Social Care and Health Overview and Scrutiny Committee

Agenda Item No.

7.

14th November, 2019

Public Health Outcomes Framework (PHOF) – outcomes focus

Ward(s) All

Portfolios: Cllr Longhi

1. Executive Summary:

Improving the health and wellbeing of the people who live and work in Walsall is a key objective of Walsall Council and its partners. To support this aim a Public Health Outcomes framework (PHOF) performance matrix (3x3 grid) has been developed to offer direction and steer for the outcomes where there should be focus.

1. Reason for scrutiny:

A planned report to inform scrutiny of public health outcomes, to assist with the development of the next Walsall Plan and provide context and focus for future opportunities to improve outcomes.

2. Recommendations:

That:

- Members note the detail of this report; areas of improvement for further consideration.
- Members to utilise the 'PHOF matrix' outside of this committee, to open up discussions and subsequent action both within and outside of the Council on how to improve public health outcomes.
- Members note that incorporating health and wellbeing considerations into decision-making across sectors and policy areas, can make a significant contribution to improving wellbeing for the people of Walsall.
- Members note that this is the beginning of a conversation to inform the development of the next Walsall Plan which will be published in 2021.

3. Background papers

- Link to 'PHOF Performance Matrix'
- Link to Public Health Outcomes Framework (PHOF) indicators

4. Report Detail

4.1 The Public Health Outcomes Framework (PHOF) sets out a high-level overview of public health outcomes, at a national and local level. An interactive web tool makes the PHOF data available publicly. This allows local authorities to assess progress in comparison to national averages and their peers, and develop their work plans accordingly.

4.2 Our health and thus public health outcomes are influenced directly and indirectly by our social and community networks and the physical, social and economic contexts in which we live (figure 1).

The Proportional Contribution to premature death

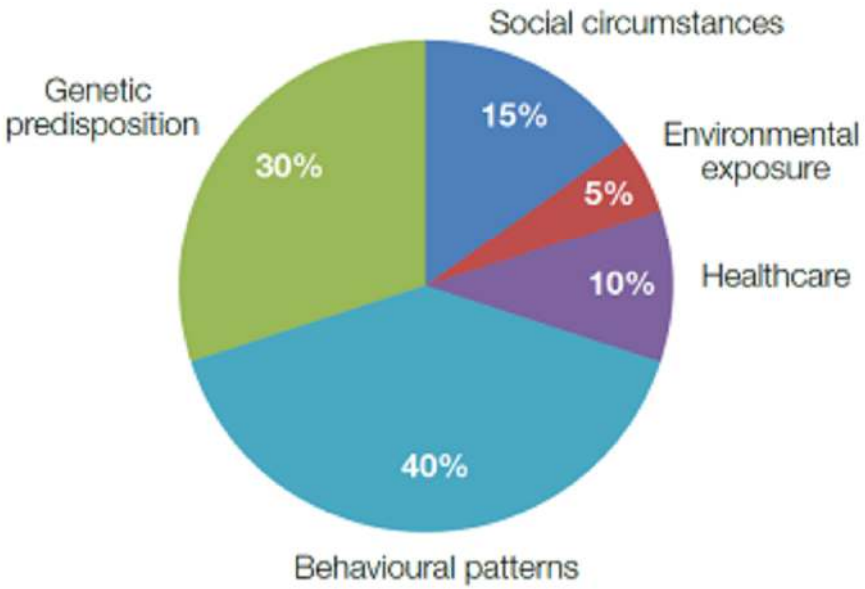


Figure 1. The proportional contribution to premature death. PHE

4.3 The socio-economic and environmental determinants of health taken together are the prime drivers of our health and wellbeing, followed by our health behaviours (for example, whether and how much we smoke and/or drink alcohol, what we eat and how physically active we are), health care, and finally genetic and physiological factors. To improve population health, we have to focus as much on those factors that lie outside the health and care system as those within it.

4.4 Local authorities, with their partners e.g. through the Health and Wellbeing Board, are well placed to take a collaborative approach to improving the wellbeing of all people in Walsall. This can be achieved by incorporating health considerations into decision-making across sectors and policy areas based on the recognition that our greatest health and wellbeing challenges are highly complex and often linked through the social and economic determinants of health and wellbeing.

4.5 To provide a quick overview of over 200 indicators within the PHOF, a simple 'PHOF Performance Matrix' has been developed (figure 2). The indicators are categorised whether their trend is **improving**, **similar** or **deteriorating** and how Walsall compares

to *statistical neighbours – statistically better, similar or worse (3x3). The PHOF matrix can be interactively accessed here.

(* 15 areas with similar characteristics to Walsall e.g. Bolton, Derby, Wolverhampton)

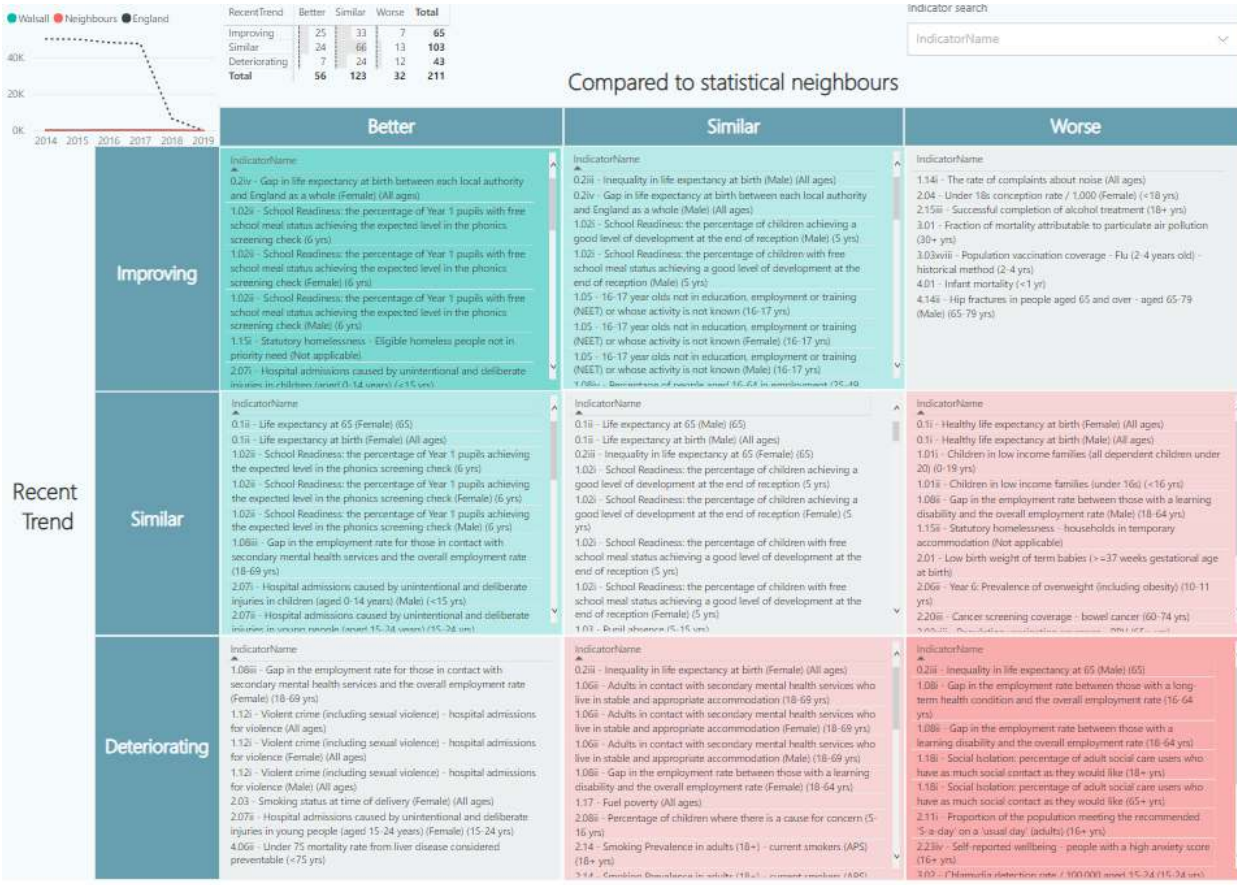


Figure 2. PHOF 3x3 matrix for Walsall.

4.6 The matrix aims to start a conversation on action that could be taken to improve outcomes. The underlying principles of a public health approach to improve outcomes is:

- focused on a defined population, often with a health risk in common
- with and for communities
- not constrained by organisational or professional boundaries
- focused on generating long term as well as short term solutions
- based on data and intelligence to identify the burden on the population, including any inequalities and
- rooted in evidence of effectiveness to tackle the problem.

These principles are being applied to the PHOF matrix to review our current approach to improve outcomes.

4.7 Note there are caveats to the matrix, for example, data is updated annually and provides a picture in time. To enrich local action, local data (where available) as well as local knowledge and expertise will help shape future action.

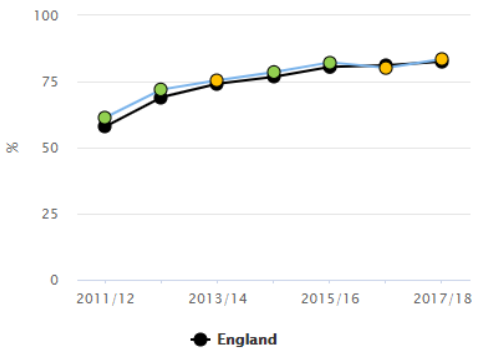
4.8 A key positive finding to report is there are currently 25 indicators in the matrix which are ***improving over time*** and show that outcomes for Walsall residents are significantly ***better than our peers***. Examples include (click here for full listing):

- Life expectancy at 65 (females) (all ages).
- **School readiness – the % of Year 1 pupils achieving the expected level in the phonics screening check (6 years).**
- Smoking prevalence in adults – current smokers (18-64 years).
- HIV late diagnosis (%) (15+).

4.9 To highlight one area - 'School Readiness – the % of Year 1 pupils achieving the expected level in the phonics screening check (6 years)'

What is the data telling us?

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	↑	-	548,146	82.5	82.4	82.6
Neighbours average	–	-	46,723	80.6*	-	-
Wigan	↑	11	3,221	84.1	82.9	85.2
Walsall	↑	-	3,245	83.5	82.3	84.6
Sunderland	↑	14	2,687	82.4	81.0	83.6
Derby	↑	7	2,880	82.0	80.7	83.2
Bolton	↑	6	3,394	81.7	80.5	82.9
Rochdale	↑	2	2,540	81.7	80.3	83.0
Wolverhampton	↑	1	2,930	81.5	80.2	82.7
St. Helens	↑	13	1,775	81.0	79.3	82.6
Rotherham	↑	9	2,763	80.8	79.5	82.1
Stoke-on-Trent	↑	12	2,706	79.9	78.6	81.3
Dudley	↑	8	3,275	79.8	78.5	81.0
Tameside	↑	5	2,459	79.2	77.8	80.6
Sandwell	↑	3	3,946	79.1	77.9	80.2
Doncaster	↑	10	2,954	79.0	77.6	80.3
Wakefield	↑	15	3,296	77.9	76.6	79.1
Oldham	↑	4	2,652	77.5	76.0	78.8



Recent trend: ↑

Period		Walsall Count	Walsall Value	Walsall Lower CI	Walsall Upper CI	Neighbrs	England
2011/12	●	2,172	61.3%	59.7%	62.9%	57.9%*	57.9%
2012/13	●	2,507	72.0%	70.5%	73.5%	67.7%*	69.1%
2013/14	●	2,735	75.4%	74.0%	76.8%	72.7%*	74.2%
2014/15	●	2,872	78.6%	77.2%	79.9%	75.2%*	76.8%
2015/16	●	3,040	82.3%	81.0%	83.4%	79.2%*	80.5%
2016/17	●	3,074	80.1%	78.8%	81.4%	79.5%*	81.1%
2017/18	●	3,245	83.5%	82.3%	84.6%	80.6%*	82.5%

Source: Department for Education, Teacher Assessments: Phonics screening check statistical series

For this specific indicator, the latest data illustrates a positive perspective for Walsall when compared to statistical neighbours and an improving trend to 83.5% for 2017/18 (latest available data).

What are we doing about this?

Illustrated in figure 3 and 4 is when a child is school ready and the importance of school readiness.

Figure 3. A Child is school ready

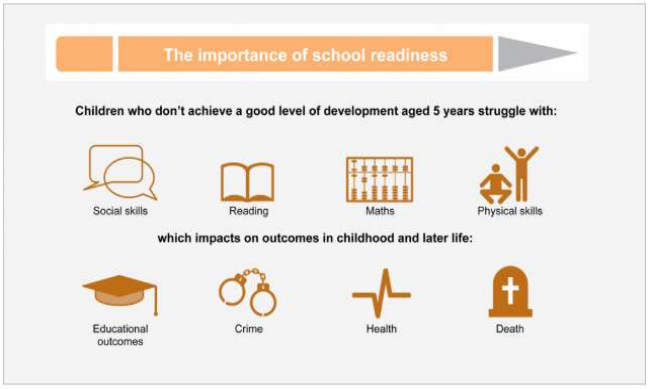


Figure 4. The importance of school readiness

4.10 There are a number of interventions with public health investment being undertaken locally which has an impact on school readiness:

- Fluoridation – Community Water Fluoridation is a safe and effective measure to help people improve their oral health. As a fluoridated local authority this makes a significant improvement to our public health outcomes. The level of tooth decay seen is significantly lower than that in other local authorities with similar levels of deprivation.
- A number of parenting programmes and initiatives such as - Super Wiggles, infant feeding - Top 10 tips for infant feeding video, physical literacy training for Early Years (Youth Sport Trust).
- Working closely with Early Years Improvement Team to provide evidence and support to improve outcomes.
- School exclusion project – A joint project by PH and Children's Services identified exclusions in younger children are increasing and a link with children who have a Special Educational Need (SEN) (see Appendix 1 for further detail).

Example tweets of Public Health raising awareness

Where do further opportunities exist?

We are embarking on the development of a 'Best Start for Walsall' approach which will require cross department and cross partner working to give Walsall children the best

start to their lives. This work will link in with Walsall Together to consider what opportunities are available to support children in Walsall from birth to adulthood.

4.11 The matrix also demonstrates there are 12 indicators which are ***deteriorating*** over time and where outcomes for Walsall residents are ***worse compared to our peers***. This offers a focus for further discussion on shared problem solving and action across the Walsall Proud Partnership. Examples include (click here for full listing):

- Inequality in life expectancy at 65 (male).
- Social isolation: % of adult social care users who have as much social contact as they would like (18+).
- **Self-reported wellbeing – people with a high anxiety score (16+ years)**
- **Under 75 mortality rate from all cardiovascular diseases (female) (<75 years).**
- Employment rate gap for those with Long Term Conditions (LTCs).

4.12 To highlight a couple of areas - 'Self-reported wellbeing – people with a high anxiety score (16+ years)'

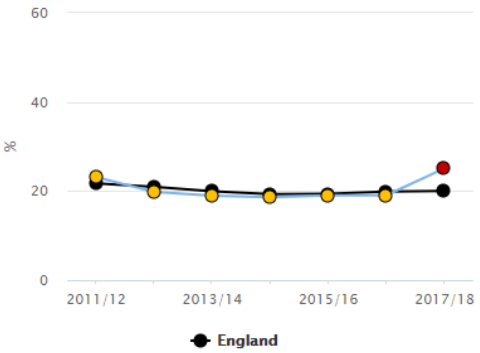
What is the data telling us?

Self-reported wellbeing - people with a high anxiety score 2017/18 — Proportion - %

Export table as image Export table as CSV file

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	-	20.0	19.7	20.3
West Midlands region	–	-	18.0	17.2	18.9
Walsall	–	-	25.1	21.6	28.5
Coventry	–	-	21.5	18.1	24.9
Shropshire	–	-	21.5	18.3	24.7
Telford and Wrekin	–	-	20.8	17.2	24.4
Stoke-on-Trent	–	-	20.1	17.0	23.2
Birmingham	–	-	19.0	16.5	21.6
Herefordshire	–	-	19.0	16.1	22.0
Warwickshire	–	-	17.8	14.4	21.1
Solihull	–	-	17.4	14.5	20.3
Staffordshire	–	-	16.0	13.4	18.6
Worcestershire	–	-	15.6	13.0	18.3
Sandwell	–	-	15.4	12.4	18.4
Dudley	–	-	14.4	11.7	17.1
Wolverhampton	–	-	14.0	11.5	16.4

Source: Annual Population Survey (APS); Office for National Statistics (ONS).



Recent trend: –

Period		Walsall Count	Walsall Value	Walsall Lower CI	Walsall Upper CI	West Midlands region	England
2011/12		-	23.1%	20.1%	26.2%	20.4%	21.7%
2012/13		-	19.8%	17.0%	22.7%	19.5%	21.0%
2013/14		-	19.0%	16.0%	22.0%	17.8%	20.0%
2014/15		-	18.6%	15.6%	21.6%	17.9%	19.3%
2015/16		-	19.0%	16.0%	22.0%	18.6%	19.4%
2016/17		-	19.0%	16.0%	22.0%	19.2%	19.9%
2017/18		-	25.1%	21.6%	28.5%	18.0%	20.0%

Source: Annual Population Survey (APS); Office for National Statistics (ONS).

For this specific indicator, the latest data illustrates a negative perspective for Walsall when compared to statistical neighbours and scores increasing for 2017/18 to 25.1% (compared to 19.0% the previous year).

What are we doing about this?

Public Health commission the MAKING CONNECTIONS WALSALL (MCW) service to reduce loneliness and social isolation, improve health and wellbeing and reduce preventable health service and social care use among people aged 50+ in Walsall. It is adopting a social prescribing approach, with referrals made into a central point (run by West Midlands Fire Service), that then links to four area-based hubs. Their social connectors (link workers) work with clients and connect them with other local groups and activities, as well as befriending services in people's own homes, monitoring their progress. It is a free service and is fully funded by Walsall Metropolitan Borough Council.

Recent activity demonstrates almost 700 clients have been seen since April 2018 and positives are evident in terms of reductions in depression and loneliness scores (35% and 23% respectively) and improvements in WHO scores (56%).

MCW has revealed the genuine need among many older people in Walsall for company, empathy and activities. It has created social value that goes beyond monetary terms and changes the lives of many people across the borough (refer to case study in appendix 2). It has also shown that a social prescribing model can help address loneliness and social isolation.

Illustrations below highlight the types of services clients are being referred to, some quotes from clients who have been supported and pictures of clients actively engaged.

You have put me in touch with so much and people that can help me and my situation

They wound my engine up again

They have helped me to get out of the home and is helping me a lot. I didn't go anywhere and now attend activities

"Seeing how from one small step forward, sometimes after a long period of being isolated and alone, that they have made new friendships, started new hobbies, and have started 'living rather than existing'"
Hub worker

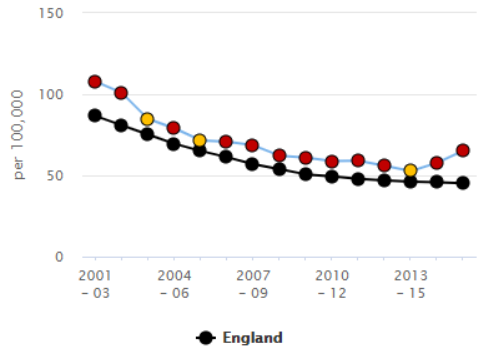
Where do further opportunities exist?
Plans are being developed to sustain the programme as part of social prescribing models being developed locally i.e. within the Resilient Communities. The model will focus on community capacity building and social connectedness and offers another opportunity to ensure that loneliness and isolation is addressed. Additionally in early gestation is the further development of a mental wellbeing programme for Walsall building on the good work already happening across the borough and West Midlands Combined Authority.

4.13 Under 75 mortality rate from all cardiovascular diseases (female) (<75 years).

What is the data telling us?

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	32,426	45.2	44.7	45.7
West Midlands region	–	3,647	48.1	46.5	49.7
Walsall	–	228	65.3	57.1	74.4
Wolverhampton	–	186	61.3	52.8	70.8
Birmingham	–	669	60.9	56.4	65.8
Telford and Wrekin	–	129	57.6	48.1	68.5
Sandwell	–	206	57.6	50.0	66.1
Stoke-on-Trent	–	161	51.2	43.6	59.7
Coventry	–	177	48.9	42.0	56.7
Dudley	–	209	47.2	41.0	54.0
Herefordshire	–	134	44.0	36.8	52.2
Warwickshire	–	348	43.1	38.7	47.9
Staffordshire	–	545	42.0	38.5	45.6
Solihull	–	125	40.6	33.8	48.4
Worcestershire	–	339	38.3	34.3	42.6
Shropshire	–	191	37.7	32.5	43.5

Source: Public Health England (based on ONS source data)



Recent trend: –

Period		Walsall				West Midlands region	England
		Count	Value	Lower CI	Upper CI		
2001 - 03	●	348	107.8	96.8	119.8	93.1	86.7
2002 - 04	●	327	100.9	90.2	112.4	86.0	80.8
2003 - 05	●	276	84.8	75.1	95.4	80.0	75.1
2004 - 06	●	257	79.1	69.7	89.3	73.2	69.5
2005 - 07	●	232	71.6	62.7	81.4	67.7	65.1
2006 - 08	●	230	70.8	61.9	80.5	63.5	61.2
2007 - 09	●	225	68.6	59.9	78.2	58.6	57.0
2008 - 10	●	208	62.2	54.0	71.2	55.9	53.8
2009 - 11	●	205	60.9	52.8	69.8	52.1	50.7
2010 - 12	●	198	58.8	50.9	67.6	50.5	49.4
2011 - 13	●	199	59.0	51.1	67.8	49.2	47.9
2012 - 14	●	191	55.9	48.2	64.4	48.6	46.9
2013 - 15	●	182	52.7	45.3	61.0	48.8	46.2
2014 - 16	●	201	57.8	50.0	66.3	48.0	45.8
2015 - 17	●	228	65.3	57.1	74.4	48.1	45.2

Source: Public Health England (based on ONS source data)

For this specific indicator, the latest data illustrates a negative perspective for Walsall when compared to statistical neighbours and rates recently increasing to 65.3%.

What are we doing about this, and where do further opportunities exist?
CVD is a complex issue and affected by several factors. One half of CVD is thought to be a direct result of high blood pressure, and is considered the number 1 risk factor for CVD mortality in England. Having high blood pressure is directly linked to smoking, alcohol intake, poor diet and low levels of physical activity. Our smoking rates are better than statistical neighbours, and the recent trend suggests our rates are not changing.

There is a tobacco control plan in place, and the current smoking cessation service commissioned is performing well to achieve 4 week quits in clients. Successful completion of alcohol treatment (18+) shows a declining trend over recent years, with statistical neighbours outperforming Walsall, however more recently, Walsall has narrowed the gap with nationally (33.5% and 38.9% respectively for 2017).

The proportion of our population eating five portions of fruit and vegetables a day is again better than statistical neighbours, but the recent trend suggests our rates are not changing. Physically inactivity in the borough (not meeting recommended 150 minutes of moderate activity per week) is in line with our statistical neighbours but still as high as 27%.

A lot of these issues are tied up in the built environment that our residents find themselves – be it where they learn, play, live or work. As a borough, we have the opportunity to improve this and the 'Town Centre Master Plan' is acting as a catalyst to help us achieve the ambition of becoming the healthiest high street in the future.

Elements of the Walsall Plan 2019 to 2021 is reducing physical inactivity in our workforce too, with one action focussing on developing travel plans for staff to use more active and sustainable methods to get to work. There are further opportunities to embed health and wellbeing more so into the wider work in the borough such as how large scale developments are built, whether they are new GP surgeries or housing units. With a stepping stone approach, and a shared mind-set, such an ambition could become a reality.

4.14 It is also important to note those indicators which show our Walsall residents have *similar outcomes to our peers ,* as it could be argued they are 'on the cusp' of both *improving* and getting *better* or *deteriorating* and getting *worse.* Examples include life expectancy at 65 (males); pupil absence (5-15 years) and hip fractures in people aged 65 and over.

4.15 The matrix will update automatically when data is available and monitoring of indicators will continue. This matrix has proved a useful starting point to assess performance on public health outcomes and is assisting with generating further discussions and action around financial planning, meeting needs of the population and generating efficiencies.

4.16 Colleagues are encouraged to utilise and engage with the matrix and use the public health principles in meetings they attend to further enhance and probe conversations which aim to take positive action to maximise health and wellbeing for Walsall residents.

4.17 In conclusion the 'matrix' and approach is an enabler allowing for a quick and effective sense check of performance in relation to indicators included within the PHOF. This can facilitate further action across the council and its partners to provide assurance on action being taken and challenge in areas where outcomes could be further improved.

5. Resource and legal considerations:
It is the responsibility of all officers, senior managers, Councillors and Partners to work collaboratively in achieving positive outcomes for Walsall residents.

6. Council Corporate Plan Priorities:
The PHOF and consequential action to improve them relate to all the priorities below in the Corporate Plan:

- **E**conomic Growth – for all people, communities and businesses.
- **P**eople – have increased independence, improved health and can positively contribute to their communities.
- **I**nternal focus – all council services are efficient and effective.
- **C**hildren – have the best possible start and are safe from harm, happy, healthy and learning well.
- **C**ommunities – are prospering and resilient with all housing needs met in safe and healthy places that build a strong sense of belonging and cohesion.

7. Citizen impact:
The ambition for improving the PHOF is to maximise the health and wellbeing of the population whilst also reducing health inequalities.

8. Environmental impact:
Action to improve the PHOF within the remit of this overview and scrutiny committee have a direct influence and impact on the environment.

9. Performance management:
PHOF is used as part of the routine and regular monitoring for the Public Health Performance Board to critique performance and utilise feedback from colleagues. Additional local knowledge, expertise and insight from commissioned services is presented and discussed for a more specialised perspective.

10. Reducing inequalities:
Improving the measures in PHOF and ultimately reducing health inequalities is a key outcome within the PHOF. Understanding the key causes and drivers of inequalities and taking proportionate action to reduce health inequalities is the ultimate aim for the DPH. Utilising such data within the 3x3 grid, and comparing Walsall with statistical neighbours, allows focused action and an ability to work collaboratively to make a difference.

11. Consultation:
None.

Appendix 1 – Poster accepted and presented at PHE Conference in September 2019 to showcase the excellent ‘school exclusions’ project.

Appendix 2 – Making Connections Walsall Case Study

Case study template for selected clients

We are putting together some short case studies about people who have found the Making Connections Walsall Service to be particularly helpful. These will include things like what has worked well for them and what changes they have made, and will tell more individual stories. Would you be happy to take part in one of these?

[NOTE TO CONNECTOR] Quickly re-cap on the following information to make sure the client is happy to take part before proceeding:

- I will take notes as we talk and I'd also like to record the case study interview so I can listen back in case I miss anything that you say
- Your answers will help us put together a short case study about your experience of using the Making Connections Walsall Service. Direct quotations made by you may be used in publications and reports that result from this study. The case study will include a bit of anonymous information about you (age, marital status etc.) but your name will not be used in any case study, publications or reports
- We will use the materials from this case study interview in leaflets, reports and presentations, including potentially at conferences and events.

Having run through these things, are you happy to take part in the case study interview? ☐
Yes

Date of completion: XX/XX/XX	**Completed by: XX XX**
Client ID and name: XXXXXXX	**Hub: Hub X**

Background information:

Q1 Connector please provide a short overview giving some background info about the client, how they came into contact with MCW; how you've worked with them; what goals have been set, and what progress has been made to date.

Through another older person's service, Silver Scheme, based at Manor Farm CA, XX was having a cleaner. Aware of his situation, she mentioned MCW, and he contacted MFCA directly. A referral form was completed and sent to WMFS (March 18).
Home visit undertaken April 18.
XX had recently lost his wife, and on top of his physical health problems, his grief was, as XX said, "all consuming". On further discussion, it transpired that he was struggling with his mental health in general, backed up by very low scores on his Wellbeing Questionnaire, and impacted further by his physical health. He was adamant that he didn't want any mental health support from clinical services, just "someone to talk to" as he was "extremely lonely". Has 2 sons, but they were both very busy, and only 1 was local.

Although XX drives, he was "at a loss" of where to go to meet people.
He wanted to remove all his wife's clothes from the bedroom as he said it was "too painful to look at", and it was too much for him, emotionally and physically, to sort out himself.
He also had Model Railway sets upstairs that he no longer wanted and was taking up room.
Set 4 goals up initially as follows:

1. Connect-join a group (gave Bereavement Help Point info)
2. Connect-join a group (discussed local Place of Welcome at the Thomas Project, Streetly CA)
3. Reduce anxiety/low mood-MCW connector to enquire on clothes collection by St. Giles Hospice
4. Reduce anxiety/low mood- MCW connector to contact Chasewater Railway/Toy museum and pass on number

XX started attending the BHP in April 18, and said it had "really helped him". Has been a regular attendee ever since. He also came independently to support the Summer Fayre at St. Giles hospice, and also started attending Streetly CA soon after for lunch after the BHP, every Tuesday.

June 18, face to face review, XX said that he was "going downhill rapidly" and things had hit him "out of the blue, like a ton of bricks". We talked through the fact that he had declined Talking Therapies initially, but it may be worth reconsidering. He said he'd like to think about it, and I gave him a flyer with details, and sent through info on Befriending organisations. Outstanding Goals closed but 2 more goals created around this:

5.Reduce Anxiety/low mood-client to have contact details of Befriending organisations
6. Reduce anxiety/low mood- client to have details for Talking Therapies, to self-refer if needed.

Following his review, after a general chat with the group at the BHP around loneliness, he, and some others at the BHP started attending the lunch club through MFCA at Rushall CC from August 18, and the day trips with the Stan Ball centre. At the Rushall Lunch clubs (run by Silver Scheme), XX occasionally delivers a discussion with the other attendees around the Memory Boxes, as part of reminiscence activities (through the course of his support, he registered as a volunteer with MFCA to do this).
XX has the numbers for St. Giles Hospice shop and the Chasewater Railway, as sourced by MCW, which he said he was grateful for, and felt happier that he could contact them when he felt the time was right.

He has also expressed a desire to attend the Wednesday Macmillan Art Class on a monthly basis, at Rushall CC. Visited, and decided it wasn't for him.
Sign off review scheduled for this month.

Questions for the client:

Q2 Can you tell me briefly in your own words what the Making Connections Walsall Service has helped you achieve and how you think it did this?

I've met lots of people through your support (MCW connector), in a similar situation to me, and I've drawn comfort from that. I'm grateful I then felt able to offer my support to others.

Q3 What did you think my role as a Connector help you do the things you wouldn't have done otherwise, and what was it in particular about the relationship that helped you do these things?

You gave me good advice and guidance, and pointed me in a direction I never thought I needed to go in! Without the information you gave me, I wouldn't have known where to go, or who to turn to,

or had the confidence to do. You gave me a virtual sign post, which showed me which way to travel, one step at a time, one foot in front of the other.
You have been very professional. You balanced authority with friendship, and been very approachable and I could relate to you. You didn't lecture, but you advised and guided me.

Q4 Can you give me some specific examples where the activities or things recommended by me (the Connector) have worked for you and what they helped you to do?

You realised I needed support for my grief. When presented with a houseful of memories, where do you start? You guided me through the first step, and invited me to the Bereavement group (Bereavement Help Point we started up, in collaboration with St. Giles Hospice). Through this, I have accumulated strength through the company of strangers, who have now become friends.
Through this I have started attending the lunch club at Rushall with some of the friends I've made, and gone on trips with the Stan Ball Centre in Bloxwich.
I've also started attending Streetly Community Centre for lunch on Tuesday.

Q5 Can you give me some specific examples of changes you have made as a <u>direct result</u> of using the Making Connections Walsall Service (things like making new friends, taking part in activities more, feeling less lonely, feeling more confident in general)?

I now feel comfortable and confident enough to deal with any curve ball that life throws at me. MCW helped me break down what I saw as big problems, into lots of smaller ones, enabling me to deal with one thing at a time and move forward. At the time when you came to see me initially, I "couldn't see the wood for the trees".
It's given me confidence to look other people in the face, and talk openly and honestly, to say "you're not alone". Peer support, and helping others is important to me.

Q6 What could the Making Connections Walsall Service do to help you carry on with these changes in future?

Just be there. Knowing I can ring them with any queries is a great comfort.

Q7 Is there anything else the Making Connections Walsall Service has helped you with apart from what you have mentioned so far?

Through MCW and the Silver Scheme at Manor Farm, I have become a volunteer, and I have engaged with the Memory Box project (Boxes that have reminiscence objects in them to deliver to groups, as a prompt for memories, talking about the "old times" etc.).
I can use my knowledge and life experiences to support others.

Q9 Lastly, can you give me specific examples of the help and support the Making Connections Walsall Service has given you that you wouldn't have been able to get had the Service not existed?

Everything I've already said. Just keep doing what you're doing!

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