Sandwell
Metropolitan Borough Council

Agenda
Health and Wellbeing Board

Wednesday, 18 October 2023 at 5.30 pm
In the Council Chamber, Sandwell Councill House, Freeth Street at Oldbury, B69 3DB

1 **Apologies for Absence**

To receive any apologies for absence.

2 **Declarations of Interest**

Members to declare any interests in matters to be discussed at the meeting.

3 **Minutes** 7 - 16

To confirm the minutes of the meeting held on 13 September 2023 as a correct record.

4 **Additional Items of Business**

To determine whether there are any additional items of business to be considered as a matter of urgency.


5	**Area Special Educational Needs and Disabilities Inspection Outcome and Next Steps** To consider and note the Area Special Educational Needs and Disabilities (ASEND) Inspection Outcome and Next Steps.	17 - 28
6	**Health and Wellbeing Board Draft Constitution** To consider and comment upon the draft Health and Wellbeing Board constitution.	29 - 36
7	**Older Adult Therapeutic Service in Sandwell** To consider and note upon the Older Adult Therapeutic Service in Sandwell.	37 - 62
8	**Child Death Overview Panel Report 2021/ 22** To consider and note the findings of the Child Death Overview Panel 2021/ 22.	63 - 102
9	**Healthwatch Sandwell Introduction** To consider and note the Healthwatch Sandwell Introduction.	103 - 130
10	**Healthwatch Sandwell Update - Diabetes in Sandwell** To consider and note the Healthwatch Sandwell Update upon Diabetes in Sandwell.	131 - 146
11	**Work Programme** Standing Item to note the Health and Wellbeing Board's Work Programme 2023/ 24.	147 - 154

Shokat Lal
Chief Executive
Sandwell Council House
Freeth Street
Oldbury
West Midlands

Distribution
Councillor Hartwell (Chair)
Councillors E Giles, Hackett, Hinchliff, Khatun, Rollins and Trumpeter.
Rashpal Bishop, Michael Jarratt, Liann Brookes- Smith, Michelle Carolan, Dr Sommiya Aslam, Phil Griffin, Alexia Farmer, Rev. David Gould, Matt Young, Tammy Davies, Marsha Foster, Mark Davis and Emma Taylor.

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Sandwell Health and Wellbeing Board

13 September 2023 at 5.30pm
In the Council Chamber, Sandwell Council House.

Present:

Councillor Suzanne Hartwell	Chair and Cabinet Member for Health and Adult Social Care
Councillor Simon Hackett	Cabinet Member for Children, Young People and Education
Councillor Laura Rollins	Cabinet Member for Housing and Built Environment
Councillor Elaine Giles	Chair of the Health and Adult Social Care Scrutiny Board
Councillor Nicky Hinchliff	Chair of the Children's Services and Education Scrutiny Board
Michael Jarrett	Director of Children and Education
Dr Sommiya Aslam	Sandwell Locality Commissioning Board Representative
Alexia Farmer	Healthwatch Sandwell Manager (substitute member)
Reverend David Gould	Chair of Public Health Faith Sector Working Group
Chief Superintendent Kim Madill	West Midlands Police
Richard Beeken	Chief Executive Sandwell and West Birmingham Hospitals NHS Trust
Mark Davies	Chief Executive - Sandwell Council of Voluntary Organisations
Emma Taylor	Chief Executive - Sandwell Children's Trust
Kuli Kaur- Wilson	Black Country Healthcare NHS Foundation Trust

In attendance

Louise Kilbride	Chief Executive – Sandwell Consortium
Dr Lina Martino	Consultant in Public Health
Ellen Blakeley	Speciality Registrar in Public Health
Diane Millichamp	Vulnerable Adults Project Manager

Cathren Armstrong	Health Protection Specialist, Public Health
Stephnie Hancock	Deputy Democratic Services Manager
John Swann	Democratic Services Officer

17/23 **Apologies for Absence.**

Apologies were received from Councillor Syeda Khatun, Liann Brookes- Smith Interim Director Public Health), Michelle Carolan (Black Country Integrated Care Board), Marsha Foster (Black Country Healthcare NHS Foundation Trust) and Phil Griffin (Healthwatch Sandwell).

18/23 **Declarations of Interest**

Councillors Simon Hackett and Suzanne Hartwell declared a pecuniary interest in the matter referred to at 25/23 (Sandwell Language Network), in that they were employees of organisations that were members of the Sandwell Consortium.

19/23 **Minutes**

Resolved that the minutes of the meeting held on the 21 June 2023 are approved as a correct record.

20/23 **Urgent Additional Items of Business**

There were no urgent additional items of business.

21/23 **Midland Metropolitan University Hospital Update**

The Board received an overview of progress that had been made with the build and delivery progression of the Midland Metropolitan University Hospital (MMUH).

The hospital was currently the biggest capital development in the English health service. Upon completion, the hospital would include an emergency department, a dedicated children's

emergency department and a midwife led birth unit. Under the acute care model for the hospital, consultants would be on site seven days a week and state of the art equipment would enhance diagnostics to support the provision of same day emergency care, preventing unnecessary admissions, ensuring that the length of stay was no longer than medically required and that patients were discharged to the most appropriate place and readmission was prevented.

Members watched a video providing an overview of the site, and highlighting that it was #MoreThanAHospital and would provide places for the wider public and local community to use, such as a community garden, a café/restaurant and a Winter Garden on the fifth floor of the building, which would also house an art gallery.

The design of the hospital centred on patient wellbeing with all rooms having an external view onto one of the courtyards or surrounding areas of the hospital. 50% of the beds were in single ensuite rooms, which would enhance infection control. Colour coded wards, with the same layout throughout the hospital, would also provide a dementia friendly environment.

Most outpatient care, day-case surgery and routine diagnostics would remain at the Sandwell (Hallam Street) and City Hospital sites. This included:-

- A 24/7 urgent treatment centre at Sandwell Hospital.
- Birmingham Treatment Centre and Birmingham and Midland Eye Centre (BMEC) at City Hospital.
- Provision for step down / rehab facilities.

Significant changes continued to take place in community and primary care services so that even more care could be provided in people's own homes. It was anticipated that the occupation of beds would reduce from the current 97% to 85-90%, which would allow for better management in peak periods. Members noted the crucial work also being undertaken across 12 service areas to transform services to support the acute care model. Excellent multi-agency relationships in Sandwell supported this programme of transformation.

The Benefits Case predicted that the hospital building would have a useable efficient lifespan of 58years and would bring benefits to patients equating to around £796m; benefits to employees equating to around £982m and to the wider population equating to around £241m.

In terms of employment, 484 new staff were required to make the business case work, with a target of 35% being from the local population. A Leaning Campus on the site would host 1280 learners a year, with a focus on addressing skills shortages and providing pathways into long term employment. A partnership between the hospital, Sandwell College and Aston and Wolverhampton universities had been established to support recruitment efforts.

Work had been undertaken to incorporate the hospital into the local transport network, 1,600 car parking spaces and an onsite bus stop had been incorporated within the site proposals. The transport plan was being finalised and would be publicly available from January 2024.

Community engagement activities with local groups had taken place to boost awareness of how healthcare provision would be changing in the Borough. A 'Midland Met Mobile' van would be used for 'roadshow' type events at libraries, shopping centres, and the heart of the community, sparking conversations about the hospital and the transformations to healthcare.

The projected opening date for the hospital was Autumn 2024, following a six- month process of testing and a familiarisation process for staff members.

From the comments and questions by members of the Board, the following responses were made, and issues highlighted:-

- The Trust would be engaging with the Council to determine an approach that would ensure that employment opportunities were available for care leavers, and other young people.
- Public consultation on the closure of the A&E department at Sandwell Hospital had taken place in 2016.
- An Urgent Treatment Centre would remain at Sandwell Hospital for mild to moderate conditions.

- There would also be an Urgent Treatment Centre at MMUH, to cater for the West Birmingham population, which anticipated demand of around 300 patients a day.
- The Trust's Estates Strategy would be published in late 2023 and would set out its community focus and the commitment to the development of integrated teams across Sandwell's six towns.
- Conversations were also taking place with the Council to identify a space for a Care Navigation Centre, which would house around 160 staff.
- Births would once again be registered in the borough of Sandwell once the MMUH had opened.
- Vacancies still remained for non-clinical staff and private sector competition with salaries made recruitment challenging. Work was ongoing with partner organisations to address this.
- A series of New Neighbours consultation events would be taking place in early 2024, which would include discussions around transport plans.

22/23 **Right Care, Right Person**

The Board received an overview of the Right Care, Right Person (RCCP) approach. RCRP was a national approach agreed between the Home Office and health partners to ensure that the right person and agency, with the right skills, training, and experience responded to calls relating to mental health or other concerns for welfare. Analyses showed that West Midlands Police Officers currently attended around 4,000 incidents per month that were not police matters, resulting in many hours of police time spent waiting in A&E departments, reducing the time available for the Police to focus on its core responsibilities to prevent and investigate crime and keep the King's peace.

The RCRP approach had been designed following consultation with partner agencies including Integrated Care Boards and NHS Trusts to ensure that the most appropriate professionals responded to an incident. RCRP would complement services, such as the proposed 'NHS 112 – Option 2' mental health crisis telephone line, which when operational would have dedicated resources including mental health ambulances.

The police were trained to refer individuals with vulnerabilities to appropriate supports via the established referral pathway. In addition, a 'Vulnerabilities Hub' was due to be established which would enable call handlers to refer individuals with specific needs to mental health tactical advisors within the force contact centre.

40% of West Midlands Police force contact officers had received training to act as 'decision makers' and identify if police were required to be despatched, with plans to train all call handlers by October 2023. Training would include trauma informed practice to gain consent for appropriate referrals. Work would be undertaken with West Midlands Ambulance Service and West Midlands Fire Service on their powers of entry.

Having appropriate referral pathways in place would support the new approach and Social Prescribing would be a key factor in this.

It was hoped that, by ensuring police officers were present for criminal matters only, trust and confidence in the Police would improve.

From the comments and questions by members of the Board, the following responses were made, and issues highlighted:-

- The RCRP approach would be aligned with the Better Mental Health Strategy and a Police representative was on the Better Mental Health Strategy Partnership.
- Further discussion was needed with the Safeguarding Children's Partnership.
- Clear communication was crucial to ensure that physicians and clinicians were aware that welfare checks was not a police duty, and vulnerable people were signposted to the right support.
- The safeguarding functions of the police would not be impacted.
- There was currently not a standardised approach to social prescribing in Sandwell and work was underway to address this.

The Police would be invited to a briefing with all councillors on the RCRP approach.

(Reverend David Gould and Emma Taylor left the meeting during the consideration of this item).

23/23 **Sandwell Better Mental Health Strategy 2023- 2026**

Further to Minute No. 7/22 (23 February 2022) the Board noted an update on the development of the Better Mental Health Strategy 2023- 2026, which had co- produced with stakeholders throughout 2022 and 2023.

A rapid needs assessment had identified factors which contributed to mental health, such as access to employment and suitable accommodation. The draft Strategy had also been updated to reflect feedback from stakeholders in relation to the impact of Covid-19, which was now better understood.

A 60-day public consultation would commence from 26 September 2023. To ensure a high response rate, the consultation would be widely publicised across all partnership networks and communication channels and community organisations would be offered grant funding to host focus groups. A video would also be produced explaining the priorities and key drivers of the strategy.

The final Strategy would be published in January 2024 and the Better Mental Health Partnership would be accountable for ensuring that the action plan was delivered, and the nine priorities and principles (previously referred to as promises) were achieved.

(In reference to Minute No. 18/23 (above), Councillors Hackett and Hartwell left the Council Chamber).

24/23 **Election of Chair**

Resolved that Councillor Rollins is elected Chair for the consideration of the matter referred to at Minute No. 25/23 (Sandwell Language Network).

25/23 **Sandwell Language Network**

The Board received an overview of the Sandwell Language Network programme, which had been co-produced in 2019 with funding from the Government's Controlling Migration Fund and aimed to tackle health and economic inequalities, reduce isolation, and promote community cohesion through language learning.

The 2021 Census had identified the challenges facing new migrant communities and established ethnic communities with 88% of Sandwell residents who spoke English as their main language compared to 92.3% nationally. Of those residents who did not have English as their main language, 24.8% could not speak English well and 5.5% could not speak English at all. In five of Sandwell's wards less than 80% of residents spoke English as their main language.

Sandwell Language Network was co- ordinated by Sandwell Consortium and delivered via 17 partner organisations. Courses were community based in nature, which enabled learners to improve their understanding of English via an informal medium. English for speakers of other languages (ESOL) was the most popular course, however over 20 courses ran per year to ensure individuals could access the relevant educational modules.

The cohort for the 2022/ 23 programme was made up of over 350 learners and incorporated IT skills to better support those in need of support. 88% of learners reached additional services and education through the network with a focus on promoting a sense of place within Sandwell.

The programme collated quantitative and qualitative feedback from participants, wider community, and community delivery partners on an ongoing basis to inform the project deliverables to ensure it continually met the changing needs of its service users.

Sandwell Council was a finalist in the 2023 Local Government Chronicle (LGC) Awards for SLN as an outstanding Public Health and community project.

(Dr Sommiya Aslam left the meeting during consideration of this item).

(Councillors Hackett and Hartwell returned to Council Chamber and Councillor Hartwell resumed the Chair).

The meeting became inquorate and therefore the remaining agenda items were deferred until the meeting on 18 October 2023.

Meeting ended at 8.07pm.

democratic_services@sandwell.gov.uk

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Sandwell Health & Wellbeing Board

18 October 2023

Subject:	Area Special Educational Needs and Disabilities (ASEND) Inspection Outcome and Next Steps
Presenting Officer and Organisation	Michael Jarrett – Director of Children and Education (DCS) Michael_Jarrett@sandwell.gov.uk
Purpose of Report	To provide an update on the Local Area Inspection of SEND conducted by Ofsted / CQC between 19 June and 7 July 2023.

1. Recommendations

1.1 That Sandwell Health and Wellbeing Board comment and note the ASEND Inspection Outcome and Next Steps

2. Links to the following Board Priorities

Priority 1	**We will help keep people healthier for longer**
Priority 2	**We will help keep people safe and support communities**
Priority 3	**We will work together to join up services**
Priority 4	**We will work closely with local people, partners and providers of services**

3. Context and Key Issues

Area SEND Inspection

- Following the last inspection of the Sandwell local area partnership for SEND in 2019, the Sandwell local area partnership for SEND was inspected over a period of 3 weeks by Ofsted / CQC between 19th June and 7th July 2023, evaluated against a new Ofsted / CQC inspection framework which was launched in January 2023.

- The revised framework 'evaluated' the effectiveness and impact of local area partners and the extent to which children and young people with SEND, including those who attend Alternative Provision (AP) settings, were receiving consistently good experiences leading to consistently good outcomes.

- The inspection team found that children and young people with SEND, including those who attend AP settings, received inconsistent experiences leading to them achieving inconsistent outcomes in Sandwell. This is commonly referred to as a 'category 2' outcome for the local area partnership. A 'category 1' outcome is available to local area partnerships which can demonstrate consistent experiences leading to consistent outcomes for children and young people with SEND, including those attending AP settings. A 'category 3' outcome is given to a local area partnership where there are endemic weaknesses found in the partnership which leads to poor experiences and poor outcomes for children and young people with SEND.

- A category 2 outcomes means that the local area partnership will be submit to routine monitoring by Ofsted / CQC and supported by the DfE in making the necessary improvements and within agreed timeframes as published in the **local area inclusion plan** (action plan). Following inspection, all local areas are required to publish a local area inclusion plan by 2024. Sandwell will be publishing theirs ahead of the deadline set by the DfE.

- The inspectors were highly complementary about the renewed energy and vision shared across the partnership for children and young people with SEND, and the new SEND eco-system transformation programme launched by the local area partnership in June 2023. This gave the inspectors a very clear understanding that the local area partners,

through the self-evaluation, are accurate in their judgements and the actions they are taking to improve the experiences and outcomes of children and young people with SEND.

- The inspection report is due to be published in early September 2023, after which the local area partnership is required to submit a **local area inclusion plan** (action plan) for improvement within 10 days of publication, and to make this publicly available to all partners, parents and carers of children and young people with SEND in Sandwell.

  - Area leaders should **strengthen multi-agency working across the partnership between education, health and social care,** so that children and young people's needs are identified and assessed in a more efficient and timely manner.

  - Area leaders should **develop co-production with children and young people with SEND at a strategic level**, so that children and young people play a key role in developing improvement strategies and plans.

  - Area leaders **should increase the number and range of short-break opportunities** to support the needs of all children and young people with SEND, including those with complex needs and post-16 young people.

- The senior leaders of the Sandwell local area partnership for SEND were pleased the inspection was both developmental and helpful and confirmed the accurate self-evaluation of the partnership.

- Since the last inspection in 2019, when the previously issued written statement of action (2017) was lifted, using a different inspection framework, the local area partnership has been working through the SEND Strategic Board and the SEND Operations Board to oversee the necessary improvements required of the local area partnership. These improvements continue to be driven and will be included in the revised action plan to be submitted to Ofsted / CQC and for publishing to partners, parents and carers.

- This is because we are not complacent in our determination to ensure all children and young people with SEND, including those who attend AP settings, in Sandwell, only receive the very best experiences leading to them securing the very best outcomes and successful transition into adulthood.

- Sandwell local area partnership for inclusion (SEND and AP) will monitor the impact and effectiveness of the local area inclusion plan, via the 8 inclusion workstream groups of the Sandwell Inclusion Eco-System Transformation Programme. Each group reports monthly to the Sandwell Inclusion Board (Operations) and provides a half termly 'highlights report' to the Sandwell Inclusion Board (Strategic).
- Both boards are attended by senior officers from across the local area partnership, including representatives from Sandwell Parents Voices United (SPVU), our parent carer forum, and children and young people. All reports are available to the Sandwell Health and Wellbeing Board which has governance oversight of SEND at a system level across Sandwell.

4. Engagement

Sandwell Local Area Partnership for Inclusion (SEND and AP)

- Local area partners have met during July to review the draft inspection report and agreed its content ahead of publication in early September 2023.
- Local area partners will meet to agree the Sandwell Local Area Inclusion Plan to be submitted to Ofsted / CQC 10 days following publication of the report and to be published to partners, parents and carers.
- The Sandwell local area inclusion plan will be delivered by the actions of the Sandwell Inclusion Eco-system and transformation programme via 8 workstreams which are co-led by the local area partners, schools, agencies, parents and carers, with children and young people with SEND fully engaged through a model of embedded co-production in re-setting and re-engineering the way we provide services to them.
- The Sandwell Inclusion Plan will operate over 3 years, between 2023 and 2026, leading up to the next inspection which should take place during the summer of 2026, and will be monitored by Ofsted / CQC and DfE colleagues during this time period.

5. Implications

Resources:	No Resources Implications directly arising from this report.
Legal and Governance:	• The local area partnership is required to fulfil its statutory duties for all children and young people with SEND, including those who attend AP settings, so they receive consistently good experiences which lead to consistently good outcomes. • Any delays to statutory processes, whether this be early help, early identification and early assessment leading to statutory assessment of SEND and the issuing of an EHC plan, and ensuring such children and young people access and attend services and schools which meet their needs, allowing them to thrive in Sandwell. • The exponential rise in demand for early / diagnostic assessment of SEND needs is putting significant demand on service delivery and the meeting of statutory duties within statutory timescales, and is currently resulting in delays in the issuing of EHC plans and in completing annual reviews of current EHC plans. • The current number of children and young people with and EHC in Sandwell is 3,228 and this is predicted to rise to at least 3,500 by July 2025. This is following a 51% rise in EHCs since 2019. • Therefore, there is significant financial pressure on the high need budget and school budgets to meet the current needs of children and young people with SEND in Sandwell, and this is resulting in the local authority placing Sandwell children outside of the borough into independent and non-maintained private settings at significant cost in both SEND and AP settings until we have sufficient places within the Sandwell borough to meet the needs of our children and young people with SEND.
Risk:	No Risk Implications directly arising from this report.
Equality:	No Equality Implications directly arising from this report.
Health and Wellbeing:	No Health and Wellbeing Implications directly arising from this report.
Social Value:	No Social Value Implications directly arising from this report.
Climate Change:	No Climate Change Implications directly arising from this report.

Corporate Parenting:	No Corporate Parenting Implications directly arising from this report.

6 Appendices

Appendix 1 – ASEND Inspection Presentation

7. Background Papers

None

Health & Wellbeing Board
18.10.23
Michael Jarrett
Director of Children and Education

ASEND Inspection – July 2023

ASEND Inspection – Outcome and Next Steps

- Following the last inspection of the Sandwell local area partnership for SEND in 2019, the Sandwell local area partnership for SEND was inspected over a period of 3 weeks by Ofsted/CQC between 19th June and 7th July 2023, evaluated against a new Ofsted/CQC inspection framework which was launched in January 2023

- The revised framework 'evaluated' the effectiveness and impact of local area partners and the extent to which children and young people with SEND, including those who attend Alternative Provision (AP) settings, were receiving consistently good experiences leading to consistently good outcomes

- The inspection team found that children and young people with SEND, including those who attend AP settings, received inconsistent experiences leading to them achieving inconsistent outcomes in Sandwell. This is commonly referred to as a 'category 2' outcome for the local area partnership. A 'category 1' outcome is available to local area partnerships which can demonstrate consistent experiences leading to consistent outcomes for children and young people with SEND, including those attending AP settings. A 'category 3' outcome is given to a local area partnership where there are endemic weaknesses found in the partnership which leads to poor experiences and poor outcomes for children and young people with SEND

ASEND Inspection - Outcome and Next Steps

- A category 2 outcomes means that the local area partnership will be submit to routine monitoring by Ofsted / CQC and supported by the DfE in making the necessary improvements and within agreed timeframes as published in the **local area inclusion plan** (action plan). Following inspection, all local areas are required to publish a local area inclusion plan by 2024. Sandwell will be publishing theirs ahead of the deadline set by the DfE

- The inspectors were highly complementary about the renewed energy and vision shared across the partnership for children and young people with SEND, and the new SEND eco-system transformation programme launched by the local area partnership in June 2023. This gave the inspectors a very clear understanding that the local area partners, through the self-evaluation, are accurate in their judgements and the actions they are taking to improve the experiences and outcomes of children and young people with SEND

ASEND Inspection - Outcome and Next Steps

Local Area Inclusion Plan – to be submitted within 10 days of publication of Inspection Report

- Area leaders should **strengthen multi-agency working across the partnership between education, health and social care,** so that children and young people's needs are identified and assessed in a more efficient and timely manner

- Area leaders should **develop co-production with children and young people with SEND at a strategic level**, so that children and young people play a key role in developing improvement strategies and plans

- Area leaders **should increase the number and range of short-break opportunities** to support the needs of all children and young people with SEND, including those with complex needs and post-16 young people

Local Area Partnership for Inclusion (SEND and AP)

- Sandwell local area partnership for inclusion (SEND and AP) will monitor the impact and effectiveness of the local area inclusion plan, via the 8 inclusion workstream groups of the Sandwell Inclusion Eco-System Transformation Programme. Each group reports monthly to the Sandwell Inclusion Board (Operations) and provides a half termly 'highlights report' to the Sandwell Inclusion Board (Strategic)

- Both boards are attended by senior officers from across the local area partnership, including representatives from Sandwell Parents Voices United (SPVU), our parent carer forum, and children and young people. All reports are available to the Sandwell Health and Wellbeing Board which has governance oversight of SEND at a system level across Sandwell

- The Sandwell local area inclusion plan will be delivered by the actions of the Sandwell Inclusion Eco-system and transformation programme via 8 workstreams which are co-led by the local area partners, schools, agencies, parents and carers, with children and young people with SEND fully engaged through a model of embedded co-production in re-setting and re-engineering the way we provide services to them

- The Sandwell Inclusion Plan will operate over 3 years, between 2023 and 2026, leading up to the next inspection which should take place during the summer of 2026, and will be monitored by Ofsted / CQC and DfE colleagues during this time period

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Sandwell Health & Wellbeing Board

18 October 2023

Subject:	Health and Wellbeing Board Draft Constitution
Presenting Officer and Organisation Sandwell Metropolitan Borough Council	Stephnie Hancock Deputy Democratic Services Manager stephnie_hancock@sandwell.gov.uk
Purpose of Report	Decision

1. Recommendation

1.1 That the Board considers and comments upon the attached refreshed constitution;

1.2 that subject to 1.1 (above), the Council be recommended to approve the Board's constitution.

2. Links to Workstreams Set out in the Health and Wellbeing Strategy

Healthy Communities	Efficient and effective governance arrangements support the achievement of the Board's priorities.
Primary Care	
Integrated Town Teams	
Intermediate Care	
Care Navigation	

4. Context and Key Issues

4.1 The Health and Wellbeing Board is a formal statutory committee of the local authority, established under Section 194 of the Health and Social Care Act 2012, as a forum where political, clinical, professional and community leaders from across the health and care system come

together to improve the health and wellbeing of our local population and reduce health inequalities.

4.2 Following changes to NHS structures in 2022, the Board reviewed its membership. The Board is now invited to consider the attached refreshed constitution to support the efficient transition of business.

5. Engagement

It is not necessary to carry out public engagement.

6. Implications

Resources:	Members of the Board are expected to commit sufficient resources in terms of attendance at Board meetings and training events, and to participate in discussions and decision making on a regular basis.
Legal and Governance:	The Health and Wellbeing Board is a formal statutory committee of the local authority, established under Section 194 of the Health and Social Care Act 2012. The Board is to be treated as if it were a committee appointed by the local authority under section 102 of the Local Government Act 1972. (Section 194(11)).
Risk:	There are no direct implications arising from this report, however, the Board considers such implications on all matters that it considers, with health and wellbeing being a key consideration of course.
Equality:	
Health and Wellbeing:	
Social Value:	
Climate Change:	
Corporate Parenting:	

7. Appendices

Appendix 1 - DRAFT Constitution

8. Background Papers

None

SANDWELL HEALTH AND WELLBEING BOARD CONSTITUTION

Introduction

The Health and Wellbeing Board is a formal statutory committee of the local authority, established under Section 194 of the Health and Social Care Act 2012 as a forum where political, clinical, professional and community leaders from across the health and care system come together to improve the health and wellbeing of our local population and reduce health inequalities.

The Board is treated as if it were a committee appointed by the local authority under section 102 of the Local Government Act 1972. (Section 194(11) However, to facilitate the membership of the specified officers the Local Authority (Public Health, Health and Well-being Boards and Health Scrutiny) Regulations 2013 disapply Section 104(1) of the LGA 1972 (which prohibits officers from being members of local authority committees).

Whilst the Board has limited formal powers; it plays an important role in encouraging integrated working between health and social care commissioners, including partnership arrangements such as pooled budgets, lead commissioning and integrated provision. It also has a statutory responsibility to produce:-

- Joint Strategic Needs Assessment (JSNA) which provides a wide source of information and data for health, care and wellbeing planning and commissioning, customised to the needs of the area and developing over time, and inform the development of a Joint Health and Wellbeing Strategy;

- Joint Health and Wellbeing Strategy (JHWS) sets out the vision, priorities and actions agreed at the Board to improve the health, care and wellbeing of local communities and reduce inequalities for all ages;

- a pharmaceutical needs assessment (PNA) for the area.

1 Membership and Voting Rights

1.1 The Health and Social Care Act (Section 194(2)) sets out the Board's core membership as follows:-

- the Director of Adult Social Services;
- the Director of Children's Services;
- the Director of Public Health;
- a representative of the Local Healthwatch organisation;
- a representative of the local Integrated Care Board (formally known as Clinical Commissioning Group);

beyond this, membership is at the discretion of the local authority.

1.2 Councillor representatives are nominated by the Leader and appointed by the Council. (Section 194(3)(a) The political balance arrangements do not apply to Councillor representation on the Board.

1.3 The Chair of the Board shall be appointed by the Council from amongst the Councillor representatives.

1.4 The Vice-Chair of the Board shall be appointed by the Board from amongst its membership.

1.5 Healthwatch shall appoint one representative, and two named substitutes. (Section 194(5)

1.6 The Black Country Integrated Care Board (ICB) shall appoint two members (Section 194(6).

1.7 The Board may appoint such additional persons to be members of the Board as it thinks appropriate. (Section 194(8)

1.8 The local authority must consult the Board before making any appointments to the Board after its establishment. (Section 194(9)

Membership of Sandwell's Board can be found at Appendix 1.

2. Quoracy

2.1 The Board shall be quorate when the following individuals are present:-

- 1 Councillor representative (with voting rights)
- 1 Director representative
- 1 Healthwatch representative
- 1 ICB representative

2.2 Healthwatch Sandwell may nominate two named substitutes at the start of each Municipal Year to attend in the event that the substantive member is unable to attend.

2.3 Where a meeting is inquorate, the meeting may go ahead, to discuss information items only, and the minutes of the meeting shall be qualified with a statement that the meeting was inquorate.

3. Meetings and Public Attendance

3.1 The Board will meet at least quarterly. Extraordinary meetings may be called by the Chair as and when appropriate.

3.2 Meetings of the Board will be open to the public and subject to the Access to Information Procedure Rules at Part 4 of the Council's Constitution.

3.3 The agenda, reports and previous meeting minutes will be available on the Council's modern.gov website at least five working days in advance of each meeting.

3.4 Members of the public may submit questions in relation to items on the published agenda in writing, no later than three working days before the day of the meeting. A response will be tabled at the meeting, and provided to the questioner in writing. Where it is not possible to table a response at the meeting, the written response will be provided to the questioner as soon as possible after.

4. Sub-Committees

The Board may establish sub-committees to advise the Board with respect to any matter relating to the discharge of its functions.

5. Decision Making

5.1 All decisions of the Board shall be taken in accordance with the Council's Procedure Rules set out in Part 4 of the Council's Constitution.

5.2 Six members may request that the names of those voting for and against any decision and those abstaining shall be recorded.

5.3 Any member may request that their vote (for or against) or their abstention shall be recorded.

6 Disorderly Conduct

If any member of the Board, or member of the public, persistently disregards the ruling of the person chairing the meeting, by behaving improperly or offensively or deliberately obstructs the business of the meeting, the person chairing the meeting may direct that person or those persons leave the meeting or that the meeting be adjourned for a specified period.

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Sandwell Health & Wellbeing Board

18 October 2023

Subject:	Older Adult Therapeutic Service (OATS) in Sandwell
Presenting Officer and Organisation	Clinical Lead- Gemma Lockley Clinical Nurse Specialist- Fiona Jones Black Country Healthcare NHS Trust bchft.oatssandwellspoke@nhs.net
Purpose of Report	Information

1 Recommendations

1.1 For the Health and Wellbeing Board to receive a brief overview on the Older Adult Therapeutic Service which provides therapeutic interventions for people over 65 with Dementia or mental health difficulties who are being supported by secondary mental health services within Sandwell. This will allow the Board to have an understanding of therapeutic services within the Sandwell Borough. We will enhance the boards understanding of how our service supports people living with mental health difficulties and how this positively affects their wellbeing.

2 Links to the following Board Priorities

Priority 1	**We will help keep people healthier for longer**
Priority 2	**We will help keep people safe and support communities**
Priority 3	**We will work together to join up services**
Priority 4	**We will work closely with local people, partners and providers of services**

2.1 This meets all four of the Boards priorities by helping people to remain healthier for longer in both their physical health and mental health. We provide our interventions within safe community environments and explore patients safety needs at all times during our interventions. We have been working closely with other services within Sandwell to ensure that patient's have a consistent approach to their needs, avoiding duplication of questions and subsequent work completed. By having an enhanced understanding of the OATS service, it will encourage people

to seek appropriate support for their mental health needs from a variety of statutory/ third sector organisations.

4 Context and Key Issues

4.1 Our service is divided into two pathways:

- Dementia Pathway: we provide short term therapeutic intervention in the form of groups for people living with dementia of any age. This may be Dementia education or nationally recommended non medication treatments.
- Functional pathway: short term therapeutic intervention is provided to people living with mental illness who are receiving support from a secondary care services. These interventions can be delivered by groups or on an individual basis dependant on the person's therapeutic needs at assessment.

4.2 All patients being referred into OATS need to demonstrate capacity and consent to engage with therapeutic interventions at the point of referral into the service.

5 Engagement

5.1 The Older Adult Therapeutic Service was created in May 2022 following the harmonisation of individual older adult community services across Black Country Healthcare NHS Trust. Within our first year we have developed therapeutic groups which form both our dementia pathway and functional pathways. We continue to review our waiting lists on a weekly basis and facilitate therapeutic groups within different areas of the community during the working week. Timescales have been set out by our trust and are reviewed by senior management to ensure standards are being met to a timely manner.

6 Implications

Resources:	Finding suitable community venues can be challenging at times due to costing of room hire. Our basic staffing is currently being met which allows us flexibility on days of providing our interventions. Purchasing of equipment for our groups is managed by Senior Management and the locality leads.
Legal and Governance:	No direct implications arising from this report.

Risk:	Risk assessments are completed by the clinicians involved for each patient and reviewed continuously. Venue risk assessments are completed for each venue we use.
Equality:	Clinicians have completed Equality and Healthcare training, our groups are developed as a Multi-Disciplinary team which forms that Older Adult Therapeutic Service ensuring that equality and diversity is maintained at all times. Staff also work to meet needs of individual patients where possible. We are looking to develop therapeutic groups within the Black Country specifically tailored for people within the South Asian community.
Health and Wellbeing:	No current implications identified, evaluations show that our interventions have improved patient's mental health and well being. Evidence based outcome measures are completed for patients pre and post intervention. This ensures that interventions are effective and beneficial to the individual. Therapeutic groups are frequently evaluated and amended based on evidence base/ patient/ facilitator feedback.
Social Value:	The Older Adult Therapeutic Service model explores social needs for patients attending our interventions. Whether this be by providing social inclusion within a group setting or signposting to an appropriate service. Peer Support workers further enhance out patients recovery by supporting them to access further occupations within the community
Climate Change:	No direct implications arising from this report.
Corporate Parenting:	No direct implications arising from this report.

6 Appendices

Appendix 1 - OATS Referral Form
Appendix 2 - Referrer's guide
Appendix 3 - OATS Model

7. Background Papers

N/A

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IMPORTANT! ALL REFERRALS TO: bchft.oatsreferrals@nhs.net

NHS
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NHS Foundation Trust

OATS referral for assessment

Please **return via email only** to **bchft.oatsreferrals@nhs.net**
ALL blue details to be completed (**other details not required if accessible via RIO)**
Internal referrals accepted only with a Steve Morgan assessment dated within 6 months on RIO

Patient Name:	**Patient NHS number:**
Patient Contact number:	**Date of birth:**
Patient Address:	**GP name and address:**
Referrers details for feedback from referral: **Name:** **Contact email:** **Confirm that evidence is documented on RiO for:** ☐Consent to OATS referral ☐Patient demonstrates capacity for assessment ☐Risk assessment has been updated within last 6 months and documented within progress notes.	**Preferred contact (if not patient) to arrange assessment :**
Next of Kin name: Please add to demographics on RIO also **Next of Kin relationship to referred person:** **Next of Kin address:** **Next of Kin contact number:**	**If referring for interventions within the Dementia pathway :** **Date and type of dementia diagnosis:** **ACE score : /100 completed:** **MINI ACE score: /30 completed:**

Please indicate primary need identified. OATS staff may deem further groups suitable at a later date.

Dementia pathway needs: ☐Dementia education ☐Seeing Past Dementia (diagnosis acceptance) ☐Group Cognitive Stimulation Therapy ☐Group Football Cognitive Stimulation Therapy ☐Memory management skills (Due 2024) ☐SANDWELL ONLY- FCD mindfulness group	**Functional pathway needs:** ☐Anxiety management ☐Wellness information ☐Activity based recovery (art, gardening) ☐Managing Difficult Emotions (group based in Wolverhampton but accessible from all locailites)

What to expect following referral:	What to expect following OATS assessment:
OATS triage referral: • **Suitable** – we will offer an initial assessment at the patient's home • **Unsuitable** – we will update the referrer and where possible make recommendations for signposting to alternative support • The referrer will be updated of the outcome via the multi-disciplinary team (MDT)	• **Unsuitable** – the patient will be discharged with recommendations for signposting to alternative supported and/or suggested therapeutic approaches for the multi-disciplinary team (MDT) • **Suitable** – the patient will be offered group interventions and/or time-limited 1:1 interventions to help access to local community/group interventions • The referrer will be updated of the outcome via the MDT

Guidance for referrers to recommended suitable intervention

Please see the below summary for each intervention to guide regarding the most suitable primary need for the referred person.

Dementia pathway:

Dementia Information Group: 4 sessions to provide further information following a Dementia diagnosis, living well with Dementia and advice on accessing further support within the community.

Seeing Past Dementia: 8 sessions to help accept a diagnosis of Dementia. Incorporates Peer Support and seeing past the diagnosis.

Cognitive Stimulation Therapy/ Football Cognitive Stimulation Therapy:14 sessions using activity/ discussion within a structured format. Recommended within NICE guidance and MSNAP core standard. Either follows a traditional theme or Football theme which take place within Wolverhampton and Sandwell but open to all localities.

Memory Management: 8 sessions based on the principles of Cognitive Rehabilitation. Support participates to identify a specific goal and how they might achieve it. Due to be rolled out into all localities in 2024.

Functional Pathway:

Wellness Information Group: 5 sessions based on Compassion Focused Therapy. Helps people to understand the purpose of emotions and introduce emotional regulation. To identify ways to regulate own emotions.

Discover Through Activity: 10 sessions with Occupational Therapy lead. Helps people to identify and explore benefits of various occupational activities to improve mood and confidence. This will be done through psychoeducational and physical activity.

Living with Anxiety: 8 session group to understand Anxiety and develop strategies which aid in managing anxiety.

Managing Difficult Emotions: 6 sessions of education to understand and identify difficult emotions. Supports them to develop skills to cope with difficult emotions to reduce likelihood of impulsivity.

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Older Adult Therapeutic Service referral guidance.

Who do we accept referrals from?

Dementia Pathway- people with a diagnosis of dementia at any age:

Clients do not need to remain open to these services for us to engage with the referred person

Information that should be available by referrer:

1) Memory Assessment Service: Steve Morgan, progress notes and MAS assessment and diagnostic form should be up to date.
2) ECMHTOA: Steve Morgan, progress notes and ECMHT assessment form should be up to date. If referrals are made outside of ECMHTOA then a MH/risk assessment should have been made there prior to referral to our services to determine suitability and consent to engage.
3) Locality dementia services (SCDS in Sandwell, PADS in Walsall, dementia connect in Wolves and Dudley): they may have documents from time occupied in MAS but referral form should be completed in entirety to ensure up to date information for triage
4) Admiral Nurses: admiral nurse risk screening tool should be completed. Please remember admiral nurses work with the carer and so there documentation is focused this way. Further information can be gathered from their documentation or by request directly to referrer.

Functional Pathway- people over 65 accessing secondary care, needs unable to be met by primary care/IAPT due to risk/complexity.

Clients MUST remain open to secondary care for us to assess and engage with the referred person.

Information that should be available by referrer:

1) ECMHTOA: Steve Morgan risk assessment, progress notes and ECMHT assessment should be completed. If referrals are made outside of ECMHTOA then a MH/risk assessment should have been made there prior to referral to our services to determine suitability and consent to engage.

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Person's type of need: Social

Main purpose
- Connect people with others (peers / organisations / local groups)
- Facilitate access to support and connectedness with others who share similar characteristics e.g. people experiencing loneliness due to mental health stigma

Appropriate for
- Functional and dementia referrals to OATS
- Nature of social group recommended will vary depending upon presentation and assessed need
- Therapeutic with a small 't' – members find experience positive, supportive and it increases their sense of belongingness etc

Liaison
- Signpost to Recovery College online hub
- Assist self-enrol to Recovery College
- Signpost to groups within locality

Groups

- Peer support groups
- Community groups
- Diversionary groups
- 1-2 signposting sessions with Therapy Assistant with smart goals
- Greenspace/Mindspace (depending on client need)
- Football and cricket memories (rolling group)
- Life after loss (Healthcare Support Worker / peer support group)

Staff
- Peer support workers
- Buddies

1:1

- Lots of interface with third sector, voluntary and community groups
- Peer support groups
- Community groups
- Diversionary groups
- 1-2 signposting sessions with Therapy Assistant with smart goals
- Greenspace / Mindspace (depending on client need)
- Football and cricket memories
- Life after loss (Healthcare Support Worker / peer support group)

Staff
- Peer support workers
- Buddies

Person's type of need: Therapeutic

Main purpose
- Remediation of long-term emotional problems
- Provide an opportunity to work through emotional issues within a group context

Appropriate for
- Level 4 groups should be therapeutic with a capital 'T'; a positive, supportive experience, increasing sense of belonging
- Should also develop self-awareness and mastery of own thoughts, feeling and behaviour
- May also open up and challenge understanding of themselves thus triggering heightened levels of emotion

Liaison
- Assist self-enrol to Recovery College for complement course to step down
- Signpost to groups within locality

Groups

Functional/MCI (usually 8-10 sessions)
- Compassionate recovery group
- Emotional regulation group – level 2
- Cognitive behaviour therapy (CBT) recovery group
- Solution-focused recovery group

Staff
- Minimum of two registered members of staff required to co-facilitate
- Band 4 staff may be in attendance to shadow and develop their competencies

1:1

Functional/MCI (usually 8-12 sessions - nurse specialist suitability qualified/supervision with psychologist)
- Eye movement desensitization and reprocessing (EMDR)
- Metabolisation (trauma)
- CBT
- CFT

Staff
- Registered members of staff under close supervision from psychology and with suitable qualifications

Older Adult Therapeutic Services (OATS)

Person's type of Need: Occupation-activity

Main purpose
- Provide people with opportunities for recovery through meaningful activity

Appropriate for
- Appropriate for functional and dementia referrals to OATS
- Meaningful activity group/s selected vary depending on stage person is at
- Therapeutic, members find experience positive/supportive, increases belongingness
- Develops sense of self-esteem, mastery and competence via participation in given activity

Liaison
- Assist self-enrol to Recovery College
- Access to Recovery College walking, gardening groups
- Assist self enrol to Recovery College for suitable course
- Signpost to groups within locality

Groups

- Recovery through activity group
- Creative expression group (Occupational Therapist (OT) led)
- Greenspace / Mindspace (depending on client need)
- Football and cricket memories (structured group)
- Mindfulness following anxiety and depression group
- Life after loss (Healthcare Support Worker / peer support group)
- Health and wellbeing group
- Cognitive stimulation therapy (CST)

Staff
- Registered members of staff to facilitate but once established, groups can be co-facilitated and supported by peer support workers, buddies, non-registered Band 4 staff, as long as they are over-seen by a registered member of staff

1:1

- Greenspace/Mindspace (depending on client need)
- Mindfulness following anxiety and depression group
- Graded exposure
- CBT approaches
- Reconnection (trauma)
- Individual cog rehab
- Wellness and recovery action planning (WRAP)

Staff
- Registered members of staff / unregistered members of staff (with supervision)

Person's type of Need: Psycho-educational

Main purpose
- Preventative and educational
- Provides understanding of their mental health from bio-psycho-social perspective
- Prevent future upsets by teaching participants effective ways of dealing with emotional stress arising from situational crises
- Provide carers and people with dementia with an understanding of dementia and living well with dementia (including impact)

Appropriate for
- Appropriate for functional and early stage dementia referrals
- Nature of psycho-educational group recommended will vary depending upon presentation and assessed need
- Level 3 groups should be therapeutic with a capital 'T'; a positive, supportive experience, increasing sense of belonging
- Develops sense of self-awareness and mastery of own thoughts, feeling and behaviours

Liaison
- Assist self-enrol to Recovery College for complement course to step-down

Groups

Functional/MCI (usually 6-8 sessions)
- Skills based groups
- Anxiety management
- Learning and coping skills
- Dealing with difficult emotions
- Depression awareness
- Emotional regulation skills – level 1

Dementia specific
- Dementia information group
- Memory management
- Living well with dementia
- Seeing past dementia
- My life, my goals (cog rehab)

Staff
- Minimum of one registered member of staff supported by one non-registered member of staff to co-facilitate
- May include Band 4 Assistant Psychologists who will have a background in psychology

1:1

Functional/MCI (usually 8-12 sessions)
- Stablisation (trauma)
- Emotional regulation skills level 1
- Narrative approaches
- CBT approaches for anxiety and depression
- DBT approaches
- Coping skills (confidence and self-esteem work)
- Dealing with difficult emotions

Dementia specific
- Start programme (carers)
- Assisted technology

Staff
- Registered members of staff / unregistered members of staff (with supervision)

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Older Adult Therapeutic Service

Presented by:
Gemma Lockley- OATS Clinical Lead
Fiona Jones- OATS Clinical Nurse Specialist

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Community Therapy service provision prior to OATS launch

Sandwell	Walsall	Wolverhampton
Therapy and Recovery Unit (TARU)	Therapy and Liaison Community Service (TALCS)	The Groves (Penn Hospital)
Day Care	Therapies	Day Care

Community transformation programme brought together the above existing services and on 16th May, 2022:

Older Adult Therapeutic Service (OATS) launched.
Specialist Service- recovery and therapies

Black Country wide- Dudley, Sandwell, Walsall and Wolverhampton

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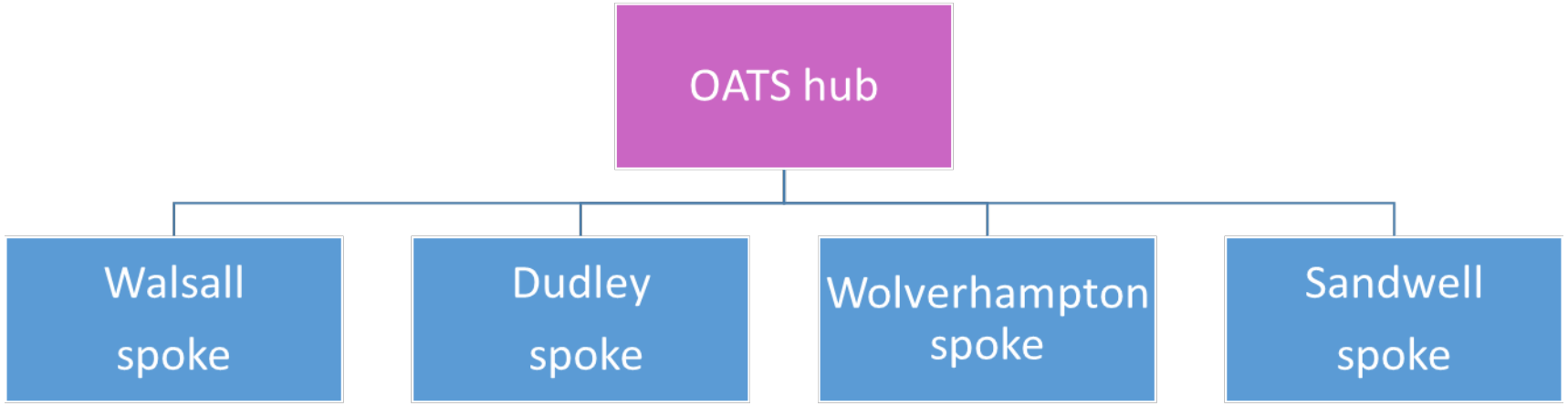
NHS Foundation Trust

OATS current Multi-disciplinary team setup



OATS Hub (Blakenall Village Centre):

- Team Manager x1
- Clinical Lead x1
- Assistant Psychologist x2

(work across 4 localities)

- Administration Officer x3

Locality spoke:

- Nurse Specialist x1
- Senior Occupational Therapist (OT) x1
- OATS Nurse/ OT x1
- Therapy Assistants
- Peer Support Co-Ordinator

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Current referral pathway into OATS

Organic:

- MAS
- ECMHTOA
- Locality Dementia Services
- Admiral Nurses

Functional:

- ECMHTOA (client must remain open for OATS to assess and engage with the referred person)

Psychology input (START/ co facilitated psychology group):

- MAS and ECMHTOA psychology
- OATS

Peer Support:

- OATS staff only following assessment and/or interventions.

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Area's where groups are currently provided

- West Bromwich Community Centre
- Farley Park Community Centre
- Haden Cross Fire Station
- Moxley People's Centre Charity
- Birmingham County FA- Ray Hall Lane

- We are currently exploring additional venues within Oldbury/ Smethwick and additional venues in West Bromwich

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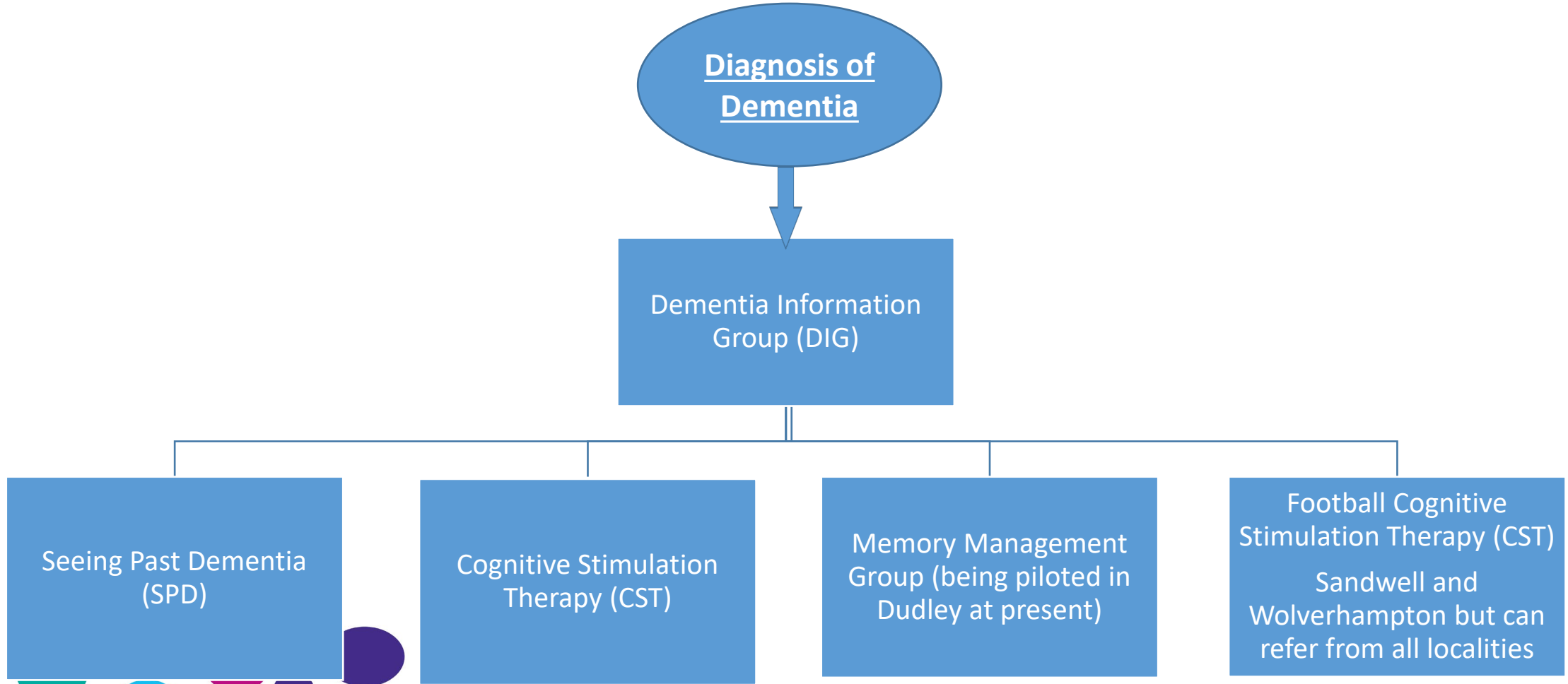
Organic pathway within OATS



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Organic groups currently provided

Dementia Information Group (DIG):

4 sessions of information for the person with Dementia.
Sessions include:

- What is Dementia?
- Managing Emotions and Impact of Diagnosis
- Living Well With Dementia
- Community Support

Cognitive Stimulation Therapy (CST):

14 sessions, recommended by NICE guidance and identified as a core standard within MSNAP framework.

Uses activities/ discussion within a structured format, evidence shows it can improve mood and cognition.

Seeing Past Dementia (SPD):

8 sessions focusing on acceptance of diagnosis. Discussion group that incorporates:
Peer support
Q and A
Seeing past a persons diagnosis/ highlighting their strengths and identity.

Sports Cognitive Stimulation Therapy:

14 sessions as above but sports themed

Currently running in:

- Wolverhampton (at Molineuex)
- Sandwell (County FA)

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NHS Foundation Trust

Functional pathway within OATS

Referral received from ECMHTIOA

- Wellness Information Group (WIG)
- Living with Anxiety (LAG) In Pilot
- Discovery Through Activity (DTA)
- Managing Difficult Emotions (MDE) In development
- Life After Loss In development

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NHS Foundation Trust

Functional groups currently provided

Wellness Information Group:
5 sessions based on Compassion Focused Therapy. Helps people to understand the purpose of emotions and introduce emotional regulation. To identify ways to regulate own emotions.

Managing Difficult Emotions (Pilot):
6 sessions of education to understand and identify difficult emotions. Supports them to develop skills to cope with difficult emotions to reduce likelihood of impulsivity.

Living with Anxiety:
8 session group to understand Anxiety and develop strategies which aid in managing anxiety.

Discovery Through Activity:
10 sessions with Occupational Therapy lead. Helps people to identify and explore benefits of various occupational activities to improve mood and confidence. This will be done through psychoeducational and physical activity

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NHS Foundation Trust

Groups currently in pilot phase

Organic Pathway:

Memory Management Group: Designed around principles of Cognitive Rehabilitation Therapy (currently Dudley only)

Punjabi Cognitive Stimulation Therapy: Currently exploring joint provision with third sector organisations

Music Appreciation Group

Functional Pathway:

Life After Loss

Managing Difficult Emotions

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Qualitative data- selection of anonymous feedback from groups and SED forms returned to OATS

DIG
" Lots of useful information and the staff know their stuff"
" Enjoyed the refreshments "

DTA
"I really enjoyed the session today, talking with different people was nice and hearing all the different interests"
"I started walking, I wouldn't have done that otherwise."

Football CST
"Excellent meeting, funny, interesting and very rewarding, excellent atmosphere and at times very funny – Great! Many thanks to staff"
" Laughing too much, perfect! Brilliant!"
Verbal feedback was received from patients relatives on collection from sessions advising they had seen an improvement in mood and confidence. 1 patient verbalised that this group has given him the confidence to attend other groups in the community in which he is interested in which he had previously avoided"

CST
" We need more sessions, I've enjoyed everything about it"
"Thanks for listening to my stories."

SPD
" You have made us all realise that's we are not alone on this journey and we would like to thank you for your support and guidance along the way." Also bought chocolates for the staff."
"Found meetings very informative"

WIG
"I have enjoyed attending the group and the discussions we have touched upon, knowing that other people are experiencing the same problems helped"
"I have really enjoyed this group, I wasn't going out now I have made a friend and we are going to go out together"

How to refer to OATS

OATS referral for assessment

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ALL blue details to be completed (**other details not required if accessible via RIO**)
Internal referrals accepted only with a Steve Morgan assessment dated within 6 months on RIO

Patient name:	**Patient NHS number:**
Patient contact number:	**Date of birth:**
Patient address:	**GP name and address:**
Referrers details for feedback from referral: **Name:** **Contact email:** **Confirm that evidence is documented on RiO for:** ☐Consent to OATS referral ☐Patient demonstrates capacity for assessment ☐Risk assessment has been updated within last 6 months and documented within progress notes.	**Preferred contact (if not patient) to arrange assessment :**
Next of Kin name: Please add to demographics on RIO also **Next of Kin relationship to referred person:** **Next of Kin address:** **Next of Kin contact number:**	**If referring for interventions within the Dementia pathway :** **Date and type of dementia diagnosis:** **ACE score : /100 completed:** **MINI ACE score: /30 completed:**
Please indicate primary need identified. OATS staff may deem further groups suitable at a later date.	
Dementia pathway needs: ☐Dementia education ☐Seeing Past Dementia (diagnosis acceptance) ☐Group Cognitive Stimulation Therapy ☐Group Football Cognitive Stimulation Therapy ☐Memory management skills (Due 2024) ☐SANDWELL ONLY- FCD mindfulness group	**Functional pathway needs:** ☐Anxiety management ☐Wellness information ☐Activity based recovery (art, gardening) ☐Managing Difficult Emotions (group based in Wolverhampton but accessible from all localites)

Black Country Healthcare
NHS Foundation Trust

Guidance for referrers to recommended suitable intervention

Please see the below summary for each intervention to guide regarding the most suitable primary need fo the referred person.

Dementia pathway:

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Seeing Past Dementia: 8 sessions to help accept a diagnosis of Dementia. Incorporates Peer Support an seeing past the diagnosis.

Cognitive Stimulation Therapy/ Football Cognitive Stimulation Therapy:14 sessions using activity, discussion within a structured format. Recommended within NICE guidance and MSNAP core standard Either follows a traditional theme or Football theme which take place within Wolverhampton and Sandwel but open to all localities.

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Functional Pathway:

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Managing Difficult Emotions: 6 sessions of education to understand and identify difficult emotions. Supports them to develop skills to cope with difficult emotions to reduce likelihood of impulsivity.

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Referrals to be sent to:

bchft.oatsreferrals@nhs.net

Queries can be discussed with locality leads:

(Fiona Jones OATS Clinical Nurse Specialist) (Erica Little Senior OT)

bchft.oatssandwellspoke@nhs.net

Black Country Healthcare
NHS Foundation Trust

Thank you

Any questions?

Together with you to achieve **healthier, happier lives**

Sandwell Health & Wellbeing Board

18 October 2023

Subject:	Child Death Overview Panel report 2021 /22
Presenting Officer and Organisation	Interim Director Public Health, Liann Brookes-Smith Sandwell Council Liann_Brookes-Smith@sandwell.gov.uk
Purpose of Report	Information

1 Recommendations

1.1 That the findings of the Child Death Overview Panel 2021/ 22 are understood and support is made to make a change within the current system.

2 Links to the following Board Priorities

Priority 1	**We will help keep people healthier for longer**
Priority 2	**We will help keep people safe and support communities**
Priority 3	**We will work together to join up services**
Priority 4	**We will work closely with local people, partners and providers of services**

4. Context and Key Issues

4.1. This is the third report from the Black Country Child Death Overview Panel, an interagency forum for Child Death Reviews. Deaths are reviewed from birth to 18 years of age. This is a statutory body, accountable to the Local authority and ICB. Learning from Child deaths is a priority and has an impact on safety and child health and wellbeing

4.2. Data for 22/23 will be available in January 2024

4.3. In 2021/22 there were 40 deaths in Sandwell which was the highest in the black country and double our Black Country neighbours. Cases have been increasing since 2019-2020 but decreasing in Dudley, Walsall and Wolverhampton.

4.4. Half (20) deaths were in the under 27 days. 7 were 29- 264 days, 5 were 1-4 years, 0 were 5-9 years, 5 were 10-14 years and 3 were 15-17 years. Most age groups have seen an increase in deaths.

4.5. Themes that have emerged from the Infant mortality (death under 1 year are

- Smoking in pregnancy
- Obesity
- Concealed pregnancy
- Working with high risk fathers

Following delivery are:

- Monitoring
- Awareness of risk factors
- Adequate staffing in high-risk deliveries.

4.6. LMNS 2022/23 Transformation - Priorities/Deliverables for Best Start Work Stream

- To ensure that every Provider has a Pre-term Birth Clinic
- To ensure that at least 85% of women who are expected to give birth at less than 27 weeks gestation can do so in a maternity unit with appropriate on-site NICU
- To halve the rates of stillbirths, Neonatal deaths, Maternal deaths, and serious intrapartum brain injuries by 2025
- To reduce the national rate of pre-term births from 8% to 6%
- LMNS' should continue to work with Neonatal Operational Delivery Networks to implement local Neonatal improvement plans with a particular focus on
- Maternity and Neonatal services working together to ensure that at least 85% of births at less than 27 weeks take place at a Maternity unit with an onsite NICU and together undertake a review of all births not in the right place. Data from these reviews should be collated at the regional level to support thematic analysis and inform targeted actions.
- Identifying routes to escalate requirements for capital investment in Neonatal services through the relevant ICS routes

4.7. Other lessons learned:

4.8. What the Public Health team are doing:

- Working to put in place a healthy pregnancy service
- Infant mortality deep dive to understand the rates of death in children compared to other areas, i.e. do we have more deaths of the same type compared to other areas.
- working to decrease obesity
- Universal best start vitamins.

5 Engagement

No Public Engagement has occurred

6 Implications

Resources:	It is funded via Public Health grant funding.
Legal and Governance:	Ensuring we are reducing risk and encouraging the best practice in our maternity units and midwifery teams.
Risk:	Raising the profile of the out comes and working with our Local Maternity and Neonatal Systems (LMNS)
Equality:	Working to tackle poorer outcomes in women from minority backgrounds.
Health and Wellbeing:	Improving infant mortality outcomes.
Social Value:	Improve the outcomes for our children and families.
Climate Change:	No climate change implication directly arising from this report.
Corporate Parenting:	Improve the outcomes for our children and families

6 Appendices

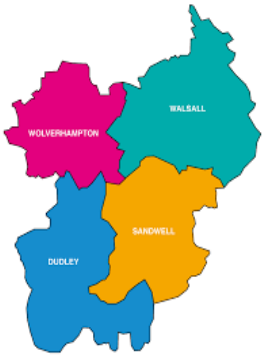
Appendix 1 - Black Country Child Death Overview Panel: Annual Report 2021- 2022

7. Background Papers

None

Black Country Child Death Overview Panel

Annual Report 2021 - 2022



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BLACK COUNTRY CHILD DEATH COORDINATOR
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1. Foreword – Independent Chair

Losing a child is the most devastating thing that can happen to a parent.

I continue to be amazed at the dedication and professionalism of those on the front line, and panel members who strive to make sure that we can learn something from each death, so that we can prevent future deaths and reduce risks to children. The global pandemic continued to interrupt and impact on child death review processes across all four areas of the Black Country, much as it does across much of the country.

This report aims to not only reflect the cases the panel has considered throughout 2021-22, but also the achievements of the partnership, future priorities for action, and issues related to the implementing the statutory child death review processes. The National Child Mortality Database, for which we provide data, is now able to provide more meaningful comparative reports, which will help support the agenda of children's safeguarding and health and wellbeing.

I would like to thank all the Panel members, for their continued commitment and hard work, to what is a particularly emotive subject. I would also like to thank Jaki Bateman and Michelle Mincher for the hard work that goes on behind the scenes to ensure that the Panel runs smoothly and keeps pace with the changing landscape.

Mike Leaf

Black Country Independent Chair

2. Introduction

This is the third report of the Black Country Child Death Overview Panel. The Black Country Death Overview Panel (BC CDOP) is an inter-agency forum for Child Death Reviews comprising of organisations from Sandwell, Dudley, Walsall, and Wolverhampton.

The Child Death Review process is an analysis of deaths of children who die in England from birth to 18 years of age. Child Death Overview Panels are a statutory body and are accountable to their respective Local Authorities and Clinical Commissioning Groups. Every child death is a devastating loss that profoundly affects the family involved.

In addition to providing support to families and carers, staff involved in the care of the child should also be considered and offered appropriate help. This is grounded in respect of the rights of the child and their family, with the objective of preventing child deaths.

Learning lessons from Child Death cases is a priority, and will have a positive impact on the safety, health and wellbeing of children and young people, and to ensure the learning is shared widely across the area, as well as regionally and nationally. This report explores the statistical and qualitative conclusions from the Child Death Overview Panel Reviews in the Black Country during the reporting year April 2021 to March 2022.

Purpose

The Black Country Child Death Overview panel is a multi-agency panel set up to conduct the independent scrutiny on behalf of the local Child Death Review partners on the reviews of deaths of children normally resident in the Black Country, to learn lessons and share findings for the prevention of child deaths.

The Child Death Overview Panel review is intended to be the final scrutiny over a child's death. The purpose of a child death review is: -
(a) to identify any matters of concern affecting the safety and welfare of children relating to the death or deaths,
(b) to consider any actions or recommendations that can be taken based on a death, or a pattern of deaths to identify trends that require a multidisciplinary response.

Statutory Framework and Governance

Chapter 5 of the new working arrangements for Child Death Overview Panels statutory and operational guidance (2018), sets out the key features of a good Child Death Review (CDR) process to be followed by all organisations involved with the process of child death reviews as of 1st April 2019. The Department of Health & Social Care have taken over statistical analysis of Child Death Review data from the Department for Education as of April 2019. Greater regionalisation of child death reviews was encouraged, and further work undertaken to develop a national database. The Department of Health will disseminate relevant learning to Local Safeguarding Childrens Partners.

Operational Overview

The Black Country Child Death Overview Panel membership is made up of senior multi-agency professionals who have knowledge and expertise in fields such as public health, children's social care, paediatrics, police, education etc. The panel consists of representation from a range of organisations who can make a valuable contribution when undertaking a child death review. Each professional provides information and advice to enable a thorough review and analysis, with the aim of identifying relevant factor, modifiable factors, and emerging themes.

The purpose of a review and analysis is to identify any matters relating to the death(s), that are relevant to the welfare of children in the area or to public health and safety, to consider whether action should be taken. The aim of the child death review process is to ensure that information is systematically captured for every death to enable learning and prevent future deaths. The Child Death Overview Panel publishes an annual report which provides an overview of local patterns and trends and evidence what has taken place because of the child death review arrangements and how effective the arrangements are in practice.

Themed Panel Meetings

Some child deaths are reviewed at the Themed Panel meeting to discuss a particular cause or group of causes. The Black Country Child Death Overview Panel holds Themed Panel meetings to review neonatal deaths (<28 days of life). Such arrangements allow for the attendance of appropriate professional experts and independent scrutiny from a neighbouring authority neonatal unit, to inform discussions and allow easier identification of themes.

Child Death Review Meetings

The Black Country Child Death Overview Panel is informed by the referral of a standardised report analysis form from the Child Death Review Meeting (CDRM). The meetings are attended by professionals who were directly involved in the care of the child during their life, and any professional involved in the review of their death. At this meeting, all matters relating to the individual child death are discussed. The composition of professionals at the CDRM varies according to the circumstances of the child death and is not limited to medical staff. The focus of this meeting is:

- To review background history, treatment, and outcomes of investigations to determine as far as possible the likely cause of death
- To ascertain any contributory or modifiable factors from the death
- To describe any learning from the death, and, where appropriate to identify any actions that should be taken arising from the death
- To review the support provided to the family and to ensure families are provided with a plain explanation of why their child died
- To ensure that the Child Death Overview Panel and, where appropriate the coroner is informed of the outcomes of any investigation into the child's death,
- To review the support provided to staff involved in the care of the child

The National Child Mortality Database (NCMD)

The National Child Mortality Database (NCMD) is a repository of data relating to all child deaths in England. The NCMD was commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England and is delivered by the University of Bristol, in collaboration with the University of Oxford, University College London (UCL) Partners and the software company QES. The

NCMD enables more detailed analysis and interpretation of all data arising from the child death review process, to ensure that lessons are learned, that learning is widely shared and that actions are taken locally and nationally, to reduce child mortality. The introduction of the NCMD aims to learn lessons that could lead to changes to improve outcomes for children.

As of the 1 April 2019, it became a statutory requirement that Child Death Overview Panels across England submit data via the NCMD. The Black Country continues to use a web-based system that submits the required data and reports are received on a quarterly basis summarising submitted data.

Black Country eCDOP Database

The eCDOP system is being used across England and feeds into the National Child Mortality database. The eCDOP Database management with Quality Education Systems continues to be used for meaningful data collection, consolidation, and analysis of data from panel reviews. The annual contract was renewed for the financial year April 2022 to March 2023.

The eCDOP system provides an online procedural structure for notifications, reporting and meeting protocol for the areas that form the Black Country Clinical Commissioning Partnership, and supports coordination of interaction between the two parts of a child death review as required under the new working arrangements for Child Death Overview Panels.

Strategic Partnership

Strategic partners, including police and safeguarding partnerships meet on a quarterly basis to ensure the statutory function of Child Death Overview Panel being robustly implemented and to highlight any concerns for escalation.

Elements of good practice, learning and modifiable factors are identified at this meeting and reported to CDR partners through Multi-agency Safeguarding Partnerships and Health and Wellbeing Boards. The Strategic partnership are also responsible for setting the budget, structure and making recommendations to agencies where concerns are highlighted. The meeting is chaired independently and supported by the Child Death coordinator.

Process: Relevant Factors & Modifiable Factors

Information is collated using the Department of Health and Social Care (DHSC) national Child Death Overview Panel reporting forms. Completed forms are presented during the Child Death Overview Panel meeting to assess the death. As part of the child death review process, the Child Death Overview Panel is responsible for analysing information to determine the categorisation of death (see appendix 2), relevant factors and modifiable factors. Such modifiable factors are defined as factors which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

Information is collated and categorised using the four domains:

Domain A: Factors intrinsic to the child:

Factors in the child (and in neonatal deaths, in the pregnancy) relating to the child's age, gender and ethnicity; any pre-existing medical conditions, developmental or behavioural issues or disability, and for neonatal deaths, the mother's health and wellbeing.

Domain B: Factors in social environment including family and parenting capacity:

Factors in family structure and functioning and any wider family health issues; provision of basic care (safety, emotional warmth; stimulation; guidance and boundaries; stability); engagement with health services (including antenatal care where relevant); employment and income; social integration and support; nursery/preschool or school environment.

Domain C: Factors in the physical environment:

Factors relating to the physical environment the child was in at the time of the event leading to death, and for neonatal deaths, the mother's environment during pregnancy including poor quality housing; overcrowding; environmental conditions; home or neighbourhood safety; as well as known hazards contributing to common childhood injuries (e.g., burns, falls, road traffic collisions)

Domain D: Factors in Service Provision:

Factors in relation to service provision or uptake including any issues relating to identification of illness, assessment, investigations, and diagnosis; treatment or healthcare management; communication or teamwork within or between agencies; and organisational or systemic issues. Consider underlying staff factors, task factors, equipment, and work environment, education and training, and team factors.

For each of the four domains, Black Country Child Death Overview Panel determines the level of relevance (0-2) for each factor, relating to the registered cause of death and to inform learning of lessons at a local, regional, and national level. The categories are:

0: Information not available

1: No factors identified, or factors identified but are unlikely to have contributed to the death

2: Factors identified that may have contributed to vulnerability, ill health, or death

As part of the review, the Child Death Overview Panel is responsible for identifying modifiable factors, although categorising a death as having modifiable factors does not necessarily mean the Child Death Overview Panel regards the death in question as preventable, but that there may be emerging trends which could reduce the risk of future child deaths.

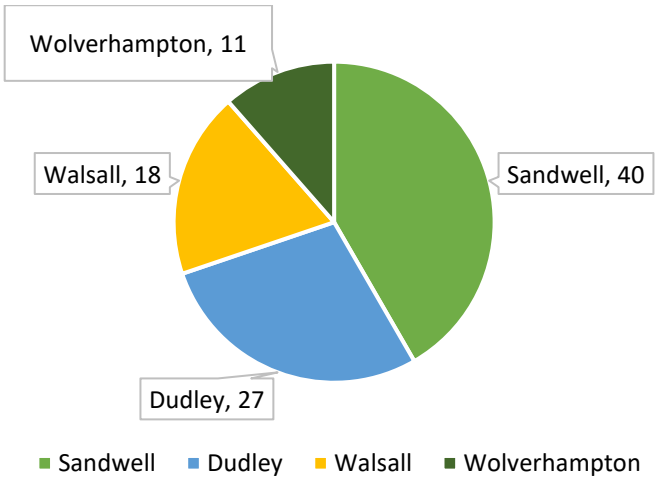
Modifiable factors identified: The review has identified one or more factors across any domain which may have contributed to the death of the child, and which might, by means of a locally or nationally achievable intervention, be modified to reduce the risk of future child deaths.

No modifiable factors identified: The review did not identify any modifiable factors Inadequate information upon which to make a judgement: The review was unable to identify if any modifiable factors were present.

3. Deaths Notified in 2021 – 2022

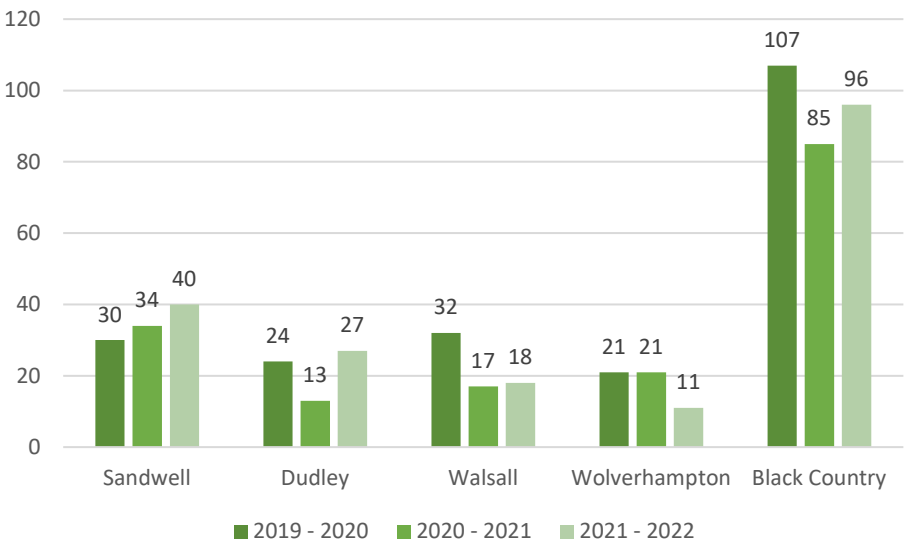
96 deaths in total were notified across the Black Country between April 2021 – March 2022. Nationally, the NCMD reports 3,470 Child Death notifications by CDOP's between April 2021 – March 2022. This is an increase of 396 child deaths from the previous year, 2020-2021, where there was a significant reduction in child death notifications.

Chart 1: Black Country Death notifications by area - 2021-2022



In 2021-2022 there were 96 child deaths notified in the Black Country with 42% in the Sandwell, 28% in Dudley, 19% in Walsall and 11% in Wolverhampton.

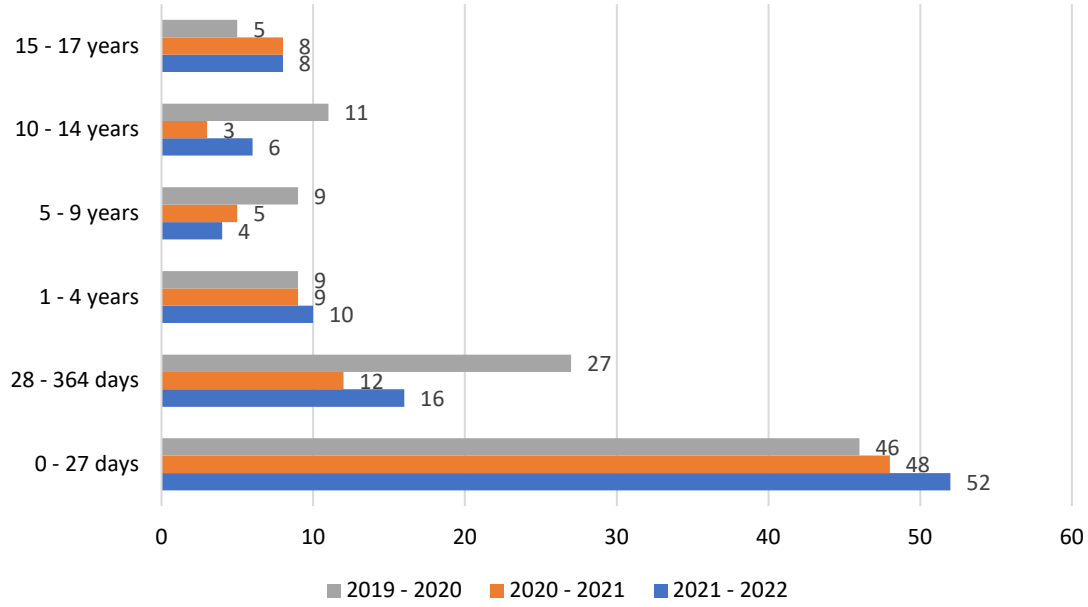
Chart 2: Black Country Death Notifications for each area – 3-year comparison 2019-2022



The chart above shows a 3-year comparison using data collected consistently from across the Black Country since the new arrangements in April 2019. Sandwell, Dudley, and Walsall have seen an increase since 2020 – 2021, where Wolverhampton has seen a 52% decrease in numbers. Overall,

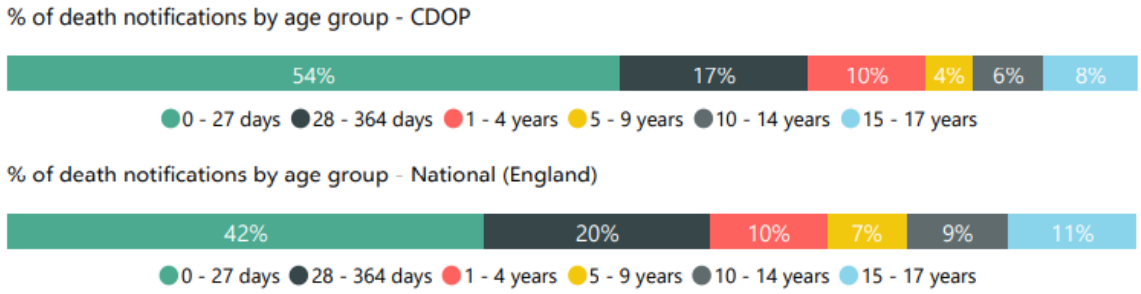
the Black Country has seen a 13% increase in child deaths from 2020 – 2021, although numbers are not as high as they were in 2019 - 2020.

Chart 3: Black Country Death Notifications by Age Group - 3 Year Comparison 2019-2022



Overall, deaths have increased in the 0 - 27 days, 28 – 364 days, 1 – 4 years and 10-14 years age groups since 2020-2021. There has been a slight decrease in the 5 – 9 years age groups and death notification have remained the same in the 15 – 17 years age group as 2020 – 2021. The pattern of notifications by age is similar to the national pattern.

Chart 4: Black Country and England Death Notifications by Age Group - 2021-2022



In 2021 – 2022, the proportion of deaths in the 0-27 days age group is 28% more in the Black Country when compared to the National (England) data. In summary the infant mortality (under one year) remains higher in the Black Country than nationally, and accounts for 69.8% of all deaths over the 3 years 2019-22. The proportion of deaths in the other age groups appears slightly lower than the National (England) figures although the notification of death for 1-4 years is at the same level.

Black Country Death Notifications by age – 2019 – 2022 – 3-year comparison for each area

Care should be taken in attempting to establish trends over time when dealing with small numbers, as they are likely to fluctuate from year to year.

Chart 5: Dudley - 3-year Comparison of Death Notifications by Age

In Dudley in 2021/2022, deaths have reduced in the 10 – 14 years age group. All other age groups have increased apart from the 5 – 9 years age group which remains the same as in 2020 – 2021. The greatest increase is in the neonatal age group, 0 – 27 days where this has more than doubled from the previous two years.

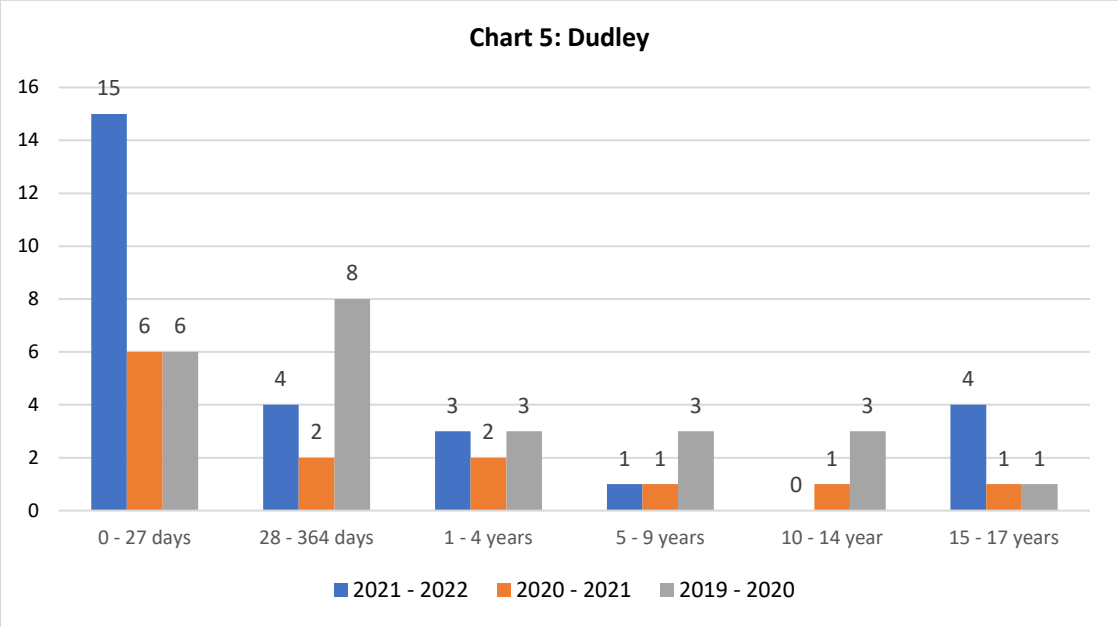


Chart 6: Sandwell - 3-year Comparison of Death Notifications by Age

In Sandwell in 2021/2022, deaths have reduced in the 5 - 9 years and 15 - 17 years age groups. However, deaths have increased in all other age groups, although numbers are small. The largest increase was in the 10 – 14-year age group.

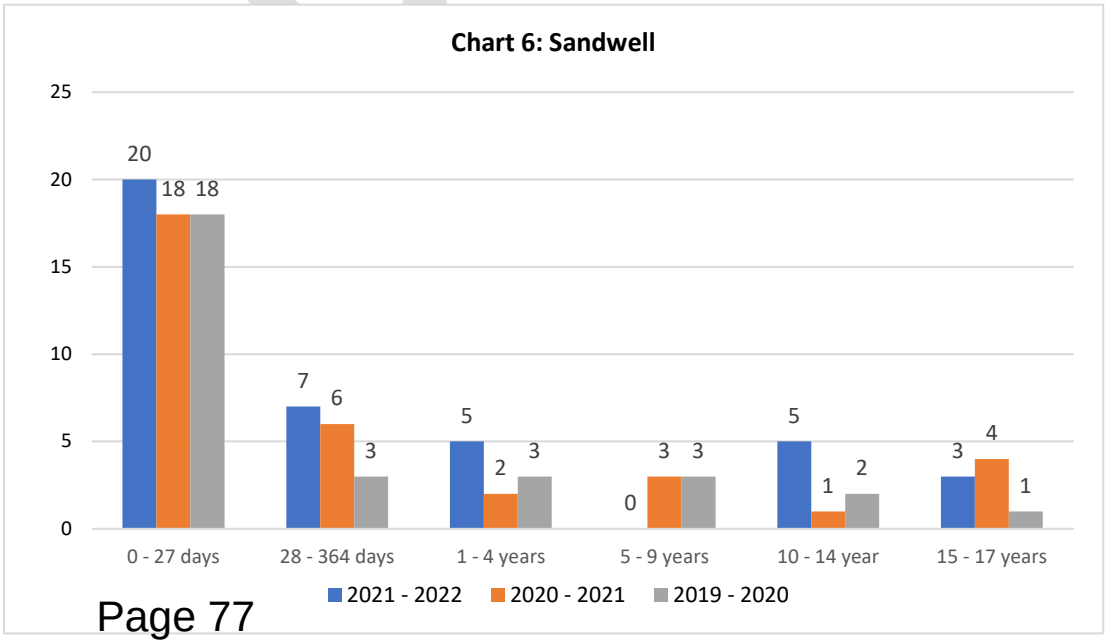


Chart 7: Walsall - 3-year Comparison of Death Notifications by Age

In Walsall in 2021/2022, deaths have increased in the 5 – 9-year age group and 28 – 364 days age group. The largest reduction in deaths was see in the 0 – 27 days age group. The other age group deaths remained the same as 2020-2021.

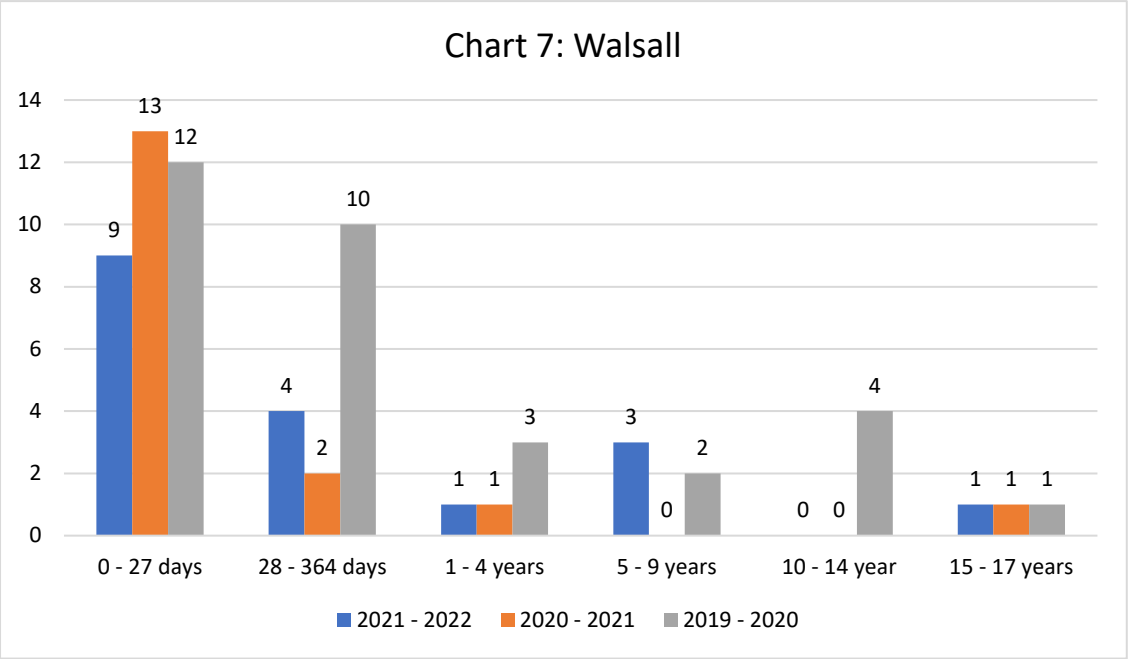


Chart 8: Wolverhampton - 3-year Comparison of Death Notifications by Age

In Wolverhampton in 2021/2022, deaths reduced in every age group, except for the 10 – 14 years age group where it remained the same as 2020-2021.

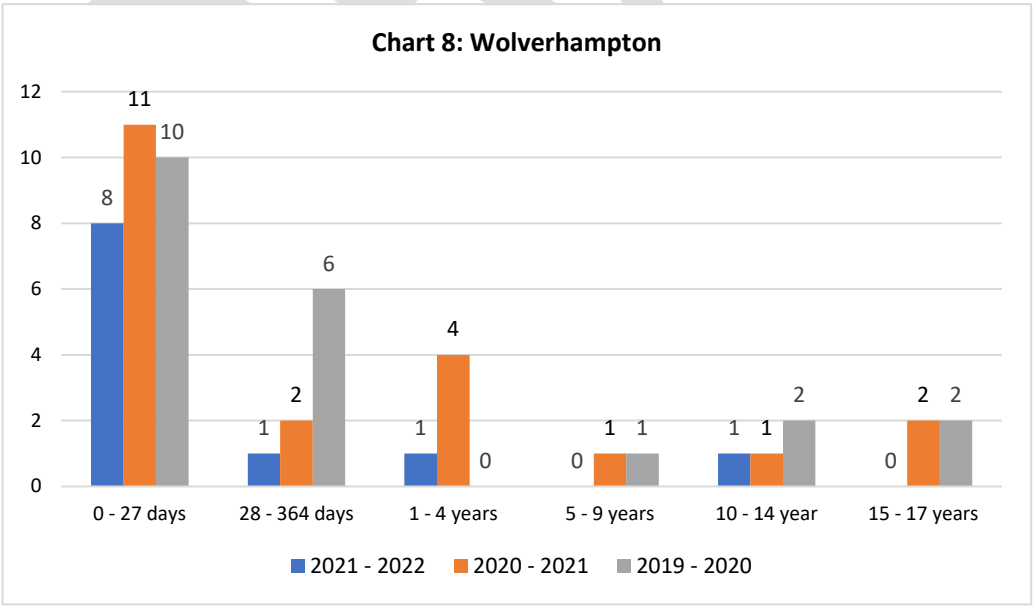


Chart 9: Black Country Death Notifications by Ethnicity – 3-year Comparison 2019 - 2022

Ethnicity	2011 Census 0-18 years	%	2019 – 2020 Notified Deaths	2019 – 2020 %	2020 – 2021 Notified Deaths	2020-2021 %	2021 – 2022 Notified Deaths	2021-2022 %
White British	41249	55.50	43	**40.19**	29	**34.12**	43	**45**
White Other	2475	3.30	5	**4.67**	8	**9.42**	5	**5**
Mixed Multiple Ethnic Group	5786	7.70	18	**16.82**	2	**2.35**	3	**3.5**
Asian British Indian	7584	10.20	8	**7.48**	9	**10.59**	12	**12.5**
Asian British Pakistani	5773	7.80	12	**11.21**	7	**8.23**	9	**9.5**
Asian British Bangladeshi	2840	3.80	3	**2.80**	2	**2.35**	5	**5**
Asian British Chinese	227	0.30	4	**3.74**	0	**0.00**	0	**0**
Other Asian	1913	2.60	0	**0.00**	4	**4.70**	3	**3.5**
Black British African	1623	2.20	4	**3.74**	7	**8.23**	4	**4**
Black British Caribbean	2552	3.40	4	**3.74**	3	**3.53**	5	**5**
Black British Other	1019	1.40	0	**0.00**	6	**7.06**	2	**2**
Other Ethnic Group/Not recorded	1335	1.80	6	**5.61**	8	**9.42**	5	**5**
Totals	74376	100%	**107 notified deaths in 2019-2020**	100%	**85 notified deaths in 2020-2021**	100%	**96 notified deaths in 2021-2022**	100%

Most deaths notified in 2021 – 2022 were from children identified as 'White - British' (45%). The second largest ethnic category of deaths notified within this reporting year was 'Asian or Asian British – Indian' (12.5%). As with previous years, this contrasts with those children from a Black, Asian or Minority background where there was a higher percentage of reported child deaths compared to the population size (0-18yrs). Hopefully this data will be more reliable and take into consideration population migration next year when new census data should be made available.

Nationally, the Ethnic group was recorded in 3,330 (96%) death notifications. Of these, 64% of deaths were of children who were recorded as being from a White ethnic group, 18% of deaths were of children from an Asian or Asian British background, 8% were from a Black or Black British background, 7% were from a mixed background and 3% were from any other ethnic group. These proportions were like the previous year.

The National Child Mortality Database highlighted the improvement in completeness of ethnicity records compared to previous years and this should help ensure mortality differences by ethnicity can be measured accurately in future years.

Background: Infant Mortality Rates and Ethnicity

Substantial inequalities in infant mortality rates are known to exist between white and ethnic minority groups in England and Wales (Gray et al., 2009), and low gestational age is strongly linked to poor health (or mortality outcomes) (Kurinczuk et al., 2009). However, information about ethnicity and gestational age is not always collected at birth registration.

Since 2005 birth registration records have been linked with NHS birth notification records. This data is then linked to death registration records for babies who died before their first birthday. By linking the 3 data sources, figures can be reported for infant mortality by gestational age and ethnicity, as well as other risk factors including: birthweight, mother's age at birth of child, marital status, and socio-economic status (based on the most advantaged parent's occupation).

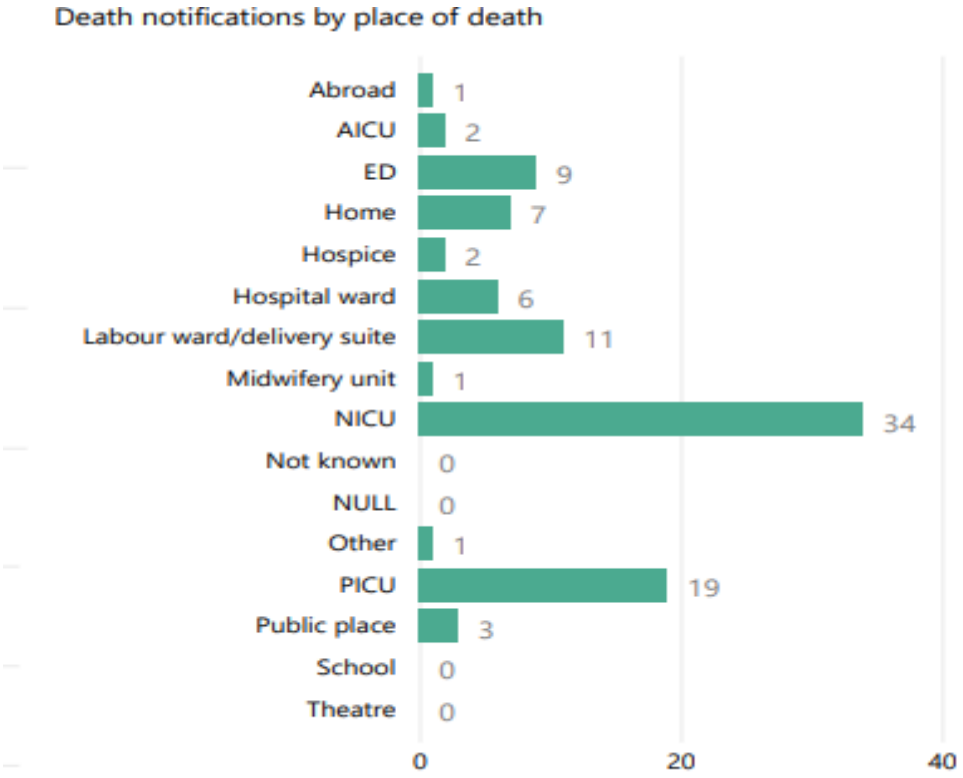
The NHS birth notifications system collects information about ethnicity to help organisations monitor their service delivery. Ethnicity is usually self-defined, for birth notifications the baby's ethnic group is defined by the mother.

Individuals may choose not to state their baby's ethnicity. In some areas with a very high proportion of "Not Stated" records opting-out may not be the sole reason for incomplete data, as the "Not Stated" response category also includes "not known", "missing" and "not asked".

Place of death

The place of death is defined at data collection as where the child is believed to have died regardless of where death was confirmed.

Chart 10: Black Country Death Notifications by place of Death – 2021-2022



It makes sense that as most deaths have occurred in the 0 – 28 days age group that the place of death reflects this with deaths occurring in the NICU and labour ward/delivery suite.

It is concerning, however, that the trend has continued from last year where large numbers of deaths have occurred at home, ED, and public places. However, as summarised last year this also corresponds to the unexpected death reported below.

Nationally, where the place of death was known, the majority (74%,) of deaths occurred in a hospital Trust, consistent with the previous year. Deaths that occurred on neonatal units accounted for 869 (25%) of deaths; the largest proportion of deaths across all locations recorded. There was an increase in the number of deaths where the place of death was recorded as the child's home or a public place in 2021-2022 when compared to previous years.

Black Country Unexpected Deaths requiring a Joint Agency Response (JAR)

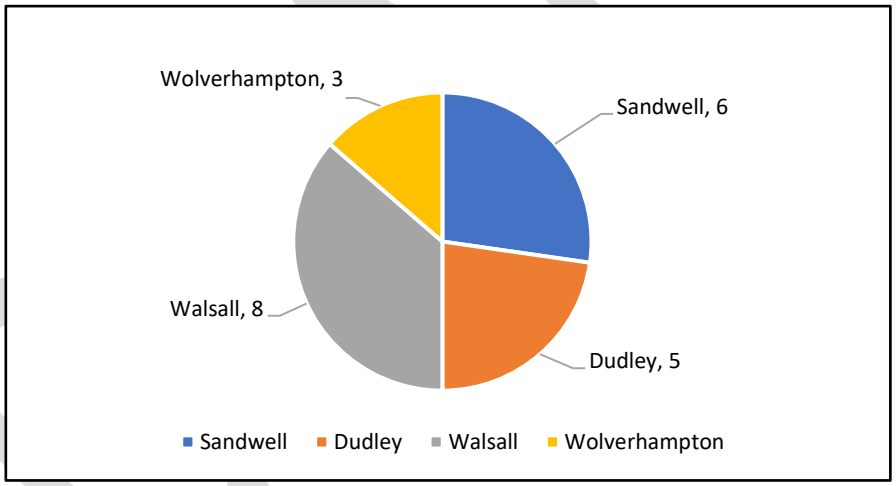
22 of the 96 (22.9%) deaths notified to the Black Country in 2021 – 2022, were unexpected and required a Joint Agency Response (JAR).

An unexpected death involves cases in which there is death (or collapse leading to death) of a child, which would not have been reasonably expected to occur 24 hours previously and in whom no pre-existing medical cause of death is apparent.

There is a requirement to perform further investigations for children who die where the cause is unknown. This process is referred to as a Joint Agency Response (JAR) and is a coordinated multi-agency response which is triggered if a child's death:

- is or could be due to external causes.
- is sudden and there is no immediately apparent cause (including SUDI/C).
- occurs in custody, or where the child was detained under the Mental Health Act
- where the initial circumstances raise any suspicions that the death may not have been natural.
- in the case of a stillbirth where no healthcare professional was in attendance.

Chart 11: Black Country Unexpected Deaths Requiring a JAR by area – 2021-2022



Overall, there was a higher proportion of unexpected deaths requiring a JAR in Walsall compared to the other areas.

Chart 12: Black Country Unexpected Deaths Requiring a JAR by gender – 2021-2022

Males represented 82% of unexpected child deaths across the Black Country.

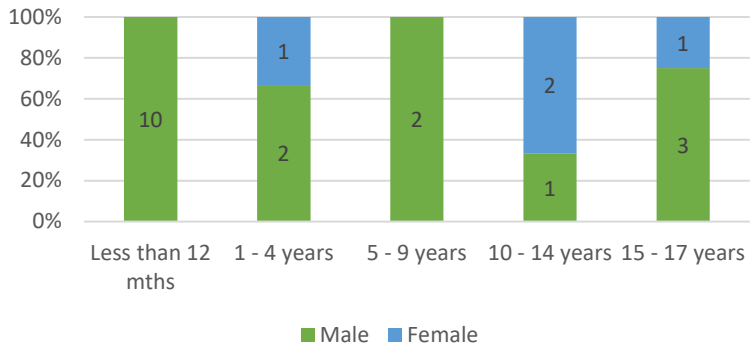
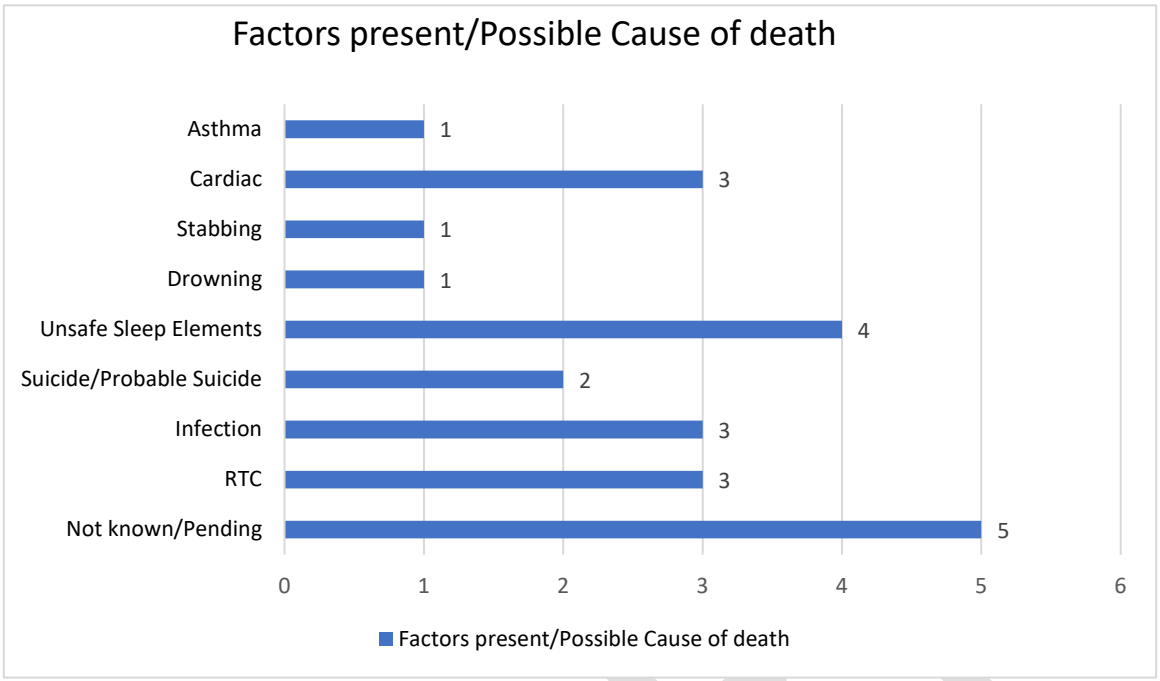


Chart 13: Black Country Unexpected deaths by category – 2021-2022



There has been a delay this year with obtaining results from the coroner due to an increased pressure on the service which is reflected in the 'Not known/Pending' section, which means that these deaths cannot be categorised. Out of the 3 infection deaths, 2 were known to be Covid-19 positive at the time of death. The cardiac cases were all children and young people over the age of 8.

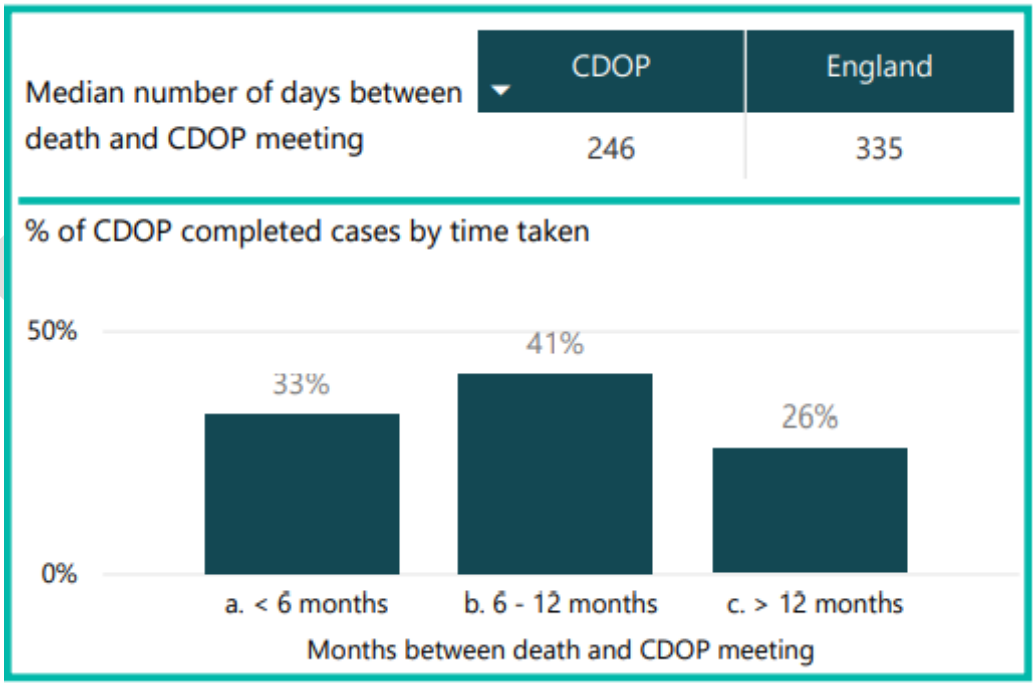
4. Deaths Reviewed 2021 – 2022

73 deaths in total from across the Black Country were reviewed in 2021 – 2022 at 8 CDOP meetings. These panels were made up of multi-agency professionals from across the health economy, Local Authorities, Children's Services, Safeguarding Partnerships and Police, representing their profession as well as their geography.

Child Death guidance states that deaths cannot be reviewed until all investigations are completed, safeguarding reviews published and relevant information gathered. Guidance in 2019 placed a responsibility on healthcare professionals to complete a draft analysis form following a Child Death Review Meeting (CDRM) which forms the basis of the final multi-agency review.

There is an inevitable time-lag (4-12 months) between notification of a child's death and discussion at CDOP and there are various factors that contribute to this: the return of Reporting Forms from professionals, the completion of the final post-mortem report by the pathologist and receipt of the final report from the local child death review meeting. On occasions when the outcome of a Coroner's inquest is awaited, there may be a delay of over a year before a case might be brought before CDOP. The undertaking of a criminal investigation or a Child Safeguarding Practice Review (previously Serious Case Review) will also affect a timely review.

Chart 14: Black Country CDOP completed cases between death and CDOP meeting 2021-2022



The top chart shows that the Black Country continued to review deaths in a shorter period than the England average in 2021 – 2022. The bottom chart highlights the majority of CDOP completed cases take between 6-12 months from notification of death to CDOP meeting.

Chart 15: Black Country reviewed deaths by area and year of death – 2021-2022

Completed CDOP Reviews by LSCB

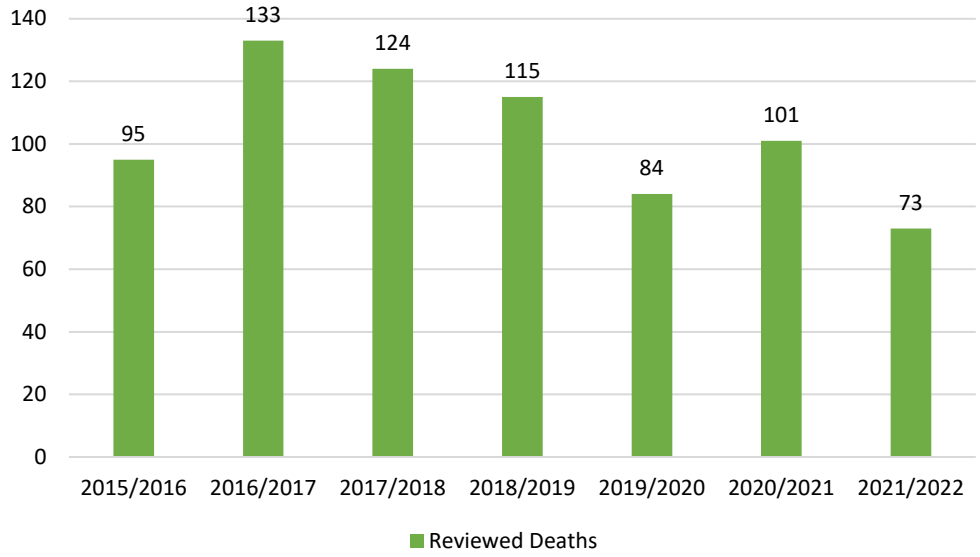
LSCB name	Cases
Dudley	16
Sandwell	33
Walsall	11
Wolverhampton	13
Total	**73**

Completed CDOP Reviews by year of death

Year of death	Cases
2018-19	1
2019-20	6
2020-21	39
2021-22	27
Total	**73**

Most deaths reviewed in 2021 – 2022 were from the previous year 2020 – 2021, where Child Death Review Meetings (CDRM) had been held and an analysis form completed as per the new process. Those deaths reviewed in earlier years were because of police and other investigations concluding.

Chart 16: Black Country Overview of reviewed deaths – 7-year comparison

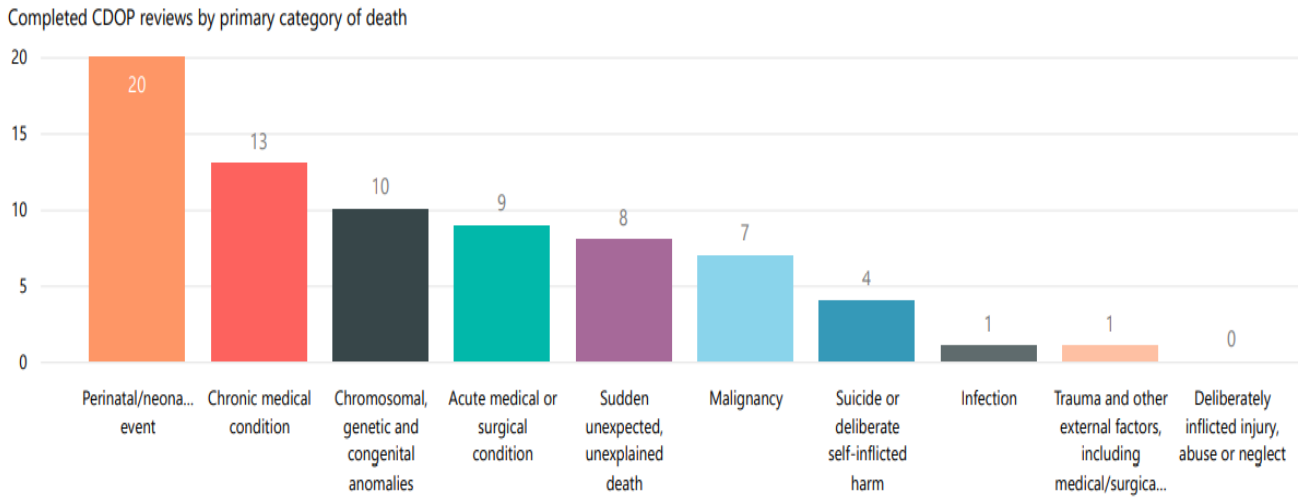


It is anticipated that between 80-100 deaths will be reviewed per year by the Black Country CDOP. In the year 2021 – 2022 only 73 deaths were reviewed which is the lowest in 7 years. This is partly explained by the continued impact of Covid-19 and in particular the unusual low number of child death notifications in the previous year (2020-2021) therefore fewer cases to review.

Nationally, 2,724 child deaths were reviewed by CDOPs in England between 1 April 2021 and 31 March 2022. Of these, 16% were reviews of children who died within the same year and 84% were reviews where the child died before 1 April 2021. This is a decrease from the previous year where 20% of reviews were of children who died within the same year.

The proportion of reviews that identified modifiable factors continues to rise each year with 37% of deaths reviewed during 2021-2022 identifying modifiable factors. Modifiable factors are defined as factors which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

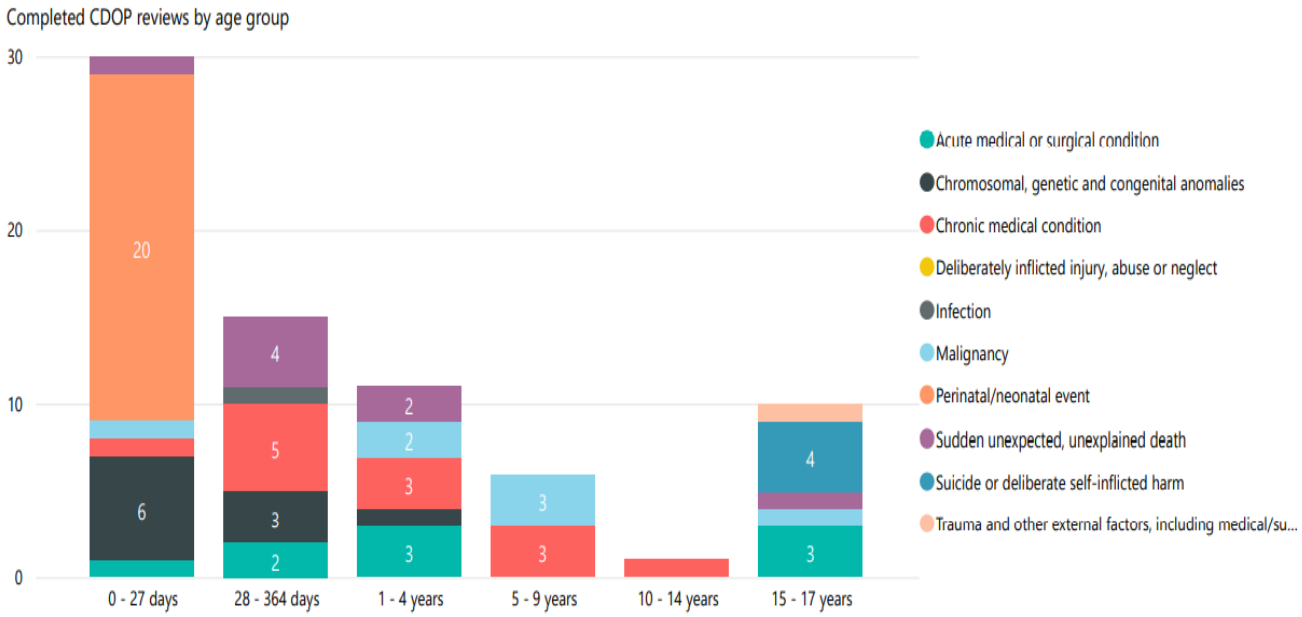
Chart 17: Black Country reviewed cases by primary category of death – 2021-2022



Of the 73 cases closed by the Black Country CDOP, the largest number of deaths were categorised as perinatal/neonatal event (27%) and chronic medical conditions (18%). Year on year, both categorises account for the largest proportion of child deaths and have remained stable overtime.

Most child deaths are due to medical causes which encompass multiple categories of death including acute medical or surgical, chronic medical, chromosomal, perinatal/neonatal event, malignancy, and infection. Small numbers were attributable to non-medical causes including trauma, deliberate harm/abuse/neglect, suicide/self-harm, and sudden unexpected/unexplained death.

Chart 18: Black Country reviewed cases by primary category of death and age group – 2021-2022



Most deaths reviewed in this period were deaths that happened for children under the age of one year and this is reflected in the greatest category of death, Perinatal/neonatal event. CDOP also reviewed 10 deaths of children aged 15 – 17 years which included four suicides.

Chart 19: Black Country reviewed cases by Ethnic group and Age group – 2021-2022

Completed CDOP reviews by ethnic group and age group

Ethnic Group	0 - 27 days	28 - 364 days	1 - 4 years	5 - 9 years	10 - 14 years	15 - 17 years	Total
White	12	8	5	3	0	5	33
Unknown	1	0	0	0	0	0	1
Other	0	0	1	0	0	0	1
Mixed	3	3	2	0	0	2	10
Black or Black British	4	3	1	0	0	3	11
Asian or Asian British	10	1	2	3	1	0	17
Total	**30**	**15**	**11**	**6**	**1**	**10**	**73**

40% of reviewed neonatal deaths were reported as White British and 33% were reported as Asian or Asian British. This is in line with the Black Country demographics.

Nationally for child death reviews during 2021-2022, 34% of reviews recorded a primary category of Perinatal/Neonatal event and 23% recorded a primary category of Chromosomal, genetic, and congenital anomalies. Deaths categorised as Malignancy (8%) and Sudden Unexpected of Unexplained death (7%) were the next most frequent categories.

Chart 20: Black Country Reviewed Cases where modifiable factors were identified by category of death – 2021-2022

% of cases where modifiable factors were identified by category of death

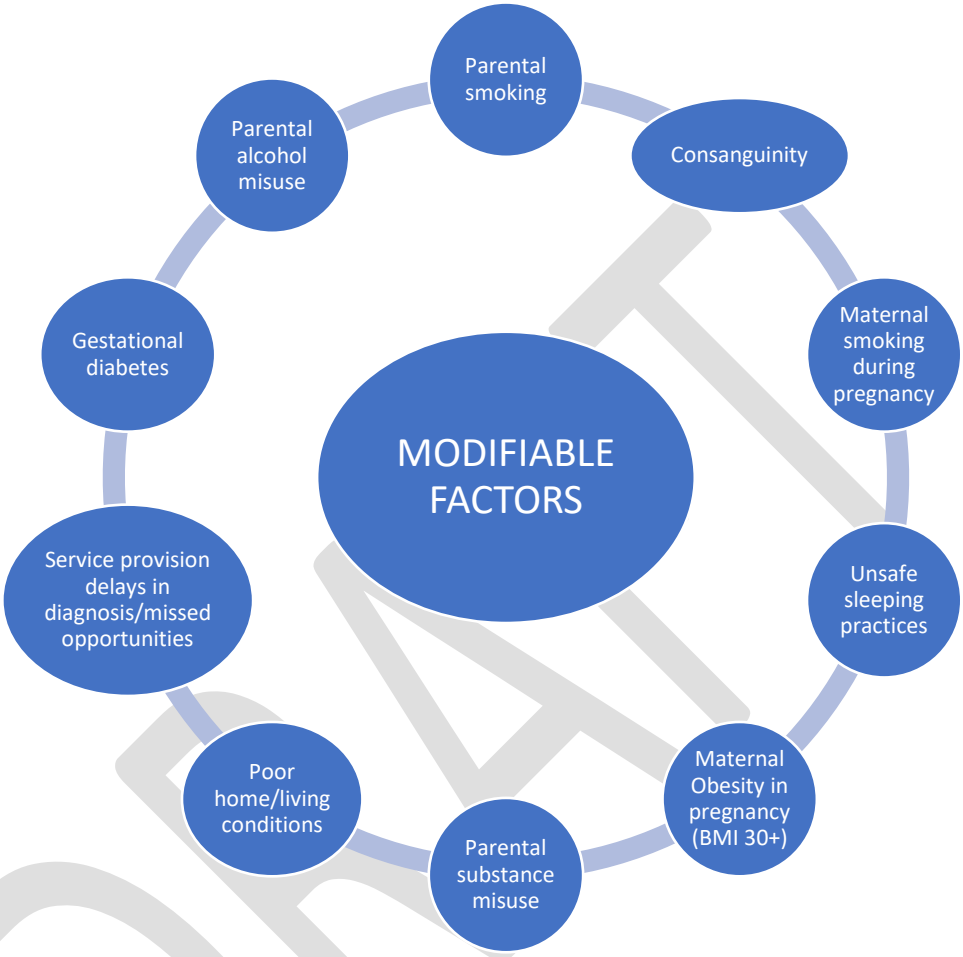
Primary category of death (CDOP)	Completed Reviews	Cases where modifiable factors identified	Modifiable Factors Identified (%)
Trauma and other external factors, including medical/surgical complications/error	1	1	100%
Suicide or deliberate self-inflicted harm	4	0	0%
Sudden unexpected, unexplained death	8	5	63%
Perinatal/neonatal event	20	16	80%
Malignancy	7	0	0%
Infection	1	0	0%
Deliberately inflicted injury, abuse or neglect	0	0	0%
Chronic medical condition	13	3	23%
Chromosomal, genetic and congenital anomalies	10	5	50%
Acute medical or surgical condition	9	3	33%
Total	**73**	**33**	**45%**

33 (45%) of the 73 deaths reviewed in 2021 – 2022 were identified as having modifiable factors. This is considerably higher than the National figure at 37%.

These are factors where local or nationally achievable intervention could be modified to potentially reduce the risk of future child deaths. Of the 33 reviewed deaths with modifiable factors, 26 (79%) died before the age of one and 20 (61%) were during the neonatal period.

Some deaths feature multiple modifiable factors which vary depending on the circumstances leading to death and the cause of death ascertained. Modifiable factors act as multiplier effect, increasing the child's vulnerability where multiple factors are present.

Chart 21: Modifiable Factors



Smoking continues to the most common modifiable factor identified by the Black Country CDOP with maternal smoking in pregnancy and household smoking a factor in deaths categorised as a perinatal/neonatal event and sudden unexpected, unexplained death. Maternal obesity, where mother has a raised body mass index (BMI) of 30+ during pregnancy is also a modifiable factor in perinatal/neonatal deaths, as is maternal alcohol and/or substance use during pregnancy. Multiple modifiable factors were also identified (antenatally and postnatally) in sudden unexpected, unexplained deaths the most common being unsafe sleeping arrangements including parental alcohol and/or substance use.

Though the numbers involved are relatively small, it emphasises that factors relating to smoking remain key modifiable factors for infant and child deaths. Despite ongoing efforts to reduce the rate of smoking, this continues to influence in the death of children and remains a steady modifiable factor. Further, the link between smoking and obesity strongly correlates with deprivation, meaning they represent a significant health inequality.

5. Infant Mortality

Infant mortality is the death of infants under the age of one year. This is measured nationally and internationally by the 'infant mortality rate', which is the number of deaths of children under one year of age per 1000 live births. Premature birth is the biggest contributor to infant mortality.

When an infant dies before the age of 28 days this is called a 'neonatal' death and when death occurs in the first 7 days of life this is usually referred to as 'early neonatal' death.

Data has once again been supplied around maternal smoking, mother's BMI, booking details, gestational age, and weight to support with the several workstreams carried out by healthcare providers and local public health teams to reduce infant mortality rates where possible.

CDOPs and CDR professionals follow the statutory child death review guidance which states that all live births of any gestational age need to be reviewed and notified. Many of the neonatal deaths are analysed using the Perinatal Mortality Review Tool (PMRT) which requires input from the antenatal and postnatal teams.

Themes that emerged from the PMRTs in the Black Country included:

- Antenatal
    - smoking in pregnancy
    - obesity
    - concealing pregnancy
    - working with high-risk fathers.

- Delivery
    - Monitoring
    - awareness of risk factors requiring senior review
    - adequate staffing in high-risk deliveries.

It remains challenging for staff to communicate with parents to ensure parents understand how unwell their child is and the chances of survival when they may not want to hear the message.

Infant Mortality in the Black Country

68 out of the 96 (70.8%) deaths notified during 2021-2022 were children under the age of one year old. Of these 68 notified deaths, 52 occurred before 28 days and 16 occurred between 28 days and 364 days.

Chart 22: Black Country Notified Neonatal deaths by area – 2021-2022 (before the age of 28 days)

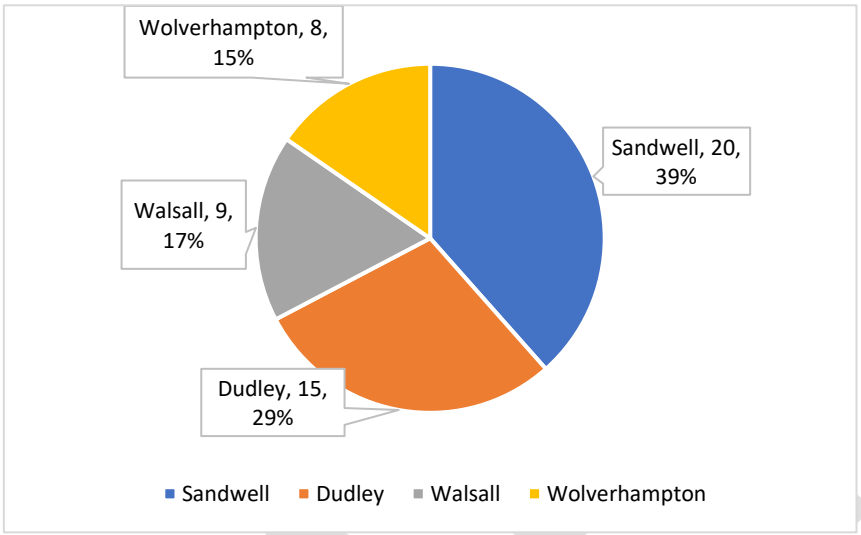
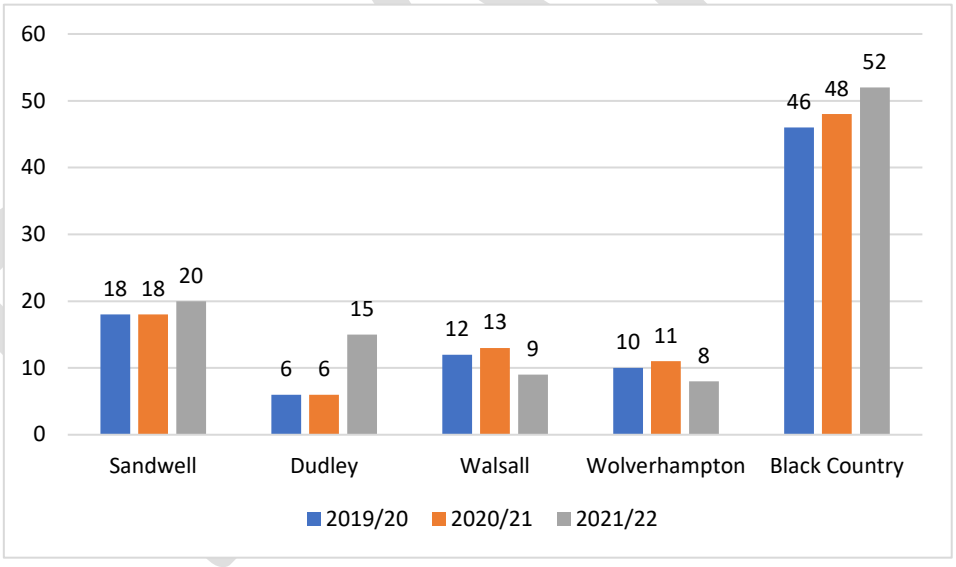


Chart 23: Black Country Notified Neonatal deaths by area – 2019-2022 - 3-year comparison



Across the Black Country there is a worrying upward trend for neonatal deaths and further analysis is needed to stop and reverse this trend.

Black Country Neonatal Deaths

Of the 52 neonatal deaths, 37 (72%) had a birth weight of less than 2500 grams, 33 of which were preterm deliveries (<37 weeks). Whilst prematurity impacts the infant's birth weight, low birth weight is also influenced by maternal lifestyle such as smoking.

When reviewing infant deaths, the Black Country CDOP identifies modifiable factors and relevant factors during pregnancy that increase the risk to both mother and baby. These factors may also contribute to an early onset of labour, leading to poorer outcomes. All the associated factors act as a multiplier effect increasing the risk of prematurity, or that the infant may not be born in the best possible condition.

Black Country Reviewed Perinatal/Neonatal events

Over half of neonatal deaths reviewed were caused by immaturity-related conditions such as respiratory and cardiovascular disorders. Other neonatal deaths result from causes during or shortly after labour (intrapartum), or in the postnatal period.

Background: Low Birth Weight

Low birth weight is defined by the WHO as weight at birth less than 2500 g (5.5 lb). Low birth weight continues to be a significant health problem and is associated with a range of both short- and long-term consequences. Low birth weight is complex and includes preterm neonates, small for gestational age neonates at term and the overlap between these two situations. Typically, both preterm and small for gestational age neonates, have the worst outcomes.

The Royal College of Obstetricians and Gynaecologists defines small for gestational age to an infant born with a birth weight less than the 10th centile. Historically small for gestational age at birth has been defined using population centiles.

The use of centiles is customised for maternal characteristics (maternal height, weight, parity, and ethnic group) as well as gestational age at delivery and infant sex, identifies small babies at higher risk of morbidity and mortality than those identified by population centiles.

Background: Maternal Obesity in Pregnancy

A modifiable and relevant factor highlighted by the Black Country CDOP is mother's raised body mass index (BMI) during pregnancy. For most adults, an ideal BMI is in the 18.5 to 24.9 range (healthy weight range).

The NHS defines the BMI categories as:

- below 18.5 – underweight
- between 18.5 and 24.9 - healthy weight range
- between 25 and 29.9 - overweight range - between 30 and 39.9 - obese weight range
- 40 and over - severely obese weight range

Being overweight increases the risk of complications for pregnant women and baby. The higher a woman's BMI, the higher the chance of complications. Problems for baby can include being born prematurely and an increased risk of stillbirth (from an overall risk of 1 in 200 in the UK to 1 in 100 if mother has a BMI of 30 or more).

The increasing chances are in relation to:

- miscarriage - the overall chance of miscarriage under 12 weeks is 1 in 5 (20%); for women with a BMI over 30, the chance is 1 in 4 (25%)

- gestational diabetes - women with a BMI of 30 or above, are 3 times more likely to develop gestational diabetes than women who have a BMI below 25
- high blood pressure and pre-eclampsia - women with a BMI of 30 or above at the beginning of their pregnancy, have a chance of pre-eclampsia which is 2 to 4 times higher than that of women who have a BMI below 25
- blood clots - all pregnant women have a higher chance of blood clots compared to women who are not pregnant, for women with a BMI of 25 or above, the chance is increased further
- the baby's shoulder becoming "stuck" during labour (sometimes called shoulder dystocia)
- heavier bleeding than normal after the birth (post-partum haemorrhage)
- having a baby weighing more than 4kg (8lb 14oz) - the overall chance of this for women with a BMI of 20 to 30 is 7 in 100 (7%); for women with a BMI of above 30, the chance is doubled to 14 in 100 (14%)
- women are also more likely to need an instrumental delivery (forceps or ventouse), or an emergency caesarean section

Deaths categorised as a perinatal/neonatal event, where mothers BMI in pregnancy is recorded as underweight (BMI <18.5) or obese (BMI 30+), are deemed a modifiable factor by the Black Country CDOP.

Maternal obesity in pregnancy continues to be a relevant factor and features as a modifiable factor in deaths categorised as a perinatal/neonatal event. Infants born to women who begin pregnancy obese have a higher risk of premature death than children born to mothers at a healthy weight.

Black Country Local Maternity and Neonatal System

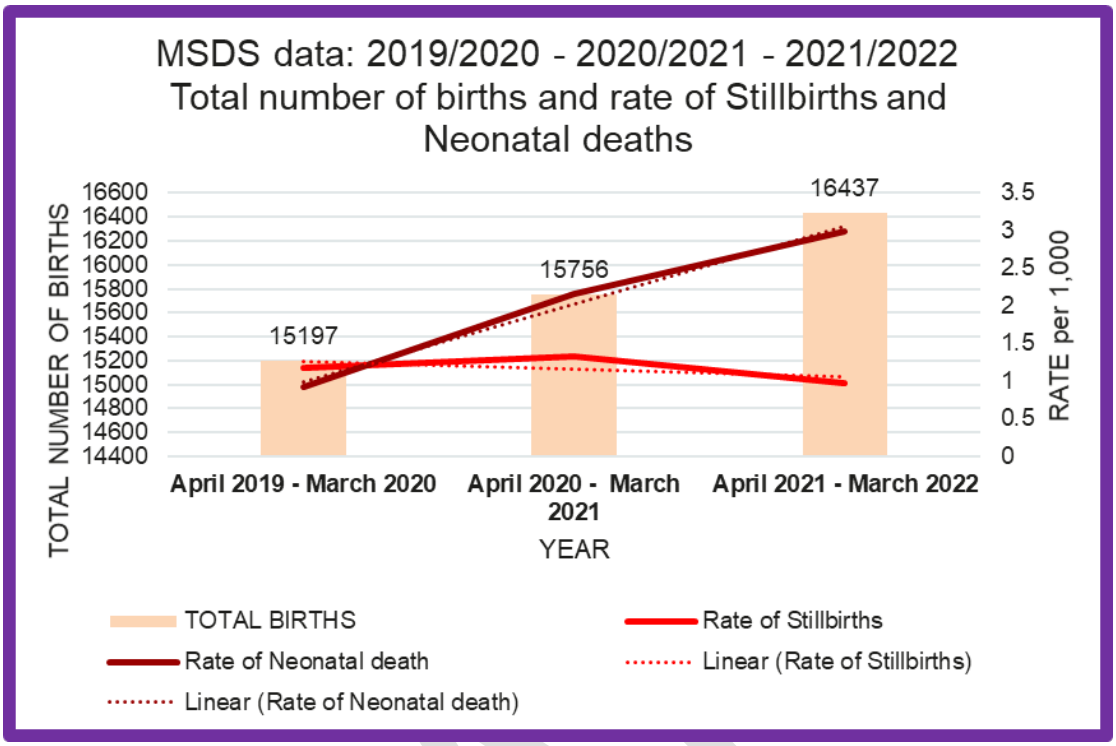
In 2021 – 2022 the Black Country continued to develop links formed with the Black Country and West Birmingham Local Maternity and Neonatal System (BCWB LMNS) to support with their local vision:

Through collaboration, we are committed to deliver high quality maternity services across the Black Country and West Birmingham shaped by the voices of local people. Our aim is to provide safe, personalised, and responsive maternity services and ensure every woman and baby receives the best possible care.

At the Black Country Oversight Quality Group in July 2022, Dawn Lewis, Chair of the Quality and Safety Work Stream within the Local Maternity and Neonatal System reported that overall, in year 2021-2022 stillbirth rate has reduced, however there has been a corresponding increase in early neonatal deaths. This has been shared and discussed further and noted by Public Health members that this is a commonly seen occurrence. The focus of the Work Streams will be to address inequalities and utilising the equity and equality strategy to achieve this.

COMPARISON from 2019/20 – 2021/22 – MSDS data

Chart 24: Total Number of births and rate of Stillbirths and Neonatal Deaths – 2019-2022 from MSDS data



The BCWB LMNS oversee a number of priorities/deliverables to support infant mortality and partners across the Black Country support the Best Start Work Stream.

LMNS 2022/23 Transformation - Priorities/Deliverables for Best Start Work Stream

- To ensure that every Provider has a Pre-term Birth Clinic
- To ensure that at least 85% of women who are expected to give birth at less than 27 weeks gestation can do so in a maternity unit with appropriate on-site NICU
- To halve the rates of stillbirths, Neonatal deaths, Maternal deaths, and serious intrapartum brain injuries by 2025
- To reduce the national rate of pre-term births from 8% to 6%
- LMNS' should continue to work with Neonatal Operational Delivery Networks to implement local Neonatal improvement plans with a particular focus on
- Maternity and Neonatal services working together to ensure that at least 85% of births at less than 27 weeks take place at a Maternity unit with an onsite NICU and together undertake a review of all births not in the right place. Data from these reviews should be collated at the regional level to support thematic analysis and inform targeted actions.
- Identifying routes to escalate requirements for capital investment in Neonatal services through the relevant ICS routes

Most parents want the best for their children. However, there are some situations where families face such complex and challenging situations that they are unable to keep a child safe, and children are moved into the care of local authorities. Particularly if a child is removed at birth, support services

to birth parents often cease. This is shown to exacerbate the already chaotic lives of parents, with increases in substance abuse, mental illness, and domestic violence. Evidence shows that many women who have had a child removed go on to have subsequent pregnancies, with the increased risks for both mother and child, including prematurity and low birth weight, in addition to neonatal abstinence syndrome. The 2022 MBRRACE report identified the high rate of suicide and death from substance misuse amongst women who had either had their child removed at birth, or who had been informed this would happen. In several cases, the woman's death also resulted in the death of her baby.

There are several programmes demonstrated to break this cycle, working intensively with women who have had a child removed at birth to improve their wellbeing and life satisfaction. These programmes aim to delay further pregnancies until the woman's life is in a better place to care for a child, although the evidence is many participants choose to avoid further pregnancy. Although this is a small cohort of families across the Black Country, this intervention is highly cost effective in preventing both health and social care costs and preventing trauma to families.

6. Additional Learning identified at CDOP:

- Dads and partners are often missed when giving bereavement support and when receiving crucial information from the health visitor and midwife.
- Co – sleeping advice needs to be consistent, repeated at every contact and include dads/partners
- Access for 24 hour palliative care within the community is crucial to enable a quality of life and death
- Parents expectations need to be carefully managed when babies are born with a poor prognosis or are given a diagnosis antenatally to support with the bereavement process
- Families should be assessed as a whole, looking at a cultural genogram to ensure the lived experience impact of the young person is assessed
- CAMHS assessment should be appropriate to age and concerns given as to whether there needs to be face to face
- It is important that agencies do not label young people as 'hard to reach' but try different ways to engage with a young person and their family, even if it means passing them on to another agency.
- Where there are numerous agencies involved with a child and family, there should be a key worker coordinating support
- There needs to be a greater awareness of the 'Dark Web'
- There needs to be effective communication with parents during treatment with a consistent management of expectations
- Palliation is not 'failure'
- Mums should be aware of the benefits of early booking and a healthy BMI
- Reviews need to be held together where there is more than one hospital involved to maximise learning.

7. Good Practice Identified at CDOP

A recurring theme throughout 2021 – 2022 has been the strong partnership working identified in reviews. This included:

- Excellent transfer planning where the specialist consultant went to local unit to meet baby/family.
- Evidence of some professionals going over and above their responsibilities, e.g., Community nurses using their own personal time to support families during palliative care
- Agencies approaching a chaotic, disturbing scene with professionalism and sensitivity
- Advice being available from a level 3 maternity unit where transfer is not possible

Other good practice identified included:

- Parents were given the opportunity and encouraged to undertake memory making activities with their baby prior to death as part of the palliative care arrangements. They helped plan the last few days of his life
- Organ donation conversations held in a sensitive manner
- Children and young people have been included in their own ACP's giving a respectful quality of life

8. Black Country Child Death Review Progression In 2021 – 2022

- Child Death Review partners have supported the priorities and deliverables from the LMNS and have engaged further in sub-groups to ensure a more joined up way of working.
- In response to the data regarding deaths involving unsafe sleeping practices across the Black Country, 'Know More' posters were developed by Dudley Public Health and shared across the Black Country for display in public arenas to begin conversations around safer sleeping.

- Members from CDOP have supported a Black Country wide Suicide Prevention group contributing to training and data collection.

- The Black Country CDOP contributed to a regional themed review on suicides that had already been reviewed at CDOP. Findings were shared widely across different agencies for learning to be implemented.
- The Black Country SUDC Protocol was ratified and shared with relevant trusts and agencies across the Black Country and region.

BLACK COUNTRY MULTI-AGENCY SUDI/C PROTOCOL 2021

Guidance for the multi-agency management of Sudden Unexpected Death in Infancy/Childhood in the Black Country based on:
Working Together, 2018
Child Death Review Statutory and Operational Guidance, 2018
Sudden Unexpected Death in Infancy and Childhood: Multi-Agency Guidelines for Care and Investigation, 2016

- Positive Recognition - To recognise and encourage good practice, or where agencies have gone above and beyond their expected duties, CDOP continue to send letters of good practice where good practice has been identified. Whilst it is the panel's responsibility to identify learning and trends from child deaths across the Black Country, the panel feel it is important to recognise the excellent care that professionals provide for the children and families that they work with.
- Progression has been made to transfer the hosting responsibilities for CDOP across to the Black Country and West Birmingham CCG
- All areas in the Black Country now have an administrator and lead health professional at place level.

9. Future Priorities - Next Steps and Objectives

- CDOP MOU to be updated considering any changes since 2019
- Self-Evaluation Framework (SEF) to be completed by each hospital to identify areas for improvement
- Audits take place to ensure processes reported on in the SEF are being followed
- Implement and embed an eCDOP user group across the Black Country
- The Key Worker role to be strengthened across the Black Country including:
    - A Key Worker to be allocated to families following a child death
    - The Key Worker ensures the voice of the parent is captured in the CDOP review
    - Links made with PALS in each Trust to ensure parents have a way of reporting into the review process if not through a key worker
- Professionals engaged in any aspect of the CDR process have a robust supervision process in place
- Develop and contribute to strategies to reduce Infant Mortality and suicide prevention
- Continue to escalate issues where agencies are not providing timely information
- Submission and ratification of the Black Country annual report
- To develop further good links with existing maternity and neonatal networks to improve outcomes
- Liaise with Medical Examiners to explore the role and relationship with child death further
- Audit the effectiveness of dissemination of learning and impact on service provision

10. Recommendations for Local Strategic Partners

Children's Safeguarding and Health and Wellbeing partners are asked to:

1. Note the contents of this report and in particular:
   a. The summary of achievements, key points and themes, and priorities for 2022-23

2. Ensure interagency initiatives are being monitored to reduce the prevalence of modifiable factors identified in the under one population including:
   - Safe sleeping
   - Risk factors for reducing premature births including:
     - High BMI (including healthy diet and physical activity)
     - High blood pressure (linked to high BMI)
     - Smoking
     - Alcohol use
     - Substance misuse
     - Domestic violence
     - Mental health
     - Diabetes (often linked to BMI)
     - Lack of physical activity

3. Support programmes which reduce the likelihood of babies being removed from mothers who live within complex and challenging situations where safeguarding challenges exist.

11. References

- National Data taken from NCMD Report: Child-death-review-data-release-2022.pdf (ncmd.info)

- http://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/pregnancyandethnicfactorsinfluencingbirthsandinfantmortality/2015-10-14#ethnicity

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Sandwell Health & Wellbeing Board

18 October 2023

Subject:	Healthwatch Sandwell introduction and work programme
Presenting Officer and Organisation	Phil Griffin Healthwatch Sandwell HAB Chair Alexia Farmer Healthwatch Sandwell Manager Sophie Shuttlewood Healthwatch Sandwell Projects and Partnership Lead. healthwatch Sandwell Engaging Communities Solutions
Purpose of Report	Information

1 Recommendations

1.1 To consider and note the Healthwatch Sandwell Introduction.

2 Links to the following Board Priorities

Priority 1	**We will help keep people healthier for longer** HWS report to and raise issues regarding health and social care, identify areas of concern and hold key stakeholders to accountant
Priority 2	**We will help keep people safe and support Communities** HWS aims to tackle health and economic inequalities, reduce isolation, and promote community cohesion by reporting and raising concerns and issues with relevant key stakeholders
Priority 3	**We will work together to join up services** HWS works in partnership with our community, voluntary sector organisations and the wider health system to build resilience deliver a positive impact on health outcomes.
Priority 4	**We will work closely with local people, partners and providers of services**

	HWS are link for patients and non-patients to key stakeholders and decision makers in Sandwell

4 Context and Key Issues

The aim of local Healthwatch is to give citizens and communities a stronger voice to influence and challenge how health and social care services are provided within their locality. Local Healthwatch organisations are a statutory service commissioned by local councils as part of the Health and Social Care Act 2012.

Healthwatch are set apart from statutory structures, voluntary and community sector they work with, as they perform public functions, deliver statutory duties, and receive public funding.

Healthwatch have a legal power to visit health and care services and see them in action. The power to Enter and View offers a way for Healthwatch to meet some of their statutory functions and allows them to identify what is working well with services and how they can improve

5 Engagement

Healthwatch work with local people and stakeholders across Sandwell in Sandwell Council, BCMHFT, ICP, ICS and voluntary organisations
We use feedback from people to better understand the challenges facing NHS and other care providers to ensure experiences improve Health and care services for everyone

6 Implications

Resources:	Healthwatch is funded through a contract with LA and an in-year contract value of £180k
Legal and Governance:	Governance is via the local Healthwatch Advisory Board who assures the work plans agreed every year through established performance reporting processes
Risk:	Risk implications, including any mitigating measures planned/taken, health and safety, insurance implications
Equality:	EDI is a strong value which underpins everything that Healthwatch Sandwell does
Health and Wellbeing:	Our work programmes and the support we give to local people helps to address access issues and to improve outcomes for local communities
Social Value:	Healthwatch employs local people and has a number of volunteers engaged in its work

Climate Change:	We give a commitment to minimise carbon footprint by encouraging work from home and using virtual meetings wherever possible
Corporate Parenting:	Healthwatch Sandwell is supported by its parent organisation Engaging Community Solutions

6 Appendices

1. Healthwatch Sandwell power point presentation
2. Healthwatch Sandwell work programme 2023/24

7. Background Papers

No background papers

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healthwatch

An Introduction to Healthwatch Sandwell, presented by Phil Griffin and Alexia Farmer

About Healthwatch

Healthwatch are the health and social care champion. We want to hear about local peoples experience of health and social care.

https://www.youtube.com/watch?v=VgjnfZFlfe0

Healthwatch Sandwell

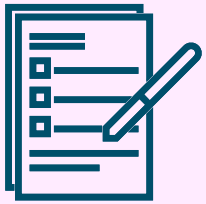
Advisory Board who oversees the work programme

Staff team

- Manager
- Projects and Partnership Lead
- Volunteer and Engagement Lead (in addition Leads on E&V Programme)
- Community Outreach Lead
- Information and Signposting Officer
- Projects Officer – Guided by You – Commissioned by the Health and Care Partnership

Work Programme 2023/24

Healthwatch has statutory functions, which require us to engage and involve local people in our work. Personal accounts inform our insight, which in turn helps in identifying themes and priority areas going forward.



- Intelligence collected
- Public consultation
- Listening events
- Stakeholder feedback

The work programme aims to set out our current thinking:

- How we will work to achieve the anticipated outcomes
- How we evidence impact
- Have we made a difference

Priority Theme 2023/24

Diabetes – exploring Sandwell health, care and support services through patient experiences and voices.

- The impact of the delay/lack of health and social care services are having on citizens with this long-term condition
- Inequality - Accessible Information Standards and language and cultural barriers.

The aim

- To produce a number of short informative reports, providing insight using lived experiences.
- Ensure recommendations are realistic
- Raise the profile of the work of Healthwatch and be the go-to organisation to contribute towards change.

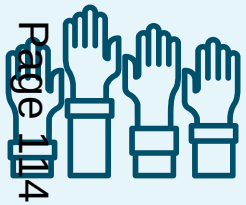
Priority Theme 2023/24

Community Engagement

We talk to local people of different ages and demographics, in different locations across our area, including outside of our normal office hours. We will proactively engage with, and respond to, the different populations that live in Sandwell to understand and help meet their health and social care needs.

- A programme of presentations
- Community Pop ups
- Explore the impact of language and cultural barriers - are people getting the support they need

Community Engagement



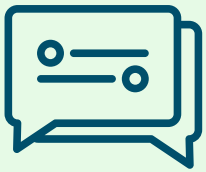
We work with organisations and groups to understand how communities are supporting local people to stay healthy, identifying the challenges and supporting people to get the best out of services

- Work in partnership with seldom heard from communities
- Collaborate with key community facility providers
- GP show case with the aim of capturing what surgeries are doing to improve the patient experience
- Use local community and voluntary contacts, newsletters, and other communications channels to raise awareness of Healthwatch information, advice and advocacy
- Attendance at PPG meetings PPG

Community Engagement

We evidence this through analysing our information

- Performance Reports
- Intelligence Reports
- Enter and View reports



We will confirm our outcomes by:

- Mapping our engagement with communities/groups
- Sharing reports in draft for comment, and further contribution
- Gain feedback from those who, buy and provide services

Enter and View

Healthwatch Sandwell have the power to visit health and social care services, where health and social care is publicly funded and delivered.

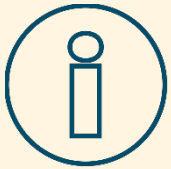
The purpose of an Enter and View visit is to observe services in action and to collect evidence of what works well. We will use this evidence to make recommendations and inform changes both for individual services as well as system wide and to improve people's experiences.

The rationale for a visit will always be evidence-based by using:

- Feedback and experience from members of the public and community
- Regulators feedback or reports
- Information from commissioners, providers and/or regulators
- Follow up points raised during a prior CQC inspection to establish whether planned corrective actions are being taken

Enter and View

The rationale for a visit will always be evidence-based by using:



- Feedback and experience from members of the public and community
- Regulators feedback or reports
- Information from commissioners, providers and/or regulators
- Follow up points raised during a prior CQC inspection to establish whether planned corrective actions are being taken
- Assessment of the impact of change
- Sharing of “best practice” in a specific area and providing support

Enter and View 2023/24

Taking into consideration the rationale and criteria for visits the Enter and View programme for 2023/24 will support the theme of the priority project

Diabetes – exploring Sandwell health, care and support services through patient experiences and voices.

The Enter and View programme will include visiting specific places of support that are associated with diabetes:

- Diabetes clinics
- Phlebotomy/retinal screening services (at hospital eye clinics and opticians)
- Foot clinics and urology

Enter and View Programme 2023/24

Other venues to be visited

Harvest View, Harvest Road, Rowley Regis with the aim of finding out what the experience of the patients/service users.

Enter and View reports

All Enter and View reports will be shared with:

- providers
- regulators,
- local authority
- NHS commissioners and quality assurers
- the public,
- Healthwatch England
- other relevant partners

Reports will be published on all our social media platforms.

Guided by You Programme

Healthwatch Sandwell were commissioned by Sandwell Health and Care Partnership to undertake citizen and public engagement through a series of public workshops across the 6 towns of Sandwell.

The attendance at each event has been between 40 and 60 people and we have engaged with over 300 people capturing an array of valuable insight on ideas for change, issues and priorities for the health and wellbeing of local people.

Around 60% of the intelligence that we have received has been none clinical and around the wider determinants of health.

The full report will be available soon.

Strategic Influencing

We will bring about long-term differences to the health and care system in Sandwell by being a strategic influencer and co-collaborator.

We will Provide Authorised Representation at agreed meetings, which we will regularly review, along with how we best use the resources available to us

- Comment on Strategies
- Share good practice and feedback the insight we gather in meaningful ways.
- Challenge appropriately and constructively and seeking opportunities for exploring what could be done differently
- Contribute and feed intelligence into local strategic priorities, areas of focus or service transformation

Collaboration

We recognise that we will benefit people by working collaboratively and in partnership with others. We aim, to do this by:

- Having an active role in the Healthwatch network, learning from and sharing good practice and impact with partners
- Working with other local Healthwatch to manage our collective resources to engage effectively with wider partnerships
- Commissioned work as appropriate

Healthwatch are your independent organisation who champion the views of patients and social care users in Sandwell. Tell us your views, needs and experiences to help Sandwell get the best possible Health and Care.

healthwatch Sandwell

Contact us on 0121 569 7211 or info@healthwatchsandwell.co.uk

Have you accessed any Health and/or Social Care services and want to share your experience?

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2

Healthwatch Sandwell Work Programme 2023/24

Healthwatch has statutory functions, which require us to engage and involve local people in our work and you will see how we aim to do this throughout this plan. Personal accounts inform our insight, which in turn helps in identifying themes and priority areas going forward.

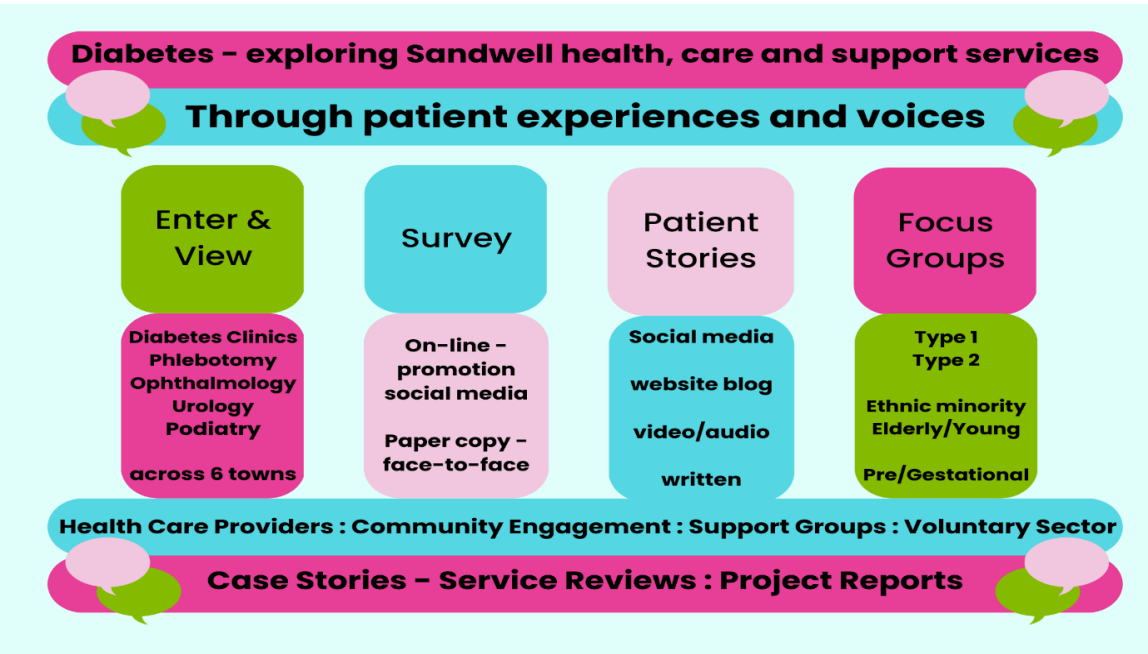
This plan sets out our current thinking as to how we will work to achieve the anticipated outcomes and how we will evidence if this has had an impact – have we made a difference?

To understand the difference, we will take the following actions

- Aim to stick to our work and follow it through to see what difference it has made
- Review unexpected outcomes and impact - what happens and the changes that have taken place that we might not have been planning for, but are of value
- Accept when we have not been able to achieve an outcome or impact but that we have understood why and been transparent about this.

Priority Theme 2023/24

HWS Project doc for WP 2023-24.docx



Community Engagement

Commuity Engegement Lead W

We will ensure we can talk to local people of different ages and demographics, in different locations across our area, including outside of our normal office hours. We will proactively engage with, and respond to, the different populations that live in Sandwell to understand and help meet their health and social care needs.

- Develop a programme of presentations which we will deliver to local community groups to increase awareness of available health and care services and to promote our information and signposting services
- Community Pop ups – looking at alternative ways of interacting with people to gain general insight
- Explore the impact of language and cultural barriers – are people getting the support they need?

We will work with organisations and groups to understand how communities are supporting local people to stay healthy, identifying the challenges and supporting people to get the best out of services

- Work in partnership with seldom heard from communities to understand the health and care beliefs as well as challenges by people within them
- Collaborate with key community facility providers, to host joint events for encouraging self-care and raising awareness of what can support people's health and wellbeing.
- GP show case with the aim of capturing what surgeries are doing to improve the patient experience
- Use local community and voluntary contacts, newsletters, and other communications channels to raise awareness of Healthwatch information, advice and advocacy
- Attendance at PPG meetings PPG meetings – giving opportunity to promote Healthwatch Sandwell and build relationships with surgeries.

We will evidence this through analysing our information. We will publish Performance Reports, Intelligence Reports and Enter and View reports. Outcomes will also be indicated in any publications.
We will conform our outcomes by:

- Mapping our engagement with communities/groups to make sure we can have achieved a good cross section of the ages and demographics across Sandwell
- Sharing reports in draft for comment, and further contribution, directly with groups, to check understanding
- Gain feedback from those who, buy and provide services if the information we provide gives
- a better understanding of experiences/needs of our communities.

Enter and View


Engagement and Volunteer Lead wor

Our unique and added value is our independence and ability to speak to residents and their families, to give voice to any concerns they may have, as well as raising awareness of potential risks to residents.

Taking into consideration the rationale and criteria for visits the Enter and View programme for 2023/24 will support the theme of the priority project : **Diabetes – exploring Sandwell health, care and support services through patient experiences and voices.**

Volunteers

Volunteers play an essential role in the delivery of Healthwatch Sandwell. They add value and support us to achieve our mission and strategic objectives. By having an effective volunteer programme Healthwatch Sandwell can provide opportunities for social inclusion, skills and confidence development and possible routes into employment.

We are keen to develop a diverse volunteer base and especially welcome interest from people with disabilities including learning disabilities and or autism, Black minority ethnic people (BME) and young people.

Strategic Influencing

We will bring about long-term differences to the health and care system in Sandwell by being a strategic influencer and co-collaborator, whilst maintaining our independence. Amongst Sandwell's health and care delivery and governance bodies

we will develop a reputation as being an informed and trusted voice of how local people view and experience support and services.

- We will Provide Authorised Representation at agreed meetings, which we will regularly review, along with how we best use the resources available to us
- Comment on Strategies
- Share good practice and feedback the insight we gather in meaningful ways.
- Challenge appropriately and constructively and seeking opportunities for exploring what could be done differently
- Contribute and feed intelligence into local strategic priorities, areas of focus or service transformation

Healthwatch Collaboration

We recognise that we will benefit people by working collaboratively and in partnership with others. We aim, to do this by:

- Having an active role in the Healthwatch network, learning from and sharing good practice and impact with partners
- Working with other local Healthwatch to manage our collective resources to engage effectively with wider partnerships
- Commissioned work as appropriate
- We may set joint priorities and work with other Healthwatch where this will produce better outcomes
- Working and supporting Healthwatch England campaigns
- Work with Healthwatch England in completing and regularly reviewing the Quality Assessment Framework that will demonstrate the effectiveness of Healthwatch Sandwell

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Sandwell Health & Wellbeing Board

18 October 2023

Subject:	Diabetes in Sandwell
Presenting Officer and Organisation	Phil Griffin Healthwatch Sandwell HAB Chair Alexia Farmer Healthwatch Sandwell Manager Sophie Shuttlewood Healthwatch Sandwell Projects and Partnership Lead. healthwatch Sandwell Engaging Communities Solutions
Purpose of Report	Information

1 Recommendations

1.1 To receive the presentation for information

1.2 To note that Diabetes is a key workstream for Healthwatch Sandwell for the 2023/ 24 period.

2 Links to the following Board Priorities

Priority 1	**We will help keep people healthier for longer** HWS report to and raise issues regarding health and social care, identify areas of concern and hold key stakeholders to accountant
Priority 2	**We will help keep people safe and support Communities** HWS aims to tackle health and economic inequalities, reduce isolation, and promote community cohesion by reporting and raising concerns and issues with relevant key stakeholders
Priority 3	**We will work together to join up services**

	HWS works in partnership with our community, voluntary sector organisations and the wider health system to build resilience deliver a positive impact on health outcomes.
Priority 4	**We will work closely with local people, partners and providers of services** HWS are link for patients and non-patients to key stakeholders and decision makers in Sandwell

4 Context and Key Issues

The aim of local Healthwatch is to give citizens and communities a stronger voice to influence and challenge how health and social care services are provided within their locality. Local Healthwatch organisations are a statutory service commissioned by local councils as part of the Health and Social Care Act 2012.

Healthwatch are set apart from statutory structures, voluntary and community sector they work with, as they perform public functions, deliver statutory duties, and receive public funding.

Healthwatch have a legal power to visit health and care services and see them in action. The power to Enter and View offers a way for Healthwatch to meet some of their statutory functions and allows them to identify what is working well with services and how they can improve

5 Engagement

Healthwatch work with local people and stakeholders across Sandwell in Sandwell Council, BCMHFT, ICP, ICS and voluntary organisations
We use feedback from people to better understand the challenges facing NHS and other care providers to ensure experiences improve Health and care services for everyone

6 Implications

Resources:	Healthwatch is funded through a contract with LA and an in-year contract value of £180k
Legal and Governance:	Governance is via the local Healthwatch Advisory Board who assures the work plans agreed every year through established performance reporting processes
Risk:	Risk implications, including any mitigating measures planned/taken, health and safety, insurance implications
Equality:	EDI is a strong value which underpins everything that Healthwatch Sandwell does

Health and Wellbeing:	Our work programmes and the support we give to local people helps to address access issues and to improve outcomes for local communities
Social Value:	Healthwatch employs local people and has a number of volunteers engaged in its work
Climate Change:	We give a commitment to minimise carbon footprint by encouraging work from home and using virtual meetings wherever possible
Corporate Parenting:	Healthwatch Sandwell is supported by its parent organisation Engaging Community Solutions

6 Appendices

Appendix 1 - Diabetes in Sandwell Presentation.

7. Background Papers

No background papers.

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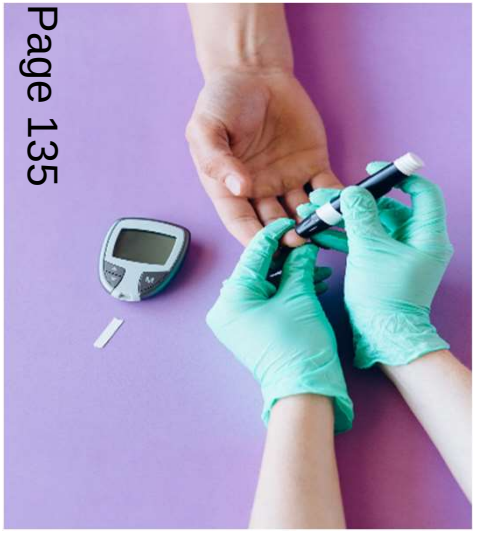


healthwatch Sandwell

Engaging Communities Solutions

Diabetes in Sandwell

Sophie Shuttlewood – Projects and Partnerships Lead

Statistics

NHS G.P. Practice data 2020-21 for Sandwell

National average **7.1%** West Midlands **8%** Sandwell **9.9% and projected to increase**

Sandwell Trends

- perform poorly on inter-related health conditions
- lower healthy life expectancy
- higher mortality rates from preventable deaths

Diabetes UK

Risk groups of concern:

- **Elderly people**
- **African/African Caribbean** and **South Asian** (Indian, Bangladeshi, Pakistani) ethnicity

How we involved people

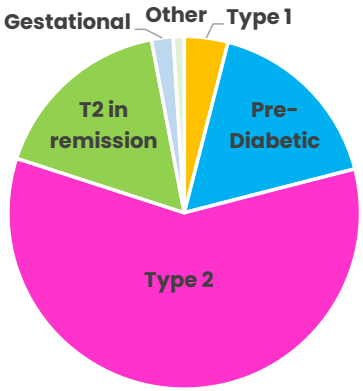
- **Enter and View programme**
- **Questionnaire**
- **Community engagement**
- **Conversations – Focus Groups:**
  - Older People
  - African/African Caribbean
  - South Asian (Indian, Bangladeshi, Pakistani)

Key Findings:
Questionnaire (Snapshot 100)

healthwatch Sandwell

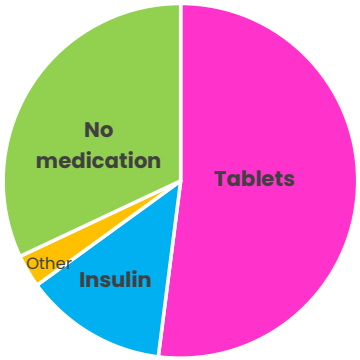
Engaging Communities Solutions

Diabetes Type

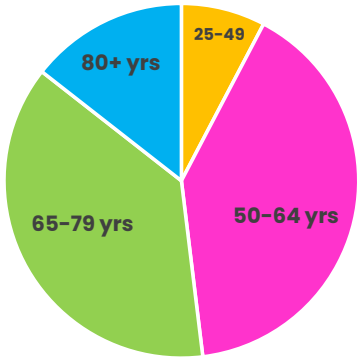


How long had diabetes

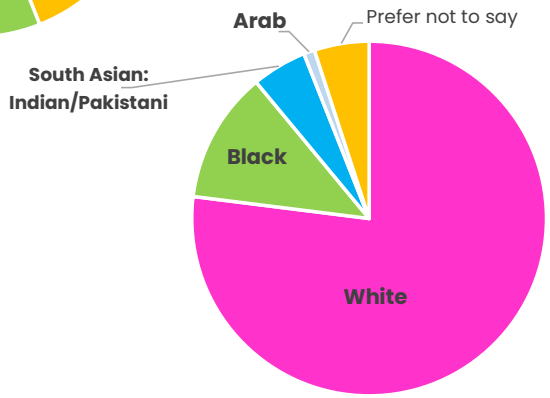
Diabetes medication



Age Group



Ethnic Group



Key Findings:
Questionnaire (Snapshot 100)

healthwatch Sandwell

Engaging Communities Solutions

Pre-diabetic diagnosis: given information/signposted to

Pre-diabetic: know where to go for information

Rating of G.P. Practice diabetes services

Maintaining a healthy weight

Being physically active for at least 150 minutes per week

Key Findings – Conversations

- Overall satisfaction with diabetes medical health care services
- Information and support at diagnosis
- Awareness and understanding of diabetes in Sandwell
- Managing diabetes – diet, weight, activity, mental wellbeing
- Focus Groups - meeting specific needs

"I found it very hard and difficult to accept. I was most upset by the result as my lifestyle would need to change."

What people are saying:
Older and Elderly People

- Diabetic retinopathy eye screening tests – less venue options, travel difficult, not consulted
- Increased multiple health risks
- Mobility impacts on diabetes management
- Social support networks
- Vulnerable elderly including dementia

"Diabetes is not the only thing wrong with a lot of people is it?"

What people are saying:
African Caribbean community

- Lack of information and culturally appropriate
- Confusion – diabetes and diagnosis
- Food:
  - eating habits and activity
  - fresh is best, mistrust
  - access and affordability
- Education within community

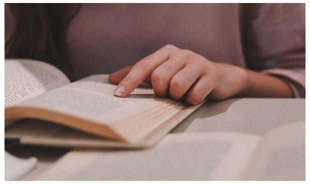
"Some African Caribbean people don't like going to the Doctors."

"It's good if you have an allotment or garden to grow your own food"

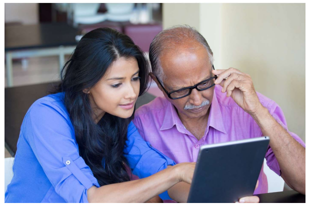
What people are saying:
South Asian Community

healthwatch Sandwell

Engaging Communities Solutions



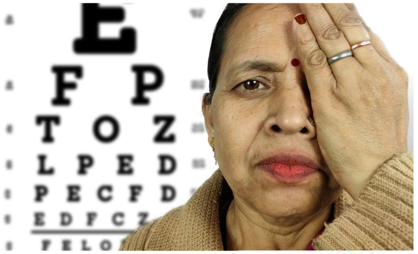
Information

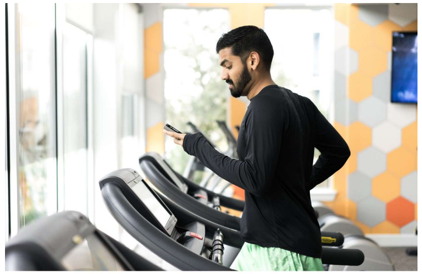


Food

Support

Health and care services





Exercise

DESI DIABETES

Leys Community Association

Key Recommendations

- **Focus on Diabetes prevention and risk reduction**
  - Integrated health, care and support partnership
- **Develop strategic relationship with Diabetes UK**
  - information, support, Community Champions
- **Invest in local communities "grass roots" support**
  - enable and empower diabetes risk prevention
- **Address Health Inequity in minority ethnic groups**
  - culturally appropriate information, earlier risk screening
- **Review management of diabetes in frail elderly**
  - activity/exercise, carer diabetes awareness/support

Thank You for listening

Any questions?

Sophie Shuttlewood – Projects and Partnerships Lead
Email: Sophie.Shuttlewood@healthwatchsandwell.co.uk
Website: www.healthwatchsandwell.co.uk

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18 October 2023

Subject:	Health and Wellbeing Board Work Programme 2023/ 24
Presenting Officer and Organisation:	Cathren Armstrong Acting Health and Wellbeing Board Officer Cathren_armstrong@sandwell.gov.uk Stephnie Hancock Deputy Democratic Services Manager Stephnie_hancock@sandwell.gov.uk

1 Recommendations

1.1 That the Board notes its work programme (Appendix 1), which sets out matters to be considered by the Board in 2023/ 24;

2 Links to the following Board Priorities

Priority 1	**We will help keep people healthier for longer**
Priority 2	**We will help keep people safe and support communities**
Priority 3	**We will work together to join up services**
Priority 4	**We will work closely with local people, partners and providers of services**

2.1 A strong and effective work programme underpins the work and approach of the Health and Wellbeing Board and is aligned to all priorities.

2.2 It is good practice for work programmes to remain fluid, to allow for consideration of new and emerging issues in a timely manner.

3. Context and Key Issues

3.1 All local authorities with adult social care and public health responsibilities are required to have a Health and Wellbeing Board by statute.

Health and Wellbeing Boards were established under the Health and Social Care Act 2012 to act as a forum in which key leaders from the local health and care system can work together to improve the health and wellbeing of their local population.

4 Engagement

4.1 It is not necessary to carry out public engagement.

5 Implications

Resources:	Members of the Board are expected to commit sufficient resources in terms of attendance at Board meetings and training events, and to participate in discussions and decision making on a regular basis.
Legal and Governance:	The Health and Wellbeing Board is a formal statutory committee of the local authority, established under Section 194 of the Health and Social Care Act 2012. The Board is to be treated as if it were a committee appointed by the local authority under section 102 of the Local Government Act 1972. (Section 194(11)).
Risk:	There are no direct implications arising from this report, however, the Board considers such implications on all matters that it considers, with health and wellbeing being a key consideration of course.
Equality:	
Health and Wellbeing:	
Social Value:	
Climate Change:	
Corporate Parenting:	

6 Appendices

Appendix 1 - Health and Wellbeing Board Work Programme 2023/ 24

7. Background Papers

None

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Date of Meeting	Item	Responsible Officer	
TBC 21st June 2023 (Reports due 7th June 2023)	Oxwell Survey	Michael Jarrett	Michael_Jarrett@sandwell.gov.uk
	LGBTQ+ Health Needs Report	Anna Blennerhassett	anna_blennerhassett@sandwell.gov.uk
	Children's Services Update	Michael Jarrett	Michael_Jarrett@sandwell.gov.uk
	5 Year Joint Plan Consultation	Michelle Carolan	mcarolan@nhs.net
	Harvey's Book	Pam and Harvey Kaur	pkaur03@gmail.com
TBC 13th September 2023 (Reports due 30th August 2023)	Update on Midland Met University Hospital	Richard Beeken	r.beeken@nhs.net
	Children Services Update	Michael Jarrett	Michael_Jarrett@sandwell.gov.uk
	Partnership Approach to Mental Health	Mick Wilkinson and Ch Supt Kim Madill	michael.wilkinson@westmidlands.police.uk
	Sandwell Better Mental Health Strategy and	Lina Martino	lina_martino@sandwell.gov.uk

	Mental Health Concordat		
	Sandwell Language Network Update	Diane Millichamp	Diane_millichamp@sandwell.gov.uk
TBC 18th October 2023 (Reports due 4th October 2023)	Children Services Update	Michael Jarrett	Michael_Jarrett@sandwell.gov.uk
	Health and Wellbeing Board constitution	Stephnie Hancock	Stephnie_hancock@sandwell.gov.uk
	OATS – Older Adult Therapeutic Services	Fiona Jones	fiona.jones19@nhs.net
	CDOP Annual Report (BC Child Death Overview Panel)	Liann BrookesSmith	Liann_BrookesSmith@sandwell.gov.uk
	Healthwatch overview	Alexia Farmer Philip Griffin	alexia.farmer@healthwatchsandwell.co.uk philip.griffin@healthwatchsandwell.co.uk
	Healthwatch update – Diabetes in Sandwell	Alexia Farmer Philip Griffin	alexia.farmer@healthwatchsandwell.co.uk philip.griffin@healthwatchsandwell.co.uk

TBC 6th December 2023 (Reports due 22nd November 2023)	Children Services Update	Michael Jarrett	Michael_Jarrett@sandwell.gov.uk
	Family Drug and Alcohol Courts	Gemma Hatfield	BlackCountryFDAC@cgl.org.uk
	Healthwatch update	Alexia Farmer Philip Griffin	alexia.farmer@healthwatchsandwell.co.uk philip.griffin@healthwatchsandwell.co.uk
	Alcohol and Drugs Service Users?	Nick Shough	Nick2_Shough@sandwell.gov.uk
	JSNA Update	Jason Copp	
	Social Prescribing	Cathren Armstrong	Cathren_Armstrong@sandwell.gov.uk
	SSAB Annual Report	Deb Ward Hayley Phelps	Deb_Ward@sandwell.gov.uk Hayley_Phelps@sandwell.gov.uk
TBC 13th March 2024 (Reports due 28th February 2024)	Children Services Update	Michael Jarrett	Michael_Jarrett@sandwell.gov.uk
	Healthwatch update	Alexia Farmer Philip Griffin	alexia.farmer@healthwatchsandwell.co.uk philip.griffin@healthwatchsandwell.co.uk
	Town Teams	Jayne Ilic (flexible, request from Lisa)	jayne.ilic2@nhs.net