CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel

29 June 2023

Time 1.30 pm **Public Meeting?** YES **Type of meeting** Scrutiny

Venue Committee Room 3 – Wolverhampton Council Civic Centre

Membership

Chair Cllr Susan Roberts MBE (Lab)
Vice-chair Cllr Paul Singh (Con)

Labour

Cllr Carol Hyatt
Cllr Jaspreet Jaspal
Cllr Milkinderpal Jaspal
Cllr Rashpal Kaur
Cllr Asha Mattu
Cllr Gillian Wildman

Conservative

Cllr Sohail Khan

Co-Opted Members
Stacey Lewis (Healthwatch)

Quorum for this meeting is three voting members.

Information for the Public

If you have any queries about this meeting, please contact the Scrutiny Team:

Contact Lee Booker
Tel/Email Lee.Booker@Wolverhampton.gov.uk
Address Scrutiny Office, Civic Centre, 1st floor, St Peter's Square, Wolverhampton WV1 1RL

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Agenda

Part 1 – items open to the press and public

Item No. *Title*

MEETING BUSINESS ITEMS

1 **Apologies**
[Chair to request notification of Apologies]

2 **Declarations of Interest**
[any declarations of interest from Panel members]

3 **Minutes of previous meeting** (Pages 3 - 4)
[To approve the minutes of the previous meeting as a correct record.]

DISCUSSION ITEMS

4 **Hearing Aids** (Pages 5 - 10)
[Presentation from the Integrated Care Board]

5 **Patient Participation Groups** (Pages 11 - 14)
[Presentation from the Integrated Care Board]

6 **Wolverhampton Joint Local Health and Wellbeing Strategy 2023- 2028** (Pages 15 - 54)
[To consider the Wolverhampton Joint Local Health and Wellbeing Strategy 2023-2028].

7 **Healthwatch Urology Survey Report** (Pages 55 - 62)
[Healthwatch to deliver report to the panel]

CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel

Minutes - 23 March 2023 Agenda Item No: 3

Attendance

Members of the Health Scrutiny Panel

Cllr Jaspreet Jaspal
Cllr Milkinderpal Jaspal
Cllr Rashpal Kaur
Cllr Sohail Khan
Stacey Lewis
Cllr Lynne Moran
Cllr Susan Roberts MBE (Chair)

Employees
Martin Stevens DL (Scrutiny Team Leader)
Lee Booker (Scrutiny Officer)
John Denley (Director of Public Health)
Richard Welch (Head of Partnerships)

Part 1 – items open to the press and public

Item No. *Title*

1 **Apologies**
An apology for absence was received from Cllr Paul Singh. There were no substitutions.

2 **Declarations of Interest**
There were no declarations of interest.

3 **Minutes of previous meeting**

Resolved: That the minutes of the meeting held on 19 January 2023 be approved as a correct record.

4 **Better Health Rewards Scheme**
The Head of Partnerships opened the presentation (a copy of the presentation is attached to the signed minutes) and gave some context on the Better Health Rewards Scheme. The Better Health Rewards pilot scheme was launched on the 17 February 2023 and was designed to last 6 months, in partnership with the Office of Health Improvement and Disparities (OHID) and Headup Systems Limited. It was designed to test whether individuals would change their behaviours to eat healthier and exercise more in response to incentivisation. The Council applied to take part in the scheme because of its commitment and interest in Behavioural Sciences and were accepted due to their willingness to try something different in response to issues like obesity and a reduced willingness across the national population to

participate in physical exercise.

The Head of Partnerships informed the Panel that the Department of Health & Social Care had made £3 million available in support of the scheme and explained some of the reward the scheme had for participants. Some major supermarkets supported the scheme. Further information was given on user set up information. Participants had to be 18 years old or above to take part in the scheme. The launch of the scheme included a volunteer led launch day, as well as advertising on a variety of national television programs, radio and newspapers. On going promotional planning was being delivered by the City of Wolverhampton Council working with partners such as Wolverhampton University. Advertising was utilised with the Wolverhampton Wanderers football club. The Head of Partnerships showed examples of video advertising which had been on going.

The Head of Partnerships summarised where the scheme was at; 20,000 residents had registered, with 16,000 fitness devices dispatched. Attrition rates would be monitored and the data would be fed back when the research findings were published by OHID.

A Panel member commented that feedback they had had was that it was not clear enough to users that it was a research program, concerns had been raised people did not know what was occurring with their data. The Director of Public Health welcomed the feedback.

A Councillor asked if the individuals not in the control group would get the opportunity to be in it at a later stage. The Director of Public Health said they would not, due to the nature of the scheme being a pilot for research.

A Councillor asked if the Council had anything in place to encourage those who had signed up but had not activated their device to move onto the next stage, he also enquired where the Council envisioned the scheme going after the 6 month trial had ended.

An Officer answered that each stage had nudge or prompts set up to engage with the service user as a reminder. The Director of Public Health replied to the Councillors second question stating that the data gathered from the trial would enable them to see what works best and utilise that data to improve the service should it go forward.

Councillors discussed issues that they had had with the technology that the app used. The Director of Public Health replied that as this was a trial, it would allow them to find out what issues occurred and then they could find out with more help with technology was required.

The Chair praised the work being done and informed the Chamber about her experiences using the device and the app, which she had found beneficial.

Agenda Item No: 4

Health Scrutiny Panel

29 June 2023

Report Title: Hearing Aids (Audiology Services)

Report of: Paul Tulley
Wolverhampton Managing Director
Black Country Integrated Care Board

Portfolio Public Health and Wellbeing

Recommendation(s) for action or decision:

The Health Scrutiny Panel is recommended to comment and ask questions on the contents of the report, including any suggestions for improvement.

1.0 Introduction

1.1 The Health Scrutiny Panel have requested an update on the provision of hearing aids (through) Audiology Services in Wolverhampton, in particular the pathway and process for obtaining hearing aids.

1.2 This paper seeks to update Panel members on the current services commissioned in Wolverhampton, any gaps which exist and next steps.

2.0 Background

2.1 Hearing loss in adults, at a personal and a societal level, can lead to social isolation, depression, loss of independence and employment challenges. In addition, evidence now shows that hearing loss can be associated with dementia.

2.2 Assessing the hearing needs of patients with hearing loss, developing an individual management plan and providing appropriate interventions can reduce isolation, facilitate continued integration with society and promote independent living.

2.3 One in six people in the UK have some form of hearing loss. Most are older people who are gradually losing their hearing as part of the ageing process, with more than 70% of over 70-year-olds and 40% of over 50-year-olds having some form of hearing loss.

2.4 Around 2 million people currently have a hearing aid in the UK, however, approximately 30% of these do not use them regularly, and there are a further 4 million people who do not have hearing aids and would benefit from them.

3.0 Audiology Services

3.1 There are two audiology services commissioned within Wolverhampton:

Community-based, adult hearing assessment service, including hearing aid fitting (where required), follow-up and aftercare services for adults aged 55 or over, with suspected or diagnosed age related hearing loss;

3.2 Routine audiology services for people aged over 55 are commissioned through an ‘Any Qualified Provider’ (AQP) approach. This means that any provider who meets the quality standards, the specified contractual terms and the specified tariff set for the service can be commissioned to deliver the service. The main provider of the service in Wolverhampton is Specsavers.

3.3 The community-based service provides the following:

- Hearing needs assessment
- Development of an Individual Management Plan (IMP)
- Provision and fitting of hearing aids in a suitable environment (quiet, confidential, privacy and dignity)
- Appropriate hearing rehabilitation such as patient education.
- Information on and signposting to any relevant communication/social support services
- Follow-up appointment to assess whether needs have been met.
- Discharge from hearing assessment and fitting pathway.
- Copy of audiometry test provided to GP.
- Aftercare service including advice, maintenance, repairs or replacement of hearing aids under warranty and review as required to meet the needs of the patient.
- Batteries, tips, domes, wax filters, tube and other consumables replacement service.
- Help and support to the housebound

3.4 Patients eligible for this service are referred directly from their General Practitioner (GP) to support a timely diagnosis and treatment. This is an NHS service and patients referred to an AQP provider are not charged for the hearing assessment or any subsequent NHS treatment (including the provision and of hearing aids).

Complex audiology services and services for adults with complex hearing loss and all under 55s.

3.5 The Complex Audiology Service sees patients who do not meet the 'Any Qualified Provider' criteria, for example, if they have additional issues such as distressing tinnitus, balance problems, asymmetric hearing loss or are under 55 years of age. The service is provided by the Royal Wolverhampton NHS Trust with the main department based at West Park Hospital.

3.6 For those patients that meet complex criteria, a range of services are offered including hearing aids, tinnitus, adults with additional needs, and hearing therapy. The hearing aid pathway is described below.

3.7 The patient pathway consists of the following stages:

- Assessment and fitting
  - Undertake full clinical assessment and diagnostic procedures, using a recognised quality assurance tool
  - Discharge any patients back to GP who meet 'Any Qualified Provider' criteria for onward referral to AQP provider
  - In collaboration with the patient, develop an Individual Management Plan (IMP) to ensure patient needs are met/ expectations managed

  Assess patient needs using Client Oriented Scale of improvement (COSI) with relevant questioning
  - Deliver appropriate hearing rehabilitation

- If a hearing aid is advisable, offer advice and counselling to reassure the patient/ manage expectations
- Discuss and agree in collaboration with the patient, the clinically appropriate type/model
- Undertake fitting; in line with BSA/BAA recommended procedures
- Advice and support to adjust to hearing aid
- Advice on maintenance and cleaning
- Patients will be given a supply of batteries
- Maintenance, advice and support

- Follow up:
  - A follow up appointment will be scheduled post fitting to assess whether needs have been met, the IMP will be updated as appropriate
  - Measure outcome using Client Oriented Scale of improvement (COSI) with relevant questioning
  - Enquire about comfort and general experience of use and provide assistance where needed
  - Fine tune where needed
  - Additional follow-ups will be provided where needed
- Aftercare Service
  - All patients with an NHS hearing aid will remain on the caseload for aftercare until a time when the hearing aid is no longer required; this will enable self-referral as required [after 3 years complex patients are entitled to a reassessment of their hearing needs and a more up to date hearing aid/aids as appropriate]
  - Routine servicing will be provided for as long as necessary
  - Battery replacement and modification of aids as required
  - Faulty hearing aids will be replaced, (within warranty - normally 3 years)

3.8 The Complex Services provide additional types of hearing aids for particularly complex patients that are not provided within the AQP Contract such as CROS (Contralateral routing of signals), hearing aids for patients with single sided deafness, a range of ultrahigh powered hearing aids and an assessment service for severe and profoundly deaf patients which may include onward referral to ‘Cochlear Implant Centres’ and bone-conduction hearing aids and bone-anchored hearing aids. Hearing aids of all types are also provided to patients with additional needs who require specialised testing.

3.9 In addition, patients with concomitant tinnitus which has not been managed successfully by using the hearing aid(s) will be referred onto the tinnitus team for further support and treatment.

Pathway issues

3.10 A number of areas for improvement have been identified in the referral and treatment pathways for audiology services. Patients are not always seen in the right place at the right time, by the right provider to ensure the most appropriate services and products are supplied. This can result in duplication of appointments, which are not a good use of NHS resources or a good experience for patients.

4.0 Ear Wax Removal

4.1 Wax is found in the ear and is used to protect the ear canal from dirt and germs. Unfortunately, ear wax can build up over time and block the ear canal if it does not fall out naturally.

4.2 Earwax build-up can cause hearing difficulties and discomfort, and it can contribute to outer ear infections. It is also important to remove earwax quickly and completely because it can prevent thorough ear examinations or ear canal impressions being taken for hearing aid fitting, which will delay assessment and management of hearing loss and underlying pathology and wastes valuable appointments.

4.3 Historically, patients requiring ear wax removal would access their GP for ear syringing. This was where a large amount of water was injected into the ear canal with the use of a syringe. The water would then be drained from the ear, making it likely that chunks of the ear wax would be drained with it. This type of treatment could be undertaken a few times to ensure that the wax would not rebuild and cause problems.

4.4 The release of the NICE Guidance NG98 “Hearing loss in adults: assessment and management” (2018) stated that manual syringing to remove earwax should not be offered to adults. There are other safer removal methods that can be used in GP practices, including electronic irrigation and micro-suction. However, these two methods have financial and other resource implications with respect to training, clinical supervision and specialist equipment.

4.5 There is not a national policy on the removal of ear wax. The NHS website - www.nhs.uk - states that “not all GP practices remove earwax” and that “you might have to pay to have them done privately”.

4.6 Ear irrigation is outside of core services commissioned from GPs. To support General Practice to be able to continue to offer ear wax removal safely, a local commissioned service is commissioned in Wolverhampton through which practices can claim reimbursement for the cost of providing ear wax removal to support patient’s, ahead of their hearing tests or to support the fitting of hearing aids.

4.7 In 2022/23, nine GP practices undertook ear wax removal funded through the ICB local enhanced service in 2022/23. Three of the six PCNs in Wolverhampton offer their patients a micro-suction service for ear wax removal provided at the Upper Zoar Street practice in Penn Fields. Patients from 21 of the 37 practices in Wolverhampton can access ear wax removal through this service, which has been operating since October 2020. It is not commissioned as a separate service by the ICB. Seven practices reported no activity in 2022/23. This variable provision of the service across general practice means that there is variation in access for the local population.

4.8 Total provision of ear wax removal across the 37 practices in Wolverhampton has increased from circa 800 procedures in 2019/20 to circa 3,700 procedures in 2022/23.

4.9 For this report we have looked a private provision and identified at least 12 local organisations offering ear wax removal privately. The average cost of the service is approximately £40 for one ear and £65 for both ears.

4.10 The issue relating to ear wax removal is not specific to Wolverhampton. Provision is commissioned from general practice in Walsall and Dudley and there are similar differences in provision between practices. In Sandwell a community ear care service is commissioned which provides a micro-suction service and covers the whole of the Sandwell population.

5.0 Next Steps

5.1 The ICB is currently undertaking a review of its commissioning policy for ear wax removal.

Sally Sandel
Head of Primary Care and Commissioning (Wolverhampton)
Black Country Integrated Care Board (ICB)

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Agenda Item No: 5

Health Scrutiny Panel

29 June 2023

Report Title: Patient Participation Groups in Wolverhampton

Report of: Paul Tulley
Wolverhampton Managing Director
Black Country Integrated Care Board

Portfolio Public Health and Wellbeing

Recommendation(s) for action or decision:

The Health Scrutiny Panel is recommended to comment and ask questions on the report, including any suggestions for improvement.

1. Introduction

1.1 This paper provides an update to members of the Wolverhampton Health Scrutiny Panel on the current position with the implementation and development of Patient Participation Groups (PPGs) in Wolverhampton.

2. Background

2.1 A Patient Participation Group is a group of volunteer patients, carers and GP practice staff who meet regularly to discuss and support the running of their GP practice. PPGs look at the services the practice offers, patient experience and how improvements can be made for the benefit of patients and the practice.

2.2 From April 2016, it has been a contractual requirement for all English practices to form a PPG.

2.4 Whilst some PPGs continued virtually during the COVID-19 pandemic, many were stood down. This was following national advice to temporarily suspend some non-urgent services so that practices could focus on core priorities, including administration and delivery of the COVID-19 vaccination programme.

2.5 To understand the current position of PPGs following the pandemic, a review was undertaken across all practices in Wolverhampton in February 2023. In order to complete the review, Primary Care Network (PCN) Managers, GP practices, and PPG chairs were contacted and practice websites were viewed.

3. Current Position and Plans

3.1 The review of PPGs showed that, of the 37 practices across Wolverhampton, 30 have an active PPG that has held at least one meeting in the last six months. The other seven practices either have or are developing plans to re-establish their PPG meetings. All PPGs have resumed with face-to-face meetings, some with a hybrid option, as this approach is generally preferred to virtual meetings.

3.2 In undertaking the review, many practices highlighted the challenges in restarting groups following the pandemic. In order to support this the ICB has commissioned training for PPG chairs and for practice managers. Priority will be given to PPGs who have not previously received the training. The training is being recorded and the materials will be available for other PPG chairs and practice managers to learn from. The first training session is planned to take place on 27 June 2023.

3.3 In addition to the training, a number of resources have been developed to support PPGs and practices across the Black Country, including:

- A PPG Patient Questionnaire, both paper based and digital.
- A meeting agenda template.
- A meeting notes template.
- Terms of Reference (ToR) which can be tailored to individual practices.

- A welcome letter to (new) members.
- An online membership form.
- A Powerpoint presentation template.
- An editable and general PPG poster.
- An editable PPG Event poster.
- A "What we've been up to" poster.

3.4 A new section within the ICB website dedicated to PPGs has been developed. It can be found here and includes links to all of the resources listed above as well as a range of information about PPGs and Primary Care Networks.

3.5 We are also about to launch a co-creation project, following feedback from a PPG chair in Wolverhampton who had recently discussed with his PCN PPG that the range of additional staff roles now employed in general practice is not widely understood amongst local residents. The PPG chair approached the ICB involvement team and we are now convening a working group with primary care colleagues for an exploratory conversation about how we can develop understanding of the roles and co-create solutions to increase awareness and understanding.

4. Conclusion

4.1 Patient Participation Groups are an important forum for patient involvement in GP practices. Having been disrupted during the pandemic, good progress is being made in reviving/re-establishing PPGs across the city, supported by a training programme for practice managers and PPG Chairs.

Anna Butters Involvement Specialist (Wolverhampton) Black Country Integrated Care Board (ICB)	07989 728044 a.butters@nhs.net
Sally Sandel Head of Primary Care and Commissioning (Wolverhampton) Black Country Integrated Care Board (ICB)	07872 055023 sally.sandel1@nhs.net

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Agenda Item No: 6

CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel

29 June 2023

Report title	Wolverhampton Joint Local Health and Wellbeing Strategy 2023-2028
Cabinet member with lead responsibility	Cllr Jasbir Jaspal Adults and Wellbeing
Wards affected	All
Accountable director	John Denley, Director of Public Health
Originating service	Public Health
Accountable employee(s)	Madeleine Freewood madeleine.freewood@wolverhampton.gov.uk

Report to be/has been considered by		
	Strategic Executive Board	30 May 2023
	OneWolverhampton Executive	05 June 2023
	Wolverhampton Place Development Senior Management Team Meeting	07 June 2023
	Health and Wellbeing Together	21 June 2023

Recommendations for noting:

The Scrutiny Board is asked to note:

1. the Wolverhampton Joint Local Health and Wellbeing Strategy 2023 – 2028.

1.0 Purpose

1.1 To present Health Scrutiny Panel with the Joint Local Health and Wellbeing Strategy 2023-2028 for comment. This will set the strategic direction for Health and Wellbeing Together over the next five years.

2.0 Background

2.1 Health and Wellbeing Together is the forum where key leaders from the health, care and wider system come together to work collectively to reduce health inequalities, support the development of improved and joined up health and social care services and set the strategic direction to improve the health and wellbeing of the local population. 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.

2.2 The Board is responsible for publishing 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 Joint Strategic Needs Assessment and other needs assessments will be addressed.

3.0 Joint Local Health and Wellbeing Strategy 2023-2028

3.1 The JLHWS for 2023-2028 is a partnership strategy. Public consultation through a range of activities including the City Lifestyle Survey, Health Related Behaviour Survey, Safety of Women and Girls Survey, and Mental Health and Wellbeing Survey, alongside local intelligence and other community data and feedback has helped shape and define the priority areas in the strategy. These are: starting and growing well, reducing addiction harm and getting Wolverhampton moving. The Board's role as system leaders in coordinating and maintaining strategic oversight of activity to improve quality and access of care and promoting mental health and wellbeing is also detailed. A collective commitment to address health inequalities is presented throughout the document.

4.0 Questions for Scrutiny to consider

4.1 The panel is invited to consider strategy implementation in the context of 29 July 2022 Department of Health and Social Care guidance for Local authority health overview and scrutiny committees: https://www.gov.uk/government/publications/health-overview-and-scrutiny-committee-principles/health-overview-and-scrutiny-committee-principles

5.0 Financial implications

5.1 There are no direct financial implications as funding for activity will be met from existing budgets. [JM/20062023/B]

6.0 Legal implications

6.1 Health and Wellbeing Boards have a duty to publish and implement at Joint Local Health and Wellbeing Strategy for their locality in line with the Health and Social Care Act 2012 and subsequent national guidance. [TC/12062023/C]

7.0 Equalities implications

7.1 Health and Wellbeing Together has adopted a set of guiding principles to support a joined-up approach to tackling health inequalities and these are detailed in the Strategy.

8.1 Climate change and environmental implications

8.1 Strategy implementation will be cognisant of the impact of climate change on the social and environmental determinants of health.

9.0 Health and Wellbeing Implications

9.1 A range of different factors shape health and wellbeing, for example, where people live, education, income, job role, lifestyles, access to green spaces, and connections with other people. The JLHWS sets out the role for Health and Wellbeing Together in addressing these wider determinants of health and coordinating a shared approach to prevention and healthy place-shaping.

10.0 Appendices

10.1 Appendix 1: Joint Local Health and Wellbeing Strategy 2023-2028.

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City of Wolverhampton
Health & Wellbeing Together

Wolverhampton Joint Local **Health and Wellbeing Strategy** 2023–2028

Contents

Foreword

Being healthy and feeling good, is about more than simply not being ill. Lots of different factors shape our health and wellbeing; where we live, our education, income, and the type of job we do, our lifestyles, access to green spaces, and the connections we have with other people.

Health and Wellbeing Together is the forum where key leaders from the health, care and wider system come together to work collectively to reduce health inequalities, support the development of improved and joined up health and social care services and set the strategic direction to improve the health and wellbeing of the local population.

Together we want to help create an environment where local people can live longer, healthier, and more active lives, and where every child in the city has the best start in life.

We will do this by working in partnership across the Council, health and social care partners, the voluntary sector, faith, and community groups, and by listening to local people, understanding their experiences, and making decisions informed by a population health approach.

We recognise that the Covid-19 pandemic has had a negative and lasting impact on many people, which has been made worse by the rising cost of living. We also understand the current pressures on the NHS and social care.

As a Board we have come together to identify where we can make the best contribution to these challenges. We believe we have a particular role to play in addressing health inequalities and coordinating a shared approach to prevention and healthy place-shaping.

Just under 7,000 people responded to our 2022-23 City Lifestyle survey. This, alongside local intelligence and other community data and feedback, has also helped us identify our core priority areas, where we can collectively make an impact, and hold each other to account.

We look forward to working together, guided by this strategy, to make a positive difference to our city and the lives of local people.

Councillor Jasbir Jaspal

Cabinet Member for Adults and Wellbeing

Chair of Health and Wellbeing Together

Paul Tulley

Wolverhampton Managing Director, Black Country Integrated Care Board

Vice-chair of Health and Wellbeing Together

What you told us

Throughout 2022 and 2023 we have been listening to local people. Our strategy is informed by insight from our local communities and partners.

WHAT WE DID

Children and Young People's Health Related Behaviour Survey (2022)

7,959
responses

WHAT WE HEARD

More primary pupils report receiving useful information about growing up from both school lessons and from parents and carers. They are also more likely to feel happy about growing up than in previous years.

The number of pupils in primary and secondary schools with a high wellbeing score has declined since 2018, as have the numbers that feel 'happy' with their life at the moment.

Parental smoking of cigarettes has declined and more parents in 2022 are using e-cigarettes than in previous years.

Girls are reporting poorer levels of emotional health and wellbeing than boys and those young people identifying as lesbian, gay, bisexual, and transgender or have special educational needs and a disability are more likely still to be experiencing behaviour suggestive of clinical emotional difficulty.

Online bullying has increased in both primary and secondary schools. Both primary and secondary pupils are less likely to say their school deals well with bullying. There is also a downward trend for secondary pupils reporting that their school challenges racism and racist bullying. More lesbian, gay, bisexual, and transgender pupils report being bullied than other groups.

The pandemic is likely to have impacted physical activity opportunities. For example, less pupils take part in regular physical activity and fewer report being able to swim in 2022 than in previous years.

Fewer pupils are smoking, contributing to a downward trend. However, pupils who live in homes with smokers have links with other health-risk behaviours.

The proportion of young people who have tried alcohol has continued to decline over time for both primary and secondary pupils.

More pupils had never visited the dentist.

WHAT WE DID

City Lifestyle Survey preliminary findings (2022/2023)

6,000+
responses

WHAT WE HEARD

Money worries are one of the biggest factors impacting on wellbeing.

Where people already used recreational drugs, many increased usage during the period of Covid-19 restrictions.

Of the people who use e-cigarettes, a majority are using them to help stop smoking.

Local parks and streets are the sites where residents are most likely to be physically active.

Where people are already gambling, family breakdown, job related stress, depression or loneliness often act as triggers to increase gambling habits.

WHAT WE DID

Safety of Women and Girls survey (2022)

2,000+
responses

WHAT WE HEARD

The majority of respondents feel safe when using sport, retail, and entertainment facilities, however parks and green spaces are areas where perceptions of safety could be improved.

WHAT WE DID

Mental health and wellbeing survey and co-creation activities

996
responses

141
beneficiaries

WHAT WE HEARD

Levels of self-reported wellbeing were significantly lower than that of the general population possibly because some of the people contributing were known to have been disproportionately impacted by the Covid-19 pandemic.

Being able to 'get out and do more things', 'having time for oneself', 'more money', and 'someone to talk to' were factors highlighted as important in improving wellbeing going forward. Better physical and mental healthcare support and better working environments also featured as likely to positively impact on future wellbeing.

Where support services were concerned, people highlighted the need for flexibility in service models to meet different people's needs. The stigma of mental health problems, awareness of locally available support services, access issues and waiting times were all discussed as continuing challenges.

WHAT WE DID

Moving More focus groups (2023)

80
participants from under-represented groups

WHAT WE HEARD

People want to be more active in their local area, including parks, green spaces, and community venues.

People want advice about how to have a healthy lifestyle, but not necessarily just from a health professional, trusted sources also included respected people in the community.

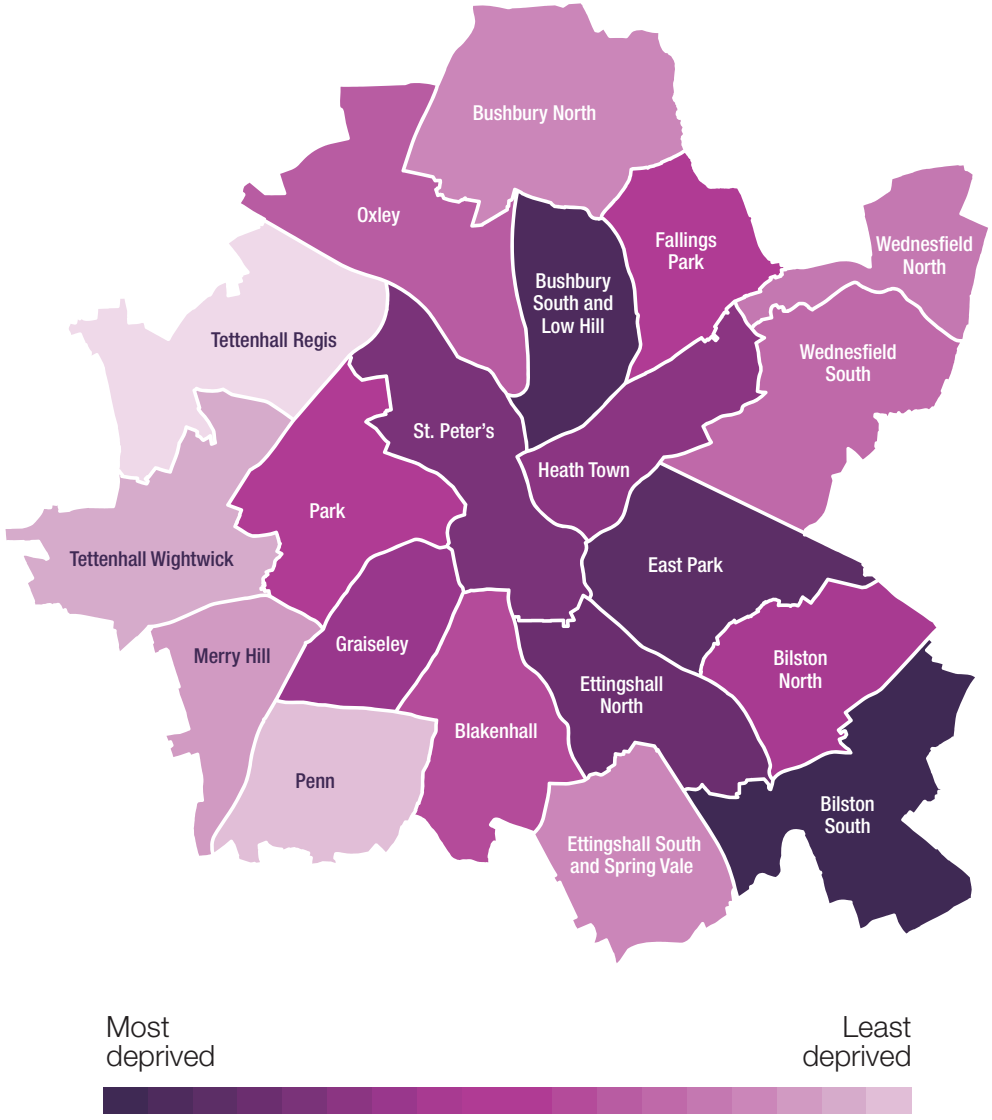
Our city profile

In addition to what local people have told us, our strategy is informed by what we know about our city. Health and Wellbeing Together has a responsibility to assess the health and wellbeing needs of the population and publish a joint strategic needs assessment (JSNA)[1]. This helps us understand our current health challenges in the city and the factors driving these. The JSNA informs the priority areas in this strategy.

WHAT DO WE KNOW?

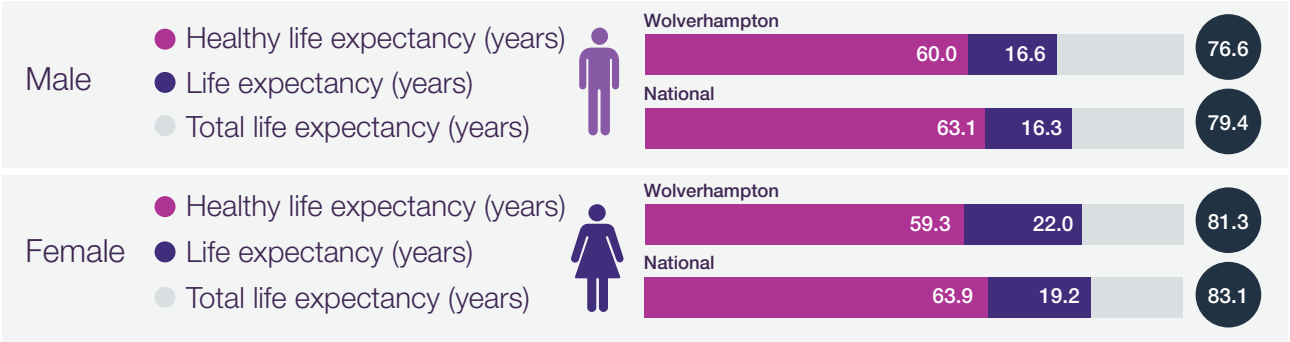
The population of the city has been growing recently and is now over 260,000, with 45% of residents from an ethnic minority group and a fifth of the population classed as disabled. The population is projected to continue to rise up to 296,102 by 2043, this is a 13% increase from 2018. While Wolverhampton has a younger population than the English average, the 65+ age group is expected to rise faster than younger cohorts.

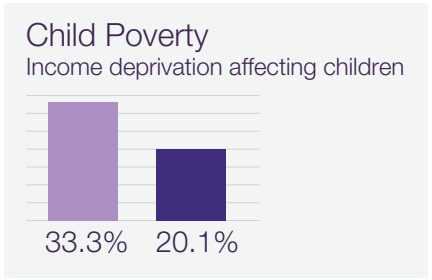
Levels of deprivation have also increased in recent years; the key components of deprivation are income, employment, health, education, crime, the living environment and barriers to housing and services.

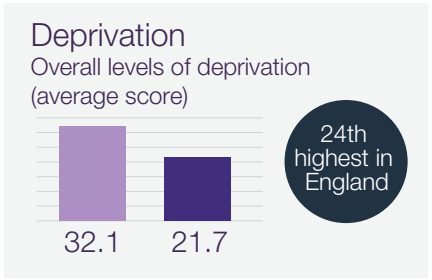


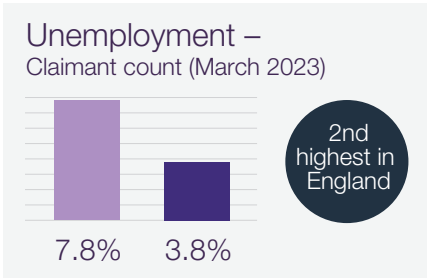
[1] https://insight.wolverhampton.gov.uk/Help/JSNA

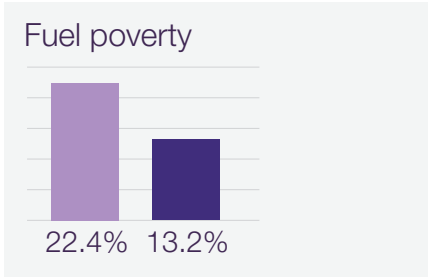
Life expectancy, alongside how much time people spend living in good health, are key measures of a population's health status. We already know there is a large difference in life expectancy in our city, driven in part by deprivation. Healthy life expectancy in Wolverhampton for both men and women is also worse than the national average. This means people in the city are likely to spend less years of their life in a state of 'good' general health in comparison to the rest of the country. This has significant implications for people's quality of life and demand on local health and social care services. We want to close this gap between different wards in the city, different populations in the city and between England and the city as a whole.

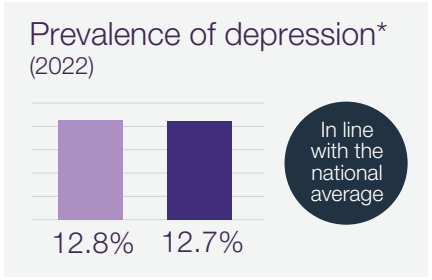












Comorbidities

30.7% of our population aged 18+ have **1-2 long-term health conditions** (approx. 71,200 residents).

An additional **7.2%** have at least **3 long-term health conditions** (16,600 residents).

Wolverhampton
National average

*Higher than previous years and the highest since 2013/14.

POSITIVE AND NEGATIVE INFLUENCES ACROSS THE LIFE COURSE[2]

The conditions in which people born, grow and live, alongside behavioural risk factors, can impact their health status throughout their lives:

Protective factors:

- having a healthy and balanced diet
- an environment that enables physical activity
- good educational attainment
- being in stable employment with a good income
- living in good quality housing
- having networks of support including friends and family

Risk factors:

- smoking
- adverse childhood experiences
- crime and violence
- drug and alcohol misuse
- poor educational attainment
- poor mental health
- social isolation
- poverty
- socially excluded

Giving children and young people the best start in life and providing a joined-up partnership response that enables people to stay well, get the right help when they need it and manage their own health and wellbeing are therefore key to improving the health of our local population.

[2] www.gov.uk/government/publications/health-matters-life-course-approach-to-prevention/health-matters-prevention-a-life-course-approach

The power of partnership: Charlie's story

MEET CHARLIE, AGED 52…

following a successful career in the Army serving in the UK and abroad, his drinking gradually increased until he was no longer able to undertake his role effectively and was medically discharged. Before he could plan a career change however, he was convicted for drink driving and lost his licence for two years, was fined and given a Community Payback order and a probation period. Unable to find work he became more isolated, living alone, neglecting any self-care including personal hygiene and diet. During the pandemic he slipped into a pattern of drink, sleep, repeat.

At this point Charlie is at risk of things escalating - he could go into debt, putting his home at risk, be unable to find new employment and experience further deterioration of his physical and mental health, making it more likely that he may eventually need emergency health care. There are lots of different partners that could help Charlie, to be effective they need to provide a coordinated and appropriate response, at the right time and place.

*This is an anonymised account based on the lived experience of a local person.

HOW DID CHARLIE TURN THINGS AROUND?

He realised his life had become unmanageable and sought help. He was referred into a detox and rehabilitation programme and started a daily routine of readings, journaling, group therapy sessions, one to one sessions with a keyworker and written work which allowed him to examine how he had become dependent on alcohol. He learned to stay sober supported by Alcoholics Anonymous. He was then able to get the right help to address his physical and mental health. He says, “accepting I had a problem with alcohol enabled me to get my life back.” Two years on he has completed a Level 4 Diploma and after undertaking volunteering he is now in full-time employment.

This partnership approach provided Charlie with the opportunity to get the right help and change his life. Enabling people to seek help even earlier or prevent things from escalating in the first place will help even more people like Charlie.

This strategy identifies priority areas for the city across the life course to help facilitate and embed a joined up approach. The benefits of this extend beyond the experience of Charlie. Increasing join-up between health and social care benefits older people[3]. Family Hubs will enable a 'one stop shop' for children and their families. This approach to integrated care recognises the importance of the wider contexts of people's lives in improving care.

[3] www.kingsfund.org.uk/audio-video/joined-care-sams-story

Closing the inequalities gap

Health inequalities are systematic, unfair, and preventable differences in health across the population, and between different groups within society. Our collective vision is based on an understanding that health inequalities are not inevitable, and that taking action requires improving the lives of those with the worst health outcomes, fastest. The Board previously agreed to adopt a set of guiding principles to support a joined-up approach to tackling health inequalities. These are outlined later in this document, see 'our guiding principles for strategy delivery'.

Health inequalities can be a result of people's different social and economic experiences and realities, where they live and level of deprivation they experience, the differences in their characteristics such as age, race, sexual orientation and if they come from a socially excluded group.

Examples of population groups that may experience disadvantage include:

- ethnic minority groups
- people who are socially excluded and typically experiencing multiple overlapping risk factors for poor health, such as poverty, violence and complex trauma, for example people experiencing homelessness or asylum seekers
- people with a learning disability and autistic people
- people with multi-morbidities
- protected characteristic groups
- young carers, children and young people in care and care leavers
- people in contact with the justice system.

Health inequalities can also lead to differences in the care that people receive and the opportunities that they have to lead healthy lives. The Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level. In addition to the population groups above, it identifies five focus clinical areas requiring accelerated improvement for both children and adults. It demonstrates the link between health inequalities and health status and provides a framework to address this. Further information is available in the supporting documents section of this strategy.

The Core20PLUS5 NHS clinical priority areas align with our Black Country priorities. The Black Country has a higher prevalence of hypertension, diabetes, chronic kidney disease, chronic heart disease, cancers, respiratory illnesses, depression, and dementia than the national average. We also have a higher rate of infant mortality[4]. For people under 75 living in Wolverhampton cancer and cardiovascular disease are of the top two biggest contributors to preventable early death and share common risk factors, for example smoking and obesity.

To close these different inequalities gaps requires having a focus on prevention and early intervention, including screening and health education, clinical conditions considered preventable and supporting people to manage long-term or multiple conditions. As the example of Charlie shows, achieving this therefore also requires action to address the 'causes of the causes', that is the wider environmental, social, and economic contexts of people's lives.

For example, households living in fuel poverty are more likely to be exposed to the risk of cold housing in winter exacerbating long-term conditions. Temporary and inadequate housing negatively impacts mental and physical health. High levels of child poverty and deprivation in the city are associated with poorer health outcomes, including childhood obesity, tooth decay, poor mental health, and higher rates of children's emergency hospital admissions.

[4] https://blackcountryics.org.uk/application/files/8216/7544/0961/Black_Country_ICP_Initial_Integrated_Care_Strategy_2023-25_V5.5.pdf

Quality and access of care: our role as system leaders

Care is delivered by lots of different professionals in a range of different places. Alongside hospital settings, much care takes place in your home or local community. For example, being delivered by a GP, pharmacist, nurse, optometrist, dentist or an allied health professional, including those working in social care, such as care workers, social prescribers, domiciliary support, and more.

WHAT DO WE KNOW?

Just as health inequalities mean some groups and communities are more likely to experience poorer health than the general population, these groups are also more likely to experience challenges in accessing care.

The reasons for this are complex and may include:

- the availability of services in their local area
- service opening times
- access to transport
- access to childcare
- language (spoken and written)
- literacy
- poor experiences in the past
- misinformation
- fear[5]

In addition, Covid-19 brought into sharp relief and exacerbated inequalities that were already well established, and in turn the pandemic changed the nature of demand leading to increased backlogs and workload. As well as experiencing worse outcomes during the pandemic, deprived communities are also experiencing disadvantage as part of recovery for example, people living in more deprived areas are waiting longer for elective care compared to people in the least deprived areas.[6]

Locally the Integrated Care Board has made improving access and quality of services a priority to be delivered by addressing waiting times, access to services, improving patient choice and joining up care. Health and Wellbeing Together as part of the wider system can also play a part in supporting this priority. In Wolverhampton the experience of the pandemic demonstrated that more deprived, disadvantaged and excluded groups and individuals were disproportionately negatively impacted. It also illustrated the benefits of working closely with faith, community, voluntary and grass roots groups and champions to identify barriers to accessing services and share health promotion messages. New and innovative ways of delivering services were piloted as a result. By building on these foundations the Board can support the wider health and care system to improve quality and access of care for our local population, with the OneWolverhampton place-based partnership acting as the delivery vehicle.

[5] www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/what-are-healthcare-inequalities/
[6] www.kingsfund.org.uk/publications/unpicking-inequalities-elective-backlogs-england

The Board is also responsible for signing off Better Care Fund Plans. These plans support health and social care integration by allowing the Local Authority and the NHS to work together to pool budgets and integrate spending plans. Our strategy will inform the continuing development of joint commissioning arrangements in the best interests of local people.

REDUCING INEQUALITIES

- Understanding whether there is unwarranted variation across specific groups in access to care.
- Understanding how services are organised to help address inequalities in access.
- Empowering local people to be more pro-active in understanding their own health needs by providing a range of opportunities in different settings, including community venues.
- Contributing to city action to address digital exclusion so everyone can benefit from digitally enabled services.
- Working in partnership to protect the most vulnerable people at risk of harm and exploitation.

LEADERSHIP

- Health and Wellbeing Together strategic oversight.
- OneWolverhampton delivery vehicle.

NEEDS ASSESSMENT

- Quantitative and qualitative data, including being informed by lived experience and taking into account the impact of the Covid-19 pandemic.
- Embedding a population health approach.

WORKING TOGETHER

- Support the development of improved and joined up health and social care services at place, including statutory duty to sign off the Better Care Fund.
- Aligning local priorities with system priorities: ICB Joint Forward Plan and Black Country Integrated Care Strategy.

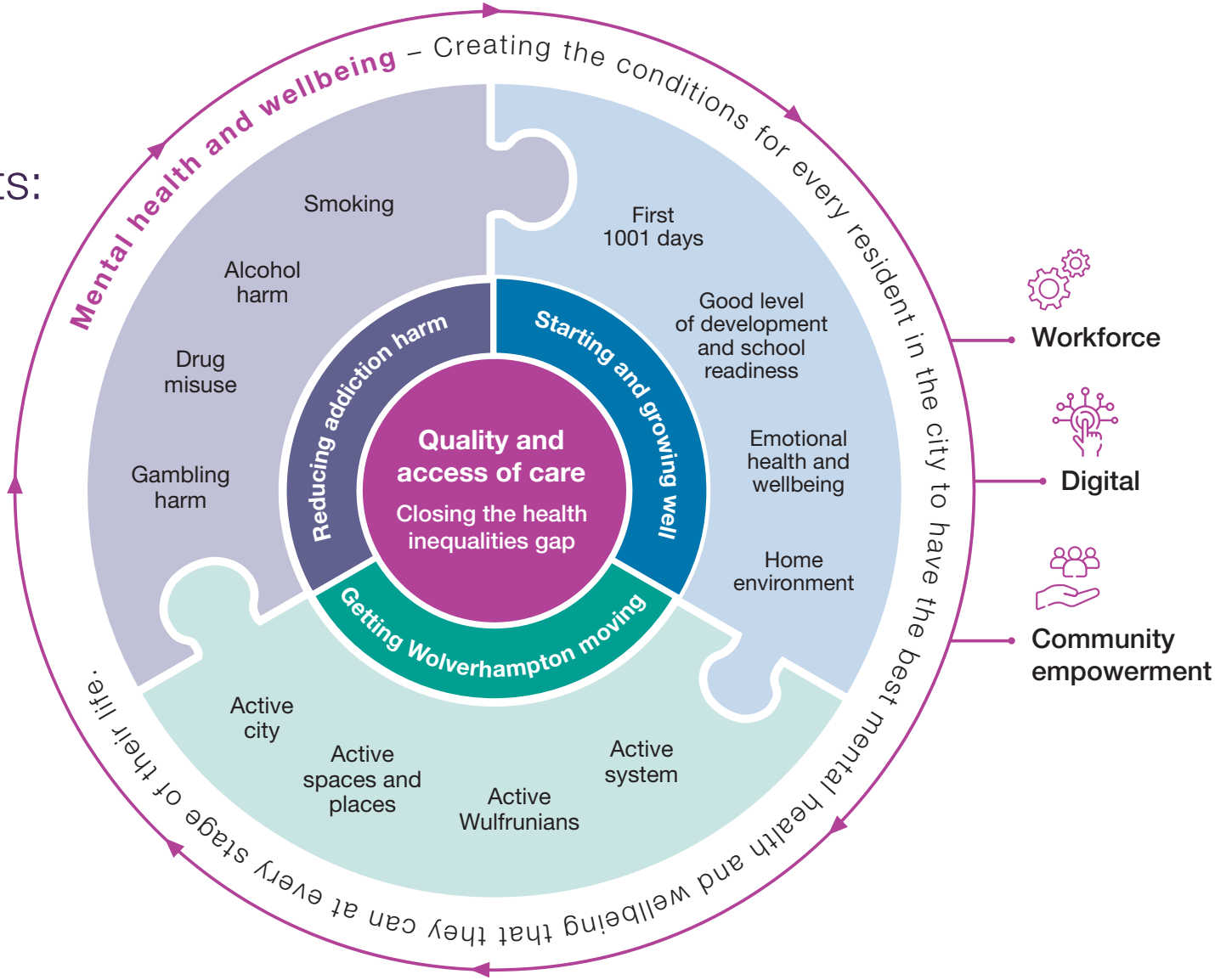
TAKING ACTION

- Work to identify and understand barriers to access, including piloting, testing and learning from innovative prevention and delivery models.
- Ensure reasonable adjustments are in place so that services are accessible to everyone, including carers and people with disabilities and learning difficulties.

DEFINING SUCCESS

- Performance against Joint Local Health and Wellbeing strategy priorities with strategic oversight of OneWolverhampton delivery and outcomes.
- Work collaboratively and iteratively with the Integrated Care Partnership.
- Local oversight of the Black Country Integrated Care Board Joint Forward Plan.

Where we will focus our efforts: priorities on a page



Strategic enablers

WORKFORCE

- Investing in the infrastructure to develop, attract, and retain high quality staff, including allied health professionals e.g., nurse prescribers, pharmacists, and a wider range of social care provision such as social prescribers, and domiciliary support.
- Providing increased opportunities for local people to access roles in the health and care sector through apprenticeships and training.
- Working together to join up different parts of the system to ensure patients receive the right care when they are ready to leave hospital and support them to return home.

DIGITAL

- Working in partnership to ensure all residents have the access to devices, connectivity, and skills to take advantage of what digital has to offer.
- Piloting and investing in digital technology to enable people to be more independent and lead healthier lives in their own homes.
- Identifying opportunities to utilise digital innovation to benefit health and wellbeing, for example digital supported Health Checks.

COMMUNITY EMPOWERMENT

- Developing a partnership approach to community engagement, consultation, and co-production.
- Identifying shared opportunities to listen to local people, including through the development of the Love Your Community initiative.
- Continuing to develop and embed bespoke opportunities for health inclusion and other vulnerable groups to share their lived experience and shape service delivery, for example people with a mental health condition, refugees or people experiencing homelessness.
- Supporting community capacity and resilience through networks and champions.
- Recognising and supporting the role of unpaid carers in the community, including young carers.
- Supporting ongoing activity to grow and stabilise the voluntary and community sector to support people to thrive in their communities.
- Maximising people's independence in the community through joining up and enhancing our Early Help and Prevention offer.

OUR HIGH-LEVEL AMBITIONS

Starting and growing well

Giving children the best start in life is a fundamental part of improving health and reducing health inequalities. Inequalities in children's development lead to multiple disadvantages, which can affect children's long-term outcomes and undermine the development of their potential.

WHAT DO WE KNOW:

The foundations for brain, emotional and physical development are established within the first 1001 days from conception to the age of two years.

Having a healthy pregnancy sets up the unborn baby for a healthy life. The mental and physical wellbeing of the mother is also important for the baby's healthy development as well as for the mother in her own right.

A higher proportion of babies are born in Wolverhampton with a low birth weight than the English average. This increases the risk of childhood mortality and of developmental problems for the child. More pregnant women are smoking in pregnancy than the national average. This in turn can lead to an increased risk of a low birth weight.

The proportion of 'new birth visits' and 'six-eight-week checks' by a health visitor that take place within the target time period are currently slightly higher compared to the West Midlands and England providing a strong foundation to build on. However, the proportion of 12-month reviews taking place within the target period is slightly below the West Midlands and England averages, although it is on an upward trend. The proportion of 2-2.5 year checks taking place within the target period in the city has increased over the last three years and is now above regional and national averages.

There are many ways parents can actively improve their child's health including through helping them brush their teeth and ensuring they receive their childhood vaccinations. Poor oral health and uptake of vaccines is often related to health inequalities.

A safe and secure home environment is also important for child development. Too many families are currently living in temporary accommodation in the city. Fuel poverty means some children are living in cold and damp homes which can lead to respiratory conditions. In addition, some families face more challenges than others. In 2022, the rate of Children in Need was higher than the West Midlands and England average.

Creating an environment where every child can flourish from conception to the first 1001 days is a shared priority involving lots of different partners. The Children and Families Together Board leads on the strategic oversight of this priority area on behalf of the wider Board.

5.2 Infant mortality rate

per 1,000

- higher than England average of **3.9 per 1,000**
- improved in recent years
- **7th highest** of our 15 nearest neigbours

17.1% Smoking in pregnancy

- Higher than England average of **12.8%**
- **9th highest** of our 15 nearest neigbours

61.9% Good level of development

(end of Reception)

- Lower than England average of **65.2%**
- Decrease in Wolverhampton larger than the decrease seen nationally

23.4% Oral health

Decayed, missing and filled teeth

- compared to England average of **23.7%**

85% MMR vaccine uptake

- Lower than England average of **89.2%** for one dose (2 years)
- **worst (16th)** among the statistical neighbours
- also lower than England average of **85.7%** for two doses (5 years)

Young carers

141 young carers in July 2019, **rising by 91%** (128 young carers) to **269 young carers** in December 2021

Our priority areas for collective action

FIRST 1001 DAYS, INCLUDING SUPPORT FOR PARENTS, AND MATERNAL MENTAL AND PHYSICAL HEALTH

- Improving timely access to quality antenatal and maternity care.
- Providing appropriate support and treatment pathways in pregnancy, including reducing tobacco, alcohol and substance use.
- Utilising the newly commissioned Healthy Pregnancy service to address the importance of physical and mental health during pregnancy.
- Maintaining the above average position for health visitor new birth and six-to-eight-week visits, focusing on the physical health, development and wellbeing of the child and mental wellbeing of parents.
- Working together, and with families, to improve uptake of breast feeding.
- Improving children's oral health and access to dental services so they experience less decay, missing, filled teeth and avoidable hospital extractions.
- Halting the decline in childhood vaccination rates and returning to pre-pandemic levels.
- Improving perinatal mental health support, including developments funded through the Family Hubs programme.
- Embedding the 'Five to thrive' approach and other strength-based ways of working to support positive infant parent relationships.

EMOTIONAL HEALTH AND WELLBEING

- Undertaking and implementing the findings from our jointly commissioned children's emotional health needs assessment, including meeting the needs of vulnerable groups e.g. children with additional needs.
- Embedding the 'i-thrive' approach to support children's emotional wellbeing.
- Improving the pathways for children, young people, and families to access mental health support and increase appropriate uptake of services at earliest point.
- Supporting the seamless transition between children and adult's mental health services.

GOOD LEVEL OF DEVELOPMENT AND SCHOOL READINESS

- Maintaining the above average position for 2-2 ½ - year development reviews.
- Developing a coordinated and consistent approach to improving speech, language, and communication needs.
- Increasing awareness and access to free childcare, particularly for families with children with additional needs, children in care and families from disadvantaged communities.

HOME ENVIRONMENT

- Driving forward multi-agency action to prevent families from entering temporary accommodation and supporting families living in temporary accommodation into secure housing.
- Addressing food and fuel poverty and maximising benefit uptake through a coordinated approach to achieving a financially inclusive city.
- Working in partnership to improve housing conditions including addressing damp and mould.
- Working in partnership to identify domestic abuse within families at the earliest possible point and ensuring that families experiencing domestic abuse can access specialist support.

Place delivery
Lead:
Children and Families Together Board

Contributing:
Family Hubs Strategic Working Group
One Wolverhampton
Better Homes Board
Financial Wellbeing Partnership Board
Safeguarding Together
Safer Wolverhampton Partnership
Early Years Steering Group
CYP Emotional Health and Wellbeing Partnership Board

OUR HIGH-LEVEL AMBITIONS

Reducing addiction harm

Damaging lifestyle behaviours create dependence and cause serious health and social problems. They disproportionately impact disadvantaged people and communities further widening health inequality, life and healthy life expectancy.

WHAT DO WE KNOW:

Smoking is the single biggest cause of preventable death and illness in England. Just over 13% of adults in the city are smokers and nearly a third of adults with a long-term mental health condition self-report as smokers. People in the city continue to die from causes that can be related to smoking at a higher rate than the national average.

Too many people in the city are drinking at harmful levels. Nationally, alcohol is one of the leading causes for house fires and car accidents. Misuse of alcohol is often an influencing factor in other crime types, for example domestic abuse, acquisitive crime, and anti-social behaviour.

During 2020, Wolverhampton had the worst alcohol-specific mortality rate in the England, and it is estimated that only one in five people who experience alcohol harm are engaged with alcohol treatment support services. This means there is an unmet need of 82% in the population. However, for those who are engaged in treatment and support, their recovery outcomes are positive, nearly 45% exit treatment successfully and do not re-present, and since 2015 the Wolverhampton treatment completions rate has been consistently higher than the national average.

Despite improvement in recent data the city has historically high rates of death from drug misuse compared to other West Midlands and nationally.

Gambling is defined in two ways, remote (using technology and includes gaming) and non-remote (in a premises). The Gambling Commission defines problem gambling as gambling to a degree that compromises, disrupts or damages family, personal or recreational pursuits. Gambling behaviours changed during the Covid-19 pandemic and during lock-down and there is some evidence to suggest there has been an increase in those vulnerable to gambling harm.

13.6% of adults smoke

- Higher than the England average of **13%**
- On a long term downward trend

21.5 Alcohol mortality

per 1,000

- Higher than England average of **13.9 per 100,000**

742 Hospital admissions for alcohol related conditions

per 1,000

- Higher than England average of **494 per 100,000**

44% Alcohol successful completions

- Higher than the England average of **36.6%**

Drugs successful completions (opiate)

- **5.5% higher** than the England average of **5%**

Drugs successful completions (non opiate)

- **32.5% lower** than the England average of **34.3%**

101.2 Drug hospital admission rates

per 1,000

- Higher than England average of **87.2 per 100,000**

45 Drugs deaths

per 1,000

- **9 times** the England average of **5 per 100,000**

28.9 Under 75 mortality rate for liver disease

per 1,000

- Higher than England average of **21.2 per 100,000**

23.8 Preventable liver related deaths

per 1,000

- Higher than England average of **18.9 per 100,000**

Our priority areas for collective action

SMOKING

- Increasing provision and types of intervention to support people to stop smoking, including supporting adult smokers to vape as a harm reduction approach.
- Increasing training for primary care staff.
- Targeting support for key groups to stop smoking, for example young people, pregnant mothers and people with mental health difficulties.
- Limiting access to tobacco through regulation.

ALCOHOL HARM

- Reducing the number of alcohol specific deaths in the city.
- Increasing the number and types of interventions available.
- Increasing the number of treatment places.
- Reducing the number of licensed premises per kilometre in Wolverhampton.

DRUG MISUSE

- Reducing the number of drug-related deaths.
- Increasing the number of people accessing in-patient detox and residential rehabilitation.
- Engaging with individuals leaving prison with a treatment need.
- Increasing provision of nasal naloxone across frontline services.

- Identify more people at risk of harm who have a treatment need but who are not currently engaging in any form of treatment.
- Increasing the number of people gaining employment whilst in treatment.
- Improving the availability of easy to access, high quality support for people with co-existing substance misuse and mental health problems.

GAMBLING HARM

- Improving understanding of prevalence of gambling related harm in the city informed by lived experience case studies.
- Increasing the number and types of interventions and treatment services available.
- Improving education for professionals (including in schools) to understand gambling related harm, aiding early identification.
- Reviewing Licence Conditions and Codes of Practice.

Place delivery

Leads:
City drug and alcohol strategic partnership

Local multi-disciplinary Gambling Harm Strategic Partnership Group

Public Health

Contributing:
OneWolverhampton

Safer Wolverhampton Partnership

OUR HIGH-LEVEL AMBITIONS

Getting Wolverhampton moving more

Being inactive increases the likelihood of depression, some cancers, diabetes, and dementia, conversely by getting people who are inactive to increase their physical activity levels, 1 in 10 cases of stroke and heart disease and up to 40% of long-term health conditions could be prevented. It is important to recognise that even small differences in people's physical activity levels can make a difference and so we are focused on getting everyone to do at least 30 minutes of physical activity per week.

WHAT DO WE KNOW:

Physical inactivity rates in Wolverhampton are higher than regional and national averages for both adults and children.

They also vary by ward with those living in the more deprived areas less physically active.

79% of residents that completed the City Lifestyle Survey wanted to be more active.

There are many benefits to moving more for both children and adults. For children and young people being more active is associated with improved learning and attainment, better mental and emotional wellbeing, and contributes to healthy weight status.

For adults being active provides a protective effect across a range of chronic conditions such as coronary heart disease, obesity, and type 2 diabetes, as well as supporting positive mental health and reducing social isolation.

Health and Wellbeing Together will continue to prioritise creating a city where people can be more physically active, including overseeing a dedicated strategy setting out our ambitions and expected outcomes.

Percentage of physically inactive adults

30.5%

Higher than England average of **22.3%**

Percentage of less active children and young people

42.5%

Higher than England average of **30.1%**

Active travel to school

43%

of pupils in the city walk to school once a week or more, with pupils form the most deprived parts of the city more likely to walk to school

Adults active travel

11.1%

of adults in the city walk for travel at least three days a week.

Lower than the West Midlands average of **12.6%** and the England average of **15.1%**

Adult obesity

30.5%

of adults are classified as obese

Higher than England average of **25.3%**

Childhood obesity – year 6

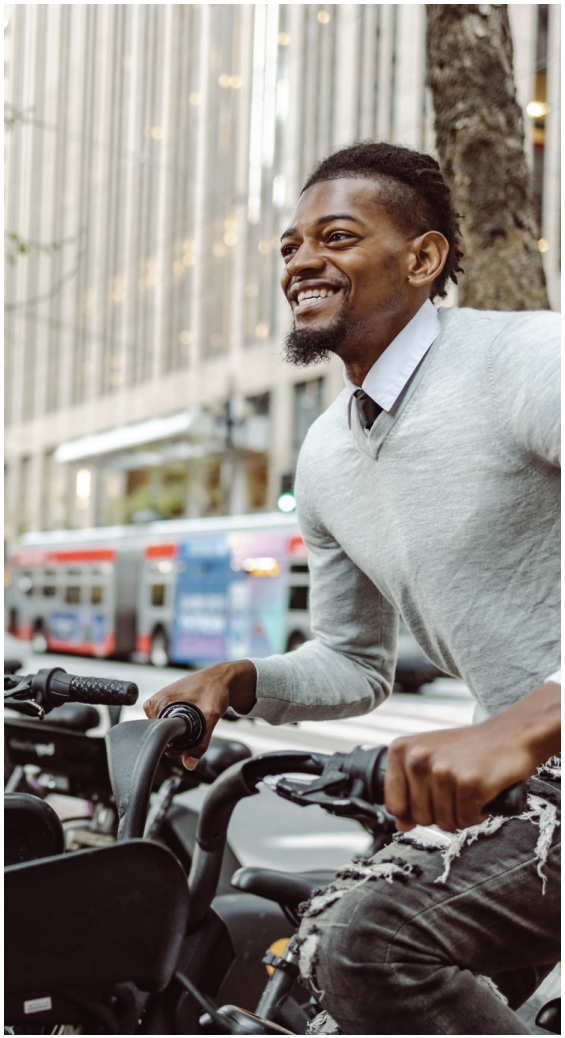
48%

of year six children are classified as obese

Higher than England average of **37.8%**

Higher than previous years

2nd highest of our 15 nearest neighbours



Our priority areas for collective action

ACTIVE SYSTEM

- Co-producing, designing, and embedding leadership, governance and partnerships models that promote physical activity across all sectors.
- Implementing our city physical inactivity strategy to drive our partnership response.
- Using data and evidence to develop tools and dashboards to inform decision making and inform interventions.
- Increasing the percentage of health referrals for physical activity.

ACTIVE WULFRUNIANS

- Working with residents and stakeholders to fully understand the barriers to moving more and how to overcome them.
- Testing, applying, and evaluating behavioural change approaches.

ACTIVE SPACES AND PLACES

- Increasing the amount of investment into physical activity in the city, including ensuring facilities are fit for the future.
- Increasing number of WVActive members, including increasing the percentage from under-represented groups.
- Increasing access to leisure activities for children and young people, including by removing financial barriers to participation.
- Making the most of parks and open spaces.

ACTIVE CITY

- Creating and promoting suitable activities and programmes to enable regular physical activity.
- Increasing the percentage of adults walking and/or cycling for travel each week.
- Supporting our community clubs and groups to thrive.
- Reducing the percentage of less active children and young people.
- Reducing the percentage of physically inactive adults, including older adults.

Place delivery

Lead:

Health and Wellbeing Together Physical Inactivity Steering Group

Contributing:

OneWolverhampton

Safer Wolverhampton Partnership

Public mental health and wellbeing: our role as system leaders

Mental health and wellbeing influence every aspect of people's lives. Mental health problems are unevenly distributed across society and half of all mental health problems have been established by the age of 14, rising to 75% by age 24. Poor mental health is both a cause and consequence of overall health inequalities due to its associations with physical health, employment, housing and lifestyle factors. Creating the conditions for every resident in the city to have the best mental health and wellbeing that they can at every stage of their life underpins delivery of our collective priorities.

WHAT DO WE KNOW:

Self-reported wellbeing in Wolverhampton has historically been worse than the West Midlands and England for Happiness, feeling life is Worthwhile and Life Satisfaction. Anxiety in the city was previously reported to be much lower compared to regional and national levels, but the recent trend shows levels of anxiety are increasing. All four areas of self-reported wellbeing were worse amongst groups at increased risk of poor mental health.

Approximately one in four adults in England will experience a mental health problem at some point in their life and one in six adults has a mental health problem at any given time, with depression and anxiety being the most common.

In England, people with a severe mental illness (SMI) die on average 15-20 years earlier, often due to preventable causes. Wolverhampton is worse than England overall for premature mortality in adults with SMI. To address this, adults with SMI should receive an annual physical health check. Available data for 2022-2023 indicates the number of completed health checks in Wolverhampton and the Black Country was below the national target.

Nationally, over 40% of people with a severe mental illness are estimated to smoke. As part of the NHS Long Term Plan, there are ambitions to develop tobacco dependence pathways for people using secondary care mental health services.

Smoking, levels of physical in-activity, being overweight or obese, alcohol and drug misuse are all factors that are inter-linked with mental health and wellbeing.

The Board already plays a strategic role maintaining oversight of the Wolverhampton Joint Public Mental Health and Wellbeing Strategy and the Suicide Prevention Strategy and oversaw the implementation of the Prevention and Promotion Programme for Better Mental health in 2021-2022.

Findings from the Prevention and Promotion Programme for Better Mental Health 2021-2022[1]

WOLVERHAMPTON BETTER MENTAL HEALTH

73% of people engaging in mental health support interventions lived in the **30% most deprived lower super output areas** (LSOAs) in England, **18% disclosed having a disability**, and **39% of people were from ethnic minority backgrounds**

357 people who attended suicide prevention awareness training are now able to support someone experiencing suicidal ideation

The '**Look out for Wolverhampton**' suicide awareness and prevention campaign was spearheaded by the Wolverhampton Suicide Prevention Stakeholder Forum helping people learn more about the campaign and where they can seek support for suicide

61 people facing complex barriers to work benefited from targeted skills and learning support to improve access to employment

150 people engaged in face-to-face interactions to help end loneliness and provide supportive social contacts

996 adults completed our in-depth **#WolvesWellbeingandMe** survey

141 people belonging to some of the groups disadvantaged by COVID-19 pandemic took part in co-creation programmes to improve mental wellbeing

205 people facing complex life challenges supported by the Head4Health pilot programme offering wellbeing sessions, social contact, physical activity, 'Walk and Talk' and 'Extra Time' initiatives

400+ hours of 1-1 counselling provided to people with more complex wellbeing needs

50 people became Mental Health First Aid (MHFA) qualified champions

400+ people are estimated to have been supported by MHFA Champions to improve their mental health and wellbeing through engagement activities using evidence based approaches

[1] www.wellbeingwolves.co.uk - Better Mental Health Programme

To enhance this system leadership role Health and Wellbeing Together has agreed to sign up to the Prevention Concordat for Better Mental Health. This is our commitment as system leaders to work to prevent mental health problems and promote mental health and wellbeing.

The Concordat is underpinned by an understanding that taking a prevention-focused approach to improving the public's mental health has been shown to make a valuable contribution to achieving a fairer and more equitable society.

It promotes evidence-based planning and commissioning to increase the impact on reducing health inequalities. The sustainability and cost-effectiveness of this approach is enhanced by the inclusion of action that impacts on the wider determinants of mental health and wellbeing.

REDUCING INEQUALITIES

Taking action to address:

- the social and economic disadvantages that underlie mental health inequalities,
- discrimination, racism and exclusion faced by particular local communities,
- mental health stigma.

LEADERSHIP

- Accountability and governance.
- Senior Mental Health Champions.

NEEDS ASSESSMENT

- Quantitative and Qualitive data e.g. JSNA and wellbeing impact assessments/asset mapping.
- Co-produced and taking account of the impact of COVID19.

WORKING TOGETHER

- Health and Wellbeing Together, Local Authority and ICS - aligning plans with health and social care, VCSE sector, education, criminal justice, emergency services.

TAKING ACTION

- Evidence based universal and targeted interventions.
- Primary, secondary and tertiary prevention and promotion.

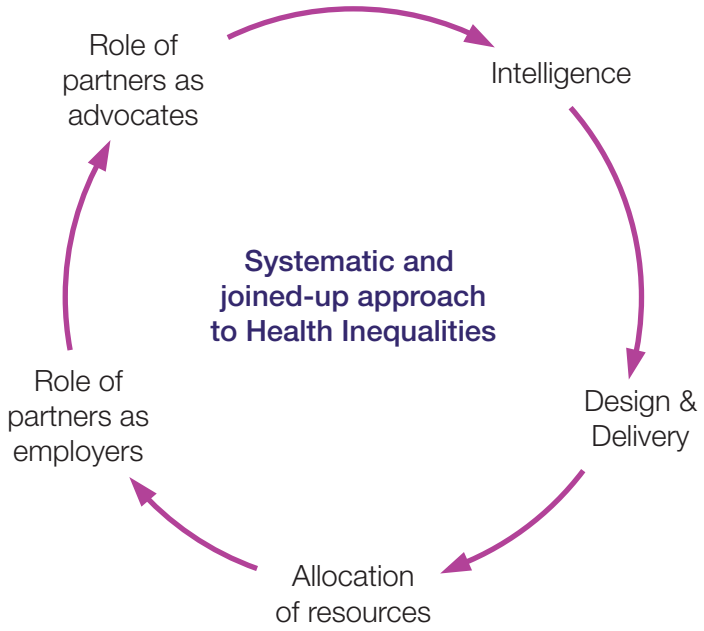
DEFINING SUCCESS

- Outcome framework; monitoring and evaluation; measuring impact through wellbeing metrics.

By working together through the Concordat, it will provide a focus for cross-sector action to deliver a tangible increase in the adoption of public mental health approaches across Local Authorities, Integrated Care Systems, NHS, Social Care, public, private and voluntary and community enterprise sector, educational settings, employers, emergency services, justice systems.

Our guiding principles for strategy delivery

Effectively addressing health inequalities involves a shared way of working as well as agreed areas for action. Board partners have committed to the following systematic and joined-up approach.



DECISION MAKING AND USE OF INTELLIGENCE:

- Adopting an agreed approach to data capture, linkage and sharing across the system to understand and respond to population need.
- Using a framework approach with common tools and resources to provide a systematic assessment of health inequalities across the system, for example, the Health Equity Assessment Tool (HEAT).
- Collectively identifying gaps and areas of alignment and to use this intelligence to inform action.

DESIGN AND DELIVERY OF SERVICES:

- Exploring the impact of decisions on health inequalities early in the decision-making process and actively consider how the design of a service may increase inequalities or disproportionately disadvantage certain people.
- Using linked data to understand and address equity of access to services and design services that are easy to navigate.
- Creating a culture that promotes and enables communities to be actively involved in shaping and coproducing activity to reduce health inequalities.
- Working collaboratively to promote and enhance digital inclusion.
- Being innovative and ambitious, with a firm view that health inequalities are not inevitable.

ALLOCATION OF RESOURCES:

- Committing to needs-based commissioning, allocating health and care resources proportionate to need.
- Collectively taking pro-active action across the life course to reduce health inequalities including investing in prevention, the wider determinants and giving every child the best start in life.
- Embedding measures that promote and enable an inclusive economy, for example working in partnership with anchor network groups so that wealth is not extracted but broadly held and is generative.
- Exploring opportunities to re-shape procurement frameworks aligned to the Wolverhampton Pound initiative.
- Using our collective assets to create economic and social value in the local community.

AS EMPLOYERS:

- By valuing staff through parity of recruitment, promotion and employment, with a commitment to build a workforce representative of the local area.
- Supporting career opportunities for local residents and under-represented groups, including through the use of apprenticeships.
- Embedding workforce wellbeing initiatives to promote work-life balance.

AS ADVOCATES:

- Considering the impact on the environment and climate change of our policy decisions including raising environmental awareness, reducing carbon emissions and increasing sustainability.
- Pro-actively identifying opportunities to have a positive impact on the wider determinants of health, for example, through planning, licensing and housing functions, use of assets and green space, and provision of facilities for usage by community groups.

COLLECTIVELY, AS A STRATEGIC BOARD:

- Through delivery of our strategic plans and a commitment to hold ourselves and each other to account.
- Working together to identify opportunities to develop and implement a 'health in all policies' approach.

Accountability and governance relationships

Health and Wellbeing Boards have played a key role in promoting integration since they were established in 2013.

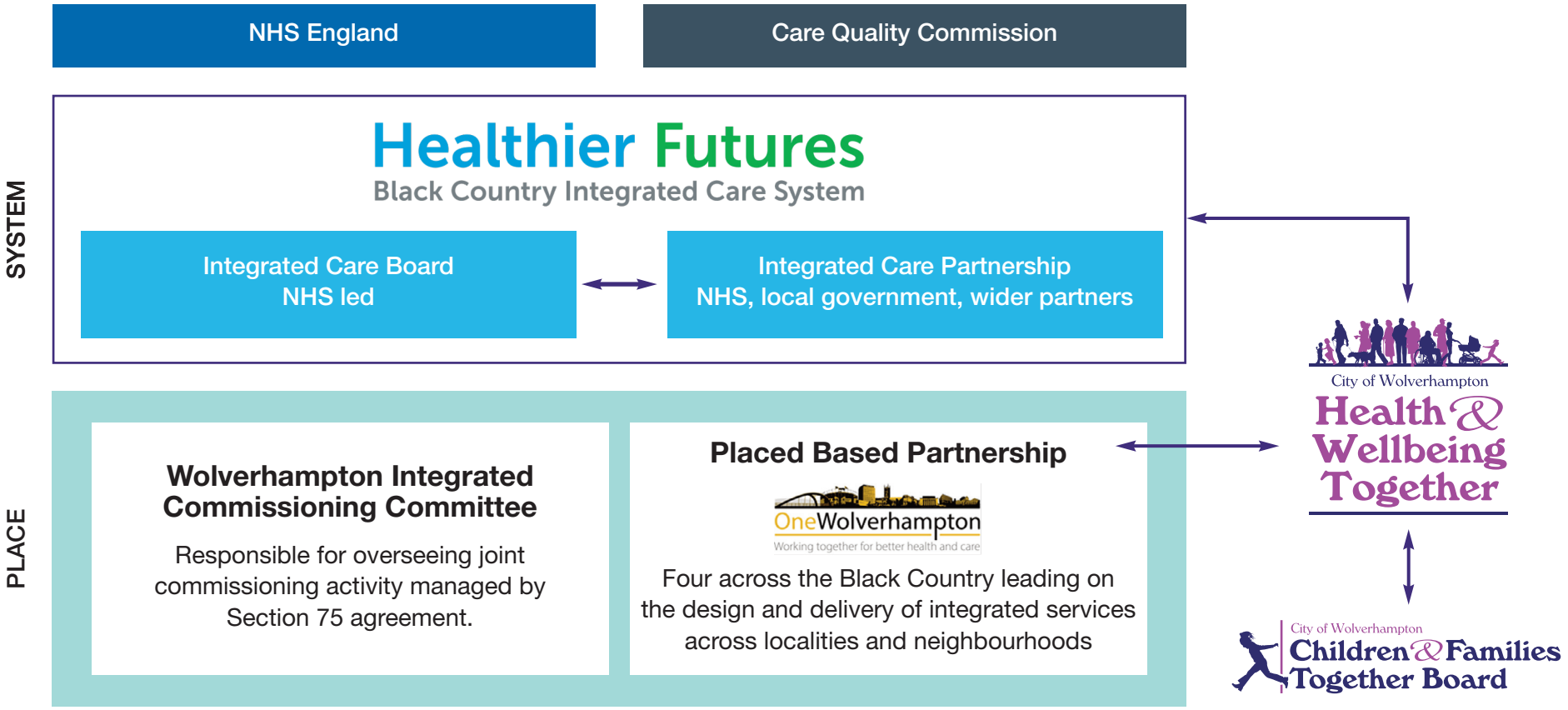
In Wolverhampton the joint response to the pandemic strengthened this partnership working, providing new and innovative ways for health and social care partners, education settings, the voluntary sector, faith groups, grass roots organisations and communities to work together.

Recent legislation[7] has acted to change the way health and care is organised, meaning Wolverhampton is now part of the Black Country Integrated Care System. Government guidance[8] reiterates the importance of Health and Wellbeing Boards in this new arrangement and says they should continue to lead action at place level to improve people's lives and remain responsible for promoting greater integration between the NHS, public health and local government.

Our strategy considers these changes and builds on the strong foundations of established partnership working. Our local priorities are shaped by what we know about our city through our Joint Strategic Needs Assessment[9], what local people have told us and the Black Country Integrated Care Strategy priorities.[10] Health and Wellbeing Together will oversee this strategy and receive updates on its progress against outcomes.

Collectively we will be a strong voice for local people in Wolverhampton, working closely with our Place Based Partnership, OneWolverhampton, and the Integrated Care Partnership in the Black Country.

[7] www.legislation.gov.uk/ukpga/2022/31/contents/enacted
[8] www.gov.uk/government/publications/health-and-wellbeing-boards-guidance/health-and-wellbeing-boards-guidance
[9] https://insight.wolverhampton.gov.uk/Help/JSNA
[10] https://blackcountryics.org.uk



To make sure our strategy stays relevant and focussed, progress will be reviewed annually, and strategic lines of enquiry related to our core themes will be regularly updated.

Working better together

Health and Wellbeing Together is made up of representatives from the following partners:

- City of Wolverhampton Council
- Black Country Integrated Care Board (Wolverhampton place)
- Black Country Healthcare NHS Foundation Trust
- Healthwatch Wolverhampton
- OneWolverhampton
- Royal Wolverhampton NHS Trust
- Safer Wolverhampton Partnership
- University of Wolverhampton
- Wolverhampton Safeguarding Together
- Wolverhampton VCSE Alliance
- Wolverhampton Voluntary Community Action
- West Midlands Fire Service
- West Midlands Police
- Better Homes Board
- Local Pharmaceutical Committee (observer status)
- West Midlands Care Association (observer status)

Find out more about the Board at **www.wellbeingwolves.co.uk**

Supporting documents

Black Country Integrated Care System:
https://blackcountryics.org.uk/about-us

Black Country Integrated Care Strategy:
https://blackcountryics.org.uk/our-plan

Core20PLUS5 for children:
www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/core20plus5-cyp

Core20PLUS5 for adults:
www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5

Joint Strategic Needs Assessment for Wolverhampton:
https://insight.wolverhampton.gov.uk/Help/JSNA

You can get this information in large print, braille, audio or in another language by calling 01902 551155

wolverhampton.gov.uk 01902 551155

WolverhamptonToday Wolverhampton_Today @WolvesCouncil

City of Wolverhampton Council, Civic Centre, St. Peter's Square,
Wolverhampton WV1 1SH

WCC 1659 09/21

Patient feedback report

Urology department – New Cross Hospital

June 2023

About Healthwatch Wolverhampton

Healthwatch Wolverhampton gives citizens and communities a stronger voice to influence and challenge how health and social services are provided within Wolverhampton. It is set apart from the statutory structures, voluntary and community sector it works within, as it performs public functions, delivers statutory duties, and receives public funding. Its core purpose is to make sure that the views of the public shape the health and care services they need.

What we did:

Between the 24th-26th May 2023, Healthwatch Wolverhampton (HWW) attended the urology department (A31) at New Cross Hospital. We had been asked by the Health Scrutiny Panel to enquire about people's experiences of the urology services and whether they had been impacted by Walsall and Wolverhampton's merging of the service. The feedback would then be used to discern whether the merging of services has proved beneficial to patients or not and to identify if change is required to address any negative feedback received.

Attendees:

In attendance were:

- Engagement Officer: Hina Rauf
- Volunteer Officer: Andrea Cantrill

HWW volunteers:

- Claire Brewer
- Tracey Hubball
- Winifred Onwuka

Survey:

We created a short survey to provide structure to our conversations (see Appendix).

Our survey focused on three main areas: **demographics**, **patient experience** of the service itself (focusing on the merger), and **travel** to the department. An additional space was included for patients to share any other thoughts they had.

Findings:

A total of **38 surveys** were conducted via a conversational method of feedback collection. The process involved engaging with patients and their friends/family members before they were called in for their appointments. The number of patients present each day was determined by the nature of the appointments. Less time was

spent with fast-track patients, whereas on other occasions, in-depth conversations were had with other patients.

Demographics:

By age group:

- 21-25 years- 2 patients
- 26-30 years- 1 patient
- 31-35 years- 1 patient
- 50-55 years- 2 patients
- 56-60 years- 4 patients
- 61-65 years- 2 patients
- 66-70 years- 7 patients
- 71-75 years- 4 patients
- 76-80 years- 7 patients
- 81-85 years- 5 patients
- 86-90 years- 1pateint
- 91-95 years- I patient
- 1 person did not respond

- Males accounted for the majority of patients seeking treatment for urology related health concerns. We spoke with **24 male** patients and **12 female. 2 people did not answer**
- White British was the most prevalent ethnic background with **29** patients identifying as white British.**1** patient identified as black British and **1** as black Caribbean. **2** patients identified as Asian. **5** did not respond to this question

- In terms of postcode, **24** patients were from the **WV** postcode, **9** from the **WS** area code, **1** patient from **Halesowen** (B6) and **2** patients from **Stourbridge** (ST). **2** did not respond

Patient experience:

Patients were asked to rate their experience of the urology services at New Cross Hospital based on a scale which ranged from: very good, good, satisfactory, bad, or very bad.

- **Twenty two** patients stated their experience was **good**. For some individuals it was their first visit to the department. Many patients who rated the department as `good` also stated that they would prefer not to go to Walsall Manor.

  'Happy with care, wouldn't go to Walsall area.'

  'First appointment here.'

  'Good treatment.'

  'Knew where to come and journey was easy.'

  'Unclear signposting, couldn't find A31 and nurse shouted at us.'

- **Six people** said they had **a very good** experience. Parking was however picked up as an area for improvement.

'First time, pathway has been good, referral picked up quickly.'

'Parking time, you must allow extra because you don't know how much time you'll need.'

'Staff are always pleasant, helpful, and knowledgeable and the building is in good condition.'

- **Seven** people said their experience was **satisfactory**. Parking was mentioned here too.

'Easy enough to get to.'

'Parking was a nightmare, have been round and round, finally found a parking space.'

'We have a blue badge so could park on double yellow lines; this is easier than finding a parking space.'

- **One** person said their experience was **very bad.** They made the following comments.

'Hard to find, no wheelchair access in some arears.'

'Signposting should be better, better access, better parking.'

'Let patients know beforehand that they will need to provide a sample.'

Travel:

- When asking people how easy or difficult they found locating the urology department within the hospital, **the majority stated that it was not easy to find**. Parking was a recurring topic of conversation as many individuals could not find parking. This meant that patients were left alone in the waiting room while their family member(s)/partner were finding an appropriate parking space.

- Patients were asked if they had knowledge on a patient transport service that is provided by New Cross Hospital. The majority of individuals spoken to said that they **had not used the transport service themselves, so are unaware of its existence.** However, they do think that the hospital should provide transport for patients.

- One woman stated that she knows a transport service exists because her mother has used it before when she has been discharged from hospital. A patient who was not aware of the transport service stated that travel could be improved if the hospital provided a shuttle bus for patients.

- Most people travelled to the hospital by car rather than public transport.

Main themes:

- **Parking:** This was was the main cause for concern and a major issue. This was due to people being unable to find a parking space. The cost of parking was also mentioned as it is very expensive.

  'Parking is appalling'

  'Parking, no space'!

  'Had to park at Bentley Bridge.'

  A small number of patients said they didn't have a problem finding the department or finding a space to park.

- **Location of appointments:** Some patients/family members stated that the consistency of appointments in terms of location had been problematic with appointments being across both locations, whereas a few people stated that it had not been a problem and they had been seen at one location rather than changing between.

  'Happy that I don't have to travel to multiple hospitals.'

- **Lack of awareness that services had combined:** It seemed that most patients were unaware that Wolverhampton and Walsall urology services are combined. This had not been communicated to them. For some individuals, it was their first appointment.

- **Hospital preference:** Some individuals stated that they would prefer to be seen at New Cross Hospital rather than Walsall Manor Hospital.

- **Suggested improvements:** When asked about improvements patients felt could be made, the most common answer to this was **parking spaces**. However, one individual stated that they felt improvements had already been made:

  'Service has been improved - I can call secretary for reassurance.'

- **Waiting times for appointment:** Wait times for appointments was also mentioned as people remain unaware of how long they will have to wait, this can impact people's personal lives. **Some people waited a very long time to be seen**. One woman mentioned that she had to get back to work afterwards.

Final comments and recommendations:

Overall, we found that patient experience was varied. Although, most people had a good experience of care, travel to the hospital, finding the ward and parking remains a concern. Most people were unaware of the merger occurring at the time we spoke to them.

We suggest the following actions to address people's concerns:

- Better signage after reaching the A29 and A30 zone, with clear directions to urology.

- More education and information that the service is combined.
- More information on alternative parking.
- More information about the shuttle service.
- More information to patients pre-appointment, outlining what to expect at the appointment, for example to bring urine samples and information to manage expectations on waiting times.

For more information:

Contact Healthwatch Wolverhampton:

Website**:** **www.healthwatchwolverhampton.co.uk/**

Call: **0800 246 5018** between the hours of 09:00 – 17:00 Monday to Friday.

Email: **info@healthwatchwolverhampton.co.uk**

Post: Healthwatch Wolverhampton, Regent House, Second Floor, Bath Avenue, Wolverhampton, WV1 4EG

Appendix – Survey questions

See below.

Urology department survey:

Brief introduction explaining that you are a volunteer with HWW and what HWW as a service do.

Demographics:

1. What is your age? **(Please circle)**

   18-20 21-25 26-30 31-35 36-40 41-45 50-55 56-60 61-65 66-70 71-75

   76-80 81-85 86-90 91-95 96+

2. What is your gender? **(Please circle)**

   Male Female Other Prefer not to say

3. What is your ethnic background?

   ---

4. What is your postcode?

Patient experience:

5. How would you describe your experience of the urology services at the hospital based on the following scale? **(Please circle)**

   Good Very good Satisfactory Bad Very bad

6. Since the services have been combined, would you describe your experience of the service as better or worse?

---

7. What do you think is better or worse?

---

8. What is different now to before?

---

9. In what ways do you think the urology service could be improved?

Travel:

On a scale of 1 – 10 (1 being the easiest and 10 the most difficult) – please rate the following:

10. Locating the urology department within the hospital **(Please circle)**

1 2 3 4 5 6 7 8 9 10

11. Travel to the department (by car) **(Please circle)**

1 2 3 4 5 6 7 8 9 10

12. Travel to the department (via public transport) **(Please circle)**

1 2 3 4 5 6 7 8 9 10

13. Do the hospital services provide transport services? **(Please circle)**

YES NO

14. Could travel to the hospital (urology department) be improved? **(Please circle)**

YES NO

15. In what ways could the travel to the hospital (urology department) be improved and why?

Any final comments: