Health and Wellbeing Together
13 March 2024

Time 10.00 am **Public Meeting?** YES **Type of meeting** Oversight

Venue Committee Room 3 - 3rd Floor - Civic Centre

Membership

Councillor Jasbir Jaspal (Chair)	Cabinet Member for Adults and Wellbeing
Paul Tulley (Vice Chair)	Wolverhampton Managing Director, Black Country ICB
Professor Farzad Amirabdollahian	University of Wolverhampton
Councillor Chris Burden	Cabinet Member for Children and Young People
Stephanie Cartwright	Royal Wolverhampton Trust Representative
John Denley	Director of Public Health
Chief Superintendent Richard Fisher	Chief Superintendent, West Midlands Police and Independent Chair, W'ton Safeguarding Together
Marsha Foster	Chief Executive, Black Country Healthcare NHS Foundation Trust
Alison Hinds	Director of Children's Services
Lynsey Kelly	Head of Community Safety
Jenny Lewington	Deputy Director of City Housing
Stacey Lewis	Manager, Healthwatch Wolverhampton
Sharon Nanan-Sen	Wolverhampton Voluntary and Community Action
Samantha Samuels	Group Commander Operations North, West Midlands Fire Service
Councillor Stephen Simkins	Leader of the Council
Laura Thomas	VCSE Alliance
Siân Thomas	OneWolverhampton Representative
Councillor Wendy Thompson	Opposition Leader
Andrew Wolverson	Director of Adult Social Care (DASS)

Information for the Public

If you have any queries about this meeting, please contact the Democratic Services team:

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Agenda

Part 1 – items open to the press and public

Item No. *Title*

MEETING BUSINESS ITEMS - PART 1

1 **Apologies for absence**

2 **Notification of substitute members**

3 **Declarations of interest**

4 **Minutes of the previous meeting** (Pages 5 - 10)
[To approve the minutes of the previous meeting as a correct record.]

5 **Matters arising**
[To consider any matters arising from the minutes of the previous meeting.]

6 **Health and Wellbeing Together Forward Plan 2023 - 2024** (Pages 11 - 16)
[To receive the Health and Wellbeing Together Forward Plan 2023-2024.]

ITEMS FOR DISCUSSION OR DECISION- PART 2

7 **Health and Wellbeing Together Development Session: Summary and Recommendations** (Pages 17 - 28)
[To approve recommendations made following the Health and Wellbeing Together Development Session in September 2023.]

8 **Joint Strategic Needs Assessment - Refresh** (Pages 29 - 60)
[To receive and comment on the refreshed Joint Strategic Needs Assessment (JSNA).]

9 **Black Country ICS – Joint Forward Plan Refresh** (Pages 61 - 124)
[To receive the refreshed Black Country ICS Joint Forward Plan for comment and feedback.]

10 **City of Wolverhampton Suicide Prevention Strategy** (Pages 125 - 146)
[To approve the City of Wolverhampton Suicide Prevention Strategy.]

11 **Wolverhampton Serious Violence Needs Assessment Executive Summary 2024** (Pages 147 - 172)
[To receive the Wolverhampton Serious Violence Needs Assessment for information and discussion.]

12 **Wolverhampton Tobacco, Smoking and Vaping Addiction Partnership Position Statement** (Pages 173 - 180)
[To receive the Wolverhampton Tobacco, Smoking and Vaping Addiction Partnership Position Statement for assurance.]

13 **Other Urgent Business**

[To consider any items of business by reason of special circumstances (to be specified) that in the opinion of the Chair are matters of urgency.]

Agenda Item No: 4

Health and Wellbeing Together
Minutes - 7 December 2023

Attendance

Members of the Health and Wellbeing Together

Councillor Stephen Simkins (in the Chair)	Leader of the Council
Councillor Wendy Thompson (in the Chair)	Leader of the Opposition
John Denley	Director of Public Health
Chief Supt. Richard Fisher	West Midlands Police and Independent Chair of Wolverhampton Safeguarding Together
Michelle Garbett	Better Homes Board Representative
Alison Hinds	Director of Children's Services
Marsha Foster	Black Country Healthcare Partnership Foundation Trust
Stacey Lewis	Healthwatch Wolverhampton
Sharon Nanan-Sen	Wolverhampton Voluntary and Community Action
Samantha Samuels	West Midlands Fire Service
Sharon Sidhu	Black Country Integrated Care Board
Laura Thomas	VCSE Alliance
Siân Thomas	OneWolverhampton Representative
Becky Wilkinson	Director of Adult Services

In Attendance

Andrea Fieldhouse	Principal Public Health Specialist
Madeleine Freewood	Public Health Partnership and Governance Lead
Shelley Humphries	Democratic Services Officer
Tapiwa Mtemachani	Black Country Integrated Care Board
Hettie Pigott	Senior Public Health Specialist
Cllr Susan Roberts	Chair of Health Scrutiny Panel

Part 1 – items open to the press and public

Item No. *Title*

1 **Apologies for absence**
The meeting was opened by the Clerk in order to vote in a Chair as the Chair and Vice Chair had submitted apologies. Following nominations, it was moved to elect the Leader of the Council to Chair the meeting on this occasion.

Apologies were received from Councillor Jasbir Jaspal, Paul Tulley, Jenny Lewington, Professor David Loughton CBE and Professor Farzad Amirabdollahian.

Resolved:
That the Leader of the Council take the Chair for this meeting.

2 **Notification of substitute members**
Michelle Garbett attended for Jenny Lewington and Sharon Sidhu represented the Black Country ICB for Paul Tulley.

3 **Declarations of interest**
There were no declarations of interest made.

4 **Minutes of the previous meeting**
Resolved:
That the minutes of the meeting of 13 September 2023 be approved as a correct record and signed by the Chair.

5 **Matters arising**
There were no matters arising from the minutes of the previous meeting.

6 **Health and Wellbeing Together Forward Plan 2023 - 2024**
Madeleine Freewood, Public Health Partnership and Governance Lead presented the Health and Wellbeing Together Forward Plan 2023 - 2024 and outlined future agenda items.

The Chair raised a query around sustainable funding and ways to pool resources in order to deliver more as a partnership going forward. It was agreed to raise as a discussion at a future meeting of Health and Wellbeing Executive.

Members were invited to suggest items for presentation at future meetings by contacting either the Chair, Madeleine Freewood or Democratic Services.

Resolved:
1. That the items on the Health and Wellbeing Together Forward Plan 2023 - 2024 be noted.
2. To hold a discussion at a future Health and Wellbeing Executive group meeting in relation to sustainable funding.

7 **Director of Public Health Annual Report 2023: The Power of Partnership**
John Denley, Director of Public Health presented the Director of Public Health Annual Report 2023: The Power of Partnership for approval and highlighted key points. The report is the professional statement about the health and wellbeing of

their local communities and aimed to inform professionals, Councillors, members of the public and other stakeholders about key activity being undertaken in partnership to realise our Public Health 2030 Vision that residents live longer, healthier and more active lives.

Siân Thomas, One Wolverhampton Representative delivered a supporting presentation to provide an overview of One Wolverhampton and how it worked with Health and Wellbeing Together to support and work towards joint priorities.

A short video was screened which featured Tim Lorimer of the Walking Hockey and Chat Group giving an overview of the Walking Hockey initiative which provided an opportunity for social interaction and for residents to take part in low-impact exercise suitable for all abilities. This also incorporated a social media chat group between sessions to keep in touch outside of sessions and look out for each other's wellbeing.

It was confirmed that paper copies of the Annual Report would be distributed in places accessible by residents and the general community for those who didn't have online access.

A concern was raised around data sharing between partners, how far the records went back and the quality of the data and it was deliberated how this process could be improved to make patients' experiences easier.

A concern was raised around early healthcare interventions and how to ensure timely screening in order to get better outcomes for patients.

It was noted it was positive to see the progression of Love Your Community through both Safer Wolverhampton Partnership and Health and Wellbeing Together and added that it encompassed residents not only being happy where they lived but an informed awareness about how they can interact with or make a difference in their community.

Thanks were extended to John Denley, Director of Public Health and the Public Health team, Madeleine Freewood, Public Health Partnership and Governance Lead and all partner organisations involved for contributions to development of the Director of Public Health Annual Report and associated work. It was acknowledged that building and maintaining partnerships continued to be key.

Resolved:

That Health and Wellbeing Together approve the publication of the Director of Public Health Annual Report for 2023.

8 **Wolverhampton Physical Activity Strategy**

At this point Councillor Wendy Thompson, Opposition Leader took the Chair.

Hettie Pigott, Senior Public Health Specialist and Andrea Fieldhouse, Principal Public Health Specialist jointly presented the Wolverhampton Physical Activity Strategy for approval and highlighted salient points.

The report set out strategic direction for physical activity until 2030 and an overview was provided of the work going on throughout the City to enable and encourage residents to become more active.

In response to a query around opening up the use of sports facilities in local schools to the general public, it was noted that this was an option that was currently being explored with Sports England and schools.

Resolved:

That Health and Wellbeing Together approve the Health and Wellbeing Together Wolverhampton Physical Activity Strategy.

9 **NHS Black Country Joint Forward Plan**

Sharon Sidhu, Black Country ICB presented the NHS Black Country Joint Forward Plan and highlighted key areas of interest. It was noted that purpose was to provide assurance that the strategic plan for the NHS is aligned with and will support delivery of the priorities set out for Wolverhampton in our Health and Wellbeing Strategy.

It was queried how Health and Wellbeing Together Board could work together with the ICB to make sure local priorities are reflected in future versions. It was noted that Paul Tulley, Black Country ICB was involved in many of the discussions in relation to the Joint Forward Plan and was a strong link as Vice Chair of Health and Wellbeing Together, ensuring feedback from both sides.

Councillor Susan Roberts, Chair of Health Scrutiny Board raised a concern around challenges with pharmacies fulfilling prescriptions and, as it was noted that pharmacies and primary care now fell under the Black Country ICB remit, it was agreed to take this feedback and investigate the matter further.

Resolved:

1. That Health and Wellbeing Together receive the NHS Black Country Joint Forward Plan for information and assurance.
2. That the concern raised around pharmacy operation be investigated by Black Country ICB.

10 **Integrated Care Partnership (ICP) Update**

Tapiwa Mtemachani, Director of Transformation and Partnership – Black Country Integrated Care Board presented the Integrated Care Partnership (ICP) Update report and highlighted key points. The report set out the context and purpose of the Integrated Care Partnership (ICP) along with its state of development within the Black Country Integrated Care System. The Health and Wellbeing Board was asked to note the report for assurance and to consider the implications of the developing arrangements.

The report also outlined the progress of governance arrangements, its relationship with health and wellbeing boards and that a Terms of Reference for the ICP committee was currently awaiting formal approval at its next meeting on 19 December 2023. An Integrated Care Strategy had been developed and signed off by the four participating local authorities and was now available to view on a dedicated ICS website.

A query was raised around funding for health inequalities in the voluntary sector that was no longer available due to funding constraints as well as how priorities would be managed. It was noted that guidance stipulated that the strategy would inform development of any forward planning by the local authority or the ICB to ensure alignment of priorities and delivery. In terms of funding, the challenges were

acknowledged and it was noted that it would be necessary to explore means of making funding go further by best use of existing resources.

The update and the progress on the strategy was welcomed, particularly the interactions with Scrutiny committees which may provide useful feedback links.

Resolved:

That Health and Wellbeing Together receive the update on progress around the development of the Black Country Integrated Care Partnership.

11 **Other Urgent Business**

The Chair announced that, following a rigorous application process to the Office of Health Improvement and Disparities, Health and Wellbeing Together had been successful in becoming a signatory to the Prevention Concordat for Better Mental Health which the Chair noted was an increasingly important area of focus.

In their feedback, the panel commented that they were impressed by the breadth of needs assessment available and the significant level of buy-in from the Board into the concordat process. It was noted that the action plan was currently in development and agreed that the Board would have a future update regarding this.

Resolved:

That an update on the Concordat for Better Mental Health Action Plan be shared at a future meeting of Health and Wellbeing Together.

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[This report is PUBLIC –
NOT PROTECTIVELY MARKED.]

Agenda Item No: 6

Health and Wellbeing Together
13 March 2024

Report title	Health and Wellbeing Together Forward Plan 2023 - 2024	
Cabinet member with lead responsibility	Councillor Jasbir Jaspal Adults and Wellbeing	
Wards affected	All wards	
Accountable director	John Denley, Director of Public Health	
Originating service	Governance	
Accountable employee	Shelley Humphries Tel Email	Democratic Services Officer 01902 554070 shelley.humphries@wolverhampton.gov.uk

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Recommendation for noting:

Health and Wellbeing Together is recommended to note:

1. The items on the Health and Wellbeing Together Forward Plan 2023 – 2024.

1.0 Purpose

1.1 To present the Forward Plan to Health and Wellbeing Together for comment and discussion in order to jointly plan and prioritise future agenda items for the Executive Group and Full Board.

1.2 The Forward Plan will be a dynamic document and continually presented in order to support a key aim of the Health and Wellbeing Together Full Board and Executive Group – to promote integration and partnership working between the National Health Service (NHS), social care, public health and other commissioning organisations.

2.0 Background

2.1 As agreed at the meeting of the Full Board in October 2016, the attached Forward Plan document seeks to enable a fluid, rolling programme of item for partners to manage.

3.0 Financial implications

3.1 There are no direct financial implications arising from this report.

4.0 Legal implications

4.1 There are no direct legal implications arising from this report.

5.0 Equalities implications

5.1 None arising directly from this report.

6.0 All other implications

Health and Wellbeing implications

6.1 The health and wellbeing implications of each matter will be detailed in each individual report submitted to the Group.

7.0 Schedule of background papers

7.1 Minutes of previous meetings of the Health and Wellbeing Together Full Board and Executive Group regarding the forward planning of agenda items.

7.2 Agenda Item Request Forms.

Health and Wellbeing Together: Forward Plan

Last updated: Jan 2024

Health and Wellbeing Together is comprised of a Full Board and an Executive group.

Full Board meetings are structured to shift focus from service silos to system outcomes by adopting a thematic approach to addressing the priorities identified in the Joint Health and Wellbeing Strategy. The primary focus of the Executive group is to sign off statutory documents and provide a strategic forum for the Council and health partners to drive health and social care integration.

KEY

Items in red are new or amended from the previous version.

Items in **bold** are regular or standing items.

[E] Executive

[FB] Full Board meeting

Date	Title	Partner Org/Author	Format	Notes/Comments
FB: 13 March 2024	Development Day Feedback	Madeleine Freewood, CWC	Report	
	Wolverhampton Culturally Responsive Joint Strategic Needs Assessment	Parmdip Dhillon, CWC and Dr João Martins, CWC	Briefing Note Document	
	NHS Black Country Joint Forward Plan	Paul Tulley, Black Country ICB	Report	
	Suicide Prevention Strategy	Parpinder Singh and Ranjit Khular, CWC and Clare Dickens MBE Chair of Wolverhampton Suicide Prevention Stakeholders' Forum	Strategy	
	Serious Violence Needs Assessment	Hannah Pawley, CWC	Document	For Discussion and Feedback
	Wolverhampton Tobacco, Smoking and Vaping Addiction Partnership	Parmdip Dhillon, CWC	Position Statement	
E: 22 April 2024	One Wolverhampton Update	Siân Thomas, One Wolverhampton, Stephanie Cartwright and Paul Tulley (in their capacity as One Wolverhampton members)	Report	Standing Item
	Update on Mental Health Services in the Black Country	Marsha Foster, Black Country Healthcare NHS Foundation Trust	Verbal Update	Standing Item
	Housing Strategy Update	Michelle Garbett / Jenny Lewington, CWC	Update	

Date	Title	Partner Org/Author	Format	Notes/Comments
	Pharmaceutical Needs Assessment (PNA) Supplementary Statement	Parmdip Dhillon, CWC Hannah Stammers, CWC	Presentation	
	West Midlands Combined Authority (WMCA) Wellbeing Board Update	Madeleine Freewood, CWC	Verbal Update	Standing Item
To be scheduled	Joint Public Mental Health and Wellbeing Framework	Dr Jamie Annakin, CWC	Report	
	Housing Strategy	Michelle Garbett / Jenny Lewington, CWC		Deferred from 7 December 2023 – Scheduled for Full Board - June 2024
	Domestic Abuse Strategy	Clare Reardon, CWC	Stakeholder Engagement	

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Agenda Item No: 7

Health and Wellbeing Together
13 March 2024

Report title	Health and Wellbeing Together Development Session: Summary and Recommendations
Cabinet member with lead responsibility	Councillor Jasbir Jaspal Adults and Wellbeing
Wards affected	All wards
Accountable director	John Denley, Director of Public Health
Originating service	Public Health
Accountable employee	Madeleine Freewood — Partnership and Governance Lead Email madeleine.freewood@wolverhampton.gov.uk
Report has been considered by	Health and Wellbeing Together Executive — 29 January 2024

Recommendation for decision:

Health and Wellbeing Together is recommended to:

1. Endorse the Health and Wellbeing Together Development Session recommendations as set out in 3.1.

1.0 Purpose

1.1 Wolverhampton's Health and Wellbeing Board, known locally as Health and Wellbeing Together (HWBT), held an externally facilitated board development session on 13 September 2023. HWBT is asked to receive the discussion findings and endorse the recommendations for future action.

2.0 Background

2.1 The Health and Social Care Act 2012 gave Health and Wellbeing Boards a range of statutory powers, including the duty to agree and publish a Joint Strategic Needs Assessment (JSNA) and Joint Local Health and Wellbeing Strategy (JLHWS). These statutory duties have not changed following the introduction of the Health and Care Act 2022, which established Integrated Care Systems with their own statutory responsibilities.

2.2 Wolverhampton's Health and Wellbeing Board, known locally as Health and Wellbeing Together (HWBT), has recently updated its JSNA and JLHWS to reflect the changes to the health and social care landscape. An externally facilitated board development session took place on 13 September 2023 to:

a. Develop how the board works, maximising contributions and impact.

b. Facilitate a clear understanding of the board's role, sharing perspectives and ideas.

c. Enable strong and effective working relationships.

3.0 Recommendations

3.1 Appendix 1 presents the thematic discussion points captured during the development session and concludes with the following recommendations for the Board to endorse:

1. Board delivery plan: to develop and implement a board delivery plan to drive the JLHWS, monitoring and evidencing impact and capitalising on the role of OneWolverhampton as primary delivery vehicle. It is proposed that the plan will inform future agenda items and be kept under annual review, supported by thematic highlight reporting.

2. Spotlights: to extend board meetings to 2/ ½ hours to allow time for thematic 'what's new in the JSNA' spotlights to be added to the agenda as a standing item. This is to support the board in its role to identify the current and future health and care needs of the local population and build a robust evidence base of local needs and local assets.

3. Community voice: utilise the OneWolverhampton Health Inequalities Transformation Group to explore how community voice and lived experience insights can be better utilised to inform board discussion and associated decision making.

4. Governance and leadership: keep the board's terms of reference under review as part of ongoing work to clarify and strengthen wider governance relationships, including review of the Children and Families Together Board.

4.0 Financial implications

4.1 There are no direct financial implications as funding for activity will be met from existing budgets.
[JM/01032024/H]

5.0 Legal implications

5.1 Health and Wellbeing Boards have a duty to publish and implement at Joint Local Health and Wellbeing Strategy (JLHWS) for their locality in line with the Health and Social Care Act 2012 and subsequent national guidance. The report recommendations will support implementation of Wolverhampton's JLHWS for 2023-2028.
[TC/28022024/A]

6.0 Equalities implications

6.1 The Board has adopted a set of guiding principles to support a joined-up approach to tackling health inequalities. The report recommendations will support partnership activity to address health inequalities in Wolverhampton.

7.0 Health and Wellbeing

7.1 Health and Wellbeing Together is the forum where key leaders from the health and care system come together to improve the health and wellbeing of the local community, work towards reducing health inequalities and support the development of improved and joined up health and social care services. The paper sets out recommendations to support the board in carrying out its key functions and evidence impact.

8.0 Appendices

8.1 Appendix 1: Health and Wellbeing Together Development Session: 13 September 2023. Summary and recommendations.

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Appendix 1

Health and Wellbeing Together Development Session: 13 September 2023

Summary and recommendations

Context

The Health and Social Care Act 2012 gave Health and Wellbeing Boards a range of statutory powers, including the duty to agree and publish a Joint Strategic Needs Assessment (JSNA)[1] and Joint Local Health and Wellbeing Strategy[2] (JLHWS). These statutory duties have not changed following the introduction of the Health and Care Act 2022, which established Integrated Care Systems with their own statutory responsibilities.

Session aims

Wolverhampton's Health and Wellbeing Board, known locally as Health and Wellbeing Together (HWBT), has recently updated its JSNA and JLHWS to reflect changes to the health and social care landscape. An externally facilitated board development session took place on 13 September 2023 to:

- Develop how the board works, maximising contributions and impact
- Facilitate a clear understanding of the board's role, sharing perspectives and ideas
- Enable strong and effective working relationships

Approach

The session facilitator used the following approach to achieve the session aims:

- Assessing how the board works against its agreed principles[3]
- Reviewing what board members have learned about how system, culture and delivery behaviours work
- Applying this learning - 'what if' …
- Identifying key actions and next steps

Thematic discussion findings: key actions and next steps

Thematic discussion points were captured during the session, these are presented as a series of key actions for the board to take forward.

❖ **Leadership**

- Capitalise on the board relationship with OneWolverhampton, including progression of shared place outcomes.[4]
- Review the board relationship with the Children and Families Together Board – ensuring prominence of the children's agenda in HWBT.
- Maximise the board's governance relationship with the CWC Health Scrutiny Panel to achieve the best outcomes for local people.
- Maximise the board's governance relationships with the Black Country Integrated Care Partnership to ensure appropriate synergy with regional priorities.
- Explore how the board can better facilitate discussion time and partnership collaboration.
- Demonstrate impact more effectively clearly illustrating how priorities are translated into practical action.

[1] https://insight.wolverhampton.gov.uk/
[2] http://wellbeingwolves.co.uk/pdf/Wolverhampton-Joint-Local-Health-and-Wellbeing-Strategy-2023-2028-Final.pdf
[3] http://wellbeingwolves.co.uk/role-of-the-board.html
[4] https://www.gov.uk/government/publications/shared-outcomes-toolkit-for-integrated-care-systems/shared-outcomes-toolkit-for-integrated-care-systems

- Explore the role of the HWBT to influence and lobby the wider system – regionally and nationally.

❖ **Integrated working and partnership**

- Build on and learn from local examples where integration/ partnership practice has already worked well e.g., Covid-19 response, Better Health Rewards etc.
- Explore how the board can continue to increase a focus towards prevention and maximise independence, including supporting people in the community.
- Work in stronger and deeper ways with the voluntary sector, maximising these relationships.
- Explore more opportunities for deeper join-up of funding streams and joint funding of activity.
- Identify new opportunities for co-commissioned services e.g., drugs and alcohol.
- Add value to system workforce priorities to make the Black Country a place where people want to work.

❖ **Place-based approach**

- Maximise use of the JSNA to support "wicked issue" conversations, identify gaps and areas of strategic focus.
- Explore how partners can work together to share the data they hold more effectively to better inform decision making, e.g. data sharing agreements; shared care records, drive action to narrow health inequalities.
- Continue to strengthen relationships with other city boards and partnerships, e.g., Safer Wolverhampton Partnership, Drug and Alcohol Partnership etc.
- Maximise linkage with the wider 'Lifestyle' offer, including a focus on building a coalition to create healthy and more active environments e.g., schools, businesses, licensing, care homes etc.
- Explore how we can give better visibility to the Better Care Fund in board meetings.

❖ **Involving local people in decision making, community and coproduction opportunities**

- Develop a shared and consistent approach to engagement and co-production, learning from existing best practice, including a shared approach across HWBT and OneWolverhampton.
- Identify opportunities for the JSNA to make more and better use of lived experience and be culturally responsive.
- Identify how we can better demonstrate that we have listened, acted and the impact.

❖ **Health inequalities**

- Focus on equity of opportunities, including access to services through partnership action.
- Build a better understanding of the impact of current thresholds of care – what are the gaps? Are these being filled?
- Use the JSNA to better understand the demographic make-up of our city and meet the needs of specific groups of interest e.g., carers.

❖ **Courage, conviction and innovation**

- Make best use of the statutory role of the board and all partners around the table to enable 'leap of faith' decisions that can't be achieved by a single organisation.
- Understand individual organisational risk appetite - working within this but also identifying where it can be challenged through a shared partnership risk.

Recommendations

1. **Board delivery plan**: to develop and implement a board delivery plan to drive the JLHWS, monitoring and evidencing impact and capitalising on the role of OneWolverhampton as primary delivery vehicle. It is proposed that the plan will inform future agenda items and be kept under annual review, supported by thematic highlight reporting.

2. **Spotlights**: to extend board meetings to 2/ ½ hours to allow time for thematic 'what's new in the JSNA' spotlights to be added to the agenda as a standing item. This is to support the board in its role to identify the current and future health and care needs of the local population and build a robust evidence base of local needs and local assets.

3. **Community voice**: utilise the OneWolverhampton Health Inequalities Transformation Group to explore how community voice and lived experience insights can be better utilised to inform board discussion and associated decision making.

4. **Governance and leadership:** keep the board's terms of reference under review as part of ongoing work to clarify and strengthen wider governance relationships, including review of the Children and Families Together Board.

Health and Wellbeing Together Delivery Plan 2023-2028 (draft)

Health and Wellbeing Together is the forum where key leaders from the health and care system come together to improve the health and wellbeing of the local community, work towards reducing health inequalities and support the development of improved and joined up health and social care services. It is the name given to the City of Wolverhampton Health and Wellbeing Board, a statutory Board established under the Health and Social Care Act 2012.The Health and Care Act 2022 did not change the statutory duties of Health and Wellbeing Boards.

Role:

- Provide a strong focus on establishing a sense of place
- Instil a mechanism for joint working and improving the wellbeing of our local population
- Set strategic direction to improve health and wellbeing

Statutory functions:

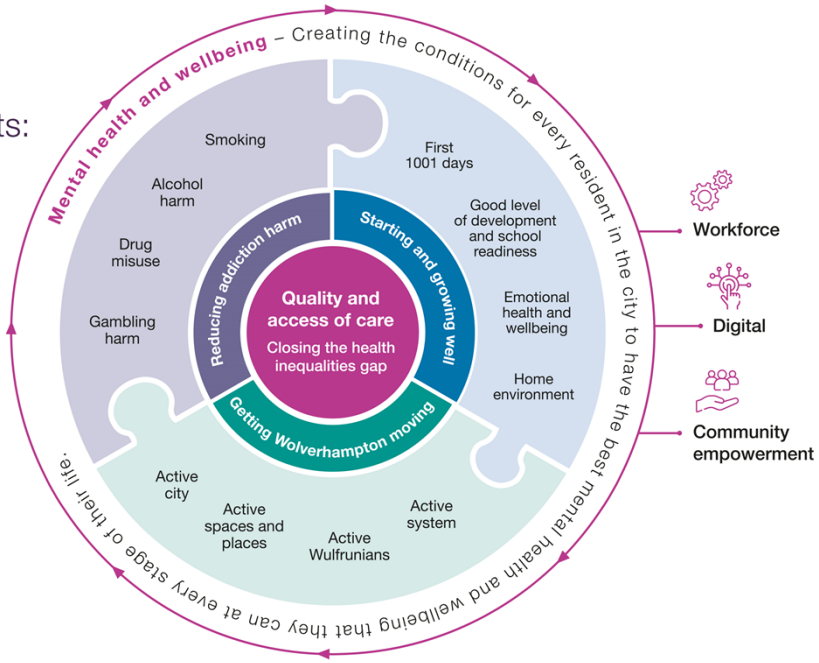
- Assess, recommend and advise on the health and wellbeing needs of the population through a published joint strategic needs assessment (JSNA), utilising a shared approach at place to turning data into actionable intelligence.
- Publish a Joint Local Health and Wellbeing Strategy (JLHWS), which sets out the priorities for improving the health and wellbeing of the local population and how identified needs in the JSNA and other needs assessments will be addressed, including reducing health inequalities.
- Ensure the JLHWS directly informs the development of joint commissioning arrangements (Section 75 of the NHS Act 2006) in place and the co-ordination of NHS and local authority commissioning, including Better Care Fund plans.
- Prepare a Pharmaceutical Needs Assessment (PNA) to ensure pharmaceutical services in Wolverhampton meet local needs.

Other responsibilities:

- Coordinate and lead action at place level working effectively with the OneWolverhampton place-based partnership, with OneWolverhampton acting as a delivery vehicle for driving forward shared priorities.
- Have strategic oversight of the Public Mental Health Framework and Suicide Prevention Strategy for Wolverhampton and actively support the Better Mental Health Concordat.
- Work collaboratively and iteratively with the Integrated Care Partnership, including being an active participant in the development of the Black Country Integrated Care Strategy and taking this into account when preparing local health and wellbeing strategies.
- Receive and feedback on all relevant documentation from the Black Country Integrated Care Board, for example the rolling five-year joint forward plan and annual report, ensuring proper account is taken of Wolverhampton's JLHWS.
- Receive the Black Country Integrated Care Board and partner NHS trusts joint capital resource use plan and any revisions for comment.
- Ensure the work of board is aligned with policy developments and strategic aims locally, regionally and nationally, including the Black Country Integrated Care System.

Health and Wellbeing Together Delivery Plan 2023-2028

Where we will focus our efforts: priorities on a page



Statutory responsibility	Activity	Outcome
We will oversee the development of the JSNA work programme for 2023-2028 ***Reporting Group:*** *Public Health with key stakeholders and relevant partnership groups to take forward recommendations and report progress back to HWBT* ***Senior Lead:*** *John Denley DPH (CWC).*	• Continued promotion of the JSNA to inform decision making. • Development of interactive dashboards to interrogate JSNA information. • Publication and dissemination of a core set of needs assessment to progress ongoing work in JLHWS priority areas. • Identify opportunities for the JSNA to make more and better use of lived experience/ community voice. • Development and implementation of an equalities responsive JSNA framework.	• More JSNA outputs are used in decision making related to population health including defining shared priorities and contributing to shared outcomes. • Approach to development of an equalities responsive JSNA fully embedded.
We will support and develop integrated commissioning intentions, including overseeing operational commissioning activity and managing pooled budgets established under Section 75 arrangement ***Reporting Group:*** *Wolverhampton Integrated Commissioning Committee* ***Senior Leads:*** *Andrew Wolverson DASS (CWC);* *Paul Tulley Wolverhampton Managing Director (ICB)*	• Development and delivery of Better Care Fund 2023-2028 • Increase opportunities for better and deeper joining up of funding streams and joint funding of activity.	• Joint activity through the Better Care Fund to support more people to live independently at home for longer; and receive the right care in the right place at the right time. • Increase in jointly commissioned activity and minimising the use of short-term funding allocations. • Evidence of strengthened partnership activity.

We will maintain strategic oversight of the Pharmaceutical Needs Assessment ***Reporting Group**: Public Health* ***Senior Lead**: Parmdip Dhillon, Principal Public Health Specialist (CWC)*	• Rolling PNA production.	• Publication of a current PNA to deadline, with strategic oversight maintained by Public Health, including recording and assessing any updates.
Overarching	**Activity**	**Outcome**
Public Mental Health and wellbeing, including suicide prevention ***Reporting Group:** Public Health in collaboration with OneWolverhampton Adult Mental Health Strategic Working Group* ***Senior Lead**: Jamie Annakin, Principal Public Health Specialist (CWC)* **Suicide Prevention** ***Reporting Group:** Public Health in collaboration with OneWolverhampton Adult Mental Health Strategic Working Group* ***Senior Lead**: Parpinder Singh, Principal Public Health Specialist (CWC)*	• Successful application to OHID for the board to become signatories of the Prevention Concordat for Better Mental Health. • Development and implementation of a new mental health and wellbeing framework, aligned to the Prevention Concordat. • Build on the 2023 Mental Health strategic needs assessment to work in partnership to challenge mental health stigma and take action to reduce health inequalities. • Receive and maintain strategic oversight of the updated Suicide Prevention Strategy.	• Enhanced system leadership role in preventing mental health problems and improving mental health and wellbeing. • Improved physical health of people with severe mental illness, including improving uptake and outcomes from the annual severe mental illness physical health check. • Reduced mental health stigma via awareness raising campaigns, resources and training. • Increased universal opportunities for improved social contact. • Increased targeted opportunities for improving social contact for people using adult social care services and carers. • Evidence of in-depth understanding of mental health inequalities and actions required to address. • Mental health awareness integrated into physical health services to support healthy ageing. • Rolling Suicide Prevention Strategy action plan aligned to each of the 4 domains of the strategy.
Health Inequalities ***Reporting Group:** OneWolverhampton Health Inequalities Transformation Group* ***Senior Lead:** Heidi Burn, Health Inequalities Lead (OneWolverhampton)*	• Development of a local PCN health inequalities network. • Utilisation of the JSNA to develop a baseline position. • Seek out lived experience allowing for a better understanding of what the data shows and contributing factors. • Identify priority areas from the Place JSNA, ICB data, JLHWS and the Core 20Plus to inform strategic action and contribute to the development of shared place outcomes, collectively identifying any gaps or opportunities for further alignment. • Develop a Health Inequalities Champion program based on the Core20Plus strategy for operational staff and link to existing Quality Improvement. • Build on engagement and partnership working with communities and ensure continuation of sense checking data with communities.	• Evidence of an increased awareness and coordinated place-based activity to address Health Inequalities. • Robust and equitable allocation of ICB place Health Inequalities funding aligned to delivery against place priorities. • Increased use of Health Equity Assessment Tool across the system. • Increased use of JSNA to inform evidence-based decision making. • Increased engagement across OneWolverhampton Strategic Working Groups and wider place groups.

JLHWS Focus	Priority area for action	Outcome
Starting and growing well **Reporting Group**: Children and Families Together Board **Senior Lead:** Alison Hinds, DCS (CWC) ***Contributing Group**: OneWolverhampton CYP Strategic Working Group* ***Senior Lead**: Bal Kaur, Consultant in Public Health (CWC)*	First 1001 days, including support for parents, and maternal mental and physical health	• Improved timely access to quality antenatal and maternity care. • Reducing tobacco, alcohol and substance misuse. • Increased physical and mental health during pregnancy • Maintain current position health visitor new birth and 6-8 week visits. • Improved uptake of breast feeding. • Improved children's oral health and access to dental services. • Return to pre-pandemic childhood vaccination rates. • Improved perinatal mental health supporting Family Hubs programme. • Embed 'Five to Thrive' approach.
	Emotional health and wellbeing	• Complete and implement emotional health needs assessment findings. • Embed 'i-thrive' model. • Improved pathways for children, young people and families to access mental health support and increase uptake of services at earliest point. • Improved transition between children and adult's mental health services.
	Good level of development and school readiness	• Maintain above average position 2-2½ year developmental reviews. • Improved speech, language and communication measures. • Increased awareness and access to free childcare.
	Home environment	• Reduced number of families entering temporary accommodation. • Increased number of families living in temporary accommodation entering secure housing. • Increased benefit maximisation. • Improved housing conditions – damp and mould. • Increased identification of domestic abuse in families at earliest point and increased uptake of specialist support.
JLHWS Focus	**Priority area for action**	**Outcome**
Reducing addiction harm ***Reporting Group:** Drug and Alcohol Partnership* ***Reporting Group**: Local multi-disciplinary Gambling Harm Strategic Partnership Group* ***Senior Lead:** John Denley DPH (CWC)*	Smoking	• Increasing provision and types of intervention – smoking cessation • Increased training primary care staff. • More people from target groups (young people, pregnant mothers, people with mental health difficulties) stopping smoking. • Limiting access tobacco through regulation.
	Alcohol harm	• Reduced number of alcohol specific deaths in the city. • Increased number and types of interventions available. • Increased number of treatment places. • Reduced number of licensed premises per km in city.

		• Identify more people at risk – not currently engagement in any form of treatment. • Increased in number of people gaining employment whilst in treatment. • Improved east of access to high quality support for people with co-existing misuse and mental health problems.
	Drug misuse	• Reduced number of drug related deaths in the city. • Increased number of people accessing in-patient detox and residential rehabilitation. • Increased engagement with individuals leaving prison with a treatment need. • Increased provision of nasal naloxone across frontline services. • Identify more people at risk – not currently engagement in any form of treatment. • Increased number of people gaining employment whilst in treatment. • Improved ease of access to high quality support for people with co-existing misuse and mental health problems.
	Gambling harm	• Improved understanding of prevalence of gambling related harm in the city. • Increased number and types of interventions and treatment services available. • Improved education for professionals – including schools, re gambling harm. • Successful review of License Conditions and Code of Practice
JLHWS Focus	**Priority area for action**	**Outcome**
Getting Wolverhampton moving more ***Reporting Group:*** *Physical Inactivity Steering Group* ***Senior Lead:*** *Michael Salmon from Active Black Country*	Active system	• Implementation of the Wolverhampton Physical Activity Strategy • Increased percentage of health referrals for physical activity.
	Active Wulfrunians	• Increased understanding of barriers to moving more – through work with residents and stakeholders • Test, apply and evaluation of behavioural change approaches.
	Active spaces and places	• Increased amount of investment into physical activity in the city. • Increased number of WVActive members, including percentage from under-represented groups. • Increased access to leisure activities for children and young people. • Increase use of parks and open spaces.
	Active city	• Increased percentage of adults walking and cycling a week. • Increase participation community groups and clubs. • Reduced percentage of less active children and young people. • Reduced percentage of physically inactive adults, including older adults

Briefing Note

CITY OF WOLVERHAMPTON COUNCIL

Title: Joint Strategic Needs Assessment - Refresh **Date: 27 February 2024**

Prepared by: Parmdip Dhillon **Job Title: Principal Public Health Specialist**

Intended Audience: Internal ☐ Partner organisation ☒ Public ☐ Confidential ☐

Purpose

To introduce the new, refreshed Joint Strategic Needs Assessment webpage, dashboard and compendium of topic specific needs assessments. To outline the future plans for continuous development of the JSNA, including wider partner involvement. To encourage utilisation of the JSNA and invite partner input into the development of the JSNA.

Background

A Joint Strategic Needs Assessments (JSNA) is a high-level assessment of the "current and future health and social care needs of the local community", which could be met by the local authority or NHS commissioning bodies. JSNAs were introduced in 2007 as a statutory duty to be met by local authorities and primary care trusts (PCT's). The Health and Social Care Act 2012 transferred the responsibility for developing and overseeing the implementation of JSNAs to local Health and Wellbeing Boards (HWB's).

The role of JSNAs is to provide HWB's with data on the health and social care needs of the local population. This enables partners to set intelligence-based priorities to improve health outcomes and reduce health inequalities and helps inform the local Joint Health and Wellbeing Strategy (JHWS) to achieve those objectives.

JSNA's collate data from multiple sources, including routine collection (e.g. Census, annual surveys), services (e.g. NHS, schools), and community engagement (e.g. community consultations, focus groups), and can be complemented by topic specific needs assessments. A topic specific needs assessment is an in-depth analysis of a particular health and wellbeing determinant or population group which helps understand a particular need or problem in more detail and informs the commissioning of services.

Local Actions

Wolverhampton's refreshed Joint Strategic Needs Assessment (JSNA) is formed of two key elements:

- Overview Dashboard – Provides a broad overview of key Health and Wellbeing factors in Wolverhampton and how they compare to comparator areas.
- Topic Specific Needs Assessments – Provide an in depth exploration of the needs and inequalities within a certain topic, taking into account the quantitative, qualitative and academic evidence.

The JSNA webpage is currently hosted on the WVInsight website, which can be accessed at https://insight.wolverhampton.gov.uk/ and the JSNA can be accessed via the JSNA tab on the top-right of the screen. At the time of writing the JSNA webpages were on schedule to be made accessible to the public following the Health and Wellbeing Together meeting on the 13th March 2024.

The plan for the JSNA is for to be a 'live document' that will be in a state of continuous development. This will aim to ensure that the JSNA changes as the Health and Wellbeing landscape changes and remains fit for use. The JSNA will go through a quarterly review process, in which the indicators available on the Overview Dashboard will be reviewed to ensure that they are the most appropriate to assess health inequalities in the City and newly available indicators will be added. The compendium of topic specific needs assessments will also be reviewed at this stage to ensure the latest topic specific needs assessments are available. We will also look to add new components to the JSNA over time to work towards making the package more culturally responsive.

However, to develop a culturally responsive JSNA, we require support from a wide range of partners across the Health and Wellbeing landscape in Wolverhampton. We would require access to more granular data and intelligence that can enable us to further highlight inequalities across the City. There needs to be further improvements in the way that data is recorded by services across the City, such as routine recording of protected characteristics, which would further enable the assessment of inequalities in the population. We are keen for there to be a collective ownership of the Joint Strategic Needs Assessment from partners across the Health and Wellbeing Together board, to further develop joint working and support it to becoming more culturally responsive.

Recommendations

That Health and Wellbeing Together agree to the following:

- To recognise the refreshed Joint Strategic Needs Assessment and encourage it's use across the Health and Wellbeing landscape in Wolverhampton.
- For partners across the Health and Wellbeing Together board to engage with City of Wolverhampton Council in the continuous development of the Joint Strategic Needs Assessment, with a view to further developing it into a culturally responsive JSNA.
- To further raise awareness of the refreshed Joint Strategic Needs Assessment, could partner organisations invite Public Health colleagues to relevant strategic meetings over the next three months, prior to the next review.

Wolverhampton Joint Strategic Needs Assessment

Culturally Responsive JSNA

Wolverhampton JSNA through a health equity lens

February 2024

Contents

Foreword

This report was written by Dr João Martins, Specialty Registrar in Public Health, between December 2023 and February 2024. It was conceived as a semi-independent review of the Wolverhampton JSNA at the request of Bal Kaur, Consultant in Public Health. It will complement and inform the on-going revamp of the Wolverhampton JSNA being undertaken by the Public Health and Data Analytics Team.

Background

A **Joint Strategic Needs Assessments (JSNA)** is a high-level assessment of the "current and future health and social care needs of the local community", which could be met by the local authority or NHS commissioning bodies. (1)

JSNAs were introduced in 2007 as a statutory duty to be met by local authorities and primary care trusts (PCTs). The Health and Social Care Act 2012 transferred the responsibility for developing and overseeing the implementation of JSNAs to local **Health and Wellbeing Boards (HWBs)**, statutory bodies formed by local authorities, local NHS commissioning bodies – initially clinical commissioning groups (CCGs) and, since 2022, integrated care boards (ICBs) – and other relevant health and care representatives. (1)

The role of JSNAs is to provide HWBs with data on the health and social care needs of the local population. This enables partners to set intelligence-based priorities to improve health outcomes and reduce health inequalities and helps inform the local **Joint Health and Wellbeing Strategy (JHWS)** to achieve those objectives.

JSNAs collate data from multiple sources, including routine collection (e.g., Census, annual surveys), services (e.g., NHS, schools), and community engagement (e.g., community consultations, focus groups), and can be complemented by **specific needs assessments**. A specific needs assessment is an in-depth analysis of either a particular health issue (health needs assessment, HNA) or population group (community profile) which helps understand a particular need or problem in more detail and informs the commissioning of ser vices.

Culturally responsive JSNAs

Following their introduction as a statutory duty in 2007, the Department of Health commissioned Shared Intelligence and Race for Health to explore the approaches used by JSNAs to understand 'race equality' and ethnic diversity, and to provide guidance to help local areas make them more culturally responsive. They started by selecting a purposive sample of twenty English JSNAs and reviewing JSNA-related documents (including supporting needs assessments), as well as other local strategy and decision documents. They then identified six areas based on good practice to develop in-depth case studies and convened an expert review group to discuss the initial findings and generate recommendations. Finally, an evidence review was conducted to complement the analysis. The final report – '**Culturally responsive JSNAs: a review of race equality and JSNA practice**' ('the report') – was published in 2010 by the Local Government Association (LGA). (2)

Language and remit

Some of the terminology used in the report was adapted to reflect changes in language since it was produced. For example, 'ethnic minority(ies)' was used instead of BAME or BME. (3) In addition, the concept of cultural responsiveness was expanded beyond ethnicity and race – **'equalities responsiveness'** – by including other equality characteristics (e.g., gender identity, disability, language) and replacing 'race equality' with **'health equity'**.

JSNA health equity framework

As part of the review, the researchers produced a 'JSNA race equality framework', here renamed **'JSNA health equity framework'** ('the framework'). It proposed 4 dimensions against which a JSNA can be reviewed to assess its cultural responsiveness:

- **Presentation of data** – whether the data is clear and comprehensive.
- **Analysis of need –** whether it goes beyond population profiles or a description of health and wellbeing.
- **Identification of action** – whether it identifies evidence-based actions on health equity to inform prioritisation and commissioning.
- **Process** – for each of the other dimensions, the degree to which the JSNA:
    - involved and engaged with community and stakeholders.
    - demonstrated leadership and ownership.
    - aligned and linked with other guiding plans and strategies.

The framework also proposed three levels of development – **developing**, **achieving**, or **excelling** – against which the first three dimensions can be evaluated. The framework was adapted to reflect a broader understanding of cultural responsiveness, extending it beyond ethnicity into other equality characteristics such as sex, religion, language spoken, migration status, gender identity, sexual orientation, and disability.

Presentation of data

This section examines how clearly presented and comprehensive the JSNA data is, as this constitutes the foundation for a coherent needs assessment.

Developing	Achieving	Excelling
Only core data: demographic data on ethnicity and other equality characteristics by age bands.	Core data + • Ethnicity and other equality characteristics across other core data points. • Ethnicity and other equality characteristics in service data. • Limited relevant local data. • Identifies data development. • Limited engagement data.	Core data + • Ethnicity and other equality characteristics across other core data points. • Ethnicity and other equality characteristics in service data. • Other relevant local data. • Identifies data development. • Equality mapping*. • Data, often qualitative, drawn from engagement (a thorough investigation and analysis conducted).

Table 1 – Presentation of data, JSNA health equity framework.
*(*compares within equality characteristics and across equity issues, such as socioeconomic disadvantage)*

Analysis of need

This section explores the degree to which JSNAs analyse their data to highlight significant needs, understand how these needs interact, and identify way to address them.

Developing	Achieving	Excelling
• Statement of consideration but not prioritisation or detail.	• Specific consideration of needs. • Equality proofing*. • Draws different data together to understand need (e.g., limited use of consultation).	• Specific consideration of needs that provides rationale for prioritisation. • Conveys distinction between absolute and relative health needs. • Equality proofing*. • Draws different data together to understand need (e.g., use of consultation). • Consideration of equality issues within relevant communities. • Identifies community strengths and assets.

Table 2 – Analysis of need, JSNA health equity framework.
*(*assessment of capacity of existing services to meet diverse population needs)*

Identification of action

This section considers the extent to which JSNAs identify evidence-based actions to meet the needs identified and address health equity.

Developing	Achieving	Excelling
• No action proposed relevant to health equity.	• Action on meeting needs within the relevant communities proposed. • Equality proofing*.	• Action on meeting needs within the relevant communities proposed. • Proposed action includes analysis of evidence of effectiveness. • Action towards influencing relative health outcomes (i.e., health equity). • Equality proofing*. • Goals for health equity expressed as tangible outcomes or specific change.

Table 3 – Analysis of need, JSNA health equity framework.
*(*general recommendations have an Equality Impact Assessment or include analysis of impact on different communities)*

Findings

Some findings identified by the review which may be relevant to this project are presented below:

- "**All JSNAs can be 'culturally responsive'** regardless of the demographic profile of the community they describe."
- **There isn't a "single definable approach** that produces the most culturally responsive JSNA."
- "Areas that had developed the **more culturally responsive JSNAs had worked with communities and stakeholders, aligned strategies** and **were leading purposefully**."
- "**In depth assessments**" – e.g., separate needs assessments for each relevant community or equality group – "**are not a precondition for culturally responsive JSNAs**, although they are helpful."

Recommendations

The report suggested five steps that local areas can implement to improve the cultural responsiveness of their JSNAs:

1. Review their existing JSNA documentation and JSNA process, and benchmark them against the report's proposed framework for culturally responsive JSNAs.
2. Examine good practice, including the six case studies provided in the report.
3. Bring together local health and other intelligence stakeholders to maximise the use of available data on culturally diverse communities.
4. Establish evaluation mechanisms for existing and planned JSNA processes.
5. Position improvements in culturally responsive practice within the overall context of improvements to JSNAs and organisational activity on equalities.

Wolverhampton JSNA

Local context

The HWB in Wolverhampton is called **Health and Wellbeing Together (HWBT)**. Beyond its statutory members – City of Wolverhampton Council and Black Country ICB –, HWBT's partner organisations include the OneWolverhampton partnership, the two local NHS Trusts (Royal Wolverhampton and Black Country Healthcare), the local Healthwatch branch and University, West Midlands Fire Service and Police, the Better Homes Board, and the voluntary sector. (4)

HWBT publish its JSNA in a purposely built website called **WVInsight**, (5) which is hosted and managed by the City of Wolverhampton Council.

Figure 1 – Wolverhampton JSNA logo. (4)

Benchmarking

The Wolverhampton JSNA is currently being reviewed and revamped. Nonetheless, a basic benchmarking exercise against the JSNA health equity framework was completed using information available on WVInsight as of January 2024.

	Developing	Achieving	Excelling
Presentation of data		→	
Analysis of need	→	→	
Identification of action	→	→	

Table 4 – Benchmarking of Wolverhampton JSNA against the health equity framework, RAG rating.

Presentation of data

The JSNA has a clear lading page and is overall relatively easy to navigate. It is currently divided into **four chapters**:

- Health & Wellbeing, which includes data on demographics and life expectancy.
- Healthy Start, which includes data on fertility rates, birth weight and age, early years (e.g., school readiness), SEND, childhood vaccinations, school attainment, and vulnerable children.
- Adult Wellbeing, which includes data on obesity, physical activity, smoking, drugs and alcohol, and hospital admissions.
- Ageing Well, which includes data on NHS health checks, chronic conditions (e.g., cancer, diabetes), falls, winter mortality, influenza, and premature mortality.

Each chapter has its own dedicated **interactive dashboard** with multiple data points, displayed in several different formats (e.g., maps, graphs, tables) and complemented by a written description (see figure 2). Some data points include a 'filter' function which should allow for a more detailed breakdown (e.g., by sex, ethnicity, deprivation) and a direct comparison between different subcategories (e.g., least with most deprived, White with Asian ethnicities). However, this function doesn't work particularly well and only allows for one subcategory to be selected at once.

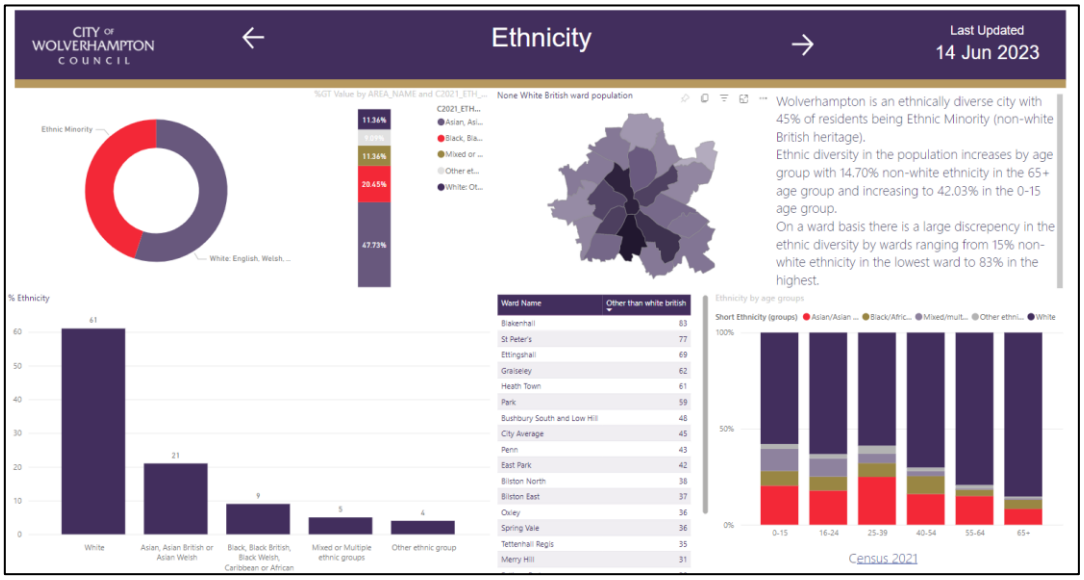


Figure 2 – Ethnicity page on JSNA dashboard, WVInsight.

Looking specifically at **ethnicity data**, the JSNA dashboard has a dedicated page with data from the Census 2021, which includes the ethnic make-up of the population by ethnic group and age band, as well as an interactive map depicting the proportion of non-white residents in each city ward. However, it is not possible to explore the ethnic profile of each individual ward in more detail. Furthermore, there is only very limited ethnicity data available beyond the core JSNA data. Only three data points –

age of mothers at birth, vaccinations, and school attainment (all under the Healthy Start chapter) – include information on ethnicity, and neither of these is easy to navigate or interpret. For example, it is only possible to analyse one ethnicity at a time, making it impossible to compare childhood vaccination rates in different ethnic groups. A similar pattern is replicated across **other equality characteristics**. Only disability has a dedicated page, with only a few data points allowing for a detailed analysis broken down by each of these characteristics.

The JSNA is further complemented by separate **'Themes' pages**. These provide additional data on different topics from demographics to health and wellbeing and include three additional JSNA dashboards (see figure 3). In particular, the Equalities page provides additional data on ethnicity, as well as languages spoken, religion, disability, gender identity, and sexual orientation. However, there is no way to filter or inquiry this data to allow for a more detailed and nuanced understanding of the needs of the population. The JSNA would also benefit from having all relevant intelligence on a single page, rather than having to look across different pages and dashboards.

Figure 3 - 'Themes' pages, WVInsight. (4)

The Council's Public Health team also produces regular specific needs assessment - here called '**Topic Specific Reports**' - to inform its actions and interventions (e.g., HNAs to inform service commissioning). These were previously not published on the WVInsight website but have been included on the JSNA landing page as part of the ongoing review. These topic specific reports are particularly good at presenting local data, including qualitative data arising from community engagement exercises. However, this is not reflected in the wider website.

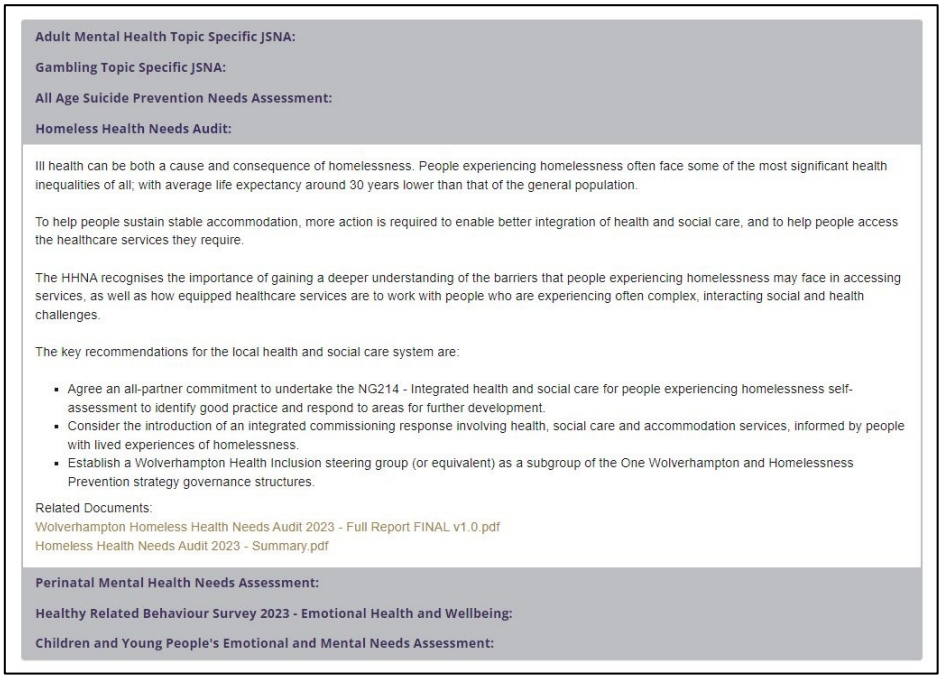


Figure 4 – JSNA Topic Specific Reports, WVInsight. (5)

Overall, reviewing the Wolverhampton JSNA against the framework on data presentation, it ranks as **achieving** and is working towards excelling.

Analysis of need and identification of action

The topic specific reports are particularly strong in relation to their subject matter (e.g. gambling, homelessness), as they provide a strong rationale for prioritisation, explore community strengths and assets, and propose clear actions to address the needs identified. However, the wider JSNA website does not go beyond a statement of intent (see below) in identifying specific needs in its population and does not present any actions to address its needs and improve health equity.

> *"This data analysis is used to help to determine what actions partners need to take, to meet health and social care needs, to address the root causes of health and wellbeing, and to reduce inequalities between different groups such as age, race and gender. The JSNA should help to inform partners to make decisions that enable Wulfrunians to live longer, healthier, active lives."*

As such, when analysing the JSNA as a whole, it is difficult to gain a comprehensive understanding of the local needs, priorities, and actions. Therefore, when analysed against the framework, it ranks somewhere between **developing** and **achieving** for both analysis of need and identification of action.

Process

Given the limited information available on WVInsight, it is not possible to comment on the process behind the development of the JSNA.

Good practice

The six case studies provided by the report were reviewed and complemented by a brief desktop exploration of other JSNAs. No single JSNA was identified as best practice in addressing health equity.

Report case studies

The report identified six case studies of innovative practice to address the different dimensions of the framework. Despite being almost 15 years old and referring to some of the earliest examples of JSNAs, these examples are still relevant today.

Presentation of data

- **North Tyneside** used social care monitoring data to identify barriers in access and the types of services provided, allowing them to better understand the challenges faced by a particular group of residents.
- **Suffolk** used one of their Director of Public Health (DPH) reports to deepen their understanding of the local Bangladeshi population using qualitative data from community engagement.
- **Birmingham** developed a public online portal to hold its JSNA data and intelligence, focusing on "integration, support and empowerment of existing networks" with regards to data collaboration.

Analysis of need

- **NHS Westminster** developed strategies to gain an insight about the needs 'on the ground', including establishing a 'BAME Health Forum' and training and employing community

researchers, which also allowed them to establish links with marginalised and less engaged communities.

Identification of action

- **Luton** conducted an evaluation of the process and impact of its JSNA to understand its role within the local prioritisation and commissioning processes.
- **Newcastle** allocated each section of its JSNA to two leads – one from the local authority and other from health(care) – with a view to identify collaborative action between local government and local services.

Other JSNAs

A very brief exploration of other JSNAs was also undertaken. Several JSNAs are **published online** with variable degrees of quality and ease of navigation. Some, like Birmingham City Council and Leicester City Council, have a dedicated JSNA webpage on its public-facing website, whilst others have their own dedicated website similar to WVInsight (e.g., 'Sandwell Trends' for Sandwell Borough Council, 'All About Dudley Borough' for Dudley Borough Council).

Some of these JSNAs (e.g., Birmingham, Sandwell) include **interactive dashboards** of variable quality. Some include dedicated pages on ethnicity as well as other equalities characteristics (e.g., Sandwell has pages on diversity/ethnicity, language, religion, and LGBTQ+). However, as with the Wolverhampton JSNA dashboards, the degree to which it is possible to breakdown and analyse the health data by each of these characteristics is very limited. Other areas, instead of providing an interactive dashboard, present their JSNA data solely in PDF format (e.g., Leicester).

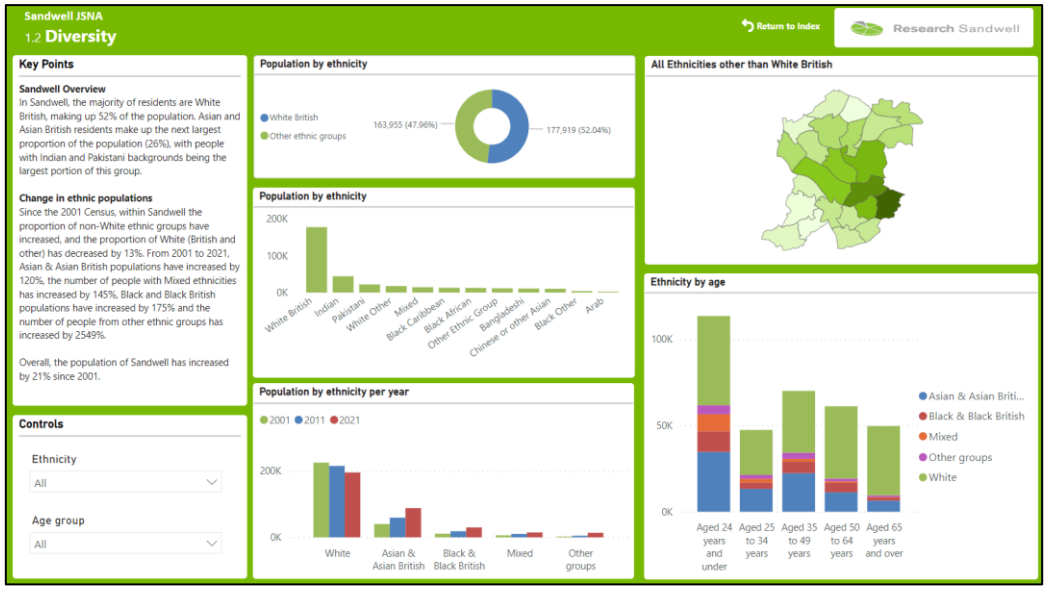


Figure 5 – Diversity page on Sandwell JSNA dashboard, Sandwell Trends. (6)

Most websites also make their **specific needs assessments** available to complement the JSNA. Having all this information in a single page makes it very easy for partners and stakeholders to identify relevant documents and intelligence. However, most JSNA websites end up acting primarily as static repositories for documents (e.g., DPH reports, specific needs assessments) instead of dynamic tools to support HWB partners in analysing the health needs of their populations, setting priorities, and identifying actions to address them.

Sheffield JSNA – data presentation

Sheffield takes a very different approach to its JSNA compared to most other areas. Its is presented in a dynamic, scrolling website (using ArcGIS software) with embedded maps, data, images, graphs, and documents. (7) This makes it interesting to use but it is unclear who practical it is. For example, the lack of a search function makes it sometimes difficult to find the necessary information. Additionally, it isn't easy to gain a quick understanding of the main priorities for action as the information is divided into multiple pages.

Figure 6 – Migration page on Sheffield JSNA. (7)

Birmingham JSNA – analysis of need

Birmingham has produced individual community profiles for several groups, including veterans, homeless, faith, LGBT communities, ethnic communities, disabled communities, and carers. These are static webpages with an introduction/explanation (e.g. what is ethnicity, what is a disability), an overview of that population in the city, and evidence of inequalities relevant to that community. These profiles are complemented by community health profiles – in-depth PDF documents analysing the health needs of individual communities (e.g. Bangladeshi, deaf and hearing loss, Muslim, Bisexual) – as well as 'deep dives' exploring the health inequities affecting particular communities (e.g. veterans, end of life). (8) However, these are time- and resource-intensive, detailed documents and it is unclear how well they inform actions by HWB partner organisations.

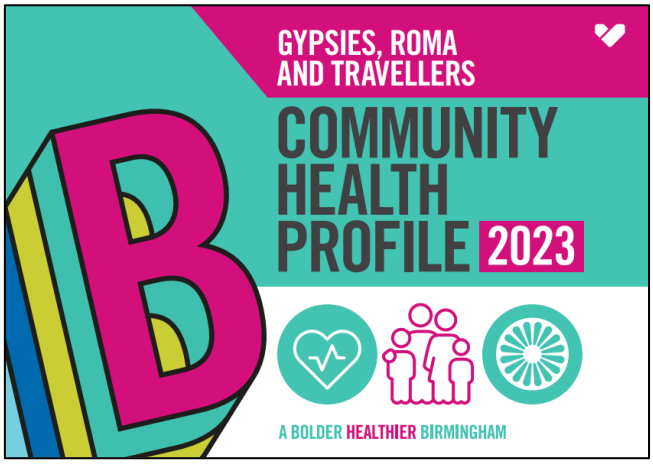


Figure 7 – Gypsies, Roma and Travellers Community Health Profile, Birmingham City Council. (8)

Next steps

Below are some recommendations to continue improving the cultural and equalities responsiveness of the Wolverhampton JSNA. These feed from the report's recommendations, as well as discussions with those involved in the on-going JSNA revamp.

Presentation of data

- Bring together local health and other intelligence stakeholders to maximise the use of available data on culturally diverse communities (recommendation 3 from report).
- Include qualitative data arising from community engagement exercises on the JSNA website (including its dashboard) to complement and contextualise the existing quantitative data.

Analysis of need

- Transpose the information on needs and priority-setting identified in topic specific reports to the wider JSNA website to make it easy for HWBT partners to access and use this information.
- Work with partners to incorporate community strengths and assets into the JSNA by adopting an asset-based approach.

Identification of action

- Transpose the actions and recommendations identified in topic specific reports to the wider JSNA website to make it easier for HWBT partners to access and use this information.
- Ensure that JSNA actions are equality proofed (e.g., using EIAs) and evidence based.

Process

- Establish evaluation mechanisms for existing and planned JSNA processes (recommendation 4 from report).
- Ensure that community and stakeholder involvement is reflected on the JSNA website.
- Ensure that the JSNA links with and informs the JHWS to improve health equity in Wolverhampton.

Acknowledgements

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References

1. Department of Health and Social Care. GOV.UK. 2022 [cited 2023 Dec 6]. JSNAs and JHWS statutory guidance. Available from: https://www.gov.uk/government/publications/jsnas-and-jhws-statutory-guidance

2. Shared Intelligence, Race for Health. Culturally responsive JSNAs: a review of race equality and Joint Strategic Needs Assessment (JSNA) practice [Internet]. Local Government Improvement and Development; 2010 [cited 2023 Dec 5]. Available from: https://www.local.gov.uk/sites/default/files/documents/culturally-responsive-jsn-66c.pdf

3. Cabinet Office. GOV.UK. 2021 [cited 2023 Dec 6]. Writing about ethnicity. Available from: https://www.ethnicity-facts-figures.service.gov.uk/style-guide/writing-about-ethnicity/

4. City of Wolverhampton Council. Health & Wellbeing Together [Internet]. [cited 2024 Jan 9]. Available from: http://wellbeingwolves.co.uk/index.html

5. City of Wolverhampton Council. WVInsight. [cited 2023 Dec 6]. JSNA. Available from: https://insight.wolverhampton.gov.uk/Help/JSNA

6. Sandwell Metropolitan Borough Council. Sandwell Trends. [cited 2024 Feb 13]. Joint Strategic Needs Assessment for Sandwell. Available from: https://www.sandwelltrends.info/jsna-2/

7. Sheffield City Council. Sheffield Joint Strategic Needs Assessment [Internet]. [cited 2024 Feb 13]. Available from: https://sheffieldcc.maps.arcgis.com/apps/Cascade/index.html?appid=96383090af4149b49112b66dadf2ea3a

8. Birmingham City Council. Joint Strategic Needs Assessment (JSNA) [Internet]. [cited 2024 Feb 13]. Available from: https://www.birmingham.gov.uk/info/50268/joint_strategic_needs_assessment_jsna

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CITY OF WOLVERHAMPTON COUNCIL

Joint Strategic Needs Assessment

Health and Wellbeing Together Board
13 March 2024

Presenters:

Parmdip Dhillon
Principal Public Health Specialist

Dr João Martins
Specialty Registrar in Public Health

Lindsey Cowan
Corporate Analytics Manager

What we are going to cover

- What the JSNA is - statutory duty for Health and Wellbeing Boards.
- What the new JSNA looks like.
- Introduce the concept of a culturally responsive JSNA.
- What we need, in order to develop our JSNA into a more culturally responsive JSNA.
- The next steps for the JSNA.

“JSNAs will be the means by which local leaders work together to understand and agree the needs of all local people, with the joint health and wellbeing strategy setting the priorities for collective action. Taken together they will be the pillars of local decision-making, focussing leaders on the priorities for action and providing the evidence base for decisions about local services.”

Department of Health, 2011

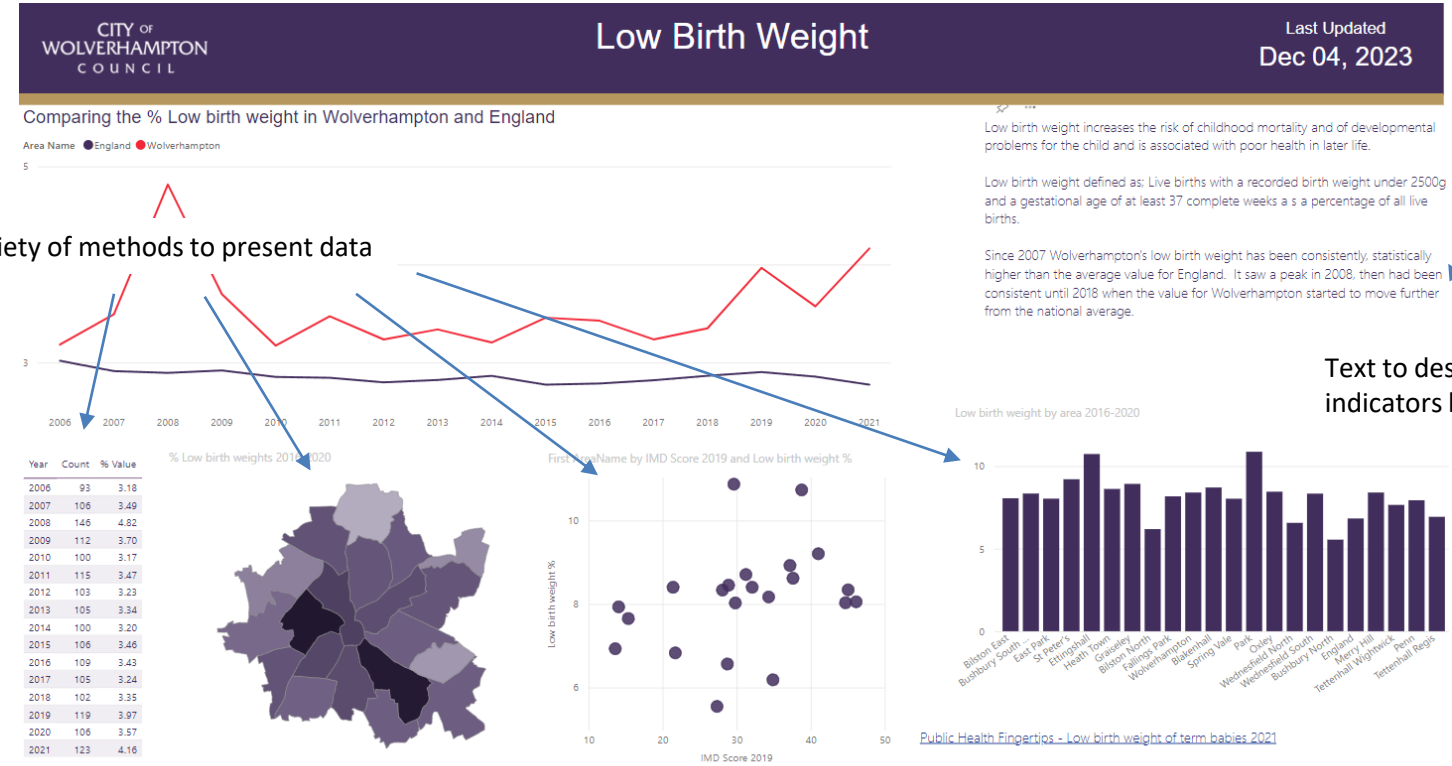
Joint Strategic Needs Assessment

- The Joint Strategic Needs Assessment (JSNA) has been refreshed and updated to better support the Council, wider health and care system and to provide the evidence base to support decision making to improve the health and wellbeing of the population and reduce inequalities.
  - Considered to be the ‘go to’ for local Health and Wellbeing Intelligence in Wolverhampton.
  - Aim is to add meaning and impact to the data
  - Establish evidence as the standard (to inform local strategies)
  - To identify priorities (for further detailed intelligence analysis and evaluation)
  - Collaboration and cross working (system wide approach - Health data, ASC, Childrens, Education, Economy)

Joint Strategic Needs Assessment

- The Joint Strategic Needs Assessment (JSNA) is formed of two key elements:
  - Overview Dashboard
  - Topic Specific Needs Assessments
- Hosted on WVInsight pages.
- Made available to the Public following presentation to the Health and Wellbeing Together Board.
- This will be a live document, with a quarterly review process.

Overview Dashboard

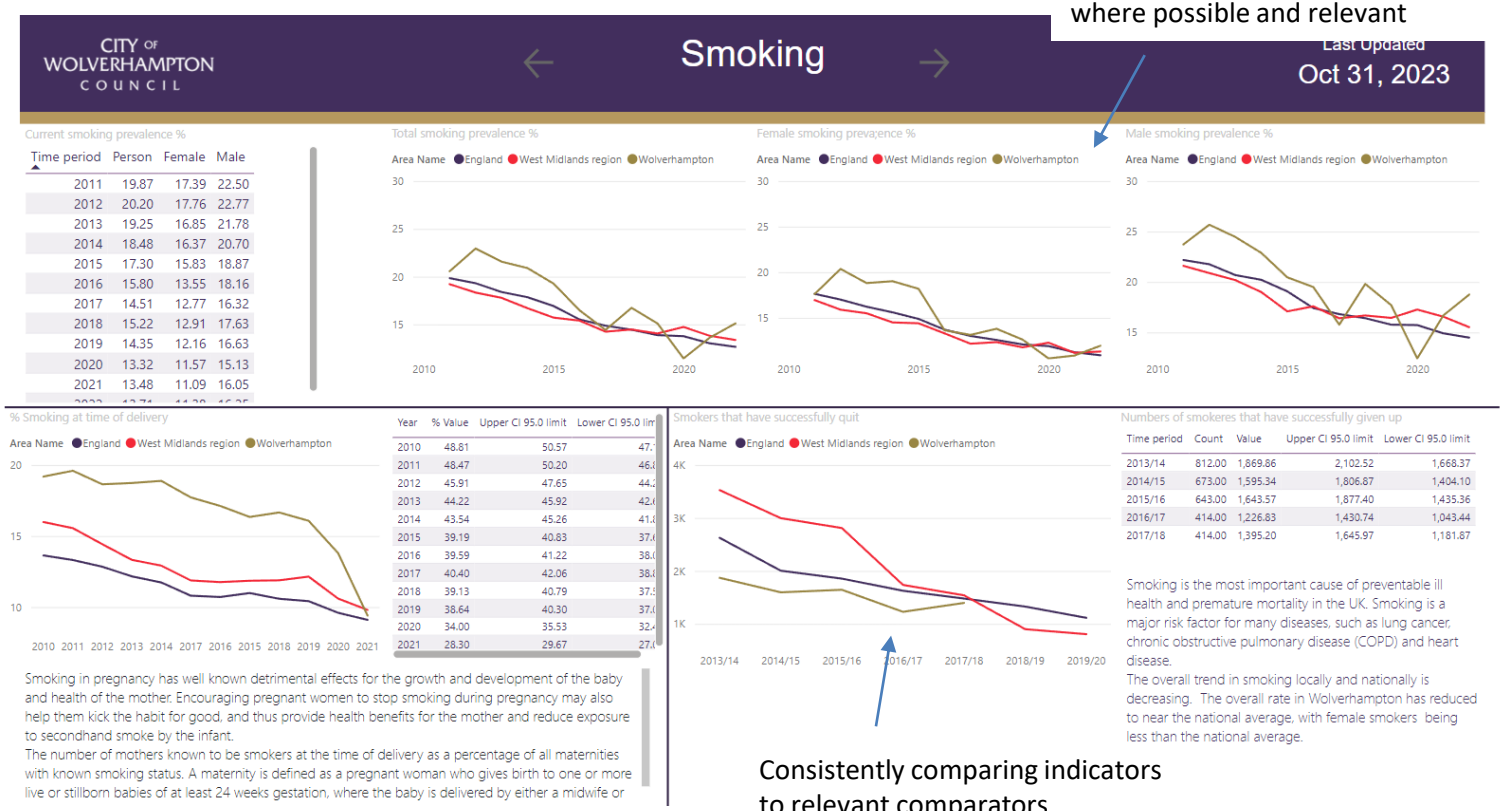


Using a variety of methods to present data

Text to describe the topic or indicators being presented

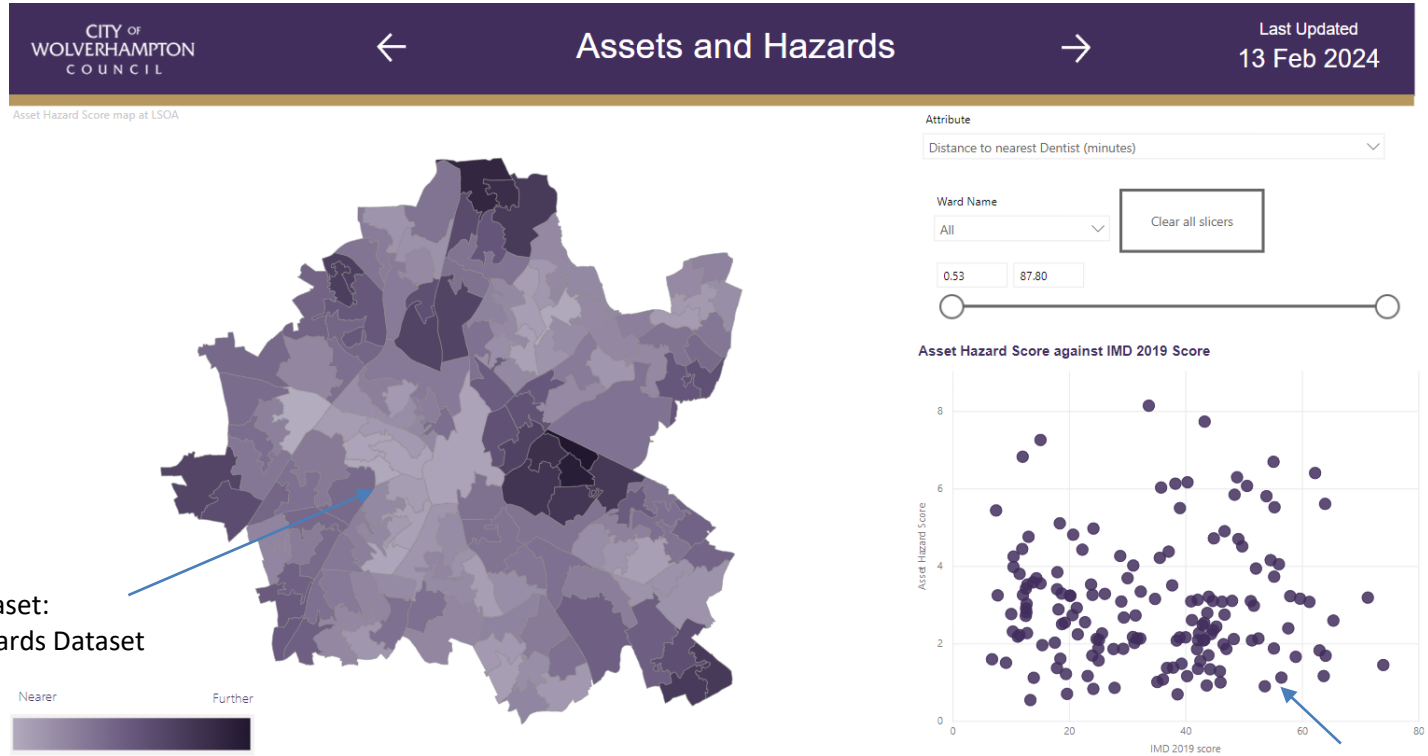
Overview Dashboard

Including a breakdown by demographics where possible and relevant



Consistently comparing indicators to relevant comparators

Overview Dashboard

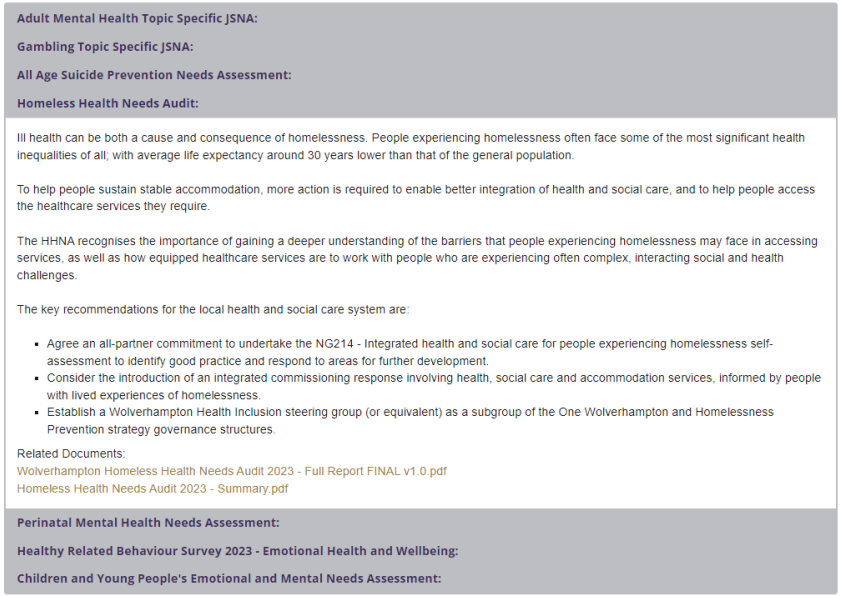


Innovative Dataset:
Assets and Hazards Dataset

Linking in Deprivation, where possible and relevant

Topic Specific Needs Assessments

- Topic Specific Needs Assessments are reports that detail a much deeper analysis of a topic area:
  - Quantitative
  - Qualitative
  - Research and Evidence
- Build a compendium of our needs assessments, evidence reviews and deep dives.



Adult Mental Health Topic Specific JSNA:

Gambling Topic Specific JSNA:

All Age Suicide Prevention Needs Assessment:

Homeless Health Needs Audit:

Ill health can be both a cause and consequence of homelessness. People experiencing homelessness often face some of the most significant health inequalities of all; with average life expectancy around 30 years lower than that of the general population.

To help people sustain stable accommodation, more action is required to enable better integration of health and social care, and to help people access the healthcare services they require.

The HHNA recognises the importance of gaining a deeper understanding of the barriers that people experiencing homelessness may face in accessing services, as well as how equipped healthcare services are to work with people who are experiencing often complex, interacting social and health challenges.

The key recommendations for the local health and social care system are:

- Agree an all-partner commitment to undertake the NG214 - Integrated health and social care for people experiencing homelessness self-assessment to identify good practice and respond to areas for further development.
- Consider the introduction of an integrated commissioning response involving health, social care and accommodation services, informed by people with lived experiences of homelessness.
- Establish a Wolverhampton Health Inclusion steering group (or equivalent) as a subgroup of the One Wolverhampton and Homelessness Prevention strategy governance structures.

Related Documents:
Wolverhampton Homeless Health Needs Audit 2023 - Full Report FINAL v1.0.pdf
Homeless Health Needs Audit 2023 - Summary.pdf

Perinatal Mental Health Needs Assessment:

Healthy Related Behaviour Survey 2023 - Emotional Health and Wellbeing:

Children and Young People's Emotional and Mental Needs Assessment:

Culturally Responsive JSNAs

- 2009 LGA report exploring
  - ethnic diversity and race equality in JSNAs
  - how to ensure JSNAs are 'culturally responsive'

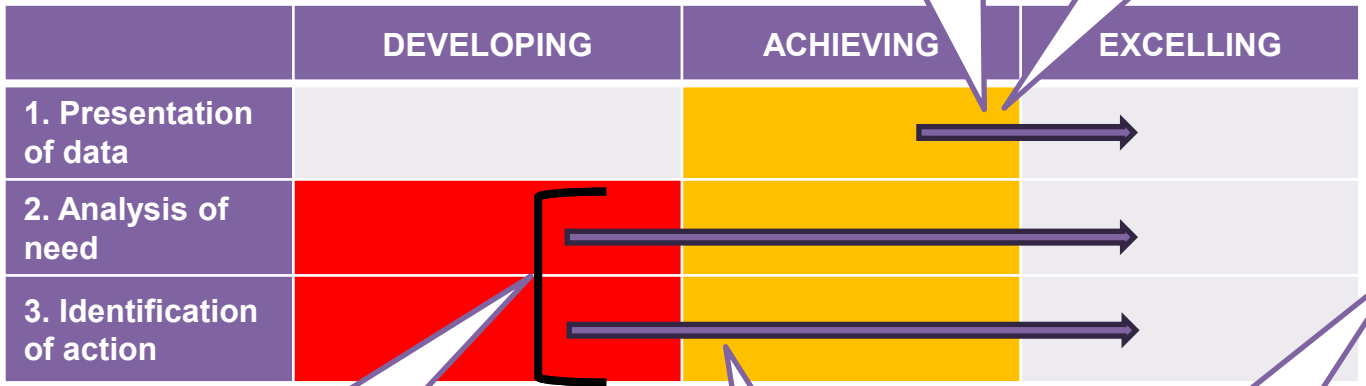
- JSNA race equality framework >> **JSNA health equity framework**
  - Used to benchmark JSNAs
  - Updated: culturally responsive >> **equalities responsive**
    - Expanded beyond ethnicity to include other equality characteristics (sex, religion, language, migration status, gender identity, sexual orientation, disability)

JSNA health equity framework

	DEVELOPING	ACHIEVING	EXCELLING
1. Presentation of data	Core data	• Ethnicity and equalities data in **other data points + service data** • **Data development**	• **Local data** • **Equality mapping** (compares across equalities characteristics) • **Engagement data** (qualitative)
2. Analysis of need	Statement of consideration	• **Consideration of need** • **Equality proofing** (assessment of service capacity vs. diverse need) • Uses **different data**	• **Rationale for prioritisation** • Use of **consultation** • **Consideration of equality issues** • **Community strengths and assets**
3. Identification of action	No action proposed	• **Actions proposed** • **Equality proofing** (e.g. use of EIAs)	• **Analysis of evidence of effectiveness** • **Tangible goals**

4. Process

Benchmarking



Need for all HWBT partners to share relevant data

How to include qualitative data in JSNA dashboard?

Done well in the topic specific reports but how to include this in JSNA dashboard?

Can we equality proof our JSNA actions and recommendations?

How do we reflect our community involvement in the JSNA dashboard?

Can we link in with JHWS?

Useful report findings

- “**all JSNAs can be ‘culturally responsive’** regardless of the demographic profile of the community they describe.”
- **There isn’t a “single definable approach** that produces the most culturally responsive JSNA.”
- Areas that “developed the **more culturally responsive JSNAs had worked with communities and stakeholders**, aligned strategies and were leading purposefully.”
- “**in depth assessments are not a precondition for culturally responsive JSNAs**, although they are helpful.”

What is the ambition and next steps?

- Our ambition for the JSNA is for it to continuously develop, include more data and intelligence that can further highlight inequalities across the City.
- To enable us to do this, we need access to more granular data from wider partners across the City. Improved recording of data by services across wider partners in the City.
- For the JSNA to be collectively owned by the partners across the Health and Wellbeing Board to ensure it remains fit for use and to make it more culturally responsive.
- Raise prominence on WVInsight making it easier to access and find and incorporating all health information in one place.

wolverhampton.gov.uk

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Agenda Item No: 9

City of Wolverhampton Health & Wellbeing Together	**Health and Wellbeing Together** 13th March 2024

Report title:	Black Country ICS – Joint Forward Plan Refresh
Report of:	Paul Tulley Wolverhampton Managing Director Black Country Integrated Care Board
Portfolio:	Public Health and Wellbeing

Recommendation(s) for action or decision:

Health and Wellbeing Together is recommended to:

1. Make comments on the refresh of the Joint Forward Plan for consideration by the ICB as it finalises the document for publication on 31st March.

2. To authorise the Chair to submit a statement of support for inclusion in the refreshed Joint Forward Plan, which confirms they are satisfied that the plan supports the priorities set out in Wolverhampton Health and Wellbeing Strategy.

1.0 Purpose

1.1 The purpose of this report is to update the Health & Wellbeing Board on the approach of the Black County ICB Joint Forward Plan refresh.

2.0 Background

2.1 All ICBs and their partner NHS Trusts were required to prepare a Joint Forward Plan in conjunction with wider system partners covering the period 2023 to 2028. The NHS Black Country Joint Forward Plan (JFP) was published in June 2023. A 'shorter-read' version was subsequently developed which is the version of the plan utilised by the System.

2.2 The Joint Forward Plan was shared with members of the Health and Wellbeing Board in draft prior to its approval to provide assurance that the strategic plan for the NHS is aligned with and supports the delivery of priorities set out in your Health and Wellbeing Strategy. A statement of support was received in response from each Health and Wellbeing Board.

2.3 Updated 'Joint Forward Plan' guidance was published on the 22 December 2023, which set out the requirement to publish a refreshed plan by the 31 March 2024.

2.4 The focus of the refresh has been on the shorter read version of the plan, reflecting progress we have made to date as well as taking into account any known adjustments to be incorporated as a result which may include changes to Health and Wellbeing Board Strategies, Place plans or Collaborative plans, including relevant alignment.

3.0 Joint Forward Plan Refresh

3.1 We set out five strategic priority areas in our 5-year plan as follows:

Priority 1 - Improving access and quality of services
Priority 2 - Care Closer to Home
Priority 3 - Preventing ill health and tackling health inequalities
Priority 4 - Giving people the best start in life
Priority 5 - Best place to work.

3.2 As we move into year two of our plan, we want to refresh it to ensure it is still fit for purpose and meeting the needs of our people and communities. The NHS as a whole in 2023/24 has experienced financial challenge The Black Country is no different, and to reflect this, we believe the update to our Joint Forward Plan should include a new priority to reflect the challenge we face and the work we will need to undertake to improve our finances on a long-term basis.

Priority 6 - Fit for the future

3.3 This new priority recognises that the Black Country health system needs to change the way that it works to embrace the opportunities and meet the challenges it faces. This includes the need to be more productive and cost-effective to meet our financial challenges. We also need to ensure that we support our Places and providers to work better together. We need to reduce the carbon footprint of the NHS and be more sustainable. All of this will require strong, sustainable leadership and enabling functions.

3.4 No change is proposed to the Wolverhampton priorities in the Joint Forward Plan, which continue to reflect the priorities set out in the Wolverhampton Health and Wellbeing Strategy.

3.5 From late February until 20th March 2024, we are holding conversations with our partners and giving people an opportunity to let us know if there is anything we are missing as we refresh the document. This year's refresh will be light touch as we prepare for a more comprehensive mid-term review in 2024/25. A summary of the refreshed plan can be found on our website and local people are invited to share their thoughts by completing an online survey.

4.0 Financial implications

4.1 There are no direct financial implications arising from the publication of the Joint Forward Plan.

5.0 Legal implications

5.1 The publication of a Joint Forward Plan is a legal requirement for Integrated Care Boards.

6.0 Equalities implications

6.1 The ICB will have regard to its legal duties regarding equalities and health inequalities in the development of the JFP refresh.

7.0 Schedule of background papers

7.1 The Joint Forward Plan is available in a range of accessible formats and can be accessed on the ICB website at https://blackcountry.icb.nhs.uk/about-us/our-priorities/our-5-year-joint-forward-plan.

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NHS
Black Country

NHS Black Country - Joint Forward Plan 2023-2028

Updated April 2024

Strategic and Enabling Workstreams Delivery Plans:

- Planned Care (Elective)
- Diagnostics
- Cancer
- Urgent and Emergency Care
- Out of Hospital
- Preventing Ill Health
- Personalisation
- Primary Care
- Maternity and Neonates
- Children and Young People
- Mental Health, Learning Disabilities and Autism
- Long Term Conditions Management
- Workforce

Draft for Involvement

Strategic and Enabling Workstreams

The following sections describe how within the Black Country we will improve the services we provide over the next four years. It is described by the type of service and includes the vision, priority actions and the improvements in health outcomes we expect to achieve.

Planned care (Elective)

Planned care is what we say when we mean a treatment which is planned, things like operations for hips and knees. This area of the plan explains how we will recover from the pandemic and ensure that capacity is there to meet future health needs and to ensure any treatment needs are identified in a timely way. Our aim is for organisations to work together to provide better, faster and safer care for local people. The plan describes how we will do this by:

- Improving access (recovery and restoration), capacity and productivity.
- Improving quality – achieve equity and address health inequalities through standardisation of care and the reduction of unwarranted variation.
- System resilience and transformation – new models of care, system strategic developments including enhancing workforce recruitment and retention.

We will be exploring the potential for centres of excellence and dedicated sites doing just elective work, to reduce the disruption in emergency care peaks. We hope to be in a position where the Black Country is seen as an exemplar for elective care and is able to support other neighbouring systems with their capacity. The big outcome for local people will be increased capacity for planned care and the introduction of new technologies and approaches.

Outcomes to be achieved

For our Patients:

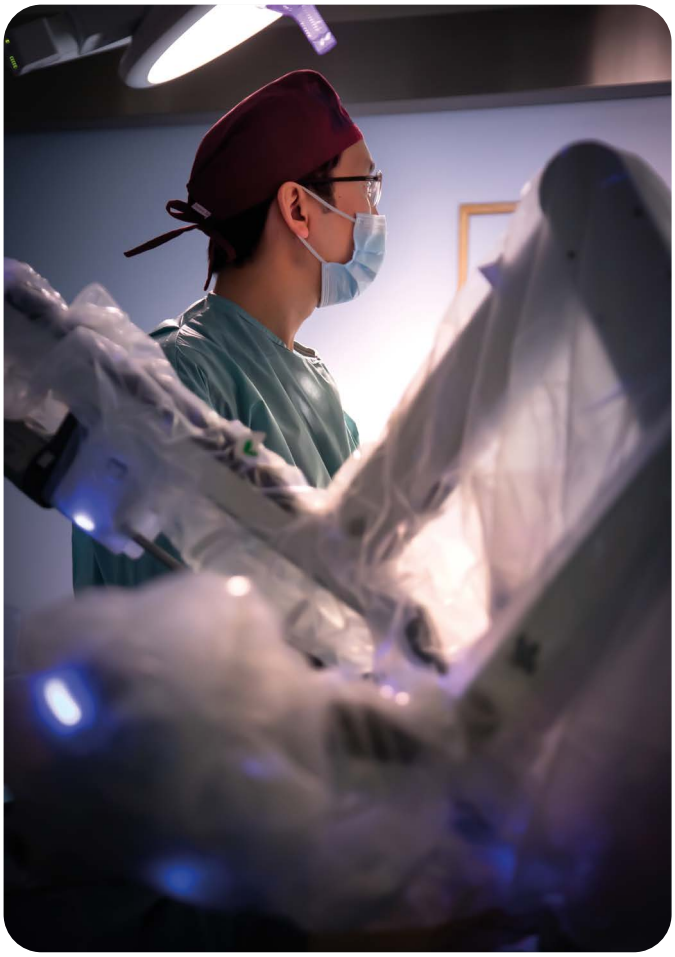
- Improved access, reduced waiting times and timely access to treatment leading to improved clinical outcomes
- Improved choice, personalisation and experience, improved life expectancy

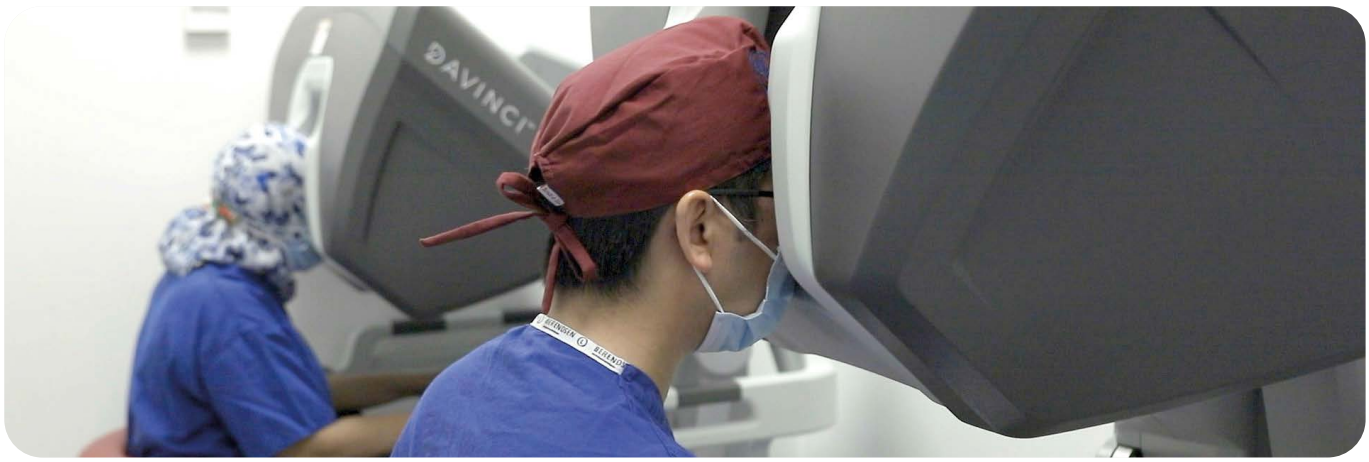
For Organisations:

- Improved organisation, productivity and workforce resilience
- New technologies and transformed care, increased capacity and service resilience
- Outpatient transformation (Follow Ups, Patient Initiated Follow Ups, Specialist Advice)

For our System:

- Greater collaboration and integration, driving system leadership
- System resilience at times of peak/ pressure





Work Programme To be delivered by:	Yr1	Yr2	Yr3	Yr4	Yr5
Improving Access/Eliminating Long Waits Through improving capacity, mutual aid, use of Patient Initiated Digital Mutual Aid System, outpatient transformation, a shared patient waiting list, and increasing the scale of inclusive initiatives, we will implement new models and ways of working to improve access.	✓	✓	✓	✓	✓
Improve Capacity and Productivity To align and implement plans such as Getting It Right First Time (GIRFT), national transformation initiatives, and local transformations such as dedicated elective care hubs, theatre reconfigurations and a new hospital site (Midland Metropolitan University Hospital). We will optimise care pathways and improve productivity.	✓	✓			
System Resilience and Transformation Through our transformation activities, use of innovative technologies, new workforce models and system leadership we will achieve greater system resilience.			✓		
Improving Quality To implement standardised approaches and pathways to both align practice and support the reduction of health access equity. Centres of Excellence will be explored to reduce unwarranted variation in access, experience and outcomes.	✓	✓	✓	✓	✓

Significant improvement made on reducing long waiting times for planned care.

Roll out of the Patient Initiated Digital Mutual Aid System (PIDMAS) which supports those patients waiting over 40+ weeks on a hospital pathway to move to a provider with a shorter waiting time. Through an accreditation process more providers are being added to PIDMAS, therefore expanding choice for patients and reducing waiting times.

Diagnostics

We know that waiting for any health diagnosis, especially cancer, can be an extremely worrying time. Our aim is to provide equitable access to modern, state of the art, high- quality diagnostics, in a timely manner. Diagnostics play a key role within our system recovery and is at the centre of disease and patient pathways, to detect disease as early as possible and accurately guide patients to the right treatments. Currently, diagnostic services are mostly based in hospital settings. We want to increase the capacity, particularly in community locations, to make it even easier to access these essential services.

Our plan includes:

- Recovery and maintenance of waiting times for diagnostic testing to pre-covid levels and meet the diagnostic standards set out for the NHS.
- Equity of testing access across the system and standardisation of pathways to reduce variation and health inequalities.
- Build a resilient, system-wide service for the future that provides value for money through continuous improvement in service delivery, capability and technological implementation.

Outcomes to be achieved

For our Patients:

- Reduced waiting times for patients, reduced uncertainty
- Ensuring equal access for all patients across our system
- Local imaging/ testing, with reporting networks across organisations, improving patient experience

For Organisations:

- Shared capacity and management of reporting backlogs to optimise reporting turnaround times
- Staffing consistency and flexibility to provide more opportunities for personal and professional development
- Sharing and levelling of resources (staff and equipment)

For our System:

- A cohesive, system-wide approach to quality improvement, addressing health inequalities
- Improved sustainability and service resilience
- Standardised system pathways with reduced variation
- Maximised economies of scale in procurement

Work Programme To be delivered by:	Yr1	Yr2	Yr3	Yr4	Yr5
Optimise Clinical Pathways Implement best practice timed pathways across urgent, elective and cancer services, driving efficiency and productivity, ensuring safe and patient-centred pathways.		✓			
Reduce Inequalities in Access Consider physical, cultural and social needs of different/ diverse population health groups and implement actions to improve pathways and achieve equity of access.		✓			
Implement Community Diagnostic Centres (CDC) Maximize the capacity of existing facilities, equipment and staff training; improve health outcomes through earlier, faster and more accurate diagnoses supporting recovery of waiting lists.				✓	
Develop and Implement a Workforce Strategy Ensure a system-wide diagnostic workforce strategy aligned to the People Plan. Identify staff shortages and skills gaps to inform recruitment actions, particularly in challenged areas.	✓	✓	✓	✓	✓
Adopted Technological/Digital Innovation Implement innovative technologies and supporting infrastructure to improve care for patients by changing how tests are conducted and analysed.		✓	✓	✓	✓

Increased diagnostic and treatment capacity resulting in reduced waiting times.

Additional investment in scanners (CT and MRI) at one of our Community Diagnostic Centre Sites.

Development of the workforce to address staff shortages and skill gaps.

Cancer

Our aim is to save lives through improvements in the prevention, detection and treatment of cancer. We will provide compassionate and consistent cancer services with improved support, outcomes and survival for people at risk of and affected by cancer.

The NHS diagnoses and treats thousands of people each year with cancer. Detecting and treating cancer early is important. This area of the plan looks at how we get the right services in place to ensure people can be seen quickly.

The plan covers our work in four key areas:

- Preventing cancer where possible, supporting healthier lifestyles and reducing the existing inequalities in the outcomes for local people.
- Improving screening and detection to enable detection of cancer at earlier stages.
- Improving diagnosis, treatment, care and support to get diagnosis early and improve access through new community diagnostic centres leading to improved outcomes and survival rates.
- Research and innovation is key in the development of new treatments and we will look to increase local participation in trials to develop new technologies.

Outcomes to be achieved

For our Patients:

- Preventing cancer where possible, supporting healthier lifestyles
- Optimal diagnosis, treatment, care and support, leading to improved outcomes and survival rates
- Best possible patient experience, timely access to information
- Faster diagnosis, increase uptake in screening programmes

For Organisations:

- Efficiencies through the deployment of innovation
- Best practice pathways informed by cancer research, early deployment of new innovations

For our System:

- Maximise improvement opportunities through collaborative working, and clinical networks
- Reducing health inequalities

Work Programme	To be delivered by: Yr1	Yr2	Yr3	Yr4	Yr5
Prevention and Reducing Health Inequalities Working collaboratively we will improve cancer prevention and develop improvement plans to reduce health inequalities.	✓	✓	✓	✓	✓
Screening and Early Detection Achieve improvements in screening programme uptake to enable detection of cancers at earlier stages, to improve patient outcomes and survival of cancer.	✓	✓	✓	✓	✓
Optimal Cancer Diagnosis, Treatment, Care and Support Monitor outcomes and patient experience to ensure our services meet the needs of our diverse population, implementing best practice pathways across our system along with innovations such as Community Diagnostic Centres.	✓	✓	✓	✓	✓
Cancer Research, Collaboration and Innovation Cancer research is a significant part in the development of new treatments to improve care; we will achieve enhanced access and participation in clinical trials, along with the deployment of innovation.	✓	✓	✓	✓	✓

- **Achieved a 45% reduction in people waiting more than 62 days for treatment.**
- **Increase in the number of patients receiving a timely cancer diagnosis.**
- **Targeted Lung Health Check programme commenced in one Place, with plans to extend the service next year.**
- **Targeted screening uptake, as set out in the earlier case study.**
- **A centre for a new specialist type of skin cancer treatment opened in Sept 2023 in a new £1.3m facility, that will ensure patients are seen quicker and treated closer to home.**

Urgent and emergency care

When you need us most, the local NHS needs to be there to respond. Our aim is to ensure patients have access to high quality urgent and emergency care services in the right place at the right time, delivered by the right person.

Our plan details how our emergency care services will work better to meet the needs of local people today and in the future. This includes:

- Improving processes and standardising the care in our hospital-based emergency services.
- Increasing out of hospital/community pathways to get people seen in the right place.
- Improving the flow through our hospitals, developing improved discharge processes and care for people to step down from hospital services with the support that they need.
- Understanding the reasons for people using emergency services inappropriately, supporting them to access care in the right place.

Outcomes to be achieved

For our Patients:

- Services delivered closer to home
- Shorter waiting times at all points in patient pathway, and improved patient experience
- Reduced emergency admissions
- Personalised Care

For Organisations:

- Enhanced triaging and streaming to increase the number of people receiving urgent care in settings outside of the Emergency Department to include Same Day Emergency Care, Urgent Treatment Centres, Urgent Community Response
- Improvements in handover times between the Ambulance Service and Emergency Departments

For our System:

- Sustainable and resilient urgent and emergency and care model across the system
- Consistency of urgent and emergency care services and pathways across our system

Work Programme	To be delivered by: Yr1	Yr2	Yr3	Yr4	Yr5
Creating a sustainable hospital based Urgent and Emergency Care Model To achieve a sustainable emergency care model that is fit for the future and meets current and future patient demand, we will improve processes and standardise care, expand Same Day Emergency Care provision and increase urgent and emergency care/bed capacity.	✓	✓			
Increasing Utilisation, Capacity and Range of Services Provided Outside Emergency Department We will improve utilisation of Urgent Treatment Centres, scale up Virtual Ward provision, develop mental health urgent response services, and improve access to urgent primary care.	✓	✓	✓		
Development of Step Down and Discharge Pathways To continue to work in partnership with Out of Hospital Services and Place Based Partnerships to deliver effective discharge pathways which promote a return to independence in community settings.	✓	✓			
Enhancing/Improving Access Identification and resolution of barriers to accessing primary and community services, reducing unwarranted variation and inequity, supporting High Intensity Service Users, and early help and prevention services.	✓	✓	✓		

Patients attending Accident and Emergency are being seen sooner, with Black Country system amongst the top performing in England.

Investment in our buildings and workforce to improve patient flow.

Increased availability of Same Day Emergency Care Services.

Supported care home facilities to reduce the number of avoidable 999 calls.

Out of hospital/community services

We recognise that people want to remain as independent as possible, for as long as possible and that they want to have care as close to home as they can. Therefore, supporting people to stay out of hospital where possible but also to return to a home setting after a hospital stay as quickly and safely as we can is important.

Our aim is to transform and build out-of-hospital and community services to deliver a 'home first' philosophy. The plan describes how we will do this by:

- Investing in community services to respond quickly when people are in need and to prevent hospital attendances.
- Recognising and preventing falls as these are a major contributor to hospital stays.
- Developing more capacity for people to receive care in a home setting through remote technology and virtual wards.
- Supporting people in their end-of-life choices and ensuring there is support and care there for people to die in a place of choice with dignity.
- Delivering the ambitions of the Black Country Integrated Care Board (ICB) Dementia Strategy ensuring it aligns to the Palliative and End of Life Strategy.
- Creating a recognised tool to assess and direct individuals to the most appropriate community service across the ICB, providing care closer to home.
- Implementing the National Chief Nurse Officer's Strategy.

Outcomes to be achieved

For our Patients:

- Increased independence
- Care Closer to Home
- Equity of services
- Reducing time spent in hospital
- Reduced readmissions to hospital

For Organisations:

- Increased efficiency/productivity by improved utilisation/standardisation of out of hospital pathways
- More efficient use of resources (workforce, equipment and estates)

For our System:

- Collaboration/joint working with wider system partners e.g. Local Authorities, third sector
- Greater integration of pathways/services
- Improved access and health outcomes
- Reduction in health inequalities

Work Programme To be delivered by:	Yr1	Yr2	Yr3	Yr4	Yr5
Single Triage Model for Urgent Community Response (UCR) Service To deliver a single integrated model that achieves consistency, removes duplication and embeds collaborative working.	✓	✓			
Recognised Falls Model in the Black Country To implement a consistent standardised falls management approach across the system, minimising risk to patients and reducing the demand for urgent and emergency care services.	✓	✓			
Continued Development of Remote Monitoring and Virtual Wards The expansion of remote monitoring in care and at home and virtual wards offer across the Black Country, working in partnership with Local Authorities to support roll out of tech enabled schemes.	✓	✓	✓	✓	
Effective Discharge from Hospitals to create flow We will discharge to the most appropriate setting in a timely/ effective way to support the best patient outcomes, ensuring flow for patients requiring acute care, working with partners and neighbouring systems.	✓	✓			
Palliative and End of Life Care Implementation of the Palliative and End of Life Care Strategy encompassing adults, children and young people.	✓	✓	✓		

Consistently met the national target for 2 hour urgent community response.

Increased the number of patients being managed in the community, through Virtual Wards and use of technology.

Working well with the social care sector to support the community workforce, fostering stronger working relationships and greater collaboration.

Preventing ill health

Preventing ill health is better than treating ill health and our growing and ageing population means that without good prevention we will see an increasing number of people needing NHS care. Our aim is to increase healthy life expectancy so people can live the life that matters to them, preventing illness and improving life expectancy.

Many conditions which can contribute to shorter healthy life expectancy are preventable. While the factors which can lead to these conditions are many and varied, through prevention our aim is to help people improve their own health through targeted support to help reduce alcohol or tobacco dependency, to offer weight management services, and increase access to cancer screening and diabetes prevention programmes. We will develop our prevention capacity and capability across the Integrated Care Partnership, working together to harness our collective assets and embed preventative approaches as a continuum, ensuring health equity is our golden thread.

Our plan includes:

- Supporting people to not smoke and to support those that are tobacco dependent with services to reduce their dependency.
- Supporting people to lose weight and make healthy life choices.
- Supporting people to not drink excessively and to support those that are alcohol dependent with services to reduce their dependency.

Outcomes to be achieved

For our Patients:

- Improved life expectancy
- Reduced preventable illness
- Reduced morbidity and mortality
- A voice for change, through co-production

For Organisations:

- Improved capacity and capability to accelerate prevention activities
- Reduced dependency on specialist services

For our System:

- Improved health outcomes, reduced health inequalities
- Reduced demand on health and social care services

Ongoing support from pharmacies to stop smoking

Work Programme	To be delivered by:	Yr1	Yr2	Yr3	Yr4	Yr5
Tobacco Dependence To complete the establishment of Tobacco Dependence Services across all inpatient and maternity services. We will identify opportunities to improve pathways and support in the community and primary care. An assurance cycle will be established to enable targeted support, along with an evaluation.		✓				
Healthy Weight To further embed the Tier 2 programme through training and awareness across sectors, with targeted support where needed. Performance monitoring will continue with analysis of the 'obesity burden profile'. A review of services is being undertaken, taking into account new guidance.		✓	✓			
Alcohol Dependence To evaluate the Alcohol Care Teams established in each hospital to inform future decision making and test the early intervention and targeted prevention pilot. A clinical audit will be undertaken during 2024/2025.		✓	✓			

The Tobacco Dependency Programme has been rolled out to the majority of providers, supporting patients in hospital (and maternity services) to access tobacco dependence treatment, thus improving the health and wellbeing of the person smoking and their family.

Alcohol care teams have been fully mobilised across the Black Country. Alcohol care teams provide specialist expertise, early intervention and access to treatment for alcohol dependent patients.

Personalisation

Personalisation is about giving power back to people – focusing on placing the individual at the centre of their care, reinforcing that the individual is best placed to know what they need and how those needs can be best met. It is one of the changes to the NHS set out in the Long Term Plan and represents a change of relationship between people, professionals and the health and care system – designed to have a positive shift in the decision-making process, enabling people to have choice and control over the way their care is planned and delivered.

Locally, we will increase personalised care planning with:

- Increased availability of personal health budgets.
- More shared decision making (SDM) training to ensure people are supported to understand the options available and can make decisions about their preferred course of action.
- More conversations about what matters to local people rather than conversations about what is the matter with them. This will be done through care planning approaches, education and awareness.
- Supporting more patient choice, ensuring that quality information is available to patients, that choice is proactively extended, and principles built into models of care and care pathways.
- Expanding social prescribing to be available to all communities including children and young people.

Shared Decision Making
Shared decision making (SDM) refers to a point in a pathway where a decision needs to be made, people are supported to understand the options available and can make decisions about their preferred course of action.

Our plans include delivering SDM training across our workforce, embedding SDM foundations in all pathways, a public awareness campaign and the development of decision support tools.

Personalised Care and Support Planning
Proactive and personalised care and support planning focuses on the clinical and wider health and wellbeing needs of the individual. Conversations should focus on what matters to the individual.

Our plans include establishing care plans and care coordinators across a range of services, embedding Compassionate Communities approach, and expanding roles in primary care to support care planning.

Enabling Choice, including legal rights to choose
Enabling choice concerns the legal right to choice of provider in respect of first outpatient appointment and suitable alternative provider if people are not able to access services within waiting time standards.

Our plans include ensuring that quality information is available to patients, that choice is proactively offered and principles built into models of care and care pathways.

Social Prescribing and Community Based Support
Social prescribing is an approach that connects people to activities, groups, and services in their community to meet the practical, social and emotional needs that affect their health and wellbeing.

Our plans include expanding the service to all communities including children and young people, workforce training and development including peer support, and building in creative cultural health opportunities.

Support Self-Management
This is the way that health and care services encourage, support and empower people to manage their ongoing physical and mental health conditions themselves.

Our plans include developing primary based self-management education, rolling out health coaching and workforce training with a focus on prevention and self-management approaches.

Personal Health Budgets
A personal health budget (PHB) supports creation of an individually agreed personalised care and support plan that offers people choice and flexibility over how their assessed health and wellbeing needs are met.

Our plans include widening the availability of PHB linked to population health need, further develop the finance and clinical governance framework to support extension, pilot integrated health and care budgets.

The personalisation agenda is a cross cutting theme and examples of key achievements delivered are set across other Strategic, Place and enabling workstreams.

Primary care

Improving access to high quality care from GPs, dentists, opticians, and pharmacists is something which local people raise with us regularly. Our aim is to implement a transformed primary care operating model that delivers equitable access to high quality care that is safe, integrated, consistent and person-centred. The plan describes the work underway to:

- Develop more joint working in primary care to support the services to be future fit.
- Support workforce growth, retention, and recruitment.
- Maximise opportunities to develop better premises.
- Implement new solutions to improve access, including new technologies.

Outcomes to be achieved

For our Patients:

- Increased primary care appointments, improved access, reduced waiting time and increased dental activity
- Increased patient satisfaction and experience
- Increased digital functionality, including telephony

For Organisations/ Our System:

- Grow our workforce, expansion of new roles
- Implementation of Fuller recommendations
- Delivery of our delegated responsibilities (GP and Pharmacy, Optometry and Dental Services)
- Optimised estates and communications
- Establishment of integrated ways of working and delivery of the Primary Care Collaborative Transformation Programme

Improved access through a variety of ways including delivering additional appointments.

Launch of 'Pharmacy First' that enables pharmacists to assess and treat minor conditions without the need to see a GP.

Improvements to GP websites making them accessible and user friendly, including better access through the use of digital tools such as online consultations and NHS App.

Improved dental access including providing tailored support to migrant and refugee groups.

Secured more urgent access dental appointments and invested in Oral Health Improvement Schemes.

Work Programme To be delivered by:	Yr1	Yr2	Yr3	Yr4	Yr5
Development/Embedding of Primary Care Collaborative Establish the governance, clinical leadership and the required infrastructure to deliver collaborative working.		✓			
Establish/Develop The Primary Care Workforce and Transformation Unit (Primary Care Delivery Vehicle) Establish new ways of working, deliver organisational development and work programme focussing on access, Long Term Condition and unwarranted variation.			✓		
Primary Care Collaborative Transformation Work Programme (Future Operating Model) Undertake strategic development and implement the transformation programme.					✓
Improving General Medical Services (GP) Access Support PCNs to implement practice-based solutions to improve patient access and experience.	✓				
Primary Care Network (PCN) Estates Programme Reconfiguration of vacant space, maximise e-booking systems, and deliver the Estates Strategy.					✓
PCN Development Programme Support PCNs to 'maturity' and embed the development programme reflecting the Fuller recommendations.			✓		
Increasing Dental Access Programme Develop a dental strategy and deliver improvement plans in line with the national recovery plan, use of health equity audit to inform the strategy with a continued focus on improving access.					✓
ICS Primary and Community Care Training Hub Contract/System Workforce Development Programme Embed workforce planning, focus on retention and secure the resources to deliver the improvements.		✓			

Maternity and neonatal

Making it safer than ever to have a baby is an area of focus for us. Supporting mothers, babies and families during pregnancy and birth is so important. Our aim is to deliver high-quality maternity and neonatal services across the Black Country, through co-production with women, which will be safe, personalised, and equitable to ensure every woman and baby receives the best possible care.

We have developed strategic priorities which are:

- Monitoring the quality of perinatal and postnatal (the period before and after birth) services to ensure they are of the highest standard.
- Improved continuity of care, and experience for mothers, families, and babies.
- A focus on workforce to create new roles, share recruitment and allow our staff to work across organisational boundaries.
- Reduced perinatal mortality and morbidity, and improved access to specialist care when needed.
- Implementation of the action plan to address improved health inequalities and accelerate work to support those mothers and babies at greatest risk of poor health outcomes.

Outcomes to be achieved

For our Patients:

- Improved safety and outcomes for women and their families
- Improved continuity of care, and experience
- Lower rates of morbidity/mortality

For Organisations:

- Improved monitoring and assurance of safety
- Strengthened workforce resilience, and succession planning

For our System:

- System leadership, supported by Maternity and Neonatal Voices Partnership
- Collaboration and peer review/ learning
- Reduced health inequalities

Work Programme	To be delivered by: Yr1	Yr2	Yr3	Yr4	Yr5
Perinatal Quality Surveillance Model To enhance the existing model a robust quality assurance process will be implemented, included peer review to achieve assurance of quality and safety, and delivery of Saving Babies Lives Care Bundle v2 and v3.	✓				
Workforce To further build on our progress, we will develop a workforce strategy focusing on consolidating recruitment for cross boundary working, new roles, shared recruitment and succession planning.			✓		
Maternity Continuity of Carer (CoC) To implement our five-year transformation plan, ensuring our model reflects the needs of our population and focuses on choice of place of birth rather than geography.					✓
Reduce Perinatal Mortality and Morbidity Work collaboratively to identify improvement actions to improve outcomes and reduce health inequalities. Improving access to specialist care where required.			✓		
Perinatal Equity and Equality Strategy and Action Plan Through our dedicated Equality, Diversion and Inclusion leads we will implement our action plan, ensuring we accelerate work to support those at greatest risk of poor health outcomes.					✓

Significant progress made towards delivering 'Saving Babies Lives' care bundle, with investment in our workforce including the appointment of LMNS Pre-Term Birth Lead to support our ambition to reduce infant mortality.

Children and young people

Our aim is that every child gets the right help, at the right time, by the right service, to ensure they meet their full potential. We want Black Country people to have the best start in life and we will be developing a separate strategy to give this the focus that it needs. Recognising that over half of our children and young people are within the 20% most deprived communities nationally, our strategy will ensure the needs of all children and young people across our diverse communities are met.

Partnerships are vital for us to achieve our aim as we initially focus on the areas of:

- Developing transformative care pathways for asthma, epilepsy, diabetes, and obesity.
- Work with partners in education, mental health, safeguarding to ensure that, no matter how complex, our children's needs are met.
- Hear the voices of children as we plan and deliver their care.
- Use the Core20Plus5 framework for children to drive improvement and reduce inequalities.

Outcomes to be achieved

For our Patients:

- Increased ability to self-manage Long Term Condition and increased quality of life years
- Co-production and ability to inform, challenge and embed service improvements
- Clear service pathways for patients

For Organisations and the System

- Developed joint commissioning, improved service efficiency and effectiveness
- Increased understanding of the needs of children and young people (CYP) across the system, embedding all age commissioning
- Improved health outcomes for our most vulnerable including Children in Care, Special Educational Needs and Disabilities, most deprived etc
- Development of an integrated specification for CYP, evidencing good partnership working and shared outcomes

Work Programme	To be delivered by: Yr1	Yr2	Yr3	Yr4	Yr5
Implement the Children and Young People (CYP) Transformation Programme An assessment will be undertaken against all elements of the programme and an action plan developed to ensure all standards/deliverables are met, robust care pathways in place and transition guidelines are robust; asthma, epilepsy, diabetes, and obesity.	✓	✓	✓	✓	✓
Establish CYP Joint Commissioning Plan Working collaboratively with partners we will develop a joint commissioning plan that meets the needs of CYP and supports them to achieve their full potential, this will including SEND, mental and physical health, safeguarding and CYP with complex needs.	✓	✓	✓	✓	✓
Implement CYP Voices Model To ensure the voices of CYP are heard during the development, review and delivery of services, we will co-produce and embed this model.	✓	✓	✓		
Tackling Health Inequalities Using the national CYP Core20PLUS5 framework we will drive improvement action across CYP services; asthma, diabetes, epilepsy, oral health and mental health.	✓	✓	✓		

New NHS website providing a range of health advice for every stage, from pregnancy and birth through to nursery, school and beyond.

New Black Country CYP Diabetes Network with a focus on rolling out of hybrid closed loop technology to all children and young people with Type 1 diabetes by 2029 and Epilepsy Network who have undertaken an in-depth consultation with 12-18 years with lived experience of epilepsy.

11 schools across the Black Country have achieved the asthma friendly school status, and a story book and lesson plans for Key Stage 2 have been developed for asthma and clean air.

Mental health, learning disabilities and autism

Creating a Black Country where people with mental health, learning disabilities and or autism have more say over their care and supporting them to live well in their communities is key. Services to support people to live in the community, get support in a crisis, and be there when they need information and guidance is important. Our aim is to ensure our citizens have access to services that are of outstanding quality, and that support people to live their best lives as part of their local community. We will do this through:

- A review of children and young people's mental health services.
- More community connected services to give people more choice and control.
- Services in place to ensure that people who find themselves accessing urgent care services have fair and equitable treatment for their physical and mental health needs.
- Reduce out of area hospital placements.
- Focus on prevention, timely diagnosis and personalised care and support for those with dementia and their families and creation of an all-age Black Country suicide prevention strategy with partners.

Outcomes to be achieved

For our Patients:

- Accessible and equitable service provision, exceptional experience of care for all
- Increased mental wellbeing and earlier intervention, Increased support in the community,
- Support our Children and Young People to thrive and Suicide prevention

For Organisations:

- Better understanding of population health and wellbeing, greater connectivity to local communities
- Improved use of resources across the system, improved workforce resilience and wellbeing

For our System:

- Parity of esteem between physical and mental health, successful achievement of national ambitions for MH and LDA, benefit from economies of scale and specialism

Work Programme To be delivered by:	Yr1	Yr2	Yr3	Yr4	Yr5
Children and Young Peoples Mental Health (MH) Services To achieve a shared and coherent vision across our system, to drive forward our transformation programme; including a full review across a number of service elements, alignment of pathways, and expansion of services where needed.				✓	
Community Mental Health Services (CMHS) Implement our new integrated model of CMHS to modernise services and workforce models, delivering holistic care aligned with Primary Care Networks, giving people greater choice and control over their care.		✓			
Urgent and Emergency Care Mental Health Services To ensure that people with MH needs who find themselves accessing urgent and emergency care services have a fair/equitable service, recognising both their physical and MH needs; through an assessment hub outside of Accident and Emergency (A&E) environment, a drug and alcohol strategy, High Intensity User support, bed strategy to maintain the low levels of Out of Area Placements.		✓			
Dementia Improve the lives of people with dementia focusing on prevention, timely diagnosis, crisis prevention, personalised care and family/carer support.			✓		
Learning Disabilities and Autism (LDA) Reduce the reliance on inpatient care for people with learning disabilities and address unwarranted variation/gaps in autism care.		✓			
Suicide Prevention Collaborative working to develop an all-age Black Country Suicide Prevention Strategy and implement associated actions including education and awareness, urgent community response model and 24/7 Liaison Teams in A&E.			✓		

Additional resources invested in Mental Health Bed Management to prevent Out of Area Placements and provide crisis beds for those with complex emotional needs. In the Black Country the number of patients placed Out of Area are currently at the lowest levels in the country, supporting patients to remain in their local communities.

Transformed community services to support people with severe mental illness to be cared for in the community.

Long-term conditions management

Locally we have high levels of deprivation, and this can mean that some people struggle to access healthcare to diagnose and manage their long-term conditions. Long-term conditions such as diabetes and cardio-vascular disease (CVD), are amongst the top five causes of early death for local people.

Our aim is to ensure we reduce the prevalence of people with long term conditions in our population, and that we support those people living with long term conditions to live longer and happier lives through effective processes of prevention, detection, and treatment.

Our plan is to:

- Prevent treatable conditions, through effective prevention programmes.
- Ensure patients continue to receive services post COVID-19 to help them to recover.
- Engage patients to improve their understanding of their condition and how to manage it.
- Support patients to manage their condition effectively, through self-care and use of digital technologies.
- Integrate pathways to manage care in primary and community settings and avoid conditions getting worse or having an urgent need for health intervention (exacerbation).
- Support the delivery of local health inequalities initiatives based upon the Core20PLUS5 framework.

Outcomes to be achieved

For our Patients:

- Earlier diagnosis
- Reduced preventable illness
- Improved life expectancy
- Reduced mortality
- Patient empowerment, increased patient led condition management

For Organisations:

- Reduced pressure on urgent and emergency care
- More effective utilisation of capacity/resources
- Better use of technologies

For our System:

- Improved health outcomes, reduced health inequalities
- Collaboration/joint working with wider system partners e.g. Local Authorities, third sector
- Greater integration of pathways/services
- Leadership through Clinical Learning Networks

Roll out of 'T2Day: Type 2 Diabetes in the Young', where patients benefit from extra one-to-one reviews as well as the option of new medicines and treatments where indicated, to help better manage their diabetes. The NHS is the first health system in the world to put in place a national, targeted programme for this high-risk group of people.

Work Programme To be delivered by:	Yr1	Yr2	Yr3	Yr4	Yr5
Diabetes Delivery of prevention, detection and treatment programmes relating to structured education programme, National Diabetes Prevention Programme, Low Calorie Diet, Extended Continuous Glucose Monitoring, Multi-Disciplinary Footcare Teams. New guidance is also been considered.	✓	✓	✓	✓	✓
Post COVID-19 Services Ensuring patients continue to receive access to post COVID-19 services in a timely manner.	✓	✓			
Cardiovascular Disease (CVD) Delivery of initiatives to improve early detection and management of CVD including hypertension case finding, Blood Pressure at Home Service, delivery of Cardiac Improvement Programme.	✓	✓	✓	✓	✓
Respiratory Development and delivery of pulmonary rehabilitation five-year plan including development of spirometry services, expansion of remote monitoring programme and lung health check programmes.	✓	✓	✓	✓	✓

Workforce

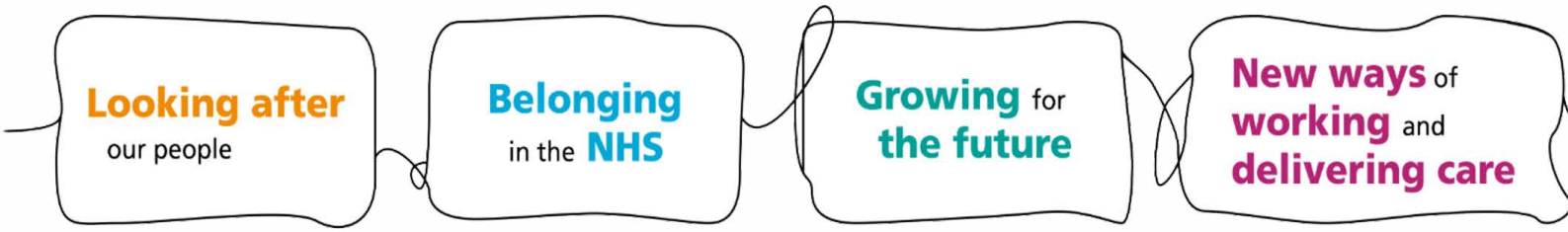
We know that a key enabler for the successful delivery of our Joint Forward Plan is our workforce. Currently there are approximately 60,000 colleagues working across health and social care in the Black Country, each providing a unique contribution to the delivery of care to our community. We know that for us to thrive we need to look after our workforce and become a place where people want to work. As a health and care system we know that as 'one workforce' we are better and that we need to develop the right culture and infrastructure for the Black Country to be the best place to work.

We hope to do this through creating psychologically safe and supportive environments, where all our diverse colleagues feel they belong and we can provide the architecture for developing a workforce that is sustainable for the future. The NHS England Long Term Workforce Plan is a key document that will act as a framework for supporting and developing our workforce.

We will:

- Focus on retaining our people and supporting them to be the best they can be, which in turn optimises our resources.
- Create an inclusive talent management approach.
- Publish a Black Country Health and Wellbeing Strategy along with our refreshed People Plan 2023-2028 that describes the priorities, actions, and impact to make the Black Country the best place to work.
- Work collaboratively to coordinate a workforce development plan that articulates our approach to workforce planning, education and training.

We pledge to our health and care workforce to support them in continuing to deliver excellent care, whilst promising to enhance their working experience. We will lead with compassion and create a culture of inclusivity and openness, with the health and wellbeing of our workforce at the heart of all we do. We will work together to create an environment free from discrimination; providing a sense of belonging to our diverse colleagues.



Continued focus on training, recruitment and staff retention.

Offering a package of support to all our staff, including emotional wellbeing, physical health, and financial support, for example.

Invested in leadership programmes to grow a more diverse staff group and ensure our future leaders are representative of the community we serve; for example, our Next Generation Senior Leadership Programme.

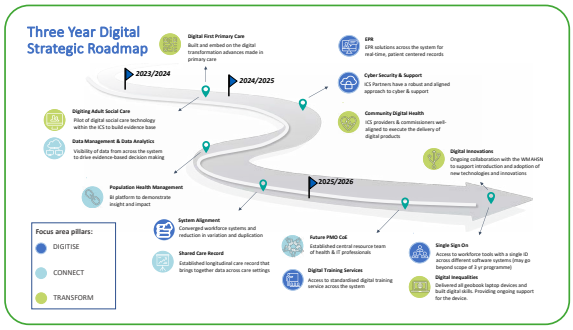
Recruitment of 29 International Radiographers who will support across hospital sites, addressing workforce challenges and improving diagnostic capacity for our patients.

Digital

Digital is a key enabler to successfully deliver the Joint Forward Plan strategic priorities. Digital innovation gives us an opportunity to improve patient care and increase efficiency, whilst supporting the wider strategic aims and objectives of the system.

Whilst the COVID-19 pandemic provided an opportunity to accelerate the implementation of digital solutions to provide care, in some cases, this unfortunately led to an increase of digital exclusion within some patient groups. It is our duty to ensure that we do not inadvertently increase digital exclusion through the implementation of technologies and we must ensure that we seek to reduce existing inequalities by working collaboratively with our system partners and local communities.

Digital strategic roadmap identifying key activities that will be achieved over the next three years.



The diagram below provides an overview of the current Digital work programme that will support delivery of the ICS Digital Strategy.

Our ambition for a digitally enabled Black Country NHS is to coordinate a system wide digital programme, ensuring our staff members and partners have access to the digital facilities to not only achieve our strategic priorities but do so in a way in which addresses digital inequalities, maximises innovation in both the organisation and delivery of care, and provides our workforce with an efficient working environment.

A Digital Roadmap has been developed with key milestones for delivery of the ICS Digital Strategy, the diagram below provides an overview of the three-year digital roadmap.

1. Digitise	2. Connect	3. Transform
Electronic Patient Record This will be real-time, patient centred records for instant information	**Data Management & Data Analytics** Data capability to enable visibility of data from across the system to drive evidence based decision making.	**Community Digital Health** This seeks to align ICS community providers & commissioners to co-design, coordinate, drive, advise on and execute the delivery of digital projects.
Cyber Security & support Ensuring that the ICS Partners' cyber & support approach is robust & aligned for the challenges that come.	**Population Health Management** Iterative, hypothesis driven use of business intelligence to quickly test out ideas, demonstrating insight and impact e.g. repeat attendance in A&E.	**Digitising Adult Social Care** Pilot digital social care technology within the ICS to build an evidence based for their impact, develop implementation guidance, assure supplier solution.
System Alignment Clinically led programme to review all clinical workforce systems – converging where appropriate to reduce variation or duplication.	**Future PMO Centre of Excellent (CoE)** A central resource team of health & care IT professionals qualified in project and programme management which can flex across partner organisations.	**Digital First Primary Care** Embed and build on the digital transformation advances made in primary care and ensure that every patient is offered digital-first primary care by 2023/24.
Digital Training Services A digital training service that will be available across the system, ensuring that there is a standardised approach to training.	**Shared Care Record** A longitudinal care record that brings together data across settings of care. This supports the proactive approach for coordinating care.	**Digital Inequalities** Providing citizens with a Geobook laptop device, connectivity, training to build their digital skills and ongoing support for the device.
Single Sign on (SSO) SSO is an authentication scheme that allows the workforce to access tools with a single ID across different software systems.		**Digital Innovations** Collaboration with the WMAHSN to support the ICS with the introduction and adoption of new innovations and technologies.

Shortlisted for HSJ Awards – Black Country Connected Programme; including Best Consultancy Partnership with the NHS, Most Impactful Project Addressing Health Inequalities, Social Value Initiative of the Year and Best Community Services with the NHS.

Increased participation in One Health and Care, our system wide patient shared care record.

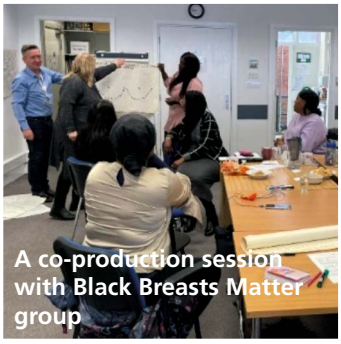
Rollout of Digital Social Care Record across Adult Social Care (ASC) Providers.

NHS Black Country

NHS Black Country
Joint Forward Plan 2023-2028

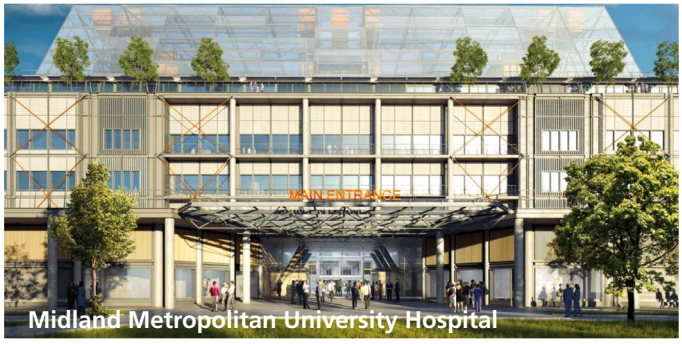
Updated April 2024

Virtual wards allow patients to get the care they need, at home safely and in familiar surroundings.

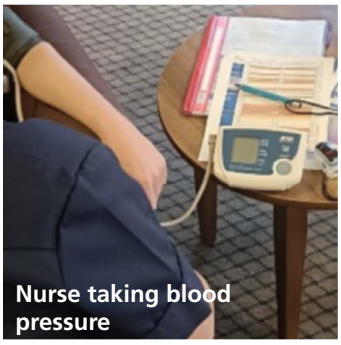


A co-production session with Black Breasts Matter group

Draft for Involvement



Midland Metropolitan University Hospital



Nurse taking blood pressure

Our vision is to improve the health outcomes for local people, making the Black Country a healthier place with healthier people and healthier futures.

Priority 1 - Improving access and quality of services
The core function of the NHS is to provide quality healthcare to the population in a timely manner. We know that across the country, and within the Black Country, there is more that we can do to ensure that where required the public have access to an appropriate intervention, and for that intervention to be of the highest quality possible. Our ambition is to improve accessibility and the quality of such care across all parts of our system.

Priority 2 - Care closer to home
The NHS has seen more people than ever before in recent years, across all parts of the NHS. Beds within our hospitals are almost always full and our GP practices have never been so busy. Our ambition is to ensure that our hospital beds are available for those people that need them, and that we have appropriate service provision in the community to care for people where appropriate.

Priority 3 - Preventing ill health and tackling health inequalities
As we know, prevention is better than cure. We intend to work with partners to invest in preventative services, where we can, to reduce the pressure on the NHS. Also, we are committed to ensuring that the health inequalities we face within the Black Country are reduced effectively.

Priority 4 - Giving people the best start in life
In order to ensure that children and young people in our communities have the best start in life, we will refocus our efforts, with partners, on delivering improved access and services for this population.

Priority 5 - Best place to work
It is vitally important that we have a vibrant, effective workforce across all parts of the Black Country system if we are to achieve our priorities. Currently, there are approximately 60,000 colleagues working across health and social care in the Black Country and we know that for us to thrive, we need to look after our workforce and become a place where people want to work.

Priority 6 - Fit for the future
This new priority recognises that the Black Country health system needs to change the way that it works to embrace the opportunities and meet the challenges it faces. This includes the need to be more productive and cost-effective to meet our financial challenges. We also need to ensure that we support our Places and providers to work better together. We need to reduce the carbon footprint of the NHS and be more sustainable. All of this will require strong, sustainable leadership and enabling functions.

In five years time there will be:

- improved quality (access, experience and outcomes) for local people
- a greater sense of belonging, value and satisfaction for our workforce
- well led, well organised, system for our partners to engage with
- a reduction in health inequalities for our population
- a financially sustainable system
- a reduced carbon footprint

Contents

Welcome to the NHS Black Country Joint Forward Plan

The NHS Black Country Joint Forward Plan has been developed in collaboration with partners and our population and sets out our challenges, health needs, strategic vision, and strategic priorities for the five year period of 2023-2028.

This update represents Year 2 of the plan and describes achievements since the plan was published in July 2023, and learning from our continued engagement with the public and partners over the last year.

The main aim of our plan is to improve the health outcomes for local people, making the Black Country a healthier place with healthier people and healthier futures.

This Joint Forward Plan describes how NHS organisations within the Black Country will support the delivery of the priorities our public and partners have described as essential in meeting the needs of our population.

We created this plan following conversations with local people and partners. Our approach to working with people and communities sets out the 11 principles for how our people and communities expect to be involved in shaping priorities, developing plans, and continually improving services to address the health and care challenges that we face locally. This plan has been informed by an internal and external involvement programme. Building on this, we are committed to a future where we start with our people and communities by default, broadcast less and listen more, and act and continually feedback to ensure that Black Country people are empowered and involved at every stage of the planning process.

Through the conversations that we have had we heard that local people want:

- Improved access
- Better preventative services
- Community focus
- More personalised care

There was also feedback to support more investment in services to tackle loneliness, isolation and mental wellbeing. Generally, it was clear that the rising cost of living, will increasingly impact upon our communities and upon health and care services in the short and long term. A big theme in conversations about the cost of living was the 'voluntary care squeeze' which was the worry expressed by some working age people caring for older/younger dependents due to the cost of care.

We know that our health is determined by much more than our access to health services.

How healthy we are and how long we live in good health is dependent upon other factors such as our health behaviours and lifestyles, the places and communities we live in, and the way in which we use health services.

Taking into account the national action, the views of local people and the advice on areas that will make the most difference to local people's health, we set our five strategic priority areas in our five-year plan as follows:

- **Priority 1**- Improving access and quality of services
- **Priority 2-** Care Closer To Home
- **Priority 3**- Preventing ill health and tackling health inequalities
- **Priority 4**- Giving people the best start in life
- **Priority 5**- Best place to work

2023/2024 as our first full year as an Integrated Care System (ICS) has evidenced the collective strength of the Black Country system partners working collaboratively to deliver more timely and efficient services. However, we need to build on the good progress made to date and ensure we change the way we work to meet the financial and other challenges we face. This includes our new Operating Model with greater devolution and responsibility to our four Places (Dudley, Sandwell, Walsall and Wolverhampton) and provider collaboratives, the leadership model to support this and how our support functions are aligned to the different ways of working. As a result, the update to the Joint Forward Plan includes a new priority for the system to reflect the challenges we face.

The new priority is:

- **Priority 6**- Fit for the future

These priorities and the contents of this plan have been shaped to respond to the local health needs and represents our commitment to addressing the challenges which local people and communities face. The challenges culminate in some stark statistics, such as Black Country people generally not living as long as people in other parts of England. The years of life spent in good health (what we call healthy life expectancy, HLE) is also less than other parts of England. This is something which we are focused on addressing now to benefit people in the years ahead.

We recognise that health can't do this alone, wider determinants are the most important driver of health. They include income, employment, education, skills and training, housing, access to services, the environment and crime. In this plan you will read about how we are working in partnership, in each of our Places, to address wider determinants of health.

Across the NHS locally, our collaborative approach has helped us to perform well against NHS targets and priorities, including referral to treatment times in elective care, and access to urgent and emergency care. However, there is no question that this is a challenging time for health and care services.

We are clear that if we are to achieve the outcomes we want in these areas, we will need to work together differently, as we shift our focus from treatment to prevention, create healthier places which support people to make healthier choices and support those who work for us to provide the highest quality care.

Within the five-year period of our plan, there will be some significant developments in our bid to make the Black Country healthier. These include a shared care record, ensuring that direct care is improved through access to the right information, and the Midland Metropolitan University Hospital, which will open its doors to new state-of-the-art facilities in 2024. There will also be improved access to diagnostics and elective care through community diagnostic centres and increased theatre capacity, resulting in the reduction in waiting lists.

The following principles will underpin our approach to delivering our plan:

- **Collaboration** – we will work across organisational boundaries and in partnership with other ICS partners, including our people and communities, in the best interest of delivering improved outcomes for the population we serve.
- **Integration** – Integrated Care System partners will work together to take collective responsibility for the planning and delivery of joined up health and care services.
- **Productivity** – we will ensure we improve productivity by making the best use of our collective resources by transforming the way we deliver services across the Black Country.
- **Tackling Inequalities** – we will ensure that we continue to focus on delivering exceptional healthcare for all through equitable access, excellent experience, and delivering optimal outcomes.

The publication of the refresh of the plan for Year 2 (2024/2025), is just the continuation of our journey. We will continue to hold conversations with local partners, people and communities to inform future iterations as the plan, which will include a significant 'Mid-Term Review' of the plan for the start of the 2025/2026 financial year. We will use this year to review and refresh our system strategies – both the Integrated Care Partnership strategy and this Joint Forward Plan – and incorporate any changes to our strategic and operational priorities based on those conversations. We look forward to continuing to engage with you over the coming 12 months - continuing the progress already made in working together in delivering the priorities in this plan and to make a real difference to the health of the Black Country.

I want to thank everyone who contributed.

Best wishes

Mark

Mark Axcell

Black Country Integrated Care Board
Chief Executive

Updates to the plan – April 2024

Since the publication of the Joint Forward Plan in July 2023 we have made progress in a number of key strategic priority areas.

We have seen the development of our Integrated Care Partnership with a formal Board established, meeting in public and bringing together partners to meet the health and wellbeing needs of our population. The Partnership has confirmed that its priorities remain Children and Young People, Mental Health, Social Care and Workforce for 2024/2025. These priorities continue to align with our six strategic priorities as demonstrated in the diagram below:

* Cross cutting priorities

To help support delivery of our partnership priorities, the ICB Academy has worked with all partners to develop a Population Outcomes Framework. The framework sets out 'four pillars' of population outcomes; Wellbeing, Prevention, Management and Intervention. The supporting digital tool enables transformation initiatives to be mapped to the four pillars, and will be used to inform, measure and take action to improve the health and wellbeing of our population.

A further significant development during the last year resulted in the ICB taking on delegated responsibility for Pharmacy, Dental and Optometry Services from 1 April 2023. This enabled us to take a more integrated and joined up approach to planning and designing care around our population's health needs. From 1 April 2024 we will also be taking on delegated responsibility for 59 Acute Specialised Services which will enable us to maximise opportunities to improve our patients' experience and outcomes across primary, community, and acute services.

Further developments have been detailed later in the document, examples include:

- Commenced our journey to develop a five-year programme to transform primary care
- Continued to evolve our Operating Model including the development of Provider Collaboratives and Place Based Partnerships
- Refreshed our transformation programmes and undertook a review of achievements to date, examples of these are captured within the Strategic Delivery Plan document. Please note these provide a sense of our core strategic achievements, rather than a complete list.

Unfortunately, the financial challenges we face have increased since last year. To date we have been a system which has delivered our financial plans, achieving a system breakeven position, however our system now faces a number of local and national pressures which are driving excess costs. The Black Country system is responsible for meeting the health needs of 1.26 million people. Our local population has a number of specific characteristics, including being the second most deprived ICS population nationally; highly diverse populations; and a significant younger population. These characteristics translate to a range of specific healthcare challenges including higher levels of obesity levels compared to the national average; some of the highest infant mortality rates in the country; lower than average healthy life expectancy and significant health inequalities which have widened since the pandemic. These healthcare challenges mean our NHS services are used more significantly, meaning more resources are required to provide the

appropriate care to our populations, which puts pressure on our finances.

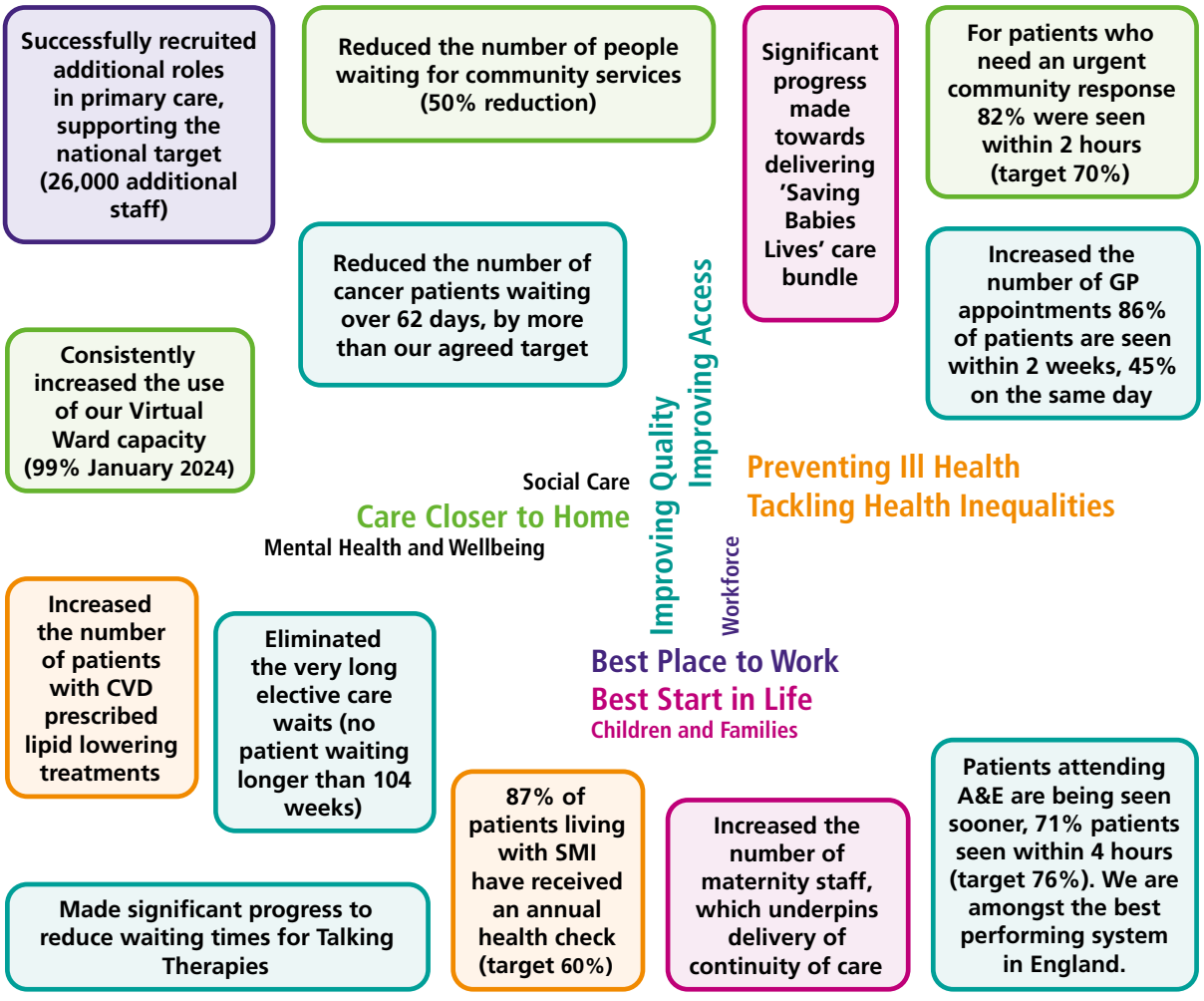
As a result of this, we have developed a system Financial Recovery Plan (FRP) which sets out our planned financial trajectory and options on how this will be delivered. Over the next year we will develop the detailed actions that will reduce our costs and achieve our financial plan.

To recognise this, we are including a new priority in our Joint Forward Plan – Fit for the Future. This will include the implementation of the system Financial Recovery Plan; adoption of new ways of working across the Black Country in line with the Operating Model; strengthen our enablers to support service improvement, such as digital and estates; and organisational development adopting the leadership behaviours required to transform the way we work. It will also include the sustainability/Greener NHS agenda.

This refresh of the plan describes the actions the NHS will undertake to implement the six strategic priorities. Updates to the plan have been made where new Health and Wellbeing Strategies have been published in 2023/2024. The plan reflects updates to the prioritisation of initiatives in each of our Places and Programme Boards, and provides a summary of some of our key achievements that support the delivery of our Joint Forward Plan and Integrated Care Partnership priorities. It also includes outputs from new conversations with the public in line with our Involving People and Communities work.

Our Successes – Achievements

Our plan sets out how we will measure our success, key headline achievements since publication in July 2023 are set out below:



Our Successes – Case Studies

A number of case studies are set out below, showcasing our more strategic developments and achievements over the last year:

Paediatric Virtual Ward Programme enabling children to go home from the hospital sooner in the Black Country

Virtual wards allow patients to get the care they need, at home safely and in familiar surroundings, helping speed up their recovery while freeing up hospital beds.

The ICS was the first in England to introduce virtual wards for children. After a successful pilot scheme in Dudley, where the first paediatric virtual ward opened on 1 March 2022 at Dudley Group NHS Foundation Trust, a total of 593 children have been treated since then. Following this success, paediatric virtual wards have now been introduced in Walsall, Wolverhampton and Sandwell, with more than 1,150 children supported to date.

How does the paediatric virtual ward work? Parents and carers are given access to state-of-the art remote monitoring technology, so their child can receive specialised care at home tailored to their unique needs. To do this the virtual ward uses Docobo's remote monitoring solution, DOC@HOME®, to monitor children who have been discharged from hospital but require a level of specialist care and monitoring to maintain their safety at home.

The children's ward team works closely with the family to train them to use the equipment, answer their questions and ensure they are fully comfortable before their children are discharged. The family then takes part in virtual "ward rounds" with clinicians and have direct telephone access to specialist clinical staff in case of any queries.

Tyler was a patient admitted to Russells Hall Hospital in Dudley last year with a severe infection. When his condition improved, the family was offered the chance to take a virtual ward kit home. Mr Lewis, parent of Tyler said: "Tyler just wanted to be at home with his family as we all do. The virtual ward was completely new to us, and we took full advantage of it. It's a brilliant piece of kit because you can bring it home and they can monitor your child at home. They can see every result from home, which is beneficial to us and the hospital. It saves them resources with beds, it saves us the time having to sort out arrangements at home, sort out businesses and work commitments, travelling back and forward, or wasting services that other people can benefit from in a more serious condition."

Midland Metropolitan University Hospital (MMUH)

MMUH is a brand-new, state-of-the-art acute hospital that will serve over half a million people living in Sandwell and West Birmingham.

When it opens later this year, MMUH will bring together all acute and emergency care services that are currently provided across City and Sandwell Hospital into one place. MMUH will provide a hub for emergency care, with the build also boosting regeneration in the local area.

The hospital will serve patients who are acutely unwell and need a hospital stay, or whose care is an emergency. All acute clinical teams will combine to operate as one and staff will work with new technology in modern purpose-built facilities, helping to improve patient care and experience.

The new state-of-the-art facility will be the first new hospital to open in the West Midlands since 2010, with a host of facilities including:

- A purpose-built ED with imaging and diagnostic services
- A dedicated children's EDand assessment unit
- Adult and children's wards with 50% of beds being within single ensuite rooms
- Operating theatres for both emergency, major planned surgery and maternity
- A midwife led birth unit next to a delivery suite, two maternity wards and an antenatal clinic
- A neonatal unit
- Same day emergency care for adults
- Sickle cell and thalassaemia centre

Visit the Sandwell and West Birmingham NHS Trust website for more information.

Recognising Walsall Together

Walsall Together Partners Celebrating their award

Walsall Together were crowned winners of the Place Based Partnership and Integrated Care Award at the HSJ Partnership Awards in November 2023, for its work to improve outcomes for the citizens of Walsall. The ceremony recognised the partnership for the significant integrated work that has been achieved from hospital avoidance, discharge pathways (NHSE national pilot site), enhanced care homes support, workforce recruitment and retention, and community resilience.

The entry was described by the panel of judges as "An excellent example of partnership and effective leadership and structure with the implementation of some unique projects. This is a shining example of what other systems should be aiming for."

Michelle McManus, Director of Transformation and Place Development for Walsall Together, said, "The partnership has gone from strength to strength since it was formally established in 2019 and this is down to the sheer passion and drive of all our partners and our wider colleagues in the voluntary and community sector. The strong relationships and can do attitude have meant we have been able to work together to make a real difference to the citizens of Walsall putting their voices at the heart of what we do and helping them to stay well and out of hospital, reduce inequalities and improving access to services for our most disadvantaged communities."

For more information about Walsall Together visit their website at www.walsalltogether.co.uk

The Frailty, Recognition, End of Life, Escalation of Deterioration (FREED) Pathway

An integrated care pathway has been introduced to provide safe, compassionate care for older people living with frailty in care homes across the Black Country.

The pathway aims to support all social care staff to improve early recognition and avoid deterioration of frailty to aid pre-empting end-of-life discussions and planning, also aiding carers and families to identify and respond to the health decline of individuals in a care home setting. We achieve this by using tools such as Stop and Watch, the NEWS2 scoring system and assessing residents clinical and soft signs of deterioration, including undertaking basic clinical observations skills ensuring responsive, timely escalation to the most appropriate service and timely access to holistic health care services.

The purpose of the pathway is to ensure the best evidence assessments and care planning prevents inappropriate admissions to hospital and ensures residents are on the right pathway, at the right time, and are cared for in the right place based on their wishes and condition, promoting choice and control at end of life.

Since September 2022, training has been delivered to more than 178 care providers and more than 3320 staff working within social care, caring for our most vulnerable. This has been extended to include the training of FREED champions within this sector building resilience and sustainability through increasing staff knowledge, confidence, competency and capability on the FREED pathway. An electronic resource pack was also developed which included tools, versions of assessments and support documents for care services including electronic version to either have printable access to these resources or to be uploaded to the electronic devices.

In recognition of their commitment to improving safety, culture and experience in patient care, the FREED team were shortlisted for the Deteriorating Patients and Rapid Response Initiative of the Year at the HSJ Patient Safety Awards 2023 and were highly commended in the HSJ Partnership Awards 2023.

Walsall's new Emergency Department

The new ED entrance at Walsall Healthacre NHS Trust

Walsall Healthcare NHS Trust has a new Urgent and Emergency Care Centre which brings much improved facilities and space for patient care.

The multi-million-pound urgent and emergency care centre significantly improves emergency care facilities and capacity – providing almost 5,000 square metres of additional clinical space.

The two-storey development – the most substantial investment Walsall Healthcare has seen - includes:

- An urgent treatment centre
- Emergency department including resus and rapid assessment and treatment area, and children's Emergency Department (ED)
- Co-located paediatric assessment unit
- Acute medical unit
- Provision for frailty and community integrated assessment services

The new £40m building also includes reconfiguration of the current ED footprint, to incorporate improved ambulatory emergency care and imaging services.

What is an NHS Joint Forward Plan?

The plan is a joint document developed in partnership with NHS organisations in the Black Country (the Black Country Integrated Care Board and our provider NHS Trusts).

The development of this plan has been an opportunity for us to work with local people, our health and care partners and staff to develop a plan that is locally owned, delivers the national ambitions and recognises our collective strength in working together to resolve our common challenges. It describes our ambition to improve quality and outcomes for people who use our services.

In addition, the plan:

- Describes how we intend to use our NHS budget to ensure that local services are of the highest quality and that they meet local need
- Sets out how we will address the challenges which we face today and those that we recognise are affecting the future health of local people
- Explains how we will support our workforce so that it is fit for the future and create a system of health and care organisations that are seen as employers of choice
- Describes how we will support local people with the knowledge and skills to have more choice and control over their own health and care
- Sets out how we will change the way organisations work together moving forward
- If after reading this summary you may want to read more, there is a full version of the plan on our website.

The Black Country

The Black Country is home to our 1.2 million people who bring a diversity within the four distinct Places: Dudley, Sandwell, Walsall, and Wolverhampton.

As NHS Black Country Integrated Care Board, we are responsible for ensuring that local people have access to the best possible NHS services. Our NHS landscape is made up of a number of partners including the Integrated Care Board (ICB) acting as the strategic commissioner, four Acute and Community Trusts, one Mental Health Learning Disabilities and Autism Trust, one Ambulance Trust, one Integrated Care Trust, four Local Authorities, a large number of GP practices, community pharmacies, community optometry sites and general dental practices.

We are all part of the Black Integrated Care System (ICS) which brings health and care partners together with a number of other partners including community and voluntary sector organisations, housing, fire, police, large employers and education to improve the health and wellbeing of Black Country people.

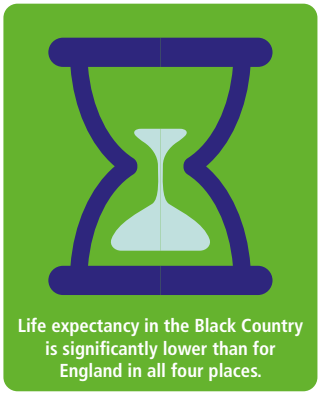
We also have thriving Voluntary, Community, Faith and Social Enterprise (VCFSE) partners in the Black Country. This is a vast and diverse sector, comprising of nearly 4,000 member organisations across our four place-based Community and Voluntary Services (CVS).

Our health challenges

We know that our health is determined by much more than our access to health services. How healthy we are and how long we live in good health is dependent upon other factors such as our health behaviours and lifestyles, the places and communities we live in and the way in which we use health services.

Map of Black Country showing our four places of Dudley, Sandwell, Walsall and Wolverhampton

Within the Black Country:



Life expectancy in the Black Country is significantly lower than for England in all four places.

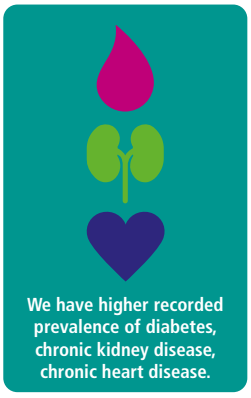
The gap in life expectancy between the Black Country and England is 2.2 years for males and 1.6 years for females.

Healthy life expectancy is also lower than for England in all four places.

The gap between life expectancy and healthy life expectancy is larger for females in the Black Country than for England; it is similar for males.

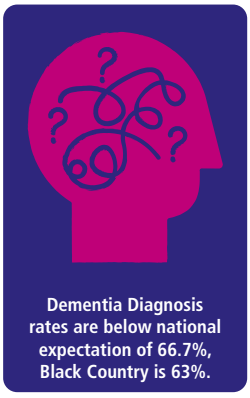
Both child (43% locally vs 35% in England) and adult (69% locally vs 64% in England) obesity rates are higher than England.

We have some of the highest infant mortality rates in the country, whilst smoking rates in pregnancy remain high and breast-feeding rates are low.



We have higher recorded prevalence of diabetes, chronic kidney disease, chronic heart disease.

We have a high number of premature deaths from Cardiovascular Disease (CVD) and respiratory disease, under 75 mortality rate for CVD is 99 per 100,000 and under 75 mortality rate from respiratory disease is 38 per 100,000.



Dementia Diagnosis rates are below national expectation of 66.7%, Black Country is 63%.

Other challenges

Whilst our Joint Forward Plan sets out our ambition over the next five years, it is important to recognise the challenging landscape within which we will deliver our plan.

Restoration and recovery from COVID-19 – Whilst significant progress has been made to reduce waiting list backlogs, we need to ensure that we continue to recover services and address existing health inequalities in access.

Urgent and emergency care pressures – Whilst we are one of the better performing systems for delivery of the four-hour accident and emergency target, urgent and emergency care remains our most pressured area. The demand for services at peak times, particularly in the colder months, is exceeding the capacity which we have.

Out of hospital care demand – Whilst we have improved access to out of hospital services, the demand for out of hospital services including primary, mental, community services and social care is continuing to increase as a result of a growing ageing population and chronic disease.

Workforce – Our workforce is a key asset to help us deliver our five year plan. We know that we have significant challenges including an ageing workforce, recruitment, and retention challenges and that looking after the health and wellbeing of staff is a key priority.

Finance and efficiency – Our system is facing significant financial challenges which only be addressed by partners working together to deliver increased productivity, transforming and redesigning services to drive improved outcomes and make better use of resources.

Writing our plan

In addition to seeking the views of local people, when writing our plan we have considered the following:

The ICS purpose

Integrated Care Systems (ICSs) are partnerships that bring together NHS organisations, local authorities and others to take collective responsibility for planning services, improving health and reducing inequalities across geographical areas. There are four core purposes of an ICS to:

- Improve health outcomes
- Tackle inequalities
- Enhance productivity and value for money
- Support social and economic development

Policy drivers

In writing our plan we have taken into consideration the following:

- NHS priorities

Each year, and periodically over longer periods, a set of 'NHS Objectives' to be achieved by NHS organisations within the NHS are published.

Guidance documents that our plan takes account of:

- NHS Long Term Plan (2019-2029)
- NHS Joint Forward Plan priorities (2023-2028)
- NHS Operational Planning Priorities (2024-2025) (Not yet published)

- Our local Integrated Care Partnership Strategy

An Integrated Care Partnership is a forum jointly convened by Local Authorities and the NHS, comprised of a broad alliance of organisations and other representatives as equal partners concerned with improving the health, public health and social care services provided to their population. The Black Country ICP has established that we should focus on the areas described below. This plan describes how the NHS will play its part, jointly with partners, in making improvements to these areas:

- Mental health
- Social care
- Workforce
- Children and young people

Integrated Care Partnership

- Core20 Plus 5

The Core20Plus5 framework is designed to support ICSs to drive specific actions to reduce health inequalities. Core20 means the most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD). Half the population of the Black Country live in these Core20 areas. Although there is variation in the proportion of people living in Core20 areas across our four Places, all four are higher than the national average.

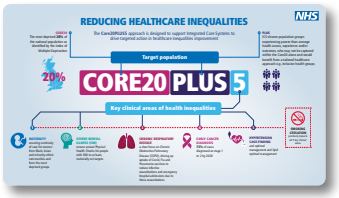
The 'PLUS' are the population groups experiencing poorer than average health access or outcomes, and who may not be captured within the Core20 alone so may benefit from a tailored approach.

PLUS groups include ethnic minority communities, inclusion health groups, people with a learning disability and autistic people, people with multi-morbidities, and other protected characteristic groups.

Along with defining target population cohorts, it also identifies five focused clinical areas requiring accelerated improvement. These are:

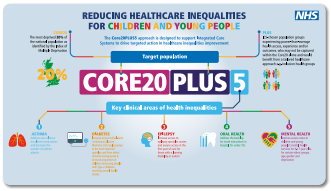
Adults:

- Maternity
- Severe mental illness (SMI)
- Chronic respiratory disease
- Early cancer diagnosis
- Hypertension



Children:

- Asthma
- Diabetes
- Epilepsy
- Oral health
- Mental health



Our approach to involving people and communities

In 2022 we worked with local people and partners to co-produce our approach to working with people and communities. The approach supports our commitment to meaningfully involving people and communities in the decisions we make, as well as outlining how we will meet our statutory duties.

The Black Country is committed to 11 co-produced principles for how our people and communities expect to be involved, these principles fit neatly into the six core themes below:

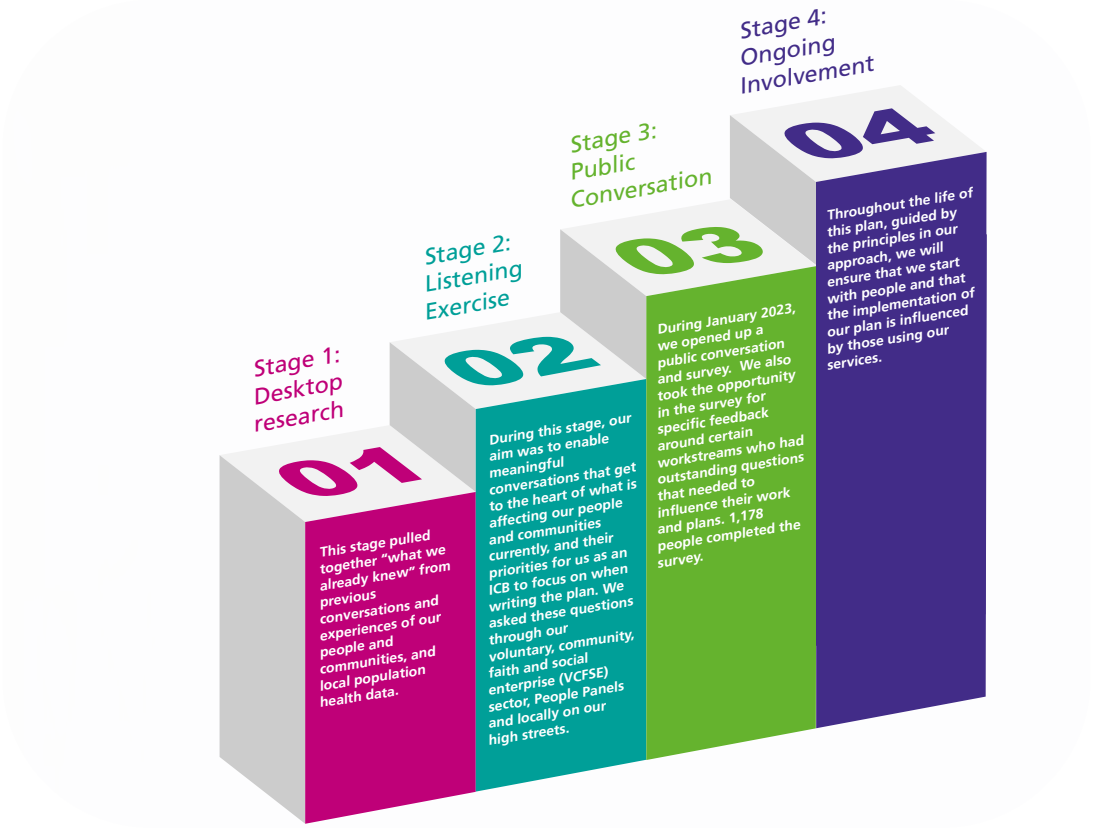
- Be accountable to our people and communities
- One size does not fit all
- Start with people and communities
- Trusted voices are key
- Invest in people and communities
- Nurture relationships across the ICS

We have developed mechanisms for involvement which crosscut neighbourhood, place and Black Country, and are designed to be participatory, inclusive, representative, and culturally competent.

The Black Country Approach can be found on our ICB website.

Involving people and communities in our plan

Ensuring that people and communities have been involved in the development of the plan is important to us, not only to discharge our statutory duties, but to ensure that the plan is reflective of the needs and wants of our communities. The development of the original five-year plan and this year's refresh has been undertaken in stages:



What we have heard

The 2023 Black Country Joint Forward Plan was informed by three stages of involvement activity to establish the overarching areas that local people wanted us to focus on. There is a full involvement report available online, but in summary local people told us they would like a focus on:

- Improved access - to appointments and emergency/urgent care, to resources and reasonable adjustments, to digital devices/ data/skills
- Better preventative services
- Community focus – clinical and non-clinical
- More personalised care options and choices

There was also feedback to support more investment in services to tackle loneliness, isolation and mental ill health. A big theme in conversations about the cost of living was the 'voluntary care squeeze' which was the worry expressed by some working age people caring for older/younger dependents due to cost of care.

These areas informed our priorities for the five-year plan and also helped the transformation workstreams to shape their plans.

Throughout the last 12 months we have continued our conversations with people and communities to support the delivery of the plan.

Refreshing our plan

Each year we will refresh our five-year plan, updating on progress made and any changes which might impact on our delivery or indeed the priority areas. This year is our first refresh and we have taken the opportunity to check in with stakeholders and communities on the priority areas and to update on the progress made in the first year.

We plan to involve local people, community leaders and trusted voices in the following ways:

- We will be hosting a period of public involvement between 27 February and 20 March 2024
- An updated short read version of the Joint Forward Plan will be published on the ICB website with an invitation to local people and stakeholders to share their feedback and views on our priorities
- During the involvement period, we will be hosting conversations with participants at People Panels to seek feedback and views from local people and stakeholders on our priorities

Along with ensuring that local people are informing the refresh of our plan, we will also be engaging with partners and other important stakeholders such as Healthwatch, Health and Wellbeing Boards and Local Authority Health Overview and Scrutiny Committees.

This section is reserved to include a summary of this involvement work which is currently underway.

Continuing the conversation

We know that conversations can create health. Instead of broadcasting and trying to 'fix' people and communities, by listening more, we can better understand what's important and what really matters. In our first year as an ICB, we made good progress in bringing to life the principles of our approach which we captured in a short video.

We know from the development of our approach to involving people and communities that starting with people by default, meeting them on their terms, and recognising that one size doesn't fit all are key to a future where we work together to improve health and happiness.

Take a look on our website at some of our involvement activities to see how we're listening, acting and feeding back what people and communities have shared with us. Highlights of our ongoing involvement work, and the participative dialogue spaces we're convening, which is shaping the delivery of this five-year plan, include:

- Records of the conversations from People Panels
- Listening to understand through Community Conversations
- Refreshing our support offer to Patient Participation Groups

Our approach is helping the ICB and Integrated Care System (ICS) partners to nurture stronger relationships, increase connectivity with the people they serve, rebuild trust and provide under-represented communities with a meaningful way to inform lasting change.

By taking a more collaborative and joined up approach to involvement, transformation workstreams are benefiting from, and beginning to respond to, what we are hearing through our mechanisms for involvement. Highlights include:

- Black Breasts Matter
- Developing a new Black Country dementia strategy
- Launching Midland Metropolitan University Hospital
- Research into usage of urgent and emergency care services
- Listening to views on elective care (planned care)

Our commitment to increasing collaboration and nurturing stronger relationships has seen us play a lead role in the development of a range of resources and opportunities for further sharing and learning with a focus on participative practices and asset-based development approaches. Examples include:

- Art of Hosting taster session
- Black Country Insight Library
- 'What If...?' community reporting project

Hearing the Voice of Black and African Caribbean Women to Improve Breast Screening Uptake

The ICB commissioned a project, led by a partnership of eight voluntary, community and social enterprise (VCSE) sector organisations from across the Black Country, representatives from the ICB involvement team, ICS colleagues and the University of Wolverhampton in order to better understand the barriers to attending breast screening appointments for Black and African Caribbean women, and to co-design solution focused initiatives.

Underpinned by the remarkable insights, stories and experiences of local women, which were only accessible through the trusted relationships nurtured by the eight VCSE organisations involved, three products were co-created to tackle common misconceptions and barriers to attending screening appointments; an infographic dispelling myths around cancer screening, a video of a mother and daughter talking about the importance of screening and a video from local TV sports presenter, Denise Lewis with a 'call' to attend screening appointments. The project has had recognition locally, regionally, and nationally for the approach taken in working with local people and communities in this way. You can hear from some of those involved in the project about what drew them to the project, and the difference the process made in a video.

There are ambitions to continue the project to create a culturally competent training package to equip the system with the knowledge of the cultural and religious beliefs that may be preventing someone from attending screening, but also on the presentation of black women with symptoms. The group has also been awarded a "Research Engagement Network Development" grant to continue their vital research into barriers to breast cancer screening for black women by training and remunerating people with lived experience as 'community reporters' who in turn, gather and curate real-life stories of others with lived experience to continue our learning and response to increasing screening uptake.

NHS Black Country Joint Forward Plan strategic priorities

Taking into account all of the above we have identified six strategic priority areas for the NHS:

Priority 1 - Improving access and quality of services
The core function of the NHS is to provide quality healthcare to the population in a timely manner. We know that across the country, and within the Black Country, there is more that we can do to ensure that where required the public have access to an appropriate intervention, and for that intervention to be of the highest quality possible. Our ambition is to improve accessibility and the quality of such care across all parts of our system.

Priority 2 - Care closer to home
The NHS has seen more people than ever before in recent years, across all parts of the NHS. Beds within our hospitals are almost always full and our GP practices have never been so busy. Our ambition is to ensure that our hospital beds are available for those people that need them, and that we have appropriate service provision in the community to care for people where appropriate.

Priority 3 - Preventing ill health and tackling health inequalities
As we know, prevention is better than cure. We intend to work with partners to invest in preventative services, where we can, to reduce the pressure on the NHS. Also, we are committed to ensuring that the health inequalities we face within the Black Country are reduced effectively.

Priority 4 - Giving people the best start in life
In order to ensure that children and young people in our communities have the best start in life, we will refocus our efforts, with partners, on delivering improved access and services for this population.

Priority 5 - Best place to work
It is vitally important that we have a vibrant, effective workforce across all parts of the Black Country system if we are to achieve our priorities. Currently, there are approximately 60,000 colleagues working across health and social care in the Black Country and we know that for us to thrive, we need to look after our workforce and become a place where people want to work.

Priority 6 - Fit for the future
This new priority recognises that the Black Country health system needs to change the way that it works to embrace the opportunities and meet the challenges it faces. This includes the need to be more productive and cost-effective to meet our financial challenges. We also need to ensure that we support our Places and providers to work better together. We need to reduce the carbon footprint of the NHS and be more sustainable. All of this will require strong, sustainable leadership and enabling functions.

Our Strategic Programme Boards all have a role to play in achieving these priorities, further details on their work programmes are set out later in the supporting delivery plan document. Delivery of these priorities will enable us to play our part in achieving the core purposes of our ICS and the triple aim which requires us to consider the effect of our decisions on the health and wellbeing of people, quality of services and efficient use of resources.

Further details on how we will address these specific priorities can be found throughout this document, or in full within our long read Joint Forward Plan available on our website.

NHS Joint Forward Plan Priorities

NHS
Black Country

Priority 1 : Improving access and quality of services

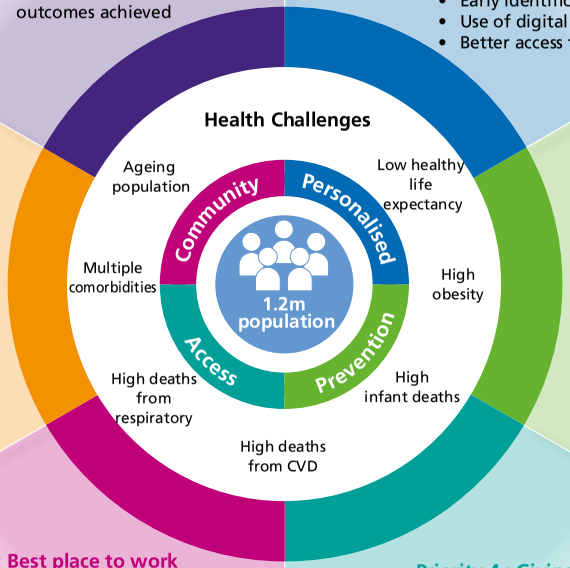
Outcomes

- Recovery from Covid-19
- Improved access to Urgent and Emergency Care
- Reduced waiting times for Elective and Diagnostic Care
- Timely diagnosis and faster treatment for Cancer
- Improved access to appointments in Primary Care
- Better Patient Experience
- More joined up care
- Accessible technologies
- Reduced variation in outcomes achieved

Priority 2 : Care closer to home

Outcomes

- Reducing the time spent in hospital, where appropriate
- Care closer to home
- Better management of Long Term Conditions
- More Personalised Care
- Early identification of illness
- Use of digital technologies for increased independence
- Better access to mental healthcare



Priority 3 : Preventing ill health and tackling health inequalities

Outcomes

- Improved screening uptake rates
- Closer working with local authorities and wider system partners
- Targeted support to those communities of greatest need
- Working with colleagues in housing, education and employment to improve the wider determinants of health

Priority 6 : Fit for the Future

Outcomes

- Financial recovery
- A sustainable and greener NHS
- New collaborative ways of system working
- Improved leadership capacity, capability and succession
- Strong enabling functions

Our vision is to improve the health outcomes for local people, making the Black Country a healthier place with healthier people and healthier futures.

Priority 5 : Best place to work

Outcomes

- Recognise and reward our staff
- Create a learning culture
- Lead with compassion and inclusivity
- Working flexibility
- Collaborative team working
- Create a safe and healthy environment for people to work in
- Upskilling staff

Priority 4 : Giving people the best start in life

Outcomes

- Reduce infant deaths
- Reduce emergency admissions for childhood related conditions including asthma
- Tackling inequalities in outcomes, experience and access for Children and Young People
- Increased protection from illness through improved childhood immunisations
- Supporting families to make healthy life choices and reduce obesity rates in children

NHS Black Country Joint Forward Plan Priorities diagram

Our principles

In implementing our plan, we will work to the following principles:

- **Collaboration** – we will work across organisational boundaries and in partnership with other system partners including our people and communities in the best interest of delivering improved outcomes for the population we serve
- **Integration** – ICS partners will work together to take collection responsibility for planning and delivering joined up health and care services
- **Productivity** – we will ensure we improve productivity by making the best use of our collective resources by transforming the way we deliver services across the Black Country
- **Tackling Inequalities** – we will ensure that we continue to focus on delivering exceptional healthcare for all through equitable access, excellent experience, and optimal outcomes

We will **use resources effectively** and find more cost-effective ways of delivering the high-quality care that local people deserve.

We will encourage **research and innovation** to bring new ideas into the way that we work. We will support **new digital technologies** and improve the coordination of care through **safe data sharing**. We will also invest in growing the skills and capabilities of local people to use new digital technology so that they can have more options for accessing care when they need it.

We will also recognise our **social, economic, and environmental role** as one of the biggest employers and investors in the local economy. Where possible we will strive to reduce our impact on the planet through **Greener NHS choices** and we will aim to increase our impact locally through investment in local supply chains, employment of local people and working with partners to support healthier local people, places, and futures.

We will **continuously improve quality** and develop a strategy which will focus on supporting an ageing, ethnically diverse population and will aim to ensure services continue to be delivered in the right way, at the right time, in the right place and with the right outcome.

We are maximising opportunities to attract funding for state of the art new facilities such as the new Midland Metropolitan University Hospital which will open its doors in 2024.

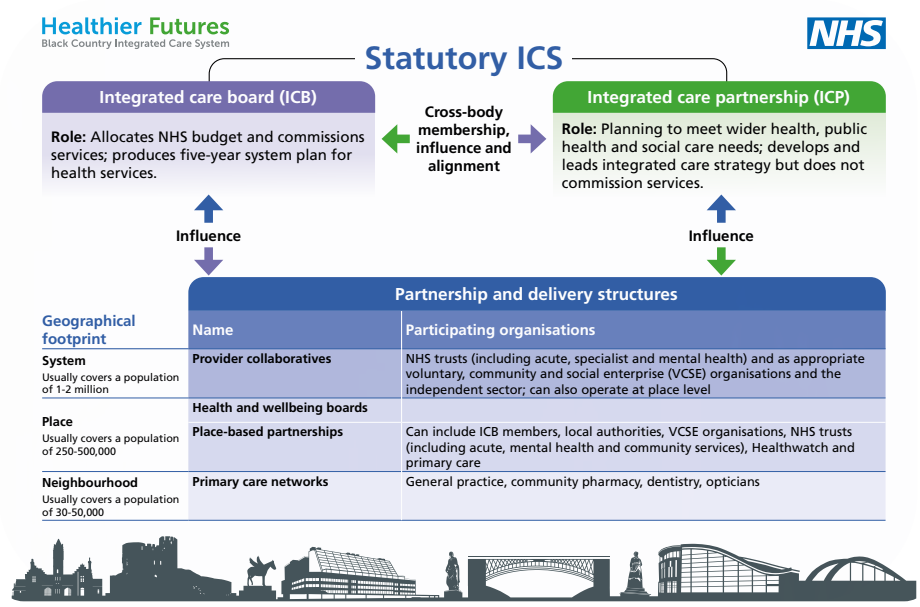
Working with partners to understand research needs and priorities, to inform the development of the research strategy. Ongoing sharing of research opportunities across system helping to support a positive approach to research.

A new Regional Network Research Delivery Network to support health and social care research is being hosted by The Royal Wolverhampton NHS Trust.

During 2023 entry-level employment initiatives were established and/or expanded in all four Places, including; Dudley's iCAN; Walsall's Work4Health; Wolverhampton's various schemes including work with Step Into Work, initiatives at Sandwell and West Birmingham Hospital Trust, the Prince's Trust and St Basil's to support young people at risk of homelessness.

Working together to enable change

Local health and care organisations will work together at three different levels to support the delivery of our key areas of work.



Health and care organisations with partnership and delivery structures for an ICS

We have defined how our system will work differently to deliver this plan. This is called our Operating Model and has the following components:

Integrated Care Board - Strategy, policy and guidance, oversight and assurance of providers, resource allocation and approval of major service change.

ICB Committees - ICB oversight and assurance, including statutory duties and Strategic Commissioning Committee as a decision-making body for the overseeing the strategic programme boards.

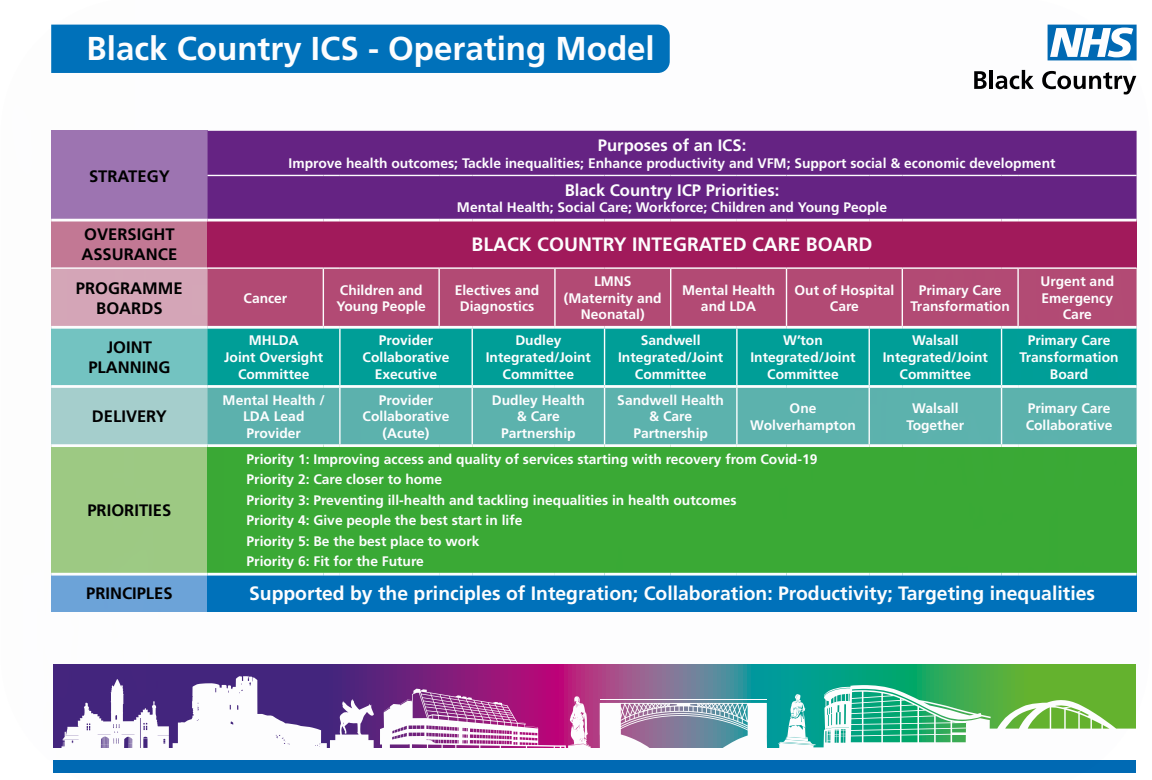
Strategic Programme Boards - Bring commissioners and providers together to develop strategy, outcomes and priorities in portfolio areas within the devolved budget. The programme boards will also oversee performance metrics and produce recovery plans for areas behind trajectory. They will identify areas for transformation, service change and service development and form business cases to define the opportunity.

Integrated/Joint Committees - Joint committees have been established to undertake joint planning between the ICB, local authorities, and where appropriate, NHS England and respective collaboratives/partnerships both at system and Place level. They will act as the vehicle to hold resource and decisions devolved or delegated by the ICB (and partners) and take joint responsibility for implementation of plans.

Provider Collaboratives - Partnerships that bring together our provider trusts to work together at scale to plan and deliver services. They are Black Country wide collaboratives, with local Place support structures, that provide and/or coordinate services with the aim of improving quality, productivity, sustainability, and effectiveness of services. There are different types of collaboratives in our system as described later.

Place Based Partnerships - Partnerships that bring together NHS, local government, public health and other local organisations to help ensure more effective use of combined resources within a local area (Place) and to tackle the wider determinants/factors that influence health and drive inequalities. They will both plan and deliver services defined as in-scope, predominantly out of hospital services, focussing on demand management, relationship management with Local Authorities and partners and targeting local inequalities.

The graphic below shows how the system will deliver the ambitions of this plan through the ways of working described.



Black Country ICS Operating Model

Developing our Operating Model

The operating model for the Black Country will evolve over time. As collaboratives and place-based partnerships mature, this will result in the ICB devolving a range of responsibilities to collaboratives and place-based partnerships, which could include:

1. Commissioning and contracting of services:
Place-based partnerships and collaboratives will be given responsibility for commissioning and contracting health and care services for the local population. This could include setting priorities, identifying the needs of the population, and working with local providers to ensure that services are delivered in a coordinated and efficient way, including setting priorities.

2. Resource allocation:
Place-based partnerships and collaboratives will be given greater control over the allocation of resources, such as funding and staff, to health and care services in their area. This could enable them to make decisions that are more tailored to the needs of their local population and ensure that resources are used efficiently.

3. Integration of services:
Place-based partnerships and collaboratives will be given greater responsibility for integrating different health and care services in their area, such as primary care, mental health services, and social care. This could involve developing new models of care and ensuring that services are joined up and patient centred.

4. Prevention and public health:
Place-based partnerships and collaboratives will be given greater responsibility for promoting prevention and public health initiatives in their area. This could include working with local authorities, community groups, and other stakeholders to promote healthy lifestyles and prevent ill-health.

Provider Collaboratives

In the Black Country we have three provider collaboratives. Provider collaboratives are partnership arrangements involving at least two NHS trusts or GP Practices working at scale across multiple places, with a shared purpose and effective decision-making arrangements, to:

- Reduce unwarranted variation and inequality in health outcomes, access to services and experience
- Improve resilience by, for example, providing mutual aid
- Ensure that specialisation and consolidation occur where this will provide better outcomes and value

- Black Country Provider Collaborative (Acute and Community)

In the Black Country there is agreement between our acute and community providers to work together to deliver effective, accessible, and sustainable acute care services. The agreement is between Sandwell and West Birmingham NHS Trust, The Dudley Group NHS Foundation Trust, The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust.

Black Country Provider Collaborative

The Black Country Pathology Services team

The collaborative has agreed a number of priorities for the short-term, including:

- Identification of new service models, including Centres of Excellence and services applicable for a Black Country networked service solution, with those services transitioning to a new service model
- Clinical improvement programmes, to improve health outcomes and performance standards where appropriate
- Corporate improvement programmes, to improve resilience, efficiency and effectiveness where required

- Mental Health, Learning Disability and Autism Lead Provider

In the Black Country we have a lead provider for mental health, learning disabilities and autism services. Black Country Healthcare NHS Foundation Trust (BCHFT). The Trust takes responsibility for the whole pathway of care, which means the Trust has the flexibility to decide the best services and support for local people (working collaboratively with a range of partners to achieve the aims of this plan). Find out more on Black Country Healthcare NHS Foundation Trust website.

A number of strategic priorities have been identified for the lead provider, including:

- Exploiting our collective strength across the Black Country, achieving a level of scale and pace of transformation that would not be accessible, or sustainable, at our individual Place based levels, whilst also addressing variation where it is agreed to be unwarranted
- Through more integrated community models across primary and secondary care, we are dissolving the boundaries and gaps between services to being greater integration between mental and physical health
- To make optimal use of our Black Country bed stock, which is flexible, therapeutic, promotes dignity and privacy

- Primary Care Collaborative

By primary care we mean, pharmacy, dental, opticians and general practice. The Black Country Primary Care Collaborative (BCPCC) was established in early 2022 and is continuing to establish its role and purpose within the system. To ensure that the BCPCC can represent the views of all primary care providers and remain connected, four Local Primary Care Collaboratives (Dudley, Wolverhampton, Walsall and Sandwell) have been established.

The Local Primary Care Collaboratives (LPCCs) are the fundamental building blocks of BCPCC, each of them with three nominated representatives with a seat at the BCPCC. The LPCCs core membership is comprised of the PCN Clinical Directors. In this way there are two-way lines of communication, engagement, representation and accountability that flow between individual providers, neighbourhoods (PCN), Place (LPCC) and System (BCPCC).

- Place-Based Partnerships

There are four local place-based partnerships in the Black Country covering populations which mirror the boundaries of local councils in Dudley, Sandwell, Walsall and Wolverhampton.

Whilst working at a Black Country level can bring the benefits of working at scale to tackling some of the bigger challenges in health and care, smaller place-based partnerships are better able to understand the needs of local people and design/deliver changes in services to meet these needs.

In the Black Country, Place is the level at which most of the work to join up budgets, planning and pathways for health and social care services will happen.

Each organisation, or partner, within a provider collaborative is also a member of a place-based partnership. This is to embed the benefit we achieve as a system of our providers, working both at scale and within their communities.

The priorities of each of our four Places are described later.

Walsall Together
Collaborating for happier communities

OneWolverhampton
Working together for better health and care

Sandwell Health and Care Partnership

Dudley Health and Care Partnership
Connecting communities and coordinating care to help citizens live longer, safer and healthier lives.

The difference our plan will make in five years

For the public:

- Improved quality (access, experience and outcomes)
- Care provided in the right place, by the right person
- Reduced harm/ incidents of poor care
- Improved physical and mental health for all
- Improved life expectancy and quality of life
- Greater choice and options to personalise care
- New models of integrated healthcare
- Supported to have the best start to life

For our staff:

- Greater sense of belonging, value and satisfaction
- Improved working conditions and succession planning
- Estate, equipment and digital technologies to enhance working practice
- Opportunities for improvement and personal development
- Pride in the care we deliver

For NHS partners:

- Well-led, well organised, system anchors
- Greater efficiency and value for money
- Reduced demand, through new models of care and improved patient outcomes
- Productive, motivated, flexible workforce
- Greater access to research and innovation
- Modernised estates and facilities
- Integrated care, with greater capacity to provide sustainable resilient services.
- Financially sustainable system

For the wider system:

- Reduction in health inequalities for our population
- Cohesive approach quality improvement and prevention
- Reduction in unwarranted variation of care
- Healthier people, healthier communities
- Thriving voluntary, social and community sector
- Engaged and growing workforce, fit for the future
- Diversity in leadership, equipped and informed to act
- Sustainable services designed to meet future need
- Reduced carbon footprint

Measuring our success

It is important to have the ability to measure whether the plan we have developed is being implemented effectively and to understand whether it is achieving the impact it intended.

To support this, we have identified key metrics and indicators aligned to each strategic priority that will be regularly reported within the system. Such indicators are likely to change dependent on priorities or issues that may arise during the year. We also recognise that we want to improve our metrics associated with National Oversight Framework.

In view of operational planning guidance publication being delayed, a further review of the key metrics will need to be undertaken as part of our mid-year full review of the plan, however we have set out a number of new metrics for measuring Priority 6.

Improving access and quality of services

- Eliminate long waits for elective care
- Continue to reduce the number of cancer patients waiting for treatment
- Increase the number of adults and older adults accessing Talking Therapies treatment
- Improve Accident and Emergency waiting times
- Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need.

Care Closer to Home

- Consistently meet or exceed the two-hour urgent community response (UCR) standard
- Continue on the trajectory to deliver more appointments in general practice
- Establish a baseline of the numbers of Children and Young People (CYP) and adult patients on Community Services waiting lists and develop and agree a plan for reduction of lists
- Increase the utilisation of virtual wards
- Recover dental activity, improving units of dental activity (UDAs) towards pre- pandemic levels

Preventing ill health and tackling health inequalities

- Ensuring annual health checks for those living with Severe Mental Illness (SMI)
- Increase percentage of patients with hypertension treated to NICE guidance
- Increase the percentage of patients aged between 25 and 84 years with a cardiovascular disease risk score greater than 20 percent on lipid lowering therapies
- A clear focus on Chronic Obstructive Pulmonary Disease (COPD) driving up uptake of COVID, flu and pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations

Giving people the best start in life

- Measles, Mumps and Rubella for two doses (5 years old) to reach the optimal standard nationally
- Reduce the number of stillbirths per 1,000 total births

Best place to work

- Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise
- Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles
- Reduce % of staff who have left the NHS during a 12-month period
- Reduce sickness absence rates for NHS staff in England
- Increase the mean score NHS Staff Survey Staff engagement theme

Fit for the future

- Adherence to Financial Recovery Plan
- Relevant metrics from Greener NHS Plan in place, aligned to Delivering a Net Zero NHS
- Achieve well led Care Quality Commission assessment in each of our organisations

Dudley - Place Delivery Plan

Our vision is connecting communities and coordinated care to help citizens live longer, safer, happier, healthier lives for all. Our mission is for health and care in Dudley to be in the right place at the right time and to be in the community where possible, hospital when necessary. Our vision will be delivered through a number of work programmes set out below. Collaboration and integration are critical when designing new and often complex solutions and through strengthening our partnership we will achieve our vision. Our health and wellbeing priorities are addressed throughout our work programme, and as an anchor network we will undertake actions to support social and economic determinants of health and wellbeing.

Health and wellbeing priorities:

- Children are ready for school
- Fewer people die from circulatory disease
- More women are screened for breast cancer

Across all of these goals, we will embed an approach to health inequalities.

Outcomes to be achieved

For our Patients:

- Care close to home with improved outcomes
- Longer healthy life expectancy
- Personalised care and improved patient experience
- More say in their care through co-production of health and care in Dudley
- Reduced unplanned hospitalisation for chronic ambulatory sensitive admissions
- Improved health and wellbeing outcomes for our CYP
- Enhanced emotional resilience for our population, and supporting people (all ages) to stay mentally well and reducing mental health inequalities
- Improved physical health for our population with severe mental illness

For Organisations:

- Increase in people attending community services, reducing pressure on hospitals, primary care and social care
- Timely discharge from hospital
- New models of integrated and coordinated healthcare
- Effective Anchor network and partnership, providing leadership for change
- Improved integrated pathways

For our System:

- Sustainable health and care system that includes a thriving voluntary and community sector with increased collaboration
- Improved health and wellbeing for our population
- Sustainable workforce reflective of the population we serve through the "I can" approach
- A system engagement strategy that draws on the wealth of community insight and eases navigation
- Increased utilisation of digital technology innovations

Work Programme To be delivered by:	Yr1	Yr2	Yr3	Yr4	Yr5
Strengthen Partnership Effectiveness A new model of care has been developed to provide care where possible in community settings, relieving pressure on acute and mental health services, but ensuring that they are accessible when required. We will work to ensure the sustainability of Dudley's thriving voluntary and community sector, to include establishing an Anchor network and Compact.	✓	✓			
Transform Citizen Experience Through Community Partnership Teams and adoption of Population Health Management approaches we will deliver safe, coordinated, and effective physical and mental health care and support in the community for, that meets the needs of our patients and utilise digital technology to support the delivery of effective services across all partners.	✓	✓	✓		
Shift the Curve of Future Demand To implement our Primary Care Strategy including the following; access, sustainability, population health, Multi-Disciplinary Teams, personalisation, collaboration, development, and resilience.	✓	✓	✓	✓	✓
Health Inequalities Implement Dudley's Joint Health, Wellbeing and Inequalities Strategy with a focus on prevention and access to reduce health inequalities in our communities.	✓	✓	✓		
Children and Young People Our priority will be Family Hubs/ Start for Life which has six specific areas of action, to provide seamless support for families and an empowered integrated workforce.	✓	✓	✓		

- Roll out of "I Can – Dudley" recruitment model offering training and placements for people with care experience and young people with Special Educational Needs and Disabilities resulting in 45 placements across both the NHS and Local Authority, embedding a culture of inclusive recruitment for all and delivering a sustainable workforce reflective of the population we serve.
- The Integrated Front Door Team have helped avoid unnecessary admissions and supported patients to remain in their usual residence by adopting a multi-disciplinary team approach working in partnership with physical and mental health, Social Care, housing and voluntary and community services. Since the launch of the service referrals have increased by 34% and 95 patients have been referred to alternative services.
- The Healthy Heart Hubs outreach model has helped support communities (circa 300 patients) to monitor and manage their blood pressure along with delivering educational cardiovascular disease reduction sessions with the support of Health and Wellbeing Coaches. In addition to focusing on hypertension the Hubs also focus on Lipid Optimisation and Smoking Cessation with a targeted approach to help reduce health inequalities.
- In partnership with Connecting Health Communities, we have commenced the Brockmoor & Pensnett Community Innovation Project which is delivered by the Institute for Voluntary Action Research. The project aims to adopt an innovative system wide approach to meeting and reducing the inequality gap for residents in this ward. Focusing on developing links between reducing childhood obesity in the ward and improving family income, employability and access to healthy food by engaging residents, community groups and voluntary organisations in the design of health and care services. To date over 60 residents have participated in community research events and are helping to co-produce plans to meet the needs of this community.
- Successfully rolled out "Advancing health equity through income maximisation" which provides welfare rights support for people with severe mental illness. This has resulted in identifying that 98% of people who have a review undertaken are receiving less than they are entitled to. In the first six months alone an additional £319,488 income which equates to an average increase of income of £1936 per person has been delivered.
- Dudley Council has received £25m from the Towns Fund to create a higher education facility in Dudley which will have a focus on health and care. The new facility, to be known as Health Innovation Dudley, is currently under construction and partners are co producing the design of the building and the services it will offer to ensure that the available facilities meet the requirements of all partners. Work is expected to be completed by the autumn of 2025.
- Recruitment of 17 Family Hub Practitioners across midwifery, Local Health and Health Visiting to the Integrated F1001 Days Team to provide early interventions and support to families. This has resulted in 50% increase in families accessing additional support, 30% increase in speech, language and communication needs early identification and intervention, increase in number of expectant and new parents accessing education opportunities, 15% increase in trained peer to peer supporters, with infant feeding peer support available across all five Hubs and an 25% increase in out of hours infant feeding support.

Sandwell - Place Delivery Plan

Our vision is that people living in Sandwell will receive excellent care and support within their local area, exactly when they need it. Our vision will be delivered by a team of people working together in partnership with local citizens. Through our partnership we will support and engage with communities to enable people and families to lead their best possible lives regardless of health status, age, background or ethnicity. Together we will tackle inequalities, supporting people born and living in Sandwell to have opportunities to lead happy, healthy lives.

Health and wellbeing priorities:

- Help people stay healthier for longer
- Help people stay safe and support communities
- Work together to join up services
- Work closely with local people, partners and providers of services

Outcomes to be achieved

For our Patients:

- Responsive, coordinated care
- Improved outcomes for people living with long term conditions, empowered to live healthier lives
- Increased GP access, person-centred approach to care
- Improved patient experience, right care right time
- Supported to maintain usual place of residence where able

For Organisations:

- Improved pathways between primary, community and secondary care to avoid duplication and delays
- Reduction in referrals, unplanned demand, and admission avoidance
- Use of digital technology/innovations

For our System:

- Utilisation of population health data to support a reduction in health inequalities
- Sustainable workforce
- Provision co-designed with local people

Work Programme To be delivered by:	Yr1	Yr2	Yr3	Yr4	Yr5
Healthy Communities Working in partnership with local communities to empower citizens to lead healthier lives; focused on lifestyle, addictive behaviours, Long Term Conditions, Children and Young People and social isolation.					✓
Primary Care Facilitate the delivery of the Directly Enhanced Service, develop a transformational approach to a sustainable future model, ensuring services are developed for local citizens.			✓		
Town Teams Develop integrated teams in each town, inclusive of community health, social care and mental health; delivering a person-centred approach.			✓	✓	✓
Intermediate Care Citizens will be supported to live their best possible lives, receiving rehabilitation, reablement and appropriate interventions when required.	✓	✓			
Care Navigation Facilitate professionals and citizens to get the right service at the right time, through a single point of access, accessing seamless pathways.		✓	✓		
Sustainable Workforce Grow a productive sustainable workforce that will increase staff satisfaction, and provide opportunities for local people.				✓	✓
Digital Utilise digital technology to support the delivery of effective services, ensuring the local people receive support to minimise digital inequalities.			✓	✓	✓

Over the last 12 months significant progress has been made towards embedding our Integrated Discharge Hub which has helped reduce the time spent in hospital and support patients in their home. Key quality improvements have been around virtual wards, urgent community response (UCR), avoiding readmission to hospital, reablement and rehabilitation delivered in an integrated way, and greater partnership working with the third sector.

Sandwell community UCR Services deliver in excess of 1500 contacts per month, with 85% of people staying at home after an assessment.

Sandwell Health and Care Partnership have supported a number of projects aimed at reducing health inequalities over the last year. The Sandwell Language Network (SLN) has delivered 42 'English for Speakers of Other Languages' (ESOL) courses, and 1 'International English Language Testing System' (IELTS) course across Sandwell, covering West Bromwich, Smethwick, Tipton and Oldbury. 483 people took part in a survey on completing the course and a positive impact reported with 84% reporting an improved ability to understand the UK NHS and 90% an improved ability to explain a personal health concern to a healthcare professional.

Produced a winter booklet for all Sandwell residents to enable them to get the information they need to support them through this winter and through the ongoing cost of living crisis. As well as being delivered to all households this resource is available online and in a variety of accessible formats.

Sandwell Health and Care Partnership

Walsall - Place Delivery Plan

Our vision is to level up on social and quality of life issues - such as mental wellbeing, uneven life expectancy, excessive elective surgery waiting time, fighting gang crime, encourage healthier lives, and creating a safer environment. Our plan outlines the intention to invest in the mental and physical wellbeing of residents to continue to build a borough to be proud of and improve the outcomes for the people of Walsall. Resilient Communities and Health Inequalities work supports ambitions to reduce differences between the health of the poorest and richest in the Borough. Our overall programme reflects our commitments to our health and wellbeing priorities and addressing wider determinants of health.

Health and wellbeing priorities:

- Maximising people's health, wellbeing and safety
- Creating health and sustainable places and communities
- Reducing population health inequalities

Outcomes to be achieved

For our Patients:

- Joined up/connected services across primary and community services
- Health and wellbeing centres/ network of specialist care
- Reduced loneliness and social isolation
- Improved health outcomes and patient experience
- Holistic approach to care
- Citizens involved in decisions about services

For Organisations:

- Outcomes framework to identify opportunities
- Digital technology and innovation
- Integrated services to remove barriers, duplication and provide better value
- Maximising opportunities across providers, streamlining access to primary and community services
- Delivering population health at scale

For our System:

- Reduction in health inequalities
- Increased social capacity and resilience
- Sustainable workforce

Work Programme To be delivered by:	Yr1	Yr2	Yr3	Yr4	Yr5
Communities (Resilient Communities) Focus on social prescribing, community associates and wellbeing outcomes framework and integrated commissioning of wellbeing	✓	✓	✓	✓	✓
Joined up Health & Social Care (Integrated Neighbourhood Teams) Focus on diabetes pathway, primary care access recovery plan and community mental health transformation	✓	✓	✓	✓	✓
Specialist Community Services Focus on end of life, frailty and falls prevention. Integrated place based teams supporting adolescents with complex needs, family hubs, dementia services, healthcare maintenance.	✓	✓	✓	✓	
Hospital Services Focus on integrated front door, and Urgent Treatment Centre alignment to community services and primary care out of hours.		✓	✓		

- We have established four Locality Family Hubs and 10 Community Spokes in Walsall all of which provide a welcoming space where children, young people aged 0-19 and up to 25 for those young people with additional needs and their families can go to get advice and support when they need it. The Hubs are in the heart of communities, services such as Midwives, Health Visitors, School Nurses, Speech & Language Early Help, Children's Social Care, DWP Housing and Police have come together to provide a central access point for families to get help and support.
- Through the Health Inequalities Improvement Programme Walsall Housing Group (WHG) ran a Kindness Champions scheme, recruiting and training Champions because of their lived experience to engage and support lonely and/or isolated residents offering emotional support, a resident-led wellbeing plan and providing a bridge to services/projects/activities in the community.
- The Integrated Assessment Hub enables people who are directly contacting the Frail Elderly Service or Ambulatory Care at Manor Hospital with post-discharge complications to be seen by Rapid Response, Enhanced Care Home Support Team or CIT team instead, and receive a community-based assessment and clinical review, thereby avoiding conveyance to hospital.
- A Care Navigation Centre (CNC), supported by a multidisciplinary team (MDT), takes referrals from primary care, care homes, domiciliary care agencies, ambulances, and social care. Citizens access the most appropriate care (e.g. rapid response, MDT) and avoid unnecessary hospital admissions. Five virtual wards are run from the CNC, primarily on a 'step-down' approach for patients following an acute admission. A total of 1,564 patients have been treated since July 2022, making a positive impact on discharge pathways during winter, easing winter pressures.
- Work4Health, an initiative supporting long-term unemployed adults into NHS jobs has helped more than 137 people to secure employment (83% were previously unemployed), generating £2.1m in social value.
- Our Intermediate Care Service has reduced the length of stay for medically stable patients from 7.3 to 2.3 days since it was introduced in 2020 – saving £4.96m a year. The savings are because of improved integration within the ICS, and we have one of the best performing ICS's and discharge rates in the country which has improved productivity outcomes and satisfaction amongst residents are positively impacted.
- Walsall Wellbeing Directory launched in January 2024, features a wide range of support, advice, activities and events to support the wellbeing of local citizens. The directory has been developed by Walsall Together Partnership in collaboration with local citizens and the voluntary, community and social enterprise sector.

Walsall Together

Collaborating for happier communities

Wolverhampton - Place Delivery Plan

Our vision is partners working together to improve the health and wellbeing of the people who live in Wolverhampton, providing high quality and accessible services and tackling inequalities in access and outcomes.

Supporting this vision is the development of joint commissioning arrangements for place, with a programme of work underpinning the vision delivered through the OneWolverhampton partnership and through other programmes of work aligned to the local Health and Wellbeing Board's Health Inequalities Strategy.

Health and wellbeing priorities:

- Quality and access of care
- Starting and growing well
- Reducing harm from smoking, alcohol, drugs and gambling
- Getting Wolverhampton moving more
- Public mental health and wellbeing

Outcomes to be achieved

For our Patients:

- Put people at the heart of what we do
- Active daily, live longer happier healthier lives
- Improved GP access, improved patient experience, and personalised care
- Patients will have greater choice about the way their care is planned, and access to information
- Access to responsible and timely interventions, including prevention
- Improved patient outcomes, early detection/screening and management of long-term conditions

For Organisations:

- Right care, right place, right time
- Reduced demand for hospital services, supporting people to stay well advise, education and support
- Admission avoidance ensuring only those needed hospital go into hospital, and expedited discharge
- Integrated, joined up services, reducing duplication and using technology

For our System:

- Work better together
- Work collaboratively to achieve our partnership objectives by making the best use of our resources and ensuring every pound is spent in the best way possible to meet the needs of our population
- Tackle unwarranted variation in service quality and reduced health inequalities, using data
- Sustainable workforce, fit for the future through investment in training and development

Work Programme To be delivered by:	Yr1	Yr2	Yr3	Yr4	Yr5
Primary Care Development Develop new services to delivery care closer to home, supporting people with long term conditions and complex needs, delivering primary care resilience.	✓	✓			
Adult Mental Health Prioritising prevention, delivering the community transformation programme, improving physical health of people with a mental health diagnosis, embedding suicide prevention approaches.	✓	✓			
Children and Young People Improving immunization uptake, care for children with asthma, deliver a first 1001 days agenda, healthy weight and oral health, and support for mental health and emotional wellbeing.	✓	✓	✓		
Living Well Increase cancer screening rates, improve health check uptake and deliver a preventative approach, delivery of health and wellbeing hubs and development of healthy lifestyle services.	✓	✓	✓		
Care Closer to Home Ensure effective discharge from hospital, supporting people to age well, high quality palliative and end of life services, high quality care home services.	✓	✓			
Urgent and Emergency Care Integrated approach to demand and capacity planning, ensuring people with urgent need can access the right care, ensure a timely experience when accessing urgent care, expand community provision and ensure effective discharge from hospital.	✓	✓	✓		

Establishment of a primary care led acute respiratory infection hub that has seen 130 patients a week on average since mobilisation successfully managed in the community, ensuring timely access to same-day treatment for individuals and reducing the demand on emergency services at New Cross Hospital.

Our integrated approach to winter planning has resulted in community services responding to more ambulance calls thereby supporting a reduction in ambulance handover delays; and, closer working with adult social care has also delivered a reduction in the number of individuals waiting for a package of care in hospital supporting them to be discharged home safely.

In December 2023, Wolverhampton's Health and Wellbeing Board became a signatory to the Prevention Concordat for Better Mental Health. To achieve this, we have evidenced our commitment to promote 'protective factors' for mental health, such as early years support, good education and good quality work. It also ensures that work is taking place to reduce 'risk factors' such as unemployment, poverty, loneliness, violence and discrimination.

We have successfully delivered a suite of interventions to both prevent falls in the city and also support people to receive treatment closer to home when falls do occur. This has included the delivery of strength and balance classes in care homes across the City and the delivery of an integrated falls service between the City of Wolverhampton Council and The Royal Wolverhampton NHS Trust.

Following targeted, multi-agency work, the alcohol-specific mortality rate has seen a significant decrease over the last reporting period and Wolverhampton has moved from having the highest mortality rate in the country to fourteenth nationally.

OneWolverhampton

Working together for better health and care

Feedback on our plan

Each of our four Places has a Health and Wellbeing Board (HWB), these are statutory forums where political, clinical, professional and community leaders from across the care and health system come together to improve the health and wellbeing of the local population and reduce health inequalities.

Each of our HWBs has commented on the plan, their feedback is summarised below:

Councillor Bevan, Chair of Dudley Health & Wellbeing Board
Await feedback on the plan

Councillor Hartwell, Chair of Sandwell Health & Wellbeing Board
Await feedback on the plan

Councillor Flint, Chair of Walsall Health & Wellbeing Board
Await feedback on the plan

Councillor Jaspal, Chair of Wolverhampton Health & Wellbeing Board
Await feedback on the plan

Find out more

To read a more detailed version of our plan and see this document in other formats please visit our website http://www.blackcountry.nhs.uk.

To follow our progress why not check out our social media accounts.

To get involved and stay in touch please contact bcicb.involvement@nhs.uk or call **0300 0120 281**.

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Agenda Item No: 10

Health and Wellbeing Together
13 March 2024

Report title	City of Wolverhampton Suicide Prevention Strategy
Cabinet member with lead responsibility	Councillor Jasbir Jaspal Adults and Wellbeing
Wards affected	All wards
Accountable director	John Denley, Director of Public Health
Originating service	Public Health
Accountable employees	Parpinder Singh, Principal Public Health Specialist Tel: 07890397695 Email: Parpinder.Singh@wolverhampton.gov.uk Ranjit Khular, Senior Public Health Specialist Tel: 07815653792 Email Ranjit.Khular@wolverhampton.gov.uk
Report has been considered by	Public Health Senior Leadership Team 20 February 2024 Cabinet Member Briefing 26 February 2024

Recommendation for decision:

Health and Wellbeing Together is recommended to:

1. Approve the refreshed 'City of Wolverhampton Suicide Prevention Strategy' as recommended by the multi-agency Wolverhampton Suicide Prevention Stakeholder Forum (SPSF).

1.0 Purpose

1.1 The purpose of this report is to present the refreshed City of Wolverhampton Suicide Prevention Strategy and seek approval for its publication. The strategy sets out the key aims and objectives of suicide prevention activity in Wolverhampton and provides information on coordination of delivery and governance structure.

2.0 Background

2.1 Suicide is a preventable and devastating loss of life, often resulting from a complex interplay of prevailing risk factors and distressing events that lead individuals to a point of overwhelming despair, making it difficult for them to envision a future. Beyond being a tragic loss in itself, suicide also causes profound ripple effects, impacting not only the individual's family and friends but also the broader community.

2.2 Evidence suggests suicide is avoidable with the right support during the period of acute distress. Tragically, not everyone receives such support, or for a myriad of reasons the support provided through different channels was unable to prevent the suicide. These complex circumstances lead to over 5,000 suicides every year across England (current national rate 10.4/100,000[1])

2.3 In Wolverhampton, suicides have recently decreased, however, the latest data informs that during the three-year rolling average period of 2020-2022, 56 residents of Wolverhampton took their life by suicide. Comparative to the national rate, Wolverhampton's rate of 8.2/100,000 is notably lower and represents the lowest rate observed across the City, the peak being 15.3/100,000 for the period of 2003-2005[2].

2.4 The national suicide prevention strategy published in 2012[3] was seminal in raising the profile of suicide prevention at local authority level and recommended locally led action. The updated national strategy[4], introduced in 2023, maintains this perspective, underscoring the fundamental role of local action in mitigating suicide risk.

2.5 Resultingly, in 2015, Public Health, City of Wolverhampton Council, published a suicide prevention needs assessment which served as the foundation for the subsequent release of the Suicide Prevention Strategy 2016-2020 and the establishment of the multiagency SPSF. The partnership continues to progress the current suicide prevention action plan and report into One Wolverhampton Adults Mental Health Group and Health and Wellbeing Together. As a result, various activity has taken place and continues to do so, including awareness campaigns, training for communities and professionals, development of data and intelligence and promotion of support services.

3.0 Revised Joint Strategic Needs Assessment (JSNA)

3.1 The topic specific JSNA for suicides in Wolverhampton was updated in 2022[5] bringing together the latest data, evidence and research. The JSNA informs that men continue to account for over three quarters of suicides in the city, with the highest rate of suicide observed for both male and female within the 45-54 age range. There was no notable

disparity in suicide breakdown by ethnicity, although intra-ethnic rates did vary amongst genders for some of the ethnic categories. Importantly, it is recognised that reporting suicide by ethnicity is very limited and not systemically captured, requiring a nationally led commitment to understanding how suicides impact different ethnic groups.

3.2 The JSNA highlighted a range of risk factors which can increase the risk of suicide such as those experiencing substance misuse, domestic violence, financial difficulties or adversely experiencing various factors that determine levels of deprivation. Wolverhampton is found to be unfavourably positioned in several of these potential determinants associated with increased suicidality, which adds an additional layer of complexity for the SPSF in addressing these challenges.

3.3 Finally, the JSNA highlighted that democratising suicide prevention is pivotal in taking a whole system approach. This includes accessible and regular training to recognise suicide ideation and how to provide initial support, working with organisations to develop policies so suicide prevention remain an important consideration and delivering awareness campaigns to the wider public to help normalise what has historically been a taboo subject. Furthermore, tailored interventions are recommended for groups at higher risk such as men and those facing significant financial challenges.

4.0 City of Wolverhampton Suicide Prevention Strategy

4.1 Completion of the JSNA enabled a relatively light-touch review of the Citywide suicide prevention strategy, for which approval from Health and Wellbeing Together is sought. The draft strategy has been compiled through the findings and recommendations within the JSNA and a stakeholder engagement event, which brought together numerous professionals across various organisations to help form the components of a suicide safer city and develop the vision, aims and objectives of the refreshed strategy.

4.2 The draft strategy is themed into four key areas:

1. **Early Intervention and Prevention:** Taking an approach of early intervention and prevention, through training, awareness campaigns, encouraging people to access services, to disrupt downward spiral of wellbeing and implementing protective factors to suicide risk early and throughout life course and services.
2. **Knowledge, Skills and Awareness:** Ensure the offers of support are well known across the city through making information accessible, and supporting people across various organisations and communities to be skilled and knowledgeable about suicide through regular up to date specialist training.
3. **Services to support those in need:** Promote the offer of a broad range of support for everyone, including early help, intervention and postvention including bereavement support. Importantly, supporting services to be accessible and in different forms.

4. **Embedding suicide prevention, making it everyone's business**: Working across organisations, sectors and communities to make suicide prevention 'everyone's business' through developing organisational policies, so that initial and early support can be accessed more universally.

4.3 The strategy further outlines that the aims and objectives will be delivered through operational action plans, which will be refreshed annually and monitored through SPSF.

5.0 Financial implications

5.1 Whilst there are no immediate financial implications associated with adopting this strategy, the SPSF are likely to independently source external funds to deliver various projects to meet the aims and objectives of the strategy. For such sourced funding, relevant processes and reporting will be adhered to in line with advice from finance colleagues.
[NC29012024/A]

6.0 Legal implications

6.1 There are not considered to be any direct legal implications from adopting this strategy, however, legal advice will be sought if and when required during the implementation of the strategy.
[RR/31012024/Q]

7.0 Equalities implications

7.1 This strategy has been informed by the suicide prevention JSNA which has highlighted that a number of groups are disproportionately affected by suicide risk factors such as men, those exposed to domestic violence, people facing difficult financial circumstances, problem gamblers, substance misusers and minority communities. The strategy proposes preventative interventions targeted at these groups as well as wider universal interventions.

7.2 An Equalities Impact Analysis is being undertaken on this strategy to ensure equalities is carefully considered.

8.0 All other Implications

8.1 The implementation of this strategy will be led by SPSF which is now an independent charity, supported through Public Health, and works in collaboration with a broad range of partners. Any actions to implement the aims and objectives of this strategy will be agreed with these partners on a project by project basis for decision.

9.0 Appendices

9.1 Appendix 1: Draft City of Wolverhampton Suicide Prevention Strategy

References

[1] Office for National Statistics (2022) *Suicides in England and Wales: 2021 registrations*. Available online: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2021registrations

[2] Office for Health Improvement and Disparities (2022) *Suicide Prevention Profile.* Available online: https://fingertips.phe.org.uk/profile/suicide/data#page/1

[3] Department of Health (2012) *Preventing suicide in England A cross-government outcomes strategy to save lives.* Available online:[Withdrawn] Preventing suicide in England - A cross-government outcomes strategy to save lives (publishing.service.gov.uk)

[4] Department of Health and Social Care (2023) *Suicide prevention strategy for England: 2023 to 2028.* Available online: Suicide prevention in England: 5-year cross-sector strategy - GOV.UK (www.gov.uk)

[5] City of Wolverhampton Council (2023) *All Age Suicide Prevention, Topic Specific Report.* Available online: wolverhampton_suicide_prevention_jsna_report_2023.pdf (openobjects.com)

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City of Wolverhampton Suicide Prevention Strategy

Content

Foreword

‘Our City, Our Plan’ sets an ambition that see’s Wolverhampton, as a city where people live longer, healthier lives. This underpins our intention and commitment to making Wolverhampton a Suicide Safer City also. A life saved from suicide, is no less valuable than any other preventable cause of death. Therefore, the first purpose of our new local strategy is to ensure that there can be no doubt that suicide prevention matters, people who are struggling matter, the lives of those we have lost, matter.

Developing a new strategy offers us space to refocus and re-set, whilst reflecting on the success of the previous strategy we now move on from. So much has happened in that time, and many of those things such as financial instability, undoubtably pose a threat to our individual and collective mental health-and at the same time, so much has been achieved in our wonderful city.

Whilst there has been a reduction in incidents of suicide in Wolverhampton in recent years, sadly 53 people died by suicide between 2019 and 2022. I want to pay homage to them and their families. This statistic is testament to the fact that more needs to be done; one life lost is one too many. We must do all we can to learn from their loss and consider what might have been done collectively different. At the same time, I am acutely aware that for every tragedy, we must conceive that there are people who survive, people who overcome such pain and we must listen to the stories they have to tell us in order to learn and commit to do more.

Our Strategy is proudly infused with survivor influence. Those voices tell us that intolerable distress that may lead us to consider that our life is not worth living, can and does pass, and therefore, suicide is preventable. Help seeking is often cited in the literature and within survivor voice alike as being one of the most formidable forces in overcoming suicidal distress. However, we must acknowledge some of the relational difficulties and barriers that people sometimes navigate when they do. As such, this strategy commits to work towards creating compassionate, aware, and equipped communities and workforces.

This strategy is also informed by a recent Joint Strategic Needs Assessment. It recognised how financial pressures, domestic abuse, and poor mental health in particular can act as circumstantial risk factors that can expose individuals to a risk of suicide in Wolverhampton. We will work towards achieving better in roads for those living with these challenges and equipping services and professionals to co-explore and develop safety plans that can be referred to in times of distress, whilst supporting those underpinning risk factors.

Any effective suicide prevention strategy has to span three distinct areas of prevention, intervention and postvention. With prevention spanning whole population awareness, stigma reduction and increased safety, intervention focused on those at increased risk of suicide, postvention focuses on support and response within the ripple effect of loss owed to suicide.

We recognise the effect that the tragedy of a suicide has on those who are the first to arrive at the scene, the family, friends, colleagues, and neighbours of someone who loses their life. It is imperative that they have timely access to help and support. The roll out of national and local Real Time Surveillance of Suspected Suicides will enable us to reach more of these individuals who are navigating a complicated and painful loss.

I am delighted to introduce this renewed strategy, it is a piece of work that represents partnership, collaboration, and commitment from the partners within the Wolverhampton Suicide Prevention Stakeholder's Forum. In developing this strategy, we have set out how we can build on the progress made, while identifying and responding to new and emerging concerns. Every single Forum member contributes daily to making Wolverhampton a suicide safer city. The co-production of this strategy will be vital to ensure its success, which will be measured through delivery against annual action plans. These action plans will support us to take what are our visions and hopes, to become tangible and realised outputs. I would like to thank partners across our forum, their tireless support and campaigning which has driven progress on suicide prevention in Wolverhampton, and I have no doubt has saved the lives of many.

Together we can achieve this vision of a suicide safer city. Together we can be kinder, better citizens and contribute to breaking down the barriers and shame that can deter those in distress from seeking help. Together, we can make Wolverhampton a city that with absolute conviction can offer our young people opportunity and hope. Together, we can save lives.

Cllr. Jasbir Jaspal
Cabinet Member for Adults and Wellbeing

Dr. Clare Dickens, MBE
Independent Chair, Wolverhampton
Suicide Prevention Stakeholder Forum

Introduction

Suicide has a profound impact on everyone involved, causing immeasurable and enduring pain and anguish. The reasons behind any suicide can be multiple and there is no simple solution. However, taking a compassionate approach and offering support during a period of acute distress may, for some, reduce the risk of suicide and help individuals to take a different path.

The City of Wolverhampton continues to be a place where most residents are able to live fulfilling and happy lives1, with access to a range of amenities and services for the diverse communities that make up the city. Inevitably, at times, people need support for various reasons which need to be addressed if they are to feel good and function well. To help with this, a range of organisations and communities in Wolverhampton provide a vast amount of support; importantly this includes supporting mental wellbeing, which helps uplift residents during time of distress.

However, like many other places, Wolverhampton also faces challenges, which means not everyone accesses support or gets the help they need at the right time. For the city this has led to generally poorer health outcomes[1] and in some cases people dying prematurely due to conditions such as Coronary Heart Disease and Cancer. One of the other reasons for premature death is, sadly, people dying by suicide.

Suicide is profoundly tragic, leaving devastating impact on friends, families and communities. People take their lives by suicide due to various interwoven triggers, typically during a period of extreme upheaval where they feel overwhelmed and overpowered by the feeling of not wanting to live any longer. Tragically this leads to over 5,000 suicides every year in England, this is around 10 people for every 100,000[2]. Whilst Wolverhampton has recently seen a welcome reduction in suicides, there were tragically 53 suicides during the most recent reporting period of 2019-20212, which is around 7 people for every 100,000 in the city.

Suicide disproportionately affects some sections of the community such as: men, who make up 75% of all suicides; certain occupations like construction and nursing; or those living within challenging circumstances such as low incomes, poor health unemployment or addiction to substances. These factors can contribute toward the risk of suicide. Therefore, interventions need to be tailored to recognise and respond to the unique needs of various groups within the wider Wolverhampton population.

The Wolverhampton Suicide Prevention Stakeholder Forum (Wolverhampton SPSF) recognises that suicide is not inevitable and may be prevented through appropriate support. It is with this in mind that partners remain committed to making Wolverhampton a city that is suicide safer and a place where Wulfrunians live longer, healthier lives as set out in 'Our City Our Plan'[3]. This suicide prevention strategy is testament to the passion of the numerous organisations, communities and people who come together under the SPSF to deliver a range of activity to make the city suicide safer. This strategy sets out the priorities to reduce suicides, how this activity will be delivered and how the work will be directed and governed.

1. Office of National Statistics
2. Office for Health Improvement and Disparities
3. City of Wolverhampton Council - Our City Our Plan

Our vision

Wolverhampton will be a city where suicide prevention will remain a priority for organisations and communities, who will come together to collectively plan and deliver interventions to reduce the risk of suicide for all residents of Wolverhampton.

Partners working together as part of the Wolverhampton SPSF wish for Wolverhampton to be a city where everyone feels they have a role to play in suicide prevention.

Early intervention and prevention to reduce suicides will be embedded across all services, communities will feel empowered to take action and support services will be more accessible, including support for those bereaved by suicide.

Wolverhampton will continue to build on the reduction in suicides seen recently and strive to prevent more avoidable deaths by suicide through a multi-pronged strategic approach set out in the action plan. Efforts of various organisations and communities will be coordinated to continue the strengthened partnership working currently seen in the city; this will ensure efforts to address this important issue are not fragmented.

Wolverhampton SPSF will work within a robust governance system ensuring key boards and groups, such as the One Wolverhampton Integrated Care Board and Health and Wellbeing Together, and their respective subsidiary delivery groups remain involved.

Key domains

Early Intervention and Prevention

Taking an approach of early intervention and prevention to disrupt a downward spiral of wellbeing. Implementing protective measures to address suicide risk throughout an individual's journey and services.

Knowledge, Skills and Awareness

Ensuring the offers of support are well known across the city and that people across various organisations and communities are skilled and knowledgeable about suicide to support people in distress.

Services to support those in need

Offering a broad range of support for everyone, from early help and intervention to postvention, including bereavement support. Importantly, services are linked, accessible and on offered in various forms.

Embedding suicide prevention, making it everyone's business

Working across all organisations, sectors and communities to make suicide prevention 'everyone's business' so that early support can be accessed where required.

Why is suicide prevention important?

Whilst the impact of suicide is devastating for families and communities, we believe that suicides could be prevented with the right support at the right time. A number of expert bodies, strategies and policies advocate that we can all play a part to prevent suicide and in Wolverhampton we recognise these various strategic levers will help us locally to fulfil our vision.

A key strategy was the national suicide prevention strategy, published in 2012, which led to the formation of Wolverhampton SPSF.

A Suicide Prevention Strategy for England 2023-28 (DHSC, September 2023)[1] seeks to deliver a collaborative approach towards reducing the suicide rate over the lifetime of the strategy– with initial reductions observed in the early half. Measures include improving support for people who have self-harmed and have been bereaved by suicide. The recommendations within this national strategy have been considered in the formulation of this local strategy.

Partners from local NHS services that are represented at Wolverhampton SPSF are working towards delivering the NHS Long Term Plan 2019[2] which reinforces the commitment to reducing the incidence of suicide, through the delivery of an enhanced mental health crisis model and 24/7 access to mental health support.

Locally, in 2019, City of Wolverhampton Council launched Our City: Our Plan[3], which outlines priorities for the period between 2019 and 2024. These priorities span the life course ensuring children get the best start possible, families are supported, the economy is thriving, and communities live a healthy and fulfilling life. These priorities are aligned with positive determinants of health and wellbeing, which can act as protective factors in preventing incidents of self-harm or suicide.

The City of Wolverhampton Council Vision for Public Health 2030[4] aims to enable residents to live longer, healthier lives and ensure everyone is protected from harm, serious incidents and avoidable health threats.

The Wolverhampton Mental Health Joint Needs Assessment[5] (completed August 2023) indicates that the building blocks of housing, employment and financial security are important to support good mental health and prevent mental ill health.

'Being mentally well' for people in Wolverhampton includes feeling emotionally balanced, resilient and able to bounce back or to cope with life challenges. It also includes feeling optimistic about the future, having good social connections and being able to access support when needed.

People feel that getting out and being able to do things would support their wellbeing as well as having time for oneself, more money, someone to talk to, better physical and mental health care and better working environments. All these factors will influence good mental health and wellbeing in residents which contribute towards reducing the risk of suicide.

1. DHSC, A Suicide Prevention Strategy for England 2023-28
2. NHS Long Term Plan, 2019
3. City of Wolverhampton Council - Our City Our Plan
4. City of Wolverhampton Council - Vision for Public Health 2030
5. City of Wolverhampton Council - Adult Mental Health Joint Strategic Needs Assessment 2023

What do we know about suicides in Wolverhampton?

Suicide rates in Wolverhampton have declined over the past two decades and are significantly below both the national and the West Midlands regional averages. However, it is important to acknowledge that over 50 people died by suicide within the city during the most recent three-year reporting period which serves as a reminder to system partners that additional efforts are necessary to address the issue effectively.

Gender

Men make up approximately 75% of suicides nationally. In 2021, the suicide rate for males in England and Wales was 16.0/100,000, consistent with rates between 2018 and 2020. For females, in 2021, this rate was 5.5/100,000; this is consistent with rates between 2018 and 2020.

ONS reporting by gender shows that, since 2001, for Wolverhampton the gender split is slightly different with males accounting for 80% of suicides and the remaining 20% of suicides being female. It is recognised that the risk factors affecting men and women are multiple and these can change in relevance throughout an individual's life.

Age

ONS reports that the highest suicide rate in 2021 was seen among people aged 45-54. Among women, those aged 45 to 49 years had the highest age-specific suicide rate at 7.8/ 100,000. Among men, those aged 50 to 54 years had the highest age-specific suicide rate at 22.7/100,000. Furthermore, data indicates that females aged 10-24 years have seen the largest increase in their suicide rate since the time series records began in 1981, albeit from a low base.

Ethnicity

A local data analysis exercise concluded that suicide by ethnicity in Wolverhampton was closely aligned to the ethnic population makeup of the city. It is, however, acknowledged there is an increased exposure to risk factors in people from minority ethnic groups including higher risks of poor mental health and higher levels of unemployment.

Risk Factors and Behaviours

Wolverhampton faces numerous challenges including significant levels of deprivation; the city is currently ranked as the 24th most deprived local authority in England. This is especially relevant considering that those residing in more deprived communities are at a heightened risk of being exposed to factors that in some circumstances have shown to contribute to suicide.

These risk factors include but are not limited to:

History of self-harm: In 2021/22 nearly 500 people were admitted to hospital for intentional self-harm – the number of people with a history of self-harm is likely to be much higher.

Having a mental health disorder: In Wolverhampton 20.5% of people aged 16-64 (33,525 people) and 12.5% of older adults over 65 (5,476 people) have a common mental health disorder.

Alcohol dependence: In 2020 Wolverhampton had the highest alcohol related mortality across the country, with 70 people dying from causes related to alcohol consumption.

What we will do

The aims of this strategy are:

- **To reduce the incidence of suicide in the city through prevention, intervention and postvention measures that recognise and address the risk factors that are known to contribute towards suicide.**
- **To recognise the needs of those affected by suicide and to strengthen the support available to them.**
- **To work collaboratively with partner organisations and strengthen the local support offer.**

Aligned to the four domains highlighted in the vision, the objectives of this strategy are as follows:

Early Intervention and Prevention

We aim to disrupt the downward spiral of wellbeing and implement protective measures early on by developing preventative interventions for the groups recognised as being at higher risk. These include men and those facing challenging circumstances such as domestic abuse, loneliness, substance misuse and gambling related harm.

We also recognise the link between financial hardship and the risk of suicide. We will therefore deliver preventative messages across the city, embed routine enquiries about financial hardship into mental health services and signpost / refer individuals for support. We will highlight and promote the protective factors that protect against suicide ideation, such as community connection and mental wellbeing as part of awareness campaigns.

Knowledge Skills and Awareness:

We will aim to help people across various organisations and communities to be skilled and knowledgeable by rolling out Suicide Prevention Awareness Training across the city, targeting those who work with the groups at higher risk.

Services to support those in need:

We will strengthen and connect the support for everyone, from early help and intervention to postvention, including bereavement support. In doing so we will embed best practice such as NICE guidance on self-harm to ensure services are evidence led and effective.

We will ensure that the offer of prevention, intervention and postvention is equitable and accessible. Services will be assisted to improve the quality of data recorded to understand better who is accessing support and why, what is the local need, and what measures can be taken to address inequalities in access to support.

Embedding suicide prevention, making it everyone's business:

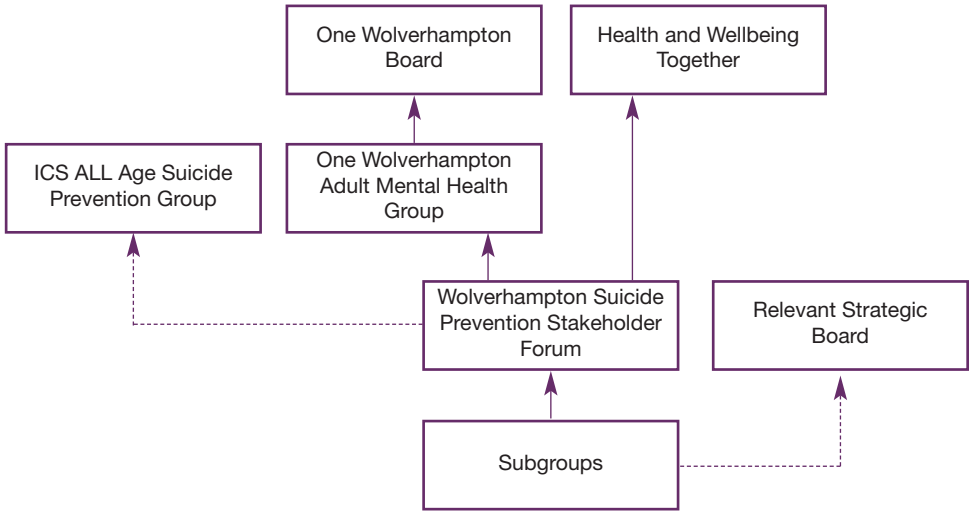
We will work across all partner organisations to influence and strengthen policy around suicide prevention, so that every partner has a role in preventing suicide.

We will continue to work with partners including the council's Highways and Planning Services, Network Rail and Mental Health services to reduce access to means of suicide. We will also monitor incidents of suspected suicides, through a regional Real Time Surveillance System, to ensure timely multi-agency action is taken, including reducing risk of further associated suicides and ensuring bereavement support is available to those affected.

How we will implement our vision

Wolverhampton SPSF will lead on the implementation of this strategy. In doing so, the forum will work in collaboration with a range of partners, to co-create and jointly deliver activities, such as awareness campaigns and training, that reach the communities in Wolverhampton and address the multiple risk factors for suicide as recognised within this strategy.

Wolverhampton SPSF will operate within a robust governance framework which is described in the chart below.



Annual Action Plans

Wolverhampton SPSF will be responsible for developing, monitoring and evaluating an annual action plan aligned to the vision, aims and objectives of this strategy for each 12 month period of the strategy's lifetime.

This will allow an annual refresh of actions, informed by any national or local developments and by local data on incidents of suicide, obtained through Coroner's office data and Real Time Surveillance of Suspected Suicides.

Assurance reporting

Regular updates on the development and delivery of the strategy will be taken to the Black Country Integrated Care System (ICS) All Age Suicide Prevention Strategy Board and the One Wolverhampton Adult Mental Health Group.

How we will measure our work

The overarching purpose of this strategy and of the collective efforts of the Wolverhampton SPSF is to prevent suicide.

Measuring the impact that this strategy will have, however, is not straightforward. As we know, each tragedy of a suicide is down to a number of contributing factors, and therefore our strategy encompasses a range of activities to address these factors.

Each project or activity delivered within the scope of this strategy will be evaluated and reported upon to Wolverhampton SPSF.

In addition, each of our Annual Action Plans will be evaluated by Wolverhampton SPSF.

We will also monitor other surveillance data that will provide longitudinal data on the incidence of suicide in the city. This data includes:

Nationally published indicators

There are a number of nationally reported indicators that this Suicide Prevention Strategy will contribute towards; these will be monitored throughout the duration of this strategy. These include Public Health Outcomes Framework (PHOF) indicators which include suicide rates for all persons, males, and females.

Coroner's Office date

Regular reports on incidents of suicide in Wolverhampton from the West Midlands Coroner's Office will be reviewed by Wolverhampton SPSF.

This will allow for the forum to recognise any contagion - series of suicides that are linked by method, geography or motivation - which will enable the forum to undertake targeted prevention work in response with partner organisations and services.

Real Time Surveillance of Suspected Suicides

Officers will have access to a Black Countrywide Real Time Suspected Suicide Surveillance system which will allow for analysis of suspected suicides rapidly, without having to wait for a Coroner's inquest to conclude.

Reviewing this data will enable Wolverhampton SPSF to monitor any increase or decrease in suspected suicides and allow for data informed, targeted intervention where this is indicated.

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Wolverhampton Serious Violence Needs Assessment

Executive Summary 2024

saferwolverhampton.org.uk

Wolverhampton
A Safe City

Contents

1 Introduction

Serious violence has a devastating impact on victims and their families, when unaddressed it can instil fear within communities and become extremely costly to society.

Since 2014 incidents of serious violence have increased across England and Wales. Following public consultation in July 2019, the Government announced that it would bring forward new legislation introducing a Serious Violence Duty[1] for specific public bodies; local authorities, integrated care boards or local health boards, probation service, fire and rescue services, local police force and appropriate criminal justice agencies.

The duty aims to ensure that these specific services and wider partners work together to share data, intelligence and knowledge allowing them to deliver targeted and appropriate interventions to prevent serious violence.

In response to the requirements of the Serious Violence Duty Wolverhampton has produced a Serious Violence Strategic Needs Assessment (SNA). The assessment draws on data and evidence from a wide range of sources, including criminal justice and health, and importantly includes qualitative information from a number of key stakeholders. The SNA aims to:

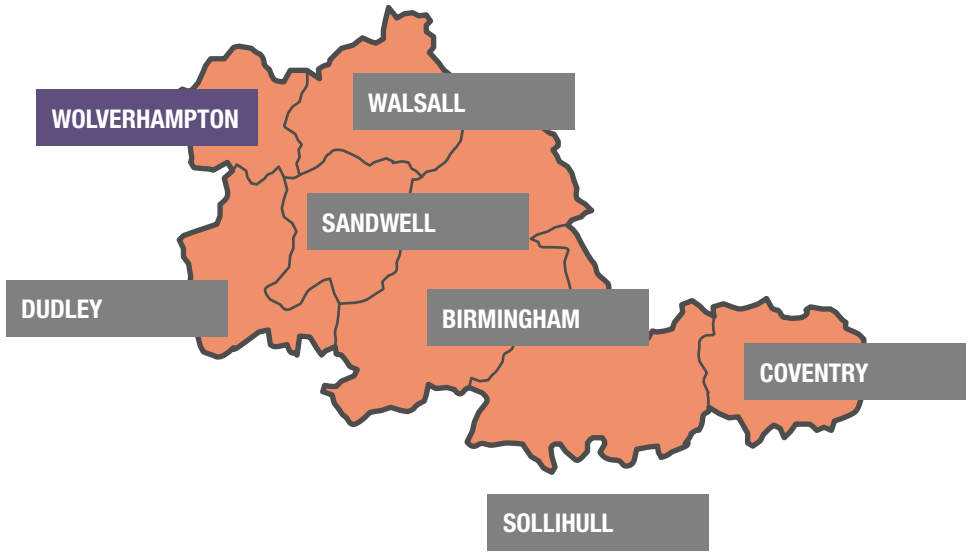
- Identify the current and future needs of Wolverhampton's population in respect of violence prevention
- Provide a greater understanding of established and emerging serious violence trends, priority locations and other high-risk concerns
- Identify current and long-term issues relating to serious violence
- Identify population groups most vulnerable to involvement in serious violence
- Inform decisions about how interventions and services are designed, commissioned and delivered to prevent violence within the city
- Identify data and intelligence gaps and challenges across the Partnership which require addressing.

The assessment focuses on the extent of violence, including volumes and rates over time and also the risk factors associated with violence at both a population-centred and place-based level. Allowing for the development of a set of recommendations which will inform future decision making in relation to violence prevention and reduction across the Partnership.

[1] Serious Violence Duty - Statutory Guidance (publishing.service.gov.uk)

2

National & regional context



Available data suggests that the Covid-19 pandemic and the temporary restrictions imposed had a significant impact in reducing crime trends nationally, this was replicated locally resulting in less crime being recorded.

Since the restrictions have been lifted police recorded crime has exceeded pre-Covid levels. The increase, in part has been attributed to changes in the way that police now record crime. Police statistics suggest that violent crime in general (in contrast to many other crime types), is rising, a pattern which has been seen for several years.[2] This is in part down to proactive activity and an increase in reporting where victims have been empowered to report crimes which may previously have gone underreported, an example of which is the reporting of domestic abuse.

[2] Violence Reduction Partnership, 2023

Key findings include:

DECREASE

VIOLENT CRIME IN ADULTS DOWN

1.29% 2022-23 1.89% 2021-22

Adults experiencing violent crime

Nationally during 2022-2023 around 1.29% of adults had experienced a violent crime (compared to 1.89% in the previous year).[3]

STABLE FIGURES

DECREASE IN VICTIMS

More Repeat Victims?

Violent Crime

Whilst the number of violent crimes remained stable in 2022-2023 compared to the previous year, there was a significant decrease in the number of victims (suggesting more repeat victims).[3]

DECREASE

STILL HIGHEST RATE

3% drop

Violence with Injury

Between April 2021 to March 2022 West Midlands had the highest rate of Violence with Injury and knife crime compared to other police forces in England and Wales, although this was a 3% decrease when compared to the previous year. [4]

MALES

SHARP OBJECT

15-24 years old

Most likely group hospitalised as a result of a sharp object

In the West Midlands Males aged 15-24 are the most likely group to be admitted to hospital as an inpatient for assault with a sharp object. They are also most likely to be a victim of stabbing. [5]

[3] Crime Survey for England and Wales, 2023 [4] Violence Reduction Partnership, 2023. [5] Violence Reduction Partnership, 2023

3 Wolverhampton

Wolverhampton has a diverse and cohesive population, communities represent a variety of different ethnicities, religions and cultures. The city has a relatively young population, with over a quarter of residents under 20 years old. Wolverhampton is a relatively deprived area with significant challenges in relation to poverty, unemployment and housing, the scale of these challenges and the response differs significantly between the diverse wards across the city.

Violence in Wolverhampton – An Overview

- Violence with injury offences recorded in Wolverhampton had seen a increasing until 2022 - 2023[6] when a slight reduction was recorded by West Midlands Police
- There has been a decrease in recorded violent crime since Autumn 2022. This reduction is particularly significant when considering incidents where the victim is under 25, a reduction of 27% was seen between September 2022 – June 2023 when compared to the same period in the previous year.[7]
- Wolverhampton has the highest rate of hospital admissions for violence (including sexual violence) in the Black Country, higher than England and West Midlands figures. Recording is likely impacted by a strong local commitment to ensure that incidents are identified and recorded by New Cross Hospital Accident and Emergency department.[8]
- The highest number of incidents of violent crime with injury occurred in Wolverhampton city centre, Heath Town and Blakenhall wards.[9]

Incidents of Violent Crime with Injury (Victim Under 25)

- 19-26
- 27-39
- 40-57
- 58-86
- 87-122

4

Views of key stakeholders

To inform the needs assessment a number of engagement events were held across the city with community members, statutory partners, young people and community and voluntary sector partners.

Over 200 people engaged with the events sharing their views and contributing to the local violence prevention approach.

Key themes from the engagement events include:

"Wolverhampton has a strong third sector and community voice. Communities are committed to supporting efforts to reduce violent crime."

"The immediate multi-agency response to a violent incident in Wolverhampton is thorough and appreciated by families, professionals and communities. It is however important to ensure that support provided to communities is clear and coordinated and well communicated."

"Whilst there is a robust response to those who are identified as being at risk of violence or exploitation, stakeholders felt that the focus of the partnership should be on identifying people at risk at an earlier point."

"Communities felt that gender was a driving factor in youth violence, stating that there is a need to increase the presence of positive male role models for young people in the city."

"There is a need for further engagement with families and communities to proactively build trusting relationships and engage them in the response to violence reduction, deliver key messages and communicate the help and support available."

> Most young people in Wolverhampton **do not carry weapons.** Those that do carry a weapon state that they do so for self defence, or because they feel unsafe."

5
Victims and offenders

The age profile of victims of knife crime is younger than the age profile of victims of all violent crime. [10]

During 2022- 2023 Wolverhampton saw a decrease in violence where the victim was under 25 when compared to the previous year. An increase was seen in violence where the victim was over 25 during the same period.[11]

Males in Wolverhampton are significantly more likely to suffer a violence related injury than females and are more likely to be perpetrators of violence.[12]

Of those under 18 in Wolverhampton who received outcomes (including custodial, out of court or outcome 22) for serious violence during 2022-2023 ages ranged between 11-17 years, with peak ages being 14 and 15 years.[13]

Where children and young people are engaged with the Youth Offending Team in Wolverhampton. Those who are black and/ or have social, emotional or mental health needs are disproportionately represented.[14]

Heath Town ward in Wolverhampton has the highest number of under 25s admitted to hospital for assault compared with all wards across the West Midlands Combined Authority Area. This contrasts with police data, which records Heath Town as 15th in violence with injury data.[15]

In Wolverhampton, younger adults are **more likely** to be victims of violent crime - this is in line with regional and national trends.

10 Violence Reduction Partnership, 2023
11 West Midlands Police, 2023
12 West Midlands Police, 2023
13 Wolverhampton Youth Offending Team, 2023
14 Wolverhampton Youth Offending Team, 2023
15 Violence Reduction Partnership, 2023

6

Prevalence of risk factors

The causes of violence can be complex and influenced by a number of risk factors impacting individual, relationship, community and societal domains. The SNA therefore considers a range of potential local drivers which contribute towards violence.

Key findings include:

Missing People
Reported missing episodes of young people in Wolverhampton have increased over the last 3 years, this is particularly notable in the 14-15 age group.[16]

Improved Grades
In 2021-2022 the percentage of Wolverhampton pupils achieving grade 4 or above in English and Maths rose above national average, in previous years the average grades in the city were below the national average.[17]

Social, Emotional and Mental Health Needs
Since 2016 there has been a significant increase in the number of young people across Wolverhampton with identified social, emotional and mental health needs.[18]

Young Claimants
Wolverhampton has significantly higher rates of Job Seekers Allowance claimants aged between 18-24 when compared to the West Midlands combined authority area and England average.

[16] City of Wolverhampton Council, 2023. [17] Department for Education, 2022 [18] City of Wolverhampton Council, 2023

7

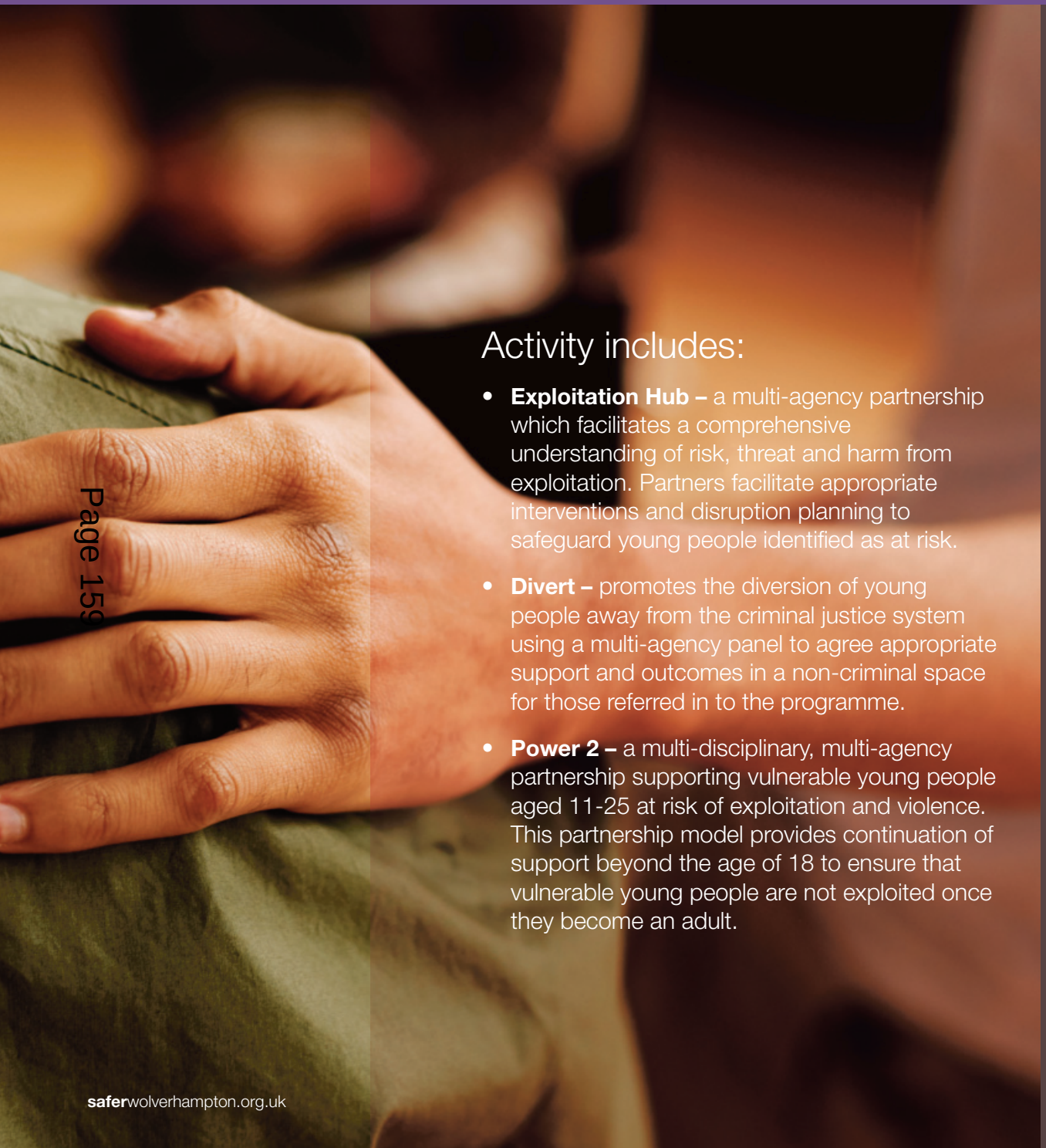
Identification, intervention and support

There is a wide range of primary, secondary and tertiary support and interventions available for young people in Wolverhampton.

Targeted support is delivered to those who are identified as being at risk of, vulnerable to, or involved in violence or exploitation. Interventions are delivered by a range experienced of statutory agencies, partners and commissioned services.

Wolverhampton takes a partnership approach to delivering initiatives and interventions to address youth violence and exploitation. The approach brings together statutory and non statutory organisations who work collectively, offering specialist support for those at risk. Reflected nationally, funding for initiatives and activities is often allocated on an annual basis and is often short term, this can provide challenges to securing long term and sustainable interventions and retaining knowledge and expertise in the city.

Youth provision exists across the spectrum of risk, the majority of provision delivered is however concentrated at secondary and/or tertiary intervention (supporting young people who have been identified as at risk of violence).



Activity includes:

- **Exploitation Hub –** a multi-agency partnership which facilitates a comprehensive understanding of risk, threat and harm from exploitation. Partners facilitate appropriate interventions and disruption planning to safeguard young people identified as at risk.
- **Divert –** promotes the diversion of young people away from the criminal justice system using a multi-agency panel to agree appropriate support and outcomes in a non-criminal space for those referred in to the programme.
- **Power 2 –** a multi-disciplinary, multi-agency partnership supporting vulnerable young people aged 11-25 at risk of exploitation and violence. This partnership model provides continuation of support beyond the age of 18 to ensure that vulnerable young people are not exploited once they become an adult.
- **Gangs Forum –** trusted partners facilitate support to identified young people and their families; support includes detached outreach, targeted intervention programmes and lived-experience workers in Accident and Emergency departments.
- **Preventative activity to address the causes of violence –** including development of a needs assessment to understand local drivers of violence, cost of living support to address poverty and vulnerability, Men @ Work programme delivered in schools to address harmful views of masculinity, Love Your Community initiative to build community cohesion and opportunities for co-production and system-wide activity to address wider determinants of health.
- **Thematic reviews –** undertaken in both exploitation and knife crime to learn lessons from local cases and modify practice.

8

Recommendations

The SNA makes a number of recommendations. These are detailed below.

Strategic

- Review and update the current Serious Violence Exploitation Strategy to emphasise a city-wide focus on the prevention of violence
- Contribute to improving the regularity and consistency of data sharing across the partnership, particularly around drivers of violence and risk factors
- Secure sufficient representation from the Education sector in violence prevention forums to ensure understanding and links between education outcomes and risks of violence, including input into strategic planning
- Strengthen the strategic focus on a collaborative approach to addressing children's substance misuse
- Consider how to further engage communities and residents in the violence prevention agenda.

Operational

- Development of a coordinated communication plan to share key messages with communities and increase perceptions of safety amongst young people and the wider community
- Continuation and expansion of training to equip professionals, communities and businesses to recognise and respond to risks associated with violence
- Further consider the links between gender and serious youth violence and the benefits of piloting preventative programmes to challenge problematic views of masculinity
- Work to embed the Community Initiative to Reduce Violence (CIRV) programme across Wolverhampton to drive uptake ad positive outcomes
- Raise awareness of the 'Teachable Moment Service' at New Cross Hospital and ensure that pathways are in place to increase referrals to support.

Commissioning

- Ensure that pathways to support for commissioned services are clear and accessible
- Ensure that commissioning across both local and regional partnerships is joined up and meet local need
- Develop a uniform evaluation framework for commissioned activity to improve understanding of successful interventions
- Continue to highlight the impact of short term funding for commissioned violence prevention services and risks around sustainability.

For further analysis

- Consider victims (aged 25+) of violence and exploitation, the drivers for this behaviour and the partnership response available to these victims.
- Better understand and consider the implications of the increased and regular use of electronic media and entertainment amongst young people.

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CITY OF WOLVERHAMPTON COUNCIL

Serious Violence Needs Assessment - Recommendations

Health and Wellbeing Together

Presenters:

Lynsey Kelly
Head of Communities

Hannah Pawley
Community Safety Manager

Purpose

- To provide an update on the current position of Wolverhampton's response to the Serious Violence Duty and Serious Violence Needs Assessment (SVNA)
- To seek endorsement of the recommendations outlined in the Executive Summary (Appendix A).

Serious Violence Duty

The Crime, Sentencing and Courts Act (2022) sets out partnership requirements in relation to addressing violence in the **Serious Violence Duty** to increase effective collaboration across agencies in preventing serious violence

Requirements of the duty:

- Formulate an evidence-based analysis of the problems associated with serious violence the local area, including the drivers of serious violence
- Produce and implement a strategy detailing how identified issues will be responded to including adequate investment in early intervention and prevention
- Review the local profile in relation to violence
- Ensure there is effective planning and collaboration to support a longer-term approach to preventing violence

The duty applies to:

- local authorities
- the police
- fire and rescue authorities
- specified criminal justice agencies

Prisons, youth custody agencies and educational authorities are also named as core partners.

Serious Violence Needs Assessment

- Developed by a **multi-agency task and finish group** with oversight from Safer Wolverhampton Partnership
- **Focus on prevention** - utilises data and information from a range of sources to examine the prevalence of violence in Wolverhampton as well as driving factors
- **First serious violence needs assessment developed locally** – plans in place for annual refresh aligned with exploitation problem profile and thematic reviews
- **Co-produced with communities** – events held to get the views of key stakeholders and communities with over 200 people engaging.

Development of HHNA Recommendations

- Recommendations developed across the range of topics covered by the needs assessment:


Overarching / strategic (3)


Coproduction & communities (2)


Communications/ training (2)


Commissioning / Interventions (4)


Evaluation and evidence (2)


Education and prevention (2)


Drug and alcohol use (1)


Older adults (1)

- Developed in conjunction with Violence Prevention Steering Group

SVNA Key Recommendations (1)

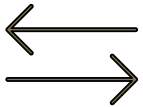
Review and update the current Serious Violence Exploitation Strategy to emphasise a city-wide focus on prevention of violence. This will include a commitment to improving regularity and consistency of data sharing across the partnership, particularly around risk factors and drivers of violence

Consider how to further engage communities and residents in the violence prevention agenda, including a coordinated communication plan to share key messages with communities and increase perceptions of safety amongst young people

Ensure that commissioning across both local and regional partnerships is joined up and meeting local need, continue to highlight the impact of short-term funding for commissioned violence prevention services and risks around sustainability

Continue and expand the rollout of training to equip professionals, communities and businesses to recognise and respond to risks associated with violence

SVNA Key Recommendations (2)



Further consider risk factors associated with violence and exploitation and consider opportunities for collaboration and to pilot preventative programmes to address them (for example, problematic views of masculinity and substance use amongst young people)

Ensure that the partnership strengthen the link with the education sector in violence prevention activity and ensure that their views and contributions are reflected in strategic planning

Continue to work to embed and promote existing provision within Wolverhampton, including the Community Initiative to Reduce Violence (CIRV) and the Teachable Moment Service in New Cross Hospital. Ensure that pathways to support are clear and accessible

Develop a uniform evaluation framework for commissioned activity to improve understanding of successful interventions and continue to add to the evidence base around ‘what works’ in relation to violence prevention

Explore opportunities to expand understanding by undertaking further exploration into the impact of social media and drivers for violence amongst those age 25+

Recommendations

It is recommended that Health and Wellbeing Together:

- Note the key findings set out in the Serious Violence Needs Assessment outlined in Appendix A

- Endorse the recommendations outlined in Appendix A and

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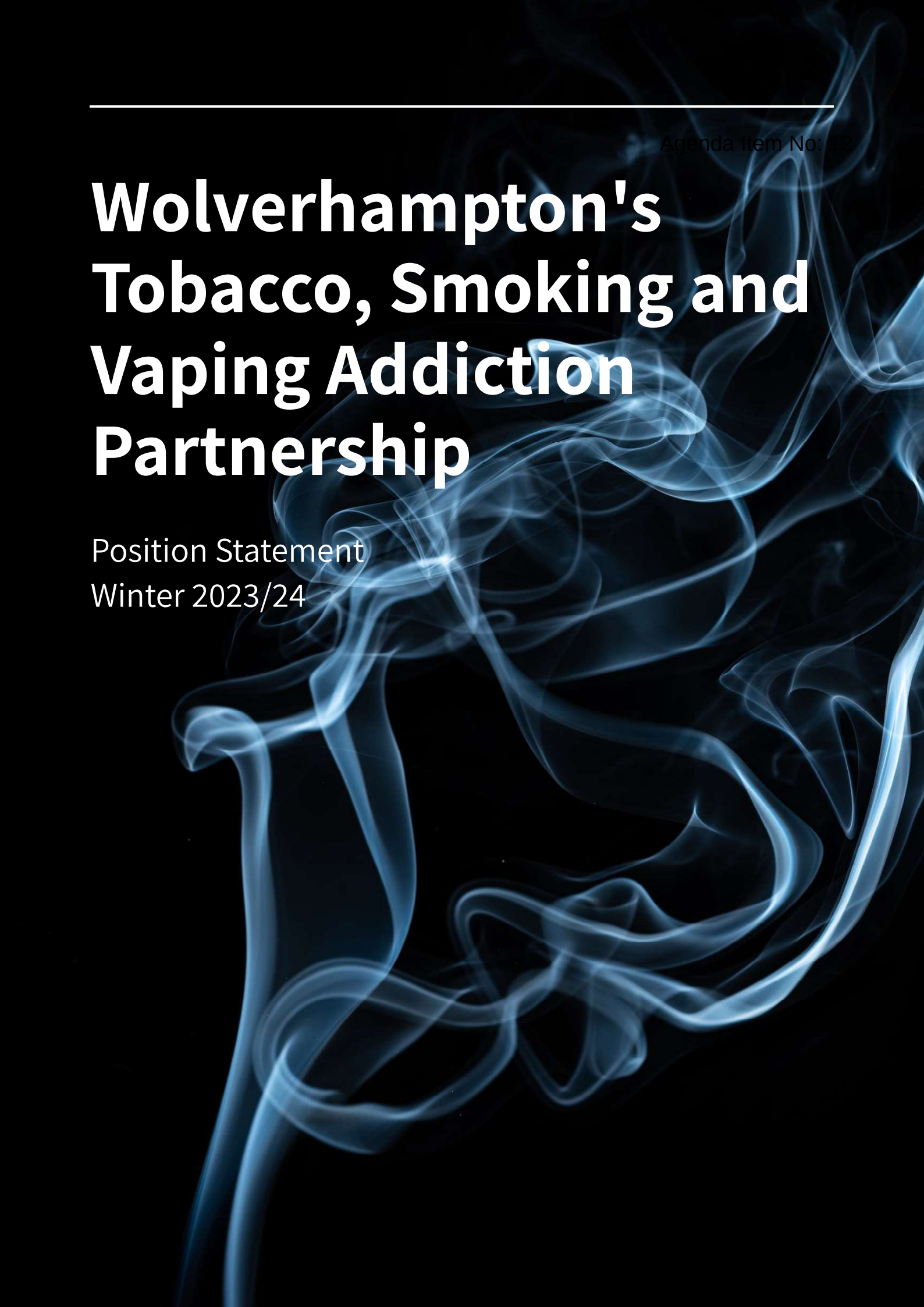
Wolverhampton's Tobacco, Smoking and Vaping Addiction Partnership

Position Statement
Winter 2023/24



Purpose of this position statement

Despite significant reductions in the prevalence of smoking in Wolverhampton over the past 10 years, there are still an estimated 31,000 smokers residing in Wolverhampton. Smoking has been proven to be one of the biggest causes of death and illness in the UK.

Smoking causes 7 out of every 10 cases of lung cancer and increases the risk of coronary heart disease, heart attack, stroke and chronic obstructive pulmonary disease. Second hand smoke or passive smoking can also increase the risk of a number of conditions. Children and babies are particularly vulnerable to the effects of second hand smoke and for women who smoke in pregnancy harms caused to their babies include low birth weight, miscarriage, still births and sudden infant deaths.

In Wolverhampton, smoking prevalence is substantially higher in deprived communities and amongst residents diagnosed with anxiety, depression and other long-term mental health conditions. Smoking prevalence in Wolverhampton is almost double amongst residents in manual and routine occupations, compared to the general population, further demonstrating inequalities amongst the City's population.

This position statement from Wolverhampton's Tobacco, Smoking and Vaping Addiction Partnership (TSAVA) and the Cabinet Member for Health and Wellbeing, has been written to support the direction of travel that the City intends to take in a bid to reduce smoking prevalence, including:

- The use of vapes as an effective method to support adults to quit smoking.
- To reduce the access to vapes for children and young people.

These actions will be in line with the Government's approach to achieving a Smokefree status by 2030.

The position set out in this document will be based on current evidence, guidance from the Khan Review and proposed Government legislation. Due to the changing landscape of evidence and Government legislation around smoking and vaping, this will be a live document.

Introduction

The Annual Population Survey (APS), which estimates the smoking prevalence among persons 18 years and over, is the most recognised measure of smoking prevalence in England. The APS estimated in 2022 that the smoking prevalence is 12.7% in England, 13.4% in the West Midlands and 15.1% in Wolverhampton. In September 2023, the UK Government announced a number of measures to bolster their efforts to achieve the Smokefree 2030 ambition set out in 2019. The term 'Smokefree' is defined as having a smoking prevalence of 5% or less.

There is long-standing evidence and consensus that smoking is one of the biggest causes of death and illness in the UK. In recent years there has been a growth in the evidence base around the use of vapes as a tool to help smokers quit smoking. The Khan Review recognises that vaping is widely considered to be much less harmful than smoking and an effective tool to support smokers to quit smoking, although it is not without it's own risks.

With the rising popularity of vapes amongst adults and availability of vapes in retail outlets across the country, there has also been a concerning rise in the use of vapes amongst school-aged children and young people. The rise in vaping amongst school-aged children and young people has raised concerns amongst the public and added an element of uncertainty, confusion and misinformation about vaping amongst the public and some healthcare professionals.

Therefore, it is imperative that the TSAVA sets out it's position in regards to reducing tobacco harm from smoking, use of vaping to help reduce the smoking prevalence and the deterrence of vaping amongst school-aged children and young people.

The TSAVA Position

The TSAVA supports the Governments legislative measures to reduce smoking prevalence to 5% or less by 2030 and becoming 'Smokefree'.

The Government's recently announced measures are based on the recommendations from the independent review by Dr Javed Khan OBE, published in 2022, 'The Khan Review'. The plan to increase the legal age to purchase tobacco by a year every year is a positive action, which will go a long way to ensure that young people do not start smoking tobacco, over time the ambition is to develop a smokefree generation. The partnership will support existing services, and services in development, in the City to deliver the 'Swap to Stop' scheme announced by the Government, as one of the trailblazers in the West Midlands. This will allow current smokers to swap their tobacco for e-cigarettes, alongside recommended behavioural change practice. The Government have also announced further funding and powers for trading standards to further enhance their work to limit the supply and sale of illicit tobacco.

The TSAVA endorses the use of vapes that meet UK regulatory standards, as an effective tool for adult smokers to stop smoking, with a view to also stop vaping in the future.

There is a growing body of evidence that show that vapes are substantially less harmful compared to smoking tobacco and there are numerous health benefits for individuals who swap smoking tobacco for vaping. Vapes are currently the most popular tool to support adults to stop smoking and evidence from clinical trials suggest that they can be effective in helping adults to stop smoking tobacco. The approach to endorse vaping as a safer alternative to smoking tobacco, is a new approach in Wolverhampton.

The TSAVA does not recommend school-aged children and young people to use vapes and will work to deter them from vaping and work as a partnership to restrict the access of vapes to residents aged under 18.

Despite the health benefits of vaping over smoking tobacco, vaping itself is not risk free. There is significant concern amongst educational settings and local communities about the rise of vaping amongst school-aged children. It is currently illegal for vapes to be sold to people aged under 18, therefore the supply of vapes to teenagers aged under 18 is a crime. The Governments plans to ban the sale of disposable vapes are very welcome and it is envisioned that they will contribute greatly to deter under 18's from vaping. Wolverhampton's Trading Standards team are a key member of the TSAVA partnership and they will be supported to continue their efforts to restrict the sale of vapes to under 18's. Illicit vapes are vapes which do not meet the UK regulations, such as those that exceed the size limit of the vape liquid or those containing chemicals or substances not permitted in the UK.

The trading standards team will also continue to work to eradicate the supply and sale of illicit vapes. We will work with educational establishments across the City to develop educational tools and materials to educate children about the risks of vaping and the links to wider behaviour that can be detrimental to the health of young people. Educational establishments will work with trading standards to share intelligence around the availability of vapes to under 18's in local retail outlets.

What can our partners do?

Local Authorities and health professionals play a pivotal role in advocating nicotine vaping as a valuable tool for smoking cessation. Aligning with guidance from reputable sources such as NICE, Cochrane review, OHID, KCL, and Dr. Javed Khan's independent review, they should provide accurate information on the benefits of vaping. By endorsing this evidence-based approach, they contribute to public health efforts, offering smokers a viable and supported option for quitting while dispelling misconceptions around vaping.

Health professionals and other frontline professionals working with Wolverhampton residents should promote vaping as an effective tool to support smokers who want to quit, ensuring they also provide accurate information about the benefits of using vapes rather than continuing to smoke tobacco. Health professionals should be aware of the latest guidance and evidence on using vapes as a smoking cessation tool from the NHS, NICE, OHID and the Khan Review, and employers should support health professionals to do this through training opportunities. The partnership will have a responsibility to promote or develop training materials that are appropriate for our population.

Public and private sector entities should implement policies that create a supportive environment for employees and customers who choose to vape. Taking a proactive approach reflects a commitment to both individual well-being and broader public health objectives.

NHS trusts, Integrated Care Boards, and primary care settings should embrace policies that facilitate the choice of vaping over smoking on hospital sites, mental health services and maternity services, aligning with the smoke-free NHS initiative. By adopting practices demonstrated by some NHS trusts, they empower staff, patients and visitors to make healthier choices, promoting harm reduction and general well-being.

Education establishments and professionals working with young people across the City can further engage with PSHE leads and work to develop localised materials that can educate pupils and parents on the potential harms of vaping and illicit vapes. Education establishments can work closely with trading standards to share intelligence about the supply of vapes and illicit vapes to residents aged under 18 years of age.

The TSAVA Partnership is made of representatives from City of Wolverhampton Council (Public Health, Trading Standards and Education), NHS Royal Wolverhampton Trust and the NHS Black Country ICB.

CITY OF WOLVERHAMPTON COUNCIL

NHS

For more information on the work of Wolverhampton's Tobacco, Smoking and Vaping Addiction Partnership, please contact: PublicHealth@wolverhampton.gov.uk