Coventry City Council

A summary of the Public Health Business Plan doe 2025-28

Public Health, Insights and Migration Business Plan 25/28 Summary

Created October 2024

Contents

Executive Summary

This summary sets out the high level detail of our plan, what the plan includes and what it doesn't include. The plan is an overarching document which captures elements of all our directorates work, Public Health, Migrant Health, Business Insights and the HDRC. It does not capture all we do, but focuses on the overlap between our teams,

The Objective of the plan is to set out where Public Health will be focusing in the next few years, our main aim is to Improve public health outcomes and reduce health inequalities in Coventry. We do that by using the Public Health Grant effectively.

This document is an internal document for the Public Health team which can be shared with other directorates of the council, so others understand our priorities. It does not include our "Business as Usual" and it is meant to be a living document that changes as our direction becomes clearer and as we deal with Public Health priorities that arise from national, local and system pressures.

The plan outlines specific areas of focus for strategic development as well as specific areas for prevention work. We will do this across the range of services, using data, intelligence and performance to drive our direction, being agile to manage new challenges.

Our Key Areas of Focus will be

- Reducing Infant mortality to improve outcomes for our Children and Young people.
- Working with Adolescents to improve their health by influencing the choices that they make.
- Further developing and ensuring that all council services are underpinned by Prevention strategies, this includes primary prevention, stopping people becoming ill in the first place.

Our approach will be

- Evidenced based and data driven.
- Collaborative and promoting co-production.
- Using evaluation to demonstrate effectiveness.
- Structured oversight of public health contracts and funding.
- Active communication and feedback collection to enhance service delivery.

We will strengthen our Governance processes to ensure that we achieve our objectives, developing further a meeting structure that ensures we do the work we need to do and improving communication across the team so that we as a team are more joined up. We will create a system of linking with others, both internally and externally to reduce "siloed" working and increase communication/co-production.

1.0 Introduction

Good physical and mental health are important at both an individual level with regards to improved quality and length of life, and at a community level as health is a vital component of local community cohesion, social mobility and prosperity. The complex link between health and wealth has long been known within public health circles but has recently been made more prominent by the COVID-19 pandemic, which laid bare the difference between those with the best and the worst health in the UK.

For the last 10 years or more, Coventry City Council has focused its efforts on reducing inequalities. Health Inequalities are defined as unfair and avoidable differences in health across the population, and between different groups within society. Within our Marmot City work, we have explicitly outlined the inequalities experienced in Coventry and have worked to reduce and eliminate this unjust variation in life chances. This is a complex task – the things that influence our health and wellbeing outcomes (also known as the wider determinants of health) are many and varied.

Improving health therefore requires action to be taken by a range of organisations and businesses - as well as by individuals and communities themselves - at different geographic levels and using a variety of interventions. In Coventry, we have gathered our allies through the Marmot Partnership to help deliver and hold all partners to account for addressing Health Inequalities.

This new Public Health Business Plan outlines a new way of working for the local public health team to meet these challenges and calls on wider public services, the voluntary and community sector and local businesses to contribute. We want to make public health everyone's business.

The plan has been developed in collaboration with the teams which sit under the Director of Public Health in Coventry. It is a living document, which will develop as the work takes place, topics are explored, and the need become clearer.

The plan outlines specific areas of focus for strategic development as well as specific areas for prevention work. We will do this across the range of services, using data, intelligence, evidence and performance to drive our direction, being agile to manage new challenges.

Many of the areas of focus and ways of working outlined are grounded in public health first principles, but we will seek to deliver support and services in new and innovative ways - working with local academics, through the HDRC, regional and national subject matter experts and those affected most by local inequalities to shape the offer.

We present this, as a team, as our intentions to amplify the work of the council to improve the health of the population of Coventry. It is our contribution to the City's One Coventry Plan and furthers the values in which we work to.

2.0 What does Public Health Do?

Traditionally, public health is defined as 'the science and art of preventing disease, prolonging life and promoting health and wellbeing through the organised efforts of society'. There are three main disciplines or 'pillars' of public health, each of which requires a range of specialist skills and experience to effectively deliver.

Every local authority is statutorily required to have a Director of Public Health (DPH) to oversee the delivery of a set of statutory and mandated functions, as defined in the Health and Social Care Act 2012.

Many services are universal however local data and insight must be used to ensure the specific needs of a population are met. Discretionary services can also be commissioned and/or directly delivered to meet any need not included in the mandated functions below.

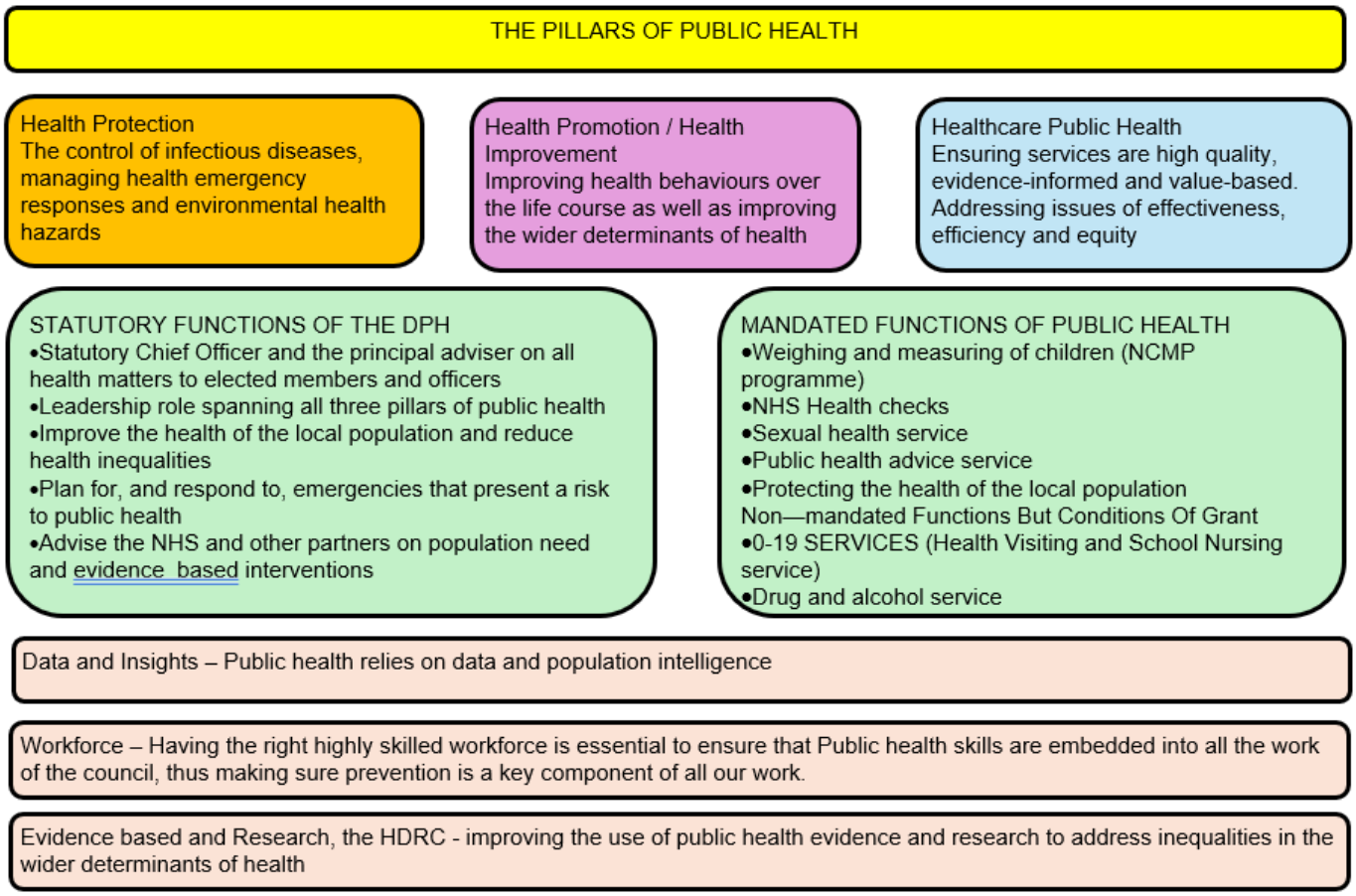

Figure 1 - Pillars of Public Health created from Key areas of work - FPH - Faculty of Public Health

At Coventry City Council, the Public Health and Insights function brings together a range of services that contribute to the delivery of the Council's statutory and wider responsibilities regarding improving public health outcomes, protecting our most vulnerable and reducing health inequalities.

3.0 Coventry, A Marmot City/

In 2013, Coventry became the first place to announce that it would become a “marmot city”. Coventry pledged to create a fairer society by addressing the social determinants and improving the lives of its citizens. Since coining the phrase “marmot city,” many other places and regions followed. The marmot approach is a way of thinking so that processes and services are designed to reduce inequalities. Change is driven by systems working together towards common goals.

At present, around 26 Coventry partners come together to champion the marmot approach. Teams from Coventry City Council, the voluntary and community sector, and statutory services like the NHS, police, and fire meet every two months, with overall functioning supported by local authority public health. The Marmot function in Coventry is not a funded programme of work, instead partners work together to champion a philosophy and ethos that can make a difference to reduce health inequalities. In 2020, an independent evaluation reported that Coventry had demonstrated commitment to making fairer decisions to improve the health of residents in the city. Proportionate universalism was used widely, and Coventry was doing well compared to similar places elsewhere in the UK. However, there were also examples of inequalities getting worse, and of challenging contexts. Since the 2020 report, there have been more challenges locally and globally, including the covid-19 pandemic.

In 2023, Coventry produced the marmot monitoring tool to describe the work done to tackle the eight “marmot principles”. The tool lists areas of work related to each principal, plus the delivery partners, measures, and statistics that can help track change.

Alongside these measures and indicators, which may not tell the full story, it is important to reflect about the direction of travel and change in the city. This report, which was prepared with support from the HDRC, presents key reflections from Marmot partners on the journey so far and next steps into the future. The Coventry HDRC is helping develop the infrastructure and use of evidence and research to address inequalities in the wider determinants of health.

Currently, Coventry City Council, is working internally to define what its contribution to this wider partnership should be. There is an opportunity to consolidate the council’s current work programmes to maximise the impact we can have on inequalities and make a more tangible impact on addressing inequalities across the city.

Our Marmot City work is firmly embedded in the City Councils main strategic plan, One Coventry, not only as a specific priority, improving outcomes and tackling inequalities within our communities, but also as a enabler for the other two priorities, improving the economic prosperity of the city and region and tackling the causes and consequences of climate change.

4.0 Our overall Approach

We will work in a collaborative way with all partners across the system to achieve our specific objectives using the big six risk factors approach.

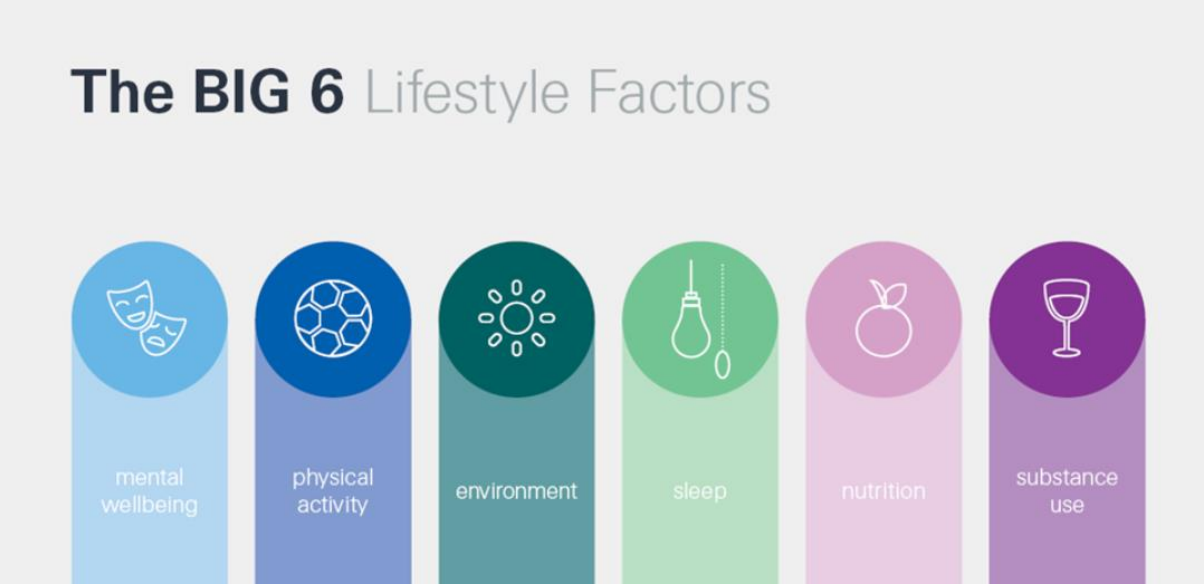

Figure 2 – the Big 6 prevention risk factors

So, for each topic, we will need to consider the six risk factors to improve health in a holistic way. This strategy is not about improving health, or indeed other statutory services, its focus is on helping people make healthy and sustainable lifestyle choices to improve health. Whilst we might assume healthy choices is an individuals responsibility, it isn't that easy! If your only accommodation is damp or the only food you can afford is of poor nutritional value, your choices are limited. By giving people the support they need to improve their standards of living, we improve their health.

Our prevention strategy needs to

- Understand the root causes of harm including trauma informed approaches, understanding the interdependencies between connecting workstreams and seeing harmful behaviour as symptoms of underlying issues
- Develop the knowledge base so that all professionals are informed, using an agreed and consistent approach, including consistent language, awareness and signposting.
- Better understanding the barriers that stop people from accessing help, these could include a lack of trust in professionals, stigma associated with services, accessibility and misinformation around service models
- A well-defined system wide policy which brings together prevention action
- Use Coventry's grant funded research collaboration (HDRC), to gain a better understanding about what interventions are effective and cost effective, providing the best value for money to benefit the people of Coventry.

5.0 Three Priorities for 2025-2028

5.1 Children and Young People, starting with a focus on Infant Mortality.

In Coventry for 2020-2022, infant Mortality is 5.9 crude rate per 1000 births. In England this rate is 3.9 per 1000 births and in the West Midlands the rate is 5.6 per 1000 births. This means that Coventry, is statistically higher than England and the West Midlands. When compared to our statistical neighbours, Coventry, alongside Derby is the worst.

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	-	3.9	3.8	4.0
Neighbours average	–	-	-	-	-	-
Coventry	–	-	-	5.9	4.6	7.4
Derby	–	1	-	5.9	4.4	7.7
Bolton	–	2	-	5.2	3.9	6.8
Leeds	–	4	-	4.9	4.1	5.9
Peterborough	–	3	-	4.6	3.3	6.4
Sheffield	–	5	-	4.2	3.3	5.3

Source: OHID, based on Office for National Statistics data

Figure 3 – OHID Fingertips – Infant Mortality

Infant mortality rates are associated with higher levels of deprivation and low-income, and most of those who die, are born extremely prematurely, before 28 weeks of pregnancy. We have completed analytical work of all the babies that died within the first year of life in 2022. This showed us that

- There were 39 deaths in the first year of life in 2022. 29 of those deaths happened in the first day of life. 25 of these babies were born before 28 weeks gestation. 50% came from white British heritage and 50% came from a variety of other ethnic backgrounds.
- 37% of mothers, either smoked, had just given up smoking or lived with a smoker, 23% consumed Alcohol during pregnancy.
- 19 of the 39 mothers were from the 30% most deprived backgrounds. 6 came from the 30% least deprived backgrounds.
- Of the mothers that had a BMI recorded, (24) 18 had a higher than normal BMI (over 25) with 12 either obese (over 30) or morbidly obese (over 40).

5.1.1 Where do we want to be?

As a starting point, we want to be at or below the national average for infant Mortality. We want to be able to monitor the number of premature deliveries within Coventry and see this number fall.

5.1.2 How will we get there?

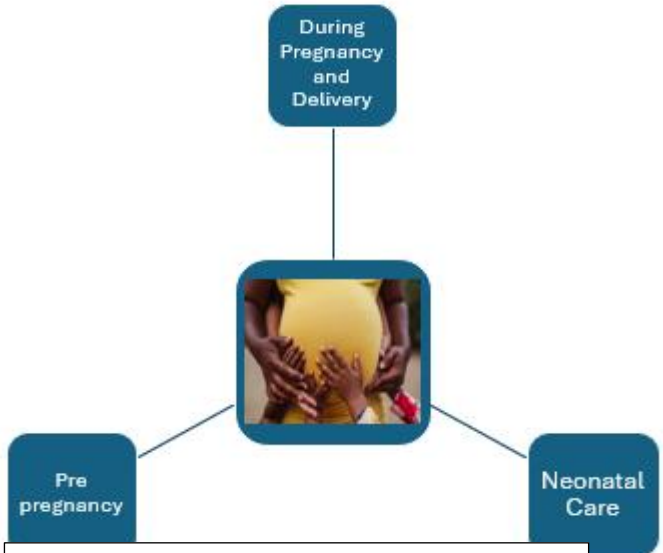

Figure 4 - model of engagement

There are three elements that impact on Infant Mortality.

- Care pre pregnancy, the health of the women, when she is becomes pregnant.
- The care and health of the mother during pregnancy and at birth including immunisations.
- The care of the baby post-delivery and in the neonatal period.

There is much work going on within the Local Maternity and Neonatal System (LMNS) to improve the services that mothers and babies receive, this is part of the NHS Long Term Plan.

However, midwives are not able to influence the health of women before they become pregnant.

There is not a single professional group that sees all women pre pregnancy, some mothers, particularly those with Long Term Conditions will seek help, but the ones we can make the most difference too are those who do not seek help, until they are pregnant. This means to impact on the health of these women we need a conversation with a broad range of professionals, including school nurses, teachers, GPs etc.

Co-Production – we need to design a campaign with all women who could become pregnant. We want the co-production to cover multiple communities from different cultural backgrounds. We want to focus on those who are the most deprived, as they are the women who are most likely to deliver prematurely and for whom a campaign needs to be most impactful for.

Marmot 2 – We want to focus on the women living within the most 30% deprived wards of Coventry. These women need information and support that helps them become pregnant ready. Any work must be accessible and achievable for these women.

Insights and Intelligence – we need to develop proxy measures which help us understand how infant mortality is changing, this includes, number of pregnancies, number of terminations, number of premature deliveries and outcomes for preterm babies.

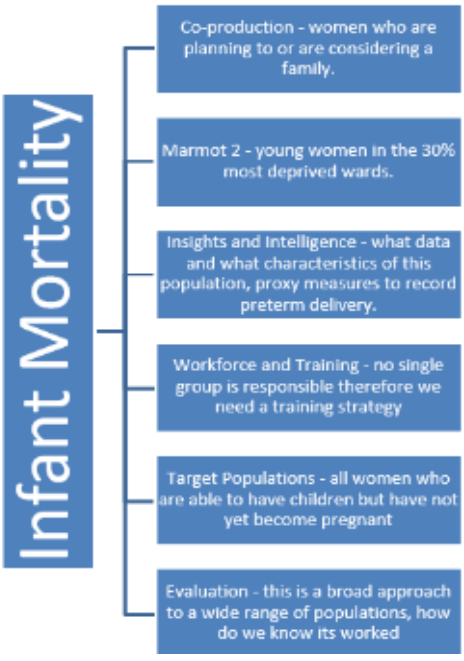

Figure 5, Infant Mortality Our Approach

Workforce and Training – No single workforce has contact with this population, although several will be key to delivery. Firstly, School Nurses play a key role in the health of adolescents, both girls and boys. Understanding how young people can ensure that they are healthy for a parenting journey is a key concept that can be introduced here. Family Planning Nurses and Sexual Health Workers are also key in supporting people to understand the importance of being healthy pre pregnancy. Finally, an important message that we need to address is the importance of early booking and early care once women become pregnant. This is particularly important for women who may have no recourse to Public Funds, as they are at higher risk of adverse outcomes at delivery, for both themselves and their child.

Target Population - whilst the overarching group is women who have yet to conceive, there are groups within that where we can have a bigger influence, these are

- Women living in the 30% most deprived areas of the city
- Women living in the 30% most deprived areas of the city and come from an ethnic minority background
- Women who have no recourse to public funds
- Women who are sex workers, work in the nighttime economy

Evaluation – this is a tricky thing to measure as it is a whole population intervention with a specific focus on the groups ahead, but success will see a reduction in late bookings, healthier women in pregnancy and women with a better understanding of how their preconception health impacts on the outcomes of a pregnancy.

5.1.3 Next Steps

There is already a lot of work going on across a wide range of partners, such as Parenting Strategy, LMNS improvement plan and Health Access for Refugees Programme (HARP).

We will bring partners together in November 2024 to map the work already underway, agree communications between those programmes to ensure that we are getting the most out of our resources. This will enable us to develop a plan on a page and undertake some specific work.

The plan on a page will be developed and agreed by January 2025.

5.2 Adolescence, starting with a focus on healthy choices.

The Child Health Profile for 2024, shows that we have significantly more children and young people living in Poverty. We have more children who are not ready for school, with less children vaccinated. Our children suffer from higher levels of obesity than national and statistical neighbours and more children are admitted to hospital for both tooth decay and A&E attendance.

On the positive side, more children are breastfed than other areas, less children are admitted to hospital because of substance misuse or alcohol. More children aged 16/17 yr. olds are in employment, training or education with fewer children seen as NEET. A Needs Assessment is being undertaken to understand more about the needs of

adolescents.

Behaviour Change – is the science of getting people to make small changes in their habits and their behaviours. Small changes make the biggest differences to health outcomes and life expectancy. Behaviour change theories work on the principles that by turning unconscious behaviour into conscious behaviour people will make better healthier decisions. If the behaviour you want is easier than the "bad" behaviour, then the good behaviour becomes the new habit.

Several services work together to support this population, school nurses provide a universal service to all school aged children, they can see children in groups or individually and are able to signpost to other more specialist services.

Within School there are Mental Health Support services, which support young people with mental health issues.

We currently have a risky behaviour service, which covers a range of behaviours, such as sexual activity, alcohol, smoking and drug services. This service supports adolescents make healthier decisions. This service has seen a rise in referrals since its inception. The service now has waiting lists because of its success.

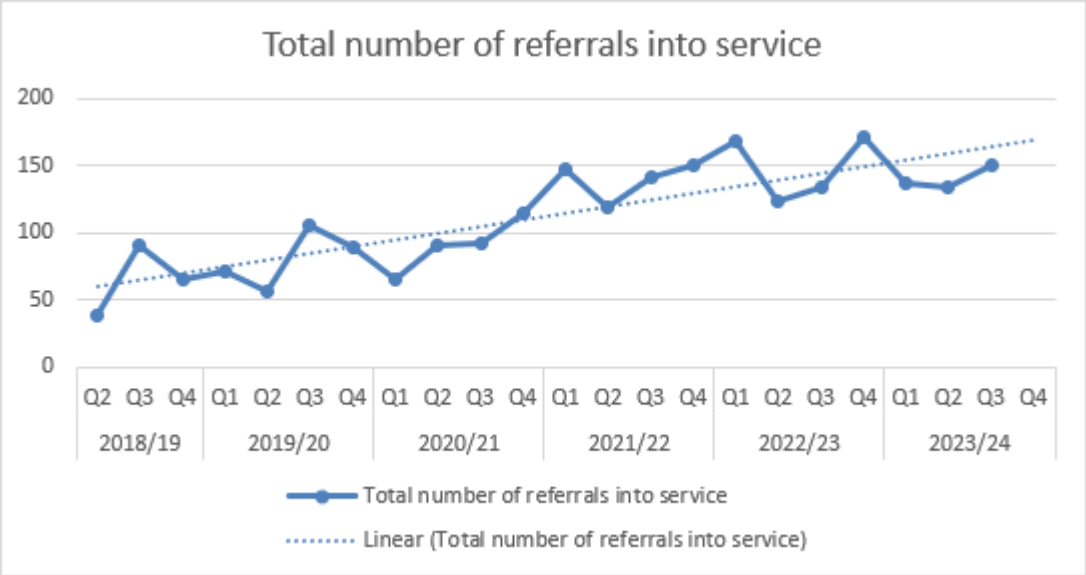

Figure 6 – Performance Data from Positive Choices showing upwards trend

Parental problem drug use can and does cause serious harm to children at every age, from conception to adulthood. Within Coventry, there were 327 parents in treatment out of a projected number of 3780 (9%). Analysis of hidden harm data shows that there are opportunities to develop the response in Coventry. Compared to our nearest statistical neighbours, the number of parents in treatment as a rate of the projected number of children affected by parental alcohol/substance misuse is low. In addition, the number of parents entering treatment has decreased.

A broader needs assessment of people misusing substances made the following recommendations:

- To develop the approach to prevention for school-aged children.
- To evaluate current diversionary activities for children and young people.

- There is a potential gap in community services for early adolescents.
- To review the local response to the 'hidden harms' caused by adverse childhood experiences, such as parents with a drug or alcohol issue.
- To review treatment services to explore the potential for expansion and collaborative working (includes positive choices).

Children and adolescents that experience Domestic Violence also have higher levels of need than others. The WISH Service works with children aged 5-18 who have been victims or who have witnessed domestic abuse and who are known to Children's' Services. Children who are referred into the WISH Service must be managed on a Children in Need Plan or be known to Children's Social Care as a Looked After Child. This leaves a gap for those who do not meet this threshold. The most common age group that the WISH service works with are aged 5 – 11. Teenagers are less likely to engage in the service. We know that Children and Young People in homes affected by DA are more likely to become perpetrators and victims in the future.

Serious Violence, youth Violence and gang violence is a real issue for this adolescent population. VWI, knife, gun, and possession of weapon crimes show an increase when comparing 2022 against the previous two years and whilst the number of victims has increased or remained the same over the 3-year period, the number of suspects shows a decrease meaning fewer people are causing more harm. 31-34% of victims and suspects of knife crimes are between the ages of 15-24. This is compared to 17% of the population.

Compared to 2021, assault and admissions and attendances to A&E during 2022 both show a decrease. Sharp objects admissions have seen a 22% increase, 41% of sharp object A&E admissions were between the ages of 15-24. As a rate per 1,000 population, sharp objects admissions for males were 12 times greater than females.

Figure 7 Picture from freepik

Children who were cautioned or sentenced for a serious violence offence were more likely to have had an Education, Health and Care (EHC) plan before their first serious violence offence. In 2021-22, 1,979 (3%) of the pupils in Coventry had an EHC plan. It was more common for children who were cautioned or sentenced for a serious violence offence to have been permanently excluded before their first serious violence offence.

Between Spring Term 2016-17 and Autumn Term 2021-22, there were 220 exclusions and 13,920 suspensions in Coventry. Keeping children in school, is a key preventative measure.

5.2.1 Where do we want to be?

Child Friendly Cov, wants Coventry to be the best city for children to grow up in. This programme of work can be explored in detail here Child Friendly Cov. Public Health will continue to support Child Friendly Cov, supporting analytical approaches to surveys and

drawing links between Child Friendly Cov and the Parenting Strategy.

For Coventry to be the best city for children to grow up, we need parents to have the right support to be the best parent that they can be. We need to ensure that our services link up in a way that creates a seamless system that provides results which are a greater than the sum of the parts.

5.2.2 How will we get there?

We want to continue helping parents make the best of their parenting journey through implementation of the parenting strategy

We will continue to improve and develop the risky behaviours offer through development of the positive choices service offer, this will include completing the needs assessment and then recommissioning the service with a view to supporting children make healthier choices.

We will develop an adolescent health steering group to co-ordinate effort from across the system, this will include pulling together the wider intelligence that we have around adolescence. The steering group will oversee the programme of work, which in the first year will develop a wider five-year action plan to go forward.

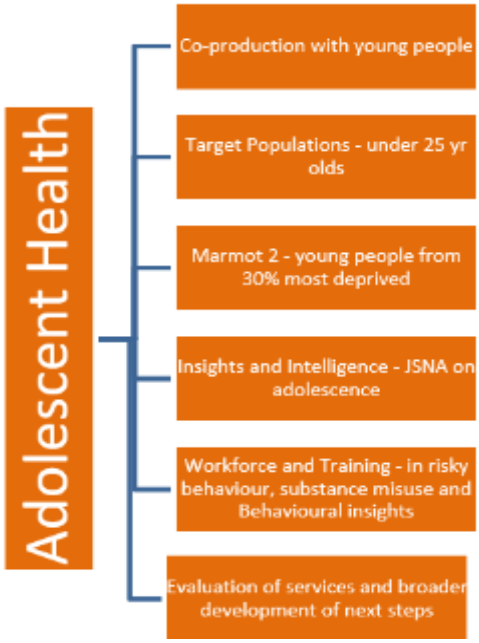

Figure 8, Adolescent Health, Our Approach

We will create an adolescence health dashboard, which includes physical, social and emotional indicators

We want to also support children and young people to further develop their mental wellbeing by being resilient to and supportive of mental ill health. We want our young people to be able to understand and cope with the pressures of life by developing techniques to deal with everyday stresses.

5.2.3 Next Steps?

This work needs some planning, as a newly focused workstream. Initial conversations show that there is a real desire to take this work forward. We will

- Create an internal Public Health Steering group to pull together all the existing data work and needs assessments into one place
- Map all the existing public health services across the public health family of services. Broaden this out to a wider audience within the system
- Explore whether implementing i-Thrive as a model would support our objectives.
- Identify issues and needs from across the system including uptake of immunisations for those at school.
- Create an action plan focusing on adolescent health with clear key deliverables and actions
- A plan agreed by partners will be in place by June 2025

5.3 Prevention offer, building further on work around the wider determinants

The prevention offer must be clear in everything we do. We deliver prevention through several routes,

- Indirectly through the services we provide. We currently have a wide range of Public Health Services which are commissioned through our small commissioning team.
- Through leadership, such as leading strategies and strategic subgroups such as the parenting strategy, SEND data subgroup and leading streams of work around serious violence, domestic abuse and through our contribution to the health and wellbeing Strategy.
- Through collaboration and influencing such as advocating for underserved communities and groups who we are particularly keen to link with. This is particularly pertinent to our work around the NHS and prevention agenda.

We measure the health of our population using fingertip indicators which can be found here. Public Health Outcomes Framework - Data | Fingertips | Department of Health and Social Care (phe.org.uk). These do not change as often as we would like and so we also use proxy measures to assure ourselves that we are moving in the correct direction.

Our commissioning team is small and there is a lack of clarity about the roles other public health team members play in reprocuring contracts. We need to redesign our teams so that the commissioning function is adequately supported and that services, and their contracts, benefit from the knowledge expertise within the team.

Using evidence and developing an evidence base through new research are important factors in our prevention offer. This is now more achievable than ever through our Coventry Health Determinants Research Collaboration.

HARP - Aligned with Core20Plus principles, the HARP project aims to reduce health disparities among refugees and asylum seekers by improving access to healthcare, enhancing understanding of health services, and raising awareness among health professionals about the challenges faced by this group. Aligned work includes improvements to maternal health pathways for pregnant asylum seeking women, efforts to reduce Do Not Attend appointments and using green space and sports activities to improve mental health and wellbeing.

Adult Intensive ESOL Support - The wider determinants of health are equally important improving the health and wellbeing of migrants. Working with Adult Education, the team have developed an intensive support programme to assist individuals who are closer to the labour market in understanding the UK employment culture and language support to enable them to access employment opportunities at the earliest time.

5.3.1 Where do we want to be?

Figure 9, Our Approach to data and intelligence

Directly delivered Prevention

We need to have key messages for each of the topics so that we are clear about the messages we wish to deliver to the public.

> We need to have dedicated support from the Comms team to ensure that key messages are delivered to the population through a variety of methods, for example online, through newsletters and via media campaigns

Contracts and procurement

We want a series of needs assessments which are available in a shared space so that we can ensure we can effectively link the intersectionality between the recommendations, the data, the research evidence and the findings.

We need to have a clear understanding of all the contracts we have, with performance data and clear timelines for ensuring timely re-procurement/tendering. We need to have the evidence of what works easily at hand to ensure our service proposals are evidenced based.

Through Leadership

We will maximise opportunities to work together on strategies, research, boards and in partnership with other organisations are clearly defined and that we all have opportunities to bring our own knowledge to the table, whilst recognising that everyone cannot attend.

Through the HDRC Research function

We now have stronger links with our universities and can connect university researchers to all relevant areas within the council. We are currently connecting and working with housing, employment and skills, economic development, sustainability and digital inclusion.

Through Partnership Working with the NHS

In the NHS, the efforts that we have make to improve the populations health, the services and the health outcomes from our interventions is termed Population health Management. We use data to identify those most at risk, adapt and deliver services to better match the needs within a specific population and then monitor outcomes. For example, by identifying people at risk of hospital admission for pneumonia, we can identify those at risk, ensure that prevention is in place, such as Vaccinations, additional flags to ensure early warning if becoming poorly with care plans which identify actions to be taken, we can prevent some admissions, this saves money, is better for the patient and ensures that health is not adversely impacted.

To achieve this all effectively, we need to redesign our approach to be more strategic with a clearer understanding of everyone's agenda's and with multiple ownership.

5.3.2 How will we get there?

This change is fundamental to how we do our work, how we deliver across the council and wider system partners including ICS, so we need time and space to recreate our approach. This will not change what we do, but how we do it. We believe that we are doing the right things, but that more traction could be obtained if the public health team worked more closely on our key priorities.

We need to have time as a senior leadership team, a wider development team and a whole Public Health Team to work more effectively. This includes looking at how we can use the direction set by the Health and Wellbeing team to galvanise action.

5.3.3 Next steps?

Arrange an away day to explore in more depth how we achieve the changes we need to deliver.

5.4 Delivering our Priorities

We need to use the enablers which are at our disposal to ensure that we achieve our goals, these are clearly set out in our full business plan but include

- Using evidence and shared data to drive improvement
- Innovative and cost effective public health interventions which are designed with communities which the intervention is for
- Exploring further the use of technology to support effective interventions
- A well trained and knowledgeable workforce across the spectrum of disciplines, both our own staff and our stakeholders so we are working together with a common language
- Well thought our research and evaluation of programmes which ensure our service delivery is robust.
- Using the councils policies and governance systems to ensure we are contributing to the broader work of the council
- High levels of communication and trust across the system

We will measure impact to ensure we are able to see the changes that we have made, where things are working, we will amplify, where things can be improved we will work with the community and others to make thing more effective, and where things are not working, we will change direction to get the results we need.

We will use existing governance processes to assure our work, and we will use the Public Health Grant to support our work programme, delivering against our targets.

6.0 Stakeholders

The Public health team works closely with the HDRC, who provide an evidence based function for the council, supporting the integration of research into council practice, the Public Health insights team who provide us with intelligence around need and the migration team who are co-responsible for some of our most vulnerable residents. For this reason, our priorities are joined and therefore our action plan is a joint action plan.

Our stakeholders can be divided into specific categories,

- Internal stakeholder such as other council directorates
- External NHS stakeholders such as ICB, NHS provider organisations
- External non-NHS stakeholders such as Police, community Safety etc.
- Coventry based non statutory organisations and third sector organisations.
- Our service users and the populations within Coventry.
- Other LA's and WMCA
- ADPH, OHID, UKHSA and other regional national bodies

To engage effectively with stakeholders, we will:

Figure 10 - Our Engagement Strategy

1. Begin conversations early to build trust between our team and other stakeholders.
2. Set a schedule for communicating with stakeholders particularly when things are changing.
3. Be honest and consistent with our messaging, using the same words so that we do not cause confusion.
4. Communicate often so that people know who we are and can come to us with issues early.
5. Listen actively and seek compromises where necessary.

The Public Health team will develop new ways of working to ensure we are able to deliver on the ambitions outlined in this strategy. The team will work in a matrix way but there will be clear leads for each area so internal directorates and wider system partners will know who to ask if they want advice and/or support. We have identified a programme of development for the team in order they can fulfil their new responsibilities. The key new approaches to our work include having:

- A defined senior management team who provides an expert consultancy function, supported by the wider delivery team
- DPH link to NHS England regional teams and to OHID regional and national team
- Named representatives aligned to each internal Coventry City Council directorates to improve internal collaboration
- Clear thematic leadership responsibility for the public health areas.

7.0 Next Steps

This plan will is currently being shared and consulted on with stakeholders, partners and population groups across Coventry. It will be formally approved, once complete in March 2025 prior to full implementation.

This doesn't mean that we will do nothing until that time. Between October 2024 and March 2025, we will hold further consultation with our external partners, we will develop detailed plans for our specific priorities, and we will ensure our baseline data so that we can effectively monitor progress.

We hope this plan excites you as much as it does us, please comment to PublicHealth@coventry.gov.uk