Walsall Joint Strategic Needs Assessment Refresh 2013

Final Version

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Acknowledgements

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Foreword

Walsall has seen some **key successes** in health and wellbeing over recent years. Life expectancy for both men and women has improved over the past decade by 4.6 years and 4.4 years respectively since 1991, meaning people in Walsall are living for longer. All cause mortality has fallen, with particular improvements in deaths from cardiovascular disease. Children and young people in Walsall are striving and achieving – the percentage of children achieving 5 GCSE's grades A* to C has increased by 20 percentage points between 2007 and 2011.

Walsall faces some **key challenges**, in 2010 Walsall ranked as the 35th most deprived of 326 Local Authorities in England. Over 1 in 6 of working age residents are out of work. Much needs to be done locally to break the cycle of intergenerational worklessness and benefit dependency. Although life expectancy has improved over the past decade it is still lower than national and regional levels. This gap is much wider for males than females.

Newly released Census information has also identified some other major **demographic challenges** – for example the Walsall population is increasing and becoming much older. A larger proportion of the population are from ethnic minority population and so local health and social care will have to adapt their service provision to the needs of these groups. Finally the number of births is increasing at a higher rate than national levels. The Health and Wellbeing Strategy needs to continue to build on local successes and narrow the gap between Walsall and our regional and national comparators.

The current economic climate poses challenges for all residents and organisations within the borough. It is vital that a coordinated strategy is in place to reduce inequalities in health and wellbeing across the borough. The changes initiated by the Health and Social care Act 2012 present opportunities for greater partnership working towards an effective Health and Wellbeing Strategy for Walsall.

The 2013 Joint Strategic Needs Assessment refresh builds further on a long history of partnership working. It recognises the diverse influences on wellbeing, from a healthy body and mind to purposeful activity, nurturing relationships and a safe, secure place to live. This diversity of influences necessitates a strategic response across all directorates of the local authority and partnership with a wide range of stakeholders. The JSNA has been strengthened as a result of stakeholder feedback with extra information on community safety, children's & young people emotional health, health protection (infectious diseases) and older people / independent Living

JSNA 2013 summarises key themes contributing to wellbeing in Walsall requiring a local partnership response. The priorities for action identified will influence and shape the content of the up and coming Health and Wellbeing Strategy for Walsall. All Walsall partners recognise that in addition to how many resources are committed to individual areas of the borough, how these resources are spent locally is of vital importance. Therefore all partners will be capitalising on opportunities to modernise and join up service delivery for the benefit of residents, in addition to reviewing overall funding levels across the borough.

Introduction

The Marmot Review: Fair Society, Healthy Lives, 2010 examined inequalities across the life course and recommended proportionate action across all social determinants of wellbeing. Collaboration and involvement of all central and local government departments and the third and private sector is essential to deliver the wider benefits of wellbeing. The Review focussed on the creation of an enabling society to maximise individual and community potential; ensuring that social justice, health and sustainability are at the heart of policies to reduce inequalities and improve wellbeing for all.

The chapters of the 2013 Walsall Joint Strategic Needs Assessment refresh are guided by the six key policy objectives from the Marmot Review, placing an emphasis on a life course approach:

- *Chapter 1 – Wellbeing in Walsall*
- *Chapter 2 - Give every child the best start in life*
- *Chapter 3 - Enable all children and young people to maximise their capabilities and have control over their lives; transition to adulthood*
- *Chapter 4 – My Money, My Home and My Job*
- *Chapter 5 – Creating and developing healthy and sustainable places and communities*
- *Chapter 6 – Improving health and wellbeing through healthy lifestyles: Making healthier choices easier*
- *Chapter 7 –Reducing the burden of preventable disease, disability and death*
- *Chapter 8 - Healthy ageing and independent living*

Disadvantage begins before birth and accumulates over time. Breaking the cycle of disadvantage requires proportionate, multi agency action across the life course.

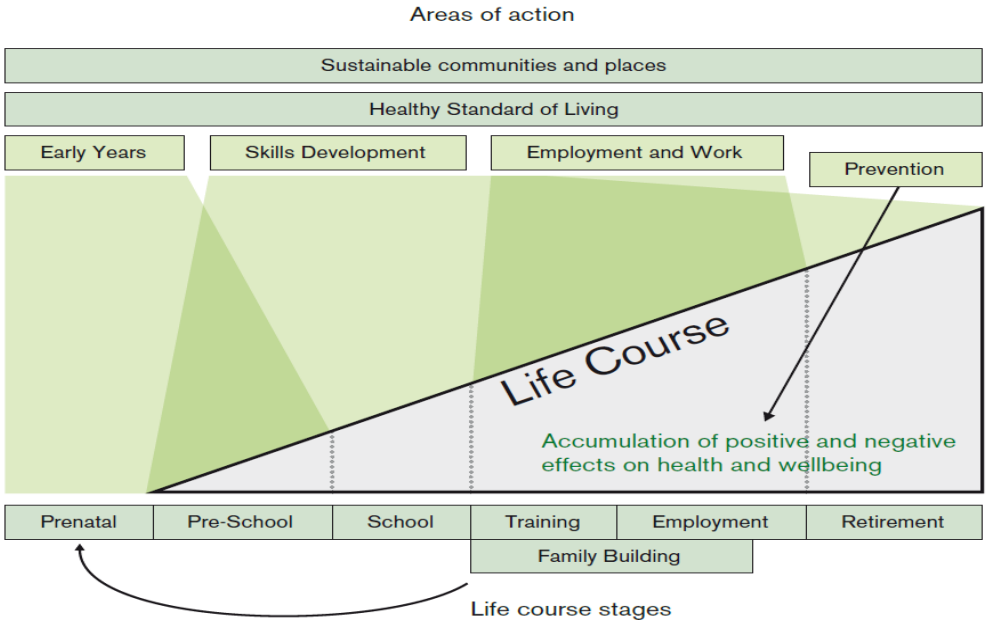


Figure 1 The Marmot Review Life course approach

Individual chapter content was informed by four key outcomes frameworks:

- *Public Health Outcomes Framework*
- *Adult Social Care Outcomes Framework*

- *NHS Outcomes Framework*
- *Children and Young People's (CYP) Plan 2013-2016* [1]

Outcomes and indicators were grouped into themes and assessed using a decision tree. This process identified key themes impacting on the wellbeing of Walsall residents, affecting more than one service across the borough and amenable to a partnership approach between local authority and health services. These themes guide chapter content.

JSNA 2013 refresh presents a high level overview of these shared themes. It does not aim to present the full range of data available. Links to further information are provided for those who are interested and wish to explore themes in more detail.

Furthermore some high level outcomes are not presented within the chapters that follow. These are generally outcomes that are priorities for one organisation and less amenable to local authority and health service partnership. This does not lessen the importance of these outcomes for health and wellbeing and they will still require a strategic response across the healthcare economy.

[1] http://www.childrenspartnership.walsall.org.uk/wct-index.htm
Children and Young Peoples Plan priorities are set out in Appendix 3

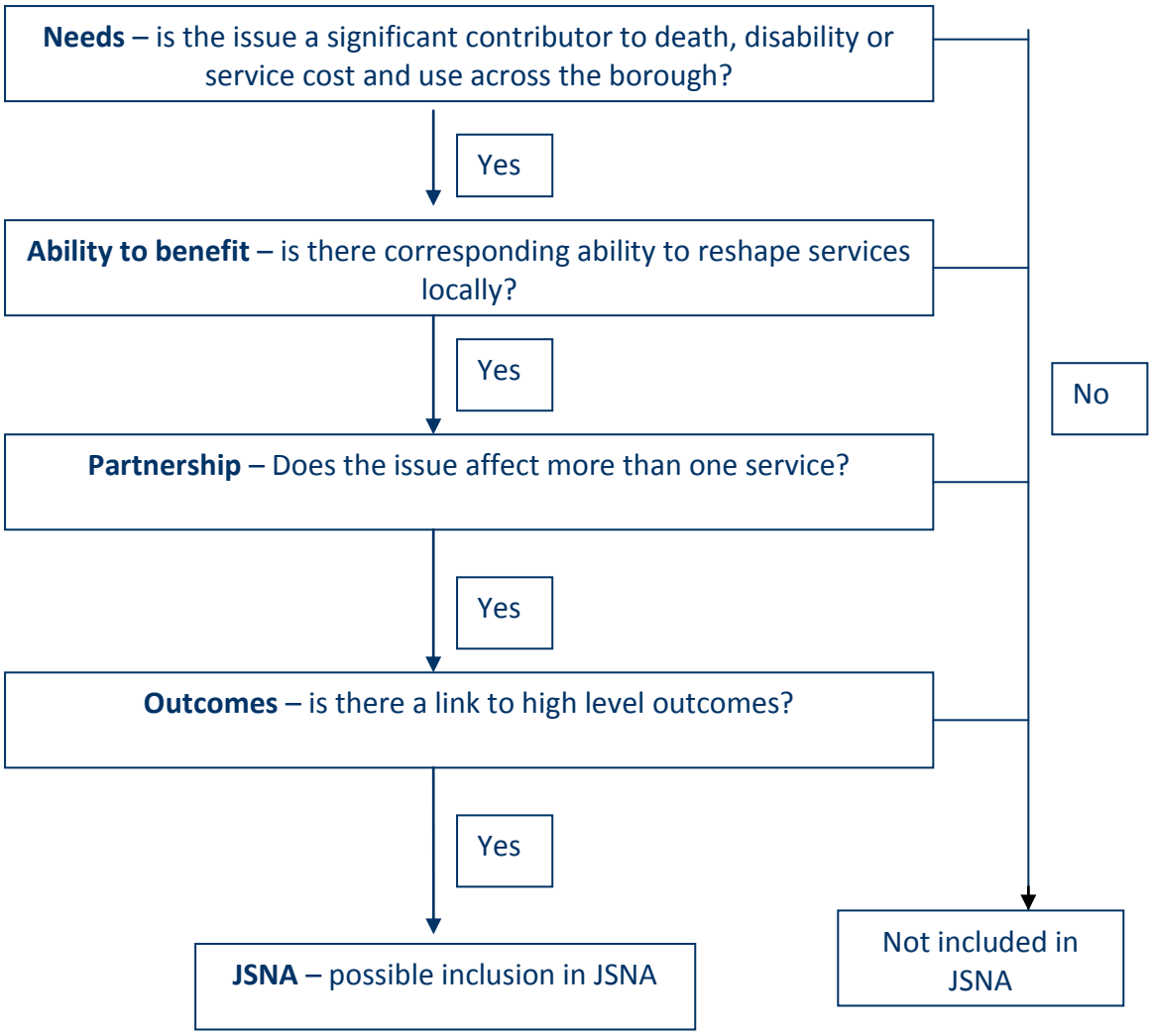


Figure 2 JSNA Decision Tree – Modified from Birmingham Health and Wellbeing Partnership: Determining whether a topic is a JSNA Level Project v1 2009

Development of the 2013 JSNA has moved towards a strong partnership approach. Public health department and the commissioning responsibilities have moved from the NHS to Walsall Council which has helped to build stronger relationships.

The key goal of the JSNA is to enhance wellbeing in Walsall through the Health and Wellbeing Strategy:

- *A healthy body*
- *A healthy mind – emotions, reason, imagination, positive self esteem, emotional resilience, problem solving skills, freedom from fear*
- *A safe and secure place to live – home safety, freedom from violence or fear of it*
- *Enough money to live on*
- *Nurturing relationships – family friends, community, a sense of belonging*
- *Purposeful activity and valued achievements – learning, working, volunteering, relaxing*

Measuring wellbeing is a harder task. Work is underway nationally to develop such an indicator which can be used as a national target for tackling health inequality, alongside life expectancy and health expectancy. The Marmot Review also emphasised the importance of improving wellbeing through the creation of conditions that enable people to control their lives and freedom to flourish – favourable and equitable

circumstances of birth, growth, life, work and ageing for all. In response to these challenges the aspiration of JSNA in Walsall is to gradually shift from a deficit based approach to an asset based approach to describe and foster the circumstances that promote wellbeing.

Walsall's position on selected key indicators relating to national positions is shown in Appendix 1. The selection of indicators on which to mention improvements in health and wellbeing will be developed further as work on the Health and Wellbeing Strategy progresses.

An asset based approach identifies and promotes the health enhancing assets (skills, knowledge, resources, networks and organisations) present in communities, empowering people and communities as co-producers of wellbeing, focussing on positive messages and goals. This approach requires collection of a different type of data. It is hoped that this JSNA will influence the nature of future detailed needs assessments, intelligence gathering and community engagement to enable a gradual shift to a Joint Strategic Needs Assessment incorporating an assets based approach, informing future Health and Wellbeing Strategies.

Figure 3 Inter-relationships between the Health and Wellbeing Strategy, JSNA and wider needs assessments

The following chapters discuss key wellbeing priorities and inequalities affecting Walsall residents from the early years to the end of life, alongside recommendations for action in the upcoming Health and Wellbeing Strategy.

Chapter 1 Wellbeing in Walsall

The opening chapter of the JSNA describes the 'golden threads' of wellbeing in Walsall and sets the scene for the chapters that follow. Overall wellbeing is determined by a range of things:

- *A healthy body*
- *A healthy mind – emotions, reason, imagination, positive self-esteem, emotional resilience, problem-solving skills, freedom from fear*
- *A safe and secure place to live – home safety, freedom from violence or fear of it*
- *Enough money to live on*
- *Nurturing relationships – family friends, community, a sense of belonging*
- *Purposeful activity and valued achievements – learning, working, volunteering, relaxing*

All of these are influenced by the circumstances in which people are born and progress through life. Deprivation and poverty in childhood rest at the heart of inequalities in wellbeing throughout life.

Individual chapters of the JSNA discuss contributors to wellbeing across the life course. The ultimate outcome of these contributors to inequalities in wellbeing is life expectancy. A better outcome measure is healthy life expectancy. A core outcome of the JSNA and subsequent Health and Wellbeing Strategy should be to narrow the gap between life expectancy and healthy life expectancy by:

- *Extending the period of time that people in Walsall experience good health and wellbeing*
- *Reducing the period of time that people in Walsall experience poor health and wellbeing*

This chapter introduces these key determinants and outcomes of inequalities in wellbeing across the borough. Appendix 1 of this document uses various indicators to provide an overview of health and wellbeing and how Walsall compares with England.

1.1 Demography

Background demography

Walsall's overall population is predicted to increase over the next 10 years by 4.5% from 269,500 in 2011 to 281,700 in 2021. In addition to this, Walsall's older population (those aged 65 and above) is also predicted to increase by 12.9%, with the number of people 85 year and older increasing from 5,467 in 2008 to 8,109 in 2021. Planning to meet the needs of a growing number of older people must be incorporated within key strategic priorities in Walsall.

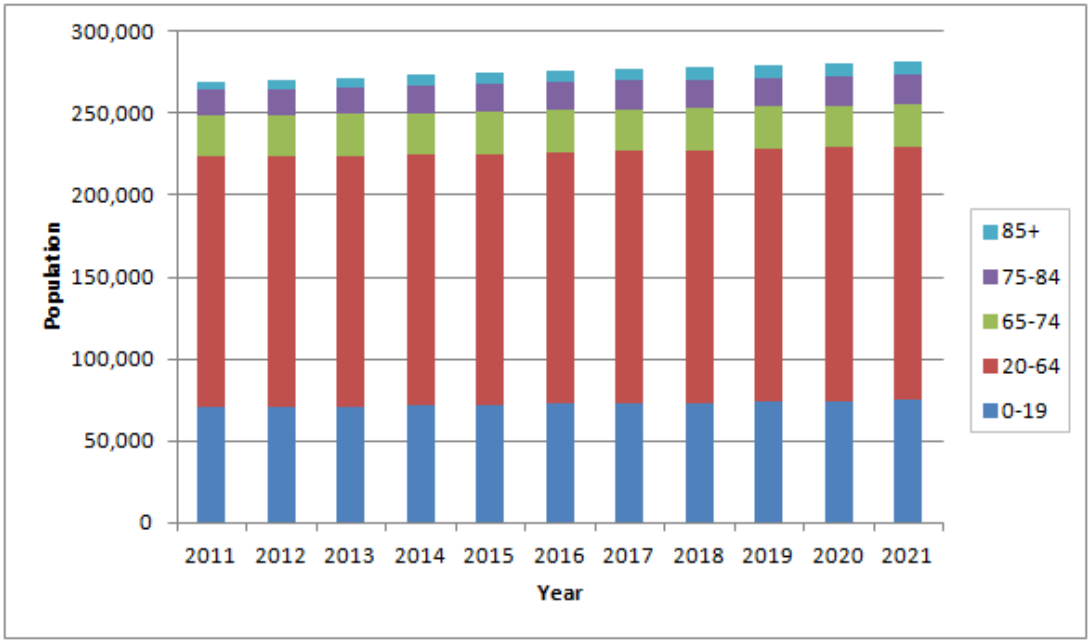


Figure 4 Walsall population projections, by age 2011-2021 (Source: ONS)

Walsall also has a culturally-mixed population. People of Indian, Pakistani and Bangladeshi background form the largest minority ethnic groups in Walsall. The number of Non-UK Born residents in Walsall has increased by 3.7% (or 9,859 people) between the 2001 and 2011 censuses. Walsall now has a small Eastern European population who make up about 1% of the area residents (2,681 people in total). Access and the appropriate provision of services depend upon a well-informed understanding of the specific needs of these different communities.

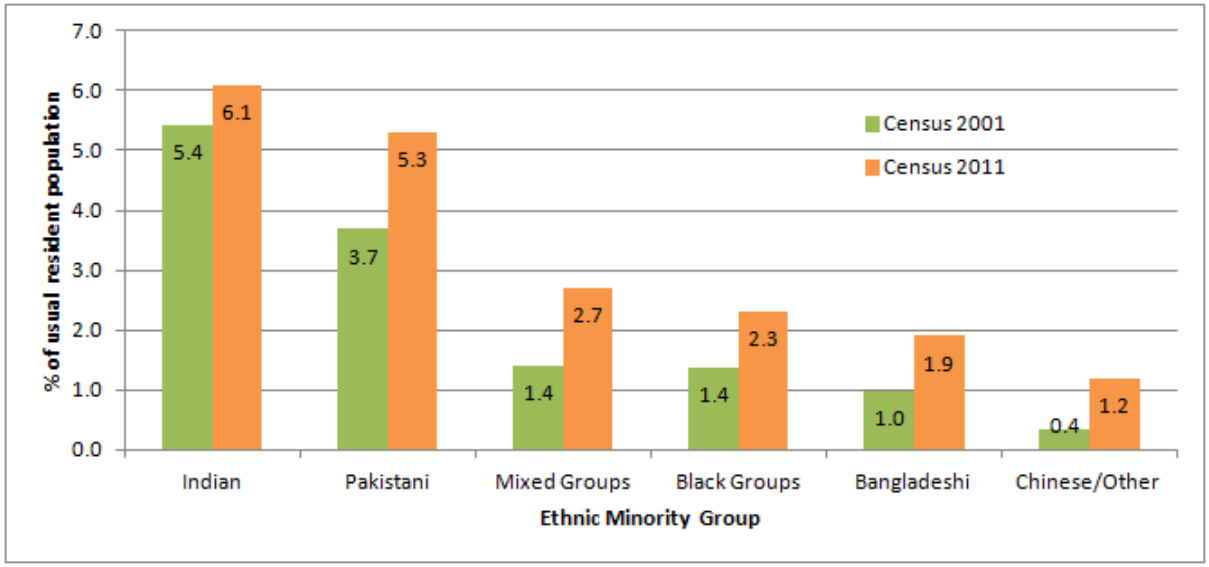


Figure 5 Minority ethnic group trends in Walsall 2001-2011 (Source: ONS)

1.2 Poverty in childhood

Child poverty is considered to be a key social determinant for the nation to tackle in order to reduce inequalities in health and social exclusion in our society. There is a strong research evidence base linking parental and child poverty to the health, wellbeing, educational attainment of children and later employment outcomes of young people.

'Reductions in child poverty will benefit everyone: more children will fulfil their potential, more families and communities will prosper and the UK will succeed. This is why it is in everyone's interests to play their role in eradicating child poverty' (HM Treasury, 2008, p32)

Indicators:

In Walsall, 29.2% of children were living in families whose income fell below 60% of the median national income in 2011 which translates to almost 16,145 children aged under 16 years living in poverty in 2011, similar to the previous year. In 2011 Walsall ranked 127th most deprived out of 152 councils in England, placing the borough in the bottom quartile. Recent welfare reforms are likely to pose additional challenges to already vulnerable groups within the borough: The Institute for Fiscal Studies (IFS) estimate an additional 300,000 children will be brought into poverty as a result of these by 2015 (about 2200 in Walsall).

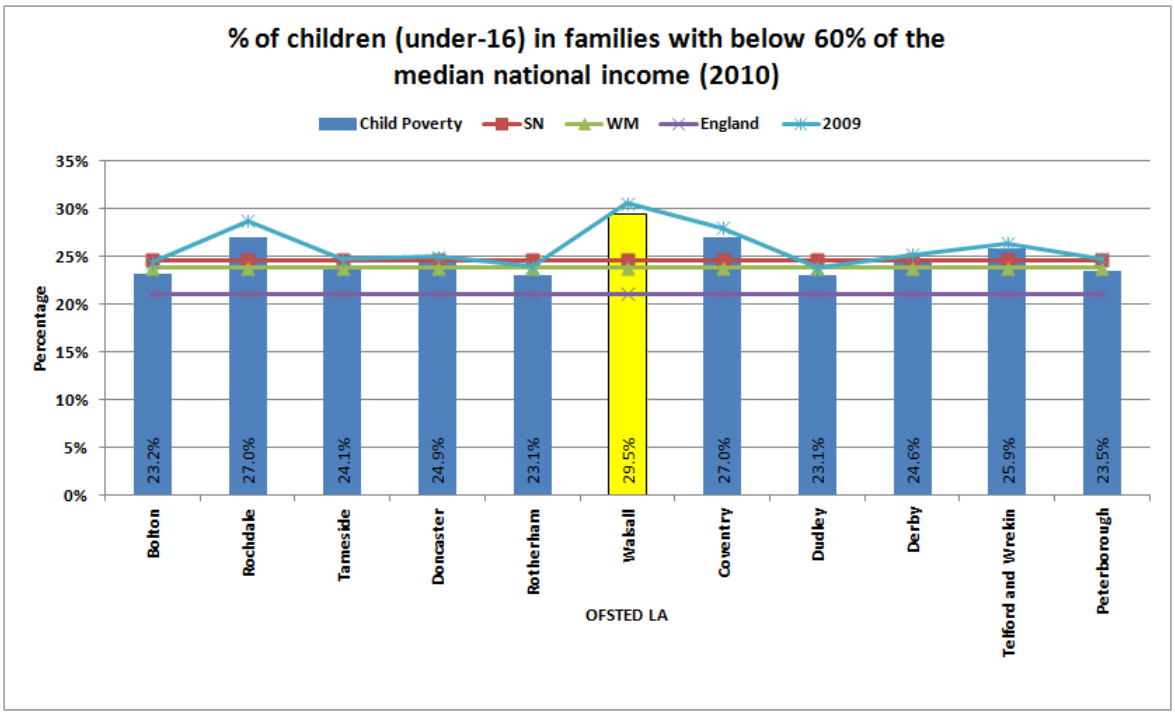


Figure 6 Percentage of under 16's in families with less than 60% of the median national income, 2010 (Source: HMRC)

In 2010, the percentage of children living in poverty in Walsall was the highest out of its statistical neighbour group, and above the average regional and national level. The geographical variation in Walsall is substantial, ranging from 48.0% of children living in poverty in Blakenall to only 4.5% in Streetly.

See Figure 7 and Figure 8 below, from: HMRC, Personal Tax Credits: Related Statistics - Child Poverty Statistics wards/LSOA Website: http://www.hmrc.gov.uk/stats/personal-tax-credits/child_poverty.htm (Accessed on 6.10.11).

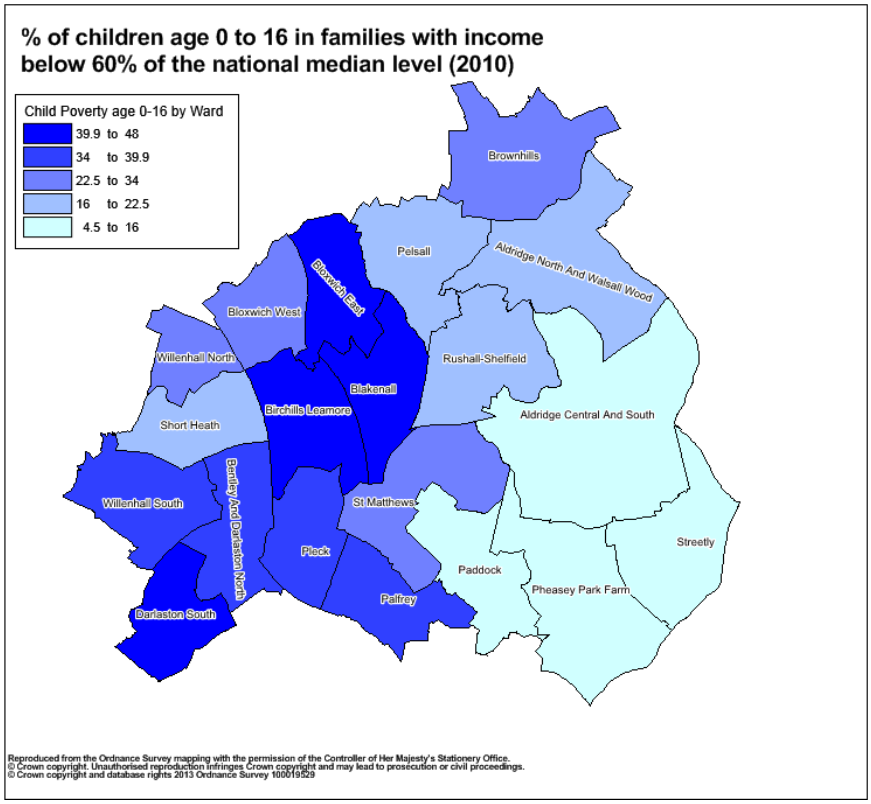


Figure 7 Percentage of children under 16 in families with less than 60% of the median national income in Walsall by ward, 2010 (Source: HMRC)

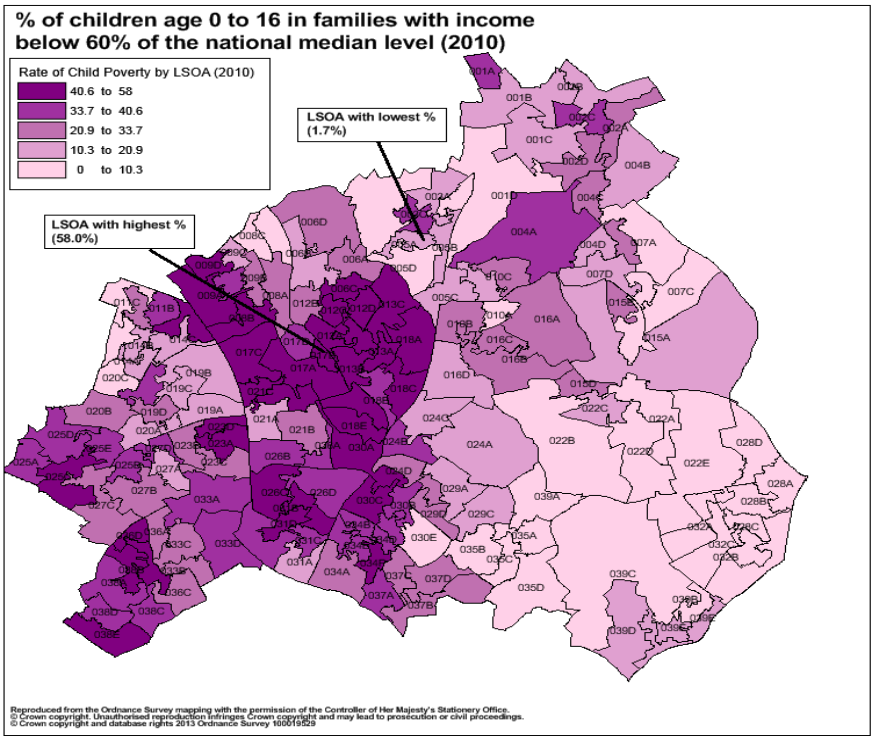


Figure 8 Percentage of children under 16 in families with less than 60% of the median national income in Walsall by LSOA, 2010 (Source: ONS)

Priorities for action:

Walsall's Child Poverty Strategy is based on a thorough needs analysis. The Child Poverty Strategy priority actions and CYP Plan are:

- *Reducing the impact of child poverty (see Appendix 3, CYP Plan Priority 8)*
- *Mitigate impact by income maximisation, money advice and tackling debt*
- *Increase wage levels with the aim of raising household incomes over the 'poverty threshold'*
- *Reduce the number of adults with no qualifications by promoting educational attainment and skills from the early years onwards*
- *Decrease the number of local parents classed as unemployed*
- *Increase the number of jobs for local people*
- *Narrow the educational attainment gap between disadvantaged pupils and their peers*
- *Build family and children's resilience and enhance parenting skills*
- *Increase aspiration of parents and children and young people*

1.3 Life expectancy

Life expectancy at birth is a way of expressing the all-cause mortality for an area. It gives an estimate of how long someone is expected to live based on current mortality rates. Life expectancy varies by social class, gender and the life choices people make. In order to increase life expectancy, a number of key areas need to be addressed, including: reducing mortality rates from the major diseases, promotion of healthier lifestyles, improving access to services and working to improve social determinants of health such as housing.

Indicators:

Typically, life expectancy is higher in women than men. For women, Walsall is on a par with regional but lower than national figures, although the gap is reducing. In contrast, male life expectancy is considerably lower in Walsall than regional and national figures; however, the gap is starting to narrow again.

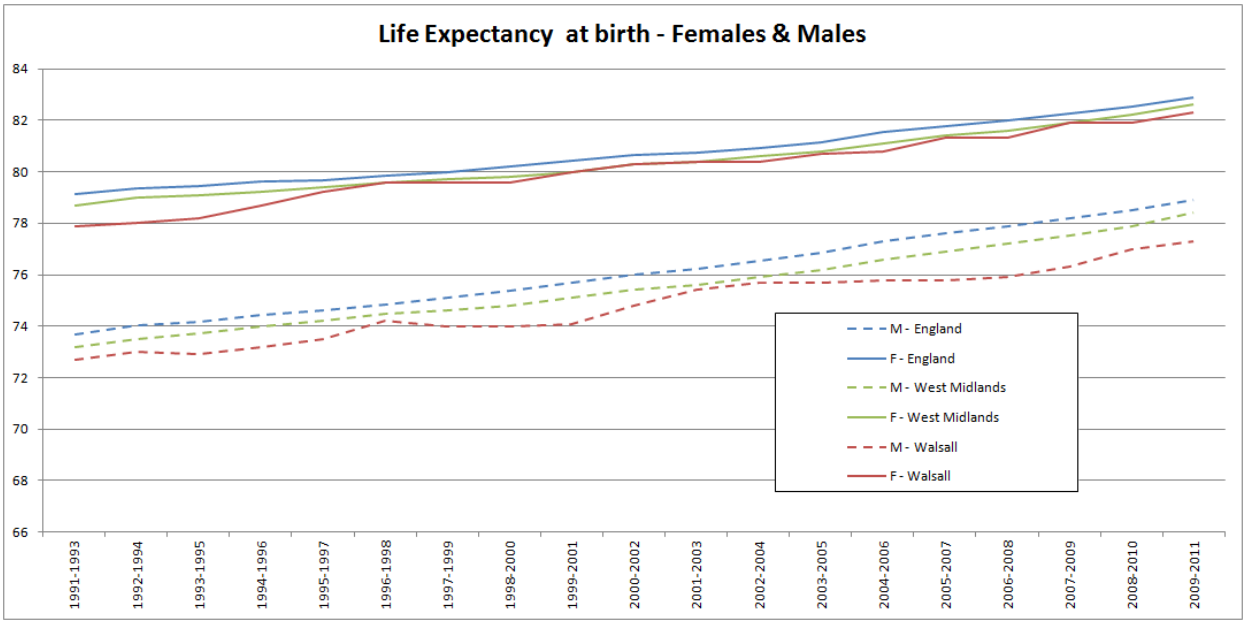


Figure 9 Trends in life expectancy 1991-2011 (Source: ONS)

1.4 Healthy life expectancy

Healthy life expectancy is an estimate of how many years are lived in good health over the lifespan. It is commonly used to try and assess whether ageing populations – including Walsall's – will be vibrant and independent, or suffer from greater chronic ill-health and poor quality of life. Extending a person's life alone is insufficient: if the quality of that life is not healthy, it will have a detrimental impact on service needs such as the planning of health and social services, long term care and pensions.

	Males		Females		Person	
	LE	HLE	LE	HLE	LE	HLE
Walsall	77.3	59.4	82.3	61.2	79.8	60.3
West Midlands	78.4	62.5	82.6	62.8	80.5	62.65
England	78.9	63.2	82.9	64.2	80.9	63.7

Figure 10 Life expectancy (LE) and healthy life expectancy (HLE) comparison, 2009-2011 (Source: ONS)

The most recent data available in relation to healthy life expectancy shown in Figure 11 illustrates that Walsall has a slightly lower healthy life expectancy age compared to regional and national comparators.

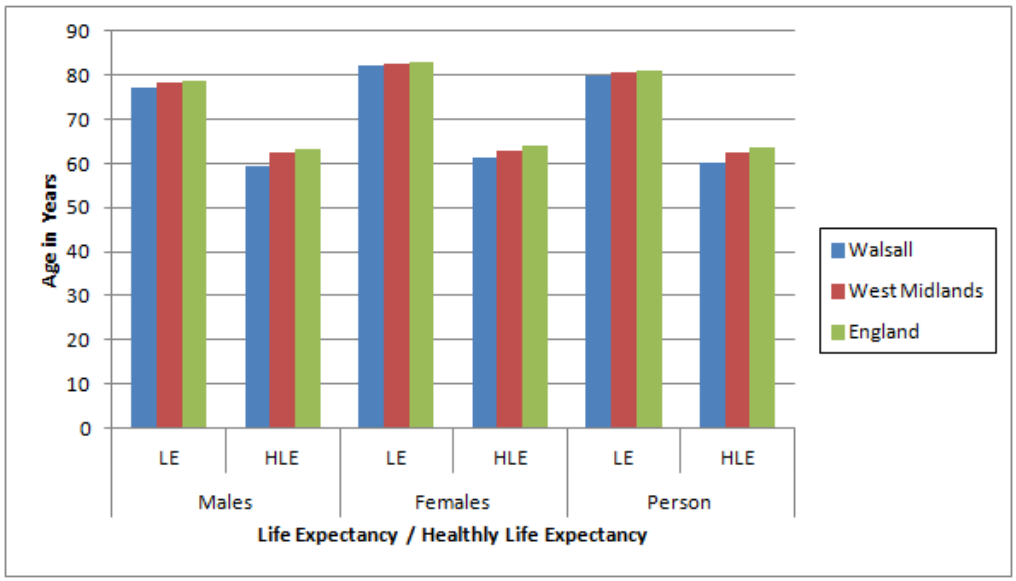


Figure 11 Life expectancy and healthy life expectancy comparison, 2009-2011 (Source: ONS)

Figure 11 above illustrates that overall life expectancy is gradually increasing for both males and females and that the gap with comparator areas has shown positive signs of narrowing. However, the focus needs to be on prolonging a healthy life expectancy and understanding and planning for the implications that will have on service need and provision.

1.5 Chapter summary and key priorities for action

Deprivation and poverty in childhood lie at the heart of inequalities throughout life. The Government's 'New Approach to Child Poverty 2011' recognised that 'poverty can be such a destructive force because of its long-term grip on families and communities, holding them back generation after generation'. The ultimate outcomes of inequalities in wellbeing are life expectancy and healthy life expectancy. Although improving in Walsall, both lag behind regional and national levels, and much needs to be done to narrow the gap between healthy life expectancy and life expectancy.

Key priorities are:

- *Proportionate action with greater intensity in areas of greater socio-economic need*
- *Reducing the impact of child poverty (see Appendix 3, CYP Plan Priority 8)*
- *Break inter-generational cycles of poverty and deprivation*
- *Partnership action from the early years onwards to ensure the growth of strong, resilient, healthy adults*
- *Maximise aspiration, educational attainment and employability across the borough*
- *Strong health focus on prevention and early intervention*
- *Robust pathways of care for all key contributors to mortality*

The following chapters describe wider determinants of wellbeing across the borough and key priority actions.

Chapter 2 Give every child the best start in life

A good start in life is at the heart of a happy childhood. Every young person should be given the opportunity to achieve their potential and grow up well-prepared for the challenges of adolescence and adulthood. Parental aspiration and support to motivate and encourage their children is critically important. Early interventions during pregnancy and ongoing support in the early years are fundamental to the long-term health of the child. Early years prevention is vitally important for improving health, reducing health inequalities and promoting educational engagement and attainment at all ages. Interventions later in life are less effective where early foundations are lacking. For this reason The Marmot Review highlighted the following priorities:

- *Reduce inequalities in the early development of physical and emotional health, and cognitive, linguistic and social skills*
- *Ensure high-quality maternity services, parenting programmes, childcare and early years education to meet need across the social gradient*
- *Build the resilience and wellbeing of young children across the social gradient*

This chapter of the JSNA reflects the importance of wellbeing in the early years, describing key indicators and early interventions in Walsall aimed at reducing inequalities in later life. Appendix 2 of this document uses various indicators to provide an overview of health and wellbeing of Walsall children and how they compare with England.

Birth rates across Walsall have risen in recent years. While infant mortality rates have declined across England as a whole, the rates in Walsall remain higher than regional and national rates and give significant cause for concern. Measures to address infant mortality rates will include a focus on reducing teenage conceptions, including repeat conceptions, housing overcrowding, smoking in pregnancy – particularly amongst pregnant teenagers – and child poverty. Babies who are not breastfed are five times more likely to be admitted to hospital with gastroenteritis, and they are more likely to become overweight or obese in later childhood.

Different patterns of birth rates between deprived and affluent areas mean that more children are living in areas of deprivation than five years ago. Children who grow up in poverty are less likely to aspire and stay on at school, to attend school regularly, to get qualifications or go on to higher education and more likely to become young parents – locking whole families into inter-generational cycles of deprivation. This is particularly relevant in Walsall where there are high levels of child poverty, with 29.2% of children growing up in poverty. This has severe and lifelong adverse effects on health and wellbeing.

2.1 Infant and perinatal mortality

Infant mortality is a sensitive indicator of the overall health of a population, providing a measure of the wellbeing of infants, children and pregnant women. Although infant mortality in England is at an all-time low and falling, significant inequalities persist. Walsall's infant mortality rate is consistently higher than regional and national rates, reflecting its high level of deprivation.

Indicators:

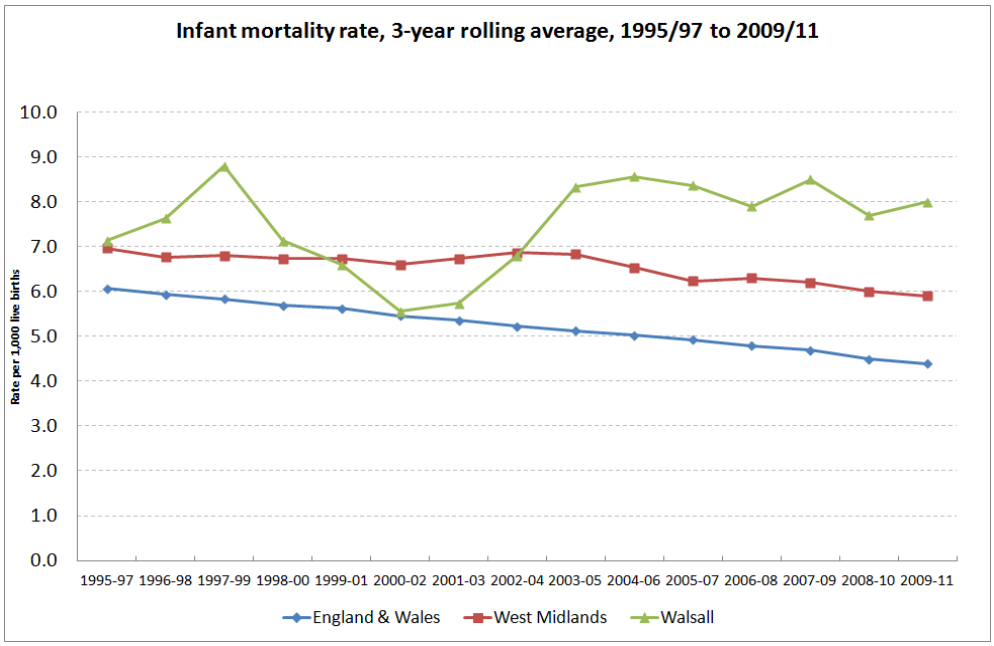


Figure 12 Infant Mortality rates 1995-2011 (Source: ONS)

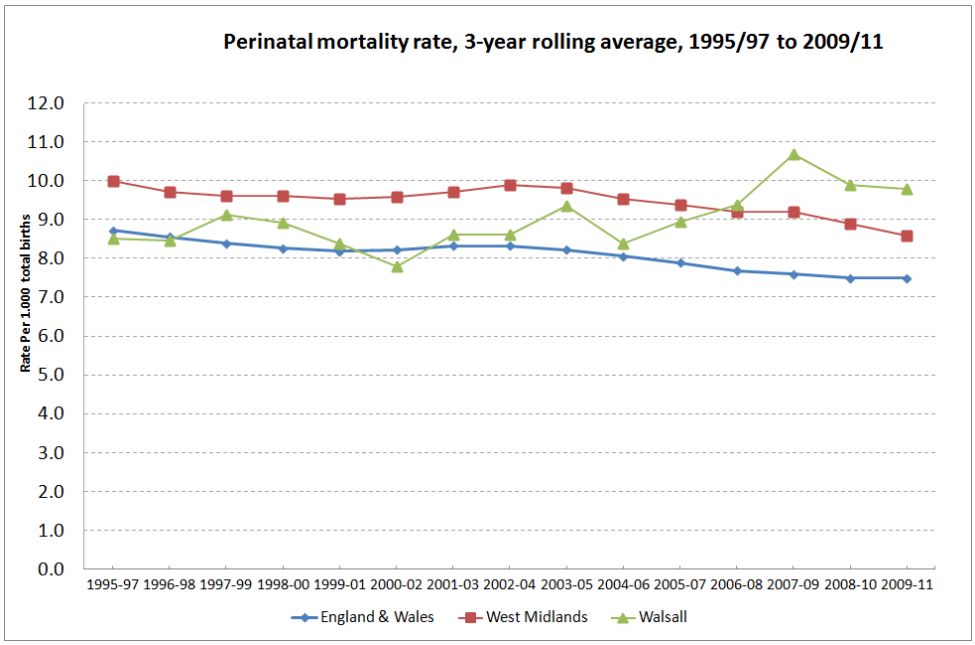


Figure 13 Perinatal Mortality rates 1995-2011 (Source: ONS)

In Walsall both infant mortality and perinatal mortality remain consistently higher than the regional and national levels (see Figure 12 and Figure 13 above). Both infant and perinatal mortality are strongly

associated with deprivation, with infant mortality rates of less than 5 per 1,000 live births[2] in the least deprived areas compared with rates of 32 per 1,000 in the most deprived areas of Walsall. Reducing health inequalities in infant mortality requires a combination of health interventions and actions on the wider social determinants of health.

Even though numbers are small and subject to greater volatility, Figure 14 shows that Walsall's level is still high in comparison to all three comparator averages; statistical neighbours 4.9, regionally 5.9 and nationally 4.4.

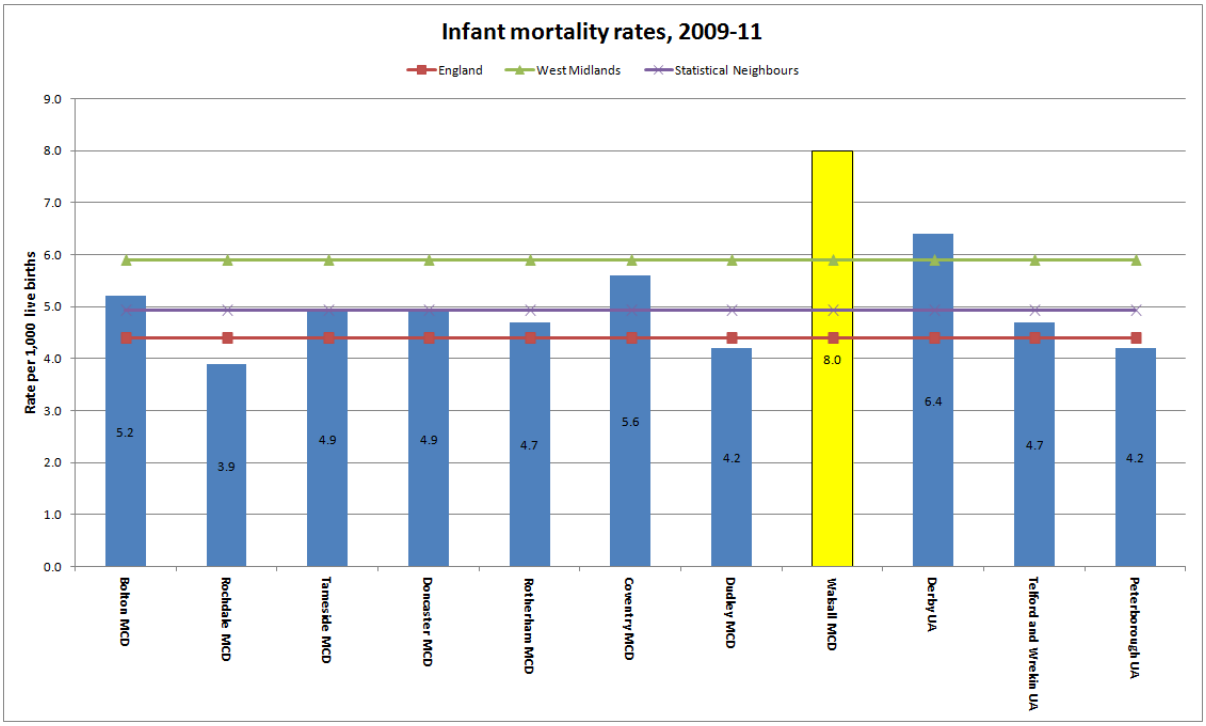


Figure 14 Infant mortality rates per 1,000 live births per year 2009-11, by Local Authority (Source: HSCIC)

Priorities for action:

An audit into infant and perinatal deaths in Walsall completed in 2008 identified four key contributing factors to infant and perinatal deaths in Walsall, namely smoking in pregnancy, consanguinity, maternal obesity and deprivation, which are in turn linked to prematurity and congenital abnormalities. Some of the key priorities within the Infant Mortality Action Plan include the following:

- *Improving antenatal care through encouraging early booking for antenatal care, continuity of carer through pregnancy and improved detection of intrauterine growth restriction (IUGR)*
- *Reducing levels of maternal obesity and smoking in pregnancy through projects such as Maternal and Early Years, Smoke-Free Homes, improving smoking cessation in pregnancy and working with ethnic communities to reduce the use of ethnic tobacco products*
- *Maintaining an effective antenatal and newborn screening programme*
- *Reducing sudden unexpected death in infancy (SUDI) and improving breastfeeding initiation and continuation rates*
- *Target vulnerable groups through specialised programmes such as the Enhanced Community Genetics service and the Family Nurse Partnership*

[2] Walsall Public Health Profiles 2012

- *Addressing social determinants such as reducing child poverty, improving housing and reducing overcrowding and reducing teenage conceptions, including repeat conceptions are also critical to reducing infant mortality*

2.2 The mental health of children and young people in Walsall

There are a large number of risk factors that increase the vulnerability of children and adolescents experiencing mental health problems. These include deprivation, poor educational and employment opportunities, enduring poor physical health, peer and family relationships, witnessing domestic violence, and having a parent who misuses substances or suffers from mental ill-health. Children who have been physically and sexually abused are at particular risk. Asylum seeker and refugee children have consistently been shown to have higher levels of mental health problems, including post-traumatic stress, anxiety and depression.

The way that children are parented, their diet and exercise, their school and education, experimentation with drink, drugs and other substances, along with many other factors, will all affect a child's mental wellbeing or mental ill-health.

Indicators:

- *The total number of patients 0-18 years with mental health disorder, self harm and factors influencing contact with health services as a primary, secondary or tertiary diagnosis was 659 spells in 2012/13.*
- *The Number of Walsall patients aged 0-18 years old admitted with a primary diagnosis of a mental health disorder has increased from 31 in 2009/10 to 39 in 2012/13.*
- *There has been a slight increase in total admissions for Walsall PCT patients under 18 years for intentional self-harm and poisoning (ICD codes X60-84) from 87 in 2009-10 to 99 in 2012-13.*
- *The number of patients aged 0-18years from Walsall admitted to acute hospitals with a primary, secondary or tertiary diagnosis of intentional self-harm increased from 113 in 2009/10 to 143 in 2012/13.*
- *For Walsall PCT patients aged 0-17 years old admitted to acute hospitals between 2009/10 and 2012/13 the majority of self-harm is by poisoning.*

Priorities for action:

Universal services

- *Ensure that all services working with children and young people adopt a whole life journey approach*
- *Enhance the capacity within the children's workforce to provide staff with the confidence to support and intervene at an early stage*
- *Ensure that children and young people, their parents, carers and professionals will have access and information about emotional health and wellbeing and know how to access support and advice*
- *Deliver the key elements relating to emotional health and wellbeing through the Healthy Child Programme, Health/social services, Teenage Pregnancy support and Youth Services , including parenting support.*
- *Promote positive activities that support mental health and emotional wellbeing*

Targeted services

- *Ensure that integrated care pathways will be implemented for child and adolescent mental health services for the key vulnerable groups*
- *Strengthen performance management by developing and implementing a Mental Health and Emotional Wellbeing Dashboard.*
- *Improve access to specialist parenting support for all parents, and in particular for vulnerable groups*
- *Ensure that children and young people with specific mental health needs, and their parents will have access to service user/parent support groups*

Specialist services

- *Ensure age appropriate care in the community and in inpatient settings*
- *Develop consultation with children, young people and families in commissioning local services and designing service delivery*
- *Develop a model of service delivery where the duration of inpatient care and numbers out of county placements are reduced as much as possible*
- *Ensure that parents with mental health problems and their children will receive coordinated intervention and support*
- *Ensure that pregnant women with mental health problems will be identified and receive support through a multiagency maternal mental health pathway*
- *Ensure effective transition from CAMHS to adult mental health services*
- *Develop options to improve out of hours care access to child and adolescent mental health services*
- *Develop clear pathways of care for therapeutic services for vulnerable children with mental health and emotional wellbeing issues*
- *Ensure that adequate levels of local inpatient services provided for those who need it*
- *Develop clear processes for discharge from inpatient services*

2.3 Educational attainment – The early years

Giving young children the best start in life includes the provision of a high standard of education from an early age. A child's progress is assessed from an early age (Foundation Stage, when the child is between 3 and 5 years of age) and assessed at Key Stage 1 (Year 2). Education is a key social determinant of inequalities in society.

Indicators:

Due to changes in the Early Years Foundation Stage Profile, a direct comparison of this year's result with previous year's results is not appropriate. However, measuring the gap to national this year and in the previous year will give a general indication of any improvement within the key stage. At present, 46% of the pupils in Walsall have been judged to have made a good level of development. This is 6% below the national average, a gap that has remained unchanged from 2012 under the previous early year's framework. Writing, particularly the boys, remains the limiting factor for more pupils achieving a good level of development. Walsall is currently ranked 112 in quartile band D for this measure.

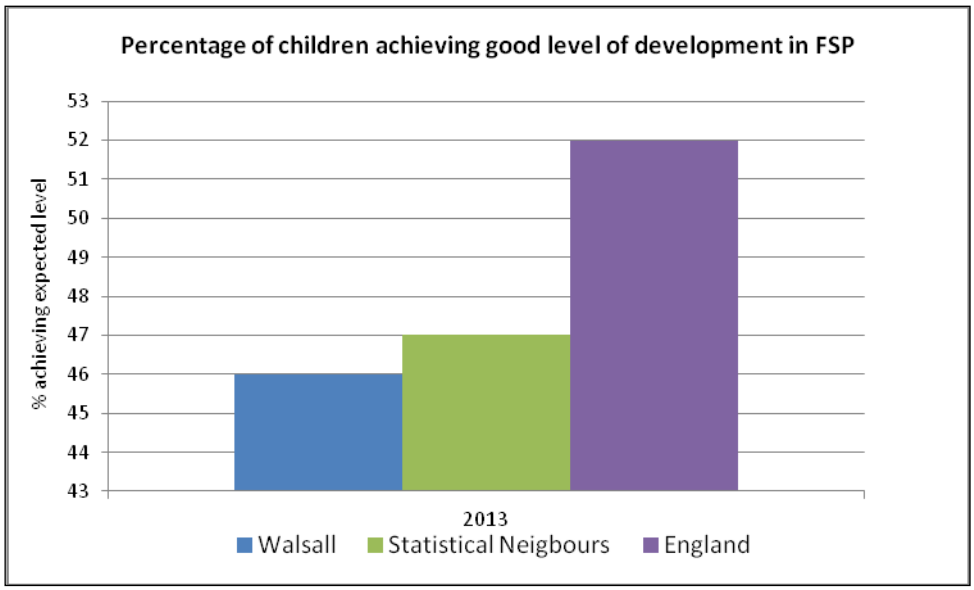


Figure 15 Percentage of children achieving a good level of development at Foundation Stage (EYFSP)
(Source: DfE: Early Years Foundation Stage Profile Results in LAIT - 5th Nov 13)

Absence rates are the key to addressing attainment as evidence shows there is a strong correlation between achievement and absence. Walsall's total absence rate is higher our comparator averages, statistical neighbours (4.4%) and England (4.4%). However, Walsall's absence rate did show a reduction from 5.4% to 4.6% in 2012 and now provisionally ranks 109th nationally.

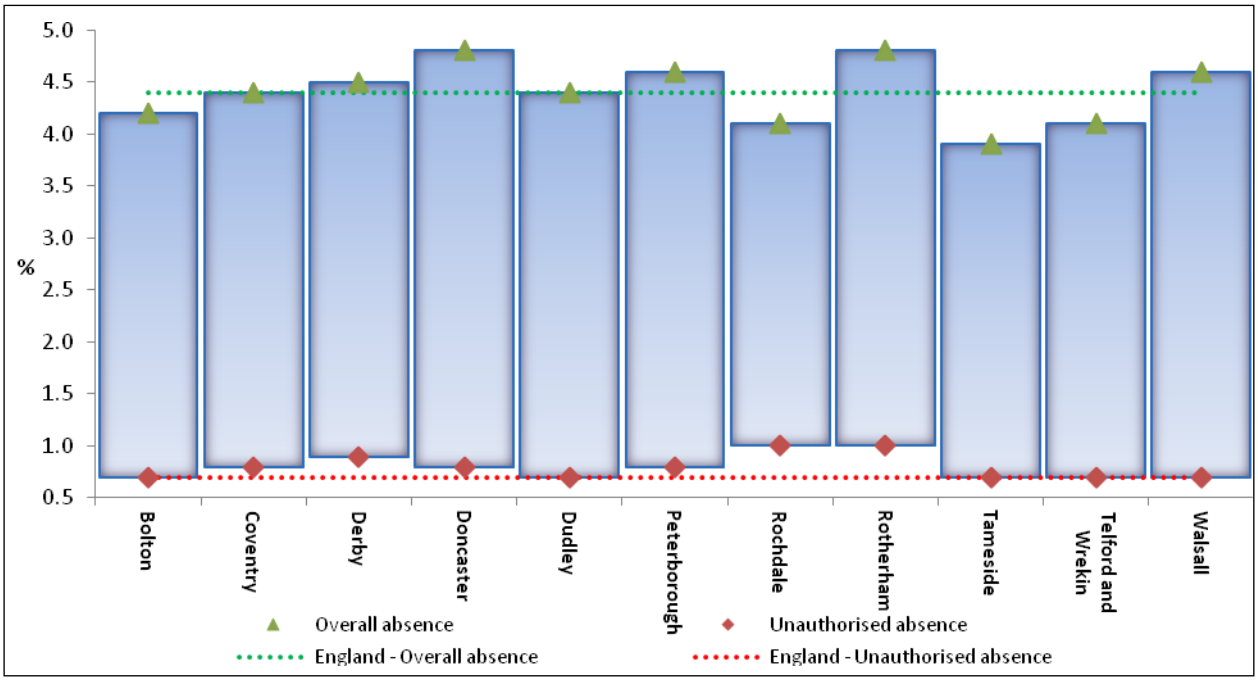


Figure 16 Overall Primary school absence rate 2011-12 (Source: DfE)

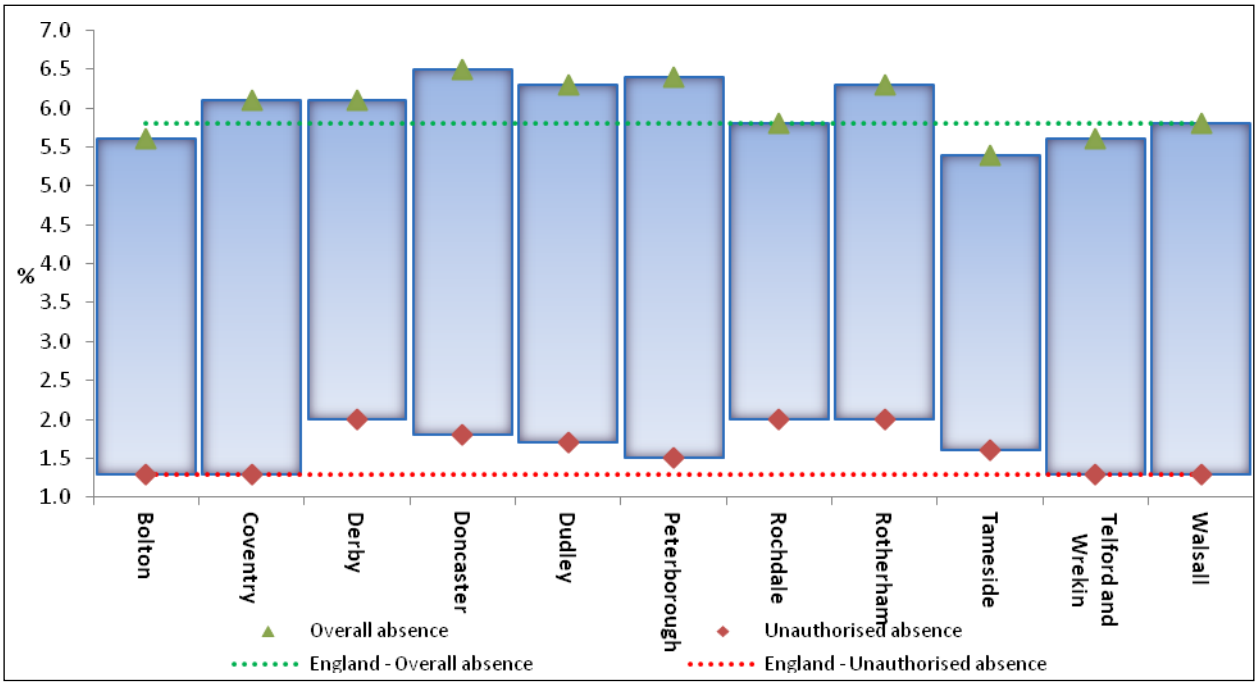


Figure 17 Overall Secondary school absence rate 2011-12 (Source: DfE)

Sub-groups of pupils, for example vulnerable children (Looked After Children (LAC),Children with Child Protection Plans), those with special needs or boys from white or mixed backgrounds need continuous close monitoring and targeted support to ensure Walsall is helping these pupils fulfil their potential and therefore reduce inequalities in educational attainment.

Priorities for action:

Investing in the early years, thereby improving early cognitive and non cognitive development and children's readiness for school is vital for later educational outcomes. High quality preschool experience can have positive effects on children's social, emotional and cognitive development.

Our priority is to target resources to support vulnerable groups and provide schools with appropriate support. Key priorities are to:

- *Increasing the percentage of children achieving a good level of development across Early Years Foundation Stage by learning from best practice in other councils*
- *Continue to focus on pupils achieving KS1 L2+ in writing and maths, particularly White British group and the achievement of pupils with Special Educational Needs (SEN) at School Action plus*
- *Ensure vulnerable groups, particularly pupils with SEN at School Action plus, LAC and children eligible for Free School Meals (FSM) receive targeted support*
- *Work with primary schools to improve overall attendance rates*

2.4 Parenting capacity

It is instinctively known and evidenced in research that parents and carers are the most influential factor in a child's life and their outcomes. The role of a parent begins from conception, to early childhood, through to adolescence and to adulthood. Multiple life stressors, such as a family history of abuse or neglect, health problems, domestic and financial stressors such as unemployment, poverty, and homelessness can diminish a parent's capacity to cope effectively with the typical day-to-day stresses of raising children.

The elements of assessing families in terms of their Parenting Capacity was outlined in the DoH Framework for the Assessment of Children in Need & their families (2000) as being able to deliver; basic care, ensure safety, provide emotional warmth, stimulation, guidance & boundaries and stability to their children.

Recently NICE's (National Institute for Health and Care Excellence) recommendations on improving the social and emotional wellbeing of children and young people, included the importance of local authorities developing parenting skills through a universal approach and also through a targeted approach for those children who were for example developing behavioural problems.

In terms of need, there are approximately 34,500 households with dependent children aged up to 19 years old in Walsall (Census 2011), approximately a quarter of which are households occupied by lone parents.

Initial estimates for households/families which could be targeted to develop their parenting skills can be formulated. The nationally rolled out Government Troubled Families Programme estimated that there were approximately 800 Troubled Families in Walsall, based on factors such as poor school attendance, level of crime and/or anti-social behaviour and worklessness in the family. About one third of the Troubled Families identified to date in Walsall were already known to Walsall Children's Social Care Services, the family had a child who was being supported by Child in Need (CiN) plan, had a child subject to a Child Protection Plan (CPP) or had a child in care (LAC). These families would benefit from more targeted parenting support.

The initial focus of Walsall's 2011 Parenting Strategy was to train practitioners (within and outside the local authority) on a range of evidence based parenting programmes. The focus going forward is now to increase the numbers of parents accessing these programmes through a targeted approach.

Indicators:

- *Reduce number of CPP and LAC*

Priorities for action:

- *Provide specialist Parenting Practitioners to deliver evidence based parenting programmes to complex & vulnerable families open to specialist services.*
- *Strengthen referral pathways from children's social care services.*

2.5 Healthy weight

Childhood obesity is a particular concern and it is widely accepted that there is a link between childhood obesity and risk of disease and death in later life. The strongest predictor of childhood obesity is parental obesity (a mixture of nature and nurture) and children who are very overweight (clinically obese) are more likely to grow up to be obese adults, therefore a vicious circle is created. In later years issues for overweight children are social and psychological, including stigma, bullying, low self-esteem and depression. In the first instance the National Child Measurement Programme (NCMP) measures Reception (age 4-5 years).

Indicators:

The indicator for obesity in Reception-aged children is the prevalence of excess weight and obesity in children aged 4-5 years, as highlighted in the Public Health Outcomes Framework. Walsall's overweight and obesity prevalence in Reception year is 24.1% (NCMP data 2011/12) which is lower than the Black Country Cluster prevalence (24.6%) but slightly higher than the Regional prevalence (23.5%) and the National prevalence (22.6%).

Obesity is associated with social and economic deprivation; there is a particularly strong gradient nationally in children, with increased deprivation being associated with increased obesity. This is reflected in local childhood obesity data, as seen in Figure 18 below, which shows that obesity rates are higher in the most deprived wards in the west of the borough.

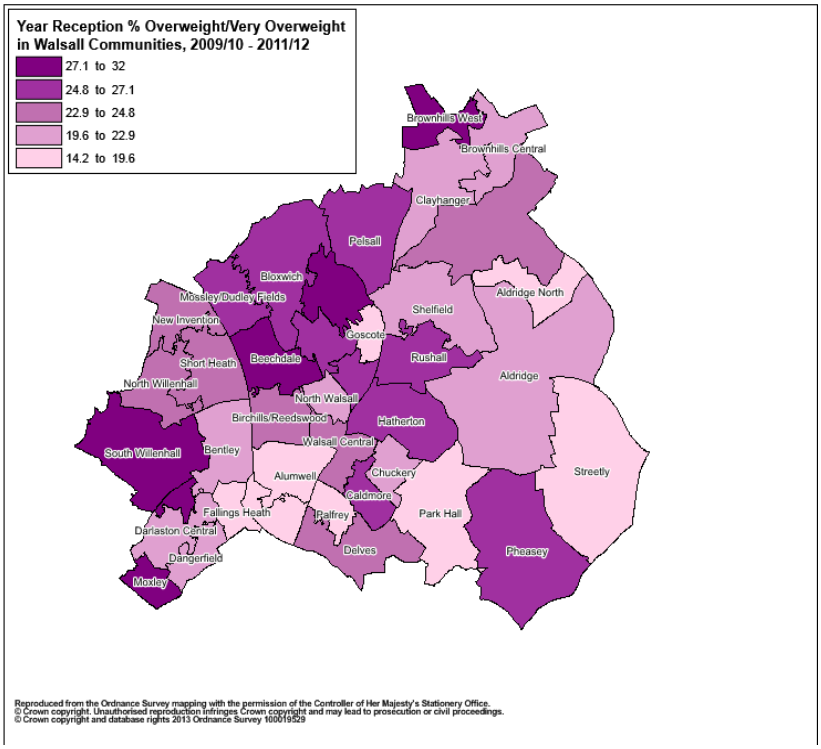


Figure 18 Walsall communities overweight/ very overweight at age 4-5, 2009-2012 (Source: National Child Measurement Programme)

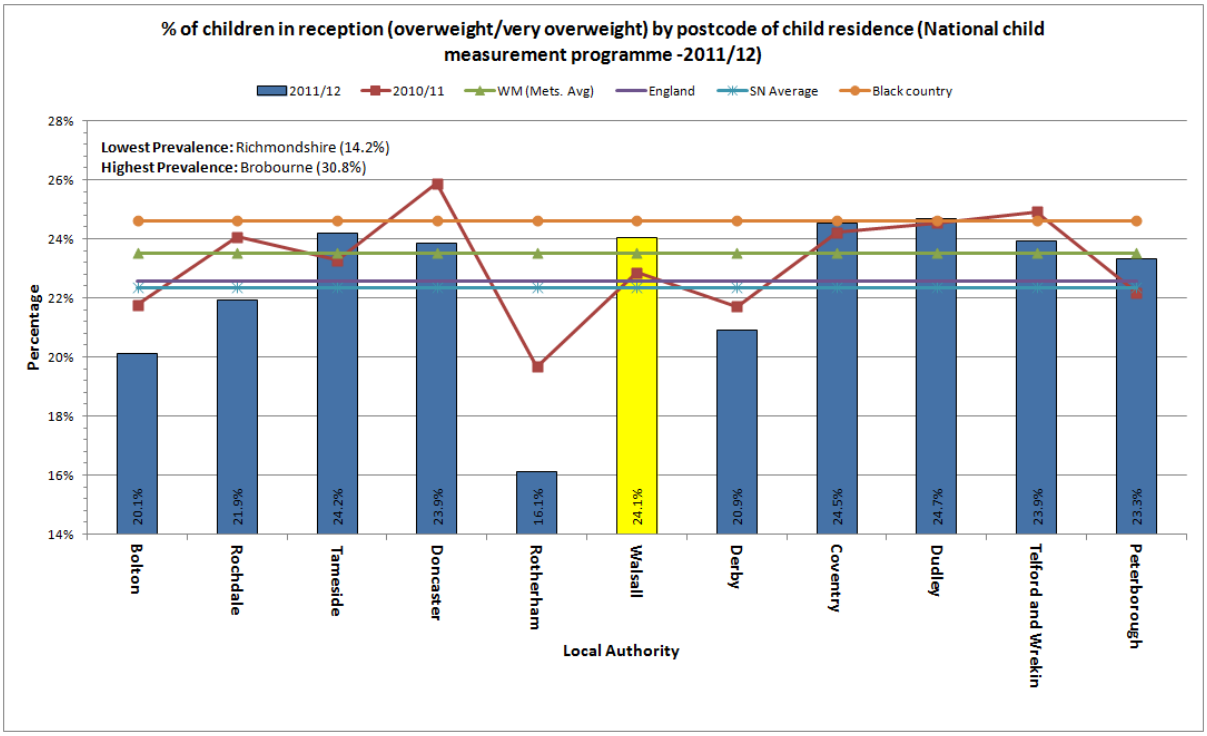


Figure 19 Percentage children in Reception overweight/very overweight (Source: National Child Measurement Programme 2011/12)

Priorities for action:

Through Walsall's Child Measurement Programme, children identified as being overweight or very overweight (clinically obese) will continue to be offered help and support through our weight management programmes, Fun 4 Life and Make it Count. Focussing on prevention is also paramount to tackling

childhood obesity; this will be achieved by working closely with partners to deliver early years interventions including:

- *Continuing to commission the Maternal and Early Years programme and increase referrals and engagement onto the programme through training and appropriate identification*
- *Rolling out the Food Dudes programme and Dining Room Experience to primary Schools (an evidenced-based behavioural programme to increase the consumption of fruit and vegetables)*
- *Initiating the Food Dudes Early Years Programme to Children's Centres and schools with attached nurseries(an evidenced-based behavioural programme to increase the consumption of fruit and vegetables)*
- *Continuing to promote the benefits of a healthy lifestyle to families, so that physical activity becomes a routine part of their daily life*

2.6 Children's Oral Health

The oral health of children remains one of the Governments public health priorities and is mentioned in the Public Health White Paper (2010). It has been confirmed that the oral health of five year olds will be monitored as a public health measure in future.
It is accepted that the condition of a person's teeth when they are five years old is a good predictor for their oral health in later life. It is therefore vital to promote good oral health habits from an early age.

It has been recognised that there is a link between poor oral health, determined by dental decay experience (decay that is untreated or treated by restoration or extraction of teeth) and social and economic factors with a clear link to deprivation.

Many expectant mothers are unaware of the implications of poor oral health on themselves and also their unborn baby. Evidence continues to link gum disease to pregnancy outcomes including low birth weight babies and not carrying to full term. Additionally mothers who have high levels of oral bacteria are at greater risk of infecting their children and increasing the risk of early childhood decay. Pregnancy therefore presents an ideal opportunity to inform.

The first four years of age is a vital stage for oral health promotion for children and parents. A regular attendance at a dentist should also be established. Managing extensive dental disease in a young child can be very complex and often treatment is offered under a general anaesthetic as this is the least distressing option. Recent figures for 5 year olds with decayed / missing / filled teeth in Walsall are lower when compared regionally and nationally (2.97 compared to 3.23 and 3.45 respectively).

Priorities for action:

- *Pregnancy is an ideal opportunity for oral health promotion and signposting into NHS dental services. Further work is required on this.*
- *Maintain fluoridation of the water supply*
- *To raise awareness of the need for oral health improvement outside of the dental community*
- *Health visitors will have a crucial role to play as they have contact with all families with preschool children.*
- *Link dental practices with early years setting across the borough*
- *Key stage 2 curriculum has the function and care of teeth as a topic alongside good nutrition. In order to maximise this opportunity we need to ensure classroom input is evidence based and consistent*
- *Partnership between the dental profession and other agencies will underpin all efforts to improve oral health across Walsall.*

2.7 Chapter summary and key priorities for action

The challenges facing children in their early years in Walsall are substantial: they have a 'poor start in life' with high infant mortality rates and poor educational attainment at ages 3-5, together with high levels of obesity.

Parents, supported by all services, are the key to achieving the best physical and mental health and wellbeing outcomes for their children; therefore parenting support is essential to improve early years outcomes. Research has identified that it is both the nature and the accumulation of risk factors that threaten children's mental and physical wellbeing and long term outcomes. This risk is countered by the accumulation of resilience factors promoting positive outcomes. In turn it is the balance of risk and resilience that determines outcomes. Hence interventions that target the development of multiple opportunities, resources and strengths in children, families and communities show the best outcomes.

Improving child safety and safeguarding includes tackling a wide range of issues, including abuse and neglect, accidental injury and death, bullying, crime and antisocial behaviour and ensuring a safe home environment. A substantial minority of children experience risk each year in Walsall and it is important that Safeguarding is treated as a high priority to ensure children are identified and appropriately protected.

Supporting parents by providing parenting programmes has a good evidence base and we need to further invest in enhancing more parents' skills in caring and motivating their children to ensure better life outcomes.

Investing in the early years, thereby improving early cognitive and non-cognitive development and children's readiness for school is vital for later educational outcomes. High quality preschool experience has proven positive effects on children's social, emotional and cognitive development that impact on their whole adult life.

Priorities for action:

- *Prioritise across the borough 'a good start in life' in recognition of the lifelong cost benefits for health and wellbeing*
- *Reduce infant mortality through holistic support for families from before birth, with a priority for maternal health interventions. This should include home visiting support for disadvantaged young parents and a focus on reducing levels of smoking in pregnancy and increasing rates of breastfeeding, particularly in deprived areas*
- *Promote and support parenting skills and build on recent improvements in the provision of evidence-based parenting programmes, advice and assistance*
- *Provide specialist Parenting Practitioners to deliver evidence based parenting programmes to complex & vulnerable families open to specialist services.*
- *Strengthen referral pathways from children's social care services.*
- *Provide good quality early years education and childcare proportionately across the social gradient*
- *Support schools and parents to improve children's attendance from early years onwards*
- *Ensure there is a focus on early years and that expenditure on early years development is focussed progressively across the social gradient*

- *Enhance safeguarding by:*
    - *Parenting support programmes for young parents to reduce neglect*
    - *Support for Domestic Violence Treatment and Prevention Projects*
    - *Targeted prevention work through the Think Family Team*

Chapter 3 Enable all children and young people to maximise their capabilities and have control over their lives: transition to adulthood

This chapter highlights the interdependence of key outcomes such as health and wellbeing, the ability to learn and achieve, and being employed, draws out some of the wider actions to address them. Reducing inequalities requires a sustained commitment to children and young people throughout the years of education.

Adolescence is not only a key transition point between childhood and adulthood, it is a distinct developmental stage in its own right, characterised by dramatic physical and neurological changes and emotional development. Many adolescents are healthy, but a significant proportion face a range of problems that have implications for their health, now and in the future, for this generation and the next – such as obesity, smoking, alcohol and other substance abuse, teenage pregnancy and mental health problems.

Good health for children and young people is crucial, because it enables them to make the best of their opportunities in education and in developing healthy lifestyles. It promotes health and wellbeing in adulthood and an ability to contribute fully to wider society. Parental and educational support of aspiration and study in order to obtain qualifications and good jobs are essential to break down the inter-generational cycle of poverty, deprivation and unemployment that affects many people in disadvantaged groups and areas.

Improving wellbeing for young people requires a commitment to maximising opportunities for educational attainment, and the development of both life skills and employment skills supported by nurturing, resilient families and communities. The Marmot Review captured this with the following priorities:

- *Reduction of the social gradient in skills and qualifications*
- *Ensuring that schools, families and communities work in partnership to reduce the gradient in health, wellbeing and resilience of children and young people*
- *Improvement in the access to and use of quality lifelong learning across the social gradient*

This chapter of the JSNA discusses key influences and strategies to improve wellbeing in the school and transition years, enabling young people to realise their aspirations and to become independent, capable adults.

3.1 Educational attainment

Continuing educational engagement and aspirations for the future are central to breaking inter-generational cycles of disadvantage. Anecdotally, and confirmed by children's perception surveys, Walsall faces a real challenge around low levels of aspiration – in common with many areas experiencing a structural industrial decline. The national Tellus Survey 2010 found that only 44% of Year 6 children expected to study after year 11, compared to 50% for similar councils. Locally, traditional views persist - that education and attainment were unimportant as young people would leave school at 16 and work in local industry not requiring high levels of qualifications. This is compounded by the economic downturn and a local lack of job opportunities (discussed further in Chapter 4). Promotion of aspiration and educational attainment is vital to move from a vicious to a virtuous cycle.

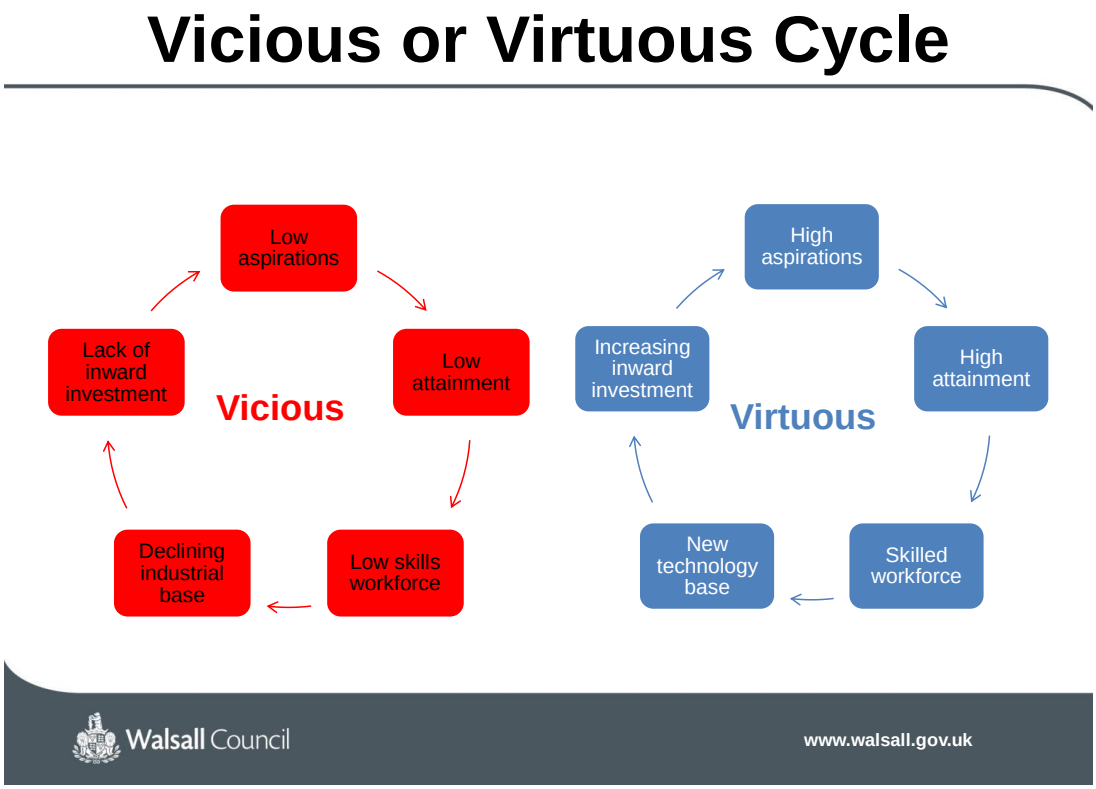


Figure 20 Vicious or virtuous cycle

3.1.1 GCSE (Key Stage 4) and A/AS Level

Good attainment at GCSE level equips young people to move confidently onto the next phase of their lives. The gold standard of each young person achieving 5 or more A*-C grades including English and Maths remains a key challenge for Walsall. Education is a key social determinant of inequalities in society. Good attainment at A/AS Level or equivalent is equally important to access further educational opportunities and/or employment opportunities.

Indicators:

Walsall's 2013 results for the percentage of pupils achieving 5+ GCSE A*-C including English and maths have improved this year. Results improved by 2% on the previous year, rising from 56% to 58% this year.

English A*-C results improved by 3% from the previous year, rising from 62% to 65%. These still remain below the 2011 outcome of 68% and below this year's result for maths at 69%.

The LA remains below the national average for the 5+ GCSE A*-C including English and maths measure, although the gap has narrowed this year. The national average has remained at around 59%, an outcome that has not changed in the last 3 years. Walsall's current LA ranking has improved to 108 and the LA is now in quartile band C for this measure.

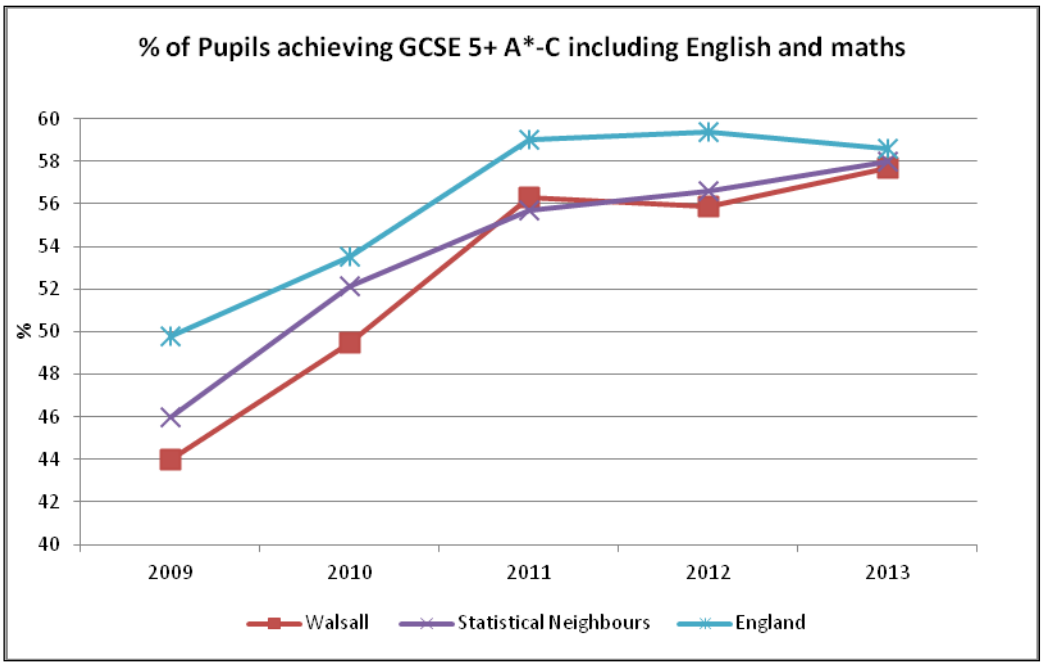


Figure 21 Key Stage 4 (GCSE) - Percentage of pupils achieving 5+ A*-C grades including English and maths (Key Stage 4 (Source: DfE: GCSE %+ A*-C including Eng Ma Results in LAIT - 5th Nov 13)

The LA's performance for pupils achieving 5+ GCSE A*-C has remained the same as the previous year at 87%, which is 6% above the national average. The national average has remained unchanged from 2012 at 81%. The LA's outcomes for pupils achieving 5+ GCSE A*-G has fallen this year by 1% to 92% but remains above the national average. Walsall's current ranking is 32 and the LA is in quartile band A for this measure.

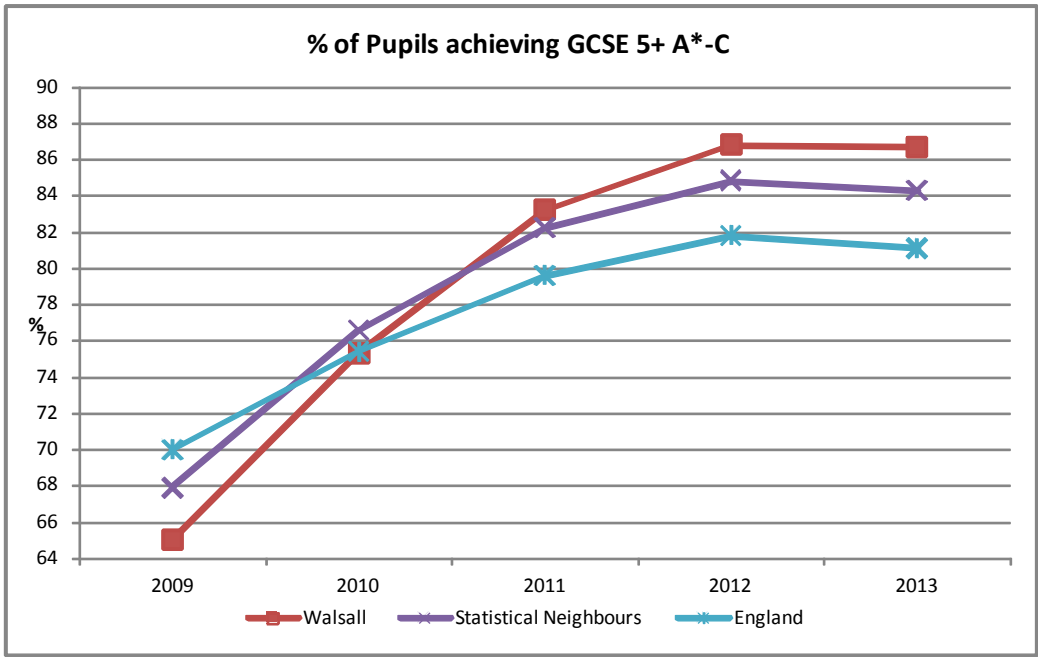


Figure 22 Key Stage 4 (GCSE) - Percentage of pupils achieving 5+ A*-C grades (Source: DfE: GCSE %+ A*-C in LAIT - 5th Nov 13)

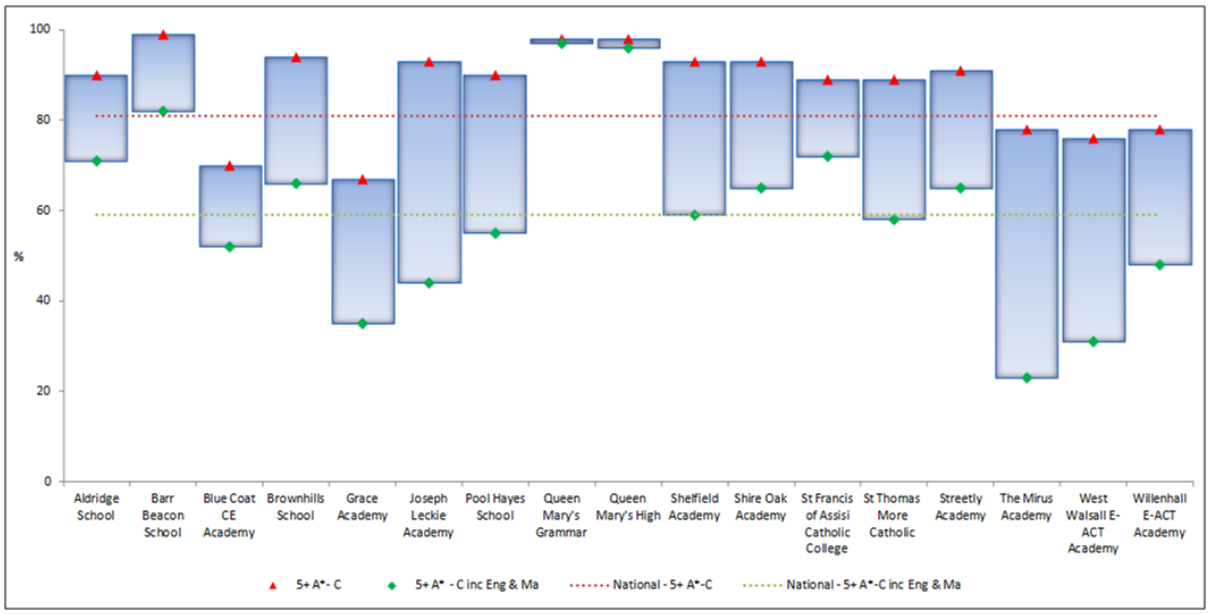


Figure 23 Key Stage 4 (GCSE) - Percentage of pupils achieving 5+ A*-C grades including English and maths versus Percentage of pupils achieving 5+ A*-C (Key Stage 4 Source: EPAS & LAIT - 5th Nov 13)

English remains the limiting factor in the LA's overall performance for the headline measure of 5+ GCSE A*-C including English and maths. This can be attributed to a gender gap between the boys and the girls' attainment. This year 58% of the boys, compared to 72% of the girls passed English with an A*-C grade.

A/AS Level attainment is measured in two ways, the average point score per candidate and average point score per entry. It is recognised that good attainment at A/AS level or equivalent is equally important to access further education opportunities and/or employment opportunities. Walsall is faced with the challenge of closing the gap between Walsall and regional/national levels.

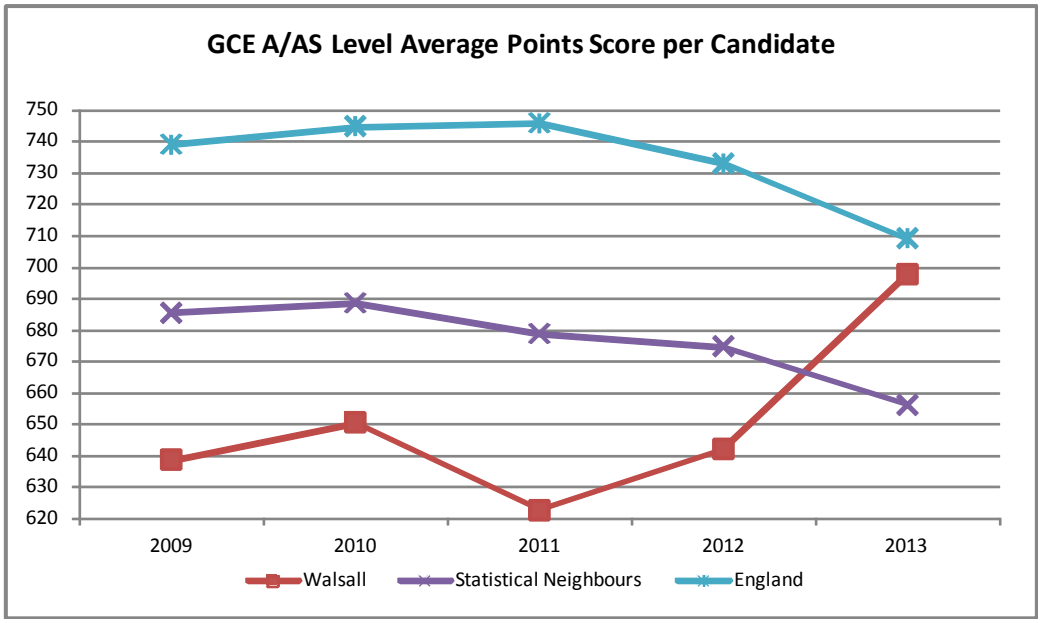


Figure 24 Key Stage 5 (A/AS Level) - Average Point Score per Candidate Key Stage5 (Source: DfE: A/As Level Average Point Score per Candidate Results in LAIT - 5th Nov 13)

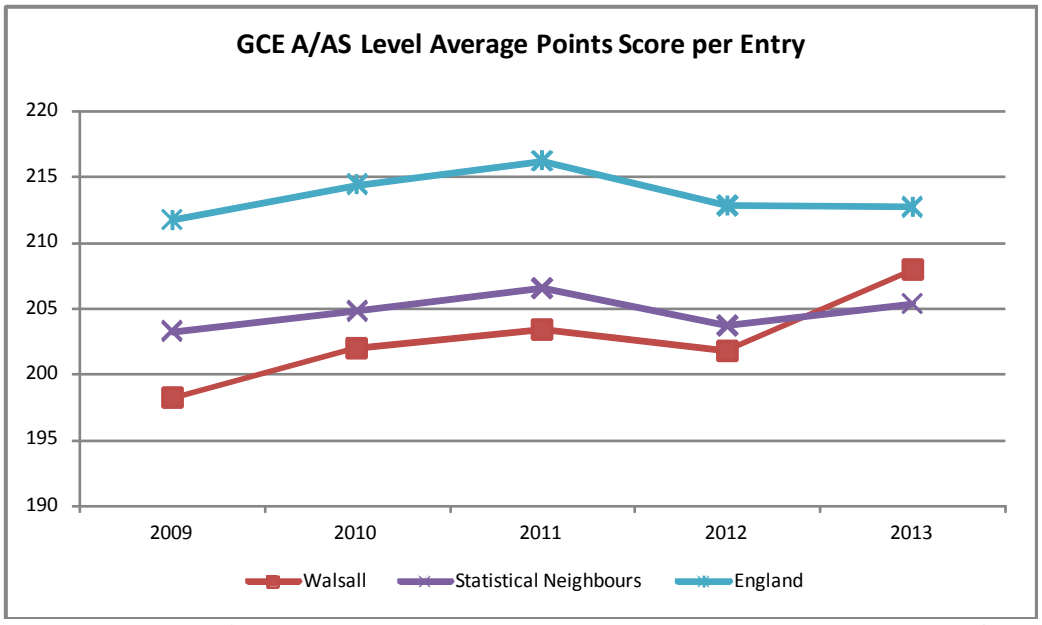


Figure 25 Key Stage 5 (A/AS Level) - Average Point Score per Entry (Key Stage5 (Source: DfE: A/As Level Average Point Score per Entry Results in LAIT - 5th Nov 13)

Outcomes for KS5 have improved in 2013 compared to the previous year. The average points per candidate improved by 56 points rising to 698 which ranks the LA 51st in the country, in quartile band B. This is in comparison to the national average which has fallen for the second year in succession, from 746 points in 2011, to 709 points in 2013. The LA's outcomes for average points per entry have also improved on the previous year. Results for the LA have improved by 6 points, from 202 points in 2012, to 208 points in 2013, which ranks the LA 81st in quartile band C. However, this still remains below the national average of 213 points per entry.

Priorities for action:

- *Target support and challenge at school and individual level where there is underperformance*
- *Promote and broker school to school support including the use of Advanced Skills Teachers (ASTs) and Local Leaders of Education (LLE)*
- *To extend the quality and range of programmes of study available to young people across the borough*
- *Provide additional resources for young people who are liable to disengage from learning, training or employment with training including more apprenticeships to support post 16 provision*
- *Continue to work with Walsall College to increase average point score by considering offering different and more qualifications per student*
- *Support school to school improvement and roll out Learning Community Pilots*
- *To develop partnership working with Academy schools and support them to improve attainment*

3.1.2 School attendance

School attendance is crucial to future well-being, as it is linked to attainment and to social inclusion. Absence rates in both primary and secondary schools in Walsall are recorded through the number of half days missed, both authorised and unauthorised, by children of compulsory school age.

Indicators:

In Walsall absence from Primary and Secondary schools has remained consistently in the bottom quartile despite reductions over time (because other councils are reducing faster). In 2012 primary total absence fell to 4.6% and ranked 109th and secondary total absence showed great improvement from 7.1% to 5.8% and ranked 70th (see Figure 26 and Figure 27).

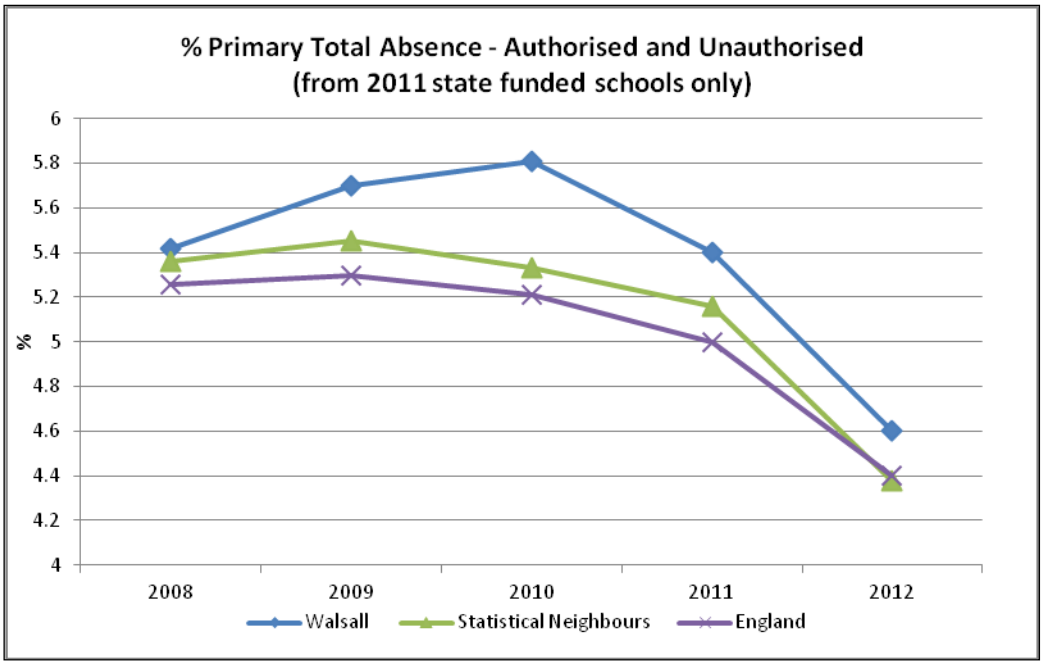


Figure 26 Primary School absence 2004-2012
(Source: DfE: Primary School absence 2004-2012 in LAIT - 5th Nov 13)

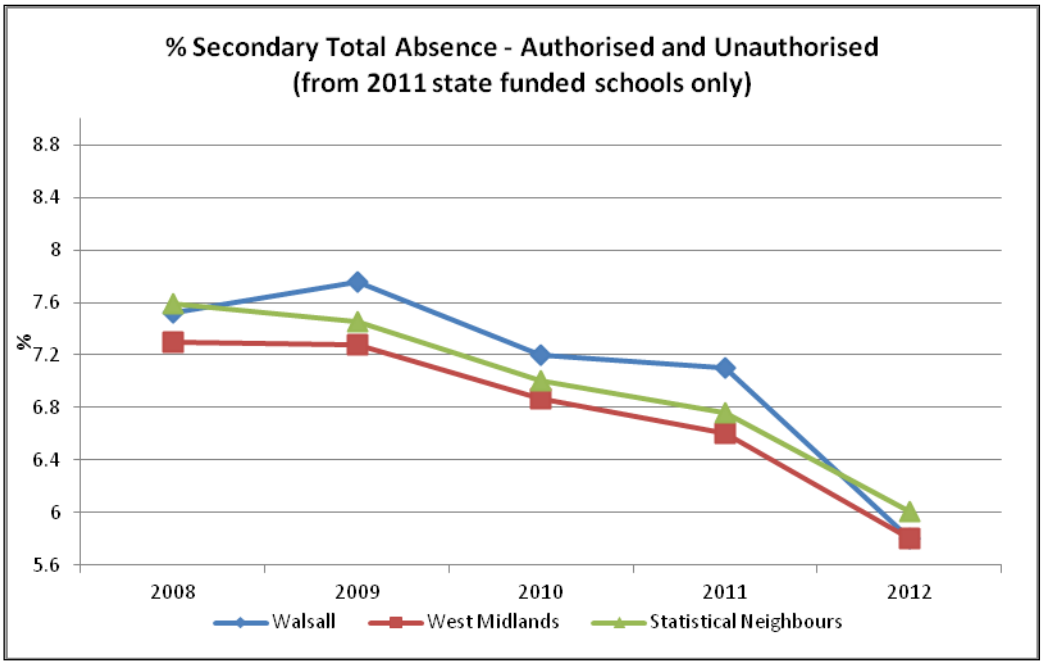


Figure 27 Secondary School absence 2004-2012
(Source: DfE: Secondary School absence 2004-2012 in LAIT - 5th Nov 13)

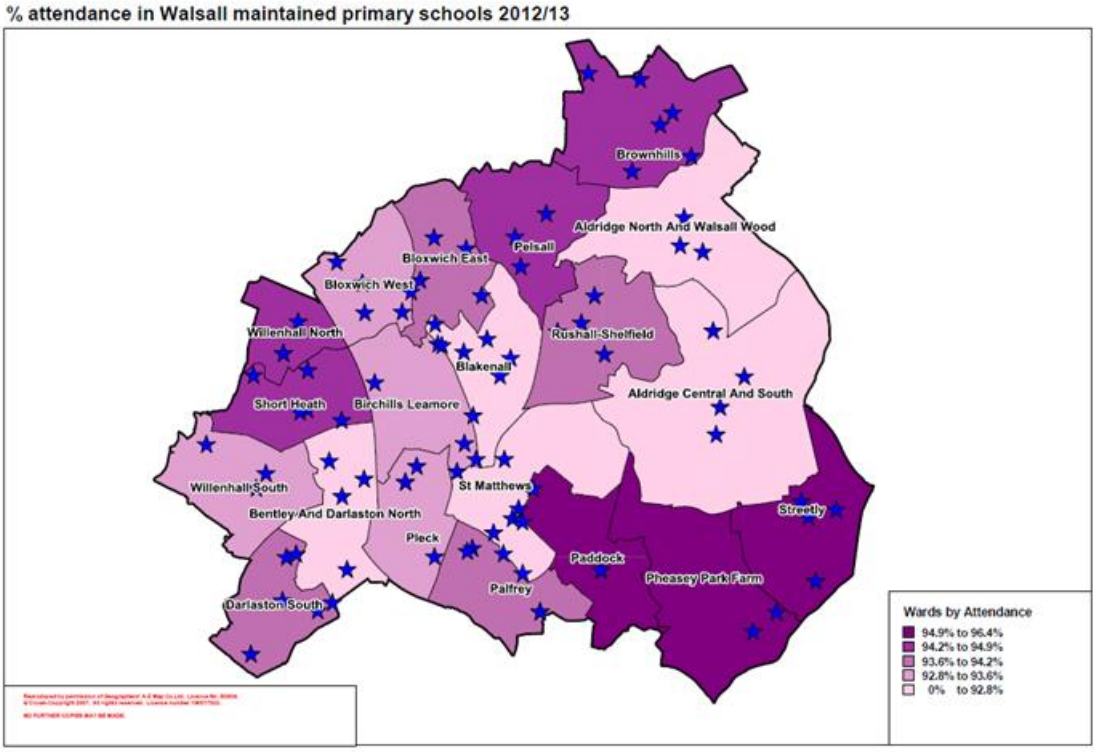


Figure 28 Primary School % of attendance by ward 2012/13 (Source: Capita One Pupil Database)

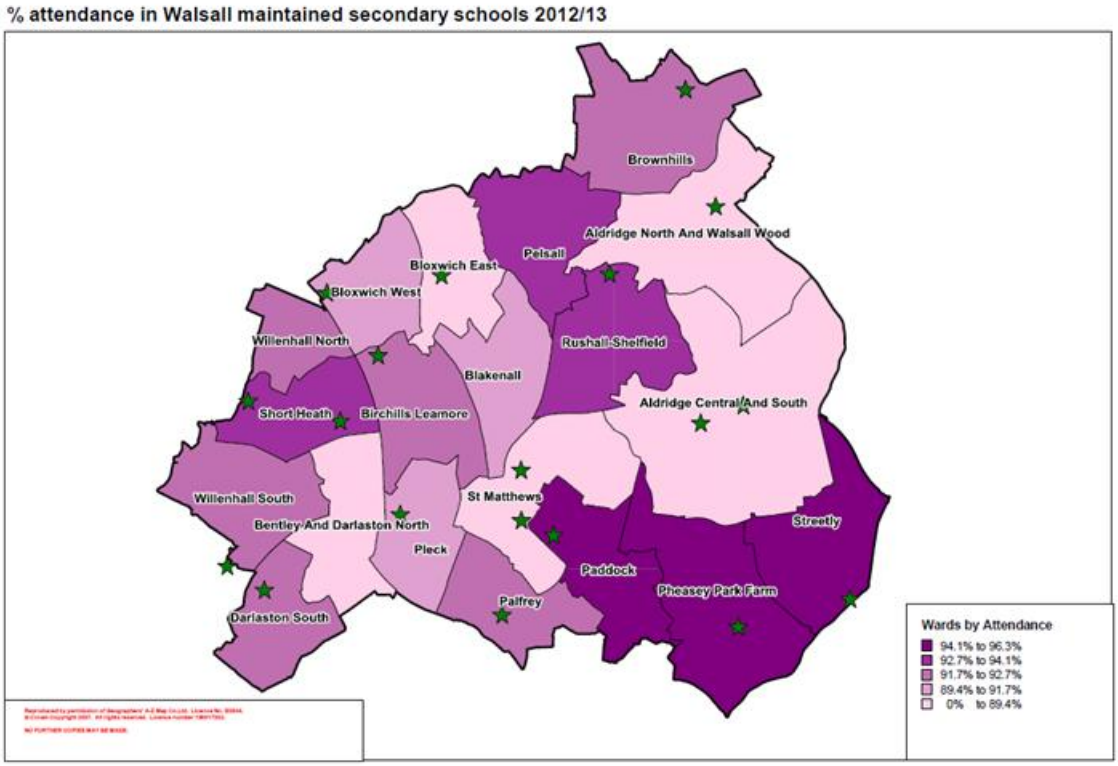


Figure 29 Secondary School % of attendance by ward 2012/13 (Source: Capita One Pupil Database)

There is a correlation between school absence and deprivation – Figure 28 and Figure 29 show wards with the lowest levels (lighter shading) of attendance in both primary and secondary schools are also those with higher levels of deprivation than the Walsall average.

Priorities for action:

- *Promoting pride in the achievements of children and young people of Walsall (see Appendix 3, CYP Plan Priority 6)*
- *Set up Learning Community Pilots to provide school to school support and share learning and best practice from schools who have improved attendance*
- *Promote prioritisation of school attendance in social care interventions and in parenting programmes*
- *Target Education Welfare support to pupils with sustained absences*
- *Close liaison with school improvement services and to analyse target interventions as required*

3.2 Healthy weight

Childhood obesity is a particular concern, and there is a link between childhood obesity and risk of disease and death in later life. The strongest predictor of childhood obesity is parental obesity (a mixture of nature and nurture): children who are obese are more likely to grow up to be very overweight (clinically obese) adults; therefore a vicious circle is created. More immediate issues for overweight children are social and psychological, including stigma, bullying, low self-esteem and depression. The National Child Measurement Programme (NCMP) measures Reception and Year 6 children and exceeds its participation rate targets annually. In addition to measuring Reception and Year 6, Walsall also measures Year 4 and Year 10 providing robust data on childhood obesity.

It is recognised that behaviour formed and set in early years becomes the norm throughout the rest of their lives. Schemes such as Food Dudes, being jointly delivered into Walsall's Primary Schools by Public Health Walsall and School Catering Services, are recognised as successful methods to assist behavioural change.

School catering plays a significant role in forming behaviours such as healthy eating; having a hot meal each day and ensuring meals are nutritionally balanced. This is particularly important for Free School Meal-eligible children. Catering in schools is not provided by a single caterer. The Council's service delivers to 73 of the borough's schools. All other schools have their own arrangements which can make overall coordination difficult.

Indicators:

The national indicator for obesity in Year 6 children is the prevalence of overweight and very overweight (clinically obese) children in 10-11 year-olds as highlighted in the Public Health Outcomes Framework. Walsall's overweight and obesity prevalence in Year 6 is 37.3% (NCMP data 2011/12) which is lower than the Black Country Cluster prevalence (39.3%) but

higher than the regional (36.3%) and national prevalence (33.9%). When measuring obesity only, this has increased by 0.4% since 2011 to 23.2%.

Locally Public Health proposes the indicator to be that 87% of Walsall's primary schools will have had the Food Dudes programmes implemented by July 2014 (an evidenced-based behavioural programme to increase the consumption of fruit and vegetables).

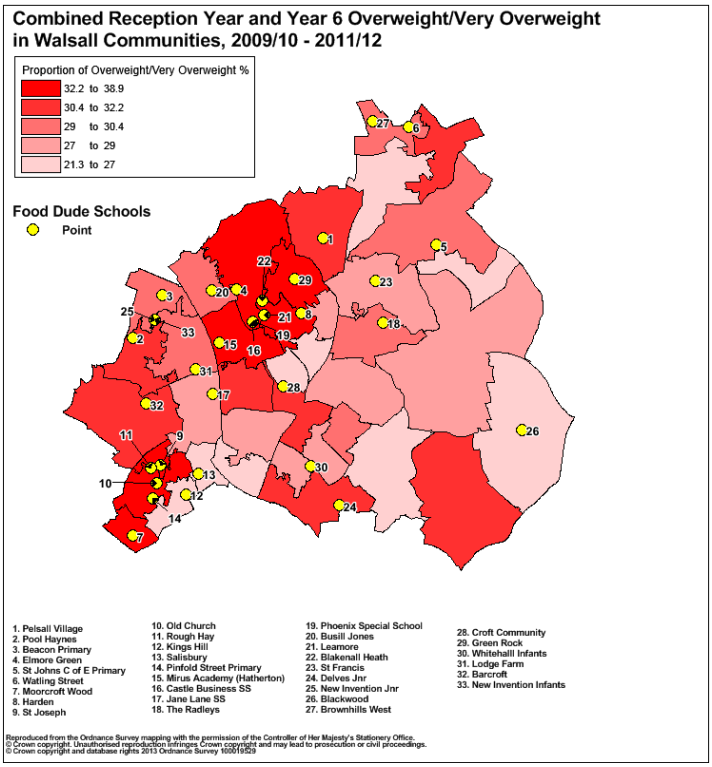


Figure 30 Walsall Combined Reception and Year 6 Overweight/Very Overweight by community 2009-12 (Food Dudes schools highlighted) (Source: National Child Measurement Programme)

Priorities for action:

Through Walsall's NCMP, children identified as being overweight or very overweight (clinically obese) will continue to be offered support through weight management and physical activity programmes, Fun 4 Life and Make it Count. Those identified as underweight can access support from Walsall Healthcare NHS Trust dieticians. Focusing on prevention is paramount to ensuring children's healthy weight. This will be achieved by partners working closely together to deliver early interventions. The focus should be on:

- *Ensuring that children maintain a healthy weight (see Appendix 3, CYP Plan Priority 2)*
- *Rolling out the Food Dudes programme to primary schools*
- *Developing a role for a young person's health advisor focusing on underweight children*
- *Ensuring school meals meet nutritional standards*
- *Developing a universal Walsall approach for the use of physical education within schools, as a means of ensuring healthy growth, appropriate skills, knowledge and motivation for later life and knowledge of healthy lifestyles*

- *Ensuring that planning policies promote the accessibility of healthy food options for young people*
- *Where existing takeaways are identified near schools, undertaking interventions with those premises to reduce the health burden of the food they produce and expand the range of foods to give children healthier option, e.g. through development of a takeaway food standard*
- *Ensuring that planning and transport policy and decisions improve the environment for health by promoting walking, cycling and active travel for school children*
- *Ensuring high profile promotion of free swimming for under-16's and robust evaluation of the programme*
- *Ensuring provision of healthier food and drinks in leisure centres*
- *Promoting the benefits of a healthy lifestyle families so that physical activity becomes a routine part of their daily life*

3.3 Sexual health

Around one third of Walsall residents are under the age of 25. This age group experiences the highest rates of sexually transmitted infections (STIs) and unplanned pregnancies; young people who live in deprived areas of the borough are the worst affected. Vulnerable groups susceptible to poor sexual health outcomes include teenagers not in employment, education or training (NEETS), Looked after Children (LAC) and children excluded from school.

Chlamydia is the most commonly-diagnosed sexually-transmitted infection. Most people who have it will have no symptoms and will be at higher risk of being infected with other STI's. Chlamydia infection can cause Pelvic Inflammatory Disease and infertility in women and painful inflammation of the testicles in men. There is an established Chlamydia Screening Programme in Walsall that aims to detect and treat infection in 15-24 year olds. Opportunistic Chlamydia screening provides key opportunities to engage with young people, through a holistic approach to improving knowledge and access to services including education, contraception, STI testing and condom distribution. Through Walsall's established sexual health services there is a multi-faceted approach to promoting good sexual health. This is focused on identifying those most at risk of contracting sexually-transmitted infections and encouraging safe behaviour and testing.

Indicators:

A key indicator of the sexual health of young people in Walsall is the Chlamydia diagnostic rate for the 15-24 year old population. This provides a measure not just of background rates of infection, but also of how young people are engaged in reducing risks associated with unsafe sex. Figure 31 show that young males and females between the ages of 20 and 24 have the highest rates of new STI's diagnosis. Figure 32 shows that the most deprived areas also have the highest Chlamydia rates in Walsall.

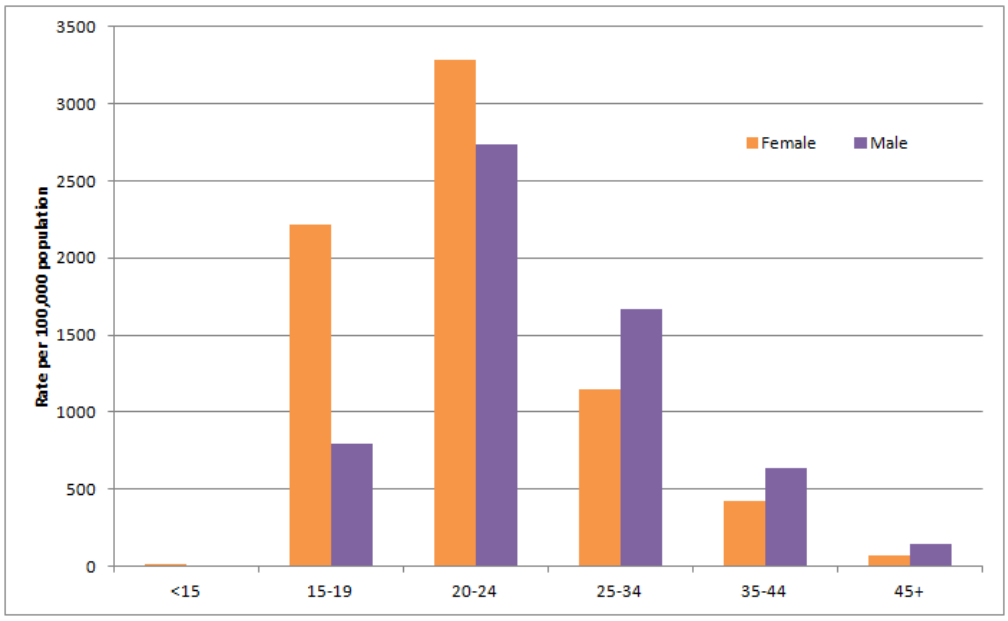


Figure 31 Rate of new STI diagnoses per 100,000 population by age, 2012 (Source: PHE)

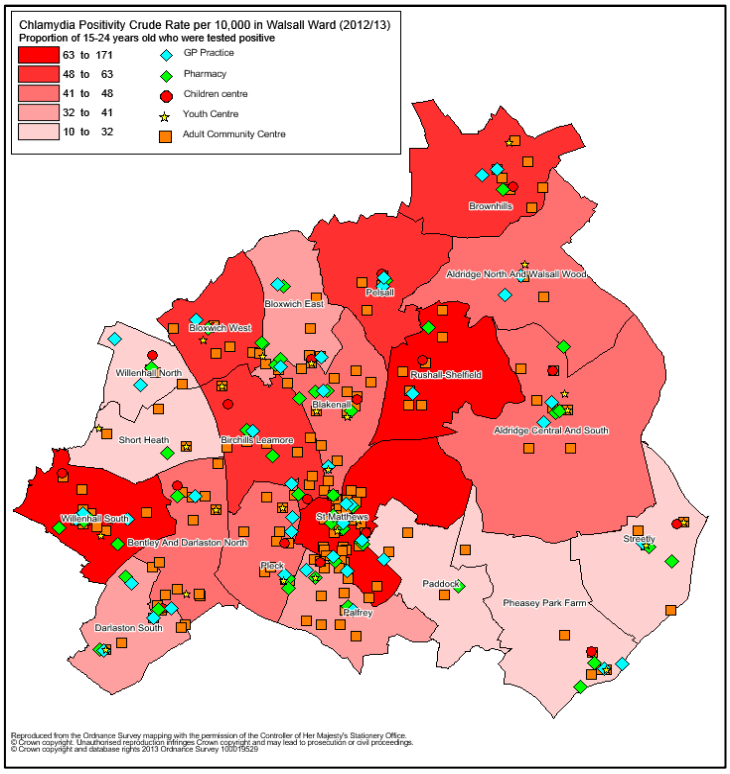


Figure 32 Chlamydia positivity crude rates per 10,000 by Walsall wards 2012/13 (Source: Black Country Chlamydia Screening Programme Database)

Priorities for action:

- *Ensure better collaboration between services which work with young people, including the Walsall Integrated Sexual Health Service, Youth Offending Teams, Looked After Children's Service, Integrated Young Peoples Support Services and*

schools, to ensure that appropriate high quality services are provided for the most vulnerable young people in Walsall

- *Improve marketing and communication of sexual health services and messages to young people*
- *Ensure appropriate outreach services are provided in Walsall to ensure gaps in healthcare provision are filled*
- *Ensure 'young-person-friendly' services that encourage and support access into mainstream sexual health services*
- *Redesign and re-launch of the Walsall Condom Distribution Service as part of a holistic young people's sexual health service*
- *Further development of the roles played by GPs, practice nurses and pharmacists*
- *Improve uptake of Long-Acting Reversible Contraceptives (LARC) amongst young people in Walsall*
- *Prioritise early diagnosis of HIV in community settings, particularly for high risk groups*

3.4 Teenage pregnancy

In Walsall the aim is to ensure that all our young people have the skills, confidence and motivation to look after their sexual health and delay becoming parents until they are ready emotionally, educationally and economically.

Indicator:

The Walsall rate in 2011 was 48.5 conceptions per 1,000 girls aged 15-17. This is significantly higher than three comparator rates; statistical neighbours, regionally and nationally. However after three years of increasing rates the fall from 2009 to 2011 is positive.

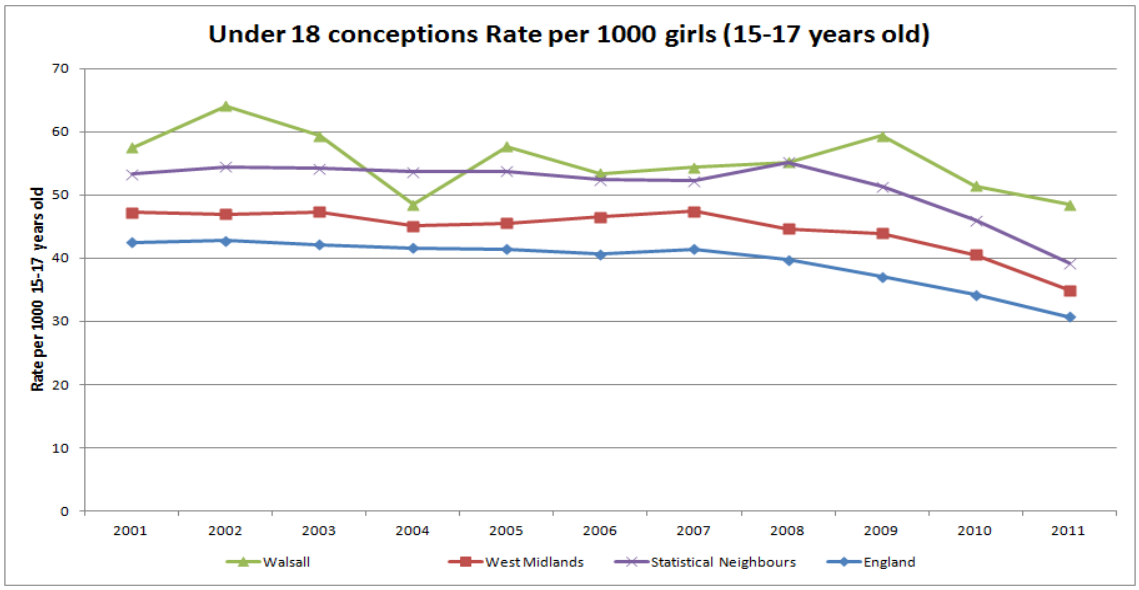


Figure 33 Under 18 conception rates per 1,000 girls aged 15-17, 2001-11 (Source: ONS)

Priorities for action:

- *Development of a systematic approach to early identification of the risk of teenage pregnancy, in particular focusing on the areas of vulnerability that have been identified in recent case reviews*
- *Implementation of planned expansion of schools work – in particular the creation of on-site services and the engagement of schools, Further Education and training providers to raise aspirations and deliver enhanced PSHE (Personal, Social, Health and Economic education) provision*
- *Implementation of plans to embed 'You're Welcome' quality criteria in GP Practices, to encourage young people to access primary care services*
- *Further improvement in the integration and coordination of support for young parents through the development of a tiered service model*
- *A focus on workforce development, ensuring raised awareness and understanding of issues related to teenage pregnancy and embedding referral pathways*
- *Promotion of a wide range of positive activities for young people, particularly activities that encourage physical activity*

3.5 Vulnerable children and young people

There are many factors which could lead to a child or young person being classed as vulnerable, either due to the circumstances that they find themselves in or due to the harm they have been subjected to.

The Children Act 1989 made provision for a specific group of vulnerable children described as 'children in need'. These children were defined as those whose vulnerability was such that they were unlikely to reach or maintain a satisfactory level of health and development, or their health and development would be significantly impaired without the provision of services, or they were disabled. In addition The Children (Leaving Care) Act 2000 specifically stated that Local Authorities would need to keep in touch with care leavers until they were at least 21, and they should continue to provide assistance with education, employment and training as they were regarded as a vulnerable group.

In general it can be said that a vulnerable child is one who is unable to keep him or herself from harm or who is at risk of not reaching their potential and achieving their outcomes.

Literature, DfE publications and statutory guidance provide the following categories that could be used to define children and young people as vulnerable.

- Looked After Children, Children Leaving Care, Children missing from care
- Children missing from their home
- Homeless young people
- Children in Need including disabled children
- Adopted children
- Children with English as an additional language
- Children unable to attend school due to medical needs

- Children at risk of permanent exclusion or subject to frequent fixed term exclusions
- School refusers or those not accessing any learning or Young people Not in Education, Training or Employment (NEET)
- Children at risk of sexual exploitation
- Gypsy, Roma, Traveller children
- Migrants, Asylum seekers and refugees
- Socially/economically disadvantaged children
- Young carers
- Teenage parents
- Young offenders

The following are related to the parent's circumstances which can reduce their ability to deliver a warm, caring environment (please refer to Section 2.4 Parenting capacity) due to:

- Having a parent(s) with drug/alcohol misuse
- Having a parent in prison
- Divorced/separated parents

Vulnerable children and young people who are in need of additional support which cannot be managed/provided by Universal services such as Health (GPs, Health Visiting), Housing and Education rely on professionals and members of the community to initiate a demand for a further service. In Walsall, all such requests now go through a Multi-Agency Screening Team (MAST) which assesses the situation and either refers the case to Children's Social Care Services, signposts to a single agency to provide the additional support, provides Information, Advice and Guidance, or makes a request for an Early Help Assessment.

Demand for specialist statutory interventions have increased over the past year: approximately 2560 cases were open to Children's Social Care Services and the Youth Offending Service in September/October 2013; 1541 had a Child in Need plan, 268 were subject to a Child Protection Plan, 603 were classed as a Looked After Child and 150 young offenders were open to the Youth Offending Service.

Figure 34 illustrates the triangle of delivery and each level of need is defined within the new multi-agency threshold document. In Dec 2013, there were approximately 490 allocated to the various Early Help teams to engage with and deliver the Early Help offer to children, young people and their families (Levels 2 and 3).

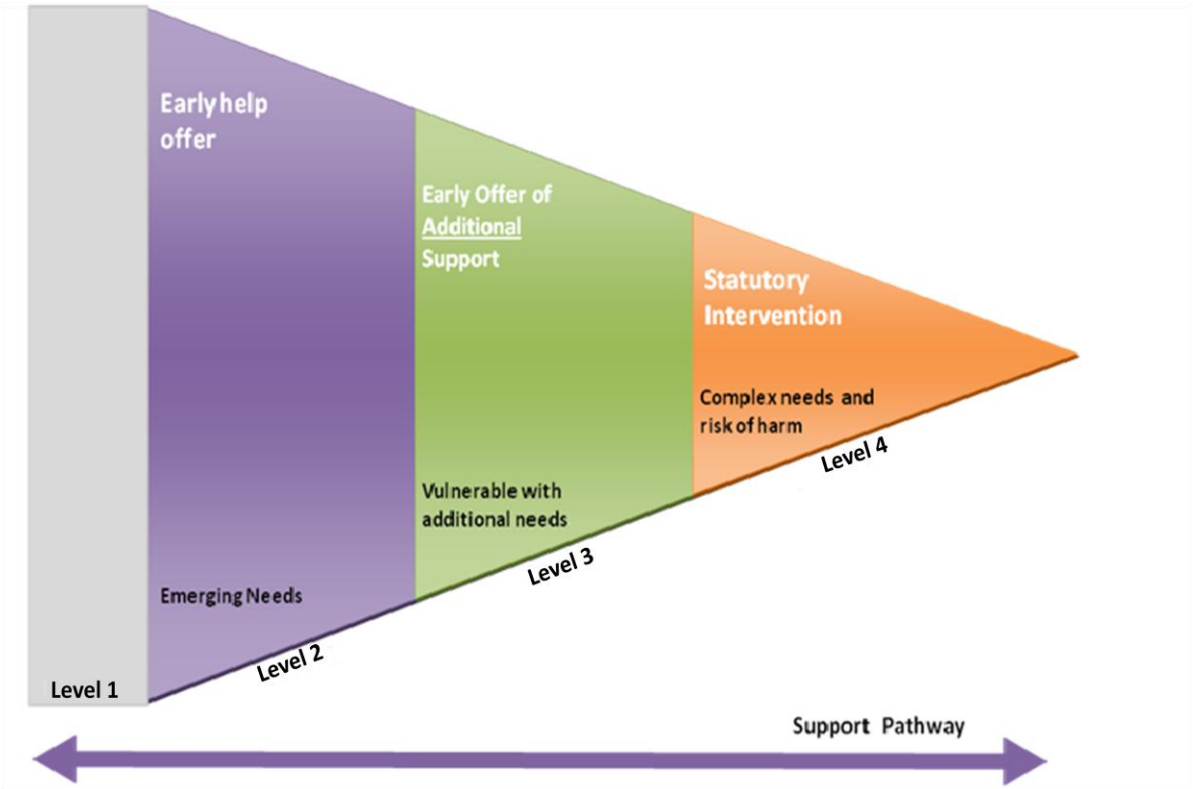


Figure 34 Spectrum of needs

Indicators:

- *Timescales for completion of Early Help assessments are monitored and achieved.*
- *Increase the number of children receiving early help in a timely way.*
- *Increase the level of Step-down from statutory children's social services to Early Help, if deemed appropriate.*
- *Troubled Families requiring additional support are offered the Early Help Offer.*
- *Decrease re-referrals into MAST following Early Help intervention.*
- *Monitor the % of Early Help cases closed with closure reason of Needs met.*

Priorities for action:

- *Supporting the most vulnerable families to provide the best start in life for children (see Appendix 3, CYP Plan Priority 1)*
- *Better communication between frontline staff in all agencies that support children and families (see Appendix 3, CYP Plan Priority 7)*
- *Firmly embed the Early Help Strategy in children's services and partners.*
- *Firmly embed the new Step-up and Step-down guidance in children's services and partners.*
- *Continue to develop Early Help Co-ordinators, Family Support workers and Area Family Support Teams (AFSTs) and embed the 'Whole family working approach' as articulated in the DCLG Report, 'Working with Troubled Families - A guide to the evidence and good practice'*

3.5.1 Looked-After children (LAC)

All local authorities have a statutory duty to protect children and young people from harm. Following a comprehensive assessment carried out by Children's Social Care Services, if the child or young person is considered unsafe in their present environment, following a court decision (or voluntary arrangement with parents) Local Authorities take on the role of a 'corporate parent' which involves placing the child/young person in a suitable safe placement – usually with a foster carer - and the child/young person is then known as a child in care.

Indicators:

There has been a substantial increase in children looked after in Walsall from 77 per 10,000 (489) age 0 to 18 in 2012 to 91 per 10,000 (576) age 0 to 18 in 2013 (see Figure 35). The decrease between 2011 and 2012 is explained for by the underestimate in population from the 2001 census for 2011 at 60,600, which increased to 63,300 in the actual 2011 census; combined with the net decrease in numbers of looked after children at 31st March 2012 from 518 to 489. Over 10-year period, Walsall's Looked After Children rate has been higher than the West Midlands, Statistical Neighbours and England averages.

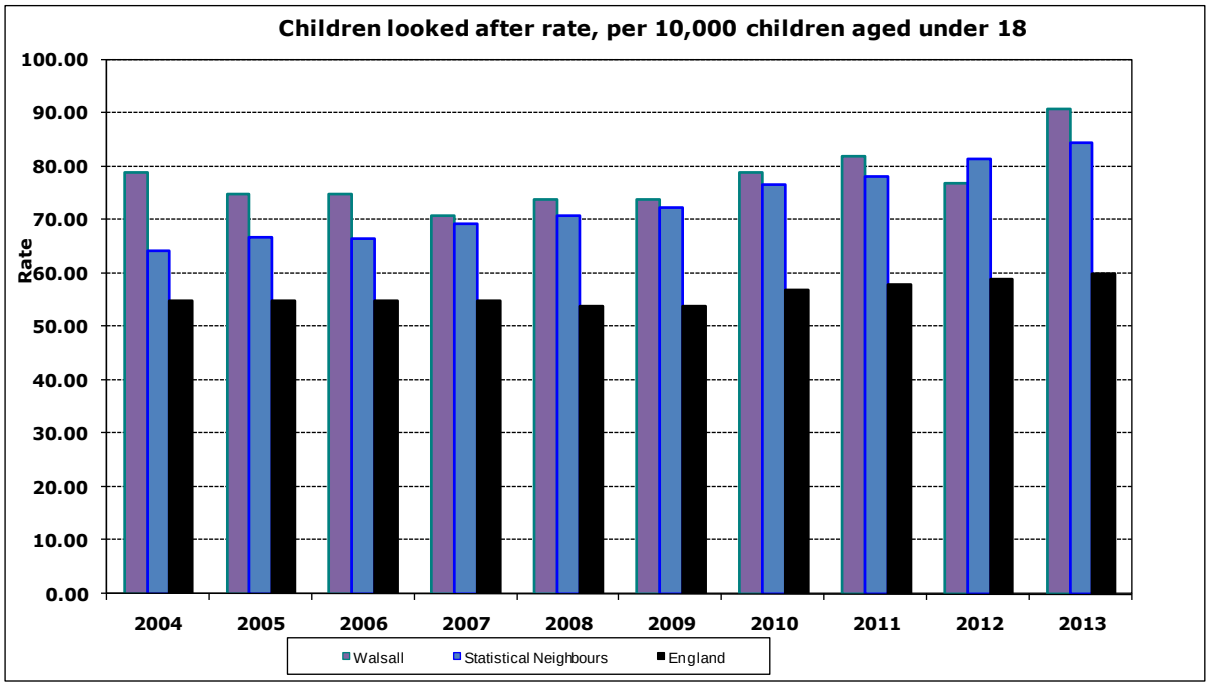


Figure 35 Walsall Looked after Children per 10,000 population aged under 18 as at 31st March 2004 to 31st March 2013 (Source: Local Authority Interactive Tool, 29th Oct 2013)

Priorities for action:

- *Improvement of outcomes by maintaining LAC numbers, despite increased child poverty, offering early prevention and help to return more quickly to family life.*
- *Reduction of 'step-up' by enhanced targeted prevention at Level 3 through new Area Family Support Teams and at Level 4 by Think Family support to Children with Protection Plans (CPP) with targeted Social Work support*

- *Increase in 'step-down' through Think Family support and with targeted Social Work intervention for earlier discharge*
- *Increase securing permanency where appropriate*
- *Ensuring that young people are prepared for, and supported in, their transition to adulthood and leaving care*
- *Supporting the child or young person to participate in the wider network of peer, school and community activities to help build resilience and a sense of belonging*
- *Development of services that address health and wellbeing and promote high quality care delivered through integrated professional working*

3.5.2 Children and Young People with Special Educational Needs or Disability

The DfE stated that the main issue was that children and young people who are identified as having special educational needs (SEN) can struggle to get the support they need to do well. It can often take too long for their families to find out that their child needs extra help. Also, the system of support available to children and young people with SEN is very complex, with teachers, health workers and social care workers often working separately to meet the particular needs of a child or young person

The Children and Families Bill includes provisions to replace Statements of Education (SEN) with Education, Health and Care Plans.

For several years the percentage of pupils in Walsall with SEN with and without a statement has consistently been below the West Midlands and England averages, illustrated in Figure 36. This may reflect a difference in SEN policy and processes across the country.

Percentage of pupils with categories of SEN (2009-2013) - all schools

	Pupils with a statement of special education needs				Pupils with SEN, without a statement			
Year	2010	2011	2012	2013	2010	2011	2012	2013
Walsall	2.1	2.1	2.1	2.2	15.0	15.1	14.2	13.0
West Midlands	3.0	3.0	3.0	3.0	18.3	18.1	17.4	16.4
England	2.8	2.8	2.8	2.8	18.3	17.8	17.0	16.0

Figure 36 Percentage of pupils with categories of special educational needs (SEN) 2010-13 (Source: Department of Education)

The Department for Children's, Schools and Families (DCSF) stated that in England:

- *29% of disabled children live in poverty*
- *The educational attainment of disabled children is unacceptably lower than that of non-disabled children*
- *Disabled young people aged 16-24 are less satisfied with their lives than their peers, and there is a tendency for support to fall away at key transition points as young people move from child to adult services*
- *Families with disabled children report particularly high levels of unmet needs, isolation and stress*
- *The prevalence of severe disability is increasing*

The number of disabled children in England was estimated to be between 288,000 and 513,000 by the Thomas Coram Research Unit. The mean percentage of disabled children in English local authorities was likewise estimated to be between 3%-4%. When these estimates are applied to Walsall, this would equate to between 1,711 and 3,080 children experiencing some form of disability, which includes children with very mild forms of disability.

There are two main data sets which can be drawn upon to gain a better understanding of the levels of identified SEN & Disabilities in Walsall. The first is Walsall Council's Education Services Schools database which shows that there are around 3,500 pupils with identified SEN or Disability needs. Pupils can access provision to meet their additional needs either via. School Action, School Action Plus or by a statement of SEN.

School Pupils with SEN and/or a Disability	**2009**	**2010**	**2011**	**2012**	**2013**
Autistic Spectrum Disorder (ASD)	259	304	336	407	420
Behaviour, Emotional and Social Difficulties (BESD)	473	474	500	546	529
Hearing Impairment (HI)	70	66	68	65	78
Moderate Learning Difficulties (MLD)	1115	1093	1156	1242	1230
Multi-Sensory Impairment (MSI)	6	16	13	15	18
Other	81	70	71	102	112
Physical Disability (PD)	125	117	118	141	141
Profound and Multiple Learning Difficulties (PLMD)	83	82	75	74	64
Speech, Language and Communication Needs (SLCN)	396	401	415	444	478
Severe Learning Difficulties (SLD)	233	225	192	196	213
Specific Learning Difficulties (SpLD)	212	193	193	221	236
Visual Impairment (VI)	93	106	116	120	121
Totals	**3146**	**3147**	**3253**	**3573**	**3640**

Figure 37 Walsall Council Education Services database

The second is Walsall's Healthcare NHS Trust Disability Database which holds the number of children and young people who have been allocated health services. For example in June 2009, there were 1,566 children in the database (some children had more than one type of need recorded). Since then there has been an increase in the number of children on the database to around 1900 which may suggest better identification of need for health services or increasing incidence of need.

Age Group	June 2009	October 2011	March 2012	July 2013
0-2	151	130	134	63
2-4	212	239	241	239
4-6	226	279	298	232
6-8	207	266	257	238
8-10	232	239	264	239
10-12	199	270	280	215
12-14	120	218	231	196
14-16	114	161	155	124
16-18	88	120	132	106
18-20	17	55	43	65
Total Children and Young People	**1566**	**1977**	**2035**	**1717**

Figure 38 Numbers on Walsall Healthcare NHS Trust Disability Database

The degree of overlap (the same child/young person appears in both datasets) will be investigated to determine a more accurate number of children and young people identified with SEN and/or a disability.

Figure 39 below illustrates the most prevalent disability types of children and young people in Walsall referred to Health, are physical disabilities, autistic spectrum disorder (ASD), behavioural, emotional and social difficulties and speech, language and communication problems.

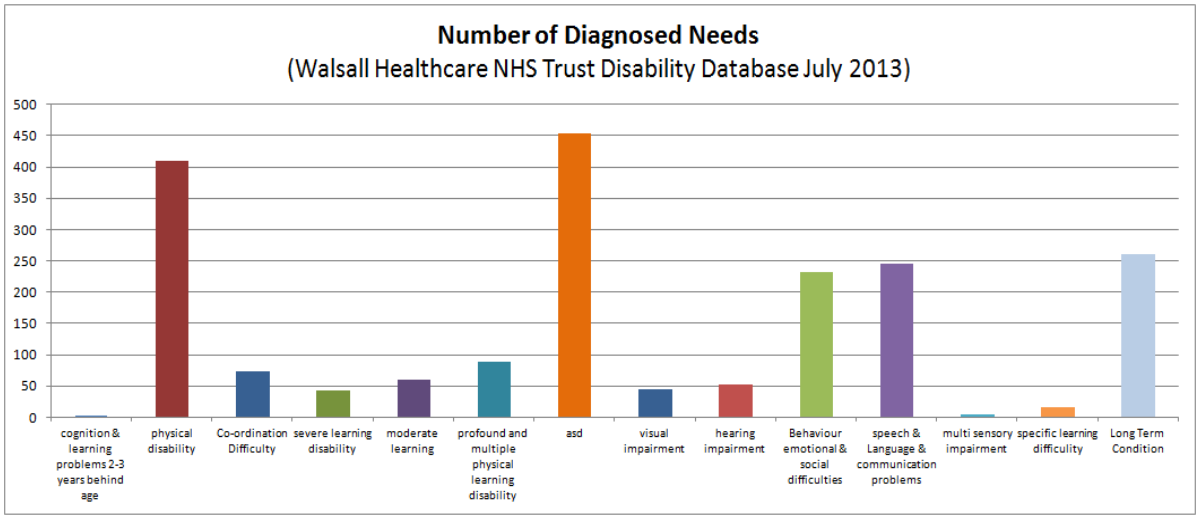


Figure 39 Number of diagnosed needs (Source: WHNHS Trust Disability Database July 2013)

Figure 40 below illustrates that some types of diagnosed needs in Health are over-represented in children and young people of certain ethnic backgrounds, when comparing against ethnic population mix of under-18s from the 2011 Census. For example, in Health, ASD appears to be over-represented in children and young people of White ethnicity, and physical disability is over-represented in children and young people of Asian ethnicity.

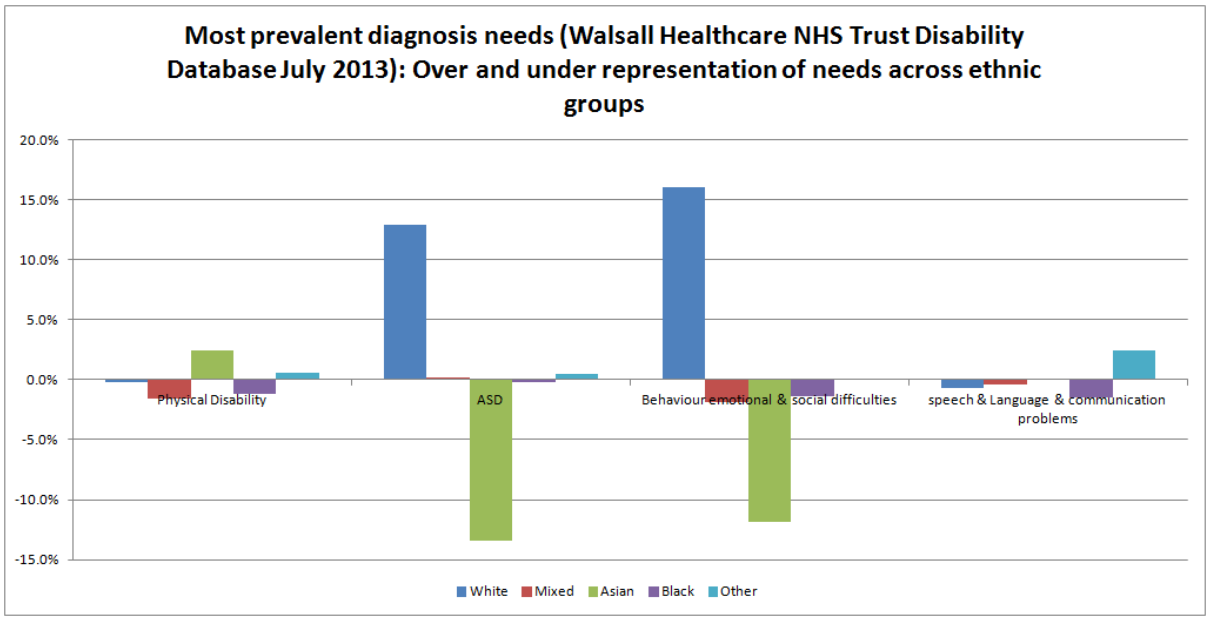


Figure 40 Over and under-representation of needs across ethnic groups (under-18's) (Source: Walsall Healthcare NHS Trust Disability Database July 2013)

Priorities for action:

- *Development of a single multi-agency assessment and planning process for children and young people aged 0-25.*
- *Review of current SEN provision to ensure it meets demand – in particular to address the growth in children with Autism Spectrum; PMLD (profound Multiple Learning Disability)/SLD and provision for post 16 years with SEN.*
- *Redraft multi-agency SEND strategy*
- *Develop local offer to include Health and Social Care provision.*
- *Increase choice, control and engagement of CYP in whole systems service development (to include access to personalised budgets).*
- *SEN data to be further analysed to ascertain whether there is a match between need and provision.*

3.5.3 Youth offending – custodial sentences

While our rate of offending is declining and low compared to other councils, the proportion of sentences that are custodial is very high and increased from 8% in 2009/10 (32 out of 400) to 10.2% in 2010/11 (33 out of 325 – ranked 145th). This has risen in 2011/12 to 11.7% (32 out of 274). This shows that although the number of sentences has fallen over the last 3 years, the number of custodial sentences has remained constant, causing an increase in the proportion of sentences amongst 10-17 year olds resulting in custody.

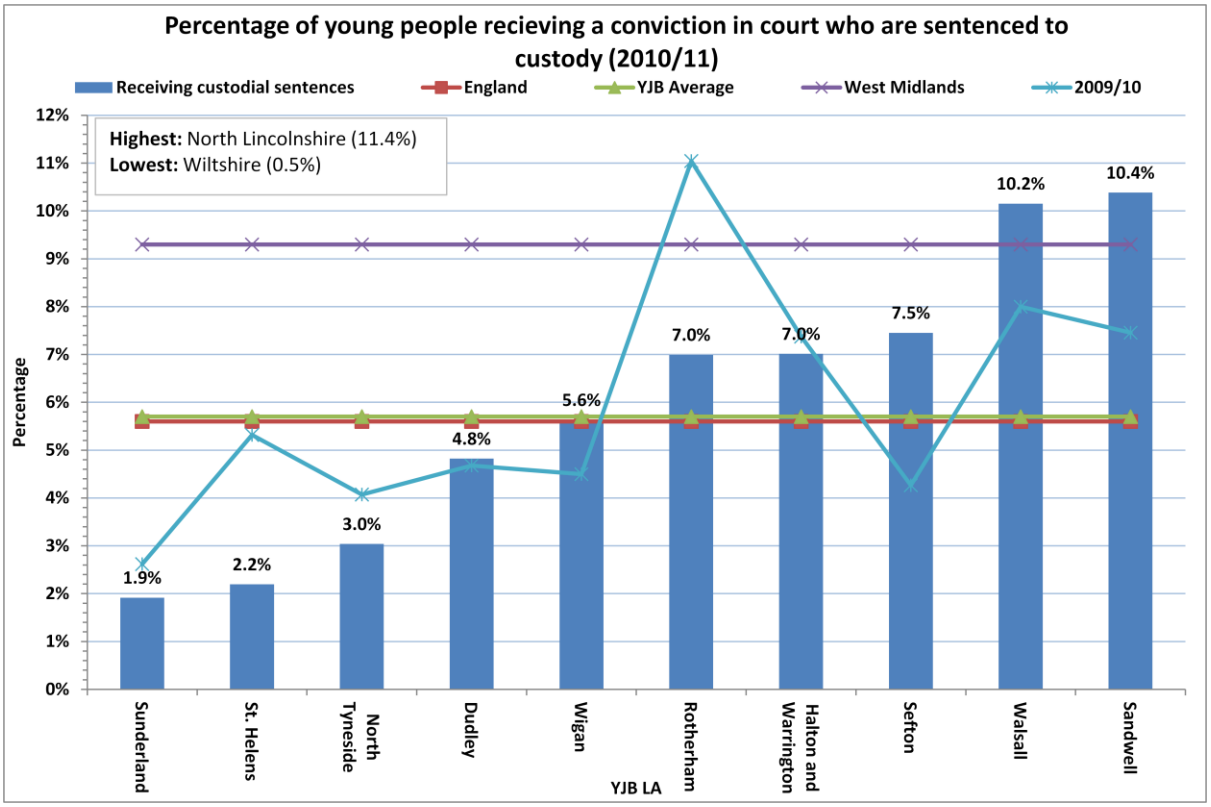


Figure 41 Percentage of young people receiving a conviction in court who are sentenced to custody 2010-11

3.6 Child safety and safeguarding

Improving child safety and safeguarding includes tackling a wide range of issues, including abuse and neglect, accidental injury and death, bullying, crime and anti-social behaviour and ensuring a safe home environment.

Department for Education Research would indicate that 29% of children experience some form of bullying during their time in school. The Tellus Survey data and the Beat Bullying Alliance have estimated this figure is closer to 50% of children during their school career. A conservative estimate would be that around 1300 children in Walsall schools have been exposed to some form of bullying. Research also indicates that the majority of these incidents go unreported.

NSPCC national research estimates that around 10% of children and young people experience severe neglect at some point during their childhood. Allowing for the impact of poverty on parents' abilities gives an estimate of 6060 who could be experiencing neglect of some form during their childhood. It does need to be noted that the severity of neglect can vary, and that many families can be helped to improve their situation at an early stage without requiring legal intervention.

Research by the Home Office has highlighted the very large impact of witnessing domestic violence on the development of children. In Walsall during 2011/12 there were 2794

incidents of domestic violence reported to the police where children were present, with 3004 children identified as experiencing domestic violence in their home.

The Child in Need (CiN) Census (Statutory DfE Return) captures the numbers of children in need defined as those who have been referred to Children's Social Care Services and who have been assessed usually through an initial assessment to be in need of social care services. The 2012/13 CiN Census reported that Walsall Children's Social Care Services had worked with approximately 4,500 children through the provision of services and assessments during the year (approx 2,450 as at 31 March 2013).

Numbers of children subject to a child protection vary during the course of a year but has averaged at around 250 since 2009/10. The numbers of children in care however have increased substantially over the past year to over 600 in recent months.

Emerging areas of concern in Walsall have been identified as:

- *the rise in the number of children in care*
- *the rise in CPPs listed as a result of neglect*
- *children who go missing from home, school or care*
- *young people at risk of sexual exploitation*
- *young people who are self-harming or have attempted suicide*
- *homeless young people coming into care*

These risk areas are often interrelated and in 2011/12 and 2012/13 there was an increase in the number of older adolescents (14 to 17 year olds) entering local authority care because of concerns. These young people often have complex needs and require very specialist services. The number of looked-after children (LAC) and those with Child Protection Plans varies widely across Walsall with a strong correlation with deprivation.

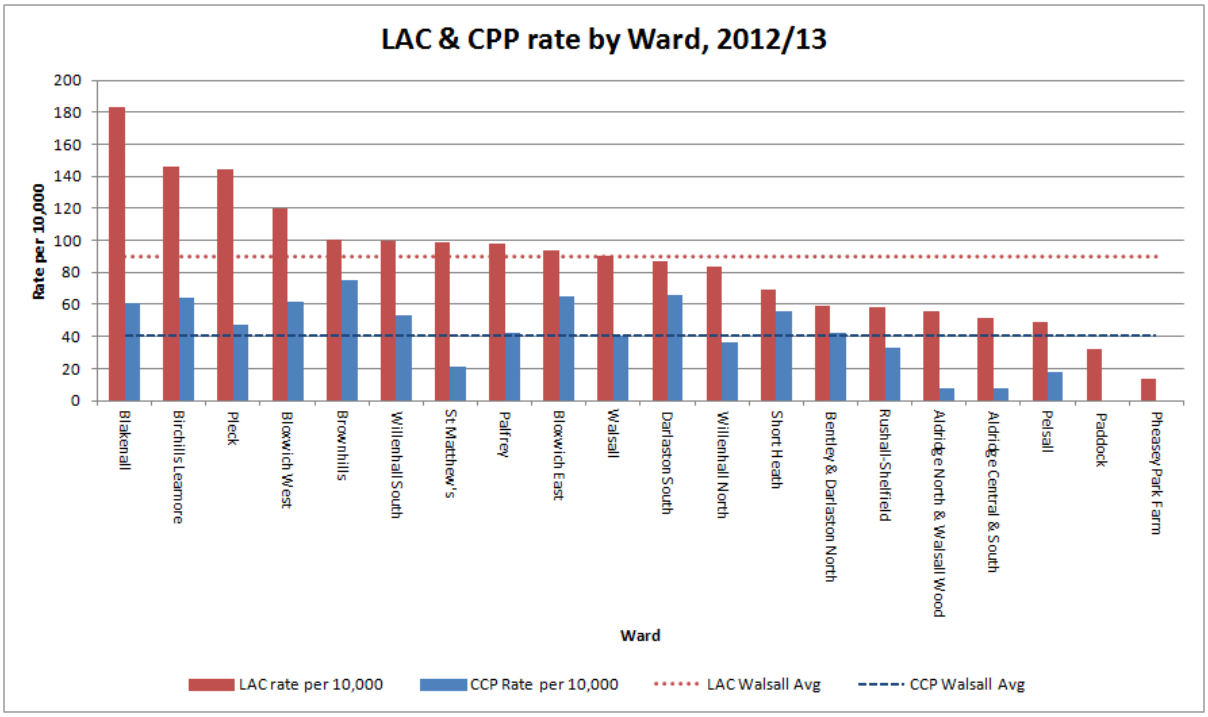


Figure 42 Ward rates of looked after children (LAC) and children with protection plans (CPP), Walsall 2012/13

The context of work with children and young people is rapidly changing and the 2013 Working Together published guidance sets out how organisations and individuals should work together to safeguard and promote the welfare of children and how practitioners should conduct the assessment of children. The coordination of safeguarding will need to include the new Health and Well-Being Boards, Faith, Independent and Academy schools and the increasing role of Adult Safeguarding.

Safeguarding priorities:

The Walsall Safeguarding Children Board (WSCB) takes the lead role in monitoring the effectiveness of services to safeguard children, and will enhance the quality-assurance systems and the processes for learning from case reviews. Strategic priorities of the WSCB for 2013/14 include:

- *Improve the effectiveness of WSCB*
- *Improve the effectiveness of safeguarding*
- *Develop a Learning and improvement framework*
- *Ensure the views of children and young people are heard*
- *Develop and implement a clear Child Sexual Exploitation strategy*
- *Learning from Serious Case Reviews*

Priorities for action:

- *Reducing the harm caused by child sexual exploitation including children missing from school, care and home (see Appendix 3, CYP Plan Priority 3)*
- *The need to strengthen our early help arrangements*
- *Continue to develop an understanding of the child's journey through the system from receiving early help to protection.*

- *Ensure that the Multi-Agency Screening Team (MAST) implemented in April 2013 has continued representation from key partnership agencies such as Education, Police and Health.*
- *The need to better understand and respond to children and young people and their families where substance misuse, mental health and domestic abuse features.*

3.7 Chapter summary and key priorities for action

The poor start in life described in Chapter 2 determines the life chances of the child, young person and adult – highlighting the urgency of addressing early years' challenges. This is confirmed by the experiences described in this chapter. Poor education outcomes – bottom quartile for several years at Key Stage 4 and 5 - do not prepare our young people well for employment. Walsall has one of the highest youth unemployment rates in the country (11th out of 406 councils in February 2012). There is some sign of improvement at Key Stage 4 with 5+ GCSE's improving as Walsall was better than SN average. The attainment gap for SEN pupils is too large. This poor level of attainment is compounded by poor attendance, particularly in deprived areas, which contributes to the gap in attainment. Obesity levels are high and increasing. Teenage pregnancy is very high, even after a large decrease in 2009/10. Looked-after children numbers have increased, as in nearly every other council, due to the recession and the impact of the "Baby Peter" case. While the numbers are around the level we would expect, and they have reduced during 2011 due to our Early Health Strategy, the double-dip recession will maintain pressure on budgets. We need to ensure that the needs of children with disability are being met.

Priorities for Action**:**

- *Promote pupil aspiration and school/college improvement to:*
    - *Ensure further sustained improvement at Key Stage 4*
    - *Urgently address poor outcomes at Key Stage 5*
    - *Ensure that children, particularly those in care, have a stable high quality education that encourages high aspiration and supports them in achieving their potential*
- *Promoting pride in the achievements of the children and young people of Walsall (see Appendix 3, CYP Plan Priority 6)*
- *Learn from the schools with best attendance and spread this to other schools*
- *Roll out the Early Help Strategy to help improve outcomes for children and ensure resources match increasing need arising from the double dip recession*
- *Prioritise reduction in social inequalities in pupils' educational outcomes and increase educational attainment particularly for vulnerable children in deprived areas*
- *Better communication between frontline staff in all agencies that support children and families (see Appendix 3, CYP Plan Priority 7)*
- *Supporting the most vulnerable families to provide the best start in life for children (see Appendix 3, CYP Plan Priority 1)*
- *Reducing the harm caused by child sexual exploitation including children missing from school, care and home (see Appendix 3, CYP Plan Priority 3)*

- *Ensuring that children maintain a healthy weight (see Appendix 3, CYP Plan Priority 2)*
- *Reduce levels of child obesity by focusing on healthy eating and physical activity with schools continuing to promote health and provide high quality PSHE*
- *Reduce the number and rate of teenage conceptions, especially in deprived areas*
- *Reduce the number of young people going into custody by working with Courts and partner agencies*
- *Ensure that young people are prepared for and supported in their transition to adulthood*
- *Development of a single multi-agency assessment and planning process for children and young people aged 0-25.*
- *Review of current SEN provision to ensure it meets demand – in particular to address the growth in children with Autism Spectrum; PMLD (profound Multiple Learning Disability)/SLD and provision for post 16 years with SEN.*
- *Redraft multi-agency SEND strategy*
- *Develop local offer to include Health and Social Care provision.*
- *Increase choice, control and engagement of CYP in whole systems service development (to include access to personalised budgets).*
- *SEN data to be further analysed to ascertain whether there is a match between need and provision.*
- *Reducing the harm caused by child sexual exploitation including children missing from school, care and home (see Appendix 3, CYP Plan Priority 3)*
- *The need to strengthen our early help arrangements*
- *Continue to develop an understanding of the child's journey through the system from receiving early help to protection.*
- *Ensure that the Multi-Agency Screening Team (MAST) implemented in April 2013 has continued representation from key partnership agencies such as Education, Police and Health.*
- *The need to better understand and respond to children and young people and their families where substance misuse, mental health and domestic abuse features.*
- *Develop services that address health and wellbeing and promote high quality care, especially for disabled children and those with mental health needs, delivered through integrated professional working, providing personalisation and single assessments*
- *Continue and expand a holistic partnership approach to tackling under-age consumption of alcohol, smoking and substance abuse*

Chapter 4: My Money, My Home and My Job

The causal link between poor health and the development of a vibrant economy is well understood in Walsall. If we are to truly increase the numbers of wealth creators, provide the labour force our employers need and reduce the numbers of our population who are economically inactive, we must ensure that our current and potential workforce is healthy. These principals are also true for helping those in lower paid employment gain greater income.

In developing the workforce of tomorrow, we also recognise the need to ensure our residents hold the skills that employers are demanding, together with adequate and affordable housing to retain and attract people within the Borough. If linked to financial independence and job security, this actively encourages people to join and remain in the workforce as wealth creators, assisted as required by appropriate support.

This Needs Assessment recognises the importance of all agencies working together to achieve the desired end results, and for us to test out new ways of working. Walsall council has established the 'Help Me With My Money, My Home, My Job' work strand, which brings together the traditional service areas of Housing Benefit / Council Tax Reduction, Housing Support, Council Tax, Welfare Rights, Customer Services, to support better co-ordinated joint working with other teams and agencies., including: the Employment & Skills team within Strategic Regeneration, local Colleges and Training Providers, Jobcentre Plus etc.

When customers come to Walsall Council for help they are often passed around the system (organisation) if they need support with more than one problem. This causes waste and duplication leading to higher costs, low staff morale and customers not being helped in the way they need it. Using a systems thinking approach, we worked with customers and collected data which told us that customers with housing benefit queries also needed help with council tax, employment support, budgeting and housing needs.

When a customer contacts the council, a member of staff will take ownership of the customer and work 'end to end' journey with them, removing any barriers that might be stopping the customer from getting the help they need. Where a member of staff is unable to help the customer with a problem, they will 'pull' in help from a colleague with the relevant skills and gain learning thus building up their capability. Our customers like the new way of working as they have one point of contact throughout their customer journey and staff enjoy being able to help customers in the way they need to be helped.

The health sector and its ways of working are also subject to change at both national and local levels, and are being requested to move away from 'diagnose and treat' way of working towards a 'predict and prevent' culture. To achieve this it requires re-modelling of both its ways of doing business (systems and procedures) and its workforce. This brings a mix of challenges and opportunities, together with the potential for significant down-stream benefits for service users and those providing the funding, who are looking to achieve more for less etc.

This re-tooling process will require new systems and procedures together with a workforce with appropriate / new skills and abilities capable of meeting the needs of customers, together with technology that assists the workforce and empowers patients. Examples include new roles like: Personal Assistants, who assist with placing patients at the centre of managing their care, this will generate new employment opportunities and ways of working, improved service delivery and hopefully reduced down-stream costs.

We will work to capture this evolving agenda within complementary strategies and their delivery plans, including: the Health & Well Being Strategy / Action Plan, to harness and co-ordinate the work partners and stakeholders. This will include exploring new ways of service delivery and the use of new technology and social media, the Digital Health agenda.

The council and partners are very aware of the impact on residents in Walsall of both changes to the welfare system and the recession and are undertaking ongoing analysis of how this is affecting people in a bid to understand how services need to respond. Various data sets are being considered that build a picture of which services are being used by residents affected by the recession and changes to welfare system to identify ways of improving access to services and ensuring services that are most needed are provided.

4.1 Deprivation

The Indices of Multiple Deprivation 2010 (IMD) is a Lower Level Super Output Area (LSOA) measure of deprivation and is made up of seven domain indices: income, employment, health and disability, education skills and training, barriers to housing and services, living environment and crime. Developed by the Department for Communities and Local Government, it is a nationally-recognised measure across England and Wales. The indices are based on the concept that deprivation consists of more than just poverty; so while poverty is related to not having enough money to live on, deprivation refers to a much broader lack of resources and opportunities.

Indicators:

In 2010, Walsall was ranked as the 30th most deprived of the 326 Local Authorities in England. This position has worsened since the last data release in 2007, where Walsall ranked 45th out of 354. The borough fares particularly badly in terms of education, income and employment deprivation. Central and western parts of the borough are typically more deprived than the east. However, while some parts of the borough such as Blakenall are among the most deprived in the borough, others rank within the very least deprived (see Figure 43 below).

The figure below also details that 114,800 (44.6%) of Walsall's total population (2010 mid-year estimates) live within the most deprived quintiles compared to 30,400 (11.8%) living in the least. Looking specifically by age, 28,100 (52.3%) of 0 to 15 year olds live within the most deprived quintiles in Walsall and 16,100 (35.5%) of over 65's. This compares to 5,000 (9.2%) of 0 to 15 year olds living within the least deprived quintiles in Walsall and 7,000 (15.6%) of over 65's.

Deprivation is also seen in the levels of fuel poverty in the borough and more details on this can be found in Chapter 8.

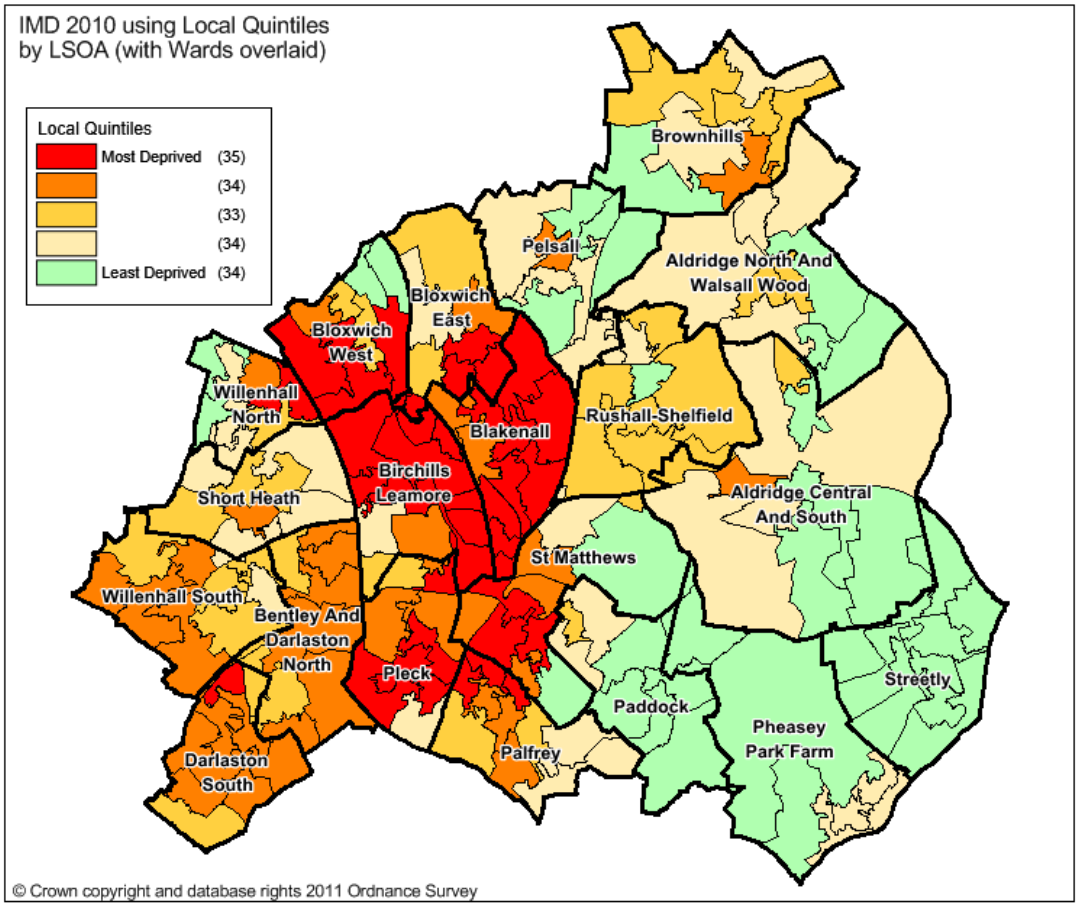


Figure 43 Walsall LSOA deprivation using Local Quintiles (Source: Department for Communities and Local Government)

Priorities for action:

Deprivation is deeply entrenched in Walsall and worsening in the current economic climate. Actions to mitigate this can be found in many theme areas of this JSNA, particularly those relating to education, income and employment deprivation.

In order to reduce inequalities in health there is a need to achieve a more rapid improvement in health and wellbeing for people living in the deprived areas than those living in the more affluent. Partnership agreement is needed on 'priority areas' based on a Lower Super Output Area (LSOA) analysis of need to enable targeting of resources and action in areas of greatest need (See Figure 43). For example, the focus for the Council's Home Energy Conservation Act Action Plan is to tackle fuel poverty across the borough but particularly within the LSOAs rated as the highest in fuel poverty.

4.2 Welfare Reforms

A range of changes delivered through the Welfare Reform (including benefit levels, introduction of a benefit cap, single room rate, spare room subsidy and proposed Universal Credit) have had an impact on the income received by many households in the borough.

In Walsall an estimated 200 households were affected by the Benefit Cap these are households with dependent children with approximately 4,050 households affected by the Social Sector Size Criteria (often referred to as the Bedroom Tax). The map below (Figure 44) shows those areas affected by the 'bedroom tax'. The darker the area, the higher the number of households in the area that are affected by the tax.

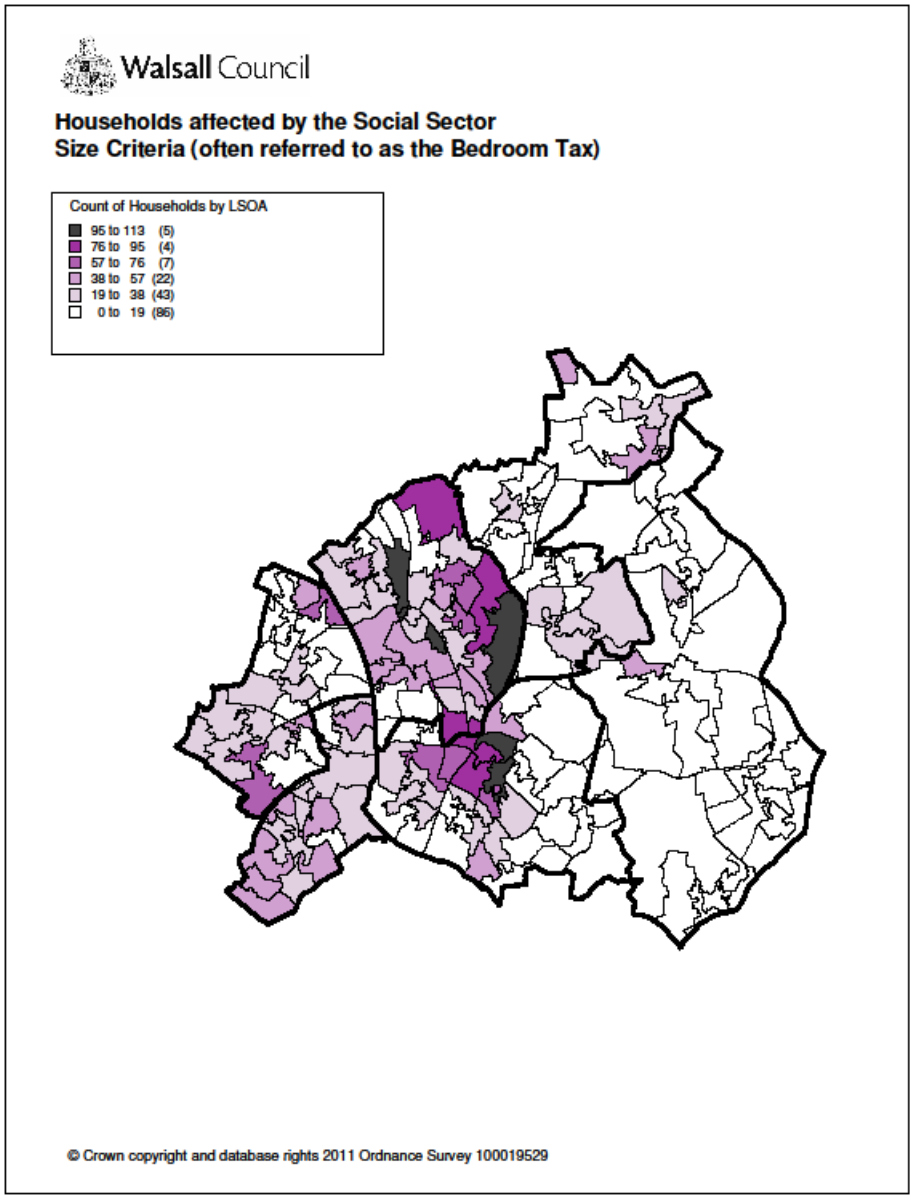


Figure 44 Households affected by the Social Sector Size Criteria

The Council has been working with those households most impacted by these changes and developed:

- A service to work with those directly affected by the Social Sector Size Criteria (often referred to as the Bedroom Tax) and benefit cap. The service helps in a range of areas including:
    - Helping households find alternative suitable accommodation
    - Helping residents to find work or prepare for work and has direct links with Job Centre Plus
    - Help with debt management and link to money advice services
    - Award Discretionary Housing Payments for those most vulnerable and affected by the Welfare Reforms.

- A Walsall Crisis Support Service (WCSS) to provide support and advice for example, debt advice, money management advice, working collaboratively with 3rd sector agencies e.g. food banks. The service also administers Crisis Awards where there is a severe risk to the health and safety of the applicant or an immediate family member or dependent which cannot be met from another source. Awards could, for example, be made to cover the following risks:
    - No access to essential needs (food, heating and clothing)
    - Imminent deterioration/deterioration in health
    - Domestic abuse, neglect and harm.
    - Breakdown of the family unit

4.3 My Home - Healthy housing

Our strategic housing priorities linked with improving health are to:

- *Help prevent homelessness and provide support for rough sleepers*
- *Increase housing choice and employment opportunities.*
- *Tackle fuel poverty and improve the quality and energy-efficiency of existing and future homes (detailed in chapter 8).*
- *Address different needs and promote independent living, health and wellbeing.*

Homelessness

Homeless people experience some of the poorest health in our communities. Homeless Link's National Health Audit [3] found that eight- in-ten have one or more physical health needs, and seven-in-ten have at least one mental health problem. Being homeless means you are more likely to suffer from mental and physical ill-health and at the same time unable to access the health services you need. Research by Crisis [4] in 2011 estimated the average age of death of a homeless person to be 43-47 years of age. This is significantly

[3] http://homeless.org.uk/sites/default/files/Health%20Audit%20Findings_National%20evidence_0.pdf (Accessed: 17 Oct 2013)

[4] http://www.crisis.org.uk/data/files/publications/Homelessness%20-%20a%20silent%20killer.pdf (Accessed: 17 Oct 2013)

lower than average for Walsall which is 80.2 years (looking at 5 year average between 2007 and 2011 for both genders).

The table below shows the principal causes of homelessness in Walsall for those households accepted as homeless. As highlighted the number of homeless acceptances has increased significantly (141%) from 2010/11 to 2012/13.

	2012/13		2010/11	
Cause of homelessness in Walsall	**No.**	**%**	**No.**	**%**
Termination of assured shorthold tenancy	52	19	10	9
Violent breakdown of relationship, involving partner	38	14	3	3
Parents no longer willing or able to accommodate	37	13	9	8
Other relatives or friends no longer willing or able to accommodate	32	11	6	5
Other causes	121	43	88	76
Total	**280**	**100**	**116**	**100**

What we are doing:

Improving the health of people who are homeless is central to reducing health inequalities. We are working in partnership with health to provide and sign-post our vulnerable customers to access to GPs, sign-post those with substance abuse issues to a dedicated support worker at Addaction, and facilitate health drop-in clinics at our supported housing projects.

Walsall Council accepted an invitation from the Department of Communities & Local Government (DCLG) to be the Accountable Body for the West Midlands and Warwickshire local authorities to commission and develop programmes fund by a grant of £1.074m to help and support specifically for single homeless people, those with complex needs and rough sleepers, partly affected by the Welfare Reform who are finding it increasingly difficult to access and secure accommodation and appropriate support. Programmes include;

- New outreach team helping support entrenched and new rough sleepers
- Improving access to the private rented sector and social sector (shared tenancies)

The number of households supported where homelessness was prevented has increased significantly (by 70%), 1,599 instances in 2012/13 compared to 938 in 2010/11. Already in qtr1 and qtr2 2013/14 we have had 1,015 households supported to prevent homelessness which is 137% more than in 2010/11 and 63% more than in 2012/13.

Over the last two years significant investment has taken place in improving the condition of the supported housing projects by developing self-contained flats with upgraded heating, bathrooms and kitchens.

Rough Sleepers

Rough Sleepers are a community who are more likely to have severe health issues including some form of substance abuse and mental health issues. As at October 2012 it is estimated there are 12 rough sleepers in Walsall. We are working in partnership with voluntary sector agencies such as Hi's N Lows and the Glebe Centre to help people move into stable accommodation. We also work closely with Midland Heat HA who provides a service specific for rough sleepers. Walsall Severe Weather Emergency Provision (SWEP) is a partnership which aims to reduce excess winter death. We provide a night shelter through the voluntary sector, and provide food and advice.

Planning for Housing

Walsall Council's Planning Policy Team is currently working on two plans for the Borough that will allocate land to seek to provide additional provision of a wide range of new homes to meet needs up to and beyond the year 2026 (including affordable housing, extra care and open market homes). These new homes will be located in the most accessible locations with the necessary access to a range of community and health services, open space and sustainable transport choices to increase levels of wellbeing and encourage healthier lifestyles. Progress of these plans can be found at www.walsall.gov.uk/planning_2026.

The quality of new homes and a range of design standards (including energy efficiency) is also considered through the Planning Application process and monitored through the Authority's Monitoring Report available at www.walsall.gov.uk/annual_monitoring_report.

Housing Quality and Hazards

We want our residents to live in safe and secure homes and this is a focus of the Council's adopted Housing Strategy (http://cms.walsall.gov.uk/47472_housing_strategy_2012-2016_v4.pdf and adopted Home Energy Act Action Plan.

The council inspects and secures improvements in existing housing in line with the Housing Health and Rating Safety System (HHSRS). The HHSRS rates 29 hazards such as damp and mould, crowding and space and personal hygiene, sanitation and drainage. These hazards are rated to give a quantifiable hazard score. Depending on the score the hazard will fit into one of two bands – Category 1 hazards or Category 2 hazards. Category 1 hazards are the more severe hazards which warrant a more rapid response.

The Council has an adopted Housing Standards and Improvement Enforcement Policy which contains the possible responses/ enforcement options available to improve housing conditions.

http://cms.walsall.gov.uk/de/appendix_1_-_housing_enforcement_policy_version_final_dl__2_.pdf

The latest private housing stock condition survey in Walsall (2007)
http://cms.walsall.gov.uk/executive_summary_final.pdf
identified the following five Category 1 risks as the highest in prevalence;

Crowding and space: 3833 homes (4.7%)
Excess Cold: 2602 homes (3.2%)
Risk of falls: 2282 homes (2.8%)
Structural Failure: 1882 homes (2.3%)
Dampness/ mould: 1228 homes (1.5%)

Geographically, above average rates of Category 1 hazard failure are associated with three areas in particular:

Palfrey and Pleck : 26.5%
St. Matthews and Birchills Leamore : 20.7%
Darlaston : 16.5%

Residents who live in a house which provides a poor physical environment, for example homes that are inadequately heated, damp, overcrowded, or in a poor state of repair are more likely to experience poor physical health and impact on their emotional wellbeing. They are at higher risk of experiencing exacerbation of chronic illnesses such as respiratory and heart disease, higher rates of some infectious diseases and higher rates of accidents in the home than those who live in good-quality housing.

There is evidence of adverse impacts on the educational attainment of children who live in overcrowded conditions. Most falls among children occur in or around their home and are related to the design and maintenance of housing and recreational areas. Examples of factors that increase the risk of falls and injuries include poor lighting, lack of window guards and missing guardrails for stairs.

Living in cold and damp conditions is a particular risk to health: mould exacerbates conditions such as asthma, and cold indoor temperatures are linked to increased rates of premature death due to heart failure. Vulnerable groups include the elderly, the very young and those suffering from long-term ill-health. These groups also tend to have the greatest exposure due to the lengthy periods that they spend indoors. Improvements in general, respiratory, and mental health have been reported following warmth and energy efficiency improvements.

People who live in very poor housing conditions are more likely to suffer from poor mental health and physical health than those whose housing is of higher quality. As most of the social housing stock in Walsall has achieved the national 'Decent Homes Standard' the priority now is to improve the physical quality of private sector housing stock, particularly those in the private rental sector. Social housing and poor-quality private sector housing is generally located in Walsall's deprived neighbourhoods to the west of the borough. In these communities, health outcomes are poorest and the health inequalities gap widest.

Levels of deprivation are reflected in the social determinants of health: poverty, unemployment, occupation, education, ethnicity, low self-esteem and isolation are some examples. These wider factors also determine people's physical and mental wellbeing and their capacity to participate in the social and economic opportunities that are generally accepted by society as the norm.

In order to achieve this we are delivering a number of measures targeted at tackling fuel poverty (see Chapter 8) and improving the quality and energy-efficiency of existing and future homes.

Key achievements in Walsall in recent years include:

A. Tackling Fuel Poverty and excess winter deaths

Walsall Health Through Warmth – Creating healthy homes

This Council-funded programme has invested £789,000 to help 425 households. The fund also helped lever-in investment of £477,000 from a variety of sources including the Department of Health, Npower, Scottish Power and the Department of Energy and Climate Change (DECC). This service has also developed or supported the following;

Raising awareness of impact of excess cold or heat in the home

Production of low cost room thermometers :

- For new parents – shaped like teddy bears and
- For vulnerable households

Reducing the cost of home energy

Developing collective switching schemes and encourage 'switching' of suppliers to help residents secure lower home energy costs. The first scheme in summer 2013 provided average annual savings of £150 for Walsall residents.

Home Energy Conservation Act (HECA) Action Plan.

Walsall Council was one of the first in the UK to adopt a HECA Action Plan – 'Improving Home Energy Efficiency Together' – in line with the revised government guidance in 2012.

Energy Company Obligations (ECO) £70M

The council has nominated two contractors (Keepmoat and Walsall Housing group) to work with residents and help secure circa £70M of funds from energy companies to improve home insulation and heating especially for households in fuel poverty and those in LSOAs with high incidence of fuel poverty. This programme

Carbon Emissions Reduction Target Funding (CERT). £11.9M+

Between 2008 and the end of 2012, a total of 24,353 homes in Walsall received an energy-saving measure (cavity wall insulation and/or loft insulation) with a total of 29,926 measures being installed. Based on an average cost of £400 per measure this equates to £11,970,000 invested in the borough.

Community Energy-Saving Programme (CESP) £21M

This programme has led to improvements to the following:

- Blakenall - £3,000,000+ from whg, British Gas, the Regional Housing Pot
- Jones House - £1,752,000 from whg, British Gas,.
- Borough-wide whg properties £9,000,000+ whg, British Gas,
- Austin House planned for this year £3,250,000 whg, British Gas

- Accord properties borough- wide £2,000,000+ Npower
- Private sector homes borough-wide £2,000,000 Npower

B. Tackling other hazards in housing

Tackling Slips Trips and Falls

In addition to the increasing number of households assisted by statutory Disabled Facility Grants the Council has for many years provide a free handyperson service for vulnerable people over the age of 55 with minor works around the home that they can't safely do that would prevent accidents and injuries.

Carbon Monoxide detectors

Joint work with West Midlands Fire Service, Public Health and the Housing Service is underway to help reduce incidence of carbon monoxide poisoning (and fear of such) in particular vulnerable groups including those 65 years-of-age or older, the disabled, smokers, those living in large households or living alone using funding from the Department of Health and our existing heating contractors and Fire Service staff to deliver and install carbon monoxide detectors. Already 700 households have been assisted.

Ensuring standards in Houses in Multiple Occupation (HMO)

There is a significantly higher risk of fire in HMOs and fire statistics show most types of HMOs have a greater risk of fire than houses occupied by a single family. There are a variety of reasons for this increased risk, but because it exists, local authorities have powers to require adequate means of escape in case of fire and other fire precautions. The Council inspects and secures improvements to both licensable and non-licensable HMOs.

Tackling electrical hazards

Electric Blanket testing

Working jointly with Trading Standards and using funding from the Department of Health, for the last two years we have been providing free electric blanket testing and replacement. The work is part of our broader help for vulnerable residents. In one session we tested over 150 blankets of which 41% failed, the oldest blanket being from 1957 but with some very recent ones (under 4 years' old) that failed/were worn out through constant use.

Support from the Electrical Safety Council (ESC)

The Council and West Midlands Fire Service are promoting the work of the ESC and in particular to help tackle dangerous home electrical installations and appliances.

C. Other work

Helping residents become and remain safe in their homes – Adaptations Service

The Council has significantly improved the delivery for customers of it's adaptations service including statutory disabled facility grants (DFGs) in recent years. This means that more households are able to be helped, helped faster and for lower costs:

- 2011 a total of 289 DFGs approved
- 2012 a total of 351 DFGs approved

- 2013 up to 5th November 424 DFGs approved (already 47% more approvals than in 2011)

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14*
Average DFG cost	£12,575	£12,297	£9,948	£8,170	£6,467	£4,998
Time in weeks from referral to approval	90	65	27	9	8	7

*As at 5th November 2013.

Walsall Health and Housing Steering Group

A group led by Walsall Housing Group and the Council is an active partnership between health, housing associations and other key statutory and third sector partners which works to address these issues through implementation of the Walsall Health & Housing Strategy.

Indicators:

Homeless household numbers, Children living in poverty, Category 1 hazards (including statutory housing overcrowding rates), fuel poverty.

Priorities for action:

- *Maximising income through better access to employment and benefits and reducing fuel poverty.*
- *Improving the condition, quality, energy-efficiency and choice of housing, particularly in the private sector.*
- *High-profile marketing of programmes such as the Energy Company Obligation (ECO) and collective switching, which will improve the energy efficiency of homes, is needed to ensure that residents in deprived areas take up measures which will also benefit their health.*
- *Through partnership working with social and private landlords, improving access to health services, encouraging tenants and residents to adopt healthy lifestyles and encouraging those with long-term conditions to take up self-care management programmes.*
- *Developing community capacity in deprived areas in relation to healthy lifestyles through health literacy, community champions and health trainers.*
- *Encourage through new development schemes, and through land allocations, the provision/improvement of good-quality green open space and play areas for the benefit of all those who live and work in the borough.*

- *Ensuring there is a wide range of housing-related support options for vulnerable people, to enable them to maintain independent living.*

- *Identifying hot spot areas of pest infestations and target through proactive pest control visits, sewer baiting and awareness-raising on dealing with infestations effectively.*

4.4 Economy and Employment

Walsall, as part of the Black Country holds similar issues to its neighbours including: contaminated Brownfield Land with low or negative land values, a lack of shovel ready employment sites to encourage Inward Investment, with a relatively low skilled workforce that's able to adapt.

As a result Walsall continues to suffer from severe economic hardship, with too few active businesses, low New Business survival rates and high numbers of people who are economically inactive, suffer from ill health, together with job seekers who are poorly equipped to take up work opportunities.

This weak local economy has a massive impact on the services provided by all aspects of the local authority its partners and existing and new employers, not least on health services.

If we are looking at re-modelling the Health Sector, early action to work with both the existing and the prospective workforce, through the design, provision and application of appropriate Learning & Development that meets employer's needs both today and for the future is essential.

During the recent economic downturn the number of businesses in the borough fell as a result of fewer business start-ups and increased failures. This has left Walsall needing a 38% increase on its 7,185 active businesses just to bring it in line with the national average for an area of its population size[5]. The result is limited employment opportunities for the borough's working age residents – over 26,000 of who now rely on out-of-work benefits to live[6]

However, this is a long term trend and even before the recession Walsall's economy was at a major disadvantage. Between 1998 and 2008, while the national economy grew strongly and employment increased by 9%, Walsall's economy experienced a 2.5% decline in employment and lost over 2,500 jobs[7]. The recession just served to further emphasise Walsall's economic vulnerability, with almost 10,000 full time jobs lost between 2008 and 2009[8] and an unemployment rate that increased more sharply than the national average[9].

[5] ONS Business Demography 2011
[6] DWP benefit claimants - working age client group, Feb 13
[7] DWP benefit claimants - working age client group, Feb 13

[8] ONS Business Register and Employment Survey
[9] ONS Claimant Count

The number of available jobs is an obvious consideration in the strength of Walsall's economy, but this is further compounded by the inability of the borough's working age population to meet the skills requirements of those employers who do have positions to fill.

Walsall faces unemployment issues across all skill levels, and even amongst those with higher level qualifications, unemployment is higher in Walsall than regionally and nationally. However, the overall skill levels amongst working age adults are low, with a significant number of local businesses in Walsall indicating that lack of appropriate skills acts as a barrier to recruiting new staff.

This puts pressure on the local economy, as employers have difficulty in recruiting suitable employees and there are low rates of progression for those who are in employment; levels of worklessness remain high as low qualifications and skills levels act as a major barrier to gaining and sustaining employment.
This again reinforces the need to work on the development of local Learning and Development solutions that supports local employers with the shift required to adapt to the new ways of working, together with those required by local people if they are to either remain in employment or enter the workforce.

Educational attainment has improved in Walsall over recent years, but still remains below national levels and there are recognised inequalities across the borough. Local employers have observed that despite improving formal qualifications, many school leavers continue to lack basic skills, for example numeracy, spelling, letter writing and customer service skills. More importantly, school leavers need to be able to show they are 'work ready' and can demonstrate a basic work ethic and sound practical skills.[10]

Within the working age population, it is the individuals with low skill levels and few formal qualifications that are most at risk of remaining unemployed. Over 1 in 6 working age adults in Walsall have no formal qualifications[11]. Literacy and numeracy standards are below the national average for the borough overall, with severe problems in some wards where 2 in 3 adults have a 'below GCSE' standard of numeracy.

ICT levels are lower than for England and again there is huge disparity between different parts of the borough. It is not surprising that the areas with low basic skills are the same as those with high levels of unemployment: Blakenall, Birchills Leamore and Darlaston South.[12]

Low income or worklessness in Walsall is strongly correlated with poor health outcomes, as well as with child poverty, crime, lack of aspirations and lower levels of educational achievement. This contributes to a vicious cycle of intergenerational unemployment that needs to be tackled from a number of angles. For many families in Walsall, breaking the cycle of poor skills and benefit dependency is crucial and can if resolved have a major positive impact on their health and well being.

[10] Walsall Council, employer focus group 2010
[11] ONS Annual Population Survey, 2012
[12] BIS, 2011 Skills for Life Survey

Employment is closely linked to wellbeing. 'Good' employment is characterised by sustainability, flexibility, decent living wages and conditions of work, and opportunities for development. Employment and employability in adulthood is a product of achievement in the early and school years as well as the aspiration levels of both individuals and the communities in which they live.
All these factors act to reinforce inequalities that can begin very early in the life course. Unemployment or poor quality work with low pay and limited opportunities is highest among those with few or no skills and qualifications, people with disabilities and mental ill health, carers and lone parents, ethnic minorities and both younger and older adults.

Poverty and lack of work is very closely related to health inequalities in a complex relationship of cause and effect. People suffering from ill health are more likely to be unable to work due to their condition and to be dependent on benefits; conversely, those who are unable to find work and subsequently live in poverty are more likely to have unhealthy lifestyles and suffer from poor health outcomes.

Ill health caused through accidents at work or occupational disease can also place a burden on the economy. Many accidents and occupational diseases are preventable and therefore collaborative work between the health services and local authority environmental health team should be able to identify vulnerable groups and emerging or existing safety risks. These risks can then be targeted to reduce the associated health and economic burdens.

The Marmot Review recognised the importance of good employment and employability with the following priorities:

- *Improve access to good jobs and reduce long term unemployment across the social gradient*
- *Make it easier for people who are disadvantaged in the labour market to obtain and keep work*
- *Improve quality of jobs across the social gradient*

In Walsall, due to the nature and scale of the challenge we face, a focused approach is necessary. Some of the key areas of concern are:

- *The growing proportion of long-term unemployed claimants, who are increasingly distanced from the labour market*
- *A high number of residents dependent on incapacity benefits*
- *Low income and benefit dependency resulting in high child poverty levels*
- *Inter-generational worklessness, where children grow up in households where no one works*
- *Geographical areas of the borough where the problems of benefit dependency are even more critical than the borough as a whole, particularly around the town centre and North Walsall*
- *Residents with health issues who are currently in employment but who may require more help and support to enable them to remain in employment rather than becoming dependent on benefits*

- *Develop and implement a comprehensive set of programmes that equip local service providers, particularly within the Health & Social Care Sector, with the knowledge and skills required to maximise the health of those they provide services for, as well as their own workforce.*
- *Develop and implement a comprehensive set of Learning & Development programmes that equips local people with the skills and abilities demanded by the Health & Care sector, so they are able to compete for and secure employment.*
- *Identify and work with key agencies (Health Education England / West Midlands, etc.) to seek out opportunities for joint working and support in the development of new approaches and ways of working, together with funding and joint delivery etc.*

Further detail is available in the following paragraphs and the Local Economic Assessment.

4.5 Adults and parents

With around 1 in 6 working age residents out of work and dependent on benefits, Walsall faces a major challenge to increase the employment rate of local residents to a level which matches the averages for West Midlands and England[13]. Current economic conditions make this more difficult than ever and there are too few jobs available for local people to access. The effect that being out of work has on the health and wellbeing of individuals has already been outlined in the introductory paragraphs, but that effect is compounded when those individuals are parents with dependent children who are reliant on the income of the adult(s).

Access to jobs requires employers who need workers, Walsall is home to around 7,180 businesses – a shortage of 2,760, when compared with the national average per size of adult population – and this means there are only 0.56 jobs per working age person, compared to 0.70 nationally[14]. Many residents also lack the necessary skills to gain and sustain employment. Latest figures show that 17% of working age adults living in Walsall have no qualifications, compared with just 9.5% nationally.

Although Walsall has seen significant improvements since 2006 when there was a high of 28.7%, this 17% figure still equates to 26,200 adults in the borough who hold no formal qualifications[15].

Indicators:

Walsall has a resident working age population of 167,300 people aged 16-64[16]. Of these, 26,580 people are not working and are claiming an 'out of work' benefit[17], which includes:

- *12,030 people claiming Employment Support Allowance (ESA)/Incapacity Benefit (IB)*
- *10,340 unemployed people on Jobseeker's Allowance (JSA)*

[13] DWP benefit claimants - working age client group, Feb 13
[14] ONS Business Demography 2011 & mid 2011 population estimates
[15] ONS Annual Population Survey, 2012
[16] ONS Mid-2011 Population Estimates
[17] DWP benefit claimants - working age client group, Nov 2012

- *3,210 lone parents on Income Support*
- *1,000 others on income-related benefits*

This equates to 15.9% of the working age population, although the borough has seen improvements over the past few years, the gap between Walsall and England (11.3%) continues to be a concern.

The number of claimants of ESA/IB in Walsall has remained relatively stable over the past decade, indicating the extent of poor health and wellbeing issues faced by our communities and the lack of progress in making headway with this customer group. In contrast, as you would expect the number of jobseekers has seen major fluctuations linked to the state of the wider economy and its influences on ours.
There was a huge increase in unemployment claimants during the recession, when Walsall fared even worse than England overall, and has still has not fully recovered; reducing benefit dependency continues to be a priority for the borough.

As shown in Figure 45 , the west of the borough is home to the majority of Walsall's benefit claimants, with Blakenall, Birchills Leamore, Pleck, Darlaston and parts of Bloxwich and Willenhall having the highest concentrations. There are also large differences in the rates of claimants between the west and the east of the borough.

Near Walsall town centre, around a third (32%) of adults in some neighbourhoods are claiming out of work benefits, while in parts of Streetly and Aldridge the figure is only around 10% However, it should also be noted that there also pockets of low benefit dependency in the west of Walsall, and vice versa.

A report by the Centre for Regional Economic and Social Research[18] suggests that there may also be extensive 'hidden' unemployment, with evidence pointing towards a significant number of people who do not appear in official measures of unemployment because they have instead been diverted into claiming other types of benefits, or because they are outside the benefit system altogether.

In Walsall, an estimated 5,300 people may have been diverted onto incapacity benefits instead of unemployment benefits; these do not represent fraudulent claims, but are people who with the right employment opportunities and support could more easily re-enter the labour market. A further 2,600 people identify themselves (via the Labour Force Survey) as unemployed, but are either not entitled to unemployment benefits or choose not to make a claim – so do not appear in the benefit claimant figures above.

The following map illustrates the levels and geographical locations of residents claiming 'Out of Work Benefits', further illustrating the divide between the West and the East of the borough.

[18] Beatty C, Fothergill S & Gore T, (2012) The Real Level of Unemployment 2012, Centre for Regional Economic and Social Research, Sheffield Hallam University

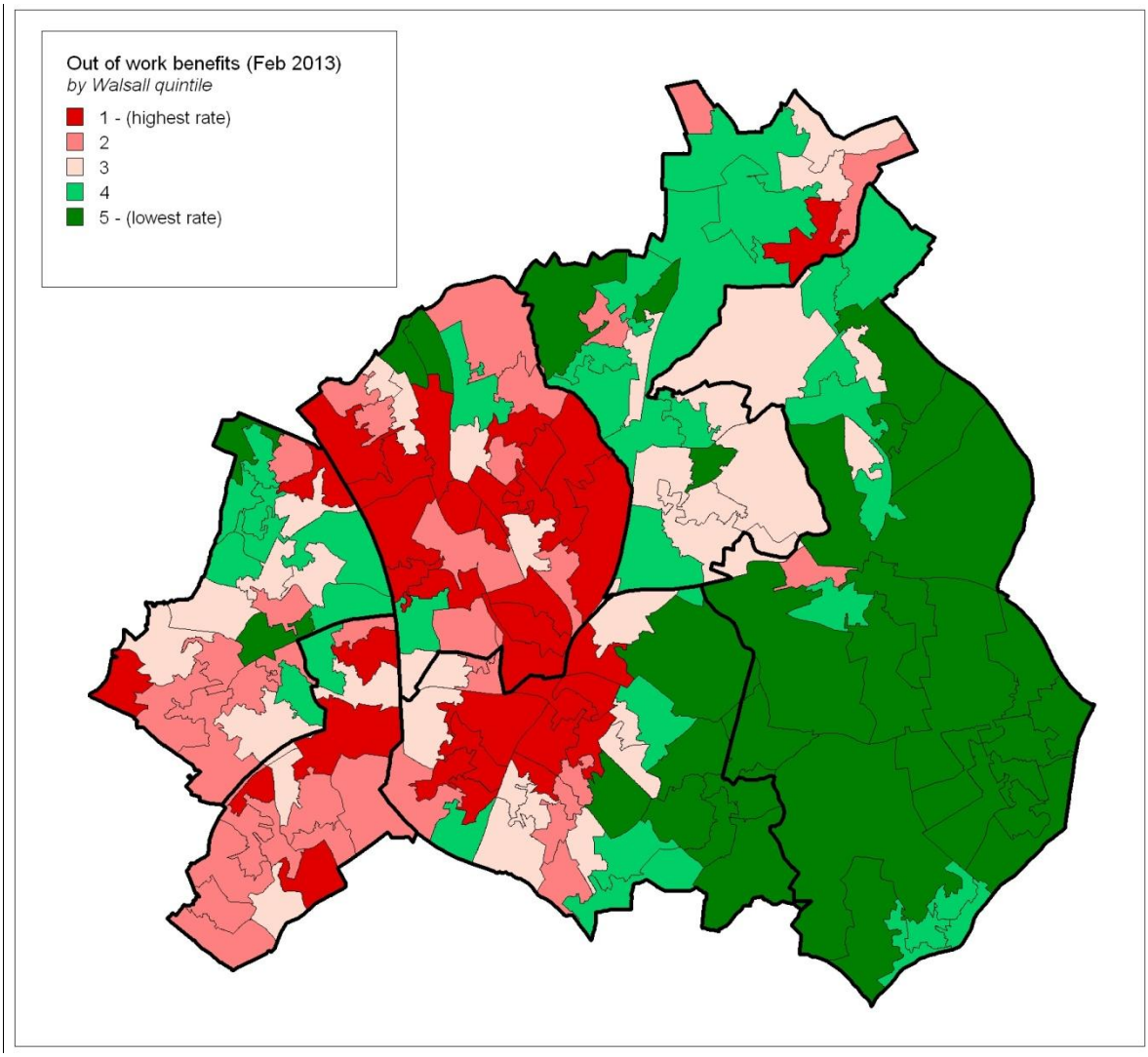


Figure 45 Walsall working age residents claiming out-of-work benefits by LSOA - February 2013

Priorities for action:

Walsall Council and its partners have a number of initiatives in place to tackle worklessness that complement mainstream provision, but it is essential to ensure that these are expanded. The end of Working Neighbourhoods Fund (WNF), which previously supported many of these schemes, poses a new challenge to identify alternative funding streams to maintain the initiatives that have proved successful in the past and to develop new projects that meet local gaps in provision. We need to:

- *Increase the availability of jobs in the borough by encouraging enterprise and inward investment, concentrating on key sectors which have the potential for growth*
- *Ensure jobs and opportunities are available at all levels and requiring different categories of qualifications, from apprenticeships through to highly skilled workers.*
- *Improve employability and access to job vacancies for local people*
- *Improve the skill levels and qualifications of local residents and match these to the needs of local businesses*

- *Increase the availability of opportunities for supported work placements and volunteering in order to facilitate individuals in gaining relevant work experience and appropriate skills*
- *Understand and tackle the barriers to work, including the problems posed by ill health or circumstances that include dependents such as young children requiring childcare*
- *Explore and utilise any available external funding (European, Lottery etc.) to support local people into training and employment.*
- *Provide appropriate support to allow people with a history of mental illness or health problems to access work placements, training and employment opportunities – and to assist those who already have jobs to remain in employment and not become long-term sick or dependent on incapacity benefits*
- *Promote and support the role of employers in maintaining and improving employee health e.g. through the NHS Healthy Workplace programme, setting up and promoting corporate health and wellbeing schemes, and identifying and tackling work place accidents/occupational disease*
- *Provide support to Walsall businesses to ensure compliance with legal requirements (including health and safety legislation) to ensure that they are competitive, able to thrive, create an environment for confident consumers and thus are able to create employment opportunities*

4.6 Young people

Young people aged 16-18 who do not participate in any form of employment or learning are popularly referred to as 'Not in Education, Employment and Training' - NEET. In Walsall, 6.4% of 16-18 year olds are NEET, equating to 630 young people[19]. Some of the key factors that contribute to a young person becoming NEET include disadvantage, poor educational attainment and educational disaffection. A key preventative focus (covered in previous chapters) should be related to high quality education and training aimed at increasing the number of young people succeeding in education, thereby reducing the number who are disaffected.

Evidence suggests that a young person being NEET is a major predictor of unemployment, low income, depression, poor mental health, and living in poverty as an adult. The individuals are at greater risk of experiencing intergenerational poverty: suffering from low aspirations and poor life chances which they in turn can pass on to their own children. All of these factors are linked to poor lifestyle choices and are likely to result in health inequalities amongst this group. The challenging economic conditions being experienced across the country, and to an even greater extent in Walsall, pose a significant challenge to supporting this particular group.

In June 2013, 2,610 young people aged 18-24 were claiming JSA in Walsall. This means that 10.7% of 18-24 year olds in the borough are actively seeking work, compared with only 6.2%

[19] Department for Education, 2012 local authority NEET figures

nationally. This is almost double the rate of unemployment in Walsall's working age population overall.

At the same time, long-term unemployment in the 18-24 age group remains an issue, with 1 in 4 young people who claim JSA having done so for more than 12 months. However, the numbers of young unemployed people in Walsall has fallen significantly over the past two years, with improvements above those seen in the rest of the Black Country; so although youth unemployment remains an issue for the borough, there is emerging evidence that work to tackle this priority in Walsall is having a positive impact.

The areas of Walsall experiencing the highest rates of 18-24 claimants mirror those with the highest number of NEETs, and teenagers who are disengaged as 16 and 17 year olds are much more vulnerable to becoming young adults who remain outside the labour market.

Indicators:

Walsall currently has around 630 16-18 year olds who are not in education, employment or training (NEET) (Prospects Services, May 2012). It should be noted that this number fluctuates on a daily basis. The proportion of young people classed as NEET has fallen every year in the borough from 10.3% in 2005/6 to 6.4% in 2011/12. However, despite this achievement, this still remains slightly above the average for England (5.8%) and the West Midlands (6.2%).

There remain concentrations of NEETs in certain parts of the borough, with particularly high numbers in the West and North: in Birchills Leamore, Blakenall, Palfrey, Brownhills, Darlaston South and St Matthews (see Figure 46 below).

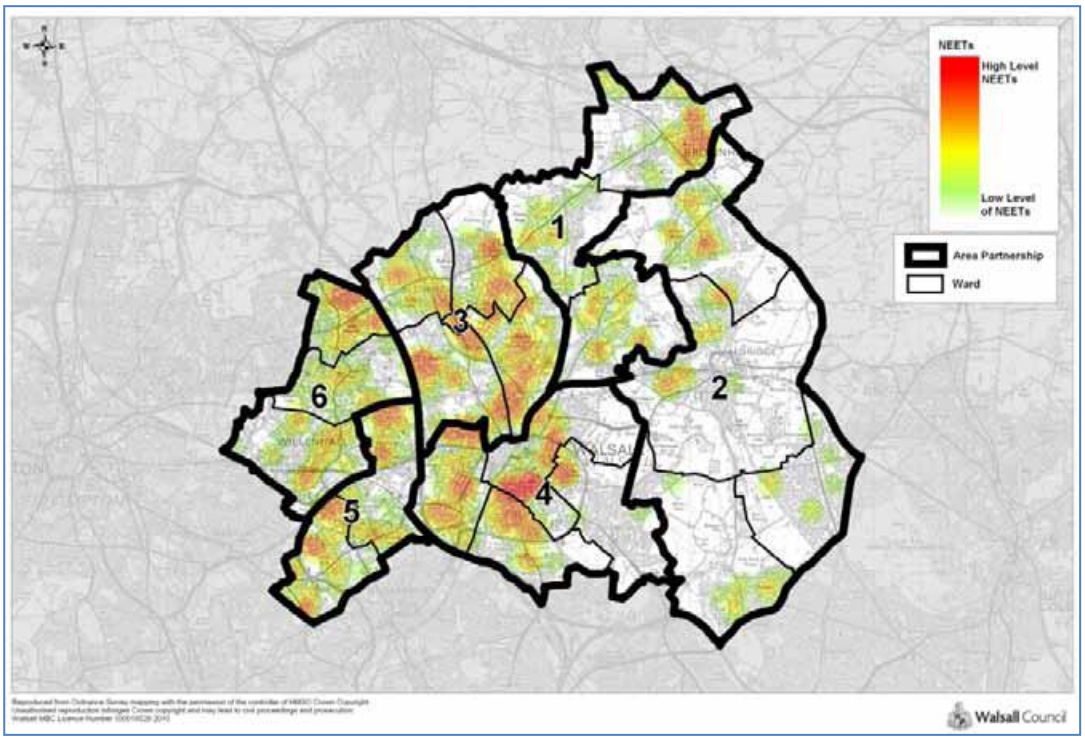


Figure 46 Walsall NEET 'hotspots' November 2010 (from Prospects 2010)

Young people who are NEET are not a homogenous group; some are much more prepared to take up the opportunities on offer to them, while some require much more intensive support. Prospects have identified 5 groups of 16-18 year olds, with particular characteristics and the type of provision potentially available to them. These groups (detailed in Figure 47) range from those who are 'opportunity ready' – competent in the labour market, or, given the chance, willing to enter training or work – to those who have a particularly complex and challenging set of needs that must first be addressed before they can access opportunities.

	Characteristics	Provision Accessed
Group 1 **'Opportunity ready'** 10%	**Competent in the labour market** Main characteristics are poor employability, basic skills, confidence and self-esteem issues. Some will have sustainability issues. Able to enter learning programmes at level 2 and above.	Apprenticeship programmes Jobs with training School/further education provision at level 2/3
Group 2 **'Opportunity ready'** 20%	**Willing to enter training or work** Relatively low qualification/ skill base – qualifications at level 1 or less Those 17/18 years of age will have some experience May lack sustainability skills	Foundation learning Lower level entry Apprenticeship programmes. Jobs without training School/further education provision at level 1/2
Group 3 15%	**Not ready to make vocational choices** Or may need some help to develop confidence, employability and basic skills	Accelerate/Foundation learning School/further education provision at Entry level/level 1
Group 4 30%	**Very low skill base and aspirations - Entry level at most** Many from areas of social, economic disadvantage Are likely to remain NEET for substantial amounts of time Many will have vulnerability characteristics. Many have Learning Difficulties or Disabilities	Accelerate/foundation learning Jobs without training School/further education provision at Entry level/specialist provision
Group 5 25%	**Most complex/challenging young people** May not be able to enter opportunities in short/medium term	Intensive support from multi agency support teams

Figure 47 'Work ready' characteristics of NEETS

A quarter of NEETs have been identified as 'Group 5', which represents the most complex and challenging young people to place into suitable opportunities. Many of these fall into a particularly vulnerable group, which include:

- *Teenage mothers*
- *Looked after children and care leavers*
- *Young offenders*
- *Those with learning difficulties and disabilities*

Employment and training places often break down due to the young person's inability to meet the demands of the course as a consequence of their limited educational, personal, social and emotional skills or the detrimental impact of their personal life; housing disruption, care of a baby, family and financial issues, or criminal record.

Young people with learning issues leaving special schools have had specialist teaching input, but this is generally not replicated in the work/training place as is the case in Further Education. Withdrawal of Educational Maintenance Allowance has also had a significant impact on the leavers from lower income families, most of whom would have relied on some form of financial incentive.

Priorities for action:

Young people who are outside education and employment have a complex range of needs where a 'one size fits all' approach is unlikely to reach many of them. Difficulties will remain for many of the vulnerable groups despite plans to raise the participation age to 18 by 2015. Given the large number of 18-24 year olds out of work, the opportunities for progression are likely to remain challenging for some time to come. There are, however, areas where we need to focus our efforts:

- *Greater diversity of choice for learning, training and employment for young people (see Appendix 3, CYP Plan Priority 4)*
- *Supporting the transition into adulthood for children and young people with Special Educational Needs or Disabilities by creating single 'through life' plans (see Appendix 3, CYP Plan Priority 5)*
- ***Links with Business** – All education providers from primary schools through to further education need to be working closely with businesses in the borough to understand the qualities, attitudes and skills – besides formal qualifications - that young people require to be successful in the labour market and to introduce them as early as possible to the world of work.*
- ***Apprenticeships and/or supported work placements** – Apprenticeship schemes for young people who are 'opportunity ready' need to be expanded as well as other placements to enable young people to experience what it is like to do a particular job and gain the relevant skills to help them become more employable. One example of good practice is the extensive apprenticeship scheme that Walsall Council is delivering called 'Walsall Works'. As well as incorporating full apprenticeship opportunities, there are also a number of pre-apprenticeship placements. These embed work preparation skills into those who lack the confidence, experience, qualifications or employability skills to sustain a traditional placement without some initial preparation and guidance.*
- ***Intensive Support for Vulnerable Young People** – Traditional formal education or apprenticeship schemes are often unsuitable for these groups as they require much more tailored and intensive support. Using teenage mothers and those with learning difficulties as examples, teenage parents often need up to date knowledge and information about benefits and housing advice and support. For those with learning difficulties or disabilities, twelve week classroom -based programmes do not give enough developmental learning time and a six month to one year structured programme which allows the young person to learn at their own pace and offers practical, workshop-based training in an informal setting would be far more beneficial.*

There is currently also a gap in the provision of training that offers real hands- on work experience for young people with any sort of additional need, who would further benefit from mentoring and more 1:1 support. All employers from the statutory, independent and voluntary/community sectors need to play their part in providing the opportunities described above.
It must be acknowledged however, that the public sector in Walsall employs the largest number of people and should provide an exemplar for employment support.

4.7 Vulnerable groups

The local authority, NHS and partners are committed to supporting vulnerable residents to:

- *Optimise life chances, health and wellbeing by reducing inequalities, maximising autonomy and prevention, and minimising dependence*
- *Ensure safety and protection, while enabling and managing risk*
- *Ensure the availability of accessible services that are empowering, socially inclusive and responsive to user preference*
- *Ensure a high quality workforce in adults social care and inclusion*
- *Deliver more efficient business processes that free up resources to give choice and control to users of services and that respond to changes in levels of need*
- *Ensure effective collaborative working to produce good outcomes for service users and support delivery of our shared objectives*
- *Explore and utilise any available external funding (European, Lottery etc.) to support local people into training and employment.*

Individuals within families with very complex and multiple problems are often inhibited from being able to access and maximise education and training opportunities and therefore the employment that potentially follows. The resulting worklessness and child poverty are symptoms that create a cycle of deprivation and it is therefore vital that we target resources according to need.

Vulnerable residents may be currently economically inactive for many reasons, but the majority in Walsall are those with health issues that prevent them from entering or sustaining employment. Support for these clients around training, re-skilling and employability is crucial and is currently provided through both mainstream and externally funded activity.

Indicators:

Adults with learning disabilities

Around 1 in 10 adults (aged 18-64) in the borough with learning disabilities were in paid employment at the time of their assessment or latest review - equal to 70 out of 665 clients,

or 10.4%[20]. This is slightly lower than the 12.6% in employment the previous year. The percentage of female adults with learning disabilities in paid employment (7.9%) was lower than for males (12.3%).

Adults with mental health problems

Only 65 out of 1,425, or 4.4%, of adults with mental health problems aged 18-69 in contact with secondary mental health services in Walsall were known to be in paid employment at the time of their assessment or latest review[21]. This figure is below the 7.8% employment for the previous year. For this group of residents, females were more likely to be employed, with 5.7% in employment compared with 3.0% of males.

Priorities for action:

If the barriers affecting the ability of the most vulnerable people in Walsall to be able to gain employment are to be overcome, then the statutory sector, independent sector and voluntary/community sector have to continue to work in partnership with our most vulnerable service users in order to ensure that the services being offered actually meet the needs of the people we are trying to help. The barriers are complex and the solutions are not easy, requiring innovative thinking that reaches across boundaries and professional disciplines.

Examples of initiatives attempting to do just that are:

- ***The 'Families with Multiple Barriers' project:*** *A multi-agency approach supports the new operating models in both Adults and Children's Services which promote independence and improved outcomes for the most vulnerable, including their prospects of gaining employment. The Early Health Strategy provides a clear direction for service delivery, outcomes and learning are maximised through the 'Families with Multiple Barriers' project (European Social Fund), which helps families to tackle and overcome their issues by supporting them into 'progress measures'. Issues include:*
    - *Coping with care responsibilities*
    - *Support with children with Learning Difficulties*
    - *Anti Social Behaviour*
    - *Financial Difficulties*
    - *Work Experience*
    - *Improving Health*
    - *English for Speakers of Other Language (ESOL)*
    - *Reducing Depression and Anxiety*
    - *Social Isolation*
    - *Risk of Homelessness*
    - *Parenting Skills*

[20] Adult Social Care Outcomes Framework (1E), 2012-13 provisional data
[21] Adult Social Care Outcomes Framework (1F), 2012-13 provisional data

- *Domestic Violence*
- *Basic and Functional Skills*
- *Motivation and Confidence*

- ***The 'Supporting People' Programme:*** *This national government programme provides housing related support to the most vulnerable client groups, helping them to live independently in their own homes and linking directly into activity that improves their economic wellbeing. The programme is delivered through a partnership between the Council, Health Service and Probation Service*
- ***Employment Strategy and pathway:*** *The Joint Commissioning Unit is currently developing an employment strategy and pathway that includes newly commissioned services to improve opportunities for adults with learning disabilities, physical and sensory disabilities and autism*
- ***Walsall Vocational Service:*** *This service is delivered by Dudley and Walsall Mental Health Partnership NHS Trust and supports individuals with severe and enduring mental health problems to gain and sustain employment. Evidence suggests that employment can support an individual's recovery and can reduce the need for clinical interventions. The team are currently piloting the Individual Placement and Support approach as it is known to be more successful in supporting people to move into competitive employment and has a sound evidence base to support that understanding. The service has gained 'Centre of Excellence' status for this model from the Sainsbury's Centre for Mental Health*
- ***Walsall Residential Service offering Crisis and Respite beds****: This service supports people with severe and enduring mental health problems who are in crisis or perhaps need support on an ongoing basis to manage their mental health problems. It is delivered by Walsall MBC in partnership with Dudley & Walsall Mental Health Partnership NHS Trust. Service users can access crisis beds in times of need when a hospital admission is not required, or can access respite beds as an ongoing support mechanism to manage their mental health symptoms. In order to improve the economic wellbeing of individuals who are in crisis and therefore accessing this service, it links directly with specialists from Walsall's Vocational Service who provide employment retention advice or support for those seeking employment*
- ***Young NEETs****: The previous section outlines some of the issues and initiatives for vulnerable groups of young people who are not in employment, education or training, including those with learning difficulties and disabilities*

4.8 Chapter summary and key priorities for action

The chapter introduction indicated key areas of concern for Walsall and the paragraphs that followed highlighted examples of good practice and ongoing initiatives.

Key Priorities for action:

Employment and employability will remain an ongoing challenge in the forthcoming years for Walsall. We must work in partnership across the statutory, independent and voluntary/community sector to provide the focus necessary to:

- *Recognise the medium and long term impact in terms of physical and mental health, as well as economic outcomes, that unemployment has on people and ensure that, in a period of limited resources, there continues to be joined up thinking, strategic commitment and targeted action to reduce unemployment in the borough*
- *Ensure that in seeking solutions to the challenges we face, we recognise the unique nature of some of those challenges in Walsall and seek to be creative and innovative in our approaches as well as employ evidence-based good practice that is working elsewhere*
- *Ensure that necessary courses and training is available to local residents, especially young people, to enable them to improve their skill levels and qualifications in order to access job vacancies and gain employment*
- *Ensure that the public, independent and voluntary/community sectors in Walsall work together to provide a wide variety of opportunities for employment support and volunteering, acting as role models and exemplars for others*
- *Increase the availability of jobs in the borough requiring the full range of qualifications and skills*
- *Develop greater diversity of choice for learning, training and employment for young people (see Appendix 3, CYP Plan Priority 4)*
- *Supporting the transition into adulthood for children and young people with Special Educational Needs or Disabilities by creating single 'through life' plans (see Appendix 3, CYP Plan Priority 5)*
- *Ensure we understand the needs of our most vulnerable and disadvantaged residents and recognise that other needs may need to be met before an individual is ready to seek employment*
- *Understand the nature and complexity of the barriers that local people face when trying to access work and the effect on the individual and dependent family members, especially children*
- *Identify resources to remove or reduce barriers to work and support local people to gain the necessary knowledge, skills and confidence to overcome them, particularly those posed by physical and mental ill health and inexperience due to age*
- *Provide incentives to employers and schemes that enable our most disadvantaged residents to enter and sustain employment*
- *Promote the role of employers in maintaining and improving employee health through healthy workplace programmes and by identifying and tackling work place accidents/occupational disease*
- *Provide support to Walsall businesses to ensure compliance with legal requirements to ensure that they are competitive, able to thrive, create an environment for confident consumers and thus be able to create employment opportunities*
- *Develop and implement a comprehensive set of programmes that equip local service providers, particularly within the Health & Social Care Sector, with the knowledge and skills required to maximise the health of those they provide services for, as well as their own workforce.*

- *Develop and implement a comprehensive set of Learning & Development programmes that equips local people with the skills and abilities demanded by the Health & Care sector, so they are able to compete for and secure employment.*
- *Identify and work with key agencies (Health Education England / West Midlands, etc.) to seek out opportunities for joint working and support in the development of new approaches and ways of working, together with funding and joint delivery etc.*
- *Explore and utilise any available external funding (European, Lottery etc.) to support local people into training and employment.*

Chapter 5 Creating and developing healthy and sustainable places and communities

There is a close relationship between the quality of the physical and social environment in which people live and their health and wellbeing. The architecture of the housing and public buildings, the transport infrastructure and the quality of public spaces all influence the health and wellbeing of residents. The built environment can have both positive and negative impacts on health: dissatisfaction with the environment can lead to low levels of physical activity, low levels of mental wellbeing and poor quality of life.

There is a strong relationship between levels of deprivation in an area and the quality of the immediate local environment. In Walsall, the difference in the quality of the environment in the east and in the west is apparent and mirrors differences in health and quality of life of residents in the borough.

It is often easy to recognise when an area gets it right, as people often flock there either to live, work or to take part in leisure activities. Pleasant environments promote community spirit and civic pride. Where it goes wrong, however, is often equally obvious from acts of anti-social behaviour, littering, graffiti, fly-tipping, poorly-looked-after space and vandalism. Such features can adversely affect mental health[22].

The environment has an important influence on the way people live their lives. Many Walsall residents undertake very little physical activity and have poor diets. This is a serious public health challenge that needs to be addressed, as the prevalence of chronic diseases related to obesity and inactivity (such as diabetes) is high and increasing. The World Health Organisation has suggested that incorporating physical activity into our daily routines may best be achieved through active travel such as walking and cycling[23]. Factors influencing physical activity include access to open space and greenery, owning dogs, levels of graffiti and litter and fear of crime. Spatial planning decisions which take into account the impact of the environment on health can significantly increase the opportunities for people to be physically active and access healthy food.

'Climate-friendly' investments in transport, housing and household energy policies can help reduce the incidence of cardiovascular and chronic respiratory disease, obesity-related conditions and cancers. Improved air quality delivered through green technology, active travel and low-carbon transport will reduce the incidence and exacerbation of respiratory diseases. Improving the energy efficiency of homes will reduce fuel poverty and reduce the impact on health of extremes of climate.

Healthy, sustainable communities are supported by factors such as good-quality housing, access to green spaces, leisure and recreation, public transport, and good-quality food, as well as increased levels of community involvement and better social networks. Strategies to

[22] Baba Y AD. Environment and Behaviour: Neighbourhood environmental satisfaction, victimisation, and social participation as determinants of perceived neighbourhood safety. Environment and Behaviour 1989;21, 763-780.

[23] World Health Organisation. Why Move for Health. Available at: http://www.who.int/moveforhealth/en/

build stronger and healthier communities must improve both the physical and social environment. Social networks and links between individuals help to build social capital which improves resilience and wellbeing in both the individual and the community.

The Marmot Review recognised the importance of both the physical and social environment in the following priorities:

- *Development of common policies to reduce the scale and impact of climate change and health inequalities*
- *Improvement of community capital and reduction of social isolation across the social gradient*

This chapter covers six theme areas that are central to creating and developing healthy and sustainable places and communities. These are:

- *Getting about*
- *Relaxing and having fun*
- *Healthier by design*
- *Stronger communities*
- *Community Safety*

5.1 Getting about

The borough or Walsall has a population of approximately 269,500 and an area of some 41 square miles through which major sources of transport-related air pollution are the M6 motorway, dissecting the borough, and major arterial roads including Wolverhampton Road (A454), Lichfield Road (A461).

Air quality has a direct influence on the health of the general public, as well as the environment. By virtue of EU directives and in-turn UK legislation, councils are tasked with duties to review and assess air quality as an on-going annual basis. Stemming from this, Walsall has declared the whole of its borough an Air Quality Management Area (AQMA) and along with five other West Midlands authorities faces the key challenge of tackling vehicle emissions.

Poor air quality is attributed to nitrogen dioxide, with exceeding the national annual air quality objective for nitrogen dioxide (NO_2) occurring notably along the M6 motorway corridor and major arterial routes (A-roads) serving the town centre. Nitrous Dioxide can have the following implications in terms of adverse health effects:

- *Toxic in high concentrations*
- *Triggers and exacerbates asthma*
- *Acts as a pre-cursor for ground level Ozone formation which can trigger sudden cardio-vascular episodes*

Such health impacts of air pollution are well documented. The Committee on the Medical Effects of Air Pollution (COMEAP) estimated that air pollution in the UK in 2009 caused 29,000 premature deaths; the Environmental Audit Commission (EAC) estimated that the cost to health from poor air quality in the UK ranges from £8.5 to £20 billion per annum; and research shows that road transport emissions account for more deaths in the UK than road traffic accidents.

The UK's air quality strategy is designed to improve and safeguard the health of exposed persons, which in the main constitutes citizens. By declaration of AQMAs, local authorities must demonstrate how they are working towards achieving national air quality objectives through the implementation of local air quality action plans and associated mitigation measures.

In light of this, the West Midlands Low Emissions Town and Cities Programme (LETCP) has been set up to improve air quality and reduce emissions from road transport regionally. The objectives of the programme are to investigate and produce regional strategies designed to improve air quality with a view to meeting national air quality objectives. By direct association this promotes compliance with EU emission limits, reduction of carbon emissions and supports the objectives of the Local Transport Plan 3 (LTP3) to improve air quality and reduce emissions from road transport. The intention is to do this by promoting the uptake of low emission fuels and technologies, establishing and sharing best practice policies, and developing various tools and resources for this purpose.

Over the past three consecutive years the LETCP has secured three elements of funding from Defra's Air Quality Grant scheme to undertake work in relation to the programme. Part of this involves work with Public Health Authorities, Health Protection Agencies, schools, and the NHS to develop an awareness campaign regarding the impacts of air pollution. This work will build on findings of a Low Emission Zone Study which incorporates a Health Impact Assessment. Work is also currently underway to develop an Air Quality/Health Awareness Project with Walsall Schools as part of the Walsall A*STARS Schools Programme.

The A*STARS programme is a series of walking, cycling, road safety initiatives, training and support given to schools to help them to develop and promote safer, healthier lifestyle choices for all. The programme promotes health and wellbeing by combining and providing road safety, health and sustainable travel education, training and awareness. It targets all educational establishments and school communities; supporting children's development at every stage from birth to adulthood.

The overall goal set out in a Low Emissions Strategy will be to improve emissions and concentrations of NO2 (together with fine particulates, which have a direct association with health impacts) through the transformation of the West Midlands vehicle fleet. The Low Emissions Strategy has the potential to influence emissions of the proportion of the national fleet whose journey originates in, transits or terminates in the region, though it is acknowledged that transformation of the vehicle fleet will require the provision of low emission vehicle infrastructure and incentives for low emission vehicle take-up. Additionally, policies and measures that discourage the use of high emission vehicles are likely to be required to meet pollution reduction goals.

In taking this forward, the Low Emissions Strategy will look at the economic impacts and benefits of intervention policies. The LETCP will work in co-ordination with Local Enterprise Partnerships and Universities, reflecting the status of the region as a national centre for low emission vehicle research and manufacturing. In short, the Low Emissions Strategy will act as a platform for inward investment for low emission vehicle demonstration and deployment.

Indicator:

- *Proportion of children who walk or cycle to school*

Priorities for action:

- *Partners should promote walking and cycling as routine ways of travelling that will help improve residents' health and wellbeing. 'Make Every Contact Count' provides a means for front-line staff to do this*
- *Improve signage, increase the number of designated or separate cycle paths and increase provision of secure cycle racks in Walsall so that cycling becomes an easy, safe and regular method of transport throughout the borough*
- *Consider a cycle hire scheme such as that used in London and Paris*
- *Use transport planning as a mechanism for improving residents' access to green spaces, health facilities, leisure opportunities and healthy food*
- *Review current 20 mph zones in residential areas and consider expanding these*
- *Encourage the use of public transport; there may be opportunities to use smart card technology such as the Oyster card in London to enable residents to collect reward points for each journey*
- *Consider what part the canal network could play in contributing to improving health and wellbeing*
- *Ensure there is a safe and good-quality fleet of private hire and hackney carriages as part of the public transport strategy, particularly to meet the needs of the elderly and those residents with disabilities*
- *Use accessibility planning software to map access to employment and services as well as health and fresh food to inform planning decisions regarding transport issues*
- *Roll out the A*STARS programme across all primary schools by March 2016;*
- *Pilot the A*STARS programme in secondary schools during 2013/14 with roll out across 50% of secondary schools by March 2015;*
- *Develop and pilot A*STARS programme in early year centres during 2013/14.*

5.2 Relaxing and having fun

Relaxing and having fun is an important part of life. Quality leisure time is integral to good health and wellbeing. Research has shown that a low level of physical activity in leisure time, as opposed to at work, is the greater health risk (Johansson et al, 1988). Sport England's Active People Survey (2006-12) has consistently identified Walsall as being among the local authorities in England with the highest levels of physical inactivity among the population, with two thirds of Walsall adults undertaking absolutely no recreational physical activity.

Happy people tend to be more content, easy going, less likely to resort to antisocial behaviour and have a better sense of their place in the world. The Taking Part survey (DCMS 2006-2010) suggests a correlation between participation in sport and culture and both knowing more people within neighbourhoods and also satisfaction with local areas. Similarly, The Power of Sport (Institute of Community Cohesion, 2007) draws together a range of case study research into sport's role in improving community cohesion and reducing anti-social behaviour.

5.2.1 Sport and Leisure

The Council currently has four leisure centres; Oak Park in Walsall Wood, Bloxwich, Darlaston and Gala Baths in Walsall town centre. The average age of these is 40 years and they are in need of replacing. The Council's emerging Active Living Review is exploring opportunities to replace two and possibly improve the third. Such an approach will help the Council deliver its purpose to 'maintain and improve the health and wellbeing of all its residents' and make *more people, more active, more often*. The 'Your Place, Your Wellbeing Walsall Lifestyle Survey' (2012) identified that a third of Walsall residents would be likely to undertake more physical activity if sport and leisure facilities were improved. The survey also indicated that swimming and gym were the two activities that were both most popular and those that people were most interested in doing more of. Where facilities have been modernised elsewhere, case studies suggest attendances can increase two or even three-fold. Not only does this attract more people to take part in physical activity and recreation but also contributes to self-confidence, social inclusion, healthy weight management and improved mental health.

Particular success has been achieved with the Free Swimming for under-16s – a national programme extended in Walsall by a partnership between Walsall Council and NHS Walsall. The programme has resulted in a large increase in participation from young people, particularly from disadvantaged communities. Such programmes encourage young people's physical activity and contribute to tackling the problem of childhood obesity.

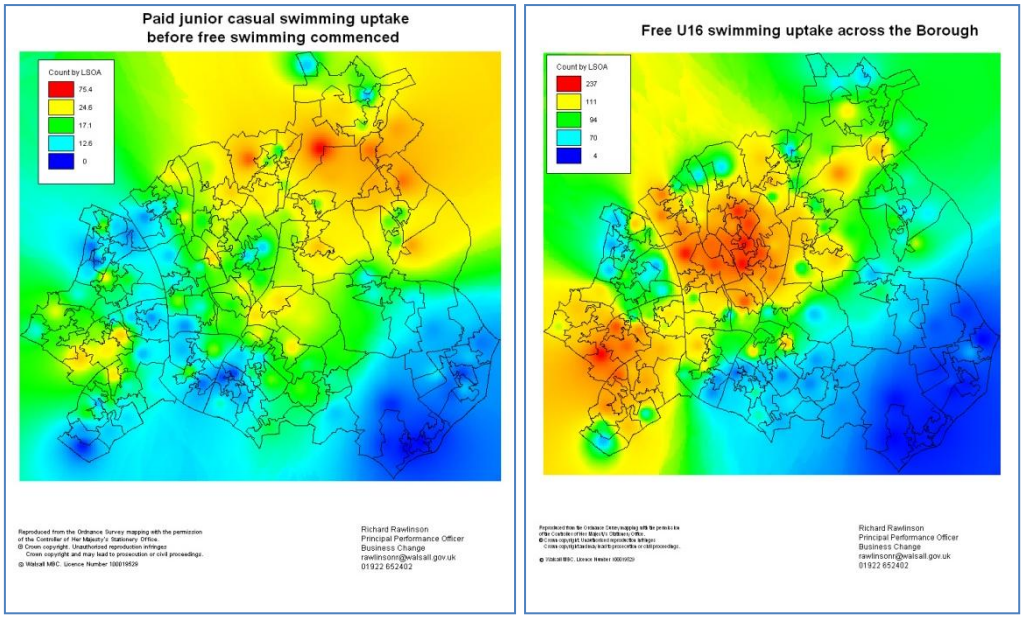


Figure 48 Uptake of swimming by under 16's (mapped by postcode of residence) before and after free swimming scheme introduced in Walsall (Source: Walsall MBC)

Research by Sport England, Barnados and the Joseph Rowntree Foundation indicates that people with disabilities require additional support to access sport and leisure provision and as a result are often excluded from such provision. This is highlighted in the large percentage (80%) of adults with learning disabilities not meeting the Department of Health's minimum recommended level of physical activity – this is considerably higher than the general population (53%-64%).

Considerable progress has been made in the last 12 months as part of the Council's Active Living Review – with Sport & Leisure and Public Health colleagues conducting more than 100 face-to-face interviews and piloting a range of interventions to encourage sedentary people to become more active. The review has seen the adoption of the principle of *Proportionate Universalism* based on a core universal service from Leisure Centres along with additional support to nine defined target groups as indicated below:

Figure 49 Proportionate Universalism Petal Diagram

Following the success of free swimming and the Active Living Review the Council's leisure discount scheme was simplified and enhanced to encourage greater use from these target groups. This has proven a tremendous success with more than 3,000 people registering in the first 6 month, a quadrupling of the previous scheme's enrolment. Enrolees have come from all categories – including a credible number self-declaring as being overweight!

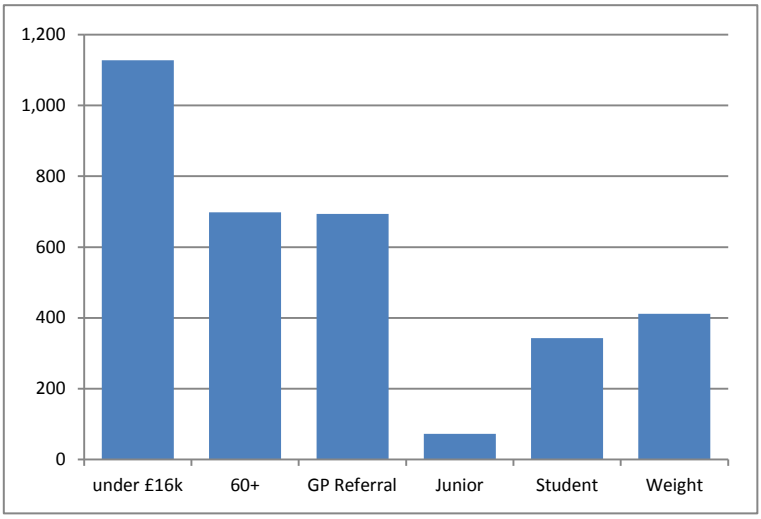


Figure 50 Uptake of Walsall's Leisure Discount Scheme within first 6 months (Source: Walsall MBC)

More impressive was the attendance levels of these new users. On average these users were visiting the leisure centres just over **once a week**. This is far in excess of Walsall's leisure centres' other registered users (who access on average 20 times a year) and is particularly impressive given these users are from traditional "hard to reach" groups with the vast majority new to exercise.

Priorities for action:

- *Where possible Upgrade or replace facilities so that there is good provision of attractive leisure facilities in the borough – with a particular focus on swimming and fitness provision*
- *Promote strong and consistent messages about the benefits of physical activity and healthy lifestyles and provide clear information about local provision e.g. through development of a single access telephone number and website*
- *Work with key organisations e.g. WHG to develop and promote joint leisure schemes*
- *Identify a consistent set of target groups and priority geographical areas*
- *Share data regarding targeted groups and populations across all partner agencies.*
- *Continue to develop and promote the Move-it scheme and consider expanding to other services.*

5.2.2 Green Spaces

Research has shown that green spaces can reduce the impact of deprivation and improve the health and wellbeing of residents[24]. Living close to green spaces is associated with reduced mortality and contributes to narrowing the gap in life expectancy[25]; access to the natural environment helps people recover from illness and reduce stress[26].

A recent study by the Commission for Architecture and the Built Environment (CABE, 2010) found that:

- *Where people perceive green spaces to be good, they are more likely to be satisfied in general with their neighbourhood and more likely to report better health*
- *When people feel safe in their local green space they are more physically active*
- *Almost half of respondents stated that better facilities would make them use their local green space more*
- *Less than 1% of those in social housing used the green spaces on their own estate due to fears about personal safety or lack of facilities*
- *Local parks accounted for 90% of the green spaces used*

About a third of the borough is green, open space. This is made up of premier parks such as the Arboretum, King George V and George Rose and Willenhall Memorial parks, countryside such as Merrions Wood and Barr Beacon as well as play areas and managed tree plantation. Recreational facilities within these can include waterways for fishing, bandstands for concerts, lido/water features for young children's play, as well as venues for healthy walks.

Walsall has developed a Green Space Strategy for the 5 year period 2012-17. This Green Space Strategy is the second such strategy for Walsall which sets out a five year plan for the future management, maintenance and development of all green space across the Borough. The first Green Space Strategy produced in 2006 was effective in providing a framework for securing investment in Walsall's Green Spaces, raising green space quality and putting in place a series of service and process improvements. As part of the development of this new strategy the Green Spaces Working Group found that over 90% of the recommendations had been delivered.

Over the last five years there has been significant change in the economic and political climate at a national and more local level. Resources for public services are being reduced and this will have an impact across all Council service areas including Green Spaces. This

[24]CABE: Community green: using local spaces to tackle inequality and improve health; CABE (2010)

[25]Mitchell, R and Popham,F; Effect of exposure to natural environment on health inequalities: an observational population study; The Lancet: 372,2008

[26]Natural England, Health and the Natural Environment: http://www.naturalengland.org.uk/ourwork/enjoying/health/default.aspx

Green Space Strategy has been developed against this backdrop and sets out the contribution that green spaces make to the Sustainable Community Strategy and the Corporate Plan. Walsall Council will be responsible for leading on the delivery of this strategy but it will need to be a partnership approach to deliver the vision and aims within this document. This will include building on existing partnerships with agencies such as West Midlands Police, Walsall CCG, with friends groups and community based organisations. It will also require the development of new partnerships with other agencies, the third sector and Walsall's diverse communities.

The Green Space Strategy was developed based on extensive consultation with Walsall residents through a household survey and with children and young people through an online survey. The Council has also consulted with parks and green space Friends Groups and other community based organisations involved in green space management and improvement.

Through a series of workshops the Council has also involved a range of agencies, organisations and stakeholders to develop and set priorities for Walsall's Green Space.
The Green Spaces Working Group, part of the Community Services Scrutiny and Performance Panel has also made a significant contribution to the development of the strategy through their work which resulted in the vision for the strategy:

"We want Walsall's green spaces to be public assets that everyone has pride in and that help secure the sustainable future of the borough for the benefit of the health and wellbeing of the whole community".

Indicator

- *The number of Green Flags in the borough's Premier Parks*

Priorities for action:

In order to achieve the strategy the analysis and recommendations are set out under a series of 7 aims which were discussed and prioritised through a series of workshops. The aim for the Walsall Green Space Strategy are to achieve:

- *Green Spaces that Make the Borough an Attractive Place to Live, Work and Socialise;*
- *Safer and More Secure Green Spaces;*
- *Green Spaces Contributing to Greater Health & Wellbeing;*
- *Well Maintained and Accessible Green Spaces;*
- *Conserving and Enhancing Biodiversity and Geo-diversity;*
- *More engaged communities & neighbourhoods;*
- *Stronger Partnerships and Innovation.*

The Walsall Green Space Strategy[27] sets out how these aims will be delivered in a detailed action plan covering the five years from 2012 to 2017.

[27] http://inside.walsall.gov.uk/staging/green_space_strategy_finalv6_opt.pdf

5.2.3 Play

As children grow they pass through various stages of development. Play is a fundamental part of childhood. It enables children to develop social skills, form friendships, develop physical skills and learn about and become confident in their environment. There are a number of play areas, multi use play areas (for 5-a-side and basketball) and skate park facilities throughout Walsall. The latter are often used for skate boards and BMX bikes as well as in-line and roller skates.

A draft Walsall Play Strategy has been written, which will require further consultation before it's presented to Cabinet for approval in 2014. The Play Strategy provides a framework for establishing access to play, provision of play and quality of play. It creates a mechanism for improving play delivery and community participation. Most importantly, it identifies priorities in light of equalities and resourcing issues and sets the vision for the next 5 year life time of the strategy.

Indicator

- *The number of play areas, multi use games areas and skate park facilities*

Priorities for action:

- *There is a need to increase the amount and quality of play and youth provision in the borough, particularly for children with disabilities, whose opportunities for play are currently more restricted (Barnardos, 2004)*
- *Where possible retain, improve or replace leisure facilities including sports pitches*

5.2.4 Allotments and Community Gardens

Community gardening can be a means of combating social isolation and promoting social cohesion by encouraging the development of social networks. It also brings positive health benefits including improved access to fresh and healthy food, increased physical activity and improved mental health. Factors which promote the use of community gardens include safety, proximity to users' homes and secured tenure.

The Council has a large number of allotments in a variety of locations across Walsall. Management of these is split between the Council and several Local Management Associations, and facilities within sites may vary.
Of two sites which were derelict and declared surplus, one has recently been brought back into use as a community garden. There is also 1 private allotment in Willenhall.

The distribution of these spaces varies significantly with 13 allotment sites in St Matthew's/Paddock/Palfrey/Pleck partnership area and just 2 in Aldridge/Streetly /Pheasey/Walsall Wood.

The Community Gardens Officer is working with groups to develop two community gardens in Darlaston; George Rose in Herberts Park Road, and Victoria Road, and is also part of a steering group to develop a Community Garden project with partners in Bentley. Other projects in Walsall borough include Goscote Green Acres and Caldmore Community Garden.

5.2.5 Walsall Allotments Strategy

A new Community Garden and Allotment Strategy is due to commence production in 2014/15 which will include a focus on the future management of Walsall's allotments and new opportunities to create allotments and or community gardens in areas of present deficiency and high waiting lists.

Priorities for action:

- *Develop self-sustaining allotments and community gardens which develop community capacity and volunteering.*
- *Heighten the profile and increase the quality and quantity of food growing spaces and opportunities which may take the form of shared community gardens. This will help increase the number of people, and extend the age range of communities involved in growing, and also increase educational and volunteering opportunities which will have benefits to health and well being.*
- *Promote allotments and gardens to local schools to encourage connections with food growing, which becomes part of Key Stage 4 curriculum in 2014. Community growing spaces can also help support other school health programmes such as school catering, encouraging a healthy diet and reducing childhood obesity through the Food Dudes behavioural change programme.*
- *Other links are being explored within community growing spaces to promote the food bank programme.*

The map below was created to show the location of food banks, allotments and community gardens (correct as of July 2013)

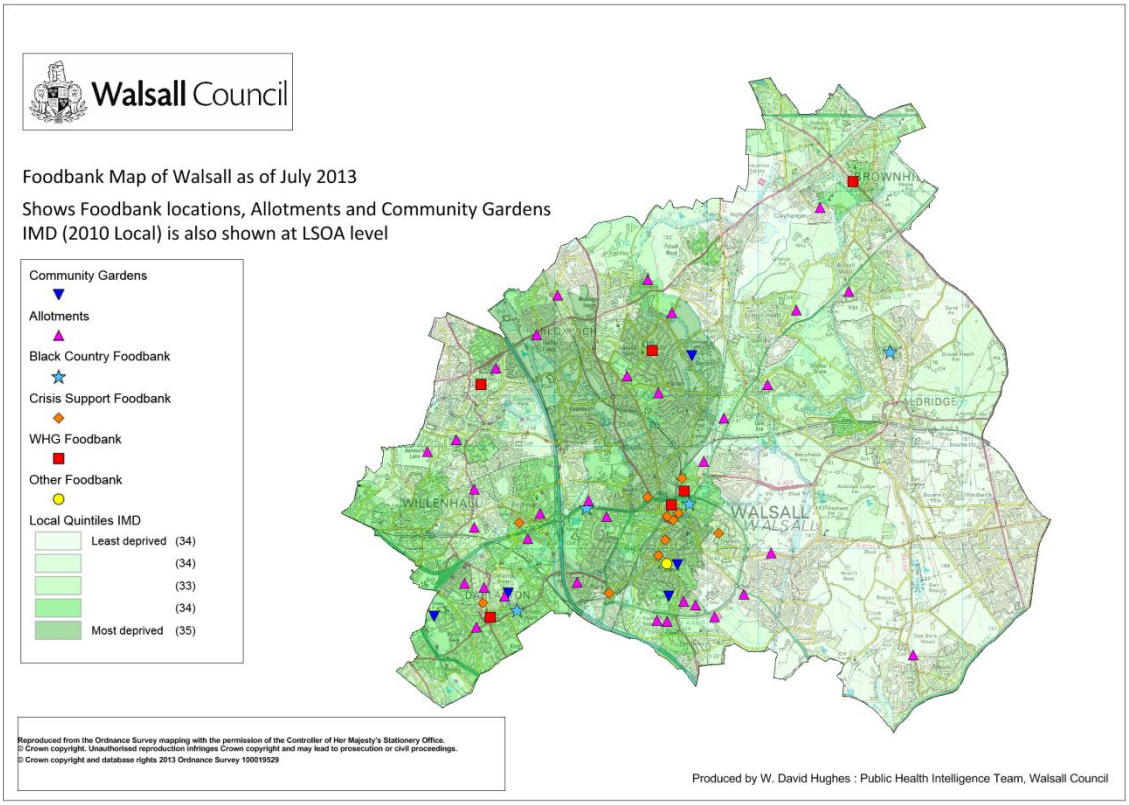


Figure 51 Foodbanks, Allotment & Community Gardens Map (Source: Walsall MBC)

5.2.6 Playing fields

Sports pitches offer an ideal opportunity for both formal and informal sport, leisure and recreation. In Walsall, there is a range of organised sports clubs which promote a number of different sports and other activities which may include recreational and dog walking and might even include the flying of model aircraft.

There is often a pressure to release sports pitches for development. The role of these facilities in maintaining and improving health should always be considered when such development is being proposed. The default position should be to retain and improve leisure facilities including sports pitches, however in the context of economic pressures for development and the paucity of capital funding, a pragmatic approach may be needed. Only where viable alternatives are available nearby should capital receipts be used and earmarked towards appropriate leisure and recreation developments where a net benefit can be evidenced. This approach is supported by Sport England through their statutory role.

Indicators:

- *Through Sport England statutory consultation, protect sports pitches from development wherever possible.*
- *The number of Green Flags in the borough's Premier Parks*
- *The number of play areas, multi use games areas and skate park facilities*

Priorities for action:

- *Where possible retain, improve or replace leisure facilities including sports pitches*
- *Increase the number of Green Flags in the borough's Premier Parks*
- *Increase the number of play areas, multi use games areas and skate park facilities for pre-school, school and youth age children*

5.2.7 Libraries, Heritage and Arts

Libraries Heritage and Arts services have a role in creating and sustaining healthy communities. Walsall's network of 16 libraries offer a centre for people to acquire information, access learning opportunities - both formally and informally, support and develop an interest or past-time or just plain have fun. Libraries cater for all ages and do, literally, offer something for everyone cradle to grave; from Cradle Clubs and Mother and Toddler Clubs for the very young; to reading groups, author visits and 50+ clubs for adults, with homework clubs, job clubs and other activities along the way.

Museums and archives offer a way into Walsall's past; how people and families lived and worked, how industry in Walsall developed from earliest times and how the past can influence the development of the future. It offer people of all ages the opportunity to experience and explore the past and helps to create a sense of place and belonging and an understanding of the communities of which they are part.

The opportunity to explore and participate in Art, in all its differing forms, can enrich people's lives and stimulate their creativity. Walsall is fortunate to have The New Art Gallery which is a National Portfolio Organisation. It is not only the home of the Garman Ryan Collection, but also offers a programme of temporary exhibitions which are of a national standard and are unique in the West Midlands. In addition, Forest Arts Centre has opportunities for people of any age to get involved with music, dance and theatre, either as part of the audience or as a participant, in a group or as an individual.

The Creative Development Team has a reputation at local, regional and national level for delivering high-quality, innovative, programmes which have a positive impact on people and communities with positive outcomes. The Team effectively engages with individuals and groups of people who are often seen as 'hard-to-reach' to fulfil a wide range of partnership aims such as health improvement, more effective service delivery and environmental regeneration.

5.3 Planning Policy

The Planning Policy Team is responsible for preparing, explaining and monitoring the statutory planning policies, contained in a series of documents that together comprise Walsall's '*development plan*'. This sets out a vision for the Borough and policies to promote, accommodate and guide new development whilst protecting and enhancing the environment. The council is required by law to take account of the policies in the

development plan when making decisions on planning applications. A key part of planning is putting new development in the right location so that it is accessible and sustainable.

The development plan for Walsall currently comprises:

- Black Country Core Strategy (BCCS) 2011
- Walsall Unitary Development Plan (UDP) 2005 – 'saved' policies
- UDP Proposals Map and Town and District Centre Inset Maps

Walsall Council is presently producing two key documents: Walsall Site Allocation Document (SAD) and Walsall Town Centre Area Action Plan (AAP). They build on the successful adoption of the Black Country Core Strategy (BCCS) by setting out the specific locations for development in Walsall and will shape the future of the Borough. They will encourage major investment in the Borough to provide growth for Walsall's housing supply, local employment opportunities and town and district centre businesses.

Walsall Site Allocation Document (SAD) - This document once adopted will identify the sites where housing, employment and other land uses such as community and leisure facilities or public open spaces should be provided throughout the whole of the Borough. It will also ensure growth happens in a sustainable manner and balances the need to protect and enhance the environment. The Site Allocation Document will be fundamental in determining what development happens, where and when, ensuring that we meet all future needs in Walsall.

Walsall Town Centre Area Action Plan (AAP) - This document will focus on Walsall Town Centre. As the economic and social hub of the Borough it's vitally important that the future economic success of Walsall is driven forward by a vibrant and prosperous centre. The AAP will allocate sites for new shops, leisure facilities, and offices, as well as setting out strategies for improvements to other aspects including transport, design and the environment

These documents are in line with the National Planning Policy Framework (NPPF), published in March 2012, which is the overarching guidance for local authority planners in making plans and assessing development proposals. This requires planners to promote healthy communities, use evidence to assess health and wellbeing needs, and work with public health leads and organisations. The NPPF includes a presumption in favour of sustainable development; the three aspects of this – environmental, social and economic development – all have significant health components and implications. There is a growing body of material available on the vital role played by planning for health, including guidance produced by the Town and Country Planning Association.

5.4 Stronger communities

Safe and strong communities have a positive influence on residents' health and wellbeing. The more deprived the neighbourhood, the more likely it is to have social and environmental characteristics that present risks to health, including poor housing, higher rates of crime and poorer air quality. Some of the adverse effects caused can be mitigated when communities are empowered to identify their own priorities for action and influence the work of partner agencies in their localities.

The 'Your place, your wellbeing: Walsall Household and Lifestyle Survey[28]' 2012 has provided an up to date perspective about residents' views and priorities. Overall this survey tells us that residents feel that low level of crime is the most important issue that makes somewhere a good place to live. Whilst the issue remains a priority for improvement it is less in need of attention now than previously, reflecting a rise in concern around job prospects, wages and cost of living and also a healthy sense that the issue is being managed relatively well (based upon Feeling the Difference Survey, see Figure 52).

Indicator	Wave 33	Wave 32	% difference
Feelings of safety during the day (% feeling safe)	97%	95%	+2%
Feelings of safety after dark (% feeling safe)	83%	75%	+8%
The Police in this area make fair decisions when dealing with local problems (% satisfied)	68%	59%	+9%
How good a job do you think the police in this neighbourhood are doing? (% good)	74%	70%	+4%
Can be relied on to be there when you need them (% agree)	81%	74%	+7%
Treat everyone fairly regardless of who they are (% agree)	86%	81%	+5%
Can be relied on to deal with minor crimes (% agree)	69%	67%	+2%
Work with people in the community to improve neighbourhoods (% agree)	64%	61%	+3%
Taking everything into account, I have confidence in the police in this area (% agree)	83%	78%	+5%
How good or poor are the relations between people in your neighbourhood and the police? (% good)	68%	61%	+7%
West Midlands Police Force provide good value for money (% agree)	72%	71%	+1%
Works hard to engage with local residents (% agree)	63%	59%	+4%

Figure 52 West Midland Police Feeling the Difference Survey. Source: West Midlands Police Force 'Feeling the Difference' survey wave 33 (December 2012 – February 2013) and 32 (May to July 2012)

Within the survey, West Midlands Police Force asked residents whether they have ever felt fearful of becoming a victim of crime at any stage over the last 12 months. Where 18% of

[28] http://www.yourplace-yourwellbeing.walsall.org.uk/

residents across the Force as a whole are fearful of crime, this rises slightly to 19% across the Walsall Local Policing Unit (LPU). The proportion saying they feel fearful, however, has dropped from 21% in Wave 32. The figures by Constituency show that those in Walsall South are most likely to fear becoming a victim of crime (25%)[29].

Walsall's Area Partnerships bring together local people, Council services and the community and voluntary sector to make Walsall a place where residents can live, work and play. There are six Area Partnerships in the borough; each has a dedicated Area Manager to facilitate local partnership working and an Area Community Plan to tackle the key issues and priorities in the locality.

West Midlands Police have identified two priority areas within Walsall LPU; Walsall Town Centre and Birchills. Bloxwich has also been identified as a local priority area (See Figure 53 below). These areas were identified utilising a range of data that when taken together, highlighted specific locations that had a greater number of community safety concerns and would benefit from a more targeted partner response.

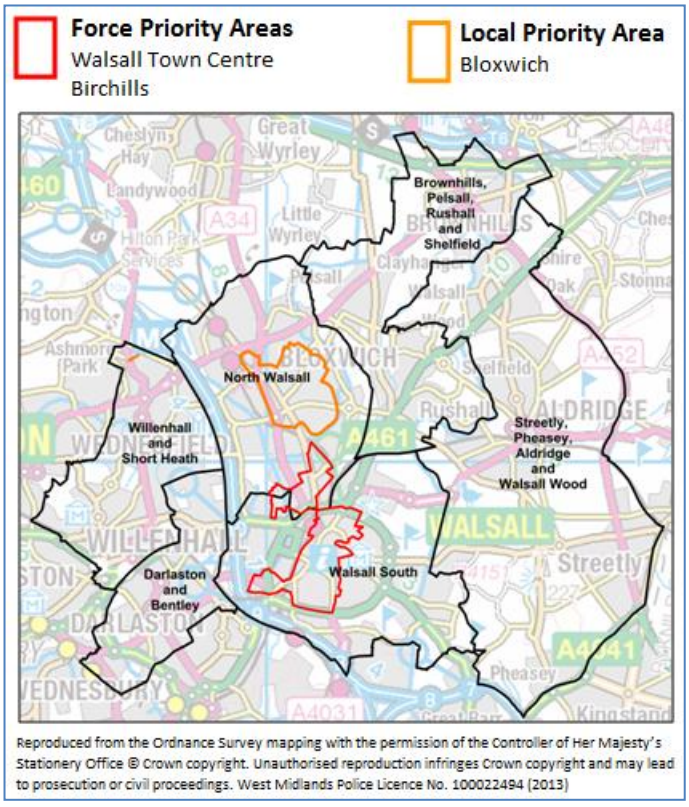


Figure 53 West Midlands Police Priority Areas

[29] Feeling the Difference – Walsall LPU Wave 33 results (December 2012 – February 2013)

5.5 Community Safety Plan

The Safer Walsall Partnership Board is responsible for the delivery of the Community Safety Plan and is the thematic lead for the creating safe, sustainable and inclusive communities' priority. The Community Safety Plan is the overarching community safety document for the borough and identifies the key strategic community safety priorities. It indicates how the agencies that make up the Safer Walsall Partnership will focus their combined activities across the borough to improve community safety and increase community reassurance by reducing crime, anti-social behaviour, drug and alcohol misuse and environmental crime. It will therefore contribute directly to improvements in health and wellbeing across Walsall.

Agencies that make up the Safer Walsall Partnership (SWP) are collectively responsible for co-ordinating activity to make Walsall a safer place and include the following:

Walsall Council, West Midlands Police, the Office of the West Midlands Police and Crime Commissioner, Clinical Commissioning Group (CCG), Staffordshire and West Midlands Probation Trust, West Midlands Fire Service and representatives from the Walsall Housing Partnership, the Chamber of Commerce, Walsall Voluntary Action and other key partner agencies.

During 2012-13 Total Recorded Crime fell by 15.4%, which is real terms means 2807 fewer victims (see Figure 54 below). Anti Social Behaviour (ASB) fell by over 27% with 2461 fewer victims. The reductions are in addition to previous substantial year on year reductions that have seen Total Recorded Crime fall by just over 13,500 offences (47%) since 2002-03 and Anti-Social Behaviour by around 10,800 offences (62%) since 2008-09. [30]

[30] Walsall Community Safety Plan 2011-2014

WALSALL				
Crime / Incident Type	2011/12	2012/13	Change	% Change
Total Recorded Crime	18232	15425	-2807	-15.4
Serious Acquisitive Crime	3733	3433	-300	-8.0
Anti Social Behaviour (Police Reported)	9082	6621	-2461	-27.1
Youth Related ASB (Police Reported)	3714	2345	-1369	-36.9
Domestic Burglary	1441	1261	-180	-12.5
Burglary Other Building	1522	1275	-247	-16.2
Criminal Damage	3348	2553	-795	-23.7
Vehicle Crime	1923	1892	-31	-1.6
Violence Against the Person	3396	2861	-535	-15.8
Robbery	388	311	-77	-19.8
Deliberate Primary Fires (WMFS Data)	405	287	-118	-29.1
Deliberate Secondary Fires (WMFS data)	1472	623	-849	-57.7
Drug Offences	628	566	-62	-9.9
Domestic Violence	1177	1071	-106	-9.0
Hate Crime	413	189	-224	-54.2

Figure 54 Walsall Crime, by Incident Type

Community Safety Plan Priorities 2011 – 2014

Following a borough-wide strategic assessment that utilised data from a range of partner agencies and extensive stakeholder and resident consultation, the partnership identified the following strategic priorities for 2011-2014 which were reflected in the borough Community Safety Plan.

Priority 1: Tackle violent crime, with specific focus on domestic abuse, town centre violence and serious youth violence.

For the performance year 2013/14 West Midlands police force has introduced a new milestone to measure 'Violence with Injury' (VWI). VWI accounts for approximately 10% of Total Recorded Crime (TRC) and 50% of violence overall.[31]

1,489 VWI offences were reported during the last financial year (2012/13). 50% of all offences have been identified as being 'Public Place Violence' (the second highest proportion of Public Place Violence offences were reported as being within a public house / nightclub); 10% have been identified as being 'Under the Influence Violence' and a further 6% of offences have been identified as being 'Licensed Premises Violence.' Weapons were identified as being used in 10% of all VWI offences, a third of which were identified as being knife related. Peak days for offending are Fridays, Saturdays and Sundays. The peak times are 15:00 – 0300 hrs. These days and time correspond with Night Time Economy trends.[4]

[31] Violence with Injury Problem Profile – West Midlands Police May 2013

Year to date (1st April – 31st August 2013); the Police have recorded 93 Town Centre VWI offences, a 7.9% reduction against the same period in 2012. Activities to reduce town centre violence and in particular night time economy related issues during recent times have included the continuation of Operation Be Safe at weekends and ongoing patrols by Street Pastors. This has led to increased support for vulnerable people and victims who have suffered minor injuries.

Serious Youth Violence

Year to date (1st April – 31st August 2013); the Police have recorded 67 VWI offences whereby the defendant is aged between 10 and 18 , a 27.2% reduction compared with the same period in 2012. There were 153 VWI offences whereby the injured party is aged between 0 and 18 years, a 0.7% increase compared to with the same time last year.

Domestic Abuse

Police reported Domestic Abuse (DA) violent offences have reduced by 7.8% and police recorded domestic incidents have reduced by 2.7% (1st December 2011 to 30th November 2012) compared to the previous year. Domestic Abuse Response Team (DART) referrals have decreased by 34% when comparing 2010/2011 to 2011/2012. However, recent exploration of data from across the wide range of referral services dealing with domestic abuse suggests that across some other agencies DA is increasing so that the overall picture of the scale and trajectory, including nature of domestic abuse, across Walsall is unclear. It is possible that victims are turning to other support services rather than reporting directly to the police.[32]

In 2012, there was further development of the governance and commissioning models for Domestic Abuse practice in Walsall. The lines of governance and communication have been strengthened between the Safer Walsall Borough Partnership Board, the Walsall Safeguarding Children Board and the Walsall Safeguarding Adults Board. Future work will see the continued shared development of a single Domestic Abuse pathway for Children and Adults partnership working and needs assessment and a shared database to facilitate a greater understanding of the overall scale and nature of Domestic Abuse.[32]

The vast majority of police reported offences of domestic abuse involved violence (85%), followed by Criminal Damage (13%). 47% of violent offences being recorded were Assault Occasion ABH, followed by Common Assault (19%). Data provided by Walsall Domestic Violence Forum between 1st April to 30th November 2012, suggests that the vast majority of victims were female (86.8%). 28.7% of victims were aged 18 to 24 years, with a further 27% aged between 30 to 39 years and 18.8% aged between 25 to 29 years. In terms of ethnicity, the vast majority were White European (78.5%), followed by Asian - Indian (5.9%) and Black - Caribbean (2.7%). Further analysis highlights that victims of domestic abuse have stated that on most occasions boyfriends (27%) have been the alleged offenders involved followed by ex partners (24%) and husbands (15%).[32]

[32] Safer Walsall Partnership Strategic Assessment – February 2013

In March 2009, the Manor hospital implemented a database within their A&E department in order to anonymously record the details of each victim of assault was dealt with. Utilising A&E data between March 2009 and December 2012, 464 victims of assault attending Walsall hospital A&E said the incident took place in the home; committed by an acquaintance (26%), relative (26%) or partner / ex partner (48%). Of this figure, 154 incidents were recorded in 2010, 140 in 2011 and 77 in 2012 representing a decrease in A&E attendances and possibly signalling a decrease in the number of Domestic Abuse incidents within the borough over the last three years. 75% of all incidents had been reported to the police prior to going to A&E and of the 117 incidents that hadn't been reported, 19% intended to do so later.[33]

Year to date (1st April – 31st August 2013) the Police have recorded 550 Domestic Violence crimes. This is a 15.8% increase compared to the same period last year. There has however been a 10.7% decrease in recorded Domestic incidents for the same period.

There have been 383 female victims of VWI year to date (1st April – 31st August 2013). This is a 17.8% increase compared to the same period last year. The highest intensity of which occurred within Walsall Town Centre.

Priority 2: Tackle anti-social behaviour

Tackling ASB remains a priority for the communities of Walsall and consistently comes out as an area of concern. There is a clear link between the satisfaction with public services and the level of perceived ASB in an area. Whilst positively analysis of police recorded ASB during 2012-13 illustrates a further reduction of 27% compared to the previous year, it is apparent that less than half of reports are made to the police. ASB covers a wide range of behaviours and can be reported to a number of agencies. [34]

The partnership continues to work collectively to tackle this issue and activities include monthly multi agency tasking documents highlighting reoccurring issues that require a partnership response, a monthly Vulnerability and Problem Solving Forum that supports the most vulnerable victims and looks at complex issues and a partnership wide review of how agencies can work more effectively together to tackle ASB which will include work on common definitions and categories.

Year to date (1st April – 31st August 2013); there have been 2,711 ASB incidents reported to the Police. This is a 16.6% reduction compared to the same period in 2012. The highest intensity of ASB is within Walsall Town Centre.

Priority 3: Address harm caused by drug and alcohol misuse

Many of the 6 priorities are related to drug and alcohol abuse. Drug and alcohol treatment service are becoming increasingly recovery focussed with success being measured in terms of positive outcomes rather than just numbers in treatment.

[33] Domestic Violence Report (Utilising A&E data) – February 2013

[34] Walsall Community Safety Plan 2011-2014

The Drug Intervention Programme (DIP) is central to government plans to tackle drug related crime. The idea is to offer offenders who commit crime to fund their drug habits the support they need to kick the habit. The testing in police custody process ensures drug users are continued to be assessed and directed into drug treatment which is proven to reduce crime, whilst reducing time drug testing those likely to test negative.[35] Between 1st December 2011 and 30th November 2012, 1,252 tests were completed in relation to individual offenders who entered the Walsall custody block. The majority (64%) of these tests proved to be negative. However these figures suggest that there is still a significant amount of offenders who are committing crime in Walsall to fund their drug habit. The most common trigger offence for individuals testing positive was theft, with a total of 58% of all records, followed by Burglary (17%). Additionally data from Walsall Probation illustrates that just over a quarter (26%) of offenders who started on an order during last year have stated that one of the reasons for their offending behaviour has been due to use of drugs. [36]

Between 1st April 2012 and 31st March 2013 there were 1503 alcohol related arrests. The top five offences were Drunk and Disorderly in a public place, Assault a person thereby occasioning them actual bodily harm, Drive motor vehicle with alcohol above limit, Criminal damage to property valued over £5000 and Assault by beating. Data from probation suggests that 35% of offenders who started on an order during last year stated that one of the reasons for their offending behaviour has been due to misuse of alcohol.[37]

Priority 4: Community, with specific focus on counter terrorism, community cohesion and public perceptions.

Walsall continues to experience low levels of extremist activity when compared with other areas of the country. Where issues do arise they are dealt with through a strong partnership approach that coordinates both proactive and reactive action.

Priority 5: Tackle serious acquisitive crime, with specific focus on reducing domestic burglary.

Overall Serious Acquisitive Crime (SAC), the definition includes Vehicle Crime, Domestic Burglary and Robbery offences has seen a reduction of 14% during the last 12 months compared to the previous 12 months.[10] Various partner activities, in addition to robust and targeted policing have contributed to this reduction.

Year to date (1st April – 31st August 2013), there have been 1,294 SAC offences, an 8% reduction compared to the same period in 2012. Over the same time period, Burglary Dwelling has had 431 recorded crimes, an 8.7% reduction compared to the same period in 2012.

Priority 6: Reduce re-offending, a cross cutting theme across all other priorities.

Through the Walsall Integrated Offender Management Programme, partners work together to reduce crime and reoffending by addressing the key issues facing perpetrators and their

[35] PowerPoint Presentation - http://intranet2/hq_departments/central_justice_services/drug_interventions_programme/targeted_testing.aspx

[36] Safer Walsall Partnership Strategic Assessment – February 2013

[37] Safer Walsall Partnership Strategic Assessment – February 2013

families. This is achieved by supporting the greater coordination of agencies and the programmes they deliver to manage offenders and ensure that individuals do not fall through the gaps. This work takes a holistic approach seeking to address the issues that contribute to offending behaviour and also to target and convict those whose behaviour does not change. Linking priority offenders between the police, probation, housing and drug and alcohol services have delivered some notable successes.

5.6 Chapter summary and key priorities for action

Priorities for action:

- *Improving the condition, quality, energy efficiency and choice of housing, particularly private sector stock, and working to reduce fuel poverty*
- *Encouraging the use of public transport and promoting walking and cycling as routine ways of travelling that will help improve residents' health and wellbeing*
- *Making cycling an easy, safe and regular method of transport throughout the borough by improvements in infrastructure and introduction of 20 mph speed limits in residential areas and delivery of Bikeability programmes in all schools*
- *Where possible upgrade or replace facilities so that there is good provision of attractive leisure facilities in the borough*
- *Promoting strong and consistent messages about the benefits of physical activity and healthy lifestyles and providing clear information about local provision e.g. through development of a single access telephone number and website*
- *Working with key organisations e.g. WHG to develop and promote joint leisure schemes*
- *Identifying a consistent set of target groups and priority geographical areas across all partner agencies*
- *Improving provision of green spaces, play and leisure facilities and promoting to residents the benefits on health and wellbeing of using these*
- *Use planning as a mechanism for improving residents' access to green spaces, health facilities, leisure opportunities and healthy food (using the 'Access to healthy food standard' – which defines the percentage of households within 20 minutes by walking, cycling or using public transport of a place where fruit and vegetables are sold)*
- *Taking into account the key role of play areas, open space and opportunities for active travel when considering planning applications for new housing developments*
- *Carrying out Health Impact Assessment on planning policies and applications*
- *Increasing the opportunity for residents to become involved in growing food sustainably*
- *Promoting the National Food Hygiene Rating Scheme to ensure that recognition is given to food businesses that comply with legal requirements*
- *Identifying health risks within existing and emerging business sectors, for example the beauty/skin piercing/laser treatment industry and ensuring appropriate interventions take place for the protection of staff and customers.*

Chapter 6 Improving health and wellbeing through healthy lifestyles: Making healthier choices easier

The economic burden of unhealthy lifestyles in Walsall is substantial. The health service is experiencing the spiralling costs of treating ill health, Social Care is struggling to meet the increasing costs of providing services for residents who have lost their ability to live independently and employers are bearing the costs of high sickness absence rates and low productivity. Most importantly the people of Walsall are experiencing poorer health and quality of life than those who live in most other areas of the country, and many have their lives cut short by entirely preventable illnesses.

Lifestyle factors such as diet, physical activity, alcohol, smoking and drug use are key determinants of health and wellbeing and are linked individually or in combination to a wide range of health and social consequences. These factors follow a social gradient; those who live in the most deprived areas of the borough are most likely to adopt the most risky lifestyle behaviours. To bring about real improvements in health and wellbeing and reduce health inequalities will require changes in both individual behaviours and in the physical and social environment of Walsall.

The Walsall Lifestyle Survey 2012 helps estimate the proportion of adults whose health could be improved through lifestyle changes. For example, the vast majority of residents do some form of physical activity but only a minority do it frequently enough to achieve health benefits. Half of residents eat fresh fruit and vegetables on a daily basis, but just one in eight has the recommended 5 portions a day.

Smoking reduces life expectancy by an average of 10 years and obesity by an average of 9 years; in Walsall there are tens of thousands of residents whose health and quality of life could be transformed by stopping smoking or losing weight.

Walsall also has high rates of harm, both to health and as a result of crime, related to alcohol consumption and drug misuse. The levels of misuse mirror the areas of the borough with the highest levels of social and economic deprivation.

This chapter discusses lifestyles and prevention in Walsall, focussing on strengthening individuals and developing environments that promote wellbeing and support positive, sustained behaviour change.

6.1 Obesity

Obesity is one of the greatest public health challenges facing Walsall today. The Foresight Report[38] predicts that by 2015, 36% of men and 28% of women aged 21-60 living in England will be very overweight (clinically obese); it is likely that rates in Walsall will be even higher. Obesity is a very significant contributor to illness and premature death in the borough. Serious health consequences include Type II diabetes, cardiovascular disease, liver disease, musculoskeletal disorders such as osteoarthritis, and certain cancers. Without action, overweight and obesity-related diseases will cost NHS Walsall an estimated £82 million per year by 2015. It is estimated that obesity-related illness will result in the loss of 43,000 working days, £9m-£14.5m in lost earnings and a £40m loss to the wider economy in Walsall[39].

Indicators:

In 2011, around 1 in 4 adults in England were classed as obese (25% men and 26% women (Health Survey for England)). By 2050 obesity is predicted to affect 60% of adult men, 50% of adult women and 25% of children (Foresight 2007).

It is estimated that in Walsall around 55,000 adults (26%) are obese and around 130,000 (62%) are overweight or obese (Health Survey for England 2008 prevalence estimates applied to locally registered population).

It is proposed that the local indicator for adult obesity would be the number of referrals to healthy weight services and community physical activity interventions from front life staff across the borough through the Making Every Contact Counts initiative.

Priorities for action:

- *Utilise the 'Your place, your wellbeing: Walsall household and lifestyle survey 2012' to establish robust baseline information to enable targeted and effective commissioning and delivery of weight management and physical activity interventions*
- *Improve identification, delivery of brief interventions and referrals from GPs and other frontline staff from a range of organisations and agencies through implementation of the 'Every Contact Counts' initiative*
- *Create and maintain an environment that promotes physical activity through planning mechanisms and policy development*
- *Implement robust pathways with key partners to identify and refer patients who will benefit most from specialist weight management services*
- *Work through planning mechanisms to limit the number of fast food outlets in Walsall, particularly in the vicinity of schools*

[38] Foresight Report (2007): Tackling Obesities: Future Choices.
http://www.idea.gov.uk/idk/core/page.do?pageId=8267926
[39] Modelled from figures reported in: Select Committee on Health, 3rd Report obesity.
http://www.publications.parliament.uk/pa/cm200304/cmselect/cmhealth/23/23.pdf

- *Develop a 'Healthy Retailers Award' for local businesses in Walsall*
- *Review the street trading policy and local conditions to determine if additional controls can be placed on the number and location of mobile catering units supplying 'fast food'*

6.2 Physical activity

The Chief Medical Officer's Report *At least five a week: Evidence on the impact of physical activity and its relationship to health*[40] evidences the preventative and therapeutic benefits of physical activity on a range of conditions including obesity, cardiovascular disease, diabetes, cancer, musculoskeletal disorders and mental wellbeing. It is estimated that the consequences of physical inactivity in the Walsall population cost the local economy £33m per year and NHS Walsall £4.3m.

Surveys show that more than 55% of Walsall residents take part in no recreational physical activity, compared to 47.4% nationally. The proportion of adults who take part in 3 x 30 minutes physical activity per week has increased from 16.1% in 2006 to 20% in 2012, but remains well below the national average of 22.5% and a best of approximately 32%. Similarly the proportion participating in 5 x 30 minutes of activity per week has increased from 8.4% to 9% against a national average of 11.3%.

Indicators:

The indicator used for physical activity in adults is:

"The percentage of adults achieving at least 150 minutes physical activity per week".

The latest figures available are for 2012 and show that Walsall had 50.5%, compared to an England average of 56%. This makes Walsall significantly worse than the England average.

Priorities for action:

The overriding principle of tackling physical inactivity in Walsall needs to be the *Proportionate Universalism* advocated in The Marmot Review:

- *Increasing and supporting attendances at leisure centres, community centres and other physical activity provision*
- *Increasing usage of the borough's green spaces, parks, green gyms, play and open spaces through Making Every Contact Count brief advice and the 'Let's Get Moving Pathway'*
- *Identifying a consistent set of target groups and priority geographical areas across all partner agencies*

[40] *At least five a week: Evidence on the impact of physical activity and its relationship to health*. Chief Medical Officer's Report, Department of Health, 2004.

- *Supporting key target groups to reduce the barriers to participation, identifying referral routes and access to specialist support and discount schemes*
- *Coordinated promotion and marketing of key programmes with the ability to deliver the increase in participation appropriately targeted to key market segments*
- *Ensuring planning approaches create a positive environment for physical activity, including building design, locality planning, accessibility and neighbourhood provision*
- *Implementing and delivering 'Making Every Contact Count' training to Walsall Healthcare NHS Trust staff, GP's and other partners, whilst incorporating the 'Let's Get Moving Pathway'*
- *Creating a borough wide network of safe cycle-ways and footpaths between major destination points i.e. town centres, schools, leisure centres, premier parks, community centres and play areas.*

6.3 Smoking cessation and tobacco control

Smoking is still the single greatest cause of illness and premature death in England, killing one in two smokers prematurely. For each cigarette smoked, a smoker's life span is shortened by about five minutes. Those who die as a result of a smoking related illness will have lost, on average, 10-15 years of life. According to Walsall's health profile for 2012, there were 242 smoking related deaths in Walsall per 100,000 population of 35 years and over (for the period 2008-10). This has reduced from 256 during the period 2007-09 but is still significantly higher than the England average of 211 deaths per 100,000 (2008-10). Smoking is the single biggest modifiable risk factor for cancer and heart disease and a major aetiological factor for Lung cancer (84% of all deaths), cardiovascular disease (17% of all heart disease deaths) and respiratory diseases, such as chronic obstructive pulmonary disease (COPD) (84% of deaths from COPD).

In March 2011 the Government launched its Healthy Lives, Healthy People: a Tobacco Control Plan for England. The plan outlines the key elements for work to address tobacco use from Government level down to local communities, which are stopping the promotion of tobacco, making tobacco less affordable, effective regulation of tobacco products, helping tobacco users to quit, reducing exposure to second hand smoke and effective communications for tobacco control. The plan also outlines 3 national ambitions:

- *To reduce adult (aged 18 or over) smoking prevalence in England to 18.5% or less by the end of 2015, meaning around 210,000 fewer smokers a year*
- *To reduce rates of regular smoking among 15 year olds in England to 12% or less by the end of 2015*
- *To reduce rates of smoking throughout pregnancy to 11% or less by the end of 2015 (measured at time of giving birth)*

These ambitions have now been translated into measures in the Public Health Outcomes Framework and will form the basis of our strategic plan which is currently in development.

Indicators:

The estimated prevalence for smoking within the Walsall population is 22.7%, representing approximately 45,000 adults.

Rates of young people's smoking are reported to be rising nationally but local figures are unclear at the moment. A young people's survey is being undertaken in autumn 2013 which will give baseline data for future monitoring. Stop Smoking Services are available to smokers from the age of 12 and we plan to do an analysis of quitters aged 15 and under to gather further insight into this group.

Rates of smoking during pregnancy are estimated from figures gathered at time of delivery. In line with the general population smoking prevalence has been high in Walsall but in the last 12 months huge improvements have been made within maternity services. The rate of women who were reported as smokers at the time of delivery at end of March 2013 has fallen to 15.1% although this is still high compared to the regional rate (14.2%) and the national rate (12.8%).[41]

Between 2010/11 and 2011/12, costs for hospital admissions for smoking related conditions were reduced from £4.8m to £4.6m (Walsall CCG analysis).

The numbers of people stopping smoking has remained constant following the high numbers produced by the introduction of the ban on smoking in public places in 2007. Encouraging smokers to quit is becoming more challenging as people believe that smoking is a stress reliever and the increased availability of cheap tobacco products.

An emerging trend is the use of electronic cigarettes (e-cigs). These are a method for nicotine delivery (generally described as Electronic Nicotine Delivery Systems (ENDS). They are currently regulated under consumer law only and though it is often implied, should not be marketed as a stop smoking aid as there is little evidence to support this. The Medicines and Healthcare Regulatory Authority have recently announced plans to regulate these products as a medicine but this will not come into force until 2015. In the meantime it will be important to keep everyone informed about these products.

Priorities for action:

Our overall aim is to have fewer people smoking. Research shows that at any one time 63% of smokers want to stop which would give us around 35,000 potential users of stop smoking services in Walsall against the 4000 people who used the services in 2010/11, therefore, there is a high level of unmet need.

Key priorities are:

- *To achieve the target of 2450, 4 week quitters by end March 2014*

[41] http://www.hscic.gov.uk/article/2021/Website-Search?productid=11816&q=satod&sort=Relevance&size=10&page=1&area=both#top (Accessed: 17 Oct 2013)

- *To maintain Stop Smoking Services provision through re-procurement of the contract during 2013 for delivery of services from April 2014*
- *To review and refresh the Tobacco Control Plan for Walsall to establish a multi agency coordinated approach to implementing ambitions in the National Strategy locally emphasising prevention*
- *To establish a baseline for number of under 15's who smoke and to review current activity to ensure that work with young people in all settings includes action on smoking, to address issues associated with this target group*
- *To address with all groups in the community the issues around use of Shisha, chewing tobacco and electronic cigarettes*
- *To continue to tackle the supply of counterfeit tobacco products in the shadow economy*
- *To continue to implement the Smoke Free legislation through statutory visits to local business.*

6.4 Substance Misuse

Walsall's Public Health Dept. commission a programme of essential drug and alcohol services for young people and adults. The treatment system is designed upon the National Standard Framework, Modes of Care (2006), with a four tier treatment intervention system based upon universal services, open-access services, structured treatment services and residential detoxification services. Clinical services are consultant led and compliant with the NICE Drug Misuse and Dependence; UK Guidance on Clinical Management (2007). The success of local drug treatment is monitored through a nationally developed tool, the Treatment Outcome Profile. Treatment Outcomes are measured across five domains to include: drug use, physical and psychological health, employment, education and offending history.

Users of the services are referred via various sources including; A&E, primary care, youth justice, education, family & friends, Children Services, Criminal Justice agencies and self-referrals.

Evidence indicates that investing in specialist interventions is a cost effective way of securing positive long-term outcomes by reducing future demands on health services, social care, mental health services, supporting the Troubled Families agenda[42] and impacting significantly upon the reduction of local crime rates.

Highlighted below are key facts relating to substance misuse in Walsall.

6.4.1 Young People Substance Misuse

The points below provide key performance information about young people (under the age of 18 years) accessing specialist substance misuse interventions in Walsall. The data is taken from the National Drug Treatment Monitoring System (NDTMS), which for young people,

[42] Public Health England; Alcohol and Drugs JSNA Support Pack, Sep 2013

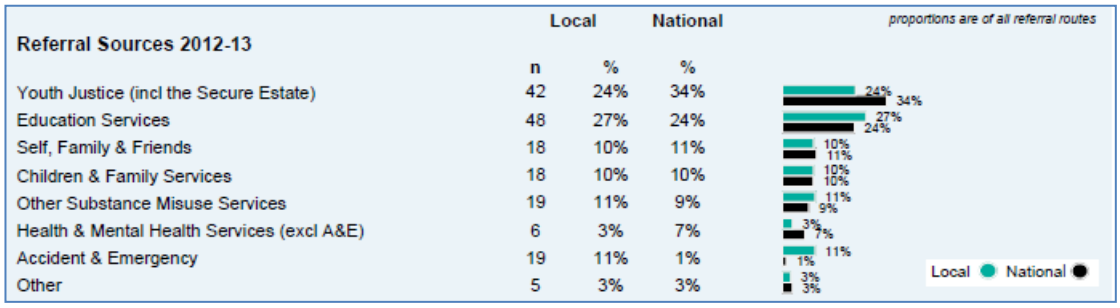
reflects specialist treatment for those with problems around both drug and alcohol misuse. Whilst the majority of young people do not use drugs (and most of those that do are not dependant), drug and alcohol misuse can have a major impact on young people's education, their health, families and their long-term chances in life.

- As shown is Figure 55 below, there are 178 young people in specialist substance misuse services. This represents 12% of the entire treatment population, compared to 9% nationally.

	2011-12		2012-13	
	Local	National	Local	National
Number of young people in specialist services YP: aged under 18, primary drug & alcohol clients	178	20,688	168	20,042
Of all adults and young people in treatment, the proportion of which were young people	13%	9%	12%	9%
Number of YP in the secure estate receiving treatment	N/A	N/A	6	1332

Figure 55 Number of Young People in Treatment (Source: Public Health England; Young People's Alcohol and Drugs JSNA Support Pack)

- The majority of young people in treatment are referred via Youth Justice or the education system as seen in Figure 56 below. 11% are referred via Accident & Emergency as a result of commissioning a specialist resource in this area.



Referral Sources 2012-13	Local		National
	n	%	%
Youth Justice (incl the Secure Estate)	42	24%	34%
Education Services	48	27%	24%
Self, Family & Friends	18	10%	11%
Children & Family Services	18	10%	10%
Other Substance Misuse Services	19	11%	9%
Health & Mental Health Services (excl A&E)	6	3%	7%
Accident & Emergency	19	11%	1%
Other	5	3%	3%

Figure 56 Young People referral sources (Source: Public Health England; Young People's Alcohol and Drugs JSNA Support Pack)

- 96% of young people in treatment receive psychosocial interventions only.
- Figure 57 below shows that 88% of young people in treatment are being treated for cannabis, alcohol or a combination of the two. 11% are treated for stimulants compared to 21% nationally.

Age by Substance	<=13	14-15	16-17	Total YP		National Total YP
	n	n	n	n	%	%
Class A (Heroin & Crack)	0	0	1	1	1%	2%
Stimulants (Cocaine,Ecsty,Amph. Not Crack)	0	10	9	19	11%	21%
Cannabis & Alcohol	6	29	23	58	35%	34%
Cannabis Only	10	20	27	57	34%	30%
Alcohol Only	4	13	15	32	19%	12%
Other Drug	0	1	0	1	1%	1%
Total YP (n)	20	73	75	168		
Total YP (%)	12%	43%	45%			
National (%)	7%	40%	52%			

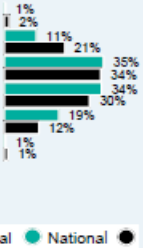


Figure 57 Substance Proportion by Age (Source: Public Health England; Young People's Alcohol and Drugs JSNA Support Pack)

- Young people presenting to treatment in Walsall generally have a lower risk/vulnerability profile than nationally, although there are a higher than average number of young people reporting involvement in sexual exploitation.
- Young people in Walsall generally present to treatment at a younger age than they do nationally.
- 78% of treatment exits in Walsall were planned, which remains in line with national figures.
- While engaged in treatment services, young people in Walsall show a significant reduction in risky behaviour such as offending and self-harm, which is broadly in line with national rates.
- The rate of alcohol related hospital admissions for under 18s (55 per 100,000 of population) is lower than the West Midlands (58 per 100,000) and slightly below the national average of 56 per 100,000.
- Alcohol specific hospital admissions for under-18s in Walsall are the lowest level since 2004/05 at 55.61 per 100,000 and are lower than the regional and national rates.
- There were 135 new treatment presentations to the young people's community drug and alcohol service last year.

6.4.2 Adults Substance Misuse

The alcohol and drug information below was obtained mainly from Local Alcohol Profiles for England (LAPE) and National Drug Treatment Monitoring System (NDTMS).

The health harms associated with alcohol consumption in England are widespread, with around 9 million adults drinking at levels that pose some level of risk to their health.

Drug addiction leads to significant crime, health and social costs. Evidence-based drug treatment reduces these and delivers real savings, particular in crime costs, but also in savings through health improvements, reduce drug-related deaths and lower levels of blood-borne disease including HIV, Hepatitis B and C. This strong value for money case was

endorsed by the National Audit Office and is the foundation of central government's significant ongoing investment in these services.

- There are an estimated 2,107 opiate and/or crack users (OCU) in Walsall, representing 13.06 per 1,000 population compared to 8.67 per 1,000 nationally (Figure 58 below)
- 1,316 individuals of this cohort are engaged in structured treatment programmes in Walsall
- In addition there are more than 500 engaged in open access, outreach and needle exchange services.
- Qualitative feedback suggests that there is a cohort of 70–100 problematic drug users that are not engaged in any form of treatment/intervention.

Prevalence estimates (Aged from 15-64)	Local n	Rate per 1000	National n	Rate per 1000
OCU	2,107	13.06	298,752	8.67
Opiate	1,889	11.71	261,792	7.59
Crack	1,238	7.68	170,627	4.95
Injecting	646	4.00	93,401	2.71

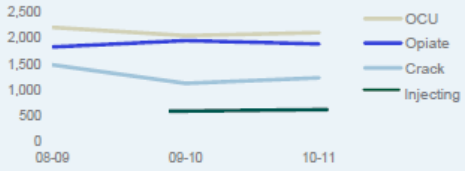


Figure 58 Drug Prevalence (Source: Public Health England; Alcohol and Drugs JSNA Support Pack)

- 99% of clients waited less than three weeks to start treatment.
- 96% of adults are considered to be effectively engaged in treatment.
- 73% of adults in treatment are unemployed. Only 1% are considered to be long term sick or disabled compared to 11% nationally.
- Walsall is achieving lower than average rates of abstinence from opiate, crack and cocaine amongst adults in treatment.
- The proportion of successful completions in Walsall is higher than the national rate and there has been a 33% growth in successful completions since 2011-12.

Growth in successful completions since 2011-12			
Opiate	33%	-7%	
Non opiate	11%	2%	
All	24%	-3%	

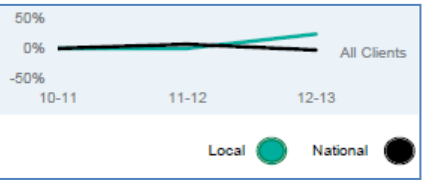


Figure 59 Successful Completions Trend (Source: Public Health England; Alcohol and Drugs JSNA Support Pack)

- People in treatment for prescription-only medications or over the counter medicines make up a much smaller proportion of the treatment population in Walsall than they do nationally.
- The number of adults in treatment using club drugs such as mephedrone or ketamine in Walsall is negligible compared to national figures.

- Only 47% of eligible clients have been tested for Hepatitis C, compared to 73% nationally. In Walsall, 16% of eligible adults receiving a Hepatitis B vaccination completed the course, compared to 20% nationally.
- 33% of drug users in treatment live with children, in line with national statistics. A further 33% are parents but do not live with their children, compared to 21% nationally.
- Walsall has an estimated 34,058 hazardous drinkers, 33,550 binge drinkers and 10,174 harmful drinkers.
- The estimate (based on a population of 269,323) for the number of people who are alcohol dependent is 10,772.
- Walsall has a higher rate of alcohol related hospital admissions (2,041 for 2011/12) than the national and regional average. This represented however a reduction of 8% on the previous year.
- There were 1,834 alcohol related crimes recorded in Walsall in 2011/12, which represents a continuation in the downward trend of the past 5 years. The crude rate per 1,000 persons has reduced from 10.11 in 2007/08 to 7.14 in 2011/12, as seen in Figure 60

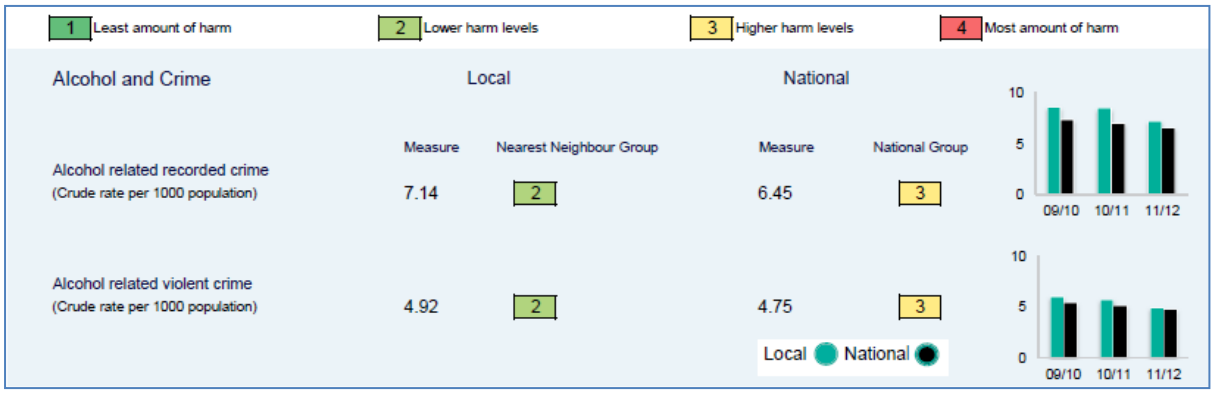


Figure 60 Alcohol and Crime (Source: Public Health England; Alcohol and Drugs JSNA Support Pack)

- The number of alcohol related crimes, whilst decreasing, is still higher in Walsall than the West Midlands (6.77) and national (7.02) average.

Walsall ranks 104 out of 326 local authority areas for the highest rates of alcohol related crimes.

Key priorities are:

- *Ensure young people have the knowledge and confidence to resist pressure and recognise risks of controlled drugs, New Psychoactive Substances (NPS) and alcohol through health promotion work in schools*
- *Develop and implement the use of the young people's Drug Use Screening Tool across all young people's services*

- *Further Integrate Health Promotion services and the Making Every Contact Count (MECC) programme to train partner agency staff to identify and deliver appropriate Brief Advice interventions to maximise opportunities to influence behavioural change*
- *Mainstream and develop further the Alcohol Liaison Service working between the hospital, primary care and specialist community alcohol services*
- *Increase the available opportunity for detoxification, in the community and in-patient residential settings, to support individual's recovery*
- *Maintain Walsall's good performance of people swiftly entering the treatment system and successfully exiting substance misuse treatment services*
- *Establish more robust support networks services to those who have exited treatment to sustain their recovery*
- *Maintain the strong support that substance misuse treatment services offer to the criminal justice system*

6.5 Emotional health and wellbeing

Wellbeing has two essential elements: feeling good and functioning well. This includes contentedness, enjoyment of life, positive relationships, having a degree of control over one's life and a sense of purpose. Just as five portions of fruit and vegetables a day are good for physical health, so the essential nutrients for good mental health and wellbeing can be distilled into five elements, which have been described as the 'five ways to wellbeing':

- *connect with people - family, friends, colleagues, neighbours*
- *be active - walk, cycle, dance, play a game that you enjoy*
- *take notice - reflect on the beauty of the world around you*
- *keep learning - try a new challenge, learn to do something new*
- *give - volunteer your time, do a favour, look out for someone in need*

Work can enhance mental wellbeing as it gives a sense of purpose and creates social relationships. Conversely unemployment and workplace stress can both impair mental health.

One in six adults has a mental health problem at any one time, and many people do not seek help because of stigma. Benefits of improved population wellbeing include improved mental health, greater resilience against mental health problems, less discrimination and stigmatisation in the workplace and reduction in suicides.

Brief interventions in primary care and improved access to psychological therapies offer a one-to-one service to improve resilience and wellbeing. Particular subgroups may benefit in particular, for instance depression is common in patients who are diabetic. The 'five ways to wellbeing' initiative, described above gives a set of evidence based actions which promote well being and can be an effective tool for individuals to assess and review themselves.

Indicator:

There is very little information on the mental wellbeing of our local population. For the first time in early 2012 the Your Place, your wellbeing: Walsall Household and Lifestyle Survey is asking a series of questions on mental health and wellbeing, including the Warwick-Edinburgh Mental Wellbeing Scale. This will provide a very useful baseline indicator of wellbeing across Walsall for future reference.

Wellbeing is a key issue for the Government and ONS are leading a programme of work to develop new measures of national wellbeing. People with higher wellbeing have lower rates of illness, recover more quickly and for longer, and generally have better physical and mental health. Local data on wellbeing is likely to be a key component of local Joint Strategic Needs Assessments and form an important part of the work of local Health and Wellbeing Boards.

The government launched the Integrated Household Survey in 2010, which is a composite survey combining questions asked in a number of Office for National Statistics (ONS) social surveys to gather basic information for a very large number of households. It covers a variety of topics, with Health & Disability being included. The first full year data from these questions was published by ONS in July 2012 and are being treated as experimental statistics. From a Health & Wellbeing perspective, there are 4 indicators which can be used. These are part of the latest Health and Wellbeing strategy for Walsall and are shown in Figure 61 below together with a West Midlands and England comparator. The percentage shown refers to the proportion of survey respondents.

Indicator	Walsall		West Midlands		England	
	2011/12	2012/13	2011/12	2012/13	2011/12	2012/13
Self-reported well-being - people with a low satisfaction score	8.06	4.91	10.66	6.10	6.65	5.77
Self-reported well-being - people with a low worthwhile score	5.32	x	6.8	4.63	4.87	4.36
Self-reported well-being - people with a low happiness score	11.40	11.27	13.35	10.95	10.84	10.36
Self-reported well-being - people with a high anxiety score	23.19	19.75	20.56	20.08	21.82	20.98

Figure 61 Self-reported wellbeing indicators (Source: ONS 2011-2013)

From this survey, it can be seen that Walsall has improved since the first year. It also compares well with the West Midlands and England with the satisfaction and anxiety score, but Walsall's residents are not as happy as the rest of the country.

Priorities for action:

A borough wide strategy to improve population mental health and wellbeing should be designed and implemented. This should cover the 'five ways to wellbeing'. Some results from the 2012 lifestyle survey are shown below and will be used to inform interventions targeted in particular areas or in particular groups within our population (for example, those who are unemployed). This survey should be repeated in subsequent years to enable changes in mental health and wellbeing to be tracked.

6.6 Chapter summary and key priorities for action

Key Priorities for action:

To bring about population level improvements in lifestyles and reduce the impact of preventable disease we need to:

- *Work with partners to support children and young people to become strong, resilient individuals able to make healthier lifestyle choices*
- *Create and maintain an environment in Walsall that promotes physical activity and helps residents to improve their health, using planning mechanisms and policy development to the full*
- *Work with partners to deliver multi agency prevention and intervention strategies for tobacco, drugs and alcohol to reduce the substance misuse associated harm to individuals, their families and their communities*
- *Ensure that GPs and frontline staff in all partner agencies are fully engaged in encouraging and supporting residents to adopt and sustain healthy lifestyles. The 'Every Contact Counts' initiative provides a real opportunity to do this systematically and on a scale that could bring about real improvements in health*
- *Coordinate the provision, promotion and marketing of key health improvement programmes such as the NHS health checks programme, free leisure activities, subsidised swimming, smoking cessation and weight management, and ensure closer working between providers*
- *Encourage large employers to promote and improve the health of their workforce, for example through participation in the NHS Healthy Workplace Programme*
- *Work through the Area Partnerships to ensure that local people are at the heart of our strategies to improve lifestyles and prevent ill health*

Other local priorities should include brief interventions in primary care and Improving Access to Psychological Therapies; continuing work with pregnant women who smoke (one-to-one sessions to address sources of stress) to help them to quit smoking; and expansion of the workforce development program to help support people with long term illness and absenteeism.

Chapter 7 Reducing the burden of preventable disease, disability and death

The preceding chapters of the JSNA have focused on reducing inequalities by promoting wellbeing in the early and school years, improving employment and employability and supporting healthy, resilient communities. The development of long-term conditions and subsequent mortality follow a clear social gradient. Evidence-based prevention, early detection and treatment of the major causes of mortality are essential to reduce inequalities across the life course. The Marmot Review recognised the importance of ill-health prevention with the following priorities:

- *Prioritise prevention and early detection of those conditions most strongly related to health inequalities*
- *Increase availability of long-term and sustainable funding in preventing ill-health across the social gradient*

This chapter addresses the prevention, early detection and treatment of key causes of morbidity and mortality in Walsall.

7.1 Mortality

Preventing early death (under the age of 75 years) is an important aim for health services.

All-age, all-cause mortality is lower amongst females than males. Over the last few years it has gradually declined (with some year-to-year fluctuation) but remains higher in Walsall than regionally and nationally. Following years of steady decline, mortality rates for Walsall men increased in 2005. More recently, the fall in male mortality rates has accelerated and the gap between the local, regional and national rates has narrowed. However, persistent efforts need to be made to prevent and to manage the main contributors to early deaths.

In the charts below, 2011 Directly Standardised Rates (DSR) have been provisionally calculated for Walsall, but equivalent figures aren't currently available for the West Midlands and England for comparison. The Walsall trend shows a continual reduction in male and female deaths.

The main causes of death in Walsall are cancer, coronary heart disease and pulmonary disease. The contribution of smoking and obesity cannot be underestimated and strenuous efforts must be made by all partners to reduce these determinants of health. The next sections provide detail of key local issues and the actions required to address them.

Indicators:

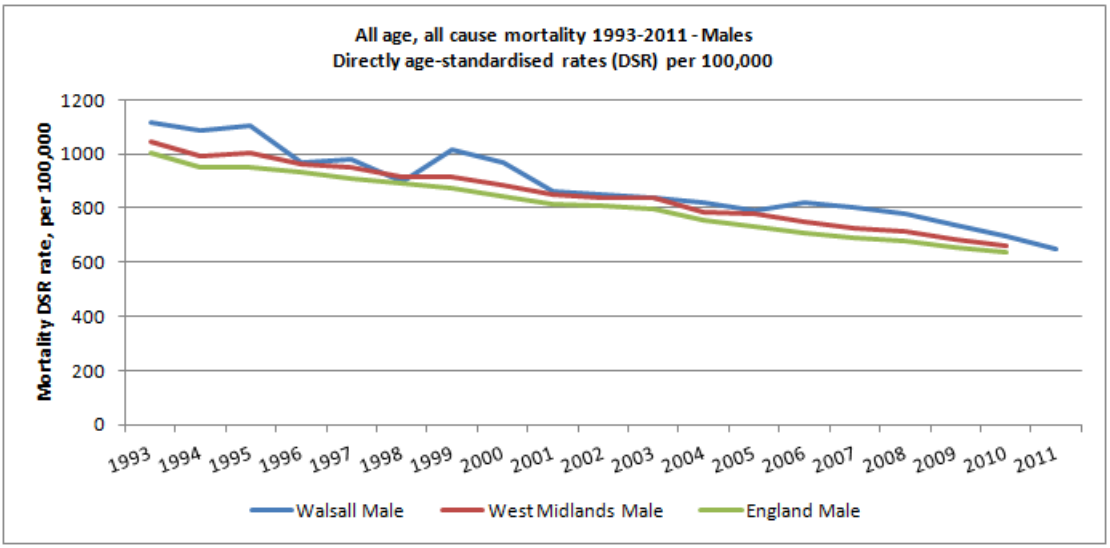


Figure 62 Male - All age all cause mortality trends 1993-2011 (Source: NHS Information Centre and Public Health Mortality File from ONS) (The rate for 2011 is provisional)

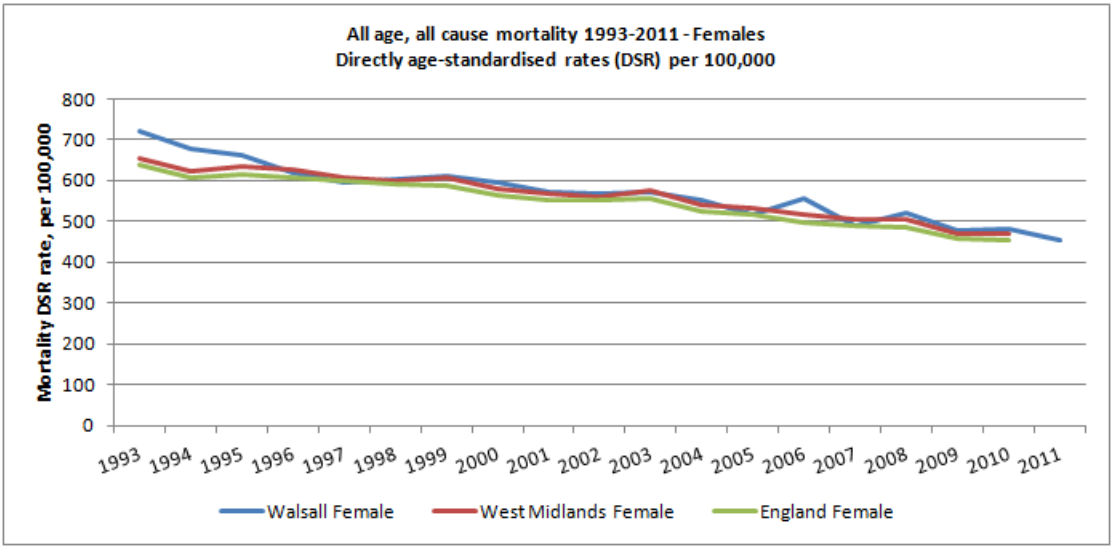


Figure 63 Female - All age all cause mortality trends 1993-2011 (Source: NHS Information Centre and Public Health Mortality File from ONS) (The rate for 2011 is provisional)

Priorities for action:

- *Partnership action to reduce the impact of smoking and obesity in the borough*
- *Robust response to the main causes of death in the borough (described below) with a focus on prevention and early detection:*
    - *Maximise opportunities to influence lifestyle choices through the Every Contact Counts initiative*
    - *Encourage participation in NHS Health Checks and national screening programmes*
    - *Robust pathways of care across all health providers*

7.2 Cancer

Cancer is the leading cause of death in under-75s in Walsall. Over 29% of all deaths in the borough in 2011 are due to cancer (there were 712 deaths to cancer in 2012).

The chart below shows that mortality from cancer has increased for both genders between 2009 and 2011. Cancer mortality for males has increased by 3.2%, while females have increased by 16.6%. In 2010, both genders mortality rate was greater than that for England. The rates for 2011 are currently provisional.

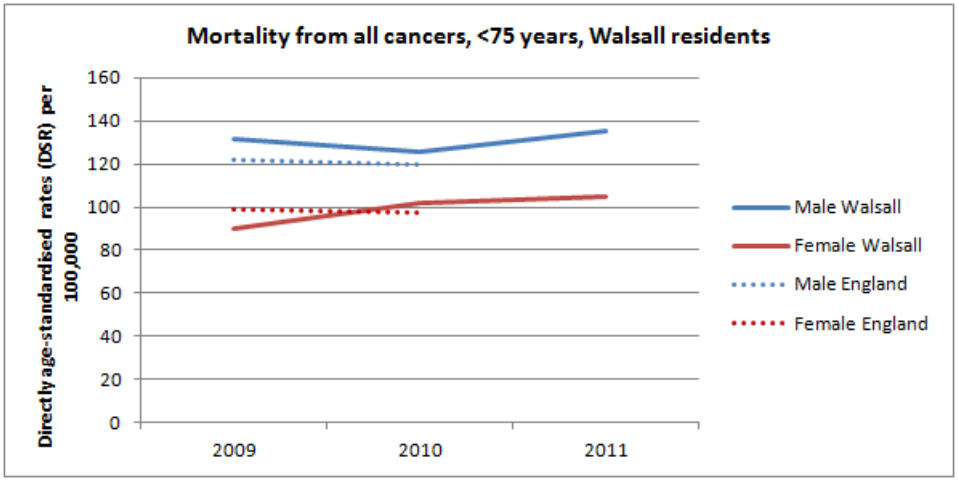


Figure 64 Mortality from all Cancers. (Source: Public Health Mortality File (from ONS))

Indicators:

Mortality rate from cancer, ages under 75, per 100,000 population varies across the borough, with male rates in Blakenall, Darlaston South and Birchills Leamore more than double the rates in Paddock and Streetly and female rates in Bloxwich East, Blakenall, Pelsall and Darlaston South more than double the rates of Pheasey, Aldridge Central and South, Aldridge North and Walsall Wood, Birchills Leamore and Pleck. The commonest types of fatal cancers in Walsall are lung, colorectal, oesophageal, breast, prostate and stomach. In the 2012-13 NHS Outcomes Framework, the survival rates at 1 year and 3 years are being reported on for three of the major cancers: colorectal, breast and lung.

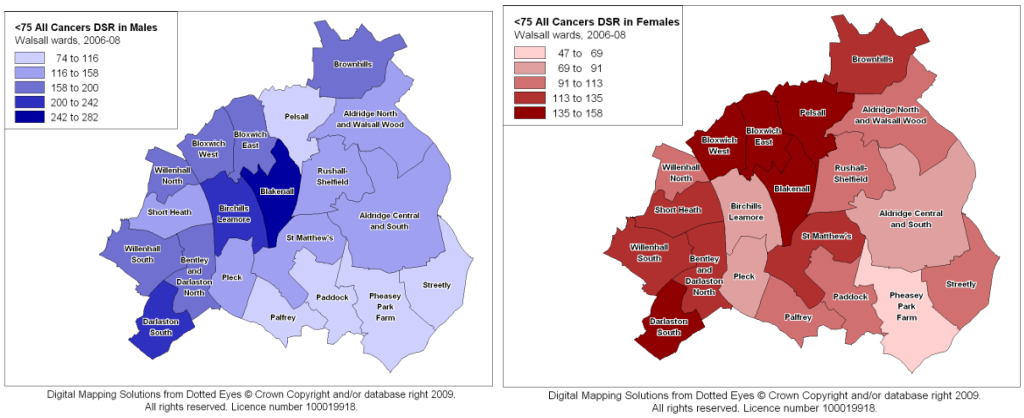


Figure 65 Under 75's all cancer DSR by community - Males (left) and Females (right) (Source: Public Health Mortality File)

Priorities for action:

A wide variety of factors can help to reduce the risk of cancer, aid early diagnosis and offer prompt and effective treatment. Modifiable population risk factors include stopping smoking, improving diet, keeping alcohol consumption moderate and engaging in physical activity. Nearly 90% of the 150 cases of lung cancer that occur each year in Walsall are due to smoking, so if everyone stopped smoking in Walsall there would be 128 fewer cases each year. A further 90 cancers of oesophagus, stomach and bowel could be prevented by healthier diets and reduction in obesity. Potentially 45% of the 670 cancers diagnosed in Walsall each year could be avoided by modifying simple lifestyle risk factors.

National public health screening programmes are in place to support and improve the early detection and treatment of breast, bowel and cervical cancer. These are having a significant impact on cancer survival, but not everyone eligible attends.

Bowel screening

For the 6 months up to February 2013, 53.4% of 60-74 year olds took up bowel screening. This is an increase on the previous year's uptake of 52.8% (at Feb 2012). The target as shown in the Health Protection Dashboard is 60% uptake.

The 2.5 year coverage rate for 60-74 year olds has increased from 52.9% in Feb 2012 to 54.7% in 2013. The target as shown in the Health Protection Dashboard is 60% coverage.

Cervical screening

The Walsall coverage rate has dropped slightly from 74.94% in 2010 to 73.3% in February 2013. This is for those aged between 25 and 64 years, over a 3.5/5.5 year coverage. The target as shown in the Health Protection Dashboard is for 80% coverage.

Breast screening

In Walsall, the uptake in breast screening (for 50 to 70 year olds) has reduced from 73.8% in Feb 2012 to 71.2% in Feb 2013. This is still above the 70% target seen in the Health Protection Dashboard.

The 36 month coverage rate however has increased from 69.1% in Feb 2012 to 71.9% in Feb 2013. Again, this is above the 70% target as seen in the Health Protection Dashboard.

Recommendations to target areas of lower than average uptake will increase the numbers of people with cancer diagnosed sooner, and hence treated when their cancer is at an earlier and more easily treated stage.

Effectiveness of treatment depends on speed of diagnosis, quality of and compliance with treatment and mitigation of social isolation. There is increasing evidence that people with poor social networks, isolation and depression have poorer survival rates than those without.

We should therefore ensure, where possible, that patients are offered the necessary social support to maximise their chances of survival.

	New cases per year		Attributable fraction		Potentially avoidable	
Site	**Males**	**Females**	**Male %**	**Female %**	**Males**	**Females**
Lung	91	59	87%	84%	79	49
Colorectal	38	28	57%	52%	22	15
Oesophagus	28	13	90%	88%	25	11
Stomach	18	8	78%	69%	14	6
Breast	-	51	-	27%	0	14
Bladder	15	6	44%	37%	7	2
Leukaemia	10	6	16%	14%	2	1
Melanoma	4	2	90%	82%	4	2
Other	123	126	[-]	[-]		
All	**371**	**300**	**45%**	**40%**	**168**	**120**

Figure 66 Walsall impact on cancer of eliminating common risk factors: Potentially avoidable cases per year

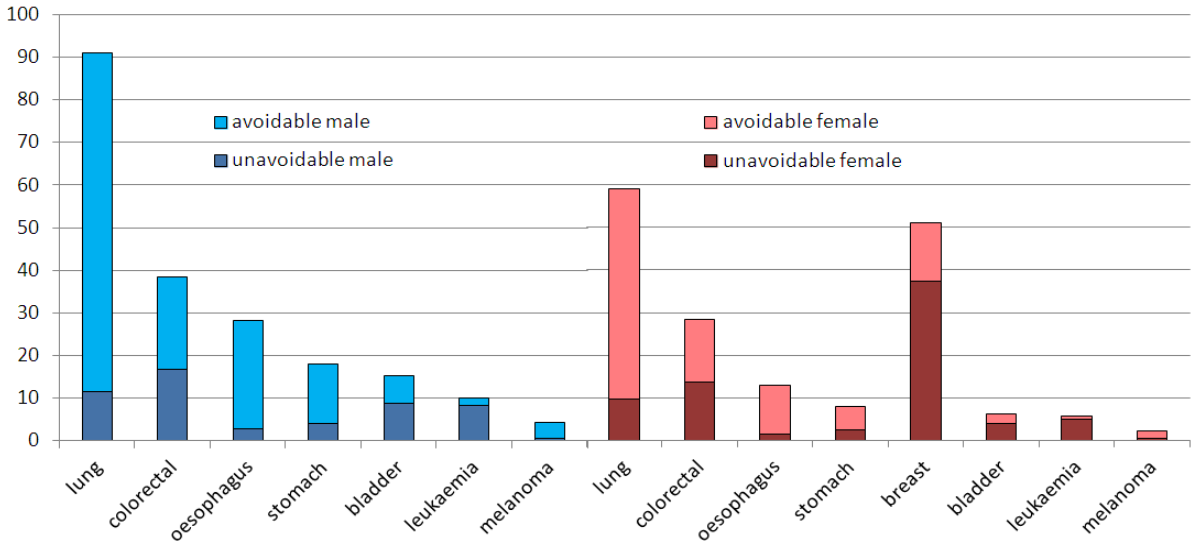


Figure 67 Walsall potential avoidable and unavoidable cancers by gender - impact of eliminating common risk factors

7.3 Heart disease

Coronary Heart Disease (CHD) is common but is a condition for which there is very strong evidence based interventions for prevention and for treatment. Whilst deaths from CHD have reduced in the past 10 years, the rates in Walsall remain higher than nationally. This means we still have too many people dying before reaching 75 years of age. Organisations and the population as a whole should redouble efforts to implement the key actions which we know will reduce CHD. In the Figure 68 below, Walsall still shows a downwards trend in mortality up to 2011, but at time of writing, comparable data isn't available for the West Midlands and England. Walsall 2011 rates are provisional.

Indicators:

The number of coronary heart disease deaths per 100,000 (DSR) is recorded and compared to the West Midlands and England.

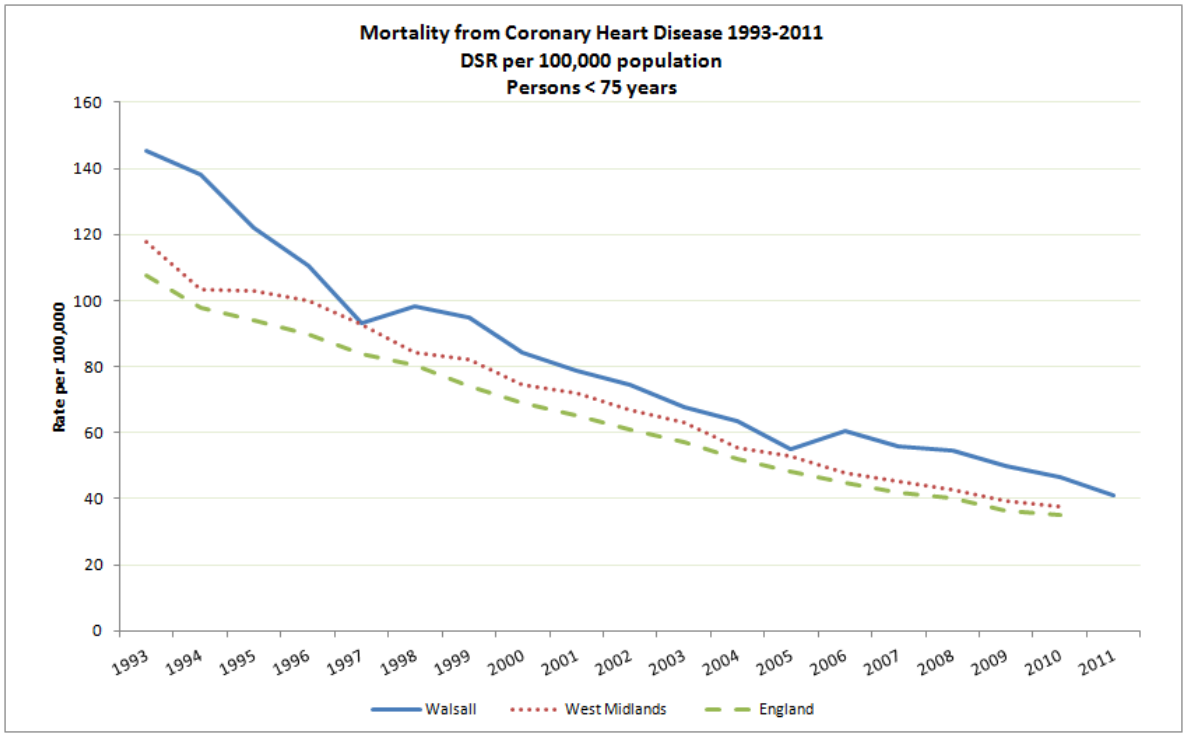


Figure 68 Under 75 Coronary Heart Disease Mortality DSR 1993-2011 (Source: NHS Information Centre and Public Health Mortality File for 2011 Walsall) (Rates for Walsall 2011 are provisional)

Priorities for action:

To reduce the prevalence of CHD and its impact on families the following actions should be taken:

- *All partners to prioritise reducing levels of smoking in our population.*
    - *This includes controlling tobacco, preventing children from starting smoking, supporting people to stop smoking.*
    - *Key areas for action are in pregnant women.*

    - *Major areas for opportunity are in the workplace*
- *Commissioners of health services need to promote the aggressive identification and management of heart disease, e.g. through the national health service health checks programme – a primary prevention initiative which identifies those at highest risk of developing heart disease and puts actions in place to reduce those risks*
- *Health professionals and patients should work consistently to manage coronary heart disease in line with best available evidence. A wider range of health professionals can contribute to this ,e.g. community pharmacists supporting patient self-care, medicine-use reviews and NHS health checks*
- *All partners should maximise opportunities to promote more active lifestyles for all ages and provide access to affordable active leisure provision*

7.4 Stroke

Stroke is the largest cause of disability in the UK, and the third commonest cause of death (after heart disease and cancer). Most cases occur in people aged over 65 but, a stroke can occur at any age, even in babies. Each year in Walsall, around 480 people have a stroke. 25% of these people die from the effects of their stroke. Of those who survive, one third have moderate to severe disability. Access to fast and effective acute treatment and high quality rehabilitation can significantly reduce both death and disability. Specific details for this are described in the Accelerating Stroke Improvement report [43].

The main preventative actions for stroke are good control of high blood pressure and correction of heart rate abnormalities (atrial fibrillation). People who have suffered 'mini strokes', also known as transient ischaemic attack (TIA), are at high risk of developing more severe strokes and effective actions to reduce this risk are of most benefit.

The charts on the next page show mortality trend resulting from stroke, between 1993 and 2011, for all persons and also separately by gender. For 'all persons', all ages, the overall reduction in recent years now shows Walsall's mortality (39.26 rate per 100,000) in 2010 is lower than the West Midlands (43.86 rate per 100,000) and England (40.89 rate per 100,000). The latest figure for Walsall shows a slight rise from 39.26 (2010) to 40 (2011), but other region comparators aren't yet available for 2011.

[43] http://www.improvement.nhs.uk/stroke/AcceleratingStrokeImprovement/tabid/134/Default.aspx (Accessed: 17 Oct 2013)

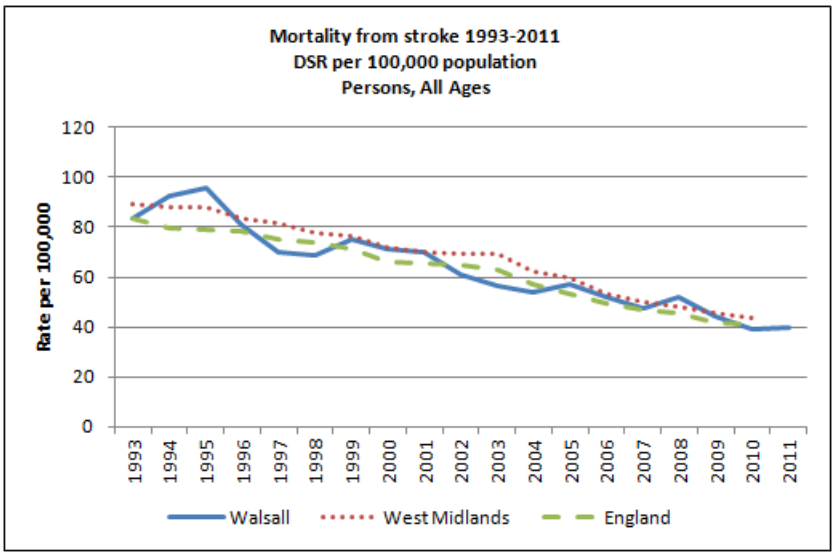


Figure 69 Mortality from Stroke (Source: NHS Information Centre; Mortality from stroke DSR between 1993 and 2011 and Public Health Mortality File for Walsall 2011)

When comparing mortality of males against females, there is a marked difference. Both genders generally have a downwards trend, but female mortality has dropped 21% between 2009 and 2010 but then there was a sharp increase of 37% between 2010 and 2011. Note however that 2011 rates are provisional. On closer inspection, more than half of these female deaths occurred in people over the age of 85. Also, it must be noted that the confidence interval for the 2011 rate is quite wide, so could affect interpretation.

Looking at the male trends of Walsall, there was a spike in 2008 of 57.82, but levels have reduced since then. Between 2009 and 2010, the level of reduction closely matches that of the West Midlands and England. The rates from 2010 show that Walsall's mortality rate (of 45.26 per 100,000) is slightly better than the West Midlands rate (45.93 per 100,000), but higher than the England value of 41.91 per 100,000.

West Midlands and England figures aren't yet available for 2011, but Walsall (provisionally) shows a substantial 24.9% drop in male stroke mortality between 2010 and 2011. As with the female statistics for 2011, there is a wide confidence interval, which could affect the trends in these charts.

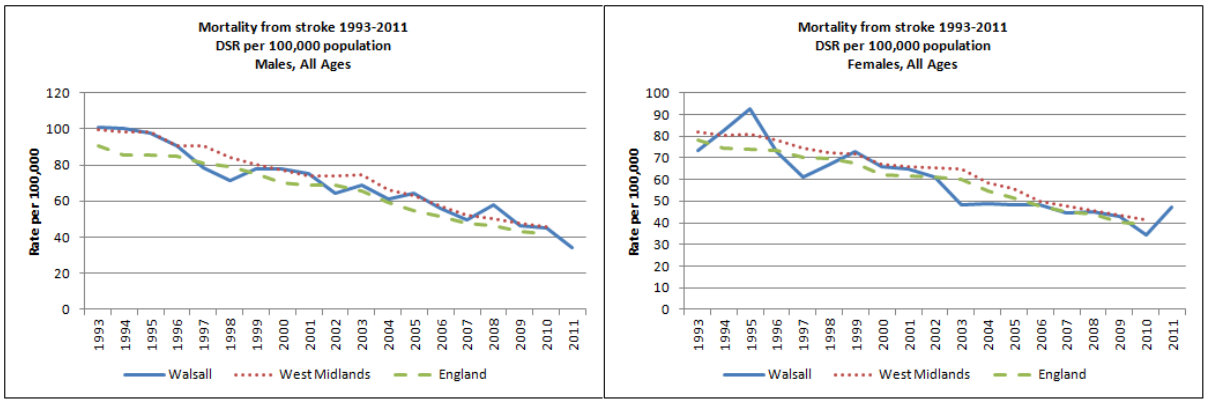


Figure 70 Mortality from Stroke, by Gender (Source: NHS Information Centre; Mortality from stroke DSR between 1993 and 2010 and Public Health Mortality File for Walsall 2011; provisional rates)

Indicators:

- *Good hyper-acute and general community rehabilitation services which compare favourably regionally and nationally*
- *Very limited vocational rehabilitation service for people of working age who suffer a stroke means the percentage of younger stroke sufferers returning to work within 12 months is low*
- *The access to specialist stroke rehabilitation is reduced for those patients with the densest strokes (eg unable to sit unaided). There is no appropriate bed-based service for rehabilitation within Walsall. There are limitations to the current nursing home-based service in terms of access to beds and appropriateness of facilities for specialist rehabilitation*
- *Insufficient specialist social worker support for the stroke pathway introduces delays in discharge.*

Priorities for action:

- *A clear and robust service for younger stroke sufferers needs to be commissioned and delivered within Walsall. This will increase the proportion of stroke sufferers returning to work within 6 (and 12) months*
- *All partners need to design and implement appropriate bed-based rehabilitation services within Walsall. This will maximise the regaining of functions for all stroke patients*

7.5 Chronic Obstructive Pulmonary Disease

Chronic Obstructive Pulmonary Disease (COPD) is a common group of disorders which includes chronic bronchitis and emphysema. About three million people in the UK have COPD and it is estimated that another half-a-million have the condition but have not been diagnosed. The main cause of COPD is tobacco smoking, but other relevant causes include exposure within the mining and pottery industries.

According to "Modelled estimate of prevalence of COPD in England", there are 10,140 people suffering from the condition in Walsall. This is made up of 5,975 males and 4,165 females.

In 2011, it was estimated that around 3.9% of Walsall's registered population had COPD. This is considerably higher than the England rate of 2.9%. [44]

COPD mainly affects people over the age of 40 and becomes more common with increasing age. The average age of diagnosis is around 67 years and it is more common in men than women.

[44] http://www.apho.org.uk/PracProf/Profile.aspx#mod,5,pyr,2012,pat,2,par,E16000066,are,-,sid1,2000010,ind1,722-4,sid2,-,ind2,- (Accessed: 17 Oct 2013)

COPD accounts for more time off work than any other illness; exacerbation of COPD is one of the most common reasons for admission to hospital (1-in-8 admissions are due to COPD).

Indicators:

Traditionally, male mortality from COPD is higher than females – 38.23 (male) compared to 16.5 (female) in 2010 (rate per 100,000). Rates in Walsall are generally higher than regionally and nationally. Female rates peaked in 2008 (31.3) but has since improved, dropping to 16.5 in 2010. However, this has since risen to 23 (rate per 100,000) in 2011 (provisional).

The male COPD mortality rates are also climbing steadily in recent years, showing an increase of 34% between 2009 and 2011 (provisional).

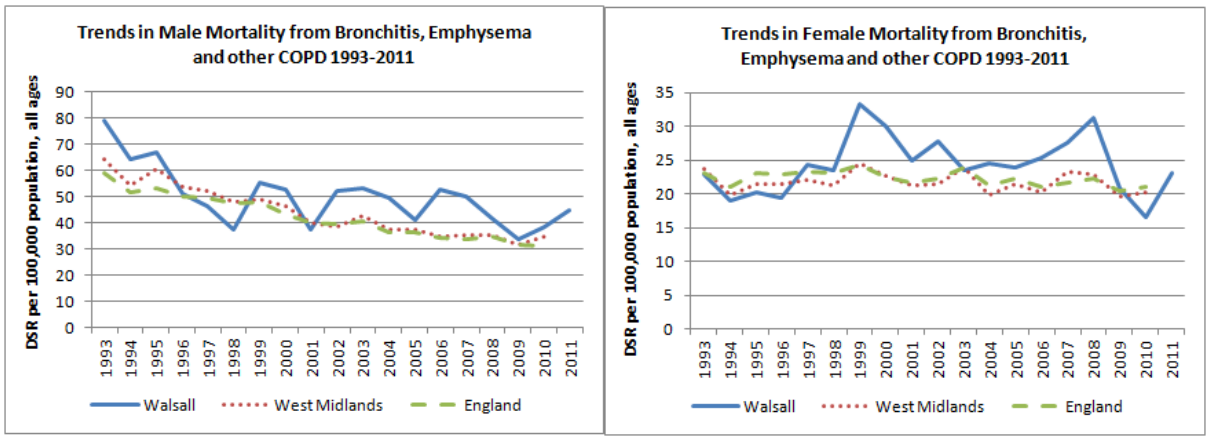


Figure 71 Trends in mortality from bronchitis, emphysema and other COPD, 1993-2011 (Source: NHS Information Centre)

Priorities for action:

The main action to prevent this high morbidity and mortality is to prevent people from smoking and to support those who do smoke to stop. This stops the damage to the lungs which leads to COPD. In addition, robust approaches to managing the condition, monitoring and aggressive treatment of flare-ups will prevent or shorten hospital stays and reduce days lost from work.

7.6 Diabetes

Diabetes mellitus (usually referred to as diabetes) is a common endocrine disease affecting all age groups. Within Walsall, a much higher proportion of the population suffer with this disease. The long term consequences of poor control are coronary heart disease, blindness, kidney disease, small nerve damage and peripheral vascular disease leading to limb amputations. This is particularly aggravated by smoking. A significant proportion of diabetes could be prevented and there is an urgency to tackle this given the exponential increase in

obesity over recent years. Effective control and monitoring can reduce mortality and morbidity.

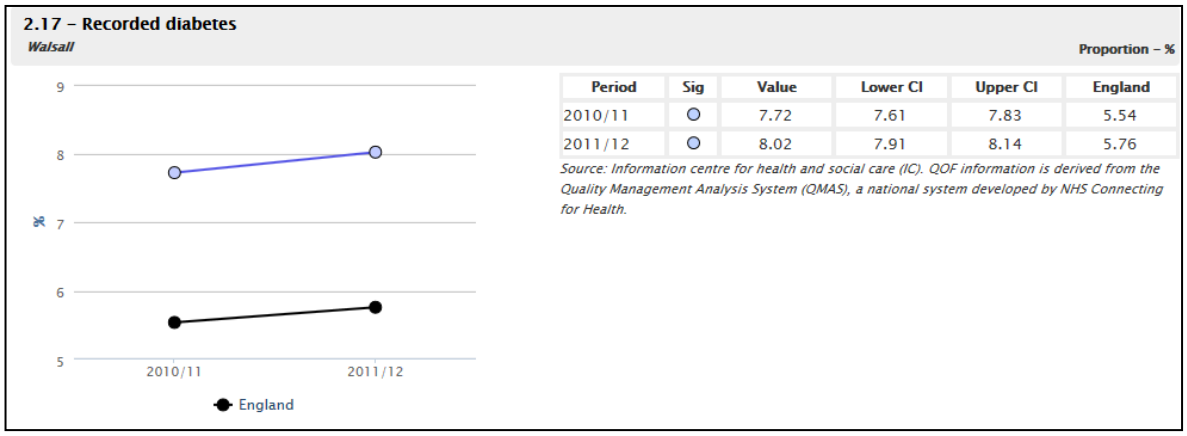
Indicators:

Walsall has the highest modelled prevalence of diabetes in 2010, an increase since 2007. However, health services within Walsall have identified over 90% of its diabetic population. Once diagnosed, there is great opportunity to manage the disease and reduce its complications. There is evidence that the proportion of our diabetic population with good control (e.g. percentage with blood pressure controlled) is not as high as it could be. In addition, there is very poor uptake of patient education programmes by people with diabetes.

The National Institute for Health and Clinical Excellence (NICE) has produced quality standards for diabetes care:

http://www.nice.org.uk/guidance/qualitystandards/diabetesinadults/diabetesinadultsqualitystandard.jsp

Key actions from all GP practices and from patients are required to improve performance against these standards. The chart below, from the Public Health Outcome Framework shows that Walsall's proportion of diabetics has risen from 7.72% in 2010/11 to 8.02% in 2011/12. In the same time period, England's rate has also increased, from 5.54% to 5.76%.



Period	Sig	Value	Lower CI	Upper CI	England
2010/11		7.72	7.61	7.83	5.54
2011/12		8.02	7.91	8.14	5.76

Source: Information centre for health and social care (IC). QOF information is derived from the Quality Management Analysis System (QMAS), a national system developed by NHS Connecting for Health.

Figure 72 Diabetes trend – Walsall and England (Source: Public Health Outcome Framework Tool)

Public Health England have developed a report (through Yorkshire and Humber Public Health Observatory), which attempts to estimate the prevalence of diabetes, in the current and future years.

The following chart shows these projections for Walsall and England (West Midlands not available).

	2013	2015	2020
Walsall	8.80%	9.10%	9.70%
England	7.40%	7.60%	8.20%

Figure 73 Estimated Diabetes Projection (Source: "Diabetes prevalence model from Yorkshire and Humber Public Health Observatory YHPHO")

Diabetes Community Health Profile

The Diabetes Community Health Profiles bring together a wide range of data on diabetes in adults into a single source for the purposes of benchmarking. A Diabetes Community Health Profile is available for each CCG in England at:

http://yhpho.york.ac.uk/diabetesprofiles/default.aspx

It was last updated on 24 June 2013. Headlines for Walsall are as follows ...

Key facts for NHS Walsall CCG

The prevalence of diagnosed diabetes among people aged 17 years and older in NHS Walsall CCG is 8.1% compared to 6.1% in similar CCGs. In 2011/12 NHS Walsall CCG 68.5% of adults with diabetes had a HbA1c measurement of 59mmol/mol or less. This is higher than in other similar CCGs and lower than England.

People with diabetes in Walsall Teaching PCT were 37.6% more likely to have a myocardial infarction, 29.3% more likely to have a stroke, 47.2% more likely to have a hospital admission related to heart failure and 39.9% more likely to die than the general population in the same area

Spending on prescriptions for items to treat diabetes in 2011/12 cost £365.46 per adult with diabetes in NHS Walsall CCG compared to £415.89 across England.

Priorities for action:

- *Implement robust pathways within the Acute Trust to identify and refer patients with long-term conditions to specialist weight-management services*
- *Commissioners to performance-manage services for patients and to increase awareness amongst patients of the actions they should take to reduce long-term complications*
- *A re-commissioning of patient education programmes coupled with actions to increase the percentage of those invited who take part is urgently required*
- *A concerted effort for more patients to confidently and robustly manage their condition day-to-day is likely to result in fewer long-term complications*
- *Support for the new Clinical Commissioning Consortium to identify those patients at highest risk of complications should be offered from the PCT's clinical decision support team*
- *A focus on smoking cessation for people with diabetes will have a major impact on reducing the complications of diabetes*

- *Promote preventative approaches such as ensuring healthy diet and adequate levels of physical activity*

7.7 Mental health and suicide

Around 22 people each year commit suicide in Walsall, though suicide rates are lower than the England average. However 75% of people who commit suicide have not had any contact with mental health services, making it potentially difficult to identify people at risk of suicide.

Data for Walsall's Suicide Prevention Strategy was refreshed in 2013. Some of the key findings are:

- Deaths from suicide and undetermined injury in Walsall have averaged 15 males and 3 females per year in the five years 2006-10. There is, however, a wide fluctuation from year to year.

- The suicide rates in Walsall are generally much lower than the rates in the West Midlands region, England and Wales.

- Almost 4 times as many men commit suicide in Walsall than women, which is in line with the national pattern.

- In recent years the rate of suicides in Walsall men has remained static whereas in England and Wales it has been falling, so the gap between Walsall and the rest of the country is shrinking.

Indicators:

A number of indicators in the NHS Outcomes Framework and the Public Health Outcomes Framework will be followed to monitor the progress of this strategy, including:

- *Self-reported population wellbeing*
- *Suicide rate*
- *Excess under 75 mortality in adults with serious mental illness*
- *Employment of people with mental illness*
- *Patient experience of community mental health services*
- *Hospital admissions as a result of self-harm*

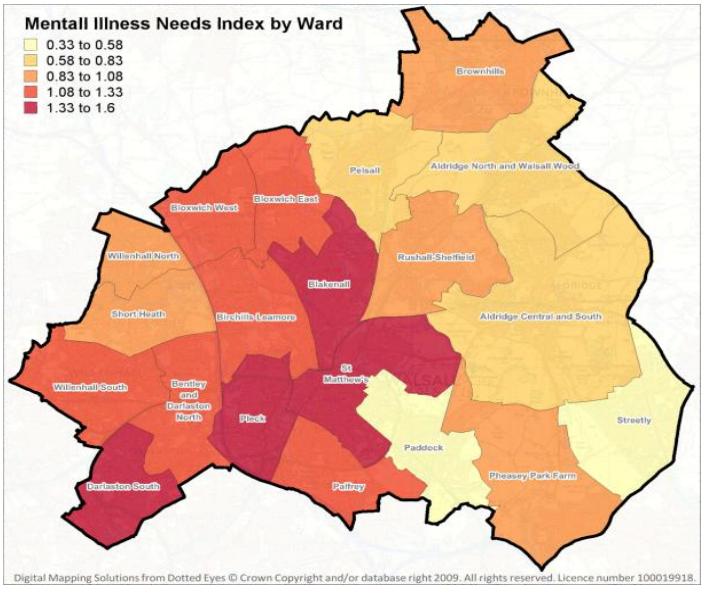


Figure 74 Mental illness needs index by ward (Source: National Psychiatric Morbidity Survey)

Priorities for action:

Current health service interventions that improve mental health and wellbeing include suicide prevention training with front-line personnel who come into contact with people at risk of mental health problems. These front-line personnel include officers in the employment and housing sectors. These actions should be continued and embedded for all staff. In addition, mental health first aid training for healthcare workers would be of benefit.

Other local priorities should include brief interventions in primary care and Improving Access to Psychological Therapies; continuing work with pregnant women who smoke (one-to-one sessions to address sources of stress) to help them to quit smoking; and expansion of the workforce development programme to help support people with long-term illness and absenteeism.

7.8 Health Protection

Infections continue to be a significant cause of ill health. In 2010 in England, infectious diseases accounted for 7% of all deaths, 4% of all potential life years lost (to age 75) and were also the primary cause of admission for 8% of all hospital bed days. They are responsible for a large proportion of sickness absence from work. The burden of disease and economic impact of infections and infectious disease is estimated at £30 billion each year in England. A characteristic of infectious disease, which separates it from other types of illness, is that the causative factors undergo rapid change, developing resistance and the emergence of new pathogenic organisms.

The challenge of reducing healthcare associated infections

The Department of Health requires the Clinical Commissioning Groups (CCG) to have no more than 72 cases of *Clostridium difficile* across Walsall in 2013/14. This includes Walsall Healthcare Trusts allowance of 28. Despite many interventions and successes there has been a slight increase in the number of *Clostridium difficile* infections since December 2012, as seen in Figure 75 below.

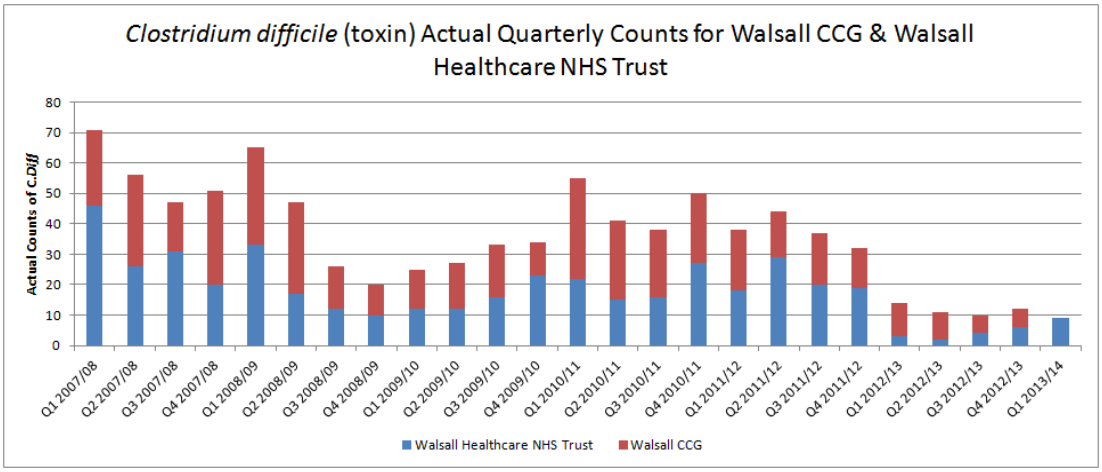


Figure 75 C. Difficile actual quarterly counts for Walsall CCG and Walsall Healthcare NHS Trust

Source: PHE (http://www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1195733750761) & (http://www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1195733750761)

Please note as of April 2013 Primary Care Organisations (PCOs) ceased to exist and were replaced by Clinical Commissioing Groups (CCGs). Therefore data published monthly is now reported by CCG rather than PCO. Archive monthly outputs reporting data to the end of March 2013 are still by PCO.

The numbers of blood infections caused by Meticillin resistant *Staphylococcus aureus* (MRSA) has been falling for a number of years, as seen in Figure 76 below. There have been 2 patients identified as having an MRSA blood stream infection reported as of October 2013.

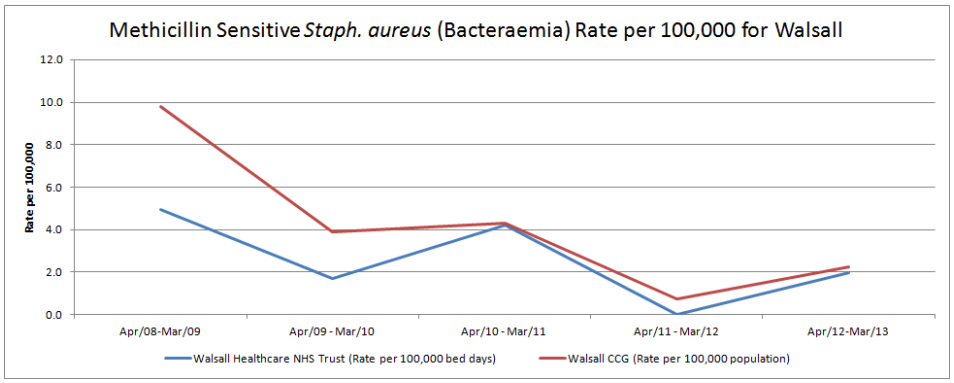


Figure 76 MRSA Infections per 100,000 population

Source: PHE (http://www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1233906819629)

* At the time of rates production PCO population estimates for 2012 were unavailable. 2012/13 rates are thus based upon 2011 population data.

An analysis of the cases of *Clostridium difficile* and MRSA blood stream infections (bacteraemia) has identified themes that are being addressed by the care providers within Walsall health economy. These include issues with antimicrobial prescribing, environmental cleanliness in healthcare and residential care home settings, adherence to infection prevention practices and improving communication between care providers.

Immunisation against childhood diseases

The uptake of childhood immunisations remains very high in Walsall at over 95%. This high uptake needs to be continued to ensure ongoing immunity within the Walsall population because there have been outbreaks of measles and whooping cough reported nationally. This year there have been changes in the vaccine schedule to include removal of the Men C vaccine at 4 years old to be replaced with a Men C vaccine for school leavers. This vaccine will be undertaken by the school nursing teams. A new vaccine was introduced in July 2013 to protect babies from rotavirus, this will be given at 3 months old. Finally a new shingles vaccine has been introduced for all 70 year olds with a catch up programme for 79 year olds.

Tuberculosis (TB)

Figure 77 shows the rates per 100,000 population since 2002 and shows a relatively stable picture whereas Sandwell and Wolverhampton appear to have increasing numbers.

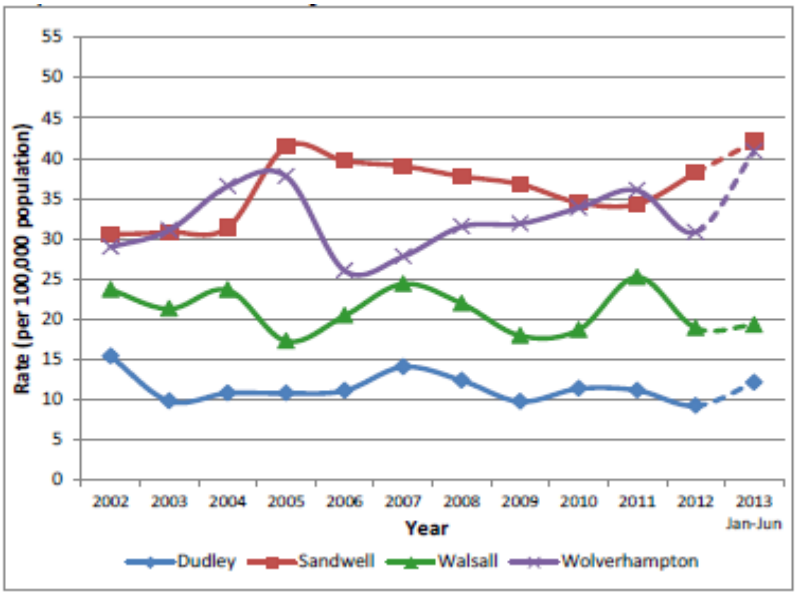


Figure 77 Tuberculosis rate per 100,000 population

It is essential that patients started on anti TB treatment complete the course due to the risk of developing resistance to the antibiotics. In 2012, 100% of patients who commenced on treatment finished the full course.

In addition to reacting to infections, proactive TB control involves identification of neonates at high risk of acquiring infection. Further work is required to ensure that high risk neonates are offered the BCG TB vaccine at the earliest opportunity.

Influenza

Last winter was another quiet flu season for England. However, some other countries experienced more severe flu, a reminder that flu can be dangerous and remains highly unpredictable. Figure 78 below shows the uptake of flu vaccine amongst the high risk groups compared to the achievements of surrounding organisations.

Org Name	Summary of Flu Vaccine Uptake %		
	65 and over	Under 65 (at-risk only)	All Pregnant Women
Birmingham East & North PCT	68.3	46.8	40.6
Coventry Teaching PCT	71.8	54.3	47.2
Dudley PCT	71.7	51.5	47.3
Heart of Birmingham PCT	73.5	52.9	34.4
Herefordshire PCT	71.6	52.1	43.6
North Staffordshire PCT	69.6	49.1	45.7
Sandwell PCT	67.2	48.0	40.3
Shropshire County PCT	72.8	53.5	55.2
Solihull PCT	71.3	46.3	44.0
South Birmingham PCT	70.2	46.2	37.4
South Staffordshire PCT	69.4	47.2	41.4
Stoke On Trent PCT	73.0	48.4	43.4
Telford And Wrekin PCT	72.4	53.1	53.3
Walsall Teaching PCT	71.5	49.9	37.6
Warwickshire PCT	73.9	53.0	46.9
Wolverhampton City PCT	70.2	49.9	48.9
Worcestershire PCT	72.9	51.2	45.2

Figure 78 Flu vaccine update summary by PCT

Our main challenges in Walsall are to increase the number of people under the age of 65 in at risk groups and pregnant women receiving flu vaccine this winter.

The flu vaccine programme seeks to protect high risk people from flu by vaccinating them and also their carers. Work is undertaken each year to encourage uptake of vaccine

amongst health and social care staff who have direct contact with patients. In addition a vaccine for 2 and 3 year olds has been introduced.

Health Emergency Planning

Public Health in the Local Authority will be responsible for ensuring plans and arrangements are in place to respond to emergencies involving a risk to public health. The Director of Public Health will lead both on ensuring all health protection plans are in place, and the provision of public health advice on health protection plans within the Local Authority.

Since transition a number of risks have been identified outlining gaps within response structures, roles and responsibilities, and the resources available in dealing with any incidents triggering risk to the health of the public.

A Health Protection Forum chaired by the DPH is in place to allow an assurance process to be carried out concerning health protection over internal and external partners in mitigating against these risks.

7.9 Chapter summary and key priorities for action

The development of long-term conditions and subsequent mortality follow a clear social gradient. Good evidence exists to support active prevention, early detection and treatment of the major causes of mortality. A re-energised local effort to put these actions in place systematically and robustly is needed to fully realise the potential for reducing the burden of disease in Walsall and the mortality rates from common conditions. Potentially 45% of the 670 cancers diagnosed in Walsall each year could be avoided by modifying simple lifestyle risk factors. In addition, heart disease, COPD admissions to hospital and days lost from work could be reduced dramatically from these same actions. The Marmot Review urges us to:

- *Prioritise prevention and early detection of those conditions most strongly related to health inequalities*
- *Increase availability of long-term and sustainable funding in ill-health prevention across the social gradient*

Priorities for action:

- *A sustained focus by individuals, communities and organisations on the BIG FOUR lifestyle changes which improve health, wellbeing and quality of life: stopping smoking, healthy eating, an active lifestyle and keeping alcohol intake to safe levels are essential to tackle the higher rates of illness and early death experienced by the people of Walsall (See Chapter 6)*
- *Making Every Contact Count (MECC), ensuring health and other staff use every opportunity to support and advise people to take up healthier lifestyles. Walsall offers a massive opportunity to develop this approach across all agencies: a few minutes each year of each member of staff's time can deliver enormous benefits. Organisations are urged to adopt this approach*
- *A renewed focus on the early identification of the risk factors of disease, including the aggressive identification and management of heart disease, e.g. through the National Health Service health checks programme – a primary prevention initiative which identifies those at highest risk of developing heart disease and puts actions in place to reduce those risks*
- *Promoting and developing all opportunities to improve self-care, through patient education programmes and telehealth for people with long-term conditions, giving patients and their families a larger stake and responsibility in the ongoing management of their condition. It also provides potential for better control of these conditions*
- *A clear focus on social support and rehabilitation and re-ablement will deliver benefits in terms of people returning to work following illness (e.g. stroke) as well as improved mental health. Investment in social worker input to clinical pathways often allows for early supported discharge and promotion of independence*
- *A clear and robust service for younger stroke sufferers needs to be commissioned and delivered within Walsall. This will increase the proportion of stroke sufferers returning to work within 6 (and 12) months*

- *All partners need to design and implement appropriate bed-based rehabilitation services within Walsall. This will maximise the regaining of function for stroke patients*

Chapter 8 Healthy ageing and independent living

The ultimate goal of prevention of ill health is not to extend life expectancy but to extend the proportion of each life lived in a healthy state. Improving lifestyles, prevention and early detection of disease and robust and effective treatment of illness will contribute to this aim. However, to fulfil aspiration for healthy living, people also need safe, secure environments, with financial assurance for their future years, independence, with support if required, and to be included in general society. Too many of our older people do not have these prerequisites for healthy older age.

National estimates suggest an increase in the number of older people (aged 65 years and over) in Walsall from 45,100 in 2010 to 50,400 in the year 2020. This poses particular challenges for Walsall to accelerate current actions to improve health with those in middle age, thus ensuring that good functioning is maintained as these citizens become older.

The key local issues:

- *There has been an increased number of falls in older people (particularly in institutional settings) with the resulting loss of independence*
- *Oral health – the first 4 years of age is a vital stage for oral health promotion for children and parents. The Care Homes Survey,2011 will provide valuable information on oral health for older people and will highlight where improvements can be made*
- *With the current and predicted rise in the number of people with dementia, the societal response has lagged behind. The proportion of people with dementia having an early diagnosis in Walsall has been one of the lowest in the West Midlands. Raising awareness of dementia amongst the population is a priority*
- *Excess winter deaths and fuel poverty – central government changed the definition in August 2013, and as a result, the percentage of households in Walsall that are fuel poor is less than regionally and has narrowed the gap with national levels*
- *High levels of older people living alone with no access to their own transport limits their ability to participate in a range of activities and often leads to social isolation. This in turn places added pressure and increased reliability on public transport.*
- *The refined Adult Social Care Operating Model, puts a stronger emphasis on prevention and early intervention as being the means by which most residents of Walsall with care and support get their initial help*
- *Making use of results and analyses from the 2012 Lifestyle survey will provide a valuable insight into what people's views are on quality of life, wellbeing and future aspirations. This potentially leaves gaps in any strategic service planning*
- *Crime can have a serious impact on the health and wellbeing of victims, particularly the elderly and vulnerable. It may adversely affect pre-existing health conditions, reduce confidence and the ability to live independently*

This chapter addresses healthy ageing, focussing on extension of independent living and end of life care in Walsall.

8.1 Health and Social Care Integration

Walsall has one of the most deprived urban populations in the UK. Despite the foundations having been put in place to significantly improve the care of older people, the current system lets down these individuals and their carers; most care, inappropriately, remains institutionalised. Current demand for emergency admissions has also increased over the last year by about 14%. The vision is that by 2018, the older people of Walsall and their carers will experience a largely home-based model of care, centred around the specific needs of individuals. The approach is to work in partnership, building on the successful parts of the system we have got right and taking steps to systematically implement a transformation at scale and pace. **We envisage integration as a means to designing the health and social care system to deliver the outcomes we have all agreed**. This is summarised in the diagram below.

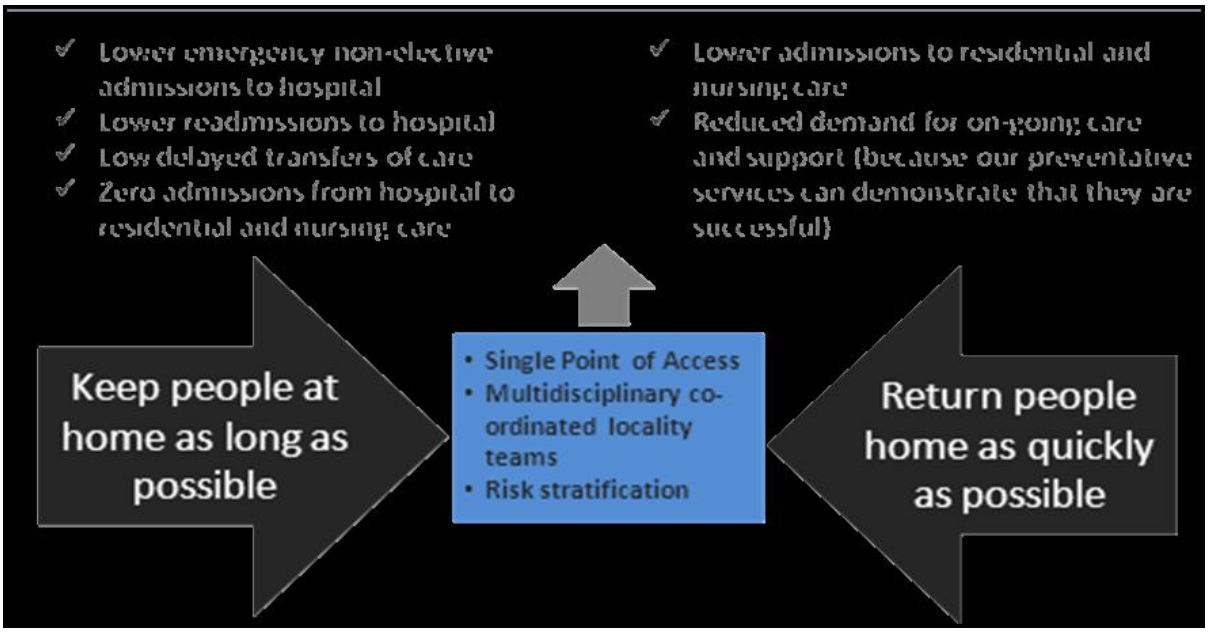


Figure 79 Walsall Health and Social Care Integration approach (Source: Health and Wellbeing Board paper on Health and Social Care Integration

Integration and the Frail Elderly

In order to reduce health inequalities Walsall CCG, Walsall Council, Walsall Healthcare NHS Trust and Dudley and Walsall Mental Health Trust recognises there is a need to achieve a more rapid improvement in health and well-being for people living in the deprived areas than those living in the more affluent, but this cannot be achieved without meaningful input and ownership from the population served. This ownership and contribution from local people would provide the input and creative solutions needed to generate positive changes to health and in turn impact on aspects of community life which are themselves determinants of health.

A range of measures demonstrate that older people in Walsall are high users of institutional care, receiving much of their treatment and care away from their homes in bedded facilities provided by general acute hospitals, mental health hospitals, nursing and residential homes. Walsall's Health and Well- being Strategy sets us the challenge of changing the way in which we use resources so that there is a better balance between ensuring those that need acute

services get the quality they need but that overall the health and well-being of the population can improve so that fewer people need institutionalised care.

The response to this seemingly enduring challenge which produces poor outcome and experiences for people is twofold:

First: responding to the identified individual needs of older people, the core skills and competences traditionally provided by professionals in primary, secondary and social care, will be combined in teams with the skills of others including community volunteers and the unpaid contributions of carers, to enable to people to live well at home. For people with high care needs, there will be an intensive community response available to care for them at home where possible.

Second: even in a transformed model of care for older people which is largely home-based, some people will need short periods of inpatient care. To respond to these specific short term needs, there will be an integrated team of professionals with health and social care competencies, to swiftly and safely transfer people back to their homes by accessing a range of services and/or interventions which give people the ability and confidence to live as independently as possible.

Indicators

The local health and social partnership has a track record of achieving whilst working together. For example we have achieved the following results: -

Frail Elderly

a) Reduced average length of stay from 13.8 day to 10.5 days in the frail elderly over 3 year period
b) Reduced the number of bed days by 15% from 7,989 days to 6,680 days over a 3 year period

Trauma Orthopaedic Musculoskeletal

a) Reduced the average length of stay from 14.10 days to 5.8 days over a 3 year period
b) Reduced the number of bed days by 57% from 1498 days to 642 days over a 3 year period

During this programme of work specific measures of outcomes and experiences relating to individuals receiving services and their families/carers, will be developed. Nevertheless all partners are agreed that the key outcomes which we will use as our measures of success for our integration programme are the following: -

- Lower emergency non-elective admissions to Hospital
- Lower readmissions to hospital
- Low delayed transfers of care
- No admissions from hospital to residential and nursing care
- Lower admissions to residential and nursing care

- Reduced demand for on-going care and support (because our preventive services can demonstrate that they are successful)
- Evidence that our investments in commissioning health and social care can demonstrate that they are delivering their intended outcomes for the people of Walsall.

Priorities for action

- *We will review the Hospital Integrated Discharge Team to enhance its effectiveness and clarify the range of services available for patients through a **single point of access**.*
- *We will utilise a tool that will **risk stratify patients** using a range of health and social care datasets – this process will allow us to understand individual needs of people to enable them to stay at home*
- *We will further develop multidisciplinary coordinated Locality Teams.*

Further Information on Integration proposals in Walsall then follows the link below.
http://www2.walsall.gov.uk/CMISWebPublic/Binary.ashx?Document=13543

8.2 Maintaining mobility and preventing falls

Maintaining mobility is dependent on good bone health and is central to healthy and independent ageing. This requires a systematic approach to prevention and treatment of bone disease starting in the early years.

Indicators:

Hospital admissions with hip fractures.

Whilst a number of agencies are working to reduce the number of people who fall and who suffer injury from falling, there remains a need for a more systematic approach to the prevention of fractures.

There are clear preventative actions which will improve bone density and strength, leading to reduced risk of fracture in older age. Exercise is one of the most effective ways to maintain independence and to reduce balance problems. Anything that challenges balance and improves muscle strength, particularly in the legs, can help to reduce falls i.e. walking, gardening and dancing. In addition to this, taking regular eye tests, which are free for those aged 60 or over, will help to reduce the risk of falls.

Opportunities for older people to maintain bone strength are often limited by access to transport, lack of provision, fear of going out or social isolation. Professionals have adopted approaches to 'spot' risks in the home and to address these. However, other concurrent

risk factors may not be addressed if their solution is in the domain of a different agency or individual.

As those who have fallen and sustained a fracture are at the highest risk of further fractures, all actions to prevent this should be put in place for all individuals. This includes changes to the physical environment, the person's physical condition and medication.

Walsall has a higher rate of emergency admissions for fractured neck of femur compared to regionally and nationally for those aged over 65 and those aged 65 to 79.

	65+			65 to 79		
	Walsall	West Midlands	England	Walsall	West Midlands	England
2010/11	463.11	461.02	451.89	208.44	229.10	224.24
2011/12	480.15	463.34	457.16	201.89	223.58	222.17

However, the increase in admissions for those aged 80 and over is more noticeable from a rate of 1609.12 in 2010/11 to 1732.35 in 2011/12 and is greater than regional and national rates.

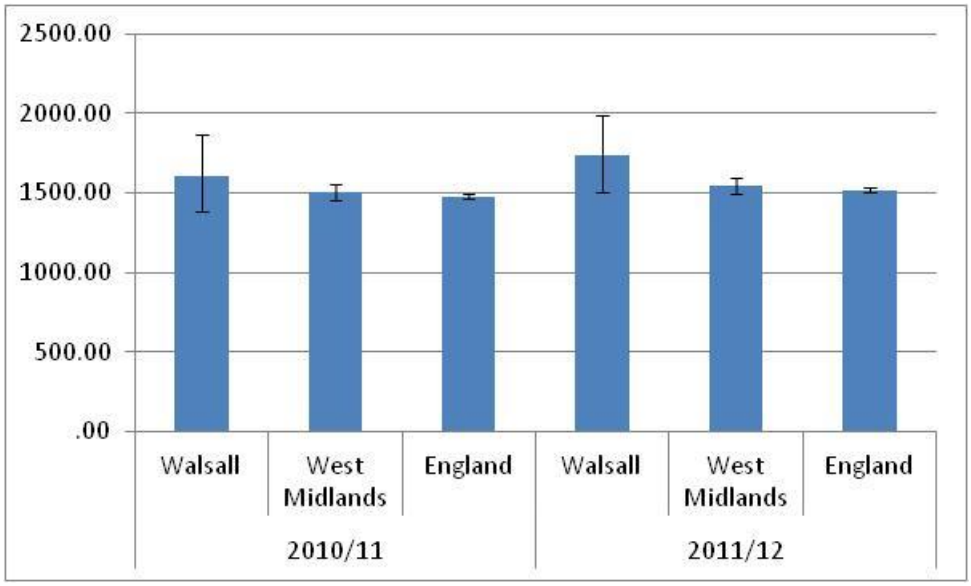


Figure 80 Age-sex standardised rate of emergency admissions for fractured neck of femur in those aged 80+ per 100,000 (Source: Public Health Outcomes Framework)

Priorities for action:

- *Focus on preventing falls through activities which improve stability, mobility, flexibility and coordination over the life course*
- *There remains a need for a more systematic approach to the prevention of fractures*
- *Hospital staff should ensure all patients seen with low impact fractures are appropriately assessed for fall and fracture risk and managed appropriately*
- *All agencies should be clear of their role in improving bone health*
- *Promotion of free eye tests for over 60s*

8.3 Adults Oral Health

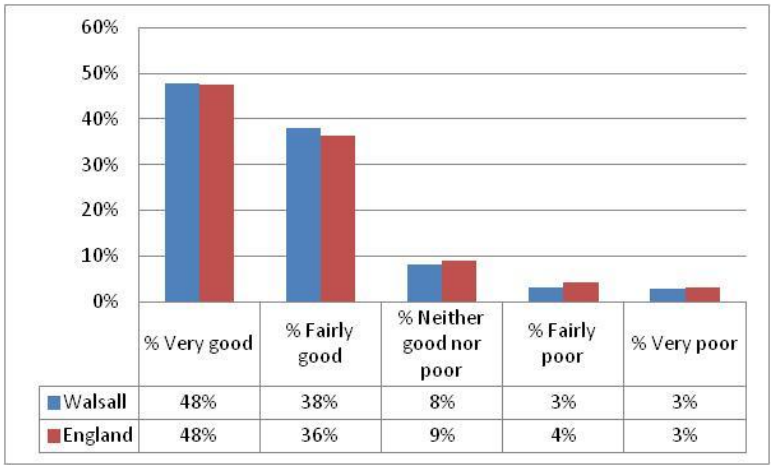
Oral health epidemiological studies are not generally carried out within adult populations leading to a lack of robust local data. However, data from the national 2012/13 GP Patient Survey is available as well as the 2011 West Midlands Dental Epidemiology Programme – Survey of Care Homes. Both of these will provide valuable data locally in terms of developing a picture of dental health within the adult population and amongst residents within care homes in Walsall.

The national 2012/13 GP Patient Survey included a section on NHS dentistry and asked patients (aged 18 and over) about their recent experiences.

	Last 3 months	3 and 6 months	6 months and a year	1 and 2 years	More than 2 years	Never
Walsall	22%	16%	14%	10%	17%	21%
England	23%	16%	13%	8%	18%	22%

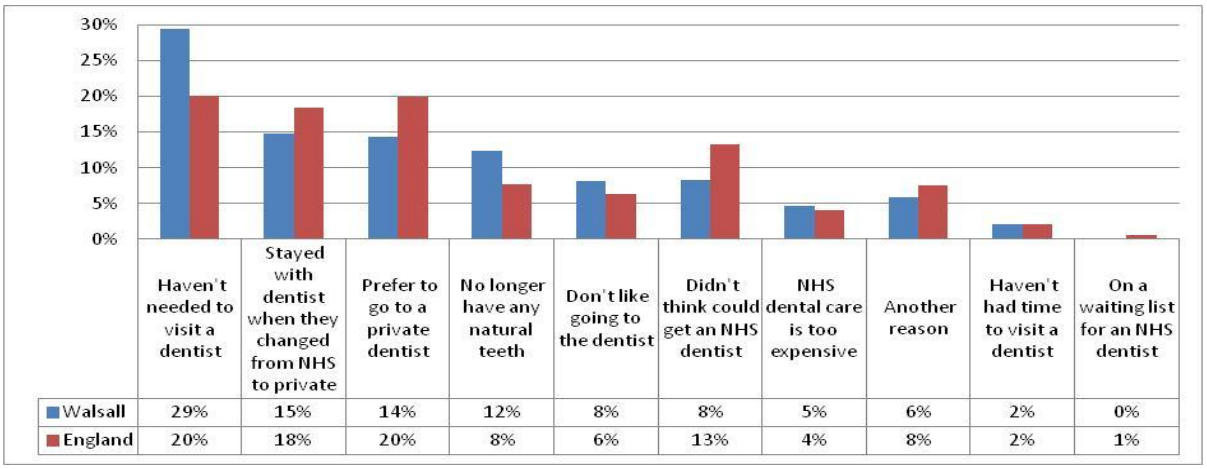
When asked about the last time a patient tried to get an NHS dental appointment, the majority of respondents in Walsall (22%) had done so in the last 3 months (23% nationally). 21% had never tried to get an appointment (compared to 22% nationally).

In terms of patients overall experience of NHS dental services, 86% of respondents' experiences were positive (very or fairly good). This is on a par with national figures.



	% Very good	% Fairly good	% Neither good nor poor	% Fairly poor	% Very poor
Walsall	48%	38%	8%	3%	3%
England	48%	36%	9%	4%	3%

The reasons respondents gave as to why they haven't tried to get an NHS dental appointment in the last 2 years varied. The most popular response in Walsall was 29% of residents felt they haven't needed to visit a dentist. Further work needs to be carried out in Walsall to encourage residents to have regular checkups and communicate the importance of doing this as a means of preventing possible problems from developing later in life. If adults were to do this, this would set precedence for their children and would positively encourage them to visit the dentist regularly as well.



	Haven't needed to visit a dentist	Stayed with dentist when they changed from NHS to private	Prefer to go to a private dentist	No longer have any natural teeth	Don't like going to the dentist	Didn't think could get an NHS dentist	NHS dental care is too expensive	Another reason	Haven't had time to visit a dentist	On a waiting list for an NHS dentist
Walsall	29%	15%	14%	12%	8%	8%	5%	6%	2%	0%
England	20%	18%	20%	8%	6%	13%	4%	8%	2%	1%

Gum disease (predominantly caused by a major build up of plaque on the teeth) is the primary cause of tooth loss in adults. 54% of the English population have a significant level of gum disease and child oral health surveys suggest that this will be higher in Walsall.

In terms of general oral health, there are two issues, the impact of poor oral health on the general health of people with long term conditions and vice versa, the impairment from the long term conditions directly affecting that persons oral health. An example being a person who has had a stroke may have difficulty in brushing their teeth and gums. Gum disease has been evidenced to systemic health including coronary heart disease, strokes. People with diabetes are at a higher risk of developing oral health problems and it appears that there is a correlation between levels of gum disease and glycemic levels.

Using synthetic analysis it is possible to determine that approximately 65% of adults currently over the age of 75 living in Walsall will have lost all their teeth. Communicating the message of good oral health is vitally important to help prevent gum disease developing.

Across the UK, 6,500 people are diagnosed each year and without early detection half of those will die, early detection can improve survival rates by up to 90%. Locally, this would equate to approximately 27 people. The groups of people at risk of mouth cancer are more diverse than they have ever been. It has traditionally been a risk for older people but new research shows a younger population are increasingly at risk. Smoking, alcohol and a poor diet are the main risk factors for mouth cancer and people who smoke and drink alcohol excessively are up to 35 times more likely to develop the disease.

Figure 81 below show a downward trend in oesophagus incidence for males and females. Rates are considerably higher amongst men (16.9) compared to 4.8 in women and further work needs to be done to reduce the gap between Walsall and England, particularly amongst men.

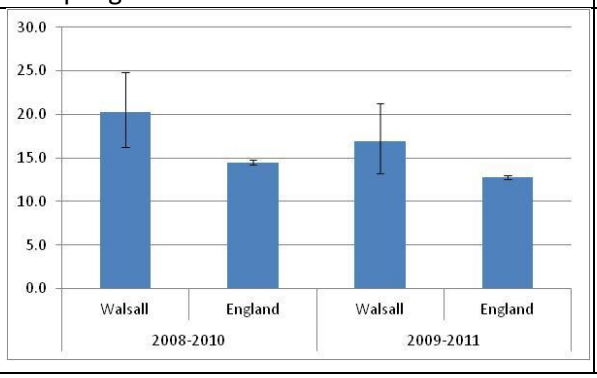
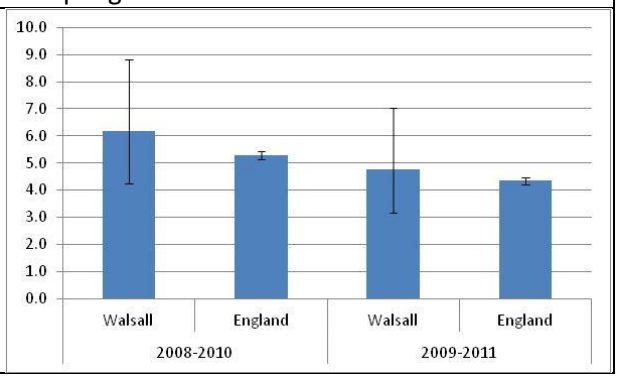
Oesophagus Incidence – Males	Oesophagus Incidence – Females
	

Figure 81 Source: National Cancer Intelligence Network (NCIN), UK Cancer Information Service (UKCIS), Accessed: June 2013

Those in long term institutional care can be vulnerable. This includes older people in residential homes who are often dependant on others for their diet, personal care and access to health services. As more older people retain their teeth for longer, their dental needs increase with root decay being a particular problem for this section of the community and can be difficult to treat.

Care home residents are not included in the National Adult Dental Health Survey, however in Walsall, the 2011 Survey of Care Homes took place in 73 care homes across Walsall of which 44 responded (60%) and have a combined number of 1,039 beds. The care homes cover a number of self declared categories, but the most common include dementia, learning disability, old age only and physical disability. The key points from the survey include:

- In relation to dental issues within the 44 care homes who responded, 30 report that an oral health assessment is included in their admission process – Walsall has the highest proportion of care homes that include such an assessment amongst all Local Authorities across the West Midlands.
- Access to dental services varies with 45.5% (20) having a dentist visit the care home, 32% (14) residents visit the dentist and 23% (10) combine both.
- 77% (34) of care home residents reported having access to urgent dental care
- Only 7 of the responding care homes reported a problem in accessing dental services, the remaining 36 had no problems at all.
- 39 care home managers reported no issues or concerns with dental providers; with 3 reporting an issue or concern.

The results from this survey will help shape and guide dental needs amongst older people and those within care homes.

Priorities for action:

- *Concentrate our oral health promotion activities on the elderly, both in the community and care homes*
- *Building on the strengths of current oral health promotion and link these messages to general health and wellbeing so that oral health improves and contributes to overall health improvement*

- *Building community and dental practice capacity to promote oral health, through training and development of members of the community and dental practice teams*
- *To lead oral health promotion efforts so that self care messages are understood and reinforced by all*
- *Utilise the provision in the existing general dental services contract, to commission services that are preventive in nature. This approach could help reduce the burden of treatment for Walsall residents. By intelligent contract monitoring evaluation it may be possible to assess the impact of this preventive approach*
- *Identify and help Walsall residents who still cannot gain access to dental services by monitoring calls to Customer Care Services.*
- *Ensure that no one in Walsall endures chronic or acute dental pain and those experiencing pain are seen within the current national target time of 24 hours*
- *Target evidenced based treatments that can prevent dental decay and periodontal disease who need them most*
- *Make use of the findings from the* 2011 West Midlands Dental Epidemiology Programme – Survey of Care Homes
- *To review the release of planned 3 year old epidemiology data expected summer 2014*

8.4 Dementia

Dementia presents a huge challenge to society. There are currently 800,000 people in the UK with dementia and there are estimated to be 670,000 family and friends acting as primary carers. There will be over a million people in the UK with dementia by 2021. The current financial cost of dementia is £23 billion a year to the NHS, local authorities and families and the cost will grow to £27 billion by 2018. In the next 30 years, the number of people with dementia in the UK will double to 1.4 million and the cost of caring for these people will rise to a staggering £50 billion a year. These are the economic costs, the cost to individuals and their families are much more profound.

Dementia affects 1 in 6, 80 year olds and 1 in 14, over 65 year olds. Women aged 75 or over are more likely to develop dementia than men. People from black and minority ethnic communities are three times more likely to develop a young onset dementia (before the age of 65) in the West Midlands.

The National Dementia Strategy: Living Well with Dementia was a five year strategy to improve outcomes in dementia which will come to an end in February 2014. Commissioners are currently developing a local dementia strategy for Walsall.

In March of 2012, the Prime Minister issued three challenges on dementia to be addressed by March 2015. They were:

- Driving improvements in health and care
- Creating dementia friendly communities that understand how to help
- Better research

The Prime Minister's ambition is to raise the diagnosis rate from the national average of 44% to 66% by March 2015.

Indicators:

Walsall has an estimated prevalence of over 3,106 people with dementia (2013-2014). Of these, 43% have a diagnosis of dementia. Walsall's diagnosis rate has increased from 28% four years ago, where it was the lowest in the West Midlands, but his is no longer the case.

Long waiting times for assessment resulted in a significant number of people not receiving their diagnosis during 2012. If those people had received a diagnosis during this period, the diagnosis rate could have been as much as 47%. These issues are being addressed in a new model Memory Assessment Service, with an additional 11 staff and crucially, will seek to address the biggest criticism of lack of support when first diagnosed.

Six Personal Assistants in Dementia will work with people for several months after diagnosis. They will provide practical help such as applying for benefits to pay for additional help at home, provide information, support and signpost to other forms of support such as Dementia Advisors and Dementia Cafés.

Some of the other ways we are trying to improve the diagnosis rate include:

- GP and practice nurse education
- Emphasising the benefits of diagnosis in Primary Care
- Ensuring the GP dementia lists capture all patients diagnosed with dementia
- The development of a desktop tool to support GPs
- A Dementia Friendly Communities programme to make Walsall a more dementia friendly place to live by working with businesses and organisations who are public facing
- Upstream interventions which help to identify people who are not yet diagnosed
- Encouraging GPs to sign up to a dementia directed enhanced service; and
- Dementia awareness campaigns – working with partners to extend to a wider range of people

The Dementia Prevalence Calculator, created by Dementia Partnerships, enables health and care communities to gain a better understanding of their local estimated prevalence of dementia in the community, and among people living in care homes. It allows General Practices and Commissioners to establish a baseline by which to set and work towards local quantified ambitions for improvement in diagnosis rates, as set out in the NHS Mandate 2012, and inform local joint strategic planning, commissioning and service redesign and improvement.

Improving dementia awareness amongst health care professionals was identified in the previous JSNA as an opportunity and steps have been taken across Walsall to improve the workforces' knowledge of dementia. Four training modules have been developed in partnership between the council, Manor hospital and mental health staff, which are offered free of charge.

Raising the public's awareness of dementia and reducing stigma are now a priority. To support this, documents in English and five South Asian languages have been developed and interpreted and recorded as podcasts. A video is offered in several languages and will be available via the Walsall dementia website which is being refreshed following the change from a PCT to a CCG.

Reducing the prescribing of antipsychotics for dementia continues to be a priority with a further audit planned. Walsall has reduced the prescribing of antipsychotics by 50% so far. Work continues in supporting care homes, hospitals and GPs to reduce this further with the development of tools, guides and the support of pharmacists.

Priorities for action –

- *Reduce the risk of developing dementia by improving healthy lifestyles will lower the prevalence over time. The message of 'healthy body, healthy mind' needs to be reinforced at every opportunity*
- *Ensure all strategic plans recognise the increasing prevalence of dementia and the required financial investment to support this*
- *All health and care providers should demonstrate how they improve the quality of care and dignity for patients with dementia who are under their care*

- *Continue the integration agenda to create more seamless services for people with dementia and their carers*
- *Continue to support carers by further developing the Dementia Advisor and Dementia Café role*
- *Continue to support the Manor hospital in its dementia care improvements*
- *Commissioners to work with mental health service providers to review the current inpatient wards and day hospital and develop an options appraisal to offer alternatives to address the changing need*
- *Continue to expand the Dementia Friendly Communities programme which has seen several services successfully receive the NHS Walsall CCG and Walsall Council dementia kite mark certificate*
- *Commission more extra care and support for living at home services that give people more confidence to remain at home longer, particularly for those people with dementia*
- *Commission a range of individually commissioned bed based services, where appropriate, which best meet the needs of the individual with dementia and particularly where there is challenging behaviour*
- *Commission services which address the gaps in dementia provision in Walsall: crisis services to prevent un-necessary hospital and care home admission, intermediate care, working age dementia services and alcohol related dementia*
- *Improve end of life care in dementia*

8.5 Excess seasonal deaths and fuel poverty

Excess winter deaths relate to the difference between the number of deaths during the four winter months (December-March) and the average number of deaths during the preceding autumn and summer (April-November). These deaths are of those people who would not have been expected to die due to illness or old age in the following few weeks or months. Many of these deaths are amongst older people, especially women, and those with underlying health problems. People living with underlying heart, circulatory or lung disease are at the highest risk. Excess seasonal deaths may also occur in the summer months due to excess heat.

Cold related illnesses severely affect cardiovascular and respiratory ailments. The provision of a warm home alleviates these ailments and combats cancer, heart disease, stroke and depression.

- *Each one degree Celsius decrease in average winter temperature results in 8,000 additional winter deaths in England. Death rates increase steadily and linearly for each degree Celsius below 20ºC. The impact on health is exacerbated for vulnerable individuals and the colder the temperature the greater the risk of harm:*
  - *Temperatures that are lower than 16 degrees appear to impair respiratory functions.*
  - *Temperatures below 12 degrees place strain on the cardiovascular system.*
- *Temperatures below 6 degrees place people at risk of hypothermia.*
- *Nationally, mortality rises 18% during the winter months. In a bad winter, this could amount to an additional 50,000 deaths. During winter 2010/2011 there were 27,500 excess winter deaths*
- *However, these deaths are preventable; some countries with more extreme weather conditions than the UK experience fewer winter-related deaths. For example, Finland has 45% fewer winter deaths than the UK*
- *After cold weather, it takes 40 days for levels of illness and death to return to normal*

Contributory factors to excess seasonal mortality include:

- *circulatory diseases (including heart attack and stroke), accounting for around 40% of excess winter deaths*
- *respiratory illnesses such as bronchitis and pneumonia, which make up around a third of excess winter deaths*
- *inhaling cold air, causing airways in the lung then to narrow and produce phlegm, worsening chronic lung disease and asthma*

Deaths related to heart problems peak after 2 days, stroke deaths after 5 days, and respiratory deaths peak 12 days after the coldest weather.

The inability to heat a home sufficiently can result in fuel poverty. A household is in fuel poverty if:

- they have fuel costs that are above average (the national median level)

- were they to spend that amount they would be left with a residual income below the official poverty line

Fuel poverty frequently affects people from vulnerable groups that already experience a disproportionately higher level of general poverty and deprivation. These groups include older people, households containing children (including lone parents), households with large adult populations, vulnerable groups (including disabled people), and single person households.

In Walsall there has been a general reduction of those households living in fuel poverty and as at 2011 16.7% of households in the borough were in fuel poverty compared to 22.6% in 2008.

Households in Fuel Poverty	2008	2009	2010	2011
Walsall	22.6%	27.4%	22.6%	16.7%
West Midlands	18.2%	26.2%	21.6%	16.9%
England	15.6%	18.4%	16.4%	15%

Figure 82 Households in Fuel Poverty (Source: www.gov.uk)

The decrease in fuel poverty in England between 2010 and 2011 was the result of a rise in income, and a reduction in energy use, through improvements in the energy efficiency of housing. These two things combined to offset the price increases seen in 2011.

In 2011 the borough had 1 Lower Super Output Area (LSOA) in the highest 1% of fuel poor in England and 33 (20% of the boroughs LSOAs) within the highest 5% of fuel poor. By 2012 this had reduced to none in the highest 1% and only 1 in the highest 5%.

Walsall residents have the right to live in safe and secure homes. In order to achieve this, a number of measures targeted at tackling fuel poverty and improving the quality and energy efficiency of existing and future homes are being delivered across the borough. The 'Health Through Warmth' programme offers to help vulnerable people who have long term, cold related illnesses and need assistance to fund and install heating and insulation in their homes. Working in partnership with governing bodies, community workers, charities, the NHS and Local Authority ensures more vulnerable people can be identified to receive help.

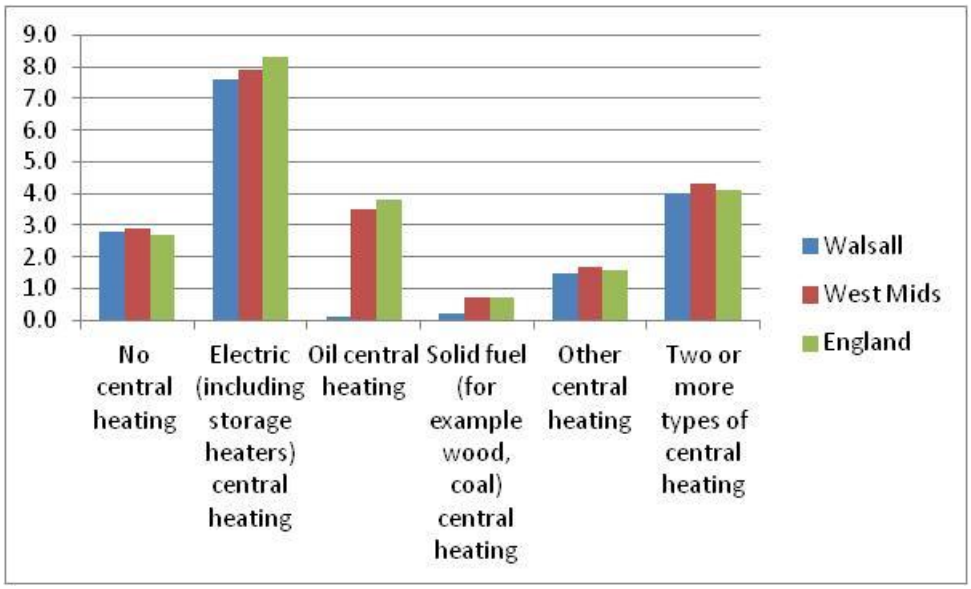


Figure 83 Households in Walsall with / without central heating (Source: 2011 Census)

The majority of households in Walsall have gas central heating fitted (83.8%) which is greater than regional and national levels of 79% and 78.8% respectively. Less than 3% of households in Walsall have no form of central heating (compared to 2001, this figure is much improved from 14%).

Key data source is The Health Impacts of Cold Homes and Fuel Poverty, Marmot Review Team.

Indicators:

The primary indicator is Excess Winter Deaths (EWD):

Excess Winter Deaths (EWD) have fluctuated over the last few years, which is to be expected as the weather is a determining factor. Current figures for 2010/11 are higher in Walsall (21.2, equivalent to 160 deaths) compared to regionally and nationally (18.2 and 17.0 respectively).

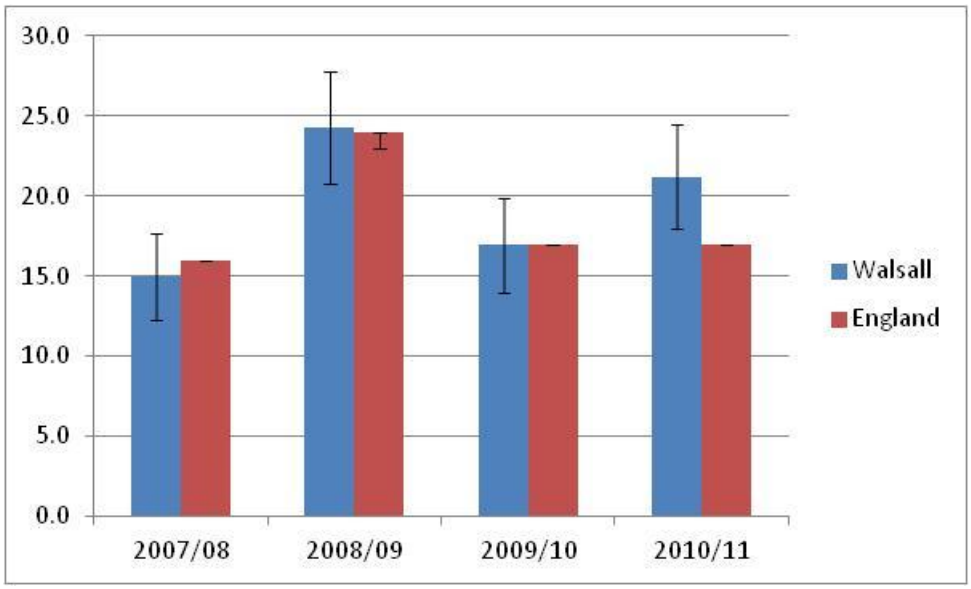


Figure 84 Excess Winter Death Trends (Source: ONS)

Priorities for action:

- ***Reducing illness especially for vulnerable groups during winter*** *- NHS Walsall undertakes a comprehensive and proactive annual flu-jab initiative supported by the council and other agencies to maximise the number of vulnerable residents immunised against influenza*
- ***Increasing energy efficiency of homes*** *- Improving the energy efficiency of homes is an essential step to reduce the number of households in fuel poverty*
- *Collectively work together to reduce unit costs of energy*
- *Build on what has been achieved to date in Walsall over the last 5 years*

8.6 Independent living and quality of life

Older people want, and have a right to be able to live their lives as they wish, feeling safe, taking part in society and being able to choose how and when they are supported. In addition, being able to decide when they need to access public services and equality of citizenship in every aspect of their lives, from housing to employment to leisure.

Good health deteriorates with old age and the recent 2012 Lifestyle Survey supports this. The survey also reveals 27% of the Walsall population claim to suffer from a long standing health problem or disability (including problems which are due to old age), which results in them having substantial difficulties doing day to day activities or work. 2011 Census information tells us there are 12.8% (13,845 over 65's) who are living alone, of these 65% do not have access to their own transport (this compares to 58% nationally). It is vitally important that these people are supported when needed to continue to live independently and to have a good quality of life. The Link Line programme in Walsall provides contact, friendship and support to elderly people across the borough through phone calls, home visits, shopping trips, small jobs in their homes as well as providing access to other agencies. Current members have praised the service – "The Link Line is my life line."

The Adult Social Care Operating Model, which came into effect September 2013, puts a stronger emphasis on prevention and early intervention (stages 1 to 4) as being the means by which most residents of Walsall with care and support needs get their initial help.
Evidence suggests that people wish to stay in their own homes for as long as possible and in older age face declining years surrounded by family and friends. This operating model is now focused on achieving outcomes and changing cultural outlooks; primarily a way of looking at disability, aging and capacity that maximises individual and community assets, focusing on prevention and not solely an approach to the provision of services.
The change to the operating model would mean that all new customers (and some existing customers) will be channelled through a range of "preventive" services before they are assessed for longer term care and support. These services are designed to offer an immediate response to the person seeking help in a way that looks at options in which they can be assisted without necessarily assuming that they will need longer term help if this first intervention can resolve their problems. The success of "preventive services" would then be demonstrated by fewer people needing long term help but people still getting their needs met in a timely and appropriate manner.

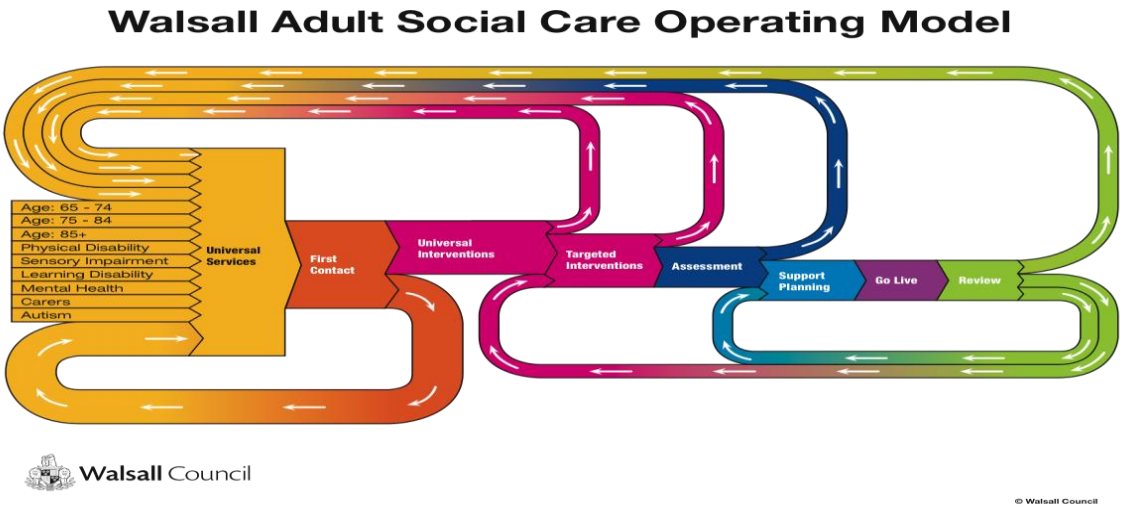


Figure 85 Walsall Adult Social Care Operating Model

There are a vast number of preventative services which are currently offered in Walsall for example community alarms (assistive technology), sensory support services and crisis response teams.

The Health and Wellbeing Strategy outlines the 4 different types of preventative services that need to be in place. There are 4 different approaches to prevention identified:

1. Universal provision
2. Services that are for people who have some needs but not critical enough to warrant an assessed social care intervention
3. Services that support recovery, rehabilitation and recuperation which reduce the need for high intensity care
4. Services that sustain a level of independence over time thus deferring the point at which people require the need for high intensity services

The implementation of this model will result in an intended outcome of a reduction of the numbers of older people being admitted into residential care (temporary or permanent basis) and a small reduction in people needing packages of long term care in their own homes.
However, there are still many people living relatively isolated lives, with little social contact and not always receiving the support services they need, either through ignorance (of themselves, families or professionals) or through lack of joined up work across agencies. In addition, as mentioned in preceding chapters, approaches to reduce disease and disability in earlier life are likely to lead to healthier older people, more able to participate actively in society. Efforts to improve the social, financial and physical environment will help to increase the proportion of older people living independently.

Exploration has been made in relation to Extra Care / Dispersed Supported Living developments in Walsall. A Balance of Care Provision report identified Darlaston South and Bentley areas to be potentially suitable and 13 sites have been identified. Further work is currently being undertaken to explore these possibilities further.

Should such developments go ahead, these would contribute significantly to the Adult Social Care Operating Model in maintaining people within the community.

Indicators:

- *Permanent admissions to residential and nursing care homes per 1000 population*
- *Readmissions to hospital from care homes and rehabilitation services*
- *Health related quality of life for older people – definition and data collection required*
- *Percentage of older people who leave their homes only once per week (or less) – Age UK data*

Priorities for action:

- *All agencies in Walsall should ensure opportunities to maximise income for older residents*
- *Specific work should be conducted in 2012 to ascertain the views of older people on quality of life, independence and wellbeing so that our objectives can be clearly aligned to the expectations of our population. This work should ensure that the views of those older people who are socially isolated are specifically included*
- *Opportunities to make services which support wellbeing more accessible to older people*
- *The Health and Wellbeing Board should agree strategies which ensure people, irrespective of illness or disability can exercise maximum control over their own life*
- *Support services for carers should be developed to improve their quality of life and the likelihood of them continuing their caring role.*
- *Rehabilitation and reablement services should be available rapidly when required to support all those who suffer temporary reduction in function to prevent this becoming permanent*
- *Commissioners should review and monitor key data on admissions from care homes to hospital at the end of life and readmissions to hospital within 30 days of discharge*
- *Implement the Adult Social Care Operating Model*
- *Continue to work towards the possible Extra care / Dispersed Living Developments*

8.7 Carers

Walsall has a higher than national percentage of people living with a long term health problem or disability where residents are limited a lot or a little in their daily activities (20.7% compared to 17.6%). Many of these will require support from families and friends which is often unpaid, and many will have health or social needs of their own. In 2001, 10.6% of the population in Walsall were caring for someone with a long term illness (11% nationally). This figure has increased in Walsall to 11.6% in 2011, with the national rate staying the same.

2011 Census respondents claim to be limited a lot in their day to day activities due to their health problem or disability in the highly deprived areas of Blakenall, Birchills and Bloxwich as well as the not so deprived area of Brownhills and pockets of Aldridge.

Walsall Carers' Strategy 2012-14 - Making Carers Count identified over 27,000 residents are carers (1 in 10), with over half aged 50+. A range of carers across the borough were contacted to gain an insight as to what caring is like. In addition, to identify what carers need and to ensure they have a voice and will be listened to. Carers identified what is important to them:

C Come and find us, understand our role. Concentrate on the things that matter to us.

A Ask us about our experiences. Appreciate us. Accept our criticism. Assess us quickly.

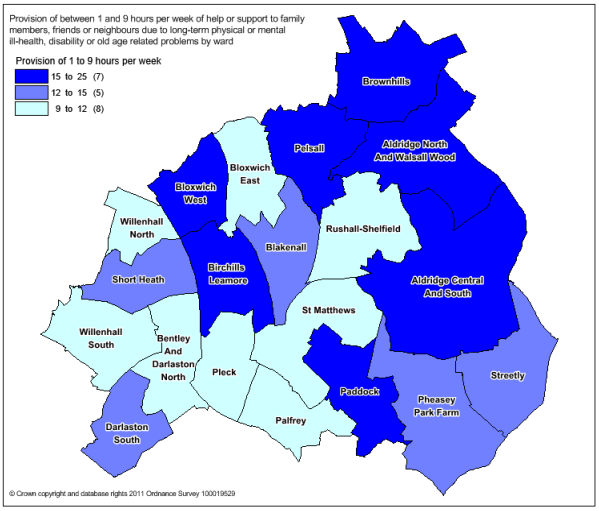
R Really listen to us. Respect the contribution we make to our communities and our council.

E Experts don't come any better than us. Expect us to shape your services. Enable us to have a life.

R Rest and Relaxation is what we need. Respite. Replacement care that is "gold standard".

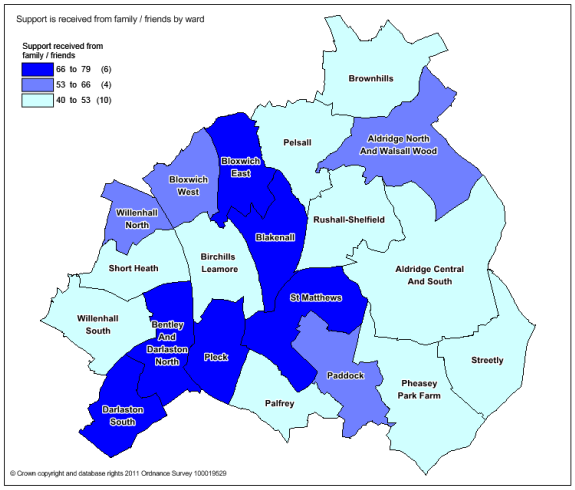
S Support us to be able to work if we are able. Show us realistic financial support if we are not.

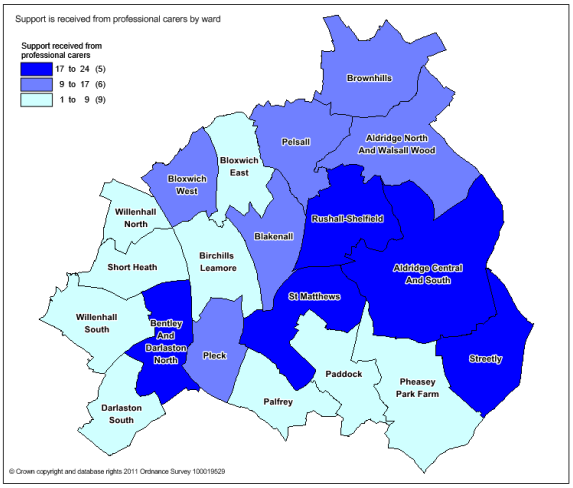
The 2012 Your place, Your Wellbeing: Walsall Household and Lifestyles survey contained specific questions on caring responsibilities and using this local data will provide a clearer local picture of this group of people and provide more of an insight as to how many residents are offering unpaid care to a relative, friend or neighbour.



In Walsall, 31% of respondents offer care ranging from 1 to over 50 hours per week (69% provide none at all). Of these, the majority provide 1 to 9 hours (14%) with respondents living in Aldridge North and Walsall Wood (25%) and Pelsall (21%) greatest compared to 9% of respondents living in Bloxwich East and Rushall-Shelfield.

Of those respondents who provide some care to a family member, friend or neighbour, half receive added support from other family members or friends compared to 39% who do not receive any other support.
Geographically, Bentley and Darlaston North (79%) and Darlaston South (73%) are the top 2 wards with the greatest proportion of respondents who receive additional support from family / friends.

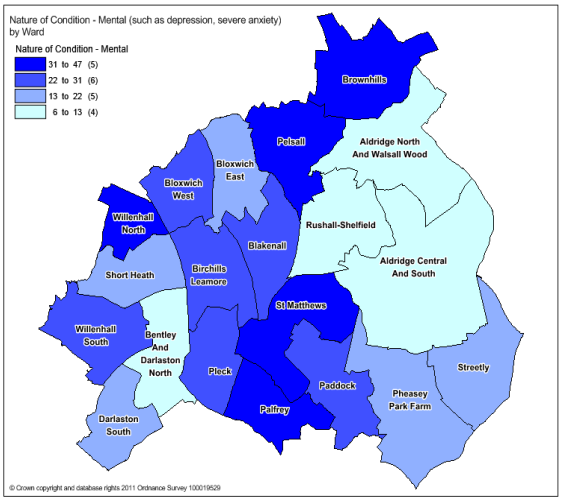


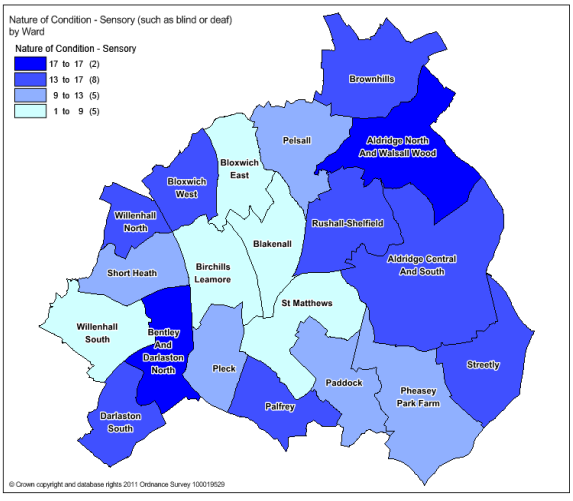


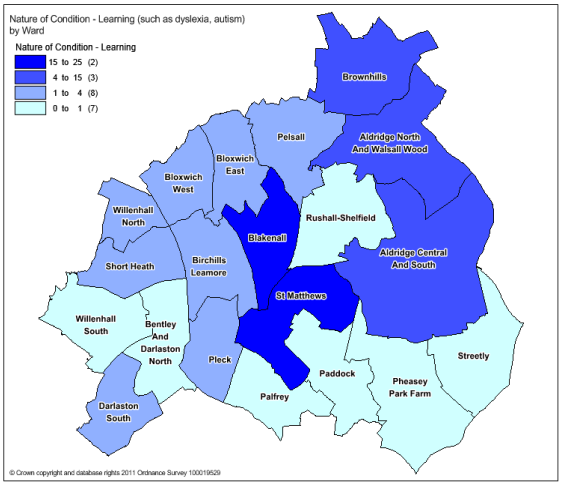
Professional carers also offer support – 13% of respondents claim to receive it. Geographically, respondents use of professional carers is greatest in Bentley and Darlaston North (24%), Aldridge Central and South ward and Streetly (21%).

When asked what the conditions the person being cared for has, the majority (40%) are longstanding, 37% are physical and 32% other, with the top 3 wards for each condition being as follows:

Longstanding	**Physical**	**Other**
Bloxwich West (59%)	Aldridge North & Walsall Wood (58%)	Aldridge North & Walsall Wood (46%)
Rushall-Shelfield (51%)	Willenhall South (54%)	Pheasey Park Farm (45%)
Willenhall South (47%)	Willenhall North (51%)	Short Heath (44%)







The other 3 conditions included within the survey are:

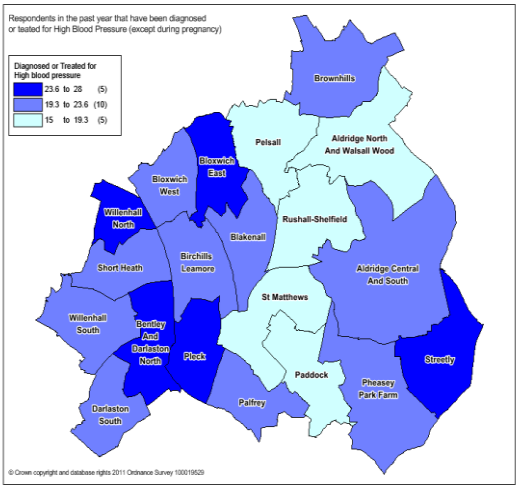
- Mental (22%) - Palfrey (47%) and St Matthew's (44%) are the 2 most prominent wards with respondents claiming to suffer from a mental condition
- Sensory (11%) - respondents who suffer from such a condition are prominent in Aldridge North and Walsall Wood ward and Bentley and Darlaston North (17%) and 15% from Birchills ward
- Learning Disability (3%) - Learning difficulties are the least common condition in Walsall but are prominent in 2 wards – St Matthew's (25%) and Blakenall (15%).

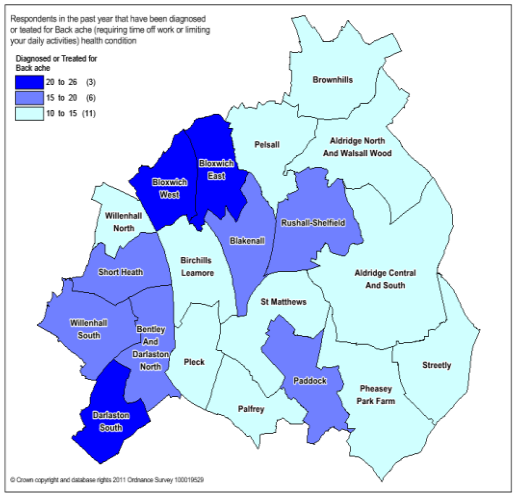
71% of respondents in Walsall agree with the statement – "There are people I know – amongst my family and friends – who would see that I am taken care of if I needed to be", compared to only 7% who do not. Rushall-Shelfield and Bloxwich West have the greatest number of respondents who agree (82% and 80% respectively). In contrast, 15% of respondents living in St Matthew's and Birchills Leamore disagree with the statement.

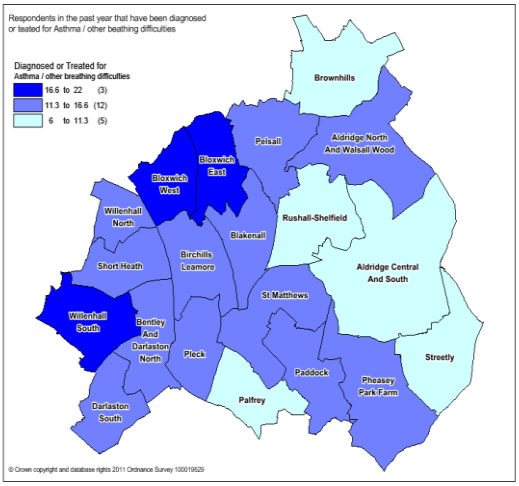
The top 3 conditions respondents state they have been diagnosed with in the past year are illustrated in the table below. Interestingly, when this data is compared to QoF 2012/13 data, higher proportions of residents are claiming to have been diagnosed with a condition – this may suggest that there are people who haven't been diagnosed by a registered GP and there are residents who require / need services but aren't currently recognised.

	2012 Lifestyle Survey	2012/13 QoF Data
High Blood Pressure	22%	15.89%
Back Ache	15%	-
Asthma	14%	6.45%

Geographically, these conditions vary, as illustrated in the maps below:







A greater proportion of respondents suffer from high blood pressure in Streetly (28%) and Pleck and Willenhall North wards (27%).

Back ache (requiring time off work or limiting daily activities) is prominent in Bloxwich West and Bloxwich East (26% and 24% respectively).

Asthma or other breathing difficulties is most prominent in Bloxwich West and Willenhall South (22%) and Bloxwich East (20%).

Longer term efforts to support carers will determine the level of services which the statutory organisations will have to provide.

Carers who give up their work or reduce their hours of paid work to support relatives, are often disadvantaged by this, with lower incomes. Low incomes or worklessness in Walsall is strongly correlated with poor health outcomes, as well as with child poverty, crime, lack of aspirations, and lower levels of educational achievement. This contributes to a vicious cycle of intergenerational unemployment and disadvantage that needs to be tackled from a number of angles.

A recent press release in August 2013 - 'Support for Working Carers Needed to Help Businesses and Boost the Economy states "Better support for working carers would give businesses and the UK economy a much needed boost and would save taxpayers £1.3 billion a year". It warns businesses risk losing experienced and valuable employees if action isn't taken to enable people with caring responsibilities to remain in employment.

Priorities for action:

- *Continue to utilise the 'Your place, Your Wellbeing: Walsall Household and Lifestyle Survey' to estimate the number of carers in Walsall and guide local service development*

8.8 End of life care

Walsall's vision and approach mirrors that of the national strategy for End of Life Care aiming to transform care for people approaching end of life, whatever their diagnosis and wherever they are, including enabling more people to be cared for and to die at home should this be their wish. In achieving this vision, the aim is to treat people with the utmost dignity, care and compassion whilst respecting their wishes and supporting carers.

Palliative care tends to be offered chiefly to patients with incurable cancer, though it has been estimated that two thirds of non-cancer deaths will be preceded by a period of chronic illness that may benefit from palliative care interventions (National Council for Palliative Care). However, potentially a third of deaths that take place in hospital might have been more appropriately managed elsewhere.

The Cancer Patient Experience Survey 2012/13 (CPES) provides information that can be used to drive local quality improvements by Trusts and commissioners. 53% of responses were from women cancer patients of whom 62% were aged between 51 and 75 years of age. This is reflective in the responses for Walsall with breast cancer as the most prominent (28%) type, followed by haematological and urological (13% each). Males according to the patients surveyed contracted cancer later on in life with 55% aged between 51 and 75 and 36% aged over 76 (compared to 18% women).

Generally, responses are on a par to 2010/11 figures, with 88% of patients rating care as excellent or very good (on a par nationally). However, one example area where improvement is needed - 41% of patients (compared to 53%) feel they were definitely given enough care from health or social services – this figure is within the lowest 20% of trusts and is considerably lower than the national figure of 60%.

Findings of both National and Regional audits relating to End of Life care reveal that there is still a large gap between where people say they would prefer to die and where they actually die. There is also a broad acknowledgement that the ability to 'track' and appropriately share preferences for end of life care together with the actual experiences of patients is an ambition rather than a reality.

The figures shown below of actual place of death for patients known to the specialist community palliative care team are relatively unchanged, with the exception of a rise in hospice deaths. This rise is a direct result of the impact of the in-patient unit within the Walsall Palliative Care Centre in Goscote.

	2010/11	2011/12
Home	45.5	41.9
Nursing Home	17.9	14.5
Hospice	6.47	14.5
Hospital	29.2	24.85
Not Known	0.95	0.79

Figure 86 Actual Place of Death for Patients known to Specialist Community Palliative Care Team, 2010/11 and 2011/12

The Centre provides care and support services for a wide range of patients and carers from across the community and its facilities provided by the NHS include:

- *A Specialist Day Hospice Facility*
- *Community Oncology and Chemotherapy Service*
- *Specialist Community Palliative Care Service*
- *Complementary Therapy Service*
- *Specialist Therapies Teams*
- *Cancer and Palliative Information and Support Services*
- *Specialist Lymphoedema Services*
- *Voluntary Services*
- *Psychology*
- *An Outpatients Department offering a range of consultation facilities*

Priorities for action:

- *Patients who are at the end of life or who have advanced and incurable disease should be able to access palliative care to manage their symptoms and improve quality of life*
- *Both patients and their carers should have an appropriate level of involvement in decisions about their preferred place of death*
- *Palliative care services should consider how to increase the proportion of patients who die in their preferred place of death. This may be particularly pertinent for elderly people living alone where additional support may be needed to help them to die at home*
- *Palliative care services should be integrated between home, hospital and hospice and improve the experience of dying from incurable disease in Walsall*
- *More support should be offered to help residents of care homes achieve death in their preferred place of care and death*
- *Health and Social care professionals should have more training and education in end of life care and bereavement*
- *Patients and carers to receive co-ordinated care between health professionals, social care professionals and third sector agencies*
- *To assess carer working days lost and to establish what is offered to our employees who are committed to providing carer support*
- *Utilise the findings from the National Cancer Patient Experience Programme 2012/13 where responses are less favourable for Walsall to improve experiences for cancer patients in Walsall in the future*

8.9 Chapter summary and key priorities for action

To fulfil aspiration for healthy living, people also need safe, secure environments, with financial assurance for their future years, independence, with support if required, and to be included in general society. Improving lifestyles, prevention, early detection of disease and robust and effective treatment of illness will contribute to this aim.

Priorities for action:

In addition, action is required in the following areas:

- *Ensure the views of older people and their carers are integral to service development and delivery, including identification of gaps in service*
- *Action across all agencies to encourage and support older people to maintain an active lifestyle to prevent and reduce falls and fractures which lead to loss of independence*
- *A systematic approach to oral health to ensure quality of life and healthy nutrition in older people*
- *Action to reduce excess winter deaths, including action to reduce fuel poverty*
- *Support from specialist palliative care services to increase the proportion of people able to die in their own home, including older people who live in residential care or in a nursing home*

Chapter 9 Summary and key priorities

The preceding chapters of the Joint Strategic Needs Assessment discussed a wide range of themes influencing health and wellbeing across the life course within the borough. The structure of the JSNA stresses the importance of a life course approach. Inequalities in early life tend to persist into adulthood, shaping the lives and wellbeing of Walsall residents.

The Marmot Review emphasised the need for proportionate universalism in reducing the social gradient in health and wellbeing. For this reason core recommendations are:

- *That the Health and Wellbeing Board recognises the need for proportionate action, with greater intensity in areas of greater social and economic disadvantage*
- *That this principle underpins all elements of the upcoming Health and Wellbeing Strategy*

Dahlgren and Whitehead recognised that health and wellbeing have a wide range of determinants; individual factors surrounded by wider social determinants (see Figure 87 below)

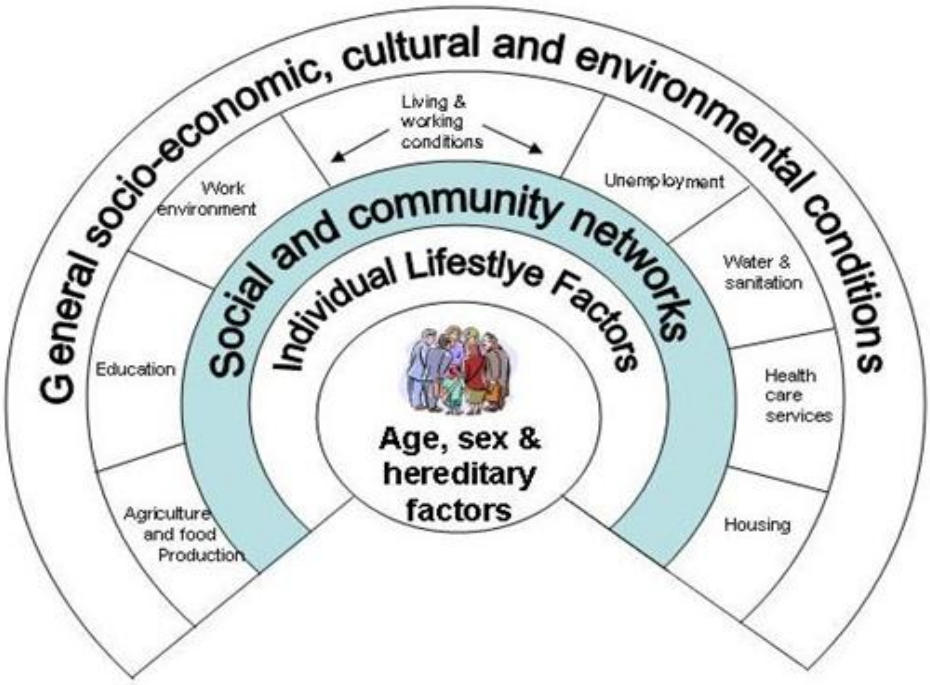


Figure 87 A Social Model for Health - Dahlgren and Whitehead 1991

The content of the JSNA reflects this wide variety of themes influencing wellbeing in the borough. Action on all of these themes is crucial to improving the wellbeing of Walsall residents. The Health and Wellbeing Strategy should recognise the need to foster personal responsibility for wellbeing within an environment that facilitates good health and wellbeing for all. All residents and organisations within the borough have a part to play in improving health and wellbeing for all. Promotion of good health and wellbeing is complex and requires wide engagement with communities and strong, coordinated partnerships across

organisations. It should be recognised that some determinants of wellbeing cannot be influenced by local action and require strategic action on a national level.

A key recommendation is that:

- *The Health and Wellbeing Board develop strong, coordinated partnerships with a wide range of organisations across the borough to tackle complex determinants of wellbeing*

The life course approach recognises the significant relationship between early intervention and outcomes in later life. For this reason this JSNA recommends that:

- *The core of the Health and Wellbeing Strategy comprises action to:*
    - *Support families and parents to promote development of strong, resilient and healthy children and young people*
    - *Promote engagement in education and attainment across the life course*
    - *Promote employability and 'good' employment for all residents*
    - *Reduce the personal, social and economic burden of preventable disease and disability at all ages by tackling the BIG FOUR:*
        - *Reduce the uptake and duration of smoking*
        - *Make healthy eating and active lifestyle choices easier*
        - *Identify harmful drinking and intervene early on*
    - *Extend healthy and independent living in old age by:*
        - *Maintaining active lifestyles*
        - *Identifying memory problems early*
        - *Supporting recovery from episodes of illness*

Each chapter and theme within the JSNA identifies specific priorities for action. Key recurring priorities for action form further recommendations for the Health and Wellbeing Strategy:

- *Embed health and wellbeing into all local planning activity – including good housing, access to good food, leisure and the promotion of active travel*
- *Ensure focus on the promotion of environments that support wellbeing and healthy lifestyles, maximising opportunities in:*
    - *Workplaces*
    - *Schools*
    - *Communities via Area Partnerships*
- *Ensure focus on prevention and early intervention through:*
    - *Every Contact Counts*
    - *Encouraging participation in National Screening Programmes and NHS Health Checks*
- *Ensure robust pathways of care for all long term conditions across the healthcare economy*

JSNA is an iterative process developing year on year. JSNA 2013 has been developed through a partnership approach, drawing on a wide range of expertise across both Public Health and the rest of the Local Authority. There is a long way to go if JSNA is to meet the Project Groups aspirations for an asset based approach. This approach requires collection of a different type of data, identifying and promoting the health enhancing assets (skills, knowledge, resources, networks and organisations) present in communities, empowering people and communities as co-producers of wellbeing. This will enable us to build active and sustainable communities by removing barriers that prevent people participating in the issues that affect their wellbeing. To support this aspiration this JSNA recommends:

- *Partners should influence the nature and content of future needs assessments to reflect an assets based approach through:*
    - *Improved intelligence and data collection*
    - *Wider community engagement and participation*

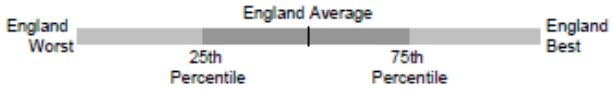
Appendix 1 – Health and Wellbeing Summary for Walsall

Health summary for Walsall

E08000030

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average



Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	122840	45.6	20.3	83.7		0.0
	2 Proportion of children in poverty	16165	29.5	21.1	45.9		6.2
	3 Statutory homelessness	127	1.2	2.3	9.7		0.0
	4 GCSE achieved (5A*-C inc. Eng & Maths)	1774	56.4	59.0	31.9		81.0
	5 Violent crime	3414	13.3	13.6	32.7		4.2
	6 Long term unemployment	3432	20.5	9.5	31.3		1.2
Children's and young people's health	7 Smoking in pregnancy ‡	673	19.0	13.3	30.0		2.9
	8 Starting breast feeding ‡	2179	61.3	74.8	41.8		96.0
	9 Obese Children (Year 6) ‡	697	23.2	19.2	28.5		10.3
	10 Alcohol-specific hospital stays (under 18)	36	59.0	61.8	154.9		12.5
	11 Teenage pregnancy (under 18) ‡	273	51.3	34.0	58.5		11.7
Adults' health and lifestyle	12 Adults smoking	n/a	22.7	20.0	29.4		8.2
	13 Increasing and higher risk drinking	n/a	20.0	22.3	25.1		15.7
	14 Healthy eating adults	n/a	21.8	28.7	19.3		47.8
	15 Physically active adults	n/a	50.5	56.0	43.8		68.5
	16 Obese adults ‡	n/a	27.8	24.2	30.7		13.9
Disease and poor health	17 Incidence of malignant melanoma	22	8.3	14.5	28.8		3.2
	18 Hospital stays for self-harm	463	180.7	207.9	542.4		51.2
	19 Hospital stays for alcohol related harm ‡	6732	2227	1895	3276		910
	20 Drug misuse	2107	12.4	8.6	26.3		0.8
	21 People diagnosed with diabetes	17125	8.0	5.8	8.4		3.4
	22 New cases of tuberculosis	54	21.0	15.4	137.0		0.0
	23 Acute sexually transmitted infections	3105	1152	804	3210		162
	24 Hip fracture in 65s and over	299	480	457	621		327
Life expectancy and causes of death	25 Excess winter deaths ‡	158	20.8	19.1	35.3		-0.4
	26 Life expectancy – male	n/a	77.3	78.9	73.8		83.0
	27 Life expectancy – female	n/a	82.3	82.9	79.3		86.4
	28 Infant deaths	30	8.0	4.3	8.0		1.1
	29 Smoking related deaths	431	222	201	356		122
	30 Early deaths: heart disease and stroke	216	73.6	60.9	113.3		29.2
	31 Early deaths: cancer	355	120.3	108.1	153.2		77.7
	32 Road injuries and deaths	74	27.7	41.9	125.1		13.1

‡ For comparison with PHOF Indicators, please go to the following link: www.healthprofiles.info/PHOF

Indicator Notes

1 % people in this area living in 20% most deprived areas in England, 2010 2 % children (under 16) in families receiving means-tested benefits & low income, 2010 3 Crude rate per 1,000 households, 2011/12 4 % at Key Stage 4, 2011/12 5 Recorded violence against the person crimes, crude rate per 1,000 population, 2011/12 6 Crude rate per 1,000 population aged16-64, 2012 7 % mothers smoking in pregnancy where status is known, 2011/12 8 % mothers initiating breast feeding where status is known, 2011/12 9 % school children in Year 6 (age 10-11), 2011/12 10 Persons under 18 admitted to hospital due to alcohol-specific conditions, crude rate per 100,000 population, 2007/08 to 2009/10 (pooled) 11 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2009-2011 12 % adults aged 18 and over, 2011/12 13 % aged 16+ in the resident population, 2008-2009 14 % adults, modelled estimate using Health Survey for England 2006-2008 15 % adults achieving at least 150 mins physical activity per week, 2012 16 % adults, modelled estimate using Health Survey for England 2006-2008 17 Directly age standardised rate per 100,000 population, aged under 75, 2008-2010 18 Directly age sex standardised rate per 100,000 population, 2011/12 19 Directly age sex standardised rate per 100,000 population, 2010/11 20 Estimated users of opiate and/or crack cocaine aged 15-64, crude rate per 1,000 population, 2010/11 21 % people on GP registers with a recorded diagnosis of diabetes 2011/12 22 Crude rate per 100,000 population, 2009-2011 23 Crude rate per 100,000 population, 2012 (chlamydia screening coverage may influence rate) 24 Directly age and sex standardised rate for emergency admissions, per 100,000 population aged 65 and over, 2011/12 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.08-31.07.11 26 At birth, 2009-2011 27 At birth, 2009-2011 28 Rate per 1,000 live births, 2009-2011 29 Directly age standardised rate per 100,000 population aged 35 and over, 2009-2011 30 Directly age standardised rate per 100,000 population aged under 75, 2009-2011 31 Directly age standardised rate per 100,000 population aged under 75, 2009-2011 32 Rate per 100,000 population, 2009-2011

More information is available at www.healthprofiles.info Please send any enquiries to healthprofiles@phe.gov.uk

Appendix 2 – Summary of Child Health and Wellbeing in Walsall

Summary of child health and well-being in Walsall

The chart below shows how children's health and well-being in this area compares with the rest of England. The local result for each indicator is shown as a circle, against the range of results for England which are shown as a grey bar. The red line indicates the England average. The key to the colour of the circles is shown below.

- Significantly worse than England average
- Not significantly different
- Significantly better than England average
- Regional average

England average

25th percentile — 75th percentile

range of values that differ significantly from the average

	Indicator	Local no. per year	Local value	Eng. ave.	Eng. worst	Eng. best
Preventable mortality	1 Infant mortality rate	30	8.0	4.4	8.0	2.2
	2 Child mortality rate (age 1-17 years)	11	19.2	13.7	23.7	7.5
Health protection	3 MMR immunisation (by age 2 years)	3,228	95.6	91.2	78.7	97.2
	4 Diphtheria, tetanus, polio, pertussis, Hib immunisations (by age 2 years)	3,329	98.6	96.1	85.7	98.8
	5 Children in care immunisations	390	98.7	83.1	0.0	100.0
	6 Acute sexually transmitted infections (including Chlamydia)	1,396	39.7	35.6	75.2	19.9
Wider determinants of ill health	7 Children achieving a good level of development at age 5	2,020	58.7	63.5	51.5	76.5
	8 GCSE achieved (5A*-C inc. Eng and maths)	1,888	55.9	59.4	40.9	79.6
	9 GCSE achieved (5A*-C inc. Eng and maths) for children in care	-	-	14.6	0.0	40.0
	10 Not in education, employment or training (age 16-18 years)	750	7.4	6.1	11.8	1.6
	11 First time entrants to the Youth Justice System	142	532.7	876.4	2,436.3	342.9
	12 Children living in poverty (aged under 16 years)	16,165	29.5	21.1	45.9	7.4
	13 Family homelessness	93	0.9	1.7	7.4	0.1
	14 Children in care	490	77.0	59.0	150.0	19.0
	15 Children killed or seriously injured in road traffic accidents	13	24.5	22.1	47.9	4.4
Health improvement	16 Low birthweight	348	9.3	7.4	11.0	5.0
	17 Obese children (age 4-5 years)	376	11.3	9.5	14.5	5.8
	18 Obese children (age 10-11 years)	692	23.2	19.2	27.8	12.3
	19 Participation in at least 3 hours of sport/PE	17,646	45.1	55.1	40.9	79.5
	20 Children's tooth decay (at age 12)	-	0.6	0.7	1.5	0.2
	21 Teenage conception rate (age under 18 years)	260	51.4	35.4	64.7	6.2
	22 Teenage mothers (age under 18 years)	99	2.7	1.3	2.8	0.3
	23 Hospital admissions due to alcohol specific conditions	34	55.6	55.8	138.3	16.9
	24 Hospital admissions due to substance misuse (age 15-24 years)	18	53.9	69.4	186.3	25.7
Prevention of ill health	25 Smoking in pregnancy	673	18.9	13.2	29.7	2.9
	26 Breastfeeding initiation	2,179	61.0	74.0	41.8	94.3
	27 Breastfeeding at 6-8 weeks	1,296	35.7	47.2	19.7	82.8
	28 A&E attendances (age 0-4 years)	7,278	407.7	483.9	1,187.4	136.3
	29 Hospital admissions due to injury (age under 18 years)	609	96.0	122.6	211.1	72.4
	30 Hospital admissions for asthma (age under 19 years)	148	221.1	193.9	484.4	73.4
	31 Hospital admissions for mental health conditions	134	211.2	91.3	479.7	22.6
	32 Hospital admissions as a result of self-harm	85	134.0	115.5	311.9	26.0

Notes and definitions - Where data are not available or have been suppressed, this is indicated by a dash in the appropriate box.

1 Mortality rate per 1,000 live births (age under 1 year), 2009-2011
2 Directly standardised rate per 100,000 children age 1-17 years, 2009-2011
3 % children immunised against measles, mumps and rubella (first dose by age 2 years), 2011/12
4 % children completing a course of immunisation against diphtheria, tetanus, polio, pertussis and Hib by age 2 years, 2011/12
5 % children in care with up-to-date immunisations, 2012
6 Acute STI diagnoses per 1,000 population aged 15-24 years, 2011
7 % children achieving a good level of development within Early Years Foundation Stage Profile, 2012
8 % pupils achieving 5 or more GCSEs or equivalent including maths and English, 2011/12
9 % children looked after achieving 5 or more GCSEs or equivalent including maths and English, 2011/12 (provisional)
10 % not in education, employment or training as a proportion of total age 16-18 year olds known to local Connexions services, 2011
11 Rate per 100,000 of 10-17 year olds receiving their first reprimand, warning or conviction, 2010/11
12 % of children aged under 16 living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income, 2010
13 Statutory homeless households with dependent children or pregnant women per 1,000 households, 2011/12
14 Rate of children looked after at 31 March per 10,000 population aged under 18, 2012
15 Crude rate of children age 0-15 years who were killed or seriously injured in road traffic accidents per 100,000 population, 2009-2011
16 Percentage of live and stillbirths weighing less than 2,500 grams, 2011
17 % school children in Reception year classified as obese, 2011/12
18 % school children in Year 6 classified as obese, 2011/12
19 % children participating in at least 3 hours per week of high quality PE and sport at school age (5-18 years), 2009/10
20 Weighted mean number of decayed, missing or filled teeth in 12 year olds, 2008/09
21 Under 18 conception rate per 1,000 females age 15-17 years, 2010
22 % of delivery episodes where the mother is aged less than 18 years, 2011/12
23 Crude rate per 100,000 under 18 year olds for alcohol specific hospital admissions, 2008-11
24 Directly standardised rate per 100,000 (age 15-24 years) for hospital admissions for substance misuse, 2009-12
25 % of mothers smoking at time of delivery, 2011/12
26 % of mothers initiating breastfeeding, 2011/12
27 % of mothers breastfeeding at 6-8 weeks, 2011/12
28 Crude rate per 1,000 (age 0-4 years) of A&E attendances, 2010/11
29 Crude rate per 10,000 (age 0-17 years) for emergency hospital admissions following injury, 2011/12
30 Crude rate per 100,000 (age 0-18 years) for emergency hospital admissions for asthma, 2011/12
31 Crude rate per 100,000 (age 0-17 years) for hospital admissions for mental health, 2011/12
32 Crude rate per 100,000 (age 0-17 years) for hospital admissions for self-harm, 2011/12

Appendix 3 – Children and Young Peoples' Board Priorities

The following table summarises the priorities as agreed by the Children and Young People (CYP) Board. These are priorities for improvement over the coming 3 years (2013-16) and each priority is "sponsored" by a member of the CYP board.

Delivery plans for each priority can be found on the following website and will be revised as required: www.childrenspartnership.walsall.org.uk

	Priority	Sponsor
1	Supporting the most vulnerable families to provide the best start in life for children.	**Director of Childrens Services**
2	Ensuring that children maintain a healthy weight.	**Director of Public Health**
3	Reducing the harm caused by child sexual exploitation including children missing from school, care and home	**Chair of Walsall Safeguarding Children Board**
4	Greater diversity of choice for learning, training and employment for young people	**Operational Director, Walsall Training Providers/Vice Principal Walsall College**
5	Supporting the transition into adulthood for children and young people with Special Educational Needs or Disabilities by creating single 'through life' plans.	**Director of Adult Social Care**
6	Promoting pride in the achievements of the children and young people of Walsall.	**Chair of Walsall Association of Secondary Headteachers**
7	Better communication between frontline staff in all agencies that support children and families	**Head of Probation - Walsall LDU**
8	Reducing the impact of child poverty	**Head of Housing**