

Joint Strategic Needs Assessment (JSNA) for children and young people aged 5-19 years old

Public Health Department
Sandwell Metropolitan Borough Council



**Research
Sandwell**

Executive summary

Sandwell borough has a population of over 300,000 people, approximately 20% of whom are aged five to nineteen years old. In the decade since 2004, there was an increase in younger residents, with the number of 5-19 year olds increasing by 4.9% (2,853 persons). By the year 2026 the population of 5-19 year olds in Sandwell is projected to increase by 15.3% to 70,546 persons.

Sandwell has some of the highest levels of deprivation in the country and children and young people are particularly affected; indicators of child poverty in Sandwell are worse than the overall measurements of deprivation for the borough. It is important to focus on younger people in order to tackle inter-generational worklessness, dependence on low-paid employment, and poverty as these conditions affect many families living in Sandwell.

Many Sandwell residents suffer poor health outcomes, with people living more than ten years longer in poor health compared to the national average. In order to tackle the causes of ill-health in Sandwell in the long term, it is important to focus on our children and young people by supporting them to adopt healthier lifestyles at an early age, and by creating a safe, healthy environment in which they can live and thrive. This JSNA looks at seven areas which impact on the health and wellbeing of 5-19 year olds, as agreed by local stakeholder engagement. Recently a separate Children and Young People's Mental Health JSNA has been published and a separate Prevention of Violence JSNA is currently undergoing consultation. The findings and recommendations of these two JSNA have not been replicated in this document.

Healthy weight

When children in Sandwell start school, their weight is similar to children living in other parts of the country; however, by the end of primary school, more children in Sandwell are overweight or obese than the national average. This shows that the primary school years are a good opportunity to prevent children gaining excess weight which they may carry into adolescence and adulthood. There is a well-established, evidence-based offer to increase physical activity among Sandwell's

primary school-aged children, both in schools and in the community, but engagement with this programme varies between schools. There are also evidence-based services to support better nutrition of children using a whole-family focused approach; however, referrals to this service do not reflect the numbers of children with excess weight which indicates further engagement with stakeholders is required to improve access.

The built environment can have a significant impact on children's weight. It is therefore necessary that new housing developments provide access to sufficient green space to encourage physical activity. It is also important that schools engage with the tools available to promote active travel to school and that transport planning maximizes opportunities for active transport for children when identifying routes for development.

Substance misuse

Young people's alcohol and drug use can increase the risk of poor health, poor emotional wellbeing, anti-social behaviour, criminal activity and failure to achieve their full potential in education. Alcohol and drug use may also lead to risk-taking behaviours such as regretted sexual contact, unprotected sex and pregnancy. There are several factors which increase the likelihood of a young person using or misusing drugs and alcohol, many of which are comparatively high among young people living in Sandwell. These include community factors such as availability of substances and tolerance of misuse; family factors including parental misuse, family conflict, and deprivation; and personal factors including low educational attainment prior to use, early anti-social behaviour and friends who engage in misuse.

Available data on alcohol use is poor because it is collected by self-reported questionnaires distributed in schools. The data from this survey shows relatively low levels of alcohol consumption among young people living in Sandwell while, in contrast, hospital data shows a high rate of alcohol-specific hospital admissions. This discrepancy highlights the need for more robust data on alcohol use patterns among young people living in Sandwell.

The data on drug use by young people in Sandwell is comparable to the rest of the Black Country and Birmingham but higher than the regional or national average. The main gap identified in drug services is provision for younger adults in the borough. Specifically tailored services are commissioned for under-18 year olds only, with those 18 and over accessing the adult drug and alcohol service. No 18 or 19 year olds accessed the adult alcohol service where the average age of presentation is the mid to late 30s. There is no evidence of reduced need for this service among this age group therefore it is important that we look at reasons for the poor uptake and tailor services toward younger adult clients where appropriate.

Increasingly, services are aimed at improving mental wellbeing and increasing resilience in young people more generally, rather than focussing on substance abuse. It is important that support around reducing harmful behaviours and increasing wellbeing in young people is consistent but also aligned. Exposure to a range of factors including domestic violence, sexual exploitation, mental illness and anti-social behaviour increase a young person's likelihood of engaging in substance misuse. There should therefore be processes in place to screen young people who use services for other vulnerabilities and to cross-refer where appropriate. Likewise, agencies dealing with young people with vulnerabilities (including social workers and safeguarding teams) should be aware of the increased likelihood of substance misuse and refer them to the appropriate services.

Sexual health

Overall, Sandwell has a higher under-18 conception rate than the national and regional averages despite a considerable overall reduction in recent years. There is also greater demand for repeat abortions in Sandwell compared to national and regional averages. While Sandwell has high levels of prescriptions of Long-acting Reversible Contraceptive (LARC) devices, there is anecdotal evidence that younger people are not accessing these services. Evidence shows links between teenage pregnancy and deprivation; however, other factors such as poor educational attainment and low aspirations have an even stronger impact. Socio-economic disadvantage can be both a cause and consequence of teenage pregnancy.

Sandwell is a high prevalence area for HIV and late diagnosis of HIV continues to be a major problem for the area. The chlamydia diagnosis rate has considerably improved over the last year and is now at the same level as national average. The proportion of younger people tested for chlamydia still remains below the regional average; however, the high positivity rate may mean that targeting of young people at greater risk of infection is better in Sandwell than in other areas.

Service gap analysis shows a need for both contraceptive and sexual health services tailored specifically for younger people and wide stakeholder engagement to improve awareness and access to these services.

Long-term conditions, learning difficulties and special educational need

Children with disabilities and other long-term conditions face a range of inequalities such as accessing services, health outcomes and educational attainment. Seventeen per cent (17%) of 5-19 year olds in Sandwell have been identified as having a special educational need. Reasons for special educational need may or may not include a learning difficulty or long-term medical condition. The gap in education attainment between Sandwell and the national averages for all pupils is also reflected within the cohort of pupils requiring SEN. For example, at Key Stage 4, only 10% of Sandwell pupils with SEN achieved 5+ A*-C (incl. maths & English) in 2015, compared with 20% nationally.

The proportion of 5-19 year olds in Sandwell with identified SEN is much lower than the national average. It is unknown whether this is a reflection of unrecognised and unmet need or a result of the process of assessment and diagnosis and the early help support available in Sandwell. Further investigation is required to better understand this situation. Currently, the Educational, Health and Care plans which some pupils with SEN receive are dominated by educational needs and there is little input from health partners. The process of developing these plans needs to be reviewed to ensure there is input from all appropriate areas and results in a holistic plan.

The main long-term medical conditions affecting the 5-19 year old age group are asthma, epilepsy and type-1 diabetes; the most common of these conditions is asthma which affects over 7,000 children in Sandwell. Management in the community should be possible for the majority of patients with these conditions and unplanned hospital admissions due to these conditions are a NHS national quality indicator. Despite this, currently around 94% of emergency admissions for children (under 19) with long-term conditions are a result of asthma, diabetes or epilepsy. Emergency admissions for both asthma and epilepsy among 5-19 year olds in Sandwell are much higher than in the rest of the country. Historically, admissions for type-1 diabetes were higher than the national average for 5-19 year olds but recently this has improved and Sandwell's figures have been comparable to the national average.

As well as the clear impact on health, children with long-term conditions are at risk of having reduced education, physical activity and social opportunities, compared to healthy children. It is important that long-term condition management plans include input and support from parents, health professions (including GP practice staff and school nurses or health visitors where appropriate), teachers and the wider community. Good disease management and avoiding admissions requires holistic support for both the patient and family. For example, care planning for asthma should include proper inhaler compliance and technique, but also information on smoking cessation services and support around decent housing (to avoid cold or damp homes which can exacerbate the conditions). Clear pathways around the roles of acute and community health professionals is important to ensure that if a child is admitted for a long-term condition, then subsequent re-admission can be avoided.

Education

Educational attainment has a key role to play in health outcomes for individuals later in life. Education influences health in three main ways: health knowledge and behaviours; employment and income; social and psychological factors such as sense of control, social standing and social support. Additionally, educational attainment affects health across generations, with the educational attainment of parents having an impact on the educational opportunities and performance of children and the socio-economic status of children.

Overall, the educational attainment picture is mixed in Sandwell. School readiness for reception pupils is below the national average; however, by the end of key stage 2, educational performance is comparable to the rest of the country with Sandwell having 91% of primary schools rated good or better. This positive trend does not continue through secondary education, as key stage 4 performance among Sandwell pupils has declined for the past two years and continues to be below the national average. There are a number of reasons for Sandwell's poor educational attainment compared to the rest of the country. The large population of new migrants has increased the numbers of children in classes whose first language is not English. Additionally, as the majority of newcomers are young families with children, this has increased the demand for school places and resulted in larger class sizes.

Despite these pressures, there are examples of Sandwell schools where pupils still have good levels of attainment. Many of these schools are located in catchment areas of high deprivation and migration. As more schools become academies the influence of the council on their day-to-day running is decreasing. However, the council still has an important role in identifying good practice within schools and ensuring learning is shared among the education community.

Safeguarding

The safeguarding issues considered in this JSNA include: being in care, child sexual exploitation, radicalisation and modern-day slavery. These issues are often associated with living in chaotic or dysfunctional households and the adverse childhood experiences which may result. A key recommendation is to develop a whole family offer to chaotic and dysfunctional households in order to minimise the requirements for safeguarding. This long-term ambition requires multi-agency partnership and sharing of information to identify and support at-risk families.

As well as a high-level ambition to embed an early identification and support system, there are also several short and medium-term recommendations to improve the children's safeguarding function in Sandwell detailed in this JSNA. The setting up of a Children's Trust will provide an opportunity to implement some of these improvements.

Safe travel

Road traffic accidents can have a life-changing impact on the mental and physical health and wellbeing of the victims, their families and wider society. Additionally, air and noise pollution from motor vehicles have a significant effect on physical and mental wellbeing. Children are disproportionately affected by motor vehicle collisions and pollution caused by motor vehicles compared to the rest of the population. Historically, Sandwell has had a low rate of road accidents involving children compared to national figures. In recent years, however, the numbers of road accidents involving children has increased in Sandwell while it has reduced nationally so that Sandwell is now comparable to the national average. The recent increase in the total number of accidents in Sandwell is due to an increase in less serious accidents.

Vehicle travel disproportionately affects the health of poorer communities; the most deprived wards in Sandwell have the highest number of road accidents and the poorest air quality in the borough.

There are a number of initiatives in place to improve road safety, reduce air pollution and support sustainable methods of travel. These include analysis of accident hotspots, walking and cycling schemes, school-based education programmes to improve safety when walking, cycling or driving, and campaigns to encourage use of sustainable transport for the 'school run'. It is important that these initiatives are coordinated. Sandwell has a Road Safety Partnership which should include the appropriate stakeholders in order to align these initiatives.

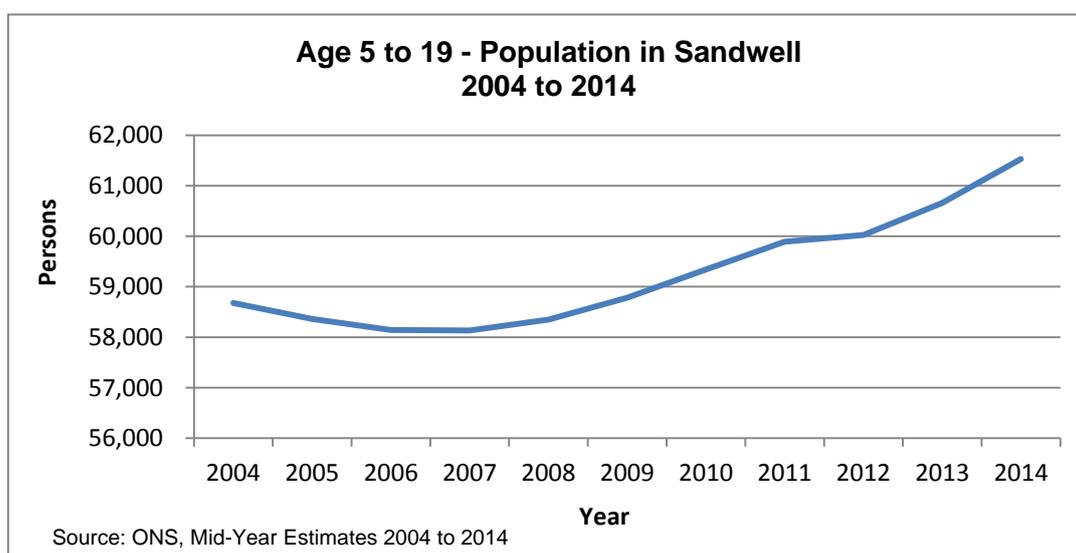
Contents

	Page
Chapter 1 Demographics	1
Chapter 2 Healthy Weight	19
Chapter 3 Substance Misuse	31
Chapter 4 Sexual health and teenage pregnancy	41
Chapter 5 Special Educational Needs and Long Term Conditions	58
Chapter 6 Educational Attainment	97
Chapter 7 Safeguarding	108
Chapter 8 Safer Travel	140

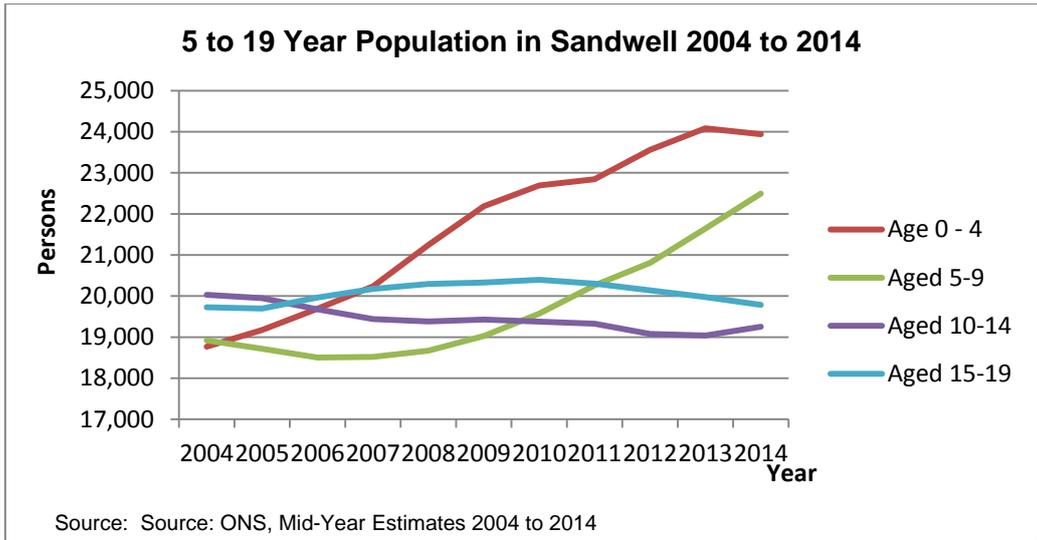
1. Demographics

1.1 Growing numbers of young people

In 2014 Sandwell had an estimated population of 316,719 people, with 19.4%, (61,530) aged 5 to 19 years old. Over the last decade Sandwell has seen an increase in the numbers of younger residents with 5-19 year olds increasing by 4.9% (2,853 persons), since 2004.

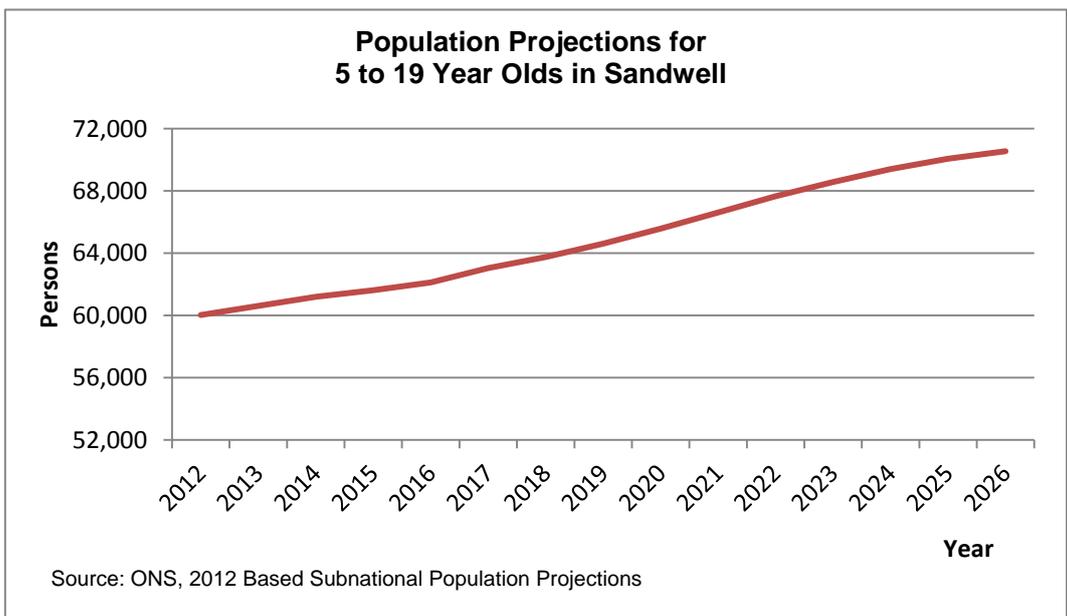


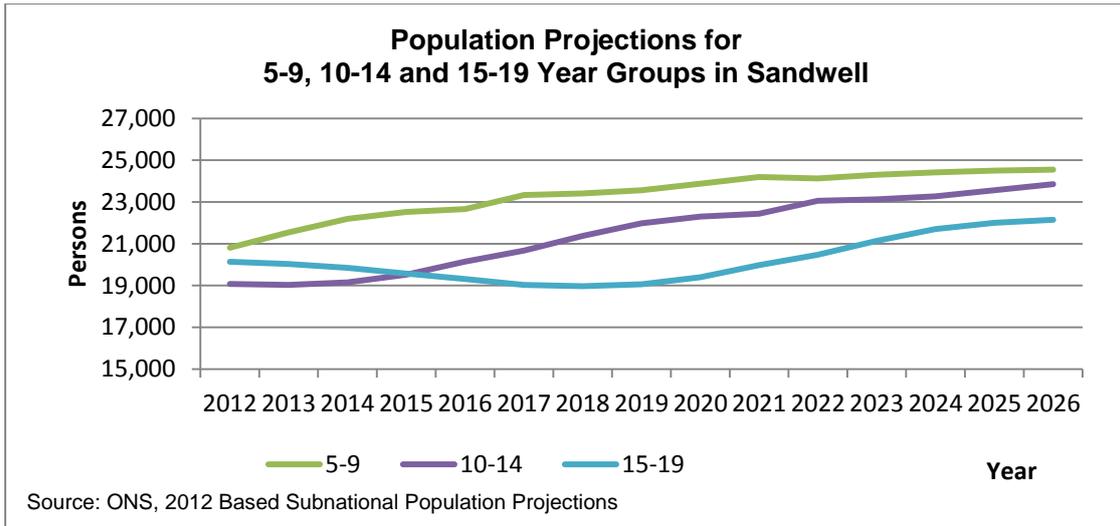
Changes over this period show marked differences in the younger sub-age groups, with 5-9 year olds increasing by 18.9%, 10-14 decreasing by -3.9% and 15-19 remaining fairly static, increasing by just 0.3%. There was also a 27.8% growth in the numbers of 0-4 year olds. These changes compare to a 9.7% increase for the whole population (all ages) in Sandwell, for the same period.



There are higher proportions of 5 to 19 year olds in Sandwell (19.4%), than in England (17.0%) and only Birmingham (21.0%) in the West Midlands has a greater proportion of this age group.

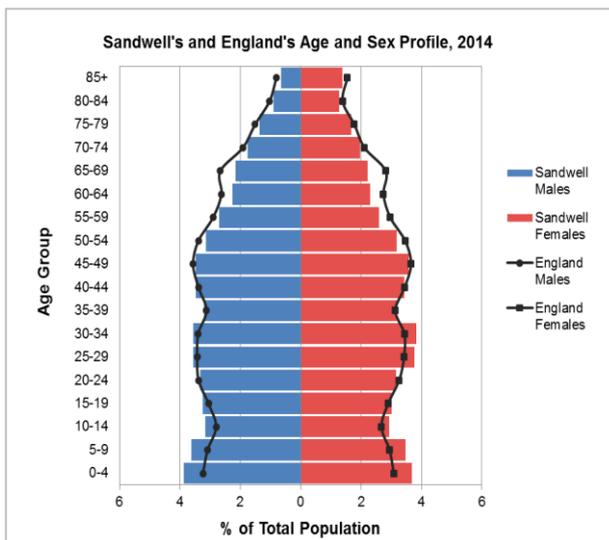
Over the next decade to 2026 the 5 to 19 population in Sandwell is projected to increase by 15.3% to 70,546 persons. The greatest increase being 24.5% within the 10-14 year age band, followed by increases of 11.6% and 10.6% in the 15-19 and 5-9 year groups.





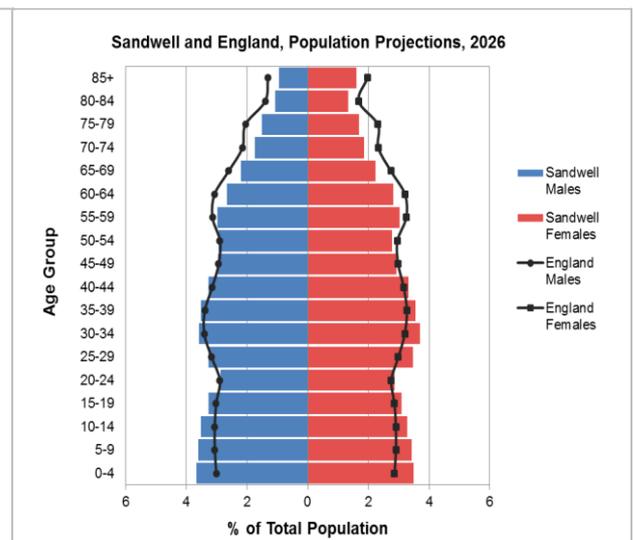
Sandwell generally has a higher proportion of younger residents and lower proportions of older residents than the national averages. This balance is projected to become more pronounced over the coming decade. In 2014, in Sandwell's younger sub-populations the differences between Sandwell and National proportions is highest for 0-4, 5-9 year olds and less for 10-14 and 15-19 years olds. The Office for National Statistics Subnational Population Projections indicate that by 2026 these differences will remain fairly static for 0-4 and 5-9 years but widen slightly for 10-14 and 15-19 year olds. The increasing numbers of younger people in Sandwell has

Sandwell Population Pyramid with England Comparator 2011 Estimates



Source: ONS, Population Mid-Year Estimates 2014

Sandwell Population Pyramid with England Comparator 2021 Estimates Projections



Source: ONS, 2012 Based, Population Projections

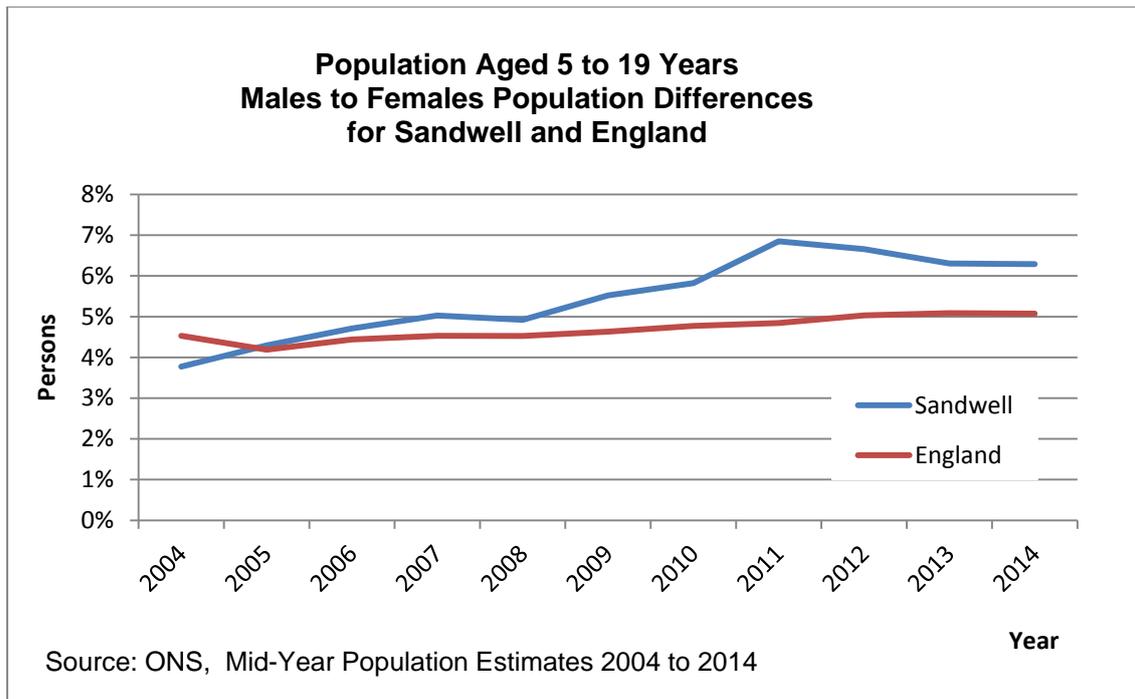
resource allocation implications for educational, health and young people focused services.

Sandwell and England - Proportions of Residents by Age Group and locality				
Age	2014 Estimates		2026 Projections	
	Sandwell	National	Sandwell	National
0-4	7.6%	6.3%	7.2%	5.9%
5-9	7.1%	6.0%	7.0%	6.0%
10-14	6.1%	5.5%	6.8%	6.0%
15-19	6.2%	5.9%	6.4%	5.9%
Sources: ONS, Mid-Year Population Estimates 2014, 2012 Based Subnational Population Projections				

1.2 Gender

In 2014, Sandwell had 31,703 males compared to 29,827 females aged 5 to 19, a difference of 1,876, 6.3% more males compared to the female population.

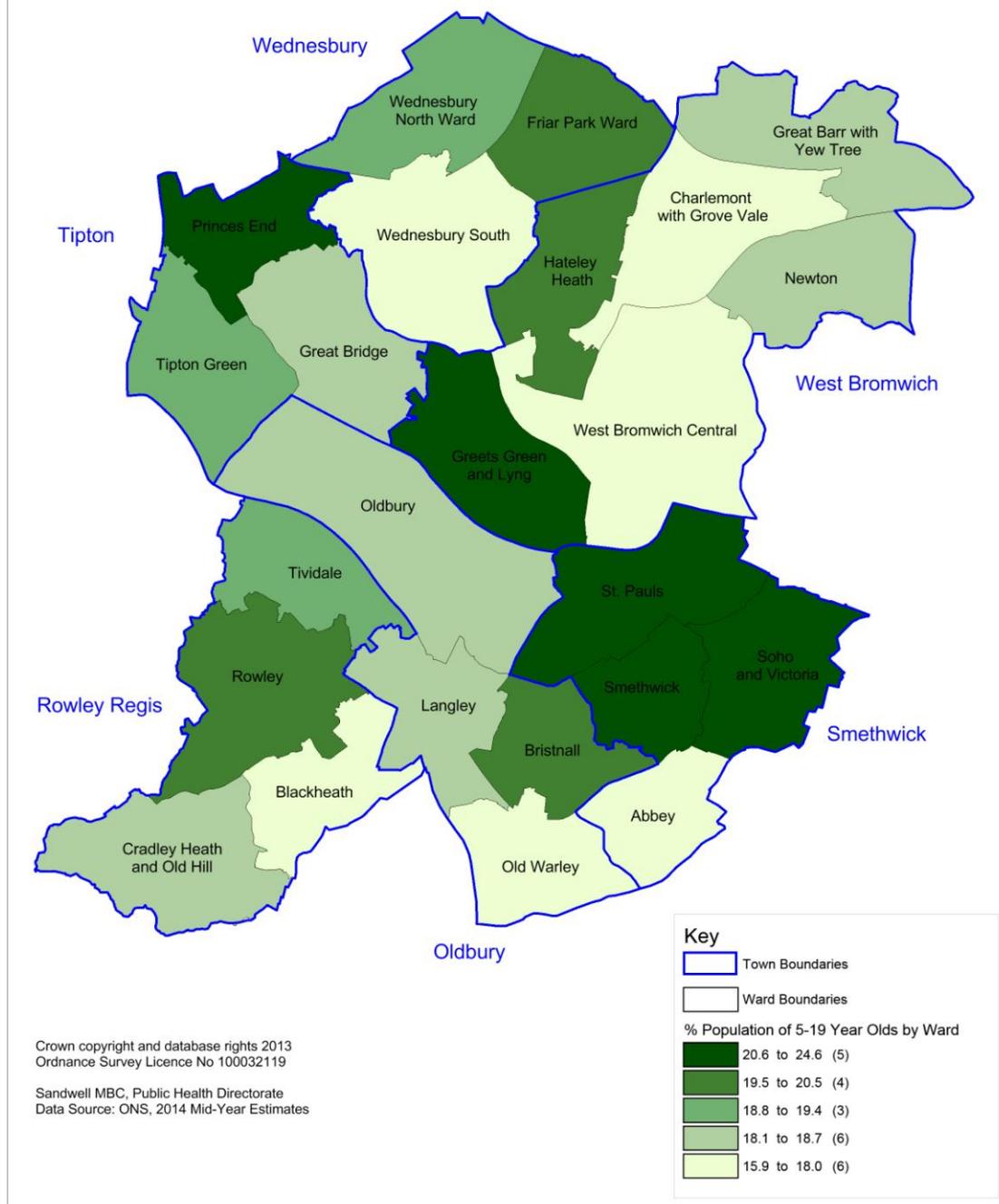
Nationally, this age group has also shown higher proportions of males compared to females, with the gap between the two genders being consistently higher for Sandwell than England since 2006.



1.3 Where do our young people live?

The map below highlights the proportion of residents for each ward in Sandwell who are aged 5 to 19 years of age. The proportions range from 16.0% in Abbey to 24.6% in Soho and Victoria ward.

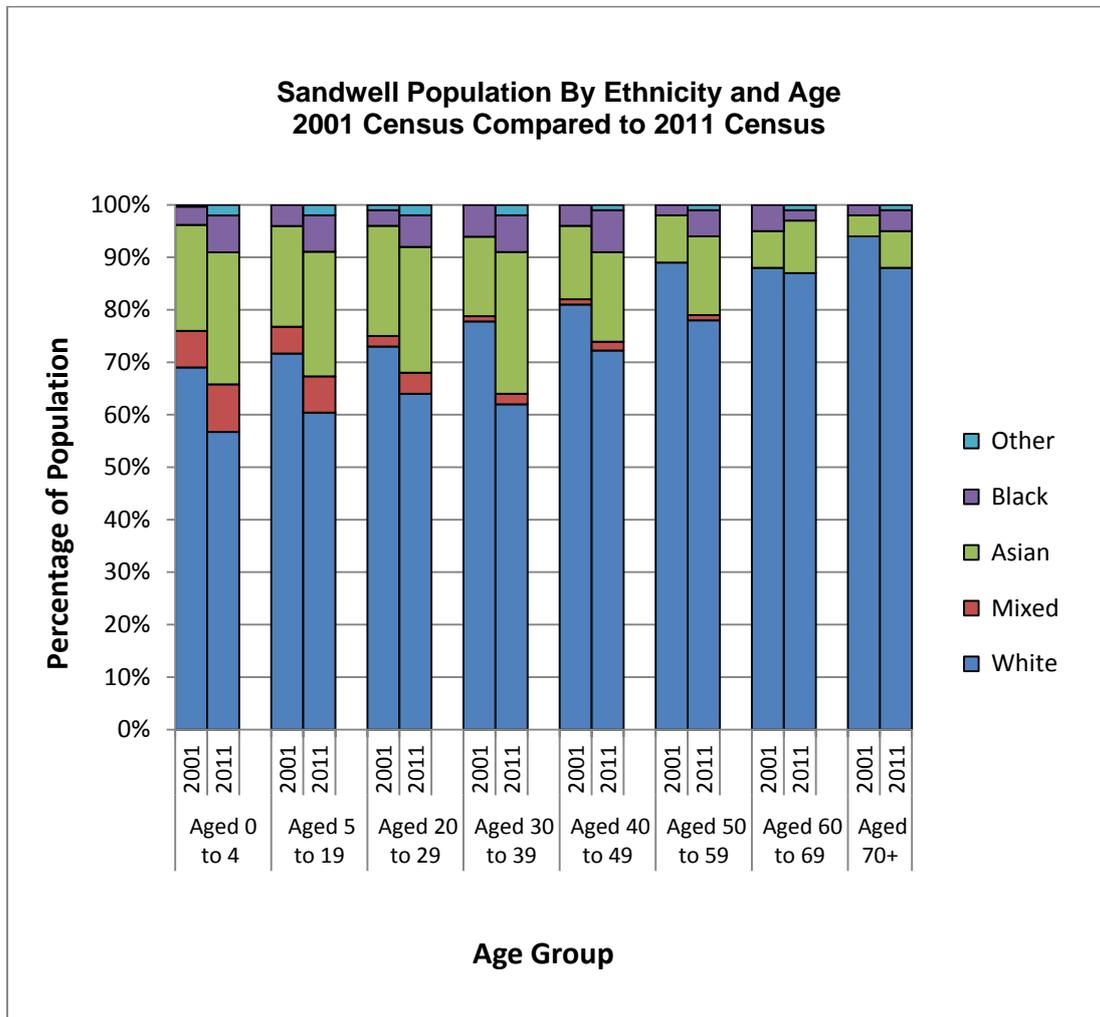
Percentage of Sandwell's Population Aged 5-19 Years Old by Ward (2014)



1.4 Growing diversity among our young people

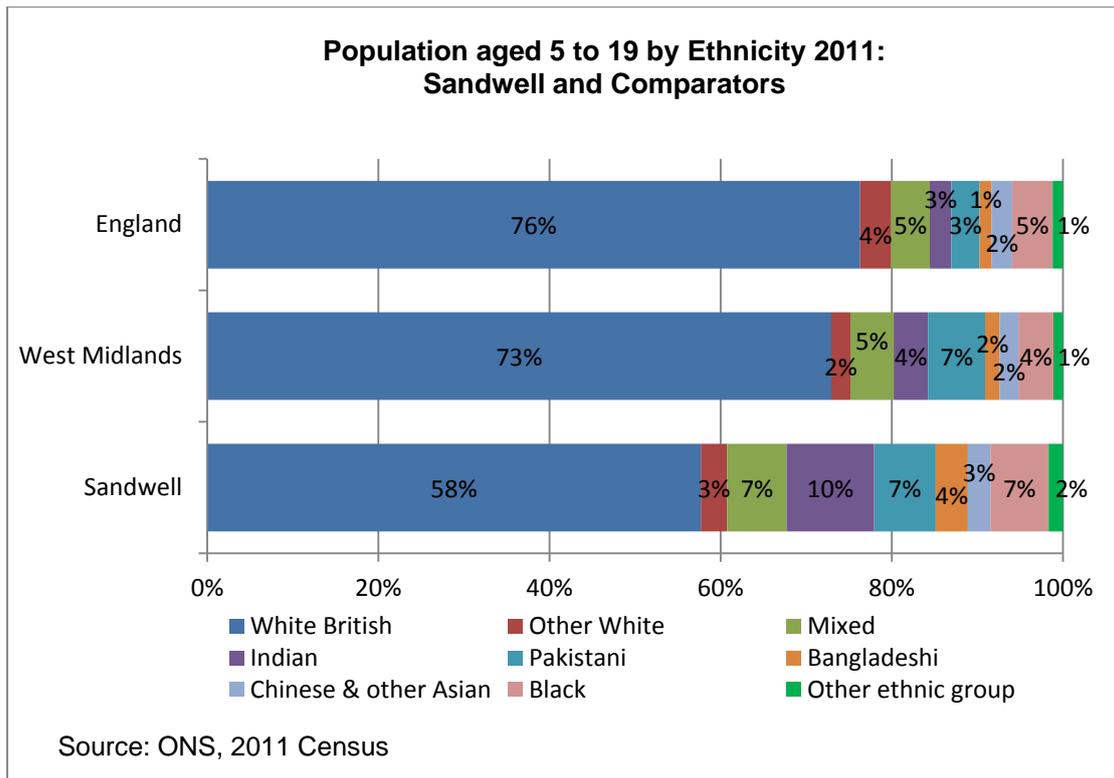
Sandwell is an ethnically diverse borough and this in particular is reflected in our younger population. The chart below shows Sandwell's 0-4 and 5-19 year olds to be

the most diverse age groups, with an increasing proportion of Asian, Mixed and Black ethnic groups between 2001 and 2011. The Asian 5-19 year old group has increased by 5 percentage points since 2001.



Source: Nomis 2001, 2011 Census, table DC2101EW

In England and the West Midlands Region respectively, 79.9% and 75.2% of young people (aged 5-19 years) are White British or other White, compared with 60.8% in Sandwell. This means that almost 40% of Sandwell's young people are from mixed, Asian, Black or other ethnic groups. 23.8% of Sandwell's 5 to 19 year olds are of Asian/Asian British origin.



As Sandwell has become more ethnically diverse, this is also reflected in terms of religion. 55.2% of Sandwell residents are Christians and 18.7% have no religion. However for the younger population there are marked differences – 45.8% of Sandwell’s 5 to 19 year olds are Christian, 13.2% are Muslim and 23.4% have no religion. This compares to 53.0%, 7.9% and 28.8% respectively nationally.

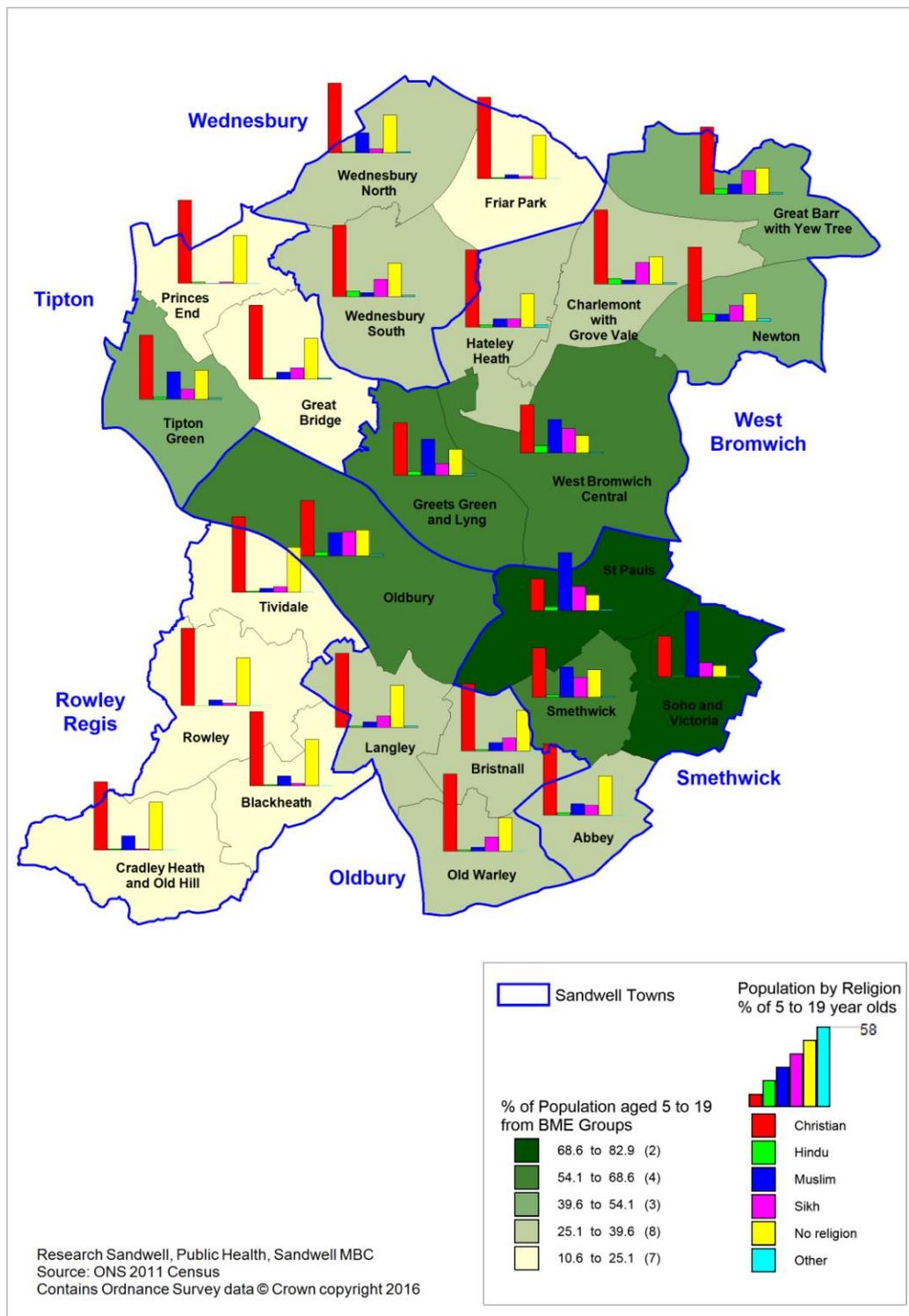
The map on page 10 shows analysis of ethnicity and religion by ward. Among 5 to 19 year olds, the BME population are predominantly concentrated in the central belt of Sandwell, from Smethwick town up to Oldbury and central West Bromwich. Soho and Victoria and St. Pauls wards have the highest proportions of BME population (in both around 80% of the 5 to 19 year olds are from BME groups), and in particular 60.7% of 5 to 19 year olds in St. Pauls ward are Asian (48% in Soho & Victoria). These areas are also those with the worst levels of deprivation in the borough.

Rowley Regis town has particularly low levels of BME population, with less than one in five 5 to 19 year olds from BME groups within all four Rowley Regis wards. Elsewhere, Princes End ward has a very small BME population, with only one in ten 5 to 19 year olds from BME groups.

In terms of religion, as may be expected the largest proportions of young people who are Christian live in those wards with a low BME population. There are 11 wards where more than half of 5 to 19 year olds are Christian, with the highest proportions in Princes End and Friar Park (57.6% and 57.5% respectively). More than 40% of young people in Soho & Victoria and St. Pauls are Muslim, and more than 20% in Greets Green & Lyng, West Bromwich Central and Smethwick. The Sikh population has a different distribution – whilst there are high proportions of Sikh 5 to 19 year olds in West Bromwich Central, Oldbury and St. Pauls (each around 17%), there are also high proportions in Great Barr with Yew Tree and Charlemont with Grove Vale (15.9% and 15.3% respectively).

Only 8.6% of young people in Soho & Victoria have “no religion” compared with 34% in Rowley.

Young People's Ethnicity and Religion by Ward



Source: ONS Census 2011 (DC2107EW - Religion by age – data NOMIS)

*Other - includes Buddhist, Jewish and other – due to small numbers

1.5 Deprivation and Poverty

It is important to note that the English Indices of Deprivation 2015 are a measure of relative deprivation, not affluence, and to recognise that not every person in a highly deprived area will be deprived and some deprived people live in the least deprived areas.

No single summary measure on the Indices of Deprivation is the 'best' measure. Each highlights different aspects of deprivation, and each leads to a different ranking of areas. Sandwell's average rank has improved since 2010, moving three places to become the 12th most deprived local authority out of a total of 326 (where 1 is the most deprived). However, this does not necessarily mean that deprivation in the borough has improved on an absolute scale, as it may have improved in all areas – only that it has improved relative to other areas.

	Rank of Average Score	Rank of Average Rank	Rank of proportion of LSOAs in most deprived 10%
Birmingham	7	11	6
Coventry	54	60	46
Dudley	110	118	101
Sandwell	13	12	28
Solihull	178	216	77
Walsall	33	41	39
Wolverhampton	17	19	21

Source: Department for Communities and Local Government (DCLG) English Indices of Deprivation 2015

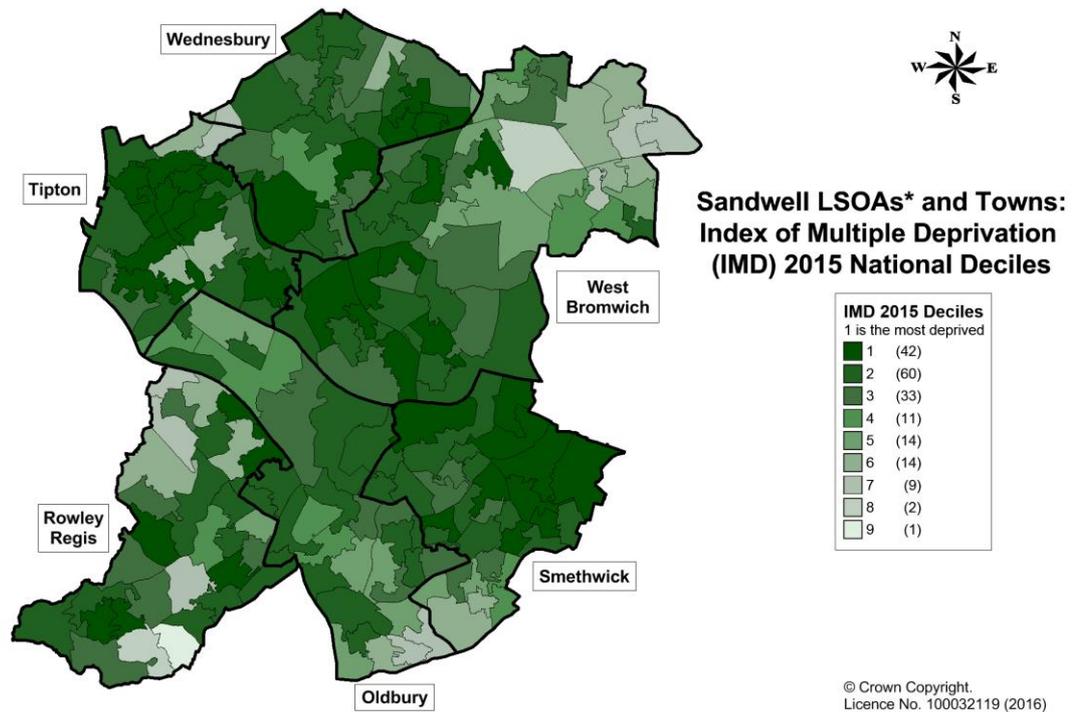
England is made up of 32,844 LSOAs (lower super output areas), 186 of which are in Sandwell. One in five of Sandwell's LSOAs fall into the most deprived 10% nationally in 2015. This shows a relative improvement, as around three in ten of LSOAs were among the 10% most deprived in both 2007 and 2010. A further third fall into the most deprived 10-20%, so overall 55% of Sandwell's LSOAs fall within the worst 20% nationally, clearly displaying the high levels of deprivation prevalent in large parts of Sandwell.

Proportion of Sandwell LSOAs in worst x% nationally

Worst x%	2007	2010	2015
Worst 10%	29.4%	30.5%	22.6%
Worst 10-20%	29.9%	28.3%	32.3%
Worst 20-30%	16.6%	16.0%	17.7%
Worst 30-40%	5.9%	7.0%	5.9%

Source: Derived from the Department for Communities and Local Government (DCLG) English Indices of Deprivation 2015

Sandwell LSOAs and IMD (Index of Multiple Deprivation) 2015 Rankings



Source: Department for Communities and Local Government (DCLG) English Indices of Deprivation 2015

1.5.1 The Income Deprivation Affecting Children Index (IDACI)

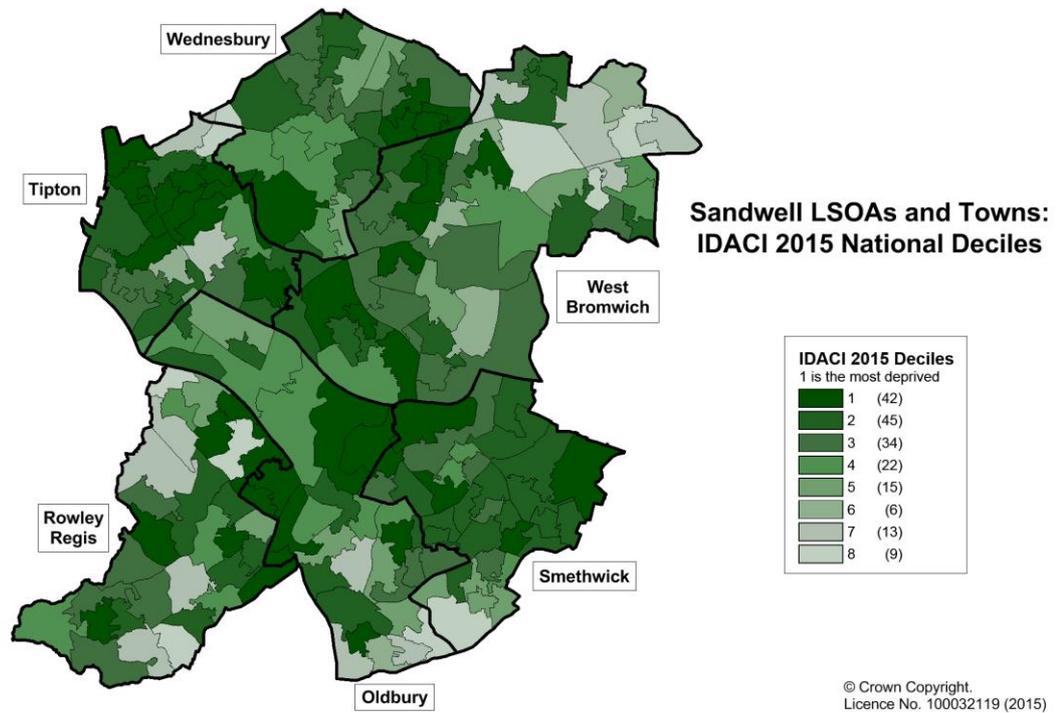
The Income Deprivation Affecting Children Index is a subset of the Income Deprivation Domain, with the Index showing the proportion of children in each LSOA that live in families that are income deprived. The definition of low income used includes both those people that are out-of-work, and those that are in work but who have low earnings.

In terms of the rank of average rank, Sandwell is the worst authority in the West Midlands County, with a rank of 11 on the IDACI. On this measure, Child poverty in Sandwell is worse than overall deprivation, relative to other areas. Nearly two thirds (121) of the 186 LSOAs in Sandwell are in the three highest ranked IDACI deciles.

Local Authority	Income deprivation affecting children index (IDACI)		
	Rank of average rank	Rank of average score	Rank of proportion of LSOAs in most deprived 10% nationally
Birmingham	18	15	21
Coventry	58	48	57
Dudley	93	89	91
Sandwell	11	18	27
Solihull	197	171	75
Walsall	28	27	23
Wolverhampton	12	12	16

Source: Derived from the Department for Communities and Local Government (DCLG) English Indices of Deprivation 2015

Sandwell LSOAs and IDACI (Income Deprivation Affecting Children Index) 2015 Rankings



Source: Department for Communities and Local Government (DCLG) English Indices of Deprivation 2015

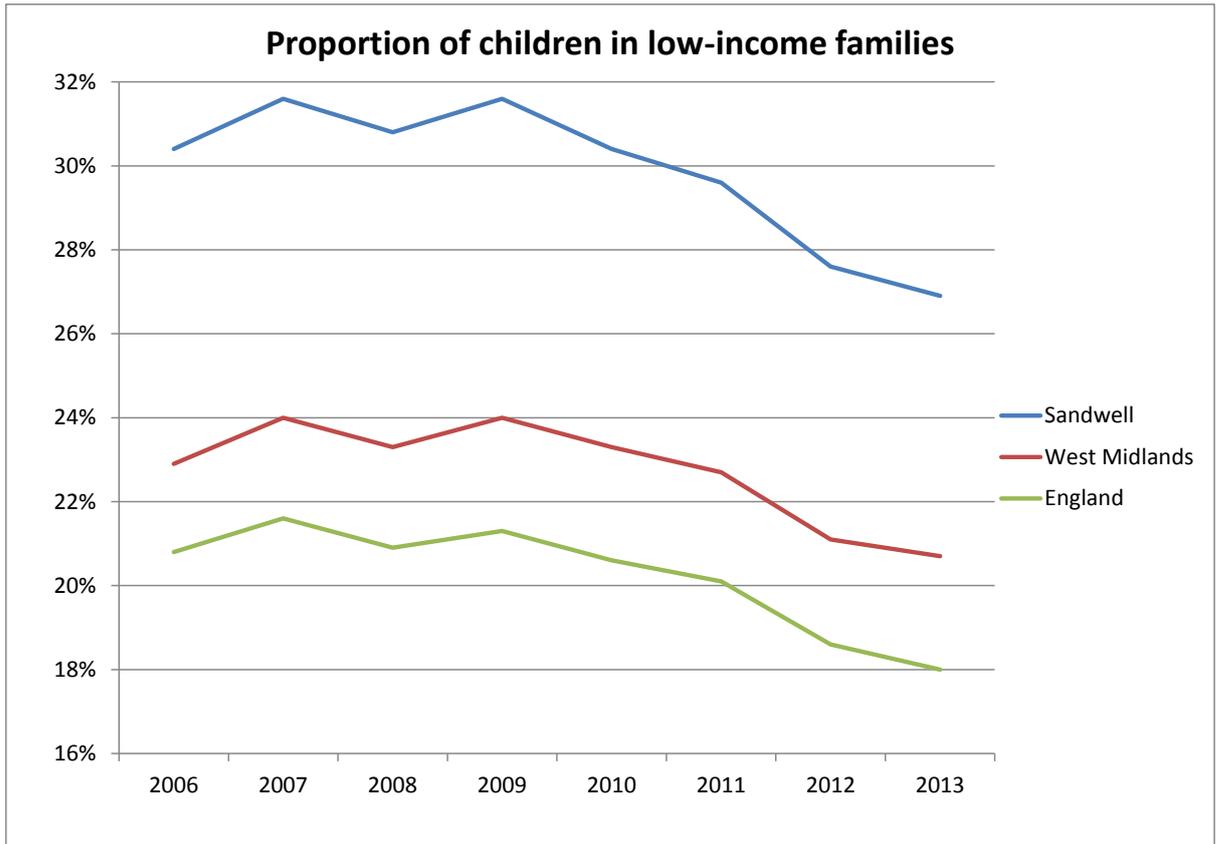
1.5.2 Child Poverty

Proportion of children in low-income families

In 2013, 26.9% of children in Sandwell were in low income families compared to 20.7% for the West Midlands Region and 18% for England. This equates to 21,585 children (under the age of 20) living in families in receipt of Child Tax Credit with a reported income of less than 60% of the median income, or in receipt of Income Support, or Income-Based JSA.

	Sandwell		West Midlands		England	
	No.	%	No.	%	No.	%
2006	21,635	30.4	279,100	22.9	2,298,385	20.8
2007	22,780	31.6	293,655	24.0	2,397,645	21.6
2008	22,645	30.8	287,105	23.3	2,341,975	20.9
2009	23,980	31.6	300,300	24.0	2,429,305	21.3
2010	23,285	30.4	292,840	23.3	2,367,335	20.6
2011	22,935	29.6	286,030	22.7	2,319,450	20.1
2012	21,830	27.6	266,975	21.1	2,156,280	18.6
2013	21,585	26.9	263,370	20.7	2,097,005	18.0

Source: HM Revenue & Customs, Personal tax credits: Children in low-income families local measure and DWP Child Poverty Basket of Indicators.



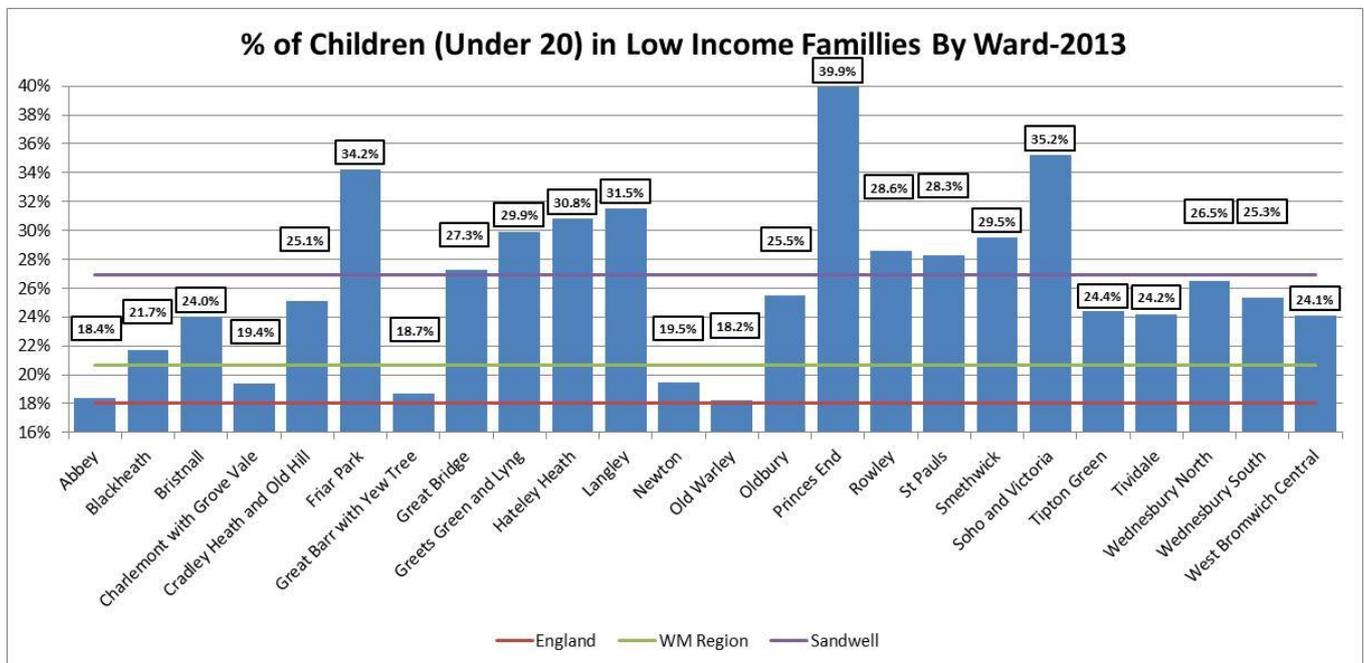
Source: HM Revenue & Customs, Personal tax credits: Children in low-income families local measure and DWP Child Poverty Basket of Indicators.

In Sandwell the proportion of children in low-income families has shown a decrease in recent years mirroring the trend in the West Midlands region and England, but this may not have led to meaningful differences to children’s lives. Child poverty in Sandwell remains consistently higher than the West Midlands region and England.

Where Do Sandwell Children in Relative Poverty Live?

All Sandwell wards have a higher proportion of children in Low Income Families than England (18%) but there is considerable variation between wards:

- 19 wards are above the West Midlands region average (20.7%)
- Princes End ward has the highest proportion of children in low income families (39.9%). This is more than double that of the ward with the lowest proportion in Sandwell - Old Warley (18.2%).



2. Healthy Weight

2.1 Introduction

As is the case across the UK, the rising prevalence of obesity is a major issue in Sandwell, with being overweight or obese now the norm within the adult population. Focusing on children and young people both with respect to prevention and treatment is an important component of any strategy to tackle obesity in the long term. The main source of data on childhood obesity comes from the National Child Measurement Programme. This data shows that in Sandwell the proportion of children with excess weight in reception is comparable to the rest of the country. However by year six over 40% of children are overweight or obese, which is much higher than comparable figure for the West Midlands or England. This highlights the importance of focussing on school-aged children to prevent or promptly reverse excess weight gain.

While there is a large body of evidence on preventing and treating excess weight, much of this evidence is not conclusive and currently no country in the world has implemented an effective long-term strategy to reverse the growing obesity trend. What is agreed is that a broad range of factors influence obesity and a multi-sector approach is required. National and local government, education, NHS, communities, families and individuals all have a role to play and an over-arching approach including these different stakeholders is required.

2.2 Evidence and Policy

In 2007 the government commissioned a Foresight Report on Tackling Obesity, the aim of which was to develop a sustainable response to obesity over the next forty years. While the report acknowledges that the problem fundamentally stems from an imbalance between energy intake and expenditure, physical and psychological drivers inherent in human biology mean that the vast majority of the population are predisposed to weight gain. It challenges the simple view that obesity is an issue of personal willpower and attributes the current trend to a complex obesogenic environment where energy-dense food is abundant and opportunities to use energy fewer.

The range of evidence available focussed on causes of obesity rather than strategies for prevention or treatment and few interventions have successfully reduced the prevalence of obesity. One of the few interventions which successfully managed to reduce rates of childhood obesity over a sustained period (over ten years) is based in the north of France and focussed on educating families on food, nutrition and physical activity predominately through engagement with children. This intervention included lessons (cookery classes, supermarket visits, food production premises visits) both school and non-school based and consistent messaging over a three-four month period through a variety of media. The intervention had significant public and private sector buy-in and funding.

There is evidence to support the theory that a number of different points within our life course present opportunities to influence behaviour. The only area in which there is strong evidence of a critical period of development being associated with long term consequences is that of breast feeding and early growth patterns. There is also some limited evidence that behaviours such as a sustained preference for fruit and vegetables can be established in early childhood. It is also important to note that the most significant predictor of child obesity is parental obesity. Evidence suggests that it is unlikely that the type of public information campaigns that urge people to avoid certain foods and exercise more frequently are sufficient to address the problem; and that interventions need to simultaneously inform, shift motivation and provide skills necessary in order to lead to behavioural change. From an individual point of view tackling obesity involves a variety of long and short term changes including altering diet, changing shopping behaviour, increasing exercise, changing transport choices. In the case of a child, level of autonomy over these choices will be largely dependent on parental choices.

The built environment provides important opportunities to tackle obesity including provision of physical activity space, promotion of active travel and accessibility to healthier food choices. However the existing level of scientific evidence linking the built environment to obesity is limited. It is also argued that embedding impact on health as a criterion for planning considerations is difficult to achieve at a local level and requires better leadership and national policy to achieve.

The National Institute for Healthcare and Clinical Excellence had produced a number of documents relating to the issue of excess weight in children, including:

- Physical Activity for Children and Young People (Jan, 2009)
- Weight Management: lifestyle services for overweight or obese children and young people (October, 2013)
- Preventing excess weight gain (2015)
- Obesity prevention (2015)

The following over-arching recommendations are included within these guidelines:

- High level commitment from Directors of Public Health, Directors of Children's Services, Children's Trust Chairs and NHS Chief Officers to raise awareness of the importance of physical activity among children and young people and their families. Strategic partnership local plans should be developed based on this commitment.
- Planning to ensure provision of spaces and facilities to support physical activity. This requires partnership between children's services, education, planning and regeneration, school heads and governors and police.
- Ensure local transport plans include ambitions to increase active travel to both school and non-school activities and increase accessibility of active travel opportunities to all children in the borough.
- Local people should be consulted on local factors which may impact on children partaking in physical activity and measures must be taken to remove barriers identified
- Ensure that opportunities for formal and informal physical activity are provided and lead by qualified staff, this includes opportunities in both school and non-school settings. These opportunities should be appropriately resourced in terms of equipment and provision for children with accessibility issues
- Provision of activities which specifically target those less likely to partake in physical activity, based on local evidence. This may include girls, those with physical disabilities or those from certain ethnic groups
- Ensure family-based, multi-component lifestyle weight management services are available as part of a community-wide, multi-agency approach.
- Commission services to meet the needs of local children including those of different ages, stages of development and backgrounds. Services should be designed and regularly reviewed by a multi-disciplinary team including a nutritionist/dietician, physical activity specialist, behaviour change specialist, psychologist and paediatric health professional; and subject to evaluation and

monitoring. Services should focus on diet and eating habits, physical activity, sedentary behaviour and behaviour change and tailored to meet individual and family's needs

- Commissioners and providers should take joint responsibility for raising awareness of courses available and ensuring an appropriate referral pathway.
- With the patients consent, updates on impact and adherence to the programme should be shared with the patients' GP so that on-going, co-ordinated support can be provided.
- Programmes should be monitored and evaluated to ensure that they are having the required impact and modified if required.
- Schools should be supported to develop and implement policies which support a whole school approach to life-long healthy eating and physical activity practices. Interventions should be sustained, multi-component and address the whole school, including after-schools, clubs and activities. Parents should be involved in school based interventions through information about events, lunch menus and after school opportunities.

2.3 Local Data

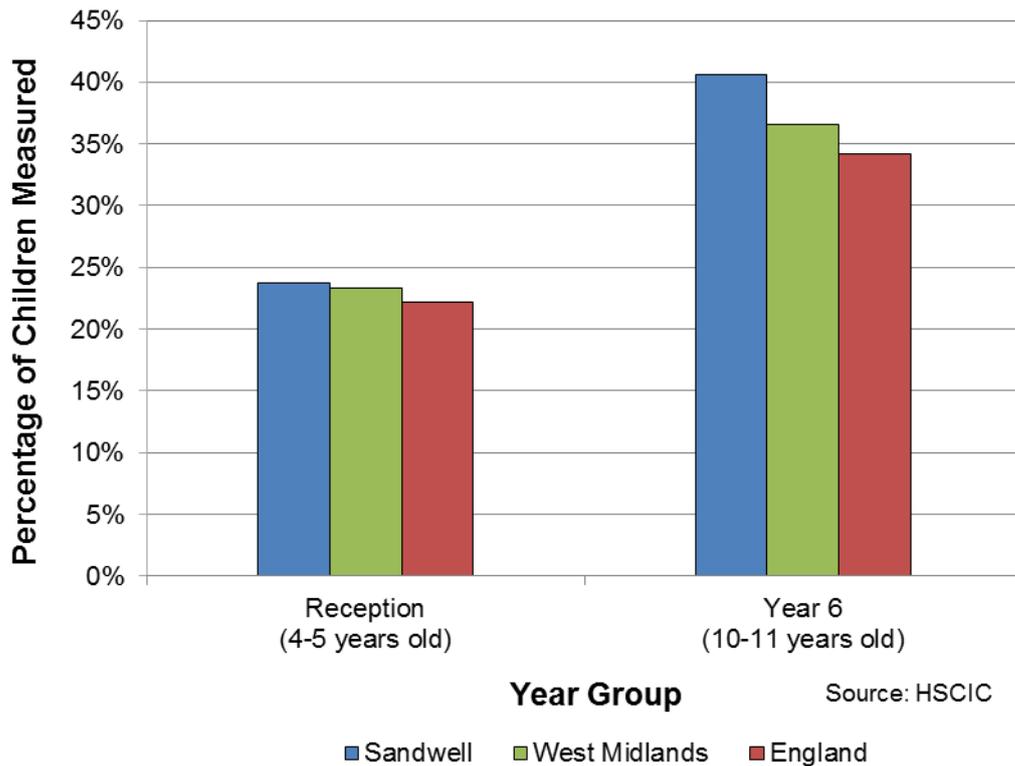
The National Child Measurement Programme (NCMP) measures the height and weight of school children every year and provides a detailed picture of the prevalence of child obesity in children at reception (4-5 year olds) and year 6 (10-11 year olds). The Health Survey for England covers a wider age range of 2-15 years but is based on a sample of data only.

The population monitoring definitions of overweight are those children in the 85th to 94.9th weight centile. The definition of obesity in children is those who are located in the 95th centile and higher. The 2014/2015 NCMP data shows that 11% of reception age children (4-5 years) were obese and a further 11.1% were overweight. Of children in year 6 (10-11 years), 25.8% were obese and another 15.4% were overweight.

Prevalence of excess weight in children at Year 6 in Sandwell is higher than both West Midlands and the England averages. 40.1% of Year 6 pupils were either overweight or obese in Sandwell, compared to 35.8% in the rest of the West Midlands and 33.2% nationally. However in reception the rate of obesity and overweight reception aged children (4-5 years) is comparable to that of the West

Midlands region (23.7% in Sandwell, compared to 23.34% in the West Midlands region and 22.1% nationally).

Figure 1: Prevalence of Overweight (including Obese) Children by Year Group, 2015-16 (School Year)



(Source: Health and Social Care Information Centre)

(Note: Data is presented based on each child's postcode of residence)

Health Survey for England data shows the percentage of children with excess weight increases throughout primary school years in Sandwell (table 1). This identifies primary school as an important potential setting to prevent excess weight gain.

Table 1: Prevalence of Overweight and Obese Children, by Age Group

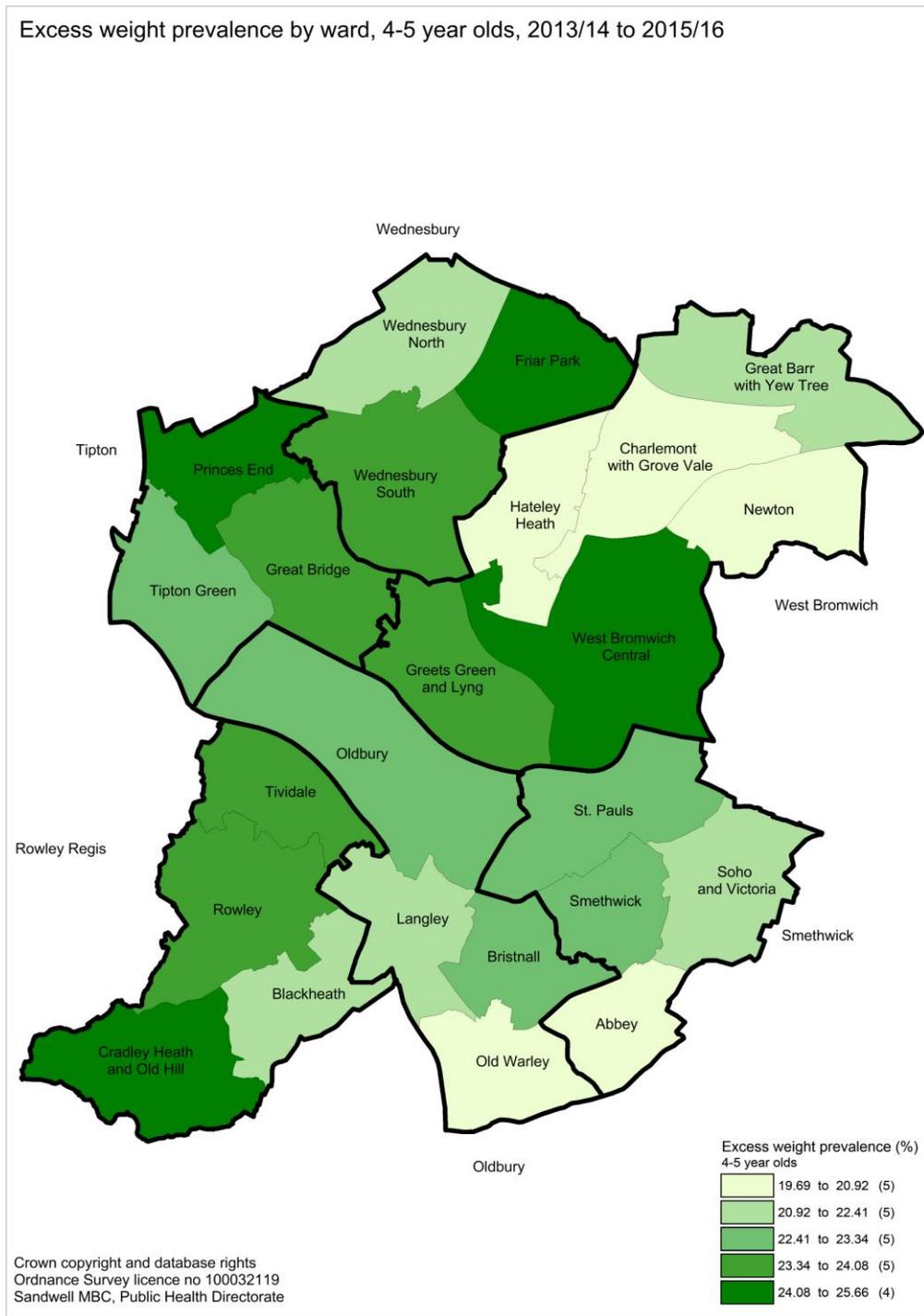
BMI Weight Classification	2-4	5-7	8-10	11-12	13-15	Total (2-15)
Overweight	14%	11%	15%	16%	16%	14%
Obese	11%	11%	16%	17%	16%	14%
Overweight or Obese	25%	22%	31%	33%	32%	28%

(Source: Health Survey for England 2015)

It is important to note, that the HSE uses self-reported data obtained through surveys of a sample of the population only.

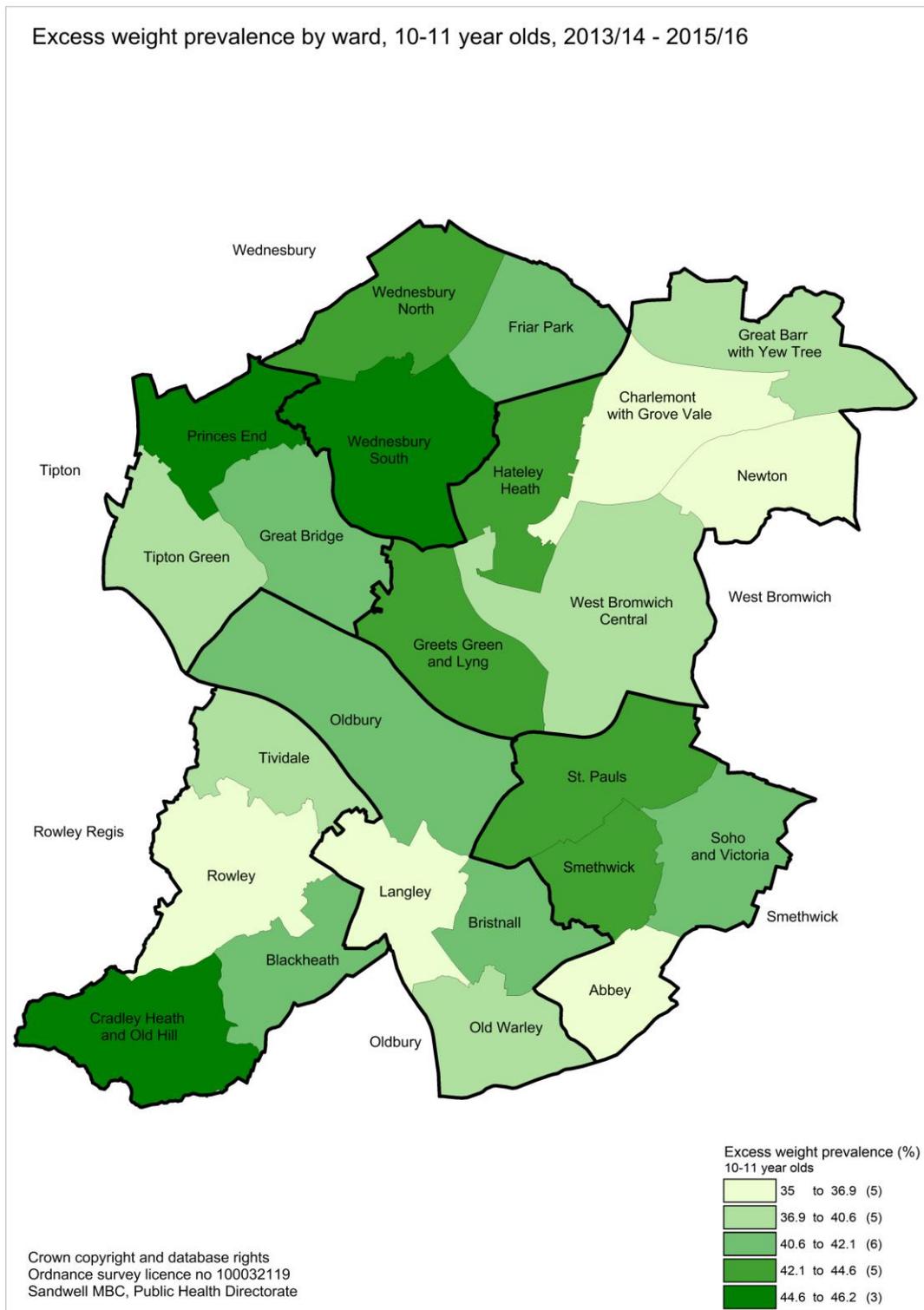
The 2007 Foresight study found that rates of obesity are highest in children from lower socio-economic backgrounds. Figures 2 and 3 identify the wards within Sandwell with the highest prevalence of excess weight at reception and year 6, respectively.

Figure 2: Excess weight prevalence by ward, 4-5 year olds



Within Sandwell, the wards of Cradley Heath and Old Hill, Princes End, Friar Park and West Bromwich Central have the highest prevalence of excess weight (with Princes End at 25.66%), though twelve of the 24 wards have over 22.76% of children between the ages of 4 and 5 being overweight/obese.

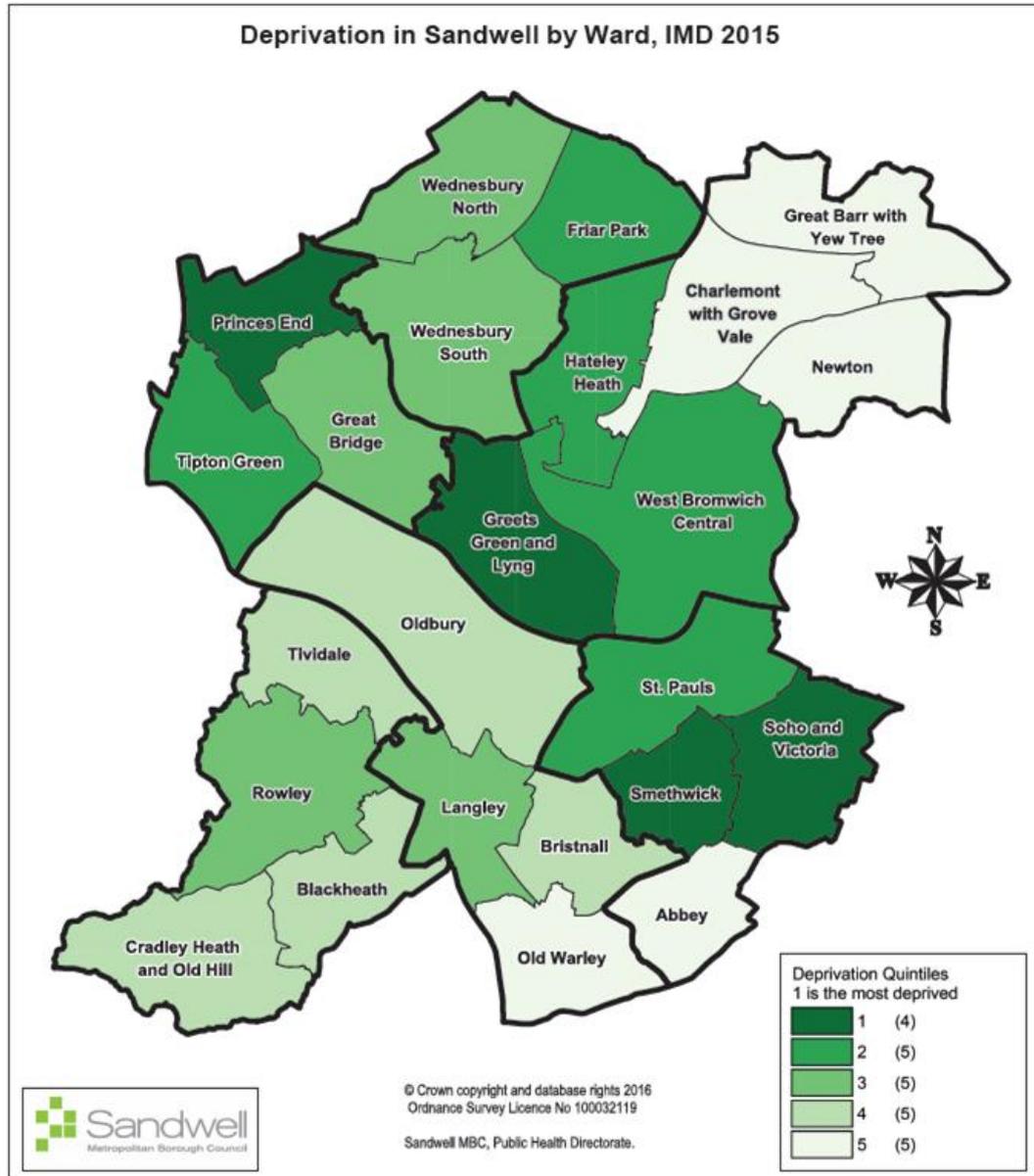
Figure 3: Excess weight prevalence by ward, 10-11 year olds



The geographic locations of excess weight in children aged 10-11 years old is similar

to the data for 4-5 year olds; however, Wednesbury South is the ward with the highest prevalence with 46.15% of the population registering as overweight/obese.

Figure 4



Whilst the areas with higher levels of deprivation largely correlate with those reporting higher levels of childhood excess weight, higher levels of excess weight are also found in areas around Cradley Heath, Blackheath and Oldbury which have lower levels of socio-economic deprivation.

2.4 Service provision

Public Health commission and deliver the following approaches to preventing excess weight in 5-19 year olds:

1. Mytime Active provides a range of lifestyle interventions to prevent and treat overweight and obesity in children and families, in order to help them achieve and maintain a healthy weight. The service has been designed with an ethos to enable people to have an intervention tailored around their needs and requirements; this is currently being rolled out throughout the borough.
2. The Community Activity Network Weight Management Development Officers are employed by Public Health in order to identify gaps in provision of weight management services at neighbourhood level. They then work with local communities to mobilise existing assets and fill gaps in provision in a way which meets the needs of local people
3. Weight Watchers GP On-Referral provides a tier 2 commercial weight management intervention for adults 18 years and above who are obese. On the premise of further learning, the age criteria has been lowered to include children 13 years and above who are obese, which will provide additional learning and insight into the effectiveness of a commercial weight intervention in relation to obese adolescents. This will inform future planning and commissioning of weight management services for children.
4. Sandwell Active Schools work with all primary schools in Sandwell to support the incorporation of at least 30 minutes of physical activity in each school day. The programme also records baseline levels of activity and physical literacy in schools so that progress can be measured.
5. Community Activity Network Development Officers work schools and community groups to identify needs around physical activity participation in particularly groups. These community assets are then mobilised to fill these gaps and increase uptake of physical activity. Sport England data and consultation with families are used to identify need and gaps in provision. CANDOs also engage with secondary schools through an engage, motivate,

move programme. This programme engages all pupils and then targets those with poor physical activity uptake with behaviour change intervention.

6. Public Health fund a Schools Food Project which has seen over 50 schools in Sandwell receive grant funding. This funding has been used to run a range of different activities including healthy eating workshops and healthy lunchbox design. Strategically, public health are working with all school meals providers in Sandwell to support them to commit to reducing sugar levels in school meals.

2.5 Gaps

Despite a strong, evidence-based service to improve nutrition and increase physical activity in children and families, uptake of this service is low. Work is needed to improve the referral pathway to ensure that children who would benefit from these services have access. As well as a strong referral pathway, awareness of the services available needs to be improved among health and non-health professionals. School nurses are responsible for weighting and measuring all children at reception and again in year 6. A clear pathway of how children with excess weight should be supported to access service needs to be developed.

Wider partnership working is required to apply evidence base around improving active travel, increasing access to green spaces and making the environment less obesogenic. A Healthy Urban Development Officer based in Public Health works closely with planning to improve access to active travel and review planning applications. However, work needs to be done at the master planning stage to ensure new housing developments support physical activity and good nutrition.

2.6 Recommendations

Commissioners and providers of family weight management services need to work closely with school nurses to ensure that children carrying excess weight are identified early and supported to access intervention

The range of health and non-health professions in contact with children needs to be mapped. These different groups need to be engaged with about the risk of excess

weight in children and the services available. The 0-19 Family Offer Project group could lead in the initial mapping and identification of professional groups to engage with

Public Health need to engage early when decisions are being made about location and layout of new housing developments to ensure that they encourage participation in physical activity. Levers such as health impact assessment tools can be used to engage with developers and support them to build houses which have a health premium and therefore more attractive to buyers. The Healthy Urban Development officer in Public Health will lead on taking this work forward.

3. Substance Misuse

3.1 Context

Young people's alcohol and drug use can increase the risk of poor emotional wellbeing, poor health, risk-taking behaviours such as regretted sexual contact, unprotected sex, pregnancy, anti-social behaviour, criminal activity and young people not achieving their full potential in education.

There are several factors which increase the likelihood of a young person using or misusing drugs and alcohol. These include community factors like availability of substances and tolerance of misuse; family factors including parental misuse, family conflict, and deprivation and personal factors including low educational attainment prior to use, early anti-social behaviour and friends who engage in misuse. Other sections in this document show that Sandwell has a high rate of many of these risk factors.

3.2 Local data

3.2.1 Alcohol use

Data from the 2014 "What About Youth" survey shows a lower rate of young people drinking in Sandwell than nationally (see Table 1). Similarly Tables 2-4 shows lower percentage non-drinkers than nationally, lower percentage of those who were drunk in the last 4 weeks and lower frequency of drunkenness. The data is useful to illustrate the drinking behaviours of young girls in particular, with a higher proportion ever having had an alcoholic drink and who have been drunk in the last six weeks than boys. This links to later adult presentations of higher female liver mortality in Sandwell (this information is drawn from social research that has been conducted.)

This data has a number of weaknesses: data was collected through schools and therefore children missing or excluded from school would not have taken part and evidence shows these individuals are more likely to have used alcohol. The measure is also self-reported and therefore young people may not have responded to questions accurately. There are no robust local estimates of the prevalence of both alcohol misuse and drug use in young people either nationally or locally.

Table 1: Percentage of 15-year-olds in Sandwell who have had an alcoholic drink

	Ever had an alcoholic drink - %		Ever had an alcoholic drink - per cent			
	Yes	No	Yes		No	
			Boys	Girls	Boys	Girls
England	62.4	37.6	59.7	65.2	40.3	34.8
Sandwell	46.3	53.7	41.9	50.8	58.1	49.2

Table 2: Frequency of alcohol use

	Had an alcoholic drink (% of all 15-year-olds)						Non-drinker
	At least once a week	Once a fortnight	Once a month	Only a few times a year	Doesn't drink now	Currently drinks	
England	6.2%	7.7%	11.4%	32.0%	4.9%	57.3%	42.7%
Sandwell	4.4%	4.4%	4.9%	25.9%	6.6%	39.6%	60.4%

Table 3: Incidence of drunkenness among drinkers

	Been drunk in past 4 weeks (% of 15-year-olds who have had an alcoholic drink)		Yes		No	
	Yes	No	Boys	Girls	Boys	Girls
	England	23.4%	76.6%	19.4%	27.2%	80.6%
Sandwell	16.4%	83.6%	13.5%	19.4%	86.5%	80.6%

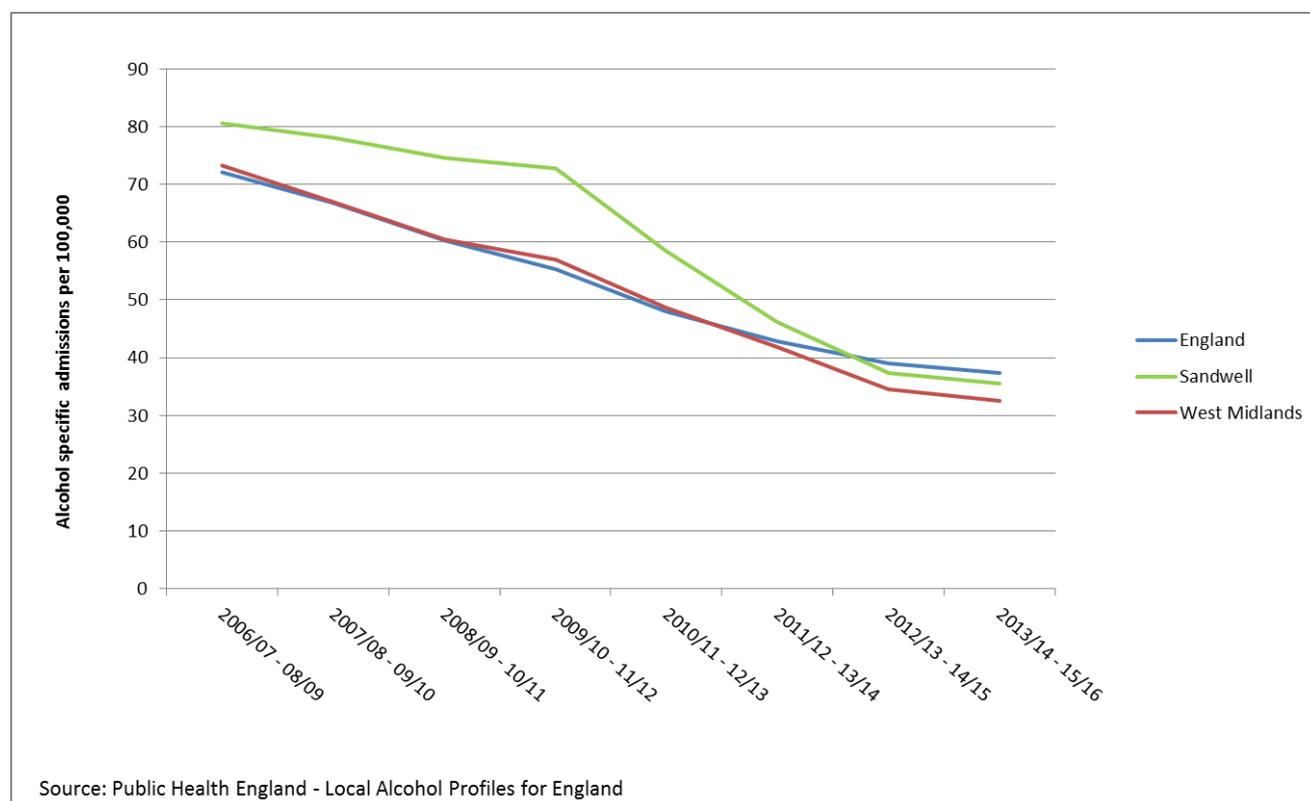
Table 4: Frequency of drunkenness among drinkers

	Frequency of drunkenness (% of 15-year-olds who have had an alcoholic drink)				
	None	Once	2-3 times	4-10 times	More than 10 times
England	77.1	13.8	7.2	1.7	0.1
Sandwell	84.0	9.7	5.0	1.2	-

3.2.2 Hospital Admissions for Alcohol

Despite the WAY survey findings of drinking among young people in Sandwell, hospital admissions for alcohol specific reasons remains higher in Sandwell than the West Midlands (Figure 1). Robust national estimates of the prevalence of drinking behaviours in the population are necessary to further understand need.

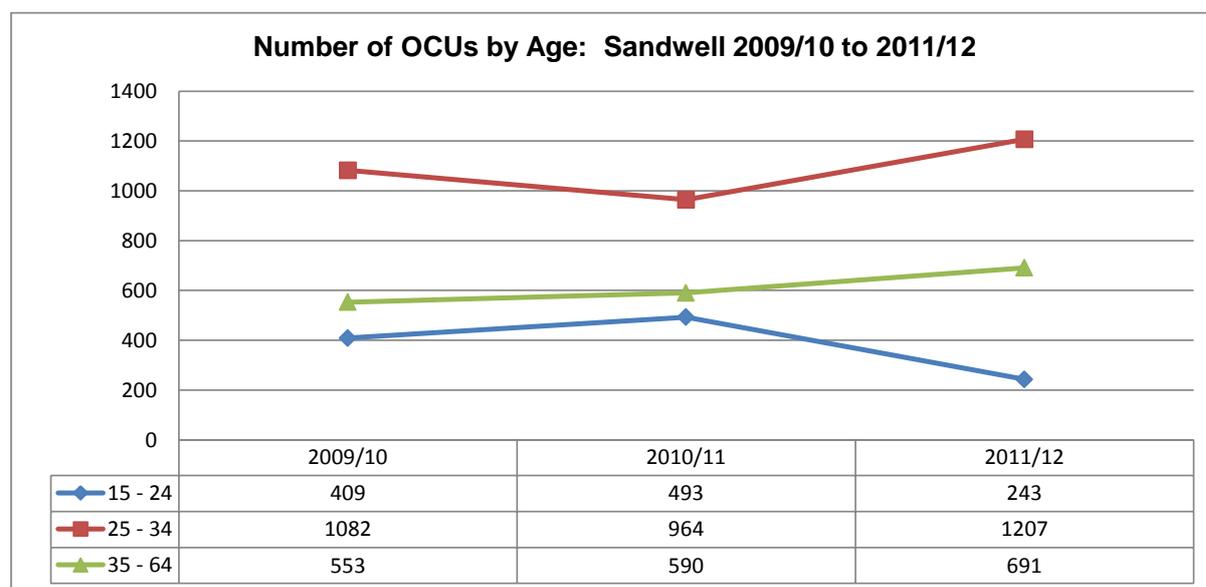
Figure 1: Alcohol-related hospital admissions for under 18-year-olds 2006/7 – 2015/16



3.2.3 Drug Use

Estimated opiate and/or crack cocaine use in Sandwell is shown in figure 2. This data shows that use of these drug types among younger people has declined significantly in recent year, reflecting national trends. Despite this decrease, rate of use is still higher in Sandwell than regionally and nationally-though similar to Birmingham and lower than Black Country neighbours.

Figure 2: Numbers of Opiate and/or Crack Cocaine Users in Sandwell by Age



Accurate local estimates of the prevalence of other drug use among young people are not available. However, Crime Survey for England and Wales found that 19.4% of 16-24 year olds had taken an illicit substance in the previous 12 months, with 8.4% using cannabis and 1.7% using powder cocaine. Therefore it is likely that overall use of illicit substances among young people in Sandwell is at least this high.

Table 5 compares proportion of permanent exclusions from school associated with drugs or alcohol and shows a higher proportion than in West Midlands or nationally. This may be further evidence of Sandwell having comparatively high misuse among young people, or alternatively that Sandwell evidences lower tolerance on this issue.

Table 5: Percentage of permanent exclusions attributed to drugs or alcohol (% of total exclusions in brackets)

Year	Sandwell		West Midlands		National	
	Total permanent exclusions	Total excluded for drugs and/or alcohol	Total permanent exclusions	Total excluded for drugs and/or alcohol	Total permanent exclusion	Total excluded for drugs and/or alcohol
2010/11	50	<5	760	30	5080	290
2011/12	60	8 (13%)	670	40 (6%)	5170	330 (6%)
2012/13	50	5 (10%)	670	40 (6%)	4630	360 (8%)
2013/14	40	5 (12.5%)	750	50 (7%)	4950	410 (8%)
2014/15	60	7 (12%)	950	80 (8%)	5800	490 (8%)

3.3 Current service provision

3.3.1 Universal Prevention

DECCA (Drug Education, Counselling and Confidential Advice) is the main provider of drug and alcohol services to young people in Sandwell. In relation to drug and alcohol DECCA provides universal prevention, early/targeted intervention and specialist treatment.

DECCA deliver prevention and harm reduction educational work in mainstream primary and secondary schools. The team deliver this universal service to around 13,500 young people every year.

In addition to a face-to-face service, the team have developed a website which contains information on alcohol, drugs and sexual health for young people and their parents/carers as well as materials for professionals. These materials were devised following consultation with young people and professionals, and using Department for Education (DfE) recommendations. The materials have won two Children and

Young People Now national awards (sponsored by the Children's Workforce Development Council) and have been sold to neighbouring authorities.

The programme has also been awarded the Feeling Safe Foundation Quality Mark by the Protective Behaviours Consortium in recognition of its contribution to building resilience and protective behaviours amongst young people.

DECCA deliver sessions to years 6 and 10. These years were chosen as key due to the transition to high school and in terms of age of first use. If issues are identified in a school further support is offered and assembly sessions have been created to allow DECCA to input with a higher number of young people as when the need arises.

3.3.2 Targeted Prevention

DECCA deliver harm reduction educational work using a structured model within non mainstream settings including Pupil Referral Units (PRU's), special educational needs schools, SMBC Youth Service, training providers, the Voluntary and Community Sector and Sandwell College. They deliver education to about 1500 young people in these types of setting per year.

Through this approach DECCA access some of the most vulnerable and at risk young people in the borough. These individuals may not be involved with mainstream education and may be classed as Not in Education, Employment or training (NEET), but through linking with a wider range of statutory and community partners DECCA are able to engage them. This targeted educational work enables earlier intervention and generates referrals into treatment. Interventions can then be delivered earlier and thus increase the chances of a successful recovery.

The educational pieces of work that DECCA have produced have been recognised by the Department of Health as models of good practice, in 2007 and 2010, for both Substance Misuse and Alcohol.

3.3.3 Early Intervention and Specialist Treatment

Young people may be referred to DECCA for 1:1 work but don't quite meet the criteria for specialist treatment; they do however still need intervention as without they may progress to the point where specialist treatment is indeed required.

The early intervention element of the service is designed to work with those with specific needs for a short period of time, to prevent them progressing into further alcohol and/or drug use.

3.3.4 Community Alcohol Project

This aims to reduce underage and unsupervised drinking by combining the available intelligence and resource within Trading Standards, Police, Police Community Support Officers, Anti-Social Behaviour Teams and Community Wardens. This project identifies 'hot spots' for activity and provides information and access to support to both parents and young people, reduces access to alcohol and develop partnerships to share information about young people's drinking across agencies. The project currently operates in Tipton, Cradley Heath and Old Hill. The Community Alcohol Project is working in partnership with DECCA and Ormiston Forge Academy to deliver Alcohol Peer Education.

3.3.5 Other Education and Engagement Projects

Groundwork delivers the Parent and Child Alcohol and Cannabis Engagement programme, the aim of which is to give parents and carers the skills and confidence to speak to their child about alcohol, substance misuse, anti-social behaviour and associated risks. There are also Parent Alcohol Theatre Workshops aimed at educating parents and carers and raising awareness about alcohol misuse.

3.3.6 Licencing Initiatives

Public Health currently funds trading standards to make visits to licenced premises, including "secret shopper" purchases to identify outlets selling alcohol to under-age individuals. These visits also include inspection for non-compliance with other licencing conditions including illegal imports.

3.4 Gaps in current provision

There is currently a problem in Sandwell where we have experienced a drop off in attendance between under and over 18s. DECCA are commissioned to provide service for under-18 year olds only, with those 18 and over accessing the adult drug and alcohol service. The number of 18 and 19 year olds accessing the adult drug services has reduced year-on-year falling from 2.5% of total caseload in 2010/2011 to just 0.8% in 2014/2015. No 18 or 19 year olds accessed the adult alcohol service where the average age of presentation is the mid to late 30s. There is no evidence of reduced need for this service and therefore it is important that we look at reasons for the poor uptake and tailor services toward younger adult clients where appropriate. Public Health has recently commissioned a research project into substance misuse amongst 18 – 24 year olds in Sandwell to understand why young adults are underrepresented in the adult treatment system.

3.5 Alignment with other services

Young people who abuse drugs and misuse alcohol are at higher risk of having unsafe sex. Chlamydia and STI screening are offered as part of DECCAs treatment service, however uptake is extreme low. It is important that we commissioning services in such a way that it maximises opportunity for cross-referral between services, where appropriate and also provides holistic wellbeing support for those accessing services. Conversely because of the links between sexual activity and substance misuse, it is important that sexual health services play a role in identifying young people attending their services that may also require treatment for substance misuse and refer appropriately.

Public Health is increasingly commissioning services aimed at improving mental wellbeing and increasing resilience in young people more generally, rather than focussing on substances abuse. DECCA are developing a similar, holistic approach when engaging with schools. It is important that support around reducing harmful behaviours and increasing wellbeing in students is consistent but also aligned.

Exposure to a range of factors including domestic violence, sexual exploitation, mental illness and anti-social behaviour increase a young person's likelihood of partaking in substance misuse. Therefore it is important that there is a process in

place to screen young people using services for other vulnerabilities and to cross refer to other services where appropriate. Likewise it is important that agencies dealing with young people with vulnerabilities (including social workers, safeguarding teams) are aware of the increased likelihood of substance misuse and refer to service where appropriate.

3.6 Recommendations

- Gain national information around estimates of children and young people drinking and using drugs. This information can be collected by making the currently survey data more robust by making the survey available to access in non-school settings or online. This data can also be extrapolated from hospital admissions data.
- Parental misuse's impact on young people to be evaluated, with a range of interventions made available through children's services to address this. This is one of a range of areas that is the focus of the Adverse Childhood Events programme. ACEs is a priority for both the Health and Wellbeing Board and Safer Sandwell Partnership and these strategic boards will lead the work around this.
- Service to be commissioned to provide a wider range of support including face to face and online resources for interventions allowing greater personalisation and accessibility
- Continue to fund the underage sales intelligence model of operation and evaluation this intervention to ensure that it is having the envisioned impact
- Ensure substance misuse is represented strategically on the wider children's agenda at LSCB, youth offending team management boards, within CAMHS and more widely
- Use collaborative commissioning where appropriate to ensure that services to prevent and reduce the impact of alcohol and drug use in young people are

commissioned as part of wider holistic support to improve wellbeing and resilience

4. Sexual health and teenage pregnancy

4.1 Context

Early onset of sexually activity in young people is a risk factor for poor educational attainment. It also increases risk of having sexually transmitted infection and increases risk of under-18 conception. Young people who engage in sexual activity early are also more likely to be from deprived households and more likely to be in or recently left care. There is also evidence that early onset of sexual activity can increase risk of poorer sexual health as an adult and increased risk of being a victim of domestic violence. Sexual health covers the provision of advice and services around contraception, relationships, sexually transmitted infections (STIs) (including HIV) and abortion. Sexual health services tailored specifically for younger people can delay onset of sexually activity, reduce under-18 conception and transmission of STIs and support the forging of healthy and mutually respectful relationships.

Despite decreases in recent years, rates of under-18 conception in Sandwell remain higher than national or regional rates.

Sandwell has higher rates of repeat abortions, compared to national and regional average. Sandwell has higher than average rates of Long Acting Reversible Contraception (LARC) usage, however there is anecdotal evidence to suggest this is low among younger patients. Sandwell is a high prevalence area for HIV and late diagnosis of HIV continues to be a major problem for the area. The Chlamydia diagnosis rate has considerably improved over the last year and is now at the same level as national average. However, despite improvement over the years, the proportion of younger people tested for Chlamydia still remains below regional average.

4.2 Evidence and Policy

NICE review of evidence for preventing sexually transmitted infection and under-18 conceptions includes the following broad recommendations:

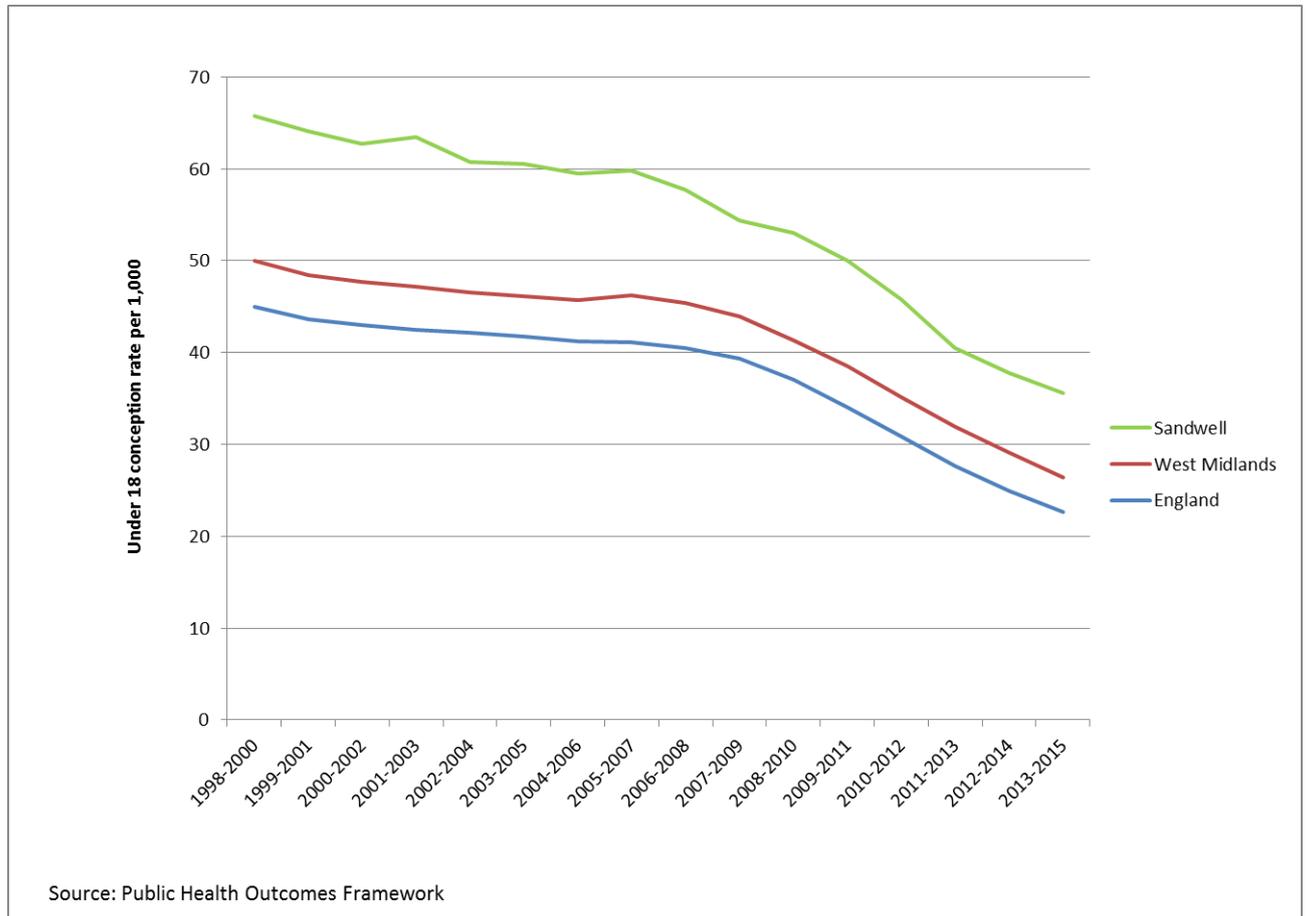
1. Provide one-to-one support and advice, which is tailored to specific age groups. Professionals within health, education and voluntary and community sectors who have contact with children and young people should be trained to provide sexual health advice
2. Support and advice should focus on how to preventing and test for STIs and access to contraception including long-acting reversible contraception and emergency hormonal contraception, where appropriate.
3. Provide advice and support around contraception and reintegration into education or work tailored to individuals who have already had an under-18 conception.
4. Advice and support around sexual health should be integrated into universal provision to improve overall resilience as well as sexually health specifically.
5. Poor sexually health and unhealthy relationships are often a risk factor for misuse of drugs and alcohol. There should be clear cross referral pathways between sexual health and drug and alcohol services

4.3 Local Data

4.3.1 Under-18 Pregnancy

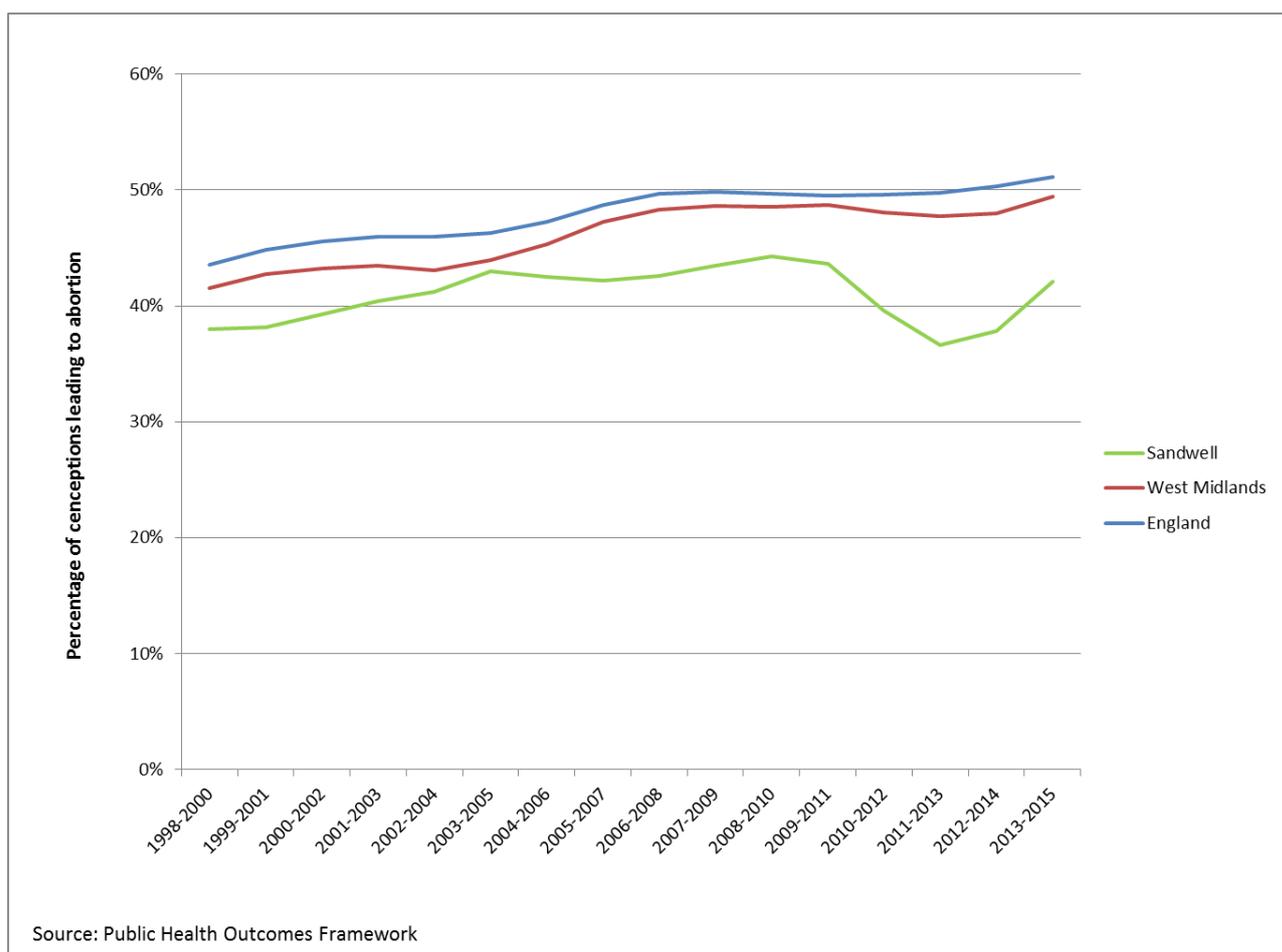
In Sandwell, we have seen a fall in the rate of conception amongst under-18s since 2006 that has largely followed a national trend. From 2005 through to 2015 there has been a 41% reduction in under-18 conception rates, more recent data then showed a slight increase in conceptions in under-18s and in 2014 Sandwell had the 7th highest under-18 conception rate in England. However figures have again improved and Sandwell has now dropped to having the 22nd highest rate of under-18 pregnancies of all the local authorities in England.

Figure 1: Under 18 conception rates, 3 year averages 1998-2000/2013-2015



Sandwell has a lower percentage of under-18 conceptions which lead to abortions than national or regional figures. Sandwell's rate has remained below the national average and fell considerably below it from 2009, but started increasing from 2013. It is important going forward that we recognise possible reasons for this trend, in order to better address it and bring us within line of national and regional averages. One suggested reason is the simplification of the referral pathway resulting in more timely access to services by residents.

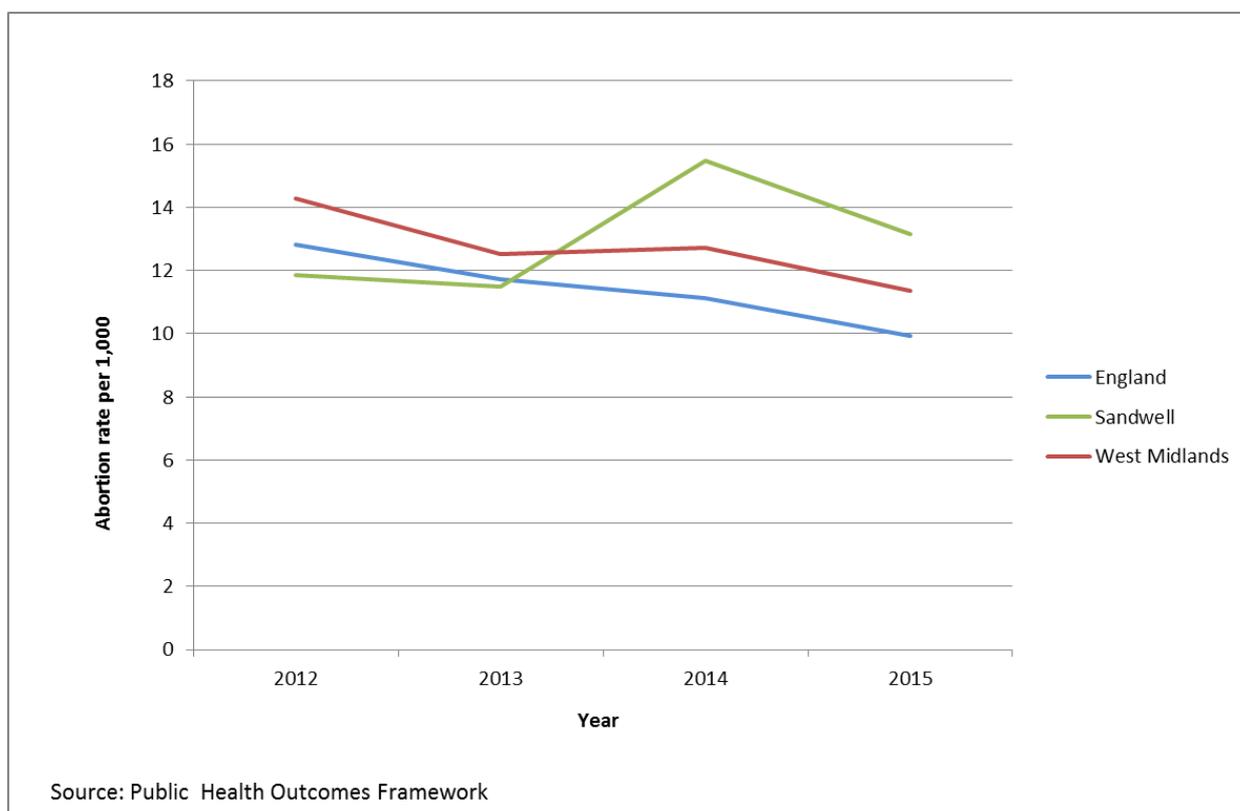
Figure 2: Percentage of under-18 conceptions leading to an abortion 3 year averages: 1998-2000 / 2013/2015



Note: The chart shows as a percentage the number of women who conceived in a particular year who then went onto have an abortion either in that year or the following year.

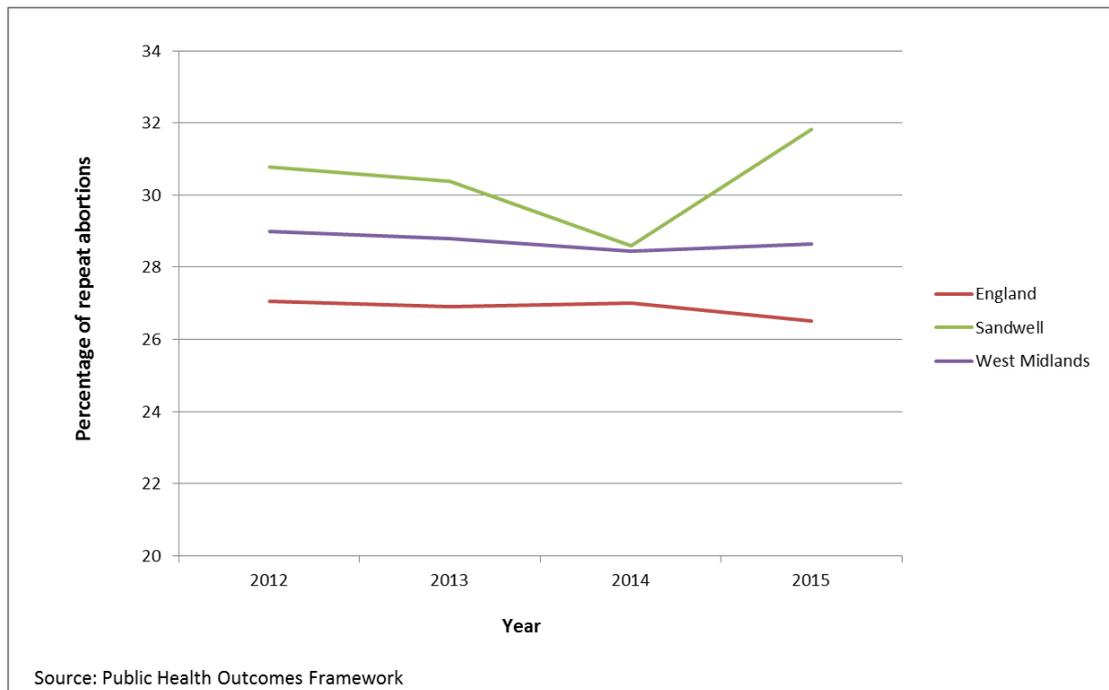
Between 2012 and 2014 the rates of women under the age of 18 seeking abortions rose considerably, increasing from 11.9 per 1000 of population in 2012 to 15.5 in 2014, a rise of almost 30% in this period. This increase is likely to have contributed to the fall in under-18 conception. However comparisons with other areas show that there is further work required to improve access and ensure that abortion services are age appropriate.

Figure 3: Abortion rates for women aged under-18 years old, 2012-2015



Repeat abortions are an important proxy measure for access to suitable contraception. No data is available on the proportion of repeat abortions in under-18 year olds. Data on under-25 years olds shows that rate of repeat abortions fell from 30.8% in 2012 to 28.4% in 2014 but rose again in 2015 to 31.8%.

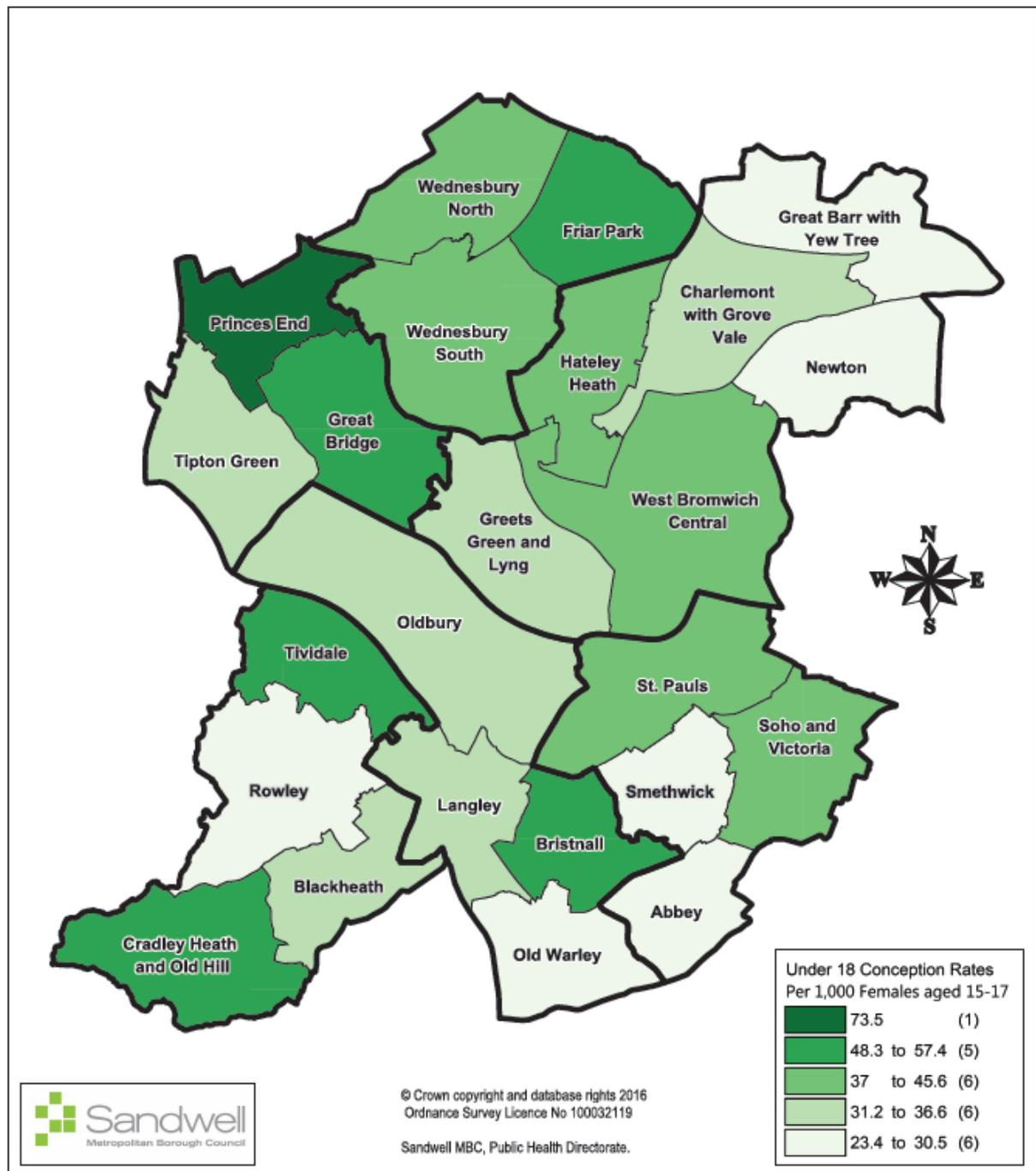
Figure 4: Percentage of repeat abortions for women aged under-25 years old



4.3.2 Ward Level Data

Figure 5 shows the areas in Sandwell that have the highest under-18 conception rates. Princes End ward has the highest rate of under-18 conceptions in Sandwell. Further work is required to examine whether differences in conception rates reflect unmet need in certain wards and if services in this area should be enhanced.

Figure 5: Under 18 conception rates by ward, 2011-13

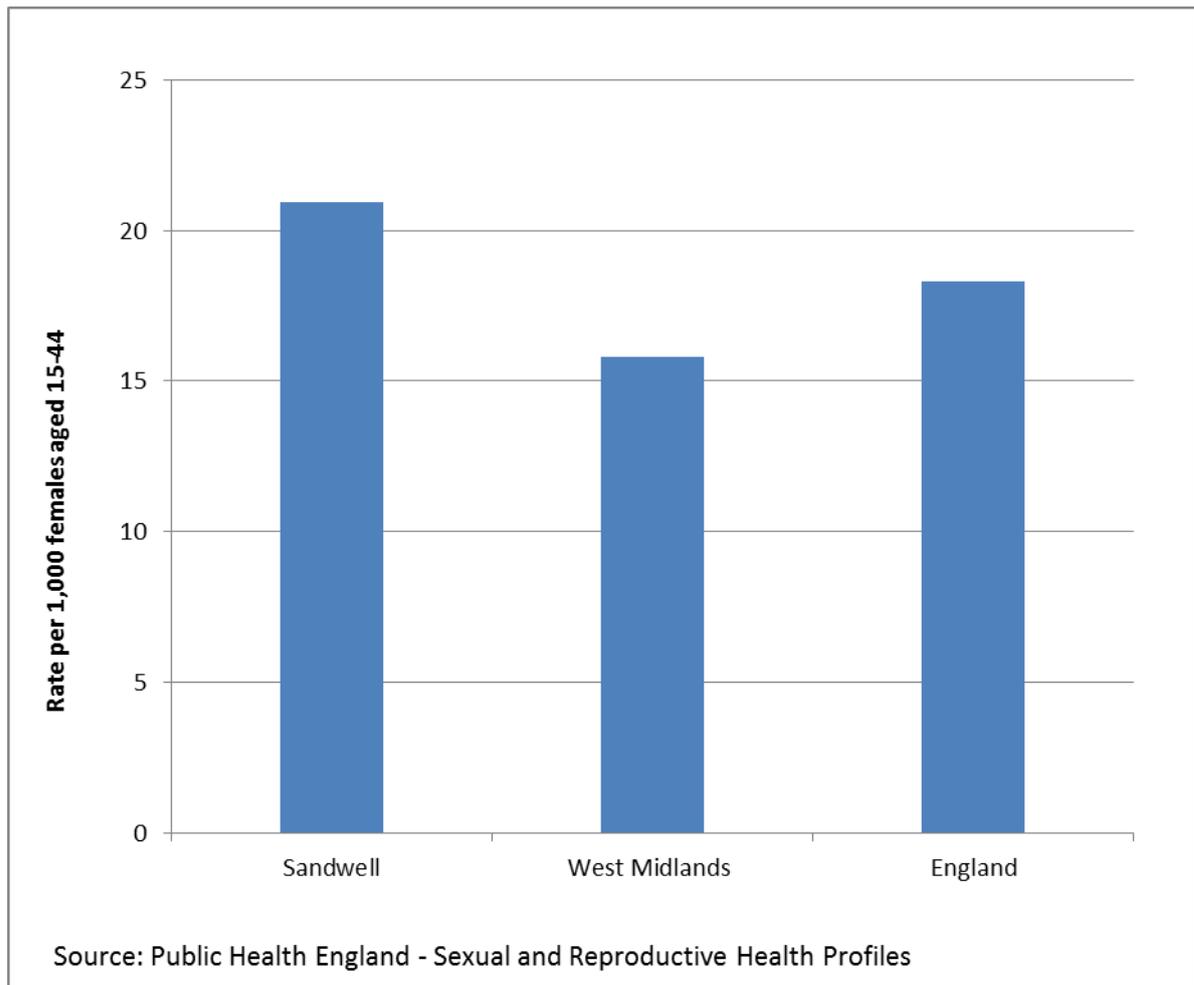


Source: ONS

4.3.3 Long-acting contraceptive provision

Figure 6 shows that Sandwell has a higher uptake of LARC than other areas for all ages. However this data is not available specifically for young people and we have anecdotal evidence to suggest that LARC provision for younger people may be inadequate.

Figure 6: Prescription Rate of LARC (excluding Injections) by SRH Services, Women of All Ages, 2015



Notes: LARC = Long Acting Reversible Contraception

SRH = Sexual and Reproductive Health

This chart shows as a rate the total number of implants, IU Systems and IU Devices prescribed in the calendar year for women of all ages. The results of this chart indicate that Sandwell has a higher rate of women taking up LARC, especially when compared to regional and national averages.

However, although the presented represents data for women of all ages within Sandwell, it has been presented as a rate of the resident population aged 15-44 to allow for a direct comparison with the total abortion rate which is constructed on this basis. However, it should be noted that there is increasing use of contraception in older age groups, which therefore skews this data.

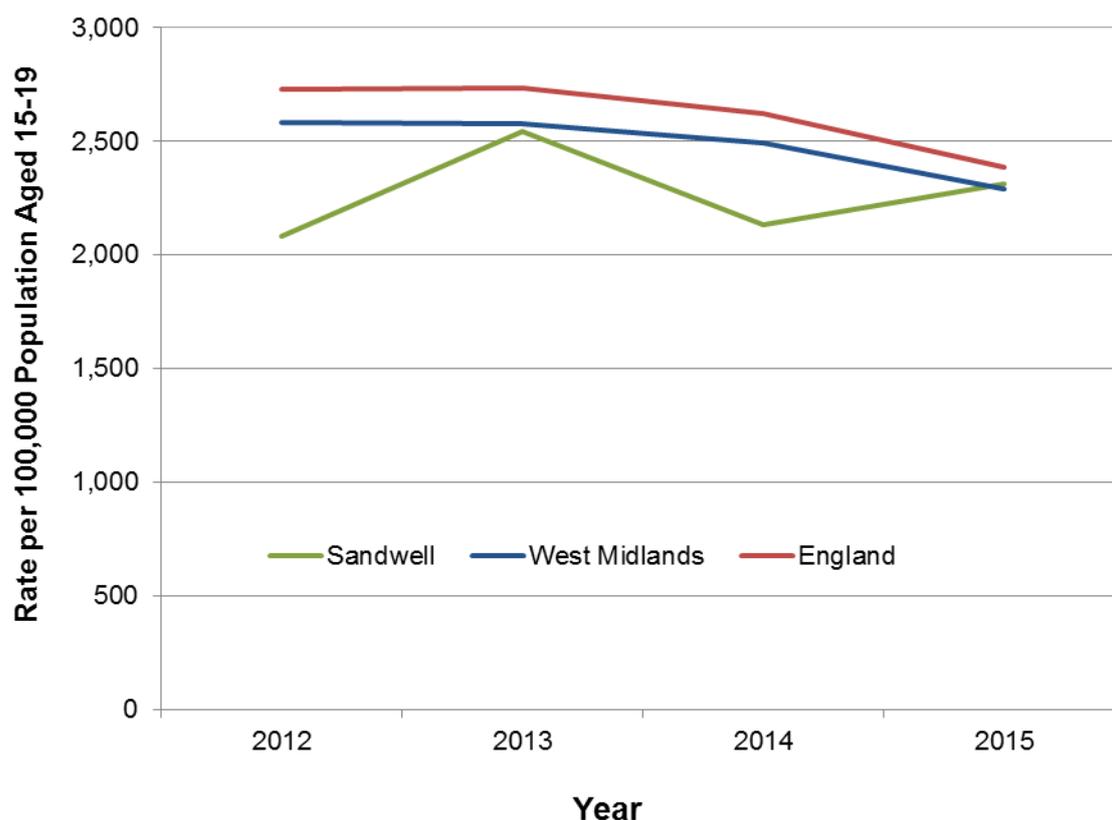
It is also important to note that as LARC products can be in place for a number of years, a prescriptions view will be an undercount of the number of women actually using LARC in any year. A strategic priority is to ensure access to the full range of contraception is available to all. An increase in the provision of LARC is a proxy measure for wider access to the range of possible contraceptive methods and should also lead to a reduction in rates of unintended pregnancy.

It also important to note that this indicator excludes injections, as they rely on repeat visits/administration within the year and have a higher failure rate than the other LARC methods. In addition to this, injections are easily given thus do not require the resources and training that other LARC methods require and injections may also fall outside of local authority contracts. However, it is also important to note that the Brook service currently provides contraceptive injections as part of its service.

4.3.4 Sexually transmitted infections

Figure 7 shows that Sandwell has lower incidences of STI diagnosis among 15-19 year olds than either the West Midlands or England. Further investigation is required to establish if this data represents a truly lower incidence or a reflection on low or inappropriate testing.

Figure 7: All New STI Diagnosis Rates, 15-19 Year Olds, 2012-15



(Source: GUMCADv2 Surveillance, Public Health England)

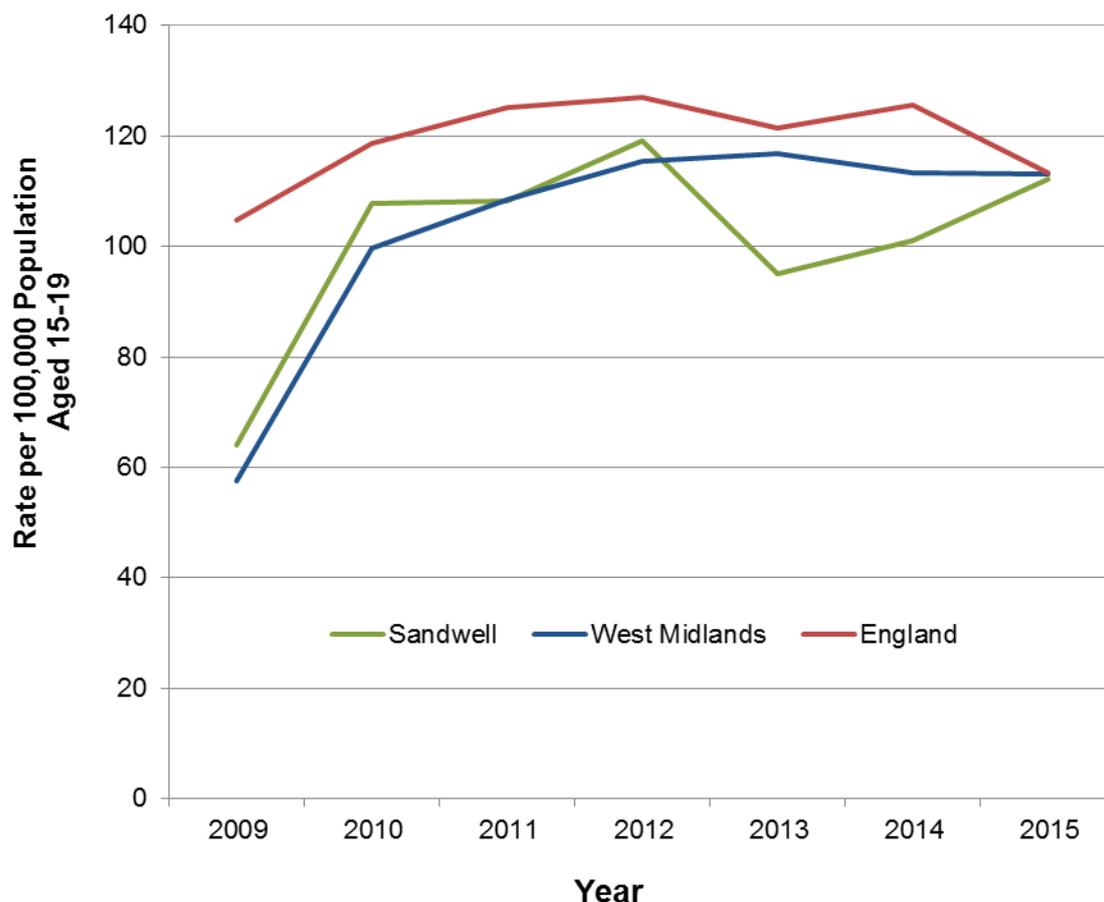
*Data is from GUM. For chlamydia data is from GUM and community services

**Number of diagnoses were taken from GUMCADv2 and then rates were calculated using the ONS mid-year population estimates for each year.

***New STIs includes: Chlamydia, Gonorrhoea, Non-specific genital infection (NSGI), Pelvic inflammatory disease (PID) and epididymitis (non specific), Syphilis (Primary, secondary and early latent), Lymphogranuloma venerum, Chancroid, Donovanosis,

Genital Herpes simplex (first episode), Genital warts (first episode), New HIV diagnosis, Molluscum contagiosum, Trichomoniasis, Scabies, Pediculus pubis.)

Figure 8: Genital Herpes (First Episode) Diagnosis Rates, 15-19 Year Olds, 2009-15

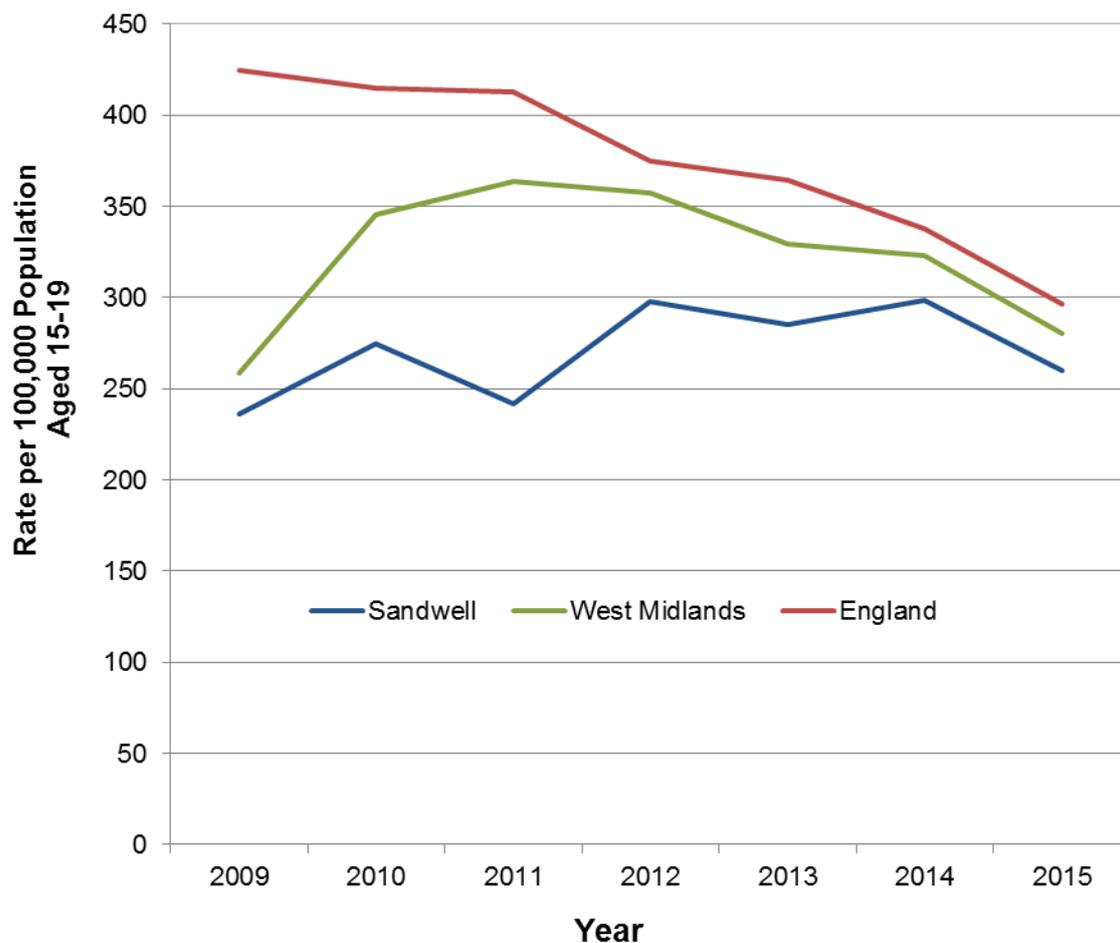


Source: GUMCADv2 Surveillance, Public Health England

Note: Number of diagnoses were taken from the GUMCADv2 and then rates were calculated using the ONS mid-year population estimates for each year.

Similarly incidence of genital herpes is lower in Sandwell than national or regional rates, while incidence of genital warts in 15 to 19 year olds in Sandwell have remained largely stable, in contrast to regional and national rates which are falling (figures 8 and 9).

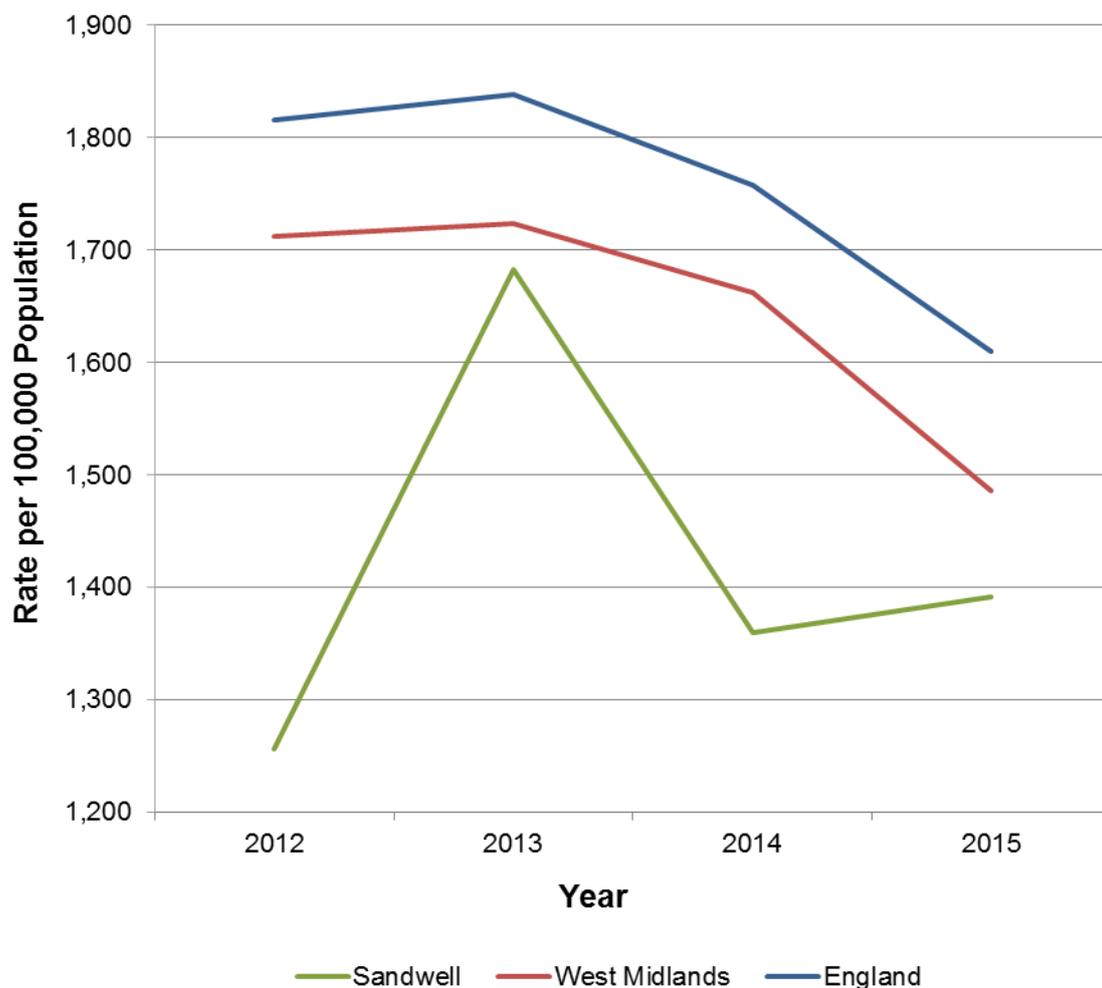
Figure 9: Genital Warts (First Episode) Diagnosis Rates, 15-19 Year Olds, 2009-2015



Source: GUMCADv2 Surveillance, Public Health England

Note: Number of diagnoses were taken from GUMCADv2 and then rates were calculated using the ONS mid-year population estimates for each year.

Figure 10: Chlamydia Diagnosis Rates, 15-19 Year Olds, 2012-15



Source: National Chlamydia Screening Programme and GOV.UK

Nationally, chlamydia screening is recommended for all sexually active people under 25 and on partner change. Public Health England recommends that local authorities should be working towards achieving a detection rate of at least 2,300 per 100,000 population. The chlamydia detection rate amongst under-25 year olds is a measure of chlamydia control activities. Increasing detection rates indicates increased control activity, rather than a measure of morbidity.

Figure 10 shows that Sandwell’s detection rate remains far lower than the national average, potentially displaying a concerning lack of appropriate screening and provision of chlamydia prevention services.

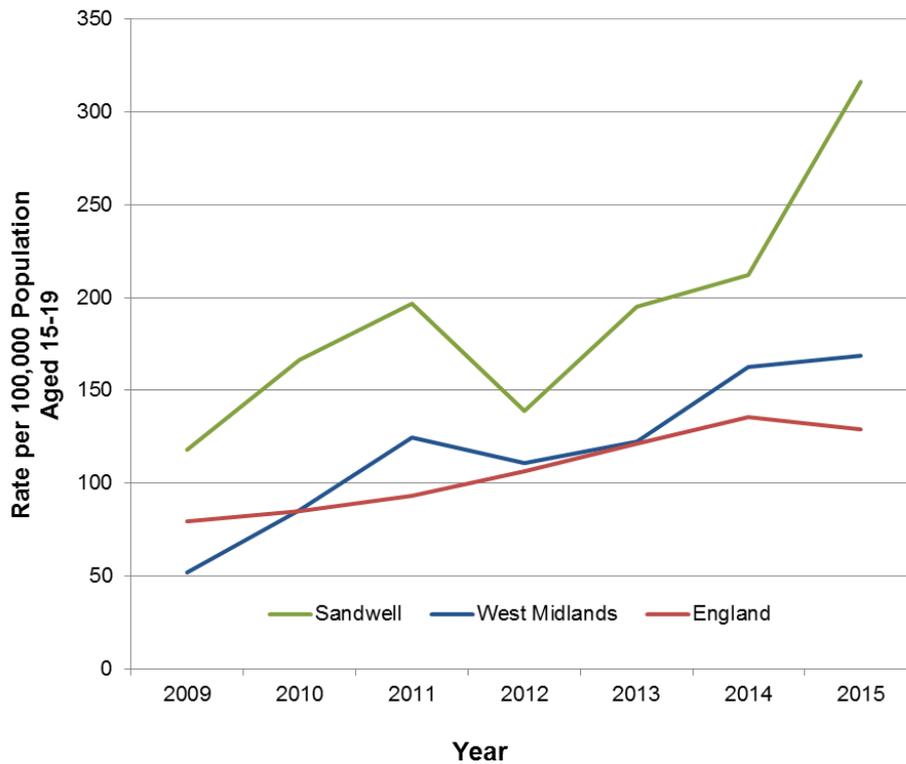
Table 1: Proportion of 15-19 Year Olds Screened for Chlamydia, 2012-14

Area	2012	2013	2014
Sandwell	8.6%	14.1%	11.5%
West Midlands	22.7%	19.4%	17.2%
England	23.2%	21.7%	19.9%

Source: National Chlamydia Screening Programme (2012 data) and GOV.UK (2013 and 2014 data)

Notes: The 2012 data for England excludes tests where there was not sufficient location information to attribute them to a local authority. For 2013 and 2014 all tests are included in the England data.

Figure 11: Gonorrhoea Diagnosis Rates, 15-19 Year Olds, 2009-15



Source: GUMCADv2 Surveillance, Public Health England

Gonorrhoea rates are used as a proxy indicator for overall sexual health. This is because the majority of cases are diagnosed in Genitourinary Medicine Service settings, and consequently the number of cases can be used as a measure of access to STI testing. It is important for us to note, however, that data reported through GUMCADv2 are not representative of the general population because they only represent patients accessing GUM services. Figure 11 shows that in 2012, the rate of gonorrhoea diagnosis within Sandwell amongst 15-19 year olds stood at 139.0 per 100,000 population. This, when measured against a regional average of 111.1, and a national average of 106.6 shows that Sandwell has had historically high levels of gonorrhoea diagnosis. The levels of young people diagnosed with Gonorrhoea has increased nationally, but Sandwell has also increased over this period, rising to 212.3 in 2014 and 316.0 in 2015 respectively.

4.4 Recommendations

4.4.1 Under-18 conception

- Evidence from reviews in high performing areas suggests that a multi-pronged approach to tackling teenage pregnancy is most effective and requires senior level leadership, clear accountability and a range of actions across all sectors.
- Ensure that all young people have access to good quality, age-appropriate, relationships and sex education, with a strong emphasis on healthy relationships and the promotion of emotional wellbeing. Provide training and resources for teachers and other front-line practitioners to deliver this.
- Support parents and carers to be more confident, informed and skilled in discussing relationships and sexual health with their children.
- Ensure that young people with multiple risk factors for poor outcomes, including teenage pregnancy, are identified and receive coordinated early help.
- Provide young people- friendly contraception and sexual health services, including in non-health settings, and promote the use of long acting reversible contraception.
- Support young parents in order to improve outcomes for them and their children, including the prevention of further unplanned teenage pregnancies.

4.4.2 Sexually transmitted infections

- The availability of a well-publicised young people-centred contraceptive and sexual health advice service, with a strong remit to undertake health promotion work, as well as delivering reactive services.
- A high priority given to PSHE in schools, with support from the local authority to develop comprehensive programmes of sex and relationships education (SRE) in all schools.

- A strong focus on targeted interventions with young people at greatest risk of teenage pregnancy, in particular with Looked After Children.
- The availability (and consistent take-up) of SRE training for professionals in partner organisations.
- GUM and CaSH service now integrated to form a central hub, which will help address unmet needs among service users of sexual health and contraceptive Services.
- A good provision of spokes placed appropriately to provide both universal and specialist GUM and CaSH services ensuring more equitable access to disadvantaged and priority groups such as BME community, younger (15-24) and migrant population.
- Delivering sexual health services from generic outreach settings including non-health settings, which will help increase screening and reduce stigma.
- Third sector should engage with the clinical staff in providing preventative and screening services to hard to reach communities of Sandwell.
- Look at ways of increasing the uptake of long acting reversible contraception, this needs to include developing a local training strategy to address the shortage of IUD fitters and the difficulty recruiting to posts.
- Consider ways of gaining efficiencies in the service by alternative commissioning arrangements

5. Special Educational Needs and Long Term Conditions

5.1 Introduction

Children with disabilities and other long term conditions face a range of inequalities, including accessing services, health outcomes and educational attainment. Many children and young people with disabilities and complex health requirements need a bespoke package of support in order to meet their needs, often requiring the services of several professionals from a number of different specialities. Across the spectrum, children and young people with disabilities and / or complex health needs often find it difficult to access a number of mainstream services including leisure and play activities and some will require additional support in school or specialist educational provision. Barriers include unsuitable environments, lack of money and the attitudes of others.

The impacts of disabilities can be multiple and complex, and may affect such normal day-to-day activities as:

- Mobility
- Ability to perceive, think, concentrate, remember or learn
- Ability to communicate through oral or written language
- Manual dexterity
- Ability to co-ordinate movement to lift, carry or otherwise move everyday objects
- Continence
- Perception of risk or danger

A child or young person has special educational needs (SEN) if they have a learning difficulty or disability which calls for special educational provision to be made for them. This could be because they:

- Have a significantly greater difficulty in learning than the majority of others of the same age; or

- Have a disability which prevents or hinders them from making use of educational facilities of a kind generally provided for others of the same age in mainstream schools or mainstream post-16 institutions.

The population of children with SEN is far greater than the population of children with a disability. Not all children with SEN are disabled, and not all disabled children and young people have SEN.

New categories of Special Educational Need have been adopted in the 2014 Code of Practice which fall under four broad categories:

- Cognition and Learning
- Communication and Interaction
- Sensory and/or physical needs
- Social, emotional and mental health difficulties

As the life expectancy of premature babies and disabled children increases, there is evidence that there will continue to be a growth in the numbers of children and young people with a range of disabilities and complex health needs who live longer and make the transition to adulthood and may during childhood have special educational needs. For example, the number of people with intellectual disabilities increased by 53% over the 35-year period from 1960 to 1995 as a result of improved socio-economic conditions, intensive neonatal care and increasing survival.

The World Health Organisation defines long term conditions as health problems that require ongoing management over a period of years or decades. Long term conditions (LTCs) can also be defined as conditions that cannot currently be cured but can be controlled with the use of medication and/or other therapies (WHO 2002). This includes a very broad range of conditions which can be classified as:

- Cerebral conditions e.g. cerebral palsy
- Respiratory conditions, of which asthma is the most common in children

- Cardiac conditions e.g. congestive heart failure
- Metabolic conditions, including diabetes
- Neurological conditions, including epilepsy
- Haematological conditions e.g. anaemia
- Gastrointestinal conditions e.g. childhood constipation
- Genito-urinary conditions e.g. chronic kidney disease
- Structural impairments, including hearing or sight impairments, bone and joint disorders
- Communicable diseases, including HIV/AIDS
- Neoplasia, including benign and malignant tumours and conditions such as leukaemia

Long term conditions have become a priority because of the increasing prevalence of conditions amongst the general population such as asthma, diabetes, cancer and epilepsy, which account for a significant and growing proportion of our health and social care resources (DH 2008).

- Children from socio-economically disadvantaged households have an increased risk of developing a long term condition and once diagnosed the condition is less likely to be managed well. This is especially true for asthma and epilepsy where there are strong links between unplanned hospital admissions and level of deprivation.
- Children and young people who have a long-term condition can be at risk of missing out on educational opportunities due to prolonged absences from school, from ill health or multiple appointments

5.2 Current policy and evidence

5.2.1 Special Educational Needs and Disabilities

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.

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.

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

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

The SEND Code of Practice provides guidance from the Department of Education to all schools and local authorities on how to carry out their responsibilities under the new arrangements, stating that:

- The more flexible and responsive a teacher's strategies are, the more likely it is that pupils with a range of learning needs will make adequate progress.

- Most children and young people with SEND will have their needs met by resources which are normally available in settings, schools and colleges.
- Every school in Sandwell has a Special Educational Needs Co-ordinator (SENCO), who is responsible for co-ordinating support for pupils with SEN in their school.
- Very occasionally, a child or young person will have a level or complexity of need that will require more resources than a setting, school or college can provide. In these cases the school will ask for a Community Assessment Meeting (CAM) to be convened at which all parties (the child or young person, parents, school, other support agencies) will meet to look at the evidence and plan a way forward.
- For children with SEND the transfer from primary school to secondary school can be particularly daunting. Proper planning along with discussions and the sharing of information between schools is vital if the children are to be identified and supported effectively during and after the transfer. Inclusion Support has worked with schools in Sandwell to produce a suite of materials to support year 6 to year 7 transition. The SEND Transition Plus materials are already in use in a number of schools in Sandwell and they will shortly be made available on the Local Authority Extranet to allow more schools to take advantage of the resources.

5.2.2 Long Term Conditions

The NHS Outcomes Framework for 2016-2017 sets out the framework and indicators that are used to hold NHS England to account for improvements in health outcomes. NHS England has to work with Clinical Commissioning Groups and others to determine how to achieve the outcomes. There are 5 domains within the outcomes framework:

- Domain 1: Preventing people from dying prematurely
- Domain 2: Enhancing Quality of Life for People with Long-Term Conditions
- Domain 3: Helping people to recover from episodes of ill health or following injury

- Domain 4: Ensuring that people have a positive experience of care
- Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm

Domain 2 is concerned with how successfully the NHS is supporting people with long-term conditions to live as normal a life as possible, but the majority of the indicators are for adults. In terms of children and young people with long-term conditions, the focus is on reducing hospital admissions. Domain 2 identifies “Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s” as an improvement area.

NHS England and their partners have published The Five Year Forward View which sets out the vision for the future of the NHS. It states that long term conditions are a central task of the NHS and caring for these needs requires a partnership with patients over the longer term rather than providing single, unconnected “episodes” of care.

NHS England state that is particularly important to support the increasing numbers of people with more than one long term condition, more commonly known as multi-morbidity; older people who need more health and care, including those living with frailty; and those in the last 12 months of their life – helping people with long term conditions to live well, age well and die well.

The ambition by 2020 is to:

- Support people with long term health conditions and their carers to live healthily and independently, with better control over the care they receive.
- Use the National Voices definition of person centred co-ordinated care that was developed by people with long term conditions to help make it a reality.

The Government in 2015 produced an updated version of Supporting Pupils at School with Medical Conditions. This document gives statutory guidance on supporting pupils with medical conditions whilst they are at school, but also applies to

activities taking place off-site as part of normal educational activities. Non-statutory advice is also provided.

The statutory guidance applies to any 'appropriate authority for a school'. This is defined as:

- Governing bodies of maintained schools (excluding maintained nursery schools)
- Management committees of Pupil Referral Units (PRUs)
- Proprietors of academies, including alternative provision academies (but not including 16–19 academies)

The key points in the guidance are:

- Pupils at school with medical conditions should be properly supported so that they have full access to education, including school trips and physical education
- 'Appropriate authorities' should ensure that all their schools develop a policy for supporting pupils with medical conditions and that this policy is implemented
- 'Appropriate authorities' must ensure that school leaders consult health and social care professionals, pupils and parents to ensure that the needs of children with medical conditions are properly understood and effectively supported

National Institute for Clinical and Healthcare Excellence (NICE) produce guidelines which make evidence-based recommendations on a wide range of topics. They also produce quality standards which set out priority areas for quality improvement in health and social care.

NICE diabetes in children and young people aged under-18 years guidance recommends that the following are included in the disease pathway:

- Age-appropriate education and information is provided on diagnosis
- Management by multiple daily injection is offered if appropriate and if not subcutaneous infusion or pump therapy is provided
- Dietary management including carbohydrate counting
- Blood glucose and HbA1c target setting and monitoring
- Monitoring for diabetic kidney disease, hyperglycaemia and blood ketones
- Psychological and social support

NICE asthma quality statements include:

- People with newly diagnosed asthma are diagnosed in accordance with BTS/SIGN guidance.
- People with asthma receive a written personalised action plan
- People with asthma are given specific training and assessment in inhaler technique before starting any new inhaler treatment
- People with asthma receive a structured review at least annually
- People with asthma who present with respiratory symptoms receive an assessment of their asthma control
- People with asthma who present with an exacerbation of their symptoms receive an objective measurement of severity at the time of presentation
- People aged 5 years or older presenting to a healthcare professional with a severe or life-threatening acute exacerbation of asthma receive oral or intravenous steroids within 1 hour of presentation
- People admitted to hospital with an acute exacerbation of asthma have a structured review by a member of a specialist respiratory team before discharge

- People who received treatment in hospital or through out-of-hours services for an acute exacerbation of asthma are followed up by their own GP practice within 2 working days of treatment

NICE epilepsy in children and young people quality statements include:

- Children and young people presenting with a suspected seizure are seen by a specialist in the diagnosis and management of the epilepsies within 2 weeks of presentation
- Initial investigations for epilepsy are completed within 4 weeks of them being requested
- Magnetic resonance imaging should be used to test for epilepsy in who meet the criteria for neuroimaging
- Following diagnosis an agreed and comprehensive written epilepsy care plan should be produced
- Children and young people with epilepsy are seen by an epilepsy specialist nurse who they can contact between scheduled reviews
- Patients with a history of prolonged or repeated seizures have an agreed written emergency care plan
- Patients meeting the criteria for referral to a tertiary care specialist are seen within 4 weeks of referral.
- A structured review with a paediatric epilepsy specialist takes place at least annually.
- Young people with epilepsy have an agreed transition period during which their continuing epilepsy care is reviewed jointly by paediatric and adult services.

The Royal College of Paediatrics and Child Health (RCPCH) State of Child Health Report 2017 considers some of the main long-term conditions suffered by children and recommends the following.

- Since 2011, the national Epilepsy12 programme has shown significant improvements in the standard of epilepsy care provided, as well as ongoing

challenges. For example, the proportion of paediatric services with input from an epilepsy specialist nurse has increased from 46% to 59%. Whilst this is welcome progress, it remains the case that over a third of paediatric services across the country do not contain a vital component of an adequate service.

- The epilepsy passport was introduced by the RCPCH in 2015 in the hope of improving emergency care for children and young people with epilepsy as vital information about a child's condition can be carried with them at all times.
- All children and young people should have access to the full range of intensive insulin therapies as recommended by NICE. All patients should receive appropriately tailored education concerning the management of diabetes from specialist multidisciplinary paediatric diabetes teams.
- Schools have a major and statutory role to play in providing support for all children and young people with Type 1 diabetes, ensuring they can achieve the same educational and social outcomes as all other children.
- A whole pathway approach is required to reduce emergency admissions for asthma, with a focus on high-quality management (through full implementation of applicable guidance, e.g. NICE, and early intervention to address any deterioration).
- Treatment needs to be tailored to the individual and all children with asthma should be provided with a personal asthma action plan and have a structured review by a healthcare professional with specialist training in asthma, at least annually.

5.3 Local context- descriptive epidemiology

5.3.1 Special Educational Needs & Disabilities

From September 2014, children or young people who are newly referred to a local authority for assessment are considered under the new EHC plan assessment process.

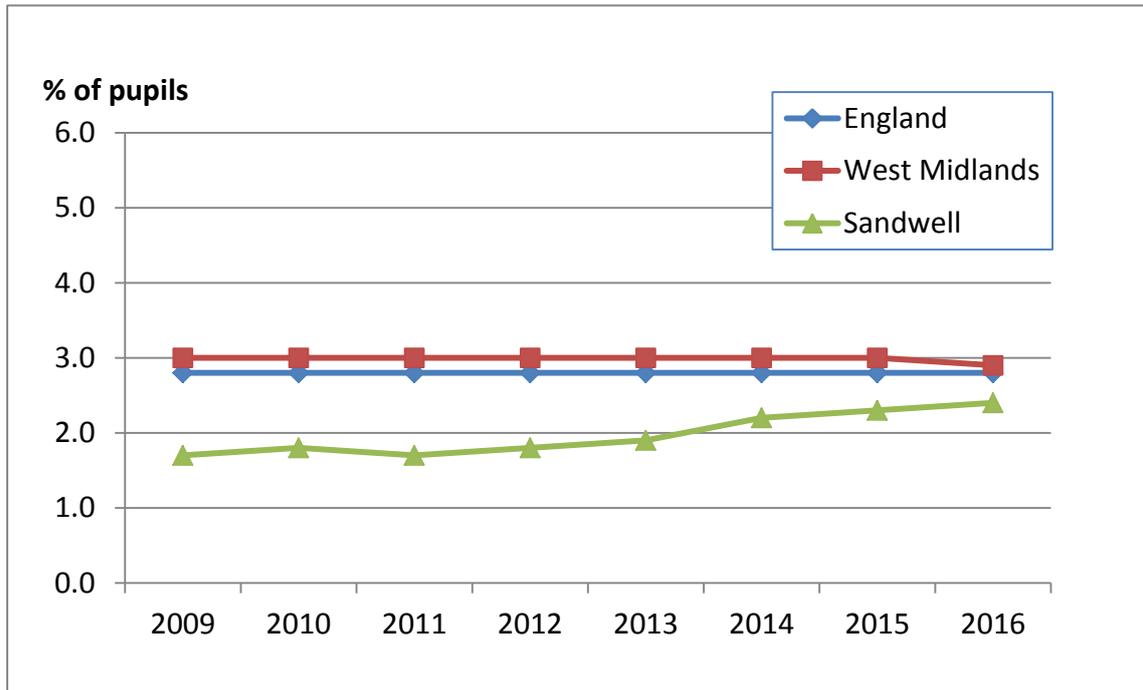
Pupils with special educational needs are currently classified as follows:

- SEN Support: Extra or different help is given from that provided as part of the school's usual curriculum. The class teacher and special educational needs co-ordinator (SENCO) may receive advice or support from outside specialists. The pupil does not have a statement or education, health and care plan.
- Statement of special educational needs (statement) or Education, Health and Care (EHC) Plan: A pupil has a statement or EHC plan when a formal assessment has been made. A document is in place that sets out the child's need and the extra help they should receive.

Nationally, the percentage of pupils with special educational needs (both those with SEN Support and those with EHC Plans) has fallen from 15.4% in 2015 to 14.4% in 2016. 14.4% of pupils had special educational needs in 2016, a fall from 15.4% in 2015.

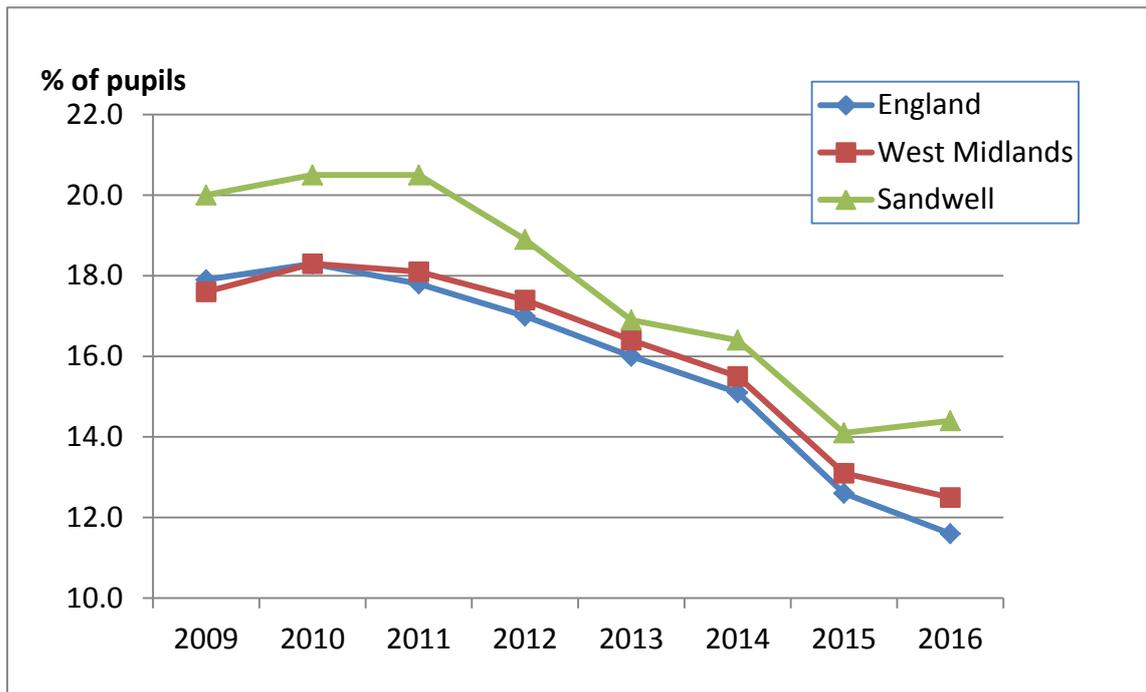
Nationally 2.8% of the total pupil population has an EHC place, which has remained constant since 2007. In Sandwell 2.4% of the pupil population had a statement or EHC plan. The proportion of Sandwell pupils with a plan has been steadily increasing (from 1.7% in 2011), however this still remains below both the regional and national average (as shown in Fig 1). The overall proportion of pupils with SEN in Sandwell is higher than the national average (Fig 2). This low proportion of those identified as having SEN but with no EHC suggests there may be unmet need in Sandwell and requires further investigation.

Figure 1: Proportion of Pupils with a Statement or EHC Plan 2009-2016



Source: Department for Education SFR29 2016

Figure 2: Proportion of Pupils with SEN Support 2009-2016



Source: Department for Education SFR29 2016

**Table 1: Pupils with special educational needs by their primary type of need
2016**

	ENGLAND	WEST MIDLANDS	Sandwell	
	%	%	No.	%
Moderate Learning Difficulty	24.2	33.3	3671	39.0
Speech, Language and Communications Needs	19.5	17.6	1831	19.5
Social, Emotional and Mental Health	16.3	13.9	1611	17.1
Other Difficulty/Disability	4.9	3.8	572	6.1
Specific Learning Difficulty	13.3	9.9	366	3.9
SEN support but no specialist assessment of type of need	3.2	3.6	303	3.2
Autistic Spectrum Disorder	8.8	8.3	260	2.8
Severe Learning Difficulty	2.9	3.0	230	2.4
Physical Disability	2.9	2.8	199	2.1
Hearing Impairment	1.8	1.7	162	1.7
Visual Impairment	1.0	1.1	118	1.3
Profound & Multiple Learning Difficulty	1.0	0.9	72	0.8
Multi-Sensory Impairment	0.2	0.1	11	0.1
Total Pupils with SEN	11,329,07	135,617	9,406	

Source: Department for Education

In Sandwell, moderate learning difficulty is by far the most prevalent primary type of special educational need, with two in five of pupils with SEN having this as their primary need. This compares with one in four nationally. Speech, language and communications needs and social, emotional and mental health are the next most prevalent types of need. These three areas are also the most prevalent nationally and regionally. However, nationally 13.3% of pupils with SEN are categorised as having “specific learning difficulties” compared with only 3.9% in Sandwell. This data needs further investigation to in order to ascertain why the Sandwell profile is

different to England and whether there are issues regarding the diagnosis of specific conditions in the borough. There were changes to the classification of type of need in 2015 and due to these changes it is not possible to produce trend analysis of need profile over time.

In Sandwell in 2016, over 40% of pupils with SEN were aged 10 to 14 years and two-thirds of those with SEN were boys.

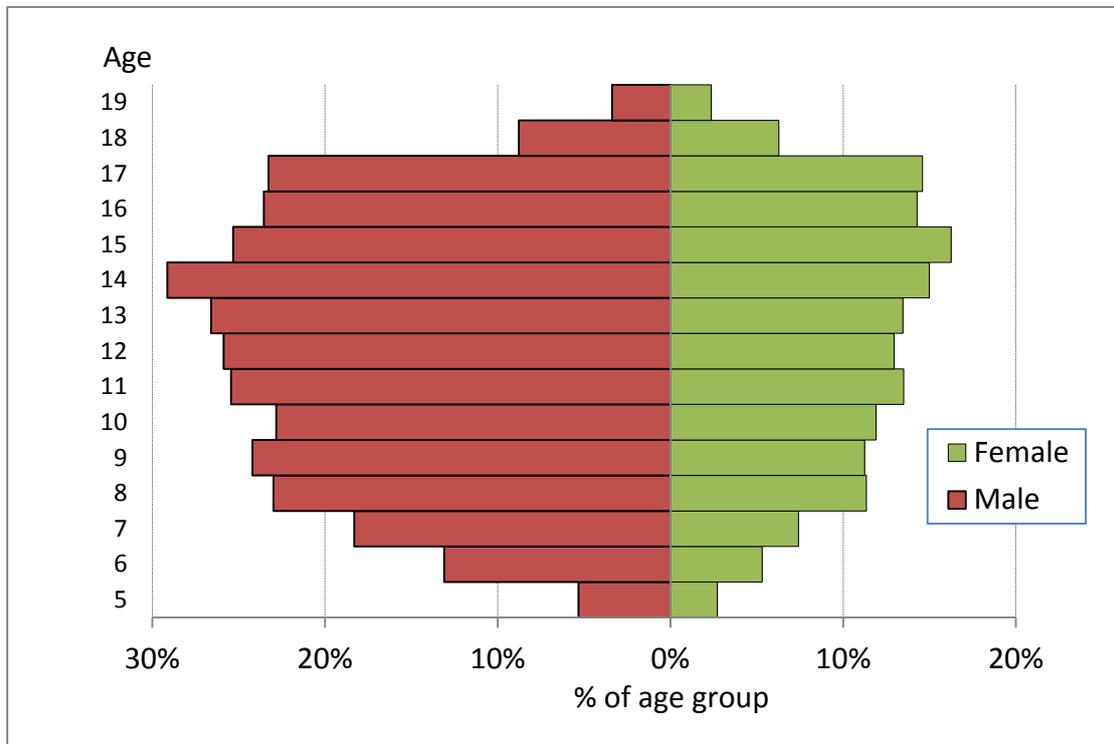
**Table 2: Pupils with Special Educational Needs by Age Group and Gender
2016: Sandwell**

	Female	Male	TOTAL	
			No.	%
5-9	848	1955	2803	29.4%
10-14	1286	2630	3916	41.1%
15-19	1001	1754	2755	28.9%
Over 19	22	30	52	0.5%
ALL AGES	3157	6369	9526	

Source: Sandwell School Census 2016

In terms of single years of age, the most prevalent group with SEN are 14 year old boys – almost 30% of this age group in Sandwell have special educational needs. Over a quarter of boys in all of the years between 11 to 15 years have SEN. Prevalence rates are much lower amongst girls – the highest proportion being amongst 15 year old girls (16.3%).

**Figure 3: Pupils with Special Educational Needs by Age and Gender 2016:
Sandwell**



Source: Sandwell School Census 2016 and 2015 mid-year population estimates (ONS)

Table 3 shows that proportion of children with SEN in each ethnic group is as would be expected given the ethnicity make of the 5-19 year old Sandwell population.

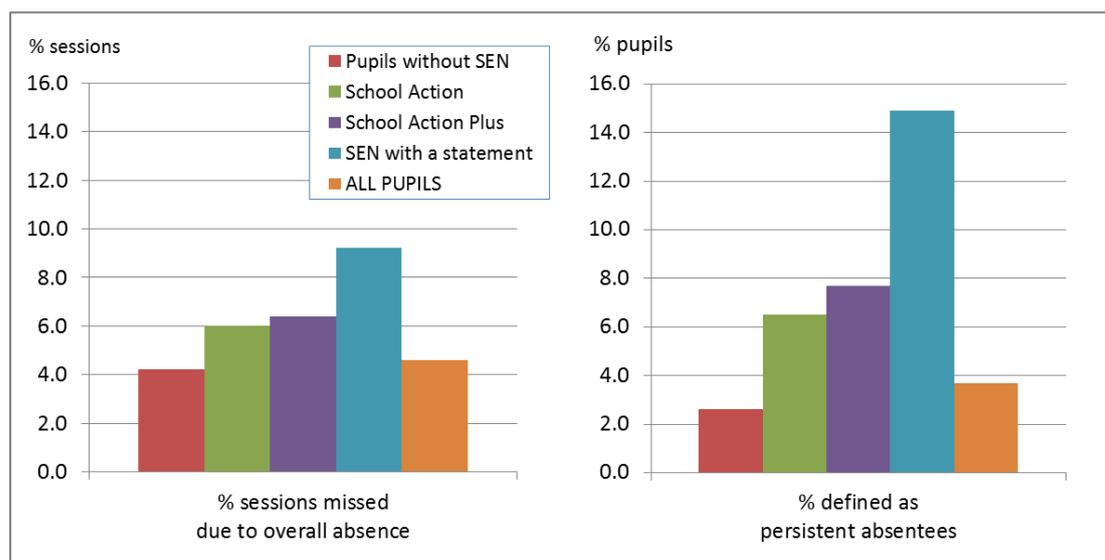
Table 3: Pupils with Special Educational Needs by Ethnicity 2016: Sandwell

	Education and Health Care Plan	Statement	School Support	ALL WITH SEN		ALL 5-19's
				No.	%	%
White	104	642	4896	5642	59.7%	60.8%
Asian	50	234	1642	1926	20.4%	23.8%
Black	26	97	714	837	8.9%	6.8%
Mixed	17	89	671	777	8.2%	7.0%
Other	2	15	130	147	1.6%	1.7%
Unknown	4	18	103	125	1.3%	-
ALL GROUPS	203	1095	8156	9454		

Source: Sandwell School Census 2016

Absence rates shown in figure 4 and 5 include both authorised and unauthorised absences, and can cover illness, attendance at medical appointments, and family holidays. A persistent absentee is defined as having an absence rate of 15% or more.

Figure 4: Absence Rates and Pupils Defined as Persistent Absentees by Special Educational Needs – Sandwell 2013/14

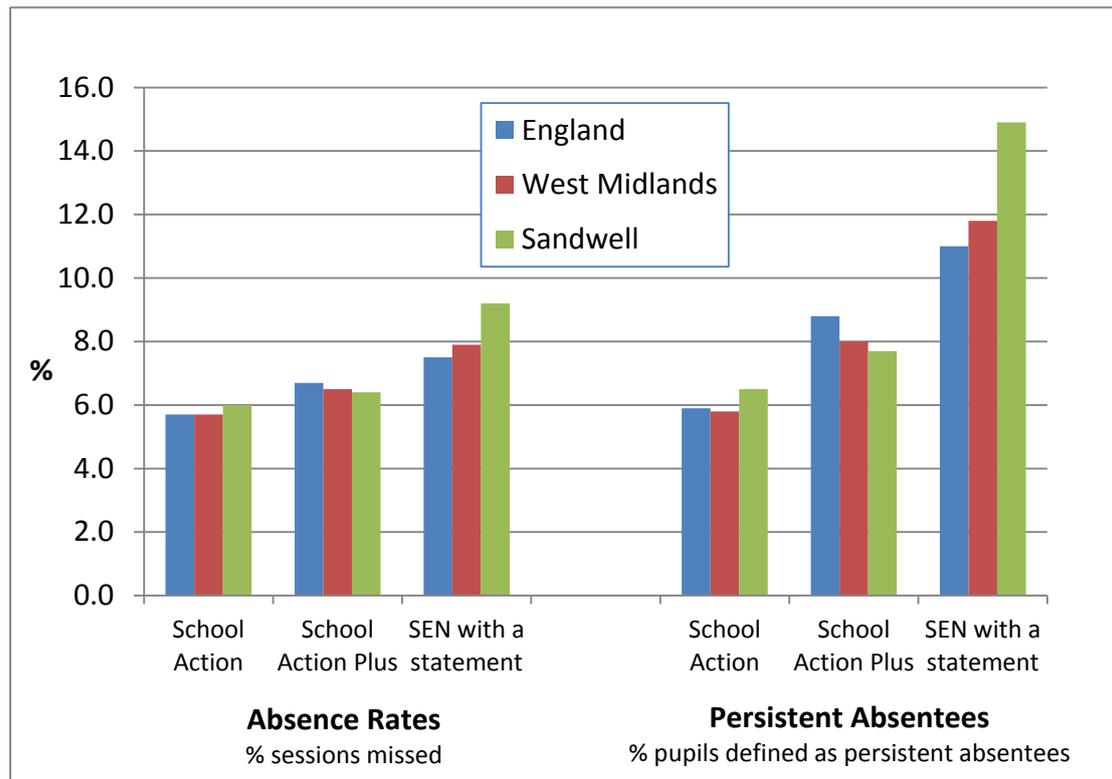


Source: Department for Education

Sandwell pupils without special educational needs are absent from a much lower proportion of sessions than those with SEN. In terms of persistent absentees, only 2.6% of Sandwell without special educational needs have an absence rate of 15% or more, compared with 14.9% of those statemented pupils. Further analysis of this data is required to establish if absenteeism is due to underlying medical conditions which may be linked to SEN.

Figure 5 shows that for those requiring SEN support, absence rates in Sandwell are similar to those in England. However those with a statement have much higher rates of both absence and persistent absence than the national or regional population.

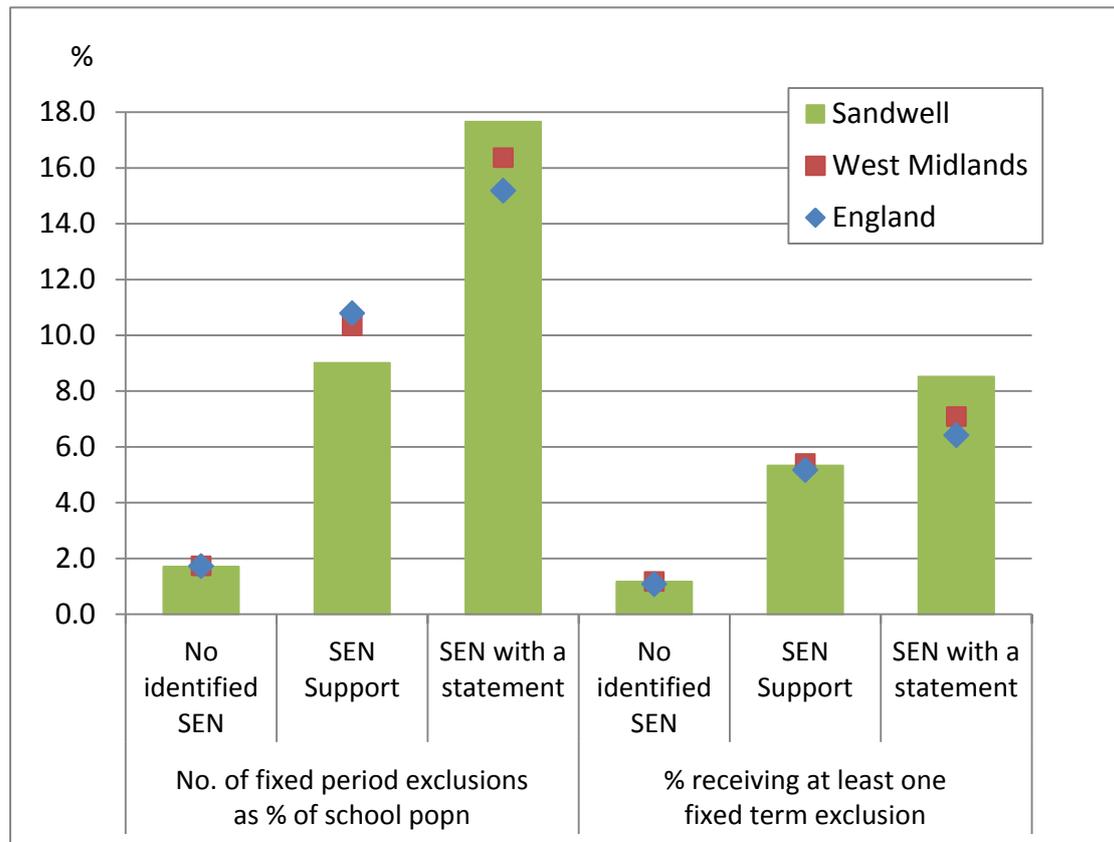
Figure 5: Absence Rates and Pupils Defined as Persistent Absentees by Special Educational Needs – Sandwell with Comparators 2013/14



Source: Department for Education

Similarly figure 6 shows that the exclusion rate for pupils in Sandwell with SEN is comparable or lower than that of the regional or national populations; those in Sandwell with SEN and a statement have much higher rates of exclusion.

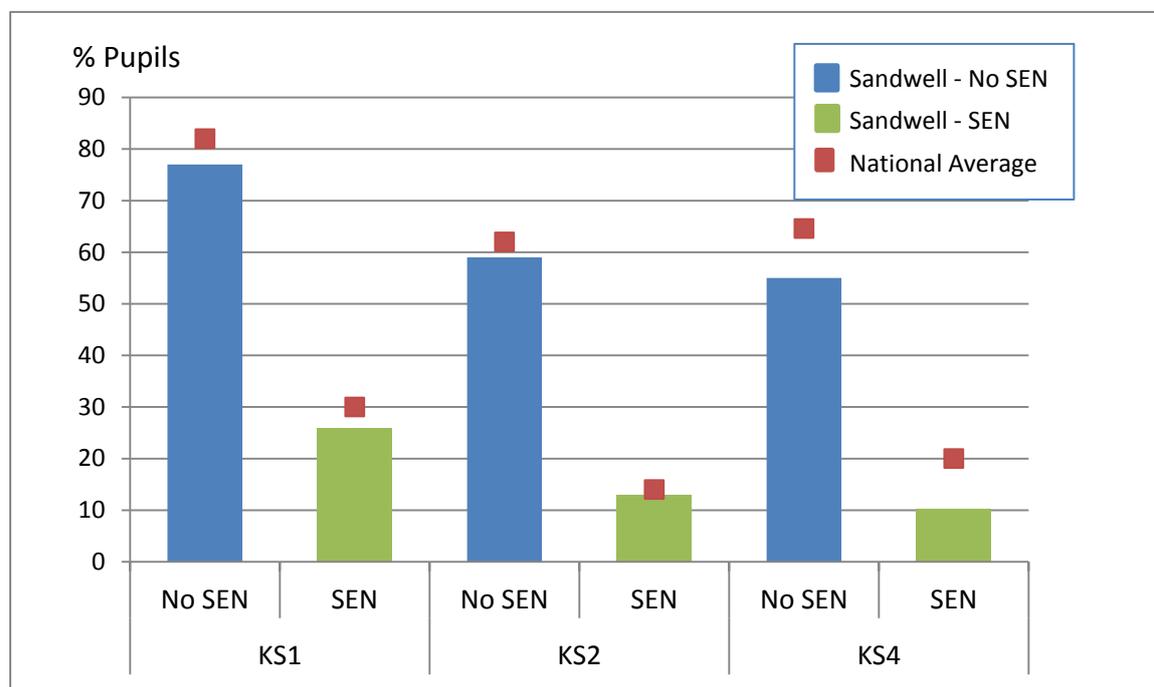
Figure 6: Fixed Term Exclusions by Special Educational Needs – Sandwell with Comparators 2013/14



Source: Department for Education

Figure 7 shows educational attainment at the three key stages for those with and without special educational needs. In the main attainment for both SEN and non-SEN pupils is less than national attainment (apart from for those pupils with SEN at Key Stage 2, where attainment is comparable). However this gap between national and Sandwell attainment increases in later key stages and by Key Stage 4 the gap between Sandwell and national averages means that only 10% of Sandwell pupils with SEN achieving 5+ A*-C (incl. maths & English) in 2015, compared with 20% nationally.

Figure 7: Educational Attainment at Key Stage 1 to 4 for Pupils with and without Special Educational Needs: 2015 (KS1 & 2) & 2016 (KS4)

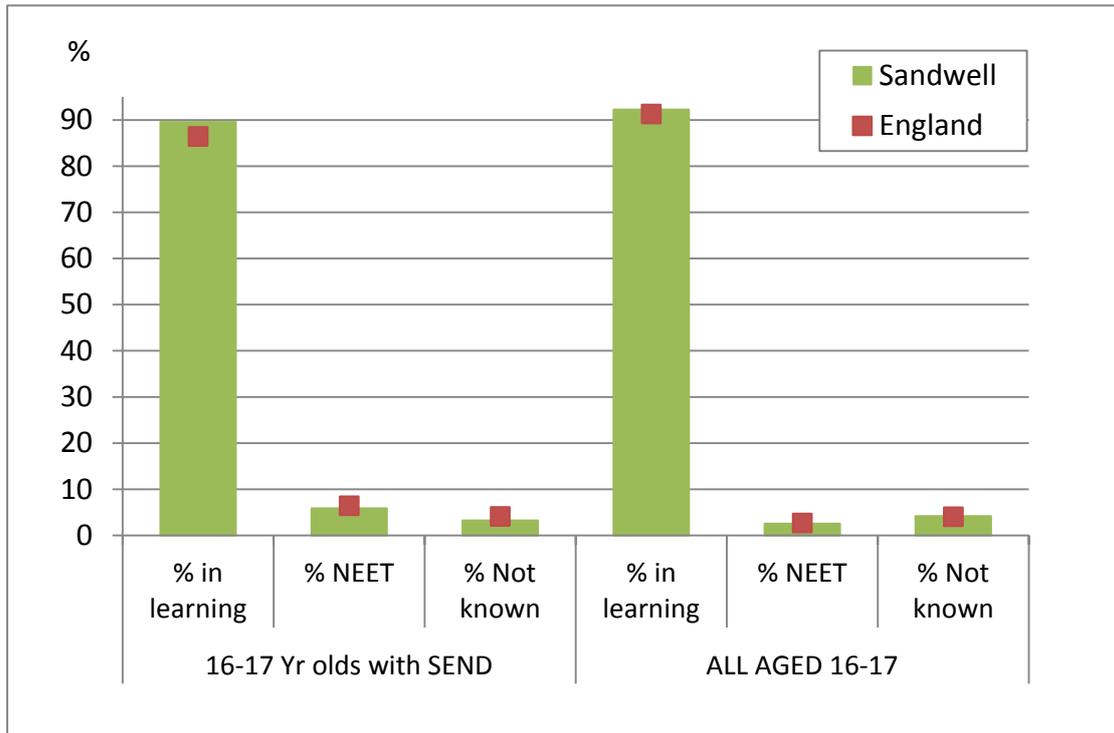


Source: Department for Education

In December 2016, 307 16 to 17 year olds (academic year 12-13) in Sandwell had special educational needs or disabilities.

- As Figure 8 shows, 89.6% of 16-17 year olds with SEND in Sandwell are in learning compared with 86.4% in England.
- 5.9% of those with SEND are not in employment, education or training (NEET), compared with 6.5% nationally. In comparison, for all pupils aged 16-17, the proportion NEET is around half this proportion both in Sandwell and England.

Figure 8: % of academic age 16-17 (yr12-13) year olds with SEND: December 2016



Source: Department for Education

In 2015 in Sandwell, one in four 19 year olds with SEN without a statement (at year 11) were qualified to level 3. This includes those with A levels, applied A levels, vocational qualifications and advanced apprenticeships. Only 14.1% of those with an SEN statement were qualified to level 3. This compares to 48.1% of all aged 19, and 56.5% of those with no identified SEN.

- The overall proportion of SEN pupils qualified at level 3 in Sandwell is below both the regional and national averages for SEN pupils. Gap between local and national proportion is greatest for non-statemented pupils.

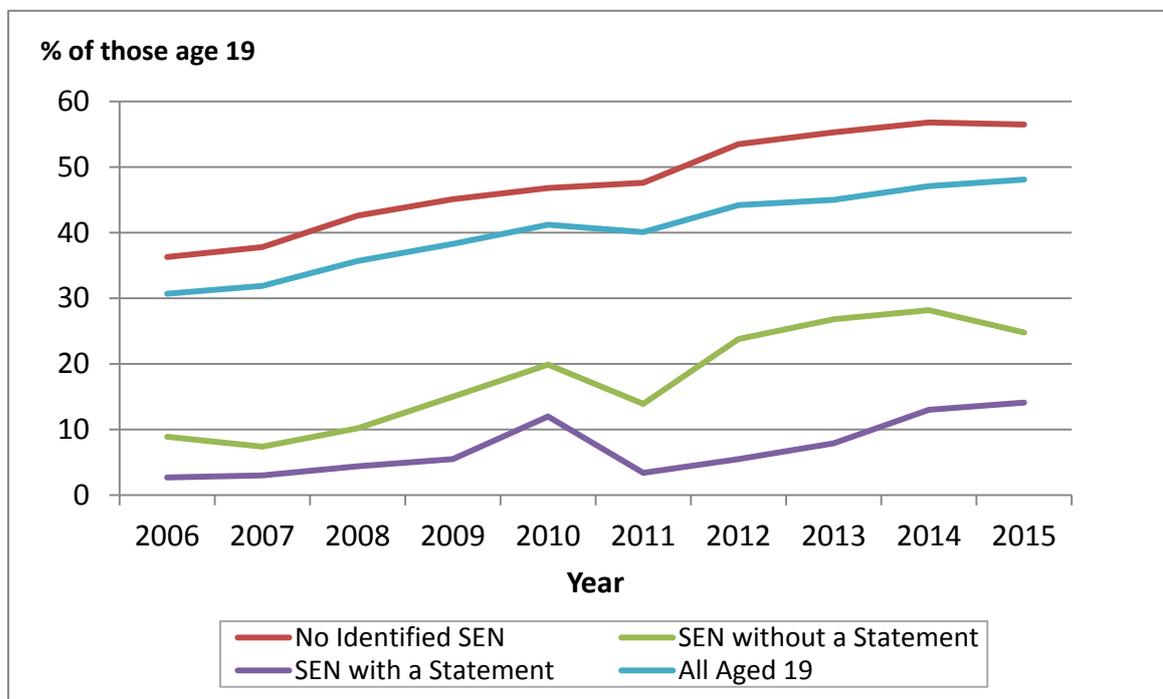
Table 4: Percentage of 19 year olds qualified to Level 3, by Special Educational Need (SEN) status in Year 11 – 2015

	No Identified SEN	All SEN Pupils	SEN without a statement	SEN with a statement	ALL PUPILS
Sandwell	56.5	24.0	24.8	14.1	48.1
West Midlands	63.7	26.9	29.8	13.2	55.3
England	65.7	28.7	31.8	13.4	57.4

Source: Department for Education

- All groups have seen an increase in the proportion qualified to level 3 since 2006. However, the improvement in those with SEN is lower than in those without SEN. In the five years since 2010, there has been a 2.1 percentage point improvement in those with stated SEN qualified to level 3, and a 4.9 percentage point increase in those with SEN without a statement. This compares with a 9.7 percentage point improvement in those with no identified SEN.

Figure 9: Percentage of 19 year olds qualified to Level 3, by Special Educational Need (SEN) status in Year 11



Source: Department for Education

5.3.2 Long term Conditions: Asthma, Diabetes and Epilepsy

Unplanned hospitalisation for asthma, diabetes and epilepsy in children and young people under-19 years is a national quality indicator in the NHS Outcomes Framework, and it measures how successfully asthma, diabetes or epilepsy in children is managed. These three conditions account for around 94% of emergency admissions for children under 19 with long-term conditions.

Table 5: Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s, Indirectly Standardised Rates per 100,000 population, 2010/11–2015/16

Year	Sandwell	England
2010/11	449.9	347.0
2011/12	441.7	319.0
2012/13	517.9	340.6
2013/14	464.0	313.4
2014/15	501.4	326.4
2015/16	479.4	311.7

Source: NHS Digital Indicator Portal

From 2010/11-2015/16 the unplanned hospitalisation rates for Sandwell and England have fluctuated year on year, but Sandwell's rates were higher than England's in each year of this period. Overall in this period, Sandwell's hospitalisation rate has increased whilst England's has fallen.

5.3.2.1 Asthma

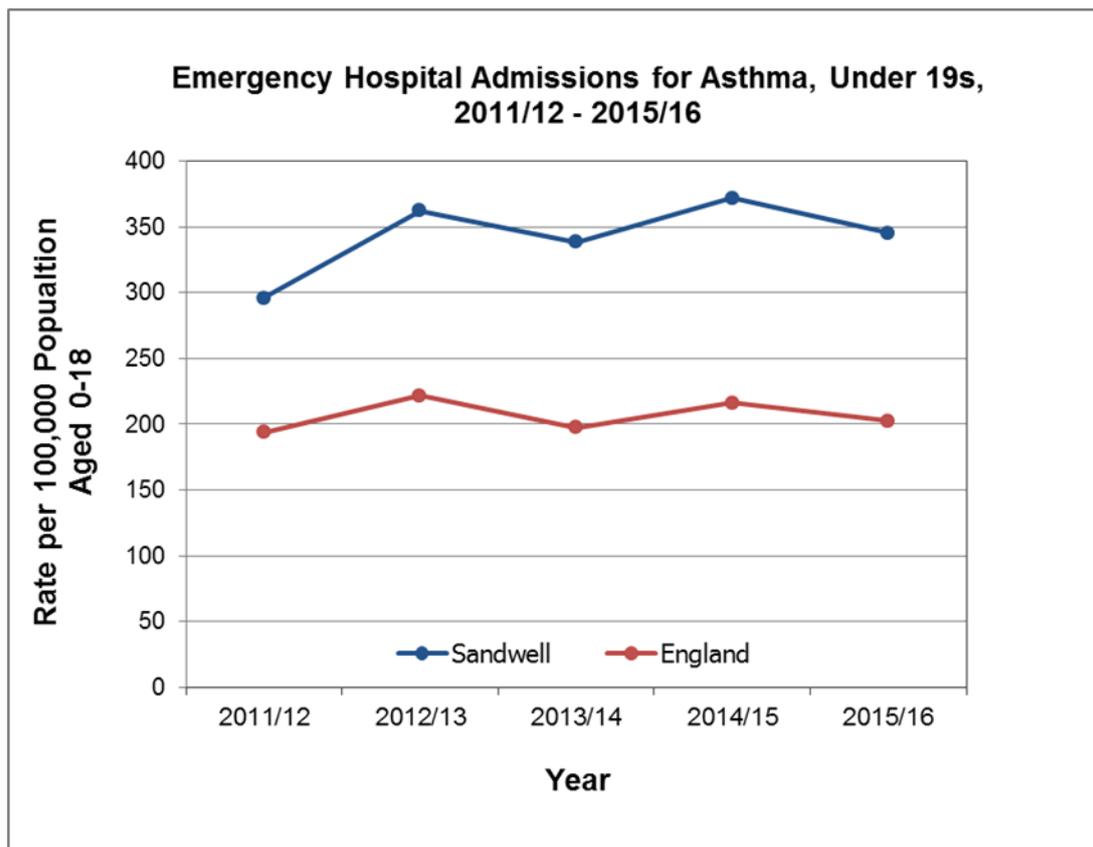
Asthma is the most common long-term medical condition in childhood. Public Health England state that emergency admissions for asthma should be avoided whenever possible.

- One in 11 children in the UK has asthma and it is the most common long-term medical condition. An estimated 7,100 children in Sandwell have asthma.
- On average there are three children with asthma in every classroom in the UK.
- The UK has among the highest prevalence rates of asthma symptoms in children worldwide.

- One million children in the UK receiving treatment for Asthma.
- Asthma attacks hospitalise someone every 8 minutes; 185 people are admitted to hospital because of asthma attacks every day in the UK. A child is admitted to hospital every 20 minutes because of an asthma attack.
- There are preventable factors in 90% of childhood deaths from asthma

Between 2011/12 and 2015/16 both Sandwell and England have seen an increase in their emergency hospital admission rates for asthma (in under 19s). The rates for Sandwell are considerably higher than nationally for each year.

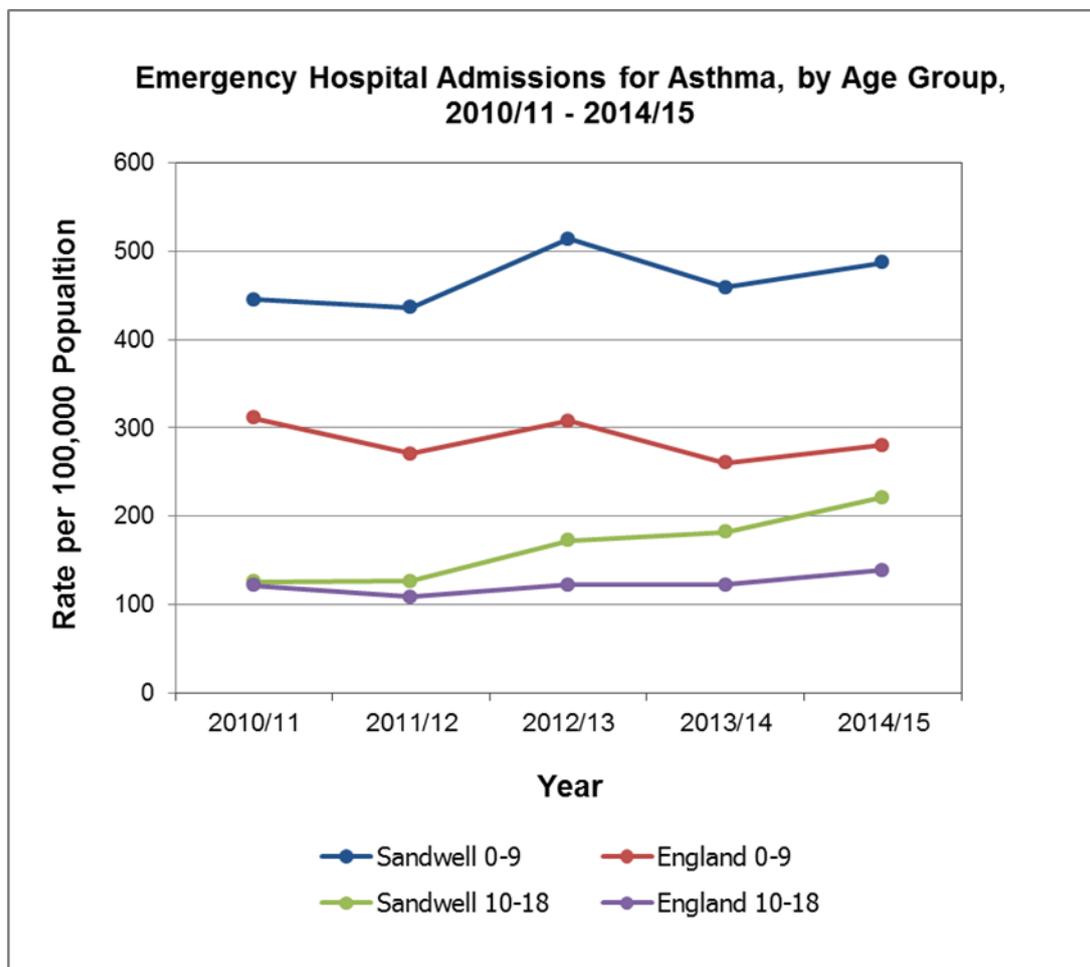
Figure 10



Source: Public Health England, Long Term Conditions and Complex Health Needs Profile

Considering emergency admissions for 0-9 year olds and 10-18 year olds, it is the 0-9s who have the highest rates in both Sandwell and England. The rate for Sandwell is above the national average for both age groups in the period 2010/11 - 2014/15. Over this period, for the 0-9 age group, Sandwell's rate has increased whilst that for England has fallen. For the 10-18 age group, both Sandwell and England have seen an increase in their rates over this period, with the increase in Sandwell being considerably higher than that nationally.

Figure 11



Source: Public Health England, Long Term Conditions and Complex Health Needs Profile

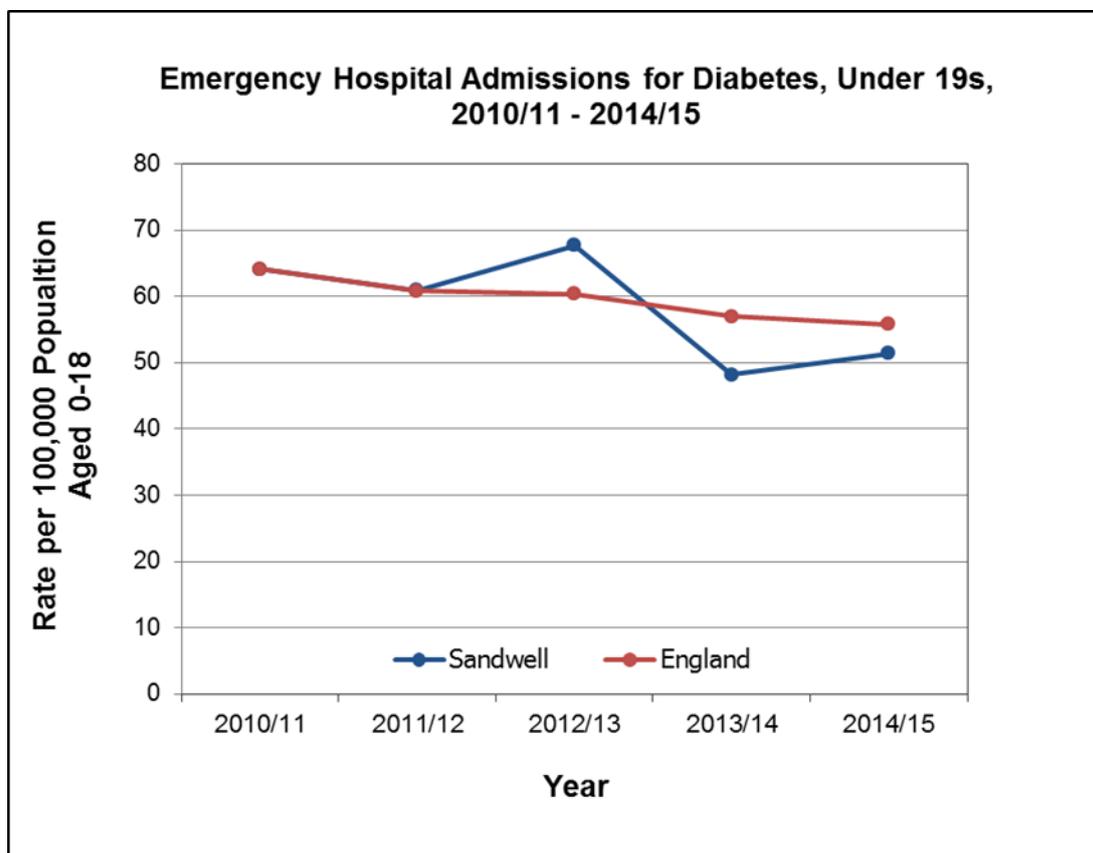
5.3.2.2 Diabetes

Whilst Type 1 diabetes is less common overall (for all age groups) than Type 2 diabetes, the vast majority of children with diabetes will suffer from Type 1. There are about 31,500 children and young people under the age of 19 with diabetes in the UK (around 0.2% of the under 19 population) and 95.1% suffer from Type 1. There is an estimated 179 under 19s with diabetes (170 of these Type 1) in Sandwell.

Since 2010/11 there has been a decrease in both Sandwell's and England's emergency admission rates for diabetes amongst under 19s, with the Sandwell rate falling from 64.1 per 100,000 in 2010/11 to 51.4 per 100,000 in 2014/15.

In 2013/14 Sandwell's rate fell below that for England and remained below it in 2014/15.

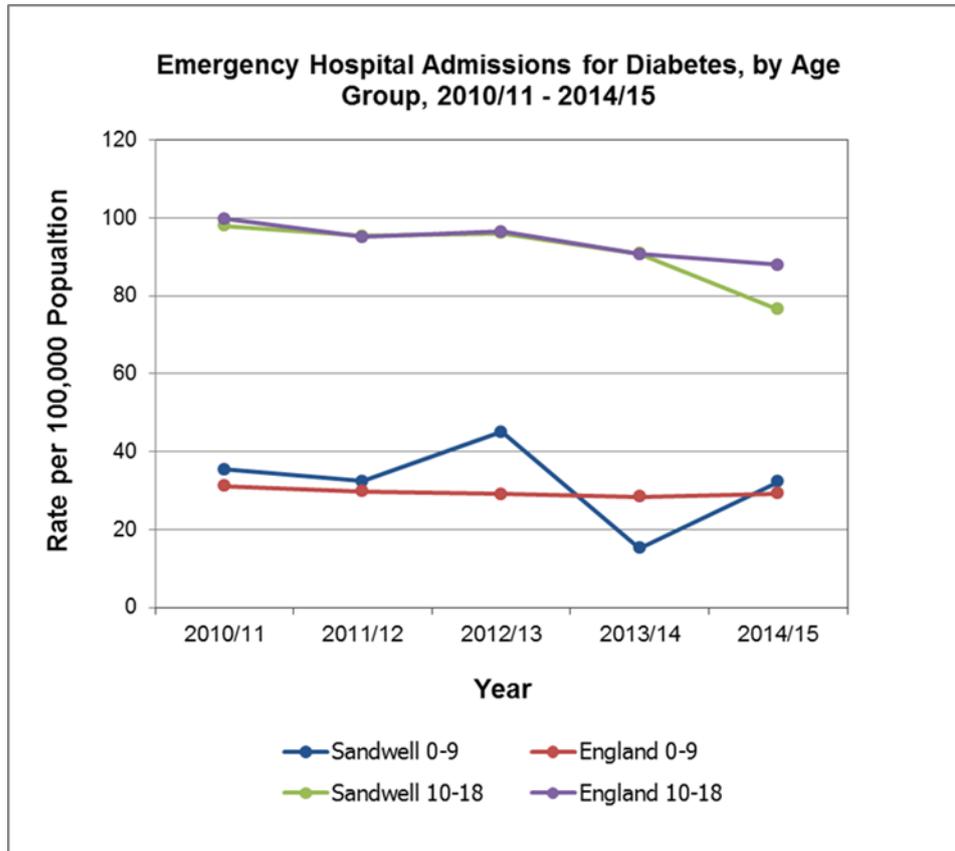
Figure 12



Source: Public Health England, Long Term Conditions and Complex Health Needs Profile

Considering emergency admissions for 0-9 year olds and 10-18 year olds, it is the 10-18s who have the highest rates in both Sandwell and England. Between 2010/11 and 2014/15, for the 0-9 age group, both Sandwell's and England's rate has fallen slightly. Both Sandwell and England have also seen a decrease in their rates for the 10-18 age group, at a faster rate than that for the younger group.

Figure 13



Source: Public Health England, Long Term Conditions and Complex Health Needs Profile

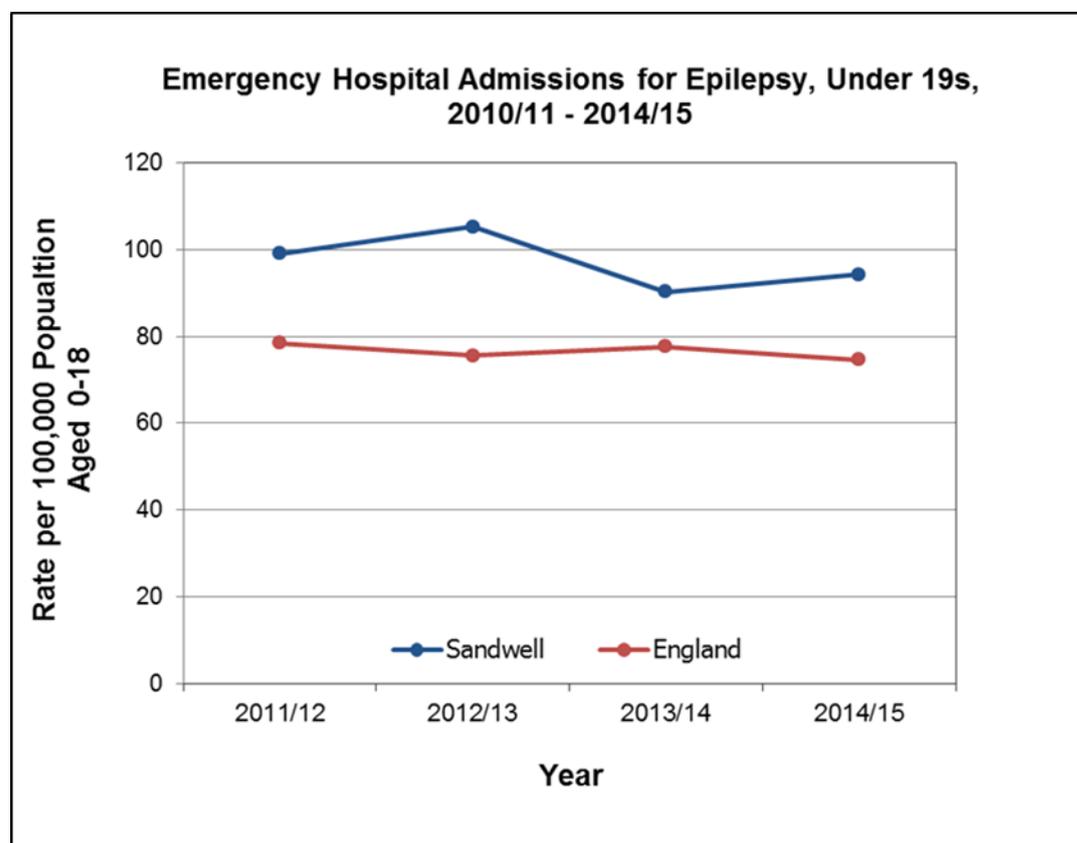
5.3.2.3 Epilepsy

In the UK, approximately 51,500 or 1 in 240 children aged 16 years and under have epilepsy and take anti-epileptic drugs. For children and young people aged 18 years and under, the total number is approximately 63,400 or 1 in 220.

When applying the UK's under 19 prevalence rate to Sandwell, it can be estimated that there are about 400 people aged under 19 who have epilepsy and take anti-epileptic drugs.

Between 2010/11 and 2014/15 both the Sandwell and England rate of emergency admissions for epilepsy has decreased. The Sandwell rate has however, remained higher than the England average throughout the period.

Figure 14



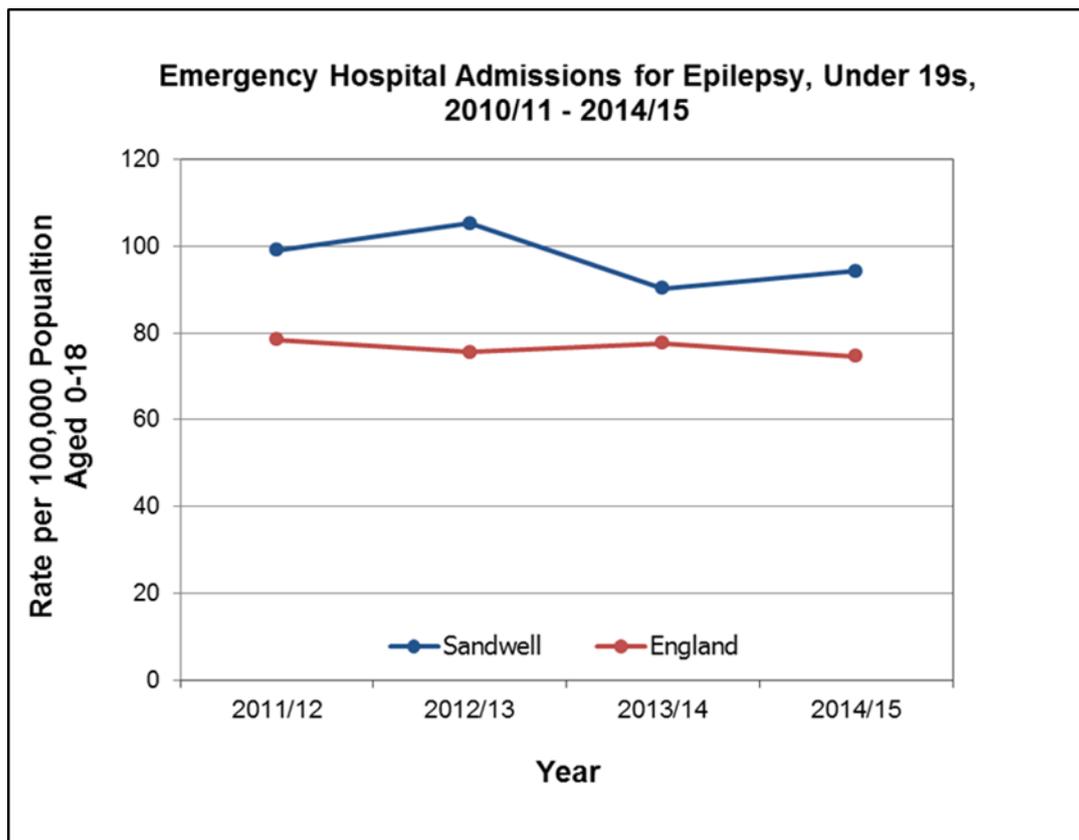
Source: Public Health England, Long Term Conditions and Complex Health Needs Profile

When Sandwell's under 19 emergency admission rate is broken down by age, it shows that from 2010/11 – 2012/13 the 0-9 age group had the higher rates, but since 2013/14 the 10-18 age group has had the highest rates. This is due to a decrease in the rates for 0 to 9 year olds, and an increase in rates for those aged 10-18. These rates need further investigation to try and understand how the rates of admissions for both age groups changed so significantly during this time period.

For England, the 0-9 age group has higher emergency admission rates than the 10-18 age group throughout the time period. The rates for both age groups nationally have been decreasing since 2010/11.

Sandwell's rates are above the national average for the 10-18 age group, but are now below the England rate for 0-9 year olds.

Figure 15



Source: Public Health England, Long Term Conditions and Complex Health Needs Profile

5.4 Current service provision

5.4.1 Special Educational Needs & Disabilities

The Council's vision for children and young people in Sandwell with special educational needs and disabilities is that they will be able to achieve their aspiration for a healthy ordinary life through meaningful employment and fulfilling relationships within the community of their choosing. To help with achieving this vision the Local Authority has produced, as required by law, a 'Local Offer' which sets out the support they expect to be available for children and young people in Sandwell with SEND.

In order to comply with the law and government guidance the Local Authority must publish, in one place, information about provision it expects to be available across education, health and social care for children and young people in its area with SEND, including those who do not have Education, Health and Care (EHC) plans.

The SEND Code of Practice states that the Local Offer has two key purposes:

- To provide clear, comprehensive, accessible and up-to-date information about the available provision and how to access it, and
- To make provision more responsive to local needs and aspirations by directly involving disabled children and those with SEN and their parents, and disabled young people and those with SEN, and service providers in its development and review.

The current local offer is compliant and continues to develop. It includes information in the following categories:

- Early Years
- Schools
- College, Apprenticeships and Training
- Education Health and Care Plans
- Early Help and Care

- Health
- Transport
- Information, Advice and Support (including Benefits)
- Becoming an Adult
- Short Breaks
- Feedback on the Local Offer

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)

When potential needs are raised by parents or a young person, the school/college is requested to hold a Community Assessment Meeting to gather information, develop outcomes and decide with parents/young person whether the resources needed require an EHC Plan. If required, an EHC plan will be produced in 20 weeks. EHC Plan requests are considered via an Assessment Moderation Panel held every 2 weeks, which includes Health, Social Care, SENCOs and parents. Published criteria are used to consider the requests – around 80% of requests result in an EHC Plan. Once children with an EHC Plan reach 14 years, those who are assessed as being

likely to require social care and support in adulthood are identified and allocated an Adults social worker. Statements and EHC Plans are reviewed on an annual basis.

5.4.2 Long Term Conditions

Identification, diagnosis and management of long term medical conditions is commissioned and provided by a range of different organisations. Health visitors, school nurses and GPs and other practice staff all have key responsibilities in the early identification of possible long term conditions, but it is also important to recognise the role of wider services including teachers, social workers and childcare providers.

Following the diagnoses of a long term condition, a partnership approach is required to ensure proper management of the condition. This approach needs to include the patient, parents, GP and other practice staff, health visitors or school nurses, teachers and childcare providers. Commissions of services, which include SWB CCG for the majority of treatment services and SMBC public health for health visiting and school nursing services, need to ensure that this partnership approach is implemented and that each provider is aware of their role in condition management.

5.5 Effectiveness of current services

The SEND Joint Triumvirate is the collaboration of the SEND Partnership Board, Parent Voice and Young People's Challenge Board, together these form the SEND Strategic Structure. .

Sandwell's local offer was designed through co-production with parents in 2013-14. Version 1 was launched at Sandwell's Parent Voice in 2014, and was reviewed by parents in 2015, and Version 2 was launched in 2016. Parents have now fed back that they would like Version 3 to be completed. Again this responds to the requirements of the SEND Code of Practice.

This good practice in terms of productive partnership work and parent child voice being heard and listened to was highlighted by the recent Ofsted SEND Inspection in January 2017. It was also found that the local offer is compliant and continues to develop, and that there is timely identification of need.

However, there were also some areas of concern:

- EHC Plans vary in quality and are too education dominated
- Speed of EHC Plan conversions and the speed of the process to reach an EHC Plan need to be increased
- The timeliness of health assessments needs improvement
- The SEND Code of Practice gives young people and parents of children who have EHC plans the right to request a Personal Budget, which may contain elements of education, social care and health funding. In Sandwell, the personal budgets system and resource allocation system is not yet in place
- Academic progress, attendance and exclusions show SEND pupils do less well (although this is not unlike other areas)
- The level of challenge and accountability across the partnership area needs to be strengthened considerably
- Statutory duties are not being met when reviewing statements and EHCPs

Sandwell has a 0-19 Family Offer Project Group meeting. This meeting includes representation from SMBC children's services, education and public health and lead commissioners from SWB CCG. One of the roles of this group is to ensure that services to identify long term conditions and to support children and their families to successfully manage conditions form an integrated pathway, regardless of service provider. It is beyond the scope of this JSNA to audit individual long term conditions pathways against best practice guidance and quality standards; however the

comparably high rate of emergency admissions for long term conditions in children and young people indicates possible late detection and poor management of conditions.

5.6 Recommendations

5.6.1 Special Educational Needs & Disabilities

- Sandwell has a much lower proportion of pupils with a SEN statement or EHC plan than the rest of the region or country, despite having a comparable proportion of pupils with SEN. The SEND partnership board should facilitate auditing of the current pathway to ensure that all pupils who would benefit from a statement or EHC are provided with one.
- Nationally 13.3% of pupils with SEN are categorised as having “specific learning difficulties” compared with only 3.9% in Sandwell, which suggests that either Sandwell has a very different profile to England overall, or there are issues regarding the diagnosis of specific conditions in the borough. This needs to be explored further.
- Academic progress, attendance and exclusions show the gap between SEN and non-SEN pupils is significant. This gap is also greater in Sandwell than the national gap. Work is required to ensure that individual support available within schools is sufficient to meet the needs of pupils.
- It has been recognised that EHC Plans are currently too education dominated with little or no input from health partners. Plans need to be developed in partnership with relevant agencies. The SEND partnership board should be responsible for moving this recommendation forward.
- SEND partnership board needs to identify in steps to progress a system of personal budgets in Sandwell and engage stakeholders to ensure implementation.

5.6.2 Long Term Conditions

- Estimates of prevalence of long term conditions in Sandwell have been modelled based on national data. Local prevalence data is required in order to plan services and identify if there is an issue with under diagnosis and unmet need.
- Local sharing of data on children with disabilities and complex health needs is required. This will ensure that health, social and education needs can be met in a co-ordinated manner.
- As lead commissioner, SWB CCG should lead on auditing existing paediatric pathways for asthma, diabetes and epilepsy to identify where best practice is not being applied. If there are gaps around co-ordination of care provided or commissioned by different organisations, the 0-19 Family Offer Project Group should facilitate improved partnership working.
- The role of school nurses in supporting the management of long term conditions in school aged children should be defined and the service commissioned by SMBC public health to reflect this

6. Educational Attainment

6.1 Context

Educational attainment has an important role to play in health outcomes for individuals in later life. There are three main interrelated pathways through which educational attainment is linked with health:

- Health knowledge and behaviours;
- Employment and income;
- Social and psychological factors, including sense of control, social standing and social support.

In addition to this, educational attainment has impacts on health across generations, with the educational attainment of parents having subsequent impacts upon the educational opportunities and performance of children and the socio-economic status of children providing just two examples (Robert Wood Foundation, 2009). Therefore this JSNA subchapter looks at the current educational attainment of children and young people in Sandwell to understand the potential impact that this will have upon the borough's health and wellbeing.

6.2 Policy and Evidence

There is a correlation across England between areas with high levels of socio-economic deprivation and lower educational attainment (Stokes et al., 2015). Whilst other factors including ethnicity can also influence attainment, evidence shows that the strongest factor impacting on educational attainment is family socio-economic status. However, while there is strong evidence that educational attainment is linked to socio-economic status, the evidence for intervention to improve educational attainment is scant. A review commissioned by the Joseph Rowntree Foundation, (www.jrf.org.uk) identified areas where there is some evidence of interventions which can reduce gap in educational attainment.

1. There is some international evidence that parental involvement programmes which help parents support learning at home can improve educational attainment. Implementation of such programmes locally needs to be subject to robust evaluation to ensure that this works with Sandwell families. Similarly nurture groups show an increase in social, emotional and behavioural competencies, but impact on education attainment has yet to be evidenced.
2. After schools activities generally focus on extra-curricular activities like sport, music or IT, however there is evidence to show that giving after schools activity on academic focus can reduce gaps in educational attainment
3. There is strong evidence that staff development and in particular peer-mentoring between schools can improve educational attainment. This is especially the case in schools who have managed to achieve good educational attainment despite being in an area of deprivation.
4. Evidence shows that any intervention designed to increase educational attainment needs to be supported by a whole-school approach which also supports social and emotional learning, has a high degree of staff engagement and development and is subject to impact monitoring.

6.3 Local Data

6.3.1 Population profile

Table 1 shows that there has been a significant increase in the population of young people in Sandwell in recent years and that Sandwell has a higher a proportion of 5 to 19 year olds (19.4% of population,) than both England (17.4%) and the West Midlands (18.2%).

In 2014 Sandwell had a general fertility rate of 72.5 births per 1000 females aged 15-44, higher than the national average of 62.2 births and a higher proportion of women

aged 15-44. Therefore, the current increase in proportion of young people is likely to continue.

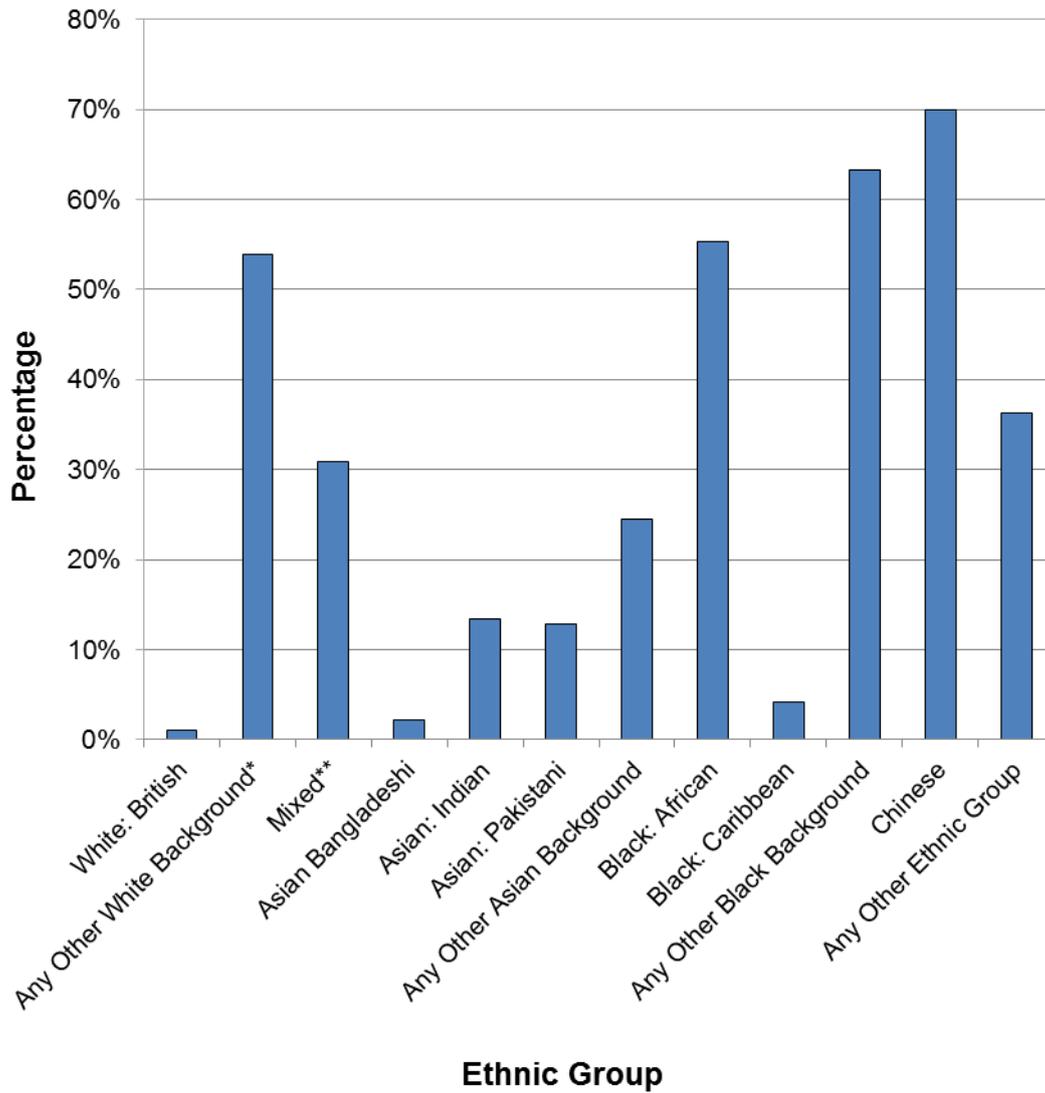
Table 1

Age Groups	2011	2012	2013	2014	Percentage change from 2011-14
Aged 5-9	20,300	20,800	21,600	22,500	10.8%
Aged 10-14	19,300	19,100	19,000	19,300	0.0%
Aged 15-19	20,300	20,100	20,000	19,800	-2.5%
Total (5-19)	59,900	60,000	60,600	61,600	2.8%

The impact that this has on our educational attainment as a borough, is that we have an increasing school aged population, which in turn places stresses upon our school places and infrastructure. As mentioned, socio-economic deprivation is high in Sandwell. The combination of high levels of deprivation and increasing pressure on school places has impacted on educational attainment.

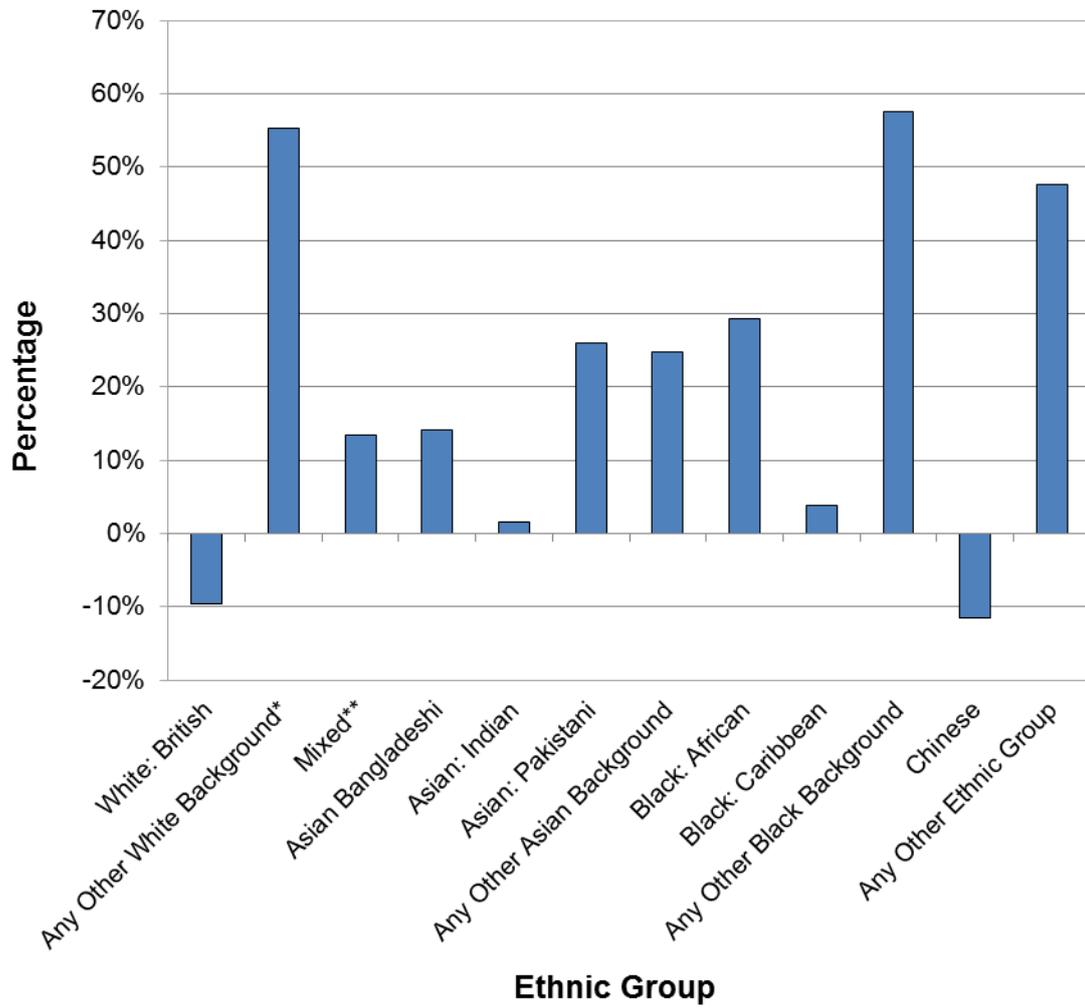
In addition to the increasing population of school-aged children and subsequent demand for school places that this is resulting in, there has been an increase in recent years of non-white British pupils. As a result of this shift in demography, increased pressure has been placed upon the school system in Sandwell, as a consequence of higher rates of pupils presenting with limited English skills, or English as a second language (figures 1-4) which consequently impacts on educational attainment.

Figure 1: Percentage Change in the Number of Primary School Pupils by Ethnic Group, 2013-16



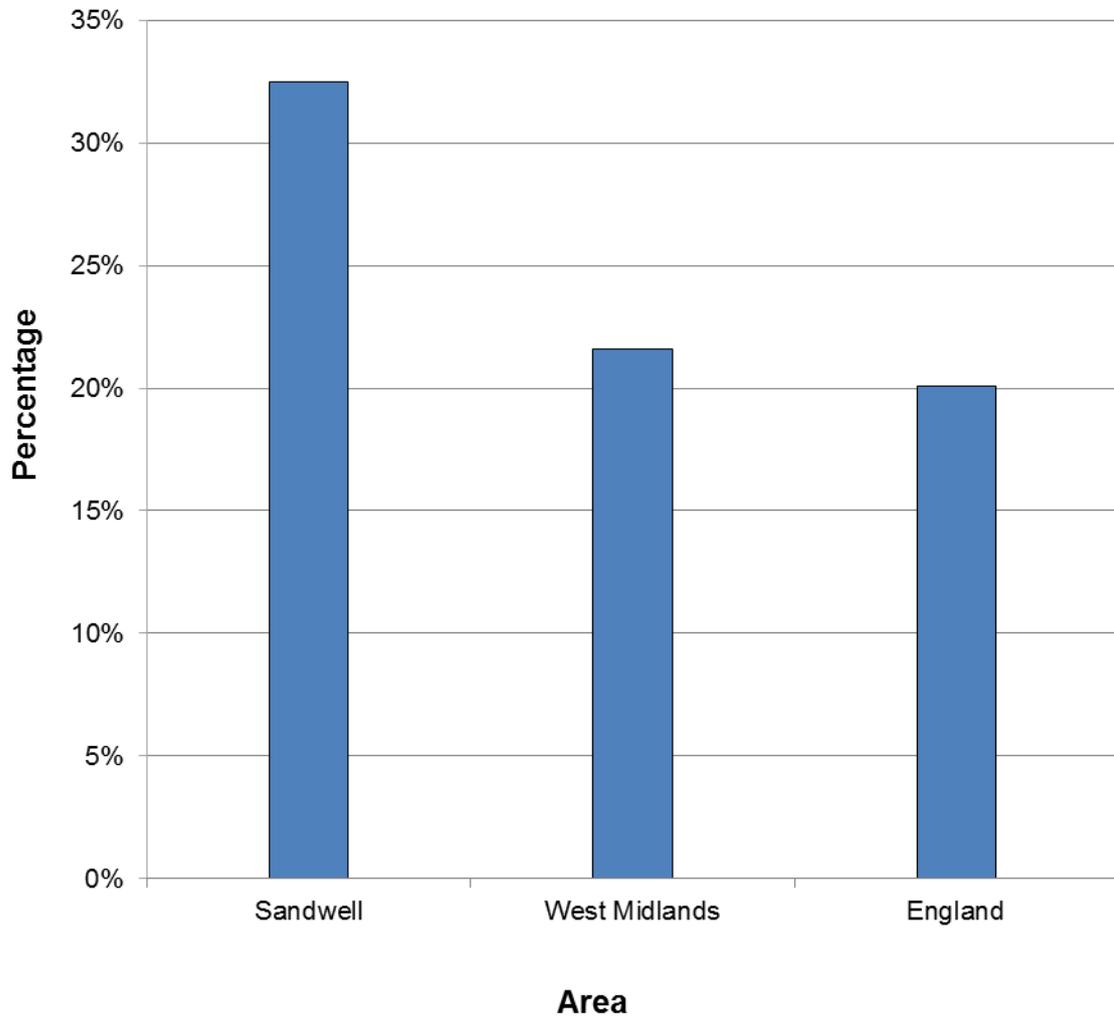
Source: Department for Education

Figure 2: Percentage Change in the Number of Secondary School Pupils by Ethnic Group from 2013-16



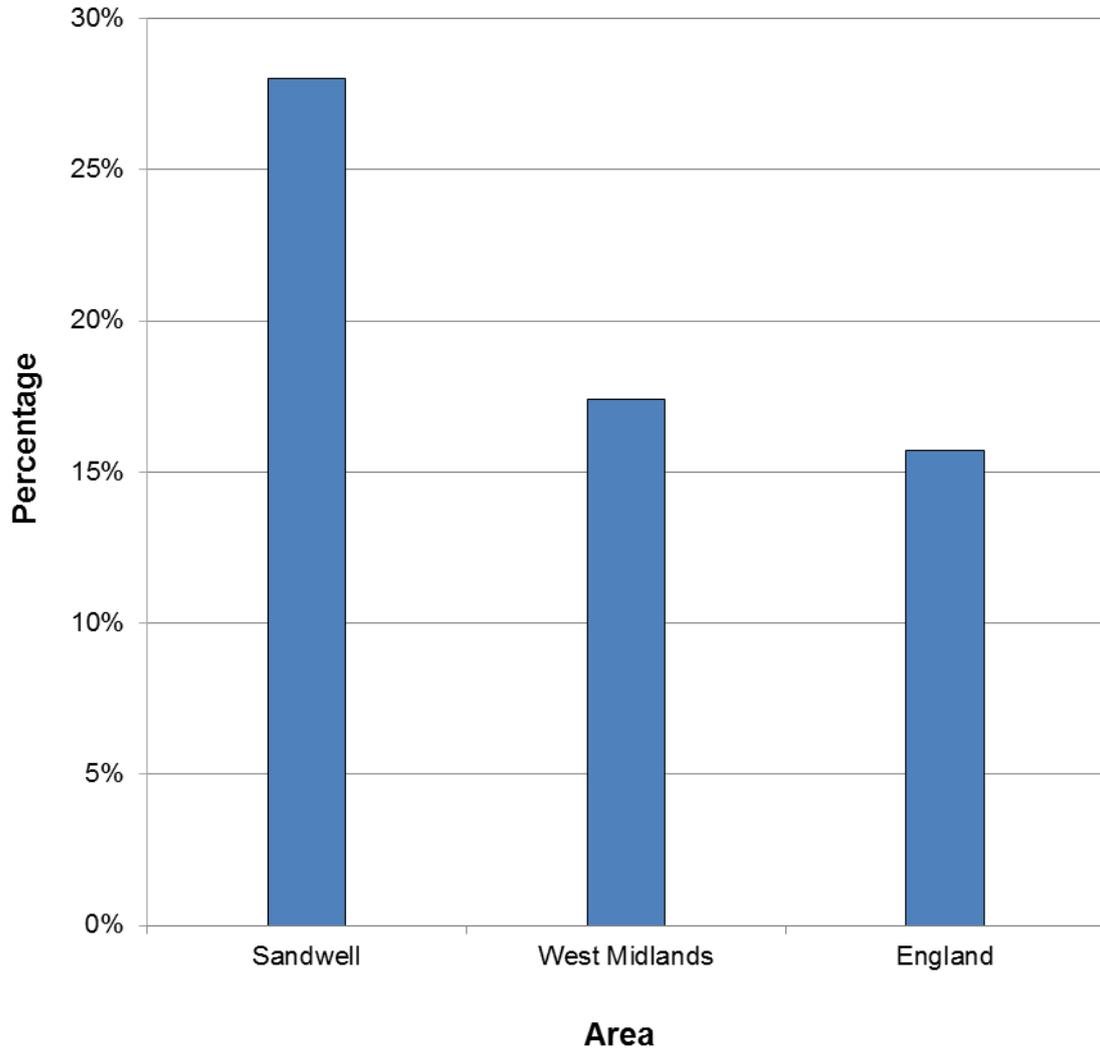
Source: Department for Education

Figure 3: Percentage of Pupils at State Funded Primary Schools whose First Language is not English, January 2016



Source: Department for Education

Figure 4: Percentage of Pupils at State Funded Secondary Schools whose First Language is not English, January 2016

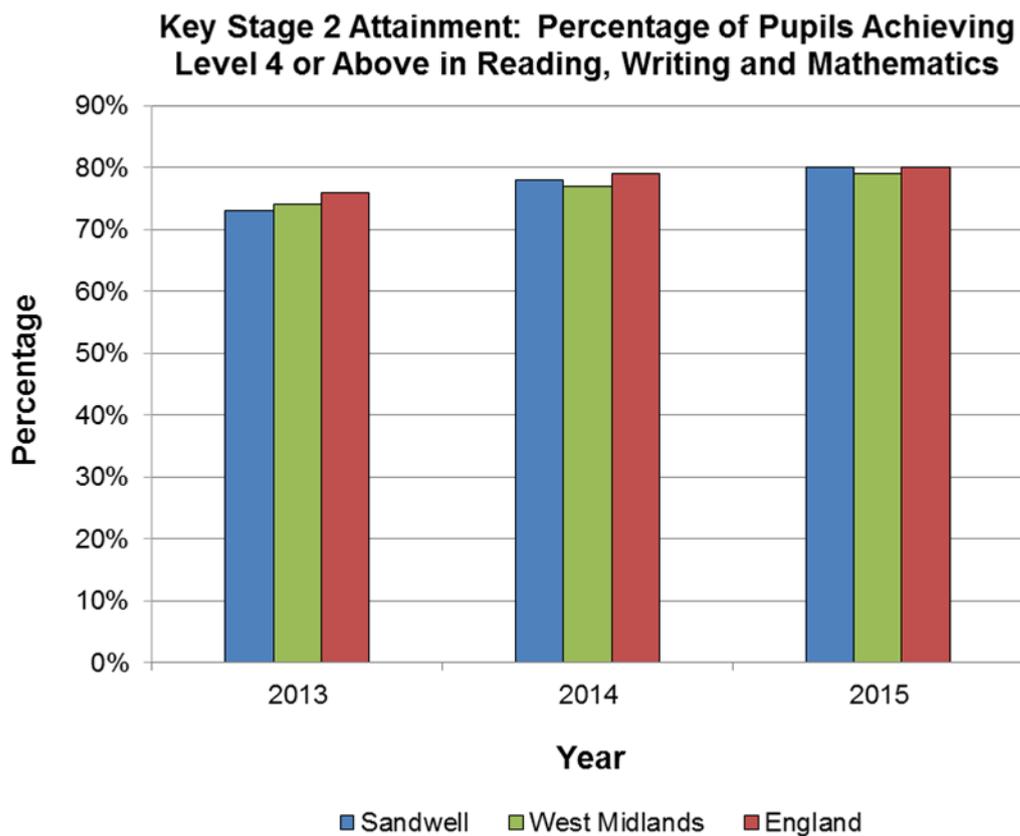


Source: Department for Education

6.3.2 Educational attainment

Overall, educational attainment shows mixed outcomes. Performance is below national average for reception pupils, however this now matches the national average performance by end of key stage 2 (Figure 5).

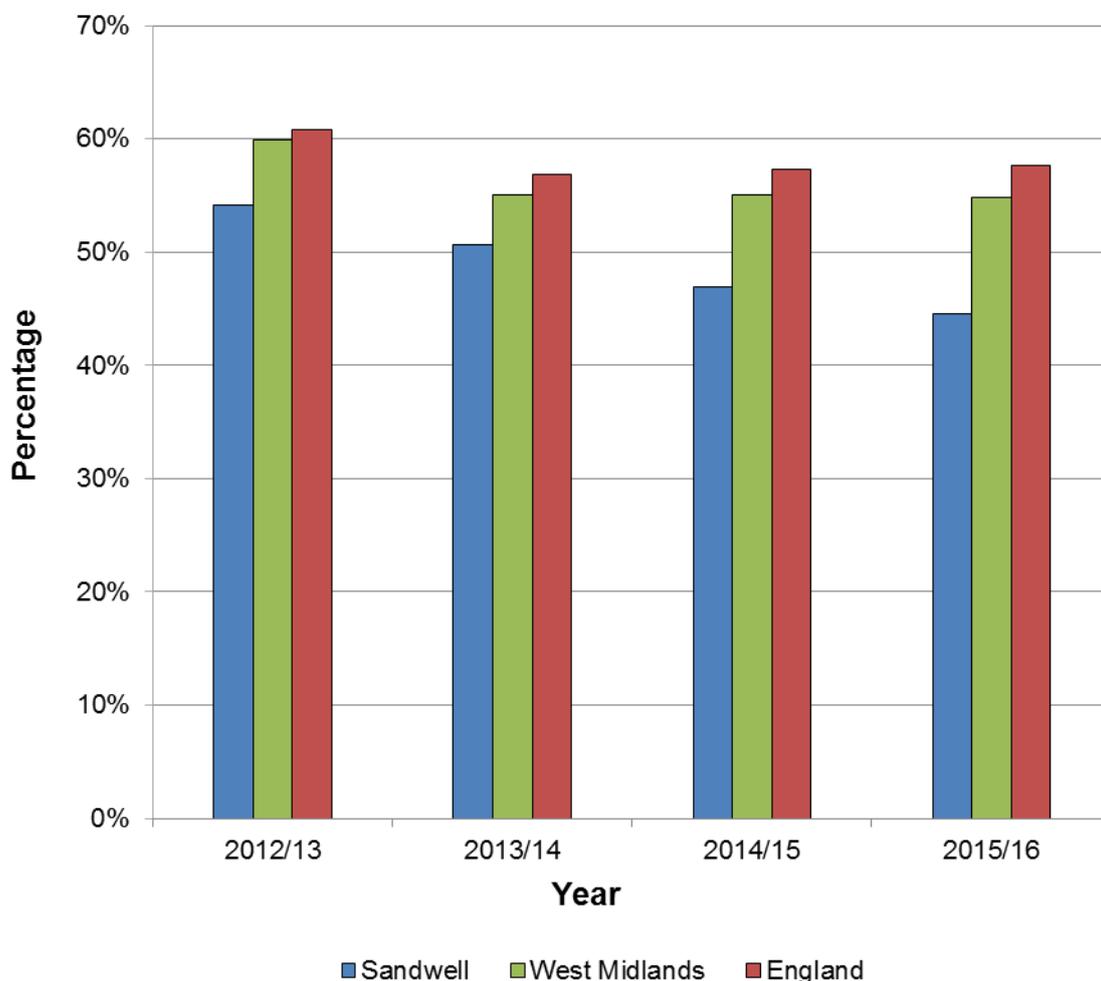
Figure 5



Source: Department for Education

However, this positive trend does not continue through the education system in Sandwell, as our key stage 4 performance has fallen below national average within recent years, declining for the past two years consecutively (Figure 6).

Figure 6: Key Stage 4 Attainment: Percentage of Pupils Achieving 5+ A*-C grades including English and Mathematics



Source: Department for Education

6.4 Current service provision and gaps

There are currently a large number of academies in Sandwell, with the majority of KS3 and KS4 education provided by Academy status schools and colleges. There is evidence that points to a lower than average performance of Academy run schools against those still operating under council control nationally (Full Fact, 2013), which may have an impact upon Sandwell’s performance against the national average. 50.7% of students attending Academies in Sandwell obtain 5 or more A*-C GCSEs, compared to a national average of 53.4%.

At the moment Sandwell has a coherent course of action to tackling the issues raised above, as the council maintains a record of low performing schools along with the steps being taken to try and improve their educational attainment. At the same time, Sandwell maintains a concurrent record of high performing schools, with a view to using the learning from their improvement to share best practice across the borough.

Sandwell attempts to encourage the schools and influence their improvement through termly visits along with additional support according to need. However, the council is limited in the extent of its intervention by the high rates of academy status education providers from the secondary sector. By sharing best practice in this manner, Sandwell aims to improve educational attainment across the borough; by maintaining a record of schools performance and improvement, the council is able to maintain a record against which improvement can be measured.

A current priority area of work for the council includes drives to improve secondary education. As previously mentioned, secondary education attainment is currently underperforming against the national and regional averages, and so the council is currently looking at ways of improving standards and improving performance within schools. There are currently council led programmes in place to improve upon Sandwell's educational performance in maths teaching.

A school has recently been set up to provide education to children who have recently migrated into Sandwell while they await a place in mainstream school (Sandwell Transition Education Partnership Service-STEPS). The aim of this school is to make children more 'school ready' once they enter mainstream education and part of the focus is to improve English language skills.

6.5 Recommendations

- Map parent support programmes for parents and academic-focussed after schools activities currently offered in schools in Sandwell and evaluate these programmes to ensure they are achieving the expected impact on educational attainment. This mapping and evaluation should be led by learning communities with the support of public health
- The learning communities act as informal peer-support networks and offer a forum to share good practice between schools. The learning communities function should be strengthened to ensure engagement by all schools and facilitate an active peer-mentoring programme between schools with similar populations with different attainment rates.
- Continue funding the STEPS centre for new migrants and evaluate the impact that this centre is having on school readiness. Public Health can support STEPS with the evaluation of this school.

7. Safeguarding

Children and young people have the right to be protected from abuse and exploitation and to have their health and welfare safeguarded. Yet in 2013, UNICEF reported that the UK ranks just 16th out of the 29 most advanced economies in the world in terms of the overall wellbeing of their children (including material wellbeing, health, education, behaviours and risk, and housing and environment). Although the trajectory is that of improvement, children's health and social care services still have a way to go to ensure that the care they provide is improving children's lives and keeping them safe.

A number of safeguarding issues are considered throughout this chapter, but they share a common risk factor - living in a chaotic or dysfunctional household or being in care. This type of adverse childhood experience (ACE) has long-term impacts on an individual's health, wellbeing and life chances, and has been shown to be associated with the development of a wide range of harmful behaviours including smoking, harmful alcohol use, drug use, risky sexual behaviour and violence and crime.

While this chapter focuses on 5-19s, due to the sources of data on safeguarding, other age groups are also discussed.

7.1 Looked-After Children

7.1.2 Background and context

On 31 March 2015, there were 69,540 children in care in England, more than 1 in 200 of the total child population, and over a 12-month period more than 99,000 children will have an episode in public care, almost 1 in 100 of the total child population. Spending some time in care is relatively common; even more common are referrals to social care, which have remained relatively static over the last 10 years: 5.2% of all children in 2004 and 5.4% in 2015. The percentage placed on a plan has stayed at 0.3–0.5% of all children. In Sandwell on 31 March 2015, there were 540 children in care, slightly above the England level at 1.37 per 200 children. Again around 1 in 100 children (0.9 compared to 0.84 nationally) in Sandwell will have an episode in care. Within Sandwell, 4% of children in 2004 spent some time in

care, and 3% in 2015. The percentage placed on a plan in Sandwell increased from 0.2 to 0.4% between 2004 and 2015.

While each child in care has a unique story there are recognisable patterns which mean that children can usually be placed in groups that share characteristics. Some children enter care for a short time period and then return home. Other young children enter care and, if the assessment of the birth parents is unfavourable and a search for extended family members does not identify suitable carers, a plan for permanency by adoption is usually made. If children enter care at an older age and with a strong relationship with their parents who are unable to care for them (because of issues which often include mental illness, drug or alcohol misuse or learning difficulties), a plan for long-term fostering and contact with parents may be appropriate. Some young people, usually from conflict zones around the world, come as unaccompanied asylum seekers and are accommodated by the local authority. Children with disabilities are another distinct group of children who may be placed in public care.

Educational outcomes for looked-after children compared with other children at Key Stage 2 and GCSE show that while the recent cohorts taking examinations do show improving outcomes, the gap remains very wide and the educational attainment of children in care lags well behind that of their peers. Another key concern is the mental health and wellbeing of children and young people in public care - children in care have significantly higher rates of mental health problems than the general child population. There is also evidence of an increased prevalence of mental illness rates for children in care. The risk of suicide for care leavers is more than twice the general population risk and studies have found other excess mortality risks for care leavers.

Children and young people in care also have high levels of risk-taking behaviours such as smoking, and alcohol and drug misuse. Looked-after children and care leavers are between four and five times more likely to self-harm in adulthood. They are also at five-fold increased risk of all childhood mental, emotional and behavioural problems, and six to seven times more likely to have conduct disorders. Looked-after teenage girls are 2.5 times more likely to become pregnant than other teenagers. Children and young people in care are also at increased risk of sexual exploitation, as recent high-profile media cases have identified.

7.1.3 Risk factors associated with entering care

A recent systematic review of the risk factors associated with children entering care found, for mothers, evidence of association with low socio-economic status, benefit receipt, single parenthood, ethnicity, age, disability, smoking in pregnancy, mental illness, alcohol misuse and learning difficulties. For children, there was evidence of association with low birth weight and prematurity, disability, injuries and attendance at Accident & Emergency departments. None of these risk factors were very specific, and research using longitudinal data sets is needed to identify more specific risk factors associated with children entering care and to combine risk factors in a cumulative risk model. Without knowing specific risk factors it is very difficult to develop targeted interventions designed to decrease numbers of children needing care.

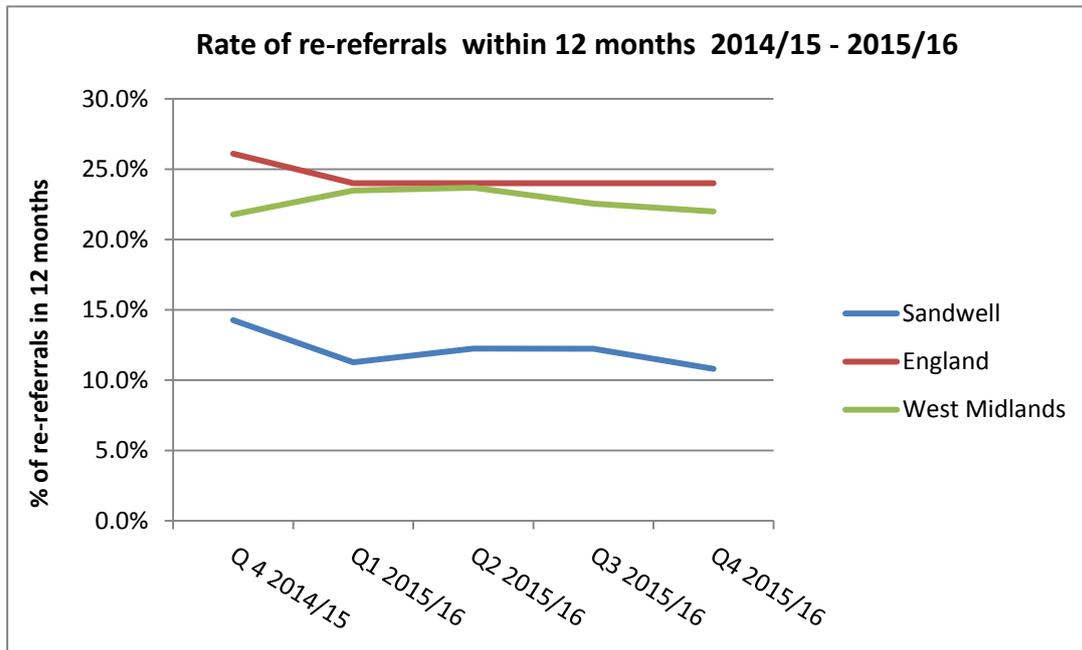
Risk factors associated with entering care are also related to work on adverse childhood experiences (ACE), which are shown to have long-term impacts on an individual's health, wellbeing and life chances. ACE such as abuse, neglect and dysfunctional home environments have been shown to be associated with the development of a wide range of harmful behaviours including smoking, harmful alcohol use, drug use, risky sexual behaviour and violence and crime.

7.1.4 Current service provision

Operationally Safeguarding and Looked-after children services in Sandwell are currently performing well and are often operating at levels that exceed the regional and national average. Figure 1 shows the re-referral rate continues to fall in response to the implementation of the MASH¹ at the front door, with current performance at 10.8%, which is well below both a regional average of 22% and a national average of 24%. This number has remained fairly static over the previous quarters. Levels of re-referral can be used as a proxy measure for appropriateness of the initial referral.

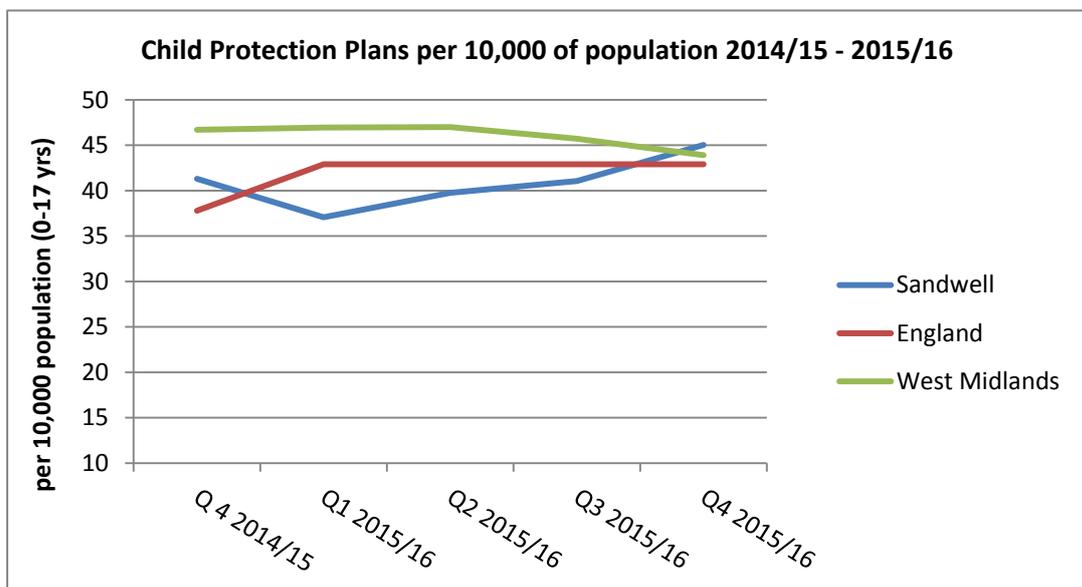
¹ Sandwell's Multi-Agency Safeguarding Hub (MASH) has been in operation since 2013. Several agencies are part of the MASH, and includes representatives from children's services, education, health, probation, police, housing, mental health services, Sandwell Women's Aid and adults' services.

Figure 1: Re-referral rate



In addition to this, the number of children and young people who current have Child Protection Plans has now risen above the national average after a period of concern in the first quarter of 2015/2016, with 45 children per 10,000 population currently in receipt of a child protection plan (figure 2).

Figure 2: Proportion of children under CPP



Another area of success is in the number of children on their second and subsequent Child Protection plans. Despite a large rise in the latest quarter, at 11.6% this is considerably below the national average of 16.6%. Low rate of children on second CPP is a measure of successful intervention (figure 3).

Figure 3: Proportion of children on 2nd or subsequent CCP

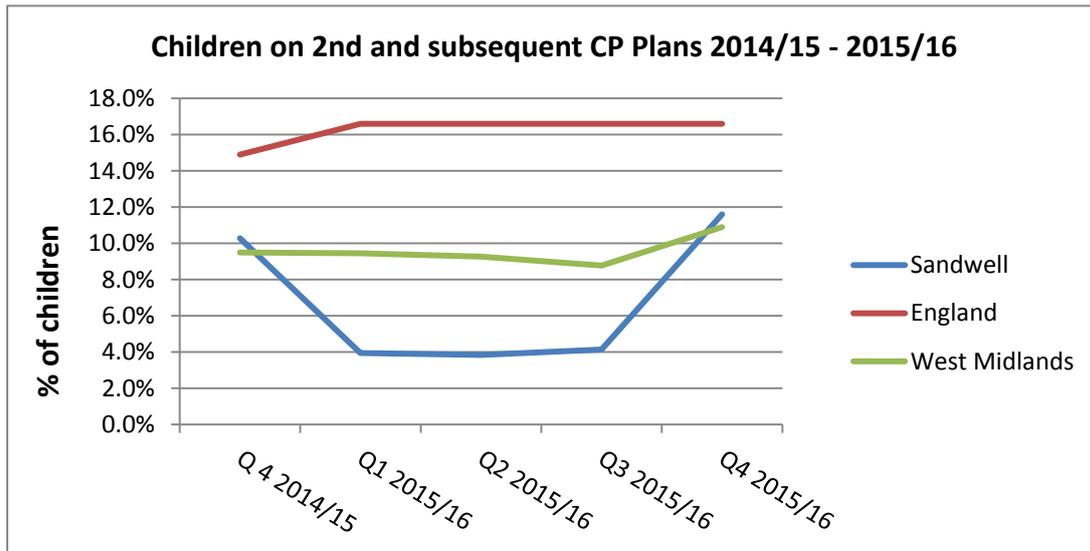
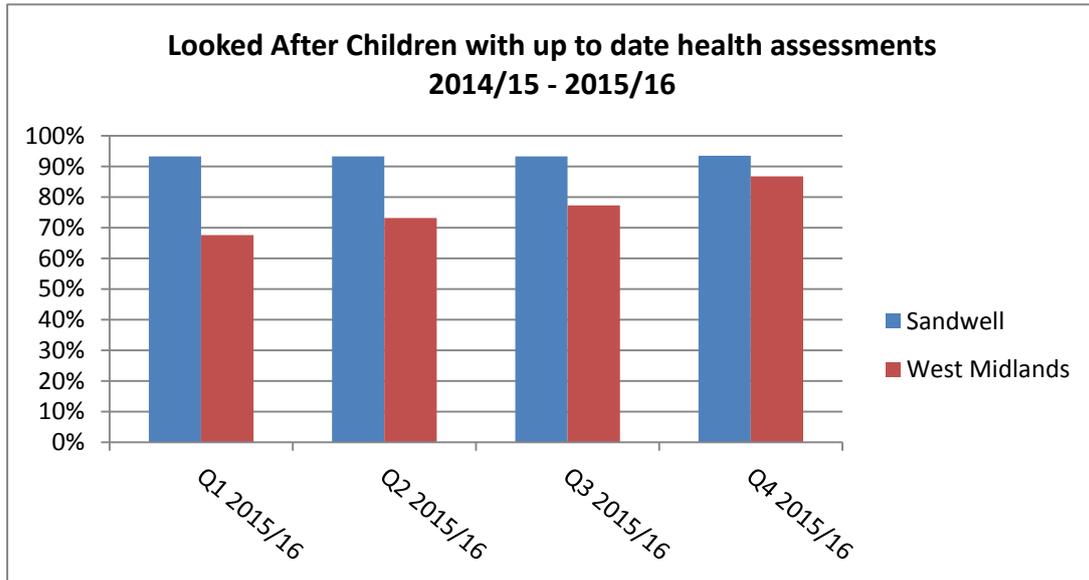


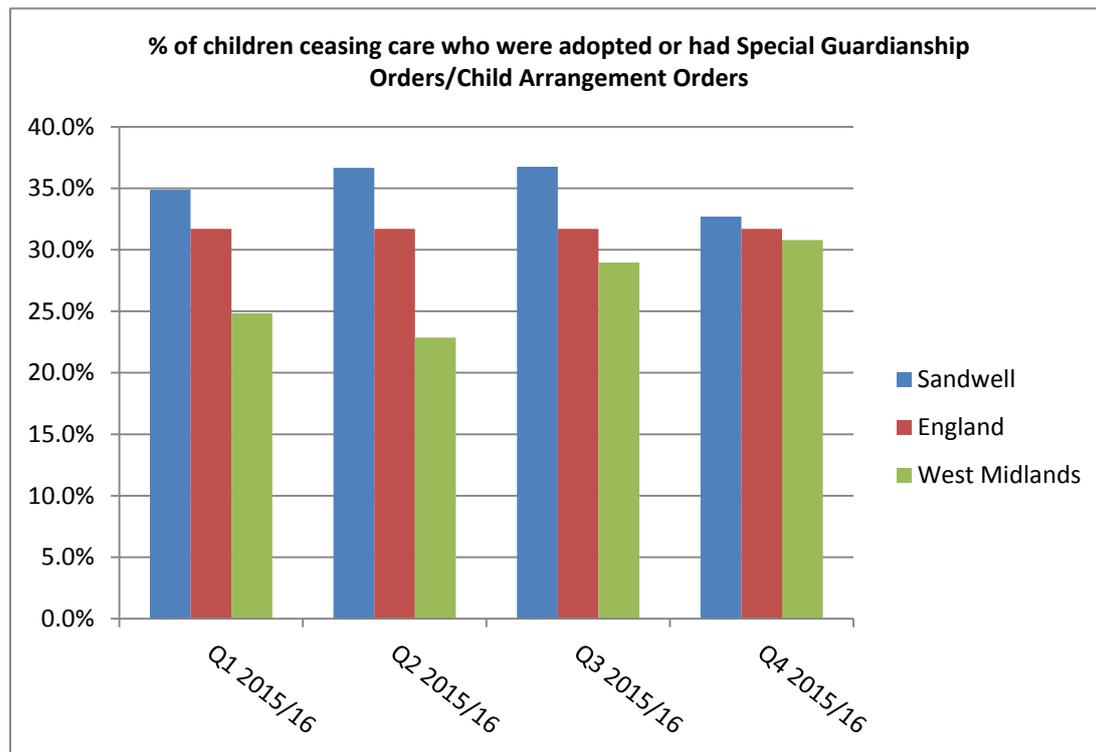
Figure 4 shows that the number of Looked-after children with an up to date health assessment currently exceeds the regional average, with 94% of looked after children currently having received up-to-date health assessments against a regional average of 87%. This percentage has remained consistent over the past three years.

Figure 4: Percentage of looked after children with health assessment



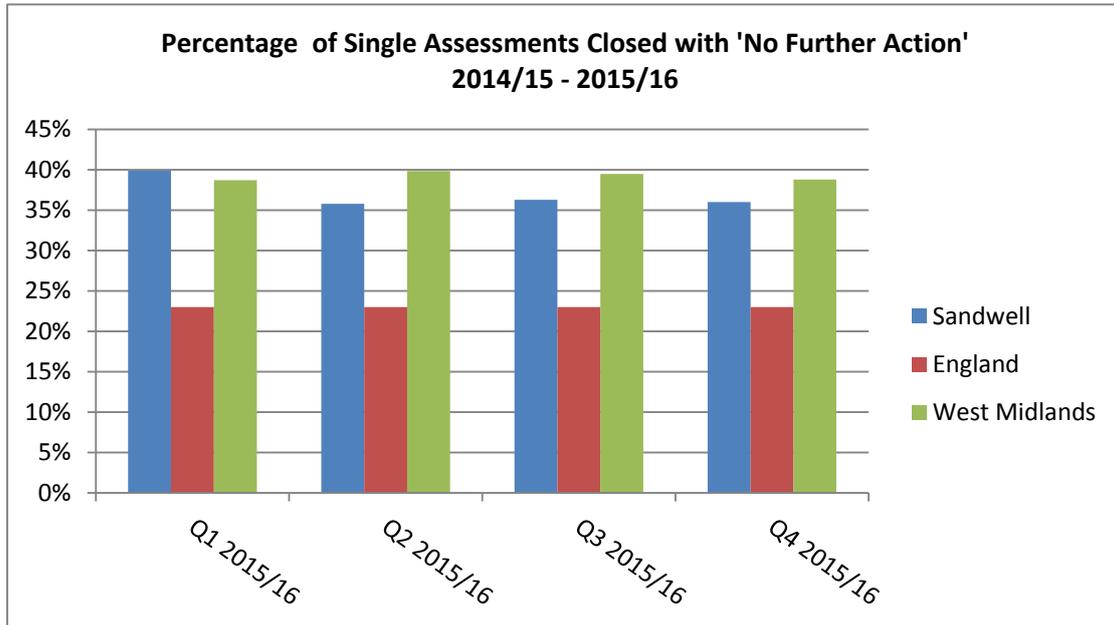
Sandwell currently exceeds national and regional averages for the adoption rate of children who are ceasing and leaving care. In Sandwell, there are currently 32.7% of children leaving care as a result of adoption (fourth quarter of 2015/2016). This exceeds the national average of 31.7% and regional average of 30.8% (figure 5).

Figure 5: Percentage of children leaving care due to Adoption, SGO or CAO



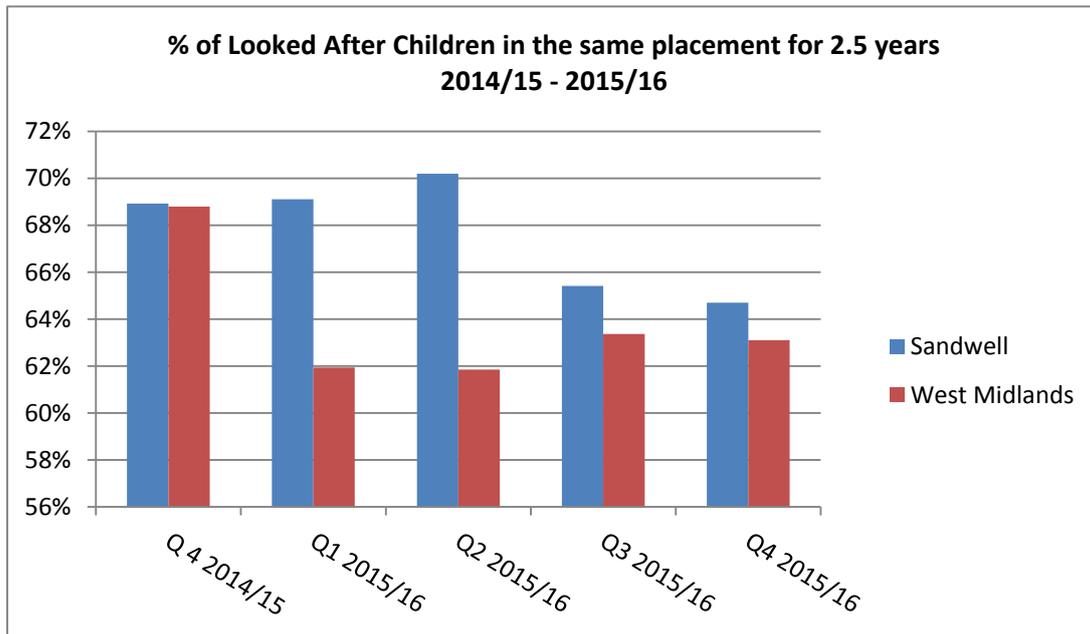
However, there are still areas where Sandwell can improve its performance. Figure 6 shows the percentage of single assessments with no further action remains high at 36%, and is considerably higher than the national average of 23%. Single assessment with no further action can be used as a proxy measure for inappropriate referral.

Figure 6: Percentage of Single Assessments with No Further Action



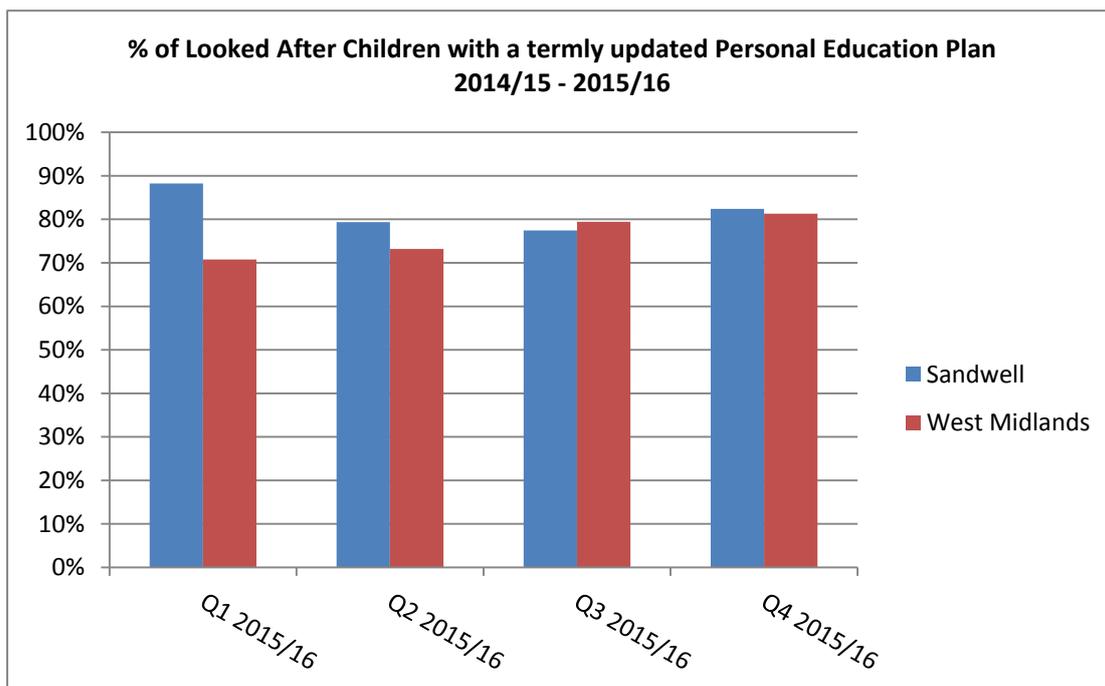
The percentage of looked after children who have been in long term council placements remains higher than the regional average, though it has fallen within the most recent quarter, with 64.7% of looked after children remaining under the council's care after 30 months against the regional average of 63.1%. This data needs further investigation to understand if the high percentage in long term placement in Sandwell is a reflection of more stable, successful placement or less permanent solutions, compared to the rest of the region.

Figure 6: Percentage of Looked After Children under Long Term Care



Another area with room for improvement is in the number of looked after children who have a termly updated Personal Education Plan. Previously, Sandwell was well above the regional average but the gap has now reduced (figure 7).

Figure 7: Percentage of looked after children with up to date PEP



Another area for improvement for Sandwell is in the number of children who are adopted within 12 months of a 'best interest decision' being taken. Although the position in Sandwell is improving, the Sandwell figure of 56% is still below the regional average of 66%. This is below the Sandwell figure of 61% in Q4 of 2014/2015 (figure 8).

Figure 8: Percentage of Children Adopted within 12 months

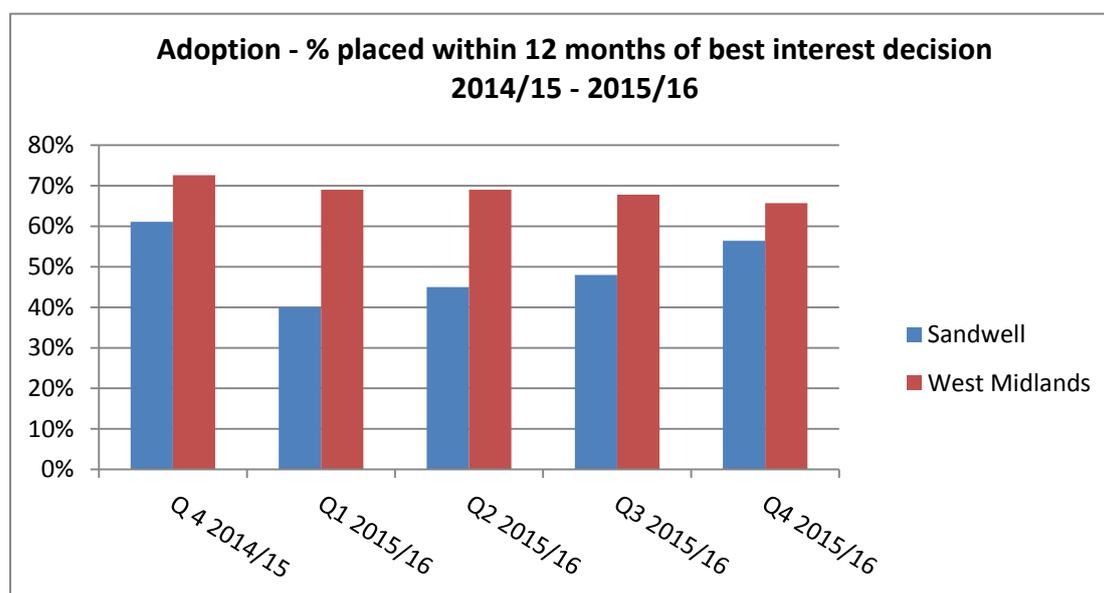
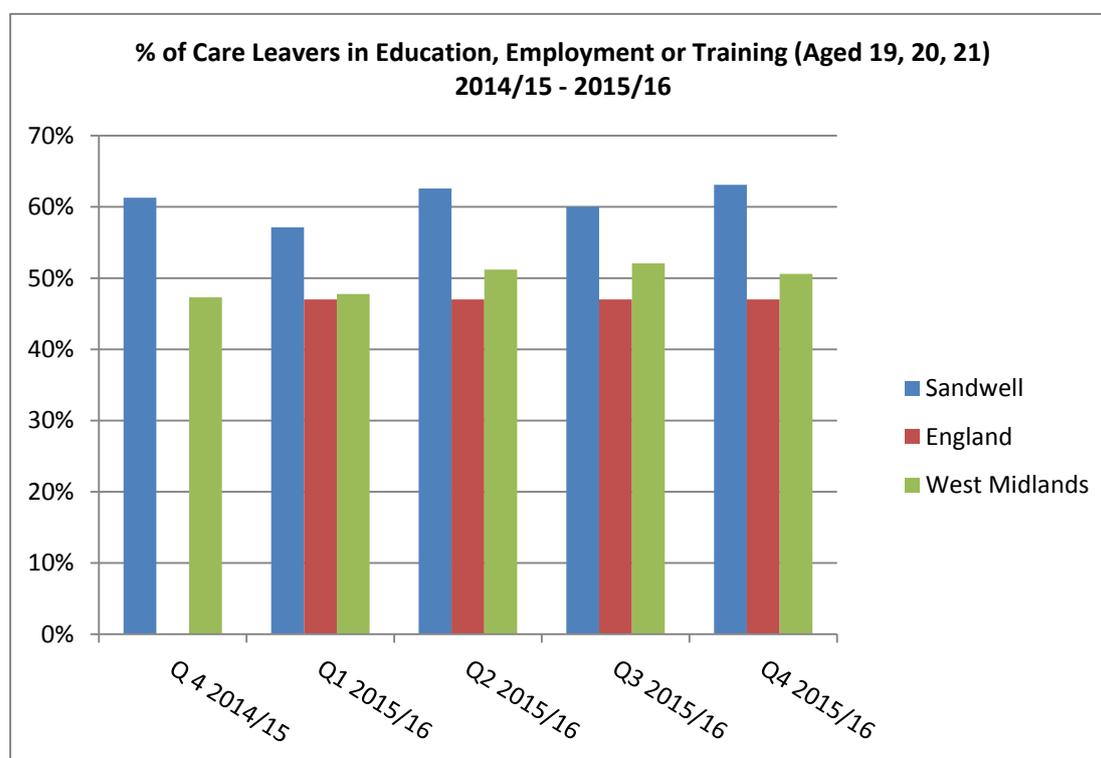


Figure 9 shows that Sandwell currently performs above both regional and national averages in the percentage of its Care leavers engaged in education, employment or training at 63% (against a regional average of 51% and national average of 47%). There has been improvement in this proportion over the last year and it is important that we look at how this can be continually improved.

Figure 9: Percentage of Care Leavers in Education, Employment or Training



There has been a significant increase in the average number of referrals that go through the MASH process. This has increase by 50%, which has in turn increased the number of Single Assessments required, which has increased by 110% across the last six months. However, the number of children who are currently under the council’s care has not been overly affected by this increase in workload and has remained around 540 since June 2015. This indicates inappropriate referral, however is in contrast to the low re-referral rate which implies that the MASH has improved referrals. The 2015 OFSTED inspection showed evidence of inappropriate application of referral thresholds which may explain the conflicting data.

The numbers of children who receive Children in Need plan have increased from 569 in June 2014 to 623. This, in turn, has had an impact on the overall number of cases being worked in the service – increasing from 1496 in June 2015 to the current number of 1709.

7.1.5 OFSTED Report Findings

Despite some good process measures, the 2015 OFSTED inspection cited evidence that some structural aspects of the service could be improved. The inspection found evidence that although assessments were being completed, these were not consistently informing plans and interventions. This failure of the assessment process results in inconsistent application of thresholds when deciding on what intervention was appropriate. The inspection also reiterated the importance of understanding what the data means - for example is the increase in numbers of Children in Need a true reflection of increased need or previously unmet need or a product of inappropriate referral. Inappropriate application of thresholds is also resulting in families not receiving appropriate level of service to safeguard children. This includes a lack of timely escalation from early help services to children's social care.

The October 2016 OFSTED Review found that the local authority has revised and implemented its improvement plan, resulting in some early, positive developments. Senior managers and leaders acknowledge that time and perseverance are required to ensure that the quality of practice is of a consistently good enough standard to effectively help and protect all children. The council has invested additional resources to increase social work capacity and management oversight in the safeguarding and assessment teams. This action has resulted in a much needed reduction in social work caseloads across the entire social work service. These positive changes are very recent and, as yet, the desired improved outcomes for children are not being demonstrated.

Guidance on the application of thresholds for intervention has been revised and re-issued to all social care staff and partners. This has resulted in a greater awareness by partner agencies and an improved response by staff and managers in the MASH; child protection concerns are starting to be identified and responded to without delay.

7.2 Child Sexual Exploitation

7.2.1 Background and Context

Child Sexual Exploitation (CSE) is a form of abuse where children received something (accommodation, drugs, affection, gifts, money, drugs) in 'exchange' for sexual activity. It is child abuse, involving the child being forced, coerced or intimidated, and sexual activity with a child under 16 is unlawful in any case. Often the victim is groomed into believing the abuser cares for them. The perpetrator is exploiting them through abuse of power, and many victims worry they won't be believed, whilst others do not recognise that they are being abused or understand that they are victims of serious crime. There are many different methods and approaches to sexually exploit children and young people, which can be undertaken by an individual, peers, groups and gangs. While there is no specific criminal offence of 'CSE', common offences can include rape and other forms of sexual assault, trafficking and child abduction.

Unlike recognised child abuse, which evidence suggests in the majority of cases is perpetrated by members of the family or perpetrators who have a relationship with the family, CSE is recognised to be more of a societal issue, with significantly fewer instances where families do play an active role in the child's abuse.

Any young person regardless of their age, gender, ethnicity and sexuality can be at risk of being sexually exploited. However, there are a number of factors that can increase a young person's vulnerability:

- Living in a chaotic or dysfunctional household (including parental substance use, domestic violence, parental mental health issues, parental criminality)
- History of abuse (including familial child sexual abuse, risk of forced marriage, risk of 'honour'-based violence, physical and emotional abuse and neglect)
- Recent bereavement or loss

- Gang association either through relatives, peers or intimate relationships (in cases of gang-associated CSE only) or living in a gang neighbourhood
- Attending school or being friends with other young people who are sexually exploited
- Learning disabilities
- Unsure about their sexual orientation or unable to disclose sexual orientation to their families
- Homelessness, or living in hostel or bed and breakfast accommodation
- Lacking friends from the same age group
- Living in residential care
- Low self-esteem or self-confidence
- Being a young carer

Some of these risk factors are discussed elsewhere in this chapter or in the wider JSNA (such as looked-after children, mental ill-health, and learning difficulties). However, it is difficult to access robust data on many of the more social factors, such as gang association or homelessness specifically among children and young people in Sandwell.

Some data on proportion of young carers in the borough is available from census data. Table 1 shows the proportion of young carers in Sandwell is higher than regionally or nationally. The Census defines a young carer as up to 24 years of age and it's not possible to determine if proportion of up to 18 years olds (i.e. those at risk of CSE) is significantly higher than elsewhere.

Table 1: Proportion of carers and young carers in Sandwell, West Midlands and England

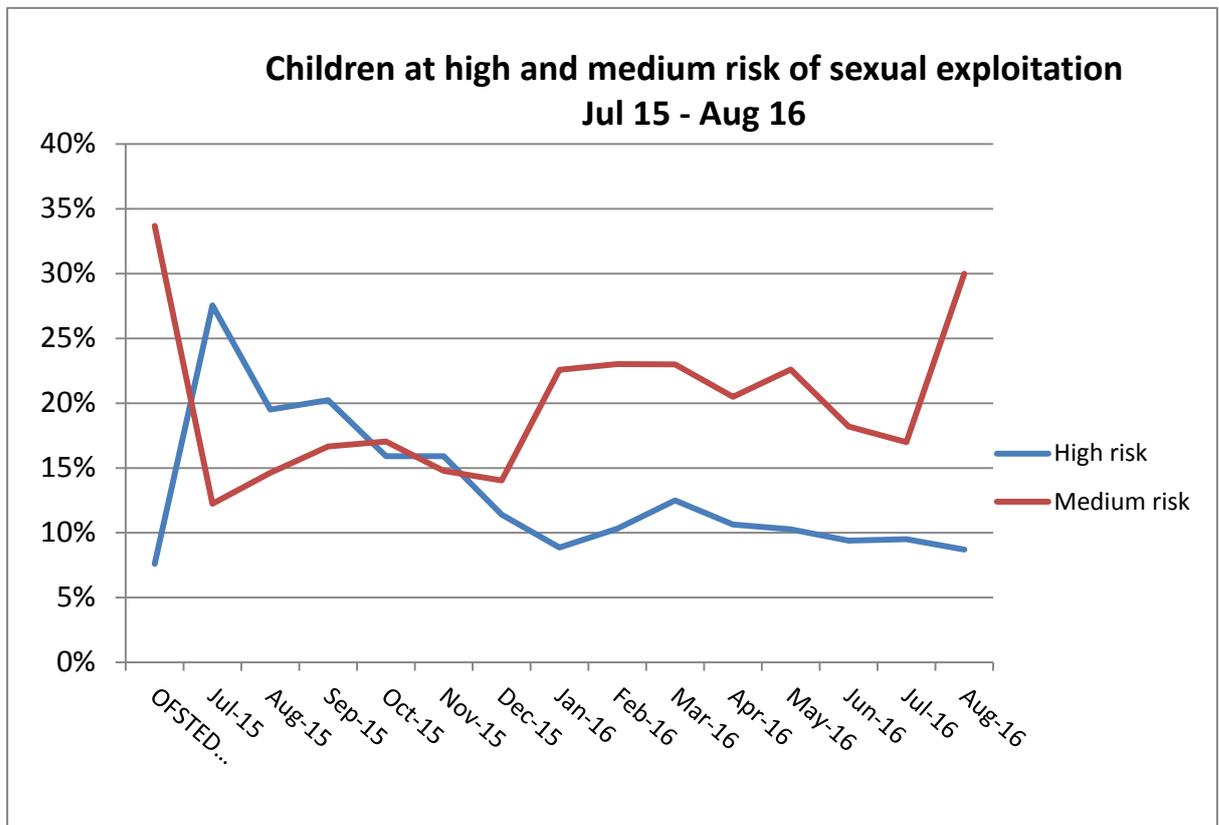
	Population: All Ages	Population: 0 to 15	Population: 0 to 24	Unpaid carers: All Ages	Unpaid carers: 0 to 15	Unpaid carers: 0 to 24	Percentage of unpaid carers: All ages	Percentage of unpaid carers: 0 to 15	Percentage of unpaid carers: 0 to 24
Sandwell	309,042	66,455	103,472	33,530	803	3,139	11%	1.2%	3.0%
West Midlands	5,608,667	1,094,524	1,772,666	614,888	12,527	47,804	11%	1.1%	2.7%
England	53,107,169	10,030,130	16,306,823	5,430,016	111,423	413,779	10%	1.1%	2.5%

In the past, specific data relating to prevalence of CSE was very poor. However, all children and young people (aged 10-17) open to children’s social care and integrated early help services or referred to children’s services are now screened for CSE. Also, the West Midlands Metropolitan Region are now committed to issuing quarterly snapshots of the nature and scale of child sexual exploitation (CSE) across the West Midlands, based on data from the seven Local Authorities within the West Midlands Police boundary, in conjunction with the police. During the period June-Sept 2016, there are a total of 161 children with identified CSE risk indicators in Sandwell. 9% of these are considered to have a serious risk, whilst 18% have a significant risk.

While the current performance data shows an increase in the number of young people identified as at risk of CSE over the past year, the number at medium and high risk has remained stable. While it is important that young people at lower risk are supported to avoid them becoming high-risk, it is also important that we focus on identifying those at currently at highest risk. Measures also show a month-on-month increase in numbers of missing children, although it is difficult to know whether this is a true increase or an increasing in reporting following OFSTED inspection.

Figure 1 shows the proportion of children and young people identified as at high and medium risk of CSE living in Sandwell. It unlikely that this graph reflects a true change in proportion at risk. It is more likely that it reflects changing in referral and identification following OFSTED inspection in January 2015. It is important that we gather information to look at identification and referrals pathways in more detail to ensure that all relevant professionals are referring appropriately.

Figure 10: Percentage of children and young people in Sandwell at medium and high risk of CSE



7.2.2 Current Service Provision

Recently Child Sexual Exploitation has taken centre stage in the public consciousness due to a number of high profile cases. Lessons learned from these cases have shown us the need to have a truly transparent and honest debate about the strength of our responses and the openness to challenge each other to ensure we are drawing on the full capacity and expertise across all partner agencies to respond to this agenda in a coordinated and effective way.

The Rotherham review by Louise Casey has shown the importance of having a truly holistic and multi-disciplinary response if the victims of CSE are to be truly heard and the perpetrators brought to justice. Whilst we are in no doubt that CSE is abuse and children must be protected by all means possible, the lessons from the Casey Review also highlighted the risks of a traditional social care response becoming a 'straightjacket' which prevents the protection of children who are being sexually

exploited being as effective as it should be. We know from our interactions with Looked after Children, for example, that vulnerable groups need to be able to build trusting relationships and not become isolated from their peers, families and local communities. Simply moving children away or taking them into care of the local authority thus removing them from potential protective factors in their families can increase their vulnerabilities. It is critical that we counter their isolation at every step possible, using all means at our disposal.

Recent national reviews have also demonstrated the challenges in engaging victims of CSE. Many may feel too ashamed at what has happened to them to come forward but may also be unable or unwilling to see themselves as victims in the first instance.

The key elements of Sandwell's CSE strategy are:

- **Focus on prevention through community awareness and resilience.** This includes engagement with schools and communities, training of Local Authority staff, working with business that may be inadvertently supporting CSE including hotels and taxi companies and identifying high risk settings including fun fairs and festivals.
- **Use existing services to protect those who are at risk of CSE or have been subjected to it.** This includes screening of those referred to children's services and those known to partner organisations, where appropriate. Cases identified as at high risk are then held by the CSE team. A primary mental health worker within the CSE team ensures timely access to therapeutic interventions where appropriate. Holistic plans to support victims and those at risk of CSE are developed and delivered through Multi-Agency Sexual Exploitation meetings.
- **Pursue and prosecute those exploiting or attempting to exploit young people.** Sandwell currently commissions a number of services designed to work directly with young people to help drive effective prosecutions. Intelligence will be shared with our partners, specifically the police, to drive prosecutions; but also with other services such as local authority trading standards to use the full range of powers available to disrupt and pursue those engaging in CSE in Sandwell.

7.2.2.1 Sandwell Safeguarding Children Board

Sandwell Safeguarding Children Board undertook a CSE Assurance Review in response to key issues identified in the OFSTED inspection report. The review took place between August and October 2015, and included interviews with senior leaders and practitioners across partner agencies, practice observations, and an audit of representative sample of 20 CSE cases.

The report found evidence of strong commitment from all partner agencies to tackle CSE, with some evidence of progress. Nevertheless, there were improvements required across all ten of the areas for assurance². The CSE Strategy and Action Plan were subsequently reviewed and updated in response to the findings and recommendations from the review.

Protecting children is one of the most important tasks the police undertake. Only the police can investigate suspected crimes, arrest perpetrators and monitor sex offenders. Police officers have the power to take a child who is in danger into a place of safety, or to seek an order to restrict an offender's contact with children. The police service also has a significant role working with other agencies to ensure the child's protection and well-being, longer term.

Black Country BASE (Barnardo's Against Sexual Exploitation) offers specialist CSE services in Sandwell and operate as part of Sandwell's CSE co-located multiagency team in delivering safe, effective and co-ordinated care pathways across the Borough. Using evidenced based practice, the service provides Missing/Return interviews for children who go missing from home with an independent and outreach approach, a high level CSE therapeutic support model for children/young people at high risk or who have been victims of CSE and some educative family support work for families. Training is also delivered on behalf of the SSCB to ensure the care pathways operating locally are embedded into evidenced based training programmes. All CSE provision works within National and Regional guidance with reporting into the local systems of YPSEM operational and strategic subgroups.

² SSCB Annual Report 2015-16: Page 21

7.2.2.2 West Midlands Police Force

Following a review of investigative structures and processes across the West Midlands Police Force area introduced in June 2014, there are now 153 constables dedicated to local Child abuse investigations across the Force, made up of 7 Child Abuse Investigation Teams (CAIT) each covering a local authority area, including Sandwell.

- These are supported by a central Online Child Sexual Exploitation Team, the central CSE team and a central referral unit, into which all referrals from partners regarding potential child protection issues are received and initially assessed before being forwarded to local CAIT for further action / strategy discussion and section 47 activity (joint agency response with children's services).
- In addition, a Vulnerability specific tasking meeting chaired by the Local Policing Chief Inspector has been introduced, which includes a specific focus on preventing children from becoming at risk of CSE, protecting victims of CSE and bringing CSE perpetrators to justice. This meeting is a multi-discipline meeting with colleagues from the PPU, neighbourhood officers, partnership team staff, West Midlands Police intelligence department and response functions to ensure a fully joined up and focused response to vulnerability, including inter familial abuse and CSE from the local police.
- Child Sexual Exploitation cases are continuing to increase with the Home office raising CSE as a national threat; the on-going focus and benefits of the work commissioned by Preventing Violence against Vulnerable People Board and the embedding of the regional framework for CSE has resulted in in the early identification of both victims and offenders. There remains a dedicated CSE Police officer working alongside the CSE team within Sandwell MASH. In Sandwell there were 170 reports, reflecting 10% of the Force total. This showed an increase from 81 reports the previous year. It is believed that rather than reflecting increased exploitation this rise indicates a great willingness to report and recognise CSE as a crime.

- The CAIT teams continue to manage CSE investigations. The Force are beginning to understand the problem, but it is suggested that they still have some way to go to gain fully understanding.
- Sandwell has continued to develop an effective Young People at risk of Sexual Exploitation forum (YPSE). This involves the commitment of partner agencies to understanding and responding to CSE in the Borough. This is chaired by the Police and is linked to the Missing Operational Group, given the overlap between Children missing and Children at risk of CSE.

7.2.2.3 Sandwell Council's Youth Offending Service and Drugs Education Confidential Counselling Advice

Sandwell Council's Youth Offending Service and Drugs Education Confidential Counselling Advice services undertake screening on cases and have representation at multi-agency meetings for cases demonstrating CSE concerns. Staff are aware that they need to be proactive in the response to this complex issue.

7.2.2.4 NHS partner organisations

NHS partner organisations have established a task & finish group has been established for health partner organisations to develop a 'health action plan' in response to the CSE strategy. The CSE Task & Finish Group mapped CSE training undertaken by staff groups across the represented health organisations and arranged for additional training to be delivered by the CSE coordinator.

- In February 2016, the group coordinated a CSE awareness/training event targeted at front line health professionals. People were asked to become "superheroes for CSE" In addition Sandwell & West Birmingham CCG commissioned through the group a short CSE film aimed at raising awareness in primary care and "what to do". This was premiered at the event and has subsequently received national recognition. It will be used widely as a training tool across health and other agencies.

- The group have a comprehensive work plan and has subsequently become an established Health CSE group reporting directly via the Chairs group to the SSCB.

7.3 Other Key Safeguarding Issues

7.3.1 Radicalisation

Young people often explore new ideas as they grow up and for a small number that may lead them into extreme groups who are strongly at odds with wider society. Most prominent are the extreme far right and Islamic extremism, but also animal rights and other forms of religious extremism can be an issue.

Children and young people can be drawn into violence or they can be exposed to the messages of extremist groups by many means. These can include through the influence of family members or friends and/or direct contact with extremist groups and organisations or, increasingly, through the internet via social media or other websites. This can put a young person at risk of being drawn into criminal activity and has the potential to lead to the child or young person suffering significant harm.

Issues that may make an individual vulnerable to radicalisation can include:

- Identity Crisis - Distance from cultural / religious heritage and uncomfortable with their place in the society around them;
- Personal Crisis - Family tensions; sense of isolation; adolescence; low self-esteem; disassociating from existing friendship group and becoming involved with a new and different group of friends; searching for answers to questions about identity, faith and belonging;
- Personal Circumstances - Migration; local community tensions; events affecting country or region of origin; alienation from UK values; having a

sense of grievance that is triggered by personal experience of racism or discrimination or aspects of Government policy;

- Unmet aspirations - Perceptions of injustice; feeling of failure; rejection of community values;
- Criminality - Experiences of imprisonment; previous involvement with criminal groups.

The Prevent duty has become a requirement since 2015 which placed a duty on specified authorities including; Local Authorities and Education to engage with the Prevent Agenda and have due regard to the need to prevent people from being drawn into terrorism. Prevent is part of the Government's Counter Terrorism Strategy with three overriding objectives, which are: (a) respond to the ideological challenge of terrorism and the threats faced from those who promote it; (b) prevent people from being drawn into terrorism and ensure that they are given appropriate advice and support; (c) work with sectors and institutions where there are risks of radicalisation which need to be addressed.

- Sandwell has been engaging with the Prevent Agenda for a number of years and is now designated as a priority area by the Home Office, with an expectation of having a strategy, delivery plan and Channel arrangements in place. Channel is a multi-agency approach to protect and support people at risk from radicalisation. The overall coordination of the Prevent Agenda now sits within the Neighbourhoods directorate and at present the Youth Offending Service continues to fund a specialist post for interventions on this area of work.

7.3.2 Modern Slavery

Modern slavery is the recruitment, movement, harbouring or receiving of children, women or men through the use of force, coercion, abuse of vulnerability, deception or other means for the purpose of exploitation. Individuals may be trafficked into, out of or within the UK, and they may be trafficked for a number of reasons including sexual exploitation, forced labour, domestic servitude and organ harvesting.

The Modern Slavery Act 2015 is designed to tackle slavery in the UK and includes a new duty for various bodies to notify the Secretary of State upon developing reasonable grounds to believe that a person may be a victim of slavery or human trafficking. The Prime Minister also established a UK cabinet taskforce to tackle such "sickening and inhuman crimes."

The Home Office estimates that there are 10,000–13,000 potential victims of modern slavery in the UK; 55% of these are female and 35% of all victims are trafficked for sexual exploitation. Around a quarter of victims are believed to be children (over 3,000). Victims experience numerous health risks prior to, during and following trafficking.

Any child transported for exploitative reasons is considered to be a victim of trafficking, whether or not they have been forced or deceived. This is partly because it is not considered possible for children in this situation to give informed consent. Even when a child understands what has happened, they may still appear to submit willingly to what they believe to be the will of their parents or accompanying adults. It is important that these children are protected also.

Most children are trafficked for financial gain. This can include payment from or to the child's parents. In most cases, the trafficker also receives payment from those wanting to exploit the child once in the UK. Trafficking is carried out by organised gangs and individual adults or agents.

Trafficked children may be used for:

- Sexual exploitation;

- Domestic servitude;
- Sweatshop, restaurant and other catering work;
- Credit card fraud;
- Begging or pick pocketing or other forms of petty criminal activity;
- Agricultural labour, including tending plants in illegal cannabis farms;
- Benefit fraud;
- Drug mules, drug dealing or decoys for adult drug traffickers;
- Illegal inter-country adoptions.

Children may be trafficked from a number of different countries for a variety of different reasons. Factors which can make children vulnerable to trafficking are varied and include such things as poverty, lack of education, discrimination and disadvantage, political conflict and economic transition, inadequate local laws and regulations. It is also true that whilst there is a demand for children within the UK, trafficking will continue to be a problem.

A study³ by ECPAT UK (a leading children's rights organisation campaigning to protect children from child trafficking and transnational child exploitation) found that in September 2014/15, 41 children in the West Midlands were identified/suspected of being trafficked, and 262 children were unaccompanied. [217 local authorities were asked to provide data, and 174-194 responded]. Nationally, 590 children were identified/suspected of being trafficked, whilst 4,744 children were unaccompanied.

The study found 167 children - more than a quarter of all trafficked children in the UK care system - went missing at least once in the 12 months to September 2015. In the West Midlands 20 children went missing over this period. It also found some 593 unaccompanied children in the UK - 13% of the total number - disappeared at least once (31 in the West Midlands). Of those, 207 trafficked and unaccompanied children have not been found.

³ Heading Back to Harm - A study on trafficked and unaccompanied children going missing from care in the UK, ECPAT UK and Missing People, November 2016

Professionals responding to the survey identified increased vulnerability amongst foreign national children, particularly those who do not speak English well or at all, those who lack identity documents, those whose asylum or immigration status is unclear and those who have links to traffickers. Ongoing links with traffickers was the reason most strongly perceived as a reason why trafficked or unaccompanied children go missing from care.

In accordance with the requirements of the Council of Europe Convention on Action against Trafficking in Human Beings, the UK has a National Referral Mechanism (NRM) for identifying and recording victims of trafficking and ensuring that they are provided with appropriate support in the UK. NRM referrals are made by professionals from a 'first responder' agency. First responder agencies include Children's Social Work Services, Police and the UK Visas and Immigration.

Barnardo's is working with the West Midlands Anti-Slavery Network, funded by the Police and Crime Commissioner Victims' Fund to support statutory bodies such as local authorities and the police to identify and safeguard child victims of trafficking, preventing them from going missing/being re-trafficked.

7.3.3 At-risk families

Adverse childhood experiences (ACE) are linked to having long-term impacts on an individual's health, wellbeing and life chances. A growing body of research is revealing the extent to which experiences and events during childhood can have an effect. ACE such as abuse, neglect and dysfunctional home environments have been shown to be associated with the development of a wide range of harmful behaviours including smoking, harmful alcohol use, drug use, risky sexual behaviour and violence and crime. They are also linked to diseases such as diabetes, mental illness, cancer and cardiovascular disease and ultimately to premature death.

The wide-ranging health and social consequences of ACEs underscore the importance of preventing them before they happen. By identifying adults who have been assessed as having experienced multiple childhood traumas based upon a

specific set of questions and putting support in much earlier with the right families, agencies will be better placed to support individuals to break the negative cycle of intergenerational problems. Adverse Childhood Experiences are causally and proportionately linked to poor physical, emotional and mental health outcomes and also have a significant impact on social and educational outcomes.

The first Troubled Families Programme was a national initiative that seeks to “turn around” the lives of 120,000 households, who were estimated to cost the public purse £9bn per year at the start of the project. This cost includes policing, health and benefits. 20,400 families have been identified as having one or more of the “troubles” in question. The implementation of the programme is by local authorities, who have selected families who meet three of the following four criteria:

- Are involved in youth crime or anti-social behaviour.
- Have children who are regularly truanting or not in school.
- Have an adult receiving out of work benefits.
- Cause high costs to the taxpayer.

The independent evaluation of the programme found widespread evidence of service transformation: the programme had scaled up family intervention provision, had begun to mainstream a ‘whole-family working’ approach (so that practitioners considered all the problems experienced by a whole family rather than focussing on individuals) and stimulated multi-agency working. Families were hugely positive about the service with a large majority (76%) saying the help they received through the programme had made more difference to their lives than previous help they had received. They also said they valued the trust, honesty and persistence of keyworkers. However, the short-term nature and methodological challenges of the evaluation mean it has been unable to attribute improvements in families' lives to the programme.

However, a report by The National Institute of Economic and Social Research (NIESR) suggests the programme has had no measurable effect on school attendance, employment or behaviour and found no consistent, measurable evidence that the scheme had improved the lives of families it aimed to help.

Using data from a quarter of the families taking part in the first stage, it found "a very small number of positive or negative results".

The new Troubled Families programme began in 2015/16. While it shares many of the features of the first programme, this is a distinct programme with a distinct set of programme aims, an evaluation that is able to inform the programme and contribute to its delivery; and a much greater level of discretion and flexibility. However at its heart it remains about improving outcomes for families with multiple problems based on a family approach.

The new programme has three objectives:

- For families: to achieve significant and sustained progress with 400,000 families with multiple, high-cost problems.
- For local services: to reduce demand for reactive services by using a whole family approach to transform the way services work with these families; and,
- For the taxpayer: to demonstrate this way of working results in cost savings.

Every family has to have at least two of the following problems to be eligible:

- Worklessness and financial exclusion
- Poor school attendance
- Crime and anti-social behaviour
- Children who need help (including Children In Need, children with special educational needs)
- Physical and mental health problems
- Domestic violence

7.4 Recommendations

7.4.1 Looked After Children

- Poverty remains the strongest risk factor for children entering care and addressing socio-economic determinants is a key prevention strategy in reducing the number of looked after children in Sandwell.
- Primary care and adult mental health workers should assess and support the parenting capacity of patients with mental illness, alcohol and drug misuse issues or learning disability. Evidence-based interventions should be considered to promote secure attachment reducing children developing major

social, educational and behavioural problems and reducing the need for children to enter care. Linked to this is the promotion of resilience to improve the health and wellbeing of looked-after children and young people. This includes warm, nurturing care, a sense of belonging and emotional support.

- Further investigation is required to understand if the high percentage of children in long term placement in Sandwell is a reflection of more stable, successful placement or less permanent solutions, compared to the rest of the region.
- A multi-agency approach is needed to address the barriers to full participation in life and promoting wellbeing for looked-after children and young people.
- Processes need to be implemented by the Sandwell Leaving Care Service to ensure that care leavers move to independence at their own pace, with a network of support to provide on-going practical help and emotional support after leaving care.
- Process should be put in place which clearly link assessment of child when entering care and subsequent development of plan and delivery of interventions to support the child.
- A process to ensure appropriate application of thresholds must be put in place, including a process to escalate cases from early help to more specialised services where appropriate.
- Evidence from a Serious Case Review and other case review information suggests the need for a more coordinated response to the needs of a small number of teenagers with complex needs and challenging behaviour.
- The creation of an independent children's services trust should be used as an opportunity to embed these recommendations.

7.4.2 Child Sexual Exploitation

As this is an emerging area it is important to recognise that we do not have strong evidence for what works in terms of prevention, protection, pursuing or prosecution. It is therefore important that the above actions are monitored to understand which have the biggest impact on desired outcomes.

In addition to the activities that have been implemented and are planned following audit, a number of other gaps have been identified including:

- OFSTED's inspection of services for children in need of help or protection described arrangements for management of children who are missing or at risk for CSE are poor in Sandwell and that neither local authority nor partners fully understand the scale of the problem. The inspection cited evidence that children at high risk were being inappropriately and ineffectively being supported by early help. This needs to be addressed by the creation of children's services trust.
- Current prevention strategy is based, to a large extent, on data about perpetrators and communities to which perpetrators are linked. This strategy needs to evolve as we continue to collect intelligence to ensure that it does not result in isolating certain communities within the borough. Likewise the prevention strategy targets known places where CSE exists including fun fairs, festivals and other large gathering. This approach must be flexible enough to respond to other high risk settings as evidence emerges.
- The effectiveness of interventions, either to prevent those at high risk becoming victims or supporting those who have become victims is not known. It is important that we properly evaluate commissioned services to ensure that are having a positive impact on victims and potential victims.
- In many cases pursuing perpetrators have not resulted in conviction. We need to understand why and what actions are required, for example around intelligence sharing or support for victims to increase prosecution rate.
- While the Local Safeguarding Children's Board have overall responsibility for preventing and reducing impact of CSE in Sandwell, it is important that other

Boards including the Police and Crime Board and Health and Wellbeing Boards and Safer Sandwell Partnership recognise their role in this agenda and a framework exists to ensure joint up working.

7.4.3 Radicalisation

Sandwell was previously a Prevent supported area but since April 2015 the Home Office has reclassified Sandwell as a Prevent priority area. This increased threat to the area has been identified. However this is not an isolated reclassification; since 2011 Local Authority Prevent priority areas have increased from 28 to 46 in 2016. This reflects the changing nature of the terrorist threat both nationally and internationally.

The overarching focus needs to continue to be coordinated activity around the 3 Prevent objectives:

- Responding to the ideological challenge of terrorism and the threats faced from those who promote it
- Preventing people from being drawn into terrorism and ensure that they are given appropriate advice and support
- Working with key sectors and institutions where there are risks of radicalisation which need to be addressed.

In addition to this, awareness raising through Prevent training and briefings to needs to continue to be rolled out to frontline staff, so that they are able to identify concerns and be confident in seeking support and making referrals where needed.

A referral process for young people at risk has been agreed and implemented with the MASH, however further work is required to track referrals to ensure that Prevent concerns are being correctly actioned and signposted.

The risk of radicalisation through social media and other online forums continues to rise. Further work is required to ensure young people are aware of the risks and

avenues to seek help. This is coupled with support for parents who may be unaware of how vulnerable their children may be when going online.

Whilst there are good relationships with some community groups in Sandwell in relation to Prevent, work needs to continue in order to expand the reach to a wider cross section of the community with whom the council and partner organisations can engage.

7.4.4 Modern Slavery

- There is a need to enhance the problem profiling of trafficked children. This is particularly the case for trafficked or unaccompanied children in care in Sandwell.
- The suitability of care placements for trafficked children must be matched with the particular needs of trafficked children.
- Processes need to be put in place which ensure the safety of children in care and help to reduce the risk of them going missing.
- Sandwell Council has a Modern Day Slavery working group who will be responsible for working with partners to take these recommendations forward.

7.4.5 At Risk Families

Data from the first troubled families programme shows that it had an impact in turning troubled families around in Sandwell although it wasn't as successful compared to many other local authorities (Sandwell ranked highly on families achieving continuous employment but less so on other results). We need to build on this first programme and learn from other authorities, with an aim to achieve better results in crime, anti-social behaviour and education outcomes.

Nationally, the new programme aims to work with a much larger number of families. The individual local targets are just the starting points for local services identifying and working with the real families and their real problems.

- The new programme includes more local discretion and flexibility in the eligibility criteria beyond anti-social behaviour, crime and school attendance, so that local authorities can work with a broader range of families and prioritise families based on local need. Sandwell needs to work across a range of headline problems and must make significant and sustained progress against all the problems that a family is experiencing.
- Accurate and relevant data is vital to the delivery of the programme, to understand families better, to measure progress and outcomes as well as to aid understanding of costs and benefits. The independent evaluation of the first programme revealed weaknesses in local data quality. Sandwell needs to fully utilise the available grant funding to improve both the quality and the analysis of data, and should make full use of the increased support around data and outcome measurements that is now available as part of the new programme.

The 2016-17 West Midlands Police Force Strategic Assessment 'Creating Safe and Healthy Futures', focuses on the impact of Adverse Childhood Experiences depicted through 'Craig's Story'; a hard-hitting and true life account which illustrates the impact of ACE on future life chances and the urgent need for effective and coordinated early intervention. The assessment took a significantly different approach to previous years, focusing on the priority of responding to violence and adversity, and embedding a different approach in the force.

- The West Midlands Violence Prevention Alliance (WMVPA) is working with partners to develop ACE-informed work across organisations, and will be working with Public Health Wales to develop a UK approach to ACE-informed schools from an American evidence base, to complement the work already underway in schools. The troubled families programme in Sandwell needs to link with this work, as there is an identified need to achieve better results in crime, anti-social behaviour and education outcomes.

8. Safer travel

8.1 Introduction

Road travel is essential to our everyday lives. Everybody uses roads by driving, riding, walking or travelling as a passenger. With this usage, accidents occur which result in people being either killed or injured. Road accidents have a life changing impact on health and wellbeing and there is also associated economical loss. Air pollution from motor vehicles also impacts of physical and mental health.

Road accidents are responsible for one third of accidental deaths among 0-14 year olds and over half of accidental deaths for 5-14 year olds⁴. The department for transport calculate the cost per casualty aged 0-15 years in 2011 to be £1.69million for fatal injuries, £189,519 for serious injury and £14,611 for slight injuries.

The government takes measures on a national level to minimise risks and provide guidance, but at a local level, local authorities are able to make decisions appropriate to the need of the community. Sandwell is 13th most deprived local authority out of a total of 326 and there is a proven link between road safety and areas of disadvantage⁵.

Multiple stakeholders are responsible for improving road safety, the reduction of road casualties and the promotion of sustainable travel methods. Schools, fire services, the police, neighbourhoods, local communities groups, transport agencies and high ways agencies are some of the service providers that Sandwell Metropolitan Borough council work with to examine, engineer, educate, enforce and encourage safer travel.

8.2 Current policies

⁴ <http://makingthelink.net/child-deaths-road-traffic-accidents>

⁵ www.makingthelink.net/government-policy/road-safety

8.2.1 National policies

Home to School Travel and Transport Guidance (2014) (Follow on from the Education and Inspections Act 2006)

This is a statutory guidance from the Department for Education that local authorities should follow when considering home to school travel and transport. Surrounding the travel arrangements and provisions, the guidance strongly promotes sustainable travel and transport. Sustainable travel being defined as travel which will improve health and well-being and the environment. There are five main elements which local authorities must undertake:

- An assessment of the travel and transport needs.
- A strategy to develop the sustainable travel and transport infrastructure.
- An audit of the sustainable travel and transport infrastructure.
- The promotion of sustainable travel and transport.
- The publication of Sustainable Modes of Travel Strategy

Highways Act 1988

Highway Authorities in England and Wales have a statutory duty under section 39 to promote road safety. The Act states that each local authority must carry out studies into road and vehicles accidents, take measures including construction to prevent accidents, provide road advice and training, maintain roads and take measures in their powers to control, protect or assess the movement of traffic. Evidence, research, education, publicity programmes, road safety engineering and maintenance measures all have a vital role. This act also features seatbelts safety rules for children who are under the age of 12 years and less than 150 centimetres in height.

Strategic Framework for Road Safety' (2011) (Department for Transport)

This policy looks at both national and local measures to reduce the number of killed or seriously injured casualties. National measures are aimed at enforcement against dangerous drivers and extending the use of education for children and for those that carry out low level offences and new drivers.

At a local level the strategy focusses on empowering local citizens to have control and make a difference through access to data and programmes such as community road watch schemes or working with voluntary organisations. The strategy allows local authorities to determine where road safety features in their priorities.

The strategy forecasts an overall (not age specific) 40% reduction in killed or seriously injured by 2020, 47% by 2025 and 55% by 2030.

8.2.2 Local policies

Sustainable Modes of Travel Strategy for Schools in Sandwell (2016)

Walking, cycling, public transport, car sharing and 'park and stride' are the focus. The strategy states that all schools should have travel plans in place and parents and pupils should be made aware of the different modes of transport and support available. Schools are encouraged to promote sustainable travel through the adoption of Modeshift STARS online system - an accreditation/award scheme for schools. It recognises cycling and walking as a means to reduce the prevalence of overweight and obese children and a means to reduce the number of cars at school travel times. Consequently reducing peak hour congestion and improving air quality.

Sandwell Metropolitan Borough Council 2013-15 Road Safety Plan

This plan recognises the need to reduce the rate of children being killed or seriously injured further. Although a reduction of all child casualties is a priority, the plan aims at specifically targeting areas that will reduce the number of children that are either killed or seriously injured in Sandwell.

The strategy aims to:

- Continue to make engineering enhancements to roads, although it is believed that all accident hotspots have been identified and improved.
- Have a coordinated approach involving road safety partnership, regional and local police forces, the fire service, local community and interest groups and local schools to persuade road users to behave more safely.
- Support and empower schools to provide road causality education.
- Increase highway services involvement at the earliest pre-application stage of externally led developments.
- Explore the use of cost effective technology and electronic warning and information signing further.

The policy covers examination, engineering, education, enforcement and encouragement as means to reduce road accidents in Sandwell. The current policy - 2013-15 Road Safety Plan and its addendum are being revised for a 2017 update.

The West Midlands Strategic Transport Plan “Movement for Growth” 2016

This is a long term plan which aims to change the West Midlands transport infrastructure in order to see improvements under the five headings below:

- Economic Growth and Economic Inclusion – covering areas such as access to work, education, skills and training
- Population Growth and Housing Development
- Environment - covering areas such as reducing carbon emissions in line with the national target of an 80% reduction from 1990 levels by 2050

- Public Health - covering areas such as reducing obesity levels and diabetes through more active travel (walking and cycling), reducing the number and severity of road traffic casualties
- Social Well-Being - covering areas such as education, family and friends, life-enhancing opportunities, particularly for socially excluded groups

These five areas are supported by 15 different council policies.

The plan is aimed at seeing improvements year on year for the next twenty years. The West Midlands Combined Authority will have ownership and it has been estimated to achieve this vision, an average of £330m will be injected into this development per year for twenty years.

Along with many other measures, baselines will include the Number of Killed and Seriously Injured Casualties, Killed and Seriously Injured Casualty Rate by mode per 100,000 km travelled, CO2 emissions per person from transport per annum.

8.3 Descriptive epidemiology

Sandwell is an industrial borough with strong motorway links. The M5 brings in commuter traffic throughout Sandwell.

The 5-19 age group spend a large proportion of their time travelling on Sandwell roads to and from schools and other educational institutes. The levels of support required to travel safely also differs with the different ages groups.

Sandwell is a diverse Borough with 42% from black and minority ethnic groups. The levels of support required to travel safely also differs within these groups due to language and communication barriers.

In Sandwell there are 102 primary schools, 12 special schools, 29 secondary schools, most with sixth forms, a further education college and a university technical

college⁶. There is a significant amount of cross boundary travel, particularly to and from sixth form provisions. Travel to educational institutes occurs at peak congestion times.

8.3.1 How many casualties in Sandwell?

Data from STATS19 (a national reporting system in Great Britain) has been used to analyse cases of accidents which occur in Sandwell. The data shows traffic accidents reported to the police where a STATS 19 form has been completed⁷. Although the accidents in some cases may involve individuals who reside outside of Sandwell it is not possible to identify this.

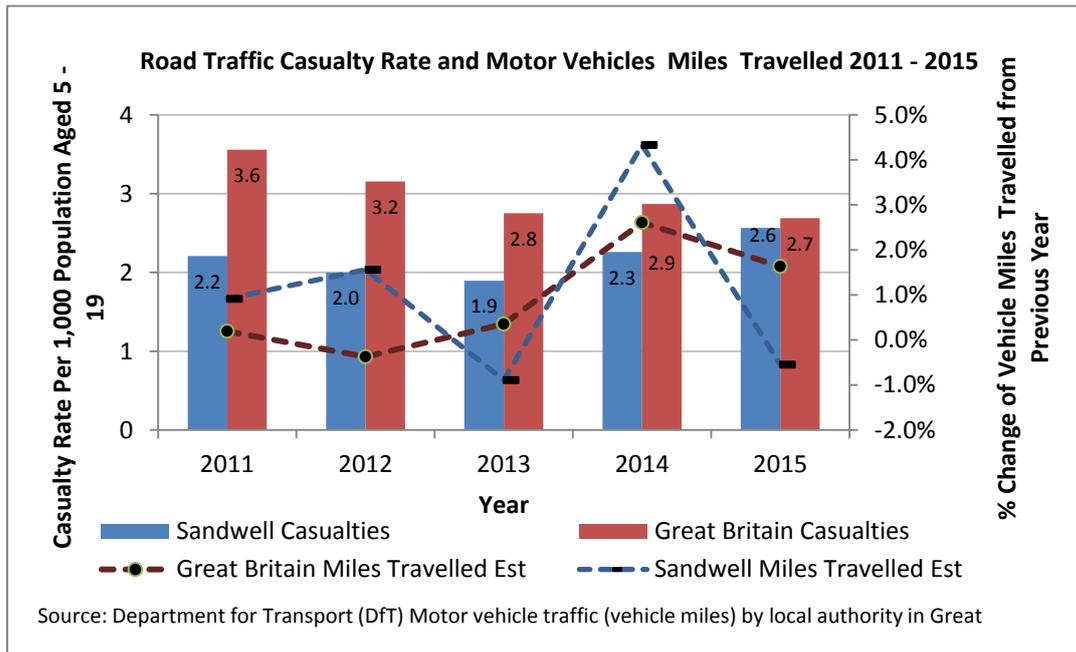
Over the five year period, 2011 to 2015, Sandwell had 666 road traffic casualties in people aged 5 -19. On average this equals 133 per year and a rate of 2.2 children in every 1,000 children aged 5-19 per year. Every month about 11 children are involved in traffic accidents.

Figure 1 shows Sandwell and Great Britain rates of casualties between 2011 and 2015. Sandwell rates have historically been lower than Great Britain. However more recently there has been an increase in rates of casualties in which has resulted in Sandwell rates now being comparable to the rest of the country.

⁶ National Consortium for Examination Results(NEXUS)

⁷ Note: STATS 19 only captures occurring accidents that have been reported.

Figure 1



Over the five years from 2011 to 2015, Sandwell has had an 18.2% increase in casualty rates for 5-19 year olds whereas Great Britain has had a reduction of 25%.

8.3.2 Do the number of miles travelled in Sandwell relate to the number of casualties?

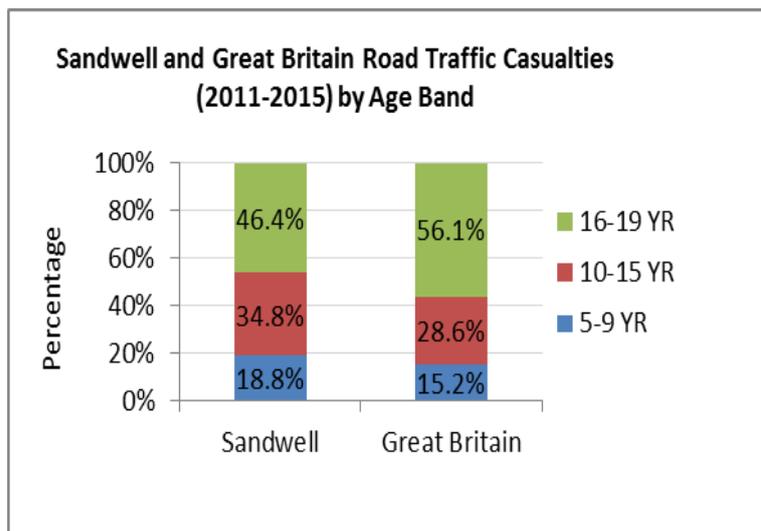
The Department of Transport publish traffic data including the number of vehicle miles travelled. Along with the yearly rate of child casualties, the year on year % change in vehicle miles travelled in Sandwell and Great Britain have been plotted in Figure 1 above. This is a broad overview of changes in miles travelled against casualty rates.

Overall the casualty rate has not followed the changes in vehicle miles travelled and further analysis looking at data covering a longer time period would be required to make the link in Sandwell's movement in casualty numbers.

8.3.3 Age groups most vulnerable to road traffic accidents

Figure 2 below shows that almost half (46.4%) of Sandwell casualties reported during 2011 and 2015 were aged 16-19 years. This was closely followed by the 10-15 year olds with a proportion of 34.8% and then 5-9 year olds at 18.8%. This is similar to the national picture.

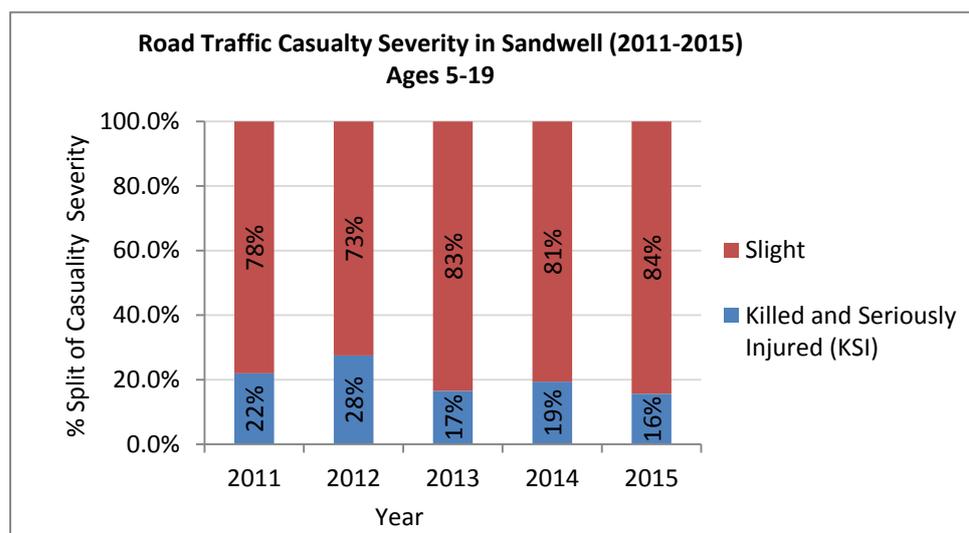
Figure 2



8.3.4 How severe are the injuries?

Figure 3 shows the proportion of casualties that were either killed⁸ or seriously injured⁹ (KSI) or sustained slight injuries¹⁰.

Figure 3



Between 2011 and 2015, 133 children were either killed or seriously injured (KSI). This is 2.2 children for every 1,000 children aged 5-19 over a five year period. Sandwell has had five fatalities in this age group between 2011 and 2015. Due to the small number it is difficult to find any major trends.

Although the number of accidents in Sandwell has increased, but according to the movement in types of injuries sustained, the increase is in those resulting in slight injury opposed to those resulting in a child being killed or seriously injured.

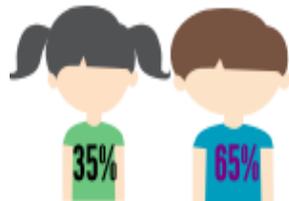
⁸ Deaths that occur within 30 days of the accident

⁹ Injuries often require hospital treatment and can cause death more than 30 days after the incident

¹⁰ Slight injuries can often be treated at the roadside

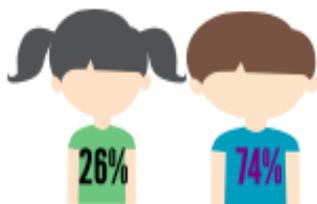
8.3.5 Risk of casualty in males and females

All casualties in 2011 - 2015



The majority (65%) of the 666 children reported as road traffic casualties are males.

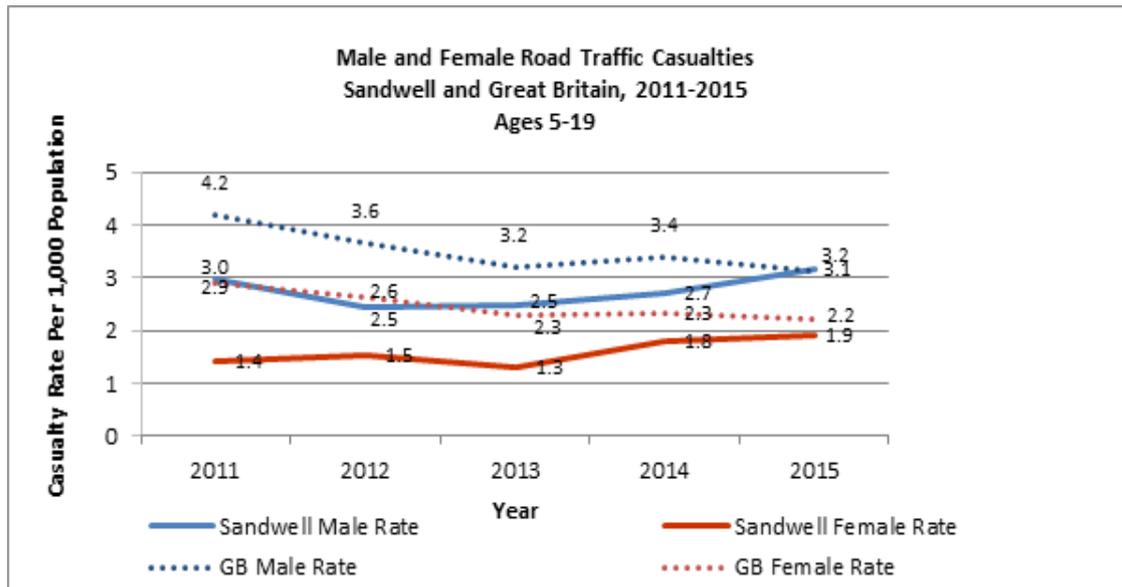
Killed or seriously injured in 2011-2015



In the KSI category almost three quarters (74%) of are males.

Figure 4 shows that historically, Sandwell casualty rates for the 5-19 year old age group were lower than national rates. However in recent years this Sandwell rates have increased while national rates have decreased and now the two are comparable for both males and females.

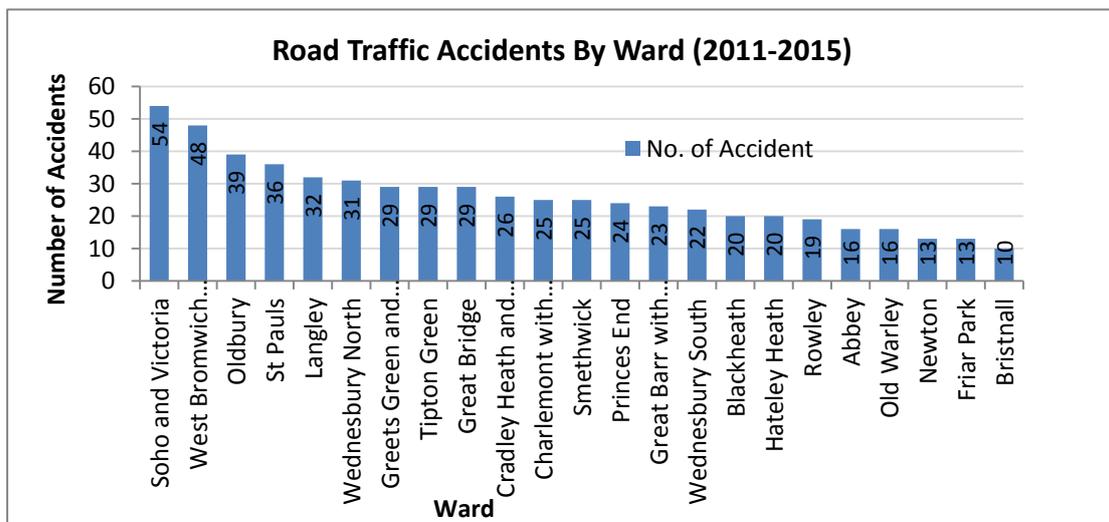
Figure 4



8.3.6 Where in Sandwell are the accidents occurring?

Figure 5 shows the number of road traffic accidents involving an individual aged 5-19 years by the ward that they occurred in. Two wards - Soho and Victoria and West Bromwich Central - had the most accidents in the five years (2011-2015) with 54 and 48 accidents respectively.

Figure 5



The data used for ward analysis only indicates the number of accidents and not the number of casualties therefore It has not been possible to provide rates per 5-19 year old population. However, as a crude measure, 6% of Sandwell's children that are aged 5-19 live in Soho and Victoria – the ward with the highest numbers of accidents and the highest proportion of children in Sandwell. However, West Bromwich – the ward with the second highest number of accidents and Bristnall – the wards with the least number of accidents in this age group both have equal proportions (5%) of Sandwell's 5-19 year old population.

Soho and Victoria has major A roads within it which serves traffic flowing across Sandwell from the M5 and from Birmingham central routes. Many shops and businesses are situated on these routes. The ward also has 7 schools. West Bromwich is also a busy ward which has major A roads and the M5 flowing through it. West Bromwich has 4 schools within it. For Bristnall, the ward with the least number of accidents, located further from the M5, with less major routes flowing through.

Many factors need to be considered when looking at hotspots for accidents, including the number of children, schools, road types, deprivation levels, the type and age of cars involved.

8.3.7 Transport mode and risk of casualty

Figure 6

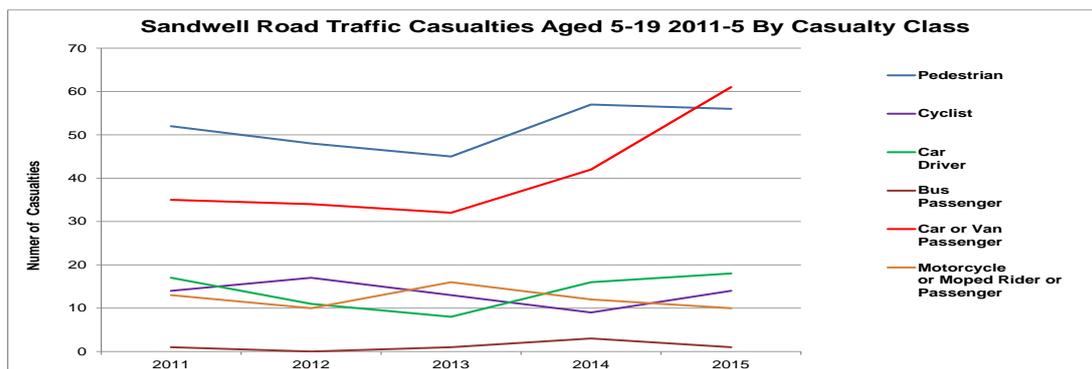


Figure 6 shows that of the reported casualties for 5-19 year olds between 2011 and 2015:

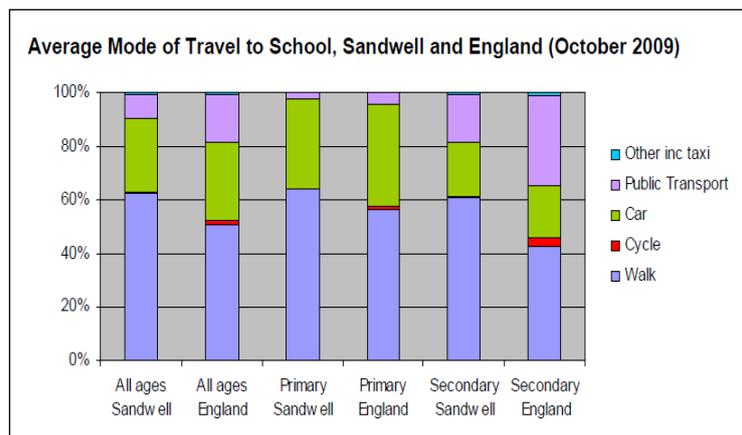
- 39% pedestrians
- 31% car or van passengers

- 11% drivers
- 10% cyclists
- 9% motorcycle or moped rider or passengers
- 1% bus passengers.

The number of casualties that are car drivers, cyclists, motorcycle/moped riders, motorcycle/moped passengers and bus passenger fluctuate year on year however the movement is very small. Casualties among passengers in a car or van had the most marked increase in recent years.

As part of the Sustainable Modes of Travel Strategy, data was previously collected on how pupils travel to and from school.

Figure 7



Source: Sustainable Modes of Travel Strategy for Schools in Sandwell 2016

Data from 2009 shows that Sandwell had higher proportion of pupils walking to and from school compared with England in both primary and secondary schools and a lower level of bus and car use. According to this data almost two thirds of Sandwell pupils walk to school. This survey is no longer conducted. The Mode Shift Stars system collects data on transport by school and therefore has the potential to target specific schools to support uptake of sustainable travel.

8.3.8 Age and risk of casualty

Figure 8

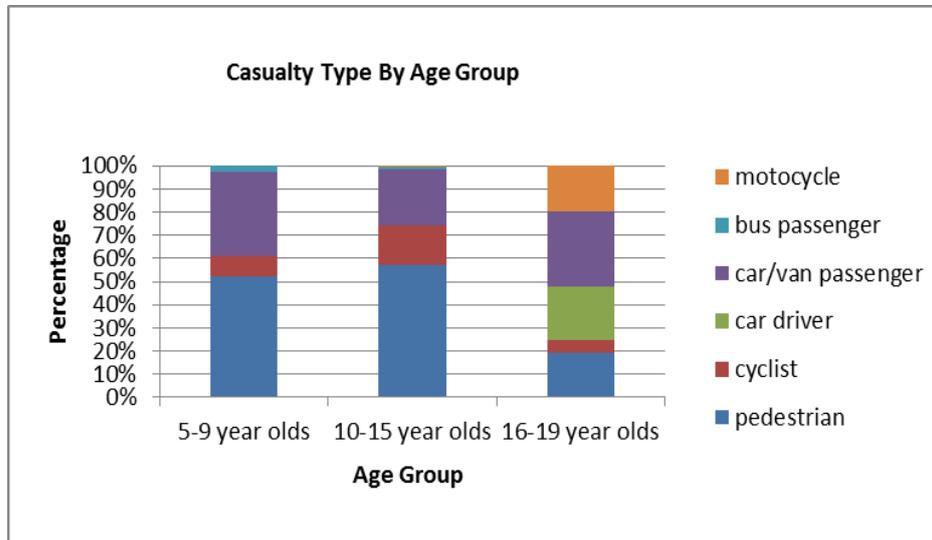


Figure 8 above, shows casualty category according to the child's age:

- Casualties that were aged 5 to 9 were mainly pedestrians (52%) and car passengers (37%)
- Casualties that were aged 10-15 were mainly pedestrians (57%) and car passenger (24%)
- Casualties that were aged 16-19 were mainly car/van passengers (33%) and car drivers (23%). Followed by 19% as motorcycle rider/ passengers 19% as pedestrians.

The differences reflect the changes in road usage and behaviours at the different ages. Pedestrians are the key casualty type in the younger age groups (five to nine and ten to fifteen) where it is Car/Van Passengers, drivers or Motorcycle/Moped riders in the sixteen to nineteen age groups. This is reflective of the age when people can first own a motor vehicle and an age when young people may start be more independent and travel as passengers in friends vehicles.

8.4 Evidence review

In 2014, Public Health England published a report entitled “Reducing unintentional injuries on the roads among children and young people under 25 years” which reviewed evidence on human and environmental factors which impact on road traffic collisions. The three key recommendations it makes are:

- Improve safety for children travelling to and from school by working with schools to devise school travel plans to encourage safe and active travel.
- Introduce 20mph limits in priority areas supported with education and publicity.
- A coordinated approach to prevent traffic injury and improve health - working in local partnerships such as communities, fire and rescue, police, schools, health services and businesses. This would aid the planning and evaluation of road safety activities with consideration for the impact on other health issues.

The World Health Organisation (WHO) 2015 Ten Strategies for Keeping Children Safe on the Road suggests that the following ten broad strategies are adopted:

- Controlling speed
- Reducing drinking and driving
- Using helmets for bicyclists and motorcyclists
- Restraining children in vehicles
- Improving children’s ability to see and be seen
- Enhancing road infrastructure
- Adapting vehicle design
- Reducing risks for young drivers
- Providing appropriate care for injured children
- Supervising children around roads

8.5 Current service provision

Sandwell Metropolitan Borough Council 2013-15 Road Safety Plan encompasses current service provision to support safer transport in Sandwell for the whole population, including those in the 5-19 age group. The following provision supports evidence-based practice to improve road safety:

- Sandwell Road Safety Partnership group has recently re-formed. This group is still in the planning phases but provides the potential to ensure a co-ordinated approach provided all the relevant stakeholders are included.
- Ward and neighbourhood analysis which looks at treatable hotspots for accidents. Trends and types of accidents, loss of control reasons and wet accidents are looked at. This analysis informs improvement programmes.
- Improved lighting levels through White LEDs and rapid attendance policies for surface and street furniture repairs to ensure pedestrians can be seen
- Walking and cycling schemes to improve road safety among these groups and ensure that sustainable transport choices are also safe
- There are a range of initiatives for school-aged children designed to improve road safety. These include an interactive road safety game for key stage one children, “Transitions Road Safety Package” to year 7, “Your Choice on the Road” presentation to year 11 and The Ripple Effect Road Safety Session to year 12. These activities are delivered through schools and can also be tailored to meet the needs of those with Special Educational Needs.
- Various schemes are in place to control speed including mobile speed camera operations, speed awareness courses, variable message and warning signs triggered by inappropriate speed.

In addition to Council's 2013-15 Road Safety Plan, there are a number of other initiatives focussing on increasing uptake of more sustainable modes of transport, including:

- Modeshift STARS online system which accredits schools which have demonstrated excellence in supporting cycling, walking and other forms of sustainable travel. The introduction of the ModeShift Star accreditation scheme is now used to encourage this continued monitoring and promotion of sustainable travel modes.

- Transport for West Midlands Sustainable Travel - Transport for Students 16 – 19 in Further Education and Training is responsible for promoting, developing and coordinating public transport across the West Midlands metropolitan area. Sandwell has a network of buses, trains and the metro which makes connections to Birmingham, Dudley, Coventry, Sandwell, Solihull, Walsall and Wolverhampton. The Sustainable Travel Team offer schools support such as:
 - Year 6 transition workshops
 - Special needs school travel training workshops
 - Provide interactive websites suitable for key stage 1 -3
 - Bespoke public transport packs
 - Journey planning advice
 - Dedicated education officers
 - Travel awareness sessions for pupils and staff
 - Advise on public transport aspects of travel plans
 - Bus behaviour issues

- Public Health has funded some social marketing work aimed at increasing uptake of sustainable transports methods, specifically targeted at schools in poor air quality areas. This campaign will be rolled out in April, 2017 and will encourage pupils and their parents to walk or take public transport to school for '1 journey' a week.

- Road safety provision for sixth Form and College Students (16-19): Sandwell Council's Parking and Safer & Sustainable Travel team regularly

attend Sandwell College Fresher's Fayre and Sixth Form Units to raise awareness of road casualty statistics, the law regarding seatbelts, drink and drug driving, and the dangers of using a mobile phone as a pedestrian and the consequences of doing so as a driver. This included recently supporting the 'For my Girlfriend campaign' in February which targets primarily young male drivers and their passengers.

8.6 Recommendations

- Data on chosen method of travel to school in Sandwell was collected in the past; however this data was last updated and collected from the school census in 2010 and the resource to collect and monitor this data is no longer collected and monitored. The Modeshift star system provides data on sustainability of travel by individual schools including transport choices. Moving forward, this data will be analysed and fed back to schools through the Schools Health Improvement Group which is chaired by the Director of Public Health, in order to encourage pupils to make healthier transport choices.
- The analysis in this chapter highlights that almost half of Sandwell casualties are aged 16-19 (46.4%). Within this group 33% are passengers, 23% drivers, 19% motorcycle riders or passenger. Therefore it is recommended that provision of healthier and safer transport education and promotion for 16-19 year olds is improved. Current services under the education theme are focusing on primary and secondary education. Comprehensive education tailored at 16-19 year olds and particularly new drivers needs to be developed and implemented. It is envisioned that Sandwell Road Safety Partnership group take this forward.

- Possible reasons for the recent 39% increase in casualty rate in this age group and the doubling of passenger casualties from 2013 to 2015 need to be explored. Without knowing reasons for this increase it's difficult to identify interventions to reverse this increase. The Sandwell Road Safety Partnership will explore possible reasons for this increase in the first instance.
- Further analysis of the accident hotspots identified by Sandwell's Highways team is required to establish what interventions need to be targeted to specific wards to reduce rate of accidents. Highways team need to work with wider Partnership to move this work forward. This work could potentially include the implementation of further 20 mile an hour zones in the borough.
- Many of the recommendation will be taken forward by the Sandwell Road Safety Partnership, it is important that all relevant stakeholders are included in this group.