of proportionate universalism and addressing the social determinants of health to achieve better health equity

| Key issues |
| --- |
| Coventry has a **high concentration of deprivation**, particularly in **income, child poverty, employment, and health.**<br><br>**Inequalities are widening** between the most and least deprived areas, affecting life expectancy, healthy life expectancy, education outcomes, and employment. |
| Clear **pattern of disadvantage** accumulating **across the life course**.<br><br>Early years, education, employment, housing, and health are deeply interconnected, and **inequalities emerge early and persist**. |
| **By age 5, children in Coventry are less likely to achieve a good level of development** than nationally, and large gaps are already evident for children from deprived households and some ethnic groups. |
| **Attainment KS2 &4 are below national average. Persistent and large gaps for FSM, SEND and children in care**.<br><br>**Absence, exclusions and suspensions** higher than average, especially for vulnerable groups. |

# Wider determinants of health

Working in partnership across the city to strengthen the Marmot approach, including applying principles of proportionate universalism and addressing the social determinants of health to achieve better health equity

## Key issues

**Life expectancy** and **healthy life expectancy remain below national averages**, with stark **differences between neighbourhoods.**

The **local economy has grown and productivity is relatively strong**. However, **employment rates are below national averages, unemployment has risen, and youth unemployment remains high**.

Many residents are in **low paid or insecure work**, and household **incomes remain below national** levels.

**Fuel poverty** and **financial insecurity** affect a substantial proportion of households.

Economic growth is not translating into widespread prosperity for residents.

**Closing this gap** requires a stronger focus on**:**

- **Skills and progression**
- **Fair pay and job quality**
- **Supporting residents into stable, secure work**

# Our health, behaviours and lifestyle



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

| Key issues |
| --- |
| While **smoking continues to fall and** some healthy behaviours are improving, **obesity, physical inactivity, and alcohol related harm remain major challenges.** |
| **Dietary habits** in Coventry are constrained by cost, time, and the local food environment. While most residents value healthy eating, fewer than a quarter meet the **5-a-day recommendation, takeaway consumption is common, and food insecurity** affects a small but significant proportion of households. Coventry has a higher density of **fast-food outlets** (124.5 per 100,000) than regional and national averages. |
| Physical inactivity is improving, but **excess weight** remains a major challenge in Coventry. A **quarter of adults are inactive, and over two-thirds are overweight or obese**. While rates in younger children are relatively better, **obesity rises sharply by Year 6** and remains high in adulthood. |
| Smoking prevalence fluctuates but has fallen since 2013. **Smoking prevalence** among people aged 15 and over in Coventry stands at **15.6%, which is higher than the national average**. |
| **Alcohol causes disproportionately high harm** in Coventry. Although more residents report not drinking, the city continues to experience **higher-than-average hospital admissions, mortality, and premature deaths linked to alcohol** - particularly among men and older adults. |

# The places and communities we live in and with

Working together in out places and with our communities to mobilise solutions informed by out understanding of local assets from our citywide JSNA

| Key issues |
| --- |
| **Growing population** increasing **pressure on housing, schools, health services and infrastructure**.<br><br>**Growth uneven** across neighbourhoods, with some communities experiencing very rapid change. |
| **Increasing diversity** creating need to **improve equitable access to services**, ensure **provision** is **culturally competent and inclusive**, and **support integration, language access**, and **community cohesion**. |
| **High levels of private renting, overcrowding and non-decent housing**, and **housing affordability worsening**.<br>**Homelessness pressures are severe**, with high numbers of households in temporary accommodation, particularly families with children. |
| **Strong sense of belonging but trust, neighbourhood engagement and active participation lower than national**.<br>**Loneliness** a concern particularly for **older people, disabled residents**, and those in **deprived areas**.<br>Strong communities reduce demand on public services, but this requires investment in neighbourhood-level capacity, safe spaces, and trusted local organisations. |

# An integrated health and care system

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

| Key issues |
| --- |
| Coventry sees **higher than average infant mortality and stillbirth rates**.<br><br>**Demand** for **mental health services**, **particularly** for **children and young people has increased greatly.** |
| Coventry performs **well in some early outcomes** (e.g. breastfeeding rates, smoking in pregnancy, child development at age 2).<br><br>However, **antenatal booking, early health visits, and developmental review coverage are below average**, risking missed opportunities for early support. |
| **Premature mortality** (deaths amongst residents aged under 75 years) in Coventry is **higher than both the regional and national averages** for both male and females and has remained consistently so. |
| Biggest **causes of death locally: cancer, CVD, digestive diseases, respiratory diseases** |
| **Increasing 85+** creating **future pressures** on **health and care services** |

Coventry City Council

# Briefing note

**To: Health and Wellbeing Board** **Date: June 2026**

**Title: Best Start in Life Strategy and Area Action Plan, and the Best Start Family Hubs**

## 1 Purpose of the Note

1.1 To provide the Health and Wellbeing Board an overview of Coventry's Best Start in Life (BSiL) Strategy and Local Area Plan (2026–2029).

1.2 To set out Coventry's statutory Good Level of Development (GLD) targets and our approach to delivery through Best Start Family Hubs and partners.

1.3 To propose the approach to governance, workforce, and monitoring, including oversight by the Health and Wellbeing Board.

## 2 Recommendations

2.1 Health and Wellbeing Board are recommended to

1) Agree to take on the governance of Best Start in Life, overseeing the BSiL Strategic Partnership.

2) Endorse the integrated delivery approach and the proposed governance and monitoring arrangements.

3) Note progress to date on the BSiL Strategy and Local Area Plan.

4) Enable the appropriate and proportionate sharing of information between agencies related to service activity and young children's outcomes to identify earlier those children at risk of not being ready for school.

5) Encourage and enable commissioned services to act responsively and flexibility to align with the new requirements of the national and local Best Start strategies and tailor their services to meet the needs of children at risk of not being school ready and achieving GLD, as well as supporting all children through the universal pathways.

## 3 Information/Background

**3.1** Nationally, all local authorities were required to publish a Best Start in Life Local Area Plan by April 2026, focusing on:

- Best support for families
- Accessible early years provision.
- High-quality early education (0–5), including Reception.

**3.2** Coventry's local response, **'Bold Start, Bright Futures'** (2026–2029) has been co-produced with partners and was published online in April 2026, and officially launched on 22nd June, 2026. The vision is that every child is safe, healthy, curious, confident, and ready to thrive by age five.

**3.3** Coventry's statutory targets by 2028 are to rise:

- Overall GLD from 65.3% to 72.3% (≈ 300 more children).
- Disadvantaged GLD from 50.5% to 58.3% (≈ 57 more children).

**3.4** The Best Start for Life Strategy 2025 (BSiL) expects accessible, high-quality, and joined-up support from pregnancy to age five. BSiL positions early years as a whole system responsibility, emphasising equity for all and earlier help for all, as well as targeting additional help to those most in need. Nationally, all local authorities were required to publish a Best Start in Life Local Area Plan by April 2026, focusing on:

- Best support for families
- Accessible early years provision.
- High-quality early education (0–5), including Reception.

3.4 Coventry has a strong early year's system including Best Start Family Hubs; parenting support; Birth-5 SEND; Quality Improvement & Safeguarding; Business, Sufficiency and Funding support of nearly 300 early years providers. However continuing challenges exist in improving outcomes including communication, language, and literacy, the GLD gap for disadvantaged children, and ward-level variation.

3.5 The national BSiL programme will invest £6.1m to Coventry (2026–2029), prioritising workforce and delivery capacity across Best Start Family Hubs and partners.

3.6 This also includes the Healthy Babies Programme which focuses on children and their families and requires the ongoing integration of services to deliver a connected offer for all families in the first 1001 days. See Appendix 2 re Coventry's current delivery system through the Best Start Family Hubs and headline achievements.

3.7 The vision is that every child is safe, healthy, curious, confident, and ready to thrive by age five. Coventry's **Bold Start, Bright Futures Strategy** and **Local Area Plan,** replaces the previous Early Years Strategy (2025–2028) and builds on the Start for Life programme (2023–2026) which included 'The first 1,001 days', Family Hubs delivery, Home Learning Environment (HLE), Parenting, SEND, and Speech, Language and Communication support. This has been coproduced with partners and was published online in April 2026 and officially launched on 22nd June 2026.

3.8 Coventry's statutory targets by 2028 are:

| Area | Coventry's Required Improvement by 2028 |
|---|---|
| **Overall GLD** | Increase from 63.3% → **72.3%** |
| **FSM GLD** | Increase from 50.5% → **58.3%** |
| **All Other Groups** | Evidence that gaps are narrowing and targeted work is in place |

This represents a significant uplift in early years outcomes and is central to our wider strategy of ensuring that every child in Coventry has the best possible start in life.

3.9 Coventry has a strong early year's system (Family Hubs; parenting support; Birth-5 SEND; Quality Improvement & Safeguarding; Business, Sufficiency and Funding support or nearly 300 providers, 174 of whom are funded.

3.10 However continuing challenges exist in improving outcomes including communication, language, and literacy, the GLD gap for disadvantaged children, and ward-level variation. – see Appendix 1 for Coventry's current position and data with analysis.

3.11 The national Best Start for Life Strategy 2025 sets the expectation that all local areas strengthen early years services through accessible, high-quality and joined up support for families from pregnancy to age five. The government makes it clear the expectation that BSiL brings together health, early education, maternity, and community services to create a joined up early years system. This means health visiting, maternity pathways, infant feeding, access, early development advice, and baby/toddler health information are all part of the national BSiL offer. Giving every child the best start in life - GOV.UK Giving Every Child The Best Start In Life | Local Government Association

The local area plan for Coventry is built around the three pillars:

- **Best Support for Families –** stronger early help, integrated health pathways, and improved parenting confidence.
- **Accessible Early Years Provision** – reducing barriers, improving take-up and strengthening community connection.
- **High-Quality Early Education (0–5)** – improving communication and language, inclusive practice and early years pedagogy across settings and schools, including in Reception classes in schools.

3.12 Coventry's The Bold Start; Bright Futures Strategy and the associated Local Area Plan is built around five commitments and strategic goals, linked to the 3 Best Start in Life Pillars**,** aligning to the national strategy.

| **Bold Start, Bright Futures Overview** | | |
|---|---|---|
| **Commitment** | **Strategic Goal** | **Best Start in Life Pillar** |
| **1. Safe and Nurtured** Children experience safe, stable, and nurturing relationships in homes, early years settings and communities. Safeguarding concerns are identified early and acted on through joined-up Families First relational approaches. | Strengthen systems for early multi-agency support for families experiencing adversity, and barriers to support. Ensure all professionals create safe, nurturing environments where children are protected and able to thrive through timely checks and intervention. | **Pillar 1:** Best Support for Families |
| **2. Healthy and Thriving** *Children have positive physical and emotional health, supported by secure early relationships, responsive caregiving and timely access to maternity, health, and Families First pathways.* | Promote healthy early development through strengthening infant–caregiver relationships, improve access to integrated maternity, health visiting, and Families First pathways, and prevent concerns from escalating. | **Pillar 1:** Best Support for Families |
| 3. **Included, Valued & Connected** Children and families feel included and connected to early education, Family Hubs and community services, experiencing belonging regardless of culture, background or need. | Improve equitable access and community connection by reducing barriers to early education, strengthening outreach through Family Hubs, and building belonging across all communities. | **Pillar 2:** Accessible Early Years Provision |
| **4. Supported Families, Strong Foundations** Families receive timely support that strengthens resilience and wellbeing and reduces inequalities. Parents are equipped with the skills, confidence, and tools to support learning at home, helping children build strong early foundations and be ready for school. | Provide an increased range of integrated family support that builds parental confidence, strengthens home learning, and ensures families receive the right help at the right time to create strong early foundations. | **Pillar 1:** Best Support for Families<br><br>**Pillar 3:** High-Quality Early Education (0–5) |
| **5. Learning, Communicating & Developing** Children develop strong early communication, language, social-emotional and cognitive skills through high-quality, inclusive early years practice that nurtures curiosity, builds confidence, and enables all children to thrive by age 5. | Improve achievement by developing and embedding high-quality, evidence-based practice and inclusive first approaches across all Early Years settings, Family Hubs, Health Visiting, and Community services to narrow the persistent achievement gaps to national outcomes. | **Pillar 3:** High-Quality Early Education (0–5) |

## 4 How this work contributes to the delivery of the Health and Wellbeing Strategy

4.1 The Best Start in Life Strategy, and the work of the Best Start Family Hubs are a key contributor to taking action on the wider determinants of health including improving the physical activity of young children, and their families, tackling childhood obesity, providing services for those with issues relating to alcohol and substance misuse and sexual health services.

4.2 The Best Start Family Hubs are a key enabler to deliver of integrated health and care system, with a wide range of partners working together to improve health outcomes and tackle healthcare inequalities.

4.3 Family hubs are identified in the strategy regarding taking action on the places and communities we live in. They are making a significant contribution to meeting the strategic ambitions of children and young people fulfilling their potential, and people live in connected, safe and sustainable communities. They also provide places in the community to combat loneliness and social isolation, support young people's mental health and wellbeing and are pioneering a range of ways of working differently with communities.

## 5 How this work aligns to Coventry's Marmot approach

5.1 Giving every child the best start in life is the first of Coventry's Marmot principles with the priorities of

- Reducing inequalities in the early development of physical and emotional health, cognitive, linguistic, and social skills.
- Working with families to support language development, including children with EAL (English as an Additional Language).
- Maximising the take up of 2, 3, and 4-year-old funded places.
- Ensuring high-quality maternity services, parenting programmes, childcare and early years' provision to meet need across the social gradient including support for families from ethnic minority backgrounds.
- Building the resilience and well-being of young children across the social gradient.

5.2 The Best Start in Life Strategy and associate local area action plan is the means to ensure these priorities are delivered through

- Integrated universal, targeted and specialist support to families from the antenatal period up to adolescence across the social gradient.
- Targeted high-quality family learning interventions to maximise children's learning in the home environment for families across the social gradient.
- Interventions at the earliest opportunity for the multiple and complex problems families face.
- Early years provision to maximise children's learning, development, and school readiness.
- General information and advice to parents and carers to support positive parenting and nurturing home environments.

- Programmes to help ensure that babies and toddlers stay safe in and around the home to reduce the number of unintentional injuries.

5.3 This strategy also contributes to the Marmot principle and priority of enabling all children, young people, and adults to maximise their capabilities and have control over their lives

## 6 Governance

6.1 A request is made to establish a clear governance accountability to the Health and Well Being Board, overseeing the BSiL Strategic Partnership which will be co-chaired by the Director of Children and Education Services and the Director of Public Health.


6.2 Health and Wellbeing Board, is the most appropriate and effective governance body, as it:

- Provides statutory leadership and legitimacy
- Aligns BSiL with wider health and wellbeing priorities
- Enables whole-system partnership working
- Prioritises prevention, early intervention, and inequalities
- Strengthens accountability and delivery

Positioning Best Start in Life under Health and Wellbeing Board governance will maximise strategic coherence, partnership ownership, and impact on outcomes for children and families.

6.3 The BSiL strategy is directly aligned with the priorities typically set out in the Joint Health and Wellbeing Strategy, including:

- Improving early childhood outcomes
- Reducing inequalities in maternal and infant health
- Supporting healthy development and family resilience

Placing governance within the Health and Wellbeing Board would ensure:

- Clear line of sight between BSiL priorities and wider system objectives
- Consistency in outcomes, performance measures, and reporting
- Avoidance of duplication across partnership strategies

6.4 **Whole-System Partnership Governance**

Effective BSiL delivery requires coordinated action across:

- NHS organisations (ICB, providers, maternity services)
- Local authority services (public health, early help, children's services)
- Voluntary and community sector partners

The HWB is uniquely positioned to convene and lead this whole-system partnership, by providing senior strategic leadership, cross-agency accountability and the forum for resolving system-wide barriers. This would ensure the BSiL action plan is not owned by a single service but is a shared system commitment.

6.5 **Focus on Prevention and Early Intervention, addressing Health Inequalities**

The HWB has a strong mandate to prioritise prevention and early intervention, which are central to BSiL. Early years investment delivers long-term benefits across health, education, and social care.

Governance through HWB would also:

- Strengthens the case for continued investment in early years
- Embeds preventative approaches across the wider system
- Ensures BSIL remains a strategic priority in the context of competing demands
- Ensure BSIL and BSFH specifically target disparities in infant mortality, parental health outcomes, as well as child development and school readiness

10.6**. Integration with Integrated Care System (ICS) Priorities**

The BSIL agenda aligns strongly with NHS and ICS priorities, including:

- Start for Life and Family Hubs programmes
- Prevention and population health management
- Reducing demand on acute services

The HWB would provide the formal interface between local authority and NHS partners, enabling:

- Strategic alignment with ICS plans
- Integrated commissioning and delivery
- Better use of pooled or aligned resources

**Appendices**

Appendix 1: Coventry's Current Position (GLD)

Appendix 2: Best Start Family Hubs and Healthy Babies Programme and achievements to date

Appendix 3: Ways we will deliver the BSIL strategy across the partnership

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## Appendix 1: Coventry's Current Position (GLD)

The new BSIL local area action plan is data-led, equity-focused and evidence-based, with a strong focus on parental engagement as children's first and enduring educators. It will be updated regularly in response to need and progress.

| Group | GLD2022/ 2023 | GLD 2023/ 2024 | GLD2024/ 2025 | 1-Year Change |
|---|---|---|---|---|
| **All Pupils** | 64.2% | 63.3% | 65.3% | +2.0 pp |

The data shows that Coventry's GLD rate for All Pupils dipped from 64.2% (2022/23) to 63.3% (2023/24) before rising again to 65.3% in 2024/25. This represents a +2.0-percentage point improvement over the last year, bringing outcomes back above pre dip levels. The one-year increase suggests the beginning of a positive recovery trend, likely to reflect improvements in early language, wellbeing and early education engagement following the pandemic related dip seen in 2023/24.

| Indicator | Coventry 2025 | National 2025 | SN 2025 | Change (2024–2025) | Gap to National | Gap to SN |
|---|---|---|---|---|---|---|
| **GLD** | 65.3% | 68.3% | 65.3% | **+1.9 pp** | -3.0 pp | 0.0 pp |
| **C&L** | 75.6% | 79.6% | 75.8% | **+0.5 pp** | -4.0 pp | -0.2 pp |

In 2024–2025, **4,154 children** were in Reception classes across Coventry. Of these, **2,701 achieved a Good Level of Development (GLD)**, giving the city an overall rate of **65.2%**. This represents a continued improvement from the previous year and shows Coventry beginning to recover from the dip seen in 2024.

Nationally, **68.3%** of children reached GLD, meaning Coventry is **3.3 percentage points below the England average**. While the gap remains, Coventry is now **closer to national outcomes** and **broadly in line with statistical neighbours**.

Communication and Language (C&L) outcomes have also improved, helping to narrow the gap slightly. However, this area remains a key challenge, particularly for **disadvantaged children and white disadvantaged boys**, where early language difficulties continue to affect later literacy.

Overall, while Coventry is moving in the right direction, **disadvantaged children, especially white disadvantaged boys will remain priority groups** for continued improvement.

**Strengths to build on.**

Coventry outcomes in 2024/25 show relative strengths in mathematics, expressive arts, and understanding the world compared with statistical neighbours. This indicates effective early years practice in these areas, including mathematical talk and practical problem-solving.

**SEND Support pupils made notable gains in 2025**, suggesting that targeted intervention and inclusive practice in the early years are having a positive effect, even within small cohorts.

The progress and achievement of white disadvantaged boys should also be noted.

| Group | GLD2022/ 2023 | GLD 2023/ 2024 | GLD2024/ 2025 | 1-Year Change |
|---|---|---|---|---|
| **All Pupils** | 64.2% | 63.3% | 65.3% | +2.0 pp |

The data shows that Coventry's GLD rate for All Pupils dipped from 64.2% (2022/23) to 63.3% (2023/24) before rising again to 65.3% in 2024/25. This represents a +2.0-percentage point improvement over the last year, bringing outcomes back above pre dip levels. The one-year increase suggests the beginning of a positive recovery trend, likely to reflect improvements in early language, wellbeing and early education engagement following the pandemic related dip seen in 2023/24.

## Appendix 2: Coventry's Current delivery system and headline achievements

### Best Start Family Hubs and Healthy Babies Programme

The Healthy Babies Programme (26–29) is a targeted early intervention initiative aimed at improving outcomes for expectant parents and infants during pregnancy and the early weeks of life. It focuses on prevention, health promotion, and reducing inequalities, particularly among families identified as having additional vulnerabilities.

**The programme seeks to:**

- Improve maternal health and wellbeing during pregnancy
- Promote healthy behaviours (e.g. smoking cessation, nutrition, breastfeeding)
- Strengthen early attachment and parent–infant relationships
- Reduce risks to infant health and development
- Ensure early identification and support for families with additional needs

**Key Components of the offer should include**

- Enhanced antenatal support: Structured contact around 26–29 weeks to assess needs and provide tailored guidance
- Health promotion: Advice on nutrition, substance use, infant feeding, and safe sleep
- Preparation for parenthood: Practical and emotional preparation for birth and early care
- Early relationship building: Support to strengthen bonding and attachment
- Multi-agency working: Coordination across midwifery, health visiting, and wider early help services

The Best Start Family Hub and Healthy Babies programme provides joined-up support from conception to age five including health visiting, midwifery, Baby & Me, stay-and-play, parenting, HLE, finance, housing, wellbeing, digital portal.

It is underpinned by strong, collaborative partnership working across the wider family support system, including key health partners such as the Public Health-commissioned SWFT Family Health and Lifestyles Service, which includes health visiting, Family Nurse Partnership for parents aged 19 and under, Infant feeding, Stop Smoking in Pregnancy and MAMTA supporting mothers from ethnic minorities. It also includes close partnership working with UHCW Midwifery Services, Social Prescribers, and CWPT Mental Health Services, alongside a broad network of commissioned, voluntary, and community sector organisations. The programme aligns closely with Public Health priorities, including the development of the Coventry Child Poverty Strategy and targeted efforts to reduce infant mortality.

This programme is also supported by the work in Children's and Education Services and closely aligns to the SEND reforms including

**SEND support (Birth–5):** This service helps families navigate early identification, inclusion, and statutory SEND processes. SEND sessions are delivered within Family Hubs, with a new requirement for each hub to have a designated SEND practitioner.

**Families and practitioners can access:**

- The SEND Birth to Five Team
- Early assessments including EHCNAs/EHCPs
- SENDIASS, impartial advice to families of children with SEND aged 0–25.
- Early Support (Children's Disability Team), available to families where a child has disability, complex health needs, or significant additional needs.

**Early Years Quality Improvement & Safeguarding:** This team provides workforce development, support guidance, and challenge for schools and early years providers. EYFS quality and safeguarding monitoring; LADO partnership; Home Learning Environment and speech and language programmes.

**Business, Sufficiency and Funding:** This service area manages sufficiency and place planning, market stability, extended free entitlement, recruitment, and Early Education Entitlements funding.

**Early Help**: This team provides personalised support relating to wellbeing, parenting, finance, housing, and relationships. Signposting and multi-agency intervention where additional needs are identified. Early Help teams work closely with early years, health, and community partners to intervene early and improve long-term outcomes.

**Voluntary, Community and Faith Sector** Voluntary, Faith and Community Groups offering local activities, connection, and support (including 0–19 support).

**Expected outcomes of the programme include:**

- Improved birth outcomes and infant health
- Increased breastfeeding initiation and continuation
- Reduced smoking in pregnancy
- Stronger parental confidence and attachment
- Earlier identification and support for vulnerable families

**Achievements to date include**

**Reaching More Families**: Since January 2024, over 27,000 families have engaged with the Family Hub offer, either in hubs, online, or through community outreach. Registartions have risen rapidly, from 8,500 in mid-2024 to 31,000 by June 2025, showing growing trust and awareness across communities.

**High-Performing Programme:** All major workstreams have met or exceeded their targets, demonstarting strong delivery and improving outcomes for children and parents.

Parenting support, perinatal mental health, early communication, and infant feeding initiatives are all showing sustained progress.

Examples of expected outcomes from the Health Visiting and Infant feeding service, commissioned by Public Health, are outlined below including current performance.

| Area of activity | 24/25 Performance | 25/26 Performance (April – Dec) |
|---|---|---|
| 6-8 week check – improved birth outcomes and infant health | 83% | 85% |
| Increased breastfeeding initiation Continuation | 61% | 63% |
| Stop smoking in pregnancy | | 57% |
| % of 2-2.5 year checks under on time | 74% | 74% |

**Digital Support for Families:** The Coventry Families Portal is now a one-stop hub for information, SEND support, session bookings, and local advice. The portal has attracted 14,600 users, 26,600 sessions and 151,000 page views, with over 1,200 app installs since launch. Available 24/7, it gives families easier access to help when they need it.

**Improving Early Learning and Communication:**

- 5,193 families have engaged with '**50 Things to do before you're five'** (apps, downloads, events, paper resources). 30.9% of users sharing postcodes live in the 20% most deprived LSOAs

- **Easypeasy**: 2,750 registered families (18.6% of Coventry's 0–5 population). 89% of families use the app weekly. 56% of active users are from the most disadvantaged areas (target: 55%)

- **Little Coventry Communicators:** A three-tier speech and language training pathway to strengthen practitioner confidence and system-wide consistency. To date:
  - 308 practitioners trained in Tier 1 (57% of settings represented)
  - 98 trained in Tier 2 (27.6% of settings)
  - 84 trained across all tiers, now Communication Champions (23.1% of settings)
  - 70 Health Visiting staff received WellComm refresher training
  - Communication & Language GLD measure increased from 74.4% (2022) to 75.6% (2025)

**Better Support for Babies, Parents and Carers:** More parents are accessing perinatal mental health support, with strong increases in participation from Black, Asian, and disadvantaged communities. Online "Togetherness" parenting registartions surpassed the 1,000 target, showing strong digital engagement. Support for fathers and partners has

expanded significantly, including new community-based sessions and targeted outreach through Fatherhood Solutions. Birth registartion and antenatal programmes have been successfully brought into more Family Hubs, making services easier to access locally.

**A strong, connected local network:** The impact of the S4L programme was stronger links with health, early years, community partners, and schools to create a more joined-up and family-friendly system. Work aligns with Coventry's Marmot City priorities, ensuring support is targeted where it can make the biggest difference.

**Appendix 3: Ways we will deliver the BSIL strategy across the partnership**

A range of evidence-based programmes will support improved outcomes. Some are already in place and others will be developed over the next three years.

- **Home Learning Environment (HLE)** – evidence-based activity across hubs, libraries, and settings; coordinated by HLE Co-ordinator and Teaching Adviser; overseen by Senior Adviser (Birth–5); new BSiL Delivery Lead from 2026.

- **Parenting support:** A hybrid delivery approach including, Antenatal Nurture, SEND Nurture, Five to Thrive Baby, Parenting Puzzle, Living with Confidence, Talking Teens, Togetherness Online/Solihull.

- **Learning and Development offers:** Utilising a universal and targeted approach. The offer will include: 50 things to do before five, Chat, Play, Read, Stay Together, Play Together, PEEP and REAL. These are evidence-based programmes selected by the DfE with a focus on reinforcing family's confidence and skills in supporting playing and learning at home.

- **Workforce Development**: Universal and targeted support based on ward level GLD, deprivation and health data for schools and early years providers.

- **Strengthened SEND offers** to support earlier identification and provide additional support to families. This includes a new offer of a specialist SEND practitioner in every Family Hub

- **Expansion of the Family Hub** approaches developed across the voluntary, community and Faith based sectors

- **Health Services** will continue to develop work previously initiated in relation to

| **Healthy Child** | **Perinatal mental health support** |
|---|---|
| • Health visiting<br>• Maternity pathways<br>• Infant feeding support<br>• Vaccination access<br>• Early development checks<br>• Integrated NHS advice | • Emotional and mental health support from conception to age 2<br>• Support for mothers, birthing people, fathers and partners<br>• Parent infant relationship interventions<br>• Better access for Black, Asian, deprived and higher risk groups |

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Coventry City Council

# Briefing note

**To: Health and Wellbeing Board** **Date: 8th July 2026**

**Title: SEND Local Reform Plan, System Governance, and Reform Delivery**

## 1 Purpose of the Note

1.1 On 23rd February 2026, the government published its Schools White Paper, including the requirement for each local area partnership to develop and submit a local Special Educational Needs & Disability (SEND) Reform Plan signed off by Chief Executives of the City Council and Integrated Care Board (ICB), and the Section 151 Officer (Director of Finance & Resources). The local area partnership submitted the plan on the 19 June 2026 following cabinet approval of the draft plan on the 9 June. The SEND & Alternative Provision (AP) Board holds the local area partnership responsibility for delivery of the plan. The final plan is included at Appendix 1.

1.2 The SEND & AP Board operates under the governance framework of the Health & Well-being Board. Due to the significance of the SEND reform and accompanying investment, the governance arrangements for the SEND & AP Board and related infrastructure have been refreshed. There is no change in the relationship between Health & Well-being Board and SEND & AP Board, but there is a refreshed terms of reference and membership, and there is additional infrastructure reporting to SEND & AP board. The refreshed governance arrangements are included at Appendix 2.

1.3 The Education Service works closely with Public Health and published a SEND Joint Strategic Needs Assessment (JSNA) in 2020. A 2024 data supplement updated the original data and information and was approved by the Health & Well-being Board and the SEND & AP Board. A further update is underway and will be completed in Autumn 2026.

## 2 Recommendations

2.1 To note the Local SEND Reform Plan and the partnership working arrangements required across Education, Health, and Care to deliver the ambitions of the plan.

2.2 To endorse the refreshed governance arrangements in place to support the delivery of the Local SEND Reform Plan.

2.3 To receive a refreshed SEND data supplement for the JSNA in the 26/27 municipal year.

## 3 Information/Background

3.1 The objective of the white paper is to ensure that every child and young person can achieve and thrive. This ambition is underpinned by a substantial national investment exceeding £7 billion over the next three years, which will promote inclusive practice within mainstream schools, facilitate access to expert support (including Educational Psychologists, Speech and Language Therapists, and Occupational Therapists) without the necessity of statutory assessments, and provide new school places for children and young people with special educational needs & disability in both mainstream and special settings. Implementation of these reforms will commence from the 2026/27 financial year.

3.2 The Local Area Partnership has developed and submitted the Local SEND Reform Plan, underpinned by a Local Partnership Maturity Assessment. These documents outline proposals for improvement and consolidation of the local SEND system, prioritising inclusive practice and early intervention. The plan is the central delivery and accountability framework for transforming SEND provision across local area partnerships. It is expected that the local authority acts as system 'convener', taking the lead in bringing together ICBs, multi-academy trusts, schools, early years settings, health partners, and other stakeholders.

3.3 The SEND and AP Partnership Board will have overall responsibility for delivery of the plan. Bringing together senior leaders from across the Local Area Partnership, the Board will provide strategic oversight, challenge, and decision-making to ensure delivery remains on track. The Board meets six times a year and will oversee progress against milestones, risks, and priorities across the full programme.

3.4 A Reform Delivery Group will support this structure by maintaining oversight of the programme and actively managing delivery between Board meetings. The group will monitor implementation, track progress against actions and milestones, identify delays or emerging risks, and coordinate corrective action where required. This will ensure a clear line of sight from day-to-day programme management through to strategic oversight by the SEND and AP Partnership Board.

## 4 How does this work contribute to the delivery of the Health and Wellbeing Strategy?

4.1 Education is a fundamental building block of health[i]. The benefits of good quality, inclusive educational environments reach far beyond learning, positively impacting social and emotional development through childhood and into later life[ii]. This provides the foundation for future wellbeing and growth. By strengthening this building block, every child and young person in Coventry with SEND will have the support to achieve, thrive, and feel a genuine sense of belonging.

4.2 The prevalence of SEND in the population is a key factor in understanding health needs and shaping joint commissioning between the NHS and the local authority. It also helps determine how the education system should respond to provide appropriate support for children and young people, while informing future adult needs. The Local SEND Reform Plan focuses on earlier intervention and support, as set out below:

- Children and young people with SEND achieve, belong, and thrive locally;
- Families have confidence in the SEND system;
- Mainstream settings are confident and supported to meet need early;
- Coventry has a sustainable, high-quality local SEND and AP offer; and

- A strong partnership drives continuous improvement.

4.3 The plan's targets and metrics apply to children and young people with SEND and are to: increase school attendance; reduce suspensions and exclusions; increase access to local provision and therapy; and improved access to positive destinations. This all contributes to the delivery of the Health and Well-being strategy.

## 5 How does this work align to Coventry's Marmot approach?

5.1 Support for children and young people with SEND is fully aligned with Coventry's Marmot approach. The Local SEND Reform plan ambition can contribute to all the Marmot principles, with close relevance to:

- giving every child the best start in life;
- enabling CYP and adults to maximise capabilities and have control over their lives;
- strengthening the role and impact of ill health prevention.

5.2 This will be considered further in the refreshed SEND data supplement for the JSNA.

**Appendices**
Appendix 1: Coventry SEND Local Reform Plan
Appendix 2: Coventry SEND & AP System Governance and Reform Delivery

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[i] What builds good health? | The Health Foundation
[ii] Education | The Health Foundation

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# Coventry SEND and AP Reform Plan

June 2026 | v3.1

# Signatories

| Role | Name | Signature | Email contact | Date |
|---|---|---|---|---|
| Chief Executive,<br>Coventry City Council | Julie Nugent | | julie.nugent@coventry.gov.uk | 18.6.2026 |
| Section 151 Officer,<br>Coventry City Council | Barry Hastie | | barry.hastie@coventry.gov.uk | 18.6.2026 |
| Chief Executive,<br>Hereford and Worcestershire ICB | Simon Trickett | | simon.trickett@nhs.net | 18.6.2026 |
| Senior Responsible Officer, Director for Childrens & Education Services,<br>Coventry City Council | Sukriti Sen | | sukriti.Sen@coventry.gov.uk | 18.6.2026 |
| SEN SRO, Executive Director of Integration & Delivery and Deputy Chief Executive H & W,<br>Herefordshire & Worcestershire ICB. | Mari Gay | | marigay@nhs.net | 18.6.2026 |

**Local Authority:** Coventry City Council
**Integrated Care Board:** Coventry and Warwickshire
**Last Updated:** 18 June 2027

# List of Abbreviations

| | |
|---|---|
| AP | Alternative Provision |
| CCC | Coventry City Council |
| CPD | Continuing Professional Development |
| DCO | Designated Clinical Officer |
| DfE | Department for Education |
| DSCO | Designated Social Care Officer |
| EBSA | Emotionally Based School Avoidance |
| EHCP | Education, Health and Care Plan |
| EKOS | Outcome measure referenced for SaLT/OT; meaning not defined in this document |
| EP | Educational Psychology / Educational Psychologist |
| FFPP | Family First Partnership Programme |
| CAMHS | Child and Adolescent Mental Health Services |
| BSiL | Best Start in Life |
| CME | Children Missing Education |
| CYP | Children and Young People |
| DCS | Director of Children's Services |
| DSG | Dedicated Schools Grant |
| EaH / EAH | Experts at Hand |
| EHC | Education, Health and Care |
| EHE | Elective Home Education |
| EOTAS | Education Other Than at School |
| FE | Further Education |

| | |
|---|---|
| ICB | Integrated Care Board |
| MAT | Multi-Academy Trust |
| NHS | National Health Service |
| PCF | Parent Carer Forum |
| PRU | Pupil Referral Unit |
| RAG | Red, Amber, Green |
| SaLT | Speech and Language Therapy / Therapist |
| SEN | Special Educational Needs |
| SEND | Special Educational Needs and Disabilities |
| HR | Human Resources |
| LA | Local Authority |
| MOU | Memorandum of Understanding |
| OT | Occupational Therapy / Occupational Therapist |
| PINS | Partnerships for Inclusion of Neurodiversity in Schools |
| QA | Quality Assurance |
| RDG | Reform Delivery Group |
| SEMH | Social, Emotional and Mental Health |
| SENCO | Special Educational Needs Coordinator |
| SRO | Senior Responsible Officer |

# Executive Summary

Over the next three years, Coventry will build on strong foundations—education partnerships, a well-established early intervention approach and a Dedicated Schools Grant (DSG) surplus position—to deliver a highly inclusive, partnership led 0–25 SEND system. This will mean greater coproduction, clearer pathways and accountability, improved outcomes and high-quality local provision for all. In this plan, **CYP** refers to children and young people.

## Build a 0–25 system where CYP receive support to achieve and thrive through more inclusive settings and stronger local partnerships

Coventry has strong foundations for inclusion and partnership working through an established education partnership and school networks, including SEND. Many CYP are supported successfully at SEN Support through early intervention and a well embedded graduated response. However, ordinarily available provision is not yet consistent across phases, and access to early specialist input—particularly health related support—remains variable. We will coproduce a shared definition of inclusion, clarify thresholds and pathways, and strengthen accountability through refreshed governance (SEND & AP Partnership Board, SEND Reform Delivery Group and themed workspaces). We will know we are succeeding when families experience clear routes to support, fewer transfers between services, and—where possible—CYP are educated successfully close to home.

## Improve capacity and capability of the mainstream and specialist workforce to identify and meet need

Education-led workforce foundations are strong, with established SENCO networks and a structured training offer that supports early identification and intervention. Education, Health & Care Plan (EHCP) timeliness has historically been strong, dipped in 2025 and has improved in 2026 following substantial investment in team capacity; sustaining this improvement is a core priority. We will build on strong SEND traded services and local specialist provision to deliver the Experts at Hand operating model—bringing specialist expertise earlier, building on the excellent workforce strategy already in place, strengthening the graduated response and reducing avoidable escalation, including preventable moves into AP and Education Other Than at School (EOTAS). In parallel, we will agree a joint commissioning approach and a therapy delivery model for Speech & Language Therapy / Occupational Therapy (SaLT/OT) that supports EHCP Section F delivery as well as earlier help. Success will be shown through wider reach of specialist advice in mainstream, more consistent practice across the city, and reduced reliance on casework-only approaches.

## Improve confidence of children, families and stakeholders in reform and readiness of the system

We recognise confidence in the system is inconsistent and that coproduction is not yet embedded consistently in decision making. Suspensions and exclusions of CYP with SEND increased in 2025 and 2026, EOTAS has risen significantly in the past year, and there are a small number of CYP with complex needs where we struggle to secure placement sufficiency. Improving inclusion, engagement and access to education is therefore a shared priority. Coventry has an established AP framework, which provides a strong platform to strengthen pathways, provide early intervention and support reintegration. We will strengthen coproduction through clearer routes for gathering views, regular touchpoints and transparent “we said / we did” feedback. We will align the SEND Reform Programme with the rollout of the Family First Partnership Programme (FFPP) so families experience one joined up front door, clear lead professional/keyworker roles, consistent communications and effective information sharing. We will continue to implement and embed our Belonging and Inclusion Approach, including behaviour pathways, alongside stronger assurance for reduced timetables and EOTAS (clear pathways, review points and escalation). Progress will be evidenced through improved qualitative feedback, fewer avoidable disputes, and increased confidence in pathways and support while waiting.

## Stabilise finances and improve value for money

Strong leadership and management, an increasing high needs block allocation, and investment in early intervention and local partnerships mean Coventry is not in an overall DSG deficit position and has not utilised a Schools Block to High Needs Block transfer. Historically, the proportion of CYP with SEND educated locally has been high; while local placements are increasing, non-local placements have also risen over the past three years. Reversing this trend is a priority for outcomes, value for money and future financial sustainability. We will strengthen the local offer by continuing to expand inclusion bases (including improving mainstream estates through targeted adaptations) and increasing local special school capacity to support CYP with the most complex needs. This will be informed by a strategic programme of work with Special School Head Teachers and the Open Thinking Partnership, ensuring our approach is coproduced and rooted in shared system leadership. Alongside this we will prioritise local capacity using a small, quality-assured independent offer where needs cannot be met locally. We will know we have achieved our three-year vision when headline metrics show sustained improvement in local placement numbers, attendance/exclusions and family experience, and clear impact of reform and capital investment on placement patterns, EOTAS and transport dependency.

# Section 1 | Vision and Goals

By **2029**, Coventry will deliver a SEND system where **CYP achieve, belong and thrive in their local communities**, supported by confident families, inclusive settings and a sustainable local offer. This means that:

## CYP with SEND achieve, belong and thrive locally

CYP with SEND will experience positive outcomes, inclusion and belonging, with more supported successfully in local settings. **Success will be shown through** improved attendance, participation and progress, and more CYP educated successfully close to home.

## Families have confidence in the SEND system

Families will experience a system that is clearer, more responsive and shaped by lived experience. **Success will be shown through** stronger family confidence, clear routes to support, decreased waits to access specialist therapies, visible co-production and fewer avoidable disputes.

## Mainstream settings are confident and supported to meet need early

Settings will identify and meet need earlier through stronger ordinarily available provision and earlier access to specialist advice. **Success will be shown through** more consistent practice, wider reach of support, better access to advice and reduced avoidable escalation.

## Coventry has a sustainable, high-quality local SEND and AP offer

Local provision will better meet need, offer value for money and reduce reliance on costly reactive arrangements. **Success will be shown through** increased local capacity, more CYP educated locally and improved financial sustainability.

## A strong partnership drives continuous improvement

Partners will work together with clear accountability, a skilled workforce, effective governance and better use of data and lived experience. **Success will be shown through** stronger partnership delivery, improved workforce capacity, shared performance oversight and sustained improvement over time.

# Section 2 | Strategy

## Where the local area partnership expects to be in the next 3 years

| Local Blueprint 2026-2029 | Where we are now? | Where we will be in the next 3 years |
|---|---|---|
| **Building Block 1**<br>Strengthening inclusion across education settings | **Overall self-assessment: Developing (with elements of Maturing)**<br><br>Coventry has strong foundations for inclusion, including effective identification, a well-embedded graduated response, and a high proportion of children supported successfully at SEN Support. There is evidence of maturing practice in parts of the system, particularly where schools are making effective use of adaptive provision.<br><br>However, the matrix also highlights inconsistency across settings and phases, and that ordinarily available provision is not yet embedded universally. As a result, inclusion is developing but not yet reliably consistent across the whole system. | By 2029, our local SEND system will:<br>• Embed a shared definition of inclusion across all partners and build it into governance and quality assurance, so decisions and expectations are consistent and the impact on outcomes is clear.<br>• Set clear, city-wide ordinarily available provision standards as a non-negotiable baseline, support settings to deliver them, and use quality assurance to show support is consistent.<br>• Identify where inclusion is not working well and take timely action with the appropriate support and challenge.<br>• Build staff confidence and strengthen the graduated response through an established Experts at Hand and workforce development offer, with practical follow-up such as coaching and peer support.<br>• Expand the support base offer, ensuring it is welcoming and high quality, with shared standards and strong take-up from schools.<br>• Use data and lived experience together to understand what is working, and to focus support where it will make the biggest difference.<br>• Enable smooth transitions between phases and settings so CYP feel well prepared and supported.<br>• Help CYP with SEND achieve stronger attainment, benchmarking well against peers in other localities and those without SEND. |
| **Building Block 2**<br>Access to specialist support and local placements | **Overall self-assessment: Developing**<br><br>The maturity assessment indicates Coventry has a strong and improving understanding of specialist provision and place planning, with | By 2029, our local SEND system will:<br>• Use Best Start in Life and FFPP to provide a well-accessed early family help offer for families of CYP with SEND.<br>• Provide clear, inclusive pathways and communication, with LA and health services working to shared plans, sharing information and being clear about responsibilities, especially at key transition points. |

| | | |
|---|---|---|
| | maturing practice in alternative provision, local special schools, and sufficiency planning. These help system leaders to understand demand, cost pressures and quality issues well.<br><br>However, access to early, universal and targeted specialist support (particularly health-related input) is less consistent, and there is reliance on specialist and high-cost provision. Overall, access to specialist support is developing, with clear foundations but not yet fully rebalanced toward early intervention. | • Align the AP Graduated Model of Support to the Targeted (Outreach), Targeted Plus (Intervention) and Specialist (Transitional) framework, with sufficient flexible capacity for SEMH, EBSA and medical needs.<br>• Ensure CYP can access timely mental health support, with clear pathways into specialist services (including CAMHS) and the right provision (mainstream, AP or specialist) when they cannot attend their usual setting.<br>• Provide clearer and earlier access to SaLT and OT through a reconfigured offer, with clear thresholds between ordinarily available and specialist provision and reliable delivery of interventions, including EHCP-specified support where required.<br>• Deliver at least 100 additional Specialist Base places, alongside strong inclusive practice, so they are welcoming for CYP and families.<br>• Deliver at least 184 additional local special school places for CYP with complex learning needs and SEMH. |
| **Building Block 3**<br>System leadership, local partnership collaboration and co-production | **Overall self-assessment: Developing**<br><br>The maturity assessment shows strong system leadership, effective partnership structures, and improving use of data to inform decision-making. Leadership and collaboration are assessed as securely developing, with some elements approaching maturing.<br><br>However, coproduction with parents, carers and children and young people is less embedded, with engagement not yet consistent across all strategic and operational decisions. As a result, this building block remains developing overall, with strong | By 2029, our local SEND system will:<br>• Embed coproduction as business as usual across the partnership, so CYP, parents/carers and professionals routinely shape priorities, pathways and practice through established feedback, representation and visible ‘we said / we did’ change.<br>• Have clear mechanisms to hold system partners to account for coproduction activity and culture through reporting to the SEND and AP Board.<br>• Use targeted engagement, accessible communication and clear feedback loops to reach specific family communities, faith and community groups, and to show how feedback has shaped change.<br>• Have strong, joined-up governance and partner accountability, including health partner engagement, clear decision records, agreed escalation routes and timely course-correction when delivery slips.<br>• Ensure services are jointly commissioned, using what families tell us is effective and what our data shows, so that support meets needs and improves outcomes for CYP with SEND. |

| | | |
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| | leadership but more work needed to ensure coproduction is fully embedded. | |
| **Building Block 4**<br>Encouraging inclusive culture and behaviours | **Overall self-assessment: Emerging → Developing**<br><br>The maturity assessment identifies growing awareness of inclusive values and behaviours, and examples of good practice across settings and networks.<br><br>However, inclusive culture is not yet consistently embedded or reinforced across the system, and expectations are not yet strong enough to ensure predictable inclusive behaviours in all settings. The system is moving from emerging into developing**,** but inclusive culture is not yet universal. | By 2029, our local SEND system will:<br>• Ensure inclusion is a felt experience for CYP so they feel safe, understood and able to learn, with early, stigma-free adjustments.<br>• Extend our 'Family Valued' approach to put relationships and relational practice at the centre of support, so CYP and families know who is alongside them, what will happen next, and how to get help if things are not working.<br>• Listen and respond to CYP and families in accessible ways, including those who are EHE or EOTAS, so their views shape support, they can see what has changed, and reintegration is supported where appropriate.<br>• Build a consistent culture of belonging that supports strong engagement in education, with shared expectations and day-to-day practice so CYP can access a full-time offer where this is right for them.<br>• Reduce missing education, reduced timetables, EHE/EOTAS driven by unmet need, and delays in securing suitable placements or support, so more CYP can access the right education close to home. |
| **Experts at Hand**<br>Details of Core Offer | Coventry already has strong foundations for an Experts at Hand offer. This includes an established support offer for schools through specialist teachers, educational psychologists and speech and language therapy; a co-produced SEND workforce development offer that includes key health elements; strong professional networks such as SENCO and Specialist Base networks; and outreach from specialist settings. | By 2029, our Experts at Hand offer will:<br>• Be coordinated by the local authority, with a clear front door that helps ensure equitable deployment of individual resource and makes information about system-wide support accessible in one place.<br>• Provide a broad core offer made up of system-wide support and school-level work, including training, strengthened network support, group supervision, and a mix of whole-school, group and individual support.<br>• Be coproduced with settings, providers and families, so it reflects lived experience and what works in practice.<br>• Be jointly commissioned by the Council and the ICB, with shared ownership of quality, consistency and impact.<br>• Build confidence and capability in settings, reduce avoidable escalation, and strengthen earlier support through a more joined-up specialist offer. |

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| | Experts at Hand will build on and strengthen this existing offer rather than create a separate system. It will bring specialist expertise earlier into mainstream practice, strengthen staff confidence, and improve equitable access to support. The local area partnership will consider how the Experts at Hand offer sits alongside Coventry's established outreach offer, so that support is coherent and equitable across settings. | • Increase specialist capacity across speech and language therapy, occupational therapy, educational psychology and specialist teaching, using a mix of qualified posts where recruitment allows and assistant or trainee roles where this is the most sustainable approach.<br>• Sit alongside and complement Coventry's established outreach offer, with the local area partnership keeping the relationship between the two under review to ensure equity and clarity across settings.<br>• Be supported by an evaluation programme from the outset, drawing on research and evaluation expertise across the partnership, including psychology, public health and ICB colleagues.<br>• Be clearly described through the digital Local Offer, so settings, families and partners can understand what support is available and how it can be accessed.<br>• Ensure expert SaLT capacity and standardised intervention programs are consistently in place through implementation of The Balance System®, overseen by the advanced practice SaLT.<br>• Increase the reach of SaLT and OT by developing robust early years and post-16 offers with a range of delivery platforms, and by aligning refreshed specialist therapy service specifications with the Experts at Hand offer to provide a seamless continuum of support.<br>• |
| **Enabler 1**<br>Capital | **Current position: Developing (with maturing elements)**<br><br>The maturity assessment shows that Coventry has strong foundations in SEND and AP sufficiency and capital planning**,** with a clear understanding of current and projected demand. This is now supported by demonstrable delivery of inclusive capital investment**,** particularly through the expansion of Specialist Bases in mainstream settings. | By 2029, our local SEND system will:<br>• Have completed our Special School Partnership Programme with Open Thinking Partnership and local special schools to improve outcomes and experience and strengthen value for money.<br>• Embed a small-grants capital plan for settings to make minor practical adaptations to support inclusion, so more children can have their needs met in mainstream provision.<br>• Have opened at least a further nine Specialist Bases as part of a coordinated strategy to strengthen specialist capacity across the local system.<br>• Have increased capacity in special schools for SEMH and broad-spectrum needs, so more children can be supported locally.<br>• Create additional highly-specialised local capacity to meet the needs of CYP with the most complex SEND, reducing reliance on out-of-city provision to the minimum necessary. |

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| | Since 2024, Coventry has opened three new primary Specialist Bases and one secondary Specialist Base (the first of its type), with a further three primary and one secondary Specialist Base in delivery for completion by early 2027. A Specialist Base Partnership Group, working jointly with schools, is in place to oversee delivery and quality. This reflects a clear shift from strategy to implementation and shows increasingly mature use of capital to strengthen local, inclusive provision.<br><br>However, the maturity assessment highlights that capital investment is not yet fully embedded as a system-wide lever for inclusion and reform. While specialist base delivery is progressing well, the impact of capital investment on placement patterns, transport dependency and reliance on high-cost provision is not yet consistently evaluated or articulated, and wider mainstream adaptations beyond specialist base settings remain developing. | • Demonstrate how all elements of our capital plan work together to provide a cohesive city-wide offer that maximises positive outcomes, families' confidence in local settings and value for money.<br>• Demonstrate how capital investment is changing placement patterns, reducing transport dependency and lowering reliance on high-cost out-of-area provision.<br>• Ensure the AP capital investment plan supports early intervention capacity, appropriate short-term and transitional provision, and reduced reliance on long-term placements across primary and secondary phases. |
| **Enabler 2**<br>Workforce | **Current position: Developing (with maturing elements)**<br><br>The maturity assessment shows that Coventry has a clear SEND workforce | By 2029, our local SEND system will:<br>• Have a shared workforce plan across the local authority and health, so capacity is planned and deployed around need rather than organisational boundaries. |

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| | strategy and a strong education-led workforce foundation**,** with good access to SEND specific training, SENCO networks and professional development. Specialist education services demonstrate maturing practice**,** supported by regular supervision, CPD and quality assurance, and there is increasing alignment between workforce development and SEND reform priorities, particularly inclusion and early intervention.<br><br>However, the maturity assessment highlights that workforce planning and deployment across education, health and care are not yet fully integrated**.** Capacity and consistency within health-commissioned services, particularly therapies, remain variable, limiting equitable access to early specialist support. While training activity is well established, system-wide consistency of practice and impact is not yet assured**,** and specialist expertise is still largely deployed through service-based models rather than system-wide, group-level approaches. | • Have a stable, well-supported specialist workforce, including EP, SaLT and OT, with clear routes for settings to access advice early and consistently.<br>• Continue to invest in the Workforce Strategy to build mainstream confidence and capability through coordinated training, coaching and networks, with clear expectations for inclusive practice and no duplication of national training.<br>• See clear benefits from the workforce development, including the use of apprentice posts in SaLT and OT to grow capacity sustainably.<br>• Have a “Working Together” charter, co-produced with experts by experience, that sets out how CYP, families and professionals will design improvements, test what works, share feedback and strengthen inclusive practice in schools.<br>• Have consistent quality assurance across services, including therapies, with learning used to improve practice and reduce variation.<br>• Strengthen understanding of SEND across children’s services and the wider early help partnership through FFPP.<br>• Have appointed a DSCO role within children’s services. |
| **Enabler 3**<br>Data and Digital | **Current position: Developing**<br><br>Coventry has established core SEND data systems and dashboards and uses | By 2029, our local SEND system will:<br><br>• Have a shared set of outcome-focused measures and leading indicators, used routinely across the partnership to guide decisions and |

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| | quantitative data to inform place planning, commissioning and performance oversight. There is good understanding of levels of need, historic trends and demand drivers, particularly in relation to EHCP growth, placement patterns and sufficiency. Data is increasingly used to support challenge and decision-making at partnership level.<br><br>However, the maturity assessment also highlights that data and digital arrangements are not yet fully matured within health or fully integrated across education, health and care, and that analysis remains largely descriptive, rather than consistently diagnostic or predictive. While qualitative data and lived experience are gathered, these are not yet systematically combined with quantitative data to inform strategy and improvement. Shared, outcome-focused metrics are still being developed and agreed across the partnership, rather than embedded as a single, routine performance framework. | improvement – including established health data sets and embedded methods for collection and sharing.<br>• Be able to demonstrate how sustained use of a combined education, health and care data set has enabled joined up decision making - especially regarding commissioning - and improved clarity of communication across the local area partnership.<br>• Use data in a more helpful way, moving from describing what is happening to understanding why, and what needs to change next.<br>• Ensure that all strategic decision-making at SEND Board is consistently grounded in the most up-to-date and relevant data and analysis.<br>• Combine lived experience with quantitative data as standard (e.g., surveys and feedback loops alongside dashboards) to target action and track what improves.<br>• Have reliable, timely data with clear ownership and data quality checks, so reporting is trusted and useful.<br>• Improve digital processes for key SEND pathways so families and professionals experience clearer information, fewer handoffs and faster responses. |
| **Success measures** ***Drawing on metrics from the accompanying data template*** *NB: These measures* | • By 2029, attendance for pupils with an EHCP and for pupils on SEND Support will be in line with or above published national averages, and persistent absence for both groups will be in line with or below published national averages.<br>• By 2029, suspensions for pupils with an EHCP will be in line with or below published national averages, and permanent exclusions for pupils with an EHCP will be in line with or below published statistical neighbour averages.<br>• From a 2025/26 baseline, the proportion of children and young people with SEND educated in registered provision will | |

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| *have been coproduced by our local partnership, and link to our partnership's goals. The rationale for each measure is set out in the accompanying Goals, Delivery Indicators and Metrics document.* | increase year on year, and the proportion remaining on a part-time timetable for more than one term will reduce year on year. For children and young people with an EHCP, 100% of part-time timetable arrangements will be formally agreed and reviewed.<br>• The proportion of CYP with an EHCP placed in independent specialist provision will reduce from 6.0% to 5.8%, and the proportion educated outside the city from 13.1% to 12.9% by 2029. Over the same period, the proportion of pupils with an EHCP educated in mainstream will increase from 39.3% to at least 40.5%.<br>• No waits over 52 weeks, 80% reduction in waits over 18 weeks for specialist SaLT and OT pathways by 2029.<br>• A co-produced measure of parent/carer and young person experience of the SEND system will be introduced and used as the core headline measure for this section. Baseline and year-on-year improvement targets will be agreed once the survey tool has been developed, tested and calibrated. In the meantime, formal complaints progressing to Stage 2, mediation activity and tribunal volumes will be monitored as supporting indicators, with reductions over time compared with the 2025/26 baseline.<br>• 20-week timeliness for new EHCPs issued will increase from 37% to at least 75% by 2029, and the proportion of annual reviews completed in timescale will increase from 49% to at least 80%.<br>• By 2029, participation in education, employment or training for SEND young people aged 16–17 will remain in line with or above national averages, with year-on-year improvement in the proportion moving into positive and sustained post-16 and post-plan destinations.<br>• From a 2025/26 baseline, Experts at Hand will be implemented across an increasing proportion of education settings year on year, alongside year-on-year improvement in the proportion of mainstream school staff who report confidence in meeting a wider range of SEND needs with access to timely specialist advice and support. |

## What is the local area partnership's strategy for delivering on the above?

Coventry's delivery strategy is built on a clear theory of change. Starting from strong local foundations, the partnership will align investment, workforce, governance, coproduction and capital delivery to strengthen inclusive practice, improve access to earlier specialist support and expand local provision. The table below sets out this logic from inputs and activities through to the outputs and outcomes we expect to achieve, showing how reform activity will translate into better experience, stronger outcomes and a more sustainable SEND system.

| Inputs | Activities | Outputs | Outcomes |
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| • Strong education partnerships and school networks<br>• Established graduated response and early intervention approach<br>• Alignment with approaches and work within FFPP and BSiL<br>• Strong traded SEND support offer and outreach from specialist settings<br>• Overall surplus DSG position and capacity to invest in early intervention and local provision<br>• Clear capital strategy and established AP framework<br>• Established SENCO networks, co-produced training offer and specialist support services<br>• Strengthening governance, co-production, data and digital arrangements | • Early recruitment to key leadership and clinical posts, including advanced practitioner SaLT<br>• Co-produce a shared definition of inclusion<br>• Clarify ordinarily available provision standards, thresholds and pathways<br>• Implement Experts at Hand, building on existing outreach and traded support<br>• Strengthen access to therapy and specialist advice, including EHCP provision<br>• Expand local capacity through Specialist Bases, special school places and mainstream adaptations<br>• Strengthen governance and accountability across the partnership<br>• Embed coproduction more consistently in decision-making and improvement activity<br>• Improve the use of shared data, dashboards and quality assurance to guide reform | • Strengthened recruitment and retention plan for EaH offer enabling a more secure roll-out<br>• A shared and more consistent understanding of inclusion across the local area<br>• Easily understood ordinarily available provision standards, thresholds and pathways<br>• Earlier and more systematic access to specialist advice and support<br>• Stronger therapy pathways and more reliable delivery of specialist provision<br>• Increased local specialist capacity and improved mainstream environments<br>• Stronger workforce confidence, capability and access to support<br>• More consistent governance, shared oversight and clearer accountability<br>• Improved use of data, lived experience and quality assurance to monitor impact and drive improvement<br>• Early information and support for families | • Needs identified and met earlier, with less avoidable escalation<br>• Improved access to specialist advice, therapy and support<br>• Improved attendance and reduced persistent absence for CYP with SEND<br>• Reduced suspensions and exclusions for CYP with SEND<br>• Reduced reliance on reduced timetables and EOTAS<br>• More CYP with SEND educated locally, including in mainstream where appropriate<br>• Improved family and young person confidence in the SEND system and in the support provided, with fewer avoidable disputes<br>• Improved timeliness and responsiveness of EHCP processes and annual reviews<br>• A more inclusive, responsive and financially sustainable SEND system in which more CYP achieve, belong and thrive locally<br>• Improved SEND knowledge and capacity within schools |

## What is the local area partnership roadmap for the next 3 years?

| Local roadmap for the next 3 years | 2026/27 | 2027/28 | 2028/29 |
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| ***Building Block 1*** *Strengthening inclusion across education settings* | • Seek a baseline confidence and skill rating from education colleagues.<br>• Co-produce and publish a shared definition of inclusion (mainstream, Inclusion Bases/Specialist Bases and specialist), with PCF input.<br>• Complete a baseline map of Coventry's ordinarily available inclusive provision (mainstream, Inclusion Bases/Specialist Bases and special), including what is currently delivered and where there are gaps.<br>• Review the current training offer and gaps, then co-produce and launch a joined-up training and support offer (including Experts at Hand) with clear delivery routes and quality expectations.<br>• Agree and publish placement thresholds/expectations for mainstream, adaptive provision, Inclusion Bases/Specialist Bases and specialist provision, with families and settings.<br>• Establish and test the **Experts at Hand** operating model (offer, pathways, interfaces and review points), including exploration of: | • Seek an updated confidence and skill rating from education colleagues, publish the results and use to inform offer.<br>• Publish the shared definition of inclusion and roles/responsibilities across partners.<br>• Map Coventry's ordinarily available inclusive provision against national inclusion standards (as applicable) and agree a time-bound improvement plan.<br>• Establish and run a peer review approach for quality assurance of inclusive practice (scope, tools, reporting and learning).<br>• Deliver the refreshed training and support offer (including Experts at Hand) and put in place a simple quality/feedback process to improve it.<br>• Implement targeted **Experts at Hand** pathway for agreed priority areas/settings (e.g., complex SEMH), aligned to the core offer, with clear referral/entry criteria, escalation routes and routine review of impact. | • Seek an updated confidence and skill rating from education colleagues, publish the results and use to inform offer. Embed as annual action.<br>• Run a regular feedback mechanism for families and settings to assess inclusion against the shared definition, with findings reported and actions tracked.<br>• Put in place an annual assurance cycle for SEND training and support (including Experts at Hand), covering quality, reach and impact, with actions agreed.<br>• Evaluate targeted **Experts at Hand** pathways (e.g., complex SEMH) and embed the learning into business-as-usual practice, including implications for scaling or adapting the wider offer.<br>• Move from pilot to business-as-usual for the parent/carer and CYP survey, including publication of findings and "we said / we did"; co-produced with PCF.<br>• Implement Transition Standards guidance and embed a review process to test consistency and |

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| | direct specialist support; multidisciplinary teams (including assistant roles with appropriate oversight); experts by experience; outreach and capacity-building from specialist settings/AP/inclusion base services; a tiered SEND workforce development offer; facilitated networks and peer support; and digital resources/training ("Experts Online").<br>• In parallel, scope and agree whether a targeted **Experts at Hand** pathway is needed for priority areas/settings (e.g., complex SEMH), including proposed criteria, workforce model and measures of impact.<br>• Review existing transition arrangements and produce a gaps and improvement actions paper; presented to SEND & AP Board.<br>• Complete an outcomes deep-dive for children with EHCPs and agree priority actions, shared through SEND networks.<br>• Establish a SEND outcomes group with clear remit, measures and reporting. | • Align SEND peer support networks and champions so settings have clear routes to advice, peer learning and escalation.<br>• Refresh Local Offer information on Inclusion Bases/Specialist Bases so it is clear, consistent and family-friendly; co-produced with PCF.<br>• Publish good practice guidance for Inclusion Bases/Specialist Bases (inclusive practice, expectations and how impact is reviewed); developed with the Specialist Base Partnership Group.<br>• Co-produce and pilot a parent/carer and CYP inclusion survey aligned to the local definition of inclusion, including a "we said / we did" feedback loop; PCF involved.<br>• Agree Transition Standards and an implementation plan; signed off by SEND & AP Board. | experience across phases; assured by SEND & AP Board. |
| ***Building Block 2***<br>*Access to specialist support and local placements* | • Publish waiting times and numbers of waiters to access specialist SaLT and OT provision.<br>• Open an additional 30 places in specialist Bases compared with the 2025/26 baseline.<br>• Open an additional 24 places in special schools for children with | • Publish waiting times and numbers of waiters to access specialist SaLT and OT provision. Compare with last set and state actions to be taken.<br>• Open an additional 70 places in specialist Bases compared with the 2025/26 baseline. | • Publish waiting times and numbers of waiters to access specialist SaLT and OT provision. Compare with last set and state actions to be taken. Embed as annual action. |

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| | complex SEMH, compared with the 2025/26 baseline.<br>• Open an additional 20 places in special schools for children with complex learning needs, compared with the 2025/26 baseline.<br>• Complete five-year demand modelling and sufficiency planning, complete the options appraisal (including consultation), agree a preferred option, and refresh/publish the Local Authority Place Strategy.<br>• Define and publish Coventry's local specialist offer (including Inclusion Bases/Specialist Bases and AP): who it is for, access routes/decision points, and quality expectations (inclusive practice, outcomes focus and review of placement impact).<br>• Agree a delivery mechanism for additional places (in city) for CYP with highly complex needs, including timescales, dependencies and the decision route for placements.<br>• Agree and implement a therapy delivery model (SaLT and OT) that covers EHCP Section F delivery and earlier help, including clear routes for settings to access advice and support.<br>• Build on a strong AP framework by implementing the revised behaviour pathway (aligned to the Belonging and Inclusion Approach) and reviewing the AP offer within the local reform plan (capital, Specialist Bases and Experts at Hand) to identify gaps it can help fill. | • Open an additional 48 places in special schools for children with complex SEMH, compared with the 2025/26 baseline.<br>• Open an additional 40 places in special schools for children with complex learning needs, compared with the 2025/26 baseline.<br>• Publish clear pathways (including entry/exit and decision points) for SEMH, AP, complex learning needs and therapy access, and update the Local Offer as a single point of truth for families and settings.<br>• Embed clear AP pathways within the local reform plan, including entry/exit criteria, reintegration expectations, and links to Experts at Hand and Specialist Bases.<br>• Embed the pathways referenced above in day-to-day practice (including referral routes, decision-making and communication), with updated Local Offer content.<br>• Put in place routine assurance and reporting for SaLT/OT delivery (including EHCP Section F and earlier help), using feedback from families and settings to improve consistency and quality.<br>• Co-produce and implement a support offer for children and young people accessing learning outside of school, including therapeutic input where needed, with clear access routes and a review cycle. | • Open an additional 110 places in Specialist Bases compared with the 2025/26 baseline.<br>• Open an additional 72 places in special schools for children with complex SEMH, compared with the 2025/26 baseline.<br>• Open an additional 60 places in special schools for children with complex learning needs, compared with the 2025/26 baseline.<br>• Keep the local specialist offer, pathways and Local Offer information under review so they stay clear, consistent and responsive to need.<br>• Implement any agreed AP adaptations/enhancements and evaluate impact on engagement, outcomes and placement stability.<br>• Maintain routine assurance of therapy delivery (SaLT/OT), with improvement actions agreed where delivery is inconsistent or outcomes are not improving. |

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| | • Coproduce (with children and families) and publish an offer for children and young people accessing learning outside of school, including support available, access routes, links to AP/reintegration and therapeutic support, and clear review points. | | |
| ***Building Block 3*** *System leadership, local partnership collaboration and co-production* | • Agree and publish a coproduction framework (what it means in Coventry, when it is required, roles, decision points, how feedback will be given, and funding).<br>• Agree a small set of priority topics with **PCF** and CYP and publish a simple "we said / we did" approach.<br>• Refresh partnership governance and terms of reference so roles, escalation routes and decision rights are clear (including how delivery is coordinated and how issues are resolved), strengthening health system engagement.<br>• Introduce a reporting cycle for SEND reform (regular reporting, actions, owners and timescales) and a single view of progress against milestones.<br>• Agree a communications approach for SEND reform (key messages, channels, and how families can raise issues and get responses).<br>• Agree a core set of headline measures and leading indicators (including confidence and lived experience measures) and how they will be reported and used. | • Embed coproduction in business-as-usual decision making (standing agenda items, clear decision records, and published feedback loops).<br>• Establish and run a consistent mechanism to gather and act on children and young people's views (including a citywide view of themes and actions).<br>• Publish an annual engagement plan with **PCF** and report progress, themes and actions taken.<br>• Strengthen how data and lived experience are used together in governance (dashboards + qualitative insight presented together, with actions tracked).<br>• Carry out a review of partnership effectiveness (what is working, what needs to change) and update governance arrangements where needed.<br>• Provide collective learning and feedback to DfE, including what has changed locally and what support is needed. | • Demonstrate that coproduction is consistently shaping decisions, with clear examples published and a routine "we said / we did" cycle.<br>• Maintain a mature assurance and improvement cycle for governance and delivery (regular review of progress, risks, mitigations and outcomes).<br>• Publish an annual impact summary that brings together data and lived experience, showing progress against the SEND reform goals and what will happen next.<br>• Keep communications and engagement approaches under review so families and settings can access clear information and timely responses.<br>• Review and publish success / learning from three-year joint commissioning plan. Create new three-year joint commissioning plan. |

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| | • Agree a three-year joint commissioning plan. | • Review progress against three-year joint commissioning plan. | |
| ***Building Block 4***<br>*Encouraging inclusive culture and behaviours* | • Agree a Belonging and Inclusion Approach (shared expectations for inclusive behaviour, language and practice across settings).<br>• Ensure the Belonging and Inclusion Approach applies to CYP educated outside school (including EHE and EOTAS), so they remain visible in our inclusion approach and oversight.<br>• Ensure staffing capacity and structures are sufficient and aligned to support this work.<br>• Implement a consistent expectation for reduced timetables and reintegration planning (case audits, escalation routes and learning).<br>• Agree and publish a "right support, right place, right time" approach for children unable to attend full-time, including reintegration pathways from AP and support to return to education.<br>• Coproduce practical guidance for families and settings on attendance, inclusion and support when things are not working well (including clear routes for help).<br>• Coproduce and publish clear family-facing guidance on what support is available, what happens while CYP are waiting, and how to raise concerns or get help when things are not working.<br>• Establish routine reporting on attendance, suspensions/exclusions, | • Embed a Belonging and Inclusion Culture in settings (communications, networks and practical tools), with examples of expected practice shared.<br>• Strengthen early intervention for attendance and behaviour for children with SEND through joined-up school support and targeted advice (linked to Experts at Hand where appropriate).<br>• Improve pathway working between mainstream, AP and specialist provision so moves are carefully planned and focused on outcomes.<br>• Embed consideration of EHE/EOTAS within inclusion practice, guidance and reporting, so CYP are not disadvantaged by where they are educated.<br>• Publish an annual thematic summary (attendance, exclusions, reduced timetables, CME) including what has improved and what will change next ("we said / we did").<br>• Implement a routine CYP and family experience measure for inclusion, support while waiting and confidence in pathways, with findings reported to SEND & AP Board and used to drive 'we said / we did' actions. | • Maintain a business-as-usual assurance cycle for inclusive culture and access to education, with risks and actions reviewed and tracked.<br>• Maintain routine assurance of inclusion and outcomes for children educated outside school (including EHE and EOTAS) as part of oversight.<br>• Demonstrate sustained improvement in attendance and engagement for children and young people with SEND, with fewer exclusions, reduced timetables and CME incidents.<br>• Embed a consistent reintegration offer so children who have been out of education or in AP can return to suitable education with the right support.<br>• Review the impact of the Belonging and Inclusion Culture with families and settings, and refresh practical guidance based on what works.<br>• Assurance of reduced timetables and access to suitable education is maintained through SEND & AP Board oversight. |

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| | reduced timetables and CME for CYP with SEND, linked to action planning. | | |
| ***Enabler 1***<br>*Capital* | • Complete delivery of the Specialist Bases currently in train (three primary and one secondary) by early 2027, with Specialist Base Partnership Group oversight of delivery and quality.<br>• Agree and publish a city-wide capital investment plan for school-led inclusion bases, including a programme of small, practical mainstream adaptations.<br>• Establish a benefits and evaluation approach to evidence how capital is shifting placement patterns, transport dependency and reliance on high-cost out-of-area provision. | • Deliver the next phase of inclusion base provision in line with a mature inclusion base strategy linked to five-year demand projections (need and geography).<br>• Agree and begin delivery of a coproduced plan for children with the most complex SEND, including specialist places and pathways within the city.<br>• Extend capital-enabled accessibility and inclusive environment improvements beyond inclusion bases (across phases, including early years and post-16). | • Use routine evidence to show how capital investment is changing placement patterns, reducing transport dependency and lowering reliance on high-cost out-of-area provision.<br>• Embed capital as a system-wide lever for inclusion (programme refresh cycle and annual review so plans remain responsive to need and impact). |
| ***Enabler 2***<br>*Workforce* | • Fast track recruitment to the advanced practitioner SaLT post.<br>• Complete an options appraisal and identify a delivery model for the specialist components of Experts at Hand (e.g. using assistant therapists / Psychologists; drawing on resource from specialist settings).<br>• Write a joint specialist workforce recruitment plan (for EP, SaLT, OT and specialist teachers) including apprentice post to boost sustainability. | • Implement integrated workforce deployment across partners so capacity is planned and used around need (not organisational boundaries), with shared pathways/interfaces for advice and escalation.<br>• Use Experts at Hand to spread specialist expertise system-wide (early help, problem-solving with settings and practice development). Reduce reliance on casework-only models.<br>• Align quality assurance across services (including therapies), using | • Maintain a stable, well-supported specialist workforce with clear career pathways, supervision/CPD.<br>• Embed a system-wide assurance and improvement cycle across education, health and care workforce delivery, including therapies.<br>• Demonstrate sustained system impact from workforce changes against agreed metrics. |

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| | • Review and refresh the SEND networks offer, including coaching and access to external expertise. Agree simple measures of reach and impact.<br>• Further expand the statutory assessment and review team workforce, through the introduction of specialist plan coordinator roles for EOTAS and dispute resolution, as well as additional main grade roles, to keep pace with the increase in demand. | learning and feedback to reduce variation and improve consistency. | |
| ***Enabler 3***<br>*Data and Digital* | • Refresh health data set requirements between ICB and providers.<br>• Agree defined outcome measure for SaLT and OT (e.g. EKOS) and request provider implementation.<br>• Agree a shared set of outcome-focused measures and leading indicators (including definitions and owners) and agree the reporting mechanism.<br>• Create a single partnership performance view bringing together education, health and care data (demand, delivery, quality and outcomes).<br>• Extend the role of the Quality Assurance Group to provide data governance (including data standards, routine checks and clear ownership) so reporting is trusted and timely. | • Seek outcome measure report for SaLT and OT for 50% minimum of CYP on specialist pathways.<br>• Use data in a more diagnostic way (why it is happening, not just what), and introduce simple forecasting (beyond current demand and place forecasting)<br>• Combine lived experience with quantitative data as standard (survey/feedback loops alongside dashboards) and report “we said / we did” actions.<br>• Improve digital processes to make the statutory assessment process easier to navigate and to offer support whilst waiting for assessment. | • Seek outcome measure report for SaLT and OT for 50% minimum of CYP on specialist pathways.<br>• Demonstrate sustained improvements in data quality, timeliness and usability (trusted reporting with clear ownership and assurance).<br>• Deliver measurable improvements to end-to-end digital user experience for families and professionals (clearer information and faster responses). Keep processes under annual review. |

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| | • Coproduce a system-wide survey to gather the views of CYP and families on SEND Services.<br>• Share sufficiency forecasts and planning regularly with partnership as part of a headline data set. | | |
| **Success measures** | • By 2029, attendance for pupils with an EHCP and for pupils on SEND Support will be in line with or above published national averages, and persistent absence for both groups will be in line with or below published national averages.<br>• By 2029, suspensions for pupils with an EHCP will be in line with or below published national averages, and permanent exclusions for pupils with an EHCP will be in line with or below published statistical neighbour averages.<br>• From a 2025/26 baseline, the proportion of children and young people with SEND educated in registered provision will increase year on year, and the proportion remaining on a part-time timetable for more than one term will reduce year on year. For children and young people with an EHCP, 100% of part-time timetable arrangements will be formally agreed and reviewed.<br>• The proportion of CYP with an EHCP placed in independent specialist provision will reduce from 6.0% to 5.8%, and the proportion educated outside the city from 13.1% to 12.9% by 2029. Over the same period, the proportion of pupils with an EHCP educated in mainstream will increase from 39.3% to at least 40.5%.<br>• No waits over 52 weeks, 80% reduction in waits over 18 weeks for specialist SaLT and OT pathways by 2029.<br>• A co-produced measure of parent/carer and young person experience of the SEND system will be introduced and used as the core headline measure for this section. Baseline and year-on-year improvement targets will be agreed once the survey tool has been developed, tested and calibrated. In the meantime, formal complaints progressing to Stage 2, mediation activity and tribunal volumes will be monitored as supporting indicators, with reductions over time compared with the 2025/26 baseline.<br>• 20-week timeliness for new EHCPs issued will increase from 37% to at least 75% by 2029, and the proportion of annual reviews completed in timescale will increase from 49% to at least 80%.<br>• By 2029, participation in education, employment or training for SEND young people aged 16–17 will remain in line with or above national averages, with year-on-year improvement in the proportion moving into positive and sustained post-16 and post-plan destinations.<br>• From a 2025/26 baseline, Experts at Hand will be implemented across an increasing proportion of education settings year on year, alongside year-on-year improvement in the proportion of mainstream school staff who report confidence in meeting a wider range of SEND needs with access to timely specialist advice and support. | | |

## What will the local area partnership deliver in the first year?

Please outline the key workstreams, milestones and trajectory your local area partnership will deliver and achieve in 2026-27, as well as how you plan to spend the investment allocation that will help fund this year's delivery. Please share key milestones and anticipated dates, success measures, cost breakdown and category. These should incorporate the core minimum requirements, be mapped to the building blocks above and reflect a more detailed trajectory to the narrative, milestones and target metrics outlined in the 2026-27 column above.

| **2026-27 Local delivery plan** | **Q2** | | **Q3** | | **Q4** | |
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| ***Workstream outline – mapped to building block***<br><br>***Outcome -*** *what you want to achieve with this workstream*<br><br>***Success measures –*** *how you measure progress drawing on metrics from the accompanying data template* | ***Milestones per workstream***<br>*What key milestones will enable you achieve your targeted trajectory* | ***Target trajectory per workstream***<br>*Where do you expect your data to be?* | ***Milestones per workstream***<br>*What key milestones will enable you achieve your targeted trajectory* | ***Target trajectory per workstream***<br>*Where do you expect your data to be?* | ***Milestones per workstream***<br>*What key milestones will enable you achieve your targeted trajectory* | ***Target trajectory per workstream***<br>*Where do you expect your data to be?* |
| **Workspace 1**<br>**Quality Assurance, Data and Digital**<br><br>***Outcome***<br>*Strengthen system assurance and intelligence across SEND and AP, ensuring that reform delivery and decision making are informed by robust quality assurance, reliable data and effective digital processes.*<br><br>**Success Measure**<br>*The partnership has trusted, routine reporting that is used to understand variation and drive improvement (not just describe performance). Multi-agency assurance and lived experience evidence are brought together to inform decisions, with clear examples of course-correction and learning.* | *Task and finish group established to review features of inclusive practice, with representation from PCF and CYP.*<br><br>*Outcomes deep dive completed for children with EHCPs, with priority actions agreed and shared through SEND networks.*<br><br>*Coventry's pillars of coproduction agreed with PCF and CYP Groups, and representation on SEND Board confirmed.* | *First inclusive practice task and finish group established.*<br><br>*EHCP outcomes deep dive completed.*<br><br>*Revised governance framework published.*<br><br>*Single SEND dataset specification agreed.* | *Draft one of the inclusion charter completed and shared with mainstream, Specialist Base and specialist groups for feedback.*<br><br>*SEND Outcomes Group established and convened, with action plan agreed and pilot schools recruited.*<br><br>*MOU with PCF and CYP groups formalised, co-production priorities for Year 1 identified, and metrics for evaluating co-production agreed.*<br><br>*Revised governance arrangements* | *First inclusion charter draft shared across 3 provision types.*<br><br>*A SEND Outcomes Group established with pilot schools recruited.*<br><br>*A formal MOU agreed with PCF and CYP groups.*<br><br>*First live reform tracker in use across core governance forums.*<br><br>*First part-time timetable audit completed.* | *Inclusion charter reviewed, amended and shared with the wider education partnership.*<br><br>*Priority actions implemented with pilot schools and initial evaluation completed.*<br><br>*Co-production framework and Year 1 progress report published and presented to SEND Board.*<br><br>*Revised governance framework evaluated at SEND Board, with any Year 2 changes agreed if required.* | *A co-production framework published.*<br><br>*First Year 1 progress report presented to SEND Board.*<br><br>*Reporting cycle embedded across governance forums.*<br><br>*Agreed partnership measure set in routine use.*<br><br>*First annual QA report completed.* |

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| **Responsible Person**<br>*Head of SEND and Designated Clinical Officer*<br>***NB:***<br>*This draws predominantly from Building Blocks 3 and 4. Please see Year 1 mapping document for further information.* | *Revised governance and delivery framework published.*<br><br>*Reporting requirements agreed through a logistics meeting with the reform programme manager, data leads and representatives from education, health and care.*<br><br>*Year 1 communication channels and key messages agreed with Co-production Leads, PCF, CYP and Council Comms team.*<br><br>*Existing data sources and reporting routes across education, health and care mapped, with requirements for a single SEND data set agreed.*<br><br>*Task and finish group established for part time timetables, with an initial audit plan agreed.*<br><br>*Specialist Plan-Coordinator post filled and Cross Agency Group established to oversee routine reporting and action planning.*<br><br>*QA measures reviewed and timetable agreed for strengthened oversight of out-of-city providers.* | | *implemented across the partnership.*<br><br>*Single headline reform progress tracker agreed, published and brought into use within the governance spine and partnership groups.*<br><br>*Feedback mechanisms reviewed and aligned, with communications used to direct families to the digital Local Offer as the front door for feedback.*<br><br>*Single SEND data set piloted and used for reporting within the governance spine and partnership groups.*<br><br>*Case audit completed for children and young people on part-time timetables.*<br><br>*Additional reporting beyond the headline dashboard agreed and reporting structure implemented under oversight from CCC Performance Group and RDG.*<br><br>*Aggregate reporting system implemented to provide a single view of QA findings across out-of-city providers.* | | *Reporting cycle embedded through routine use across the governance spine and partnership groups.*<br><br>*Communications approach embedded through routine use across reform activity and family engagement.*<br><br>*Headline measures and leading indicators embedded as the agreed partnership view of SEND outcomes and progress.*<br><br>*Options paper completed and submitted to SEND Board.*<br><br>*CME trends analysed and findings reported to SEND Board.*<br><br>*Options report prepared for SEND Board setting out Year 1 QA activity, quality of provision, key concerns and priorities for Year 2.* | |

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| **Workspace 2**<br>**Commissioning and Workforce Development**<br><br>***Outcome***<br>*Strengthen system capacity and capability to meet the needs of children and young people with SEND, through improved commissioning and workforce development.*<br><br>**Success Measure**<br>*Settings can access earlier specialist advice and support through Experts at Hand, underpinned by increasing and better-deployed specialist capacity (EP/SaLT/OT) and clearer routes for therapy access and Section F delivery. Evidence of reach, consistency and feedback is used to refine the offer.*<br><br>**Responsible Person**<br>*Head of SEND and SEND Joint Commissioning Lead*<br><br>***NB:***<br>*This draws predominantly from Building Blocks 1 and 2. Please see Year 1 mapping document for further information.* | *Current training offer reviewed with the wider partnership, gaps identified, funding requirements agreed, and development plan shared with SEND Board.*<br><br>*EAH Lead appointed, subgroup established, and data from summer workshops analysed, with draft EAH Plan published and shared with partners. Further focused work with early years and further education completed.*<br><br>*Consultation completed with settings, early years, schools and further education to identify city-wide priorities for bespoke EAH provision, with a maximum of three priority areas agreed and delivery plan confirmed across Years 1, 2 and 3.*<br><br>*SaLT demand and capacity assessment completed, with additional SaLT and OT capacity secured through employed posts and a strengthened commissioning framework.*<br><br>*AP framework and behaviour pathway reviewed, with key gaps and links to wider reform identified.*<br><br>*Partners engaged to shape the Belonging and* | *A refreshed training offer baseline completed.*<br><br>*An EAH lead and subgroup in place.*<br><br>*Up to 3 bespoke EAH priorities agreed.*<br><br>*A SaLT demand and capacity assessment completed.*<br><br>*A cross-agency reporting group established.* | *Additional training capacity secured and delivery model agreed, including "Experts Online", with implementation of the revised offer underway.*<br><br>*Key clinical posts filled across psychology, therapy and specialist teaching teams, including advanced SaLT practitioner, with commissioning arrangements for outreach providers and an experts-by-experience model agreed, drawing on the PINS model.*<br><br>*Resource for the Year 1 bespoke EAH priority agreed and secured, with the bespoke Year 1 offer planned and implementation underway.*<br><br>*Additional capacity fully integrated into day-to-day delivery, with clear communication across council and NHS services to ensure consistent delivery.*<br><br>*Revised pathway co-produced and tested, with AP priorities agreed within the wider SEND offer.*<br><br>*Shared vision, expectations and practical implications for settings agreed with partners.* | *Additional training capacity secured, including Experts Online.*<br><br>*Key posts filled across 3 specialist workforce areas.*<br><br>*Resource secured for the first bespoke EAH priority.*<br><br>*A revised AP pathway tested with agreed priorities.*<br><br>*Commissioning options reviewed across EHE, EOTAS and NHS support* | *Revised training offer embedded, with clear links to the wider EAH model.*<br><br>*Single front door for EAH established and first phase of the offer launched, with clear guidance on the minimum offer for settings for the remainder of Year 1 and Year 2.*<br><br>*Year 1 bespoke offer fully implemented and evaluated, with Year 2 priority resourced and rollout planned.*<br><br>*Impact evaluated, demand and capacity assessment revisited, and additional provision secured if needed to ensure full delivery of EAH alongside Section F provision.*<br><br>*Revised pathway implemented, with AP delivery refined in response to identified gaps.*<br><br>*Belonging and Inclusion Strategy and supporting guidance published for implementation across the partnership.*<br><br>*Additional AP and NHS support secured and made available through a clearly communicated offer to families.* | *A single front door for EAH established.*<br><br>*First phase of the EAH offer launched.*<br><br>*Year 1 bespoke offer implemented and evaluated.*<br><br>*A revised AP pathway implemented.*<br><br>*A partnership-wide Belonging and Inclusion Strategy published.* |

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| | *Inclusion Strategy and identify key issues in current practice.*<br><br>*Specialist Plan-Coordinator post filled and Cross Agency Group established to oversee routine reporting and action planning.* | | *Commissioning options for children and young people accessing EHE and EOTAS reviewed, gaps identified, and tendering activity completed with framework providers. Access to NHS mental health support reviewed and plan agreed to strengthen access.* | | | |
| **Workspace 3**<br>**Capital and Sufficiency**<br><br>***Outcome***<br>*Ensure a sustainable, planned approach to meeting current and future demand for SEND and Alternative Provision.*<br><br>**Success Measure**<br>*Sufficiency decisions are based on robust demand analysis and are delivered through a clear, managed pipeline (including Specialist Bases), with readiness grip and benefits tracking. Evidence is used to adjust plans and reduce reliance on out-of-city provision over time.*<br><br>**Responsible Person**<br>*Head of SEND and Education Capital Lead*<br><br>***NB:***<br>*This draws predominantly from Building Blocks 1 and 2. Please see Year 1 mapping document for further information.* | *Five-year demand modelling completed and options appraisal drafted. Options appraisal presented to CCC leadership for sign-off on capital investment, with the preferred option confirmed and shared with the SEND & AP Partnership Board.*<br><br>*Specialist Bases will open at two primary schools, creating 20 additional places.*<br><br>*Phased opening of new provision at Woodfield Special School will create 28 places across primary and secondary.*<br><br>*Review current practice and existing work with Specialist Bases and special schools to identify the key features of effective placement expectations across the continuum of provision.* | *First five-year demand model completed.*<br><br>*A task group established with multi-agency representation.*<br><br>*Initial specialist offer framework agreed for Local Offer content.* | *Refreshed Local Authority Place Strategy published and adopted across governance and partnership groups, with the agreed plan informing future capital and sufficiency decisions.*<br><br>*Develop and test draft placement expectations with children and young people, parents/carers and settings, refining them through feedback.*<br><br>*Gaps and improvement actions paper developed, drawing on feedback from children and young people, families, settings and partners.*<br><br>*Common template agreed for sharing information via the Local Offer, with all settings and services providing data.*<br><br>*Initial capital plan agreed and timescale set, with information shared within governance groups.* | *A preferred capital option confirmed through governance.*<br><br>*Draft placement expectations tested with families and settings.*<br><br>*A common Local Offer template agreed across settings and services.*<br><br>*An initial capital plan and timetable agreed.* | *Specialist Bases will open at one primary school, creating 10 additional places.*<br><br>*Agree, publish and embed placement expectations within decision-making processes across the partnership, with clear routes for implementation and oversight.*<br><br>*Transition improvement paper presented to SEND & AP Board, with priority actions agreed for implementation.*<br><br>*Local specialist offer published, with information about settings and services and supporting narrative.*<br><br>*Delivery of the capital project commenced.*<br><br>*Revised guidance published and training piloted.* | *A refreshed Place Strategy published and adopted.*<br><br>*Placement expectations embedded in partnership decision-making.*<br><br>*A local specialist offer published through the Local Offer.*<br><br>*Delivery of the capital project commenced.* |

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| | *Current transition arrangements across phases, settings and pathways reviewed, with evidence gathered on strengths, gaps and variation in practice.*<br><br>*Current Local Offer content reviewed, gaps identified, and framework for presenting the offer agreed.*<br><br>*Potential special school providers consulted, delivery partner agreed, and proposed model agreed, including the physical environment and pedagogy model.*<br><br>*Current guidance on support for children with extended non-attendance at school reviewed, with gaps and required updates identified.*<br><br>*Task group established, with representation from young people, parents, settings, specialists and the EOTAS Plan Coordinator.* | | *Draft revised guidance published, with work started on a complementary training programme.*<br><br>*Options paper drafted and presented to SEND Board.* | | *Implementation of the action plan commenced.* | |

**Projected Investment Spend per Quarter**

*Please specify funding source for each category*

*Example categories*:
Programme oversight/additional leadership capacity.
Workforce
Recruitment
Workforce training and development
Data/Digital

**Total Spend**

| | Q2 (£000) | Q3 (£000) | Q4 (£000) | Total (£000) |
|---|---|---|---|---|
| Transformation (Administration) | 150 | 150 | 300 | 601 |
| Workforce | 586 | 586 | 1,171 | 2,342 |
| Other | 15 | 15 | 30 | 61 |
| **Total** | **751** | **751** | **1,502** | **3,004** |

*Numbers rounded to the nearest thousand.

## How will the local area partnership deliver the first-year plan?

To ensure sufficient capacity and capability to implement this plan, the local area will strengthen both governance and programme infrastructure. We will implement a revised governance structure, with a Reform Delivery Group (RDG) providing day-to-day grip, pace and problem-solving across workstreams, and enabling the SEND Board to focus on strategic oversight, system challenge and decisions on prioritisation. This will include refreshed engagement and commitment through named leads within the ICB and provider functions to ensure a direct line of sight from the reform plan to delivery. It will also include the advanced SaLT practitioner to ensure therapy integration and sustainability are core to capacity discussions. Corporate functions will be engaged through this governance, including a dedicated finance link on the SEND Board to support financial compliance, value-for-money decision making and alignment between reform activity and available resources. It will include a robust three-year joint commissioning plan to bring together a single vision with shared and evidenced accountability.

We are increasing programme capacity within both the Local Authority and the ICB through a dedicated programme manager post for the reforms, supported by a clear delivery rhythm: a single integrated plan, defined owners and milestones, routine highlight reporting, and escalation routes to unblock delivery quickly. We will also refresh our approach to co-production to ensure it is central to implementation (not an add-on), by setting clear expectations for when co-production is required, how decisions are recorded, and how we will demonstrate impact through consistent “we said / we did” feedback loops.

To strengthen data and analytics capability, we will extend the role of the Quality Assurance Group to include stronger oversight of data governance and digital systems, including agreed definitions, owners and data quality checks so reporting is trusted and timely. We will quickly review and enhance health data collection expectation to support implementation of a local area dashboard which brings together education, health and care intelligence on demand, delivery, quality and outcomes, aligned to the measures in this plan. A clear reporting cadence will be established and used consistently across SEND Board, schools groups and organisational performance management forums, so insights inform decisions on prioritisation, resource deployment and course-correction throughout the year.

## Other Funding

Coventry has not made a Schools Block to High Needs Block transfer in 2026/27.  The LA is not in an overall DSG deficit position and has continued to deliver high-quality support for CYP through strong local partnerships and a sustained focus on early intervention.

## Capital Strategy

Coventry's high needs capital strategy is designed to strengthen inclusion, grow local capacity and reduce reliance on out-of-city placements through a planned continuum of provision:

- inclusive mainstream (with improved estate and workforce capacity),
- inclusion bases,
- in-city special school capacity for children with the most complex needs, and
- a small, quality-assured independent offer used only where needs cannot be met within city provision.

Following the planned investment in local special school capacity, Coventry's capital plan will place greater emphasis on mainstream inclusion, delivering high-quality local provision for children, young people and families within their own communities.

As part of the reform programme, we have reviewed Coventry's existing capital strategy against national priorities and the evidence from our Maturity Assessment and Data Return. This has confirmed that our balanced approach remains the right one for Coventry: prioritising investment in mainstream inclusion and Specialist Bases, alongside targeted expansion of local special school capacity. The overall capital plan also considers how existing premises can be adapted, reconfigured or used more effectively, alongside proposals for new or expanded provision. This approach supports CYP to be educated successfully in their local communities while improving value for money. Delivery will be led through the Capital and Sufficiency Workspace, with benefits realisation and evaluation overseen through the Quality Assurance, Data and Digital Workspace. This will ensure that capital proposals are tested against placement sufficiency, deliverability, outcomes, value for money and transport implications, including travel distance, journey times and cost.

Expansion of Specialist Bases is our primary capital lever. We currently have 10 Specialist Bases open, providing 87 places across primary and secondary phases. Over the programme period, we will deliver at least an additional 100 Specialist Base places focused on autism/complex communication and cognition and learning, reflecting forecast growth in these cohorts and our parallel approach for SEMH.

Our Specialist Base Gateway process – which has been co-produced with our Inclusion Base Partnership – assesses:

- schools' inclusive vision and self-assessment against agreed quality standards;
- geography and population need, to improve local availability of places; and
- capital feasibility and deliverability.

This ensures a fair and transparent pipeline while maintaining strong expectations for inclusive practice and reintegration.

Capital work is ongoing in three primary schools, with specialist bases due to open late in 2026 or early 2027; capital work will shortly begin at a partner secondary school, with our second secondary base due to open in 2027.

Alongside Specialist Base expansion, we will continue to increase in-city special school capacity. By 2029 we will increase special school places for SEMH by 100 at Woodfield School and broad-spectrum needs by 85 at Baginton Fields, building on investment already made. Our next phase of special school investment will focus primarily on children with highly complex needs, where the level of specialist environment, staffing and multi-agency input required cannot currently be met through specialist provision within the city. This work will be undertaken in partnership with our established Special Schools Partnership Group and we have already identified a potential partner special school with the space needed for capital work.

This is complemented by our existing SEMH approach, which combines expanded SEMH specialist capacity with a strengthened alternative provision (AP) pathway, to support earlier intervention and timely reintegration where appropriate. We will also consult on whether further broad-spectrum capacity is required beyond 2027, based on updated demand modelling and placement trends.

To improve the suitability of the mainstream estate (including innovation such as assistive technology), we will implement a small-grants programme for schools to fund practical adaptations that enable inclusive practice, including breakout spaces, sensory rooms and assistive technology. The local authority will provide planning and commissioning support for larger or more complex projects where required.

These capital improvements will be aligned with our Experts at Hand (“team around the school”) model so that estates changes and workforce practice development reinforce each other and provide earlier support in mainstream.

Where independent provision is required, we will work with a small number of trusted providers who demonstrate strong outcomes, value for money and reasonable proximity to Coventry, while continuing to prioritise local capacity first.

For post-16, we have established a Post-16 SEND Partnership Group to co-produce the local response, including any capital requirements for FE settings. Across the programme, we will track impact through agreed measures such as in-city placement rates, access to Specialist Base places, travel distance and journey times, using this evidence to refine the capital plan year by year.

Sufficiency of placements in early years will be reviewed through our existing Early Years partnership, with particular regard to the local offer for children with the most complex SEND needs.

## System partner and stakeholder engagement, and co-production

We will engage system partners and stakeholders through a refreshed governance 'spine': the SEND and AP Partnership Board (strategic decisions), the Reform Delivery Group (RDG) (programme delivery and escalation) and themed workspaces (for co-design and implementation). Partnership groups connect into this spine through:

- **Representation** (partners sit on Board/RDG/workspaces);
- **Co-production** (priority reform elements designed with children, young people and families and partners);
- **Consultation** (technical elements led by a nominated organisation with structured input from relevant groups).

This approach meets the core minimum requirements by ensuring CYP, parents/carers, education settings and health partners are involved early, influence decisions, and receive feedback on how their input has been used. In the context of changing roles and responsibilities set out in the Schools White Paper, we will use the RDG as the main interface with education partners to agree shared expectations and manage transition. We would welcome DfE support at summer term sessions with education leaders and Parent Carer Forum leaders to accelerate shared understanding and commitment.

## How partners connect:

Engagement and co-production with CYP and families is coordinated by the SEND Engagement Lead, whilst the LA's Head of SEND coordinates engagement with settings and organisations. Issues and actions are routed through relevant workspaces and the RDG. An early action for this work will be to explore a local application of existing coproduction models such as the four cornerstone approach.

**CYP:** We will use existing youth voice routes (including Strong Voices Coventry) and broaden engagement across mainstream settings, community provision and elective home education. The SEND and AP Partnership Board includes a standing item on CYP voice, with opportunities for direct input where requested.

**Parents and carers:** Coventry's Parent Carer Forum (PCF) is positioned to provide strategic input and challenge. Co-production is embedded through regular liaison with the SEND Engagement Lead, Head of SEND and Designated Clinical Officer (DCO), and through PCF representation on the SEND and AP Partnership Board; actions are tracked and feedback provided on how PCF input has informed decisions.

**Early years:** Early years contributes through strategic representation on the SEND and AP Partnership Board and an operational lead in the RDG, with involvement in relevant workspaces (inclusion, pathways, workforce and data). Existing early years networks across provider types will be used to test proposals and feed system intelligence into the RDG.

**Schools:** We engage all school types (maintained schools, academies/MATs, primary, secondary and all-through, special schools, PRUs and other LA-maintained settings) through the mainstream Inclusion Group, the Special Schools Partnership Group and (since 2025) the Inclusion Base Partnership Group delivering our school-led Inclusion Base Strategy and support for school-led adaptive provision. These groups interface into the reform programme through the RDG, providing routes for shared problem-solving, escalation and decision-making, including on specialist capacity (places in special schools).

**FE and post-16 (including out-of-area):** In Summer 2026 we established a Post-16 Partnership Group (colleges, adult education and supported internship providers) to shape our post-16 offer. The group interfaces with the RDG to agree priorities, resolve barriers and drive reform for young people aged 16+ and is represented on the SEND and AP Board.

**Alternative provision:** We will engage AP leaders and providers through established AP governance (including Primary and Secondary AP Working Groups/Multi-Agency Panels) and through representation in the governance spine (AP workspace and the RDG). This will be complemented by targeted co-production on priorities such as early intervention, placement pathways and reintegration, and consultation on commissioning and practice standards as national arrangements evolve.

**SENDIASS and dispute resolution:** SENDIASS is a key partner, providing independent, high-quality information and advice to families. Its independence is protected; SENDIASS operates under a separate service arrangement and does not participate in placement decision-making, ensuring families can engage with confidence. Local mediation and dispute resolution arrangements incorporate parent and CYP voice. Metrics are reported through the SEND and AP Board.

## Risks and Mitigations

| Risk | Impact | Likelihood | RAG | Mitigation | Residual RAG |
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| There is insufficient specialist capacity (EP/SaLT/OT) to deliver the **Experts at Hand** model at scale leading to long waits and inconsistent support to settings, and an underspend of grant funding. | **High** | **High** | **Red** | • Appoint to the advanced SaLT practitioner post at pace to support recruitment modelling, capacity and sustainability.<br>• Utilise apprentice SaLT and OT posts to attract staff and build sustainability.<br>• Use the existing SEND Workforce Development Strategy as a basis from which to build, ensuring that high-quality training is available, free at the point of contact to settings, from early in the programme.<br>• Confirm a blended specialist outreach delivery model, including assistant therapists and psychologists, specialist teachers and multi-therapy assistants.<br>• Ensure that within these models, quality clinical supervision builds expertise and ensures that the offer adds value for settings.<br>• Work across the local area partnership, with specialist settings and AP providers, to draw on outreach support from skilled staff in settings.<br>• Build in a network supervision model, which maximises use of professional time across settings.<br>• Map existing SaLT and OT ordinarily available provision onto the new service model to eliminate duplication and direct resource at the earliest opportunity. | **Amber** |
| If grant funding for **Experts at Hand** does not continue after three years, there is a risk of workforce and system instability (loss of capacity, reduced early support to settings and variable access), which would weaken inclusive practice and continuity of support for children and young people. | **High** | **Medium** | **Red** | • Design **Experts at Hand** as an evolution of Coventry's strong traded specialist SEND services and SEND networks (not a parallel offer), with clear interfaces and agreed service standards.<br>• Agree a sustainability and transition-to-BAU plan from year 1 (ownership, core components, workforce model, costs and decision points), overseen through the Commissioning & Workforce Workspace and SEND & AP Partnership Board.<br>• Build capacity through approaches that can be sustained (training/coaching, network support, outreach from mainstream/special/AP partnerships, group and whole-setting interventions), reducing dependency on time-limited posts. | **Amber** |

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| | | | | • Use evaluation and performance evidence (reach, impact and value for money) to inform commissioning decisions and secure ongoing funding, including options for blended funding and continued traded elements where appropriate. | |
| Partners do not align decision-making and resource deployment (education, health and care), causing delays in key dependencies (therapy model, pathways, commissioning decisions) and undermining pace and credibility of reform. | **High** | **Medium** | **Red** | • Refresh governance and terms of reference to clarify decision rights and escalation across a revised governance structure.<br>• Establish a Reform Delivery Group to maintain grip on plan delivery and ensure key decisions are escalated to SEND Board with the information needed for the board to take strategic decisions.<br>• Secure representation from senior leads at SEND Board and operational Leads at RDG.<br>• Appoint a SEND Reform Programme Manager to ensure coordination and information flow throughout the system.<br>• Ensure that key decisions are taken jointly by SEND Board and that project work is coproduced, ensuring system wide ownership.<br>• Adhere to the three-year joint commissioning plan. | **Green** |
| Data and evaluation are not strong enough to evidence impact (e.g., on placement patterns, exclusions, attendance, therapy delivery, family confidence), reducing ability to review, prioritise, plan, and revise the Local Area Plan. | **High** | **Medium** | **Amber** | • Extend the data set request within health at pace.<br>• Extend Quality Assurance Group oversight of data governance (definitions, owners, data quality checks) and refresh membership to include expertise from setting and service leads.<br>• Agree a single partnership performance view which is shared across all SEND Workspaces and partnership groups.<br>• Implement benefits/evaluation approach for capital and inclusion base expansion;<br>• Coproduce a survey for parents, carers and young people, to allow lived experience to be considered alongside quantitative metrics; | **Green** |
| Capital developments are not completed to planned timescales, delaying the opening of new Specialist Bases and special school places, reducing local sufficiency and slowing the impact of reform on | **High** | **Medium** | **Amber** | • Maintain a managed pipeline of capital projects through the Capital and Sufficiency Workspace, with clear milestones, dependencies, decision points and escalation routes through RDG and SEND Board.<br>• Use the Specialist Base Gateway process to ensure projects are selected on the basis of inclusive vision, geography/population need and deliverability. | **Amber/Green** |

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| placement patterns, travel and reliance on out-of-city provision. | | | | • Track operational readiness alongside build progress, including workforce recruitment, admissions, thresholds, policies, therapy input and pathway alignment.<br>• Retain a phased sufficiency approach, including targeted mainstream adaptations and trusted independent provision where necessary to manage short-term pressure.<br>• | |
| Difficulties recruiting and retaining the specialist workforce needed for Experts at Hand and expanding Specialist Bases reduce capacity to deliver early support and new local provision, leading to slower implementation, variable quality and continued pressure on specialist placements. | **High** | **High** | **Red** | • Develop a joint recruitment and workforce plan across education, health and care, covering EP, SaLT, OT, specialist teachers and key support staff.<br>• Build on Coventry's existing traded SEND support offer, specialist outreach and workforce strategy, so Experts at Hand grows from established provision rather than relying solely on new posts.<br>• Use a blended delivery model including assistant roles, outreach from specialist settings, coaching, network supervision and group-based support to maximise scarce specialist capacity.<br>• Align recruitment for Experts at Hand, therapy delivery and Specialist Bases through the Commissioning and Workforce Workspace, with phased implementation and oversight of quality, reach and impact. | **Amber** |
| Earlier identification of need and improved access to advice and support drive an increase in requests for EHC needs assessments and EHCPs, creating additional pressure on statutory capacity, specialist provision and financial sustainability if growth outstrips available resource. | **High** | **High** | **Red** | • Strengthen ordinarily available provision, Experts at Hand and clear thresholds/pathways so more needs are met earlier and only children requiring statutory support progress to EHC assessment.<br>• Use the SEND outcomes group, shared data set and demand modelling to track growth in requests, understand drivers and take early action where demand is rising faster than capacity.<br>• Continue to expand statutory assessment and review capacity, including specialist plan coordinator roles, so the local authority can respond to increased volume while maintaining timeliness and quality.<br>• Align sufficiency, workforce and commissioning decisions through the governance spine so resource follows emerging need and pressure does not simply transfer into later crisis, dispute or expensive placements. | **Amber** |

| | | | | | |
|---|---|---|---|---|---|
| School capacity is insufficient to engage fully with Experts at Hand, including releasing staff and prioritising time for training, supervision and follow-up work, reducing reach and consistency of the offer and weakening impact on inclusive practice. | **High** | **Medium** | **Amber** | • Design Experts at Hand as a flexible delivery model, using a mix of system-wide support, networks, group supervision, whole-school work and targeted support so schools can engage in different ways without diluting the offer.<br>• Use the local authority front door and clear priorities to target support where it will have the greatest impact, ensuring equitable deployment and avoiding duplication with existing outreach and training offers.<br>• Align Experts at Hand with existing SEND networks, workforce development and school improvement activity, so participation feels coherent and manageable rather than additional to other asks on settings.<br>• Maintain clear expectations and oversight through partnership governance, using feedback, reach data and engagement information to identify where schools are not able to participate fully and agree practical solutions. | **Amber/Green** |

## Dependencies

### *Family Co-production & Communications & Take-up, Trust and Reduced Dispute*

The local area has prioritised co-production, particularly with families and young people, as a core component of the SEND Reform Programme. However, the programme arrives at a time when family confidence in the system is under pressure. System leaders will need to engage openly and sensitively with families at all levels, maintain clear feedback loops (“we said / we did”), and respond consistently to concerns to rebuild trust and ensure reforms have the intended impact.

### *Workforce Supply & Expansion of Inclusion Bases*

The Local Area has expanded the number of places available within inclusion bases. Recruitment to these roles has drawn, in part, from special schools, creating a risk of reduced capacity in the specialist sector. Delivery of further expansion therefore depends on a coordinated workforce approach that grows overall capacity (rather than shifting it), including joint recruitment/retention actions, targeted training and clear pathways into specialist roles for teachers and teaching assistants.

### *Clinical Commissioning Model & Experts at Hand Delivery*

Recruitment for the Experts at Hand programme, statutory advice for EHC needs assessments, and delivery of EHCP Section F will draw on the same limited pool of professionals. A coordinated, joint commissioning approach is therefore needed to ensure specialist capacity is deployed in line with local SEND priorities.

### *ICB Reorganisation & Strategic Commissioning Capacity & Continuity*

The ICB is undergoing restructuring as part of a national review of ICB arrangements, which will overlap with the early phase of this SEND Reform Programme. Delivery of reforms (including therapy pathways and the Experts at Hand offer) depends on maintaining strategic commissioning, contract management and transformation capacity, with clear decision-making routes and continuity of key roles. The ICB has strengthened its commissioning function in relation to SEND, with Board Executive for SEND, senior CYP commissioners and additional SEND leads.

### *Capital Delivery Milestones & Operational Readiness*

A significant strand of the SEND Reform Programme relies on the timely delivery of capital projects to increase places within inclusion bases and special schools within the city. Delays to the capital programme would have a knock-on impact on overall programme delivery. In addition, opening new provision depends on operational readiness (workforce recruitment, admissions and thresholds, timetables, policies, and alignment to pathways and the therapy delivery model). The

sufficiency workspace within the revised governance structure will maintain grip on both capital milestones and readiness actions, with risks escalated through the RDG/SEND Board.

### *Family First Partnerships Programme and Integrated Neighbourhood Health Teams & Best Start in Life*

Delivery of the Family First Partnerships Programme and the roll out of integrated neighbourhood health teams, will run alongside SEND reforms and, together, will change how families experience services within the city. These programmes need to align so families experience one joined-up system, including consistent front-door arrangements (referral routes and thresholds), clear lead professional/keyworker roles, joined-up communications, and effective information sharing across partners. A SEND Engagement Lead has been appointed to work across both programmes, ensuring alignment of approach and messaging. Early Years elements of the SEND Reform programme also need to align with the local area's strategy for Best Start in life. The ICB leads on the commissioning of Neighbourhood Health and is committed to developing neighbourhood health model for CYP. This will enhance early intervention and prevention as well as coordination between our schools and primary care.

# Section 3 | Monitoring and Evaluation

## How will the local area partnership know delivery is on track?

Coventry's monitoring and evaluation approach builds on established performance management within the Council and partner organisations, and will be strengthened through the SEND Reform Programme to provide a single, shared view of progress, impact and lived experience. At present, core SEND performance metrics are gathered and managed within individual organisations. SEND performance is overseen through the Council's monthly performance board (chaired through the corporate performance framework and overseen by the Director of Children's Services), with parallel performance and quality processes operating within providers and the ICB. Alongside this, a cross-agency Quality Assurance (QA) group operates a shared QA framework with a focus on customer experience, the quality of EHC Plans and key service performance indicators; this is reported into the SEND & AP Partnership Board. The Council also maintains a SEND performance dashboard, which is shared with the SEND and AP Partnership Board.

By 2027 we will move to a more integrated local area approach. Work is already underway to create a shared local area dashboard by bringing together health performance data with Council data, so we can track demand, delivery, quality and outcomes across education, health and care in one place. This shared dashboard will align to the success measures set out in this plan, including leading indicators (such as the reach of the Experts at Hand offer, growth in EHC needs assessment requests, reduced timetables/EOTAS volume and duration, and therapy delivery measures) and outcome indicators (including attendance, suspensions/exclusions, placement patterns and stability, and confidence/experience measures). We will agree clear definitions, data owners and data quality checks so that reporting is trusted and timely, and so that partners can use the same evidence base for prioritisation and resource decisions.

We will strengthen how lived experience is gathered and used alongside quantitative performance. Working with the Parent Carer Forum (PCF) and with CYP, we will co-produce and implement a small set of standardised surveys and feedback tools to gather consistent qualitative information about experience, confidence, and whether support is helping CYP to achieve and belong. This will enable a clearer "line of sight" between what families and CYP are telling us, the actions we take, and what changes as a result (including a routine "we said / we did" feedback loop). The revised QA approach will focus more on integrating qualitative and quantitative data and moving from describing what is happening to understanding why it is happening, including identifying variation by cohort, locality and setting and testing what actions make the biggest difference.

Work will be coordinated through a strengthened Quality Assurance, Data and Digital Workspace, which will link directly with the PCF and with the young people's forum and will oversee the shared QA framework, data governance and evaluation activity. The reporting structure will align to the metrics and milestones set out in the Reform Plan: the Workspace will provide routine insight and any agreed deep-dives; this will be summarised and escalated through the Reform Delivery Group (RDG) to maintain grip on delivery and to agree corrective actions where milestones slip or indicators deteriorate; and the SEND & AP Partnership Board will use this information for strategic evaluation, decision-making and course-correction (including prioritisation, commissioning intent and changes to approach). This ensures that monitoring and evaluation are not separate activities, but an embedded improvement cycle that supports pace, accountability and sustained impact across the partnership.

# Section 4 | Governance

## How will the local area partnership ensure delivery of plans remains on track?

| Governance Mechanism | Purpose/ Responsibilities | Membership | Cadence | Decision Rights | Escalation Route |
|---|---|---|---|---|---|
| **SEND and AP Partnership Board** | Strategic oversight of SEND & AP; approves priorities and tracks delivery against outcomes, finance and risk. | Chaired by LA DCS/DfE SRO. Membership: LA SEND lead/SRO, education leaders (mainstream, special, AP), ICB SEND/commissioning lead, provider trusts (therapies), social care lead, finance lead, PCF rep, CYP participation rep. | Half-termly | Agree priorities, resource alignment, commissioning intent, key pathways/standards; sign-off escalation actions; hold partners to account. | Health and Wellbeing Board |
| **Reform Delivery Group** | Tactical delivery grip: integrates workstreams, manages dependencies/risks, monitors milestones and unblocks issues. | Chaired by SEND Reform Programme Manager / LA SEND lead. Membership: workstream/workspace leads, ICB commissioning/therapy lead, education reps, social care, data/QA lead, finance link, PCF rep, CYP rep. | Half-termly | Operational decisions within agreed plan; recommend decisions to Board; agree corrective actions, issue escalation, and resource deployment within delegated limits. | SEND and AP Partnership Board |
| **Quality Assurance, Data and Digital Workspace** | Assurance and intelligence: QA framework, data governance, dashboard/reporting, evaluation and learning; tracks impact and variation. | Chaired by QA/Data lead. Membership: LA performance/data, ICB analytics, service leads (SEND, therapies), school reps, AP rep, social care, PCF rep, CYP rep. | Half-termly | Agree QA tools/standards, data definitions and reporting cadence; commission deep-dives; recommend improvement actions and escalations. | SEND and AP Partnership Board |
| **Commissioning and Workforce Workspace** | Joint commissioning and workforce: therapy model, Experts at Hand resourcing, workforce plan, training/CPD and service standards. | Chaired by LA/ICB commissioning lead. Membership: ICB commissioning, therapy provider leads, LA SEND lead, workforce lead/HR, EP/SaLT/OT leads, school reps (SENCO/special), AP rep, PCF rep. | Half-termly | Design recommendations on commissioning/workforce; agree draft pathways and service specs for Board approval; track delivery of agreed actions. | SEND and AP Partnership Board |
| **Capital and Sufficiency Workspace** | Sufficiency and capital: demand modelling, place planning, capital programme delivery, readiness, and impact on placement patterns. | Chaired by sufficiency/capital lead (role). Membership: LA sufficiency/capital, finance, school place planning, special/AP reps, ICB rep (for therapy/readiness links), commissioning link, transport (as needed), PCF rep. | Half-termly | Recommend sufficiency options and capital priorities; agree delivery plans/readiness actions; escalate risks (cost, delay, capacity). | SEND and AP Partnership Board |

## Section 5 | Central Government Support

To maximise the impact of Coventry's SEND Reform Programme, we would welcome targeted central government support in the following areas:

- Support to broker and accelerate system-wide solutions for SaLT/OT and diagnostic capacity, aligned to our Experts at Hand model and to reliable delivery of therapy specified in EHCP Section F, so families experience timely access and consistent provision.
- Workforce support for scarce specialist roles (EP/SaLT/OT and specialist teachers), including regional pipeline and recruitment support, and early clarity on sustainability options beyond the three-year grant so we can transition Experts at Hand into business-as-usual as an evolution of our strong traded specialist SEND services, networks and school partnerships.
- Practical guidance and templates to evidence the impact of high needs capital on inclusion and value for money (e.g., placement patterns, travel/transport dependency, and reduced reliance on out-of-city placements), and support to remove barriers that could slow delivery and mobilisation of inclusion base and mainstream adaptation programmes.
- DfE-facilitated sessions with education leaders and PCF leaders to accelerate a shared definition of inclusion, shared expectations for ordinarily available provision, and mutual accountability—building on Coventry's strong education partnerships and SEND networks and supporting improvements in attendance, exclusions and reduced timetables/EOTAS.
- Tools and benchmarking packs to strengthen our evaluation and diagnostic use of data (combining lived experience and quantitative measures), including outcome measures for Experts at Hand, inclusion bases and AP pathways, enabling faster course-correction and clearer evidence of impact.

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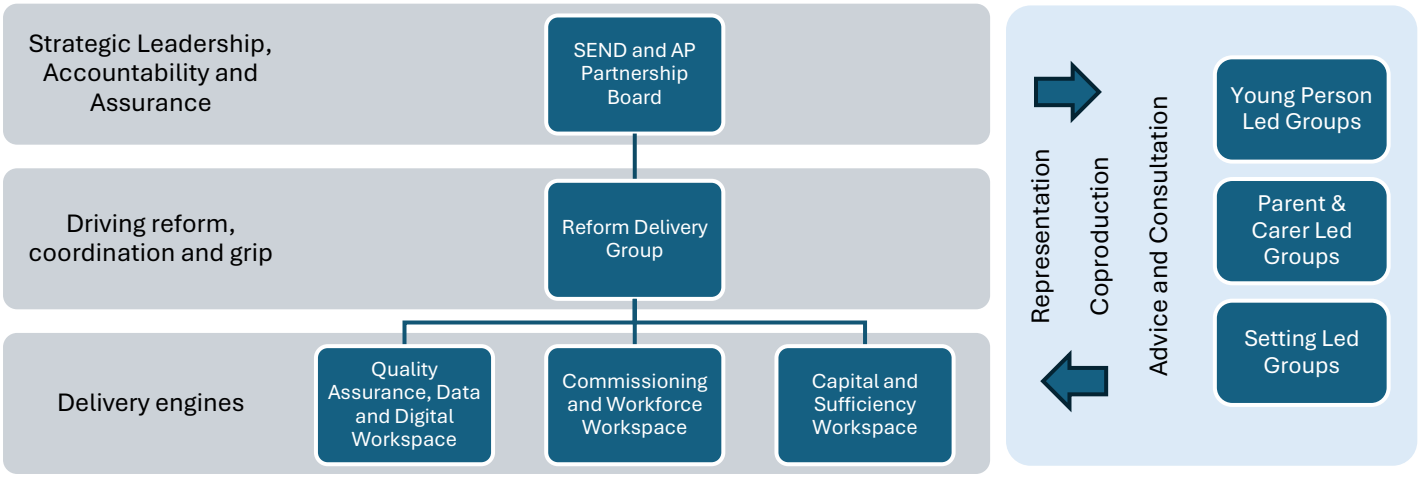
# Coventry SEND and AP
# System Governance and Reform Delivery

May 2026 | Final

# System Overview

Coventry has established strong SEND governance arrangements over time, with clear strategic leadership, partnership working and delivery structures. As the local area enters a new phase of national SEND reform, we have taken the opportunity to refresh and realign our governance model to ensure it remains coherent and resilient and well positioned to drive forward local SEND Reform.

The refreshed model builds on existing good practice, by introducing a new 'tactical' layer, the Reform Delivery Group (RDG) to ensure a strong grip on the local reform plan and through realignment of the three SEND workspaces.




Together, the three layers form a coherent system:

- The Board sets direction and holds accountability
- RDG provides delivery grip, coordination and assurance
- Reform Workspaces deliver agreed reform activity at pace

## How the governance structure works together

### SEND & AP Partnership Board – strategic leadership and accountability

The SEND & AP Partnership Board provides the strategic leadership, system accountability and assurance for SEND and Alternative Provision across the local area. The Board:

- sets strategic direction and priorities
- approves and oversees the SEND & AP Strategy and Local SEND Reform Plan
- holds collective accountability for statutory compliance, outcomes, sufficiency and sustainability
- retains final decision-making- authority for nondelegable matters and -system level- risk

The Board operates deliberately at strategic level, providing challenge and assurance rather than undertaking operational delivery.

### SEND Reform Delivery Group (RDG) – delivery grip and coordination

Operational delivery of the SEND Reform Programme is formally delegated by the Board to the SEND Reform Delivery Group (RDG). RDG is:

- *"the single place where SEND reform is driven and kept on track"*
- responsible for translating Board intent into coordinated delivery
- accountable for managing pace, dependencies and emerging risk
- expected to resolve delivery issues wherever possible before escalation
- links priorities in reform plan to work ongoing elsewhere in the wider system

RDG operates as a trusted executive delivery group, not a strategic governance body, and escalates to the Board only where issues are strategic, systemic or carry significant risk.

### Reform Workspaces – where delivery happens

Beneath RDG sit three standing SEND Reform Workspaces, established as the primary delivery engines of the Reform Plan:

- Quality Assurance, Data and Digital
- Commissioning and Workforce
- Capital and Sufficiency

Each Workspace has a clear brief defining its focus and contribution to reform delivery. Workspaces are:

- Accountable for delivery within delegated scope
- May agree and implement approaches, reprioritise activity and reach agreement between partners
- However, any decisions introducing significant statutory, financial, sufficiency, reputational or delivery risk are escalated to RDG

Each Workspace is chaired by a senior operational leader and supported by a named RDG Senior Sponsor, ensuring alignment, challenge and a clear escalation route.

## How school-led and parent-led groups fit into the system

### School-led groups – operational insight and implementation intelligence

School-led groups (including SENCo networks, mainstream and specialist partnerships) play a critical role in informing and shaping reform, particularly around feasibility, implementation- and impact in practice.

Within the refreshed model:

- School-led- groups are not governance bodies
- They do not hold decision--making authority for the overall SEND Reform Programme
- They provide operational insight, challenge and co-design input

Reform Workspaces and RDG may engage these groups flexibly and purposefully to support delivery, testing and implementation, without creating parallel governance or diluting accountability.

Head Teacher representatives from mainstream and special school groups are permanent members of the SEND and AP Board, contributing to the strategic governance of our local SEND system.

## Parent-led and lived experience groups – influence without dilution

Co-production and lived experience remain central to Coventry's SEND system.

The Parent Carer Forum (PCF):

- is formally represented at SEND & AP Partnership Board level
- contributes to strategic discussion, challenge and assurance

At delivery level:

- Reform Workspaces may engage directly with parent-led or lived- experience- groups where this supports effective delivery
- Engagement is structured but flexible, avoiding standing governance roles within Workspaces

This ensures that lived experience influences decisions and priorities, but keeps input parent and carer led and avoids overburdening Coventry's developing PCF with administrative demands.

# Coventry SEND & AP Partnership Board

Terms of Reference

## Purpose

The Coventry SEND & AP Partnership Board ("the Board") provides strategic leadership, system accountability and assurance for SEND and Alternative Provision across the local area.

The Board exists to:

- Set strategic direction and priorities for SEND and AP
- Approve and oversee delivery of the SEND & AP Strategy and Local SEND Reform Plan
- Provide challenge, assurance and system leadership across education, health and care partners
- Hold the partnership collectively to account for impact, outcomes and sustainability
- Ensure that coproduction with children, young people and families meaningfully informs strategic decision-making

The Board operates at strategic level and does not undertake operational delivery.

## Decision making authority

The Board is the top tier decision-making body for SEND and AP within the local area partnership.

The Board retains and exercises final decision-making authority for:

- Approval and review of the SEND & AP Strategy
- Sign-off of the Local SEND Reform Plan
- Agreement of systemwide priorities, trade-offs and strategic focus
- Acceptance of system level risk
- Escalation to the Health and Wellbeing Board, political leadership or national bodies where required

These decisions are not delegable.

## Delegation and delivery

Operational delivery of the SEND Reform Programme is delegated by the Board to the SEND Reform Delivery Group (RDG).

The Board:

- Sets outcomes, expectations and strategic direction
- Receives assurance on delivery, risk and impact

- Does **not** prescribe how delivery is undertaken

The RDG is responsible for managing delivery activity and holding delivery risk within parameters set by the Board.

## Risk, assurance and escalation

### Mandatory escalation to the Board

The Board requires escalation where there is risk relating to:

- Statutory compliance
- Significant financial risk
- Sufficiency (including places, workforce, provision and services)
- Partnership failure risk

### Board response to escalated risk

Where such risks are escalated, the Board may:

- Direct the Reform Delivery Group by setting required outcomes and expectations
- Escalate within member organisations through their internal governance routes (e.g. Local Authority, ICB, NHS providers)
- Hold partners to account for delivery failure or non-alignment, proportionately and explicitly

## Scope and boundaries

To maintain strategic focus and governance discipline:

The Board:

- Does not consider individual cases
- Does not engage in direct operational problem solving

Operational matters sit with the Reform Delivery Group and delivery structures beneath it.

## Assurance, reporting and information flow

The Board receives a small, consistent assurance pack, providing a system-wide view of progress, risk and impact.

This will include:

- Progress against Reform Plan milestones (reported by the Reform Delivery Group)
- Risks identified through the three Reform Workspaces:
    - Quality Assurance, Data and Digital
    - Commissioning and Workforce

    - Capital and Sufficiency
- Quality Assurance reports
- Other exceptional issues requiring Board attention
- Concerns escalated by individual partner organisations

The Board will also receive direct input through standing agenda space from:

- Children, Young People and Family-Led groups (including the Parent Carer Forum)
- Setting-led (school-led) groups

This ensures triangulation between data, professional insight and lived experience.

## Challenge and accountability

The Board provides constructive but robust challenge across the partnership.

- Challenge will be explicit and visible
- Follow-up will be proportionate, with significant issues resulting in agreed actions
- Board members are expected to escalate issues internally within their own organisations where required to support system delivery

## Co-production at Board level

At Board level, co-production means:

- Assuring that meaningful co-production is embedded across the SEND system
- Using lived experience and setting insight to inform strategic decision-making
- Jointly shaping priorities and strategic focus with CYPF input

The Board does **not** act as a service co-design or delivery forum.

## Governance position

The SEND & AP Partnership Board reports to the **Coventry Health and Wellbeing Board** and provides system level assurance on SEND and AP.

## Membership and attendance

Membership comprises senior leaders across education, health and care. Members attend as system leaders, representing their organisations within the partnership context.

## Review

These Terms of Reference will be reviewed annually, or sooner if required. These terms of reference were last reviewed by the Board in May 2026.

# SEND Reform Delivery Group (RDG)

Terms of Reference

## Purpose

The SEND Reform Delivery Group (RDG) is the single place where SEND reform is driven and kept on track. The purpose of the RDG is to:

- Drive coherent delivery of the Local SEND Reform Plan
- Translate Board intent into practical, coordinated action
- Maintain grip on delivery, pace and dependencies
- Resolve delivery issues wherever possible without escalation
- Provide the Board with confidence judgements, options and recommendations
- Links priorities in the SEND Reform Plan with ongoing work in the wider system and delegates priorities to reform workspaces where needed.

The RDG operates as a trusted executive delivery group, not a strategic governance body.

## Role within the governance model

The RDG operates under delegated authority from the SEND & AP Partnership Board. The RDG does **not** hold strategic decision making- authority reserved to the Board.

## Decision making authority

Within Board agreed- direction, the RDG may:

- Prioritise activity within the agreed Reform Plan
- Sequence and re-sequence work to manage dependencies
- Resolve conflicts or duplication between Reform Workspaces
- Agree mitigations and adjustments to address delivery slippage
- Propose Task & Finish Groups where focused action is required

### Task & Finish Groups

- Task & Finish Groups may be proposed by the RDG
- Board ratification is required before any Task & Finish Group begins work
- Once established, Task & Finish Groups are accountable to the RDG and disband upon task completion.

## Relationship with Reform Workspaces

The RDG provides delivery coordination and grip across the three Reform Workspaces:

- Quality Assurance, Data and Digital
- Commissioning and Workforce

- Capital and Sufficiency

In relation to the Workspaces, the RDG will:

- Set priorities and focus areas
- Resolve overlap, conflict or duplication
- Re-sequence or pause activity to manage dependencies

The RDG does **not** performance manage- individual workspaces or teams.

## Managing delivery risk and escalation

### Delivery risk at RDG level

The RDG is responsible for:

- Actively identifying and tracking delivery risks
- Maintaining visibility of slippage and pressure points
- Taking action to resolve issues within delegated authority

The RDG does **not** formally accept or hold system risk on behalf of the Board.

### Escalation to the Board

The RDG will escalate to the Board where:

- Delivery confidence drops, even if formal risk categories are not yet triggered
- Issues require decisions outside the agreed Reform Plan
- Judgement indicates Board intervention or direction is required

Escalation is expected to be proportionate and judgement-based, not rules-driven.

## Reporting and assurance

The RDG provides assurance to the Board through:

- Clear reporting on progress against Reform Plan milestones
- Visibility of risks and delivery confidence
- Identification of issues requiring strategic decision or direction

The RDG brings options, confidence judgements and recommendations.

## Membership

RDG members are:

- Senior leaders within their organisations
- Close enough to delivery to understand how change must be implemented

- Able to unblock issues, manage dependencies and drive progress.

## Review

These Terms of Reference will be reviewed annually, or sooner if required. These terms of reference were last reviewed by the Board in May 2026.

# SEND Reform Workspaces

Terms of Reference

## Purpose

The SEND Reform Workspaces are the delivery engines for the Local SEND Reform Plan. They exist to turn reform priorities into coordinated, practical action across education, health and care, within a clear governance and accountability framework.

Each Workspace is accountable for delivering its defined area of the Reform Plan within delegated authority, contributing to system improvement, pace and coherence.

## Role within the Governance Model

The Reform Workspaces operate as part of the SEND reform governance structure:

- Strategic leadership, statutory accountability and system risk sit with the SEND & AP Partnership Board
- Overall delivery coordination, assurance and escalation sit with the SEND Reform Delivery Group (RDG)
- Reform Workspaces are responsible for operational delivery of agreed reform activity within their remit

Each Reform Workspace reports directly to the SEND Reform Delivery Group and is supported by a named RDG Senior Sponsor

## Authority and Decision Making

Within their agreed scope, Workspaces may:

- agree and implement changes to how reform activity is delivered
- re-prioritise or sequence activity to manage delivery risk and capacity
- reach agreement between partners on actions, contributions and approaches

Workspaces must escalate to RDG where proposed decisions introduce significant risk.

Reform Workspaces are accountable for delivery within their delegated scope.

Overall assurance, escalation and accountability for the Reform Programme sit with the SEND Reform Delivery Group, reporting to the SEND & AP Partnership Board.

## Membership and Chairing

Membership of each Reform Workspace will comprise senior operational leaders from relevant partner organisations who are:

- close enough to delivery to understand operational realities and constraints
- senior enough to represent their organisation and unblock issues internally

Each Workspace will have a named Chair and an RDG Senior Sponsor, providing alignment, challenge and escalation support. Membership may be flexed to include additional contributors where this supports delivery.

## Cadence and Ways of Working

- Reform Workspaces meet monthly
- Extraordinary meetings may be convened where delivery needs require
- Meetings will be focused on delivery, progress and risk, not general discussion

Reform Workspaces are not general engagement or stakeholder forums.

## Core Outputs and Expectations

Each Reform Workspace provides:

- a clear delivery plan for its area of the Reform Plan
- routine progress updates to RDG
- active identification and management of delivery risk

The emphasis is on grip and pace, not reporting volume.

# SEND Reform Workspaces

Workspace Briefs

## Reform Workspace: Quality Assurance, Data and Digital

### Purpose

The Quality Assurance, Data and Digital Reform Workspace exists to strengthen system assurance and intelligence across SEND and AP, ensuring that reform delivery and decision-making are informed by robust quality assurance, reliable data and effective digital processes.

### Scope and focus

Within its delegated scope, the Workspace will:

- Lead the development and use of a coherent SEND quality assurance framework, aligned to statutory duties, inspection frameworks and the local SEND Self-Evaluation Framework (SEF)
- Use data, performance intelligence and lived experience insight to identify strengths, weaknesses, emerging risk and the impact of reform activity
- Oversee the development and effective use of SEND data and dashboards to support shared, outcome-focused decision-making
- Drive improvements to digital systems and processes that support timely, lawful and efficient SEND practice and improved experiences for children and young people

### Key outputs

The Workspace will provide quality assurance insight, data-led intelligence and practical improvements to data, assurance and digital ways of working.

## Reform Workspace: Workforce & Commissioning

### Purpose

The Commissioning and Workforce Reform Workspace exists to strengthen system capacity and capability to meet the needs of children and young people with SEND, through improved commissioning and workforce development.

### Scope and focus

Within its delegated scope, the Workspace will:

- Support implementation of national and local reform approaches, including design and implementation of the Experts at Hand model.
- Address workforce capacity and capability challenges aligned to the Local Area SEND Workforce Development Strategy
- Identify and manage market, provider and workforce risks affecting delivery and sufficiency

- Lead SEND commissioning activity, including joint and aligned commissioning across education and health
- Oversee the commissioning and development of Alternative Provision that supports inclusion and positive outcomes

### Key outputs

The Workspace will provide commissioning and workforce activity aligned to Reform Plan priorities, with clear insight into market, Alternative Provision and workforce risk.

## Reform Workspace: Capital and Sufficiency

### Purpose

The Capital and Sufficiency Reform Workspace exists to ensure a sustainable, planned approach to meeting current and future demand for SEND and Alternative Provision.

### Scope and focus

Within its delegated scope, the Workspace will:

- Lead SEND and AP sufficiency planning to ensure the right provision is available in the right places
- Oversee capital planning and investment aligned to inclusion priorities and national reform expectations
- Support the local roll-out of inclusion bases as a key mechanism for strengthening mainstream inclusion
- Use data and forecasting to inform planning and identify emerging capacity pressures
- Identify and manage sufficiency and capital risks impacting sustainability and delivery

### Key outputs

The Workspace will provide clear sufficiency and capital activity aligned to Reform Plan priorities, with insight into emerging capacity and place-related risks.

Coventry City Council

# Report

**To: Coventry Health and Wellbeing Board** **Date: 8 July 2026**

**From: Pete Fahy – Director of Adult Care, Health and Housing**

**Title: Better Care Fund – 2025/26 review and 2026/27 planning approval**

## 1 Purpose

The purpose of this report is to:

a) Provide a review of the 2025/26 Better Care Fund programme including what has been achieved

b) Seek approval for the 2026/27 Better Care Fund programme submission to NHSE

## 2 Recommendations

Coventry Health and Wellbeing board are recommended to:

a) Note the review comments regarding the 2025/26 Better Care Fund programme

b) Endorse the 2026/27 Better Care Fund programme submission to NHSE

## 3 Information/Background

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

3.2 It is based on the concept of a pooled budget between Integrated Care Boards and Local Authorities with one party agreeing to 'host' the pool which is managed by a s75 legal agreement. The Coventry BCF pool is hosted by Coventry City Council and is overseen by the Coventry Care Collaborative.

3.3 BCF planning periods are established by NHSE which tend to be on one year or two-year cycles.

3.4 As well as submission of Better Care plans to correspond with the planning cycles the local authority, as lead agency is also required to submit quarterly performance returns to NHSE demonstrating progress against the BCF metrics.

3.5 The body with overall local responsibility for the BCF is the Coventry Health and Wellbeing board.

## 4 Review of progress against the 2025/26 BCF plan

4.1 The pooled fund associated with the 2025/26 plan totalled approximately £148m which delivered against 73 separate lines of expenditure across Health and Social Care. Areas of expenditure included social care residential care, learning disability support, dementia, carers, disabled facilities grant and support to enable effective hospital discharge.

4.2 The metrics associated with the plan as set by NHSE were:

- Emergency admissions to hospital for people aged 65+ per 100,000 population
- Average length of discharge delay for all acute adult patients (Derived from a combination of: Proportion of adult patients discharged from acute hospitals on their discharge ready date (DRD); and, for those adult patients not discharged on DRD, average number of days from DRD to discharge)
- Long-term admissions to residential care homes and nursing homes for people aged 65+ per 100,000 population.

4.3 The two BCF Objectives had the following six agreed BCF Plan priorities:

4.4 **BCF Objective 1: reform to support the shift from sickness to prevention**

4.4.1 Priority one: The Community Integrator programme aims to improve support for people in the community by using population health management to identify those most at risk and better coordinate care. It is Coventry's response to the Neighbourhood Health model, focusing on integrating services for people with complex needs.

*Progress builds on the 2024 transfer of adult physical health community services to UHCW, strengthening integration across health and care. The programme aligns with the Government's 10-year plan (July 2025), promoting neighbourhood-based care, reduced reliance on acute services, and the development of Integrated Neighbourhood Teams (INTs).*

*Key developments include:*

- *Launch of the first INT in December 2025 (west Coventry), targeting individuals with complex needs and high service use.*

- *Plans for citywide INT rollout by June 2027.*
- *Improved early intervention through population health management.*
- *Greater integration across primary care, community services, adult social care, and the voluntary sector.*

*Delivery is overseen by the Coventry Care Collaborative, supporting system-wide coordination and effective resource use. Coventry is also part of the national implementation programme, enabling it to shape and test the neighbourhood health model.*

*Additionally, the Coventry Coordination Hub has been introduced as a single point of triage, improving access, reducing duplication, strengthening information sharing, and supporting INTs to deliver coordinated, proactive care.*

4.4.2 Priority Two: Develop our approach to the use of home adaptations and technology and progressing improvements in our home adaptations response as a result of working with Foundations (support organisation to MHCLG)

*Good progress has been made in maximising the use of Disabled Facilities Grant (DFG) funding, with increased emphasis on targeting resources towards those most in need and ensuring timely delivery of adaptations. Activity levels have improved and there is a continued focus on reducing waiting times and improving the end-to-end customer journey.*

*A programme of service transformation and restructure took place to create a more streamlined and integrated home adaptations service. This is strengthening coordination between housing, adult social care and health partners, improving oversight of demand and capacity, and enabling a more efficient and responsive service offer. The service restructure in conjunction with new Housing assistance policy has improved waiting times and streamlined the process.*

*This approach is informed by our work with Foundations (the national body supporting MHCLG), with a focus on simplifying pathways, improving performance, and embedding best practice. Collectively, these changes are supporting a more preventative, person-centred model, ensuring adaptations and technology are considered earlier, reducing escalation of need, and supporting independence, hospital discharge and reduced reliance on long-term care.*

*Further work underway is the development of an enhanced digital offer for equipment and adaptations, supporting more streamlined access and improved customer experience. This includes expanding self-service options where appropriate, enabling individuals, and professionals to request and track equipment online, and improving visibility of available solutions. The digital approach will help to speed up assessment and delivery, reduce unnecessary handoffs, and support more timely provision of low-level equipment. It also supports a more preventative model, enabling people to access straightforward*

*solutions quickly while ensuring that more complex cases receive targeted professional input.*

4.4.3 Priority Three: Improve our support for unpaid carers through remodelling the support provided from the voluntary sector and ensuring we are giving unpaid carers more flexibility over the support services they receive through increasing the proportion of direct payments. This also includes ensuring that services for carers commissioned through the Accelerated Reform Fund are of tangible benefit to unpaid carers.

*Coventry has recommissioned its carers support services following extensive engagement, aligning the new model with the Coventry Carers Action Plan 2024–2026. The redesigned service focuses on what carers say matters most, including flexible breaks, personalised and timely support, and better access to information, advice and guidance.*

*Launched in October 2026 and delivered by Carers Trust Heart of England, the service works with partners to provide coordinated, preventative support. It continues to promote carers direct payments, alongside support funded through the Accelerated Reform Fund.*

*My Time Project (since April 2025) offers one-off breaks such as hotel stays and day trips, matched to carers' preferences through donated opportunities. By April 2026, 213 carers had benefited, reporting improved wellbeing, reduced isolation, and feeling valued. Over 40 businesses have contributed.*

*Bridgit Online Support Tool (since December 2024) provides AI-driven information and over 90 support modules. Between December 2024 and April 2025, 6,591 users created 9,471 self-help plans, most commonly accessing information on Carer's Allowance, caring responsibilities, and assessments.*

*UHCW Carer Support has been strengthened through an additional hospital liaison worker funded by the Accelerated Reform Fund. This supports carers in hospital pathways and improves identification through a Carer Card, offering benefits such as extended visiting hours and access to support. Engagement activities include ward presence and drop-in sessions, with positive feedback from the hospital.*

4.5 **BCF Objective 2: reform to support people living independently and the shift from hospital to home**

4.5.1 Priority One: The work completed under the previous BCF plan through the Improving Lives programme has had a demonstrable impact on preventing avoidable hospital admissions. This work will be built on and further embedded over this BCF plan.

*The Improving Lives programme and development of the OCIT model has continued to demonstrate positive impact in reducing avoidable hospital admissions, with key interventions now more systematically embedded across health and care pathways. Over the course of this BCF period, there has been*

*a sustained focus on early intervention, multidisciplinary working, and proactive care planning for individuals at higher risk of hospital admission.*

*Expansion and improved coordination of community services have enabled more people to be supported safely at home, reducing reliance on acute care settings. Alignment with discharge processes has ensured that individuals leaving hospital receive appropriate ongoing support, and reinforcing prevention.*

**4.5.2** Priority Two: Integrating P3 and Fast Track approaches with other D2A discharge capacity to ensure people are supported in the most appropriate manner and to achieve more timely and effective discharge from acute and community, including end of life care.

*Coventry continues to develop an integrated Discharge to Assess (D2A) model, ensuring Pathway 3 (P3) and Fast Track Continuing Healthcare (CHC) are aligned with wider system capacity to enable timely, person-centred discharge from acute and community settings.*

*We have dedicated staffing aligned to P3 beds to provide a consistent and timely response. We continue to collaborate with system partners to support timely discharges and ensure people are supported via the right pathway and support is available and timely once discharged.*

*System pressures continue to exist with regards to therapy support to ensure people's independence is maximised at every opportunity and closer working with UHCW colleagues, ICB and OCIT continues to support discharge flow.*

**4.5.3** Priority Three: Reviewing our commissioning capacity to ensure this is appropriately sized and resourced to support demand. Our Improving Lives programme has evidentially reduced the numbers of people requiring ongoing residential care following discharge from hospital so ensuring the changes are embedded and the benefits maximised will form a key part of this plan.

*The* Improving Lives Programme *has delivered demonstrable impact across Coventry, with evidence showing a sustained shift in discharge outcomes. There has been an increase in the number of people returning home with short-term home support services, rather than entering short-term residential provision. This reflects a continued move towards strengths-based practice, increased utilisation of community-based support, and a stronger focus on recovery, independence, and prevention.*

*Commissioning capacity has been actively reviewed and adjusted to support this shift, ensuring sufficient provision within domiciliary care and community services to meet changing demand. For 2026/27 further work has commenced to explore alternative options to short term home support service as a discharge alternative to support people to return home.*

*The number of people requiring ongoing residential care has remained consistent with the previous year, indicating further work is required to fully realise the preventative ambition of the programme. This will be further*

*supported by the continued development of Integrated Neighbourhood Teams, which will play a key role in strengthening early intervention and preventative support, enabling more people to remain independent at home. Alongside this, maintaining a strong focus on timely hospital discharge and effective reablement will be critical.*

4.6 **In respect of delivery against the metrics the position at end of 2025/26 was as follows:**

4.6.1 Rate of emergency admissions to hospital for people aged 65+ per 100,000 population – **Target met**

| **Emergency Admissions** (rate per 100k) | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|
| Target | 2,124 | 1,997 | 2,142 | 2,171 |
| Performance | 2,054 | 1,918 | 2,060 | 2,028 |

Factors contributing to the achievement of this target include the work developing the OCIT model along with the development of the care co-ordination Hub, alongside ongoing work with West Midlands Ambulance Service (WMAS) on 'Call Before Convey' to avoid conveyances and hospitalisations.

4.6.2 Average length of discharge delay for all acute adult patients – **Target met**

| **Length of discharge delay** (av. days) | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|
| Target | 1.13 | 1.10 | 1.10 | 1.10 |
| Performance | 0.75 | 0.81 | 0.86 | 0.87 |

As with target one the work associated with the OCIT model and WMAS has also contributed to this target being met. Interfaces between UHCW and OCIT has also supported improved discharge flow.

4.6.3 Long term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100k population (65+) – **Target not met**

| **Length of discharge delay** (av. days) | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|
| Target | 76 | 76 | 76 | 75 |
| Performance | 63 | 106 | 75 | 94 |

Annual count of admissions for 65 + cohort was 338 against a target of 303. Although the target wasn't met this year, we are predicting a lower number of residential admissions in 26/27. Work is ongoing to increase the number of people being discharged from hospital to home, rather than bedded facilities. In the community we are making best use of technology to support people to remain at home where possible. We also have a strong Housing with Care market to reduce the need for some residential placements. Our integrated work in developing integrated neighbourhood teams will also support the preventative agenda to support more people to remain at home.

## 5 Summary of the 2026/27 BCF plan

5.1 The Better Care Fund Plan for 2026/27 required submission to NHSE by Tuesday 19 May 2026. As there was not an available HWBB meeting to correspond with this timescale, this update on the 2026/27 plan is retrospective. As the NHSE timescales for completion of the 2026/27 plan were compressed, retrospective reporting is not unusual for this planning round.

5.2 Once submitted the BCF plan goes through a regional assurance process before confirmation of approval is received. As at 26 June 2025 no communication had been received from the regional BCF team to confirm approval or otherwise. As it is a 12-month plan for which three months have now elapsed we are continuing on the assumption that the plan has been approved.

5.3 The length of the narrative plan return has been reduced significantly for 2026/27 reflecting LA and ICB feedback on the benefits of a more focused BCF assurance process. The narrative plan is appended to this report and below are some key points to note in relation to changes to the BCF for 2026/27.

5.4 Although BCF plans cover distinct periods of time much of the work does not sit neatly within a 12- or 24-month cycle so there is a large degree of continuity between plans. Our progress as a set of Health and Care partners does progress and as such the key changes since the 2025/26 plan are:

5.5 A review of some health and social care funded programmes was conducted to ensure the funding responsibility aligned with organisational responsibilities and intended outcomes.

5.6 For 2026/27 the total value of the BCF fund is approximately £157M which is deployed to deliver 51 separate lines of activity and services. Although this is a significant sum of money it is all allocated against existing service spend. Details of the £9.6M increase in BCF funding total are set out below but the increase does not represent new spending power.

- The minimum NHS contribution for Coventry has increased by £1M (2.89%). Of this the minimum contribution which has to go to ASC has increased by £0.5M (4.4%). This is new money, but it is entirely consumed by inflation on services funded via BCF.

- The additional LA contribution has increased by £1.7M. This is mainly due to additional contributions into the BCF Pooled Budget in 2025/26 from the ICB which are one-off in nature, this is offset by a reclassification of some budgets as 'non-BCF' in recognition of the move towards neighbourhood health plans. A further adjustment relates to including the full DFG reserve in the BCF. This is a technical change as advised by NHSE but doesn't change spending plans.

- The additional NHS contribution has increased by £7.2M mainly due to the increase in budget for out of hospital residential nursing care. This is a budget adjustment to better reflect the true expenditure level - it does not represent new spending.

5.7 The 2026/27 plan contains the following priority actions against the 2 overarching BCF objectives:

*Purpose of the BCF: The aim of the BCF is to support ICBs and local authorities in designing and delivering more integrated and preventative care, particularly for people with more complex health and social care needs, helping people stay independent for longer.*

5.8 <u>Objective 1: Reform to support the shift from sickness to prevention</u>

5.8.1 Progress the delivery of Community Integrator Programme and Neighbourhood Health Model

- Scale the Community Integrator Programme to improve system-wide community support to improve system wide effectiveness

- Embed population health management to identify risk early and enable prevention.

- Strengthen alignment with the Neighbourhood Health model through multidisciplinary working.

- Improve outcomes by reducing avoidable admissions, delays, and demand via targeted community interventions.

5.9 <u>Objective 2: reform to support people living independently and the shift from hospital to home</u>

5.9.1 Assistive Technology and digital offer.

- Further develop and implement a strategic approach to assistive technology, focusing on prevention, independence, and timely hospital discharge.

- Increase the uptake and integration of technology-enabled care solutions to support people to remain safely and independently in their own homes.

- All priorities will contribute to reducing inequalities, improving independence, and delivering sustainable demand management across health and care, with a focus on outcomes, co-production, and value for money.

5.10 The BCF metrics will as always form a significant part of the quarterly reporting requirements. The target metrics for 2026/27 have been set using intelligence from both commissioners and providers in the NHS and social care and are aligned with NHS planning submissions. Targets within the BCF are considered locally to be challenging but achievable in the context of currently known factors. The assurance process will provide appropriate challenge as to whether targets are acceptable to NHSE.

5.11 <u>The three metrics are summarised below and set out in detail within the narrative plan:</u>

5.11.1 Emergency hospital admissions for people aged 65+ per 100,000 population:

- The implementation and evolution of OCIT and particularly Integrated Neighbourhood Teams will help to better manage the demand for services from our older population but will require time to fully embed and align to relevant services to optimise performance delivery.

- In addition, partners are mindful of the relatively high population growth rates for 65+ year olds (and even higher for 75+, 85+ etc) and the resulting, absolute increases in frail elderly and complex unplanned care episodes.

- Both ambition and target data reflect this current position in terms of demographic data and service development, and targets will be reviewed and adjusted following completion of the NHS Planning exercise, given the interdependency with BCF planning.

5.12 Average length of discharge delay for all acute adult patients, derived from a combination of: Proportion of adult patients discharged from acute hospitals on their discharge ready date (DRD). For those adult patients not discharged on DRD, average number of days from DRD to discharge:

- The 2026/27 plan for ‘proportion discharged on DRD’ is derived from the NHS acute provider plans and shows an improvement of 0.7% to 82.9%. This represents an approximate 50% bridge of the gap to the peer group

average. The plan presents a delivery challenge that will require service change which will be supported by community developments including the ongoing evolution of the recently initiated (December 2025) Care Co-ordination Hub and related OCIT improvements supporting discharge flows.

- The 2026/27 plan for 'average number days of discharge delay' is based on straight-line forecast from historical averages, with further reductions planned for the following two years. Community workstreams outlined above will also positively impact this metric along with ongoing hospital and collaborative workstreams to reduce discharge delays. As NHS planning guidance and provider mitigations are finalised, targets will be revised to reflect improved positions and changing circumstances.

5.13 Long-term admissions to residential care homes and nursing homes for people aged 65+ per 100,000 population:

- As a result of our Improving Programmes, the number of starts in P2 beds has declined significantly, with the expectation for this trend to continue into 2026/27. This reduction reflects the effectiveness of delivery against the 2025/26 plan, resulting in fewer P2 bed placements. Our target for 2026/27 is to maintain this improved position and further reduce the use of spot beds that support peaks in service demand across UCHW's system.

- Due to increases in demand maintaining this performance at the rate of 340 Long-term admissions to residential will be achieved by building on the success of our short-term reablement approach, increasing P0 discharges, and reducing reliance on spot-purchased reablement beds. Recommissioning our Long-Term Home Support offer and expanding Direct Payments will further support this, while the introduction of neighbourhood teams will enable more people to be supported at home or without formal care.

5.14 Governance and Oversight

5.15 For the 2026/27 BCF plan the Coventry Care Collaborative will be the primary place of oversight for Coventry with reports to the Coventry HWBB to correspond with quarterly submissions to NHSE.

5.16 Changes to the BCF in respect of areas of spend will be kept under review as services develop and demands change.

## 6 Options Considered and Recommended Proposal

6.1 The recommendations are contained at section 2 of this report.

6.2 There are no other options or recommendations related to the content of this report.

**Appendices:**
Appendix 1 - 2026/27 BCF narrative plan

**Report Author(s):**

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Department of Health & Social Care | Ministry of Housing, Communities & Local Government | NHS England

# Better Care Fund 2026-27
# Narrative return

## Introduction and guidance

This return has been designed to enable ICBs and local authorities, working with Health and Wellbeing Boards (HWBs), to submit information which demonstrates how their plans for the Better Care Fund (BCF) meet the national conditions and planning requirements for 2026-27. Completing and submitting the BCF narrative return is a required part of the overall BCF submission process. Planning leads should ensure that all questions within this narrative return are fully addressed.

This year, the length of the narrative return has been reduced. This reflects feedback on the benefits of a more focused BCF assurance process. In completing the return, HWBs, ICBs and local authorities may wish to develop more detailed joint plans for BCF expenditure for their own use and/or draw on other joint plans.

Each question in the return has a suggested length of around a page (around 500 words) and we would generally expect the overall submission to be around 2500 words. These act as a guide to support a more focused assurance process rather than strict limits.

The narrative provided in this return should align with the expenditure plans and the ambitions for the national metrics set out in your BCF excel numerical return.

When completing the narrative return, please use the following documents for guidance and support, these can be found on the BCF Exchange:

- **Planning Principles:** outlines what good practice looks like in relation to each narrative question and aligns with the relevant national conditions.
- **Metrics Handbook:** provides the formal technical specifications for the national metrics within the framework, including the rationale, methodology, required data inputs and worked examples.

**Submission Requirements:**

- Each HWB area must have its own BCF excel numerical return, but a single narrative BCF return covering multiple HWBs may be submitted where this reflects local integrated working arrangements.
- Each HWB area included in a combined narrative return should provide clarity and state any specific details relevant to the separate HWBs within the narrative questions (and more words may be required for this than a single HWB return). Local authorities, ICBs and HWBs for each area should formally sign off the shared narrative return and their individual numerical excel BCF return.

- The deadline for completing this narrative return is **19 May 2026.**
- Please submit this return to both: england.bettercarefundteam@nhs.net and your regional better care manager(s).

## Submission details

| ***Adapt as necessary*** | **HWB area 1** | **HWB area 2** |
|---|---|---|
| **HWB** | **Coventry** | |
| **ICB** | **Coventry, Warwickshire, Herefordshire and Worcestershire** | |
| **ICB** | | |
| **ICB** | | |

1. **Please provide a short statement setting out the rationale for using BCF funding to maximise delivery of integrated and preventative care linked to the relevant areas of neighbourhood health and social care services.**

The Coventry and Warwickshire Integrated Care System (ICS) Five Year Joint Forward Plan places the maintenance of independence at home for local residents at the very centre of our system-wide approach. The aims of the ICB cluster strategy (diagram below) is also supported by the BCF which will also be aligned with the ICB commissioning strategy which is currently in development.


Through highly effective joint working and collaboration, partners from across the Integrated Care Board (ICB), Local Authority (LA), and University Hospitals Coventry and Warwickshire (UCHW) are harnessing the opportunities afforded by the Better Care Fund (BCF) to strengthen integrated and preventative care within neighbourhood health and social care services.

The BCF is pivotal in enabling these organisations to align their priorities, pool resources, and deliver coordinated support that tackles health inequalities, prevents the escalation of need, and improves outcomes for the people of Coventry and Warwickshire. This collaborative approach is particularly vital within our neighbourhoods, where demand for community-based health and social care is rising and the complexity of needs continues to grow. By working together, the ICB, LA, and UCHW can ensure that services are not only responsive to local requirements but also delivered in a way that is both sustainable and effective.

Central to this joint endeavour is the enhancement of multidisciplinary neighbourhood teams, which bring together expertise from social care, community health, primary care, housing, and the voluntary sector. These teams, developed as part of the Community Integrator programme, exemplify the Coventry response to the Neighbourhood Health model. The Community Integrator programme, led by NHS partners and supported by social care, is designed to improve the effectiveness of community services in supporting independence and reducing unnecessary hospital admissions.

Through population health management, partners are now able to identify those most at risk of escalating health needs, allowing for targeted interventions that prevent crisis and promote wellbeing.

The rationale for using BCF funding to maximise delivery is rooted in its focus on prevention, demand management, and improved access to support close to home. Targeted BCF-funded initiatives—such as reablement, community support, and services for carers—are delivered through joint commissioning and operational collaboration. These initiatives directly reduce avoidable hospital admissions, support timely discharge, and prevent premature entry into long-term care through providing support that enables people to regain levels of functioning and supporting unpaid carers effectively. By prioritising cost-effective alternatives to acute and crisis services, partners can promote independence, resilience, and enhanced wellbeing for service users.

Moreover, BCF investment strengthens neighbourhood-level capacity by supporting workforce integration and shared infrastructure across the ICB, LA, and UCHW. This includes joint training programmes, the development and use of shared data and digital tools, aligned care planning, and the co-location of teams. These enablers create a unified and responsive system, able to adapt quickly to changing population needs and local priorities. The close working relationships fostered by the BCF ensure that health and social care pathways are seamless, and that service users and carers experience joined-up, high-quality support.

BCF resources are also directed towards core priorities such as reducing delayed discharges, improving hospital flow, supporting people with complex conditions, and raising the overall quality of care. Through collaborative commissioning and delivery, the ICB, LA, and UCHW can manage system pressures more effectively, reducing the need for escalation to acute services and delivering better experiences for those who use our services. Regular pathway reviews, multidisciplinary team discussions, and strengths-based assessments ensure that decisions about long-term care are made appropriately and only when all other options have been explored.

In summary, the BCF is essential for maximising integrated and preventative care because it provides the flexibility, collaboration, and sustainability required to transform neighbourhood services. The joint working and collaboration between the ICB, LA, and UCHW is fundamental to this success, ensuring that health and social care partners can jointly address local needs, reduce inequalities, and support people to live independently for longer. Through targeted, place-based investment, the BCF continues to drive system-wide improvements, strengthen community resilience, and deliver better outcomes for the residents of Coventry and Warwickshire.

**2. Please provide a brief explanation of the rationale for how you have set out goals for the metrics of non-elective admissions (for those 65 years old and over) and delayed discharges. Please also set out how you will monitor and drive progress in preventing avoidable long-term care home admissions and improving outcomes from reablement, including through any locally agreed goals for long term admissions to residential care and nursing homes.**

The objectives for non-elective admissions among those aged 65 and over, as well as targets for reducing delayed discharges, have been established using a blend of local baseline data, population health insights, and system-wide imperatives for enhancing flow across health and social care. These targets are intentionally ambitious yet realistic, considering the demographic challenges associated with an ageing population. The overarching aim is to improve outcomes, minimise avoidable escalation of need, and preserve system resilience while ensuring care remains person-centred and effective.

Targets for delayed discharges have been formulated to optimise patient flow, shorten unnecessary hospital stays, and reduce the risk of deconditioning for older adults. This is achieved by refining discharge processes, expanding capacity within reablement and home-care pathways, and reinforcing collaborative arrangements between hospitals, community services, and social care. The rationale is grounded in “discharge to assess” principles, ensuring that individuals remain in hospital solely for clinical reasons, and aligning system-wide capacity planning to mitigate bottlenecks that can contribute to delays.

Local targets for reducing long-term admissions to residential and nursing care are underpinned by investment in preventative services, strengths-based practice, and community alternatives designed to help people maintain their independence for longer. Routine pathway reviews, multidisciplinary team discussions, and strengths-based assessments ensure that decisions regarding long-term care are appropriate and only taken when all other options have been exhausted. Central to this approach is the enhancement of reablement outcomes, with a focus on expanding capacity, improving responsiveness, and embedding therapy-led models that empower individuals to regain independence following illness or crisis.

Our work through the Improving Lives Programme in Coventry is founded upon the principle of enabling people to live independently at home. With the introduction of a new operating model in June 2024, the focus over the 2026/27 BCF plan period will be on embedding this model fully and enhancing its effectiveness, aligning it with the neighbourhood model approach to ensure consistency and sustained impact.

We anticipate continued success in supporting more people at home and reducing reliance on P2 beds. Over 2026/27, ongoing capacity requirements will be reviewed considering evolving demand, ensuring that services remain responsive and effective.

Coventry has managed and maintained a robust and responsive care market with a significant degree of elasticity.  This means we are in the fortunate position of being able to source and arrange care and support quickly to facilitate hospital discharge and avoid admissions.  We do not experience a market that is unable to respond to demand.  There are however pockets of activity we have identified to explore and determine whether they are operating at the optimum level of effectiveness over this plan, for example the commissioning of P3 and Fast Track services will be assessed to

confirm their integration within the local care system and ensure they complement the overall model of support. The opportunities to increase P0 discharges will also be explored along with the support required to achieve an increase in P0 and therefore reduce demand for pathway discharges that require care and support services.

Coventry Health and Social Care partners participate in the 'Community Integrator' programme, an NHS-led initiative aimed at enhancing the effectiveness of community services in promoting independence and reducing hospital admissions. This ambitious programme, with social care as an integral component, is monitored through clear deliverables and robust oversight.

1. Emergency hospital admissions for people aged 65+ per 100,000 population

The current target may appear unambitious as appears to be a maintenance of the performance output achieved in 2025/26. However, our provider planning has gone beyond using a single year baseline to define seasonality, so a simple adjustment using 25-26 has not been observed. The submitted plan at an annual level does however show an **improvement** on 25-26.

In addition, population growth is not yet fully factored into our calculations however partners are mindful of the relatively high population growth rates for 65+ year olds (and even higher for 75+, 85+ etc) and the resulting, absolute increases in frail elderly and complex unplanned care episodes.

The implementation and evolution of OCIT and particularly Integrated Neighbourhood Teams will help to better manage the demand for services from our older population but will require time to fully embed and align to relevant services to optimise performance delivery.

Both ambition and target data reflect this current position in terms of demographic data and service development, and targets will be reviewed and adjusted following completion of the NHS Planning exercise, given the interdependency with BCF planning.

2. Average length of discharge delay for all acute adult patients

2.1 Proportion of adult patients discharged from acute hospitals on their discharge ready date (DRD)

The 2026/27 plan is derived from the NHS acute provider plans and shows an improvement of 0.7% to 82.9%. This represents an approximate 50% bridge of the gap to the peer group average.

In agreeing this target commissioners note that DRD benchmarking has challenges including variable DQ nationally (9% of providers not submitting acceptable data). Also UHCW migrated their Electronic Patient Record (EPR) in the latter half of 2024 with some unavoidable disruption to data completeness, making comparisons to 25-26 less valid. Again, we are deriving our BCF plan from the NHS Provider plans which in the specific case of the DRD metrics is especially valid to ensure

consistent understanding and reality to the plan. The submitted plan at an annual level does however show an **improvement** on 25-26 of 0.7% to 82.9%.

It is recognised that this target may not be considered particularly stretching but it will however present a delivery challenge that will require service change which will be supported by community developments including the ongoing evolution of the recently initiated (December 2025) Care Co-ordination Hub and related OCIT improvements supporting discharge flows.

There will be a focus increasing the % of Pathway 0 discharges, currently 72% against the national average of 85%.

2.2 For those not discharged on DRD, average days from DRD to discharge

The target of 5.5 days is better than the peer group average of 5.8. It is based on a straight-line forecast from historical averages (with further reductions planned for the following two years).

Community workstreams to support 2.1 will also positively impact 2.2, along with ongoing hospital and collaborative workstreams to reduce discharge delays.

Population growth has not yet been accounted for. As NHS planning guidance and provider mitigations are finalised, targets will be revised to reflect improved positions and changing circumstances.

3. Long-term admissions to residential and nursing homes for people aged 65+ per 100,000 population

As a result of our Improving Programmes, the number of starts in P2 beds has declined significantly, with the expectation for this trend to continue into 2026/27.

This reduction reflects the effectiveness of delivery against the 2025/26 plan, resulting in fewer P2 bed placements. Our target for 2026/27 is to maintain this improved position and further reduce the use of spot beds, that support peaks is service demand across UCHW's system.

Due to increases in demand maintaining this performance at the rate of 340 Long-term admissions to residential This will be achieved by building on the success of our short-term reablement approach, increasing P0 discharges, and reducing reliance on spot-purchased reablement beds. Recommissioning our Long-Term Home Support offer and expanding Direct Payments will further support this, while the introduction of neighbourhood teams will enable more people to be supported at home or without formal care.

BCF funding continues to underpin a range of preventative initiatives supporting people in their own homes and promoting a ‘home first’ ethos. This includes investment in affordable warmth schemes, initiatives to combat loneliness, and targeted support for deprived communities through programmes such as Healthier Communities Together.

Our integrated approach to commissioning pathway support places reablement, strengths-based working, and independence at the forefront, offering both step-up and step-down support to optimise outcomes.

Pathway 1 home support services were recommissioned in Spring 2024, with a renewed emphasis on improving independence outcomes. This commissioning was informed by collaborative work across the system to enhance experiences for those at risk of, or admitted to, hospital.

We are undertaking a piece of work during 2026/27 to look at the measurement of this indicator and how it aligns with that of other systems to ensure we are consistent with the approaches being taken more widely. We are aware that currently our stat includes moves between Nursing and Residential, as well as depleted funds cases, for example, when arguably these don’t represent real ‘new’ admissions.

**3. Please provide a short explanation of the planned impact of BCF funding on achievement of goals.**

**Coventry City Council** aims to maximise the impact of Better Care Fund (BCF) investment by prioritising prevention and independence-focused support. This approach is designed to reduce the number of people progressing into crisis, hospital admission, or long-term care. BCF-funded initiatives, such as integrated community services, reablement, home-first/discharge to assess models, carers’ support, and preventative schemes such as tackling loneliness and affordable warmth, are coordinated to help residents remain at home for longer and decrease reliance on residential and nursing placements. The recommissioned pathway 1 home support now places greater emphasis on independence, further supporting these objectives.

**Coventry and Warwickshire Integrated Care Board (ICB)** leverages BCF funding to improve system flow and alleviate pressure on acute services. Investment is directed towards integrated neighbourhood and community services, which are key to preventing avoidable admissions—particularly for those aged 65 and over—and facilitating timely discharges. The Community Integrator programme supports multidisciplinary neighbourhood teams, aligning BCF targets with NHS planning to maintain improvements in discharge performance and reduce long-term care admissions through joint commissioning and shared oversight.

The BCF enables health and social care partners—including the ICB, local authorities, and NHS providers—to pool resources and deliver coordinated, preventative care within neighbourhood health and social care services. This collaborative approach addresses health inequalities, prevents escalation of need, and improves outcomes for residents. By supporting multidisciplinary teams, BCF funding enhances community service effectiveness and reduces unnecessary hospital admissions through targeted interventions and population health management.

BCF funding is allocated to reablement, community support, carers' services, and initiatives utilising the expertise of the voluntary sector. These are delivered via joint commissioning and operational collaboration, aiming to reduce avoidable admissions, support timely discharge, and prevent premature entry into long-term care. The fund also supports workforce integration, joint training, shared digital tools, and aligned care planning, resulting in a unified, responsive system that can adapt to changing population needs. This ensures seamless health and social care pathways and promotes joined-up support for service users and carers.

In terms of BCF metrics, the funding underpins efforts to reduce non-elective admissions among those aged 65+, minimise delayed discharges, and prevent unnecessary long-term care home admissions.

Over the 2026/27 two specific proposals will be progressed to achieve a proof of concept for further scaling in future years as follows:

1. **Non-elective admissions:** Though our plan we will be investing in increased physiotherapy to be targeted at discharge through our One Coventry Integrated Teams (OCIT). One of the ASCOF indicators linked to non-elective admissions is 'readmissions within 12 weeks' which has been identified as an area for improvement. Through improving the physiotherapy offer at discharge we plan to impact of non-elective admissions through specifically targeting readmissions.
2. **Discharge delays:** In Coventry we are in the fortunate position of having a robust and responsive care market so rarely experience significant delays due to market capacity. There is however the potential to make more effective use of market capacity through testing whether lower level support options could increase P0 discharges and therefore contribute to a further reduction in delays.

Alongside these two specific proposals we will continue to -invest in preventative services to support a reduction in admissions and our strengths-based practice approach helps people to build resilience and maintain independence, while enhanced reablement outcomes support individuals to regain independence after illness or crisis. Recommissioned home support and expanded direct payments further reduce reliance on institutional care and sustain improvements in community-based support.

Robust governance arrangements, such as Coventry's Section 75 partnership and the Care Collaborative, ensure effective oversight of expenditure, impact monitoring, and continuous improvement. This guarantees that BCF-funded schemes deliver value for money and meet local needs, reduce inequalities, and support residents to live independently for longer. Through targeted, place-based investment, the BCF drives system-wide improvements, strengthens community resilience, and delivers better outcomes for Coventry and Warwickshire residents.

4. **Please outline how ICBs and local authorities have confidence that the services funded through the BCF represent value for money, and how they will seek to raise the productivity of services.**

Value-for-money assurance is embedded through Coventry's long-standing **Section 75 pooled budget arrangements**, providing both partners with full visibility of expenditure, activity and outcomes across adult social care, community health, reablement, intermediate care and discharge pathways. Expenditure and impact are jointly scrutinised, enabling challenge, shared learning and timely corrective action. The costs of care and support are also benchmarked regionally through our West Midlands ADASS (Association of Directors of Adult Social Services) networks and annual regional and national LGA benchmark data on costs of care and support along with numbers of people in receipt of care and support – both costs and population in receipt of support are important indicators of value for money. At an individual provider level our procurement processes are focussed on value for money (quality and cost) and subject to contract management activity to ensure impact is delivered.

**System-level oversight and accountability**
The **Better Care Programme governance** and wider **Care Collaborative** arrangements link operational delivery with strategic oversight across the ICB, Local Authority and Health and Wellbeing Board. These arrangements ensure BCF investment is aligned to agreed priorities, monitored against outcomes and held to account through formal decision-making routes.

**Outcome-focused use of resources**
Confidence in value for money is underpinned by clear evidence of impact from BCF-funded pathways, including:

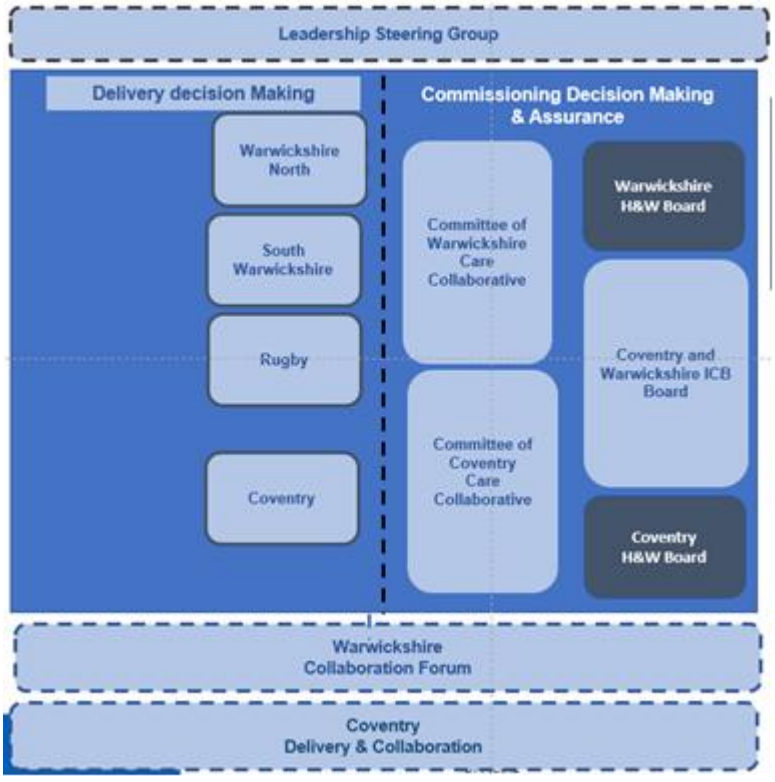
- sustained improvements in discharge performance.
- reduced reliance on long-term residential and nursing care; and
- increased use of short-term reablement and "home-first" approaches.
  Investment decisions prioritise services that demonstrably prevent escalation, reduce avoidable hospital utilisation and support independence.

**Continuous review and adaptation**

Partners operate in a dynamic way, flexing BCF plans in response to system pressures and learning from delivery. This "learning by doing" approach—successfully applied through the Improving Lives programme—provides assurance that funding continues to be directed to interventions that deliver the strongest outcomes relative to cost. A demonstration of our pursuit of continuous improvement to constantly drive value for money and improved productivity is the recent review of OCIT delivery undertaken by the City Council and UHCW. This review specifically led to the two proposals in question 2, above which covered issues of capacity, workforce, pathway effectiveness and performance. In addition as a local authority we have been developing our approach to the use of Technology Enabled Care (TEC) which although is outside of the BCF will provide learning on opportunities for use of TEC for consideration in future years plans.

5. **Please outline your robust joint governance for managing the expenditure of BCF funding, including assessing impact of funding, value for money and continuous improvement.**

Coventry has established a comprehensive and mature joint governance framework to oversee, manage, and continually enhance the expenditure of Better Care Fund (BCF) resources. These arrangements are shown graphically below.




The core elements of this governance structure are:

1. The Committee of Coventry Care Collaborative is a formal subgroup of the Integrated Care Board and is where the ICB oversight of BCF and ICB sign-off is achieved. The Committee encompasses partner members from the following organisations and as such takes broad view on BCF ambition and progress.

- Coventry City Council
- Coventry and Warwickshire Integrated Care Board
- Coventry and Warwickshire Partnership Trust
- University Hospital Coventry and Warwickshire
- Voluntary, Community and Social Enterprise (VCSE) sector
- Coventry Healthwatch
- Primary Care

2. The Delivery decision making group in the graphic above is then accountable for enacting the decisions of the Committee, which include BCF. This has membership from the same organisations as the committee but at a less senior level.

3. Section 75 governance through Adult Commissioning Group – the day-to-day governance of BCF implementation is managed through the Adult Commissioning Group, which operates as the agreed Section 75 partnership governance mechanism. This group provides robust oversight of expenditure, monitors the impact of funding, and ensures value for money through continuous evaluation and improvement.

4. The Health and Wellbeing board retains primary oversight and sign-off for BCF plans and activity which ensures accountability and strategic alignment with wider health and wellbeing priorities for the city.

The Care Collaborative governance model, illustrated by our governance diagram, demonstrates clear links between the Integrated Care Board and the Health and Wellbeing Board. This integrated approach supports the effective management of BCF resources, robust assessment of impact, and a relentless focus on delivering value for money and continuous improvement across Coventry's health and care system.

In delivering within this governance structure our approach to BCF planning is firmly rooted in the ethos of integrated health and care organisations working in partnership to support individuals. Operating within a dynamic environment, we have demonstrated the ability to adapt and modify BCF

plans responsively to support emerging pressures and shifting priorities. This adaptability is made possible by constructive engagement with NHS partners, ensuring that our plans remain relevant and effective. At the heart of this process is a commitment to collaboration and a user- and patient-centred focus, ensuring that governance arrangements are always aligned with the needs of those we serve.

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