

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

Chapter 1	Demographics and Risk Factors
Chapter 2	Healthy Pregnancy
Chapter 3	Safeguarding
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Public Health

Sandwell Metropolitan Borough Council



Research
Sandwell

Executive Summary

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

Key findings and recommendations for this JSNA are summarised below:

- Certain features of the Sandwell population including high levels of deprivation and ethnic diversity have the potential to negatively impact on health and wellbeing in the early years. It is important that we deliver services designed to meet the needs of our whole population.
- Sandwell has a higher birth rate, higher rate of infant mortality and lower rate of breast feeding than the rest of the West Midlands and England. We need to look at pregnancy and early year's services to identify how we can improve rates of early booking, increase uptake of stop smoking services and increase breast feeding. An important aspect of this is ensuring that services provided meet the needs of the local population and are culturally sensitive.
- Referrals into children's services have decreased in recent years and it is important to understand the reasons for this. Proportions of referrals from some ethnic groups are less than would be expected given the population make up of Sandwell; we also need to understand reasons for this. All stakeholders who potentially come in contact with parents of young children (including those working in the voluntary and community sector) should be aware of universal and early help services available and signposting at the earliest opportunity should be encouraged.
- In Sandwell just over 50% of children reach a 'good' level of development at 5 years of age; however, there is no standard measure of school readiness. A standard measure of school readiness needs to be adopted so that we can identify areas within the borough with poor school readiness where services should be targeted. While uptake of Nursery Education Funding is high, uptake of Early Learning for Two-year-olds is low throughout the borough and

as low as 30% in some wards. We need to understand reasons for this poor uptake and improve offer and access to places where appropriate.

- The majority of Special Education Needs referrals in 0-4 year olds are for speech, language or communication needs. There is evidence of delays in referrals in this age group. Sharing of information on children with possible SEND needs between agencies is poor. It is important to improve data sharing to facilitate timely referral to services.
- While some of the recommendations within the JSNA have named organisational owners, most of the recommendations will require a partnership approach. It is envisioned that the Children and Families Joint Planning and Commissioning Group will consider these recommendations and how they can be taken forward.

1. Demographics and Risk Factors

Key Points

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

1.1 Introduction

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

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

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

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

1.2 Descriptive epidemiology

1.2.1 Children in Poverty

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

with 27.63% of all its dependent children aged under 20 in relative poverty. This equates to 21,830 dependent children aged under 20 and living in poverty.

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

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

	Sandwell	West Midlands	England
Children in poverty (under 16 years) (2012)	28.3%	21.9%	19.2%

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

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

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

	Sandwell	West Midlands	England
Eligible and claiming free school meals (2014)	22.0%	18.6%	16.0%

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

1.2.2 Black and Minority Ethnic groups

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

1.2.3 Lone Parent families

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

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

1.2.4 Long term illness and disability

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

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

Area	All households		One person in household with a long-term health problem or disability: With dependent children	
	Number	%	Number	%
Sandwell	121,498	100	7,866	6.5
England	18,163,035	100	870,658	4.8
West Midlands	1,944,564	100	104,846	5.4

Source: (Nomis 2011 Census) KS106EW

1.2.5 Smoking

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

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

1.2.6 Alcohol Misuse

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

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

1.2.7 Substance Misuse

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

1.2.8 Obesity

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

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

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

Table 4: Proportion of Reception Children Classified as Overweight or Obese, 2014-2015

	Sandwell	West Midlands	England
Overweight or Obese Children (4-5 years) (2014/15)	22.10%	23.10%	21.90%
Obese children (4-5 years) (2014/15)	11.30%	10.20%	9.10%

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

1.2.9 Teenage Pregnancy

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

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

	2006	2007	2008	2009	2010	2011	2012	2013
Sandwell	62.7	58.2	56.4	52.7	55.8	46.1	38.5	36.6
West Midlands	46.3	46.6	43.2	42.1	38.5	34.9	32	28.9
England	40.6	41.4	39.7	37.1	34.2	30.7	27.7	24.3

Source: Public Health Outcomes Framework (PHOF)

2. Healthy pregnancy

Key Points

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

2.1 Introduction

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

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

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

2.2 Descriptive Epidemiology

2.2.1 Population of Sandwell

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

2.2.2 Live Births

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

Table 6: Year on Year Percentage Change in the Number of Live Births, 2008-14

Area	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	Total Change 2008-15
Sandwell	-1.2%	2.1%	3.5%	3.1%	-6.0%	-3.4%	2.3%	0.1%
West Midlands	-1.0%	1.5%	1.3%	1.3%	-3.7%	-1.5%	-0.5%	-0.9%
England	-0.3%	2.4%	0.2%	0.9%	-4.3%	-0.5%	0.4%	-1.2%

Source: ONS

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

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

Area	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25	2016-2025
Sandwell	0.00%	2.08%	2.04%	2.08%	0.00%	0.00%	0.00%	0.00%	0.00%	2.08%
West Midlands	1.13%	0.97%	0.41%	0.41%	0.55%	0.27%	0.27%	0.00%	0.14%	3.94%
England	1.04%	0.84%	0.60%	0.44%	0.32%	0.27%	0.14%	0.07%	0.20%	3.43%

2.2.3 Maternal age

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

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

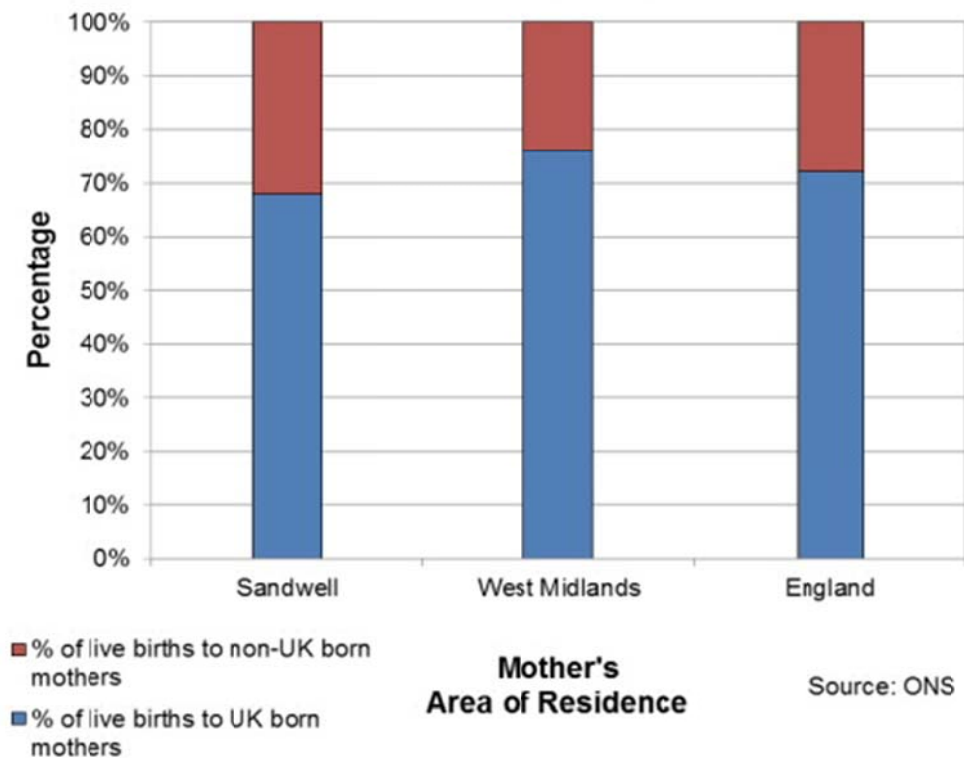
Year	Maternal Age (years)							
	Under 18	Under 20	20-24	25-29	30-34	35-39	40-44	45+
2012	2.1%	6.1%	23.1%	32.1%	25.7%	10.7%	2.1%	0.2%
2013	1.9%	6.5%	20.6%	32.5%	26.3%	11.5%	2.4%	0.2%
2014	1.9%	5.2%	20.5%	33.3%	26.2%	11.9%	2.8%	0.2%

Source: ONS

2.2.4 Maternal country of origin

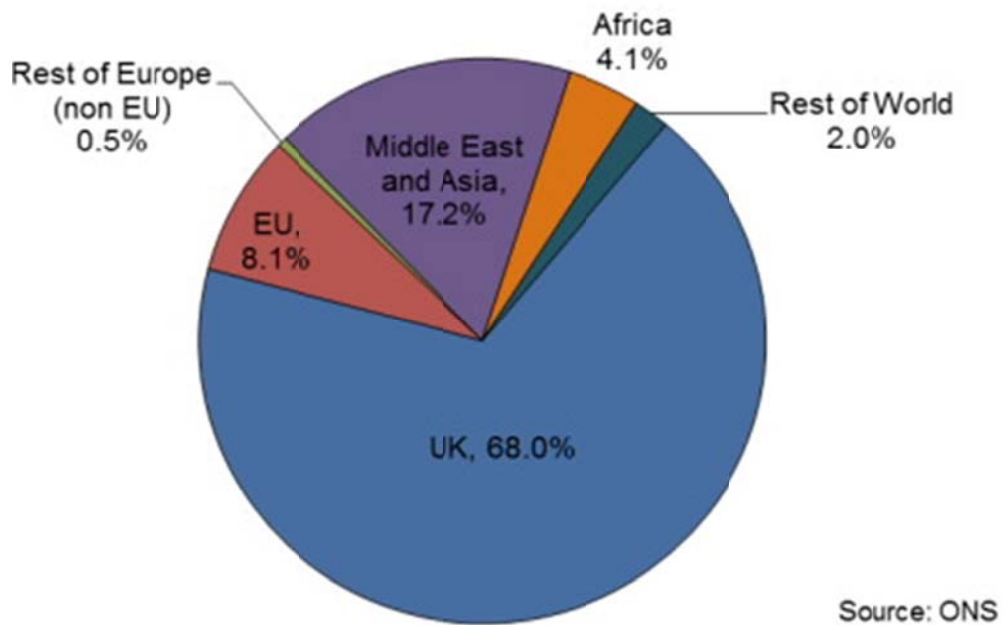
Public Health England has reported that 60% of Sandwell's increase in births between 2001 and 2012 was contributed by non-UK born women. The number of births to non-UK born mothers increased from 18.3% in 2001 to 29.9% in 2012 to 32% of all births in 2014 compared to 27% across England in the same year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

Figure 1: Percentage of Live Births by birthplace of mother 2014



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

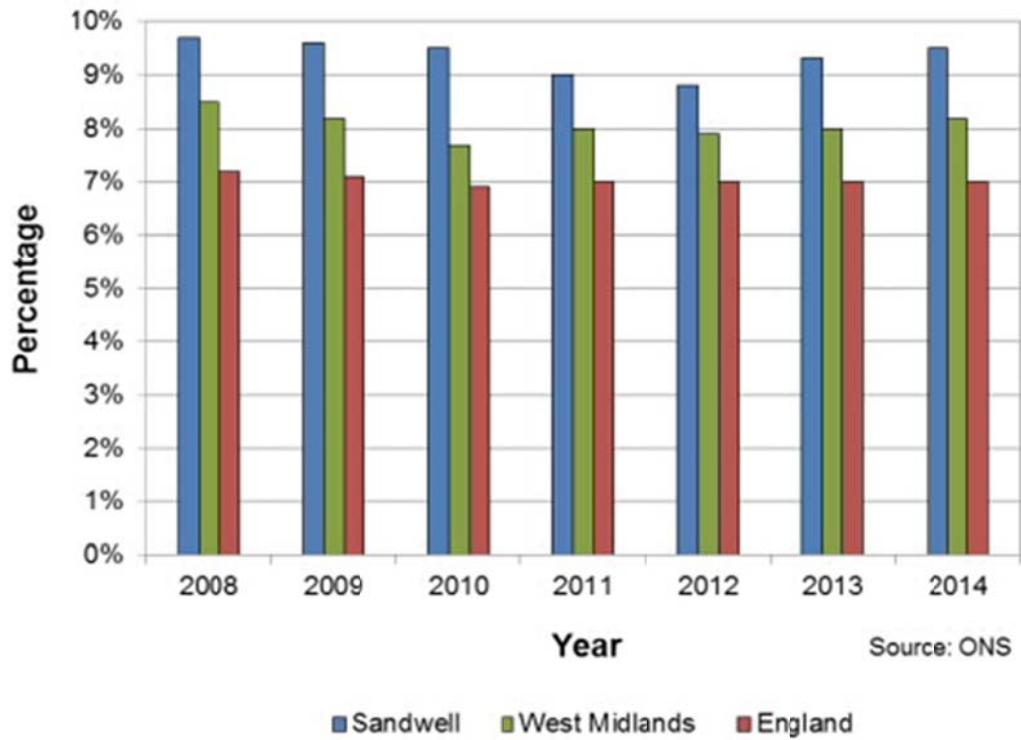
Figure 2: Live Births by Birthplace of Mother, 2014



2.2.5 Birth weight

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

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



2.2.6 Infant mortality

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

Figure 4: Stillbirths per 1,000 Total Births in Sandwell, West Midlands and England, 2011-13

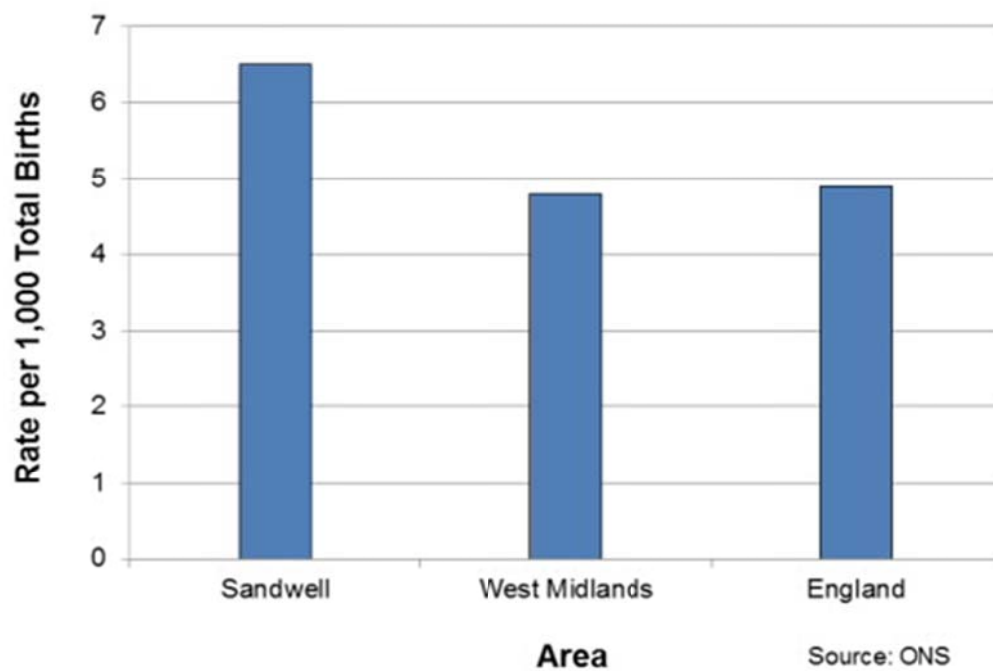
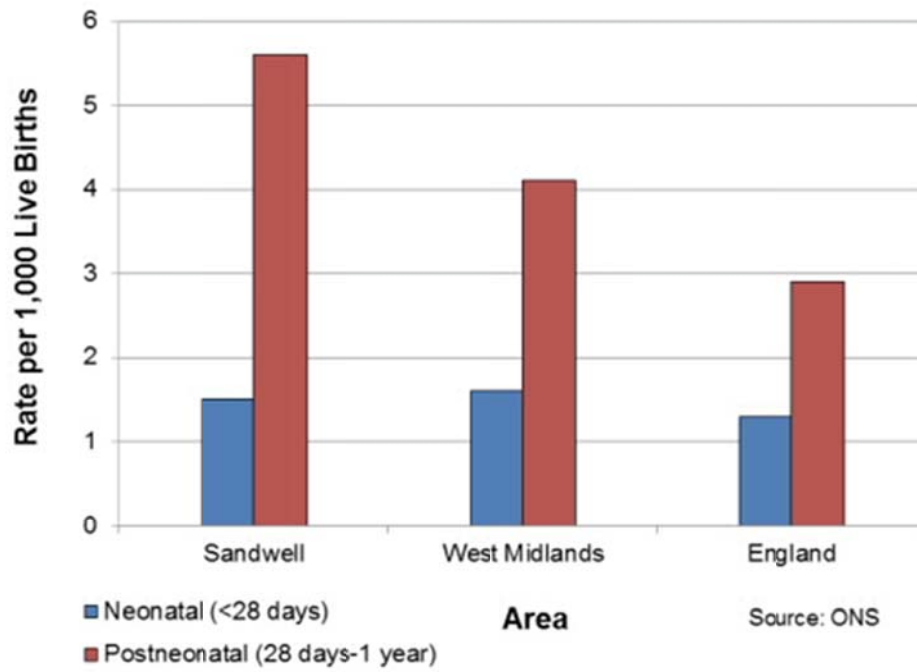


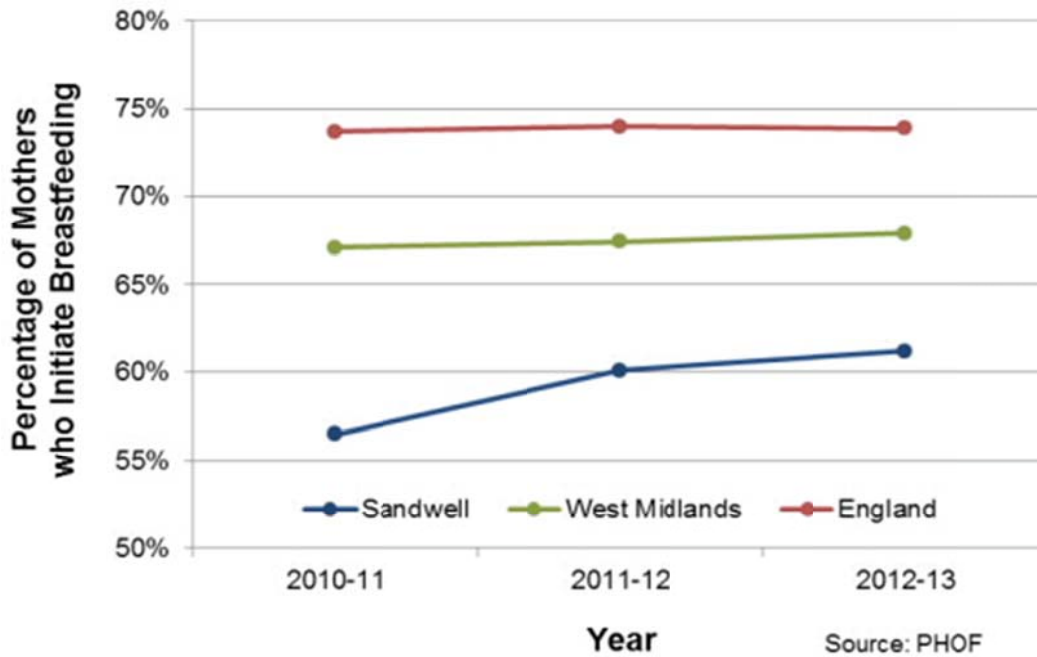
Figure 5: Neonatal and Post neonatal Mortality per 1,000 Live Births 2011-13



2.2.7 Breastfeeding

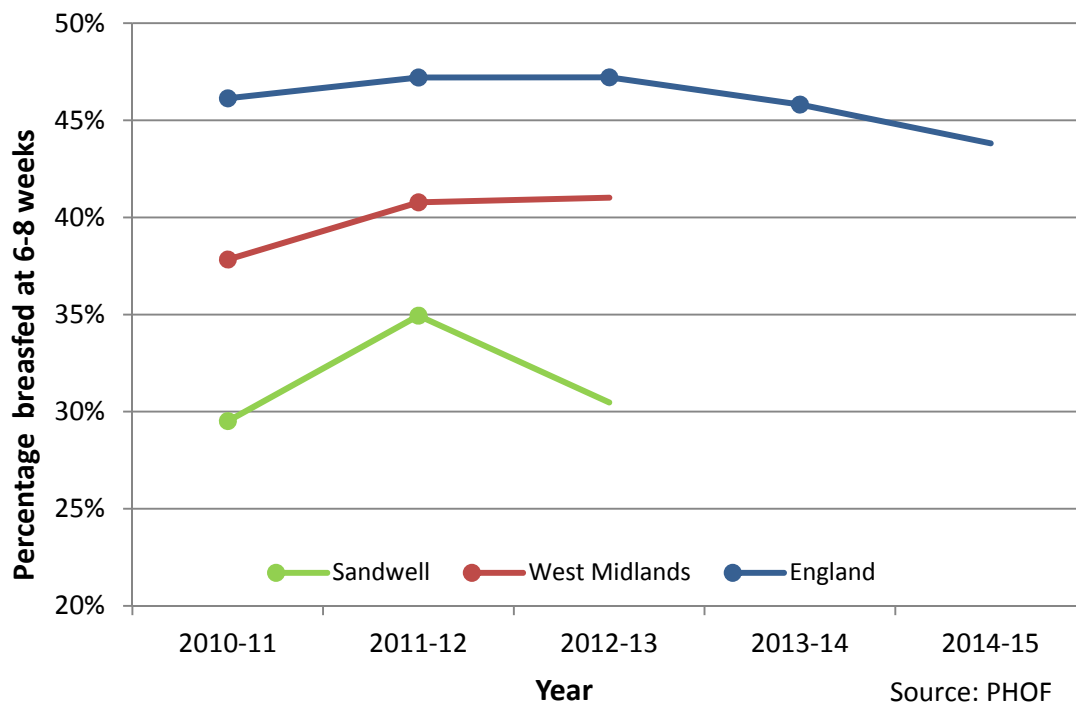
Breastfeeding initiation in Sandwell is improving and in 2012-13 61% of mothers started breastfeeding in the first 48 hours. This is still significantly lower than England at 74% (Figure 6).

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



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

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



2.2.8 Smoking

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

2.2.9 Obesity

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

2.3 National guidelines and recommendations

2.3.1 Maternal age

Pregnancy can be complicated at both extremes of maternal age.

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

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

Table 9: Risk of Down syndrome according to maternal age

Maternal Age	Downs Syndrome Risk Morris et al 2003
25	1:1350
30	1:940
35	1:350
40	1:85

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

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

2.3.2 Maternal country of origin

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

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

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

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

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

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

2.3.3 Service Mapping

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

The National Nursing Research Unit report, 2011 describes an association between a high ratio of obstetricians to midwives with a lower probability of readmission. The

publication 'The Future Role of the Consultant' (RCOG, 2005) suggests that there should be 40 hours consultant presence per week in a maternity unit with fewer than 5,000 births per annum, increasing to 60 hours consultant presence per week in units with more than 5,000 births per annum. However, the demographic profile of those giving birth in Sandwell (including high proportion of deprived mothers and those from migrant groups) may lead to more birth complications and this should be considered when planning services.

2.3.4 Infant Birthweight

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

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

2.3.5 Infant mortality

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

2.3.6 Breastfeeding

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

2.3.7 Smoking in Pregnancy

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

NICE: Antenatal care for uncomplicated pregnancies 2008 advises that smoking status should be identified at first contact which can be difficult as many women may not want to disclose they smoke for fear of judgement and therefore information should be provided about the risks posed to the unborn child and the hazards of exposure to second hand smoke in a non-judgemental manner. Concerns about stopping smoking should be addressed and information should be personalised.

Encourage pregnant women to use local NHS Stop Smoking Services and the NHS pregnancy smoking helpline, by providing details on when, where and how to access them. Consider visiting pregnant women at home if it is difficult for them to attend specialist services. Smoking status should be monitored throughout pregnancy and advice, encouragement and support to stop smoking should also be available during pregnancy and after delivery.

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

2.3.8 Maternal obesity

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

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

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

and should be given the opportunity to discuss this further and advice should be available on ways to minimise this risk.

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

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

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

The dose should be prescribed according to maternal weight.

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

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

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

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

2.4 Current service provision and effectiveness of these services

2.4.1 Maternal age

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

2.4.2 Maternal country of origin

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

2.4.3 Service Mapping

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

Table 10: Ratio of Midwives and Deliveries per consultant at three different trusts

	Sandwell and West Birmingham Hospitals	The Dudley Group of Hospitals NHS Foundation Trust	Birmingham Women's NHS Foundation Trust
Midwives per Consultant	4	4.7	4.8
Deliveries per Consultants	104.9	142.6	140.5
Required Hours Presence on the Ward	60	40	60

Source: Health and Social Care Information Centre

2.4.4 Infant birthweight, infant mortality, smoking in pregnancy

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

2.4.5 Breastfeeding

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

2.4.6 Maternal obesity

Pregnant women who are obese are at a higher risk of complications and so should be identified and offered appropriate support; however, there is currently no specific service provision for maternal obesity. Public Health has commissioned through a new lifestyle contract with Mytime Active a range of lifestyle interventions to prevent and treat overweight and obesity in children and families with a specific package for new parents, in order to help them achieve and maintain a healthy weight. The service has been designed with a 'person' (rather than 'programme') focus and ethos intended to provide lifestyle packages and interventions which are tailored around individual needs and requirements; this is currently being rolled out throughout the

borough. A key component within the development of the behaviour change and maintenance pathway, is collaborative working through the Community Activity Network 'Weight Management Development Officer (WMDO) delivery model' established by Sandwell Council in order to build an integrated service pathway at a neighbourhood level that addresses any gaps in service provision and meets the needs of local people.

2.5 Consultation with stakeholders

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

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

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

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

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

2.7 Recommendations

- Services in Sandwell need to identify risk factors for infant mortality early and intervene. Service commissioners and providers need to be jointly responsible for this. This will be complex as pre-pregnancy, maternity and post-natal services are commissioned and provided by a range of organisations and strong partnership working will be required. The CCG are currently leading on an infant mortality programme to identify gaps in service provision and to work in partnership with other stakeholders to improve services.
- Service providers need to audit the current maternal services to see if they are in line with the NICE guidelines. Although the acute service currently uses tools to audit different parts of the maternity pathway, these tools need to be reviewed in line with NICE recommendations.

- Building upon the universal weight prevention and weight management services being developed and commissioned, there needs to be more targeted packages and programmes focusing upon the needs of women at pre-conception, pregnancy and post-natal stages, and their babies. In addition, opportunities for partnership working towards an integrated obesity service pathway for pregnant and post-natal women at tier 1 (universal) and tier 2 (brief intervention) need to be explored between specialist services across neighbouring boroughs, for example, Sandwell and West Birmingham Hospital, Walsall Manor Hospital, Dudley's Russells Hall Hospital and weight management providers.
- Breastfeeding – barriers to breast feeding identified through social marketing need to be used to inform service provision and health promotion materials. We are currently relying on nation PHOF measures to measure local uptake rates. This means that there is a delay in reporting this data and there have also been issues with the quality of this data in recent years. Maternity services and health visiting need to work in partnership with their commissioners to develop a method of collecting breast feeding data in a robust and timely way.
- There are few specific services targeted at pregnant women from migrant or minority ethnic population. The needs of women in this group should be assessed and services adapted to ensure their needs are being met or new services commissioned to meet these needs.
- Map the current 'customer journey' to identify where there may be the issues around providing a holistic service and identify points where appropriate referral to services does not exist. Consider a more holistic offer to pregnant patients including physical, mental and emotional support. Explore the feasibility of pooling budgets, sharing data and having common technology to achieve this.
- There is no robust source of data on maternal weight. Maternity services need to work with commissioners to develop a system for collecting this information and reporting in a timely manner.

3. Safeguarding

Key Messages

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

3.1 Introduction

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

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

(Working Together to Safeguard Children, 2015)

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

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

3.2 Policy

3.2.1 National Policy

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

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

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

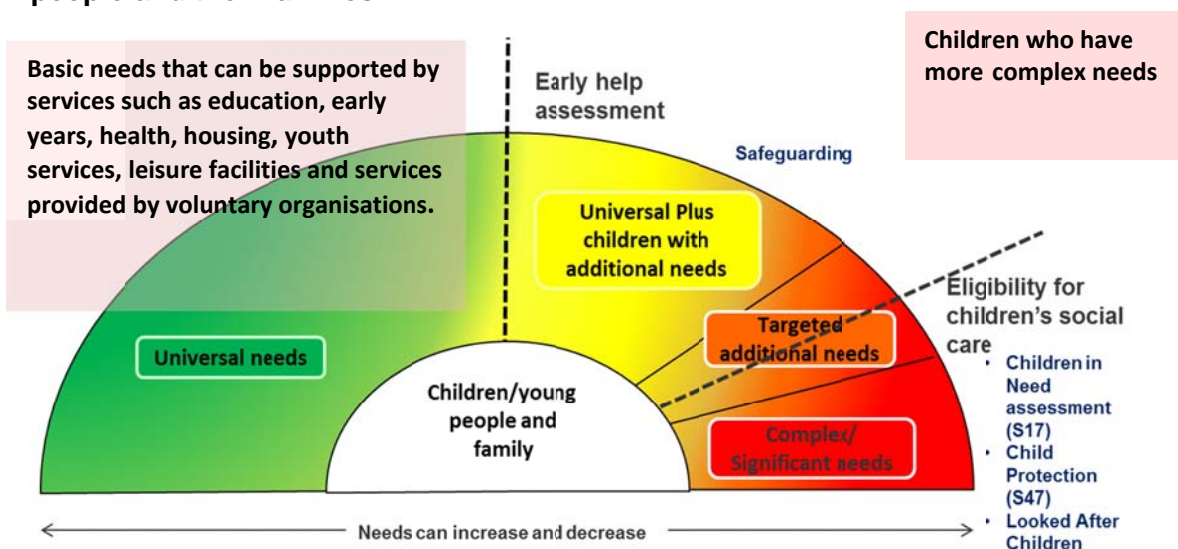
3.2.2 Local Policy context

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

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

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

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



Source: Sandwell Safeguarding Children Board (SSCB)

The board has 3 key principles in accessing support for children and families and these are:

1. The intervention should be at the lowest level and meet the child's needs and prevent the need for more specialist services (through universal provisions).
2. Consideration should always be given to an Early Help assessment and forming a 'Team around the Family' (TAF) to resolve the child's difficulties and prevent the need for a specialist service.
3. If there are child protection concerns (health, development or welfare), professionals must make an immediate referral to Children's Social Care by completing a multi-agency referral form (MARF).

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

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

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

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

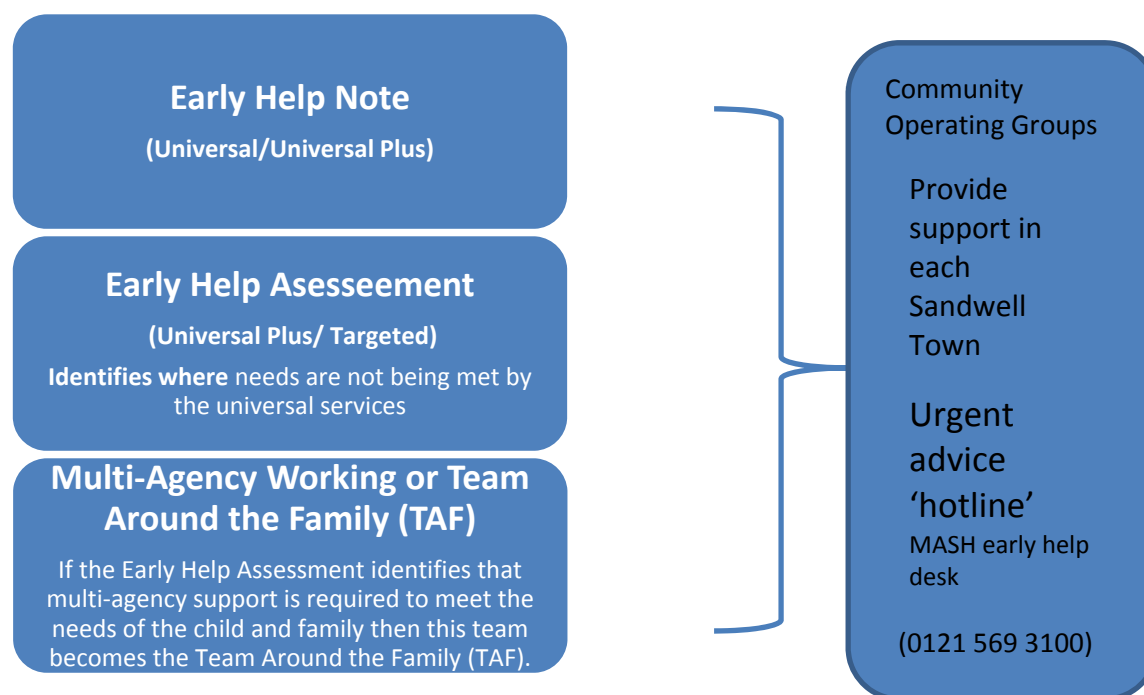
Figure 9: The Framework for the Assessment of Children in Need and their Families



Source: Sandwell Safeguarding Children Board (SSCB)

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

Figure 10: Sandwell Assessment framework available by level of intervention needed



3.3 Safeguarding Risks

3.3.1 Life chances

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

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

3.3.2 Compromised care

Factors such as domestic violence, smoking, alcohol and substance misuse, mental health issues and learning disability in parents compromises their ability to care for the children rendering them susceptible to neglect and abuse (Working Together to Safeguard Children, 2013; Action on Smoking and Health, 2014; NHS Choices,

2015; Mattejat, 2008). These factors have been explored in the 'Parental lifestyles' chapter of the JSNA.

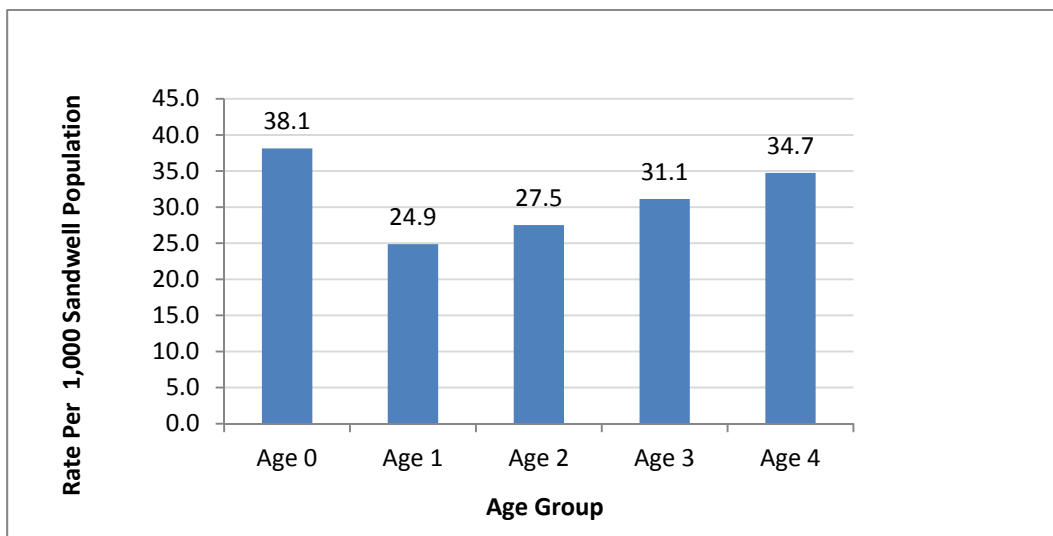
3.4 Profile of local needs in Sandwell

3.4.1 Early Help referrals

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

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

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



Source: ONS

Children under the age of one have the highest early help referral rates amongst the 0-4 population in Sandwell. Ward, Brown and Westlake (2012) have also identified that infants under the age of one are more likely than others to be subjects of child protection plans due to physical abuse and more than twice as likely to be subjects of child protection plans due to neglect. They are also the subject of 45% of serious case reviews (following child death or serious incident), as well as being at eight times the average risk of child homicide. 3% of the referrals were for unborn children.

Figure 12: Map showing Early Help referrals by ward of residence in Sandwell

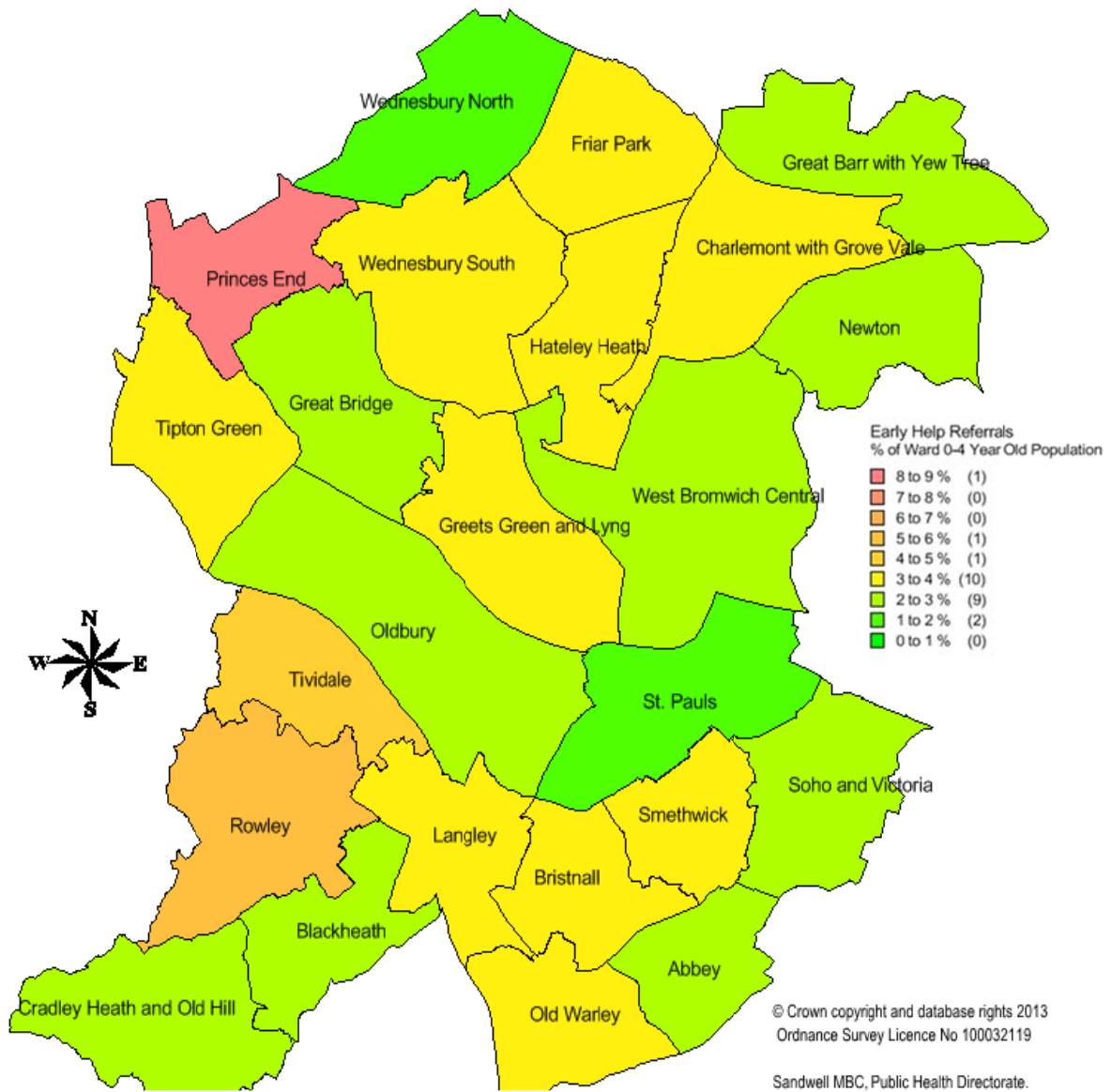
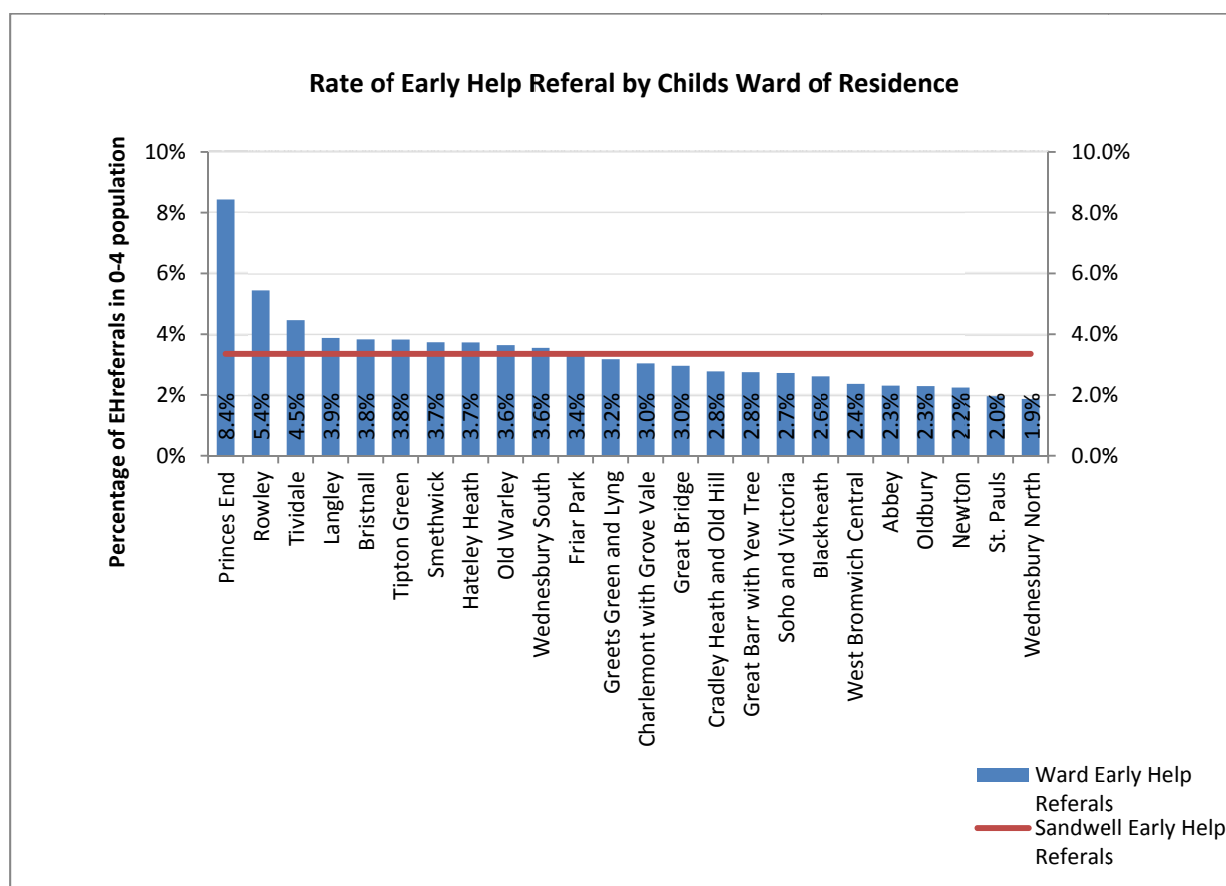


Figure 13: Early Help referrals by ward of residence in 0-4 population



Source: SMBC - The Social Care Performance and Data Team

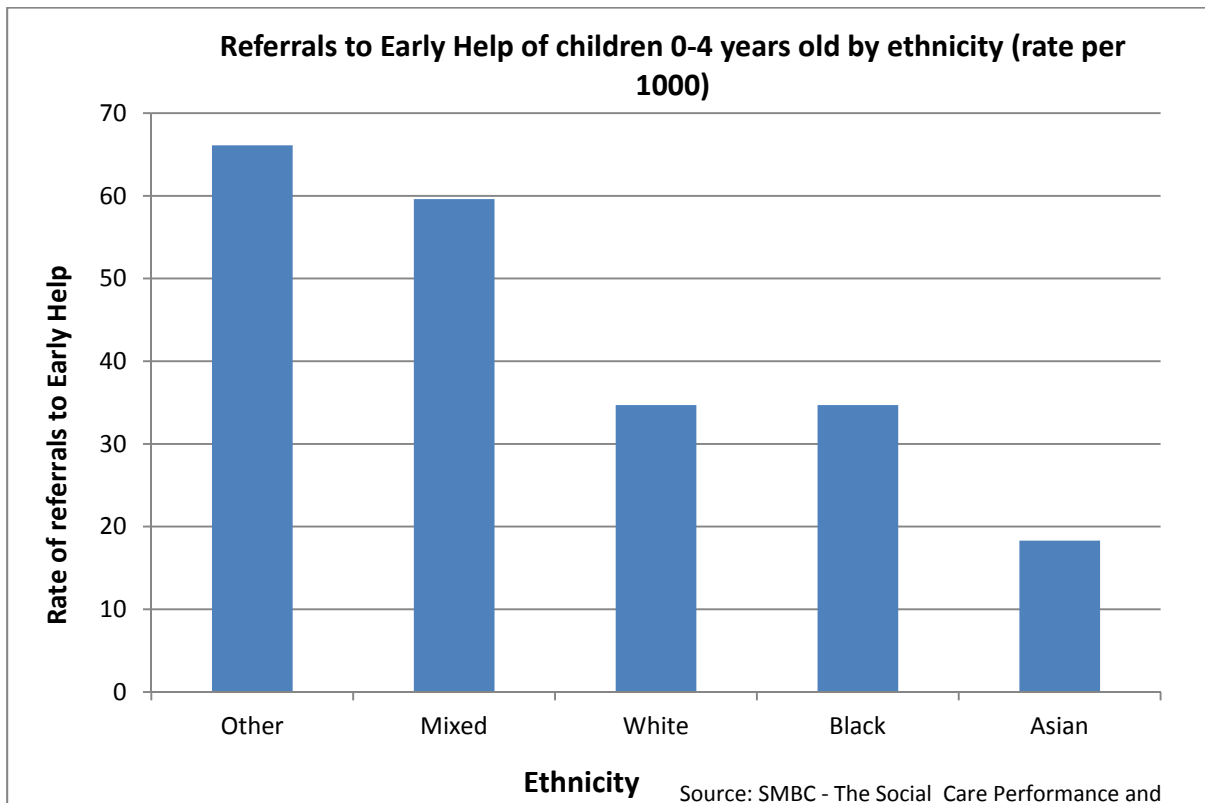
The percentage of early help referrals is greatest from wards such as Princess End followed by Rowley, Tividale and Langley, which are higher than the Sandwell average, shown in Figure 6. This suggests the need for further exploratory analysis to look into the cause for greater numbers of referrals from Princess End versus other similarly deprived areas such as Friars Park, Soho and Victoria and Smethwick, to determine whether the lower number of referrals in these areas is due to lesser need or the need for better recognition and management in these areas.

Table 11: Early help referrals by ethnicity

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

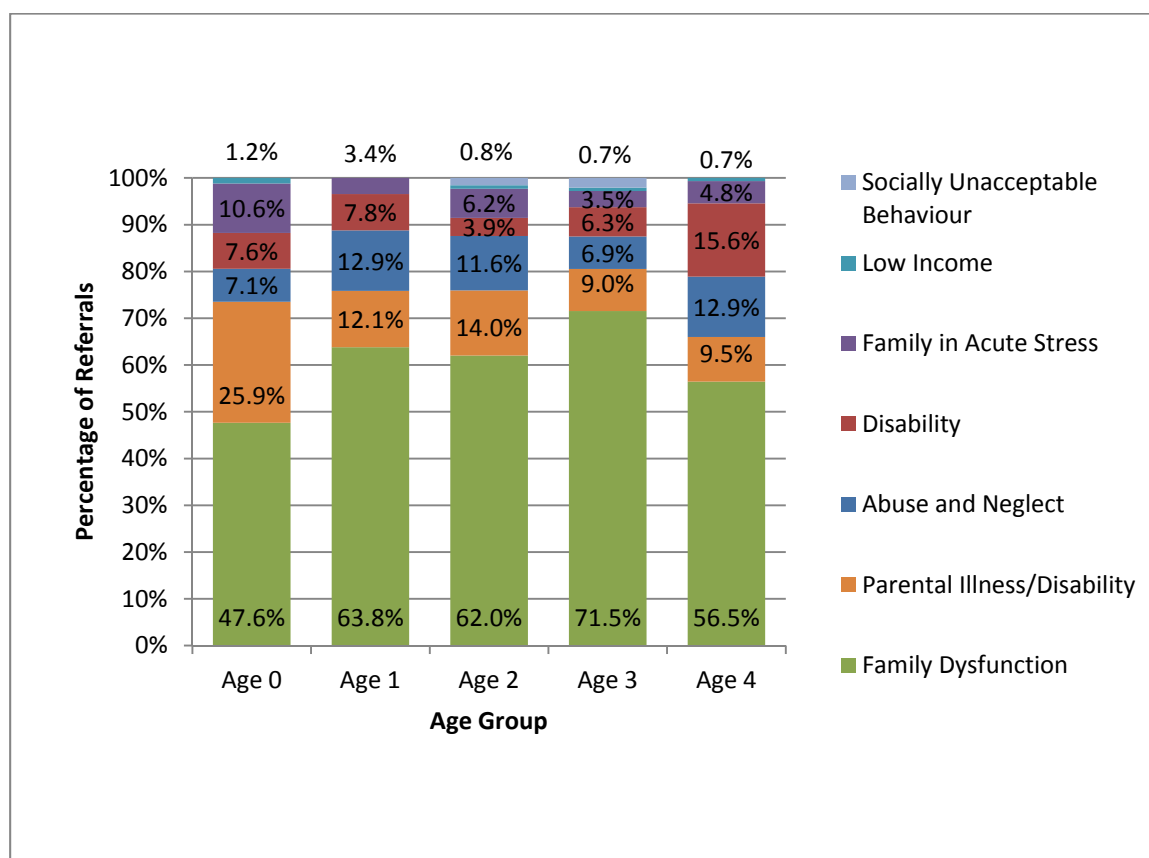
Source: SMBC - The Social Care Performance and Data Team

Figure 14: Early help referrals by ethnicity, 2014



The referral rate per 1000 is greatest for the 'Other group' (66.1) and Mixed Ethnic group (59.6) groups, followed by the white and the black ethnic groups. The referral rate was found to be lowest for the Asian population. As the difference in referral rate is so stark between groups, it is important that we investigate this further to understand if the low referral rate is a reflection of under referral among this group which is masking unmet need.

Figure 15: Primary need of early help referral by age group, 2014



Source: SMBC - The Social Care Performance and Data Team

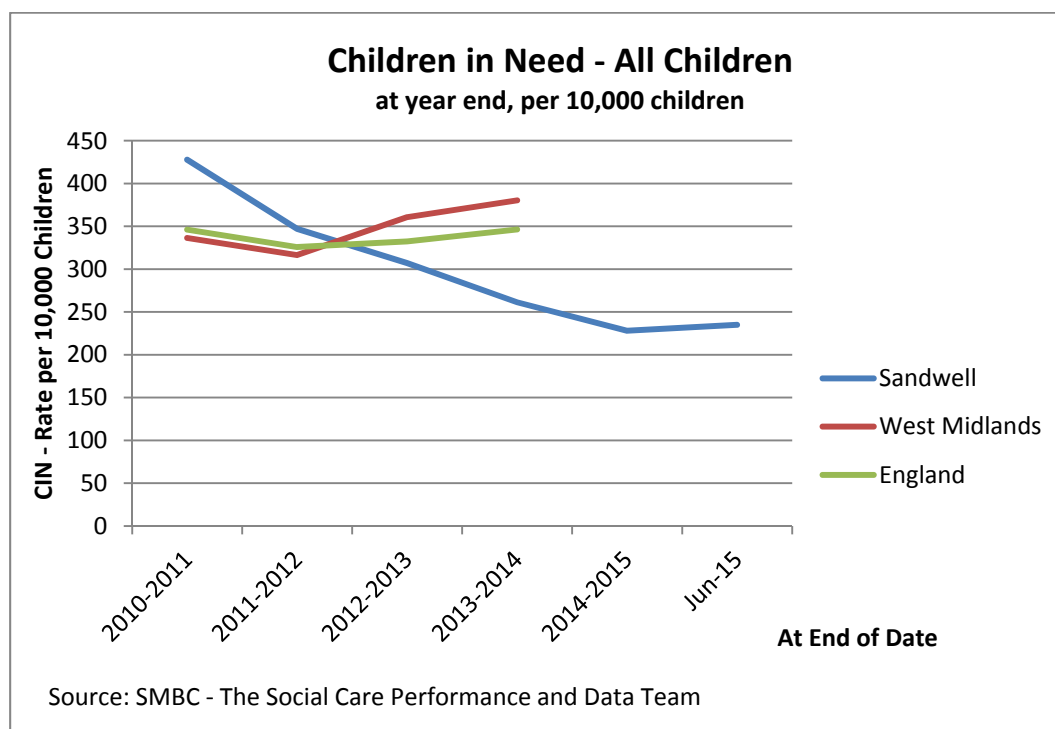
The primary need for early help referral at all age groups was greatest for family dysfunction (Figure 15), others reasons for referral being abuse and neglect, disability, family in acute stress, low family income, parental illness/disability and socially unacceptable behaviour. A high proportion of referrals in the under one population are due to parental illness or disability as compared to the other year groups in the 0-4 population. This may be a result of better screening and reporting in the antenatal/pregnancy or postpartum period. ‘Family in acute stress’ is another commonly reported reason for referral in the under one population.

3.4.2 Children in Need

Based on the legal definition of ‘children in need’ under Section 17 of the Children Act 1989, a child in need is one who has been assessed by children’s social care to be in need of services and is unlikely to maintain a reasonable standard of health or development and whose health and development is likely to be significantly impaired without the provision of services by a local authority. This includes children who have a substantial or permanent disability.

The children in need per 10,000 children at year end, excluding child protection cases and looked after children, for Sandwell, West Midlands and England are presented in Figure 16.

Figure 16: Children in need per 10,000 population



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

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

Of the 938 children, 21% of children were under the age of five years. In both the under one and one to four age groups the percentage in Sandwell is less than that nationally.

Table 12: Age Breakdown of Children in Need - as at 21/4/2015 (excluding LAC and CP Cases) with an open referral on ICS

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

Source: SMBC - The Social Care Performance and Data Team

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

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

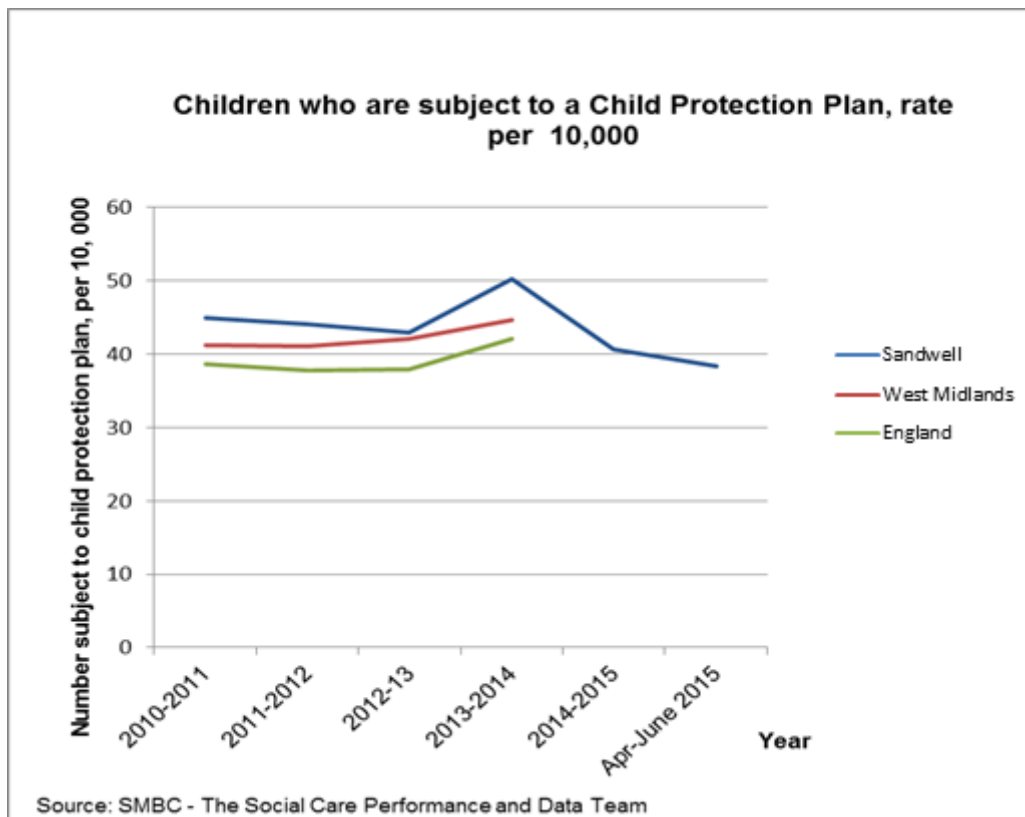
Ethnic Group	Total	CIN Proportion of Ethnic Group (2011 Census)
Asian or Asian British	138	0.80%
Black or Black British	126	2.40%
Mixed	112	1.90%
White	466	1.10%
Other ethnic background	43	3.20%
Declined to specify	1	
Not recorded/ information not obtained	52	
Total	938	

Source: SMBC - The Social Care Performance and Data Team

3.4.3 Child Protection Plan

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

Figure 17: Child protection plans for Sandwell



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

Figure 18: Child protection plans by age

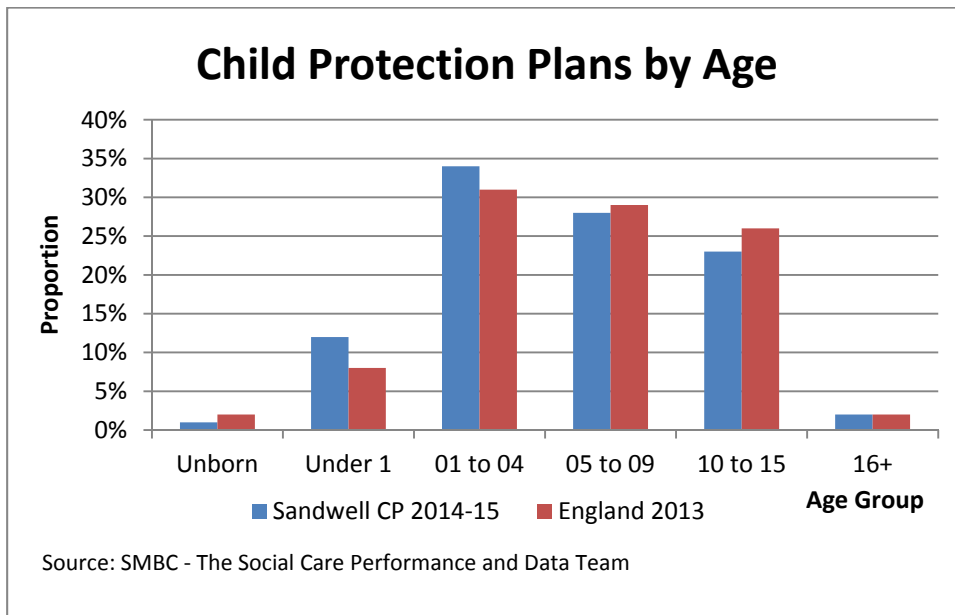


Table 14: Child protection plans for 0-4s by gender

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

Source: SMBC, Social Care Performance and Data Team

Table 15: Ethnic breakdown of Child Protection Cases aged 0-4

Ethnic Group	Rate per 1,000 Population of the ethnic population (Aged 0-4)		
	2012/13	2013/14	2014/15
White	6.3	7.5	7.7
Asian or Asian British	3.0	3.0	2.8
Mixed Ethnicity	12.4	11.9	11.4
Black or Black British	4.4	3.2	3.8
Other	8.5	10.7	6.4
Total	6.0	6.7	6.7

Source: SMBC, The Social Care Performance and Data Team

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

3.4.4 Looked after children

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

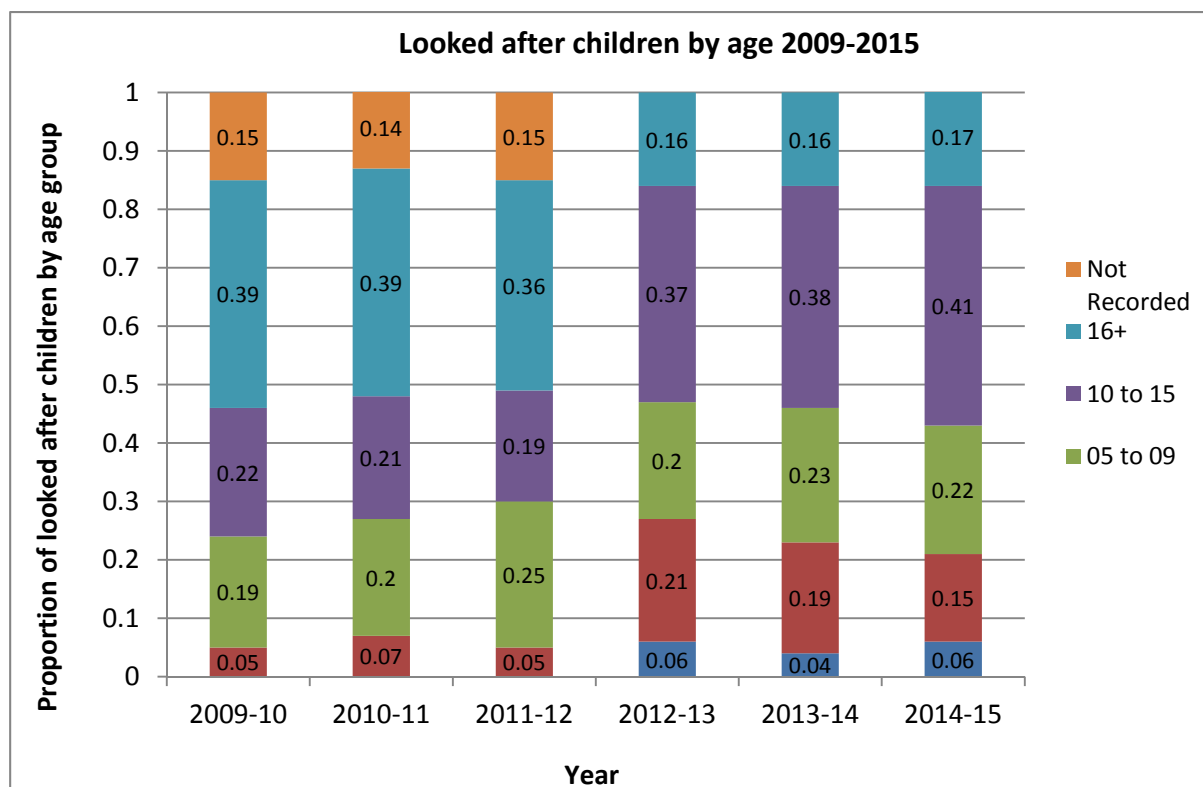
Table 16: Looked After Children (31 March 2014) Age Breakdown

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

Source: SMBC, Social Care Performance and Data Team

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

Figure 18: Looked After Children by age



Source: SMBC, Social Care Performance and Data Team

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

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

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

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

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

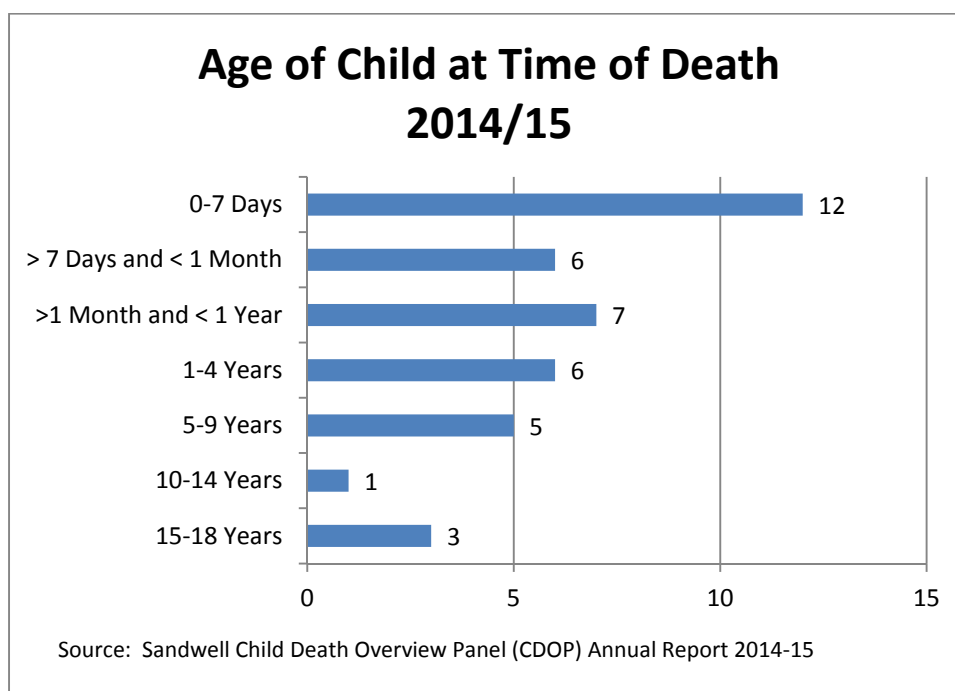
Ethnic Group	Rate per 1,000 Population of ethnic group (aged 0-4)		
	2012/13	2013/14	2014/15
White	8.6	6.1	5.8
Asian or Asian British	1.7	1.7	1.0
Mixed Ethnicity	13.8	14.8	9.1
Black or Black British	5.1	5.1	2.5
Other	19.2	19.2	6.4
Ethnicity Not Recorded	N/A	N/A	N/A
Total	7.3	6.0	4.7

Source: SMBC, The Social Care Performance and Data Team

3.4.5 Child Deaths

There were 40 child deaths reported to Sandwell Child Death Overview Panel (CDOP) in 2014 to 2015. 11 of these were deemed as unexpected. An unexpected child death is defined as ‘the death of an infant or child which was not anticipated as a significant possibility, for example, 24 hours before the death, or where there was an unexpected collapse or incident leading to or precipitating the events which lead to the death’, (Working Together 2015, Chapter 5 guidance).

Figure 19: Age of Child at Time of Death 2014/15



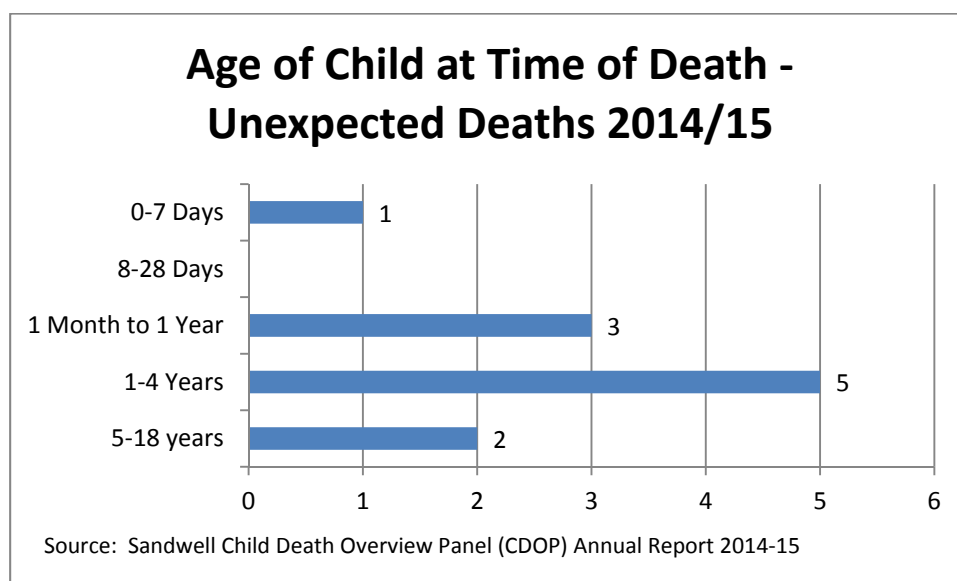
In 2014/15, 78% of all Sandwell child deaths occurred within the first four years of life, accounting for 31 of 40 deaths reported and 30% of all child deaths happened within 7 days of birth.

3.4.6 Unexpected Deaths

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

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

Figure 20: Age of Child at Time of Death - Unexpected Deaths 2014/15



3.4.7 Modifiable Factors

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

3.5 Current service provision

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

- Being safe
- Being healthy
- Enjoying and achieving
- Making a positive contribution
- Economic wellbeing

Further consultation was conducted to identify the strengths, weaknesses, areas of opportunity and potential threats to services area which support 0-4 safeguarding. This is presented in table 19 below.

Table 19: SWOT analysis of Safeguarding services in Sandwell

<p>Strengths</p> <ul style="list-style-type: none"> • Presence of MASH (Multiagency safeguarding Hub) • Thresholds clear – know where the documents are and how to use them • Locality model- well understood • A lot of services in place and available • Family information service 	<p>Weaknesses</p> <ul style="list-style-type: none"> • Awareness by each service within the model of whole model • Poorly co-ordinated services • Shrinking of resources for direct delivery of services • No good sign posting system
<p>Opportunities</p> <ul style="list-style-type: none"> • Better use of midwifery & Health Visitor to provide information on services & Children’s Centres • Specialist? Domestic violence advisors – make contact with lower risk clients – could use to make more general information “every contact counts” • Enhance information given to families in contact with general practice – resource dependent • Multi agency training “signs of safety” 	<p>Threats</p> <ul style="list-style-type: none"> • Continued funding cuts make it difficult to explore more integrated delivery options • Negative Ofsted reports resulting in staff being cautious of new ways of working • Negative perception of the aims of safeguarding and lack of articulation of the benefits of early intervention • Silo working between organisations • Culture of over-referral fuelled by negative reports and high profile cases • Recent increasing focus on Child Sexual Exploitation means resources are diverted from younger children’s safeguarding

3.6 Gaps

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

3.7 Recommendations

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

- Effective early identification of families with young children who may be at risk of neglect and harm – especially where a combination of risk factors are identified. This will require agencies to work in partnership and develop processes for intelligence sharing to identify vulnerable children. The Children's Joint Commissioning Partnership should consider how commissioned services can focus more on prevention and early identification and intervention going forward
- The effective application of referral thresholds by all agencies. There is anecdotal evidence that the recent decline in numbers of Children in Need is a result of more cautious referral. A consistent approach between agencies is required to ensure that all at risk children are identified and referred. The Children's Safeguarding Board should lead on implementing this approach.
- Sandwell Council Children's Social Care Performance and Data team should further investigate possible explanations for the low rate of referral in some ethnic groups to identify evidence of unmet need in these groups
- Sandwell Council Children's Services should review policies to identify possible reasons for the recent decline in referral rates and understand possible implications of this.
- Disseminating and implementing 'Lessons from Serious Case Reviews regarding babies and young children' to all relevant stakeholders.
- Providing accessible and culturally sensitive services in localities to meet key needs, such as mental health, domestic abuse, drugs, child poverty and

housing. This will include working with commissioners and providers of these services to ensure that appropriate safeguarding measures are in place.

- To broaden “Every Contact Counts” across services to cover Safeguarding for all front line staff and also raise staff awareness of available services.
- Safeguarding Board to roll out shared approach to working with families (“signs of safety”)
- Use the existing localities model to further integrate services for families.
- Using an asset based approach – building on locality model to identify existing resources in the community which could support safe parenting and to refer to appropriate services if a Safeguarding issue is suspected. This may include, for example, the development of peer mentoring for parents.
- Identify and engage with voluntary and community organisations serving groups who currently don’t engage with children’s services and work to tailor services to these groups.
- Raise awareness of services available (for example Family Information Services, Early Help Service) to all relevant professional groups to facilitate improved signposting. Moving forward the Children’s Commissioning Partnership should consider where greater alignment of services to provide more holistic support for families is appropriate.

4. School Readiness

Key points

- In Sandwell just over a half of children reached a good level of development by the age of five. Girls continue to outperform boys, and the performance of white pupils is not improving at the same rate as other ethnic groups.
- Initial results of the Making it REAL (Raising Early Achievement in Literacy) project are very encouraging. Sandwell will need to consider how the good practice from the project is cascaded and embedded across the borough.
- The Wellcomm screening tool is used to assess children's speech and language development. Almost a third of Sandwell children have made 'no progress' in 2013/2014, which is a major concern.
- Over a quarter of early years providers inspected in Sandwell were judged by Ofsted to be inadequate or require improvement. However, the quality of Children's Centres in the borough is much higher.
- The take-up rates for Nursery Education Funding (for 3 & 4 year olds) is generally high in Sandwell, however some wards have take-up of less than 80%. The take-up of Early Learning for Twos is growing, but again there is variation by ward, with some areas having a take-up rate below 30%.

4.1 Introduction

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

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

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

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

- Is a process which starts from birth
- Covers the time before a child starts at reception class in school
- Must involve parents

- Prepares children to be emotionally ready for school e.g. being separated from their main carer
- Prepares parents for the transition process
- Ensures children have sufficient language to communicate
- Ensures children have experience of play with their peers
- Ensures children show a degree of independence e.g. toilet trained; able to dress themselves
- Ensures children are able to hold a pencil

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

4.2 Descriptive epidemiology

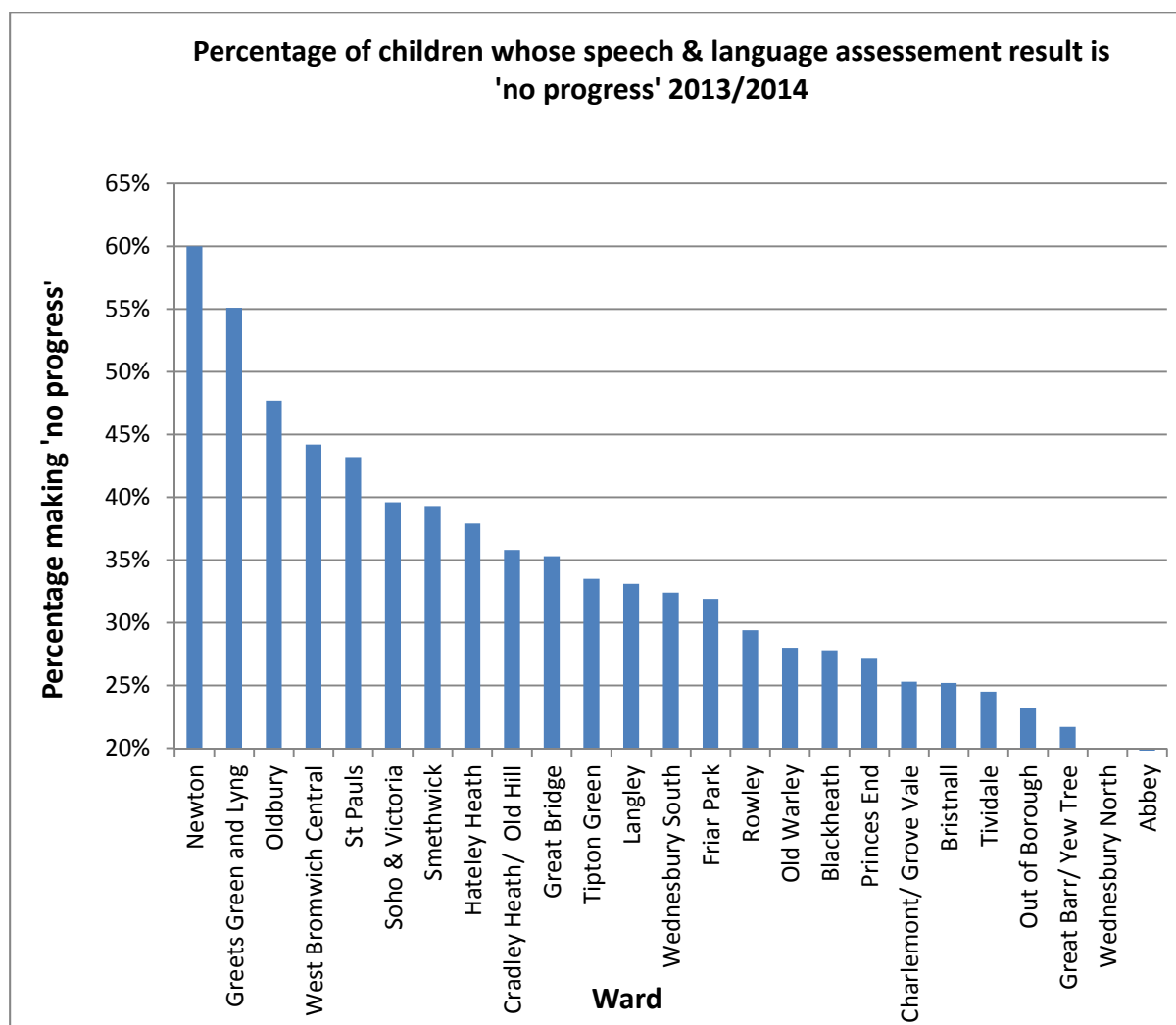
Too many children start school without the range of skills they need. Across the country in 2014 only 60% of all children reached a good level of development by the age of five based on the Early Years Foundation Stage (Dept. for Education, 2014). In Sandwell just over a half of children reached this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

4.2.1 Speech and Language

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

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

Figure 21: Assessment of the speech and language screening tool in all Sandwell settings 2013/2014



4.2.2 Child development

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

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

Table 20: Percentage points for Early Years Foundation Stage Key Indicators in Sandwell and in England, 2014

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

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

Table 21: Percentage achieving a good level of development by gender and ethnicity 2013 and 2014

	Sandwell (%)		England (%)	
	2013	2014	2013	2014
Boys	40	45	44	52
Girls	58	63	60	69
White	47	54	52	62
Mixed	50	60	53	62
Asian	45	55	47	57
Black	48	58	51	59
Chinese	22	17	49	58
All	46	54	52	60

4.3 National guidelines and recommendations

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

- Where providers have developed close partnerships with other agencies, they were more likely to have developed a localised mutual understanding of what was expected in terms of children’s readiness at the time of transfer.
- Evidence of good practice in engaging parents and carers was seen mainly through children’s centres, which worked with other agencies to engage vulnerable parents and target support where it was most needed.
- Good practice in disadvantages areas, where providers worked closely with parents in the transition period e.g. increasing parents understanding of what was expected and providing information and guidance.
- There were a significant number of children with learning and development delay. Three main areas identified were social and emotional development, physical development and communication.
- Importance of specific programmes of support in helping children to develop their speaking, listening and communication skills.

- Positive impact on children’s communication development when staff spoke clearly and understood the importance of promoting opportunities for children to speak in sentences and initiate questions.
- Benefit of adult-led sessions with small groups of children.
- Schools using Pupil Premium funding to ensure early identification and specialist support from their starting points.
- Accurate assessments being completed and joint work between providers and schools to ensure accuracy of those baseline assessments.
- Taking a broad view of issues in the locality and taking action accordingly.

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

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

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

4.4 Current service provision and effectiveness of these services

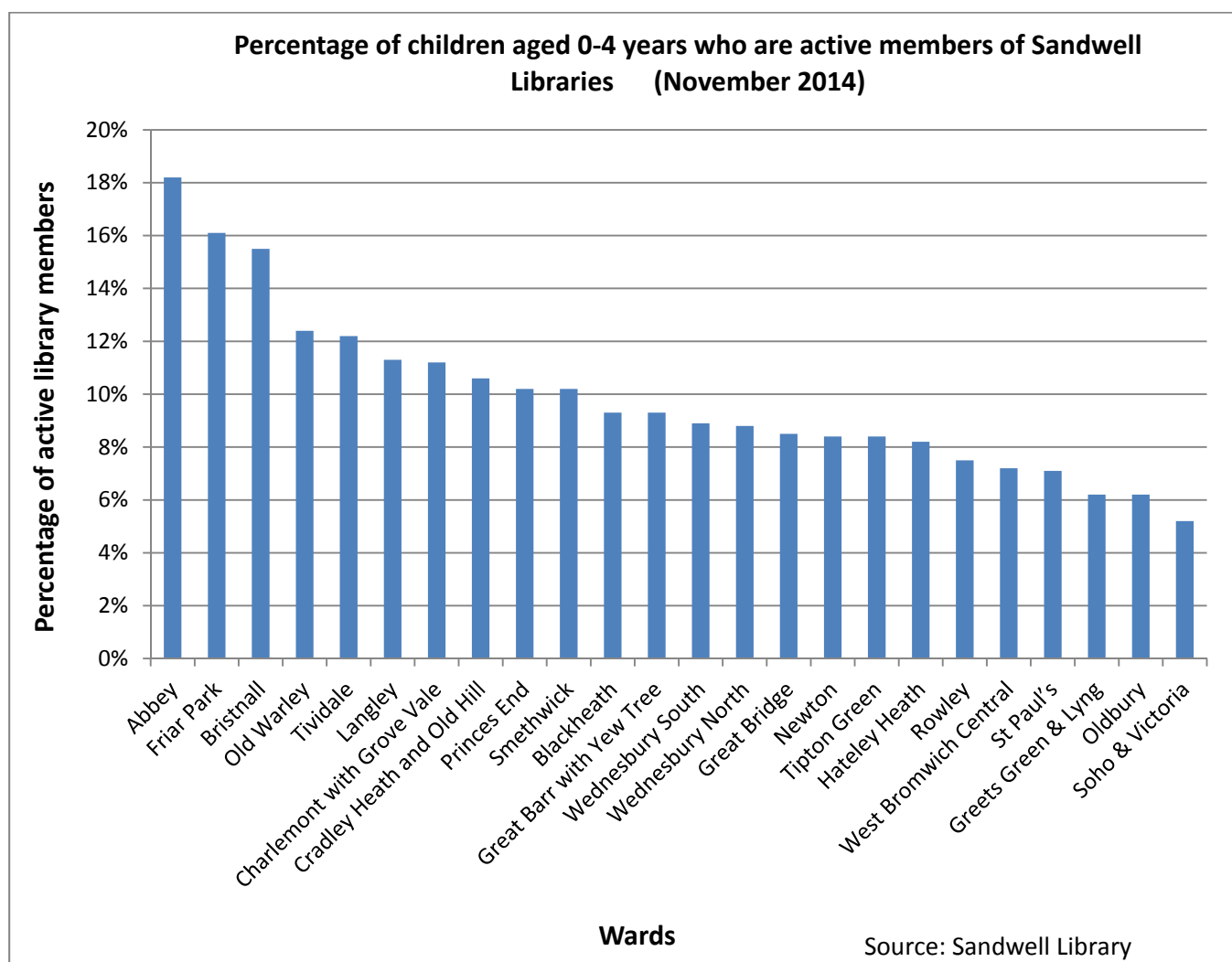
4.4.1 Literacy

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

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

Figure 22 provides an analysis of library membership over a 12 month period. This shows active members (defined as a child who has a minimum of two withdrawals in a 12 month period) aged under 5 by ward, based on home address. However the library service did note that many parents of young children will take out books for their children on their own membership rather than their children's. The lowest levels of active library membership amongst the under 5s are in the wards of Soho & Victoria, Greets Green & Lyng and Oldbury. These wards are among the lowest in Sandwell on child development (EYFSP scores 2011/12). The highest levels of active library membership amongst the under 5s are in the wards of Abbey and Friar Park. These wards are among the highest in Sandwell on child development (EYFSP scores 2011/12).

Figure 22: Active members (0-4 years) in Sandwell libraries November 2014



Making it REAL (Raising Early Achievement in Literacy) is an evidence-based family literacy intervention for 2-5 year olds. The Making it REAL training and projects are designed to enable practitioners to use the REAL evidence-based approach that reaches out to parents and families, building confidence and knowledge to support the early home learning environment: this has been shown to have a powerful impact on children's outcomes and on family literacy practice. Sandwell is one of eight local authority development projects working with National Children's Bureau (NCB) Early Childhood Unit as part of a DfE National Prospectus Grant.

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

Table 22: Results of the REAL Project 2014

Outcome measure	Total National Project results		Sandwell results	
	Pre	Post	Pre	Post
Oral language (to know one or two nursery rhymes)	24%	61%	22%	83%
Share books	43%	74%	54%	79%
Drawing and mark making	38%	69%	47%	80%
Identifies more than two words/letters/logos	6%	35%	12%	56%

4.4.2 Child Care Provision

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

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

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

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

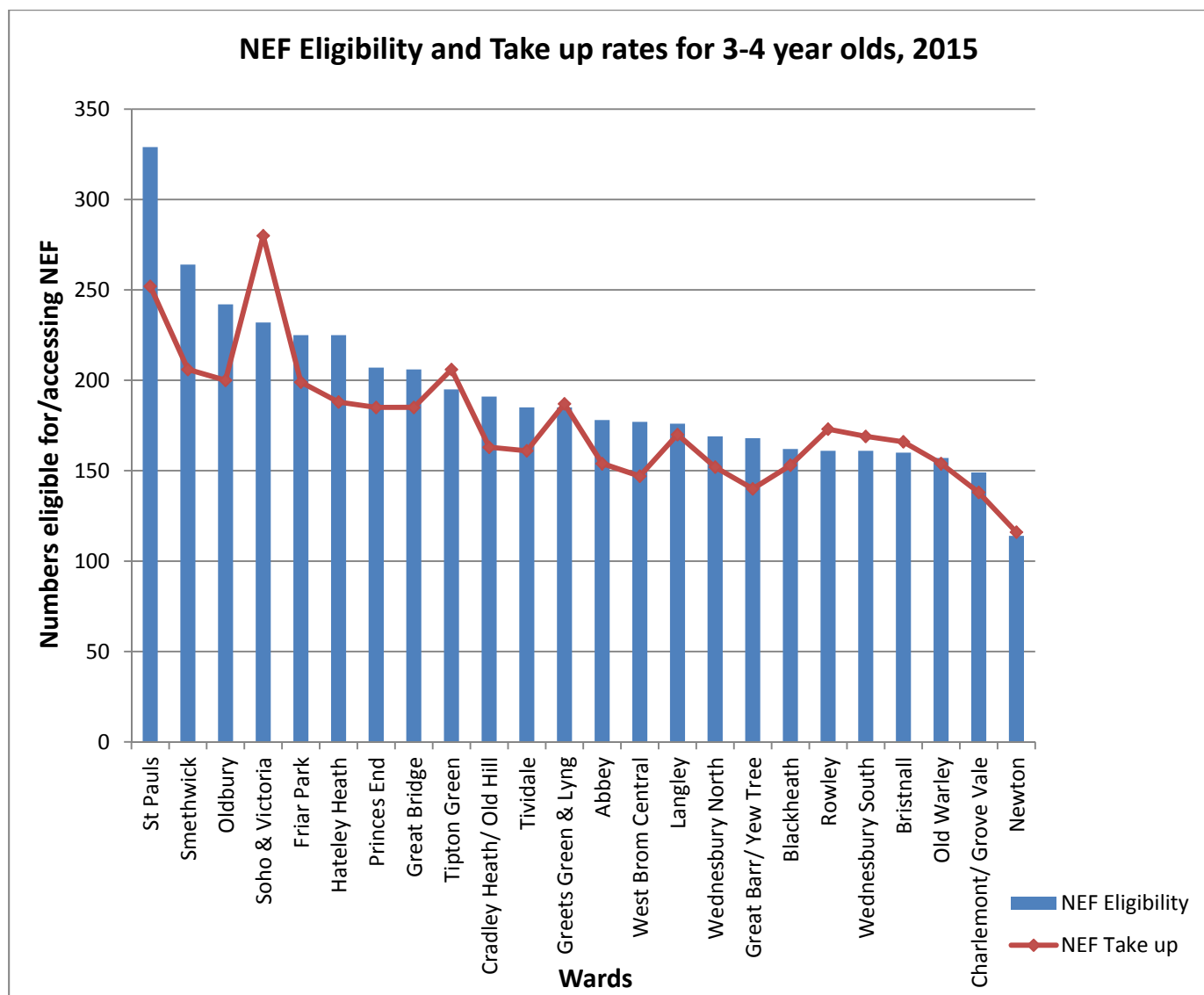
There is a network of 20 locality children's centres across the borough together with a specific Children's Centre for Young Parents. Centres work primarily with children under 5 years of age and their families - their core purpose is to improve outcomes for young children and their families and reduce inequalities between families in the greatest need and their peers. Ofsted inspection of children's centres found 89% of settings good or outstanding which is significantly higher than the national level.

In addition to childcare provision many local authority, private and voluntary sector providers offer parent and toddler or stay and play sessions. This aspect of the early years sector is not required to be registered with Ofsted as the children are not left in the care of other people. It is therefore more difficult to maintain accurate records of provision. Local children’s centres offer support to these groups as part of the universal services available in the area.

4.4.3 Service uptake

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

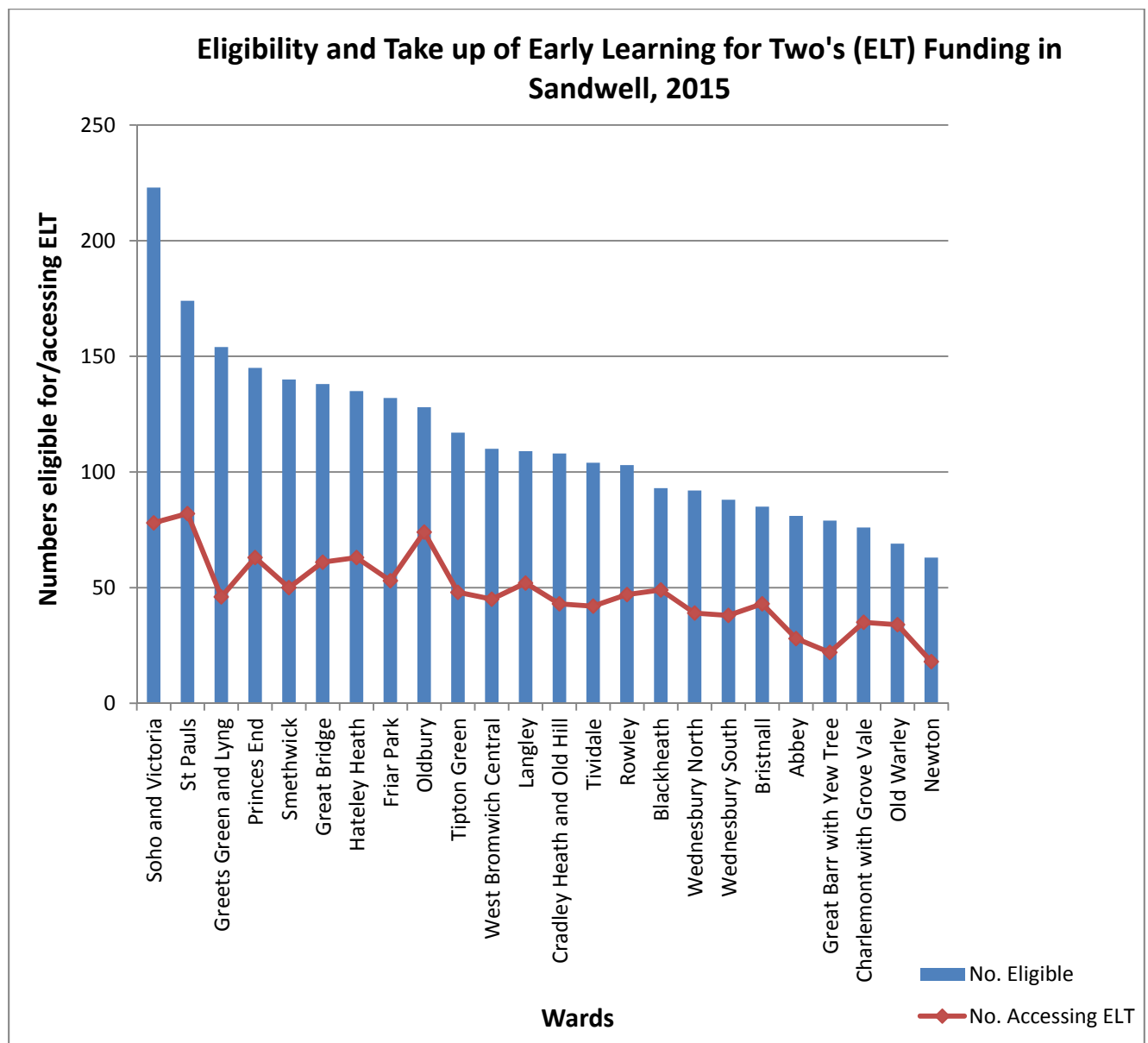
Figure 23: Take up rates of NEF for 3-4 year olds in Sandwell by ward



Source: Sandwell Family Information Service

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

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



Source: Sandwell Family Information Service

4.5 Consultation with Stakeholders

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

Strengths:

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

Weaknesses:

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

Opportunities:

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

Threats:

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

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

From the SWOT analysis key priorities are

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

4.7 Recommendations

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

5. Special Education Needs and Disabilities

Key Messages

- Of the children in Sandwell aged 0-4 in nursery with Special Educational Needs and Disability, a large proportion have a speech, language or communication need.
- 17% of children were aged 4 or over at referral in 2014-15 to the Inclusion Support Early Years' Service (ISEY) (a targeted and specialist service for children under the age of 5 years). The greatest number of referrals to the service is noted for speech, language and communication needs. Appropriate and timely referral rates must improve to enable early intervention and therefore minimise any long term effects of delayed development.
- Information on individual children with Special Educational Needs and Disability needs to be shared more readily between services than is currently the case.
- Joint commissioning is required to meet the needs of children and young people with SEND aged from 0-25, overseen by the SEND board.

5.1 Introduction

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

5.2 Descriptive epidemiology

5.2.1 High Level Prevalence Indicators

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

Table 23: Prevalence of disability in Sandwell, 2011

	Boys	Girls	Total
Mild disability	1624	1469	3093
Severe disability	17	9	26

Source: ONS 2011

5.2.2 Language Development

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

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

Prevalence (%)	Estimate
10	2072
15	3108

Source: Royal College of Speech and Language therapy

5.2.3 School census information – children 0-4 years in nursery with Special Educational Needs or disability (2012-2014)

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

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

	Nursery 1 (age 3)			Nursery 2 (age 4)		
	2012	2013	2014	2012	2013	2014
Autistic Spectrum Disorder	-	1	-	3	1	5
Behaviour, Emotional & Social Difficulties	1	1	-	8	7	6
Hearing Impairment	2	-	-	2	2	2
Moderate Learning Difficulty	-	-	1	11	4	5
Other Difficulty/Disability	-	1	-	1	6	2
Physical Disability	-	-	-	4	5	6
Profound & Multiple Learning Difficulty	2	6	1	7	5	4
Speech, Language & Communication Needs	9	4	8	82	86	98
Severe Learning Difficulty	2	3	1	8	8	12
Specific Learning Difficulty	-	-	1	3	3	2
Visual Impairment	-	-	1	4	5	1

Source: SMBC Inclusion Support Early Years and Child Development Centre

5.2.4 Specialist Support

There were 18 new referrals into Inclusion Support for Educational and Child Psychology support during the last academic year. A total of 26 Community Assessment Meetings were also held supported by Educational Psychologists, Inclusion Support-Early Years workers, and health services.

5.2.5 Sensory Support Team - Hearing Impairment (HI) and Visual Impairment Services (VI)

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

Figure 25: Number of Children on Sensory Team caseload aged under 5 in August 2015 by area

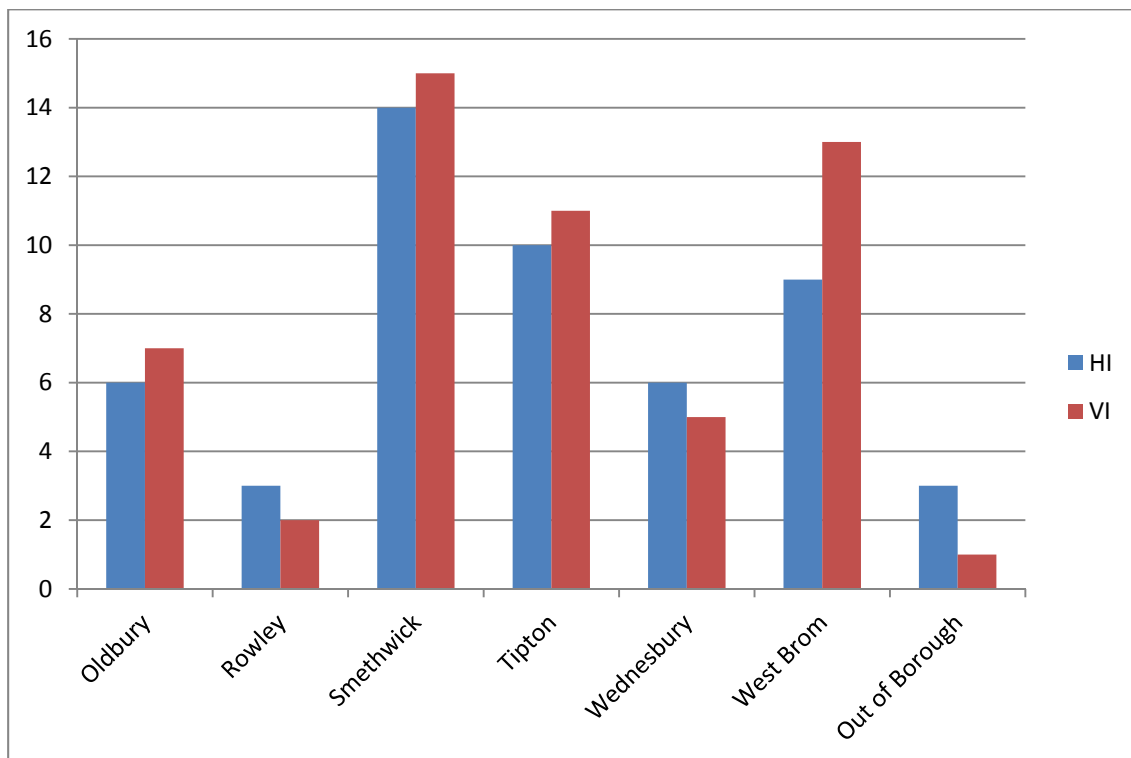
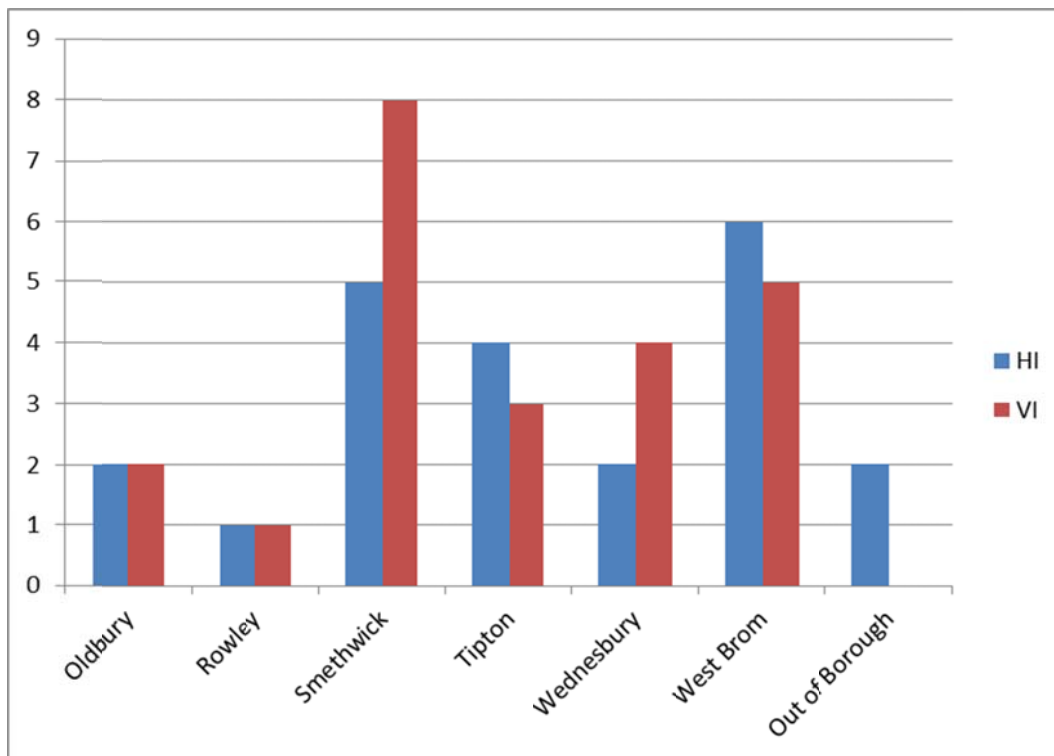


Figure 26: Number of children under 5 years of age referred to Sensory Team 2014-15 by area



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

Figure 27: Sensory Team caseload aged under 5 in August 2015 by area-Rate per 1,000 Children

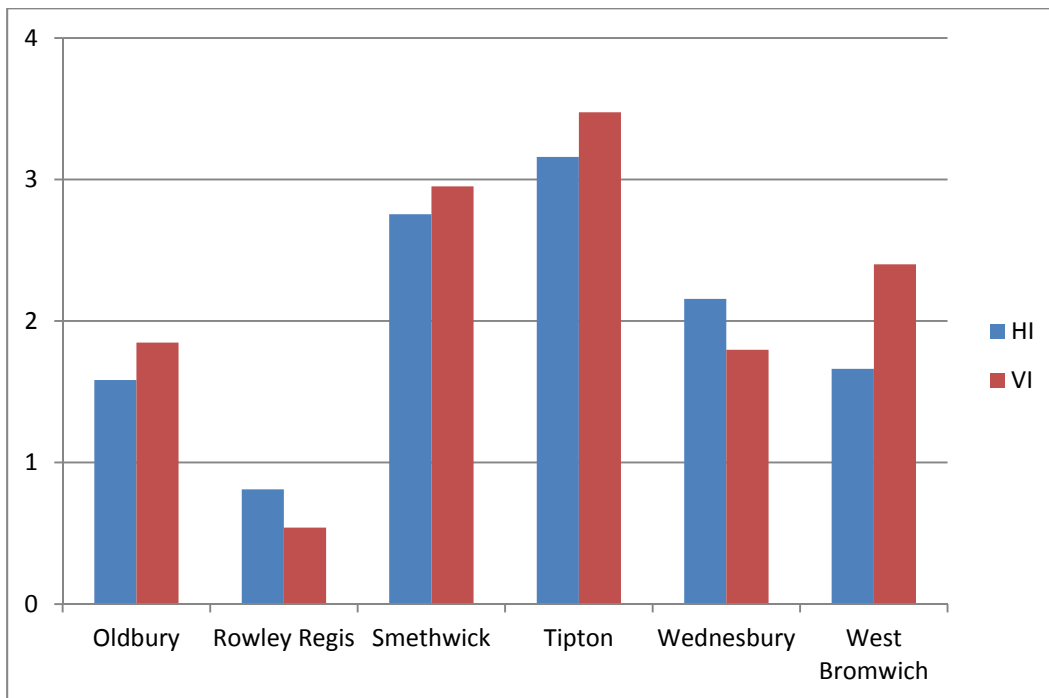


Figure 28: Under 5 years of age referrals to Sensory Team 2014-15 by area-Rate per 1,000 Children

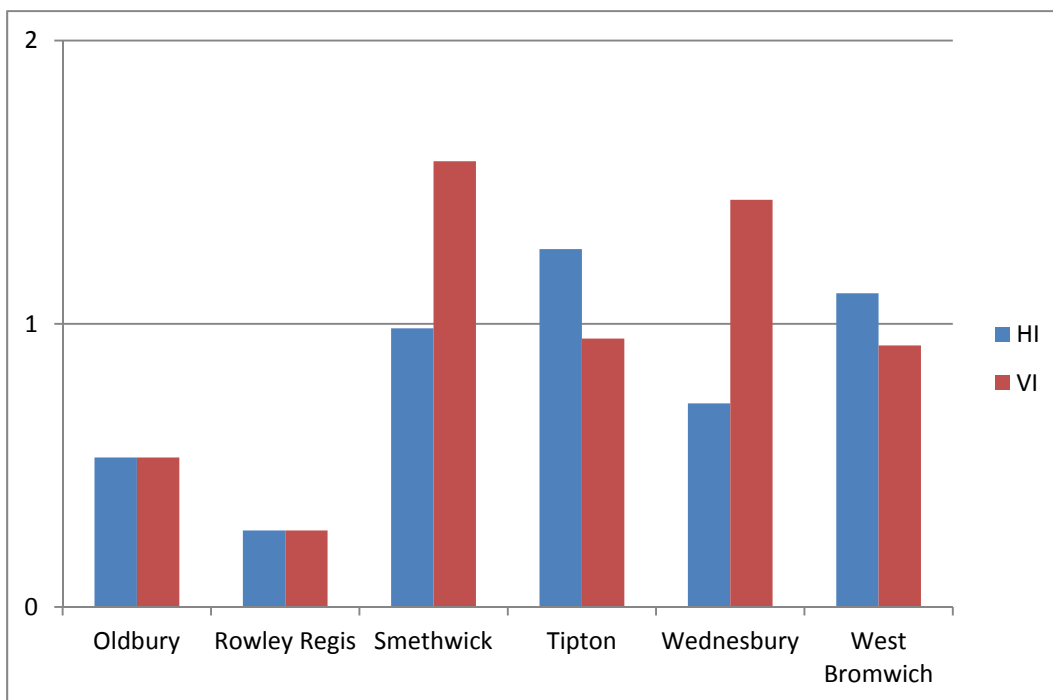
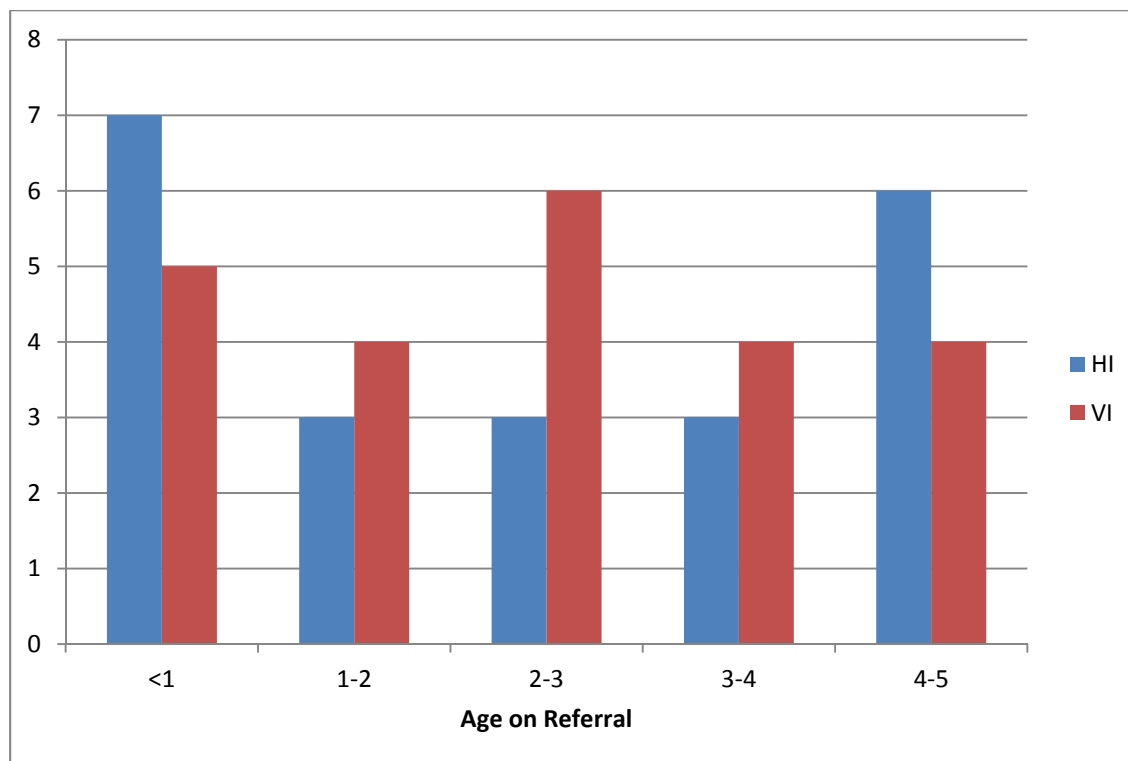


Figure 29 indicates that referrals spike in the first year of life, especially for hearing, which reflects referrals from universal new born screening. Vision referrals spike between 2 and 3 years, possibly reflecting 2.5 year development check.

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



Source: SMBC Inclusion Support Early Years and Child Development Centre

5.3 National guidelines and recommendations

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

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

In addition, the SEND Code of Practice highlights the role of the Joint Strategic Needs Assessment (JSNA) in understanding local needs:

- Joint commissioning should be informed by a clear assessment of local needs. Health and Wellbeing Boards are required to develop Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies, to support prevention, identification, assessment and early intervention and a joined-up approach. Under section 75 of the National Health Service Act 2006, local authorities and CCGs can pool resources and delegate certain NHS and local authority health-related functions to the other partner(s) if it would lead to an improvement in the way those functions are exercised. (Para 3.4 Code of Practice)
- The Joint Strategic Needs Assessment (JSNA) is the means by which the Board understands and agrees the needs of all local people. It is the basis for the joint health and wellbeing strategy which sets the priorities for joint action. (Para 3.22 Code of Practice)
- The JSNA will inform the joint commissioning decisions made for children and young people with SEND, which will in turn be reflected in the services set out in the Local Offer. At an individual level, services should co-operate where necessary in arranging the agreed provision in an EHC (Education, Health and Care) plan. Partners should consider how they will work to align support delivered through mechanisms such as the early help assessment and how SEND support in schools can be aligned both strategically and operationally. They should, where appropriate, share the costs of support for individual children and young people with complex needs, so that they do not fall on one agency. (Para 3.24 Code of Practice).

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

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

Language Development

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

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

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

5.4 Current service provision and effectiveness of these services

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

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

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

- To improve understanding of the SEND population and recent trends in Sandwell
- To develop a plan and implement a coordinated programme of change in line with national expectations
- To develop a communications plan for all key stakeholders
- To act as champions for the implementation of change across the partnership, using reference groups where appropriate.
- To direct the use of the additional Department for Education funding to support the implementation of reform

Services in Sandwell include those at the universal, targeted and specialist levels from all agencies, listed below;

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

5.4.1 Inclusion Support Early Years' Service (ISEY) information

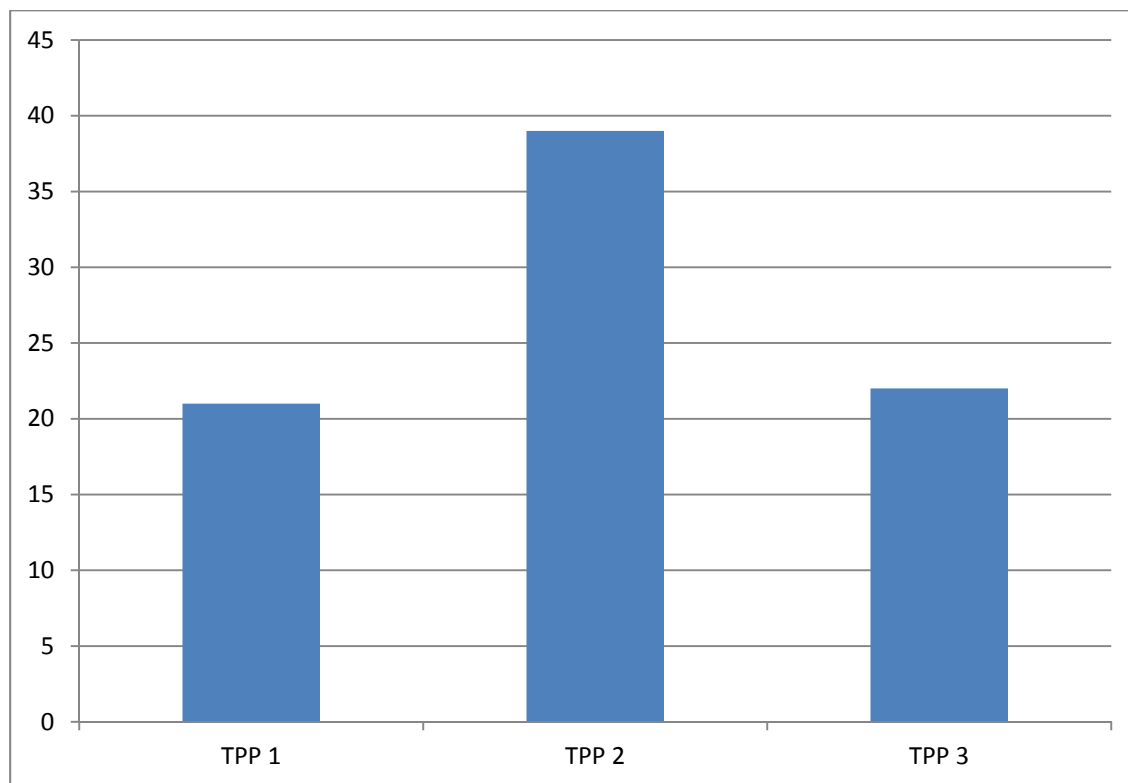
Inclusion Support - Early Years (ISEY) is based at The Coneygre Centre, Tipton and supports children in their early years that have individual or special educational needs (SEN) / disabilities. This service offers a multi-disciplinary team provided by the Sandwell and West Birmingham Hospitals NHS Trust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

TTP:

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

Figure 30 demonstrates that the most common pathway used in Sandwell is Transition plus pathway 2.

Figure 30: Number of Inclusion Support Early Years Transition Pathways into school September 2015



Source: SMBC Inclusion Support Early Years and Child Development Centre

The service also provides advice and guidance to childcare settings so they can offer quality inclusive provision ensuring the needs of children with SEND are being met. In the last academic year Inclusion Support Early Years trained 696 practitioners, accessing 51 training courses. There was an overall satisfaction rating of good and excellent of 96%.

Sandwell data showing referral patterns to this service are given below. Figure 31 demonstrates in 2014-15, the greatest number of referrals to the service was for speech, language and communication needs.

Figure 31: Area of need for children accessing Inclusion Support Early Years (ISEY) prior to entry into school nursery 2014-15

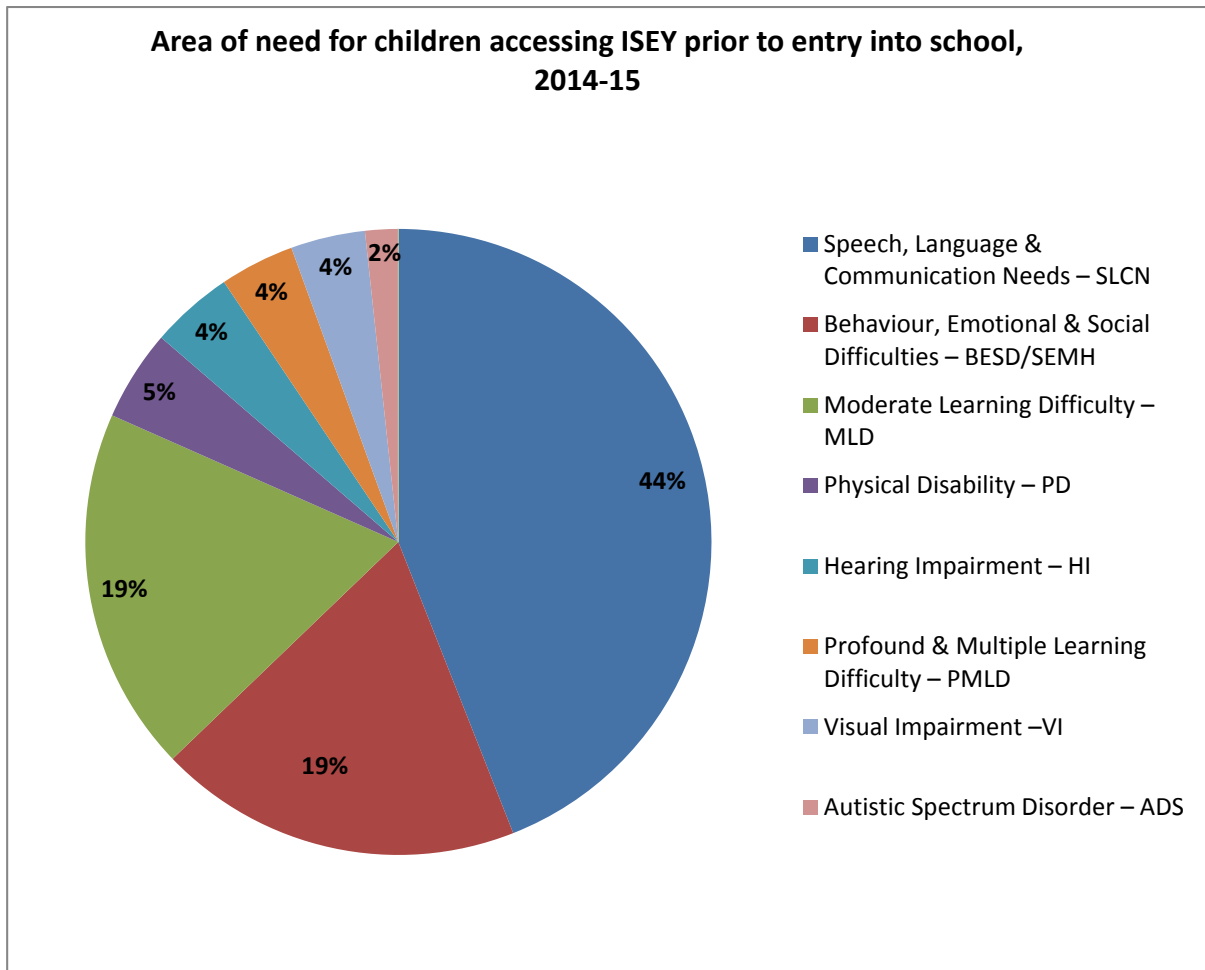
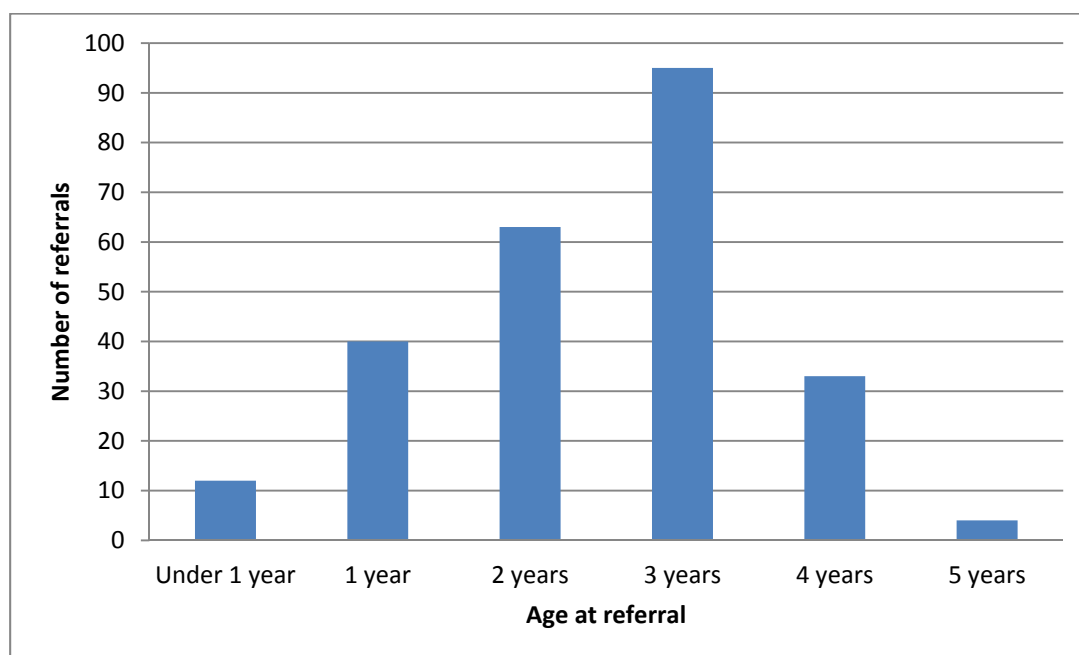


Figure 32: Age of referral to ISEY, 2014-15



Source: SMBC Inclusion Support Early Years and Child Development Centre

5.4.2 Children's Centres

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

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

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

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

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

5.4.3 Paediatric therapies

Speech and Language therapists work with children who may have difficulties with speech sounds, language, stammering, feeding difficulties or their voice.

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

5.4.4 Children with Disabilities

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

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

5.4.5 Effectiveness of current services

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

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

5.5 Consultation with Stakeholders

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

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

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

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

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

5.7 Recommendations

- Children and Families Joint Commissioning Group should consider whether a strategy is required to ensure a consistent, multi-agency approach to early identification and intervention is adopted
- Continue to extend the awareness across all universal services of the need to screen the development of young children to ensure early access to support and intervention.
- Monitor and continue to develop the Local Offer for SEND, so that families are provided with information on the support and services available in Sandwell for children and young people with SEND.
- Improve and align the collection and sharing of information on individual children across health and Local Authority agencies
- Align data sources and develop partnership commissioning arrangements which analyse and review changing patterns of incidence and demand.
- Further data analysis is required to identify evidence of delayed referral. This should include looking at age of referral to see how Sandwell bench-marks against other areas and also high referral into Transition Plus Pathway 2. We need to establish whether individual children would have been suitable for TPP1 if identified earlier and if this would have improved outcomes

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