CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board
11 April 2018

Time 12.30 pm **Public Meeting?** YES **Type of meeting** Oversight

Venue Training Room – Ground Floor – Civic Centre, St Peter's Square, Wolverhampton WV1 1SH

Membership

Councillor Roger Lawrence	Leader of the Council
Councillor Val Gibson	Cabinet Member for Governance
Councillor Sandra Samuels OBE	
Councillor Paul Sweet	Cabinet Member for Children and Young People
Councillor Paul Singh	
Jo-Anne Alner	
David Baker	West Midlands Fire Service
Emma Bennett	Director of Children's Services
Helen Child	Third Sector Partnership
Brendan Clifford	Service Director - City Health
John Denley	Director of Public Health
Dr Helen Hibbs	Chief Officer, Wolverhampton CCG
Dr Alexandra Hopkins	University of Wolverhampton
Tim Johnson	Deputy Managing Director/Strategic Director - Place
Steven Marshall	Director of Strategy & Information, Wolverhampton CCG
Chief Supt Jayne Meir	West Midlands Police
Elizabeth Learoyd	Healthwatch Wolverhampton
David Loughton CBE	Royal Wolverhampton Hospital NHS Trust
Linda Sanders	Independent Chair of Adults and Childrens Safeguarding Board
Sarah Smith	Head of Strategic Commissioning
Mark Taylor	Strategic Director - People
Jeremy Vanes	Royal Wolverhampton Hospital NHS Trust
David Watts	Director of Adult Services
Lesley Writtle	Associate Chief Operating Officer, Black Country Partnership Trust

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 - 10 January 2018** (Pages 5 - 12)
[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 Board Forward Plan 2017/18** (Pages 13 - 20)
[To consider and comment on the items listed on the Forward Plan]

ITEMS FOR DISCUSSION OR DECISION - PART 2

7 **City of Wolverhampton Public Health Annual Report 2017-2018** (Pages 21 - 84)
[John Denley, Director of Public Health, City of Wolverhampton Council to present report]

8 **City of Wolverhampton Vision for Public Health 2030** (Pages 85 - 100)
[John Denley, Director of Public Health, City of Wolverhampton Council to present report]

9 **Health and Wellbeing Board Development Event - Issues Update** (Pages 101 - 106)
[Brendan Clifford, Service Director – City Health, City of Wolverhampton Council to present report]

10 **City of Wolverhampton Partnership Response to People with No Recourse to Public Funds (NRPF)** (Pages 107 - 112)
[Neeraj Malhotra, Consultant in Public Health, City of Wolverhampton Council to present report]

11 **Strengthening Governance and System Leadership** (Pages 113 - 140)
[Brendan Clifford, Service Director – City Health, City of Wolverhampton Council to present report]

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CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

Agenda Item No: 4

Minutes - 10 January 2018

Attendance

Members of the Health and Wellbeing Board

Councillor Val Gibson	Cabinet Member for Children & Young People
Councillor Paul Singh	Conservative
Councillor Paul Sweet	Cabinet Member for Public Health and Well Being
Bhawna Solanki	University of Wolverhampton
David Baker	West Midlands Fire Service
David Loughton CBE	Royal Wolverhampton Hospital NHS Trust
Dr Helen Hibbs	Wolverhampton Clinical Commissioning Group
Elizabeth Learoyd	Healthwatch Wolverhampton
Emma Bennett	Director of Children's Services
Helen Child	Third Sector Partnership
John Denley	Director of Public Health
Jeremy Vanes	Royal Wolverhampton Hospital NHS Trust
Linda Sanders	Independent Chair of Adults and Children's Safeguarding Board
Mark Taylor	Strategic Director - People
Sarah Smith	Head of Strategic Commissioning
Steven Marshall	Wolverhampton Clinical Commissioning Group
Councillor Jasbir Jaspal	Chair of the Health Scrutiny Panel – as an observer

Employees

Madeleine Freewood	Development Manager - City Health
Helen Tambini	Democratic Services Officer

Part 1 – items open to the press and public

Item No. *Title*

1 **Apologies for absence**
Apologies for absence were received from Councillor Roger Lawrence, Councillor Sandra Samuels OBE, Brendan Clifford, Chief Superintendent Jayne Meir, David Watts, Dr Alexandra Hopkins and Tim Johnson.

2 **Notification of substitute members**
Bhawna Solanki attended on behalf of Dr Alexandra Hopkins.

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

4 **Minutes of the previous meeting - 18 October 2017**

Resolved:

That the minutes of the meeting held on 18 October 2017 be confirmed 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 Board Forward Plan 2017-2018**

Helen Tambini, Democratic Services Officer presented the report and highlighted key points.

John Denley, Director for Public Health confirmed that the Public Health Annual Report 2016-2017 would include a vision for public health and business going forward.

Linda Sanders, Independent Chair of Adults and Children's Safeguarding Board advised that the Adults and Children's Safeguarding Annual Reports would be available in the Autumn for the Board to receive.

In answer to a question regarding the rate of progress nationally for Placed Based Commissioning, Steven Marshall, Wolverhampton Clinical Commissioning Group (CCG) and Mike Sharon, Royal Wolverhampton Hospital NHS Trust (RWT) advised that there were no fixed models to follow and it was expected that each area would shape its own development and Wolverhampton wanted to be ahead with progress. National policy was changing and it was hoped that in the next six months some progress would be made.

Madeleine Freewood, Development Manager – City Health referred to item 10 on the agenda which proposed a five-step action plan for strengthen governance and system leadership within the Board. As part of that action plan, it was recommended that several issues would be added to the Forward Plan and that could be considered at the next Agenda Group meeting.

Resolved:

1. That the Board approve the current Forward Plan.
2. That the Adults Safeguarding Board Annual Report and the Children's Safeguarding Board Annual Report be added to the Forward Plan for consideration in Autumn 2018.

7 **Wolverhampton CCG Operational Plan 2017-2019 Update**

Steven Marshall, Wolverhampton CCG stated that the Wolverhampton CCG Operational Plan was a standing agenda item. The NHS had amended the annual cycle and it had now become a two-year plan. As the Operational Plan was still live, it was considered appropriate to give an overview of the key priorities and main activities of the last year.

Steven Marshall gave the following Operating Plan update:

Local Place Based Models of Care/Primary Care:

- Primary care groupings established, joint working underway with hub working together to deliver increased access in primary care on weekends and bank

holidays. Discussions underway to identify services that could be delivered at scale across primary care, for example wound care and joint injections.
- Development of Local Quality and Outcomes Framework (QOF) scheme underway.
- Performance dashboards developed for each care model to help determine patient outcomes, demand and variation.
- Working with key stakeholders across the health economy to develop an Accountable Care Alliance model, aiming towards shadow form by 1 April 2018.
- Implemented risk stratification, social prescribing and enhanced rapid response service provision which will help strengthen partnership/multidisciplinary (MDT) working with Health and Social Care as well as delivering admission avoidance and care closer to home.
- Two-way text messaging currently being piloted with a view to being rolled out to all practices by the end of the financial year.
- First phase of Care Navigation being rolled out in primary care (Minor Eye Conditions, Minor Ailments Scheme, etc.)
- Primary Workforce Strategy drafted and in the process of being finalised.
- Clinical Pharmacists working in practice groups.
- Practices undertaken Practice Resilience training.

Urgent and Emergency Care/Improving Flow and Admission Avoidance:
- Discharge to Assess Pathways implemented across all wards, regional recognition for D2A work and Direct Transfers of Care (DTOCs) reduced on track to hit NHS England trajectory.
- Frail elderly pathways being developed and falls service being redesigned in partnership with trust to have a much greater focus on prevention.
- Step up beds commissioned.
- Developed Integrated Emergency Care Passport jointly with Social Care, West Midlands Ambulance Service and RWT.
- Rapid response service provision has been enhanced to include seven days a week provision (over six months 3,375 patients were seen, 3,155 were successfully treated in the community, representing an 85% admission avoidance rate).
- Enhanced risk stratification and MDT approach with primary and community and social care services.
- Launch of red bag scheme.
- A&E Delivery Board is continuing to support schemes that will help improve patient flow and reduce impact on A&E during the winter period.

Elective Care:
- Musculosketal (MSK) service is embedded, community eye care services have been recently re-procured and work is ongoing with the Trust to redesign ophthalmology pathways and shift services into the community closer to home where possible.
- Currently scoping out opportunities to implement clinical assessment services in other specialities.
- The CCG is also currently in the process of reviewing and redesigning other pathways such as wound care pathway, End of Life, neuro rehab and heart failure.
- Continuing to support practices with offering choice to patients at point of referral.

- Working with providers to ensure patients are not waiting more than 18 weeks from referral to treatment and ensuring remedial action plans are put in place where required to deliver improvements.

Cancer:

- Strategic Cancer Group set up, responsible for ensuring oversight and implementation of Achieving World Outcomes Strategy.
- Recovery and Health Wellbeing sessions being delivered by RWT for breast cancer patients and looking to roll out to further specialities.
- Working with Cancer Research UK and GP practices to improve knowledge and information.
- Working with Cancer Research, RWT, GP practices and other key stakeholder to improve uptake of bowel screening.

Mental Health:

- Implementation of Primary Care Counselling Service.
- Improved access and waiting times, early intervention in psychosis and eating disorders with additional investment and remodelling of the pathways.
- Pump priming investment in peri-natal mental health (including multi-agency training) running this programme for our Sustainability and Transformation Plan (STP).
- Recommissioned autism and Attention Deficit Hyperactivity Disorder (ADHD) diagnostic are on a pathway for adults.
- Reducing out of area placements (acute overspill and specialist).
- Better Care Fund – focus on urgent mental health care pathway, further alignment of all age 24/7 crisis care as part of crisis concordant with a focus to move to mental health liaison core 24.
- CAHMS Transformation Plan developed with focus on (Children and Young People (CYP), IAPY, CAHMS crisis services, tier 3 and improved access to tier 4, increasing access prevalent population).

In answer to a question regarding End of Life care, Steven Marshall confirmed that those were better for cancer patients due to the additional resources and focus. There was also a difference depending on where you lived in the city and it was hoped to standardise that. As there were no additional resources, any investment in one area would mean a loss in another and it was a question of prioritisation.

The Chair advised that hospices provided services for cancer patients; however, it was much more difficult to decide the type of End of Life care required for people suffering from other, longer term conditions.

In answer to a question regarding the priorities for improving primary care, Steven Marshall confirmed that quality and coverage where the key elements, with GPs working collaboratively using a multi-disciplined model. That included GP practices merging to provide better quality services in the community.

Helen Child, Third Sector Partnership stated that better care in the community was welcomed and she referred to the importance of supporting people with mental health issues, as many where left without support if they did not meet specific criteria.

Steven Marshall advised that previously under urgent care pathways some people had not meet the criteria and had been left without support. However, with primary care counselling and a more considered approach it was hoped to avoid that in the future.

The Chair advised that if the Operational Plan was updated before next year then a report would be submitted to the Board, if not the Board would receive the update report in 2019.

Resolved:
That the verbal update be noted.

8 **Future of Acute Services**

David Loughton CBE, Royal Wolverhampton Hospital NHS Trust and Mike Sharon, Royal Wolverhampton Hospital NHS Trust gave a presentation on the Future of Acute Services in the Black Country and highlighted key points.

Councillor Sweet referred to the pressure on acute services and the excellent work undertaken by staff at the RWT to minimise the impact on the public.

David Loughton CBE referred to maternity services and confirmed that the Trust had not experienced any problems in filling vacancies and the ratio of midwives to births was currently at target.

In answer to a question regarding changes to patient geography, David Loughton CBE advised that the changes since 2013-2014 were based on volume of numbers and he confirmed that people were happy with the service at Cannock.

Resolved:
That the update be noted.

9 **Wolverhampton Pharmaceutical Needs Assessment 2018-2021**

Seeta Wakefield, Public Health Speciality Registrar presented the report and gave a presentation on the Wolverhampton Pharmaceutical Needs Assessment 2018-2021 and highlighted key points.

She advised that 256 members of the public had responded to the pharmacy survey. The key findings of the survey related to opening times, accessibility and facilities. She confirmed that in terms of opening times and accessibility there were now several pharmacies open from 7am weekdays, several on Saturdays and 10 were open on Sundays. Those 10 were concentrated in more deprived areas where people could walk or there was good public transport; with people from more affluent areas more likely to be able to access those facilities by car. Most pharmacies were within a 30-minute drive or walk, or could be accessed by public transport. In respect of facilities, most had staff that could speak other languages; there was greater wheelchair access, more consultation rooms and home dispensing.

She confirmed that Lloyds Pharmacies would be releasing 190 pharmacies nationally (either through closure or by selling them to other pharmacies). There were eight Lloyds pharmacies in Wolverhampton; however, as yet there was no notification of how many, if any, would be affected, and if they were, in what way. Public Health would continue to monitor the situation on behalf of the Board.

The Chair referred to the important work undertaken by pharmacies in providing general health care advice.

John Denley, Director for Public Health referred to the importance of pharmacies in attracting people and other businesses to an area as they were very good businesses.

Jeremy Vanes, Royal Wolverhampton Hospital NHS Trust suggested that the Board would benefit from speaking with pharmacist to build a level of awareness regarding where and how to provide services.

Helen Child, Third Sector Partnership stated that it was often pharmacy staff who noticed problems at first hand, as they often saw people on a regular basis and during home visits and it was important that those skills were utilised appropriately.

John Denley advised that although facilities and building fabric were important, the most important thing was the build-up of relationships and being part of the community.

Seeta Wakefield confirmed that of the 64 customer facing pharmacies, 63 had closed rooms and the only outstanding pharmacy was looking to add a room.

Helen Child and Linda Sanders both referred to the terminology in correspondence and suggested that it would be helpful to simplify it.

Seeta Wakefield confirmed that this year timescales had been very tight; however, in future years issues including language, terminology and accessibility would be looked at more closely. She also advised that the HWBB would be consulted at an earlier stage next time in the process.

Councillor Sweet stated that he was aware of one pharmacy that had a private consultation room; however, it was very small and at the back of the premises and had limited availability.

Seeta Wakefield acknowledged that the situation was not perfect; however, improvements continued to be made to make premises more accessible, with 55 being wheelchair accessible.

Resolved:
That the report and presentation be noted.

10 **Strengthening Governance and System Leadership**

Madeleine Freewood, Development Manager – City Health presented the report and highlighted key points and asked the Board to consider the five recommendations.

The Chair stated that it was a very opportune moment to undertake a review and the recommendations should be supported.

Linda Sanders, Independent Chair of the Adults and Children's Safeguarding Board supported the recommendations and suggested that as part of the review, thought should be given to how the Board evidenced outcomes and impact. She referred to the joint protocol document referred to in the report, which was in the process of being reviewed, a pre-meeting had been scheduled for February 2018 and a meeting

would be held on 22 March 2018. She referred to the development of a HWBB Communications Strategy and suggested the potential value of aligning that with other partnership board communication plans. She referred to the Be Safe Junior Safeguarding Board and the important issues raised by members, including aspects around feeling safe, tackling drugs and alcohol abuse, domestic violence, guns, gangs and knife crime and the use of social media. Members had requested more information about partnership boards, in particular quarterly updates and as the Chair already provided meeting updates, it would be possible to add the Be Safe Junior Safeguarding Board to the mailing list.

Resolved:

That the Health and Wellbeing Board agree the five-step Action Plan, including the five recommendations listed below, to strengthen the governance and system leadership of the Board:

1. 360-degree review.
2. Update the Joint Health and Wellbeing Strategy for Board approval in July 2018.
3. Development of a Health and Wellbeing Board Engagement and Communications Plan, including mapping community stakeholders.
4. Develop a Wolverhampton specific Health and Wellbeing Board identity, including branding and web presence.
5. Identify opportunities for learning from others.

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Agenda Item No: 6

CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

11 April 2018

Report title	Forward Plan 2017-2018
Cabinet member with lead responsibility	Councillor Paul Sweet Public Health
Wards affected	All
Accountable director	John Denley, Director of Public Health
Originating service	Governance
Accountable employee(s)	Helen Tambini — Democratic Services Officer Tel — 01902 554070 Email — Helen.Tambini@wolverhampton.gov.uk
Report to be/has been considered by	Strategic Executive Board 27 March 2018

Recommendation for action:

The Health and Wellbeing Board is recommended to review the latest version of the Forward Plan and contribute to the planning of future agenda items.

1.0 Purpose

1.1 To present the Forward Plan to the Board for comment and discussion in order to jointly plan and prioritise future agenda items.

1.2 The Forward Plan will be a dynamic document and continually presented in order to support a key aim of the Board – 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 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.
[MI/26032018/T]

4.0 Legal implications

4.1 There are no direct legal implications arising from this report.
[RB/26032018/U]

5.0 Equalities implications

5.1 There are no direct equalities implications arising from this report.

6.0 Environmental implications

6.1 There are no direct environmental implications arising from this report.

7.0 Human resources implications

7.1 There are no direct human resources implications arising from this report.

8.0 Corporate landlord implications

8.1 There are no direct corporate landlord implications arising from this report.

9.0 Schedule of background papers

9.1 Minutes of previous meetings of the Health and WellBeing Board regarding the forward planning agenda items.

Health and Wellbeing Board: Forward Plan

Updated 29 March 2018

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

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

Date	Title	Partner Org/Author	JHWBS Priority	Format	Notes/comments
10 January 2018	Wolverhampton CCG Operational Plan 2017-2019 - Update	CCG/Helen Hibbs/Steven Marshall		Verbal Update	Discussion Item. Operational Plan last considered 15 February 2017. Update report agreed at Agenda Group meeting 28 November 2017.
	Future of Acute Services	RWT/David Loughton		Presentation	Discussion Item. New item agreed at Agenda Group meeting on 3 August 2017.
	Pharmaceuticals Needs Assessment	CWC/Seeta Wakefield		Paper	Discussion Item. New item agreed at Agenda Group meeting on 12 September 2017.
	Strengthening Governance and System Leadership in the HWBB	CWC/Brendan Clifford/Madeleine Freewood		Paper	Discussion Item. New item agreed at Agenda Group meeting on 28 November 2017.

Key: JHWBS priorities

11 April 2018	City of Wolverhampton Public Health Annual Report 2017-2018	CWC/John Denley		Paper	Discussion Item. Removed from agenda of meeting on 20 September 2017 as not yet completed. Agreed at Agenda Group meeting on 28 November 2017.
	City of Wolverhampton Vision for Public Health 2030	CWC/John Denley		Presentation and paper	Discussion Item. Agreed at Agenda Group meeting on 6 March 2018.
	Mental Health Strategy 2017-2019 DEFERRED	CCG/BCPFT/ CWC Steven Marshall/Sarah Fellows/Lesley Writtle/David Watts		Paper	Discussion Item. Considered at Development Event meeting on 18 October 2017. Update report requested for April 2018. Agreed on 29 March 2018 at the Executive Commissioning Group that the item be deferred to the meeting in July 2018.
	Health and Wellbeing Board – Development Event – Issues Update: • West Midlands Combined Authority Board. • Shared Approaches – Estates.	CWC/Brendan Clifford CWC/Julia Nock		Paper	Discussion Item. Update report requested for April 2018. Report will cover all three identified areas.

Key: JHWBS priorities

	• Workforce.	CWC/RWT Brendan Clifford/ Jeremy Vanes			
	City of Wolverhampton Partnership Response to People with No Recourse to Public Funds (NRPF)	CWC/Neeraj Malhotra		Paper	Discussion Item. Paper to focus on the establishment of an NRPF Forum. A copy of the policy and an update on the findings from a six-month pilot by RMC to support families expedite their immigration claims to be included as appendices. Agreed at Agenda Group meeting on 28 November 2017.
	Strengthening Governance and System Leadership: • 360-degree Review Board. • Development of Engagement and Communication Plan. • Development of HWBB web identity and branding. • Joint Health and Wellbeing Strategy update.	CWC/Brendan Clifford/ Madeleine Freewood John Denley		Paper	Discussion Item. Report considered at meeting on 10 January 2018.
11 July 2018	Mental Health Strategy 2017-2019	CCG/BCPFT/ CWC		Paper	Discussion Item.

Key: JHWBS priorities

		Steven Marshall/Sarah Fellows/Lesley Writtle/David Watts			Considered at Development Event meeting on 18 October 2017. Deferred from meeting on 11 April 2018.
	Quality and Improvement Strategy 2017-2020	**CCG/Sally Roberts**		**Paper**	**Discussion item.** **Last considered June 2017.**
	Overview of Primary Care Strategy	**CCG/Helen Hibbs**		**Paper**	**Discussion item.** **Last considered June 2017.**
	Estates Strategy Update	**CCG/RWT/CWC**		**Paper**	**Discussion Item.** **Agreed at Agenda Group meeting on 6 March 2018 to make this a separate item and for all partners to be involved.**
	Case for Change – West Park	**CCG/Helen Hibbs**		**Paper**	**Discussion Item.** **Agreed at Agenda Group meeting on 6 March 2018.**
	Better Care Fund (BCF) Update Report	**CCG/Steven Marshall and CWC David Watts**		**Paper**	**Discussion item.** **Regular joint update paper.** **Last considered 20 September 2017.**
17 October 2018	Adults Safeguarding Board Annual Report			Paper	Discussion Item. Last considered September 2017. Agreed at meeting on 10 January 2018.

Key: JHWBS priorities

	Children's Safeguarding Board Annual Report			Paper	Discussion Item. Last considered September 2017. Agreed at meeting on 10 January 2018.
To be scheduled	Future Commissioning across the Black Country and Integrated Care System	CCG/Helen Hibbs		Paper	Discussion Item. Removed from agenda of meeting on 20 September 2017 as not yet completed. To be deferred to a future meeting.
	Place Based Commissioning (Social Care and Accountable Care System)	CCG/RWT Helen Hibbs/David Loughton			Discussion Item. Removed from agenda of meeting on 20 September 2017 as not yet completed. Considered at Development Event meeting on 18 October 2017. Update report requested for a future meeting.

Key: JHWBS priorities

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Agenda Item No: 7

CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

11 April 2018

Report title	City of Wolverhampton Public Health Annual Report 2017-2018	
Cabinet member with lead responsibility	Councillor Paul Sweet Public Health	
Wards affected	All	
Accountable director	John Denley, Director of Public Health	
Originating service	Public Health	
Accountable employee(s)	John Denley Tel Email	Director of Public Health 01902 551095 John.Denley@wolverhampton.gov.uk
Report to be/has been considered by	People Leadership Team Strategic Executive Board	26 March 2018 27 March 2018

Recommendation for action:

The Health and Wellbeing Board is recommended to agree the publishing of the Director of Public Health's Annual Report for 2017-2018.

1.0 Purpose

1.1 To present the Director of Public Health's Annual Report for 2017-2018 which focusses on how the health of the city's population compares nationally and between wards.

2.0 Background

2.1 Directors of Public Health have a statutory requirement to write an annual report on the health of their population. The Director of Public Health's Annual Report is a vehicle for informing local people about the health of their community, as well as providing necessary information for decision makers in local health services and authorities on health gaps and priorities that need to be addressed.

3.0 Director of Public Health's Annual Report 2017-2018

3.1 This year's report includes an overview of the health and wellbeing of the City of Wolverhampton's population, and provides a focus on the scale of the problems we face across the wards in the city. The report also outlines the four key workstreams in Public Health moving forward and the planned improvements in the quality of the services we commission in public health over the next 12 to 18 months.

4.0 Financial implications

4.1 Funding for Public Health is provided to the Council by the Department of Health in the form of a ring-fenced grant. The final grant allocation for 2017-2018 was £21,317,000. There are no direct financial implications arising from this report.
[MI/26032018/J]

5.0 Legal implications

5.1 There are no direct legal implications arising from this report.
[RB/27032018/R]

6.0 Equalities implications

6.1 This report does highlight health inequalities that are known and addressed through the priorities outlined and the services commissioned by Public Health.

7.0 Environmental implications

7.1 There are no direct environmental implications arising from this report.

8.0 Human resources implications

8.1 There are no direct human resource implications arising from this report.

9.0 Corporate landlord implications

9.1 There are no direct corporate landlord implications arising from this report.

10.0 Schedule of background papers

10.1 There are no background papers in relation to this report.

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Public Health Annual Report 2017

Health in City of Wolverhampton at a glance

wolverhampton.gov.uk

CITY OF WOLVERHAMPTON COUNCIL

Contents

Foreword
Councillor Paul Sweet

I would like to personally offer a warm welcome to John Denley who has recently joined the Council in his new post as Director of Public Health in City of Wolverhampton. I had the pleasure of working with the previous Director, Ros Jervis, and was proud of the achievements made since Public Health transitioned into the Council in 2013. However, looking forward, I am dedicated to tackling the entrenched challenges which the City still faces. Working towards the priorities identified under each work area in this annual report offers a real, tangible opportunity to support all residents to take health improving steps, regardless of individual circumstance. This report shows the variation in outcomes across the wards in City of Wolverhampton. This demonstrates the inequality in outcomes that persist in our city and a key challenge going forward will be to reduce these levels of inequality.

Councillor Sweet

Portfolio holder for Health and Wellbeing

Foreword
John Denley, Director of Public Health

Public health is about helping all people to stay healthy for longer and to protect against threats to health. Life expectancy and healthy life expectancy are the overarching outcomes we monitor to demonstrate how well we are doing. There are many factors which affect our health, from the environment, such as the air we breathe or the quality of the house we live in; our lifestyle, including the food we eat and exercise we take- plus smoking and alcohol; school attainment; our family's household income and stability of job, to health service delivery and possible infections.

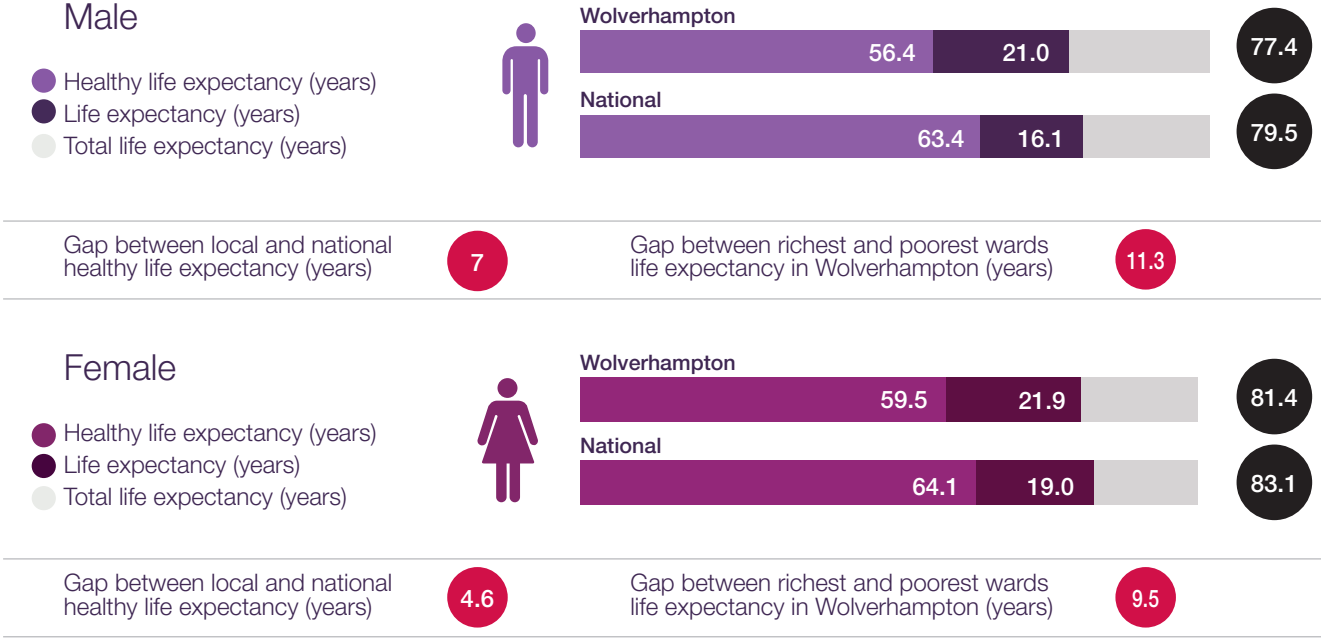
I am very happy to share my first annual report, which demonstrates the scale of the problems we face across the wards in the City and the focus of the 4 key workstreams in public health moving forward. In addition, this report lays out the planned improvements in the quality of the services we commission in public health over the next 12-18 months.

John Denley
Director of Public Health

The overarching measures of Public Health

A marker of overall public health is the life expectancy and healthy life expectancy within an area. Wolverhampton men and women live 7.0 and 4.6 years respectively in poorer health than the average in England. Equally, the gap between healthy life expectancy and life expectancy, the years lived in poorer health for Wolverhampton men is 21.0 years and for women, 21.9 years. It is these years lived in poorer health which usually lead to higher demand on our health and social care services in City of Wolverhampton.

Life expectancy and healthy life expectancy for men and women, Wolverhampton and England

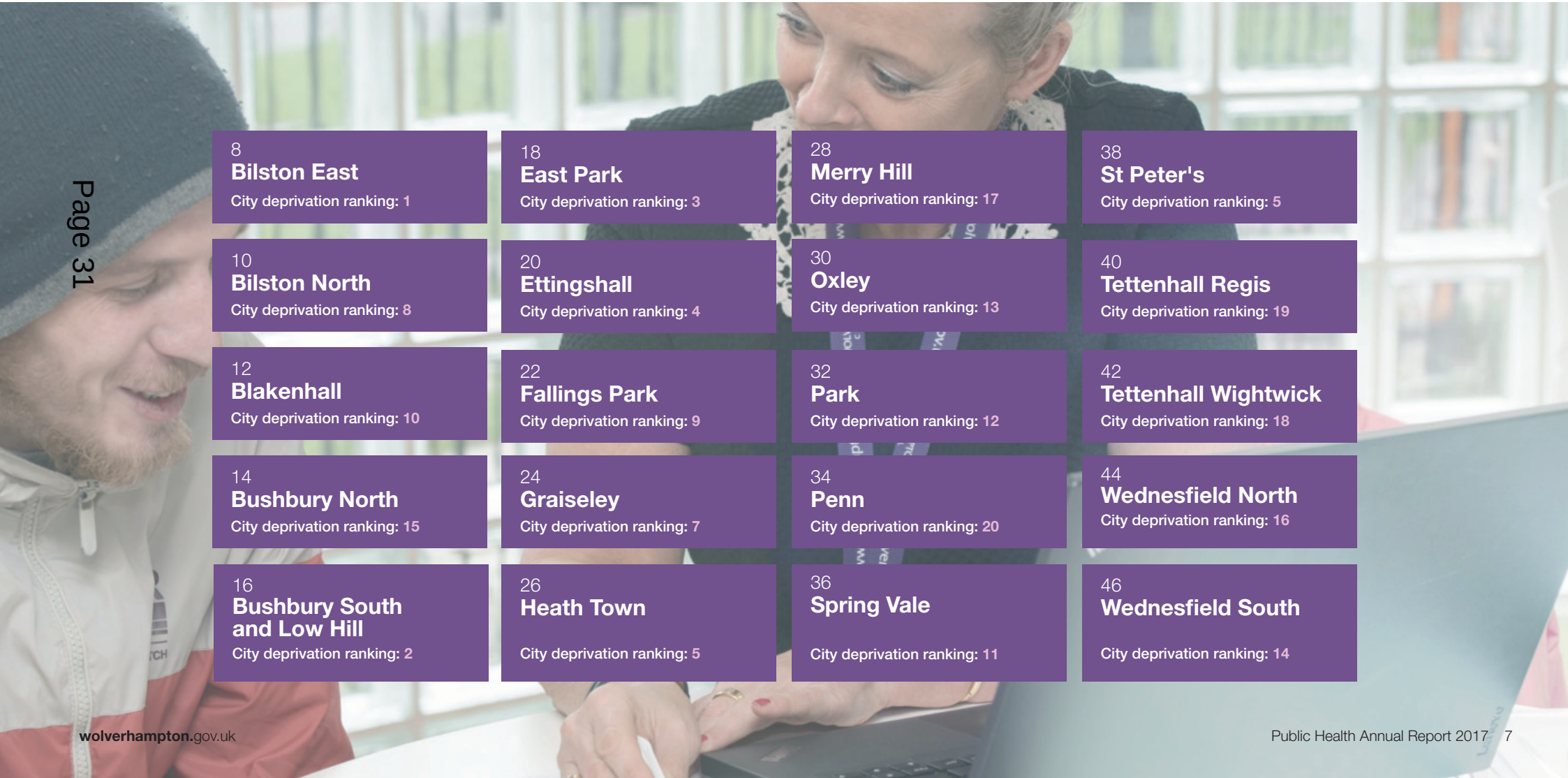


Priority	Indicators		
Starting and Developing Well (0-24 age group)	• Increase the number of children ready to enter school • Tackle inequalities in educational attainment	• Continue to reduce levels of teenage pregnancy • Continue to tackle infant mortality	• Top performer in chlamydia detection
Healthy Life Expectancy	• Increase access to employment for people with mental health problems • Reduce substance misuse related reoffending	• Top performer in drug and alcohol recovery • Reduce the number of rough sleepers	• Increase physical activity • Reduce smoking prevalence • Top performer in uptake of NHS Health Checks
Healthy Ageing	• Increase wellbeing of carers	• Increase uptake of influenza vaccination	• Keeping people well in their community
System Leadership	• Embed Public Health and prevention in an integrated health and social care system	• Joint intelligence unit established for the City	• Working together across the whole public sector to improve health outcomes

The City of Wolverhampton public health team in has been reorganised to meet the challenges public health faces over the coming years. This reorganisation has led to the formulation of 4 key workstreams (above). Each of these workstreams will be led by a consultant in public health.

The following pages show the key indicators across each of these work areas across the wards of Wolverhampton. The systems leadership priority will work to underpin this work across the whole of Public Health.

Your ward at a glance



8
Bilston East
City deprivation ranking: 1

10
Bilston North
City deprivation ranking: 8

12
Blakenhall
City deprivation ranking: 10

14
Bushbury North
City deprivation ranking: 15

16
Bushbury South and Low Hill
City deprivation ranking: 2

18
East Park
City deprivation ranking: 3

20
Ettingshall
City deprivation ranking: 4

22
Fallings Park
City deprivation ranking: 9

24
Graiseley
City deprivation ranking: 7

26
Heath Town
City deprivation ranking: 5

28
Merry Hill
City deprivation ranking: 17

30
Oxley
City deprivation ranking: 13

32
Park
City deprivation ranking: 12

34
Penn
City deprivation ranking: 20

36
Spring Vale
City deprivation ranking: 11

38
St Peter's
City deprivation ranking: 5

40
Tettenhall Regis
City deprivation ranking: 19

42
Tettenhall Wightwick
City deprivation ranking: 18

44
Wednesfield North
City deprivation ranking: 16

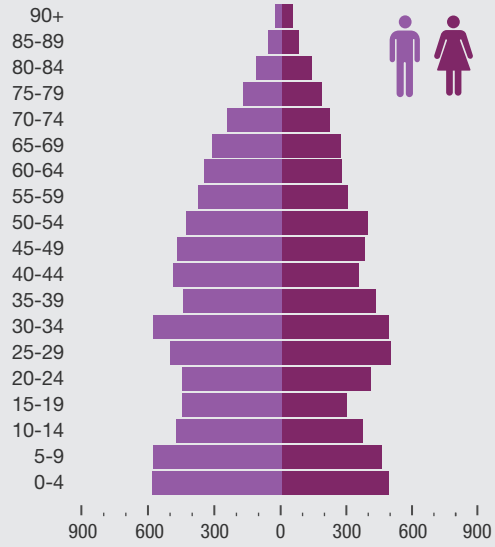
46
Wednesfield South
City deprivation ranking: 14

Your ward at a glance:

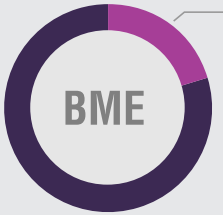
Bilston East

Wards

Total population: **14,542**



Key Demographic Facts



20.5%
of the population is
Black or Minority Ethnic
(City average: 32%)

Deprivation score:
51.2
(City average: 33.2)

Key features from MOSAIC

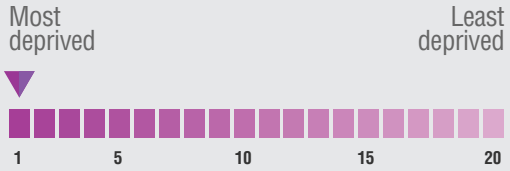
experian

Key feature 1
Elderly

Key feature 2
Living alone

Key feature 3
Low income

City deprivation ranking: 1



0-24 age group

Starting and Developing Well

24.2%
of pupils achieved grade 9-5 English and Maths GCSE

This is worse than the city average

35.9
teenage pregnancies per 1,000 under-18 yr olds

This is close to the city average

117.7
children per 10,000 are in **Local Authority Care**

This is close to the city average

Childhood obesity

30.4%
of children at **year 6 are obese**

This is worse than the city average

25-64 age group

Healthy Life Expectancy

4.8%
claimed **unemployment benefits** in November 2017

This is close to the city average

13.4%
of houses with one or more **category 1 hazards** identified

This is better than the city average

Predominant clusters from Healthy Lifestyle survey

1. **Healthy Weight Poor Lifestyle**
2. **Obese and Average Wellbeing**
3. **Overweights**

65+ age group

Healthy Ageing

10.2%
of people **providing unpaid care** are in **bad or very bad health**

This is worse than the city average

28.5%
of people over 65 years old have an **illness that limits their daily activities**

This is close to the city average

1,660
people per 100k are living in **residential or nursing care** permanently

This is close to the city average

14.6%
of people aged 65 years and over have **below average or very low wellbeing**

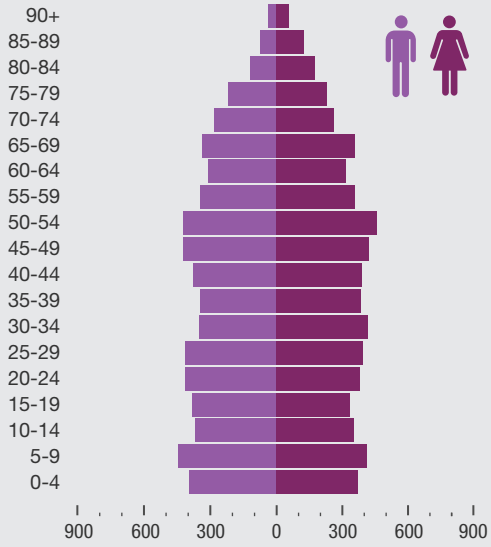
This is worse than the city average

Your ward at a glance:

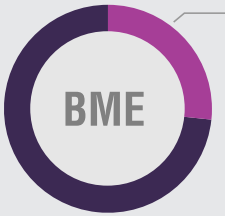
Bilston North

Wards

Total population: **12,297**



Key Demographic Facts



26.8%
of the population is
Black or Minority Ethnic
(City average: 32%)

Deprivation score:
36.5
(City average: 33.2)

Key features from MOSAIC

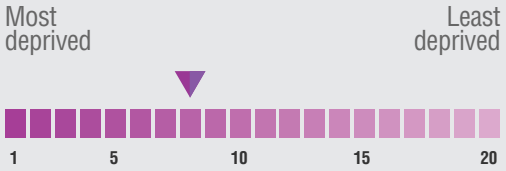
experian

Key feature 1
Families with children

Key feature 2
Aged 25 to 40

Key feature 3
Limited resources

City deprivation ranking: 8



0-24 age group

Starting and Developing Well

31.9% of pupils achieved grade 9-5 English and Maths GCSE

This is close to the city average

40.4 **teenage pregnancies** per 1,000 under-18 yr olds

This is worse than the city average

96.9 children per 10,000 are in **Local Authority Care**

This is close to the city average

Childhood obesity

29.3% of children at **year 6 are obese**

This is worse than the city average

25-64 age group

Healthy Life Expectancy

3.7% claimed **unemployment benefits** in November 2017

This is close to the city average

14.9% of houses with one or more **category 1 hazards** identified

This is close to the city average

Predominant clusters from Healthy Lifestyle survey

1. Healthy Weight Poor Lifestyle
2. Overweights
3. Obese and Average Wellbeing

65+ age group

Healthy Ageing

8.2% of people **providing unpaid care** are in **bad or very bad health**

This is close to the city average

20.4% of people over 65 years old have an **illness that limits their daily activities**

This is better than the city average

1,596 people per 100k are living in **residential or nursing care** permanently

This is better than the city average

8.1% of people aged 65 years and over have **below average or very low wellbeing**

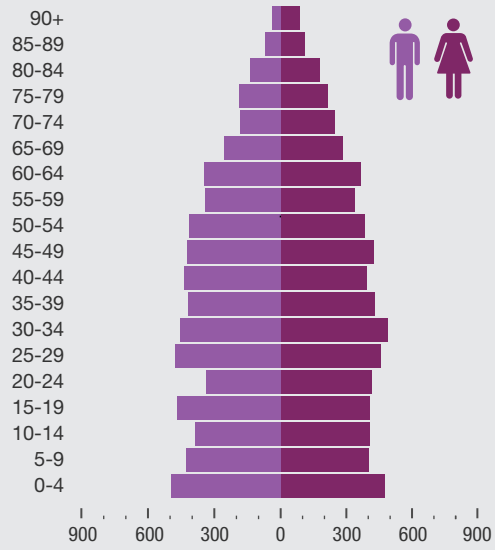
This is close to the city average

Your ward at a glance:

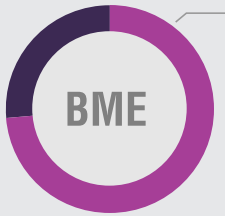
Blakenhall

Wards

Total population: **12,790**



Key Demographic Facts



73.7%
of the population is
Black or Minority Ethnic
(City average: 32%)

Deprivation score:
32.9
(City average: 33.2)

Key features from MOSAIC

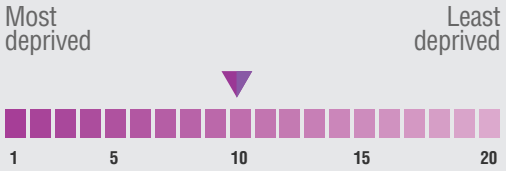
experian

Key feature 1
Settled extended families

Key feature 2
City suburbs

Key feature 3
Multicultural

City deprivation ranking: **10**



0-24 age group

Starting and Developing Well

42.1%
of pupils achieved grade 9-5 English and Maths GCSE

This is better than the city average

26.3
teenage pregnancies per 1,000 under-18 yr olds

This is close to the city average

99.6
children per 10,000 are in **Local Authority Care**

This is close to the city average

Childhood obesity

28.1%
of children at **year 6 are obese**

This is close to the city average

25-64 age group

Healthy Life Expectancy

3.9%
claimed **unemployment benefits** in November 2017

This is close to the city average

20.9%
of houses with one or more **category 1 hazards** identified

This is worse than the city average

Predominant clusters from Healthy Lifestyle survey

1. **Healthy Weight Poor Lifestyle**
2. **Overweights**
3. **Healthy Eaters**

65+ age group

Healthy Ageing

8.3%
of people **providing unpaid care** are in **bad or very bad health**

This is close to the city average

21.4%
of people over 65 years old have an **illness that limits their daily activities**

This is better than the city average

8,622
people per 100k are living in **residential or nursing care** permanently

This is worse than the city average

12.8%
of people aged 65 years and over have **below average or very low wellbeing**

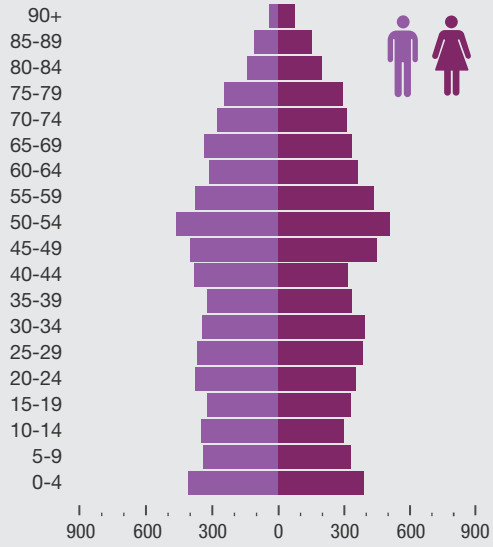
This is close to the city average

Your ward at a glance:

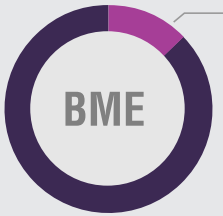
Bushbury North

Wards

Total population: **11,971**



Key Demographic Facts



12.8%
of the population is
Black or Minority Ethnic
(City average: 32%)

Deprivation score:
27.8
(City average: 33.2)

Key features from MOSAIC

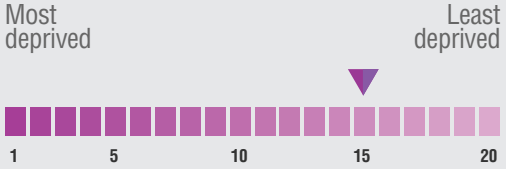
experian

Key feature 1
Younger households

Key feature 2
Full-time employment

Key feature 3
Private suburbs

City deprivation ranking: 15



0-24 age group

Starting and Developing Well

28.1%
of pupils achieved grade 9-5 English and Maths GCSE

This is worse than the city average

28.3
teenage pregnancies per 1,000 under-18 yr olds

This is close to the city average

105.6
children per 10,000 are in **Local Authority Care**

This is close to the city average

Childhood obesity

25.9%
of children at **year 6 are obese**

This is close to the city average

25-64 age group

Healthy Life Expectancy

3.3%
claimed **unemployment benefits** in November 2017

This is close to the city average

14.5%
of houses with one or more **category 1 hazards** identified

This is close to the city average

Predominant clusters from Healthy Lifestyle survey

1 — **Healthy Weight Poor Lifestyle**

2 — **Used to Smoke**

3 — **Healthy Eaters**

65+ age group

Healthy Ageing

7.8%
of people **providing unpaid care** are in **bad or very bad health**

This is close to the city average

22.6%
of people over 65 years old have an **illness that limits their daily activities**

This is close to the city average

1,817
people per 100k are living in **residential or nursing care** permanently

This is close to the city average

8.3%
of people aged 65 years and over have **below average or very low wellbeing**

This is close to the city average

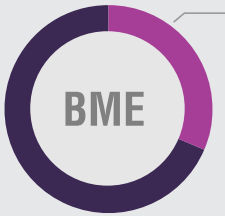
Your ward at a glance:

Bushbury South and Low Hill

Wards

Total population: **15,853**

Key Demographic Facts



31.6%
of the population is
Black or Minority Ethnic
(City average: 32%)

Deprivation score:
47.8
(City average: 33.2)

Key features from MOSAIC

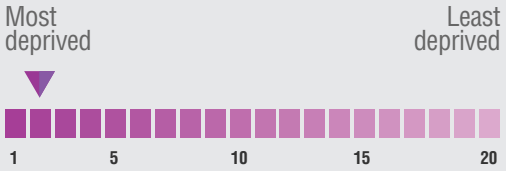
experian

Key feature 1
Families with children

Key feature 2
Aged 25 to 40

Key feature 3
Limited resources

City deprivation ranking: **2**



0-24 age group

Starting and Developing Well

24.6%
of pupils achieved grade 9-5 English and Maths GCSE

This is worse than the city average

49.0
teenage pregnancies per 1,000 under-18 yr olds

This is worse than the city average

190.2
children per 10,000 are in **Local Authority Care**

This is worse than the city average

Childhood obesity
28.1%
of children at **year 6 are obese**

This is worse than the city average

25-64 age group

Healthy Life Expectancy

5.6%
claimed **unemployment benefits** in November 2017

This is worse than the city average

17.3%
of houses with one or more **category 1 hazards** identified

This is close to the city average

Predominant clusters from Healthy Lifestyle survey

1. **Healthy Weight Poor Lifestyle**
2. **Overweights**
3. **Obese and Average Wellbeing**

65+ age group

Healthy Ageing

9.0%
of people **providing unpaid care** are in **bad or very bad health**

This is close to the city average

28.0%
of people over 65 years old have an **illness that limits their daily activities**

This is close to the city average

3,945
people per 100k are living in **residential or nursing care** permanently

This is worse than the city average

21.6%
of people aged 65 years and over have **below average or very low wellbeing**

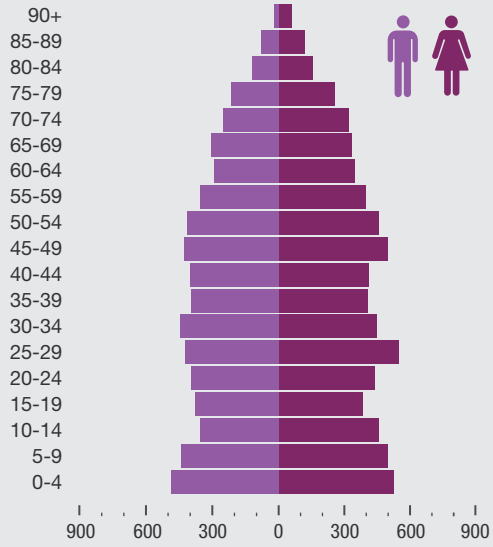
This is worse than the city average

Your ward at a glance:

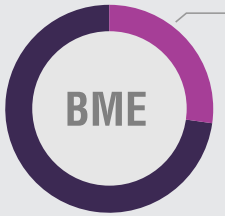
East Park

Wards

Total population: **12,892**



Key Demographic Facts



27.4%
of the population is
Black or Minority Ethnic
(City average: 32%)

Deprivation score:
44.7
(City average: 33.2)

Key features from MOSAIC

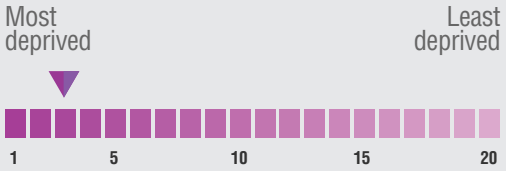
experian

Key feature 1
Families with children

Key feature 2
Aged 25 to 40

Key feature 3
Limited resources

City deprivation ranking: 3



0-24 age group

Starting and Developing Well

25.4%
of pupils achieved grade 9-5 English and Maths GCSE

This is worse than the city average

55.5
teenage pregnancies per 1,000 under-18 yr olds

This is worse than the city average

197.9
children per 10,000 are in **Local Authority Care**

This is worse than the city average

Childhood obesity

27.2%
of children at **year 6 are obese**

This is close to the city average

25-64 age group

Healthy Life Expectancy

6.1%
claimed **unemployment benefits** in November 2017

This is worse than the city average

14.0%
of houses with one or more **category 1 hazards** identified

This is close to the city average

Predominant clusters from Healthy Lifestyle survey

1. **Healthy Weight Poor Lifestyle**
2. **Obese and Average Wellbeing**
3. **Used to Smoke**

65+ age group

Healthy Ageing

10.3%
of people **providing unpaid care** are in **bad or very bad health**

This is worse than the city average

28.9%
of people over 65 years old have an **illness that limits their daily activities**

This is worse than the city average

1,646
people per 100k are living in **residential or nursing care** permanently

This is close to the city average

10.9%
of people aged 65 years and over have **below average or very low wellbeing**

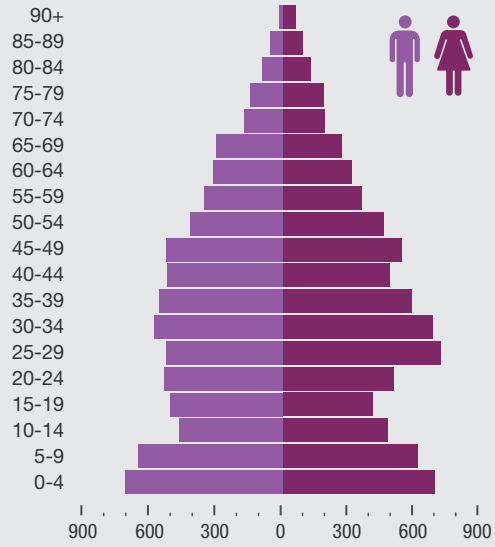
This is close to the city average

Your ward at a glance:

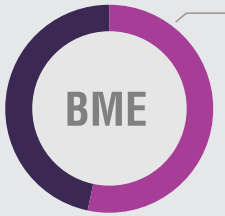
Ettingshall

Wards

Total population: **15,245**



Key Demographic Facts



53.5%
of the population is
Black or Minority Ethnic
(City average: 32%)

Deprivation score:
43.8
(City average: 33.2)

Key features from MOSAIC

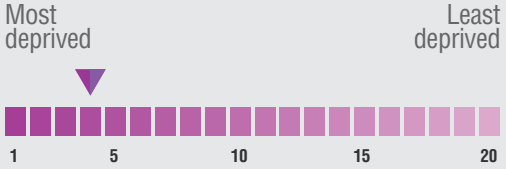
experian

Key feature 1
Private renters

Key feature 2
Low length of residence

Key feature 3
Low cost housing

City deprivation ranking: 4



0-24 age group

Starting and Developing Well

29.5%
of pupils achieved grade 9-5 English and Maths GCSE

This is close to the city average

34.2
teenage pregnancies per 1,000 under-18 yr olds

This is close to the city average

189.6
children per 10,000 are in **Local Authority Care**

This is worse than the city average

Childhood obesity
25.9%
of children at **year 6 are obese**

This is close to the city average

25-64 age group

Healthy Life Expectancy

5%
claimed **unemployment benefits** in November 2017

This is close to the city average

17.7%
of houses with one or more **category 1 hazards** identified

This is worse than the city average

Predominant clusters from Healthy Lifestyle survey

1. **Healthy Weight Poor Lifestyle**
2. **Overweights**
3. **Used to Smoke**

65+ age group

Healthy Ageing

7.4%
of people **providing unpaid care** are in **bad or very bad health**

This is close to the city average

18.5%
of people over 65 years old have an **illness that limits their daily activities**

This is better than the city average

2,060
people per 100k are living in **residential or nursing care** permanently

This is close to the city average

12.7%
of people aged 65 years and over have **below average or very low wellbeing**

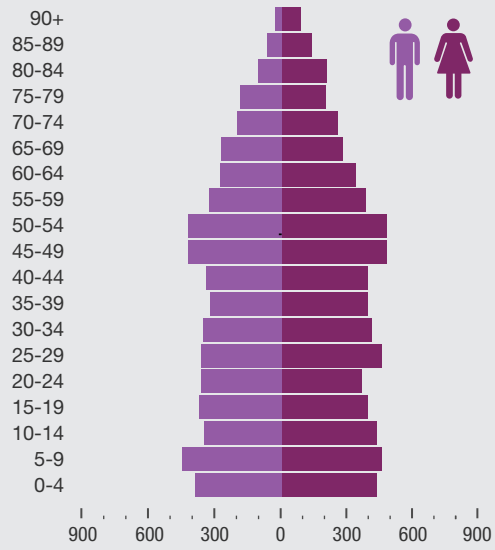
This is close to the city average

Your ward at a glance:

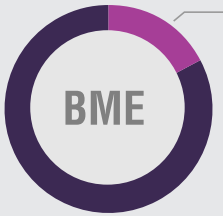
Fallings Park

Wards

Total population: **12,199**



Key Demographic Facts



17.4%
of the population is
Black or Minority Ethnic
(City average: 32%)

Deprivation score:
34.6
(City average: 33.2)

Key features from MOSAIC

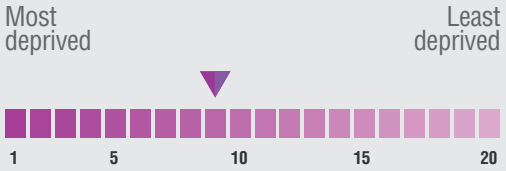
experian

Key feature 1
Younger households

Key feature 2
Full-time employment

Key feature 3
Private suburbs

City deprivation ranking: 9



0-24 age group

Starting and Developing Well

27.5% of pupils achieved grade 9-5 English and Maths GCSE

This is worse than the city average

37.5 **teenage pregnancies** per 1,000 under-18 yr olds

This is worse than the city average

134.5 children per 10,000 are in **Local Authority Care**

This is worse than the city average

Childhood obesity

28.8% of children at **year 6 are obese**

This is worse than the city average

25-64 age group

Healthy Life Expectancy

4.3% claimed **unemployment benefits** in November 2017

This is close to the city average

17.2% of houses with one or more **category 1 hazards** identified

This is close to the city average

Predominant clusters from Healthy Lifestyle survey

1 **Overweights**

2 **Healthy Weight Poor Lifestyle**

3 **Obese and Average Wellbeing**

65+ age group

Healthy Ageing

7.1% of people **providing unpaid care** are in **bad or very bad health**

This is close to the city average

30.3% of people over 65 years old have an **illness that limits their daily activities**

This is worse than the city average

2,180 people per 100k are living in **residential or nursing care** permanently

This is close to the city average

7.2% of people aged 65 years and over have **below average or very low wellbeing**

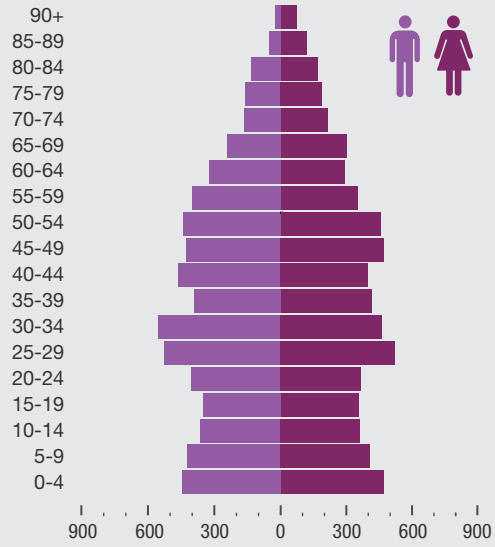
This is better than the city average

Your ward at a glance:

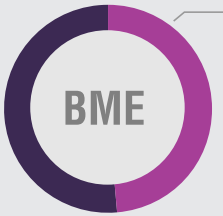
Graiseley

Wards

Total population: **12,607**



Key Demographic Facts



48.8%
of the population is
Black or Minority Ethnic
(City average: 32%)

Deprivation score:
37.1
(City average: 33.2)

Key features from MOSAIC

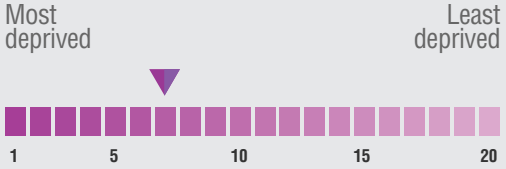
experian

Key feature 1
Private renters

Key feature 2
Low length of residence

Key feature 3
Low cost housing

City deprivation ranking: 7



0-24 age group

Starting and Developing Well

38.9%
of pupils achieved grade 9-5 English and Maths GCSE

This is close to the city average

35.9
teenage pregnancies per 1,000 under-18 yr olds

This is close to the city average

139.0
children per 10,000 are in **Local Authority Care**

This is worse than the city average

Childhood obesity

25.5%
of children at **year 6 are obese**

This is close to the city average

25-64 age group

Healthy Life Expectancy

5.1%
claimed **unemployment benefits** in November 2017

This is worse than the city average

20.9%
of houses with one or more **category 1 hazards** identified

This is worse than the city average

Predominant clusters from Healthy Lifestyle survey

1. **Healthy Weight Poor Lifestyle**
2. **Overweights**
3. **Healthy Eaters**

65+ age group

Healthy Ageing

7.2%
of people **providing unpaid care** are in **bad or very bad health**

This is close to the city average

22.3%
of people over 65 years old have an **illness that limits their daily activities**

This is close to the city average

4,864
people per 100k are living in **residential or nursing care** permanently

This is worse than the city average

10.5%
of people aged 65 years and over have **below average or very low wellbeing**

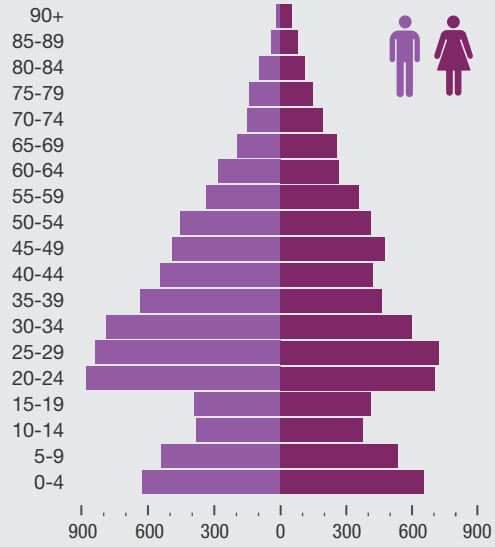
This is close to the city average

Your ward at a glance:

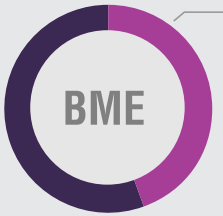
Heath Town

Wards

Total population: **15,090**



Key Demographic Facts



44.5%
of the population is
Black or Minority Ethnic
(City average: 32%)

Deprivation score:
42.6
(City average: 33.2)

Key features from MOSAIC

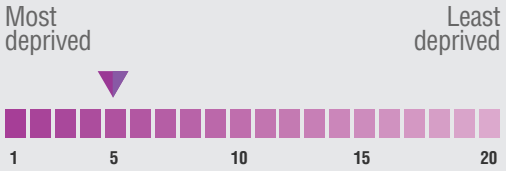
experian

Key feature 1
Families with children

Key feature 2
Aged 25 to 40

Key feature 3
Limited resources

City deprivation ranking: 5



0-24 age group

Starting and Developing Well

34.2%
of pupils achieved grade 9-5 English and Maths GCSE

This is close to the city average

42.3
teenage pregnancies per 1,000 under-18 yr olds

This is worse than the city average

119.5
children per 10,000 are in **Local Authority Care**

This is close to the city average

Childhood obesity
27.1%
of children at **year 6 are obese**

This is close to the city average

25-64 age group

Healthy Life Expectancy

5.5%
claimed **unemployment benefits** in November 2017

This is worse than the city average

13.2%
of houses with one or more **category 1 hazards** identified

This is better than the city average

Predominant clusters from Healthy Lifestyle survey

1. **Healthy Weight Poor Lifestyle**
2. **Obese and Average Wellbeing**
3. **Overweights**

65+ age group

Healthy Ageing

9.3%
of people **providing unpaid care** are in **bad or very bad health**

This is worse than the city average

24.3%
of people over 65 years old have an **illness that limits their daily activities**

This is close to the city average

4,304
people per 100k are living in **residential or nursing care** permanently

This is worse than the city average

10.6%
of people aged 65 years and over have **below average or very low wellbeing**

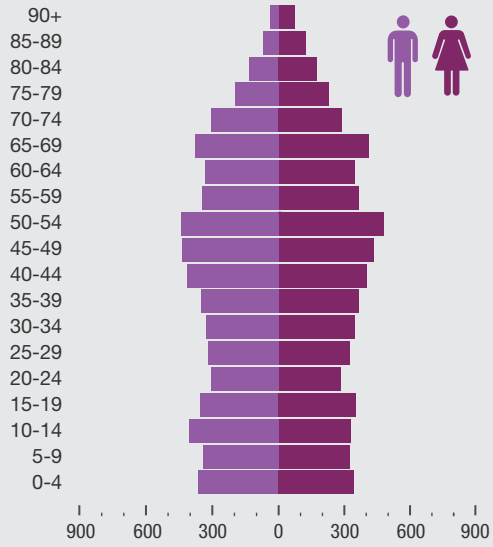
This is close to the city average

Your ward at a glance:

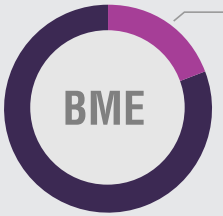
Merry Hill

Wards

Total population: **11,931**



Key Demographic Facts



19.4%
of the population is
Black or Minority Ethnic
(City average: 32%)

Deprivation score:
21.1
(City average: 33.2)

Key features from MOSAIC

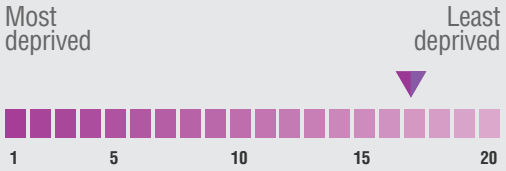
experian

Key feature 1
Elderly singles and couples

Key feature 2
Homeowners

Key feature 3
Comfortable homes

City deprivation ranking: 17



0-24 age group

Starting and Developing Well

42.3%
of pupils achieved grade 9-5 English and Maths GCSE

This is better than the city average

22.9
teenage pregnancies per 1,000 under-18 yr olds

This is close to the city average

62.8
children per 10,000 are in **Local Authority Care**

This is close to the city average

Childhood obesity

21.6%
of children at **year 6 are obese**

This is better than the city average

25-64 age group

Healthy Life Expectancy

3.0%
claimed **unemployment benefits** in November 2017

This is better than the city average

15.4%
of houses with one or more **category 1 hazards** identified

This is close to the city average

Predominant clusters from Healthy Lifestyle survey

1. **Healthy Weight Poor Lifestyle**
2. **Overweights**
3. **Drinkers and Smokers**

65+ age group

Healthy Ageing

7.1%
of people **providing unpaid care** are in **bad or very bad health**

This is close to the city average

34.1%
of people over 65 years old have an **illness that limits their daily activities**

This is worse than the city average

143
people per 100k are living in **residential or nursing care** permanently

This is better than the city average

20.0%
of people aged 65 years and over have **below average or very low wellbeing**

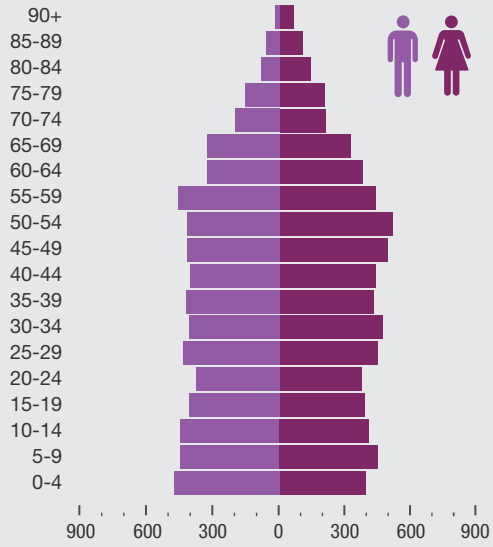
This is worse than the city average

Your ward at a glance:

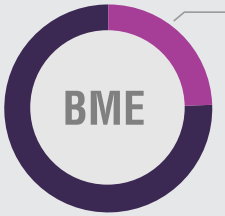
Oxley

Wards

Total population: **12,823**



Key Demographic Facts



24.5%
of the population is
Black or Minority Ethnic
(City average: 32%)

Deprivation score:
29.7
(City average: 33.2)

Key features from MOSAIC

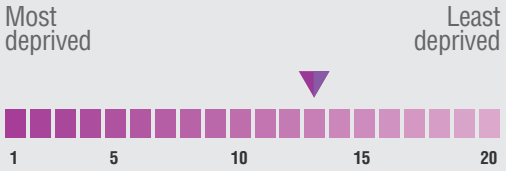
experian

Key feature 1
Families with children

Key feature 2
Aged 25 to 40

Key feature 3
Limited resources

City deprivation ranking: **13**



0-24 age group

Starting and Developing Well

31.5%
of pupils achieved grade 9-5 English and Maths GCSE

This is close to the city average

27.9
teenage pregnancies per 1,000 under-18 yr olds

This is close to the city average

81.5
children per 10,000 are in **Local Authority Care**

This is close to the city average

Childhood obesity

26.1%
of children at **year 6 are obese**

This is close to the city average

25-64 age group

Healthy Life Expectancy

3.9%
claimed **unemployment benefits** in November 2017

This is close to the city average

12.3%
of houses with one or more **category 1 hazards** identified

This is better than the city average

Predominant clusters from Healthy Lifestyle survey

1. **Healthy Weight Poor Lifestyle**
2. **Overweights**
3. **Healthy Eaters**

65+ age group

Healthy Ageing

7.3%
of people **providing unpaid care** are in **bad or very bad health**

This is close to the city average

25.2%
of people over 65 years old have an **illness that limits their daily activities**

This is close to the city average

1,673
people per 100k are living in **residential or nursing care** permanently

This is close to the city average

9.4%
of people aged 65 years and over have **below average or very low wellbeing**

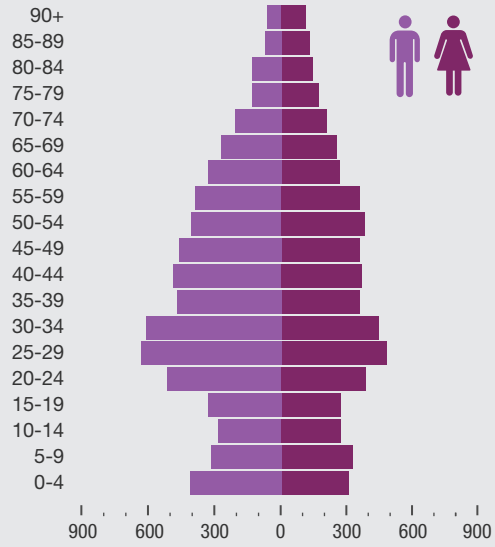
This is close to the city average

Your ward at a glance:

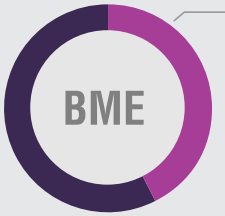
Park

Wards

Total population: **12,480**



Key Demographic Facts



42.7%
of the population is
Black or Minority Ethnic
(City average: 32%)

Deprivation score:
30.8
(City average: 33.2)

Key features from MOSAIC

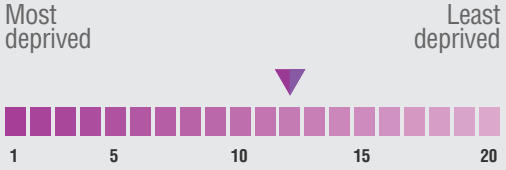
experian

Key feature 1
Aged 18-35

Key feature 2
Private renting

Key feature 3
Singles and sharers

City deprivation ranking: **12**



0-24 age group

Starting and Developing Well

44.7%
of pupils achieved grade 9-5 English and Maths GCSE

This is better than the city average

34.9
teenage pregnancies per 1,000 under-18 yr olds

This is close to the city average

98.0
children per 10,000 are in **Local Authority Care**

This is close to the city average

Childhood obesity
22.5%
of children at **year 6 are obese**

This is better than the city average

25-64 age group

Healthy Life Expectancy

5.0%
claimed **unemployment benefits** in November 2017

This is close to the city average

21.9%
of houses with one or more **category 1 hazards** identified

This is worse than the city average

Predominant clusters from Healthy Lifestyle survey

1 **Vigorously Active**

2 **Healthy Weight Poor Lifestyle**

3 **Drinkers and Smokers**

65+ age group

Healthy Ageing

6.5%
of people **providing unpaid care** are in **bad or very bad health**

This is better than the city average

18.6%
of people over 65 years old have an **illness that limits their daily activities**

This is better than the city average

9,670
people per 100k are living in **residential or nursing care** permanently

This is worse than the city average

14.6%
of people aged 65 years and over have **below average or very low wellbeing**

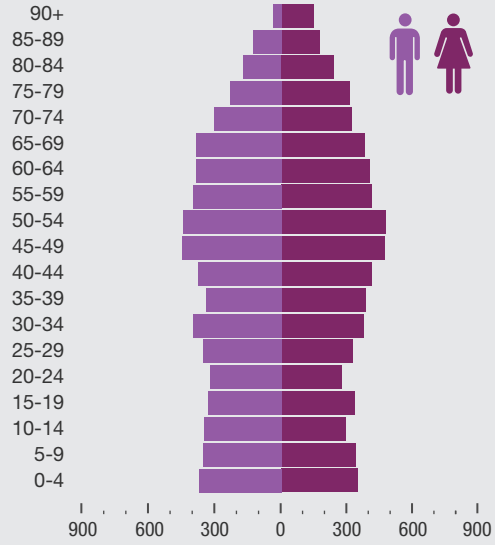
This is worse than the city average

Your ward at a glance:

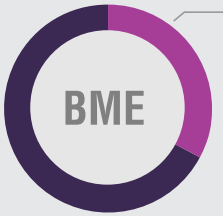
Penn

Wards

Total population: **12,508**

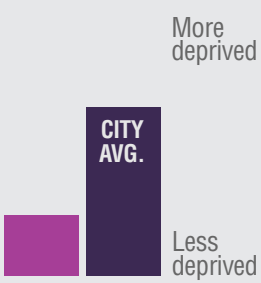


Key Demographic Facts



33.0%
of the population is
Black or Minority Ethnic
(City average: 32%)

Deprivation score:
12.0
(City average: 33.2)



Key features from MOSAIC

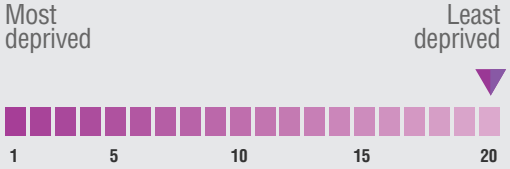
experian

Key feature 1
Older families

Key feature 2
Some adult children at home

Key feature 3
Suburban mid-range homes

City deprivation ranking: **20**



0-24 age group

Starting and Developing Well

47.2%
of pupils achieved grade 9-5 English and Maths GCSE

This is better than the city average

10.1
teenage pregnancies per 1,000 under-18 yr olds

This is better than the city average

<25
children per 10,000 are in **Local Authority Care**

This is better than the city average

Childhood obesity

20.5%
of children at **year 6 are obese**

This is better than the city average

25-64 age group

Healthy Life Expectancy

1.7%
claimed **unemployment benefits** in November 2017

This is better than the city average

17.7%
of houses with one or more **category 1 hazards** identified

This is worse than the city average

Predominant clusters from Healthy Lifestyle survey

1 Healthy Eaters

2 Healthy Weight Poor Lifestyle

3 Overweights

65+ age group

Healthy Ageing

4.6%
of people **providing unpaid care** are in **bad or very bad health**

This is better than the city average

21.5%
of people over 65 years old have an **illness that limits their daily activities**

This is close to the city average

3,851
people per 100k are living in **residential or nursing care** permanently

This is close to the city average

5.9%
of people aged 65 years and over have **below average or very low wellbeing**

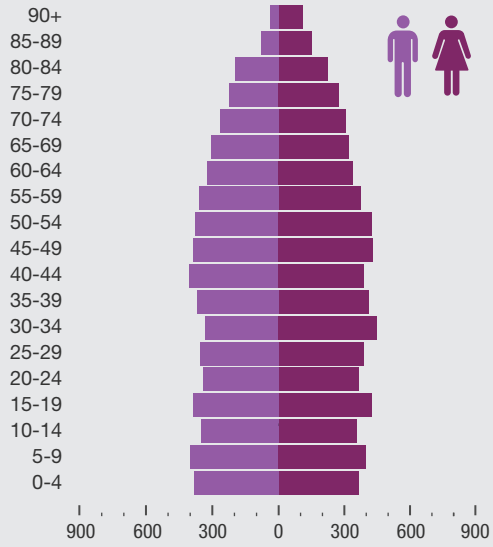
This is better than the city average

Your ward at a glance:

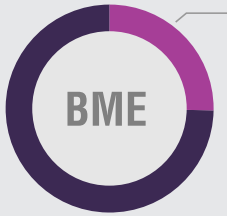
Spring Vale

Wards

Total population: **12,054**



Key Demographic Facts



25.4%
of the population is
Black or Minority Ethnic
(City average: 32%)

Deprivation score:
31.1
(City average: 33.2)

Key features from MOSAIC

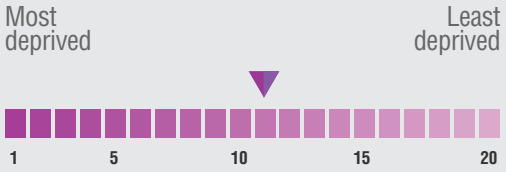
experian

Key feature 1
Families with children

Key feature 2
Aged 25 to 40

Key feature 3
Limited resources

City deprivation ranking: **11**



0-24 age group

Starting and Developing Well

29.4%
of pupils achieved grade 9-5 English and Maths GCSE

This is close to the city average

18.5
teenage pregnancies per 1,000 under-18 yr olds

This is better than the city average

56.3
children per 10,000 are in **Local Authority Care**

This is better than the city average

Childhood obesity

25.7%
of children at **year 6 are obese**

This is close to the city average

25-64 age group

Healthy Life Expectancy

3.3%
claimed **unemployment benefits** in November 2017

This is close to the city average

14.6%
of houses with one or more **category 1 hazards** identified

This is close to the city average

Predominant clusters from Healthy Lifestyle survey

1. **Healthy Weight Poor Lifestyle**
2. **Obese and Average Wellbeing**
3. **Overweights**

65+ age group

Healthy Ageing

9.1%
of people **providing unpaid care** are in **bad or very bad health**

This is worse than the city average

27.5%
of people over 65 years old have an **illness that limits their daily activities**

This is close to the city average

3,396
people per 100k are living in **residential or nursing care** permanently

This is close to the city average

4.4%
of people aged 65 years and over have **below average or very low wellbeing**

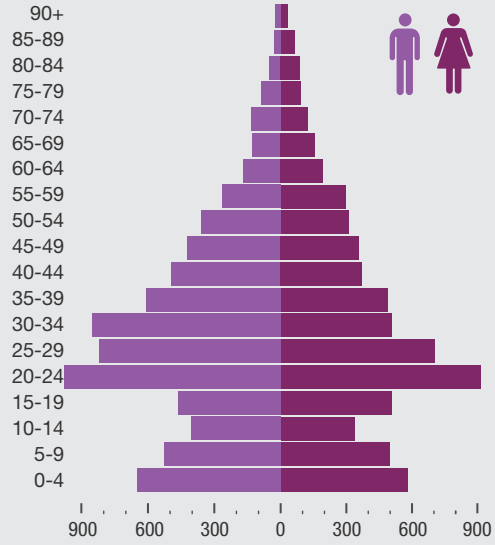
This is better than the city average

Your ward at a glance:

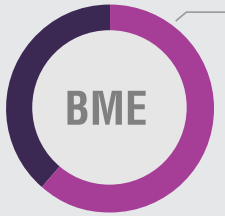
St Peter's

Wards

Total population: **14,044**



Key Demographic Facts



61.6%
of the population is
Black or Minority Ethnic
(City average: 32%)

Deprivation score:
42.6
(City average: 33.2)

Key features from MOSAIC

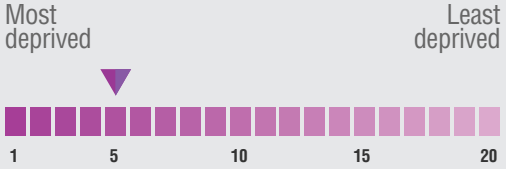
experian

Key feature 1
Private renters

Key feature 2
Low length of residence

Key feature 3
Low cost housing

City deprivation ranking: 5



0-24 age group

Starting and Developing Well

29.7%
of pupils achieved grade 9-5 English and Maths GCSE

This is close to the city average

33.7
teenage pregnancies per 1,000 under-18 yr olds

This is close to the city average

117.7
children per 10,000 are in **Local Authority Care**

This is close to the city average

Childhood obesity

29.9%
of children at **year 6 are obese**

This is worse than the city average

25-64 age group

Healthy Life Expectancy

6.2%
claimed **unemployment benefits** in November 2017

This is worse than the city average

17.5%
of houses with one or more **category 1 hazards** identified

This is close to the city average

Predominant clusters from Healthy Lifestyle survey

1. **Healthy Weight Poor Lifestyle**
2. **Overweights**
3. **Used to Smoke**

65+ age group

Healthy Ageing

11.0%
of people **providing unpaid care** are in **bad or very bad health**

This is worse than the city average

17.4%
of people over 65 years old have an **illness that limits their daily activities**

This is better than the city average

154
people per 100k are living in **residential or nursing care** permanently

This is better than the city average

15.6%
of people aged 65 years and over have **below average or very low wellbeing**

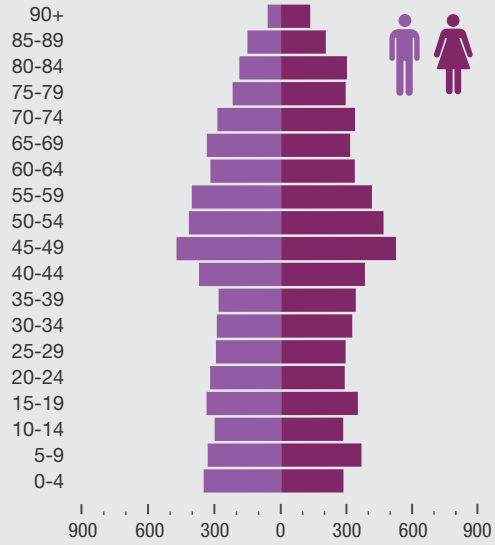
This is worse than the city average

Your ward at a glance:

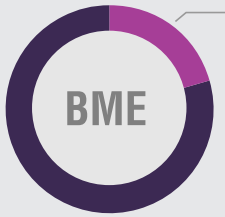
Tettenhall Regis

Wards

Total population: **11,820**



Key Demographic Facts



22.2%
of the population is
Black or Minority Ethnic
(City average: 32%)

Deprivation score:
13.6
(City average: 33.2)

Key features from MOSAIC

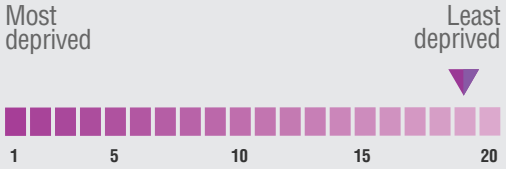
experian

Key feature 1
Younger households

Key feature 2
Full-time employment

Key feature 3
Private suburbs

City deprivation ranking: **19**



0-24 age group

Starting and Developing Well

47.3%
of pupils achieved grade 9-5 English and Maths GCSE

This is better than the city average

7.2
teenage pregnancies per 1,000 under-18 yr olds

This is better than the city average

39.2
children per 10,000 are in **Local Authority Care**

This is better than the city average

Childhood obesity

23.5%
of children at **year 6 are obese**

This is close to the city average

25-64 age group

Healthy Life Expectancy

1.8%
claimed **unemployment benefits** in November 2017

This is better than the city average

15.8%
of houses with one or more **category 1 hazards** identified

This is close to the city average

Predominant clusters from Healthy Lifestyle survey

1. **Healthy Eaters**
2. **Healthy Weight Poor Lifestyle**
3. **Drinkers and Smokers**

65+ age group

Healthy Ageing

5.7%
of people **providing unpaid care** are in **bad or very bad health**

This is better than the city average

28.4%
of people over 65 years old have an **illness that limits their daily activities**

This is close to the city average

3,039
people per 100k are living in **residential or nursing care** permanently

This is close to the city average

4.9%
of people aged 65 years and over have **below average or very low wellbeing**

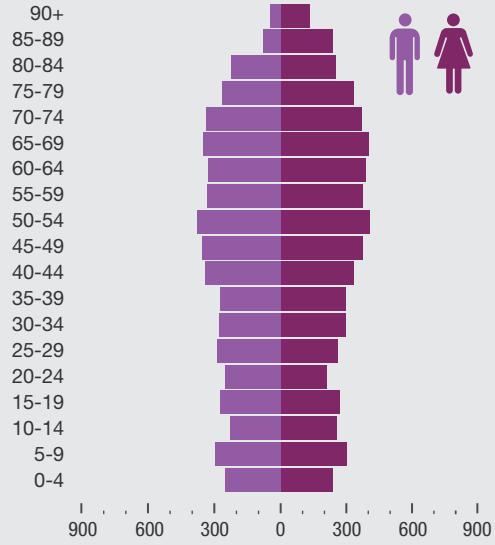
This is better than the city average

Your ward at a glance:

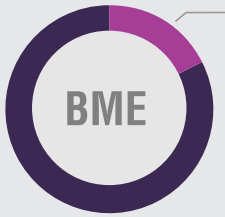
Tettenhall Wightwick

Wards

Total population: **10,946**



Key Demographic Facts



17.6%
of the population is
Black or Minority Ethnic
(City average: 32%)

Deprivation score:
14.2
(City average: 33.2)

Key features from MOSAIC

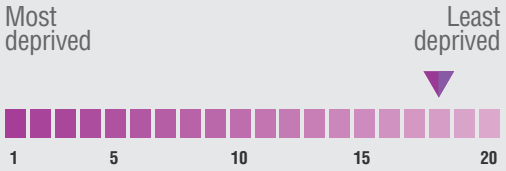
experian

Key feature 1
High value detached homes

Key feature 2
Married couples

Key feature 3
Managerial and senior positions

City deprivation ranking: **18**



0-24 age group

Starting and Developing Well

38.7% of pupils achieved grade 9-5 English and Maths GCSE

This is close to the city average

12.3 **teenage pregnancies** per 1,000 under-18 yr olds

This is better than the city average

<25 children per 10,000 are in **Local Authority Care**

This is better than the city average

Childhood obesity

17.7% of children at **year 6 are obese**

This is better than the city average

25-64 age group

Healthy Life Expectancy

1.9% claimed **unemployment benefits** in November 2017

This is better than the city average

11.7% of houses with one or more **category 1 hazards** identified

This is better than the city average

Predominant clusters from Healthy Lifestyle survey

1. Healthy Eaters
2. Healthy Weight Poor Lifestyle
3. Overweights

65+ age group

Healthy Ageing

6.1% of people **providing unpaid care** are in **bad or very bad health**

This is better than the city average

25.1% of people over 65 years old have an **illness that limits their daily activities**

This is close to the city average

957 people per 100k are living in **residential or nursing care** permanently

This is better than the city average

7.7% of people aged 65 years and over have **below average or very low wellbeing**

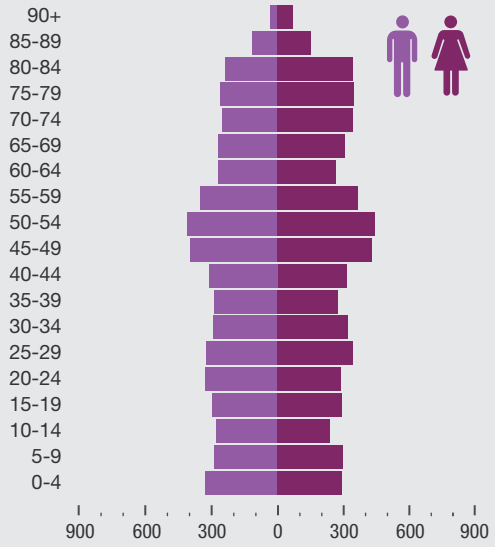
This is close to the city average

Your ward at a glance:

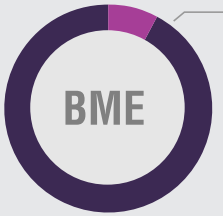
Wednesfield North

Wards

Total population: **11,019**



Key Demographic Facts



8.0%
of the population is
Black or Minority Ethnic
(City average: 32%)

Deprivation score:
27.3
(City average: 33.2)

Key features from MOSAIC

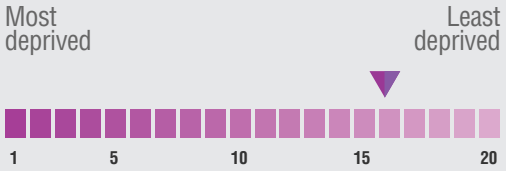
experian

Key feature 1
Mature age

Key feature 2
Homeowners

Key feature 3
Affordable housing

City deprivation ranking: **16**



0-24 age group

Starting and Developing Well

32.9% of pupils achieved grade 9-5 English and Maths GCSE

This is close to the city average

19.9 **teenage pregnancies** per 1,000 under-18 yr olds

This is better than the city average

43.3 children per 10,000 are in **Local Authority Care**

This is better than the city average

Childhood obesity

25.2% of children at **year 6 are obese**

This is close to the city average

25-64 age group

Healthy Life Expectancy

3.3% claimed **unemployment benefits** in November 2017

This is close to the city average

13.8% of houses with one or more **category 1 hazards** identified

This is better than the city average

Predominant clusters from Healthy Lifestyle survey

1 Healthy Eaters

2 Healthy Weight Poor Lifestyle

3 Overweights

65+ age group

Healthy Ageing

8.4% of people **providing unpaid care** are in **bad or very bad health**

This is close to the city average

31.1% of people over 65 years old have an **illness that limits their daily activities**

This is worse than the city average

2,316 people per 100k are living in **residential or nursing care** permanently

This is close to the city average

5.7% of people aged 65 years and over have **below average or very low wellbeing**

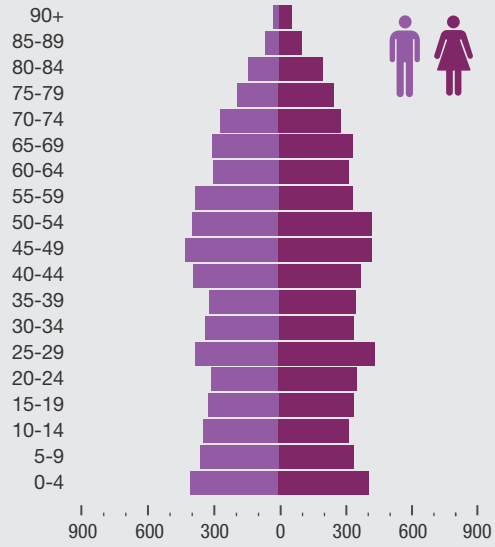
This is better than the city average

Your ward at a glance:

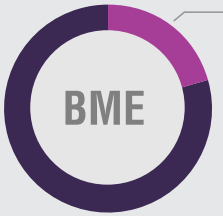
Wednesfield South

Wards

Total population: **11,510**



Key Demographic Facts



20.7%
of the population is
Black or Minority Ethnic
(City average: 32%)

Deprivation score:
27.9
(City average: 33.2)

Key features from MOSAIC

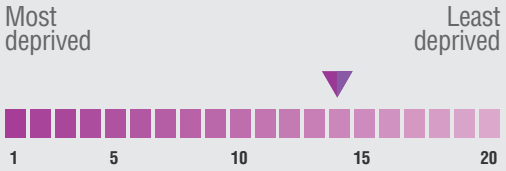
experian

Key feature 1
Elderly

Key feature 2
Living alone

Key feature 3
Low income

City deprivation ranking: 14



0-24 age group

Starting and Developing Well

35.9%
of pupils achieved grade 9-5 English and Maths GCSE

This is close to the city average

24.7
teenage pregnancies per 1,000 under-18 yr olds

This is close to the city average

63.0
children per 10,000 are in **Local Authority Care**

This is close to the city average

Childhood obesity

21.7%
of children at **year 6 are obese**

This is better than the city average

25-64 age group

Healthy Life Expectancy

3.6%
claimed **unemployment benefits** in November 2017

This is close to the city average

15.0%
of houses with one or more **category 1 hazards** identified

This is close to the city average

Predominant clusters from Healthy Lifestyle survey

1 **Overweights**

2 **Healthy Weight Poor Lifestyle**

3 **Healthy Eaters**

65+ age group

Healthy Ageing

6.9%
of people **providing unpaid care** are in **bad or very bad health**

This is better than the city average

29.8%
of people over 65 years old have an **illness that limits their daily activities**

This is worse than the city average

652
people per 100k are living in **residential or nursing care** permanently

This is better than the city average

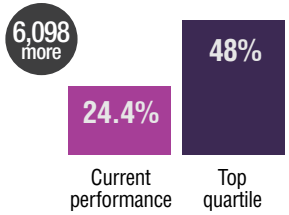
10.2%
of people aged 65 years and over have **below average or very low wellbeing**

This is close to the city average

Contracted services

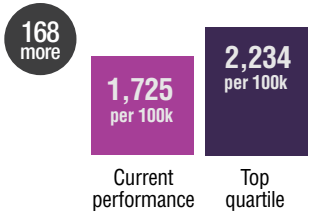
We aim to improve the performance of our contracted services to be in the top 25% of the country. This performance level is described as “top quartile”. This will help us to deliver the key priorities under each of the workstreams. This equates to the following performance standards which will be driven through our contracts.

NHS Health Checks



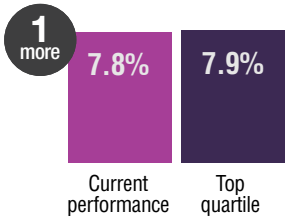
40 - 70 year olds
6,098 extra health checks
needed per year to hit top quartile

STI Screening

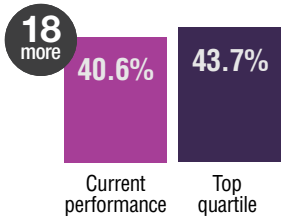


Chlamydia
168 more people detected
needed to hit top quartile

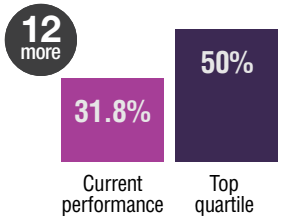
Drugs and Alcohol Treatment Completion Rates



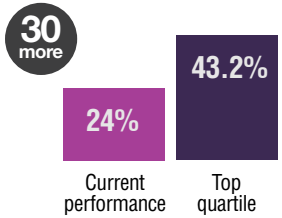
Opiates
1 more completion
needed to hit top quartile



Alcohol
18 more completions
needed to hit top quartile

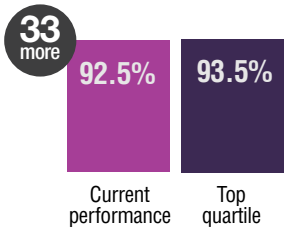


Non-opiates
12 more completions
needed to hit top quartile



Alcohol and non-opiate
30 more completions
needed to hit top quartile

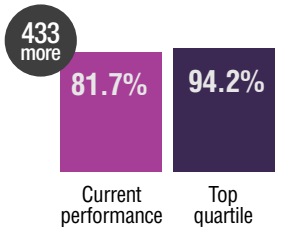
Healthy Child Programme (0-19s) four mandated check areas of the Health Visiting service



New born visit within 14 days

33 more visits

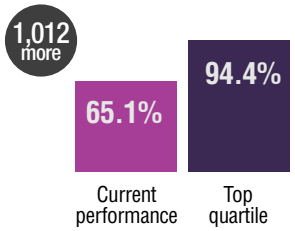
needed to hit top quartile



6-8 week review

433 more

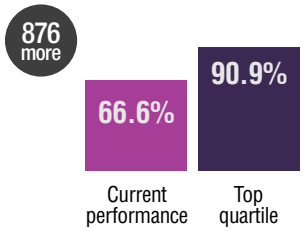
needed to hit top quartile



12 month review

1,012 more

needed to hit top quartile

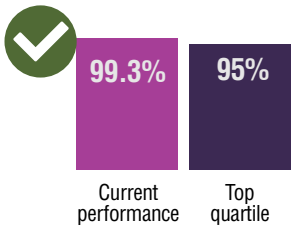


2-2½ year review

876 more

needed to hit top quartile

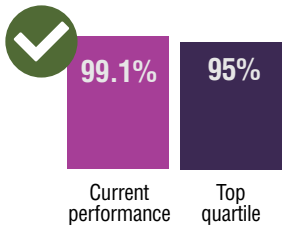
National Child Measurement Programme



Year R

We are already exceeding top quartile!

National Child Measurement Programme



Year 6

We are already exceeding top quartile!

Conclusion

Public Health has been through a restructure which has left the team skilled and excited to work differently. The new approach seeks to strengthen existing relationships with our wider colleagues; work at the population level on entrenched issues across the whole of the City; and target work at reducing inequalities on explicit issues in defined locations. This annual report has set the scene of an era of an ageing population with complex health needs, increasing austerity and a recognised growing increase in the gap of life expectancy between the richer and poorer regions across Britain. This could make our job tougher and we could see a decrease in our key indicator of healthy life expectancy.

However, a true marker of our success to embed our new model of working, vision and work plans will be that next year's Annual Report is written in partnership with the whole system and can demonstrate achievements in areas such as joint planning and project initiation; short, medium and longer-term plans to tackle entrenched problems in the system whilst reducing inequalities. We should also see improved performance in our services due to a more collaborative and supportive approach with providers.

This year we are taking our first steps in the journey of meeting our 2030 vision, by which time we aspire that life expectancy for men will have improved to 81 years and to 84 for women. We will also see improvements in healthy life expectancy in men to 66 and in women to 69 years of age whilst reducing the gap in life expectancy between the richest and poorest for men to eight years and for women to six years.

Appendix 1. Ward indicators

Compared to city avg. Worse Similar Better

Starting and Developing Well

Ward	0-24 population	Educational attainment % achieving a 9-5 English and Maths GCSE 2016/17	Infant mortality rate per 1,000 2007-2016	Under 18 conception rate per 1,000 2013-15	% Children in poverty – Income deprivation affecting children 2015	LAC rate per 10k population 2018	Oral health – mean dmft in children aged 5 2014/15	% Obese at year R 2012/13-2016/17	% Obese at year 6 2012/13-2016/17
Bilston East	5005	24.2	6.7	35.9	43.0	117.7	1.0	15.5	30.4
Bilston North	3869	31.9	8.1	40.4	35.2	96.9	0.9	11.5	29.3
Blakenhall	4215	42.1	9.9	26.3	25.6	99.6	1.3	16.0	28.1
Bushbury North	3437	28.1	9.0	28.3	26.4	105.6	0.7	9.4	25.9
Bushbury South and Low Hill	6363	24.6	6.0	49.0	43.2	190.2	1.1	13.8	28.1
East Park	4248	25.4	2.1	55.5	43.6	197.9	1.1	12.8	27.2
Ettingshall	5578	29.5	7.2	34.2	39.5	189.6	1.5	12.8	25.9
Fallings Park	4008	27.5	6.9	37.5	36.2	134.5	0.9	11.5	28.8
Graiseley	3926	38.9	3.4	35.9	30.2	139.0	1.4	12.6	25.5
Heath Town	5505	34.2	8.1	42.3	38.3	119.5	1.5	14.3	27.1
Merry Hill	3425	42.3	7.2	22.9	18.5	62.8	0.7	11.0	21.6
Oxley	4124	31.5	6.9	27.9	31.9	81.5	0.7	14.5	26.1
Park	3523	44.7	5.2	34.9	25.1	98.0	1.0	12.0	22.5
Penn	3313	47.2	6.3	10.1	10.9	<25	0.5	9.9	20.5
Spring Vale	3667	29.4	4.8	18.5	30.5	56.3	0.7	11.6	25.7
St Peter's	5843	29.7	11.2	33.7	35.4	117.7	1.8	13.5	29.9
Tettenhall Regis	3172	47.3	3.5	7.2	12.5	39.2	0.8	7.9	23.5
Tettenhall Wightwick	2587	38.7	3.3	12.3	14.9	<25	0.6	9.2	17.7
Wednesfield North	2932	32.9	5.2	19.9	24.0	43.3	0.6	13.4	25.2
Wednesfield South	3456	35.9	4.8	24.7	27.1	63.0	0.6	12.6	21.7
Wolverhampton	82196	35.2	6.6	30.0	31.3	110.6	1.01	12.4	26.0
West Midlands	-	39.3	4.3	28.6	-	75	0.7	10.4	21.4
England	-	39.1	5.9	26.1	19.9	62.0	0.8	9.4	19.4

- data unavailable

Compared to city avg. Worse Similar Better

Healthy Life Expectancy

Ward	24-64 population	Unemployment – % claiming benefits Jan-18	% highest qualification degree/NVQ 5 or higher for those aged 16-64 2016	DSR per 100,000 Alcohol admissions 2013/14-2015/16	% Smoking prevalence 2016	% of houses with 1 or more cat. 1 HHSRS hazard identified 2016	DSR rate per 100k diabetes prevalence 2017	Predominant cluster from healthy lifestyles survey 2016	Predominant cluster 2 from healthy lifestyles survey 2016	Predominant cluster 3 from healthy lifestyles survey 2016
Bilston East	7459	4.8	12.1	336.2	26.0	13.4	1511.3	Healthy Weight Poor Lifestyle	Obese and Average Wellbeing	Overweights
Bilston North	6145	3.7	7.6	303.6	19.7	14.9	1182.1	Healthy Weight Poor Lifestyle	Overweights	Obese & Average Wellbeing
Blakenhall	6588	3.9	23.7	453.8	13.0	20.9	2269.8	Healthy Weight Poor Lifestyle	Overweights	Healthy Eaters
East Park	6478	6.1	12.9	285.4	20.4	14.0	1459.3	Healthy Weight Poor Lifestyle	Obese and Average Wellbeing	Used to Smoke
Ettingshall	7955	5.0	11.8	477.4	30.9	17.7	2035.2	Healthy Weight Poor Lifestyle	Overweights	Used to Smoke
Spring Vale	5956	3.3	13.5	257.0	22.1	14.6	1063.6	Healthy Weight Poor Lifestyle	Obese and Average Wellbeing	Overweights
Bushbury North	6059	3.3	10.0	235.9	18.3	14.5	1352.3	Healthy Weight Poor Lifestyle	Used to Smoke	Healthy Eaters
Bushbury S. & Low Hill	7810	5.6	14.9	401.3	31.9	17.3	1733.2	Healthy Weight Poor Lifestyle	Overweights	Obese and Average Wellbeing
Fallings Park	6164	4.3	14.2	248.5	20.6	17.2	1406.6	Overweights	Healthy Weight Poor Lifestyle	Obese and Average Wellbeing
Heath Town	8090	5.5	12.9	392.8	27.9	13.2	1543.6	Healthy Weight Poor Lifestyle	Obese and Average Wellbeing	Overweights
Oxley	6822	3.9	14.0	259.6	22.1	12.3	1357.9	Healthy Weight Poor Lifestyle	Overweights	Healthy Eaters
Wednesfield North	5376	3.3	14.1	261.8	20.4	13.8	1149.2	Healthy Eaters	Healthy Weight Poor Lifestyle	Overweights
Wednesfield South	5853	3.6	16.1	299.3	29.3	15.0	1118.0	Overweights	Healthy Weight Poor Lifestyle	Healthy Eaters
Graiseley	6856	5.1	17.3	458.5	26.0	20.9	1779.6	Healthy Weight Poor Lifestyle	Overweights	Healthy Eaters
Merry Hill	6071	3.0	11.2	452.5	28.0	15.4	1129.9	Healthy Weight Poor Lifestyle	Overweights	Drinkers and Smokers
Park	7001	5.0	29.6	462.1	17.3	21.9	1487.9	Vigorously Active	Healthy Weight Poor Lifestyle	Drinkers and Smokers
Penn	6377	1.7	31.3	146.1	12.8	17.7	1059.1	Healthy Eaters	Healthy Weight Poor Lifestyle	Overweights
St Peter's	7194	6.2	17.1	476.3	24.6	17.5	2329.3	Healthy Weight Poor Lifestyle	Overweights	Used to Smoke
Tettenhall Regis	5855	1.8	29.0	207.3	12.3	15.8	1042.7	Healthy Eaters	Healthy Weight Poor Lifestyle	Drinkers and Smokers
Tettenhall Wightwick	5320	1.9	32.5	137.8	14.2	11.7	1009.7	Healthy Eaters	Healthy Weight Poor Lifestyle	Overweights
Wolverhampton	131429	4.2	16.6	325.7	22.5	15.9	1451.0	Healthy Weight Poor Lifestyle	Overweights	Healthy Eaters
West Midlands	-	2.4	31.5	-	15.4	-	-			
England	-	1.9	37.9	-	15.5	-	-			

- data unavailable

Compared to city avg. Worse Similar Better

Healthy Ageing

Ward	65+ population	% people providing unpaid care provision 2011	% people providing unpaid care in bad or very bad health 2011	% Limiting illness which limits daily activities a little or a lot 2016	Male Life expectancy at birth 2012-16	Female Life expectancy at birth 2012-16	DSR per 100,000 falls admissions in 65+ 2011/12-2015/16	DSR per 100,000 respiratory admissions in 65+ 2011/12-2015/16	DSR rate per 100,000 dementia prevalence 2017	Permanent placements in residential or nursing care rate per 100,000 65+ 2015/16-Oct 2017/18	Community based service provision* rate per 100,000 65+ 2015/16-Oct 2017/18	% below average or very low wellbeing 65+ 2016	Income Deprivation Affecting Older People Index (IDAOPI) 2015	% Fuel poverty 2016
Bilston East	2078	10.6	10.2	28.5	76.3	80.9	2305.3	2106.2	186.0	1660	6249	14.6	35.9	11.5
Bilston North	2283	11.4	8.2	20.4	78.0	82.0	1938.0	1781.4	137.0	1596	4788	8.1	25.6	11.4
Blakenhall	1987	10.3	8.3	21.4	76.2	79.7	1880.1	1817.2	290.6	8622	4682	12.8	29.5	16.4
Bushbury North	2475	12.2	7.8	22.6	77.1	83.8	1910.8	1795.9	126.6	1817	4636	8.3	22.3	10.7
Bushbury S. & Low Hill	1680	9.7	9.0	28.0	73.8	77.8	2722.1	2541.4	251.5	3945	5399	21.6	34.9	17.3
East Park	2166	9.9	10.3	28.9	77.3	80.4	2407.9	2296.7	168.3	1646	4796	10.9	31.6	12.5
Ettingshall	1712	9.2	7.4	18.5	75.5	80.7	1991.2	1704.3	245.7	2060	4709	12.7	34.5	15.3
Fallings Park	2027	11.2	7.1	30.3	77.0	81.9	2154.5	1978.5	193.0	2180	4016	7.2	25.6	13.1
Graiseley	1825	10.5	7.2	22.3	74.8	80.5	1988.3	1807.7	267.7	4864	6180	10.5	31.5	15.8
Heath Town	1495	8.3	9.3	24.3	74.9	78.6	2209.8	2009.7	212.9	4304	4615	10.6	35.8	18.4
Merry Hill	2435	13.0	7.1	34.1	79.6	82.9	1996.4	1348.5	110.0	143	4871	20.0	19.9	11.3
Oxley	1877	10.5	7.3	25.2	78.1	82.3	2130.5	1609.7	135.8	1673	4047	9.4	27.4	9.7
Park	1956	10.3	6.5	18.6	76.5	79.7	1822.4	1675.9	306.6	9670	4419	14.6	21.4	16.2
Penn	2818	12.6	4.6	21.5	81.4	83.5	1957.8	1262.9	183.2	3851	4374	5.9	14.1	10.9
Spring Vale	2431	11.2	9.1	27.5	78.5	83.8	2556.2	1670.3	198.7	3396	5102	4.4	24.3	10.4
St Peter's	1007	7.5	11.0	17.4	76.6	83.0	1556.4	1907.8	193.7	154	8506	15.6	43.5	19.2
Tettenhall Regis	2793	12.7	5.7	28.4	78.9	83.3	1870.9	1290.9	182.7	3039	3317	4.9	10.9	10.4
Tettenhall Wightwick	3039	13.4	6.1	25.1	81.5	84.8	2125.8	1261.0	132.7	957	3444	7.7	14.9	9.9
Wednesfield North	2711	13.1	8.4	31.1	79.1	82.9	2078.9	1802.1	166.1	2316	4318	5.7	21.6	10.1
Wednesfield South	2201	11.5	6.9	29.8	77.9	83.3	1875.7	1715.2	108.4	652	4455	10.2	21.8	11.1
Wolverhampton	42996	10.9	7.8	25.1	77.5	81.8	2067.5	1744.0	189.9	3228	4762	10.3	25	13.1
West Midlands	-	10.2	7.1	19.0	78.8	82.7	2068.0	-	-	-	-	-	-	-
England	-	11.0	6.6	17.6	79.5	83.1	2114.0	-	-	-	-	-	16.2	10.6

- data unavailable

Appendix 2. Healthy Lifestyle Clusters

The Wolverhampton population was segmented into 10 clusters following a lifestyle survey of over 7,000 representative individuals.

Cluster 1: **Vigorously Active**

643, 8.7% of total sample population, 22,326 of Wolverhampton population

Individuals in this cluster have higher wellbeing compared to the overall population. The majority of this cluster have never smoked and are more likely to be a healthy weight. People in this cluster are much less likely to be high risk drinkers and more likely to eat healthily, however, a substantial number still eat unhealthily.

Dominant features:

- Male
- Under 39
- Asian ethnic background
- Mainly working population
- Students
- Most likely to have higher level qualifications

Ward with largest distribution:

- Park
- Spring Vale

Cluster 2: **Healthy Eaters**

924, 12.5% of total sample population, 32,078 of Wolverhampton population

More likely to have higher wellbeing compared to the overall population. People in this cluster are less likely to be smokers and high-risk drinkers. Substantially less likely to be obese and more likely to be a healthy weight, however, slightly more in this cluster are overweight than compared to the overall average. Individuals in this cluster are not vigorously active.

Dominant features:

- Female
- Over 65
- Mainly white
- Working/retired
- Deprived under represented

Ward with largest distribution:

- Tettenhall Wightwick
- Tettenhall Regis

Cluster 3:
Used to Smoke

757, 10.2% of total sample population, 26,175 of the Wolverhampton population

These individuals are most likely to have average wellbeing. Although most of this cluster are not vigorously active they are more likely to be moderately active. Healthy eating is not significantly different from the overall population level. This cluster is less likely to abstain from drinking alcohol compared to the overall population, however, they have similar levels of high risk drinking. People from this cluster are more likely to be overweight and significantly more likely to be obese.

Dominant features:

- Slightly more Males
- Over 70
- White over represented
- Retired over represented
- Deprived
- Less likely to have high level qualifications

Ward with largest distribution:

- St Peters
- Bushbury North

Cluster 4:
Healthy Weight Poor Lifestyle

1529, 20.6% of total sample population, this is the largest cluster, 52, 864 of the Wolverhampton population

People in this cluster are more likely to have average wellbeing. Despite being a healthy weight nearly all the people in this cluster eat unhealthily. Compared to the overall population people in this cluster are more likely to be smokers. People from this cluster mainly abstain from drinking and none are high risk drinkers. They are much less likely to engage in vigorous activity.

Dominant features:

- More females
- More aged under 29
- Deprived
- Over representation of students

Ward with largest distribution:

- Bushbury South and Low Hill
- Graiseley

Cluster 5:
Overweights

1137, 15.3% of total sample population, progression from cluster 4, 39,263 of the Wolverhampton population

People in this cluster are more likely to have average wellbeing. All of the people in this cluster eat unhealthily however, most do not smoke and none are high risk drinkers. This cluster is much less likely to engage in vigorous activity.

Dominant features:

- Equal gender
- Younger population
- Over-representation of Asian population
- Most work full time also high retired
- More likely to have no qualifications

Ward with largest distribution:

- Graiseley, St Peters
- Ettingshall

Cluster 6:
Drinkers and Smokers

685, 9.2% of total sample population, 23,609 of the Wolverhampton population

Nearly half of people in this cluster are current smokers, significantly higher than the overall population. The majority of those in this cluster have average wellbeing. For this cluster people are more likely to be overweight and less likely to be obese compared with the overall population. For this cluster activity levels and healthy eating behaviour are also worse than the overall population.

Dominant features:

- Males
- Aged 25-49
- White
- Deprived under-represented
- Work full time
- Unemployed over represented

Ward with largest distribution:

- Tettenhall Regis
- Graiseley

Cluster 7:
Obese and Average Wellbeing

908, 12.2% of total sample population, 31,308 of the Wolverhampton population

The overwhelming majority of those in this cluster have average wellbeing. People in this cluster have similar healthy eating behaviour to the overall population and are less likely to be vigorously/moderately active. However most of this cluster do not smoke and are most likely to abstain or drink at low risk.

Dominant features:

- Females
- Over 50
- Slight over-representation of black population
- Work full time but retired over represented
- More likely to have no qualifications

Ward with largest distribution:

- Bilston East
- Heath Town

Cluster 8:
Underweights

208, 2.8% of total sample population, 7,185 of the Wolverhampton population

The majority of this cluster eat unhealthily and are much more likely to be smokers. More of this cluster abstains from drinking. This cluster has a similar profile for wellbeing as the overall population. Moderate activity levels for this cluster are just below the overall population average whilst vigorous activity is slightly higher.

Dominant features:

- Female
- Under 29
- Asian population over-represented
- Deprived
- Students and unemployed over represented

Ward with largest distribution:

- Bushbury South and Low Hill
- Fallings Park

Cluster 9:
Below Average Wellbeing

456, 6.2% of total sample population, 15,911 of the Wolverhampton population

People in this cluster are much more likely to be obese, smoke and not take part in vigorous/moderate activity. In addition, they are much more likely to eat unhealthily. Rates of high risk drinking for this cluster are a little lower than the levels for the overall population and they are slightly more likely to abstain from alcohol.

Dominant features:

- Slightly more females
- Over 40
- White
- Deprived
- Retired/ long term sick disabled
- More likely to have no qualifications

Ward with largest distribution:

- Bushbury South and Low Hill
- Merry Hill

Cluster 10:
Very Low Wellbeing

167, 2.3% of total sample population, progression from cluster 9, 5,902 of the Wolverhampton population,

People in this cluster are much more likely to eat unhealthily, not take part in moderate/vigorous activity, smoke and be obese. However, they are more likely to abstain from drinking alcohol but have higher risk drinking rates similar to the overall population level.

Dominant features:

- Slightly more females
- 45-64
- White
- Deprived
- Unemployed/ long term sick-disabled
- More likely to have no qualifications

Ward with largest distribution:

- Bushbury South and Low Hill
- Merry Hill
- Bilston East

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Agenda Item No: 8

CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

11 April 2018

Report title	City of Wolverhampton Vision for Public Health 2030	
Cabinet member with lead responsibility	Councillor Paul Sweet Public Health	
Wards affected	All	
Accountable director	John Denley, Director of Public Health	
Originating service	Public Health	
Accountable employee(s)	John Denley Tel Email	Director of Public Health 01902 551095 John.Denley@wolverhampton.gov.uk
Report to be/has been considered by	People Leadership Team Strategic Executive Board	26 March 2018 27 March 2018

Recommendation for action:

The Health and Wellbeing Board is recommended to endorse the Vision for Public Health.

1.0 Purpose

1.1 To inform the Board of the development of a Vision for Public Health for the City of Wolverhampton by 2030. The Vision provides an approach and framework for improving the health and wellbeing and reducing inequalities of the city's population.

1.2 This report is being presented to the Board to seek their formal approval of the final version of the Vision.

2.0 Background

2.1 Since 2013 the City of Wolverhampton has seen a reduction in life expectancy of its residents and a widening of the gap between the health of our wealthiest and most deprived communities. This has resulted in the need to reframe our approach to improving the health and wellbeing of the city's residents, which is captured in this document.

3.0 Vision for Public Health

3.1 Having the best start in life, an excellent education, a stable, rewarding job and a decent home in a thriving community are the strongest factors that influence both how long a person is likely to live and their quality of life.

3.2 Evidence suggests that getting these factors right, coupled with enabling access to high quality health and care services, will have a significant impact on the behaviours, lifestyle choices and health of our residents. This Vision focusses on making the greatest impact on these areas that influence health and wellbeing and outlines a way of working that will help support doing so.

4.0 Financial implications

4.1 Funding for Public Health is provided to the Council by the Department of Health in the form of a ring-fenced grant. The final grant allocation for 2018-2019 is £20.8 million. There are no direct financial implications arising from this report.
[MI/26032018/J]

5.0 Legal implications

5.1 There are no direct legal implications related to this report.
[RB/27032018/T]

6.0 Equalities implications

6.1 This report does highlight health inequalities that are known and addressed through the priorities outlined and the services commissioned by Public Health.

7.0 Environmental implications

7.1 There are no direct environmental implications arising from this report.

8.0 Human resources implications

8.1 There are no direct human resource implications arising from this report.

9.0 Corporate landlord implications

9.1 There are no direct corporate landlord implications arising from this report.

10.0 Schedule of background papers

10.1 There are no background papers in relation to this report.

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The vision for Public Health 2030

Longer, healthier lives

wolverhampton.gov.uk

CITY OF WOLVERHAMPTON COUNCIL

Our vision for the City of Wolverhampton in 2030

In 2030 the City of Wolverhampton will be a healthy, thriving city of opportunity where we…

CELEBRATE **ENTERPRISE, EDUCATION AND SKILLS**

HAVE A **CITY CENTRE** WE'RE PROUD OF

ARE SERIOUS ABOUT BOOSTING **HEALTH AND WELLBEING**

have a vibrant civic society that's focussed on the future, empowers local communities and is supported by local businesses and institutions

are committed to **sustainability** for future generations

all play our part in creating a confident, buzzing city that's synonymous with **ambition, innovation** and **inclusion**

have a **buoyant** and **resilient economy** that includes international manufacturing companies with local roots and a strong, vibrant and innovative business base

retain more of the value produced by our economy to **benefit the whole city**

have world class public services that **continually improve** and have collaboration and co-production at their heart

care and are **confident** about our **diversity**

make it **easy for businesses and visitors to access the city** and are well connected to the wider world through our infrastructure

Our vision for the health and wellbeing of our residents

By 2030,

our thriving City will:

- Help people live longer, healthier and more active lives
- Offer every child the best start in life
- Close the gap in healthy life expectancy between Wolverhampton and the England average
- Ensure everyone is protected from harm, serious incidents and avoidable health threats

To achieve these, we are aspiring to be a 'health improving council' by:

- Maximising the positive impact of the health and wellbeing of our residents across everything the Council delivers and buys and the policies which are developed
- Driving a City-wide focus on tackling the wider determinants of health and wellbeing
- Providing leadership with partners to prevent ill health, especially targeting those in our City whose outcomes are worse
- Improving health outcomes through the genuine integration of health and social care
- Ensuring our statutory Public Health duties continue to be delivered

Foreword
Councillor Paul Sweet, Cabinet Member for Public Health and Wellbeing and John Denley, Director of Public Health

Having the best start in life, an excellent education, a stable rewarding job and a decent home in a thriving community are the strongest factors that influence both how long a person is likely to live and their quality of life. We believe that getting these factors right, coupled with enabling access to high quality health and care services, will have a significant impact on the behaviours, lifestyle choices and health of our residents.

The repositioning of Public Health from the NHS to local government in 2013[1] provided an unprecedented opportunity for councils to have an additional positive impact on these factors.

Over the past five years the City of Wolverhampton Council has made some very good progress.

However, since 2013 we have seen a reduction in life expectancy and a widening of the gap between the health of our wealthiest and most deprived communities.

Too many of our residents also live the last 20 years of their life in poor health. Austerity and Government cuts to service provision play a part in this. The challenge then, within this context of continuing financial pressures, is to tackle some of the most entrenched issues which impact on the health of the whole population.

We believe we need to rethink our approach to improving health. Last year provided the opportunity to do so when key local partners came together and agreed the vision, 'New Horizons - Our Vision for the City of Wolverhampton in 2030[2].' This provides a blueprint for a sustainable, successful future for the next generation of Wulfrunians.

The New Horizons vision sets a tone, outlining a firm commitment to working in partnership towards a common goal whilst recognising that we all need to play our part. It has created the opportunity to transform our approach to improving the health of residents at a population level.

It involves moving away from providing traditional behaviour change services to individuals and focusing more on making a difference to the factors that influence healthy life expectancy at a population level.

To prepare for our new approach, Public Health is going through a transformation. We are building a service designed to offer expert public health advice and support to all parts of the Council and external partners, especially the NHS.

We recognise that our approach is ambitious and significantly different, but evidence and need has demonstrated that we must act now.

The improvements we want to make will take time to achieve. That is why we have chosen a range of short to medium term public health indicators which, if we deliver well, and in partnership, will show that we are moving in the right direction together.

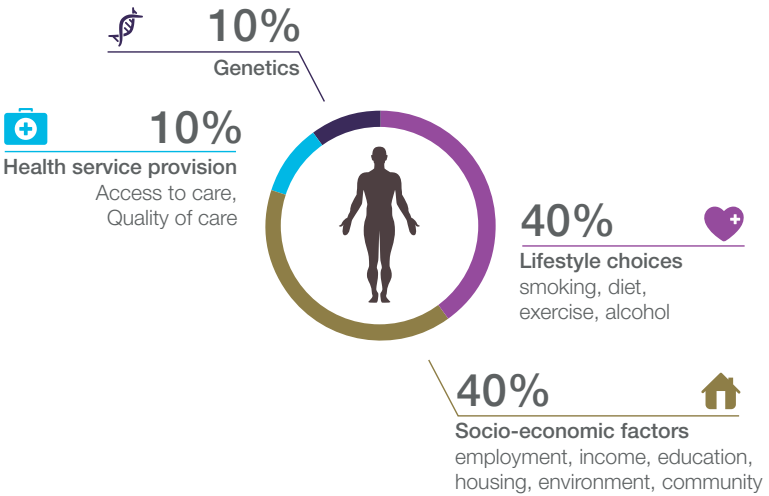
[1] Health and Social Care Act 2012. legislation.gov.uk/ukpga/2012/7/contents/enacted
[2] New Horizons - Our vision for the City of Wolverhampton in 2030. wolverhampton.gov.uk/vision2030

Photographs (left) Councillor Paul Sweet, Cabinet Member for Public Health and Wellbeing (right) John Denley, Director of Public Health

What factors influence our health?

The City of Wolverhampton is similar to most local authorities in that it faces common public health challenges. These include high obesity levels, smoking, alcohol misuse, rising levels of sexually transmitted infections, poor mental health and an ageing, unhealthy population.

There are a number of factors which strongly influence these challenges, making them very complex and difficult to tackle. The diagram below shows that these factors fall across four domains:



These factors are interrelated. For instance, residents who have a poor level of educational attainment are more likely to smoke.

Likewise, although harmful alcohol use is common across social groups, people with low incomes are more likely to be admitted to hospital with alcohol related conditions. Harmful alcohol use is exacerbated by poor mental health.

Evidence shows focusing on delivering services to individuals with unhealthy lifestyles, as we have done - such as stop smoking and weight management services - will not have a sustained positive impact on outcomes at a population level over the longer term.

We believe the scale and complexity of the challenges that Wolverhampton faces means that no single part of the system can make sustained progress on its own. This is why our approach will do more than support behaviour change and health services, but seek improvements in the broad factors which impact on people's lives. Only by working in partnership across the 'whole system,' on strategic, longer term goals, can we achieve good health for our population. In particular we seek to accelerate improvements in health for those groups which are most disadvantaged.

City health check - how do we compare?

1 in 3 children live in poverty

- 10% higher than the England average of 19.9%

22.5% of **adults smoke**

- rates improving
- higher than national average

Teenage pregnancies down from 56.8 per 1,000 in 2010 to 28 per 1,000 now

- rapid improvement since 2010
- higher average than England (17.7) and West Midlands (21.1)

School readiness rise from 44.2% in 2012/13 to 62.4% in 2017/18

- 18% improvement in last 4 years
- lower than national average of 69.3%

18%

24.5%

- 15.4% lower than the national average of 39.9%

of those eligible received an NHS health check in the last 5 years

Alcohol admissions rise to 897 per 100,000

- rates stabilising
- upward trend
- higher than rate of 647 admissions nationally

Childhood obesity

26.7% of children at year 6 are obese

- upward trend is continuing to increase
- higher than England average of 20%

Adult obesity

28.5% of adults are classified as obese

- higher than England average of 24.4%

At 5.6 per 1,000 our **infant mortality rate** is 7th highest of our 16 nearest neighbours

- improved in recent years
- higher than England average of 3.9 per 1,000

4.1% claimed **unemployment benefits** in November 2017

- improved from a high of 8% at the beginning of 2013
- higher than England average of 2%

25.2% of carers get as much social contact as they desire and this is the 2nd worst compared to our neighbours

- decreasing trend
- lower than 35.5% average for England

35.6% of pupils achieved grade 9-5 English and Maths GCSE

- trend recently improved
- lower than 39.6% in England, and 39.8% for the West Midlands

What do we want to achieve?

We want all residents of the City of Wolverhampton to live longer and have a good quality of life.

Being in good health for as long as possible (known as having a 'healthy life expectancy') will impact on relationships with family and friends, the ability to fully participate in the community, and contribute to the local economy. Staying in good health into older age is also closely related to how much support and care a person needs and their use of services such as adult social care.

In Wolverhampton actual life expectancy and healthy life expectancy for both males and females remains significantly lower than the national average. People living in Wolverhampton on average spend the last 20 years of their lives living with health related problems. Our vision is to increase life expectancy and healthy life expectancy considerably by 2030 as well as to close the gap in life expectancy between our richest and poorest communities.

Our targets for 2030

Male

- Healthy life expectancy (years)
- Life expectancy (years)

	2010	2015	2025	2030
Healthy life expectancy (years)	59.3	56.4	Continued improvement in line with our 2030 target	66
Life expectancy (years)	76.7	77.4		81
Gap between richest and poorest (years)	13.7	11.3		8

Female

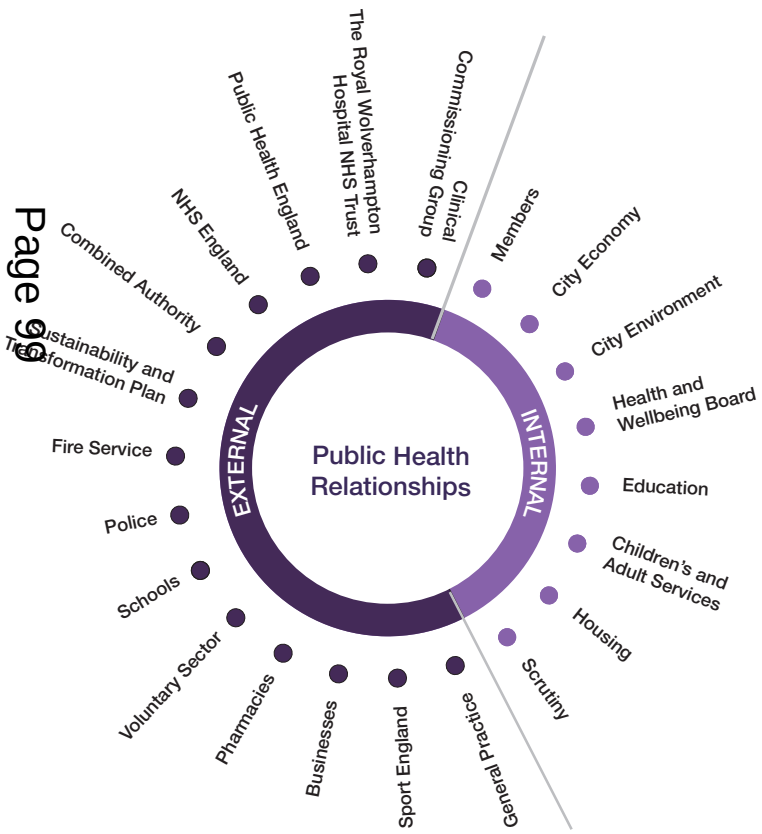
- Healthy life expectancy (years)
- Life expectancy (years)

	2010	2015	2025	2030
Healthy life expectancy (years)	58.3	59.5	Continued improvement in line with our 2030 target	69
Life expectancy (years)	80.3	81.4		84
Gap between richest and poorest (years)	9.6	9.5		6

Improvements we will see along the way

Priority	Indicators		
Starting and Developing Well (0-24 age group)	• Increase the number of children ready to enter school • Tackle inequalities in educational attainment	• Continue to reduce levels of teenage pregnancy • Continue to tackle infant mortality	• Top performer in chlamydia detection
Healthy Life Expectancy	• Reduce inequalities in employment rates • Reduce substance misuse related reoffending	• Top performer in drug and alcohol recovery • Reduce the number of rough sleepers	• Increase physical activity • Reduce smoking prevalence • Top performer in uptake of NHS Health Checks
Healthy Ageing	• Increase wellbeing of carers	• Increase uptake of influenza vaccination	• Keeping people well in their community
System Leadership	• Embed Public Health and prevention in an integrated health and social care system	• Joint intelligence unit established for the City	• Working together across the whole public sector to improve health outcomes

Who will we work with and how?



We want to maximise the health impact of everything we do through the City of Wolverhampton Council and extend this to the actions of our partners.

This is why the Council's Public Health service is being transformed to provide the necessary expertise and technical advice to help make this happen.

The repositioning of the service will deliver our statutory public health responsibilities while also offering public health advice and support internally to embed the idea of improving health and reducing inequalities to all parts of the Council.

The Council and public sector partners will be working together as one to transform health outcomes across the City. Public Health will support and provide external advice to partners beyond the NHS and social care in taking a place based approach.

Key to extending the reach of public health will be a service equipped with the skills to engage, influence and persuade, with the ability to tell the story using data and evidence, whilst continually strengthening relationships.

Our role will be to facilitate a more co-ordinated strategic development of longer term planning for entrenched and future issues in health and social care; to encourage partners to think more broadly than current crises and; importantly, to make investments now for the long term health of the population of Wolverhampton.

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Agenda Item No: 9

CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

11 April 2018

Report title	Health and Wellbeing Board – Development Event Issues Update
Cabinet member with lead responsibility	Councillor Roger Lawrence Health and Wellbeing Board Chair
Wards affected	All
Accountable director	David Watts, Director of Adults Services
Originating service	City Health
Accountable employee(s)	Brendan Clifford – Service Director – City Health Tel 01902 555370 Email Brendan.Clifford@wolverhampton.gov.uk Madeleine Freewood – Development Manager – City Health Tel 01902 553528 Email Madeleine.Freewood@wolverhampton.gov.uk
Report to be/has been considered by	People Leadership Team 19 March 2018 Strategic Executive Board 27 March 2018

Recommendation for action:

That the Health and Well Being Board (HWBB) note the updates from the issues considered at the Development Event in October 2017 and direct any further action as required.

1.0 Purpose

1.1 To update the HWBB on relevant factors related to issues considered at the October 2017 Development Event.

2.0 Background

2.1 At the Development Event on 18 October 2017, the HWBB requested that updates be provided at the meeting in April 2018. The three issues were:

- the work of the West Midlands Combined Authority Board (WMCA);
- the next phase for the use of estates and shared premises more productively;
- workforce issues.

3.0 West Midlands Combined Authority Board

3.1 Senior appointees were taking up their posts in the WMCA around the time of the HWBB October 2017 Development Event.

3.2 Councillor Sweet has continued to attend the WMCA Wellbeing Board where there are currently five main workstreams:

- Cardiovascular Disease and Diabetes – where initial focus has been on three areas:
  - Improving levels of physical activity in children and adults.
  - A WMCA/STP Prevention Programme.
  - Developing a West Midlands joint Local Government/Health Alliance - involving professionals and clinicians from local government and health organisations across the West Midlands to reduce health inequalities across the region by creating strong preventive pathways.

- Children and Young People - Scoping work/data analysis setting out the current West Midlands position has been undertaken. Detailed proposals for Children and Young People being considered in April 2018.

- WMCA Physical Activity Strategy – West Midlands on the Move.[1]

- Mental Health Strategy[2] under the “Thrive” heading with progress on-going in the following areas:
  - Employment and Employers.
  - Housing First.
  - Criminal Justice.
  - Improving Care.
  - Community Engagement.

[1] https://www.wmca.org.uk/what-we-do/public-service-reform/west-midlands-on-the-move/
[2] https://www.wmca.org.uk/what-we-do/mental-health-commission/

- Health and Transport Strategy – Focused on using transport to improve health by linking healthy travel with ambitions to manage demand for public services; improve productivity and close the inequality gap.

4.0 **Shared Approaches - Estates**

4.1 Health & Social Care Hub Solution:

4.2 The City of Wolverhampton Council has been successful in achieving "One Public Estate" (Round 5, 2016) funding for a feasibility study on the proposed Heath and Social Care Hub Solution. The Council is working in partnership with Community Health Partnerships which has been instrumental in the delivery of the feasibility.

4.3 The programme is progressing well, and Phase 1, the Health and Social Care Service Strategy is now complete. This has been endorsed by the Local Estates Forum which is represented by key stakeholders - Wolverhampton Clinical Commissioning Group (CCG), Royal Wolverhampton Trust (RWT), Black Country Partnership Foundation Trust (BCPFT) and Community Health Partnerships (CHP).

4.4 The Service Strategy is recommending a three-hub solution comprising:

- One hub solution in a location within the St Peter's area and including a broad range of primary, community, out of hospital services, social care and complimentary services.
- Two peripheral hub solutions including a range of primary, community, out of hospital services, mental health, social care and complimentary services located:
  - Towards the north-west area of Bilston East ward.
  - Towards the south-east area of Bushbury South and Low Hill ward and also serving the neighbouring population of Heath Town ward.

4.5 This model addresses the four priority populations with the most significant health needs. The three-hub solution can be delivered in phases and configured differently in terms of service offer, given their central (St Peter's) and peripheral (Bilston East and Bushbury/Heath Town) locations.

4.6 The project has now reached Phase 2 and the Council are currently out to tender to appoint an organisation that will undertake an outline business case on the estates based solutions of the above recommendations.

4.7 Public Sector Hub:

4.8 In December 2016, The Council was successful in achieving further One Public Estate Funding of £50,000 (Round 6) for a Public-Sector Hub feasibility. The Council is in the process of developing the Feasibility Delivery Plan together with timescales. The Council and RWT have match funded this project to give a total feasibility pot of £125,000.

4.9 Initial due diligence has been undertaken identifying interest from government organisations such as Department for Work and Pensions (DWP) and the NHS. This has led to discussions advancing, particularly with Public Health, CHP, the CCG, RWT, West Midlands Police and the University, which has clearly directed the site to be predominantly

health focussed. Given the scale of health services offered across the city, there is scope for consolidation and integration to make a significant impact in the conurbation.

5.0 Workforce

5.1 With regard to the social care workforce, there remains continued emphasis:

- Recruitment and retention of social workers for the Council's Children's and Young People's service.
- Developing the Careers into Care partnership for adult social care employees to maintain the quality of the workforce. Job Fairs have continued to be held since the HWBB Away Day and the city hosted a national Social Care Employer's Event where the City's Careers into Care Partnership achievements had been showcased at a previous meeting. This gave further opportunity to showcase the city activity to colleagues nationally and was well-received.

5.2 The NHS Local Workforce Action Board (LWAB) continues to be an active part of the Sustainability and Transformation Partnership structure and a prioritisation session was held in the City of Wolverhampton on 15 March 2018. Any feedback from this will be reported verbally to the Board.

5.3 Awareness of the economic value of care is widening building on the City of Wolverhampton's early work on the economic value of social care in the city published in 2016. A wider report on social care as a local economic solution for the West Midlands value of health care in the Black Country was completed in 2017 by the New Economic Foundation.[3] Likewise, in the health sector a report on the economic impact of healthcare in the Black Country was published by the Strategy Unit in 2017.[4]

5.4 With regard to the RWT, workforce supply continues to be the highest risk within the Trust. In line with the majority of NHS Trusts, the supply of appropriate workforce outstrips the demand and there are vacancies in a number of areas.

5.5 Given the age demographics of the NHS and the output from nursing and medical schools, this is a gap that is likely to be around for some time to come. To try and enhance the supply side of our workforce, overseas recruitment for nursing posts has been previously undertaken and the Trust is currently looking overseas for doctors with the Clinical Fellows Programme. However, the availability of Certificate of Sponsorship licences continues to be a challenge, as it does for most NHS Trusts.

5.6 In addition to this, the Trust has undertaken a number of larger scale recruitment events which have recently proved reasonably successful. The Trust is also expanding its target audience for recruitment and have had an increased focus on employing people who are leaving the armed forces.

5.7 Recognising that there is a finite supply of staffing resource, the Trust is also having an increased focus on retaining existing staff. This is being progressed through a number of

[3] http://neweconomics.org/wp-content/uploads/2017/09/West-Midlands-Social-Care-report.pdf
[4] http://www.strategyunitwm.nhs.uk/publications/economic-impact-nhs-spending-black-country-full-version

initiatives, such as considering options for more flexible working, reviewing the personal development offered to staff and reviewing the benefits provided to staff, whilst still working within a national framework for terms and conditions. New job roles are also being explored within the Trust to help address some of the vacancies but this is a much longer-term approach. Finally, like most Trusts, RWT is working to ensure that productivity is ensured through utilising a range of electronic tools such as e-roster.

6.0 Financial Implications

6.1 There are no direct financial implications arising from this report. Any action arising from this report will be met from existing budget held across the partner agencies.

6.2 The feasibility work outlined in section 2.4 is funded from a combination of grant funding from One Public Estate of £50,000 and partner contributions totalling £75,000 (CWC £50,000, and RWT £25,000).
[AS/22032018/J]

7.0 Legal Implications

7.1 The Health and Wellbeing Board is a statutory Board established under the Health and Social Care Act 2012. It has a statutory duty, with CCGs to produce a joint Strategic Needs Assessment and a joint Health and Wellbeing Strategy for its local population.
[RB/1903208/Z]

8.0 Equalities Implications

8.1 A shared approach to the development of community hubs will allow public services in the city to work more closely with local communities. This should support increased responsiveness to local need for all members of the community.

9.0 Environmental implications

9.1 There are no direct environmental implications arising from this report.

10.0 Human resources implications

10.1 There are no direct human resource implications arising from this report.. Agency workforce strategies will embrace the actions required to create and maintain a sustainable workforce.

11.0 Corporate landlord implications

11.1 There are no direct corporate landlord implications arising from this report.

12.0 Schedule of background papers

12.1 There are no background papers in relation to this report.

Agenda Item No: 10

CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

11 April 2018

Report title	City of Wolverhampton Partnership Response to People with No Recourse to Public Funds (NRPF)
Cabinet member with lead responsibility	Councillor Paul Sweet Public Health
Wards affected	All
Accountable director	John Denley, Director of Public Health
Originating service	Public Health
Accountable employee(s)	Neeraj Malhotra Consultant in Public Health Tel 01902 558667 Email Neeraj.Malhotra@wolverhampton.gov.uk
Report to be/has been considered by	People Leadership Team 19 March 2018 Strategic Executive Board 27 March 2018

Recommendations for action:

The Health and Wellbeing Board is recommended to:

1. Note the establishment of a multi-agency forum which is accountable to the Health and Wellbeing Board
2. Provide feedback on the proposed content of the multi-agency protocol for working with people with no recourse to public funds

1.0 Purpose

1.1 To bring together four separate areas of work that are all concerned with improving the response to people who have no recourse to public funds (NRPF).

1.2 This paper describes how these areas of work are interconnected.

2.0 Background

2.1 NRPF applies to migrants who are 'subject to immigration control' and as a result of this have no entitlement to certain welfare benefits, local authority housing and homelessness assistance.

The definition of 'subject to immigration control' is set out in section 115 (9) Immigration and Asylum Act 1999, and includes non-EEA nationals who:

- require leave to enter or remain in the UK but do not have it;
- have leave to enter or remain in the UK which is subject to a condition that they do not have recourse to public funds; or
- have leave to enter or remain in the UK given as a result of a maintenance undertaking (for example, adult dependant relatives of people with settled status).

2.2 The three criteria outlined above belie the complexities that can be faced because different types of migrants can have NRPF status. It does not necessarily mean they are in the UK unlawfully.

2.3 Despite the NRPF condition, families and individuals may have a right to financial assistance (accommodation and subsistence) from Social Services to avoid destitution.

2.4 The City of Wolverhampton Council has developed a No Recourse to Public Funds Policy and procedure document that is scheduled to be considered by the Cabinet in April 2018. This Policy focuses on social care and welfare rights.

3.0 Four distinct areas of work that are all related to NRPF

The four distinct areas that will be brought together are:

- The City of Wolverhampton Council's Policy on NRPF.
- The NRPF pilot.
- The multi-agency forum.
- The multi-agency protocol.

These are described in the following sections.

3.1 The City of Wolverhampton Council's Policy on NRPF

This Policy has been in development for some time and has been produced to assist practitioners to assess the appropriate support and necessary actions required when working with children, young people, adults and families who have NRPF. This Policy is scheduled to be presented to the Cabinet in April 2018.

3.2 **The NRPF pilot**

The budget that the Council has to support people with NRPF status (see 2.3 above) needs to be used to best effect. One key way of achieving this is to minimise the time taken to receive an immigration decision. A six-month pilot initiative was set up to understand how this can be achieved. The findings from this pilot will be available in the foreseeable future and will be separately circulated to members of this Board.

3.3 **The multi-agency forum**

A recently published Serious Case Review (SCR) raised a number of issues relating to the child's mother and her family who had NRPF status and their relocation to Wolverhampton from a London Borough and the problems that arose with communication.

One of the recommendations in the SCR was for the Wolverhampton Safeguarding Children's Board to ensure that any "No Recourse to Public Funds" protocols used by agencies in the area incorporate all the learning from this SCR, and to consider how best to ensure that:

a. Practitioners (including staff in schools) acquire a better understanding of the needs and vulnerabilities of families who do not have leave to remain.

b. Families with NRPF gain better access to universal services and targeted support, where appropriate, including that provided by the voluntary sector.

In order to meet the recommendation in the SCR report it was identified by both the Health and Wellbeing Board and the Safeguarding Children's Board that a city-wide NRPF Forum should be established. Public Health has been asked to chair this Forum.

3.4 **The multi-agency protocol**

The Forum is responsible for the development of a multi-agency protocol to ensure there is a consistent and co-ordinated approach to working with people with NRPF status across services and organisations in the city. It is envisaged that the protocol will make reference to, but not duplicate, the Council Policy. A description of what is in scope for this protocol is described in section 5 of this report.

4.0 The establishment of the multi-agency NRPF Forum

4.1 The inaugural meeting of the NRPF Forum was held on 17 January 2018, with good attendance from a range of agencies including: Public Health, Education, Housing, Health (Clinical Commissioning Group and Royal Wolverhampton NHS Trust), Safeguarding, Social Care, Commissioning and the voluntary sector. At the second meeting on 7 March 2018, West Midlands Police was represented and Wolverhampton Voluntary Sector Council represented the Interfaith Forum.

4.2 A key objective of the meetings held to date has been to understand the issues as they present to a range of services and organisations. This understanding is informing the development and agreement of a city-wide protocol.

4.3 It was clear from the feedback that organisations external to the Council can feel they are working in isolation. Case studies were provided, for example from both schools and health, which indicated that working with NRPF issues can take up considerable time and energy often at very little notice. Services have also struggled to identify leads within the Council for NRPF issues resulting in delays in resolving issues. There has been a clear call for support when organisations are faced with NRPF issues from both the Council and other voluntary sector partners. It is envisaged that the Council NRPF Policy, when implemented, will help to achieve an improved response.

4.4 There was a consistent call for training on NRPF issues. A request will be made that NRPF training is part of Safeguarding Children's Board training schedule for the year ahead.

4.5 The Forum identified the need to make connections with the Interfaith Forum. As a result of that dialogue, Public Health had a meeting with the 'Oasis of Love' Church. In the course of that meeting it became apparent that this church provides approximately £5,000 a month from congregation donations to support to people with NRPF status.

4.6 Alongside the case studies from Forum members, it has been identified that it may be helpful to get an idea of the size of the impact NRPF issues are having on different sectors, particularly given the findings from Oasis of Love. Surveys will be drafted and circulated tor the voluntary sector, schools and the health visiting service.

4.7 The Forum has identified the need to engage with the modern slavery group and the headteachers' safeguarding group on the NRPF agenda. These meetings are scheduled to take place in March and April 2018.

4.8 The issue of free school meals for children with NRPF status has been flagged by members of the Forum. This requires further investigation.

4.9 It has been identified that there could be stronger working relationships between social care working with NRPF families and housing, particularly the private rented sector team. This dialogue will commence in the weeks ahead.

4.10 There is appreciation about being part of a network and achieving an improved city-wide response. However, there remains the issue of inter-Council dialogue about NRPF families. This has been escalated to the Association of Directors of Children's Services.

4.11 Once the protocol has been developed and ratified, it is envisaged that the Forum will continue to meet quarterly to have oversight of its implementation and continue to be a space for sharing learning and good practice.

5.0 The multi-agency protocol

5.1 The development and implementation of a multi-agency protocol has been identified by the NRPF Forum as a key deliverable of the group. The aim of such a document is to

establish consistent ways of working across partners as well as fostering a more co-ordinated approach to supporting and safeguarding families who have NRPF. It will be developed over the next few months by a sub-group of the Forum and the wider Forum will provide feedback, especially on the sections most relevant to them.

5.2 It is envisaged that the rollout of NRPF training to partners (section 4.4) will be a useful channel through which to promote the protocol once ratified.

5.3 Key principles underpinning the protocol that have been identified by the Forum include:

- To be written in a style that is as accessible as possible given the wide variety of audiences that may want to make use of it.
- To address the recommendations from the SCR.
- To not duplicate what is in the Council's Policy but ensure there is a good 'fit' between the two documents. In particular, a link is made to the Council's Policy document so it is clear what can be expected of the Council.
- The protocol should set out what is expected of partners, such as notification of people with NRPF status – with a full description of what this process is (N.B this process is still to be developed and agreed).

5.4 The suggested framework for the protocol is as follows:

- A background section including what NRPF means, which funds are not available but very importantly, what is available to people with NRPF status. This is to dispel the myth that people with NRPF status cannot access anything.
- A 'step-by-step' guide of what to do when faced with people with NRPF status including a checklist of questions to help identify what type of migrant this is, what has already been achieved as part of their journey into England. This will also include flowcharts to help services and organisations navigate their way ahead. It is envisaged that there will be sections that are service specific such as education, primary care, secondary care, police, voluntary sector.
- A section on how to contact the Council in the event of a query or submission of a notification. In such an event, it has been identified that there needs to be a very clear case put forward for why information is being captured, particularly given the understandable suspicion that people with NRPF status may have about sharing such data. The protocol needs to include statements about the positive reasons for gaining such information as well as how it is done in a way that is compliant with the law.
- A link to the Wolverhampton Information Network and how to find relevant resources on this platform both to support services and the people with NRPF status.

6.0 Next steps

6.1 Once the multi-agency protocol has been drafted and agreed by its members, it will need to come to the Health and Wellbeing Board for ratification. The intention is to bring the protocol to the Health and Wellbeing Board in October 2018.

7.0 Financial implications

7.1 There are no direct financial implications arising from this report. [NM/15032018/A]

8.0 Legal implications

8.1 There are legal implications for the development of a multi-agency protocol. These implications apply mainly to the Council but it is possible they extend to other key partners. Specifically, this is about clearly stating why information is being captured on people with NRPF status, how this information will be used and how the methods of data capture are compliant with the General Data Protection Regulation 2018. [TS/14032018/T]

9.0 Equalities implications

9.1 Migrant status is not a protected characteristic under the Equalities Act; however, it could be argued that people with NRPF status are at increased risk of being disadvantaged or discriminated against due to their circumstances. This is not just on the grounds of ethnicity (although that is the most visible protected characteristic) but the other characteristics also apply to this population. As part of the surveys that have been proposed, to be distributed to the voluntary sector, education and health visiting, information related to gaining a better understanding of our NRPF population and the issues they face will be sought.

10.0 Environmental implications

10.1 There are no direct environmental implications arising from this report.

11.0 Human resources implications

11.1 There are no direct human resources implications arising from this report.

12.0 Corporate landlord implications

12.1 There are no direct corporate landlord implications arising from this report.

13.0 Schedule of background papers

13.1 There are no background papers in relation to this report.

Agenda Item No: 11

CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

11 April 2018

Report title	Strengthening Governance and System Leadership
Cabinet member with lead responsibility	Councillor Roger Lawrence Health and Wellbeing Board Chair
Wards affected	All
Accountable director	David Watts, Director of Adults Services
Originating service	City Health
Accountable employee(s)	Brendan Clifford — Service Director – City Health Tel — 01902 555370 Email — Brendan.Clifford@wolverhampton.gov.uk Madeleine Freewood — Development Manager – City Health Tel — 01902 553528 Email — Madeleine.Freewood@wolverhampton.gov.uk
Report to be/has been considered by	People Leadership Team 22 March 2018 Strategic Executive Board 27 March 2018

Recommendations for action:

That the Health and Well Being Board (HWBB):

1. Receive and comment on the content of the attached 'City of Wolverhampton Health and Wellbeing Board Review', specifically the recommendations grouped under the five main headings: Governance; Place Based and System Leadership; Engagement and Communications; Branding and Website and Joint Health and Wellbeing Strategy approach presented on pages 21 and 22 of the report attached as an Appendix.

2. To approve the direction of travel presented in the 'City of Wolverhampton Health and Wellbeing Board Review' for final submission to the meeting of the Health and Wellbeing Board on 11 July 2018.

1.0 Purpose

1.1 To advise the Health and Well Being Board (HWBB) of the outcome of its action plan/review for strengthening the governance and system leadership of the HWBB.

2.0 Background

2.1 At its meeting of 10 January 2018, the HWBB approved a five-step action plan for strengthening the governance and system leadership of the Board, including commencing work to update the Joint Health and Wellbeing Strategy.

2.2 The following areas were identified for further reflection and engagement with partners for the April Board meeting:

- A 360-degree review of the Wolverhampton Health and Wellbeing Board.
- Development of a draft Health and Wellbeing Board Engagement and Communications Plan and/or recommendations.
- Development of draft proposals for a Health and Wellbeing Board, including branding and web presence.
- A short update on progress to date and approach being taken to update the Joint Health and Wellbeing Strategy.

2.3 An overall report on the outcome of the process is attached as an Appendix. In summary, it covers:

- The 360-degree review - this was completed through interviews with members of the HWBB held between February and March 2018. A semi-structured interview framework was used as the basis for discussion with twenty-six participants. Detailed findings of the review are summarised in the attached report and presented verbally for consideration.
- Engagement and Communications Plan – in the process of the HWBB review Board members noted a need for a more integrated, planned approach amongst partners to engagement and communication. City Health officers will work with Healthwatch on behalf of the HWBB to co-produce an Engagement and Communications Plan for 2018-2019.
- HWBB identity (branding and web presence) – draft logos and an approach to branding have been commissioned for consideration at the HWBB.
- Joint Health and Wellbeing Strategy - the Council's Public Health service is taking this forward in conjunction with the Clinical Commissioning Group (CCG). It is proposed to hold a partnership workshop/development session prior to the July meeting of the HWBB to further develop the Strategy. A draft will then be presented to the HWBB for approval in July 2018.
- Learning from others – wider learning e.g. from the New Local Government Network and the Kings Fund, have been sourced as good practice benchmarks to inform the review and are included in the body of the report. There is interest amongst members of the HWBB in the possible use of a Peer Review process at an appropriate stage in current Board development. More detailed opportunities for learning from others will be presented to the meeting in July 2018.

4.0 Financial Implications

4.1 There are no direct financial implications arising from this report. Any action arising from this report will be met from existing budget held across the partner agencies. [AS/13032018/X]

5.0 Legal Implications

5.1 The Health and Wellbeing Board is a statutory Board established under the Health and Social Care Act 2012. It has a statutory duty, with the CCG to produce a joint Strategic Needs Assessment and a joint Health and Wellbeing Strategy for its local population. [RB/20032018/N]

6.0 Equalities Implications

6.1 The content of the review has included issues relating to equalities and diversity such as the need for better engagement with city people. The proposed update of the Joint Health and Wellbeing Strategy gives the Health and Wellbeing Board the opportunity to extend its commitment to equalities and diversity through the delivery of the Strategy.

7.0 Environmental implications

7.1 There are no direct environmental implications from this report.

8.0 Human resources implications

8.1 There are no direct human resource implications from this report.

9.0 Corporate landlord implications

9.1 There are no direct corporate landlord implications from this report.

10.0 Schedule of background papers

City of Wolverhampton Health and Wellbeing Board – City Health 360-degree review of the Board – Discussion Points.

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City of Wolverhampton Health & Wellbeing Board Internal Review

JAN-APRIL 2018

Brendan Clifford & Madeleine Freewood
CITY HEALTH | CITY OF WOLVERHAMPTON COUNCIL

Contents

Background

1.1 The City of Wolverhampton Health and Wellbeing Board is committed to a cycle of continuous improvement in order to drive the transformational change required to deliver sustainable improvements in the health and wellbeing of local communities.

1.2 New appointments within the City of Wolverhampton Council, the confirmation of an updated Clinical Commissioning Group Board, a re-energised Systems Development Board and the expiry of the current Joint Health and Wellbeing Strategy in 2018, have all created a timely opportunity to reflect on current practice and strengthen the system leadership of the Health and Wellbeing Board going forward.

1.3 As a result, a Health and Wellbeing 'paving report' approved the following actions be undertaken and reported back to the April board meeting:

- A 360-degree review of the Wolverhampton Health and Wellbeing Board.
- Development of a draft Health and Wellbeing Board Engagement and Communications Plan and/ or recommendations.
- Development of draft proposals for a Health and Wellbeing Board, including branding and web presence.

1.4 In addition, Public Health officers, in consultation with Wolverhampton Clinical Commissioning Group colleagues, were tasked with presenting a draft updated Joint Health and Wellbeing Strategy to the July 2018 board meeting. A short update on progress to date and approach is therefore also provided in this report.

Purposes of the Health and Wellbeing Board

2.1 Health and Wellbeing Boards are statutory partnerships given specific functions under The Health and Social Care Act 2012.[1] The regulations relating to Health and Wellbeing Boards are published as Statutory Instrument 2013 No. 218 entitled, The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.[2]

2.2 The principal responsibilities of Health and Wellbeing Boards as defined in legislation, guidance and good practice documents are:

- To assess the needs of their local population – children, young people and adults - through a Joint Strategic Needs Assessment (JSNA).
- To set out how these needs will be addressed through a Joint Health and Wellbeing Strategy as a strategic framework for Clinical Commissioning Groups, local authorities and NHS England to make commissioning decisions.
- Improvement of the health of the local population.
- Improvement of the quality of health services.
- Promotion of integration in the care and health system.
- Sign-off of relevant plans such as the Clinical Commissioning Group Commissioning Strategy.
- Local co-ordination of national policy e.g. Dementia challenge; Better Care Fund etc.
- Over-seeing effective engagement with local people.
- Any other functions that may be delegated by the council under section 196(2) of the Health and Social Care Act 2012. For example, this could include specific public health functions, functions relating to the joint commissioning of services or the operation of pooled budgets between the NHS and the council. These delegated functions could also include housing, planning, work on deprivation and poverty, leisure and cultural services, all of which have an impact on health, wellbeing and health inequalities.

2.3 Legislation allows flexibility to councils and their partners to determine how they set up and run Health and Wellbeing Boards; and boards have the freedom to develop ways of working that reflect the wishes of their members and the needs of the communities they serve.

[1] http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted
[2] http://www.legislation.gov.uk/uksi/2013/218/contents/made

360-degree Board Review Methodology

3.1 A desk-top review of key documents was undertaken to identify best practice and guidance including published Health and Wellbeing Board Peer Review findings.

3.2 This informed the development of a semi-structured discussion framework[3] which was shared with members of the Health and Wellbeing Board prior to a series of interviews that took place over a three-week period. This framework covered five key areas: lived experience of the board, governance, the Joint Health and Wellbeing Strategy, integration and engagement.

3.3 Following each interview notes taken were emailed back to the participant with the invitation to check for accuracy and make any further additions.

3.4 This review also enabled the Wolverhampton Health and Wellbeing Board to reaffirm its commitment to the principles underlying the creation of Health and Wellbeing Boards:

- Shared leadership of a strategic approach to the health and wellbeing of communities that reaches across all relevant organisations.
- A commitment to driving real action and change to improve services and outcomes.
- Parity between board members in terms of their opportunity to contribute to the board's deliberations, strategies and activities.
- Shared ownership of the board by all its members (with commitment from their nominating organisations) and accountability to the communities it serves.
- Openness and transparency in the way that the board carries out its work.
- Inclusiveness in the way it engages with patients, service users and the public.[4]

3.5 Limitations - This report has aimed to be as inclusive as possible in bringing together all the comments made by board members. It may be that some point made by board members has been overlooked in the task of collation. Board members may wish to refer to anything in discussion, which they regard as important, which has not been included in the body of the report.

HWBB Review Report Appendix A.(

[3]

[4] Page 4 Health and wellbeing boards: A practical guide to governance and constitutional issues https://www.local.gov.uk/sites/default/files/documents/health-and-wellbeing-boar-44f.pdf

Presentation of Interview Responses

4.1 The Wolverhampton Health and Wellbeing Board is made up of members who helped establish the board and attended in shadow form, through to newly appointed members. Long serving members understood the board as being on a journey, they felt the foundations were now laid and they looked forward to the next stage in its development and to unleashing new opportunities.

4.2 The New Local Government Network report *"Get Well Soon – Re-imagining Place Based Health"*[5] argues that this next stage in the evolution of Health and Wellbeing Boards is the move towards becoming system leadership forums. It suggests that to achieve this involves a series of key shifts:

4.3 Interview responses chimed with this model and direction of travel.

4.4 Given this, interview responses have been thematically grouped and are presented as a composite under the headings "Now" and "Opportunity". Individuals are not identified, but as board members were advised, the origins of specific comments may be clear.

4.5 The "Key Shifts" required to enable the Wolverhampton Health and Wellbeing Board to realise its aspirations and opportunities are then presented as a series of recommendations for the board to consider.

[5] http://www.nlgn.org.uk/public/wp-content/uploads/Get-Well-Soon_FINAL.pdf

Health and Wellbeing Board: Now

5.1 There was a consistent view articulated in participant discussions that the Wolverhampton Health and Wellbeing Board has the right organisations round the table (with the possible exception of the Ambulance Service), that positive working relationships have been established and there is a shared consensus on direction of travel.

Membership and balance of members is appropriate, all the main players are now round the table.

Since establishing the Shadow Board huge progress has been made and the framework and governance of the board is now successfully embedded.

5.2 The senior membership of the Health and Wellbeing Board is seen as a powerful and genuine asset offering a real opportunity to give the Health and Wellbeing Board a central role in driving system change. There is an understanding and appreciation that organisational diversity enables a healthy and necessary plurality of voices.

…. the inclusion of the Fire Service, Police and Voluntary Sector representatives on the Health and Wellbeing Board can act as a critical friend and offer appropriate challenge, provide an alternative point of view.

5.3 The seminar format of the 'development day' meeting and networking lunch was regarded as useful at facilitating opportunities for discussion and tackling silo thinking. There is a clear understanding that the Health and Wellbeing Board is a strategic, not operational group, with core business that it must attend to e.g. statutory reporting, monitoring of Better Care Fund etc. However, there was a repeated concern that the board needs to more consistently evidence outcomes and impact and spend less time signing off retrospective documents, investing more time instead in building insight and shaping future direction.

Health and Wellbeing Board meetings often have a reactive agenda, there will always be important, time limited, issues, however need to balance against wider thematic issues. In particular, how health and wellbeing can enable people to reach their full potential, build social capital and contribute to the wider economy.

5.4 There is a genuine commitment to 'place' and working together to deliver tangible and positive health outcomes that improve the health and wellbeing of local people and communities. It was argued for example, that the refreshed Joint Health and Wellbeing Strategy needed to *"reflect the story of place".*

5.5 Partnership working is valued and examples were provided where this had worked well which offered positive models to learn from more widely; i.e. the collaboration between the CCG and Police in relation to BCF and "*high intensity users".* Non-health partners in particular wanted to enhance collaboration even further and referred to shared priorities and a desire to be more active participants.

5.6 There is a broad-brush commitment to, and belief in, the opportunities offered by integration of health and social care and new care models - however more work is needed to understand what this means in practice, the contributions of all partners and how best to deal with the challenges of a shifting and politicised health landscape.

It's not yet possible for the Health and Wellbeing Board to have an agreed view on what integration looks like – this is a work in progress, not least because the Government position keeps changing.

Integration is essential, but it depends what you mean by it. Need to understand priorities where integration would help. Need collaboration on best outcomes for people.

Steady progress is being made, within the city there is a growing consensus about the path to follow. The problem for the Health and Wellbeing Board comes as soon as you cross borders. Artificial geographical footprints are being imposed on the city in a top down way e.g. Black Country STP doesn't fully recognise Trust's relationship with South Staffordshire. Wolverhampton can carry on embedding vertical integration, developing whole city system and innovating on our own terms, however this doesn't stop the government imposing conditions on how integration must work across a geographical footprint that is counter intuitive to the work taking place on the ground or existing relationships.

5.7 Board members understood the review as presenting them with an opportunity to both reflect on the current working of the board, but also recast the board, and there was an appetite to embrace innovation.

Recognise that the Health and Wellbeing Board needs to deliver its statutory responsibilities. How far can we make it something else? And what is that?

Do we want the Health and Wellbeing Board review to lead to an improved business as usual model or is there potential to do something more innovative?

Future focus can now be on the health and wellbeing system not any specific service area such as Council Public Health, CCG strategies and the like

… now [the Health and Wellbeing Board is] established – what next? There is an opportunity to do something radical.

Health and Wellbeing Board: Opportunities

6.1 Interview conversations revealed a striking consensus amongst Health and Wellbeing Board members about the opportunities to drive the board forward, and, also, the tensions and challenges inherent in this. This consensus is thematically presented below.

6.2 Members recognised that while the Health and Wellbeing Board is a statutory board, it *"didn't have teeth*" to enforce or compel. Instead, its power was very much understood in terms of the effectiveness of the relationships between members as well as their ability to exercise place and system leadership. A recurrent theme was therefore how to enable these relationships to develop, including the provision of space to "surface and resolve conflicts"[6] as part of the consensus building process.

Strengthening partner relationships involves having the time and space to do this. Formal meetings will have their own etiquette and powerplay, disrobing back into a workshop mode can create the opportunities for new types of conversations/ relationships to develop.

For the Health and Wellbeing Board to have consensus there needs to be space and time for private discussion. … the benefit of this would be that the agendas for the open public meetings could be more tailored for public consumption and real engagement.

6.3 In addition to strengthening the existing development day a number of board members suggested creating an executive group as a means to achieving this *"space and time"* for strengthening relationships, building consensus and broadening the scope of the agenda:

Health and Wellbeing Board meetings will always need to respond to big ticket health priorities … Using the JSNA and Public Health vision to inform there or four key priorities the board could adopt a thematic approach to meetings, the core membership could then be reduced but a greater variety of partners invited to attend the themed meeting most relevant to them.

6.4 There was a collective view that the current Health and Wellbeing Board vision and mission was a positive contribution on the board's development journey, and while members liked the focus on the life course, the evolution of the board now called for a new "systems within systems"[7] approach. In particular, board members wanted to strengthen and develop relationships both between members and between the board itself and other city partnership/operational groups, including for example, Children's Trust Board, Safer Wolverhampton Partnership, Systems Development Board, LEP, City Board, etc, *"ensuring minimal overlap but no gaps".*

6.5 Given the above some board members questioned the value of the Health and Wellbeing Board continuing to have its own vision and mission, when a wider co-produced vision and mission for the city already exists in the form of the *City Vision 2030*. In addition, an updated Joint Health and Well Being

[6] https://www.kingsfund.org.uk/publications/leading-across-health-and-care-system
[7] https://www.kingsfund.org.uk/publications/place-based-systems-care/ten-design-principles

Strategy will express the board's vision and mission in the context of the updated strategy.

Don't think there is a value in the Health and Wellbeing Board having its own separate vision and mission – should be contributing to a wider vision and mission for the city (possibly 2030 vision) through defined and agreed priorities.

Walsall Health and Wellbeing Board recently went through a process to refresh its priorities. As part of this it looked at how it linked in with other partnership boards, for example community safety and safeguarding boards. They considered if all the different partnership boards were required, levels of duplication etc. and came to the conclusion that it's important for there to be a single vision linking all the related boards together. There is potential for Wolverhampton to undertake a similar approach – this could be underpinned by 2030 vision. … the refresh led them to reduce the number of priorities and concentrate on where they can make the biggest difference.

6.6 There was also a view consistently articulated that issues related to children and young people were under-represented at board meetings, as were the linked topics of early intervention, prevention, education and aspiration, which chimed with the forward-looking view of the *City 2030 vision*.

6.7 Members wanted to move away from a deficit model of the city and citizens to a more asset based approach which sought to more fully understand the wider determinates of health and had a longer-term focus.

The Joint Health and Wellbeing Strategy, the Vision and Mission of the Health and Wellbeing Board and Joint Strategic Needs Assessment data shouldn't just be used to present a deficit model of the city. The strengths of the city, what makes people come and stay are equally important. These strengths include the quality of its people, social cohesion, nurturing culture and super diversity. By understanding what is good about the city, we can seek ways to work these harder.

6.8 At the same time board members expressed a view that they wanted to deepen and broaden partnership working and identify more opportunities for co-production at all levels within their organisations and at an earlier stage in the report writing process.

6.9 It was also argued that the Health and Wellbeing Board needed to act as a place leader or place shaper using the *"sphere of influence"* of its current membership to both *"make links more explicit, identify new opportunities and promote a joined-up approach"* as well as more proactively influence and lead at a regional level to ensure best outcomes for local populations, communities and people.

Going forward the Health and Wellbeing Board should have a focus on 'place' i.e. what services are provided where; what do the right conglomerations of services look like; what is the right coverage – how do we ensure services are in the right places while accepting not everyone can have every service on their doorstep. In terms of "place" – this refers to Wolverhampton, the Black Country and the Combined Authority geographical footprints – the Wolverhampton Health and Wellbeing Board therefore needs to … make use of existing partnership forums …, rather than seek to create new networks and additional meetings which there isn't the capacity to attend.

6.10 Board members recognised that the working of the board and a definition of place was complicated by these overlaid, and sometimes competing, regional

geographical footprints for which no single organisation was entirely responsible.

6.11 In addition, the physical location of anchor institutions did not denote the totality of their sphere of influence. For example, only 37% of Royal Wolverhampton Trust income is derived from work for the City of Wolverhampton. Adding to this complexity, local partnership arrangements could be undermined by national directives, the political imperative for short term impact could skew activity away from long term initiatives and different organisational and financial incentives could work to act against integration.

6.12 While this complexity presented a challenge to the Health and Wellbeing Board, it also presented an opportunity, as the board and its collective membership was a constant running through these multiple footprints. This meant that Health and Wellbeing Board had the potential to *"be at the heart … concentrating on the offer to the citizen."* The Health and Wellbeing Board could see the whole picture to *"ensure breadth was considered."* The board's membership, particularly the elected members, also provide a direct level of local accountability.

6.13 Accountability lines and measuring outcomes and impact were raised by members of the board. There was a consensus view that the board needed to strengthen these and make them more explicit, so as to be able to monitor both progress and impact, to clearly understand how it was *"making a difference"* to the local citizen. Tied to this was the view that the board, informed by the *City Vision 2030*, should widen its scope to move beyond the integration of health and social care to take a much broader view of the role housing, business, access to jobs and skills, the voluntary and community sector, social enterprises and people themselves; and concentrate its efforts on the areas where it can make the biggest difference through an agreed set of metrics.

6.14 The board was united in its commitment to activity to strengthen community capacity. There was a clear understanding that the board *"needs to invite cooperation of citizens not tell them what to do."* At the same time there was an understanding that the role of engagement activity was to inform the board.

[The Health and Wellbeing Board] shouldn't duplicate – [it] shouldn't do what agencies themselves are doing.. Health and Wellbeing Board should use what agencies do.

6.15 There was therefore a view the board could utilise Healthwatch more strategically. It was also clear that The Police, Fire Service, University and Voluntary Sector were all engaged in activity focussed on building community resilience and if this could be joined up more effectively would more likely to succeed. It was suggested that individual agencies should (for want of a better word) "cede" authority to the overall partnership which would make individual agencies more effective in meeting their aims.

6.16 These observations about the future direction of the board present a series of opportunities that inform the recommendations in the next section of the report.

Health and Wellbeing Board: Key Shifts & Recommendations

7.1 Interview conversations demonstrate a clear commitment by Health and Wellbeing Board members to innovate and they identified opportunities for board development. To realise these opportunities involves a key shift in the way the board operates both in terms of its governance arrangements and how the board positions itself in the wider system.

7.2 This section of the report therefore summarises the board "asks" grouped under these headings and seeks to translate these into a series of recommendations for board consideration.

7.3 **Governance asks** – interview comments can be summarised as follows:

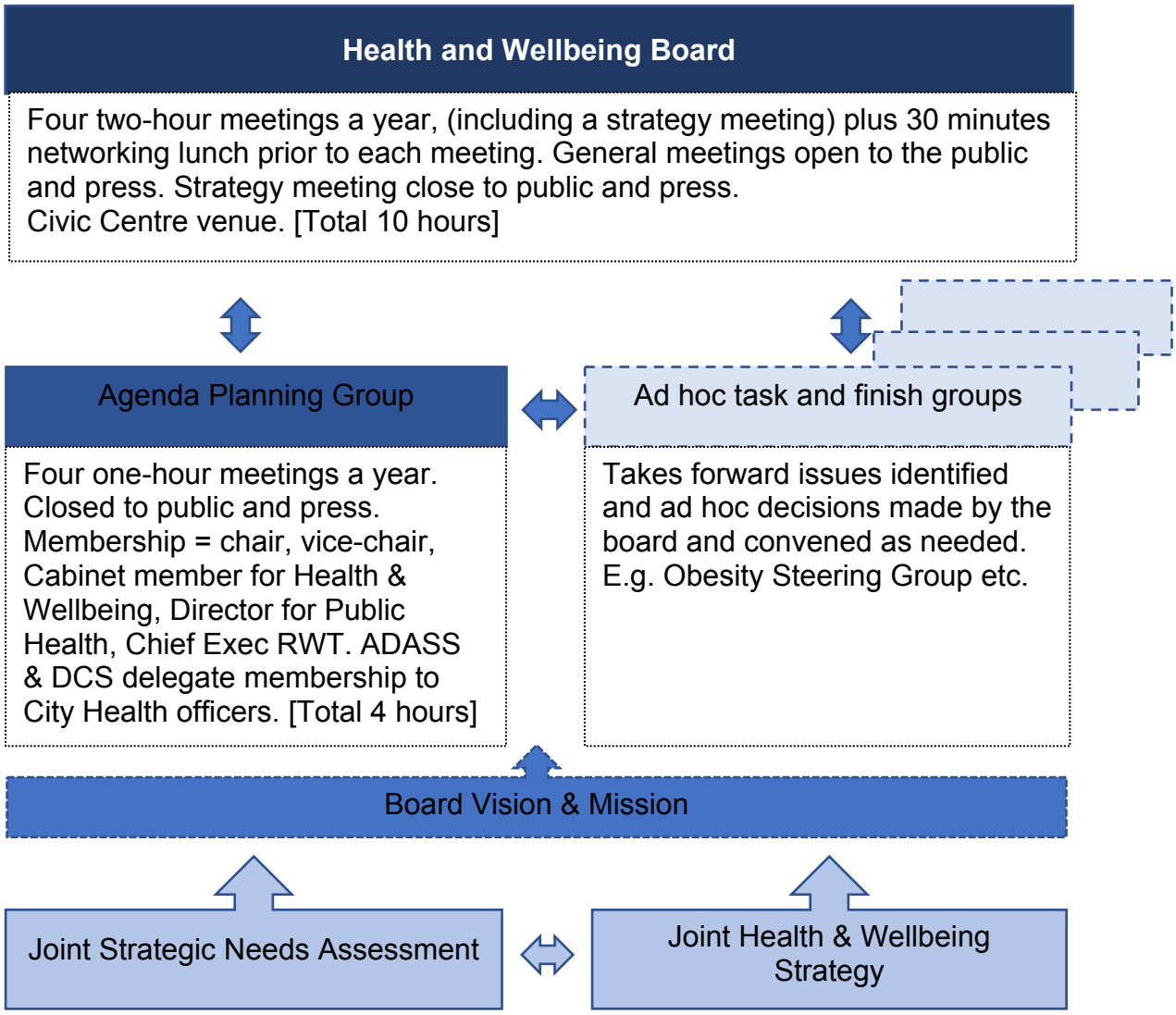
- More space for active discussion and time to invest in board member relationships and shared priorities, including building on the existing annual "development day".
- A forward-looking agenda enabling members to more actively shape and influence future direction, including a greater focus on prevention, early intervention and aspiration.
- A smaller core membership to be responsible for statutory functions of the board.
- A clear set of agreed metrics to measure outcomes, impact and plan for the future, learning from areas where this was already being done well, e.g. BCF, Estates programme.
- Greater clarity about the relationship between the Health and Wellbeing Board with Health Scrutiny.
- More opportunity for partner organisations to co-produce/ collaborate on reports earlier in the process.
- To incorporate a thematic approach to meetings that enables consideration of the wider determinants of health, underpinned by the *2030 City Vision* and an understanding of the important part education, housing, skills, jobs, economic regeneration etc. play in relation to community resilience and wellbeing.
- To provide a more welcoming and open meeting for members of the public to attend, balanced against the need for private and closed time for focussed discussion and consensus building.
- For specific discussions with a narrow health focus on integration to take place outside the formal meetings of the Health and Wellbeing Board.
- To more clearly position the Health and Wellbeing Board in a place based leadership role.

7.4 **Governance recommendations**:

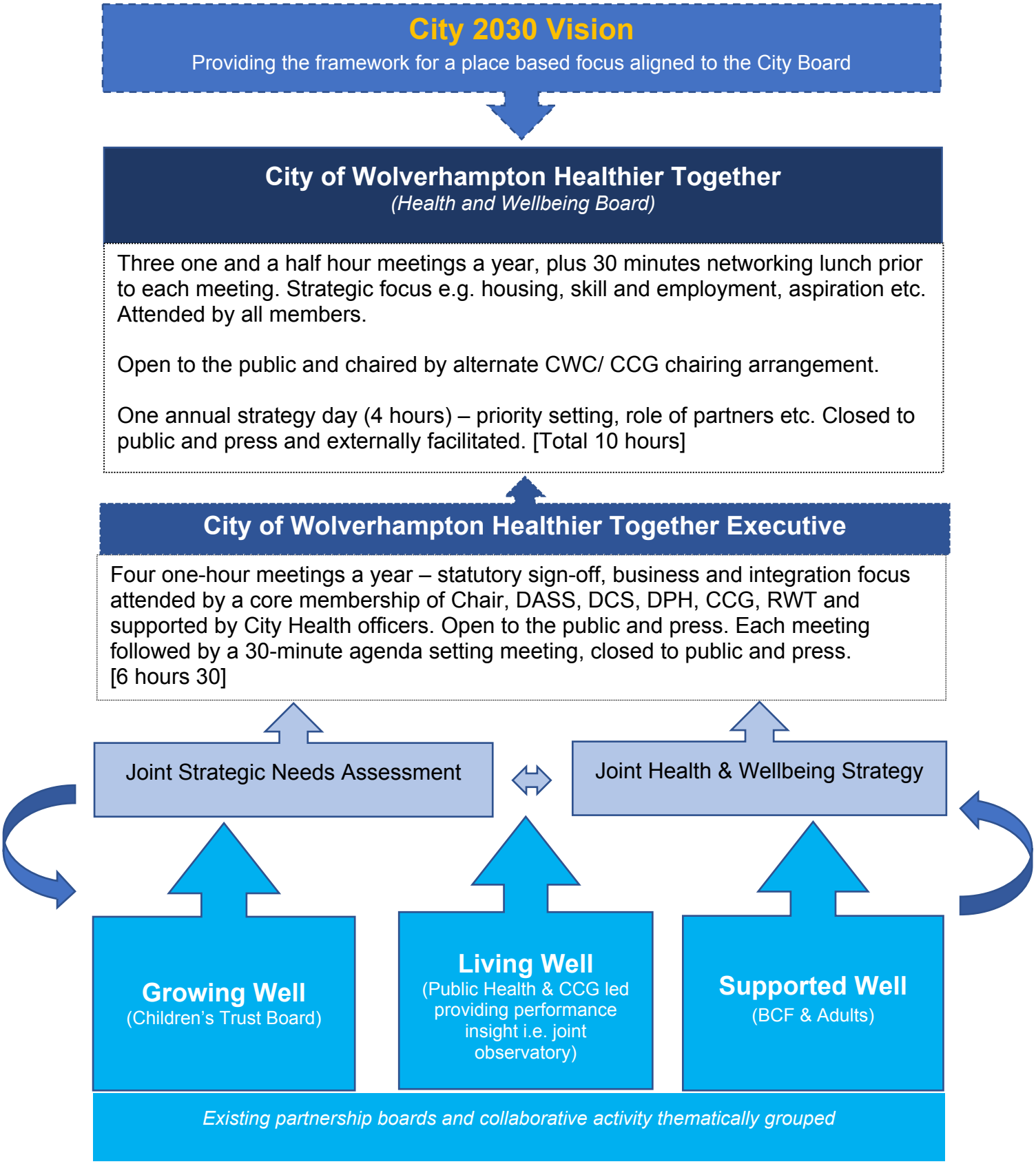
- To rename the Wolverhampton Health and Wellbeing Board to emphasise its place and system leadership role. The final name to be consulted on – working examples included in this report are 'Healthier Together' or the 'Together Board'.
- To replace the existing Health and Wellbeing Board vision and mission with the *City 2030 Vision* and work more collaboratively with the City Board on its implementation.
- To establish an Executive, made up of a smaller number of existing board members, to undertake the statutory *"sign off"* functions of the board, therefore providing the whole board membership with more space and time for strategic discussion and thematic agenda items.
- To replace the existing use of *ad hoc* task and finish groups with more clearly defined links to existing partnership boards and collaborative activity - and to rename and thematically cluster under three headings - the final names to be consulted on. Working examples presented in the report are Growing Well; Living Well and Supported Well.
- To re-state delegation to these new groupings to: (a) rebalance the agenda ensuring focus on the whole life course, (b) better inform the board of outcomes and impact; and (c) provide more opportunity for partner organisations to co-produce/ collaborate on reports earlier in the process.
- To support the development of strong and purposeful relationships within the board through an annual strategy meeting; to employ best practice from across the sector e.g. lessons from experience and the use of relational audit tool, to facilitate system leadership
- To work with others to review and refresh the governance documents supporting the current Health and Wellbeing Board to include a Health Scrutiny protocol, guidance for members of the public attending board meetings and contribute to an updated partnership/boards joint working protocol.
- To align timelines for the annual Joint Strategic Needs Assessment with the Strategic Assessment undertaken by the West Midlands Police on behalf of the Safer Wolverhampton Partnership Board to promote joint working and avoid duplication.
- To change the current meeting cycle, balancing senior leader's diary capacity while recognising other regional Health and Wellbeing Boards meet more frequently.

These suggested changes are illustrated overleaf.

7.5 Health and Wellbeing Board now:



7.6 Proposed:

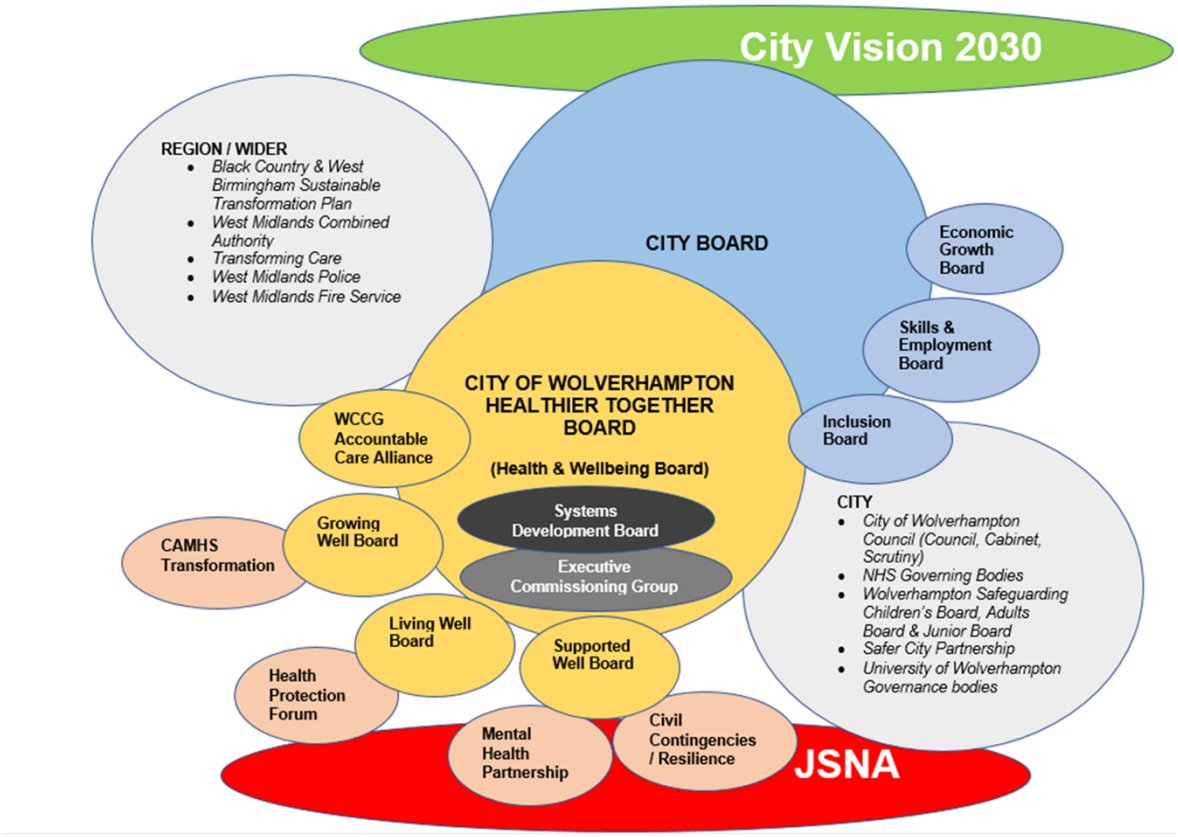

City 2030 Vision
Providing the framework for a place based focus aligned to the City Board
City of Wolverhampton Healthier Together
(Health and Wellbeing Board)
Three one and a half hour meetings a year, plus 30 minutes networking lunch prior to each meeting. Strategic focus e.g. housing, skill and employment, aspiration etc. Attended by all members.
Open to the public and chaired by alternate CWC/ CCG chairing arrangement.
One annual strategy day (4 hours) – priority setting, role of partners etc. Closed to public and press and externally facilitated. [Total 10 hours]
City of Wolverhampton Healthier Together Executive
Four one-hour meetings a year – statutory sign-off, business and integration focus attended by a core membership of Chair, DASS, DCS, DPH, CCG, RWT and supported by City Health officers. Open to the public and press. Each meeting followed by a 30-minute agenda setting meeting, closed to public and press. [6 hours 30]
Joint Strategic Needs Assessment
Joint Health & Wellbeing Strategy
Growing Well
(Children's Trust Board)
Living Well
(Public Health & CCG led providing performance insight i.e. joint observatory)
Supported Well
(BCF & Adults)
Existing partnership boards and collaborative activity thematically grouped

7.7 **Place based and system leadership asks** – board members stated that they wanted:

- To enhance the role of board members as place leaders and the role of the board to shape and influence all the different geographies of health for the benefit of local people.
- Greater practical opportunities to work together on place based leadership with other partnership boards/ regional bodies, while ensuring each board *"retains its own identity".*
- To build this synergy with existing partnership boards without creating duplication or additional meetings.
- To ensure a line of accountability back to community and individual wellbeing so that the impact of regional decisions can be understood at the local level.
- To view integration through the lens of a whole system approach, for example, while integration of health and social care services has less of a direct impact on the Police, stress in the system this has a knock-on impact on Police resource; and this is the same for other partners.
- To capitalise on the reach and sphere of influence of the board at a regional level through active dialogue with the West Midlands Combined Authority, Sustainable Transformation Plan, Local Enterprise Partnership, Association of Black County Authorities etc.
- To strengthen the relationship with all partners enhancing collaboration on shared priorities.

7.8 **Place based and system leadership recommendations**:

- To hold one of the board's annual strategy days jointly with the City Board.
- To undertake a joint engagement activity with citizens, for example, board members were interested in holding a "citizen summit" style event, this could be jointly hosted with City Board with a health, care and wealth focus.
- To enable greater dialogue with the City Board through the members who sit on both boards for example, using the work of the Inclusion Board, Economic Growth Board or Skills and Employment Board to inform the bigger picture for the Health and Wellbeing Board.
- To share annual planning documents between city partnership boards.
- To review opportunities for joint communications, conference activity and chair's meetings between city partnership boards.
- To invite the Systems Development Board reports into the renamed Health and Wellbeing Board and develop metrics to measure the outcome and impact of integration.
- To explore opportunities for further aligning activity taking place within all partner organisations (including West Midlands Police, West Midlands Fire Service, Wolverhampton University and the community and voluntary sector) as well as thematic issues such as children and young people with board priorities.
- To explicitly position the renamed Health and Wellbeing Board at the heart of the multiple geographies of health and maximise opportunities to shape decision making at the WMCA and other regional bodies to the benefit of the city – see overleaf.


City Vision 2030
REGION / WIDER
Black Country & West Birmingham Sustainable Transformation Plan
West Midlands Combined Authority
Transforming Care
West Midlands Police
West Midlands Fire Service
CITY BOARD
Economic Growth Board
Skills & Employment Board
Inclusion Board
CITY OF WOLVERHAMPTON HEALTHIER TOGETHER BOARD
(Health & Wellbeing Board)
WCCG Accountable Care Alliance
Systems Development Board
Executive Commissioning Group
CAMHS Transformation
Growing Well Board
Living Well Board
Supported Well Board
Health Protection Forum
Mental Health Partnership
Civil Contingencies / Resilience
JSNA
CITY
City of Wolverhampton Council (Council, Cabinet, Scrutiny)
NHS Governing Bodies
Wolverhampton Safeguarding Children's Board, Adults Board & Junior Board
Safer City Partnership
University of Wolverhampton Governance bodies

Engagement and Communications Plan

8.1 In order to deliver on its principle responsibilities, the Health and Wellbeing Board is committed to actively engaging with partners, stakeholders and the wider Wolverhampton community. This includes both formal statutory consultation as well as an on-going dialogue focused on the experience and health needs of the population.

8.2 Board members felt that there was more scope for learning from one another's evidenced track record and expertise in community engagement and building community capacity. All partners articulated a desire to more positively contribute to this activity and the wider board going forward. They consistently highlighted the need to avoid duplication and co-ordinate existing activity more effectively. Board members also referred to utilising Heathwatch more strategically.

8.3 A "citizen summit" style event was also suggested by various board members as a way to engage wider stakeholders.

When focusing on a community assets approach it is important that different public sector organisations – police, council, health, voluntary sector etc. are working together with a coherent approach – including branding - otherwise the community is getting multiple approaches, with multiple variations of the same message and multiple different brands – which weakens and undermines what is trying to be achieved, as well as creating unnecessary duplication. A coordinated approach to improving wellbeing between all the different agencies utilising vehicles such as business week, residents' week etc. and ensuring minimal overlap, but no gaps, is therefore key.

Individual agencies should find a way of being together for the greater good, making their contribution bend to the Health and Wellbeing Board direction.

A Health and Wellbeing conference, potentially linked to residents' week could also provide a good engagement opportunity.

8.4 Based on this interview feedback it is proposed to undertake the following recommendations:

Engagement and communication recommendations

- A Health and Wellbeing Board engagement and communications plan for 2018/19 be co-produced with Healthwatch, informed by and capturing wider partner expertise.
- This plan to identify opportunities to align with the city conference season (i.e. Residents week, Visitors week and Business week), including using the http://www.livelearnworkwolves.com/ platform as a vehicle to engage with the public. The benefit of this being the shared ownership and reach of this site.
- To explore the option of holding a 'citizen summit' sponsored by the Health and Wellbeing Board (possibly in conjunction with the City Board) and timed to coincide with conference season activity.
- To structure ways of working which enables engagement by making best use of existing opportunities e.g. engaging with young people via the Youth Council, Junior Safeguarding Board, Children in Care Council and Police and Crime Youth Commissioners etc.

Branding and Website

9.1 The Health and Wellbeing Board approved a recommendation to develop a Wolverhampton specific Health and Wellbeing Board identity, including branding and web presence, with the aim of raising the profile of the board and enhancing shared ownership between partners.

9.2 A business case for development of a dedicated micro-site to be hosted by City of Wolverhampton Council has been approved. Work to produce the site will commence once branding has been approved by the Board. It is proposed to demo the site with members prior to launch.

9.3 It is proposed to consult on the final wording for a new name for the Health and Wellbeing Board and to develop a logo featuring the city skyline to represent the place based focus of the board; possible examples below:

9.4 Presuming the governance recommendations outlined on page 15 are supported, it is proposed to consult on developing a related suite of logos in collaboration with relevant stakeholders. Suggested examples below:

9.5 This approach could also extend to other partnership boards – for example the City Board.

9.6 **Branding and website recommendations**

- To approve work on the board micro-site commence – with a demo version to be shared with the board prior to launch.
- To consult on the final wording for a new name for the Health and Wellbeing Board and to develop a logo featuring the city skyline.
- To explore developing a related suite of logos in collaboration with the relevant stakeholders.

Joint Health and Wellbeing Strategy - Update

10.1 Health and Wellbeing Boards have a statutory duty to produce a Joint Strategic Needs Assessment (JSNA) and a Joint Health and Wellbeing Strategy for their local population.

10.2 The existing Wolverhampton Joint Health and Wellbeing Strategy was approved by Cabinet on 4th September 2013 and is due for renewal in 2018. This provides a timely opportunity to update the strategy to more accurately reflect the significant local, regional and national changes that having taken place over that period and to further build on our community assets by increasing engagement with the business, voluntary, community and faith sectors.

10.3 Public health officers at the City of Wolverhampton Council are working collaboratively with the Wolverhampton Clinical Commissioning Group on a draft strategy to be presented to the July meeting of the Health and Wellbeing Board and the content and format of the strategy is being developed in consultation with the Clinical Commissioning Group Senior Management Team and the Executive Commissioning Group. In addition, it is proposed to hold a partnership workshop/ development session prior to the July meeting of the Health and Wellbeing Board to enable all partners to contribute to the development of the strategy.

10.4 The strategy will set a small number of key strategic priorities with clear outcomes that will make a real impact on people's lives, and reduce inequalities. Outcomes will represent milestones on the journey towards the *City 2030 Vision*. The findings of the Joint Strategic Needs Assessment will be taken into consideration, alongside the strategic priorities of partners on the Health and Wellbeing Board. Consideration will be given to how far needs can be met more effectively by integration. Discussions will be held with Healthwatch as to how the public can be best involved in the process.

10.5 **Joint Health and Wellbeing Strategy recommendations**

- To approve the approach being adopted to produce the draft Joint Health and Wellbeing Strategy, including a workshop/ development session to enable all partners to contribute to the development of the strategy.

Summary - Recommendations

1. **Health and Wellbeing Board Governance Recommendations** (page 13):

- To rename the Wolverhampton Health and Wellbeing Board to emphasise its place and system leadership role. The final name to be consulted on – working examples included in this report are 'Healthier Together' or the 'Together Board'.
- To replace the existing Health and Wellbeing Board vision and mission with the *City 2030 Vision* and work more collaboratively with the City Board on its implementation.
- To establish an Executive, made up of a smaller number of existing board members, to undertake the statutory *"sign off"* functions of the board, therefore providing the whole board membership with more space and time for strategic discussion and thematic agenda items.
- To replace the existing use of *ad hoc* task and finish groups with more clearly defined links to existing partnership boards and collaborative activity - and to rename and thematically cluster under three headings - the final names to be consulted on. Working examples presented in the report are Growing Well; Living Well and Supported Well.
- To re-state delegation to these new boards to: (a) rebalance the agenda ensuring focus on the whole life course, (b) better inform the board of outcomes and impact; and (c) provide more opportunity for partner organisations to co-produce/ collaborate on reports earlier in the process.
- To support the development of strong and purposeful relationships within the board through an annual strategy meeting; to employ best practice from across the sector e.g. lessons from experience and the use of relational audit tool, to facilitate system leadership
- To work with others to review and refresh the governance documents supporting the current Health and Wellbeing Board to include a Health Scrutiny protocol, guidance for members of the public attending board meetings and contribute to an updated partnership/boards joint working protocol.
- To align timelines for the annual Joint Strategic Needs Assessment with the Strategic Assessment undertaken by the West Midlands Police on behalf of the Safer Wolverhampton Partnership Board to promote joint working and avoid duplication.
- To change the current meeting cycle, balancing senior leader's diary capacity while recognising other regional Health and Wellbeing Boards meet more frequently.
- To review the location of meetings.

2. **Health and Wellbeing Board Place Based and System Leadership Recommendations** (page 16):

- To hold one of the board's annual strategy days jointly with the City Board.
- To undertake a joint engagement activity with citizens, for example, board members were interested in holding a "citizen summit" style event, this could be jointly hosted with City Board with a health, care and wealth focus.
- To enable greater dialogue with the City Board through the members who sit on both boards for example, using the work of the Inclusion Board, Economic Growth Board or Skills and Employment Board to inform the bigger picture for the Health and Wellbeing Board.

- To share annual planning documents between city partnership boards.
- To review opportunities for joint communications, conference activity and chair's meetings between city partnership boards.
- To invite the Systems Development Board reports into the renamed Health and Wellbeing Board and develop metrics to measure the outcome and impact of integration.
- To explore opportunities for further aligning activity taking place within all partner organisations (including West Midlands Police, West Midlands Fire Service, Wolverhampton University and the community and voluntary sector) as well as thematic issues such as children and young people with board priorities.
- To explicitly position the renamed Health and Wellbeing Board at the heart of the multiple geographies of health and maximise opportunities to shape decision making at the WMCA and other regional bodies to the benefit of the city.

3. **Health and Wellbeing Board Engagement and Communications Recommendations** (page 18):

- A Health and Wellbeing Board engagement and communications plan for 2018/19 be co-produced with Healthwatch, informed by and capturing wider partner expertise.
- This plan to identify opportunities to align with the city conference season (i.e. Residents week, Visitors week and Business week), including using the http://www.livelearnworkwolves.com/ platform as a vehicle to engage with the public.
- To explore the option of holding a 'citizen summit' sponsored by the Health and Wellbeing Board (possibly in conjunction with the City Board) and timed to coincide with conference season activity.
- To structure ways of working which enables engagement by making best use of existing opportunities e.g. engaging with young people via the Youth Council, Junior Safeguarding Board, Children in Care Council and Police and Crime Youth Commissioners etc.

4. **Health and Wellbeing Board Branding and Website Recommendations** (page 19):

- To approve work on the board micro-site commence – with a demo version to be shared with the board prior to launch.
- To consult on the final wording for a new name for the Health and Wellbeing Board and to develop a logo featuring the city skyline.
- To explore developing a related suite of logos in collaboration with the relevant stakeholders.

5. **Joint Health and Wellbeing Strategy Recommendations** (page 20):

- To approve the approach being adopted to produce the draft Joint Health and Wellbeing Strategy, including a workshop/ development session to enable all partners to contribute to the development of the strategy.

With **thanks** for their contribution to this review –

City of Wolverhampton Council:
Cllr Roger Lawrence, Leader, Chair of the Health and Wellbeing Board
Cllr Val Gibson, Cabinet Member for Children
Cllr Sandra Samuels, Cabinet Member for Adults
Cllr Paul Singh, Shadow Cabinet Member for Health and Wellbeing
Cllr Paul Sweet, Cabinet Member for Health and Wellbeing

City of Wolverhampton Council:
Tim Johnson, Deputy Managing Director/ Strategic Director for Place
Mark Taylor, Strategic Director for People
Emma Bennett, Director of Children's Services
Claire Nye, Director of Finance
Meredith Teasdale, Director of Education
David Watts, Director of Adult's Services
John Denley, Director of Public Health
Sarah Smith, Head of Strategic Commissioning

Black Country Partnership, NHS Partnership Trust
Jo Cadman, Strategy and Transformation Director

Healthwatch Wolverhampton
Elizabeth Learoyd, Chief Officer

NHS England
Jo-anne Alner, Locality Director, West Midlands

The Royal Wolverhampton Hospitals NHS Trust
David Loughton, Chief Executive
Jeremy Vanes, Chairman

Third Sector Partnership
Helen Child, Chief Officer, Citizens Advice Wolverhampton

University of Wolverhampton
Dr Alexandra Hopkins, Dean of the Faculty of Education, Health and Wellbeing
Dr Ranjit Khutan, Associate Dean, Institute of Community & Society

West Midlands Fire Service
David Baker, Operations Commander, Black Country

West Midlands Police
Chief Superintendent Jayne Meir

Wolverhampton Clinical Commissioning Group
Dr Helen Hibbs, Chief Officer
Steven Marshall, Director of Strategy & Transformation

Wolverhampton Safeguarding Board
Linda Sanders, Independent Chair

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