Birmingham and Solihull Integrated Care System
Caring about healthier lives

Solihull Metropolitan Borough Council

Solihull Health Inequalities Strategy 2026 - 2032

Contents

Foreword

Solihull sits in the heart of the West Midlands and is host to some major national and global economic players. Investment over the last 20 years has regenerated key parts of the borough and there are plans in place to expand this.

But this masks some significant differences within Solihull. These can be seen across a range of socio-economic measures, which in turn, have a major influence on people's health, wellbeing, quality and length of life.

Health inequalities arise because of the conditions in which we are all born, grow, live, work and age. These conditions influence our opportunities for good health in profound ways. Only an estimated 20% of our health is down to the care we receive from the NHS.

Our very early years development, getting the education and skills to get a good quality job and level of income, as well as the quality of our homes and surroundings all shape our mental health, physical health, and wellbeing.

Inequalities exist between people and places. Differences in health outcomes in different parts of Solihull matter, and so do differences by group characteristics like race, disability, or sex. Identifying and narrowing these differences is a key part of our strategy.

Following on from the refresh of the Joint Local Health and Wellbeing strategy and development of the Solihull Local Outcomes Framework, we have undertaken a reset of this Health Inequalities Strategy. This is to ensure greater strategic alignment between these efforts to reduce inequalities and wider health improvement initiatives.

This strategy is a key enabler of our Council Plan: this commits us to take action to reduce inequalities and sets out our vision that thriving economy, health and wellbeing, and environmental sustainability go hand in hand.

Cllr Tony Dicicco

Chair of Solihull Health and Wellbeing Board

Ruth Tennant

Director of Public Health SMBC

1. Strategic aims

This Strategy sets out Solihull's aims to reduce health inequalities over the next seven years. It draws on the Solihull Joint Local Health and Wellbeing Strategy and the Birmingham and Solihull Integrated Care System Health Inequalities Programme and prevention priorities. It is a key enabler of the Solihull Council Plan 2025-30.

At its most fundamental, improving health inequalities requires improving the lives of those with the worst health outcomes, the fastest.

The objective of this strategy is to reduce health inequalities by supporting those population groups at greatest risk of poor outcomes.

2. What do we mean by health inequalities?

Health inequalities are systematic, unfair, and avoidable differences in health between different people in society[1].

There are many kinds of health inequality, and many ways in which the term is used, so it is useful to be clear about what is unequally distributed, and between whom.

Inequalities of what?

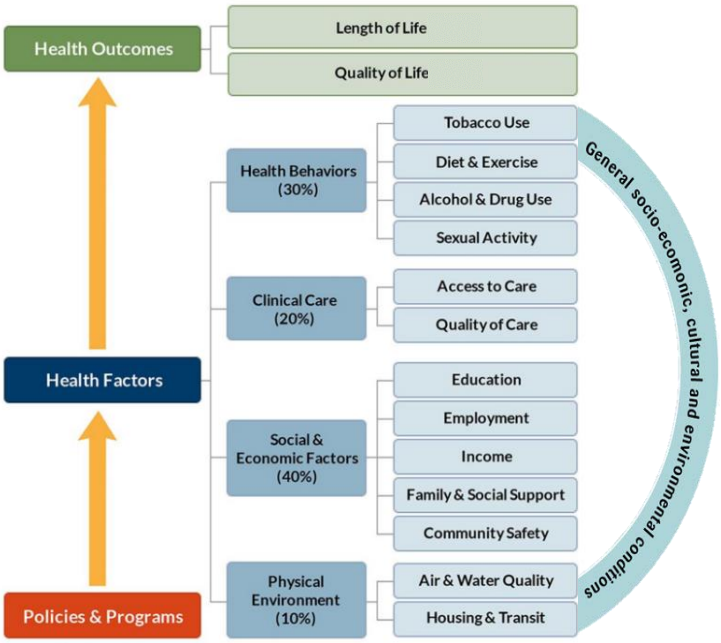
Health inequalities can include differences in:

- **health status** (e.g., length of life, quality of life, prevalence of disease)
- **access to care** (e.g., availability of treatments or other vital public services)
- **quality and experience of care** (e.g., outcomes following treatment or care, patient satisfaction of it)
- **health behaviours** (e.g., tobacco, alcohol, or drug use)
- **wider determinants of health** (e.g., family support, income, transport, education, housing quality)

Figure 1 shows how these elements, and more, work together as a system to cause a pattern of differences in health outcomes. General social, economic, cultural, and environmental conditions, for example, set the context in which policies and programmes are selected, that in turn, affects a wide range of "health factors" that ultimately causes systematic differences in length of life and quality of life between people and places.

[1] https://www.kingsfund.org.uk/publications/what-are-health-inequalities

Figure 1 What causes systematic differences in health outcomes?



Source: Adapted from the County Health Ranking Model. Note: % figures are estimates and averages, the relative contribution for an individual's life will be unique to them. For illustrative purposes only.

In Figure 1, clinical care - such as healthcare provided by in the community (general practice, pharmacy, other community services and hospitals) – contributes roughly 20% to differences in health outcomes, meaning 80% is explained elsewhere, by things like the physical environment, social and economic factors, and health behaviours.

Figure 1 is illustrative only. Estimates of the different contributors do vary. But there is consensus that factors outside of clinical care, known collectively as the "wider determinants of health", play the largest role in contributing to health inequalities overall.

Inequalities between whom?

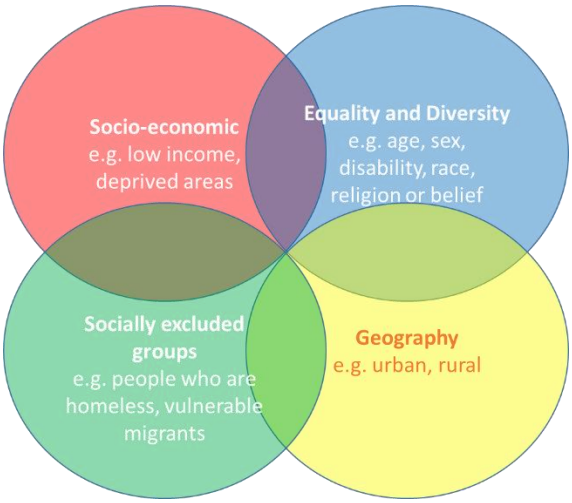
The above section describes some of the things that can be unequally distributed to create health inequalities; this section describes between whom. Health inequalities between groups can usefully be described across four domains (Figure 2):

- **socio-economic groups** (e.g., those on low incomes, unemployed, living in deprived areas)
- **geographic groups** (e.g., Solihull localities (North, West, East) urban or rural)
- **equality and diversity groups:** including nine protected in law (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race (which includes traveller communities), religion or belief, sex, and sexual orientation)
- **socially excluded groups:** (e.g., people experiencing homelessness, children who have experienced care, vulnerable migrants).

People experience different combinations of these groupings, and they can interact, called intersectionality. For example, the interconnected nature of social categorisations such as race,

class, and sex, can create overlapping and interdependent systems of discrimination or disadvantage that are greater than the sum of their parts.

Figure 2 Four overlapping dimensions of health inequalities.



3. What works

The largest evidence review on health inequalities in England, The Marmot Review (2010) and follow up report 10 Years On (2020), recommended six policy objectives for reducing health inequalities long term:

- giving every child the best start in life
- enabling all people to maximise their capabilities and have control over their lives
- ensuring a healthy standard of living for all
- creating fair employment and good work for all
- creating and developing healthy and sustainable places and communities
- strengthening the role and impact of ill health prevention

4. Progress since the first strategy

Since the publication of the health inequalities strategy in 2022, Solihull has made progress across health, wellbeing, and inclusion priorities. While many initiatives have been completed or embedded into business-as-usual practices, some areas remain in development.

Against the first Marmot principle of giving every child the best start in life, system-wide changes have strengthened antenatal care through workforce training, advice and support on smoking, alcohol use and perinatal mental health, alongside improved referral pathways and safer sleeping messaging.

The launch of the Healthy Babies Programme 2025–28 consolidates these efforts, prioritising vulnerable families and aiming to reduce infant mortality and low birth weight. Parenting education has expanded significantly, with Solihull becoming a national leader in the uptake of Togetherness online parenting courses, complemented by peer support embedded in Family Hubs and SEND services.

Family Hubs, located in areas of highest need, have transformed local support for complex needs, with four hubs and two outreach venues now operating across 24 service areas and involving 79 partner agencies. Support from the hubs has been increasing each quarter with over 30,000 visits to date.

Most recent comparative data show reductions in smoking in pregnancy rates and improvements in infant mortality rates in recent years.

Employment and skills initiatives have shifted focus toward economically inactive residents, who now make up over two-thirds of the service users.

We have delivered a range of interventions to improve employment outcomes for residents with learning disabilities. This has included wellbeing workshops, confidence-building courses and investment in skills and access to work. This has moved Solihull from the lower to upper quartile nationally. Furthermore, 53 local businesses are now Disability Confident.

For adults with disabilities, we have continued to develop and shape the local care and support market to meet needs, increased the number of people who are supported by social care who are in employment and worked with health colleagues to push for increased use of health checks.

We updated our specialist inclusion support service (SISS) so staff can support more children with social, emotional, and mental health needs directly in their own schools. The Early Years Team have been working with Solihull Educational Psychology Service to support early years registered settings to identify social, emotional and mental health (SEMH) difficulties earlier.

We have worked with our carers to redesign and enhance the local support offer, including more flexible carers direct payments, increased respite options and improved information and advice available online and in leaflets with a clear carers' offer. The carers support contract has been redesigned with carers to support more access in localities and more peer support, reflecting what carers told us was important to them.

The Here2Help brand has grown as a central advice hub, focusing on food and fuel poverty. We also launched multilingual web pages for migrants and asylum seekers, supported by QR-coded cards for easy access to healthcare, education, and mental health information.

We have strengthened our work around ill-health prevention by expanding key services including smoking cessation, tobacco control and substance misuse, as well as enhancing our physical activity offer. We provided additional funding to general practice to recover NHS Health-checks after the COVID pandemic and developed leading edge industry partnerships with Jaguar Land Rover as a national pilot to deliver workplace Health checks.

The £3.6 million Fairer Futures Fund created by Birmingham and Solihull Integrated Care Board is supporting a range of pilot schemes to address inequalities and improve health and wellbeing across the life-course including programmes led by the voluntary and community sector. This includes a range of small grants and larger schemes including Solihull's Connected Care Network for children, young people and families and the Health in the Hearts programme in North Solihull, delivered by Colebridge Trust.

5. Where we are we now?

Our Joint Strategic Needs Assessment (JSNA) is a collection of data which informs the Council Plan. It shows that inequality in length of life and quality of life in Solihull is the one of the widest in the country.

The Solihull Local Outcomes Framework 2025/26 shows that Solihull often performs well when compared with England and the West Midlands region. However, we are now presenting our data on rankings with our nearest CIPFA nearest neighbours and other local authorities with similar socioeconomic deprivation levels. The Solihull Local Outcomes Framework is updated annually and is how we measure progress against the Joint Local Health and Wellbeing Strategy.

The latest data (2021-23) on the gap in life expectancy has shown a small improvement in the last reporting period but this is still wider than in 2011. The data shows that, on average, men in the 10% most deprived areas of Solihull can expect to live around 12 years less than men in the 10% least deprived areas (Fig. 3). Similarly, women in the most deprived areas live on average 11 years less than those in the 10% least deprived areas (Fig. 4). Even more stark, is that those living in the most deprived areas of Solihull spend much longer in ill-health, up to 17 years more for men and 21 years for women, compared with the least deprived (Public Health Profiles – Inequality in Healthy Life Expectancy).

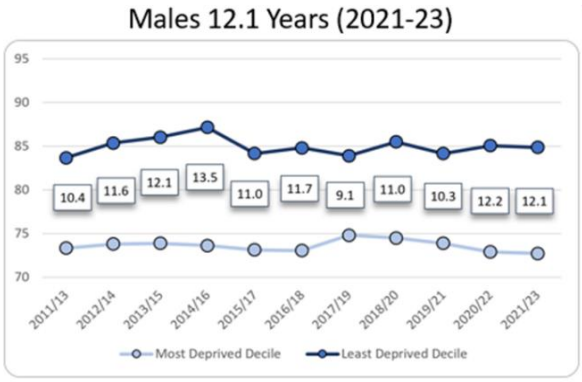


Figure 3 Gap in life expectancy (Males)

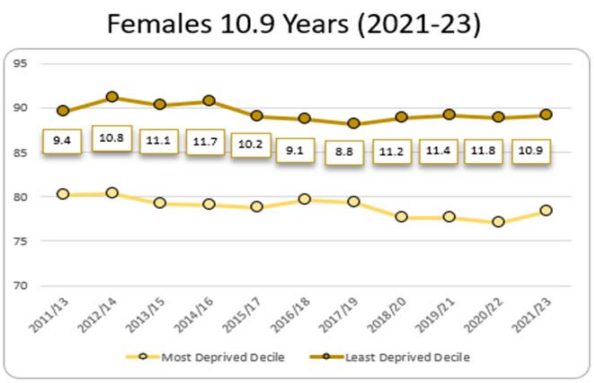


Figure 4 Gap in life expectancy (Females)

6. Our Priorities

The priorities of this Strategy align with the themes of the Solihull Joint Local Health and Wellbeing Strategy .

This section provides an overview of future actions with more specific actions detailed in the delivery plan.

Priority 1: Pregnant Women, Babies & Children

The groundwork for a healthy life occurs in the first 1001 days - encompassing pregnancy and the first two years of life.

The provision and quality of early learning and care and development for a young child is vital to their immediate and long-term health, wellbeing, and achievement. A secure foundation is essential if children are to be ready for school and to narrow the development and attainment gaps that exist between more disadvantaged children and their peers. This is particularly so in the areas of speech, interaction, and writing.

Around 95% of Early Years settings in Solihull are judged to be at least good by Ofsted and this has been consistently high. In Early Years education, Solihull performs above national average across five key areas of communication and language; personal, social, and emotional development; physical development; literacy and mathematics.

However, nationally and within Solihull, fewer children from low-income families reach the expected level of development. In 2024 the percentage of children eligible for free school meals who achieved a good level of development at the end of their reception year was 55% - a decline of 1% on the previous year.

Achievement gaps between the performance of disadvantaged pupils and their peers remain stubbornly wide at all Key Stages and the gap persists as pupils move through the school system. Although there has been a narrowing of the gaps for certain cohorts, the achievement of disadvantaged pupils remains an important priority for the borough.

What have we done since last time?

Concerted efforts have meant that numbers of children in care have steadily reduced. An Early Help offer has been established. We have conducted an analysis of child deaths in more depth and consideration of good practice elsewhere has informed the development of the Healthy Babies programme which is routinely overseen at the NHS-led Local Maternity & Neonatal Service Board.

What we will do:

We will reduce the number of babies being born at low birth weight by training the workforce and strengthening pathways for pregnant women who are at risk of poorer outcomes, such as from smoking, alcohol use, or obesity through continued delivery of the Healthy Babies Plan. We will continue to provide focused support for families with children with developmental delay following

their 2-year-old check to support an increase in school readiness as part of the Solihull Best Start Plan.

Priority 2: Young People

The population of children and young people is growing. The number of Solihull residents aged 19 and under increased by 3495 (7%) between 2014 and 2024.

Improving the health and wellbeing of young people is a priority for Solihull because once children have experienced a good start in life, we then need to continue to support them to grow well, be equipped with the education, skills and access to training to find and stay in good quality jobs.

The Director of Public Health's annual report 23/24 identified that educational attainment at all stages throughout childhood is a key marker of longer-term adult health and employment outcomes. There is detailed national and local tracking in place to monitor this and to enable action to be taken.

At secondary school Key Stage 4 the 'Attainment 8' score (average academic performance across 8 GCSE subjects), Solihull performs better that the national average, but there is a gap between those pupils who are not known to be disadvantaged and those who are disadvantaged.

When considering youth unemployment across Solihull, the overall youth claimant rate in Solihull is 6.5%, compared to 5.3% for England and 7.3% for the West Midlands.

However, the average rate in the three North Solihull regeneration wards of Chelmsley Wood, Kingshurst & Fordbridge and Smith's Wood is 12.3%, compared with 4.8% across the rest of the Borough.

Poor health, including poor mental health, is affecting our young people's life chances and this is a fast-growing issue. This finding is reinforced by the data included in our needs assessment for our children and young people with Special Educational Needs and Disabilities (SEND JSNA). In this report it was found that Social, Emotional and Mental Health (SEMH) issues are the most prevalent primary need among Solihull pupils with SEND. There has been a marked increase in the prevalence of SEMH in recent years, which is reflective of a national picture.

Young carers provide critical support for people with health and social care needs in Solihull, but their own health often suffers. They are twice as likely as other young people to report a mental health condition, like stress, anxiety, or depression, feel more socially isolated and report physical illness such as hair loss and asthma.

What have we done since last time?

We have developed a specialist team to help people with learning disabilities secure paid work and have a dedicated outreach team for those who are economically inactive. We have improved our local offer to care experienced young people by working with employment and skills to foster inclusive employment and expanding the offer at the Next Steps hub.

What we will do:

Our aim is to narrow the gap in educational attainment between our most and least deprived communities; reduce the numbers of young people not in education, employment and training and provide support to those furthest from work into employment including reviewing mental health support for this group.

Priority 3: Working Age Adults

The Joint Strategic Needs Assessment has identified that Solihull has a marked gap in life expectancy. Men living in the least deprived areas of Solihull can expect to live more than 12 years longer than those living in the most deprived areas. The gap in life expectancy for women is 11 years. This life expectancy gap is largely due to higher mortality rates from circulatory disease, cancer and respiratory diseases in the most deprived areas, particularly in men aged 40-79 years.

The Director of Public Health's Annual Report for 2023/24 identified that about 1 in 3 employees in Solihull have a long-term health condition, with 1 in 8 having a mental health condition and 1 in 10 having a musculoskeletal disorder (MSK). Solihull has a higher proportion of people who report a long-term MSK to their GP: 20.8% reported MSK compared with 17.6% for England.

There is also a higher proportion of people living in Solihull who report at least two long-term conditions, such as high blood pressure or cardiovascular disease.

We need to enable working age adults to be in good health and reduce the risk of dying prematurely (i.e. under the age of 75) from heart attacks and strokes. This includes creating the environment which enables people to be active, improving the uptake in health checks to spot early signs of increased risk, supporting people to stop smoking, and assisting people with alcohol dependency into treatment. Such interventions need to sit alongside other initiatives, such as helping people who are experiencing financial pressures.

What have we done since last time?

We have completed work to improve health checks with 'accelerating prevention' funding post Covid and have run the first national workplace pilot of NHS Health checks with Jaguar Land Rover. Our new Tobacco Control Strategy is in place, providing a clear framework to address smoking and vaping related harm, with additional investment in smoking support services to be rolled out. Additional investment in drugs and alcohol services means that more people are being identified and supported to manage addictions and into recovery including support back into work through the Independent Placement Service. The new WorkWell programme, currently operating in East Birmingham and North Solihull is supporting people with health conditions affecting their ability to work to stay in work or return work.

What we will do:

In 2026 we will launch a new health of working aged adults programme to coordinate and drive delivery of a range of interventions to address ill-heath in working aged adults. Through allocations in the Public Health Grant and other relevant national funding, this will see further investment in evidence-based interventions to address smoking, substance abuse, improve the impact and quality

of NHS Health-checks and progress plans to support people to access work where health issues act a barrier. We will work with the NHS to develop localised approaches to work and health including supporting the roll-out of WorkWell and the sub-regional Work and Health Strategy. We will also work with the West Midlands Combined Authority to maximise the impact of funding at local level.

Priority 4: Healthy Ageing

Better healthcare and living standards mean more people are living longer.

The Director of Public Health Annual Report 24/25 focuses on ageing well in Solihull.

Solihull has an aging population. 45,600 residents (21%) are aged 65+ and this was the fastest growing section of the population from 2011 to 2021 (+15%).

The Solihull 65 and over population is projected to increase by over 5,500 people (12%) in the 10 years from 2025 to 2035 and includes sharp projected rises in people aged 85 to 89 (42%) and those aged 90 and over (33%).

As people get older, they are more likely to develop a chronic health problem. This can include heart disease, diabetes, high blood pressure, cancer, or dementia. It is also more likely that they will have more than one chronic health condition the older they get.

The risk of falling increases with age and falls are the largest cause of emergency hospital admissions for older people and are a major reason for people moving from their own home into long term nursing or residential care.

A fall can have catastrophic effect on an older person's life. Falls can lead to fractures, prolonged hospital stays and physical deconditioning, which in turn can severely impact mobility. Reduced mobility, as well as fear of further falls, can cause people to lose confidence in their own ability making them more dependent on others. There are notable differences in rates of hospital admissions for falls between our most deprived and least deprived populations. This indicates that more can be done, 'upstream' with people in more deprived areas.

An ageing population will also be affected by dementia. The likelihood of developing dementia roughly doubles every five years after the age of 65. It is estimated that 1 in 3 people will care for someone with dementia in their lifetime with half of those carers being employed. These carers may have to cut their working hours or give up work completely. This is important in terms of 'health inclusion'.

Vaccinations in older people are crucial for protecting against various preventable diseases, with common recommendations including the annual flu vaccination, pneumococcal vaccine, shingles vaccine, and the RSV vaccine.

What have we done since last time?

We have brought together into a single service a Home Improvement Agency (known as Solihull Independent Living Service) for residents that need support to live well in their homes, that includes aids and adaptations service, home adaptations, handyperson service, technology enabled care and a home hazards service.

A team of NHS community frailty practitioners now also supports residents who are at risk or have had a fall. This work happens alongside work undertaken to prevent falls by Adult Social Care and the voluntary and community sector.

The rate of falls in the over 65s has steadily reduced in recent years and given the number of people aged over 65 is set to markedly increase in Solihull, this is positive news. The gap in the falls rate between the most deprived and least deprived has also reduced but there remains much room for improvement.

We have introduced new respite services which are especially beneficial for people with dementia because they can be delivered in their own home, keeping surroundings familiar and reducing distress when their carer has a break.

What we will do:

Current falls initiatives will be reviewed in line with new NICE guidance, and a new frailty pathway will be developed locally, working across primary, secondary and community services, adult social care and public health.

We will take steps to ascertain and quantify any inequalities within the efforts to better identify and diagnose people with dementia.

We will take joint action across the NHS and public health to improve vaccination uptake and support efforts to reduce any inequalities in access to vaccines. This work is reported through the Health Protection Board which reports annually to the Health and Wellbeing Board.

Priority 5: End of Life

Solihull has an ageing population which means that at any given point in time there will be approx. 2300 people in their last twelve months of life (based on 1% of the population).

Data from primary care has shown that there is a variation in recording when people have come into their last twelve months of life across the borough. This has led to further system-wide work on the identification and recording of patients.

Between April 2024 – September 2024 frailty was the greatest recorded cause of death across all settings in over 85 yr olds across Birmingham and Solihull. Of those the largest proportion (41%) had a place of death recorded as hospital.

It is of vital importance that people have a dignified death in the location of their choice.

What have we done since last time?

We have identified challenges in data capture across the system and plans have been put in place to improve this. This will help us understand whether there are inequalities in access to high quality end of life care.

What we will do:

Through work that is being led by the NHS on a shared care data platform, our aim is to improve the identification of people entering their last twelve months of life and in doing so, reduce any variation in access to high quality end of life care in their preferred place.

Priority 6: Mental Health

At a national level, surveys have found that mental disorders are more prevalent in certain population groups[2]. This has included Black, Black British, those not in employment, those in receipt of benefits and those in poor physical health. Surveys have found a common factor is social disadvantage.

At a local level, a new All Age Mental Health Strategy is currently in development which will incorporate findings from the needs assessment and look at inequalities in access to care and support. The Mental Health Collaborative (led by Birmingham and Solihull Mental Health Trust) is leading this work.

This will consider the steps we want to take collectively to:

- Help people to stay mentally well
- Help people recognise the signs for when they start to struggle and signpost to support
- Reduce isolation
- Improve access to primary care
- Reduce waiting times for specialist services
- Reduce the number of people in crisis
- Reduce the number of suicides
- Improve recovery

Partners overseeing the mental health delivery plan will work closely with colleagues who support our populations with the social circumstances that impact on wellbeing, such as income and fuel poverty. The Health and Wellbeing Board will continue to oversee the work led by the Mental Health Provider Collaborative to achieve these goals.

Children's mental health also remains a focus with the latest data showing that when looking at hospital admissions for mental health conditions in under 18's, the rate is 3 times higher in girls than boys (Solihull Local Outcomes Framework 2025/26).

What have we done since last time?

Led by Birmingham and Solihull Mental Health Foundation Trust, a draft updated all-age mental health strategy and delivery plan has been produced. We have introduced the Orange Button scheme (suicide prevention initiative) that has trained over 680 people to offer a listening ear and provide support, signpost to services and reduce the stigma around suicide. We developed Solihull Active Minds, a community wellness programme to help people with poorer mental health to be

[2] Mental Health 360 | Inequalities | The King's Fund

more active. We have launched a mental health enablement service which promotes the regaining/gaining of skills to maximise independence and has supported over 200 people to date, and this has been supported by a network of mental health drop-in services across the borough for people to use to maintain that better health.

What we will do:

We will support the implementation of the new all-age mental health strategy, led by the Mental Health provider collaborative. The new all-age model of care will have addressing inequalities in mental health at its core, including transforming the way children and young people, parents and carers are supported. We will support the Solihull specific plan that will be developed in 2026.

We will continue to provide detail around our mental health support offer through the Here2Help web pages and booklets.

Priority 7: Inclusion Health

Inclusion health is an umbrella term used to describe people who are socially excluded, who typically experience multiple overlapping risk factors for poor health such as a disability, neurodivergence, living in poverty, being exposed to violence and complex trauma.

People belonging to inclusion groups are at risk of poor health outcomes, often much worse than the general population and a lower average age of death.

Poor access to health and care services and negative experiences can also be commonplace for inclusion health groups due to multiple barriers, often related to the way services are delivered.

Adults with Learning Disabilities have a much shorter life expectancy than the general population[3] are more likely to experience preventable causes of ill health.

Adults with severe and enduring mental illness are also more likely to suffer poor physical health than the general population and have a life expectancy that is 20 years shorter[4].

They are less likely to be employed and are more likely to live in poverty with poor housing.

Unpaid carers provide critical support for people with health and social care needs in Solihull, but their own health often suffers.

A 2021 rapid evidence review by Public Health England showed that carers of older people experience poor mental health, including anxiety and depression, a higher risk of musculoskeletal conditions, cardiovascular disease, generalised cognitive deterioration and function, and poor sleep.

Social isolation and loneliness can happen at various stages of life or after certain life events. However, some groups are more likely to experience these challenges than others. Addressing social

[3] Health and Care of People with Learning Disabilities, Experimental Statistics: 2018 to 2019, NHS Digital
[4] Health matters: reducing health inequalities in mental illness - GOV.UK

isolation and loneliness has been identified as priority area for the cross-council Living Well in Solihull programme in 2026/27.

What have we done since last time?

For adults with disabilities, we have continued to work to develop and shape the local care and support market to meet needs, increased the number of people who are supported by social care who are in employment and worked with health to push for increased use of health checks. We have Learning Disability and Autism Partnership Boards that are chaired by people with lived experience, which help us shape improvements.

We have worked with our carers to redesign and enhance the local support offer, including more flexible carers' direct payments, increased respite options and improved information and advice available online and in leaflets with a clear carers' offer. The carers support contract has been redesigned with carers to support more access in localities and more peer support, reflecting what carers told us was important to them.

We have continued to develop the Here2Help brand as a 'one stop shop' for advice and guidance on a range of subjects, with a particular focus on people experiencing food and/or fuel poverty.

A suite of web pages for migrants who may face language barriers had been developed: Support for asylum seekers | Solihull Metropolitan Borough Council. The pages highlight the translation functions available on the website. In addition, 'business cards' have been developed with QR codes so that without too many words, our asylum-seeking and refugee population can be directed to these pages of information. The range of topics was drawn up by working in collaboration with a range of colleagues and include registering with a GP, access to medication, vaccinations, maternity services, dentistry, education and mental health.

We have contributed to the work of the BLACHIR programme across Birmingham & Solihull that sets out to address health inequalities that exist in Black African and Black Caribbean communities. For Solihull, this has involved improving the way we capture data to show variation amongst different population groups and work with partners to address that variation.

What we will do:

Our aim is to support all groups at higher risk of poor health outcomes by collaborating with partners to develop more inclusive services, informed by better health equity assessments.

Working with new communities we aim to improve language skills and health literacy. We will train community health champions to help people build confidence, understand local services, and navigate health and care systems. We will provide targeted support for new and expectant parents and look to preventing health inequalities in early years by linking resettlement and family support programmes to Start for Life and Healthy Babies initiatives, ensuring children from new communities have equal access to immunisations, nutrition advice, and early education.

For Armed Forces including Veterans we aim to improve awareness and signposting to mental health services, reduce social isolation, provide support for early years and family health and provide support for those with addictions.

We will continue to develop an all-age community of practice to promote a better understanding of social isolation and loneliness, bringing together the opportunities, assets and services that can help to prevent children, young people and adults from becoming chronically isolated or lonely, and support people to reconnect to their community where this might already be the case.

7. Healthy Places

We cannot address health inequalities without taking account of the places in which people are born, grow, live work and age.

As shown in Figure 1, factors like planning, housing, transport and air quality have an important role in determining whether people grow well, live well and age well.

Through our public health duties, the council will continue to shape strategy, policy, and the environment in ways that enable and encourage people to make healthier lifestyle choices. This requires coordinated action across planning, infrastructure, food systems, and community programmes, ensuring that healthy lifestyles are embedded into everyday decision-making and service delivery.

Our existing strategies such as our air quality strategy already include steps to improve health. We also want to work to ensure that the national planning framework, currently subject to national consultation enables us to maximise health gain.

We also work closely with the West Midlands Combined Authority so that regional policies and strategies, such as the spatial planning strategy also contribute towards local health outcomes.

There is an increasing focus on place-based working that aims to better coordinate local service delivery: locally our Chelmsley Wood Pride in Place will see significant investment into the area and the Kingshurst regeneration scheme is also being designed with health improvement in mind.

8. Working with others

There is currently significant change happening across the NHS with the clustering of Integrated Care Boards, the development of integrated neighbourhood teams and locality working. It will be essential that this strategy is considered as the new BSol & Black Country ICB cluster rolls out its strategic commissioning plans so that system partners can work together to address inequalities. These plans aim to be underpinned by a Population Health Management approach, which ensures our health services considers populations, not just patients. Understanding which populations are not accessing health care, or accessing it too late, will be a key part of this work and is integral to understanding and addressing inequalities in health.

The national focus on healthcare inequalities continues through the Core20Plus5 programme which defines a target population and identifies five clinical areas requiring accelerated improvement. There is a programme for adults and another for children and young people (Fig.5).

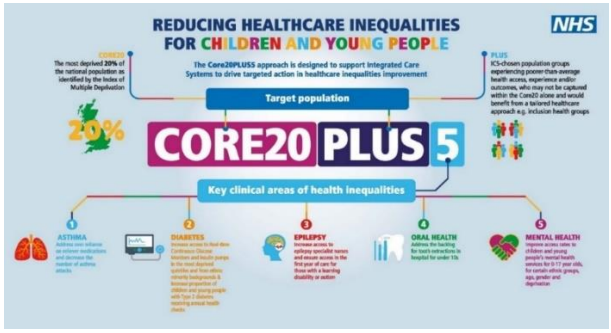


Figure 5 NHS Core 20+5 Adults & Children and Young People.

9. Governance and Ownership

Living Well in Solihull (LWIS) prevention board will take a lead role co-ordinating local delivery and have oversight of this Strategy. Multi-agency ownership and oversight will be through local joint commissioning arrangements, with progress reports to the Health and Wellbeing Board on an annual basis.

10. Measuring Performance

A Solihull Health Inequalities dashboard has been developed which shows in-borough variation complementing the borough level indicators in the Solihull Local Outcomes Framework.

The Health Inequalities dashboard views data across geography, ethnicity, age and sex (as appropriate) to identify inequalities that exist and monitor progress of work in these areas.

Solihull Health Inequalities Dashboard

A small area analysis has also been developed which helps us look holistically at neighbourhoods using a range of indicators. Data on health, housing, benefits, crime, demography and deprivation are combined to give a broad overview of need at a small geography.

Comparing areas at neighbourhood level will identify the 'shift' needed to have an influence on the level of deprivation in an area.

These three tools will be used to identify need and measure progress in reducing the inequalities gap across the priorities.

11. Next Steps

The delivery plan for this strategy, mentioned in section 9, identifies the areas of our health and care 'system' that are responsible for delivering work to address the health inequalities gap. The delivery plan also includes baseline measurements and is where the owners of actions will set targets. This is a 'live' document that will regularly be reviewed, updated and progress fed back to the Living Well in Solihull Board, with annual reporting to the Health and Wellbeing Board.