Sandwell Health and Wellbeing Board

Tuesday 12th January, 2017
at 4.30pm in Committee Room 1
at the Sandwell Council House, Freeth Street, Oldbury

Agenda
(Open to Public and Press)

1. Apologies for Absence

2. Declarations of Interest in matters to be discussed

3. To confirm the Minutes of the meeting held on 22nd November, 2016

Main Discussion Item

4. Priority 3 – We will work together to join up services – proposed board development plan (spring board to priorities)  
   Paul Southon

For discussion/decision

5. Adult mental health joint strategic needs and assets assessment (Paul Southon)  
   Paul Southon

6. 0 – 4 years joint strategic needs assessment  
   Jyoti Atri

For Information

[IL0: UNCLASSIFIED]
7. Chairs correspondence – Police and Crime Commissioner. (police and health and wellbeing boards)  

8. Board forward plan (standing item)

Dates of future Meetings at 4.30pm on:-

- Thursday 2 March 2017
- Thursday 4 May 2017

Jan Britton  
Chief Executive

Sandwell Council House  
Freeth Street  
Oldbury  
West Midlands

Distribution:

Voting Members of the Board:  
Sandwell MBC Representatives:  
Leader of the Council – Cllr S Eling;  
Cabinet Member for Social Care – Cllr A Shackleton;  
Cabinet Member for Children’s Services - Cllr S Hackett;  
Cabinet Member for Public Health and Protection – Cllr P Gill.

Sandwell and West Birmingham Clinical Commissioning Group:  
Vice-Chair - Chair of Sandwell Health Alliance locality/CCG Partnership lead - Dr Basil Andreou;  
Chair of Black Country Commissioning locality - Dr Ian Sykes;  
Healthworks Locality – Dr Ram Sugavanam.

Healthwatch Sandwell  
Chair of Healthwatch Sandwell – John Clothier
Non-Voting Members of the Board:
Sandwell MBC:
Director - Adult Social Care, Health and Wellbeing - David Stevens;
Director of Children’s Services - Matthew Sampson;
Director - Public Health - Jyoti Atri.

NHS England - Birmingham, Solihull and the Black Country Area Team
Director of Operations and Delivery – Vacant.

Sandwell and West Birmingham Clinical Commissioning Group:
Accountable Officer - Andy Williams.

Discretionary Members:-
West Midlands Police
Chief Superintendent Matthew Ward.

West Midlands Fire Service:-
Group Commander Steven Ball

Sandwell Voluntary Sector Organisation:-
Chief Executive Mark Davies

Sandwell and West Birmingham Hospitals NHS Trust
Chief Executive Toby Lewis.

Black Country Partnership NHS Foundation Trust
Deputy Chief Executive - Tracy Cotterill

Agenda prepared by Shane Parkes
Democratic Services Unit - Tel: 0121 569 3190
Email: shane_parkes@sandwell.gov.uk

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Please note that this meeting may be filmed by members of the public and press, and may be filmed by the Council for live or subsequent broadcast on the Council’s website.
Agenda Item 1

Apologies

To receive any apologies from members
Agenda Item 2

Declarations of Interest

Members to declare any interests in matters to be discussed at the meeting.
Minutes of the Sandwell Health and Wellbeing Board

22nd November 2016 at 4.30pm
at Sandwell Council House, Oldbury

Present:

Sandwell Metropolitan Borough Council (SMBC):
Councillor Ann Shackleton (Chair) Cabinet Member for Social Care;
Councillor Simon Hackett Cabinet Member for Children’s Services;
Councillor Syeda Khatun Deputy Leader – Cabinet Member for Neighbourhoods and Communities;
Councillor Preet Gill Cabinet Member- Public Health and Protection;
Jyoti Atri Director - Public Health.

Sandwell and West Birmingham Clinical Commissioning Group (CCG):
Andy Williams Accountable Officer, CCG.

Healthwatch Sandwell:
John Clothier Chief Exec. Healthwatch Sandwell.

West Midlands Police:
Matthew Ward Chief Superintendent WMP

West Midlands Fire Service:
Neil Griffiths Group Commander WMFS
Steven Ball Group Commander WMFS

Sandwell and West Birmingham Hospitals NHS Trust:
Toby Lewis Chief Executive of Sandwell and West Birmingham Hospitals NHS Trust;

Sandwell Voluntary Sector Organisation
Mark Davis Chief Executive.

Apologies:
Councillor Steve Eling Leader of Sandwell Council;
Dr Basil Andreou (Vice Chair) Chair of Sandwell Health
Sandwell Health and Wellbeing Board – 22nd November, 2016

Alliance, Locality/CCG Partnership Lead;
Dr Ram Sugavanam Healthworks Locality;
Dr Ian Sykes Chair of Black Country Commissioning Locality;
Christine Guest Divisional Manager Adult Social Care SMBC;
David Stevens Director - Adult Social Care, Health and Wellbeing;
Matthew Sampson Director – Childrens Services
Tracey Cotterill Deputy Chief Executive.

In attendance:
Paul Southon Health and Wellbeing Programme Manager SMBC;
Dawn Maycock Health and Wellbeing Board Project Officer SMBC;
Conrad Parke RGF Programme Manager
Diane Osbourne SWB CCG Commissioning Manager.
Rosalind Baker Mental Health Project Officer – Changing our Lives

57/16  
Minutes

The minutes of the meeting held on 1st September, 2016 were confirmed as a correct record.

The Chair asked that best wishes for a speedy recovery be sent to Doctor Andreou who had recently undergone surgery.

Main Discussion Items

58/16  

The board received a presentation and watched a film entitled ‘Craig’s Story’, a case study of a young violent convicted offender from a neighbouring borough.

The Health and Wellbeing Board had agreed that the prevention of violence and exploitation was the theme for the board’s priority 2; “we will help people stay safe and support communities”.
This was a shared priority across all four statutory partnership boards.
  • Health and Wellbeing Board;
  • Sandwell Safeguarding Children’s Board;

[IL0: UNCLASSIFIED]
At the meeting on 1 September 2016 (minute no. 51/16), the board agreed the next steps for delivery of priority 2.

There had been progress made against each of the agreed next steps. This included the preparation of a draft action plan that operated across all four statutory partnership boards.

As part of the needs assessment, service mapping was underway across the council, police, NHS and wider partners. Board members were asked to circulate the service mapping template to the relevant officers in their organisations.

For the action plan to progress, the health and wellbeing board would need to review the plan. This included a decision on whether the proposed role for the board in the action plan was correct or whether the plan needed amending.

The proposed governance for the programme was through the Joint Partnership Board, which included the chairs of all four boards.

A small partnership task and finish group currently managed delivery of the priority. As the work programme developed there may be a need for dedicated capacity to programme manage delivery across the four boards and wider partners. A personnel specification would be prepared to outline the skills required for the support role. Partners would consider if they had capacity within their organisations to support this role.

The Chair commented that it would be necessary to focus on deliverables and outcomes. This would be brought back to the board in the future.

For discussion/decision

Mental Health and Wellbeing Standards feedback from launch event

At the Health and Wellbeing Board on the 12th May, 2016 (minute no. 27/16, the Sandwell Mental Health Parliament presented the quality of life standards.
The board received feedback from the event which was held on the 18th October 2016, to launch the standards. Norman Lamb MP endorsed the standards with an impassioned speech about the importance of people who had life experience of mental health having choice and independence in their care.

The event was well attended, with representation from councils, NHS commissioners, NHS providers, voluntary and community based organisations and people with lived experience of mental health services.

The quality of life standards were being included in service commissioning by Sandwell and West Birmingham Clinical Commissioning Group.

An Ideas Festival was a tool for working in coproduction with people with lived experience of mental health problems and the community. An ideas festival had been arranged for the 27th January 2017, and the board was invited to attend.

It was planned to develop a community place of safety café. This would be community based and self-sustaining it was felt that this would relieve pressure on Accident and Emergency departments. Changing our Lives were exploring ways of securing investment from large businesses and grants.

The Chair asked if there would be an age limit on the place of safety. It was confirmed that there would not be an age limit, however, as this was an evening initiative it was unsuitable for young children but could be used by Adolescents.

The board would be updated on progress at a future meeting.

**Child and Adolescent Mental Health Services (CAMHS) transformation plan update**

The Board received a progress report on the refreshed CAMHS Local Transformation Plan.

The original plan had been submitted in October 2015 and had been fully approved with an 88% assurance rating from NHS England. The transformation plan outlined clear plans for a five
year term. The plan had been approved by the governing body and
presented to the Health and Wellbeing Board at the meeting on the
3rd March 2016, (Minute Number 21/16).

NHS England requested the refresh in October 2016, the draft was
submitted on the 7th October and following assurance from NHS
England the plans were approved and published by 31st October.

Feedback from NHS England on the draft refresh gave Sandwell
and West Birmingham CCG an assurance rating of ‘Fully Confident’
with just four minor issues to address.

The Key priorities were as follows:-

- To develop a single point of access;
- To explore links to adults emotional wellbeing and mental
  health services;
- To develop a crisis management and home treatment service;
- To develop an Eating Disorder service;
- To Improve Access to Psychological Therapies programme,
  and improve early intervention provision;
- To provide a 136 suite (place of safety);
- To complete a training needs analysis, and commission multi-
  agency training on emotional wellbeing and mental health
  concerns;
- To improve the IT systems and CAMHS physical environment;
- To improve neurodevelopmental provision for Autism
  Spectrum Disorder and Attention deficit hyperactivity disorder.

The successes to date were outlined.

The single point of access was a multi-agency venture with a clear
directive and a monitoring process. Data and information gathered
from the evaluation in May 2016 was being used to inform on future
improvements with regard to the procurement of the new Emotional
Health and Wellbeing model and incorporated the management of
the point of access.

The establishment of a community based primary mental health
worker service had been commissioned in line with Government
policy. The focus of the service had been switched to one of early
intervention and prevention. The service provided nine workers in
Sandwell in various locations.
A place of safety suite had been established for vulnerable children and young people at Penn Hospital, Wolverhampton. The provider trust had liaised with all relevant emergency services to make them aware of the service which would prevent vulnerable young people being placed into police custody.

The home treatment and crisis intervention team continue to progress and the team operates seven days a week from 8am – 8pm, a 24/7 provision would be available by 2020. There had been problems with recruitment however both elements were in place in Sandwell.

Sandwell had joined the East Midlands Learning Collaborative and the children and young people Improve Access to Physiological Therapies (IAPT) was integral to the whole system of Children and Young People’s Mental Health Transformation. The workforce in Sandwell would be improved through training.

The board’s view had been that the engagement service must be a strong voice for children and young people, championing their rights and reducing the impact of inequalities. The tender process was completed in November and Brook had been awarded the contract.

Links had been made to Adult Mental Health as follows:

- Gold standard Early Intervention to Psychosis service, 8am – 8pm aged 14-35;
- Access to the Triage: rapid support for vulnerable children and young people;
- Development of an all age Eating Disorder Service.

A CAMHS practitioner had been appointed into the early year’s team, the post commenced in July 2016 and improvement had been made by increasing the capacity within the team.

The priorities for 2017–18 were detailed in the plan,

NHS England had made an offer of additional funding. A business case was being prepared for an initiative to reduce waiting times. A further offer of additional funding had been received from NHS England two weeks ago. CAMHS and the youth justice team are
developing a health worker post to work with the youth offending team and young people in custody.

Further updates on progress would be brought to the Health and Wellbeing Board in the future and the link to the final CAMHS transformation Plan circulated to the Board.

**61/16 Board development session – 27th September, 2016 (update/feedback)**

The Health and Wellbeing Programme Manager updated on the development session. The board recognised that there had been substantial restructuring across board partners and there was a need to understand how the board had been affected and how it needed to change to remain effective.

Based on the findings from the workshop, three themes for board development had been proposed.

i. Developing partnerships, relationships and trust between board partners;

ii. Making sure the board was able to deliver on their priorities;

iii. Making the board more accessible and an effective forum for partnership decision making and for making a positive difference for the people of Sandwell;

The Executive group would develop a draft action plan based on the three areas to bring back to the board in January.

**62/16 Update on Midland Metropolitan Hospital**

The board received a report from the Partnership and Regeneration Manager regarding the Midland Metropolitan Hospital and the planned development of the surrounding Smethwick and Ladywood area and the impact on those communities.

The Hospital would be open in October 2018 and up to six new housing development sites consisting of approximately 6,500 new homes had been planned. The Planning and Public Health teams from Sandwell MBC and Birmingham City Council would like to propose an approach that views these new assets as not only health and housing investments but an investment that could positively impact across a whole range of issues and across a whole community in terms of indicators such as employment, educational...
attainment, healthy lifestyles and social cohesion.

An Urban innovation Action Award of £3 million over the next three years had been made.

There would be an impact assessment of the regeneration work associated with the hospital development. The approach to this is being agreed, it would identify the potential health benefits and harms from the initiative and how the benefits can be maximised and the harms minimised.

If a proactive approach were adopted to maximise the impact of these assets it would help deliver a successful, sustainable hospital at the heart of a neighbourhood that offered better quality of life for the community with happier, more prosperous people benefiting from better education and better employment prospects with minimal extra funding required. It was important to create a safe and secure environment for those living and working in the area.

A cross departmental and inter-agency approach to asset based regeneration could then be used on many other assets, existing and new across other neighbourhoods in Birmingham and Sandwell.

A number of the workforce who would be based in the hospital already resided in the area. A cross border Stakeholder event had been planned for March 2017 to obtain senior support and commitment to the regeneration plans.

63/16

**Update on Sustainability and Transformation Plan**

The Accountable Office for the CCG updated on the Sustainability and Transformation plan. Black Country and West Birmingham had published their proposals to transform local services on the 21st November 2016, along with an executive summary.

18 local health and social care organisation had contributed to the development of the proposals.

The key commitments were:-

- The Midland Metropolitan Hospital;
- New Models of Care;
- Primary care;
- Maternal and Infant Health - reducing mortality.
Local people were invited to have their say on the proposals through a comprehensive programme of engagement, beginning with a public event on 6th December at Bethel Convention Centre, Kelvin Way, West Bromwich, B70 7JW.

The Cabinet Member-Public Health and Protection remarked that it was necessary to integrate health and social care and a public voice was essential to getting it right.

For Information and/or Comments

64/16

Board forward plan – standing item

The updated plan had been circulated to members.

Date of Next Meeting

the next meeting of the Board would be held at 4.30pm on Thursday 12th January, 2017.

(Meeting ended at 6.20pm)
### Sandwell Health and Wellbeing Board

**Date 12 January 2017**

<table>
<thead>
<tr>
<th>Report Topic:</th>
<th>Priority 3: We will work together to join up services – proposed board development plan</th>
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<tr>
<td>Contact Officer:</td>
<td>Health and Wellbeing Programme Manager</td>
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### Purpose of Report:

- To propose a plan for the future development of the board
- To seek the views of board partners and gain board agreement to the plan

### Key Discussion points:

- The board held a development workshop, facilitated by the Local Government Organisation, on 27 September 2016
- Following discussion at the board on 22 November 2016 the board executive group was asked to prepare a draft board development plan based on three themes;
  - Developing partnerships, relationships and trust between board partners
  - Making sure the board is able to deliver on its priorities
  - Making the board more accessible and an effective forum for partnership decision making and for making a positive difference for the people of Sandwell
- The executive group has developed the draft development plan for discussion at the board. This plan is attached to this report.
- The proposal is that, when the board has agreed the final development plan, the board executive group will monitor delivery of the plan.

### Recommendations

- That the board discusses the proposed plan and comments on changes needed to the plan
- That the board agrees to the Health and Wellbeing Board executive group monitoring delivery of the plan
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<th>Implications</th>
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<td>(if applicable)</td>
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<tr>
<td><strong>Financial</strong></td>
<td>No financial implications</td>
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<tr>
<td><strong>Wider Engagement</strong></td>
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<td><strong>Other</strong></td>
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## Board Development Action Plan

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<th>Objective</th>
<th>Action</th>
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<th>When</th>
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<tr>
<td><strong>1. Developing partnerships, relationships and trust between board partners</strong></td>
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| Support board members to understand each other’s roles, priorities and challenges | The next board development workshop to include ‘getting to know each other’ sessions for board members  
- Discuss with the Local Government Association to see what support is available to facilitate board development | HWB executive | Proposal to March HWB |
| Support new board members to understand the governance and priorities of the board | Develop a formal induction for new board members, including meeting with other board members and health and wellbeing board executive | HWB support officers | April 2017 |
| Ensure clarity of governance and decision making pathways for the board and for each of the board members | Develop and agree a clear description of the decision-making pathways for all partners, including the role of the HWB within these pathways | HWB executive / HWB board | May 2017 |

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<th>Objective</th>
<th>Action</th>
<th>Delivered by</th>
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<td><strong>2. Making sure the board delivers its priorities</strong></td>
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| Clear governance and oversight of each of the board priorities | Each board priority to have a named board member lead and identified lead officer  
- Board lead responsible for maintaining an overview of the delivery and progress for the | Board to nominate board member lead. | May HWB meeting |
<table>
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<tr>
<th>Priority and reporting this to the board on a quarterly basis</th>
<th>Board member lead to nominate lead officer.</th>
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<tr>
<td>- Lead officer to be responsible for coordinating and monitoring delivery of a priority action plan</td>
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<td>- All priorities to provide update reports to the board quarterly</td>
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<td>- Detailed reports and board discussions twice yearly for each priority, with exception reporting when needed to ensure continued progress in delivering the priority</td>
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<tr>
<th>Ensure a focus on the board priorities</th>
<th>Board support officers / HWB executive</th>
<th>March HWB meeting</th>
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<td>All board reports to describe how they contribute to delivery of one or more of the board priorities</td>
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<td>- How they will deliver clear outcomes and positive change for the people of Sandwell</td>
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<td>- Guidance to be prepared for report authors</td>
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<td>- Reports to be reviewed for compliance</td>
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<th>Ensuring actions from board discussions are captured and followed up</th>
<th>Board support officers</th>
<th>Immediate</th>
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<td>3 questions to be asked at the end of every item discussed at the board</td>
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<tr>
<td>- Does this item need to come back to the board?</td>
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<td>- If yes, when does it need to come back?</td>
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<td>- What does the board expect when it comes back?</td>
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<td>- All returning items to be scheduled into the board forward plan</td>
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<td>Work of the HWB to be co-ordinated with the other statutory partnership boards</td>
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<td>- Health and Wellbeing Board</td>
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<td>- Safer Sandwell Partnership and Police and Crime Board</td>
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<td>- Sandwell Safeguarding Children’s Board</td>
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<td>- Sandwell Safeguarding Adults Board</td>
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<tr>
<th>Boards to share the priorities and delivery plans with the other boards</th>
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<tr>
<td>- HWB Priority 2 (prevention of violence and exploitation) is a shared priority across all four boards</td>
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<td>- Joint Chair’s group to have oversight of delivery plans to ensure the work of the boards is coordinated where appropriate</td>
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<th>Democratic services and board support officers</th>
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<td>Chairs of the partnership boards</td>
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### 3. Making the board accessible and an effective forum for partnership decision making

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<th>Tell people what the board is doing, allow people to comment, ask questions and influence delivery of the board priorities</th>
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<tr>
<td>- Work with existing engagement groups and networks to raise awareness of the board priorities and to develop routes for consultation with stakeholders</td>
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<td>o E.g. SHAPE, older people’s ambassadors, mental health and learning disability people’s parliaments, voluntary and community sector</td>
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<td>- Produce and share clear and concise descriptions of the current board priorities and action plans</td>
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<td>- Develop routes for people to ask questions or comment on plans</td>
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<td>- Produce clear descriptions of what is discussed and decided in board meetings, to be shared through existing networks</td>
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<th>HWB executive</th>
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<td>Plan to the March HWB</td>
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<td>Review what would help people become more involved in the work of the board</td>
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**Sandwell Health and Wellbeing Board**

**Date 12 January 2017**

<table>
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<tr>
<th><strong>Report Topic:</strong></th>
<th>Adult Mental Health Joint Strategic Needs and Assets Assessment</th>
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<td><strong>Contact Officer:</strong></td>
<td>Health and Wellbeing Programme Manager</td>
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**Purpose of Report:**

- To update the board on progress on the preparation of the joint strategic needs and assets assessment (JSNAA)
- To summarise the findings from the needs assessment
- To set out the plan and timescale for completion of the JSNAA

**Key Discussion points:**

- The board agreed that the scope for the first phase of the adult mental health JSNAA would focus on access into services and on access to recovery and support for independent living
- The JSNAA has been developed through a co-assessment approach. This has included consultation and involvement from a range of statutory and voluntary sector partners and people with lived experience of mental health services.
- Information and data were gathered from commissioners and providers of mental health services, from service users and people with lived experience. Information was also provided by non-mental health providers who support vulnerable people and people with mental health problems.
- The needs assessment describes what is known about the levels of wellbeing, common mental health disorders and severe and enduring mental illness in Sandwell. The indications are that the levels of mental illness in Sandwell are higher than the national average, though not all data sources are consistent.
• The range of services available in Sandwell have been mapped, including operating hours and waiting times where this information is available.

• Key findings so far have identified deficits and assets related to wellbeing and mental health services in Sandwell. The main themes are;

• Substantial challenges in emergency crisis referral pathways and access to assessment and treatment

• Unclear pathways into assessment and treatment for routine referrals, including inconsistency in people being discharged for non-attendance and needing re-referral.

• Difficulties for people with substance misuse problems accessing mainstream services for support.

• A lack of overall coordination of pathways, referral routes, and access to assessment and treatment across all partners

• The contribution provided by non-mental health providers and organisations in supporting people with mental health problems. These are an important asset that provide much support to vulnerable people and their contribution is not always fully recognised.

• There needs to be more coordination of approaches, pathways and support between statutory and voluntary mental health providers and the non-mental health providers that are supporting vulnerable people and people with mental health problems.

• A need for a coordinated approach to workforce development across all partners, including increased training and support for non-mental health providers.
Further analysis is needed of the information gathered from partners and people with lived experience.

Once this analysis is complete, work will be undertaken with all partners to develop and agree the final recommendations from the JSNAA.

The final JSNAA, with recommendations, will be prepared ready for the next board meeting on March 3rd 2017.

The role of the partnership mental health strategy group has recently been reviewed. This group will provide the partnership forum that will develop and deliver a partnership mental health transformation plan for Sandwell, based on the recommendations from the JSNAA.

**Recommendations**

- That the board discusses and comments on the JSNAA and the findings presented.
- That the board receives the final JSNAA at the next board meeting in March 2017.

**Implications**

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<tr>
<th>Financial</th>
<th>No financial implications</th>
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<tr>
<td>Wider Engagement</td>
<td>A wide range of partners and stakeholders have been involved in developing the JSNAA.</td>
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<td>Other</td>
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Sandwell Joint Strategic Needs Assessment

Adult Mental Health and Well-being in Sandwell

A Needs and Assets Assessment
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Executive Summary

To be completed for final JSNAA following final analysis of responses.
**Recommendations**
To be developed and agreed with partners, providers and people with lived experience.
Adult Emotional Health and Wellbeing in Sandwell: A Needs and Assets Assessment

1. Introduction

Objectives for the Joint Strategic Needs and Assets Assessment
The purpose of this Joint Strategic Needs and Assets Assessment (JSNAA) chapter is to support the people of Sandwell, and the commissioners and providers of services, in maintaining and improving mental health and wellbeing in Sandwell. The JSNAA will,

- Identify the assets that exist within the communities of Sandwell to support people’s mental health and wellbeing
- Identify the levels of need in relation to mental health and wellbeing
- Provide an overview of the relevant evidence and guidance
- Describe how these needs are currently addressed and identify gaps in provision
- Make recommendations for action

This will help with;

- Recognising, supporting and building on the existing assets within the communities of Sandwell
- Developing joint approaches to support people with maintaining and improving their emotional wellbeing and mental health
- Commissioning interventions that will improve emotional health and well-being and support early intervention
- Commissioning services for people experiencing both common and severe and enduring mental health problems

Asset Based Approach
The Department of Health, in Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategies Explained, describes joint strategic needs assessments as “The means by which local leaders work together to understand and agree the needs of all local people”.

However, understanding the needs alone can lead to a deficit-based approach. This can fail to recognise the value of the assets that already exist within communities. These include community leaders and activists, community and voluntary sector organisations and the knowledge, skills and experience that exist within communities.

In producing this needs and assets assessment, the intention was to capture the assets as well as the needs in Sandwell. To do this we used a co-design approach. Co-design is a stage within co-production, which is defined as;

“Delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours.”
Local people with lived experience (including the Sandwell Mental Health Parliament), voluntary sector organisations and statutory commissioner and provider organisations have been involved throughout the writing of the JSNAA.

Definitions of emotional health and well-being
There are a number of different terminologies used to describe emotional wellbeing and mental health. For the purposes of this needs assessment the definitions used are taken from Better Mental Health for All, published by the Faculty of Public Health in 2016.  

Public mental health
Public mental health is a term that has been coined to underline the need to emphasise the neglected element of mental health in public health practice. It spans promotion, prevention, effective treatment, care and recovery. It is built on the same principles as all areas of public health.

Mental health
The term mental health describes a spectrum from mental health problems, conditions, illnesses and disorders through to mental wellbeing or positive mental health.

This emphasises positive health rather than illness, and is informed by the widely recognised WHO definition of mental health, ‘... a state of wellbeing in which the individual realises his or her 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’.

Wellbeing
We use the term wellbeing as synonymous with the 1946 WHO definition of health – a state of mental, physical and social wellbeing. This is a holistic state to which all aspects of the human being contribute. The term wellbeing is often used as synonymous with mental wellbeing partly, perhaps, to counterbalance prevailing trends to focus on physical wellbeing. Mental and social wellbeing are inextricably linked in both cause and effect ways. Indeed the definition of mental wellbeing includes the capacity for healthy relationships.

Mental wellbeing
The term mental wellbeing is used in this report to cover the positive end of mental health covering both the hedonic (feeling good) and eudemonic components (functioning well). Feeling good is subjective and embraces happiness, life satisfaction and other positive affective states. Functioning well embraces the components of psychological wellbeing (self-acceptance, personal growth, positive relations with others, autonomy, purpose in life and environmental mastery).

Resilience
The term resilience is used to mean ‘being able to cope with the normal stress of life’ and ‘bounce back from problems’. This is an important component of many definitions of mental wellbeing, with great relevance for the prevention of mental health problems.

Mental health problems
We use the term mental health problems synonymously with poor mental health or to cover the range of negative mental health states including, mental disorder – those mental health problems meeting the criteria for psychiatric diagnosis, and mental health problems that fall short of diagnostic criteria threshold. Mental health problems can be further categorised into the common mental problems such as anxiety and depression which may be transient (relapsing, remitting and recovered); and severe mental health problems such as schizophrenia and bipolar disorder; and the various behavioural disorders.

**Person with lived experience/experts by experience**

There has been a move within the field of mental health, largely led by people with lived experience, to avoid the term ‘patient’ and use instead alternatives including ‘survivor, ‘service user’ and person with lived experience/experts by experience. This language draws on the social model of disability, which moves away from defining people by a clinical diagnosis or service use to focus on people’s individual and collective everyday realities. Seventy five per cent of people with a mental health problem of a severity to warrant diagnosis, do not receive secondary mental health services, and thus may never regard themselves as a ‘patient’ or ‘service user’.

2. The determinants of mental health and wellbeing

This section will provide a brief overview of the determinants of mental health and wellbeing and, where possible, descriptions of how these determinants affect the people of Sandwell. Within the narrative, there are references that provide more detailed information and discussion. Unless otherwise indicated, the data used is from the Public Health Outcomes Framework website.

The social, economic and physical environments in which people live have a strong influence on their mental health and wellbeing; these are the social determinants of health. The World Health Organisation report “Social Determinants of Mental Health” provides a detailed examination of this topic.

The independent Foresight Mental Capital and Wellbeing Project Final Report states that;

> An individual’s mental capital and mental wellbeing crucially affect their path through life. Moreover, they are vitally important for the healthy functioning of families, communities and society. Together, they fundamentally affect behaviour, social cohesion, social inclusion, and our prosperity.

At all stages of life, the risk factors for common mental health disorders are strongly associated with poverty and disadvantage. The relationship with wellbeing is less clear, wellbeing is more strongly associated with education and the quality of social relationships.

The British Social Attitudes Survey 2016 explores people’s attitudes towards mental health and wellbeing. People said that spending time with family, work-life balance, having enough sleep and finances were the most important influences on their mental wellbeing.
These findings from the survey align with the New Economics Foundation five ways to wellbeing.  

**Individual Factors**

Gender is a factor in the risk of common mental disorders such as depression, with women having a higher prevalence, incidence and morbidity associated with depressive disorders compared with men. It is thought that these differences are due to a combination of biological, psychological and sociocultural vulnerabilities. The population of Sandwell over the age of 25 has a higher proportion of females than males, in line with the national population.

**Figure 1: Sandwell population estimates by sex (25+)**

![Sandwell Population Estimates by Sex (25+)](chart.png)

The risk of depression is disproportionately higher in people from the African-Caribbean, Asian, refugee and asylum seeker communities. The Ethnic profile in Sandwell differs to the national average, with a higher proportion of ethnic minorities:
As illustrated above, Sandwell has a higher proportion of people aged 25 and above from the Black and Minority Ethnic (BME) community (25.5%) compared to both the West Midlands (13.5%) and England (11.8%)\(^\text{10}\).

- The 2011 census showed that in the Sandwell 25+ age group there were:
  - 34,841 people of ‘Asian/Asian British’ ethnicity
  - 11459 people of ‘Black/African/Caribbean/Black British’ ethnicity
  - 2966 people of ‘Mixed/multiple ethnic group’ ethnicity
  - 2935 people of ‘Other ethnic group’ ethnicity

**Education, Learning and Development**

A higher level of educational attainment is a protective factor for mental health\(^\text{5}\). Inversely, low educational attainment is linked to a higher risk of common mental health conditions (anxiety and depression)\(^\text{12}\). Access to educational opportunities is important in promoting mental health, resilience and wellbeing, and lifelong learning reduces the risk of mental illness\(^\text{6,13}\). Learning is thought to improve overall wellbeing and recovery from mental health problems by improving self-esteem, self-efficacy, sense of purpose and social integration\(^\text{8}\).

- Sandwell has a relatively poor level of educational attainment, with only 48.9% of pupils achieving 5 or more A*-C GCSEs (compared to England average of 57.3% and West Midlands average of 55.0%).
- 22.2% of Sandwell residents have no qualifications (compared to England average of 8.6% and the West Midlands average of 13.0%)\(^\text{10}\).
Childhood
While children and adolescents are outside the scope of this document, childhood mental health and wellbeing is important to consider in relation to adulthood. The Children and Young People’s Emotional Health and Wellbeing in Sandwell (2016) JSNA report provides more detail on this area.

The evidence is clear that the social determinants of health such as housing, education, employment and environment, are major influences on children and young people’s emotional health and wellbeing. Poor mental health and wellbeing in childhood is negatively associated with many adult health outcomes, including poor adult mental health, higher rates of alcohol and substance misuse and an increased risk of suicide.

- 27.6% of Children (under 16) in Sandwell live in low-income households compared to 18.6% nationally and 21.5% regionally.
- Single parent households make up 9.0% of Sandwell households, compared to 7.1% nationally and 7.5% regionally.

Being in care when young is also a determinant of adult mental health, such as levels of antisocial behaviour, emotional instability and psychosis.

- 69.5 out of every 10,000 children in Sandwell are in local authority care, lower than the national average of 60.0/10,000, and lower than the West Midlands average of 74.5/10,000.

Teenage pregnancy is a risk factor for poor mental health outcomes. Teenage mothers are less likely to finish their education, are more likely to bring up their child alone and in poverty and have a higher risk of poor mental health than older mothers.

- In children aged 13-15, the annual rate of conception is 8.2 per 1000 females, higher than the national rate of 4.4 and the regional rate of 5.2.
- In children aged 15-17, the annual rate of conception is 38.3 per 1000 females, higher than the national rate of 22.8 and the regional rate of 26.5.

Parental mental illness is a risk factor for childhood mental illness, with children of mothers with mental ill health being five times more likely to have a mental disorder.

- There are 108.3 parents attending treatment for substance misuse for every 100,000 children in Sandwell. This is on par with the national rate of 110.4.
- There are 63.2 parents attending treatment for alcohol misuse for every 100,000 children in Sandwell. This is significantly lower than the national rate of 147.2.
**Relationships**
Having an intimate, trustworthy partner is a protective factor for mental health. Being married appears to be beneficial to mental wellbeing. Married individuals have a greater reported satisfaction with life compared to those who are unmarried. High marital relationship quality is associated with higher wellbeing and lower risk of depression\(^\text{16}\).

- 11.2% of people in Sandwell report their marital status to be separated or divorced. This is slightly lower than the national average of 11.6 and comparable to the regional average of 11.3%.

**Lifestyle**
Several epidemiological studies have shown that physical activity can delay or even prevent the onset of different mental disorders. Exercise also has therapeutic benefits when used as sole or adjunct treatment in mental disorders\(^\text{17}\). People with psychiatric disorders who exercised regularly reported higher health-related quality of life in a cross-sectional study\(^\text{18}\).

- Regular exercise and physical activity are associated with improved mental health and wellbeing. Sandwell’s is a relatively inactive population, with only 47.1% engaging in recommended levels of physical activity (compared to 55.5% in the West Midlands, 57.0% in England).
- It is estimated that only 12.4% of the population use outdoor space for exercise (compared to 17.9% of England, 16.9% of the West Midlands).

Smoking is associated with psychiatric disorders but the causal pathways are unclear. There is some evidence that those who smoke are more likely to develop a mental disorder but further studies are needed to validate this and investigate why\(^\text{19}\). People with a mental health problem smoke approximately 42% of all cigarettes smoked in England\(^\text{20}\). Those with severe mental health problems have an average life expectancy of between 10 and 25 years lower than the national average, and it is suspected that smoking is responsible for a large proportion of this excess mortality\(^\text{21,22}\). Other risk factors include physical inactivity and obesity\(^\text{21}\).

- 20.6% of people over the age of 18 are current smokers; higher than the national and regional averages of 18.0% and 16.9% respectively.
- 27.2% of adults in Sandwell are obese – compared to 24.0% nationally and 26.1% regionally.

People with disorders of substance use have higher rates of co-morbid mental disorders than vice versa. The causal pathways differ between both substances and disorders. There is strong evidence in particular that alcohol misuse increases the risk of depression\(^\text{23}\).

- The percentage of Sandwell residents who drink alcohol at ‘increasing risk’ or ‘higher risk’ levels are estimated to be relatively low at 18.5% (compared to 22.3% nationally and 21.4% regionally). This may be due to differences in ethnic groups.
The estimated prevalence of opiate and/or crack cocaine use is 10.7/1000 of the population aged 15-64 (higher than the national average of 8.4/1000 and the regional average of 9.5/1000).

Health
Mental health and physical health are interlinked, mutually affecting each other. Chronic physical health problems are associated with increased risk of mental health disorders. Depression is 2-3 times more common in people with long-term health conditions. Equally, poor mental health leads to poor physical health. A person suffering from a mental illness is almost twice as likely to die from coronary heart disease and four times more likely to die from respiratory disease. An estimated 12-18% of NHS expenditure on the management of long-term conditions is associated with poor mental health and wellbeing.

- 20.9% of people in Sandwell have a long-term health problem or disability that limits their daily activities. This is higher than the national average of 17.6% and the West Midlands average of 19%.
- 6.47% of households with dependent children have at least one person with a long-term health problem or disability, higher than the national and regional averages of 4.62% and 5.14% respectively.
- The health-related quality of life for older people (measured in those over 65 years of age using the EQ-5D scale) is 0.652 in Sandwell (compared to 0.709 in the West Midlands and 0.726 in England).

Social and Economic Factors
Deprivation is associated with an increased risk of mental illness. Those in the lowest socio-economic classes have the highest prevalence of psychiatric disorders. Common mental disorders such as anxiety and depression are distributed along a gradient of economic disadvantage such that the poor and disadvantaged suffer disproportionately from common mental disorders. As an example, the incidence of mental health problems in children from the lowest income families is 12-15%, compared to 5% in children from families with the highest income. Poorer areas have higher rates of hospital admission for mental illness, and more outpatient mental health service use. Higher income inequality is linked to higher rates of mental illness, lower social capital, and increased hostility, violence and racism. While poor mental health and well-being can be an outcome of poverty, it can also be a determinant of it, further compounding the problem.

- There are high levels of deprivation in Sandwell. 55.7% of people living in Sandwell are currently living in the 20% most deprived areas in England. (England average 20.2%, the West Midlands average 29.3%).
- This fact is also reflected in Sandwell’s index of multiple deprivation score (IMD 2015) of 34.6 – significantly higher than the country’s average score of 21.8.
- 16.4% of the households experience ‘fuel poverty’ – more than the national average of 10.4% and the regional average of 13.9%.
• Average (median) gross weekly pay is lower in Sandwell at £453.00 compared to £492.50 in the West Midlands and £532.60 in England.\(^{10}\)
• The Average (median) gross annual pay is £23,241 in Sandwell, £25,650 in the West Midlands, £27,869 in England.\(^{10}\)
• The average gross disposable household income (GDHI) in Sandwell is £12,100, compared to £15,551 in the West Midlands and £17,842 in England.

**Employment**
Having a permanent job is a protective factor for mental health.\(^{31}\) Unemployment is associated with poor mental health, increasing both the risk of common mental disorders by a factor of 2.7 and of disabling mental disorders by a factor of 4.3.\(^{27}\)

• 67.0% of people of working age (16-64) are in employment (compared to the average of 73.9% in England 70.7% in the West Midlands)\(^{10}\).
• 8.2% are currently unemployed (compared to England average of 5.1% and the West Midlands average of 5.8%)\(^{10}\).
• 1.62% of people of working age living in Sandwell are in long-term unemployment (compared to England average of 0.61%, and the West Midlands average of 0.93%).
• 7% of families in Sandwell have no adults in employment; compared to 4.2% nationally and 4.8% regionally.
• 3.25% of the local population are providing substantial unpaid care (50+ hours/week) – compared to 2.37% nationally and 2.68% regionally.
• There is a job density in Sandwell of 0.70 (i.e. there are 7 jobs for every 10 people aged 16-24) – compared to 0.83 in England and 0.78 in the West Midlands.\(^{10}\)

**Social Cohesion and Capital**
Social networks and good social support promote wellbeing may be protective against mental health problems.\(^{12, 32}\) As stated previously, migrants, refugees and asylum-seekers have a disproportionately higher risk of depression.\(^{11}\)

• Sandwell scores favourably compared to the rest of the country when looking at social isolation. Surveys of users of social care services and of adult carers show that 51.5% and 45.7% respectively have as much social contact as they would like (compared to national averages of 44.8% (44.2% West Midlands) and 38.5% (38.4% West Midlands) respectively). These figures are of limited usefulness however, as they focus on social care users and carers rather than the broader population. The problems of loneliness and social isolation are obviously not limited to these groups.
• 4.26% of people in Sandwell state they cannot speak English or speak it well. This percentage is dramatically higher than the national average of 1.65% and the regional average of 1.99%.
• Migrant GP registration provides a proxy measure for the migrant population in a local authority. The Sandwell rate of migrant GP registration is 9.9 per 1000 residents – lower than the national average of 11.7 per 1000 residents.
• Population turnover is lower in Sandwell than the national average (85.3/1000 compared to England’s 90.7/1000), perhaps suggesting a higher degree of social cohesion.

Environmental Factors
Violence is negatively associated with mental health and wellbeing. Countries afflicted by violence and war have particularly high rates of mental health problems. Children exposed to physical and psychological abuse, and those growing up in families with domestic violence are more likely to have psychiatric disorders in adulthood.

• Levels of violent crime are relatively low in Sandwell; with 11.4 annual offenses per 1000 population (compared to England average of 13.5/1000, and the West Midlands average of 12.8/1000).
• The incidence of reported domestic abuse in Sandwell (22.4/1000 population) is higher than the national and regional averages (20.4/1000 & 20.3/1000 respectively).

Housing
Being homeless increases the risk of mental disorders. In particular, it multiplies the risk of developing probable psychosis by 11.3 and of neurotic disorder by 3.9. The risk of substance misuse is also associated with homelessness, increasing the risk of alcohol and drug dependence by a factor of 5.5 and 5.6 respectively.

• 4.5 per 1000 people in Sandwell are homeless (compared to England average of 2.4/1000 and the West Midlands average of 3.4/1000).
• 6.8% of Sandwell households are overcrowded (i.e. having an occupancy rating of -1 or lower); compared to 4.8 nationally and 4.6 regionally.
Figure 3: Risk and protective factors in Sandwell

<table>
<thead>
<tr>
<th>EDUCATION AND SKILLS</th>
<th>SANDWELL</th>
<th>STATISTICAL NEIGHBOUR AVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Five or more GCSEs A* to C including English and Maths</td>
<td>48.9%</td>
<td>50.2%</td>
</tr>
<tr>
<td>UK residents aged 16 to 64 with no qualifications</td>
<td>22.2%</td>
<td>13.49%</td>
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<thead>
<tr>
<th>ECONOMY</th>
<th>SANDWELL</th>
<th>STATISTICAL NEIGHBOUR AVERAGE</th>
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<tbody>
<tr>
<td>Real net national disposable income per head</td>
<td>£12,505</td>
<td>£13,346</td>
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<tr>
<th>PERSONAL FINANCE</th>
<th>SANDWELL</th>
<th>STATISTICAL NEIGHBOUR AVERAGE</th>
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<tbody>
<tr>
<td>Median annual income</td>
<td>£23,241</td>
<td>£23,999</td>
</tr>
<tr>
<td>Households experiencing fuel poverty</td>
<td>16.4%</td>
<td>12.9%</td>
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<thead>
<tr>
<th>WHERE WE LIVE</th>
<th>SANDWELL</th>
<th>STATISTICAL NEIGHBOUR AVERAGE</th>
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<tbody>
<tr>
<td>Violent crime (including sexual violence) offenses per 1,000 population</td>
<td>11.4</td>
<td>12.8</td>
</tr>
<tr>
<td>Households with good transport access to key services or work (Indexed against England average of ‘100’)</td>
<td>125</td>
<td>109</td>
</tr>
<tr>
<td>Statutory homelessness (per 1,000 households)</td>
<td>4.5</td>
<td>2.5</td>
</tr>
<tr>
<td>Overcrowded households</td>
<td>6.8%</td>
<td>5.2%</td>
</tr>
<tr>
<td>People using outdoor space for exercise</td>
<td>12.4%</td>
<td>15.2%</td>
</tr>
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<thead>
<tr>
<th>NATURAL ENVIRONMENT</th>
<th>SANDWELL</th>
<th>STATISTICAL NEIGHBOUR AVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total greenhouse gas emissions (millions of tonnes)</td>
<td>5.9</td>
<td>5.7</td>
</tr>
<tr>
<td>Green belt areas (hectares per 1,000 people)</td>
<td>2.57</td>
<td>16.5</td>
</tr>
<tr>
<td>All-cause adult mortality attributable to particulate air pollution</td>
<td>6.1%</td>
<td>5.3%</td>
</tr>
<tr>
<td>Household waste that is recycled (including composted and reused)</td>
<td>42.7%</td>
<td>44.9% (UK)</td>
</tr>
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<thead>
<tr>
<th>GOVERNANCE</th>
<th>SANDWELL</th>
<th>STATISTICAL NEIGHBOUR AVERAGE</th>
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<tbody>
<tr>
<td>Voter turnout in UK General Elections</td>
<td>59.53%</td>
<td>59.57%</td>
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<thead>
<tr>
<th>HEALTH</th>
<th>SANDWELL</th>
<th>STATISTICAL NEIGHBOUR AVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy life expectancy at birth (years — male/female)</td>
<td>58.7/58.4</td>
<td>59.2/58.3</td>
</tr>
<tr>
<td>Reported a long term illness and disability</td>
<td>20.91%</td>
<td>20.16%</td>
</tr>
<tr>
<td>Adults who are obese</td>
<td>27.2%</td>
<td>26.7%</td>
</tr>
<tr>
<td>Health-related quality of life for older people (EQ-5D scale)</td>
<td>0.668</td>
<td>0.692</td>
</tr>
<tr>
<td>People feeling moderately or extremely depressed or anxious (CGI)</td>
<td>13.9%</td>
<td>13.4% (Average of 10 similar CCGs)</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>WHAT WE DO</th>
<th>SANDWELL</th>
<th>STATISTICAL NEIGHBOUR AVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unemployment rate</td>
<td>7.75%</td>
<td>7.98%</td>
</tr>
<tr>
<td>Adult participation in 30 mins of moderate intensity sport, once per week</td>
<td>31.1%</td>
<td>34.6%</td>
</tr>
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<table>
<thead>
<tr>
<th>PERSONAL WELL-BEING [2014/15—ONS]</th>
<th>SANDWELL</th>
<th>STATISTICAL NEIGHBOUR AVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very high rating of satisfaction with their lives overall</td>
<td>22.96%</td>
<td>25.90%</td>
</tr>
<tr>
<td>Very high rating of how worthwhile the things they do are</td>
<td>29.37%,</td>
<td>31.76%</td>
</tr>
<tr>
<td>Rated their happiness yesterday as very high</td>
<td>33.49%</td>
<td>31.80%</td>
</tr>
<tr>
<td>Rated their anxiety yesterday as very low</td>
<td>40.71%</td>
<td>42.45%</td>
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<thead>
<tr>
<th>OUR RELATIONSHIPS</th>
<th>SANDWELL</th>
<th>STATISTICAL NEIGHBOUR AVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult social care users who have as much social contact as they would like</td>
<td>51.5%</td>
<td>44.0%</td>
</tr>
<tr>
<td>Adult carers who have as much social contact as they would like</td>
<td>45.7%</td>
<td>39.1%</td>
</tr>
<tr>
<td>People who are separated or divorced</td>
<td>11.2%</td>
<td>12.0%</td>
</tr>
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3. Wellbeing, mental health and mental illness in Sandwell

The Health Survey for England monitors trends in the nation’s health to estimate the proportion of people in England who have specified health conditions. The most recent survey, published in December 2016, reports the results from a survey undertaken in 2014. This includes a chapter on prevalence of mental illness in the population, including lifetime experience, recent treatment and experience and the relationships between mental illness and the other aspects of people’s lives. Some key findings from this survey were that, in England;

- 26% of all adults reported having ever been diagnosed with at least one mental illness. A further 18% of adults reported having experienced a mental illness but not having been diagnosed
- Women were more likely than men to report ever having been diagnosed with a mental illness (33% compared with 19%).
- The most frequently reported mental illness ever diagnosed was depression, including post-natal depression, with 19% of adults (13% of men, 24% of women) reporting this.
- The next most frequently reported conditions ever diagnosed were panic attacks, mentioned by 8% of adults, and generalised anxiety disorder, mentioned by 6%. Lifetime prevalence of each other condition was very low, at 3% or less.
- People may have more than one condition, and may have conditions and disorders in more than one type (for example, a common mental disorder and a serious mental illness). There is considerable overlap between types.

This section will describe the levels of wellbeing and mental health disorders in Sandwell. The data and intelligence presented come from a range of data sources. Some of these report data by local authority boundaries. Other data sources report data for clinical commissioning group boundaries. For each data source the population referred to will be stated.

This variation in reporting geographies does make it difficult to draw definitive conclusions about the level of need and of services provision at a Sandwell MBC level. Where possible data will be compared between data sources to provide the most accurate possible picture of the level of need in Sandwell.

Wellbeing in Sandwell

The Office of National Statistics (ONS) publishes estimates of well-being for UK local authorities. These are based four personal wellbeing questions. The questions are based on ten aspects of life that people said mattered to their wellbeing. These include; personal wellbeing, relationships, health, economy and environment. The questions are;

- Overall, how satisfied are you with your life nowadays?
- Overall, to what extent do you feel the things you do in your life are worthwhile?
- Overall, how happy did you feel yesterday?
- Overall, how anxious did you feel yesterday?
People are asked to respond on a scale of 0 to 10, where 0 is “not at all” and 10 is “completely”. Figure 4 shows a comparison between Sandwell, the West Midlands and the England average. This chart shows the percentage of the population who scored low (0-4) for satisfaction, worthwhile and happiness and high (6-10) for anxiety. The differences in low satisfaction and low happiness scores between Sandwell and England are statistically significant. The difference in the number of people reporting a low score for worthwhile and people reporting a high level of anxiety are not statistically significant when compared to the England average.

**Figure 4: Wellbeing in Sandwell, responses to the ONS 4 wellbeing questions**

![Wellbeing Chart](chart.png)

Source: Public Health Profiles

In 2014, the Public Health Department undertook a population wellbeing survey in Sandwell. This was a postal survey based on the Short Warwick and Edinburgh Mental Wellbeing Scale (WMWBS). This seven-item questionnaire covers subjective wellbeing and psychological functioning.

The profile of the respondents to the survey was biased towards the groups listed below. The findings therefore include consideration of this bias:

- The older population aged 65+ (43%)
- Those who are retired from work (44%)
- Those who suffer from a limiting long term illness (42%)

The survey identified that the average wellbeing score for Sandwell as measured by SWEMWBS was 24.37 which was slightly lower than the national average of 25.3 (Health Survey for England 2010, Understanding Society, the UK’s Household longitudinal study 2011).
More detailed analysis of the SWEMWBS scores has shown that the main factor is likely to be the presence of a long-term illness that significantly limits the individual’s activities. Similarly, those who subjectively assessed their health as bad or very bad had significantly lower wellbeing (20) than those who rated it both fair (22.5) and good or very good (26.5).

A limiting long-term illness and subjective assessment of one’s health as bad correlated to the lowest SWEMWBS scores more than all other demographic factors. This finding is supported by the qualitative analysis of the responses to the questions ‘what has the biggest positive and biggest negative effect on your wellbeing’. The responses to this question indicated that participation in hobbies and activities was one of the positive contributing factors and ill health was one of the strong negative contributing factors.

Other factors that showed a significant correlation with SWEMWBS wellbeing scores were:
- Older age, where those aged 65-74 had a significantly higher level of wellbeing compared to all other age groups. This finding concurs with previous studies on wellbeing that indicate that wellbeing follows a U shaped pattern across the life course\(^3\).
- Being a carer was positively correlated with higher levels of wellbeing.
- Being single or living alone was negatively correlated with wellbeing, which became evident in the qualitative responses where many respondents talked about loneliness having a negative impact on their wellbeing.
- In terms of ethnicity, black respondents reported significantly higher wellbeing than all other ethnic groupings.
- Non-smokers had higher wellbeing than people who smoke.
- Individuals who practice or participate actively in their faith (whether religious or spiritual) have significantly higher wellbeing than those who are non-practicing.
- Individuals with higher levels of social trust had significantly higher wellbeing than individuals with low levels of social trust.

**Common mental health conditions:**
Estimates of prevalence for common mental health disorders vary considerably. NICE guidance provides estimates for prevalence based on the Office of National Statistics 2007 national survey\(^7\).
- Generalised anxiety disorder – 4.4%
- PTSD – 3.0%
- Depression – 2.3%
- Phobias – 1.4%
- Obsessive-compulsive disorder – 1.1%
- Panic disorder – 1.1%

Estimates of proportion of people who are likely to experience specific disorders during their lifetime are:
- Major depression – 4%-10%
- Generalised anxiety disorder – 5.7%
- Panic disorder – 1.4%
- Specific phobias – 12.5%
- Social anxiety disorder – 1.6%
- Obsessive compulsive disorder – 1.6%
- Post-traumatic stress disorder – 6.8%

There are limitations to the data available to describe the levels of common mental health disorders in Sandwell. Much of the data comes from GP practice data, for which there are difficulties with recording and variations between practices in data completion and quality. This approach will not identify people not in contact with primary care. Other data comes from hospital admissions, and there are variations in the recording of admissions and hospital contacts between areas and providers.

Where data is limited or contradictory, it is important to examine different sources of intelligence to support triangulation of intelligence. This can provide the most complete picture possible given the available data. The following section will examine a number of different data sources.

Public Health England publishes annual local area profiles that summarise the data and intelligence about common mental health disorders based on clinical commissioning group boundaries. Table 1 provides a summary of these indicators based on the geographical footprint of Sandwell and West Birmingham clinical commissioning group (SWCCG).

Table 1: Common mental health conditions: summary indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Time period</th>
<th>SWBCCG</th>
<th>England</th>
<th>Statistical significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>People estimated to have any common mental health disorder. Estimated % of population aged 16-74</td>
<td>2014/15</td>
<td>16.10</td>
<td>10.29</td>
<td>Not measured</td>
</tr>
<tr>
<td>Recorded prevalence of depression aged 18+</td>
<td>2014/15</td>
<td>6.16</td>
<td>7.33</td>
<td>Sandwell lower</td>
</tr>
<tr>
<td>New cases of depression: Adults with a new diagnosis of depression as a % of all patients on the GP register</td>
<td>2014/15</td>
<td>0.98</td>
<td>1.20</td>
<td>No difference</td>
</tr>
<tr>
<td>Depression and anxiety among GP survey respondents: % of people completing GP patient survey reporting they feel moderately or extremely anxious or depressed</td>
<td>2013/14</td>
<td>14.1</td>
<td>7.2</td>
<td>Sandwell higher</td>
</tr>
<tr>
<td>Secondary care contacts for common mental health disorders: Rate per 100,000 population aged 18+</td>
<td>2014/15</td>
<td>803</td>
<td>532</td>
<td>Sandwell higher</td>
</tr>
<tr>
<td>Use of mental health services by BME groups Percentage of mental health service users</td>
<td>2012/13</td>
<td>36.78</td>
<td>11.19</td>
<td>Sandwell higher</td>
</tr>
</tbody>
</table>

Source: Public Health Outcomes Framework
The last of these indicators, use of services by people from BME groups, identifies that the proportion of BME groups in the Sandwell population is 30.06%, the data shows that they make up 36.78% of people using services. However, there are uncertainties and possible inconsistencies in how ethnicity is recorded. At this time, it is not possible to determine whether this difference between population and service use is statistically significant.

Sandwell and West Birmingham Clinical Commissioning Group commission the Black Country Partnership Foundation Trust (BCPFT) to provide mental health services for the population of Sandwell. Data from BCPFT on referrals into their services is shown below in figures 5 and 6. Figure 5 shows the proportion of referrals by ethnicity for each of the previous five years. This shows a possible increase in referrals from black and Asian groups, although it is not possible to identify whether this trend is significant.

**Figure 5: Referrals by ethnicity 2011/12 to 2015/16**

![Referrals by ethnicity 2011/12 to 2015/16](chart)

Figure 6 shows the proportion of referrals from each ethnic group compared to the proportion of that group within the population. This shows a possible under representation of Asian groups in referrals into services compared to the proportion of Asian groups in the population.

Recent studies have shown that, in general, people from Black backgrounds are over-represented in mental health services, especially in acute services and in people subject to detention under the Mental Health Act\(^39\). From the data from BCPFT, this over representation is not apparent in referrals into services in Sandwell. Further data collection and analysis will be required to understand the ethnicity of people in acute mental health services or in detention under the Mental Health Act in Sandwell.
Much of the data on common mental health disorders comes from general practice registers. This introduces possible bias into the data. Not all people register with GPs, and people who are particularly vulnerable may be less likely to register with a GP. For example, people who are homeless, people misusing alcohol or drugs and new arrivals.

There are also concerns regarding the variation in the quality and completeness of data recording between primary care practices. There are inconsistencies between the data sources. For example, the levels of common mental health problems identified through GP practice surveys are higher than the levels of these problems registered on practice registers.

Other intelligence comes from hospital contacts for people with mental health disorders. Although the rates of diagnosis for common mental health disorders on GP registers are lower than England, the number of secondary care contacts for common mental health disorders are higher than England.

### Table 2: Hospital contacts for common mental health disorders

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Time period</th>
<th>SWBCCG</th>
<th>England</th>
<th>Statistical significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency admissions for depression per 100,000 population</td>
<td>2014/15</td>
<td>36</td>
<td>32.1</td>
<td>Similar</td>
</tr>
<tr>
<td>Emergency admissions for neuroses per 100,000 population</td>
<td>2014/15</td>
<td>27.1</td>
<td>21.7</td>
<td>Similar</td>
</tr>
<tr>
<td>A&amp;E attendances for a psychiatric disorder</td>
<td>2014/15</td>
<td>54.4</td>
<td>243.5</td>
<td>Sandwell lower</td>
</tr>
<tr>
<td>People coming into contact with CCG mental health services per 100,000 population</td>
<td>2013</td>
<td>2732</td>
<td>2160</td>
<td>Sandwell higher</td>
</tr>
</tbody>
</table>
Prescribing levels for medications used for common mental health disorders also provide information on the level of identified need in Sandwell. This will only identify people who have been diagnosed with a mental health disorder, so will be subject to the same limitations as other GP practice based data.

To compare one GP practice or clinical commissioning group to another, the size of the practice or CCG has to be taken into account. Practices with more patients on their lists will need to prescribe more. Prescribing rate can be expressed as the number of prescriptions per patient (or per number of patients) on the practice list. However, comparative data can be analysed using a variety of patient denominators such as STAR-PU; ‘specific therapeutic group age-sex related prescribing units’ that allow for benchmarking of spend between areas. Table 3 shows the prescribing levels for common mental health disorders in Sandwell compared to the England average.

### Table 3: Prescribing levels of medications for common mental health disorders

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Time period</th>
<th>SWBCCG</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care prescribing spend on mental health (£) per person</td>
<td>2013/14</td>
<td>11.47</td>
<td>12.31</td>
</tr>
<tr>
<td>Antidepressant prescribing: average daily qualities (ADQs) per STAR-PU</td>
<td>2015/16</td>
<td>1.09</td>
<td>1.36</td>
</tr>
<tr>
<td>Hypnotics prescribing: average daily qualities (ADQs) per STAR-PU</td>
<td>2015/16</td>
<td>0.90</td>
<td>0.99</td>
</tr>
</tbody>
</table>

Source: Public Health Outcomes Framework

These show that the levels of prescribing of antidepressants and hypnotics are lower in Sandwell than the England average. The statistical significance of these differences between Sandwell and England is not benchmarked within the data source.

These data as presented provide an indication of the prevalence of common mental health disorders within the population. However, due to the limitations of the data, as discussed, they cannot provide a complete and definitive picture of the level of need in Sandwell.

### Referrals into services

Referrals into mental health services provide information on the numbers of people accessing mental health services in Sandwell. The data presented in this section does not identify the reasons for referral or separate common mental health disorders from severe and enduring mental illness, but it does provide information to support triangulation across data sources.
Sandwell and West Birmingham Clinical Commissioning Group commission the Black Country Foundation Partnership Trust (BCPFT) to provide mental health services for the population of Sandwell.

Figure 7 shows the pattern of referrals by age of the person referred. This shows an increase in the number of referrals at age 9, reflecting the age criteria for the services provided. The number of referrals then decreases between 40 and 60. After this, the number of referrals increases to a peak at around age 80 years. It is likely that this is due to increased referrals for age related mental illness including dementia.

**Figure 7: Referrals by age: Total referrals 2011 to 2016**

Figure 8 shows the pattern of referrals by gender over the past five years. Over 2011 to 2013 the data show a higher rate of referrals for females, whereas in 2015/16 there is a possible higher rate of referral for males. At this point the data does not allow for a clear conclusion about whether these are significant differences or normal variation.
Figure 8: Referrals by gender 2011/12 to 2015/16

Figure 9 shows the routes of referrals into mental health services. This is relevant to this needs assessment because of the focus on access into services. However, with the substantially increased proportion from the non-defined ‘other’ category it is not possible to be clear on whether the pattern of referrals has changed over this period.

Figure 9: Referrals by source of referral
Suicide and self-harm

Data on self-harm is available from the public health outcomes framework. The data available are hospital stays due to self-harm in Sandwell (figure 10). The difference in the rates between England and Sandwell are statistically significant, with Sandwell having consistently higher rates of hospital admission due to self-harm.

**Figure 10: hospital stays for self-harm, Sandwell and England: 2012/13 to 2014/15**

![Graph showing hospital stays for self-harm in Sandwell, West Midlands, and England from 2012/13 to 2014/15.](image)

The Office of National Statistics collates data on suicide at a local authority level. This includes both deaths due to suicide and those due to injury of undetermined intent. Figure 11 shows the level of suicide in Sandwell compared to the West Midlands region and England. The trend is for the suicide rate in Sandwell to be slightly lower than that for West Midlands and for England, though this difference is not statistically significant.

The Parliamentary Health Select Committee has recently published a report from a review of suicide and suicide prevention in England. This has found that there is significant variation in the recording of suicide between areas, largely due to the differences in how coroners record deaths. This means that the variation in suicide rates between areas may not reflect the actual number of suicides. The report has recommended that coroners are supported to improve consistency in how suicide is recorded.
Severe and enduring mental illness

Table 4 shows summary indicators from the public health outcomes framework for severe and enduring mental illness in Sandwell and West Birmingham CCG, compared to England.

Table 4: Severe and enduring mental illness: summary indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Time Period</th>
<th>SWBCCG</th>
<th>England</th>
<th>Statistical significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated prevalence of psychotic disorder – percentage of population aged 16+</td>
<td>2012</td>
<td>0.51</td>
<td>0.40</td>
<td>Not measured</td>
</tr>
<tr>
<td>QOF prevalence of severe mental illness: percentage of people on GP register</td>
<td>2014/15</td>
<td>1.05</td>
<td>0.88</td>
<td>Sandwell higher</td>
</tr>
<tr>
<td>Detentions under the Mental Health Act, annual rate per 100,000 population</td>
<td>2012/13</td>
<td>78.20</td>
<td>58.60</td>
<td>Sandwell higher</td>
</tr>
<tr>
<td>GP prescribing of drugs for psychoses and related disorders: items (quarterly) per 1000 population</td>
<td>2015/16</td>
<td>45.04</td>
<td>46.87</td>
<td>Sandwell lower</td>
</tr>
<tr>
<td>Schizophrenia emergency admissions: rate per 100,000 population aged 18+</td>
<td>2009/10 – 11/12</td>
<td>58.00</td>
<td>57.0</td>
<td>Similar</td>
</tr>
</tbody>
</table>

Source: public health outcomes framework
This data indicates that Sandwell may have a higher rate of severe mental illness, including psychotic illness, than the England average.

Recent studies have shown that some ethnic groups, specifically Black, are often over-represented in severe mental illness services and in detentions under the Mental Health Act. More work will be needed to understand the ethnicity of people in these services to determine whether this is the case in Sandwell.

**Perinatal Mental Health**

It is estimated that between 10% and 20% of women are affected by mental health problems at some point during pregnancy or in the first year after childbirth.\(^{41}\)

Perinatal mental health is a priority in Sandwell, particularly in relation to children’s and young people’s mental health and wellbeing. It is a priority within the Sandwell Child and Adolescent Mental Health Services (CAMHS) Transformation Plan.\(^{42}\)

The National Child and Maternal Health Intelligence Network provides estimates of the prevalence of perinatal mental health disorders in Sandwell. These estimates are calculated by applying the national prevalence to the population of Sandwell. Due to the limitations associated with the estimates it is not possible to benchmark against other areas.\(^{43}\) This data is summarised in table 5.

**Table 5: Estimates of women with mental health problems during pregnancy and after childbirth**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Time period</th>
<th>Sandwell (number)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated number of women with postpartum psychosis</td>
<td>2013/14</td>
<td>10</td>
</tr>
<tr>
<td>Estimated number of women with chronic serious mental illness</td>
<td>2013/14</td>
<td>10</td>
</tr>
<tr>
<td>Estimated number of women with severe depressive illness</td>
<td>2013/14</td>
<td>135</td>
</tr>
<tr>
<td>Estimated number of women with mild-moderate depressive illness and anxiety (lower estimate)</td>
<td>2013/14</td>
<td>450</td>
</tr>
<tr>
<td>Estimated number of women with mild-moderate depressive illness and anxiety (upper estimate)</td>
<td>2013/14</td>
<td>675</td>
</tr>
<tr>
<td>Estimated number of women with post-traumatic stress disorder</td>
<td>2013/14</td>
<td>135</td>
</tr>
<tr>
<td>Estimated number of women with adjustment disorders and distress (lower estimate)</td>
<td>2013/14</td>
<td>675</td>
</tr>
<tr>
<td>Estimated number of women with adjustment disorders and distress (upper estimate)</td>
<td>2013/14</td>
<td>1,345</td>
</tr>
</tbody>
</table>

**Co-existing mental illness and substance misuse**

Dual diagnosis refers to people with a severe mental illness (including schizophrenia, schizotypal and delusional disorders, bipolar affective disorder and severe depressive episodes with or without psychotic episodes) combined with misuse of substances (the use
of legal or illicit drugs, including alcohol and medicine, in a way that causes mental or physical damage). Recent studies have estimated prevalence rates of 20-37% in secondary mental health services and 6-15% in substance misuse settings.  

Difficulties in accessing services for this group have been reported both nationally and locally. During the stakeholder consultation for this needs assessment there was anecdotal reporting of people with a substance misuse problem having difficulty accessing both mental health and wider physical health services.

People who misuse alcohol over a long period are at risk of alcohol related brain damage (ARBD). This can lead to difficulty with memory and possible confusion. This can make it more difficult for people with ARBD to access services and to maintain treatment. They are likely to need more intensive support to manage their alcohol intake.

Table 6 shows the summary indicators for co-existing mental illness and substance misuse in Sandwell compared to England.

**Table 6: Co-existing mental illness and substance misuse: summary indicators**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Time period</th>
<th>Sandwell</th>
<th>England</th>
<th>Statistical significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated prevalence of opiate and/or crack cocaine use per 1000 population aged 15-64</td>
<td>2011/12</td>
<td>10.73</td>
<td>8.40</td>
<td>Sandwell higher</td>
</tr>
<tr>
<td>Admission to hospital for mental and behavioural disorders due to alcohol per 100,000 population</td>
<td>2014/15</td>
<td>105.69</td>
<td>84.39</td>
<td>Sandwell higher</td>
</tr>
<tr>
<td>Concurrent contact with mental health services and substance misuse services for alcohol misuse (proportion of all individuals entering alcohol services)</td>
<td>2014/15</td>
<td>25.28</td>
<td>20.01</td>
<td>Similar</td>
</tr>
<tr>
<td>Concurrent contact with mental health services and substance misuse services for drug misuse (proportion of all individuals entering drug services)</td>
<td>2014/15</td>
<td>17.46</td>
<td>20.96</td>
<td>Similar</td>
</tr>
</tbody>
</table>

Source: Public Health Outcomes Framework

These indicators suggest that overall drug use is higher in Sandwell than in England, and admissions to hospital for alcohol related behavioural disorders are higher than the England average. Concurrent contact with mental health services and substance misuse services are similar to the England average.

Local service data provides more detail for Sandwell. Of 901 individuals commencing a new treatment journey in 2015/16, 149 (16.5%) were recorded as having a dual diagnosis need.
Analysis by substance type shows:

- Alcohol only: 15.5%
- Opiates: 14.9%
- Non-opiates: 21.5%
- Non-opiates and alcohol: 24.7%

Those individuals with a dual diagnosis need receive additional support from a community psychiatric nurse within the service but this does not negate the need for clients to be able to access mainstream mental health services.

**Health of people with mental illness**

People with severe mental illness have a 10 to 25 year shorter life expectancy than the general population. The majority of these deaths are due to long-term health conditions such as cardiovascular disease, respiratory and infectious diseases, diabetes and hypertension. The other major cause of death is suicide.\(^{46}\)

This higher prevalence of long-term conditions in this population is largely caused by unhealthy lifestyles such as smoking, physical inactivity and diet. People with severe mental illness are often at a socioeconomic disadvantage, are far less likely to be employed and to suffer substantial discrimination.

Table 7 summarises the main available indicators for the health of people with severe mental illness in Sandwell.

**Table 7: Health of people with severe mental illness in Sandwell: summary indicators**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Time period</th>
<th>Sandwell</th>
<th>England</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premature (&lt;75) mortality in adults with serious mental illness</td>
<td>2012/13</td>
<td>1361.60</td>
<td>1319</td>
<td>Similar</td>
</tr>
<tr>
<td>Excess under 75 mortality rate in adults with serious mental illness</td>
<td>2013/14</td>
<td>369.3</td>
<td>351.8</td>
<td>Not calculated</td>
</tr>
<tr>
<td>Smoking prevalence in adults with severe mental illness (%)</td>
<td>2014/15</td>
<td>41.3</td>
<td>40.5</td>
<td>Similar</td>
</tr>
<tr>
<td>Smoking prevalence in adults – current smokers</td>
<td>2015</td>
<td>17.7</td>
<td>16.9</td>
<td>Similar</td>
</tr>
</tbody>
</table>

Source: public health outcomes framework

These indicators show that people in Sandwell with serious mental illness, in common with the rest of England, have a higher rate of premature mortality than the general population. The indicators suggest that the level of premature mortality is not significantly different from the England average.

The smoking prevalence in adults with severe mental illness is substantially higher than the general population. This is in agreement with a number of studies that have shown that people with mental illness have higher rates of smoking.\(^{47,48}\)
Smoking is the single largest cause of the gap in life expectancy between people with mental illness and the general population. While smoking rates in the general population have steadily fallen over the past 20 years, in people with mental illness they have hardly changed. Smoking can be part of a coping mechanism for managing the mental illness, though the evidence suggests that smoking in itself can be harmful for mental health. Stopping smoking can have a substantial benefit in terms of improved mental health.

A recent study by the Action on Smoking and Health identified that people with mental illness want to stop smoking, but that they face more barriers to quitting. They may also be more dependent and need more intensive support to help them stop smoking.

Vulnerable groups

There are vulnerable groups within the population who are at a substantially higher risk of experiencing poor mental health but who are likely to find it more difficult to access support and services. Many of the people within these groups will be socially isolated and excluded. These groups include people who are homeless, new arrivals including asylum seekers, refugees and undocumented migrants. People who are carers, or have been carers but have suffered bereavement are also at a higher risk of poor mental health and mental illness.

The nature of these groups means that it can be difficult to gather accurate data on the number of people, where they are living and what health issues they experience. There are recent reports that provide information on the levels of mental illness experienced by these groups.

People who are homeless

Homeless Link undertook a health audit of homelessness in 2014. This audit was based on 2590 responses from people using services in 19 areas across England. The audit identified that 80% of homeless people reported some form of mental health issue, and 45% had been diagnosed with a mental health disorder.

In 2009 Crisis, the homelessness charity, published Mental Ill Health in the Adult Single Homeless Population: a review of the literature. This suggested that the prevalence of common mental health problems is more than twice that of the general population, and psychosis 4-15 times as high. People who are street homeless may be 50 – 100 times more likely to have a psychotic illness compared to the general population. Other key findings were;

- Homeless people, in particular those with mental ill health, have higher mortality rates than the general population. They are up to nearly 5 times more likely to die than the equivalent age group of the general population.
- Rates of reported personality disorder are also high. In a recent survey of homeless services in England, staff estimated two thirds of their clients presented with characteristics consistent with personality disorder, many of whom were thought to be undiagnosed.
- Among people who are in touch with psychiatric services there is a significant minority that is homeless. A recent European study found that just under a third of the British
sample of patients with schizophrenia had experienced homelessness in their lifetime, with over a tenth having experienced “rooflessness.”

- Women experience some risk factors (such as physical and sexual violence as a child) for both mental health and homelessness to a greater extent than men.
- The proportion of homeless people who are mentally ill from BME groups is disproportionate compared to their proportion in the general population.
- Overall research shows that as the stability of housing increases then rates of serious mental illness decrease.

**New arrivals, asylum seekers and refugees**

Whilst many asylum seekers do arrive in the UK in relatively good physical health, health problems can rapidly develop whilst they are in the UK. Reasons for this include:

- Difficulty in accessing healthcare services
- A lack of awareness of entitlement;
- Problems in registering and accessing primary and community healthcare services, particularly if their claim has been refused;
- Language barriers.

However, some asylum seekers can have increased health needs relative to other migrants. There are a number of reasons for this;

- A number have faced imprisonment, torture or rape prior to migration, and will bear the physical and psychological consequences of this
- Many may have come from areas where healthcare provision is already poor or has collapsed
- Some may have come from refugee camps where nutrition and sanitation has been poor so placing them at risk of malnourishment and communicable diseases
- The journey to the UK can have effects on individuals through the extremes of temperatures, length of the journey, overcrowded transport and stress of leaving their country of origin

Mental health needs of asylum seekers can be significantly worsened (and even start to develop in the UK) because of the loss of family and friends' support, social isolation, loss of status, culture shock, uncertainty, racism, hostility, housing difficulties, poverty and loss of choice and control. Some asylum seekers and refugees will have also experienced traumatic experiences, such as torture, loss of relatives and abuse, possibly during the journey to England.

Mental health problems can include depression and anxiety. Post-traumatic stress disorder due to traumatic experiences can also be present, though it is likely that this is under-diagnosed. Different cultural understandings of mental health can mean that mental distress may manifest as physical complaints, this can influence the diagnosis and treatment of mental illness in this population.
Carers
Carers have worse general physical and mental health than the general population. Their caring responsibilities can mean that they neglect their own health. People who are caring for someone else often become socially isolated. Carers UK undertook research that found that 80% of carers have felt lonely or socially isolated because of their caring responsibilities. They found that this could be due to a lack of understanding from friends, colleagues and families, inadequate care services and financial pressures\(^\text{53}\).

When the person someone is caring for dies, the carer can become increasingly socially isolated. This can have a detrimental impact on their health and mental health.

In Sandwell, in 2015, there was a consultation with carers to inform a refresh of the Sandwell Carers Strategy and to understand the needs of carers in Sandwell. The Sandwell Carers Alliance, made up of 15 organisations working with carers in Sandwell, carried out the survey. This survey highlighted that carers valued emotional support to deal with the isolation and loneliness associated with the caring role.

Modern Day Slavery
An emerging challenge is the impact of modern day slavery (MDS). Although this has probably existed for many decades, or longer, it is now gaining more recognition. The current scale and scope of MDS is becoming apparent through partnership approaches across the government, police, local authorities, the voluntary sector and businesses. The Modern Day Slavery Act (2015) established a ‘duty to notify’. This means that anyone who is a ‘first responder’, including council and NHS services, must notify the relevant body if they suspect modern day slavery.

The British Government estimated in 2013, that there are around 13,000 people in MDS in the UK today. PROTECT, a recent research project, showed that 1 in 8 NHS professionals reported having contact with a patient they suspected may have been trafficked\(^\text{54}\).

People subjected to MDS can be new arrivals, or can come from the resident population. MDS can include sexual exploitation and trafficking, forced labour, domestic servitude and forced into criminal activity. This is often associated with substance and alcohol misuse\(^\text{55}\).

People who are experiencing, or have experienced, modern day slavery are likely to have complex health needs, including mental health needs. Services will need to have the expertise, and capacity to support these people.
4. Policy and Guidance

National policy
All government and wider policy can potentially have a direct or indirect impact on mental health and wellbeing. The following summaries of policy and guidance are restricted to those that will directly influence the interventions to improve population mental wellbeing and the commissioning of services for people with mental health problems.

HM Government (2010)
This document describes the government’s vision for improving the mental health and wellbeing of the population as a whole.

- Use a life course approach to ensure a positive start in life and healthy adult and older years.
- Build strength, safety and resilience: address inequalities and ensure safety and security at individual, relationship, community and environmental levels.
- Develop sustainable, connected communities: create socially inclusive communities that promote social networks and environmental engagement.
- Integrate physical and mental health: develop a holistic view of well-being that encompasses both physical and mental health, reduce health-risk behaviour and promote physical activity.
- Promote purpose and participation to enhance positive well-being through a balance of physical and mental activity, relaxation, generating a positive outlook, creativity and purposeful community activity

No health without mental health: delivering better mental health outcomes for people of all ages.
Department of Health (2011)
This policy document outlines the governments overall approach to improving mental health outcomes. It describes the government’s key pledges. It also explains how public sector reform will transform public mental health and mental health services. It has six main objectives and, along with an implementation plan, describes the roles of health, social care, wider local government (including housing and education) and wider stakeholders in delivery of these objectives.

i. More people will have good mental health
ii. More people with mental health problems will recover
iii. More people with mental health problems will have good physical health
iv. More people will have a positive experience of care and support
v. Fewer people will experience stigma and discrimination

The report also includes a commitment to develop intelligence about mental health and wellbeing and the measurement of outcomes including the development of a national mental health dashboard.
Closing the Gap: priorities for essential change in mental health.
Department of Health (2014)

Closing the Gap sets out the challenge that, although progress is being made, much more needs to happen to achieve the objectives set in No Health Without Mental Health. It identifies twenty-five areas of mental health care and support where there need to be tangible changes within the next two years. These areas are grouped into four themes.

- Increasing access to mental health services
- Integrating physical and mental health care
- Starting early to promote mental wellbeing and prevent mental health problems
- Improving the quality of life of people with mental health problems

Commitments within the report include improving information and intelligence around mental health, involving people in their own care, improved management of mental health crisis and increased integrated working. The report also covers the role of wider stakeholders including criminal justice and schools and supporting people with mental health problems to gain and maintain employment.

Mental health crisis care concordat: improving outcomes for people experiencing mental health crisis
HM Government (2014)

The Mental Health Crisis Concordat is a national agreement between services and agencies involved in the care and support of people in crisis. It sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis. The concordat is arranged around;

- Access to support before crisis point
- Urgent and emergency access to crisis care
- The right quality of treatment and care when in crisis
- Recovery and staying well, and preventing future crisis

Local areas are required to develop a local crisis care concordat agreed by relevant local organisations. In Sandwell the concordat has been co-produced with the Sandwell Mental Health Parliament and is overseen by the health and wellbeing board.

Achieving better access to mental health services by 2020
Department of Health / NHS England (2014)
This report builds on *No Health Without Mental Health* and *Closing the Gap* to support parity of esteem for mental health. It identifies that when the report was published there were no waiting time standards for mental health services. The report introduced access standards and waiting times that will be introduced during 2015 to 2016.

- Treatment within 6 weeks for 75% of people referred to the Improving Access to Psychological Therapies programme, with 95% of people being treated within 18 weeks.
- Treatment within 2 weeks for more than 50% of people experiencing a first episode of psychosis.
- A £30 million targeted investment to help people in crisis to access effective support in more acute hospitals.


**Guidance to support the introduction of access and waiting time standards for mental health services in 2015/16**


This report provides detailed guidance on the introduction of access and waiting time standards for mental health services. The report describes the funding support available and the expectations of commissioners and providers in introducing and embedding the standards.

The document aims to:

1. Clarify the requirements of each of the new 15/16 mental health access and waiting time standards and associated expectations of CCG commissioners in line with the planning guidance.
2. Outline the intention to implement access and waiting time standards for eating disorders in community CAMHS from 2016.
3. Update commissioners, providers, commissioning support units, regional and sub-regional teams and wider system stakeholders regarding the national programme of support for implementation of the new access and waiting time standards.


This report is supported by a range of more detailed and technical guidance available from NHS England. [https://www.england.nhs.uk/mentalhealth/resources/access-waiting-time/](https://www.england.nhs.uk/mentalhealth/resources/access-waiting-time/)

**The five year forward view for mental health**

Independent Mental Health Taskforce report to NHS England (2016)

*Implementing the Five Year Forward View for Mental Health*

NHS England (2016)

The Five Year Forward View for Mental Health sets out the start of a ten-year transformation to the approach to preventing and treating mental health problems. It
makes recommendations about what the NHS needs to do to achieve parity of esteem between mental and physical health for the whole population.

- A 7 day NHS
- An integrated mental and physical mental health approach
- Promoting good mental health and preventing poor mental health

The report makes recommendations about the need for wider action in relation to housing, jobs and social networks. Mental health problems disproportionately affect people living in poverty, people who are unemployed and who already face discrimination. The report has a particular focus on tackling these inequalities.

The implementation report sets out the blueprint for delivery of the five year forward view. It describes five common principles for implementation.

- Co-production with people with lived experience of services, their carers and families
- Working in partnership with local public, private and voluntary sector organisations
- Identifying needs and intervening at the earliest appropriate opportunity
- Designing and delivering person-centred care, underpinned by evidence
- Outcome focused, intelligent and data driven commissioning


Mental health and prevention: taking local action for better mental health
Public Health England / Mental Health Foundation (2016)

Public Health England (PHE) commissioned the Mental Health Foundation to review the evidence for prevention in mental health. It explores the evidence across a number of domains, setting out the case for change, the evidence for intervention and recommendations for action. The report is cross-referenced with the Five Year Forward View for Mental Health. The high-level domains are;

- Whole population approaches
  - Mental health literacy
  - Mentally healthy communities and places
  - Reducing stigma and discrimination
  - Integrated approaches to health and social care

- Life course approach
  - Pregnancy and young people
  - Working age
  - Ageing well

Better Mental Health for all: a public health approach to mental health improvement
Faculty of Public Health (2016)

This report focuses on what can be done, individually and collectively, to enhance the mental health of individuals, families and communities by using a public health approach. Its objective is to act as a resource for public health practitioners to support the development of knowledge and skills in public mental health. The report explains why public mental health is essential to improving the health of the population. It outlines the risk and protective factors for positive mental health and addresses approaches and interventions to improve mental health across the life course and in different settings.

The report recognises the lack of robust evidence for what works in improving public mental health, partly due to the complex interactions of the determinants. It calls for an expanded approach to research and methodology to build the evidence base for public mental health. The report finishes with a practical guide to enable practitioners to support their own mental wellbeing.

http://www.fph.org.uk/better_mental_health_for_all

Local Policy

Sandwell Joint Health and Wellbeing Strategy
The Sandwell Health and Wellbeing Board agreed, following consultation with local people and stakeholders, five new priorities for the next five years. These have been included within a new Joint Health and Wellbeing Strategy (JHWS), which the health and wellbeing board endorsed in March 2016. The main priority for the board is to increase healthy life expectancy in Sandwell. This recognises that the main influences on healthy life expectancy are people’s lifestyle choices, and that these choices are heavily influenced, and constrained, by people’s emotional health and wellbeing and the social determinants of health.

The refreshed Joint Health and Wellbeing Strategy provides a clear partnership strategy describing how all partners will work together to improve the emotional health and wellbeing of people of all ages in Sandwell. It will provide a framework for improving wider health and wellbeing and reducing the gap in healthy life expectancy.

Crisis Care Concordat
The Mental Health Crisis Care Concordat is a national agreement between services and agencies involved in the care and support of people in crisis. It sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis.

Local areas are required to develop a local crisis care concordat. Sandwell and West Birmingham CCG are leading on the development of the Sandwell crisis care concordat on behalf of the health and wellbeing board. A partnership planning group is in place and the work is informed by a co-produced plan developed with the third sector through the Sandwell Mental Health Parliament.
Sandwell Mental Health Quality Standards
Sandwell Mental Health People’s Parliament is a strategic body led by people with lived experience of mental health difficulties. These people receive training to support them in acting as Members of the Parliament. Its function is to hold decision makers to account for improvements in services and supports so that people who experience mental health difficulties can have an improved quality of life and be in greater control of their own mental wellbeing.

The Mental Health Parliament has developed a series of quality of life standards for mental health services in Sandwell. These standards were developed in coproduction with people who have either current or recent lived experience of mental health problems. The standards have been endorsed by the Sandwell Health and Wellbeing Board and are being incorporated into commissioning by Sandwell and West Birmingham Clinical Commissioning Group.

West Midlands Combined Authority – Mental Health Commission
The West Midlands Combined Authority has commissioned research into mental health and its impact on the public sector. It is believed this commission is the first of its type in the country.

The commission will consider evidence from around the West Midlands region and beyond and it will consider the experiences of real people with real mental health experiences, as well as the knowledge of professional mental health practitioners and mental health organisations. The commission is chaired by Norman Lamb MP, former minister of state for care and support and has identified the following key areas of enquiry:

- Employment and housing
- Early intervention principles
- Criminal justice/troubled individuals
- Role of employers
- Primary care
5. Evidence: National Institute of Health and Clinical Excellence

CG 123 Common mental health problems: identification and pathways to care

This guidance relates to common mental health disorders. These include depression, generalised anxiety disorder (GAD), obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD) and social anxiety disorder. The report highlights that treatment for up to 90% of diagnosed depressive and anxiety disorders takes place in primary care. These figures may be underestimates because many individuals do not seek treatment, especially for mild disorders. Recognition of these problems in primary care may be low, with recognition of anxiety disorders particularly poor.

The intention of this guideline, which focuses on primary care, is to improve access to services (including primary care services themselves), improve identification and recognition, and provide advice on the principles that need to adoption to develop appropriate referral and local care pathways. It brings together advice from existing guidelines and combines it with new recommendations concerning access, assessment and local care pathways for common mental health disorders.

The key priorities for implementation are:

- Improving access to services
  - Primary and secondary care clinicians, managers and commissioners should collaborate to develop local care pathways that promote access to services.

- Identification
  - Be alert to possible depression (particularly in people with a history of depression, somatic symptoms of depression or a long-term health condition with functional impairment. The guideline recommends two questions to identify depression.
  - Be alert to possible anxiety disorders (particularly in people with a history of anxiety disorder, somatic symptoms or a recent traumatic event. Use the GAD-2 scale.

- Developing local pathways
  - Primary and secondary care clinicians, managers and commissioners should design local care pathways that promote a stepped-care model of delivery. The NICE pathway contains a stepped-care model and an algorithm for identification and assessment.
  - Primary and secondary care clinicians, managers and commissioners should design local care pathways that provide an integrated care programme across primary and secondary care.
  - Primary and secondary care clinicians, managers and commissioners should ensure effective communication about the functioning of the local care pathway.
CG 90 Depression in adults: recognition and management

This guideline makes recommendations on the identification, treatment and management of depression in adults aged 18 years and older, in primary and secondary care. This guideline covers people whose depression occurs as the primary diagnosis; the relevant NICE guidelines should be consulted for depression occurring in the context of other disorders.

The key priorities for implementation are:

- **When assessing a person who may have depression, conduct a comprehensive assessment that does not rely simply on a symptom count. Take into account both the degree of functional impairment and/or disability associated with the possible depression and the duration of the episode.**

- **All interventions for depression should be delivered by competent practitioners. Psychological and psychosocial interventions should be based on the relevant treatment manual(s), which should guide the structure and duration of the intervention. Practitioners should consider using competence frameworks developed from the relevant treatment manual(s).**

- **Be alert to possible depression (particularly in people with a history of depression, somatic symptoms of depression or a long-term health condition with functional impairment. The guideline recommends two questions to identify depression.**

- **For people with persistent subthreshold depressive symptoms or mild to moderate depression, consider offering one or more of the following interventions, guided by the person’s preference:**
  - Individual guided self-help based on cognitive behavioural therapy (CBT)
  - Computerised CBT
  - Structured group physical activity programme

- **Guidance on when antidepressants are indicated, they should not be used routinely to treat persistent subthreshold depressive symptoms or mild depression.**

- **Use of antidepressants and high intensity psychological intervention for moderate to severe depression.**

- **Continuation of medication for at least 6 months after remission.**

- **Recommendations for treatment in people at risk of relapse, individual CBT or mindfulness-based cognitive therapy.**

CG 91 Depression in adults with a chronic physical health problem: recognition and management

This guideline makes recommendations on the identification, treatment and management of depression in adults aged 18 years and older who also have a chronic physical health problem (such as cancer, heart disease, diabetes, or a musculoskeletal, respiratory or neurological disorder).

The key priorities for implementation are;
• Principles for assessment, take into account both the degree of functional impairment and/or disability associated with the possible depression and the duration of the episode.
• All interventions should be delivered by competent practitioners and based on the relevant treatment manuals.
• Be alert to possible depression in patients with a past history of depression or a chronic physical health problem. The guideline recommends two screening questions.
• The guideline recommends appropriate interventions and treatment for persistent subthreshold depressive symptoms, mild to moderate depression and moderate depression.
• The guideline recommends when antidepressant drugs are appropriate for use with patients.
• Collaborative care is recommended for patients with moderate to severe depression when it has not responded to appropriate treatment.

**QS95 Bipolar disorder in adults**

This quality standard covers recognition, assessment and management of bipolar disorder (including bipolar I, bipolar II, mixed affective and rapid cycling disorder) in adults (18 years and older) in primary and secondary care.

The quality standard states that services for adults with bipolar disorder should be commissioned from and coordinated across all relevant agencies encompassing the whole bipolar disorder care pathway.

The quality standard sets out seven quality statements for care for adults with bipolar disorder:

1. Adults presenting in primary care with symptoms of depression are offered a referral for a specialist mental health assessment if they have experienced over activity or disinhibited behaviour lasting 4 days or more.
2. Adults with bipolar disorder have their early warning symptoms and triggers of relapse, preferred response during relapse and personal recovery goals specified in their care plan.
3. Carers of adults with bipolar disorder are involved in care planning, decision-making and information sharing about the person as agreed in the care plan.
4. (developmental) Adults with bipolar disorder are offered psychological interventions.
5. Adults with bipolar disorder prescribed lithium have their dosage adjusted if their plasma lithium levels are outside the optimum range.
6. Adults with bipolar disorder have a physical health assessment at least annually.
7. Adults with bipolar disorder who currently work, and those who wish to find or return to work, receive supported employment programmes.
CG 178: Psychosis and schizophrenia in adults: prevention and management
This guideline covers the treatment and management of psychosis and schizophrenia and related disorders in adults (18 years and older) with onset before 60 years. The term 'psychosis' is used in this guideline to refer to the group of psychotic disorders that includes schizophrenia, schizoaffective disorder, schizophreniform disorder and delusional disorder. The key priorities for implementation are;

- The use of cognitive behaviour therapy for people at increased risk of developing psychosis and interventions recommended in NICE guidance with any of the anxiety disorders, depression, emerging personality disorder or substance misuse.
- Recommendations regarding appropriate treatment and interventions for first episodes of psychosis.
- Recommendations regarding appropriate treatment and interventions for subsequent acute episodes of psychosis or schizophrenia and referral in crisis
- The promotion of recovery and possible future care

NG 32 Older people: independence and mental wellbeing
This guideline provides recommendations on how older people can be supported to maintain their independence and mental wellbeing. The key recommendations are;

- Support, publicise and, if there is not enough provision, consider providing a range of group, one-to-one and volunteering activities that meet the needs and interests of local older. In particular, target older people who are identified as being most at risk of a decline in their independence and mental wellbeing.
- Provide a range of group activities combining singing programmes, arts and crafts, tailored community based physical activity programmes, intergenerational activities.
- Offer one to one activities such as;
  - Programmes to help people develop and maintain friendships
  - Befriending opportunities
  - Information and advice on available services
- Make older people aware of the value and benefits of volunteering and provide opportunities.
- Recommendations on identifying those at most risk of a decline in their independence and mental wellbeing.

CG 192: Antenatal and postnatal mental health: clinical management and service guidance
General guidance

- Guidance on areas for discussion and advice for women who have a new, existing or past mental health problem.
- Guidance on recognising mental health problems in pregnancy and the postnatal period and appropriate referral. This includes the use of the 2 item generalized anxiety disorder scale (GAD-2)
- The development of clinical networks for perinatal mental health services managed by a coordinating board of healthcare professionals, commissioners, managers and service users and carers.
During pregnancy and the postnatal period
- Develop an integrated care plan which includes care of the mental health problem and which identifies the responsibilities of the professionals involved.
- Advice that should be provided by mental health professionals to the woman and other professionals.
- Advice on starting, using and stopping treatment for mental health problems during pregnancy and the postnatal period, including specific advice on different types of medication
- Care for women who have experienced a traumatic birth, stillbirth or miscarriage.

**CG113 Generalised anxiety disorder and panic disorder in adults: management**

Generalised anxiety disorder (GAD) is one of a range of anxiety disorders that includes panic disorder (with and without agoraphobia), post-traumatic stress disorder, obsessive–compulsive disorder, social phobia, specific phobias (for example, of spiders) and acute stress disorder. Anxiety disorders can exist in isolation but more commonly occur with other anxiety and depressive disorders. This guideline covers both 'pure' GAD, in which no comorbidities are present, and the more typical presentation of GAD comorbid with other anxiety and depressive disorders in which GAD is the primary diagnosis. NICE is developing a guideline on case identification and referral for common mental health disorders that will provide further guidance on the identification and treatment of comorbid conditions.

The key priorities for implementation are;

Identification: identify and communicate the diagnosis of GAD as early as possible to help people understand the disorder and start effective treatment promptly.

The remaining guidance provides a stepped approach to treatment of GAD. The level of treatment is dependent on severity of symptoms and response to treatment at each step.


This guideline makes recommendations for the physical, psychological and social assessment and treatment of people in primary and secondary care in the first 48 hours after having self-harmed.

This guidance includes statements about the experience of service-users who have self-harmed and the challenging nature of this work.
- The experience of care for people who self-harm is often unacceptable. All healthcare practitioners involved in the assessment and treatment of people who self-harm should ensure that the care they offer addresses this as a priority.
- Providing treatment and care for people who have self-harmed is emotionally demanding and requires a high level of skills. All staff undertaking this work should have regular clinical supervision in which the emotional impact upon staff members can be discussed and understood.
The key priorities for implementation are:
- People who have self-harmed should be treated with the same care, respect and privacy as any patient. In addition, healthcare professionals should take full account of the likely distress associated with self-harm.
- Ensuring all staff that may meet someone who has self-harmed should have appropriate training.
- Activated charcoal should be immediately available in all settings where care is needed for people who have self-harmed by poisoning.
- Guidance on triage of people who have self-harmed including use of the Australian Mental Health Triage Scale and providing an appropriate safe and supportive environment.
- Guidance on treatment, including addressing the physical consequences of the self-harm and assessment of physical, emotional and social needs.
- Risk assessment for the individual.
- Psychological, psychosocial and pharmacological interventions where appropriate.

**CG 133: Self-harm: longer-term management**
This guideline is concerned with the longer-term psychological treatment and management of both single and recurrent episodes of self-harm, and does not include recommendations for the physical treatment of self-harm or for psychosocial management in emergency departments. The guideline is relevant to all people aged 8 years and older who self-harm, and it addresses all health and social care professionals who come into contact with them. Where it refers to children and young people, this applies to all people who are between 8 and 17 years inclusive.

- Guidance for professionals on the principles that should be applied when working with people who self-harm.
- Use of integrated and comprehensive psychosocial assessment of needs.
- Detailed guidance for the risk assessment of people who self-harm or are at risk of suicide. The guideline states that risk assessment tools and scales to predict future suicide or self-harm should not be used.
- The use of care plans and the aims of longer term treatment which have been discussed and agreed with the individual.
- The use of risk management plans which should be a clearly identifiable part of the overall care plan.
- Offering 3 to 12 sessions of psychological interventions that are specifically structured for people who self-harm.
- The treatment of associated mental health conditions including psychological, pharmacological and psychosocial interventions.
CG 31: Obsessive compulsive disorder
This guideline provided detailed guidance on services for people, adults and children, with obsessive compulsive disorder and body dysmorphic disorder. This summary covers the guidance relevant to children and young people.

General guidance
- All organisations that provide mental health services should have access to a specialist obsessive-compulsive disorder (OCD)/body dysmorphic disorder (BDD) multidisciplinary team offering age-appropriate care.
- OCD and BDD can have a fluctuating or episodic course, or relapse may occur after successful treatment. Therefore, people who have been successfully treated and discharged should be seen as soon as possible if re-referred with further occurrences of OCD or BDD, rather than placed on a routine waiting list.

Children and young people with OCD or BDD
- The guideline recommends a stepped approach based on the severity of the condition and the level of functional impairment experienced. This is based on the use of CBT as a first intervention and the use of pharmacological interventions (SSRI) where this is not effective. This treatment should involve the family or carers and be suited to the developmental age of the child or young person.

CG 9: Eating disorders
This provides guidance on the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders. The priorities for implementation within the guidance are;

Anorexia nervosa
- Most people should be managed on an outpatient basis from a service with the relevant specialist knowledge and experience.
- Where in-patient treatment is needed this should be in a specialist unit.
- Family interventions that directly address the eating disorder should be offered to children and adolescents.

Bulimia Nervosa
- A possible first step is an evidence based self-help programme.
- Adults may be offered a trial of an antidepressant drug and a specifically adapted form of CBT (CBT-EN).
- Adolescents may be treated with CBT-EN adapted to their age and including the family as appropriate.

Atypical eating disorders
- It is recommended that treatment follows the guidance on the treatment of the eating problem that most closely resembles the individual patient’s eating disorder.
CG72 Attention deficit hyperactivity disorder: diagnosis and management
This guideline recommends an evidence based approach to diagnosis and treatment of attention deficit hyperactivity disorder.

The guideline includes recommendations on;
- Organisation and planning of local services
- Information, consent and support for people with ADHD and their carers
- Training of healthcare and education professionals
- Identification, pre-diagnostic intervention in the community and referral to secondary services
- Identification and referral in adults with ADHD
- Dietary and general advice
- Treatment for children and young people
- Pre-drug treatment assessment and medication
- Transition to adult services
- Treatment of adults with ADHD

PH48 Smoking: acute, maternity and mental health services
Stopping smoking at any time has considerable health benefits for people who smoke, and for those around them. For people using secondary care services, there are additional advantages, including shorter hospital stays, lower drug doses, fewer complications, higher survival rates, better wound healing, decreased infections, and fewer re-admissions after surgery.

Secondary care providers have a duty of care to protect the health of, and promote healthy behaviour among, people who use, or work in, their services. This duty of care includes providing them with effective support to stop smoking or to abstain from smoking while using or working in secondary care services.

This guidance aims to support smoking cessation, temporary abstinence from smoking and smoke free policies in all secondary care settings. It recommends:
- Strong leadership and management to ensure secondary care premises (including grounds, vehicles and other settings involved in delivery of secondary care services) remain smoke free –to help to promote non-smoking as the norm for people using these services.
- All hospitals have an on-site stop smoking service.
- Identifying people who smoke at the first opportunity, advising them to stop, providing pharmacotherapy to support abstinence, offering and arranging intensive behavioural support, and following up with them at the next opportunity.
- Providing intensive behavioural support and pharmacotherapy as an integral component of secondary care, to help people abstain from smoking, at least while using secondary care services.
• Ensuring continuity of care by integrating stop smoking support in secondary care with support provided by community-based and primary care services.
• Ensuring staff are trained to support people to stop smoking while using secondary care services.
• Supporting all staff to stop smoking or to abstain while at work.
• Ensuring there are no designated smoking areas, no exceptions for particular groups, and no staff-supervised or staff-facilitated smoking breaks for people using secondary care services.

Wider NICE guidance
Other NICE documents relate to mental health and wellbeing but are outside of the scope of this JSNAA.
• Mental wellbeing in over 65s: occupational therapy and physical activity interventions
• Autism in adults: diagnosis and management.
• Violence and aggression: short-term management in mental health, health and community settings.
• Mental wellbeing at work
• Workplace health management practices

NICE guidance under development
• Healthy workplaces, improving employee mental health and physical health and lowering sickness absence (Jan 2017)
• Mental health problems with learning disability – quality standard (Jan 2017)
• Mental health of adults in contact with the criminal justice system (Feb 2017)
• Severe mental illness and substance misuse (dual diagnosis) – community health & social care services (Nov 2016)
• Transition between inpatient mental health settings and community and care home settings (Guideline Aug 2016, Quality Standard July 2017)
6. Service Mapping Exercise

23 mental health providers in Sandwell responded to a service mapping questionnaire. Services available accommodated both low level mental health problems and well-being, as well as severe and enduring mental health problems. In addition to targeting mental health, many services also offered social and supportive care services. In some cases, these services extend to the patient’s family and carers.

The 23 mental health providers are listed below, separated by commissioning body.

**Mental health providers commissioned by Sandwell and West Birmingham Clinical Commissioning Group**

**Table 8: Mental health providers commissioned by the Clinical Commissioning Group**

<table>
<thead>
<tr>
<th>Name of Service (Community Wellbeing and Khushi)</th>
<th>No. of users (approx. per annum)</th>
<th>Activities Provided</th>
</tr>
</thead>
</table>
| P3 Cooperage Court | 52 | 24 hours supported housing
Support customers’ needs including alcohol and substance misuse, mental health, offending, complex and chaotic behaviour |
| Sandwell African Caribbean Mental Health Foundation | 150 | Counselling for individual, couples or family therapy.
Outreach support service to offer practical support.
Ujima user-led service.
Mentoring, volunteering opportunities, organising social activity co-production.
Carers support service. |
| Kaleidoscope (Community Wellbeing and Khushi) | 9500 attendances | Group therapies: Self-help support groups, educational and vocational groups
Individual therapies; Eco therapies
Social, leisure and physical groups and events
Information, advice and signposting |
| Kaleidoscope (IAPT – Improving Access to Psychological Therapies) | 2000 | Cognitive behavioural therapy (CBT) interventions
6-8 sessions each session lasting approximately 45 min - 1 hour.
Through face to face, telephone, email and text. |
| Mental Health Team (Street Triage) | 797 | Attend scenes / provide telephone advice to 999 services regarding persons at the scene suffering from mental health.
Triage and signposts into mental health services. |
| The Wellbeing Hub | 12,500 | Acts as a single point of access for Primary Care. All referrals triaged by a Clinical Duty Officer.
Emotional and Mental Health Services and Support |
| Treatment Teams North and South | TBC | MH and other professional specific assessments, risk assessments and management.
PA framework including care/crisis planning, 1:1 intervention with specific professionals. |
<table>
<thead>
<tr>
<th>Service Description</th>
<th>Quantity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recovery Model including WRAP plans, psycho-education, psychological interventions/Talking Therapies including CBT/SFT/DBT, Assertive Engagement, Access to a Duty Officer. Signposting to appropriate services, joint work with other services and agencies, medication administration and monitoring, MH/Physical health comorbidity monitoring, social needs assessment, group work.</td>
<td></td>
<td>Recovery Model including WRAP plans, psycho-education, psychological interventions/Talking Therapies including CBT/SFT/DBT, Assertive Engagement, Access to a Duty Officer. Signposting to appropriate services, joint work with other services and agencies, medication administration and monitoring, MH/Physical health comorbidity monitoring, social needs assessment, group work.</td>
</tr>
<tr>
<td>Therapy and recovery unit</td>
<td>25 per day</td>
<td>Therapeutic Group work</td>
</tr>
<tr>
<td>Single Point of Referral Service</td>
<td>3600</td>
<td>We will screen, triage and assess all referrals into the service. Clinicians are also able to provide short term solution focussed interventions and to provide advice and information to non-mental health trained medical and nursing staff</td>
</tr>
<tr>
<td>Criminal Justice Team</td>
<td>550</td>
<td>Assessments, liaison and joint working with other services and agencies, Psychological/Talking Therapies including CBT, MH monitoring, signposting, risk assessments and management, Coping strategies, psycho-education.</td>
</tr>
<tr>
<td>Mental Health Liaison Team at Sandwell A&amp;E</td>
<td>1500</td>
<td>Psychosocial assessment of patients in ED, including risk assessment, liaison with stat and non-stat services, safe discharge planning. Signposting and referral into appropriate community, or inpatient service. Teaching to colleagues within the acute trust regarding mental health related issues.</td>
</tr>
<tr>
<td>Early Intervention Service in First Episode Psychosis</td>
<td>130</td>
<td>CBT informed care (e.g. Graded Exposure and Behavioural Activation). NICE level Family Therapy, Family Intervention Brief Family Therapy, Psycho-Social Training, Relapse prevention Social groups, Vocational support, Occupational Therapy assessment and intervention, Family support groups Physical health monitoring, Welfare rights advice</td>
</tr>
<tr>
<td>Crisis and Home Treatment Team Adults</td>
<td>TBC</td>
<td>Assess and treat Service users in their Home environment. We are able to undertake assessment 24 hours a day, 7 days a week. The team responds to requests for assessment from Accident and Emergency Departments; Mental Health Liaison teams and Single Point of Referral services, or signpost to appropriate others. We aim to Gate keep 100% of admissions into adult acute wards in Sandwell, and carryout face to face in reach / contact within 48hours. We are able to offer a wellness Recovery Action Plan (WRAP), Provide psychological approaches and Interventions. E.g. Mindfulness, relaxation, techniques for managing difficult experiences and emotions. Advocate for Service Users, Carers and Relatives</td>
</tr>
</tbody>
</table>
Sandwell IAPT  TBC  Predominantly counselling and structured psychological therapies CBT, psycho-education psychological interventions and group work

Recovery College  50  Coproduced Educational courses Opportunities for people with lived experience to undertake volunteering roles Opportunities for people to coproduce /co-facilitate courses to share experiences.

**Mental health providers commissioned by Sandwell Metropolitan Borough Council**

**Table 9: Mental health providers commissioned by SMBC**

<table>
<thead>
<tr>
<th>Name of Service</th>
<th>No. of users (approx. per annum)</th>
<th>Activities Provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>SMBC (Specialist Employment Team)</td>
<td>175</td>
<td>Support to find and sustain paid employment.</td>
</tr>
<tr>
<td>Kaleidoscope (Nicholl Grange)</td>
<td>15-20</td>
<td>14 bed registered care home for people with mental health problems. 24 hour staffing. Residents in these flats budget and shop for their own food, and prepare it themselves.</td>
</tr>
<tr>
<td>Kaleidoscope (Mental Health Grant)</td>
<td>3,653</td>
<td>Promote the preservation and the safeguarding of mental health and the relief of persons suffering from mental disorder through the provision of a range of care, support and advisory services. Covers organisational activities and community engagement and development of services</td>
</tr>
<tr>
<td>Kaleidoscope (SORT - Floating Support)</td>
<td>150 - 200</td>
<td>Provides support with daily living ie, bills, finances and routine household tasks. SORT cannot offer any kind of personal care, such as assistance with washing, dressing or administering medication, however are able to refer to other agencies who can help.</td>
</tr>
<tr>
<td>Ideal for All (Growing Opportunities)</td>
<td>691</td>
<td>Health and wellbeing activities utilising community garden sites. Variety of community based programmes: healthy eating/cooking, therapeutic gardening, floristry, seasonal crafts, packaging and distribution of produce, money management, keeping active outdoors and learning and skills development.</td>
</tr>
<tr>
<td>Ideal for All (Independent living services)</td>
<td>&gt;4000</td>
<td>Information and advice on disability-related issues. Promoting and encouraging participation of disabled people, their families and carers in the diverse services and activities. Occupational Therapy (OT) Service: information and advice on daily routine, leisure or work activities. Drop in Duty Service: provides equipment for maintaining</td>
</tr>
</tbody>
</table>
independence. Fibromyalgia, Arthritis, Deaf and Hard of Hearing support groups. Employment and Skills development provide a range of employment training and courses, including a high level of learning support. Young people peer support group offers young people from the age of 14 to 25 not in education, employment or training.

<table>
<thead>
<tr>
<th>Pohwer IMHA</th>
<th>264</th>
<th>Comprehensive support and advocacy under the MHA - Information and Advice/ signposting. Aspects of the MCA / Equality Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Mental Health Team</td>
<td>500+</td>
<td>Intervention under 1983 Mental Health Act Assessment/review/care management Duty service/advice/signposting.</td>
</tr>
</tbody>
</table>

Access to Mental Health Providers

Operating Hours

Most services were available during normal working hours of 0900 am to 1700 pm. with a very small number providing Out of Hours on a needs basis.

Services offering accommodation are listed below as operating 24 hours a day. The rest operating between 12 and 24 hrs are services specialising in assessment and triage, and/or severe mental health disease.

Table 10: Service operating hours

<table>
<thead>
<tr>
<th>Weekdays 0900-1700</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sandwell African Caribbean Mental Health Foundation</td>
</tr>
<tr>
<td>Community Mental Health Team</td>
</tr>
<tr>
<td>The Wellbeing Hub</td>
</tr>
<tr>
<td>Treatment Teams North and South</td>
</tr>
<tr>
<td>Therapy and recovery unit</td>
</tr>
<tr>
<td>Single Point of Referral Service</td>
</tr>
<tr>
<td>Ideal for All (Independent Living Services )</td>
</tr>
<tr>
<td>Out of Hours on a needs basis</td>
</tr>
<tr>
<td>Kaleidoscope (IAPT – Improving Access to Psychological Therapies)</td>
</tr>
<tr>
<td>Kaleidoscope (Mental Health Grant)</td>
</tr>
<tr>
<td>Kaleidoscope (SORT - Floating Support)</td>
</tr>
<tr>
<td>Out of Hours</td>
</tr>
<tr>
<td>Kaleidoscope (Nicholl Grange)</td>
</tr>
<tr>
<td>Mental Health Team (Street Triage)</td>
</tr>
</tbody>
</table>
Crisis and Home Treatment Team Adults | 24 hour service 7 days a week
---|---
Mental Health Liaison Team at Sandwell A&E | 08.00-22.00 covering ED for all ages 18 and over; Mon-Fri 08.00-16.00 for Older Adults referred from the wards
Early Intervention Service in First Episode Psychosis | 8am – 8pm
Kaleidoscope (Community Wellbeing and Khushi) | 6 days a week evenings and day times
P3 Cooperage Court | 24 hours

**Referral Pathways**

52% (12/23) services accepted referrals from anyone (individual, family, and health professionals), whereas others only accepted referrals from professionals within the multidisciplinary team, or via specific routes (ie, Wellbeing hub).

57% of mental health services reported that they accept self-referrals.

**Table 11: Referral pathways and routes**

<table>
<thead>
<tr>
<th>Mental Health Provider</th>
<th>Accepts Referrals From:</th>
<th>Self-referrals?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crisis and Home Treatment Team Adults</td>
<td>Anyone</td>
<td>No</td>
</tr>
<tr>
<td>Mental Health Liaison Team at Sandwell A&amp;E</td>
<td>Any clinician from the MDT within the acute trust</td>
<td>No</td>
</tr>
<tr>
<td>Early Intervention Service in First Episode Psychosis</td>
<td>Anyone</td>
<td>Yes</td>
</tr>
<tr>
<td>Kaleidoscope (Community Wellbeing and Khushi)</td>
<td>Anyone</td>
<td>Yes</td>
</tr>
<tr>
<td>P3 Cooperage Court</td>
<td>Accepts referrals from Black Country Foundation Trust Crisis Home Treatment Team only</td>
<td>No</td>
</tr>
<tr>
<td>Mental Health Team (Street Triage)</td>
<td>Police and Ambulance</td>
<td>No</td>
</tr>
<tr>
<td>The Wellbeing Hub</td>
<td>Anyone</td>
<td>Yes</td>
</tr>
<tr>
<td>Treatment Teams North and South</td>
<td>GPs, others services and agencies, other Trusts, internal teams and services including wards/acute, outpatients, medics, crisis team etc.</td>
<td>No</td>
</tr>
<tr>
<td>Therapy and recovery unit</td>
<td>Consultants psychiatric nurse, occupational therapy, Memory service</td>
<td>No</td>
</tr>
<tr>
<td>Single Point of Referral Service</td>
<td>GP’s, Psychiatric outpatients, IAPT, A&amp;E and any other health professional</td>
<td>No</td>
</tr>
<tr>
<td>Criminal Justice Team</td>
<td>GPs, police, court, probation, prison</td>
<td>Yes</td>
</tr>
<tr>
<td>Sandwell IAPT</td>
<td>GPs, others services and agencies, other Trusts, internal team.</td>
<td>Yes</td>
</tr>
<tr>
<td>Recovery College</td>
<td>Self-referral only</td>
<td>Yes</td>
</tr>
<tr>
<td>Sandwell African Caribbean Mental Health Foundation</td>
<td>Individual, health professional and families</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Ideal for All (Growing opportunities) | Anyone | No
---|---|---
Ideal for All (Independent Living Services) | Anyone | No
Pohwer IMHA | Individual, health professional and families | Yes
SMBC (Specialist Employment Team) | Anyone | Yes
Community Mental Health Team | Anyone | Yes
Kaleidoscope (IAPT – Improving Access to Psychological Therapies) | Via the Wellbeing Hub | Yes
Kaleidoscope (Mental Health Grant) | TBC | TBC
Kaleidoscope (SORT - Floating Support) | Anyone | Yes
Kaleidoscope (Nicholl Grange) | Anyone | Yes

Crisis referrals are accepted by the following services – 39% (9/23):

1. Crisis and Home Treatment Team
2. Mental Health Liaison Team at Sandwell A&E
3. Kaleidoscope (Community Wellbeing and Khushi)
4. P3 Cooperage Court
5. Mental Health Team (Street Triage)
6. Community Mental Health Team
7. Kaleidoscope (IAPT – Improving Access to Psychological Therapies)
8. Kaleidoscope (SORT - Floating Support)
9. Kaleidoscope (Nicholl Grange)

The other services do not accept crisis referrals, and almost exclusively refer/signpost to the Crisis Team, Emergency Department or Mental Health liaison service.

**Waiting Lists**

Most mental health providers which accept crisis referrals do not have a waiting list. For services which do have a waiting list, waiting times range from between 5 to 42 days, with an average of 18 days.

**Table 12: Waiting lists**

<table>
<thead>
<tr>
<th>Service</th>
<th>Waiting List?</th>
<th>How long (days)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crisis and Home Treatment Team Adults</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Mental Health Liaison Team at Sandwell A&amp;E</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Early Intervention Service in First Episode Psychosis</td>
<td>Yes</td>
<td>15</td>
</tr>
<tr>
<td>Kaleidoscope (Community Wellbeing and Khushi)</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>P3 Cooperage Court</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Mental Health Team (Street Triage)</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>The Wellbeing Hub</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Treatment Teams North and South</td>
<td>Yes</td>
<td>28</td>
</tr>
</tbody>
</table>
Therapy and recovery unit | Yes | 14
--- | --- | ---
Single Point of Referral Service | Yes | 28
Criminal Justice Team | Yes | 10
Sandwell IAPT | Yes | 28
Recovery College | Yes | 14
Sandwell African Caribbean Mental Health Foundation | Yes | 5
Ideal for All (Growing opportunities) | No |
Ideal for All (Independent Living Services) | No |
Pohwer IMHA | Yes | 5
SMBC (Specialist Employment Team) | Yes | 5
Community Mental Health Team | No |
Kaleidoscope (IAPT – Improving Access to Psychological Therapies) | Yes | 42
Kaleidoscope (Mental Health Grant) | TBC |
Kaleidoscope (SORT - Floating Support) | No |
Kaleidoscope (Nicholl Grange) | No |

**Exclusion Criteria**

Exclusion criteria set out by the mental health service provider are described in the figure below. Several services (i.e., Therapy and recovery unit, Treatment Teams North and South, and Community Mental Health Team) require a pre-existing mental health diagnosis. Some services such as The Wellbeing Hub and Kaleidoscope IAPT specified they do have a criteria, but did not give details.
Non Mental Health Providers
20 non mental health providers, who have contact with service users who have mental health problems, were asked to participate in a questionnaire. The aim was to understand the characteristics of their service users with mental health problems, and how well equipped the service provider felt they were at managing their mental health needs.

Non mental health providers:

1. Ideal for All Growing Opportunities
2. Carers Advice & Resource Establishment, Sandwell (CARES)
3. Fry Housing Trust
4. West Midlands Ambulance Service
5. Trident Reach
6. SHARP
7. Healthy Sandwell, Public Health
8. Tipton COG
9. Midland heart
10. Sandwell Libraries
11. West Midlands Police
12. Sandwell Women's Aid
13. P3
14. IRiS Sandwell
15. action on hearing loss
16. Agewell CIC
17. Citizens Advice Sandwell
18. KeyRing Living Support Networks
19. YMCA Black Country Group Supported Lodgings
20. Swanswell
We asked the non-mental health providers “What proportion of the people you work with experience the following levels of mental health and wellbeing?” with 3 categories of mental health severity:

1. Wellbeing/low level mental health issues like low mood, debt worries, poor relationships
2. Common mental health disorders: Like depression, anxiety
3. Serious mental health illness: like bi-polar, schizophrenia

For each category, the options were 0%, 25%, 50%, 75% or 100%.

Figure 12 shows the results. The majority of service users had wellbeing and low-level mental health issues. One third of the service users had serious mental illness.

**Figure 12: Levels of mental health and wellbeing problems in services**
We also asked how well the non-mental health service providers felt they were meeting the needs of their service users with mental health problems:

**Table 13: How well providers feel they meet the needs of service users**

<table>
<thead>
<tr>
<th>Provider</th>
<th>To what extent do you feel you are doing well?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Swanswell</td>
<td>Very well</td>
</tr>
<tr>
<td>action on hearing loss</td>
<td></td>
</tr>
<tr>
<td>KPG</td>
<td></td>
</tr>
<tr>
<td>Sandwell Women's Aid</td>
<td></td>
</tr>
<tr>
<td>Tipton COG</td>
<td>Fairly well</td>
</tr>
<tr>
<td>Midland heart</td>
<td></td>
</tr>
<tr>
<td>Sandwell Libraries</td>
<td></td>
</tr>
<tr>
<td>West Midlands Police</td>
<td></td>
</tr>
<tr>
<td>KeyRing Living Support Networks</td>
<td></td>
</tr>
<tr>
<td>Carers Advice &amp; Resource Establishment, Sandwell (CARES)</td>
<td></td>
</tr>
<tr>
<td>Healthy Sandwell, Public Health</td>
<td></td>
</tr>
<tr>
<td>Ideal For All</td>
<td></td>
</tr>
<tr>
<td>SHARP</td>
<td></td>
</tr>
<tr>
<td>West Midlands Ambulance Service</td>
<td></td>
</tr>
<tr>
<td>YMCA Black Country Group Supported Lodgings</td>
<td></td>
</tr>
<tr>
<td>IRiS Sandwell</td>
<td></td>
</tr>
<tr>
<td>Citizens Advice Sandwell</td>
<td></td>
</tr>
<tr>
<td>Trident Reach</td>
<td>Not very well</td>
</tr>
<tr>
<td>Sandwell MBC</td>
<td></td>
</tr>
<tr>
<td>Healthy Sandwell, Public Health</td>
<td></td>
</tr>
<tr>
<td>Fry Housing Trust</td>
<td></td>
</tr>
</tbody>
</table>
Non mental health providers: referral pathways

We asked non-mental health providers about the referral pathways they use for their clients.

We found that most routine referrals were made to the client’s GP in the first instance, or sometimes The Wellbeing Hub. Other referrals were made to various support groups, employment support, welfare rights, friendship groups and community services.

The police refer to Street Triage, use Mental Health Act, Mental Capacity Act, Psychiatric Liaison (Mental Liaison team Sandwell A&E) and Crisis team.

Referral pathways are not adequately catering for clients with sensory deprivation such as hearing loss. Action on Hearing Loss reported that there are almost no routes for deaf people to access, and they are usually sent away and told to come back with an interpreter.

How effective are the referral pathways?

Table 14: Effectiveness of referral pathways

<table>
<thead>
<tr>
<th>Positives</th>
<th>Negatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Adult service referrals are effective because there is feedback or two way communication regarding clients.</td>
<td>Waiting times and communication</td>
</tr>
<tr>
<td>• In a crisis we contact the Crisis Team and generally the response is good.</td>
<td>• Waiting times can be long, effective sometimes, not consistent service.</td>
</tr>
<tr>
<td>• When we need emergency services for support the response is also good.</td>
<td>• Timescales for other agency response is adequate however different services have different sections that may not respond equally well dependent upon demand.</td>
</tr>
<tr>
<td>• Kaleidoscope: Waiting times for the groups provided is within 24 hours.</td>
<td>• Referrals to counselling services and psychology take a while due to their waiting list.</td>
</tr>
<tr>
<td></td>
<td>• Referrals to the Wellbeing Hub: We have experienced offer of assessment appointments are fairly quick but follow on appointments can take up to 12 weeks</td>
</tr>
<tr>
<td></td>
<td>• Referrals for structured one to one sessions can wait up to 12 weeks. (KPG)</td>
</tr>
<tr>
<td></td>
<td>• No feedback from GPs or Primary Care Teams.</td>
</tr>
<tr>
<td></td>
<td>• With Wellbeing Service there is only signposting and there is no feedback or follow up</td>
</tr>
<tr>
<td>Item 6a Draft Adult MHW Jsnaa</td>
<td>04/01/2017 60</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-------------</td>
</tr>
</tbody>
</table>

- Almost no routes for deaf people to access, no interpreters provided at initial enquiry stage. Deaf people are usually sent away by well-meaning staff and told to come back with an interpreter.
- Referrals to IRiS Dual Diagnoses Service: IRiS provide the dual diagnoses service for Sandwell residence. Waiting times can be up to 3 weeks
- Referrals to the Wellbeing Hub: We can experience blockages with referrals due to some of our client’s level of alcohol use

**Transition**

- When a Young Person turns 18, there is a lack of continuity for them and I don't think the transition is always as smooth as it could be.

### Suggested improvements to mental health provider services

**Information and awareness**

- If we had improved access to information about access and pathways.
- Greater awareness of services defined access criteria and defined service offer.
- Open days/ "market place" so staff can meet each other and understand roles/ functions

**Joint working**

- An agreement on joint working protocols between agencies for Dual Diagnosis clients.
- To make all signposting as referrals and introduce follow up to be implemented as part of the pathway, with Wellbeing service in particular.
- Explanations and notifications if cases are not accepted - alternatively provision proposed.
- Links with Primary Care for Police to be able to inform Primary Care /GP’s about people they are concerned about.
Crisis and emergency pathways

- Another option to A&E and the Mental Health Act

Making referrals and assessment

- Shorter waiting times, easier referrals as some can only be made by professionals.
- Being able to phone to make appointments for clients while the client is with us.
- Currently, the service is not able to refer directly to tier three mental health services, referrals have to be made via the clients G.P. It would reduce the wait to access tier three mental health services, if medical staff (nurses and non-medical prescribers) were able to directly refer.
- Direct support from our local mental health service for Swanswell patients when they are in crisis. Immediate access to telephone assessment may prevent the need call to 111/request an ambulance/police presence.

Training

- Ensure staff are trained on what to do if they have a referral from a deaf person.

Patient and users experience of accessing mental health and wellbeing services

We found that this was not the best way to collect experience. Although the findings are not wholly representative, they are still valid. We collated comments that relate to access issues building on themes from previous consultations with 86 adults (Changing our Lives – Rights based organisation supports the Mental Health Parliament). Missing the Primary Care

Patient experience

- Approx 40 current responses expressing views on mainstream mental health and wellbeing services provided by NHS (BCPFT/Acute hospital), SMBC (ASC) and VCS.
- Service areas/themes include:
  A&E, Crisis and home treatment, experience with the police, Talking therapies, Referral routes/waiting times, vulnerable and minority ethnic groups, Recovery and staying well, groups (treatment & self help), patient and mental health advocacy

Some of the negative and positive comments we received about accessing mental health and wellbeing services are:
Table 15: Access to mental health services: positive and negative stakeholder responses

<table>
<thead>
<tr>
<th>Negatives</th>
<th>Positives</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Long waits and difficulties accessing out of hours - A&amp;E, Crisis Team, Home Treatment, CBT, CPN, and psychologist</td>
<td>• not a long waiting list (IAPT)</td>
</tr>
<tr>
<td>• Some negative experience with the police, lack of police awareness/training</td>
<td>• Ability to self -refer and easy access (Kaleidoscope Plus Group)</td>
</tr>
<tr>
<td>• Talking therapies: access, thresholds to receive treatment – not ill enough <em>(to be treated).</em></td>
<td>• Positive, quick and easy access to culturally sensitive services (Sandwell African Caribbean Health Foundation)</td>
</tr>
<tr>
<td>• Cancelations, one chance to turn up or the referral process has to start all over again.</td>
<td>• positive staff attitude/approach (A&amp;E)</td>
</tr>
<tr>
<td>• Mainstream mental health services not understanding or meeting cultural needs &amp; lack of knowledge of availability of culturally sensitive services.</td>
<td>• Fast access to talk to someone about my mental health (KPG)</td>
</tr>
<tr>
<td>• Asking GP repeatedly for help, having to self-refer</td>
<td>• Peer groups, Mental Health Parliament</td>
</tr>
<tr>
<td>• Refusing to treat people with drug or alcohol problems</td>
<td>• Groups - you can just turn up for immediate access (PIM &amp; Wellbeing Group) Meeting others with mental health problems</td>
</tr>
<tr>
<td>• Recovery model – hospital should be the last resort, being discharge home too early</td>
<td></td>
</tr>
<tr>
<td>• Groups can create dependency need to normalise recovery</td>
<td></td>
</tr>
</tbody>
</table>

What could make things better?

Address identified negative issues and build on the positives. Some suggestions for improvements included:

• Single point of access, GP’s made more aware of services available, a diverse staff team trained in cultural understanding and awareness. Informed of and given more choice of culturally sensitive services
• Recovery support should be available in the community, doing normal things in the community, peer support
• More and longer group sessions

Implementing the:
• Crisis Care Concordat Action Plan- in Sandwell the CCC Action plans has been co-produced by people who have experience of mental health crisis. Action plan themes
  o Access to support before a crisis
Urgent & emergency aces to crisis care
Recovery & staying well/preventing further crisis
Quality of treatment & care when in a crisis

- Mental Health Parliament Quality of Life Standards launched on 18th Oct 2016. These standards have been developed to ensure everyone gets a good quality support that promotes good mental health and wellbeing, prevents mentally ill-health and enables recovery when a person becomes mentally unwell.

**Workforce development**

We asked mental health services what mental health and wellbeing training their staff received?

- Responses provided a whole range of service and professional training, training related to Continuing Professional Development needs, mandatory training including safeguarding and some in-house training
- Suicide Prevention training – ASIST & STORM, Mental Health First Aid, well recognised mental health and suicide prevention awareness training mentioned by some services.

We also asked non mental health service providers what training their staff had received:

- Responses ranged from ‘very little’ to a number of service specific training, informal and in-house training, basic mental health awareness/training (KPG) including Mental Health First Aid and ASIST

Further training needed:

- On-going, regular and refresher training from basic awareness, different agency perspectives, to specific areas e.g. bereavement, impact of medication, dealing with difficult situations and complex mental health needs.
- Delivered by mental health services and combined input e.g. mental health professional and specialist police officer
- Raises a number of organisations (including Public Health) are commissioning and providing the same or similar training - unco-ordinated.

**Feel good 6 Wellbeing Activity in Sandwell**

We are finding that organisations are keen to support our Sfg6 engagement campaign

- 76 statutory, voluntary organisations and community groups have signed up to Sandwell’s feel good 6

And are already contributing to supporting people to take action on the 6 ways which are Connect, Move, Notice, Learn, Give & Talk

We are developing a more holistic picture of both problems but also the assets and what’s good and working well to support people in Sandwell to feel good
Stakeholder event feedback

About the event

Connecting and learning
- Got a lot of different people together, a mixture of organisations, range of services to start conversations.
- The information gathered and networking with others sharing and gaining information. Different services/agencies working together.
- Good to know that others share identical concerns. Other professionals with same challenges.
- Networking and planning for the future.
- Networking – gained insight into other services and others views.
- Networking opportunities and a change to share views and experiences.
- Opportunity to meet people involved with mental health services. Get an overview of the aims of the assessment and process.
- Information sharing and the possibility of creating joint working with other agencies.
- Opportunities to lead and implement change.
- That people able to make change are listening.
- The hope that access for deaf people to services shall change and improve.

Process
- Information presented e.g. data collected.
- Table discussions.
- Highlighting gaps and difficulties.
- Chance to feedback and gather intelligence.

Missed Services in mapping exercise:
- BUDS; Enhanced rent housing service (i.e. Crown House, Phoenix House, YMCA) Fire Service.
- Sandwell Hub - Fire co-ordination; Michale Hough, WMFS - Providers not aware of this service.
- Training Providers not included: Juniper (for those who have dropped out of education); Neats (Neets); Job Centre; NACRO – offending young persons; Sandwell College – do they have MH/Safeguarding professionals working with students?; Krunch – young fathers.
- Voluntary Sector: Marbles, Loaves and Fishes; Faith Groups – Mosques/Imams Led Groups.
- Issues with mixed footprint for CCG area – not all services run over all CCG.

Process - what we could have done better
- Need more Service User Feedback – look to support Service Users to complete the survey.
- Not enough time allowed to providers to complete surveys and gain views.
- Access views from wider public and wellbeing Service Users.
- Diverse delegates – more patients/service users/carers.
- More inclusion of other providers.
- Let’s hear from people who have tried to access services and their recommendations.
- Highlight the need for data which should help to get it when you meet people in person.
• From presentation on the day - Differing picture concerning waiting lists, opening times across for services, need overarching view
• Collaborative working investment in mental health services.
• More opportunities to discuss and plan changes
**Acknowledgements**

People with lived experience
Kate O’Hara
Dr Robert Woodford
Dr Xiaoxuan Liu
Paul Southon (Editor)
Richard Cooksey
Jayne Leeson
References

1 Department of Health (2011) Joint strategic needs assessment and joint health and wellbeing strategies explained: commissioning for populations. DH, London


16 Holt-Lunstad J, Birmingham W, Jones B. Is There Something Unique about Marriage? The Relative Impact of Marital Status, Relationship Quality, and Network Social Support on


Joint Strategic Needs Assessment (JSNA) for children 0-4 years old

Chapter 1  Demographics and Risk Factors
Chapter 2  Healthy Pregnancy
Chapter 3  Safeguarding
Chapter 4  School Readiness
Chapter 5  Special Education Needs and Disabilities

Public Health
Sandwell Metropolitan Borough Council
Executive Summary

Experiences prior to birth and in early childhood have an impact on health and wellbeing throughout life, all the way into old age. The Health and Wellbeing Board recognise the potential to improve the wellbeing of future generations by focusing on early years. The aim of this Joint Strategic Needs Assessment is to highlight gaps in current provision across a number of services which support 0-4 year olds and to make recommendations to improve services in the future. The four key areas of focus were chosen following consultation with a wide range of stakeholders. It is recognised that there are other areas which significantly impact on 0-4 year olds health and wellbeing which are not included in this document. Separate JSNAs have been produced on 0-25 mental health and on domestic violence which include recommendations relating to this age group; this JSNA does not duplicate these recommendations.

Key findings and recommendations for this JSNA are summarised below:

- Certain features of the Sandwell population including high levels of deprivation and ethnic diversity have the potential to negatively impact on health and wellbeing in the early years. It is important that we deliver services designed to meet the needs of our whole population.

- Sandwell has a higher birth rate, higher rate of infant mortality and lower rate of breast feeding than the rest of the West Midlands and England. We need to look at pregnancy and early year’s services to identify how we can improve rates of early booking, increase uptake of stop smoking services and increase breast feeding. An important aspect of this is ensuring that services provided meet the needs of the local population and are culturally sensitive.

- Referrals into children’s services have decreased in recent years and it is important to understand the reasons for this. Proportions of referrals from some ethnic groups are less than would be expected given the population make up of Sandwell; we also need to understand reasons for this. All stakeholders who potentially come in contact with parents of young children (including those working in the voluntary and community sector) should be aware of universal and early help services available and signposting at the earliest opportunity should be encouraged.

- In Sandwell just over 50% of children reach a ‘good’ level of development at 5 years of age; however, there is no standard measure of school readiness. A standard measure of school readiness needs to be adopted so that we can identify areas within the borough with poor school readiness where services should be targeted. While uptake of Nursery Education Funding is high, uptake of Early Learning for Two-year-olds is low throughout the borough and
as low as 30% in some wards. We need to understand reasons for this poor uptake and improve offer and access to places where appropriate.

- The majority of Special Education Needs referrals in 0-4 year olds are for speech, language or communication needs. There is evidence of delays in referrals in this age group. Sharing of information on children with possible SEND needs between agencies is poor. It is important to improve data sharing to facilitate timely referral to services.

- While some of the recommendations within the JSNA have named organisational owners, most of the recommendations will require a partnership approach. It is envisioned that the Children and Families Joint Planning and Commissioning Group will consider these recommendations and how they can be taken forward.
1. Demographics and Risk Factors

Key Points

- Sandwell was ranked the 13th most deprived authority in England in 2015
- 34.2% of Sandwell’s population is of Black and Minority Ethnic (BME) origin
- There are 13,512 lone parent families in Sandwell and 37.7% of these families (5090) have a dependent child at age 0-4
- Sandwell has 6.5% of homes where an adult has either a long term illness or a disability and has dependent children
- The prevalence of women who are known smokers at the time of delivery is recorded at 9.7% compared to 12.0% nationally
- In 2013-14, 10.9% of children in Sandwell were classed as obese at school entry compared with 9.5% nationally
- In 2013, Sandwell had 36.6 conceptions per 1,000 women aged less than 18 years compared to 24.3 per 1,000 conceptions nationally
1.1 Introduction

Pregnancy and the early years are one of the most important stages of the life course as this is when the foundations of a child’s future health and wellbeing are laid down. It is also an important time as this is a period when parents are particularly receptive to learning and making changes.

Brain development occurs shortly after conception and rapidly progresses in the first few years of life. The early synaptic connections form the basis of a person’s lifelong capacity to learn, adapt to change, maintain resilience as well as impact on physical and mental health (UNICEF, 2014). This signifies the importance of the role as parents. In a recent study, it was shown that cognitive stimulation from parents to a child at the age of four was the key factor in predicting the development of several parts of the cortex (Avants et al, 2012).

The lifestyle of the mother before and during pregnancy impacts on the chance of having a healthy child particularly in the first five years. Behaviours and risk factors such as substance misuse, smoking and maternal obesity can profoundly affect the health of an unborn child. In addition parental mental illness has a range of influences, which may impact on child development and behaviour (UNOCINI, 2011-12). Children consider their parents as role models and are more likely to have similar healthy or unhealthy behaviours (Stevens, 2007).

The Marmot review of health inequalities (2010) identified that giving every child the best start in life is crucial for securing health and reducing health inequalities across the life course. The foundations for virtually every aspect of human development whether physical, intellectual or emotional are laid in early childhood. This chapter describes some of the demographic and childhood risk factors which can predict positive life outcomes.

1.2 Descriptive epidemiology

1.2.1 Children in Poverty

The English Indices of Deprivation 2015 have recently been published, which update the 2010 Indices and it shows Sandwell’s average deprivation score has improved since 2010, falling one place to become the 13th most deprived local authority out of a total of 326 (where 1 is the most deprived). Despite the small improvement, this still reflects the high levels of need for children, young people and their families in Sandwell. In 2012 Sandwell was ranked 21st nationally out of 152 local authorities...
with 27.63% of all its dependent children aged under 20 in relative poverty. This equates to 21,830 dependent children aged under 20 and living in poverty.

The proportion of children living in poverty is calculated by HM Revenue & Customs as the proportion of children living in families who receive out of work benefits or tax credits where their reported income is less than 60 per cent median income. Table 1 below shows the proportion of children living in poverty in Sandwell and how this compares regionally.

Table 1: Children in Poverty (under 16s), 2012

<table>
<thead>
<tr>
<th></th>
<th>Sandwell</th>
<th>West Midlands</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children in poverty (under 16 years) (2012)</td>
<td>28.3%</td>
<td>21.9%</td>
<td>19.2%</td>
</tr>
</tbody>
</table>

Source: National Child and Maternal Health Intelligence Network (CHIMAT)

In England, children are eligible to receive free school meals if their parents receive certain benefits. While this relates to school age children, eligibility for free school meals may be used as an indicator of material deprivation, which can be associated with low attainment and low aspirations (Department for Children, Schools and Families, 2009). Sandwell has a higher numbers of eligible families claiming school meals than the regional rate (Table 2).

Table 2: Proportion of Pupils Eligible and Claiming Free School Meals Children, 2014

<table>
<thead>
<tr>
<th></th>
<th>Sandwell</th>
<th>West Midlands</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligible and claiming free school meals (2014)</td>
<td>22.0%</td>
<td>18.6%</td>
<td>16.0%</td>
</tr>
</tbody>
</table>

Source: National Child and Maternal Health Intelligence Network (CHIMAT)

1.2.2 Black and Minority Ethnic groups

Black and minority ethnic groups include all ethnic groups except White British. Sandwell is a multicultural and diverse borough, where just over a third of the population (34.2%) is of Black and Minority Ethnic (BME) origin. This percentage increases for the age group 0-15, where the proportion of children of BME origin rises to almost half (45.6%) (ONS).
1.2.3 Lone Parent families

The Child and Poverty 2014 report into child poverty and social exclusion found that children in lone adult families are at higher risk of poverty, with greatest risk in families with two or three children. Higher levels of mental ill health are also reported among lone parents.

The 2011 Census reported Sandwell to have 13,512 lone parent families. 37.7% of these families (5090) have the youngest dependent child at age 0-4. This is a higher proportion than England (33.7%) and the West Midlands (34.7%) as a region.

1.2.4 Long term illness and disability

The 2011 census has reported Sandwell to have 7,866 homes (6.5%) where an adult has either a long term illness or a disability and has dependent children to look after. Sandwell's proportion of homes with this composition is higher than the average rate for England (4.8%) and the West Midlands (5.4%) as a region. A dependent child is any person aged 0 to 15 in a household (whether or not part of the same family) or a person aged 16 to 18 who has a spouse, partner or child living in the household.

Table 3: Number and % of households in Sandwell, West Midlands and England with a long term health problem or disability and dependent children

<table>
<thead>
<tr>
<th>Area</th>
<th>All households</th>
<th>One person in household with a long-term health problem or disability: With dependent children</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
</tr>
<tr>
<td>Sandwell</td>
<td>121,498</td>
<td>100</td>
</tr>
<tr>
<td>England</td>
<td>18,163,035</td>
<td>100</td>
</tr>
<tr>
<td>West Midlands</td>
<td>1,944,564</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: (Nomis 2011 Census) KS106EW
1.2.5 Smoking

The data for 2015 shows 17.7% of adults in Sandwell were smokers. This is lower than the national average and lower than the prevalence in similar local authorities. However, Sandwell had 338.5 smoking deaths per 100,000 population (aged 35+ standardised rate 2011-13) compared to 288.7 nationally. The prevalence figure is calculated from survey data and therefore we need to explore if this data is robust or if more accurate data is required.

In Sandwell 446 mothers in 2013-14 were identified as still smoking at time of delivery. The prevalence of women who are known smokers at the time of delivery is recorded at 9.7% compared to 12.0% nationally. It is encouraging that this is less than the national figure; however, it is unknown why this is the case. Further work is needed to ensure that data on smoking status at time of delivery is being measured and recorded accurately.

1.2.6 Alcohol Misuse

In the period 2007-2011 there have been fewer than five cases of Foetal Alcohol Syndrome (FAS) diagnosed in children aged between 5-15 and 15-20 years, this indicates under-diagnosed of the syndrome in Sandwell. Population estimates suggest there are 4 children born with FAS in Sandwell each year.

Between 2007-2011 there were 17 A&E admissions for 9 pregnant women with a coding for alcohol use. This represents a group of women who are putting their unborn children at risk from excessive alcohol consumption in pregnancy; one may have resulted in miscarriage (although alcohol may only have been a contributing cause).

1.2.7 Substance Misuse

The Public Health Profile (2015) estimates that there are 10.7 per 1,000 (aged 15-64 years) drug misusers using opiate and /or crack cocaine in Sandwell (2011/12) compared to 8.4 nationally. Local data on people who are engaged in structured treatment programmes for substance misuse identifies that in 2012/13 76 people (21%) were identified as having parental responsibilities and this increased to 110 (26%) in 2013/14. It should be noted that this does not represent the total treatment population, only those actively engaged in structured treatment who started treatment in that financial year.
1.2.8 Obesity

Obesity and being overweight presents a challenge of comparable significance and scale to smoking. It is projected nationally that by 2050, 25% of children will be obese and 30 per cent overweight. In Sandwell, as reported in the National Child Measurement Programme (NCMP) Local Authority Profile data tool, 21.7% of children are classed as overweight or obese at school entry and reception class. The need to work with parents and take a whole family approach to obesity is recommended given that in the main, obese and overweight children have obese and overweight parents. Evidence shows that the majority of overweight or obese children have at least one parent who is obese or overweight.

It is estimated that in 2014 68.6% of adults in Sandwell were obese compared to 64.6% nationally and 66.6% in the West Midlands. Sandwell has significantly lower number of physically active adults (taking part in 150 minutes physical activity per week) 47.1% compared to 57.0% nationally (2014).

The data in Table 4 below is from the NCMP which weighs and measures children in reception (aged 4–5 years) to assess the levels of overweight and obese children. 'Obese' is defined as having a body mass index (BMI) greater than the 95th percentile. 'Overweight' is defined as having a BMI greater than or equal to the 85th percentile but less than the 95th percentile.

<table>
<thead>
<tr>
<th></th>
<th>Sandwell</th>
<th>West Midlands</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overweight or Obese Children (4-5 years) (2014/15)</td>
<td>22.10%</td>
<td>23.10%</td>
<td>21.90%</td>
</tr>
<tr>
<td>Obese children (4-5 years) (2014/15)</td>
<td>11.30%</td>
<td>10.20%</td>
<td>9.10%</td>
</tr>
</tbody>
</table>

Source: National Child Measurement Programme (NCMP) Local Authority Profile
1.2.9 Teenage Pregnancy

The latest figures in 2013 show that Sandwell has 36.6 conceptions per 1,000 women aged less than 18 years. This has reduced in recent years but is still considerably higher than the England average. In England, 24.3 in every 1,000 women less than 18 years became pregnant in 2013 (Table 5).

Table 5: Under 18 conceptions, rate per 1,000 populations

<table>
<thead>
<tr>
<th></th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sandwell</td>
<td>62.7</td>
<td>58.2</td>
<td>56.4</td>
<td>52.7</td>
<td>55.8</td>
<td>46.1</td>
<td>38.5</td>
<td>36.6</td>
</tr>
<tr>
<td>West Midlands</td>
<td>46.3</td>
<td>46.6</td>
<td>43.2</td>
<td>42.1</td>
<td>38.5</td>
<td>34.9</td>
<td>32</td>
<td>28.9</td>
</tr>
<tr>
<td>England</td>
<td>40.6</td>
<td>41.4</td>
<td>39.7</td>
<td>37.1</td>
<td>34.2</td>
<td>30.7</td>
<td>27.7</td>
<td>24.3</td>
</tr>
</tbody>
</table>

Source: Public Health Outcomes Framework (PHOF)
2. Healthy pregnancy

Key Points

- Estimated population of women of childbearing age (15-44 years) in Sandwell stood at 64,552 in 2014
- Sandwell had 10 more births per 1000 women aged 15-44 compared to England in 2014
- Percentage of births to non-UK born mothers in Sandwell has nearly doubled in 13 years
- Post-neonatal mortality per 1,000 live births is consistently higher than that of England
- Only 61% of mothers started breastfeeding in the first 48 hours in 2012-13 compared to 74% nationally
- Last estimate showed that 27% of women giving birth and living in Sandwell had a body mass index of 30+
2.1 Introduction

Maternity services are used by over 700,000 families per year in England (NHS, 2012) and it is the single largest reason for admission to hospital. During pregnancy women are dependent on both primary and secondary care.

Maternity care has had a high political and public profile in recent years with a number of reviews, strategies and guidelines for commissioning services. There is a review into the current service provision that is due to be published at the end of this year.

This chapter compares information nationally and locally to compare the population and factors affecting pregnancy. It maps out services available and the gaps that need to be considered for commissioning of services that are adapted to the population of Sandwell.

2.2 Descriptive Epidemiology

2.2.1 Population of Sandwell

The latest estimate for people living in Sandwell is 316,719. This is the 2014 mid-year estimate produced by the Office for National Statistics (ONS). The estimated population for women of childbearing age (15-44 years) in Sandwell stood at 64,552 in 2014 (ONS).

2.2.2 Live Births

The crude number of live births has increased slightly overall since 2008 in Sandwell, in contrast to the overall increase both regionally and nationally. Table 6 shows the percentage change in the number of live births in Sandwell, West Midlands and England.

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Sandwell</td>
<td>-1.2%</td>
<td>2.1%</td>
<td>3.5%</td>
<td>3.1%</td>
<td>-6.0%</td>
<td>-3.4%</td>
<td>2.3%</td>
<td>0.1%</td>
</tr>
<tr>
<td>West Midlands</td>
<td>-1.0%</td>
<td>1.5%</td>
<td>1.3%</td>
<td>1.3%</td>
<td>-3.7%</td>
<td>-1.5%</td>
<td>-0.5%</td>
<td>-0.9%</td>
</tr>
<tr>
<td>England</td>
<td>-0.3%</td>
<td>2.4%</td>
<td>0.2%</td>
<td>0.9%</td>
<td>-4.3%</td>
<td>-0.5%</td>
<td>0.4%</td>
<td>-1.2%</td>
</tr>
</tbody>
</table>

Source: ONS
Table 7 shows the percentage change between 2015 and 2015, based on live birth projections. This shows a predicted increase in live births for Sandwell; however this is smaller than the predicted regional and national increases. It is important that we recognise this likely increase when planning maternity and child services.

Table 7: Projected Year on Year Percentage Change in Number of Live Births, 2016-2015

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Sandwell</td>
<td>0.00%</td>
<td>2.08%</td>
<td>2.04%</td>
<td>2.08%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>2.08%</td>
</tr>
<tr>
<td>West Midlands</td>
<td>1.13%</td>
<td>0.97%</td>
<td>0.41%</td>
<td>0.41%</td>
<td>0.55%</td>
<td>0.27%</td>
<td>0.27%</td>
<td>0.00%</td>
<td>0.14%</td>
<td>3.94%</td>
</tr>
<tr>
<td>England</td>
<td>1.04%</td>
<td>0.84%</td>
<td>0.60%</td>
<td>0.44%</td>
<td>0.32%</td>
<td>0.27%</td>
<td>0.14%</td>
<td>0.07%</td>
<td>0.20%</td>
<td>3.43%</td>
</tr>
</tbody>
</table>

2.2.3 Maternal age

Table 8 shows the percentage of live births by maternal age from 2012 to 2014. In Sandwell, the highest proportion of live births between 2012 and 2014 were to women aged 25-29 accounting for 32.1% in 2012, 32.5% in 2013 and 33.3% in 2014. The proportion of live births to women under the age of 20 has steadily declined from 6.1% in 2012 to 5.2% in 2014. The proportion of live births to mothers aged 35 to 39 had increased over this period with 11.9% of births in this age group in 2014, births in mothers older than 45 have remained static over this time period.

Table 8: Percentage of live births per maternal age group 2012-2014 in Sandwell

<table>
<thead>
<tr>
<th>Maternal Age (years)</th>
<th>Year</th>
<th>Under 18</th>
<th>Under 20</th>
<th>20-24</th>
<th>25-29</th>
<th>30-34</th>
<th>35-39</th>
<th>40-44</th>
<th>45+</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2012</td>
<td>2.1%</td>
<td>6.1%</td>
<td>23.1%</td>
<td>32.1%</td>
<td>25.7%</td>
<td>10.7%</td>
<td>2.1%</td>
<td>0.2%</td>
</tr>
<tr>
<td></td>
<td>2013</td>
<td>1.9%</td>
<td>6.5%</td>
<td>20.6%</td>
<td>32.5%</td>
<td>26.3%</td>
<td>11.5%</td>
<td>2.4%</td>
<td>0.2%</td>
</tr>
<tr>
<td></td>
<td>2014</td>
<td>1.9%</td>
<td>5.2%</td>
<td>20.5%</td>
<td>33.3%</td>
<td>26.2%</td>
<td>11.9%</td>
<td>2.8%</td>
<td>0.2%</td>
</tr>
</tbody>
</table>

Source: ONS
2.2.4 Maternal country of origin

Public Health England has reported that 60% of Sandwell's increase in births between 2001 and 2012 was contributed by non-UK born women. The number of births to non-UK born mothers increased from 18.3% in 2001 to 29.9% in 2012 to 32% of all births in 2014 compared to 27% across England in the same year (Figure 1).

Figure 1: Percentage of Live Births by birthplace of mother 2014
The chart in Figure 2 shows the proportions of live births in Sandwell in 2014 by birthplace of mother. Of the 1,498 births to non-UK born mothers, 59% (907) were to mothers born in the Middle East and Asia and 21% (318) were to mothers born in the European Union.

**Figure 2: Live Births by Birthplace of Mother, 2014**
2.2.5 Birth weight

Percentages of local live births that are of low birth-weight (figure 3) have been relatively static over the past six years and Sandwell still experiences a higher proportion than the West Midlands and England.

**Figure 3: Percentage of Live Births weighing less than 2500 grams, 2008-2014**
2.2.6 Infant mortality

Sandwell has a higher stillbirth rate than England (Figure 4; 6.5 per 1000 vs. 5 per 1000). Furthermore Post neonatal mortality (defined as deaths between 28 days and 1 year) has been consistently higher than that of England per 1,000 live births (Figure 5).

Figure 4: Stillbirths per 1,000 Total Births in Sandwell, West Midlands and England, 2011-13
Figure 5: Neonatal and Post neonatal Mortality per 1,000 Live Births 2011-13
2.2.7 Breastfeeding

Breastfeeding initiation in Sandwell is improving and in 2012-13 61% of mothers started breastfeeding in the first 48 hours. This is still significantly lower than England at 74% (Figure 6).

**Figure 6: Percentage of Mothers who Breastfed in the First 48 Hours after Delivery, 2010-2013**

Source: PHOF
However the proportion of women in Sandwell continuing to breastfeed at 6-8 weeks has dropped in recent years and continues to be lower than both national and West Midlands rates (Figure 7).

**Figure 7: Percentage of Mothers who were breastfeeding at 6-8 weeks**

2.2.8 Smoking

In 2010-11 approximately 15% of local pregnant women smoked at time of delivery, based on data collected by maternity services. However, comparable data for neighbouring boroughs is much higher (approximately 20% in both Wolverhampton and Walsall), despite having a similar population, which suggests that there may be problems with the data quality.

2.2.9 Obesity

Data collected as part of the Reducing Perinatal Mortality project showed that 27% of women living in the Sandwell PCT area, giving birth in 2007, had a body mass index of greater than 30+ which is obese, and of these 7.9% had a BMI of greater than 35+, which is severely obese (Sandwell PCT, 2011). As this data is not collected routinely we do not have more recent data and we do not know how Sandwell rates compare to other areas.
2.3 National guidelines and recommendations

2.3.1 Maternal age

Pregnancy can be complicated at both extremes of maternal age.

Complications associated with older maternal age include: ectopic pregnancy, gestational trophoblast disease, pre-eclampsia, gestational diabetes, myocardial infarction, cerebrovascular accidents, antepartum and postpartum haemorrhage, increased numbers of operative vaginal deliveries and caesarean sections, venous thromboembolism, increased stillbirth risk. For the foetus there are the following risks: greater risk of Downs syndrome, Intra uterine growth restriction (IUGR) and prematurity.

As a result of this NICE guidelines recommend such women should have consultant led care; those identified as having pre-existing medical conditions should be referred to a specialist as soon as possible. The Down syndrome risk significantly increases in women over the age of 40 (Table 9) and therefore serum and nuchal translucency screening should be offered and invasive testing such as chorionic villous sampling and amniocentesis considered if risk is <1:150. Maternal age greater than 40 is a moderate risk factor for gestational hypertension and so Aspirin 75mg daily from 12 weeks until birth is known to cause a 10% reduction in risk of preterm delivery and pre-eclampsia and should be considered. Women of advanced maternal ages are also recommended to have serial growth scans to look for IUGR and repeatedly assessed for the risk factors of venous thromboembolism.

<table>
<thead>
<tr>
<th>Maternal Age</th>
<th>Downs Syndrome Risk Morris et al 2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>25</td>
<td>1:1350</td>
</tr>
<tr>
<td>30</td>
<td>1:940</td>
</tr>
<tr>
<td>35</td>
<td>1:350</td>
</tr>
<tr>
<td>40</td>
<td>1:85</td>
</tr>
</tbody>
</table>

Sailsbury NHS foundation trust. Antenatal and Intrapartum Care for Women of Advanced Maternal Age.

Young pregnant woman (aged under 20 years) may feel uncomfortable using antenatal services which are mainly used by older age groups. They may have difficulty getting to and from antenatal appointments and may be reluctant to recognise their pregnancy due to fear of parental reactions. Health care professionals should encourage the use of antenatal care services by offering age appropriate services. These include antenatal services in the community, information about transportation to and from appointments, and provision of opportunities for the partner to be involved in care. Health care professionals dealing with these young women should be given training to ensure they are knowledgeable about safeguarding responsibilities for both the young woman and her unborn baby.
2.3.2 Maternal country of origin

Immigrant mothers face additional challenges because they face language difficulties and have a lack of familiarity with care systems which often results in late presentation to maternity services (Small et al, 2014). Depending on country of origin they may also be at increased risk of infectious diseases including HIV and Hepatitis B which may cause birth complications and also be transmitted from mother to baby.

The NICE Guideline ‘Pregnancy and social factors: a model for service provision for pregnant women with complex social factors’ (2010) suggests that pregnant women who are recent migrants, asylum seekers or refugees, or who have difficulty reading or speaking English, may not make full use of antenatal care services. This may be because of unfamiliarity with the health service or because they find it hard to communicate with healthcare staff.

Healthcare professionals should help support these women’s uptake of antenatal care services by:

- Using a variety of means to communicate with women
- Telling women about antenatal care services and how to use them
- Undertaking training in the specific needs of women in these groups.

Commissioners should monitor emergent local needs and plan and adjust services accordingly. Healthcare professionals should ensure they have accurate information about a woman’s current address and contact details by working with local agencies such as asylum centres that provide housing and other services for recent migrant’s asylum seekers and refugees. Sufficient time during appointments should be allocated to allow time for the use of interpretation services. The interpreter should not be a member of the woman’s family and time should be taken to ensure understanding of topics discussed at each stage.

Healthcare providers should receive training on the specific health needs of these women such as needs arising from female genital mutilation, the specific social, religious and psychological needs of women in these groups and the most recent government policies on access and entitlement to care.

2.3.3 Service Mapping

The Royal College of Midwifery recommends a ratio of one midwife per 28 hospital births (RCM, 2007). There were 5,348 deliveries in 2013-14 and 204 full time equivalent registered midwives working in maternity services or Neonatal Nursing (including Special Care Baby Units), therefore a calculated ratio of 26.2 which is below the cited ratio from the Royal College of Midwifery.

The National Nursing Research Unit report, 2011 describes an association between a high ratio of obstetricians to midwives with a lower probability of readmission. The
The publication ‘The Future Role of the Consultant’ (RCOG, 2005) suggests that there should be 40 hours consultant presence per week in a maternity unit with fewer than 5,000 births per annum, increasing to 60 hours consultant presence per week in units with more than 5,000 births per annum. However, the demographic profile of those giving birth in Sandwell (including high proportion of deprived mothers and those from migrant groups) may lead to more birth complications and this should be considered when planning services.

### 2.3.4 Infant Birthweight

On an individual basis, birthweight is a good predictor of health (WHO, 2004). Low birth weight (LBW) contributes to 60-80% of all neonatal deaths (WHO, 2015). The reasons for this include small for gestational age and preterm births. Low birthweight (LBW) is defined as less than 2,500 grams, less than 1,500 grams is defined as very LBW, and less than 1,000 gram is defined as extreme LBW (WHO, 2004).

NICE recommends Symphysis–fundal height should be measured and recorded at each antenatal appointment from 24 weeks.

### 2.3.5 Infant mortality

Causes of stillbirths are often unclear; however, there are known risk factors such as smoking, drinking alcohol, poor antenatal care attendance or being overweight during pregnancy (Ashish et al, 2015). Also older maternal age is associated with stillbirths. These factors should all be addressed during antenatal appointments.

### 2.3.6 Breastfeeding

NICE: Antenatal care for uncomplicated pregnancies (2008) advised at booking or ideally by 10 weeks: pregnant women should be given information and encouragement to attend pelvic floor exercise classes and breastfeeding workshops. At or before 36 weeks: breastfeeding information, including technique and good management practices that would help a woman succeed, such as detailed in the UNICEF Baby Friendly Initiative should be provided.

### 2.3.7 Smoking in Pregnancy

Smoking during pregnancy can cause serious health problems including those during labour and miscarriage, prematurity, stillbirths, low birth weight and sudden death (RCP, 1992).

NICE: Antenatal care for uncomplicated pregnancies 2008 advises that smoking status should be identified at first contact which can be difficult as many women may not want to disclose they smoke for fear of judgement and therefore information should be provided about the risks posed to the unborn child and the hazards of exposure to second hand smoke in a non-judgemental manner. Concerns about stopping smoking should be addressed and information should be personalised.
Encourage pregnant women to use local NHS Stop Smoking Services and the NHS pregnancy smoking helpline, by providing details on when, where and how to access them. Consider visiting pregnant women at home if it is difficult for them to attend specialist services. Smoking status should be monitored throughout pregnancy and advice, encouragement and support to stop smoking should also be available during pregnancy and after delivery.

Discuss the risks and benefits of nicotine replacement therapy (NRT) with pregnant women who smoke, particularly those who do not wish to accept the offer of help from the NHS Stop Smoking Service. If a woman expresses a clear wish to receive NRT, use professional judgement when deciding whether to offer a prescription. Advise women using nicotine patches to remove them before going to bed.

2.3.8 Maternal obesity

The prevalence of obesity in the general population in England is continuing to increase with first trimester maternal obesity doubling from 7.6% to 15.6% over 19 years. There is substantial evidence that obesity in pregnancy contributes to increased complications for mother and baby with increased likelihood of miscarriage, foetal congenital abnormalities, diabetes, pre-eclampsia, complicated labour, postpartum haemorrhage and wound infections (Centre for Maternal & Child Enquiries/ Royal College Obstetricians & Gynaecologists, 2010). There is a higher caesarean section rate and lower breastfeeding rates in obese women compared with those with a normal BMI. The increased levels of complications in pregnancy and labour represent a fivefold increase in the cost of antenatal care.

Joint guidelines were published in 2010 by the Centre for Maternal and Child Enquiries and the Royal College of Obstetricians and Gynaecologists (Centre for Maternal & Child Enquiries/ Royal College of Obstetricians & Gynaecologists, Joint Guidelines: Management of women with Obesity in Pregnancy, 2010.) They have created a number of recommendations. Obese women of childbearing age (BMI ≥30) should be identified in primary care setting, provided with information regarding the risks of obesity in pregnancy and given the opportunity to optimise their weight prior to pregnancy. This can be done through advice on weight loss and lifestyle modifications and regular monitoring of weight, BMI and waist circumference during family planning consultations. These women should also be advised to take 5mg Folic acid daily from at least one month before conception to after the first trimester and 10 micrograms of Vitamin D daily during pregnancy and whilst breastfeeding.

Management of obesity in pregnancy should be integrated into all antenatal clinics, with providers aware of polices and available guidelines. There should be appropriate equipment to measure BMI and this should be regularly monitored at each visit and recorded in handheld notes and electronic notes. These women should be provided with accurate information about the risks of obesity in pregnancy.
and should be given the opportunity to discuss this further and advice should be available on ways to minimise this risk.

Particular increased risks are pre-eclampsia and gestational diabetes which should be investigated for accordingly, it is important to note the appropriate size blood pressure cuff should be used to measure blood pressure to avoid inaccurate readings and the size of this cuff should be recorded in the notes.

Thromboprophylaxis should be considered. RGOG Green Top guideline number 37 advises that:

- A woman with a BMI 30 who also has two or more additional risk factors for thromboembolism should be considered for prophylactic low molecular weight heparin (LMWH) antenatally. This should begin as early in pregnancy as practical.
- All women receiving LMWH antenatally should usually continue prophylactic doses of LMWH until six weeks postpartum, subject to postnatal risk assessment.

The dose should be prescribed according to maternal weight.

Women should be advised to mobilise as soon as is possible following delivery to reduce risk of thromboembolism however women with a BMI of ≥40 should be given post-partum prophylaxis regardless.

Women with a BMI of ≥40 should have an antenatal consultation with an obstetric anaesthetist to ensure potential difficulties such as venous access can be identified; additionally, an anaesthetic management plan for labour and delivery should be discussed and documented in the medical notes. In the third trimester an assessment to determine manual handling requirements and consider tissue viability issues should be undertaken and appropriate arrangements made.

During labour venous access should be established early, there should be continuing midwifery care and the anaesthetist should be aware of the patient. These women are at an increased risk of infection following a caesarean section and so prophylactic antibiotics should be given.

Obesity is associated with low breastfeeding initiation and maintenance rates therefore such women should receive appropriate advice antenatally and postnatally regarding the benefits of initiation and maintenance of breastfeeding. Such women should also continue to have access to information and support regarding weight reduction following pregnancy.
2.4 Current service provision and effectiveness of these services

2.4.1 Maternal age

To address the needs of young mothers the Family Nurse Partnership (FNP) has been introduced in the UK. Nulliparous women aged 19 or under with a confirmed pregnancy were eligible to take part in the programme. The FNP is an intensive home visiting structure developed in the USA and modified for use in the UK. FNP consists of 64 home visits from early pregnancy until the child’s second birthday covering domains of personal and environmental health, life course development, maternal role and access to health and social services with the aims of improving maternal and child outcomes. This programme is in line with the NICE guidelines on young pregnant women however this programme is mainly for vulnerable young women and so not all young pregnant women would receive this programme. Additionally a recent evaluation found the FNP programme not to be cost effective for a number of short-term outcomes including smoking at delivery, birth weight, and immunisation uptake.

2.4.2 Maternal country of origin

There are few specific services aimed at women from different ethnic backgrounds. These women would use existing services where provisions should be made to support them to make the most of these services, whether this involves providing interpreters during consultations or ensuring written information is provided in a language women can understand. Sandwell and West Birmingham Clinical Commissioning Group are currently commissioning a third sector organisation to engage with ethnic minority groups around their use of health services during pregnancy. The results of this work will be used to improve services for expectant mothers for minority ethnic groups.

2.4.3 Service Mapping

Table 10 below compares the number of obstetrics and gynaecology consultants to the number of deliveries and number of midwives in three local hospital trusts that mothers within Sandwell may deliver their babies. Within Sandwell and West Birmingham NHS Trust there are 4 midwives per consultant, which is the fewest amongst the three trusts. However there is the fewest number of births per consultant in this trust.
### Table 10: Ratio of Midwives and Deliveries per consultant at three different trusts

<table>
<thead>
<tr>
<th></th>
<th>Sandwell and West Birmingham Hospitals</th>
<th>The Dudley Group of Hospitals NHS Foundation Trust</th>
<th>Birmingham Women's NHS Foundation Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midwives per Consultant</td>
<td>4</td>
<td>4.7</td>
<td>4.8</td>
</tr>
<tr>
<td>Deliveries per Consultants</td>
<td>104.9</td>
<td>142.6</td>
<td>140.5</td>
</tr>
<tr>
<td>Required Hours Presence on the Ward</td>
<td>60</td>
<td>40</td>
<td>60</td>
</tr>
</tbody>
</table>

Source: Health and Social Care Information Centre

#### 2.4.4 Infant birthweight, infant mortality, smoking in pregnancy

This should form part of the routine antenatal care for women, which requires partnership working as services within the antenatal care pathway are commissioned and delivered by a range of organisations. The family nurse partnership (FNP) provides support to improve lifestyle during pregnancy tailored to young vulnerable first time mothers.

#### 2.4.5 Breastfeeding

Within Sandwell and West Birmingham Hospitals there is an infant feeding team consisting of midwives and support workers that work within the maternity unit to support mothers before and after delivery. There is also a breastfeeding network, which is free to use. Sandwell Borough Council has also introduced support groups in children’s centres to support and educate mothers. Professionals in health and non-healthcare settings have also been trained to support mothers’ breastfeeding. In addition to this Sandwell Metropolitan Borough Council Public Health has commissioned social marketing work to identify barriers to breast feeding, especially for younger white mothers (whose breastfeeding rates are the lowest). Outcomes of this work will be used to inform future strategies to improve breastfeeding rates.

#### 2.4.6 Maternal obesity

Pregnant women who are obese are at a higher risk of complications and so should be identified and offered appropriate support; however, there is currently no specific service provision for maternal obesity. Public Health has commissioned through a new lifestyle contract with Mytime Active a range of lifestyle interventions to prevent and treat overweight and obesity in children and families with a specific package for new parents, in order to help them achieve and maintain a healthy weight. The service has been designed with a ‘person’ (rather than ‘programme’) focus and ethos intended to provide lifestyle packages and interventions which are tailored around individual needs and requirements; this is currently being rolled out throughout the Dudley Group of Hospitals NHS Foundation Trust, Birmingham Women's NHS Foundation Trust, and Sandwell and West Birmingham Hospitals.
borough. A key component within the development of the behaviour change and maintenance pathway, is collaborative working through the Community Activity Network ‘Weight Management Development Officer (WMDO) delivery model’ established by Sandwell Council in order to build an integrated service pathway at a neighbourhood level that addresses any gaps in service provision and meets the needs of local people.

2.5 Consultation with stakeholders

Stakeholder consultation was carried out most recently in June 2015 and included both local authority and NHS commissioning and provider partners. The main themes which came up during this consultation included:

Need for more holistic, joined-up service provisions. It was agreed there were several strengths within the services provided but difficulty in ensuring that individual patients received the most appropriate services for them.

Need to utilise technology including apps to improve access to services and information and advice but also to collect feedback on service quality from patients.

2.6 Priorities over the next year and over the next 5 years

Immediate priority would be to audit current services to ensure they are meeting NICE guidelines. In the longer term, structural changes are needed to deliver more joined up services.

2.7 Recommendations

- Services in Sandwell need to identify risk factors for infant mortality early and intervene. Service commissioners and providers need to be jointly responsible for this. This will be complex as pre-pregnancy, maternity and post-natal services are commissioned and provided by a range of organisations and strong partnership working will be required. The CCG are currently leading on an infant mortality programme to identify gaps in service provision and to work in partnership with other stakeholders to improve services.

- Service providers need to audit the current maternal services to see if they are in line with the NICE guidelines. Although the acute service currently uses tools to audit different parts of the maternity pathway, these tools need to be reviewed in line with NICE recommendations.
• Building upon the universal weight prevention and weight management services being developed and commissioned, there needs to be more targeted packages and programmes focusing upon the needs of women at pre-conception, pregnancy and post-natal stages, and their babies. In addition, opportunities for partnership working towards an integrated obesity service pathway for pregnant and post-natal women at tier 1 (universal) and tier 2 (brief intervention) need to be explored between specialist services across neighbouring boroughs, for example, Sandwell and West Birmingham Hospital, Walsall Manor Hospital, Dudley’s Russells Hall Hospital and weight management providers.

• Breastfeeding – barriers to breast feeding identified thorough social marketing need to be used to inform service provision and health promotion materials. We are currently relying on nation PHOF measures to measure local uptake rates. This means that there is a delay in reporting this data and there have also been issues with the quality of this data in recent years. Maternity services and health visiting need to work in partnership with their commissioners to develop a method of collecting breast feeding data in a robust and timely way.

• There are few specific services targeted at pregnant women from migrant or minority ethnic population. The needs of women in this group should be assessed and services adapted to ensure their needs are being met or new services commissioned to meet these needs.

• Map the current ‘customer journey’ to identify where there may the issues around providing a holistic service and identify points were appropriate referral to services does not exist. Consider a more holistic offer to pregnant patients including physical, mental and emotional support. Explore the feasibility of pooling budgets, sharing data and having common technology to achieve this.

• There is no robust source of data on maternal weight. Maternity services need to work with commissioners to develop a system for collecting this information and reporting in a timely manner.
3. Safeguarding

Key Messages

- Safeguarding is everyone’s business (Adult Safeguarding Resource, 2013)
- Sandwell has 23,939 children aged 0-4 (ONS, Mid-Year Est. 2014)
- 2933 Early Help Assessments were carried out in Sandwell in 2014, of which 760 (335.26 per 10,000) were for 0-4 year olds
- Early help referrals are greater for boys, more from the mixed and ‘other’ ethnic backgrounds and greatest from Princess End, Langley and Tividale with ‘family dysfunction’ being the most common reason for referral
- Under-fives constitute one fifths of the total children in need and 47% of the total child protection cases in Sandwell of which 51.7% are males, 47% are females and 1.3% are unborn children
- 21% of looked after children in Sandwell are under the age of five years
- 40 child deaths were reported to Sandwell Child Death Overview Panel (CDOP) in 2014 to 2015 of which 31 (78%) were in the under-five population and 30% happened within 7 days of birth
- 11 out of 40 (28%) child deaths were unexpected of which 9 (82%) occurred in the under-five population with 36% occurring before the child reached the age of one
- All professionals involved in the care of children have a responsibility to protect children and keep them safe from accidents, neglect and abuse
- A number of services are available such as Multi-Agency Safeguarding Hub (MASH), Family Intervention Service and clear thresholds are identified which is a strength but often poor coordination between services, lack of awareness of the whole model and signposting system and lack of resources have been identified as weaknesses
3.1 Introduction

Safeguarding is everybody's responsibility. It has been defined as:

‘Protecting children from maltreatment, preventing impairment of children’s health or development, ensuring that children are growing up in circumstances consistent with the provision of safe and effective care and taking action to enable all children to have the best outcomes’

(Working Together to Safeguard Children, 2015)

With regards to young children (pre-birth to 5yrs) much of the focus of safeguarding relates to parenting and parental ability to prioritise their child’s needs. All professionals in Sandwell who have direct or indirect contact with children, families and indeed everybody in the local community, have a responsibility to protect young children from undue harm and keep them safe from accidents, neglect and abuse.

Any form of maltreatment whether physical, emotional, sexual or neglect, can have major long term effects on children’s health, development and well-being. The huge costs of abuse and neglect to the individual and society, makes it imperative that all agencies are proactive and work in collaboration to safeguard children.

3.2 Policy

3.2.1 National Policy

The Children Acts 1989 and 2004 and ‘Working Together to Safeguard Children’ 2015 set out the statutory framework and practice guidance for safeguarding children. This includes specific duties in relation to children in need and children suffering or likely to suffer significant harm, under sections 17 and 47 of the Children Act 1989. Local agencies, including the police and health services have a duty under Section 11 of the Children Act 2004 to ensure that the need to safeguard children and promote their welfare is considered, when carrying out their duties and to cooperate with the local authority to promote the welfare of children under section 10 of the same act.

The Children Act 1989 introduced the concept of significant harm as the threshold to justify compulsory intervention in family life in the best interests of children. Local authorities have a duty to make enquiries where it has reasonable reason to suspect that the child is suffering or likely to suffer significant harm.

Effective safeguarding systems adopt a child centred approach. Section 53 of the Children Act 2004 requires local authorities to give due consideration to a child’s wishes in determining services to provide and in making decisions about actions to be taken to protect them.
3.2.2 Local Policy context

Sandwell’s Safeguarding Children’s Board (SSCB) is a statutory board which has been set up as part of ‘Every Child Matters’ government reforms to coordinate local safeguarding work and to ensure the effectiveness of member organisations working individually and together. It has a role in developing inter-agency policies and procedures with regards to actions needed when there are concerns about a child’s safety or welfare; deciding on the threshold for intervention; training, recruitment and supervision of people working with children and to ensure cooperation with neighbouring Children’s Social care authorities and their board partners.

SSBC recognises that children and young people have a number of basic needs that can be supported through a range of universal services. These services include education, early years, health, housing, youth services, leisure facilities and services provided by voluntary organisations. They also recognise that some children have more complex needs and may require access to specialist services to support them.

The ‘windscreen-wiper’ diagram provides an illustrative overview of the levels of need and the intervention that may be required by children/young people and family (figure 8):

Figure 8: Level of need and intervention that may be required by children, young people and their families

Source: Sandwell Safeguarding Children Board (SSCB)
The board has 3 key principles in accessing support for children and families and these are:

1. The intervention should be at the lowest level and meet the child’s needs and prevent the need for more specialist services (through universal provisions).

2. Consideration should always be given to an Early Help assessment and forming a ‘Team around the Family’ (TAF) to resolve the child’s difficulties and prevent the need for a specialist service.

3. If there are child protection concerns (health, development or welfare), professionals must make an immediate referral to Children’s Social Care by completing a multi-agency referral form (MARF).

3.2.3 The framework for the assessment of children in need and their families

The local framework for the Assessment of Children in Need and their Families consists of three domains:

- Child’s developmental needs
- Parenting capacity
- Family & environmental factors

The Framework provides a systematic basis for collecting and analysing information to support professional judgements about how to help children and families in the best interests of the child. Practitioners should use the framework to gain an understanding of a child’s developmental needs; the capacity of parents or caregivers to respond appropriately to those needs, including their capacity to keep the child safe from harm; and the impact of wider family and environmental factors on the parents and child including the complex interplay of factors across all the three domains. Each of these domains are represented by a side of the assessment triangle (Figure 9) and correspond to the three domains used in the Threshold Matrix which are made up of tables that aid in establishing the level of need.
Figure 9: The Framework for the Assessment of Children in Need and their Families

Source: Sandwell Safeguarding Children Board (SSCB)

If a practitioner has concerns about a child and their family's needs they should complete the appropriate assessments which are demonstrated in Figure 10. The Community Operating Group has problem-solving forums consisting of partner agencies to share information and devise action plans.
3.3 Safeguarding Risks

3.3.1 Life chances

Safeguarding risks arise not only due to direct or intentional harm but can be a result of social or economic circumstances, which play a critical role in shaping the life chances of children. The life expectancy at birth varies considerably across the borough, in the period 2007 to 2011, figures indicated a range across wards in Sandwell from 72.9 to 79.7 for males and 77.9 to 85.8 for females.

Factors such as poor nutrition, smoking and substance misuse during pregnancy can have a major impact on birth weight and the health of the child including maternal mental health issues such as postnatal depression (WHO, 2004; RCP, 1992). These issues have been explored in the ‘Healthy Pregnancy’ chapter of this JSNA document.

3.3.2 Compromised care

Factors such as domestic violence, smoking, alcohol and substance misuse, mental health issues and learning disability in parents compromises their ability to care for the children rendering them susceptible to neglect and abuse (Working Together to Safeguard Children, 2013; Action on Smoking and Health, 2014; NHS Choices,
2015; Mattejat, 2008). These factors have been explored in the ‘Parental lifestyles’ chapter of the JSNA.

3.4 Profile of local needs in Sandwell

3.4.1 Early Help referrals

Sandwell has 23,939 children aged 0-4 (ONS, Mid-Year Est. 2014). Some of these children are more vulnerable than others and as a local authority we have a responsibility to identify and intervene in support of their health and wellbeing needs as early as possible.

In total there were 2,933 Early Help Assessments in 2014, of these, 760 (335.26 per 10,000) were for 0-4 year olds. The number of early help referrals by age and ward of residence are presented in Figures 11-14 and referrals by ethnicity is shown in Table 11.

Figure 11: Early Help referrals by age of child per 1,000 Sandwell population, 2014

Source: ONS

Children under the age of one have the highest early help referral rates amongst the 0-4 population in Sandwell. Ward, Brown and Westlake (2012) have also identified that infants under the age of one are more likely than others to be subjects of child protection plans due to physical abuse and more than twice as likely to be subjects of child protection plans due to neglect. They are also the subject of 45% of serious case reviews (following child death or serious incident), as well as being at eight times the average risk of child homicide. 3% of the referrals were for unborn children.
Figure 12: Map showing Early Help referrals by ward of residence in Sandwell
The percentage of early help referrals is greatest from wards such as Princess End followed by Rowley, Tividale and Langley, which are higher than the Sandwell average, shown in Figure 6. This suggests the need for further exploratory analysis to look into the cause for greater numbers of referrals from Princess End versus other similarly deprived areas such as Friars Park, Soho and Victoria and Smethwick, to determine whether the lower number of referrals in these areas is due to lesser need or the need for better recognition and management in these areas.

Table 11: Early help referrals by ethnicity

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>White</th>
<th>Mixed</th>
<th>Asian</th>
<th>Black</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 0-4 Population (2011 Census)</td>
<td>12,783</td>
<td>2,098</td>
<td>5,735</td>
<td>1,584</td>
<td>469</td>
</tr>
<tr>
<td>0-4 Referrals -2014</td>
<td>444</td>
<td>125</td>
<td>105</td>
<td>55</td>
<td>31</td>
</tr>
<tr>
<td>Rate per 1000 children aged 0-4</td>
<td>34.7</td>
<td>59.6</td>
<td>18.3</td>
<td>34.7</td>
<td>66.1</td>
</tr>
</tbody>
</table>

Source: SMBC - The Social Care Performance and Data Team
The referral rate per 1000 is greatest for the ‘Other group’ (66.1) and Mixed Ethnic group (59.6) groups, followed by the white and the black ethnic groups. The referral rate was found to be lowest for the Asian population. As the difference in referral rate is so stark between groups, it is important that we investigate this further to understand if the low referral rate is a reflection of under referral among this group which is masking unmet need.
The primary need for early help referral at all age groups was greatest for family dysfunction (Figure 15), others reasons for referral being abuse and neglect, disability, family in acute stress, low family income, parental illness/disability and socially unacceptable behaviour. A high proportion of referrals in the under one population are due to parental illness or disability as compared to the other year groups in the 0-4 population. This may be a result of better screening and reporting in the antenatal/pregnancy or postpartum period. ‘Family in acute stress’ is another commonly reported reason for referral in the under one population.

3.4.2 Children in Need

Based on the legal definition of ‘children in need’ under Section 17 of the Children Act 1989, a child in need is one who has been assessed by children’s social care to be in need of services and is unlikely to maintain a reasonable standard of health or development and whose health and development is likely to be significantly impaired without the provision of services by a local authority. This includes children who have a substantial or permanent disability.
The children in need per 10,000 children at year end, excluding child protection cases and looked after children, for Sandwell, West Midlands and England are presented in Figure 16.

**Figure 16: Children in need per 10,000 population**

Sandwell shows a decreasing trend in the proportion of children in need (CIN) per 10,000 population, with a high proportion in 2010-2011 and falling below the West Midlands and England rates beyond 2012. This fall in the proportion of CIN should be regarded with caution as it is important to determine that the children in need in the 0-4 population in the community are being adequately recognised and managed appropriately. It is unlikely that the proportion of children in need is going down in Sandwell while it goes up both regionally and nationally. Therefore it is important that we investigate this further, look for possible explanations to this rapid decline and consider any implications for this.

As of 21st April 2015, 938 open CIN cases were allocated to a team or individual worker. This number has increased from 789 on 22nd January 2015 (18.8% increase).

Of the 938 children, 21% of children were under the age of five years. In both the under one and one to four age groups the percentage in Sandwell is less than that nationally.
Table 12: Age Breakdown of Children in Need - as at 21/4/2015 (excluding LAC and CP Cases) with an open referral on ICS

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Total</th>
<th>Percentage</th>
<th>CIN Census England Average 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 1</td>
<td>42</td>
<td>4%</td>
<td>6%</td>
</tr>
<tr>
<td>1 to 4</td>
<td>156</td>
<td>17%</td>
<td>21%</td>
</tr>
<tr>
<td>5 to 9</td>
<td>239</td>
<td>25%</td>
<td>24%</td>
</tr>
<tr>
<td>10 to 15</td>
<td>238</td>
<td>25%</td>
<td>30%</td>
</tr>
<tr>
<td>16 +</td>
<td>238</td>
<td>25%</td>
<td>18%</td>
</tr>
<tr>
<td>Not recorded or unborn</td>
<td>25</td>
<td>3%</td>
<td>2%</td>
</tr>
<tr>
<td>Total</td>
<td>938</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: SMBC - The Social Care Performance and Data Team

The proportion of Children in need is greatest in ‘Other’ ethnic backgrounds (3.2%) and Black or Black British population (2.4%) see Table 13.

Table 13: Ethnic Group Breakdown of Children in Need - as at 21/4/2015 (excluding LAC and CP Cases) with an open referral on ICS

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Total</th>
<th>CIN Proportion of Ethnic Group (2011 Census)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian or Asian British</td>
<td>138</td>
<td>0.80%</td>
</tr>
<tr>
<td>Black or Black British</td>
<td>126</td>
<td>2.40%</td>
</tr>
<tr>
<td>Mixed</td>
<td>112</td>
<td>1.90%</td>
</tr>
<tr>
<td>White</td>
<td>466</td>
<td>1.10%</td>
</tr>
<tr>
<td>Other ethnic background</td>
<td>43</td>
<td>3.20%</td>
</tr>
<tr>
<td>Declined to specify</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Not recorded/ information not obtained</td>
<td>52</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>938</td>
<td></td>
</tr>
</tbody>
</table>

Source: SMBC - The Social Care Performance and Data Team
3.4.3 Child Protection Plan

Sandwell had a higher proportion of children on a protection plan compared to West Midlands and England between 2013-14. Figure 17 demonstrates the annual number of children per 10,000 on a protection plan from 2010 to 2015. There was a sharp rise in the proportion of child protection plans in 2012-2014 followed by a sharp fall from 2014 to 2015.

Figure 17: Child protection plans for Sandwell

The percentage of child protection plans by age is presented in Figure 18. The 0-4 population accounts for 47% of the total child protection cases in Sandwell of which 51.7% are males, 47% are females and 1.3% are unborn children.
Table 14: Child protection plans for 0-4s by gender

<table>
<thead>
<tr>
<th>Child Protection Plans</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>CP Cases aged 0-4 - Number of Cases 0-4 Years (% of All Cases)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number (% of All Cases)</td>
<td>135 (41.8%)</td>
<td>151 (39.2%)</td>
<td>151 (47.0%)</td>
</tr>
<tr>
<td>CP Cases aged 0-4 by sex - Number of Cases 0-4 Years (% of All 0-4 Cases)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Females</td>
<td>69 (51.1%)</td>
<td>74 (49.0%)</td>
<td>71 (47.0%)</td>
</tr>
<tr>
<td>Males</td>
<td>61 (45.2%)</td>
<td>67 (44.4%)</td>
<td>78 (51.7%)</td>
</tr>
<tr>
<td>Unborn</td>
<td>5 (3.7%)</td>
<td>10 (6.6%)</td>
<td>2 (1.3%)</td>
</tr>
</tbody>
</table>

Source: SMBC, Social Care Performance and Data Team
Table 15: Ethnic breakdown of Child Protection Cases aged 0-4

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Rate per 1,000 Population of the ethnic population (Aged 0-4)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2012/13</td>
</tr>
<tr>
<td>White</td>
<td>6.3</td>
</tr>
<tr>
<td>Asian or Asian British</td>
<td>3.0</td>
</tr>
<tr>
<td>Mixed Ethnicity</td>
<td>12.4</td>
</tr>
<tr>
<td>Black or Black British</td>
<td>4.4</td>
</tr>
<tr>
<td>Other</td>
<td>8.5</td>
</tr>
<tr>
<td>Total</td>
<td>6.0</td>
</tr>
</tbody>
</table>

Source: SMBC, The Social Care Performance and Data Team

Table 14 shows percentage of Child Protection Cases which are for children 0-4 years and the proportion of these which are male, female and unborn. Table 15 shows the number of cases per 1,000 population for each ethnic group. This table shows that the number of cases are highest among children of mixed ethnicity and lowest among Asian children. Further investigation is required to determine if this is a true reflection of need or represents under-referral from specific ethnic groups.

3.4.4 Looked after children

Sandwell has 54 per 10,000 looked after children (LAC) under the age of one and 57 per 10,000 children between the age of one and four years. Compared to the West Midlands and England, Sandwell has a lower proportion of LAC in the less than 1 age group. For the 1-4 year olds, Sandwell is comparable to West Midlands but has higher proportion of children than England. This data is presented in Table 16. LAC in other age groups are higher than the West Midlands or England average which may reflect a delay children becoming looked after in Sandwell.
Table 16: Looked After Children (31 March 2014) Age Breakdown

<table>
<thead>
<tr>
<th></th>
<th>Aged Under 1</th>
<th></th>
<th>Aged 1 to 4</th>
<th></th>
<th>Aged 5 to 17</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Persons</td>
<td>Rate 10,000</td>
<td>Persons</td>
<td>Rate 10,000</td>
<td>Persons</td>
<td>Rate 10,000</td>
</tr>
<tr>
<td>Sandwell</td>
<td>25</td>
<td>54</td>
<td>110</td>
<td>57</td>
<td>440</td>
<td>81.8</td>
</tr>
<tr>
<td>West Midlands</td>
<td>520</td>
<td>73.3</td>
<td>1,680</td>
<td>57.2</td>
<td>6,920</td>
<td>77.6</td>
</tr>
<tr>
<td>England</td>
<td>3,880</td>
<td>58.4</td>
<td>11,440</td>
<td>41.3</td>
<td>53,520</td>
<td>65.6</td>
</tr>
</tbody>
</table>

Source: SMBC, Social Care Performance and Data Team

The under-fives constitute 21% of the looked after children in Sandwell. Table 18 presents the age composition of the looked after children from 2010 up to 2015. The percentage of under 1s has increased from none in 2012 to 6% in 2015. This trend is likely to be a result of early recognition and management of safeguarding needs in this population. The percentage of children in the over 16 age group has decreased over the years. It is evident that data collection and documentation has improved with none in the 'not recorded' category for age since 2012.
Figure 18: Looked After Children by age

Source: SMBC, Social Care Performance and Data Team

One fifth of looked after children in Sandwell are under the age of five years with the proportion of girls slightly higher than boys (Table 17).

Table 17: Looked after children (LAC) by gender and ethnicity

<table>
<thead>
<tr>
<th>Looked After Children</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>LAC Cases aged 0-4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number (% of All Cases)</td>
<td>166 (27.4%)</td>
<td>136 (23.4%)</td>
<td>107 (20.1%)</td>
</tr>
<tr>
<td>LAC Cases aged 0-4 by sex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Females</td>
<td>74 (44.6%)</td>
<td>67 (49.3%)</td>
<td>54 (50.5%)</td>
</tr>
<tr>
<td>Males</td>
<td>92 (55.4%)</td>
<td>69 (50.7%)</td>
<td>53 (49.5%)</td>
</tr>
</tbody>
</table>

Source: SMBC, Social Care Performance and Data Team
Table 18 shows mixed ethnicity children have the highest rate of LAC and Asian the lowest. We need to understand if this is a true reflection of need within these ethnic groups or if there is evidence of under reporting within specific groups.

Table 18: Ethnic Group Breakdown of Looked After Children aged 0-4

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Rate per 1,000 Population of ethnic group (aged 0-4)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2012/13</td>
</tr>
<tr>
<td>White</td>
<td>8.6</td>
</tr>
<tr>
<td>Asian or Asian British</td>
<td>1.7</td>
</tr>
<tr>
<td>Mixed Ethnicity</td>
<td>13.8</td>
</tr>
<tr>
<td>Black or Black British</td>
<td>5.1</td>
</tr>
<tr>
<td>Other</td>
<td>19.2</td>
</tr>
<tr>
<td>Ethnicity Not Recorded</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>7.3</strong></td>
</tr>
</tbody>
</table>

Source: SMBC, The Social Care Performance and Data Team

3.4.5 Child Deaths

There were 40 child deaths reported to Sandwell Child Death Overview Panel (CDOP) in 2014 to 2015. 11 of these were deemed as unexpected. An unexpected child death is defined as ‘the death of an infant or child which was not anticipated as a significant possibility, for example, 24 hours before the death, or where there was an unexpected collapse or incident leading to or precipitating the events which lead to the death’, (Working Together 2015, Chapter 5 guidance).
In 2014/15, 78% of all Sandwell child deaths occurred within the first four years of life, accounting for 31 of 40 deaths reported and 30% of all child deaths happened within 7 days of birth.

### 3.4.6 Unexpected Deaths

The 11 deaths classified as unexpected accounted for 28% of all Sandwell child deaths in 2014/15. In this year, the majority of unexpected deaths occurred in children aged 1 year and over (64%) compared to all child deaths where the majority occurred in children before the age of 1 (63%).

The Child Death Overview Panel (CDOP) Annual report 2014/15 states that, ‘In the 3 deaths that occurred between the ages of 1 month and 1 year, co-sleeping with an adult and other children, was considered a significant factor’. There was no pattern identified in the deaths in the 1-4 year age group.
3.4.7 Modifiable Factors

It is a primary function of CDOP to identify areas of practice, both operationally and strategically, to be developed as a result of reviewing child deaths. Within the 29 child deaths reviewed during 2014/15, 7 were identified as having modifiable factors by the CDOP panel members. Advice given with the aim of preventing similar deaths included; access to suicide and self-harm support for young people, death following a medical/ surgical procedure, maternal smoking, maternal alcohol misuse and suicide following possible exposure to child sexual exploitation.

3.5 Current service provision

Consultation with key professional stakeholders helped to identify the key services at the universal, universal plus, targeted and specialist levels and categorised them into the following areas:

- Being safe
- Being healthy
- Enjoying and achieving
- Making a positive contribution
- Economic wellbeing
Further consultation was conducted to identify the strengths, weaknesses, areas of opportunity and potential threats to services area which support 0-4 safeguarding. This is presented in table 19 below.

**Table 19: SWOT analysis of Safeguarding services in Sandwell**

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Presence of MASH (Multiagency safeguarding Hub)</td>
<td>• Awareness by each service within the model of whole model</td>
</tr>
<tr>
<td>• Thresholds clear – know where the documents are and how to use them</td>
<td>• Poorly co-ordinated services</td>
</tr>
<tr>
<td>• Locality model- well understood</td>
<td>• Shrinking of resources for direct delivery of services</td>
</tr>
<tr>
<td>• A lot of services in place and available</td>
<td>• No good sign posting system</td>
</tr>
<tr>
<td>• Family information service</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Opportunities</th>
<th>Threats</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Better use of midwifery &amp; Health Visitor to provide information on services &amp; Children’s Centres</td>
<td>• Continued funding cuts make it difficult to explore more integrated delivery options</td>
</tr>
<tr>
<td>• Specialist? Domestic violence advisors – make contact with lower risk clients – could use to make more general information “every contact counts”</td>
<td>• Negative Ofsted reports resulting in staff being cautious of new ways of working</td>
</tr>
<tr>
<td>• Enhance information given to families in contact with general practice – resource dependent</td>
<td>• Negative perception of the aims of safeguarding and lack of articulation of the benefits of early intervention</td>
</tr>
<tr>
<td>• Multi agency training “signs of safety”</td>
<td>• Silo working between organisations</td>
</tr>
<tr>
<td></td>
<td>• Culture of over-referral fuelled by negative reports and high profile cases</td>
</tr>
<tr>
<td></td>
<td>• Recent increasing focus on Child Sexual Exploitation means resources are diverted from younger children’s safeguarding</td>
</tr>
</tbody>
</table>
3.6 Gaps

Frontline knowledge and gathering of intelligence at a grass root level were identified as areas for improvement. Training of frontline staff outside of children’s services was suggested to provide a better ‘filter’ before MARF. It was felt to be important that all staff know their service area and local parks to be safe. Service provision during holidays was suggested. It was thought that post-asylum and transient economic migrants were not adequately engaged in services. The need for specialist services post adoption was mentioned. A gap in the services for children in older age groups (primary school age), young girls and other cultural groups e.g. Eastern Europeans was recognised. The need for better information sharing between existing services was emphasized.

3.7 Recommendations

The following priorities have been identified for 0-4 population in Sandwell:

- Effective early identification of families with young children who may be at risk of neglect and harm – especially where a combination of risk factors are identified. This will require agencies to work in partnership and develop processes for intelligence sharing to identify vulnerable children. The Children’s Joint Commissioning Partnership should consider how commissioned services can focus more on prevention and early identification and intervention going forward.

- The effective application of referral thresholds by all agencies. There is anecdotal evidence that the recent decline in numbers of Children in Need is a result of more cautious referral. A consistent approach between agencies is required to ensure that all at risk children are identified and referred. The Children’s Safeguarding Board should lead on implementing this approach.

- Sandwell Council Children’s Social Care Performance and Data team should further investigate possible explanations for the low rate of referral in some ethnic groups to identify evidence of unmet need in these groups.

- Sandwell Council Children’s Services should review policies to identify possible reasons for the recent decline in referral rates and understand possible implications of this.

- Disseminating and implementing ‘Lessons from Serious Case Reviews regarding babies and young children’ to all relevant stakeholders.

- Providing accessible and culturally sensitive services in localities to meet key needs, such as mental health, domestic abuse, drugs, child poverty and
housing. This will include working with commissioners and providers of these services to ensure that appropriate safeguarding measures are in place.

- To broaden “Every Contact Counts” across services to cover Safeguarding for all front line staff and also raise staff awareness of available services.

- Safeguarding Board to roll out shared approach to working with families (“signs of safety”)

- Use the existing localities model to further integrate services for families.

- Using an asset based approach – building on locality model to identify existing resources in the community which could support safe parenting and to refer to appropriate services if a Safeguarding issue is suspected. This may include, for example, the development of peer mentoring for parents.

- Identify and engage with voluntary and community organisations serving groups who currently don’t engage with children’s services and work to tailor services to these groups.

- Raise awareness of services available (for example Family Information Services, Early Help Service) to all relevant professional groups to facilitate improved signposting. Moving forward the Children’s Commissioning Partnership should consider where greater alignment of services to provide more holistic support for families is appropriate.
4. School Readiness

Key points

- In Sandwell just over a half of children reached a good level of development by the age of five. Girls continue to outperform boys, and the performance of white pupils is not improving at the same rate as other ethnic groups.

- Initial results of the Making it REAL (Raising Early Achievement in Literacy) project are very encouraging. Sandwell will need to consider how the good practice from the project is cascaded and embedded across the borough.

- The Wellcomm screening tool is used to assess children’s speech and language development. Almost a third of Sandwell children have made ‘no progress’ in 2013/2014, which is a major concern.

- Over a quarter of early years providers inspected in Sandwell were judged by Ofsted to be inadequate or require improvement. However, the quality of Children’s Centres in the borough is much higher.

- The take-up rates for Nursery Education Funding (for 3 & 4 year olds) is generally high in Sandwell, however some wards have take-up of less than 80%. The take-up of Early Learning for Twos is growing, but again there is variation by ward, with some areas having a take-up rate below 30%.
4.1 Introduction

The quality of a child’s early experience determines their future success in life. It is shaped by many factors such as the effects of socio-economic status, impact of high quality early education and care and influence of ‘good parenting’. High-quality early education is crucial in countering the effects of socio-economic disadvantage. Working in partnership with parents and carers can help to develop the home learning environment to improve the child’s progress and help them make a better start at school (Ofsted, 2014).

It is important that at the age of five, children are ready to start school life. Children living in poverty generally perform poorly in school and have lower educational attainment. The longer those children live in poverty, the greater their academic deficits. This persists into adulthood contributing to lifetime reduced occupational attainment (Hair et al, 2015). For many children, especially those living in the more deprived areas such as Sandwell, educational failure can start early. There are strong associations between a child’s social background and their readiness for school as measured by their scores on entry into year one. Very young children require healthy learning and exploration for optimal brain development. Unfortunately, in impoverished families there tends to be a higher prevalence of such adverse factors as teen motherhood, depression, and inadequate health care, all of which lead to decreased sensitivity toward the infant and, later, poor school performance and behaviour on the child’s part (Jenson, 2009). Poverty can also present as a chronic stress for children and families which is likely to interfere with successful adjustment to developmental tasks, including school achievement. Children raised in low-income families are at risk for academic and social problems as well as poor health and well-being, which can in turn undermine educational achievement (Engle, Black, 2000).

Education attainment is one of the main markers for wellbeing through the life course and so it is important that no child is left behind at the beginning of their school life. Public Health England (PHE) has made ensuring every child has the best start to life by being ‘ready’ to learn at two and ‘ready for school’ at five, one of the organisation’s seven national priorities (Public Health England, 2015).

The Ofsted document reports that there is no nationally agreed definition for the term ‘school readiness’. However, as part of the work for the JSNA, consultation sessions were undertaken in November 2014 with both children’s centre managers and managers from the private and voluntary day care sector in Sandwell, to gather their perspective on school readiness. It was agreed that ‘school readiness’:

- Is a process which starts from birth
- Covers the time before a child starts at reception class in school
- Must involve parents
• Prepares children to be emotionally ready for school e.g. being separated from their main carer
• Prepares parents for the transition process
• Ensures children have sufficient language to communicate
• Ensures children have experience of play with their peers
• Ensures children show a degree of independence e.g. toilet trained; able to dress themselves
• Ensures children are able to hold a pencil

This chapter looks at information locally and nationally to compare the population and factors affecting school readiness. This chapter will map out current services available and audit the effectiveness of these services against national guidelines and recommendations; identifying gaps in service provision and providing recommendations to fill these gaps.

4.2 Descriptive epidemiology

Too many children start school without the range of skills they need. Across the country in 2014 only 60% of all children reached a good level of development by the age of five based on the Early Years Foundation Stage (Dept. for Education, 2014). In Sandwell just over a half of children reached this level, furthermore children in Sandwell eligible for free school meals lagged 10 percentage points behind their peers. This gap has not altered significantly in the last four years and has serious implications for further development; very few of those who start of behind their peers catch up by the time they leave education (Dept. for Education, 2014).

4.2.1 Speech and Language

The Wellcomm speech and language screening tool (developed within the borough) is used to assess children’s speech and language development. Completion of the tool enables the assessor to grade as red, amber or green. Assessors can use the associated ‘book of ideas’ to tailor support for individual children and where appropriate, they can assist parents with making a referral to the Speech and Language Therapy service. Early Years Practitioners are asked to use the tool both at the beginning and end of the academic year for 3 and 4 year olds.

Figure 21 shows the results of this exercise for all settings in Sandwell in 2013/14; there was an average of 33% of children making no progress, which was particularly high in Newton, Greets Green & Lyng and Oldbury wards.
4.2.2 Child development

Early Years Foundation Stage was introduced in September 2012 and it is completed in the summer term of children’s reception year at school. Teachers make best-fit assessment of whether children are emerging, expecting or exceeding against 17 early learning goals. Children are deemed to have a good level of development if they achieve the expected level in the prime areas of personal, social and emotional development; physical development; and communication and language and the specific areas of literacy and mathematics.

Sandwell has lower percentage points for each of the key indicators compared to nationally. Girls outperform in each of the categories which mirrors national trends. The total average points score for all children in Sandwell was 31.7 compared to 33.8 nationally. The gap between the bottom 20% and the rest has narrowed from 36.6% (2013) to 33.9% nationally but remains unchanged with a slight increase of 0.6% (from 39.4% to 40.0%) in Sandwell.
### Table 20: Percentage points for Early Years Foundation Stage Key Indicators in Sandwell and in England, 2014

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Sandwell (%)</th>
<th>England (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Achieving a Good Level of Development</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boys</td>
<td>45</td>
<td>52</td>
</tr>
<tr>
<td>Girls</td>
<td>63</td>
<td>69</td>
</tr>
<tr>
<td>All</td>
<td>54</td>
<td>60</td>
</tr>
<tr>
<td>% Achieving Prime Areas</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boys</td>
<td>58</td>
<td>65</td>
</tr>
<tr>
<td>Girls</td>
<td>75</td>
<td>80</td>
</tr>
<tr>
<td>All</td>
<td>66</td>
<td>72</td>
</tr>
<tr>
<td>% Achieving Specific Areas of Learning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boys</td>
<td>42</td>
<td>53</td>
</tr>
<tr>
<td>Girls</td>
<td>60</td>
<td>69</td>
</tr>
<tr>
<td>All</td>
<td>51</td>
<td>60</td>
</tr>
<tr>
<td>Average Points Score</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boys</td>
<td>30.2</td>
<td>32.6</td>
</tr>
<tr>
<td>Girls</td>
<td>33.2</td>
<td>35.1</td>
</tr>
<tr>
<td>All</td>
<td>31.7</td>
<td>33.8</td>
</tr>
<tr>
<td>% Gap between bottom 20% and the rest</td>
<td>40</td>
<td>33.9</td>
</tr>
</tbody>
</table>

The proportion of children achieving a good level of development is up by 8 percentage points nationally, from 52% last year to 60% with a similar increase noted for Sandwell, from 46% in 2013 to 54% in 2014. There has been an increase in the proportion of pupils achieving a good level of development from 2013 to 2014 in all ethnic groups, with the exception of the Chinese pupils. However, the performance of White pupils has not improved as much as that of Mixed, Asian or Black pupils in Sandwell.
Table 21: Percentage achieving a good level of development by gender and ethnicity 2013 and 2014

<table>
<thead>
<tr>
<th></th>
<th>Sandwell (%)</th>
<th>England (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2013</td>
<td>2014</td>
</tr>
<tr>
<td>Boys</td>
<td>40</td>
<td>45</td>
</tr>
<tr>
<td>Girls</td>
<td>58</td>
<td>63</td>
</tr>
<tr>
<td>White</td>
<td>47</td>
<td>54</td>
</tr>
<tr>
<td>Mixed</td>
<td>50</td>
<td>60</td>
</tr>
<tr>
<td>Asian</td>
<td>45</td>
<td>55</td>
</tr>
<tr>
<td>Black</td>
<td>48</td>
<td>58</td>
</tr>
<tr>
<td>Chinese</td>
<td>22</td>
<td>17</td>
</tr>
<tr>
<td>All</td>
<td>46</td>
<td>54</td>
</tr>
</tbody>
</table>

4.3 National guidelines and recommendations

Several surveys have been undertaken in this area; the Are you ready? Good practice in school readiness (Ofsted, 2014) survey aimed to establish how the most successful Early Years providers ensure disadvantaged and vulnerable children were better prepared to start school. The key findings were:

- Where providers have developed close partnerships with other agencies, they were more likely to have developed a localised mutual understanding of what was expected in terms of children’s readiness at the time of transfer.
- Evidence of good practice in engaging parents and carers was seen mainly through children’s centres, which worked with other agencies to engage vulnerable parents and target support where it was most needed.
- Good practice in disadvantages areas, where providers worked closely with parents in the transition period e.g. increasing parents understanding of what was expected and providing information and guidance.
- There were a significant number of children with learning and development delay. Three main areas identified were social and emotional development, physical development and communication.
- Importance of specific programmes of support in helping children to develop their speaking, listening and communication skills.
• Positive impact on children’s communication development when staff spoke clearly and understood the importance of promoting opportunities for children to speak in sentences and initiate questions.
• Benefit of adult-led sessions with small groups of children.
• Schools using Pupil Premium funding to ensure early identification and specialist support from their starting points.
• Accurate assessments being completed and joint work between providers and schools to ensure accuracy of those baseline assessments.
• Taking a broad view of issues in the locality and taking action accordingly.

The Best practice for a Sure Start (All Party Parliamentary Sure Start Group, 2013) proposed key recommendations on supporting parental engagement in children’s learning which included encouraging centre staff to support and facilitate parents to play with their babies and children in ways that encourage their development—emphasising the benefits of talking to children and affectionate praise; the promotion of local singing and story sessions for parents with their young children and babies and in antenatal and post-natal groups encouraging parents to speak to their baby and also encouraging fathers to have an active role in their child’s life.

The Effective Pre-school, Primary and Secondary Education (EPPSE) Research (Sylva, K., Melhuish, E., Sammons, P., Siraj-Blatchford, I., Taggart, B., 2014) highlighted the importance of pre-school experience in enhancing all-round development in children particularly if the child attend pre-school when less than three years of age. Full time attendance at pre-school compared to part time offered no advantages and this effect was significant in disadvantaged children. Centres that have staff with higher qualifications have higher quality scores and children that attend these centres make more progress. The quality of the home learning environment is more important for intellectual and social development of the child rather than parental occupation, education or income.

Conception to age two – the age of opportunity (Wave Trust, 2013) report emphasised the importance of this phase. The early years are when language is being acquired, children begin to recognise sounds and associate them with objects and ideas within 6 months of birth and therefore it is important to provide an environment rich in spoken language. Furthermore language development at age two is strongly associated with later school readiness. The early communication environment in the home provides the strongest influence on language at age two – stronger than social background.
4.4 Current service provision and effectiveness of these services

4.4.1 Literacy

Libraries are a key service in engaging parents and children with early literacy. Sandwell's network of 19 community libraries co-ordinate the 'Book Start' programme:

- A baby pack is distributed by the Health Visiting service to encourage early literacy and reinforce the view that it is never too early to start reading to children. A Treasure Bag is then distributed to three and four year olds through schools.
- The Bookstart schemes have been very successful in reaching families, achieving a 100% gifted target last year for both packs.
- The ‘Booktastic’ scheme was launched in October 2014. This provides universal library membership for all reception children in Sandwell schools.

Figure 22 provides an analysis of library membership over a 12 month period. This shows active members (defined as a child who has a minimum of two withdrawals in a 12 month period) aged under 5 by ward, based on home address. However the library service did note that many parents of young children will take out books for their children on their own membership rather than their children’s. The lowest levels of active library membership amongst the under 5s are in the wards of Soho & Victoria, Greets Green & Lyng and Oldbury. These wards are among the lowest in Sandwell on child development (EYFSP scores 2011/12). The highest levels of active library membership amongst the under 5s are in the wards of Abbey and Friar Park. These wards are among the highest in Sandwell on child development (EYFSP scores 2011/12).
Making it REAL (Raising Early Achievement in Literacy) is an evidence-based family literacy intervention for 2-5 year olds. The Making it REAL training and projects are designed to enable practitioners to use the REAL evidence-based approach that reaches out to parents and families, building confidence and knowledge to support the early home learning environment; this has been shown to have a powerful impact on children's outcomes and on family literacy practice. Sandwell is one of eight local authority development projects working with National Children’s Bureau (NCB) Early Childhood Unit as part of a DfE National Prospectus Grant.

The NCB Research Centre first year evaluation of REAL local authority development projects was published in August 2014. The report showed positive outcomes across the board with Sandwell figures at the upper end of performance indicators as shown in table 4. Additionally parents reported greater understanding and confidence in their role as early educators with 89% of parents indicating they now carry out new activities at home to help their children learn.
Table 22: Results of the REAL Project 2014

<table>
<thead>
<tr>
<th>Outcome measure</th>
<th>Total National Project results</th>
<th>Sandwell results</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre</td>
<td>Post</td>
</tr>
<tr>
<td>Oral language (to know one or two nursery rhymes)</td>
<td>24%</td>
<td>61%</td>
</tr>
<tr>
<td>Share books</td>
<td>43%</td>
<td>74%</td>
</tr>
<tr>
<td>Drawing and mark making</td>
<td>38%</td>
<td>69%</td>
</tr>
<tr>
<td>Identifies more than two words/letters/logos</td>
<td>6%</td>
<td>35%</td>
</tr>
</tbody>
</table>

4.4.2 Child Care Provision

Childcare in Sandwell is delivered by a range of provider types and is a mixture of local authority-funded and self-funded provision. All three and four year olds are entitled to 570 hours of free early education and childcare (NEF) a year. Early Learning for two year olds (ELT) has been recently introduced and is targeted at the most disadvantaged families (those on specific benefits and with an income below a certain level, or where children are looked after by the local authority).

The child minding sector is reasonably stable however only providers who have received a good or outstanding OFSTED rating are eligible to provide local authority-funded provision. There are a total of 160 child-minders in the borough, approximately 30% of these offer ELT places. A range of local authority support is given to child minders who have received a less than good OFTED rating.

There continues to be an ever growing private and voluntary childcare sector in the borough. Virtually all of this provision offers both NEF and ELT places. 93% of these settings have achieved a good or outstanding OFSTED rating.

The majority of primary schools in the borough have provision for NEF and a small number (2) have begun to offer places for ELT. The number of schools offering ELT in the borough is expected to raise in the future.

There is a network of 20 locality children’s centres across the borough together with a specific Children’s Centre for Young Parents. Centres work primarily with children under 5 years of age and their families - their core purpose is to improve outcomes for young children and their families and reduce inequalities between families in the greatest need and their peers. Ofsted inspection of children’s centres found 89% of settings good or outstanding which is significantly higher than the national level.
In addition to childcare provision many local authority, private and voluntary sector providers offer parent and toddler or stay and play sessions. This aspect of the early years sector is not required to be registered with Ofsted as the children are not left in the care of other people. It is therefore more difficult to maintain accurate records of provision. Local children’s centres offer support to these groups as part of the universal services available in the area.

4.4.3 Service uptake

The take-up rates for NEF at 97% (DfE LAIT Jan 2015) are good and are just above the national average. This indicates that the concept of nursery education for three and four year olds is well-embedded across the borough. The wards with the lowest level of take-up are St. Pauls and Smethwick.

Figure 23: Take up rates of NEF for 3-4 year olds in Sandwell by ward

Source: Sandwell Family Information Service
Early Learning for two year olds (ELT) has been recently introduced and is targeted by government at the most disadvantaged families (those on specific benefits and with an income below a certain level, or where children are looked after by the local authority). The take-up for ELT in the borough has continued to grow. In April 2014, 716 children were taking up places and this had grown to 1209 by December 2014. The numbers eligible for places in December 2014 was 2792 children (a take-up rate of 43.3%). The figures presented in Table 8 exclude children taking up their ELT out of the borough. The wards with the lowest levels of take-up (less than 30%) are Great Barr with Yew Tree, Newton and Greets Green & Lyng.

Figure 24: Take up of Early Learning for Two's (ELT) funding in ward by Sandwell

Source: Sandwell Family Information Service
4.5 Consultation with Stakeholders

Current services were analysed during the multi-agency JSNA workshop in June 2015.

**Strengths:**

- Good universal support for parents and children
- Multiagency approach/more partnership working
- Passion to get things right
- Visibility of services – local services
- Greater understanding of families’ needs
- Common goal in improving the situation before children start school

**Weaknesses:**

- Not consistent support/services across all the borough
- Need greater integration to avoid duplication
- We still have children that slip through the net
- Lack of shared agreement of the term ‘school readiness’

**Opportunities:**

- Early Years Pupil Premium from 1.4.15
- School registration lowered to 2 years from September 2015.
- Greater integration
- More child development training for schools (currently only engage those that are already converted)
- Schools to do more with parents on child development

**Threats:**

- Budget reductions
- Changes to Government agenda
- Changes to systems e.g. latest change to baseline measures which will make it impossible to have a national data set.
- Rising expectations from Primary schools which result in them addressing issues inappropriately e.g. use early phonics teaching.
4.6 Priorities over the next year and over the next 5 years

From the SWOT analysis key priorities are

- Formulate Sandwell’s multiagency school readiness strategy
- Maximisation of early years education places
- Continue to develop new Early Learning for two year olds places
- Improve children’s speech and language development

4.7 Recommendations

- Sandwell Children and Families Joint Planning and Commissioning Group to establish a working group to develop and deliver a multiagency school readiness strategy.
- Early years, children and young people’s services to target wards with low uptake of funded early years placements to understand reasons for low uptake and support parents to access places.
- All agencies to work together to encourage parents to access library services for their children and to read to their children, particular in wards with low library usage.
- That agencies work together to complete a two year old check on all children and that multi-agency systems should be developed to follow up on any child not accessing their two year old check.
- A strategy is developed to roll-out and embed the principles of REAL across the borough, specifically targeting wards with low library usage and low uptake of early year’s education.
- Providers are supported in the development of the use of the early year’s pupil premium and examples of good practice are cascaded across the borough.
- Prioritising multi-agency agreement of a measure of school readiness and ensure that this is measured robustly and consistently, so that we can show that any interventions implemented are successful
- Consider reasons for the variation in progress measured by WellComm by ward and share lessons learned from wards with good progress
5. Special Education Needs and Disabilities

Key Messages

- Of the children in Sandwell aged 0-4 in nursery with Special Educational Needs and Disability, a large proportion have a speech, language or communication need.

- 17% of children were aged 4 or over at referral in 2014-15 to the Inclusion Support Early Years’ Service (ISEY) (a targeted and specialist service for children under the age of 5 years). The greatest number of referrals to the service is noted for speech, language and communication needs. Appropriate and timely referral rates must improve to enable early intervention and therefore minimise any long term effects of delayed development.

- Information on individual children with Special Educational Needs and Disability needs to be shared more readily between services than is currently the case.

- Joint commissioning is required to meet the needs of children and young people with SEND aged from 0-25, overseen by the SEND board.
5.1 Introduction

The Children and Families Act 2014 drives the recent reforms to Special Educational Needs and Disabilities (SEND) policy and practice. The ‘Special educational needs and disability code of practice: 0 to 25 years 2014’ provides statutory guidance for organisations on duties, policies and procedures relating to Part 3 of the Children and Families Act 2014 for those who work with and support children and young people with SEND.

5.2 Descriptive epidemiology

5.2.1 High Level Prevalence Indicators

The majority of children with disability (3093) have a mild disability, while a small number (26) suffer from a severe disability.

Table 23: Prevalence of disability in Sandwell, 2011

<table>
<thead>
<tr>
<th></th>
<th>Boys</th>
<th>Girls</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild disability</td>
<td>1624</td>
<td>1469</td>
<td>3093</td>
</tr>
<tr>
<td>Severe disability</td>
<td>17</td>
<td>9</td>
<td>26</td>
</tr>
</tbody>
</table>

Source: ONS 2011

5.2.2 Language Development

The national prevalence data from the Royal College of Speech and Language Therapy have provided estimates for the 0-4 population in Sandwell based on a prevalence of 10 and 15% (Table 24).

Table 24: Speech and Language impairment prevalence estimates (RCSLT 2008)

<table>
<thead>
<tr>
<th>Prevalence (%)</th>
<th>Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>2072</td>
</tr>
<tr>
<td>15</td>
<td>3108</td>
</tr>
</tbody>
</table>

Source: Royal College of Speech and Language therapy
5.2.3 School census information – children 0-4 years in nursery with Special Educational Needs or disability (2012-2014)

Table 25 demonstrates the most prevalent SEND is in speech, language and communication skills.

Table 25: Primary SEND of children in school nurseries aged 3 and 4, 2012-14

<table>
<thead>
<tr>
<th></th>
<th>Nursery 1 (age 3)</th>
<th>Nursery 2 (age 4)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2012</td>
<td>2013</td>
</tr>
<tr>
<td>Autistic Spectrum Disorder</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Behaviour, Emotional &amp; Social Difficulties</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Hearing Impairment</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Moderate Learning Difficulty</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other Difficulty/Disability</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Physical Disability</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Profound &amp; Multiple Learning Difficulty</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Speech, Language &amp; Communication Needs</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>Severe Learning Difficulty</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Specific Learning Difficulty</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Visual Impairment</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Source: SMBC Inclusion Support Early Years and Child Development Centre

5.2.4 Specialist Support

There were 18 new referrals into Inclusion Support for Educational and Child Psychology support during the last academic year. A total of 26 Community Assessment Meetings were also held supported by Educational Psychologists, Inclusion Support-Early Years workers, and health services.
5.2.5 Sensory Support Team - Hearing Impairment (HI) and Visual Impairment Services (VI)

The Sensory Support Team provides specialist support to children who present with a hearing and visual impairment from the point of diagnosis through to potentially the age of 25 under the new SEN arrangements. The work can be with families, settings or schools and is designed to remove the barriers caused by a hearing or visual impairment so that the children can achieve the overarching outcomes of independence, employment and contributing to society. The vast majority of referrals come from health services and the bulk of early referrals to hearing impairment services are through the New-born Hearing Screening Programme. Caseload and referral data for the year September 2014-15 is shown below.

Figure 25: Number of Children on Sensory Team caseload aged under 5 in August 2015 by area
Figure 26: Number of children under 5 years of age referred to Sensory Team 2014-15 by area

The areas with low caseload are Oldbury, Rowley and Wednesbury. Figure 2 also demonstrates that referrals from Oldbury and Rowley are also low. We would expect a greater number of referrals and a higher case load from towns with more children. Figures 3 and 4 show the equivalent rates per 1,000 children in the population. These show a high case load from Smethwick and Tipton, broadly similar rates in Oldbury, West Bromwich and Wednesbury and low case load in Rowley (figure 3). There are broadly similar referral rates in Tipton, West Bromwich, Smethwick and Wednesbury; with lower rates in Oldbury and Rowley. Differences may be due to unmet need in Rowley, but is difficult to say conclusively due to small numbers.
Figure 27: Sensory Team caseload aged under 5 in August 2015 by area-Rate per 1,000 Children

Figure 28: Under 5 years of age referrals to Sensory Team 2014-15 by area-Rate per 1,000 Children
Figure 29 indicates that referrals spike in the first year of life, especially for hearing, which reflects referrals from universal new born screening. Vision referrals spike between 2 and 3 years, possibly reflecting 2.5 year development check.

**Figure 29: Age details of under 5 year olds referrals to Sensory Team 2014-15**

Source: SMBC Inclusion Support Early Years and Child Development Centre

### 5.3 National guidelines and recommendations

The Special Educational Needs and Disability Code of Practice, 2014 makes specific reference to the expectation of joint commissioning to plan for and meet the needs of children and young people with SEND aged from 0-25:

- ‘Local authorities and clinical commissioning groups (CCGs) must make joint commissioning arrangements for education, health and care provision for children and young people with SEN or disabilities. The term ‘partners’ refers to the local authority and its partner commissioning bodies across education, health and social care provision for children and young people with SEN or disabilities, including clinicians’ commissioning arrangements and NHS England for specialist health provision.’ (Para 3.3 Code of Practice)

In addition, the SEND Code of Practice highlights the role of the Joint Strategic Needs Assessment (JSNA) in understanding local needs:
Joint commissioning should be informed by a clear assessment of local needs. Health and Wellbeing Boards are required to develop Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies, to support prevention, identification, assessment and early intervention and a joined-up approach. Under section 75 of the National Health Service Act 2006, local authorities and CCGs can pool resources and delegate certain NHS and local authority health-related functions to the other partner(s) if it would lead to an improvement in the way those functions are exercised. (Para 3.4 Code of Practice)

The Joint Strategic Needs Assessment (JSNA) is the means by which the Board understands and agrees the needs of all local people. It is the basis for the joint health and wellbeing strategy which sets the priorities for joint action. (Para 3.22 Code of Practice)

The JSNA will inform the joint commissioning decisions made for children and young people with SEND, which will in turn be reflected in the services set out in the Local Offer. At an individual level, services should co-operate where necessary in arranging the agreed provision in an EHC (Education, Health and Care) plan. Partners should consider how they will work to align support delivered through mechanisms such as the early help assessment and how SEND support in schools can be aligned both strategically and operationally. They should, where appropriate, share the costs of support for individual children and young people with complex needs, so that they do not fall on one agency. (Para 3.24 Code of Practice).

The Code of Practice particularly emphasises the importance of early identification of SEND.

All those who work with young children should be alert to emerging difficulties and respond early. In particular, parents know their children best and it is important that all practitioners listen and understand when parents express concerns about their child’s development. They should also listen to and address any concerns raised by children themselves (Para 5.5 Code of Practice).
Language Development

Children who have speech, language and communication needs should be helped as soon as possible. The Royal College of Speech and Language Therapy states an early delay in speech adversely affects the ability for the child to communicate their needs, communication with others in social environments and may upset the child.

Studies show that speech impairments involving phonological impairments and developmental verbal dyspraxia have long lasting sequellae (Conti-Ramsden et al 2001, Law et al 1998).

Those children with moderate SEND who do not have a significant disability identifiable at birth or shortly afterwards, may be identified through the monitoring of the development of language skills.

5.4 Current service provision and effectiveness of these services

In order to coordinate and oversee the local implementation of the national reforms a local SEND Partnership Board was established in November 2013. The board meets on a monthly basis and membership of this board includes:

- Education – SEN strategic lead, adviser, operations manager, Lead Manager, Post-16 and Adult Learning
- Principal Educational Psychologist & Inclusion Support Manager
- Team Manager, Children with Disabilities
- Adult Social Care – commissioner and practitioner
- Children’s care commissioner
- Senior Commissioning Manager, Sandwell & West Birmingham CCG
- Sandwell Parent Partnership
- Chief Executive, Changing Our Lives
- Designated Health officer
- Senior Joint Commissioning manager, Public Health
- Head teacher, Special school

The SEND partnership board has an implementation plan which is reviewed regularly and up-dated. The terms of reference for the board include the following:

- To improve understanding of the SEND population and recent trends in Sandwell
- To develop a plan and implement a coordinated programme of change in line with national expectations
- To develop a communications plan for all key stakeholders
- To act as champions for the implementation of change across the partnership, using reference groups where appropriate.
- To direct the use of the additional Department for Education funding to support the implementation of reform
Services in Sandwell include those at the universal, targeted and specialist levels from all agencies, listed below:

- **Universal**
  - Children’s centres
  - Health Visitors
  - G.P.s
  - Early Years’ day care settings, child minders etc.
  - Early Years team
- **Targeted and specialist**
  - Paediatric therapies – Speech and Language Therapy, Physiotherapy, Occupational therapy
  - Paediatricians
  - Inclusion Support Early Years
  - Complex Care nurses
  - Children with Disabilities team (Children’s Social Care)

### 5.4.1 Inclusion Support Early Years’ Service (ISEY) information

Inclusion Support - Early Years (ISEY) is based at The Coneygre Centre, Tipton and supports children in their early years that have individual or special educational needs (SEN) / disabilities. This service offers a multi-disciplinary team provided by the Sandwell and West Birmingham Hospitals NHS Trust with Education services. The service works in collaboration with other agencies to provide appropriate support packages and early intervention. The service works with children in their own homes, at the centre and in a range of early years settings, holiday play schemes and out of school clubs. Transition packages of support tailored to the individual needs of the child provide advice, guidance and training to school settings in preparation for a child entering nursery or reception class. Early years settings follow Sandwell’s Transition Plus Pathway (TPP).

**TTP:**

- Transition Plus Pathway 1 – The Watchful Eye
- Transition Plus Pathway 2 – The helping Hand
- Transition Plus Pathway 3- The Human Bridge
- High Needs Block Funding/ EHCP

Figure 30 demonstrates that the most common pathway used in Sandwell is Transition plus pathway 2.
The service also provides advice and guidance to childcare settings so they can offer quality inclusive provision ensuring the needs of children with SEND are being met. In the last academic year Inclusion Support Early Years trained 696 practitioners, accessing 51 training courses. There was an overall satisfaction rating of good and excellent of 96%.

Sandwell data showing referral patterns to this service are given below. Figure 31 demonstrates in 2014-15, the greatest number of referrals to the service was for speech, language and communication needs.
Figure 31: Area of need for children accessing Inclusion Support Early Years (ISEY) prior to entry into school nursery 2014-15

Area of need for children accessing ISEY prior to entry into school, 2014-15

- Speech, Language & Communication Needs – SLCN
- Behaviour, Emotional & Social Difficulties – BESD/SEMH
- Moderate Learning Difficulty – MLD
- Physical Disability – PD
- Hearing Impairment – HI
- Profound & Multiple Learning Difficulty – PMLD
- Visual Impairment – VI
- Autistic Spectrum Disorder – ADS

2% 19% 4% 4% 5% 4% 19% 44%
5.4.2 Children's Centres

Sandwell has 21 Children's Centres that aim to deliver better outcomes for young children and families. They are based on a commitment to improve the coordination, quantity and quality of services for young children. This stems from the belief that the joining up of services and disciplines such as education, care, family support and health is a key factor in determining good outcomes for children.

All Children's Centres including those in Sandwell will offer access to the following core services:

- Early education integrated with childcare
- Family support and outreach to parents
- Child and family health services. These include those provided primarily through health visiting for example, baby clubs, development checks, clinics which are run at the centres.

Children’s centre services in Sandwell remain as having a universal base although many of the services are targeted at families in greatest need for example, child protection cases.

SEND children can access a range of services such as early years play services like parent and child sessions and playgroup; family support services which offer tailored support to families; access to clinics, baby clubs and so forth; information points for other services.
5.4.3 Paediatric therapies

Speech and Language therapists work with children who may have difficulties with speech sounds, language, stammering, feeding difficulties or their voice. Physiotherapists work with children who may have difficulties with mobility, muscle weakness, balance, or development. Occupational therapists work with children and young people who have a physical disability that affects participation in everyday activities. The difficulties may impact upon play, leisure and/or access to education. Physical conditions that might affect the child include cerebral palsy and dyspraxia.

5.4.4 Children with Disabilities

There is a local social care team that supports children and young people with disabilities up to the age of 18, and their families. The team provide:

- Information on the impact of a disability on a child or young person and their family.
- Support at home for parent or carers in caring for a child with a disability.
- Short breaks during the day in a family’s home and in the community or overnight in foster care and residential units.
- Play and leisure opportunities.
- Direct payments to enable families to buy in their own care.
- Signposting to other agencies that may be able to help.
- Counselling to talk through worries and problems.

5.4.5 Effectiveness of current services

Whilst there is a wide range of services to support children with SEND in the years before entry to school it is essential that:

- All universal services, health visitors, GPs and children’s centres particularly, have a sound understanding of the need to routinely screen the development of all young children. Some children are continuing to fall through the net of universal services such that 80 children were referred in 2013-14 for specialist support aged 3 and above. Further work could be undertaken to extend awareness of the benefits of early identification of SEND including routine monitoring of the take-up of the health visitor check at 2 years.
- Families are helped to access support at the most local setting, such as Children’s Centres, so that intervention can be provided at the earliest opportunity. This is particularly relevant given that a significant majority of SEN in the early years relate to delayed speech and language skills. Interventions to develop language can be appropriately and successfully provided by high quality universal services but the impact of such support is dependent upon promoting early access.
5.5 Consultation with Stakeholders

The views and opinions of parents are represented by the membership of Sandwell SEND partnership service at the strategic SEND partnership board. In addition, the parent forum provides opportunities for services to consult on developments and policy changes.

Parents of children under school age with significant SEND engage with staff and managers from the Inclusion Support Early Years’ Service on a frequent basis. The service offer is closely focussed on supporting and consulting parents through their routine engagement.

5.6 Priorities over the next year and over the next 5 years

A key priority over the next few years will be to improve and align the collection and sharing of information on individual children. This includes information from Health Visitors on New Baby and 2-year-old checks, from early years practitioners on 2-year-old checks and Wellcomm Screening, and from school nurses on Year 1 Health Checks, as well as specialist services. It is especially important in the early years to intervene promptly and support children with SEND in order to improve their readiness for entry to school and ensure that appropriate support is made available in a timely manner.

The Government expects that Local Authorities and Clinical Commissioning Groups (CCGs) make joint commissioning arrangements for education, health and care provision for children and young people with SEN or disabilities. This commissioning activity will need to be informed by a shared understanding of our population. A priority for the future will be to align data sources and to develop partnership commissioning arrangements which analyse and review changing patterns of incidence and demand. This intelligence should then allow for effective commissioning of services and support for children and their families.
5.7 Recommendations

- Children and Families Joint Commissioning Group should consider whether a strategy is required to ensure a consistent, multi-agency approach to early identification and intervention is adopted.

- Continue to extend the awareness across all universal services of the need to screen the development of young children to ensure early access to support and intervention.

- Monitor and continue to develop the Local Offer for SEND, so that families are provided with information on the support and services available in Sandwell for children and young people with SEND.

- Improve and align the collection and sharing of information on individual children across health and Local Authority agencies.

- Align data sources and develop partnership commissioning arrangements which analyse and review changing patterns of incidence and demand.

- Further data analysis is required to identify evidence of delayed referral. This should include looking at age of referral to see how Sandwell bench-marks against other areas and also high referral into Transition Plus Pathway 2. We need to establish whether individual children would have been suitable for TPP1 if identified earlier and if this would have improved outcomes.
References

Chapter 1. Demographics and Risk Factors


Chapter 2. Healthy Pregnancy


Royal College of Midwifery. Safer Childbirth. 2007.


Chapter 3. Safeguarding


Chapter 4. School Readiness


Chapter 5. Special Educational Needs and Disabilities (SEND)


TO:
Chairs of Health and Wellbeing Boards
Chief Constables
Police and Crime Commissioners

15 November 2016

Dear All

Police and Crime Commissioners and Health and Wellbeing Boards

We are writing to highlight and support some of the important benefits that can be realised through closer collaboration between policing and health partners.

The interface between crime and public health is well-documented – in the Department of Health’s public health outcomes framework, for example, which contains a number of indicators that recognise the links, including: entry to the youth justice system, people in prison with a mental illness, domestic abuse, violent crime, re-offending, drug treatment outcomes and perception of community safety.

In many areas of the country, police and health and care partners, in both the NHS and Local Government, are working collaboratively to deliver better outcomes for individuals, including the most vulnerable and local communities and there is potential for further joint working. For example, local authorities, the NHS and the police are required members of Safeguarding Adult Boards which help ensure a collaborative, inter-agency approach to the responses and prevention of abuse or neglect.

In addition, many health and wellbeing boards already include amongst their membership either their Police and Crime Commissioner (PCC) or representatives from their local police force or criminal justice agencies. This has enabled boards to take a broader strategic view of their area beyond health and social care, and through Joint Strategic Needs Assessments (JSNAs) provides boards with the opportunity to better understand the nature of public needs and demands on local services – which can in turn influence local commissioning strategies.
There are already a number of areas where greater collaboration has had positive outcomes including:

- Every area in England is now working to implement their local Mental Health Crisis Care Concordat action plans, involving NHS services, police forces and local authorities, and many of these local partnerships are using their Boards to ratify their plans and support progress. Local action plans and other helpful information on the Concordat can be found here: http://www.crisiscareconcordat.org.uk.

- In addition, around 30 police forces now have some form of street triage in operation. These models, often jointly commissioned by the PCC and Clinical Commissioning Groups, ensure mental health nurses staff support and advise police officers in their responses to people in mental health crisis. In some forces mental health workers and police officers provide joint responses in the community; in others mental health professionals work in emergency call centres in order to provide real time advice and support to frontline officers. The evaluation of nine initial pilot sites evidenced that the schemes contributed towards large reductions in the use of police custody as a place of safety for those vulnerable people detained under section 136 of the Mental Health Act.

- Around 25 police forces operate a drug intervention initiative which involves policing and health partners working together to identify, assess and refer users into appropriate treatment pathways. Investment in treatment is proven to reduce reoffending, with every £1 spent saving £2.50 for the Criminal Justice System, and with access to treatment reducing the impact of wider health harms including the spread of blood borne viruses and drug related mortality.

- A recent Home Office and Public Health England initiative in Middlesbrough brought together senior partners in policing, health and probation to consider the impact of heroin misusing offenders in their area and the wider implications this was having on individuals and the community. This has galvanised further collaborative working, including the development of a joint strategy to address their local needs and consider opportunities for developing a multi-agency commissioning approach for treatment services.

- The first phase of the local alcohol action areas programme, which ran until March 2015, saw police and health partners work closely together to reduce a range of alcohol-related harms. For example, Gravesham began a one-year pilot of a Make Every Adult Matter approach to street drinkers. An operational group is led by the area’s alcohol and drug treatment provider with members including the police, third sector organisations, primary care providers, Jobcentre Plus and the Prison Service. Early indications are that the project is working well and that links between partner agencies are much improved and that better coordinated services for individuals with multiple needs are emerging. Invitations to apply to take part in the second phase of the programme were sent to PCCs, chief constables and all local authorities in England and Wales last month. The programme will begin in January and will again encourage active partnerships between local agencies to reduce alcohol harms.
Given the benefits outlined above, and the pressures on health and care services and police forces, we would like to ask Health and Wellbeing Boards and PCCs to consider how they can better work together by ensuring appropriate representation from both sectors on Health and Wellbeing Boards.

The Rt Hon Amber Rudd MP

The Rt Hon Jeremy Hunt MP
Thank you for your letter regarding collaboration between police, Police and Crime Commissioners and Health and Wellbeing Boards.

In Sandwell the Health and Wellbeing Board fully recognises the value of working closely with the police and the Police and Crime Commissioners. The local police borough commander represents the police on the board and the police are contributing to the delivery of all of the health and wellbeing board priorities.

With regard to the mental health crisis concordat, the Sandwell Health and Wellbeing Board have oversight of the local concordat and delivery plan. The Sandwell concordat was co-produced with the Sandwell Mental Health People’s Parliament and the police are central to the partnership group delivering the concordat action plan.

In Sandwell, there is a long history of joint working between the police, the NHS and the local authority on tackling alcohol and substance misuse. This is mainly coordinated through the Safer Sandwell Police and Crime Board, the local community safety partnership. This involves a drug intervention initiative and developing work on joint approaches to addressing offending linked to the misuse of alcohol.

The Sandwell Health and Wellbeing Board published the latest Joint Health and Wellbeing Strategy earlier this year. The strategy contains four priorities for the next five years. The second of these focuses on partnership approaches to reducing violence and exploitation. Initially the Health and Wellbeing Board agreed this priority. The adult and children’s safeguarding boards and the community safety partnership have now also adopted this as a joint priority. It is therefore a shared priority across the four statutory partnership boards in Sandwell. The police borough commander sits on all four partnership boards and is central to driving this work forward.

Delivery of a reduction in violence and exploitation is through a partnership action plan agreed by the four statutory boards. A key workstream is developing a partnership joint strategic needs assessment on violence and exploitation in Sandwell. This includes substantial work to collate and analyse data and intelligence across the local authority, the police, the NHS and wider partners. A key part of this work is gaining an understanding of adverse childhood experiences in Sandwell. The police are developing new intelligence to support this programme.

This joint strategic needs assessment is informing the development of specific initiatives and improved coordination of programmes across the partners represented on the Health and Wellbeing Board and the other statutory partnership boards. This work aligns closely to that of the West Midlands Violence Prevention Alliance, led by Public Health England and the West Midlands Police and Crime Commissioner.

Again, I would like to thank you for your letter raising the importance of joint working with the police and the Police and Crime Commissioner. I hope that through this brief overview of the wide range of partnership working in Sandwell, I have demonstrated that we fully recognise the value of joint work with the police and that we are working hard to realise the potential of these relationships.
# Health and Wellbeing Board & Executive Forward Plan

**Executive**

14 December 2016

- Actions from November HWB
- Priority 3 update/Board development
- 0-4 JSNA
- Adult MH JSNA
- Midland Met Update/Impact Assessment
- Black Country STP Update

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### Actions

- Impact Assessment
- Progress on autism diagnosis confirmed waiting times
- HWB – external requests for HWB support
- Communication & Engagement Plan
- Inclusion of standing items at Exec meetings
- Community representation at HWB
- Chairs Correspondence – HWB & PCC
- Children’s Partnership Commissioning Plan

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| Board 12 January 2017 | • Actions from November HWB  
• Priority 3 update and action planning from HWB development plan  
• SMBC vision consultation  
• 0-4 JSNA  
• Adult MH JSNA  
• Chairs Correspondence – HWB & PCC | All  
DS  
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| Executive 24 January 2017 | • Actions from January HWB  
• Autism diagnosis waiting times update | All  
| | • Chairs correspondence – comments from public attendees at November board meeting |  
| Executive 14 February 2017 |  
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| 02 March 2017 | - Actions from January HWB  
                 - Priority 4 update: Feedback from Engagement Plan  
                 - Final Adult MH JSNA  
                 - Children’s Partnership Commissioning Plan | All, PS, PS, TBA |       |
<p>| 21 March 2017 | - Actions from March HWB                                               | All       |       |
| 11 April 2017 | - -                                                           |           |       |
| 04 May 2017   | - Actions from March HWB                                               | All       | - Changing Our Lives – Feedback from Ideas Festival |
| 23 May 2017   | - Actions from May HWB                                                | All       |       |</p>
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Items to be allocated

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<td>Healthwatch annual report</td>
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Items for future consideration

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