Martin Reeves
Chief Executive
Coventry City Council
Council House
Earl Street
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11 December 2013

Dear Martin

Health and Wellbeing Peer Challenge - 21st to 24th October 2013

On behalf of the peer team, I would like to say what a pleasure and privilege it was to be invited into Coventry City Council to deliver one of the early pilot health and wellbeing peer challenges as part of the LGA's health and wellbeing system improvement programme. This programme is based on the principles of sector led improvement, i.e. that health and wellbeing boards will be confident in their system wide strategic leadership role, have the capability to deliver transformational change, through the development of effective strategies to drive the successful commissioning and provision of services, to create improvements in the health and wellbeing of the local community.

Peer challenges are delivered by experienced elected member and officer peers. The make-up of the peer team reflected your requirements and the focus of the peer challenge. Peers were selected on the basis of their relevant experience and expertise and agreed with you. The peers who delivered the peer challenge at Coventry City Council were:

- Chris Bull – Lead Peer, Associate and current Chair of the Public Health Systems Group
- Councillor Steve Bedser – Chair of Health and Wellbeing Board, Birmingham City Council
- Dominic Harrison – Director of Public Health, Blackburn with Darwen Borough Council
- Sarah Price – Chief Officer, Haringey Clinical Commissioning Group
- Daniel Ratchford – Chief Executive, Quality Health
- Gill Boston – National Care Forum and Voluntary Organisations Disability Group
- Pete Rentell – Challenge Manager, Local Government Association
- Satvinder Rana – LGA Senior Adviser (Shadow)

Scope and focus of the peer challenge

The LGA's new health and wellbeing system improvement programme has been co-created with a number of national organisations. Health and wellbeing peer challenge is one of the core elements and Coventry City Council is acting as one of the early pilot sites.

The LGA peer review team consisted of 7 team members with a breadth of experience and professional backgrounds. In three days the peer review team attended 36 sessions, met with 6 Councillors; 113 staff and partners; 5 visits and observed the Health and Wellbeing Board meeting.

The purpose of the health peer challenge is to support councils in implementing their new statutory responsibilities in health from 1st April 2013, by way of a systematic challenge through sector peers in order to improve local practice. In this context, the peer challenge has focused on two elements in particular:

- Cultural issues arising from NHS staff coming into the council in terms of how they are welcomed and how well prepared they are to adjust;
- Review of the cultural differences around procurement and joint commissioning and how these drive change

Our framework for the challenge consisted of four headline questions and our response to the two elements detailed above are incorporated under these headings:

1. How well are the health challenges understood and how are they reflected in the Joint Health and Wellbeing Strategy (JHWS) and in commissioning?

2. How strong are governance, leadership, partnerships, voices, and relationships?

3. How well are mandated and discretionary public health functions delivered?

4. How well are the strengths of the Director of Public Health (DPH) and her team being used?

It is important to stress that this was not an inspection. Peer Challenges are improvement focused. The peers used their experience and knowledge to reflect on the information presented to them by people they met, things they saw and material that they read.

This letter provides a summary of the peer team's findings. It builds on the feedback presentation delivered by the team at the end of their on-site visit. In presenting this feedback, the Peer Challenge Team acted as fellow local government and health officers and members, not professional consultants or inspectors. We hope this will help provide recognition of the progress Coventry City Council and its Health and Wellbeing Board (HWB) have made during the last year whilst stimulating debate and thinking about future challenges.

1. Headline messages

Overall the peer challenge team were impressed by the way in which the transition into the new public health system had been managed in Coventry. We were equally impressed by the scale of ambition which we found and, in our feedback, many of our messages relate to the actions which may be needed to achieve those ambitions which were often described to us within the framework of Coventry being a Marmot City. Early in the peer challenge we were told that Coventry was committed to fundamentally changing the health outcomes of people in the City to the point where the City was no longer in the bottom quartile in relation to measures of premature mortality but, rather had moved into the top quartile. There was also a sense of urgency in that both politicians and senior officers wanted to see evidence of real progress over the next eighteen months.

In this context our headline messages were:

- The transfer of the Public Health function to the council had been achieved successfully. There was a real sense that the Council had embraced its new responsibilities and were describing a strategy where health improvement was at the heart of the Council's vision. Public health staff are well integrated into the Council and many of the people we spoke to demonstrated an understanding of the importance of this agenda for the people of Coventry. This is an example of good practice which provides an excellent basis from which Coventry can move forward.
- The ambition to improve the public's health was clear and expressed through the Marmot City framework. The scale of the challenge facing Coventry was well understood and there was a real energy around people wanting to contribute to meeting the challenge. However it was difficult to find the strategy expressed in a single document and therefore to understand how progress was being understood and measured. This will necessitate detailed work to calculate what has to be done to deliver your stated ambition, for example what modelling have you done on the number of deaths you need to avert, the programmes that will underpin this and the trajectories they will work towards.
- Notwithstanding that there was a clear understanding of the needs of the population supporting the ambition. However it may be that the narrative needs to be expressed in a way where the needs of particular black and ethnic minority communities are more easily understood.
- The political and managerial leadership of the Council is well regarded across the local system. This creates an opportunity for the Council through the Health and Wellbeing Board to work with partners to tackle the issues which may prevent Coventry's ambition being realised.
- In doing this the Health and Wellbeing Board may want to consider whether it is structured in a way that means that all partners can contribute effectively.
- There is a widely acknowledged need to tackle some of the service based issues which have the potential to slow progress. The long term viability of

acute services, variability in primary care and the need to accelerate progress on integration are examples of such issues. In the short term there is an opportunity to focus on improving performance in the delivery of mandated public health services, such as health checks, and in further development of Healthwatch.

2. How well are health and wellbeing challenges understood and reflected in the JHWS and in commissioning?

There is a good overall understanding of need and health inequalities in Coventry and the fact that they have been invited to become a Marmot City is recognition that there is a clear vision for Health and Wellbeing locally. Being a Marmot City demonstrates the council's commitment to improving the health of all people living in Coventry so that it compares with the best Nationally. Marmot principles have been incorporated into the HWB priorities and therefore directly into the Board's work and they link into work themes and initiatives of other Directorates within the council to change practice. The intent is to embed Marmot into the DNA of everybody that works in the organisation.

There is a good narrative around how public health relates to economic prosperity, housing, growth, regeneration and job creation. As an example there was a quotation around a cycling initiative *"they are getting healthier but actually all they know is that it's easier for them to now get to work".* Place Directorate have historically been actively involved in public health issues such as smoking and active lifestyles.

Coventry has a good handle on life expectancy gap between males and females in each of its wards using the analogy of a bus route driving through each ward demonstrating the variability and thus greater need in some compared to others. In addition, they are able to show how they compare to other authorities from premature deaths caused by heart disease and strokes, liver disease, cancer and lung disease. This helps to inform the Joint Strategic Needs Assessment (JSNA) which has evolved over a number of years and appears to be meaningful and informing the Joint Health and Wellbeing Strategy (JHWS). The JSNA has also informed other commissioning strategies such as the CCG commissioning strategy which has resulted in reduction in smoking in pregnancy, reducing alcohol related hospital admissions and increasing uptake in cervical screening priorities. Regardless there is still a need to better understand and act on the needs of particular places and communities and this appeared to the peer team to be a gap.

The JSNA process is improving but there is still a way to go in ensuring it is accessible to all and the development of the knowledge hub and better use at turning data into intelligence will greatly assist. The JSNA is in some areas informing prioritisation through pooling of budgets and joint commissioning e.g. historically the Coventry Health Improvement Programme (CHIP), which has now been mainstreamed, and commissioning of TB services, however, this needs further discussion at the HWB to

ensure members are all sighted on commissioning outcomes. More qualitative evaluation is required to drive an outcome focused approach. There is a wealth of data and outcomes available and the council need to ensure that what they are measuring and use is proportionate and meaningful and there is a need to accelerate the performance management of health care system delivery of preventative interventions such as health checks.

Coventry has a strong corporate research capacity, good public health analysts and two Universities with a very strong track record in research, evaluation and teaching in health and wellbeing relevant subjects. The review team felt that more could be made of this capacity through better alignment or integration. The council might benefit from considering whether a City wide (virtual or real) Knowledge management function would bring added value to the existing efforts and capacities of all partners across the city including the two universities. This could include the development of a City–wide CV and Virtual Knowledge Hub for research evaluation, intelligence analysis insight and publication. This capacity would also assist with creating an independent capacity for developing 'monitory democracy' by placing the outcomes of local public services within the public domain. The Academic network can add significant value to the area of qualitative evaluation and are developing a robust evaluation framework and the HWB must get fully engaged in this work programme.

There is a potential conflict between longer term outcomes and political aspiration for short-term achievements along with a perception that the wisdom of Marmot City investment in areas of need is being frustrated by the imperative to make cuts and cost savings. This will need strong and courageous political leadership to ensure the work of the HWB remains a key agenda item corporately and doesn't get reduced to being just the work of a PH department. There is a sense that the HWB is emerging as the centre of decision-making and this momentum must be maintained for effective governance across the statutory bodies.

The HWS along with the Marmot initiative demonstrate that local plans and strategies are ambitious and challenging. There is an issue over the number of local priorities and the number of organisations (CCG, acute providers, council) with competing priorities so this might need to be reviewed and rationalised. Whilst we found supporting evidence for various sub-elements of the work covered by the HWS there was a need to bring these together into a coherent work programme to support the scale of Coventry's ambition. This will require a refreshed HWS and action plan mirroring the ambition of the Marmot City project, which in turn will require stronger integration aspirations in order to achieve this.

We found a coherent story of the Place across stakeholders we met and a long history of strong and effective partnership working. Nevertheless there is a need to ensure that the HWB and other partnership organisations are able to tackle the significant issues in the local system and ensure wide and meaningful engagement. Although we found the voluntary and community sector to be generally well engaged in the health

agenda their contribution, along with other service providers, needs to be further strengthened.

The health and wellbeing challenges are articulated by everyone you meet: the need to reduce health inequalities, to achieve more for residents and deliver the sorts of health outcomes that people across England experience. There is real commitment to this across the partnership and at different levels within organisations. As Coventry have committed to being a Marmot City, the implications of this for policy across the partnership organisations needs to be better understood and clearly set out so each organisation knows what it needs to do and where it fits in the delivery programme.

The CCG are very committed to the HWB and are supportive of the Council in its lead role. The understanding of the scale of the challenge amongst the wider Governing Body does not appear to be as embedded and the commitment to delivery of the prevention agenda needs strengthening, for example in the delivery of the health checks programme. The use of case findings should be a priority for the CCG in delivering shorter term improvements in outcome, but this does not come across clearly in the plans shared with the Peer Review Team.

The development of primary care is recognised as an important part of achieving improved health outcomes, but it is largely seen as a health service issue. The CCG stated that they want to reduce the number of poorly performing practices in the city, and encouraging practices to federate. The Health and Wellbeing Board can support this drive to improve the quality of services offered to citizens in many ways, for example in thinking through the challenges of premises and single handed practices when developing the more deprived areas of the city as part of the regeneration programme.

The Integration Transformation Fund (ITF) is an opportunity to take forward the vision for a Marmot City at scale. The partnership seems unsure what the future of this could be and the engagement of a wider group of partners needs strengthening.

3. How strong are governance, leadership, partnerships, voices and relationships?

There was overwhelming agreement that the political and managerial leadership for Health and Wellbeing is very strong in Coventry and is seen to be both effective and well respected. The Chair of the HWB has considerable experience, knowledge and contacts from working previously in the health sector which coupled with strong leadership from the Chief Executive of the council ensures that this agenda is very high on the corporate priority list. We found a high level of credibility and political capital in the local system.

The Board membership has now been condensed to ensure a more focused view to deliver effective outcomes. There is strong member representation, including the Leader of the Council and Opposition member, and involvement from other key strategic partners such as Fire and Police which is useful in terms of the wider

determinants of health. There is also good involvement from the voluntary and community sector in terms of development of the JSNA, priorities and the Marmot work though it is too early to see what impact this has made. Although representation includes individuals at the right level of seniority there is a view that their role and contribution to the Board needs to be made more explicit. The peer team observed the October HWB meeting and found competent and engaged discussion on key health issues and the meeting was well chaired. Everyone we met spoke highly of the HWB Chair and there is a good foundation for her to lead the Board in transformational change and development into a systems leader.

The removal of providers from the membership has not been well received by some or particularly well managed with them feeling disengaged. It may be challenging for the Board to function effectively without such key partners and we would suggest that a review is undertaken to ensure their voice is heard and they play a role. The key objective is to ensure the Board is strategic and does not just become a 'talking shop' through involvement of too many partners. To date attendance has been variable so commitment from individuals must be addressed to question their prioritisation of the agenda. In addition, we suggest the HWB considers how to recruit more BME members to ensure it reflects the diversity of Coventry.

We are aware that the Shadow Board benefitted from a series of development sessions. It would be useful to consider another Board away day to strengthen the leadership and functioning of the team and also to consider meeting more frequently outside of formal Board meetings to build trust and relationships. This will enable the Board to objectively consider more challenging and controversial issues. There is a need to ensure greater focus on transformation in the local system. The peer team would also question whether the current arrangements for dual membership of Scrutiny and HWB enable clarity of roles and adequate challenge as it appears to be a conflict of interest. However the peer team view was that the scrutiny function was generally considered to be robust and challenging. There is also scope for gaining added value through consolidation of existing knowledge management resources to inform effective outcomes.

Coventry has a good track record of partnership with the voluntary and community sector (VCS) with a range of mechanisms for engagement, for example Coventry Partnership which works with various sector representatives to work on the vision for the City and Here 2 Help (H2H) Consortium owned and run by local voluntary organisations. Under the Shadow HWB providers had a seat on the Board. Following changes to membership they no longer sit on the Board resulting in tensions around the rationale for that decision and a concern over how the voice of providers is heard in that forum. One quotation we received of current VCS involvement was *"after a good start the momentum seems to have slowed down."* As an example of this the new PH commissioning team haven't as yet had any involvement with H2H

If providers are not to be on the HWB there needs to be a coherent strategy that makes them feel engaged with it. It might be helpful to consider using and

experimenting with a range of different engagement mechanisms, given the variety of size and type of local providers. Provider involvement in the design and development of engagement mechanisms will lead to stronger and more successful engagement across a board locality.

In terms of delivering the Joint HWB Strategy a co-operative relationship between commissioners and providers is essential, with providers actively involved in design and development, working closely with commissioners to get the outcomes needed. Some market shaping may be needed to help move it in a direction to effectively deliver the strategy. The mechanisms for making this happen are not clear and would benefit from a more systematic transparent approach.

Healthwatch has its own unique challenge as a Board member to ensure they are not only on the Board to represent their organisation but also to effectively channel and gather the wider community views and feed them into the Board. Healthwatch was commissioned on 1st October 2013 and has been awarded to the Here 2 Help (H2H) Consortium using a cluster of member organisations to deliver different elements. This has caused some confusion given that H2H now have a presence on the HWB and were previously a provider so their role as the consumer champion might be difficult to separate from their other roles. In addition, the amount of grant they received was less than they expected which is causing some operational difficulties. The peer team suggests offering Healthwatch some support around their scrutiny function and need to hold the Board to account which could be done in a number of ways:

- Proactively determine how the entire board will work with the scrutiny function of the local authority to hold commissioner members to account and clarify the specific role of Healthwatch in this process.
- Ensure performance data is more visible and accessible to enable/improve scrutiny and accountability
- The model by which public health staff work with other departments is an example of good practice so consideration could be given to extending this to Healthwatch
- Although Healthwatch may be well placed to act as a critical friend, their resources and reach may be restricted. It may be helpful for a member to be an ‘engagement champion’ to work closely with them to support their engagement and involvement role.

Careful attention needs to be paid to maximising the opportunities created by Healthwatch as an emerging organisation and this should be given immediate attention.

Whilst the challenge and vision is clear there is work to do on ensuring the HWB is clear on its purpose. It should be driving things forward and developing how organisations do things in a different way rather than being a place where things are signed off. There are a number of sub-groups to the HWB, such as the Health Protection Committee as well as other local partnerships such as the Community

Safety Partnership, which will be effective forums to brief and advise the Board on key issues such as drugs and alcohol, chaotic lifestyles and mental health. We suggest you consider strengthening collaborative links with other areas i.e. Warwickshire given that the CCG area includes Rugby. We picked up that joint commissioning for adults was weaker than that for children's and the effective work undertaken by children's services in the 0-5 years project provided transferable learning.

The CCG is in a position as commissioner of acute, mental health and community services to ensure that healthcare services are taking a preventive approach, and working with NHSE to drive up quality in primary care. This could include using their CQUINs to focus trusts in achieving reductions in smoking, alcohol related violence or tackling obesity for example. Given the very ambitious transformation that the HWB wish to see, achieving the top 10% in terms of outcomes, the CCG need to use this commissioning strength to support the ambition and seek alternative ways to focus their providers on these outcomes.

The HWB is seen as the centre of decision-making by the full range of stakeholders, so it has the mandate to provide the strategic direction to deliver their ambition for Coventry. With this very strong leadership, the board will need to tackle some of the bigger issues that will hold them back, like the form of the health landscape in future. They will need to establish ways in which they can engage providers in this discussion. The groups that have been set up to take forward key policy areas, like integration, may be the best way to do this, but will need to ensure that they are inclusive, have clear governance and can make decisions.

Having NHS England at the Health and Wellbeing Board is very positive and an opportunity to think about primary care development in its broadest sense, not least in working through the roles of both CCG and NHSE in driving up practice performance. The core offer of Public Health between the PH department and the CCG appears clear with a memorandum of understanding in place. Relationships with Public Health England are starting to develop and there are regular meetings with DPH and other organisations to share information and ensure culturally that they are moving in the same direction in a joined up manner. However, further work needs to be done to embed clarity on roles and responsibilities of these different organisations.

4. How well are mandated and discretionary public health functions delivered?

The operating model of the Public Health team is, in the view of the peer team, exemplary. There is clear evidence of very significant strengths in health protection and emergency planning (resilience) services and partnerships. Services have been able to continue seamlessly to a good standard and were transferred across safely.

Sexual Health is a large element of the PH budget and a new area of responsibility for the council. Incidence rates of certain diseases are increasing and high in a number of vulnerable groups and there is currently an opportunity to review how this is delivered

in future. There is some innovative work led by the PH department into HIV testing in primary care and Coventry is also part of a national “3Cs and HIV” pilot to support improved prevention and early detection of sexually transmitted disease in primary care for young people.

The PHE Local Area Team have responsibility for screening and immunisation as part of the child health work programme and despite safe handover of contracts and local knowledge there are still some areas where there is confusion around responsibilities, though this will become clearer as the system matures. In terms of NHS healthchecks the uptake is lower than the West Midlands average though performance has improved. Coventry jointly commission Drugs and Alcohol services with Warwickshire County Council as a new arrangement with a new provider involving moving from a treatment service to a recovery service. The peer team visited the team at Walsgrave hospital and were very impressed with the passion and enthusiasm of staff involved and the clear pathway provided.

There is some evidence that the variability in the quality of primary care (including some single handed and other poorly performing GP practices dealing with mainly ethnic minority populations) is struggling with low rates of case finding for chronic disease and with the whole system unsustainably escalating elective and non-elective admissions to the hospital. For instance, the CCG had a 12.7% growth in elective admissions between 2007/8 and 2011 but their ONS cluster average was 3.8% in the same period and they had a 5.1% growth in non-elective with cluster average 1.2%

This outlier position compared to cluster average performance suggests possible problems, in particular sub-optimal disease management in primary care causing avoidable escalation to secondary care admission. The costs of this are likely to drain CCG capacity to re-invest resources on building primary care capacity for community based prevention and early intervention. These primary care challenges in cost, quality and health outcomes terms are likely to ‘hole below the water line’ the longer term Marmot effect and they will cause the wider public health aspirations of the city to stall. They need immediate attention.

It is equally clear that whilst primary care has a clear role to play that the acute trust also needs to come to the table to work with partners to ensure that people are able to receive the right care, at the right time in the right setting. It is likely that the system changes which are required to ensure that Coventry has sustainable and well integrated services will require change by all partners.

The council might wish to consider:

- Clarifying roles and responsibilities for ‘recovery planning’ within the distributed system of primary care quality improvement between the CCG, NHS England, the local Authority Public Health team and the Health and Wellbeing Board.
- Identifying a clear system lead for driving rapid improvement action in poorly performing GP practices in primary care.

- Developing improved data analysis on primary care performance outcomes and costs and a more active strategy for placing this data in the public domain (especially through the HWB Board who are now to be the local system managers and who should be holding the system to account).
- Increasing the access of Health Scrutiny and Healthwatch to GP practice level and hospital costs, outcome and performance data and better communication of 'issues' to the public though the mass media.
- Raising public expectations of the local health and wellbeing services through more vocal civic demand for health improvement has to be a key tool for change but it can only be enabled if clear and accurate data with analytical interpretation is offered. The public health team are well placed to enable this.
- Whether the existing lifestyle services for PH might be better re-configured to provide a new integrated wellbeing service offer across the council and other public services
- Increased professional and partner challenge on performance, outcomes and costs throughout the health and wellbeing system, particularly in relation to wider system deficiencies that are often already known to the key players.
- Further investigation of sub-optimal care in individual outlier general practices with a particular focus on 'case finding' establishing accurate disease registers and the identification of the causes of the rapid rise in elective and non- elective admissions by GP referral to secondary care.
- A more robust culture of outcome reporting and peer challenge by all partners on the HWB Board.
- A specific review of health outcomes in the black and ethnic minority population of the City with particular attention given to the quality and access to good quality primary care and preventative interventions.

Historically joint commissioning in Coventry was robust and monitored through joint commissioning processes, including the Adults Joint Commissioning Board and supported by a number of jointly funded posts between the NHS and Coventry City Council. We found clear internal commissioning processes underpinning mandated services supported by the wider council. The development of a new People Directorate will be an important opportunity to review joint commissioning arrangements and develop a more streamlined approach to commissioning. The example of an integrated Early Help offer for 0-5 years in children's centres is a good example of joint commissioning and there is transferable learning arising from this. Nevertheless, there is still a need to raise awareness and understanding of what procurement and commissioning respectively are to ensure a shared view and to ensure the necessary commissioning skills (contract management, market management, and negotiation) are held internally. This may necessitate a skills gap analysis.

The transition has presented opportunities to do things in a different way working collaboratively with others e.g. Warwickshire County Council to consider market testing for some key service areas. Consistent negotiation strategies with other local commissioners, particularly the CCG, are essential as public health holds a number of

contacts with the same providers. As commissioned public health services need to be targeted effectively to address health and wellbeing priorities of the council and the HWB, services would benefit from agreeing differential outcome indicators for areas with the greatest health inequalities at the ward and neighbourhood level. This would be further enhanced by bringing these indicators into the HWB performance framework.

The 'Core Offer' delivered to the CCG is appreciated and valued by both officers and GPs. The team have worked hard to ensure that the relationship with the CCG has remained strong over the transition period and since the DPH came into post. The CCG are supportive of the Health and Wellbeing Strategy but this could be more strongly linked to their commissioning intentions and their role in prevention and early detection prioritised. Engagement of GPs both on the wider Governing Body and amongst the membership on this agenda should be prioritised by the Public Health team and supported by the CCG Chief Operating Officer, AO and Chair. The Core Offer is a two way agreement and Public Health need to ensure they are getting what they need from the CCG too.

5. How well are the strengths of the Director of Public Health and her team being used?

The Public Health team has been very well integrated into the council and staff clearly understand the issues and feel energised by the current direction of travel. Coventry's early engagement to transfer responsibilities has had clear benefits for the agenda and partner organisations. The Director of Public Health is effectively engaged in the corporate leadership of the council. Placing the team within the Chief Executives Directorate works for Coventry and staff we spoke to could articulate how health was everybody's business and how it was cross-cutting into all service areas. In addition, the health agenda was woven into the corporate plan of the council and the corporate priorities. There is good cross-party support and commitment to the vision for health. Culturally, health staff feel part of the council culture in terms of working with elected members, decision-making and scrutiny role.

We were impressed by the energy and passion of the individual members of the public health team whom we met. There is a clear commitment to their role, and a strong sense of ambition to improve health and wellbeing in the City.

The transition of the public health team from the PCT to the local authority has been handled well, with shadowing arrangements in place for twelve months prior to the formal transfer on 1st April this year. We were impressed with how quickly the public health staff had settled into the local authority environment, and how much they had been welcomed.

Whilst some staff described cultural differences between NHS organisations and the local authority (for example, working directly with elected members), and some differences in language and interpretation (for example, around the word

'commissioning'), we saw no evidence that these differences were causing any practical problems. The council must continue to raise awareness of public health across the whole organisation so that staff are clear as to the role of public health and the challenge will be to influence and drive behavioural change throughout the organisation. There is more work to be done to fully embed this but there are pockets of good activity such as work between the planning and PH team and occupational health services around delivery of the NHS healthcheck to staff. There will be inevitable tensions given that the PH budget is ring-fenced which goes against the HWB having responsibility locally for the prioritisation of tackling the wider health determinants.

The Director of Public Health reports directly to the Chief Executive, and the public health team sits within the Chief Executive's department. This appears to be working well, with the Director clearly engaged in corporate processes, and the public health team positioned to have a positive corporate impact across the authority.

Senior members of the public health team have been 'matched' with each department in the council. They attend management team meetings, and act as advisers on cross-cutting public health issues. This arrangement works very well, and allows the public health impacts of services changes and major projects to be understood at an early stage. It had been in place during the year before transition, and is a key reason behind the excellent understanding that public health staff have of the wider local authority agenda. We saw many examples of this in practice, such as in the Place Directorate, where public health staff have helped the management team to adjust plans for green spaces, transport schemes, planning frameworks and public realm improvements so that they support the wider Marmot agenda. Another early success is the development of asset-based approaches in deprived areas. Though small initiatives at the moment in certain wards, this type of approach can be scaled up to deliver significant benefits but will need strong leadership to have an impact 'at scale'. This approach is also linked to the Troubled Families agenda and is starting to tackle reduced dependency.

The majority of the team are not new to their roles, so there is a good understanding of local issues, and excellent networking and relationships with individuals in the various NHS and stakeholders groups in the City. Staff we met spoke highly of the good use of social media and social marketing (Facebook and twitter) with regard to behavioural change to move away from a sedentary lifestyle. The Godiva festival was very well attended and enabled PH messages to be communicated and active lifestyle work undertaken over the summer was an excellent example of the council/CCG/General Practitioners working together effectively. The "Be Healthy Be Well" campaign was well received and has over 1000 downloads each time it is published. Despite this positive feedback the teams view is that more robust social marketing should target campaigns/intervention based on detailed knowledge of local communities.

The relationship with the CCG is strong and the skills the public health team bring to the work they are doing is valued. The poor performance of the healthchecks

programme is of concern and it is unclear why GPs are reluctant to deliver the checks, particularly in the more deprived areas of the city where unmet need is likely to be high. The Public Health team are working hard to encourage GPs to participate and have identified a GP Champion who is very enthusiastic. Reviewing payments and targeting practices may create some improvement in performance along with reporting at practice level on this and other prevalence data.

The JSNA and other documents show the challenge Coventry faces clearly. With such good relationships and working practice between Public Health and the CCG, the team could ask more of the CCG in supporting their work. While there are examples of focusing effort, using the information they have to target the areas of highest deprivation more consistently, may deliver improvement. Examples would be in the CCGs 'Care Closer to Home' work where they are reviewing care pathways and commissioning services in the community rather than in hospitals.

6. Moving forward

Based on what we saw, heard and read we suggest the Council and HWB consider a number of actions. These are things we think will help improve and develop your effectiveness and capacity to deliver future ambitions and plans and drive integration across health and social care.

Coventry is well placed to meet these challenges. The political and managerial commitment to improving health is exemplary. We would recommend that in order to support this that Coventry:

- Continues to articulate its ambition to improve health as a core component of the corporate strategy for the City.
- Develops a structured programme plan to support the scale of the ambition. This is not to suggest that all change can or should be delivered through a single process but rather to ensure that the milestones which will need to be met and the roles which different organisations will play are understood across the system.
- Delivers a focus on tackling the issues in the local health and care system which could impede progress. In order to achieve this, the Health and Wellbeing Board will need to exercise its system leadership role and ensure that it is structured in a way which enables it to do so.
- Builds on the many examples of innovation and good practice that we saw. The asset based approach of working with communities was just one example of those.

7. Next steps

The Council's political leadership, senior management and members of the HWB will undoubtedly wish to reflect on these findings and suggestions before determining how the Council wishes to take things forward. As part of the Peer Challenge process, there is an offer of continued activity to support this. We made some suggestions about how this might be utilised. I look forward to finalising the detail of that activity as soon as possible.

In the meantime we are keen to continue the relationship we have formed with you and colleagues through the peer challenge to date. Howard Davis, Principal Adviser (West Midlands) is the main contact between your authority and the Local Government Association. Howard can be contacted at Howard.Davis@local.gov.uk (or telephone 07920 061197) and can provide access to our resources and any further support.

We are keen to work with you on producing a short article for publication around the approach used within Coventry as discussed at the feedback session between Howard Davis and Jane Moore, Director of Public Health. I will be in contact shortly to arrange this.

In the meantime, all of us connected with the peer challenge would like to wish the Council every success going forward. Once again, many thanks for inviting the peer challenge and to everyone involved for their participation.

Yours sincerely,

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