Health Scrutiny and Performance Panel

Agenda Item No. 6

24 APRIL 2012

Update on development of Joint Strategic Needs Assessment (JSNA) for Walsall 2012

Ward(s) All

Portfolio: Cllr Zahid Ali- Portfolio for Health

Purpose

To brief the members of the Health Scrutiny and Performance Panel on the progress to date in the development of the Walsall's JSNA 2012 and to invite comments.

Recommendations

That members

- note the progress to date
- submit comments either as a Panel or as individuals

Detail

JSNA stands for JOINT STRATEGIC NEEDS ASSESSMENT. All local authorities and PCTs have had a duty to undertake JSNA since 2007. Joint Strategic Needs Assessment is both a process and a product. The process of joint strategic needs assessment involves the analysis and interpretation of data from a wide range of sources to describe the health and well-being of all age-groups of people in Walsall and to see how things are improving and where things are getting worse. The JSNA is an ongoing process, as new data is received throughout the year. The Health and Well-being Board is given key responsibilities in the development of JSNA in the Health and Social Care Bill.

The Walsall JSNA 2012 (enclosure 1) is a document identifying HIGH-LEVEL priorities for action targeted at commissioners and decision makers in the borough. More accessible summary documents will be available for wider dissemination. It focuses on those large, complex problems where a co-ordinated response across two or more agencies is required to deliver improvement.

The JSNA 2012 will be followed later in the year with a Health and Wellbeing Strategy which will provide more detail on the actions required at all levels in the Borough to address those priority areas for action described in the JSNA. Close links will be developed between the Health and Well-being Strategy and the Sustainable Communities Strategy, which is due to be updated.

This is a developing process. The aspiration is develop a shared understand wellbeing in Walsall, what improves it, what damages it and to be able to describe and promote an asset based approach, focussing on promoting strength and resilience in our communities. The annual JSNA report will evolve to meet this aspiration.

Nationally the vision is to improving the health and well-being of the population, improving the health of the poorest, fastest. The Health and Well-being Board will be working on a local vision for Walsall and the development of a shared understanding of 'well-being'.

This year JSNA 2012 follows the structure of The Marmot Review, "Fair Society, Healthy Lives", an in-depth review of health inequalities in England and incorporates themes from across the 4 national outcomes frameworks; Public Health, NHS, Adult Social Care and Every Child Matters. Themes included in the JSNA were areas contributing to significant service use across the borough with ability to benefit from a local partnership approach.

The first draft of the JSNA was presented to the Health and Well-being Board in March 2012, and comments received from them and others have been incorporated into this current draft which is now being circulated widely for comment. Deadline for submission of comments is 14 May 2012. The revised JSNA will be presented to the Health and Well-being Board in June 2012 and will then inform development of the Health and Well-being Strategy.

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Walsall Joint Strategic Needs Assessment 2012

Towards a Strategy for Health and Well-being for the people of Walsall

Version 2

Draft for comment

April 2012

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Acknowledgements

The JSNA was informed and guided by the JSNA Project Group: Dr Isabel Gillis, Councillor Marco Longhi, Dr Barbara Watt, Andy Rust, Adrian Roche, Darrell Harman, Denise Perry, Anna Sansom and Dr Jane Fowles.

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Introduction

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

The 7 chapters of the 2012 Walsall Joint Strategic Needs Assessment are guided by the 6 key policy objectives from the Marmot Review, placing an emphasis on a life course approach;

- *Chapter 1 - Give every child the best start in life*
- *Chapter 2 - Enable all children, young people and adults to maximise their capabilities and have control over their lives; transition to adulthood*
- *Chapter 3 - Employment and employability*
- *Chapter 4 - Create and develop healthy and sustainable places and communities*
- *Chapter 5 - Strengthening the role and impact of ill health prevention across the life course; Mortality and long term conditions*
- *Chapter 6 - Strengthening the role and impact of ill health prevention across the life course; Lifestyles and prevention*
- *Chapter 7 - Healthy ageing and independent living*

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

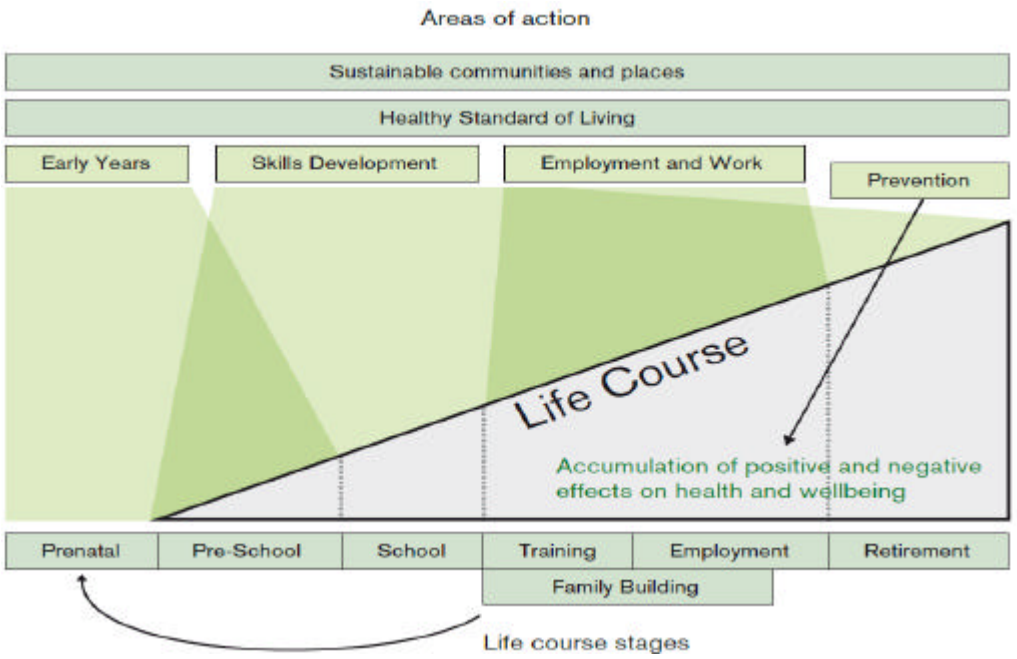


Figure 1 The Marmot Review Life course approach

Individual chapter content was informed by 4 key outcomes frameworks;

- *Public Health Outcomes Framework*
- *Adult Social Care Outcomes Framework*
- *NHS Outcomes Framework*
- *Every Child Matters Outcomes Framework*

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

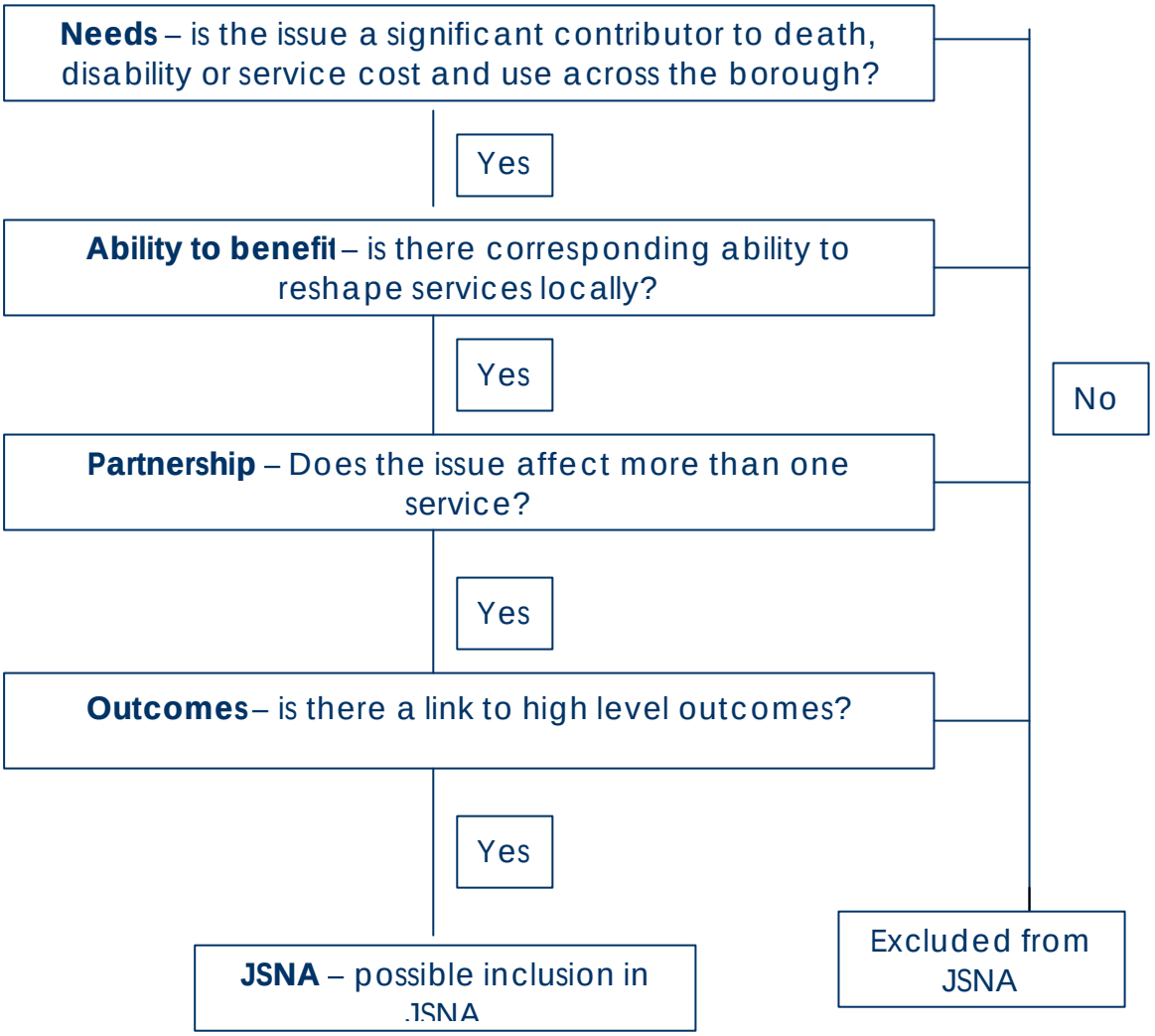


Figure 2 JSNA Decision Tree – Modified from Birmingham Health and Well-being Partnership: Determining whether a topic is a JSNA Level Project v1 2009

Development of the 2012 JSNA has moved towards a stronger partnership approach than previous years. Each chapter has been developed in partnership by a Public Health and Local Authority lead, drawing on the expertise of many individuals across both organisations.

The key goal of the JSNA is to enhance well-being in Walsall through the Health and Well-being Strategy, defining well-being as;

- *A healthy body*
- *A healthy mind – emotions, reason, imagination, positive self esteem, emotional resilience, problem solving skills, freedom from fear*
- *A safe and secure place to live – home safety, freedom from violence or fear of it*

- *Enough money to live on*
- *Nurturing relationships – family friends, community, a sense of belonging*
- *Purposeful activity and valued achievements – learning, working, volunteering, relaxing*

Measuring well-being is a harder task. Marmot recommended that once a suitable indicator of well-being is developed this should form a national target for tackling health inequality, alongside life expectancy and health expectancy. Marmot also emphasised the importance of improving well-being through the creation of conditions that enable people to control their lives and freedom to flourish – favourable and equitable circumstances of birth, growth, life, work and ageing for all. In response to these challenges the aspiration of JSNA in Walsall is to gradually shift from a deficit based approach to an asset based approach to describe and foster the circumstances that promote well-being.

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

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

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

Walsall overview

Chapter 2 Give every child the best start in life

A healthy start in life is at the heart of a happy childhood and the ability of every young person to achieve their potential and grow up well prepared for the challenges of adolescence and adulthood. Early interventions during pregnancy and ongoing support in the early years are critical to the long term health of the child. Early years prevention is vitally important for improving health and reducing health inequalities at all ages. Interventions later in life are less effective where early foundations are lacking. For this reason the Marmot review highlighted the following priorities;

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

The opening chapter of the JSNA reflects the importance of well-being in the early years, describing key indicators and early interventions in Walsall aimed at reducing inequalities in later life.

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

Different patterns of birth rates between deprived and affluent areas mean that more children are living in areas of deprivation than five years ago. Children who grow up in poverty are less likely to stay on at school, to attend school regularly, to get qualifications or go on to higher education and more likely to become young parents, locking whole families into intergenerational cycles of deprivation. This is particularly relevant in Walsall where there are comparatively high levels of child poverty, with 29.7% (18,900) of the children aged 0-18 in Walsall growing up in poverty.

1.1 Child Poverty

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

Priority Indicators

In Walsall, 30.6% of children were living in families whose income fell below 60% of the median national income in 2009 which translates to almost 16,675 children aged under 16 living in poverty in 2009, up by 1,010 from the previous year. In 2009 Walsall ranked 124th out of 152 councils in England, placing Walsall in the bottom quartile.

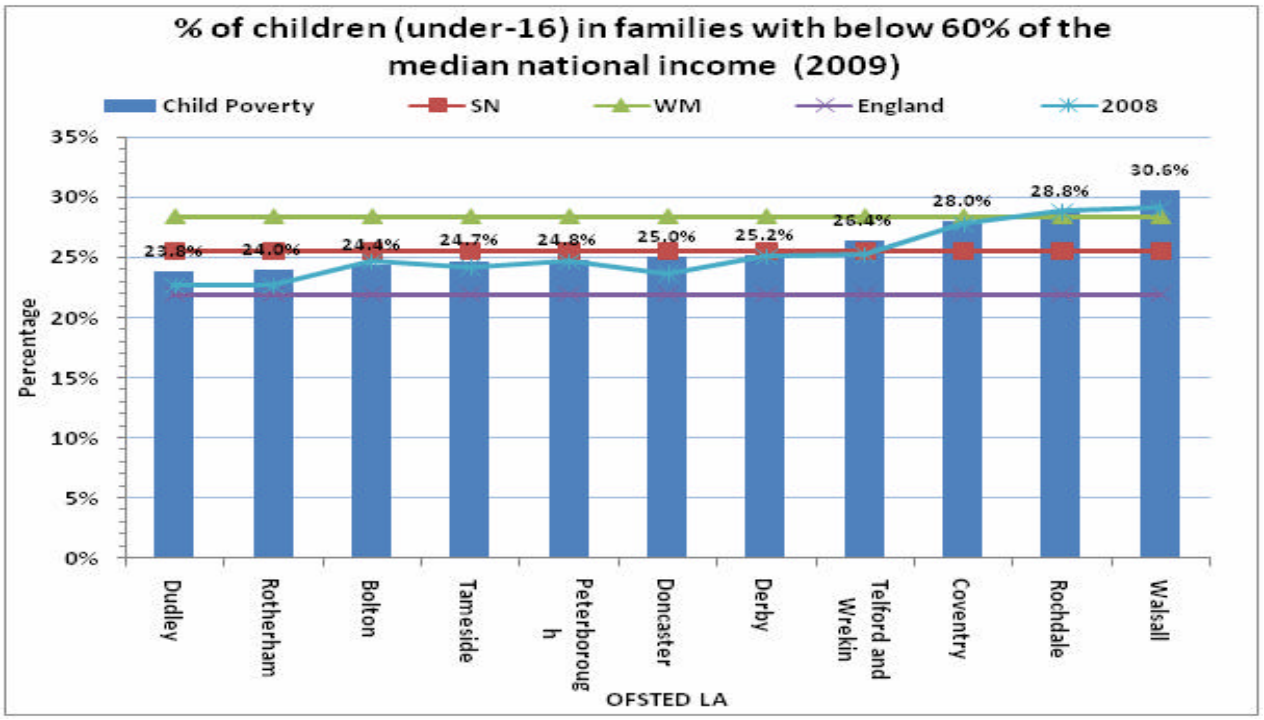


Figure 4 Percentage of under 16's in families with less than 60% of the median national income, 2009

In 2009, the percentage of children living in poverty in Walsall was the highest out of its statistical neighbour group, and above the average regional and national level.

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

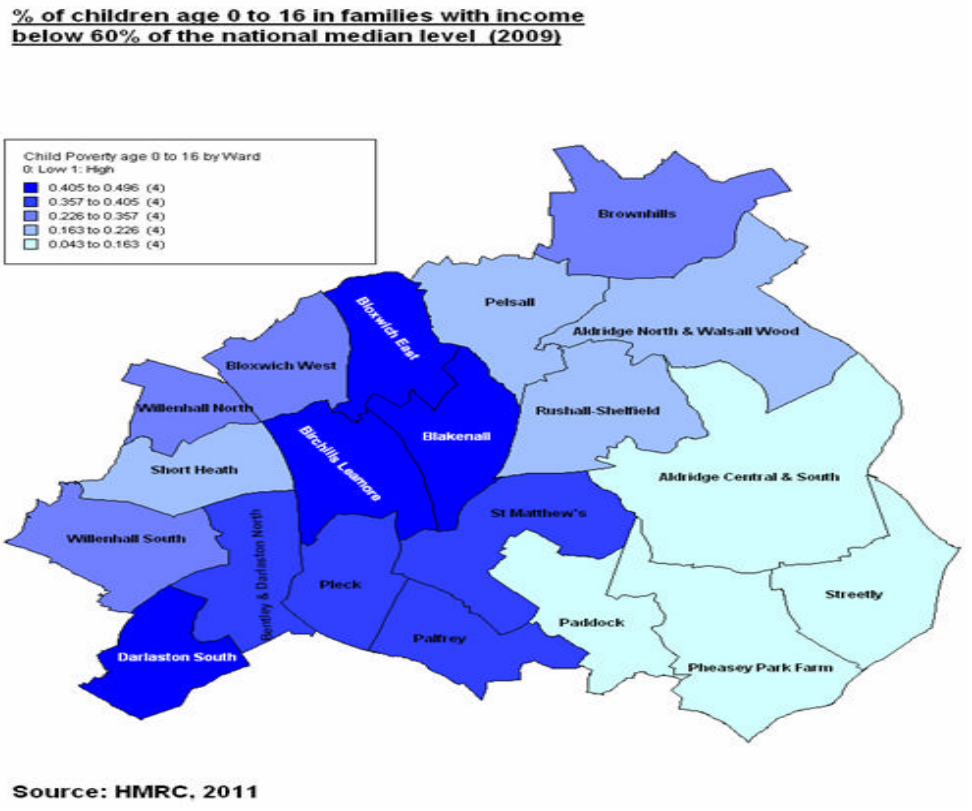


Figure 5 Percentage of children under 16 in families with less than 60% of the median national income in Walsall by ward, 2009

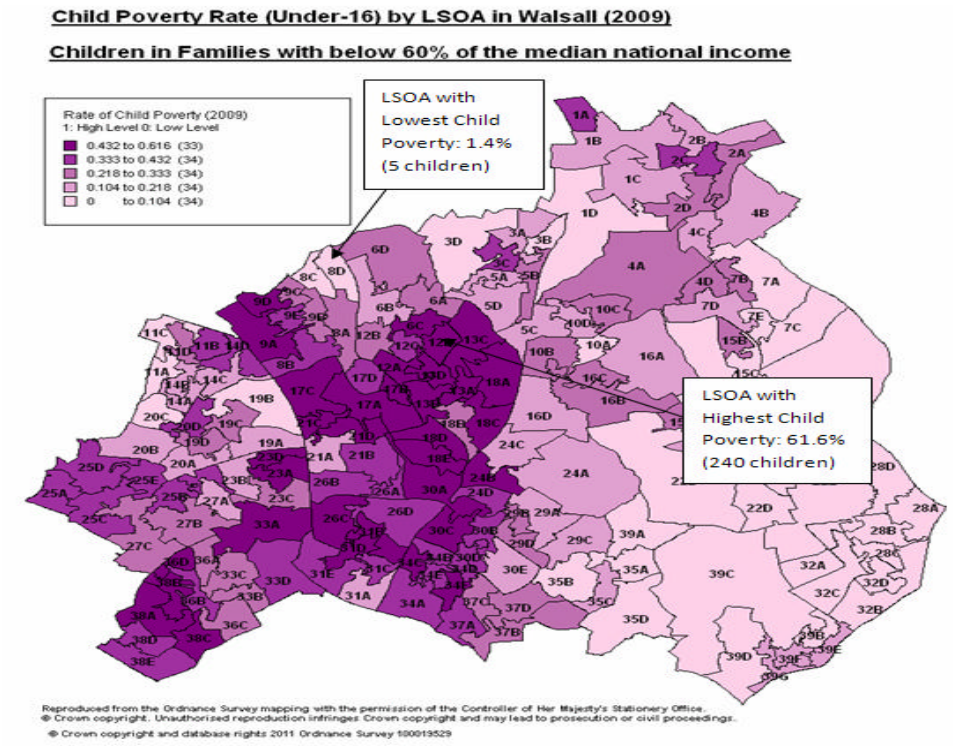


Figure 6 Percentage of children under 16 in families with less than 60% of the median national income in Walsall by LSOA, 2009.

Recommendations

Walsall has drafted a Child Poverty Strategy to address the issue and prioritised this issue in our worklessness reduction agenda. We have secure funding to support Families with Multiple Problems and secured work for them on payment by results funding. Our priority actions are;

- Mitigate impact by income maximisation and money advice
- Increase wage levels with the aim of raising household incomes over the 'poverty threshold'
- Reduce the number of adults with no qualifications
- Decrease the number of local parents classed as workless
- Increase the number of jobs for local people
- Narrow the gap between disadvantaged pupils and their peers
- Build family and children's resilience and enhance parenting skills
- Increase aspiration of parents and children and young people

1.2 Infant and perinatal mortality

Infant mortality is a sensitive indicator of the overall health of a population, providing a measure of the well-being of infants, children and pregnant women. Although infant mortality in England is at an all-time low and falling, significant inequalities persist.

Priority Indicators

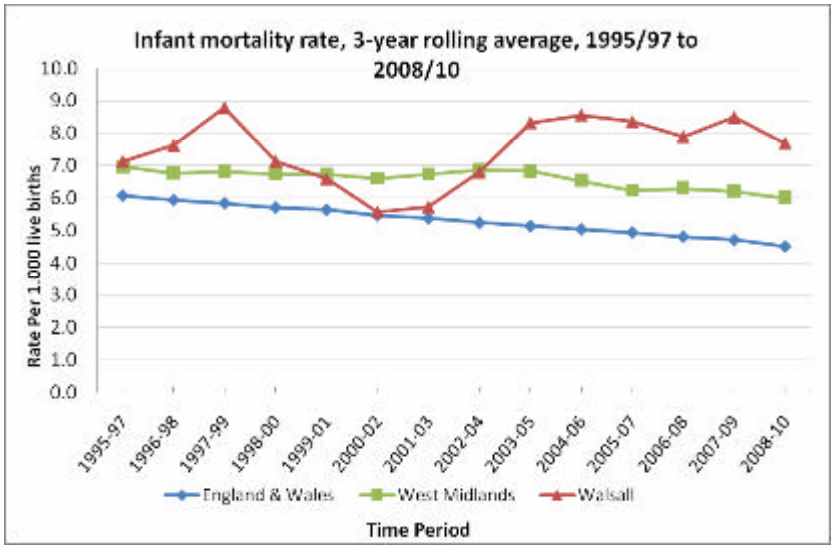


Figure 7 Infant mortality rates 1995-2010

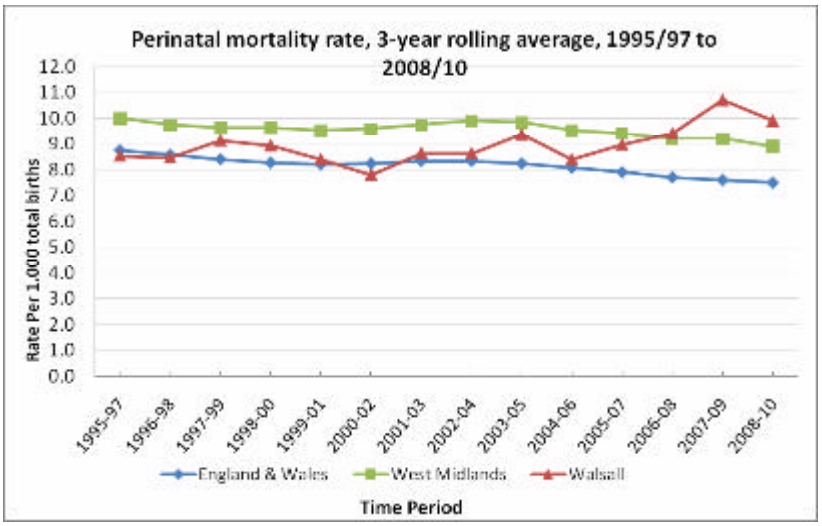


Figure 8 Perinatal Mortality rates 1995-2010

In Walsall both infant mortality and perinatal mortality remain consistently higher than the regional and national levels (see Figs 7 and 8). Both infant and perinatal mortality are strongly associated with deprivation with infant mortality rates of 0 per 1000 live births in the least deprived areas compared with rates of 32 per 1000 in the most deprived areas of Walsall. Reducing health inequalities in infant mortality requires a combination of health interventions and actions on the wider social determinants of health.

Recommendations

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

- Improving antenatal care through encouraging early booking for antenatal care, continuity of carer through pregnancy and improved detection of intrauterine growth restriction (IUGR)
- Reducing levels of maternal obesity and smoking in pregnancy through projects such as Maternal and Early Years and improving smoking cessation in pregnancy
- Maintaining an effective antenatal and newborn screening programme
- Reducing sudden unexpected death in infancy (SUDI) and improving breastfeeding initiation and continuation rates
- Target vulnerable groups through specialised programmes such as the Enhanced Community Genetics service and the Family Nurse Partnership
- Addressing social determinants such as reducing child poverty, improving housing and reducing overcrowding and reducing teenage

conceptions, including repeat conceptions are also critical to reducing infant mortality

1.3 Parenting

There are children and young people, living in households where the parenting capacity is not fully meeting their needs and which may affect their overall health and development. In line with our approach to early intervention and prevention, we have recently developed a local Evidence Based Parenting Strategy which details how we will work to deliver a greater and more coherent suite of parenting programmes for citizens of Walsall. The Parenting Strategy was approved by the Children and Young People's Partnership Board in Sept 2011

Priority Indicators

Evidence Based Parenting Strategy – Delivery Targets
'The Walsall Way of parenting'

	Delivery Targets		
Measure	2012/2013	2013/2014	2014/2015
The Workforce and Development Parenting Team have arranged training places for 151 multi agency staff in evidence based parenting groups. Once trained these practitioners will be able to deliver - Teen Triple P, Strengthening Families Strengthening Communities, Mellow Parenting and Solihull Parenting to groups of Walsall Parents/careers. We will measure the number of group programmes these new parenting practitioners deliver, where they deliver their groups and the number of parents that attend. We will also evaluate the outcomes for families attending these groups by measuring parents wellbeing, confidence and style and children and young people's behaviour before and after the group programmes.	60 groups Evidence based parenting groups delivered by a variety of services across the Walsall borough	100 groups	100 groups

Figure 9 'The Walsall Way of Parenting' – Evidence Based Parenting Strategy

Recommendations

Programme suite - The types of programmes offered should be appropriate to the carefully assessed needs of each child and family and in particular the level of severity of identified problems and/or of maltreatment. In response to Professor Munro's report (The Munro Review of Child Protection Interim Report: The Child's Journey) we will bring together stakeholders across the Children and Young People's Partnership in Walsall to gather views on the local requirements for Evidence Based Practice. We will establish a range or suite of programmes which fit with the needs across 4 different tiers and across 3 different life stages. This will become Walsall's 'Toblerone' model (Fig 10). We will ensure that we are delivering the right programmes to the right families.

Multi-agency delivery - We have set an ambitious target t o run 100 programmes in 2012/13. These programmes will be a mix of group and 1:1 sessions delivered by multi-agency staff across Walsall. This is a significant increase on the 38 programmes delivered in 2010/11 and will require a significant investment in terms of both time and funding. Delivery of these programmes will be based on demand to ensure that we are delivering programmes in the right place at the right time.

Workforce development - In order to achieve our ambitious delivery target of 100 programmes per year we will need to increase the numbers of staff trained t o deliver programmes. Based on our ratio of practitioners delivering 0.54 programmes on average per year we would need to increase our practitioner numbers to 200 from 71. It is expected that programmes will run with 2 trained practitioners, hence 200 practitioners delivering 100 programmes.

Staff will be trained dependent upon at which level they work with families. Based on our tiers, there will be a greater requirement to train staff at level 1 and 2, with fewer at level 3. We will have 15% (30) of practitioners trained at level 3 with the remaining 85% (170) trained at level 1 and 2. In addition to this we will increase awareness at level zero for the entire children's workforce to ensure that there is a consistent message and understanding of the Walsall Way of Parenting, who could or should access programmes and how they are accessed.

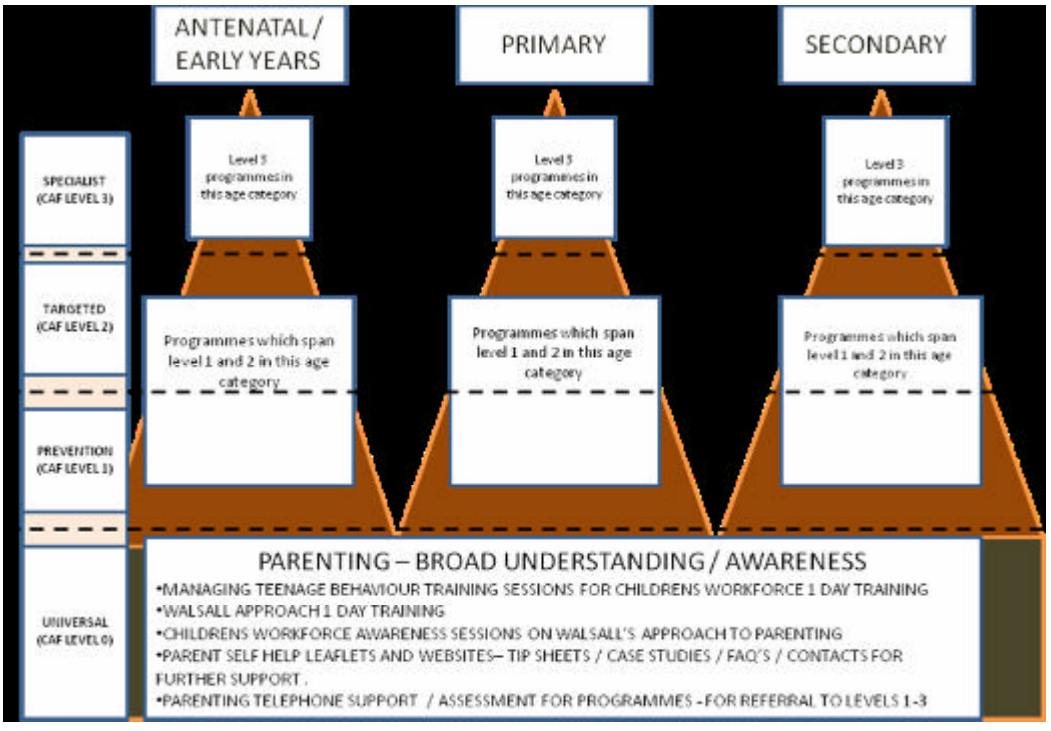


Figure 10 Parenting 'Toblerone'

1.4 Educational attainment – The early years

Giving young children the best start in life includes the provision of a high standard of education from an early age. A child's progress is assessed from an early age (Foundation Stage, when the child is between the age of 3 and 5 years of age) and assessed at Key Stage 1 (Year 2) and finally at Key Stage 2 (Year 6, the final year of primary school). The goal is to prepare children for the challenges of secondary school level education so that they can ultimately achieve and progress through life successfully. Education is a key social determinant of inequalities in society.

Priority Indicators

In Walsall although attainment has improved at Foundation Stage, it is has been consistently below regional and national levels with the gap widening in the recent year (see Fig 11). This year's results at Foundation Stage show a plateau, with results broadly the same as last year. Walsall shows good performance amongst pupils with English as an alternative language and also demonstrates performance in line with all comparator averages for pupils of Asian ethnicity. Historically girls continue to exceed boys' performance in all 13 scales.

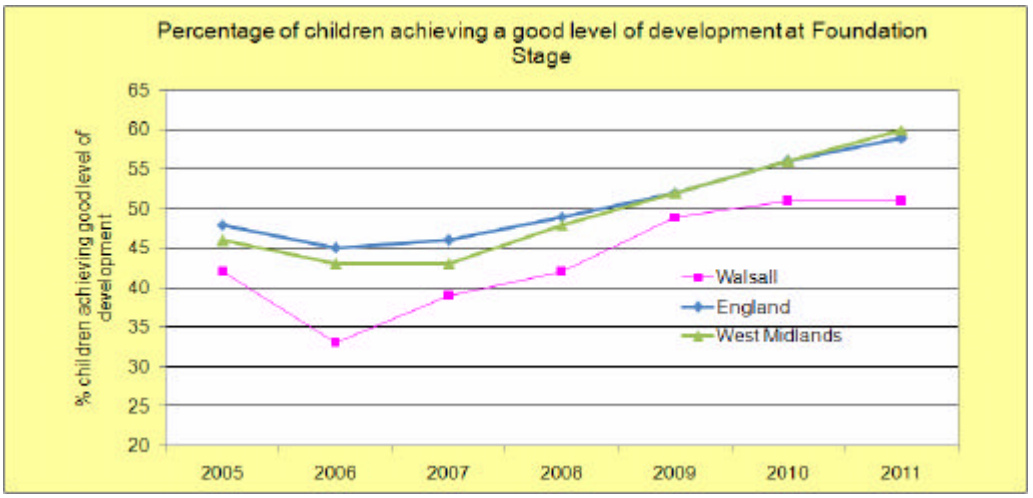


Figure 11 Percentage of children achieving a good level of development at Foundation Stage

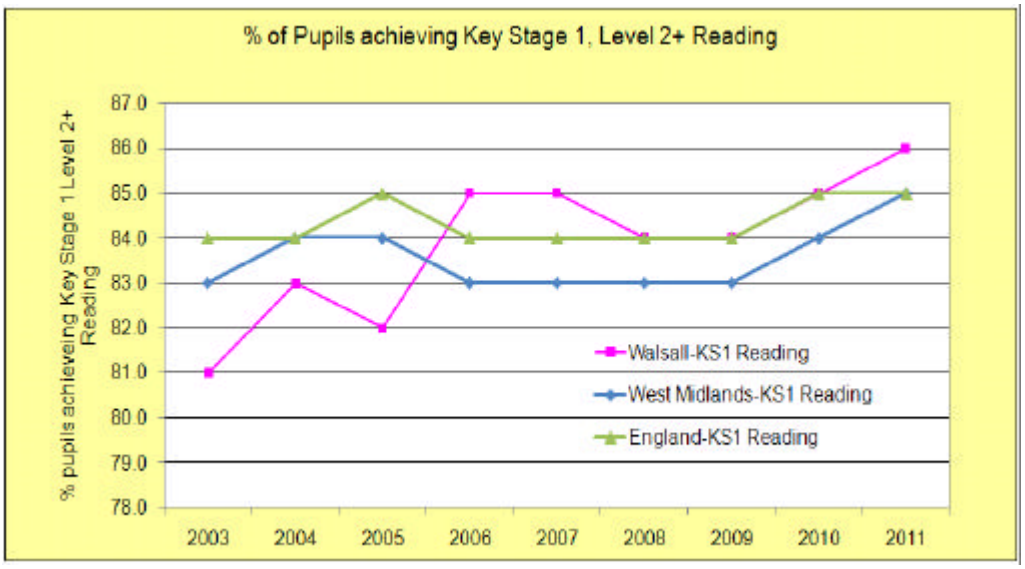


Figure 12 Reading at Key Stage 1: Percentage of pupils achieving Level 2+

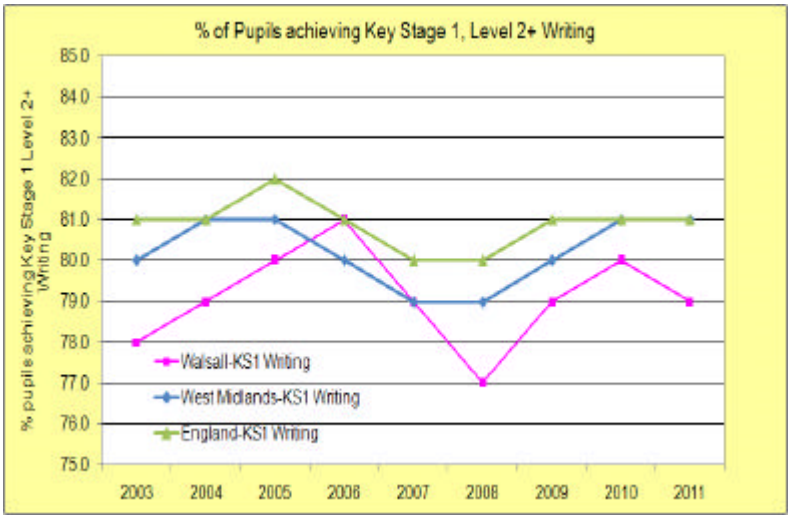


Figure 13 Writing at Key Stage 3: Percentage of pupils achieving Level 2+

Attainment levels for Key Stage 1 at Level 2+ are measured in Reading, Writing, Maths and Science. Performance of Reading at Level 2+ has been on an upward trend since 2008, exceeding regional and national levels in 2011 (see Fig. 12). Performance at Writing Level 2+ has improved since 2008 although remains below regional and national levels (see Fig. 13). It is worth note that Walsall is now ranked the 44th best performing LA out of the 152 in the country for reading at KS1. Walsall has improved by 12 places this year when compared with its 2010 rankings (56th). In 2011, Walsall's attainment for reading was above the national average for the first time. The percentage of Walsall pupils achieving Level 2+ in Maths is now at 89%. This result exceeds our statistical neighbour average and ranks Walsall as one of the best performing LA's in the Black Country. Results in KS1 writing have declined slightly this year when compared to 2010 after 3 years of continual improvement (Level 2+).

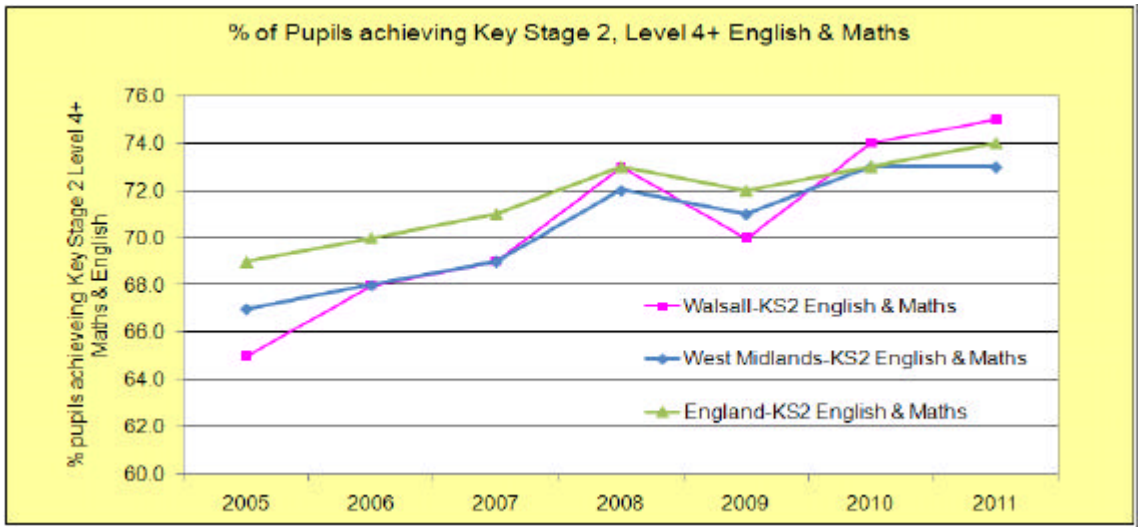


Figure 14 English and Maths Key Stage 2: Percentage of pupils achieving Level 4+

Encouragingly performance of Walsall pupils has improved since 2009 and has exceeded regional and national levels for the past two years (see Fig. 14).

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

Recommendations

Our priority is to target resources to support vulnerable groups as per data analysis and provide schools with appropriate support. Key priorities are to;

- Increase % of children achieving 78 points across Early Years Foundation Stage with at least 6 in each of the scales in personal social and emotional development and communication, language and literacy, specifically focusing on improving LSL (linking Letters and Sounds) Writing scales, Physical Development and Social Development strands.
- Continue to focus on pupils achieving L2+ in writing and maths, particularly White British group and achievement of pupils with Special Educational Needs (SEN) at School Action plus.
- Continue to focus on maths at KS2 particularly for Pakistani pupils, achievement of pupils wit h SEN at School Action plus and achievement of LAC.

- Children eligible for Free School Meals (FSM) remain a target for additional support.

1.5 Healthy weight

Childhood obesity is a particular concern and it is widely accepted that there
is a link between childhood obesity and risk of disease and death in later life. The strongest predictor of childhood obesity is parental obesity (a mixture of nature and nurture) and children who are obese are more likely to grow up to be obese adults, therefore a vicious circle is created. More immediate issues for overweight children are social and psychological, including stigma, bullying, low self-esteem and depression.
The National Child Measurement Programme (NCMP) measures Reception (age 4-5 years) and Year 6 (age 10-11 years) children and in addition to the required measurements Walsall also measures children in Year 4 and Year 10 providing robust data on childhood obesity.

Priority Indicators

The priority indicator for obesity in Reception aged children is the prevalence of overweight and obesity in children aged 4-5 years as highlighted in the Public Health Outcomes Framework. Walsall's overweight and obesity prevalence in Reception year is 23.4% 9 (NCMP data 2010/11) which is lower than the Regional prevalence (23.7%) and the Black Country Cluster prevalence (24.2%) but slightly higher than the National prevalence (22.6%).

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

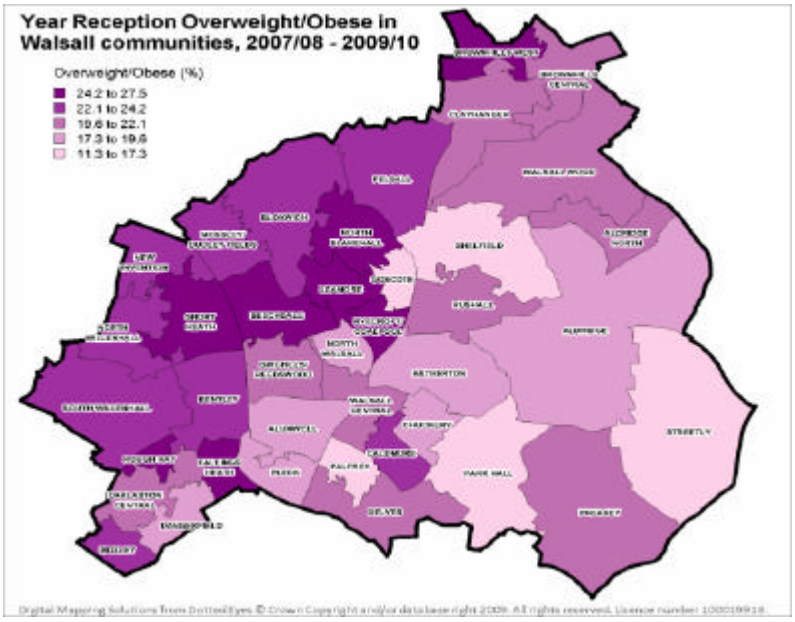


Figure 15 Walsall communities overweight/obese at age 4-5 2007-2010

Recommendations

Through Walsall's Child Measurement Programme children identified as being overweight or obese will continue to be offered help and support through our weight management programmes. Focusing on prevention is also paramount to tackling childhood obesity, this will be achieved by working closely with partners to deliver early years interventions including;

- Continue to commission the Maternal and Early Years programme and increase referrals and engagement onto the programme through training and appropriate identification.
- Extend work from schools into pre-school settings, with a Healthy Early Years Award scheme.
- Roll out the Food Dudes programme to all primary Schools (an evidenced based behavioural programme to increase the consumption of fruit and vegetables).

1.6 Summary and Recommendations

Parents are the key to achieving the best physical and mental health and well-being outcomes for their children. Our investment in parenting programmes is to increase family resilience so parents are better able to support their child's development needs. There is a growing body of evidence that parenting programmes underpinned by strong research evidence can provide positive gains for parents and children.

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

Investing in the early years, thereby improving early cognitive and non cognitive development and children's readiness for school is vital for later educational outcomes. High quality preschool experience can have positive effects on children's social, emotional and cognitive development. Despite the lower than expected levels of attainment at Foundation Stage for Walsall pupils by age 5 (which could be due to differences in judgement during the assessments), the percentage of Walsall pupils achieving Level 4+ at Key Stage 2 outperformed regional and national levels in both 2010 and 2011.

Key Priorities for action:

- Holistic support for families from before birth with a priority for maternal health interventions. This should include home visiting support for disadvantaged young parents and a focus on reducing levels of smoking in pregnancy and increasing rates of breastfeeding, particularly in deprived areas.
- Build on recent improvements in the provision of evidence based parenting programmes, advice and assistance
- Providing good quality early years education and childcare proportionately across the social gradient.
- Ensuring that there is a focus on early years and that expenditure on early years development is focussed progressively across the social gradient.

Chapter 2 Enable all children and young people to maximise their capabilities and have control over their lives: transition to adulthood

This chapter attempts to recognise and highlight the interdependence of key outcomes such as health and well-being and the ability to learn and achieve, and to draw out some of the wider actions to address them. Reducing inequalities requires a sustained commitment to children and young people throughout the years of education.

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

Good health for children and young people is crucial, because it enables them to make the best of their opportunities in education and in developing healthy lifestyles. It promotes health and well-being in adulthood and an ability to contribute fully to wider society. It will also help to break down the intergenerational cycle of poverty, deprivation and joblessness that affects many people in disadvantaged groups and areas.

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

- *Reduce the social gradient in skills and qualifications*
- *Ensure that schools, families and communities work in partnership to reduce the gradient in health, well-being and resilience of children and young people*
- *Improve the access and use of quality life long learning across the social gradient*

The second chapter of the JSNA discusses key influences and strategies to improve well-being in the school and transition years enabling young people to realise their aspirations and to become independent, capable adults.

2.1 Educational attainment

2.1.1 GCSE (Key Stage 4) & A/AS Level

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

Priority Indicators

In Walsall the percentage of pupils achieving 5 or more A*-C grades at GCSE level including English & Maths has improved year on year from 2007 and the gap to regional and national levels further closed in 2011 (see Fig 18). A/AS Level attainment is measured in two ways, the average point score per candidate and average point score per entry. Walsall is faced with the challenge of closing the gap between Walsall and regional/national levels

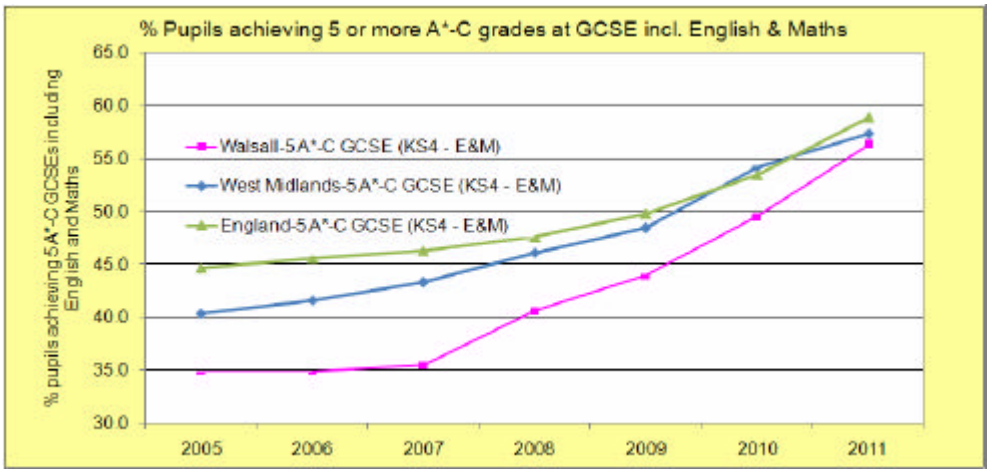


Figure 16 Key Stage 4 (GCSE) – Percentage of pupils achieving 5+ A*-C grades

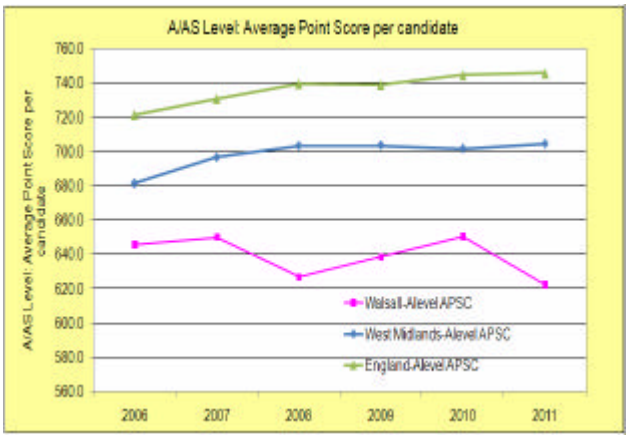


Figure 18 A/AS Level Average Point Score per candidate

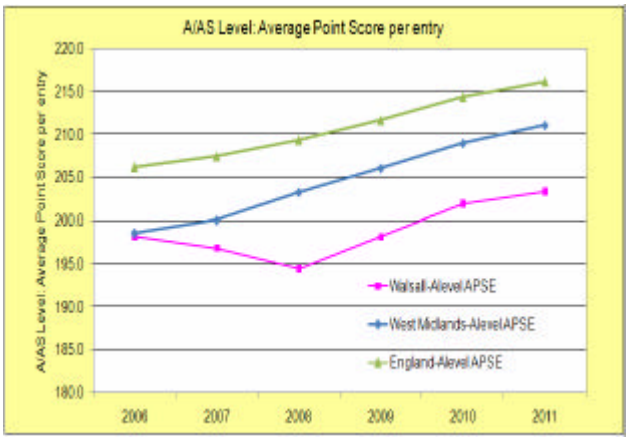


Figure 17 A/AS Level Average Point Score per en

(Fig 17 & 18; Local Authority Interactive Tool – Accessed 31/1/12)

Over the period 2007 - 2011 the percentage of pupils in Walsall attaining 5 + A* - C, including English and Maths has risen by 20 percentage points to 56%, with an increase of almost 7 percentage points to 56.3% between 2010-11. This is better than the national rate of improvement of 5.5%. Based on these results Walsall is ranked as the 8th most improved authority in the country. Currently validated data is not available to identify specific groups of pupils that do not achieve as well as national.

Since 2007 there has been a steady decline in the number of pupils in Walsall being entered for A/AS Level qualifications. This has coincided with the increase in popularity of vocational courses being studied in Walsall which has led to a decrease in the average amount of points per candidate that has been generated from A/AS Level qualifications over this period of time.

Recommendations

Currently our priority is to further analyse validated attainment data to identify specific groups of pupils that do not achieve as well as national performance and to engage the partnership in determining key actions. Priorities are;

- To identify where there is underperformance and target support and challenge at school and individual level.
- Promote and broker school to school support including the use of Advanced Skills Teachers (ASTs) and Local Leaders of Education (LLE).
- To extend the quality and range of programmes of study available to young people across the borough
- Provision of additional resources for young people who are liable to disengage from learning, training or employment with training – including more apprenticeships to support post 16 provision

2.1.2 School attendance

School attendance is crucial to future well-being, as it is linked to attainment and to social inclusion. Absence rates in both primary and secondary schools in Walsall are recorded through the number of half days missed, both authorised and unauthorised, by children of compulsory school age. Walsall is currently ranked 138th nationally placing Walsall in the bottom quartile.

Priority Indicator

In Walsall absence from Primary and Secondary remain consistently higher than the regional and national levels (see Fig 21 and 22). Absence for both primary and secondary is shown to be falling in line with the comparator averages since 2002.

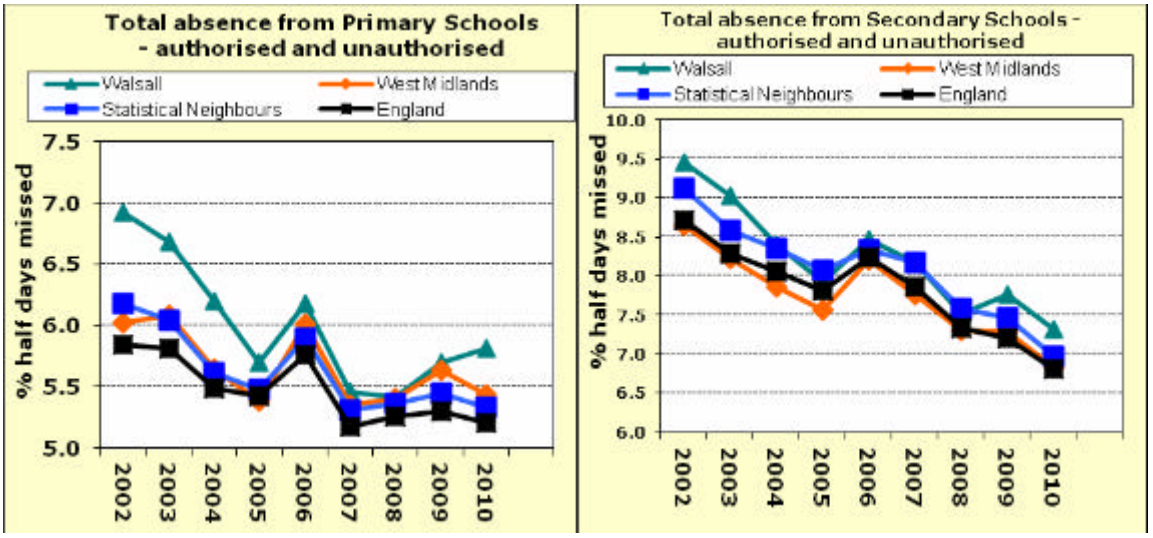


Figure 19 Primary school absences 2002-10 Figure 20 Secondary school absences 2002-10

(Data source: Local Authority Data Matrix, 4th Jan 2012)

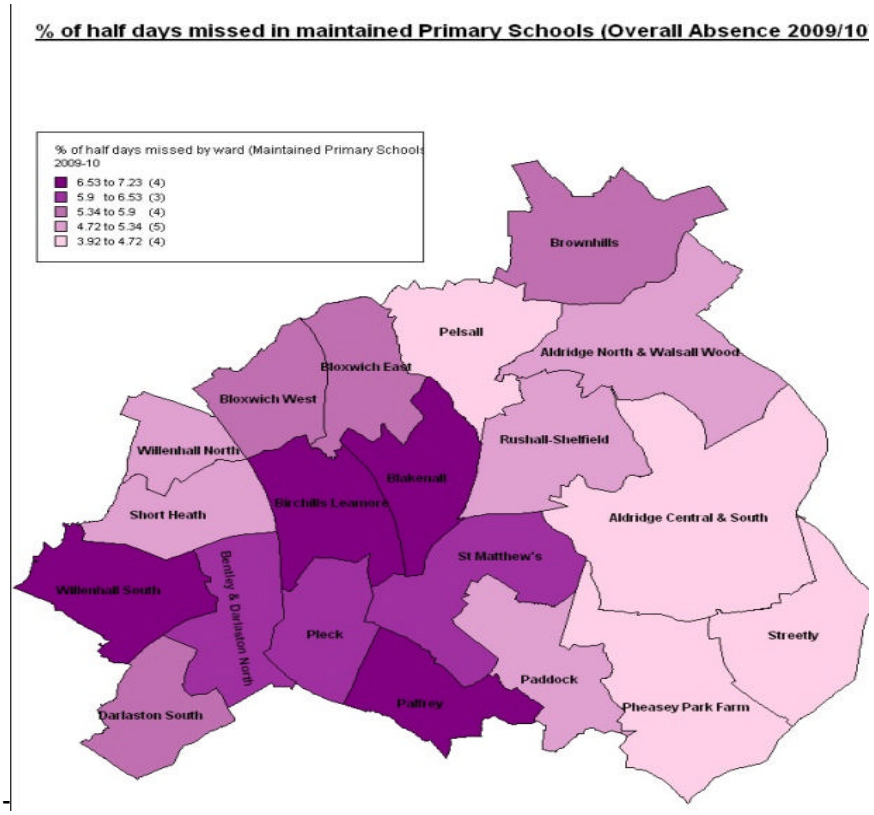


Figure 21 Primary School Absences by ward 2009/10

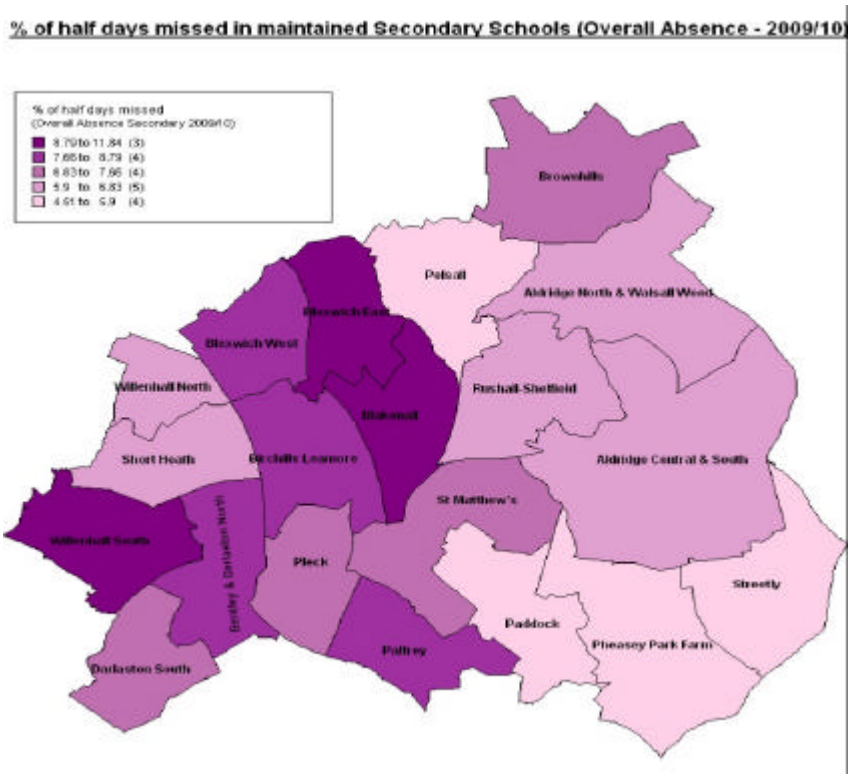


Figure 22 Secondary school absences by ward 2009/10 (Data Source: Office of National Statistics,

The wards with the top bands (darker shading) of half days missed through absence in both primary and secondary have higher levels of deprivation than the Walsall average. The wards with the lowest bands (lighter shading) have relatively lower levels of deprivation. The reducing trend for overall absence has followed regional and national trends. Walsall has been closing the gap between the national average since 2002.

Early indicators are that primary overall absence in 2010-11 has reduced further and the gap between the national average and Walsall has reduced to 0.39% based on Autumn and Spring data. The way absence is measured for secondary overall absence is changing significantly. Currently the measure relates to LA Maintained schools only and with the onset of new academies, the number of maintained schools has reduced. Year on year comparisons are not based on the same number of schools so the data will reflect this.

Recommendations

The impact of separating academy data from maintained schools has yet to be reported. However data suggests a trend of improving attendance supporting a continued focus through the current approach. These improvements have been secured through reorganised service provision and a traded service base. It is recommended that current service provision and strategic approach be maintained. The focus for future interventions will be;

- Continuing development of effective trading with schools to support a continuing reduction in absence
- Close dialogue with school improvement services through DSIN analysis to target interventions as required in the context of individual school autonomy

2.2 Healthy weight

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

Priority Indicators

The national priority indicator for obesity in Year 6 children is the prevalence of overweight and obese children in aged 10-11 year olds as highlighted in the Public Health Outcomes Framework. Walsall's overweight and obesity prevalence in Year 6 is 36.5% (NCMP data 2010/11) which is lower than Regional prevalence (37.0%) and the Black Country Cluster prevalence (38.0%) but higher than National prevalence (33.4%).

Locally Public Health proposes the priority indicator to be 44% of Walsall's primary schools will have had the Food Dudes programmes implemented by April 2013 (an evidenced based behavioural programme to increase the consumption of fruit and vegetables).

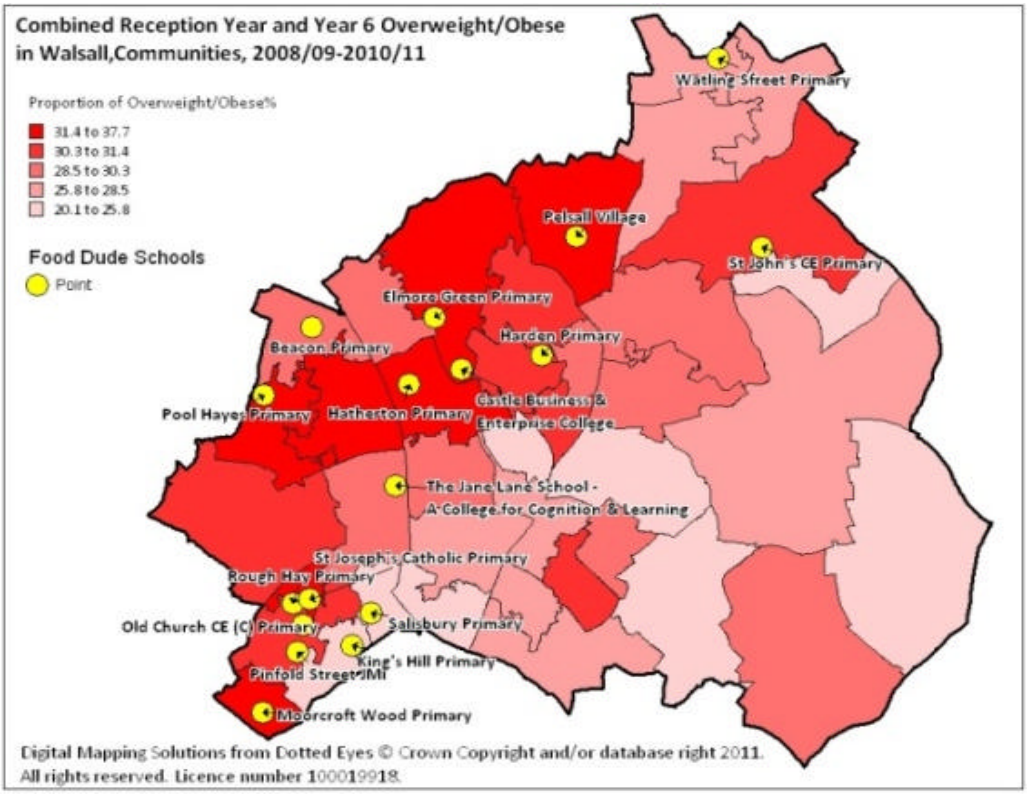


Figure 23 Walsall Combined Reception and Year 6 Overweight/Obese by community 2008-11 (Food Dudes schools highlighted)

Recommendations

Through Walsall's NCMP, children identified as being overweight or obese will continue to be offered support through weight management and physical activity programmes. Focusing on prevention is also paramount to tackling childhood obesity this will be achieved by partners working closely together to deliver early interventions. The focus should be on;

- Roll out the Food Dudes programme to all primary schools (an evidenced based behavioural programme to increase the consumption of fruit and vegetables).
- Developing a universal Walsall approach for the use of physical education within schools, as a means of ensuring healthy growth, appropriate skills, knowledge and motivation for later life and knowledge of healthy lifestyles.
- Ensuring that planning policies restrict the licensing of hot food takeaways in the vicinity of all schools within the borough.
- Ensuring that planning and transport policy and decisions improve the environment for health by promoting walking, cycling and active travel for school children.
- Continuing to provide free swimming for under 16s and working to provide healthy food in leisure centres and evaluating the impact of these.

2.3 Sexual health

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

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

Priority Indicator

A key indicator of the sexual health of young people in Walsall is the Chlamydia diagnostic rate for the 15 – 24 year old population. This provides a measure not just of background rates of infection, but also of how engaged young people are in reducing risks associated with unsafe sex. As the map indicates, the highest rates of infection are in young people living in the more deprived areas of the borough.

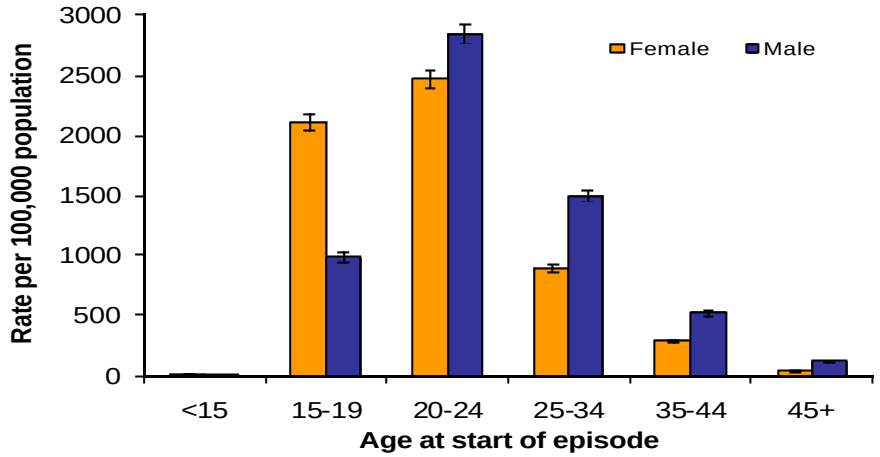


Figure 24 Rate of new STI diagnoses per 100,000 population by age, 2010

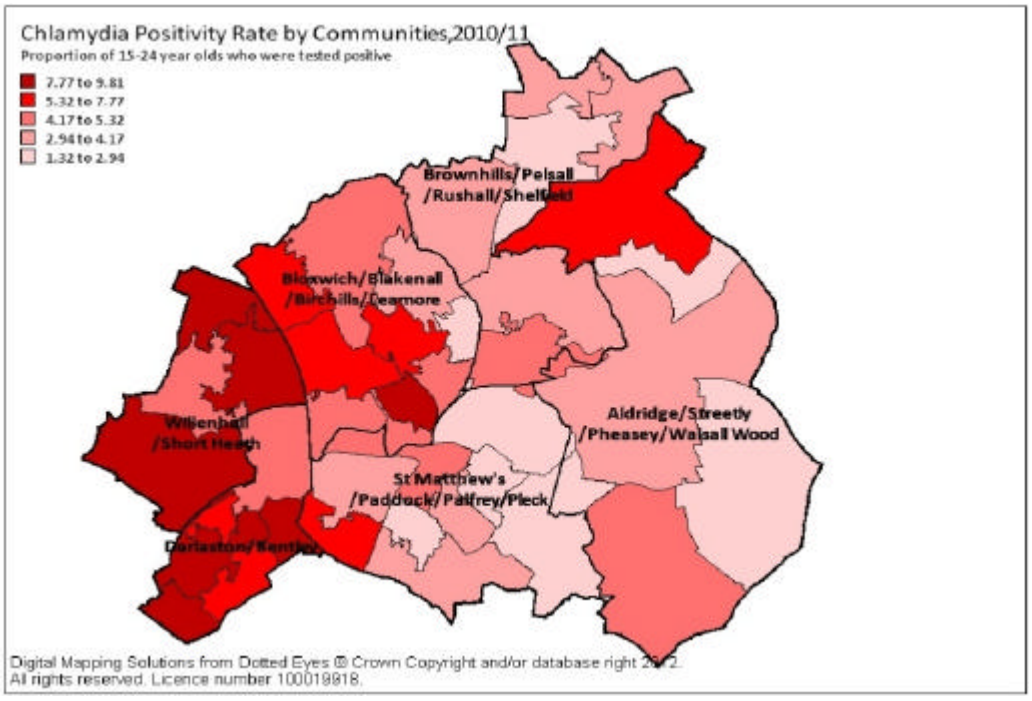


Figure 25 Chlamydia positivity rates by Walsall community 2010/11

Recommendations

- Ensure better collaboration between services which work with young people, including the Walsall Integrated Sexual Health Service, Youth Offending Teams, Looked After Children's Service, IYPSS and schools to ensure that appropriate high quality services are provided for the most vulnerable young people in Walsall.
- Improve marketing and communication of sexual health services and messages to young people
- Ensure appropriate outreach services are provided in Walsall to ensure gaps in healthcare provision are filled

- Ensure 'young person friendly' services that encourage and support access into mainstream sexual health services
- Redesign and re-launch of the Walsall Condom Distribution Service
- Further develop of the roles played by GPs, practice nurses and pharmacists
- Improve uptake of long-acting reversible contraceptives (LARC) amongst young people in Walsall

2.4 Teenage pregnancy

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

Priority Indicator

The Walsall rate in 2009 was 59.4 conceptions per 1,000 girls aged 15-17. In addition, Walsall achieved the 3rd lowest drop in rates in the West Midlands region from the 1998 baseline, a reduction of 11.6%. In 2009, England had a rate of 38.2 conceptions per 1,000 girls aged 15 to 17. This is a drop of 18% since the 1998 baseline. West Midlands rates were slightly lower with an average rate of 43.9 conceptions per 1,000 girls aged 15 to 17. Teenage conception rates at Local Authority level show a strong correlation with the Indices of Multiple Deprivation ($R^2 = 0.46$). As illustrated, Walsall rates are way above what would be expected based on deprivation (45.8 conceptions per 1,000 girls).

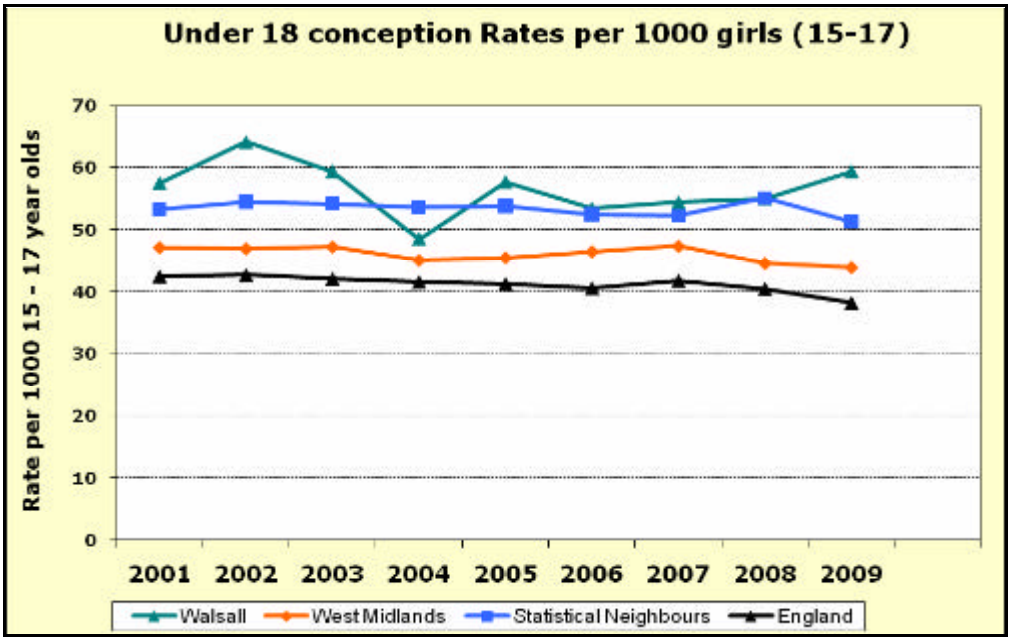


Figure 26 Under 18 conception rates per 1000 girls aged 15-17, 2001-09

Recommendations

- Develop a systematic approach to identifying early the risk of teenage pregnancy, in particular focussing on the areas of vulnerability that have been identified in recent case reviews.
- Implement planned expansion of schools work, in particular the creation of on-site services and engaging schools, Further Education and training providers to raise aspirations and deliver enhanced PSHE provision.
- Follow through the local sexual health needs assessment, moving to a 'hub and spoke' model and securing additional investment. .
- Implement plans to embed 'You're Welcome' quality criteria in GP Practices, to encourage young people to access primary care services.
- Further improve integration and coordination of support for young parents through the development of a tiered service model.
- A focus on workforce development ensuring raised awareness and understanding of issues related to teenage pregnancy and embedding referral pathways.

2.5 Parenting – Vulnerable children and safety from harm

All Local Authorities have a statutory duty to protect children and young people from harm. Following a comprehensive assessment carried out by Children's Social Care Services, if the child or young person is considered unsafe in their present environment, following a court decision (or voluntary arrangement with parents) Local Authorities take on the role of a "corporate parent" which involves placing the child/young person in suitable safe accommodation and the child/young person is then known as a "Looked After Child". Unfortunately many looked after children stay in care too long so the focus is increasingly to prevent the necessity of a child/young person coming into care or if they do come into care, to return them to their families quickly by placing the necessary support around the family.

Priority Indicator

In Walsall the rate of Looked After Children has been on an upward trend since 2007/8. The increase is in line with Walsall's Ofsted statistical neighbours and the increase can be seen in the national figures also. Walsall's LAC rates are above the regional average and above the statistical neighbour's average. However following the 2008 economic recession, Walsall now has the highest level of child deprivation within its own statistical neighbours group. Research shows that there is a link between the need in the

community (measured by deprivation levels) and demand to Children's Social Care Services. When this is taken account the number of LAC is appropriate to the level of need.

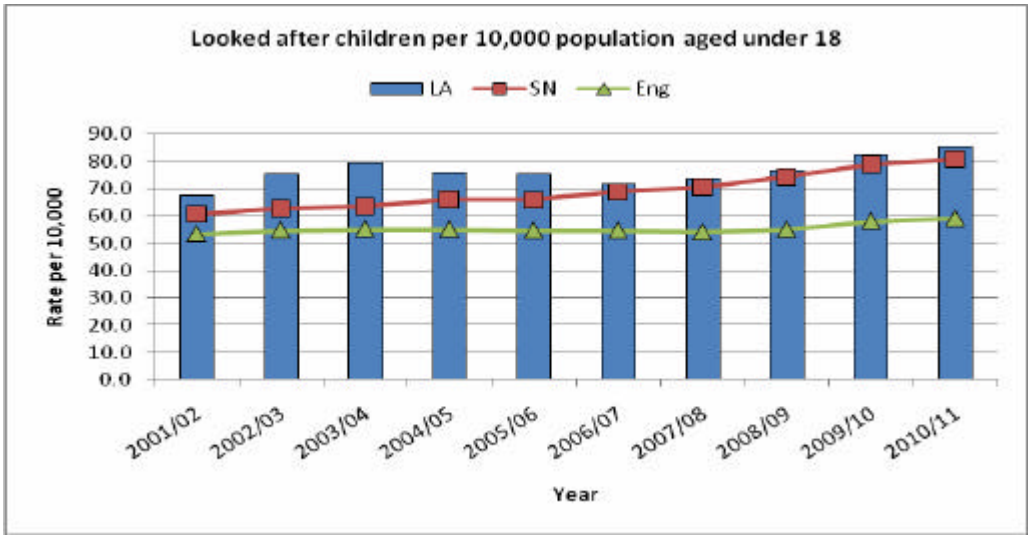


Figure 27 Walsall Looked After Children per 10,000 population under 18 – 2001-11
Data accessed: Local Authority Interactive Tool, 31st Jan 2012

Recommendations

- Reduce LAC to 477 by 2014 through service redesign in the New Operating Model
- Reduce 'step-up' by enhanced targeted prevention at Level 2 through new Area Family Support Teams and at level 3 by Think Family support to CPP
- Increase step down through Think Family support for earlier discharge
- Increase speed of permanency where appropriate
- Ensure that young people are prepared for and supported in their transition to adulthood
- Support the child or young person to participate in the wider network of peer, school and community activities to help build resilience and a sense of belonging
- Develop services that address health and well-being and promote high quality care delivered through integrated professional working.

2.6 Summary and Recommendations

Local areas of concern include;

- Rising numbers of children and young people in care in Walsall - A stable education built on high aspirations is essential to promoting

quality of life for looked-after children and young people. Transition to adulthood can often be traumatic for a young person in care. Without access to services to support this transition young people can end up unemployed, homeless or in custody, experiencing a downward spiral of rejection.

- Childhood obesity - Evidence indicates that carrying excess weight in childhood can continue through to adulthood and impact on a wide range of outcomes including increased risks of diabetes, coronary heart disease and cancer.
- Sexually transmitted infections - Chlamydia and genital warts being the most prevalent sexually transmitted infections in the 15-19 age groups.
- Teenage conception - rates have fallen to 59.4 per 1000 young women aged 15-17 in 2009. This is a decline of only 11.6% below the 1998 baseline. Critical to accelerating progress in reducing teenage pregnancy is improving young people's knowledge and use of effective contraception.

There is considerable evidence that health programmes in schools can have significant impacts on health outcomes, such as those targeting mental health and wellbeing, healthy eating and physical activity.

Key Priorities for Action:

- Prioritising reduction in social inequalities in pupils' educational outcomes and increasing educational attainment in deprived areas
- Build on recent improvements in the provision of evidence based parenting programmes, advice and assistance
- Reducing child poverty
- Reducing levels of child obesity by focusing on healthy eating and physical activity
- Reducing the number and rate of teenage conceptions, especially in deprived areas
- Schools continue to promote health and provide high quality PHSE
- Ensure that children, particularly those in care, have a stable experience of education that encourages high aspiration and supports them in achieving their potential
- Ensure that young people are prepared for and supported in their transition to adulthood.
- Develop services that address health and well-being and promote high quality care delivered through integrated professional working.

Chapter 3 Employment and improving employability

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

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

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

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

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

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

- The growing proportion of long-term claimants who are increasingly distanced from the labour market
- Inter-generational worklessness, where children grow up in households where no one works

- Low income and benefit dependency resulting in high child poverty levels
- Geographical areas of the borough where the problems of benefit dependency are even more critical than the borough as a whole, particularly around the town centre and North Walsall
- Those residents with health issues who are currently in employment and require more help and support to enable them to remain in employment rather than becoming dependent on benefits.

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

3.1 Adults

With over one in six working age residents out of work and dependent on benefits, Walsall faces a major challenge to increase the employment rate of local residents to a level which matches the averages for West Midlands and England. Current economic conditions make this more difficult than ever and there are too few jobs available for local people to access. Walsall is home to around 7,500 businesses – a shortage of 2,000 compared with the national average per size of adult population – and this means there are only 0.66 jobs per working age person, compared to 0.78 nationally. Many residents also lack the necessary skills to gain and sustain employment: 1 in 5 adults in Walsall has no formal qualifications.

Priority Indicators

Walsall has a resident working age population of 157,900 people aged 16-64 (ONS, mid-2010 estimate). Of these, 27,860 people are not working and are claiming an 'out of work' benefit (DWP, May 2011). These include:

- 10,090 unemployed people on Jobseeker's Allowance (JSA);
- Lone parents on Income Support;
- 12.900 people claiming Employment Support Allowance (ESA)/Incapacity Benefit (IB) customers;
- Others on income-related benefits.

This equates to 17.6% of the working age population, and is higher than the proportion in the West Midlands (13.6%) and England (12.1%). Although Walsall has seen some improvements in the numbers of people out of work from a high of 18.8% during the recession in 2009, the gap between Walsall and the West Midlands/England remains. The number of claimants of ESA/IB in Walsall has remained relatively stable over the past decade. In contrast, the number of jobseekers has seen major fluctuations linked to the state of the wider economy. There was a huge increase in unemployment claimants during the recession, when Walsall fared even worse than England overall

and still has not recovered – figures for the borough are currently twice as high as they were at the start of 2005.

As shown in Fig 29 below, the west of the borough is home to the majority of Walsall's benefit claimants, with Blakenall, Birchills Leamore, Pleck, Darlaston and parts of Bloxwich and Willenhall having the highest concentrations. There are also large differences in the rates of claimants between the west and the east of the borough. Near Walsall town centre, up to 45% of adults in some neighbourhoods are claiming out of work benefits, while in parts of Streetly and Aldridge the figure is below 4%. However, it should also be noted that there also pockets of low benefit dependency in the west of Walsall, and vice versa.

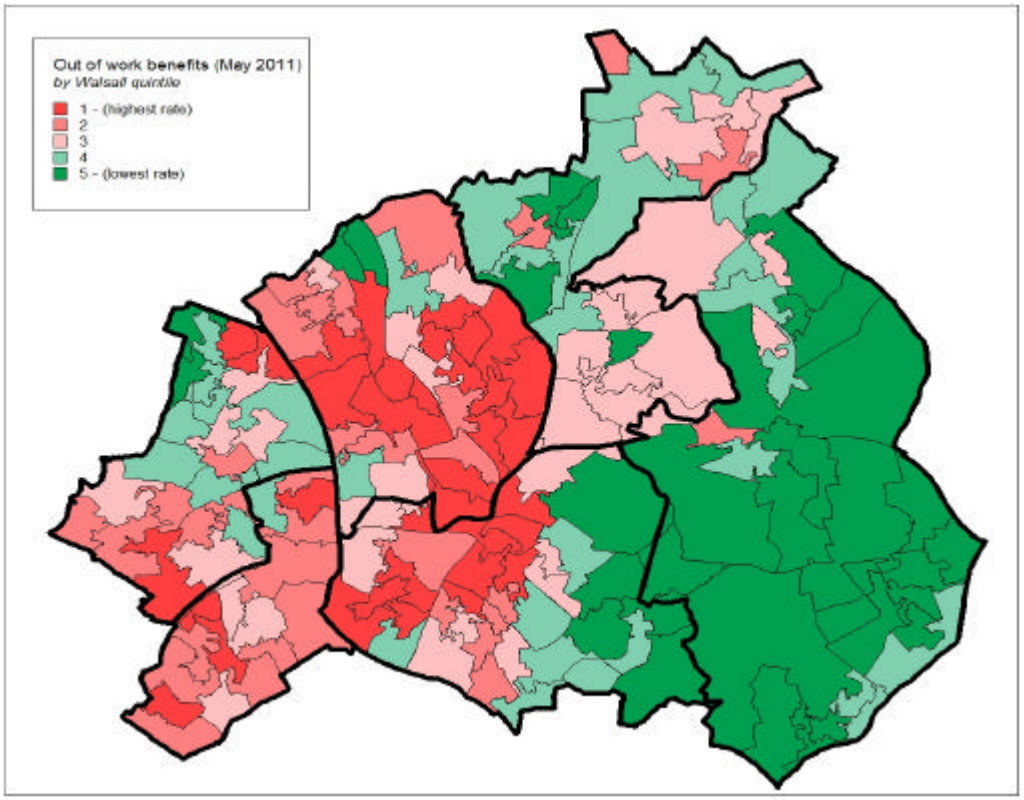


Figure 28 Walsall working age residents claiming out of work benefits by LSOA – May 2011

Recommendations

Walsall Council and its partners have a number of initiatives in place to tackle worklessness that complement mainstream provision, but it is essential to ensure that these are expanded. We need to:

- Increase the availability of jobs in the borough by encouraging enterprise and inward investment. These jobs must be at all levels and requiring different categories of qualifications
- Improve employability and access to job vacancies for local people

- Improve the skill levels and qualifications of local residents and matching these to the needs of local businesses
- Understand and tackle the barriers to work, including the problems posed by ill health

Bespoke employment support for those residents with poor health has been provided through Working Neighbourhoods Fund and initiatives like the Walsall Mental Health Intermediate Labour Market. This initiative placed unemployed residents who suffered/had suffered from mental health issues with an employer for a six month work placement with training. Further support was provided to sustain them into long term employment. It is these types of initiatives that, where successful, need to be sustained and the models replicated. Current examples include:

- Walsall Absence Management Service - a preventative health programme providing early assistance to those employees in danger of becoming long term sick and /or even incapacity benefit claimants.
- Pilot Benefits Advice – providing small and medium sized businesses with funding to purchase equipment and make modifications to enable new recruits with a physical disability or health issues to take up and sustain employment.

3.2 Young people

Young people aged 16 to 18 who do not participate in any form of employment or learning are popularly referred to as 'Not in Education, Employment and Training' - NEET. In Walsall, 7.9% of 16 to 18 year olds are NEET, equating to almost 700 young people. Two key factors that contribute to a young person becoming NEET are disadvantage and educational disaffection, which is manifested by low attainment.

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

In Sept 2011, 3,530 young people aged 18-24 were claiming JSA in Walsall. This means that over 15% of 18-24 year olds in the borough are unable to find work, compared with only 8% nationally. This is also more than double the rate of unemployment in Walsall's working age population overall. At the same time, long-term unemployment in the 18-24 age group is becoming an

increasing issue: in Sept 2005, 17% of Walsall's 18-24 JSA recipients had been claiming for over 6 months, but by Sept 2011 this had risen to 37%.

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

Priority indicator

Walsall currently has 697 16 to 18 year olds who are not in education, employment or training (NEET) (Prospects, October 2011).

The proportion of young people classed as NEET has fallen every year in the borough from 10.3% in 2005/6 to 7.9% in 2010/11. However, despite this achievement, this still remains above the figure for England (6.0%) and the borough also remains above the average for the West Midlands (6.2%) and its statistical neighbours (7.1%).

There are concentrations of NEETs in certain parts of the borough, with particularly high numbers in the West and North: in Birchills, Leamore, Blakenall, Palfrey, Brownhills, Darlaston South and St Matthews (see Fig 28 below)

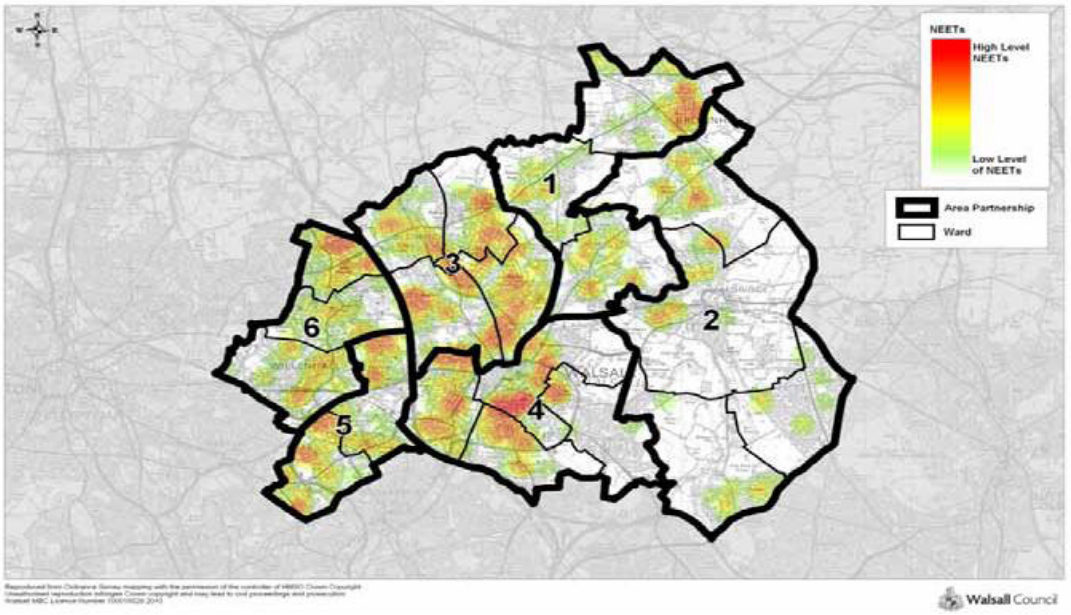


Figure 29 Walsall NEET 'hotspots' November 2010 (from Prospects 2010)

Young people who are NEET are not a homogenous group; some are much more prepared to take up the opportunities on offer to them, while some require much more intensive support. Prospects have identified 5 groups of 16-18 year olds, with particular characteristics and the type of provision potentially available to them. These groups range from those who are

'opportunity ready' – competent in the labour market, or, given the chance, willing to enter training or work – to those who have a particularly complex and challenging set of needs that must first be addressed before they can access opportunities.

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

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

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

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

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

Recommendations

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

- Links with Business – All education providers from primary schools through to further education need to be working closely with businesses in the borough to understand the qualities, attitudes and skills – besides formal qualifications - that young people require to be successful in the labour market.
- Apprenticeships – Apprenticeship schemes for young people who are 'opportunity ready' need to be expanded. One example of good practice is the extensive apprenticeship scheme at levels 2 and 3 that Walsall Council is currently developing. It will incorporate pre-apprenticeship work preparation skills for those who lack the confidence, experience or employability skills to sustain a traditional placement without some initial preparation and guidance.
- Intensive Support for Vulnerable Groups – Traditional formal education or apprenticeship schemes are often unsuitable for these groups as they require much more tailored and intensive support. Using teenage mothers and those with learning difficulties as examples, teenage parents often need up to date knowledge and information about benefits and housing advice and support. For those with learning difficulties or disabilities, twelve week classroom -based programmes do not give enough developmental learning time and a six month to one year structured programme which allows the young person to learn at their own pace and offers practical, workshop-based training in an informal setting would be far more beneficial.

There is currently also a gap in provision of training that offers real hands on work experience for young people with any sort of additional need, who would further benefit from mentoring and more 1 to 1 support.

3.3 Vulnerable groups

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

- Optimise life chances, health and well-being by reducing inequalities, maximising autonomy and prevention, and minimising dependence
- Ensure safety and protection, while enabling and managing risk
- Ensure the availability of accessible services that are empowering, socially inclusive and responsive to user preference
- Ensure a high quality workforce in adults social care and inclusion
- Deliver more efficient business processes that free up resources to give choice and control to users of services and that respond to changes in levels of need
- Ensure effective collaborative working to produce good outcomes for service users and support delivery of our shared objectives

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

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

Priority indicators

NI 145 – Just over a third of adults (aged 18-64) in the borough with learning disabilities and known to Walsall Council were in settled accommodation at the time of their assessment or latest review (provisional data for the period April 2010 - March 2011, collected by NHS Information Centre): equal to 240 out of 635 clients, or 37.5%. This is much lower than the 59.1% in England overall, and is also well below the West Midlands average of 51.7%. The percentage of female adults with learning disabilities in settled accommodation (40.9%) was higher than for males (34.7%), but again both were lower than the national and regional average.

NI 146 – Around 1 in 10 adults (aged 18-64) in the borough with learning disabilities and known to Walsall Council were in paid employment at the time of their assessment or latest review (provisional data for the period April 2010 - March 2011, collected by NHS Information Centre): equal to 60 out of 635 clients, or 9.5%. This figure is higher than the 6.6% in England overall, and

also better than the West Midlands regional average of 5.5%. The percentage of female adults with learning disabilities in paid employment (7.6%) was lower than for males (11.1%), but again both were higher than the national and regional average.

NI 149 – 71.9% of the 64 adults with mental health problems aged 18-69 in contact with secondary mental health services in Walsall were known to be in settled accommodation at the time of their assessment or latest review (informed by 2010 – 2011 data, supplied by NHS Trusts providing specialist mental health services). This is higher than the average for England of 66.8%

NI 150– 6.3% of adults with mental health problems aged 18-69 in contact with secondary mental health services in Walsall were known to be in paid employment at the time of their assessment or latest review (informed by 2010 – 2011 data, supplied by NHS Trusts providing specialist mental health services). This is below the average for England of 9.5%.

Recommendations

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

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

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

- The 'Supporting People' Programme: This national government programme provides housing related support to the most vulnerable client groups, helping them to live independently in their own homes and linking directly into activity that improves their economic well-being. The programme is delivered through a partnership between the Council, Health Service and Probation Service

- Employment Strategy and pathway: The Joint Commissioning Unit is currently developing an employment strategy and pathway that includes newly commissioned services to improve opportunities for adults with learning disabilities, physical and sensory disabilities and autism.

- Walsall Vocational Service: This service is delivered by Dudley & Walsall Mental Health Partnership NHS Trust and supports individuals with severe and enduring mental health problems to gain and sustain employment. The team are currently piloting the Individual Placement and Support approach as it is known to be more successful in supporting people to move into competitive employment and has a sound evidence base to support that understanding. The service is aiming to gain 'Centre of Excellence' status for this model from the Sainsbury's Centre for Mental Health.

- Walsall Residential Service offering Crisis and Respite beds: This service supports people with severe and enduring mental health problems who are in crisis or perhaps need support on an ongoing basis to manage their mental health problems. It is delivered by Walsall MBC in partnership with Dudley & Walsall Mental Health Partnership NHS Trust. Service users can access crisis beds in times of need when a hospital admission is not required, or can access respite beds as an ongoing support mechanism to manage their mental health symptoms. In order to improve the economic well-being of individuals who are in crisis and therefore accessing this service, it links directly with specialists from Walsall's Vocational Service who provide employment retention advice or support for those seeking employment.

3.4 Summary and Recommendations

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

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

- Recognise the medium and long-term impact in terms of physical and mental health, as well as economic outcomes, that unemployment has on people and ensure that, in a period of limited resources, there continues to be joined up thinking, strategic commitment and targeted action to reduce unemployment in the borough.
- Ensure that in seeking solutions to the challenges we face, we recognise the unique nature of some of those challenges in Walsall and seek to be creative and innovative in our approaches as well as employ evidence based good practice that is working elsewhere.
- Ensure that necessary courses and training are available to local residents to enable them to improve their skill levels and qualifications in order to access job vacancies and gain employment.
- Increase the availability of jobs in the borough requiring the full range of qualifications.
- Ensure we understand the needs of our most vulnerable and disadvantaged residents and recognise that other needs may need to be met before an individual is ready to seek employment.
- Understand the nature and complexity of the barriers that local people face when trying to access work and the effect on the individual and their families.
- Identify resources to remove or reduce barriers to work or support local people to gain the necessary, knowledge, skills or confidence to overcome them, particularly those posed by physical and mental ill-health and inexperience due to age.
- Provide incentives to employers and schemes that enable our most disadvantaged residents to enter and sustain employment

Chapter 4 Creating and developing healthy and sustainable places and communities

Well-being has close links with the quality of the physical and social environment in which people live, which in turn, is linked with the levels of deprivation in the community. Healthy, sustainable communities are promoted by factors such as, good quality housing, access to green spaces and public transport, good quality food, supported by community participation and social networks. Strategies to build stronger, healthier communities must improve both the physical and social environment. Social networks and links between individuals help to build social capital which improves resilience and well-being in both the individual and the community.

This chapter introduces social determinants of health and well-being, including deprivation, environmental pollution, housing issues, building stronger communities, community safety and crime. The Marmot review recognised the importance of both the physical and social environment in the following priorities;

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

4.1 Deprivation

The Indices of Multiple Deprivation 2010 (IMD) is a Lower Level Super Output Area (LSOA) measure of deprivation and is made up of the following 7 domain indices: income, employment, health and disability, education skills and training, barriers to housing and services, living environment and crime. Developed by the Communities and Local Government, it is a nationally recognised measure across England and Wales.

Priority Indicators

In 2010, Walsall was ranked as the 35th most deprived of the 326 Local Authorities in England. This position has worsened since the last data release in 2007, where Walsall ranked 45th. The borough fares particularly badly in terms of education, income and employment deprivation. Central and western parts of the borough are typically more deprived than the east. However, while some parts of the

borough such as Blakenall are among the most deprived in the country, others rank within the very least deprived (see figure).

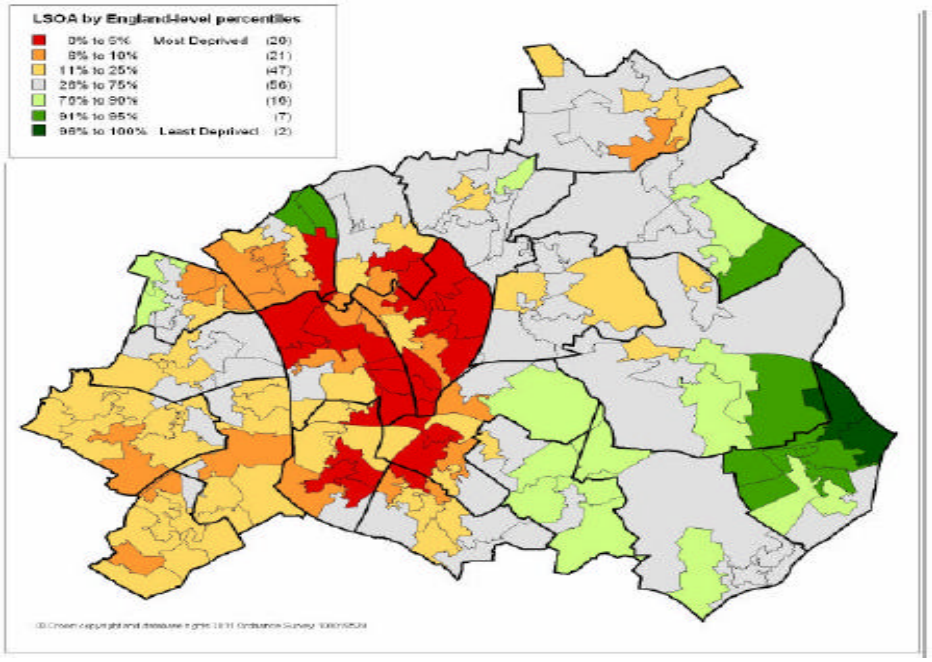


Figure 30 Walsall LSOA deprivation by England percentiles

114,788 (44.6%) of Walsall's total population (2010 mid-year estimates) live within the most deprived quintiles compared to 30,384 (11.8%) living in the least. Looking specifically by age, 28,083 (52.3%) of 0 to 15 year olds live within the most deprived quintiles in Walsall and 16,089 (35.5%) of over 65's. This compares to 4,948 (9.2%) of 0 to 15 year olds living within the least deprived quintiles in Walsall and 7,046 (15.6%) of over 65's (See Appendix 1 for ward deprivation ranking).

Recommendations

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

In order to reduce inequalities in health there is a need to achieve a more rapid improvement in health and well-being for people living in the deprived areas than those living in the more affluent. Partnership agreement is needed on 'priority areas' based on a super output area analysis of need to enable targeting of resources and action in areas of greatest need.

4.2 Housing

Homelessness is both a cause and effect of poor physical and mental health. Where homelessness is threatened, worry and stress can exacerbate existing health problems and children admitted to temporary accommodation are at a greater risk of developing behavioural problem, stress, infections and poor sleep.

The local authority accepts a statutory duty towards households who are homeless through no fault of their own and in priority need. Broadly speaking, this includes households with dependent children, individuals who are acutely ill, fleeing domestic violence or who are young or elderly.

Prevention of homelessness and facilitating access to alternative housing are clear priorities in the Council's Housing Strategy. The Council's focus on early intervention and prevention has seen 938 households prevented from becoming homeless in 2010/11; statutory homeless acceptances have decreased by 65% in the last 5 years down from 331in 2005/6 to 116 acceptances in 20010/11. Corresponding reductions in households placed in temporary accommodation have also been achieved and bed and breakfast usage eliminated for all but emergencies.

The main reasons for homelessness in Walsall that continue to dominate are:

- Friends and relatives not willing or able to provide accommodation
- Relationship breakdown, including those caused by domestic abuse
- Mortgage repossessions
- End of a private tenancy

Rough sleeping is the most extreme form of homelessness. There are estimated to be 12 people sleeping rough in Walsall. Most are older, single people who do not meet the statutory threshold for assistance; many have been evicted in the past from accommodation for behaviour issues associated with drug and or alcohol abuse or have undiagnosed mental health problems. Poor diet, lack of clean and safe accommodation and the impact of substance misuse make this group more vulnerable to certain health problems.

There are a number of evidence based interventions that the Council, registered Housing Providers and partners are currently working on together in order to reduce the incidence of homelessness in the Borough. These include:

- A sanctuary scheme providing security measures to keep victims of domestic abuse safe and secure in their own homes

- A bond scheme to help households who are homeless or threatened with homelessness to find quality accommodation in the private rented sector
- A court desk to provide advice to homeowners facing repossession due to mortgage arrears
- Agreement of Walsall's Severe Weather Emergency Plan which will see the Council work with voluntary and community sector partners to prevent rough sleeping through the provision of appropriate accommodation and support
- Development of a new housing strategy for the Borough. This will incorporate actions to increase the supply of affordable housing, improving access to affordable privately rented homes and strengthening the work undertaken to support clients to sustain a tenancy
- Establishment of a jointly funded nurse practitioner post to improve the health of homeless households.

Priority Indicators

The primary indicator is the number of households accepted as homeless to whom the Authority owes a statutory duty[1]

The latest information indicates a rate of 1.14 per 1000 households for Walsall compared with 3.8 for the West Midlands and 2 for England.

Table 772: Homeless households accepted by local authorities, by Region and Table 784: Local authorities' action under the homelessness provisions of the Housing Acts: Financial year 2010-11 (Revised)

Recommendations

Current initiatives and planned activities are focused on three key areas:

- Preventing homelessness
- Reducing rough sleeping
- Improving the quality of temporary accommodation.

It is essential that the current partnerships existing between the Council, registered Housing Providers and their partners such as Health, the police, the voluntary sector etc continue to flourish and strengthen in order that this work maintains its focus and can pool the available resource effectively and efficiently

[1] Link for all homeless statistics: http://www.communities.gov.uk/housing/housingresearch/housingstatistics/housingstatisticsby/homelessnessstatistics/livetables/

4.3 Transport

4.3.1 Access to public transport

Access to Transport is important for accessing vital services such as Health and fitness services and also fresh food. Encouraging the use of sustainable forms of transport is also important to encourage walking and cycling rather than the door to door culture of car use. Both of these areas have clear links to the health of the population. Access to services was an indicator in West Midlands Local Transport Plan 2 – with access to hospitals used to show this.

Encouraging sustainable use of transport to give good accessibility will promote a healthy population with less obesity and less pollution.

Priority Indicator

Until April 2011 the authority was still monitoring levels of accessibility jointly on a Metropolitan Area level through the West Midlands LTP Indicator LTP1b

"Increase the total population within thirty minutes inter-peak travel time of a main NHS hospital by 'accessible' public transport by 50% by 2011".

This links in closely with the National Indicator NI175 Access to Services and Facilities. Our NI175 figure (population within 30 minutes of a main hospital by "accessible" public transport" – largely our Bus Showcase routes) is calculated using Accession.

Year	Total Population
2005 Baseline	252,571
2006	402,540
2007	428,941
2008	450,731
2010/11	434,312

West Midlands Local Transport Plan 3 has set new targets. The related targets are:

- Safety & Security on Public Transport
- Public Transport Trips to Centres
- Active Travel
- Travel to School
- Access to Employment

Recommendations

Transport is but a means to an end. One of the main aims is to give people access by sustainable means to essential services. Walsall

Council officers will work with partners to increase access for Walsall residents through:

- Local Sustainable Transport Fund
- Bus Network Reviews and other bus measures – North Walsall and West Walsall are complete and South Walsall is programmed in for the next few years.
- Work through the West Midlands PEG Accessibility Planning Working Group which has looked at using accession software to map access to employment and services as well as health and fresh food. This work will continue into the foreseeable future.

4.3.2 Road traffic accidents

During 2010, 555 personal injury road traffic accidents occurred on Walsall roads. Five of these accidents involved fatalities and another 60 involved serious injury, the remaining 490 were slight in severity. Each accident involved one or more person being injured and there were a total of 773 casualties including 6 deaths, 68 serious injury and 699 receiving slight injury.

Road traffic accidents impose a range of impacts on people and organisations, including pain, grief and suffering, lost economic output, medical and healthcare costs, material damage, police costs, insurance administration, legal and court costs. The total costs for these collisions were approximately £32 million of which approximately £1.9million would be directly attributable to medical and ambulance costs[2].

Priority Indicators

Previously two indicators were used nationally to report on road casualties:
NI47 - People killed or seriously injured in road traffic accidents and NI48 - children (aged under 16 years) killed or seriously injured (KSI) in road traffic accidents;

Performance against these targets required a 40% reduction in the 1994-98 baseline for NI47 and a 50% reduction over the same baseline by 2010. Locally both of these targets have been met in the previous year although the final figures for 2011 are still to be determined.

However, with the recent introduction of the Strategic Framework for Road Safety all national indicators and targets have been replaced

[2] The Accidents Sub-Objective TAG Unit 3.4.1 April 2011.

with a series of road safety outcomes and casualty forecast levels which represent neither a target nor a definitive forecast. It should be noted that the Governments Transport Committee has decided to undertake an inquiry into the new framework and this is now ongoing.

Regionally through the West Midlands Local Transport Plan 3 a new indicator has been adopted which is to reduce the number of people killed or seriously injured in road traffic accidents by 17.3% between the baseline 2005-09 average and the 2011-15 average.

Recommendations

Road safety continues to be an important influence for Public Health and the future changes in the structure and delivery of Public Health may support improved integration across this field. Focusing on prevention is paramount to tackling road safety this will be achieved by working closely with partners to deliver a range of interventions including:

- To identify synergies as part of the review and integration of Public Health functions
- To develop stronger partnership working in this area through continued support for Walsall's Area Road Safety Partnership
- Support the Local Authority in undertaking an annual review of collisions to identify trends and patterns to be addressed through implementing a programme of engineering, education and enforcement
- Support work targeting key vulnerable road users such as the elderly, children particularly those from deprived areas as well as the more vulnerable modes of transport such as cycling and motorcyclists.

4.4 Building safe and strong communities

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

Walsall's Area Partnerships bring together local people, Council and partner services and the community and voluntary sector to make

Walsall a place where residents can live, work and play. There are six Area Partnerships in the borough; each has a dedicated Area Manager to facilitate local partnership working and each has an Area Community Plan to tackle the key issues and priorities in the locality.

The Area Community Plans describe a wide-range of issues which affect our neighbourhoods. Issues have been identified by consulting with local communities and by examining health profiles and other data. Epidemiological data provides high level needs at Community level, and communities themselves provide evidence of local need and issues which impact on their lives. A wide range of interventions are in place and a number of different partners are leading on activity and/or assisting in the delivery of activity. Over 1,200 actions have been identified across the six Area Partnerships. Area Partnerships aim to involve a wide range of Council services and partner agencies, as well as residents, to resolve these issues and ensure that the outcomes are sustained at a local level.

Priority Indicators

Some issues, such as anti-social behaviour hot spots, are very localised and require an immediate operational response. Others such as reducing obesity in children and young people are more strategic in nature and require a number of short, medium and long term responses designed to achieve a longer term goal.

There is no single priority indicator that measures how communities are being strengthened through this approach; though activity locally is assisting in working towards a range of key indicators for partner agencies.

Through the Walsall Intelligence Network, data collection and analysis is being brought together across partners to provide timely and relevant intelligence at both a strategic and local level. This will enable partners to focus resources on real areas of need.

Recommendations

Some of the issues identified are long-standing and complex and a number of agencies will need to work together to resolve them. As Area Managers work directly in the Areas, issues have surfaced where partner agencies are working independently, rather than together.

- Integrated planning and closer working is needed to ensure effective activity and better outcomes for residents.
- Following the successes of the Area Partnership approach in dealing with localised and operational issues, there is now a

need to develop the borough-wide area partnership approach to tackling strategic priorities.

4.5 Community safety and crime

The Walsall Community Safety Plan outlines the strategic priorities for the borough, based upon the findings of the strategic assessment, a refresh of which is currently underway. The following themes feature within the 6 priorities;

- Incidents of domestic violence
- Rates of violent crime
- Reduction in proven reoffending

The coalition government has dispensed with many of the indicators against which performance was previously measured, therefore much of the data collected before is no longer held. Similarly, the Place Survey has also ceased. Perception levels are currently collected through police surveys such as 'Feel the Difference' and through localised consultation (such as the recent Town Centre survey), which forms part of targeted activity. The 'Your place, your well-being: Walsall Household and Lifestyle Survey' will provide up to date information about residents' views and priorities.

The impact of other changes such as those concerning Police and Crime Commissioners and their role in budget holding and priority setting have yet to be assessed.

Priority Indicators

- People killed or seriously injured on roads - Between 1st November 2010 and 31st October 2011 there have been 63 fatal and serious road traffic collisions within Walsall compared to 68 during the same period the previous 12 months.
- First time entrants to youth justice - Between 1st October 2010 and 30th September 2011 the Youth Offending Service dealt with 208 new first time entrants in Walsall compared to 192 during the same period the previous 12 months.
- Incidents of domestic violence - Between 1st November 2010 and 31st October 2011 there have been 3474 domestic incidents within Walsall compared to 4072 during the same period the previous 12 months.(Police data)
- Rates of violent crime - Walsall currently experiences 17.5 violent crimes per 1000 residents.
- Reduction in proven reoffending - Below is data available for reoffending rates for Walsall, based upon Probation service case-load.

	31-Mar-10	30-Jun-10	30-Sep-10	31-Dec-10	31-Mar-11
Actual Re-offending	358	358	339	315	289
Caseload	3,934	3,934	3,739	3,624	3,559
Actual Re-offending Rate	9.1	9.1	9.1	8.7	8.1

Recommendations

- Road Traffic Accidents - require co-ordination between relevant sectors in order to ensure effective integrated action.
- First time entrance to Youth Justice – a multi-agency approach to working with young people, addressing the needs of them, their families and their communities. Early recognition of need and timely intervention are key and delivered through the coordinated input of agencies e.g. via IYPSS, Area Partnerships and the soon to be launched Vulnerability Forum. Greater coordination is now apparent and must continue to develop.
- Incidents of domestic abuse - Integrated pathway and development of a commissioning model currently underway - data held by services can be unclear and inconsistent i.e. police data doesn't match WDVF, requiring further work.
- Rates of violent crime - This is a recurrent strategic priority made up of diverse elements. Key areas currently identified:
    - Emerging gang/collectives culture – issues currently being mapped and local response developed.
    - Domestic Abuse amongst young people - work developing through Children's Services and partners within Walsall DA Steering Group to promote healthy relationships.
    - Evidence of alcohol fuelled violence - particularly within town centre/ night-time economy - gap in tackling street drinking and addressing perceptions.
- Reduction in proven re-offending - Preventing reoffending underpins all strategic priorities, but greater coordination and sharing of data still required. IDOM project will form part of coordinated response to vulnerability (both in terms of victims and perpetrators).
- Older people's perceptions of community safety - Anecdotal evidence suggests that older people continue to hold perceptions that rates of crime and anti-social behaviour are high and informing negative perceptions remains a challenge with dwindling resources for consultation. Targeted communication is delivered throughout the year on key themes, but this needs to be on a very local basis i.e. street/neighbourhood information. Community cohesion issues are emerging around lack of knowledge about migrant

communities and understanding/acceptance of different lifestyles, often reported as anti social behaviour.

4.6 Environment Inequalities

Air pollution - It is estimated that in the UK poor air quality reduces life expectancy by an average of seven to eight months and is responsible for the premature death of up to 50,000 people a year[3]. Road vehicles contribute most to the public's exposure to pollutants, being responsible for up to 70% of air pollution in urban areas. Air quality is poorest in the most deprived areas of Walsall, particularly in the vicinity of the M6 motorway and this contributes to the health inequalities that exist in the borough.

Poor air quality leads to poor human health. Children and the elderly are most susceptible to the adverse effects that may include short-term respiratory difficulties or more serious impacts due to long-term exposure including permanent reductions in lung function. Air pollution has been linked to asthma, chronic bronchitis, cardiovascular disease and cancer; the resulting annual health cost is estimated at up to £317 billion[4]

Contaminated land - Due to its industrial heritage there are many sites across Walsall that may contain pollutants with the potential to harm health or pollute controlled waters. As part of its statutory duty, the council has been investigating the sites likely to contain contaminants and identifying those likely to present the greatest risk (see map below). There is clearly a prevalence of these sites in the West of the Borough, corresponding with areas of deprivation/reduced life expectancy.

The council is working within statutory limits to reduce peoples' exposure to contaminants by addressing these sites through the planning process and proactively through Part IIA of the Environmental Protection Act 1990. Through its regulatory responsibilities the council is also guiding industry in order to prevent future contamination.

Environmental Noise - Noise is an inevitable consequence of our society. Government policy is to promote good health and a good quality of life through the effective management and control of

[3] House of Commons Environmental Audit Committee Fifith Report, March 2010. http://www.publications.parliament.uk/pa/cm200910/cmselect/cmenvaud/229/22902.htm

[4] Priority Regulatory Outcomes A New Approach to Refreshing the National Enforcement Priorities for Local Authority Regulatory Services, Local Better Regulation Office, November 2011 http://www.lbro.org.uk/docs/priority-regulatory-outcomes-report.pdf

environmental, neighbour and neighbourhood noise as part of its Noise Policy Vision.

Noise exposure can cause annoyance and effects such as sleep disturbance that can impact upon mental health and quality of life. Emerging evidence recognises that long term exposure to some types of noise can additionally cause an increased risk of direct health effects including hypertension, ischaemic heart disease, poor cognitive development in school children and hearing impairment.

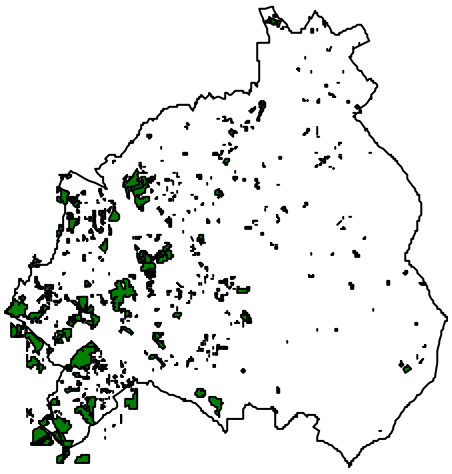
Noise policy aims to mitigate and minimise the impact of noise, thereby avoiding significant adverse impacts in terms of health and quality of life. The broad aim of noise management is to minimise noise as far as is reasonably practicable and to separate noise sources from individuals/receivers particularly sensitive to noise.

Priority Indicators

Air Pollution*:* Relevant indicators include:

- Reduction in the area of predicted exceedances of the NO_2 national air quality objective at relevant receptors/geographical area *per se*. over a set time frame.
- A reduction in NO_2 annual mean concentrations at defined Walsall MBC continuous air quality monitoring stations over a given period comparative to a 2010/2011 base year.
- A % reduction in NO_2 annual mean concentrations at defined Walsall MBC continuous air quality monitoring stations over a given period comparative to a 2010/2011 base year.

Contaminated land



Environmental Noise

Priority: Reduction in population exposure to road traffic

Map showing sites of potential concern re: land contamination

Map showing priority areas

Recommendations

- Air Pollution - Measures being taken by the local authority are recognised by Government as part of the Localism agenda and will need to be continued and developed. Ensuring that residents experience good air quality is an important factor in preventing ill health and is a particular challenge in urban authorities such as Walsall.

- Contaminated land

    - Ensure the remediation of land identified as having a statutory potential to cause harm to health.
    - Continue our research into those sites that have the potential to cause harm.
    - Continue to support the development control (planning) process to ensure that any new development is built in a way that protects future users of the site.

- Environmental Noise

    - Protect the residents of Walsall through implementing the Noise Action Plan West Midlands Agglomeration. This identifies current approaches to noise management, results of noise mapping, identification or problems/situations to be investigated, actions the Competent Authority has to take, and long term strategy for road traffic noise.
    - Target key arterial road network/M6 motorway, a 'First Priority and Important Areas'.
    - Identify 'Quiet Areas'.

4.7 Summary and Recommendations

Local areas of concern include:

- The level of deprivation in Walsall has worsened. In 2007 Walsall was ranked as the 45th most deprived of the 326 Local Authorities in England, it is now ranked 35th worst in the country.

- Walsall has areas of poor air quality, particularly in the vicinity of the M6 motorway and an industrial legacy of widespread land contamination.
- With the current difficult economic situation, increasing numbers of residents are at risk of homelessness or ill health associated with living in poor housing.
- Anecdotal evidence suggests that older people continue to hold perceptions that rates of crime and anti-social behaviour are high.
- Community cohesion issues are emerging around lack of knowledge about migrant communities and understanding/acceptance of different lifestyles, often reported as anti social behaviour.

Key priorities for action:

- Deprivation is deeply entrenched in Walsall and worsening in the current economic climate. Actions to mitigate this can be found in many theme areas of this JSNA, particularly those relating to education, income and employment deprivation. The value of initiatives designed to build resilience and well-being in our communities must be recognised alongside initiatives directly tackling identified environmental issues in order to ensure sustainability when successful.
- Partnership agreement needs to be secured on 'priority areas' to enable targeting of resources and action in areas of greatest need.
- We must continue to work within regulatory frameworks to reduce the impacts of environmental pollution in Walsall.
- We must ensure there is an integrated approach to enable residents to take positive action about their lifestyles in order to improve their health. This should include proactive planning to develop an environment that promotes walking and other forms of exercise.
- Integrated planning and closer working through the area partnership model is necessary to ensure effective activity and better outcomes for residents.
- A borough-wide area partnership approach to tackling strategic priorities must be developed.

Chapter 5 Strengthening the role and impact of ill health prevention across the life course: Mortality and long term conditions

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

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

Chapter 5 addresses the prevention, early detection and treatment of key causes of morbidity and mortality in Walsall.

5.1 Life expectancy

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

Priority Indicators

Typically life expectancy is higher in women than men. For women, Walsall is on a par with regional but lower than nationally, however the gap is reducing.
In contrast, male life expectancy is considerably lower in Walsall than regional and national figures and the gap appears to be widening.

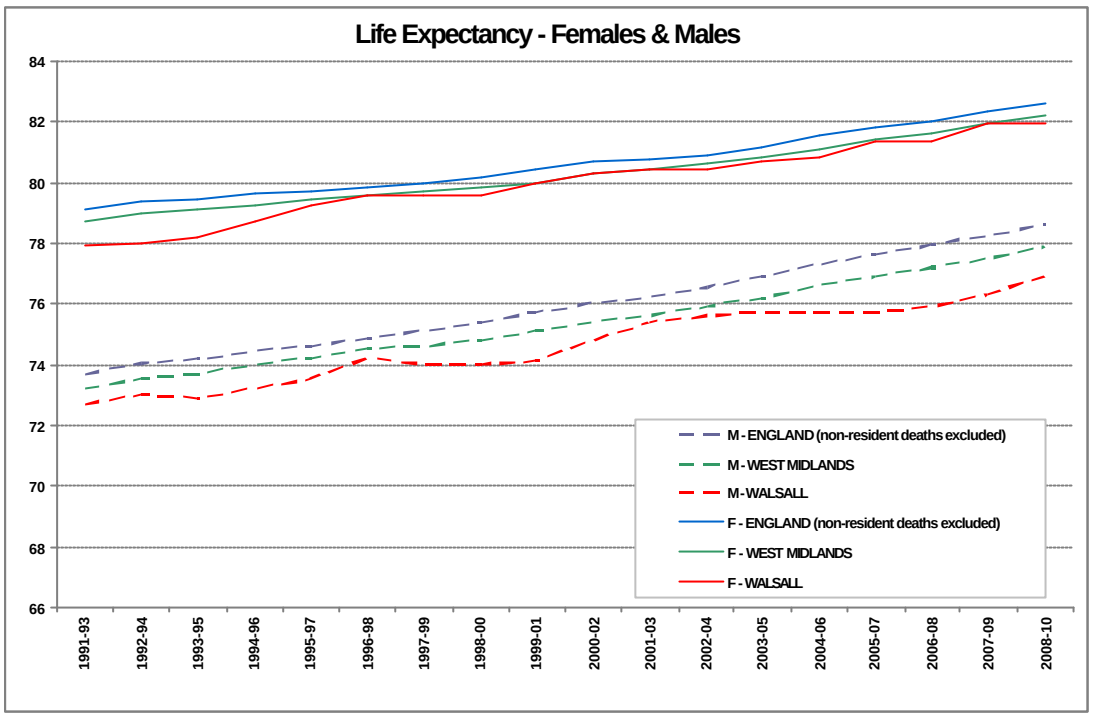


Figure 31 Trends in life expectancy 1991-2009

Recommendations

5.2 Mortality

Traditionally all age, all cause mortality is lower amongst females than males. Over the last few years it has gradually declined (but with the odd sporadic increases and decreases between 2005 and 2008) but remains higher in Walsall than regionally and nationally. Generally, levels of male mortality all ages, all causes have been less sporadic when compared to females. Levels are higher in Walsall (when compared to regional and national figures) and did increase in 2005 following several years of steady decline. However, 2006 figures illustrate a gradual decrease to narrow the gap slightly.

Priority Indicators

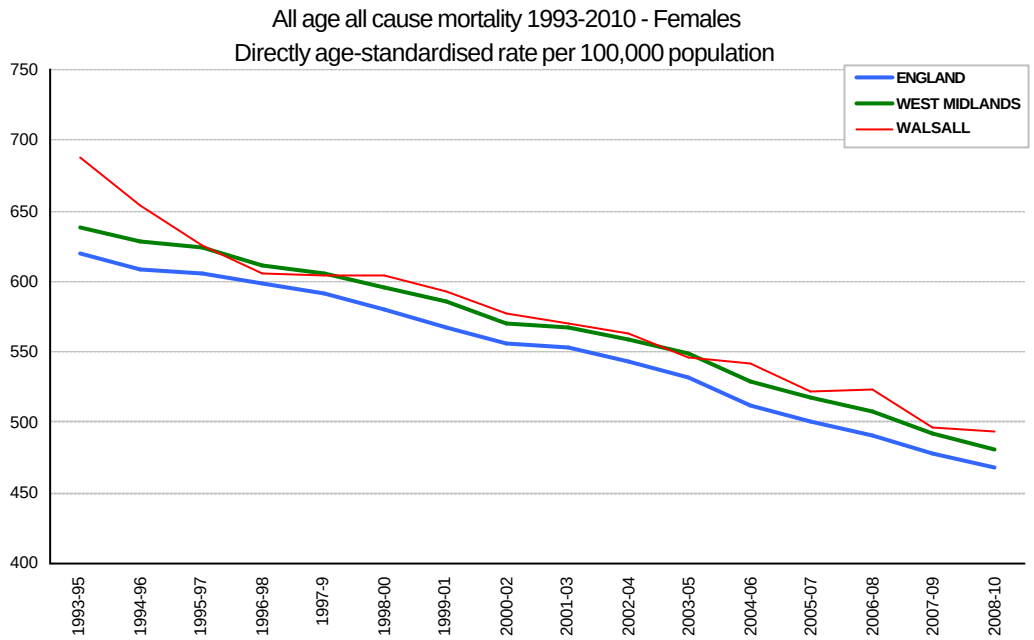


Figure 32 Female - All age all cause mortality trends 1993-2009

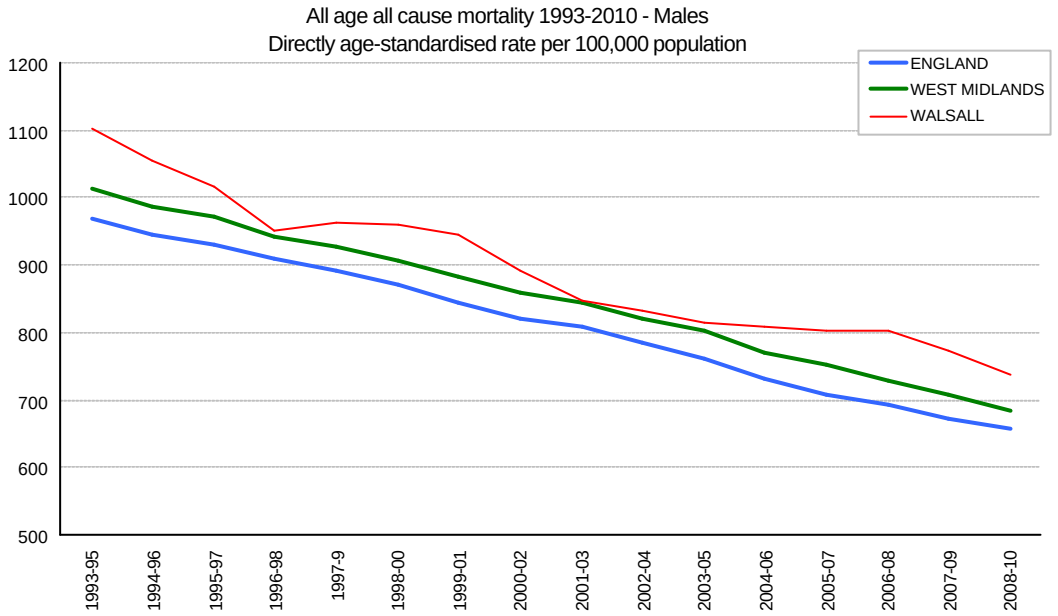


Figure 33 Male - All age all cause mortality trends 1993-2009

Recommendations

5.3 Cancer

Cancer is the leading cause of death in under-75s in Walsall. Over 27% of all deaths in the borough are due to cancer, almost 700 per year,

which is 54 more deaths than would be expected if Walsall had the same as the England average rates.

Priority Indicators

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

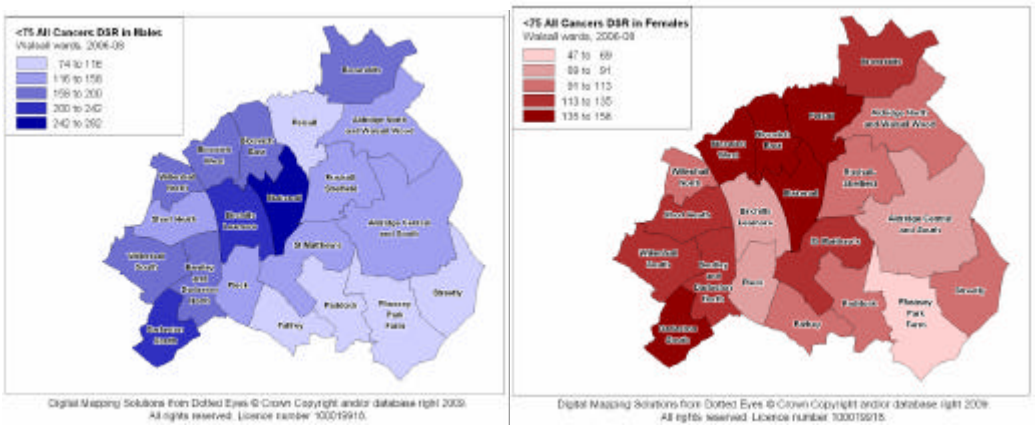


Figure 34 Under 75 all cancer DSR by community– Males (left) and Females (right)

Recommendations

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

National public health screening programmes are in place to support and improve the early detection and treatment of breast, bowel and cervical cancer. These are having a significant impact on cancer survival, but not everyone eligible attends. In Walsall in 2010-11, 50.8% of 60-69 years olds took up bowel screening (compared to a West Midlands average of 56.7%), 77.3% of women between 25 and 64 had cervical screening (West Midlands average 78%) and in 2009-10 75.2% of women between 53 and 70 had breast screening, compared to a West Midlands average of 77.2%. Recommendations to target areas of lower than average uptake will increase the numbers of people with cancer diagnosed sooner and hence treated when their cancer is at an earlier and more easily treated stage.

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

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

5.4 Heart disease

Coronary Heart Disease (CHD) is common but is a condition for which there are very strong evidence based interventions for prevention and for treatment. Whilst deaths from CHD have reduced in the past 10 years, the rates in Walsall remain higher than national ones. This means we still have too many people dying before reaching 75 years. Organisations and the population as a whole should redouble our efforts to implement the key actions which we know will reduce CHD.

Priority Indicators

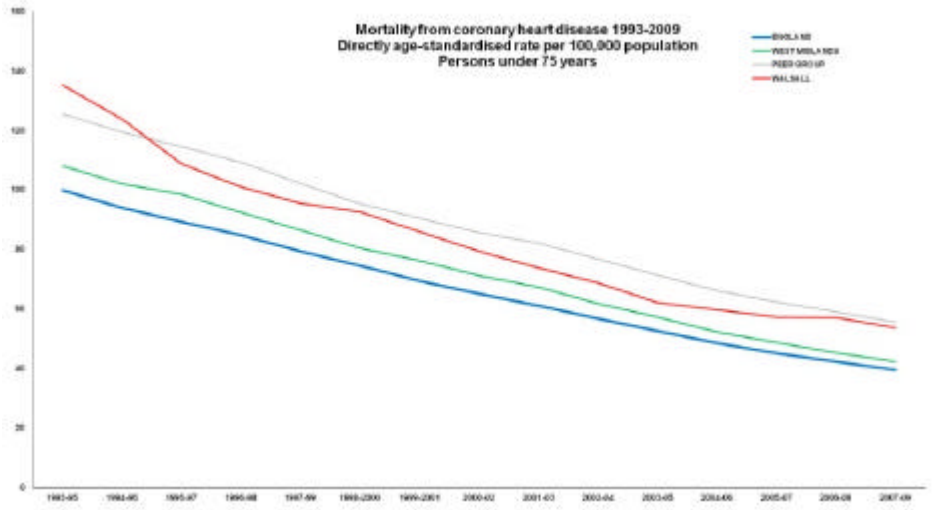


Figure 35 Under 75 Coronary Heart Disease Mortality DSR 1993-2009

Recommendations

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

- All partners to prioritise reducing levels of smoking in our population. This includes controlling tobacco, preventing children from starting smoking, supporting people to stop smoking. Key areas for action are in pregnant women. Major areas for opportunity are in the workplace.
- Commissioners of health services need to promote the aggressive identification and management of heart disease e.g. through the national health service health checks programme – a primary prevention initiative which identifies those at highest risk of developing heart disease and puts actions in place to reduce those risks.
- Maximise opportunities to promote more active lifestyles e.g. supported physical activity programmes for all ages
- Workplace Health -……..

5.6 Stroke

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

significantly reduce both death and disability. ***Figures for proportion of residents of nursing homes admitted because of disability and loss of independence following stroke.***

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

Priority Indicators

Key issues within Walsall include:

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

Recommendations

Key priorities are;

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

5.7 Chronic Obstructive Pulmonary Disease

Chronic Obstructive Pulmonary Disease (COPD) is a common group of disorders which includes chronic bronchitis and emphysema. About three million people in the UK have COPD and it is estimated that another half million people have the condition but have not been

diagnosed. The main cause of COPD is tobacco smoking, but other relevant causes include exposure within the mining and pottery industries.

Within Walsall, 5,548 people suffer from COPD. COPD mainly affects people over the age of 40 and becomes more common with increasing age. The average age of diagnosis is around 67 years and it is more common in men than women.

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

Priority Indicators

Traditionally, male mortality from bronchitis, emphysema and other COPD is higher than females – 26.6 compared to 41.8 in 2007- 2009. Rates in Walsall are higher than regionally and nationally but recent figures do show a reduction in the gap and over time, the rates have slowly reduced. Rates amongst females have seen a steady increase in Walsall from 2004-2006, peaking in 2006-2008. Recent rates for 2007-2009 have slightly reduced compared to the previous year but the gap between regional and national rates is greater than for males.

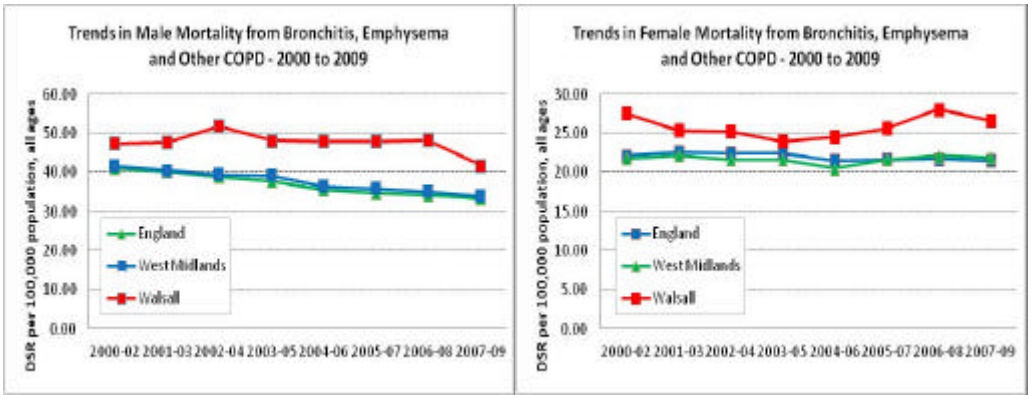


Figure 36 Trends in mortality from bronchitis, emphysema and other COPD, 2000-09 – Males (left) and females (right)

Recommendations

5.8 Diabetes

Diabetes mellitus (usually referred to as diabetes) is a common endocrine disease affecting all age groups. Within Walsall, a much higher proportion of the population suffer with this disease. The long term consequences of poor control are coronary heart disease, blindness, kidney disease, small nerve damage and peripheral vascular

disease leading to limb amputations. This is particularly aggravated by smoking. A significant proportion of diabetes could be prevented and there is an urgency to tackle this given the exponential increase in obesity over recent years. Effective control and monitoring can reduce mortality and morbidity.

Priority Indicators

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

Key actions from all GP practices and from patients themselves are required to address this.

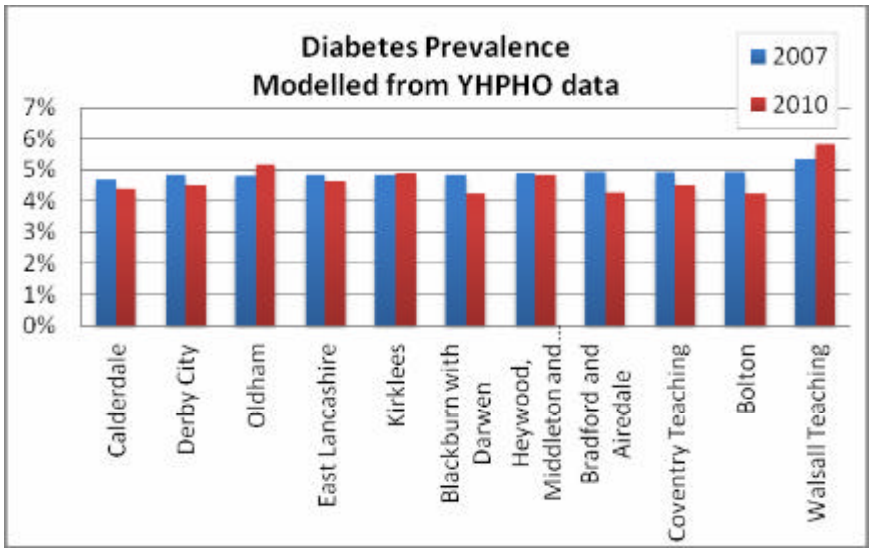


Figure 37 Diabetes prevalence – YHPHO data 2007 and 2010

Recommendations

- Implement robust pathways within the Acute Trust to identify and refer patients with Long Term Conditions to specialist weight management services.

- Commissioners to performance manage services for patients and to increase awareness amongst patients of the actions they should do to reduce long term complications.
- A recommissioning of patient education programmes coupled with actions to increase the percentage of those invited who take part is urgently required.
- Support for the new Clinical Commissioning Consortium to identify those patients at highest risk of complications should be offered from the PCT's clinical decision support team.
- A focus for smoking cessation for people with diabetes will reduce the complications of diabetes.

5.9 Mental health, well-being and suicide

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

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

Brief interventions in primary care and improved access to psychological therapies offer a one-to-one service to improve resilience and well-being. Particular subgroups may benefit in particular – for instance depression is common in patients who are diabetic.

There are around 55 deaths per year in Walsall in which mental health-related problems are the underlying cause of death. Around 22 people each year commit suicide in Walsall, though suicide rates are lower than the England average. However 75% of people who commit suicide have not had any contact with mental health services, making it potentially difficult to identify people at risk of suicide.

Priority Indicators

The 2012-13 NHS Outcomes Framework proposes two indicators for mental illness: reducing premature (under 75) death in people with serious mental illness and enhancing the quality of life for people with mental illness by measuring the employment of people with mental illness. Current health service interventions that improve mental health

and wellbeing include suicide prevention training with front-line personnel who come into contact with people at risk of mental health problems. These front line personnel include officers in the employment and housing sectors. In addition, mental health first aid training for healthcare workers is of benefit.

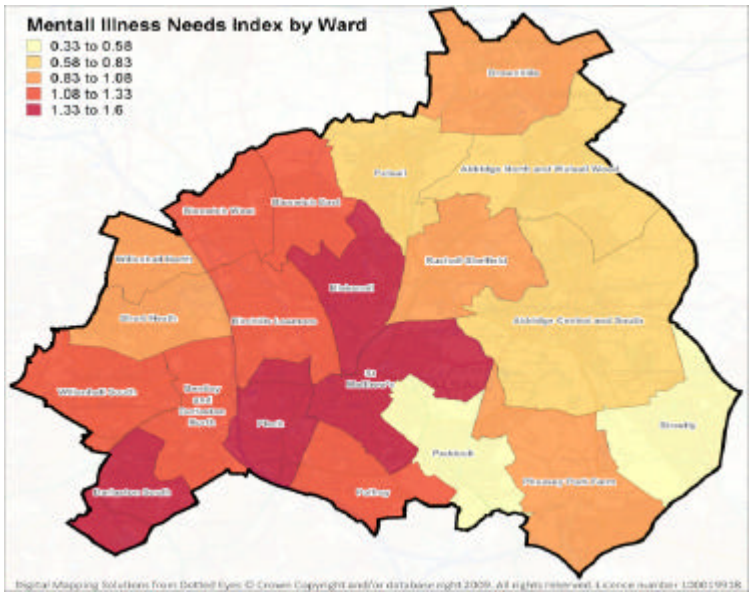


Figure 38 Mental illness needs index by ward

Recommendations

Results from the 2012 lifestyle survey are awaited and will need to inform interventions targeted in particular areas or in particular groups within our population (for example, those who are unemployed).

Key priorities are;

- Repeating the mental well-being scale in the future to enable changes in mental health and well-being to be tracked.
- Local work to build on the brief interventions in primary care and on Improving Access to Psychological Therapies.
- Continuing work with pregnant women who smoke (one-to-one sessions to address sources of stress) to help them to quit smoking.
- Expansion of the workforce development program to help support people with long term illness and absenteeism.

5.10 Summary and Recommendations

Chapter 6 Strengthening the role and impact of ill health prevention across the life course: Lifestyles and well-being

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

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

The chart below shows the estimated number of adults in Walsall whose health and well-being could be improved by making changes in their lifestyles. More than half of residents do not undertake any physical activity and an even higher proportion do not eat the amounts of fruit and vegetables recommended for a healthy diet. Smoking reduces life expectancy by an average of 10 years and obesity by an average of nine years; in Walsall there are tens of thousands of residents whose health and quality of life could be transformed by stopping smoking or losing weight.

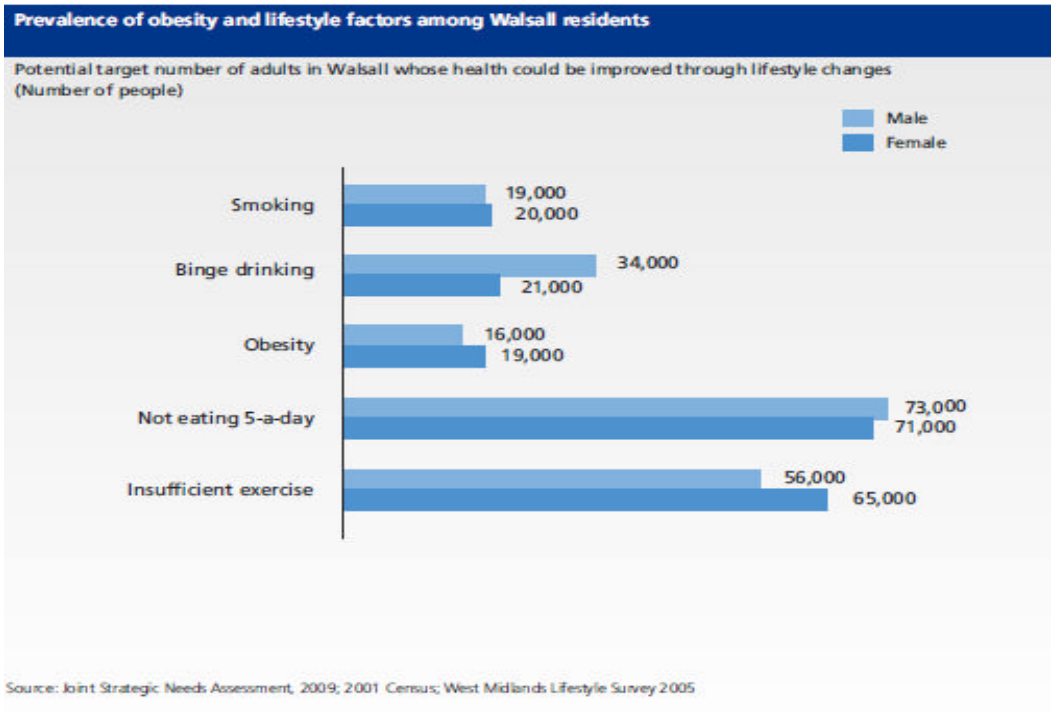


Figure 39 The potential number of adults in Walsall whose health could be improved through lifestyle changes

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

Chapter 6 discusses lifestyles and prevention in Walsall, focussing on strengthening individuals and developing environments that promote well-being and support positive, sustained behaviour change.

6.1 Obesity

Obesity is one of the greatest public health challenges facing Walsall today. The Foresight Report[5] predicts that by 2015, 36% of men and 28% of women aged 21-60 living in England will be obese; it is likely that rates in Walsall will be even higher Obesity is a very significant contributor to illness and premature death in the Borough. Serious health consequences include Type II diabetes, cardiovascular disease, liver disease, musculoskeletal disorders such as osteoarthritis, and certain cancers. Without action, overweight and obesity-related diseases will cost NHS Walsall an estimated £82 million per year by 2015. It is estimated that obesity-related illness will result in the loss of 43,000

[5] Foresight Report (2007): Tackling Obesities: Future Choices. http://www.idea.gov.uk/idk/core/page.do?pageId=8267926

working days, £9M – £14.5M in lost earnings and a £40M loss to the wider economy in Walsall[6].

Priority Indicators

In 2008, around 1 in 4 adults in England were classed as obese. Local prevalence is more difficult to determine. The West Midlands Public Health Observatory conducted a regional lifestyle survey in 2005 using a random sample of people on the electoral roll. There were 2575 responses from Walsall, but less than a third of people who were sent a survey responded. The proportion of males who reported a weight and height that classified them as obese was 18% and the proportion of females classified as obese was 19%. The true figure is likely to be higher since people who reply to health surveys are more likely to be healthy than non-responders.

Using more reliable national survey data applied to local population figures, it is estimated that in Walsall around 55,000 adults (26%) are obese and around 130,000 (62%) are overweight or obese (Health Survey for England 2008 prevalence estimates applied to locally registered population).

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

Recommendations

- Carry out a local lifestyle survey to establish robust baseline information to enable targeted and effective commissioning and delivery of weight management and physical activity interventions – 'Your place, your well-being: Walsall Household and Lifestyle Survey 2012'
- Improve identification, delivery of brief interventions and referrals from GPs and other frontline staff from a range of organisations and agencies through implementation of the 'Every Contact Counts' initiative
- Create and maintain an environment that promotes physical activity through planning mechanisms and policy development

[6] Modelled from figures reported in: Select Committee on Health, 3rd Report obesity. http://www.publications.parliament.uk/pa/cm200304/cmselect/cmhealth/23/23.pdf

- Implement robust pathways within Walsall Healthcare Trust to identify and refer patients who will benefit most from specialist weight management services
- Work through planning mechanisms to limit the amount of fast food outlets in Walsall, particularly in the vicinity of schools.
- Develop a 'Healthy Retailers Award' for local businesses in Walsall.

6.2 Physical activity

The Chief Medical Officer's Report *At least five a week: Evidence on the impact of physical activity and its relationship to health*[7] evidences the preventative and therapeutic benefits of physical activity on a range of conditions including obesity, cardiovascular disease, diabetes, cancer, musculo-skeletal disorders and mental well-being. It is estimated that the consequences of physical inactivity in the Walsall population cost the local economy £33m per year and NHS Walsall £4.3m.

Surveys show that more than 55% of Walsall residents take part in no recreational physical activity, compared to 47.4% nationally. The proportion of adults who take part in 3 x 30 minutes physical activity per week has increased from 16.1% in 2006 to 19.1% in 2010, but remains well below the national average of 22.5%. Similarly the proportion participating in 5 x 30 minutes of activity per week has increased from 8.4% to 9% for 5 x 30 minutes against a national average of 11.3%.

Priority Indicators

The priority indicator for physical activity is 3 x 30 minutes. This is collected annually through Sport England's Active People Survey. This survey also measures 5 x 30 as per recommended activity guidelines. At present Walsall is placed as the 14th worst performing area of the 339 local authorities participating in the survey (bottom 4%). However as the map indicates, participation varies significantly within the borough, from 21.52% in Park Hall through to as low as 12.78 % in Leamore (from 2010 data).

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

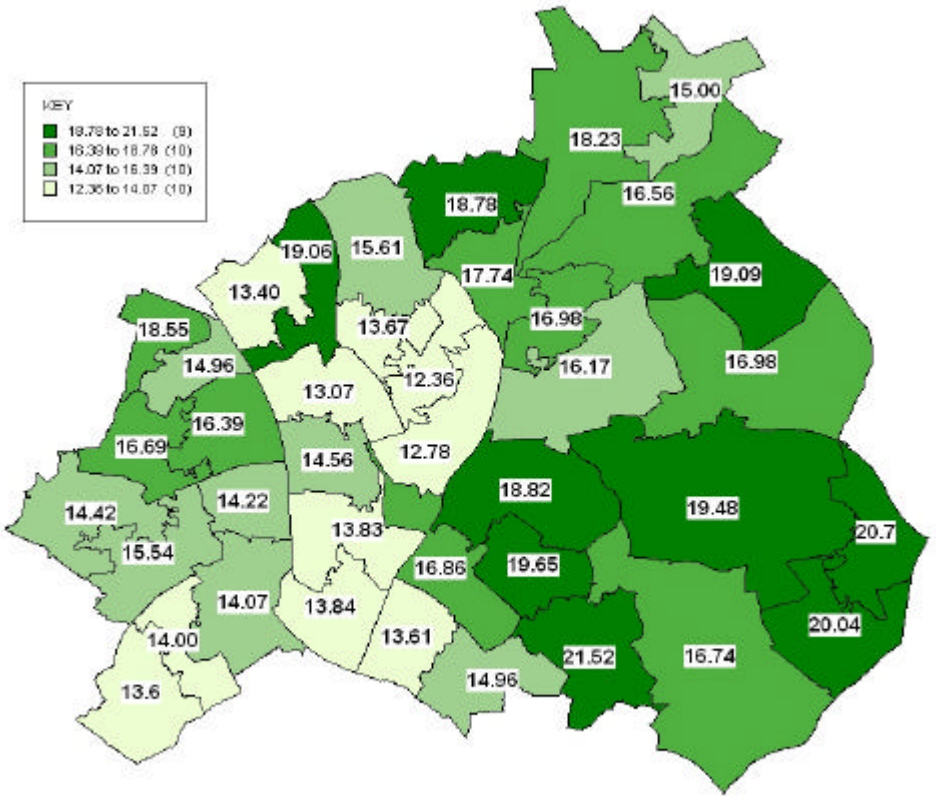


Figure 40 Walsall rates of participation in physical activity by community

Although the 3x30 headline would be the priority indicator, the greatest health impact is from moving the completely sedentary to taking part in some activity (i.e. those moving from 0x30 to 1x30). This is particularly relevant in Walsall with 55.5% taking part in no physical activity; on this measure Walsall is the 7th poorest performing authority (bottom 2%). Therefore secondary indicators would be 0 x 30 as well as 5 x 30.

Recommendations

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

- Increasing and supporting attendances at leisure centres, community centres and other physical activity provision.
- Increase usage of the borough's green spaces, parks, play and open spaces through Every Contact Counts brief advice and the 'Let's Get Moving Pathway'.
- Co-ordinated targeting, and support to key target groups to reduce the barriers to participation. Includes identification at source, referral routes and support and barrier reduction.

- Co-ordinated promotion and marketing of key programmes with the ability to deliver the increases in participation appropriately targeted to key market segments.
- Ensure planning approaches create a physical activity enhancing environment, including building design, locality planning and neighbourhood provision.
- Implement and deliver 'Every Contact Counts' training to Walsall HealthCare Trust staff, GP's and other partners incorporating the 'Let's Get moving Pathway'

6.3 Smoking cessation and tobacco control

Smoking is still the single greatest cause of illness and premature death in England – killing one in two smokers prematurely. For each cigarette smoked, a smoker's life span is shortened by about five minutes. Those who die as a result of a smoking related illness will have lost, on average, 10-15 years of life. During 2009 there were 1192 smoking related deaths in Walsall showing a downward trend from previous years bringing Walsall in line with the national average. Smoking is the single biggest modifiable risk factor for cancer and heart disease and a major aetiological factor for: Lung cancer (84% of all deaths), cardiovascular disease (17% of all heart disease deaths) and respiratory diseases, such as chronic obstructive pulmonary disease (COPD) (84% of deaths from COPD)

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

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

Priority Indicators

The estimated prevalence for smoking within the Walsall population is 24.5%, representing approximately 50,000 adults. Rates of young people's smoking are reported to be rising nationally but local figures are unclear at the moment. Rates of smoking during pregnancy are also high in Walsall with the latest reported at 16.8%, above the national rate of 14%. In 2009/10 costs for hospital admissions for smoking related conditions were £4.7m.

The numbers of people stopping smoking has remained constant following the high numbers produced by the introduction of the ban on smoking in public places in 2007. Encouraging smokers to quit is becoming more challenging as people believe that smoking is a stress reliever and the increase in the availability of cheap tobacco products. Also nationally the cutback in costs for promotional campaigns and general awareness raising means that we are no longer working against a national backdrop for local cessation work.

Recommendations

Research shows that at any one time 70% of smokers want to stop which would give us around 35,000 potential users of stop smoking services in Walsall against the 4000 people who used the services in 2010/11. Therefore there is a high level of unmet need. The introduction of Payment By Results contracts for Stop Smoking Services has increased the numbers of providers of Stop Smoking Services which in turn has increased the numbers of people accessing services.

Key priorities are;

- Development of a Tobacco Control Plan for Walsall to develop a multi agency coordinated approach to implementing the National Strategy locally.
    - To have fewer people smoking
    - To achieve 1910 4 week quitters by 31 March 2012 (final reporting date June 2012)
    - To reduce prevalence of smoking amongst pregnant women at delivery (target 17%)

6.4 Reducing alcohol related harm

Nationally alcohol related deaths have doubled between 1991 (3,415) and 2008 (7,334). Walsall has high alcohol related harm across a number of health and crime indicators. Comparisons with other areas can be made using the Local Alcohol Profiles for England (LAPE), which measure alcohol misuse in each local authority in England using 23 separate indicators. These include months of life lost due to alcohol

misuse, alcohol related violent crimes and rates of binge drinking. The General Household Survey (2010) estimates Walsall has 34,058 hazardous drinkers, 33,550 binge drinkers and 10,174 harmful drinkers.

The rate of alcohol related crime has fallen in Walsall in the last 5 years, though it remains higher than the regional and national rates (Walsall Alcohol Needs Assessment 2011). The reduction in alcohol related recorded crime has occurred during a period of sustained partnership working on a number of initiatives; a local alcohol arrest referral scheme, Operation Be Safe (concentrating on the town centre night-time economy) and campaigns to test purchasing to reduce sales of alcohol to children. It is recognized that tackling alcohol abuse in Walsall requires a multi-agency approach given that alcohol use is likely to coexist with other problems including mental health issues, homelessness and poly drug use.

Priority Indicators

The priority health indicator by which alcohol related health harm is currently measured is the number of alcohol related hospital admissions per 100,000 of population. Walsall has a higher rate of admissions than the national and regional average. The most recent figure (2009/10) was 2,121, which was an increase of 6% on the previous year. This represented a slight improvement in as much that the national rate of increase during this period was 7%. The rate of admissions for under 18's (59 per 100,000 of population) is considerably lower than the West Midlands (65) and slightly below the national rate of (62). This downward trend has been evident since 2008 providing evidence of the increasing effectiveness of the strategy being employed to reduce alcohol abuse in Walsall and is being reinforced by ongoing campaigns of targeted education.

There were 2,174 alcohol related recorded crimes in Walsall in 2009/10 which represented a continuation in the downward trend of the past 5 years. This positive development is tempered by the fact that alcohol related crimes remain higher in Walsall than the regional and national average. Walsall ranks 89 of the 327 local authority areas for the highest rates of alcohol related recorded crimes. In local consultations this is high on the list of concerns raised by the community in Walsall.

Recommendations

Progress will be reported on a number of alcohol metrics across both health and community safety including. Key priorities are;

- Maintaining the Alcohol Liaison Service between the hospital and community alcohol implementing every contact counts

- Maintaining the strong links between criminal justice and treatment
- Training health and partner agency staff in delivering Identification and Brief Advice
- Promotional work ongoing with ambulance service, local schools and utilizing the service offered by health trainers in support of the Alcohol Local Enhanced Service, which is offered from GPs surgeries.
- Increase the available opportunity for detoxification, in the community and in-patient settings, to enable dependent drinkers to access recovery.
- Work with Area Partnership Managers to address local community concerns.
- Establish aftercare provision, to support those who have exited alcohol treatment.

6.5 Substance misuse

There are an estimated 2,000 problematic drug users (i.e. those who misuse heroin or crack cocaine) in Walsall[8]. Based on the most recent data (September 2011), there are 1,316 individuals engaged in structured treatment programmes in Walsall and more than 700 engaged open access, outreach and needle exchange services. Qualitative feedback suggests that there is a cohort of 70–100 problematic drug users that are not known to the service providers or are not engaged in any form of treatment /intervention.

The success of local drug treatment is monitored through a nationally developed tool, the Treatment Outcome Profile. Outcomes are measured across 5 domains to include: drug use, physical and psychological health, employment, education and offending history. Progress in these domains is assessed and reviewed at 12 week intervals.

Walsall has two main providers of drug treatment. Addaction is a national Voluntary Sector Provider, offering primarily open access services, criminal justice liaison and limited substitute prescribing services. In 2010/11 Addaction's open access case load was 797 clients. The other main agency is Dudley and Walsall Mental Health Trust, operating at Lantern House, offering structured interventions and medical substitute prescribing services. These services also include significant work with local GPs to jointly offer services from GP surgeries for the care of their patients. In 2010/11 Lantern House's case load totalled 1,148. Addaction and Lantern House work in close partnership with the police and probation service providing drug interventions for

[8] Glasgow University annual prevalence report

offenders, such as the Drug Intervention Programme and court mandated Drug Rehabilitation Order.

Priority Indicators

There are a range of indicators that the partnership uses to measure the performance, effectiveness and quality of Walsall's drug treatment system, these include:

- Number of clients in treatment
- Waiting times
- Treatment outcome measures
- Hepatitis B and C screening and treatment
- Successful completions and re-entries into treatment

Walsall's performance is similar to other partnerships across the region and the nation, reflecting quick access into treatment for high volumes of individuals. Local Criminal justice and offender management partnerships are well developed and perform well. Further development is required to strengthen performance on successful completions.

Recommendations

Key priorities are;

- Continuation of a whole system approach to structured substance misuse services, with a focus on;
    - Facilitating swift access to treatment interventions for those patients who need them
    - Appropriate support to enable patients to successfully recover from dependence.

Future developments should focus on;

- Support for patients leaving treatment to sustain their recovery and independence from illicit drugs
- Work in partnership with other agencies to support the family agenda
- Shift the emphasis from responding to complex needs by working in partnership to contribute to the preventative agenda

6.6 Summary and Recommendations

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

- Create and maintain an environment in Walsall that promotes physical activity and helps residents to improve their health, using planning mechanisms and policy development to the full.
- Ensure that GPs and frontline staff in all partner agencies are fully engaged in encouraging and supporting residents to adopt and sustain healthy lifestyles. The 'Every Contact Counts' initiative provides a real opportunity to do this systematically and on a scale that could bring about real improvements in health.
- Coordinate promotion and marketing of key health improvement initiatives such as the NHS health checks programme, free leisure activities, subsidised swimming, smoking cessation and weight management.
- Work through the Area Partnerships to ensure that local people are at the heart of our strategies to improve lifestyles and prevent ill health.
- Work with partners to reduce the number of young people who start smoking.
- Increase the numbers of drug users successfully exiting treatment.
- Reduce the demand of alcohol related hospital admissions and levels of alcohol related offending.

Chapter 7 Healthy ageing and independent living

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

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

The key local issues:

- There has been an increased number of falls in older people (particularly in institutional settings) with the resulting loss of independence
- With the current and predicted rise in the number of people with dementia, the societal response has lagged behind. The proportion of people with dementia having an early diagnosis in Walsall has been one of the lowest in the West Midlands. In line with the national position, awareness of dementia amongst the population is low and in some areas, this condition remains stigmatised.
- Excess winter deaths and fuel poverty – Walsall has a higher proportion of excess deaths than the region as a whole. There are also significant numbers of households living in fuel poverty and with the current economic climate, this is unlikely to reduce without more focused action.
- Walsall has high numbers of older people living in poverty. This limits their ability to participate in a range of activities and often leads to social isolation.
- The proportion of people dying in their preferred place of death is low. Too many people are sent from care homes to hospital acute wards for their final days and hours when appropriate, dignified care could be provided within the community.

- Across Walsall we do not know what older people's views are on quality of life, wellbeing and future aspirations. This potentially leaves gaps in any strategic service planning.

Chapter 7 addresses healthy ageing, focussing on extension of independent living and end of life care in Walsall.

7.1 Maintaining mobility and preventing falls

Priority Indicator

Hospital admissions for fractured neck of femur

Recommendations

There are clear preventative actions which will improve bone density and strength, leading to reduced risk of fracture in older age. For example, ensuring weight bearing exercise in childhood or identifying adults at risk of osteoporosis and providing appropriate interventions.

7.2 Dementia

Dementia presents a huge challenge to society. There are currently 750,000 people in the UK with dementia and 570,000 people in England alone. The cost to the UK economy is currently £17 billion a year. In the next 30 years, the number of people with dementia in the UK will double to 1.4 million and the cost of caring for these people will rise to a staggering £50 billion a year.

These are the economic costs, the cost to individuals and their families are much more profound. There are four national priorities for dementia:

- Early diagnosis
- Care homes
- Hospital care
- Reducing use of anti-pyschotics

Priority Indicators

Walsall has a prevalence of over 3,350 people with dementia with only one third of these with a formal diagnosis. This is a low detection rate

and compares unfavourable regionally and nationally. The prevalence is predicted to rise to nearly 4,000 by 2017.

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

There is a lack of local data from specialist memory services on the numbers of people being seen with dementia. The spend on dementia services by local Commissioners has not risen in line with national expectation. In addition, the West Midlands Strategic Health Authority has identified a role for primary care liaison workers (model developed with Worcester University) but this recommendation has not been taken up by organisations in Walsall.

Whilst work began in 2011 to improve early detection in Walsall, the results of this work will not be available until after the end of the financial year 2011-12.

Improving dementia awareness amongst health care professionals has been identified as an opportunity and work has started across Walsall to improve the workforce's knowledge of dementia. The next stage of dementia training will commence in the Spring and will be open to people from a variety of organisations. The training will be backed up with e-Learning via a portal on the dementia website to the Social Care Institute for Excellence's e-Learning, which was developed with the Alzheimer's Society. New services will commence in Spring which will support people soon after diagnosis and then long term on the dementia pathway. These include: dementia cafés, dementia advisors, a dementia diagnosis support worker and a hard to reach groups support worker.

Raising the public's awareness of dementia and reducing stigma are now a priority. To support this, documents in English and five South Asian languages have been developed and interpreted and recorded as podcasts. Video is available in several languages via the Walsall dementia website http://www.walsall.nhs.uk/Services/Dementia.asp.

Recommendations

Key priorities:

- Ensure the required financial investment which has been devolved by national government is utilised for dementia services.

- Reducing the risk of developing dementia by improving healthy lifestyles will lower the prevalence over time. The message of "healthy body, healthy mind" needs to be reinforced at every opportunity.
- Commissioners to performance manage local services to ensure accurate and timely data on numbers and types of service users are collated and shared by Providers.
- Review the need for the recommended primary care liaison workers.

7.3 Excess winter deaths and fuel poverty

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

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

- Each one degree Celsius decrease in average winter temperature results in 8,000 additional winter deaths in England.
- Nationally, mortality rises 18% during the winter months. In a bad winter, this could amount to an additional 50,000 deaths. During winter 2010/2011 there were 27,500 excess winter deaths
- However, these deaths are preventable; some countries with more extreme weather conditions than the UK experience fewer winter-related deaths. For example, Finland has 45% fewer winter deaths than the UK.
- After cold weather, it takes 40 days for levels of illness and death to return to normal.

Contributory factors to excess seasonal mortality include:

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

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

Fuel poverty is when a household needs to spend more than 10% of its income on total fuel use to heat its home to an adequate standard of warmth (under Central Government review – Hills Report).

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

Key data source is The Health Impacts of Cold Homes and Fuel Poverty; Marmot Review Team
http://www.foe.co.uk/resource/reports/cold_homes_health.pdf

Priority Indicators

The primary indicator is Excess Winter deaths:
http://www.wmro.org/noncms/instantatlas/Excess-winter-deaths_NW/LAD-fourth-attempt/atlas.html

The latest published information (2006/07) indicates a rate of 14.0 for Walsall compared to 15.2 for England and 16.6 for the West Midlands. This equates to 115 EWDs in 2006/07

Recommendations

Reducing slips trips and falls – The Council, NHS Walsall and partners works towards reducing trips and falls within households with elderly and vulnerable residents, both of which can contribute to excess seasonal deaths. Many initiatives exist to help in this area including:

- Handyperson scheme
- Disabled Facility Grants
- Aids and Adaptations
- Preventative Adaptations

Reducing illness especially for vulnerable groups during winter - NHS Walsall undertakes a comprehensive and proactive annual flu-jab initiative to maximise the number of vulnerable residents who do not contract influenza

Increasing energy efficiency of homes - Fuel poverty is a product of 3 factors:

- Energy efficiency of the home
- Cost of heating fuel
- Household income and as such how much a 10% spend on heating would be.

Improving the energy efficiency of homes is an essential step to reduce the number of households in fuel poverty. As such this is included as NI 187 which measures increase in Standard Assessment Procedure (SAP) or energy efficiency ratings of homes. The Council undertakes a broad range of initiatives that tackle energy efficient homes and increase SAP ratings. Between 2008/09 and 2009/10 survey results showed an increase in homes with a SAP rating of over 65 from 29% to 42%. During the same period those with the lowest SAP ratings reduced from 6% to 4%.

7.4 Independent living and quality of life

Older people want, and have a right to expect to be able to live their lives as they wish, feeling safe, taking part in society and being able to choose how and when they are supported when they need to access public services and equality of citizenship in every aspect of their lives, from housing to employment to leisure. Unfortunately, there has been little true discussion with our older citizens about what well-being means for them and how they would wish to be supported in different aspects of their lives e.g. housing, leisure, transport. Previous national surveys by the charity Age UK have identified that older people have a wide range of needs, aspirations and expectations and for this reason, no assumptions should be made by statutory bodies of the range and type of services required locally without specific and regular communication with the people they serve.

In the future, we want people to have maximum choice, control and power over the support services they receive. A start point could be to dispel assumptions about the 'burden' of older people on public services. For example, whilst the percentage of our population aged 85 years and over is increasing, over 4 in 5 people in this group **do not** suffer from dementia.

The impact of the current and anticipated ongoing economic crisis is likely to fall heavily on those aged over 65 years (and not in work). Poverty limits the choices open to an individual to participate in their communities and addressing economic hardship must be a key action for us all if we are to maximise the independence of our older citizens.

However, there are still many people living relatively isolated lives, with little social contact and not always receiving the support services they need, either through ignorance (of themselves, families or professionals) or through lack of joined up work across agencies. In addition, as mentioned in preceding chapters, approaches to reduce disease and disability in earlier life are likely to lead to healthier older people, more able to participate actively in society. Efforts to improve the social, financial and physical environment will help to increase the proportion of older people living independently.

Priority Indicators

% unpaid carers in Walsall – estimates only
Permanent admissions to residential and nursing care homes per 1000 population
Health related quality of life for older people – definition and data collection required
% older people who leave their homes only once per week (or less) – Age UK data
in receipt of social care support services
% over 65 year olds who are reliant on state benefits solely with no other source of income.

Recommendations

- All agencies in Walsall should ensure opportunities to maximise income for older residents.
- Specific work should be conducted in 2012 to ascertain the views of older people on quality of life, independence and well-being so that our objectives can be clearly aligned to the expectations of our population. This work should ensure that the views of those older people who are socially isolated are specifically included.
- Opportunities to make services which support well-being more accessible to older people.
- The Health and Well-being Board should agree strategies which ensure people, irrespective of illness or disability can exercise maximum control over their own life.
- Support services for carers should be developed to improve their quality of life and the likelihood of them continuing their caring role.
- Rehabilitation and reablement services should be available rapidly when required to support all those who suffer temporary reduction in function to prevent this becoming permanent.

7.5 Carers

7.6 End of life care

End of life services are designed to support people who are approaching the end of life to live as well and comfortably as possible until their death, and to support their carers in that process. It can include any adult with advanced incurable and progressive disease and take place in any setting, hospice, hospital, home, or elsewhere in the community.

Palliative care tends to be offered chiefly to patients with incurable cancer, though it has been estimated that two thirds of non-cancer deaths will be proceeded by a period of chronic illness that may benefit from palliative care interventions (National Council for Palliative Care). However, potentially a third of deaths that take place in hospital might have been more appropriately managed elsewhere.

Patient surveys repeatedly show that the majority of people would prefer to die at home, yet comparatively few patients achieve this. In Walsall only around 21% of patients take place at home, and a further 13% take place in nursing homes. 62% of deaths occur in hospital and just over 4% take place in hospices, of which the main one locally is St Giles Walsall, which opened in early 2011. There is also a community palliative care service and day hospice, and palliative care teams not only in the Manor Hospital but in other local hospitals too.

Priority Indicators

- To increase the proportion of Walsall patients who die in hospices
- To reduce the proportion who die in hospital

Recommendations

- Patients who are at the end of life or who have advanced and incurable disease should be able to access palliative care to manage their symptoms and improve quality of life.
- Both patients and their carers should have an appropriate level of involvement in decisions about their preferred place of death.
- Palliative care services should consider how to increase the proportion of patients who die in their preferred place of death. This may be particularly pertinent for elderly people living alone where additional support may be needed to help them to die at home.

- Palliative care services should be integrated between home, hospital and hospice and improve the experience of dying from incurable disease in Walsall.
- Health professionals should have more training and education in end of life care.

7.7 Summary and Recommendations

Recommendations

The preceding 7 chapters of the Joint Strategic Needs Assessment discussed a wide range of themes influencing health and well-being across the life course within the borough. The structure of the JSNA stresses the importance of a life course approach. Inequalities in early life tend to persist into adulthood, shaping the lives and well-being of Walsall residents.

The Marmot Review emphasised the need for proportionate universalism in reducing the social gradient in health and well-being. For this reason core recommendations are;

- That the Health and Well-being Board recognises the need for proportionate action, with greater intensity in areas of greater social and economic disadvantage
- That this principle underpins all elements of the upcoming Health and Well-being Strategy

The content of the JNSA explores a wide variety of themes influencing well-being in the borough. Action on all of these themes is crucial to improving the well-being of Walsall residents. However, the life course approach recognises the significant relationship between early intervention and outcomes in later life. For this reason this JSNA recommends that;

- The core of the Health and Well-being Strategy comprises action to;
    - Support families and parents
    - Promote engagement in education and attainment across the life course
    - Promote employability and 'good' employment for all residents

JSNA is an iterative process developing year on year. JSNA 2012 has been developed through a partnership approach, drawing on a wide range of expertise across both Public Health and the Local Authority. There is a long way to go if JSNA is to meet the Project Groups aspirations for an asset based approach. This approach requires collection of a different type of data, identifying and promoting the health enhancing assets (skills, knowledge, resources, networks and organisations) present in communities, empowering people and communities as co producers of well-being. This will enable us to build

active and sustainable communities by removing barriers that prevent people participating in the issues that affect their well-being. To support this aspiration this JSNA recommends;

- Partners should influence the nature and content of future needs assessments to reflect an assets based approach through;
    - Improved intelligence and data collection
    - Wider community engagement and participation

Appendix 1 Indices of Deprivation 2010 by Ward

Ward Name	Deprivation Score	Deprivation Ranking*	Elected Councillors
Aldridge Central and South	16.33	17	Councillor Tom Ansell Councillor John Murray Councillor John Rochelle
Aldridge North and Walsall Wood	18.44	15	Councillor Michael Flower Councillor Anthony Harris Councillor Keith Sears
Bentley and Darlaston North	38.32	8	Councillor Rose Burley Councillor Keith Chambers Councillor Bill Madeley
Birchills Leamore	50.17	2	Councillor Lee David Jeavons Councillor Tina Joan Jukes Councillor Tim Oliver
Blakenall	54.71	1 (most deprived)	Councillor Ian Robertson Councillor Bob Thomas Councillor Ann Young
Bloxwich East	41.27	4	Councillor Shaun Francis Fitzpatrick Councillor Julie Fitzpatrick Councillor Kath Phillips
Bloxwich West	34.90	10	Councillor Sue Ann Fletcher-Hall Councillor Louise Ann Harrison Councillor Fred Westley
Brownhills	27.91	11	Councillor Barbara Cassidy Councillor Alan Paul Councillor David Turner
Darlaston South	40.46	5	Councillor Paul Bott Councillor Douglas James Councillor Graham Wilkes
Paddock	14.71	18	Councillor Zahid Ali Councillor Rose Martin Councillor Barbara McCracken
Palfrey	39.41	6	Councillor Allah Ditta Councillor Mohammad Munir Councillor Mohammad Nazir
Pelsall	18.19	16	Councillor Oliver Don Bennett Councillor Marco Longhi

			Councillor Garry Perry
Pheasey Park Farm	13.14	19	Councillor Adrian Andrew Councillor Mike Bird Councillor Christopher Towe
Pleck	46.89	3	Councillor Dennis Anson Councillor Khizar Hussain Councillor Harbans Sarohi
Rushall-Shelfield	25.86	13	Councillor Rachel Andrew Councillor Ron Carpenter Councillor Lorna Rattigan
St Matthew's	38.73	7	Councillor Mohammed Arif Councillor Imran Azam Councillor Eileen Bridie Russell
Short Heath	26.06	12	Councillor Daniel James Barker Councillor John Cook Councillor Doreen Shires
Streetly	5.92	20 (least deprived)	Councillor Gary Clarke Councillor Brian Douglas-Maul Councillor Eddie Hughes
Willenhall North	25.55	14	Councillor Gareth Illmann-Walker Councillor Ian Shires Councillor Val Woodruff
Willenhall South	35.92	9	Councillor Sean Coughlan Councillor Diane Coughlan Councillor Carl Usher Creaney

Source - DCLG, ONS, Walsall Council, NEPHO

*1=most deprived and 20=least deprived

Note - Summary scores for electoral wards, Middle Layer Super Output Areas (MSOAs) and Regions have been calculated by the London Health Observatory and North East Public Health Observatory, using methods which are consistent with those used by DCLG, i.e. averages of LSOA-level scores which have been population-weighted using adjusted 2008 mid-year estimates.