Walsall Council

Health and Wellbeing Board

Tuesday 25 January at 4.00 p.m.

Digital meeting via Microsoft Teams.

Public access via this link: https://youtu.be/acF2KDyfEhU

Membership:
Councillor S. Craddock (Chairman)
Councillor K. Pedley
Councillor T. Wilson
Councillor I. Robertson
Ms. K. Allward, Executive Director Adult Services
Ms. S. Rowe, Executive Director Children's Services
Mr. S. Gunther, Director of Public Health
Dr. A. Rischie (Vice-Chair)] Clinical
Mr. G. Griffiths-Dale] Commissioning Group
Dr. H. Lodhi] representatives
Ms. M. Poonia, Healthwatch Walsall
Ms S. Samuels, Group Commander, West Midlands Fire Service
Chief Supt. P. Dolby, West Midlands Police
Ms S. Taylor, One Walsall
Mr D. Loughton, Walsall Healthcare NHS Trust
Ms. F. Shanahan, Walsall Housing Partnership/Housing Board
Ms. M. Foster, Black Country Healthcare NHS Foundation Trust
Ms. R. Davies, Walsall College
NHS England

Quorum: 6 members of the Board

Democratic Services, The Council House, Walsall, WS1 1TW
Contact name: Helen Owen, Telephone (01922) 654522 *helen.owen@walsall.gov.uk*
www.walsall.gov.uk.

Memorandum of co-operation and principles of decision-making

The Health and Wellbeing Board will make decisions in respect of joined up commissioning across the National Health Service, social care and public health and other services that are directly related to health and wellbeing, in order to secure better health and wellbeing outcomes for the population of the Borough, and better quality of care for all patients and care users, whilst ensuring better value in utilising public and private resources.

The board will provide a key form of public accountability for the national health service, public health, social care for adults and children, and other commissioned services that the health and wellbeing board agrees are directly related to health and wellbeing.

The Board will engage effectively with local people and neighbourhoods as part of its decision-making function.

All Board members will be subject to the code of conduct as adopted by the Council, and they must have regard to the code of conduct in their decision-making function. In addition to any code of conduct that applies to them as part of their employment or membership of a professional body. All members of the board should also have regard to the Nolan principles as they affect standards in public life.

All members of the board should have regard to whether or not they should declare an interest in an item being determined by the board, especially where such interest is a pecuniary interest, which an ordinary objective member of the public would consider it improper for the member of the board to vote on, or express an opinion, on such an item.

All members of the board should approach decision-making with an open mind, and avoid predetermining any decision that may come before the health and wellbeing board.

Part 1 – Public Session

1. Welcome

2. Apologies and Substitutions

3. **Minutes: 19 October and 15 December 2021**
   - To approve as correct records – copies **enclosed**

4. **Declarations of interest**
   [Members attention is drawn to the Memorandum of co-operation and principles of decision making and the table of specified pecuniary interests set out on the earlier pages of this agenda]

5. **Local Government (Access to Information) Act, 1985 (as amended)**:
   There are no items for consideration in the private session of the agenda

Discussion/Decision Items

6. Mental Health and Wellbeing Strategy
   - Report of Director of Public Health – **enclosed**

7. Health Protection Strategy (incorporating Annual report)
   - Report of Director of Public Health - **enclosed**

Assurance Items

8. Walsall Adults and Children's Safeguarding Board Annual Reports
   - Report of Chair of the Safeguarding Board - **enclosed**

9. Commissioning/spending Plans

   a) Adult Social Care
   b) Public Health
      - report of Interim Director of Commissioning Adult Social Care – **to follow**

   c) Clinical Commissioning Group Operational Planning 2022/23
      - Presentation by Chief Executive, Walsall Clinical Commissioning Group - **enclosed**

10. Special Educational Needs and Disabilities – Improvement Board
    - Report of Executive Director, Children's Services - **enclosed**

Information Items

11. Child Death Overview Panel report.
    - Report of Director of Public Health – **enclosed**

12. Work programme 2021/22
    - Copy enclosed

Date of next meeting – Note new date - **5 April 2022**

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The Relevant Authorities (Disclosable Pecuniary Interests) Regulations 2012

Specified pecuniary interests

The pecuniary interests which are specified for the purposes of Chapter 7 of Part 1 of the Localism Act 2011 are the interests specified in the second column of the following:

Subject	Prescribed description
Employment, office, trade, profession or vocation	Any employment, office, trade, profession or vocation carried on for profit or gain.
Sponsorship	Any payment or provision of any other financial benefit (other than from the relevant authority) made or provided within the relevant period in respect of any expenses incurred by a member in carrying out duties as a member, or towards the election expenses of a member. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Regulations (Consolidation) Act 1992.
Contracts	Any contract which is made between the relevant person (or a body in which the relevant person has a beneficial interest) and the relevant authority: (a) under which goods or services are to be provided or works are to be executed; and (b) which has not been fully discharged.
Land	Any beneficial interest in land which is within the area of the relevant authority.
Licences	Any licence (alone or jointly with others) to occupy land in the area of the relevant authority for a month or longer.
Corporate tenancies	Any tenancy where (to a member's knowledge): (a) the landlord is the relevant authority; (b) the tenant is a body in which the relevant person has a beneficial interest.
Securities	Any beneficial interest in securities of a body where: (a) that body (to a member's knowledge) has a place of business or land in the area of the relevant authority; and (b) either: (i) the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body; or (ii) if the share capital of that body is more than one class, the total nominal value of the shares of any one class in which the relevant person has a beneficial interest exceeds one hundredth of the total issued share capital of that class.

Schedule 12A to the Local Government Act, 1972 (as amended)

Access to information: Exempt information

Part 1

Descriptions of exempt information: England

1. Information relating to any individual.

2. Information which is likely to reveal the identity of an individual.

3. Information relating to the financial or business affairs of any particular person (including the authority holding that information).

4. Information relating to any consultations or negotiations, or contemplated consultations or negotiations, in connection with any labour relations matter arising between the authority or a Minister of the Crown and employees of, or office holders under, the authority.

5. Information in respect of which a claim to legal professional privilege could be maintained in legal proceedings.

6. Information which reveals that the authority proposes:

   (a) to give any enactment a notice under or by virtue of which requirements are imposed on a person; or

   (b) to make an order or direction under any enactment.

7. Information relating to any action taken or to be taken in connection with the prevention, investigation or prosecution of crime.

8. Information being disclosed during a meeting of a Scrutiny and Performance Panel when considering flood risk management functions which:

   (a) Constitutes a trades secret;

   (b) Its disclosure would, or would be likely to, prejudice the commercial interests of any person (including the risk management authority);

   (c) It was obtained by a risk management authority from any other person and its disclosure to the public by the risk management authority would constitute a breach of confidence actionable by that other person.

Health and Wellbeing Board

Tuesday 19 October 2021 at 4.00 p.m.

Venue: **Town Hall, Lichfield Street, Walsall.**

Present (in person)	Councillor S. Craddock (Chair) Councillor R. Martin Mrs K. Allward, Executive Director, Adult Social Care Mr. S. Gunther, Director of Public Health Mrs S. Rowe, Executive Director, Children's Services Ms C. Jennings, Housing Sector (substitute) Ms S. Samuels, West Midlands Fire Service
Present (Remote)	Councillor I Robertson Mr. G. Griffiths-Dale, Managing Director, Clinical Commissioning Group Ms. M. Poonia, Chair, Healthwatch Walsall Chief Supt. P. Dolby, West Midlands Police Ms. M. Foster, Black Country Healthcare NHS Trust Mr M. Sharon Strategic Director Walsall Healthcare NHS Trust (Substitute)
In Attendance: (In Person)	Mrs H. Owen, Democratic Services Officer
In Attendance: (Remote)	Mrs A. Farrer, Healthwatch Walsall Mrs C. Williams, Specialist Project Manager, Public Health. Mr M. Dodd, Walsall Healthcare NHS Trust

751. **Welcome**

Councillor Craddock opened the meeting by welcoming everyone, and explaining the rules of procedure and legal context in which the meeting was being held. He said that he would consult all Board members on their views if a vote was required however, only those Board members present in the Council House were able to vote and that this would be done by a show of hands which would be recorded.

Members of the public viewing the meeting to the papers which could be found on the Council's Committee Management Information system (CMIS) webpage.

752. **Sir David Amess MP**

At this point, Councillor Craddock made the following statement.
"Before the meeting starts, I wish to say that the tragic death of Sir David Amess MP in Leigh-on-Sea on Friday will have shocked and saddened us all. I would like to offer my sincere condolences to Sir David's family and also to his wider Houses of Parliament colleagues".

753 **Apologies and substitutions**

Apologies for non-attendance were received on behalf of:
Dr A. Rischie, Dr M. Lodhi, Ms F. Shanahan, Prof. David Loughton and Ms R. Davies.

Substitute members:
Ms C. Jennings for Ms F. Shanahan, Housing Sector representative
Mr M. Sharon for Prof. David Loughton, Walsall Healthcare NHS Trust

754 **Minutes**

(a) **Health and Wellbeing Board**

Resolved

That the minutes of the meeting held on 20 July 2021, copies having been sent to each member of the Board be approved and signed as a correct record.

(b) **Local Outbreak Engagement Board Sub-Committee**

The minutes of the meeting of the Local Outbreak Engagement Sub-Committee held on 6 July 2021 were submitted for information:

Resolved

That the minutes be noted.

755 **Declarations of interest**

There were no declarations of interest

756 **Local Government (Access to Information) Act, 1985**

There were no items to be considered in private session.

757 **Joint Strategic Needs Assessment (JSNA)**

In attendance: Mrs E. Thomas, Public Health Intelligence Manager

Mrs Thomas presented a report which provided the emerging key findings of the Walsall Joint Strategic Needs Assessment

(see annexed)

Members discussed the report and comments included:

- West Midlands Police had identified crime involving under 25's as one of its key priorities however, there was a recognition that offenders needed support in addition to the victim.

- The JSNA was only as good as the information put in and members were urged to make sure that they had appropriate representation and expertise from their organisation on the Walsall Insight Group.
- The increase statistically on the numbers of missing children was not necessarily a negative trend, it meant that there was heightened awareness through more effective joint work and information sharing between West Midlands Police and the Council's Children's Services to support children and young people.

Mrs Thomas summed up and reiterated the need to ensure that the data was read and understood in context.

Councillor Craddock thanked Mrs Thomas and her team for their work and it was:

Resolved:

1) To note the emerging findings of the JSNA for the purpose of identifying priorities for the Walsall Joint Health and Wellbeing Board Strategy.

2) To agree to further contributing to, and utilising Walsall's JSNA to help inform organisational priorities and action.

758 **Joint Health and Wellbeing Strategy**

The Director of Public Health, Mr S. Gunther, presented a report which set out the intention for the development of the new Joint Health and Wellbeing Strategy (Walsall Plan) for 2022-25

(see annexed)

Resolved:

That the Health and Wellbeing Board agrees to the proposal for the approach to structure and format for the updated Joint Health and Wellbeing Strategy (Walsall Plan) for 2022-25

759 **Healthwatch Walsall (HWW) Annual Report**

Mrs M. Poonia and Mrs A. Farrer, Healthwatch Walsall, presented the Annual report of Healthwatch Walsall**.**

(see annexed)

Councillor Craddock said that he was pleased to see that one of the priorities was Young Peoples Mental Health. He also thanked the volunteers at Healthwatch Walsall for their support.

Mrs Poonia and Mrs Farrer responded to questions during which time members were advised:

- Healthwatch Walsall volunteers had been undertaking virtual visits to social care establishments during the pandemic however, they were intending to resume their Enter and View visits towards the latter part of the month having regard to protocols and guidance in place at the time.
- GP access had been a difficulty for HWW being mindful of significant digital exclusion cohorts however, the Board should be assured that HWW

worked actively with individual cases, linking closely with the CCG. The work to understand the findings relating to the increase in footfall to the Urgent Care Centre was being mobilised towards the end of the year and that the manager of the centre was being engaged to make arrangements to undertake a survey at the centre.

The Group Commander, WM Fire Service, Ms S. Samuels complemented the detailed work undertaken by HWW and said that the Fire Service were focussed on health outcomes so would be keen to connect with HWW to work better together in the future.

A discussion then ensued in relation to the Covid vaccination take-up. Members took the opportunity to stress the importance of vaccinations to protect the individual themselves and to lessen the wider societal impact. It was noted that the HWW quarterly newsletters replicated the CCG messages in this respect. Members were concerned about the low take-up from 12-15year olds and the importance of understanding the reasons for this. The use of the fire service 'brand' and stations as a different vaccination venue was offered, as was raising the issue with Walsall school governors at their collective meeting.

Councillor Craddock thanked the presenters for their report and it was:

Resolved:

1) To note the key messages from the Annual Report.

2) To thank the Healthwatch Walsall volunteers for their contribution

3) To note the work priorities for 2021/2022.

760 **Mental Health and Wellbeing Strategy – progress update**

In attendance: Mrs A. Aitken, Senior Programme Development and commissioning manager, Health and Wellbeing.

Mrs Aitken presented a report, the purpose of which was to provide the Board with an update of the progress of the Walsall Multiagency Mental Wellbeing Strategy.

(see annexed)

Mrs Aitken responded to questions and points of clarification during which time she advised that to be successful in delivering the actions, it would need the multi-agency partners working closely together and aligning linked strategies to recognise mental wellbeing and incorporate into their organisations' policies, identifying impact using the mental wellbeing impact assessment tools. She confirmed that local residents would be able to contribute to the strategy and also the housing sector partners.

In response to a question from Councillor Craddock, Ch. Supt. Dolby advised that over 25% of everything the police deal with was mental health related. He said that the police were being increasingly called upon, particularly at night, to deal with issues requiring mental health support to both victims and criminals which required more expertise than the service was always able to provide at the time.

Members welcomed the production of the strategy as a preventive approach to improving mental wellbeing. Councillor Craddock reported that the Council's Cabinet was being asked to approve spend of a £1m of funding which would provide a momentum.

Members thanked Mrs Aitken for her presentation and it was

Resolved

1) That the Health and Wellbeing Board note the progress of the Walsall Multi-Agency Mental Wellbeing Strategy.

2) That the Health and Wellbeing support the approach to the development and completion of the Walsall Multi-Agency Mental Wellbeing Strategy.

761. **Walsall Together Progress Report**

In attendance Matthew Dodd, Director, Walsall Healthcare NHS Trust

Mr M. Sharon, Director, Walsall Healthcare NHS Trust presented a report which provided an overview of the progress of the partnership since the previous report was presented in October 2020 and outlined the potential to establish assurance reporting arrangements through the Health and Wellbeing Board in the future.

(see annexed)

In responding to questions from members, Mr Dodd advised that the inequalities work was being fed into the public health team through professional and clinical leaders group linkages and that objective measures were being put in place to monitor impact. It was noted that Walsall Together should be taking its strategic direction from the Health and Wellbeing Board and this would be managed between the two bodies through those members who were involved in both boards. Mr Dodd confirmed that whilst it was the intention to strengthen the current governance arrangements through the alliance agreement, there would be no change to the Section 75 agreement.

Councillor Craddock thanked Mr Sharon and Mr Dodd and it was

Resolved

That the report be noted

762 **Better Care Fund – update on submission of plan for 2021/22**

In attendance: Ms S. Thompson, Better Care Fund Manager

Ms Thompson presented a report which updated on the recently published 2021/22 Better Care Fund (BCF) Policy Framework and planning requirements to complete the local BCF plan for financial year 2021/22 in line with compliance.

(see annexed)

In presenting the report, Ms Thompson advised that in view of the lateness in publishing their requirements, dates and templates, the national BCF team had agreed to the plan being submitted to the regional team on 16 November in advance of the submission to the Health and Wellbeing Board in January although it would not receive national approval until it was confirmed that the Health and Wellbeing Board had agreed the plan. She confirmed that the report to the January meeting would explain the assurance mechanisms which included prior submission and agreement through the Joint Commissioning Committee.

Resolved

1) That the Health and Wellbeing Board receives and notes requirements and responsibilities in relation to submission of the Walsall BCF 2021/22 plan.

2) That the Health and Wellbeing Board notes timescales for submission of the 2021/22 BCF plan, and acknowledge the completed plan will be presented in January 2022 for approval.

763 **Work programme**

The work programme was submitted and noted. Councillor Craddock asked members to check when their reports were due for submission so that they comply with the relevant deadlines.

Date of next meeting – 25 January 2022.

The meeting terminated at 6.05.p.m.

Chair:

Date:

Health and Wellbeing Board

Minutes: Wednesday 15 December 2021 at 5.00 p.m.

Venue: **Conference Room 2, Council House, Lichfield Street, Walsall.**

Present (in person)	Councillor S. Craddock (Chair) Councillor M. Bird Councillor K. Pedley Mr. S. Gunther, Director of Public Health Mrs C. Thompson, Better Care Fund Manager Ms S. Samuels, Group Commander, West Midlands Fire Service
Present (remote)	Mr. G. Griffiths-Dale, Managing Director, Clinical Commissioning Group Ms S. Taylor, Health and Wellbeing Manager, One Walsall Prof. D. Loughton, Chief Executive, Walsall Healthcare NHS Walsall. Ms F. Shanahan, Housing Sector representative.
In Attendance: (In Person)	Mr C. Goodall, Principal Democratic Services Officer

764 **Welcome**

Councillor Craddock opened the meeting by welcoming everyone, and explaining the rules of procedure and legal context in which the meeting was being held. He also directed members of the public viewing the meeting to the papers which could be found on the Council's Committee Management Information system (CMIS) webpage.

Introductions took place and a quorum of members present was confirmed.

765 **Apologies and substitutions**

Apologies for non-attendance were submitted on behalf of:
Councillor Wilson, Councillor Robertson, Marsha Foster Dr. Rischie, Ch Supt Dolby, Sally Rowe

Substitutions: Councillor Bird for Councillor Wilson and Charlene Thompson for Kerrie Allward

766 **Declarations of interest**

There were no declarations of interest

767 **Local Government (Access to Information) Act, 1985 (as amended)**:
There were no items for discussion in the private session of the agenda.

768 **Walsall Better Care Fund 2021-2022 Planning Template and Narrative Plan**

The Better Care Fund Manager, Mrs C. Thompson presented a report which updated on the completion of the Plan, completed in accordance with National Better Care fund reporting requirements.

(see annexed)

In presenting the report, Mrs Thompson confirmed that the Plan had been submitted to the West Midlands Regional Team and recommended to the National BCF funding team. She added that the Regional Director NHS England had also agreed the plan.

The Chairman asked if there were areas where there would need to be a funding increase to which Mrs Thompson advised that there was likely to be a need to review the funding around the Intermediate Care Service to support capacity and demand in that area however, a contingency fund had been agreed to ensure that any overspend in that area could be funded with the agreement of partners and avoid overspend across the programme. She said that as programme manager, she was confident that the funding was being used appropriately with good schemes in place to contribute to the system in a positive way.

With regard to the impact of the latest wave of Covid-19, the Managing Director of Walsall Clinical Commissioning Group, Mr G. Griffiths-Dale advised that whilst this had been challenging, the CCG had been aligning additional funding coming into the system to the BCF on a non-recurrent basis to support service delivery and enable flexibility with in the partnership to switch capacity to manage those challenges.

Before putting the recommendations to the vote, the Chairman sought and received consensus from all members joining the meeting, including those attending remotely. Consensus was received.

It was Moved by the Chairman, seconded by Councillor Bird and upon being put to the vote:

Resolved:

1) That the Health and Wellbeing Board receives and agrees the 2021-2022 Walsall Better Care Fund Planning Template for approval to be sought at national level.

2) That the Health and Wellbeing Board receives and agrees the Better Care Fund 2021-2022 Narrative Plan for approval to be sought at national level.

The meeting terminated at 5.15 p.m.

Chair:

Date:

Health and Wellbeing Board

25 January 2022

Walsall Multi-Agency Mental Wellbeing Strategy

1. Purpose

1.1 The purpose of this report is for the Health and Wellbeing Board (HWBB) to **APPROVE** the Walsall Multiagency Mental Wellbeing Draft Strategy.

2. Recommendations

2.1 That the HWBB **APPROVE** the Walsall Multi- Agency Mental Wellbeing Strategy

2.2 That the HWBB **APPROVE** that the Mental Wellbeing Multi-Agency Partnership take ownership of the delivery of the strategy and report back to the HWBB on an annual basis

2.3 That the HWBB **DECIDE** whether they want all the Health and Wellbeing partner logos add to the strategy or if they would prefer to take a different approach to demonstrate a joint commitment to the strategy

3. Report detail

3.1 Promoting and supporting mental wellbeing in Walsall has become a key issue for the Health and Wellbeing Board (HWBB) in the development of the Joint Strategic Needs Assessment, and as a key theme in response to the COVID-19 pandemic.

3.2 During the Covid-19 pandemic response, a mental wellbeing multi-agency team was set up to identify and coordinate action to support the mental wellbeing needs identified. This group, along with other strategic and community partnerships and groups have contributed to the development of a Mental Wellbeing Strategy for the borough.

3.3 The strategy takes a dual approach to reach and engage Walsall residents (universal and targeted) to improve population mental wellbeing:

- A universal approach to promote good mental health and emotional resilience and prevent mental ill health for all age groups and populations
- A proportionately targeted approach to reduce mental wellbeing and health inequalities, to consider the clear mental health inequalities,

both in terms of who experiences the greatest risk of poor mental health and in terms of unequal access to treatment.

3.4 The strategy takes a 10-year view to improve some of the social and economic challenges. These are as follows:

- Years 1-2: Addressing immediate wellbeing challenges including the Covid-19 impact on mental wellbeing
- Years 3-5: Beyond equilibrium
- Years 1-10: Aim higher for Walsall residents

3.5 The strategy proposes the following definition of mental wellbeing;

> "*Mental health is a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community." (WHO, 2001).*

3.6 It is about "*How you are feeling and how well you can cope with day-to-day life. Our mental wellbeing is dynamic. It can change from moment to moment, day to day, month to month or year to year." (Mind, 2016)*

3.7 The mental wellbeing of the population is affected by social networks, income, unemployment, and inadequate quality of work[i], the quality of the natural and built environment, such as air quality, the quality of green spaces, and housing[ii].

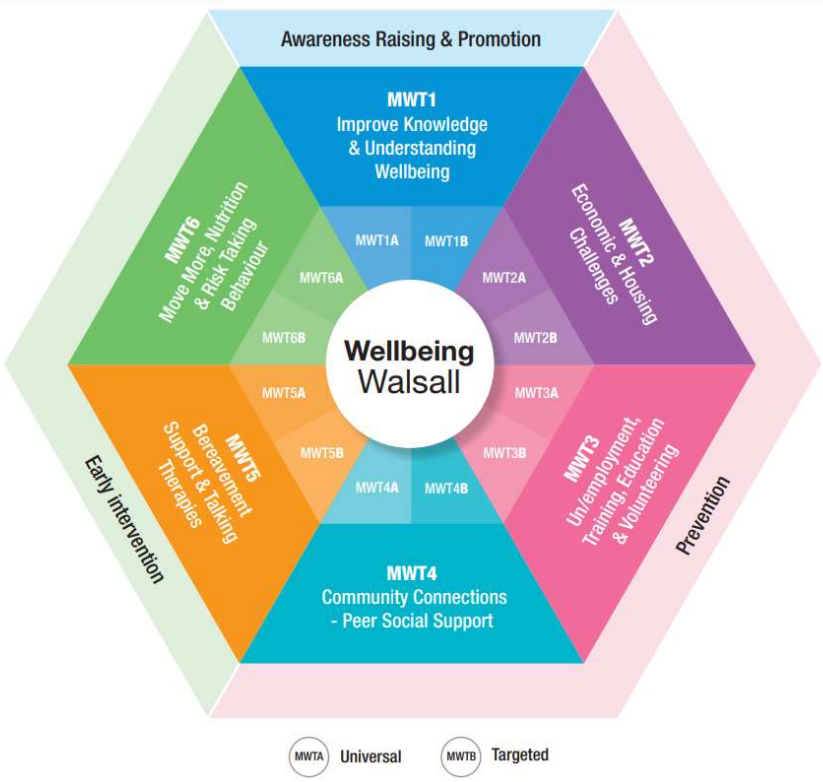
3.8 The strategy has been informed by drawing on evidence of what works and by undertaking a range of consultation and co-production exercises. Through this approach local needs and issues were explored from the viewpoint of partner and resident stakeholders. These activities include:

- The HWBB Partnership deep dive into mental health and wellbeing
- The Community Mental Health and Wellbeing Partnership
- The Walsall Multi-Agency Suicide Prevention Partnership
- The Mental Health & Wellbeing IMT
- Walsall Ethnic Minority Communities Steering Group
- One-to-one HWBB Member engagement and wider one-to-one multi-agency stakeholder consultation
- Commissioned community members consultation (University Wolverhampton and Birmingham CVS)
- The Walsall for All Partnership
- The Walsall Together Resilient Communities Partnership
- The Adult Social Care, Public Health and Hub Black & Asian Employee Network
- Multi-Agency Consultation Survey

3.9 The ambition is to achieve optimal mental wellbeing for all Walsall residents and reduce mental health and wellbeing inequality.

3.10 To achieve the ambition, multi-agency stakeholders will need to work together to increase opportunities for better mental wellbeing. This will include raising awareness of mental wellbeing, tackling mental health stigma, providing training, self-care and directing focus towards tackling common causes of poor mental wellbeing in Walsall.

3.11 The approach for delivering the Walsall Multi-Agency Mental Wellbeing Strategy is set out in the Mental Wellbeing Wheel.



3.12 There are 3 Levels to this strategy; Mental Wellbeing Promotion, Mental Illness Prevention and Early Intervention delivered through the following 6 priorities:

- Improving the population's understanding of mental wellbeing and knowledge of how to access support and tackling mental health stigma
- Working together to improve how some of the economic and housing challenges impact on the population's mental wellbeing
- Working in partnership with employers to support their employees
- Enhancing community connections, peer support and networks
- Making bereavement and counselling support more accessible by locating delivery within local communities and making them more culturally appropriate
- Utilising prevention and early intervention provision such as physical activity and nutrition.

Next Steps

- The Mental Wellbeing Multi-Agency Partnership group is to work closely with key strategic Walsall partnerships to deliver this strategy
- Develop and implement a Multi-Agency annual Action Plan which drives the delivery of the strategy

4 Implications for Joint Working arrangements:

4.1 Making it Happen, Leadership, Partnership & Resources

- To improve mental wellbeing across Walsall, it is vital to work as part of a wider strategic system, which takes into account the social and other determinants of mental wellbeing.
- The multi-agency team will provide strategic leadership and will become accountable to the HWBB for delivering the strategy.

5. Health and Wellbeing Priorities:

5.1 Mental wellbeing is emerging as a key priority for the HWBB within the developing JSNA and Health and Wellbeing Strategy. The development of this strategy will be a key component of the delivery of that priority.

5.2 The proposal has been tested against the Marmot principles to reduce mental health inequalities. It contributes to the following objectives:

- Enable all children, young people and adults to maximise their capabilities and have control over their lives
- Ensure a healthy standard of living for all
- Create and develop healthy and sustainable communities
- Strengthen the role and impact of ill-health prevention.

Author

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[i] Compton, M.T. and Shim, R.S., 2015. The social determinants of mental health. *Focus*, *13*(4), pp.419-425.
[ii] Evans, G.W., 2003. The built environment and mental health. Journal of urban health, 80(4), pp.536-555.

Walsall Multi-Agency Mental Wellbeing Placed Based Strategy

Mental Wellbeing Walsall "Together We Can"

2022- 2032

Walsall Council

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Foreword

Prevention and taking into account the wider determinants is vital to improve population mental wellbeing across Walsall. For this reason, Walsall Health and Wellbeing Board has prioritised improving population mental wellbeing and has committed to working together to achieve advances for residents. This strategy drives action to achieve this commitment by empowering stakeholders including residents, individually, collectively and across the system to accomplish improvements in Walsall.

Walsall is a diverse Borough, located in the Black Country of the West Midlands. It has a wealth of strong community assets, which include (but are not limited to) an active voluntary and community sector, plenty of open green spaces, and a strong sense of local identity that celebrates the diverse backgrounds of residents. All of these, in addition to many other assets, contribute positively to the mental health and wellbeing of residents. Despite this, on average Walsall residents overall experience higher levels of mental ill-health and lower levels of mental wellbeing than the England average.

A contributory factor for poor mental health and wellbeing in Walsall is that it has a high level of multiple deprivations. Walsall is ranked the 25th most deprived Local authority area in England (out of 317).

The inextricable link between mental wellbeing and physical health is not well understood by all Walsall stakeholders. Those with the poorest mental wellbeing are at an increased risk of experiencing poor physical health, whilst those with the poorest physical health are at an increased risk of experiencing low mental wellbeing.

Whilst most people are aware of the measures they can take to improve their physical health, the same cannot be said for mental wellbeing. A significant proportion of the community do not understand what it is or how they can improve their mental wellbeing. The reality is, regardless of where on the continuum of mental health we start, we can all take steps to make improvements.

Population improvements in mental wellbeing can be achieved by working together and ensuring that all residents are aware of the opportunities available to them to improve and maintain positive mental wellbeing. For this reason, the Health and Wellbeing Strategy for Walsall (2019 - 2021) identifies mental wellbeing as a key priority.

This strategy brings out key strategic and delivery themes and workstreams delivered through the Health and Wellbeing Board Partners and other key partnerships. It articulates a cohesive, population-based approach and it draws on the available local assets and resources, to increase mental wellbeing awareness and builds on individual and community resilience.

Background

Globally, we are experiencing major economic challenges, and these challenges are marked in Walsall. Nationally, poor mental health is estimated to cost the economy approximately £105 billion per year, including £34 billion on dedicated mental health support and services. The Walsall Health and Wellbeing Board and its many Multiagency partners understand that investing in prevention and early intervention to improve population mental wellbeing is a sound investment. This strategy is therefore focused on mental wellbeing, not on mental ill-health.

Walsall is a diverse borough, both economically and demographically. Around half of Walsall residents live in the most deprived 20% of neighbourhoods in England and the rate of unemployment in our borough also falls within the worst 20%. Moreover, there has been a sharp increase in unemployment claims throughout the COVID-19 pandemic, which has disproportionately affected our younger people. Deprivation and unemployment are strongly and consistently linked to low levels of wellbeing, and higher rates of depression, anxiety and suicide.

Indeed, in our Walsall 2020 Resident Experience and Wellbeing survey, respondents reported a "medium" level of wellbeing. However, of the residents that did report a low level of wellbeing, poor general health, unemployment and financial stress were cited as the most prominent reasons. Notably, younger people, males, and those furloughed during the pandemic reported significantly lower wellbeing than average.

Walsall has a rich ethnic and cultural diversity, with around a quarter of our population from minority ethnic communities. Throughout the COVID-19 pandemic in the UK, people of "other than white" ethnicity have experienced lower life satisfaction than the white population , whilst simultaneously having a higher loneliness score. At the same time, people in minority ethnic communities are less likely to receive medication, counselling or therapy for mental ill-health.

Housing and the environment are important social determinants of health and wellbeing. The quality of housing stock available, its affordability, overcrowding and poverty have a direct association with mental wellbeing. Around a quarter of homes in Walsall are socially rented, with another 16% rented privately. A higher proportion of individuals who rent their homes report lower life satisfaction and high anxiety scores than those that have a mortgage or own a house outright.

In addition, Walsall has a higher proportion of overcrowded households than the national average, with about 5.2% of households affected. Fuel poverty, linked to cold homes, is associated with poor health and wellbeing outcomes, and an increased risk of morbidity and mortality for all age groups. Around 13.7% of households in Walsall experience fuel poverty, and this is likely to be exacerbated by the anticipated rise in fuel and energy costs.

Social contact, a feeling of connectedness with one's family and friends, community and broader society is fundamental to good wellbeing. However, of adults who have social care needs in Walsall, it was reported that only around 4 in 10 had as much social contact as they would like. In addition, of all adult carers in Walsall, only 27% of them had as much social contact as they would like. Therefore, these groups are highly likely to experience lower wellbeing and have been significantly affected by the pandemic.

In addition to these groups, many children and young people have experienced loneliness during the lockdown and school closures. In particular, they are likely to have been affected by lack of physical contact with their friends, families and peers, and the boredom and frustration associated with a loss of all the activities they have been used to taking part in.

Bereavement can be an extremely distressing time for relatives, families and friends, and can have a devastating impact on mental wellbeing. The COVID-19 pandemic has already left many grieving the sudden loss of relatives and friends. In Walsall, this has resulted in an increased demand for already strained bereavement and counselling services.

Lifestyle factors strongly impact an individual's quality of life both physically and mentally. Smoking, drug and alcohol misuse, gambling and physical inactivity are all major risk factors for poor mental health and mental wellbeing. Overall, around 15.6% of adults in Walsall smoke, but the prevalence is much higher in people with anxiety and depression at about 28.1%. Regular physical activity is also strongly associated with improved mental wellbeing. In Walsall, 63.2% of adults are physically active, and encouraging a further increase in this proportion will have a protective effect on the mental wellbeing of Walsall residents.

How the mental wellbeing strategy has been developed

This strategy which focuses on mental wellbeing, not on mental ill-health, seeks to develop a coherent relevant local approach, which draws on local and national epidemiological data concerning mental wellbeing in the Borough of Walsall. **The Strategy Briefing and Data Paper** provides data on the current position and includes evidence of what works.

The development of the strategy involved seeking the views of a wide range of stakeholders, fact-finding, co-production and consultation activities including undertaking engagement of:

- The Health and Wellbeing Board Partnership deep dive into mental wellbeing
- The community Mental Wellbeing Strategic Partnership
- The Walsall for All Partnership
- The Walsall Multi-Agency Suicide Prevention Partnership
- The Mental Health & Wellbeing IMT
- Walsall Ethnic Minority Communities Steering Group
- One-to-one Health and Wellbeing Board Members
- Commissioned community members consultation
- Wider Multi-Agency Stakeholder consultation
- The Resilient Communities Partnership
- Adult Social Care, Public Health and Hub Black & Asian Employee Network
- Walsall Housing Working Group

What is Mental Health and Wellbeing?

The first step to improving population mental wellbeing in Walsall is for our partners and the residents of Walsall to develop a comprehensive understanding of what mental wellbeing is, and how it differs from mental health. It is also important to recognise that mental wellbeing and mental health are two related yet independent concepts.

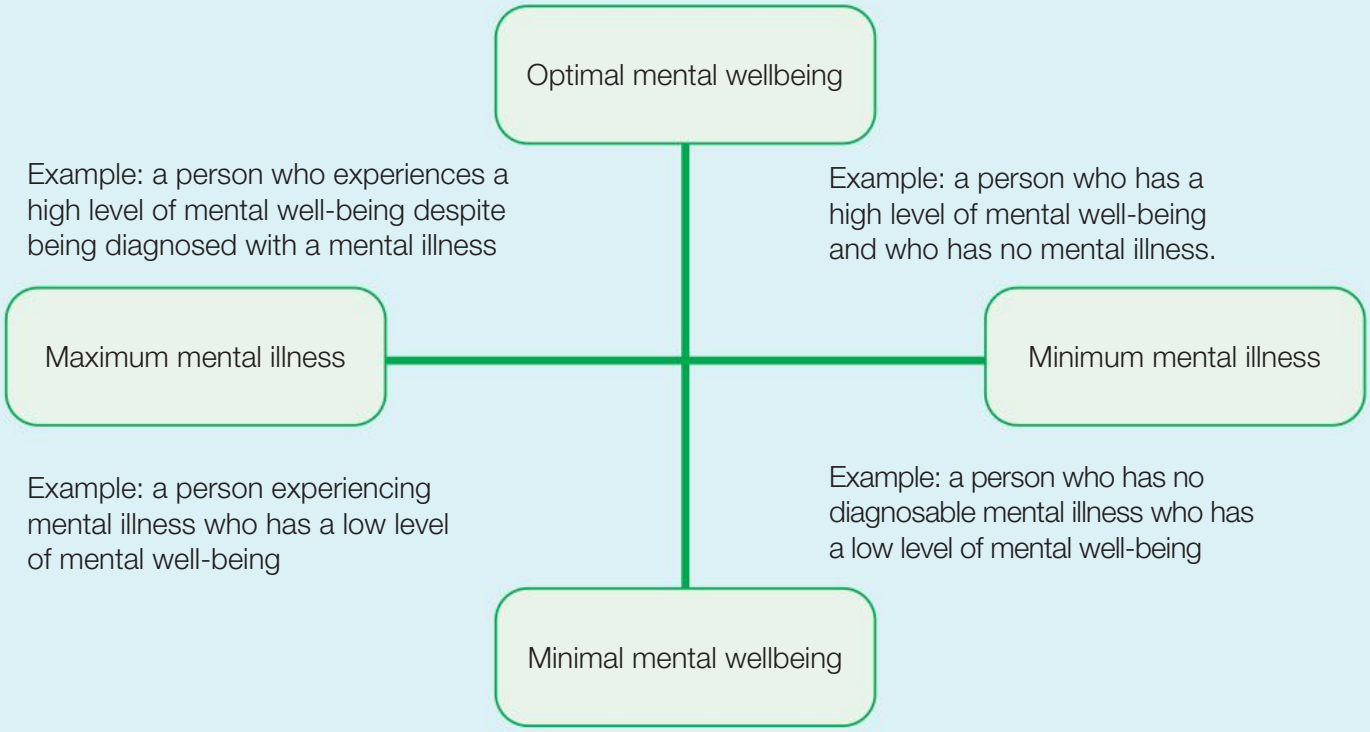
The World Health organisation states that:

"Mental health is a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community." (WHO, 2001).

Mind describes mental wellbeing as a mental state, which is about

"How you are feeling and how well you can cope with day-to-day life. Our mental wellbeing is dynamic. It can change from moment to moment, day to day, month to month or year to year." (Mind, 2016)

Mental wellbeing refers to a person's emotional state at any given time. Mental Wellbeing is the bedrock from which other things flow. It is the positive end of a spectrum of mental health and describes both feeling good and functioning well.



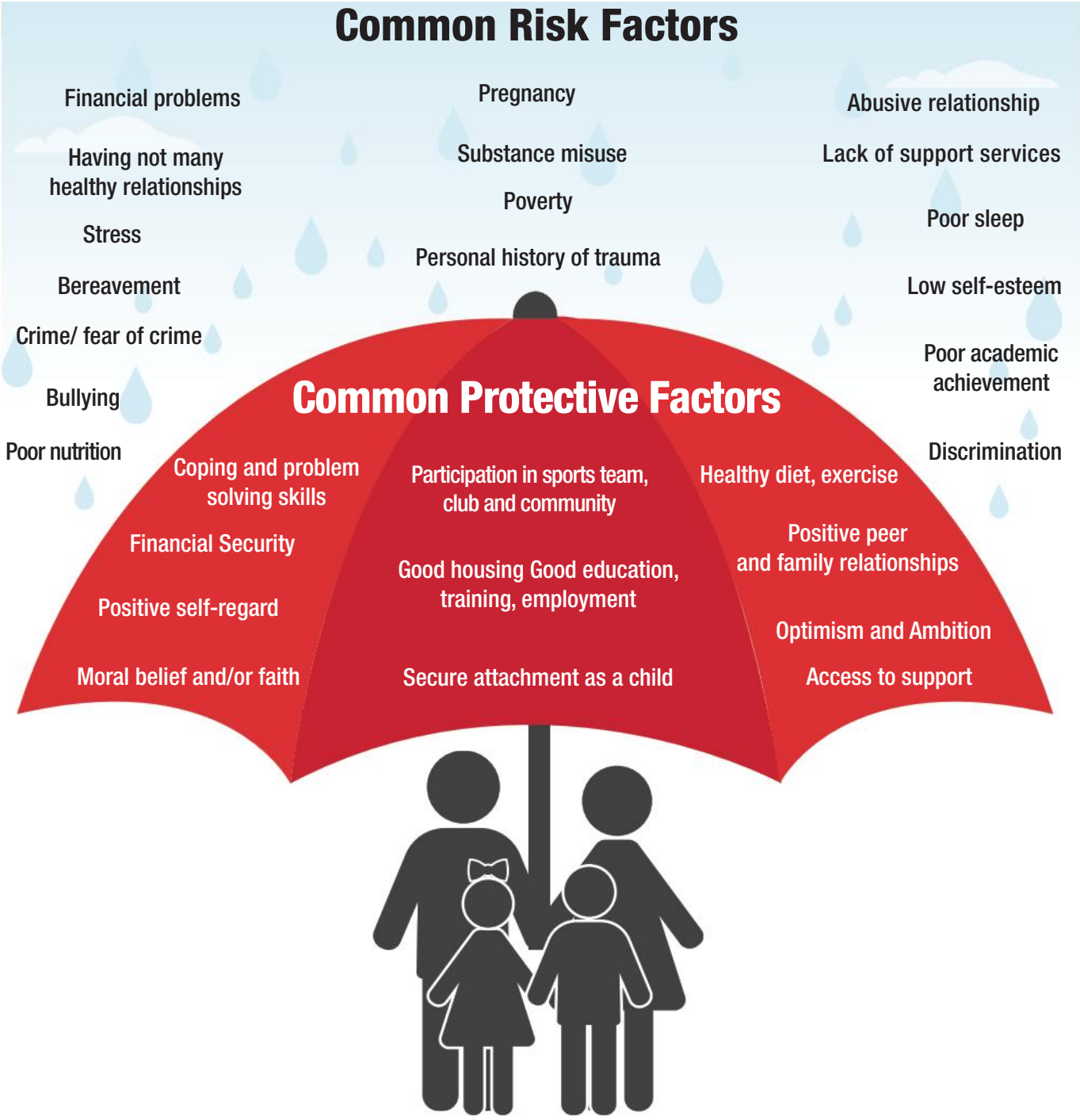
SOURCE: Adapted from Keyes (2002)[3]

The meaning of mental wellbeing can differ from person to person and organisation to organisation. The 2020 Resident Experience and Wellbeing Survey found that 28% of respondents rated their mental wellbeing as low. However, the true rate may be higher due to the populations varied understanding of what is meant by mental wellbeing.

Having good mental wellbeing increases an individual's resilience to challenging situations. It reduces the risk of depression and supports the building and maintenance of strong relationships. It is important to note that a person living with a mental illness can achieve positive mental wellbeing, like someone who has neither mental nor physical illnesses.

Mental Wellbeing Risk and Protective factors

Mental wellbeing is affected by a range of factors, such as social networks, income, unemployment, quality of work , the quality of the natural and built environment, including, air quality, the quality of green spaces and housing. These factors can act as protective factors for positive mental wellbeing, or conversely can lead to poor mental wellbeing.



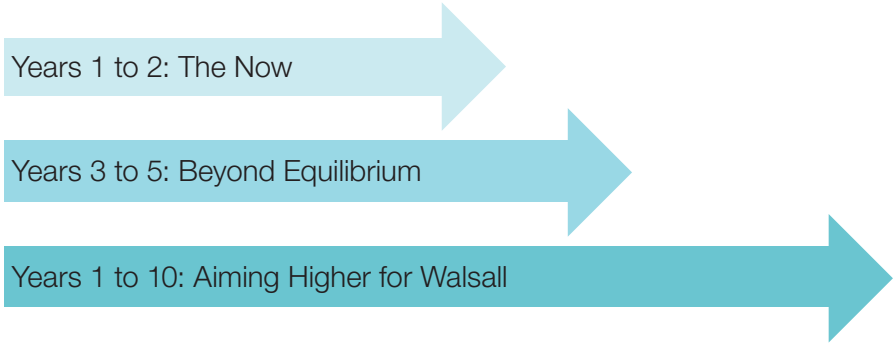
Strategy Structure - Our Approach to Mental Wellbeing in Walsall

Section 1 of the strategy defines mental wellbeing and sets out the ambitions for Walsall, the priorities, and the strategic approach, including the interaction with other policies and strategies.

Section 2 of the strategy provides a summary of data linked to the accompanying data and briefing paper. It includes what the evidence says, and what stakeholders say they want to achieve for Walsall.

Section 3 of the strategy sets out the current position in Walsall, it includes the challenges, makes recommendations, and demonstrates how the ambitions can be achieved through leadership and partnership working.

A 10-year Strategic Approach



This 10-year strategy takes a sustained approach to address some of the social and economic challenges to achieve short term, medium-term and long-term (1 -10 years) outcomes

Years 1- 2: Immediate Mental Wellbeing challenges including the COVID-19 impact

The issues in scope, which give rise to stress and anxiety and impact on people's quality of life include housing, income, benefits, the health system, social connections, bereavement, the environment, and society. The pandemic has exacerbated these challenges across Walsall.

- We will build on the work of our Walsall multiagency partners i.e., the Walsall Together Resilient Communities Partnership, Walsall Mental Health and Wellbeing Multi-Agency Team, Walsall Ethnic Minorities Steering Group and Walsall Community Mental Health and Wellbeing Partnership, to achieve equilibrium by:
  - Continuing to work with our population to address the challenges our residents are experiencing to rebalance the mental wellbeing challenges that were present before and as a result of the pandemic
  - Expanding support to improve residents' ability to navigate challenges which trigger stress, anxiety and mental wellbeing needs that have escalated during the pandemic
  - Supporting action to build capacity, skills and confidence to enable residents to access self care

Years 3 - 5: Beyond Equilibrium – Together as partners, we will focus on:

Building community resilience and increasing opportunities for Walsall residents to thrive and improve their mental wellbeing. A key element of this is the provision of:

- Achieving better mental wellbeing for our residents than was experienced prior to the COVID-19 pandemic
- Further developing and coordinating the work of building community resilience began prior to and during the pandemic
- Increasing opportunities for Walsall residents to enable them to thrive, in order to improve population mental wellbeing
- Achieving greater effectiveness and efficiency of the range of existing and developing provision

Years 1-10: Aiming Higher for Walsall Residents

We want mental wellbeing to have significantly improved in Walsall and we will learn from the best to do so. Everything we do over the next 10 years will maintain focus on this ambition. By year 10 we want;

- To achieve a culture change, where all Walsall strategic partners, organisations, and community groups prioritise mental wellbeing as fundamental to their business
- Mental Wellbeing Impact Assessments to systematically and consistently be carried out by all partners when developing any policies, strategies, delivering services and when undertaking any major plans, projects or making proposals
- System stakeholders, including residents to want to and feel able to openly talk about their mental wellbeing, and to be able to easily access appropriate support at the right time in the right place

Walsall's Mental Wellbeing Ambition

Our ambition is to achieve optimal mental wellbeing for all Walsall residents and to reduce mental wellbeing inequality.

We will work to ensure everything we do in Walsall considers the impact on mental wellbeing and mitigates risks of poor mental wellbeing.

To achieve this ambition, Walsall Multi-Agency stakeholders have committed to work together to raise the aspiration of achieving good mental wellbeing for Walsall residents. Partners will sign up to the Mental Wellbeing Prevention Concordat to achieve strategic and system-wide engagement and delivery.

The drive to achieve a shared understanding of population mental wellbeing, enhance residents' abilities to self-care and improve access to mental wellbeing intervention at the right time, in the right place for those with the greatest need is central to this strategy. This strategy takes:

- **A universal approach** to encourage good mental wellbeing, emotional resilience and self-care across all age groups and populations.
- **A targeted approach** to tackle mental wellbeing inequalities, to reach, engage, and improve the mental wellbeing of those at an increased risk of the worst outcomes.

The Mental Wellbeing Strategic Priorities

We will improve mental wellbeing in Walsall by working together to deliver the following priorities:

Improving knowledge and understanding of mental wellbeing by:

- Raising awareness of mental wellbeing in our residents
- Making mental health and wellbeing training available
- Reducing mental health stigma
- Increasing knowledge of how and where to access support and reducing barriers to access

Improving some of the economic and housing challenges that impact residents' mental wellbeing

Reducing unemployment and working with employers to support their employees

Enhancing social capital, social connections, peer support and community champions and networks, and building on current good practice by Walsall multi-agency partnerships

Making bereavement and counselling support more accessible by:

- locating delivery within communities
- making support more culturally appropriate

Utilising prevention and early intervention by linking to other strategies e.g., those that increase access to physical activity, and improvements in nutrition

Interactions with local policy

Key Strategic and Policy Drivers

- **NHS Mental Health Implementation Plan 2019/20 – 2023/24**
- **Five Year Forward View for Mental Health (2016)**
- **No Health Without Mental Health: a cross-government outcomes strategy (2011)**
- **Transforming children and young people's mental health provision: a green paper (2017)**
- **Preventing suicide in England: Fifth progress report of the cross-government outcomes strategy to save lives (2021)**
- **Thrive Mental Health Commission (WMCA, 2017): An Action Plan to drive better mental health and wellbeing in the West Midlands**

There is a wide range of contributory factors to mental wellbeing. As a result, this strategy interlinks with other existing and developing local strategies and policies (listed in box xx below). Although many of these policies/strategies may not make explicit mention of mental wellbeing, it is important to recognise and make the interconnections to synergise working.

Local Strategic Link and Policy Overlap with this Strategy

- Carers Strategy – **In development**
- **Walsall Corporate Plan 2018-2021**
- **Walsall Early Help Strategy**
- **Walsall-Multiagency-Suicide-Prevention-Strategy-2018 - 2023**
- **Walsall College Corporate Strategy 2021 - 2024**
- **Walsall Housing Strategy 2020 to 2025**
- **Emotional Wellbeing and Behaviour Pathway Toolkit**
- **Walsall Homelessness Strategy 2018-2022**
- **The Walsall Plan: Our Health and Wellbeing Strategy 2019-2021**
- **whg Health and Wellbeing Strategy: 2021 - 2024**
- **Healthy lifestyle related strategies for example a physical activity framework is in development**
- **Walsall Joint Strategic Needs Assessment**
- **Black Country Core Strategy 2011-2026**

Outside the scope of this strategy:

- Specific actions of the Walsall Multi-Agency Suicide Prevention Strategy
- Mental health treatment services
- Physical Activity Strategy
- Substance Misuse Strategy
- Children and Young People's Strategy

Walsall's Mental Wellbeing – Data Summary- What the data says

1 IN 4 ADULTS
experiences a mental health condition in any given year

On average people with serious mental health illness die **15-20** years earlier

People living in the most deprived areas of England were **2x** as likely to be referred to IAPT

x2

Carers are more likely to suffer mental health problems than non-carers.

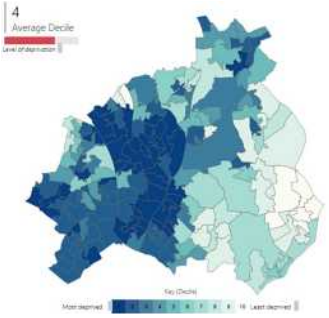
Medication Counselling

Black & Asian communities are more likely to be prescribed medications than be referred for counselling

In Walsall, **5.2%** of households are overcrowded

28% of people rated their mental well-being as low In Walsall

Children from the **poorest 20%** of households are **4x** more likely to have serious mental health difficulties by the age of 11 as those from the **wealthiest 20%**



In Walsall **50%** of residents live in the **20%** most deprived neighbourhoods in England

21% bereaved people nationally said that they had not spoken to a support service about their bereavement but would have liked to

In Walsall **1 in 1000** households were in temporary accommodation in 2017/18

85% of older people with depression receive no NHS support

Fuel poverty, is associated with poor wellbeing. **13.7%** of households in Walsall experienced fuel poverty in 2022 this is likely to increase due to increasing national energy costs.

40%

40% of adults with social care needs in Walsall said they had as much social contact as they would like.

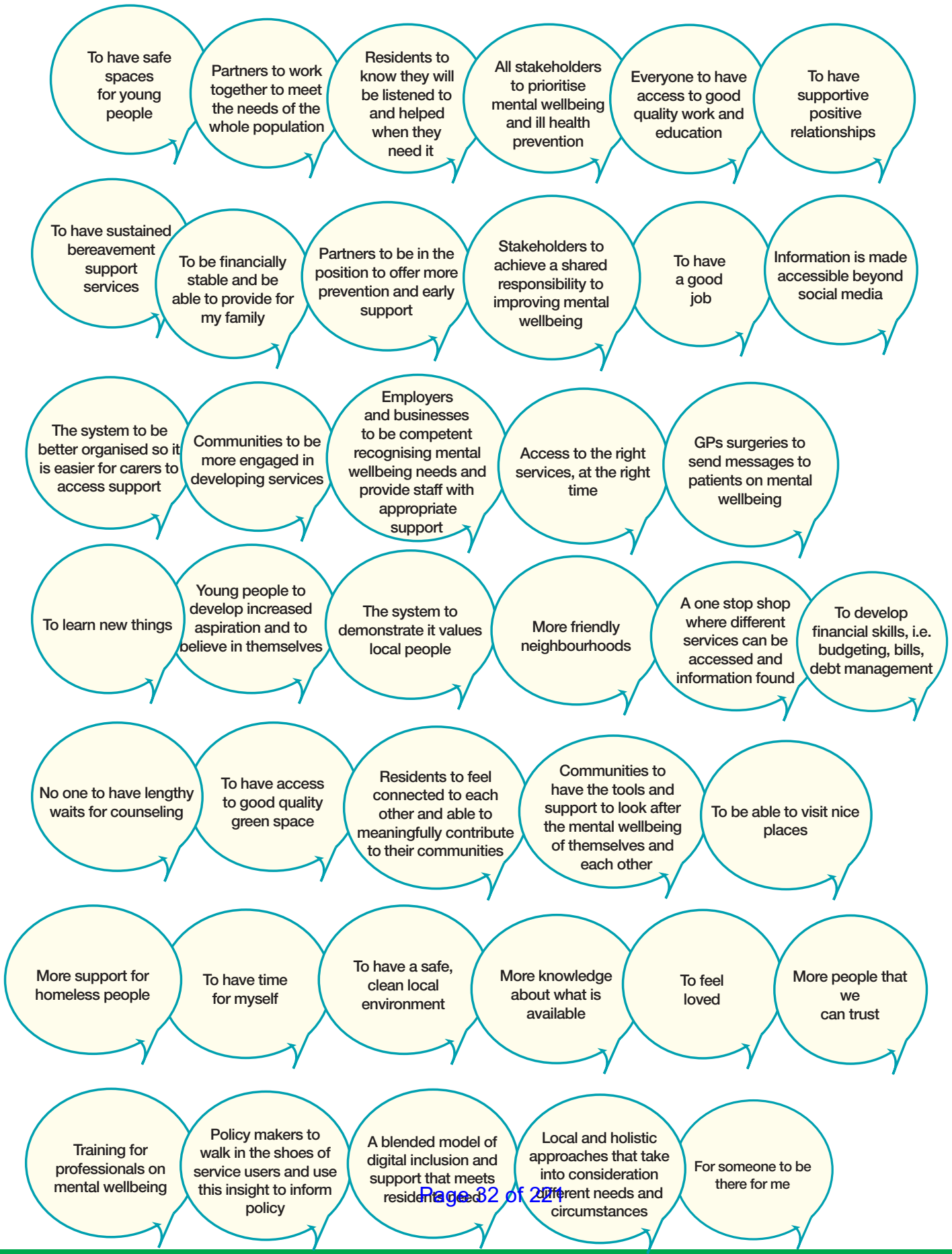
19.4% of Walsall residents experience anxiety or depression

Walsall Council

Local Stakeholder Views

Through the process of consulting stakeholders, including residents and young people, a range of key views and hopes concerning mental wellbeing in Walsall were highlighted. **Stakeholders stated:**

We Want...



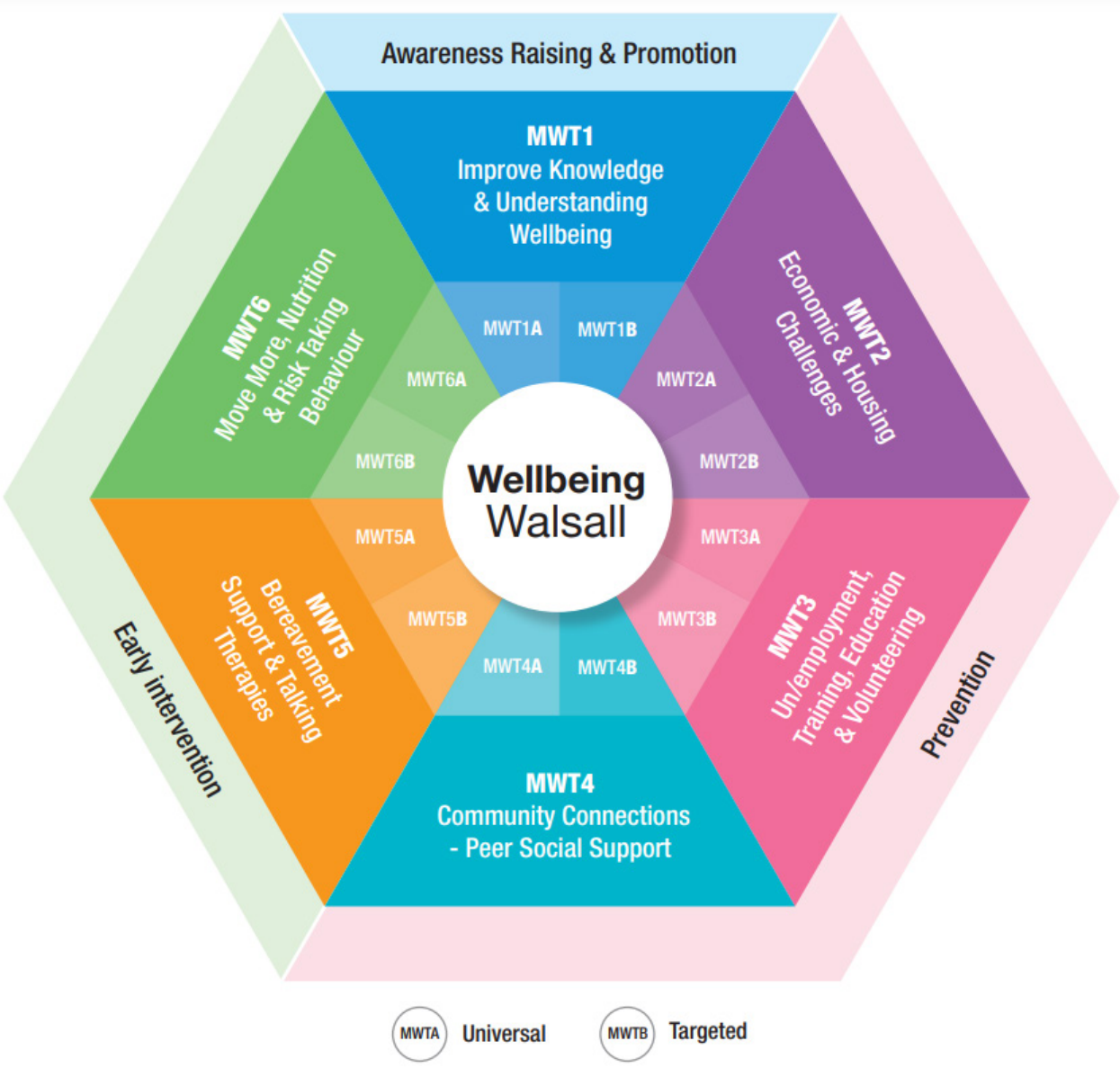
Walsall Mental Wellbeing Thematic Wheel and the Strategic Approach

The strategic approach for mental wellbeing is set out in 3 categories of interventions and is delivered through 6 themes. See table.

Mental wellbeing promotion	Theme 1. Improve Knowledge & Understanding of Mental Wellbeing
Mental illness prevention	Theme 2. Economic & Housing Challenges Theme 3. Thrive Intervention Unemployment & Employment Theme 4. Community Connections & Peer Social Support
Early intervention	Theme 5. Bereavement Support & Talking Therapies Theme 6. Health Behaviour and Wellbeing

The themes are coordinated through the colours of the thematic wheel.

Mental Wellbeing Thematic Wheel



Stigma remains a huge barrier to recognising and addressing poor mental wellbeing in Walsall. By improving knowledge and understanding of mental wellbeing, access to timely and appropriate support will be improved for residents.

MWT1A Improve Knowledge & Understanding of Mental Wellbeing – Universal	
Current Position	Local Challenges
• Primary care mental health nurses are available in Primary Care Networks • A community forum is in place to bring together pathways and improve mental wellbeing • A range of online and face to face training is available on mental wellbeing, suicide prevention and Mental Health First Aid • There has been an increased investment in Improving Access to Psychological Therapies in Walsall • Walsall has a Community Mental Health Enablement service responsible for a mental health information hub, a crisis café and a 24-hour single point of access • Emotional wellbeing tool kits are available to enable signposting to support children and young people • A range of community outreach provision available i.e., whg Social Prescribers, Kindness Champions, Making Connections Walsall Social Connectors, Wellbeing Walsall Mobile Unit • No Wrong Door Network • Vibrant VCS organisations and groups, which deliver interventions that improve mental wellbeing	• There has been reduced access to mental health and wellbeing support due to the pandemic i.e., un/employment and isolation • Population knowledge of mental wellbeing self-care is low • People not recognising when to seek support, which increases the risk of poor health • Residents and staff are unclear about what support is available • Capacity and confidence to access mental wellbeing support is limited • More people attending A&E are being sectioned who previously were not known to services • A significant proportion of the population do not have digital access and are unable to access digital self-care or online training • Self-reported mental wellbeing has declined due to the pandemic • Self-reported wellbeing is below the national average • The level of stress in the population has increased • Access to Primary Care
For Walsall we want	
• Life satisfaction and wellbeing scores reported by our residents to improve • Health and care providers to prioritise mental wellbeing as part of the whole person • System-wide awareness of available prevention and mental wellbeing support • To enhance access to opportunities in addition to those accessible through social media • Policies, strategies, and partnerships to undertake a mental wellbeing impact assessment when making key decisions or implementing significant policy change • Residents to understand the impact of mental wellbeing on them and their families • Consider building on the No Wrong Door Network to achieve a one-stop shop in the town centre • Stakeholders to have a shared understanding of mental wellbeing and to take collective responsibility for improving population mental wellbeing. • Stakeholders to be able to recognise signs and symptoms of mental wellbeing decline and know how to access support when it is needed • Stakeholders to be comfortable talking openly about their mental health and wellbeing and to be able to challenge mental health stigma	

Mental Wellbeing Promotion - Awareness raising

Stigma remains a huge barrier to recognising and addressing poor mental wellbeing in Walsall. By improving knowledge and understanding of mental wellbeing, access to timely and appropriate support will be improved for residents.

MWT1B Improve Knowledge & Understanding of Mental Wellbeing – Targeted	
Current Position	Local Challenges
• BCHFT lead an Ethnic Minorities Communities Steering Group which supports VCS organisations to improve mental health and wellbeing for diverse and vulnerable communities • Benefit staff have a basic awareness of what mental wellbeing is, which means those accessing benefits can ask for help • Investment is available to develop population mental wellbeing provision for those at an increased risk of mental well-being decline • There is a local recognition of the need to develop culturally appropriate provisions to meet the diverse population needs • There is a low understanding of the impact caring has on the mental wellbeing of carers locally and of the impact of care policies • Police have increased understanding of mental wellbeing	• A range of services are not available to appropriately meet the needs of underserved populations i.e., men, Black, Asian and traveller communities, those identifying as LGBTQ, gender neutral, non-binary, young people, deaf communities, and pregnant women • Underserved populations are at an increased risk of low mental wellbeing, are less likely to recognise mental wellbeing needs, and are less likely to know what support is available • Carers, the unemployed, men and Black and Asian communities' groups and those who already have mental health challenges are at the most risk of reaching crisis point and are least likely to receive or seek help
For Walsall we want	
• Mental wellbeing services and VCS providers to be culturally appropriate to meet the diverse needs of the population • The conversation around mental health and wellbeing to be normalised in different communities and access to appropriate support when needed • Men to be empowered to develop and lead projects that meet the diverse mental wellbeing needs of men in Walsall • Men to realise that it is OK to say they are not ok, to know where to access support and to accept help • Carers to be supported to optimise their mental wellbeing • Members of underserved communities to be confident to access mental wellbeing support • Accessible early intervention and prevention services are available which respond to the needs of families • All women and their families to understand the signs of perinatal depression and how the menopause can impact mental wellbeing and can easily access support	

My Wellbeing Plan

Level 2 - Mental Illness Prevention

8 Steps to Wellbeing

Mental wellbeing affects how we feel about all areas of life. Looking after our mental wellbeing can improve the way that we feel every day. Self-care can be quick and is cost-effective.

This strategy builds on the Five Ways to Wellbeing, and adds hydration, nutrition, sleep and hope for the future, to achieve a comprehensive approach to improve mental wellbeing and tackle stigma. For this reason, Wellbeing Plans based around 8 steps to Wellbeing have been developed and are being promoted across Walsall. Undertaking Wellbeing plans will help residents understand what they can do to enhance, maintain and/or improve their mental wellbeing.

Be Active

Learn Something New

Take Notice

Hydration and Nutrition

Connect

Sleep for Wellbeing

Give Something to others

Hope for the Future

Through taking this Walsall developed eight steps to wellbeing approach, we will:

- Maximise the opportunities to promote public mental wellbeing
- Encourage individuals and communities to develop their approach for improving mental wellbeing.
- Integrate mental wellbeing into all aspects of the work of our multiagency partnerships

Case Study

Funded by the NHS in partnership with Walsall Together, whg's team of Kindness Champions have been recruited to work alongside and support customers who are feeling alone or isolated.

'Tom' has a long-term mental health illness and which was impacted by Covid-19 and bereavement. Prior to lockdown he was working and had lots of contacts with others. Like many people, lockdown and the loss of a family member had a huge impact. His personal relationship had begun to suffer, he was not taking his medication and was using alcohol to cope. He felt unable to work and had been signed off by his GP. Tom felt isolated and lonely.

whg's Kindness Champions worked with Tom to increase his confidence and coping skills and encouraged him to focus on the positives in his life. Tom was referred to bereavement counselling which directly led to improvements in his personal relationships. Tom was encouraged to take part in activities on a local allotment which increased his contact with others and improved his mood generally. He has recently returned to work and re-established a number of his friendships.

With support from our Kindness Champions, Tom's mental health has improved, he feels less lonely and isolated and more hopeful for the future.

The correlation between employment, housing and mental wellbeing are undeniable. For this reason, prioritising economic and housing challenges is essential.

MWT2A Economic & Housing Challenges Universal	
Current Position	Local Challenges
• Walsall has several financial wellbeing and debt advice services including Walsall Citizen Advice Bureau, money home jobs team, whg benefits advice and wellbeing mobile unit • Financial advice is a priority of the Mental Health & Wellbeing Multi-Agency Team but there is not enough support available to meet the demand • Variable standards of housing are available in Walsall. Some good social housing, but poor standards within some private renting and HMO housing • Social housing evictions are decreasing	• People who have never struggled with finances falling into rent arrears and debt due to loss of employment • The resident's risk of unemployment has increased. People are increasingly struggling to pay the bills • Increasing reliance on one off discretionary payments and Government schemes • Increasing debt and higher numbers of people using food banks and loan sharks • Some groups are at an increased risk of homelessness e.g. single men and some ethnic minority groups. • An increasing number of households are reliant on benefits and council tax support including free school meals • People in employment on low income i.e., Zero-hour contracts are at an increased risk of poor mental wellbeing • Changes to financial circumstances because of bereavement is common • Increased risk of fuel poverty and the implication for household debt caused by the fuel crisis • Low availability of social rented homes for larger families'
For Walsall we want	
• People to be happy, to be able to live on their incomes and be able to build up saving to mitigate the risk of financial insecurity • More local community based accessible, employment, financial and benefits advice is available in community settings • Residents to recognise the value of and have access to quality green spaces, arts, leisure and culture • Multi-agency partners to have a clearer understanding of how the whole system-wide health and social-economic system functions together i.e., housing and Department of Work and Pension • All housing providers to work together to reduce homelessness, and provide more people with quality housing, that is also affordable to heat • The population to recognise and seek to access to enriching employment opportunities • More people to know how to access support to recover following the loss of employment	

Whilst all people have the potential to experience economic and housing challenges, providing targeted support to improve opportunities for those with the most risk of deprivation is essential.

MWT2 Economic & Housing Challenges targeted	
Current Position	Local Challenges
• A large number of housing associations and private rented stock are tenanted by diverse underserved communities • Some Black, Asian, and other minority families living in substandard housing • Some emerging communities and migrant families who are not working are housed within poor housing conditions • Some groups are at an increased risk of homelessness e.g. single men and some ethnic minority groups.	• Rogue landlords, HMO and overcrowded housing conditions are impacting people's mental health • Caregivers are at increased risk of stress due to financial / housing loss as a result of caregiving and/or bereavement • The proportion of carers providing over 20 hours of unpaid care is higher in Walsall, compared to the West Midlands and England • Some communities have high levels of crime and anti-social behaviour resulting in residents feeling unsafe • Barriers to training and employment exist for some disadvantaged young people, including those who are looked after, care leavers or who are in pupil referral units • some groups are disproportional affected by homelessness such as single men and those from people from ethnic minority groups
For Walsall we want	
• All people regardless of their background have equality of opportunity of access to decent quality housing and financial stability • Those caring for others have access to timely affordable appropriate support to enable them to cope with providing care to someone else	

We want Walsall employers to commit to actively protecting and improving the mental wellbeing of their workforce, enabled through the Workforce programme.

MWT3 Thrive Intervention Unemployment & Employment – Universal	
Current Position	Local Challenges
• Walsall has a multi-agency economic board where issues can be raised and addressed • A range of employment services and schemes are available to help people back into employment and training e.g., Walsall Works, Black Country Impact, Restart • BCHFT retention and employment support (Thrive into Work) • The pandemic has revealed the availability of a range of volunteers in Walsall, and businesses offering volunteers to address local challenges • The BCHFT Staff Hub is available to Health and Social Care staff, provide mental health support and signposting • Services are in place that liaise with education establishments towards mental wellbeing	• Lack of core industry following the historic collapse of industry • Local organisations and businesses struggle with how they can support the mental wellbeing of employees • People are exhausted, personally and professionally • Unemployment rates and zero-hour contracts lead to financial insecurity for many, increasing work-related stress and fear of losing work • Limited ability to attract local people to local jobs • High rental areas that are transient, harm the stability of communities • Lack of ability to access digital services and provision • High levels of low self-esteem and feelings of helplessness amongst those who are unemployed • Some people working from home struggle to achieve a work-life balance
For Walsall we want	
• Residents, employers and staff to have a shared understanding of what good mental wellbeing means • Employers to prioritise the mental wellbeing of their staff and invest in mental wellbeing interventions, in addition to occupational health • Residents and employees to have high ambition for themselves in employment and/or in business • To create opportunities for individuals to get involved in volunteering, hobbies and community activities, including arts, culture and accessing green spaces • Expand existing initiatives which target vacancies to local populations who are also supported into work for example e.g., Impact and whg work with the Health Trust • Employers and business networks agree to provide new local employment to local people e.g., Wolverhampton Trust has a policy that 60% of the workforce must be from the Black Country	

This strategy seeks to tackle inequalities by highlighting the need to improve the accessibility of appropriate employment opportunities.

MWT3B Thrive Intervention Unemployment & Employment targeted	
Current Position	Local Challenges
• Employment support and workplace health programmes are working hard to help people to remain at work • The pandemic has highlighted issues of social and racial inequalities and injustice in employment and unemployment • Education establishments are offering upskilling courses to enable people to access employment	• Underserved communities i.e., people with mental ill health, physical, learning and learning disability or ASD and Black, Asian, and other ethnic groups are disproportionally affected by long term unemployment, poor employment, and limited opportunities • Many young people do not know how to access training, education or career support • Highly qualified young people have reduced access to opportunities compared to pre-pandemic levels • High multi-generational unemployment rates in some wards result in low aspiration and poverty, impacting mental wellbeing • Older workers at risk of job loss and struggle with being re-employed • Carer's struggle to provide self-care, work and socialise whilst providing care
For Walsall we want	
• Opportunities of employment and success to be equitable across populations, and barriers to success are removed • Mature employees' skills and experiences to be valued, and fair recruitment applied across all ages • All partners to be aware of what employment support exists across Walsall and to be able to signpost to relevant support • To increase aspiration in Walsall and encourage residents to consider a range of career paths and opportunities • To improve emotional wellbeing support and advice in workplaces in general and in particular in traditionally male-dominated workforces • Key workers to access mental health and wellbeing support	

Case Study

In August 2020 whg launched '**Work 4 Health'**, in partnership with Walsall NHS Healthcare Trust to support the recruitment of multiple key worker job opportunities available at Walsall NHS Trust.

The programme empowers and supports customers to develop their confidence and work-related skills within the health and care sector to maximise their chances of success when applying for positions with Walsall NHS Trust.

whg customer said:

"The course was brilliant, I gained so much knowledge from it, everything was explained in the best detail possible and everyone on the course was treated the same. No one was treated differently based on circumstances. I jumped at the opportunity as I was determined to follow my dreams and focus on my career before I hit 30 years of age. I'm so glad I built the courage up to participate and achieve what I have today. My confidence has grown so much since starting the course. Thank you so so much".

The importance of social support, connections, and relationships for mental wellbeing should not be underestimated.

MWT4A Community Connections - Peer Social Support (Universal)	
Current Position	Local Challenges
• Walsall has a range of effective partnerships including Walsall Together Resilient Communities, Walsall Community Mental Health Partnership and Primary Care Network • Walsall has a range of community champions and social prescribers e.g., whg, Kindness Champions and community champions, and Making Connections Walsall Social Connectors, One for all Community Champions and PCN Social Prescribers • Walsall has a range of community interventions delivered by VCS organisations • One Walsall infrastructure organisation that provides support to community VCS organisations • There is a range of strong community organisations, projects and informal groups i.e., coffee mornings, befriending projects, walking groups. • Relationships between statutory bodies and the VCS are good and improved during the pandemic • People want to make a difference to others across the system	• Some disjointed provisions resulted in inefficiency across the system • Some VCS projects are stretched, and some local projects and charities have gone out of business resulting in reduced community support • Communication with statutory services has been reduced resulting in residents struggling to access support, resulting in increased stress • Some networks including social prescribers require a greater understanding of mental health and wellbeing • Some families have limited access to information technology resources resulting in them being less able to use online provision • There is limited recognition that volunteers need resourcing
For Walsall we want	
• All residents to feel safe and to have positive connections with other residents and positively contribute to the lives of others at home in communities and the workplace • To enable and empower residents to have a stronger voice and greater control over their communities • All residents have access to information technology and have the training to use it • Volunteers to be valued and for it to be recognised that volunteers require investment • There to be an availability of a range of meaningful activities, hobbies and volunteering • Multi-Disciplinary Teams to be knowledgeable about what is available and to be confident to signpost people for mental wellbeing support • Training for social prescribers so they are knowledgeable and competent in delivering mental wellbeing support and signposting	

Case Study

MAKING CONNECTIONS WALSALL

This gentleman lost his wife and found himself socially isolated and in need of some support. He lives alone and has muscular skeletal problems. He is very self-reliant and does his own housework and shopping. He says he misses his wife very much.

"I now have people to chat with…I have made new friends and I take part in activities alongside others. I certainly feel less lonely as it gives purpose to my life. It has helped me to get out and about, make friends and given me opportunities that I wouldn't have found out about without Making Connections."

Male MCW client

Social connections and networks are experienced differently across the population. The intervention, therefore, needs to be proportionately targeted to meet diverse population needs.

MWT4B Community Connections - Peer Social Support – Targeted	
Current Position	Local Challenges
Walsall has • A range of VCS groups and organisations working with diverse communities across Walsall • A Community Inclusion Team • Black Country Mental Health Trust Community Development Workers working with under-represented groups to reduce health inequalities • Faith organisations which act as a community hub for many diverse communities • Housing Associations which invest in a range of interventions to engage and support people in different communities	• There are not enough culturally appropriate services available to meet the diverse mental wellbeing needs of the Walsall population e.g., ASD, people with hearing or sight loss, Black, Asian and other minority groups, speakers of other languages and people identifying as LGBTQ, gender neutral or non-binary. • There is a lack of awareness of services available for men in Walsall • Carers have struggled in the pandemic due to service closures and have become more isolated • Some vulnerable people are trapped indoors - fearful to leave their homes, including elders, across different communities • Community cohesion challenges increased during the pandemic • Some groups are excluded from the use of information technology e.g., the elderly and those who are deprived
For Walsall we want	
• To have enough services that meet the diverse mental wellbeing needs of the Walsall population • Greater awareness of what exists for diverse communities is to be achieved • Elders from diverse communities to engage in community activities • Community development initiatives that foster strong community cohesion, to provide local solutions to local issues and strengthen neighbourhoods • Vulnerable people to feel safe to go back into the community including places of worship	

Level 3 - Early intervention

Early intervention is crucial to preventing the escalation of mental wellbeing need. Whilst it is not always possible to prevent mental health illness, it is possible to identify early interventions which prevent the deterioration of mental wellbeing.

MWT5A- Counselling Bereavement and Therapy Support- Universal	
Current Position	Local Challenges
Walsall has fewer voluntary sector counselling and bereavement services compared to other areas. The current provision includes: • A well-established Improving Access to Psychological Therapies programme • WPH Counselling and Education Services for young people • Walsall Bereavement Support Service (WBSS)	• Pathways to bereavement and therapy support are not seamless • There is limited gold-plated bereavement support, which is unable to meet population needs. • WBSS is without secure or mainstream funding • Investment is tied up in crisis services which reduce the ability to invest in timely prevention and early intervention from the VCS • Investment in the VCS is short-term which impacts negatively on service stability • There are long waiting times for therapy provision • Families are struggling to come to terms with bereavements due to preventable deaths – e.g., COVID-19 and/or multiple loss
For Walsall we want	
• Therapy services that meet a wider population need, are easy to access and have reduced waiting times • People to be aware of how to access counselling and therapy services and recognise counselling as the natural first option for support after self-care • Clearer more joined-up financially sustained counselling therapy and bereavement support services on clear pathways	

Diverse population groups have access to therapy and experience intervention at different rates. Targeted intervention is essential to meet population needs.

MWT5B- Counselling Bereavement and Therapy Support - Targeted	
Current Position	Local Challenges
• Support services available for patients of the Mental Health Trust • Limited counselling services available for Black, Asian, and other diverse communities • Many of those working in at-risk industries are from diverse ethnic populations and are often dealing with their grief alone • We do not understand how many people would benefit from cultural appropriate support • High level of death among the Black and Asian elderly due to COVID-19 resulted in increased fear to engage in communities	• Low uptake of bereavement support by men and people from diverse communities • Access to cultural appropriate provision is unequal and there is limited understanding of the support available • Experiences of trauma, recently arrived migrants and victims of crime have no trauma-focused support available • The impact of migration on individuals and separated families is not well understood • The stigma of talking about mental health in communities impacts engagement • Many communities have not been able to grieve in the traditional sense
For Walsall we want	
• Men to have access to therapy support that engages and works for them • People to recognise the benefit of therapy for older people • To co-develop and commission a range of provision which meets the diverse needs of all Walsall residents	

MWT behavioural activities i.e. risk-taking behaviour, move more, nutrition hydration

The inextricable link between mental wellbeing and physical health is generally not well understood[1]. Achieving parity of esteem between physical and mental health is essential to improving mental health and wellbeing. The impact unhealthy lifestyles/behaviours (e.g., smoking, inactivity/sedentary, poor nutrition etc.) have on mental wellbeing are well evidenced.

By improving physical health, we will also improve the mental wellbeing of Walsall's residents. Healthy lifestyle-related strategies will help to achieve this. For example, a physical activity framework is being developed which will provide an overarching umbrella to bring together relevant national, regional and local policy, practice and partners around healthy lifestyles.

Making it Happen – Leadership, Partnership & Resources

As a partnership, we commit to:

- Working in partnership across agencies, to implement integrated approaches to mental wellbeing promotion, support and care
- Developing a Mental Wellbeing Prevention Concordat to facilitate local action around improving good mental wellbeing, which partner organisations sign up to
- Continue to co-ordinate activity to improve mental wellbeing outcomes through multi-agency partnerships
- Building on the No Wrong Door Network, which partners sign up to
- Implementing Mental Wellbeing Impact Assessments, a tool to be used across the system when undertaking any major plan, project or proposal
- Partner organisations sign up to facilitate residents' completion of personal wellbeing plans

Resources

Allocating resources proportionately, with a focus on the social determinants, is key to delivering improvements.

This strategy is written during a period of major challenge as a result of the COVID-19 pandemic, in a time of significant financial concerns. A multi-agency approach to financial planning is required to achieve improvements in mental wellbeing. We need to:

Achieve system leadership for mental wellbeing

- Provide a key leadership role post-COVID-19 in plans to Build Back Fairer Communities
- Continue to support Walsall's integrated health and care system to be a true population health system, by working in partnership across the Black Country
- Develop health equity targets for Walsall, with clear lines of accountability to reflect priorities for reducing health inequalities

Prioritise inequalities in mental wellbeing

- Increase mental wellbeing provision in workplaces
- Expand programmes that focus on mental health prevention, and strengthen monitor, and evaluation for equity
- Work with planners to develop mentally healthy high streets and access to good quality green space
- Improve community safety by reducing anti-social behaviour

Giving prevention interventions time to succeed

- Strengthen focus on the fundamentals of mental wellbeing
- Implement long term multi-agency investment into interventions over 5 and 10 years, and improve and share best practice between local authorities across the Black Country
- Identifying and embedding learning from the COVID-19 pandemic, including the value of place-based services and other 'bottom-up' approaches

Risks

Aligning this strategy with the economic, social and mental health system circumstances is a challenge that has increased as a result of the pandemic. Nevertheless, addressing these challenges is essential and the success of this strategy is reliant on multiagency strategic prioritisation.

How we will monitor, evaluate and review strategy impact

An action plan will be developed to support this strategy. This strategy will feed into the Health and Wellbeing Board through the Community Mental Health and Wellbeing Partnership. It will be evaluated by:

- Developing and agreeing, key indicators for mental wellbeing between multi-agency partners
- Inviting feedback from the general populations, community groups and professional stakeholders, including evaluating the satisfaction of those accessing the service provision
- Working with stakeholders to capture the impact of their delivery and monitoring the impact of interventions
- Measuring and monitoring help-seeking behaviours

Outcome Measures

An overarching evaluation and monitoring framework will be developed as part of this strategy. This will include indicators relating to wider determinants, vulnerable groups, service activity and outcomes.

Awareness-raising

- Knowledge of how and where to access prevention and early intervention support
- Access to mental health and wellbeing training
- Increase self-rated population wellbeing scores
- Adults undertaking wellbeing plans to improve healthy lifestyles

Reducing stigma

- Willingness to talk about mental health and wellbeing
- Confidence to access support for mental wellbeing needs

Wider determinants

- Increase use of green spaces for physical activity (green spaces strategy)
- Literacy, education, training and skills enable people to contribute to their community and our economy (Regeneration, Housing and Economy)
- Access to financial/debt/housing advice support

Community connections

- Increase social connections and community networks (Resilient Communities)

Vulnerable groups

- Increase carers' ratings of their wellbeing
- Reduce inequalities in accessing support
- Access to bereavement and counselling support across communities

Definitions

Barriers to access: not knowing about the services available, physical accessibility, the way an individual perceives or experiences a service, financial barrier to access the service distance of service, cultural and language barriers

BCHFT: Black Country Health Care Foundation Trust

Black and minority ethnic groups (BME): refers to members of non-white communities in the UK

Carers: a family member or paid helper who regularly looks after a child or a sick, elderly, or disabled person that need long-term support

Culturally appropriate: responsive to people's cultural identity, heritage, beliefs or conventions. It covers a range of things, for example, ethnicity, nationality or religion, sexuality or gender identity, language

Digital access: the ability to fully participate in a digital society, which includes access to tools and technologies, such as the Internet and computers that allow for full participation

Financial stress is emotional tension that is specifically related to money. Anyone can experience financial stress, but financial stress may occur more often in households with low incomes i.e. not having enough money to pay the bills, and buy groceries

Fuel poverty: In general, fuel poverty relates to households that must spend a high proportion of their household income to keep their home at a reasonable temperature

LGBT/LGB&T/ LGBTQ: lesbian, gay, bisexual and transgender are some of the terms used to describe sexual and gender identity

Mental ill-health: Mental illness, also called mental health disorders, refers to a wide range of mental health conditions/disorders that affect your mood, thinking and behaviour

Mental Health Stigma: stereotyping and labels someone as tainted or less desirable due to having a mental illness, resulting in barriers to accessing support for fear of being labelled

Mental wellbeing: Mental wellbeing refers to a person's emotional state at any given time. Mental Wellbeing is the bedrock from which other things flow. It is the positive end of a spectrum of mental health and describes both feeling good and functioning well

Mental Wellbeing Prevention Concordat: The Prevention Concordat for Better Mental Health is intended to provide focused cross-sector action to deliver a tangible increase in the adoption of public mental health approaches across the borough

Self-care: is "the ability of individuals, families and communities to promote health, prevent disease, maintain health, and to cope with illness and disability with or without the support of a healthcare provider"

Social capital: the networks of relationships among people who live and work in a particular society, enabling that society to function effectively

Social networks: a network of social interactions and personal relationships

Social prescribers/connectors: people who connect residents to community groups and statutory services for practical and emotional support.

Stakeholders: professional partners and residents both have an interest in outcomes

Underserved populations: populations who face barriers in accessing and using services for a range of reasons including geographic location, religion, sexual orientation, gender identity, underserved race and ethnicity

WHG: Walsall Housing Group

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Contributors include:

The Walsall Health and Wellbeing Board Members

The Multiagency partnership groups noted within the strategy

Individual contributions from colleagues in the following organisations and departments:

- 118 Pharmacy
- Ablewell Advice Walsall
- Black Country Healthcare - Mental Health and Wellbeing Hub, Liaison and Diversion and Criminal Justice Services, Primary Care Mental Health, mental health inpatients, Commissioning
- Black Country Innovate CIC
- Bloxwich Community Partnership
- Walsall Council - Regeneration, Housing and Economy
- Kaleidoscope plus group
- Lloyds Pharmacy
- Modality GP Practice
- Moxley Medical Centre
- New Invetions Health Centre
- One Walsall
- Rethink Mental Illness
- Saddlers Health Centre
- The Big Happiness Experiment CIC
- The MindKind Projects CIC
- Voluntary with Walsall Friends of the Earth
- Walsall Bereavement Support Service
- Walsall Black Sisters Collective
- Walsall Carers
- Walsall College
- Walsall Council - Children services, Corporate Consultation & Equalities, Environmental Health, Healthy Space Team, Public Health, Adult Social Care; Commissioning and Delivery (mental health, older people, disabilities)
- Walsall Health Care Trust
- Walsall Housing Group
- Walsall Manor Hospital
- West Midlands Fire Service
- West Midlands Police
- WPH Counselling

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Walsall Multi-Agency Mental Wellbeing Strategy

Data and Briefing Document

Summary

Mental wellbeing is affected by many factors. Our physical health, housing, work, environment, social contacts and finances all contribute to our mental wellbeing.

Our 2020 survey of our residents found that the majority of people in Walsall felt a "medium" level of wellbeing. However, of those that reported low levels of mental wellbeing, poor health, unemployment and financial stress were the most common reasons.

Rates of deprivation and unemployment are significantly higher in Walsall than the national average, and have been exacerbated by the COVID-19 pandemic, with our younger people being particularly affected.

Social contact, a feeling of connectedness with one's family and friends, community and broader society are fundamental to good wellbeing. Both care service users and carers in Walsall reported feelings of social isolation and not having as much social contact as they would like. These groups are likely to have been highly affected by the COVID-19 pandemic.

In addition to these groups, many children and young people are also likely to have experienced loneliness during the lockdown and school closures. In particular, they are likely to have been affected by lack of physical contact with their friends, families and peers, and the boredom and frustration associated with a loss of all the activities they have been used to taking part in.

The COVID-19 pandemic has left many of our residents bereaved and distressed. There will very likely be a increased demand for counselling and bereavement services, that are already stretched. However, bereavement support for our residents will be very important in improving population level mental wellbeing in Walsall.

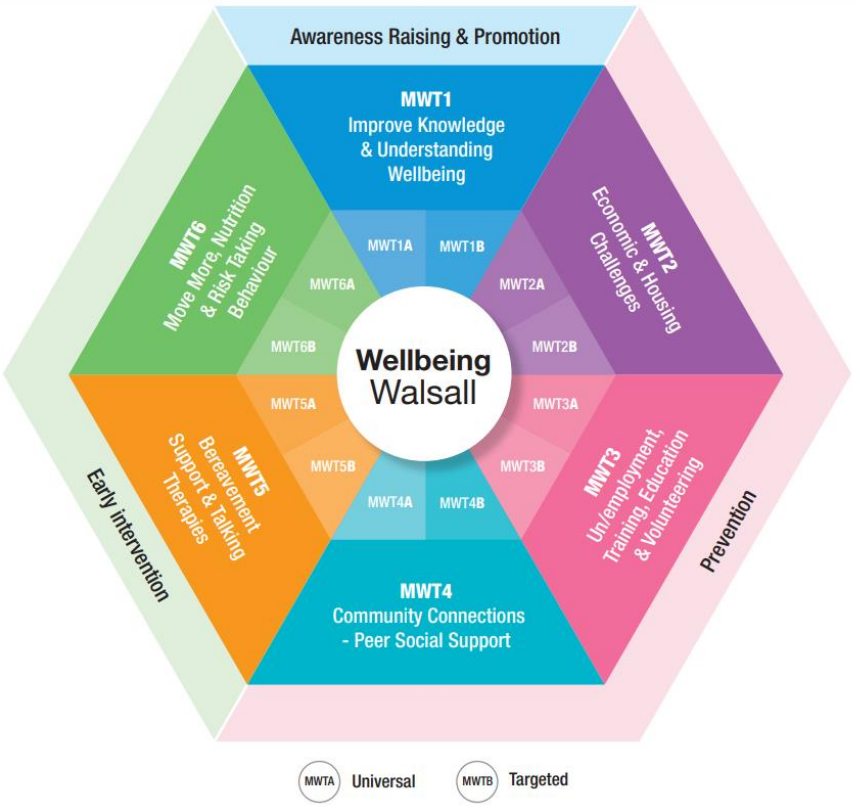
Lifestyle factors, such as physical activity, smoking, drug and alcohol misuse, and obesity strongly impact an individual's quality of life both physically and mentally. Work that strives to improve these factors will have a strong protective effect on the mental wellbeing of Walsall residents.

The rate of mental illness in Walsall is worse than the national average. Without the focussed efforts set out in this strategy to improve the mental wellbeing of the Walsall population and early intervention to prevent the deterioration of mental health, this rate is projected to continue to increase.

Purpose

The purpose of this document is to provide data, information and context to the 6 domains of the Walsall Multi-Agency Mental Wellbeing Strategy which are illustrated in Figure 1 below.

Figure 1. Domains of the Walsall Multi-Agency Mental Wellbeing Strategy



Overview of Mental Health and Wellbeing in Walsall.

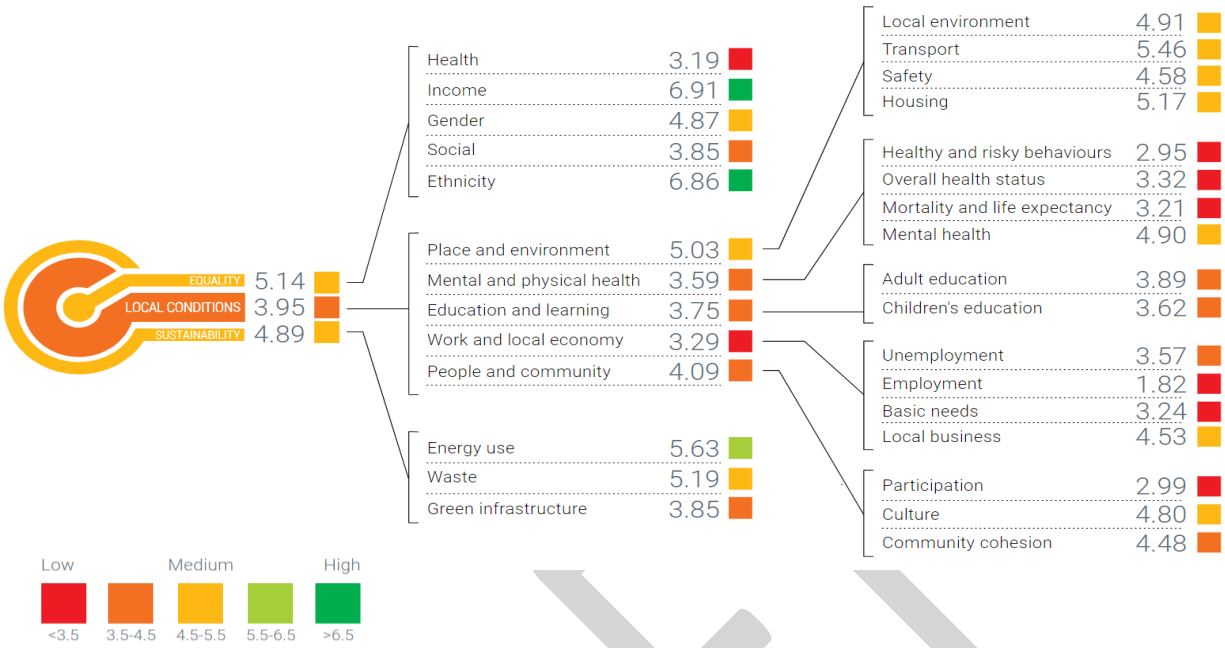
Attainment of Wellbeing

There are many factors that contribute to good health and wellbeing, both physical and mental.

The Thriving Places Index (TPI) identifies the local conditions required for good mental wellbeing and measures whether those conditions are being delivered fairly and sustainably.

Walsall's scores in the TPI are shown in the figure below:

Figure 2 The Thriving Places Index of Walsall.



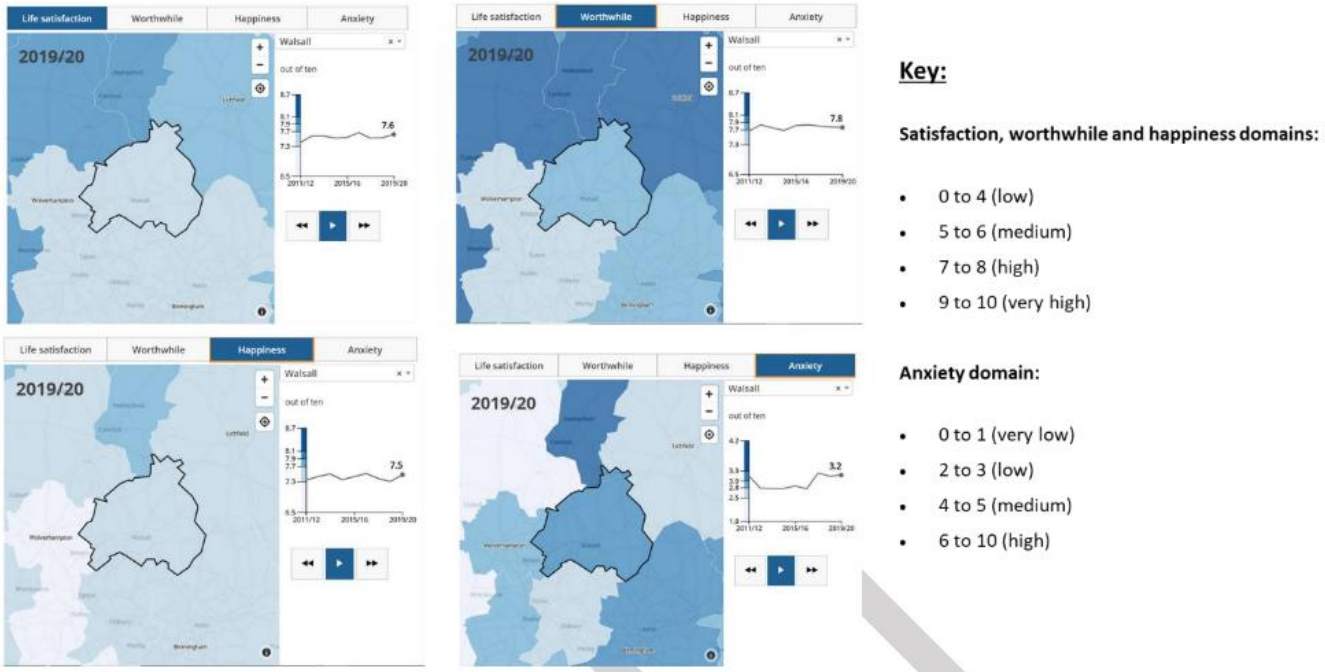
The TPI suggests that in Walsall, there are a number of fundamental factors that support good mental wellbeing that we could improve on including; obesity, diet, exercise, and risky sexual behaviours.

Also, the TPI suggests that improving the local environment and transport networks and employment would increase mental wellbeing in our residents.

Life satisfaction

In 2019/20, **on average**, people in Walsall reported “high” levels of life satisfaction, feeling that life is worthwhile and happiness, and low levels of anxiety although this had increased over the course of the COVID-19 pandemic.

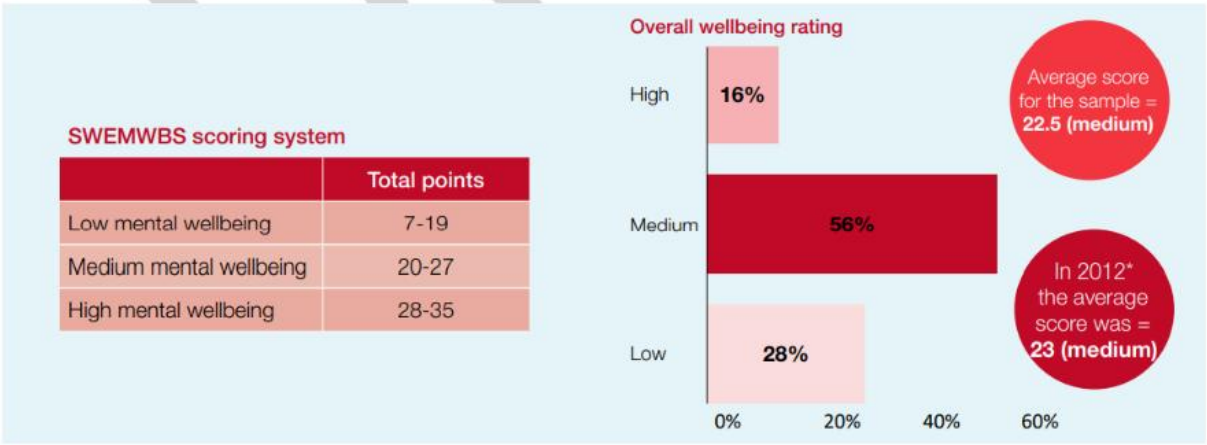
Figure 3. Personal Wellbeing Scores in Walsall.



The maps above indicate the estimated annual score of self-reported life satisfaction, feeling that the things done in life are worthwhile, happiness and anxiety in Walsall residents. It should be noted that these data cover the period in the build up to the national lockdown of the UK in response to the coronavirus (COVID-19) pandemic.

Figure 4. Self-reported wellbeing of Walsall Residents.

The health and wellbeing survey of Walsall residents conducted in late 2020[1] revealed that the majority of our residents experienced a "medium" level of overall wellbeing, which is similar to the findings of the 2012 survey.



[1] Findings from the Walsall Council Residents Survey November 2020

The graphic above summarises the key finding of the Walsall residents survey conducted at the end of last year. Overall, the majority (56%) of residents, reported a “medium” level of wellbeing, with a score that has not notably changed since the previous survey that was conducted in 2012.

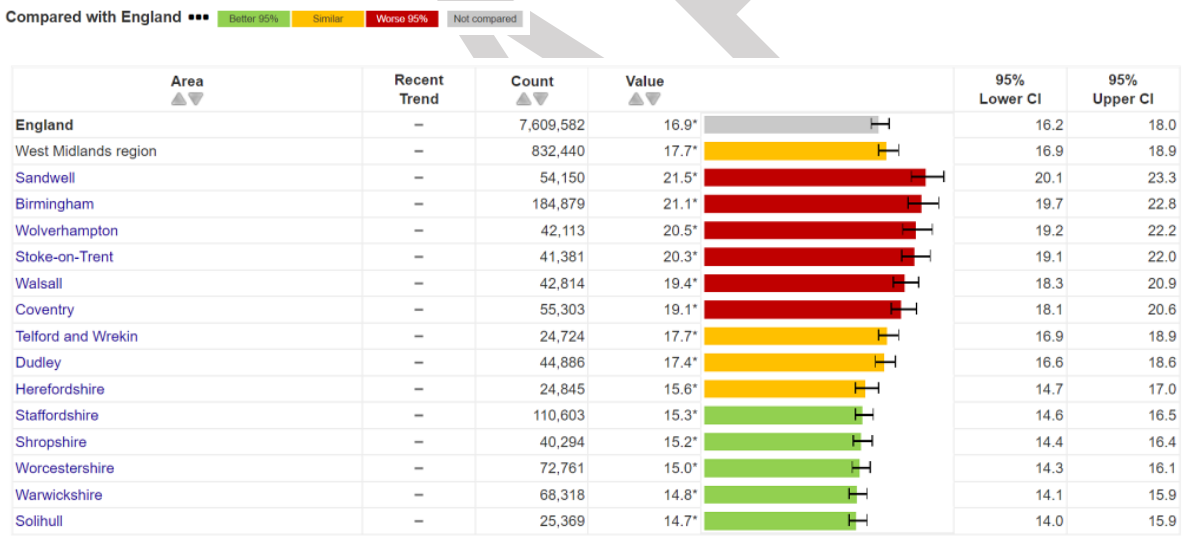
However, of the residents that did report a low level of wellbeing, poor general health, unemployment and financial stress were cited as the most prominent reasons.

Of note, in the survey, younger people, males, and those furloughed during the pandemic also reported significantly lower wellbeing than the average population of Walsall.

Mental health disorders

The key ambitions of the Walsall Multi-Agency Mental Wellbeing Strategy are the overall improvement of mental health and wellbeing in our resident population, and the early intervention in instances of poor mental wellbeing, in order to prevent deterioration in to more severe mental ill-health.

Figure 5. Estimated prevalence of common mental health disorders (% of population aged 16+).



Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	7,609,582	16.9*	16.2	18.0
West Midlands region	–	832,440	17.7*	16.9	18.9
Sandwell	–	54,150	21.5*	20.1	23.3
Birmingham	–	184,879	21.1*	19.7	22.8
Wolverhampton	–	42,113	20.5*	19.2	22.2
Stoke-on-Trent	–	41,381	20.3*	19.1	22.0
Walsall	–	42,814	19.4*	18.3	20.9
Coventry	–	55,303	19.1*	18.1	20.6
Telford and Wrekin	–	24,724	17.7*	16.9	18.9
Dudley	–	44,886	17.4*	16.6	18.6
Herefordshire	–	24,845	15.6*	14.7	17.0
Staffordshire	–	110,603	15.3*	14.6	16.5
Shropshire	–	40,294	15.2*	14.4	16.4
Worcestershire	–	72,761	15.0*	14.3	16.1
Warwickshire	–	68,318	14.8*	14.1	15.9
Solihull	–	25,369	14.7*	14.0	15.9

The chart above shows the estimated proportion of the population aged 16 years and over who have a common mental disorder (CMD), where CMD is defined as any type of depression or anxiety.

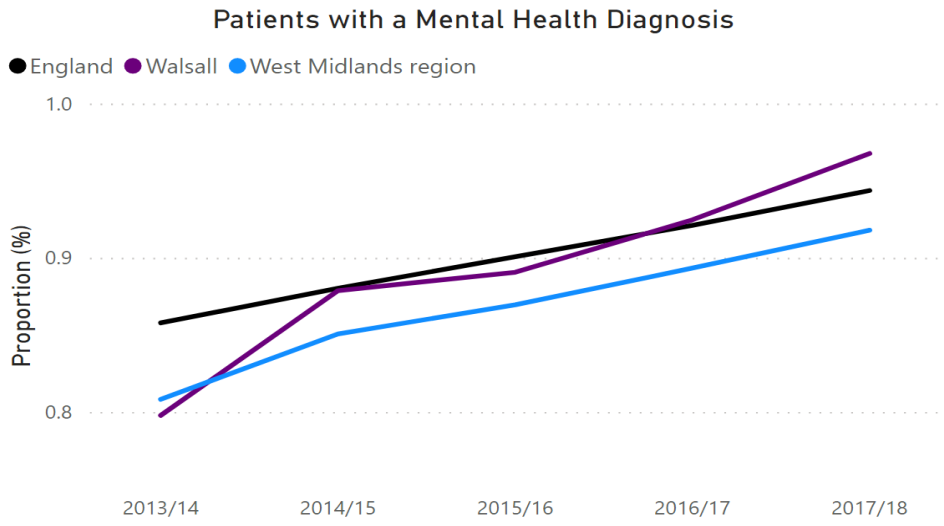
In Walsall the prevalence of CMD is significantly higher than the national average, with 19.4% of residents experiencing anxiety or depression.

Figure 6. Estimated prevalence of Common Mental Health Disorders (% of population aged 65+).

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	1,027,792	10.2*	9.1	11.9
West Midlands region	–	114,900	10.7*	9.5	12.4
Sandwell	–	6,577	13.4*	11.2	16.6
Birmingham	–	18,687	12.7*	10.9	15.5
Stoke-on-Trent	–	5,426	12.6*	10.7	15.3
Wolverhampton	–	5,402	12.5*	10.7	15.1
Walsall	–	5,843	11.7*	10.2	14.0
Coventry	–	5,686	11.4*	10.1	13.4
Telford and Wrekin	–	3,233	10.9*	9.7	12.7
Dudley	–	6,877	10.6*	9.5	12.4
Herefordshire	–	4,594	10.0*	8.6	12.1
Shropshire	–	7,495	9.9*	8.6	11.5
Staffordshire	–	17,891	9.6*	8.6	11.2
Worcestershire	–	12,302	9.4*	8.4	11.0
Warwickshire	–	10,760	9.2*	8.2	10.8
Solihull	–	4,127	9.2*	8.1	10.8

In older adults, the prevalence of CMD is estimated at about 11.7%, which is similar to the national average. This suggests that anxiety and depression is experienced more in younger residents of Walsall than our older residents.

Figure 7. The proportion of the population who have a mental health diagnosis.



There is an increasing trend in the proportion of Walsall residents that have a mental health diagnosis of schizophrenia, bipolar affective disorder and other psychoses recorded on GP practice disease registers. The prevalence of mental health disorders in Walsall is higher than the West Midlands region, and the national average.

Figure 8. Projected prevalence of a variety of mental health disorders in Walsall by 2035.

Mental health by gender	2019	2020	2025	2030	2035
Males aged 18-64 predicted to have a common mental disorder	12,039	12,098	12,304	12,495	12,598
Males aged 18-64 predicted to have a borderline personality disorder	1,556	1,564	1,590	1,615	1,628
Males aged 18-64 predicted to have an antisocial personality disorder	4,013	4,033	4,101	4,165	4,199
Males aged 18-64 predicted to have psychotic disorder	573	576	586	595	600
Males aged 18-64 predicted to have two or more psychiatric disorders	5,651	5,679	5,775	5,865	5,913
Females aged 18-64 predicted to have a common mental disorder	19,242	19,335	19,658	19,866	20,097
Females aged 18-64 predicted to have a borderline personality disorder	2,416	2,427	2,468	2,494	2,523
Females aged 18-64 predicted to have an antisocial personality disorder	1,499	1,507	1,532	1,548	1,566
Females aged 18-64 predicted to have psychotic disorder	583	586	596	602	609
Females aged 18-64 predicted to have two or more psychiatric disorders	6,248	6,278	6,383	6,450	6,525

On the current trajectory, without intervention, the prevalence of mental health problems across a wide range of morbidities, from anxiety to antisocial behavior disorder, to psychotic disorders is projected to continue to increase over the next 10 years without focused intervention. Common mental health disorders, antisocial personality disorders, and psychotic disorders are all predicted to each increase by 4-5% in Walsall by la2035[2].

Common mental health disorders (CMD), such as anxiety and depression are increasingly more prevalent in Walsall than nationally. Nationally, 1 in 6 adults that have experienced CMD in the past week[11]. This increasing trend is especially true in the younger population as around 1 in 8 children aged 5 to 19 years are estimated to have at least one mental health problem[11]. Moreover, this increasing trend and significantly higher rate is also reflected in more acute mental health diagnoses, such as schizophrenia and bi-polar disorder.

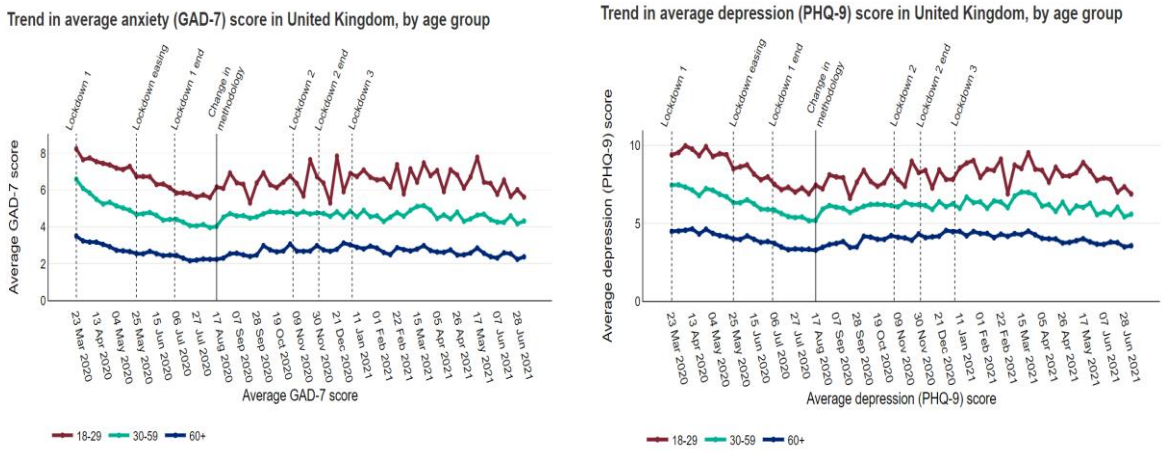
People identifying as Black are more likely than average to have experienced a CMD in the last week, with non-British people identifying as White people being less likely[12].

CMD also contribute to the reasons that individuals can be involuntarily excluded from the labour market, and the proportion of people excluded from employment for these reasons is higher in Walsall than the national average and increasing further.

Middle aged men have the highest rates of suicide and young women have the highest rates of being admitted into hospital because of self-harm.

[2] Projecting Adult Needs and Service information https://www.pansi.org.uk/ 2021

Figure 9 Trends in Anxiety and Depression by age groups



Younger people (aged 18-29) have reported significantly higher levels of anxiety and depression over the duration of the COVID-19 pandemic than older age groups. Sequentially, 30-59 year olds reported higher anxiety and depression levels than 60+ year olds.

People from Black, Asian and other minority ethnic communities have an increased risk of mental health stigma and late mental health diagnosis[9]. Cultural norms and specific religious beliefs amongst diverse groups was also a contributory factor of stigma amongst Black African Caribbean and Asian groups. Amongst these groups feeling of shame of mental health contribute to people suppressing discussions around mental wellbeing.

People who identify as LGBT+ have higher rates of common mental health problems and lower wellbeing than heterosexual people[3]. The National LGBT Survey in 2018[4] found that 24% of respondents had accessed mental health services in the last year, but a further 8% had tried to get help and failed.

Discrimination

Around 90% of people with mental health problems have reported that they have also experienced discrimination in various aspects of their lives, which in turn impact negatively and can exacerbate existing problems.

People with mental health problems are among the least likely groups with a long-term health condition or disability to be employed, have stable relationships, live in quality housing and be socially included.

Stigma and discrimination can also prevent or delay people with mental health problems from accessing early interventions and mental health services. In addition,

[3] Semlyen, J., King, M., Varney, J. *et al.* Sexual orientation and symptoms of common mental disorder or low wellbeing: combined meta-analysis of 12 UK population health surveys. *BMC Psychiatry* **16,** 67 2016.

[4] National LGBT Survey 2018: Research report - GOV.UK (www.gov.uk)

mental health services might not meet the needs of Black and minority ethnic individuals.

There is a 63% gap in the employment rate between people who are in contact with secondary mental health services and the overall employment rate.

MWT1 - Improve Knowledge and Understanding of Wellbeing

What we know

We know that the prevention of **poor** mental wellbeing is the best policy, both morally and economically[5]. To improve mental health and wellbeing across the borough of Walsall, this strategy places an emphasis on the awareness raising and prevention agenda.

Strategy Brief

We know that by improving Walsall residents' knowledge and understanding of mental wellbeing, and improving access to timely and appropriate support, our residents will be better equipped to make effective decisions about their health. For this reason, this strategy takes an assets-based community approach to develop mental wellbeing resilience in communities, which will include the promotion of wellbeing.

This strategy takes a comprehensive approach to tackle the stigmas associated with mental ill health. In doing so, it will identify and raise the awareness of contributor ***risk factors to developing mental health problems,*** with a view to addressing the risk factors together as a partnership.

Mental health stigma remains a huge barrier to recognising and addressing mental ill-health for the public and for those dealing with mental health conditions and symptoms.

By promoting good mental health and intervening early, particularly in the crucial childhood and teenage years, we can help to prevent mental illness from developing and mitigate its effects when it does.

Children from the poorest 20% of households are four times as likely to have serious mental health difficulties by the age of 11 as those from the wealthiest 20%[6]. The challenges experienced by children and young people in Walsall, in terms of their mental wellbeing are addressed specifically in the Walsall Children and Young People's Strategy, which aligns closely with this strategy.

Economic and Housing Challenges

[5] McDaid *et al.* The Economic Case for the Prevention of Mental Illness, Annual Review of Public Health, 2019.
[6] Gutman, Leslie & Joshi, Heather & Parsonage, Michael & Schoon, Ingrid. (2015). Children of the new century: mental health findings from the Millennium Cohort Study.

Whilst all people can experience financial challenges, economic and housing challenges are not equally spread across diverse populations. Targeted support is therefore essential to improve opportunities for those with the least opportunities

Walsall has a range of employers and small medium and large businesses. It is our vision that Walsall employers are actively working towards protecting and improving the mental health and wellbeing needs of their workforce. To achieve this, we will raise awareness of the mental health and wellbeing needs of their workforce and promote good practice for organisations.

It is well recognised the job insecurity low income and benefits increase the risk of mental wellbeing decline. We also know that people in employment who develop mental health needs are at a significant risk of becoming unemployed. As such we want to ensure that employers are enabled through the Workforce programme to support, protect, and improve the wellbeing of their workforce.

This strategy seeks to tackle inequalities by highlighting the need to improve the accessibility of appropriate employment opportunities.

Figure 10. Walsall's Score and Rank across the domains of the Index of Multiple Deprivation.

	England Rank (out of 317)*		
Domain	Average LSOA Score	% of LSOAs in the most deprived 10%	% of population experiencing deprivation
Index of Multiple Deprivation (IMD)	**25**	**22 (26%)**	-
Income deprivation	16	11 (32%)	20.0%
- affecting children (IDACI)	17	15 (29%)	26.1%
- affecting older people (IDAOPI)	35	24 (24%)	21.2%
Employment deprivation	38	44 (20%)	14.3%
Education, skills and training deprivation	11	17 (28%)	-
Health deprivation and disability	53	65 (14%)	-
Crime	93	113 (6%)	-
Barriers to housing & services	234	250* (0%)	-
Living environment deprivation	68	146 (5%)	-

** All local authorities with no LSOAs in the most deprived 10% share a rank of 250*

Walsall performs very poorly on income deprivation, ranking 16th for average LSOA score and 11th based on the proportion of highly deprived neighbourhoods in the borough. Employment deprivation is also an issue, with an average score rank of 38. However, the borough performs the worst on the education, skills and training deprivation domain, with an average score that ranks it as the 11th most deprived local authority in England.

However, the borough's relative performance on these domains is similar to 2015, worsening only slightly for income and education, but showing some relative

improvement for employment. Scores in the income and employment deprivation domains are based on the actual proportion of residents experiencing that aspect of deprivation.

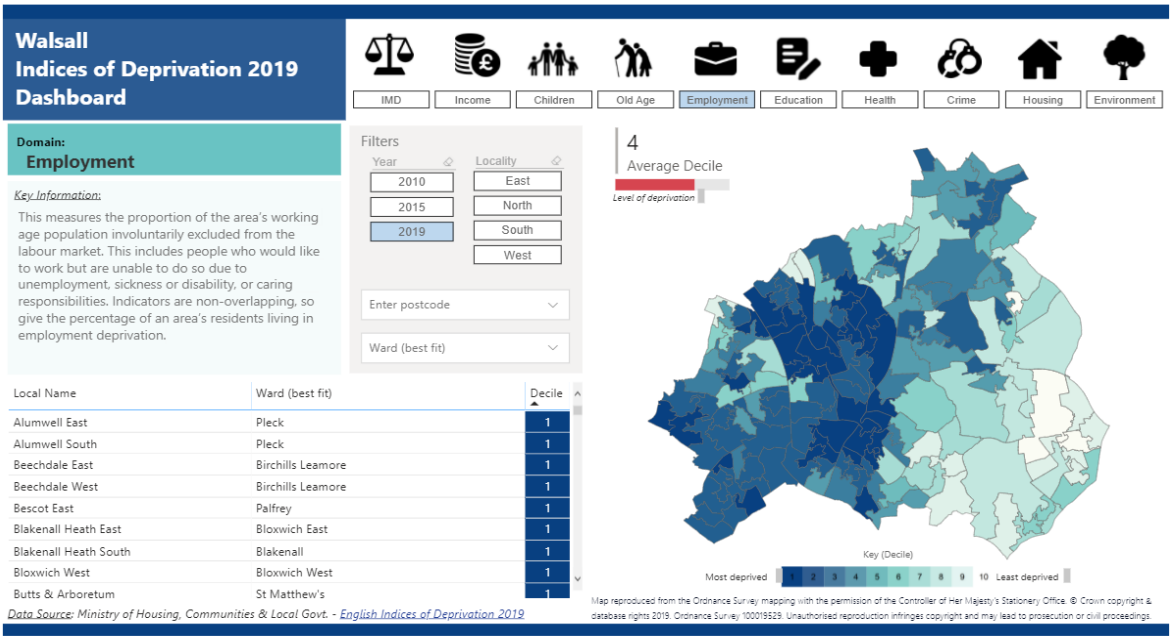
Around half of Walsall residents live in the most deprived 20% of neighbourhoods in England. Healthy life expectancy, the number of years a person can expect to live in good health, is strongly associated with deprivation and is significantly lower in Walsall, than the national average in both males and females. On average a male in Walsall can expect to live 57.9 years in good health, and females for 58.7 years. This is more than 5 fewer years than the national average. There are however stark differences across the Borough ranging from the lowest in **Blakenall** at 54.1 years) and highest in **Streetly** at 70.6 years.

Notwithstanding the increased prevalence of depression and anxiety in more deprived communities, people from these communities are less likely to access services and complete treatment. Of people from the most deprived 10% of areas that were referred to talking therapies, only 35% recovered, compared to 55% of people from the least deprived areas.

Sex and ethnicity also impacts on recovery rates. Recovery rates were higher amongst white ethnicities compared to all other ethnicities. Nationally, white females had the highest recovery rate (50.5%), while the rate was for Asian or Asian British Pakistani males (33.5%). The overall national recovery rate was 46.3%.

Unemployment is consistently related to higher rates of depression and anxiety and suicide. The Employment Deprivation Domain measures the proportion of the working-age population in an area involuntarily excluded from the labour market. This includes people who would like to work but are unable to do so due to unemployment, sickness or disability, or caring responsibilities.

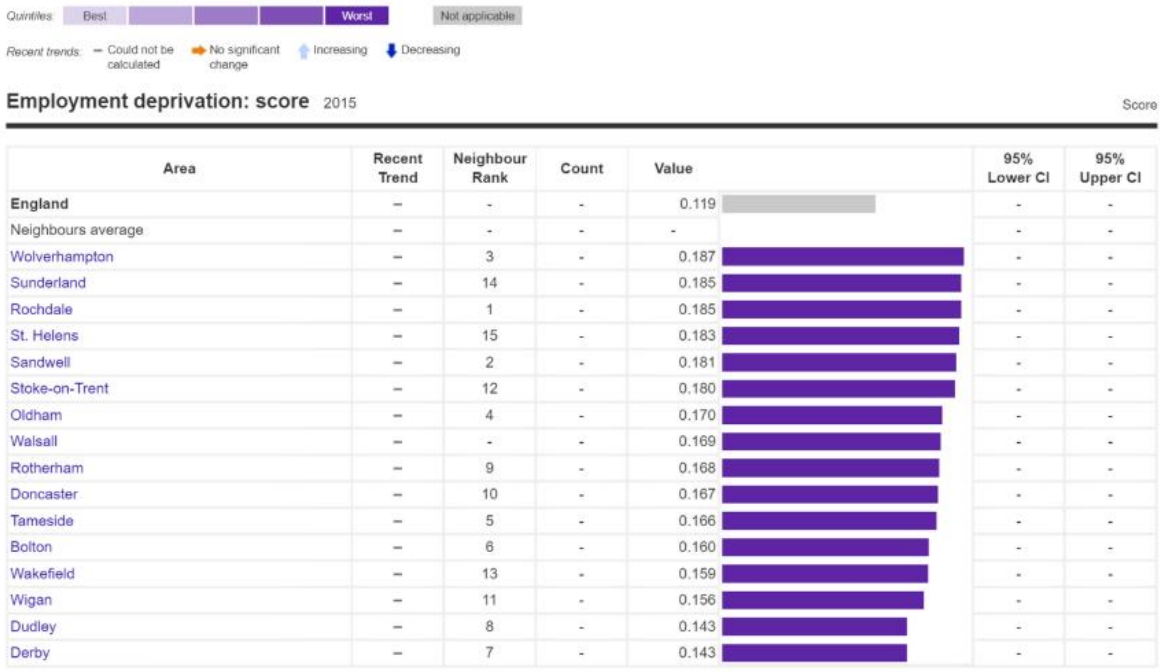
Figure 11 Employment deprivation in Walsall



On average, Walsall falls within the 4th most deprived decile with regard to employment, as measured in the Indices of Multiple Deprivation. However, many

LSOA's in the borough fall within the most deprived decile nationally, in terms of the lack of attainment and skills in the local working age population involuntarily excluded from the labour market.

Figure 12 Comparison of Employment Deprivation to Walsall's statistical neighbours



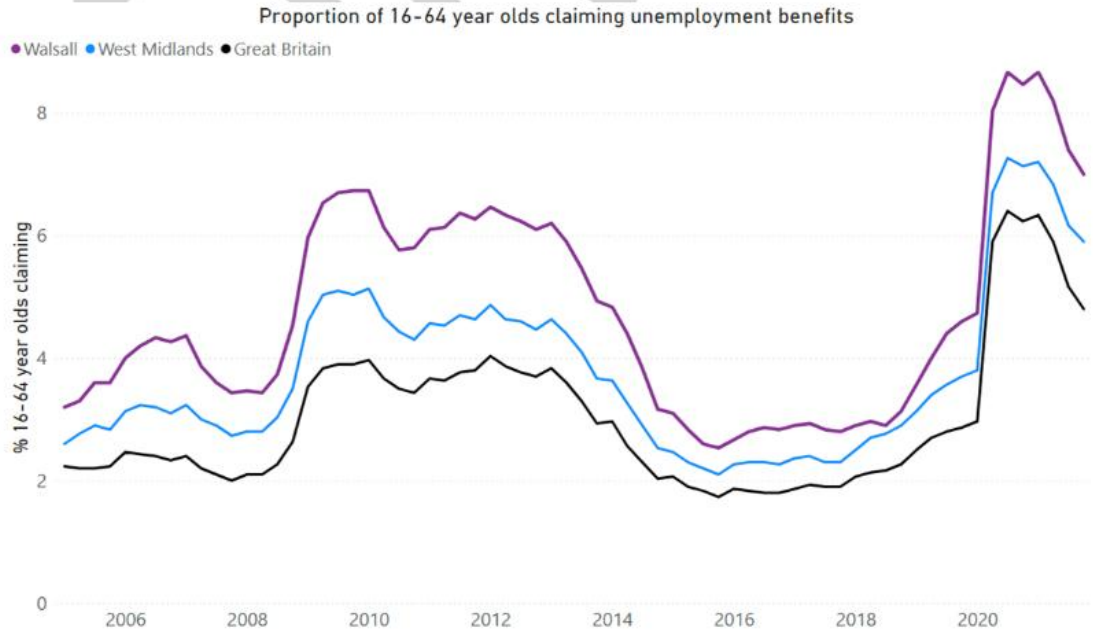
Employment deprivation: score 2015

Score

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	-	0.119	-	-
Neighbours average	–	-	-	-	-	-
Wolverhampton	–	3	-	0.187	-	-
Sunderland	–	14	-	0.185	-	-
Rochdale	–	1	-	0.185	-	-
St. Helens	–	15	-	0.183	-	-
Sandwell	–	2	-	0.181	-	-
Stoke-on-Trent	–	12	-	0.180	-	-
Oldham	–	4	-	0.170	-	-
Walsall	–	-	-	0.169	-	-
Rotherham	–	9	-	0.168	-	-
Doncaster	–	10	-	0.167	-	-
Tameside	–	5	-	0.166	-	-
Bolton	–	6	-	0.160	-	-
Wakefield	–	13	-	0.159	-	-
Wigan	–	11	-	0.156	-	-
Dudley	–	8	-	0.143	-	-
Derby	–	7	-	0.143	-	-

Similarly to its statistical neighbours, Walsall falls within the worst quintile of employment deprivation nationally.

Figure 13 Proportion of unemployment benefit claimants in Walsall

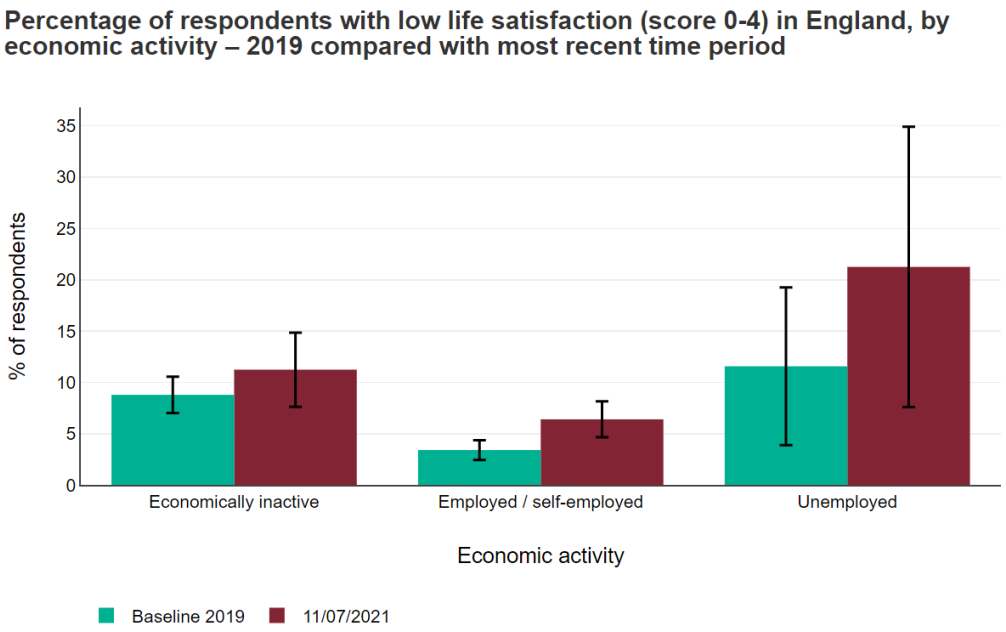


The chart above showing the local economic impacts of the pandemic. There has been a sharp increase in unemployment claims at the start of the pandemic, despite support

for employers, such as the furlough scheme. The number of claimants – the figure, just under 15,000 claimants remained steady since then,

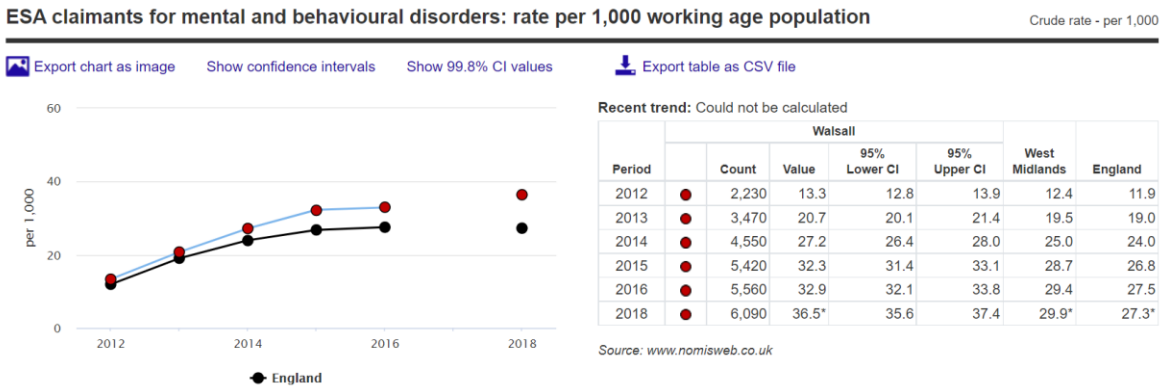
Younger people have been affected disproportionately by unemployment and furloughing – the same demographic that is reporting low wellbeing scores.

Figure 14 Life Satisfaction Scores by economic activity status



Nationally, individuals who are unemployed or otherwise economically inactive are more likely to report lower life satisfaction scores than those that are employed.

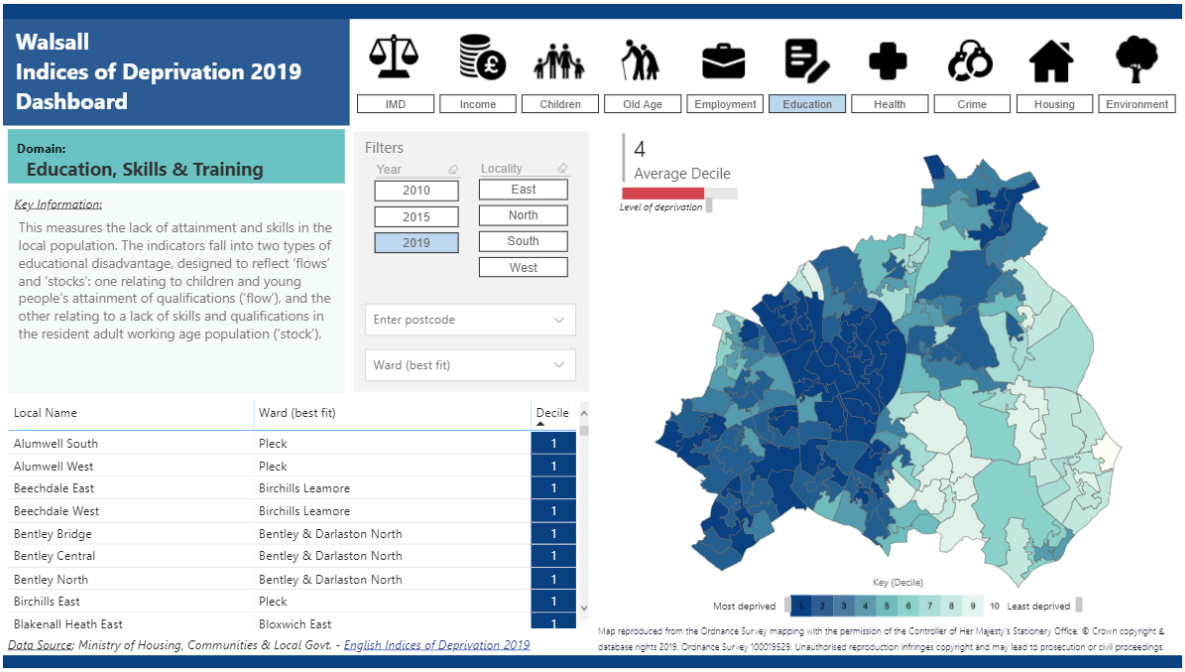
Figure 15 The rate of Employment Support Allowance that is claimed for mental and behavioural disorders in Walsall.



Period		Walsall Count	Value	95% Lower CI	95% Upper CI	West Midlands	England
2012		2,230	13.3	12.8	13.9	12.4	11.9
2013		3,470	20.7	20.1	21.4	19.5	19.0
2014		4,550	27.2	26.4	28.0	25.0	24.0
2015		5,420	32.3	31.4	33.1	28.7	26.8
2016		5,560	32.9	32.1	33.8	29.4	27.5
2018		6,090	36.5*	35.6	37.4	29.9*	27.3*

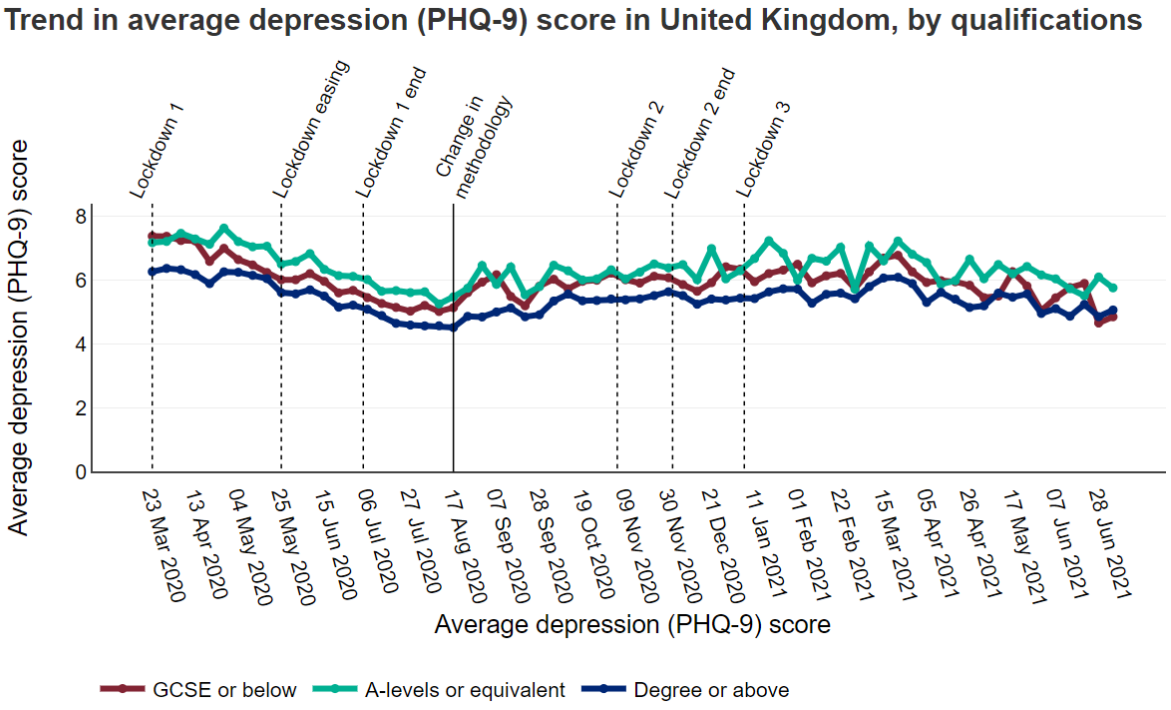
Mental and behavioural disorders contribute to the reasons that individuals can be involuntarily excluded from the labour market. The rate of claimants for Employment Support Allowance for mental and behavioural disorders is significantly higher than the national average and also increasing in trend.

Figure 16 Education, Skills and Training Deprivation in Walsall



On average, Walsall falls within the 4th most deprived decile with regard to education, skills and training, as measured in the Indices of Multiple Deprivation. However, many LSOA's in the borough fall within the most deprived decile nationally, in terms of the lack of attainment and skills in the local population.

Figure 17 Trends in depression prevalence by qualifications



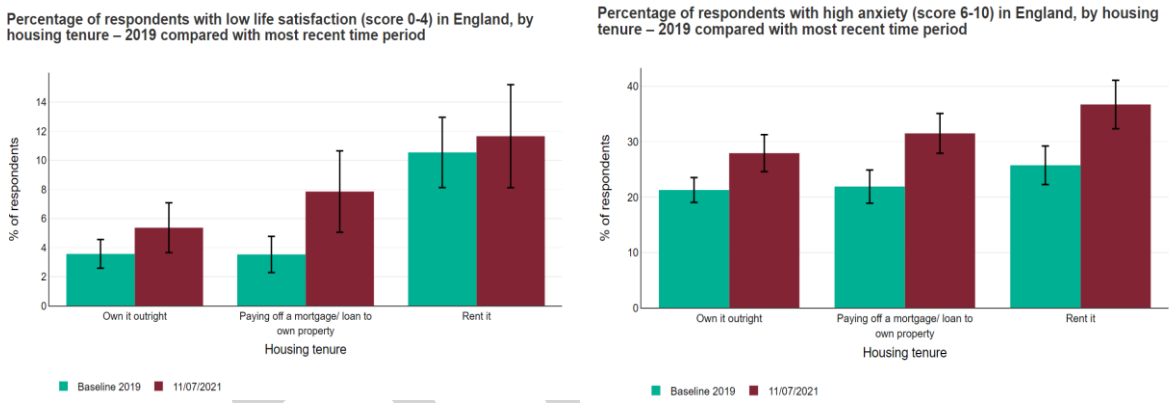
National data collated over the duration of the COVID-19 pandemic has shown that individuals with a degree level of education or higher have reported lower depression scores on average than individuals without a degree level education.

Housing and Wellbeing

Housing and environment is an important social determinant of health and wellbeing. The quality of housing stock available, its affordability, overcrowding and poverty can all affect wellbeing, from the individual level – for example, the time spent commuting to work, through to the community level, in terms of community cohesion.

There is a direct association between unaffordable housing and poor mental health, that goes beyond the effects of general financial hardship. In addition, the type of housing tenure may impact upon how an individual experiences and responds to housing affordability problems.

Figure 18 Life Satisfaction and Anxiety scores by housing tenure



A higher proportion of individuals who rent their homes reported low life satisfaction scores than those that have a mortgage or own a house outright. A higher proportion of renters also reported high anxiety scores, although to a lesser degree.

Decent quality housing is also fundamental to health and wellbeing. In Walsall, 12-14% of homes are estimated to have some type of hazard e.g. fall hazards, excess cold, disrepair or overcrowding[4]. This is true in the private owned, private rented and socially rented sectors.

Overcrowding is associated with negative mental wellbeing. In 2020, 30% of adults in the UK reported psychological distress, compared to 24% of adults in non-crowded households. The proportion of overcrowded households in Walsall is significantly higher than nationally, with about 5.2% of households affected.

Fuel poverty, strongly linked to cold homes, is associated with poor health and wellbeing outcomes and an increased risk of morbidity and mortality for all age groups. Around 13.7% of households in Walsall experienced fuel poverty in 2017. This is likely to be exacerbated by the anticipated rise in fuel and energy costs nationally.

Homelessness is associated with severe poverty and, subsequently, adverse health, educational and social outcomes, particularly for children. Statutorily homeless households contain some of the most vulnerable members of our community. In Walsall, 1 in every 1000 households were in temporary accommodation in 2017/18.

Unemployment, training education and volunteering

Health, unemployment and financial stress

Unemployment is consistently related to higher rates of depression, anxiety, and suicide. Employment deprivation, which is the proportion of people in Walsall who are involuntarily excluded from the labour market, due to unemployment, sickness or disability and caring responsibilities, is within the 4th worst decile in the country.

Unemployment levels remain above pre-pandemic levels, with younger people being disproportionately affected by unemployment and furloughing. Poor health, unemployment and financial stress are the most common reasons residents reported poor levels of wellbeing. These factors are disproportionately felt by younger people, particularly males, and those furloughed during the pandemic.

Education Skills and training

Education, skills, and training deprivation also contributes to employment deprivation and inequalities in Walsall. Individuals with higher educational attainment have lower depression and anxiety scores on average.

Community Connections – Peer social support

Social contact

Social contact, a feeling of connectedness with one's family and friends, community and broader society is a fundamental of good wellbeing. Only 40% of adults with social care needs in Walsall said they had as much social contact as they would like. Similarly, less than 30% of adult carers had as much social contact as they would like. This indicates that social isolation and loneliness is a significant wellbeing issue in these groups, and they are likely to have been particularly highly affected by the pandemic[7].

Mental health needs amongst the older population are under-recognised by health-care professionals and by older people themselves. Symptoms of depression amongst older people are often overlooked[8]. Problems such as loneliness and social isolation contribute to the development of mental health conditions such as depression and anxiety and the worsening of underlying mental health conditions.

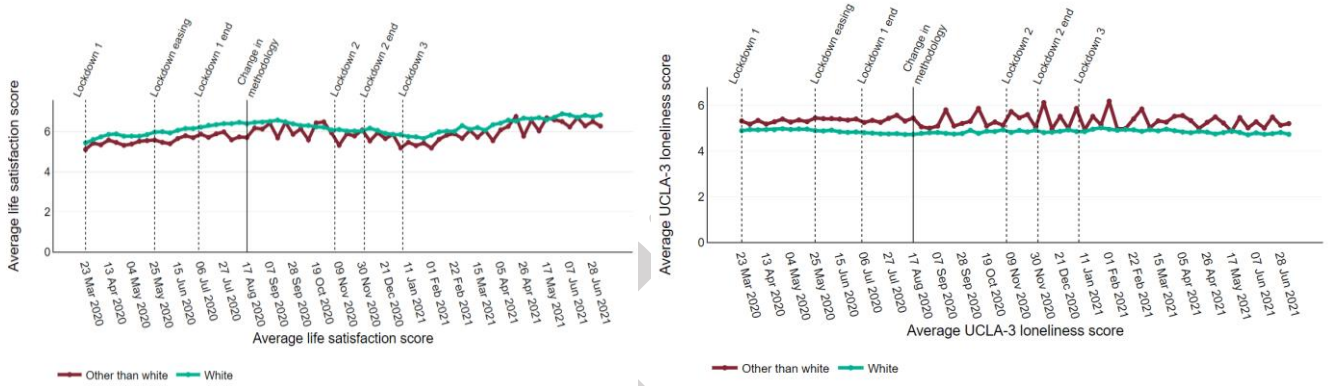
People with mental health needs, carers and Asian women were at an increased risked of social isolation and loneliness. Similarly, those from the Lesbian, gay, bisexual, and transgender (LGBT) community experience several health inequalities

[7] Loneliness beyond COVID-19, Campaign to End Loneliness 2021
[8] Mental Health Policy Position Paper, Age UK 2019

which are often unrecognised in health and social care settings,[9] and little is known about their emotional wellbeing and mental health in Walsall.

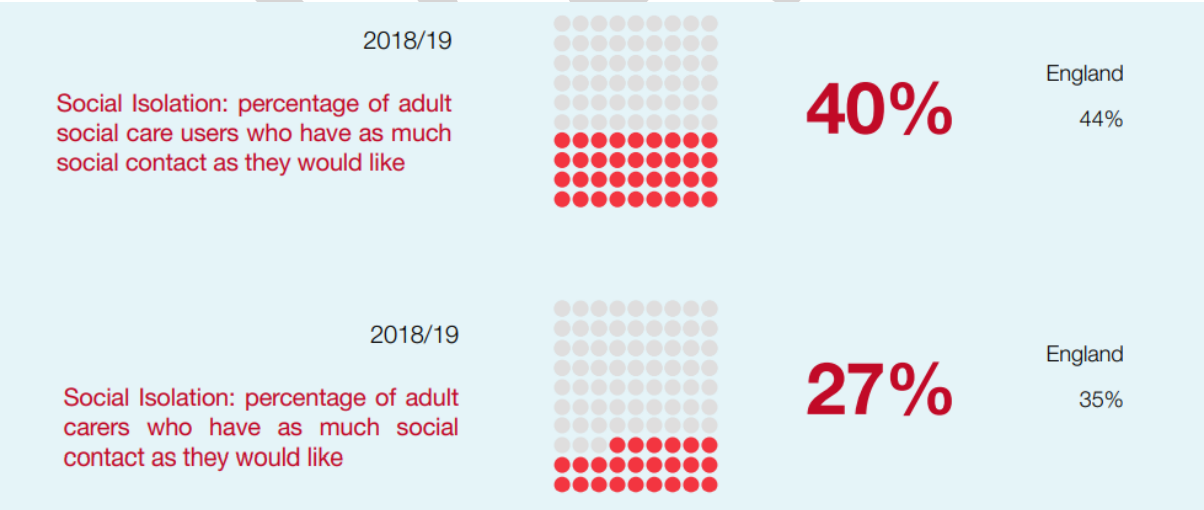
85% of older people with depression receive no NHS support[10] and Carers are twice as likely to suffer mental health problems as non-carers.

Figure 19 The trend in average life satisfaction and loneliness scores in the United Kingdom by ethnicity



Throughout the course of the COVID-19 pandemic in the UK, people of "other than white" ethnicity have experienced lower life satisfaction than the white population, whilst simultaneously having a higher loneliness score.

Figure 20 Prevalence of feelings of social isolation in adult social care users and adult carers in Walsall.



Social contact, a feeling of connectedness with one's family and friends, community and broader society is fundamental to good wellbeing.

[9] Racial disparities in mental health: Race Equality Foundation, 2020.

[10] Better access to mental health services for older people , A. Burns 2015

Of adults who have social care needs in Walsall, only around 4 in 10 had as much social contact as they would like – which is lower than the national average for England of 44%.

In addition, of all adult carers in Walsall only 27% of them had as much social contact as they would like – again significantly lower than the national average of 35%.

These groups are highly likely to experience lower wellbeing, and have been highly affected by the pandemic. In fact, since March 2020, 9.9% of the Making Connections Walsall service users reported that they felt lonely.

Bereavement Support and Talking Therapies

Bereavement can be an extremely distressing time for relatives, families and friends. Whilst some find support through their existing relationships and networks (family, friends, religion etc.) others struggle and need help to deal with the challenges of death. With the COVID pandemic, a growing population and ageing society the annual number of deaths increased and so too has the demand for support

Counselling and talking therapies are extremely important for these purposes and is proven to prevent people's wellbeing deteriorating further. Nationally, waiting times for NHS psychological therapy (IAPT) vary from 4 days to 61 days in different parts of England[11].

Demand for IAPT services is higher in deprived areas. People living in the most deprived areas of England were twice as likely to be referred to IAPT as those living in the least deprived areas in 2017/18. However, a lower percentage of those referred from the most deprived area entered treatment and finished treatment compared with the least deprived areas[11].

In a national survey of bereaved people, when asked whether they had talked to anyone from any support services since the death, 21% of people said that they had not, but would have liked to. This was significantly higher for female respondents (23% versus 16% for males) and younger respondents (25% for under 60 years and 17% for those 60 years and over).

The COVID-19 pandemic has already left many grieving the sudden loss of relatives and friends, and this is likely to precipitate an increased demand for bereavement and counselling services that are already strained.

Black adults are the least likely ethnic group to report being in receipt of medication for mental health, or counselling, or therapy[12]. Furthermore, Black, Asian, and other ethnic communities are more likely to be prescribed medications than to be referred for counselling services.

Around 14% of people who accessed IAPT nationally identified as being was captured did not identify as white. Those that did access IAPT, were less likely to complete a

[11] Baker, C., 2020. Mental health statistics for England: prevalence, services and funding
[12] Black, Asian and Minority Ethnic Communities. The Mental Health Foundation, 2021.

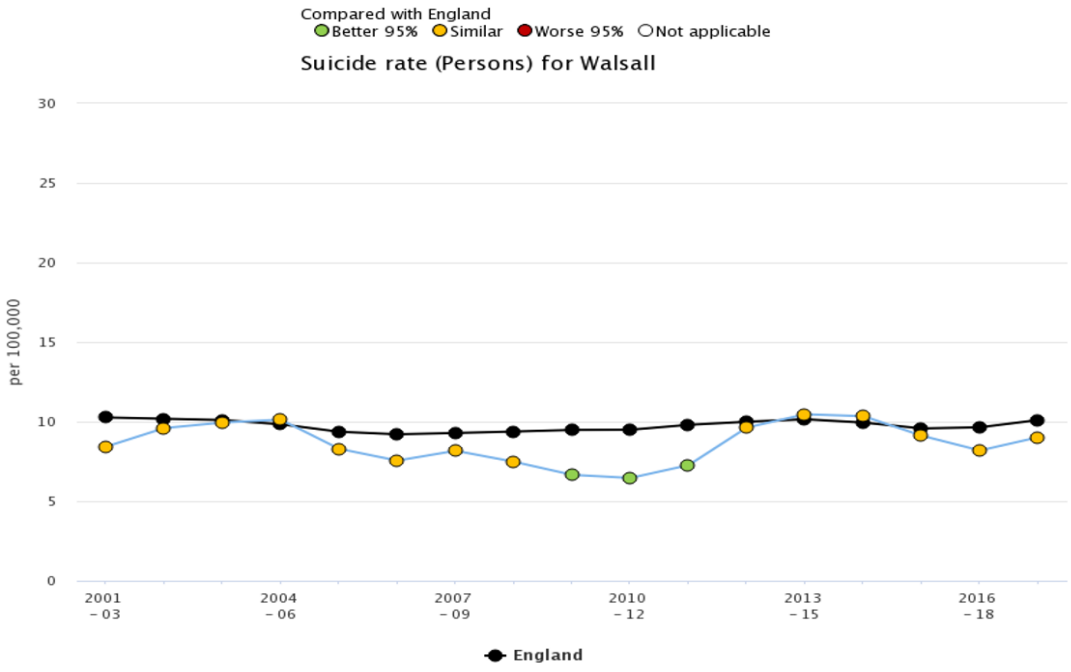
course of IAPT treatment and were less likely to see an improvement in their conditions[11].

Around 11% of people referred to IAPT in 2018/19 reported having a disability[13]. They were less likely to improve or recover after IAPT therapy (61%) than those without a disability (68%). People with a hearing disability had recovery and improvement rates similar to people with no disability[11].

Women are slightly more likely to be in contact with mental health and learning disability services than men (5.0% of women and 4.7% of men). Men are at a greater risk of mental ill health but are less likely to seek help whilst older people are less likely to be referred to counselling[11].

There is an absence of evidence on outcomes bereavement care for people from an ethnic background. Accessibility of provision, readily available information' and inclusive approaches is essential to meet the needs of diverse population groups[14].

Figure 21 Suicide Rate in Walsall



Suicide prevention is outside the scope of this strategy, but is addressed elsewhere in the specific Walsall Multi-agency suicide prevention strategy[15].

However, for context, it is important to note that the suicide rate in Walsall has seen an increasing trend over the last decade and is not significantly different from the national rate for England.

[13] Improving Access to Psychological Therapies (IAPT) data set reports - NHS Digital
[14] Mayland CR, Powell RA, Clarke GC, Ebenso B, Allsop MJ (2021) Bereavement care for ethnic minority communities: A systematic review of access to, models of, outcomes from, and satisfaction with, service provision. PLOS ONE 16(6)
[15] Walsall Multi-Agency Suicide Prevention Strategy 2018-23

Move More, Nutrition and Risk Taking behaviour

Integrating physical and mental health is a national and local priority. Achieving parity of esteem for people with mental health problems is a local priority. The impact unhealthy lifestyles have on mental wellbeing and the need to address the issues of unhealthy lifestyles in the borough is well evidenced[16].

Healthy Lifestyle

Lifestyle factors can impact upon an individual's quality of life both physically and mentally[17]. Smoking, drug and alcohol misuse, gambling and physical inactivity are all major risk factors for poor mental health and wellbeing.

Smoking is the most important cause of preventable ill health and premature mortality in the UK and is a major risk factor for many diseases, such as lung cancer, chronic obstructive pulmonary disease (COPD) and heart disease[18].

Studies have shown that people with mental health conditions are more likely to smoke than the general public and that smoking rates increase with the severity of illness[19].

Overall, around 15.6% of adults in Walsall smoke, but the prevalence is much higher in people with anxiety and depression at about 28.1%[20]. Forty percent of cigarettes smoked in England are smoked by people with a mental health problem[21].

Physical inactivity is another major leading risk factor for mortality accounting for 6% of deaths globally[22]. People who have a physically active lifestyle have a 20-35% lower risk of cardiovascular disease, coronary heart disease and stroke, diabetes, various cancers and obesity compared to those who have a sedentary lifestyle[23]. Regular physical activity is also strongly associated with improved mental health. In Walsall, 63.2% of adults are physically active[23], and encouraging a further increase in this proportion will have a protective effect on the mental health of Walsall residents.

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[16] Healthy lives for people in the UK, The Health Foundation, 2017
[17] The Walsall Plan: Our Health and Wellbeing Strategy 2019 - 21
[18] Smoking and Tobacco: applying all our health. Department for Health Improvement and Disparities, 2021.
[19] Health Matters: Smoking and Mental Health, Public Health England, 2020.
[20] Local Tobacco Control Profile: Fingertips Public Health Profiles, Department for Health Improvement and Disparities, 2020
[21] Smoking prevalence in adults commentary: current smokers aged over 18 years by wellbeing group and region, Public Health England, 2021.
[22] Lee et. al. Impact of Physical Inactivity on the World's Major Non-Communicable Diseases, Lancet 2012.
[23] Physical Activity Profile: Fingertips Public Health Profiles, Department for Health Improvement and Disparities, 2022.

Health and Wellbeing Board

25 January 2021

Item 7

Health Protection Strategy

For Approval

1. Purpose

The purpose of this report is to.

- Describe the current challenges to health protection in Walsall
- Describe the shared partnership approach to addressing these challenges. The Health Protection Strategy describes the strategy for health protection in Walsall from 2022 to 2025.

2. Recommendations

2.1 That the Health and Wellbeing Board approve the Walsall Health Protection Strategy 2022- 2025

3. Report detail

3.1 The Health Protection Strategy describes the strategic approach to health protection in Walsall over the next 4 years from 2022 to 2025. Health Protection is a statutory function of the Council.

3.2 This strategy is a partnership document developed with input and support from key stakeholders within Walsall, including the Black Country and West Birmingham CCG, Walsall Healthcare NHS Trust, UK Health Security Agency and NHS England.

3.3 Health protection is a term used to encompass a set of activities within the public health function.

3.4 Health Protection involves:

- Ensuring the safety and quality of food, water, air and the general environment
- Preventing the transmission of communicable diseases
- Managing outbreaks and the other incidents which threaten the public health

3.5 The profile of health protection has increased significantly in recent years with issues such as immunisation, food borne infections, pandemics, healthcare associated infection and communicable diseases regularly being in the public eye.

Health protection issues include the prevention and control of infectious diseases and environmental threats to the health of the population.

3.6 The Walsall Health Protection Strategy does not cover the strategic response to COVID 19, as this covered within the Walsall Local Outbreak Management Plan

3.7 The Walsall Health Protection Strategy is supported by a live Action Plan. The implementation of the Action Plan is overseen by the Walsall Health Protection Forum.

4. Implications for Joint Working arrangements:

4.1 Benefits of a more integrated approach and pooling resources with a range of both internal and external stakeholders will result in increased effectiveness in addressing health protection challenges in Walsall and greater impact on health.

4.2 In order to achieve a healthy environment and minimise the health protection challenges experienced by Walsall, this programme of work cuts across other boards, teams and externally commissioned services highlighting that this programme of work cannot be achieved in isolation.

5. Health and Wellbeing Priorities:

5.1 The key Health and Wellbeing Board priority is to Maximise People's Health and Wellbeing and Safety and in particular the focus of this report is to minimise the impact of health protection challenges on the health and wellbeing of the people of Walsall.

5.2 Work to reduce health protection challenges is a role for all partner organisations in Walsall and not just the statutory sector. In particular, health protection challenges posed by infections such as tuberculosis and blood borne viruses require close working with organisations supporting the homeless, and refugee and migrant communities.

5.3 Marmot's approach to addressing health inequalities as set out in Fair Society, Healthy Lives requires action across the social determinants of health and beyond the reach of the NHS. It also shows the importance of addressing the environmental and social factors affecting health.

5.4 Safeguarding: Recommendations and actions arising from this report directly supports safeguarding and will benefit the most vulnerable sectors in the community.

Background papers

None

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Walsall Health Protection Strategy

2022 -2025

Contents

Table of figures

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Rebecca Temple- Purcell - Deputy Chief Nurse, Black Country Healthcare NHS Foundation Trust

List of Acronyms and Abbreviations

AAA	Abdominal Aortic Aneurysm
AMR	Antimicrobial Resistance
CCG	Clinical Commissioning Groups
C. diff	Clostridium *Difficile*
COMEAP	Committee on the Medical Effects of Air Pollutants
DAA	Direct-acting antiviral
DESP	Diabetes Eye Screening Programme
DNA	Did not attend
DTaP	Diphtheria, tetanus and pertussis
EH	Environmental Health
FSA	Food Standards Agency
GP	General Practice
G and T	Gypsies and Travellers
HBV	Hepatitis B Virus
HCAI	Healthcare Associated Infections
HCV	Hepatitis C Virus
HiB	Haemophilus influenza type B
HPV	Human papillomavirus
HSE	Health and Safety Executive
IPC	Infection Prevention and Control
IPV	Polio vaccine
LA	Local Authority
LAC	Local Authority Circular
LHRP	Local Health Resilience Partnerships
LRF	Local Resilience Forums
LTBI	Latent Tuberculosis Infection
MMR	Measles, Mumps and Rubella
MRSA	Methicillin-resistant staphylococcus aureus
MSM	Men who have sex with men

MSSA	Methicillin-susceptible Staphylococcus aureus
NHSE	NHS England
NHSI	NHS Improvement
NIHP	National Institute for Health Protection
NO_2	Nitrogen dioxide
PCNs	Primary Care Networks
PHOF	Public Health Outcomes Framework
PM	Particulate matter
PPE	Personal Protective Equipment
RAG	Red-Amber-Green
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
SHS	Sexual Health Service
STIs	Sexually Transmitted Infections
TB	Tuberculosis
UAs	Unitary authorities
UKHSA	UK Health Security Agency
UTIs	Urinary Tract Infections
UTLAs	Upper Tier Local Authorities
WHO	World Health Organization
WHT	Walsall Healthcare Trust

Walsall Health Protection Strategy
Plan on a page

Our vision:

- **Protect the population of Walsall from threats and hazards to human health**
- **Reduce inequalities in the burden of communicable disease**
- **Ensure the highest possible quality and uptake of immunisation and screening**

Our Approach:

- **A system wide "team of teams" approach including every agency in Walsall**
- **We will address every area of health protection**
- **We will be driven by data, evidence and guidance on best practice**

Areas to cover

- **Vaccination and Immunisation–** focus on ensuring we keep population vaccination and immunisation levels at the highest we can, reduce inequalities and ensure high quality
- **Screening –** achieve optimal screening coverage and quality
- **TB**
- **Hepatitis B and C**
- **Health emergency planning**
- **Sexually Transmitted infections**
- **Infection Control–** drive down infections in health and social care settings
  - **Antimicrobial resistance**
- **Communicable Disease Control**–from food hygiene to outbreaks of rare diseases, protect our population from communicable diseases
- **A Healthy Environment**– from zoonoses to contaminated land and planning, specify and co-ordinate the health protection aspects of sustainable growth
  - **Air Quality**
  - **Hazards**–ensure that environmental, chemical, biological, radiological and nuclear threats and hazards are understood and the Health Protection issues addressed

Our objectives

1. We will develop a system wide approach to health protection
2. We will develop the analytical systems and tools necessary to enable this
3. We will ensure that evidence informs activity
4. We will ensure that pathways are in place enable this approach
5. We will ensure that the workforce is equipped with the right knowledge and skills
6. We will ensure that the right investment enables this to happen

What does good practice look like?

National guidance defines what Good Looks like for Health Protection and the system leadership role of the local Public Health Service. The hallmarks of this are:

- **Strong partnerships**
- **Foresight**– horizon scanning for emerging threats and hazards
- **A systems approach**
- **When things go wrong**–ensure that lookback exercises are conducted where necessary partners apply the learning from these

Our vision:

We want every person, irrespective of their circumstances, to be protected from infectious and non-infectious environmental health hazards and, where such hazards occur, to minimise their continued impact on the public's health. We do this by preventing exposure to such hazards, taking timely actions to respond to threats and acting collectively to ensure the best use of human and financial resources

Aims:

- Protect the population of Walsall from threats and hazards to human health
- Reduce inequalities in the burden of communicable disease
- Ensure the highest possible quality and uptake of immunisation and screening

Our Approach:

- We will develop a system wide approach to health protection
- We will develop the analytical systems and tools necessary to enable this
- We will ensure that evidence informs activity
- We will ensure that pathways are in place to enable this approach
- We will ensure that the workforce is equipped with the right knowledge and skills
- We will ensure that the right investment enables this to happen

Scope:

- **Vaccination and Immunisation–** focus on ensuring we keep population vaccination and immunisation levels at the highest we can, reduce inequalities and ensure a high quality service
  - Working with Primary Care Networks (PCNs) to improve childhood immunisation uptake
  - Annual flu vaccination campaign
  - Working with the UK Health Security Agency (UKHSA)/National Institute for Health Protection (NIHP) on one off campaigns eg measles/ gypsies and travellers (G and T) communities

- **Screening Quality –** achieve optimal screening coverage and quality

        - **Antenatal and new born screening**[Error! Bookmark not defined.]

        - Cancer screening
            - Cervical
            - Breast
            - Bowel

        - Non cancer screening
            - Diabetic retinopathy
            - Abdominal Aortic Aneurysm (AAA)

    - **Health care associated infections–** drive down infections in health and social care settings
        - **Antimicrobial Resistance (AMR)**

    - **Communicable Disease Control**–from food hygiene to outbreaks of rare diseases, protect our population from communicable diseases
        - **Sexual health**
        - **Blood borne viruses**
        - **Tuberculosis (TB)**

    - **COVID.** The COVID pandemic is expected to continue to have an impact for the foreseeable future. The strategy for COVID is contained in the Local Outbreak Management Plan and is not covered here.

    - **A Healthy Environment**– from zoonoses to contaminated land and planning, specify and co-ordinate the health protection aspects of sustainable growth

    - **Health emergency planning**

    - **Health Inequalities** Threats to health are not equally shared; the impoverished, incarcerated, institutionalised and homeless are often at far higher risk of illness and premature mortality than the general population. Marginalised populations experience extremes of poor health due to a combination of poverty, social exclusion and increased burden of risk factors.

      Where inequalities are greatest, resources will be targeted at people with greatest need. We will work to reduce the health inequalities of the homeless population in particular

What will good practice look like?

National guidance defines what Good Looks like for Health Protection[1] and the system leadership role of the local Public Health Service. The hallmarks of this are:

- Strong partnerships
- Foresight– horizon scanning for emerging threats and hazards
- A systems approach
- When things go wrong–ensure that lookback exercises are conducted where necessary partners apply the learning from these

The Health Protection System

At the local level, local authority Directors of Public Health provide leadership for the public health system working closely in partnership with NHS partners and UKHSA[2].

Local Health Resilience Partnerships (LHRP), co-chaired by a Director of Public Health and NHS England (NHSE) and NHS Improvement (NHSI), provide a strategic forum for organisations to facilitate health sector preparedness and planning for emergencies, working closely with Local Resilience Forums (LRF).

On a day-to-day basis, health protection practice aims to prevent, assess and mitigate risks and threats to people's health.

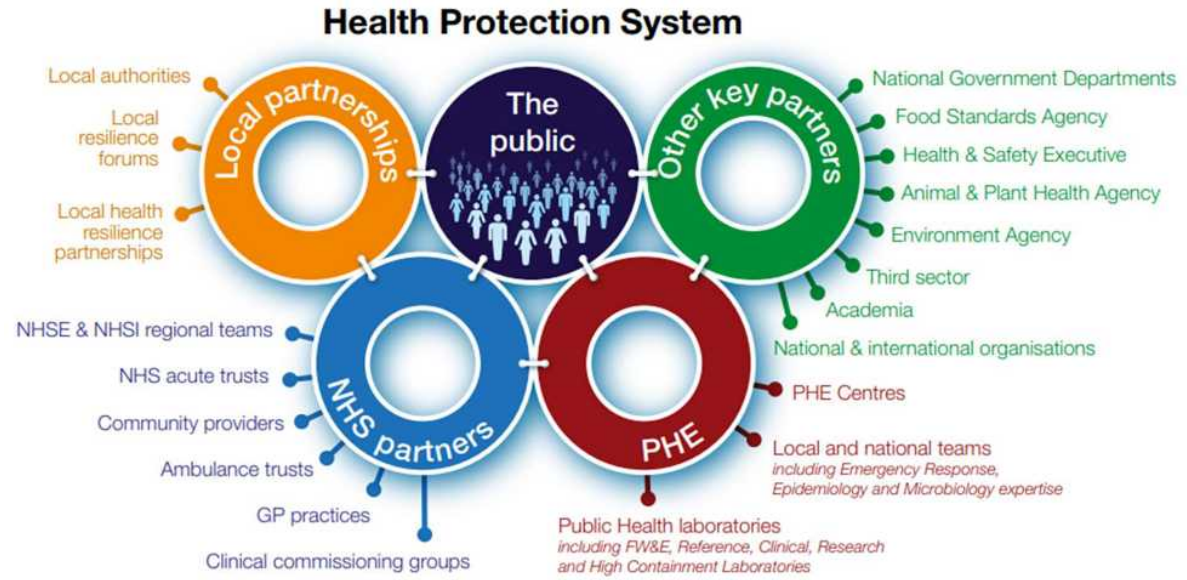
To deliver this combination of public health protection duties and services requires close partnership working between Directors of Public Health and their health protection teams, UKHSA, the NHS, national government and agencies, industry, and the public.

The Walsall Health Protection Forum is the vehicle to drive forward the implementation of the Walsall Health Protection Strategy.

[1] What-Good-Looks-Like-for-High-Quality-Local-Health-Protection-Systems.pdf (adph.org.uk)

[2] UK Health Security Agency

Figure 1: Schematic of Health Protection System



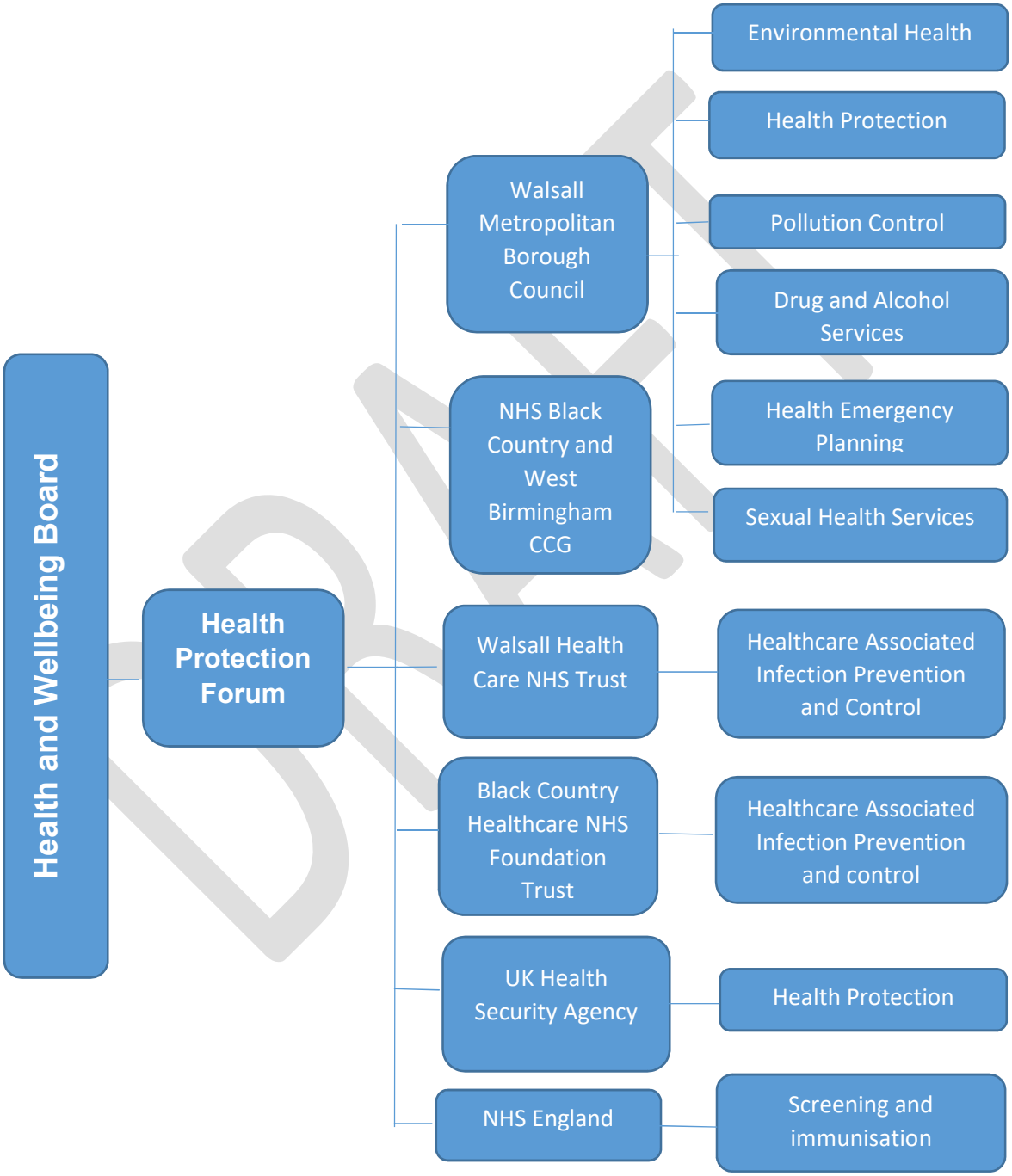
[3]

[3] PHE Infectious Diseases Strategy 2020-25 PHE_Infectious_Diseases_Strategy_2020-2025 (publishing.service.gov.uk)

The Governance Structure for Health Protection in Walsall

The larger health economy wide health protection team meet at the quarterly Health Protection Forum, chaired by the Director of Public Health. The forum includes representatives from the partners shown in the governance diagram below.

All of these agencies have a legal duty to respond to health protection emergencies. These legal responsibilities are described in the Civil Contingencies Act 2004.



Implementation

The implementation of this strategy will be carried out jointly by partner organisations, and implementation groups and Boards which already exist e.g. the Walsall Health Protection Forum, Infection Prevention and Control Committee for Walsall Healthcare Trust (WHT), Walsall Flu Group etc

This strategy will be supported by a live action plan which will be monitored through the Health Protection Forum.

Priorities for implementation will be identified at the start of each financial year.

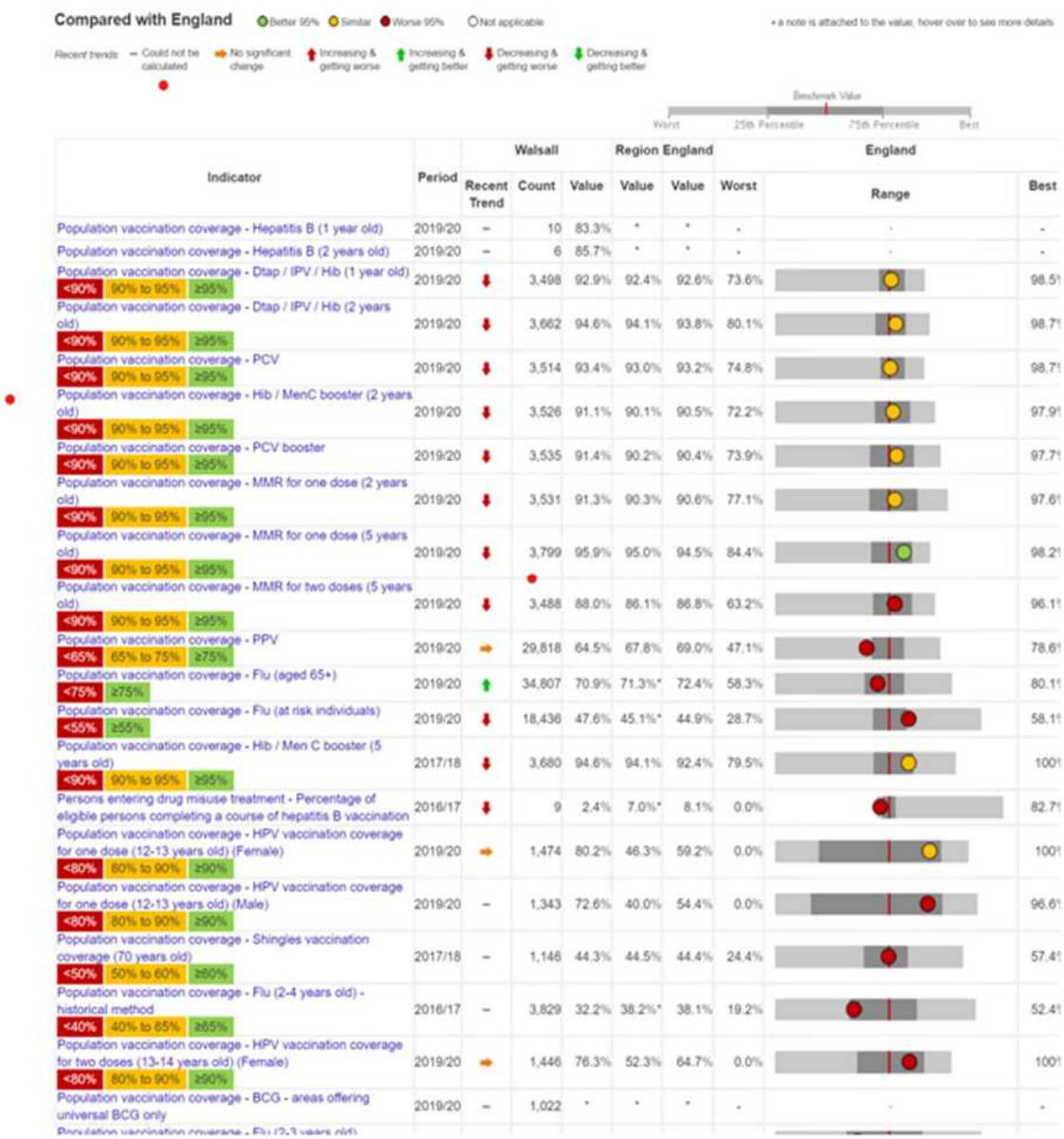
Vaccination and Immunisation

Immunisation programmes are currently commissioned by NHS England, with UKHSA providing oversight of the programmes. However, local authorities, and Directors of Public Health on their behalf, maintain the responsibility for health protection assurance.

Scope:

- Routine childhood immunisations, including measles, mumps and rubella (MMR)
- Flu vaccination and COVID booster vaccination
- Maternal pertussis
- Human papillomavirus (HPV)
- Older people's vaccinations

Figure 2: Immunisations in Walsall



Compared with England Better 95% Similar Worse 95% Not applicable • a note is attached to the value, hover over to see more details

Recent trends: Could not be calculated | No significant change | Increasing & getting worse | Increasing & getting better | Decreasing & getting worse | Decreasing & getting better

Benchmark Value: Worst | 25th Percentile | 75th Percentile | Best

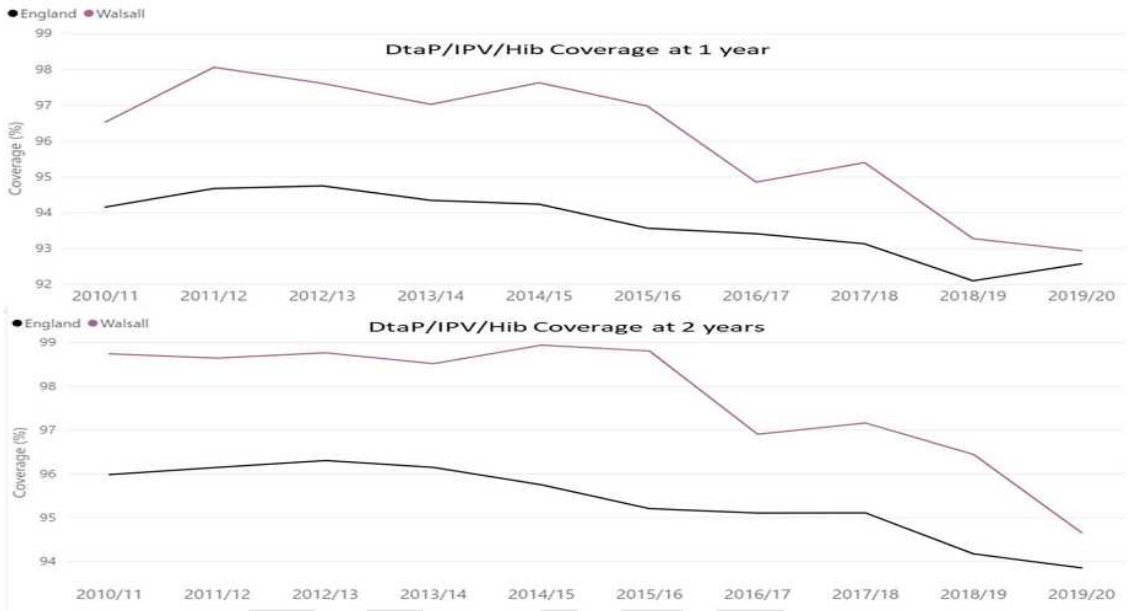
Indicator	Period	Walsall			Region England	England			
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Population vaccination coverage - Hepatitis B (1 year old)	2019/20	–	10	83.3%	*	*	-		-
Population vaccination coverage - Hepatitis B (2 years old)	2019/20	–	6	85.7%	*	*	-		-
Population vaccination coverage - Dtap / IPV / Hib (1 year old) <90% 90% to 95% ≥95%	2019/20	↓	3,498	92.9%	92.4%	92.6%	73.6%		98.5%
Population vaccination coverage - Dtap / IPV / Hib (2 years old) <90% 90% to 95% ≥95%	2019/20	↓	3,662	94.6%	94.1%	93.8%	80.1%		98.7%
Population vaccination coverage - PCV <90% 90% to 95% ≥95%	2019/20	↓	3,514	93.4%	93.0%	93.2%	74.8%		98.7%
Population vaccination coverage - Hib / MenC booster (2 years old) <90% 90% to 95% ≥95%	2019/20	↓	3,526	91.1%	90.1%	90.5%	72.2%		97.9%
Population vaccination coverage - PCV booster <90% 90% to 95% ≥95%	2019/20	↓	3,535	91.4%	90.2%	90.4%	73.9%		97.7%
Population vaccination coverage - MMR for one dose (2 years old) <90% 90% to 95% ≥95%	2019/20	↓	3,531	91.3%	90.3%	90.6%	77.1%		97.6%
Population vaccination coverage - MMR for one dose (5 years old) <90% 90% to 95% ≥95%	2019/20	↓	3,799	95.9%	95.0%	94.5%	84.4%		98.2%
Population vaccination coverage - MMR for two doses (5 years old) <90% 90% to 95% ≥95%	2019/20	↓	3,488	88.0%	86.1%	86.8%	63.2%		96.1%
Population vaccination coverage - PPV <65% 65% to 75% ≥75%	2019/20	→	29,818	64.5%	67.8%	69.0%	47.1%		78.6%
Population vaccination coverage - Flu (aged 65+) <75% ≥75%	2019/20	↑	34,807	70.9%	71.3%*	72.4%	58.3%		80.1%
Population vaccination coverage - Flu (at risk individuals) <55% ≥55%	2019/20	↓	18,436	47.6%	45.1%*	44.9%	28.7%		58.1%
Population vaccination coverage - Hib / Men C booster (5 years old) <90% 90% to 95% ≥95%	2017/18	↓	3,680	94.6%	94.1%	92.4%	79.5%		100%
Persons entering drug misuse treatment - Percentage of eligible persons completing a course of hepatitis B vaccination	2016/17	↓	9	2.4%	7.0%*	8.1%	0.0%		82.7%
Population vaccination coverage - HPV vaccination coverage for one dose (12-13 years old) (Female) <80% 80% to 90% ≥90%	2019/20	→	1,474	80.2%	46.3%	59.2%	0.0%		100%
Population vaccination coverage - HPV vaccination coverage for one dose (12-13 years old) (Male) <80% 80% to 90% ≥90%	2019/20	–	1,343	72.6%	40.0%	54.4%	0.0%		96.6%
Population vaccination coverage - Shingles vaccination coverage (70 years old) <50% 50% to 60% ≥60%	2017/18	–	1,146	44.3%	44.5%	44.4%	24.4%		57.4%
Population vaccination coverage - Flu (2-4 years old) - historical method <40% 40% to 65% ≥65%	2016/17	–	3,829	32.2%	38.2%*	38.1%	19.2%		52.4%
Population vaccination coverage - HPV vaccination coverage for two doses (13-14 years old) (Female) <80% 80% to 90% ≥90%	2019/20	→	1,446	76.3%	52.3%	64.7%	0.0%		100%
Population vaccination coverage - BCG - areas offering universal BCG only	2019/20	–	1,022	*	*	*	-		-

Routine Childhood Immunisations

Where we are now:

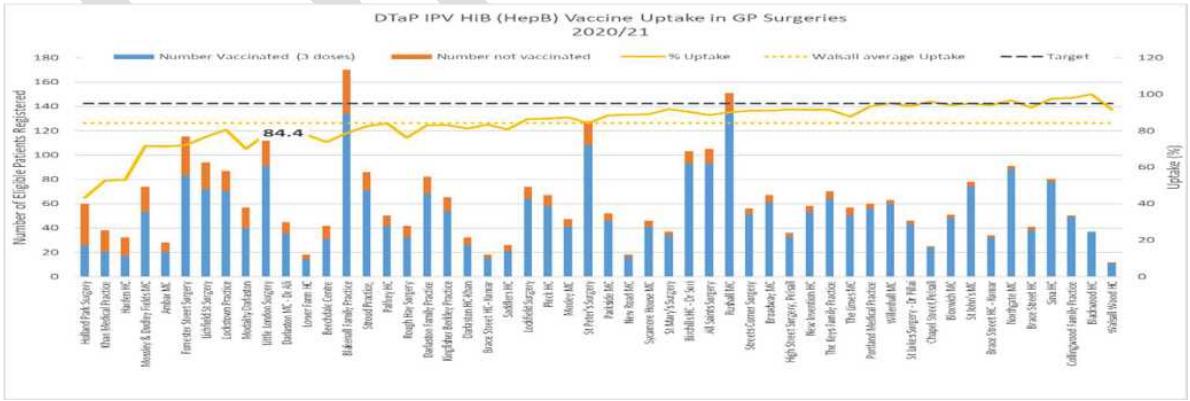
- Walsall is not meeting targets for most routine childhood immunisations

Figure 3:Trends in DTaP/IPV/HiB (HepB) Coverage in Walsall, 2010/11 to 2019/20



- There has been a fall in the uptake of routine childhood immunisations across all children in Walsall since 2015/16

Figure 4:DTaP/IPV/HiB/Hep B uptake in general practices in Walsall

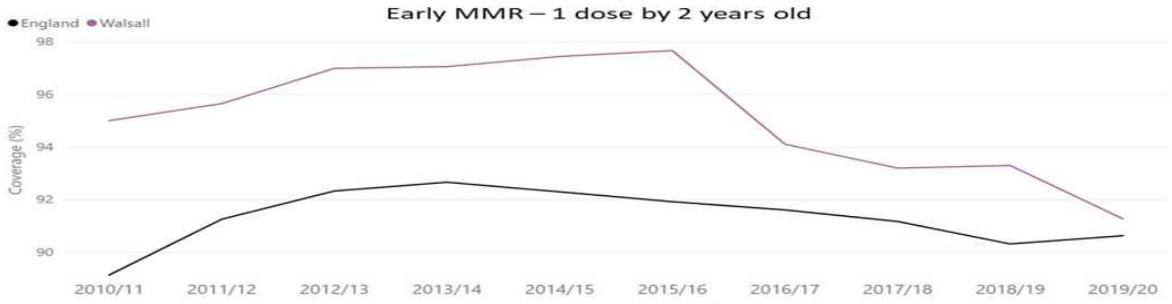


- There is considerable variation in diphtheria, tetanus and pertussis (DTaP)/polio (IPV)/haemophilus influenza type B (HiB)/hepatitis B (Hep B) vaccine uptake across

general practices in Walsall with some of the poorest performing practices achieving less than 60% uptake.

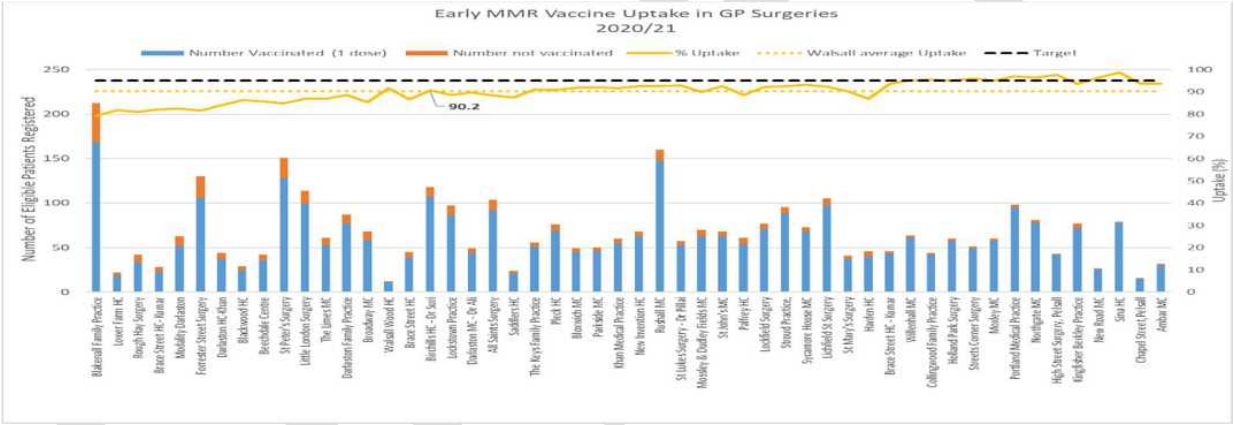
MMR[4]

Figure 5: Trends in uptake of one dose of MMR by 2 years in Walsall



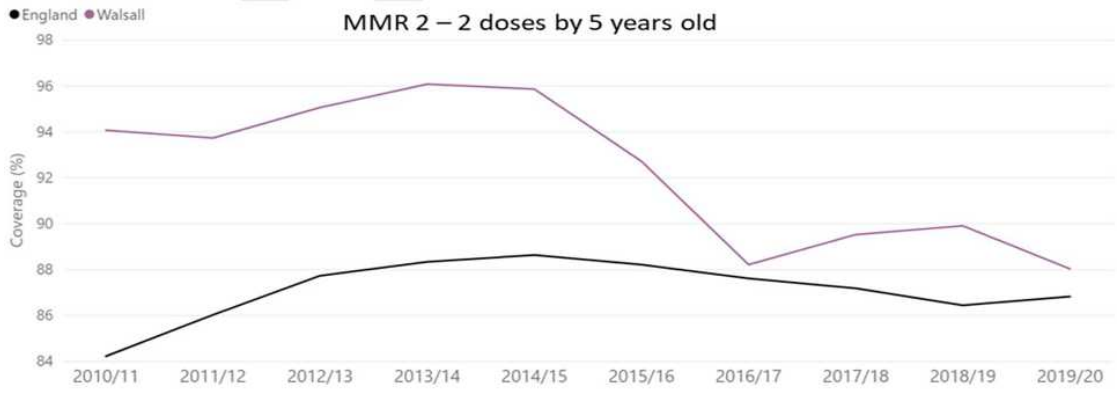
- The uptake of one dose of MMR by 2 years has seen a decline but is currently higher than the England average

Figure 6: MMR1 uptake in general practices in Walsall



- As seen in Figure 5 above, more than ½ of all Walsall practices are not achieving the national target of 95% for the first dose of MMR by 2 years of age.

Figure 7: Trends in uptake of two doses of MMR by 5 years in Walsall 2010/11 to 2019/20



- The uptake of 2 doses of MMR by the age of 5 is currently at only 86.8%

[4] Measles, mumps and rubella

- There has been a decline in the uptake of 2 doses of MMR by the age of 5 since 2016/17

Figure 8: Hepatitis B Population Coverage in 2 year olds (born to Hepatitis B positive mothers).*

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	-	*	-	-
West Midlands region	–	-	*	-	-
Wolverhampton	–	11	100	74.1	100
Telford and Wrekin	–	12	100	75.8	100
Stoke-on-Trent	–	12	100	75.8	100
Staffordshire	–	-	100*	51.0	100
Shropshire	–	-	100*	43.9	100
Herefordshire	–	-	100*	34.2	100
Dudley	–	12	100	75.8	100
Birmingham	–	101	96.2	90.6	98.5
Coventry	–	23	95.8	79.8	99.3
Warwickshire	–	15	93.8	71.7	98.9
Worcestershire	–	8	88.9	56.5	98.0
Walsall	–	6	85.7	48.7	97.4
Sandwell	–	14	82.4	59.0	93.8
Solihull	–	-	*	-	-

Where do we want to be?

- To maintain/increase uptake in all immunisation programmes, with a focus on groups with low uptake, and reduce service-related disparities in uptake
- Improve the uptake of 2 doses of MMR by the age of 5
- A strategic and joined up approach to address screening and immunisation inequalities and provide for vulnerable groups.

How do we get there?

- Roll out of the West Midlands measles elimination strategy and wider work to improve MMR coverage.
- Improve follow up of did not attend (DNA) appointments for routine childhood immunisation through the health visiting services
- Work with commissioners and services supporting Looked after Children to increase uptake of routine immunisations

Influenza

Seasonal influenza is a respiratory viral infection which in otherwise healthy individuals is typically a self-limiting disease. The public health effect varies considerably with the predominant circulating strains, the age groups most affected and the match of the vaccine. Up to a third of people with flu display no symptoms, yet some people, particularly those with underlying risk factors, can experience a much more serious infection. Influenza is a contributing factor to excess winter deaths.

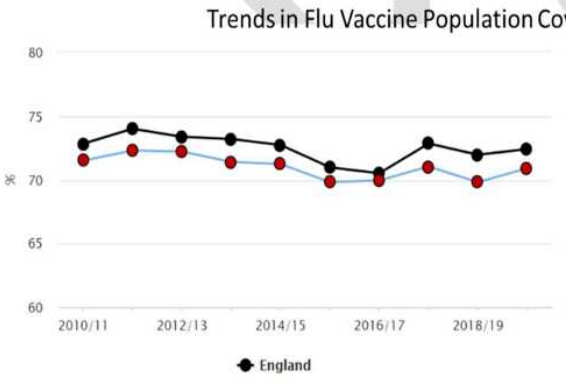
Where we are now:

Figure 9: Summary of Influenza Vaccine Uptake in Target Groups in 2020/21 Season

Clinical Commissioning Group	Target Group				
	65 and over	Under 65 (at-risk only)	Pregnant Women	All 2 year olds	All 3 year olds
	% vaccine uptake	% vaccine uptake	% vaccine uptake	% vaccine uptake	% vaccine uptake
NHS Dudley CCG	79.5	53.1	45.0	56.0	58.5
NHS Sandwell and West Birmingham CCG	71.6	42.7	33.8	44.1	47.3
NHS Walsall CCG	78.8	52.0	41.6	48.2	52.6
NHS Wolverhampton CCG	75.4	47.0	33.5	44.2	51.1

- Uptake of flu vaccination was higher than previous years for the 65 years and over
- There has been an increase in flu vaccine uptake across all categories in 2020/21 as compared to 2019/20

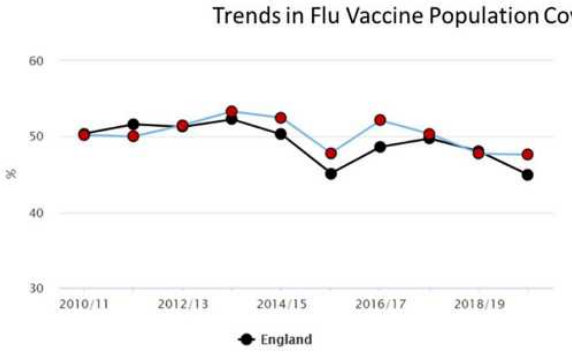
Figure 10: Trends in Flu Vaccine Uptake in people aged 65+ in Walsall



Benchmarking against goal: <75% ≥75%

Period		Walsall Count	Walsall Value	Walsall 95% Lower CI	Walsall 95% Upper CI	West Midlands	England
2010/11		30,310	71.5%	71.1%	71.9%	71.3%*	72.8%*
2011/12		33,161	72.3%	71.9%	72.7%	72.6%*	74.0%*
2012/13		33,611	72.2%	71.8%	72.6%	72.2%*	73.4%*
2013/14		34,178	71.4%	71.0%	71.8%	72.4%*	73.2%
2014/15		34,448	71.2%	70.8%	71.6%	72.3%*	72.7%
2015/16		33,693	69.8%	69.4%	70.2%	70.4%*	71.0%
2016/17		33,635	69.9%	69.5%	70.4%	70.1%*	70.5%
2017/18		33,700	71.0%	70.6%	71.4%	72.1%*	72.9%
2018/19		33,918	69.8%	69.4%	70.2%	71.1%*	72.0%
2019/20		34,807	70.9%	70.5%	71.3%	71.3%*	72.4%

Figure 11: Trends in Flu Vaccine Uptake in people at clinical risk in Walsall



Benchmarking against goal: <55% ≥55%

Period		Walsall Count	Value	95% Lower CI	95% Upper CI	West Midlands	England
2010/11	●	13,610	50.2%	49.6%	50.8%	50.0%*	50.4%*
2011/12	●	14,438	50.0%	49.4%	50.6%	51.0%*	51.6%*
2012/13	●	15,333	51.5%	50.9%	52.1%	51.6%*	51.3%*
2013/14	●	16,337	53.3%	52.8%	53.9%	52.8%*	52.3%
2014/15	●	17,510	52.5%	51.9%	53.0%	51.9%*	50.3%
2015/16	●	18,548	47.8%	47.3%	48.3%	46.4%*	45.1%
2016/17	●	18,248	52.1%	51.6%	52.7%	49.5%*	48.6%
2017/18	●	20,023	50.4%	49.9%	50.9%	49.9%*	49.7%
2018/19	●	20,087	47.7%	47.3%	48.2%	47.8%*	48.0%
2019/20	●	18,436	47.6%	47.1%	48.1%	45.1%*	44.9%

- There is a striking variation in uptake of flu vaccination by ethnicity and deprivation, according to an analysis of flu vaccination uptake in the Black Country. For example, amongst the at risk under 65s, only 37% of people of Pakistani ethnicity from the most deprived quintile had taken the flu vaccine as opposed to 69% of white people from the least deprived quintile.
- Flu vaccination uptake in care home staff remains a challenge at 25% (as of December 8th 2021)

Where do we want to be?

- Improve performance against national targets for flu by 10% over 2020/21
- Plans to roll out a combined flu/COVID booster campaign for 2021/22 starting in September 2021

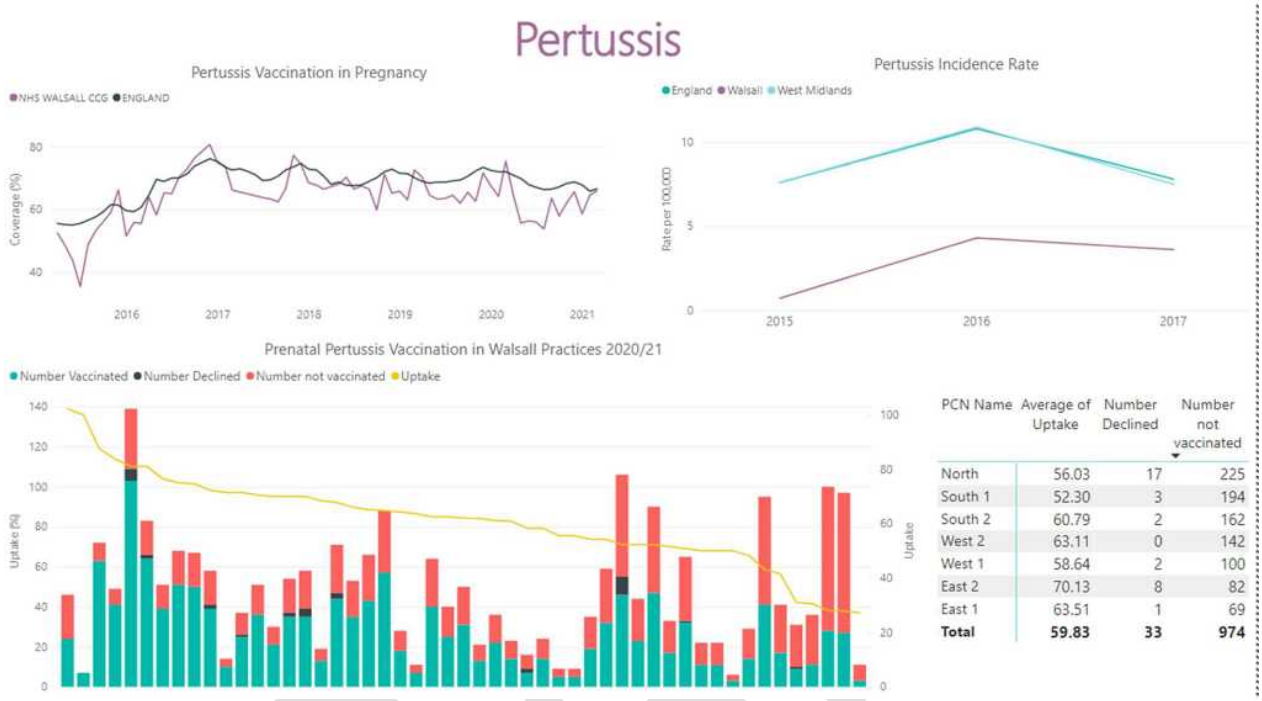
How do we get there?

- The Flu Fairies funded by Public Health will continue to work in the antenatal department talking to expectant mothers and encouraging them to have the flu vaccine.
- Provision of comic style booklets for all school age children encouraging them to become “Flu Fighters”. This was developed in Wolverhampton for the 2018/19 season, and which saw an increase in uptake of 8%.
- The Clinical Commissioning Groups (CCG) identify and support general practices with low uptake as per previous years.
- Joined up media campaign between the CCG, WHT and Local Authority (LA).

Maternal Pertussis

Where are we now?

Figure 12: Incidence of Pertussis and Prenatal Pertussis Vaccine Uptake in Walsall GPs/PCNs



PCN Name	Average of Uptake	Number Declined	Number not vaccinated
North	56.03	17	225
South 1	52.30	3	194
South 2	60.79	2	162
West 2	63.11	0	142
West 1	58.64	2	100
East 2	70.13	8	82
East 1	63.51	1	69
Total	**59.83**	**33**	**974**

- 60% of pregnant women in Walsall are taking the prenatal pertussis vaccine
- There is a considerable variation in the uptake of the prenatal pertussis vaccine across general practices in Walsall

Where do we want to be?

- The uptake of prenatal pertussis vaccination needs to rise to at least 75% in the first 12 months of this strategy, building up to 95% uptake by the 2025.

How do we get there?

- We will launch a campaign to improve prenatal pertussis vaccination uptake in 2022.

HPV[5]

Where are we now?

Figure 13: Trends in HPV Vaccine Coverage in Walsall 2015/16 to 2019/20

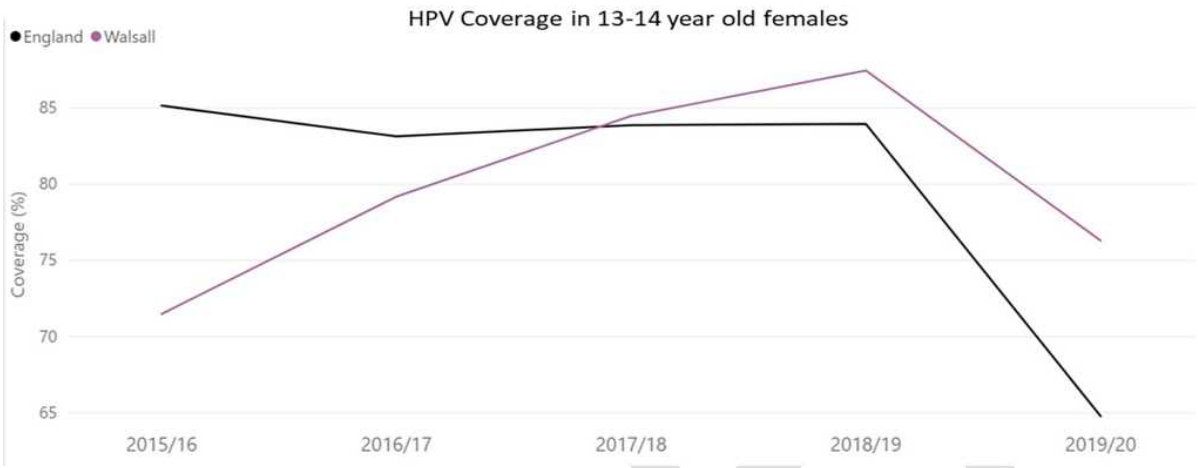


Figure 14: HPV Vaccine Uptake in 12-13 year old males and females in Walsall

Local Authority	Females Cohort 17: 12-13 Year Olds (Year 8) Birth Cohort: 1 September 2006- 31 August 2007					Males Cohort 1: 12-13 Year Olds (Year 8) Birth Cohort: 1 September 2006- 31 August 2007				
	Number of females in Cohort 17 (Year 8)	No. vaccinated with at least one dose by 20/03/2020	%	No. vaccinated with two doses by 20/03/2020	%	Number of males in Cohort 1 (Year 8)	No. vaccinated with at least one dose by 20/03/2020	%	No. vaccinated with two doses by 20/03/2020	%
DUDLEY LOCAL AUTHORITY	1,698	1,583	93.2	674	39.7	1807	1589	87.9	643	35.6
SANDWELL LOCAL AUTHORITY	2,018	440	21.8	0	0.0	2214	304	13.7	0	0
WALSALL LOCAL AUTHORITY	1,837	1,474	80.2	344	18.7	1850	1343	72.6	188	10.2
WOLVERHAMPTON LOCAL AUTHORITY	1,820	1,457	80.1	596	32.7	1743	1281	73.5	487	27.9
ENGLAND	**320,056**	**189,457**	**59.2**	**12,890**	**4.0**	**331308**	**180207**	**54.4**	**11671**	**3.5**

- The uptake of HPV in girls at 80.2% is higher than regional and national levels and is achieving targets
- The uptake of HPV in boys at 72.6% is below target

Where do we want to be?

- Continue to achieve high levels of uptake in girls and improve uptake in boys to achieve national targets.

How do we get there?

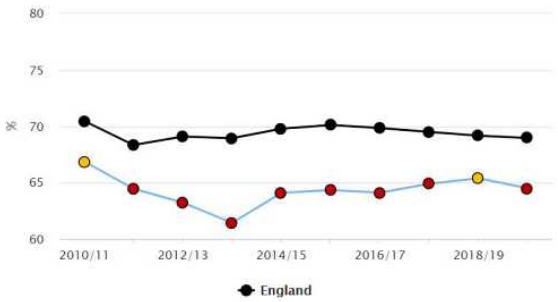
- We will work with the immunisation provider and with local schools to improve awareness and increase uptake.

[5] Human Papilloma Virus

Older Adult Vaccinations

Where are we now?

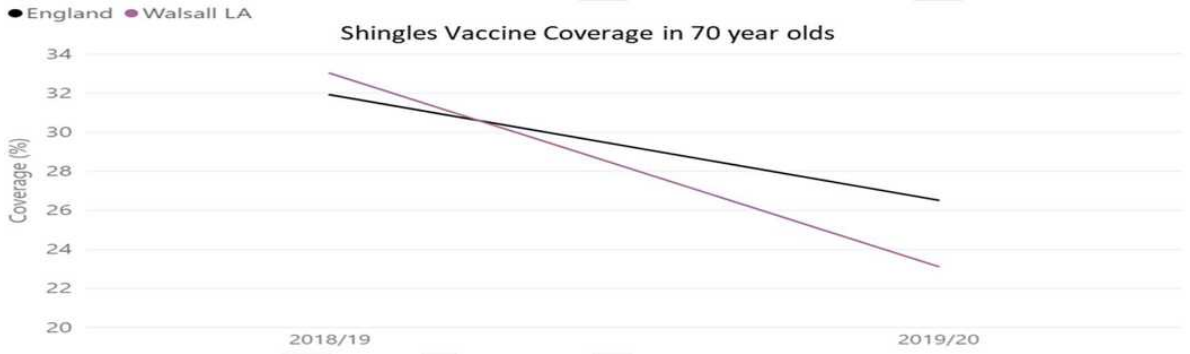
Figure 15: Trends in Pneumococcal Polysaccharide Vaccine Uptake in Walsall



Benchmarking against goal: <65% | 65% to 75% | ≥75%

Period		Walsall Count	Walsall Value	Walsall 95% Lower CI	Walsall 95% Upper CI	West Midlands	England
2010/11		13,898	66.9%	66.2%	67.5%	68.7%*	70.5%*
2011/12		24,439	64.5%	64.0%	64.9%	67.6%*	68.3%*
2012/13		24,696	63.2%	62.8%	63.7%	68.1%*	69.1%*
2013/14		28,948	61.4%	61.0%	61.9%	67.5%	68.9%
2014/15		30,481	64.1%	63.4%	64.8%	68.5%	69.8%
2015/16		28,215	64.3%	63.9%	64.8%	69.1%*	70.1%
2016/17		27,209	64.1%	63.7%	64.6%	68.5%	69.8%
2017/18		30,009	64.9%	64.4%	65.3%	68.7%	69.5%
2018/19		31,789	65.4%	65.0%	65.8%	68.3%	69.2%
2019/20		29,818	64.5%	64.1%	65.0%	67.8%	69.0%

Figure 16: Trends in Shingles Vaccine Uptake in Walsall 2018/19 to 19/20



- The uptake of pneumococcal vaccination in Walsall is currently below target at 69%, this is below national levels.
- The uptake of shingles vaccination is currently at 23% which is similar to national levels

Where do we want to be?

- Increase the uptake of pneumococcal and shingles vaccination to meet national targets

How do we get there?

- We will work with Walsall CCG and PCNs to improve vaccination uptake of older people's vaccines
- We will analyse health inequalities in the uptake of pneumococcal and shingles vaccination in Walsall.

Screening

Screening programmes are currently commissioned by NHS England, with UKHSA providing oversight of the programmes. However, local authorities, and Directors of Public Health on their behalf, maintain the responsibility for health protection assurance.

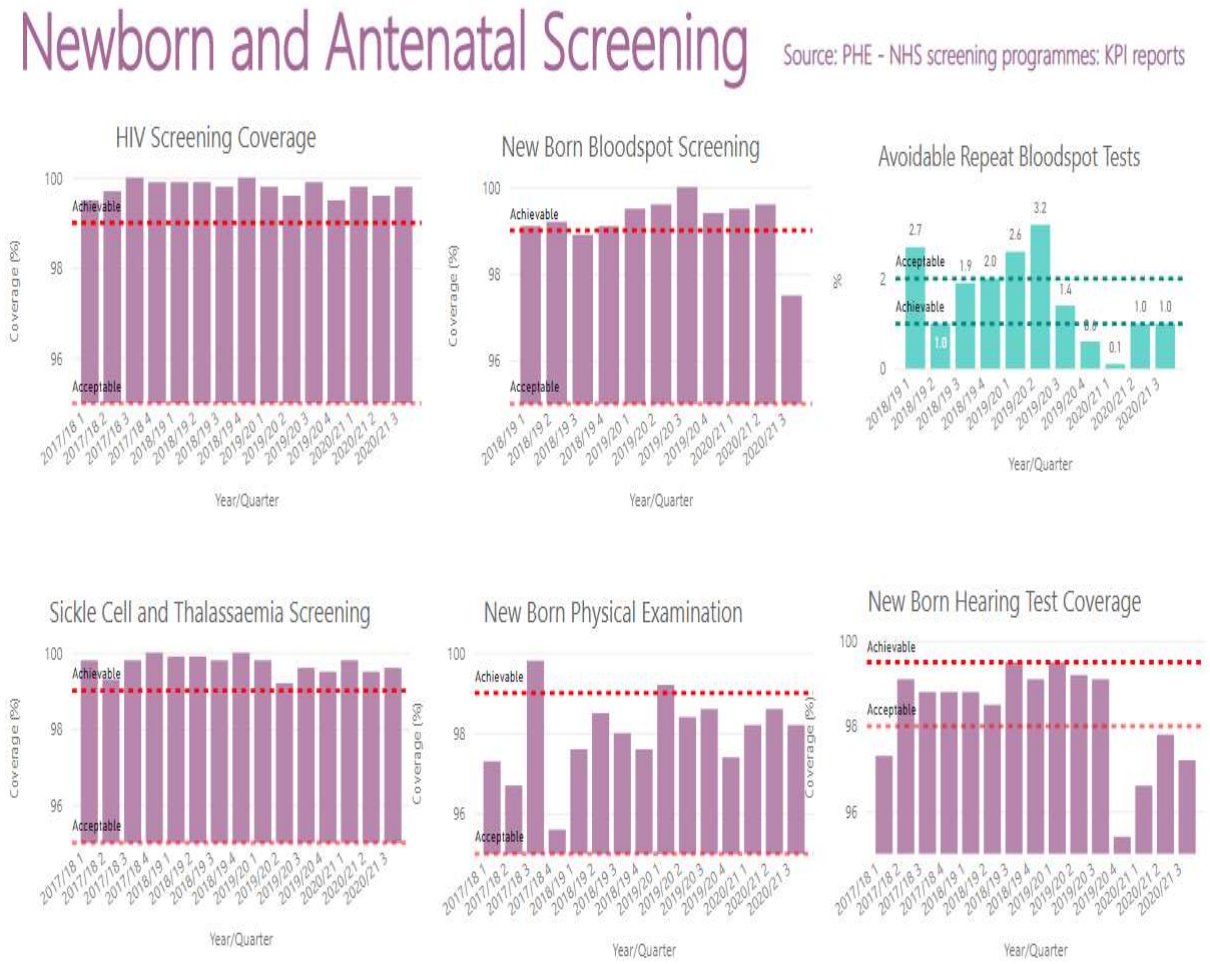
Scope

- Antenatal and new born screening
- AAA screening
- Diabetic retinopathy screening
- Cancer screening – breast, bowel, cervical

Where are we now

New born and Antenatal Screening Programmes

Figure 17: Antenatal and new born screening uptake in Walsall 2017/18 to 2020/21



- The uptake of new born and antenatal screening has remained high in Walsall through the pandemic with the exception of blood spot screening, new born physical examination and new born hearing screening.

Adult Non Cancer Screening Programmes

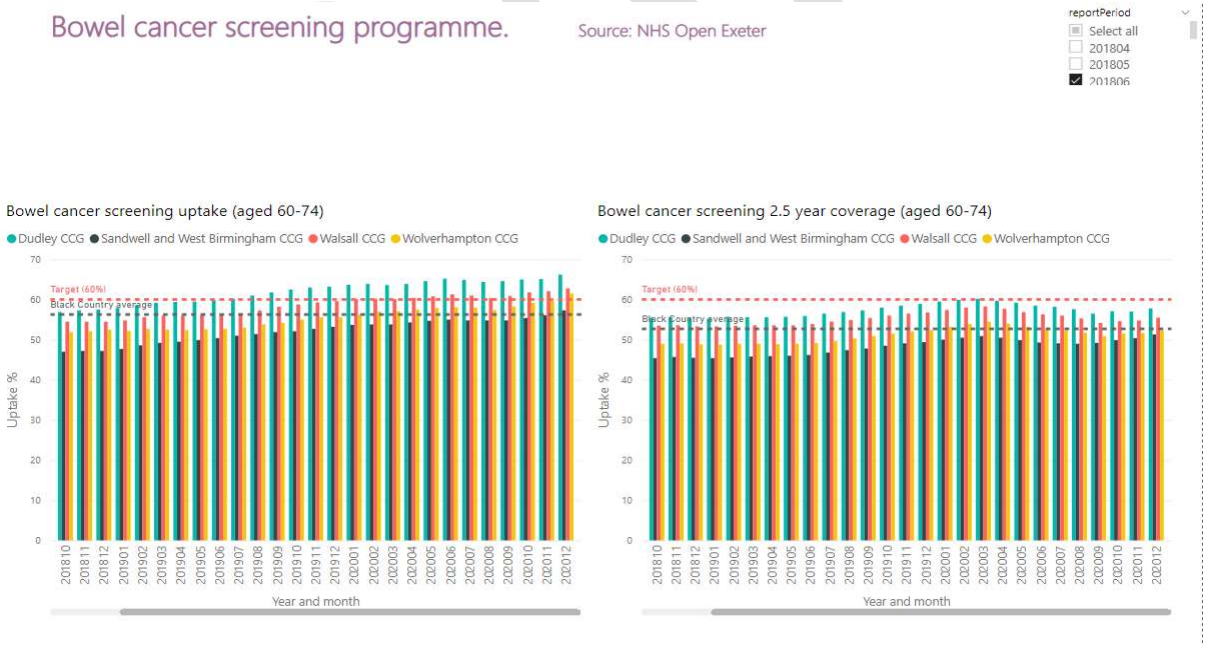
Figure 18: Trends in adult non cancer screening programme in the Black Country

- As seen above there has been a steep decline in the uptake of AAA screening at the point of the implementation of the first lockdown linked to the COVID pandemic. There has been some recovery but uptake remains very poor both in Walsall and nationally.
- Diabetic eye screening has also seen a decline since the onset of the COVID pandemic.

Adult Cancer Screening Programmes

Bowel Cancer Screening

Figure 19: Trends in bowel cancer screening in Walsall



- The bowel cancer screening programme is achieving the target for uptake in 60-75 year olds in Walsall.
- However the bowel cancer screening 2.5 year coverage is not achieving the target.

Figure 20: Uptake of bowel cancer screening in Walsall in comparison to the West Midlands

Compared with England ▪▪▪ Better 95% | Similar | Worse 95% | Not compared

Recent trends: – Could not be calculated | → No significant change | ↑ Increasing & getting worse | ↑ Increasing & getting better | ↓ Decreasing & getting worse | ↓ Decreasing & getting better

Cancer screening coverage - bowel cancer 2020

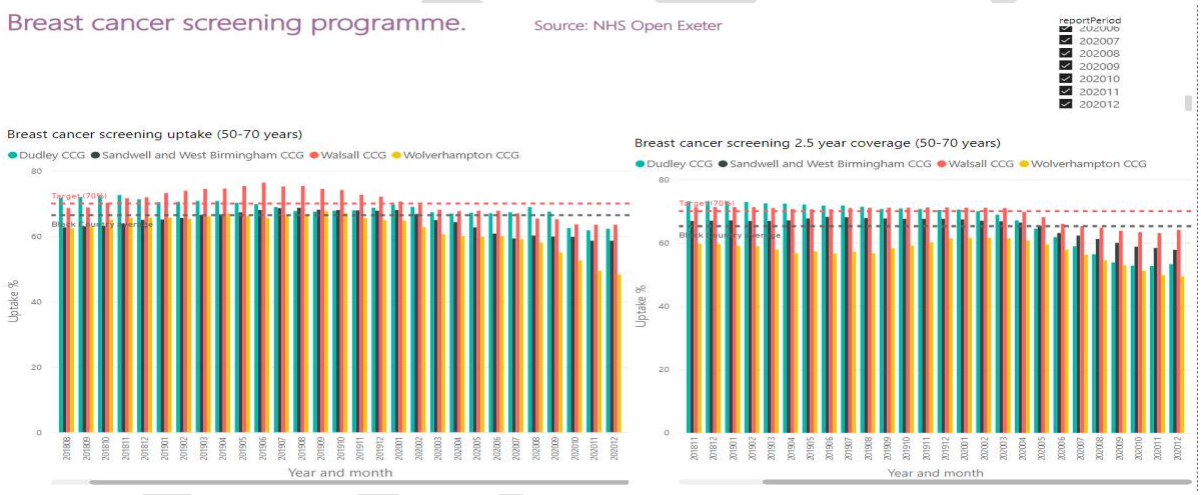
Proportion - %

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↑	5,246,042	63.8*	63.8	63.9
West Midlands region	↑	537,856	62.0*	61.9	62.1
Herefordshire	↑	24,307	67.5	67.0	68.0
Shropshire	↑	40,360	67.4	67.1	67.8
Worcestershire	↑	68,067	66.3*	66.0	66.6
Warwickshire	→	60,521	65.6*	65.3	65.9
Staffordshire	↑	95,383	65.4*	65.2	65.7
Solihull	↑	21,386	64.0	63.5	64.5
Telford and Wrekin	↑	16,698	63.0	62.4	63.5
Dudley	↑	30,585	62.2	61.8	62.7
Walsall	↑	23,202	60.4	59.9	60.9
Coventry	→	24,580	59.2	58.8	59.7
Stoke-on-Trent	↑	21,480	58.9	58.4	59.4
Wolverhampton	→	19,648	56.4	55.8	56.9
Sandwell	↑	23,302	55.5	55.0	56.0
Birmingham	↑	68,337	53.0	52.8	53.3

- However, bowel cancer screening uptake in Walsall at 60.4% is poorer than the England and West Midlands levels.

Breast Cancer Screening

Figure 21: Trends in breast cancer screening in Walsall



- The breast cancer screening programme in Walsall is not achieving targets on uptake or 2.5 year uptake. This decline in performance started prior to the pandemic.

Cervical Cancer Screening

Figure 22: Uptake of breast cancer screening in Walsall in comparison to the West Midlands

Compared with England ▪▪▪ Better 95% | Similar | Worse 95% | Not compared

Recent trends: – Could not be calculated | → No significant change | ↑ Increasing & getting worse | ↑ Increasing & getting better | ↓ Decreasing & getting worse | ↓ Decreasing & getting better

Cancer screening coverage - breast cancer 2020 — Proportion - %

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	→	4,572,938	74.1*	74.0	74.1
West Midlands region	↓	470,561	73.4*	73.3	73.5
Shropshire	↓	33,843	81.1	80.7	81.5
Staffordshire	→	82,774	78.4*	78.2	78.7
Telford and Wrekin	↓	15,642	78.3	77.7	78.8
Worcestershire	↓	57,144	77.5*	77.2	77.8
Stoke-on-Trent	→	19,697	74.5	74.0	75.1
Warwickshire	↓	50,155	74.1*	73.8	74.5
Walsall	→	21,172	73.4	72.8	73.9
Herefordshire	↓	18,082	72.5	71.9	73.0
Solihull	↓	17,785	71.1	70.6	71.7
Dudley	→	25,189	71.1	70.6	71.6
Sandwell	→	22,931	70.4	69.9	70.9
Birmingham	↓	68,374	67.7	67.4	68.0
Coventry	↓	20,456	65.6	65.1	66.2
Wolverhampton	↓	17,317	63.9	63.4	64.5

- The breast cancer screening uptake at 73.4 % is similar to the West Midlands level but below the England levels of 74.1%.

Cervical Cancer Screening

Figure 23: Trends in cervical cancer screening in Walsall

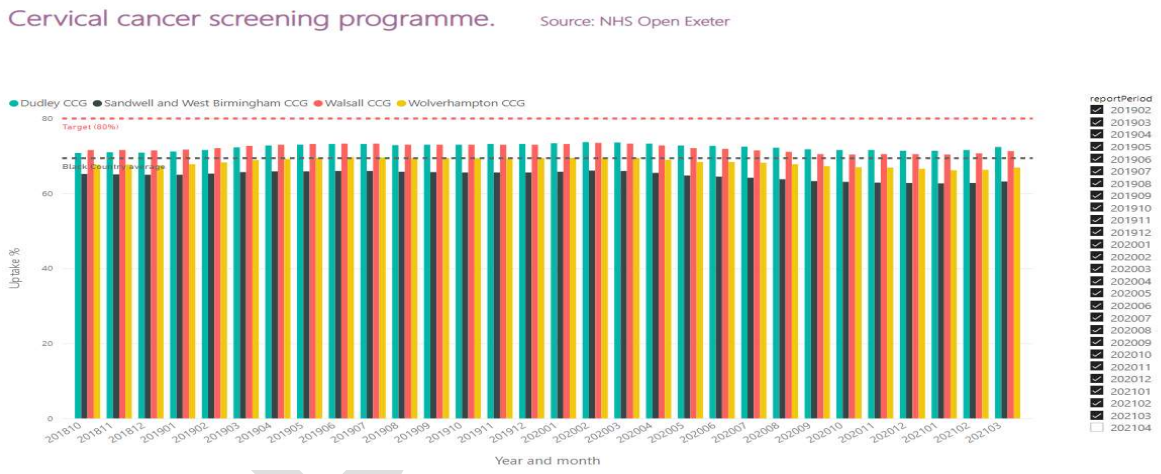


Figure 24: Uptake of cervical cancer screening in Walsall in comparison to the West Midlands

Compared with England ▪▪▪ Better 95% | Similar | Worse 95% | Not compared

Recent trends: – Could not be calculated | → No significant change | ↑ Increasing & getting worse | ↑ Increasing & getting better | ↓ Decreasing & getting worse | ↓ Decreasing & getting better

Cancer screening coverage - cervical cancer (aged 25 to 49 years old) 2020 — Proportion - %

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	→	7,281,502	70.2*	70.2	70.3
West Midlands region	↑	715,135	70.1*	70.0	70.2
Shropshire	↑	33,555	77.5	77.2	77.9
Staffordshire	↑	101,861	75.5*	75.3	75.7
Worcestershire	↑	70,552	75.5*	75.2	75.7
Solihull	→	26,633	73.9	73.5	74.4
Dudley	↑	38,274	73.5	73.2	73.9
Warwickshire	↑	73,073	73.5*	73.2	73.8
Herefordshire	↑	19,452	73.2	72.6	73.7
Telford and Wrekin	↑	22,851	73.1	72.6	73.6
Walsall	↑	35,424	72.0	71.6	72.4
Stoke-on-Trent	↑	31,621	69.4	68.9	69.8
Wolverhampton	↑	33,894	67.4	67.0	67.9
Sandwell	→	42,710	67.1	66.7	67.4
Coventry	↓	43,253	65.1	64.7	65.4
Birmingham	↓	141,982	62.3	62.1	62.5

- Uptake of cervical screening programmes at 72% is higher than the national average
- However the uptake is below the national target of 80%

Where do we want to be?

- To maintain/increase uptake in all screening programmes, with a focus on groups with low uptake, and service-related disparities in uptake. In particular, we would like to focus on
    - Breast and cervical cancer screening
    - AAA
- Age extension of the bowel cancer screening to 50 -59 year olds
- A strategic and joined up approach to address screening and immunisation inequalities and provide for vulnerable groups.

How do we get there?

- Work with the CCG and primary care networks to address bowel cancer screening uptake and address inequalities in uptake
- COVID recovery for AAA, diabetes eye screening programme (DESP), bowel and breast where the services need to be back on schedule with screening

.

Infection Prevention and Control

Infection Prevention and Control is concerned with preventing the spread of infection in health and care settings. Healthcare-associated infections can affect patients of all ages. Healthcare workers, family members and carers are also at risk of acquiring infections when supporting patients. All providers of healthcare services are expected to have appropriate provision for infection prevention and control.

Outbreaks like norovirus within a health or social care setting can impact on the ability to deliver effective services. This can add to severe demands and pressures on resources/systems, especially in the winter season. There is also a significant need for effective infection prevention alongside the healthcare sector, for example within social care settings, schools and nurseries. Significant progress has been made over the last 10 years, both nationally and locally, in reducing rates of health-care associated infections such as methicillin-resistant staphylococcus aureus 10 (MRSA) (which lives on the skin, and in the nose and throat, but can get into the body and cause life-threatening infections) and Clostridium *Difficile* (C. diff) (which causes infectious diarrhoea). Continuing this progress is essential.

Antimicrobial Resistance

Antimicrobials are vital to almost all aspects of modern medicine, including surgery and cancer treatment. AMR describes the change of an organism which makes a previously effective treatment ineffective.

In 2014 the World Health Organization (WHO) raised concerns that globally we are entering a 'post antibiotic' era; organisms and bacteria are developing multiple resistances to available antibiotic and antimicrobial treatments, meaning that common infectious diseases will no longer be able to be treated effectively.

One of the main drivers of AMR is the use of antibiotics. On a global level, it is estimated that AMR is responsible for 700,000 deaths each year which could increase to 10 million deaths per year by 2050 without coordinated action. This includes better sanitation, improved public awareness and a rapidly developed new drug pipeline.

The UK's 20-year vision and 5-year national action plan on AMR 2019-2024[6] were co-developed across government, its agencies, the health family and administrations in Scotland, Wales and Northern Ireland with support from a range of stakeholders. The national action plan builds upon the UK 5-year AMR strategy (2013 to 2018) and sets out the first step towards the UK's vision for AMR in 2040. It focuses on three key ways of tackling antimicrobial resistance:

- Reducing need for, and unintentional exposure to, antimicrobials
- Optimising use of antimicrobials; and
- Investing in innovation, supply and access

The plan also sets out key measures of success to ensure progress towards the 20-year vision which include:

- Halve healthcare associated Gram-negative blood stream infections
- Reduce the number of specific drug-resistant infections in people by 10% by 2025
- Reduce UK antimicrobial use in humans by 15% by 2024

[6] UK 5-year action plan for antimicrobial resistance 2019 to 2024 - GOV.UK (www.gov.uk)

- Be able to report on the percentage of prescriptions supported by a diagnostic test or decision support tool by 2024

Vision

- To reduce the incidence and duration of outbreaks in health and care settings, and
- Develop and deliver a system-wide AMR strategy

Range of Health and Care Settings

- Care sector and community
- Primary care including dentistry
- WHT
- Mental health services (Black Country Mental Health Partnership)

Care sector and community

Where are we now

Nursing and Residential Care Homes

Due to the COVID 19 pandemic care homes undertook annual Infection Prevention and Control (IPC) self-audit. The results of this were as follows:

1. Between 1st April 2020 – 31st March 2021 out of 63 homes on the database (NB 6 of these will be Parklands Court) 55 returned a self-audit (87%)
2. Red-Amber-Green (RAG) rating of the above of the 55 returned self-audits:
   46 (83.6%) were RAG green (score >90%),
   8 (14.5%) were RAG amber (score > or =75%)
   1 (1.8%) was RAG red (score <74%)

This gave the IPC team the space to focus on the COVID response and provide IPC support and education by actively visiting care homes throughout the pandemic.

Domiciliary Care

Domiciliary care sector has been supported initially through weekly providers meetings, ensuring that a constant infection prevention and control presence has been available to answer questions and queries concerning the rapidly changing COVID 19 guidance. The IPC team has continued to provide support to the domiciliary care sector in the form of outbreak management and IPC link worker sessions and IPC webinars.

Link worker sessions offered to all health and social care workers including domiciliary care.

Donning and doffing training: bespoke leaflets explaining personal protective equipment (PPE) and standard precautions were printed out and distributed to all domiciliary care providers for their workforce. They were also given access to the PPE donning and doffing App. “Care at home” IPC workbooks were purchased by the council and offered to all providers for their staff training just prior to the COVID 19 outbreak.

Children’s homes

- Children’s homes in Walsall have been offered training on IPC and donning/doffing of PPE and the management of COVID outbreaks.

Educational settings

- Education settings have received IPC input regarding effective COVID 19 outbreak management, risk assessing, IPC standards such as cleaning, decontamination of a COVID 19 infected environment and respiratory etiquette.
- Education settings have also been provided with resources such as the spotty book, COVID 19 guidance for schools along with regular webinars for out of term activity groups.

Where do we want to be?

- Improved standards of IPC in care homes, domiciliary care settings and schools and childcare facilities, in line with NICE NG63
- Improve IPC awareness with domiciliary care providers

How do we get there?

- Audit of all red and amber rated homes by October 2021; all homes by end of March 2022
- Domiciliary Care annual audits to be considered; adapt existing audit tool for care home to suit the domiciliary care sector
- Reinstate face to face link worker training
- Work with adult social care commissioners to ensure engagement of the care sector (particularly domiciliary care) with link worker training
- Promotion of hand and respiratory hygiene, general IPC and vaccine uptake in a range of settings including **schools and childcare facilities**, in line with NICE NG63

Infection Prevention and Control in Primary Care

Where are we now

- General practice (GP) and dental practice audits have been suspended during the COVID 19 pandemic.
- The Walsall Health Protection team has continued to support outbreak management in primary care. There is a heavy reliance on physical inspections from Public Health. More ownership required from the Practices.
- COVID should have improved and increased awareness around important of IPC.
- Variation in policies and procedures within Practices

Where do we want to be?

- Establish a baseline of performance in infection prevention and control across primary care, working with CCG IPC lead

How do we get there?

- To address the variation between the IPC policies and guidance used at GP surgeries across Walsall, all GP surgeries will be offered access to evidence based infection prevention and control educational workbooks, policies and guidelines, to ensure standardisation of practice in Walsall.
- Updated audit tool for primary care
- Practices will undertake self-audit, with follow up visits by the Health Protection Team to allow more time for training.
- Introduce spot check audits to address areas of concern.
- Work closely with Health Protection and Prevention Specialist within the CCG supporting Practices etc.
- Part of the 2021/2022 Annual IPC audit time is going to be used to discuss updates and new guidance with Lead IPC Practice Nurses, who can then disseminate the information to the rest of the practice staff.
- The Walsall Health Protection Team also plan to attend the CCG-led quarterly Practice Nurse Forum meetings to provide IPC updates.
- The Health Protection Team are working closely with planners and builders to ensure that any new build practices are compliant with infection prevention standards.
- The Health Protection Team will seek slots to speak at Protected Learning Time sessions to reach staff who are unable to attend any other training sessions.

Infection Prevention and Control – Walsall Healthcare Trust

The WHT maintain an annual work plan and report which are signed off by the Trust Board. The summary below captures key highlights from this report.[7]

Where are we now?

- The Trust has achieved the planned infection prevention and control activities outlined in the annual programme 2020/21 including planned audits, teaching sessions and undertook additional duties to support the Trust in response to the COVID-19 pandemic.

- The Trust experienced 2 cases of MRSA bacteraemia during 2020-21 against a target of zero.

- There were 32 toxin positive reportable cases of C. diff against a locally set trajectory of no more than 29 cases, ending the year 3 cases over trajectory.

- Mandatory surgical site surveillance was completed in elective orthopaedic hip and knee replacements for 1 quarter; no infections were identified.

- During 2020/21 the COVID-19 pandemic was a challenging year for the IPC team and Trust wide services, posing additional demand in the prevention and control of infection within healthcare premises.

- The Trust is currently rated red by NHS England and Improvement for Infection Prevention and Control in June 2021 with a revisit due late 2021. The review acknowledged significant improvements in most clinical areas reviewed but with two departments requiring improvement to achieve an overall improved rating.

- A point prevalence study has been undertaken to estimate the burden of healthcare associated infections (HCAI) within WHT in June 2021

Where do we want to be?

WHT would like to

- Achieve a reduction in the proportion of patients developing HCAIs
- Achieve a reduction in the rates of
    - Hospital acquired pneumonia
    - Catheter associated urinary tract infections (UTIs)
    - Surgical site infections
- Meet the nationally set targets for reductions in the following infections
    - C. diff
    - MRSA/methicillin-susceptible Staphylococcus aureus (MSSA)
    - E coli bacteraemia
    - Klebsiella pneumonia

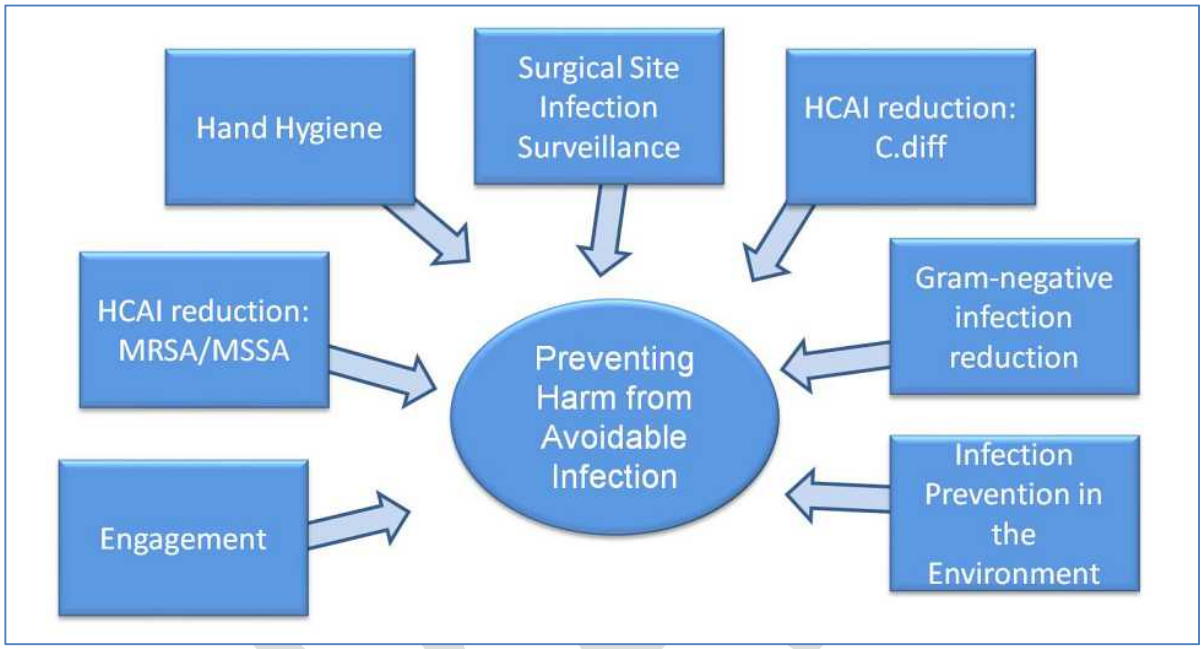
[7] Infection Prevention and Control Annual Report 2020/21, Walsall Healthcare Trust

- Pseudomonas pneumonia
- Carbapenemase Producing Enterobacteria
- Vancomycin resistant enterococcus

How do we get there?

The HCAI work plan for WHT focuses on improving outcomes for patients and provides a framework for the operational work plan.

Figure 25: Conceptual Diagram of the HCAI Work plan for WHT



The work plan will be reviewed on a monthly basis by the Infection Prevention and Control Team and feedback on progress shared at the monthly Infection Prevention and Control Committee.

Infection Prevention and Control - Black Country Healthcare Trust

Where are we now

Black Country Healthcare NHS Foundation Trust is committed to ensuring that a robust IPC function operates within the Trust, which supports the delivery of high-quality healthcare and protects the health of those who use its services. IPC is an integral part of the way in which the Trust operates. In the last twelve months the IPC focus for the Trust has been on:-

- A continued and ongoing response to the COVID-19 Pandemic.
- Delivery of the Trusts IPC annual work-plan.
- Merging the former Black Country Partnership and Dudley and Walsall Mental Health Partnership Trust's IPC Teams work streams and policies and ensuring that monitoring systems are in place across new divisional structures.
- Reviewing and strengthening the IPC resource within the Trust and recruiting new members to the team.
- IPC input to key estates projects including refurbishments and new builds.
- Water Safety Management.
- Delivering the Seasonal influenza staff and service user vaccination programme.
- Supporting the Trusts regulatory and mandatory requirements and ensuring IPC is at the centre of the Trusts governance frameworks.

Where do we want to be?

The above areas remain highly pertinent for the Trust to focus on over the next twelve months. A number of additional specific priorities are also identified below:-

- Improved uptake of Seasonal flu and COVID-19 vaccines through Trust wide vaccination programmes.
- Work to strengthen practice to support appropriate urine sampling and UTI pathways along with appropriate antibiotic prescribing.
- Continued work to support the national aim to reduce gram negative bloodstream infections.
- Continuation of the 'Mouthcare Matters' quality improvement project including ongoing training and development to support consistent use of oral hygiene assessment tool and care pathway.

How do we get there?

- Retaining the existing high profile and focus on IPC from Board to Ward through strengthened leadership, clear plans and effective infection prevention and control governance structures within the organisation.
- Embedding of new structures and roles within the IPC team.
- Re energising the IPC Link worker programme across the organisation as a vehicle to embedding effective infection prevention and control practice.
- Developing and implementing a robust vaccination programme and utilising quality improvement methodology to support and underpin this.
- Effective links and partnership work with IPC colleagues at a PLACE and system level and ongoing active involvement with NHSE/NHSI IPC networks to support continued improvement and best practice.

Communicable diseases

The vision for this strategy is to use our networks and data to recognise and manage cases, clusters, outbreaks and incidents of infectious disease in partnership with UKHSA.

- Sexually transmitted infections, including HIV
- TB
- Viral Hepatitis

Sexually Transmitted Infections

Where are we now

Figure 26: Sexually transmitted infections in Walsall

Indicator	Period	Walsall			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
New STI diagnoses (exc chlamydia aged <25) / 100,000	2019	↓	1,296	733	701	900	4,418		0
All new STI diagnosis rate / 100,000	2019	↓	1,823	639	655	816	360		3,915
STI testing rate (exc chlamydia aged <25) / 100,000	2019	↓	18,767	10,612	15574	19654	4,694		83,173

Overall, the number of new sexually transmitted infections (STIs) diagnosed among residents of Walsall in 2019 was 1,823. The rate was 639 per 100,000 residents, lower than the rate of 816 per 100,000 in England, and similar to the average of 637 per 100,000 among its nearest neighbours.1

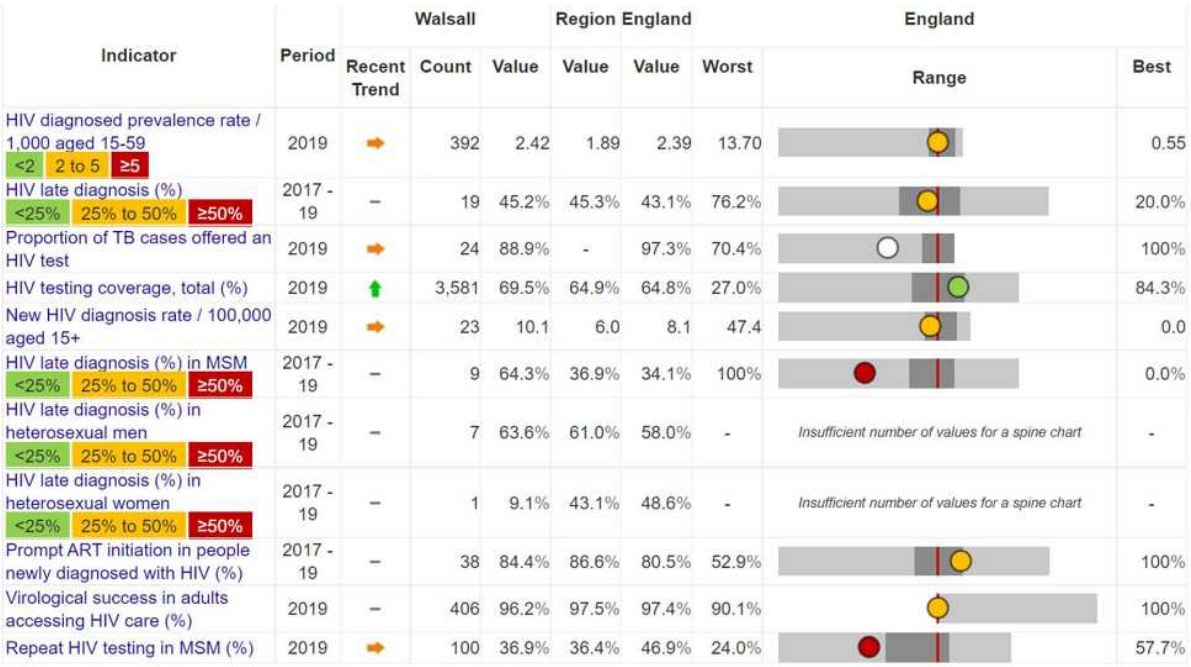
- Walsall ranked 63rd highest out of 149 upper tier local authorities (UTLAs) and unitary authorities (UAs) for new STI diagnoses excluding chlamydia among young people aged 15-24 years in 2019, with a rate of 733 per 100,000 residents, better than the rate of 900 per 100,000 for England.

Figure 27: Sexually transmitted infections in Walsall: Syphilis, Gonorrhoea and Chlamydia

Indicator	Period	Walsall			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Syphilis diagnostic rate / 100,000	2019	→	31	10.9	7.6	13.8	168.4		1.8
Gonorrhoea diagnostic rate / 100,000	2019	↑	313	110	99	123	1,112		20
Chlamydia detection rate / 100,000 aged 15 to 24 <1900 1900 to <2300 ≥2300	2019	↓	499	1,497	1698	2043	1,136		5,583
Chlamydia proportion aged 15 to 24 screened	2019	↓	3,283	9.8%	15.3%	20.4%	8.6%		50.4%

- The chlamydia detection rate per 100,000 young people aged 15-24 years in Walsall was 1,497 in 2019, in comparison to a rate of 2,043 for England.
- The rank for gonorrhoea diagnoses (a marker of high levels of risky sexual activity) in Walsall was 51st highest (out of 149 UTLAs/UAs) in 2019. The rate per 100,000 as 110, in comparison to a rate of 124 in England.

Figure 28: HIV in Walsall



Indicator	Period	Walsall			Region	England		England	
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
HIV diagnosed prevalence rate / 1,000 aged 15-59 <2 2 to 5 ≥5	2019	→	392	2.42	1.89	2.39	13.70		0.55
HIV late diagnosis (%) <25% 25% to 50% ≥50%	2017 - 19	–	19	45.2%	45.3%	43.1%	76.2%		20.0%
Proportion of TB cases offered an HIV test	2019	→	24	88.9%	-	97.3%	70.4%		100%
HIV testing coverage, total (%)	2019	↑	3,581	69.5%	64.9%	64.8%	27.0%		84.3%
New HIV diagnosis rate / 100,000 aged 15+	2019	→	23	10.1	6.0	8.1	47.4		0.0
HIV late diagnosis (%) in MSM <25% 25% to 50% ≥50%	2017 - 19	–	9	64.3%	36.9%	34.1%	100%		0.0%
HIV late diagnosis (%) in heterosexual men <25% 25% to 50% ≥50%	2017 - 19	–	7	63.6%	61.0%	58.0%	-	*Insufficient number of values for a spine chart*	-
HIV late diagnosis (%) in heterosexual women <25% 25% to 50% ≥50%	2017 - 19	–	1	9.1%	43.1%	48.6%	-	*Insufficient number of values for a spine chart*	-
Prompt ART initiation in people newly diagnosed with HIV (%)	2017 - 19	–	38	84.4%	86.6%	80.5%	52.9%		100%
Virological success in adults accessing HIV care (%)	2019	–	406	96.2%	97.5%	97.4%	90.1%		100%
Repeat HIV testing in MSM (%)	2019	→	100	36.9%	36.4%	46.9%	24.0%		57.7%

- Among sexual health service (SHS) patients from Walsall who were eligible to be tested for HIV, the percentage tested in 2019 was 69.5% (64.8% in England).
- The number of new HIV diagnoses among people aged 15 years and above in Walsall was 23 in 2019. The prevalence of diagnosed HIV per 1,000 people aged 15-59 years in 2019 was 2.4, similar to the rate of 2.4 in England. The rank for HIV prevalence in Walsall was 51st highest (out of 149 UTLAs/UAs).
- In Walsall, in 2017 - 19, the percentage of HIV diagnoses made at a late stage of infection was 45.2%, similar to 43.1% in England

Where do we want to be?

A sustained reduction in the transmission of HIV and STIs; based on the following –

- Early detection in conjunction with rapid and successful treatment alongside partner notification
- Open-access to sexual health services for the prevention, diagnosis, treatment, and care of STIs
- Universal services delivered to the general population as well as focus on groups with greater sexual health needs, including young adults, black ethnic minorities and men who have sex with men (MSM).
- Promotion of correct and consistent use of condoms as an extremely effective way to prevent STI and HIV transmission.
- Detection and treatment of chlamydia infection is central to chlamydia control activities. The Public Health Outcomes Framework (PHOF) includes a measure of chlamydia detection, with a recommendation that local areas achieve an annual detection rate of at least 2,300 per 100,000 15-24 year old population

- Expanded HIV testing to reduce late diagnosis of HIV (a PHOF indicator), undiagnosed HIV infection and onward HIV transmission
- Sustained reduction in gonorrhoea transmission ensuring treatment-resistant strains of gonorrhoea do not persist and spread.

How do we get there?

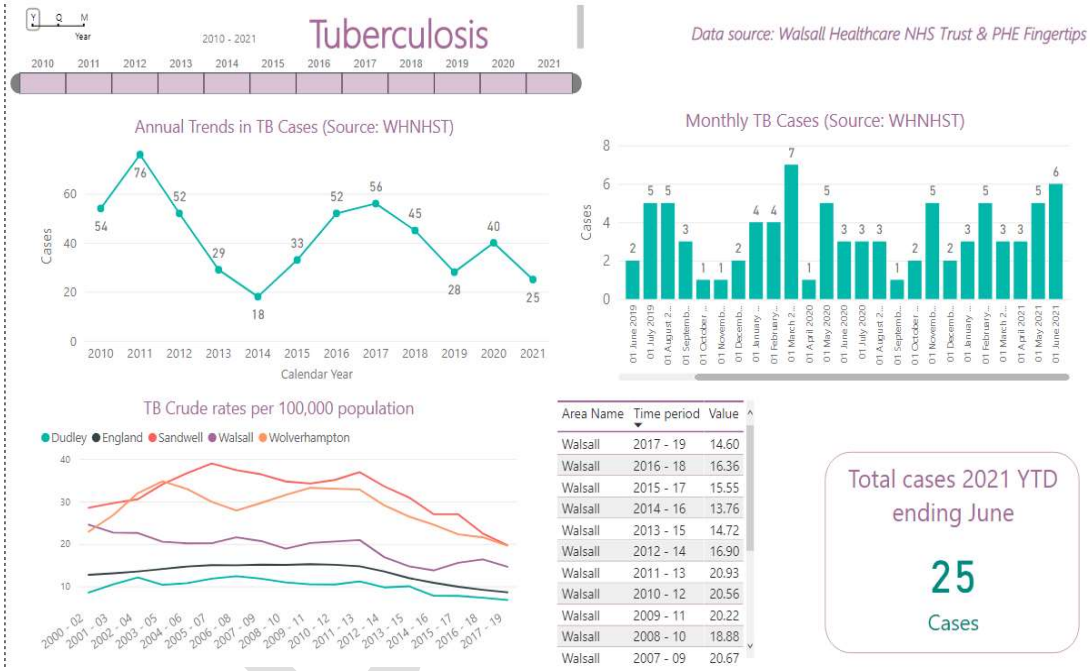
- There are several approaches to the prevention of HIV transmission and continued funding in prevention activities remains critical to control HIV.
- Routine HIV testing in primary care and for people who are admitted to hospital.
- HIV tests offered and recommended to all eligible attendees, especially MSM, black Africans and attendees born in countries with a diagnosed HIV prevalence >1%.
- MSM and black Africans should be encouraged to have frequent and regular HIV tests at sexual health services or other settings where HIV testing is offered.
- Early detection and treatment of chlamydia infection is central to chlamydia control - effective, high quality patient pathway is in place with treatment and partner notification standards being met.
- Prompt diagnosis and treatment gonorrhoea according to national treatment guidelines, testing for antibiotic resistance and identifying and managing potential treatment failures effectively
- Re-testing after a positive diagnosis within 3 months of initial diagnosis, and screening annually and on change of sexual partner.
- Promotion and take up of self-assessment and self-sampling STI and HIV kits on-line.
- Reduce stigma and other socio-cultural barriers that prevent people from testing and seeking long-term care must be strengthened.
- Establish joint working between substance misuse and sexual health services to ensure an integrated approach to care.
- Environmental Health - Working in conjunction with the Health Protection team to help them identify and jointly visit high-risk premises, including sex establishments, to look at enhanced infection control in relation to STI. The aim is to work with the identified businesses is to voluntary establish a regime of enhanced infection control this will be a joint collaboration utilising the expertise of the Health Protection team in relation as well as promoting key issues such as screening and testing.

Tuberculosis

TB is an infectious disease that usually affects the lungs, although it can affect almost any part of the body. TB rates in England have decreased dramatically over the last century.
TB is a disease associated with inequality. In England in 2016, the incidence rate of TB in the non-UK born population was 15 times higher than the rate in the UK born population. Of the total number of TB cases among people born in the UK in 2010 to 2015, 18.2% had a social risk factor (history of drug misuse, alcohol misuse, homelessness or imprisonment) which is 2.6 times higher than the percentage among non-UK born people.
The UKHSA has launched a five year action plan to drive down TB cases in England. The significant impacts of the pandemic require renewed effort to eliminate TB. The TB Action Plan for England, 2021 to 2026 focused on five key priority areas to reduce the incidence of TB[8].

Where are we now

Figure 29: Trends in the Incidence of tuberculosis Walsall



- The incidence of TB in Walsall has been declining over recent years to 14.6/100,000. This mirrors national trends.

[8] Tuberculosis (TB): action plan for England - GOV.UK (www.gov.uk)

Figure 30: TB incidence and treatment completion rates for Walsall

Better 95% | Similar | Worse 95% | Not compared

Indicator	Period	England	West Midlands region	Birmingham	Coventry	Dudley	Herefordshire	Sandwell	Shropshire	Solihull	Staffordshire	Stoke-on-Trent	Telford and Wrekin	Walsall	Warwickshire	Wolverhampton	Worcestershire
TB incidence (three year average)	2017 - 19	8.6	10.4	20.1	20.8	6.8	2.4	19.7	1.5	4.2	3.8	9.4	5.1	14.6	4.8	19.6	3.2
Proportion of drug sensitive TB cases who had completed a full course of treatment by 12 months	2018	83.6	84.0	86.3	89.6	82.6	57.1	91.8	57.1	66.7	84.6	80.0	-	73.8	77.3	84.0	82.6
Proportion of TB cases offered an HIV test	2019	97.3	-	97.5	95.1	100	-	98.2	-	100	100	95.0	90.0	88.9	94.1	93.8	100
Proportion of pulmonary TB cases starting treatment within four months of symptom onset	2019	69.1	65.9*	67.9	65.8	77.8	-	67.9	-	-	69.2	64.3	-	78.3	44.4	57.1	37.5

- 73.8% of drug sensitive TB cases completed a full course of treatment within 12 months. This is lower than the national average of 83.6%
- 89% of TB cases were offered HIV testing in 2019
- 78% of all TB cases started treatment within 4 months of symptom onset. This compares favourably with the national average of 69%.

The annual cohort review for TB in Walsall for 2019 identified the following:

- Delays in presentation to health care
- Delays in referral of TB to secondary care
- High rates of treatment completion

Where do we want to be?

- To improve prompt diagnosis of suspected TB, and reduce delays in presentation to healthcare
- Continue to maintain high treatment completion rates,
- Strengthen the latent TB case finding programme
- Arrangements in place to support TB patients with social risk factors during diagnosis and treatment including those who are homeless and those with no recourse to public funds.
- Focus on education of health professionals regarding epidemiology of TB, when to "think TB", and thereby reduce delays in referral to secondary care

How do we get there?

TB Service

- To develop the Latent TB Infection screening service within the TB service.

Latent Tuberculosis Infection (LTBI) Screening

- Increase throughput in LTBI screening

Other

- Continued participation in quality initiatives including cohort review
- Engagement with all GP Practices to improve early identification and management of TB

- Raise TB awareness among high-risk communities to improve knowledge and early diagnosis in under-served groups.
- Strengthen partnerships for managing patients with complex medical and social needs

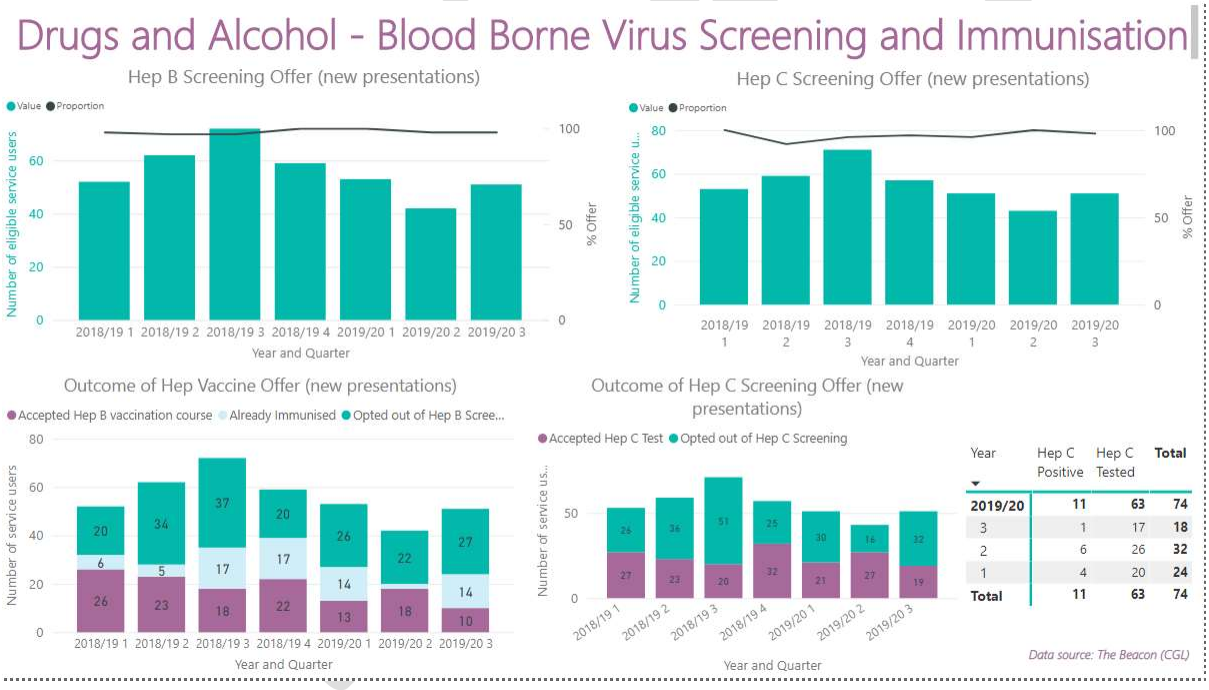
Viral Hepatitis (Hepatitis B and C)

Hepatitis C is a blood borne virus that is often asymptomatic, and symptoms may not appear until the liver is severely damaged. Consequently, many individuals with chronic infection remain undiagnosed and fail to access treatment.

Direct-acting antiviral (DAA) medications, a new class of drugs for the treatment of hepatitis C, came to market in 2014. The combination of over 90% cure rates, shorter course duration and fewer side effects have transformed prospects for disease control. Regular, confidential hepatitis C testing of people who inject drugs, with linkage to treatment and care services, is a major component to hepatitis C control.

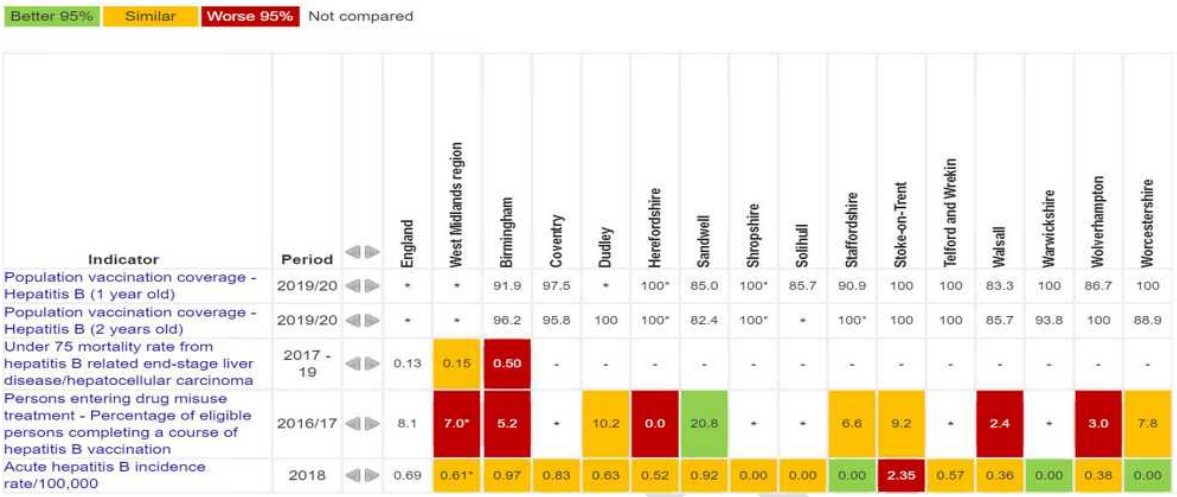
Where are we now

Figure 31: Hepatitis B and C screening for substance misuse patients in Walsall



- The offer of Hepatitis B and Hepatitis C screening remains high in Walsall

Figure 32: Hepatitis B incidence, vaccination rates and mortality in Walsall

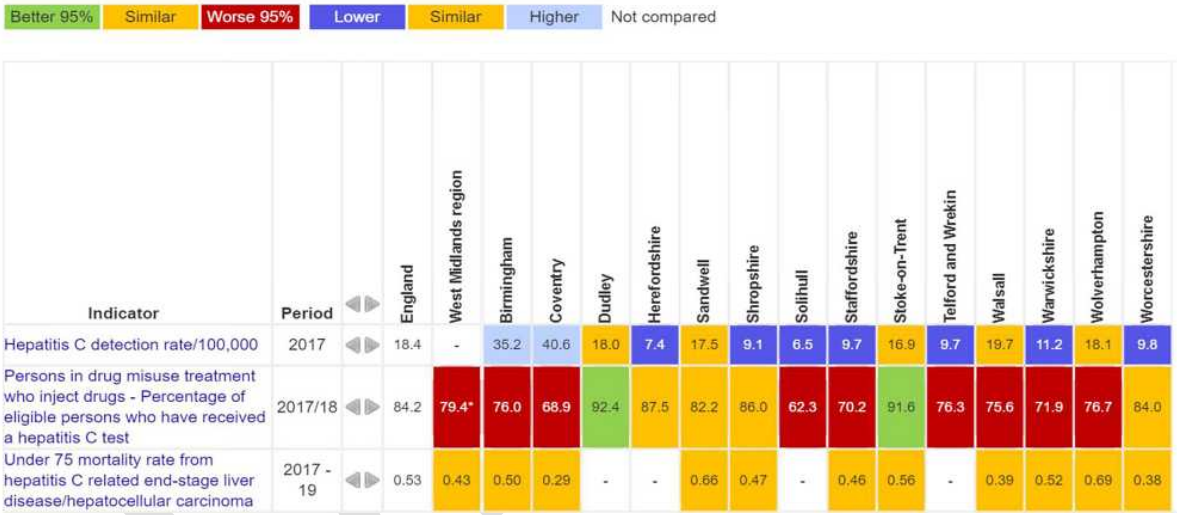


Better 95% | Similar | Worse 95% | Not compared

Indicator	Period	England	West Midlands region	Birmingham	Coventry	Dudley	Herefordshire	Sandwell	Shropshire	Solihull	Staffordshire	Stoke-on-Trent	Telford and Wrekin	Walsall	Warwickshire	Wolverhampton	Worcestershire
Population vaccination coverage - Hepatitis B (1 year old)	2019/20	*	*	91.9	97.5	*	100*	85.0	100*	85.7	90.9	100	100	83.3	100	86.7	100
Population vaccination coverage - Hepatitis B (2 years old)	2019/20	*	*	96.2	95.8	100	100*	82.4	100*	*	100*	100	100	85.7	93.8	100	88.9
Under 75 mortality rate from hepatitis B related end-stage liver disease/hepatocellular carcinoma	2017 - 19	0.13	0.15	0.50	-	-	-	-	-	-	-	-	-	-	-	-	-
Persons entering drug misuse treatment - Percentage of eligible persons completing a course of hepatitis B vaccination	2016/17	8.1	7.0*	5.2	*	10.2	0.0	20.8	*	*	6.6	9.2	*	2.4	*	3.0	7.8
Acute hepatitis B incidence rate/100,000	2018	0.69	0.61*	0.97	0.83	0.63	0.52	0.92	0.00	0.00	0.00	2.35	0.57	0.36	0.00	0.38	0.00

- The proportion of eligible persons entering drug misuse treatment who complete a course of Hepatitis B vaccination is very low at 2.4%

Figure 33: Hepatitis C incidence, screening and mortality rates in Walsall



Better 95% | Similar | Worse 95% | Lower | Similar | Higher | Not compared

Indicator	Period	England	West Midlands region	Birmingham	Coventry	Dudley	Herefordshire	Sandwell	Shropshire	Solihull	Staffordshire	Stoke-on-Trent	Telford and Wrekin	Walsall	Warwickshire	Wolverhampton	Worcestershire
Hepatitis C detection rate/100,000	2017	18.4	-	35.2	40.6	18.0	7.4	17.5	9.1	6.5	9.7	16.9	9.7	19.7	11.2	18.1	9.8
Persons in drug misuse treatment who inject drugs - Percentage of eligible persons who have received a hepatitis C test	2017/18	84.2	79.4*	76.0	68.9	92.4	87.5	82.2	86.0	62.3	70.2	91.6	76.3	75.6	71.9	76.7	84.0
Under 75 mortality rate from hepatitis C related end-stage liver disease/hepatocellular carcinoma	2017 - 19	0.53	0.43	0.50	0.29	-	-	0.66	0.47	-	0.46	0.56	-	0.39	0.52	0.69	0.38

- The proportion of eligible persons in drug misuse treatment who are screened for Hepatitis B is 75% which is lower than the England and West Midlands levels
- The Hepatitis C detection rate and under 75 mortality from Hepatitis C remain similar to national levels

Where do we want to be?

- Achieve high rates of Hepatitis B Virus (HBV) vaccination coverage in all high-risk groups, as per NICE QS65. Increase uptake of appropriate Hepatitis B vaccinations for individuals in high risk groups and contacts of cases.
- Reduce the spread of Hepatitis B/C through appropriate targeted testing and screening and engagement with treatment.

- Increase testing for HBV and Hepatitis C Virus (HCV) in primary care and secondary care for all patients within higher risk groups for infection, including those from intermediate and high-risk countries
- To develop high quality treatment for those diagnosed, and the public health management of contacts

How do we get there?

- Appropriate targeted testing and screening and engagement with treatment.
- Support commissioned Sexual Health and Drug and Alcohol service providers to increase appropriate identification, treatment and vaccination within their service area.
- Embed NICE guidance into future commissioning planning and service specifications for treatment and care of individuals with Hepatitis B/C.

A healthy environment

The environment is increasingly recognised as a key element in protecting and improving the public's health. Environmental public health forms part of a broader national and international environmental and public health agenda. Much of this must be developed, customised and delivered locally with local partners including the NHS, Public Health England, other government departments and agencies, the voluntary sector, and many others.

- Land contamination
- Air quality

Land Contamination

As with many other industrialised nations, the UK has a legacy of contaminated sites, including former factories, mines, steelworks, refineries and landfills. At these sites, there can be a variety of potentially harmful substances such as oils and tars, waste metals, organic compounds, gases and mining materials that are left over from, or created by, historical activities on site.

The legal framework established to deal with contaminated land in England is Section 57 of the Environment Act 1995 which created Part 2A of the Environmental Protection Act 1990 Land is only considered to be "contaminated land" in the legal sense, if it poses a sufficiently high risk to justify action, and meets the criteria for Part 2A.

Where are we now?

- We have an up to date database of contaminated land sites which lists the former Willenhall Town gas works

Where do we want to be?

- We will work with UKHSA and Pollution Control on matters including risk assessment and risk communication.
- Work with UKHSA to support the development of 'Do's and Don'ts' advice to use when communicating with members of the public.

How do we get there?

- We need to have an up to date Contaminated Land Strategy
- We need to ensure that a robust risk assessment process is in place to support decision making on remedial action for contaminated land

Air Quality

The major pollutants in urban environments, particulate matter (PM 2.5 and PM 10, which are particles with diameters smaller than 2.5µm and 10µm respectively) and nitrogen dioxide (NO_2), derive predominantly from transport. Committee on the Medical Effects of Air Pollutants (COMEAP) provides independent advice to government departments and agencies on how air pollution impacts on health[9].

Where are we now

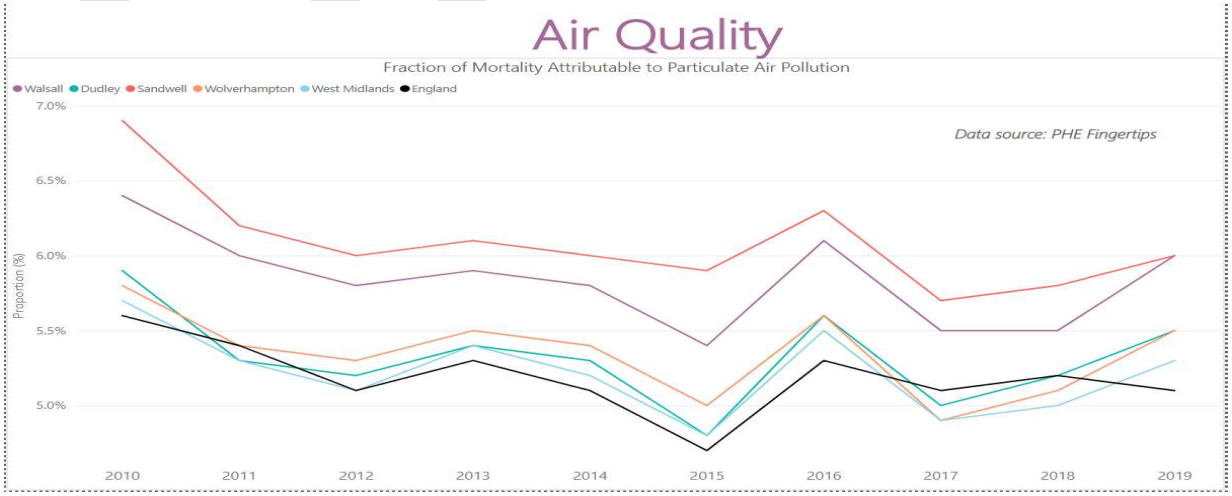
Figure 34: PM 2.5 levels in Walsall, 2019

Air pollution: fine particulate matter 2019 — Mean - µg/m3

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	-	9.0	-	-
West Midlands region	–	-	9.4	-	-
Sandwell	–	-	10.7	-	-
Walsall	–	-	10.5	-	-
Birmingham	–	-	10.3	-	-
Coventry	–	-	10.0	-	-
Solihull	–	-	9.8	-	-
Wolverhampton	–	-	9.7	-	-
Dudley	–	-	9.6	-	-
Stoke-on-Trent	–	-	9.2	-	-
Warwickshire	–	-	9.1	-	-
Staffordshire	–	-	9.0	-	-
Worcestershire	–	-	8.4	-	-
Telford and Wrekin	–	-	8.1	-	-
Herefordshire	–	-	7.4	-	-
Shropshire	–	-	7.3	-	-

- PM 2.5 levels in Walsall are amongst the highest in the West Midlands and considerable higher than the England average

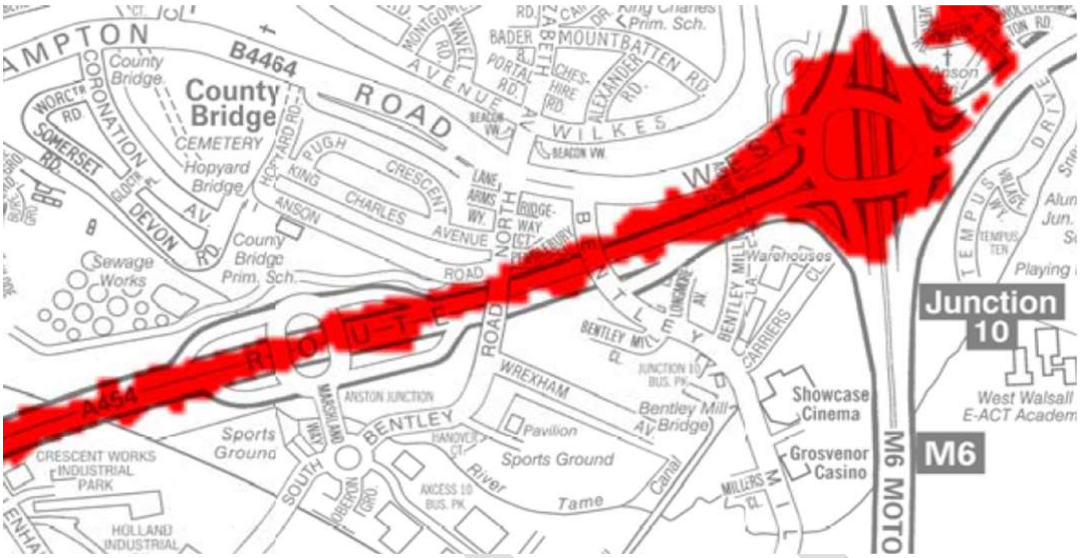
Figure 35: Trends in the fraction of mortality attributable to particulate air pollution in Walsall, 2010 - 2019



- The fraction of mortality attributable to air pollution has been declining, however, at 6% it remains significantly higher than the England average of 5.1%

[9] Committee on the Medical Effects of Air Pollutants - GOV.UK (www.gov.uk)

Figure 36:Map showing NO2 exceedances in Walsall



- There had been a recent decline in NO_2 levels across Walsall
- However, there is a continued exceedance of NO_2 levels in parts of the borough adjoining the M6

Where do we want to be?

- To reduce the concentrations of air pollutants which have a negative impact on health, with a focus on areas of poorest air quality
    - Continued drop in concentrations of $N0_2$
    - Reduction in levels of PM 2.5
- Reduced use of cars for short journeys
- An increase in the development and use of cycle paths

How do we get there?

- Establishment of an air quality alliance to meet regularly and identify areas for collaborative action
- Targeted active travel schemes to be explored and introduce in poor air quality areas
- Explore opportunities for improving fleet vehicles
- We will support the development of an air quality ‘early warning’ system to serve sufferers of respiratory disease in Walsall

Health emergency planning

There is a single framework for civil protection, which places a legal responsibility on local responders with a clear set of responsibilities. Walsall Council must ensure that we are capable of responding to a major incident of any scale in a way that delivers optimum healthcare, assistance to the victims, minimises the consequential disruption to healthcare services, and more importantly bring about a speedy return to normal business.

Some NHS incidents may present a major threat to public health; predominantly health protection issues, whereas others may present a threat to, or require special arrangements of health services.

The Civil contingencies Act (2004) places a legal obligation on Local Authorities to have in place a full set of civil protection duties, requiring them to:

- Assess the risk of emergencies occurring and use this to inform emergency planning and business continuity planning
- Put in place emergency plans
- Put in place business continuity plans
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency
- Share information with other local responders to enhance co-ordination
- Co-operate with other local responders to enhance co-ordination and efficiency.

Where are we now

Incident response plans within health protection include:-

Health Protection and Outbreak Plan

A framework to enable a co-ordinated response to an incident or outbreak; including procedures to ensure outbreaks of communicable disease, infection or chemical incidents are effectively investigated, controlled and evidenced (for legal purposes), and that, where possible measures are taken to prevent similar incidents in the future.

Heatwave and Cold Weather Plans

A response framework for a prolonged period of severe hot or cold weather, following Department of Health guidance. It outlines roles and responsibilities, local command and control and route of escalation to a multi-agency response.

Pandemic Flu Plan

Pandemic influenza remains one of the top risks on the National Risk Register as one of the most severe natural challenges likely to affect the UK. Walsall's Flu Plan was reviewed in January 2020 following various multi-agency exercises and the National Resilience Standards #15 - Pandemic Influenza Preparedness. The Pandemic flu plan is currently undergoing an update in light of the learning from the COVID-19 pandemic.

Where do we want to be?

- Strengthen our response to major incidents and emergencies, including pandemic influenza
- To develop a comprehensive system wide pandemic flu plan
- Focus on continuous improvement in outbreak planning arrangements
- Improve support and advice to care homes and domiciliary services in relation to responding to and preparing for managing an infectious disease incident, responding to severe weather events.

How do we get there?

National changes are being made with the implementation of the UKHSA, and locally Walsall CCG has now formally merged with Dudley, Sandwell & West Birmingham and Wolverhampton CCGs to form the Black Country & West Birmingham CCG.

To enable Walsall Council to plan for and respond to a wide range of infectious disease outbreaks, incidents or emergencies that could affect health or patient care we will ensure arrangements for responding to emergencies are flexible and can be scalable and adaptable to work in a wide-range of specific scenarios. This will be achieved by working with partners within the health economy to ensure that we protect the public with integrated local response plans that are resilient, proportionate, flexible and maintainable in responding to an incident.

- Ensuring all plans are updated to reflect the changes within the CCG and where necessary review any Service Level Agreements to outline the roles and responsibilities of partners to enable smooth escalation and response to incidents
- Conduct multi-agency stress-test exercises to identify good practice, share new ideas and identify potential gaps or issues within the planned response
- Ensure preparedness plans are regularly reviewed to ensure they reflect the latest expert advice and national guidance
- Attend link worker training to provide support and advise to care homes and domiciliary workers on long-term planning and year-round work to reduce the impact of climate change and ensure maximum adaption to reduce harm from heatwaves.

Environmental Health

Food Safety

SCOPE

There are approximately 2300 registered food businesses in Walsall, which include a broad sector of the food industry. The Food Safety team helps to protect public health from food borne disease, contaminated food and undeclared allergens by implementing a programme of inspections; investigating complaints about hygiene, malpractices and food poisoning; food sampling; providing advice to businesses; and, when necessary, instigating formal enforcement action.

The delivery of the team's food safety services were restricted during 2019 and 2021 because of the need for Officers to undertake Covid-19 regulatory duties and because of restrictions imposed on businesses and working practices. Currently, reported team outputs are not representative of the scope of the team's work because of Covid-19. Instead, outputs for 2019 are detailed below to provide a representation of the scope of service delivery.

FOOD SAFETY TEAM – REPORTED OUTPUTS 2019	
Programmed food hygiene inspections	589
Inspections of new unrated food businesses	186
Investigation of food complaints	422
Emergency closure of food businesses	4
Hygiene Improvement Notices served	4
Food borne infectious diseases	215

WHERE ARE WE NOW?

During 2020/21 the service was compelled to deliver controls prioritised by the Food Standards Agency (FSA) to provide short-term responses during the pandemic including remote proactive assessment/surveillance of businesses and the investigation of food complaints and foodborne diseases. The controls delivered in 2020/21 included:

FSA COVID-19 PRIORITISED CONTROLS 2020/21
120 remote assessments of non-compliant food businesses (Food Hygiene Ratings of 0, 1 or 2)
10 remote assessments of overdue Category A and B food businesses.

From 1st January 2021 until the year to date the service completed:

SERVICE DELIVERY FROM 1ST JANUARY 2021 TO YEAR TO DATE	
Programmed inspections of food businesses	63
Inspections of unrated food businesses	104
Food related complaints/enquiries	347
New registrations of food businesses	293
Emergency closure of food businesses	2
Service of Improvement Notices	2
Notifications of Infectious Disease	193

WHERE DO WE WANT TO BE?

The service aims to prevent unsafe practices and foodstuffs, and outbreaks of communicable diseases by delivering at an operational level the following:

In July 2021, following the easing of Covid-19 restrictions, the FSA introduced a national Recovery Plan requiring local authorities to re-set their interventions programmes. The deadlines set by the Recovery Plan will require:

- The inspection of 600 businesses rated A, B, C (less than Broadly Compliant), D (less than Broadly Compliant) and C (Broadly Compliant) by the end of 2022/23.
- The inspection of approximately 320 existing unrated businesses by the end of 2022/23 and the inspection of new businesses that will register during this period (300 new food business registrations can be expected annually).
- Responding to food related complaints, notifications of infectious diseases, and registrations of new food businesses received during 2021/22. The received volumes of these respective service demands are likely to be in line with reported outputs for in 2019

HOW WILL WE ACHIEVE THIS?

- Implementation of the Food Law Enforcement Service Plan 2021/22 and compliance with the requirements of the FSA Recovery Plan
- Responding to complaints about trading practices and the completion of investigations within service standards' timescales.
- Carrying out a reactive microbiological food sampling programme focusing on high risk premises and manufacturers
- Instigation of formal enforcement action and legal proceedings in respect of cases posing serious risk to public health as they arise in 2021/22.
- Responding to all Infectious Disease notifications using response times developed by the UKHSA
- Maintenance of the Food Hygiene Rating System

SKIN PIERCING ACTIVITIES

SCOPE

Unsafe or unhygienic practices by tattooing/body piercing practitioners can lead to the risk of transmission of blood-borne viruses, for example Hepatitis B, Hepatitis C, Hepatitis D or HIV that can affect the health of both clients and practitioners. Additionally, poor practice may result in localised skin infections at the site of the tattoo or piercing. Therefore, practitioners must follow safe working practices and infection control practices at all times.

The Local Government (Miscellaneous Provisions) Act 1982 requires the registration of persons and premises carrying on the practices of acupuncture, tattooing, ear piercing or electrolysis. The Health and Safety at Work etc. Act 1974 requires good standards through the maintenance of established hygiene controls in respect of premises, equipment, procedures and practices.

The present system of registration does not allow regulators to specify conditions, qualifications and competency requirements, or to remove anyone from a practitioner register

The current regulatory regime does not extend to wider emerging aesthetic invasive treatments for which there is no requirement to carry out infection control inspection.

WHERE ARE WE NOW?

The table below shows the number of registrations within Walsall for persons to carry out different Skin Piercing Activities.

NUMBER OF REGISTRATIONS IN WALSALL FOR SKIN PIERCING ACTIVITIES	
Tattooists	467
Ear Piercing	152
Electrolysis	7
Acupuncturist	36
Total	**662**

In 2020/21 Environmental Health received 43 applications for registration to carry on skin piercing activities.

All new applications are registered and are subject to a full inspection of Health and Safety and infection control. Additionally, new and existing businesses receive advice and support relating to enhanced infection control.

Officers liaise with the UKHSA and Public Health to ensure that all information provided to practitioners is in accordance with national and local protocols/best practice. Within these teams, learning about new procedures is shared as it emerges.

Membership of the West Midlands inter-authority Special Treatments Group which shares knowledge and intelligence about best practice, non-compliance, progressive treatments, issues of concerns and collaborative working.

WHERE DO WE WANT TO BE?

- Identify all unregistered practitioners within the borough and secure their registration.
- Secure the compliance of all practitioners within the borough.
- Continue to secure and maintain good standards through the maintenance of established hygiene controls in respect of premises, equipment, procedures and practices.
- Educate the public to use legitimate registered practitioners and to prevent the operation of "Scratchers" in Walsall (Scratchers are tattoo artists that operate outside of studios and have taught themselves how to tattoo rather than being professionally trained).
- Develop best practice in relation to dealing with the Public Health risk associated with emerging and novel invasive treatments legally administered by non-medical practitioners
- Working with "training" academies/schools setting up training practitioners including collaborative work with Walsall Public Health infection control team, regional partners, UKHSA relating to best practice and running events such as train the trainer.

An amendment to the Health and Care Bill, which is currently at the Committee stage, seeks to introduce a national licensing scheme for cosmetic procedures in England. Environmental Health supports this amendment and aims to be able to implement the provisions on the Bill once they become law.

HOW DO WE GET THERE?

- Registration of new applicants within service standard timescales with a follow up full inspection of Health & Safety and infection control measures.
- Responding to complaints about unregistered practitioners and unsafe or unhygienic practices and the completion of investigations within service standards' timescales.
- Instigation of formal enforcement action and legal proceedings in respect of cases posing serious risk to public health.
- Responding to all Infectious Disease notifications associated with Skin Piercing times within response times developed by the UKHSA.
- Continued membership of the West Midlands inter-authority Special Treatments Group
- Social Media campaigns including Twitter and Council web pages to heighten public awareness of public health risks posed by Skin Piercing Activities and safe practices

- Tracking the progress of the enactment of Health and Care Bill and the timely implementation of new legislative provisions as required.
- Continue collaborative work with the UKHSA and Public Health to for purpose of sharing best practice with practitioners.

Legionella

SCOPE

Legionnaires' disease is a severe form of pneumonia caused by the bacterium Legionella pneumophila which is common in natural water sources. Outbreaks occur because of exposure to Legionella in man-made water systems where water is maintained in conditions conducive for the rapid growth of the organism. These systems can be both commercial and domestic hot and cold water systems.

The Health and Safety at Work etc. Act 1974 requires employers and persons in control of work premises to take precautions to control the risk of exposure to legionella. Environmental Health has powers to inspect potential sources associated with cases, clusters and outbreaks to review risk assessments, to monitor and enforce legislation relating to legionella and to undertake sampling.

The Notification of Cooling Towers and Evaporative Condensers Regulations 1992 requires the registration of cooling towers or evaporative condensers located within the borough.

The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations requires employers to report cases of legionella occurring in employees who have worked on cooling towers or hot water systems.

WHERE ARE WE NOW?

There are currently 12 premises and 15 cooling towers or evaporative condensers registered with Walsall Council.

Environmental Health contributed to the recently published Chartered Institute of Environmental Health national guidance on the management of increased risk of Legionella in hot and cold water services serving premises which had been closed for prolonged periods during periods of Covid lockdown.

During 2020/21 advisory letters were sent to 458 identified premises, including hotels, leisure facilities, gyms, and private members clubs etc., deemed to be at a higher risk of legionella due to their water systems following Covid-19 lockdown. This was reinforced by officer follow up visits in a number of cases.

In 2020/21 a car wash and 2 domestic house water systems were associated with cases of Legionella and were dealt with during this period.

During 2020/21 3 UKHSA legionella notifications were received and investigated by Environmental Health. Their investigation included sampling of water systems.

WHERE DO WE WANT TO BE?

- No reported cases, clusters and outbreaks of legionella associated with local authority enforced premises.
- Duty holders to properly manage the risk of legionella associated with cooling towers, evaporative condensers and hot and cold water systems.

HOW DO WE GET THERE?

- Targeted visits by Officers to premises where we are aware that the Duty Holder is not properly managing water systems and therefore Legionella risks.
- Investigation of complaints concerning work-related disease.
- Continue to work with businesses to educate and inform them about their legal responsibilities regarding water systems and Legionella. This includes the production and issue of guidance and mailshots for businesses potentially at risk of Legionella.
- Enforcement action including Improvement and Prohibition notices where there is a serious risk or duty holder not willing to manage risks.
- Investigate notifications of Legionella from UKHSA.

Health and Safety at work

SCOPE

Workplace accidents and work related ill health continue at a significant level. Within Great Britain, work related ill health and occupational disease affects up to 1.6 million workers (source Health and Safety Executive [HSE]). LA and Environmental Health (EH) departments have a key role in helping deliver England's wider health and work priorities. Local Authorities as well as the HSE do this through their specific roles as independent regulators enforcing the requirements of the Health and Safety at Work etc. Act 1974 and the associated regulations. The essence of this legislation is to prevent a person's exposure to harm in or from a workplaces activity.

The main types of businesses that LAs regulate include Service, Warehousing and Wholesale, Retail and Residential Care Homes. The table below shows the number of Health and Safety related visits/contacts/reports made to Environmental Health for the period: 1st April 2019 to 31st March 2020.

HEALTH AND SAFETY REGULATION 2019/20	
Accident Notifications/Investigations (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations [RIDDOR])	121
Unsatisfactory premises/poor working conditions	13
Health and Safety enforcement	35
Health and Safety enquiries	24
Skin Piercing activities complaints	18
Improvement Notices served	2
Prohibition Notices served	8

WHERE ARE WE NOW?

Environmental Health activity relating to health and safety is very broad and regulated by only a small team of officers, and includes:

a. the proactive inspection of high risk businesses, locally determined, and those businesses which form part of priority visits which is determined through the – "National Code" and LAC 67/2 (Local Authority Circular) from the HSE,
b. contact with, where necessary, by visits to businesses where there has been a request for service, complaint made, or allegations of unsafe or harmful work practices,

c. take samples/arrange for samples to be taken, where there may be a potentially harmful workplace/environment,
d. take proportional enforcement action to secure compliance with the relevant health and safety legislation,
e. work with other enforcement partners to help secure legal compliance,
f. undertakes investigations and criminal investigations where there are serious risks to health or safety, or legal breaches have been identified,
g. undertake investigations for potential causes or sources for work related accidents/diseases. These are typically notified through the Reporting of Injuries, Diseases and Dangerous Occurrences system (this is where certain accidents, incidents and diseases are reported to this department via the HSE) or via Health Security Agency (HSA, formally known as the PHE),
h. inspect licensed asbestos removal works, as appropriate,
i. provide advice and work with businesses to assist them in meeting their compliance with health and safety legislation and advice around workplace health,
j. permit officers to attend training, so they can better inform businesses and carry out investigations as necessary,
k. working with other agencies to reach additional businesses, and to help the department target its limited resources to keep employees and public safe.

WHERE DO WE WANT TO BE?

Improved health and safety compliance in Walsall.

Reduced notifiable incidents, dangerous occurrences and cases of work-related illness in local authority enforced premises.

HOW DO WE GET THERE?

Through regulatory and advisory activities and supporting/influencing wider health interventions when they are related to work matters within the Walsall Local Authority enforced sector including:

- Investigate notifiable incidents, dangerous occurrences and cases of work-related illness in accordance with national incident selection criteria.
- Investigate complaints about health, safety and welfare in workplaces.
- Inspection of high risk premises in accordance with inspection programme.
- Provision of advice to businesses on a needs basis including HSE led initiatives (LAC 67/2) and in respect of matters of imminent concern.

Health and Wellbeing Board

25 January 2022

Walsall Safeguarding Partnership (Children and Adult's) Annual Reports 2020-21

For Assurance

1. Purpose

It is important that the Health and Wellbeing Board is sighted on the work, priorities, assurances or developments being progressed by the Safeguarding Partnership. Shared areas of interest and the opportunity for shared understanding have led to the Annual Report being presented as part of the routine interconnectivity and governance between the two boards.

2. Recommendations

2.1 That the Board note the content of the Annual Reports.

2.2. That the Board consider, as part of future business, any opportunities for collaboration on joint issues.

3. Report detail

Children

3.1 Although this year has been challenging due to a pandemic, there continues to be evidence that children are safe in Walsall (data on page 8 of full report):

I. An appropriate reduction in referrals to MASH
II. Positive impact of Early Help services
III. Positive reductions seen in the number of children subject to child protection plans
IV. Positive increase of the number of families supported through the Family Safeguarding Model

3.2 Partnership focus on safeguarding has continued through regular meetings between statutory partners despite the challenges brought by the pandemic.

3.3 Attendance at multi-agency meetings has improved, particularly since they moved online. This virtual or blended approach allows for greater flexibility moving forward.

3.4 A successful bid to the TCE (Tackling Child Exploitation) Programme saw work with local colleagues begin to develop work in relation to community resilience and engagement and consider the role which the wider community can take in developing an effective, strategic all-age response to exploitation.

3.5 The CSA Strategy was updated and re-agreed by partners and an action plan developed.

3.6 The Neglect Strategy was revisited to bring a renewed focus.

3.7 Progress was made with the All-Age Exploitation pathway and included the development of an Exploitation Hub.

3.8 The multi-agency audit programme continued to obtain learning in order to improve practice and saw improvements in the case ratings.

3.9 During the year there were 5 multi-agency audits carried out, 4 were linked to the safeguarding partnership priorities and one (during quarter three) was in response to the 3.10 Parliamentary Under- Secretary of State for Children and Families request for assurance in respect of services to new-borns and infants during lockdown . In respect of the latter, all the children had been seen by the relevant multi-agency professionals with good recording regarding whether this was face to face or virtually. All case files audited had relevant risk assessments in place and PPE was utilised appropriately as required for in person contact. There was consistent evidence of good information sharing across agencies. Needs identified during assessment were being met and children and their families were being supported. Where risks had escalated, there was clear evidence that the appropriate actions had been taken to respond and consider these in a multi-agency forum, leading to an initial child protection plan for one infant.

3.11 Work has taken place to embed the SARC (Sexual Assault Referral Centre) pathway, supported by SARC Lunch and Learn training sessions.

3.12 An independent review (by Penny Thompson, CBE) commissioned by the 3 statutory partners in Autumn 2020 to consider the first year of the new arrangements was a proactive and positive undertaking. The report commented on the committed and effective Safeguarding Partnership Business Unit and the openness, candour and self-reflection demonstrated by the partnerships leaders.

3.13 Approaching the end of the contract held by the previous Independent Chair (Liz Murphy) the statutory partners reflected on the independent scrutiny of the Safeguarding Arrangements and opted to re-appoint an Independent Chair. Recruitment took place in the early part of 2021 with the new post holder (Sally Hodges) commenced in April 2021.

3.14 **Areas for improvement or focus in 2021-22**

I. To implement recommendations made by Penny Thompson in her independent review of the Safeguarding Partnership Arrangements, including creating an Executive Group and reducing the number of partnership priorities to provide more focus and impact.

II. To consider and implement recommendations from the Wood Review.

III. Progression and sign off the All-Age Exploitation Strategy.

IV. Revision and continued delivery of the Neglect Strategy.

V. To review the participation strategy to ensure we effectively engage with young people and practitioners and improve our communication with partners

VI. Implementation of the ICON Programme across Walsall

VII. Strengthen the links between the Family Safeguarding model and Walsall Safeguarding Partnership

VIII. Develop a positive and productive relationship between Safeguarding Partnership and the Safer Walsall Partnership

IX. Due to Covid-19 there was limited inspection activity of the statutory partners during this year. Once this re-commences the Partnership will be sighted on and respond to the respective findings.

X. Track the impact that learning from our reviews and audits have had by carrying out a range of assurance activities and engaging with practitioners.

XI. To embed Impact Evaluations across the Partnership as part of management oversight and supervisions.

Adult's

3.15 Despite the pandemic, there continues to be evidence of awareness of the safeguarding adults agenda as the number of safeguarding concerns that are being raised has increased from 2019-2020.

3.16 Adults continue to be consulted with and their desired outcome of the safeguarding concern captured, there are only a consistent low number of adults not asked their outcomes alongside a reduced number of outcomes not achieved. This can be due to outcomes not being realistic and unable to be achieved e.g. a police prosecution.

3.17 The numbers of individuals where a risk was identified, was reduced or removed was 82% (compared with 89.8% during 2019-2020) of cases showing positive outcomes for adults in Walsall.

3.18 The continuation of the Quality in Care Team has proved invaluable during the pandemic, ensuring homes have adequate personal protective equipment and access to regular advice and information from the team. This has ensured that care standards are monitored and improving. This was further evidenced through the Provider Collaboration Review carried out by change to; the Care Quality Commission during July 2020.

3.19 The Partnership held weekly Safeguarding Meetings in response to the pandemic to ensure a collective ownership and accountability of safeguarding practice, between Police, Health and Local Authority (adults and children) and regular key messages were developed and distributed to keep the wider workforce informed.

3.20 A variety of high quality learning opportunities were offered throughout the pandemic. The rapid lockdown meant that all planned learning had to move from face to face to virtual and this was managed very effectively. Given the additional pressures on partners as a result of the pandemic the engagement has been encouraging and we now have a wealth of recorded webinars on the website. A number of comments in the evaluations highlighted that those who attended would be cascading their learning to others so the learning is reaching further than the Partnership set out to.

3.21 Additionally, partners continued to contribute to multi-agency audits over the year which assisted in ensuring greater consistency of practice. Some engagement from partners was impacted by the pandemic including the vaccination roll out but enough multi-agency contributors made the audits worthwhile and provided quality assurance in key areas of the partnership work.

3.22 Progress was also made on reviewing forms and guidance, this included:

I. A Review of the Adult Safeguarding Concern Form

II. Development and roll out of the Safeguarding Medication Guidance

III. Review of the Decision Making Support Tool

IV. Assurance exercises in relation to caused enquires and Position of Trust to begin to quality assure how partners are embedding these processes

3.23 Towards the end of the year WSP commissioned an Independent Review of its Arrangements, ensuring there was an equal voice for all partners. The purpose was to review the effectiveness of the Local Safeguarding Arrangements and the robustness of quality assurance arrangements.

3.24 However, there is still some work to do to ensure we are an effective learning system, this includes:

I. Finalising and implementing an All-Age Exploitation Strategy

II. Completion and implementation of the multi-agency revised Self Neglect Pathway, Guidance & Governance structure

III. Implementing the findings from the WSP Review of its arrangements

IV. Capturing the views adults with care and support needs who have experienced safeguarding to shape strategy, planning and service delivery needs

V. Increasing the conversion rate of safeguarding enquiries through raising awareness and understanding of the legal framework within the partnership

VI. Contribute to embedding the Domestic Abuse Strategy for the Partnership

VII. Measuring the impact of reviews and audits has had on adult safeguarding practice

VIII. Embedding the new Learning Disability Partnership Board

IX. Embedding Impact Evaluations across the Partnership as part of management oversight and supervisions

X. Revisiting the Practice Improvement Strategy and Competency Framework, to explore any gaps in the learning and development offer

XI. Continue the quality assurance work on Caused Enquiries and Position of Trust

Looking Forward (2021-22):

3.25 We (WSP) have agreed a smaller set of priorities for the forthcoming year, these are focused on Adult Neglect, Child Neglect and All-Age Exploitation.

3.26 We will continue to monitor the impact of Covid-19 and the increased service demand this may bring and look to reset the way we conduct our business by learning from good practice from this year and we will also focus on embedding our revised arrangements.

3.27 We will be further engaging with the voluntary and community sector to capture the views of adults with care and support needs. We will use this feedback to shape strategy, planning and service delivery.

3.28 We will also be closely tracking the impact that learning from our reviews and audits have had by carrying out a range of assurance activities and engaging with practitioners.

4. Implications for Joint Working arrangements:

a. The requirements of the partnership arrangements are set out in the Care Act 2014 and Working Together 2018.
b. The Business Unit which supports the arrangements is joint funded through the Local Authority, Clinical Commissioning Group and West Midlands Police.

5. Health and Wellbeing Priorities:

5.1 This annual report and the priorities and work of the Safeguarding Partnership has associations to all of the HWBB priorities, to a greater or lesser extent. The success or otherwise of safeguarding practice will directly impact on individuals abilities to achieve other positive outcomes sought by the HWBB (and Marmot principles), such as being ready to start school and access education, good mental health, making positive contributions to communities.

5.2 Safeguarding: This report is an overview of safeguarding partnership activity, assurance and priorities.

Background papers

The overview detailed above is taken from the full Annual Report for the Children's Safeguarding Partnership, which can be accessed on the WSP website here, are embedded below and attached.

Safeguarding Children's Annual Rep

Safeguarding Adult's Annual Report 2020 -

Author

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Organisation

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Walsall Safeguarding Adults Board

(part of Walsall Safeguarding Partnership)

Annual Report

2020 - 2021

Walsall Safeguarding Partnership

Right for Children, Families and Adults

Contents

Introduction

Thank you for taking the time to read Walsall Safeguarding Partnership (WSP) Adults Annual Report which covers the period 1st April 2020 to 31st March 2021

The report is published by Walsall Council, West Midlands Police and Walsall Clinical Commissioning Group (CCG) (merged to Black Country and West Birmingham Clinical Commissioning Group from 1st April 2021). Walsall has local arrangements to support the co-ordination, quality assurance and continuous improvement of activity to safeguard individuals across the life course and incorporate the statutory functions of the Safeguarding Adult Board.

This year we have drawn information from our subgroups, the work commenced around our engagement strategy and included, as statutory guidance requires, information about completed Safeguarding Adults Reviews (SARs) and other reviews.

2020-21 was a challenging year with the Pandemic however, the Care Act easements, created under the Coronavirus Act did not alter the adult safeguarding provisions and protections in Walsall. WSP continued to exercise oversight over adult safeguarding, whilst mindful of the pressure that health, police, social care and care providers have been and continue to be under. During the Pandemic, WSP held weekly partnership meetings to review how services have been responding to the challenges that the virus has created.

We have maintained close oversight on arrangements led by the Police, CCG and the Local Authority to Safeguarding Adults. We maintain a close focus on our safeguarding adult reviews and on learning from our assurance activity.

There is, of course, more to do and more that should be done to continue to improve safeguarding services and become an effective learning system.

The Partnership would like to thank agencies for the work they have done to keep our communities safe and to respond to the needs of adults at risk of abuse and neglect in Walsall.

We would like to express thanks to Liz Murphy as Independent Chair for her Leadership and the work that she has helped progress during this reporting period and welcome our new chair Sally Hodges to Walsall Safeguarding Partnership from 1st April 2021.

Kind Regards

Sarah Barker / Lisa Burn
Business Manager / Assistant Business Manager
Walsall Safeguarding Partnership

Walsall 'At a glance'

There are 20 x wards within 4 Localities in the Walsall Borough, 63% of the Walsall population are aged over 18yrs, of these, 23% are aged 65yrs or over.

Adults aged over 65yrs live predominantly in the East locality, Streetly Ward has the highest population of over 65's closely followed by Aldridge and Pelsall, typically more affluent areas and least deprived areas of Walsall

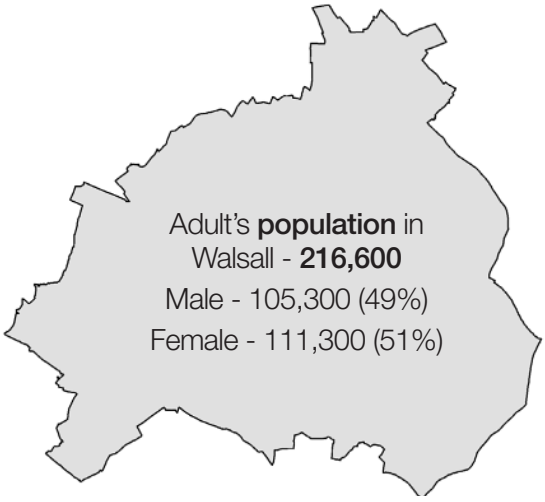
Life expectancy in Walsall is lower than regional & national comparators, Females 82 years old, Males 77 years old. However, females have a lower 'healthy' life expectancy of only 57.2yrs of 'good' health. Females in Walsall live 30% of their life in 'poor health' compared to males at 25%

56.8% adults are physically active in Walsall, this is significantly worse than the national average of 66.4% (2019-20)

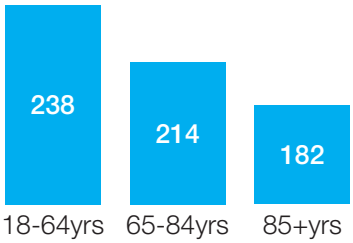
Sources; Public Health England – LA Health Profile-fingertipstool

Walsall Insight – www.walsallintellinge.org

2020/21 data should be regarded as provisional pending validation and publication by NHS Digital



Age of Adults at point of S42



Concerns	Enquiries	Conversion
2,563	766	29.7%
(2,311-19/20)	(645-19/20)	(27.9%-19/20)

Of the Individuals that progressed to S42

Ethnicity of Adults at S42	
White/ British	87.5%
Asian/ British	7.9%
Black/ British	2.4%
Mixed/Multiple	1.1.%
Other/Unknown	1.2%

86% were asked & expressed their Desired Outcomes at S42

Top 3 Types of Abuse at Section 42 Conclusion		
379 Neglect	196 Psychological	181 Physical
Financial Abuse now ranks in 4th place compared to 2nd in 2019/20		

57% Desired Outcomes fully achieved and 34.6% were partially achieved

73.6% "I feel as safe as I like"
84.6% ''My Care & Support services help me in feeling safe" (2019-20)

Source of Risk at S42 Enquiry		
Known to Individual	Provider	Unknown to Individual
58% (440)	38% (294)	4% (29)

82% Risk Removed or Reduced at point of concluded S42

- Concerns are reports into the local Adult Safeguarding process for consideration for a safeguarding enquiry
- An enquiry is any action that is taken (or instigated) by a local authority under Section 42 of the Care Act 2014, in response to indications of abuse or neglect in relation to an adult with care and support needs who is at risk and is unable to protect themselves because of those needs

About Walsall Safeguarding Partnership

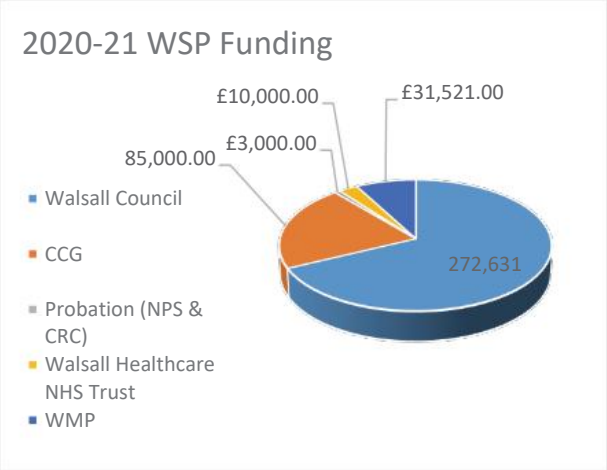
Walsall Safeguarding Partnership incorporates the statutory functions of the Safeguarding Adults Board. The job of the Partnership is to make sure that there are arrangements in Walsall that work well to help protect adults with care and support needs from abuse or neglect.

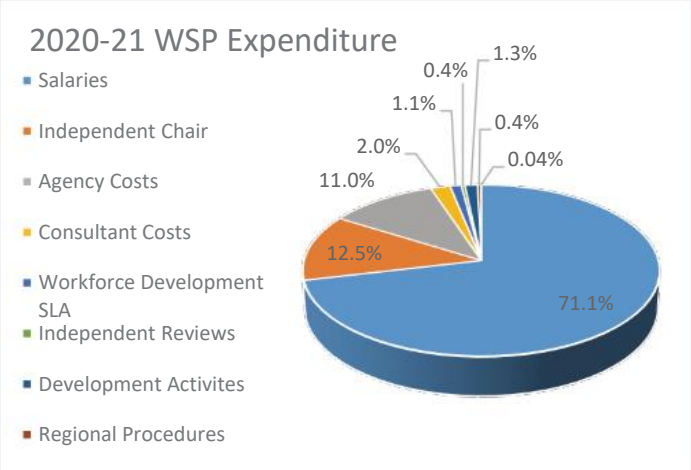
The statutory functions of the Safeguarding Adults Board are:

- To publish a Strategic Plan
- To publish an Annual Report detailing what the Board has done to achieve its objectives and implement its plans
- To conduct Safeguarding Adult Reviews (SARs) in accordance with Section 44 of the Care Act This report seeks to outline how partners in Walsall have delivered these functions.

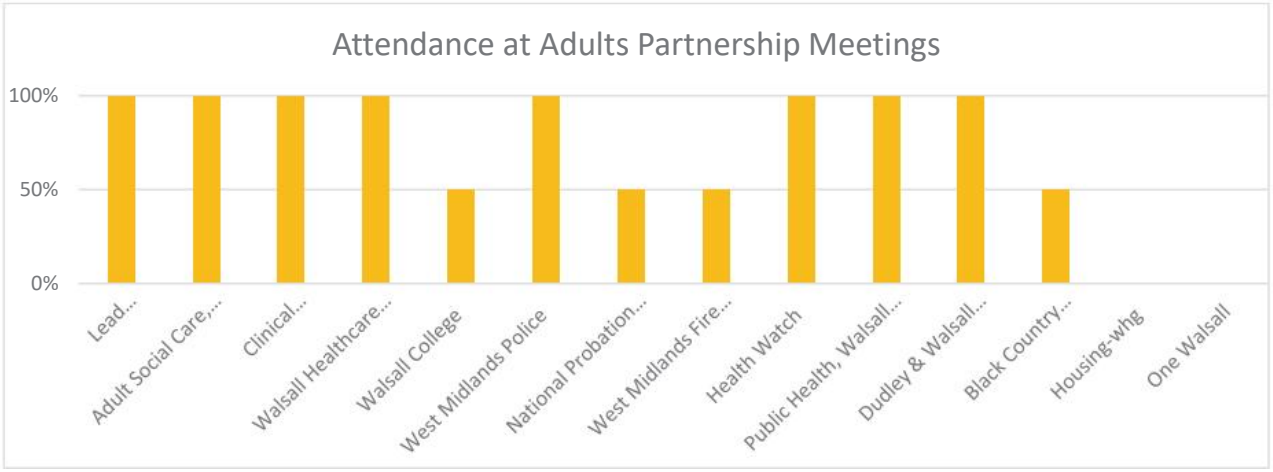
Statutory responsibility for WSP sits with Walsall Council. The Care Act also defines the Clinical Commissioning Group (CCG) and Police as statutory board partners for safeguarding adult arrangements. These agencies jointly fund the Business Unit and associated activities between them with additional contributions from Walsall Healthcare Trust and Probation Services.

In 2020-21 the partnership had £402,000 pooled into a partnership budget. This money was used to pay for Business Unit Staffing, the Independent Chair, Regional Procedures, Service User Involvement, Consultancy, Training, and to keep some saved in case of the need to carry out Safeguarding Adults Reviews.





During 2020-2021 the Partnership held two meetings virtually and covered a wide range of business including progress reports from subgroups on work plans and WSP priorities and assurance reporting.



What the Partnership has focussed on over 2020/21

During this year, not only have we focused on our strategic priorities, we have focused on ensuring that partnership agencies have been able to continue to deliver safeguarding services to adults with care and support needs during the coronavirus pandemic.

Therefore, our practice development opportunities, audit processes and multi-agency meetings were quickly adapted to embrace using virtual platforms in response to the national lockdown to support ongoing multi-agency learning opportunities and gain assurance.

Our Priorities	What we said we would do:	What we did:
Assurance regarding transition arrangements for agreed vulnerable groups between children and adult services. Tackle exploitation and supporting those children and adults who are victims of exploitation and/or go Missing.	• Gain more assurance that agencies are embedding a think family approach in practice through audit activity • Embed the Exploitation Transition Protocol • Establish a multi-agency, all-age, Exploitation Hub • Launch an Exploitation Screening Tool and Pathway • Establish an Exploitation Panel (as part of the Pathway) • Further develop the data scorecard to include more data about adults that are being exploited • Embed the Herbert Protocol across the Partnership • Develop joint children's and adult courses in relation to Exploitation	✓ Carried out a joint children's and adults audit to review the effectiveness of the Transition Exploitation Protocol ✓ Launched the Exploitation Panel, Pathway and Assessment Tool ✓ Launched the All-Age Exploitation Hub ✓ Began to develop an All-Age Exploitation Strategy ✓ Continued to develop an All-Age Exploitation Scorecard ✓ Launched the Herbert Protocol across the West Midlands ✓ Family Safeguarding Model was launched ✓ Held an All-Age Exploitation Webinar ✓ Carried out a financial abuse/exploitation audit
To support the local and professional community to respond to Self-Neglect in a person centred way.	• Continue to promote the Self-Neglect Pathway and Panel • Further Embed the pathway in the Locality Panel arrangements • Hold Multi-agency training re Self-Neglect and Hoarding (including MSP vs risk enablement) • Increase public awareness of issues and support available	✓ Carried out an audit which considered adults who may be self-neglecting ✓ 7 minute audit briefing shared to promote referrals to the panel ✓ 13 cases were presented to the Self-Neglect Panel ✓ Held a Self-Neglect Webinar ✓ Developed and disseminated leaflets for the community ✓ Commenced a Review of the Self-Neglect Panel Arrangements
Improving the quality, practice and outcomes for Service Users in Care Homes and by Care Providers (incl. Learning Disability provisions and out of area hospital placements).	• Continue to work with the Quality in Care Board • Deliver key messages to practitioners regarding learning from reviews and audits • Raise awareness in the community regarding standards of care and their right to expectations of outstanding quality	✓ Undertook an audit to quality assure safeguarding practice in care ✓ Disseminated a 7 minute briefing of the audit findings ✓ CQC undertook a Walsall Provider Collaboration Review ✓ Held information sharing meetings with care providers ✓ Quality in Care Team closely supported Walsall providers through the pandemic

Communication and Engagement

The Partnership Joint Engagement Strategy (2020-2022) aims to help the partnership achieve the vision of having children, young people and adults as equal partners alongside the Local Authority, Health and Police. The strategy outlines 4 key steps to achieve engagement with adults: consultation, representation, decision-sharing and co-production.

During the year we:

Created and distributed a **leaflet** to **support adults that needed to isolate** at the start of the first lockdown	Created an **online tool kit** for professionals and volunteers who may be seeing vulnerable adults during the pandemic to raise awareness of safeguarding	Distributed regular **Key Messages** to professionals in partner agencies in relation to Covid-19 and partnership work	Employed an **Engagement Officer** in the Business Unit to progress the work of involving our 4th Partner in our work	Developed a **database of engagement contacts** and reached out to those groups to raise the profile of the Safeguarding Partnership
Held 4 Walsall webinars that related to adult safeguarding or think family • **Domestic Abuse** (113 attended) • **Self-Neglect** (68 attended) • **Exploitation** (201 attended) • **Domestic Homicide Reviews** (17 attended)	These Webinars have been uploaded to our **website and accessed 785** times.	Supported **#16days action against domestic abuse** campaign on twitter (181 clicks on the content and 11,747 views)	Held two regional webinars during **National Safeguarding Adults Week** on: • **Understanding Legal Literacy** (256 attended as a live event) • **Closed Cultures** (179 attended as a live event)	Ran a Twitter campaign during **National Safeguarding Adults Week** (250 clicks on the content and had 8,752 views)
Supported **Sexual Abuse and Sexual Violence Awareness Week** on twitter (17 clicks on the content and 755 views)	Delivered an **engagement and training forum** with Healthwatch Walsall to 38 residents of Walsall	Held an engagement and training forum with a Walsall community network group to deliver key safeguarding messages	Supported **#WorldElderAbuse day** (37 clicks on the content and 1,842 views)	Developed and distributed **7 Minute Briefings** on: • Multi-agency audit findings • Adults Position of Trust • Domestic Abuse
Published a **Domestic Abuse Awareness poster** in the Health and Community Guide which reaches over 40,000 residents of Walsall	Healthwatch completed **engage and share virtual meetings** with 4 Learning Disability Homes (14 adults	**Shared learning** from all our Walsall Reviews to all partner agencies	**Supported service users** to hold interviews for the new Independent Chair of the Safeguarding Partnership	**Developed the future engagement project** and delivery of strategy for 2021-22

What has our Partnership work meant for adults in Walsall?

Making Safeguarding Personal Case Study - 1

A 71 year old resident at a care home since January 2019 with a mental health diagnosis of Bipolar Disorder. Concerns have been raised previously about self-neglect and financial abuse in the community and on this occasion a concern was raised by the care home manager about a physical assault by a fellow resident.

Staff reacted quickly to the concern, the police were informed, attended and interviewed the resident at his request, he wanted his complaint acknowledged.

The gentleman was supported by the provider during lockdown restrictions, enabling him to achieve his desired outcomes through police engagement.

The Quality in Care Team noted that the care home paperwork was very comprehensive and well organised. There was also evidence of a mental capacity assessment in relation to refusal of wound care in 2019 which demonstrated good understanding of the Mental Capacity Act.

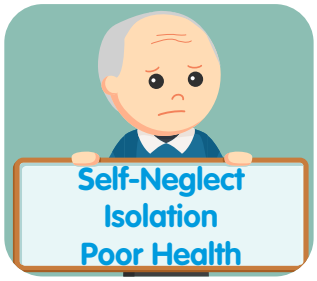
Future risk was mitigated through resolution between the adults involved.

Making Safeguarding Personal Case Study - 2

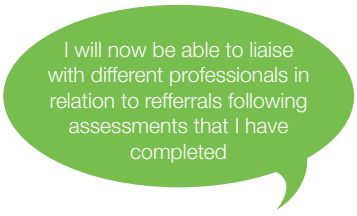
The 83 year old lady lives in a multi storey tower block in the centre of Walsall. The lady is in good physical health but admitted to becoming increasingly concerned about their safety due to frailty and emerging issues with their mobility. They report that their mental health has recently deteriorated and they are feeling in low mood, anxious and worried about their health and wellbeing. They have no regular contact with family or friends. Family members do not live locally and friends are now passing away leading to further isolation. The person is reported to be fiercely independent and recognises that they don't like asking for or receiving help. The Covid pandemic contributed to feelings of low mood, poor appetite, neglecting personal hygiene and no longer feeling able to go for daily exercise.

Whg worked closely with this lady using a person centred, strengths based approach in working with her. She was introduced to, and developed skills in using a range technology which increased independence, connectivity and improved her feelings of safety in her home.

Adults are listened to with 86% asked about their desired outcomes and 57% of these were fully achieved



Adults who may be self neglecting are recognised and supported as 87.5% more cases are being discussed at the Self-Neglect Panel than the previous year



Adults Practitioner Feedback from Exploitation Training

Adults Pracitioner Feedback from Closed Cultures Webinar

CQC Quality Assured Walsall Providers and provided feedback

Volunteers were given tools to recognise and report abuse of those that may have been shielding due to the pandemic

Learning from Safeguarding Adult Reviews (SARs)

Safeguarding Adults Boards (SABs) must arrange a SAR when an adult dies either as a result of abuse or neglect, known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult". (Care & Support Statutory Guidance, Amended 21/4/21)

The overall purpose of a SAR is to promote learning and improve practice, not to reinvestigate or apportion blame.

Key activity within the period of this annual report is as follows:

One referral was received in September 2020, however it was agreed to await the outcome of the Coroner Report prior to progressing discussions, this was later considered in March 2021 and did not progress to a SAR

One case referred in the previous reporting period but reviewed during 2020/21, led to a proposal to develop learning disability partnership board

A 7 minute briefing was developed and disseminated to staff in all agencies to remind them to make SAR referrals if required.

Two further referrals were received in February and March 2021 (meetings are planned for April 2021 and findings will be reported in the next financial year)

Key themes related to:
Mental Capacity Act,
Learning Disabilities,
Advocacy,
Mental Health
Self-Neglect

Specific learning newsletters were created to share learning from all previous reviews with all agencies

Due to the recurrent learning for adults in relation to the Mental Capacity Act (MCA), a practitioner event in the operational implementation of the MCA is in development.

A workshop was held to refine the action monitoring process, requiring single agency action to be monitored through respective governance processes enabling the partnership to focus on the multi-agency actions

Measuring the impact of recommendations will be a key focus for 2021-22

Learning from Multi-Agency Audits

During the year there were 4 multi-agency audits carried out which linked to the safeguarding priorities, key learning from the audits included:

Q1
Safeguarding Practice in Care

There were a number of findings around application of the Making Safeguarding Personal approach and application of the Mental Capacity Act. Further clarity concerning information sharing and processes arose from this audit which will support improvement in safeguarding practice across the partnership. This further ensures that we improve our service to adults in Walsall with care and support needs who are experiencing or at risk of abuse or neglect. Older adults who are resident in care homes, many of whom are experiencing some form of mental impairment, must be strongly advocated for by the safeguarding partnership.

Q2
Transition Exploitation Protocol

The audit demonstrated the complexity of working with young people for whom there are concerns in relation to exploitation which becomes exacerbated as they approach adulthood. it was evident that understanding the emotional needs of these children was evidently challenging; indeed possibly even understanding exactly how they were being exploited. There was little evidence of a collective, real understanding of the impact of the traumatic experiences these children had survived or were still experiencing. The audit highlighted a need to review the current Transition Exploitation Protocol.

Q3
Self- Neglect

It was acknowledged that practitioners in the community, from housing officers to social workers, police and health professionals can find working with people who self-neglect extremely challenging. There was a clear recognition and celebration of what good practice looks. There was clear demonstration of how this is evidenced through partnership working, case recording and outcomes for individuals. There were excellent examples of single agencies working closely with individuals and using creativity to establish effective relationships and outcomes particularly in challenging times of the Covid-19 pandemic. However the audit highluighted a need for multi-disciplinaryteam working.

Q4
Financial Abuse / Exploitation

This audit identified good and outstanding practice and working with individuals to determine their wishes and outcomes. There were good examples of risk assessment and risk management in complex situations. There was, however, a number of cases where the ongoing risk was unclear and the need for a plan should have been further explored. It is likely that this was due to inconsistent sharing of information in respect of single agency actions taken and a lack of understanding around the ongoing management and disruption of perpetrators of financial exploitation.

There were less cases graded at outstanding and good compared with last year, however there was an improvement in cases graded inadequate.

	Outstanding	Good	Requires Improvement	Inadequate
2019-2020	11%	47%	32%	11%
2020-2021	5%	42%	47%	5%

7 minute briefings were disseminated for each audit which included learning for all partners in an accessible format. Recommendations were followed up during the year and areas of impact will be a significant area of focus for 2021-22.

How effective have our arrangements been?

Although this year has been challenging due to a pandemic, there continues to be evidence of awareness of the safeguarding adults agenda as the number of safeguarding concerns that are being raised has increased from 2019-2020.

Adults continue to be consulted with and their desired outcome of the safeguarding concern captured, there are only a consistent low number of adults not asked their outcomes alongside a reduced number of outcomes not achieved. This can be due to outcomes not being realistic and unable to be achieved e.g. a police prosecution.

The numbers of individuals where a risk was identified, was reduced or removed was 82% (compared with 89.8% during 2019-2020) of cases showing positive outcomes for adults in Walsall.

The continuation of the Quality in Care Team has proved invaluable during the pandemic, ensuring homes have adequate personal protective equipment and access to regular advice and information from the team. This has ensured that care standards are monitored and improving. This was further evidenced through the Provider Collaboration Review carried out by change to; the Care Quality Commission during July 2020.

The Partnership held weekly Safeguarding Meetings in response to the pandemic to ensure a collective ownership and accountability of safeguarding practice, between Police, Health and Local Authority (adults and children) and regular key messages were developed and distributed to keep the wider workforce informed.

A variety of high quality learning opportunities were offered throughout the pandemic. The rapid lockdown meant that all planned learning had to move from face to face to virtual and this was managed very effectively. Given the additional pressures on partners as a result of the pandemic the engagement has been encouraging and we now have a wealth of recorded webinars on the website. A number of comments in the evaluations highlighted that those who attended would be cascading their learning to others so the learning is reaching further than the Partnership set out to.

Additionally, partners continued to contribute to multi-agency audits over the year which assisted in ensuring greater consistency of practice. Some engagement from partners was impacted by the pandemic including the vaccination roll out but enough multi-agency contributors made the audits worthwhile and provided quality assurance in key areas of the partnership work.

Progress was also made on reviewing forms and guidance, this included:

- A Review of the Adult Safeguarding Concern Form
- Development and roll out of the Safeguarding Medication Guidance
- Review of the Decision Making Support Tool
- Assurance exercises in relation to caused enquires and Position of Trust to begin to quality assure how partners are embedding these processes

Towards the end of the year WSP commissioned an Independent Review of its Arrangements, ensuring there was an equal voice for all partners. The purpose was to review the effectiveness of the Local Safeguarding Arrangements and the robustness of quality assurance arrangements. The findings from the review will be implemented in the following year.

However, there is still some work to do to ensure we are an effective learning system, this includes:

- Finalising and implementing an All-Age Exploitation Strategy
- Completion and implementation of the multi-agency revised Self Neglect Pathway, Guidance & Governance structure
- Implementing the findings from the WSP Review of its arrangements
- Capturing the views adults with care and support needs who have experienced safeguarding to shape strategy, planning and service delivery needs
- Increasing the conversion rate of safeguarding enquiries through raising awareness and understanding of the legal framework within the partnership
- Contribute to embedding the Domestic Abuse Strategy for the Partnership
- Measuring the impact of reviews and audits has had on adult safeguarding practice
- Embedding the new Learning Disability Partnership Board
- Embedding Impact Evaluations across the Partnership as part of management oversight and supervisions
- Revisiting the Practice Improvement Strategy and Competency Framework, to explore any gaps in the learning and development offer
- Continue the quality assurance work on Caused Enquiries and Position of Trust

Looking forward to next year

We have agreed a smaller set of priorities for the forthcoming year, these are focused on Adult Neglect, Child Neglect and All-Age Exploitation.

We will continue to monitor the impact of Covid-19 and the increased service demand this may bring and look to reset the way we conduct our business by learning from good practice from this year and we will also focus on embedding our revised arrangements.

We will be further engaging with the voluntary and community sector to capture the views of adults with care and support needs. We will use this feedback to shape strategy, planning and service delivery.

We will also be closely tracking the impact that learning from our reviews and audits have had by carrying out a range of assurance activities and engaging with practitioners.

Walsall Safeguarding Partnership

Right for Children, Families and Adults

For more information or to report an Adult Safeguarding Concern please visit our website: www.WalsallSP.co.uk

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Right for Children, Families and Adults

Walsall Safeguarding Children Partnership

Annual Report 2020-21

Contents

Introduction

Welcome to the 2020-2021 Children's Annual Report of Walsall's Safeguarding Partnership.

Following the publication of Working Together 2018, partner agencies in Walsall established Multi-Agency Safeguarding Arrangements and published their plans on 1st September 2019, launching the Walsall Safeguarding Partnership, which replaced previous arrangements, including the Local Safeguarding Children Board. Further information on the detail of these arrangements can be found here.

Following the first 12 months of the new arrangements the statutory partners commissioned an independent review of their arrangements. The review focused on the effectiveness of the Local Safeguarding Arrangements; the Strategic Plan; robustness of Performance and Quality Assurance; effectiveness of Learning from Serious Incidents and the impact of Independent Chair Arrangements and proposals for future Independent Scrutiny, in Walsall. Penny Thompson (CBE) undertook this review in autumn 2020 and shared her findings with partners in December 2020. Achievements which were highlighted included the Learning & Development offer; timeliness of Rapid Reviews; the management of the impact of Covid-19 and improved Communications with practitioners. The review noted the 'openness, candour and self-reflection' of those involved, it also acknowledged a consensus that some adaptation to the current arrangements would be helpful, and that these will be behavioural and cultural as well as organisational. Area's for further focus included ownership and leadership by the statutory partners, a reduction in meetings and priorities and greater attention to the underpinning values agreed by the partners. These will be taken forward in 2021 by a newly formed Executive Group of the partners. A breakdown of the partnership funding can be found in Appendix 1.

2020-21 was a challenging year with the Pandemic however, WSP continued to exercise oversight over children's safeguarding, whilst mindful of the pressure that health, police and social care have been and continue to be under. During the Pandemic, WSP held weekly partnership meetings to review how services have been responding to the challenges that the virus has created.

We have maintained close oversight on arrangements led by the Police, CCG and the Local Authority to Safeguarding Children. We maintain a close focus on our child safeguarding practice reviews and on learning from our assurance activity.

There is, of course, more to do and more that should be done to continue to improve safeguarding services and become an effective learning system.

The Partnership would like to thank agencies for the work they have done to keep our communities safe and to respond to the needs of children at risk of abuse and neglect in Walsall.

The partners would like to express thanks to Liz Murphy for her work as Independent Chair, for her support and leadership and the work that she has helped progress during this reporting period and throughout her 3 years in Walsall.

Walsall at a glance

Population of 286,716
69,375 (24.2%) of whom are children aged 0-17
2020 mid year population estimate

The number of children and young people aged 0-17 is projected to rise to 71,822 by 2020

Children and young people have more health challenges than their peers

3.5% of babies are born with a low birth weight
Compared with 3.3% to the West Midlands and 2.9% nationally (2019 data)

6.8 per 1000 children die before their first birthday
Compared with 5.6 in the West Midlands and 3.9 nationally (2017-2019 data)

3.0% of young girls get pregnant at 15, 16 or 17
compared with 1.9% in the West Midlands and 1.7% nationally (2018 data)

7.3 per 10,000 would be admitted to hospital as an inpatient for mental health issues
compared with 9.2 in the West Midlands and 9.0 nationally (2019-20 data)

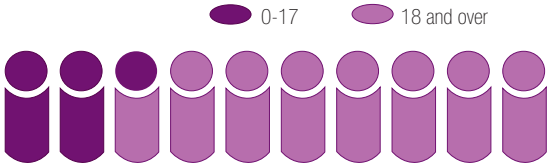
1.5 per 10,000 admitted to hospital for alcohol related issues
compared with 2.6 in the West Midlands and 3.1 nationally (2017-18 – 2019-20 data)

Deprivation levels are high

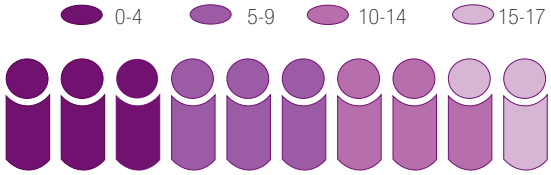
In the Indices of Deprivation Affecting Children (IDACI)

Walsall is the **19th most deprived Local Authority** in the country with (29%) of neighbourhoods in the top 10% of most deprived neighbourhoods nationally which is the 15 highest.

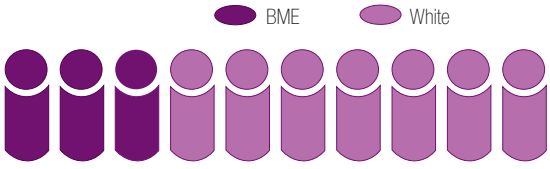
Two of Walsall's three parliamentary constituencies are in the **top 50** constituencies with the highest levels of child poverty



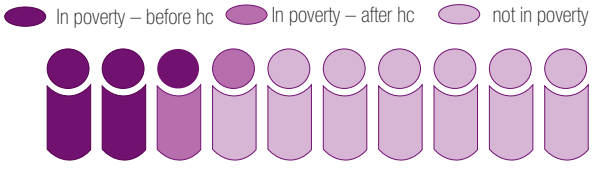
24.2% of the population are children and young people
2020 mid-year population estimates



28% of Children are aged 0-4, **29%** are aged 5-9, **28%** are aged 10-14 and **15%** are aged 15-17
2017 mid-year population estimates



31.2% of Children are from BME backgrounds
2011 Census



39% of Children live in poverty after housing costs
Campaign to end child poverty – May 2021

What the Safeguarding Partnership has focussed on during 2020/21

During this year, not only have we focused on our strategic priorities, we have focused on ensuring that partnership agencies have continued to deliver safeguarding services during the pandemic. Regular Safeguarding Partnership Covid Meetings were held to discuss service response and assurance, risks and opportunities, key issues or messages and staffing. This offered partners the opportunity to respond to and manage risk, support other services and utilise local resources. It also provided a risk escalation process for the partners.

Our practice development opportunities, audit processes and multi-agency meetings were quickly adapted and we embraced using virtual platforms in response to the national lockdown to support ongoing multi-agency learning opportunities as well as business activities and meetings.

Our Priorities	What we said we would do:	What we did:
To support the local and professional community to ensure that children and families receive the right help at the right time	• Launch the multi-agency CSA strategy. • Effective communications strategy to deliver key messages. • Embed a Child Exploitation pathway. • Ensure appropriate police referrals to MASH in relation to Domestic Abuse. • Improved timeliness of early help assessments and interventions. • Ensure information from GP's and mental health is available in MASH in a timely way. • Launch and embed the Family Safeguarding Model.	• 13 Right Help Right Time virtual training events (235 attendees). • A Practice Reflection Learning Event: Injuries in non-mobile babies and children (109 attendees). • Domestic Abuse webinar, April 2020. • CSA Strategy revised and agreed. • Developed and disseminated regular Key Messages newsletter, to quickly update partners and practitioners with relevant information. • GP / MH info is now available via the Named Nurse in MASH. • Quarterly partnership newsletters. • Learning from Reviews Newsletter, February 2021. • Developed information materials and revised our website to support Covid volunteers. • 7 minute briefings: including – Domestic Abuse, CSA, Babies born during lockdown. • CSA focused partnership event facilitated by CSA Centre for Excellence. • Family Safeguarding Model was launched • Launched the All-Age Exploitation Panel, pathway and assessment tool • Held multi-agency Exploitation webinar. • Timeliness of Early Help Assessments (within 5 days) has doubled.

Our Priorities	What we said we would do:	What we did:
To support the local and professional community to recognise, respond to and reduce the impact of neglect in a child centred way	• Neglect is identified and assessed consistently well across the system • Neglect is tackled holistically via a whole family approach • Increased professional challenge and curiosity • Families are enabled and empowered to make positive and timely change and to identify support • where possible from their own networks • Professional practice supports timely and effective interventions to reduce risk and promote positive • change within families • Assessment, intervention, decision-making and recording is focused on the lived experience of the child • Pilot of the NSPCC pre-birth assessment tool • Continue the Look, Say, Sing, Play campaign (NSPCC) • Implement the Family Safeguarding Model (FSM)	• Family Safeguarding Model was launched and implemented. • Undertook a multi-agency Neglect Audit. • Neglect webinar, November 2020. • Look, Say, Sing play roll-out continued
Assurance regarding **transition** arrangements for agreed vulnerable groups between children and adult services. Tackle **exploitation** and supporting those children and adults who are victims of exploitation and/ or go **Missing**.	• Gain more assurance that agencies are embedding a think family approach in practice through audit activity. • Embed the Exploitation Transition Protocol • Establish a multi-agency, all-age, Exploitation Hub. • Launch an Exploitation Screening Tool and Pathway. • Establish an Exploitation Panel (as part of the Pathway). • Further develop the data scorecard. • Develop joint children's and adult courses in relation to Exploitation	• Carried out a joint children's and adults audit to review the effectiveness of the Transition Exploitation Protocol • Launched the all age Exploitation Panel, pathway and assessment tool • Launched the All-Age Exploitation Hub • Began to develop an All-Age Exploitation Strategy • Continued to develop an all-age exploitation scorecard • Launched the Herbert Protocol across the West Midlands • Held an All-Age Exploitation Webinar • Successful Tackling Child Exploitation programme bid.

What has this meant for children and families in Walsall?

Early Help, identifying need and appropriate thresholds

Contacts to Early Help have increased by 7%
4,893 contacts were received between 01 April 2020 and 31st March 2021

Top three referrers to **Early Help** are:
Police (20.2%)
LA Services (19.8%)
Health (16.7%)

Top three presenting **needs** to **Early Help** are:
Challenging Behaviour (18.4%)
Emotional Wellbeing (child) (14.7%)
Domestic Abuse (parent/carer) (14.3%)

Timeliness of Early Help contacts is improving
89%
were completed within the **5-day target**
Up from 70% in 2019-20

Timeliness of Early Help assessments has doubled
56%
were completed within the **5-day target**
Up from28% in 2019-20

Referrals to social care have reduced by over 30% since **Right Help, Right Time** was launched in 2019

3,431
referrals were received between 01 April 2020 and 31st March 2021 compared to 4,401 last year and 5,267 the previous year

Top three presenting **needs** to Social Care are:
Domestic Abuse (37.9%)
Emotional Abuse (29.4%)
Neglect (16.3%)

83.5%
of **contacts** to social care were completed **within 48 hours**

58% are completed **within 24 hours**

Timelessness of assessments is improving
90.2%
were completed **within 45 days**
Up from 74.8% in 2020

75%
of children age **5 or over** are **seen alone** as part of their assessment

Family Safeguarding

265
Children from **141 families** have or are being supported through the **Family Safeguarding** model

Children subject ofa child protection plan has halved
203
Children were subject of a plan 31st March 2021 compared with 408 in March 2018

Initial Child Protection Conferences are **timely**
85%
are completed within **15 days** of the strategy discussion and **80.4%** **lead to a child protection plan**

Adolescents entering care have reduced by
29%
63 in 2020-21 compared with 89 in 2019-20

Care Applications have **reduced** by
28%
78 in 2020-21 compared with 108 in 2019-20

The number of children going **missing has decreased**
To **233** in 2020-21 compared with **319** in 2019-20 but missing episodes have **reduced** by
26%

Views

94%
of children have heard at their **child protection conference**
31% attend their conferences

95 children and young people are at **risk**, **21** are at **significant risk** and **9** are at **serious risk of sexual or criminal exploitation**
75
Had their **risk reduced** throughout 2020-21

Timeliness of return interviews is **improving**
398 Return home interviews were offered and **accepted**
68.1%
were completed with **72 hours**
Compared with 52.6% in 2019-20

- Multi-agency audit findings:

  When undertaking multi-agency case file audits a noticeable improvement on previous years was found in practice.

Grade	2019/20	2020/21
Outstanding	0	**4%**
Good	23%	**61%**
Requires improvement	62%	**30%**
Inadequate	15%	**4%**

- Practitioner's and young people's voice:

"I will apply the guiding principles into my everyday practice and be honest and open with our parents and families and work in ways that builds on family's strengths."

Practitioner changed their practice, following Right Help, Right Time training.

"I will be able to apply it to situations that arise when younger children present ….. we have a duty to find out why there is bruising and have professional curiosity."

Practitioner changed their practice, following Bruising in Non Mobile Babies webinar.

"Working within a multi-disciplinary team, using a restorative approach to support families, has been the missing piece to the puzzle. I'm delighted to be a part of this project …… barriers will be broken down."

Practitioner involved in Family Safeguarding.

Kids not getting the correct nurture

A child always playing alone when their parents are always on their phone

Young people's views were heard on what neglect means to them.

Hello my name is *** and I'm15, all through the summer I had Sarah as my support worker. I had been struggling a lot and my anxiety was really bad. I've had many social workers etc in the past and I have never really bonded with them or been helped by them, they never had an impact on me however when I met Sarah she was really calm and helped me control my anxiety and I really wish I could have had her long as she helped me so much. She is amazing and I can see she helps many children, and I just wanted to thank you for letting her be my support worker, if I didn't have her I'm not sure where I would be today. My granddad and my auntie really appreciate what Sarah did for me so thank you.

Walsall Young Person was supported to succeed.

Over 200 parents and professionals attended 3 events to promote Look, Say, Sing, Play

Hundreds of parents have signed up to 'brain building tip's' online

Communication and Engagement

The Partnership Joint Engagement Strategy (2020-2022) aims to support the safeguarding partnership achieve the vision of having children, young people and adults as equal partners alongside the Local Authority, Health and Police. The strategy outlines 4 key steps to achieve engagement with adults: consultation, representation, decision-sharing and co-production.

We also set out in our vision that we wanted to raise the profile of the Safeguarding Partnership, with the community and professionals, and have sought to do this in a number or ways.

The partnership recognises that one of the effects with Covid-19 is the reduced ability to engage with the workforce and with children, despite this the workforce has continued to get information through our communication below. For the young people we have made concerted efforts to keep in touch via virtual means.

During the year we:

Created and distributed a leaflet to support those that needed to isolate at the start of the first lockdown	Created an online tool kit for professionals and volunteers who may be seeing vulnerable families during the pandemic, to raise awareness of safeguarding.	Distributed regular Key Messages to professionals in partner agencies in relation to Covid -19 and partnership safeguarding work	Employed an Engagement Officer in the Business Unit to progress the work of involving our 4th Partner in our work	Invited young people to discuss the Family Safeguarding Model.
Held 4 Walsall webinars • Domestic abuse (113 attended) • Exploitation (201 attended) • Trauma Informed Practice (163 attended) • Neglect (87 attended)	These Webinars have been uploaded to our website and accessed 874 times.	Supported #16days action against domestic abuse campaign on twitter (181 clicks on the content and 11,747 views)	Youth Safeguarding Partnership (YSP) Interviewed and influenced the appointment of the new Independent Chair.	Developed and distributed 7 Minute Briefings on • Multi-agency audit findings • Injuries in non-mobile babies • CSA • Domestic Abuse • Learning from Alex (W11) SCR
Supported Sexual abuse and sexual violence awareness week on twitter (17 clicks on the content and 755 views)	Delivered an engagement and training forum with Healthwatch Walsall to 38 residents of Walsall	Published a Domestic Abuse awareness poster in the Health and Community guide which reaches over 40,000 residents of Walsall	Shared learning from all our Walsall Reviews to all partner agencies	Developed the future engagement project and delivery of strategy for 2021-22
Maintained contact and held 7 virtual meetings with YSP.	Discussed with young people, what neglect means to them.	Young people reviewed the WSP website and a film produced by Walsall College.	Began planning 2021-22 YSP events / activities.	

Learning from Case Reviews and Audits

5 children were referred to the Practice Review Subgroup for consideration of a review during the year.

None of these were Child Safeguarding Incidents notified to the National Panel or Ofsted by the LA.

One case progressed to a Local Child Safeguarding Practice Review (LCSPR, W13) and is due to be completed in summer 2021.

2 cases were teenagers, the others were all aged 3 years or younger.

There was learning identified in all of the case discussions and associated actions were monitored by the Practice Review Subgroup with cross reference to the Practice Development Subgroup as appropriate.

Walsall also contributed to the National Panels report 'Out Of Routine: A review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm' which was published in July 2020. The published report was shared across the partnership and included discussions at the Black Country CDOP, which has led to plans to commission and roll out the ICON Babies Cry You Can Cope programme in 2021/22.

Disseminating and implementing the learning included:

- A 7 minute briefing on W11 SCR (Alex) was produced and shared across the partnership.
- A 'Learning from Reviews' Newsletter was produced and shared across the partnership.
- A multi-agency leaflet on Bruising in Non-Mobile Babies was developed and a webinar facilitated by the CCG and WHT, which was positively evaluated.
- One of the cases influenced the review of the CSA Strategy and plans for future audits and CSA training.
- A standardised agenda template for Strategy Meetings was developed and implemented to support good practice and consistency.
- Awareness raising of adult self-neglect and hoarding issues took place with practitioners who work with children.

In summer 2019 the Walsall Local Safeguarding Children Board published a Serious Case Review which included learning in relation to Connected Carers. During quarter 3 of 2020-21 a multi-agency audit was undertaken to provide an insight into practice in relation to children placed with connected carers and review the impact of this previous learning.

Overall the multi-agency team determined that of the 5 cases audited, one case was 'Outstanding' and two cases were 'Good'. Of the remaining two cases, while the audit team recognised that the outcomes for the child in each case were good, in the specific area of ensuring notifications to agencies were timely, improvement was required.

The audit demonstrated that while in every case the required notifications to Out of Authority agencies and to the local Healthcare Trust had been made, they had not all been made in a timely way in every case. As with all multi-agency audits an action plan was put in place.

There was evidence of good multi-agency information sharing about planned placement moves to ensure seamless transition of health provision and where children were of an age (5yrs plus), there was good evidence that the voice of the child had been sought in planning and preparing the child for a move to connected carers.

In order to further embed this learning a webinar will be planned for 2021.

How effective have our arrangements been?

What has worked well?

- Although this year has been challenging due to a pandemic, there continues to be evidence that children are safe in Walsall (data on page 8):
  - An appropriate reduction in referrals to MASH
  - Positive impact of Early Help services
  - Positive reductions seen in the number of children subject to child protection plans
  - Positive increase of the number of families supported through the Family Safeguarding Model
- Partnership focus on safeguarding has continued through regular meetings between statutory partners despite the challenges brought by the pandemic.
- Attendance at multi-agency meetings has improved, particularly since they moved online. This virtual or blended approach allows for greater flexibility moving forward.
- A successful bid to the TCE (Tackling Child Exploitation) Programme saw work with local colleagues begin to develop work in relation to community resilience and engagement and consider the role which the wider community can take in developing an effective, strategic all-age response to exploitation.
- The CSA Strategy was updated and re-agreed by partners and an action plan developed.
- The Neglect Strategy was revisited to bring a renewed focus.
- Progress was made with the All-Age Exploitation pathway and included the development of an Exploitation Hub.
- The multi-agency audit programme continued to obtain learning in order to improve practice and saw improvements in the case ratings.
- During the year there were 5 multi-agency audits carried out, 4 were linked to the safeguarding partnership priorities and one (during quarter three) was in response to the Parliamentary Under-Secretary of State for Children and Families request for assurance in respect of services to new-borns and infants during lockdown . In respect of the latter, all the children had been seen by the relevant multi-agency professionals with good recording regarding whether this was face to face or virtually. All case files audited had relevant risk assessments in place and PPE was utilised appropriately as required for in person contact. There was consistent evidence of good information sharing across agencies. Needs identified during assessment were being met and children and their families were being supported. Where risks had escalated, there was clear evidence that the appropriate actions had been taken to respond and consider these in a multi-agency forum, leading to an initial child protection plan for one infant.
- Work has taken place to embed the SARC (Sexual Assault Referral Centre) pathway, supported by SARC Lunch and Learn training sessions.
- An independent review (by Penny Thompson, CBE) commissioned by the 3 statutory partners in Autumn 2020 to consider the first year of the new arrangements was a proactive and positive undertaking. The report commented on the committed and effective Safeguarding Partnership Business Unit and the openness, candour and self-reflection demonstrated by the partnerships leaders.
- Approaching the end of the contract held by the previous Independent Chair (Liz Murphy) the statutory partners reflected on the independent scrutiny of the Safeguarding Arrangements and opted to re-appoint an Independent Chair. Recruitment took place in the early part of 2021 with the new post holder (Sally Hodges) commencing in April 2021.

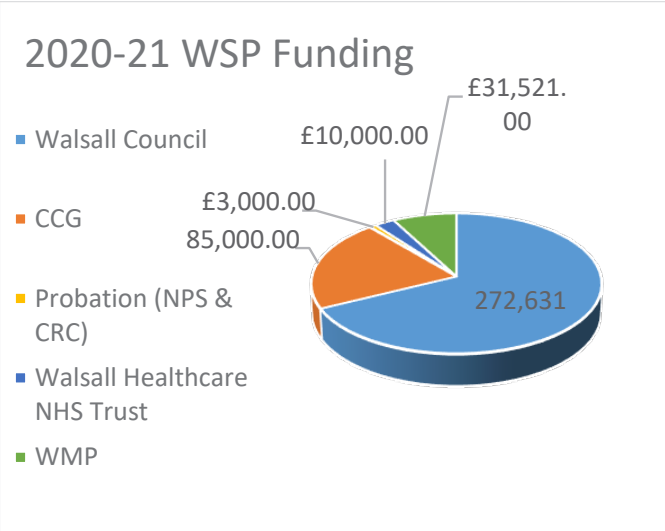
Areas for improvement or focus in 2021-22

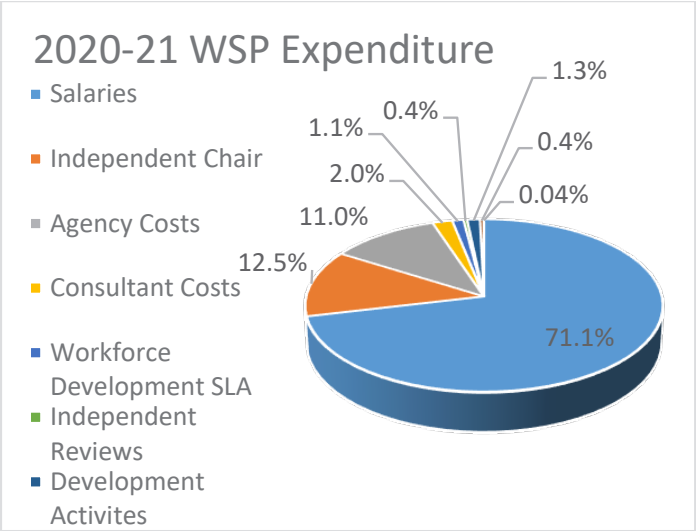
- To implement recommendations made by Penny Thompson in her review of the Safeguarding Partnership Arrangements, including creating an Executive Group and reducing the number of partnership priorities to provide more focus and impact.
- To consider and implement recommendations from the forthcoming Wood review
- Progression and sign off the All-Age Exploitation Strategy.
- Revision and continued delivery of the Neglect Strategy.
- To review the participation strategy to ensure we effectively engage with young people and practitioners and improve our communication with partners
- Implementation the ICON Programme across Walsall
- Strengthen the links between the Family Safeguarding model and Walsall Safeguarding Partnership
- Develop a positive and productive relationship between Safeguarding Partnership and the Safer Walsall Partnership
- Due to Covid-19 there was limited inspection activity of the statutory partners during this year. Once this re-commences the Partnership will be sighted on and respond to the respective findings.
- Track the impact that learning from our reviews and audits have had by carrying out a range of assurance activities and engaging with practitioners.
- To embed Impact Evaluations across the Partnership as part of management oversight and supervisions

Appendix 1: Financial Summary

In 2020-21 the partnership had £402,000 pooled into a partnership budget. This money was contributed by the Statutory Partners, plus the local Healthcare Trust and Probation. The majority of the resource was used to pay for Business Unit staffing. Other costs include the Independent Chair, Regional Procedures and online products used for business processes, Service User Involvement, Consultancy and Training.

The charts below show the proportion of the contributions by organisation and also the percentage split of the expenditure.






A B C D E F
H I J K L M
O P Q R S
U V W X


Walsall Safeguarding Partnership
Right for Children, Families and Adults

Health and Wellbeing Board

25 January 2022

Public Health & Adult Social Care Commissioning Intentions 2021-24

1. Purpose

The purpose of this joint report is to inform the Health and Wellbeing Board of Walsall Council's Public Health and Adult Social Care commissioning intentions for 2021/22 - 2023/24, and also to consider the nature of future reporting in order to represent a whole council approach to Health and Wellbeing.

The Board received the last report on Public Health commissioning intentions in July 2019. For transparency purposes this report will also cover this year's investments where the investment relates to future commissioning intentions.

2. Recommendations

That the Board notes the content of the report.

That the Board sets a date within it's forward plan to receive detail of the Adult Social Care Transformation Plan.

That the Board agrees that future reporting be focussed on a whole council, all age approach that aims to demonstrate the intentions and impact of all services and interventions that support the health and wellbeing of the residents of Walsall.

3. Report detail

The original intention of this report was to advise the Board of the joint commissioning intentions of Public Health, Adult Social Care and Walsall Clinical Commissioning Group as set out in the forward plan.

The realisation of this has been impacted by a number of factors including:

- The refresh of Adult Social Care's Strategic Transformation plan which looks to connect the full span of the council and local health and care system's work around community and wellbeing in order to deliver better outcomes for Walsall residents.
- The planned decommissioning of the Clinical Commissioning Group as part of the implementation of the Health & Care Bill.
- The postponement of the Health & Care Bill. (Originally planned for going live on April 2022, current indications are now that this will take place in the Summer 2022).

Adult Social Care is at a critical point of change with the planned implementation of the Health and Care Bill and the Government's planned reforms. In addition, the sector is facing significant challenges due to increases in demand and significant issues in the availability of care. This has resulted in significant existing commissioning capacity being diverted to supporting the care market and administering various Covid-19 related support grants.

It has been evident through the pandemic that Walsall has many strengths and assets within it's communities and health and care system which, when working together, can greatly enhance the wellbeing of residents.

Whilst there is detail within the report of current Adult Social Care and Public Health commissioning activity it is proposed that the Health and Wellbeing Board accept a recommendation to receive further information of the Adult Social Care Strategic Transformation Plan and a revised set of commissioning intentions at a future meeting in order to promote further discussion.

It is also proposed that the Health and Wellbeing Board, by using the principle that many of the enablers of Health and Wellbeing are cross-cutting across both Walsall Council and it's partners, request future reports to detail at a minimum a whole council, all age approach to commissioning Health and Wellbeing.

The local authority has a number of mandatory requirements to improve the public's health and as such receive the ring fenced Public Health annual Grant from the Department of Health. The Commissioning Intentions as set out below are intended to align the delivery of the statutory Public Health functions with the Health and Wellbeing Strategy.

In order to meet the conditions of the Grant, an annual statement of assurance has to be signed off by the Director of Public Health, Council Chief Executive and Chief Finance Officer.

The Public Health and Adult Social Care Commissioning Intentions**:**

- Review the existing mandated commissioned services to ensure they meet the required clinical and service qualities in light of learning from the last 18 months, namely; Sexual Health Services, National Child Measurement Programme, NHS Health Checks, Drug and Alcohol Services
- Review the 0-19 Services (to include Health Visiting, Teenage Pregnancy and School Nursing Services) in the context of the Integrated Care Partnership to optimise the opportunities
- Align the Sexual Health Services to the place based Walsall Together partnership as part of the Health and Social Care Place Based Partnership putting support and care where people need it
- Review and reconfigure the present diverse investment in lifestyle related services to implement a Wellbeing Service whilst also delivering a £500,000 saving covering social, physical, mental and financial wellbeing
- Implement Adult Weight Management Tier 2 interventions with particular interest in communities and specific target groups with high prevalence (PHE Grant £269,000 2020/21)
- Implement Mental Health Prevention interventions aligned to the findings from the recent Mental Wellbeing review and forthcoming Strategy (PHE Grant £368,000 2020/21)
- Invest an additional £1M over 3 years in Mental Wellbeing to include; campaigns, education, individual advice and support and bereavement services (PH non-recurrent £1,000,000 2022-25) in alignment with developing mental wellbeing strategy
- Implement Drugs and Alcohol Universal Grant to improve the access to treatment for offenders and reduce drug related deaths (PHE Grant £422,000 2020/21)
- Implement a Young Adult Tier 2 Prevention Service for 16-25 year olds (PH non-recurrent funding £400,000 2022-24)
- Offer specialist substance misuse support to the Family Safeguarding Model (PH non-recurrent £262,500 2021-24)

- Delivery of a domiciliary care framework which moves away from time and task to facilitate the delivery of positive outcomes for people who access home care services

- Procurement of advocacy services (IMCA, IMHA, ICAS and Care Act) to meet changing legislation
- Review of replacement care to ensure services continually improve in line with customer trends
- Review of day opportunities to ensure services continually improve in line with customer trends
- Review of existing intermediate care services to ensure services continually improve in line with service and customer demand including transitional care beds framework
- Development of the Walsall Autism strategy aligned to the national strategy. Development and implementation of an action plan for the Health Self-Assessment.
- Re-procurement of the carers centre contract in line with changing customer demand
- Re-procurement of the DPSS service provider contract to meet the changing needs and empowering customers to take control of their finances
- Strategic Commissioning of Walsall Together
- Mental Health review and re- procurement of the Community Mental Health Service

4. Implications for joint Working Arrangements

The financial, legal and resource implications for the wider system and partner organisations will be assessed and reviewed as part of the engagement, consultation and implementation of these commissioning intensions.

5. Health and Wellbeing Priorities

Delivering improvement in public health and ASC outcomes and reducing inequalities is a system wide challenge. The investments included in this report are not stand alone investments they form part of a coordinated strategic investment to deliver the Health and Wellbeing Strategy supported by and complementing Council and Partner's investments, to reduce inequalities and contribute to better health and wellbeing outcomes for the people of Walsall.

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Healthier Futures
Black Country and West Birmingham

Black Country & West Birmingham ICS

Operational Planning 2022/23

27.12.21

Building Healthier, Happier Communities

Introduction

Key ambitions for 2022/2023 are to continue to restore services, meet new care demands, reduce care backlogs as a result of pandemic:

- **accelerate plans to grow the substantive workforc**e and work differently as we keep our focus on the health, wellbeing and safety of our staff
- use what we have **learnt through the pandemic** to rapidly and consistently **adopt new models of care** that **exploit the full potential of digital technologies**
- work in partnership as systems to make the most **effective use of the resources** available to us across acute, community, primary and social care settings, to **get above pre-pandemic levels of productivity** as the context allows
- use the additional funding government has made available to us to **increase our capacity** and **invest in our buildings and equipment** to support staff to deliver safe, effective and efficient care.

Objectives for 2022/23 based on COVID-19 returning to a low level

Effective partnership & four strategic purposes of ICS is critical to achieving the priorities set out:

- Improving outcomes in population health and healthcare
- tackling inequalities in outcomes, experience and access
- enhancing productivity and value for money
- supporting broader social and economic development

New target date of 1 July 2022 has been agreed for new statutory arrangements to take effect and ICBs to be legally and operationally established. Designate ICB leaders should continue to **develop system-level plans for 2022/23** and **prepare for the formal establishment of ICBs** in line with the updated transition timeline.

NHS financial arrangements for 2022/23 will continue to support a **system-based approach to planning and delivery** and will **align to the new ICS boundaries agreed during 2021/22**.

One year revenue allocations for 2022/23 and **three year capital allocations to 2024/25** to be issued shortly. Remaining **two-year revenue allocations to 2024/25** will be **published in the first half of 2022/23**

2022/23 National Planning priorities

A – **Invest in our workforce** - **with more people** (e.g. additional roles in primary care, expansion of mental health and community services, and tackling substantive gaps in acute care) and **new ways of working**, and by **strengthening the compassionate and inclusive culture** needed to deliver outstanding care.

B – Respond to COVID-19 ever more effectively - delivering the NHS **COVID vaccination programme** and **meeting the needs of patients with COVID-19**

C - Deliver significantly more elective care to **tackle the elective backlog**, **reduce long waits** and **improve performance against cancer waiting times standards**

D - **Improve the responsiveness of urgent and emergency care (UEC) and build community care capacity** – keeping patients safe and offering the right care, at the right time, in the right setting. This needs to be supported by **creating the equivalent of 5,000 additional beds**, in particular through **expansion of virtual ward model**s, and includes **eliminating 12-hour waits in emergency departments (EDs)** and **minimising ambulance handover delays**.

E - Improve timely access to primary care – **maximising the impact of the investment** in primary medical care and primary care networks (PCNs) to expand capacity, **increase the number of appointments available** and **drive integrated working at neighbourhood and place level.**

F - Improve mental health services and services for people with a learning disability and/or autistic people – **maintaining continued growth in mental health investment** to **transform and expand community health services and improve access**

G - Continue to **develop our approach to population health management, prevent ill health and address health inequalities** – using **data and analytics** to **redesign care pathways and measure outcomes** with a **focus on improving access and health equity for underserved communities.**

H - **Exploit the potential of digital technologies** to transform the delivery of care and patient outcomes – **achieving a core level of digitisation in every service across systems.**

I - Make the most **effective use of resources** – **moving back to & beyond pre pandemic levels of productivity** when the context allows this

J - **Establish ICBs and collaborative system working** – work together with local authorities & other partners across their ICS to develop **a five-year strategic plan** for their system and places

2022/23 National Planning priorities

Maintain focus on reducing **preventing ill-health and tackling health inequalities** by redoubling our efforts on the **five priority areas**:

1. Restore NHS services inclusively
2. Mitigate against digital exclusion
3. Ensure datasets are complete & timely
4. Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes
5. Strengthen leadership & accountability

ICSs will take a lead role in tackling health inequalities, building on the **Core20PLUS5 approach introduced in 2021/22** to support the reduction of health inequalities experienced by adults, children and young people, at both the national and system level. ICBs, once established, and **trust board performance packs** are therefore expected to be **disaggregated by deprivation and ethnicity**

Trusts and ICBs, once established, are expected to have a **board-level Net Zero lead and a Green Plan**, and are asked to **deliver carbon reductions against this**, throughout 2022/23

ICS's need to develop plans that reflect these priorities & ensure triangulation across activity, finance & workforce. **Immediate focus** should remain **priorities** set out in **Preparing NHS for the potential impact of the Omicron variant**, planning timetable been amended to reflect this with **draft plans due in mid-march 2022.**

A. Invest in Our Workforce

Whole system workforce plans & **local people plans** should reflect ambition to:

Look after our People

- **improve retention** by delivering the NHS People Promise to improve the experience of our staff, through a focus on flexible working, early/mid/late career conversations and enabling staff to understand their pensions
- continue to **support the health and wellbeing of our staff**, including through effective health and wellbeing conversations and the mental health hubs
- improve attendance by addressing the root causes of non COVID-related sickness absence and, where appropriate, supporting staff to return to work

Improve belonging in the NHS

- Improve the Black, Asian and minority ethnic disparity ratio, **delivering the six high impact actions** to overhaul recruitment and promotion practices
- implement plans to **promote equality** across all protected characteristics.

Work Differently

- **accelerate the introduction of new roles**, such as anaesthetic associates and first contact practitioners, and expanding advanced clinical practitioners
- **develop the workforce** required to deliver multidisciplinary care closer to home, including supporting the rollout of virtual wards and discharge to assess models
- ensure the **highest level of attainment** set out by the '**meaningful use standards**' for e-job planning and e-rostering is met to optimise the capacity of the current workforce
- **establish**, or become part of, **volunteer services** such as the NHS cadets and NHS reservists.

A. Invest in Our Workforce

Grow for the future

- **expand international recruitment** through ongoing ethical recruitment of high quality nurses and midwifes
- **leverage the role of NHS organisations as anchor institutions/networks** to widen participation and create training and employment opportunities, including through expanding apprenticeships as a route into working in health and care
- make the most **effective use of temporary staffing**, including by expanding collaborative system banks and reducing reliance on high-cost agency staff
- **ensure training of postgraduate doctors continues**, with adequate time in the job plans of supervisors to maintain education and training pipelines
- **ensure sufficient clinical placement capacity** to enable students to qualify and register as close to their initial expected date as possible.

Health Education England and NHS Improvement Regional teams will support systems to develop and deliver workforce plans through:

- **investment to expand** the national nursing international recruitment programme and support to recruit more allied health professionals
- the national healthcare support worker (HCSW) recruitment and retention programme
- **continued funding of mental health hubs** to enable staff access to enhanced occupational health and wellbeing and psychological support
- a suite of **national GP recruitment and retention initiatives** to enable systems to support their PCNs to expand the GP workforce and make full use of the digital locum pool
- the **Additional Roles Reimbursement Scheme (ARRS)** to **deliver 26,000 roles in primary** care, to support the creation of multidisciplinary teams.

B. Responding to COVID-19 ever more effectively

Vaccinations

- Delivery of the **vaccine programme** is expected to remain a **key priority as we look ahead to 2022/23** and systems are asked to plan to maintain the infrastructure that underpins our ability to respond as needed
- Continue to **prioritise roll out of new treatment options**, including neutralising monoclonal antibodies and oral antivirals, are now available for non-hospitalised NHS patients at greater risk from COVID-19.
- Government has also launched a study to assess the efficacy of antivirals in the UK's predominately vaccinated population. Dependent on the results of that study, NHSE/I will **develop plans for wider access to antivirals from the spring**.

Long Covid

Due to **variation** in **referral rates**, **waiting times & access** to clinics systems are asked to:

- **increase the number of patients** referred to post-COVID services and **seen within six weeks of referral**
- **decrease the number of patients waiting longer than 15 weeks**, to enable their timely placement on the appropriate management or rehabilitation pathway

£90 million is being made available to support this work in 2022/23.

C1. Elective Recovery – Maximise elective activity & reduce long waits taking full advantage of opportunities to transform the delivery of services

- Every system is required to develop an **elective care recovery plan for 2022/23**, setting out how the first full year of longer term recovery plans will be achieved
- Crucial that we continue to deliver elective care and ensure that the **highest clinical priority patients** – including patients on cancer pathways and those with the longest waits – **are prioritise**d.
- Wherever possible over winter, we need systems to continue to **separate services** and to **maintain maximum possible levels of inpatient, day case, outpatient and diagnostic activity,** recognising the requirement to release staff to support the vaccination programme and respond to the potential increase in COVID-19 cases. This should include the independent sector as separate green pathway capacity.
- Set an ambitious goal to deliver around **30% more elective activity by 2024/25 than before the pandemic**, after accounting for the impact of an improved care offer through system transformation, and specialist advice, including advice and guidance.
- Continue to work to return to pre-pandemic performance as soon as possible with an **ambition in 2022/23 for systems to deliver over 10% more elective activity than before the pandemic and reduce long waits**. Treatment should continue to be prioritised based on clinical urgency and steps should be taken to address health inequalities. Systems should make use of alternative providers if people have been waiting a long time for treatment.

Systems are asked to:

- **eliminate waits of over 104 week**s as a priority and **maintain this position through 2022/23** (except where patients choose to wait longer)
- **reduce waits of over 78 weeks** and **conduct three-monthly reviews for this cohort of patients**, extending the three-monthly reviews **to patients waiting over 52 weeks from 1 July 2022**
- develop plans that support an overall **reduction in 52-week w**aits where possible
- accelerate the progress we have already made towards a more personalised approach to follow-up care in hospitals or clinics, **reducing outpatient follow-ups by a minimum of 25% against 2019/20 activity levels by March 2023** and going further where possible. Specific targets will be agreed with systems through the planning process.

C1. Elective Recovery – Maximise elective activity & reduce long waits taking full advantage of opportunities to transform the delivery of services

Our ability to fully deliver on the objectives is linked to the ongoing level of healthcare demand from COVID-19 and will depend on:

- **holding elective activity** through the winter
- systems **eliminating the loss in productivity** caused by the **operating constraints** resulting from the pandemic.

The opportunity to reduce outpatient follow-ups will **differ by trust and specialty** and **local planning** should inform **how the ambition will be delivered across the system**, supported through a combination of:

- patient initiated follow-up (PIFU) – expanding the uptake of PIFU to all major outpatient specialties, **moving or discharging 5% of outpatient attendances to PIFU pathways by March 2023**
- **effective discharge**, particularly of those patients for whom clinical interventions have been exhausted
- more **streamlined diagnostic pathways**
- referral optimisation, including through use of specialist advice services to enhance patient pathways – **delivering 16 specialist advice requests, including advice and guidance (A&G), per 100 outpatient first attendances by March 2023**.

Systems are asked to plan how the **redeployment of the released capacity** (including staff) is **used to increase elective clock-stops or reduce clock-starts** proactively.

£2.3 billion of elective recovery funding has been allocated to systems to support the recovery of elective services in 2022/23. Further details will be shared in additional guidance

£1.5 billion of capital above that funded within core envelopes has been made available to the NHS over three years to support new surgical hubs, increased bed capacity and equipment to help elective services recover.

Systems are asked to demonstrate how their **capital proposals support a material quantified increase in elective activity**, e.g. through schemes that enable the separation of elective and non elective activity, the setting up or expansion of elective hub sites, day case units or increased bed capacity. Further detail on these requirements and the process will be set out in additional guidance.

C1. Elective Recovery – Maximise elective activity & reduce long waits taking full advantage of opportunities to transform the delivery of services

Systems are asked to rapidly draw up **delivery plans across elective inpatient, outpatient and diagnostic services for adults and children (including specialised services) for April 2022 to March 2023**. These plans should set out how:

- **systems will meet the ambitions set out above**, reflecting the additional revenue and capital funding being made available. We will set out further details in additional guidance
- services will be organised and delivered to maximise productivity opportunities and secure the best possible outcomes for patients
- **local independent sector capacity is incorporated** as a core element to deliver improved outcomes for patients and reduce waiting times sustainably
- the **updated UK Health Security Agency (UKHSA) guidance will be implemented**, ensuring safety concerns are appropriately balanced.
- systems will ensure **inclusive recovery and reduce health inequalities** where they are identified
- elective care, UEC, social care and mental health will be managed in a way that ensures elective recovery can be protected and any disruptions minimised.

C2. Elective Recovery – Complete recovery and improve performance against cancer waiting time standards

Systems should therefore, as a priority, complete any outstanding work on the post-pandemic cancer recovery objectives set out in the 2021/22 H2 planning guidance, to:

- **return the number of people waiting for longer than 62 days to the level in February 2020** (based on the national average in February 2020)
- meet the **increased level of referrals** and treatment required to **reduce the shortfall in number of first treatments**

Priority actions should centre on ensuring there is sufficient diagnostic and treatment capacity to meet recovering levels of demand, with a particular focus on the three cancers making up two-thirds of the national backlog **(lower GI, prostate and skin),** including:

- provision of **sufficient commissioned capacity** so that **every urgent suspected lower GI cancer referral is accompanied by a faecal immunochemical test (FIT) result**
- **delivery of the optimal timed pathway** for prostate cancer, **including ensuring mpMRI prior to biopsy** to eliminate the need for biopsy wherever possible
- **making teledermatology available** as an option for clinicians in all providers receiving urgent cancer referrals.

Systems are asked to work with Cancer Alliances to develop and implement a plan to:

- **improve performance against all cancer standards**, with a **focus on the 62-day urgent referral** to first treatment standard, the **28-day faster diagnosis standard** and the **31-day decision-to-treat** to first treatment standard
- make progress against the ambition in the NHS Long Term Plan to **diagnose more people with cancer at an earlier stage**, with a particular **focus on disadvantaged areas where rates of early diagnosis are low**er

Delivery of these plans is expected to support:

- **Timely presentation and effective primary care pathways including:**
  - working with PCNs to support implementation of cancer early diagnosis as set out in the Network Contract Directed Enhanced Service (DES)
  - running local campaigns to complement national advertising to raise public awareness of cancer symptoms and encourage timely presentation.

C2. Elective Recovery – Complete recovery and improve performance against cancer waiting time standards

- **Faster diagnosis, including:**
  - extending coverage of non-specific symptom pathways – **with at least 75% population coverage by March 2023**
  - **ensuring at least 65% of urgent cancer referrals** for suspected prostate, colorectal, lung, oesophago-gastric, gynaecology and head and neck cancer meet timed pathway milestones.
- **Targeted case finding and surveillance, including**:
  - **maximising the uptake of targeted lung health checks (TLHC)** and the **effective delivery of follow-up low dose CT scans**, to meet trajectories agreed with the national team. From 2022/23, all Cancer Alliances will have at least one TLHC project
  - ensuring that every person diagnosed with **colorectal and endometrial cancer is tested for Lynch syndrome** (with cascade testing offered to family members), and patients who qualify for **liver surveillance** under National Institute for Health and Care Excellence (NICE) guidance are **identified and invited to surveillance.**

Plans will form basis of Cancer Alliance Funding agreements.

ICBs and Cancer Alliances are also asked to work with trusts to:

- ensure they have fully operational and sustainable **patient stratified follow-up (PSFU) pathways for breast, prostate, colorectal** and **one other cancer** by the end of the **first quarter of 2022/23**; and for **two further cancers** (one of which should be endometrial cancer) **by March 2023**
- for systems participating in **colon capsule endoscopy** and **cytosponge projects**, **deliver agreed levels of activity**
- **increase the recruitment and retention** of clinical nurse specialists, cancer support workers and pathway navigators, and promote take up of clinical training opportunities for the cancer workforce.

Maintaining and restoring cancer screening programmes is critical to our efforts to fully restore cancer services. For **breast cancer screening** in particular, any systems that have not restored compliance with the three-year cycle by the end of March 2022 are expected to have done so by the **end of June 2022**.

C3. Elective Recovery – Diagnostics

Systems are asked to:

- increase diagnostic activity to a minimum of **120% of pre-pandemic levels across 2022/23** to support these ambitions and meet local need
- **develop investment plans** that lay the foundations for further **expansion of capacity through CDCs** in **2023/24 and 2024/25**.

Three-year capital funding allocations will be included in system envelopes for this purpose, national investment through HEE planned to facilitate training & supply staff of workforce. Systems will be able to access dedicated revenue funding to support set up and running of CDCs, subject to the necessary business case approvals. Revenue will be allocated to align with the programmes of work or agreed capital business cases.

Systems are asked to utilise targeted capital allocations to:

- increase the number of endoscopy rooms, **levelling up to a guide level of 3.5 rooms per 100,000 population over 50 years of age**. Systems should consider using this funding to locate endoscopy services in CDCs and supplement available CDC funding allocations, seeking to co-locate endoscopy and imaging services where possible. Funding will also be available to units that have yet to meet Joint Advisory Group (JAG) on Gastrointestinal Endoscopy accreditation to upgrade their services
- **invest in CT capacity to support expansion the Target Lung Health Checks programme from 2023/24,** with target coverage to be agreed between Cancer Alliances and the National Cancer Programme team. Cancer Alliances will receive this targeted funding on the basis of their remaining unscreened population and existing CT capacity and should coordinate with ICSs.
- develop additional digitally connected imaging capacity and **ensure that acute sites have a minimum of two CT scanners**
- **procure new breast screening units** to deliver the 36-month cycle.

Operational capital resources should continue to be used to reduce the backlog of diagnostic equipment replacement over 10 years old

C3. Elective Recovery – Diagnostics

Pathology & Imaging Networks

- Pathology and imaging networks to complete the delivery of their **diagnostic digital roadmaps** as part of their **digital investment plans**. National funding will be provided that is broadly consistent with these roadmaps, taking account of progress to date.
- **Refreshed roadmaps need to include specific plans** setting out how pathology and imaging networks and CDCs will with their systems support **artificial intelligence (AI) research and innovatio**n, and the **scalable and sustainable integration of AI-driven diagnostics**.
- The implementation of digital diagnostic investments is expected to deliver at least a 10% improvement in productivity by 2024/25, in line with the best early adopters.
- Systems should ensure that pathology networks reach, as a minimum, the **'maturing' status** for delivery of pathology services on the pathology network **maturity framework by 2024/25**
- They should also meet the requirements of all national data collections for diagnostic services and support the work to scope creation of endoscopy and clinical physiology networks.

Programme funding of £21 million is available to support pathology and imaging networks to deliver on these priorities in 2022/23 alongside the implementation of CDCs.

C4. Delivering Improvements in Maternity Care

- ICSs should undertake formal, structured and systematic oversight of how their LMS delivers its functions and there should be a direct line of sight to the LMS board.
- Providers are asked to continue to **embed and deliver the seven immediate and essential actions** identified in the **interim Ockenden report**, along with any future learning shared in the second Ockenden report and East Kent review (when published). LMSs should continue to oversee quality in line with Implementing a revised perinatal quality surveillance model
- LMSs are asked to support providers to prioritise reopening any services suspended due to the pandemic, ensuring women can take somebody with them to all maternity appointments and supporting work to increase vaccination against COVID-19 in pregnancy. LMSs should implement local **maternity equity and equality action plans** in line with Equity and equality: Guidance for local maternity systems.
- LMSs are also asked to continue to work with providers to **implement local plans to deliver Better Births**, **the report of the national maternity review**, including:
  - delivering local plans for midwifery continuity of carer (MCoC) in line with Delivering midwifery continuity of carer at full scale, prioritising MCoC so that most Black, Asian and mixed ethnicity women and most women from the most deprived areas receive it once the building blocks are in place
  - offering every woman a personalised care and support plan in line with the Personalised care and support planning guidance
  - fully implement Saving Babies' Lives. Providers should have a preterm birth clinic and act so that at least 85% of women who are expected to give birth at less than 27 weeks' gestation are able to do so in a hospital with appropriate on-site neonatal care.

Funding of c£93 million to support the implementation of Ockenden actions through investment in workforce will go into **baselines from 2022/23**. Programme funding will also be made available to support the delivery of the Better Births priorities

D1. Urgent & Emergency Care

An essential requirement is to increase the capacity of the NHS by the equivalent of at **least 5,000 G&A beds** and return, as a minimum, to pre-pandemic levels of bed availability through a combination of:

- **national funding** for the further **development of virtual wards** (including hospital at home)
- **system capital plans** to **increase physical bed capacity** as part of **elective recovery plans**
- re-establishing bed capacity consistent with latest UKHSA IPC guidance.

Systems are therefore asked to:

- reduce **12-hour waits in EDs** towards **zero and no more than 2%**
- improve against **all Ambulance Response Standards**, with plans to achieve Category 1 and Category 2 mean and 90th percentile standards
- minimise handover delays between ambulance and hospital, allowing crews to get back on the road and contribute to achieving the ambulance response standards. This includes:
  - **eliminating handover delays of over 60 minutes**
  - **ensuring 95% of handovers take place within 30 minutes**
  - **ensuring 65% of handovers take place within 15 minutes**
- ensure stability of services and have planned contingency in advance of next winter.

Systems are asked to build on the work already commenced, as indicated in the UEC 10 Point Action Recovery Plan. This should incorporate:

- **Increasing capacity within NHS 111** to ensure the service is the credible first option for patients, enabling their referral to the most appropriate care setting, including:
  - call handling capacity to meet growing demand
  - clinical capacity within the clinical assessment service to support decision making, with >15% of calls received having clinical input

- ensuring there is a full range of available options in the Directory of Services to meet local need
- adopting the new regional/national route calling technology.

- **Expanding urgent treatment centre (UTC) pro**vision and increasingly moving to a model where **UTCs act as the front door of ED,** to enable emergency
- Systems are asked to put in place **integrated health and care plans for children and young people's services that include a focus on urgent care;** building on learning from pilots placing paediatric staff within NHS 111 services; better connections between paediatric health services; joining up children's services across the NHS and local authorities; improving transitions to adult services; and supporting young people with physical and mental health needs within acute and urgent care settings.
- Systems are asked to consistently **submit timely Emergency Care Data Set** (ECDS) data, now **seven days a week.**

D2. Transform & build community services capacity to deliver more care at home & improve hospital discharge

Virtual Wards

- Systems to develop detailed plans to maximise the rollout of virtual wards to deliver care for patients who would otherwise have to be treated in hospital, by enabling earlier supported discharge and providing alternatives to admission. **These plans should be developed across systems and provider collaboratives, rather than individual institutions, based on partnership between secondary, community, primary and mental health services**. Systems should also consider partnerships with the independent sector where this will help grow capacity.
- **By December 2023,** we expect systems to have completed the comprehensive development of virtual wards towards a national ambition of **40–50 virtual wards per 100,000 population**. Successful implementation will require systems to:
  - maximise their overall bed capacity to include virtual wards
  - prevent virtual wards becoming a new community-based safety netting service; they should only be used for patients who would otherwise be admitted to an NHS acute hospital bed or to facilitate early discharge
  - maintain the most efficient **safe staffing and caseload model**
  - **manage length of stay** in virtual wards through establishing **clear criteria to admit and reside for services**
  - **fully exploit remote monitoring technology** and wider digital platforms to deliver effective and efficient care

Up to £200 million will be available in 2022/23 and up to £250 million in 2023/24 (subject to progress of systems) to support the implementation of these plans. We expect plans to cover two years. The scale of funding awarded in 2022/23 will depend on credible ambition for delivery of virtual wards by December 2022 to provide capacity for next winter. Systems will want to consider approaches that address patients with lower intensity and higher intensity needs (ie Hospital at Home services). We will set out further guidance on the virtual ward model, the support available and the funding criteria.

D2. Transform & build community services capacity to deliver more care at home & improve hospital discharge

Urgent Community Response

Over 2022-23 providers and systems will be required to:

- **Maintain full geographic rollout** and continue to grow services to reach more people extending operating hours where demand necessitates and at a minimum operating **8am to 8pm, 7 days a week in line** with national guidance
- Improve outcomes through reaching patients in crisis in under 2 hours where clinically appropriate. Providers will be required to achieve, and ideally exceed in the majority of cases, the minimum **threshold of reaching 70% of 2 hour crisis response demand within 2 hours from the end of Q3.**
- **Increase the number of referrals from all key routes**, with a focus on UEC, 111 and 999, and increase care contacts
- Improve **capacity in post urgent community response services** to support flow and patient outcomes including avoiding deterioration into crisis again or unnecessary admission
- Ensure **workforce plans support increasing capacity and development of skills and competencies** in line with service development
- **Improve data quality and completeness in the Community Services Dataset (CSDS**) as this will be the key method to monitor outcomes, system performance and capacity growth

Anticipatory Care

ICSs should design, plan for and commission AC for their system. Systems need to work with health and care providers to develop a plan for delivering **AC from 2023/24 by Q3 2022**, in line with forthcoming national operating model for AC.

Enhanced Health In Care Homes

Ensure **consistent and comprehensive coverage of Enhanced Health in Care Homes** in line with the national framework.

D2. Transform & build community services capacity to deliver more care at home & improve hospital discharge

Community Service Waiting Lists

Systems must **develop and agree a plan for reduction of community service waiting lists** and **ensure compliance of national sitrep reporting**. Specifically, systems are asked to:

- develop a trajectory for reducing their community service waiting lists
- significantly reduce the number of patients waiting for community services
- prioritise patients on waiting lists
- consider transforming service pathways and models to improve effectiveness and productivity.

Hospital Discharge

Additional funding for the Hospital Discharge Programme will end in March 2022, as part of preparing the NHS for the potential impact of the Omicron variant and other winter pressures, we have asked systems to work together with local authorities and partners, including hospices and care homes, to release the maximum number of beds, **as a minimum this should be equivalent to half of current delayed discharges**. Systems should **seek to sustain the improvement in delayed discharges in 2022/23** working with local authority partners and supported by the Better Care Fund and the investment in virtual wards.

Digital

Systems are asked to:

- **identify digital priorities to support the delivery of out-of-hospital models of care** through the development of system digital investment plans, ensuring community health services providers are supported to develop robust digital strategies to support improvements in care delivery
- ensure providers of community health services, including ICS-commissioned independent providers, can **access the Local Care Shared Record as a priority in 2022/23**, to enable urgent care response and virtual wards
- deliver radical **improvements in quality and availability against national data requirements and clinical standards**, including the priority areas of **urgent care response and musculoskeletal (MSK)**

E. Improving access to Primary Care – expanding capacity & increasing the number of appointments available

We expect systems to **maximise the impact of their investment in primary medical care and PCNs** with the aim of driving and **supporting integrated working at neighbourhood and place level.** Systems are asked to look for opportunities to **support integration between community services and PCNs**, given they are an integral part of solutions to key system challenges that require a whole system response, including elective recovery and supporting more people in their own homes and local communities. Systems should also consider how community pharmacy can play a greater role in local plans as part of these integrated approaches.

Expanding the primary care workforce remains a top priority to increase capacity, systems are expected to:

- support their PCNs to have in place their share of the 20,500 FTE PCN roles **by the end of 2022/23** (in line with the target of 26,000 by the end of 2023/24) and to work to implement shared employment models, drawing on more than £1 billion of Additional Roles Reimbursement Scheme (ARRS) funding across system development funding (SDF) and allocations
- **expand the number of GPs** towards the 6,000 FTE target, with consistent local delivery of national GP recruitment and retention initiatives, thereby continuing to make progress towards delivering 50 million more appointments in general practice by 2024.

Other key priority areas include:

- Systems are asked to support the continued delivery of good quality access to general practice through increasing and optimising capacity, addressing variation and spreading good practice
- Every opportunity to **secure universal participation in the Community Pharmacist Consultation Service** should be taken. Systems should drive the transfer of lower acuity care from both general practice and NHS 111 under this scheme, supported by a new investment and impact fund indicator for PCNs which incentivises contributions to a minimum of two million appointments in 2022/23.
- Systems will need to implement **revised arrangements for enhanced access** delivered through PCNs from October 2022.
- Systems are asked to support practices and PCNs to ensure the commitment that every patient has the right to be **offered digital-first primary care by 2023/24 is delivered.**
- From **April 2022** there will be a phased introduction of **two new DES services – anticipatory care and personalised care** – and an expanded focus on cardiovascular disease (CVD) diagnosis and prevention.

E. Improving access to Primary Care – expanding capacity & increasing the number of appointments available

- Systems are asked to support their PCNs to work closely with local communities to **address health inequalities**
- Practices should continue the critical job of catching up on the **backlog of care for their registered patients who have ongoing condi**tions, to ensure the best outcomes for them and to avoid acute episodes or exacerbations that may otherwise result in avoidable hospital admissions or even premature mortality. Systems are asked to take every opportunity to use **community pharmacy to support this**; for example, in the delivery of care processes such as blood pressure measurement under new contract arrangements.
- Systems should also **optimise use of pharmacy services** around smoking cessation on hospital discharge, the expanded new medicines service and the discharge medicines service
- For dental services, the focus is on maximising clinically appropriate activity in the face of ongoing IPC measures, and targeting capacity to meet urgent care demand, minimise deterioration in oral health and reduce health inequalities.
- Subject to the passage of the Health and Care Bill, ICBs will become the delegated commissioners for primary medical services and, in some cases, also dental, community pharmacy and optometry services, during 2022/23. Once established, **ICBs should develop plans, working with NHS England regional commissioning teams to take on effective delegated dental, community pharmacy and optometry commissioning functions from 2023/24**

F1. Expand and improve mental health services

Systems are asked to:

- **Continue to expand and improve their mental health crisis care provision for all ages**. This includes improving the operation of all age 24/7 crisis lines, crisis resolution home treatment teams and mental health liaison services in acute hospitals. Systems are also asked to increase the provision of alternatives to A&E and admission, and improve the ambulance mental health response. Over the next three years £150 million targeted national capital funding will be made available to support improvements in mental health UEC, including mental health ambulances, extending Section 136 suites, safe spaces in or near A&E.
- **Ensure admissions are intervention-focused, therapeutic and supported by a multidisciplinary team**, utilising the expansion of mental health provider collaboratives across the whole mental health pathway where systems plan such developments. These collaboratives will support systems to transform services and reduce reliance on hospital-based care delivered away from people's local area.
- Continue the **expansion and transformation of mental health services, as set out in the NHS Mental Health Implementation Plan 2019/20–2023/24**, to improve the quality of mental healthcare across all ages. The mental health LTP ambitions tool will support systems to understand their delivery requirements for expanding access, as well as the Mental Health Delivery Plan 2022/23.
- Continue to **grow and expand specialist care and treatment for infants, children and young people** by increasing the support provided through specialist perinatal teams for infants and their parents up to 24 months and through continuing to expand access to children and young people's mental health services.
- Subject to confirmation, encourage **participation in the first phase of the national Quality Improvement programme** to support implementation of the Mental Health Act reforms.
- Systems **maintain a focus on improving equalities across all programmes**, noting the actions and resources identified in the Advancing Mental Health Equalities Strategy

F1. Expand & grow mental health services

Delivery of the Mental Health Investment Standard (MHIS) remains a mandatory minimum requirement, ensuring appropriate investment of baseline funding and SDF to deliver the mental health NHS Long Term Plan objectives by 2023/24. Where SDF funding supports ongoing services, these will continue to be funded beyond 2023/24. This will support the continued expansion and transformation of the mental health workforce. For this:

- systems are asked to develop a **mental health workforce plan to 2023/24** in collaboration with mental health providers, HEE and partners in the voluntary, community and social enterprise (VCSE) and education sectors
- PCNs and mental health trusts are asked to continue to use the **mental health practitioner ARRS roles** to improve the care and treatment for adults, children and young people in line with NHS Long Term Plan ambitions.

Capital funding made available through system allocations is expected to support urgent patient safety projects for mental health trusts, such as those that address ligature points and other infrastructure concerns that pose immediate risks to patients. **Funding to eradicate mental health dormitories will continue in 2022/23 and 2023/24**

Systems are asked to work with the Mental Health Provider Collaboratives to produce a **clear plan of requirements for CYPMH general adolescent and psychiatric intensive care in-patient beds to meet the health needs of their population, strengthen local services and eliminate out of area placements for the most vulnerable young people.** These bed plans should be an integral part of the overall plan for CYP mental health services to ensure a local, whole patient pathway for patients with mental health, learning disability and/or autism needs. The plans should be complete **by the end of Q1 2022/23** and should be funded through system operational capital. Investing in this way is expected to reduce operating costs as a direct result of improving access to local services and reducing out of area patient flows. Further guidance on the development of these plans will be issued before the start of 2022/23.

All NHS commissioned services must flow **data to the national datasets and relevant bespoke collections**. Provision for this must be included and agreed in commissioning arrangements planned for 2021/22, as part of this process

F2. Meeting the needs of people with learning disability and autistic people

Systems are asked to:

- Increase the rate of annual health checks for people aged 14 and over on a GP learning disability register towards the **75% ambition in 2023/24.** Every annual health check should be accompanied by a health action plan to identify actions to improve the person's health.
- Continue to **improve the accuracy of GP learning disability registers** so that the identification and coding of patients is complete, and particularly for under represented groups such as children and young people and people from ethnic minority groups.
- Maintain a strong commitment to **reducing reliance on inpatient care for both adults and children** with a learning disability and/or who are autistic, consistent with the ambition set out in the NHS Long Term Plan, and to develop community services to support admission avoidance and timely discharge.
- **Build on the investment made in 2021/22** to develop a range of care and diagnostic services for autistic people delivered by multidisciplinary teams. This includes access to community mental health services; support for autistic children and young people and their families; and access to the right support and housing. Systems should adopt best practice to improve local diagnostic pathways to minimise waiting times for diagnosis, improve patient experience and ensure that there is accurate and complete reporting of diagnostic data.
- **Implement the actions coming out of Learning Disability Mortality Reviews** (LeDeRs), including following deaths of people who are autistic, to tackle the inequalities experienced by people with a learning disability; these have been exacerbated by the pandemic.

Service development funding support of £75 million is being made available in 2022/23 to achieve the above ambitions.

G. Continue to develop our approach to population health management, prevent ill-health & address health inequalities

- ICSs will take a lead role in tackling health inequalities by building on the **Core20PLUS5 approach introduced in 2021/22**.
- Systems are asked to **develop plans by June 2022** to put in place the systems, skills and data safeguards that will act as the foundation for this.
- **By April 2023, every system** should have in place the technical capability required for **population health management, with longitudinal linked data available to enable population segmentation and risk stratification, using data and analytics to redesign care pathways and measure outcomes with a focus on improving access and health equity for underserved communities**. Systems are encouraged to work together to share data and analytic capabilities.

We are asking systems to **develop robust plans for the prevention of ill-health, led by a nominated senior responsible officer (SRO).** These plans should reflect the primary and secondary prevention deliverables as outlined in the NHS Long Term Plan, and the key local priorities agreed by the ICS. Plans should set out how system allocations will be deployed to:

- Support the **rollout of tobacco dependence treatment services in all inpatient and maternity settings**, in line with agreed trajectories and utilising £42 million of SDF funding.
- **Improve uptake of lifestyle services**, the Diabetes Prevention Programme, Low Calorie Diets, the new Digital Weight Management Programme and digitally supported self-management services.
- Restore diagnosis, monitoring and management of hypertension, atrial fibrillation and high cholesterol and diabetes, as well as asthma and COPD registers and spirometry checks for adults and children, **to pre-pandemic levels in 2022/23**, as per the Quality and Outcomes Framework (QOF), Integrated Investment Fund and Direct Enhanced Service targets
- **Progress against the NHS Long Term Plan high impact actions** to support respiratory, stroke and cardiac care, implementing new models of care and rehabilitation, including remote and digital models, and increasing respiratory, hypertension, atrial fibrillation and high cholesterol detection and monitoring/control to pre-pandemic levels. This should include how systems plan to implement national procurements and population health agreements such as those in place for inclisiran and direct oral anticoagulants (DOACs). NHS England's new DOAC framework agreement will make treatment more affordable, allowing the NHS to provide DOACs to 610,000 additional patients. Uptake of DOAC treatment at this level will help prevent an estimated 21,700 strokes and save 5,400 lives over the next three years

G. Continue to develop our approach to population health management, prevent ill-health & address health inequalities

- **Reduce antibiotic use in primary and secondary care** through early identification and treatment of bacterial infections, and support reduced lengths of hospital stays by ensuring that intravenous antibiotics are only used for as long as clinically necessary, with a switch to oral antibiotics as soon as appropriate.

Systems are also asked to:

- renew their focus on **reducing inequalities in access to and outcomes** from NHS public health screening and immunisation services
- continue to adopt **culturally competent approaches to increasing vaccination uptake** in groups that have a lower than overall average uptake as of March 2022
- continue to deliver on the **personalised care commitments set out in the NHS Long Term Plan** – social prescribing referrals, personal health budgets, and personalised care and support plans are key enablers of population health and prevention

H. Exploit the potential of digital technologies to transform the delivery of care and patient outcomes

- Acute, community, mental health and ambulance providers are required to meet a core level of digitisation by March 2025, in line with the NHS Long Term Plan commitment. **By March 2022, systems should develop plans** that set out their first year's priorities for achieving a core level of digitisation across all these settings (as set out by the Frontline Digitisation minimum viable product, which will be published by 31 December).
- **Costed three-year digital investment plans should be finalised by June 2022** in line with What Good Looks Like (WGLL). We will fund systems to establish dedicated teams to support the development and delivery of their plans, which should:
  - include provisions for **robust cyber security across the system**. We will continue to provide and further enhance centralised cyber security capabilities systems; however, local organisations are responsible for managing their own cyber risk
  - **reflect ambitions to consolidate purchasing and deployment of digital capabilities**, such as electronic patient records and workforce management systems, at system level where possible
  - set out the steps being taken locally to **support digital inclusion**
  - consider how digital services can support the **NHS Net Zero Agenda**.

Capital will be available to systems for three years from 2022/23, to support digitisation of acute, mental health, ambulance and community services. £250 million will initially be allocated to systems for 2022/23 while they develop digital investment plans, funding will be directed towards those services/settings that are the least digitally mature.

Systems are asked to ensure that:

- **by March 2023**, all systems within a Shared Care Record collaborative can exchange information across the whole collaborative, with a view to **national exchange by March 2024**. Standards will be published to support this
- local authorities with social service responsibilities within their footprint are connected to their local Shared Care Record solution by **March 2023**, and that all social care providers can **connect within six months** of them having an operational digital social care record system
- suppliers comply with interoperability standards as these are finalised by **April 2022**
- general practice promotes the NHS App and NHS.UK to reach 60% adult registration **by March 2023**
- plans are developed to support skilling up the workforce to maximise the opportunities of digital solutions
- Ambition for the **NHS e-Referral Service (e-RS**) to become an any-to-any health sector triage, referral and booking system by **2025**. Mental health and other additional services are being evaluated for inclusion in 2022/23.

I. Making the most effective use of resources

- The 2021 Spending Review (SR21) provided the NHS with a three-year revenue and capital settlement covering 2022/23 to 2024/25. The government committed to spend an additional £8 billion to support tackling the elective backlog over the next three years, from 2022/23 to 2024/25.
- This allows NHSE to prioritise **£2.3 billion in 2022/23** to support **elective recovery**.
- SR21 also confirmed that the NHS will receive total capital resources of £23.8 billion over the next three years, including £4.2 billion of funding to support the building of 40 new hospitals and to upgrade more than 70 hospitals; £2.3 billion to transform diagnostic services; £2.1 billion for innovative use of digital technology; and £1.5 billion to support elective recovery.
- NHSE will shortly issue **one-year revenue allocations to 2022/23** and **three-year capital allocations to 2024/25**. NHSE intend to publish the remaining two-year revenue allocations to 2024/25 **in the first half of 2022/23**.

Use of Resources

- With this funding the NHS is expected to **fully restore core services** and make **significant in-roads into the elective backlog and NHS Long Term Plan commitments.**
- The SR21 settlement assumes the **NHS takes out cost and delivers significant additional efficiencies**, on top of the NHS Long Term Plan requirements, to address the excess costs driven by the pandemic response, moving back to and beyond pre pandemic levels of productivity when the context allows this
- The scale of the efficiency requirement will be sustained throughout the SR21 period and systems should ensure they **develop plans that deliver the necessary exit run-rate position** to support delivery of future requirements.

I. Making the most effective use of resources

Financial Framework

The 2022/23 financial and contracting arrangements are summarised as:

- A glidepath from current system revenue envelopes to fair share allocations. **ICB revenue allocations will be based on current system funding envelopes**, which continue to include the funding previously provided to support financial sustainability. In addition to a **general efficiency requirement**, we will apply a convergence adjustment to bring systems gradually towards their fair share of NHS resources. This will mean a tougher ask for systems consuming more than their relative need.
- Increased clarity and certainty over capital allocations, **with multi-year operational capital allocations set at ICB level**, building on the approach taken in the last two years, and greater transparency over the allocation of national capital programmes.
- A collective local accountability and responsibility for delivering system and ICB financial balance. The Health and Care Bill includes provisions which are designed to ensure that ICBs and trusts are **collectively held responsible for their use of revenue and capital resources**. Each ICB and its partner trusts will have a financial objective to deliver a financially balanced system, **namely a duty on breakeven**.
- A **return to signed contracts and local ownership for payment flows under simplified rules**. To restore the link between commissioning and funding flows, commissioners and trusts will have **local ownership for setting payment values on simplified terms,** supported by additional guidance from NHSE. While written contracts between commissioners and all providers (NHS and non-NHS) will be needed to cover the whole of the 2022/23 financial year, systems and organisations should **continue to take a partnership approach to establishing payment terms and contract management** such that focus on delivery of operational and financial priorities can be maximised. We are separately publishing an updated draft of the **NHS Standard Contract for 2022/23** for consultation; the final version of the contract, to be used in practice, will be published in **February 2022**.
- A commitment to support systems to tackle the elective backlog and deliver the NHS Long Term Plan. **Additional revenue and capital funding will be provided to systems to support elective recovery**, with access to additional revenue where systems exceed target levels. Provider elective activity plans will be funded as per the aligned payment and incentive approach, with payment linked to the actual level of activity delivered. ICBs will continue to be required to deliver the MHIS, as well as to meet other national investment expectations. We will set these out in additional guidance.
- A continued focus on integration of services to support the transition for future delegations. For those services that continue to be commissioned by NHS England in 2022/23, mechanisms to strengthen joint working with ICBs will be established.

J. Establish ICBs & Collaborative System Working

New target date of 1 July 2022 has been agreed for new statutory arrangements for ICSs to take effect and ICBs to be legally and operationally established:

- CCGs will remain as statutory organisations
- CCG leaders will work closely with designate ICB leaders in key decisions that will affect the future ICB, notably commissioning and contracting.
- NHS England and NHS Improvement will retain all direct commissioning responsibilities not already delegated to CCGs

During Q4 2021/22, NHSE will consult with CCGs on changes to their boundaries, to align with the ICS boundary changes decided by the Secretary of State in July 2021. CCG boundary changes coming into effect from 1 April 2022 would support the smooth transition from CCGs to ICBs at the implementation date.

Next Steps

- Continue preparations for closure of CCGs & establishment of ICB's working towards new date, systems should ensure they have **clear & effective plans for local communications** & engagement with the public, staff, trade unions and other stakeholders
- ICB designate chairs and chief executives should **continue to progress recruitment to their designate leadership teams.** Current/planned **recruitment activities for designate leadership roles should continue where this is the local preference**, but **formal transition to the future leadership arrangements** should now be **planned for the new target date of 1 July 2022.**
- **Employment commitment arrangements** for other affected staff and the talent based approach to people transition previously set out will be **extended to reflect the new target date**.
- The requirements for **ICB Readiness to Operate and System Development Plan submissions** currently due in mid-February 2022 will be **revised to reflect the extended preparatory period**.
- Designate ICB leaders, CCG accountable officers and NHS England and NHS Improvement regional teams will be asked to **agree ways of working for 2022/23 before the end of March 2022**. This will include agreeing how they will work together to support **ongoing system development during Q1**, including the **establishment of statutory ICS**s and the **oversight and quality governance arrangements** in their system.

Planning during 2022/23

- The Health and Care Bill before Parliament will require each ICB to **publish a five-year system plan before April each year**. This plan must take **account of the strategy produced by the integrated care partnership (ICP)**, and **the joint strategic needs assessments** and **joint health and wellbeing strategies** produced by the relevant health and wellbeing board(s).
- Require **ICBs' refreshed five-year system plans in March 2023**. This will give each ICB and its local authority partners sufficient time to agree a strategy for the ICP that has broad support, and to develop a plan to support its implementation, including the development of place based integration. ICBs will **undertake preparatory work through 2022/23** to ensure that their five-year system plans:
  - **match the ambition for their ICS**, including delivering specific objectives under the **four purposes** to:
    - improve outcomes in population health and healthcare
    - tackle inequalities in outcomes, experience and access
    - enhance productivity and value for money
    - support broader social and economic development
  - reflect the **national priorities and ambitions** for the NHS
  - take **account of the responsibilities** that they will be **taking on** for commissioning services that are currently **directly**
  - **commissioned by NHS Engla**nd, such as **primary care** and some **specialised serv**ices.

Health and Wellbeing Board

25 January 2022

Update Report for the Walsall Local Area SEND Improvement Programme.

For Assurance

1. Purpose

The SEND Local Area Improvement Programme is designed to address the nine areas of concern identified by Ofsted and the Care Quality Commission in the SEND Local Area inspection in February 2019. As a result of the inspection findings, the Walsall Local Area were required to outline how it intended to improve SEND services via a Written Statement of Action (WSoA). The implementation of the WSoA is overseen by the Local Area Improvement Board (LAIB) who monitor progress and provide challenge. As part of the governance arrangements, the LAIB are required to provide updates and assurance to the Health and Wellbeing Board on a regular basis.

The purpose of this report is to provide the latest update and assurance.

2. Recommendations

2.1. That the Health and Wellbeing Board consider the content of this report and acknowledge and comment on the progress made to date in the improvement of SEND services.

2.2. That the Health and Wellbeing Board note the concerns in relation to the re-organisation of health and the implementation of the ICS and seek assurances from partners that the impact of this on services for children, and in particular those with additional needs are being given appropriate consideration.

3. Report detail

Background

3.1. Following the SEND Local Area Inspection of Walsal Council by Ofsted and the CQC it was found that there were 9 areas of concern and that a Written Statement of Action (WSoA) was needed from the Council. The Statement of Action was deemed 'fit for purpose' by Ofsted in October 2019 and was published on the council's website: http://go.walsall.gov.uk/education/sendi.

3.2. The actions within the WSoA have been split across four workstreams: Co-production and Engagement, Improving Outcomes, EHCP Assessment Processes and Joint Commissioning.

3.3. A Local Area Improvement Board (LAIB) was established to oversee the implementation of the WSoA and meets monthly. The LAIB is independently

chaired by Vicki Whittaker-Stokes – a parent and foster parent of children with SEND who has SEND needs herself and is now vice chaired by Louise Hudson, Walsall's SEND Independent Advice Service (SENDIAS) manager. The board is also attended by the workstream leads, the relevant strategic leads from the LA, CCG, schools representatives and the portfolio holder for Education and Skills.

3.4. The Local Area also receives support and is regularly assessed for progress by advisors from the Department for Education (DfE) and the Care Qualtiy Commission (CQC). Walsall's advisors are Pat Tate (DfE) and Deborah Ward (CQC)

Preparation for re-inspection

3.5. As at November 2020 there has been 117 Local Area Inspections since the Walsall SEND inspection in February 2019. Of these, 60 (51.3%) have been instructed to implement a WSoA. All local areas that are instructed to implement a WSoA are required to undergo re-inspection to ensure that they have made sufficient progress against the areas of concern raised at the inspection. This should typically be around two years after the initial inspection, however, due to the Covid-19 pandemic many re-inspections have been delayed.

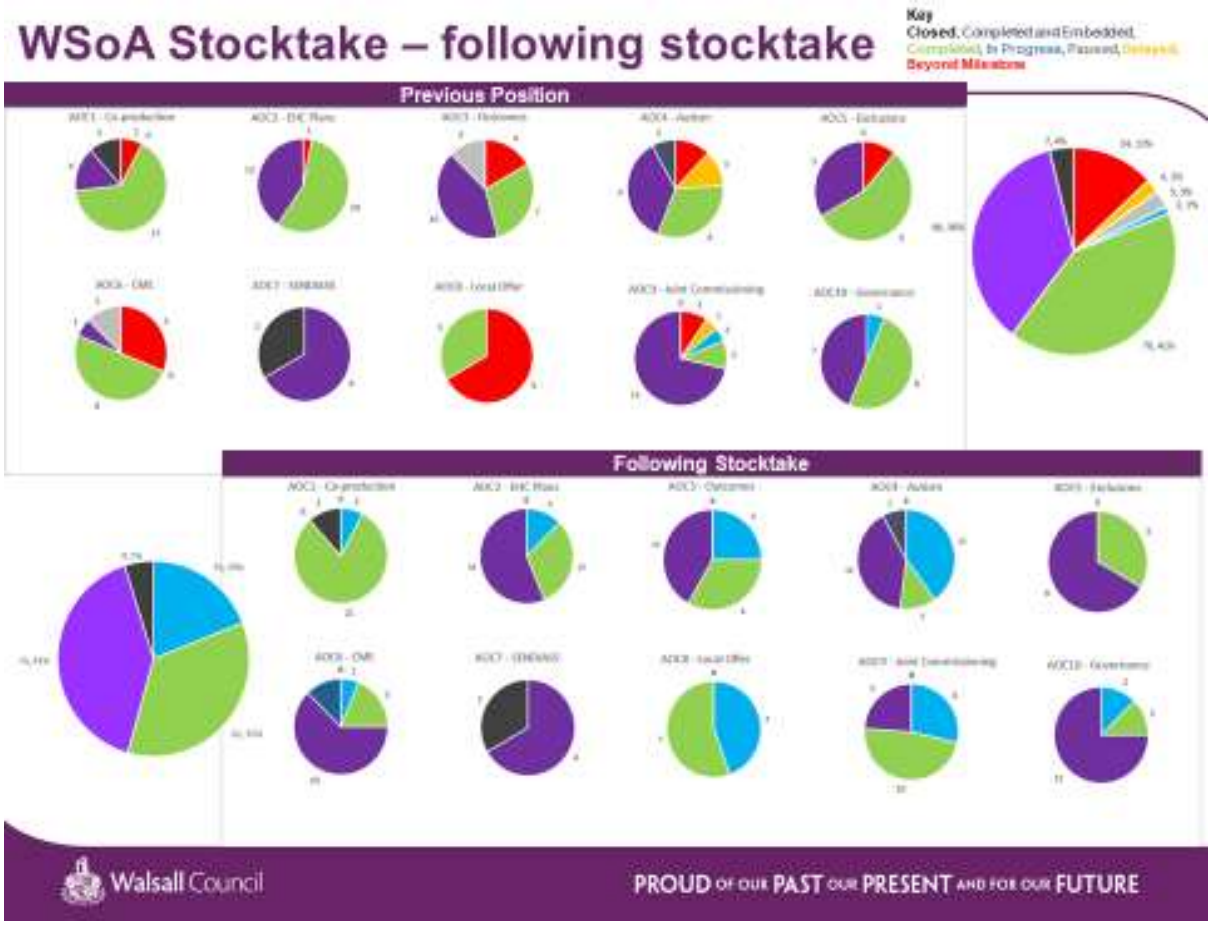
3.6. Broadly speaking, SEND re-inspections are typically completed in the order of the original SEND inspections, however this is not an exact science. Staffordshire are currently undergoing their re-inspection and as they were originally inspection just before Walsall, the Local Area expects to be re-inspected from February 2022.

3.7. We are currently in the process of gathering evidence for re-inspection, which will clearly evidence our journey, detailing achievements and the outcomes and difference they have made to children, young people and families. Walsall's DfE and CQC advisors are supporting the local area through this process, providing additional guidance and support.

Programme Update

3.8. In line with the aforementioned evidence gathering, a 'stocktake' has been undertaken of the actions in the Written Statement of Action (WSoA) to consolidate and confirm the progress to date and identify any outstanding priority areas for focus. This is outlined in the programme status below:

Not Started	Beyond Milestone	Delayed	Paused - Covid Exception	In Progress	Complete	Complete and Embedded	Closed	
0	0	0	0	35	65	75	9	Current Action RAG Ratings - Following Stocktake
Not Started	Beyond Milestone	Delayed	Paused - Covid Exception	In Progress	Complete	Complete and Embedded	Closed	
0	24	4	5	2	76	66	7	Previous Period Action RAG Ratings



3.9. The stocktake provided assurance that there has been significant progress against the majority of the actions outlined in the WSoA. Analysis of the programme status shows that the majority, 81% (149 out of 184) of actions are completed. These actions are also clearly evidenced in the form of documentation.

3.10. Completion of the stocktake has also highlighted the significant developments and progress which have been made in addition to the progress in the WSoA. Although not directly listed as areas of concern within the WSoA, it is important to acknowledge the additional developmental activity the local area has conducted, evidencing it as appropriate. Where relevant, these have been interlinked with the areas of concern in the WSoA, and added into the 'key components of change' which identify improvements. This additional activity includes:

- Covid support including risk assessments for children with an Education Health and Care Plan (EHCP) and monitoring of keeping in touch;
- Support for education staff throughout the Covid-19 pandemic including the Headspace programme;
- Introduction of the Social, Emotional and Mental Health (SEMH) and Behaviour Frameworks (see AOC5);
- A significant amount of training opportunities (a training summary is currently being produced);
- The implementation of the LAIB Shadow Board, which will maintain the effective cross partnership links and strategic collaborative work developed in the LAIB while providing parents, carers and young people with additional opportunities to ensure their voices are heard;

- Recruitment of Emotional and Literacy support workers to work with parents and children who are Electively Home Educated;

- Holiday Activity and Food Scheme (HAF);
- Health review and the merger of the Walsall Clinical Commissioning Group (CCG) into the Black Country and West Birmingham CCG. Further detail around this is included below as it is currently a key area of concern.

3.11. There are a number of areas where there remain outstanding actions and these are being prioritised to ensure that any avoidable drift and delay is addressed prior to re-inspection. This includes actions in the following focussed areas:

- **AOC1 - Co-production and engagement** – there remain some outstanding actions in relation to locality working. Some work around this has been undertaken, but it is too soon for this to have been completed. Locality work has been developed across children's services and the partnership - this is an in depth and ongoing piece of work which is the introduction of a new way of working and service delivery. Original timescales were too ambitious for mirroring this with parents and carers as the ways of working professionally needed to be established and embedded. As locality working continues to embed we are now starting to have the conversations with parents and carers about how this locality model can be rolled out to how we work with them. There is also further work to be done in establishing more regular and ongoing feedback mechanisms for parents, carers and young people.

- **AOC2 - EHC Assessment Process** – there continues to be a significant backlog of EHC reviews and despite improvements made previously in the year, a re-emerging backlog of EHC assessments. As this is one of the most high profile areas within the SEND improvement plan, a detailed update on this work is below. Within this workstream there also remain outstanding actions in relation the introduction of the Single Health Record and some assurance work to be undertaken in relation to the quality of advices for EHC assessments provided by CAMHS.

- **AOC3 – Improving Outcomes** – There are outstanding actions in this area in relation to raising attainment, however, this is due to the lack of evidence available following the cancellation of formal assessments during the pandemic. There are also actions relating to ensuring children with specific literacy or dyslexia receive the right support. This is being addressed through the ongoing Specialist Provision Review which is looking at the current and future predicted need for specialist education for children with SEND to support the commissioning and identification of additional specialist places to ensure that there is sufficient capacity in the system to meet needs.

- **AOC4 – Autism** – There have been some significant delays with progressing some of the actions identified in this area of concern due to both the pandemic and the changes within health. However, this work is now picking up pace again and the LAIB has asked for a specific update around the work being done in this area as part of a focus on the progress of the health review.

- **AOC8 – Local Offer** – Although significant progress has been made in updating the Local Offer website, including the launch of a new website which has so far had positive feedback, there is still some significant work to be done in ensuring that all of the information that parents, carers, young people and professionals need in relation to SEND is

available and up to date. A specific co-ordinator role is being implemented to ensure that the Local Offer remains up to date.

This area of concern also includes outstanding actions in relation to Transition to adulthood with work ongoing to develop a toolkit for transitions for professionals working with young people who are approaching adulthood. There is additional work in progress to develop a toolkit specifically for young people with SEND who are approaching adulthood and their parents and carers to ensure that they are able to access relevant, useful and supportive information is available toe parents, carers and young people.

AOC9 – Joint Commissioning – There are outstanding actions in this area relating to delayed sign off of the memorandum of understanding which formalises and supports joint commissioning work. There is also further work ongoing to evidence how data is being used effectively to plan services, transition protocols within health and the implementation of electronic records within health.

- **AOC10 – Governance –** Work is ongoing in this area in relation to the implementation of the Walsall Learning Alliance which replaces the Strategic Education and Improvement Board (SEIB), following development work undertaken in partnership with the Staff College. Following re-inspection, and assuming the Walsall Local Area are deemed to have made sufficient progress against the WSoA, the LAIB will be disbanded and responsibility for the ongoing improvement of SEND services in Walsall will sit with the Walsall Learning Alliance. To ensure consistency and resilience of all planned work.

Joint Commissioning Workstream

3.12. A number of the actions relating to improvements in the Health system for children with SEND, and in particular those relating to joint commissioning and autism have been delayed due to the merger of Walsall CCG into the Black Country and West Birmingham CCG and the subsequent health review which has begun.

3.13. The LAIB held an extraordinary meeting in April 2021 where the health review was launched and the action plan presented to the Board for discussion and agreement. In the update at the most recent LAIB on 12th January 2022, a number of risks and ongoing delays to actions within the action plan were highlighted.

3.14. In addition, the current uncertainty in health in relation to the implementation of the Integrated Care System and likely upcoming changes to health commissioning arrangements on a national scale is causing some concern about the focus and capacity within health to deliver the required improvements at pace to support children and young people in Walsall with SEND and assurance is being sought from health colleagues in relation to this.

EHCP Assessment Processes Workstream

3.15. Significant projects have been undertaken within the SEND system in Walsall to ensure continued developments and future sustainability. These are outlined below:

- Review of specialist provision and SEND sufficiency;
- Launch of the Inclusion, SEND and Accessibility Strategies;

- Implementation of a new High Needs Funding (HNF) Model;
- Implementation of an EHC Panel, ensuring improved scrutiny of EHC needs assessments, quality assurance and processes;
- Quality Assurance of EHC Plan writing and professional advice;
- Revised processes to EHC plan phased transfers, transitions and annual reviews;
- Development of a tribunal working group to ensure effective management of tribunal matters;
- Commissioning of a new Special Educational Needs and Disabilities Information and Advice Support (SENDIAS) service to support parents, carers, children and young people;
- Procurement of a new Mediation and Disagreement Resolution Service (PRIME Resolution).

3.16. EHC assessment timeliness and compliance is a key focus of the WSoA and timeliness data has been reported to the LAIB board on a monthly basis with action plans being developed accordingly. Performance is also reported on a monthly basis to the DfE advisor and are monitored locally on a weekly basis.

3.17. EHCP performance figures are reported and monitored on a weekly basis by the EHC Assessment team and a reported on a monthly basis to the LAIB and DFE. The current figures reported to the DFE are summarised below: We still continue to focus on the development of the EHCP alongside the timeliness.

3.18. Performance for the last 12 months is shown below alongside a comparison of improving performance since the inspection:

	2021											
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Plans Issued (excluding exceptions)	31	32	24	23	17	18	35	38	35	23	25	14
Issued in 20 weeks	21	20	11	17	5	9	7	13	8	6	6	0
% in 20-weeks (in month)	67.7%	62.5%	45.8%	73.9%	29.4%	50.0%	20.0%	34.2%	22.9%	26.1%	24%	0.0%
% in 20-weeks (cumulative)	**25.3%**	**29.7%**	**31.8%**	**34.9%**	**37.5%**	**39.5%**	**39.2%**	**39.9%**	**40.8%**	**44.2%**	**40.0%**	**39.0%**

	2019	**2020**	**2021**
Plans Issued (excluding exceptions)	247	488	315
Issued in 20 weeks	11	96	123
% in 20-weeks	4%	20%	39%
Direction of travel		↑	↑

3.19. The impact of the Covid-19 pandemic has and continues to impact the SEND service pathways, causing an increased pressure on the EHC Assessment Team and supporting services such as the Educational Psychology Service. This has resulted in a further backlog of assessments

developing and in response the EHC Pathways Recovery Plan has been developed and approved for implementation by the LAIB.

Achieving the EHC Pathways Recovery Plan

3.20. From the 29th November to 1st March 2022, the SEND Assessment team will all operate within an EHC Pathways Recovery Programme (RP). All the team have been reallocated temporary focused roles to support with the work under either an assessment recovery pathway or a review recovery pathway. Training, development, and support will be offered throughout the programme.

3.21. The aim of the programme is to reduce and remove backlogs through a dedicated systematic approach. Clearer roles and process will result in improvements within the EHC assessment backlog and timeliness being consistently above 60%. All processes within the SEND team have been and are continually being reviewed or developed to ensure long term compliancy and timeliness. The recovery programme will end on the 1st March 2022 and be replaced with a 'transformation programme' which will look to the future to secure better outcomes and aspirational practice across pathways. The transformation programme will last a further six months to embed and strengthen both pathways.

3.22. An interim senior management team has been appointed and will support with the oversight and supervision of the recovery programme and regularly report to the SEND team manager and Head of Inclusion. This will allow for frequent and accurate feedback to senior leaders within the council. The SEND team has been split into two teams with one focusing on completion of the 20-week EHC assessments within time, and the other dedicating resources to EHC Annual Reviews. Each team is supervised by highly experienced interim senior officers who are able to support, challenge and give capacity to the focus pathway. Furthermore, both teams are directly managed by an interim manager who will have oversight of the progression and outcomes of the children and young people identified within the programme. Caseloads for all staff, both interim and permanent have been reallocated dependent on their area of work. This is supported by regular supervision over tasks, timescales and step by step guides for consistency. During the programme, the senior programme management team are meeting weekly to discuss outcomes and completion rates and for quality assurance feedback.

3.23. Key EHC Assessment performance milestones:

- Number of backlog assessments reduced by 50% (75 out of 151)
- New and current statutory assessments managed at compliant (58%) timeliness or above.

Risks and Further Actions Taken

3.24. Nationally, there were 430,697 children and young people with an EHC plan maintained by local authorities as at January 2021, this is an increase of 40,588 (10%) from 2020. This increase is also reflected in the West Midlands, with an increase of 4,230 (10%) EHC plans from 2020. In Walsall there is a significant increase in the number of CYP for whom the Council maintain an EHC Plan. On the census return date (14th January 2021) this stood at 2,596; the highest number of EHC Plans recorded in Walsall for the

past five years. Walsall's increase is much higher than of National and the West Midlands, at 23.3%; this is an increase of 490 EHC plans from 2020.

3.25. The number of children and young people with an EHC Plan has been gradually increasing since March 2019. In November 2020, this stood at 2,622 and has increased by 8.2% over the last 12 months and now stands at 2,838. As of the 30th November 2021, there were 1,976 school age children (NCY 0-11) with an EHC plan maintained by Walsall. 34.6% are attending maintained special schools, 25.8% attend mainstream academies and 24.7% attend mainstream LA schools. 5.4% attend an independent special school and 3.6% attend a special school: academy/free. The remaining school age children account for less than 2% each across all of the remaining SEN school types.

3.26. The current increase in EHCP's is placing a greater demand on special school places. As a result the LA are undergoing a specialist provision and sufficiency review which will enable greater capacity planning to meet this increase in need.

3.27. Research on the Educational Psychologist workforce was commissioned by the Department for Education (DfE) in 2019, examined the distribution and demographics of the current Educational Psychologist (EP) workforce in England, and looked to provide evidence of any factors driving recruitment shortages. They found that there are insufficient EP's both in the workforce and in the training pipeline, to meet demand. Monthly recruitment data from the Association of Educational Psychologists (AEP) showed that public sector recruitment of Educational Psychologists fell by a third between 2015 and 2017, with a downward trend continuing into 2018.

3.28. In Walsall, the aforementioned recruitment pressures, in conjunction with the Covid-19 pandemic, are happening at a time when educational psychology (EP) services are at higher demand. Both of which provide an additional challenges to EHC Assessment Pathways and SEN Support. However positively, we have managed to secure a number of locum Educational Psychologists and more will be joining the service in to provide support with EHC needs assessments in January 2022. Furthermore, as a short term measure, we have redesigned our service delivery, which will enable us to support schools, children/young people and their families most effectively through both the EP traded offer and the completion of EHC needs assessments. The EP service will be adjusting their offer to schools over the next two terms, allowing for greater capacity to complete EHC needs assessments in addition to the increase of locum EP support.

4. Implications for Joint Working arrangements:

4.1. **Financial implications:** Local Area partner organisations are responsible for their own budgets in delivering SEND, however, both the council and CCG have contributed to the additional financial commitments that have been needed to run the improvement programme.

4.2. **Legal implications:** The delivery of SEND services within the Local Area is a statutory requirement outlined in the SEND Code of Practice. Failure to deliver SEND services to the required standard can result in a direction from central government resulting in government intervention to improve the delivery of SEND services.

4.3. **Other Resource implications:** Local Area partner organisations are required to continue to provide the relevant resources needed to address the actions outlined in the WSoA to deliver the improvements operationally and ensure there is appropriate oversight at a strategic level through engagement in and delivery of agreed governance mechanisms.

5. Health and Wellbeing Priorities:

5.1. Delivery of SEND improvement in Walsall will ensure that children with additional needs have the best start in life and are supported in their transition to adulthood. The work aligns closely with four of the six Marmot objectives:

- **Giving every child the best start in life** – by ensuring that children with additional needs have their needs recognised early and receive the appropriate health, social care and education support they need.
- **Enabling all children, young people and adults to maximize their capabilities and have control over their lives** – by ensuring that children and young adults with SEND are supported to achieve their potential and that their voices are heard, both in the planning of their own support and the development and improvement of SEND services generally.
- **Creating fair employment and good work for all** – by ensuring that children and young people with SEND receive the support they need to access employment opportunities in the same way as their peers without SEND where they have the capability and capacity to do so and by ensuring that employers are creating those opportunities.
- **Ensuring a healthy standard of living for all** – by ensuring that children and youth people with SEND received the diagnosis and support they need to meet their specific health needs and that universal health provision is accessible to those with SEND in a fair and equitable way.

Background papers

Walsall Local Area SEND Inspection Outcome Letter – January 2019

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Health and Wellbeing Board
25 January 2022

Agenda item 11

Black Country Strategic Child Death Overview Panel

1. Purpose

1.1 The purpose of this report is to

- Update the Walsall Health and Wellbeing Board on activity within the Black Country Strategic Child Death Overview Panel (BC CDOP) 2020 to 2021
- Outline some of the challenges, issues and responses seen in Walsall relating to child deaths
- Provide a summary of data from 2020 – 2021

2. Recommendations:

2.1 The Health and Wellbeing Board partners are asked to:

- Note the below update and challenges
- Accept future reports from the Strategic Child Death Overview Partnership and any accompanying recommendations for learning.
- Relate relevant learning and suggested recommendations in point 13.1 and 13.2 to their organisations and make changes accordingly
- To report on organisational actions undertaken as a result of this CDOP report at future HWBB meetings with particular reference to whole organisation actions around to reducing inequalities and promoting of safe sleep

3. Report Detail

3.1 Background and Context

3.2 The purpose of a CDOP is to identify the cause of child deaths in an area and to learn and share lessons that may prevent future deaths. Its role is also to consider whether action should be taken in relation to any matters identified. Where it is identified that action should be taken by a person or organisation, they are informed.

3.3 The responsibility for ensuring child death reviews are carried out is held by 'child death review partners', who, in relation to a local authority area in England, are defined as the local authority for that area and any clinical commissioning groups (CCGs) operating in the local authority area as set out in the Children Act 2004 (the Act), as amended by the Children and Social Work Act 2017.

3.4 The processes to be followed when a child dies are currently outlined within "Working Together to Safeguard Children 2018: Chapter 5 Child Death Review Processes and Child Death Review: Statutory and Operational Guidance 2018" https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england

3.5 The Black Country Child Death Overview Panel

3.6 In the Black Country the child death review partners are the Black Country Local Authorities and Clinical Commissioning Groups:

- Wolverhampton Council; Sandwell Council; Walsall Council; Dudley Council
- Wolverhampton CCG; Sandwell and West Birmingham CCG; Walsall CCG; Dudley CCG all of whom are combining into one strategic CCG.

3.7 Each of the four Black Country areas contribute an equal amount of funding to support the Black Country CDOP Coordination team and fund actions based on learning across the whole area. Walsall contributes £14,145 per annum.

3.8 The Black Country CDOP works alongside each of the Safeguarding Boards in the Black Country and each share learning and base actions on recommendations made in each agency's reports and from individual child death reviews.

Appendix 1 describes the review process for the Black Country and its oversight by the Black Country Child Death Strategic Partnership.

4. Progress over the past year within the Black Country CDOP

4.1 Black Country CDOP Achievements

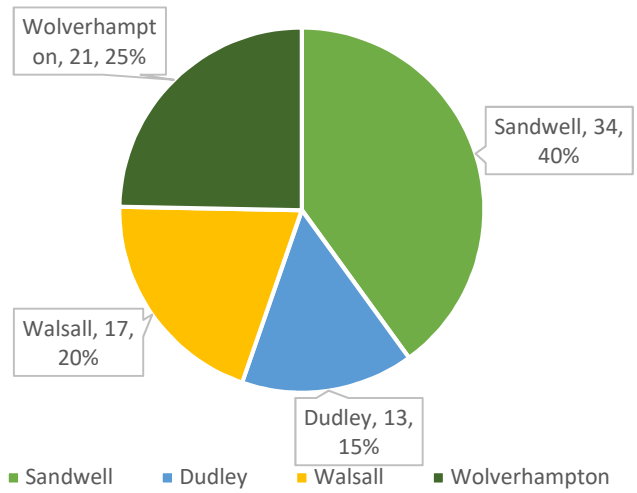
- The role of the Independent Chair into the Strategic Partnership and Operational Panels has now been embedded and has had a positive impact ensuring consistency and progress
- The Key Worker Role has been developed but is still work in progress to ensure the voice of the child/parent is reflected
- Assurance has been received that there is bereavement support for professionals working within the child death arena
- Progress has been made with developing a CDOP section on the new CCG website allowing for wider dissemination of learning and raising the profile of the child death review process
- CDOP has provided data and links for developing and contributing to strategies such as Safe Sleeping, ICON and Suicide Prevention

4.2 Black Country CDOP Challenges:

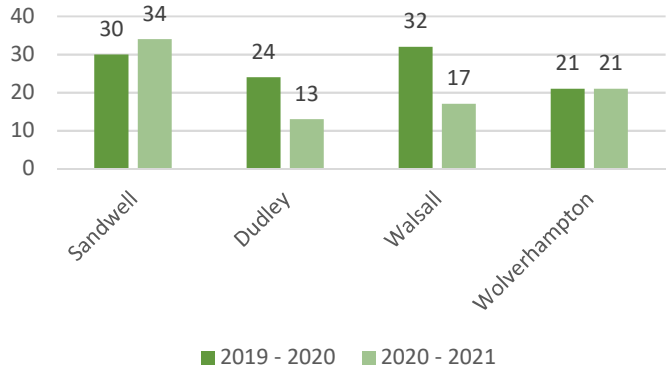
4.3 Extra challenges were encountered in 2020/2021 due to the restrictions brought about by Covid-19. However, CDOP continued to function in this period despite these challenges. Health professionals were supported to complete reviews in a timely manner.

5. Summary of Local Data 2020 – 2021

Black Country Deaths Notified 2020 – 2021



2 Year Comparison



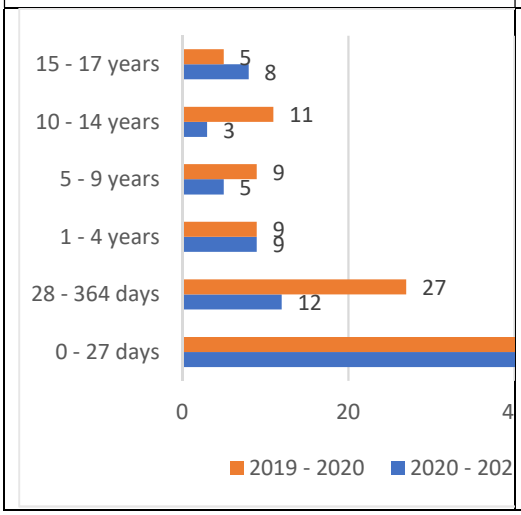
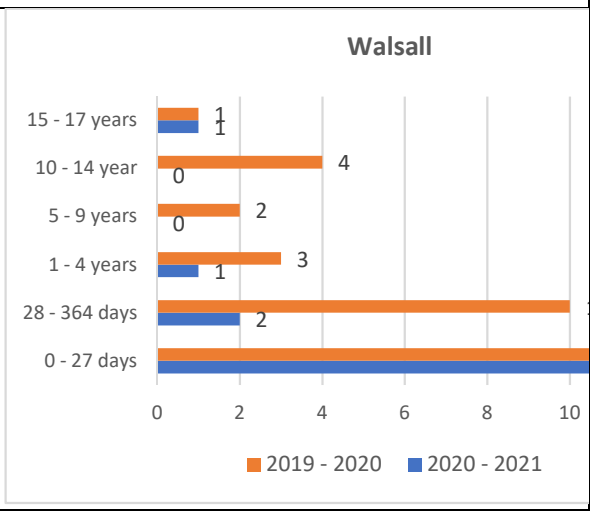
85 deaths were notified in total in the Black Country in 2020 – 2021.

17 of these deaths were reported to be Walsall residents which made up 20% of the total deaths reported in the Black Country.

Out of the 85 deaths notified to the Black Country in 2020 – 2021, 23 were unexpected and required a Joint Agency Response (JAR). 1 of these was a Walsall death

Although CDOP have not had national figures at point of reporting, it is believed that the Black Country has followed the general pattern of reduction in child deaths notified in the reporting period 2020 – 2021. Early analysis of this pattern has found that due to the reduction of social interactions, deaths from infections and deaths as a result of elective surgeries have significantly reduced.

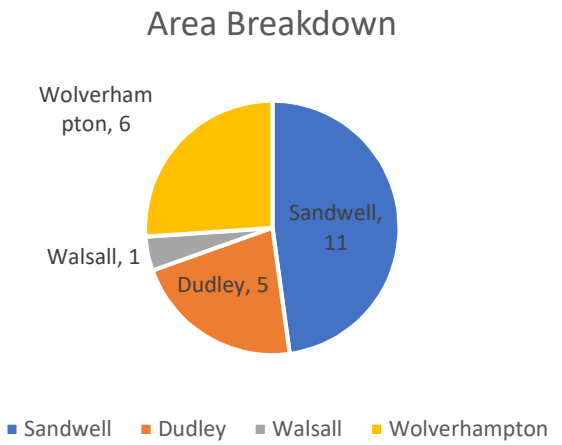
Walsall has seen a 53% reduction in child deaths from 2019 – 2021.

Death Notifications by Age Group Black Country, 2 Year Comparison	Death Notifications by Age Group Walsall, 2 Year Comparison
	

In Walsall in 2020/2021, deaths have reduced from 32 in 2019/20 to 17 in 2020/21.

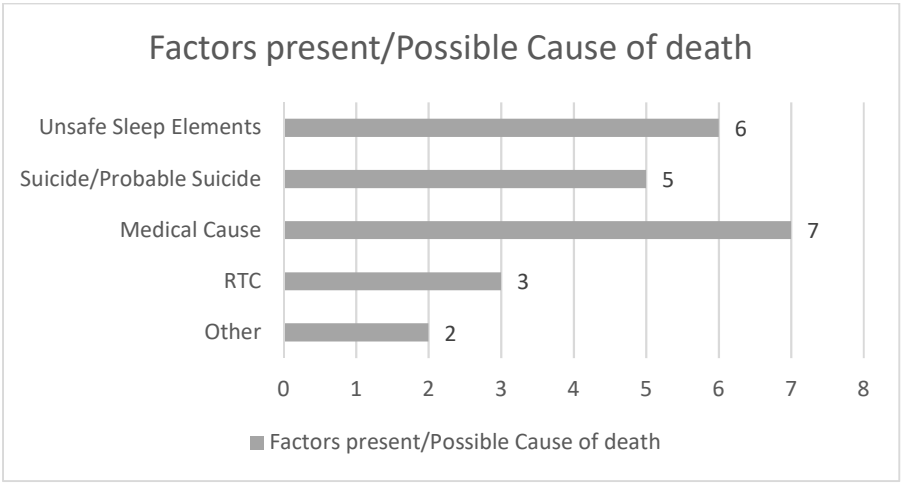
Child deaths in the 28 – 364 days, 1 – 4 years, 5 – 9 years and 10 – 14 years age groups have reduced. However deaths increased slightly in the 0 – 27 days age group moving from 12 to 13 deaths notified.

6. Unexpected Deaths across the Black Country



Out of the 85 deaths notified to the Black Country in 2020 – 2021, 23 were unexpected and required a Joint Agency Response (JAR). The summary of these deaths is as follows

6.1 Breakdown of unexpected deaths by category:



6.2 Unexpected death in Walsall

The unexpected Walsall death is thought to be a death due to suicide, but as this has not completed the coronial process yet, it can only be described as a probable suicide. This death was reported to Safeguarding Partnership in Walsall who decided to carry out a Child Safeguarding Practice Review (CSPR).

6.3 Analysis of Unexpected Deaths

6.4 The analysis of all unexpected deaths across the Black Country (**6.1**) showed that the following social and agency factors contributed to the death:

Social factors:

- Unsafe sleeping practices
- Parental misuse of drugs or alcohol
  Disguised compliance
- Neglectful home conditions/ Chaotic household
- Smoking in the household
- Unsafe sleeping practices
- Overcrowding

Agency factors

- Not born in appropriate level hospital
- Non engagement with services
- Pregnancy related factors
- Parental smoking during pregnancy
- Consanguinity
- Delay in induction of labour

7. Unexpected NeoNatal Deaths

7.1 Over half of neonatal deaths reviewed were caused by immaturity-related conditions such as respiratory and cardiovascular disorders. Congenital anomalies, such as heart and neural tube defects, account for approximately 30% of the total, followed by antepartum infections, which account for approximately 10%. Other neonatal deaths result from causes during or shortly after labour (intrapartum), or in the postnatal period.

7.2 Black Country and Walsall Response to Neonatal Deaths

7.3 As a result of this analysis, a region wide focus group was formed to address these issues. Work is taking place in Walsall and across the Black Country to focus on the following areas:

- Safer Sleeping
- Maternal smoking during pregnancy
- Smoking in the household
- Consanguinity
- Late booking and as a consequence to this delay of support services
- Maternal obesity
- Deprivation
- Neglect

7.4 In addition, a preconception campaign has been taken forward in primary care to support parents to enter pregnancy as healthily as they can be.

7.5 In Walsall safe sleep is discussed by midwives and the Health Visitors with

all parents in the ante natal period and at every visit in the post-natal visit.

7.6 In addition, CDOP recommended that agencies should be aware of the importance of including fathers during the pandemic in scans and medical issues. Walsall now has two father's workers within the Walsall Health in Pregnancy team who are available to support all dads and who offer particular support vulnerable fathers.

8 Black Country Response to Suicides

8.1 Strategic Partners were concerned about the unusual number of deaths by probable suicide/confirmed suicide reported in 2020 – 2021 across the Black Country. As a result of an increase in the number of suicides/probable suicides between October 2020 – March 2021, a deep dive was carried out by child death review partners to assess whether there were any patterns or trends highlighted for immediate action.

8.2 The report found that there were no obvious trends or patterns in probable suicides across the Black Country. It identified that few comparisons can be made with regards to age and gender, although more males than females have died by probable suicide. Three out of the five cases died by hanging, which may have some relevance as hanging, strangulation and suffocation are reported to be the most common suicide methods in young people. https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2019registrations

8.3 The report concluded that it needs to be recognised that, although unusual to the Black Country, the probable suicide deaths reported are still quite small and each case has unique elements, some of which are unknown, and could remain unknown.

8.4 The report also recommended that the current Covid-19 situation also needed to be analysed more closely to assess whether it had had an impact on deaths in some way; whether social, emotional, limited/restrictive agency interactions or unknown factors yet to emerge.

8.5 The BC CDOP also recommended that further consideration should also be given to the presence of ACE's (Adverse Childhood Experiences) in each young person. This information is not fully available in all deaths but could hold possible comparisons.

8.6 CDOP made a particular recommendation that agencies do not label a young person as hard to reach but try different ways to engage with a young person and their family

9. Walsall Action resulting from the Black Country Analysis into probable suicides

9.1 In response to the spike in suicides in young people 2020- 21, Walsall Public Health worked with the Black Country Mental Health Trust, Walsall Education team and young people to develop a Walsall suicide and self-harm prevention campaign titled "Let's Talk". This has resulted in a leaflet aimed at young people who are at risk of suicide or self harm, their friends and family and also a pathway document outlining what is available to support young people when issues first emerge and in the community and what support is available externally when issues become acute.

These are hosted on Walsall Childrens Services early help website

https://go.walsall.gov.uk/children_and_young_people/early_help/early_help_for_children_and_young_people/mental_health

9.2 A group is also meeting across the Black Country to develop Black Country support and resources which will benefit Walsall young people.

10 BC CDOP Next Steps and Objectives

10.1 In 2022 the Black Country CDOP team aims to;

- Further support the Black Country and West Birmingham CCG in maintaining consistent place-based child death review processes
- Develop and contribute to strategies to reduce Infant Mortality and suicide prevention
- Consolidate the role of the Key Worker
- Introduce a feedback letter for parents to ensure their voices are heard
- Continue to escalate issues where agencies are not providing timely information
- Submission and ratification of the third Black Country annual report
- To ensure there are good links with existing maternity and neonatal networks to improve outcomes
- Publish a Black Country multi-agency SUDIC protocol and ensure all areas of the Black Country are compliant

11 Health and Wellbeing Priorities:

11.1 The key Health and Wellbeing Board priority is to Maximise People's Health and Wellbeing and Safety and in particular the focus of this report is to Improve Maternal and New Born Health and to support young people's mental health.

11.2 Work to reduce child deaths and in particular infant mortality is a role for all in Walsall and not just the statutory sector. The role of voluntary and community teams is also key.

12 Health Inequalities

12.1 Marmot's approach to addressing health inequalities as set out in Fair Society, Healthy Lives requires action across the social determinants of health and beyond the reach of the NHS. It also shows the importance of intervening in early childhood as well as addressing the social factors affecting health. Central to the Marmot Review is the recognition that disadvantage starts before birth and accumulates throughout life. Children born in disadvantage are more likely to be affected by infant mortality and accidents. See the Annual Report for the Black Country CDOP, 2020 – 2021 (**5.2**). Through actions undertaken as a result of CDOP learning, Marmot objective 1 will be achieved; Giving every child the best start in life.

13 Safeguarding

13.1 Recommendations and actions arising from this report directly supports safeguarding and will benefit the most vulnerable sectors in the community.

14. Implications for Joint Working arrangements in Walsall:

14.1 In order to reduce unexpected deaths in Walsall, Health and Wellbeing Board partners are required to identify what actions they are able to take forward. In order to reduce child deaths, commitment is required from all agencies to reduce inequalities and promote safe sleep practices in 2022 and report to the Walsall Health and Wellbeing Board of activity undertaken.

14.2 Suggested commitments

- Walsall Housing providers to support reducing overcrowding or chaotic households and highlight the importance of not smoking in the household
- Maternity Service to promote Making Every Contact Count and ensure that women give birth in the appropriate level hospital
- All to work to reduce the impact of deprivation on young babies and children and young people
- Voluntary and community teams to support actions to identify and reduce neglect and support parenting.
- All including peer supporters to encourage safe sleep practices and increase breastfeeding.
- All to ensure that work is set in place to support young people's mental health.
- All to publicise the link to the Walsall "Let's talk" young people's suicide prevention and self-harm prevention resources

15. Background papers

15.1 National Child Mortality Database Monitoring Report - Walsall

Walsall - Black Country CDOP - NCM

15.2 The Annual Report for the Black Country CDOP, 2020 – 2021.Black Country

BCCDOPAR(JB)Final.pdf

15.3 Black Country CDOP, 2020 – 2021Walsall summary CDOP

BCCDOP Walsall Summary 20_21.docx

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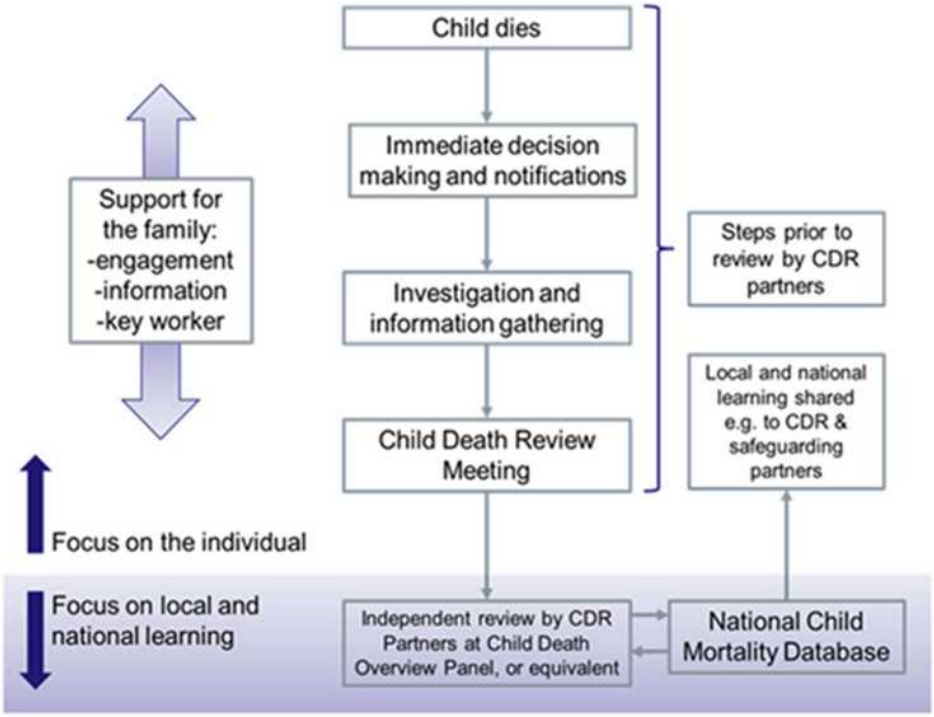
Appendix 1

Black Country Child Death Overview Panel Process

The processes followed by the Black Country Child Death Overview panel are currently outlined within “Working Together to Safeguard Children 2018: Chapter 5 Child Death Review Processes and Child Death Review: Statutory and Operational Guidance 2018”
https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england

The partners have made arrangements to review all deaths of children normally resident in the local area and, where it is considered appropriate, for any non-resident child who has died in their area.

They are summarised as follows:



The Strategic Child Death Overview Panel is responsible for ensuring that these processes and reviews are carried out as outlined in legislation.

Health and Wellbeing Board – Work Programme 2021/22

REPORT ITEM	LEAD	June Workshop	20 July Board	Mid Sept Workshop	19 Oct Board	November Workshop	December Workshop	25 Jan Board	February Workshop	March Workshop	26 April Board
Priorities for Health and Wellbeing Board		Mental Health	Areas of focus for 2021/22	Draft JSNA - teasing out priorities		Using JSNA to inform JHWBS for 2022-25	Inequalities and Poverty		Focus to be confirmed	Focus to be confirmed	Identify priorities for HWBB focus for 22-25
Review of Public Health Commissioning Intentions	DPH										
Director of Public Health Annual Report	DPH										For information
Public Health Outcomes Framework	DPH										Annual Report for information
Joint Strategic Needs Assessment: JSNA	DPH		Progress update	Workshop focus	Draft	Workshop focus		Final – moved to April			Final JSNA for approval
Joint Health and Wellbeing Strategy	DPH				Structure and format	Workshop focus		Final – moved to April			Final JWBS for approval
Mental Health & Wellbeing Strategy	DPH				Progress update			Final MH&W Strategy			
Health Protection Annual Report	DPH		Postponed *see note at end of document								
Health Protection Strategy	DPH										
Child Death Overview Panel	DPH							Annual Report			
Pharmaceutical Needs Assessment	DPH				2022						

Health and Wellbeing Board – Work Programme 2021/22

REPORT ITEM	LEAD	June Workshop	20 July Board	Mid Sept Workshop	19 Oct Board	November Workshop	December Workshop	25 Jan Board	February Workshop		26 April Board
SEND Report	ED Children's										
Annual Report of Children's Safeguarding	ED Children's										
Better Care Fund (dates subject to National BCF Directives)	ED ASC		Q1 postponed to October		Q1 & Q2			Q3			Q4 and finance reporting for approval
Local Authority Commissioning/ Spending Plans	ED ASC										
Annual Report of Adults Safeguarding	ED ASC										
Walsall Together	WHT Board Member				Progress Report						
CCG Commissioning/ Spending Plans	Chief Officer CCG										
Children and Adolescent Mental Health Services CAMHS	Chief Officer CCG										Progress report for assurance
Healthwatch	Chair Health watch				Annual Report						Progress on Projects /Public Engagement for assurance

NOTES:

This is a 'working' document. The dates are provisional and are dependent on agreement from Lead Officers in accordance with reporting schedules

Health and Wellbeing Board – Work Programme 2021/22

*Health Protection Annual report. This is due to July meetings but has been postponed until January 2022 due to the focusing of resources on Covid-19 and production of Health Protection Strategy.

ASC	Adult Social Care	**BCF**	Better Care Fund	**WMCA**	West Midlands Combined Authority
DPH	Director of Public Health	**ED**	Executive Director		
JHWBS	Joint Health and Wellbeing Strategy (the Walsall Plan).	**CCG**	Clinical Commissioning Group		
WHT	Walsall Healthcare Trust	**HWBB**	Health and Wellbeing Board		