Sandwell
Metropolitan Borough Council

Agenda
Health and Wellbeing Board

Wednesday, 22 September 2021 at 5.00 pm
At Council Chamber, Sandwell Councill House, Freeth Street at Oldbury, B69 3DB

1	**Apologies for Absence**	
2	**Declarations of Interest** Members to declare any interests in matters to be discussed at the meeting.	
3	**Minutes** To confirm the minutes of the meeting held on 30 June 2021 as a correct record.	7 - 16
4	**Covid-19 - current position update**	17 - 18
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9	**Integrated Care Systems / Integrated Care Partnerships - update on progress to date** Standing item to provide a progress update on Integrated Care System (ICS) / Integrated Care	91 - 92



Partnerships (ICPs).

Kim Bromley-Derry CBE DL
Interim Chief Executive
Sandwell Council House
Freeth Street
Oldbury
West Midlands

Distribution

Voting Members of the Board:

Sandwell MBC Councillors

Cllr Suzanne Hartwell – Chair and Cabinet Member for Adults, Social Care and Health
Cllr Maria Crompton – Deputy Leader and Cabinet Member for Finance and Resources
Cllr Karen Simms – Cabinet Member for Children and Education
Cllr Zahoor Ahmed – Cabinet Member for Housing

Black Country and West Birmingham Clinical Commissioning Group

Dr Ian Sykes – Vice-Chair and Primary Care Network Representative
Dr Priyanand Hallan – Primary Care Network GP Representative
Dr Sommiya Aslam – Primary Care Network GP Representative
Michelle Carolan – Managing Director – Sandwell
*3 voting members allowed at each meeting.

Healthwatch Sandwell

John Taylor – Chair of Healthwatch Sandwell
Alexia Farmer – Healthwatch Sandwell Manager
*1 voting member allowed at each meeting.

Non-voting Members of the Board

Sandwell MBC Councillors

Cllr Elaine Giles – Chair of Health and Adult Social Care Scrutiny Board
Cllr Ann Shackleton – Chair of Children and Education Scrutiny Board

Sandwell MBC Officers

Kim Bromley-Derry CBE DL – Interim Chief Executive
Rashpal Bishop - Director of Adult Social Care
Dr Lisa McNally – Director of Public Health
Katharine Willmette – Interim Strategic Director Children and Education
Melanie Barnett – Acting Operational Director Children and Education and Statutory Director of Children Services

NHS England – Black Country Area Team

Vacant – Director of Operations and Delivery

Discretionary Members

Dr Richard Beeken – Interim Chief Executive Sandwell and West Birmingham Hospitals NHS Trust
Mark Axcell – Chief Executive of Black Country Partnership NHS Foundation Trust
Chief Superintendent Ian Green – West Midlands Police
Matt Young – West Midlands Fire Service
Mark Davis – Chief Executive of Sandwell Voluntary Sector Organisation
Emma Taylor- Sandwell Children's Trust

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Sandwell Health and Wellbeing Board

30 June 2021 at 5.00pm
Held at the Council Chamber, Sandwell Council House.

Present:

Sandwell Metropolitan Borough Council (SMBC):

Councillor Suzanne Hartwell	Cabinet Member for Living and Ageing Well (Chair)
Councillor Zahoor Ahmed	Cabinet Member for Quality Homes and Thriving Neighbourhoods
Councillor Elaine Giles	Chair of Health and Adult Social Care Scrutiny Board
Councillor Ann Shackleton	Chair of Children's Services and Education Scrutiny Board
Lisa McNally	Director – Public Health
Lesley Hagger	Executive Director – Children's Services
Katharine Willmette	Interim Director – Adult Social Care

Black Country and West Birmingham Clinical Commissioning Group (CCG):

Dr Ian Sykes	GP Representative (Vice Chair);
Dr Priyanand Hallan	Primary Care Network GP Representative;
Michelle Carolan	Managing Director - Sandwell Transforming Care Partnership Black Country & West Birmingham CCG;

Healthwatch Sandwell:

John Taylor	Chair;

Sandwell Voluntary Sector Organisation:

Mark Davis	Chief Executive;

In Attendance:

Councillor Sukhbir Singh Gill	
James Cole	Black Country and West Birmingham Clinical Commissioning Group;
Chris Guest	Divisional Manager Adults Social Care;
Justin Haywood	Operations Manager, Adult Social Care Commissioning;
Jayne Leeson	Chief Executive, Changing Our Lives;
Vicki Merrick	Commissioning Team Manager, Adult Social Care Commissioning;
Siraaj Nadat	Changing Our Lives;
Clair Norton	Board Project Manager;
Ashi Williams	Director of People, Black Country Healthcare NHS Foundation Trust;

11/21 Apologies for absence

Apologies for absence were received from Councillor Simms (Cabinet Member for Best Start in Life) (voting member); Mark Axcell (Chief Executive, Black Country Partnership NHS Foundation Trust); and Richard Beeken (Interim Chief Executive, Sandwell and West Birmingham NHS Hospitals Trust) (discretionary members).

12/21 Declarations of Interest

There were no declarations of interest.

13/21 Minutes

The minutes of the meeting held on 31 March 2021 were received.

> **Resolved** that the minutes of the meeting held on 31 March 2021 are approved as a correct record, subject to reference to “Sandwell and Birmingham CCG” in Minute No. 8/21 being corrected to read “Sandwell and West Birmingham CCG”

14/21 Development of the Board

Councillor Hartwell Health introduced herself as the new Chair of the Board.

She reported that she would be setting up a workshop event to shape the future direction and work programme of the Board.

15/21 Primary Care Update

The Board noted an update on the current situation in primary care in Sandwell.

It was clarified that GP practices had continued to operate and see patients throughout the pandemic, albeit there had been longer waiting times and telephone consultations were the main type of consultation offered. Some practices were working together with one in three seeing patients face to face.

GP practices remained extremely busy and were offering 32,000 appointments each week, 57% of which were face-to-face. In addition, primary care had delivered over 100,000 covid-19 vaccinations. In Sandwell, 38% of 40-49 year olds, 50% of over 50s and 83% of over 60s had now received two doses of the covid-19 vaccination.

111 and 999 services were operating at 25-30% above predicted demand, with 4,500 999 calls a day being taken. Attendance records at A&E had reached their highest ever in May as people were now addressing health issues that they previously had not due to the lockdown.

Virtual appointments via Zoom or other platforms were likely to become an accepted practice. Those people who required face-to-face appointments were encouraged to contact their local practice via telephone or digitally first, so they could be directed to the appropriate medical professional more quickly.

The Board commended the excellent work by health colleagues and the voluntary and community sector in delivering the vaccination programme.

[Councillor Shackleton left the meeting.]

16/21 Sandwell Good Mental Health Strategy - Update

The Board received a draft Good Mental Health Strategy for Sandwell. This was to be the first standalone strategy of its kind for Sandwell. Separate autism and joint carers strategies were also being developed.

Changing Our Lives had been commissioned to undertake a piece of public engagement in 2019-2020. The 'State of Sandwell' engagement was a series of conversations that asked residents what mental health meant to them and what they thought was important for good mental health. The engagement focused on general population, rather than specifically on people who accessed mental health services. Views had also been sought specifically from minority ethnic communities and new migrants.

The feedback from the consultation had resulted in the development of eight promises, which also reflected the key strategic priorities detailed in the NHS Long Term Plan and West Midland Combined Authority's Thrive Programme:-

- Sandwell will be a mental health aware community
- Think all age

- Available when you really need it
- Zero suicide
- Recovery
- Safe places
- Tackle the causes of poor mental health
- Expert response

To reflect other strategies, a ninth promise would be added.

The promises were high level and further detail would be set out in an action plan.

In response to questions and comments, it was noted that:

- A Mental Health Task Force already existed, led by Public Health, and was seeing positive work bringing agencies together.
- Children's Services had carried out engagement with young people and would make the findings available to support the development of the Strategy.
- An all-age, all-needs pathway was required, with a preventative focus, to avoid the need for more complex services.
- It was felt there was too much discussion around thresholds for accessing mental health services. This contradicted the aim of developing services designed for early prevention.
  A partnership approach was key, in line with the Integrated Care Partnership.
- Reconnecting people and reducing the impact of social isolation was essential to facilitate good mental health.
- A personalised approach would be taking to targeting BAME communities, where stigma still existed around mental health. Resources were required to support grass roots organisations in the voluntary and community sector to grow support in the community.

The Board endorsed the eight promises (with the ninth promise to be developed). The final strategy and the action plan would be presented to the board before the official launch of the strategy in 2022.

Resolved that the draft Sandwell Good Mental Health strategy, and the eight promises set out within it, are endorsed as a basis for formal stakeholder and public engagement, with a view to formal launch of the final Strategy by end March 2022.

17/21 Joint Carers Strategy – Update

[Councillor Ahmed left during the consideration of this item; therefore, the Board was not quorate for the remainder of the meeting].

The Board received an update on the development of a Joint Carers Strategy for 2021-25. The publication of the new Strategy had been delayed due to the covid-19 pandemic. It was proposed that, rather than delay publication further, a review and refresh would be undertaken 12 months. It was noted, however, that the delays had allowed for the Strategy to be reflective of the NHS Long Term Plan and the Carers National Action Plan.

The 2011 census had identified around 30,000 people in Sandwell having an informal caring role and this was expected to increase by 7,000 in the 2021 census. A marked increase was expected in the number of carers aged over 50.

The aspiration was to develop a truly joint strategy that positively shared the responsibility for supporting carers between the Council, the CCG, Health Trusts, the Voluntary and Community Sector and local businesses / employers.

The Strategy set out nine local promises based around five key themes identified in the Carers National Action. 300 carers' views were represented, including young and parent carers, carers of people with mental ill health and BAME carers. 200 carers had been engaged through Healthwatch and 60 carers engaged through West Bromwich African Caribbean Resource Centre. Carers would also be invited to a future meeting of the Board to share their experiences.

The Strategy set out nine Promises for Carers in Sandwell:-

- Awareness and Diversity

- Information, Advice & Assessment
- Workforce
- Carers Health & Wellbeing
- Employment & Financial Wellbeing
- Living Well in the Community
- Managing & Reducing Risk of Carer Breakdown
- Supporting Young and Parent Carers
- Innovation & Best Practice.

In response to questions and comments, the following was noted:

- The whole Board acknowledged the enormous contribution of unpaid carers. Unpaid carers provided annual public saving of £800 million in the UK;
- Healthwatch was keen to continue to be involved in the further development of the Strategy and was keen to ensure that the hidden impact of covid-19 on carers was considered.
- There had been a scaling back of services during the pandemic, which had impacted on many carers so building trust was very important.
- Concerns were expressed about the ability to deliver the final Strategy in six weeks.

Progress on the Strategy would be presented again to the Board in September 2021, along with proposals for a refresh of the Strategy in September 2022 and any views emerging from partners and consultations with carers could be added then.

Resolved:-

1) that the nine Promises for Carers in Sandwell, are endorsed as a framework for the final Joint Carer's Strategy;

2) that plans to review the Joint Carers Strategy after 12 months, in order to enhance the strategy with learning coming out of Covid-19 in relation to the experiences of carers, are endorsed.

18/21 Sandwell Autism Strategy – Update

The Board noted an update on the development of an Autism Strategy. Work had commenced in 2019 with Changing Our Lives being commissioned to lead on its development.

A series of consultation events had been held in 2019 involving a range of key stakeholders, including people with autism. The workshops had been structured around three key questions:

- What does a good life look like for an autistic person?
- What are the barriers to autistic people living a good life?
- What needs to change so that Sandwell is a great place to live for autistic people?

Clear priorities had emerged from the workshops, which had been converted into nine Promises:-

- Awareness and acceptance
- Friendships and connections
- Making everyday services accessible
- Coproducing a better future for autistic people
- Improving access to diagnosis and post-diagnostic support
- A skilled and knowledgeable health and care workforce –
- Autistic people and their families receive the right amount of support at the right time
- Transitions throughout life
- Access to employment, increasing skills and learning opportunities.

The Bard noted that just 15% of autistic people were in full or part-time employment.

In response to questions and comments, the following was noted:

- Autism had been identified as a system priority by the CCG and the Strategy tied in with a wider piece of work that the was being undertaken at a Black Country level. Significant funding was expected and the CCG was working with Changing Our Lives, Autism West Midlands,

the Combined Authority, the voluntary and community sectors and Black Country Healthcare.

- The number of autism diagnoses and requests for assessments had increased significantly in the last year.
- There was no national strategy for autism and Sandwell was the first area to produce one.
- A Strategic Needs Assessment was needed in order t plan services effectively.
- It was noted that schools were improving in terms of diagnosing autism, including having people trained to recognise autism, but lack of enough dedicated school provision for people diagnosed with autism was an ongoing concern;

The nine Promises and findings from the consultation would now be shared with statutory partners, the voluntary and community sector and local businesses. An action plan would be co-produced with key stakeholders that enhanced and contributed to interdependent strategies and action plans. The three year Strategy and action plan would be launched in 2022.

Resolved :-

1) that the Board endorses the nine Promises set out in the Autism Strategy and the next steps to be undertaken in development of the strategy;

2) that the Board endorses the next steps towards the launch of the final Strategy in 2022.

Meeting ended at 6.50pm.

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Sandwell Health & Wellbeing Board

Agenda Item 4

Sandwell Health and Wellbeing Board
22nd September 2021

Update Topic:	**Covid-19 – Current Position Update**
Contact Officer:	**Lisa McNally, Director of Public Health** **Lisa_McNally@sandwell.gov.uk**
Link to board priorities	1. We will help keep people healthier for longer 2. We will help keep people safe and support communities 3. We will work together to join up services 4. We will work closely with local people, partners and providers of services
Purpose of Update:	• To provide a verbal update on the current position regarding Covid-19 in Sandwell, including regional and national policy.
Recommendations	• That the Board note the content of the verbal update.

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Sandwell Health & Wellbeing Board

Agenda Item 5

Sandwell Health and Wellbeing Board
22nd September 2021

Report Topic:	**End of Life Care**
Contact Officer:	**Suni Patel (Public Health, SMBC) / Anna Lock (SWBH NHS Trust)**
Link to board priorities	**3. We will work together to join up services** **4. We will work closely with local people, partners and providers of services**
Purpose of Report:	• To provide an update on the work of the End of Life Care Strategic group supporting End of Life care in Sandwell
Recommendations	• That the Board note the content of the report and presentation
Key Discussion points:	**Priority 3. We will work together to join up services** The aim of this focus theme has been to work collaboratively and creatively and by introducing a 'Public Health' approach to improving health and wellbeing at the end of life. It also focuses on working towards developing a compassionate community approach through influence of policy and practice to move towards encouraging local citizens to talk about death and dying sooner. The multi-agency Sandwell End of Life Strategic group has representatives from the local hospital trust, the CCG, voluntary sector and key services from the council including adult social care, public health, bereavement services, housing and neighbourhoods and holds meetings bi-monthly (currently virtually).

Progress to date

Previously the issues for improving the palliative and end of life care service for local people included: multiple service providers, gaps and duplication in services, confusion for patients, lack of crisis response and patients unable to choose their preferred place of death. The Sandwell End of Life strategic group have been working on a strategy and action plan that;

- Continues to encourage a borough wide conversation and awareness about end of life
- 'Opening up' of conversations about death and dying, moving towards a culture which sees death as a natural part of life rather than something to avoid discussing
- Linking up partners and providing necessary skills / education to enable people to access information and support about death & dying

Based on previous stakeholder engagement outcomes such as a change in culture / attitude to dying, an opportunity to choose where they die, communication across the professionals involved in care and training for all professionals involved in end of life care, the strategic group has worked hard on creating an accessible strategy and action plan. We also created a communication and engagement plan to co-exist with the action plan. These documents are regularly reviewed and updated during the bi-monthly meetings. We also hosted a virtual engagement event for consultation on the strategy document in March 2020 (originally this had been intended to be a community engagement event but had to be cancelled due to the Covid-19 pandemic). Despite limited responses, the group were able to finalise and complete the strategic document. The final format is on one page with 6 key promises each with a number of action points – please see attached appendix 1. The group wanted a strategic

	document that could enable delivery of the key action points and support involvement of all partners. **Priority 4. We will work closely with local people, partners and providers of services** As outlined previously, this workstream developed a multi-agency approach to shape and deliver the End of Life Care Strategic action plan and creating the strategy on a page (SOAP) entitled Sandwell Better Endings – End of Life Care Strategy 2021-2026 - please see attached appendix 1. The group successfully hosted a virtual event during Dying Matters week in May 2021. This was attended by over 85 stakeholders including residents, key professionals and representatives from community & faith based organisations. Based on the 6 key promises the sessions were themed as follows; **1. Conversations in preparation:** - Focusing on the benefits that making plans in advance of dying have and how this can help those left behind **2. Talking openly about death and dying:** - Exploring how the African Caribbean community in West Bromwich and Neighbourhood Services at Sandwell Council are joining the conversation **3. Death and younger people:** - Hearing from the young people from The Shape Programme about their bereavement experiences and what they would like to happen to make things better **4. A confident workforce:** - With many people wanting to die at home, discussions about how working with care homes and primary care teams can make a difference to how people can live well until they die **5. A compassionate community:** - exploring how a local Yemini community centre has responded to meet the needs of their bereaved community members as

	well as a new compassionate community initiative led by the voluntary sector in Sandwell **6. Employers and Bereavement:** - discussing employers and bereavement as many people who are bereaved are also working with a personal experience of bereavement and how work place policy can affect bereavement. This session also covered how Covid impacted support SWBH offered bereaved families and the difference this makes. Some of the initial feedback from the event was very positive and people were encouraged by the way this thematic work had been formatted including having conversations at a younger age, involving schools & families and local community organisations. They were also supportive about the involvement of key agencies for example from housing teams and bereavement services from the council. One of the key pieces for engaging and raising awareness was a collaborative doodle video which is accessible online and was played at the start of the event. This can be viewed here - Healthier Futures - End of life care The next steps are to consolidate the feedback from the event and the actions arising. At the next strategic group meeting we shall be updating our Terms of Reference to ensure that we have essential partners and their support to continue with delivery of our key action points. We also have strategic reach via the wider Black Country work on the theme of death & dying included in the Healthier Futures website: https://www.healthierfutures.co.uk/transformation-areas/end-of-life-care
Implications (e.g. Financial, Statutory etc)	
None currently	

What engagement has or will take place with people, partners and providers?	We held a virtual engagement event with partners & services users as part of the consultation on the strategy on a page (SOAP) document (Better Endings) We held a virtual event during Dying Matters week in May 2021 discussing the 6 key themes of the Better Endings strategy This workstream was developed and is supported by key partners

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Sandwell
Health & Wellbeing Board

Sandwell End of Life Care update

Suni Patel

Anna Lock

Sandwell End of Life Care Strategy

- The Sandwell End of Life Care strategic group has worked collaboratively to create a strategy on a page entitled Better Endings – Sandwell End of Life Care strategy 2021-2026.
- The aim is to encourage conversations and raise awareness around death & dying with the strategy comprising of 6 key promises
- Each promise has action points for the group to aim to deliver to the people of Sandwell

Sandwell Health & Wellbeing Board

Sandwell Better Endings – End of Life Care Strategy 2021 – 2026:

Aim: To deliver 6 promises for people in Sandwell

1 Improving Awareness

Key Outcome:

To ensure people who are approaching the end of life can access the right information at the right time, in the right place

2 Ensuring Communication

Key Outcome:

To make talking about death and dying less of a taboo subject.

To ensure those at the end of life have the opportunity to plan ahead, receive good end of life care and be able to die in accordance with their wishes

3 Providing Education Opportunities

Key Outcome:

To ensure patients / the public have access to a range of educational opportunities around death and dying

4 A Skilled Workforce

Key outcome:

To ensure professionals coming in to contact with those at end of life will receive the support, awareness and training needed, from knowledgeable and skilled professionals and via other channels

5 Service Development

Key outcome:

To ensure earlier intervention via continuous service improvement and opportunities to reach out as widely as possible.

To improve people's end of life care experience regardless of organisation

To achieve key multi-organisational outcomes for end of life care as identified by the Integrated Care Partnership Boards

6 Policy

Key outcome:

To ensure that key local organisations lead by example in the review and implementation of policies

To ensure those living and working in Sandwell can benefit from agreed policies

Dying Matters Week event May 2021

- National event annually usually mid-May
- The Sandwell End of Life strategic group hosted a virtual event with over 85 people ‘attending’
- These included key professionals & partners, representatives from community and faith based organisations and members of the public

Dying Matters Event
May 2021

6 sessions based on the 6 strategic promises

- **1. Conversations in preparation:** - Focusing on the benefits that making plans in advance of dying have and how this can help those left behind
- **2. Talking openly about death and dying:** - Exploring how the African Caribbean community in West Bromwich and Neighbourhood Services at Sandwell Council are joining the conversation
- **3. Death and younger people:** - Hearing from the young people from The Shape Programme about their bereavement experiences and what they would like to happen to make things better
- **4. A confident workforce:** - Discussions about how working with care homes and primary care teams can make a difference to how people can live well until they die
- **5. A compassionate community:** - Exploring bereavement support via a local Yemeni community centre and a new compassionate community initiative led by the voluntary sector in Sandwell
- **6. Employers and Bereavement:** - Discussing employers and bereavement as many people who are bereaved are also working

Next steps

- The Sandwell End of Life Care strategic group continue to meet virtually updating on our action plan and implementing the strategy action points
- Linking with Healthier Futures website (across Black Country)
- Link to collaborative doodle video -

https://www.healthierfutures.co.uk/transformation-areas/end-of-life-care

Sandwell Better Endings – End of Life Care Strategy 2021 – 2026:

Aim: To deliver 6 promises for people in Sandwell

1

Improving Awareness

- Raising general awareness about death, dying and inequalities in different communities
- Helping local organisations keep up to date to better support people
- Helping people make informed choices (e.g. dying where they want to die)

Key Outcome:

To ensure people who are approaching the end of life can access the right information at the right time, in the right place

2

Ensuring Communication

- Communicating key messages about death and dying with statutory, voluntary and community organisations and the public
- Developing information on the services and support available in a variety of formats

Key Outcome:

To make talking about death and dying less of a taboo subject.

To ensure those at the end of life have the opportunity to plan ahead, receive good end of life care and be able to die in accordance with their wishes

3

Providing Education Opportunities

- Develop and identify education opportunities for patients and the public, including children and young people
- Promote e-learning for volunteers, patients and the public

Key Outcome:

To ensure patients / the public have access to a range of educational opportunities around death and dying

4

A Skilled Workforce

- Encourage ALL organisations to identify their own training needs
- Identify existing resources
- Developing 'train the trainer' approaches for the community / voluntary sector, residential homes etc.

Key outcome:

To ensure professionals coming in to contact with those at end of life will receive the support, awareness and training needed, from knowledgeable and skilled professionals and via other channels

5

Service Development

- Explore opportunities to enable seamless delivery of integrated care across different organisations
- Ensure wider reach to support seldom heard communities
- Work with partners to explore the compassionate neighbours approach and better collaboration

Key outcome:

To ensure earlier intervention via continuous service improvement and opportunities to reach out as widely as possible.

To improve people's end of life care experience regardless of organisation

To achieve key multi-organisational outcomes for end of life care as identified by the Integrated Care Partnership Boards

6

Policy

- Support local organisations, both statutory and community / voluntary to review and develop policies that support the delivery of high-quality End of Life care and bereavement support aligned to the national 'Ambitions for End of Life care'

Key outcome:

To ensure that key local organisations lead by example in the review and implementation of policies

To ensure those living and working in Sandwell can benefit from agreed policies

END OF LIFE CARE
STRATEGY ON A PAGE
(VERSION FINAL 2021)

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Sandwell Health & Wellbeing Board

Agenda Item 6

Sandwell Health and Wellbeing Board
22nd September 2021

Update Topic:	**Carers Strategy Update**
Contact Officer:	**Justin Haywood, Operations Manager for Commissioning, Adult Social Care** **Justin_Haywood@sandwell.gov.uk**
Link to board priorities	1. We will help keep people healthier for longer 2. We will help keep people safe and support communities 3. We will work together to join up services 4. We will work closely with local people, partners and providers of services
Purpose of Update:	• To provide a verbal update on the progress in delivering a Carers Strategy.
Recommendations	• That the Board note the content of the verbal update.

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Agenda Item 7

Sandwell Health and Wellbeing Board
22nd September 2021

Report Topic:	**Suicide Prevention Strategy**
Contact Officer:	**Lina Martino, Consultant in Public Health** **Lina_martino@sandwell.gov.uk**
Link to board priorities	1. We will help keep people healthier for longer 2. We will help keep people safe and support communities 3. We will work together to join up services 4. We will work closely with local people, partners and providers of services
Purpose of Report:	• To provide an update on the Suicide Prevention Strategy
Recommendations	• That the Board note the content of the report and presentation

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Sandwell Health & Wellbeing Board

Health and Wellbeing Board

22nd September 2021

Suicide Prevention Strategy and Action Plan

Local Needs Assessment 2020-2021

Sandwell Health & Wellbeing Board

Background

- Sandwell's Suicide Prevention Strategy and Action Plan were drafted at the start of 2020 as the Partnership's route towards achieving the 'Six Promises' in line with national guidance . These promises are:

    1. To fulfil the national Zero Suicides Ambition.
    2. To guarantee the highest quality of care and support.
    3. To encourage a better awareness of suicides within local organisations and communities.
    4. To reduce the chances of suicides in high-risk populations.
    5. To create an open culture where we listen to those with lived experience.
    6. To reduce access to the means of suicide.

- To help us shape a strategy and action plan, it was decided to undertake a Local Needs Assessment that would provide a contemporary picture of the needs in the borough.

- Due to the constraints of the Covid-19 Pandemic, the needs assessment would be carried out through desk-based analysis and virtual sessions.

Methods

We have used a mixed-methods approach by analysing the most recently available data as well as interviews with key partners and those with lived experience. This has allowed us to identify key demographics and trends while understanding the experience of those affected.

We used data from 3 sources to build the statistical picture:

- Public Health England's Suicide Prevention Profile
- Hospital Episode Statistics (HES) (2015-2020)
- Annual Coroner's Summary Report (2019/2020)

We also conducted 1-hour long semi-structured interviews that provided us with the experience from an organisational as well as individual point of view.

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Findings

Sandwell's average suicide rate for the last reported period (2017/29) is 10.8 per 100,000. This is statistically similar to the West Midlands (10.2) and England (10.1) averages and has remained fairly constant over the past 20 years, illustrating that suicide continues to be a problem at local, regional and national levels. There also continues to be a much higher rate in males (17.6) than in females (4.5).

These are the key points:

- The most at-risk group for suicide continues to be males aged between 40 and 60.
- Compared to population statistics for the borough, there is an over-representation of those who identify as White (British/Irish/Other) in the Hospital Episode Statistics. At the same time, there is an under-representation of those who identify as Black/Black British, Asian/Asian British or Mixed Ethnicity.
- The most common method and location are hanging at home/ a private residence. The second most common method is through an overdose.

Findings

The themes from interviews with organisation/charity representatives were:

- Awareness of Services
- Accessibility of Services
- Impact of Deprivation
- Impact of Covid-19
- Impact of Training
- Lack of Funding

Sandwell
Health & Wellbeing Board

Findings

The themes from interviews with those with lived experience were:

- Disappointment with Clinical Pathways
- Pro-activity from Services
- Understanding Risk Factors
- Reaction by Communities
- Treatment by the Media

Recommendations

These are the recommendations that will form the core of the Action Plan:

1. *Raise awareness of suicide prevention and bereavement support through training for all frontline staff through online platform.*
2. *Pilot town-based, community-led forums.*
3. *Support community organisations with funding applications.*
4. *Work with Community Development Workers to identify gaps in accessibility.*
5. *Encourage referrals from GP's to targeted services and establish an explicit pathway.*
6. *Expand awareness and access of bereavement support to all First Responder and bereavement-related partners so that an offer of support can be made immediately.*
7. *Identify and prioritise high-risk populations through working groups.*
8. *Improve data collation and intelligence gathering.*
9. *Engage with media organisations to work co-operatively on the reporting of suicides.*
10. *Commission further assessments, on a larger scale, that considers further populations.*

Sandwell
Health & Wellbeing Board

Next Steps

1. Receive endorsement for the Local Needs Assessment and 10 recommendations for action on Suicide Prevention.

2. Receive endorsement to update the Sandwell Suicide Prevention Strategy and Action Plan based on these recommendations.

3. Present the final Strategy and Action Plan to the Health and Wellbeing Board for approval before official launch in 2022.

Sandwell Suicide Prevention Partnership: Local Needs Assessment 2020 – 2021

Background

Current Situation

Sandwell has a preliminary strategy and action plan which relates to our Suicide Prevention priorities. These priorities have been developed alongside the Sandwell and West Birmingham CCG's Mental Health Strategy as well as the national guidance in the 2012 'Preventing Suicide in England' strategy by the Department of Health and Social Care.

Between 2017-19, Sandwell's average annual suicide rate was 10.8 per 100,000[1]. In line with national trends, the average rate in men is far higher than in women and the majority age range is between 35 and 64 years old[2]

The Suicide Prevention agenda within Sandwell is generally co-ordinated through the Sandwell Suicide Prevention Partnership (SSPP), which is attended by several key partners, including Samaritans, Kaleidoscope Plus and Papyrus who all provide an immediate suicide prevention service, and an NHS Mental Health Specialist. The partnership meets monthly to provide feedback on the strategy, share data insights and co-ordinate the local approach. The partnership is the primary group responsible for delivering the action plan.

The LNA uses the '6 Priorities' taken from the strategy (see Appendix 1). The principal priority is that by 2030, no-one will die of suicide in Sandwell.

The current six priorities of the Sandwell Suicide Prevention Strategy are:

1. To fulfil the 'Zero Suicides' Ambition.
2. To ensure the highest quality of care and support guaranteed by professionals.
3. To encourage a better awareness of suicide within local organisations and our communities.
4. To reduce the chances of suicide in high-risk populations.
5. To create an open culture where we listen to those with lived experience.
6. To reduce access to the means of suicide.

[1] PHE Suicide Prevention Profiles, https://fingertips.phe.org.uk/suicide#page/0/gid/1938132828/pat/6/par/E12000005/ati/102/are/E08000028/cid/4/tbm/1/page-options/ovw-do-0 (Accessed: 09/02/2021)

[2] PHE Suicide Prevention Profiles, (Accessed: 14/04/2021)

Purpose

The Suicide Prevention Strategy and Action Plan were drafted at the start of 2020. The picture in the borough and the ability to provide services has been forced to change by the Covid-19 Pandemic and so it is sensible to re-assess what the precise local situation is with regards to suicide prevention. This needs assessment uses both quantitative (i.e. statistical) and qualitative (i.e. interviews) data to analyse suicide prevention in Sandwell.

The outcome of this analysis will allow us to better understand what services are already available, how accessible these services are and whether they are functioning effectively or not. From the perspective of those most affected, they will also provide an invaluable insight into the lived experience that will ultimately inform our action plan.

Once the needs assessment has been completed, the Partnership can develop an action plan based on both data and lived experience. The tasks of this action plan will be carefully linked to the specific needs identified as well as the services and support groups available in the borough. This action plan will help the partnership to deliver on the 6 Suicide Prevention Priorities that will underpin the new strategy.

Methods

This needs assessment has used a mixed methods approach. We have used data from three primary sources as our quantitative approach. This has allowed us to identify our key demographics and highlight trends.

Our three primary data sources were:

1. **The Public Health England Suicide Prevention Profiles**, which provides access to historic data regarding suicide and self-harm as well as associated risk factors. This will provide us with the national, regional and local picture. The most contemporary data set is from 2017 to 2019 as they are recorded in 3-year periods.
2. **Hospital Episode Statistics (HES)**, relating to intentional self-harm. This details Sandwell residents who have been admitted into hospital for intentional self-harm. The codes which we have used for this data are X60 through to X84. The data sets are broken down by 3 key identity characteristics. Firstly, number of admissions, within annual ranges, covering the period from 2015 to 2020. Secondly, age group which is broken down both by sex and approximate brackets of 14 years. Thirdly, ethnicity which is broken down into sex again and ethnic groups.
   The data from the HES will provide insight as to which groups of the population in particular are at a higher risk of being admitted to hospital for intentional self-harm, and therefore potentially at a higher risk of attempting and/or completing suicide.
3. **Annual Coroner's Summary Reports**, summary reports compiled by the Public Health Research and Intelligence Team with data shared from the conclusions of the Black Country Coroner's Office. They provide a snapshot of the suicides that have occurred in Sandwell over a 12-month period. This is the most contemporary and local source of data available to us.

We have used interviews as our qualitative approach. This has provided us with an understanding of the experiences and insights of those affected as well as those who work towards suicide prevention. The interviews were semi-structured and lasted no more than 1 hour. There are two different versions of the interview questions, one for organisations and one for individuals (Appendix 4 and 5).

Four interviews were conducted with key 3rd sector partners and community organisations who all contribute to Sandwell's suicide prevention agenda. These partners were:

- *Papyrus UK*; specific suicide prevention support for ages 0-35
- *Samaritans*; all-age crisis support and partner training.
- *Kaleidoscope Plus*; post-vention support for those bereaved by suicide.
- *Tough Enough to Care*; local men's mental health charity.

All those who consented to being interviewed were informed of the purposes of the Needs Assessment, generally, and the interviews, specifically. Interviews were conducted by Tanith Palmer, a consultant in Public Health with prior experience of qualitative research methods, and Alexander Quarrie-Jones, a graduate in Public Health. Interviews were recorded for transcription purposes and then deleted afterwards. All interviewees were informed that they reserved the option to ask for their answers to be amended or deleted up to 2 weeks after the date of the interview. All the interviewees signed consent forms and agreed to the terms and conditions of the interviews as well as the overall purpose of this needs assessment. These forms also provided contact numbers for mental health and wellbeing support organisations in case the individual wanted to stop the interview and seek support.

Findings

Epidemiology of suicide in Sandwell

National, Regional and Local Data from 'Public Health England: Suicide Prevention Profile'

This is a publicly-accessible database that has been produced by Public Health England (PHE) to help develop understanding at the local level and support an intelligence-driven approach to suicide prevention[3]. For reference, it uses the Office of National Statistics' (ONS) definition of suicide, which is "*deaths with an underlying cause of intentional self-harm (ages 10 years and over) and deaths with an underlying cause of event of underdetermined intent (ages 15 and over)*"[4].

General Overview of Sandwell's suicide rates

In Graph 1, we can see that Sandwell's average suicide rate has fluctuated for the past 20 years rather than demonstrating any clear upwards or downwards trend. For the most contemporary reporting period 2017-19, the average rate of suicide (persons) in Sandwell

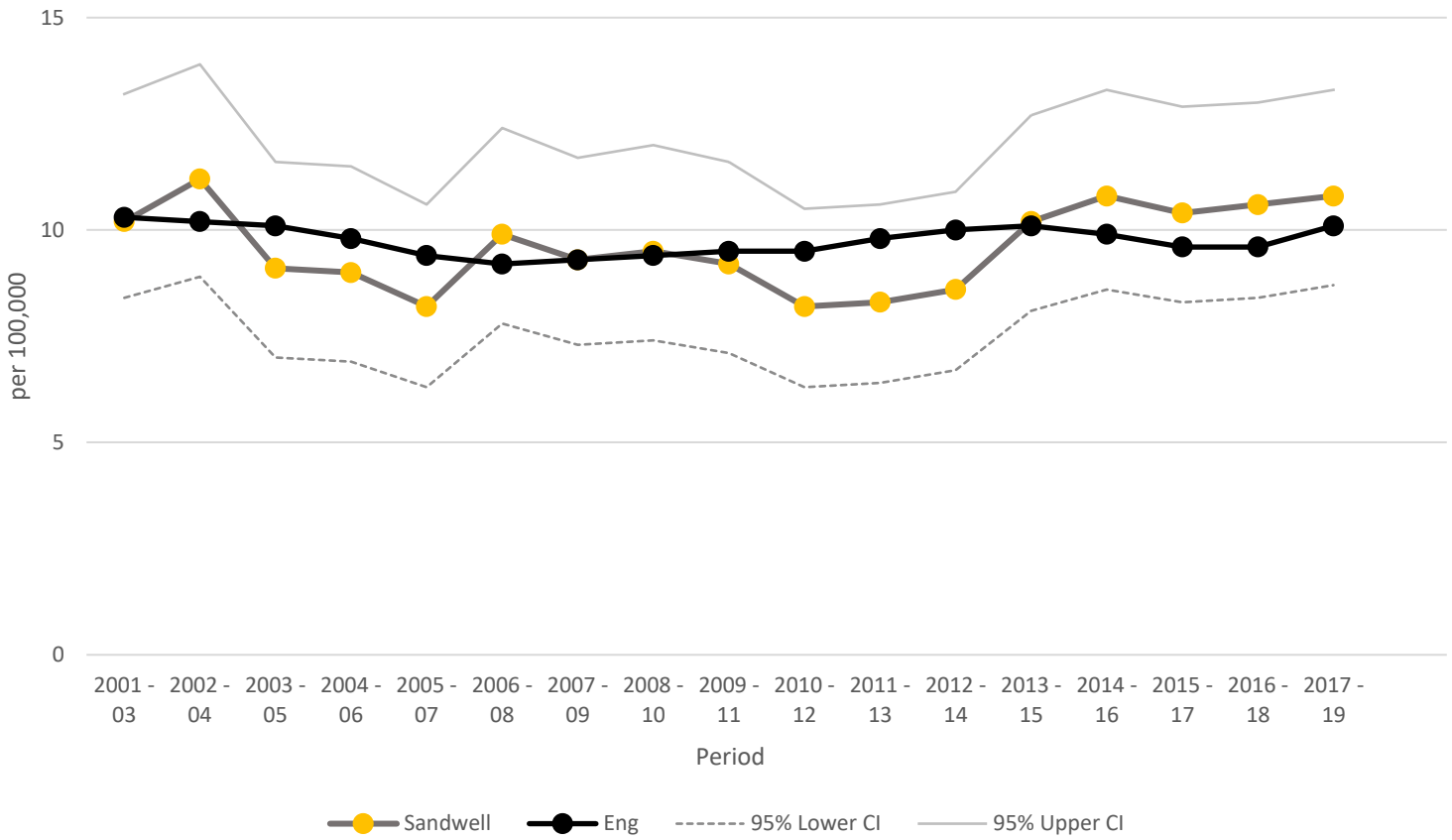
[3] https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide (Accessed: 18/02/2021)

[4] Office of National Statistics, https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/methodologies/suicideratesintheukqmi (Accessed: 23/02/2021)

was 10.8 per 100,000. This is slightly higher than both the regional West Midlands average (10.2) and the national England average (10.1).

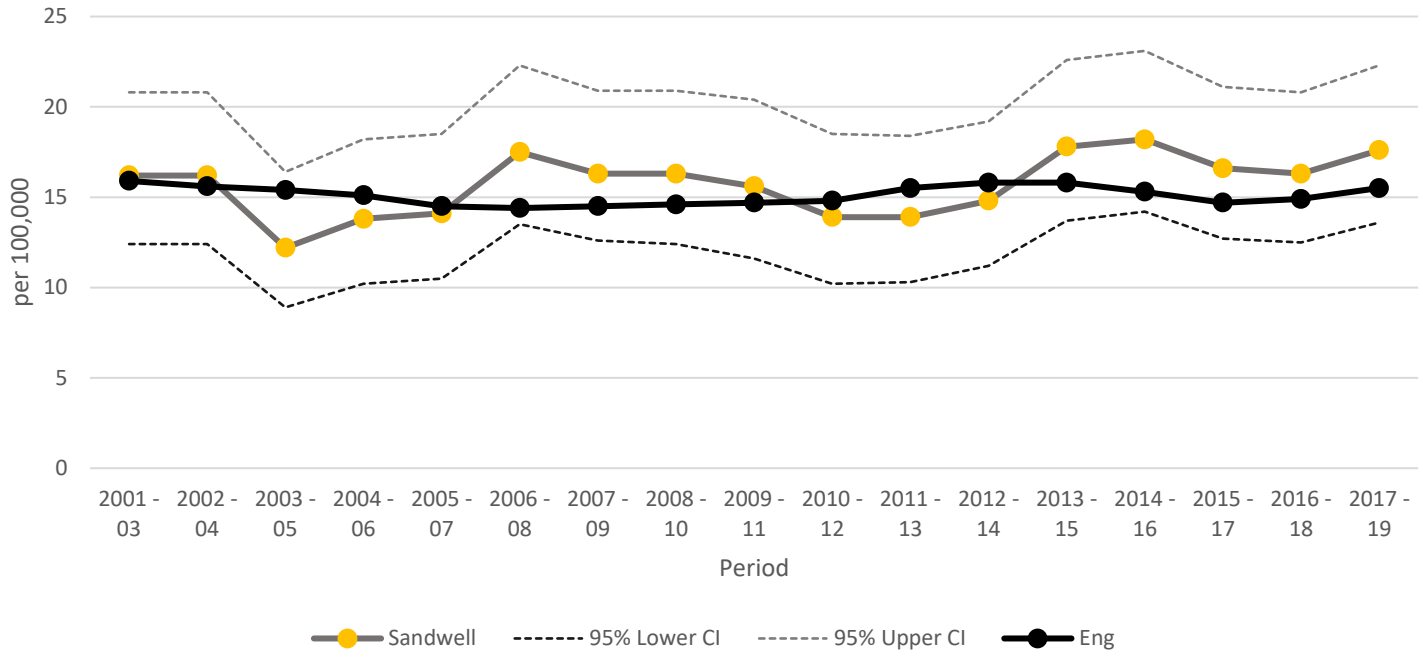
While these differences are not statistically significant, relatively small numbers at the local level means that we should interpret this with caution, as Sandwell's 'true' rates could fall anywhere between the upper and lower confidence intervals (dotted lines). Nevertheless, this demonstrates that suicide continues to be an issue of concern in Sandwell, the West Midlands region, and in England overall.

Graph 1: Sandwell average suicide rate per 100,000 with England average



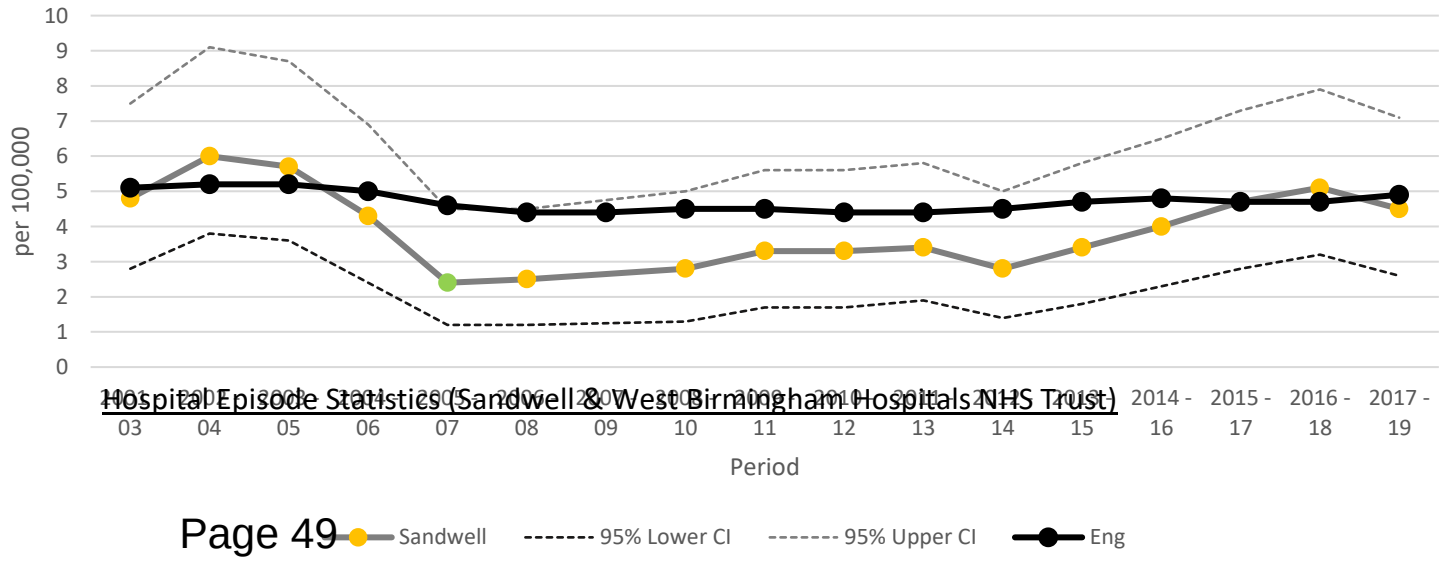
In line with the overall national and regional picture, Sandwell's rate of suicide in males is far higher than in females. As we can see in Graph 2, for the 2017-19 period, the rate in males was 17.6 per 100,000. Again, the Sandwell rate has fluctuated more widely than the national rate, especially in the last 6 to 7 years. For the reporting period 2017-2019, 79.77% of persons completing suicide were recorded as male.

Graph 2: Sandwell average suicide rate (Male) per 100,000 with England average



Graph 3 shows that Sandwell's suicide rate in females, for the period 2017-19, is slightly lower than the national rates. The Sandwell rate is 4.5 per 100,000 compared to 4.8 per 100,00 in the West Midlands and 4.9 per 100,000 in England. It should be noted though that the rate has only decreased compared to the national rate in the most recent reporting period and was otherwise on an upwards trajectory.

Graph 3: Sandwell average suicide rate (Female) per 100,000 with England average



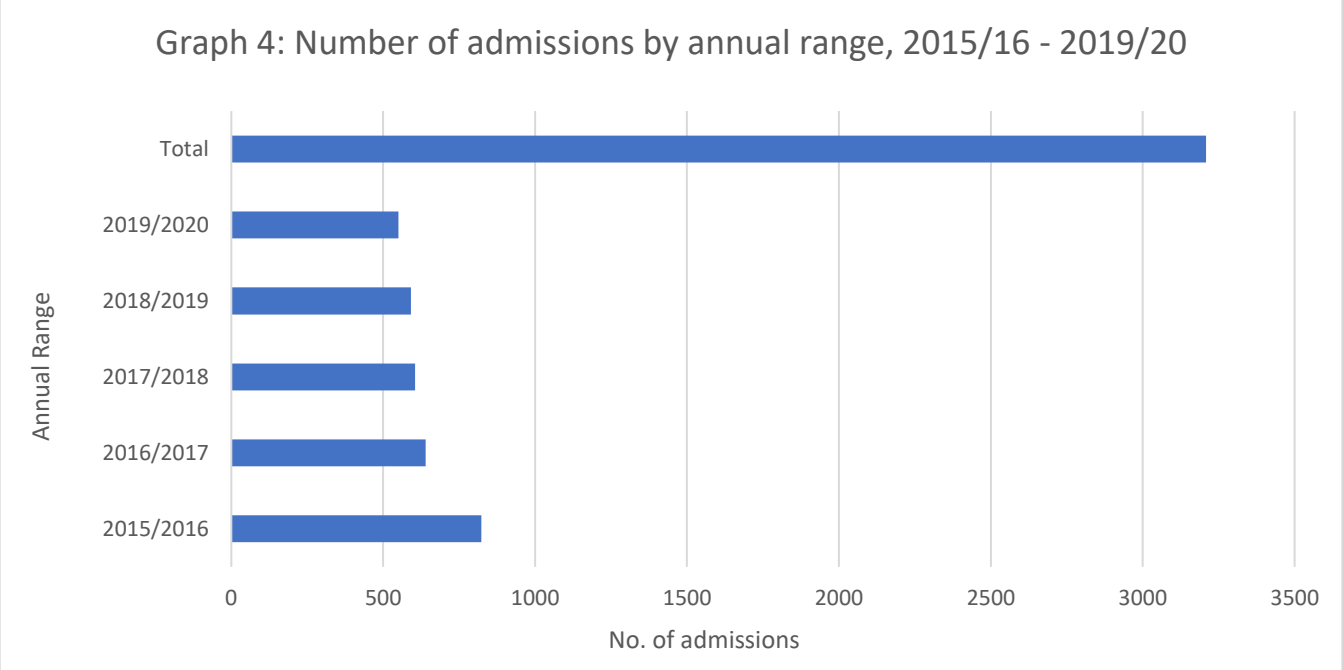
Hospital Episode Statistics (Sandwell & West Birmingham Hospitals NHS Trust)

Hospital Episode Statistics (HES) are recorded every time there is an admission of a patient to hospital. They are categorised through ICD 10 codes. We have used ICD 10 codes X64 through X80 as these relate to intentional self-harm.

Number of Admissions by Annual Range

Table 1: Number of Annual Admissions, 2015/16 – 2019/20		
Year	Number of admissions	% Proportion of Sandwell's population
2015/2016	823	0.26
2016/2017	640	0.20
2017/2018	605	0.19
2018/2019	591	0.18
2019/2020	550	0.17
Total	3209	*N/A*

The data in Table 1 gives us an overview of the admissions, categorised by the ICD10 codes above, in the past 5 years. As such, we can only comment about general trends. For example, we can see that the trend is generally decreasing over this most recent 5-year period, with admissions dropping by approximately 33% from 823 to 550. We can also see that the rate of admissions is dropping compared to the % proportion of Sandwell's population. This is best displayed in Graph 4 below.



We cannot definitively explain why this is the case, although an increase in awareness and conversation around mental health in recent years may be partially attributable. It should be mentioned though that hospital admissions for intentional self-harm will only make up a fraction of actual instances of self-harm and/or attempted suicide as most will go unreported. Also, while we see a decrease in admissions here, there has been no equal

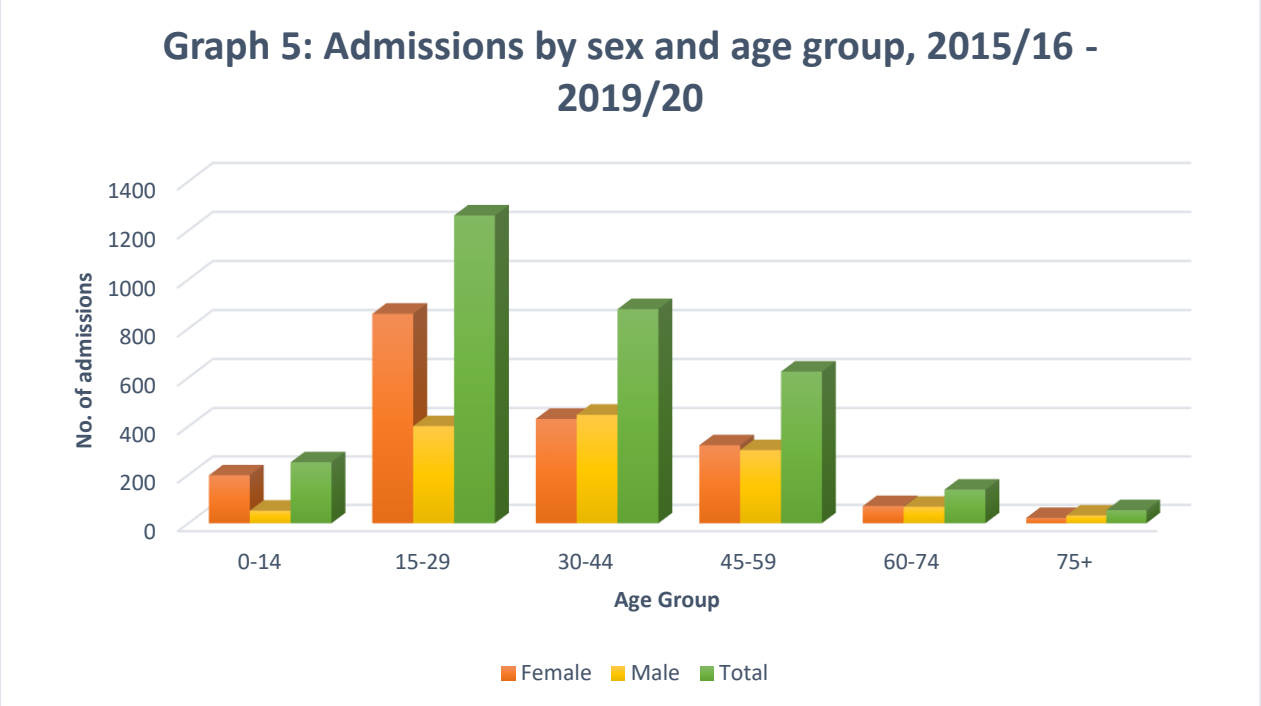
decrease in the average suicide rate so completed suicides are not following this trend. Therefore, we are using these figures as a proxy for wider trends, but this may not accurately reflect the whole situation.

Age Groups

Table 2: Admissions by sex and age group, 2015/16 - 2019/20			
Age group	Female	Male	Total
0-14	198	52	252
15-29	860	401	1261
30-44	431	448	879
45-59	322	302	624
60-74	71	68	139
75+	22	32	54
Total			3209*

*Some values suppressed due to values <6.

Table 2 displays the admissions in the past 5 years broken down by sex and age group. In line with national statistics, the largest group being admitted for intentional self-harm is females aged between 15-29. Equally, there is a higher proportion of females than males being admitted for this reason.



Graph 5 illustrates a clear peak in the 15-29 range with a significant decease after the 45-59 range. This is generally mirrored by the trends for females only. It should be noted again that within the 15-29 range, females make up over 66% of the whole group. It should also be noted that while a smaller proportion compared to later age groups, females represent 79% of admissions in the 0-14 age group. This may suggest that mental health issues appear

to either manifest at an earlier age than in males or are expressed more outwardly through intentional self-harm than seen in males.

Another trend to explore is within the 30-44 age group where the admissions for males is slighter higher than for females (448 to 431). This contributes to the trend that while the risk of intentional self-harm appears to decrease for females as they move from late adolescence/20's into their 30s, there is an increase for males. While the increased admission rate between 15-29 and 30-44 for males is approximately 10%, and this data does not confirm whether these were attempted suicides or not, it is representative of the overall increase in risk that appears to characterise this population group.

Ethnicity

Table 3: Admissions by ethnicity and sex, 2015/16 – 2019/20			
Ethnicity (general)	Female	Male	Total
White (British/Irish/Other)	1329	955	2284
Black or Black British	84	21	105
Asian or Asian British	198	119	317
Mixed	52	24	76
Other Ethnic Group	43	28	71
Not Stated/ Not Known	198	157	356*
Total	1904	1304	3209

*Some values suppressed due to values <6.

Table 3 displays a breakdown of sex and ethnicity, with the latter being grouped into general categories. When examining these figures, we should consider the demographic nature of Sandwell to understand the representation of different ethnicities in the admissions data relative to the wider ethnic populations. Using the data collected from the 2011 Census, we can summarise that 66.5% of Sandwell's population are White British while 33.5% of the population are from a Minority Ethnic Group[5]. It is acknowledged that population size will have likely changed since 2011 so these figures are for general reference. A further breakdown is displayed in Table 4 below:

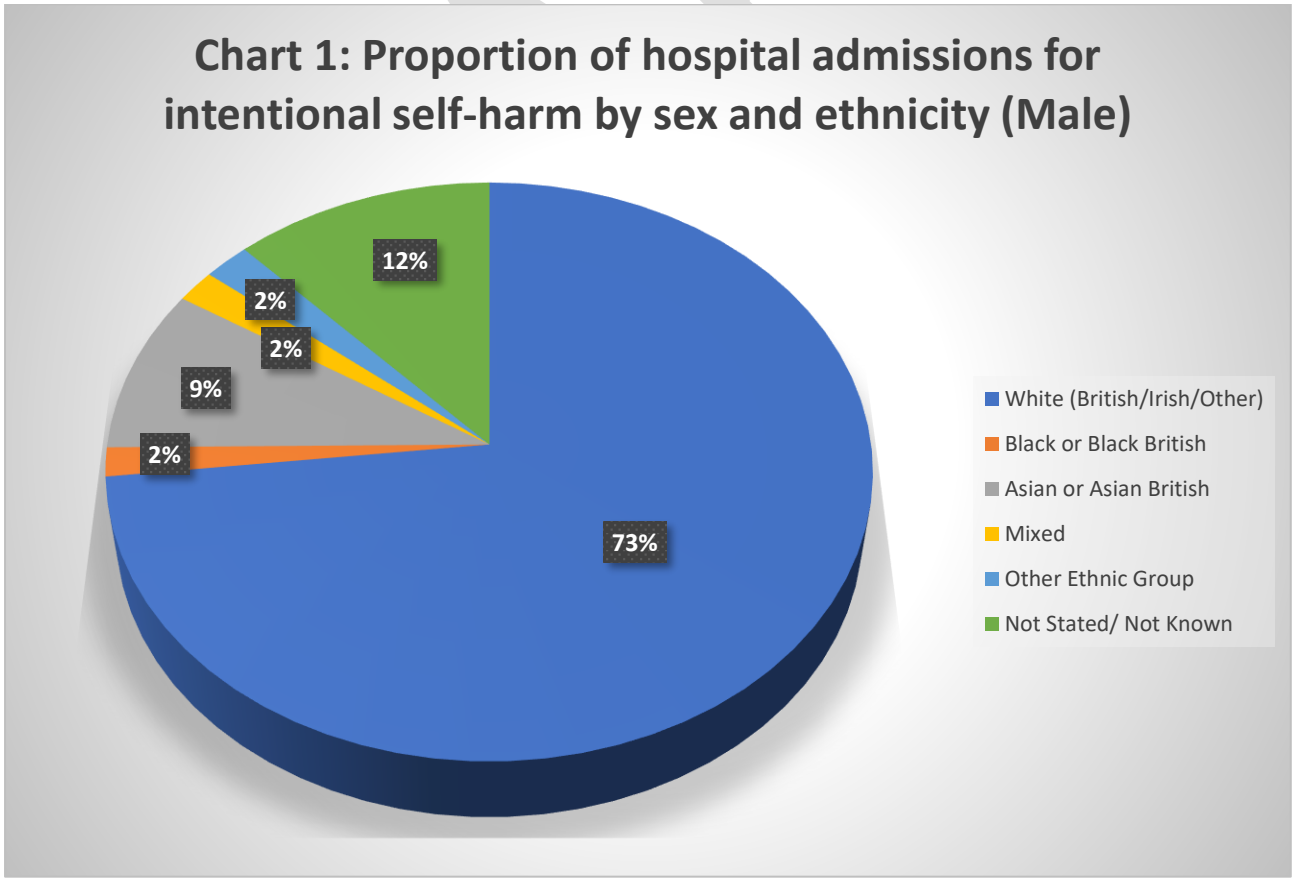
Table 4: Sandwell population by ethnicity, 2011		
Ethnicity	No. of People	% of Population
White (British/Irish/Other)	205,008	66.5
Black or Black British	15,778	5.1
Asian or Asian British	52,779	17.1
Mixed	8,721	2.9
Other Ethnic Group	901	0.3

[5] Sandwell Trends, https://www.sandwelltrends.info/2011-census/2011-census-ethnicity-hub/ (Accessed: 09/02/2021)

N.B. The 2021 Census will take place in March and will provide more contemporary data. Therefore, this document could be updated when the data is available to reflect the new trends.

Considering the data from Table 3, the percentage of White (British/Irish/Other) people of both sexes being admitted is approximately 71% while Black or Black British is 3%, Asian or Asian British is 10%, Mixed ethnicity is 2% and Other ethnic groups are 2%. Comparing this to the figures in Table 4, we can see that there is a higher representation of White (British/Irish/Other) people relative to population. On the other hand, there is a lower representation for most of the other major ethnicities in Sandwell. This is explored further in the discussion section.

In Table 3, we can also see that there have been more admissions for females than males, regardless of ethnicity, during the period 2015-20. Charts 1 and 2 below display how the proportions for each ethnicity broken down by sex. They show that there is a slighter higher proportion of non-White female representation in the overall figures for females compared to males. However, the trend of overrepresentation of White (British/Irish/Other) people in the figures continues in both sexes.



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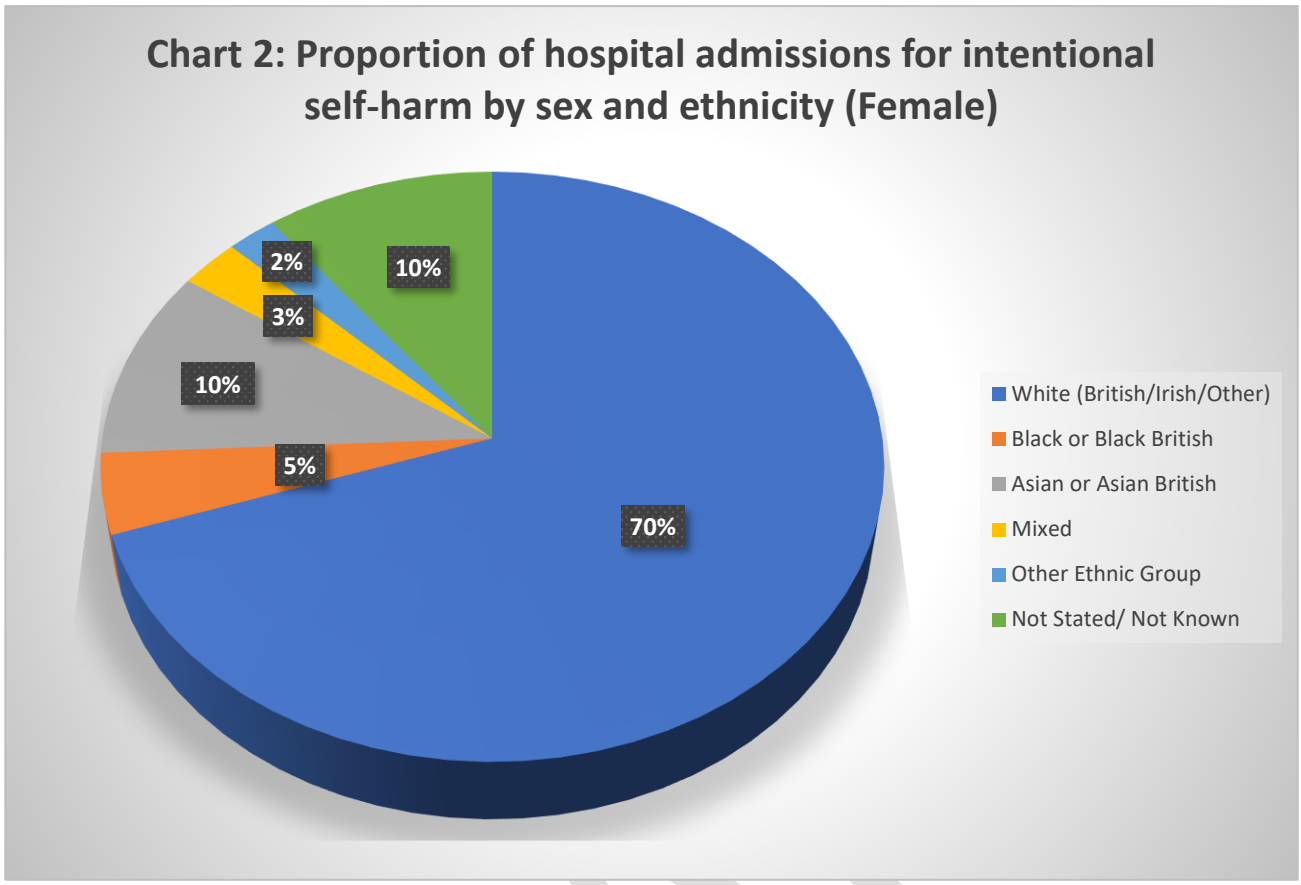

Annual Coroner's Summary Reports (2019/2020)

Coroner's reports for the years 2019 and 2020 were examined to understand the characteristics of those who had recently died by suicide in Sandwell. There were 19 deaths recorded as suicide in January-September 2019 and 18 in the same period for 2020. The January to September reporting window is due to the data only being available for the Research and Intelligence Team in October.

In this section we summarise key trends and learning points derived from the data that will help to inform our recommendations for next steps. However, detailed statistical breakdowns are not given due to small numbers in some of the categories, which could compromise the anonymity of some individuals.

Local data appear to reflect national trends:

- Males accounted for the majority of completed suicides recorded across both periods. The number of recorded suicides was almost four times higher for males than for females.
- The majority of suicides were in those aged 40-69. It should be said that these figures do not reflect the anecdotal increase in reported suicides in children and young persons that have occurred over the 2020/2021 winter months.
- The majority of suicides took place at home or at a private location, with a minority taking place in public settings such as parks and railway stations.

Key Themes and Circumstances

Across the reports for both 2019 and 2020, there were a number of key themes that emerged. These themes can provide insights into factors that may contribute to risk of suicide and help us to identify where support may be needed. It should be noted however that the factors involved in suicide are complex, and that we cannot assume any single issue or combination of issues was the cause of suicide.

Key issues identified across the 2-year period were as follows:

- Relationship breakdown (including child custody issues) was cited in almost a quarter of reports. Approximately two-thirds of people who died by suicide in 2019 and 2020 were single, divorced/separated or widowed, and over one-fifth had recently experienced bereavement.
- Approximately 40% were unemployed or retired.
- Substance and/or alcohol use problems were noted in over one-third of recorded deaths by suicide over the 2-year period.
- Previous suicide attempts and/or admission to hospital for self-harm episodes were noted in over a third of reports. Almost half of people who died by suicide were known to mental health services.

Social isolation is potentially a common underlying factor, particularly among those experiencing relationship breakdown or bereavement, or those who are unemployed. These issues may also be linked to increased financial difficulty, particularly when they co-exist with other difficulties or risk factors. Although it is not possible to determine this from the data, these are areas that may warrant further exploration.

While the number of recorded suicides was similar across both periods, considerably fewer reports in 2020 mentioned contact with mental health services, self-harm admissions or substance and/or alcohol use problems compared with the previous year. This may reflect impacts of the pandemic on access to and interactions with health services.

Qualitative Analysis

Interviews with Partners and Community Organisations

From the interview responses, key themes have been identified and outlined here. These themes were; awareness of services, accessibility of services, the impact of deprivation, the impact of Covid-19, the impact of training and lack of funding. These themes have been explored below:

1. **Awareness of Services**; It was felt that there was a general lack of awareness around non-medical services relating to suicide prevention and bereavement by suicide. All interviewees highlighted this as a major issue in Sandwell. People with lived experience described a lack of follow up or further support following the initial contact with primary care services. This was supported by service providers who felt that partners and associates failed to promote their availability widely enough and that some healthcare professionals weren't aware of them. One interviewee also suggested that using grassroots organisations would help to encourage awareness and discussion of the wider issues around suicide that could lead to better knowledge of services.
2. **Accessibility of Services**; Interviewees felt that services can be difficult to access for residents due to language barriers or low confidence in their offer/s. Multiple interviewees said that with Sandwell's diverse population, there are those that do not speak and/or read English as a first language and therefore find it more difficult to engage with services. This is the case in both physical literature and digital material. One interviewee also noted that they were anecdotally aware of more issues then were being recorded because many residents did not want to formally 'access' the service.
3. **Impact of Deprivation**; There is a higher than average level of deprivation in Sandwell. Interviewees felt that this made risk factors for suicide more widespread and compounded. It was also noted by one interviewee that in areas with high levels of deprivation, more of the population rely on public medical services rather than being able to afford private therapy, for example. This puts extra pressure on these services when services offered by partners should be able to intervene.
4. **Impact of Covid-19**; all interviewees felt there had been an impact of the service they deliver from Covid-19. In particular, they noted that as time goes on, the average number of calls or contacts has only increased as mental health issues are either newly developed or exacerbated by isolation, anxiety or lack of support. Service providers felt that they had managed to adapt their services quickly so that they could still deliver services at the same level as before but in alternative formats.
5. **Impact of Training**; Training can vary from short, online sessions to day-long courses and certifications. Interviewees all spoke positively about the impact of training, mostly because it raises professional awareness of a very complex subject. However, interviewees expressed different ideas on whether training should be provided generally or to more specific groups. One interviewee felt that training did not have

to relate just to suicide awareness/prevention and could be about how they could run a more effective organisation for that purpose.

6. **Lack of Funding**; increases in funding would allow services and organisations to expand their offer, for example, by employing more permanent staff or arranging sessions on a more frequent basis. Several interviewees said that there was scope to expand in their organisations but that they risked a loss of quality if they tried to stretch their current resources. This was in part because some of their funding comes from pots of money that they have to spend time and effort creating bids for.

Interviews with People with Lived Experience

The key themes identified through these interviews were; disappointment with clinical pathways, pro-activity from services, context of risk factors, reactions by communities and treatment by the media. These themes have been explored further below:

1. **Disappointment with Clinical Pathways**; Interviewees were dissatisfied with the routes offered by their GP's after seeking help for mental health issues. They described the common pathways as prescription of medication or referral for therapy, which they felt was over-subscribed with long-waiting lists. One interviewee said "*my GP just didn't have the focus on mental health. He recommended that I see a therapist but that couldn't happen for another 6 months, so I paid to go see someone eventually*". Another interviewee said that despite being quite distressed to visit the GP, they received little support and were "*fobbed off"* by being prescribed medication with little discussion of the actual issues. Another interviewee thought that going to the doctors first and ending up at a support group after all other options had been exhausted meant that the pathway was the wrong way around.
2. **Pro-activity from Services**; It was felt that the expectation that individuals who are/have been affected by suicide or suicidal ideation to "*make the call*" puts people off of accessing services because they might not be emotionally ready to move by themselves. One interviewee said that services need to reach out at the earliest point to families and friends affected by suicide. The interviewees stressed that there needed to be recognition by services that people will engage at very different points following their trauma. But if the offer is there then it's on the person's terms when they take it up. Similarly, one interviewee said that they thought it was only through luck that they managed to access a group therapy service after hospitalisation from an attempted suicide because no-one told them about it until they asked.
3. **Understanding Risk Factors**; There was a feeling that the wider context of common risk factors, especially in high-risk populations needs to be appreciated. For example, one interviewee when explaining why they thought suicide rates were much higher in men than in women remarked that for many men, their identity comes in part from their job. Therefore, if they become unemployed then they lose a key part of their identity which only heightens issues such as depression or anxiety. This theme was also touched on by another interviewee who said that the presence of structure in their life was one of the main factors in their recovery because they could appreciate succeeding in "*the positive small things*". For example, they said that when at their lowest even getting out of bed was physically difficult because it is like "*feeling the weight of a ten-tonne duvet*". Equally, one interviewee said it was the combination of a number of risks factors that caused them to attempt suicide. When identifying high-risk populations, we should consider first those who will already be affected by multiple factors.
4. **Reactions by communities**; interviewees who had lived experience of suicidal ideation said that despite the conversation on mental health, and more recently

men's mental health, coming on leaps and bounds, there is still a stigma around emotional wellbeing. The biggest issue, they felt, was getting those who are most neglected to share. One interviewee noted that setting is very important and meeting men "*on their terms*" might help their ability to trust those with complex thoughts. Another interviewee who had suffered a bereavement by suicide said that the stigma against talking about it was even worse, especially in their community. They found there were lots of "*closed doors*" and very little professional help that realised how difficult it was to discuss the bereavement in recent terms. As a result, the interviewee felt very isolated and became affected from poor mental well-being.

5. **Treatment by the media**; Interviewees explained how reporting on suicides and treatment of bereaved families needed to be improved as some media outlets currently take a very unsympathetic approach. One interviewee said that that the media were very aggressive in their questioning and cared very little that their family had suffered a trauma so recently. The interviewee said that one reporter even "*got into my home on the day of the funeral to question my partner*". They also said that they reported inaccuracies and failed to respond to the family's complaints.

Discussion

Key Points from Findings

- The qualitative data and parts of the qualitative interviews confirm that the most at-risk group continues to be males aged between 40 to 60. Therefore, recommendations should in part focus on actions for this high-risk population.
- Within the 88% where ethnicity was known on the HES figures, only 15% of people identified as not White (British/Irish/Other). According to the 2011 Census, 33.5% of people in Sandwell identified as non-white. This suggests that fewer non-white people are attending hospital for self-harm/suicide attempts than we would expect. We can conclude at the least that there is over-representation in the HES by those who are recorded as White or from another, less common ethnic group in Sandwell while there is an under-representation of those who are Black/Black British, Asian/Asian British or Mixed ethnicity. A possible reason for this that those with a White ethnicity are more likely to suffer with poor mental health, however, there are not many factors to support that. Another reason could be that those from under-represented ethnicities are less likely to engage with services over mental health issues and as a result are not 'on the radar'.
- The prevalence of recorded suicides occurring at home through hanging can make discussions of measures more complex and this demonstrates the need to have digital tools available as much as physical ones. This data can also be used to ensure that we have partner organisations who can work to specifically prevent locations in certain places (e.g. railway stations/tracks).
- Those who had lived experience of serious mental health issues and/or had had a suicidal ideology acknowledged that self-referral is very difficult and complex. Therefore, there needs to be much greater encouragement to 'spot the signs' and openly discuss these issues regardless of group or settings.
- Those affected from a bereavement by suicide should be treated with support that is more appropriate and specific to their needs. There also cannot be a singular approach to all those affected; for example, within a family, the approach that is taken with parents might not necessarily be suited for siblings or wider family.
- There was broad agreement by both sets of interviewees that action and support at the grassroots community level is the most impactful. Moreover, for those with lived experience, one of the best features of support that they received was being able to talk to those who had experienced exactly the same as them.

Limitations

- Even though Sandwell's average suicide rate generally and in males appears higher than the England average, the relatively small figures for Sandwell mean that it is difficult to say whether it is actually any higher or lower statistically.
- Similarly, any changes in the average rate over time will reflect small changes (e.g. 1 or 2 more suicides a year will make the rate look even higher) so we should instead consider the trend over a period of years.

- While useful, it is important to distinguish that the HES data on intentional self-harm will not directly translate to other data we have on suicide. For example, according to the HES data, the most at-risk group is females aged 15-29. However, in our other data sources, this is a low-risk group. This is because intentional self-harm, while containing attempted suicide, does not always prove a suicidal intention. It does however, give us an insight into self-harm and highlights that these groups may need to be supported in different ways as the targeted suicide services are unlikely to provide the support they need.
- The most recent data from some sources is now approaching being 2 years old and therefore not still accurately representing the borough.
- It should be noted that the even the most up-to-date data will likely not fully reflect the effects of the Covid-19 pandemic yet, although significant effects are expected due to the detrimental impact on mental health.
- Fewer individuals came forward to participate in the interviews than was hoped for in the participants with lived experience. This could be because of the sensitive nature of the topic as well as the difficulty of only being able to use virtual means of communication. Despite this, common themes were found between the interviews that were undertaken.
- We were not able to engage with any individuals under the age of 18 so we are lacking in qualitative data from a child/young person's perspective.

Recommendations

1. **Raise awareness of suicide prevention and bereavement support through training for all frontline staff through online platform;** there is already a wide-ranging e-learning package around safeguarding available for council employees. We should consider using a similar approach for a training package that would cover these topics and link to wider themes on mental health and emotional wellbeing.
2. **Pilot town-based, community-led forums**; there are currently two different pilots based in Tipton with one in particular being wholly-community led with minimal steer from Public Health. This type of grassroots model is one that should be replicated if it works well enough because actions taken by and within the community are much more impactful.
3. **Support community organisations with funding applications**; Public Health and similar organisations with experience of the application process should aid community organisations with bid writing for funding so that they can access the means to grow.
4. **Work with Community Development Workers to identify gaps in accessibility**; one of the major issues highlighted was the lack of accessibility for suicide prevention services. Therefore, Public Health, the CDW's and partners should all actively work to remove the common barriers, whether these be in language or digital literacy or confidence.
5. **Encourage referrals from GP's to targeted services and establish an explicit pathway**; partners can work alongside GP's to ensure that they are aware of non-medical services as well as increase confidence that there is support available for anyone who has been affected by suicide. Part of this will require GP's to have a working knowledge of all up-to-date services so information and communication flow will be critical.
6. **Expand awareness and access of bereavement support to all First Responder and bereavement-related partners so that an offer of support can be made immediately**; similarly, to the point above, knowledge of bereavement services by professionals can help families and friends feel that help is available, at any time which they chose to take it.
7. **Identify and prioritise high-risk populations through working groups**; the data we've looked at has helped to identify high-risk populations which will require more intense efforts to fight the issues that affect them. There is currently a group undertaking work into suicides in children and young people that is making excellent progress. Further to this, we should actively engage with these populations because they will provide the best insight. Possible future working groups should be focused on populations such as middle-aged men who have recently been unemployed and/or faced a relationship breakdown. Ethnic minority communities, emerging groups directly and indirectly affected by the pandemic.
8. **Improve data collation and intelligence gathering**; there are multiple sources for statistical data that can be shared on a regular basis to identify developing trends. Equally, there should be encouragement for recorded and anecdotal evidence from

the borough to be shared among partners so that we can continue to understand what is happening at every level. This also feeds into the requirement to link to the Police's real-time surveillance activities.

9. **Engage with media organisations to work co-operatively on the reporting of suicides**; we should ensure that media organisations have a responsibility to report accurately and compassionately on suicides. We should also establish awareness training sessions with media organisations and reporters so that they understand the impact of their messages on bereaved families and friends.
10. **Commission further assessments on a larger scale that considers further populations**; as noted, this exercise has identified some key issues but has demonstrated that there is scope to commit to further assessments that can explore more specific populations. For example, an investigation into the link between self-harm and suicide may provide further insight when analysis HES data.

Digital Sources

https://www.sandwelltrends.info/2011-census/2011-census-ethnicity-hub/

https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/methodologies/suicideratesintheukqmi

https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide

Appendices

Appendix 1: Sandwell's Suicide Prevention Six Priorities

Sandwell Suicide Prevention Partnershi

Appendix 2: Interview Questions for Partners/Community Organisations

Sandwell Suicide Prevention JSNA 202(

Appendix 3: Interview Questions for Individuals

Sandwell Suicide Prevention JSNA 202(

Appendix 4: Interview Guide and Consent Form

Sandwell Interview Information and Cons

Appendix 5: Needs Assessment PowerPoint Presentation

SSPP NA Presentation Apr 12 2

Sandwell Health & Wellbeing Board

Agenda Item 8

Sandwell Health and Wellbeing Board
22nd September 2021

Update Topic:	**Health Inequalities Update**
Contact Officer:	**Clair Norton, Health and Wellbeing Board Manager** **Clair_Norton@sandwell.gov.uk**
Link to board priorities	1. We will help keep people healthier for longer 2. We will help keep people safe and support communities 3. We will work together to join up services 4. We will work closely with local people, partners and providers of services
Purpose of Update:	• To provide an update on health inequalities within Sandwell and Sandwell compared to the regional and national figures.
Recommendations	• That the Board note the content of the update.

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Healthier Futures
Black Country and West Birmingham

BCWB ICS
Health Inequalities Improvement Programme

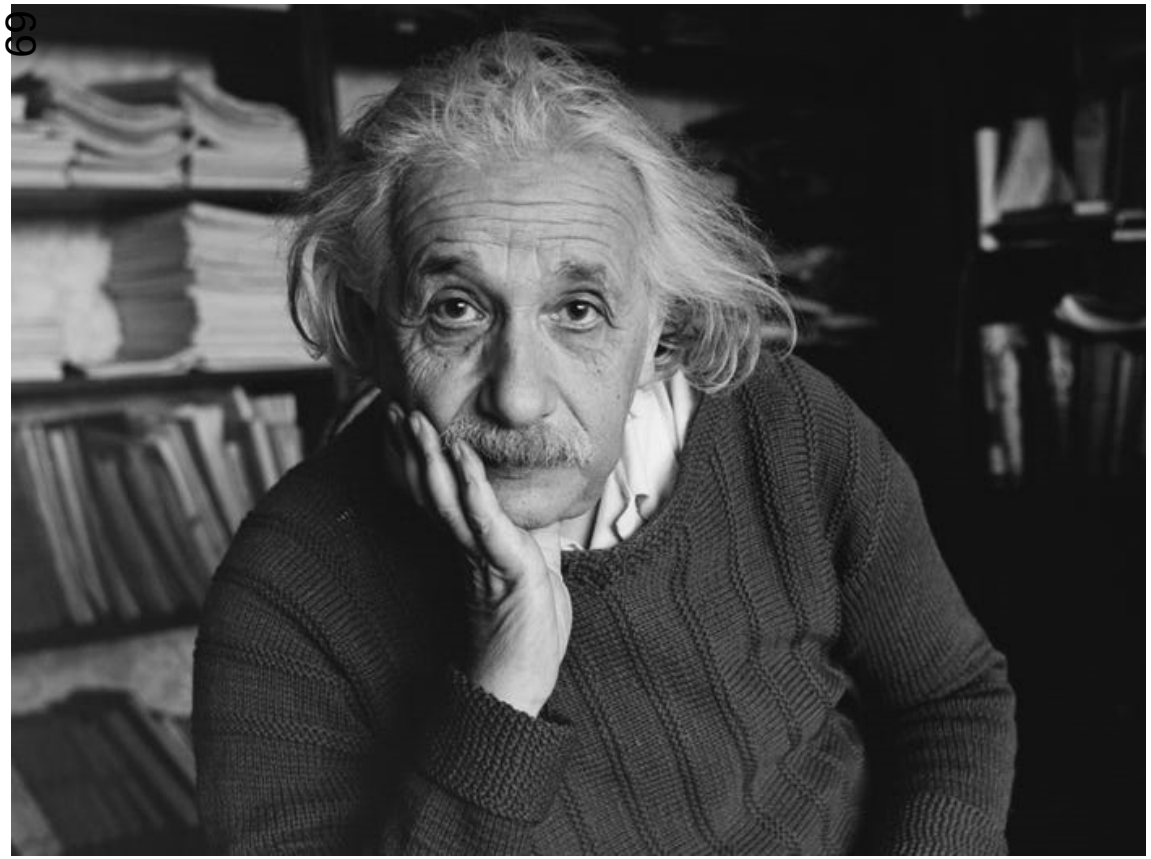
14th September 2021

Building Healthier, Happier Communities

Taps Mtemachani
Director of Transformation and Partnership

Big Issue

The Big Issue 1



“We cannot solve our problems with the same thinking we used when we created them”

Albert Einstein

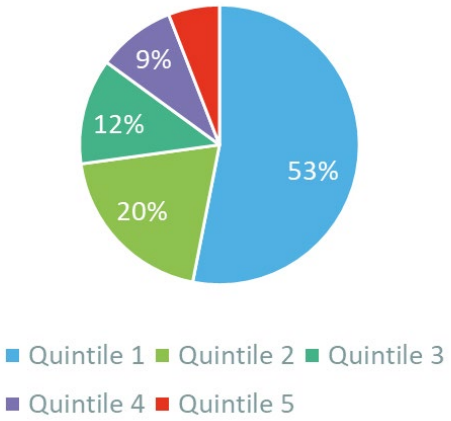
The Big Issue 2

Health inequalities are avoidable, unfair and systematic differences in health between different groups of people. There are many kinds of health inequality, and many ways in which the term is used. This means that when we talk about 'health inequality', it is useful to be clear on which measure is unequally distributed, and between which people.

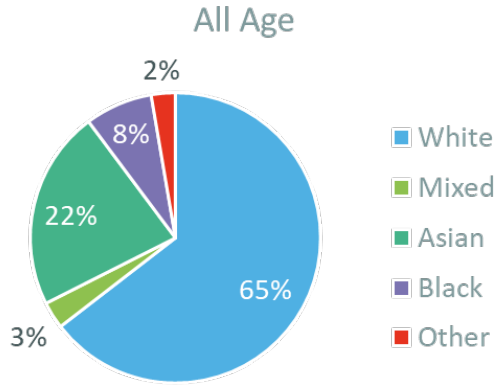
1. **Inequalities between BCWB and England – There is a significant gap between BC&WB and the National average for both life expectancy and healthy life expectancy:**
   a) . **This equates to approximately 22,500 years of life lost each year** (based on 14,075 deaths across BCWB in 2018 and a 1.6year life expectancy gap between BCWB and England).
   b) The healthy life expectancy gap between BCWB and England is 5.2 years for males and 5.6 years for females. **This equates to approximately 100,000 healthy life years lost each year** (based on a HLE gap between BCWB and England of 5.4 years).
2. **Inequalities within BCWB – there is a lot of variation in life expectancy within the BCWB – 2 examples as follows:**
   a) People in contact with mental health services life expectancy is 18 years less for males and 15 years less for females than the general BCWB population. **This equates to 24,000 years of life lost each year**.
   b) People living in the most deprived 20% nationally live approximately 4 years less than the general BCWB population. **This equates to 30,000 years of life lost each year**.
3. **Mortality across vulnerable groups**
   a) There are approximately 1,400 deaths per year in people aged 18-74 with serious mental illness. The life expectancy gap is 17 years. **Therefore 23,800 years of life lost**.
   b) 14,075 deaths in BCWB in 2018. 53% of our population live in the most deprived quintile. **Therefore, approx. 7,500 deaths a year in this group**. 4 year gap in life expectancy between the most deprived quintile nationally (76 years) and BCWB as a whole (80 years).

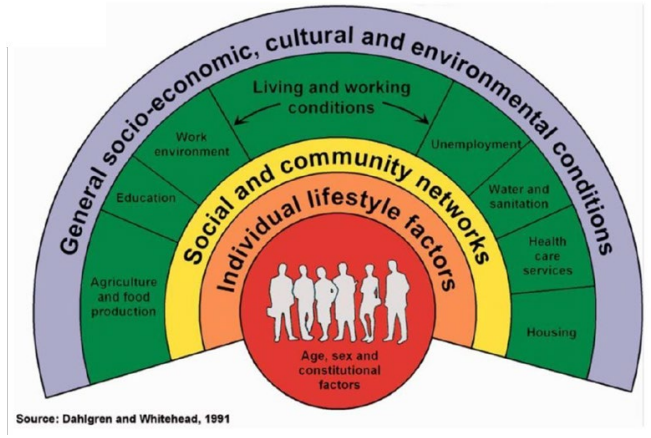
The Big Issue 3 – causal and compounding factors

Over half the population of the Black Country and West Birmingham live in the most deprived national quintile. There is variation across our five places with Dudley in particular having fewer people living in areas in national IMD quintile 1 and more people living in quintiles 4 and 5.



35% of the population of Black Country and West Birmingham is from Black and Ethnic Minority communities. This is higher in our under-18 population with 44% of the population being from Black and Ethnic Minority communities. This is significantly higher than England at 23%.





- In BCWB, there is a **high proportion of people with low qualifications or none**, especially amongst men;
- For level 4 qualifications (first or higher degree, professional qualifications or equivalent) Asian and Black populations outperform while White and Mixed populations underperform, with the reverse being true at lower levels;
- The apprenticeship level is dominated by the White population (90% from a 70% cohort);
- **Unemployment rates in BCWB are significantly higher than national averages** especially for Mixed ethnic group and Pakistani/Bangladeshi populations;
- high numbers of children living in poverty (17.7% live in workless households and 28% in relative low-income families);
- In 2018, 12.4% of households were living in fuel poverty, above the national average of 10.3%;
- The high levels of air pollution, with 32% of neighbourhoods in the 'worst' category nationally.

Principles

Our Response – The Principles

- Having some understanding the extent/scale of inequalities – the deprivation factor and the richness of our diversity (willingness to go further in understanding) – understanding those as **opportunities for improvement;**
- **Recognising the knowledge and expertise within partners organisations** particularly LAs and VCSE and developing a governance infrastructure that reflects that;
- Addressing **HIs as a golden thread** across all of our commissioning **with focused capacity** to drive/coordinate the work through the **Health Inequalities Improvement programme;**
- **Acknowledging the primacy of place** not only in terms of delivery but in terms of connectivity with our communities establishing a **co-production process at Place**;
- Building a governance infrastructure that supports these principles at ICS and Place level and then **being clear about the issues we are going to resolve and when** – reflected in an ICS Health Inequalities Strategy and Place developed and driven Implementation Plan.

Health Inequalities Improvement
The Fundamental Approach

Improvement

- Promote development, cultural change and momentum with a strategic ambition to level up health and wellbeing and drive out inequality
- Support the development of a nimble and learning culture in all interventions
- Address complexity and seek to understand historic / current barriers to successful improvement
- Reflect current system pressures presented by Covid and its wider impact on health and care services identifying improvement opportunities and monitoring delivery
- Connect development and learning across our places

Collaborative working

- Build on existing initiatives and relationships across our places to maximise deliverability of improvements
- Understanding and managing risk across the partnership – facilitating mutual aid where feasible
- Provide clarity about role of system and place in the delivery of initiatives
- Reflect the ambitions of the Integrating Care White Paper
- Maximising anchor network opportunities and supporting delivery across our places
- Foster creativity and innovation in partnership, combined with realism and practicality – ideas need to be deliverable

Intelligence-led design

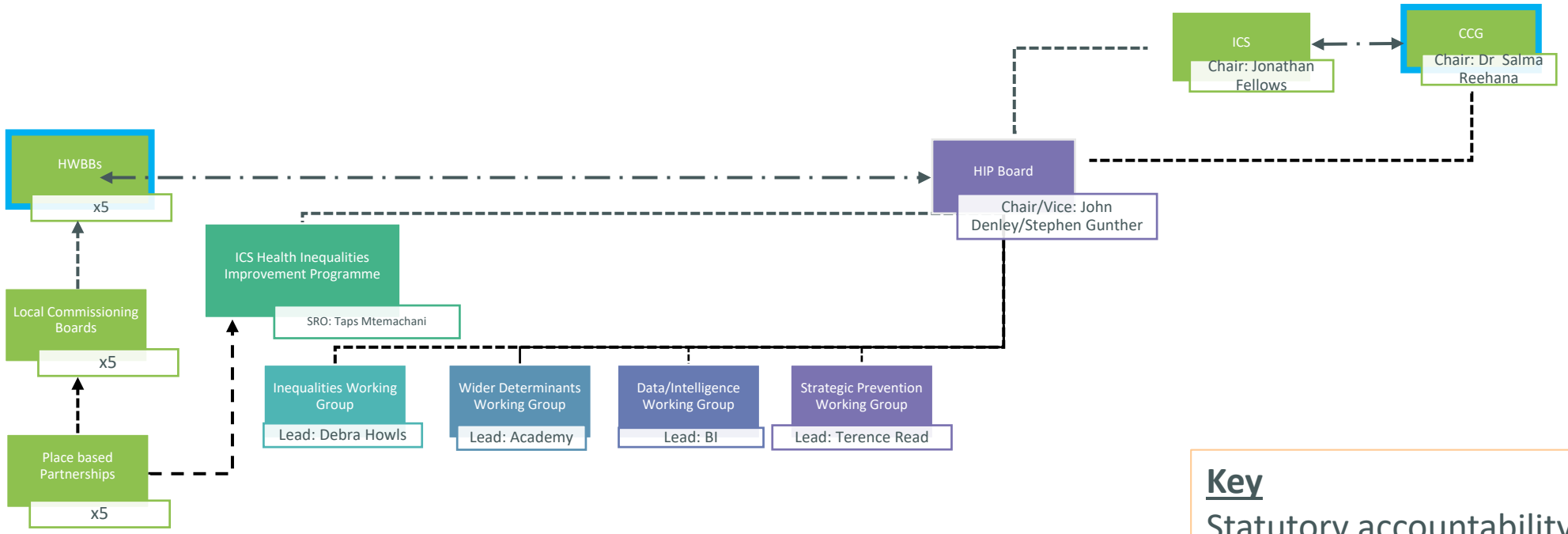
- Intelligence and evidence led design, including wider determinants of health
- Promote transparency – using data and intelligence to inform, baseline and measure impact
- Build foundations on population health management and foster a culture of health improvement
- Build in qualitative data capturing and synthesis as part of our overall population health management
- Evaluation of 21/22 deliverables as a bridge into a longer-term strategy from 2022 onwards

Engagement and co-production

- Engagement, co-production/co-design in collaboration with our communities
- Build in Person/Population led evaluation to better understand impact of activities/interventions
- Strengthening the role of the VCS in reaching communities
- Supporting/strengthening the resilience of community assets
- Delivering social value

Governance, Accountability and Leadership

Current Governance, Accountability and Leadership for HIs



Key

Statutory accountability: ——

Reporting to: - - - - - - - - - - →

Symbiotic link: ←· — · — · —→

Future governance/delivery (ICB and Place based Partnerships)

Role of the ICB

- Facilitating best practice and learning – e.g. PDSAs – and unblocking challenges where possible
- Quarterly reviews of impact and measures
- Longer-term discovery phase and strategy development

Role of the PbPs

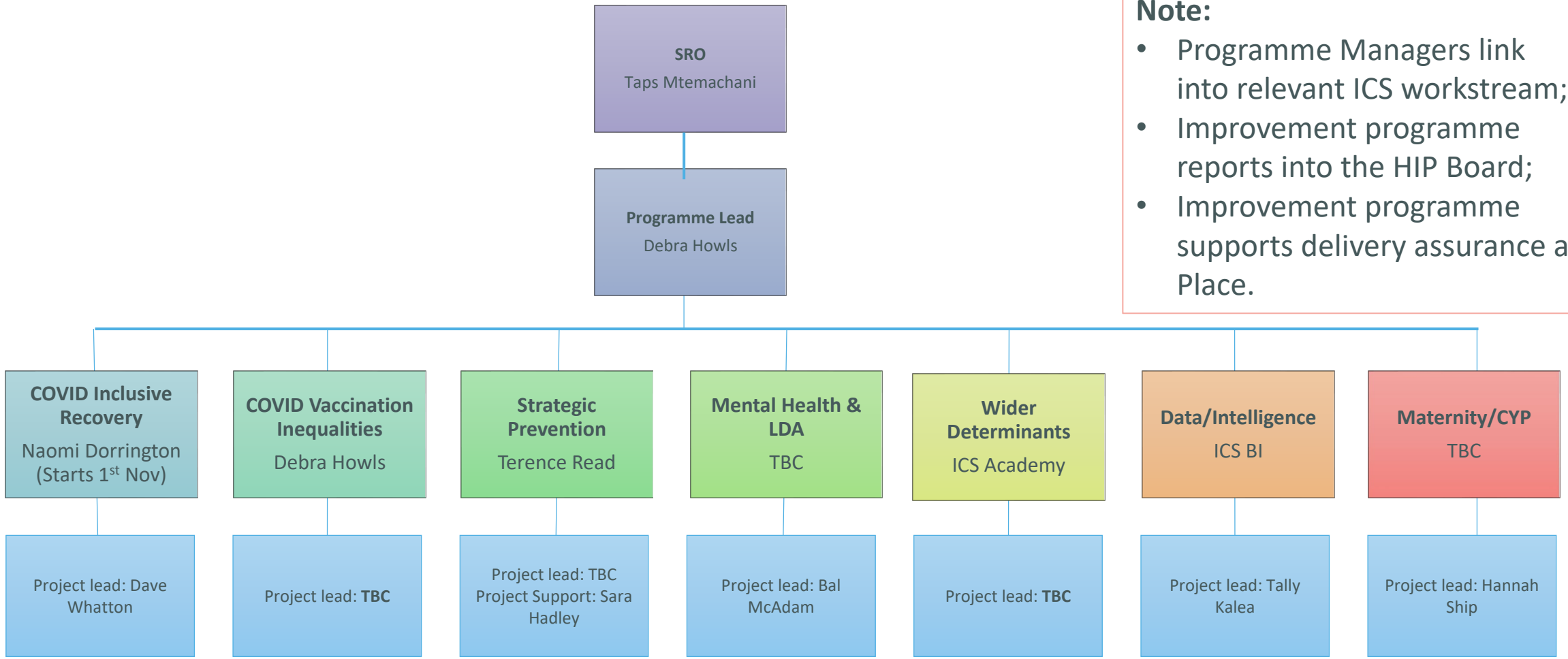
- Coordinated delivery of initiatives to address inequalities
- Supporting providers to deliver
- Monitoring and reporting progress

Governance, Accountability and Leadership

- HIP Board currently reports through to the ICS Board as an advisory/implementation forum;
- HIP Board chaired by DPH (John Denley and Stephen Gunther) supported by Taps Mtemachani as ICS SRO for Inequalities and Strategic Prevention;
- Subgroups to HIP board include:
  - Wider determinants (currently led by the academy);
  - Data/Intelligence (in development – will be led by BI);
  - Inequalities working group (in development – will be led by CCG Transformation Team)
  - Strategic prevention forum (in development – will be led by the CCG Transformation Team).
- The longer term view is for the Inequalities agenda to have oversight from ICS Partnership Board with a dual reporting mechanism through to the ICB;
- The Health Inequalities Improvement Programme (described overleaf) will coordinate the development and implementation of a Health Inequalities Strategy and Monitoring Framework working with Place Boards and reporting into the HIP Board;
- Delivery against the strategy will be driven by Local partnership/delivery arrangements – (currently with oversight from LCBs with a mandate from the CCG Governing Body – eventually this will be through the Place Partnership Boards);
- Place Partnership Board will report through to the HWBBs on Health Inequalities via the DPH;
- HWBBs to operate a symbiotic link to the HIP board through DsPH.

The Programme

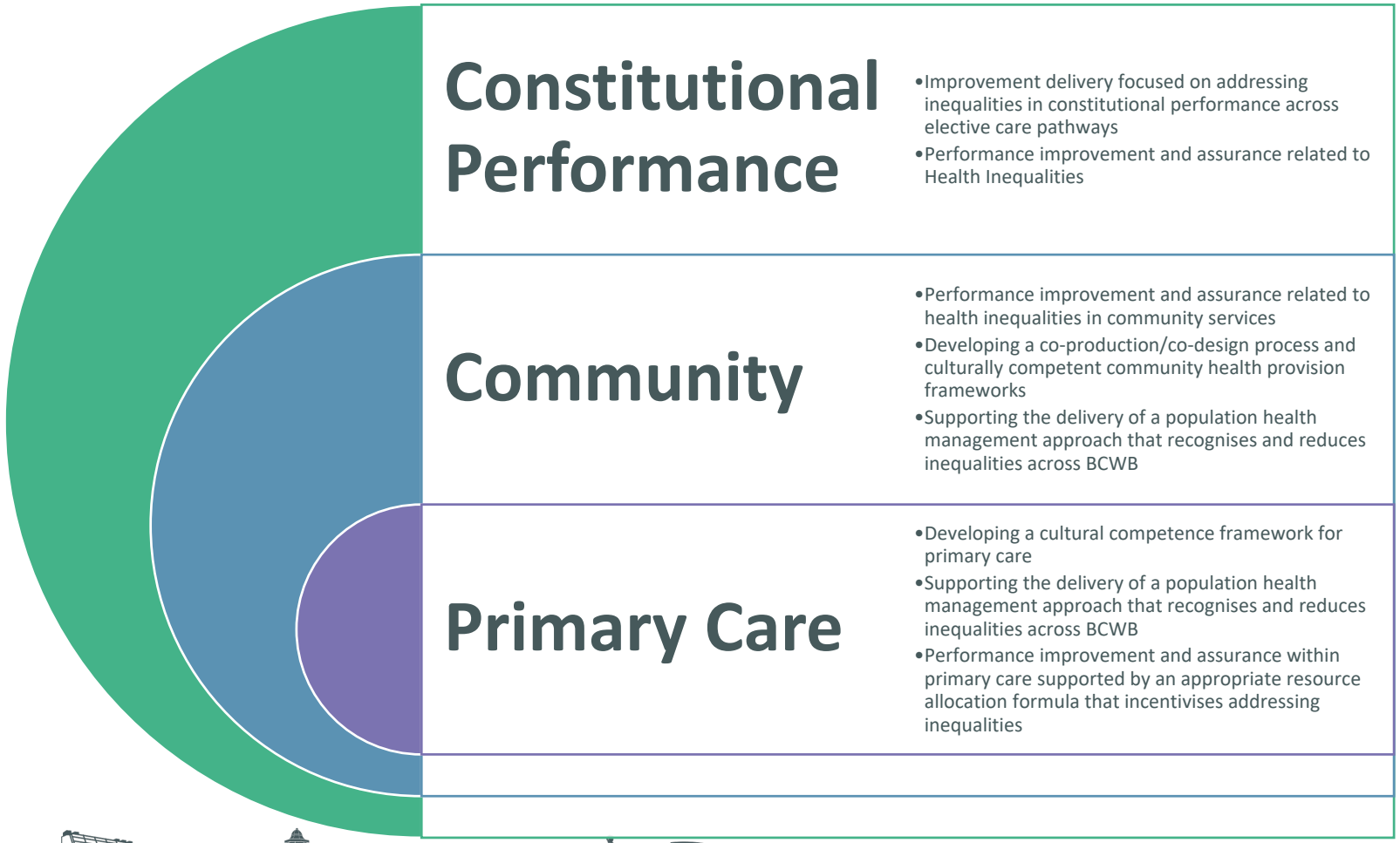
Health Inequalities Improvement Programme



Note:

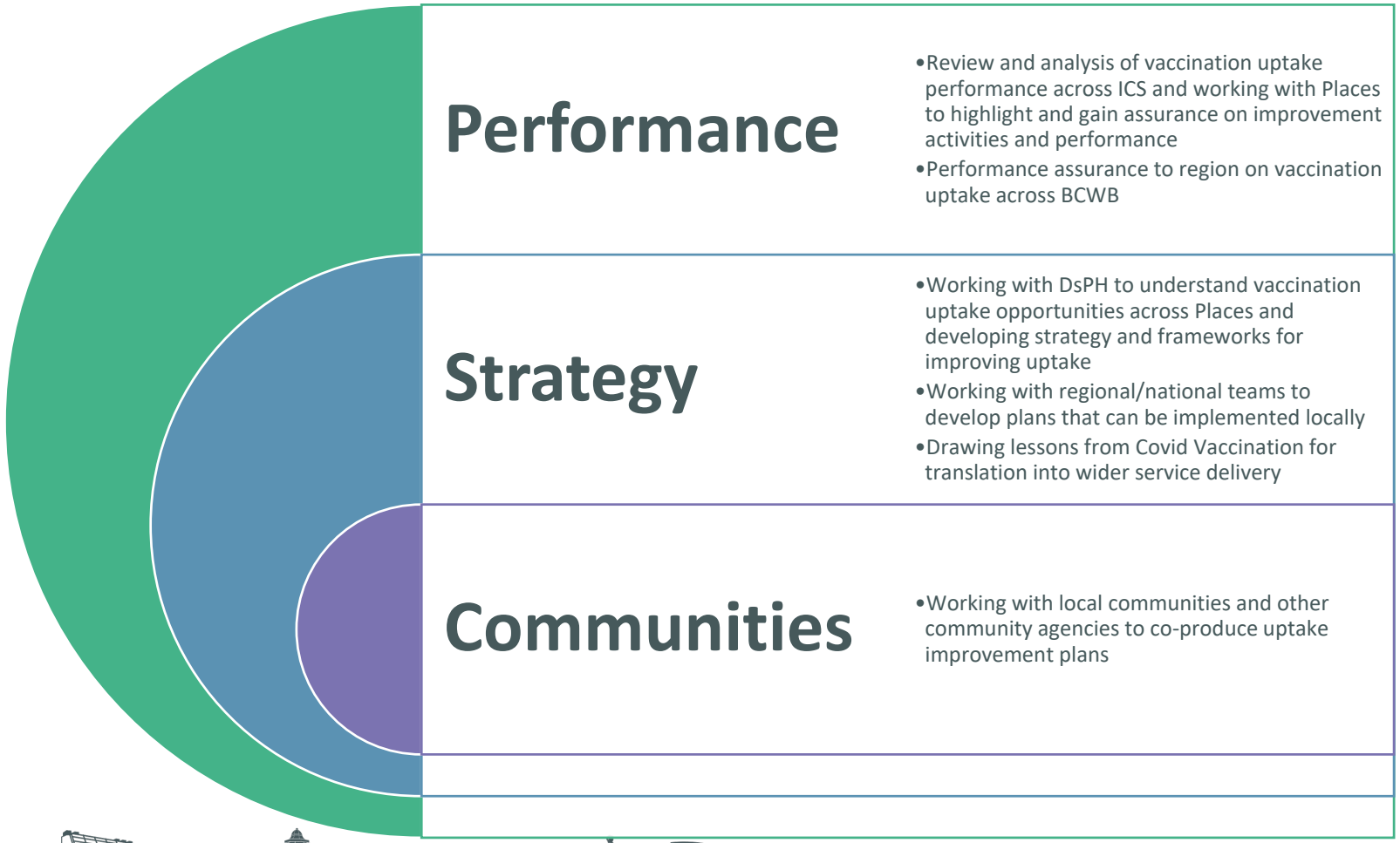
- Programme Managers link into relevant ICS workstream;
- Improvement programme reports into the HIP Board;
- Improvement programme supports delivery assurance at Place.

Health Inequalities Improvement Programme
COVID Inclusive Recovery



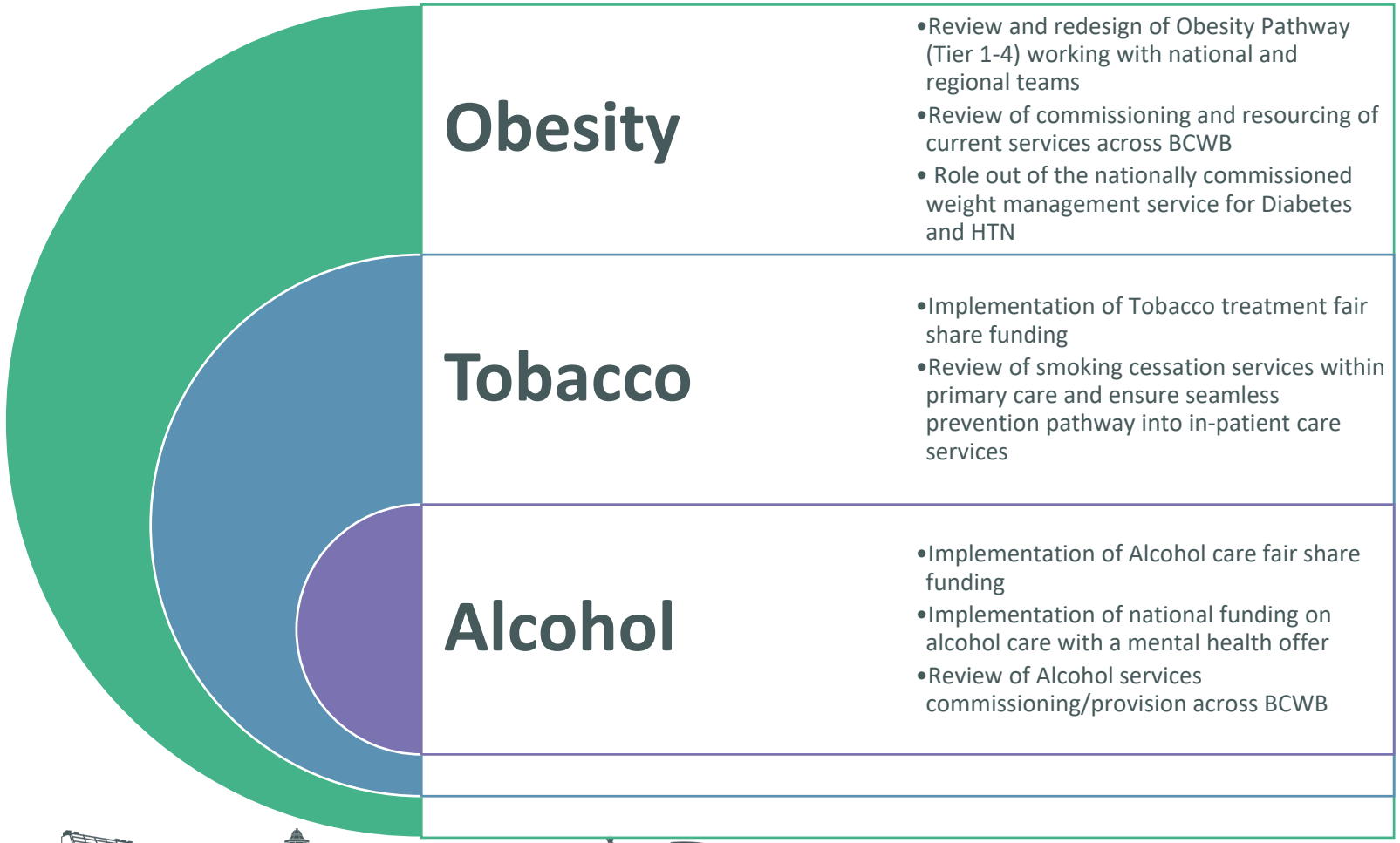
Health Inequalities Improvement Programme

COVID Vaccination Inequalities



Health Inequalities Improvement Programme

Strategic Prevention



Obesity

- Review and redesign of Obesity Pathway (Tier 1-4) working with national and regional teams
- Review of commissioning and resourcing of current services across BCWB
- Role out of the nationally commissioned weight management service for Diabetes and HTN

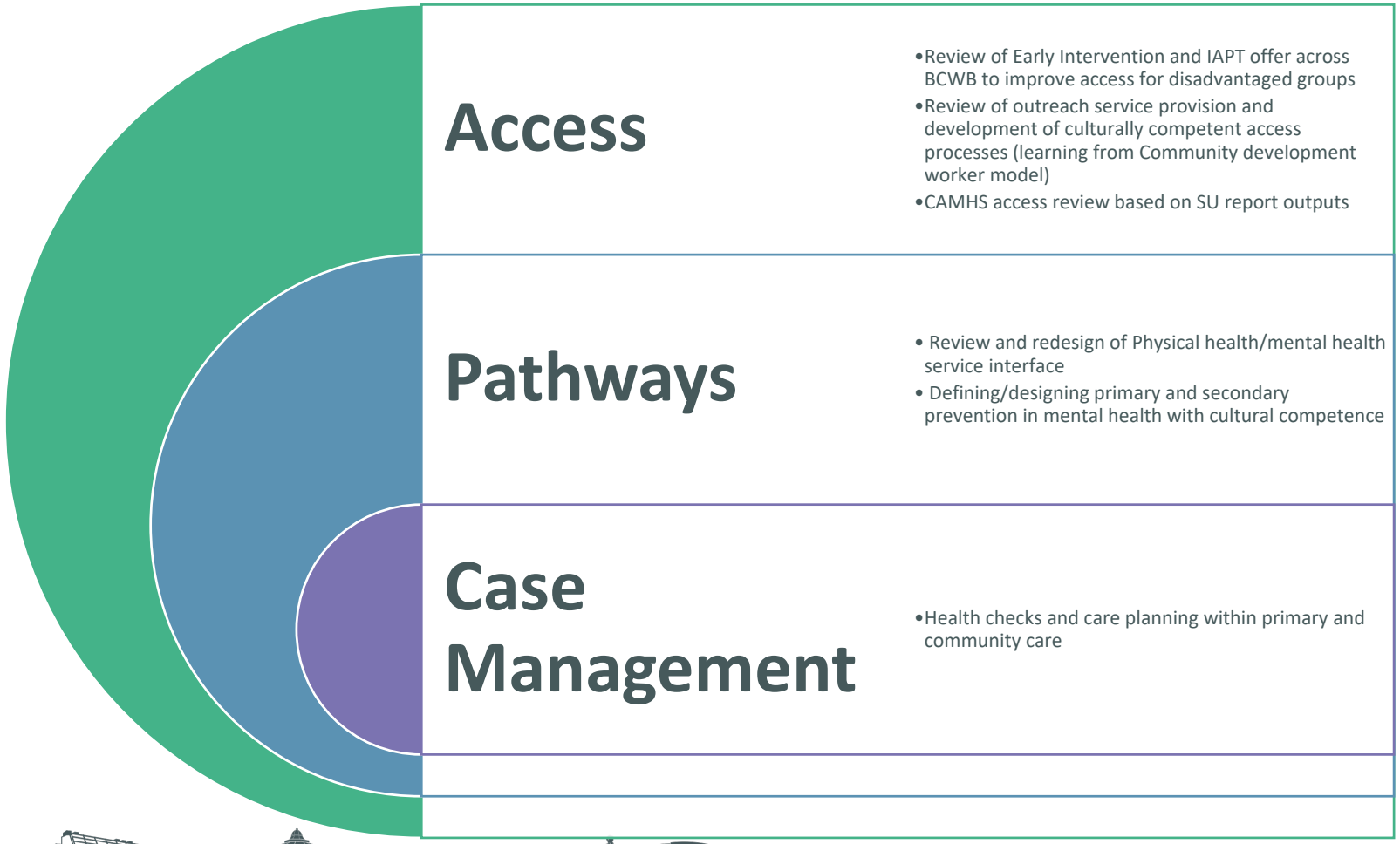
Tobacco

- Implementation of Tobacco treatment fair share funding
- Review of smoking cessation services within primary care and ensure seamless prevention pathway into in-patient care services

Alcohol

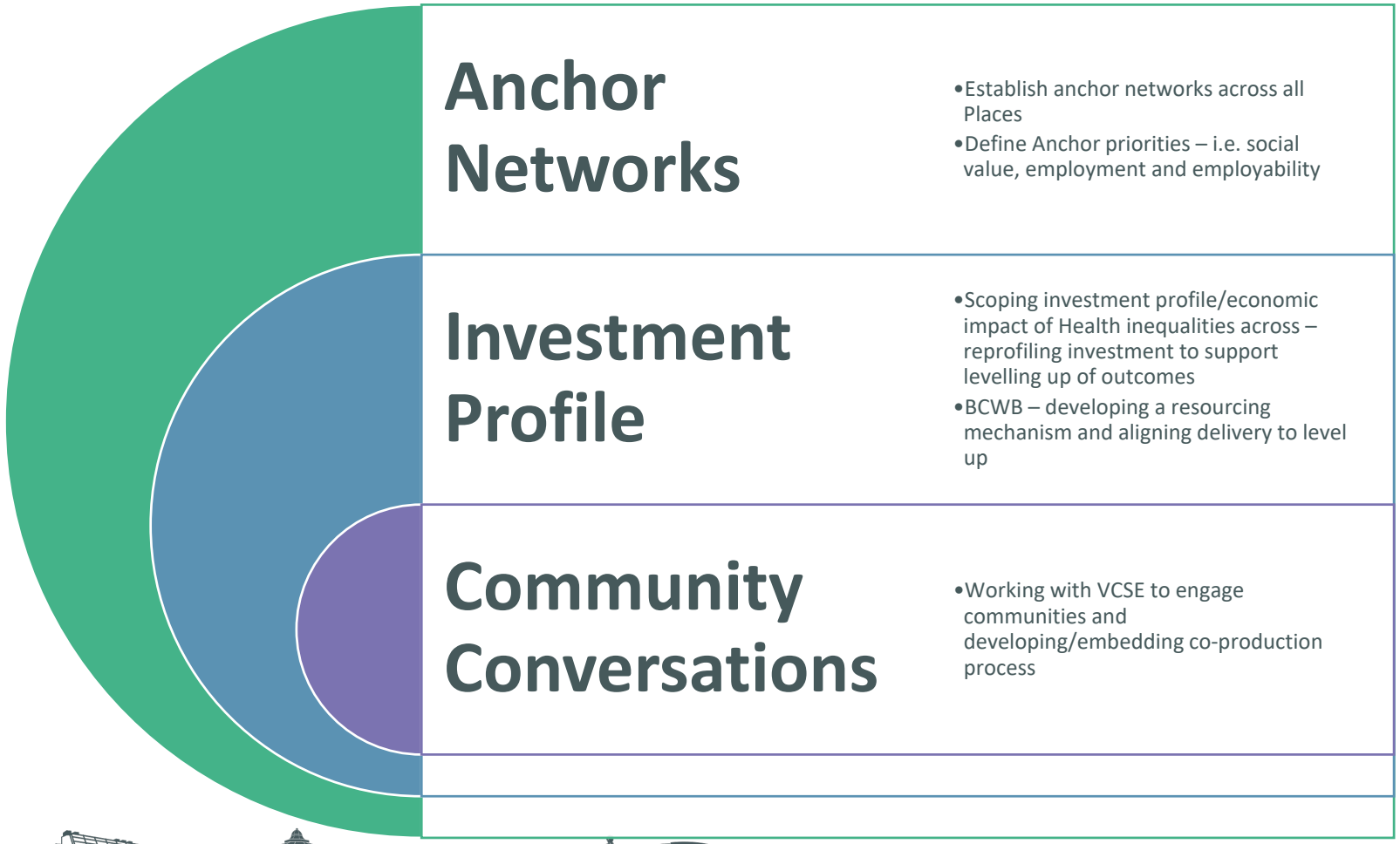
- Implementation of Alcohol care fair share funding
- Implementation of national funding on alcohol care with a mental health offer
- Review of Alcohol services commissioning/provision across BCWB

Health Inequalities Improvement Programme
Mental Health & LDA



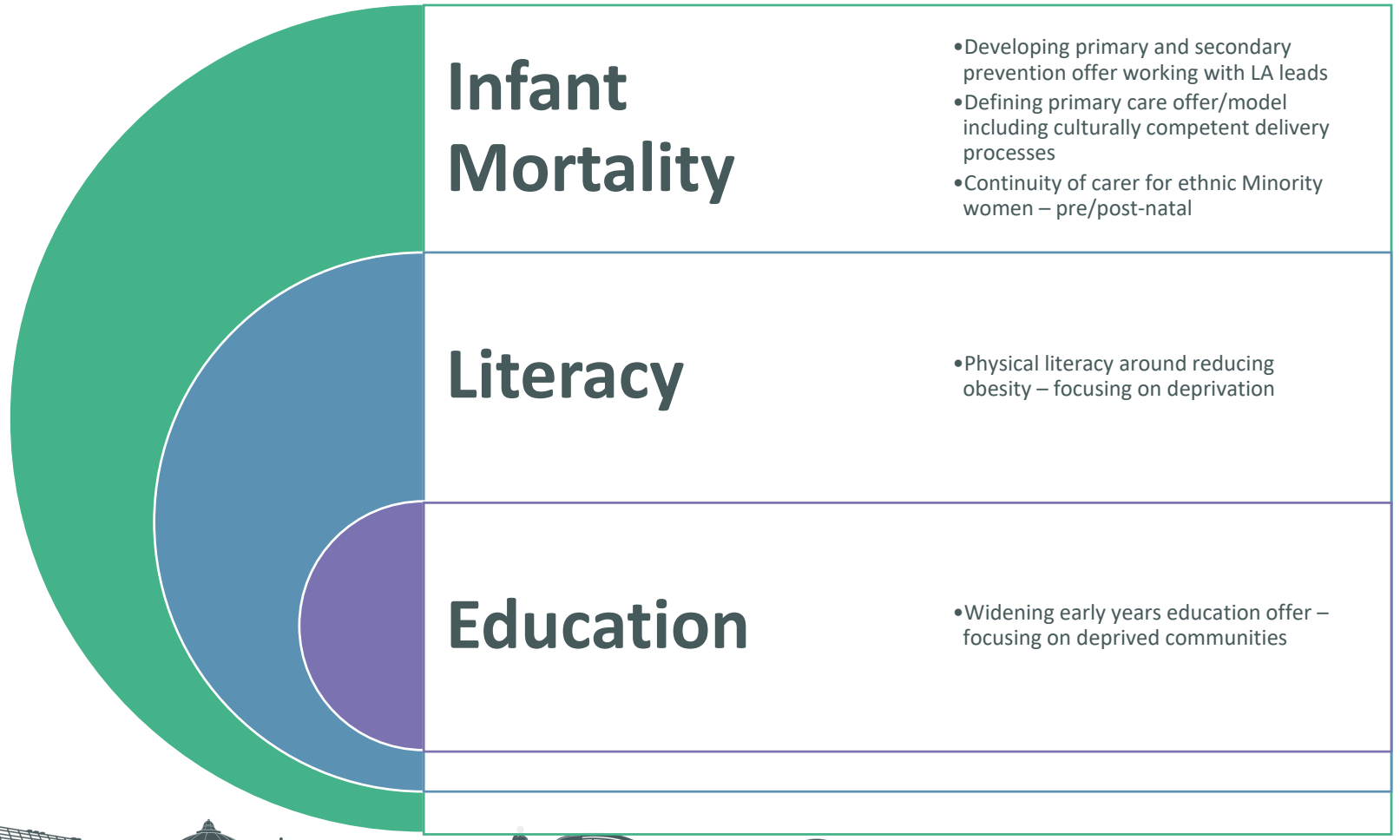
Health Inequalities Improvement Programme

Wider Determinants



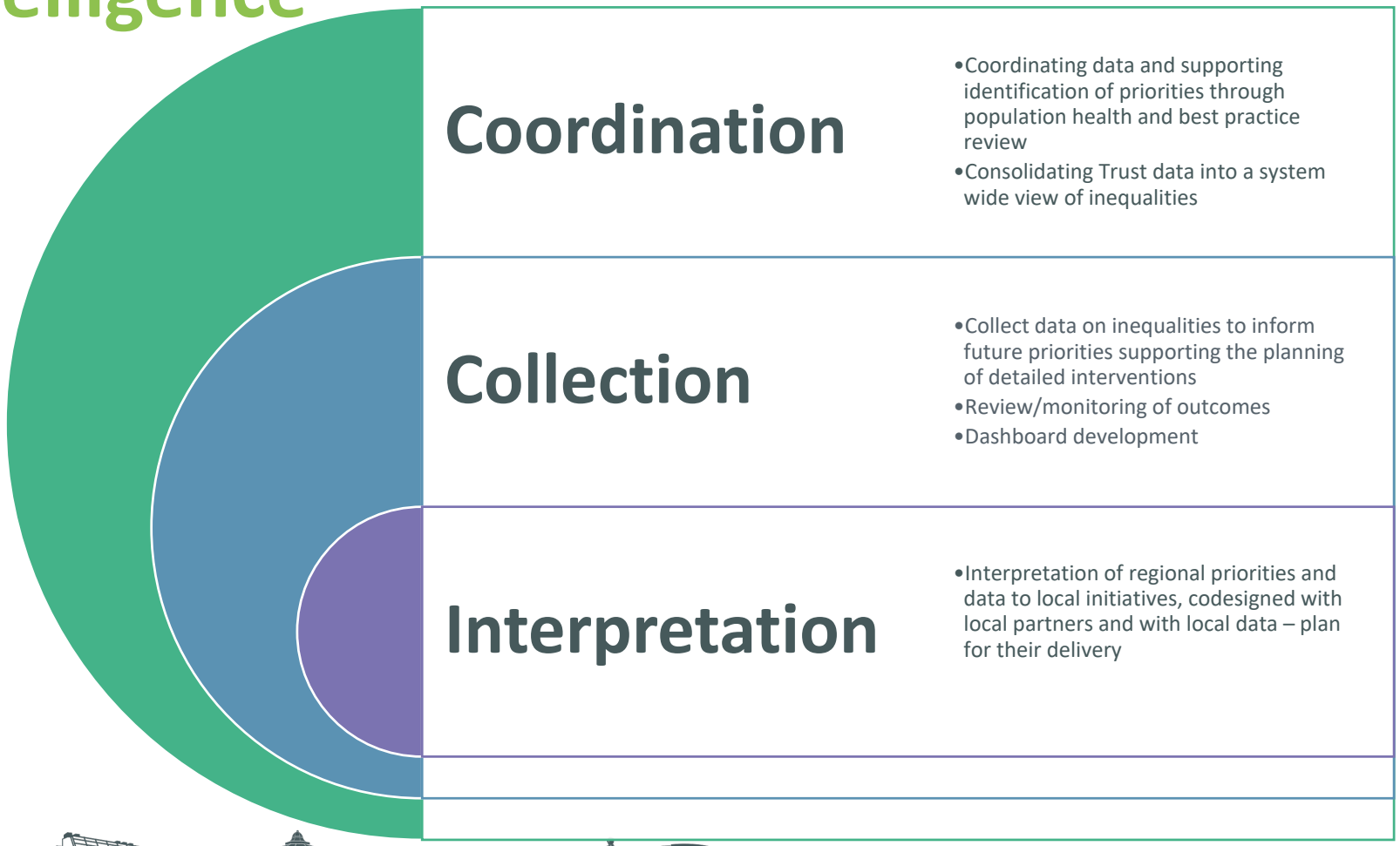
Health Inequalities Improvement Programme

Maternity/CYP



Health Inequalities Improvement Programme – Key enabling programme

Data/Intelligence



Health Inequalities Delivery Plan

Health Inequalities Delivery Plan 21/22

- Through MDs, all LCBs have been issued the ICS delivery plan with a request for a detailed Implementation Plan by the end of July;
- Place implementation plan will be turned into a monitoring framework for accountability arrangements with ICS Health Inequalities Improvement Programme Team;
- Whilst the majority of the Improvement delivery will be driven at Place – some of this will be driven from the central team including the following for which funding has been allocated by NHSEI (£TBC):
  - Smoking Cessation
  - Alcohol
  - Obesity
- In addition we have also been selected for regional funding (£530k) from NHSEI for the following:
  - Reducing violence/reduction of vulnerability;
  - Alcohol services offering MH support;
  - Increasing uptake of preventative services (in partnership with BSOL).

Health Inequalities Delivery Plan 21/22: Segmented approach

CYP: Physical literacy around reducing obesity (focusing on deprivation)	**Adults**: Smoking cessation	**Adults with Long Term Conditions** Inequalities in Mental Health early intervention	**Adults with Complex Needs** Diabetes and obesity	**COVID** – Vaccination inequalities & access	**COVID –** Elective restart (incl. cancer, respiratory & CVD)

scope

The 2021/22 plan focusses on health inequalities that within the segments set out above, along with very current inequalities related to the impact of Covid-19.

Data analysis

The data pack contained in the appendix contains evidence demonstrating the scale of inequalities that exist in these areas with further data analysis setting out specifically which geographical areas appear to have the greatest inequalities.

BCWB existing work

The research aims to highlight any existing work that is already being delivered by system partners in these areas to ensure duplication is minimised and identifying delivery networks which should be harnessed prior to agreeing interventions in specific communities.

Best practice

This sets out a plan of 'where to look' in order to make the greatest impact in improving inequalities, and is followed up with examples of best practice approaches to reduce inequalities using examples from around the world and in the UK.

Agenda Item 9

Sandwell Health and Wellbeing Board
22nd September 2021

Update Topic:	**Integrated Care Systems / Integrated Care Partnerships – Update on Progress to Date**
Contact Officer:	**Dr Ian Sykes, Vice-Chair, Sandwell Health and Wellbeing Board** **ian.sykes@nhs.net**
Link to board priorities	1. We will help keep people healthier for longer 2. We will help keep people safe and support communities 3. We will work together to join up services 4. We will work closely with local people, partners and providers of services
Purpose of Update:	• To provide a verbal progress update on the Integrated Care Systems (ICSs) and Integrated Care Partnerships (ICPs).
Recommendations	• That the Board note the content of the verbal update.

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Sandwell Health & Wellbeing Board

Agenda Item 10

Sandwell Health and Wellbeing Board
22nd September 2021

Update Topic:	**Councillor Hartwell (Chair of Health and Wellbeing Board) – Cabinet Member Update**
Contact Officer:	**Clair Norton, Health and Wellbeing Board Manager** **Clair_Norton@sandwell.gov.uk**
Link to board priorities	1. We will help keep people healthier for longer 2. We will help keep people safe and support communities 3. We will work together to join up services 4. We will work closely with local people, partners and providers of services
Purpose of Update:	• To provide a verbal update on the job description and responsibilities of the Chair of Health and Wellbeing Board in her responsibility as the Cabinet Member for Adults, Social Care and Health.
Recommendations	• That the Board note the content of the verbal update.

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VISION 2030 SANDWELL

BIG PLANS FOR A GREAT PLACE
...FOR THE PEOPLE OF SANDWELL

Sandwell Metropolitan Borough Council

LEADER OF THE COUNCIL
CABINET MEMBER APPOINTMENTS AND PORTFOLIOS

I, Councillor Rajbir Singh, Statutory Leader of Sandwell Council hereby confirm the Cabinet Portfolios and Cabinet Member appointments pursuant to the Local Government Act 2000(as amended), Local Government Public Involvement in Health Act 2007 (as amended) and associated Regulations with effect from 6 September 2021.

I confer all executive functions, powers and responsibilities falling within the scope of each Cabinet Portfolio to the respective Cabinet Member as detailed in Appendix 1 hereto (unless otherwise reserved to the Statutory Leader of the Council or the Cabinet or Council Officer under Appendix 1 and/or the Council's Executive's arrangements including the Scheme of Delegation to Officers).

	Cabinet Portfolios	**Cabinet Member**
1.	Leader of the Council	Leader
2.	Finance and Resources	Cllr Maria Crompton (Deputy Leader)
3.	Children and Education	Cllr Karen Simms
4.	Regeneration and Growth	Cllr Iqbal Padda
5.	Neighbourhoods and Communities	Cllr Kerrie Carmichael
6.	Adults, Social Care and Health	Cllr Suzanne Hartwell
7.	Housing	Cllr Zahoor Ahmed
8.	Community Safety	Cllr Bob Piper
9.	Environment	Cllr Ahmad Bostan
10.	Culture and Tourism	Cllr Danny Millard

Signed [redacted]

Date 6 September 2021

Councillor Rajbir Singh
Leader of the Council

Leader of the Council: Cllr Rajbir Singh

Scope & Responsiblities

To provide overall political leadership and strategic policy direction in relation to all executive functions, duties and responsibilities failing within this Portfolio (and all other Portfolios as required/necessary).

To act as the Council's principal spokesperson on Council policy and/or matters affecting the Borough or its citizens at local, regional, national and international level.

Notwithstanding any delegations approved by the Leader of the Council in this Appendix or otherwise, to undertake and discharge all Executive duties and responsibilities, and exercise all Executive powers and authorities in accordance with the Leader and Cabinet Executive form of governance.

SCOPE

- Setting political and strategic direction of the council
- Corporate Plan
- Strategic partnerships with government, WMCA, Mayor, PCC, NHS
- Combined Authority
- Communications, campaigns and public affairs
- Emergency planning and resilience
- Governance and Democracy
- Trade Unions
- Public Relations

Cabinet Member for Finance and Resources
Cllr Maria Crompton (Deputy Leader of the Council)

Scope & Responsibilities

Unless otherwise delegated, to exercise all executive powers and authority, including the provision of political leadership and strategic policy direction, in relation to all executive functions, duties, powers and responsibilities falling within the scope and responsibilities of this Portfolio.

To act as the Council's principal spokesperson on Council policy and/or matters falling within the scope of this Portfolio affecting the Borough or its citizens at local, regional, national and international level.

To be the Executive lead with the Combined Authority in relation to all the functions, duties and responsibilities falling within the scope of this Portfolio.

SCOPE

- Budget & Financial Planning
  - Council tax setting
  - Council Tax benefits
  - Business rates
- Facilities management
- Procurement
- Pension fund
- Digital inclusion
- ICT
- HR strategic oversight
- Internal and External Audit
- Risk Management and Insurance
- Health and Safety
- Transformation and Change Programmes
- Revenue and Benefits
- Council Graduate Schemes and Apprenticeships
- Customer Services
- Complaints and Members Enquiries

Cabinet Member for Children & Education: Cllr Karen Simms

Scope & Responsibilities

Unless otherwise delegated, to exercise all executive powers and authority, including the provision of political leadership and strategic policy direction, in relation to all executive functions, duties, powers and responsibilities falling within the scope and responsibilities of this Portfolio.

To act as the Council's principal spokesperson on Council policy and/or matters falling within the scope of this Portfolio affecting the Borough or its citizens at local, regional, national and international level.

To be the Executive lead with the Combined Authority in relation to all the functions, duties and responsibilities falling within the scope of this Portfolio.

SCOPE

- Children Safeguarding
- Schools and Education
    - Standards and Attainment
    - Schools building programme
    - Pupil placement
    - School meals
- Children's Social Care
- SEND
- Creating opportunities for young people
- Reducing child poverty
- Early intervention and prevention
- Fostering and adoption
- Corporate Parenting and care leavers
- Play services
- Child and Adolescent Mental Health
- Sandwell Children's Trust

Cabinet Member for Regeneration & Growth:
Cllr Iqbal Padda

Scope & Responsibilities

Unless otherwise delegated, to exercise all executive powers and authority, including the provision of political leadership and strategic policy direction, in relation to all executive functions, duties, powers and responsibilities falling within the scope and responsibilities of this Portfolio.

To act as the Council's principal spokesperson on Council policy and/or matters falling within the scope of this Portfolio affecting the Borough or its citizens at local, regional, national and international level.

To be the Executive lead with the Combined Authority in relation to all the functions, duties and responsibilities falling within the scope of this Portfolio.

SCOPE

- Town Centres
- Urban regeneration
- Major Developments
- Strategic and Development Planning
- Business Liaison and Support
- Employment and skills
- Apprenticeships
- Community Wealth
- Inward Investment and Urban Design
- Strategic Land and Assets
- Acquisitions and disposals

Cabinet Member for Neighbourhoods & Communities:
Cllr Kerrie Carmichael

Scope & Responsibilities

Unless otherwise delegated, to exercise all executive powers and authority, including the provision of political leadership and strategic policy direction, in relation to all executive functions, duties, powers and responsibilities falling within the scope and responsibilities of this Portfolio.

To act as the Council's principal spokesperson on Council policy and/or matters falling within the scope of this Portfolio affecting the Borough or its citizens at local, regional, national and international level.

To be the Executive lead with the Combined Authority in relation to all the functions, duties and responsibilities falling within the scope of this Portfolio.

SCOPE

- Strategic relationship with voluntary and community sectors
- Equalities, Inclusion and Diversity
- Development and building of stronger communities, community cohesion and resilience.
- To ensure that the work of other portfolio holders is effective in promoting inclusion
- Town and Neighbourhood Development and Working
    - Town Centre chairs to report
- Promoting resident engagement
- Bereavement and Registrars
- Coroner
- Animal Welfare

Cabinet Member for Adults, Social Care and Health:
Cllr Suzanne Hartwell

Scope & Responsibilities

Unless otherwise delegated, to exercise all executive powers and authority, including the provision of political leadership and strategic policy direction, in relation to all executive functions, duties, powers and responsibilities falling within the scope and responsibilities of this Portfolio.

To act as the Council's principal spokesperson on Council policy and/or matters falling within the scope of this Portfolio affecting the Borough or its citizens at local, regional, national and international level.

To be the Executive lead with the Combined Authority in relation to all the functions, duties and responsibilities falling within the scope of this Portfolio.

SCOPE

- Adult Social Care
- Safeguarding Adults
- Adult and community learning
- Health inequalities and outcomes
- Public Health and Wellbeing
- Healthy living
- Ageing well
- Mental health
- Food
- Residents with disabilities and health conditions
- Nursing and care homes
- Liberty Protection Safeguards

Cabinet Member for Housing – Cllr Zahoor Ahmed

Scope & Responsibilities

Unless otherwise delegated, to exercise all executive powers and authority, including the provision of political leadership and strategic policy direction, in relation to all executive functions, duties, powers and responsibilities falling within the scope and responsibilities of this Portfolio.

To act as the Council's principal spokesperson on Council policy and/or matters falling within the scope of this Portfolio affecting the Borough or its citizens at local, regional, national and international level.

To be the Executive lead with the Combined Authority in relation to all the functions, duties and responsibilities falling within the scope of this Portfolio.

SCOPE

- Housing Strategy and Development
- Council homes and estates
- Housing associations
- Lobbying government
- Health and safety
- Improvement and maintenance
- Private rented sector
- Tenant and leaseholder participation and engagement
- Homelessness & Rough Sleeping
- Adaptations
- Empty homes
- HMOs
- Safer Homes
- Housing Support
- Welfare Rights

Cabinet Member for Community Safety:
Cllr Bob Piper

Scope & Responsibilities

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SCOPE

- Safer Neighbourhoods
- PCC and Police Liaison
- Reducing violence, including knife crime
- Youth offending and gang intervention
- Violence against Women and Girls (VAWG)
- Domestic Abuse
- Trading Standards
- Environmental Health
- Antisocial behaviour
- Noise nuisance
- Public space protection orders

Cabinet Member for Environment:
Cllr Ahmad Bostan

Scope & Responsibilities

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SCOPE

- Highways
  - Transport Connectivity
  - Highway Network Maintenance
- Street maintenance (including lighting) and cleansing
- Recycling and waste management
- Waste Authority
- Road Safety
- Traffic and Parking Management
- Waste and Recycling
- Climate Change
- Clean Air
- Transport
- Transport Environmental Policy
  - Greener/Cleaner Transport
- Strategic Flood Management
- Canals and Watercourses

Cabinet Member for Culture & Tourism:
Cllr Danny Millard

Scope & Responsibilities

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SCOPE

- Commonwealth Games
- Culture, Arts and Events
- Libraries
- Museums
- Parks
- Night time Economy
- Licensing
- Markets
- Leisure
    - Sport
    - Physical activity
    - Recreation

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