

Agenda

Health and Wellbeing Board

Wednesday, 21 June 2023 at 5.00 pm
At Council Chamber - Sandwell Council House, Oldbury

1 Apologies for Absence

2 Declarations of Interest

Members to declare any interests in matters to be discussed at the meeting.

3 Minutes

To confirm the minutes of the meeting held on 13 March 2023 as a correct record.

4 Additional Items of Business

To determine whether there are any additional items of business to be considered as a matter of urgency.

5 NHS Black Country ICB Joint Forward Plan

7 - 54

To note and comment on the NHS Black Country Joint Forward Plan.



- | | | |
|---|--|-----------|
| 6 | Keeping Active is Fun – Story Book | 55 - 68 |
| | To note the details of the “Keeping Active is Fun” Story Book and to consider the feasibility of the distribution of the book to children in Sandwell. | |
| 7 | Sandwell LGBTQ+ Health Needs Report | 69 - 106 |
| | To note and endorse the Sandwell LGBTQ+ Health Needs Report and ongoing work. | |
| 8 | OxWell School Survey Research Project and Eton College Partnership | 107 - 116 |
| | To agree to provide support to the future development of the Eton College Partnership and OxWell School Survey Research project. | |

Shokat Lal
Chief Executive
Sandwell Council House
Freeth Street
Oldbury
West Midlands

Distribution
Councillor Hartwell (Chair)
Councillors Hallan, Piper, Hackett, Rollins, E M Giles, Hinchliff, Fox, Mavi, Aslam, Carolan, Farmer, Muflihi, Griffin, Foster, Beeken, Davis, Taylor, Young, Bishop, Jarrett and McNally

Contact: democratic_services@sandwell.gov.uk

Information about meetings in Sandwell



If you are attending the meeting and require assistance to access the venue, please contact Democratic Services (democratic_services@sandwell.gov.uk).



If the fire alarm sounds, please follow the instructions of the officers present and leave the building by the nearest exit.



Only people invited to speak at a meeting may do so. Everyone at the meeting is expected to be respectful and listen to the discussion.



Agendas with reports with exempt information should be treated as private and confidential. It is your responsibility to ensure that any such reports are kept secure. After the meeting confidential papers should be disposed of in a secure way.



This meeting may be recorded and broadcast on the Internet. If this is the case, it will be confirmed at the meeting and further information will be provided.



You are allowed to use devices for the purposes of recording or reporting during the public session of the meeting. When using your devices they must not disrupt the meeting – please ensure they are set to silent.



Members who cannot attend the meeting should submit apologies by contacting Democratic Services (democratic_services@sandwell.gov.uk)



All agenda, reports, minutes for Sandwell Council's meetings, councillor details and more are available from our [website](#)



Sandwell Health and Wellbeing Board
21 June 2023

Report Topic:	NHS Black Country ICB Joint Forward Plan
Contact Officer:	Michelle Carolan mcarolan@nhs.net
Link to board priorities	<p>Please include in your report how your work links to one or more of our board priorities:</p> <ol style="list-style-type: none"> 1. We will help keep people healthier for longer 2. We will help keep people safe and support communities 3. We will work together to join up services 4. We will work closely with local people, partners and providers of services
Purpose of Report:	<ul style="list-style-type: none"> • To update Sandwell Health & Wellbeing Board and provide assurance on the NHS Black Country Joint Forward Plan • The NHS Black Country Joint Forward Plan is concluding and not for consultation. Please note the plan has already been circulated to all members and is coming to HWBB retrospectively as meeting dates did not align.
Recommendations	<ul style="list-style-type: none"> • That the Health and Wellbeing Board note the NHS Black Country Joint Forward Plan for assurance.
Key Discussion points:	<p>Our vision will be delivered by a team of people working together in partnership with local citizens. Through our partnership we will support and engage with communities to enable people and families to lead their best possible</p>

	<p>lives regardless of health status, age, background, or ethnicity. Together through joining up working with Local Authorities and our partners we will tackle inequalities, supporting people born and living in Sandwell to have opportunities to lead happy, healthy lives.</p>
<p>Implications (e.g. Financial, Statutory etc)</p>	
<p>The requirement to deliver a balanced finance position may impact on the ability to invest in services to deliver our plans.</p>	
<p>What engagement has or will take place with people, partners and providers?</p>	<p>Engagement/Consultation with Local Authority partners.</p>





Black Country
Integrated Care Board

Page 7

NHS Black Country Joint Forward Plan

May 2023



Black Country Integrated Care Board

Contents

Page 8

1 Our Places, Health & System Challenges

2 Our Priorities

3 Public Involvement

4 Health Inequalities Approach

5 How will we measure success

6 Strategic Workstreams

7 Place Plans

8 Enabling Workstreams

9 Delivery of Plan – Operating Model

10 Strategic Risks



Welcome to the Black Country draft Joint Forward Plan.

The plan has been developed in collaboration with wider system partners & sets out our challenges, health needs, strategic vision & strategic priorities over the next five years.

Whilst Our Joint Forward Plan sets out our vision and strategic priorities over the next five years, it is important to recognise the challenging landscape within which we will deliver our plan as we recover from Covid-19 and face a challenging financial position across our System.

Implementation of our plan will see in the following achievements

- Opening of the Midland Metropolitan University Hospital in Spring 2024.
- Implementation of our Black Country Operating Model, with effective Provider Collaborative & Place Based Partnerships whose role is to deliver efficient, productive, high quality services, address health inequalities and deliver integration of health & social care services
- As we recover from Covid, delivery of maximum wait time guarantee of no patients waiting more than 52 weeks by 2024/2025, and a return to no patients waiting more than 40 weeks by 2026/2027.
- Improving access to a number of our services, including primary care
- Implemented a shared care record that brings together data across health and care settings by 2024/2025
- Improved health outcomes and reduced health inequalities across our population

In addition, the ICB will take commissioning responsibility for Pharmacy, Optometry and Dental Services from 1st April 2023 and Specialised Commissioned services from 1st April 2024 which will allow us greater control of resources for these services.

The plan has been informed by an internal and external engagement programme which has been undertaken over the course of the last six months.

The publication of the final plan on the 30th June is just the start of our journey, we will continue to evolve and develop our plans over the next year, the plan will be reviewed and updated on an annual basis.



Principles

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



Collaboration – We will work across organisational boundaries and in partnership with other system partners in the best interest of our patients, local community and the wider population



Integration – Integrated Care System partners will work together to take collection responsibility for planning and delivering joined up health & care services



Productivity – We will ensure we improve productivity by making the best use of our collective resources by transforming the way we deliver services across the Black Country



Tackling Inequalities – We will ensure that we continue to focus on delivering exceptional healthcare for all through equitable access, excellent experience, and optimal outcomes

As the System transitions to a new way of working in line with our Operating Model, we have secured an Organisational Development partner to help facilitate cultural development and behaviours which will strengthen the way we work with partners across our system.



Our Places & Integrated Care System Partners

Page 11

The Black Country has 1.26 million residents and is made up of four distinct places: Dudley, Sandwell, Walsall and Wolverhampton.

We recognise that the Black Country is a hugely diverse area and there is no “one size fits all” approach to working with local people or partners.

The Black Country Integrated Care System (ICS) is made up of a number of partners including an Integrated Care Board (ICB) acting as the strategic commissioner, four Acute and Community Trusts, one Mental Health & Learning Disabilities Trust, one Ambulance Trust, one Integrated Care Trust, four Local Authorities, 181 GP practices, 288 Community Pharmacies, 121 Community Optometrists & 159 General Dental Practices in addition to wider voluntary & third sector partners.



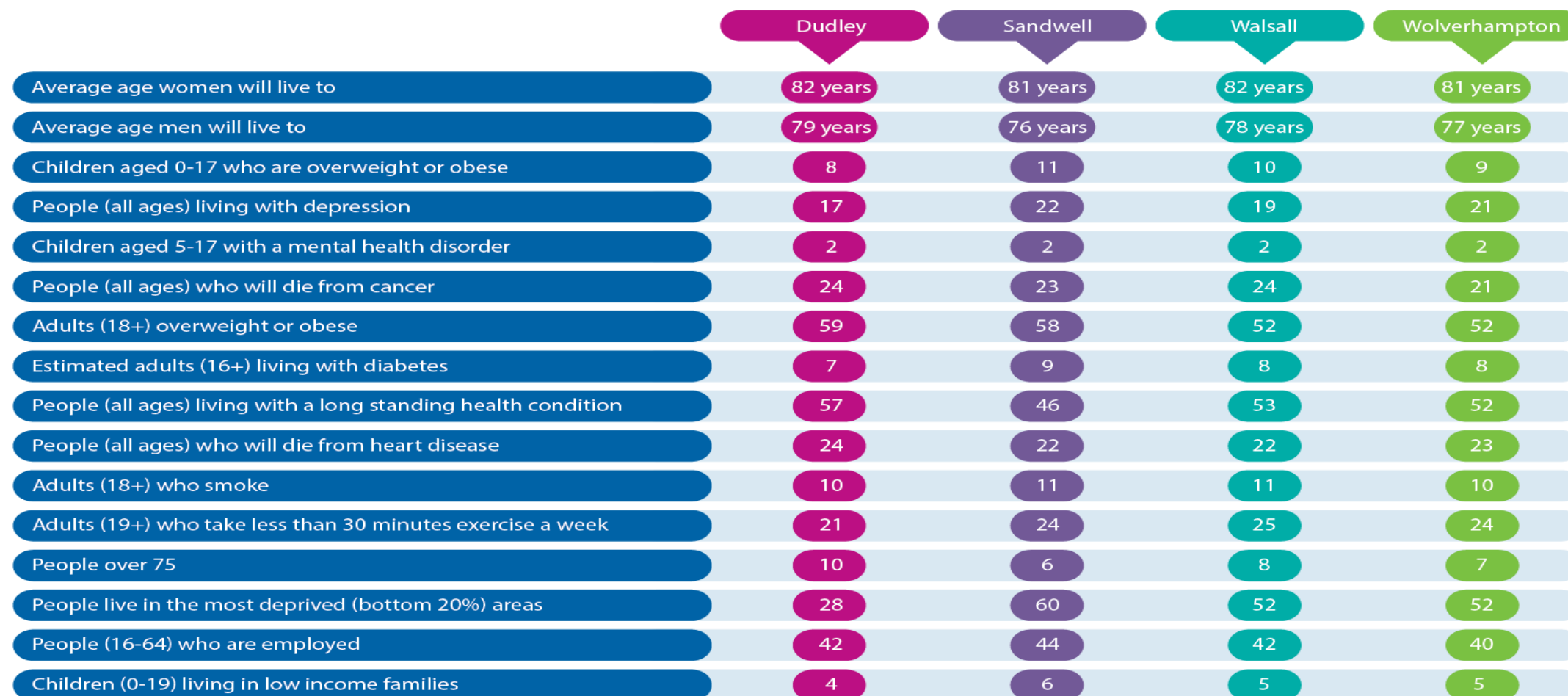
Our Health Challenges

The gap in life expectancy and healthy life expectancy (HLE) between the Black Country and England is driven by wider determinants of health, our health behaviours and lifestyles, the places and communities we live in and with and our health services.

Within the Black Country:

- Life expectancy is 77 years for males and 82 years for females, less than life expectancy of 79 years for males and 83 years for females in England
- People with mental health problems and learning disabilities have shorter life expectancies (18 years for males, 15 years for females) which is driven by their physical health.
- Healthy life expectancy is 59 years for males and 60 years for females, which is lower than the national healthy life expectancy of 63 years for males and 64 years for females.
- Wider determinants are the most important driver of health. They include income, employment, education, skills and training, housing, access to services, the environment and crime.
- Both child (43% vs 35%) and adult (72% vs 63%) obesity rates are higher than England, whilst physical activity levels (56% vs 66%) are significantly lower.
- We have some of the highest infant mortality rates in the country, whilst smoking rates in pregnancy remain high and breast-feeding rates are low.
- Locally, we have higher recorded prevalence of diabetes, chronic kidney disease, chronic heart disease (1 & or more)
- High number of premature deaths from CVD & respiratory disease, under 75 mortality rate for CVD is 99 per 100,000 & under 75 mortality rate from respiratory disease is 38 per 100,000
- Dementia Diagnosis rates are below national expectation of 66.7%, Black Country is 62%

Our Health Challenges



The graphic above identifies the variation in our population for a number of indicators and shows how many people in each place would be affected if there were 100 people in each place.



Wider System Challenges

Page 14 Whilst Our Joint Forward Plan sets out our ambition over the next five years, it is important to recognise the challenging landscape within which we will deliver our plan.

- **Restoration & recovery from COVID-19** - Whilst significant progress has been made to improve access to services and recover waiting lists there is further work to do to ensure patients are treated in a timely manner. By working in partnership across our system we have made some good progress starting with clearing the backlog of patients waiting more than 104 weeks and are now focusing on reducing 78 week waits. Primary Care have delivered an 7.8% increase in the number of additional appointments compared to pre-pandemic levels (period February 2019/20 compared to February 2022/23).
- **Urgent & Emergency Care Winter Pressures** – Urgent care remains of our most significant pressures, with the challenge surrounding patient flow of patients from the Emergency Department into hospital and with delays in ambulance response times and hospital handover delays. In addition there has been pressure in regards to discharging people from hospital. Whilst we have made some progress in recent months, by taking an more integrated approach with our social care providers and expanding our Out of Hospital Pathways there is still further opportunity to effectively support patients into the most appropriate setting as quickly as possible, thereby minimising all non-essential hospital stays.
- **Workforce** – Our workforce is a key asset to help us deliver our plans over the next five years, we know that we have significant work challenges including an ageing workforce, recruitment & retention challenges and that looking after the health & being of staff is a key priority.
- **Finance & Efficiency** – Our system is facing significant financial challenges which only be addressed by partners working together to transform & redesign services to drive improved outcomes and & make better use of resources which will help support system wide financial sustainability.
- **Our Health Population Needs** – We know that the Black Country population has significant health challenges & that COVID-19 has exacerbated existing health inequalities. By tackling these challenges we can ensure people across the Black Country can start well, live well and age well

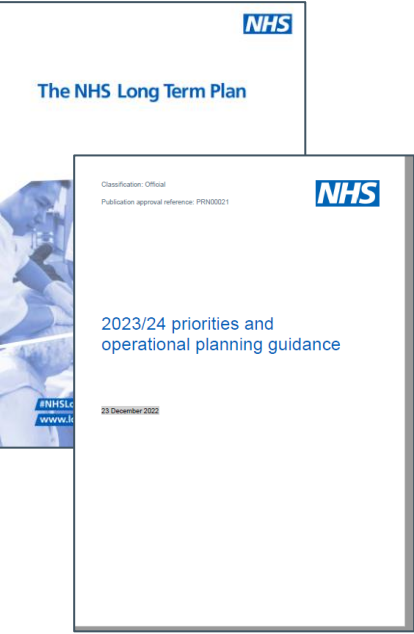


Priority Drivers



Purposes of an ICS:

- Improve health outcomes
- Tackle inequalities
- Enhance productivity and VFM
- Support social and economic development



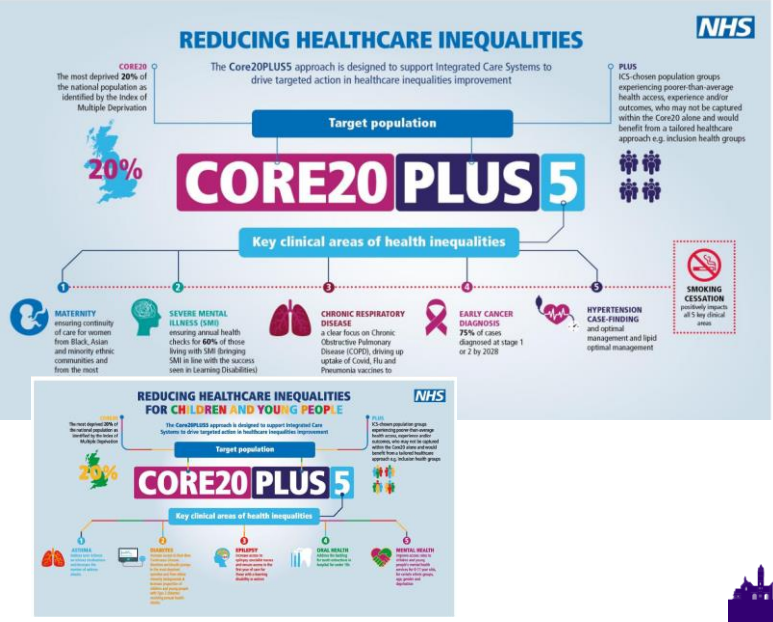
NHS Planning Priorities:

- NHS Long Term Plan (2019-2029)
- NHS Joint Forward Plan priorities (2023-2028)
- NHS Operational Planning Priorities (2023/24)



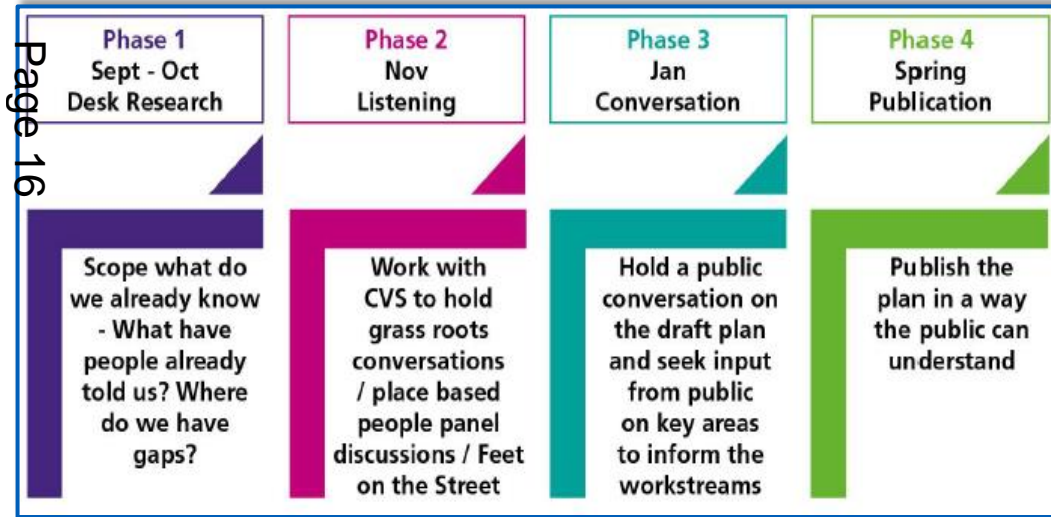
Black Country ICP Priorities:

- Mental Health
- Social Care
- Workforce
- Children & Young People



NHS Core20PLUS5 Programme



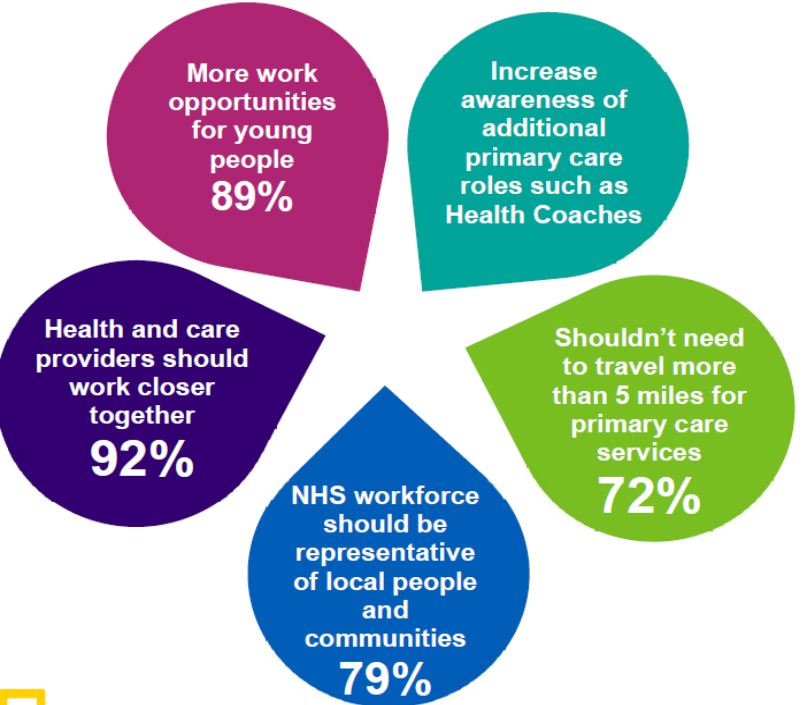


3 phase involvement approach which included desk research, public events, a survey a conversations through CVS partner services

We attended/hosted 41 activities during January at community venues, libraries and warm hubs to talk to people about the plan and help complete paper/online surveys.

1,178 completed the survey, which as a sample size of the Black Country population gives us a margin of error of 2.86%.

27 VCSE organisations hosted friendly cooking lessons, crafts sessions and coffee mornings to return insights from people who all too often go unheard.



People would like a focus on ...

- Improved access - to appointments and emergency/urgent care, to resources and reasonable adjustments, to digital devices/data/skills
- Better preventative services
- Community focus – clinical and non-clinical
- More personalised care options and choices
- Services to tackle, loneliness, isolation and mental wellbeing
- A Cost of living theme was the 'voluntary care squeeze' - the worry of working age people caring for older/ younger dependents due to cost of care
- Cost of living will increasingly impact upon those determined as 'comfortable communities' impacting on health and care services in the short and long term

Approach to Reducing Health Inequalities

Page 17

Our approach to reducing health inequalities is centred on focusing on the key clinical areas set out in the Core20 PLUS5 framework for Adults & Children

- In recognition of the significant health inequalities being experienced for patients with diabetes, the Black Country has agreed diabetes as a sixth local clinical priority area.
- Noting everyone has a role & responsibility to address Health Inequalities our plans to address our clinical priority areas is interwoven into respective Strategic Workstream, Enabling & Place delivery plans
- We have adopted a whole system approach to tackling inequalities which includes five strategic pillars of activity which will help us address complex & varied inequalities faced by our communities
 - Involving People & Communities
 - Population Health Management
 - Achieving Health Equity
 - Focusing on Prevention
 - Wider Determinants of Health



NHS Joint Forward Plan Priorities

Priority 1 : Improving access and quality of services

Outcomes

- Recovery from COVID 19
- Improved access to Urgent and Emergency care
- Reduced waiting times for Elective and Diagnostic Care
- Timely diagnosis and faster treatment for cancer
- Access to appointments in Primary Care
- Improved choice of care provider
- Better Patient Experience
- More joined up care
- New technologies
- Reduced variation in way services are delivered and outcomes achieved

Priority 2 : Community where possible Hospital where necessary

Outcomes

- Reducing the time spent in hospital
- Care Closer to home
- Better management of Long Term Conditions
- More Personalised care
- Early identification of disease
- Use of digital technologies for increased independence

Priority 5 : Best place to work

Outcomes

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

Priority 4 : Giving people the best start in life

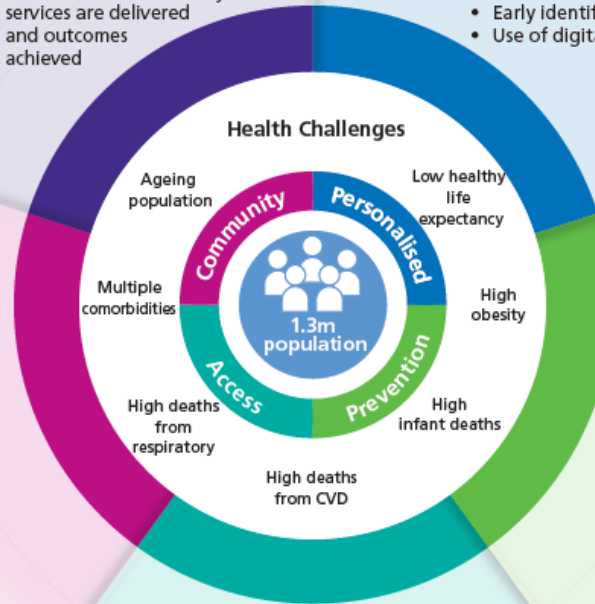
Outcomes

- Increase in breast feeding rates
- Reducing smoking in pregnancy
- Improving neonatal deaths
- Increased protection of disease through improved childhood immunisations
- Supporting families to make healthy life choices and reduce obesity rates in children

Priority 3 : Preventing ill health and tackling health inequalities

Outcomes

- Improve screening
- Closer working with local authorities and wider system partners
- Supporting our most deprived communities with better prevention, detection and treatment of ill health
- Working with colleagues in housing, education and employment to improve the wider determinants of health



What will be different for our population?



How will we measure delivery of our priorities?

Priority 1 - Improving access & quality of services starting with recovery from covid-19

Example Metrics

- Reduced waiting times, 52/ 65 week waits, 62 Day Cancer waits, Cancer Faster Diagnosis Standard, IAPT, OOA Placements, patient experience, readmissions

Priority 2 – Community where possible, hospital where necessary

Example Metrics

- Primary Care Appointments, Units of Dental Activity, Virtual ward occupancy, community waiting lists

Priority 3 – Preventing ill health and tackling health inequalities in health outcomes

Example Metrics

- Proportion of people adult or maternity settings offered tobacco dependence services, vaccination/flu uptake, Core20PLUS5, screening uptake

Priority 4 – Give people the best start in life

Example Metrics

- Number of neonatal deaths, childhood vaccinations, engagement with Family Hubs/ Start for Life Programme

Priority 5 – Best place to work

Example Metrics

- Staff Sickness levels, turnover/vacancy rates, staff survey results

We will identify key metrics to support each strategic priority and report regularly on delivery

Delivery of our Plan – Operating Model

Black Country ICS – Operating Model to support Joint Forward Plan							
DRIVERS	<p>Purposes of an ICS: Improve health outcomes; Tackle inequalities; Enhance productivity and VFM; Support social & economic development</p> <p>Black Country ICP Priorities: Mental Health; Social Care; Workforce; Children & Young People</p>						
STRATEGY	<p>BLACK COUNTRY INTEGRATED CARE PARTNERSHIP BLACK COUNTRY INTEGRATED CARE BOARD HEALTH & WELLBEING BOARDS</p>						
JOINT FORWARD PLAN PRIORITIES	<p>Priority 1: Improving access and quality of services starting with recovery from Covid-19 Priority 2: Community where possible, hospital where necessary Priority 3: Preventing ill-health and tackling inequalities in health outcomes Priority 4: Give people the best start in life Priority 5: Be the best place to work</p>						
JOINT PLANNING	MHLDA Joint Oversight Committee	Provider Collaborative Joint Oversight Committee	Dudley Integrated/Joint Committee	Sandwell Integrated/Joint Committee	Wolverhampton Integrated/Joint Committee	Walsall Integrated/Joint Committee	Primary Care Joint Oversight Committee
DELIVERY	Mental Health / LDA Lead Provider	Provider Collaborative (Acute)	Dudley Health & Care Partnership	Sandwell Health & Care Partnership	One Wolverhampton	Walsall Together	Primary Care Collaborative
PRINCIPLES	Supported by the principles of Collaboration: Integration; Productivity; Targeting inequalities						



Strategic Workstreams



Elective Care

Our vision is to deliver as one healthcare system, across multiple sites, working in partnership to provide better, faster and safer care to the population of the Black Country and beyond.

Strategic Priorities

Working as one healthcare system, across the Acute Collaborative's Clinical Networks, Primary Care and the system's network of Operational Groups, we will apply evidenced best practice to improve safety and optimise efficiencies in pathways and processes. Our strategic priorities are as follows:

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

Outcomes to be Achieved

For our Patients:

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

For Organisations:

- Improved organisation, productivity and workforce resilience
- New technologies and transformed care
- Outpatient transformation (FUs, PIFU, SA)
- Increased capacity and service resilience

For our System:

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

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

Cancer

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



Black Country
Integrated Care Board

Strategic Priorities

A priority area is to better understand differences in cancer outcomes and experience across our diverse population and ensure that unwarranted variation is addressed. It is imperative that we are able to reach and engage with our population groups in order to improve their cancer outcomes once diagnosed. Cancer shares many of the same risk factors as other major causes of ill health and early death, for example obesity and smoking, therefore our work programmes to improve prevention and tackle wider determinants will support a reduction in cancer incidence. Earlier diagnosis is a priority and we plan to accelerate improvements through better engagement with our population and working collaboratively to better utilise the resources we have to improve services. We aim to ensure that patients have the best experience possible through every stage of their cancer journey and we will do that by providing caring and compassionate services for our population.

Outcomes to be Achieved

For our Patients:

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

For Organisations:

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

For our System:

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

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

Diagnostics

Our vision is to provide equitable access to modern, state of the art, high-quality diagnostics, in a timely manner



Black Country
Integrated Care Board

Strategic Priorities

Diagnostics plays a key role within system recovery and is at the centre of disease and patient pathways, to detect disease as early as possible and accurately guide to the right treatments. Currently, these services are predominantly based in our main hospitals, serving urgent as well as routine planned care. The need to increase capacity provides an opportunity to deliver services in a different way. We will develop our diagnostic strategy ensuring alignment with wider workstreams such as elective care and cancer.

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

Outcomes to be Achieved

For our Patients:

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

For Organisations:

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

For our System:

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

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

Urgent and Emergency Care (UEC)

Our vision is to ensure patients have access to high quality urgent and emergency care services in the right place at the right time, delivered by the right professional.

Strategic Priorities

Our overarching aim is to ensure that we can deliver an Urgent & Emergency Care Service that is fit for the future. We will do this by reviewing our current capacity & demand to ensure that we have a sustainable UEC model that will meet future demand. Our strategic priorities include focusing on expanding and better joining up new types of care outside of Emergency Departments (Out of Hospital/Community Services) by ensuring effective utilisation of Urgent Community Response Services, Urgent Treatment Centres, the expansion of Virtual Wards and use of remote monitoring. We will also ensure that we continue to improve development at pace of step down and hospital discharge pathways to effectively deescalate need and promote a return to independence in community settings following a UEC health crisis. The delivery of the UEC plan is underpinned by strong system leadership through the Urgent & Emergency Care Strategic Board and the System Control Centre.

Outcomes to be Achieved

For our Patients:

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

For Organisations:

- Enhanced triaging and streaming to increase the number of people receiving urgent care in settings outside of the Emergency Department to include SDEC, UTC and UCR.
- Improvements in handover times between the Ambulance Service and Emergency Departments

For our System:

- Sustainable & resilient Emergency & Care Model across the system
- Consistency of Urgent & Emergency Care Services & pathways across our system

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

Out of Hospital

Our vision is to transform and build Out of Hospital & Community Services to deliver a ‘home first’ philosophy. Supporting people to stay well and independent for as long as possible, through the provision of high quality and accessible services, tackling inequalities in access and outcomes, whilst ensuring a supported, skilled and fulfilled workforce.

Strategic Priorities

There are a number of core strategic priorities that will help achieve our Out of Hospital vision centred around promoting greater care in patients homes, increasing the use of virtual wards and investment in remote monitoring. Achieving equitable access to services will only be achieved in collaboration with system partners and with the co-production of seamless pathways with health & social care partners, including third sector to create seamless pathways, which reduce duplication and variation across the Black Country. A priority is to understand the demands on the care home sector and ensure the availability of effective and supported care, for example implementing the Enhanced Care in Care Homes Framework. Underpinning delivery of the plan is of transparency of data to enable outcomes measures to be monitored as well as stakeholder engagement and effective communication to citizens on prevention, education, self care, access and experience & investment into the community workforce to enable the home first philosophy to grow.

Outcomes to be Achieved

For our Patients:

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

For Organisations:

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

For our System:

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

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

Long Term Conditions Management

Our vision is to ensure we reduce the prevalence of people with Long Term Conditions in our population, and that we support those people living with Long Term Conditions to live longer and happier lives through effective processes of prevention, detection and treatment.



Black Country
Integrated Care Board

Strategic Priorities

The Black Country is recognised as suffering from one of the highest levels of deprivation across England and many people struggle to access healthcare to diagnose and manage their long-term conditions. It is recognised that long term conditions such as Diabetes and Cardio-Vascular Disease (CVD), are amongst the top five causes of early death in our population. Our priority is to prevent treatable conditions, through effective prevention programmes, active patient engagement and improved health literacy. We will ensure that where patients have long term conditions they are supported to manage them effectively, through self-care and use of digital technologies. We will integrate pathways to manage care in primary and community settings and avoid exacerbation and inappropriate admission to hospital. Our programme of work will support the delivery of local health inequalities initiatives based upon the Core20PLUS5 framework.

Outcomes to be Achieved

For our Patients:

- Earlier Diagnosis
- Reduce preventable illness
- Improved life expectancy
- Reduced mortality
- Patient empowerment, increase in patient led condition management

For Organisations:

- Reduced pressure in unplanned & urgent care
- More effective utilisation of capacity/resources
- Better use of technologies

For our System:

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

Work Programme	To be delivered by:	Yr1	Yr2	Yr3	Yr4	Yr5
Diabetes	Delivery of prevention, detection and treatment programmes relating to structured education programme, National Diabetes Prevention Programme, Low Calorie Diet, Extended Continuous Glucose Monitoring, Joint Diabetes & Improving Access to Psychological therapies pilot, Multi Disciplinary Footcare Teams	✓	✓	✓	✓	✓
Post COVID-19 Services	Ensuring patients continue to receive access to post Covid 19 services in a timely manner	✓	✓			
CVD	Delivery of initiatives to improve early detection & management of CVD including hypertension case finding, BP at Home Service, delivery of Cardiac Improvement Programme	✓	✓	✓	✓	✓
Respiratory	Development & delivery of pulmonary rehabilitation five year plan including development of spirometry services, expansion of remote monitoring programme & lung health check programmes	✓	✓	✓	✓	✓

Children and Young People Services

Our vision is that every child gets the right help, at the right time, by the right service, to ensure they meet their full potential



Black Country
Integrated Care Board

Strategic Priorities

To achieve our vision we will develop a Children and Young People's Strategy that will provide focus and clarity on the priorities for improving services and life opportunities for children and young people living in the Black Country. Our strategy will ensure the needs of all CYP across our diverse population are met, recognising that 53% of our CYP are within the 20% most deprived IMD sectors nationally. In light of our local challenges, the system has committed to delivering the national Transformation Programme for CYP. CYP access care across all sectors and domains of health our Joint Forward Plan recognises this. We will develop robust monitoring mechanisms for use across the system to understand and take action where variation and/or outcomes requires improvement actions. The ambition is to ensure all services provide high quality and equitable services for all, including CYP across the Black Country.

Outcomes to be Achieved

For our Patients:

- Increase ability to self-manage LTC and increase quality of life (QALY)
- Co-production and ability to inform, challenge and embed service improvements
- Clear service pathways for patients

For Organisations and the System

- Developed joint commissioning, improved service efficiency and effectiveness
- Increased understanding of the need of CYP across the system, embedding all age commissioning
- Improved health outcomes for our most vulnerable including LAC, SEND, most deprived etc
- Development of an integrated specification for CYP, evidencing good partnership working and shared outcomes

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

Maternity and Neonatal Services

To deliver high-quality maternity and neonatal services across the Black Country, through co-production with our women, which will be safe, personalised and equitable to ensure every woman and baby receives the best possible care



Black Country
Integrated Care Board

Strategic Priorities

There are a number of strategic priorities to address the core challenges for the Local Maternity and Neonatal Service (LMNS), which will transform maternity and neonatal services and meet both locally identified priorities and national expectations. These strategic priorities are Perinatal Quality Surveillance, Maternity Continuity of Carer (CoC), Workforce, Reduced Perinatal Mortality and Morbidity and implementation of the action plan to improve Perinatal Health Inequalities. Our LMNS is well established with all partners engaged in collaborative working and collective learning, supported by a strong Maternity and Neonatal Voices Partnership (MNVP) ensure our service users voices are heard. Reducing health inequalities and fulfilling our Core20PLUS5 requirements is a core element of all work programmes.

Outcomes to be Achieved

For our Patients:

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

For Organisations:

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

For our System:

- System leadership, supported by MNVP
- Collaboration and peer review/ learning
- Reduced health inequalities

Work Programme	To be delivered by:	Yr1	Yr2	Yr3	Yr4	Yr5
Perinatal Quality Surveillance Model To enhance the existing model a robust quality assurance process will be implemented, included peer review to achieve assurance of quality and safety, and delivery of Saving Babies Lives Care Bundle v2 & v3.		✓				
Workforce To further build on our progress, we will develop a workforce strategy focusing on consolidating recruitment for cross boundary working, new roles, shared recruitment and succession planning.				✓		
Maternity Continuity of Carer (CoC) To implement our 5-year transformation plan, ensuring our model reflects the needs of our population and focuses on choice of place of birth rather than geography.						✓
Reduce Perinatal Mortality and Morbidity Work collaboratively to identify improvement actions to improve outcomes and reduce health inequalities. Improving access to specialist care where required.				✓		
Perinatal Equity and Equality Strategy and Action Plan Through our dedicated EDI leads we will implement our action plan, ensuring we accelerate work to support those at greatest risk of poor health outcomes.						✓

Mental Health and People with Learning Disabilities and Autism

Our vision is to ensure our citizens have access to services that are of outstanding quality, and that support people to live their best lives as part of their local community

Strategic Priorities

We have a comprehensive programme of work to increase access and availability of support across the pathway from helping people to stay mentally well, to urgent and crisis support when needed. Through our programmes we are embedding community focused and trauma informed models of care, with integrated pathways across agencies. We have a strong focus on community advocacy, engagement and inclusion, and are committed to advancing health equity and increasing focus on the wider determinants of health.

Outcomes to be Achieved

For our Patients:

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

For Organisations:

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

For our System:

- Parity of esteem between physical and mental health
- Successful achievement of national ambitions for MH & LDA
- Benefit from economies of scale and specialism

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

Medicines Management

Our vision is to transform pharmacy and galvanise medicines optimisation so that our population gets the best from their medicines and pharmacy services, leading to improved health outcomes and reduced health inequalities, improved service quality and sustainability.

Strategic Priorities

Medicines are the most common therapeutic intervention and the second highest area of NHS spending after staffing costs. We invest approximately 13% of the total funding on medicines, therefore prescribing plays a vital role in improving health outcomes and ensuring the most efficient use of NHS resources. It is of vital importance our decision-making processes are clear, transparent and decrease unwarranted variation, whilst ensuring we engage with all stakeholders involved in prescribing and supply of medicines across the Black Country. In addition, we recognise that medicines optimisation is a key enabler to support delivery of our Joint Forward Plan across a number of workstreams.

Outcomes to be Achieved

For our Patients:

- Early prevention of infections
- Appropriate prescribing and use of antimicrobials
- Effective management of infections/ disease
- Reduced medicine related errors, reducing harm for patients
- Reduced risk of hospitalisation of our most vulnerable people
- Improved detection of conditions such as hypertension

For Organisations:

- Maximise value through medicines supply and use
- Efficient use of resources

For our System:

- Reduced unwarranted variation in prescribing across our system

Work Programme	To be delivered by:	Yr1	Yr2	Yr3	Yr4	Yr5
Appropriate Use of Antibiotics Implement our strategy and annual work plan to deliver education to all sectors, surveillance of antibiotic usage and reduction of 'watch and reserve' antibiotics.			✓	✓	✓	✓
Medicines Safety Establish a multi-sector network and education programme to reduce high dose opioid prescribing and reduce administration errors.			✓	✓		
Covid Medicines Delivery Unit Ensure accessible services are in place to meet the needs of our population. Equitable access will be achieved through delivering treatment to the patient home.		✓	✓			
Maximise Value A Better Value Medicines Programme will be established to maximise efficiencies across sectors, along with a High Cost Drugs Group to monitor use and spend.		✓	✓			
Reduce Unwarranted Variation in Prescribing Formulary harmonisation across the system will be achieved to reduce differences in the prescribed medication available to patients.		✓				

Primary Care

Our vision is to implement a transformed Primary Care operating model that delivers equitable access to high quality care that is safe, integrated, consistent and citizen-centred across the care continuum

Strategic Priorities

Our priorities are to develop the future integrated operating model of primary care, embed the Black Country Primary Care Collaborative as a key vehicle for consensus building and collaboration leading and driving the provision of excellent integrated primary care, and to enable Primary Care Networks to maximise their contribution within resilient communities. Working together we will embark on a 'big conversation' with local people and improve access sustainably through addressing quality, improving the working lives of our staff, adopting digitisation, optimising our estates and communications, whilst embracing the opportunities afforded by best practice, research and national policy, including the Fuller recommendations. We will also ensure we have the infrastructure, capacity, and capability to deliver our delegated responsibilities regarding the commissioning of GP and Pharmaceutical, General Ophthalmic and Dental services (the four pillars of primary care).

Outcomes to be Achieved

For our Patients:

- Increase GP appointments, improve access, and reduce waiting times
- Increase dental activity
- Increase patient satisfaction and experience
- Increase digital functionality, including telephony

For Organisations/ Our System:

- Grow our workforce, expand new roles
- Implementation of Fuller recommendations
- Deliver our delegated responsibilities (GP & POD)
- Optimised estates and communications
- Establish integrated ways of working
- Deliver the PCC Transformation Programme

Work Programme	To be delivered by:	Yr1	Yr2	Yr3	Yr4	Yr5
Development/embedding of Primary Care Collaborative – establish the governance, clinical leadership and the required infrastructure to deliver collaborative working			✓			
Establish/develop the primary care workforce and transformation unit (primary care delivery vehicle) – establish new ways of working, deliver OD & work programme focussing on access, LTC & unwarranted variation				✓		
PCC transformation work programme (future operating model) – undertake strategic development and implement the transformation programme						✓
Improving general medical services (GP) access – support PCNs to implement practice based solutions to improve patient access and experience		✓				
PCN Estates Programme – reconfiguration of vacant space, maximise e-booking systems, and deliver the Estates Strategy.						✓
PCN Development Programme – support PCNs to 'maturity' and embed the development programme reflecting the Fuller recommendations				✓		
Increasing Dental Access Programme – Develop a dental strategy & deliver improvement plans						✓
ICS Primary and Community Care Training Hub contract/system workforce development programme – Embed workforce planning & secure the resources to deliver the improvements			✓			

Social, Economic, and Environmental Development

Our vision is to deliver positive economic, social and environment outcomes locally through collaboration and collective action



Black Country
Integrated Care Board

Strategic Priorities

The wider determinants of health are a diverse range of social, economic and environmental factors which influence people’s mental and physical health. Our established Black Country Anchor Institutions Network (BCAIN) will harness their collective assets for economic and social benefits, driving positive change to achieve a more inclusive economy. BCAIN will evolve to become more strategic and engage wider employers to better focus local assets on areas of need/impact. Through the use of insights and economic data we will gain a better understanding of the wider determinants of health factors for our population, thus enabling us to shape the social and economic context in which our services are provided. We will maintain oversight of the ‘Economy of Together 2030 Action Plan’ building mutual accountability, focusing on leadership and spreading the intentionality of the anchor movement. This will enable us to scale up local initiatives, working with partners, for the benefit of our population.

Outcomes to be Achieved

For our Patients:

- Fairer more equitable society with equality of opportunity
- Closing the inequality gap
- Education system that provides the same opportunities for all
- A more physically activity and engaged population, with access to safe spaces

For Organisations:

- Careers and employment initiatives that inspire all members of society to fulfil their potential
- Improved workforce resilience, representative of the communities they serve

For our System:

- Diversity in leadership, equipped and informed to act
- A thriving well supported social enterprise sector
- Maximise local employment in our supply chains

Work Programme	To be delivered by:	Yr1	Yr2	Yr3	Yr4	Yr5
Local Employment Opportunities	To contribute to the local economy by skilling up and employing local people who are unemployed or at risk of unemployment, and committing to inclusive practices and continued professional development for our existing staff.	✓	✓	✓	✓	✓
Enable new procurement / supply chain policies	To source goods/services locally and ensure economies are inclusive. Use contracts to improve social, environment & economic value, including prioritising investment that reduces inequalities, and build this approach into sourcing processes.	✓	✓	✓	✓	✓
Collective Action on Climate Change	Support achievement of Our Greener NHS Plan, through using our assets to pursue projects that take action towards our climate change goals, improve the lives of our population and reduce health inequalities in our communities.	✓	✓	✓	✓	✓
Oversight of the Economy of Together 2030	Strive towards our ambition for a more equitable Black Country, better educated, enterprising with greater social responsibility, and healthier and environmentally friendly.	✓	✓	✓	✓	✓

Prevention

Our vision is to increase healthy life expectancy so people can live the life that matters to them, preventing illness and improving life expectancy

Strategic Priorities

Improving the population's health and preventing illness and disease is key to reducing health inequalities and is at the heart of the NHS Long Term Plan. Many conditions which can contribute to shorter healthy life expectancy are preventable. While the factors which can lead to these conditions are many and varied, through prevention our aim is to help people improve their own health, through targeted support to help people reduce their dependency on alcohol or tobacco, to offering weight management services, to cancer screening and through access to the Diabetes Prevention Programme. We will develop our prevention capacity and capability across the Integrated Care Partnership, working to harness our collective assets and embedding preventative approaches as a continuum, ensuring health equity is our golden thread.

Prevention is a key theme across the Joint Forward Plan, please see wider workstreams for further action on prevention, eg Long Terms Conditions, Out of Hospital, Primary Care, etc.

Outcomes to be Achieved

For our Patients:

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

For Organisations:

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

For our System:

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

Work Programme	To be delivered by:	Yr1	Yr2	Yr3	Yr4	Yr5
Tobacco Dependence To complete the establishment of Tobacco Dependence Services across all inpatient and maternity services. We will identify opportunities to improve pathways and support in the community and primary care. An assurance cycle will be established to enable targeted support, along with an evaluation.		✓				
Healthy Weight To further embed the tier 2 programme through training and awareness across sectors, with targeted support where needed. Performance monitoring will continue and analysis of the 'obesity burden profile'. Further exploration of inequity across tier 3/4 interventions to be undertaken and addressed.		✓	✓			
Alcohol Dependence To evaluate the Alcohol Care Teams established in each hospital to inform future decision making, and test the early intervention and targeted prevention pilot.		✓				

Place Plans



Dudley Place

Community where possible; hospital when necessary, by working together, connecting communities, enabling coordinated care for our citizens to live longer, happier and healthier lives.

Strategic Priorities

Our vision will be delivered through a number of work programmes set out below. Collaboration and integration are critical when designing new and often complex solutions and through strengthening our partnership we will achieve our vision. Our health and wellbeing priorities are addressed throughout our work programme, and as an anchor network we will undertake actions to support social and economic determinants of health and wellbeing.

Health & Wellbeing Priorities

- Improving school readiness
 - Reducing circulatory disease deaths
 - Improving breast cancer screening coverage
- With a focus on those neighbourhoods with the greatest need

Outcomes to be Achieved

For our Patients:

- Care close to home with improved outcomes
- Longer healthy life expectancy
- Personalised care and improved patient experience

For Organisations:

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

For our System:

- Thriving VCS with increased collaboration
- Sustainable health and care system
- Improved health and wellbeing for our population
- Sustainable workforce reflective of the population we serve

Work Programme	To be delivered by:	Yr1	Yr2	Yr3	Yr4	Yr5
Strengthen Partnership Effectiveness We will work to ensure the sustainability of Dudley’s thriving voluntary and community sector, to include establishing an Anchor network and Compact.						✓
Transform Citizen Experience (Integrated Care Teams) Through Integrated Care Teams and adoption of Population Health Management approaches we will deliver safe, coordinated and effective care in the community, that meets the needs of our patients.						✓
Shift the Curve of Future Demand To implement our Primary Care Strategy including the following; access, sustainability, population health, MDT, personalisation, collaboration, development and resilience. We will grow and nurture our workforce from our local community.						✓
Health Inequalities Contribute to Dudley’s Joint Health, Wellbeing and Inequalities Strategy with a focus on prevention and access. To reduce health inequalities with a specific focus on our health and wellbeing priorities, and addressing wider determinants of health.						✓
Children and Young People Initially we will focus on Family Hubs/ Start for Life which has 6 specific areas of action, to provide seamless support for families and an empowered workforce						✓

Sandwell Place

People living in Sandwell will receive excellent care and support within their local area, exactly when they need it.



Black Country
Integrated Care Board

Strategic Priorities

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

Health & Wellbeing Priorities

- We will help people stay healthier for longer
- We will help people stay safe and support communities
- We will work together to join up services
- We will work closely with local people, partners and providers of services

Outcomes to be Achieved

For our Patients:

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

For Organisations:

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

For our System:

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

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

Walsall Place

To level up on social and quality of life issues - such as mental wellbeing, uneven life expectancy, excessive elective surgery waiting time, fighting gang crime, encourage healthier lives, and creating a safer environment

Strategic Priorities

Our plan outlines the intention to invest in the Mental and Physical Wellbeing of residents to continue to build a Borough to be proud of and improve the outcomes for the people of Walsall. Our overall programme reflects our commitments to our health and wellbeing priorities, and addressing wider determinants of health.

Health & Wellbeing Priorities

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

Outcomes to be Achieved

For our Patients:

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

For Organisations:

- Outcomes framework to identify opportunities
- Digital technology and innovation
- Integrated services to remove barriers, duplication and provide better value

For our System:

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

Work Programme	To be delivered by:	Yr1	Yr2	Yr3	Yr4	Yr5
Primary Care Networks (PCN) Development Programme - To support delivery of the DES, establish stronger partnerships and join up care.						✓
Resilient Communities (Tier 0) - Working together to ensure citizens are supported to live healthy lives; Prevention, identification, early intervention & self-care.						✓
Family Hub programme - Focus on Family Hubs/ Start for Life which has 6 specific areas of action, with seamless support for families and an empowered workforce.						✓
Integrated Place Based Teams (Tier 1) - Integrated Primary, Social and Community Services, delivering care at scale through a hub & spoke model across each locality.						✓
Specialist Community Services (Tier 2) - Accessible, high quality care with local hospital teams working in a locality 'Health and Wellbeing Centres'			✓			
Intermediate, Unplanned and Crisis Services (Tier 3) - Network of care delivered from Health and Wellbeing Centres, preventing unnecessary hospital admissions			✓			
Acute and Emergency Services (Tier 4) - Access to high quality acute hospital services for patients needing specialist intervention	✓					
BCH Community Mental Health Transformation - working together to expand working relationships, review current pathways and development opportunities.						✓

Wolverhampton Place

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

Strategic Priorities

Supporting this vision is the development of joint commissioning arrangements for Place, with a programme of work underpinning the vision delivered through the One Wolverhampton partnership and through other programmes of work aligned to the HWB Health Inequalities Strategy.

Health & Wellbeing Priorities

- Growing Well (Early Years & CYP Mental Wellbeing)
- Living Well (Workforce, City Centre, Prevention)
- Ageing Well (Integrated Care, Dementia Friendly)
- System Leadership

Outcomes to be Achieved

For our Patients:

- Active daily, live longer happier healthier lives
- Improved GP access, improved patient experience
- Access to responsible and timely interventions, including prevention
- Improved patient outcomes, early detection/screening and management of long term conditions

For Organisations:

- Admission avoidance and expedited discharge
- Reduced demand for hospital services
- Integrated, joined up services, reducing duplication

For our System:

- Tackle unwarranted variation in service quality
- Reduce health inequalities
- Sustainable workforce

Work Programme	To be delivered by:	Yr1	Yr2	Yr3	Yr4	Yr5
Physical Inactivity Exemplar - Residents supported to have longer, happier and healthier lives, enabled to be active every day including safe spaces, address wider determinants.					✓	✓
Primary Care Development - support delivery of the DES, improve pathways, share good practice and achieve consistent standards.		✓	✓			
Adult Mental Health - delivery of the community transformation programme, understand local need and deliver responsive/enhanced services.		✓	✓			
Children and Young People - support the development of Family Hubs/ Start for Life, integrating services to improve the interface between services and access.		✓	✓	✓		
Living Well - supporting people to live well and as independently as possible within their communities, increasing opportunities for self-help and community resilience, increasing uptake of screening, health checks and diagnosis.		✓	✓	✓		
Out of Hospital - further develop existing services and discharge pathways, ensure a joined up approach, supporting people with complex needs.		✓	✓			
Urgent and Emergency Care - Expansion of the integrated front door model and wider integration with care coordination, improved access to urgent diagnostics.		✓	✓	✓		

Enabling Workstreams



Page 42
What?



- As 'one workforce' we're better
- Developing the culture and infrastructure for 'one workforce'
- Adopting NHS England guidance on the ICS people function
- Co-creating a People Plan across the system in collaboration with partners



Why?

Through creating psychologically safe and supportive environments, where all of our diverse colleagues feel belonged, we can provide the architecture for developing a workforce that is sustainable for the future.
Coordinated workforce planning, education and training to develop an optimised model and drive improvements in health inequalities.

How?

Focus on retaining our people and supporting them to be the best they can be, which in turn optimises our resources

Underpinned with an inclusive talent management approach

Co-produce a system People Plan 2023 – 2028 that describes the priorities, actions and impact to make the Black Country the best place to work.



When?

Develop 2022/23 annual report for the people programme	April 2023
Facilitate two workshops that aim to co-produce the governance framework and people priorities for 2023/24	May 2023
Create people programme delivery plan for 2023/24 and commit investment and resources	June 2023
Co-produce the system People Plan for 2023 – 2028 and engage stakeholders for feedback and sign off	July 2023

During the planning period we aim to achieve financial sustainability as a System. This will be supported by the development of a financial framework, the purpose of which will be:

Page 43

To set out the financial strategy and approach for the Black Country Integrated Care System to support the delivery of its aims and core strategies. This will include:-

- To outline the strategic context (including “why this is an imperative now”).
- To describe the current financial position in the Black Country.
- To outline options for the improvement to the depth, quality, and reporting of key financial information to all parties.
- To summarise the recent planning guidance and how it might affect the ICS.
- To explore the approach to the development of strategy and resource allocation.
- To describe options for the cross-system management of key issues.
- To outline options for better working and collaboration.

Provide a ‘staging post’ in respect of policy, history and direction of travel.

Support the improvement of organisational relationships and collaboration.

Part of a new way forward to improve services and benefit patients.

Key Themes with the Financial Framework

- **Principles** agreed by system CFOs to improve joint working, including:-
 - Transparent, system first, compliance with Nolan principles of public office, share risk, collaborate at scale, etc.

Page 44

Developing the level of **collaboration** within system finance

Statutory financial duties and supporting metrics

- All NHS organisations within the ICS have a statutory duty to maintain a balanced financial position (capital and revenue).
- Supporting metrics include MHIS, cash, Better Care Fund, Running Costs Allowance/Trust corporate costs, agency spend, supplier payment, etc.
- **Improving financial planning**
 - Acknowledge the need to improve our system financial planning arrangements and consider improved methods for the future, e.g., an eight quarters 'rolling' financial plan.
- **Developing the system's financial reporting**
 - Mandated elements, e.g., national and regional reporting to NHSE
 - Local elements,
- **Internal Reporting** (CFO/AO/Productivity and Value Group, partner organisations, system committees, etc.)
- **Additional Reporting** (Benchmarking, productivity, linkages to workforce and activity, etc.)
 - Improved decision making/maximising the use benchmarking information to optimise use of Black Country resources, VFM, etc.
- **Resource distribution**
 - Limited resource in short to medium-term (In 2023/24 - the baseline capital allocation is £79.6m and revenue £2.6 billion)
 - Considerations for distribution (both financial and non-financial)
 - To ensure a fair distribution linked to output, performance, need, etc.
 - Consideration of sector-based approaches to resource distribution.
- **Developing future productivity and efficiency programmes** to ensure long-term financial sustainability
 - Efficiency and increasingly strategic transformation programmes will be essential as we enter a period of financial challenge.
- **Governance and system oversight arrangements**
 - Role of the Productivity and Value Group/proposed oversight arrangements

Personalisation is about giving back power to people – focusing on placing the individual at the centre of their care, reinforcing that the individual is best placed to know what they need and how those needs can be best met (Carr, 2008). It provides an overarching lens or ethos for the care provided over the whole course of a person’s life from birth to end of life and enables people to have choice and control, considering what matters to them and empowering them to have responsibility over their own health. Our Joint Forward Plan describes our commitment to implementing the Comprehensive Model of Personalised Care. The model core components and our strategic actions are set out below, further detail can be found within our wider workstreams regarding the implementation of personalised care across our Joint Forward Plan.

Shared Decision Making

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

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

Personalised Care and Support Planning

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

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

Enabling Choice, including legal rights to choose

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

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

Social Prescribing & Community Based Support

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

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

Support Self-Management

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

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

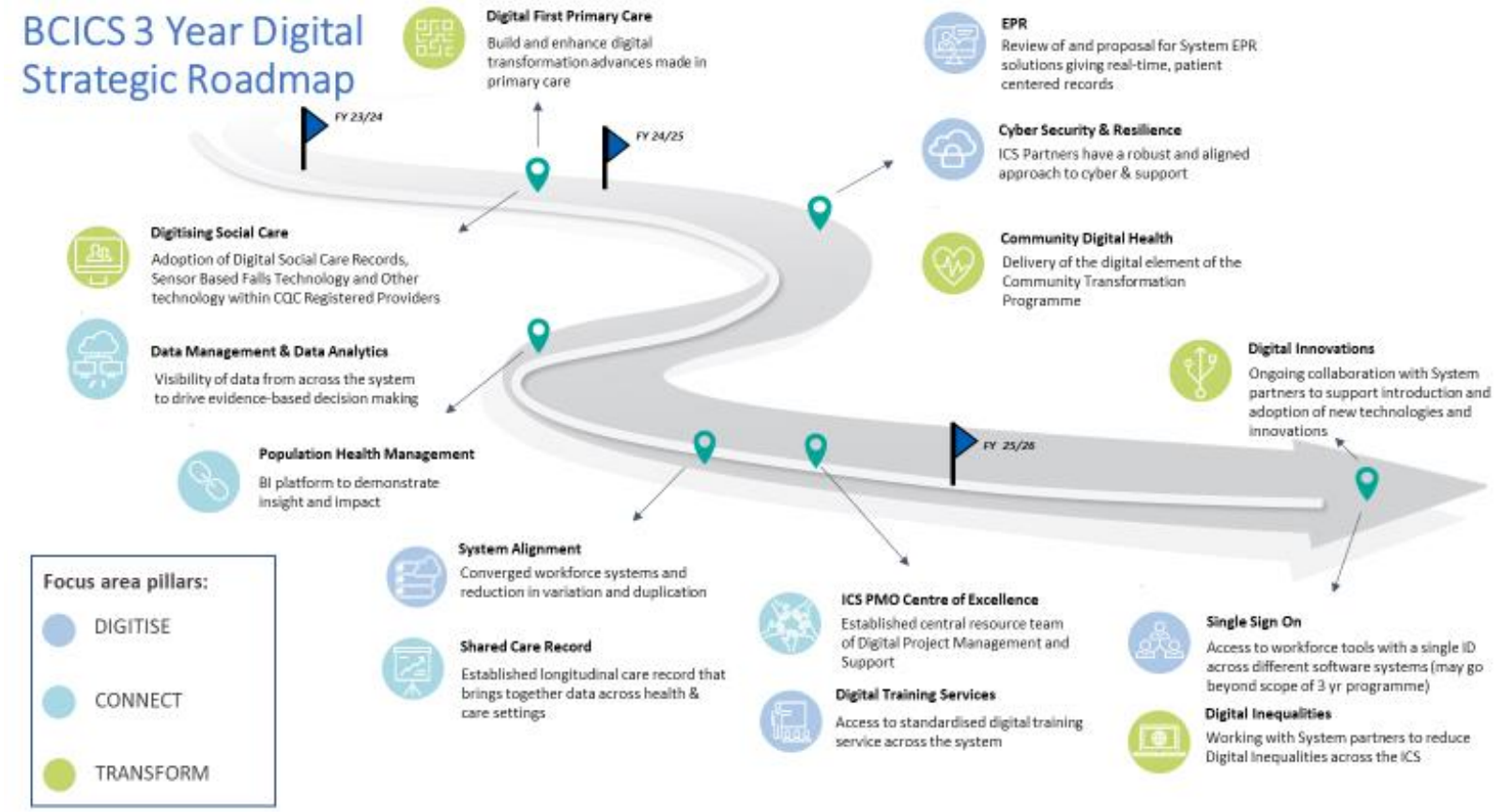
Personal Health Budgets

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

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

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

The ICS Digital Programme Board has recently agreed the systemwide Digital Strategy and costed milestone delivery plan. This was co-developed between over 80 representative across system partners and patient groups to support and enable all sections of this Joint Forward Plan, a high level roadmap is shown below.



Climate Change

Our ambition as an ICS is to support the NHS in the Black Country - through our organisations, teams, and individual staff members and in collaboration with our wider partnerships - to drive changes which achieve the NHS net zero targets, support the health and wellbeing of our patients and staff and improve the local environment.



Black Country
Integrated Care Board

Page 48

Greener Clinical Care and Procurement

Through this programme we will consider environmental and social factors when purchasing, including how we can reduce the environmental impact of consumables used in clinical practice, and also implementing a national policy so that all our tenders included a minimum 10% net zero and social value weighting. We will use all available mechanisms within our procurement routes to lower our carbon footprint and deliver improved environmental and social impacts.

Digital Transformation

This programme seeks to maximise opportunities to deliver services more efficiently and effectively. Though using eConsult and telephone appointments for Primary Care we have reduced travel, similar service models are being used in Secondary Care. In addition remote monitoring technology enables patients to measure blood pressure and undertake ECG at home. We will continue to work with our digital team and wider workstreams/partners to maximise opportunities.

Estates and Waste Management

This programme will focus on sharing best practice and wider opportunities across system to improve the utilisation of our existing estate and expand services, without extending our estates carbon footprint. We will ensure compliance with green planning regulations and developing greener and more efficient waste management systems.

Travel and Transport

We are delivering a programme to transition our vehicle fleet to ultra-low emission /zero emission vehicles and encouraging staff to also do this through salary sacrifice schemes. Elective vehicle charging points are available on a number of sites and we are working with public transport to develop initiatives to encourage staff and visitors to use active travel / public transport to get to work or access services.

Medicines and Anaesthetic Gases

Through this programme we will achieve reductions in the numbers of inhalers that use an aerosol spray more potent than carbon dioxide. We intend to move to lower carbon inhalers without compromising patient care. Our use of desflurane, an anaesthetic gas with a large carbon impact, has been reduced during 2022/23. We are also reviewing our use of nitrous oxide, developing plans to limit the impact use of this produce has on the environment.

Research and Innovation

Our ambition is to develop, promote and facilitate high quality research that is integral to delivering health and care, for the benefit of our population. We will promote the adoption and spread of innovations that enable the achievement of our system priorities and support the reduction of health inequalities.



Black Country
Integrated Care Board

Research

Through a system wide collaborative approach to health and care research, we will achieve our aims to increase participation in research both at organisational and population level, enable equity of access to research opportunities and generate impact in health and care pathways. We will develop a Research Strategy with partners, ensuring all decisions and processes are underpinned by robust evidence based policies and an ethical decision making framework. There is a clear focus on disease/ condition priorities and ensuring alignment of research activities with key system priorities. We will increase the participation of system partners in research studies, and work with research teams to understand and grow the participation by underserved communities, to ensure adequate diversity and inclusion in research. The **Black Country Research Academy** will be critical to the delivery of this.

Through research we will:

- Improve Outcomes – research evidence will inform commissioning decisions to improve patient care, outcomes, and experience
- Tackle Inequalities – research provides us with a better understanding of our local populations and the wider determinants of health, and the steps required to maintain health and narrow health inequalities.
- Enhancing Productivity – we will consider how research is undertaken and delivered, increasing the flexibility of workforce or recruitment, while reducing bureaucracy and improving research productivity and value for money
- Supporting social and economic development – we will create an active research ecosystem, bringing revenue and jobs to the region

Innovation

Our ICB will develop strong working partnerships across sectors and organisations, including the West Midlands Academic Health Science Network (WMAHSN) and our Voluntary, Community and Social Enterprise (VCSE) groups and community advocates, to promote the adoption and spread of innovations that enable the achievement of our system priorities, support the reduction of health inequalities, and address the needs of inclusion groups in the Core20PLUS5 health inequalities framework. We will develop an ICS Innovation Strategy, describing our ambition to improve cross-sector/organisation partnerships, and introduce the **Black Country Innovation Hub**.

Our objectives include the following:

- Adopt and adapt good innovation practices building on the UK Standards for Public Involvement in research and aligning with our principles for working with people and communities
- Capture and share widely our community, clinical and care and digital knowledge to inform and shape our innovation priorities in clinical and care model design, improve digital clinical safety, ease complex pathways, reduce digital inequalities, enable care integration and care in the community, while encompassing the core clinical and care leadership pillars empowering our workforce to build future capabilities.
- Use our collective knowledge to develop inclusive and sustainable mechanisms e.g. our proposed remuneration and recognition policy, accessibility assessment group and co-production framework to enable the development and adoption of innovations that meet the needs of our communities and workforce.
- Make the Black Country innovation approach accessible to all parts of the system, reaching across places and into neighbourhoods.

Strategic Risks

There are a number of strategic risks that may impact on delivery of our plan

Risk	Description	Mitigation
Workforce Capacity	Risk that there will be insufficient workforce, resilience & retention of staff to deliver our plan	<ul style="list-style-type: none"> • Ongoing local recruitment continues at place, more collaboration and engagement with local communities and encourage uptake of post from those new to care. • Skills mix reviews at provider level to continue; • Social Care recruitment partnership forum now set up support recruitment into social care – run by WM Consortium. • System retention plan in place focusing on staff over 55; retire and return flexibilities. Reviewing action plans from year 1 retention plan on flexible working for new and existing staff to aid retention & health and wellbeing. • Robust monitoring of sickness absence levels at system level monitored by People Board. • Range of Health & Wellbeing initiatives in place across the system, example include menopause training for managers
Finance	Challenging financial landscape, requirement to deliver a balanced finance position may impact on ability to invest in services to deliver our plans	<ul style="list-style-type: none"> • System Productivity and Value Group established to drive productivity and efficiency improvements and oversee financial improvement trajectories. • Enhanced expenditure controls to be put in place to maximise the value for money and health impact of every pound spent.
Seasonal Winter Pressure Challenges	Risk that winter pressures lead to increasing demand for health services including primary (GPs) hospital & emergency services, increase in importing out of area ambulance activity resulting in additional pressure and increased risk to patient safety resulting in ambulance handover delays	<ul style="list-style-type: none"> • Urgent Treatment Centre, • Increased GP appointments available • Ambulance receiving centre & discharge lounges/hubs in across a number of system partners Consistent approach to patient initial triage and streaming by Emergency • Consistency of zoning arrangements within Emergency Departments • Departments, to maximise capacity within departments and ensure patients are accessing care at the correct point of entry



Strategic Risks Cont....

Page 51

Risk	Description	Mitigation
Social Care Capacity	Risk that there will be insufficient workforce, resilience & retention of staff to deliver plan	<ul style="list-style-type: none"> System partners working together via Place Based Partnerships to ensure use of adult social care funding and BCF arrangements helps minimise social care discharge delays
Independent Sector Capacity	Risk that there may be insufficient Independent Sector capacity to help support delivery of our system elective plan	<ul style="list-style-type: none"> Oversight and monitoring of elective care plan delivery and utilisation of Independent Sector taking place through Elective Care and Diagnostic Strategic Board, remedial actions being agreed where necessary Utilisation of alternative capacity available through use of DMAS or mutual aid
Physical Capacity	Risk that reliance on sourcing external capital funding to replace equipment estates and facilities will impact on our ability to deliver our plans	<ul style="list-style-type: none"> Prioritisation of capital schemes taking place Estates plan in place to review and maximise physical estates utilisation All opportunities for additional funding being explored
Government instability	Potential change in government with elections due in 2024 may result in a potential change in government & policy regime	<ul style="list-style-type: none"> Plan will be reviewed and refreshed on annual basis to take into account any emerging changes in policy approach
Cost of Living/Inflation	Current economic climate is a threat as it contributes towards deprivation and wider determinants of health. The cost of living crisis & fuel poverty are recognised as factors which may impact on health outcomes and exacerbate inequalities	<ul style="list-style-type: none"> Government assistance with fuel payments Council warm spaces



Feedback on Plan

Page 52

Thank you

Email address for comments: bcicb.strategicplanning@nhs.net

Comments to be received by **22nd May 2023** please





Sandwell Health and Wellbeing Board
Wednesday 21 June 2023

Report Topic:	Keeping Active is Fun – Story Book
Contact Officer:	Pam Kaur
Link to board priorities	<p>Please include in your report how your work links to one or more of our board priorities:</p> <ol style="list-style-type: none"> 1. We will help keep people healthier for longer 2. We will help keep people safe and support communities 3. We will work together to join up services 4. We will work closely with local people, partners and providers of services
Purpose of Report:	<ul style="list-style-type: none"> • Help encourage children to keep active, stay safe, be kind and accept disability and diversity.
Recommendations	<ol style="list-style-type: none"> 1.1 That the Director of Public Health, in consultation with the Director of Children and Education, make the “Keeping Active is Fun” book available to as many children in Sandwell as possible. 1.2 That, in relation to 1.1, the Director of Public Health and Director of Children and Education explore the feasibility of sponsoring language interpretation and distribution of the book. 1.3 That, in relation to 1.1, the Director of Children and Education considers the distribution of the book via Sandwell Council’s HAF programme.

<p>Key Discussion points:</p>	<p>(please include links to our board priorities as shown above)</p> <ul style="list-style-type: none"> * Encouraging children to eat healthy foods and keep hydrated * Encouraging children to keep active through playing sports or going to the park * Encouraging children to be kind, accept disability and diversity
<p>Implications (e.g. Financial, Statutory etc)</p>	
<p>What engagement has or will take place with people, partners and providers?</p>	<p>We have published 2 books and have had 4 book launch events in Sandwell libraries, with parents and children participating.</p> <p>We would like to work with primary schools and organisations in Sandwell to help encourage children to read both our books and support us in encouraging children to keep active.</p>



Keeping Active is Fun



BLACK COUNTRY FOODBANK



World Kindness Day Donations

Certificate of Appreciation and Thanks awarded to:

Harvey

Thank you so much for collecting food and toiletries for families and individuals in your local community.

We will use all the food you have donated to make emergency food parcels for people in crisis.

You have donated 376.3kgs of food and 8kgs of non-food, enough to provide 753 meals and 8 toiletry packs.

This is absolutely wonderful and we are so thankful that you have supported us in this amazing way.

THANK YOU!!



Feeding the Community

Registered Charity No: 1136676

November 2020

Donations resulted in 753 meals

Schoolboy praised as he calls on fellow children to consider others

JAMES VUKMIROVIC
Community News Reporter

The community spirit of a Black Country youngster has been praised by a representative of the Queen.

Harvey Kataria has been calling on young people across Dudley and Sandwell to make a donation to food banks as a way to support World Kindness Day.

The 12-year-old from Oldbury is asking his peers to bring one item of food to school each day between November 9 and 12, ahead of World Kindness Day on November 13.

He said: "I decided it's important to stock up food banks for Christmas and, as it's World Kindness Day on November 13, I think we should all try and help each other in different ways." Harvey's cause has been supported by St John's Ambulance, with local volunteers stepping in to provide vehicles to collect and transport donations to Black Country Food Bank in Brerley Hill. The campaign has received the support of the Lord Lieutenant for the West Midlands John Crabtree OBE, who offered his own praise to Harvey.

He said: "Harvey is a wonderful example of the community spirit of young people we have within the West Midlands."



Lord Lieutenant for the West Midlands John Crabtree, Harvey Kataria, Darren Elgeron and Diana Crabtree



NHS BIRTHDAY 5TH JULY

Local schools

Nurseries

Care homes

2023 is our 4th Year



CHRISTMAS CARDS FOR CARE HOME RESIDENTS & STAFF





Keeping Active is
Fun





KEEPING ACTIVE IS FUN & LET'S PLAY

Playing a sport

Warm ups

Washing our hands

Brushing our teeth twice in the day

Not talking to strangers

Accepting disability and diversity

Giving our eyes a break – playing on consoles

Recycling

Keeping hydrated

Healthy eating

Bereavement – losing a pet

Bike safety

Safety at pedestrian crossings

BOOK LAUNCH EVENTS

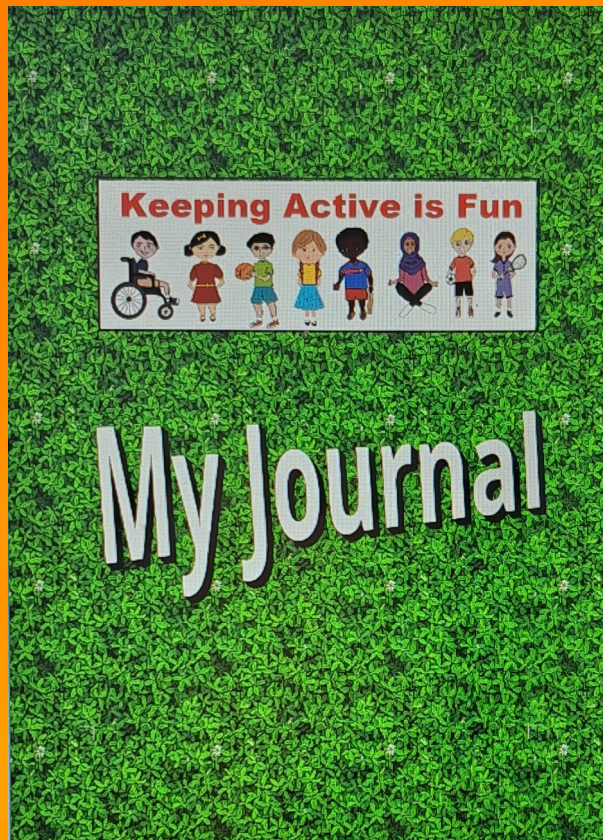
Talking to parents

Talking to children

Talking to library staff



JOURNAL



How are you feeling – happy, sad, tired, angry?

Have you had a good day?

Have you been active?

Did you drink enough water?

What have you liked the most about your day?

What haven't you liked about your day?

Colouring/Wordsearch activity

20	21	22	23	1	2	3			
19				24	<h1>KEEPING ACTIVE IS FUN</h1>	4			
18				25		5			
17				26			6		
16				27		28	29	Home 	7
15	14	13	12	11		10	9	8	

Thank you - Sandwell Council for all your support

Sandwell Councillors

Sandwell General Hospital

St John Ambulance

Primary Schools

Care Homes

WASUP – World Against Single Use Plastic

The Young Active Citizen Award - 2020





Sandwell Health and Wellbeing Board June 2023

Report Topic:	Sandwell LGBTQ+ Health Needs Report
Contact Officer:	Dr Anna Blennerhassett -Consultant in Public Health Anna_blennerhassett@sandwell.gov.uk
Link to board priorities	Please include in your report how your work links to one or more of our board priorities: <ol style="list-style-type: none"> 1. We will help keep people healthier for longer 2. We will help keep people safe and support communities 3. We will work together to join up services 4. We will work closely with local people, partners and providers of services
Purpose of Report:	<ul style="list-style-type: none"> • Update Health & Wellbeing Board on the LGBTQ+ Health Needs report, which was published in spring 2023 and provide an overview of progress with implementation of recommendations from the report.
Recommendations	<ul style="list-style-type: none"> • That the Health and Wellbeing Board note and endorse the Sandwell LGBTQ+ Health Needs Report and ongoing work.
Key Discussion points:	<p>In September 2022 Public Health commissioned a quantitative engagement & consultation exercise to gather insight & understand the needs and experiences of LGBTQ+ adults and young people in the Sandwell.</p> <p>This led to the publication of the LGBTQ+ Health Needs report in March 2023 and was followed by a launch event to engage local partners and stakeholders.</p>

The four key theme areas of the report are:

- Physical health & health behaviours
- Mental Health & wellbeing
- Health Services and access to health services
- Social Capital

We will help keep people healthier for longer

National evidence shows that people who identify as LGBTQ+ face health inequalities and worse health outcomes and experiences of healthcare than the rest of the population. The engagement and consultation exercise which took place with the LGBTQ+ community in Sandwell, provided the opportunity to gain insight into health experiences and develop opportunities to develop work to improve these outcomes.

We will help keep people safe and support communities

Providing accessible and safe spaces for members of the LGBTQ+ community to meet and access relevant support and information is one of the recommendations within the report. There will be opportunities to address this through the work which has progressed since the publication of the report.

We will work together to join up services

A partnership Task & Finish group has been established to drive the implementation of the recommendations. This includes local partners from SMBC, NHS, Schools and Further Education and the voluntary and community sector. This partnership will continue to drive the recommendations from the Health Needs report.

We will work closely with local people,

	<p>partners and providers of services</p> <p>A key outcome of the engagement and consultation work has been the proposal to run a small grants scheme with Sandwell Community and Voluntary Sector Organisation (SCVO) to support the council to address the health inequalities faced by the LGBTQ+ community. The fund will seek bids from community organisations that help to improve:</p> <ul style="list-style-type: none"> • access to healthcare services • physical activity • mental health and wellbeing • social isolation
<p>Implications (e.g. Financial, Statutory etc)</p>	
<p>There are no financial or statutory implications to be considered by the Board</p>	
<p>What engagement has or will take place with people, partners and providers?</p>	<p>The LGBTQ+ Health Needs report has been published following an engagement and consultation exercise with local people. The report outcome has been shared with local partners through the launch event and the work of the multi-agency Task & Finish group.</p>



This page is intentionally left blank



Sandwell LGBTQ+ Community

Health Needs Report

Foreword

Myself and Cllr Bill Gavan were approached last year to take part in the initial consultation by Public Health into local health inequalities of LGBTQ+ people in Sandwell. We are pleased to jointly write this foreword to the findings of the report.

Both myself and Cllr Gavan are advocates and campaigners for LGBTQ+ rights and equalities. Often LGBTQ+ people have faced discrimination, hate crimes or poor mental health in the past. We both are approached regularly by members of the LGBTQ+ community about their experiences of living in Sandwell and the inequality that they can face. We are constantly working towards changing that locally and are pleased that as a council this is increasingly becoming a priority. We still have some way to go though.

Often in the past the LGBTQ+ community have felt on the outskirts of society, that their needs are not valid or important. We want everyone in Sandwell to feel a sense of belonging, to feel included and engaged and this work goes towards the start of recognising the struggles that most of the LGBTQ+ community face.

Myself and Cllr Gavan are both openly gay local councillors and we hope that by being open and our authentic selves we will help those who are struggling to accept themselves in Sandwell.

Sandwell is a diverse borough and we were pleased that the Public Health team were investigating and opening up consultation about the health needs of the local LGBTQ+ communities.

The report details the many inequalities that LGBTQ+ people face when accessing health care. The findings have not come as a surprise to us as we have seen and lived these inequalities and barriers. We hope that this hard evidence will now go towards righting the imbalances and removing those barriers that the LGBTQ+ community experience in Sandwell. We both will continue to fight for equality for all.

Finally, I would like to thank the Public Health Team for taking a proactive approach to look at local inequalities for all minorities in Sandwell, spearheading equality, diversity and inclusion.

Thank you



**Richard Jones -
Mayor**



Cllr Bill Gavan



Table of Contents

02	—	Foreword
05	—	Introduction
07	—	Methodology
09	—	Key Findings
10	—	Lived experiences
29	—	What is working
30	—	What are the key takeaways

Introduction

The Sandwell Metropolitan Borough Council Public Health Team is working to reduce health inequalities across all demographics and is especially looking at narrowing the health gap in groups with protected characteristics.

This report summarises the key findings following an engagement exercise carried out between September and November 2022, in which the Sandwell LGBTQ+ community provided details of their lived experience with healthcare using surveys, interviews and informal events.

We had a fantastic response from the community which was amazingly transparent with the information shared. It was a very rewarding experience to speak with the many LGBTQ+ community groups across Sandwell, and the work they do is vital in supporting the community with the many issues facing them.

We hope our findings contribute towards positive improvement in healthcare in the Sandwell area and help to amplify the voices that can be seldom heard within minority communities.

Thank you to everyone within the Sandwell LGBTQ+ community; this work could not have been done without them, and we are very grateful.

Background and National Context

There is national evidence that the LGBTQ+ community has disproportionately worse health outcomes and experiences of healthcare. The statistics below, compiled from existing national reports, help to highlight the challenges faced by the LGBTQ+ community:

- 70% of respondents reported being impacted by transphobia when accessing general healthcare services.
- 98% of respondents described the transition-related healthcare available on the NHS as inadequate, with 47% responding that it is 'not at all adequate'. A more significant proportion of disabled trans people reported inadequacy of service.[1]
- 14% of LGBTQ+ people have avoided accessing healthcare for fear of being discriminated against because of their LGBTQ+ identity.[2]
- 28% of respondents who had accessed or tried to access mental health services in the 12 months preceding the survey said it had not been easy.[3]
- LGBTQ+ young people are twice as likely to feel lonely and more than twice as likely to worry daily about their mental health than their non-LGBTQ+ peers, with over half (55%) of LGBTQ+ young people worrying daily about their mental health.[4]
- 25% of LGBTQ+ secondary school pupils are experiencing daily tensions in the place they are living, while half (48%) say they have received little to zero positive messaging at school about being LGBTQ+ in the last 12 months.[4]

Sandwell Metropolitan Borough Council Public Health Team engaged Autrac to help understand the health needs of the LGBTQ+ population in Sandwell and uncover the individual lived experiences. The information contained within this report will help begin to address health inequalities within the LGBTQ+ community

[1]Trans Lives Survey 2021

[2]LGBTQ+ Foundation Findings

[3]National LGBTQ+ Survey

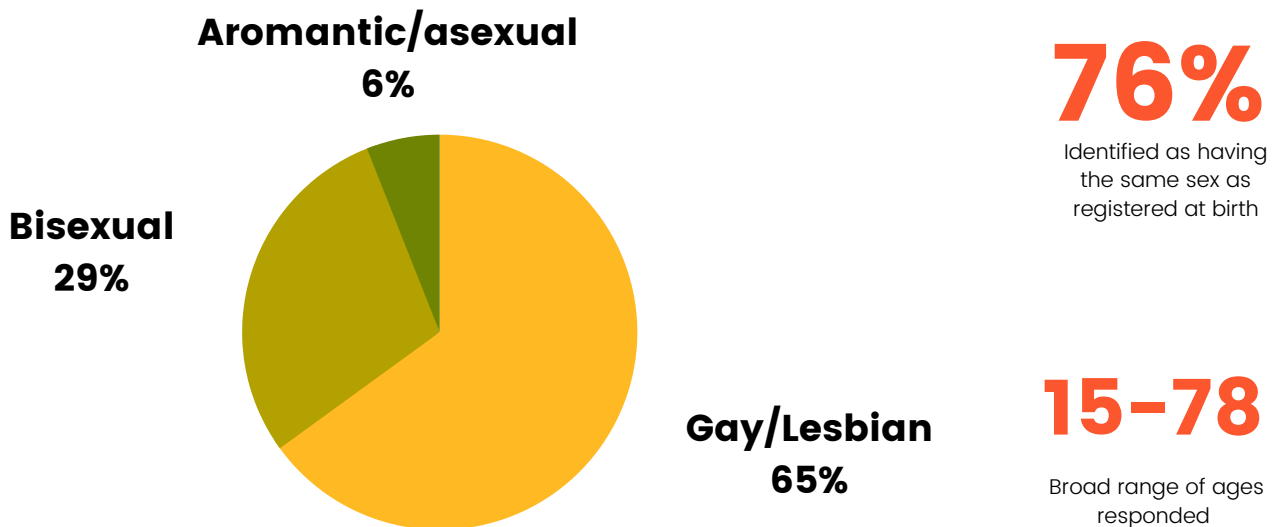
[4]Just Like Us, the LGBTQ+ young people's charity's report 'Growing Up LGBTQ+: the impact of school, home and coronavirus on LGBTQ+ young people'

Methodology

We completed this engagement exercise between September–November 2022 within the LGBTQ+ community of Sandwell.

The LGBTQ+ community is a minority group and, as such, it can be difficult to uncover the voices within the community in order to understand the challenges they face. Our engagement approach was to work with the many LGBTQ+ community groups within Sandwell, asking for their support to share the information with their membership.

This approach led to a wonderfully diverse demographic range which is demonstrated below:



We received responses from all towns of Sandwell including Oldbury, Rowley Regis, Smethwick, Tipton, Wednesbury and West Bromwich

We were particularly interested in hearing from the younger community and, as such, designed a different question set and engagement process tailored to the younger generation. The young people's insights are interwoven within the report as well as presented within a separate section.

This engagement exercise was completed through two significant phases:

Phase 1: Digital survey of 45 questions delivered to the LGBTQ+ community through identified LGBTQ+ community groups.

Phase 2: Discussions with community groups and individuals focusing on their experiences with healthcare.

The voices of young people were accessed through a separate bespoke survey administered through young people's groups and educational establishments.

The phase 2 discussions were framed by the following principles:

- What are your experiences with healthcare in the Sandwell area relating to your LGBTQ+ identity?
- What else would you like to see within Sandwell to support the LGBTQ+ community?

We let the conversations evolve naturally to understand the lived experiences of the community. This approach allowed us to understand the challenges the community face and identify additional help and resources that would further support the LGBTQ+ community.

Approximately 75 contacts were established through this exercise, which included a discussion with Chairs of community groups who provided information on behalf of their group and members.

We have anonymised the quotations within this report, changing the names and adding an age range to ensure no information is personally identifiable.

This engagement exercise was commissioned and supported by Sandwell Metropolitan Borough Council and delivered by Autrac.

Key Findings

We approached the engagement exercise by asking the community four key lines of enquiry around an individual's:

- physical health and health behaviours
- mental health and well-being
- feelings toward health services and access to health services
- social health and social capital

This approach allowed us to gather a full range of information from the community and triggered interesting conversations that were a valuable part of this engagement exercise. Although the quantitative data is vital to any information-gathering exercise, we were keen to understand the communities' lived experiences.

We have tried to amplify the voices of the community, including their struggles, feelings on the Sandwell health care services, and what services would benefit them moving forwards.

Age Range			
16-18	12%	45-54	6%
19-24	12%	55-68	18%
25-35	0%	69-78	11%
35-44	41%	79+	0%
Religion			
No religion			65%
Christian			29%
Prefer not to say			6%
Sexual orientation			
Gay/lesbian			65%
Bisexual			29%
Other			6%
Ethnicity			
English/Welsh/Scottish/Northern Irish/British			94%
Prefer not to say			6%
Gender identity			
Male			54%
Female			46%



What did we learn about an individual's physical health and health behaviours?

The respondents answered broadly about their physical health and health behaviours, helping to paint a picture of the health of the Sandwell LGBTQ+ community.



What were the key themes?

Strong themes emerged around how important community support is. A majority of the conversations involved individuals explaining how the health challenges relating to the LGBTQ+ community could be a struggle.

The LGBTQ+ community found group activities both motivating and supportive. Peer activities provide the space for discussion around issues, helping them to understand what LGBTQ+ services are available within Sandwell.

Community activities are found to help on two levels: first, the surface benefit of improving an individual's health and second, helping to reduce anxiety around issues and the accessibility of services by providing a structured time and place for the community to discuss issues important to them.





What did the findings tell us?

40%

of individuals explained how they have a physical or mental impairment which has had a substantial long-term effect on their ability to carry out day-to-day activities.

Questions about addictive behaviours were asked as part of this engagement study and, unfortunately, **four out of ten** respondents felt they were becoming dependent on something and couldn't stop. This behaviour ranged from smoking, to spending money and self-harm.

Of the engagement participants:

- 40% of individuals describe themselves as 'non-drinkers'
- 80% of individuals reported never taking recreational drugs
 - 80% identify as non-smokers

Amongst the community, physical exercise and an active lifestyle were identified as behaviour that helped contribute to overall well-being.

7%

of individuals described never undertaking physical activity

47%

of respondents undertake physical activity twice or more a week.



Individual and group walking was one of the most popular activities mentioned by the community, with many enjoying group walks arranged by independent LGBTQ+ community groups. These walks offer the community the dual benefits of physical exercise and a social value, with members meeting new people and having an opportunity to discuss issues with LGBTQ+ peers.



What actions could help?

To improve the engagement with central activities and groups and to improve the communication methods and literature.

Individuals described difficulties in reading and understanding the literature coming from healthcare organisations and councils. Requests were made for sharing the importance of accessibility considerations in communications, such as using plain English and easy-to-read font sizes and colours.

Increase support to existing LGBTQ+ active groups.

Individuals explained how peer community support groups have previously helped to identify and tackle health issues and are essential to providing well-being support to struggling individuals. Supporting these groups where possible will help these groups to flourish and improve access for the LGBTQ+ community.





An individual's mental health and well-being

Although mental well-being is closely associated with an individual's physical and health behaviours, we wanted to carry out a 'deeper dive' with the Sandwell LGBTQ+ community to understand the specific well-being challenges associated with an LGBTQ+ identity.



What were the key themes?

From discussions, key themes arose around the limitations of specific LGBTQ+ mental health and well-being support. The community felt that access to mental health and well-being services was difficult, with very little provision to support specific LGBTQ+ issues.

There is a high prevalence of mental health issues within the LGBTQ+ community and a feeling that these issues have increased during the COVID pandemic. Independent LGBTQ+ community groups are a valuable resource for peer support and often are able to help with mental health and well-being issues at an early stage.

It can be difficult for the LGBTQ+ community groups to support, due to a lack of clarity on what LGBTQ+ specific services are available to Sandwell residents.



What did the findings tell us?

Our engagement with the Sandwell LGBTQ+ community showed that:

- 20% of individuals described their mental health as poor, with 50% being diagnosed/experiencing depression and anxiety.
- 14% of individuals have hurt themselves over the past 12 months, with 50% having considered taking their own lives at some point.
- Encouragingly, 64% of individuals knew how to access support, but further work is required to ensure that the other 36% are also able to access essential mental health services.

"Access to diagnosis and mental health support has been terrible over the last 2-3 years. I have experienced some challenging times and have been left to muddle along. The community group has helped get me through it, but these are independent and struggling to continue without wider support."

Brian, 35-44, identifies as a gay man.

A particular concern was raised around domestic abuse issues: it was felt that the guidance focused on male/female relationships and that gay relationships were often overlooked. The respondent described in his experience how domestic abuse in gay relationships is often hidden and, unfortunately, very widespread. It was felt that targeted support would help many in an often missed aspect of mental well-being.

A higher percentage of young people commented on concerns over their eating habits, with

50%

of respondents explaining that they – or someone close to them – has been concerned with their eating habits over the past 12 months.

Young people also expressed a higher percentage of occasions of hurting themselves on purpose over the past 12 months.



What actions could help?

Focused young persons' support networks

Young people described support networks within their colleges and schools but suggested these were very limited and only available to students. The young LGBTQ+ community within Sandwell feel they need a more comprehensive support network or youth service independent from educational establishments.

"Having a hub would be helpful as it would be in one place, and I would get used to the people there."

Sam, young person

Young people also feel a 'one hub' approach would be beneficial, offering access to all support, advice and guidance in one place. Accessing services can be intimidating for young people and having a central hub will help reduce anxieties whilst accessing healthcare.



Clear signposting for LGBTQ+ mental health and well-being services.

LGBTQ+ community groups would like clear guidance on what is available to the community. This will help correctly support individuals who are seeking help and cannot access formal support due to long waiting times.

LGBTQ+ considerations when mental health and well-being support offers are provided. Issues raised above highlights how considering LGBTQ+ aspects within services will help to support the community and improve access.

Access to mental health and well-being support guidance for community group leaders. Discussions showed that community group leaders are often asked for mental health and well-being support directly by individuals. A base level of support and guidance will allow for a consistent and supportive response to be provided, which may offer much-needed intervention while individuals await formal health and well-being support.



An individual's health services and access to health services

With the previous Sandwell local responses in mind, good access to health services is essential and this section of the engagement exercise focused on how the local Sandwell LGBTQ+ community engages with health services and their experiences with them.



What were the key themes?

Key themes emerged from discussions around the general LGBTQ+ knowledge within healthcare, with the community feeling that the level of LGBTQ+ understanding amongst healthcare professionals was inconsistent. This lack of awareness contributes towards unfair treatment and the community shared experiences which included misgendering by healthcare professionals, occasions of feeling unheard, and experiences of homophobic treatment within healthcare.

The community described poorer experiences when accessing services within general practice surgeries, as opposed to larger healthcare Trusts. A general lack of understanding of LGBTQ+ issues and poor awareness from GPs and limited services available for the community, led to negative experiences.

It was felt that there was a considerable lack of knowledge of LGBTQ+ issues within GP surgeries.

The community raised issues with the location of services, feeling that they have to travel too far for essential services, which has a negative impact on access. Particular examples around gender reassignment have been given in the following sections.



What did the findings tell us?

Our engagement exercise into the LGBTQ+ communities' experience with health services found that 29% of respondents described being mistreated by healthcare staff regarding their LGBTQ+ identity. This was more prevalent in young people, with 50% describing being unjustly treated.

A third of respondents feel healthcare professionals' behaviour has been inappropriate at some point during treatment. This was echoed in the young people's responses, with one young person commenting:

"I got told by a nurse that I was confused, when asked about my relationship status and finding out I was with a girl."

Anna, young person, identifies as bisexual

Experiences and incidents like these can shape a young person's future engagement with health services and could completely isolate the young people from health care.

An individual shared a time when, while being admitted to an accident and emergency in a Sandwell hospital, they overheard offensive, homophobic language by healthcare professionals, which made them feel very uncomfortable and led to a formal complaint.

The community felt a lack of confidence in GP surgeries, with 80% of respondents rating their experience with GPs as poor, which was over twice as negative as experiences with mental health, sexual health, maternity and in-patient services.

Situations where GP practice receptionists have been insensitive to LGBTQ+ issues were uncovered as part of this engagement exercise, with respondents having experienced a lack of understanding and use of derogatory language within GP practices.

There was general confusion on what services are available to the Sandwell LGBTQ+ community and participants shared experiences in which GP surgeries are unclear on what referral options are available.

14% of respondents expressed concern about being denied services due to their LGBTQ+ identity.

"GP surgeries should be a hub, helping us to understand what is out there; they don't seem to know, which makes getting help a very stressful and confusing process."

Simon, 45-54

"I feel like a second-class citizen when I visit my GP with LGBTQ+ issues."

Diane, 55-68, identifies as lesbian

"My GP actively refrained from referring me to a gender identity clinic."

Ryan, 35-44

"Waiting times for gender dysphoria diagnosis are ridiculously long. The aim is 18 weeks to be seen for non-urgent care. I am now at about 19 months after the referral and expect at least another year to wait. It is difficult not to interpret this as deliberate withholding of treatment by the NHS."

Jo, Trans woman, 35-44

Gender reassignment patients are having to travel to Nottingham for treatment and this long distance travel is an access barrier to Sandwell residents.

The Sandwell LGBTQ+ community is unclear if there is a central strategy for services, and it is unclear to a majority where and how to access support.



A third of respondents do not make their LGBTQ+ status known to healthcare professionals when undertaking treatment, with 15% of respondents describing avoiding treatment due to the worry of LGBTQ+ discrimination and a lack of understanding of LGBTQ+ issues within healthcare.



What actions could help?

Greater LGBTQ+ awareness within general practice. The Sandwell LGBTQ+ community groups are keen to ensure GP services are aware of support groups and LGBTQ+ services in the area and are able to promote and signpost their services. From discussions, there are very different levels of LGBTQ+ awareness within GP practices.

Focused work to identify what LGBTQ+ services are required within Sandwell. The community feels a review of what is needed within the Sandwell area will help to support the community better and increase access to healthcare services.





Individual health and social capital

An essential part of this engagement exercise was to understand where and how the LGBTQ+ community finds support and whether this is professional support or more informal support from friends and the local community.



What were the key themes?

Although great strides have been taken towards equality over the years, evidence of abusive behaviour towards those who identify as LGBTQ+ has been seen during this engagement process. The community still experiences physical and verbal violence and aggression which can impact mental health and well-being.

Once again, the importance of LGBTQ+ community networks was a key theme through this section of the engagement process: the community groups act as a forum to understand and process occasions of targeted aggression and community group members pull together to offer support.

It is encouraging to see the LGBTQ+ community receiving support from multiple avenues, including friends, families, community organisations, faith organisations and the wider Sandwell community. However, the community feels they have to travel too far to access more formal groups, which seem to be Birmingham-focused.

The adverse effects of social isolation have been the strongest theme that has emerged from this engagement process, with individuals from all demographics expressing the need for more local community hubs.



What did the findings tell us?

Through the engagement process, we found the following:

Half of the respondents have experienced or witnessed targeted physical or non-physical abuse due to LGBTQ+ behaviour, with young people in particular describing incidents of online abuse, incidents at school or college and a general feeling of not being supported by these establishments.



I have been spat at, sworn at...there have been attempts at burning down my house...my car and van have been vandalised.

Lisa, 55-68, Identifies as lesbian



"I have been assaulted twice".

Nick, 55-68, Identifies as Gay



Young people recounted that they are able to access support through education, youth clubs, and family and friends. However, the educational support can be limited to attendees of the specific location, leaving limited options to those who do not attend or feel comfortable with these groups.

Many vibrant LGBTQ+ community groups exist within Sandwell and respondents have expressed how important these are in supporting LGBTQ+ issues.

The community explained how the groups and their organisers are a critical focal point for signposting towards healthcare services and these groups are very valued within the community.

However, it was mentioned how individuals have to travel outside of Sandwell to access more formal groups. A local LGBTQ+ community centre previously located in Wolverhampton, has been closed for over a decade, leaving many groups relocating to Birmingham, thus presenting access issues to the Sandwell LGBTQ+ community.

Seeing the community groups moving to virtual platforms over the pandemic was rewarding but the community expressed how this has often made them feel socially isolated and lonely. A strong message from the community is that they find the return of face-to-face meetings beneficial and would like more opportunities to meet with their peers.

We spoke directly with a prominent member of the Sandwell LGBTQ+ community who has worked to support the community with many initiatives over five decades, helping individuals through difficult times.

This individual spoke very positively about the changes in LGBTQ+ acceptance over the years and explained how isolation and loneliness were their most significant concerns for the community, especially amongst the 50yrs+ demographic, where much time is spent supporting individuals to access support and guidance.

The community was clear on what would benefit the LGBTQ+ community in the Sandwell area, with most individuals suggesting more local provisions.

“

More localised services for the community are needed so that travel is not an issue...to feel looked after on your doorstep, which is not too much to ask

”

Steve, 35-44, identifies as gay

“

It would be good to have switchboard help, particularly for parents of children identifying as gay

”

Julie, 69-78, Identifies as lesbian

“

Assistance and advice around the legal requirements of changing your identity seem unavailable on any organised level unless you can pay a lawyer

”

Jo, 35-44, Trans woman

“

Specific community groups, specific elderly support for LGBTQ+ people

”

Mick, 35-44, identifies as gay

“

More awareness or support for elderly members

”

Gilbert, 55-68, identifies as gay

“

Doesn't feel like it's specific to Sandwell; need more groups in Sandwell

”

Guy, 35-44, Identifies as gay

“

Help for parents of children questioning their sexual identity and a safe place for counselling

”

Claudia, 69-78, Identifies as lesbian

“

My college does a drop-in, but other than that, I do not know of anything. The college provision is also only available to students at the college

”

Sam, young person, identifies as asexual

“

Support for Transgender people

”

Annie, young person



What actions could help?

Further support for community groups: A similar theme has emerged from the community where access to LGBTQ+ community groups offers peer support to help with issues of targeted aggression. The Sandwell community groups offer a very vital and valued service and would benefit from formal support.

Enhanced guidance and support for specific LGBTQ+ issues: the community often encounters issues that require more specialist support – be it from parental support, to legal guidance – and the community feels that a central hub through a formal local authority supported network would help to improve the access to specialist LGBTQ+ services.

Methods to help address social isolation: the community feels that isolation within the LGBTQ+ community is ever more prevalent living in a post-pandemic world. Individuals are still shielding or facing anxiety in returning to face-to-face interactions. Support to help reach the isolated members of the community would be a beneficial addition to the support provided by local authorities.





LGBTQ+ Engagement – The Young Persons' Voice

Throughout this engagement exercise we have attempted to retain the voice of the young LGBTQ+ community within Sandwell. As a unique demographic with unique requirements we feel it is important to present separately the findings relating specifically to young people.



What were the key themes that were unique to young people within the LGBTQ+ Sandwell community?

The general findings remained consistent across both the adults' and young people's demographics. However, the young people within the Sandwell LGBTQ+ community demonstrated more occasions of self-harm and eating disorders.

They felt the LGBTQ+ focused mental health and well-being support to help these concerns are isolated to schools and colleges, with a feeling that there isn't much available outside of educational establishments.

The young people's community expressed an interest in having a wider community network to discuss issues, find guidance and to meet other LGBTQ+ young people within Sandwell. Encouragingly, young people were aware of national online support but a more local provision would be beneficial.

This engagement exercise found specific occasions of online abuse and aggressive incidents at school, demonstrating the unique challenges young people face.

Young people also shared experiences of unfair treatment by healthcare staff at higher rates than the adults. In a similar theme to the adult LGBTQ+ community, young people felt healthcare professionals demonstrate a lack of awareness of LGBTQ+ issues and would benefit from targeted awareness training.



What actions could help?

This report identifies general actions that will benefit both the adult's and young people's LGBTQ+ communities within Sandwell, but the following suggestions are unique to supporting young people:

A formal LGBTQ+ young people's support group. The young people felt a support group outside of educational establishments would be a great help to the challenges they face and would provide a neutral, safe space to meet people and discuss issues close to their heart.

One place to access LGBTQ+ specific healthcare guidance and support. The young people felt confused by what support is available and how to access it. They expressed anxiety around finding these services and felt a 'single hub' would help reduce anxiety around accessing services.

What is working?

It was apparent there is a lot of valuable 'good practice' occurring within the community.



It is encouraging to see the Sandwell LGBTQ+ community having a varied selection of support networks, including friends, family, the workplace and vibrant, independent, organised community groups.



Throughout this engagement exercise, it has been apparent that, as an often-marginalised group, the LGBTQ+ community within Sandwell encourages peer support, with many fantastic individuals doing essential work within the community.



Individuals described that awareness of LGBTQ+ issues within healthcare is improving, and campaigns within the NHS have helped to support inclusiveness

What are the Key Takeaways

From our time with the Sandwell LGBTQ+ community, we have summarised the information we have received into the following takeaways:

The importance of community groups and a peer network

- The work of the independent LGBTQ+ community groups is valued and vital. These groups act as a support network, reduce social isolation and provide valuable information on healthcare to members of the community. Many community groups are struggling with funding and the administration for managing their charitable status.
- The need for more local groups is apparent, with individuals travelling outside Sandwell to access specific groups. The young LGBTQ+ community within Sandwell has expressed the need for more specific groups outside of educational establishments to help them meet their peers and support each other.
- These community groups are vital in signposting individuals to LGBTQ+ healthcare services and act as a central information hub for the community. But they are struggling and need support.

The importance of raising LGBTQ+ awareness within healthcare, in particular within general practice.

- It has been apparent that there is a lack of consistency in LGBTQ+ knowledge and understanding within health services. The Sandwell LGBTQ+ community has demonstrated the differing standards in healthcare organisations which can reduce the willingness to engage with health services and subsequently increase the anxiety of accessing support.
- The community feels that increased awareness of LGBTQ+ issues will help to reduce the awkwardness of encounters, lower anxiety and lead to greater healthcare access for the community.
- Individuals mentioned that standardised training or targeted campaigns to help professionals understand LGBTQ+ issues will help to improve communication, increasing the community's engagement levels with healthcare.

Support with mental health and well-being

- Mental well-being issues are rising dramatically across the nation. The LGBTQ+ community has a disproportionate level of vulnerability and our engagement exercise shows Sandwell is not an exception.
- Alongside the more general improvements to mental health services required, a large percentage of the Sandwell LGBTQ+ community is experiencing challenging times.
- As a 'difficult to reach' demographic for many social reasons, the community requires bespoke and more specific LGBTQ+ well-being support, with a particular focus on engaging with the Sandwell LGBTQ+ young people's community.

This page is intentionally left blank



Sandwell Health and Wellbeing Board
21 June 2023

Report Topic:	OxWell School Survey Research Project and Eton College Partnership
Contact Officer:	Michael Jarrett – Director of Children and Education (DCS)
Link to board priorities	<p>Please include in your report how your work links to one or more of our board priorities:</p> <ol style="list-style-type: none"> 1. We will help keep people healthier for longer 2. We will help keep people safe and support communities 3. We will work together to join up services 4. We will work closely with local people, partners and providers of services
Purpose of Report:	<ul style="list-style-type: none"> • To provide an update on the OxWell School Survey Research project and the Eton College Partnership with Sandwell MBC.
Recommendations:	<ul style="list-style-type: none"> • That Sandwell Health and Wellbeing Board note the information provided in this report. • That Sandwell Health and Wellbeing Board and provide support for the future development of the OxWell School Survey Research project and the Eton College Partnership with Sandwell MBC.

<p>Key Discussion points:</p>	<p>OxWell School Survey Research project</p> <ul style="list-style-type: none"> • The OxWell Student Survey is a collaboration between young people, schools, local authorities, the NHS and the OxWell research team at the University of Oxford’s Department of Psychiatry. • It is a large-scale online survey designed to measure the wellbeing (health and happiness) of children and young people aged 9–18 years old. The survey has run since 2019 and in 2021 more than 30,000 students from 180 schools participated. • OxWell aims to better understand the mental health and wellbeing of school students by: <ul style="list-style-type: none"> ○ Asking about their worries and how they might like to receive support. ○ Providing schools and services with information about what young people want. • A 2023 pilot is running in three schools across Sandwell (Holly Lodge High School, Q3 Academy Great Barr and George Salter Academy) as part of OxWell’s commitment to supporting, understanding and improving the mental health and wellbeing of Sandwell’s children and young people and ensure youth voice remains central to decision-making. • Sandwell Council, NHS and University of Oxford will have access to the results including a breakdown per school/college. • This will help local services to ensure that the resources available can be targeted at areas of most need and to monitor the impact of interventions.
--------------------------------------	--

Eton College Partnership

- Eton College is submitting an application to build a free school (sixth form) in Dudley.
- Places would be available for Sandwell students (numbers to be confirmed), with priority given to disadvantaged young people, care leavers and those from challenging backgrounds.
- There is also a wider partnership offer available to Sandwell schools which includes:
 - Opportunities for young people to participate in residentials at Eton College.
 - Opportunities for Sandwell students to visit Eton College, with transport arranged.
 - Collaboration and networking with schools in other areas involved with the project (38 currently).
 - Open access to Eton X, a digital platform hosting resources for teachers and students, courses, PHSE focused materials for Y8-Y13 pupils and GCSE/A-Level resources. Pupils can complete courses independently. (No cost to schools.)
 - Professional development opportunities for teachers, virtually and In-person.
 - An option for CPD for students.
 - Access to a fully funded place at Eton College.
- The partnership offer is mainly focused to the secondary phase currently, but with opportunities to develop into the primary phase.

Implications (e.g. Financial, Statutory etc)

OxWell School Survey Research project

- Funding needed to enable all Sandwell schools can participate in the survey. (Costings to be confirmed.)
- Thematic issues identified will be used to inform strategic planning at groups including the Children and Young people’s Partnership Boards, Education Partnership Boards, and the Local Transformation Plan Group for CYP Mental Health.
- Participating schools will be able to use the findings from their surveys to plan their approach to mental health and wellbeing, the curriculum, PSHE and Healthy Schools work more effectively to better meet the identified needs of their pupils.

Eton College Partnership

- Funded opportunities for Sandwell students to access high quality education and training.
- Funded opportunities for Sandwell teachers to access high quality professional development.
- Contributes to raising aspirations for students across the borough.

What engagement has or will take place with people, partners and providers?

OxWell School Survey Research project

- Pilot with 3 secondary schools 2023 led by OxWell research team in collaboration with Sandwell Education Services.
- Dissemination of findings to all Sandwell schools Autumn 1 2023/24
- Planned engagement of all schools to participate in the survey 2023/24

Eton College Partnership

- Meetings have taken place with the Head of Educational Opportunities at Eton College to discuss and develop the partnership with Sandwell MBC
- The Head of Educational Opportunities will be invited to the Joint Executive Board and to

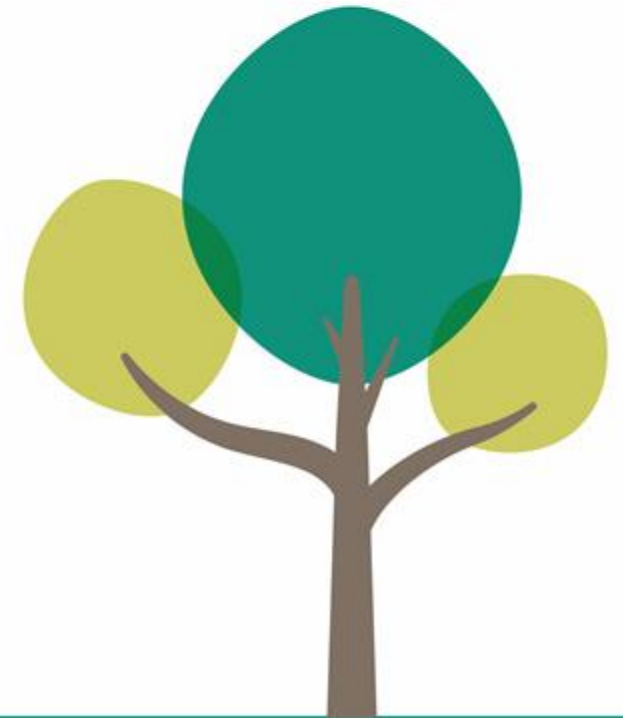
	<p>Headteacher Partnership meetings (Autumn term 2023/24 onwards).</p> <ul style="list-style-type: none">• Eton College is already working with 2 Sandwell Secondary schools.
--	---



This page is intentionally left blank

**Health & Wellbeing Board
21.6.23
Michael Jarrett
Director of Children and Education**

- ❖ **Eton College Partnership**
- ❖ **OxWell School Survey Research Project**
- ❖ **Children and Education Updates June 2023**



Eton College Partnership

Eton College is submitting an application to build a free school (sixth form) in Dudley.

Places would be available for Sandwell students (numbers to be confirmed), with priority given to disadvantaged young people, care leavers and those from challenging backgrounds.

There is also a wider partnership offer available to Sandwell schools which includes:

- Opportunities for young people to participate in residentials at Eton College.
- Opportunities for Sandwell students to visit Eton College, with transport arranged.
- Collaboration and networking with schools in other areas involved with the project (38 currently).
- Open access to Eton X, a digital platform hosting resources for teachers and students, courses, PHSE focused materials for Y8-Y13 pupils and GCSE/A-Level resources. Pupils can complete courses independently. (No cost to schools.)
- Professional development opportunities for teachers, virtually and In-person.
- An option for CPD for students.
- Access to a fully funded place at Eton College.

The partnership offer is mainly focused to the secondary phase currently, but with opportunities to develop into the primary phase.



OxWell School Survey Research Project

The OxWell Student Survey is a collaboration between young people, schools, local authorities, the NHS and the OxWell research team at the University of Oxford's Department of Psychiatry.

It is a large-scale online survey designed to measure the wellbeing (health and happiness) of children and young people aged 9–18 years old. The survey has run since 2019 and in 2021 more than 30,000 students from 180 schools participated.

OxWell aims to better understand the mental health and wellbeing of school students by:

- Asking about their worries and how they might like to receive support.
- Providing schools and services with information about what young people want.

A 2023 pilot is running in three schools across Sandwell (Holly Lodge High School, Q3 Academy Great Barr and George Salter Academy) as part of OxWell's commitment to supporting, understanding and improving the mental health and wellbeing of Sandwell's children and young people and ensure youth voice remains central to decision-making.

Sandwell Council, NHS and University of Oxford will have access to the results including a breakdown per school/college.

This will help local services to ensure that the resources available can be targeted at areas of most need and to monitor the impact of interventions.



Children & Education Update - June 2023

➤ Priority Education Investment Area (PEIA)

➤ Attendance

➤ Area SEND Inspection (ASEND)

➤ Family Hubs – Launch on 17 July 2023

