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Eastern Cheshire Clinical Commissioning Group

South Cheshire Clinical Commissioning Group

Health and Wellbeing Board

Agenda

Date:	**Tuesday 25th June 2013**
Time:	**2.00 pm**
Venue:	**Committee Suite 1,2 & 3, Westfields, Middlewich Road, Sandbach CW11 1HZ**

The agenda is divided into 2 parts. Part 1 is taken in the presence of the public and press. Part 2 items will be considered in the absence of the public and press for the reasons indicated on the agenda and at the foot of each report.

PART 1 – MATTERS TO BE CONSIDERED WITH THE PUBLIC AND PRESS PRESENT

1. **Apologies for Absence**

   To receive apologies for absence.

2. **Declarations of Interest**

   To provide an opportunity for members of the Board to declare any disclosable pecuniary and non-pecuniary interests in any item on the agenda.

For requests for further information
Contact: Julie North
Tel: 01270 686460
E-Mail: julie.north@cheshireeast.gov.uk with any apologies

3. **Minutes of Previous meeting** (Pages 1 - 8)

To approve the minutes of the meeting held on 30 April 2013 as a correct record.

4. **Public Speaking Time/Open Session**

In accordance with Procedure Rules Nos.11 and 35 a period of 10 minutes is allocated for members of the public to address the meeting on any matter relevant to the work of the meeting. Individual members of the public may speak for up to 5 minutes but the Chairman or person presiding will decide how the period of time allocated for public speaking will be apportioned where there are a number of speakers. Members of the public are not required to give notice to use this facility. However, as a matter of courtesy, a period of 24 hours' notice is encouraged.

Members of the public wishing to ask a question at the meeting should provide at least three clear working days' notice in writing and should include the question with that notice. This will enable an informed answer to be given.

5. **NHS Eastern Cheshire Clinical Commissioning Group 2013-14 Prospectus** (Pages 9 - 12)

The Board is asked to note the content of the NHS Eastern Cheshire Clinical Commissioning Group Prospectus for 2013-14.

6. **Responding to Major Emergencies in Cheshire East following the Transfer of Public Health Duties on the 1st April 2013 - an Update** (Pages 13 - 20)

The Board is asked to note the revised major emergency response structures, roles and responsibilities that were introduced on the 1st April 2013 following the transfer of public health duties to the local authority

7. **Public Health England 'Longer Lives'** (Pages 21 - 40)

Public Health England has published 'Longer Lives', which presents data for the four biggest causes of premature mortality in England: cancer, heart disease and stroke, lung disease and liver disease. It highlights variations across all the local authorities in England and offers guidance to help make improvements.

The Board to receive a verbal report on the data for Cheshire East

8. **Health and Social Care Integrated 'Pioneers' Bid**

The Board to receive a verbal report on the Integrated Pioneers Bid

9. **Child Health Profile Data** (Pages 41 - 48)

In May, the Child and Maternity Health Observatory produced its annual profile against some key child health indicators for 2012/13. The Local Safeguarding Children's Board is seeking assurance from the Health and Wellbeing Board that services to children and young people are being appropriately commissioned to reduce the concerns these statistics raise.

The Board is asked to provide the Local Safeguarding Children's Board with an understanding of the issues raised and an assurance that these are being addressed.

10. **Ageing Well Programme Annual Report** (Pages 49 - 58)

The Ageing Well Programme Board presents its first annual report of the 5 year programme aimed at making Cheshire East a good place to grow old. This paper summaries the work to date, the achievements in 2012/13 and plans for 2013/14.

The Board is asked to consider and comment on the report.

11. **Children and Families Bill** (Pages 59 - 64)

The Board is asked to consider a report which sets out the main provisions of the Children and Families Bill, in particular, the changes to arrangements for children with special educational needs

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Agenda Item 3

CHESHIRE EAST COUNCIL

Minutes of a meeting of the **Health and Wellbeing Board**
held on Tuesday, 30th April, 2013 in Committee Suite 1,2 & 3, Westfields, Middlewich Road, Sandbach CW11 1HZ

PRESENT

Councillor J Clowes, Councillor Rachel Bailey, Councillor D Flude, Dr H Grimbaldeston, B Smith, Dr P Bowen, J Hawker, S Whitehouse, Dr A Wilson, A Tonge and M O'Regan

Officers In attendance
L Butcher – Strategic Director of Commissioning, Cheshire East Council; G Kilminster – Head of Health Improvement, Cheshire East Council; A Fisher – Strategic Planning and Housing Manager, Cheshire East Council; J Blackburn - Performance and Partnerships Manager, Cheshire East Council; C Tickle - Public Health Manager, Cheshire East Council; T Butcher - Assistant Director Service Improvement NW Ambulance Service; D Kitchen - Head of Service Cheshire and Merseyside NW Ambulance Service and M Moore - Manager for the Central and East Cheshire Service, NW Ambulance Service.

1 **APPOINTMENT OF CHAIRMAN**

RESOLVED

That Cllr Janet Clowes be appointed as Chairman for the 2013/14 Municipal year.

2 **APPOINTMENT OF VICE-CHAIRMAN**

RESOLVED

That Dr Paul Bowen be appointed as Vice-chairman for the 2013/14 Municipal year.

3 **APOLOGIES FOR ABSENCE**

Apologies for absence were received form Tony Crane.

4 **WELCOME**

The Chairman welcomed members of the Board, speakers and the public to the first meeting of the Health and Wellbeing Board and explained the remit and Terms of Reference of the Board, and how it would operate, in accordance with the relevant legislation. It was proposed that voting would be by consensus, rather than by formal vote. It was noted that other

partners and providers would influence the work of the Board and that their involvement and expertise would be invaluable in the work of sub-groups. The Board did not have a budget and was an influencing body, which would influence the way in which those bodies who did hold budgets spent them.

The secondary legislation relating to Health and Wellbeing Boards stated that they did not have to be politically proportionate, as other Council Committees were, but the major opposition group had been invited to nominate a representative to the Board; this was currently Cllr D Flude, but as she was to be Mayor in the forthcoming year, she was to be replaced by Cllr Janet Jackson at the next meeting.

5 **MINUTES OF THE SHADOW HEALTH AND WELLBEING BOARD HELD ON 26 MARCH 2013**

RESOLVED

That the minutes be approved as a correct record.

6 **DECLARATIONS OF INTEREST**

Drs Paul Bowen and Andrew Wilson declared an interest as they were GP practitioners contracted to provide NHS health needs as required by public health.

7 **PUBLIC SPEAKING TIME/OPEN SESSION**

There were no members of the public present wishing to use the public speaking facility.

8 **NORTH WEST AMBULANCE SERVICE PRESENTATION**

Tim Butcher, Assistant Director Service Improvement, and Dave Kitchen, Head of Service Cheshire and Merseyside, for the NW Ambulance Service attended the meeting to provide a presentation in respect of the NW Ambulance Service. Mike Moore, Manager for the Central and East Cheshire Service, was also present.

Mr Butcher explained the Services vision, which was to deliver the right care, at the right time, and in the right place. The Service included the 999 paramedic emergency service, the urgent care patient transport service and major incident management.

The area covered over 5,400 square miles, with a population of seven million and included 5 NHS Local Area Teams with 33 Clinical Commissioning Groups and 38 NHS Provider Trusts. 5000 staff were employed in the service, which had an annual income of £260 million. There were three emergency control centres and the service dealt with 1.1

million 999 calls a year (900 000 emergency patient transport episodes) with 1.1 million planned Patient Transport Service journeys.

Current priorities included managing increased 999 demand, reducing A&E attendance through alternative pathways, improving turnaround at hospitals, the new PTS contract, managing public expectations, achieving Foundation Trust status, system integration and Estates Strategy.

Mr Kitchen outlined the performance standards for 999 calls. All calls were prioritised to determine appropriate level of response. 75% of red calls (immediately life threatening, e.g. cardiac arrests, breathing difficulties, strokes) were responded to within 8 minutes and 95% within 19 minutes.

Details of Ambulance provision in East Cheshire, current local NWAS initiatives and current performance for red calls for 2012/13 were also outlined.

It was noted that the service had a number of health and wellbeing initiatives, including frequent caller identification, falls prevention, accident prevention, chain of survival, public safety campaigns and public education programmes. The service would be happy to work with other agencies and to attend and report to future meetings of the Board, as required.

Following the presentation members of the Board asked a number of questions and requested additional information with regard to what the service was doing in order to improve performance levels, including an action plan.

It was **resolved:-**

That the NW Ambulance Service be requested to produce a report for consideration at a future meeting of the Health and Wellbeing Board, in respect of the historic position in relation to the service, improvements made to date and how it was proposed to make future improvements to the Service, including an action plan.

9 **CHESHIRE EAST LOCAL PLAN PRESENTATION**

Adrian Fisher, Strategic Planning and Housing Manager attended the meeting and provided a presentation in respect of the Cheshire East Local Plan and its links to health. It was noted that it was a statutory development plan, the purpose of which was to guide growth and development and provided a benchmark for planning applications.

The Local Plan key influences were health infrastructure, promoting health and independence in housing and healthy communities. The Plan proposed 27,000 homes over the next 20 years, with new district communities and the Council would need to ensure there were accompanying community facilities for residents.

It was noted that the Localism Act established a new duty to co-operate, which included the health sector. Flowing from this, the Local Plan would be accompanied by an infrastructure plan that set out key requirements. The Community Infrastructure Levy could assist with this, but it was hugely oversubscribed.

As well as providing the basic standards of layout, privacy and amenity, the Local Plan would need to provide for the right mix, tenure and support for healthy independent living and provide housing for an ageing population.

The planning system had a large role in environmental protection e.g. pollution, flooding and quality of life and the Local Plan would have policies to cover these issues. In addition, one of the priorities in the Local Plan would be to promote green infrastructure and recreation, with a view to active and healthy lifestyles.

It would also be necessary to ensure that development was linked with different travel modes, allowing for active lifestyles. There were also broader considerations to ensure that there was adequate access to open space and recreation. There was also a need for Local Plan Policies with 'hooks' to health objectives and Health & Social Care Impact assessments to assess how development would impact on communities.

Finally, reference was made to Building Control. Although this was not part of the Local Plan, it was important in achieving health objectives, such as fire safety, ventilation etc.

The next steps for the Local Plan process were outlined as follows:-

- 26 February – consultation on 'preferred option' ended
- 3 May – 30 May – alternative sites consultation
- March / June – preparation of final local plan core strategy
- July – approval process
- July / September– statutory consultation on final plan
- Autumn – submission of plan to secretary of state
- Winter 2013/14 independent examination
- Spring / Summer 2014 – adoption

Following the presentation, members of the board asked a number of questions. It was noted that it would be important for the Health and Wellbeing Board to work in partnership with Planners in respect of this matter.

RESOLVED

That a service commissioning workshop take place at the next informal meeting of the Board on 21 May, to consider the above issues.

10 **MAPPING THE DEMENTIA GAP 2012**

Consideration was given to a report informing the Board that the Alzheimer's Society had recently published 'Mapping the Dementia Gap 2012: Progress on improving Diagnosis of Dementia 2011-2012', which was appended to the report. The report showed that, within the area of the Central and Eastern Cheshire PCT, there had been a 0.6% increase in diagnosis with 44.7% people with Dementia now diagnosed. However, it also appeared to show that the improvement in the rate of diagnosis was far lower than elsewhere, placing the area at 160th out of 178 (where 1 is most improved). The Health and Wellbeing Strategy identified the improvement of co-ordinated care for people with dementia as one of the priorities. It was estimated that in Cheshire East there would be an increase of 78% in the numbers of over 65s with dementia by 2030.

A review of the 2010 – 2013 Joint Commissioning Plan was now underway, with the two CCGs and CEC engaged through the Dementia Steering Group. The review group were looking at both the Workplan and the Strategy to inform the refreshed 2013 – 2015 Strategy. In addition the Council's Adult Overview and Scrutiny Committee's Task and Finish Group looking at Dementia had recently published its report. This was also being considered by the Steering Group. Both Clinical Commissioning Groups had identified dementia as a priority for action within their Commissioning Intentions. It would be for the Steering Group to determine the most effective way of delivering across the system improvements that would help to achieve an improved diagnosis rate.

The Health and Wellbeing Board was requested to agree that the Dementia Steering Group take on the work required by the Board, overseen by the Joint Commissioning Leadership Team.

RESOLVED

That it be agreed that the Dementia Steering Group consider the scope of the work required by the Board, overseen by the Joint Commissioning Leadership Team.

11 **NHS HEALTH CHECKS UPDATE**

Catherine Tickle, Public Health Manager, Cheshire East Council, attended the meeting and presented a report updating the Board on NHS Health Checks.

The Health and Social Care Act 2012 had introduced a statutory requirement for the Local Authority to undertake NHS Health Check Assessments as part of its Public Health responsibilities. The report outlined the requirements and progress made to undertake these within Cheshire East.

The Health and Wellbeing Board was invited to receive the report and requested to support the implementation of NHS Health Checks within Cheshire East.

RESOLVED

That the report be received and the implementation of NHS Health Checks within Cheshire East be supported by the Health and Wellbeing Board.

12 **JOINT STRATEGIC NEEDS ASSESSMENT (JSNA)/JOINT HEALTH AND WELLBEING STRATEGY (JHWS) UPDATE**

An update was provided in respect of the Joint Strategic Needs Assessment.

The JSNA was in the process of being refreshed, with a view to completing by August. This work was concentrating on the main priorities of end of life care, dementia, health care and children in need. The next phase would concentrate on predictable death work and an important part of this work would be to identify health inequalities.

It was considered that there needed to be further discussion around the JSNA, as to how to widen it out to include the housing and poverty agenda and how to bring the various intelligence together.

It was suggested that it would be appropriate to hold an Away Day to consider this issue and it was agreed that this matter should be considered at the next informal meeting of the Board on 21 May, together with the scoping of the JHWS. It was noted that that the Fire Authority did a lot of work in the community and it was felt that a representative from the Fire Authority should be invited to send a representative, in order to consider how their data could be fed into the JSNA.

It would be necessary to start to consider where the opportunities and strengths were with partners coming together and where the Health and Wellbeing Board could make a difference. The suggested objectives would be reported back to the Board.

13 **LEARNING DISABILITIES COMMUNITY BUDGET**

Consideration was given to a report, which provided a brief overview of the Community Budgeting expression of interest submitted to Government on 15 April.

Brandon Lewis MP, Parliamentary Under Secretary of State in DCLG, had written to all Local Authorities inviting them to put forward partnership Expressions of Interest to join the newly formed Public Services Transformation Network. The deadline for EOIs was 15 April.

The network was announced in the Budget and aimed to spread the learning from the existing four Whole-Place Community Budget pilots and worked directly with local areas to co-design practical public service reforms. If an area was successful in its EOI it would be invited to join the network and thereby have access to the representatives from Whitehall and from 4 pilot areas, who could provide advice and learning on public service reform. It was understood that DCLG were hoping for 4-6 new areas to join the network in the current year and a further 4-6 in 2014/15.

The Government would provide £1.5 million of funding for the new network, and those areas who joined the network would be asked to make a contribution to match the Government's funding. How this aspect of the network would operate was not entirely clear at this stage.

In light of the good progress in setting up a review of Learning Disability in Cheshire East, it was considered that this would be a good focus for a community budgeting approach. A brief proposal had, therefore, being prepared and submitted to Government on 15 April. The Expression of Interest document was attached to the report.

RESOLVED

That the expression of interest be noted.

The meeting commenced at 2.00 pm and concluded at 4.30 pm

Councillor J Clowes

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Health and Wellbeing Board

Date of Meeting:	25 June 2013
Report of:	Chief Officer for NHS Eastern Cheshire Clinical Commissioning Group
Subject/Title:	2013/14 Clinical Commissioning Group Prospectus

1.0 Report Summary

1.1 *Everyone Counts: Planning for Patients 2013/14*[1] outlined the requirement for clinical commissioning groups to produce a prospectus for its population. The content of the prospectus was at the discretion of clinical commissioning groups but was expected to outline in more detail the group's plans for delivering on its priorities outlined in its annual plan on a page, its links to the Health and Wellbeing Strategy and the role of the clinical commissioning group.

2.0 Decision Requested

2.1 That the Health and Wellbeing Board note the content of the prospectus

3.0 Reasons for Recommendations

3.1 To ensure that the membership of the Health and Wellbeing is aware of the 2013/14 plans of NHS Eastern Cheshire Clinical Commissioning Group and the publication that it is making available to members of the public.

4.0 Policy Implications including - Health

4.1 There are no direct policy implications

5.0 Financial Implications

5.1 There are no direct financial implications in relation to this report.

6.0 Legal Implications

6.1 N/a

7.0 Background

7.1 Clinical Commissioning Groups were required to produce an annual 'Plan on a Page' (Appendix One) which was intended to outline the health need priorities of its local area, the major programmes of work to be undertaken to address these needs and the how it will demonstrate that a difference has

[1] Everyone Counts: Planning for Patients 2013/14, NHS England, http://www.england.nhs.uk/everyonecounts/

been made. It was also required to identify the national and local measures that it will working towards achieving

7.2 *Everyone Counts: Planning for Patients 2013/14*[1] outlined the requirement for clinical commissioning groups to produce a prospectus for its population. The content of the prospectus was at the discretion of clinical commissioning groups but was expected to outline in more detail the group's plans for delivering on its priorities outlined in its annual plan on a page, its links to the Health and Wellbeing Strategy and the role of the clinical commissioning group.

7.3 The 2013/14 Prospectus for NHS Eastern Cheshire Clinical Commissioning Group contains the following sections:

- foreword
- reflection on 2012
- who we are
- snapshot of Eastern Cheshire
- how we spend your money
- establishing our priorities for 2013/14
- annual Plan on a Page 2013/14
- Caring Together programme
- mental health and alcohol programme
- quality improvement programme
- listening to, learning from and delivering for our population
- the Governing Body of the Clinical Commissioning Group

7.4 The Clinical Commissioning Group intends to produce two versions of this report:

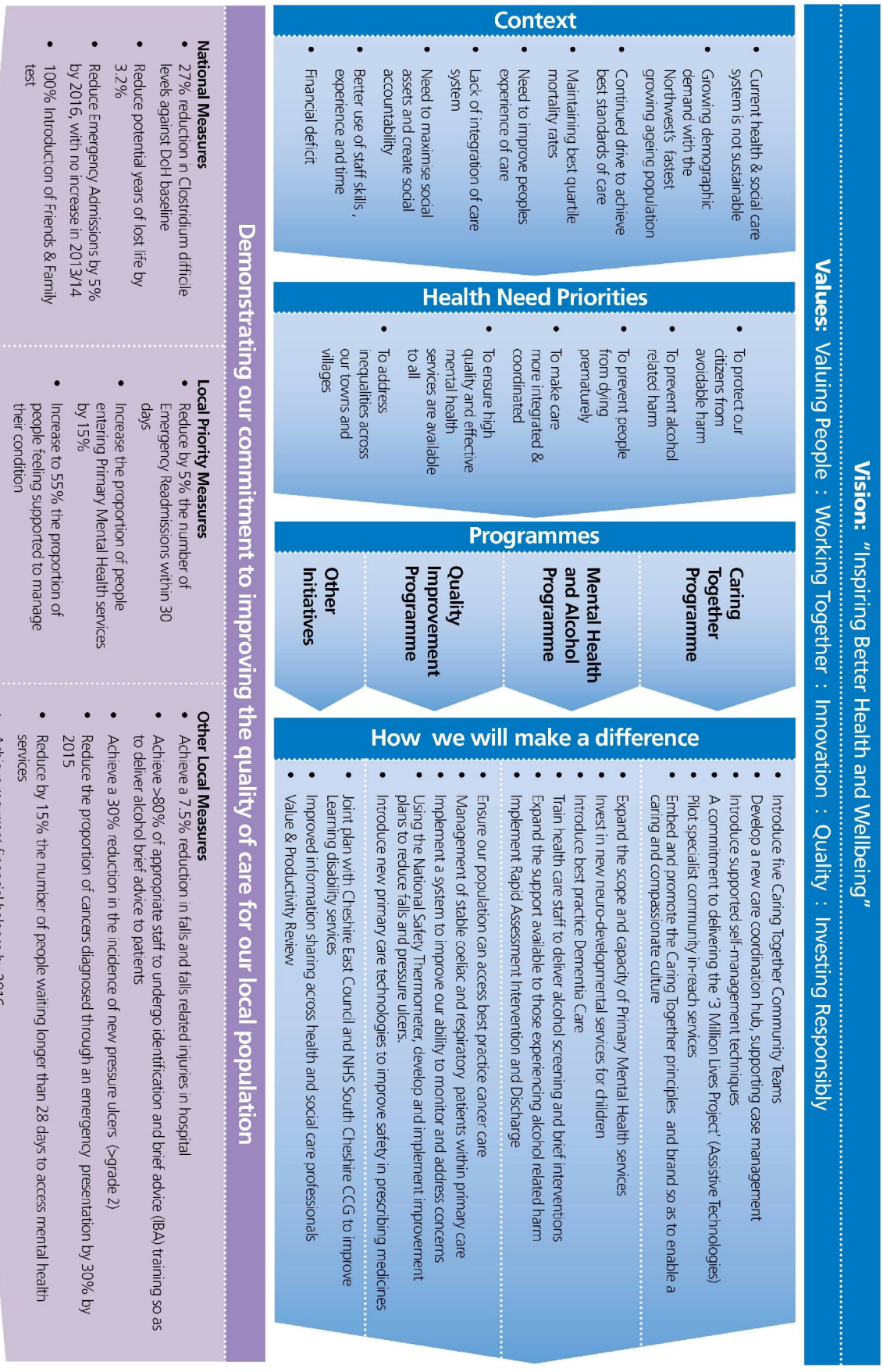
- **Version One** - the one that is presented today and which will be available electronically as a pdf and as a hard copy for distribution
- **Version Two** - an digital version which will encompass interactive technologies

8.0 Access to Information

Any further information related to the development of this prospectus can be obtained from the report writer:

Name: Matthew Cunningham
Designation: Corporate Services Manager
Tel no: 01625 663338
Email: matthew.cunningham@nhs.net

Appendix One: NHS Eastern Cheshire Clinical Commissioning Group 2013/14 Annual Plan on a Page



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Health and Wellbeing Board

Date of Meeting:	25 June 2013
Report of:	Manager, Joint Cheshire Emergency Planning Team
Subject/Title:	Responding to Major Emergencies in Cheshire East following the Transfer of Public Health Duties on the 1st April 2013 – an Update

1. Purpose of Report

1.1. The purpose of this report is to reassure members of the Health and Wellbeing Board that the revised council major emergency response structures, roles and responsibilities that were introduced on the 1st April 2013 following the transfer of public health duties to the local authority, are in place, are clear and are working.

1.2. The report will also provide an update from a multi-agency/ health perspective in regards to planning and response arrangements implemented from the 1st April.

2. Background

2.1. On the 1st April 2013 major changes to the health system were enacted, under the Health and Social Care Act 2012, with Directors of Public Health and Public Health Teams transferring to local authorities with a new and enhanced role.

2.2. Other major changes to the national health system, announced in the Health and Social Care Act 2012, also became fully operational including:

- Establishment of Clinical Commissioning Groups (CCGs), the NHS Commissioning Board (NHS CB) and Public Health England (PHE), the latter of which assumed many of the health protection responsibilities of the now defunct HPA.
- PCTs and SHAs were abolished.
- Health and Wellbeing Boards were established to bring together the right stakeholders to forge a new culture towards a shared local vision of good health and wellbeing for all.
- A new planning and response landscape for Emergency Preparedness, Resilience and Response (EPRR) within the health system was introduced.

2.3. Ahead of these changes taking place, officers from the Joint Cheshire Emergency Planning Team (JCEPT) analysed the impact of these changes on the authority from an emergency preparedness and response perspective, and implemented a number of changes, thus ensuring that the authority was ready to respond effectively to any major incidents from the handover date. That work included the following:

- Officers held a number of discussions with key stakeholders involved in the process including Guy Hayhurst (CEC Public Health Team), Andy

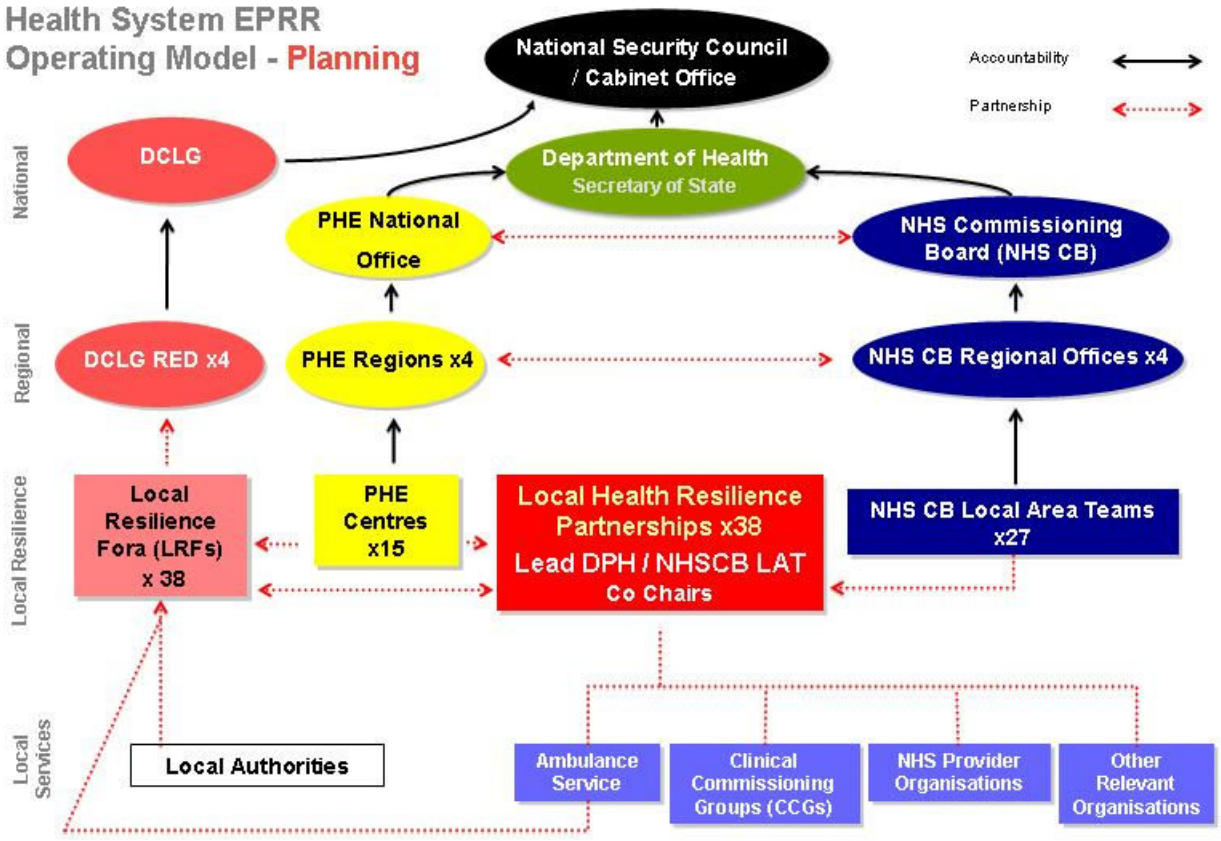
Meadows (NHS Commissioning Board Local Area Team), and Rita Robertson (Chair, Cheshire & Wirral Local Health Resilience Partnership).

- In October 2012 an exercise was held to test the new public health responsibilities of local authorities. Using a number of scenarios (Legionella Disease outbreak and a major flood incident), this ensured that there was a shared understanding amongst partners of the new system and that testing was carried out to ensure resilience during the final transition phase.
- The Council Major Emergency Response Plan was updated to reflect the new Public Health role of the authority and issued to key stakeholders at the end of March 2013 following a consultation period.
- Levels of awareness were also raised amongst key stakeholders within the authority regarding the changes to our emergency response and recovery procedures as part of the launch of the revised plan

3. Situation Report on Revised Arrangements

3.1. So how is the emergency planning and response landscape looking nearly three months after the transfer date? What actions are required to ensure that the revised arrangements continue to operate effectively?

3.2. **Multi-Agency Planning & Preparedness Update** - the diagram below shows the revised EPRR landscape in place since the 1st April from a planning and preparedness perspective:



3.3. **Cheshire Local Resilience Forum**

3.3.1. This multi-agency forum was introduced in conjunction with the introduction of the Civil Contingencies Act (2004) and is the key body tasked with ensuring an effective multi-agency response to major incidents. Cheshire East Council, a Category (1) responder under the CCA, is a key partner in this forum.

3.3.2. The LRF has recently approved a revised structure to be introduced in April 2014, which will provide time and travel cost efficiencies at the operational level and will provide greater challenge, focus and performance management at the tactical and strategic levels.

3.3.3. These changes will ensure that Cheshire LRF continues to improve, and retain its status as one of the leading LRFs in England and Wales.

3.4. **Cheshire, Warrington and Wirral LHRP**

3.4.1. To help coordinate NHS and public health planning for major emergencies, each NHS CB Local Area Team has established a Local Health Resilience Partnership, which is required to meet every quarter. This body is intended as a strategic forum for joint planning and preparedness for emergencies across the health system and also to support health's contribution to multi-agency planning and preparation through the LRF.

3.4.2. Co-chaired by the Area Team's Director of Operations (Andrew Crawshaw) and a representative Director of Public Health (currently Rita Robertson from Warrington Council) the membership comprises of 'board-level' manager from all the local NHS organisation in Cheshire, together with representatives from Public Health England, and of course the representative Local Authority Director of Public Health.

3.4.3. Cheshire's LHRP has met three times since November 2012 and has adopted a 3-year strategy supported by an annual work plan. Issues such as the STAC Activation Plan and the Infectious Disease Outbreak Plan have been discussed at these Partnership meetings.

3.4.4. Public Health England is also separately represented on Cheshire LRF.

3.4.5. Adult Social Care Representation on LHRP - from what we understand one Adult and Social Care representative will be asked to represent the four Local Authorities on the LHRP – this representative has yet to be confirmed.

3.4.6. Effective linkages with Cheshire LRF are in place with Andrew Crawshaw representing the Local Area Team and wider NHS at LRF strategic meetings, and Andy Meadows (Head of EPRR, Local Area Team, NHS Commissioning Board) representing the Local Area Team and wider NHS at LRF General Working Group meetings.

3.5. **Cheshire East Council:**

3.5.1. Information and Advice – Cheshire East Council has a new health protection duty, which involves the local authority discharging aspects of the Secretary of State's duty to take steps to protect public health. The duty takes the form of a statutory requirement to provide information and advice to certain responsible persons and relevant bodies with a view to promoting the preparation of local health protection arrangements under regulation 8 of the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013

3.5.2. In regulation 8, a "responsible person" means:
(a) an NHS body,
(b) a Chief Constable of a police force,
(c) a fire and rescue authority, and
(d) Public Health England;

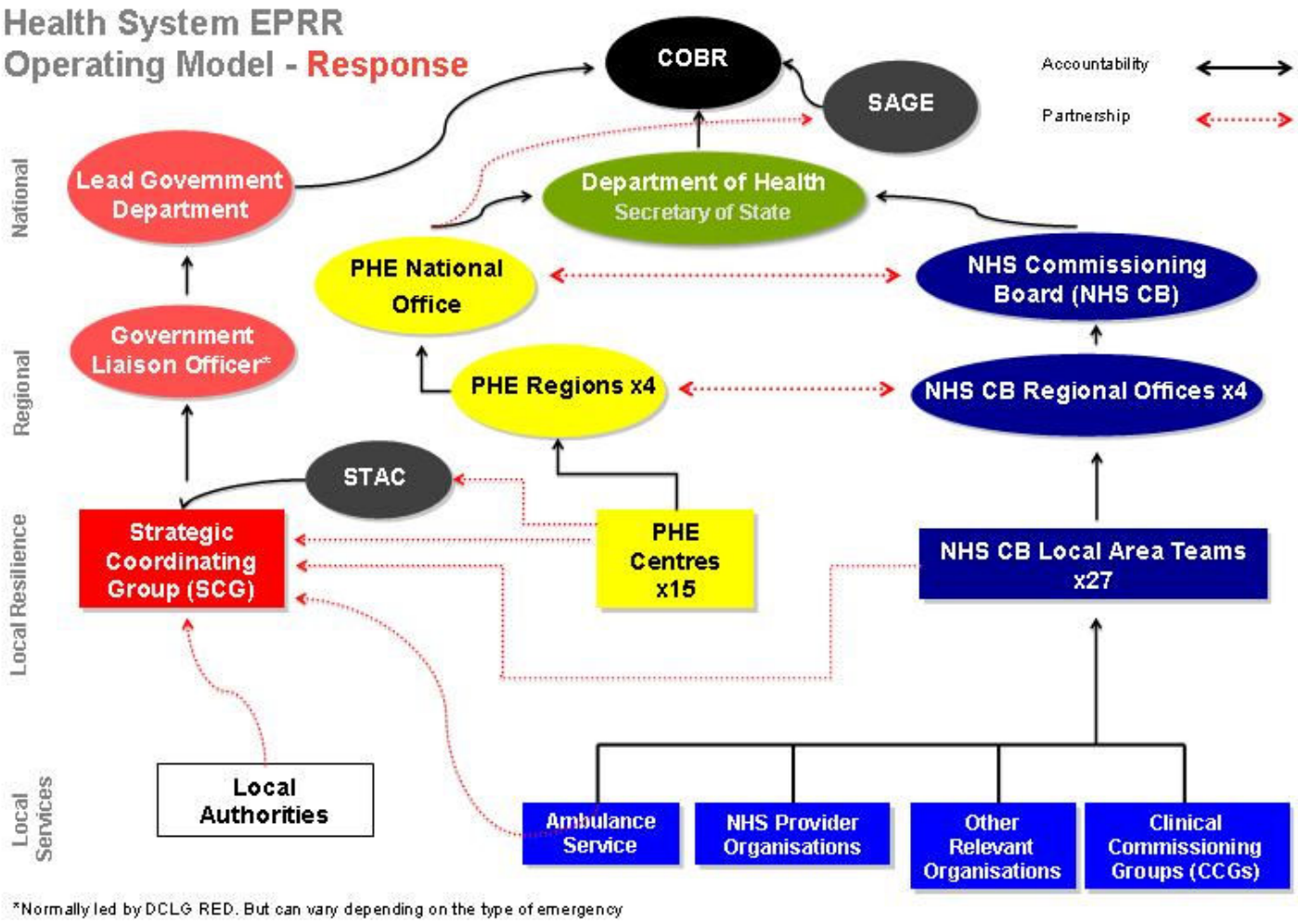
3.5.3. In regulation 8, a "relevant body" means a body whose activities, in the opinion of the local authority, have a significant effect upon, or whose activities may be significantly affected by a threat to, the health of individuals in the local authority's area, and may include:
(a) the governing body of a maintained school,
(b) a body which is the proprietor of a school which is not maintained by the local authority,
(c) providers of social care services,
(d) voluntary organisations,
(e) charities, and
(f) businesses.

3.5.4. The Director of Public Health is responsible for providing information, advice, challenge and advocacy on behalf of Cheshire East Council to promote the preparation of health protection arrangements by relevant organisations operating in the local authority area. This may include information and advice on the following:
(a) the appropriate co-ordination of roles and responsibilities between any responsible or relevant bodies;
(b) effective testing by the responsible and relevant bodies of the health protection arrangements;
(c) appropriate emergency provision to deal with incidents which occur outside the normal working hours of the responsible or relevant bodies;
(d) arrangements for epidemiological surveillance;
(e) arrangements for environmental hazard monitoring;
(f) arrangements with other local authorities for managing incidents which affect the area of more than one authority in an integrated and co-ordinated manner;
(g) arrangements for stockpiling of medicines and medical supplies.

3.5.5. These new arrangements for preventing and planning responses to health protection incidents and communicable disease outbreaks that do not require mobilisation of a multi-agency response under the Civil Contingencies Act 2004 complement the revised EPRR arrangements.

3.5.6. With the restructuring of the senior team of Cheshire East Council, new reporting arrangements will provide a clear line of accountability between the Joint Cheshire Emergency Planning Team, relevant Heads of Service and the Director of Public Health.

3.6. **Multi-Agency and Cheshire East Council Response Update** - The diagram below shows the EPRR response landscape in place since the 1st April:



3.6.1. From an NHS perspective, the way NHS providers respond to an emergency incident has changed little as a result of these reforms. East Cheshire NHS Trust and Mid Cheshire Hospitals NHS Foundation Trust have plans in place to respond to a range of emergency incidents, which are regularly updated, tested and exercised in line with national contract requirements and guidance, sometime in conjunction with other NHS organisations and multi-agency partners.

3.6.2. The demise of Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs) has had a more significant impact however. In particular it should be noted that Clinical Commissioning Groups have not taken on the majority of the emergency response roles of the former PCTs as they are classed as Category 2 Responders under the Civil

Contingencies Act 2004. As such the majority of the emergency response roles of both the former PCTs and SHAs have now become the responsibility of NHS England (the NHS Commissioning Board). NHS England has issued a range of guidance documents outlining the roles and responsibilities of all NHS, including core competencies and the requirement for all NHS organisations to have a 'board-level' Accountable Emergency Officer. In addition NHS England has established three levels of emergency preparedness and response arrangements – nationally, across its 4 regional offices and across its 27 Area Teams.

3.6.3. Locally this means that NHS England's Cheshire, Warrington and Wirral Area Team has responsibility for planning and responding to major emergencies, in coordination with local NHS organisations and multi-agency partners. The Area Team:

- represents the NHS on the Cheshire Local Resilience Forum,
- operates a two-tier on call rota to represent the NHS at multi-agency incident commands (the Cheshire NHS Strategic Commander Rota and the Cheshire NHS Tactical Commander Rota) and, if necessary,
- has the power to command and control the response of all NHS organisations during an incident.

3.6.4. The Area Team has plans in place which are regularly tested and exercised, for example in June alone the Area Team will be taking part in three multi-agency exercises within Cheshire.

3.6.5. Locally Public Health England's (PHE) Cheshire & Merseyside Centre is working with local authority Directors of Public Health across Cheshire and Merseyside to ensure a proportionate response to requests for public health advice and support for any incident that occurs across Cheshire and Merseyside. PHE Cheshire & Merseyside Centre has:

- established rotas and put in place arrangements to access public advice for major emergencies
- with Local Authority Directors of Public Health across Cheshire and Merseyside, put in place a rota to support a Scientific and Technical Advice Cell (STAC), if one is required
- developed a STAC Activation Plan for Cheshire and Merseyside (together with a process to train those on this STAC rota)
- developed a Multi-Agency Outbreak of Infectious Diseases Plan which is being reviewed to take account of the new organisational arrangements / responsibilities in respect of changes to the NHS and public health

3.6.6. The Health and Social Care Act 2012 makes clear that both NHS England and CCGs are under a duty to obtain appropriate advice, including from persons with a broad range of professional expertise in "the protection or improvement of public health". This includes the advice of local authorities, usually delivered through their Director of Public Health.

3.6.7. In addition, regulation 7 of the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013 requires local authorities to provide a public health advice service to CCGs, which includes advice on health protection.

3.7. **Cheshire East Council:**

3.7.1. Council Major Emergency Response Plan (MERP):

3.7.1.1. As mentioned earlier the Council Major Emergency Response Plan was updated to reflect the new Public Health role of the authority and went live at 0000 hours on the 1st April 2013.

3.7.1.2. The key change to the MERP, which utilises a Functional Response Model, was the establishment of a new role in the Council Emergency Management Response Team (CEMART) – that of Public Health Lead. This officer's role is to provide specialist public health advice to the Council Incident Co-ordinator, working in partnership with Public Health England. The Director of Public Health, Heather Grimbaldeston or one of her senior public health consultants performs this role.

3.7.1.3. Outside office hours, the responding agencies can access public health advice through the Cheshire and Merseyside Public Health England Duty Officer in the first instance, with the CEC Public Health Team providing support where required.

3.7.1.4. When the STAC (Science and Technical Advice Cell) is in play during an incident that body will take primacy over any public health advice. When the STAC is not in play, the Public Health Lead will work with Public Health England to agree on what needs to be communicated to the public on behalf of the Council Incident Co-ordinator and the authority.

3.7.1.5. These arrangements are robust, flexible and ensure that public health advice is available on a 24/7 basis to the responding agencies.

3.7.2. Future Actions:

3.7.2.1. Awareness Raising – awareness levels continue to be raised amongst managers and staff in regards to the recent changes as part of the Emergency Management Workshops taking place across the authority between May and August 2013. Our team will continue to raise awareness at every available opportunity as the year progresses.

3.7.2.2. Exercising – The Council Major Emergency Response Plan is exercised regularly, most recently through the Emergency Management Workshops series for CEC senior managers. In

addition, the BAE Systems COMAH[1] Major Live Exercise in October 2013 will provide an opportunity to test the revised arrangements in a live multi-agency setting. Any lessons learned in the meantime as result of incident response will also be fed back to key stakeholders and the plan revised accordingly.

4. Conclusion

4.1. In conclusion, members of the Cheshire East Health and Wellbeing Board can be re-assured that, following the introduction of reforms under the Health and Social Care Act 2012, the revised planning and response arrangements at both an authority and multi-agency level will ensure a robust and well co-ordinated response to any future incidents. However these arrangements will continue to be monitored and exercised by the appropriate organisations and, where required, revisions made to ensure continuous improvement. With the authority currently going through a period of restructuring, board members can also be reassured that the Functional Response Model utilised provides both a high level of resilience and flexibility allowing the authority to respond effectively to any major incident over that phase and beyond.

For further information:

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Email: chris.samuel@cheshiresharedservices.gov.uk

[1] COMAH – Control of Major Accident Hazard Regulations (1999)

Public Health England

Longer Lives

A new way to connect with community health

June 2013

Professor John Newton
Chief Knowledge Officer
Public Health England

‘Public Health England is a new organisation with new ideas about how to improve and protect health. One of the first things we are doing is publishing *Longer Lives,* an initiative presenting a clear picture of health in local areas – where it is good and bad – so everyone involved can consider and agree how to make improvements from a common basis of knowledge. The data is provided alongside evidence of what needs to be done as well as case studies, and, with your support and over time, will increase in scope and richness.

‘I am convinced that *Longer Lives* has the potential to make a real difference to the health of each and every community in England, and England as a whole. I really hope you’re as excited about its potential as I am.’

What is *Longer Lives?*

***Longer Lives* is a new initiative from Public Health England (PHE). It makes information about the health of the nation available to everyone and connects people with the knowledge and resources they need to help the country work together towards better health.**

This, the first phase of *Longer Lives*, presents data for the four biggest causes of premature mortality in England: cancer, heart disease and stroke, lung disease and liver disease, enabling easy interpretation and comparison. It highlights variations across all the local authorities in England and offers guidance to help make improvements.

Longer Lives comes at a time when the health and care system is undergoing great change, and will support local government in its new role as the champion for their public's health.

The project is just beginning and, with your support and participation, can grow to provide genuine insight into the issues and opportunities in each area. The range and depth of data will be enhanced in line with feedback, and the resources expanded, helping anyone with a stake in health make a real difference to their community.

longerlives.phe.org.uk

What is Public Health England?

PHE works to help people live longer, healthier lives by supporting and enabling local government, the NHS and the public to protect and improve health and wellbeing and reduce inequalities. *Longer Lives* is one of its first initiatives.

Duncan Selbie
Chief Executive
Public Health England

‘Wherever you sit, whether you’re in industry or in government, whatever the role you’re fulfilling, you can come to Public Health England with any question and we’ll direct you to the evidence and what works’

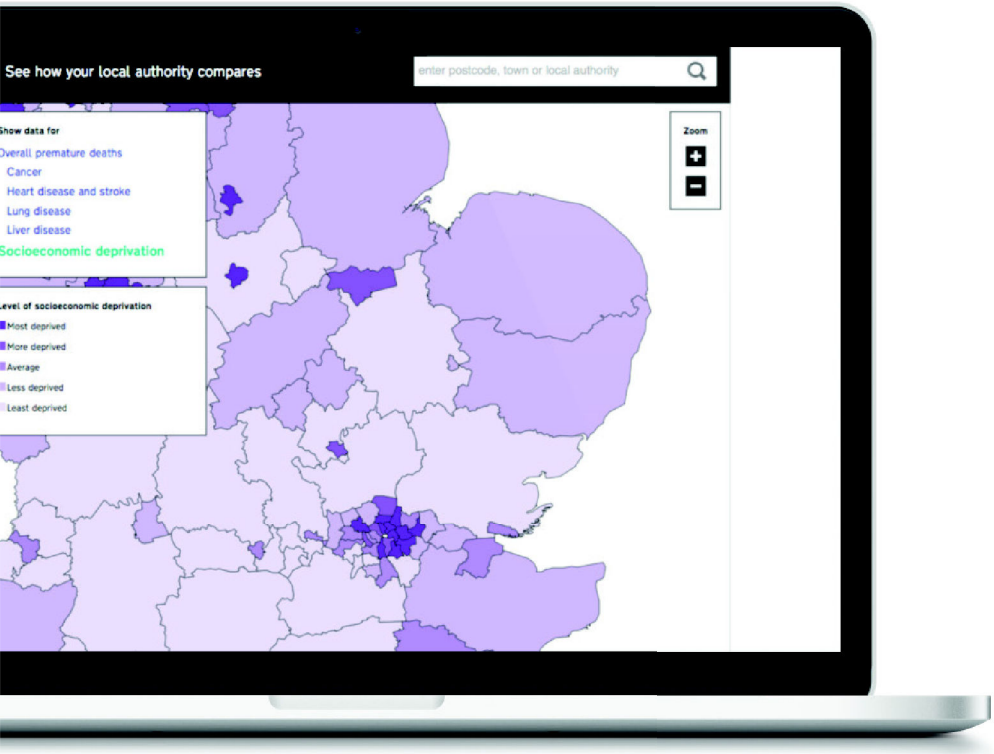
How was *Longer Lives* created?

The data provided in *Longer Lives* is from the Public Health Outcomes Framework (PHOF). This is not the first time it has been published, but the first time it has been published in this form, making the information easy to access, view and compare. It is also the first time it has been published alongside relevant supporting information, such as the intervention guidance provided by the National Institute for Health and Clinical Excellence (NICE).

The design process began with careful consideration of the audience for *Longer Lives* and ways to help them access and use the website to its fullest potential. In line with the government's digital strategy, this, its first phase, has been delivered quickly and with feedback from a small group of stakeholders. From May 2013 it will undergo a process of continuous iteration in response to feedback from everyone.

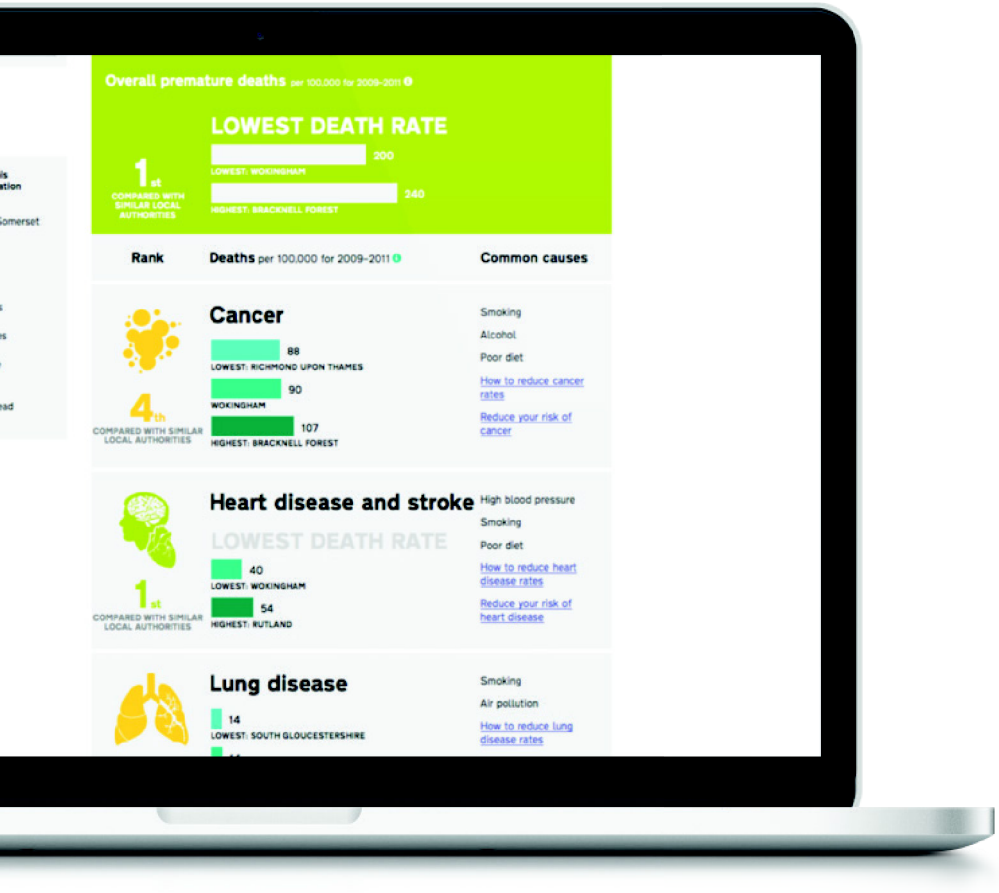
Longer Lives is accessed primarily through the PHE homepage on GOV.UK, the website for government services and information. However, you will find links to it on many health domains, including NHS Choices.

What does *Longer Lives* look like?



Interactive map

The map offers a view of England's health in a single glance, using a simple colour key. Users can opt to view overall premature deaths, deaths by each of the four diseases or by socioeconomic deprivation.

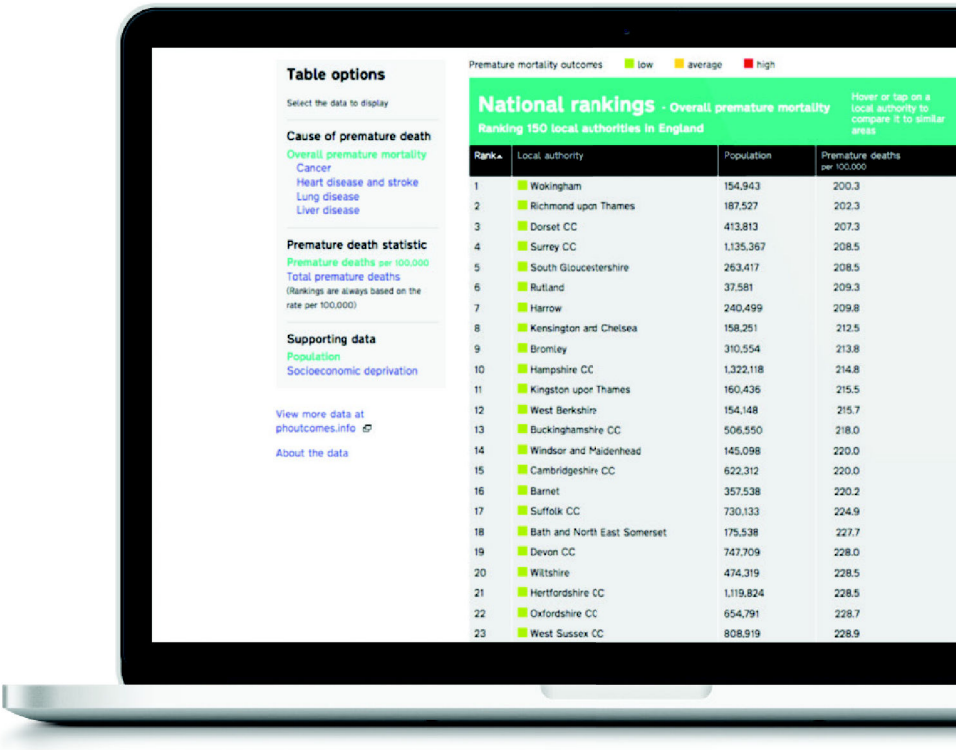


Local authority pages

Each of the 150 local authority pages lists the area's population, total premature deaths in a given timeframe, its premature mortality ranking and socioeconomic deprivation ranking. Bar charts show how it compares to the local authorities with the highest and lowest rates, both for overall premature mortality and each disease. Users can see how their local authority compares both nationally and within their socioeconomic deprivation decile.

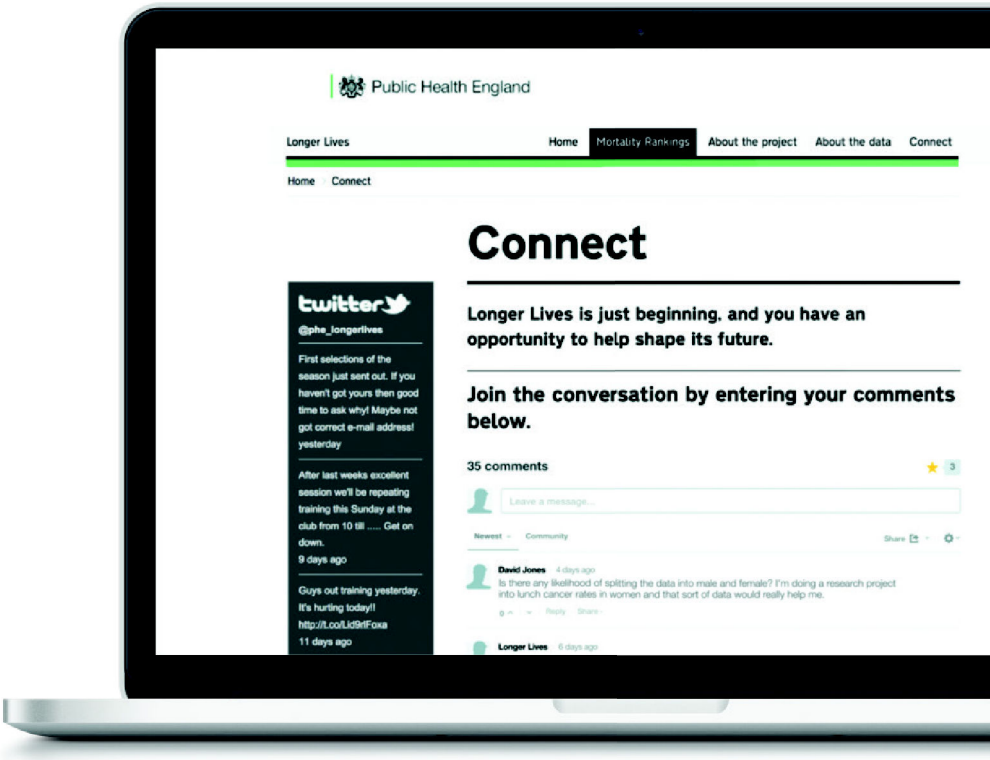
Mortality rankings

This shows the country's premature mortality data in table form. Users can arrange the data by overall premature mortality or by each disease and can easily toggle between information on overall deaths or rates per 100,000, and between population size or socioeconomic deprivation.



Disease page

Each of the four diseases covered in the first stage of *Longer Lives* has a dedicated page, with information about it and any inequalities that exist in its mortality rates. This is where you can find out the common causes of the disease and recommended interventions, and read a local authority case study.



Connect

This page helps users have their say about the project by submitting their feedback and responding to others'.

What outcomes are expected?

Making England's premature mortality data transparent can lead to any number of positive outcomes, not just for local authorities.

Anyone can use and benefit from *Longer Lives.*

If you're a director of public health, a local authority officer or member, a member of a health and wellbeing board or clinical commissioning group, or have any other role in making decisions about how budgets should be spent on health in your area, *Longer Lives* offers you a valuable insight into the issues within your community. It can be used to identify and align effort on areas that need attention, and commission effective interventions.

If you have an interest in community health – perhaps you're a member of the public or media – the *Longer Lives* data can function as an authoritative context for conversations and challenges to those in positions of responsibility. And if you belong to a voluntary and community sector, professional body or are an academic expert, it can help you contribute to progress.

Most importantly, *Longer Lives* gives anyone and everyone the opportunity to participate in open and honest debate on reducing premature mortality, fostering a collaborative approach to community health and care in which successes are readily and regularly shared. The result, it is hoped, will be real and tangible improvements.

Why is *Longer Lives* important?

Because our premature mortality rates must improve

England's premature mortality rates (deaths under age 75) place us 7th out of 17 European countries for men and 15th for women, and must improve. For premature deaths caused by lung disease, we are 16th, and figures for liver disease deaths are worsening compared with European improvement.

Because there are huge variations across the country

In England today, a person's likelihood of dying prematurely from one of the top four killers varies widely between local authorities due to differences in risk factors and socioeconomic determinants. For example, more than twice as many people from the most deprived areas die of cardiovascular disease than those from the most affluent.

Because better health begins in the community

Every community faces its own distinct challenges in health and determinants of it – everything from air quality to transport, housing and outdoor spaces. The responsibility for these determinants lies with local government. And that's why, from April 2013, there will be a far greater emphasis on local decision-making and ownership.

Because interventions could make a real difference

Interventions such as smoking cessation, improved diet and early diagnosis, could drastically reduce the 103,000 avoidable premature deaths in England every year (that's two thirds of all premature deaths). However, effective interventions demand a clear understanding of how and, crucially, where, change is needed.

Because positive action starts with accessible information

The starting point for improving community health is transparency of health data. *Longer Lives* enables people for whom health and healthcare is a daily concern to understand what is happening and work together towards improvement.

Why is *Longer Lives* happening now

In March 2013, Jeremy Hunt, the Secretary of State for Health, issued a challenge: help England achieve the lowest rates of premature mortality in its European peer group. There is a long way to go before this challenge can be truly fulfilled, however, the changes to the health and care system that came into effect in April 2013 ensure that work has begun.

These changes put local government in the driving seat for health improvement in their communities, a move that complements their responsibilities for the wider determinants of health – everything from air quality to road deaths, housing and outdoor spaces. New health and wellbeing boards, populated by local authority representatives, individuals from local clinical commissioning groups and local healthwatch, and professionally supported by the local director of public health, are charged with looking strategically at the needs of their communities and taking action.

Public Health England plays a vital role in this local health and care system, giving these parties the information they need to make better decisions. Information availability in a health system can help improve performance, accountability and create better care and better outcomes. As such, transparency and open data is one of PHE's remits and a hugely important one for the success of the new system and achievement of its ambitions.

This is where *Longer Lives* comes in. The project gives every local authority in England a clear picture of its local health and an understanding of how it compares with similar areas. Later, it will also give an indication of how England compares with other countries in Europe, placing communities within a wider context of health and providing the foundation on which to fulfil the Secretary of State's challenge.

‘I call on all those involved across the health and care system and beyond to come together to determine what they should be doing to support their local communities to live longer, healthier lives. We will not be the best in Europe immediately. But we need to start making changes now. It is time to be bold and ambitious for health.’

Jeremy Hunt, Secretary of State for Health,
‘Living Well For Longer’, March 2013

Questions and answers

To help answer your questions about *Longer Lives*, and help you answer questions you may be asked about it as part of your job, we've put together a list of common questions and their answers.

Will any more data be added to *Longer Lives*?

Yes. We'll be expanding the causes of death to include injury, which is largely preventable and a big killer, and subdividing current causes of death, e.g. splitting cancer into breast, colorectal and lung as these have different underlying causes and preventive actions.

We are also drilling down to smaller areas including lower tier local authorities and electoral wards in response to requests from local government.

We'll add trends to highlight areas of improvement and risk factors to help local authorities understand where to focus public health action to tackle premature mortality.

How will the 2011 census impact this data?

Population data from the last census taken in 2001 has been used to estimate population figures in each of the local authorities.

The number of premature deaths per area uses the average number of deaths between 2009 and 2011.

When new population estimates based on the 2011 census are published we will update the data in *Longer Lives* and include trend data for death rates.

Why is the data only for England?

One of the aims of the *Longer Lives* project is to enable people to use the information to take positive action in their own communities.

Under the new health and care structure, Scotland, Wales and Northern Ireland will address these issues in their own health and care systems.

Why is there no data for the Isles of Scilly and the City of London?
The data presented is for 150 of the 152 upper tier local authorities in England.

The two local authorities not included – Isles of Scilly and City of London – have less than 25 observed deaths, which is too few to calculate death rates (which make allowances for differences in age between area) reliably.

How is socioeconomic deprivation calculated?
Socioeconomic deprivation data is taken from the Indices of Multiple Deprivation published by the Department for Communities and Local Government (DCLG).

We rank 150 local authorities in England on their overall deprivation score and split them into deciles – 10 groups of 15 authorities with similar scores.

Since deprivation scores are highly predictive of premature death rates, this allows us to compare areas likely to have similar death rates.

Note that in the deprivation map we subdivide local authorities into five groups, whereas in the rankings we use the deciles.

Why does *Longer Lives* focus on only four diseases?
Cancer, liver disease, lung disease, and heart disease and stroke, together accounted for 75% of premature deaths in England in 2012.

While *Longer Lives* will initially focus on deaths from these conditions, the data will be enhanced in line with user feedback and future data releases, to create an increasingly in-depth view of premature mortality in England.

What if someone dies from more than one condition?
Cause of death is based on rules applied by the Office for National Statistics to death notifications.

Why are stroke and heart disease combined?

At this time, the data for heart disease and stroke are reported together to reflect the public health outcomes framework (PHOF). We plan to split out heart disease and stroke in future releases.

How are the colours on the maps and the profiles determined?

Every local authority is colour coded to show how its premature mortality compares with the average for England.

We have used a red, yellow, orange and green colour scheme to denote the extent of variation from the national average or the average of similar areas.

Green represents rates that are statistically significantly better than the England average and red denotes rates that are statistically significantly worse.

Yellow denotes rates that are within expected limits but better than average, and orange denotes rates within expected limits but worse than average.

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June 2013

Agenda Item 9

Health and Wellbeing Board

Date of Meeting:	25 June 2013
Report of:	Head Integrated Safeguarding Unit
Subject/Title:	Child Health Profile Data for Cheshire East

1.0 Report Summary

1.1 The Local Safeguarding Children's Board (LSCB) has a reciprocal challenge and scrutiny role with other strategic Boards and will occasionally seek assurance in respect of issues concerning the children and young people of Cheshire East that fall more appropriately to the core business of others.

1.2 In May of this year the Child and Maternity Health Observatory (CHiMat) produced its annual profile against some key child health indicators for 2012/13. There are some recurring issues within that report that the LSCB would seek assurance from the Health and Wellbeing Board that services to children and young people are being appropriately commissioned to reduce the concerns these statistics raise.

2.0 Decision Requested

2.1 That the Health and Wellbeing Board provide the Local Safeguarding Children's Board with an understanding of the issues raised and assurance that these are being addressed

2.2 That the Board ensure that if there are current gaps in services that will reduce these concerns that steps will be taken to address this.

3.0 Reasons for Recommendations

3.1 To ensure that the Health and wellbeing of children and young people is promoted.

4.0 Policy Implications

4.1 The Health and Social Care Act 2012 introduced a number of significant changes. This includes the establishment of the Cheshire East Health and Wellbeing Board, the GP Clinical Commissioning Groups and the transfer of the Public Health responsibilities from the PCT to the Local Authority.

4.2 To achieve improved health and wellbeing outcomes for local communities, the Act identified the need for increased joint working between the NHS and local authorities, with high quality local leadership and relationships being an essential foundation. The Act described Health and Wellbeing Boards as having the key role of improving joint working by bringing together key commissioners and through their function of encouraging integrated working in relation to commissioning.

4.3 The Joint Health and Wellbeing Strategy is the mechanism by which the needs identified in the Joint Strategic Needs Assessment are met, setting out the agreed priorities for collective action by the key commissioners, the local authority, the Clinical Commissioning Groups and the NHS Commissioning Board. This statistical data should inform those priorities and influence relevant changes.

5.0 Financial Implications

5.1 There are no direct financial implications in relation to this report. The questions raised through this report may require examination of the effective use of allocated funding to address recognised challenges across relevant council and health services in effectively meeting the needs of our children and young people to reduce the impact of harm and improve their health and well being.

6.0 Legal Implications

6.1 N/A

7.0 Risk Management

7.1 The health and well-being of children and young people in Cheshire East will be a priority for the Health and Wellbeing Board. Failure to commission effectively will have an impact.

8.0 Background

8.1 The Child and Maternal Health Observatory produces an annual profile for each area in the country. This profile provides a snapshot of child health in Cheshire East. It is designed to help the local authority and health services improve the health and well-being of children and tackle health inequalities. The data also shows how children's health and well-being in Cheshire East compares with the rest of England.

8.2 There is much in the report that gives a positive picture of good and improving child health, for example, the development of children at 5 years of age. Whilst this is a crude reflection of the issues that lie behind the health of children and young people in Cheshire East, there are nonetheless some clear patterns when the data is compared with the regional and England data and over a couple of years. Whilst Cheshire East has some areas of deprivation its demographic profile would set an expectation that it compares well with the national picture. It is appropriate that the LSCB raise this with the Board and that assurance is provided.

8.3 In particular the LSCB is seeking an understanding of why Cheshire East is higher than the England rate for:

- admission to hospital for injuries to children
- children killed or seriously injured on the road

- admission to hospital due to alcohol and substance misuse and
- a higher than England average re mental health /self harm – particularly as this is gradually increasing year on year.

8.4 The issues of mental health, substance and alcohol misuse are often prevalent in adults who are unable to care effectively for their children and it is vital therefore that we are effective in the treatment and prevention of these issues where they occur for our children and young people.

8.5 Alongside this it would be helpful to know what commissioning activity can be sited to manage and reduce the areas identified, the measures of success/impact and the timescale for achieving this

.

9.0 Access to Information

The background papers relating to this report can be inspected by contacting the report writer:

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Child Health Profile

ChiMat
Child and Maternal Health Observatory

Cheshire East

March 2013

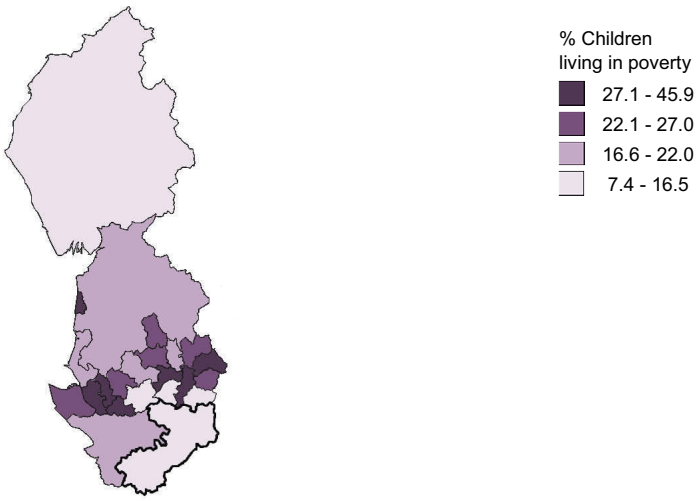
This profile provides a snapshot of child health in this area. It is designed to help the local authority and health services improve the health and well-being of children and tackle health inequalities.This profile is produced by the Child and Maternal Health Observatory (ChiMat) working with North West Public Health Observatory (NWPHO).

The child population in this area

	Local	North West	England
Live births in 2011	4,013	88,752	688,120
Children (age 0-4 years), 2011	20,100	432,900	3,328,700
% of total population	5.4%	6.1%	6.3%
Children (age 0-19 years), 2011	83,400	1,690,200	12,710,500
% of total population	22.5%	24.0%	23.9%
Children (age 0-19 years) in 2020 (projected)	84,532	1,744,967	13,575,943
% of total population	21.8%	23.8%	23.7%
School children from black/ethnic minority groups	3,562	149,950	1,661,440
% of school population (age 5-16 years)	7.9%	17.1%	25.6%
% of children living in poverty (age under 16 years)	13.0%	22.9%	21.1%
Life expectancy at birth			
Boys	79.5	77.0	78.6
Girls	82.9	81.1	82.6

Children living in poverty

Map of the North West, with Cheshire East outlined, showing the relative levels of children living in poverty.



Data sources: Live births, Office for National Statistics (ONS) 2011; population estimates, ONS 2011 Census mid-year estimates; population projections, ONS interim 2011-based subnational population projections; black/ethnic minority maintained school population, Department for Education 2012; children living in poverty, HM Revenue & Customs (HMRC) 2010; life expectancy, ONS 2008-10

Key findings

22.5% of the population of Cheshire East is under the age of twenty. 7.9% of school children are from a black or minority ethnic group.

The health and well-being of children in Cheshire East is mixed compared with the England average. Infant and child mortality rates are similar to the England average.

The level of child poverty is better than the England average with 13.0% of children aged under 16 years living in poverty. The rate of family homelessness is better than the England average.

Children in Cheshire East have better than average levels of obesity. 8.3% of children aged 4-5 years and 17.0% of children aged 10-11 years are classified as obese. 59.1% of children participate in at least three hours of sport a week which is better than the England average.

The hospital admission rate for injury is higher than the England average. The rate at which children were killed or seriously injured in road traffic accidents is higher than the England average. 75 children were killed or seriously injured on the roads in 2009-2011.

A higher than average proportion of children are judged to have achieved a good level of development at the end of the foundation stage, with 73.5% achieving this milestone. The foundation stage assessment is completed in the final term of the academic year in which a child reaches the age of five.

YHPHO
YORKSHIRE & HUMBER PUBLIC HEALTH OBSERVATORY

NorthWest Public Health Observatory

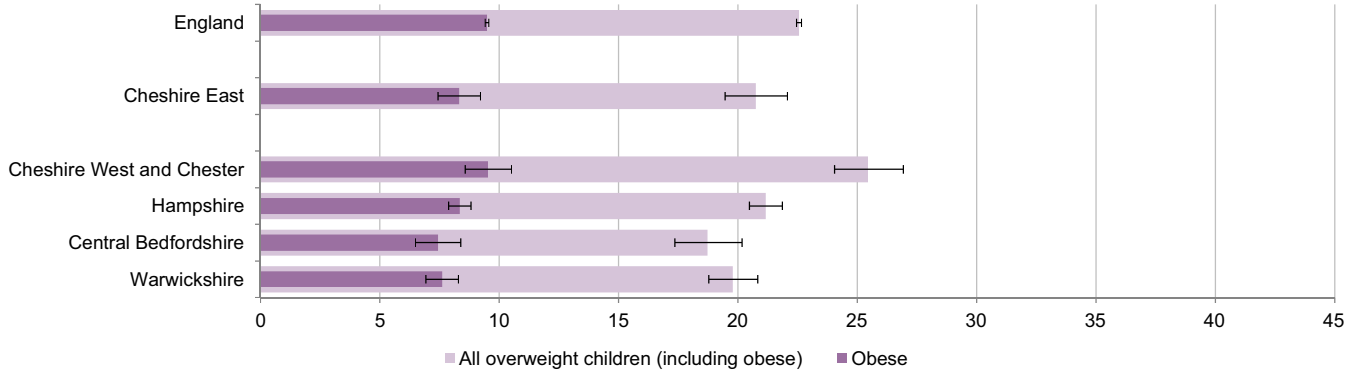
NHS North West

ChiMat is funded by the Department of Health and is part of YHPHO.
This profile is produced by ChiMat working with NWPHO on behalf of the Public Health Observatories in England.

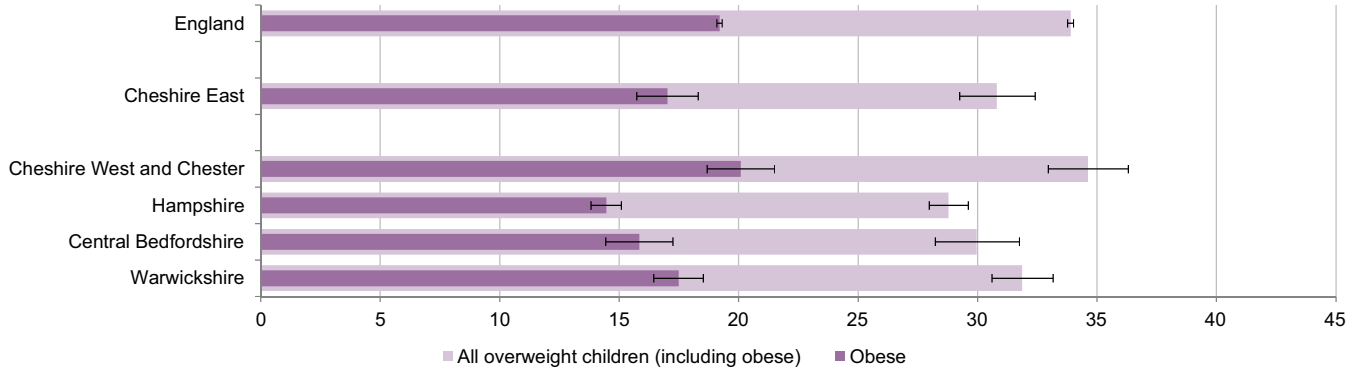
Childhood obesity

These charts show the percentage of children classified as obese or overweight in Reception (aged 4-5 years) and Year 6 (aged 10-11 years) by local authority compared to their statistical neighbours. This area has a lower percentage in Reception and a lower percentage in Year 6 classified as obese or overweight compared to the England average.

Children aged 4-5 years classified as obese or overweight, 2011/12 (percentage)



Children aged 10-11 years classified as obese or overweight, 2011/12 (percentage)



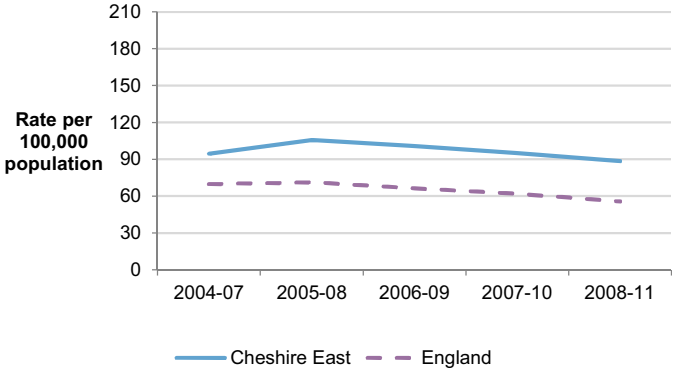
Note: This analysis uses the 85th and 95th centiles of the British 1990 growth reference (UK90) for BMI to classify children as overweight and obese.
I indicates 95% confidence interval.

Data source: National Child Measurement Programme (NCMP), The Information Centre for health and social care

Young people and alcohol

Young people aged under 18 admitted to hospital with alcohol specific conditions (rate per 100,000 population aged 0-17 years)

In comparison with the 2004-07 period, the rate of young people under 18 who are admitted to hospital because they have a condition wholly related to alcohol such as alcohol overdose remains broadly similar in the 2008-11 period. Overall rates of admission in the 2008-11 period are higher than the England average.

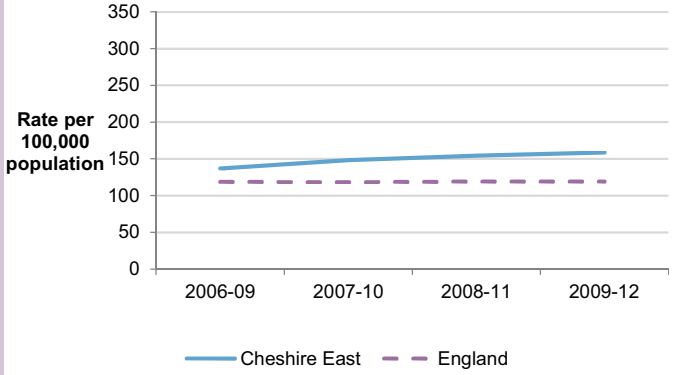


Data source: Local Alcohol Profiles for England, North West Public Health Observatory

Young people's mental health

Young people aged under 18 admitted to hospital as a result of self-harm (rate per 100,000 population aged 0-17 years)

In comparison with the 2006-09 period, the rate of young people under 18 who are admitted to hospital as a result of self-harm has increased in the 2009-12 period. Overall rates of admission in the 2009-12 period are higher than the England average*. Nationally, levels of self-harm are higher among young women than young men.

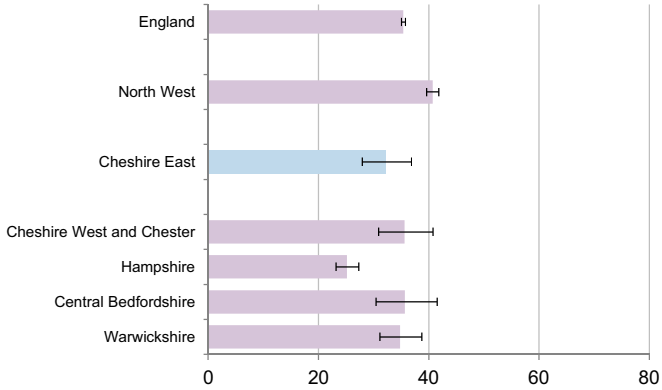


*Information about admissions in the single year 2011/12 can be found on page 4

Data source: Hospital Episode Statistics, The Information Centre for health and social care

These charts compare Cheshire East with its statistical neighbours, the England and regional average and, where available, the European average.

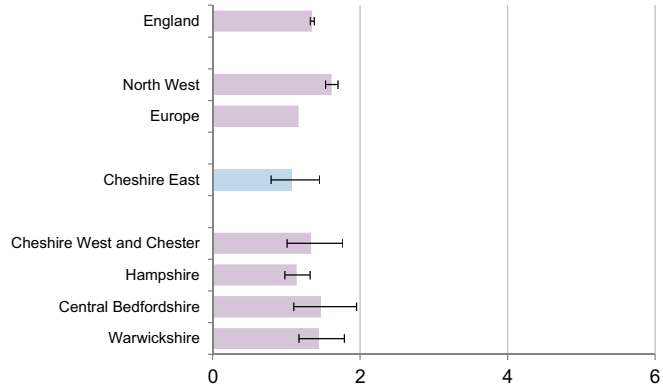
Teenage conceptions in girls aged under 18 years, 2010 (rate per 1,000 female population aged 15-17 years)



In 2010, approximately 32 girls aged under 18 conceived for every 1,000 of the female population aged 15-17 years in this area. This is lower than the regional average. The area has a similar teenage conception rate compared to the England average.

Data source: Department for Education

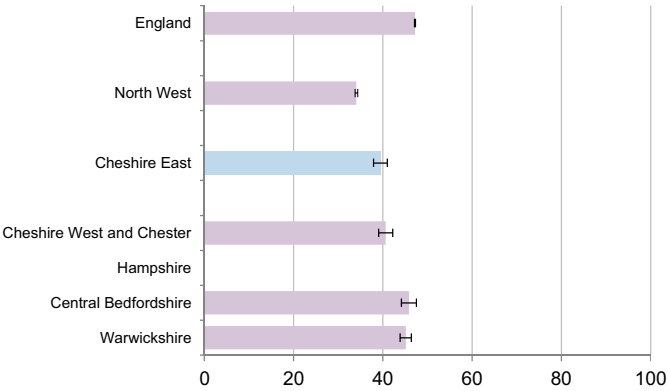
Teenage mothers aged under 18 years, 2011/12 (percentage of all deliveries)



In 2011/12, 1.1% of women giving birth in this area were aged under 18 years. This is lower than the regional average. This area has a similar percentage of births to teenage girls compared to the England average and a similar percentage compared to the European average of 1.2%*.

Data source: Hospital Episode Statistics, The Information Centre for health and social care
* European Union 27 average, 2009. Source: Eurostat

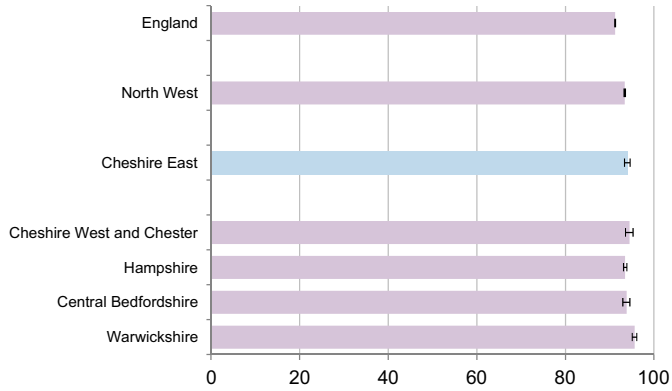
Breastfeeding at 6 to 8 weeks, 2011/12 (percentage of infants due 6 to 8 week checks)



In this area, 39.4% of mothers are still breastfeeding at 6 to 8 weeks. This is lower than the England average. 68.3% of mothers in this area initiate breastfeeding when their baby is born. This area has a lower percentage of babies who have ever been breastfed compared to the European average of 89.1%*.

Data source: Department of Health
* European Union 21 average, 2005. Source: Organisation for Economic Co-operation and Development (OECD) Social Policy Division

Measles, mumps and rubella (MMR) immunisation by age 2 years, 2011/12 (percentage of children age 2 years)



A higher percentage of children (94.0%) have received their first dose of immunisation by the age of two in this area when compared to the England average. By the age of five, the percentage of children who have received their second dose of MMR immunisation is lower with 89.7% of children being immunised. This is higher than the England average. In the North West, there were 31 laboratory confirmed cases of measles in young people aged 19 and under in the past year.

Data source: The Information Centre for health and social care, Health Protection Agency

Note: Where no data are available or have been suppressed, no bar will appear in the chart for that area.

Summary of child health and well-being in Cheshire East

The chart below shows how children's health and well-being in this area compares with the rest of England. The local result for each indicator is shown as a circle, against the range of results for England which are shown as a grey bar. The red line indicates the England average. The key to the colour of the circles is shown below.

- Significantly worse than England average
- Not significantly different
- Significantly better than England average
- Regional average

England average: 25th percentile – 75th percentile

range of values that differ significantly from the average

	Indicator	Local no. per year	Local value	Eng. ave.	Eng. worst	Eng. best
Preventable mortality	**1** Infant mortality rate	14	3.4	4.4	8.0	2.2
	2 Child mortality rate (age 1-17 years)	7	10.4	13.7	23.7	7.5
Health protection	**3** MMR immunisation (by age 2 years)	4,981	94.0	91.2	78.7	97.2
	4 Diphtheria, tetanus, polio, pertussis, Hib immunisations (by age 2 years)	5,156	97.3	96.1	85.7	98.8
	5 Children in care immunisations	335	97.1	83.1	0.0	100.0
	6 Acute sexually transmitted infections (including Chlamydia)	1,287	31.6	35.6	75.2	19.9
Wider determinants of ill health	**7** Children achieving a good level of development at age 5	2,908	73.5	63.5	51.5	76.5
	8 GCSE achieved (5A*-C inc. Eng and maths)	2,420	61.9	59.4	40.9	79.6
	9 GCSE achieved (5A*-C inc. Eng and maths) for children in care	-	-	14.6	0.0	40.0
	10 Not in education, employment or training (age 16-18 years)	680	5.5	6.1	11.8	1.6
	11 First time entrants to the Youth Justice System	232	663.9	876.4	2,436.3	342.9
	12 Children living in poverty (aged under 16 years)	8,430	13.0	21.1	45.9	7.4
	13 Family homelessness	64	0.4	1.7	7.4	0.1
	14 Children in care	435	58.0	59.0	150.0	19.0
	15 Children killed or seriously injured in road traffic accidents	25	38.0	22.1	47.9	4.4
Health improvement	**16** Low birthweight	267	6.6	7.4	11.0	5.0
	17 Obese children (age 4-5 years)	307	8.3	9.5	14.5	5.8
	18 Obese children (age 10-11 years)	557	17.0	19.2	27.8	12.3
	19 Participation in at least 3 hours of sport/PE	27,190	59.1	55.1	40.9	79.5
	20 Children's tooth decay (at age 12)	-	0.6	0.7	1.5	0.2
	21 Teenage conception rate (age under 18 years)	209	32.2	35.4	64.7	6.2
	22 Teenage mothers (age under 18 years)	41	1.1	1.3	2.8	0.3
	23 Hospital admissions due to alcohol specific conditions	67	88.6	55.8	138.3	16.9
	24 Hospital admissions due to substance misuse (age 15-24 years)	40	101.1	69.4	186.3	25.7
Prevention of ill health	**25** Smoking in pregnancy	572	15.4	13.2	29.7	2.9
	26 Breastfeeding initiation	2,537	68.3	74.0	41.8	94.3
	27 Breastfeeding at 6-8 weeks	1,563	39.4	47.2	19.7	82.8
	28 A&E attendances (age 0-4 years)	6,987	345.4	483.9	1,187.4	136.3
	29 Hospital admissions due to injury (age under 18 years)	1,048	139.7	122.6	211.1	72.4
	30 Hospital admissions for asthma (age under 19 years)	179	224.9	193.9	484.4	73.4
	31 Hospital admissions for mental health conditions	96	128.0	91.3	479.7	22.6
	32 Hospital admissions as a result of self-harm	105	140.0	115.5	311.9	26.0

Notes and definitions - Where data are not available or have been suppressed, this is indicated by a dash in the appropriate box.

1 Mortality rate per 1,000 live births (age under 1 year), 2009-2011
2 Directly standardised rate per 100,000 children age 1-17 years, 2009-2011
3 % children immunised against measles, mumps and rubella (first dose by age 2 years), 2011/12
4 % children completing a course of immunisation against diphtheria, tetanus, polio, pertussis and Hib by age 2 years, 2011/12
5 % children in care with up-to-date immunisations, 2012
6 Acute STI diagnoses per 1,000 population aged 15-24 years, 2011
7 % children achieving a good level of development within Early Years Foundation Stage Profile, 2012
8 % pupils achieving 5 or more GCSEs or equivalent including maths and English, 2011/12
9 % children looked after achieving 5 or more GCSEs or equivalent including maths and English, 2011/12 (provisional)
10 % not in education, employment or training as a proportion of total age 16-18 year olds known to local Connexions services, 2011
11 Rate per 100,000 of 10-17 year olds receiving their first reprimand, warning or conviction, 2010/11
12 % of children aged under 16 living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income, 2010
13 Statutory homeless households with dependent children or pregnant women per 1,000 households, 2011/12
14 Rate of children looked after at 31 March per 10,000 population aged under 18, 2012
15 Crude rate of children age 0-15 years who were killed or seriously injured in road traffic accidents per 100,000 population, 2009-2011
16 Percentage of live and stillbirths weighing less than 2,500 grams, 2011
17 % school children in Reception year classified as obese, 2011/12
18 % school children in Year 6 classified as obese, 2011/12
19 % children participating in at least 3 hours per week of high quality PE and sport at school age (5-18 years), 2009/10
20 Weighted mean number of decayed, missing or filled teeth in 12 year olds, 2008/09
21 Under 18 conception rate per 1,000 females age 15-17 years, 2010
22 % of delivery episodes where the mother is aged less than 18 years, 2011/12
23 Crude rate per 100,000 under 18 year olds for alcohol specific hospital admissions, 2008-11
24 Directly standardised rate per 100,000 (age 15-24 years) for hospital admissions for substance misuse, 2009-12
25 % of mothers smoking at time of delivery, 2011/12
26 % of mothers initiating breastfeeding, 2011/12
27 % of mothers breastfeeding at 6-8 weeks, 2011/12
28 Crude rate per 1,000 (age 0-4 years) of A&E attendances, 2010/11
29 Crude rate per 10,000 (age 0-17 years) for emergency hospital admissions following injury, 2011/12
30 Crude rate per 100,000 (age 0-18 years) for emergency hospital admissions for asthma, 2011/12
31 Crude rate per 100,000 (age 0-17 years) for hospital admissions for mental health, 2011/12
32 Crude rate per 100,000 (age 0-17 years) for hospital admissions for self-harm, 2011/12

Ageing Well in Cheshire East
A programme for people aged 50 and over
2012 – 2017

Annual Report
2012 - 13

1. Overview of the Programme

The ageing population of Cheshire East represent an enormous resource in terms of talent, experience and knowledge. “Ageing Well in Cheshire East” is seeking to make the borough a good place to grow old by maximising the opportunities for the ageing population to prepare for the later stages of life, maintain their quality of life during later life and have access to person centred services when required.

The Programme is founded on the principle that we wish to enable our ageing population;

- To have a strong voice in influencing local policy and services
- To take and maintain responsibility for their lives
- To remain healthy and active
- To retain their independence
- To ensure access to services
- To benefit from and contribute through employment, volunteering and learning
- To live in a safe environment that maintains links with family and friends
- To maintain their roles as partners, carers, grandparents, employees, etc.

If the programme is successful then Cheshire East will see a fundamental cultural and organisational shift, so that, over time,

- Older people will have more choice and control, can receive the help they need and are valued and respected within their communities
- Public, private and voluntary sectors will work together with communities in a seamless way to ensure services, facilities and resources meet demand and are accessible
- Services and support will be locally based, cost-effective and sustainable

Ageing Well in Cheshire East was launched early in 2012 and is based on seven work streams which reflect the issues that older people told us were most important to them:

- Care and Support
- Communication and Engagement
- Community Safety
- Healthy Ageing, Culture and Learning
- Housing
- Income and Employment
- Transport

Throughout the development of the programme we have consulted with older people. Local residents remain involved in our activities, with representatives from the Fifty Plus Network and Cheshire East Local Involvement Network (LINks) on each of our work stream groups, steering group and Programme Board. We look forward to working with Cheshire East Healthwatch as it takes over from LINks in the coming year

The Ageing Well Programme reports to the Cheshire East Health and Wellbeing Board. The Programme supports the delivery of the Health and Wellbeing Strategy as follows:

	Health and Wellbeing Strategy Priority Outcome - Older People Targets for this outcome				
Work Stream	**Improve Care for Older People**	**Support older people to live independently for longer**	**Reduce the number of older people that have falls**	**Provide good palliative care for people at the end of life**	**Support older people with end of life planning**
Care and Support	✓	✓	✓	✓	
Community Safety		✓			
Healthy Ageing Culture and Learning		✓	✓		
Housing	✓	✓	✓		
Income and Employment		✓			✓
Transport		✓			

Further information about the **Ageing Well in Cheshire East Programme - A plan for people aged 50 and over - 2012 – 2017** can be found at:
www.cheshireeast.gov.uk/ageingwell

2. Delivery of Work Streams

The seven work streams are the foundation of the Programme and are where the work happens. Each one works differently, reflecting the people and organisations involved. The work is recorded in a detailed set of action plans, which include outcomes and where appropriate measurements. Below are some of the highlights from 2012/13:

- 160 hits for our online video capturing the experiences of Older People in Cheshire East (Communication and Engagement work stream)
- Events celebrating International Older People's Day including the Cheshire Hidden Talent Show (Communication and Engagement work stream)
- 266 people attended Be Steady, Be Safe exercise classes to help reduce their risk of falls (Healthy Ageing work stream)
- 350 people trained as InfoLink Champions and accreditation of the InfoLink scheme. InfoLink is a centralised directory of services in Central and Eastern Cheshire that can help support health and wellbeing. For further information, visit www.infolinkcheshire.nhs.uk (Healthy Ageing work stream)
- Almost 50% of all learners engaged on adult learning programmes delivered by Cheshire East Lifelong Learning service are over 50 years of age (2011-12) (Learning work stream)
- Regular Rural Touring Arts events are held at Oakmere Avantage Extra Care Housing (Culture work stream)
- Arts and dementia activities rolled out across the borough (Culture work stream)
- Nantwich Museum and Bridgend Heritage Centre currently developing memory box resources and service for dementia sufferers (Culture work stream)
- Progress on the enhanced housing options which will enable better access to information for specialist housing options (Housing work stream)
- Delivery of the winter warmth campaign (Housing work stream)
- Delivery of the house of Hazards campaign to raise awareness of home safety issues and prevent falls (Healthy Ageing work stream)
- Work with Plus Dane Housing to develop a quick referral tool with five key questions for use with tenants (Housing work stream)
- Poynton Local Area Partnership are developing a list of reliable tradespeople to whom people can be signposted (Local Area Partnerships)
- Establishing the Income and Employment work stream from the many diverse areas involved in promoting income, employment and preparing for later life, but who had previously not worked together (Income and Employment work stream)
- Promoting the use of the Hot Spots scheme which allows people to ask for benefits review via a simple card left in their home by a front line worker (Income and Employment work stream)
- Sharing knowledge on dignity and local action taking place to ensure services are planned and provided to maintain dignity (Care and Support work stream)
- Increasing understanding of assistive technology and identifying areas where its use can be promoted (Care and Support work stream)

3. Highlights of 2012 - 13

In addition to the work streams the Ageing Well Programme has led a number of programme wide events and initiatives. These include:

3.1 Launch Event

Ageing Well in Cheshire East was formally launched in January 2012 at Legends Social Club in Crewe by the Chief Executive of Cheshire East Council.

The programme included talks by local older people from the Fifty Plus Network, who shared their own experiences of ageing with great enthusiasm, energy and passion and a more formal presentations about the National Ageing Well Programme by the Director for Ageing Society and State Pensions from the Department of Work and Pensions.

The event was very well attended with representatives from over 40 different organisations. Delegates also took the opportunity to meet the work stream leads and to browse a range of market place stands.

3.2 Programme Board

As part of the governance arrangements for the Programme, we have established a Board for the Ageing Well Programme. We received support from the national Ageing Well Programme team to recruit our Board Members from a wide range of organisations and have a membership whose different backgrounds and knowledge of different sectors is a real asset to the Programme.

A diagram showing all of our board members is shown on page 9.

3.3 Learning Event with Warrington

To mark the end of the support from the national Ageing Well Programme, Cheshire East hosted a learning exchange event with Warrington. The event enabled over 50 people from the two areas to share their learning and look at how the work could be sustained in the future. The event also included presentations and workshops on issues that needed further consideration in future years.

Brian Keating, from the Department of Work and Pensions (DWP), described the national picture and guest speakers from London and Manchester provided thought provoking information and examples of tackling social isolation and alcohol screening and prevention. Those present had a chance to debate these topics and develop local action plans to feed into the respective local ageing well programme.

3.4 Embracing the Older Generation

This event in October 2012 was the faith communities response to the Cheshire East Ageing Well Programme – it began as an idea to gather together a few people from churches and faith groups who work and volunteer with older people to share ideas, stories and experience but rapidly grew into a one day conference where people were able to encourage one another and increase understanding of the challenge of meeting the needs of the growing number of older people in Cheshire East.

Groups explored a range of themes including

- Living with loss & bereavement support
- The Cheshire Living Well Dying Well Programme

- Spirituality in older age
- Men ageing
- Improving spiritual and pastoral support in residential care.
- What people said:

Feedback was overwhelmingly positive and a range of potential projects were identified, including

- Setting up and training groups to offer friendship and support to those experiencing loss and bereavement
- Using church buildings and events as hubs for information, advice and support
- Addressing the specific concerns of men as they age and face significant transitions in life

3.5 Health and Wellbeing Fayre

Crewe and Nantwich Senior Forum and Crewe Local Area Partnership worked together to stage a Health and Wellbeing Fayre with the aim to provide an innovative method of engaging the wider community on the hot topic of Ageing Well in Crewe.

The event provided a one stop shop for people to access valuable health information and also acted as an opportunity for service providers who are tackling healthy ageing an opportunity to meet service users.

Over 300 older people attended the event and left better informed about what is happening in their area. Crewe LAP informed people about the priorities for the Crewe Area Plan 2013, and consulted on health issues affecting the ageing population.

3.6 Working Together on the Moss

The Moss Rose Estate is situated about a mile away from Macclesfield town centre and is home to approximately 6,000 people. A fifth of the population living on the Moss Rose Estate are pensioners and more than a third of this group are aged over 80.

Statistics demonstrate high levels of deprivation compared to other areas of Macclesfield within close proximity, highlighting the contrast of a 'pocket of disadvantage' surrounded by an area of some affluence, a fact which reinforces the strong sense of community on the Estate.

Working Together on the Moss was established as a community budgeting pilot for Cheshire East, with a Steering Group established in February 2011.

Following consultation with local residents, a range of activities has taken place to improve the quality of life for older people including the provision of a central, accessible and safe meeting place for social activities and regular lunch clubs. Plans are now being developed to improve older people's access to information technology both at home and in community venues.

The Ageing Well programme team worked to adapt the national self-assessment tool developed for use with strategic partnerships for use with local communities and tested this out with a group of older people and agencies on the Moss Rose Estate.

Following this engagement and consultation with local residents, a range of activities have taken place to improve the quality of life for older people including the provision of a central, accessible and safe meeting place for social activities and regular lunch clubs. Plans are now being developed to improve older people's access to information technology both at home and in community venues and promote the local pharmacy services, e.g. minor ailments and medication reviews.

4. Cheshire Living Well, Dying Well Partnership

The Cheshire Living Well, Dying Well Partnership aims to improve health and wellbeing by normalising death and dying in society, breaking down taboos and supporting a change in public knowledge, attitude and behaviour so that people consider, discuss and plan for end of life throughout their lives.

The Partnership is supported by St. Luke's (Cheshire) Hospice, Macmillan Cancer Support and the local Public Health Teams.

The highlights for 2012 - 13 were as follows:

- Making a presentation to the All Party Parliamentary Group on the Living Well, Dying Well Partnership at the House of Lords. This was an opportunity to highlight the innovative nature of the work being done in Cheshire and the unique way in which it is funded
- Launching CLWDW at an event which included a keynote address from Fiona Bruce MP
- Developing of a range of support and training sessions for the community and wider public health workforce

5. Plans for Year 2 (2013 – 14)

5.1 Delivery of work streams

We will continue to deliver the programme through our work streams who will deliver the Programme objectives over the next 4 years. A programme action plan captures the full detail of the work plans and can be made available. Below is a sample of the plans:

- Continue to develop schemes such as Street Safe and Nominated Neighbours that promote social inclusion and support older people to feel safe within their communities
- Development of a Falls Awareness E-Learning training programme for key front line staff
- Support museums and heritage venues to develop and deliver dementia friendly services
- Development of cultural programmes and activities in partnership with other agencies and partners, to meet the needs of vulnerable older people contributing to their physical and mental health and wellbeing
- Tackle fuel poverty and improve the energy efficiency and condition of older people's homes
- Improve access to suitable housing for people with disabilities and care needs
- Develop and implement a new Community Transport Grants scheme that supports local transport initiatives

5.2 Focus on social Isolation

Social isolation is a recurring theme and one that cuts across all of our work streams. We will take a Programme wide approach and work with other partners to review how we can link up what is already

in place in communities and consider what additional action is required to reduce the impact of loneliness on local people.

We are planning to work with the Department of Work and Pensions Ageing Society Team (DWP) to progress ageing well with local Parish and Town Councils and Local Area Partnerships, which will include actions to strengthen community cohesion and reduce loneliness.

5.3 Links to other Programmes of Work

Although Ageing Well in Cheshire East is a broad ranging Programme there are a number of issues that fall outside our remit as they are already part of existing programmes of work. These issues include Dementia, Carers, Safeguarding of vulnerable adults and End of Life Care. In year 2 we will formalise our links with these other programmes to ensure that there are no gaps and to encourage closer working between different programmes where this will deliver better outcomes for older people.

5.4 Good Retirement Show

Feedback from older people and from our work stream membership tells us that people do not always feel well prepared for their later life. We are proposing to hold an event for members of the public (of all ages) to come and find out more about what to expect from retirement, how people can plan in order to “Age Well” and what help is available to support people in making decisions for their later life.

5.5 3 Million Lives (3ML)

Eastern Cheshire Clinical Commissioning Group and Cheshire East Council have been successful in being selected as a pathfinder site for the "3 Million Lives" initiative to deliver the challenge of providing 10,000 people with long term health conditions with new technologies to improve their health.

5.6 Anticipated challenges – Spreading the Ageing Well programme across Cheshire East

The economic downturn will continue in year 2 of the Programme and we will continue to work with very limited resources. In fact we are recognised by the DWP as being outstanding in what we have managed to achieve with no dedicated budget. As we know, Ageing Well in Cheshire East relies primarily on people making a difference through their “day jobs”. It is the intention to continue to spread the work of the programme across greater numbers of people and organisations, thereby enabling the programme to continue to progress through many people making small actions/changes that contribute in a big way to making Cheshire East a better place to grow old.

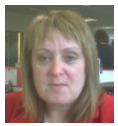
Acknowledgements

The Ageing Well Programme Team would like to extend an enormous thank you to everyone who has been involved in any way in assisting in the delivery of Year 1 of the programme. It would not have been possible without your passion, commitment and time. We hope that you will continue to work with us during Year 2 as we all strive to make Cheshire East a “good place to grow old”.

Bernadette Bailey
Programme Lead

The Ageing Well Programme Board

	Name	Organisation	Work stream/Project
	Madelyn Bridge	Age UK Cheshire East	3 Million Lives
	Bill Brookes	Cheshire East LINk	Care and Support work stream
	Cllr David Brown	Cheshire East Council	
	Cllr Janet Clowes	Cheshire East Council	Parish Councils
	Mike Doran (Chair)	Plus Dane Housing	Income and Employment work stream
	Jacquie Grinham	Cheshire East Congress	Transport work stream
	Cllr Olivia Hunter	Cheshire East Council	Good Retirement Show
	Carolyn McQuaker	Go Project and the faith sector	Communications and Engagement work stream

	Name	Organisation	Work stream/Project
	Evan Morris	Cheshire Fire and Rescue Service	3 Million Lives
	Dr Sabu Oomman	Cheshire and Wirral Partnership NHSFT	Cheshire East Dementia Strategy
	Davina Parr	Cheshire East Council	Cheshire East Dementia Strategy
	Lucia Scally	Cheshire East Council	Transport work stream
	David Scott (Deputy Chair)	Fifty Plus Network	Care and support work stream
	Kath Senior	East Cheshire NHS Trust	Healthy Ageing, Culture and Learning work stream
	Lawrence Tudin	SAS Daniels	Housing work stream
	Jacki Wilkes	NHS Eastern Cheshire CCG	Cheshire East Dementia Strategy

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Health and Wellbeing Board

Date of Meeting:	25 June 2013
Report of:	Director of Children's Services
Subject/Title:	Children and Families Bill

1.0 Report Summary

1.1 This report sets out the main provisions of the Children and Families Bill, in particular, the changes to arrangements for children with special educational needs (SEN).

2.0 Decision Requested

2.1 The Board is asked to:

2.2 note the content of the report

2.3 nominate appropriate colleagues from health (NHS,CCG) to join the SEN Strategy Group

2.4 request a progress report on the local offer and single plan to be reported at the next Health and Wellbeing Board

2.5 request the SEN strategy group report progress towards implementation of new SEN Code of Practice on a regular basis to the Health and Wellbeing Board.

3.0 Reasons for Recommendations

3.1 For the Health and Wellbeing Board to gain a better understanding of the Children and Families Bill, in particular the impact on children with SEN.

4.0 Policy Implications - Health

4.1 The local authority will need to revise its policies and procedures around SEN to reflect the requirements of the new law, regulations and code of practice when they take effect.

5.0 Financial Implications

5.1 There will be financial implications particularly in regard to personal budgets and this needs further development.

6.0 Legal Implications

6.1 If implemented, the Children and Families Bill will replace some of the existing legislation and statutory guidance around SEN, family law, adoption, childcare and statutory rights to leave, pay and time off work.

7.0 Risk Management

7.1 If Cheshire East and its partners are not fully prepared for the implementation of the Children and Families Bill there is a risk of non compliance and to reputation.

8.0 Background

8.1 The Children and Families Bill, which was introduced to Parliament on 5th February 2013, takes forward the Coalition Government's commitment to improve services for vulnerable children and support strong families. It underpins wider reforms to ensure that all children and young people can succeed, no matter what their background. The Bill will reform the systems for adoption, looked after children, family justice and special educational needs. It will encourage growth in the childcare sector, introduce a new system of shared parental leave and ensure children in England have a strong advocate for their rights. Royal assent is expected in Spring 2014 for implementation in September 2014.

9.0 Main provisions of the Bill

9.1 **Adoption -** Children wait an average of almost two years between entering care and moving in with an adoptive family. The Bill aims to reduce delays by supporting the reforms set out in *An Action Plan for Adoption: Tackling Delay.* This includes promoting fostering for adoption and improving support for adoptive families.

9.2 **Virtual school head (VSH) -** The educational attainment of cared for children, whilst improving, is not doing so fast enough. The Bill will require every local authority to have a virtual school head to champion the education of children in the authority's care, as if they all attended the same school.

9.3 **Family justice system -** The Bill will implement commitments the Government made in response to the Family Justice Review, including introducing a time limit of 26 weeks when courts are considering whether a child should be taken into care and making sure more families have the opportunity to try mediation before applying to court.

9.4 **Childcare -** The enabling measures in the Bill support wider reforms to substantially increase the supply of high quality, affordable and available

childcare and include introducing childminder agencies to help more childminders into the market and offer greater support and quality assurance and removing bureaucracy so that it is easier for schools to offer wrap-around care.

9.5 **Office of the Children's Commissioner (OCC) -** The Bill will help improve the Children's Commissioner's effectiveness, taking forward recommendations in John Dunford's *Review of the Office of the Children's Commissioner (England)* including giving the Commissioner a statutory remit to promote and protect children's rights.

9.6 **Shared parental leave and flexible working -** The Government is committed to encouraging the full involvement of both parents from the earliest stages of pregnancy, including by promoting a system of shared parental leave, and to extending the right to request flexible working to all employees. The Bill will implement the commitments in the Government's response (November 2012) to the modern workplaces consultation.

9.7 **Special Educational Needs (SEN) -** The Government is transforming the system for children and young people with special educational needs (SEN), including those who are disabled, so that services consistently support the best outcomes for them.

10.0 **Focus on Special Educational Needs (SEN)**

Children and Families Bill

10.1 The Children and Families Bill will extend the SEN system from birth to 25, giving children, young people and their parents greater control and choice in decisions and ensuring needs are properly met. It takes forward the reform programme set out in *Support and aspiration: A new approach to special educational needs and disability: Progress and next steps.*

10.2 The Bill includes the following clauses:

- A new duty for joint commissioning which will require local authorities and health bodies to work in partnership when arranging provision for children and young people with SEN.
- A requirement on local authorities to publish a "local offer" of services they expect to be available for children and young people with SEN.
- A duty on local authorities to draw up Education, Health and Care plans.
- A requirement on all local authorities to prepare a personal budget for children or young people with an EHC Plan if asked to do so by the child's parent or the young person.

10.3 The Children and Families Bill received its Second Reading in the House of Commons on 25 February 2013. During this, Parliamentarians identified a number of areas where they wanted to see further debate including:

- Whether children with health and social care needs, but without significant educational needs, should be eligible for Education, Health and Care plans.
- Placing stronger duties on health and social care services to provide the services identified in Education, Health and Care plans
- The creation of a single point of appeal about the content of Education, Health and Care plans;
- How the provision set out in the local offer could be strengthened

Draft Regulations and the indicative draft Code of Practice

10.4 On 15 March 2013 the Government released an 'indicative' version of a new Special Educational Needs Code of Practice and draft new regulations to support the Children and Families Bill. The draft regulations give an indication of how the new legal framework will work in more detail. They cover a number of sections in the Bill, including the local offer, Education, Health and Care assessments and plans and SEN information

10.5 The move to minimise statutory requirements and put in place a framework requiring co-operation between LAs, partner agencies and providers and parents, children and young people with SEN is still the subject of great debate. Many are concerned that removing School Action Plus, statements of special educational need and downgrading review rights will leave parents worse off even though placing them at the heart of new processes. There are also concerns that, with no common format, EHC plans may create more confusion for parents, particularly over what is legally enforceable.

10.6 As there is limited prescription, the local authority can set out local arrangements with parents and other groups, but will need to work with health partners to clarify what the role of relevant clinical commissioning groups in the local context.

10.7 Some of the detail (for example on the role of the SENCO in early years settings, or on managing transition) is to be added later. This will be particularly important given the intention to focus more on preventative approaches, early intervention and support.

11.0 Access to Information

The background papers relating to this report can be inspected by contacting the report writer:

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